COMMONWEALTH of VIRGINIA

S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

June 30, 2018

The Honorable Thomas K. Norment, Jr.,
The Honorable Emmett W. Hanger, Jr.
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

Please find enclosed the report in accordance SB260. Staff at the department are available should you wish to discuss this request.

Sincerely,

S. Hughes Melton, MD, MBA

Cc:
Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan E. Massart
Mike Tweedy
Daniel Herr

COMMONWEALTH of VIRGINIA

S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

June 30, 2018

The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

Please find enclosed the report in accordance SB260. Staff at the department are available should you wish to discuss this request.

Sincerely,

S. Hughes Melton, MD, MBA

Cc:
Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan E. Massart
Mike Tweedy
Daniel Herr

COMMONWEALTH of VIRGINIA

S. HUGHES MELTON, MD, MBA
FAAFP, FABAM
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

June 30, 2018

The Honorable Ralph S. Northam, Governor
Commonwealth of Virginia
Patrick Henry Building
P.O. Box 1475
Richmond, VA 23218

Dear Governor Northam:

Senate Bill 260 of the 2014 Legislative Session required the Department of Behavioral Health and Developmental Services (DBHDS) "*submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*"

Please find enclosed the report in accordance SB260. Staff at the department are available should you wish to discuss this request.

Sincerely,

S. Hughes Melton, MD, MBA

Cc:
Hon. Daniel Carey., M.D.
Marvin Figueroa
Susan E. Massart
Mike Tweedy
Daniel Herr

Virginia Department of Behavioral Health & Developmental Services

Annual Report on the Implementation of Senate Bill 260 (2014)

June 30, 2018

DBHDS Vision: A Life of Possibilities for All Virginians

1220 BANK STREET • P.O. BOX 1797 • RICHMOND, VIRGINIA 23218-1797
PHONE: (804) 786-3921 • FAX: (804) 371-6638 • WEB SITE: WWW.DBHDS.VIRGINIA.GOV

Annual Report on the Implementation of Senate Bill 260 (2014)

Preface

This report is submitted in response to Senate Bill (SB) 260 (Chap. 691, 2014), which amended and added several sections of the *Code of Virginia* related to emergency custody and temporary detention of adults and minors. The fourth enactment clause of this legislation reads as follows:

> *4. That the Department of Behavioral Health and Developmental Services shall submit an annual report on or before June 30 of each year on the implementation of this act to the Governor and the Chairmen of the House Appropriations and Senate Finance Committees. The report shall include the number of notifications of individuals in need of facility services by the community services boards, the number of alternative facilities contacted by community services boards and state facilities, the number of temporary detentions provided by state facilities and alternative facilities, the length of stay in state facilities and alternative facilities, and the cost of the detentions in state facilities and alternative facilities.*

Annual Report on the Implementation of Senate Bill 260 (2014)

Table of Contents

Introduction

In July 2014, SB 260 was enacted in response to specific concerns with Virginia's behavioral health emergency response system. SB 260 was intended to ensure that every individual who met clinical criteria for involuntary hospitalization under temporary detention was provided with access to inpatient psychiatric care. In the four years since the enactment of SB 260, the Department of Behavioral Health and Developmental Services (DBHDS) has continued to collaborate with all involved stakeholders, including the community services boards (CSBs), state psychiatric hospitals, private hospitals, and other stakeholders to implement and monitor the requirements set forth in SB 260. An overview of the legislation can be found in Appendix A. Outlined below is a brief overview of the most salient impacts of SB 260 on Virginia's emergency response system.

- Importantly, no individual subject to an emergency custody order (ECO) who was clinically evaluated and determined to meet clinical criteria for temporary detention has been turned away for lack of a psychiatric bed.

- There was an initial growth in the *average daily number* of face-to-face evaluations completed by CSBs emergency services clinicians for involuntary hospitalizations. Since FY 2016, the trend has appeared to stabilize.
  - FY 2015: 229 evaluations per day; 83,701 total
  - FY 2016: 262 evaluations per day; 96,041 total
  - FY 2017: 256 evaluations per day; 93,482 total
  - FY 2018 (first two quarters): 250 evaluations per day; 90,192 projected total

- Following a slight increase in the second year, the *number of temporary detention orders (TDOs) issued daily* has remained relatively consistent over time.
  - FY 2015: 68 TDOs issued daily; 24,889 total
  - FY 2016: 71 TDOs issued daily; 25,798 total
  - FY 2017: 71 TDOs issued daily; 25,852 total
  - FY 2018 (first two quarters): 71 TDOs issued daily; 25,632 projected total

