AMENDMENT 3

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FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT

MASTER AGREEMENT ~~FY 24-25~~

EXHIBIT K
Collaborative Discharge Requirements for
Community Services Boards and State Hospitals
~~Adult & Geriatric~~
Contract No. P1636.CSBCode.3

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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 operating ~~operating~~ CBSs, administrative policy CBSs, 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 or in local or regional jails. ~~-~~ 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. CSBs and state hospitals are responsible for training new hires in the Collaborative Discharge Protocols.

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.

DBHDS state psychiatric facilities operate as acute care psychiatric settings. The intent is for the individual to receive timely care for stabilization and discharge back into the community (including jail). DBHDS facilities are not long-term care settings. There should be careful attention paid to timely and appropriate discharge planning while assuring the individuals rights to treatment and services in least restrictive settings is maintained.

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Protocols for Children and Commonwealth Center for Children and Adolescents

~~DEFINITIONS:~~

~~Acute admissions or acute care services: Services that provide intensive short-term psychiatric treatment in the child and adolescent state mental health hospitals, for a period of less than 7 days after admission.~~

~~Case management CSB: 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 in which a minor's parent or legal guardian resides. The case management CSB is responsible for case management, liaising with the hospital when a minor is admitted to a state hospital, and discharge planning. If the minor, the parents of a minor receiving service, or legal guardian chooses 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 case management CSB, the parent/legal guardian, and the state hospital to effect a smooth transition and discharge. The case management CSB is ultimately responsible for the completion of the discharge plan. Reference to CSB in these protocols means case management CSB, unless the context clearly indicates otherwise.~~

~~Collaborative Treatment Planning: The planning process that is an integral part of daily morning meetings and begins upon admission. The minor's plan is developed by the treatment team which consists of the minor, the parent or legal guardian, treatment providers and, the CSB and involves therapeutic discussion with each to solicit participation in the process. The purpose is to guide, direct, and support all treatment aspects for the minor.~~

~~Co-occurring disorders: The simultaneous occurrence of: mental health disorders, intellectual or developmental disability (ID/DD/ASD), or substance use disorders. Minors 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 from more than one of these categories (e.g., mental health and substance use disorder, intellectual 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 § 16.1-346.1 of the Code of Virginia in consultation with the minor, parent/legal guardian and the state hospital treatment team. This plan must include mental health, developmental, substance abuse, social, educational, medical, employment,~~

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~~housing, legal, advocacy, transportation, and other services and supports needed by the minor, 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 § 16.1-346.1, of the Code of Virginia. A completed or finalized discharge plan means the documents on which all of the services to be received upon discharge are shown, the providers that have agreed to provide those services are identified, the frequency of those services is noted, and a specific date of discharge is entered.~~

~~Extended treatment: Refers to length of stay for a period of 7 days or more after admission that offers intermediate or extended treatment in a state hospital for minors with severe psychiatric impairments, emotional disturbances, or multiple service needs.~~

~~EBL meeting: Refers to the twice monthly meetings for children and adolescents on the Extraordinary Barriers List at CCCA. Meetings are held every second and forth week on Tuesdays, Wednesdays, and Thursdays, and include the CCCA treatment team, community providers, case managing CSB, parent/guardian, DBHDS Community Transition Specialist, and other DBHDS staff and community partners as needed. These meetings focus on discharge planning, addressing the significant barriers identified by participants.~~

~~Involuntary admission: An admission of a minor that is ordered by a court through a civil procedure pursuant to § 16.1-346.1 §16.1-340 § 16.1-345 of the *Code of Virginia*.~~

~~Minor: An individual who is under the age of 18 years. Any minor must have a legal guardian unless emancipated by a legal process. A minor who is 14 years of age or over must give consent for admission and treatment or a parent/legal guardian may consent to a voluntary objecting minor.~~

~~Parent/legal guardian: (i) A biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint decree or agreement, (ii) a biological or adoptive parent with whom the minor regularly resides, (iii) a person judicially appointed as a legal guardian of the minor or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. The director of the local department of social services or his designee may stand as the minor's parent when the minor is in the legal custody of the local department of social services.~~

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~~Primary substance use disorder: A minor who is clinically assessed as having one or more substance use disorders per the current 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.~~

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

~~Statewide Census Management Meeting: A bi-monthly meeting with the child and adolescent state hospital representatives and CSB/BHA case managers and Child and Family Directors (or designee) to discuss plans extraordinary barriers to discharge when a minor is determined by the state hospital treatment team to be clinically ready.~~

~~Treatment plan: A written plan that identifies the minor's treatment, educational, 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, in collaboration with the minor and family/legal guardian, directs the course of care during the first hours and days after admission; and~~
~~2. The "individualized treatment plan," developed by the treatment team and minor will be shared with the CSB and family within 5 days; the plan guides, directs, and supports all treatment of the individual and informs the discharge plan.~~
~~3. The "treatment plan update", meetings or conferences held, as needed, for cases with extenuating barriers. Participants may include the treatment team, CSB, DSS, legal guardian and/or other relevant community members.~~

~~Treatment team: Typically comprised of the inpatient psychiatrist, clinical social worker and psychologist in addition to the minor, family/legal guardian.~~

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~~***Add information required/requested upon admission?**~~

I. Collaborative Responsibilities Following Admission to State Hospital

	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.1	State hospitals staff shall assess each minor upon admission and periodically thereafter to determine whether the state hospital is an appropriate treatment site. Inappropriate admissions including minors with a primary diagnosis of substance abuse disorder will be reported to the CSB. ~~within one business day.~~	*Within ~~In~~ one (1) business day of admission*	As active participants in the discharge process and consultants to the treatment process, CSB staff shall participate in discussions to determine whether the state hospital is an appropriate treatment facility.	

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1.2	State hospital staff shall contact the case management CSB ~~within one (1) business day of admission~~ to notify the CSB of the new admission. State hospital staff shall also provide a copy of the admissions information/face sheet, including the name and phone number of the social worker assigned and the name of the admitting unit, to the CSB ~~within one (1) business day of admission~~. If the information has references to substance use disorder, a release of information must be signed by the minor and/or legal guardian or the information related to substance use and treatment must be redacted. For minors who are discharged prior to the development of the individualized treatment plan; the treatment team is responsible for completing the Discharge Instructions in consultation with the CSB.	*W~~w~~ithin one (1) business day of admission* *W~~w~~ithin one (1) business day of admission*	Upon notification of admission, CSB staff shall begin the discharge planning process for both civil and forensic admissions. If the CSB disputes case management responsibility for the minor, the CSB shall notify the state hospital social worker ~~immediately~~ upon notification of admission. 1. For minors who are discharged prior to the development of the individualized treatment plan, CSB responsibilities post discharge will be reflected in the discharge instructions. 2. For every admission to a state hospital from the CSB's service area that is not currently an open case at that	*Immediately upon notice of admission~~immediately~~*

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			CSB, the CSB shall develop an open case and assign case management responsibilities to the appropriate staff 3. CSB staff shall establish a personal contact (face-to-face, telephone, etc.) with the assigned social worker at least once for an acute hospitalization, at least weekly for minors receiving extended treatment, and within 2 days prior to the minor's discharge.	
1.3	Upon identification that the minor admitted to the state hospital has a co-occurring diagnosis of ID/DD/~~ASD,~~ the hospital social worker will notify the designated CSB lead for discharge coordination and will:		If the minor has an ID/DD/ ~~ASD~~ and co-occurring SMI, the CSB MH and ID Directors (or their designees) will identify and inform the state hospital social worker whether the ID or MH	

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	1. Assist the case managers to compile the necessary documentation to implement the process for waiver and/or out of home placement. 2. Serve as a consultant to the ID/DD case manager as needed; 3. Assist with coordinating on-site assessments by representatives from potential placement options.		case manager will take the lead in discharge planning and work collaboratively with the CSB mental health discharge liaison on eligibility-planning activities and state hospital discharge procedures. CSB ID/DD responsibilities include the following: 1. ~~1.~~ Assessment of the minor for Medicaid Waiver eligibility; 2. If applicable, initiate the process for Medicaid Waiver-/ Money Follows the Person funding for ~~t~~ the minor receiving services; 3. ~~-~~Initiating the referral to Child REACH;	

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			4. -Participation in the development and updating 5. of the discharge plan; 6. Participation in treatment team meetings, discharge planning meetings and other related meetings; 7. Assist in coordinating assessments; 8. Assistance in locating and securing needed specialists who will support minor in the community once they have been discharged, i.e., doctors, behavioral support; 9. Providing support during the transition to community services; 10. Facilitation of the transfer of case management responsibilities to the receiving CSB or private provider according to the *Support Coordination/Case Management Transfer*	

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			Procedures for Persons with Intellectual Disability.	
1.4	State hospital staff shall make every effort to contact the CSB Case Manager and legal guardian ~~within one (1) business day of admission~~ to discuss goals for treatment that will result in a timely discharge.	*W~~w~~ithin one (1) business day of admission*	It is the joint responsibility of the hospital social worker and CSB staff to contact each other ~~within one (1) business day of~~upon admission to discuss case specifics.	*W~~w~~ithin one (1) business day*

