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Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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Attachments:
Appendix A: Out of Catchment Notification/Referral Form
Appendix B: Memo Regarding Patient Choice at Discharge
Appendix C: DAP Memory Care Justification Form
Appendix D: Admission Notifications
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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 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.

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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 should not be considered 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

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 (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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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.2	State hospital staff shall contact the case management CSB 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. 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	*Within one (1) business day of admission* *Within 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 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.	*Immediately upon notice of admission*

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
	Discharge Instructions in consultation with the CSB.		2. For every admission to a state hospital from the CSB's service area that is not currently an open case at that 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.	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
1.3	Upon identification that the minor admitted to the state hospital has a co-occurring diagnosis of DD/ the hospital social worker will notify the		If the minor has an DD/ and co-occurring SMI, the CSB MH and ID Directors (or their designees) will identify and	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
	designated CSB lead for discharge coordination and will: • Assist the case managers to compile the necessary documentation to implement the process for waiver and/or out of home placement. • Serve as a consultant to the DD case manager as needed; • Assist with coordinating on-site assessments by representatives from potential placement options.		inform the state hospital social worker whether the ID or MH 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 DD responsibilities include the following: 1. Assessment of the minor for Medicaid Waiver eligibility; 2. If applicable, initiate the process for Medicaid Waiver funding for the minor receiving services;	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
			3. Initiating the referral to Child REACH; 4. Participation in the development and updating of the discharge plan; 5. Participation in treatment team meetings, discharge planning meetings and other related meetings; 6. Assist in coordinating assessments; 7. Assistance in locating and securing needed specialists who will support minor in the community once they have been discharged, i.e., doctors, behavioral support; 8. Providing support during the transition to community services;	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time Frame
			9. Facilitation of the transfer of case management responsibilities to the receiving CSB or private provider according to the *Support Coordination/Case Management Transfer Procedures for Persons with Developmental Disability.*	
1.4	State hospital staff shall make every effort to contact the CSB Case Manager and legal guardian to discuss goals for treatment that will result in a timely discharge.	*Within one (1) business day of admission*	It is the joint responsibility of the hospital social worker and CSB staff to contact each other upon admission to discuss case specifics.	*Within one (1) business day*

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II. Needs Assessments & Discharge Planning

Joint Responsibility of the State Hospital & CSB				
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 for each minor. This assessment shall provide information to help determine the minor's needs upon discharge.	*Within 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: • include the anticipated date of discharge from the state facility; • identify the services needed for successful discharge, to include outpatient, educational, residential or community placement and the frequency of those services; and specify the public or private providers that have agreed to provide these services.	

2.3			The CSB shall initiate development of the discharge plan. 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-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	*Immediately upon notice of admission*

			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				
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**

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3.1	The CSB shall be notified 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 • The minor has stabilized to the extent that inpatient psychiatric treatment in a state hospital is no longer the least restrictive treatment intervention.	*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*
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 involve the participation of the hospital social worker(s).	*At 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.	

IV. Discharge Readiness Scale – Child and Adolescent

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 • 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 • 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.

V. Finalizing Discharge

Joint Responsibility of the State Hospital, CSB, and DBHDS Central Office 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, 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.			
State Hospital Responsibilities	Timeframe	CSB responsibilities	Timeframe
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 the determination that the youth is clinically ready for discharge, the CSB shall	*Within three (3) business days or five (5) calendar days of determination that individual is clinically ready for discharge*

		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.	

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.

Joint Responsibility of the State Hospital & CSB	
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."			
	State Hospital Responsibilities		**CSB Responsibilities**	**Time Frame**
5.3			All discharge plans are expected to be implemented. 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.	*Within no more than four (4) calendar days of notification of clinical readiness.*

Joint Responsibility of the State Hospital & CSB	
5.4	The 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.

