HPR V Regional Protocol for Locating a Bed for Individuals Requiring TDO

Revised June 10, 2014
Effective July 1 2014
Next Planned Revision - June 23, 2014

Editor Notes: The Revised Protocols are effective July 1 and coincides with the effective date of Virginia Code as revised § 37.2-808 J and § 37.2-809 et. seq.

The practice of law enforcement officers to notify the Community Services Board (CSB) precedes this revision in many localities.

Introduction

In an effort to develop a consistent and timely response, these guidelines follow the nine steps as developed by the Department of Behavioral Health and Developmental Services (DBHDS) (Appendix B).

HPR V has utilized emergency bed protocols for several years. These revised protocols enhance those currently in place and affirms the following core principles:

1. The time frames to vacate a bed will remain the same or similar to the current HPR V Guidelines for Psychiatric/Behavioral Emergencies and the use of the Eastern State Hospital Emergency Beds. The state facility and Community Services Board (CSB) workers will make every effort to locate a local hospital bed at the time of the commitment hearing or if no local bed is appropriate, identify an alternative.

2. Emergency service workers and local hospital workers will continue to make every effort to provide care within the individual's community.

3. ESH beds will be displayed on the Virginia Acute Psychiatric and CSB Bed Registry (Bed Registry) and all vacant beds are considered safety net beds. The emergency service workers and local hospital workers will also utilize the Bed Registry to assist locating and identifying available beds. However, the state facility may not refuse an adult or a juvenile under a Temporary Detention Order even if no bed vacant. The Facility Management Committee will oversee bed utilization as well as continue to oversee the requests for local inpatient transfer to ESH.

Procedures for Emergency Service Staff

At the time a law enforcement officer initiates custody under either an emergency custody order or law enforcement authority:

1. The officer executing the ECO or initiating law enforcement custody will notify the CSB emergency services office that a person is in custody and the emergency service staff

shall then notify the state facility by phone that an evaluation will commence (refer to Appendix H for the ESH information on the process).
2. The custody officer will provide the detainee a copy of the *Explanation of Emergency Custody Procedures (DC-4050)*in advance of the prescreening.

At the time of an emergency evaluation,

1. Emergency services worker will prescreen an individual and determine if a TDO is required. A medical evaluation[1] will be arranged to assure no medically emergent condition exists which may prevent/delay acceptance by a treatment facility. The emergency services worker should request transport to a medical facility for medical evaluation be directed in either an ECO or TDO whenever a potential treatment facility may require a medical evaluation. A provisional treatment plan, including the possible service adjuncts, will be arranged when necessary prior to the expiration of the ECO period. A partial list of support services is summarized in Appendix A.

2. Procedures that apply during the period of evaluation (these steps do not preclude other requirements during an evaluation):
    a. The emergency services worker seeks admission to a psychiatric bed at a local hospital, starting with any hospital in the HPR V geographical area (Appendix D). The emergency services work may consult the Bed Registry as well as contact facilities not listed on the Bed Registry or listed as not having vacant beds. The emergency services will continue to maintain their own records for each individual of facilities contacted and responses by their intake workers when an ongoing search is required.
    b. As soon as possible after the evaluation is completed, the CSB emergency service staff will notify the State Facility of the outcome (for example if a TDO is warranted, if a local bed has been located or a local bed will be pursued, or if no TDO is warranted).
    c. Upon determination by the emergency services worker that a person who is experiencing mental illness and that no inpatient acute bed is available, the emergency services worker will contact their supervisor not later than 6 hours after the ECO has begun[2]. The hospital emergency department staff should also consult their hospital protocols.
    d. In the event a medical evaluation has not been completed within the first 6 hours of custody, the emergency services worker will contact their supervisor for guidance.
        i. In the event of community to state facility transfer, the emergency services worker will coordinate transfer and transportation with ESH staff.

[1] Medical evaluation has the goal of preventing delays in receiving medical care and identifying an appropriate mental health treatment facility:
1. Identify medical condition and provide treatment at the closest location
2. Include EMTALA transfer documentation
3. Includes physician to physician consent and consultation to resolve any clinical issues
4. Upon arrival at ESH, the individual may transfer to a local medical hospital
5. Regional training and continuing education is recommended as part of implementing protocols.

[2] The ECO period begins when a law enforcement officer initiates custody.

ii. If the person is to be taken to ESH from a hospital emergency department, the attending MD shall contact the State Facility physician. The consent for safe transfer (EMTALA) will be included in the clinical record materials provided to ESH.

e. The CSB emergency services worker will contact Eastern State Hospital (ESH) staff of the crisis situation and that a safety net bed may be needed (Appendix H). The CSB emergency services worker would not need to provide detailed information at the time of the alert. If the bed is later determined as not needed, the emergency services worker will notify ESH staff that the bed is no longer needed.

f. The emergency services supervisor will review the situation and the plans for the next stage of treatment.

g. A TDO should be requested from the appropriate magistrate office at least 30 minutes prior to expiration of the ECO with ESH or another state facility designated as the treatment facility if no other bed is located.

3. In the event that a safety net bed is needed, the emergency services supervisor will consult the Guidelines for Psychiatric/Behavioral Emergencies and the use of the Eastern State Hospital Emergency Beds and determine the potential for returning to a local hospital at the time of the hearing.
    a. The local emergency department and the CSB emergency services worker or designee will fax the needed information to ESH.
    b. If the individual is currently under the care of a local hospital, the local hospital will provide clinical information such as but not limited to medical evaluation[1] and EMTALA documents. Physician to physician communication may be necessary.
    c. In the event that the individual leaves the hospital or evaluation location before a TDO is executed by a law enforcement officer, the emergency services worker will notify local law enforcement as well as the emergency services supervisor and local hospital administration (if in a local hospital)[3].