II. Needs Assessments & Discharge Planning

Joint Responsibility of the State Hospital & CSB

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2.1	The treatment team and CSB shall ascertain, document and address the preferences of the minor and his/her legal guardian in the individualized assessment and discharge planning process that will promote elements of recovery, self-determination, empowerment, and community integration.			
	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
2.2	The state hospital social worker shall complete the social work comprehensive assessment or readmission assessment update ~~within seven (7) calendar days of admission~~ for each minor. This assessment shall provide information to help determine the minor's needs upon discharge.	*W~~w~~ithin seven (7) calendar days of admission*	Discharge planning begins on the Initial Pre-Screening form and continues on the CSB/BHA discharge plan document. In completing the discharge plan, the CSB shall consult with members of the treatment team, the minor, his parent/legal guardian, and, with appropriate consent, other parties in determining the needs/preferences of the minor upon discharge. The Discharge Plan shall be developed in accordance with the *Code of Virginia* and the community services performance contract and shall:	

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			1. include the anticipated date of discharge from the state facility; ~~1.~~2. identify the services needed for successful discharge, to include outpatient, educational, residential or community placement and the frequency of those services; and 3. specify the public or private providers that have agreed to provide these services.	
2.3			The CSB shall initiate development of the discharge plan ~~immediately upon admission~~. The discharge plan shall address the discharge needs identified in the comprehensive assessment in addition to other pertinent information within the clinical record. For minors whose primary legal residence is out of state, the pre-	~~*immediately upon admission*~~*Immediately upon notice of admission*

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			screening CSB shall retain discharge planning responsibility. *Note:* According to § 16.1-346.1 of the Code of Virginia the CSB retains ultimate responsibility for a timely and appropriate discharge plan for all minors discharging from a state hospital, therefore oversight and responsibility for said plan of minors in the custody of the Department for Social Services remains with the CSB.	
2.4	As a minor's needs change, the state hospital social worker shall document changes in the state hospital social worker's progress notes and update the CSB Case Manager.		If the minor's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly.	
Joint Responsibility of the State Hospital & CSB				

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2.5	The treatment team in collaboration with the CSB shall ascertain, document, and address the preferences of the minor and parent or legal guardian as to the placement upon discharge. These preferences shall, to the greatest degree practicable, be considered in determining the optimal and appropriate discharge placement. *NOTE:* This may not be applicable for certain forensic admissions due to their legal status.

III. Readiness for Discharge

	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
3.1	The CSB shall be notified ~~within one (1) business day~~ when the treatment team determines that the minor is clinically ready for discharge and/or state hospital level of care is no longer required or, for voluntary admissions, when consent has been withdrawn or *any of the following:* • The minor is unlikely to benefit from further acute inpatient psychiatric treatment; or	~~*Within one (1) business day*~~	Once the CSB has received notification of readiness for discharge, steps shall be taken to implement the discharge plan. The minor should be discharged from the state hospital when deemed clinically ready for discharge.	*Immediately upon notice of admission*

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	• The minor has stabilized to the extent that inpatient psychiatric treatment in a state hospital is no longer the least restrictive treatment intervention. •			
3.2	The hospital will conduct regularly scheduled reviews of all minors who are rated clinically ready for discharge or nearly ready (Rating of 1 or 2). These meetings will ~~occur at least twice a month and will~~ involve the participation of the hospital social worker(s).	*A~~a~~t least twice a month*	The CSB liaison (or their designee) assigned to any minor who is rated 1 or 2 on the Discharge Readiness scale will participate in all discharge review meetings and provide information related to discharge planning and any anticipated or experienced barriers to discharge.	

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~~3.3~~

~~DISCHARGE READINESS RATING SCALE~~

~~Rating Code~~	~~Description~~
~~1~~	~~Has met treatment goals and no longer requires inpatient psychiatric hospitalization~~ ~~Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment~~ ~~No longer requires inpatient hospitalization even if there are barriers preventing discharge such as lack of placement~~
~~2~~	~~Has made significant progress towards meetings treatment goals, but requires additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties~~

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			~~Receiving medication changes that must be monitored in an inpatient setting~~ ~~Exhibiting significant clinical improvement, but court ordered "ten-day" evaluation is not completed~~
		~~3~~	~~Displays symptoms typical of child psychiatric hospitalizations such as suicidality, aggression, depression or anxiety but has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting~~ ~~Displays symptoms atypical of child psychiatric hospitalizations (such as psychosis, etc.), is making progress towards treatment goals, but still requires further stabilization in an acute psychiatric inpatient setting~~
		~~4~~	~~Recent admission still requiring assessment~~

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			~~· Displays symptoms atypical of child psychiatric hospitalizations such as psychosis, delusional and disorganized thoughts or paranoia~~ ~~· No progress toward psychiatric stability since admission~~ ~~· Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting~~ ~~· Presents significant risk and/or behavioral management due to psychiatric diagnosis that requires psychiatric hospitalization to treat~~ ~~· Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability~~ ~~•~~
	~~NOTE:~~ ~~Discharge planning begins on admission and is continuously active throughout hospitalization independent of the clinical readiness for discharge rating~~		

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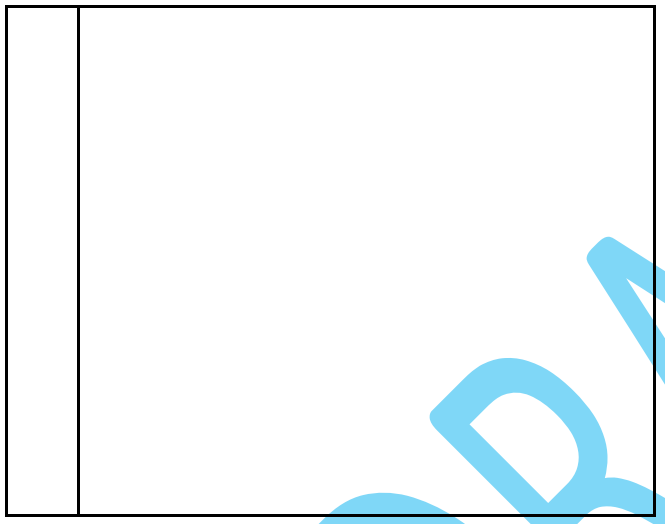

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IV. Discharge Readiness Scale – Child and Adolescent

Rating Code	Description
1	1. Has met treatment goals and no longer requires inpatient psychiatric hospitalization 2. Is exhibiting baseline behavior that is not anticipated to improve with continued inpatient treatment 3. No longer requires inpatient hospitalization even if there are barriers preventing discharge such as lack of placement
2	1. Has made significant progress towards meetings treatment goals, but requires additional inpatient care to fully address clinical issues and/or there is a concern about adjustment difficulties 2. Receiving medication changes that must be monitored in an inpatient setting 3. Exhibiting significant clinical improvement, but court ordered "ten-day" evaluation is not completed
3	1. Displays symptoms typical of child psychiatric hospitalizations such as suicidality, aggression, depression or anxiety but has not made significant progress towards treatment goals and requires treatment and further stabilization in an acute psychiatric inpatient setting 2. Displays symptoms atypical of child psychiatric hospitalizations (such as psychosis, etc.), is making progress towards treatment goals, but still requires further stabilization in an acute psychiatric inpatient setting

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4	1. Recent admission still requiring assessment 2. Displays symptoms atypical of child psychiatric hospitalizations such as psychosis, delusional and disorganized thoughts or paranoia 3. No progress toward psychiatric stability since admission 4. Requires constant 24 hour a day supervision in an acute inpatient psychiatric setting ~~5. Presents significant risk and/or behavioral management due to psychiatric diagnosis that requires psychiatric hospitalization to treat~~ Unable to actively engage in treatment and discharge planning, due to psychiatric or behavioral instability 3.

NOTE:
Discharge planning begins on admission and is continuously active throughout hospitalization independent of the clinical readiness for discharge rating.

V. Finalizing Discharge

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

~~**Add in information about review of individuals meeting clinical readiness for discharge**~~

~~The Office of Community Integration shall monitor [community transition specialist role here]~~

~~W~~When a disagreement between the state hospital and the CSB occurs regarding the discharge plan for an individual, both parties shall attempt to resolve the disagreement and will include parent/legal guardian as appropriate. If these parties are unable to reach a ~~resolution,there~~resolution, the state hospital will notify their Community Transition Specialist within three business days to request assistance in resolving the dispute. Please see appendix 4 for the Dispute Process.

