Partnership Planning Region III Regional Admissions Procedures

Serving the individuals and communities for the following Community Service Boards (CSBs) and State Facilities:

Cumberland Mountain Community Services (CMCS), Dickenson County Behavioral Health Services (DCBHS), Highlands Community Services (HCS), Mount Rogers Community Services Board (MRCSB), New River Valley Community Services (NRVCS) and Planning District 1 Behavioral Health Services (PD1 BHS).

Southwestern Virginia Mental Health Institute (SWVMHI) and Southwestern Virginia Training Center (SWVTC).

These written Policies and Procedures will strengthen the regional safety net for individuals with serious mental illness including those with co-occurring intellectual disabilities and/or substance use disorders. By clearly outlining the sequence involved in seeking a bed for an emergency situation it will improve both understanding and expectations among the CSBs, state facilities, private hospitals, members of law enforcement and other public safety stakeholders.

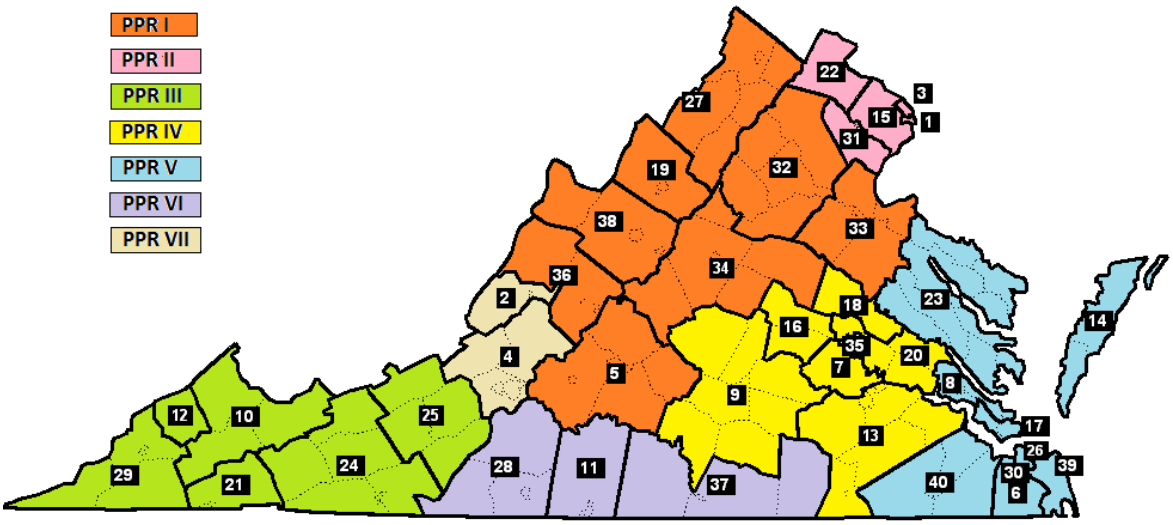
It may be impossible to develop a policy for every contingency and variable within an emergency evaluation and search for an appropriate bed. But it is possible to outline the communication process and decision points when a safety net bed must be accessed. The search for a bed outside of the region and involvement of additional services for individuals with additional needs (Intellectual Disability, Deaf/HoH, etc.) is also outlined.

The Southwest Virginia Behavioral Health Board is the Regional Management Group for the Partnership Planning Region III (PPR III) of far Southwest Virginia. It is comprised of the Executive Directors of the six CSBs, State Facility Directors for SWVMHI and SWVTC and 6 consumer and family members from the region. The Memorandum Of Agreement for the Southwest Virginia Behavioral Health Board (SWV BHB) directs the overall management of regional projects such as the Local Inpatient Purchase Of Services (LIPOS) and Discharge Assistance Project (DAP) in the manner required by the Department of Behavioral Health and Developmental Services (DBHDS) in the Performance Contract. The SWV BHB will amend this same Memorandum Of Agreement to include these Regional Admissions Procedures and the Quality Improvement Process described within. These policies and procedures will be updated and amended as experience and necessity requires with substantive changes being made available to all stakeholders impacted by any such changes.

Partnership Planning Region III (PPR III)		
Community Service Board	Emergency Services Contact Information:	Serving Counties/Cities of:
Cumberland Mountain Community Services (CMCS)	Weekdays, 0830-1630 - Cedar Bluff: 276-964-6702; Tazewell: 276-988-7961; Lebanon: 276-889-3781; Grundy: 276-935-7154. After Hours, Wkends, etc: 800-286-0586	Buchanan, Russell & Tazewell Co.
Dickenson County Behavioral Health Services (DCBHS)	276-926-1680	Dickenson Co.
Highlands Community Services (HCS)	276-676-6277	Washington Co. & Bristol City
Mount Rogers Community Services Board (MRCSB)	Weekdays, 0830-1700 – Carroll/Grayson: 276-238-9700; Wythe/Bland: 276-223-3202; Smyth: 276-783-8185. After Hours, Wkends, etc: LE Dispatch has monthly On-Call lists for ES.	Bland, Carroll, Grayson, Smyth & Wythe Co. & Galax City
New River Valley Community Services (NRVCS)	ACCESS: 1-540-961-8400	Floyd, Giles, Montgomery & Pulaski Co. & Radford City
Planning District 1 Behavioral Health Services (PD1 BHS)	Lee: 276-346-3590; Scott: 276-225-0976; Wise: 276-523-8300	Lee, Scott & Wise Co. & Norton City