4. If ESH does not have a bed the Facility Director or designee will seek a bed from a local hospital or sister state hospital.

5. If a bed cannot be found in a reasonable time at a local hospital or another state hospital, ESH Facility Director will contact the DBHDS Assistant Commissioner for Behavioral Health or designee to find a bed.

6. DBHDS staff is monitoring and tracking outcomes with CSBs, private hospitals, state hospitals, the use of Bed Registry data, and will introduce continued quality improvement activities based on data and experience.

[3] Under §§ 37.2-808 (Adult ECO) and 16.1-340 (Juvenile ECO), a person remains in custody under an ECO until a TDO is issued, the person is released, or the ECO expires after 8 hours.

7. In collaboration with the hospital forum, regional training and education that includes all stakeholder groups (individual, law enforcement, magistrates, special justices, as well as local hospitals and CSBs) will be developed.

8. If the individual is admitted to the state facility, the CSB worker will develop a plan with the state facility team to return to the community at the earliest opportunity. If a return to the community cannot be completed by the time of the commitment hearing, the CSB Clinical Director will notify the Reinvestment Project Director.

9. These procedures apply to the CCCA protocols (attached) with the exception of Part III.

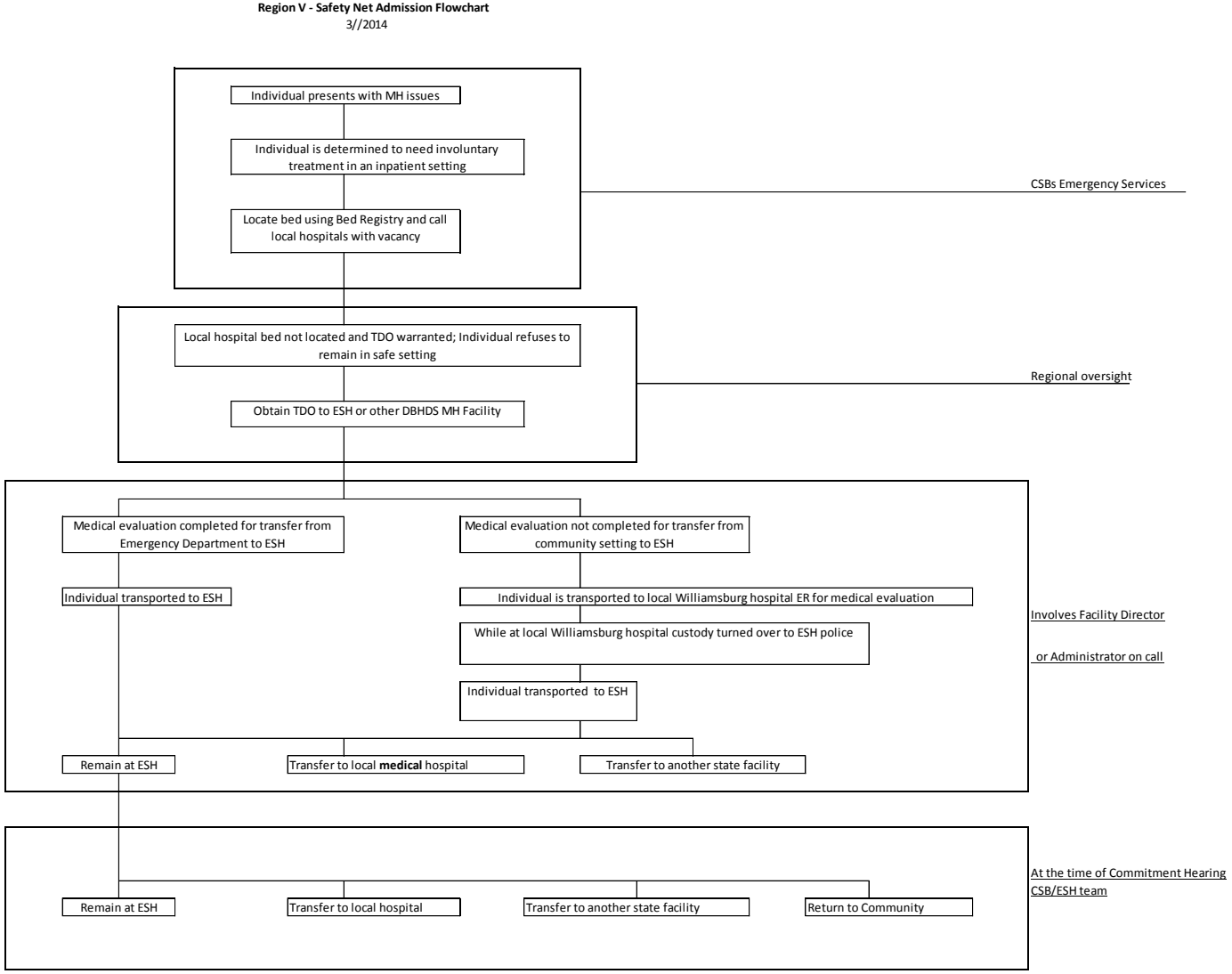
10. Additional Considerations
    a. Effective July 1, 2014, the evaluation process must be completed and a treatment facility identified within 8 hours (starting with the time of custody) if the person appears to meet criteria for a TDO.
    b. On a case by case basis, these situations will be evaluated through local officials (may include CSB workers, Magistrates, Law Enforcement)
        i. Any TDO that cannot be executed or cannot be served
        ii. Any instance of a declined hospital admission after a TDO is written
        iii. Any instance of a re-directed hospital admission after a TDO is written (Notice of Alternative Facility of Temporary Detention, DC-4044) and (Order for Transportation to Alternative Facility of Temporary Detention, DC-4046)
11. Tentative Procedures for Inter-facility Transfers Effective July 1, 2014:
    a. Various provisions of laws effective July 1, 2014 allow for an adult to be transferred for an initial treatment facility to a more appropriate treatment facility at any time during the TDO period. The transfer authority does not apply to juveniles.
    b. If, following execution of a TDO, a more appropriate facility is identified before law enforcement transfers custody of the individual to the originally-designated treatment facility, the emergency services worker should contact the law enforcement agency as soon as possible and redirect the transporting officer(s) to the alternative facility.
    c. If a more appropriate facility is identified after law enforcement transferred custody of the individual to the original facility, the emergency services worker should prepare an Order for Transportation to Alternative Facility of Temporary Detention (DC-4046).
        i. The order should include the original TDO number or court case number, identify the court to which the original TDO was returnable, and include the respondent's name, address, date of birth, and gender. It should also identify the original treatment facility and the alternative facility.
        ii. If the basis for the TDO is that the person is unable to care for self, the order may also request that an Alternative Transportation Provider be designated if available and able to safely conduct the transport. Alternative Transportation may not be authorized if the basis for the TDO is that the individual is a danger to self or others. If no Alternative Transportation provider is available or authorized, the order should indicate that a law enforcement agency will conduct the transport.
        iii. The emergency services worker should then call the magistrate office that issued the TDO and fax the order to a magistrate at that office or an available magistrate