~~CSB responsibilities~~State Hospital Responsibilities	Timeframe	~~State hospital responsibilities~~CSB responsibilities	Timeframe

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The state psychiatric hospital will make every attempt to include all relevant parties in notification up to and including DSS, JDC and family~~In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge within three (3) business days/five (5) calendar days of the determination that the youth is clinically ready for discharge, the CSB shall document in the CSB medical record the reason(s) why the discharge cannot occur within three (3) business days/five (5) calendar days of determination. The documentation shall describe the barriers to discharge - reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.~~	~~*Within three (3) business days/five (5) calendar days of determination that individual is clinically ready for discharge*~~	In the event that the CSB experiences extraordinary barriers to discharge and is unable to complete the discharge the determination that the youth is clinically ready for discharge, the CSB shall document in the CSB medical record the reason(s) why the discharge cannot occur The documentation shall describe the barriers to discharge - reason for placement on the Extraordinary Barriers List (EBL) and the specific steps being taken by the CSB to address these barriers.	*Within three (3) business days or~~/~~ five (5) calendar days of determination that individual is clinically ready for discharge*
~~***Additional information on DSS and JDC involvement here?** ADD language to include collaboration/communication between DBHDS and private hospitals in discharge planning when there are barriers to discharge for private hospital DBHDS bed buys?*~~*There is expectation of collaboration of all relevant parties. CSBs maintain discharge responsibility and therefore should include DSS or JDC as required in any cases.* *Note: Discharge planning begins at admission and is continuously active throughout hospitalization, independent of an individual's clinical readiness for discharge rating.*			

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	Joint Responsibility of the State Hospital & CSB
~~3.4~~5.1	To the greatest extent possible, CSB staff, the minor and/or his legal guardian shall be a part of the discussion regarding the minor's clinical readiness for discharge. The state hospital social worker is responsible for communicating decisions regarding discharge readiness to the CSB staff. The state hospital social worker shall provide written notification of readiness for discharge when extraordinary barriers are known or anticipated and document the contact in the minor's medical record. NOTE: For minors under the jurisdiction of DJJ security regulations, discharge notification will occur within one (1) calendar day of discharge to jail, DJJ state hospital or juvenile detention center. According Virginia Code § 16.1-346.1 "A minor in detention or shelter care prior to admission to inpatient treatment shall be returned to the detention home, shelter care, or other facility approved by the Department of Juvenile Justice within 24 hours by the sheriff serving the jurisdiction where the minor was detained upon release from the treating facility, unless the juvenile and domestic relations district court having jurisdiction over the case has provided written authorization for release of the minor, prior to the scheduled date of release."
~~3.5~~	~~*Dispute Process*~~ ~~1. The CSB discharge liaison shall notify the assigned CCCA Social Worker and the state hospital social work director (or designee) via fax or encrypted email, of their disagreement with the treatment team's designation of the individual's clinical readiness for discharge by the close of business of the second business day. Adult hospitals – within three calendar days (72 hours) of receiving the discharge readiness notification.~~

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	~~2. The state hospital social work director (or designee) shall initiate a resolution effort to include a meeting with the 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 Clinical Services (i.e. Community Transition Specialist). This meeting shall occur within one business day of receipt of the CSB's written disagreement.~~ ~~3. The RFD dispute letter shall include the following information:~~ ~~a. Community concerns for discharge~~ ~~b. Reasons for continued stay at CCCA~~ ~~c. Unaddressed barriers to discharge~~ ~~4. 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 (or designee). The Commissioner (or designee) shall provide written notice of their decision regarding discharge to the CSB executive director and state hospital director.~~ ~~5. 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 the clinical readiness for discharge.~~ ~~6. Should the Commissioner (or designee) 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).~~ ~~1.~~			
	State Hospital Responsibilities		CSB Responsibilities	Time Frame
~~3.6~~5.3			All discharge plans are expected to be implemented. The CSB shall initiate an Extraordinary Barriers Report on the minor and	*Within no more than four (4) calendar days of notification of*

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			update the DBHDS and the state hospital regularly in the event that barriers delay the discharge more than 4 days past clinical readiness. The report shall describe the barriers to discharge and the specific steps being taken to address them.	*clinical readiness. ~~All discharge plans are expected to be implemented within no more than four calendar days of notification of clinical readiness. The CSB shall initiate an Extraordinary Barriers Report on the minor and update the DBHDS and the state hospital regularly in the event that barriers delay the discharge more than 4 days past clinical readiness. The report shall describe the barriers to discharge and the specific steps being taken to address them.~~*
Joint Responsibility of the State Hospital & CSB				
5.4~~3.7~~	The ~~Assistant Commissioner for Behavioral Health and their designees~~Office of Patient Clinical Services, Chief Medical Officer and Deputy Commissioner of Facility Services and CSB Executive Director shall monitor the progress of those minors with extraordinary barriers to discharge.			

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~~I~~VI. Completing the Discharge Process

	State Hospital Responsibilities		CSB Responsibilities	
4.~~1~~6.1	T~~h~~he treatment team shall prepare the discharge information and instructions (DIIF.) Prior to discharge, state hospital staff shall review the DIIF with the minor and/or parent/legal guardian and request his/her signature. Distribution of the DIIF shall be provided by the state hospital to the CSB ~~no later than 24 hours post discharge or the next business day.~~ NOTE: Minor's review of the DIIF may not be applicable for certain forensic admissions due to their legal status.	~~#~~*No later than 24 hours post discharge or the next business day.*	To reduce re-admissions to state mental health facilities, CSBs, in conjunction with the treatment team, shall develop and complete, as clinically determined, a safety and support plan that is part of the minor's final discharge plan. It is the CSB liaisons responsibility to distribute any requested copies of the DIIF (DBHDS form 226) and supporting documentation to other next level providers and to other CSB care providers. NOTE: Safety and support plans are generally not required for court ordered evaluations, restoration to competency cases, and transfers from DJJ and detention. However, at the clinical discretion of the treatment team or the CSB, the development of a specialized safety and support plan may be advantageous when the minor presents significant risk factors, and for	

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			those minors who may be returning to the community following a brief incarceration period.	
~~4.2~~6.2	The facility medical director shall be responsible for ensuring that the discharge summary is provided to the case management CSB (and DJJ when appropriate) ~~within thirty (30) calendar days of the actual discharge date.~~	*W~~w~~ithin ten (10) calendar days of the actual discharge date.*	CSB staff shall ensure that all arrangements for psychiatric services and medical follow-up appointments are in place prior to discharge, either by consultation with private providers or by arrangement with the CSB.	
6.3~~4.3~~			CSB staff shall ensure the coordination of any other intra-agency services, e.g. outpatient services, residential, etc.	
6.4~~4.4~~			If the CSB is providing services, minors discharged from a state hospital with continuing psychotropic medication needs shall be scheduled to be seen by the CSB psychiatris.t ~~within seven (7) calendar days post discharge, or sooner if the minor's condition warrants.~~	*W~~w~~ithin seven (7) calendar days post discharge, or sooner if the minor's condition warrants.*

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			In no case shall this initial appointment be scheduled longer than fourteen (14) calendar days following discharge. If the minor is treated by a psychiatrist in the community, the CSB is expected to ensure the aforementioned schedule is met either with the community-based psychiatrist or through the CSB. *Note:* In no case should agency policy or procedure place an undue burden on the family or delay in meeting this expectation.	

VII. Transfer of Case Management CSB Responsibilities

	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time frame

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~~5.1~~7.1	The state hospital social worker shall indicate in the progress notes any intention that is clearly expressed by the parent/legal guardian to change or transfer case management CSB responsibilities and the reason(s) for doing so. This shall be documented in the minor's medical record and communicated to the case management CSB. EXCEPTION: This process may be accelerated for discharges that require rapid response to secure admission to the community or residential placement.	*Immediately upon notification*	Transfers shall occur when the parent/legal guardian decides to relocate to another CSB service area. Should a placement outside of the minor's catchment area be pursued, the case management CSB shall notify the CSB affected by the potential placement. ~~T~~The case management CSB must complete and forward a copy of the out of catchment 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 advancement of the transfer.	
~~5.2~~7.2				~~a~~*Prior to the actual discharge date*

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			At a minimum, the CSB shall meet (either in person, telephone, or video conferencing) with the minor and the treatment team ~~prior to the actual discharge date~~. The case management CSB is responsible for completing the discharge plan, and safety and support plan.. The case management CSB shall stay involved with the minor.	

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Protocols for Adult and Geriatric Patients~~**Adults and Geriatric**~~

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I. 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~~Director of Clinical Services (or designee) with the names of CSB personnel who are serving as the CSB's state hospital discharge liaisons,~~.~~ Forensic Discharge Planners,~~.~~ ~~and~~ Forensic Admissions Coordinator~~.~~, MH directors or supervisors, DD directors and Executive Directors	CSBs	*At least quarterly, or whenever changes occur*
The DBHDS ~~Office of Community Integration~~Office ~~of Patient~~of Patient Clinical Services will update and distribute listings of all CSB discharge planning and state hospital social work contacts to the Office of Forensic Services, the 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.	DBHDS ~~Office of Community Integration~~Office ~~of Patient~~of Patient Clinical Services	*At least quarterly*
~~Each region shall~~DBHDS shall ~~t~~ 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~~ DBHDS shall review and update	~~CSB regions~~Office of Patient clinical Services	*Updated at least quarterly*

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the list and ensure that it is available to CSB state hospital liaisons, CSB Forensic Discharge Planners, state hospital Forensic Coordinators, and state hospital social work staff, ~~and Central Office Community Transition Specialists~~ to ensure that all resource options are explored for individuals in state hospitals. At each census management meeting, there shall be a review (bed availability/updates) of the DBHDS funded programs in census management meetings.		
~~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 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.~~	~~CSB regions~~	~~*Updated as needed*~~

II. Collaborative Responsibilities Following Admission to State Hospitals: Civil/Non-Forensic Admissions

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*		

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CSB staff shall begin the discharge planning process for both civil and forensic admissions.	*Upon notice of admission*	State hospital staff shall contact the CSB to notify them of the new admission- See Appendix D.	*Within one (1) business day*
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). See dispute section Appendix D	*Upon notice of 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 and the DD Director 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. Even if the hospital liaison takes the lead, the hospital will notify the support coordinator of all	*Within one (1) business day*
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.	*Upon admission*		
2. CSB shall document in the EHR case management and discharge planning activities.	*Ongoing*		
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3. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, jail providers, private providers, etc.) are engaged with state hospital social work staff and attend treatment plan meetings as necessary.		treatment team meetings, census management meetings, etc.	
4. CSB staff shall establish a personal contact (preferably in person) with the hospitalized individual in order to initiate collaborative discharge planning.	*Within seven (7) calendar days of admission*		
5. CSB staff shall maintain contact with the patient (in person, phone calls, or virtually) at least monthly to ensure consideration of patient preference and choice in discharge planning.	*At least monthly*		

