FY 2023

State Hospital Last Resort and Related Legislation

Region 4 Emergency Services Protocols

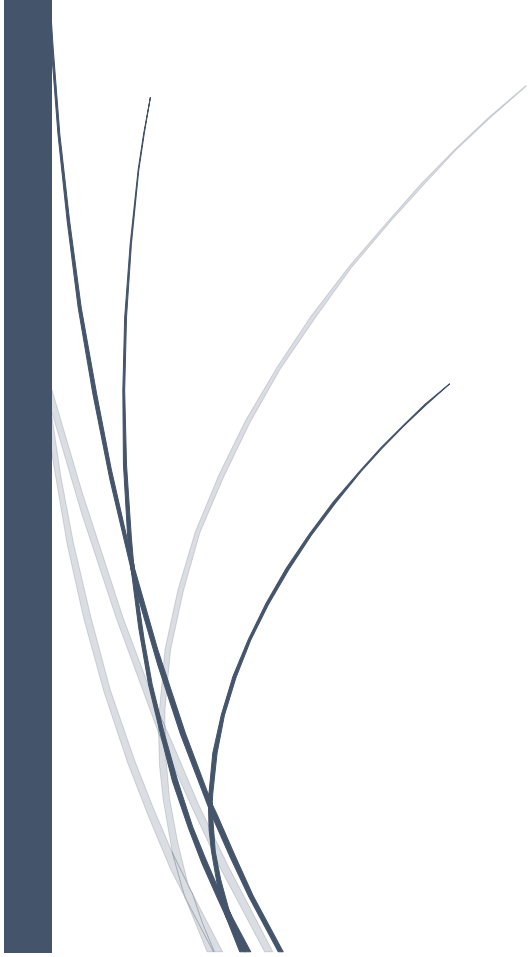

TABLE OF CONTENTS

I. Introduction

The following is a description of protocols and practices for Region 4 Community Services Boards/Behavioral Health Authority to utilize when accessing beds of "last resort" at state psychiatric facilities operated by the Virginia Department of Behavioral Health and Developmental Services on behalf of individuals experiencing an acute behavioral health crisis.

The implementation of "last resort" legislation in 2014 and legislation that has followed since fundamentally altered how and when Region 4 Community Services Boards/Behavioral Health Authority interact with its state psychiatric facilities, namely Central State Hospital, Piedmont Geriatric Hospital, and Commonwealth Center for Children and Adolescents. The shift in policy and practice was most notable for Central State Hospital in Petersburg, VA, which was utilized effectively by the region for over a decade as a long-term care facility for individuals who could not be stabilized in the short-term, despite the best efforts of community hospital partners. Thus, the intent of these regional protocols is to lay out the essential steps that must be taken by CSBs to access a bed of "last resort" when less restrictive community-based options are not available and/or appropriate to meet the needs of an individual in a psychiatric crisis.

II. Individuals under ECO

a. Notification to CSBs, State Hospitals

Law Enforcement (LE) will notify the CSB Emergency Services (ES) department serving its locality, regardless of where the ECO'd individual resides. CSB ES departments will be responsible for providing the phone number by which LE can directly contact ES on a 24/7/365 basis.

LE must provide ES, at a minimum:

- the name of individual
- DOB of individual
- the ECO start time.

If the CSB receiving the call from LE is notified that an ECO is being transferred out of the receiving CSB's jurisdiction, then the CSB shall notify the evaluating CSB immediately via phone using a phone number that is operational 24/7/365.

In the event of a law enforcement issued ECO, LE will be responsible for providing the individual with a copy of the ECO /procedures and protections document (DC-4050 rev. 7/20). In the event of a Magistrate issued ECO, LE will provide the individual in custody with a copy of the ECO that has the ECO/procedures and protections document printed on the back. The designated ES evaluator will, during the course of the face-to-face assessment, verify with the individual that they received a copy of the document from LE and will provide the individual a copy of the ECO procedures and protections document in the absence of LE doing so.

b. ECO Notification Process

For adults under 65 y.o., all ECO notifications by a Region 4 CSB will go to **Central State Hospital (CSH)**. The ES evaluator will send an email to the designated CSH email address: **ECONotification.csh@dbhds.virginia.gov**

For adults 65+ y.o., all ECO notifications by a Region 4 CSB will go to **Piedmont Geriatric Hospital (PGH)**. The ES evaluator will send an email to the designated PGH email address: **PGHECONotification@dbhds.virginia.gov**

For youth under 18 y.o., all ECO notifications by a Region 4 CSB will go to **Commonwealth Center for Children & Adolescents (CCCA).** The ES evaluator will send an email to the designated CCCA email address: **CCCA-ECO.notification@dbhds.virginia.gov**

ES will provide the state facility with:

- the individual's initials,
- contact person's name and CSB affiliation, and
- ECO start time.

c. Documentation of Alternative Dispositions/Bed Searches

Region 4 ES evaluators are required to call the Region 4 LIPOS contracted hospitals, Region 4 CSUs, REACH mobile crisis or Crisis Therapeutic Homes, and/or CReST mobile crisis and attempt to confirm inability to admit.