office covering that jurisdiction. The magistrate will designate the responsible Alternative Transportation Provider or law enforcement agency and sign the order. The designated law enforcement agency may or may not be the same agency that executed the original TDO.

iv. If an Alternative Transportation Provider is authorized, the magistrate will fax the signed order to the emergency services worker for delivery to the original facility or Alternative Transportation Provider.

v. If a law enforcement agency is designated, the magistrate will deliver the order to the designated law enforcement agency for execution.

Graphic 1:Admission Flow Chart



Procedures for Utilization Review and Performance Improvement

In order to assure a consistent process, utilization review and performance improvement procedures will include these elements whenever a state facility bed is used for an individual who is subject to involuntary civil or involuntary criminal commitment:

1. Uniform screening assessment is completed by the emergency services worker and identifies the individual's care needs and also identifies that these needs are in accordance with inpatient admission criteria.

2. Insurance information has been verified and listed on the uniformed screening assessment.

3. The individual has been determined to be unwilling to receive inpatient treatment or is incapable of making an informed decision.

4. Using the Bed Registry, the emergency services worker begins contacting the hospitals on the referral list. Contacts are initiated with the local hospitals closest to the individual's location. Contacts are made with consideration of the hospital's proximity and individual's preference. A third consideration is continuity of care, and contacting the hospital where the individual recently received care. The emergency services worker is to remain mindful of the ECO time constraint as this may limit the number of hospitals that can be contacted.

5. If a bed is not available, all contacts are documented on the CSB hospital roster[4]. The emergency services worker is to document who was contacted and state the reason why no beds were available, moving to the next facility on the list (Appendix D). Results are to be documented on the Bed Registry.

6. Effective July 1, 2014, an ECO is in effect for 8 hours after a law enforcement officer initiates custody. No extensions are authorized. At the 6th hour, [2], if there is still not a likely willing facility, the emergency services worker must call and speak to the CSB emergency services supervisor or designee.

7. If it is determined after consultation with emergency services supervisor or designee, that a bed will be needed at a state facility, then the emergency services supervisor will initiate the Guidelines for Psychiatric/Behavioral Emergencies and the use of the Eastern State Hospital Emergency Beds and transmit the safety net plan to the HPR V Project Director.

8. If hospital has a bed, provide the hospital the necessary documentation to include all clinical and medical information.

[4] Each CSB will continue the current practice whereby the emergency services worker logs the bed search and ES TDO log.

9. If the basis for the TDO is that the individual is unable to care for self and not that he or she is a danger to self of others, the emergency services worker should determine if a family member or other person is available to act as an Alternative Transportation Provider and safely transport the individual to the treatment facility.

10. Once a bed has been secured at a facility, the emergency services worker will immediately present their assessment to the Magistrate and request a TDO. The emergency services worker should also request authorization for an Alternative Transportation Provider if available.

11. If the Magistrate declines the request to issue the TDO, the emergency services worker will contact the Program Coordinator or designee.

12. If emergency services worker determines TDO criteria have been met and there is not a petitioner or the petitioner rescinds the support for a TDO, the emergency services worker may request a TDO from the magistrate without written petition. The emergency services worker may also create a less restrictive level of care and/or a safety plan that shall be documented in the evaluation.