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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.	*Ongoing*	State hospital staff shall inform the CSB by email of the date and time of CTP meetings.	*At least two (2) business days prior to the scheduled CTP meeting.*
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.	*Within two (2) business days of the missed meeting*	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.	*At least two (2) business days prior to the rescheduled meeting*
Note: While it may not be possible for the CSB to attend every treatment planning meeting, 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 initial 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 participate in as many treatment team meetings as possible.	*Within seven (7) calendar days of admission*

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III. Collaborative Responsibilities Following Admission to State Hospitals for Justice-Involved Persons admitted ~~from Jail~~ for ~~Initial~~ Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail

Justice-involved ~~P~~persons admitted from Jail or community for ~~Initial~~ Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB staff shall begin the discharge planning process for persons admitted from jail, or the community if on bond, -as soon as possible following admission to a state hospital. If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document). See Appendix E	*Upon notice of admission ~~or start of competency restoration and/or psychiatric emergency treatment period~~* *Upon notice of admission*	Once admitted to a state hospital, state hospital staff shall contact the CSB designated ~~staff or Forensic Discharge Planner (FDP)~~liaison to notify them of the new admission. Hospital staff shall provide a copy of the admissions information/face sheet to the CSB, as well as the name and phone number of the ~~social worker~~social worker ~~assigned~~ and ~~pretrial f~~Forensic ~~coordinator~~ Coordinator ~~worker~~ assigned, and the name of the admitting unit.	*Within one (1) business day*

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For every ~~pretrial/jail-based~~ person admitted to a state facility who is from the CSB's catchment area but is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management and discharge planning responsibilities to the appropriate staff. ~~, f~~For ~~those CSB's with an FDP, that will be the staff person assigned to the case.~~ CSBs with DBHDS-funded Forensic Discharge Planning (FDP) staff positions, CSBs ~~are encouraged~~should ~~to~~ leverage those positions to -support the successful transition and discharge planning of individuals returning to jail following hospital discharge. CSB shall document in the EHR case management and discharge planning activities.	*Upon notice of admission*	~~Hospital staff will provide the CSB timely updates on the forensic evaluators' findings, , and updates on court dates during the admission.~~ ~~Treatment team social worker will collaborate with pretrial forensic coordinator to determine likely case disposition, as many persons admitted for CR competency restoration will likely return to jail, engage in a plea agreement, be sentenced and then be released shortly thereafter. The time one remains in jail following treatment may be related to the seriousness of the charges, and prior criminal history; it is advised that treatment teams collaborate routinely with the pretrial forensic coordinator and monitor court dates. For persons monitored on a Behavioral Health Docket, information about potential disposition of their court case may be coordinated with the CSB liaison.~~	*Within seven (7) calendar days of admission; and ongoing during treatment planning* *Ongoing, as Needed* ~~*Within seven calendar days of admission; and*~~

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CSB staff shall establish personal ~~a personal~~ contact (preferably in person) with the individual in order to initiate collaborative discharge planning and to ~~-~~establish process for "warm hand-off" when returned to ~~jail, initiate collaborative discharge planning, and assessment of need to reinstate benefits~~jail.	*Ongoing* *Within seven (7) calendar days of admission*	~~Social worker~~Hospital staff will track court dates ~~and maintain updates~~ from the Virginia Judiciary Online Case Information System 2.0 found at: Virginia Judiciary Online Case Information System. Hospital staff will provide the CSB timely updates on the forensic evaluators' findings, and updates on court dates during the course of hospitalization. Note: SSI reinstatement of ~~-of~~ benefits could occur without need for a new application within 12 months of being incarcerated.~~,~~ If the incarceration was over 12 months a new SSI application would be needed. If Medicaid coverage is required the jail will initiate contact with Cover Virginia Incarcerated Unit (CVIU) using the DOC Pre-Release window of 45 days. Expedited coverage can be requested if discharge	~~*ongoing during treatment planning*~~ ~~*Within seven calendar days of admission; and ongoing during treatment planning*~~

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		would occur before the 45 days. ~~coord. With feds?~~	
The CSB's designated state hospital liaison ~~will designate a discharge planner, familiar with their local jail and/or the FDP (in communities that have one)~~ will attend inpatient CTP and TPR meetings in person. At a minimum, the CSB staff who is assigned lead discharge planning responsibilities shall participate in all treatment team meetings and discharge planning meetings; however, it is most advantageous if the FDP staff can participate in treatment teams as much as possible. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, FDP staff, private providers, etc.) are engaged with state hospital social work staff and included in CTP and TPR meetings as needed to facilitate successful discharge.	*Ongoing* *Ongoing* *Ongoing*	State hospital staff shall inform the- CSB ~~designatited~~designated hospital liaison ~~discharge planner and/or FDP~~ by email of the date and time of CTP and TPR meetings. The initial CTP meeting shall be held within seven calendar days of admission. If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall ensure that the CSB is made aware of this change via email.~~.~~ It is expected that the state hospital will provide alternative accommodations (such as ~~phone or~~ video or phone) if CSB staff are unable to attend	*At least two (2) business days prior to the scheduled meeting* *Within seven (7) calendar days of admission* *At least two (2) business days prior to the rescheduled meeting*

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If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for ~~telephone or~~ video conference. ~~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.~~ 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. ~~It is expected that "discharge to jail" will occur with a full continuum of discharge planning; person who will remain in jail for 21 days or more following release shall have a monthly face-to-to face check-in while they remain incarcerated.~~	*Within two (2) business days of the missed meeting* ~~*Ongoing*~~ ~~*O*~~*Ongoing*	in person, and that meetings will be scheduled so that liaisons can participate in as many treatment team meetings as possible. The state hospital social worker and pretrial forensic coordinator will invite appropriate jail staff to ~~patriciate~~ participate in treatment team planning and/or discharge meetings as needed. .	*Ongoing* *Ongoing*

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CSB staff are responsible for identifying treatment and support needs not only in the community but also in local or regional jails, in cases where the individuals will return to jail upon hospital discharge ~~in the jail and in the community, initiating referrals for services, and communicating any updates on the individual's progress to the treatment team social worker and jail-based mental health provider.~~	~~*Ongoing*~~		
Note: It is expected that individuals returning to jail upon state hospital discharge will receive a full-continuum of discharge planning services, including but not limited to: ongoing face-to-face follow-up from the CSB at least monthly in cases where the person who will remain in jail for 21-days or more following hospital discharge, coordination with jail security and medical staff to monitor the individual's adjustment upon return to jail, and continued coordination of services upon the individual's release from jail. The length of time one ~~r~~remains in jail following discharge from the state hospital will vary, and may depend on the seriousness of the charges, prior criminal history, or other factors beyond the state hospital's or CSB's control. It is advised that treatment team social workers and CSB liaisons collaborate routinely with the state hospital ~~f~~Forensic ~~c~~Coordinator to discuss potential criminal case dispositions and monitor court dates, in order to provide effective discharge planning upon return to jail. For persons participating on a Behavioral Health Docket, information about potential disposition of their court case may be coordinated with the CSB's Docket liaison.			

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~~Collaborative Responsibilities Following Admission to State Hospitals: Civil/Non-Forensic Admissions~~

~~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 from the local jail~~	~~*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"~~	~~*Upon admission*~~	~~State hospital staff shall contact the CSB to notify them of the new admission. See Aappendix D.~~ ~~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~~	~~*Within one business day*~~ ~~*Within one business day*~~

~~contained in the glossary of this document).~~ ~~See dispute section A~~appendix D ~~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.~~ ~~CSB shall document in the EHR case management and discharge planning activities.~~ ~~1.~~ ~~1. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program staff, jail providers, private providers, etc.) are engaged with state hospital social work staff and attend treatment plan meetings as necessary.~~ ~~CSB staff shall establish a personal contact (preferably in person) with the~~	~~*ongoing*~~	~~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 and the DD Director to~~ Director 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. Even if the hospital liaison takes the lead, the hospital will notify the support coordinator of all treatment team meetings, census management meetings, etc.~~	

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~~hospitalized individual in order to initiate collaborative discharge planning.~~ ~~2. CSB staff shall maintain contact with the patient (in person, phone calls, or virtually) at least monthly to insure consideration of patient preference and choice in 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~~	~~*Ongoing*~~ ~~*Ongoing*~~	~~State hospital staff shall the state hospital shall make every effort to ensure that the CSB is made aware of this change, the state hospital shall notify the CSB 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 participate in as many treatment team meetings as possible~~	~~*At least two business days prior to the scheduled meeting. At least two business days prior to the scheduled CTP meeting.*~~ ~~*At least one week prior to the scheduled TPR meeting.*~~ ~~*Immediately upon reschedule*~~

~~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, 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.~~	~~*Within two business days of the missed meeting*~~		~~*Within seven calendar days of admission*~~

