COMMONWEALTH of VIRGINIA

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COMMISSIONER

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January 11, 2022

The Honorable L. Louise Lucas, Chair
Senate Education & Health Committee
The Honorable Mark D. Sickles, Chair
House Health, Welfare, & Institutions Committee
Pocahontas Building
900 East Main Street
Richmond, VA 23219

Dear Senator Lucas and Delegate Sickles,

Chapter 249 of the 2021 Acts of Assembly (SB1304) directs the Department of Behavioral Health and Developmental Services to establish a work group with the Virginia Association of Community Services Boards to review the planning process for discharging individuals from state mental health hospitals and develop a plan to expedite these processes. Specifically, the language requires:

> *That the Commissioner of Behavioral Health and Developmental Services shall establish a work group with representatives of the Virginia Association of Community Services Boards to (i) review the current process for discharging patients from state mental health hospitals, including the current assigned responsibilities of state hospital staff and community services board staff, as well as the barriers to timely discharge for patients clinically ready to discharge, and (ii) develop potential options to expedite the discharge process for individuals who can be safely discharged back into the community. The work group shall develop a plan that includes recommendations for expediting the discharge process and shall identify the necessary funding to ensure that individuals receive essential services upon discharge and that discharges are timely. The work group shall report its findings and conclusions and its plan to the Chairmen of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health by September 1, 2021.*

In accordance with this item, please find enclosed the report on Chapter 249 of the 2021 Acts of Assembly. Staff are available should you wish to discuss this report.

Sincerely,
Alison G. Land, FACHE

CC: Vanessa Walker Harris, MD
Susan Massart
Mike Tweedy

Virginia Department of Behavioral Health & Developmental Services

Report on Chapter 249 of the 2021 Acts of Assembly (SB1304)

Report on the State Hospital Discharge Process

To the Chairs of the Senate Education & Health and House Health, Welfare, and Institutions Committees

Tuesday, January 11, 2022

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Executive Summary

Virginia state psychiatric hospitals have been running near or over capacity for the past several years, with patient discharge posing a particular challenge to the bed census crisis. Discharges have outpaced admissions at all Virginia state hospitals by a very small margin, with many patients having lengths of stay of 30 days or more. DBHDS, in partnership with the Community Services Boards, requested a workgroup as a result of SB1304 to study the discharge process for individuals in state hospitals.

As a result of bed of last resort legislation (SB260, 2014), state hospitals have taken a necessary shift to a more acute model of care. Focus on readmission rates for patients has increased as this shift occurred. Virginia has a higher than average 30-day readmission rate compared to the national average. Nationally, the average 30-day readmission rate for 2017 through 2019 was 7.4 percent, while Virginia's was 9.6 percent, though this slightly improved in FY2020.

Discharging patients in a timely manner becomes more important given this information, but there are multiple barriers to doing so for patients that are clinically stable. Patients in state hospitals are regularly rated on their readiness for discharge, with a "1" rating indicating they are clinically ready for discharge. Once an individual receives a rating of "1" for more than 7 days, they are tracked on the extraordinary barriers to discharge list (often referred to as the EBL). The EBL distinction enables state hospitals and CSBs to focus specific attention and resources on discharge planning for this group of individuals.

In FY20, thirty percent of the individuals on the EBL were actively looking for a residential placement: either an Assisted Living Facility (ALF) or Nursing Home (NH). For individuals referred to ALFs, these placements are typically referred to because they provide a 24 hour supervision. Most ALFs do not provide behavioral health support, and primarily provide supervised housing and assistance with medications and other medical health care needs. ALFs often report that they do not have the training and necessary structure to serve individuals discharging from state hospitals. 83 percent of DAP (discharge assistance program) funds are used to support individuals in assisted living facilities.

The census crisis is multifaceted and many approaches and strategies are necessary to address the challenges. If we are to broadly enhance discharge-planning efforts, there are several overarching factors to consider, to include workforce challenges and aligning pay of employees with experience and qualifications.

Other factors that the workgroup identified as assisting in discharge planning relate to diversion of individuals from admission state psychiatric hospitals. There are some unknowns regarding how the new statewide mobile crisis services, coming online in calendar year 2022, will affect diversions and temporary detention orders (TDOs). Some data from other states suggests that mobile crisis services will assist with preventing the need for hospitalization for certain individuals over time. However, there are also concerns that as Marcus Alert co-responding programs are initiated there may actually be an increase in individuals identified needing psychiatric hospitalization.

The workgroup recommends the review and updating of medical clearance criteria (last reviewed in 2018), and guidance for individuals recommended for inpatient hospitalization, in order to

