Virginia Department of Behavioral Health & Developmental Services

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

June 30, 2021

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 response to concerns about Virginia's behavioral health crisis response system, the General Assembly enacted SB 260 in 2014 to ensure that every individual who met the criteria for temporary detention was provided with timely access to inpatient psychiatric care. Since the enactment of SB 260, Department of Behavioral Health and Developmental Services (DBHDS) has continued to partner with the relevant stakeholders, including the community services boards (CSBs), state psychiatric hospitals, private hospitals, magistrates, law enforcement, and others to monitor the requirements set forth in SB 260. An overview of the legislation can be found in Appendix A. The most salient impacts of SB 260 for Virginia's behavioral health crisis response system are described below. The COVID-19 pandemic, experienced most acutely in the last two quarters of FY20 and the first two quarters of FY21, has affected the number of evaluations for temporary detention orders (TDOs), TDOs issued, and daily TDO admissions to state hospitals. State hospitals experienced a decrease in admissions during the first four months of the pandemic, however, they have since experienced increased census and critical staffing shortages from that point forward into FY21.

- Following an initial increase in the second year, the **average daily number of face-to-face evaluations** completed by CSB emergency services clinicians for involuntary hospitalizations in FY 2016 has decreased steadily.
    - 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: 251 evaluations per day; 91,718 total
    - FY 2019: 239 evaluations per day; 87,490 total
    - FY 2020: 208 evaluations per day; 75,805 total
    - FY 2021: (first two quarters) 216 evaluations per day

- After a slight increase in the second year, the **number of temporary detention orders (TDOs) issued daily** has remained relatively stable 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: 70 TDOs issued daily; 25,679 total
    - FY 2019: 69 TDOs issued daily; 25,205 total
    - FY 2020: 64 TDOs issued daily; 23,512 total
    - FY 2021 (first two quarters): 72 TDOs issued daily

- Since the enactment of SB 260, there was a continual increase in the **daily number of state hospital admissions** of individuals under a TDO between FY 2015 and FY 2019, growing by 389 percent between FY 2013 and FY 2019. The final two quarters of FY 2020 indicate a slight decrease in the daily number of state hospital admissions of individuals under a TDO.
    - 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 10.5 persons per day under a TDO or a total of 3827 admissions
- In FY 2018, state hospitals admitted an average of 14.7 persons per day under a TDO or a total of 5357 admissions
- In FY 2019, state hospitals admitted an average of 18.2 persons per day under a TDO or a total of 6649 admissions
- In FY 2020, state hospitals admitted an average of 14.8 persons per day under a TDO or a total of 5412 admissions.
- In FY 2021 (first two quarters), state hospitals admitted an average of 17.2 per day under a TDO

The information above shows that while the number of face-to-face evaluations and TDOs are relatively steady across Virginia, TDO admissions to state hospital have overall increased dramatically, growing from 1,359 TDO admissions prior to the implementation of SB 260 to a total of 6,649 admissions in FY 2019, for a growth rate of 389%. TDO rates to state hospitals decreased slightly in FY 2020, which correlated with a decrease in overall evaluations. This is likely related to the impact of the COVID-19 pandemic in the third and fourth quarter of FY 2020. Thus far in FY 2021, evaluation rates and TDO rates have increased to pre-pandemic levels. One of the reasons for the continued high rates of TDO admissions to state hospitals is the declining rate of private hospital admissions for individuals under a TDO, dropping from 91.2% in FY 2015 to 77% in FY 2020. This overall trend continued in the first two quarters of FY 2021.

