REGION 1 TDO ADMISSIONS PROTOCOL

REVISED JULY 1, 2018

Serving the individuals and communities for the following Community Service Boards (CSBs):

Alleghany Highlands Community Services Board, Harrisonburg-Rockingham Community Services Board, Horizon Behavioral Health, Northwestern Community Services, Rappahannock Community Services Board, Rappahannock Rapidan Community Services, Region Ten Community Services Board, Rockbridge Community Services Board, and Valley Community Services Board.

Dennis B. Vaughn, M.A.

Regional Initiatives Director

Region 1

dennis.vaughn@regionten.org

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I. INTENT OF REGIONAL PROTOCOLS AND ANNUAL REVIEW

Intent of a Regional Admissions Protocol

It is of critical importance to achieve a safe placement for individuals in crisis within the time limit afforded by the Code of VA. Clear and consistent procedural expectations are to be established among the stakeholders of Region 1 to define what steps are to be taken to seek TDO admissions to private psychiatric hospitals. This protocol establishes the process to be followed when a private hospital bed is not readily available and an admission to a state hospital is necessary. By establishing this protocol, it is the goal of Region 1 to find appropriate placement for TDO eligible individuals within the allotted time frame and to ensure that no one who requires a TDO admission is released to the community without receiving adequate treatment.

Annual Review

Region 1 will review and update the regional protocols and submit them to DBHDS by June 15th each year for inclusion on the DBHDS website.

II. ADULT (AGES 18-64) TDO ADMISSIONS

Individuals Under an Emergency Custody Order (ECO)

I. Notification to CSBs and Western State Hospital

As mandated by VA Code, a law enforcement officer taking Emergency Custody of an individual for the purpose of a preadmissions screening assessment will contact the local CSB Emergency Services program as soon as is practicable to notify them of the need for an assessment (contact information for Region 1 CSB Emergency Services programs can be found in Appendix D). The CSB prescreener will then respond to the designated ECO location to begin the process of the preadmissions screening assessment as quickly as possible. Historically, response time guidelines have suggested a response of one hour or less for urban CSBs and two hours or less for rural CSBs.

In addition, VA Code requires that all individuals taken into emergency custody will be provided with a written summary that explains the ECO procedure. This summary should be provided to the individual by the law enforcement officer who takes the individual into custody as soon as is practicable upon taking emergency custody of that individual.

Once the CSB prescreener is notified of a pending preadmissions screening evaluation for an individual under an ECO (paper or paperless), they will then notify Western State Hospital via email (ECONotification.WSH.dbhds.virginia.gov) as soon as practicable.

When a TDO admission is indicated by the prescreening assessment and, in the clinical judgment of the prescreener appears likely to necessitate a state admission, the completed preadmission screening form should be sent via FAX to Western State Hospital (WSH), along with a notification phone call. The state hospital may perform their own search for an alternate hospitalization in collaboration with the CSB prescreener and, if successful, will notify the CSB prescreener immediately that a willing private hospital has been located.

In addition, the designated state hospital is to be notified via email upon the completion of the preadmission screening assessment for individuals under an ECO (paper or paperless) when hospitalization is not indicated.

II. Timeline For Bed Search and Documentation of Bed Search

Region 1 is comprised of nine CSBs that cover a large and diverse area. Over the years, the ES department at each Board has developed working relationships with a number of private hospitals. These hospitals typically are the ones closest to the CSB geographically, recognizing the best practice of hospitalizing individuals close to home and family as best as possible in order to enable families to better participate in treatment and discharge planning when appropriate. However, CSBs also have established strong relationships with private hospitals, both within the

Region 1 service area and outside it, that have LIPOS contracts with Region 1 and utilize them for TDO admissions frequently.

The CSBs will use the standard list of private hospitals but may prioritize their own order of this list rather than attempting to create a "one size fits all" list of hospitals for all to use. This will allow each Board to continue to best serve their clients by utilizing those hospitals nearest to them in proximity or that have the best working relationships with them by calling them first to seek admission.

If TDO admission is the indicated disposition of the preadmission screening evaluation, the CSB prescreener will initiate the process to secure a private TDO admission.

Private psychiatric hospitals and Crisis Stabilization Units (CSUs) will be contacted first to secure a TDO bed. For the sake of timeliness and to maximize the number of private hospitals that can be called, it will be necessary for the prescreener to contact a number of these hospitals simultaneously to request a bed. It is the expectation of this protocol that hospitals will work to give responses regarding admissions (either approving or declining admissions) as promptly as possible. It is recommended that the private hospital or CSU contact the prescreener to confirm receipt of all required documentation and an estimated time frame for a final response to the TDO admission request. Once an admission is secured, the prescreener should contact the appropriate state hospital by phone to cancel the potential request for a bed.

For each prescreening, the CSB prescreener shall complete the Hospital Call List form (or an alternative document approved by the Regional Initiatives Director and DBHDS) documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital and transmit the form to WSH along with the preadmission screening form.

III. Western State Hospital Admission Process

When the ECO reaches the **6** hour mark from the time it was executed and a private hospital bed has yet to be secured, a call will be made by the prescreener to WSH to notify admissions staff that a TDO bed search is in process and the bed search is extending past **6** hours. It should be emphasized that this call is not made to necessarily seek admission to WSH at that time but rather to continue the collaboration with the state facility and the discussion of admission should it become necessary. It should be stressed that the 6 hour mark is the maximum time at which WSH should be contacted. In cases where complicating factors may exist (e.g. medical complications, issues related to acute behaviors, etc.), the CSB is strongly encouraged to notify WSH earlier.

If no private psychiatric bed has been identified by the **7** hour mark of the ECO period, the prescreener will notify Western State Hospital to consult regarding a possible TDO admission. WSH admissions staff will notify the prescreener ASAP when admission has been approved to allow adequate time for the prescreener to pursue the TDO from the Magistrate. The formal process of securing the TDO from the Magistrate should begin no less than **30** minutes before the expiration of the in order to ensure TDO disposition within the allowable time parameters. However, the search for a private bed should be continued up to and beyond the confirmation of

admission to WSH to every extent feasible so as to take every step possible to avoid state hospitalization as appropriate.

The emergency services clinician shall notify via email the designated CSB discharge planner of every admission to a state hospital within 24 hours of the issuance of the temporary detention order (TDO).

Adults Not Under ECO But Requiring TDO

Any adult who meets TDO criteria but is not under ECO for which private hospitalization has been eliminated by conducting and documenting an extensive bed search including CSUs, the regional state hospital will consider acceptance and will not deny admission.The CSB prescreener will contact WSH Admissions and provide the preadmission screening assessment, the bed search documentation, and other records as needed.

Diversion to Another State Hospital

In circumstances in which a state hospital gets a TDO bed request and they determine that they need to divert, the State Hospital Director is responsible for contacting Hospital Directors at sister state facilities in order to find a diversion bed. The diverting state hospital will then communicate the name and contact info of the receiving state hospital to ES, who will contact the receiving hospital to facilitate the pre-admission process. It is expected that the diverting hospital will verify that an exhaustive bed search, including state funded diversion beds (subject to contract and availability), has been completed. The diverting hospital will send all information received on the individual to the diversion hospital. ES will send the information to the diverted hospital if the information has not been received by the regional state hospital.