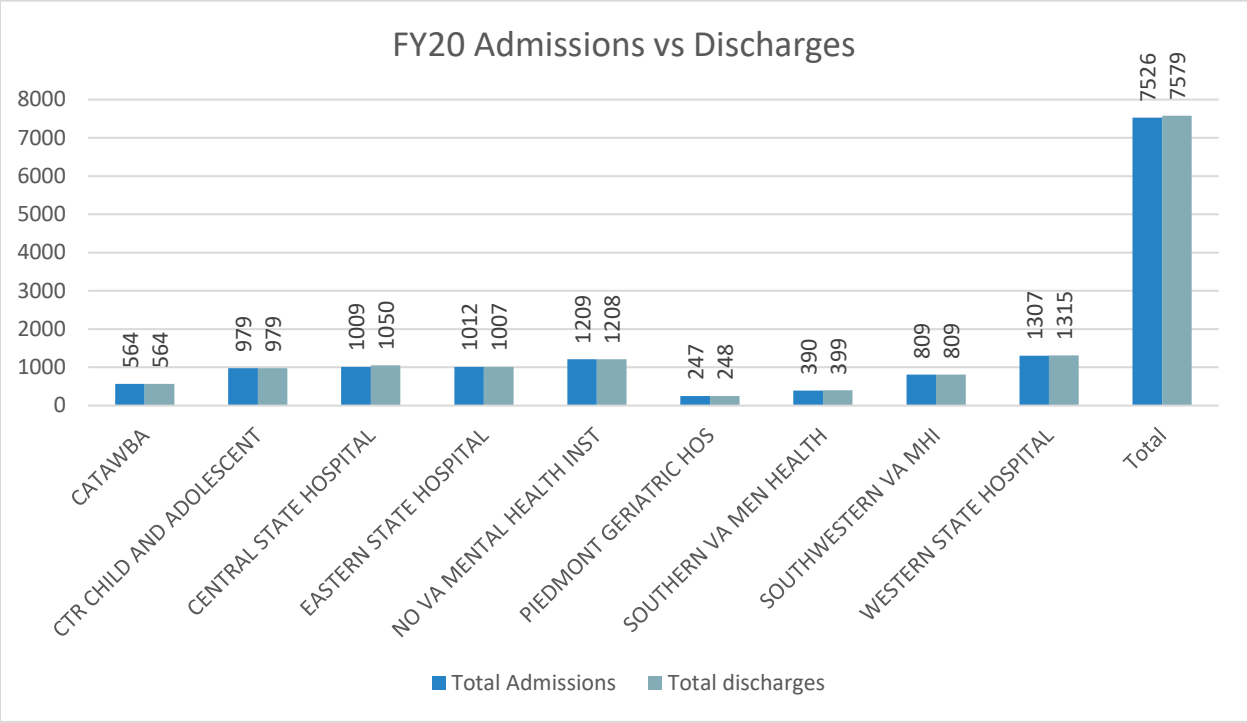
avoid psychiatrically hospitalizing those whose primary need is medical care. The workgroup additionally recommends increased efforts in developing community resources for the following specialized populations from this group: individuals with dementia, traumatic brain injury, and personality disorders. The workgroup reviewed current discharge processes for efficiencies and further discussed several areas where improvement or potential changes could be made: overall system, responsibility for discharge planning, training, discharge planning and continuity of care, and discharge placement options.

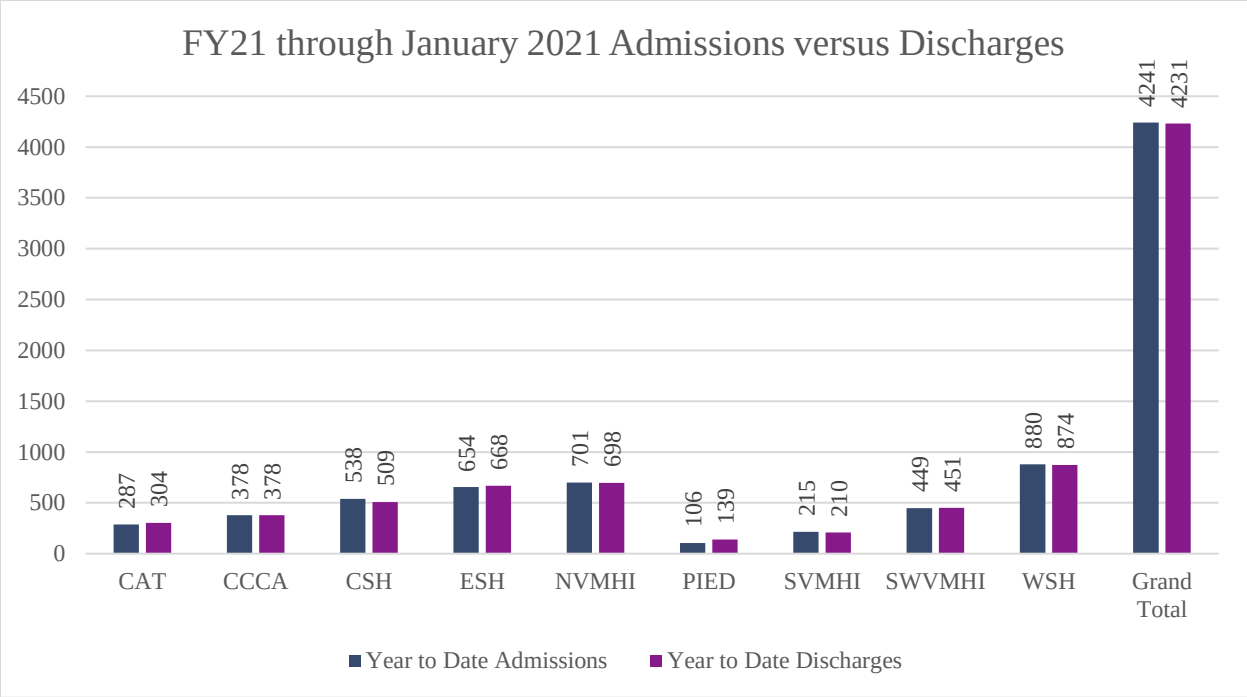
Background

As an unintended consequence of the Bed of Last Resort Legislation that was passed in 2014 (SB 260), Virginia state psychiatric hospitals have been running near or over capacity for the past several years. The challenge of addressing the state hospital census crisis is multifaceted. To ensure patient safety, there is a need for a multipronged approach. DBHDS, in partnership with the Community Services Boards, requested a workgroup as a result of SB1304 to study the discharge process for individuals in state hospitals.