Figure 1: Evaluations, TDOs and Admissions, FY 2015 – FY 2021 (through the 2nd quarter)

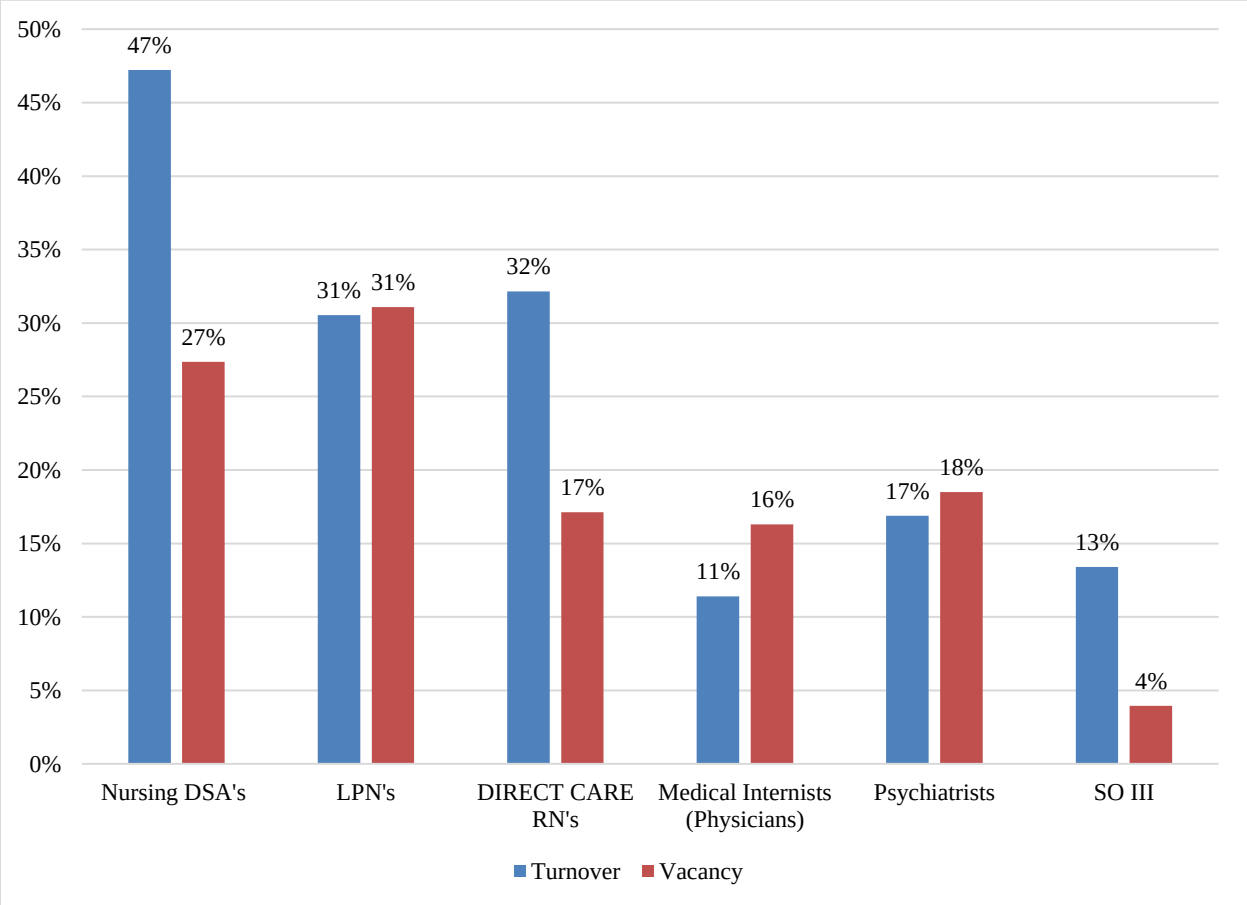
Year	# of crisis evals	# of TDOs	% of evals resulting in TDOs	% TDO admits to private/community hospitals	% TDO admits to state hospitals
FY 2015	83,701	24,889	29.7%	91.2%	8.8%
FY 2016	96,041	25,798	26.8%	86.5%	13.5%
FY 2017	93,482	25,852	27.7%	84.6%	15.4%
FY 2018	91,718	25,679	28%	80.6%	19.4%
FY 2019	87,490	25,205	28.8%	76.1%	23.9%
FY 2020	74,805	23,512	31.4%	77%	23%
FY 2021 (first two quarters)	39,433	13,187	33.4%	76.2%	23.8%

Virginia's state hospitals are operating at a 98% utilization rate or above. Research and national standards show that operating at 85% of capacity is optimal for both patients and staff. Utilization rates significantly above 85% can compromise the quality of care and impact patient and staff safety.