IV. Collaborative Responsibilities Following a Not Guilty by Reason of Insanity (NGRI) Finding

Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB staff shall begin the discharge planning process for NGRI acquittees as soon as possible following admission to a state hospital for	*Upon notice of inpatient admission*	If an acquittee is admitted to a state hospital, state hospital staff shall contact the CSB NGRI Coordinator and CSB discharge planner to notify	*Within one (1) business day of admission*

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Temporary Custody evaluation or notification that an NGRI acquittee has been placed on Outpatient Temporary Custody (OPTC) status.	*or start of the OPTC period*	them of the new admission. Hospital staff shall 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.	
If the CSB disputes case management CSB/discharge planning responsibility for the individual, the CSB shall notify the state hospital social work director (for reference, please see the definition of "case management CSB/CSB responsible for discharge planning" contained in the glossary of this document).	*Upon notice of admission or start of OPTC period*	The Office of Forensic Services will provide the CSB NGRI Coordinator copies of the court order and contact information for the acquittee, court, attorneys, and DBHDS Forensic Coordinator that will be responsible for oversight of the evaluation process.	*Within (7) calendar days of admission or start of OPTC period*
For every NGRI admitted to a state facility or placed onto Outpatient TC status who is from the CSB's catchment area but is not currently open to services at that CSB, the CSB shall open the individual to consumer monitoring and assign case management and discharge planning responsibilities to the appropriate staff.	*Upon notice of admission or start of OPTC period*	Hospital staff will provide the CSB timely updates on the Temporary Custody evaluators' findings, copies of all reports including the IARR, and updates on court dates during the Temporary Custody period.	*Within two (2) business days*
CSB staff shall establish a personal contact (preferably in person) with the NGRI acquittee in order to initiate collaborative discharge planning.	*Within seven (7) calendar days of*	In cases where one or both evaluators recommend conditional or unconditional release from Temporary Custody, the state hospital will notify the CSB via email of the need to prepare a written	*Within one (2) business days of*

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For Outpatient TC cases, CSB staff are responsible for identifying treatment and support needs in the community, initiating referrals for services, and communicating any updates on the individual's progress to the DBHDS facility's Forensic Coordinator and Office of Forensic Services. 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. If an NGRI acquittee is approved by the court for Conditional or Unconditional Release following the Temporary Custody period, the CSB is responsible for implementing the release plan.	*admission or start of OPTC period* *Upon start of OPTC period and Ongoing* *By the deadline indicated by the state hospital* *Upon receipt of court order approving release*	Conditional or Unconditional Release Plan and the due date for the plan to be returned. The state hospital will establish a due date no less than ten (10) business days from notification. The hospital will work jointly with the CSB in the development of the Conditional or Unconditional Release Plan. Hospital staff will provide notice to the CSB of the outcome of the Temporary Custody court hearing and copies of any orders issued from that hearing.	*receipt of the evaluation(s)* *Ongoing* *Within two (2) business days of the court hearing or receipt of order*
NGRI Inpatient Commitment for Treatment			

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The CSB NGRI Coordinator and/or the CSB discharge planner will attend inpatient CTP and TPR meetings in person. At a minimum, the CSB staff who is 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.	*Ongoing*	State hospital staff shall inform the CSB NGRI Coordinator and CSB discharge planner by email of the date and time of CTP and TPR meetings. The initial CTP meeting shall be held within seven calendar days of admission.	*At least two (2) business days prior to the scheduled meeting* *Within seven (7) calendar days of admission*
If the CSB NGRI Coordinator is unable to attend CTP and TPR meetings, the CSB discharge planner will ensure that they receive a summary update following each meeting. However, the CSB NGRI Coordinator shall attend any CTP and TPR meetings for NGRI patients with approval for unescorted community not overnight privileges and higher. If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for telephone or video conference.	*Ongoing* *Ongoing*	If CTP and TPR meetings must be changed from the originally scheduled time, the state hospital shall ensure that the CSB is made aware of this change via email. It is expected that the state hospital will provide alternative accommodations (such as phone or video) if CSB staff are unable to attend in person, and that meetings will be scheduled so that liaisons can participate in as many treatment team meetings as possible.	*At least two (2) business days prior to the rescheduled meeting* *Ongoing*
The individual assigned to take the lead in discharge planning will ensure that other relevant		State hospital staff shall provide notice to the CSB NGRI Coordinator of any meetings scheduled to	*At least two (2) business days prior*

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parties (CSB program staff, private providers, etc.) are engaged with state hospital social work staff. 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. The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI. 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 by the due date indicated.	*Ongoing* *Within two (2) business days of the missed meeting* *Within ten (10) business days of receiving the draft RMP from the state hospital* *By the deadline indicated by the state hospital*	review an acquittee's appropriateness for a privilege increase or release. The state hospital shall provide notice to 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 privilege request packet must be developed. This notification will be emailed and will include a deadline by which the CSB should submit the required documentation; at a minimum the CSB should be provided 10 business days to supply the necessary product.	*to the scheduled meeting* *Within two (2) business days of identifying the need for a RMP, CRP, or UCRP*

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Note: Virginia Code §§ 19.2-182.2, 19.2-182.5 (C), and 19.2-182.6(C) explicitly require CSBs or BHAs to plan for conditional release in conjunction with hospital staff and to implement the conditional release plan approved by the court. The conditional release plan shall be prepared jointly by the hospital and the CSB or BHA where the acquittee shall reside upon conditional release.

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 effectively with other involved CSBs, and ensures that these plans are signed as soon as possible according to the time frames above.

Note: While it may not be possible for the CSB to attend every treatment planning meeting, 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.

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V. Needs Assessment

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Discharge planning begins ~~on the initial~~at the ~~prescreening evaluation~~point of admission 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.	*At admission and ongoing thereafter*	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 (7) calendar days of admission* *Ongoing*
The CSB shall obtain required releases of information.	*At admission and ongoing thereafter*		
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	*As soon as possible upon admission and ongoing*		

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• The specific public and/or private providers that have agreed to provide these services • If returning to jail, outline a ~~steps~~plan for CSB follow-up in the jail until the individual's ~~ongoing psychiatric stability until~~ return to the community. •			
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 (1) week of admission*
If the individual's needs change or as more specific information about the discharge plan becomes available, the CSB staff shall update the discharge plan accordingly	*Ongoing*	As an individual's needs change, the hospital social worker shall document changes in their progress notes and through communications/meetings with the CSB.	*Ongoing*
Note: 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)			

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~~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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VI. 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~~services, 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 ~~Other relevant services~~ • Substance Use Services~~????~~ • PHP/IOP • Individual/group therapy • Other relevant services	*Within five (5) ~~buisness~~business ~~10 business~~ days of receiving the referral*	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 • Substance Use Services~~???~~ • PHP/IOP • Individual/ group therapy • Other relevant services	*Within two (2) business days of the treatment team identifying the need for the services*

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The CSB shall share the outcome of the assessment and the date when the services will be available with the hospital treatment team.	*Immediately upon completion of the assessment*		
		~~Individuals Returning to Jail:~~	
		The treatment team social worker in collaboration with the state hospital Forensic Coordinator will ensure the treatment team has a copy of the jail medication formulary.	*Ongoing*
		For medications that are not on the jail formulary but that the prescriber believes is necessary for patient care, the social worker will consult with the jail medical provider prior to the individual's return to jail and incorporate into the discharge plan the support needed for ongoing stability.	
~~NGRI acquittees:~~		~~NGRI acquittees:~~	
~~The CSB Executive Director shall appoint an individual with the appropriate~~		~~State hospital staff shall provide notice to the NGRI Coordinator of any meetings scheduled~~	

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~~knowledge, skills, and abilities to serve as NGRI~~		~~to review an acquittee's appropriateness for a privilege increase or release~~	~~*At least two business days prior to the scheduled meeting*~~
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 to DBHDS Central Office Forensics staff within two (2) business days*	~~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~~	~~*Within one business day of the treatment team identifying the individual as being eligible for a privilege increase or release*~~
~~Coordinator for their agency (please see glossary for specific requirements)~~	~~*Ongoing*~~ ~~*Ongoing*~~	~~The state hospital shall complete the packet requesting an increase in privilege level or release~~	
~~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~~			

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~~community not overnight privilege level or higher.~~ ~~The CSB NGRI Coordinator shall review, edit, sign, and return the risk management plan (RMP) for individuals adjudicated as NGRI~~ ~~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~~ ~~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~~	~~*Within 10 business days of receiving notice from the state hospital*~~ ~~*Within 10 business day of being notified that the individual has been recommended for release*~~ ~~*Ongoing*~~		~~*Within 10 business days of the treatment team identifying the individual as being eligible for a privilege increase*~~

~~plans are signed as soon as possible according to the time frames above.~~ ~~*Return to local and regional jails:*~~ ~~*The CSB shall be responsible for the case management and discharge planning of persons entering the state hospital under a pretrial commitment. Some may return to jail and be released to the community quickly, while others may remain in jail for longer. The CSB will coordinate treatment information with the hospital social worker, and the jail.*~~		~~The treatment team social worker in collaboration with the pretrial forensic coordinator will ensure the team has a copy of the jail formulary~~ ~~For medications that are not on the jail formulary, but the prescriber believes is necessary for patient care, the social worker will consult with the jail medical provider, prior to the return to jail and incorporate into the discharge plan the support needed for ongoing stability~~	
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~~,~~ and lack of a guardian is a barrier to	*Within two ~~(2)~~ business days of notification*	Guardianship: Evaluation for the need for a guardian shall start upon admission and be addressed at each treatment team meeting for all patients; both civil and forensic. Activities related to securing a guardian (if needed) start and continue regardless of a patient's discharge readiness level.	*Ongoing*