VI. Completing the Discharge Process

	State Hospital Responsibilities		CSB Responsibilities	
6.1	The 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 **NOTE:**	*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:**	

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	State Hospital Responsibilities		CSB Responsibilities	
	Minor's review of the DIIF may not be applicable for certain forensic admissions due to their legal status.		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 those minors who may be returning to the community following a brief incarceration period.	
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 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			CSB staff shall ensure the coordination of any other intra-agency services, e.g. outpatient services, residential, etc.	

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	State Hospital Responsibilities		CSB Responsibilities	
6.4			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 psychiatrist. 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.	*Within seven (7) calendar days post discharge, or sooner if the minor's condition warrants.*

VII. Transfer of Case Management CSB Responsibilities

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time frame
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. 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**.**	

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	State Hospital Responsibilities	Time Frame	CSB Responsibilities	Time frame
7.2			At a minimum, the CSB shall meet (either in person, telephone, or video conferencing) with the minor and the treatment team. 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.	*Prior to the actual discharge date*

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Protocols for Adult and Geriatric Patients

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 Clinical Services (or designee) with the names of CSB personnel who are serving as the CSB's state hospital discharge liaisons, Forensic Discharge Planners, Forensic Admissions Coordinator, MH directors or supervisors, DD directors and Executive Directors	CSBs	*At least quarterly, or whenever changes occur*
The DBHDS Office 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	DBHDS Office of Patient Clinical Services	*At least quarterly*

hospital social work directors, with the expectation that these will be distributed to individual CSBs and state hospital social workers.		
DBHDS shall develop a process for developing, updating, and distributing a list of available housing resources funded by DBHDS for individuals being discharged from state hospitals. DBHDS shall review and update 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, Forensic Coordinators and Director of Psychology and Forensic Services 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 by the community transition specialist.	Office of Patient clinical Services	*Updated at least quarterly*

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*		
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*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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	*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*		
3. The individual assigned to take the lead in discharge planning will ensure that other relevant parties (CSB program	*Ongoing*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
staff, jail providers, private providers, etc.) are engaged with state hospital social work staff and attend treatment plan meetings as necessary.		all 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 twice monthly*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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 for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail

Justice-involved persons admitted from Jail or community for 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.	*Upon notice of admission*	Once admitted to a state hospital, state hospital staff shall contact the CSB designated 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 and Forensic Coordinator assigned, and the name of the admitting unit.	*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 (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*	Hospital staff will track court dates from the Virginia Judiciary Online Case Information System 2.0 found at: Virginia Judiciary Online Case Information System.	*Within seven (7) calendar days of admission; and ongoing during treatment planning*
For every 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	*Upon notice of admission*		*Ongoing, as*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB shall open the individual to consumer monitoring and assign case management and discharge planning responsibilities to the appropriate staff. For CSBs with DBHDS-funded Forensic Discharge Planning (FDP) staff positions, CSBs should 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. CSB staff shall establish personal contact (preferably in person) with the individual in order to initiate collaborative discharge	*Ongoing* *Within seven (7) calendar days of admission*	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 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 would occur before the 45 days.	*Needed*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
planning and to establish process for "warm hand-off" when returned to jail.			
The CSB's designated state hospital liaison will attend inpatient CTP and TPR meetings in person whenever possible. At a minimum, the CSB staff who is assigned lead discharge planning responsibilities shall participate in 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*	State hospital staff shall inform the CSB designated hospital liaison 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.	*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* *Ongoing*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
If CSB staff are unable to physically attend the CTP or TPR meeting, the CSB may request arrangements for video conference. 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. 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.	*Ongoing* *Within two (2) business days of the missed meeting* *Ongoing*	It is expected that the state hospital will provide alternative accommodations (such as video or phone) 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. The state hospital social worker and Forensic Coordinator will invite appropriate jail staff to participate in treatment team planning and/or discharge meetings as needed.	*Ongoing*

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Justice-involved persons admitted from Jail or community for Forensic Evaluation, Competency Restoration, or Emergency Treatment from Jail			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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 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 Forensic 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.			