Virginia

Community Service Boards



1	Alexandria	11	Danville-Pittsylvania	21	Highlands	31	Prince William
2	Alleghany Highlands	12	Dickenson	22	Loudoun	32	Rappahannock-Rapidan
3	Arlington	13	District 19	23	Mid Peninsula-Northern Neck	33	Rappahannock Area
4	Blue Ridge	14	Eastern Shore	24	Mount Rogers	34	Region Ten
5	Central Virginia	15	Fairfax-Falls Church	25	New River Valley	35	Richmond
6	Chesapeake	16	Goochland-Powhatan	26	Norfolk	36	Rockbridge Area
7	Chesterfield	17	Hampton-Newport News	27	Northwestern	37	Southside
8	Colonial	18	Hanover	28	Piedmont	38	Valley
9	Crossroads	19	Harrisonburg-Rockingham	29	Planning District 1	39	Virginia Beach
10	Cumberland Mountain	20	Henrico Area	30	Portsmouth	40	Western Tidewater

(Other PPR Regional Admissions P&P may be found here: http://www.dbhds.virginia.gov/civilcommitmentlawchanges.htm)

Regional Admission Policies & Procedures:

In order to promote care that is geographically and culturally sensitive to residents of far Southwestern Virginia, every effort will be made to utilize private psychiatric facilities within our catchment area. Only after regional resources are exhausted would CSBs approach facilities in other regions.

When there is an Emergency Custody Order (ECO):

Notification of an Emergency Custody Order (ECO) by Law Enforcement

1. Pursuant to VA Code 37.2-808 when a Law Enforcement Officer executes an ECO and takes the individual in custody they will notify the CSB responsible for the evaluation as soon as practicable. A list of the CSBs, the counties/cities they serve and means of contacting them is listed on page 2 of this Policy & Procedures.
2. This list of CSB contact information will be made available to all Law Enforcement within the PPR III region and published by the DBHDS on their website.
3. It shall be reviewed and updated at least annually for accuracy and completeness.
4. LEO shall provide the individual taken into custody with a written summary of the emergency custody procedures and the statutory protections associated with those procedures.

Notification of an Emergency Custody Order (ECO) by CSB to State Facility.

1. Upon notification of the ECO, the CSB shall contact the state facility serving the area in which the CSB is located and notify it (giving a "Heads Up") that the individual will be transported to it upon the issuance of a TDO if an alternative facility cannot be identified by the expiration of the 8 hour emergency custody period.
2. The SWVMHI shall provide a single contact number for the CSBs to utilize for these notifications. **(Pager #: 1-800-289-2337, PIN: 7813)** When SWVMHI staff receives notification of potential referral for admission, they will record the individual's name, notifying CSB and the date and time of call. If a TDO not ultimately issued, or if the individual is accepted at another facility, the CSB will notify SWVMHI staff of such, who will then document this information accordingly.
3. If the ECO evaluation will result in a TDO admission to SWVMHI, the CSB shall provide information about the individual to the state facility to allow it to determine the services the individual will require on admission.

Contacting Private or State Facilities for a TDO admission under an ECO:

1. The preadmission screener will decide which facilities to contact, and in what order, based on the clinical presentation of the individual and the degree to which the individual is able to express preferences.
2. The preadmission screener may access the Psychiatric Bed Registry to explore possible placement options, if electronic access in-the-field permits.
3. The preadmission screener will determine the need for and timing of initiating medical assessment of stability. Medical assessment may or may not be required by private psychiatric facilities, and is dependent upon multiple factors which are better assessed in real time by the preadmission screener. See *Guidance on Medical Screening and Medical Assessment.*
4. Once the determination is made that the individual requires in-patient psychiatric care, **private facilities are to be contacted for consideration of admission in rapid succession**. The preadmission screener will not wait for decision of admission before approaching the next facility.

5. If a private psychiatric facility has made no response within 20 minutes of the referral, this will be considered a denial of admission. If a facility determines to accept the referral after the 20 minute time period, they should contact the preadmission screener with the decision.
6. The preadmission screener will maintain a list of psychiatric facilities called in pursuit of admission. The list, at a minimum, will include name of facility contacted, name of staff spoken to, time of contact, and referral outcome. This list will be provided along with the Preadmission Screening Form to the state-level facility, if that facility is ultimately contacted for consideration of admission.
7. **A referral for TDO admission to SWVMHI should be made when the ECO has 4 hours left but certainly no less than two hours, and no private facility is accepting the TDO referral.** The PAS will have called the Institute with a "Heads Up" on the execution of the ECO and now will begin the information exchange for a potential admission to the Institute.
8. In the meantime, the preadmission screener may attempt to call psychiatric facilities that previously denied admission to facilitate reconsideration. Note that the CSB may continue to seek alternative to state facility admission, if such exists.
9. In the event that the private facilities contacted do not have available beds, and before the expiration of the 8 hour ECO the individual will be admitted (or accepted for admission) to SWVMHI. The PAS will have already provided information about the individual to SWVMHI to allow them to determine the services the individual will require on admission. (SWVMHI Admissions Pager: 1-800-289-2337 and PIN#: 7813)
10. Once notified, the SWVMHI may conduct a search for alternative facility and/or may contact another state facility if it is unable to provide temporary detention and appropriate care.
11. If SWVMHI finds an alternative facility, prior to the individual's arrival, they shall notify the CSB and the CSB shall designate the alternative facility on the preadmission screening report.
12. When the TDO is executed, the individual shall be provided a written summary of the temporary detention procedures and the statutory protections associated with those procedures. Law Enforcement will likely provide this but the CSBs will also maintain copies if needed.
13. If a TDO admission occurs that causes SWVMHI to be operating over capacity and/or that another state facility is serving as emergency back-up to the region; on the next working day, the region's Community Services Boards will conduct an emergency review and discharge planning effort in conjunction with SWVMHI staff for the individuals from their catchment area who are at the state hospital(s).