State Contract Diversion Beds

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

Change of Facility Prior to the Expiration of the TDO (VA Code 37.2-810)

Pursuant to VA Code 37.2-810, the facility may be changed at any point from the actual execution of the TDO until the time of the commitment hearing. In situations wherein a TDO is issued to a state facility, the CSB is encouraged to continue searching for alternate placement to a private facility in order to better manage the utilization of state hospital resources.

It may also be practical, particularly during periods of high state facility census, to consider changing facilities for individuals from private hospital to state hospital, and vice versa, to assist

with managing bed utilization, managing difficult behaviors, and/or managing medical needs that exceed the facility's capacity.

III. GERIATRIC TDO ADMISSIONS

Region 1 is served by two different state facilities for treatment of geriatric patients (defined as having reached age 65 or older). Rappahannock CSB, Rappahannock Rapidan CSB, and Region Ten CSB are served by Piedmont Geriatric Hospital, while Alleghany Highlands CSB, Harrisonburg-Rockingham CSB, Horizon Behavioral Health, Northwestern CSB, Rockbridge Area CSB, and Valley CSB are served by the geriatric unit of Catawba State Hospital.

Geriatric Individuals Under an Emergency Custody Order (ECO)

A. Notification to CSBs and Designated State Hospital

As mandated by VA Code, a law enforcement officer taking Emergency Custody of an individual for the purpose of a preadmissions screening assessment will contact the local CSB Emergency Services program as soon as is practicable to notify them of the need for an assessment (contact information for Region 1 CSB Emergency Services programs can be found in Appendix D). The CSB prescreener will then respond to the designated ECO location to begin the process of the preadmissions screening assessment as quickly as possible. Historically, response time guidelines have suggested a response of one hour or less for urban CSBs and two hours or less for rural CSBs.

In addition, VA Code requires that all individuals taken into emergency custody will be provided with a written summary that explains the ECO procedure. This summary should be provided to the individual by the law enforcement officer who takes the individual into custody as soon as is practicable upon taking emergency custody of that individual.

Once the CSB prescreener is notified of a pending preadmissions screening evaluation for an individual under an ECO (paper or paperless), they will then notify their designated state geriatric facility (*either Catawba State Hospital via the Catawba Admissions Line 540-375-4289 or Piedmont Geriatric Hospital via email at PGHECONotification@dbhds.virginia.gov*) as soon as practicable.

When a TDO admission is indicated by the prescreening assessment and, in the clinical judgment of the prescreener appears likely to necessitate a state admission, the completed preadmission screening form should be sent via FAX to their designated geriatric state hospital, along with a notification phone call. The state hospital may perform their own search for an alternate hospitalization in collaboration with the CSB prescreener and, if successful, will notify the CSB prescreener immediately that a willing private hospital has been located.

In addition, the designated state hospital is to be notified via email upon the completion of the preadmission screening assessment for individuals under an ECO (paper or paperless) when hospitalization is not indicated.

B. Timeline For Bed Search and Documentation of Bed Search

Region 1 is comprised of nine CSBs that cover a large and diverse area. Over the years, the ES department at each Board has developed working relationships with a number of private hospitals. These hospitals typically are the ones closest to the CSB geographically, recognizing the best practice of hospitalizing individuals close to home and family as best as possible in order to enable families to better participate in treatment and discharge planning when appropriate. However, CSBs also have established strong relationships with private hospitals, both within the Region 1 service area and outside it, that have LIPOS contracts with Region 1 and utilize them for TDO admissions frequently.

The CSBs will use the standard list of private hospitals but may prioritize their own order of this list rather than attempting to create a "one size fits all" list of hospitals for all to use. This will allow each Board to continue to best serve their clients by utilizing those hospitals nearest to them in proximity or that have the best working relationships with them by calling them first to seek admission.

If TDO admission is the indicated disposition of the preadmission screening evaluation, the CSB prescreener will initiate the process to secure a private TDO admission.

Private psychiatric hospitals and Crisis Stabilization Units (CSUs) will be contacted first to secure a TDO bed. For the sake of timeliness and to maximize the number of private hospitals that can be called, it will be necessary for the prescreener to contact a number of these hospitals simultaneously to request a bed. It is the expectation of this protocol that hospitals will work to give responses regarding admissions (either approving or declining admissions) as promptly as possible. It is recommended that the private hospital or CSU contact the prescreener to confirm receipt of all required documentation and an estimated time frame for a final response to the TDO admission request. Once an admission is secured, the prescreener should contact the appropriate state hospital by phone to cancel the potential request for a bed.

For each prescreening, the CSB prescreener shall complete the Hospital Call List form (or an alternative document approved by the Regional Initiatives Director and DBHDS) documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital and transmit the form to designated state hospital along with the preadmission screening form.

C. Geriatric State Hospital Admission Processes

Catawba Hospital Geriatric ECO/TDO Protocol

Contact Numbers:

24 hour admissions line: (540) 375-4289

Business hours fax: (540) 375-4399

After hours and weekend fax: (540) 375-4374

1. Upon notification from law enforcement of an ECO, the CSB will contact Catawba Hospital via the admissions line to notify them of the ECO 24/7. The information required is the following: ECO start time, name/initials of patient, gender, DOB, CSB, and contact information for prescreener. All information is documented in a call log.

2. Upon completion of the prescreening assessment, the CSB will contact Catawba Hospital via the admissions line to inform whether a TDO is recommended.

3. **ECO 4.5 hour mark**: If a TDO is recommended and a bed has not found been found elsewhere, the CSB will fax the prescreen, medical clearance information, and bed search log to Catawba for review (it is acceptable to fax earlier in the process).

Upon receiving the prescreen and medical information, SW staff or the nursing supervisor will review the information received and ensure that the accepting physician has the information for review.

If a private bed is secured, the CSB will contact Catawba via the admissions lines to notify them of this.

4. **ECO 7 hour mark**: If Catawba has not received notification that a private bed has been located, Catawba SW staff (day) or nursing supervisor (after hours) will notify the CSB that the individual is accepted for admission to Catawba.

**Multiple medical issues may result in the need to request a TDO pending for medical clearance that may extend beyond the ECO timeframe. Some examples include: high BAC, not receiving labs, the physician or MOD requesting additional medical information that cannot be obtained in the ECO timeframe, the Catawba physician or MOD believing that the individual is not stable for transfer for Catawba and has not received call back from the ED to further discuss, etc. In these cases, Catawba can accept the patient on a TDO pending medical clearance. At this point, we are committed to taking the patient. However, it is requested that the patient not be transferred to Catawba's facility until the patient is medically cleared by Catawba's accepting physician. Once needed medical clearance has occurred, Catawba social worker or nursing supervisor will notify the CSB that the patient is accepted for transport to Catawba.

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PIEDMONT GERIATRIC HOSPITAL

TDO Admission Protocol

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

PGH TDO Admission Protocol

ECO Notification reports:

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

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

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

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

ECO 5th hour:

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

5th hour PGH contact is the same process as the Notification process provided above. If the Answering Service is contacted, request a call back. The ES staff can anticipate a call back from the PGH AOC within 10 minutes.

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

- CSB prescreen

- bed search status: hospitals still pending, reasons patient is being declined, etc.