Admissions, Discharges and Length of Stay

In FY20, the state psychiatric hospitals admitted 7,526 patients and discharged 7,579 patients. Discharges outpaced admissions by only 53 patients. For FY21 (through January 2021) admissions are outpacing discharges by 10 (admissions = 4,241; discharges = 4,231). In other words, the state facilities are "treading water" in regards to their census levels. For FY20, the length of stay of individuals discharged averaged 67.3 days. Sixty-six percent of the individuals admitted in FY20 were discharged from state hospitals in less than 30 days.




FY21 through January 2021 Admissions versus Discharges
4500
4000
3500
3000
2500
2000
1500
1000
500
0
287
304
378
378
538
509
654
668
701
698
106
139
215
210
449
451
880
874
4241
4231
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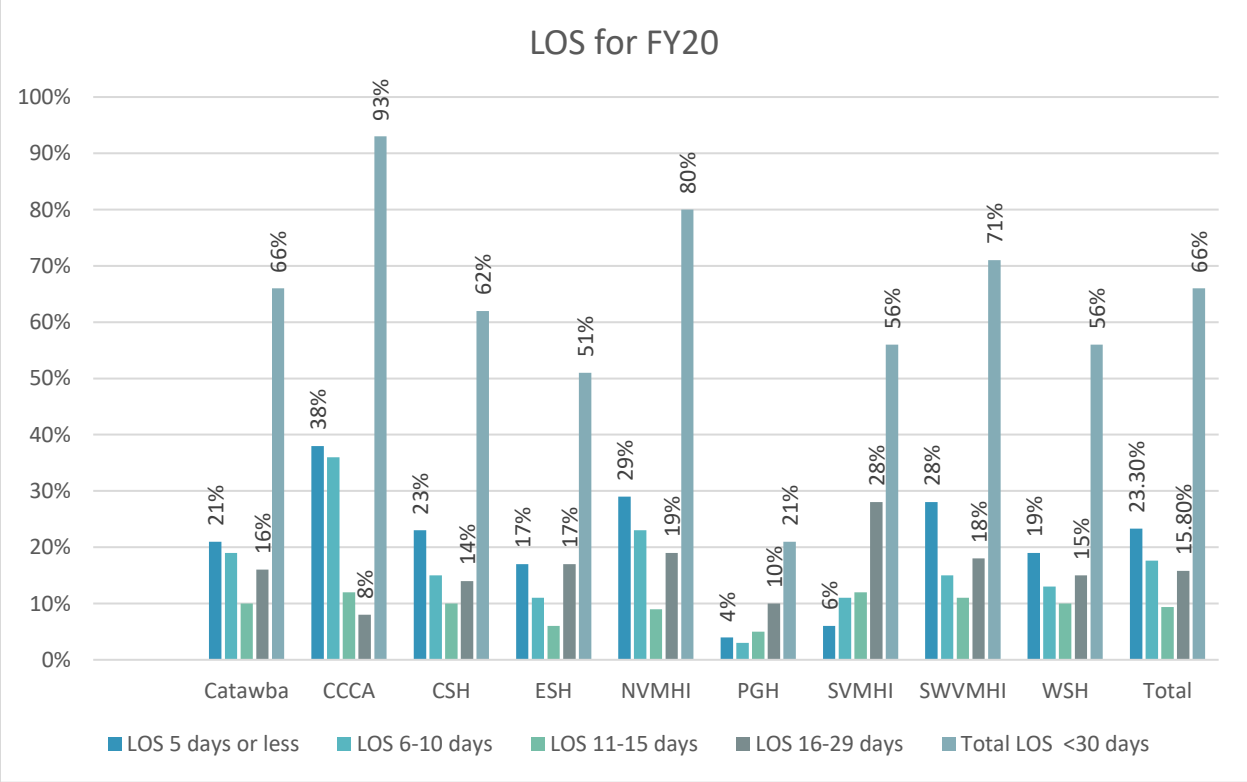
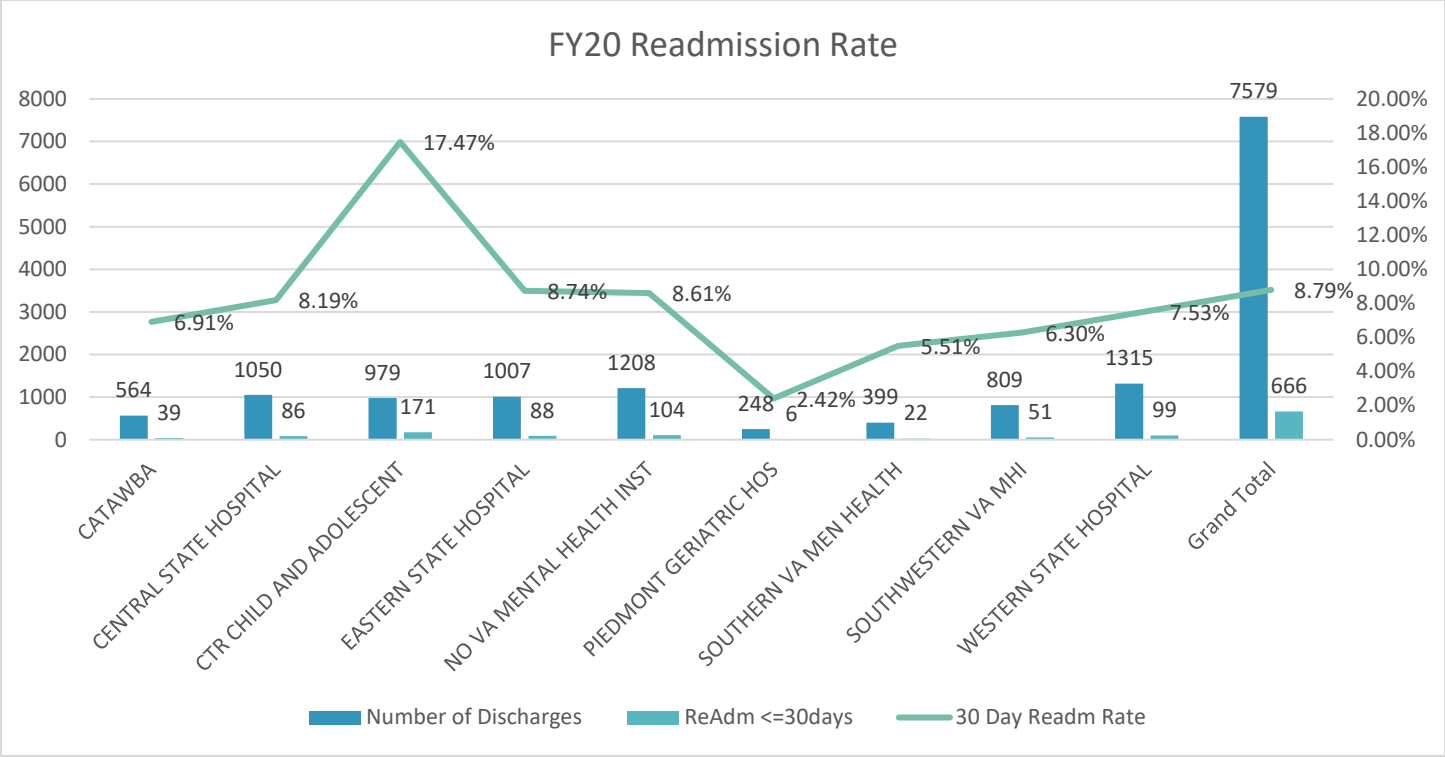
ESH
NVMHI
PIED
SVMHI
SWVMHI
WSH
Grand Total
Year to Date Admissions
Year to Date Discharges