13. The emergency services worker must call and speak to the CSB emergency services supervisor or designee if a willing facility has not been identified by the start of the 6th hour. [2]

14. Training and development plan
    a. Provide updates to the Regional Hospital Forum and members will also be involved in providing guidance in the development of any curriculum.
    b. Institute and provide updates at quarterly meetings with the Magistrates, law enforcement, commonwealth attorneys, and public defenders,
    c. Implement a section on the HPR V Reinvestment website devoted to guidelines and protocols related to Emergency Services and Emergency Department practices.
    d. The first training program will be scheduled for June/July 2014.

15. Performance improvement plan
    a. Incorporate Bed Registry data after 3 – 6 months experience and after finalized guidance on the frequency of Bed Registry updates.
    b. Quarterly regional reporting. Prior to final publishing utilization results with the RLT, the constituent regional groups will evaluate for accuracy and trends. These reports will include but will not be limited to: number of individuals admitted, number of individuals discharged, census, number of individuals under TDO, length of hospital stay, inpatient bed days purchased and dollars spent.
    c. Continue current procedures related to the Facility Management Committee, which include review of the transfer requests from local hospitals, discharge readiness plans and forensic services including forensic orders received, outpatient restoration and discharge planning from state facilities.

d. Implement the use of crisis planning and advanced directives to promote the development of intensive community resources which can then be mobilized at the time of Emergency Services evaluation.
e. These protocols will be evaluated 90-days after implementation.

Protocol Development Committee

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Sherwin Davis, Southeastern Virginia Training Center
John Dool, HPR V Reinvestment Project
Dan Longo, Colonial Behavioral Health Services
Jackie Schaede, Norfolk Community Services Board
Priscilla Scherger, Eastern State Hospital
Mary Witwer, Virginia Beach Department of Human Services

Participating also are:

Council of HPR V Emergency Service Managers
HPR V Hospital/CSB Executive Forum

Protocol Development Committee (June 10, 2014)

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Dan Longo, Colonial Behavioral Health Services
Jackie Schaede, Norfolk Community Services Board
Priscilla Scherger, Eastern State Hospital
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David Lyon, Eastern State Hospital
Thomas Cahill, Chief Magistrate for Virginia Beach
Scott Burke, Portsmouth Police Department
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Regional Leadership Team: Approved in principle 3/13/14
Effective: 3/15/14

June 10, 2014 pending final approval

Appendix A

A partial list of supports that may be contained in a provisional treatment plan developed prior to issuing a TDO:

a. Individuals who are deaf – as mandated by State Code, VDDHH (Virginia Department for the Deaf and Hard of Hearing) maintains a directory of Qualified Interpreter Services (for example certified (RID) or qualified (VQAS)) and works to remove communication barriers. DBHDS, in cooperation with the CSBs, provides comprehensive consultative services.
b. Individuals who require intellectual/developmental services - contact REACH HPR-V for all emergent calls for individuals with intellectual and/or developmental disabilities for technical assistance and possible referral. The REACH program will not prevent a bed from being needed however the program would provide a collateral service. REACH will continue to collaborate on treatment and discharge planning as may be appropriate.
c. Older adult individuals – Consider Senior Adult Services at Hampton Newport News CSB, Middle Peninsula Northern Neck CSB and Virginia Beach Department of Human Services.
d. Individuals who may have experienced traumatic brain injury
e. Individuals who may have demonstrate symptoms or behaviors associated with dementia and early onset dementia
f. Involving law enforcement for those situations where public safety is threatened

Appendix B: Process

Guidelines: Required protocol elements for state hospitals, CSBs, private hospitals Issued by DBHDS, Jan. 15, 2014

Step 1	CSB prescreener evaluates person and determines if TDO is necessary
Step 2	CSB arranges for necessary medical screening according to clearly established regional hospital requirements
Step 3	Using bed registry and other contacts, CSB begins contacting private hospitals in the area according to regional protocols
Step 4	Before the ECO expiration if it is appearing likely that the community hospital bed search will not be successful, CSB alerts state hospital director (or designee) (Detail outlined in section titled: *Protocol Working Draft and Quality Assurance*)
Step 5	If state hospital director is satisfied protocols are complete and person's needs can be met (medical clearance) an admission is arranged at the primary hospital
Step 6	If the primary hospital does not have an appropriate bed the primary hospital director seeks a bed from sister state hospitals
Step 7	If bed can't be found in a reasonable time at another state hospital, the primary hospital director will contact the Asst Comm. for BH or designee to find a bed if available in the state hospital system
Step 8	If necessary Central Office will direct admission at a state hospital
Step 9	DBHDS staff will develop a processes to monitor and track outcomes with CSBs, private hospitals, state hospitals, the use of bed registry data, and to introduce continued quality improvement based on data and experience

Appendix C: Contact lists

Deaf/Hard of Hearing Services

Kathy Baker, Coordinator of Services at 540/213-7527

Deaf/Hard of Hearing Services in HPR V

Paula Markham, Regional Deaf Services Coordinator, Hampton Newport News CSB
Office number: 757-788-0201 (Hrs: 8:30 a.m. - 5:00 p.m.)