– labs & tests as follows to rule out medically induced psychiatric symptoms:

- Physical exam to include VS, allergies, current medications and medical problems

- CBC

- CMP

- UA, UDS

- Chest x-ray

- EKG -
BAL and/or medication levels if pt. it symptomatic (ex: Lithium, Depakote)

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

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

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

ECO 7th hour:

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

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

Additionally:

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

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

Release of Geriatric Individuals from an Emergency Custody Order (ECO)

It is understood that, under no circumstance, should an individual who is medically appropriate and who meets TDO criteria be released from an ECO without an admission to a psychiatric

facility and the disposition should not take longer than the maximum time period allowed by VA Code for an ECO (8 hours). CSB Executive Directors are to report any instances where this may occur to DBHDS according to established reporting procedures.

Geriatric Individuals Not Under ECO, Requiring TDO

Any person who meets TDO criteria but is not under ECO for which private hospitalization has been eliminated by conducting and documenting an extensive bed search including CSUs, the regional state hospital will consider acceptance and will not deny admission.

The CSB prescreener will contact Admissions of the designated geriatric state facility (Catawba or Piedmont) and provide the preadmission screening assessment, the bed search documentation, and other records as needed.

Diversion to Another State Hospital

In circumstances in which a geriatric state hospital gets a TDO bed request and they determine that they need to divert, the State Hospital Director is responsible for contacting Hospital Directors at sister state facilities in order to find a diversion bed. The diverting state hospital will then communicate the name and contact info of the receiving state hospital to ES, who will contact the receiving hospital to facilitate the pre-admission process. It is expected that the diverting hospital will verify that an exhaustive bed search, including state funded diversion beds (subject to contract and availability), has been completed. The diverting hospital will send all information received on the individual to the diversion hospital. ES will send the information to the diverted hospital if the information has not been received by the regional state hospital.

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Change of Facility Prior to the Expiration of the TDO (VA Code 37.2-810)

Pursuant to VA Code 37.2-810, the facility may be changed at any point from the actual execution of the TDO until the time of the commitment hearing. In situations wherein a TDO is issued to a state facility, the CSB is encouraged to continue searching for alternate placement to a private facility in order to better manage the utilization of state hospital resources.

It may also be practical, particularly during periods of high state facility census, to consider changing facilities for individuals from private hospital to state hospital, and vice versa, to assist

with managing bed utilization, managing difficult behaviors, and/or managing medical needs that exceed the facility's capacity.

IV. CHILD AND ADOLESCENT TDO ADMISSIONS

The Commonwealth Center for Children and Adolescents (CCCA) serves all of the CSBs in Region 1. In fact, as the only state facility that treats children and adolescents in Virginia, it serves all 40 CSB/BHAs in the Commonwealth. As a result of this factor, some differences may be noted in certain aspects of the admissions protocol for this facility.

Children/Adolescents Under an Emergency Custody Order (ECO)

I. Notification to CSBs and State Facility

As mandated by VA Code, a law enforcement officer taking Emergency Custody of an individual for the purpose of a preadmissions screening assessment will contact the local CSB Emergency Services program as soon as is practicable to notify them of the need for an assessment (contact information for Region 1 CSB Emergency Services programs can be found in Appendix D). The CSB prescreener will then respond to the designated ECO location to begin the process of the preadmissions screening assessment as quickly as possible. Historically, response time guidelines have suggested a response of one hour or less for urban CSBs and two hours or less for rural CSBs.

In addition, VA Code requires that all individuals taken into emergency custody will be provided with a written summary that explains the ECO procedure. This summary should be provided to the individual by the law enforcement officer who takes the individual into custody as soon as is practicable upon taking emergency custody of that individual.

Once the CSB prescreener is notified of a pending preadmissions screening evaluation for an individual under an ECO (paper or paperless), they will then notify the Commonwealth Center for Children and Adolescents (CCCA) via email (CCCA-ECO.notification@dbhds.virginia.gov) as soon as practicable.

When a TDO admission is indicated by the prescreening assessment and, in the clinical judgment of the prescreener appears likely to necessitate a state admission, the completed preadmission screening form should be sent via FAX to CCCA, along with a notification phone call. The state hospital may perform their own search for an alternate hospitalization in collaboration with the CSB prescreener and, if successful, will notify the CSB prescreener immediately that a willing private hospital has been located.

In addition, the designated state hospital is to be notified via email upon the completion of the preadmission screening assessment for individuals under an ECO (paper or paperless) when hospitalization is not indicated.

II. Timeline For Bed Search and Documentation of Bed Search

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The CSBs will use the standard list of private hospitals but may prioritize their own order of this list rather than attempting to create a "one size fits all" list of hospitals for all to use. This will allow each Board to continue to best serve their clients by utilizing those hospitals nearest to them in proximity or that have the best working relationships with them by calling them first to seek admission.

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For each prescreening, the CSB prescreener shall complete the Hospital Call List form (or an alternative document approved by the Regional Initiatives Director and DBHDS) documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital and transmit the form to CCCA along with the preadmission screening form.

III. CCCA Admissions Process

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan
July 2018

DBHDS maintains 48 acute inpatient psychiatric hospital beds for Virginians who are under 18 years of age. These beds are at the Commonwealth Center for Children & Adolescents (CCCA) in Staunton, VA, which serves the entire Commonwealth. With this 48-bed limit, CCCA and its community partners, including private hospitals, juvenile detention and correctional centers and community services boards (CSBs), have been successful in meeting all emergency hospitalization needs utilizing the plan below.

CCCA serves as the safety net for children and adolescents who require short-term, crisis acute inpatient psychiatric care and cannot be admitted to or remain in any other child/adolescent psychiatric hospital in Virginia. CCCA is operated under the guidance of the pertinent Code of Virginia:

Virginia Code 16.1 – 345 (below).

1. Because of mental illness, the minor (i) presents a serious danger to himself or others to the extent that severe or irremediable injury is likely to result, as evidenced by recent acts or threats or (ii) is experiencing a serious deterioration of his ability to care for himself in a developmentally age-appropriate manner, as evidenced by delusionary thinking or by a significant impairment of functioning in hydration, nutrition, self-protection, or self-control;

2. The minor is in need of compulsory treatment for a mental illness and is reasonably likely to benefit from the proposed treatment;

