Virginia state psychiatric hospital census: Guidance for state hospitals, DBHDS central office, community services boards, emergency departments, and law enforcement

1. **State Hospitals will:**
    a. Focus on expeditious discharges including such things as discharge prior to a TDO hearing when clinically appropriate, evaluating all individuals rated level 2 and 1 on the discharge readiness scale for step down to a crisis stabilization unit based upon the regions' CSU protocols. For individuals who may have a discharge placement identified that is not immediately available, state hospitals will refer patients to the Access CSU for which DBHDS has a current contract for state hospital discharges. For individuals who no longer meet commitment criteria, state hospitals will insist upon discharge to the first clinically appropriate option, even if that option may not be the individual's first choice.
    b. Fill all available beds prior to seeking diversion to another state hospital.
    c. Once the state hospital system is at 100% of its total bed capacity, state hospitals will not agree to serve as the facility of temporary detention for individuals who are not under an emergency custody order. For individuals who are under emergency custody, the state hospital shall inform the CSB and request that the admission be delayed until a state hospital bed is available. State hospitals will work with the CSB and law enforcement or the alternative transportation provider to determine when a bed will become available and transfer and transport to the state facility can safely commence.
    d. Admission protocols related to COVID – 19 testing will be implemented to include symptom and exposure risk questionnaire screenings and vitals/temperature checks prior to admission. In situations in which a patient is suspected of having or is confirmed to have COVID-19, as well as situations in which a patient may refuse to consent to a COVID-19 test, the state hospital physician will participate in a doctor-to-doctor communication with the physician at the hospital where the patient is located for emergency custody.
    e. State hospitals shall update information in the acute psychiatric bed registry whenever there is a change in bed availability, but not less than twice daily.
    f. The state hospitals will adhere to the dispute resolution process regarding patient discharge readiness as outlined at the end of this document when they receive official notification from the CSB of their disagreement with a patient's determination of clinical readiness for discharge.

2. **Central Office will:**
    a. Maintain a 24/7 CSB emergency services consultation and assistance line for ES managers and directors.
    b. Partner with CSBs to triage individuals for whom admission is delayed and who are deemed to be at a high risk of an adverse outcome or who are at risk of being released from custody while clinically in need of continued hospitalization.
    c. Convene "emergency calls" with CSB emergency services as needed based upon changes in the numbers of individuals for whom admission is delayed and/or the overall increase in risk presented by individuals for whom admission is delayed.
    d. The Commissioner will provide all relevant stakeholders, including the VACSB, the VHHA, the Virginia Sheriff's Association, the Virginia Association of Chiefs of Police, and the Virginia College of Emergency Physicians, with notification when the state-operated psychiatric hospitals are at 100% of their total bed capacity, as well as with timely information about the process for managing delayed admissions, and advance

notice of time periods when delayed admissions are expected to increase. When the state-operated psychiatric hospital system is at 100% capacity, the Commissioner will request assistance and collaboration from all stakeholders.

e. Share strategies with the CSB executive directors for diverting admissions to state hospitals including such things as:
    i. increasing CSB staffing support for discharge planning activities at state hospitals
    ii. increasing staffing support for individuals at risk for hospitalization, such as enhanced case management, access to PACT services 24/7, peer support/drop in centers for individuals who are vulnerable for decompensation, including homeless services outreach
    iii. identifying opportunities for maximizing the effectiveness of the existing array of crisis services, such as:
        1. *Residential Crisis Stabilization*: Ensuring the CSU has enough staff to take as many admissions as possible by recruiting additional staff from other programs who are trained and who want to earn overtime and engaging with staff to reduce any delays or barriers to admission;
        2. *Mobile Crisis Services*: CSBs with mobile crisis stabilization services extending hours of operation to the greatest extent possible and offering support to emergency departments as needed; and
        3. *Crisis Intervention Training and Assessment Centers*: extending the hours of operation whenever possible and considering CITACs with medical care as an alternative site for individuals in an emergency department for whom admission to a state hospital is delayed;
    iv. making peer specialists and other QMHPs available to help support individuals while they are waiting for beds; and
    v. ensuring that REACH responds to all calls by emergency services for evaluation and assistance and provides 24/7 support to individuals and care providers for any individual with DD for whom admission to a state hospital is delayed.
f. Consult with the Office of Licensing regarding modifications to the CSU admission and program requirements during times of intense state hospital census pressures.
g. Work with the Office of the Executive Secretary of the Supreme Court of Virginia to ensure that court personnel, including magistrates, judges, and special justices, are aware of the state hospital census pressures and the potential impact on the civil commitment process.
h. Provide monitoring, oversight, and technical assistance to ensure that state-operated psychiatric hospitals, CSBs/BHAs, and private inpatient providers licensed by DBHDS are updating the bed registry whenever there is a change in bed availability, but no less than twice per day.
i. For individuals subject to temporary detention orders to a state hospital, DBHDS will reimburse providers for the cost of COVID-19 testing if no other payment source is available.
j. Central Office will adhere to the dispute resolution process regarding patient discharge readiness as outlined at the end of this document.