ES evaluators will maintain compliance with the Admission and Discharge Requirements for state hospital census management and will document the disposition/bed search process for individuals through the use of the Region 4:

- Adult Bed Search Form (click here for pdf form) Appendix A
- Geriatric Bed Search Form (click here for pdf form) Appendix B
- Youth Bed Search Form (click here for pdf form) Appendix C

The ES evaluator will contact the appropriate state facility (SF), after the prescreening evaluation has been completed, only if/when it appears the individual will require admission to a SF. If, during the period of ECO, a disposition has been secured and/or if the individual does not require a TDO, then the evaluator will not need to contact the SF. Disposition is documented on the prescreening form.

d. State hospital admission process

Prior to the expiration of the 8 hour ECO period and **no later than hour 5 of the ECO,** and regardless of how many contracted hospitals have been unable to admit or been nonresponsive, **the CSB evaluator makes telephone contact** with the appropriate SF that a state hospital bed may be needed and **follows up by faxing the prescreening and other documentation as directed.**

Before the ECO expires, and no later than the 7th hour, the ES evaluator will proceed with petitioning the magistrate for the TDO to the appropriate, if no local accepting facility has been found.

i. **For CSH, contact:**

Contact	Contact hours	Phone	Fax
Director of Social Work or designee	**M-F, 8am-5pm**	**804-712-2279**	**804-524-4645**
Administrative Officer on Duty (AOD)	**M-F, 5pm-8am, weekends, holidays**	**804-524-7151/-7002**	**804-524-4635**

The ES evaluator will fax to the CSH:

- the completed prescreening;
- medical information;
- final bed search form; and
- other pertinent documentation obtained through the prescreening process.

ii. **For PGH, contact:**

Contact	Contact hours	Phone	Fax
Admissions line	**M-F, 7:30am-4pm**	**434-294-0112**	**866-718-8593**
Answering service	**Evenings, weekends, holidays**	**855-493-7193**	

PGH will work with the ES evaluator on initiating the Medical Screening and Assessment process. ES will fax prescreening and medical screening information to PGH for their review and discussion about attempts to place individual in a community bed.

If plans are made to admit the individual to PGH, please reference the *PGH TDO Admission Protocol* document (Appendix D) for detailed guidance on steps to take at hour 5 and at hour 7.

iii. **For CCCA, contact:**

Contact	Contact hours	Phone	Fax
Intake/Admissions Office	**24/7**	**540-332-2120**	**540-332-2202**

CCCA will work with the ES evaluator to review referral and will request information including prescreening and medical clearance information as detailed in the CCCA Bed Management Plan (Appendix E).

e. Release of Individual from an ECO

If the ES evaluator determines that an individual will be released from an ECO, the ES evaluator must:

- notify the ECO petitioner(s) of the decision; inform the petitioner(s) of their right to contact the magistrate if they disagree with the outcome of the prescreening to

present their concerns/evidence; provide the petitioner with information to contact the magistrate; and facilitate communication between the petitioner and magistrate if so requested; and,
- notify the ED physician; and,
- notify the CSB ES supervisor/designee on duty, if the ES evaluator is newly certified (within 3 months) or as required by each CSB; and,
- LE, if they were not the petitioner of the ECO.

Each CSB will maintain a list of magistrates serving their jurisdiction/catchment area.

III. Individuals not under ECO, requiring TDO

Any person not under ECO for which private hospitalization has been eliminated by conducting and documenting an extensive bed search, including CSUs, mobile crisis, REACH, and other community services, the regional SF will consider acceptance and will not deny admission, except where exclusionary criteria applies. The ES evaluator is required to provide the state hospital with the bed search documentation, prescreening form, and medical clearance information (see below), following the admissions processes above without the time constraints of the ECO.

IV. Medical Assessment & Screening

a. DBHDS/VHHA guidance document

In addition to the guidance provided in the appendices, please see the *Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization unit (ADULTS)* from DBHDS and VHHA.

For a list of available medical services at Central State Hospital, please reference Appendix F, *CSH Medical Capabilities*.

b. TDO pending medical clearance (§ 37.2-1104)

i. Acute medical problems or intoxication may mimic psychiatric symptoms and may be suspected in individuals who have no previous psychiatric history. Frequent causes of acute delirium include: pneumonia, infections, dehydration, organ failure, some cancers and a stroke. These individuals need to be treated in an acute care facility prior to admission to a SF. To rule out medically induced psychiatric symptoms and to ascertain whether this individual can be appropriately treated at a SF, additional tests may be recommended depending on results to assure that this individual can be cared for at a SF.

ii. A PCP is on call 24/7 and works as follows:
- PCP or MOD is available for MD to MD communication to clarify what is needed for the SF to medically clear the individual;
- PCP or MOD reviews the tests results;
- SF PCP or MOD medically clears the individual for admission as appropriate;
- SF Admissions staff inform the CSB that SF is ready to accept the individual. Only at this point should individuals be transported to SF;
- If SF does not medically clear the individual, reasons will be provided to the CSB staff person who will need that information as they search for beds at other hospitals.

iii. Doctor-to-Doctor Dispute Resolution Protocol – Both CSB and SF Admissions Staff shall follow up with their respective parties for outcomes of each stage and to move through the stages efficiently. Admissions will provide contact numbers when requested by CSBs.