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

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

Admissions Process

- CCCA admits children and adolescents up to 18 years of age who are in need of inpatient acute psychiatric hospitalization from within the Commonwealth of Virginia
- The Intake/Admissions Office (540-332-2120) is staffed and accepts appropriate admissions 24 hours a day, 7 days a week
- The CCCA Admissions Coordinator or designee receives all referral calls for potential admissions
- The Admissions Coordinator reviews all referrals for appropriateness for admission based on criteria set forth in the Psychiatric Treatment of Minor's Act (see §16.1-335 *et seq*.) and/or mandated by legislation requiring state hospitals to serve as facilities of last resort. (see 16.1-340.1(d)
- All admissions must first be prescreened by a CSB. A prescreening is also requested for those admissions ordered pursuant to VA§ 16.1-275 or 16.1-356 (court-ordered evaluations) to assist in the assessment and discharge planning processes
- Admission requests not from CSBs are referred to the CSB for appropriate pre-admission prescreening
- The Admissions Coordinator consults with the CSB Emergency Services Prescreener on every referral to:
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried or that may be available
    - Review all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act and/or last resort legislation
    - Consider the need for hospitalization, and if hospitalization is needed, the availability of other options; particularly those that keep the child or adolescent in their community
- While the Admissions Coordinator may encourage the prescreener to explore options not considered, including providing names of alternative hospitals, Crisis Stab and/or Child REACH, CCCA will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option (i.e. those under TDO)
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If a child is under an ECO, and the bed search is not successful by hour 6, the prescreener will notify the CCCA Admissions Coordinator at hour 6 via telephone call and fax the Uniform Prescreening Report to CCCA as well as any available medical information.
- At hour 7 if a bed has not been identified, the prescreener will contact CCCA to request a TDO bed acceptance pending medical clearance if the youth is in the ED
- If a child is in the Emergency Department, lab results, MAR, physician review of systems and physical exam must be received for CCCA RN/MD review prior to transport of an accepted admission
- The Admissions Coordinator will review medical concerns and consult as needed with the RN and physician to determine if additional medical information is necessary or if medical issues require attention prior to admission
- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which the facility believes the child's needs would not be best served at CCCA and there is no legal directive to admit, the referring party will be encouraged to identify alternative, more suitable means of treatment

Bed Management

A. Diversion

When bed space is limited:

- The CSB Emergency Services Departments are contacted and informed of the lack of available beds and requested to divert admissions if at all possible;
- Forensic admission referrals for Court Ordered Evaluation pursuant to §16.1-275 of the Code of Virginia will be placed on a waiting list and will be admitted within 10 days in the order in which the referral was received or as otherwise determined appropriate. Court Ordered Evaluations are ordered for children *not in psychiatric crisis*, but for whom an evaluation of treatment needs is warranted. These children are most often in detention centers and therefore in a safe place to await admission to CCCA;
- Forensic admission referrals for Evaluation of Competency to Stand Trial pursuant to §16.1-356, these referrals will be placed on a waiting list and will be admitted within 10 days, in the order in which the referral was received or as otherwise determined appropriate. Such children are in juvenile detention centers or in the community as determined appropriate by a judge and will remain in that setting to await admission;
- Admission may be deferred for patients who are in a safe place (e.g., another facility, hospital or detention)
- If attempts to find an alternative bed are not successful and a community safety plan is not a safe option, the child will be accepted for admission as a TDO.

B. Discharge

The availability of beds for admission is dependent on patients being discharged when clinically appropriate and when there is no basis for civil commitment. Clinical teams work closely with families and communities to facilitate timely discharge, collaborating to manage challenges related to the transition to the appropriate setting.

To support this, CCCA will:

- Encourage families and communities to begin discharge planning upon admission and rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged to another level of care or do not meet criteria for civil commitment.
- Hold bi-monthly (1st and 3rd Wednesday of each month) Statewide Census Management/Ready for Discharge Meetings to discuss extraordinary barriers

C. Partnerships

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

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

Release of Children/Adolescents from an Emergency Custody Order (ECO)

It is understood that, under no circumstance, should a child or adolescent who is medically appropriate and who meets TDO criteria be released from an ECO without an admission to a psychiatric facility and the disposition should not take longer than the maximum time period allowed by VA Code for an ECO (8 hours). CSB Executive Directors are to report any instances where this may occur to DBHDS according to established reporting procedures.

Children/Adolescents Not Under ECO, Requiring TDO

Any child or adolescent who meets TDO criteria but is not under ECO for which private hospitalization has been eliminated by conducting and documenting an extensive bed search including CSUs, the regional state hospital will consider acceptance and will not deny admission.

The CSB prescreener will contact CCCA Admissions and provide the preadmission screening assessment, the bed search documentation, and other records as needed.

State Contract Diversion Beds

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

Change of Facility Prior to the Expiration of the TDO (VA Code 37.2-810)

Pursuant to VA Code 37.2-810, the facility may be changed at any point from the actual execution of the TDO until the time of the commitment hearing. In situations wherein a TDO is

issued to a state facility, the CSB is encouraged to continue searching for alternate placement to a private facility in order to better manage the utilization of state hospital resources.

It may also be practical, particularly during periods of high state facility census, to consider changing facilities for individuals from private hospital to state hospital, and vice versa, to assist with managing bed utilization, managing difficult behaviors, and/or managing medical needs that exceed the facility's capacity.

V. MEDICAL ASSESSMENT/SCREENING

A. DBHDS/VHHA Guidance Document

All policies and procedures related to medical screening and assessment will be in accordance with the Adult/Geriatric Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit (Appendix A) or the Adolescent Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit (Appendix B) document issued by DBHDS/VHHA.

B. TDO Pending Medical Clearance (VA Code 37.2-810)

I. Allows for magistrates to include a medical facility for further medical evaluation or treatment prior to placement as required by a physician at the admitting temporary detention facility.

C. Substance Using Individuals

Individuals with active or even severe Substance Use Disorders must also meet TDO criteria for Danger to Self/Others or Unable to Care for Self due to their disorder. Prescreeners should attempt to place these individuals in facilities that offer SUD treatment or can provide rapid step-down when the client is stabilized as appropriate. The SUD Diversion Clinician will maintain a list of suggested placements and can be consulted regarding specific cases.

State hospitals will advise ER physicians when the individual's clinical needs exceed the hospital's medical capacity to safely monitor and treat, consistent with EMTALA law. There is no specific cut-off for BAL. Individuals with withdrawal management concerns will be subject to the guidelines involving medically compromised individuals as established in the Medical Review section.

D. Pregnant Women

If the likelihood of pregnancy is indicated via the preadmission screening, medical assessment, individual or collateral reporting, or other means, this information will be communicated clearly to any prospective receiving facilities, including but not limited to state hospitals, private hospitals, crisis stabilization units, and residential substance use treatment facilities.

E. Medical TDO Regulations (VA Code 37.2-1104B)

I. Requires the CSB is to re-evaluate any individual who was subject of an ECO and required a Medical TDO prior to discharge or at the expiration of the Medical TDO. The evaluation is to be conducted upon the completion of the observation, testing or treatment. The medical facility is responsible to notify the CSB before the individual is to leave or upon the expiration of the Medical TDO.

II. The medical facility in which the subject of a Medical TDO is detained shall be responsible for notifying the CSB if the individual is ready to be discharged prior to the expiration of the Medical TDO. However, the CSB should contact the medical facility before the expiration of the Medical TDO in order to ensure that the individual is not discharged without an evaluation to determine if a psychiatric TDO might still be indicated.

VI. SPECIAL POPULATIONS

A. Individuals with Developmental Disabilities

Individuals with developmental disabilities shall be supported with services that allow the individual to live the most inclusive life possible in his/her community which includes access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services when indicated.

For the purposes of REACH services, the three northernmost CSBs of Region 1 (Northwestern, Rappanahannock-Rapidan and Rappahannock Area) are served by the REACH program from Region 2, while the other Region 1 CSBs are served by Region 1 REACH services.

