FY 22-23 Exhibit K

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Adult & Geriatric

Department of Behavioral Health and Developmental Services

This document is designed to provide consistent direction and coordination of activities required of state hospitals and community services boards (CSBs) in the development and implementation of discharge planning. The activities delineated in these protocols are based on or referenced in the Code of Virginia or the community services performance contract. In these protocols, the term CSB includes local government departments with a policy-advisory CSBs, established pursuant to § 37.2-100 of the Code of Virginia, and the behavioral health authority, established pursuant to § 37.2-601 et seq. of the Code of Virginia.

Shared Values:

Both CSBs and state hospitals recognize the importance of timely discharge planning and implementation of discharge plans to ensure the ongoing availability of state hospital beds for individuals presenting with acute psychiatric needs in the community. The recognition that discharge planning begins at admission is an important aspect of efficient discharge planning.

The Code of Virginia assigns the primary responsibility for discharge planning to CSBs; however, discharge planning is a collaborative process that must include state hospitals.

Joint participation in treatment planning and frequent communication between CSBs and state hospitals are the most advantageous method of developing comprehensive treatment goals and implementing successful discharge plans. The treatment team, in consultation with the CSB, shall ascertain, document, and address the preferences of the individual and their surrogate decision maker (if one has been designated) in the assessment and discharge planning process that will promote elements of recovery, resiliency, self-determination, empowerment, and community integration.

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General Requirements

Regional responsibility	Responsible entity	Timeframe
The CSB emergency services clinicians shall complete a tracking form documenting all private hospital contacts prior to seeking a bed of last resort at a state hospital, and transmit the form to the receiving state hospital, along with the preadmission screening form.	CSB emergency services	*Upon admission request to state hospital*
Each CSB shall provide the DBHDS Director of Community Integration (or designee) with the names of CSB personnel who are serving as the CSB's state hospital discharge liaisons. The DBHDS Office of Community Integration will update and distribute listings of all CSB discharge planning and state hospital social work contacts to CSB regional managers and state hospital social work directors, with the expectation that these will be distributed to individual CSBs and state hospital social workers.	CSBs DBHDS Office of Community Integration	*At least quarterly, or whenever changes occur* *At least quarterly*
Each region shall develop a process for developing, updating, and distributing a list of available CSB and regional housing resources funded by DBHDS for individuals being discharged from state hospitals. The resource listing should include willing private providers. Regions shall review and update the list and ensure that it is available to CSB state hospital liaisons, state hospital social work staff, and Central Office Community Transition Specialists to ensure that all resource options are explored for individuals in state hospitals.	CSB regions	*Updated at least quarterly*
In order to facilitate communication and timely problem solving, each region shall establish, regularly review, and update a regional bidirectional process, with time frames, and clearly defined steps for notification, discussion, and	CSB regions	*Updated as needed*

resolution of issues surrounding discharge planning for both adult and geriatric hospitals, to include CSBs, state hospitals, and Central Office levels. A copy of this process shall be submitted to each region's Community Transition Specialist.		

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Collaborative Responsibilities Following Admission to State Hospitals

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB emergency services clinician shall notify the CSB discharge planner of every admission to a state hospital	*Within 24 hours of the issuance of the TDO*		
CSB staff shall participate in discussions to determine whether the state hospital is the most appropriate treatment site	*Immediately upon admission and ongoing*	State hospital staff shall assess each individual to determine whether the state hospital is the most appropriate treatment site	*Immediately upon admission and ongoing*
CSB staff shall begin the discharge planning process for both civil and forensic admissions. If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director immediately upon notification of the admission (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). 1. For every admission to a state hospital from the CSB's catchment area that is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management/discharge planning responsibilities to the appropriate staff. 2. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, private providers, etc.) are engaged with state hospital social work staff.	*Upon admission*	State hospital staff shall contact the CSB to notify them of the new admission State hospital staff shall also provide a copy of the admissions information/face sheet to the CSB, as well as the name and phone number of the social worker assigned and the name of the admitting unit For individuals admitted with a primary developmental disability (DD) diagnosis, or a co-occurring mental health and DD diagnosis, the hospital social work director (or designee) shall communicate with the CSB discharge liaison to determine who the CSB has identified to take the lead in discharge planning (CSB liaison or DD staff). At a minimum, the CSB staff is who assigned lead discharge planning responsibilities shall participate in all treatment team meetings and discharge planning meetings; however, it is most advantageous if both staff can participate in treatment teams as much as possible.	*Within one business day* *Within one business day*