- Overall, there has been a continual increase in the *daily number* of state hospital admissions of individuals under a TDO, growing by 224 percent between FY 2013 and FY 2017.
  - In FY 2013, state hospitals admitted an average of 3.7 individuals per day under at TDO or a total of 1,359 admissions
  - In FY 2014, state hospitals admitted an average of 4.3 persons per day under a TDO or a total of 1,579 admissions
  - In FY 2015, state hospitals admitted an average of 6.0 persons per day under a TDO or a total of 2,192 admissions
  - In FY 2016, state hospitals admitted an average of 9.6 persons per day under a TDO or 3,497 admissions
  - In FY 2017, state hospitals admitted an average of 12.1 persons per day under a TDO or a total of 4,391 admissions

The information above illustrates the impact of the implementation of SB 260 across Virginia. After an initial growth in both the number of face-to-face evaluations and TDOs, the trends for both of these categories appears stabilized. However, TDO admissions to state hospitals has continued to

increase dramatically, growing from 1,359 TDO admissions prior to the new law's implementation to a projected total of 4,983 admissions in FY 2018 (or a 375 percent increase).

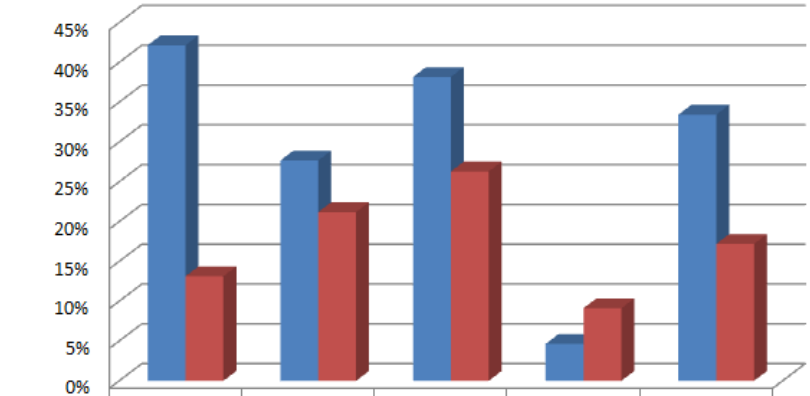
One factor contributing to this growth in state hospital TDO admissions is the declining rate of private hospital admissions for individuals under a TDO. In FY 2015, private hospitals admitted 22,687 individuals under a TDO (91.2 percent of all TDOs) and in FY 2017, private hospitals admitted 21,861 individuals under a TDO (84.6 percent of all TDOs). Based upon the admission trends for the first six month of FY 2018, private hospitals are projected to admit 20,649 individuals under a TDO (80.6 percent of all TDOs). At the present time, Virginia is using approximately 28.4 more state psychiatric hospital beds each year.

Figure 1: Evaluations, TDOs and Admissions, FY 2015 – FY 2018 (Projected)

Year	Number of Crisis Evals	Number of TDOs	% of Evals. Resulting in TDOs	TDOs Admits to Private Hospitals	% of TDO Admits to Total Admits to Private Hospitals
FY 2015	83,701	24,889	29.7%	(91.2%) 22,687	(47.0%) 48,223
FY 2016	96,041	25,798	26.8%	(86.5%) 22,322	(45.8%) 48,709
FY 2017	93,482	25,852	27.7%	(84.6%) 21,861	(43.8%) 49,952
FY 2018 *Projected*	90,192	25,632	28.4%	(80.6%) 20,649	(40.6%) 50,825

The dramatic increase in the TDO admissions to Virginia's nine state hospitals has created an unsustainable utilization rate for the state hospitals, with majority of the hospitals routinely operating at 95 percent or more of capacity. National standards and research recognize that operating at 85 percent of capacity is safest for both patients and staff. By consistently operating well above 85 percent, the pressures of the state hospital census are placing both staff and patients alike in potentially unsafe conditions, compromising the quality of care provided, and leading to unprecedented increase in turnover in critical staff. During FY 2017, the turnover rate was the highest it had been in ten years. Correspondingly, the vacancy rates are increasing as hospitals struggle to fill open positions. Figure 2 shows the turnover and vacancy rates for key positions in FY 2017.