CSBs emergency services shall: notify the regional REACH program of any individual suspected of having a DD who is experiencing a crisis and seeking emergency services as soon as possible, preferably at the onset of pre-admission screening evaluation. When possible, this would allow REACH and emergency services to appropriately divert the individual from admission to psychiatric inpatient services when possible.

The emergency services staff will also include REACH in problem solving, staffing and consulting prior to rendering a decision for involuntary temporary detention. While REACH staff does not replace the role and responsibility of the preadmission screening evaluator, it is expected that together they will identify the least restrictive options for treatment and care.

All individuals receiving Adult REACH services must be aged 18 or older, and have a diagnosis of a Developmental Disability, with co-occurring mental illness and/or significant behavioral challenges that are active or cyclical in nature. For Children's REACH services, the child may receive services up until their 18th birthday at which time they will be transitioned into the adult program if needed. The child must also have a diagnosis of Developmental Disability, with co-occurring mental illness and/or significant behavioral challenges that are active or cyclical in nature.

B. Deaf or Hard-of-Hearing Individuals

While individuals who are deaf or otherwise hearing-impaired may have specialized needs in terms of treatment, the Admission Protocol should be followed as for any other adult person with private facilities to be sought for admission whenever possible. As mandated by State Code, VDDHH (Virginia Department for the Deaf and Hard of Hearing) maintains a directory of Qualified Interpreter Services and works to remove communication barriers. DBHDS, in cooperation with the CSBs, provides comprehensive consultative services; contact Kathy Baker, Coordinator of Services at 540/213-7527.

C. Non-English Speaking Individuals

The importance of comprehension on the part of subjects of preadmission screenings cannot be understated, both in terms of being able to understand and actively participate in the assessment process, as well as in terms of being effectively assessed for TDO criteria on the part of the

evaluator. Therefore, each CSB should maintain a directory of local foreign language interpreter services for use when assessing an individual for whom English is not their preferred language. Interpreters are to be held to confidentiality standards per CSB requirements. These resources should primarily be interpreters who can be present in person during the evaluation but, under certain circumstances, interpreters involved either telephonically or online may be used, provided that every available effort is made to preserve confidentiality.

D. Incarcerated Individuals

Incarcerated individuals who are subject to TDO admissions are required to be admitted to state facilities, rather than private psychiatric hospitals or CSU facilities. For adults, Western State Hospital should be contacted first to determine if the individual can go to that facility or will need to go to the forensic unit at Central State Hospital. Geriatric and Child/Adolescent individuals will go to the designated geriatric state facility or to CCCA, respectively.

VII. UTILIZATION REVIEW PROCESS

Critical to the success of any Regional admissions protocol is the demonstrated ability to derive the maximum benefit from a limited pool of resources. This is especially true of the need to keep potential state hospital “safety net” beds open to the greatest extent possible in order to make certain they are available to accommodate emergency TDO admissions when they are needed. To keep these beds as available as possible, it is imperative to monitor bed utilization in the state hospitals from admission to discharge.

Region 1 has historically been proactive in terms of bed utilization reviews at Western State Hospitals. CSB Liaisons meet on a monthly basis to review WSH patients who are either ready for discharge or are approaching readiness for discharge in order to collaborate to achieve successful and timely discharges from WSH as appropriate. In addition, individuals at WSH who are on the EBL or are listed as Ready For Discharge are discussed on a regional conference call on a monthly basis, with attendance from each CSB mandatory. Catawba and Piedmont also have monthly meetings to address the EBL and RFD individuals in order to obtain the most up-to-date information regarding discharge planning and to allow for collaboration when faced with discharge barriers.

When an individual is admitted to a state facility on a direct TDO due to lack of availability of a private hospital bed, the CSB clinician who performed the preadmission screening will notify the CSB Emergency Services Manager (or designee) via email no later than the start of the next business day and will cc the Region 1 Regional Initiatives Director (or designee). The CSB Discharge Manager/Liaison will also be notified of the state admission by the start of the next business day in order to begin the discharge planning process.

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) requires each CSB to submit monthly reports of any instances involving TDOs that, for whatever reason, extended past the allotted 8 hour ECO period or that were not issued when required. These reports are submitted to the Region 1 Regional Initiatives Director who reviews and compiles the data before submitting a Regional report to DBHDS. This data is instrumental as a barometer of success of the Regional Admissions Protocol and will be reviewed regularly by all involved stakeholders as part of the ongoing quality improvement and review process. In cases where a TDO admission was required but was not achieved, the CSB Executive Director is to be notified as soon as possible, and is required to submit a written notification of this event to DBHDS within 24 hours of the event.

For a Regional Admissions Protocol to be successful and adaptive to ongoing changes to legislation, private and state psychiatric hospital resources, and CSB resources, among other changes, there needs to be an active and robust Quality Improvement and Review process. The practical effectiveness and overall success in reaching its goals needs to be assessed on a regular basis, with feedback from every stakeholder involved in the TDO process. In addition to ongoing protocol development, the Quality Improvement process must also be responsive to resolving problems that may arise in the implementation of the protocol in a timely fashion, in order to prevent these problems from re-occurring to the greatest extent possible.

In Region 1, there currently exists organizational infrastructure that would appear to be well-suited for overseeing and administering much of the Quality Improvement process. Specifically, these would be the Regional Access Committee (RAC), the Utilization Management Team (UMT), and the Executive Directors (ED) Forum.

The RAC is composed of representatives from the nine CSBs in Region 1 (typically from the Emergency Services department), representatives from the Admissions Department at Western State Hospital, the Region 1 ID/DD Project Manager, the Regional SUD Diversion Clinician and the Region 1 Regional Initiatives Director. Each CSB RAC representative is responsible for communicating and collaborating with private hospitals for cases involving individuals served by their Boards. This group meets twice each week (on Tuesday and Thursday mornings, with the exception of holidays) via conference call, but also has the ability to meet at other unscheduled times on an emergency basis as the need arises. The primary purpose of the RAC is to review potential transfers of patients from private psychiatric facilities to Western State Hospital, taking into consideration appropriateness for transfer as well as the triaging of potential transfers bases upon severity of need, acuity and dangerousness, etc. In addition, cases involving direct TDO admissions to Western State Hospital (due to lack of private hospital bed availability or other factors) are discussed in the RAC call. Because this group meets frequently and involves so many stakeholders, it would seem logical that this group would be the first place to discuss cases that involved problematic TDO cases. If necessary, the Regional Initiatives Director will reach out to any and all private psychiatric hospitals that were involved in the case to seek further information and input from the hospitals. The RAC representative from the CSB that performed the preadmission screening in question will be responsible for staffing the problem TDO with the RAC group at the soonest RAC conference call. Through collaboration and constructive problem-solving, it is expected that the majority of problem cases will result in resolution and, in some cases, suggestions for potential changes to the protocol. In cases where RAC makes recommendations for corrective actions, the Regional Initiatives Director will notify the hospitals and CSBs that were directly involved in the problem TDO and what, if any action is recommended by the RAC team.