3. CSB staff shall establish a personal contact (preferably in person) with the hospitalized individual in order to initiate collaborative discharge planning.	*Within seven calendar days of admission*		
CSB staff will make arrangements to attend CTP and TPR meetings in person. If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conference. For NGRI patients with approval for unescorted community not overnight privileges and higher, the CSB NGRI Coordinator shall also make arrangements to attend any CTP and TPR meetings in person, or, if unable to attend in person, may request alternative accommodations. In the event that the arrangements above are not possible, the CSB shall make efforts to discuss the individual's progress towards discharge with the state hospital social worker within two business days of the CTP or TPR meeting. Note: While it may not be possible for the CSB to attend every treatment planning meeting,	*Ongoing* *Ongoing* *Within two business days of*	State hospital staff shall make every effort to inform the CSB by email of the date and time of CTP meetings. For NGRI patients with approval for unescorted community not overnight privileges and higher, state hospital staff will include the CSB NGRI Coordinator in these notifications. If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall make every effort to ensure that the CSB is made aware of this change The CTP meeting shall be held within seven calendar days of admission. Note: It is expected that the state hospital will make every effort to include CSBs in CTP and TPRs, including providing alternative accommodations (such as phone or video) and scheduling meetings so that liaisons can	*At least two business days prior to the scheduled meeting* *Within seven calendar days of admission*

participation in person or via phone or video conference is expected. This is the most effective method of developing comprehensive treatment goals and implementing efficient and successful discharge plans.	*the missed meeting*	participate in as many treatment team meetings as possible	

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Needs Assessment

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Discharge planning begins on the initial prescreening evaluation and continues throughout hospitalization. In completing the discharge plan, the CSB shall consult with the individual, members of the treatment team, the surrogate decision maker, and (with consent) family members or other parties, to determine the preferences of the individual upon discharge. The CSB shall obtain required releases of information. The discharge plan shall include: • The anticipated date of discharge from the state hospital • The identified services needed for successful community placement and the frequency of those services • The specific public and/or private providers that have agreed to provide these services	*At admission and ongoing thereafter* *As soon as possible upon admission*	The state hospital social worker shall complete the comprehensive social work assessment. This assessment shall provide information to help determine the individual's needs upon discharge. The treatment team shall document the individual's preferences in assessing their unique needs upon discharge.	*Prior to the CTP or within seven calendar days of admission* *Ongoing*
CSB shall assist with any required forms of identification, or obtaining required documents that an individual may already have.	*As needed*	The state hospital shall assess if any form of identification will be required for discharge planning purposes, what forms of identification the individual may already have available, and begin the process of obtaining identification if needed	*Within one week of admission*
If the individual's needs change or as more specific information about the discharge plan	*Ongoing*	As an individual's needs change, the hospital social worker shall document changes in their	*Ongoing*

becomes available, the CSB staff shall update the discharge plan accordingly		progress notes and through communications/meetings with the CSB.	

The CSB and the state hospital treatment team shall ascertain, document, and address the preferences of the individual and the surrogate decision maker as to the placement upon discharge. These preferences shall be addressed to the greatest degree possible in determining the optimal and appropriate discharge placement (please see attached memo regarding patient choice in state hospital discharges)	*Ongoing*

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Pre-Discharge Planning

Note: please see glossary for information regarding state and federal regulations concerning release of information for discharge planning purposes

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
For the following services, the CSB shall confirm the availability of serves, as well as the individual's appropriateness for services; or refer to a private provider for services • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region The CSB shall share the outcome of the assessment and the date when the services will be available with the hospital treatment team.	*Within 10 business days of receiving the referral* *Immediately upon completion of the assessment*	The state hospital treatment team shall review discharge needs on an ongoing basis. If referrals for the following services are needed for the individual, the hospital social worker shall refer the individual to the CSB responsible for discharge planning for assessment for eligibility • Case management • Psychosocial rehabilitation • Mental health skill building • Permanent supportive housing • PACT/ICT • Other residential services operated by the CSB or region	*Within two business days of the treatment team identifying the need for the services*
NGRI acquittees: The CSB Executive Director shall appoint an individual with the appropriate knowledge, skills, and abilities to serve as NGRI Coordinator for their agency (please see glossary for specific requirements)	*Ongoing. Changes in assigned NGRI Coordinator should be communicated*	**NGRI acquittees:** State hospital staff shall provide notice to the NGRI Coordinator of any meetings scheduled to review an acquittee's appropriateness for a privilege increase or release	*At least two business days prior to the scheduled meeting*