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 Temporary Custody evaluation or notification that an NGRI acquittee has been	*Upon notice of inpatient admission or start of the OPTC period*	If an acquittee is admitted to a state hospital, state hospital staff shall contact the CSB NGRI Coordinator and CSB discharge planner to notify them of the new admission. Hospital staff shall provide a copy of the admissions	*Within one (1) business day of admission*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
placed on Outpatient Temporary Custody (OPTC) status. 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). 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. CSB staff shall establish a personal contact (preferably in person) with the NGRI acquittee	*Upon notice of admission or start of OPTC period* *Upon notice of admission or start of OPTC period* *Within seven (7) calendar days of*	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. 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. 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. In cases where one or both evaluators recommend conditional or unconditional release from Temporary Custody, the state	*Within (7) calendar days of admission or start of OPTC period* *Within two (2) business days* *Within one (2) business days of*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
in order to initiate collaborative discharge planning.	*admission or start of OPTC period*	hospital will notify the CSB via email of the need to prepare a written 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.	*receipt of the evaluation(s)*
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.	*Upon start of OPTC period and Ongoing*	The hospital will work jointly with the CSB in the development of the Conditional or Unconditional Release Plan.	*Ongoing*
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 deadline indicated by the state hospital*	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.	*Within two (2) business days of the court hearing or receipt of order*
If an NGRI acquittee is approved by the court for Conditional or Unconditional Release following the Temporary Custody period, the	*Upon receipt of court order approving release*		

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
CSB is responsible for implementing the release plan.			
NGRI Inpatient Commitment for Treatment			
The CSB NGRI Coordinator and/or the CSB discharge planner will attend inpatient CTP and TPR meetings in person whenever possible. At a minimum, the CSB staff who is assigned lead discharge planning responsibilities shall participate in treatment team meetings and discharge planning meetings; however, it is most advantageous if both staff can participate in treatment teams as much as possible. 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	*Ongoing* *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. 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	*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* *Ongoing*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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. 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.	*Ongoing* *Ongoing* *Within two (2) business days of the missed meeting*	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. State hospital staff shall provide notice to the CSB NGRI Coordinator of any meetings scheduled to 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	*At least two (2) business days prior to the scheduled meeting* *Within two (2) business days of identifying the need for a RMP, CRP, or UCRP*

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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.	*Within seven (7) business days of receiving the draft RMP from the state hospital* *By the deadline indicated by the state hospital*	be provided 10 business days to supply the necessary product.	
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.			

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Initial NGRI Temporary Custody Evaluation Period			
CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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 at the point of admission and continues throughout hospitalization. This should include those released at hearing. In completing the discharge plan, the CSB shall consult with the individual, members of the treatment team, the surrogate decision maker, and (with consent) family members or other parties, to determine the preferences of the individual upon discharge. The CSB shall obtain required releases of information. The discharge plan shall include: • The anticipated date of discharge from the state hospital • The identified services needed for successful community placement and the frequency of those services	*At admission and ongoing thereafter* *At admission and ongoing thereafter* *As soon as possible upon admission and ongoing*	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 72 hours as noted by TJC)* *Ongoing*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
• The specific public and/or private providers that have agreed to provide these services • If returning to jail, outline a plan for CSB follow-up in the jail until the individual's 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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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 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 • Substance Use Services • PHP/IOP • Individual/group therapy • Other relevant services	*Within five (5) 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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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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. For medications that are not on the jail formulary but that the prescriber believes is necessary for patient care, the current prescriber 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.	*Ongoing*
NGRI Acquittees: The CSB Executive Director shall appoint an individual with the	*Ongoing;*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
appropriate knowledge, skills, and abilities to serve as NGRI Coordinator for their agency (please see glossary for specific requirements)	*Changes in assigned NGRI Coordinator should be communicated to DBHDS Central Office Forensics staff within two (2) business days*		
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 discharge, they shall notify the state hospital to begin the process of referral for a DBHDS guardianship slot. They will provide relevant documentation of attempts to find suitable guardian.	*Within two (2) business days of notification* *Within ten (10) business days of notification of need for a guardian*	**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. 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.	*Ongoing* *Within two (2) business days of determination*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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 shall retain an attorney on behalf of the individual to file a guardianship petition with the court.	*Immediately upon notification of acceptance by the guardianship program*	If notified by the CSB that a suitable candidate for guardianship cannot be located, the state hospital shall begin the process of referring the individual to DBHDS Central Office for a DBHDS Guardianship slot. This referral shall include a comprehensive assessment of the individual's lack of capacity, and potential for regaining capacity. This assessment shall be shared with the CSB upon completion by the evaluating clinician. Guardianship referrals required for forensic patients hospitalized for restoration should be submitted immediately upon being found unrestorably incompetent to stand trial (URIST) by the court.	*Immediately upon notification by the CSB of the need for a DBHDS guardianship slot*
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.			