SWVMHI Admissions Protocol

1. When the preadmission screener assesses the situation as requiring possible state-level admission, assessment for medical stability will be immediately facilitated. See *Guidance and Procedures for Medical Screening and Medical Assessment.* (Attachment A)
2. Within our region, SWVMHI is the state facility to be called in pursuit of placement for adults and geriatric persons who have no violent felonies, with the exception noted in *Referral of Forensic Patients to the Central State Hospital Forensic Unit.* (Attachment B)
3. Referrals are made to Central State using guideline *Referral of Forensic Patients to the Central State Hospital Forensic Unit*. (Attachment B)

4. Catawba Hospital is the first state-level facility contacted by NRVCS for geriatric admissions.
5. As noted above, admission materials should be delivered to SWVMHI if an alternative facility cannot be found within 4 hours of an 8 hour ECO, but certainly no less than two hours remaining on the ECO.
6. The Pre-Screener will call the Nurse/Admissions Coordinator, (referred to hereafter as "SWVMHI staff") who receives this alert on a specified pager (1-800-289-2337, PIN#: 7813). The SWVMHI staff member will then promptly contact the referring Pre-Screener. Should the call pertain to potential geriatric admission, the SWVMHI staff member will then contact the Geriatric Unit for further follow-up.
7. Pre-Screener conveys initial information to begin process, recorded by SWVMHI staff on SWVMHI *Admission Cover Sheet*. (Attachment C)
8. SWVMHI staff member also completes the *Call Processing Checklist*, recording information about successive procedural steps and the times at which they occur. (Attachment D*)*
9. Pre-Screener faxes Pre-Screening and any other relevant information (hereafter referred to as "Admissions Packet," or AP) to SWVMHI staff member.
10. SWVMHI staff member promptly delivers AP to Medical Officer of the Day (MOD)
11. MOD reviews AP and, within 20 minutes, contacts the evaluating physician to consult as to medical stability for transfer. If the MOD is attending to another issue of an emergent nature, call may be delayed.
12. If additional information is required for a final disposition on medical stability for transfer issues, MOD will relate this directly to attending physician.
13. When medical stability disposition made, MOD will promptly inform the SWVMHI staff member and return the AP to him/her.
14. SWVMHI staff member will contact Pre-Screener to communicate disposition.
15. On individuals accepted for admission, SWVMHI staff member will then submit Admission Cover Sheet and Call Checklist to Patient Registrar for data entry purposes.
16. Upon conclusion of admissions referral process, the Admissions Cover Sheet and Admissions Checklist will be placed in Admissions Coordinator's internal mailbox for review.

Change of Facility during the TDO period

1. **NOTE: This process only applies to Adults and not Minors**.
2. The CSB may change the facility of temporary detention and may designate an alternative facility at any point during the period of temporary detention.
3. The CSB must determine that the alternative facility is a more appropriate facility given the specific security, medical, or behavioral needs of the person.
4. CSB shall notify the Clerk of the Court that issued the TDO, of the name and address of the alternative facility.
5. If facility of temporary detention is changed, transportation is provided in accordance with 37.2-810.
6. If law enforcement or an alternative transportation provider has custody of the person when the change is made, individual shall be transported to the alternative facility. The CSB staff will communicate this through the LEO dispatch.
7. If individual has been transported to initial TDO facility, the CSB shall request the magistrate to enter an order specifying an alternative transportation provider or, if no alternative transportation provider, the local law enforcement agency where the person resides or is located if 50-mile rule is applicable.
8. For Minors, a change of facility can only occur within the first 4 hours after the expiration of the 8 hour ECO period.

Procedures when Preadmission screening occurs without an ECO

1. When the PAS is conducted without an ECO, the preadmission screener will monitor for any escalation of risk or change in the voluntary status of the individual and request an ECO or law enforcement assistance to mitigate risk to the individual and/or others.
2. When a PAS results in a recommendation for TDO and there is difficulty in finding a bed at a private psychiatric facility, the prescreener will contact SWVMHI after all reasonable options have been exhausted. Without the time constraints of an ECO, the decision about when during the process to contact SWVMHI will rely on multiple factors. These would include; but be limited to, the individual's willingness to participate in the evaluation, assessment of risk, medical stability and demands for other clinical assessments.
3. If the PAS has resulted in a recommendation for TDO and the individual refuses continued interventions or elopes from the assessment, the prescreener will request an ECO from the magistrate to complete the PAS or TDO as appropriate.

Managing Children's and Adolescent Admissions

1. The Commonwealth Center for Children & Adolescents (CCCA) is the only state facility for those under the age of 18. The 48 beds at CCCA are limited but valuable resource for the Commonwealth. Every effort will be made by CSBs to access local, regional or even extra-regional private beds for children and adolescents in need of emergency hospitalization.
2. As with adult admissions, when the expiration of an ECO time limit is a possibility while contacting private facilities; the pre-screener will contact CCCA to inform them of the developing situation.
3. As a resource to the Commonwealth, CCCA may be able to suggest alternatives outside of the region if they are near capacity or may begin the referral process to their facility. See the *CCCA Bed Management Plan*. (Attachment F)

4. If the pre-screener is completing a crisis referral or admission via TDO and there is not an ECO, then the clinical presentation of the youth along with risk-assessment will drive the decision to contact CCCA for guidance and possible referral.

Managing the Admission of Those with Intellectual Disabilities

1. When the preadmission screener suspects or has knowledge that an individual being evaluated has a co-occurring Intellectual Disability, the REACH representative will be contacted. The ID case manager may also be contacted. The REACH staff person may participate in the evaluation and provide assistance/information to the pre-screener.
2. If the individual meets the criteria for hospitalization, REACH and the ID case manager will work with the receiving facility. If the individual does not meet criteria and is not hospitalized, refer to the attached *REACH Emergency Crisis Facility Admission Flowchart*, provided by REACH Regional Coordinator. (Attachment E)
3. The preadmission screener will document on the preadmission screening form, if applicable, the name and contact information for the ID case manager and the REACH staff person that will be involved with the individual during the hospitalization.