Staff turnover and vacancy rates have grown along with the increase in average daily census at the state hospitals. The vacancy rates have increased as the state hospitals struggle to retain current staff and successfully recruit new staff.

Figure 2 shows the turnover and vacancy rates for key positions in FY 2021 (through May 2021). In FY 2019, DBHDS received $12.2 million to bring the salaries of registered nurses (RNs), license practical nurses (LPNs), and direct service associates (DSAs) within 3% of the market salary. These increases went into effect on January 10, 2019. Since that time turnover and vacancy rates have continued to increase for DSA and LPN positions. The vacancy rates for RN positions have improved slightly, however RN turnover has increased. The Medical Internist turnover rate has decreased slightly from the previous reporting period while the vacancy rate has increased; and the psychiatrist turnover and vacancy rates have slightly decreased since the last reporting period. State facility staffing has reached critical levels due to compensation well below market rates, safety and risk to self, high patient acuity, and the increased number of direct care vacancies. Current direct care staffing levels are not sufficient to maintain safe operations and quality care within our behavioral health hospitals.

Figure 2: FY 2021 Turnover and Vacancy Rates for Hospital Key Positions (July 2020 – May 2021)



The lack of community-based housing and support services further compounds state hospital census pressures. In FY 2018, a monthly average of 167 persons, or approximately 12% 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. In FY 2019, the number grew to an average of 13% of all individuals in state hospitals, and in FY 2020 the percentage increased even more to 17%. In the first two quarters of FY 2020, an average of 16% of all individuals in state hospitals were considered clinically ready for discharge but unable to leave due to a lack of appropriate community resources. There are currently 188 persons who are clinically ready for discharge from state behavioral health hospitals for at least 14 days.

DBHDS continues to work diligently with the community services boards and private providers to address the growing census pressures related to individuals who are clinically ready to leave state hospitals by investing in residential and support services. Beginning in FY 2017, DBHDS began working with three CSBs to create assisted living facilities (ALF) for individuals who require an ALF level of care after discharged from state hospitals. In FY 2018, DBHDS also invested in the development of four additional transitional group homes for individuals who are able to transition into more integrated community settings, in addition to the two group homes that already existed. DBHDS also partnered with the Department of Aging and Rehabilitation Services (DARS) in 2017 in order to provide public guardianship slots for individuals in state hospitals who require this prior to discharge, as well as contracting for additional private guardianship slots in FY 2019 and FY 2020. In FY 2020, DBHDS began additional initiatives to assist in expediting discharge of individuals from state hospitals who are clinically ready to discharge, including increased partnering with CSB crisis stabilization units (CSUs) for state hospital stepdown and discharges, as well as partnering with a private assisted living provider and a long-term care organization to facilitate state hospital discharges for individuals who require these levels of care. In FY 2021, DBHDS initiated several partnerships to create specialized residential services for individuals discharging from state hospitals.
These include:

- the addition of two transitional group homes for adolescents discharging from CCCA;
- partnerships with eight CSBs for additional transitional supervised housing resources for adults discharging from state hospitals;
- partnerships with Mount Rogers CSB and Western Tidewater CSB to develop and provide specialized behavioral health services for older adults, including those with dementia;
- and partnerships with two private hospital systems to provide specialized diversion and stepdown services to individuals who would otherwise be served by a state hospital.

In FY 2022, DBHDS will continue to expand services for children and adolescents discharging from CCCA, as well as specialized services for older adults.