	to DBHDS Central Office Forensics staff	The state hospital shall provide notice to CSB staff, including the CSB NGRI Coordinator, of the need for a risk management plan (RMP), a Conditional Release Plan (CRP), or an Unconditional Release Plan (UCRP) once the determination has been made that a packet must be completed	
The CSB NGRI Coordinator or designee (with decision-making and signatory authority) shall attend in person or via telephone any meetings scheduled to discuss an acquittee's appropriateness for privilege level increases at the unescorted community not overnight privilege level or higher.	*Ongoing*		*Within one business day of the treatment team identifying the individual as being eligible for a privilege increase or release*
The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI		The state hospital shall complete the packet requesting an increase in privilege level or release	
The CSB NGRI Coordinator shall develop and transmit to the state hospital a fully developed conditional release plan (CRP) or unconditional release plan (UCRP) with all required signatures	*Within 10 business days of receiving notice from the state hospital*		*Within 10 business days of the treatment team identifying the individual as being eligible for a privilege increase*
Please note: For some NGRI patients, the RMP or CRP may involve more than one CSB. It is essential that the CSB responsible for the development of these plans communicates efficiently with other involved CSBs, and ensures that these plans are signed as soon as possible according to the time frames above.	*Within 10 business day of being notified that the individual has been recommended for release*		

Guardianship: Upon being notified of the need for a guardian, the CSB shall explore potential individuals/agencies to serve in that capacity. If the CSB cannot locate a suitable candidate who agrees to serve as guardian, they shall notify the state hospital to begin the process of referral for a DBHDS guardianship slot.	*Within two business days of notification* *Within 10 business days of notification of need for a guardian*	**Guardianship:** Evaluation for the need for a guardian shall start upon admission. Activities related to securing a guardian (if needed) start and continue regardless of a patient's discharge readiness level. The hospital social worker shall notify the CSB discharge planner that the treatment team has determined that the individual is in need of a guardian in order to be safely discharged. If notified by the CSB that a suitable candidate for guardianship cannot be located, the state hospital shall begin the process of referring the individual to DBHDS Central Office for a DBHDS guardianship slot. This referral shall include a comprehensive assessment of the individual's lack of capacity, and potential for regaining capacity. This assessment shall be shared with the CSB upon completion by the evaluating clinician.	*Within two business days of determination* *Immediately upon notification by the CSB of the need for a DBHDS guardianship slot*

Assisted Living (ALF) referrals: The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts to facilities regarding bed availability and willingness to consider the individual for placement. The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential placement, the CSB shall be follow up with providers regarding potential placements. It is expected that the CSB will continue to communicate with the provider about potential placement until a disposition decision is reached or the patient discharges to a different placement.	*As soon as an ALF is being considered, and prior to the individual being determined to be RFD* *Within one business day after the individual is rated as RFD* *Within five business days of sending the referral*	**Assisted Living referrals:** The state hospital shall complete the UAI. The state hospital shall transmit the UAI to the CSB The state hospital shall assist in the facilitation of interviews/assessments required by potential ALF providers	*Within five business days of the individual being found discharge ready level 2* *Immediately upon completion of the UAI* *As requested*

If it is determined that a secure Memory Care unit is recommended and that DAP will be required to fund this placement, the CSB shall completed the Memory Care Justification form, submit to the Community Transition Specialist for their hospital, and receive approval prior to referring to secure memory care units.	*Prior to referring to private pay Memory Care units*		
Nursing home (NH) referrals: The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts regarding bed availability and willingness to consider the individual for placement. The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential placement, the CSB shall follow up with providers regarding potential placements. It is expected that the CSB will continued to communicate with the provider about potential placement until a disposition decision is reached	*As soon as an NH is being considered, and prior to the individual being determined to be RFD* *Within one business day after the individual is rated as RFD*	**Nursing home referrals:** The state hospital shall complete the UAI For individuals who require PASRR screening, the state hospital shall send the referral packet to Ascend The results of the level 2 PASRR screening shall be transmitted to the CSB The state hospital shall assist in the facilitation of interviews/assessments required by potential nursing home providers	*Within five business days of the individual being found discharge ready level 2* *Within one business day of the individual being found clinically ready for discharge* *Immediately upon receipt of the screening results*

or the patient discharges to a different placement.	*Within five business days of sending the referral*		*As requested*
Shelter placements: Both the CSB responsible for discharge planning, and the CSB that serves the catchment area where the shelter is located shall follow the same procedures as outlined in the CSB transfers section for out of catchment placements.		**Shelter placements:** If discharge to a shelter is clinically recommended and the individual or their surrogate decision maker agrees with this placement, the hospital social worker shall document this recommendation in the medical record. The hospital social worker shall notify the director of social work when CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director (or their designee). Following this review, the medical director (or designee) shall document	