Figure 2: FY 2017 Turnover and Vacancy Rates for Hospital Key Positions



	Nursing DSA's	LPN's	DIRECT CARE RN's	Medical Internists (Physicians)	Psychiatrists
Turnover	42%	28%	38%	5%	33%
Vacancy	13%	21%	26%	9%	17%

The pressures of the state hospital census are further compounded by the lack of appropriate housing and community based services for individuals who are clinically ready for discharge from our state hospitals. Data about individuals who are clinically ready to leave, but for whom appropriate housing, services and supports are not available, is collected through the extraordinary barriers list, or EBL. The EBL is a list generated by DBHDS and identifies individuals in state health hospitals who have been clinically ready for discharge for more than 14 days but are unable to leave because the necessary community housing and support services are not available to ensure a safe discharge. At any point in time during the past year, approximately 13 percent of all individuals in state hospitals were clinically ready to leave but were unable to do so due to a lack of community resources. DBHDS is currently working to address the growing census pressures related to individuals who are clinically ready to leave state hospitals. For example, in partnership with three CSBs, and a contractual relationship with a nonprofit organization, DBHDS invested in the development of four transitional group homes for individuals who are able to transition into more integrated community settings, and three assisted living facilities for those who have more complex care needs and require more supervision.

In an effort to help address state hospital census issues, the 2017 General Assembly required the development of a plan for the financial realignment of Virginia's public mental health system. DBHDS put forth a budget request to provide the state hospital discharge services and develop the additional housing alternatives to state hospital placement. These elements would help accomplish year one of the financial realignment plan. DBHDS will continue working with the Administration, the General Assembly, CSBs and stakeholders to manage hospital census and build community services needed to discharge individuals more promptly from state hospitals.

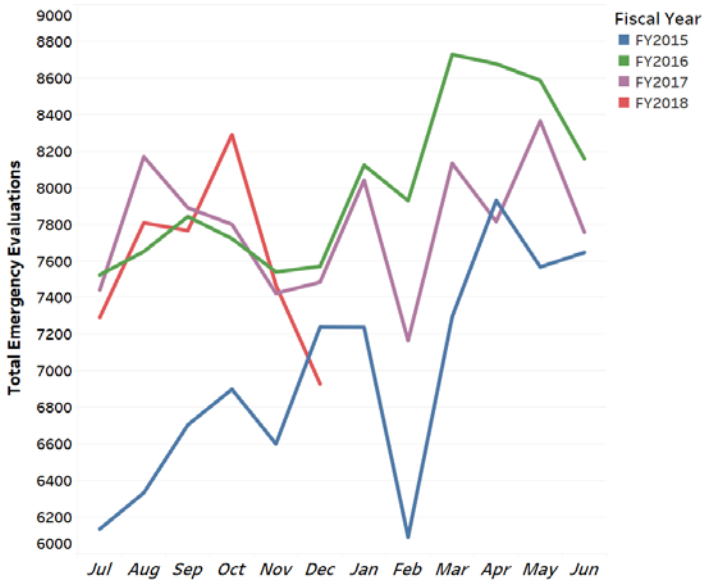
Impact of SB 260

SB 260 developed new standards and protocols to ensure that no individual in acute psychiatric crisis, meeting clinical criteria for temporary detention, would fail to receive that care due to lack of a clinically appropriate and available bed. This section describes these new standards and protocols and summarizes the impact of the legislation in the following key areas.

Emergency Custody Orders, CSB Emergency Evaluations, and Executed TDOs – Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis. These evaluations may be conducted in person or electronically by two-way video and audio communication. An emergency custody order (ECO) is issued by a magistrate authorizing a person to be taken into custody for up to eight hours and transported for an evaluation to determine if the individual meets the criteria for temporary detention and to assess the need for hospitalization and treatment. Figure 3, below, shows the frequency of ECOs during FY 2016 and 2017 and the first two quarters of FY 2018. ECO data has been collected since November 2015.

Figure 3: Number of Emergency Custody Orders, FY 2016-Mid-Year FY 2018

Figure 4: Number of CSB Emergency Evaluations, FY 2015 - Mid-Year FY 2018



During the ECO period, if an individual is determined to meet temporary detention criteria, a TDO is issued by a magistrate authorizing a person to be taken into custody for up to 72 hours and transported to a psychiatric facility. A TDO is considered executed at the time when the individual is served with the TDO and taken into custody for the purpose of being transported to the hospital for admission. Figure 5, below, shows the number of executed TDOs for FY 2015, FY 2016, FY 2017 and the first two quarters of FY 2018.