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discharge, they shall notify the state hospital to begin the process of referral for a DBHDS guardianship slot.	*Within ten (10) business days of notification of need for a guardian*	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~~ 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. Guardianship r~~R~~eferrals required f~~f~~or forensic patients hospitalized for restoration should be submitted immediately upon being found unrestorably incompetent to stand trial (URIST) by the court.	*Within two (2) business days of determination* *Immediately upon notification by the CSB of the need for a DBHDS guardianship slot*
~~I~~If DBHDS awards a Mental Health Guardianship slot to the individual and the individual is accepted by a public or private guardianship program, the CSB	*~~Im~~Immediately upon notification of acceptance by the guardianship program*		

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shall retain an attorney on behalf of the individual to file a guardianship petition with the court.			
Note: Discharge planning should include an evaluation of patient preferences in addition to their support and service needs based on least restrictive settings and available resources. DBHDS funded programs and services must be exhausted before DAP funding can be utilized. CSB shall keep a tracking sheet of all referrals made, date referred, follow-up dates, and outcomes. ~~***example of tracking in addendum~~			
Permanent Supportive Housing (PSH) The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referral to PSH program.	*As soon as PSH is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by PSH provider	*Upon request*~~*As requested*~~

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Contract No. P1636.CSBCode.3

The CSB shall obtain required documentation and send the referral packet to the PSH program.	*As soon as PSH is being considered, and prior to the individual being determined to be RFD*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for PSH application	*Within one (1) business day of request from CSB*
The CSB will determine options for a step-down, such as a hotel, while PSH unit is pending. If a patient is denied, the CSB should attempt to obtain the reason for denial	*As soon as accepted to PSH program* *~~At~~Upon notice of denial*		
Transitional The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referral to transitional program.	*As soon as a transitional housing is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by transitional provider. The state hospital will provide any copies of vital records and financial (benefits)	*~~As~~Upon requested~~d~~*

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The CSB shall obtain required documentation and send the referral packet to the transitional program. CSB will refer to PSH prior to discharge if the individual will transition to PSH upon completion of transitional program. If a patient is denied, the CSB should attempt to obtain the reason for denial	*Within two (2) ~~-~~business days of becoming discharge ready level 2* *~~Simultaneously,~~Simultaneously ~~as making~~with referrals ~~to~~for transitional* *Upon notice of denial~~At denial~~*	information to the CSB for transitional application The state hospital will document in the EHR and in the hospital discharge instructions that the individual is recommended for PSH, if appropriate, upon completion of transitional program.	*Within one (1) business day of request from CSB* *Prior to discharge*
Mental Health Group Homes The CSB shall obtain verbal consent and releases, if necessary, from the individual or the surrogate decision maker to make referrals to mental health group homes.	*As soon as a mental health group home is being considered, and prior to the individual being determined to be RFD*	The state hospital shall assist in the facilitation of interviews/assessments required by transitional provider The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for transitional application	*~~As requested~~ Upon request*

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The CSB shall obtain required documentation and send the referral packet to mental health group homes. If a patient is denied, the CSB should attempt to obtain the reason for denial	*Within two (2) business days of becoming discharge ready level 2* *Upon notice of~~A~~ denial*		*Within one (1) business day of request from CSB*
Assisted Living (ALF) referrals:		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.	*As soon as an ALF is being considered, and prior to the individual being determined to be RFD* *Within one (1) business day of receiving the UAI*	The state hospital will not recommend congregate settings without first completing the housing first evaluation to determine patient needs and preferences. The state hospital shall complete the UAI and DMAS-96.	*Within five (5) business days of the individual being found discharge ready level 2* *Immediately upon completion of the UAI*

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		The state hospital shall transmit the UAI and DMAS- 96 to the CSB	*Upon request* ~~*As requested*~~
~~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.~~ If the CSB does not receive a response from a potential placement, the CSB shall be follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is reached or the patient discharges to a different placement.	*Within two (2) business days of sending the referral and at least weekly thereafter* ~~*Within one two business day after the individual is rated as RFD and at least weekly thereafter*~~	The state hospital shall assist in the facilitation of interviews/assessments required by potential ALF providers	
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial* ~~*Every referral*~~		

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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.	~~*Within five business days of sending the referral*~~ *Prior to referring to private pay Memory Care units*		
Nursing home (NH) referrals:		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	*As soon as an NH is being considered, and prior to the individual being determined to be RFD*	The state hospital shall complete the UAI	*Within five (5) business days of the individual being found discharge ready level 2* *Within one (1) business day of the*

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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 or the patient discharges to a different placement.~~ If the CSB does not receive a response from a potential placement, the CSB shall be follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is reached or the patient discharges to a different placement.	*Within one (1) business day after receiving the UAI* *~~Wi~~Within one business day after the individual is rated as RFD* *~~W~~ithin ~~five~~ two (2) business days of sending the referral and at least weekly thereafter* *Upon notice of denial* *~~Every referral~~*	For individuals who require PASRR screening, the state hospital shall send the referral packet to ~~Ascend~~Maximus 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	*completion of the UAI.* *~~Within one business day of the individual being found clinically ready for discharge~~* *Immediately upon receipt of the screening results* *~~As requested~~Upon request*

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If a patient is denied, the CSB should attempt to obtain the reason for denial.			
Shelter placements:		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.~~ In the case of out of catchment shelter placements, CSB staff shall notify the CSB that serves the catchment area of the shelter and will follow the procedures as outlined in the CSB transfers section for out of catchment placements.	*As soon as shelter discharge is identified as the discharge plan*	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	

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		CSB responsible for discharge planning, as well as the CSB that serves the catchment area of the shelter.	*Prior to discharge*

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~~Individuals with a developmental disability (DD) diagnosis:~~		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~~	~~*Within two business days of admission*~~	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).	*Immediately upon notification of diagnosis*
~~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~~	~~*Within ten business days of admission*~~	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.	*Ongoing*
~~If applicable, the CSB shall ensure that the individual has been added to the DD Waiver waitlist.~~	~~*Within three calendar days of admission*~~	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 including conducting psychological testing and assessments as needed.	~~*As needed*~~*Ongoing, Required psychological testing and assessment shall*
~~The CSB liaison and support coordinator shall participate in the development and updating of the discharge plan, including attending and participating in treatment~~	~~*Immediately upon notification of need*~~		

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~~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.~~	~~*At admission and ongoing*~~ ~~*At the time that an individual is rated a discharge ready level 2*~~ ~~*Ongoing*~~ ~~*Prior to discharge*~~	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.	*be completed within 21 calendar days of referral* *Ongoing* *At the time that the individual is rated a discharge ready level 2* *Ongoing*

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~~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 funding, the CSB shall completed an application for DD crisis funds.~~ Individuals with a developmental disability (DD) diagnosis:	~~*According to timelines set forth in the transfer procedure*~~ ~~*Immediately upon notification of need*~~		
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, census management and other related meetings.	~~*Immediately upon notification of need*~~ *Within one (1) business day of admission*		
The CSB shall send referrals to multiple potential placements. The referrals are to be sent simultaneously. If the CSB does not receive a response from a potential			

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placement, the CSB shall follow up on the status of the referral. It is expected that the CSB will continue to communicate with the provider until a disposition decision is reached or the patient discharges to a different placement.	~~*Within one business day of admission*~~		
The CSB shall assist in scheduling tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*Within ten (10) business days of request for services*		
The CSB shall locate and secure needed specialists who will support the individual in the community at discharge.			
If the individual is moving outside their home area, the CSB shall notify the CSB in which the individual will reside upon discharge.			
If it is anticipated that an individual with a DD diagnosis is going to require	*Immediately upon notification of need*		

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transitional funding, the CSB shall complete an application for DD crisis funds.			
The CSB will maintain contact with all service providers to ensure timely completion of tasks required for discharge.	*Within three (3) business days of admission*		
The Support Coordinator shall consult with the Community Integration Manager and or a Community Resource Consultant, as needed, to ensure required services are identified and in place prior to discharge. These supports may include, but are not limited to:	*Upon~~At~~ admission and ongoing*		
• Therapeutic Consultation provider to develop, monitor, and revise a Behavior Support Plan • Customized Rate for increased staffing, specialized staffing, and or programmatic oversight • REACH Community Crisis Stabilization Support	*~~At admission~~*		

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• Support training for residential provider staff • Private duty or skilled nursing • Day Services	~~*Ongoing*~~		
	~~*Prior to discharge*~~		
	Immediately upon notification of need		
	~~*Prior to discharge*~~		

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	Ongoing		
	As needed		
	~~*Immediately upon notification of need*~~		
	~~*Ongoing*~~		

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VII. 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 ~~(Note: there is a separate readiness scale for persons committed undder a pretrial forensic status).(See Appendix)~~ The state hospital social worker shall notify the CSB and DBHDS Community Transition Specialist 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 ~~EHR~~* *Within one (1) 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.~~	*~~Within two business days~~ Weekly by Close of business Friday*	~~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~~	*~~Weekly~~ Weekly, no later than Wednesday*

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~~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.~~ CSB liaisons will provide a discharge planning update on all of their patients rated clinically ready for discharge (level 1) weekly either via email or participation in the census management meeting.		~~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.~~ ~~Note: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals.~~ 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, Community Integration Manager (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.	