		endorsement of the plan for discharge to a shelter in the individual's medical record. In the case of out of catchment shelter placements, hospital staff shall notify both the CSB responsible for discharge planning, as well as the CSB that serves the catchment area of the shelter.	*Prior to discharge*
Individuals with a developmental disability (DD) diagnosis: The CSB shall determine and report to the hospital if the individual is currently receiving DD services, has a waiver, is on the waiver waiting list, or should be screened for waiver When indicated based on the information above, the VIDES shall be completed The CSB shall initiate a referral to REACH for any individual who is not already being followed by REACH If applicable, the CSB shall ensure that the individual has been added to the DD Waiver waitlist.	*Within two business days of admission* *Within ten business days of admission* *Within three calendar days of admission*	**Individuals with a developmental disability (DD) diagnosis:** Upon identification than an individual admitted to the state hospital has a DD diagnosis, the hospital social work director shall notify the CSB liaison/case manager and the CSB DD director (or designee). The state hospital shall notify the designated CSB lead for discharge planning of all relevant meetings, as well as the REACH hospital liaison (if REACH is involved) so attendance can be arranged. The state hospital shall assist the CSB in compiling all necessary documentation to implement the process for obtaining a DD waiver and/or bridge funding. This may	*Immediately upon notification of diagnosis* *Ongoing* *As needed. Required*

The CSB liaison and support coordinator shall participate in the development and updating of the discharge plan, including attending and participating in treatment team meetings, discharge planning meetings, and other related meetings. The CSB shall contact and send referrals to potential providers, and assist in coordinating assessments with these providers. The CSB shall assist in scheduling tours/visits with potential providers for the individual and/or the individual's surrogate decision maker. The CSB shall locate and secure needed specialists who will support the individual in the community at discharge. If required, the CSB shall facilitate the transfer of case management responsibilities to the receiving CSB according to the *Transferring Support Coordination/DD Waiver Slots* policy. The CSB shall request an emergency DD waiver slot if the individual is determined to be eligible for waiver, prior to requesting DAP funding. If it is anticipated that an individual with a DD diagnosis is going to require transitional	*Immediately upon notification of need* *At admission and ongoing* *At the time that an individual is rated a discharge ready level 2* *Ongoing* *Prior to discharge* *According to timelines set forth*	including conducting psychological testing and assessments as needed. The state hospital shall serve as a consultant to the DD case manager as needed. The state hospital shall assist with coordinating assessments with potential providers. The state hospital shall facilitate tours/visits with potential providers for the individual and/or the individual's surrogate decision maker. Note: When requested referrals or assessments are not completed in a timely manner, the state hospital director shall contact the CSB Executive Director to resolve delays in the referral and assessment process.	*psychological testing and assessment shall be completed within 21 calendar days of referral* *At the time that the individual is rated a discharge ready level 2* *Ongoing*

funding, the CSB shall completed an application for DD crisis funds.	*in the transfer procedure* *Immediately upon notification of need* *Immediately upon notification of need*		

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Readiness for Discharge

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Once the CSB has received notification of an individuals' readiness for discharge, they shall take immediate steps to implement the discharge plan	*Immediately upon notification*	The treatment team shall assess and rate the clinical readiness for discharge for all individuals The state hospital social worker shall notify the CSB through the use of email when the treatment team has made a change to an individual's discharge readiness rating. This includes when an individual is determined to be ready for discharge and no longer requires inpatient level of care. Or, for voluntary admissions, when consent has been withdrawn.	*A minimum of weekly* *Within one business day*
In response to the state hospital's weekly email including all patients who are RFD, the CSB shall "reply all" with discharge planning updates. Note: These email correspondences are not required to occur on weeks when CSBs and state hospitals collaboratively review patients who are ready for discharge. These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.	*Within two business days*	On weeks in which CSB and state hospital census/barriers meetings do not occur, the state hospital shall use encrypted email to provide notification to each CSB's liaison, the liaison's supervisor, the CSB behavioral health director or equivalent, the CSB executive director, the state hospital social work director, the state hospital director, the appropriate Regional Manager, and the Central Office Community Transition Specialist (and others as appropriate) of every individual who is ready for discharge, including the date that the individual was determined to be clinically ready for discharge.	*Weekly*

		Note: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.	

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Clinical Readiness for Discharge Rating Scale

1. **Clinically Ready for Discharge**
   - Has met treatment goals and no longer requires inpatient hospitalization
   - Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment
   - No longer requires inpatient hospitalization, but individual/family/surrogate decision maker is reluctant to participate in discharge planning
   - NGRI patients with approval to begin 48 hour passes*
   - NGRI patient for whom at least one forensic evaluator has recommended conditional or unconditional release and there is a pending court date*
   - NGRI on revocation status and treatment team and CSB recommend conditional or unconditional release and there is a pending court date*
   - Any civil patient for which the barrier to discharge is not clinical stability
   - Other forensic legal status (CST, restoration, etc.): clinically stable, evaluations completed and ready to be discharged back to jail*
2. **Almost Clinically Ready for Discharge**
   - Has made significant progress towards meetings treatment goals, but needs additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties
   - Can take community trial visits to assess readiness for discharge; may have the civil privilege level to go on temporary overnight visits
   - NGRI with unescorted community visits, not overnight privilege level
   - Other forensic legal status: significant clinical improvement, evaluations not yet completed
3. **Not Clinically Ready for Discharge**
   - Has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting
   - NGRI and does not have unescorted community visits privilege
   - Other forensic legal status: may present with symptoms, willing to engage in treatment, evaluations not yet completed
4. **Significant Clinical Instability Limiting Privileges and Engagement in Treatment**
   - Not nearing psychiatric stability
   - Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting
   - Presents significant risk and/or behavioral management issues that requires psychiatric hospitalization to treat
   - Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability

- Other forensic legal status: not psychiatrically stable or nearing psychiatric stability, evaluations not completed

**For any patient in which the legal system (e.g. court system, probation, etc.) is required to approve their discharge plan, their designation on the discharge ready list should be notated with a double asterisk(**)*

Note: Discharge planning begins at admission and is continuously active throughout hospitalization, independent of an individual's clinically readiness for discharge rating.

Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office

1. The CSB shall notify the state hospital social work director (or designee), in writing, of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge within three calendar days (72 hours) of receiving the discharge readiness notification.
2. The state hospital social work director (or designee) shall initiate a resolution effort to include a meeting with the state hospital and CSB staff at a higher level than the treatment team (including notification to the CSB executive director and state hospital director), as well as a representative from the Central Office Community Integration Team. This meeting shall occur within one business day of receipt of the CSB's written disagreement.
3. If the disagreement remains unresolved, the Central Office Community Integration Team will immediately give a recommendation regarding the patient's discharge readiness to the DBHDS Commissioner. The Commissioner shall provide written notice of their decision regarding discharge to the CSB executive director and state hospital director.
4. During the dispute process outlined above, the CSB shall formulate a discharge plan that can be implemented within three business days if the decision is in support of clinical readiness for discharge.
5. Should the Commissioner determine that the individual is clinically ready for discharge and the CSB has not developed a discharge plan to implement immediately, then the discharge plan shall be developed by the Department and the Commissioner may take action in accordance with Virginia Code § 37.2-505(A)(3).

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Finalizing Discharge

Joint Responsibility of the State Hospital, CSB, and DBHDS Central Office

At a minimum, twice per month the state hospital and CSB staff shall review individuals rated a 1 on the clinical readiness for discharge scale. Individuals rated a 2 on the clinical readiness for discharge scale shall be jointly reviewed at least once per month. To ensure that discharge planning is occurring at an efficient pace, the CSB shall provide updated discharge planning progress that shall be documented in these reviews. The regional utilization structures shall review at least monthly the placement status of those individuals who are on the EBL.

The Office of Community Integration shall monitor the progress of those individuals who are identified as being ready for discharge, with a specific focus on individuals who are on the EBL.

When a disagreement between the state hospital and the CSB occurs regarding the discharge plan for an individual, both parties shall attempt to revolve the disagreement and will include the individual and their surrogate decision maker, if appropriate. If these parties are unable to reach a resolution, the state hospital will notify their Central Office Community Transition Specialist within three business days to request assistance in resolving the dispute.

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge within seven (7) calendar days of the determination that the individual is clinically ready for discharge, the CSB shall document in the CSB medical record the reason(s) why the discharge cannot occur within seven (7) days of determination. The documentation shall describe the barriers to discharge (i.e. reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.	*Within seven (7) calendar days of determination that individual is clinically ready for discharge*		

The reduce readmissions to state hospitals, CSBs, in conjunction with the treatment team, shall develop and complete (when clinically indicated) a safety and support plan as part of the individual's discharge plan Note: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period. Exception: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan	*Prior to discharge*	The state hospital shall collaborate and provide assistance in the development of safety and support plans Note: Safety and support plans are generally not required for court-ordered evaluations, restoration to competency cases, and jail transfers; however, at the clinical discretion of the CSB and/or treatment team, the development of a safety and support plan may be advantageous when the individuals presents significant risk factors, and for those individuals who will be returning to the community following a brief incarceration period. Exception: Due to having a risk management plan as part of the conditional release plan, NGRI acquittees do not require a safety and support plan	*Prior to discharge*

CSB staff shall ensure that all arrangements for psychiatric services and medical follow up appointments are in place. CSB staff shall ensure the coordination of any other intra-agency services (e.g. employment, outpatient services, residential, etc.) and follow up on applications for entitlements and other resources submitted by the state hospital. The CSB case manager, primary therapist, or other designated clinical staff shall schedule an appointment to see individuals who have been discharged from a state hospital. The CSB case manager, discharge liaison, or other designated clinical staff shall ensure that an appointment with the CSB (or private) psychiatrist is scheduled when the individual is being discharged on psychiatric medications	*Prior to discharge* *Prior to and following discharge* *Within seven calendar days, or sooner if the individual's condition warrants* *Within seven days of discharge*		