- Stage 1: When there is a disagreement between the referring physician and receiving physician about any requested laboratory work or evaluations, and/or admission, the physicians should attempt to resolve the matter amicably.
- Stage 2: If such resolution cannot be reached between the physicians, the referring physician may request that the dispute be escalated to the Medical Director (or designee) of the referring facility to initiate a discussion with the Medical Director (or designee) of the receiving facility for resolution.
- Stage 3: If the matter remains unresolved or the Medical Director is unavailable, the Medical Director (or designee) at the referring facility may request that the dispute be brought to the Chief Medical Officer (or equivalent) of the receiving facility for resolution. This discussion should be facilitated by either the referring facility's Medical Director (or designee) or the Chief Medical Officer (or equivalent).

iv. If the SF PCP believes the individual's medical needs exceed the capabilities of the state facility, the state hospital physician will communicate that information to the ER physician.

v. The requirements of EMTALA must be met by the sending facility and sending an individual to a hospital that cannot safely manage the individual's medical condition is not acceptable.

vi. An optimal option would be for ER physician to keep and treat the individual until he/she is stable enough to be transferred to the TDO facility and/or consider the appropriateness of a medical TDO.

If no other ACP facility has an appropriate bed and the ECO period is ending (approaching 8 hours), arrangements are then made for state hospital admission, with acceptance at the facility pending medical clearance, utilizing the *Medical Screening and Medical Assessment Guidance Materials* referenced above.

In the event medical clearance is not completed within 8 hours (i.e. high BAC; incomplete labs or other medical testing) or the individual's co-morbid medical condition(s) cannot be managed by the receiving state facility, then:

The state hospital physician should communicate with the ER physician. If the ER physician decides to send anyway, then the individual must come to the SF and the SF will need to plan what it will do. This may include immediate transport to the nearest ER or attempting to secure medical admission elsewhere. Even though the new law requires a state facility to accept an individual for temporary detention if an alternative facility cannot be found, the requirements of EMTALA, if applicable to the sending facility, must still be met by the sending facility.

Transferring an individual to a facility that has stated it cannot safely manage the individual's medical condition is taking a risk on the part of the sending hospital, which could be liable under EMTALA for an inappropriate transfer. The best scenario for the

individual in a situation where the state facility is not able to meet the individual's medical needs would likely be for the ER physician to keep and treat the individual until he is stable enough to be transferred to the TDO facility, though this will require collaboration with law enforcement.

c. Substance using individuals

If an individual meets the criteria for TDO and is also intoxicated, all other options for community-based treatment (i.e. CSU, medically-assisted withdraw management, local ARTS beds) should be considered, exhausted, and documented on the bed search list before considering a SF admission.

State Medical Directors advocate that a patient's BAL be below the legal limit before being evaluated for a TDO. Patients with a history of delirium tremens or severe withdrawal symptoms are not appropriate for psych units and should be considered for Medical TDO for monitoring and treatment. However, if there is an ECO in place, the evaluation must proceed.

d. Pregnant women

Pregnant women being considered for admission to a state hospital should undergo an evaluation of fetal and maternal health; ideally, a sonogram ascertaining fetal status is advised, with a Doppler evaluation at a minimum.

Pregnant women who are substance using and who are referred for CSB services must be seen within 48 hours of the referral. If evaluated for hospitalization, the individual's pregnancy and substance use must be highlighted during medical screening and/or clearance, along with any withdrawal symptoms (past or present).

e. Medical TDO regulations (§37.2-1104B)

The CSB is to re-evaluate any individual, who was the subject of an ECO and required a Medical TDO, prior to discharge or at the expiration of the Medical TDO. The evaluation is to be conducted upon the completion of the observation, testing, or treatment that occurred during the Medical TDO.

The medical facility is responsible for notifying the CSB before the individual is to leave or upon the expiration of the Medical TDO. The CSB ES evaluator will also make contact with the admitting unit at the medical facility every 24 hours to inquire as to the status of the individual under Medical TDO.

V. Special Populations

a. Individuals with developmental disabilities

In any preadmission screening involving an individual with either a documented or suspected Intellectual Disability or Developmental Disability, the **Region 4 REACH program will be contacted at 855-282-1006** as soon as the ES evaluator is aware of the ID/DD diagnosis. It is understood that REACH many not be able to divert a psychiatric admission at the time of the preadmission screening; however, a REACH consultation may indicate additional resources to resolve the crisis or, in many cases, begin the process of expediting discharge planning or facilitate step-down admissions to a REACH Crisis Therapeutic Home.

A state hospital social worker should also contact the appropriate DS director and Region 4 REACH liaison and Director when an individual with an ID/DD diagnosis is admitted to the SF ***and*** when an individual is given a provisional ID/DD diagnosis by a state hospital physician after admission, to ensure linkage to CSB DS services, if appropriate, can begin as soon as possible.

b. Deaf or hard-of-hearing

Federal regulations require all hospitals to provide interpreter services as necessary, and the Admission Protocol should be followed for individuals who are deaf or severely hard of hearing as for any other adult person. As mandated by State Code, the Virginia Department for the Deaf and Hard of Hearing maintains a directory of Qualified Interpreter Services and works to remove communication barriers.