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		Note: These notifications and responses shall occur for all individuals, including individuals who were diverted from other state hospitals. Upon receipt of the CSB liaison's update, the state hospital will review	

~~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 Unescorted Community, Overnight 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*~~

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- ~~***if a patient is going through medication changes, they should not be rated a level 1 and moved back to at least a level 2 until medication adjustments are completed~~
- ~~~~

~~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.~~

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~~Discharge Readiness Dispute Process for State Hospitals, CSBs, and DBHDS Central Office~~ ~~Move to appendix~~

~~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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VIII. 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.~~ At a minimum, the state hospital and CSB staff shall review individuals rated a 1 on the clinical readiness for discharge scale on a weekly basis and document in the EHR on the identified form. ~~.~~

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~~Office ~~of Patient~~of Patient Clinical Services 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.

~~DEFINE THE EBL~~Please see EBL definition in Glossary.

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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*		

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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*

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~~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~~ If an individual would benefit from a trial pass due to clinical reasons, the CSB will make a request to the hospital to include the clinical reasons the pass is being requested.	*Prior to discharge,* *as needed* ~~*Prior to and following discharge*~~ ~~*Within seven calendar days, or sooner if the individual's condition warrants*~~	Trial passes to an identified placement are approved on a case by case basis. The hospital will collaborate with the CSB and identified placement to address any issues that may arise during a trial pass.	~~*When Requested*~~ ~~*When Requested*~~*Upon request* *Upon request*

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If a trial pass is approved, the CSB ~~will take~~will take the lead on planning to include collaborating with the hospital on transportation,	~~*Within seven days of discharge*~~ ~~*As needed*~~		
The CSB shall check in daily with the identified provider to include any problem solving for issues that may arise. The CSB will keep the hospital informed.			
If the tri~~i~~al pass is a pass to discharge, the CSB will continue with discharge planning activities and confirm with the identified provider that discharge will move forward. until the individual is officially discharged.	*Once approved*		

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	Daily		
	As needed		

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CSB staff shall ensure that all arrangements for psychiatric services and medical follow up appointments are in place.	*Prior to discharge*	The state hospitals shall complete the H&P, PPD, other admissions paperwork, and signed orders for the placement.	*As soon as placement is identified*
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.	*Prior to and following discharge*	The state hospitals shall provide medication and/or prescriptions upon discharge.	*At discharge*
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.	*Within seven (7) calendar days, or sooner if the individual's condition warrants*		

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	Within seven (7) calendar days of discharge		

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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 complete the SSA-1696 Appointment of Representative Form and provide a copy to the hospital social worker or benefits coordinator. 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* *Within three (3) business days of being requested* *Upon submission* *30 days post-discharge, and every 15 days thereafter until benefits are active*	Benefit applications: State hospital staff will verify insurance and benefits upon admission. 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 *Note: For patients that will be applying for an Auxiliary Grant some exceptions may apply for programs with other agreements. *State hospital will request that the CSB complete the SSA-1696.* To facilitate follow-up, if benefits are not active at the time of discharge, the state hospital shall	*Prior to discharge and per federal and state regulations*

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		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.	*When SSA benefits are being applied for*

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Vital Documents~~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 acquiring vital documents if patient can not provide those. ~~applications for Social Security benefits.~~ The CSB shall complete the SSA-1696 Appointment of Representative Form and provide a copy to the hospital social worker or benefits coordinator. The CSB shall contact the entity responsible for acquiring~~processing~~ these items~~entitlement applications~~ (SSA, DMV, VDH~~SS~~, etc.) to ensure that the ~~benefits application~~information has been received and w~~h~~at these entities may ~~have all~~ require~~d~~ for documentation. If vital documents~~benefits~~ have~~are~~ not been acquired ~~active~~ within 30 days of the patient's discharge, the CSB shall again contact the entity	*As soon as admission occurs ~~discharge date is finalized~~* *Within three (3) business days of being requested* *Upon submission* *30 days post-discharge, and every*	~~Benefit applications~~Vital Documents: State hospital staff will verify ~~insurance and benefits~~ vital documents upon admission. State hospital staff shall initiate applications for Photo ID's, Birth Certificates~~edicare, Medicaid~~, Social Security ~~cardsb~~cards~~enefits, Auxiliary Grant~~, and other ~~financial entitlements~~documents 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~~ ~~*Note: For patients that will be applying for an Auxiliary Grant some exceptions may apply for programs with other agreements.~~ *State hospital will request that the CSB complete the SSA-1696.* To facilitate follow-up, if vital documents~~benefits~~ are not active at the time of discharge, the state	*Prior to discharge and per federal and state regulations* *When SSA benefits are being applied for*

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responsible for processing ~~the entitlement application in order to expedite benefit approval.~~	*15 days thereafter until ~~benefits are active~~acquired*	hospital shall notify the CSB of the type of ~~entitlement application~~the vital documents still needed, as well as the date it was requested~~submitted~~, and include a copy of any ~~entitl~~applications with the discharge documentation that is provided to the CSB	

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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	*Prior to discharge*

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		discharge summary is provided to the CSB responsible for discharge planning (and prison or jails, when appropriate)	~~*No later than one calendar day post-discharge*~~*~~A~~At discharge* *At discharge~~s soon as possible post-discharge~~*

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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. **see appendix for out of catchment referral 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	*Prior to discharge as soon as accepting placement is confirmed* *Prior to discharge as soon as accepting placement is confirmed*	The state hospital social worker shall indicate in the ~~medical record any possibility of a transfer out of the original CSB catchment area~~ discharge instructions the Case Management CSB and the Discharge CSB to indicate a change in CSB.	*~~Ongoing~~At discharge*

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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 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.			

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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 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* *as soon as accepting placement is confirmed*		

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	Within two (2) business days of notification of intent to transfer ~~*Prior to*~~		

	~~*discharge as soon as accepting placement is confirmed*~~		
If the two CSBs cannot agree on the transfer at discharge, they shall seek resolution from the ~~Director of Community Integration~~Director of Clinical Services (or designee). The CSB responsible for discharge planning shall initiate this contact.	~~*Within three calendar Two business days of notification of intent to transfer*~~		

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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, in the case of a minor, a minor's parent or legal guardian resides, or for adults, the~~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, or parent/legal guardian (in the case of a minor) 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:

1. 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.
2. 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.
3. 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.
4. 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

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5. 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.

Census Management Meetings:~~ definition~~ Collaborative meetings that are consistently facilitated between CSBs and state facilities in an effort to address barriers to discharge.

Comprehensive treatment planning meeting (CTP): ~~TThe meeting,~~A meeting which follows the initial treatment meeting and occurs within seven days (three days for children/adolescents) 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 (or parent/legal guardian for minors), the CSB and, with the individual's (parent/legal guardian for minors) 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, parent/legal guardian (in the case of minors) and the state hospital treatment team. This plan must include the mental health,

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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.

~~EBL:~~ Extraordinary Barriers List (EBL): ~~defi ne~~

- Patients with a civil legal status who have been identified as 1- clinically ready for discharge and who have been RFD for 31+ days with a primary need of Willing Provider, Guardianship, Individual or Guardian unwilling to work toward discharge.
- Patients with a civil legal status who have been identified as 1- clinically ready for discharge RFD for 16+ days with a primary need of DD waiver process or Other.
- Patients with other barriers not resolved after escalation

~~Process Barriers~~

EBL meeting: Refers to the twice monthly meetings for children and adolescents on the Extraordinary Barriers List at CCCA. Meetings are held every second and forth week on Tuesdays, Wednesdays, and Thursdays, and include the CCCA treatment team, community providers, case managing CSB, parent/legal guardian, DBHDS Community Transition Specialist, and other DBHDS staff and community partners as needed. These meetings focus on discharge planning, addressing the significant barriers identified by participants.

Forensic Discharge Planners (CSB); ~~Roles and Responsibilities~~ (see ~~: *from* "*DBHDS[Revised]*~~ *Forensic Discharge Planner Protocol for Community Service Boards & Local and Regional Jails," Revised ~~2018~~2023):* Refers to staff positions at the CSB that are funded by DBHDS to provide Forensic

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AMENDMENT 3

AMENDED AND RESTATED

FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT

MASTER AGREEMENT ~~FY 24-25~~

EXHIBIT K
Collaborative Discharge Requirements for
Community Services Boards and State Hospitals
~~Adult & Geriatric~~
Contract No. P1636.CSBCode.3

Discharge Planning to individuals with Serious Mental Illness (SMI) and co-occurring disorders who are in local or regional jails in Virginia. The forensic discharge planner is the single point of contact responsible for coordinating all necessary referrals and linkages within the jail and in the community upon release. This individual should be a "boundary spanner," capable of navigating various criminal justice, clinical, and social services systems to ensure proper linkage. This role involves the development of a written discharge plan which prioritizes goals and objectives that reflect the assessed needs of the inmate. It also consists of care coordination with state hospital, community providers, and community supervision agencies, including the exchange of treatment records, communication of treatment needs, and linkage of clients with available services and support options upon release. In the context of state hospital admissions of individuals admitting from or returning to jail, the FDP staff are encouraged to participate in CTP/TRP meetings for individuals that they have determined qualify for services and who will be returning to jail from the state hospital. CSBs with FDP positions should leverage those positions to support the successful transition and discharge planning of individuals returning to jail following hospital discharge.