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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*
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.	*As soon as accepted to PSH program*		
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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.	*Upon request*
The CSB shall obtain required documentation and send the referral packet to the transitional program.	*Within two (2) business days of becoming discharge ready level 2*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for transitional application	*Within one (1) business day of request from CSB*
CSB will refer to PSH prior to discharge if the individual will transition to PSH upon completion of transitional program.	*Simultaneously with referrals for transitional*	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.	*Prior to discharge*
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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	*Upon request*
The CSB shall obtain required documentation and send the referral packet to mental health group homes.	*Within two (2) business days of becoming discharge ready level 2*	The state hospital will provide any copies of vital records and financial (benefits) information to the CSB for transitional application	*Within one (1) business day of request from CSB*
If a patient is denied, the CSB should attempt to obtain the reason for denial	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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.	*As soon as an ALF is being considered, and prior to the individual being determined to be RFD*	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*
The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.	*Within one (1) business day of receiving the UAI*	The state hospital shall transmit the UAI and DMAS- 96 to the CSB	*Immediately upon completion of the UAI*
		The state hospital shall assist the CSB in the facilitation of interviews/assessments required by potential ALF providers	*Upon request*
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	*Within two (2) business days of sending the referral and at least weekly thereafter*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
reached or the patient discharges to a different placement. If a patient is denied, the CSB should attempt to obtain the reason for denial 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.	*Upon notice of denial* *Prior to referring to private pay Memory Care units*		
Nursing home (NH) referrals: The CSB shall obtain verbal consent and releases from the individual or the surrogate decision maker to begin initial contacts regarding bed availability and willingness to consider the individual for placement.	*As soon as an NH is being considered, and prior to the individual being determined to be RFD*	**Nursing home (NH) referrals:** The state hospital shall complete the UAI	*Within five (5) business days of the individual being found discharge ready level 2*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB shall obtain required documentation and send referral packets to multiple potential placements. The referrals are to be sent simultaneously.	*Within one (1) business day after receiving the UAI*	For individuals who require PASRR screening, the state hospital shall send the referral packet to Maximus.	*Within one (1) business day of RFD date*
		The results of the level 2 PASRR screening shall be transmitted to the CSB.	*Immediately upon receipt of the screening results*
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*	The state hospital shall assist the CSB in the facilitation of interviews/assessments required by potential nursing home providers.	*Upon request*
If a patient is denied, the CSB should attempt to obtain the reason for denial.	*Upon notice of denial*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Shelter 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*	**Shelter placements:** If discharge to a shelter is clinically recommended and the individual or their surrogate decision maker agrees with this placement, the hospital social worker shall document this recommendation in the medical record. The hospital social worker shall notify the director of social work when CSB consultation has occurred. The director of social work shall review the plan for discharge to a shelter with the medical director (or their designee). Following this review, the medical director (or designee) shall document endorsement of the plan for discharge to a shelter in the individual's medical record. In the case of out of catchment shelter placements, hospital staff shall notify both the CSB responsible for discharge planning, as well as the CSB that serves the catchment area of the shelter.	 *Prior to discharge*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
Individuals with a developmental disability (DD) diagnosis:		**Individuals with a developmental disability (DD) diagnosis:**	
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.	*Within one (1) business day 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). 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.	*Immediately upon notification of diagnosis* *Ongoing*
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 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 ten (10) business days of request for services*	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 include conducting psychological testing and assessments as needed.	*Ongoing. Required psychological testing and assessment shall be completed within 21*