Benefit applications: For any patient who is committed to a state facility (or CMA), and whose hospital stay is less than 30 days, the CSB shall initiate applications for Social Security benefits. The CSB shall contact the entity responsible for processing entitlement applications (SSA, DSS, etc.) to ensure that the benefits application has been received and that these entities have all required documentation. If benefits are not active with 30 days of the patient's discharge, the CSB shall again contact the entity responsible for processing the entitlement application in order to expedite benefit approval.	*As soon as a discharge date is finalized* *30 days post-discharge, and every 15 days thereafter until benefits are active*	**Benefit applications:** State hospital staff shall initiate applications for Medicare, Medicaid, Social Security benefits, Auxiliary Grant, and other financial entitlements as necessary. Applications shall be initiated in a timely manner per federal and state regulations **Note: For patients whose hospital stay is less than 30 days, the CSB will be responsible for Social Security applications* To facilitate follow-up, if benefits are not active at the time of discharge, the state hospital shall notify the CSB of the type of entitlement application, as well as the date it was submitted, and include a copy of entitlement applications with the discharge documentation that is provided to the CSB	*Prior to discharge and per federal and state regulations*
Discharge Transportation: The CSB shall ensure that discharge transportation is arranged for individuals discharging from state hospitals. Note: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	*Prior to scheduled discharge date*	Note: When transportation is the only remaining barrier to discharge, the state hospital and CSB will implement a resolution process for resolving transportation issues when these are anticipated to result in discharges being delayed by 24 hours or more.	

		Discharge Instructions: The treatment team shall complete the discharge information and instructions form (DIIF). State hospital staff shall review the DIIF with the individual and/or their surrogate decision maker and request their signature. Distribution of the DIIF shall be provided to all next level of care providers, including the CSB. The state hospital medical director shall be responsible for ensuring that the physician's discharge summary is provided to the CSB responsible for discharge planning (and prison or jails, when appropriate)	*Prior to discharge* *No later than one calendar day post-discharge* *As soon as possible post-discharge*

Transfers between CSBs

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Transfers shall occur when an individual is being discharged to a different CSB catchment area than the CSB responsible for discharge planning. If a determination is made that an individual will be relocating post-discharge, the CSB responsible for discharge planning shall immediately notify the CSB affected. The CSB shall complete and forward a copy of the Out of Catchment Notification/Referral form to the receiving CSB. Note: Coordination of the possible transfer shall, when possible, allow for discussion of resource availability and resource allocation between the two CSBs prior to the transfer. Exception to above may occur when the CSB, individual served, and/or their surrogate decision maker wish to keep services at the original CSB, while living in a different CSB catchment area. For NGRI patients, CSB NGRI coordinators will consult regarding any possible transfers between CSBs. Transfers of NGRI patients shall be accepted by the receiving CSB unless the necessary services in the release plan are	*Prior to discharge* *Prior to discharge*	The state hospital social worker shall indicate in the medical record any possibility of a transfer out of the original CSB catchment area.	*Ongoing*

permanently unavailable, resulting in increased risk to the community or to the NGRI acquittee. For individuals who are enrolled in CSB DD services, please follow the *Transferring Support Coordination/DD Waiver Slots* policy.			
At a minimum, the CSB responsible for discharge and the CSB that serves the discharge catchment area shall collaborate prior to the actual discharge date. The CSB responsible for discharge planning is responsible for completing the discharge plan, conditional release plan, and safety and support plan (if indicated), and for the scheduling of follow up appointments. While not responsible for the development of the discharge plan and the safety and support plan, the CSB that serves the catchment area where the patient will be discharged should be actively involved in the development of these plans. The arrangements for and logistics of this involvement are to be documented in the	*Prior to discharge*		

discharge plan and the individual's medical record. The CSB responsible for discharge planning shall provide the CSB that serves the catchment area where the patient will be discharging with copies of all relevant documentation related to the treatment of the individual.	*Prior to discharge*		
If the two CSBs cannot agree on the transfer, they shall seek resolution from the Director of Community Integration (or designee). The CSB responsible for discharge planning shall initiate this contact	*Within three calendar days of notification of intent to transfer*		

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Adult & Geriatric

Glossary

Acute admissions or acute care services: Services that provide intensive short-term psychiatric treatment in state mental health hospitals.