LOS for FY20
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
21%
16%
66%
38%
8%
93%
23%
14%
62%
17%
17%
51%
29%
19%
80%
4%
10%
21%
6%
28%
56%
28%
18%
71%
19%
15%
56%
23.30%
15.80%
66%
Catawba
CCCA
CSH
ESH
NVMHI
PGH
SVMHI
SWVMHI
WSH
Total
LOS 5 days or less
LOS 6-10 days
LOS 11-15 days
LOS 16-29 days
Total LOS <30 days

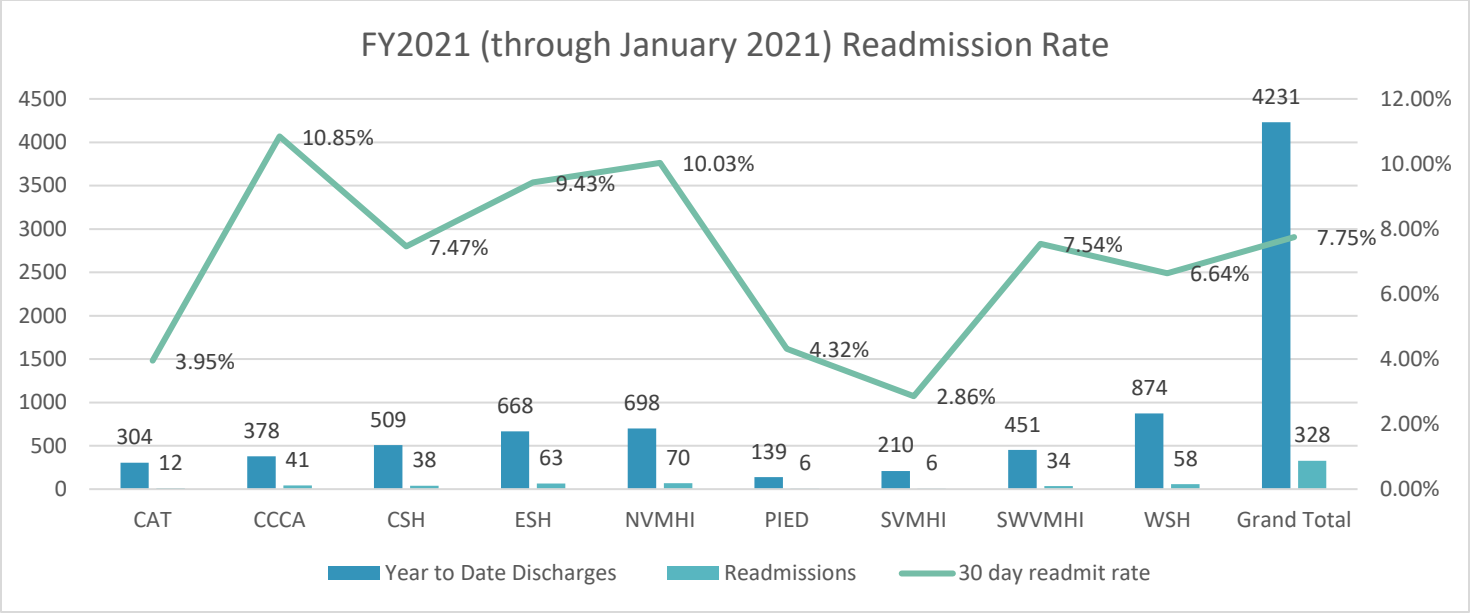
Readmissions

The shift of state hospitals to a more acute model of care has been necessary as a result of bed of last resort legislation. As state psychiatric facilities have accepted more acute patients, there has been an increased focus on the readmission rate; specifically, state facilities and DBHDS Central Office have tracked and reviewed 30 day readmission rates. This data is specific to state hospital discharges and readmissions, and does not capture individuals who may have been served in a private/community inpatient unit, discharged, and admitted to a state hospital within 30 days; nor does it capture individuals hospitalized in a state hospital, discharged, and admitted to a private/community inpatient unit within 30 days.