REACH HPRV

REACH 24 Hour emergency assistance - (855) 807-8278 (toll free)
Office Telephone: (757) 325-8673
Office Fax: (757) 788-0984

Eastern State Hospital

Contact the facility switchboard at 757-253-5161 and ask for Admissions (during business hours) or the Nursing Supervisor (after hours/weekends/holidays)

Appendix D: Hospital Contact List

Hospital Roster Form Updated 03/10/14

Client _____ Case # _____ Date: _____ Total Phone Time: _____

HPR V Facilities

Hospital Name	Approximate Distance From SNGH	Address	Phone Number	Fax Number	TDO	Minors	Staff Contacted	Faxed?	Accepted?	Accepting MD	Comments
Senara Norfolk General	At Location	600 Gresham Drive, Norfolk, VA 23507	Page MD	757-388-3641	Yes	No					Has a geriatric unit.
Sentara Virginia Beach General	19.0 Miles, 29 Minutes	1060 First Colonial Road, VB, VA 23454	757-395-1999	757-222-0317	Yes	No					Has a geriatric unit.
Maryview Behavioral Medical Center	4.7 Miles, 11 Minutes	3939 High Street, Portsmouth, VA 23707	757-398-2400	757-399-8991	Yes	Yes					
Virginia Beach Psychiatric Center	19.0 Miles, 29 Minutes	1100 First Colonial Drive, Virginia Beach, VA 23454	757-496-3500	757-496-4403	Yes	No					Has a geriatric unit.
Obici	22.1 Miles, 32 Minutes	2800 Godwin Boulevard, Suffolk, VA 23434	757-934-4786	757-934-4357	Yes	No					
Riverside Behavioral Health Center	24.8 Miles, 32 Minutes	2244 Executive Dr, Hampton, VA 23666	757-827-1001	757-827-9145	Yes	Yes					
Pavilion at Williamsburg Place	54.7 Miles, 1 Hour 2 Minutes	5477 Mooretown Road, Williamsburg, VA 23188	1-800-582-6066	757-941-6418 or 757-941-6419	Yes	No					Takes Geriatrics
Spotsylvania Regional Medical Center	141 Mile, 2 Hours 31 Minutes	4600 Spotsylvania Parkway, Fredericksburg, VA 22408	540-498-4563	540-498-4566	Yes	No					
Twin County Regional Healthcare	303 Miles, 5 Hours 53 Minutes	200 Hospital Drive, Galax, VA 24333	276-236-1700	276-236-1731	Yes	No					

Other Virginia Facilities

Hospital Name	Approximate Distance From SNGH	Address	Phone Number	Fax Number	TDO	Minors	Staff Contacted	Faxed?	Accepted?	Accepting MD	Comments
Kempsville Center	6.9 miles, 17 Minutes	860 Kempsville Road, Norfolk, VA 23502	757-461-4565	757-455-0326 or 757-455-0298	Yes	Yes					Minors Only
Cumberland Hospital for Children and Adolescents	73.4 Miles, 1 Hour 27 Minutes	9407 Cumberland Road, New Kent, VA 23124	1-800-368-3472	Ask for Fax Number	No	Yes					Only admits during daytime hours.
John Randolph Hospital	74.2 Miles, 1 Hour 44 Minutes	411 W. Randolph Road, Hopewell, VA 23226	804-541-1600	804-452-3656	Yes	No					

Southside Regional Medical Center	75.5 Miles, 1 Hour 45 Minutes	200 Medical Park Boulevard, Petersburg, VA 23845	804-765-5530	804-765-5708	Yes	No					
Poplar Springs	75.9 Miles, 1 Hour 44 Minutes	350 Poplar Drive, Petersburg, VA 23805	804-796-2100 or 866-546-2229	804-862-6322	Yes	Yes					
Southern Virginia Medical Center	80.3 Miles, 1 Hour 36 Minutes	727 North Main Street, Emporia, VA 23845	434-348-4580	434-348-4938	Yes	No					Ages 30 and over ONLY
Bridges (Rappahannock General Hospital)	82.5 Miles, 1 Hour 53 Minutes	101 Harris Drive, Kilmarnock, VA 22482	804-435-8490	804-435-8234	Yes	No					
Richmond Community Hospital	93.9 Miles, 1 Hour 42 Minutes	1500 North 28th Street, Richmond, VA 23223	804-287-3582	804-545-3205	Yes	No					
Virginia Treatment Center for Children (VTCC)	95.5 Miles, 1 Hour 46 Minutes	515 North Pence Street, Richmond, VA 23219	8a-10p: 804-828-8822, 10p-8a: 804-828-4999 pager 2500	Ask for Fax Number	Yes	Yes					Children and Adolescents Only.
MCV-VCU	96.8 Miles, 1 Hour 46 Minutes	1250 East Marshall Street, Richmond, VA 23298	804-828-2000	804-828-8002	Yes	No					
St. Mary's Hospital	103 Miles, 1 Hour 55 Minutes	5801 Bremo Road, Richmond, VA 23266	804-287-7836	804-281-8557	Yes	No					
Tucker Pavillion	106 Miles, 1 Hour 54 Minutes	7101 Jahnke Road, Richmond, VA 23225	804-323-8846	804-323-8253	Yes	Yes					
Peidmont Geriatric Hospital	131 Miles, 2 Hours 46 Minutes	5001 East Patrick Henry Highway, Burkeville, VA 23922	M-F 8a-5p: 434-767-4926 After Hours: 434-480-6855	Ask for Fax Number	Yes	No					Ages 65 and up ONLY. Daytime alternative #: 434-294-0112
Snowden Hospital	147 Miles, 2 Hour 36 Minutes	1200 Sam Perry Boulevard, Fredericksburg, VA 22401	1-800-362-5005 or 540-741-3900	540-741-3926	Yes	Yes					
UVA	167 Miles, 2 Hours 57 Minutes	1215 Lee Street, Charlottesville, VA 22903	434-531-7773	434-982-1604	Yes	No					
Prince William Hospital (CPAC)	187 Miles, 3 Hours, 22 Minutes	ER: 8700 Sudley Road, Manassas, VA 20110, Unit: 8680 Hospital Way, Manassas, VA 20110	703-369-8464	703-369-8467	Yes	No					Accepts alcohol/MH dual dx as TDO
Courtland Center	191 Miles, 3 Hours 55 Minutes	620 Court Street, Lynchburg, VA 24504	434-455-2098 (Press 9)	434-455-2098	Yes	No					Specializes in SA/MH dual dx. Accepts SA/MH dual Dx on TDO.
INOVA "Central Access" (Includes INOVA Fairfax Hospital, INOVA Loudoun Hospital, and INOVA Mount Vernon Hospital)	192 Miles, 3 Hours 25 Minutes	INOVA Fairfax Hospital: 3300 Gallows Road, Falls Church, VA 22042	703-289-7561	Ask for Fax Number	Yes	No					Get address to accepting hospital
Dominion Hospital	194 Miles, 3 Hours 28 Minutes	2960 Sleepy Hollow Road, Falls Church, VA 22044	703-538-2872	703-536-2523	No	Yes					
Danville Regional Medical Center	195 Miles, 3 Hours 49 Minutes	142 South Main Street, Danville, VA 24541	434-799-2243	434-799-2260	No	No					