i. CSBs may have access to qualified interpreters via contract and ES evaluators should attempt to know those resources in advance of needing them
ii. Qualified interpreters may be found via vendors such as Proprio, Purple (signlanguage.com), accessos.io, and Virginia Relay (varelay.org)

c. Non-English speaking

CSBs and state hospitals shall utilize on-site or telephonic interpretation services (i.e. Proprio) for all individuals who are non-English speaking.

d. Incarcerated individuals

To initiate a forensic admission to Central State Hospital, the CSB contacts the Chief Forensic Admission Officer or their designee M-F from 8:00am-5:00pm and the AOD M-F from 5:00pm-8:00am, weekends, and holidays CSH through the regular protocols and notifies staff of a pending admission. The CSB sends a copy of the prescreening, along with a copy of the jail's committal or continued custody form, a copy of the warrants, and medical clearance documentation (i.e. labs, vital signs, EKG and UDS).

Each CSB/BHA is responsible for developing protocols, MOUs, etc. with the local and/or regional jails located within their jurisdiction that address notification and timeliness of responding to behavioral health crises involving incarcerated individuals. The jail or facility that has custody of the individual is required to petition for a TDO and not a family member or CSB under § 19.2-169.6.

The protocols as outlined in the following section e. are true for Region 4 as of February 2023, though efforts are currently underway to modify and or further clarify the state hospital diversion, waitlist, and bed registry procedures (found further down in Section VI). Updates to this document will be provided as soon as practicable, once system changes are made and clarified.

e. Diversion to another state hospital

In circumstances in which a state hospital gets a TDO bed request and they determine that they need to divert, current DBHDS guidance will be followed regarding diversion to another SF. The diverting SF will then communicate the name and contact info of the receiving SF to ES, who will contact the receiving hospital to facilitate the pre-admission process. It is expected that the diverting hospital will verify that an exhaustive bed search, including state funded diversion beds (subject to contract and availability), has been completed. The diverting hospital will send all information received on the individual

to the diversion hospital. ES will send the information to the diverted hospital if the information has not been received by the regional state hospital. Current DBHDS guidance will be followed when directed in lieu of the previous mentioned process for diverting to another state facility.

i. **State hospital waitlist procedure:**

At the point it is determined that beds are not available in the community (as soon as possible and no later than 5 hrs into the ECO):

a) CSB ES evaluator is to contact the AOD at the appropriate SF and provide general demographic information, including: ECO start time, prescreen date/time, age, name, location, disposition, CSB/locality prescreening

1)In the event the individual being referred is not under ECO, the ES evaluator must have completed at least one round of hospital bed searches before making SF referral to the waitlist

b) SF AOD places the individual on SF waitlist

c) CSB ES evaluator continues to bed search while the individual is on the waitlist; if a local bed is found or individual no longer requires hospitalization, CSB will notify AOD at SF to remove individual from waitlist.

d) SF AOD will make contact with diversion facility(ies) to determine availability of bed for next available person on waitlist; SF AOD will provide daily update to CSB ES as to status of individual on waitlist

e) SF AOD will contact CSB at least daily to get updates on case

-Once bed is identified for individual on waitlist, then the SF responsible for admitting person (whether home SF or not) will make contact with CSB to inform and begin process of admission

ii. **Waitlist management: Pre vs post-hearing**:

a) If the CSB has conducted the hearing at a local hospital ED, and the individual is determined to need either involuntary or voluntary commitment, the CSB will update the SF AOD as to the individual's disposition

b) CSB will send commitment paperwork to the SF AOD via encrypted email

c) SF AOD will update the status of the individual to committed and provide status (vol/invol)

d) CSB should notify SF AOD as to status to problem solve around waitlist status

f. State contract diversion beds

Hospital Directors or their designee will facilitate diversion to a state contract diversion bed. The diverting hospital (**state facility**) will notify the CSB of the willingness of a private hospital (**contracting facility**) to consider diversion under state contract. ES will send the information to the diverted hospital (**contract hospital)** if the information has not been received by the regional state facility.

g. Change of facility prior to the expiration of the TDO (§37.2-810)

Region 4 has a long-standing practice of utilizing CSH as a long-term care facility and, as such, has held the expectation that for any individual TDO'd to CSH a local hospital bed would be sought and the individual transferred as soon as possible.

It remains the joint responsibility of the CSB/ES staff and CSH/state hospital discharge planners to continue to seek alternate placement in the community to help manage the utilization of the limited state hospital beds.

If a transfer to a local facility is arranged, then it will be the responsibility of the CSB to: complete the Change in TDO paperwork with the magistrate; order and arrange transportation from the state hospital to the accepting local facility.

In the event the Change in TDO occurs while the individual is en route to the state hospital: Before LE initiates transport of an individual under a TDO to any hospital, the ES evaluator will be sure they have a direct contact phone number for the LE officer providing transport, in the event the accepting facility changes en route.

The evaluating ES program will contact the clerk of the court by the next business day to provide an update on the change in TDO accepting facility.

VI. Psychiatric Bed Registry/Regional Bed Searches (§37.2-308.1)

Region 4 Emergency Services staff will utilize a combination of bed check lists and the Bed Registry to locate available beds in inpatient psychiatric hospitals, regional Crisis Stabilization Units, regional Crisis Therapeutic Homes, and the SFs. Each CSB/BHA will maintain a **current** list of all the Region 4 contracted (Acute Care Project) facilities. Notes about calls to each facility may be maintained on the bed check list, bed registry site or noted directly on the prescreening supplement.