Figure 5: Number of TDOs Executed, FY 2018 – Mid-Year 2018

Following an increase in the number of TDOs issued in the second year of SB 260, the number of TDOs executed daily has remained consistent. In addition to data shown above, the CSBs also collect data on critical events associated with CSB emergency services utilization, TDOs, and the factors contributing to these events. DBHDS requires this data to be submitted monthly by each CSB and geographic region. DBHDS also requires case-specific reports from individual CSBs within 24-hours of any event involving an individual who has been determined to require temporary detention for which the TDO is not executed for any reason. These reports are aggregated and analyzed monthly.

State Hospital Admissions – Overall, admissions to state hospitals have increased significantly since the passage of SB 260. Figure 6, below, shows the trend in state hospitals for FY 2015, FY 2016, FY 2017 and the first two quarters of FY 2018.

Figure 6: Number of State Hospital (SH) Admissions, FY 2015 – Mid-Year FY 2018

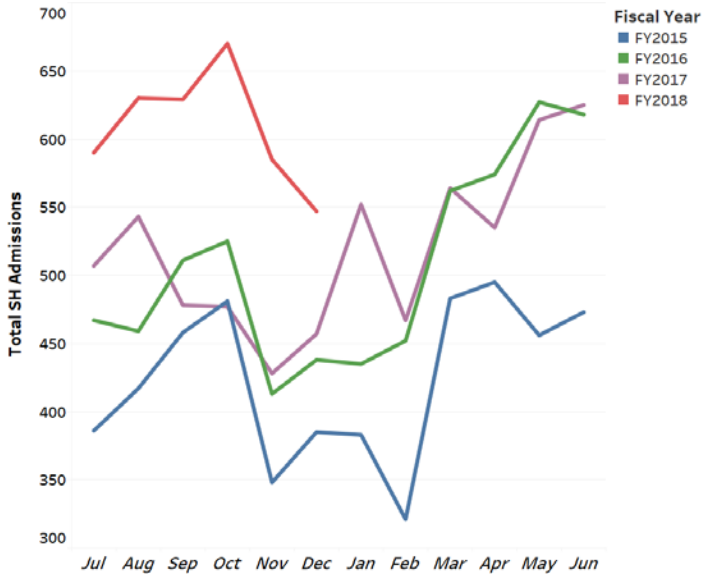
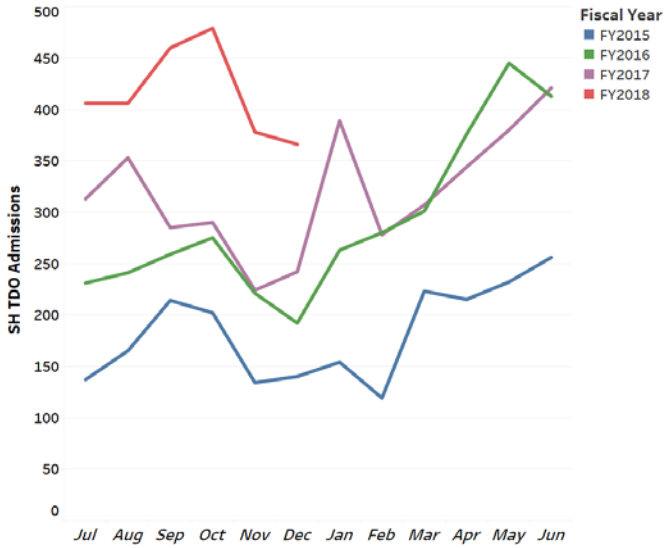


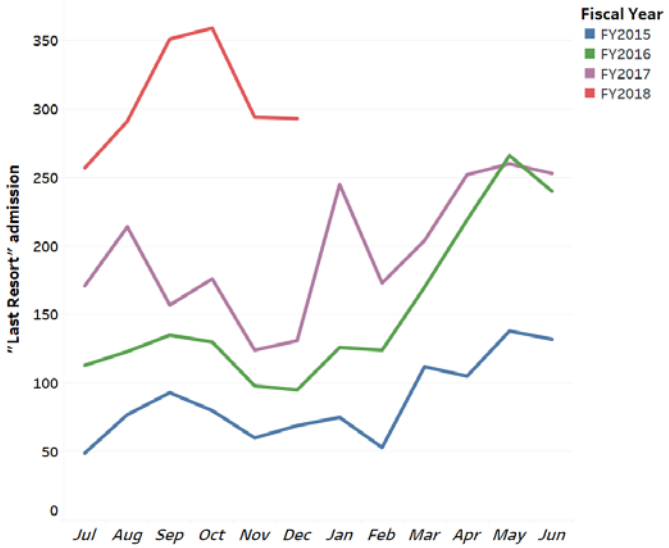
Figure 7, below, shows only the civil TDO admissions. TDO admissions to state hospitals have increased dramatically since 2014 and the passage of SB 260 with the sharpest increase in the first two quarters of FY 2018.