The UMT meets bimonthly (every other month) and is a larger group, composed of the same individuals in RAC, plus representatives from private psychiatric hospitals, Region 1 Regional Crisis Stabilization Units (CSUs), representatives from DBHDS, and other CSB staff, including Mental Health Directors, etc. The primary function of this group is to review the utilization of resources in Region 1 to make certain that they are being used in the most effective and efficient manner possible. The Region 1 Regional Initiatives Director will report, at each UMT meeting, any problem cases that were reported to and discussed by RAC, as well as provide information regarding the resolution and disposition of the cases as available. The UMT group will be tasked with providing continuous oversight of the Regional Admissions Protocol and its effectiveness and will serve as an advisory group to the Region 1 Executive Directors Forum to provide any input, suggestions, or recommendations regarding potential modifications to the Regional Admissions Protocol.

The Region 1 Executive Directors Forum meets on a monthly basis and, as its name implies, is composed of the Executive Directors of the eight CSBs in Region 1. However, this meeting is also attended by other stakeholders, including (but not limited to) DBHDS, Western State Hospital, the Commonwealth Center for Children and Adolescents, Central Virginia Training Center, and the Region 1 ID/DD Project Manager and the Region 1 Regional Initiatives Director. The Region 1 Regional Initiatives Director will include, in his monthly report to the ED Forum, discussion of problem TDO cases that were discussed by RAC and/or UMT, including dispositions and protocol revision suggestions as appropriate. The Region 1 ED Forum is the organizational body responsible for establishing Regional protocols and will make the final decision regarding the content of the Regional Admissions Protocol, as well as any modifications made to the protocol moving forward.

Appendix A

Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit (ADULTS)

- **General Assumptions for Recommendations**
- **Standardized Exclusion Criteria for Adult Admission to State Hospitals and Crisis Stabilization Units**
- **Medical Assessment and Screening Guidelines for Adult Admissions**

General Assumptions

- The following guidelines are meant to supplement the Medical Screening & Medical Assessment Guidance Materials issued by the Department of Behavioral Health and Developmental Services (DBHDS) on April 1, 2014. This document does not supersede any Virginia or federal law.

- An individual who is actively violent may not be appropriate for admission to a Crisis Stabilization Unit.

- Doctor-to-doctor communication is requested to ensure continuity of care and is required to resolve disagreements in patient care.

- Doctor-to-doctor communication is required when there is a question about the medical stability of a patient.

- Whenever practical, individuals without acute exacerbation of co-morbid medical conditions can seek medical assessment through an emergency or non-emergency department setting. When these patients present on their own to the emergency department, appropriate examination and laboratory work will be offered. Wherever medical assessment occurs, these guidelines will apply. A more complex medical assessment may be clinically warranted for individuals with exacerbation of medical conditions or for whom there is concern that an underlying medical condition might be the cause of the behavioral, cognitive, or emotional presentation.

- Patients presenting with a primary medical need should be stabilized prior to referral for psychiatric treatment and considered for a medical temporary detention order (TDO) pursuant to Virginia Code §37.2-1104 (https://law.lis.virginia.gov/vacode/title37.2/chapter11/section37.2-1104/). Pursuant to Virginia Code §37.2-810 (https://law.lis.virginia.gov/vacode/title37.2/chapter8/section37.2-810), when a patient is transported by law-enforcement or alternative transporter to a medical facility for medical evaluation or treatment, such medical evaluation or treatment shall be conducted immediately in accordance with state and federal law.

- Patients who are determined to need an acute level of medical care will be admitted medically and emergency departments will request a medical temporary detention order when this is

appropriate.

- All psychiatric providers will evaluate medically stabilized patients for admission and pursuant to Virginia Code Subsection B 20 of §32.1-127 (https://law.lis.virginia.gov/vacode/title32.1/chapter5/section32.1-127/), each hospital shall establish protocols authorizing doctor-to-doctor communication when there is a refusal to admit a medically stable patient and develop protocols that require verbal communication between the on-call psychiatric physician and a clinical toxicologist or other person who is a Certified Specialist in Poison Information, if requested by the referring physician, when there is a question about the medical stability or appropriateness of an admission due to a toxicology screening.

- Those under the age of 18 are referred to facilities serving children & adolescents. The exception is emancipated minors which a court may declare in the following circumstances: (i) the minor has entered into a valid marriage, whether or not that marriage has been terminated by dissolution; or (ii) the minor is on active duty with any of the armed forces of the United States of America; or (iii) the minor willingly lives separate and apart from his or her parents or guardians, with the consent or acquiescence of the parents or guardians, and that the minor is or is capable of supporting himself or herself and competently managing his or her own financial affairs; or (iv) the minor desires to enter into a valid marriage and the requirements of Virginia Code §16.1-331 (https://law.lis.virginia.gov/vacode/title16.1/chapter11/section16.1-331/) are met.

Doctor-to-Doctor Dispute Resolution Protocol

- Stage 1: When there is a disagreement between the referring physician and receiving physician about any requested laboratory work or evaluations, and/or admission, the physicians should attempt to resolve the matter amicably.

- Stage 2: If such resolution cannot be reached between the physicians, the referring physician may request that the dispute be escalated to the Medical Director (or designee) of the referring facility to initiate a discussion with the Medical Director (or designee) of the receiving facility for resolution.

- Stage 3: If the matter remains unresolved or the Medical Director is unavailable, the Medical Director (or designee) at the referring facility may request that the dispute be brought to the Chief Medical Officer (or equivalent) of the receiving facility for resolution. This discussion should be facilitated by either the referring facility's Medical Director (or designee) or the Chief Medical Officer (or equivalent).

Note: When DBHDS state facilities are involved in a dispute, the chain of command should be followed with escalation after the CMO to the State Hospital Facility Director, and if not successful, escalation to the DBHDS Chief Clinical Officer and/or DBHDS Commissioner is appropriate.

Protocol Review and Monitoring Committee (PRMC)

A Protocol Review and Monitoring Committee (PRMC) will be established to monitor providers' adherence to the medical assessment guidelines and ensure unified implementation. As needed, the PRMC will also review cases that were escalated to determine what steps can be taken to improve resolution earlier in the process and cases in which a significant medical condition was not identified or stabilized.

- The PRMC membership will consist of one representative from each of the following organizations; Department of Behavioral Health & Developmental Services, Psychiatric Society of Virginia, Virginia Association of Community Services Boards, Virginia College of Emergency Physicians, and Virginia Hospital & Healthcare Association. Each organization shall designate an alternate to attend meetings as necessary. Meetings will be held as necessary, but no fewer than twice a year. Members will serve for two years and may be reappointed for additional terms. In cases where specific facilities are being discussed, representatives from the facilities will be invited to attend the meeting.

- These guidelines are intended to provide consistency in evaluation of persons with mental illnesses and suspected comorbid medical conditions by emergency department physicians and for referrals to all psychiatric hospitals, inpatient psychiatric units and CSUs in Virginia. The ultimate decision for admission is that of the receiving physician.