Impact of SB 260

In response to SB 260, DBHDS and the CSBs developed new standards and protocols to ensure that individuals in acute psychiatric crisis and meeting clinical criteria for temporary detention

would receive the care they needed. This section describes the standards and protocols developed in response to SB 260 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. This evaluation will serve 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 2017, FY 2018, FY 2019, FY 2020, and the first two quarters of FY 2021. ECO data has been collected since November 2015.

Figure 3: Number of Emergency Custody Orders, FY 2017-2021 (first two quarters)

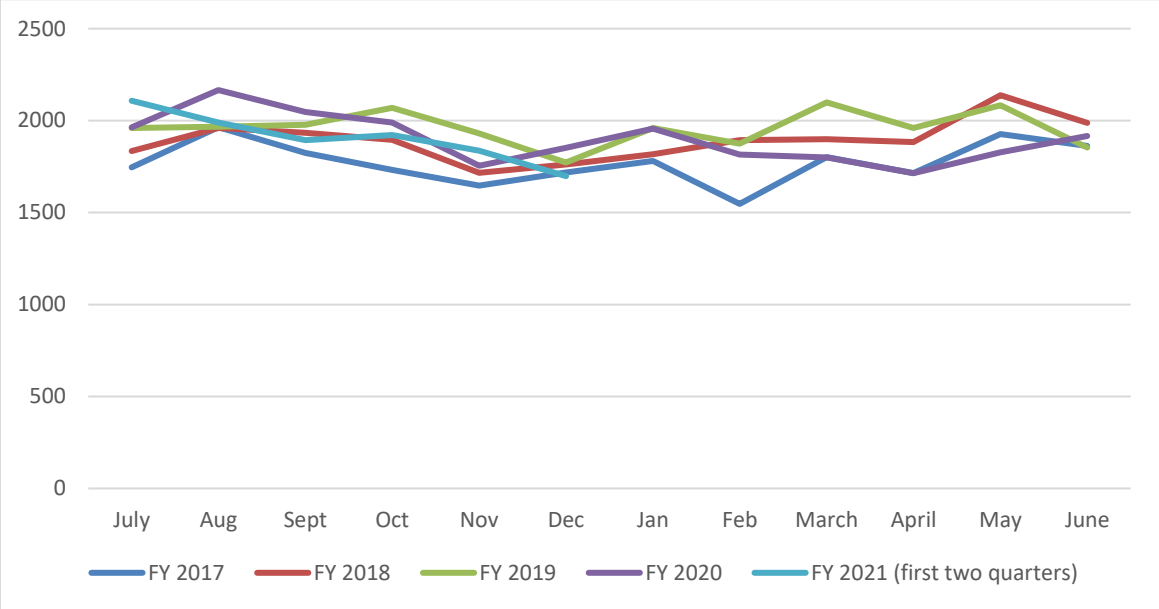
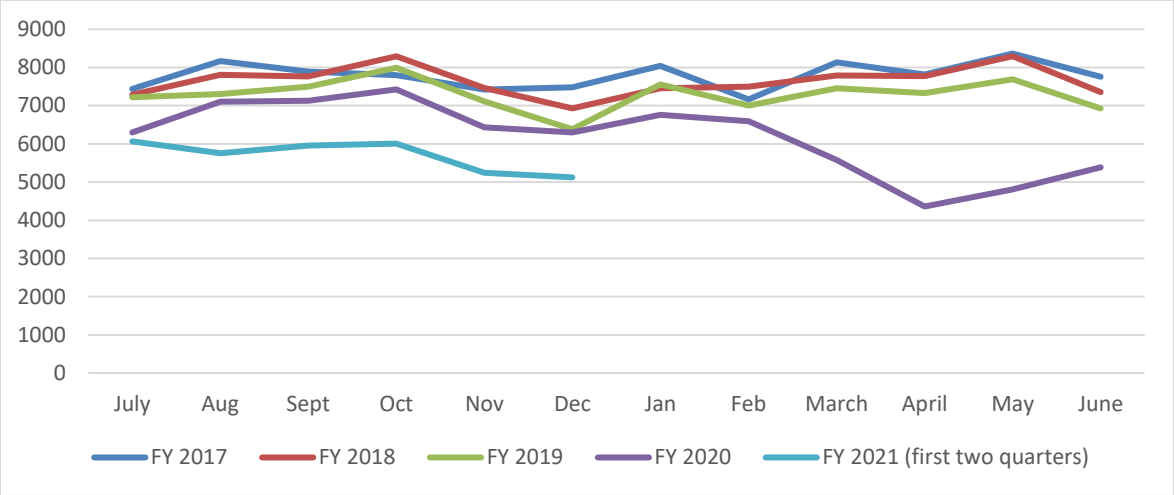
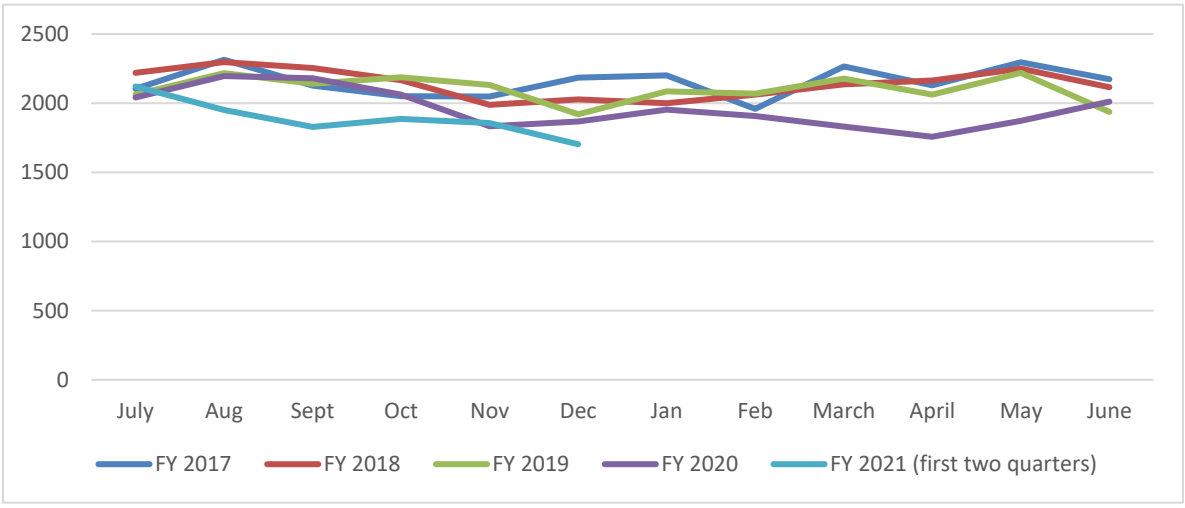