Case management CSB/CSB responsible for discharge planning: The public body established pursuant to § 37.2-501 of the *Code of Virginia* that provides mental health, developmental, and substance abuse services within each city and county that established it and in which an adult resides or in which surrogate decision maker resides. The case management CSB is responsible for case management and liaising with the hospital when an individual is admitted to a state hospital, and for discharge planning. If the individual or surrogate decision maker chooses for the individual to reside in a different locality after discharge from the state hospital, the CSB serving that locality becomes the receiving CSB and works with the CSB responsible for discharge planning/referring CSB, the individual, and the state hospital to effect a smooth transition and discharge. The CSB responsible for discharge planning is ultimately responsible for the completion of the discharge plan. Reference in these protocols to CSB means CSB responsible for discharge planning, unless the context clearly indicates otherwise.

Case management/ CSB responsible for discharge planning designations may vary from the definition above under the following circumstances:

- When the individual's living situation is unknown or cannot be determined, or the individual lives outside of Virginia, the CSB responsible for discharge planning is the CSB which completed the pre-screening admission form.
- For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the CSB responsible for discharge planning.
- When a CSB other than the pre-screening CSB is continuing to provide services and supports to the individual, then the CSB responsible for discharge planning is the CSB providing those services and supports.
- For individuals in correctional facilities, in local hospitals, or Veteran's Administration facilities, or in regional treatment/detox programs, the CSB responsible for discharge planning is the CSB serving the catchment area in which the individual resided prior to incarceration, or admission to local hospitals, Veterans Administration facilities, or regional detox programs
- In instances in which there is a dispute related to which CSB is responsible for discharge planning, the state hospital will work collaboratively with the CSBs involved to determine which CSB is responsible within two business days. If resolution cannot be reached, the state hospital will contact their Community Transition Specialist who will make a determination based on the available information.

Comprehensive treatment planning meeting: The meeting, which follows the initial treatment meeting and occurs within seven days of admission to a state hospital. At this meeting, the individual's comprehensive treatment plan (CTP) is developed by the treatment team in consultation with the individual, the surrogate decision maker, the CSB and, with the individual's consent, family members and private providers. The purpose of the meeting is to guide, direct, and support all treatment aspects for the individual.

Co-occurring disorders: Individuals are diagnosed with more than one, and often several, of the following disorders: mental health disorders, developmental disability, or substance use disorders. Individuals may have more than one substance use disorder and more than one mental health disorder. At an individual level, co-occurring disorders exist when at least one disorder of each type (for example: a mental health and substance use disorder or developmental disability and mental health disorder) can be identified independently of the other and are not simply a cluster of symptoms resulting from a single disorder.

Discharge plan or pre-discharge plan: Hereafter referred to as the discharge plan, means an individualized plan for post-hospital services that is developed by the case management CSB in accordance with § 37.2-505 and § 16.1-346.1 of the Code of Virginia in consultation with the individual, surrogate decision maker, and the state hospital treatment team. This plan must include the mental health, developmental, substance abuse, social, educational, medical, employment, housing, legal, advocacy, transportation, and other services and supports needed by the individual, consistent with subdivision A.3 of § 37.2-505, following an episode of hospitalization and must identify the public or private providers that have agreed to provide these services and supports. The discharge plan is required by § 37.2-505, § 16.1-346.1, and § 37.2-508 of the Code of Virginia.

Level 2 PASRR Screening: Federal law requires that all individuals (regardless of payer source) who apply as a new admission to a Medicaid-certified nursing facility (NF) be evaluated for evidence of possible mental illness or intellectual disability. This evaluation and determination is conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible, and that individuals receive needed services, wherever they are living. The process involves two steps, known as Level 1(UAI) and Level 2 screening. The use of a Level 1 and Level 2 screening and evaluation is known as the Preadmission Screening and Resident Review (PASRR) process. In Virginia, level 2 PASRR screenings are conducted by Ascend. Individuals with a sole or primary diagnosis of dementia are exempt from Level 2 screenings.

NGRI Coordinator (CSB): Required knowledge:

- Understanding of the basic criminal justice process and the Virginia Code related to insanity acquittees
- Understanding of risk assessment and risk management in the community as well as the knowledge of what community resources are needed for risk management
- Ability to work with an interdisciplinary team
- Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
- Knowledge of person-centered planning practices that emphasizes recovery principals.

Responsibilities:

1. Serving as the central point of accountability for CSB-assigned acquittees in DBHDS state hospitals
   a. Ensuring adequate and prompt communication with state hospital staff, Central Office staff, and their own agency staff related to NGRI patients
   b. Working with state hospital staff to resolve any barriers to treatment or release planning for NGRI patients