Virginia Hospital Center	196 Miles, 3 Hours 34 Minutes	1701 North George Mason Drive, Arlington, VA 22205	703-558-6451	703-558-6771	Yes	No					
VA Baptist Hospital	196 Miles, 3 Hours 59 Minutes	3300 Rivermont Avenue, Lynchburg, VA 24503	434-200-4444	Ask for Fax Number	Yes	Yes					
Augusta Medical Center	197 Miles, 3 Hours 24 Minutes	78 Medical Center Drive, Fishersville, VA 22939	540-932-4060	540-932-4068	Yes	No					
Rockingham Memorial Hospital	217 Miles, 3 Hours 51 Minutes	5010 Health Campus Drive, Harrisonburg, VA 22801	540-689-1000 (Ask for PET Team)	540-689-4560	Yes	No					
Memorial Hospital of Martinsville and Henry	227 miles, 4 Hours 19 Minutes	320 Hospital Drive, Martinsville, VA 24115	276-666-7477	276-634-4915	Yes	Yes					
Winchester Medical Center and Behavioral Health (Also inludes Page Memorial Hospital, Shenandoah Memorial Hospital, and Warren Memorial Hospital)	238 Miles, 4 Hours 11 Minutes	WMC: 1840 Amherst Street, Winchester, VA 22601	540-536-8152 or 540-536-8597	540-536-2160	Yes	No					Get address to hospital if accepted by Shenandoah Memorial, Page Memorial, or Warren Memorial
Carilion "Connect" (Inludes Roanoke Memorial Hospital Rehab and St. Alban's Hospital)	287 Miles, 4 Hours 53 Minutes (To RMH)	RMH: 2107 South Jefferson Street, Roanoke, VA 24014	540-981-8181	540-342-3247	Yes	Yes					Get address if accepted by St. Alban's
Lewis Gale "Respond" (Includes Lewis Gale Pavillion and Alleghany Hospital)	287 Miles, 4 Hours 54 Minutes (To LGP)	LGP: 1902 Braeburn Drive, Salem, VA 24153	540-776-1100	Ask for Fax Number	Yes	"May be"					Alleghany Hospital specializes in Geriatrics, get address to hospital if accepted.

Military/Veteran Hospitals

Hospital Name	Approximate Distance From SNGH	Address	Phone Number	Fax Number	TDO	Minors	Staff Contacted	Faxed?	Accepted?	Accepting MD	Comments
Portsmouth Naval Medical Center	5.2 Miles, 11 Minutes	620 Effingham Street, Portsmouth, VA 23704	Unit: 757-953-5000 Admit Office: 757-953-0825	757-953-0825	No	No					Military only
Hampton VA Medical Center	15.6 Miles, 29 Minutes	100 Emancipation Drive, Hampton, VA 23667	757-722-9961	Ask for Fax Number	No	No					Veterans Only. TDO for H/NNCSB only.

State Hospitals

Hospital Name	Approximate Distance From SNGH	Address	Phone Number	Fax Number	TDO	Minors	Staff Contacted	Faxed?	Accepted?	Accepting MD	Comments
Eastern State Hospital	54.6 Miles, 1 Hour 9 Minutes	4601 Ironbound Rd, Williamsburg, VA 23188	757-253-5161 (Ask operator to transfer you)	Ask for Fax Number	Yes	No					
Central State Hospital	83.9 Miles, 1 Hour 54 Minutes	26317 West Washington Street, Petersburg, VA 23803	804-524-7000	Ask for Fax Number	Yes	No					Criminal TDOs
Western State Hospital	201 Miles, 3 Hours 27 Minutes	1301 Richmond Avenue, Staunton, VA 24401	540-332-8000	Ask for Fax Number	Yes	No					
Commonwealth Center for Children and Adolescents	201 Miles, 3 Hours 27 Minutes	1355 Richmond Avenue, Staunton, VA 24401	540-332-2100	Ask for Fax Number	Yes	Yes					Children and Adolescents Only

Appendix E

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

Appendix F

Serving Deaf and Hard of Hearing Consumers in Crisis Situations.