Managing the Admission of Those who are Deaf or Hard-of-Hearing

1. Preadmission screeners follow the guideline *Serving Deaf and Hard-of-Hearing Consumers In Crisis Situations*, provided by the Regional Deaf Services Program. (Attachment G)

Utilization of Crisis Stabilization Units

1. CSUs will be accessed primarily by the CSB associated with their operation.
2. CSUs will admit those individuals with whom they can maintain a primary focus on the prevention of exacerbation of critical symptoms that could ultimately result in a more restrictive placement. The individual and their symptoms should be amenable to treatment in an unlocked, less secure environment.
3. The director of the CSU will be called for consideration of out-of-area referrals.
4. A denial of admission from a TDO capable CSU will be counted as a private denial when seeking TDO placement.

Quality Improvement Process

1. PPR III will adopt a Quality Improvement Process that will regularly review issues and problems that arise during the disposition of the civil commitment process.
2. Policies & Procedures for this QI Process are attached to this Regional Admissions Procedures.
3. Existing policies and procedures, after action reports, modifications and issues of compliance will be reviewed and communicated on a monthly basis within the region's Census And Review Team (CART). The CART serves as the regional authorization committee for LIPOS and census management issues at SWVMHI.
4. Observations and recommendations for improvement will be communicated to CSBs, SWVMHI, private facility partners and law enforcement as they are identified. Regular reports on these QI Process activities and their resolutions (solutions) will be routinely reported to the SWV BHB as well as the DBHDS as requested.

- These policies can be seen in *PPR III Quality Improvement Process* and the *Critical Event Reporting Form* attachments. (Attachments H and I)

Census Management

1. PPR III reviews and manages the census at the SWVMHI through the regional workgroups, CART and RDAP.
2. The CART meets each Monday to review LIPOS utilization, admissions and transfers to SWVMHI and also the SWVMHI monthly statistics by individual CSBs. These will include; number of admits, number of discharges, length of stay and total bed days.
3. Transfer requests to the SWVMHI are managed by a regional review of requests for available beds and prioritization of those most in need of transfer when there are more requests than beds.
4. The RDAP meets monthly and reviews the Ready For Discharge (RFD) and the Extraordinary Barriers List (EBL) from the SWVMHI. Notes on progress of individuals, barriers for community placement and plans to support the discharge are discussed by the regional workgroup.

Attachment A

Guidance and Procedures for Medical Screening and Medical Assessment.

The purposes of the medical screening is to attempt to make sure that the individual is not experiencing a serious medical event that is masquerading as a psychiatric disorder or being concealed by a psychiatric disorder and that the receiving facility can provide the medical care the individual needs.

This procedure contains key elements that will be further detailed in the forthcoming "*DBHDS Medical Screening and Medical Assessment: Guidance Materials*," developed in joint fashion with the key stakeholders.

Psychiatric hospitals and units typically have fewer medical and medical nursing resources than hospital medical and surgical units. These free standing psychiatric hospitals and psychiatric units may lack access to immediate labs or other tests (especially on a STAT basis), have no electronic monitoring capability, may not be able to provide IV fluids or medications, and may have less clinical experience on hand at both the Nursing and Physician level.

Examples of conditions which typically cannot be managed safely in these psychiatric settings include acute delirium, head trauma, unstable fractures, unstable seizure disorders, active GI bleeding, bowel obstruction, acute respiratory distress, sepsis, overdoses, open wounds, surgical drains, severe burns, intracranial bleeds, pulmonary embolus, acute drug withdrawal with autonomic instability, active labor, major serum electrolyte abnormalities, and so forth.

A typical psychiatric unit can monitor vital signs non-invasively, provide oral medications, monitor fluid "input and output," monitor pulse oximetry intermittently, institute common preventative actions, and observe for signs of distress. Units that are part of general hospitals have more immediate access to emergency medical care, STAT labs and other tests, but typically no more capacity to provide more intensive medical treatment.

Preventative monitoring and management of some drug or alcohol withdrawals can typically be done. Pregnant patients (other than high risk), individuals with HIV, individuals with type I diabetes, individuals with PEG tube feedings, and those requiring a wheelchair can typically be managed safely. Physical therapy may be available. Nursing interventions to prevent decubitus ulcers, oropharyngeal aspiration, bowel obstruction, and transmission of most communicable diseases are generally possible.

During the Pre-Admission Screening (PAS), information will obtained on past and current medical illnesses and conditions, previous psychiatric hospitalizations and medical hospitalizations, psychoactive and other medications used, and substance use or dependence, including risk for intoxication and/or substance withdrawal. If an individual is already under care of a medical facility when the PAS is requested then EMTALA regulations governing screening, stabilization and transfer will apply. And in the event that transfer seems indicated from the PAS, then the treating physician and receiving facility will make the determination of medical stability and appropriateness of such.

Given the complexity of both human illness and health care systems, each case is to be reviewed with consideration of the individual's needs, the resources of the receiving facility and the resources of the local medical community. When medical conditions are assessed to determine if they are both stable and within the capabilities of a receiving facility, these decisions shall be rendered in a timely manner by both the sending and receiving facility. The prescreener will be responsible for notifying both the evaluating facility and receiving facility of elapsing time on the ECO.