In comparing Virginia state hospital 30 day readmissions rates in 2017-2019 with the rest of the country, Virginia's state hospital 30 day readmission rates were higher than the national average: Virginia's 30 day readmission rate was 9.6 percent, versus a national state hospital readmission rate average of 7.4 percent. In FY20, Virginia state hospital's readmission rate was 8.79 percent.



In FY 21 (through January 2021), the state hospital readmission rate had decreased further, to 7.75 percent.



When reviewing the original length of stay for individuals readmitted, the majority of individuals had an original length of stay of less than 30 days. For instance, 73 percent of individuals readmitted in FY21 had an original length of stay of less than 30 days. In addition, these individuals were only in the community an average of 11.98 days before developing a crisis that lead to readmission to the state hospital.

The above data speaks to not only the "back door" (discharges) of state hospitals; it also speaks to the "front door" (admissions) to state hospitals. The revolving door of acute hospitals stays creates challenges in the hospitals, as well as the community.

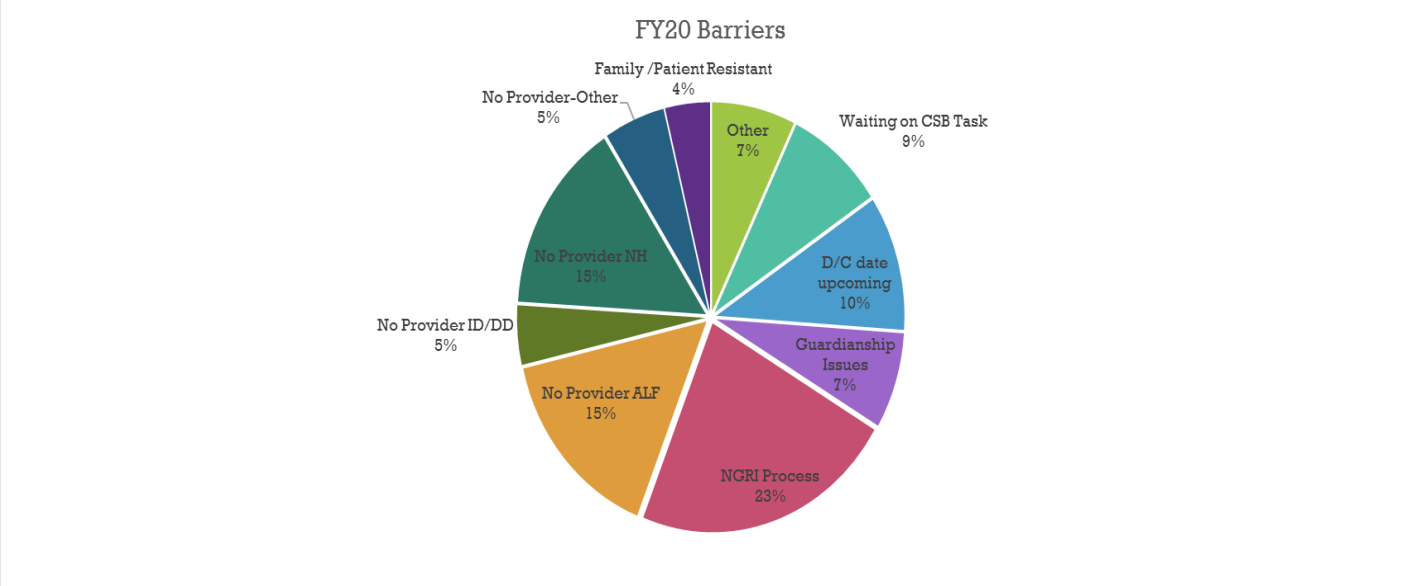
Extraordinary Barriers to Discharge

An important facet of the state hospital census crisis is the multiple barriers to discharging patients that are clinically stable. As part of the treatment process, individuals in state hospitals are regularly rated on a scale of their readiness for discharge. Once a patient has been rated a 1 (ready for discharge) for more than 7 days, they are tracked on the extraordinary barriers to discharge list (often referred to as the EBL). The EBL distinction enables state hospitals and CSBs to focus specific attention and resources on discharge planning for this group of individuals. The most common barriers to discharge of individuals on the EBL are defined in the chart below.

DBHDS Barrier to Discharge	Explanation
No willing provider-Assisted Living Facility (ALF)	Level of care is identified as an ALF. No ALF placement has been found or no bed available so other placements should continue to be sought.