Figure 7: Number of SH TDO Admissions, FY 2015 – Mid-Year FY 2018



Number of "Last Resort" Admissions – Figure 8, below, shows the number of cases when an individual was admitted to a state hospital under the last resort provision of §§37.2-809.1 and 16.4-340.1:1 because no other alternative facility could be found at the conclusion of the eight hour period of emergency custody. There has been an unprecedented increase in the number of last resort admissions to the state hospitals in the first two quarters of FY 2018. This data reflects a continuing decline in the percent of TDO admissions admitted to private psychiatric hospitals. In FY 2015, private psychiatric hospitals admitted 91.2 percent of all individuals admitted under a TDO. In the first two quarters of FY 2018, July 1, 2017 – December 31, 2017, private psychiatric hospitals admitted 80.7 percent of all individuals admitted under at TDO.

Figure 8: Last Resort Admissions – FY 2015 - Mid-Year 2017 (CSB Reports)



Length of Stay for Temporary Detention – SB 260 extended the maximum period of temporary detention for adults from 48 hours to 72 hours. In FY 2014, the average length of stay for adults admitted to state hospitals under a temporary detention order was 4.43 days, in FY 2015 it was 2.25 day and in FY 2016 it was 2.31 days. In FY 2017, the average length of stay for adults admitted to state hospitals under a TDO was 2.51 days, and from July 1, 2017 to December 31, 2017, it was 2.60. Corresponding data are not available from private psychiatric hospitals.

Number of Alternative Hospitals Contacted – Prior to the passage of SB 260, each region developed regional admissions protocols, which established the processes for contacting the alternative hospitals prior to requesting admission to the regional state hospital. Each region identified alternative hospitals to be contacted based on variations in resources within the region including: (1) Number of crisis stabilization beds, (2) Number of private hospitals, and (3) Capacity of those hospitals to serve individuals with specialized and intensive needs.

In the fall of 2017, representatives from DBHDS, CSBs, state hospitals, and regional managers met to develop a table of contents to aid regions in updating their regional protocols and to develop a standard order to each of the regional protocols. Each of the regions is expected to have their protocols completed by the end of FY 2018 and submitted to DBHDS for review and placement on the department website.

Treatment Costs for Individuals under Temporary Detention – DBHDS is unable to provide a complete and comprehensive estimate of the full cost of temporary detention in the Commonwealth because the costs are paid from various sources, including private insurance, Medicare, Medicaid, and other funds. There is no available source data for all this information. Figure 9, below, shows the costs for temporary detention in state hospitals for FY 2014 - FY 2017 and through the first two quarters of FY 2018. During the first two quarters of FY 2018, the cost for civil TDO beds at state hospitals has already exceeded the total for the entirety of FY 2014 and FY 2015.

Figure 9: Costs for Individuals Under TDO Admitted to State Hospitals for FY 2014 – Mid-Year 2018

Total cost for TDO Bed Days by FY at State Hospitals			
	Total Civil TDO Bed Days	Average cost for a Bed Day	**Total Cost for Civil TDO Bed Days[1]**
FY 2014	82,151	$723.83	$59,463,358.33
FY 2015	95,477	$747.14	$71,334,685.78
FY 2016	125,208	$757.86	$94,890,134.88
FY 2017	151,599	$755.50	$114,533,044.50
FY 2018 (Jul-Dec 2017)	89,913	$777.35	$69,893,870.55

[1] *Civil bed days times average bed day cost*

A more comprehensive measure of the cost of temporary detention is the total charges to the Involuntary Commitment Fund (IMCF) administered by Department of Medical Assistance Services (DMAS). An individual's TDO stay may be covered by private insurance, by other public insurance, by Medicaid, or it may not be covered. When there is no payer available, the psychiatric hospital submits its claims to DMAS for payment through the IMCF, which is funded entirely by general fund dollars. The IMCF pays the hospital and physician costs for uncovered costs associated with individuals hospitalized under a TDO. The TDO Fund in Figure 10 below represents statewide expenditures paid by DMAS through the IMCF to private and state psychiatric hospitals in Virginia

for temporary detention services. The Medicaid Fund column represents TDO costs covered by Medicaid. The total IMCF and Medicaid expenditures for FY 2018, FY 2016, FY 2017 and the first two quarters of FY 2018 are displayed below.