EXCLUSION CRITERIA: Adult Admission to State Hospitals and Crisis Stabilization Units

	Criteria for Exclusion
1	Burns (severe) requiring acute care; if the burn could be cared for at home, it is not an exclusion.
2	Acute Delirium.
3	Dementia as primary diagnosis; in the absence of clinically significant psychiatric symptoms. *State Hospital Units & Crisis Stabilization Units (CSU) are not equipped to treat individuals with dementia as primary diagnosis. These individuals are also at risk of victimization.*
4	Acute Head Trauma/Traumatic Brain Injury in absence of a mental illness.
5	Unstable fractures, open or closed and joint dislocations, acute, until reduced.
6	Unstable seizure disorders.
7	Bowel Obstruction, requiring active treatment or medical observation.
8	Acute Respiratory Distress.
9	Acute drug intoxication, withdrawal or, high risk for complicated withdrawal, including history of delirium tremens.
10	Active GI bleed and/or active bleeding from other unknown sites.
11	Active TB; other infectious disease requiring isolation and/or treatment by IV antibiotics to be discussed by providers based on facility's ability to provide.
12	Draining wound, open, requiring daily complex wound care.
13	Intravenous fluids or IV antibiotics. *State Hospitals & CSUs are not a safe environment for managing intravenous fluids or IV antibiotics.*
14	Vent and Trach patients excluded; other oxygen dependent patients based on facility's ability to provide care (e.g. BiPAP, CPAP at night, Oxygen Concentrator).
15	Tubes or drains, chest or abdominal, including ostomies (unless the individual provides their own ostomy care).
16	Hemodialysis patients excluded. Peritoneal dialysis patients based on facility's ability to safely manage patient.
17	Individuals requiring hospice or end of life care.
18	*For Crisis Stabilization Units only:* Durable medical equipment that is not able to be secured by CSU.

MEDICAL EVALUATION GUIDELINES: Adult Admission to All Psychiatric Hospitals and Units & Crisis Stabilization Units*

**Requests for further testing, without an agreement of medical necessity will require doctor- to- doctor communication.*

	Guideline for Evaluation
1	*ALL adult patients presenting at the emergency department for medical assessment prior to admission to a psychiatric service or crisis stabilization unit will receive an appropriate medical screening exam including a problem focused history, neurological, and physical exams, as well as the following:* *Healthy patients <60 years:* *a. Alcohol level (serum or breath)* *b. UDS* *c. Urine pregnancy test for females of child bearing age* *Patients >=60 years:* *a. Alcohol level (serum or breath)* *b. UDS* *c. CBC without differential* *d. BMP* *e. UA* Notes: • Patients taking medications and symptomatic for toxicity should have levels drawn and checked in the emergency department. This includes: Dilantin, Lithium, Depakote, and Tegretol. Patients with a possible overdose of Acetaminophen or Salicylate should have those levels checked. • Patients with other medical issues should have focused workup done such as a glucometer blood glucose level or BMP in the setting of known diabetes. • Patients who are anuric (e.g. dialysis dependent and unable to produce urine) will not have a drug screen performed. • Patients who have capacity to make informed decisions and do not consent to collection of a urine or blood specimen will not be forced, including under an emergency custody order (ECO). The provider or screener in the emergency department should relay this information to the facility considering admission. • Patients with new onset of severe psychiatric symptoms (e.g. psychosis) should be considered for a more extensive workup including brain imaging.
2	*Vital Signs:* *a. Doctor-to-doctor communication is necessary for: sustained heart rate <50 or >120 and sustained Systolic Blood Pressure <90 or >180.* *b. Heart Rate >120 requires EKG.* *c. Stable chronic HTN does not need to be WNL.* *d. Temp >101 requires explanation.*
3	*Psychiatric Disorders of thought, cognition and/or mood, especially in the context of a mental status change:* *a. Rule out delirium;* *b. Basic neurological examination;*

	c. *Explain any abnormalities.*
4	*Alcohol Abuse, Dependency or Intoxication:* a. *A CIWA Score of 8 or lower is required. If CIWA score is higher than 8, utilize the CIWA protocol.* b. *BAL < 0.25 and clinically sober, as assessed by the clinical team at the bedside.*
5	*Pregnancy:* *Provider discussion of current physical status of mother and fetus. Locales with OB consultation availability will accept. High risk pregnancies evaluated on a case by case basis.*
6	*Diabetes Mellitus:* a. *Blood sugar less than 250, no additional work up unless other associated conditions or issues require other labs.* b. *Initial blood sugar above 250 mg/dl and below 60 mg/dl, blood sugar stabilized consistently below 250 mg/dl and above 60 mg/dl for a 2-hour period before approval and within one hour of transfer. Any requests outside this standard should be handled via doctor-to-doctor communication.* c. *Doctor-to-doctor communication is necessary for patients with insulin pumps or a similar medication delivery method.*
7	*MRSA in the absence of complex wound care, notification to accepting facility and doctor-to-doctor communication is necessary.*
8	*Mechanical assistance or wheelchair:* *Patients able to move or transfer independently with mechanical assistance or wheelchair will be accepted – follow ADA Guidelines.*

Appendix B

Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit (PEDS)

- **General Assumptions for Recommendations**
- **Standardized Exclusion Criteria for Pediatric Admission to State Hospitals and Crisis Stabilization Units**
- **Medical Assessment and Screening Guidelines for Pediatric Admissions**

General Assumptions

- The following guidelines are meant to supplement the Medical Screening & Medical Assessment Guidance Materials issued by the Department of Behavioral Health and Developmental Services (DBHDS) on April 1, 2014. This document does not supersede any Virginia or federal law.

- An individual who is actively violent may not be appropriate for admission to a Crisis Stabilization Unit.

- Doctor-to-doctor communication is requested to ensure continuity of care and is required to resolve disagreements in patient care.

- Doctor-to-doctor communication is required when there is a question about the medical stability of a patient.

- Whenever practical, individuals without acute exacerbation of co-morbid medical conditions can seek medical assessment through an emergency or non-emergency department setting. When these patients present on their own to the emergency department, appropriate examination and laboratory work will be offered. Wherever medical assessment occurs, these guidelines will apply. A more complex medical assessment may be clinically warranted for individuals with exacerbation of medical conditions or for whom there is concern that an underlying medical condition might be the cause of the behavioral, cognitive, or emotional presentation.

- Patients presenting with a primary medical need should be stabilized prior to referral for psychiatric treatment and considered for a medical temporary detention order (TDO) pursuant to Virginia Code §37.2-1104 (https://law.lis.virginia.gov/vacode/title37.2/chapter11/section37.2-1104/). Pursuant to Virginia Code §37.2-810 (https://law.lis.virginia.gov/vacode/title37.2/chapter8/section37.2-810), when a patient is transported by law-enforcement or alternative transporter to a medical facility for medical evaluation or treatment, such medical evaluation or treatment shall be conducted immediately in accordance with state and federal law.

- Patients who are determined to need an acute level of medical care will be admitted medically and emergency departments will request a medical temporary detention order when this is appropriate.

- All psychiatric providers will evaluate medically stabilized patients for admission and pursuant to Virginia Code subsection B 20 of §32.1-127 (https://law.lis.virginia.gov/vacode/title32.1/chapter5/section32.1-127.1:03/), each hospital shall establish protocols authorizing doctor-to-doctor communication when there is a refusal to admit a medically stable patient and develop protocols that require verbal communication between the on-call psychiatric physician and a clinical toxicologist or other person who is a Certified Specialist in Poison Information, if requested by the referring physician, when there is a question about the medical stability or appropriateness of an admission due to a toxicology screening.