Figure 4: Number of CSB Emergency Evaluations, FY 2017 – 2021 (first two quarters)



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 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. Most CSB Emergency Evaluations do not result in a recommendation for a TDO. Figure 5, below, shows the number of executed TDOs for FY 2015, FY 2016, FY 2017, FY 2018, FY 2019, FY2020, and the first two quarters of FY 2021.

Figure 5: Number of TDOs, FY 2017 – FY 2021 (first two quarters)



The number of TDOs executed daily has remained relatively consistent after an initial increase in the number of TDOs issued in the second year of SB 260. 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 continue to increase significantly since the passage of SB 260. Figure 6, below, shows the trend in state hospitals for FY 2015 through FY 2020 and through May FY 2021.

Figure 6: Number of State Hospital (SH) Admissions, FY 2015 –FY 2021(End of May)

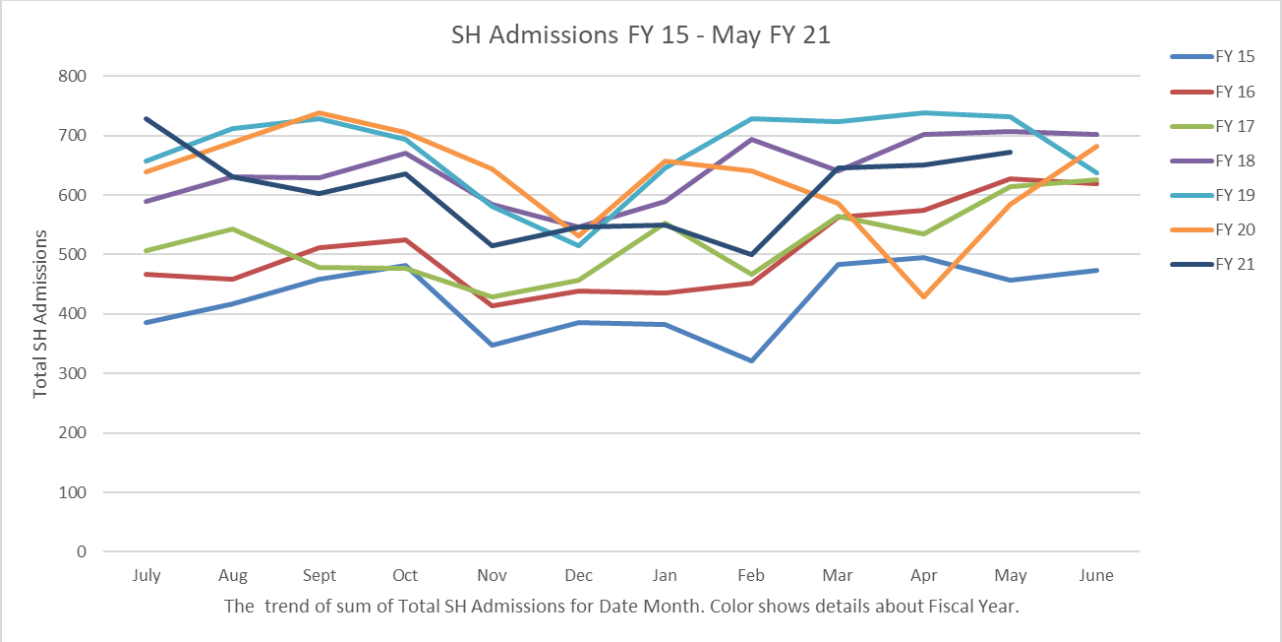
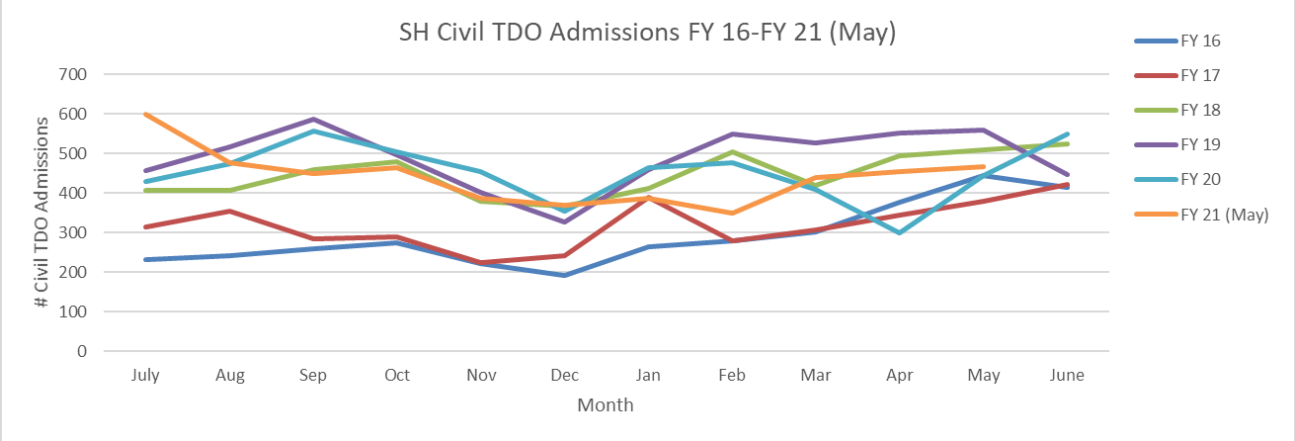