Figure 10: Reimbursements for Temporary Detention from the ICMF and Medicaid

Temporary Detention Order Expenditures	ICMF TDO Fund	Medicaid Fund
FY 2015	$14,608,199.46	$1,460,856.37
FY 2016	$16,146,916.20	$1,089,591.37
FY 2017	$17,633,225.52	$1,292,112.50
FY 2018 (July-December 2017	$9,211,182.62	$560,460.87

Source: DMAS

Notifications to State Hospitals – SB 260 added requirements throughout the emergency custody process. First, a law enforcement officer must notify the appropriate CSB of the ECO "as soon as practicable" after the officer takes the individual into emergency custody. After receiving this notification, the CSB evaluator is, in turn, required to notify the appropriate state hospital of the pending ECO evaluation, and to communicate that, if no alternative hospital placement is found, the individual will be referred to the state hospital for temporary detention. The CSB evaluator is required to make another notification to the state hospital to convey the results of the evaluation. The CSB evaluator may continue to communicate with the state hospital until the case is resolved. DBHDS state hospitals are required to document the initial notifications.

LIPOS Bed Usage – Local Inpatient Purchase of Services (LIPOS) contracts with private hospitals to provide acute, short-term mental health psychiatric inpatient services instead of admitting these individuals to inpatient treatment in state hospitals. While there is no requirement in SB 260 related to LIPOS, DBHDS continues to monitor usage of the program by private hospitals as a way to understand and plan for increases in state hospital admissions. As shown below in Figure 11, data from FY 2017 and projected numbers based on the first three quarters of FY 2018 show a decline in LIPOS usage by private hospitals. This further accounts for the recent trend in increased admissions and census pressures on the state hospitals. DBHDS will continue collecting LIPOS data and analyzing trends related to private hospital usage of this program. Figure 11 also includes information on the regional psychiatric beds that are available per 100,000 population.

Figure 11: Regional LIPOS Beds

Region	**LIPOS Beds**		**LIPOS Funds**		**Psychiatric Beds per 100,000**		
	FY 2017	*FY 2018 Projected*	*Total LIPOS Funds Allocated*	*LIPOS $ per 100,000*	*Private*	*State*	*Total*
Region 1	481	416	$696,978	$56,211	7.99	23.57	31.56
Region 2	925	848	$2,925,782	$157,250	10.65	8.92	19.57
Region 3	996*	585	$527,882	$176,650	38.9	44.4	83.3
Region 4	506	559	$2,802,757	$267,644	35.33	18.9	54.23
Region 5	1,134	1,064	$1,170,263	$80,317	16.19	20.9	37.09
TOTAL	**4,042**	**3,472**	**$8,123,662**	**$738,074**			

* In FY 2017, some of the CSBs in Region 3 had been counting people who qualified for LIPOS even if LIPOS wasn't used to pay for the admission. This was corrected for FY 2018.

In addition, DBHDS contracts with private hospitals to purchase beds with the intention of diverting individual from state hospital admission when a bed of last resort is requested by a CSB. Typically, private bed purchase by CSBs occurs during the TDO bed search during the ECO period, but if no private bed can be located and a state hospital admission is requested, the state hospital can access the DBHDS LIPOS contract to request admission. The contract is currently held between DBHDS and Poplar Springs Hospital. Figure 12 below shows the number of bed days purchased under the LIPOS contract for adults at Polar Springs and the number of children and adolescents who were diverted from the Commonwealth Center for Children and Adolescents under the contract.