Regional Deaf Services Program (RDSP), Southwest, Virginia.
Administered by Hampton-Newport News Community Services Board (HNNCSB)

Serving: Chesapeake CSB, Colonial Services Board, Eastern Shore CSB, HNNCSB,

Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth Behavioral Health Services,

Virginia Beach CSB, Western Tidewater CSB

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 two-tiered response process and is meant to serve as a resource for crisis clinicians.

Tier One: Contact a qualified sign language interpreter to assist you. Attached is a list of 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 Regional Coordinator (RC) of Deaf Services (Paula Markham, PsyD, LPC: office: 757-788-0261; PMarkham@hnncsb.org; text: 757-570-4969; fax: 757-788-0950) as soon as possible (while crisis ongoing if possible). Dr. Markham can provide consultation, begin arrangements for an outpatient discharge appointment, and provide the reimbursement forms if needed. Please refer these patients immediately to the Regional Deaf Services Program by phone, email, or fax. If possible, provide a synopsis of the crisis event. (Be prepared to obtain a release of information for Regional Deaf Services, 200 Medical Drive, Hampton, Va, 23666.)

Tier Two: If unable to secure an interpreter, document your efforts and include the names of interpreters that you contacted. Do the best you can to conduct a sound clinical evaluation. Try to communicate directly with the individual by writing, speech/speech-reading. Speak in your normal tone of voice, a little slower than usual, and make eye contact while speaking. Make sure your environment is quiet and well lit. Make sure the light source is above you or shining on you, not behind you. Take your time. First *ask about* communication preferences with the individual (e.g., Write notes? Lip read? Show me (act out safely) what happened? Family or friend helps sign? *But do NOT use children*). Keep in mind that family members often have a bias as to their preferred outcome and may skew their interpretation that way. Also remember that family members may be an emotional trigger for the individual and thus may exacerbate an already volatile situation. 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. Assess your ability to communicate with the individual before gaining clinical information (e.g., NOT: Do you understand? BUT: Can you tell me what I just said?). Ask open ended questions and see what response you get. Ask the same question in different ways if necessary.

Possible alternative: Many hospitals now have Video Remote Interpreting (VRI). If you are in a remote location where there are few interpreters, it may be beneficial to call the hospital in your area and determine if they have VRI services available for their emergency room. If so, you may be able to work out a cooperative agreement whereby a deaf individual could voluntarily go to the ER where you could conduct your interview via VRI. Even if the hospital does not have VRI, you could try calling their emergency room to see what interpreters they have used in the past…preferably before a crisis occurs.

Inpatient Resources.

The Mental Health Center for the Deaf at Western State Hospital (WSH) no longer exists and is no longer a first-line crisis option for our pre-screeners. WSH continues to serve deaf consumers from their own region and may accept an individual when local resources have been exhausted or a transfer from a local hospital. Follow normal protocols for seeking local inpatient admissions. Once you have secured a bed, inform the hospital that the individual is deaf and that they will need an interpreter for all physician appointments, groups, and any other services that are routinely accessed by hearing patients (equal access). As a courtesy, you may provide them the attached list of interpreters. Please provide the Regional Deaf Services Counselor/Coordinator's contact information.

List of Sign Language Interpreters for Emergency (Crisis) Services, HPR 5

Name	Number*	Location	Notes
Ivy Brothers	(252) 796-7288 Cell ibrothers@netscape.com	Elizabeth City; covers Hampton Roads	Nationally Certified (CT, CI) *Full-time; Willing to coordinate/find interpreter for you if one is available*
Theresa Heath	(757) 467-5855 Home (757) 701-4535 Cell Terrysigns4u@cox.net	Virginia Beach; covers Hampton Roads	Nationally Certified (CT, CI, SC:L, NIC) *Evenings & Weekends, Summers full-time*
LaVerne Johnson	(757) 766-1718 Jodela9@verizon.net	Hampton; covers Hampton Road	Nationally Certified (CT, CI) *Full-time*

Karen King	kykingterp@gmail.com	Suffolk; covers Hampton Roads	Nationally Certified (NIC) *Full-time*
Patricia Isaacs	(804) 227-2200 consaacs@earthlink.net	Doswell, VA	Nationally Certified (CSC) *Full-time*
Chris York-Nanez	(757) 287-9044 Lsn1@cox.net Lsn2@cox.net	Virginia Beach, covers Hampton Roads	Nationally Certified (NIC, Master) *Full-time; President of Interpreting Services Network, Inc.*
Steve Markham	(757) 646-5416 Cell Bchbum3@aol.com	Norfolk, covers Hampton Roads	VQAS Level III *Full-time; Will come out in middle of night*
			.
Amy Utter	(757) 673-4369 amyutter@cox.net	Portsmouth, covers	Nationally Certified (CT, CI) *Full-time*
			.
Cynthia Wood	(414) 687-8622 Cell dctxturtle@tmail.com	Smithfield	Nationally Certified (NIC) *Evenings & Weekends; subject to availability*

* You are encouraged to report any updates of phone numbers or emails to PMarkham@hnncsb.org

Note: Dr. Markham, Regional Deaf Services Counselor & Coordinator, has compiled a more complete listing of interpreters specific to the southeastern region. You are encouraged to contact her for this listing that she could then send to you by email attachment. This listing may be especially helpful for hospitals that will need to provide an interpreter for several days. When you contact Dr. Markham after the crisis, please provide a hospital contact name, phone, and email where this listing can be sent. Thank you.