See Appendices for copies of the Region 4 Adult, Geriatric, and Child/Adolescent Bed Search forms.

VII. Utilization Review Process

At least monthly, the regional ES managers, state facility points of contact (Social Work directors), and Regional director will conduct a quality review of all exceptional cases, specifically those that are to be reported via the established format to DBHDS, and identify areas for improved collaboration, communication or other processes that will help reduce or eliminate such incidents in the future.

As necessary, these protocols will be reviewed, updated, and distributed to regional partners and DBHDS.

VIII. Annual Review

Regions will review and, as necessary, update their regional protocols and submit to DBHDS to be posted on the webpage on an annual basis by June 15.

IX. Appendices

Appendix A – Adult bed search form

ADULT BED SEARCH FORM

Date _____ Name_____ ID #_____ ECO start_____ 7 hour_____
ECO end_____

	Hospital	Phone	Address and CSB	Name, time	Notes	Denial codes
VCU Health		**855-546-7792**	1300 E. Marshall, RVA 23298			
Bon Secour Access		287-7836, **1**				
a	Richmond Community	225-1730	1500 N. 28th Str, RVA 23223			
b	St. Mary's	281-8266	5801 Bremo Rd, Henrico, 23226			
c	Rappahannock	804-435-8490	101 Harris Rd, Kilmarnock 22482 Fax prescreening to MP/NN CSB			
d	**Southside Regional Medical Center ID Exclusionary**	765-6823	200 Medical Park, Petersburg 23805 Fax prescreening to D-19 CSB			
e	**Southern VA Medical Ctr** **Mod ID Exclusionary**	434-348-4580	727 N. Main Str Emporia, 23847 Fax prescreening to D19 CSB			
POPLAR SPRINGS **ID Exclusionary**		862-6330 748-7490	350 Poplar Dr Petersburg 23805 Fax prescreening to D19			
TUCKER PAVILION **We are STILL supposed to call them for our admissions**		Nursing Shift Coordinator 483-1338	7101 Jahnke Rd RVA 23225			
ARC for HCA hospitals			877-886-7026. option 3			
a	Parham Drs Moderate ID exclusionary	672-4370	7700 E. Parham, RVA 23294 Fax prescreening to Henrico CSB			
b	Retreat	200-1880, 1	2621 Grove Ave, RVA 23220			

c	Lewis Gale	855-544-9337	1900 Electric Rd, Salem 24153 Fax prescreening to Blue Ridge CSB			
d	Spotsylvania	540-498-4000	4600 Spotsylvania Ave F'burg Fax prescreening to Rappahannock Area CSB			
e	John Randolph	804-541-7517	411 W. Randolph Str, Hopewell 23860 Fax prescreening to D-19 CSB			
SNOWDEN **ID Exclusionary**		540-741-3933 800-362-5005	1200 Sam Perry Blvd, F'burg 22401 Fax prescreening to Rap Area CSB			
MARYVIEW **ID exclusionary**		888-478-6596 Option 4	3636 High Str, Portsmouth 23707 Fax prescreening to Portsmouth CSB			
Williamsburg Pavilion **Mod ID exclusionary**		757-941-6410, press 1	5483 Mooretown Rd, W'burg 23188 Fax prescreening to Colonial CSB			
Riverside Behavioral Health **Mod ID exclusionary**		757-827-3119	2244 Executive Dr, Hampton 23666 Fax prescreening to Hampton/NN CSB			
VA Baptist **ID Exclusionary**		800-947-5442	330 Rivermont Av, Lynchburg 24503 Fax prescreening to Horizons CSB			
Stone Springs (Call Dominion Access) **Moderate ID exclusionary**		703-538-2872, 2 **VOLUNTARY REQUESTS ONLY**	2960 Sleepy Hollow Road, Falls Church 22044 Fax prescreening to Fairfax-Falls Church CSB		**VOLUNTARY ADMISSIONS ONLY**	
Central State Hospital Daytime – M-F 8-5 712-2279		Other times 524-7151, or 7002	26317 W. Washington Street Petersburg, 23803			

DENIAL CODES – 1. Medical Complications 2. No Available Beds 3. Acuity of Client 4. Client Illness Chronicity 5. Milieu Issues 6. Diagnosis 7. No timely response 8. Other issues

Appendix B – Geriatric bed search form

Geriatric Bed Search

Date _____Client Name/#_____ ECO start_____ Contact at 5hr_____7 Hour time_____ ECO end_____