Figure 12: Last Resort Diversion LIPOS Contract with Poplar Springs, FY 2017 – FY 2018 (July – April)

	LIPOS Diversion Contract for Adults		LIPOS Diversion Contract for Children & Adolescents	
	Number of adult bed days	Total funds to purchase beds	Number of children & adolescents diverted	Total funds to purchase children & adolescent beds
FY 2017	185	$132,555	243	$1,285,340
FY 2018 (July - April)	12	$10,260	151	$973,908

Enhancements to the Psychiatric Crisis Response System

Concurrent with the enactment of SB 260, DBHDS implemented educational, training, certification, and quality oversight requirements for emergency services clinicians to further strengthen the public behavioral health system. The requirements described below were effective July 1, 2016 and included in subsequent performance contracts with the CSBs:

- All new hires for preadmission clinicians must have an educational attainment of a Master's or Doctoral Degree with an associated professional license or educational attainment that would be required for a license in Virginia.
- Supervisors of Certified Preadmission Screening Clinicians must be licensed and have a minimum of two years of experience working in emergency services or with persons with serious mental illness and be a Certified Preadmission Screening Clinician.
- All Certified Preadmission Screening Clinicians must have 24/7 access to clinical consultation by a qualified supervisor.
- Every Certified Preadmission Screening Clinician must have documentation of a minimum of 12 hours of individual or group supervision annually.
- All Certified Preadmission Screening Clinicians must have completed a minimum of 16 hours of documented hours of continuing education annually.
- Prior to certification, the individual must have completed all the required training modules and an emergency services orientation that meets the requirements of DBHDS.
- Certified Preadmission Screening Clinicians must re-certify every two years.

During FY 2016, 1,041 CSB Preadmissions Screening clinicians were certified. During FY 2017, an additional 139 individual achieved the certification and in the first two quarters of FY 2018 there

have been 34 individuals certified. As of March 30, 2018, Virginia has 1,125 active Certified Preadmission Screening Clinicians.

There are 956 Certified Preadmission Screening Clinicians who will be applying for re-certification during June 2018 as their current certification cycle will end on June 30, 2018. This will end the first two-year cycle of the certification process under the new requirements. The workforce providing the services of evaluations for individuals in emergency custody or identified as needing evaluation for temporary detention has adapted to the provisions of SB 260. The workforce struggles to meet the demands and has found recruitment for individuals willing to become Certified Preadmission Screening Clinicians difficult due to the demands of the position.

Acute Psychiatric Bed Registry

On March 3, 2014, DBHDS, in collaboration with the Virginia Hospital and Healthcare Association (VHHA) and Virginia Health Information (VHI), launched the psychiatric bed registry to assist CSB emergency evaluators in locating available beds for individuals who are under an emergency custody order and need to receive mental health treatment under a TDO.

In the fall of 2016, prior to the expiration of the current contract with VHI, DBHDS issued an invitation for bids to host the bed registry services and Etelic, Inc. was selected to provide the bed registry service for Virginia. The transition from the service hosted by VHI to the services hosted by Etelic occurred on March 13, 2017. Etelic's service was intended to contain the same functionality as the VHI's service; however, some of the visuals, screens, and processes differ from those hosted by VHI. DBHDS and other key stakeholders compiled a list of enhancements to the platform for Etelic to develop.

The new platform was trial tested and released in February 2018. Feedback about the enhancements from CSB Emergency Service prescreeners has been very positive. The system is more intuitive, adjustments were made to the work-flow that reduced the number of screens that need to be navigated and new reports were created so aggregate information can be extracted from the system.

System Reforms

DBHDS continues move toward the implementation of System Transformation Excellence and Performance (STEP-VA) as a core component of the behavioral health care system. STEP-VA is based on a national best practice model that contains deliberately chosen services for a comprehensive, accessible behavioral health care system. STEP-VA services improve access, increase quality, build consistency, and strengthen accountability across Virginia's public behavioral health system. The core components of STEP-VA are:

- Same Day Access
- Outpatient Services
- Primary Care Screening
- Detoxification
- Care Coordination
- Peer and Family Support
- Psychosocial Skill Rehabilitation/Skill Building
- Targeted Case Management
- Veterans Services
- Person-Centered Treatment
- Mobile Crisis Services

Through STEP-VA's focus on behavioral health wellness, early identification of treatment needs, and prompt intervention in behavioral health conditions, individuals are able to receive the necessary treatment before it reaches crisis level and requires inpatient hospitalization. In 2017, the General Assembly enacted HB1549 and SB1005, which required the implementation of same day access and primary care screening in FY 2019 and the remaining services in FY 2021. It also provided $4.9 million for building out Same Day Access, the first step in STEP-VA. As of the writing of this report, the 2018 General Assembly has yet to complete work on its budget that would include the next steps for same day access and primary care screening.