Appendix G

REACH Protocol: Individuals with Intellectual and Developmental Disabilities the REACH mobile team provides:

- Face-to-Face crisis assessment and support services for individuals who are experiencing behavioral challenges or in a crisis.
- Services to individuals under TDO: Mobile team responds to the crisis in conjunction with emergency services staff. If the individual does not meet the requirements of a TDO then the emergency services worker will refer to REACH for further follow up. REACH will then provide the individual with stabilization services via conducting a crisis assessment and implementing a crisis plan. REACH will collaborate with the hospital social worker and support team in the discharge planning process for the individual. **REACH does not replace Emergency Services.**
- No services to individual under an ECO. REACH services will not initiate services until a TDO determination has been authorized
- Therapeutic home services to individuals with case management, permanent place of residence prior to program entry, and resides in the catchment area.
- Does not provide long-term residential services or supports to individuals abusing substances or requiring detox treatment.
- Referrals made to the REACH program can be made via calling the 24hr Emergency Crisis Line at (855) 807-8278.

Appendix H

Notification of State facility at the (applies community ECO and hospital ECO) (Effective July 1, 2014)

For all contacts for admission: Information Center 757-253-5161

a. During regular business hours ask to be connected to the Admissions Office (or call direct at 757-208-7579)

b. During evenings, weekends and holidays, ask to be connected to the Nursing Office.

Call Procedures (completed by the emergency service worker)

a. After being contacted by a law enforcement officer, the emergency services worker will contact ESH that an ECO has been issued. The emergency services worker will provide:
    a. Consumer's name, location of evaluation and the time the ECO began
    b. When providing a progress report, provide the consumer's name and the current status of bed search/need for safety net bed
b. After completing the evaluation and prior to the end of the ECO period, the emergency services worker will contact ESH and report if a local hospital bed has been located.
c. If no local hospital bed can be located within 6 hours, the emergency services worker will
    a. contact the emergency services supervisor at their agency prior to contacting ESH
    b. contact the ESH and report that a safety net bed is needed,
    c. continue seeking a local hospital bed, and if a local bed is located prior to end of ECO period, the emergency services worker will call ESH to cancel the bed
d. Based on local practices and/or client needs but not less 30 minutes, the emergency services worker will notify ESH that safety net bed is needed. The magistrate is also contacted not less than 30 minutes before the end of the custody period.

Appendix I

Source: Martinez, Jim (DBHDS) May 23, 2014

1) Law enforcement notifies the CSB of any ECO executed and the need for CSB to do the evaluation. Law says:

§ 37.2-808 J. *A representative of the primary law-enforcement agency specified to execute an emergency custody order or a representative of the law-enforcement agency employing a law-enforcement officer who takes a person into custody pursuant to subsection G or H shall notify the community services board responsible for conducting the evaluation required in subsection B, G, or H as soon as practicable after execution of the emergency custody order or after the person has been taken into custody pursuant to subsection G or H.*

2) CSB calls state hospital after receiving the above call. Law says:

§ 37.2-809.1. A. In each case in which an employee or designee of the local community services board as defined in § 37.2-809 is required to make an evaluation of an individual pursuant to subsection B, G, or H of § 37.2-808, an employee or designee of the local community services board shall, upon being notified [by law enforcement, per above call] *of the need for such evaluation, contact the state facility for the area in which the community services board is located and notify the state facility that the individual will be transported to the facility upon issuance of a temporary detention order if no other facility of temporary detention can be identified by the time of the expiration of the period of emergency custody pursuant to § 37.2-808…….*

3) CSB calls state hospital back with more detailed info right after ECO evaluation is done. Law says:

§ 37.2-809.1. ……Upon completion of the evaluation, the employee or designee of the local community services board shall convey to the state facility information about the individual necessary to allow the state facility to determine the services the individual will require upon admission.

4) State facility may conduct its own search for an alternative after being notified by call 2) or 3) above, and if successful, then the state facility has to call the CSB with the information. Law says:

§ 37.2-809.1.B. A state facility may, following the notice in accordance with subsection A, conduct a search for an alternative facility that is able and willing to provide temporary detention……. If an alternative facility is identified and agrees to accept the individual for temporary detention, the state facility shall notify the community services board, and an employee or designee of the community services board shall designate the alternative facility on the prescreening report.

5) This is not in law, but at some point, hopefully for most cases, CSB will call the state hospital and say "We don't need a bed after all for this person, we found one somewhere else, and we're closing out such-and-such case" etc.

6)) This is not in law, but at some point (say after 4 hours), in order to give ample time to state hospital to do something, CSB calls the state hospital and says "Hey, we're still looking for bed for this person, and its not looking very good at this point" or whatever, etc.

7) This is not in law, but as 8 hours is about to expire, CSB should call state hospital to confirm that the TDO will be to state hospital (or back-up as determined by state hospital if the state hospital can't admit for some reason, or if state hospital hasn't found an alternative on its own).
Law says:
§ 37.2-809. E.….*Subject to the provisions of § 37.2-809.1, if a facility of temporary detention cannot be identified by the time of the expiration of the period of emergency custody pursuant to § 37.2-808, the individual shall be detained in a state facility for the treatment of individuals with mental illness and such facility shall be indicated on the temporary detention order.*