Attachment B

Referral of Forensic Patients to the Central State Hospital Forensic Unit

(November 21, 2012)

This protocol is intended to provide guidance to state facilities regarding when forensic admissions should be considered for referral to the Central State Hospital (CSH) Forensic Unit. The presumption is that local civil beds are the default admission location except in more serious criminal cases. The following guidelines apply to persons admitted to DBHDS facilities pursuant to court orders for the following: pretrial evaluation (19.2-169.1 and 19.2-169.5); competency restoration (19.2-169.2); emergency treatment (19.2-169.6). The placement of persons adjudicated unrestorably incompetent (19.2-169.3) currently in jail or housed in the community and civilly committed, while rare, should generally be considered along the same general guidelines.

General Guidelines

1. If a patient is out on bond, but has pending legal charges and has been ordered for inpatient admission, from a risk perspective he/she should be treated like any other civil admission and should therefore be admitted to a civil hospital in the absence of extenuating circumstances.
2. If a patient is an insanity acquittee on conditional release, unless he/she is being revoked for serious/dangerous violations he/she should be admitted to a civil hospital (regardless of whether he/she was conditionally released straight from the maximum security unit at CSH).
3. The presence of a felony charge should not result in automatic referral to CSH. Each potential admission should be treated on a case-by-case basis with consideration of the following factors: current level of aggressiveness in jail, history of assaults/violence, history of violence during previous admissions to a state facility, significance of escape risk (facing long [10+ years] prison sentence), other/previous violent crimes, particularly heinous aspects of history/crime, and history of victimizing frail/mentally ill. Presumption is that defendants will be admitted to a civil hospital in the absence of significant behavioral and legal considerations.

The following is a list of charges which may lead to placement in the CSH Forensic Unit. The list is in no way exclusionary, and these charges should not automatically lead to CSH admission in every case. Please see the "Comments" section for each charge for additional guidance. Each admission must be decided on a case by case basis. For guidance regarding the admission of new insanity acquittees for temporary custody, please consult the *Guidelines for the Management of Persons Found Not Guilty by Reason of Insanity.*

Charge	Code Section	Comments
Murder	18.2-31, 18.2-33	Given the escape risk, individuals charged with murder will rarely be placed in a civil hospital, but it may be appropriate when the defendant is significantly impaired or incapacitated, and currently not aggressive.
Malicious Wounding	18.2-51	Less serious offenses may be admitted to a civil hospital, particularly if there is no other history of serious aggression and the person is not currently aggressive.
Escape from jail or correctional facility	53.1-203 18.2-477	If jailed on other offense, but has history of escape, then will likely need to go to CSH.
Kidnapping by Force	18.2-47	Individuals charged with abduction not involving physical aggression may be appropriate for civil hospital placement.
Rape, Sexual Assault,	18.2-67 18.2-61	Those charged with less serious sexual charges, but that involve preying on sick/vulnerable

		individuals may go to CSH. Individuals charged with Indecent Exposure, Statutory Rape, or Sexual Battery may be considered for civil hospital placement, with consideration given to their known history of sexual offending, if any.
Participating in Riot	18.2-405	The defendant's history, current presentation, and dynamics of the alleged offense must be taken into consideration. Some individuals with this charge may be appropriate for civil hospital placement.
Robbery with Use of Firearm	18.2-58	Individuals with this charge will rarely be placed in a civil hospital, but it may be appropriate when the defendant is significantly impaired or incapacitated, and currently not aggressive.
Probation Violation for serious crimes	18.2-479	If facing imposition of large period of incarceration, then may go to CSH
Assault & Battery on Police Officer	18.2-57	If assault is serious/malicious admission to CSH may be necessary; however, many individuals with serious mental illness who incur this charge can be appropriately placed in a civil facility.
Assault & Battery (Misdemeanor)	18.2-57	Such cases can typically be admitted to civil hospitals unless there are unusual or extenuating risk factors.

Attachment C

Admission Cover Sheet

Revised 03/2014

AB – Ext. 208/409 CD - Ext.212/ 419 F - Ext. 209/435 Karol Shepard – Ext. 250

Section I to be completed by the Admission Call person:

Date: _____

Client's name: _____ DOB: _____ SSN: _____

Facility / CSB / Pre-screener's name: _____

Caller / Pre-screener's contact phone number: _____

Current location of client:_____

Admission Legal Status: ☐**Voluntary (8 hr. notice)** ☐**Voluntary before Judge** ☐**Involuntary** ☐**TDO**

Forensic, what are the charges?_____

Does the client have a current or previous history of aggression? _____

Medical / Psych Facility / Emergency Dept. phone number:_____

Medical / Psych Facility / Emergency Dept. MD name: _____

Admission call person signature:_____

Section II to be completed by the MOD/Attending on duty:

Time MOD spoke to E.R. Dept. Physician or Medical Professional: _____

From the clinical information provided by the transferring facility / Medical Professional, does the review indicate that the client's medical needs can be met at this facility? ☐YES ☐NO
(If no, document medical issues / concerns on back of form)

Admission call person notified of acceptance? ☐**YES** ☐**NO** **Time notified:** _____

Attending / MOD signature: _____

Section III to be completed by Admission Call person:

Date / Estimated time of arrival: _____ Actual time of arrival:_____

Check Team Assigned to: ☐A ☐B ☐C ☐D ☐F ☐Other: _____

Avatar Codes: Reason for admission:_____ **Referral Source:** _____
Admission call person signature:_____

Fax Numbers: AB: 276-783-0825; CD: 276-783-0824; F: 276-783-0816; Admission suite: 276-783-1216

Attachment D

Call Processing Checklist

Patient's Name: _____

Section I

1. Initial Request for Admission received at:_____ (time)
2. Contacted prescreener at: _____ (time)
3. Received initial admission packet (AP) information at: _____ (time)

   AP is:

   ☐ Legible
   ☐ Complete

4. Emergency Custody Order Issued? ☐YES ☐NO (if YES, time issued_____)

   NOTE: Contact Administrator on Call (AOC) if:

   ☐ Felony charges
   ☐ Referral from community nursing facility
   ☐ Referral from outside SWVMHI catchment area
   ☐ TDO referral when census at capacity (see capacity guidelines in call book)

5. AP delivered to Medical Officer of the Day (MOD) at: _____ (time)
6. AP received from MOD, with disposition regarding medical acceptability at: _____ (time)
7. Contacted prescreener to notify of disposition at: _____ (time)
8. If individual accepted, notified:

   ☐ Admissions clerk
   ☐ Staffing Nurse Coordinator (SNC)
   ☐ Receiving ward/unit (if different from one taking call)

Section II

9. Admissions clerk/SNC notify AOC if:

   ☐ There is admissions paperwork/legal question
   ☐ Treatment team rotation question

Attachment E

REACH Emergency Crisis Facility Admission Flowchart

Client and primary team recognize psychiatric or behavioral crisis they feel puts individual at risk

Contact local emergency services and 1-855-887-8278

Emergency services evaluates for psychiatric hospitalization while REACH co-evaluates for services. If individual meets criteria for hospitalization→ Indiivudal is hospitalized, REACH continues to follow through to facilitate discharge. This may include step down to REACH respite house. If individual does not meet criteria for hospitalization and is psychiatrically cleared:

REACH on call staff determines with REACH crisis services what service may be appropriate

If REACH on-call staff determine that the respite facility may be an appropriate service, they contact the on-call REACH supervisor

REACH on-call supervisor determines whether admission to the Respite facility is possible or appropriate, based on space availability and other current guests. If admission is not appropriate or available->REACH will attempt to locate or develop other resources that may include community/home based plan. If admission is approved:

Individual must be medically cleared, to include a chest x-ray or physician clearance of TB/other communicable disease. Signed prescriptions for all medications, and all medications must be in original containers. All documentation must be faxed to the respite facility (540) 267-3323. Admission is not approved and team should not transport until verification has occurred that all documentation has been received and reviewed at respite facility.

If admission is approved, REACH Coordinator and primary team must arrange transportation to the facility. REACH should not be relied on to be the primary transportation provider, but will assist as able.

Within 48 hours, the REACH Coordinator will schedule an admission meeting or conference call will be scheduled to discuss goals of respite and set tentative discharge date. REACH Coordinator will be the point of contact for communication while individual is at the REACH Respite facility.

Attachment F

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan
June 2014

DBHDS maintains only 48 acute inpatient psychiatric hospital beds for Virginians who are under 18 years of age. These beds are at the Commonwealth Center for Children & Adolescents (CCCA) in Stanton, which serves the entire commonwealth. With this 48-bed limit, CCCA and its community partners, including private hospitals, juvenile detention and correctional centers, and community services boards (CSBs), have been successful in meeting all emergency hospitalization needs utilizing the plan below.

CCCA serves as the safety net for children and adolescents who require acute inpatient psychiatric care and cannot be admitted to or remain in any other child/adolescent psychiatric hospital in Virginia. All valid referrals are accepted for admission assuming adequate exploration of alternative placements, medical clearance, and available bed space. To date the system has been able to meet the emergency placement needs of all children and adolescents through appropriate diversions and bed management at CCCA through discharge planning.

Unlike the eight regional DBHDS psychiatric hospitals serving adults, CCCA does not have a back-up hospital within the system to accept patients if full. This, along with a high volume of admissions and a short average length of stay, intensifies the need for active and effective bed management at the facility and community levels. In addition to the steps taken by CCCA and community partners related to admissions and discharges described below, it is of course the case that adequate support for community-based crisis management services, as well as those services providing pre-crisis interventions, will both prevent hospitalizations that would otherwise be necessary and aid in more rapid discharges, thus preserving space at CCCA for necessary admissions and maximizing the number of children and adolescents who can be served close to home.

<u>Admissions Process</u>

- CCCA accepts referrals of young people up to 18 years of age who are in need of inpatient psychiatric hospitalization from the entire Commonwealth
- Our Intake/Admissions Office is staffed 24 hours a day, 7 days a week, and we accept admissions 24 hours a day, 7 days a week (540-332-2120)
- The CCCA Admissions Coordinator or designee receives all referral calls for potential admissions. The Admissions Coordinator reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act (see §16.1-335 *et seq*.)
- Other than admissions ordered pursuant to VA§ 16.1-275 or 16.1-356 (court-ordered evaluations), all admissions must first be prescreened by a CSB
- Any calls not from CSBs (other than in cases of VA§ 16.1-275, in which we still request though cannot require a CSB prescreen), are referred to the CSB for appropriate pre-admission prescreening
- Our Intake/Admission Specialist consults in every referred case with the CSB Emergency Services Prescreener to
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried and that may be available
    - Reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act

    - Consider the need for hospitalization, and if hospitalization is needed the availability of other options, particularly those that keep the child or adolescent close to home
- While the Intake/Admission Specialist may encourage the prescreener to explore options not considered, including providing names of alternative hospitals, we will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option
- There is no minimum number of other hospitals that must be called; admission elsewhere will be encouraged if possible, with greater emphasis if the child/adolescent is from far away and/or we have fewer available beds
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If there are active medical issues, the Intake/Admission Specialist will consult with our on-call physician to determine if medical clearance is necessary
- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Voluntary, Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which we believe an admission to be inappropriate, we may exert considerable pressure on the community to identify alternatives. Assuring the appropriateness of admissions serves to prevent unnecessary and possibly distressing separation of the child/adolescent from his/her community, avoid unnecessary resource utilization, and maintain available bed space for appropriate admissions