- Those under the age of 18 are referred to facilities serving children & adolescents. The exception is emancipated minors which a court may declare in the following circumstances: (i) the minor has entered into a valid marriage, whether or not that marriage has been terminated by dissolution; or (ii) the minor is on active duty with any of the armed forces of the United States of America; or (iii) the minor willingly lives separate and apart from his or her parents or guardians, with the consent or acquiescence of the parents or guardians, and that the minor is or is capable of supporting himself or herself and competently managing his or her own financial affairs; or (iv) the minor desires to enter into a valid marriage and the requirements of Virginia Code § 16.1-331 (https://law.lis.virginia.gov/vacode/title16.1/chapter11/section16.1-331/) are met.

Doctor-to-Doctor Dispute Resolution Protocol

- Stage 1: When there is a disagreement between the referring physician and receiving physician about any requested laboratory work or evaluations, and/or admission, the physicians should attempt to resolve the matter amicably.

- Stage 2: If such resolution cannot be reached between the physicians, the referring physician may request that the dispute be escalated to the Medical Director (or designee) of the referring facility to initiate a discussion with the Medical Director (or designee) of the receiving facility for resolution.

- Stage 3: If the matter remains unresolved or the Medical Director is unavailable, the Medical Director (or designee) at the referring facility may request that the dispute be brought to the Chief Medical Officer (or equivalent) of the receiving facility for resolution. This discussion should be facilitated by either the referring facility's Medical Director (or designee) or the Chief Medical Officer (or equivalent).

  Note: When DBHDS state facilities are involved in a dispute, the chain of command should be followed with escalation after the CMO to the State Hospital Facility Director, and if not successful, escalation to the DBHDS Chief Clinical Officer and/or DBHDS Commissioner is appropriate.

Protocol Review and Monitoring Committee (PRMC)

- A Protocol Review and Monitoring Committee (PRMC) will be established to monitor providers' adherence to the medical assessment guidelines and ensure unified implementation. As needed, the PRMC will also review cases that were escalated to determine what steps can be taken to improve resolution earlier in the process and cases in which a significant medical condition was not identified or stabilized.

- The PRMC membership will consist of one representative from each of the following organizations; Department of Behavioral Health & Developmental Services, Psychiatric Society of Virginia, Virginia Association of Community Services Boards, Virginia College of Emergency Physicians, and Virginia Hospital & Healthcare Association. Each organization shall designate an alternate to attend meetings as necessary. Meetings will be held as necessary, but no fewer than twice a year. Members will serve for two years and may be reappointed for additional terms. In cases where specific facilities are being discussed, representatives from the facilities will be invited to attend the meeting.

- These guidelines are intended to provide consistency in evaluation of persons with mental illnesses and suspected comorbid medical conditions by emergency department physicians and for referrals to all psychiatric hospitals, inpatient psychiatric units and CSUs in Virginia. The ultimate decision for admission is that of the receiving physician.

EXCLUSION CRITERIA: Pediatric Admission to State Hospitals & Crisis Stabilization Units

	Criteria for Exclusion
1	Burns (severe) requiring acute care; if the burn could be cared for at home, it is not an exclusion.
2	Acute Delirium.
3	Acute Head Trauma/Traumatic Brain Injury in absence of a mental illness.
4	Unstable fractures, open or closed and joint dislocations, acute, until reduced.
5	Unstable seizure disorders.
6	Bowel obstruction, requiring active treatment or medical observation.
7	Acute Respiratory Distress.
8	Acute drug intoxication, withdrawal, or high-risk for complicated withdrawal, including history of delirium tremens.
9	Active GI bleed and/or active bleeding from other unknown sites.
10	Active TB; other infectious disease requiring isolation and/or treatment by IV antibiotics to be discussed by providers based on facility's ability to provide.
11	Intravenous fluids or IV antibiotics *State Hospitals & CSUs are not a safe environment for managing intravenous fluids or IV antibiotics.*
12	Draining wound, open, requiring daily complex wound care.
13	Vent and Trach patients excluded; other oxygen dependent patients based on facility's ability to provide care (e.g. BiPAP, CPAP at night, Oxygen Concentrator).
14	Tubes or drains, chest or abdominal, including ostomies (unless the individual provides their own ostomy care).
15	Hemodialysis patients excluded. Peritoneal dialysis patients based on facility's ability to safely manage patient.
16	Individuals requiring hospice or end of life care.
17	*For Crisis Stabilization Units only:* Durable medical equipment that is not able to be secured by CSU.

MEDICAL EVALUATION GUIDELINES: Admission to State Hospitals & Crisis Stabilization Units*

**Requests for further testing, without an agreement of medical necessity will require doctor-to-doctor communication.*

	Guideline for Evaluation
1	Pediatric patients presenting at the emergency department for medical assessment prior to admission to a psychiatric service or crisis stabilization unit will receive an appropriate medical screening exam including a focused problem history, neurologic, and physical exam, as well as: a. UDS > 12 y/o (note that this doesn't screen for all drugs of abuse) b. Urine pregnancy test for females of child bearing age Consider if first episode or acute change in mental status and for all pediatric patients with an eating disorder concern: c. Basic Chemistry Panel d. CBC Notes: • Patients taking medications and symptomatic for toxicity should have levels drawn and checked in the emergency department. This includes: Dilantin, Lithium, Depakote, and Tegretol. Patients with a possible overdose of Acetaminophen or Salicylate should have those levels checked. • Patients with other medical issues should have focused workup done such as a glucometer blood glucose level or BMP in the setting of known diabetes. • Patients who are anuric (e.g. dialysis dependent and unable to produce urine) will not have a drug screen performed. • Patients who have the capacity to make informed decisions and do not consent to collection of a urine or blood specimen will not be forced, including under an emergency custody order (ECO). The provider or screener in the emergency department should relay this information to the facility considering admission.
2	Vital Signs: a. Within normal limits for age group, may require doctor to doctor communication if concern is expressed.
3	Psychiatric Disorders of thought, cognition, or mood: a. Basic neurological examination; rule out delirium. b. Explain any abnormalities. c. Consider Head CT – for acute behavioral changes out of the context of an identified mental health disorder with focal neurological deficit.
4	Alcohol Abuse, Dependency or Intoxication: a. Evaluation cannot take place until patient mental status is cleared and BAC = 0.0. *
5	Pregnancy: Provider discussion of current physical status of mother and fetus. Locales with OB consultation availability will accept. High risk pregnancies evaluated on a case-by-case basis.

6	Diabetes Mellitus: a. Blood sugar stabilized consistently below 250 mg/dl for a 2-hour period before approval and within one hour of transfer. Any requests outside this standard should be handled via doctor-to-doctor communication. b. Doctor-to-doctor communication is necessary for determination on patients with insulin pumps.
7	MRSA in the absence of complex wound care, notification to accepting facility and doctor-to-doctor communication is necessary.
8	Mechanical assistance or wheelchair: Patients able to move or transfer independently with mechanical assistance or wheelchair will be accepted – follow ADA Guidelines.

** A review of the appropriateness of the minimum blood alcohol concentration (BAC) of 0.0 will be reexamined in May of 2019 by representatives from the Virginia College of Emergency Physicians, the Department of Behavioral Health and Developmental Services, and the Virginia Hospital & Healthcare Association. If practical experience proves that the minimum BAC level should be increased, the representatives will collaboratively determine an appropriate level.*