~~Coordinate with State Hosptial social work staff when an inmate is referred for treatment – FDP will serve on the participant's treatment team in order to engage them early on, and to plan for the participant's return to jail post restoration or emergency treatment. FDP will integrate ESH discharge summary into care plan~~

~~oLinkage to a mental health provider in the community (CSB or private provider) that provides psychiatric, therapy, and/or case management services. This includes scheduling an appointment for follow-up services and providing necessary records to the provider to facilitate the intake process.~~

~~oLinkage to emergency or transitional housing (shelter, crisis stabilization, halfway houses).~~

~~oLinkage to long-term residential service providers/resources (referral to assisted living facilities, nursing homes, group homes, permanent supportive housing programs, rental assistance programs, housing grant programs, etc.).~~

~~oPhoto ID assistance (gathering necessary documentation to obtain DMV identification).~~

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~~oBirth certificate assistance (gathering necessary information and submitting application for certified copies of birth certificates).~~

~~oMedicaid and/or GAP application/reinstatement assistance (completing necessary paperwork and providing documentation to begin the process prior to release).~~

~~oTransportation assistance (providing bus tokens, cab vouchers, or providing direct transportation from the jail to the follow-up appointments/providers/discharge placement).~~

~~oEmergency food or clothing assistance (linkage to a food bank, food vouchers, clothing donation assistance centers, etc.).~~

~~oSocial Security disability/SSI assistance (completing the necessary paperwork and providing documentation to begin process of reinstatement/application prior to release).~~

~~oLinkage to medical providers for treatment of any identified medical conditions.~~

~~oConnection to community support groups (AA, NA, Grief and Loss, etc.).~~

~~oLinkage to the Department for Aging and Rehabilitative Services or other employment assistance services in the community.~~

~~oLinkage to the Department of Veterans Affairs.~~

~~oLinkage to substance use services.~~

~~oCoordination with community-based supervision (probation or pretrial).~~

~~oLinkage to peer support services (individual peer counseling or peer-led groups such as WRAP) or consumer-operated service programs.~~

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Forensic Evaluator: ~~(GET Blurb from BH)~~ A licensed clinical psychologist or psychiatrist with specialized training, education, and experience in completing forensic evaluations. ~~, trained...~~

High-Service Utilizer: A person admitted to a state hospital under a civil and/or pretrial forensic commitment 3 or more times within a 2-year period over the last 3 years. Due to the readmissions, this group may require special attention to discharge planning needs and placement in order to explore and address reasons for readmission and or repeated criminal justice involvement.

Involuntary admission: An admission of a minor that is ordered by a court through a civil procedure pursuant to § 16.1-346.1 §16.1-340-§ 16.1-345 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.

Minor: An individual who is under the age of 18 years. Any minor must have a legal guardian unless emancipated by a legal process. A minor who is 14 years of age or over must give consent for admission and treatment or a parent/legal guardian may consent to a voluntary objecting minor.

~~NGRI Coordinator (State Hospital): (DEFINE)~~

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NGRI Coordinator (CSB):

Required knowledge:

1. Understanding of the basic criminal justice process and the Virginia Code related to insanity acquittees
2. Understanding of risk assessment and risk management in the community as well as the knowledge of what community resources are needed for risk management
3. Ability to work with an interdisciplinary team
4. Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
5. 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).

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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
   b.
   ~~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~~6-month court report.~~s~~
   c.

~~Pretrial~~ Forensic Coordinator (State ~~Hosptial~~Hospital):

Required knowledge:

1. Understanding of the basic criminal justice process and the Virginia Code related to pretrial defendants
2. Serves as a liaison between the jails, courts, ~~and~~ the state hospital, the Office of Forensic Services, and the Forensic Review Panel

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3. Ability to work with an interdisciplinary team
4. Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
5. Knowledge of person-centered planning practices that emphasizes recovery principals.

Responsibilities:

1. Ensures compliance regarding admissions, transfers and discharges of patients transferred from jails or other correctional facilities in accordance with facility and Departmental policies and procedures; the laws of Virginia; court orders, NGRI Guidelines~~Manual~~, and ethical and legal standards.
2. Ensures that patients transferred from ~~jails~~ correctional facilities are served in the most appropriate level of security.
3. Works collaboratively with admissions staff to ensure forensic patients are admitted according to DBHDS guidelines/Virginia statutes.
4. Reviews forensic waitlist daily, triages patients for admissions as needed
5. Works with CSB and medical/mental health staff in ~~jails~~ correctional facilities for care coordination.
6. Reviews each court order for pretrial hospitalization, evaluation, commitment, emergency treatment or temporary custody for legal sufficiency. If indicated, works with courts and attorneys to obtain revised court orders which meet legal standards and seeks assistance from the Office of Forensic Services, if needed.
7. Reviews, approves, and signs all correspondence to courts regarding ~~pretrial~~ forensic patients to ensure that policies and procedures are followed and comply with Virginia Code.
8. Communicates/consults with treatment teams and other staff regarding management decisions for patients transferred from jails.

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9. Works closely with administrative assistant of forensic services ~~and treatment~~and treatment team(s) and courts to monitor the schedules of due dates of reports and hearing dates. Maintains current listing of all scheduled court hearings, and due dates for reports to courts; ensure that appropriate persons and entities are notified of hearing dates and ensure that reports are submitted to court(s) on time
10. Supervises or collaborates with evaluation team or assigned evaluators for DBHDS.

~~Fo~~~~Pretrial Forensic Coordinator~~~~Pretrial Forenisc~~~~Forensic Contact (CSB?)? as we know, not all CSB's have any dedicated staff focused on pretrial patients but soemone in the lagency has some degree of authority~~

Parent/legal guardian: (i) A biological or adoptive parent who has legal custody of the minor, including either parent if custody is shared under a joint decree or agreement, (ii) a biological or adoptive parent with whom the minor regularly resides, (iii) a person judicially appointed as a legal guardian of the minor or (iv) a person who exercises the rights and responsibilities of legal custody by delegation from a biological or adoptive parent, upon provisional adoption or otherwise by operation of law. The director of the local department of social services or his designee may stand as the minor's parent when the minor is in the legal custody of the local department of social services.

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.

Process Barriers: Any Barrier identified for an individual who is ready for discharge in which a CSB or State hospital process is causing a delay in movement to discharge. This includes identified CSB Tasks, Hospital tasks or Individuals with an identified discharge plan and a date is scheduled in the future.

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AMENDMENT 3

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EXHIBIT K
Collaborative Discharge Requirements for
Community Services Boards and State Hospitals
~~Adult & Geriatric~~
Contract No. P1636.CSBCode.3

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 and their parent/legal guardian (if a minor), 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 (or "initial plan of care")," which directs the course of care during the first hours and days after admission; and

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~~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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~~FY 24-25~~ **Exhibit K**

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, Forensic Discharge Planner, 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, either in the community or in a local or regional jail.~~-~~
2. CSBs will have a state hospital 30 day readmission rate of 7% or below
3. ~~C~~Civil 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 or as available.~~-~~

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FY 24-25 Exhibit K

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Adult & Geriatric

Appendix D- Admission Notifications

Individuals to include in admission notification: hospital liaison, liaison supervisor, MH/Clinical Director, ID Director if applicable

EMAIL TEMPLATE:

For the purpose of continuity of care, we are informing you that an individual was admitted to XXXX from your CSB/BHA catchment area on XXXX

Patient Name:

MRN #

Admitted under (legal status):

Social Worker:

Please respond to the questions below. In addition, if there are any of the following documents at your agency - medical/psychiatric records, most recent notes, last assessment, and medication list, please fax them to xxx-xxx-xxxx or send them via encrypted email.

Is the individual open to a core service at the CSB/BHA (if yes, specify which service)?

Person responsible for discharge planning:

Name:

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~~FY 24-25~~ **Exhibit K**

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

~~**Adult & Geriatric**~~

~~Phone:~~

~~Email:~~

~~Supervisor/administrator phone and email:~~

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FY 24-25 Exhibit K

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Adult & Geriatric

Appendix E

CSB Case Management Responsibility Dispute Process for State Hospitals, CSB, and DBHDS Central Office

The CSB shall notify the state hospital social work director (or designee), in writing, of their disagreement of case management responsibility within one business day of receiving the notification of admission.

Once the state hospital receives a dispute of case management CSB/discharge planning responsibility for the individual, the social work director or designee will coordinate with the initially identified CSB, the potential CSB who has also been identified to resolve the dispute. If this cannot be resolved within 2 business days, the Community Transition Specialist shall be notified for resolution.

If the disagreement remains unresolved, the Community Transition Specialist will review the information and provide a determination of CSB assignment within one business day.

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

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 two business days of receiving the discharge readiness notification.

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, Office of Clinical Services. This meeting shall occur within two business day of receipt of the CSB's written disagreement.

If the disagreement remains unresolved, the Central Office, Office of Clinical Services will give a recommendation regarding the patient's discharge readiness to the DBHDS Commissioner (or designee) within one business day. The Commissioner (or designee) shall provide written notice of their decision regarding discharge to the CSB executive director, state hospital director, and state hospital social work director.

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~~FY 24-25~~ Exhibit K

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

~~Adult & Geriatric~~

~~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.~~

~~Should the Commissioner (or designee) 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).~~

~~Appendix Out of Catchment Referral~~

~~*****Appendix Revised Readiness for Discharge (Non-Forensic and Forensic)~~

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