No willing provider-Nursing Home (NH)	Level of care is identified as a NH. No NH placement has been found or no bed available so other placements should continue to be sought.
No willing provider-Permanent Supportive Housing (PSH)	Level of care is identified as permanent supportive housing (PSH). Has not been accepted into PSH. If they're accepted into PSH but barrier is finding an apartment, they should go into "no willing provider-other" category.
No willing provider-ID/DD Services	This is utilized for DD individuals who need placement but no provider has accepted. This category is also used when the barrier is no willing provider for other ID/DD services, such as applied behavior analysis or other specialists.
No willing provider-other	Level of care identified is something other than noted in other categories and a placement has not been found. The level of care could include but is not limited to ICRT, mental health group homes, boarding homes, transitional living placements, brain injury rehab, residential substance abuse treatment, etc.
Guardianship Barriers	The primary barrier to discharge is guardianship. The individual could need a guardianship provider or, more frequently, is awaiting the completion of the legal appointment process.
Patient and/or family/AR is resistant to discharge	This barrier is chosen when either the patient or family/authorized representative (AR)/other surrogate decision maker is resistant to discharge and that is the primary barrier to discharge. An example would be when an appropriate discharge placement (or placements) is identified and the patient and/family/decision maker is not agreeing to proceed with discharge
Not Guilty by Reason of Insanity (NGRI) Process	The NGRI graduated release process is the primary barrier. This would include the need to complete passes before requesting Conditional Release, or the need for court approval for Conditional Release. Please note if the barrier for the patient is securing a placement for the passes or Conditional Release, then the "no willing provider" barrier should be used.
Awaiting completion of CSB discharge planning tasks	This barrier is chosen when the CSB needs to complete something in order for the discharge to move forward. This can include, but is not limited to, completing a DAP request, executing a contract with the provider, scheduling appointments, etc.
Awaiting discharge-discharge date scheduled	This barrier is when a discharge plan is finalized and there is a date scheduled for the discharge, but the patient hasn't yet left at the time of the monthly review meeting.
DD waiver process	This category should be used for individuals where the CSB is working through the process of qualifying the individual for services/waiver (i.e. obtaining records, VIDES, etc.)
Other	This category should be used rarely. Some examples for use are non-NGRI forensic barriers.

For FY20, the statewide EBL averaged over 200 patients in any given month who were ready for discharge but had an extraordinary barrier to discharge. Below is a chart with the percentage of specific barriers. (In FY20 the EBL was defined as patients ready for discharge for 14 days or longer. FY22 that has been updated to be patients ready for discharges 7 days or longer)



Nearly a quarter of the individuals who are ready for discharge are part of the NGRI (Not Guilty by Reason of Insanity) graduated release process. This process allows for individuals to be rated ready for discharge but not have a Conditional Release plan approved. Often the individuals in this category are preparing to do 48 hour passes to ensure safety and appropriateness before a conditional release plan is presented to the court.

In FY20, thirty percent of the individuals on the EBL were actively looking for a residential placement: either an Assisted Living Facility (ALF) or Nursing Home (NH). For individuals referred to ALFs, these placements are typically referred to because they provide a 24-hour supervision. They are often used when more structured community services are unavailable. It is important to note, however, that most ALFs do not provide behavioral health support, and primarily provide supervised housing and assistance with medications and other medical health care needs. ALFs often report that they do not have the training and necessary structure to serve individuals discharging from state hospitals. ALFs that do state the ability to serve these individuals report that they require significant funding in order to support these individuals. Of note, 83 percent of DAP (discharge assistance program) funds are used to support individuals in assisted living facilities.

Workgroup Process

Participants for the workgroup were identified collaboratively, with members being appointed by the Virginia Association of Community Services Boards (VACSB) and DBHDS Central Office. The members included CSB, hospital, and Central Office leadership, front-line discharge planning staff, and a representative from disability Law Center of Virginia. Initially, three meetings were scheduled. A fourth meeting was required in order to complete the work of the group. Among other tasks, the workgroup reviewed data on state hospital discharges and

readmissions, reviewed and discussed evidence-based models of discharge planning, discussed factors unique to Virginia, and developed discharge planning recommendations.

Recommendations

Discharge planning is just one element of census management. The census crisis is multifaceted and many approaches and strategies are necessary to address the challenges. If we are to broadly enhance discharge-planning efforts, there are several overarching factors to consider. As with many health care entities, the behavioral health field is facing workforce challenges. To ensure adequate and qualified staffing, it is recommended that efforts are made to align pay with experience and qualifications.

Other factors that the workgroup identified as assisting in discharge planning relate to diversion of individuals from admission state psychiatric hospitals. Currently, there are some unknowns regarding how the new statewide mobile crisis services will affect diversions and temporary detention orders (TDOs). They will come online in calendar year 2022. Some data from other states suggests that mobile crisis services will assist with preventing the need for hospitalization for certain individuals over time. However, there are also concerns that as Marcus Alert co-responding programs are initiated there may actually be an increase in individuals identified needing psychiatric hospitalization.[1]

The workgroup recommends the review and updating of medical clearance criteria (last reviewed in 2018), and guidance for individuals recommended for inpatient hospitalization, in order to avoid psychiatrically hospitalizing those whose primary need is medical care. Specific individuals or disorders such as individuals with neurocognitive disorders, children with ID/DD diagnoses, individuals with a primary diagnosis of dementia, traumatic brain injury, or individuals with personality disorder diagnoses, are often hospitalized due to the lack of targeted community services to specifically address the behavioral health needs of these populations. They are also often are more difficult to discharge for the same reason. The workgroup recommends increased efforts in developing community resources for the following specialized populations from this group: individuals with dementia, traumatic brain injury, and personality disorders.

The workgroup reviewed current discharge processes for efficiencies and discussed several areas where improvement or potential changes could be made: I. Overall System; II. Responsibility for Discharge Planning; III. Training; IV. Discharge Planning and Continuity of Care; and V. Discharge Placement Options.

These recommendations are framed through the lenses of creativity and flexibility.

I. Overall System Review

As mentioned, addressing discharge planning inefficiencies alone will not address the full spectrum of the census crisis.