<u>Bed Management</u>

A. Diversion

The only time CCCA would defer a valid admission is if it is at or near capacity. Because the 48 beds are the only public acute psychiatric beds for the entire Commonwealth, and because admissions are unpredictable and may be heavy (e.g., 20 or more admissions in a week or 5 or more admissions in a day) there are times when capacity becomes an issue. When we are near or at capacity,

- We contact CSB Emergency Services Departments and inform them, noting our available beds at the time and requesting that they divert if at all possible;
- Forensic admission referrals for Court Ordered Evaluation pursuant to §16.1-275 of the Code of Virginia will be placed on a waiting list and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Court Ordered Evaluations are ordered for children not in psychiatric crisis, but for whom an evaluation of treatment needs is warranted. These children are most often in detention centers and therefore in a safe place to await admission to CCCA;
- Forensic admission referrals for Evaluation of Competency to Stand Trial pursuant to §16.1-356 will be placed on a waiting list and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Such children are in juvenile detention centers or in the community as determined appropriate by a judge and will remain in that setting to await admission;
- When CCCA is full and a child who has been prescreened by a CSB and found to meet criteria for emergency civil voluntary or involuntary admission per the Code of Virginia cannot be safely admitted, the CSB will be notified and encouraged to implement a crisis/safety management plan and maintain the child in the community or in the present placement until bed space at CCCA is available if that is determined to be a safe option;
- If diversion strategies are unsuccessful, attempts will be made to have the child admitted to a private inpatient facility utilizing TDO admission, Medicaid, or other third party means;
- Admission may be deferred for patients who are in a safe place (e.g., another facility or detention) until space becomes available
- If attempts to find an alternative bed are not successful and a community safety plan is not a safe option, the child will be accepted for admission as soon as s/he can be safely admitted. If there is more than one such

child, pending admissions will be prioritized in consultation with CSB referral staff, taking into account acuity of the situation and safety of the child.

B. Discharge

The availability of beds for admission is dependent on patients being discharged when clinically appropriate. Clinical teams always work closely with families and communities to facilitate timely discharge, working together to manage challenges that include delays before desired community-based resources become available or the absence of such resources, differences of opinion about clinical readiness for discharge or discharge placement options, transportation availability, etc. When CCCA nears capacity, we also

- Encourage families and communities to rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged but remain in the hospital based on clinical discretion

Attachment G

Serving Deaf and Hard of Hearing Consumers in Crisis Situations.

Regional Deaf Services Program (RDSP), Southwest, Virginia.

Administered by Cumberland Mountain Community Services, serving:
Highlands Community Services, Dickenson County Behavioral Health, Planning District One/Frontier Health, Mount Rogers Community Services Board and New River Valley Community Services.

Mental health crisis situations with deaf and hard of hearing persons can be stressful for both consumer and clinician. The obvious and immediate challenge is to bridge the communication gap between provider and consumer to allow services to be rendered as they would in a similar situation with a hearing person. This paper suggests a four-tiered response process and is meant to serve as a resource for crisis clinicians.

Tier One: Contact the Regional Coordinator (RC) of Deaf Services (Mike Bush, LPC), for direct assistance 24/7/365. Mike is fluent in sign language and a certified pre-screener. In most circumstances, Mike is immediately available to drive to the site of the prescreening and conduct the clinical portion of the crisis evaluation. Mike can be reached on his cell phone 24/7 at **(276) 971-7672** and will make every effort to assist by conducting the prescreening, providing consultation, or providing an outpatient appointment to meet with the client the next business day.

Tier Two: If you are unable to reach the RC, contact a qualified sign language interpreter to assist you. Attached is a list of recommended interpreters in the area who can serve as a resource for mental health emergencies. Your CSB is required to pay for the interpreter, but an interpreter fund administered by Valley CSB will reimburse at a rate of 50% as funds are available. Contact the RC, after the fact, for forms and details. Please refer these patients immediately to the Regional Deaf Services Program.

Tier Three: (Coming soon!!!) Use a Polycom system to connect to a 24/7 remote video interpreter.

Tier Four: Document that your efforts to gain assistance in Tiers 1-3 were unsuccessful. Do the best you can to conduct a sound clinical evaluation. Try to communicate directly with the individual. Make sure your environment is quiet and well lit. Make sure the light source is above you or shining on you, not behind you. Speak in your normal tone of voice, a little slower than usual, and make eye contact while speaking. Talk *about* communication with the consumer. Assess your ability to communicate with the individual before gaining clinical information. Ask open ended questions and see what response you receive. Ask the same question in different ways if necessary. Take your time. Use family members to interpret with great caution; be aware of whether the consumer is placing a family member in an interpreting role, or if the family member is placing themselves in this role.

Inpatient Resources.

The Mental Health Center for the Deaf at Western State Hospital (WSH) no longer exists and is no longer a crisis option for our pre-screeners. WSH continues to serve deaf consumers from their own region and may accept a transfer from SWVMHI. Follow normal protocols for seeking local inpatient admissions. SWVMHI now has experience serving signing deaf adults and hiring interpreters to make their services accessible.

Attachment H

PPR III Quality Improvement Process

The Quality Improvement Group serves to address concerns with the PPR III admission and civil commitment process. The group will convene at least monthly either face-to-face or by teleconference for the purpose of identifying problems, investigating causes, review utilization data propose or develop solutions that assures effective collaboration and prevents reoccurrence of identified issues. Discussions and work of the QI Process group shall be considered Privileged and Confidential pursuant to Virginia Code § 8.01-581-17.