	HOSPITAL	PHONE	ADDRESS	TIME/CONTACT NAME	TIME INFO FAXED	TIME HOSP. RESPONDED	REASON FOR NO ADMIT
1	VCU Health System	**855-546-7792** f- 628-4042	1300 E. Marshall Street, RVA 23298 RBHA CSB				
	Bon Secour Access	**287-7836**	fax: 281-8557				
2	**Community**	**225-1730**	1500 N. 28th Str, RVA 23223 RBHA CSB				
3	**St. Mary's**	281-8266	5801 Bremo Rd, RVA 23226 Henrico CSB				
4	**Rappahannock**	435-8490	101 Harris Rd, Kilmarnock, VA 22482 Middle Pen/Northern Neck CSB				
5	**Southern VA Regional Medical Center**	434-348-4580	727 N. Main Street Emporia, VA D-19 CSB				
6	**Tucker Pavilion NSC**	**483-1338**	7101 Jahnke Rd, RVA 23225 RBHA CSB				
7	**Poplar Springs**	**862-6330**	350 Poplar Drive, Petersburg D-19 CSB	**Will accept some geriatric**	**on case by**	**Case basis.**	
8	**ARC for** Lewis Gale	**483-0050, 4** 855-544-9337	1 Arh Lane, Low Moor, VA 24457 Allegheny CSB fax 540-965-2105				
9	**Pavilion at Williamsburg**	**757-941-6410** Fax 757-941-6419	5483 Mooretown Rd W'burg, VA 23188 Colonial CSB fax – 757-253-4118				

10	**Va Baptist Hospital**	**800-947-5442** Fax – 888-308-0489	3300 Rivermont Ave, Lynchberg Horizon CSB – fax 434-485-8964				
11	**Riverside Behavioral**	**757-827-3119**	2244 Executive Drive, Hampton 23666 Hampton/NN CSB – fax-757-788-0965				
12	**Dickenson Community Hospital**	**276-926-0251** Fax 276-926-0254	312 Hospital Drive, Clintwood VA 24228 Dickenson CSB 276-926-9179				
13	**PIED MONT GERIATRIC STATE HOSPITAL**	**24 hour number 434-294-0112** New fax- 866-718-8593	5501 W. PATRICK HWY BURKEVILLE, VA 23922				

Denial codes – 1. Medical complications. 2. No available beds 3. Acuity of client 4. Chronic illness

5. Acuity of the unit 6. Diagnosis 7. No timely response 8 Other – specify

Appendix C – Child & Adolescent bed search form

LIST OF 13 CHILD AND ADOLESCENT HOSPITALS

DATE_____ NAME_____ ID_____ ECO START_____
ECO 6 HOUR_____ ECO END_____

HOSPITAL	TELEPHONE	ADDRESS	TIME & NAME OF CONTACT	TIME INFO WAS FAXED	TIME OF RESPONSE	CODE FOR DENIAL
VTCC (ages 4-17)	**855-546-7792** Fax 628-4042	1308 Sherwood Ave RVA 23222 CSB – RBHA fax 819-4263				
NSC for TUCKERS (ages 5-17)	**483-1338-office** Fax – 483-1339	7101 Jahnke Rd, RVA 23225 CSB – RBHA – fax – 819-4263				
Poplar Springs (ages 11+)	**748-7490** Fax 862-6322	350 Poplar Dr. Petersburg, VA 23805 CSB D- 19 – fax – 722-4291				
Snowden (ages 13-17)	**540-741-3933** Fax 540- 741-4765	1200 Sam Perry Blvd. F"burg VA 22401 CSB Rappanhannock Area –Fax 540-373-6876				
Kempsville Center for Bx. Health (ages 5-18)	**757-461-4565** Fax 757-455-0298	860 Kempsville Rd. Norfolk VA 23502 CSB – Norfolk fax – 757-664-7690				
Riverside Behavioral Health (ages 12+)	**757-827-3119** Fax757-827-9145	2244 Executive Dr Hampton 23666 CSB Hampton/NN fax – 757-788-0011				
Cumberland Hospital Day and night	804-966-1638 Fax – 510-2246	9407 Cumberland Road New Kent VA 23124 Henrico CSB covers hearings				
Newport News (ages 8-17)	**757-888-0400, "1"** Fax – 757-369-5335	17579 Warwick Blvd Newport News, 23608 CSB – Hampton/NN – 757-788-0011				

North Springs (ages 7-17)	**703-554-6300, '3"** Fax – 703-737-6715	42049 Victory Lane Leesburg, VA 20176 CSB – Loudon fax – 703-777-0320				
VA Baptist Hospital (ages 6-17)	**800-947-5442** Fax: 888-308-0489	3300 Rivermont Ave Lynchburg 24503 CSB – Horizon – fax – 434-847-2795				
Carilion Clinic (Roanoke Memorial) (ages 9-17)	**Connect Care "3" 540-981-8181** Fax – 540-857-5211	2017 S. Jefferson St. Roanoke VA 24014 CSB – Blue Ridge – fax 540-266-9204				
HCA ARC Lewis Gale Medical Center (ages 13-17)	**877-886-7026, #3** Fax – 477-1259	1902 Braeburn Dr. Salem VA 24153 CSB – Blue Ridge – fax – 540-266-9204				
St. Joseph's Villa CSU (ages 5-17)	**874-9119** Fax 955-4240	7700 Brook Rd. Richmond, VA 23227	**Voluntary admit only**			
Commonwealth Center for Children And Adolescents	**540-332-2120** b/u 540-332-2110/2100 Unit-540-332-2140	1355 Richmond Ave. Staunton VA 24401				

Denial reason / Declined admission codes: 1. Medical complications/clearance 2. No available beds

3. Acuity of client 4. Client illness chronicity 5. Milieu issues/acuity of unit 6. Diagnosis

7. No timely response 8. Other (specify)

PIEDMONT GERIATRIC HOSPITAL

TDO Admission Protocol

Piedmont Geriatric Hospital, a 123-bed freestanding, psychiatric facility, has limited medical care capability for acute cases. PGH is located in a rural location 20 minutes away from the nearest community hospital. PGH does not have 24/7 onsite physicians, pharmacy or lab/radiology.