[1] https://dbhds.virginia.gov/assets/doc/EI/dbhds-one-pager-step-va-and-marcus-alert.pdf

Recommendation:

1. Engage outside consultation to complete a system review of pressure points and areas from admission to discharge that could be approved in order to reduce census. Additional consideration should focus investment in the continuum of community based services through funding remaining STEP-VA steps and Medicaid BRAVO services and identification of gaps for specialized populations.

II. Responsibility for Discharge Planning

Prior to the implementation of this workgroup, DBHDS submitted legislative and budgetary requests that would enable state hospitals to take on the role of primary responsibility for discharge planning (currently this role is held by the CSBs, per the Code of Virginia 37.2-505). DBHDS asserts that CSB staffing resources could be better utilized by providing community based services, and that DBHDS could (with additional staffing support) assume the primary discharge planning burden in order to safely discharge individuals to the community and connect them with CSB case management and services, as appropriate. Given that the patient is in the presence of the state hospital staff and discharge planning is expected to begin at admission, DBHDS state hospitals could increase discharge planning efficacy by assuming the primary discharge planning role and initiating planning on the day of admission. Given the shift to almost 24/7 admissions since Bed of Last Resort statute took effect, the CSBs do not have sufficient staff resources to deploy discharge liaisons to the state hospitals timely and initiate planning soon after admission.

There was some group consensus that a version of this model may increase some discharge planning efficiencies, due to the hospital's direct access to the patient for discharge planning; as well as provide a centralized approach for obtaining documentation for referrals and submitting these to providers, and enabling discharge planning to truly begin at admission. However, the frequently voiced challenges include recruitment of staff in the midst of the current workforce shortages, the ability of the CSBs to provide follow-up appointments in a timely manner, and the process for managing DAP on an ongoing basis. The DAP process relies heavily on CSB participation and funding to place individuals on the EBL in the community

Given the above considerations, the workgroup members agreed that state hospitals conducting discharge planning for individuals who are hospitalized less than 30 days may have some utility in increasing the efficiency in discharge planning.

*Recommendations***:**

1. Based on these discuss, DBHDS recommends a pilot of state facility discharge planning for short term civil acute care admissions. The pilot should be no less than six months. The Region 4 CSBs, located in the central Virginia region, have indicated they are prepared to conduct such a pilot with Central State Hospital with appropriately documented protocols and procedures to ensure individuals are connected, as needed, with Region 4 CSBs after short term discharges. As part of this pilot:
    a. Additional resources should be provided to Central State Hospital to absorb the discharge planning tasks.

b. DBHDS, Central State Hospital, Designated Central Office representatives and the Region 4 CSBs would collaboratively develop protocols for the process as well as agreed up on success metrics.

c. Based on the review of the relevant data from the pilot, DBHDS and VACSB would identify methods to expand the model to other regions with the aim of statewide implementation.

III. Training

In reviewing discharge planning processes across the nine state psychiatric hospitals and 40 Community Services Boards, one of the most glaring issues is a lack of consistency and process in discharge planning and roles. DBHDS publishes Collaborative Discharge Requirements for Community Services Boards and State Hospitals, also known as the "Discharge Protocols". Beginning in FY22, these requirements are part of the Performance Contract with the CSBs. Despite these guidelines, there is still much variability in the application of these protocols. Staff implementing these guidelines are largely discharge liaisons employed by CSBs and social workers employed by state hospitals. Both the discharge liaisons at the CSBs and the state hospital social workers often have additional job responsibilities beyond discharge planning. Training for these positions are the responsibility of the hiring agency and vary greatly.

In addition, DBDHS is often called on to support private/community psychiatric inpatient units in their discharge efforts for more complex patients. In an effort to increase the knowledge base and skill of the private/community hospital discharge planners, as well as increase the likelihood of acceptance of these patients to private/community units, DBHDS would like to extend training efforts and financial resources to private hospitals willing to partner on this effort. The workgroup had several consensus recommendations to improve training:

Recommendations:

1. Development of quality control measures to review consistency in application of Discharge Protocols.

2. Development of statewide training curriculum for those directly involved in discharge planning. This training would require cross training opportunities for hospital and CSB staff, allowing for an understanding of strengths and limitations of each team member.

3. Development of specific guidelines and approved processes regarding individuals/families/surrogate decision makers resistant to discharge.

4. Development of a discharge planning certification process for private/community hospital discharge planners to increase knowledge of complex discharge issues and resources.

    a. For those private/community hospitals/units certified, offer access to financial resources for patient needs at discharge for individuals with complex barriers to discharge. Management/approval of funding would be similar to DAP and remain at DBHDS Central Office, but would offer resources that are not currently available for these patients at private facilities.

Resources needed:

1. DBHDS staff position to develop, review, and implement quality control measures across all hospitals and CSBs
2. DBHDS staff position to develop and implement curriculum and ensure training is kept relevant and update to date. (These listed positions could combine for one FTE)
3. Funding required for the development and execution of regular training events.
4. DAP-like funding for complex discharge planning needs for certified private/community hospitals/units.
5. DBHDS staff position to support certification, consultation, and funding efforts for private/community hospital discharge planning.

IV. Discharge Planning and Continuity of Care

Currently, discharge planning and aftercare is not a single continuous activity, as it is often disrupted at various points in the process. Ideally, discharge planning and aftercare would be a service that encompasses efforts at the state hospital and post-discharge. This continuity of care is integral to ensuring community success and reducing readmissions to state hospitals. Discharge planning is currently funded only by general fund dollars for both the state hospitals and CSBs, as there is no reimbursement mechanism for these services. There are pockets of this continuity throughout the state that has shown to work well.