In addition, DBHDS is working with the Administration, the General Assembly, CSBs and stakeholders to manage hospital census and build community services needed to discharge individuals more promptly from state hospitals. To prioritize the reduction of the EBL, DBHDS decreased the criteria to be placed on the list from 30 to 14 days in December 2015. In 2017, DBHDS worked with CSBs and provided one-time funds to discharge 131 people statewide from the EBL. This critical project helped release pressure on state hospitals, but because more people will be added to the EBL over time, it is considered temporary. Also, DBHDS has invested in the development of four transitional group homes for individuals who are able to transition into more integrated community settings and three assisted living facilities for individuals who require more supervision and have complex care needs.

Also in an effort to help address state hospital census issues, the 2017 General Assembly required the development of a plan for the financial realignment of Virginia's public mental health system. DBHDS crafted a four-year phased plan to reduce the EBL and implement financial realignment across Virginia. DBHDS put forth a budget request to provide the state hospital discharge services and developing the additional housing alternatives to state hospital placement. These elements would help accomplish year one of the financial realignment plan.

STEP-VA infuses the critical community services individuals need to more effectively manage symptoms and avoid crises, hospitalizations, and interactions with the criminal justice system. Through implementing STEP-VA and developing the housing and discharge service solutions to the state hospital census pressures, Virginia's imbalanced system finally begins to favor stronger community services. DBHDS will continue working with the Administration, General Assembly, CSBs, private hospitals and other stakeholders to reform the system in a strategic manner that provides consistent, quality services in the community as well as prompt access to inpatient care when needed.

Appendices

Appendix A: Overview of SB 260

SB 260 bill was signed into law as Chapter 691 by Governor McAuliffe effective April 6, 2014. The salient features of this bill are described below:

- *Eight hour maximum period of emergency custody*: The legislature extended the maximum period of emergency custody to eight hours from four hours with a possible two hour extension, in §§ 16.1-340 (minors), 19.2-182.9 (NGRI acquittees on conditional release) and 37.2-808 (adults).
- *Law officer notification*: SB 260 specified that a law officer who executes an ECO under §§ 16.1-340 (minors) and 37.2-808 (adults) must notify the appropriate community services board (CSB) of the execution of the emergency custody "as soon as practicable" after execution.
- *Written explanation of ECO and TDO process*: An adult taken into emergency custody or temporary detention must be given a written explanation of the process and the statutory protections associated with these procedures (§§ 37.2-808 and 37.2-809).
- *Eight hour mandatory outpatient treatment (MOT) examination period*: The period of custody to perform an examination required for court review of a MOT plan was changed from four hours to eight hours in §§ 16.1-345.4 (minors) and 37.2-817.2 (adults).
- *State hospitals are "last resort" hospitals for temporary detention*: Under §§ 16.1-340.1 (minors) and 37.2-809 and 37.2-809.1 (adults), state hospitals are required to admit any individual for temporary detention who is not admitted to an alternative treatment facility, such as a community private psychiatric hospital, prior to the expiration of the emergency custody period. This provision ensures that no individual meeting clinical criteria for temporary detention is denied access to care, because the state hospital will serve as the "last resort" in the event the treatment cannot be accessed in a private psychiatric community hospital or other facility. Finally, to ensure that no individual slips through system cracks, an individual who is deemed to need temporary detention may not be released from custody except for the purposes of transportation to the temporary detention facility.
- *State hospitals may seek alternative facilities*: Under §§ 16.1-340 (minors) and 37.2-808 (adults), state hospitals and CSBs may continue to search for an alternative temporary detention hospital for an additional four hours following admission for anyone who is admitted because a suitable alternative facility could not be found by the time the eight hour emergency custody period expired. Any such alternative facility must be willing and able to provide appropriate care. A second enactment clause in SB 260 specified that these provisions expire on June 30, 2018. SB 673 of the 2018 legislative session repealed the expiration of this provision allowing it to be used beyond June 30, 2018.
- *72-hour maximum period of temporary detention*: The maximum period of temporary detention prior to a hearing was extended from 48 hours to 72 hours in §§ 19.2-169.6 (jail inmates), 19.2-182.9 (NGRI acquittees on conditional release) and 37.2-809 and 37.2-814 (adults).
- *Acute Psychiatric Bed Registry*: § 37.2-808.1 was added to SB 260 requiring DBHDS to operate an acute psychiatric bed registry to provide real-time information on bed availability to designated searchers so that CSBs, inpatient psychiatric hospitals, public and private residential crisis stabilization units, and health care providers working in an emergency room of a hospital, clinic or other facility rendering emergency medical care could access information about psychiatric bed availability through the bed registry and this information.