Figure 7 shows only the civil TDO admissions. TDO admissions to state hospitals have increased dramatically since 2014 and the passage of SB 260.

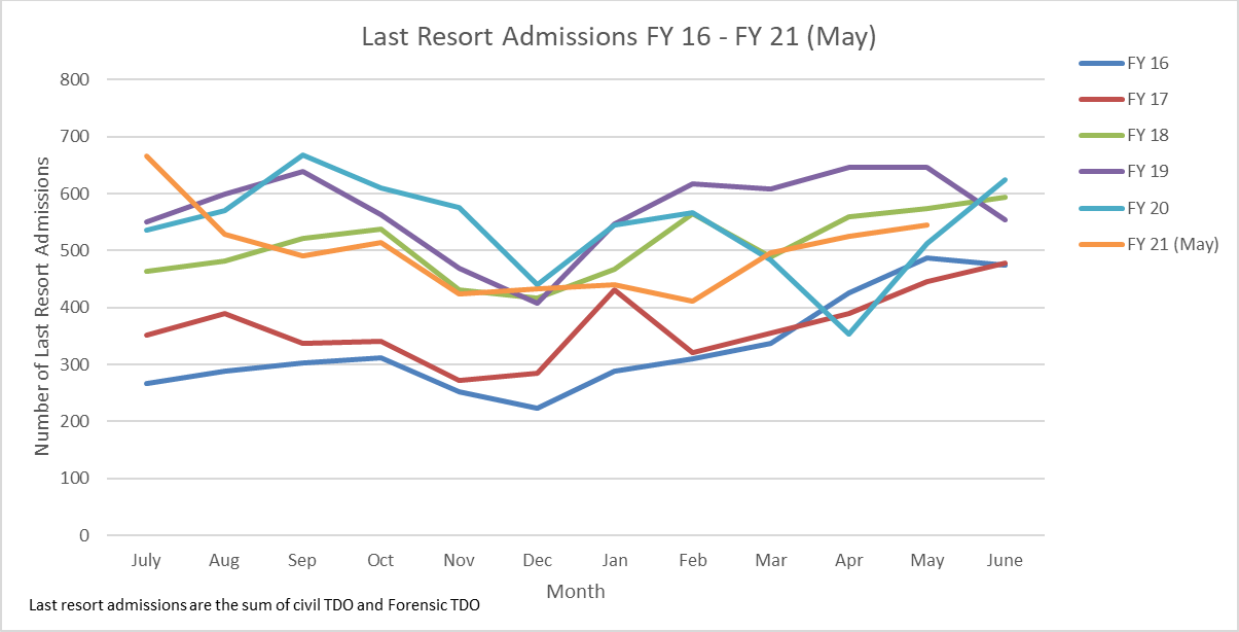
Figure 7: Number of SH TDO Admissions, FY 2016 – FY 2021 (End of May)



Number of "Last Resort" Admissions

There has been an unprecedented increase in the number of last resort admissions to the state hospitals and this trend has continued through the first two quarters of FY 2020. 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 FY 2020 the private psychiatric hospitals admitted 77 percent of all individuals admitted under at TDO.