   c. Participating in all meetings where their presence is necessary in order to make decisions related to NGRI privilege increases or release
   d. Jointly preparing Risk Management Plans, Conditional Release Plans, or Unconditional Release Plans; Promptly responding to requests for modifications, reconciling differences, and returning signed documents to prevent delays to NGRI patient progress towards discharge
2. Serving as the central point for accountability and overseeing compliance of the CSB and the NGRI acquittee when court ordered for Conditional Release:
   a. Oversee compliance of the CSB with the acquittee's court-ordered Conditional Release Plan (CRP).
   b. Monitor the provision of CSB and non-CSB services in the CRP through agreed-upon means, including written reports, observation of services, satisfaction of the acquittee, etc.
   c. Assess risk on a continuous basis and make recommendations to the court
   d. Be the primary point of contact for judges, attorneys, and DBHDS staff.
   e. Coordinate the provision of reports to the courts & DBHDS in a timely fashion
   f. Assure that reports are written professionally and address the general and special conditions of the CRP with appropriate recommendations
   g. Prepare correspondence to the courts and DBHDS regarding acquittee non-compliance to include appropriate recommendations for the court to consider
   h. Provide adequate communication and coordinate the re-admission of NGRI acquittees to the state hospital when necessary
   i. Represent the CSB in court hearings regarding insanity acquittees
3. Maintain training and expertise needed for this role.
   a. Agree to participate in any and all DBHDS-developed training developed specifically for this role
   b. Agree to seek out consultation with DBHDS as needed
   c. Train other CSB staff and other provider staff (as appropriate) regarding the responsibilities of working with insanity acquittees, including the monthly and 6 month court reports

Primary substance use disorder: An individual who is clinically assessed as having one or more substance use disorder per the current Diagnostic and Statistical Manual of Mental Disorders (DSM) with the substance use disorder being the "principle diagnosis" (i.e. the condition established after evaluation to be chiefly responsible for the admission). The individual may not have a mental health disorder per the current DSM or the mental health disorder is not the principle diagnosis.

Releases of Information: The practice of authorizing a healthcare entity to release protected health information to other healthcare providers, non-healthcare organizations, or individuals. Obtained a signed release of information is best practice and should occur if at all possible; however, collaboration and information sharing for the purposes of discharge planning does not require a release of information, with the exception of SUD information protected by 42 CFR Part 2. While releases of information are best practice, they should not be a barrier to discharge. These activities are explained in the Code of Virginia § 37.2-839. Additionally please see HIPAA requirements on Treatment, Payment, & Health Care Operations. Lastly this provision is covered in the Human Right Regulations 12VAC35-115-80- B.8.g.

State hospital: A hospital or psychiatric institute, or other institution operated by DBHDS that provides acute psychiatric care and treatment for persons with mental illness

Surrogate decision maker: A person permitted by law or regulations to authorize the disclosure of information or give consent for treatment and services, including medical treatment, or participation in human research, on behalf of an individual who lacks the mental capacity to make these decisions. A surrogate decision maker may include an attorney-in-fact, health care agent, legal guardian, or, if these are not available, the individual's family member (spouse, adult child, parent, adult brother or sister, or any other relative of the individual) or a next friend of the individual (defined in 12VAC35-115-146).

Treatment team: The group of individuals responsible for the care and treatment of the individual during the period of hospitalization. Team members shall include, at a minimum, the individual receiving services, psychiatrist, a psychologist, a social worker, and a nurse. CSB staff shall actively participate, collaborate, and consult with the treatment team during the individual's period of hospitalization. The treatment team is responsible for providing all necessary and appropriate supports to assist the CSB in completing and implementing the individual's discharge plan.

Treatment plan: A written plan that identifies the individual's treatment, educational/vocational and service needs, and states the goals, objectives, and interventions designed to address those needs. There are two sequential levels of treatment plans:

1. The "initial treatment plan," which directs the course of care during the first hours and days after admission; and
2. The "comprehensive treatment plan (CTP)," developed by the treatment team with CSB consultation, which guides, directs, and supports all treatment of the individual.

Treatment plan review (TPR): Treatment planning meetings or conferences held subsequent to the CTP meeting.

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Adult & Geriatric

CSB State Hospital Discharge Planning Performance Measures

1. **Eligible patients will be seen by CSB staff (outpatient therapist, case manager, psychiatrist, etc.) within seven calendar days of discharge from a state hospital (assessments by emergency services are not considered follow-up appointments). 80% of eligible patients will be seen by a CSB clinical staff member within seven calendar days of the discharge date.**
2. **CSBs will have a state hospital 30 day readmission rate of 7% or below**
3. **Patients followed by CSBs will have an average length of stay on the extraordinary barriers list (EBL) of 60 days or less. *Please note this measure will exclude NGRI patients.**
4. **CSBs that serve a population of 100,000 or more will have an average daily census of ten (10) beds or less per 100,000 adult and geriatric population. DBHDS shall calculate the CSBs' average daily census per 100,000 for the adult and geriatric population for patients with the following legal statuses: civil temporary detention order, civil commitment, court mandated voluntary, voluntary, and NGRI patients with 48 hours unescorted community visit privileges.**

All data performance measure outcomes will be distributed to CSBs by DBHDS on a monthly basis.