PGH TDO Admission Protocol

ECO Notification reports:

M-F, 7:30am-4:00pm
- call the Admission Coordinators cell # 434-294-0112
- email # PGHECONotification@dbhds.virginia.gov
- call the Answering Service- # 855-473-7193

Weekends, after hours or holiday
- call the Answering Service- #855-493-7193 (available 24/7)

PGH will anticipate the following information- pt. name/initials, DOB, gender; CSB; ES staff name and contact #; ECO start time

All emails, phone calls and Answering Service contacts are recorded by the PGH Admission Coordinators on the TDO Tracking Log.

ECO 5th hour:

Due to the increased medical complexity that may present with the geriatric population, PGH request the ES staff make verbal contact with PGH Admission on Call staff (AOC) at the 5th hour to begin dialogue regarding the possible need for a State Hospital "Last Resort" bed.

5th hour PGH contact is the same process as the Notification process provided above. If the Answering Service is contacted, request a call back. The ES staff can anticipate a call back from the PGH AOC within 10 minutes. If you do not receive a call from PGH AOC in 10 minutes, please call the Answering Service again.

At the 5th hour PGH will anticipate the following information:

- CSB prescreen
- bed search status: hospitals still pending, reasons patient is being declined, etc.
- labs & tests as follows to rule out medically induced psychiatric symptoms:

- Physical exam to include VS, allergies, current medications and medical problems
- CBC
- CMP
- UA, UDS
- Chest x-ray
- EKG
- BAL and/or medication levels if pt. it symptomatic (ex: Lithium, Depakote)

A PGH physician may request additional testing for PGH medical clearance as appropriate (ex: CT scan of the head based on recent falls; Cardiac enzymes based on pt.'s current presentation and medical history, etc.)

The PGH physician may also request doctor-to-doctor communication with the ER physician if there are questions or disagreements related to labs or other tests requested and/or medical clearance.

To maximize patient safety, we request stabilization of acute medical problems prior to TDO admission.

ECO 7th hour:

PGH will make every effort to complete their medical screening/clearance and provide their final disposition by the 7th hour to allow the ES staff sufficient time to petition for a TDO from the magistrate prior to the end of the ECO.

If, however, PGH medical clearance is still pending, a "TDO pending medical clearance," can be obtained by the CSB. This will allow time for completion of all labs and testing by the sending facility and for the PGH physician to thoroughly assess that PGH can adequately meet the medical needs of the patient. The patient should not be transported to PGH until our physician has communicated their final disposition.

PGH requests a nurse to nurse report, from the sending hospital, to the Admission Unit Charge Nurse, 434-767-4906, prior to the patient transfer.

Additionally:

If PGH has no available beds, at the time the ES staff makes contact with the AOC for a 'Last Resort " bed, the AOC will contact the PGH Director. Our Director will then notify an appropriate State hospital director of the need for a diversion to their facility.

The ES staff will be provided with the contact name and number for the State facility. The completion of the ECO-TDO process will be in accordance with the protocol directed by the receiving hospital of diversion.

Appendix E: CCCA Bed Management Plan

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan

November 1, 2017

DBHDS maintains 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 Staunton, 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 referrals meeting safety net criteria (TDO) are accepted for admission after exploration of alternative placements, and medical clearance.

The high volume of admissions and a short average length of stay for children at CCCA intensifies the need for active and effective bed management at the facility and community levels. The steps listed below help assure bed space is available when it is needed.

<u>Admissions Process</u>

- CCCA admits children and adolescents up to 18 years of age who are in need of inpatient psychiatric hospitalization from the entire Commonwealth of Virginia
- The Intake/Admissions Office (540-332-2120) is staffed and accepts admissions 24 hours a day, 7 days a week
- 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 forth in the Psychiatric Treatment of Minor's Act (see §16.1-335 *et seq*.) and/or mandated by legislation requiring state hospitals to serve as facilities of last resort. (see 16.1-340.1(d)
- All admissions must first be prescreened by a CSB. A prescreening is also requested in those admissions ordered pursuant to VA§ 16.1-275 or 16.1-356

(court-ordered evaluations) to assist in the assessment and discharge planning processes

- Any admission request not from CSBs are referred to the CSB for appropriate pre-admission prescreening
- The Admissions Coordinator consults with the CSB Emergency Services ES evaluator on every referral to:
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried or that may be available
    - Review all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act and/or last resort legislation
    - Consider the need for hospitalization, and if hospitalization is needed, the availability of other options; particularly those that keep the child or adolescent in their community
- While the Admissions Coordinator may encourage the ES evaluator to explore options not considered, including providing names of alternative hospitals, CCCA will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option (i.e. those under TDO)
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If a child is under an ECO, and the bed search is not successful by hour 6, the ES evaluator will notify the CCCA Admissions Coordinator at hour 6 via telephone call and fax the Uniform Prescreening Report to CCCA
- At hour 7 if a bed has not been identified, the ES evaluator will contact CCCA to ask request a TDO bed acceptance pending medical clearance if youth is in the ED.
- If a child is in the Emergency Department, lab results, MAR, physician review of systems and physical exam must be received for CCCA RN/MD review prior to transport of an accepted admission
- The Admissions Coordinator will review medical concerns and consult as needed with the RN and physician to determine if additional medical information is necessary or if medical issues require attention prior to admission
- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which the facility believes the child's needs would not be best served at CCCA and there is no legal directive to admit, the referring party will be encouraged to identify alternative, more suitable means of treatment