Figure 8: Last Resort Admissions, FY 2016 – FY 2021 (End of May)



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 TDO was 4.43 days, in FY 2015 it was 2.25 days, 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, in FY 2018 it was 2.56 days, in FY 2019 it was 2.72 days, and in FY 2020 it was 2.51 days. Corresponding data are not available from private psychiatric hospitals.

Number of Alternative Hospitals Contacted

The CSBs in each region have regional admissions protocols which establish the processes for contacting the alternative hospitals prior to requesting admission to the regional state hospital. The regional admissions protocols identify 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.

On average, emergency services staff contact 25 to 30 private hospitals prior to seeking admission to the regional state hospital.

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 2020 and through the first two quarters of FY 2021. In FY 2020, the cost for civil TDO beds at state hospitals grew by 18.2% when compared to the total costs of FY 2019.

Figure 9: Costs for Individuals under TDO Admitted to State Hospitals for FY 2014 – Mid-Year 2021

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	201,844	$811.00	$163,695,484.00
FY 2019	216,448	$820.00	$177,487,360.00
FY 2020	214,182	$979.63	$209,819,112.66
FY 2021 (7/20-12/20)	115,584	$1,089.46	$125,924,144.64

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

A more comprehensive measure of the cost of temporary detention includes 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, by a Medicaid Managed Care Organization, 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 2015 through FY 2020, and the first two quarters of FY 2021 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	$16,987,753.57	$1,127,452.49
FY 2019	$17,798,267.70	$1,116,459.45
FY 2020	$11,859,484.19	$1,707,139.33
FY 2021 (July-December 2020)	$7,395, 419.33	$627,606.77

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 the utilization of LIPOS by CSB regions and private hospitals. In order to more effectively manage LIPOS funds and ensure the ability to quickly provide funds to regions as their LIPOS needs change, DBHDS will begin managing LIPOS based on a reimbursement model with the five CSB regions, and two sub-regions, in FY 2022.

As shown below in Figure 11, data from FY 2020 and projected numbers based on the first three quarters of FY 2021, there has been a significant decline in LIPOS usage by private hospitals. The Virginia Hospital and Healthcare Association attributes the decrease in uninsured individuals under a TDO to the increased rates of voluntary admissions. The CSB regions also note that implementation of Medicaid expansion has also contributed to the decreased use of LIPOS. 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: Regional LIPOS Beds

Region	LIPOS Bed Days			LIPOS Funds
	FY 2019	*FY 2020*	*FY21 Qtr 1-3*	*Total LIPOS Funds Allocated FY21*
Region 1	1201	696	477	$600,000
Region 2	5088	3736	2,551	$3,500,000
Region 3	1685	713	487	$1,085,000
Region 4	2587	1849	947	$2,000,000
Region 5	3,897	2341	1,750	$1,485,000
TOTAL	**14,458**	**9,335**	**6,222**	**$8,670,000**

In addition, DBHDS contracts with private hospitals to purchase beds with the intention of diverting individuals from state hospital admission when a bed of last resort is requested by a CSB. Typically, private bed purchase by DBHDS occurs during the TDO bed search during the ECO period. 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. Currently there are two contracts held by DBHDS for this purpose: one with Poplar Springs Hospital for child/adolescent diversions from Commonwealth Center for Children and Adolescents (CCCA); and one that was implemented in March 2020 with Williamsburg Pavilion for adult and geriatric patients. Figure 12 below shows the number of adult and geriatric patients diverted from state hospitals, as well as the number of children and adolescents diverted from CCCA and the total cost of those diversions.

Figure 12: Last Resort Diversion LIPOS Contracts with Diamond Healthcare and UHS (July – March)

	LIPOS Diversion Contract for Adults (Williamsburg Pavilion)		LIPOS Diversion Contract for Children & Adolescents (UHS)	
	Number of adult/geriatric patients diverted bed days	Total funds to purchase beds	Number of children & adolescents diverted	Total funds to purchase children & adolescent beds
FY 2021 (July - March)	65	$296,775	50	$129,768

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.