3. The CSB should:

a. Fully explore all available community resources and supports for the individual prior to rendering a decision to seek a TDO and document all efforts to utilize a less restrictive approach prior to seeking a TDO on all individuals on the prescreening or an addendum.
b. For individuals with DD, delay the communication of a recommendation for a TDO until REACH has provided consultation on alternative supports or options potentially available to the individual in the community preferably in person but at a minimum by phone consultation; Seek support for other regional REACH services as appropriate.
c. Communicate to relevant stakeholders, including private hospitals and magistrates, when state hospitals are at 100% of their total bed capacity and unable to agree to serve as the facility of temporary detention for individuals not under emergency custody orders, as well as continue to search for placement for these individuals.
d. Work with their local stakeholders, including private hospitals, magistrates, law enforcement, and special justices to ensure they understand the state hospital census pressure.
e. Advise DBHDS of changes in an individual's clinical, behavioral, or legal status that warrant consideration of triage and priority admission to a state hospital by contacting the DBHDS after hours number.
f. Contact the involved entities (e.g., hospital, law enforcement, etc.) to request updated information on each individual for whom admission to a state hospital is delayed, ideally every 12 hours but not less frequently than once every 24 hours.
g. Continue to engage in creative problem solving to support individuals remaining in the community or whose admission to a state hospital is delayed.
h. Advise the state hospital of individuals not under an ECO, who meet the criteria for a TDO, but for whom no private hospital or CSU bed have been located.
i. Plan for the potential of holding hearings in emergency departments.
j. Update the bed registry for applicable programs whenever there is a change in the bed registry, but not less than twice daily.
k. If a CSB disagrees with a state hospital's identification of an individual as ready for discharge, they shall document that disagreement in the individual's treatment plan (CSB medical record) within 72 hours of the state hospital's notification of the individual being considered clinically ready for discharge. They shall also initiate in the dispute process regarding patient discharge readiness as outlined at the end of this document within 72 hours of notification of the individual's clinical readiness for discharge.

4. The Hospital/Facility where patients are prescreened and medically cleared should:

a. Contact the state facility of temporary detention to ensure that a bed is available prior to transport.
b. For patients who are under emergency custody orders and subject to TDOs for which the state hospital has had to delay the admission due to being at 100% capacity or above, the facility is encouraged to work with the state hospital to determine when a bed will become available and transfer and transport can safely commence and to delay transportation until the state facility verifies that they can provide a bed for the individual.

c. Prior to releasing a patient under a TDO for transport to a state hospital, providers participating in the State Medicaid Plan must comply with the applicable *Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit*, found at: http://www.dbhds.virginia.gov/assets/doc/about/masg/adults-medical-and-screening-guidelines-11-5-2018.pdf.
d. Hospitals with emergency rooms that are subject to the federal Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd, must ensure that transfers of patients under temporary detention orders to state-operated psychiatric hospitals are appropriate transfers, including taking into account a patient's COVID-19 status and the inability of the state-operated psychiatric hospitals to isolate and treat such patients properly.
e. Section 37.2-1104 of the *Virginia Code* provides a medical temporary detention process that should be used in certain circumstances to address and stabilize an individual's medical condition before transfer to a state-operated psychiatric hospital. For patients experiencing intoxication, using the medical temporary detention process where applicable may alleviate the need for further psychiatric hospitalization. Appropriate use of the medical temporary detention process will ensure that patients receive the medical care they need and could help to reduce the census pressures at the state hospitals. To that end, if a patient undergoing an emergency mental health evaluation has an acute medical condition, including COVID-19 or intoxication, and is incapable of making an informed decision regarding treatment, consideration should be given to whether the criteria for a medical temporary detention order under § 37.2-1104 of the *Virginia Code* are met.
f. Facilitate doctor to doctor communication with the state-operated psychiatric hospital prior to transfer regarding any patient suspected of having COVID-19, as well as in situations in which a patient refuses to consent to a COVID-19 test.

5. Private/community inpatient providers licensed by DBHDS will:

a. Update information included in the psychiatric bed registry whenever there is a change in bed availability, but not less than twice daily, to assist in the location of facilities of temporary detention for individuals experiencing a mental health crisis.

6. Law enforcement and alternative transportation providers:

a. Are strongly encouraged to contact the state facility of temporary detention to ensure that a bed is available for the patient prior to transport. If the state-operated psychiatric hospital system is at or over total bed capacity, law enforcement and alternative transportation providers are encouraged to work with the state facility to determine when a bed will become available and transfer and transport can safely commence.
b. Are encouraged to delay transportation of the patient until the state facility can provide a bed.

7. State Hospital Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office:

a. The CSB shall notify the state hospital social work director, in writing, of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge within three calendar days (72 hours) of receiving the discharge readiness notification.
b. The state hospital social work director (or designee) shall initiate a resolution effort to include a meeting with the state hospital and CSB staff at a higher level than the treatment team, as well as a representative from the Central Office Community Integration Team. This meeting shall occur within one business day of receipt of the CSB's written disagreement.
c. If the disagreement remains unresolved, the Central Office Community Integration Team will immediately give a recommendation regarding the patient's discharge readiness to the DBHDS Commissioner. The Commissioner shall provide written notice of their decision regarding discharge to the CSB executive director and state hospital director.
d. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within three business days if the decision is in support of clinical readiness for discharge.
e. Should the Commissioner determine that the individual is clinically ready for discharge and the CSB has not developed a discharge plan to implement immediately, then the discharge plan shall be developed by the Department and the Commissioner may take action in accordance with Virginia Code § 37.2-505(A)(3).