The workgroup reviewed several evidence-based models of discharge planning. Almost all of these models included a multi-disciplinary team format. As DBHDS and Virginia continues to develop the mental health service model through STEP-VA, there is an opportunity to expand the current definitions of care coordination and case management to include discharge care. The workgroup agreed this will require more resources, but it is a necessary step to expand community capacity, decrease hospital census, and ensure the successful integration of individuals into their communities post-discharge.

Recommendations:

1. Explore the intersection of Discharge Continuity of Care as a complete service, and integration of this service into STEP-VA with Care Coordination and Case Management.
    a. Review intersection with Project Bravo
    b. In conjunction with DMAS, review and update regulations on individual's Medicaid status throughout hospitalization.
    c. In conjunction with DMAS, review reimbursement and definition of discharge planning activities to ensure sustainability for any discharge related improvements.
2. Adoption of Critical Time Intervention (CTI) as a model of care for discharge planning to allow for evidenced based interventions, warm hand-off of care, and reduced readmissions

3. Addition of a position at CCCA that is an employee of the Department of Social Services (DSS) to effectively work on the specific discharge planning needs of individuals at CCCA who are DSS involved.

Resources needed:

1. Potential increased funding to CSBs to cover cost of discharge planning positions as part of STEP –VA; this was not included in original estimates and any change in the definition will increase costs.
2. Potential increase to funding for Project Bravo and DMAS to reimburse for discharge planning activities.
3. Funding for staff positions, training, and implementation of CTI as a model of care.
4. Funding for position at CCCA for DSS involved individuals.

V. Discharge Placement Options

For discharge planning and community care to be fully effective, it is essential that there is community capacity and appropriate options for individuals to be able to reintegrate back into their communities. This challenge is not new to our system. The individuals with the most challenges to discharge planning are those with unique barriers or diagnoses which require specialized levels of care. These can include those with dementia, traumatic brain injury, or personality disorders. Mental health residential treatment options are currently unavailable in Virginia. Leveraging Medicaid to fund these types of services would allow for effective discharges, but more importantly, diversions from state psychiatric hospitals.

Recommendations:

1. Expand specialized services, specifically residential services, for individuals with specialized needs, including but not limited to dementia, traumatic brain injury, personality disorders, and for children with dual diagnosis presenting with chronic aggression/self-harm.

Develop mental health residential treatment options funded by Medicaid.

Resources needed:

1. Additional general fund specific to specialized residential services.
2. Additional DMAS funds to provide for Medicaid-reimbursed mental health residential treatment options.

SB1304 Exercise: Benefits and Challenges of Shifting Discharge Planning Responsibilities to State Facilities

August 5, 2021

Reporting entity	Benefits	Challenges/Disadvantages
CSB	Targeted effort re relationships with residential community resources	Recruitment and retention of positions at hospitals. May create competition in behavioral health workforce with CSBs.
CSB	Immediate access to individual	CSBs are most familiar with services within CSB and community. Hospital staff work with multiple CSBs, making it more challenging to be aware of resources in each jurisdiction
State hospital	Direct line of communication with providers versus current process, creating potentially more efficiency	Staffing-benefits coordinator, discharge transports. Ensuring discharge appointments in needed time frame.
CSB	Everything coming from centralized location (information packages, documentation)	Clients may be moved to first available discharge location, versus home community or community of choice. Clarification how this would interact with NGRI individuals considering CSB's role in graduated release process.
CSB	For short-term, acute stay individuals, it may be beneficial for the hospital to be the lead on these discharges	Concerns about how the discharge would be managed ongoing (DAP plans and contracting, relationships with community providers)
CSB		Would require robust aftercare team if responsibilities shift
State hospital	Efficiency, streamline processes. Potentially less delays.	How would it be staffed? Even with additional of discharge planners, it doesn't fill a third party. Challenges for hospitals to stay up to date with resources available across the region.
CO	Alleviate issues with competing priorities (current staff have multiple job tasks). Allow DBHDS to hold staff accountable within the agency.	Knowledge about resources. Not immediately having the CSBs involved who may have long relationships with patients.
CO	Benefits to moving certain tasks to state hospitals or possibly related to length of stay	
CSB	Already experiencing hospitals taking the lead on short stay individuals and it seems to be working well.	Solution doesn't necessarily address the main problems, specifically the way the system is set up. Money may be more beneficial to use towards an overall study of the system.
State hospital	Improved efficiency, streamlined process. Decrease some of the back and forth that occurs currently. Efficiency may decrease LOS for some patients. State hospital may be able to anticipate movement and manage beds more effectively.	Not just awareness of resources in the community, but access to those resources within the community. Concern about the potential for system to become more siloed, versus continuum of care. This can lead to poorer quality and individuals falling through the cracks.
dlcv	Timeliness, efficiency, streamlining. Direct access to the individual may lead to a better understanding of needs and preferences.	Transitional support-ensuring there is a plan in place for warm handoff into the community, would reduce recidivism.
CSB		CSBs know their individuals, their settings, and their community. State hospital may not be aware of these. State hospitals may not have the time or resources to do some of the work that the CSB currently does. CSB may have better understanding of baseline.

State hospital	In current climate, there can be a diffusion of tasks, which could be decreased as hospitals wouldn't have to wait and would be clear about their tasks. Currently a challenge to be aware of all CSBs processes. Currently, around half of patients admitted don't have a pre-existing relationship with CSBs.	Won't address the need for specialized placements, which is one of the biggest challenges to timely discharges.
CSB		Will require legislative changes, which will be inherited by the next administration
State hospital	State hospital may also know discharge resources well.	
CO	Discharge planning begins on day 1, including weekends.	Blurred lines of responsibilities, knowing whose role is which
CSB		Possibility of making CSB liaison roles redundant