<u>Bed Management</u>

A. Diversion

When bed space is limited:

- The CSB Emergency Services Departments are contacted and informed of the available beds and requested to divert admissions 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 within 10 days 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 within 10 days, 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;
- Admission may be deferred for patients who are in a safe place (e.g., another facility, hospital or detention)
- 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 a TDO.

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 related to the transition to the appropriate setting.

To support this, CCCA will:

- Encourage families and communities to rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged to another level of care
- Hold bi-monthly Statewide Census Management/Ready for Discharge Meetings to discuss extraordinary barriers

C. Partnerships

DBHDS may enter into contractual agreements with one or more non-DBHDS hospitals to provide acute care beds to patients who would otherwise be admitted to CCCA. These agreements are at the discretion of DBHDS and the partner hospitals. For such arrangements:

- Referrals to partner hospitals will come only from CCCA Admissions staff
- Certain patients will not be eligible because of clinical, behavioral, or other needs that exceed the capacities of the partner hospitals

Central State Hospital Medical Capabilities

Psychiatric Unit or State Facility Medical Care Capabilities and Exclusion Criteria

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.

Psychiatric hospitals and units typically have more limited medical and medical nursing resources than medical units. They 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.

A typical psychiatric unit can monitor vital signs manually, provide oral medications, monitor fluid "input and output", monitor pulse oximetry, institute 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 not really more capacity to provide more intensive medical treatment.

Psychiatric Units (generally) and State Psychiatric Facilities lack the capacity to treat general medical conditions found in General Hospitals. Limitations with respect to Medical and Nursing expertise, access to diagnostic testing and continuous monitoring, and limited or absent capabilities to provide intravenous therapy, maintain central lines, provide wound and drain management, and delayed access to emergency care will place individuals at potentially grave risk if placed in a setting that is unable to provide the required care. At the same time, such facilities are generally able to manage most chronic conditions for individuals who can be treated with oral medications, manual vital sign monitoring, non-emergent consultations, and routine labwork and diagnostic testing.

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 or frank bowel obstruction, acute respiratory distress, sepsis, overdoses, open wounds, surgical drains, severe burns, intracranial bleeds, pulmonary embolus, acute drug withdrawal, active labor, and so forth.

Preventative detox for alcohol and benzodiazepines can be done, pregnant patients, individuals with HIV, individuals with insulin dependent diabetes, and those requiring a wheelchair can typically be managed safely and interventions to prevent decubitus, aspiration, and bowel obstruction are generally possible.

Facility or Unit: ____Central State Hospital____

Capabilities:

Physician

Primary Care Physician in house 24/7	NO (MOD may be a PCP, psychiatrist or PA/NP)
Psychiatrist in house 24/7	NO (MOD may be a PCP, psychiatrist or PA/NP)
Physician on call by phone only after hours/weekends	NO (MOD is required to be on grounds)

Nursing

RN on unit 24/7	YES
RN on site 24/7, but not on each unit	N/A

Nursing Services

Frequent vital signs, q 2 hours or less	YES
Intake and output monitoring	YES (limited by patient cooperation)
Weights (b.i.d. or less)	YES
Accuchecks for blood glucose monitoring	YES
O2 Saturation	YES

Diagnostic Testing

STAT labs on site regular working hours	YES
STAT labs on site 24/7	NO
Routine X Rays on site regular working hours	YES
STAT X Rays on site 24/7	NO
EKG/STAT EKG regular working hours	YES
STAT EKG 24/7 (on site)	NO
Arterial blood gas (on site)	NO
Venous Doppler (on site)	NO
Bladder Ultrasound (on site)	NO
Swallow Studies on site regular work hours (on site)	NO
Percutaneous procedures (drain fluids, biopsy, etc.)(on site)	NO
Interventions (on site)	

Continuous electronic monitoring (VSs, O2, etc.)	NO
IV Fluids	NO
IV Antibiotics or other medications	NO
Indwelling urinary catheter management	YES (with risks associated from peers)
PICC Management	NO
Total Parenteral Nutrition (TPN)	NO
Feeding through G or J tube	NO
Isolation	NO
Decubitus management Stage 1 – 2	NO
Decubitus Management Stage 3 – 4	NO
Surgical Drain Management	NO
Tracheostomy Management	YES (chronic only)
In and Out Urinary Catherization	NO
Analgesic Pumps	NO
Methadone Maintenance for SA	YES
Chemotherapy	NO
Basic CPR plus AED	YES
Advanced CPR (ACLS)	NO

Emergency Treatment

Immediate: In house	NO
Call 911 only	YES

Time from 911 call to ER < 30 min 30 – 60 min (depending on length of time EMT works on the patient on site before transporting to ER)