Events addressed by the group include Preadmission Screenings (PAS) approaching ECO time limits, other process improvement issues, and Critical Events. Critical Events include: PAS's exceeding ECO time limits, PAS's requiring SWVMHI going over capacity to accept a TDO, and PAS's resulting in the failure to obtain a bed for persons requiring a TDO. Monthly meetings of the QI Process group will review all of the events listed above and report on a regular basis to the Southwestern Virginia Behavioral Health Board and to the DBHDS as requested. In addition to these monthly meetings, for Critical Events Post hoc meetings will occur more frequently, convened by the region's Project Manager. These Post hoc discussions and proposed solutions of a Critical Event shall be made part of the monthly QI Process meeting. The monthly QI Process meetings shall occur as part of the regularly scheduled regional authorization committee, Census And Review Team (CART), that meets each Monday and will be scheduled for the second Monday of each month. The CART is attended by the ES Director (or designee) of each CSB in the region as well as the SWVMHIs Facility Director (or designee), admissions officer, social work director(s) and clinical directors.
Personnel included in the monthly QI Process meetings includes: ES Directors or designees from each CSB in the region, the SWVMHI Facility Director or designee, and may include other invited stakeholders relevant to discussions of process improvement. Post hoc meetings shall occur at least weekly for identified Critical Events. Convened by the regional manager and utilizing electronic communication it shall be attended by: the CSB ES Director (or designee) associated with the Critical Event, the SWVMHI Facility Director (or designee), other regional CSB ES Directors (or designees). The ES Director reporting a Critical Event will also notify the Executive Director of their CSB, provide a copy of the Critical Event Reporting Form and invite to participate in the Post hoc meeting. For Critical Events when a TDO is sought but not obtained, this MUST be reported to the Executive Director of that CSB as soon as possible. The Executive Director will complete required notification, within 24 hours of the event, to the DBHDS leadership using a form from the "TDO Exception Report" guidance of 06/04/14 from the Department.

The Post hoc meetings will use the attached form to report on key elements of a Critical Event with the goal to identify any deviations from accepted protocols, evaluate for medical/legal/social complications and discuss the extent that they influenced or created the Critical Event. The outcome shall be a consensus report to the larger QI Process group with recommendations for solutions. Other stakeholders may also receive recommendations for proposed solutions when appropriate
Suggestions for process modifications may be submitted by the QI Process group to the regions Regional Authorization Committee (CART), the SWVBHB, individual CSBs and state/private facilities. Suggestions related to adherence or deviation from established Regional Admission Protocols shall be vetted through the CART and addressed by any combination of the QI Process group as it most appropriate. Suggestions for QI outside of this Regional Admissions Protocol shall be reported to the SWVBHB for direction. These could include issues with judicial courts (Magistrates or Special Justices), intersection with private hospital system policies, etc.

As part of the Regional Admissions Protocol, this policy and procedure and associated forms will be updated as needed and agreed upon by the CART. Revision dates will be noted and any changes will be reported to the SWVBHB.

CRITICAL EVENT REPORTING FORM (Page 1 of 2) (CONFIDENTIAL: For Quality Improvement Process Only) ATTN: Project Manager; QI

Process Instructions: This form must be completed when a CSB has a CRITICAL EVENT (defined below) and sent to Project Manager. QI Review is Weekly or Next Business Day.

CLIENT NAME:	CSB: ID#:	Date/Time of Event:	ECO (Incl. paperless): Y / N	Total Time for PAS:	Psych Bed Registry Used?: Y / N

Location of Assessment:
Hospital: _____ **(OR) Other:** _____ **(AND) County/City:** _____

CRITICAL EVENT (Weekly Review):
☐ **PAS exceeding an ECO time limits**
☐ **PAS required State Facility to exceed capacity to admit a TDO.**
Fac. Director/Admin Name: _____
(List facilities contacted on page 2, or attach own contact record)

CRITICAL EVENT (Next Bus. Day Review):
☐ **PAS resulting in failure to obtain a bed for persons requiring a TDO.**
(List facilities contacted on page 2, or attach own contact record)

DESCRIPTION of CRITICAL EVENT:
_____
_____
_____
_____
_____
_____
_____
_____
_____

OUTCOME FOR CLIENT
☐ **Admitted:** Type: **TDO / Medical /**
Other:_____
OR
☐ **NOT Admitted:** (select one below)
☐ Remained in: ED / Nsg. Home or ALF /
Other:_____
☐ Community Supports available & implemented.
(Safety Plan developed even though not best outcome)
☐ No further intervention, against clinical advice (Client refused to participate in safety plan or accept any offered service)
☐
Other:_____

Follow-Up:
_____
_____
_____
_____
_____
_____

Recommendations:
☐ None
☐ Educate/Correct staff
Specify:_____
☐ Educate/Correct facility, agency
Specify:_____
☐ Rec Change in Protocols
☐ Other: _____

Designee for Follow-Up:
_____
Date:_____

Re-Visit Rec.? Y / N
Date:_____
Designee:_____

Signature of ES Director:_____ Date:_____ Executive Director Notified (incl. CE Reporting Form): Y / N

Fax completed form to Derek Burton, Project Manager. 1-276-223-1633 -OR- Send in an ENCRYPTED e-mail to derek.burton@mrcsb.state.va.us

Ver:06/10/14

CRITICAL EVENT REPORTING FORM (PAGE 2 of 2) (CONFIDENTIAL: For Quality Improvement Process Only) ATTN: Project Manager; QI

CLIENT NAME:	CSB: ID#:

List Facilities and data when: (Or attach own contact list with same information)

1. **PAS required State Facility to exceed capacity to admit a TDO.**

OR

2. **PAS resulting in failure to obtain a bed for persons requiring a TDO.**

FACILITY	REASON FOR REFUSAL		
	No PHYSICAL bed	No APPROPRIATE bed	No Definite Reason Given