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB shall assist in scheduling tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*Immediately upon notification of need*	The state hospital shall serve as a consultant to the DD case manager as needed.	*calendar days of referral* *Ongoing*
The CSB shall locate and secure needed specialists who will support the individual in the community at discharge.	*Within three (3) business days of admission*	The state hospital shall assist with coordinating assessments with potential providers.	*At the time that the individual is rated a discharge ready level 2*
If the individual is moving outside their home area, the CSB shall notify the CSB in which the individual will reside upon discharge	*Upon admission and ongoing*	The state hospital shall facilitate tours/visits with potential providers for the individual and/or the individual's surrogate decision maker.	*Ongoing*
If it is anticipated that an individual with a DD diagnosis is going to require transitional funding, the CSB shall complete an application for DD crisis funds.	*Immediately upon notification of need*	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.	

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
The CSB will maintain contact with all service providers to ensure timely completion of tasks required for discharge.	*Ongoing*		
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: • 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 • Support training for residential provider staff	*As needed*		

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
• Private duty or skilled nursing • Day Services			

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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 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* *Within one (1) business day*
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.	*Weekly by Close of business Friday*	The state hospital shall use encrypted email to provide notification to each CSB's liaison, DS director if applicable 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	*Weekly, no later than Wednesday*

		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. **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	

VIII. Finalizing Discharge

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

Please see EBL definition in Glossary.

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.	*Within seven (7) calendar days of determination that individual is clinically ready for discharge*		

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.			
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.	*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.	*Prior to discharge*

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.		**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	
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. If a trial pass is approved, the CSB will take the lead on planning to include collaborating with the hospital on transportation, The CSB shall check in daily with the identified provider to include any problem	*Prior to discharge, as needed* *Once approved* *Daily*	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. This will include set time and completion of an approved pass form with contacts, obligations, and agreement from facility to hold the individual.	*Upon request* *Upon request*

solving for issues that may arise. The CSB will keep the hospital informed. If the trial 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.	*As needed*		

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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.	*Prior to and following discharge*	The state hospitals shall provide medication and/or prescriptions upon discharge.	*At discharge*
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.	*Within seven (7) calendar days, or sooner if the individual's condition warrants*		
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 of discharge*		

AMENDMENT 3

AMENDED AND RESTATED

FY2026 AND FY2027 COMMUNITY SERVICES PERFORMANCE CONTRACT

MASTER AGREEMENT

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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 notify the CSB of the type of entitlement application, as well as the date it	*Prior to discharge and per federal and state regulations* *When SSA benefits are being applied for*

		was submitted, and include a copy of entitlement applications with the discharge documentation that is provided to the CSB.	

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Vital Documents: 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 cannot provide those. 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 these items (SSA, DMV, VDH, etc.) to ensure that the information has been received and what these entities may require for documentation. If vital documents have not been acquired within 30 days of the patient's discharge, the CSB shall again contact the entity responsible for processing.	*As soon as admission occurs* *Within three (3) business days of being requested* *Upon submission* *30 days post-discharge, and every 15 days thereafter until acquired*	**Vital Documents:** State hospital staff will verify vital documents upon admission. State hospital staff shall initiate applications for Photo ID's, Birth Certificates, Social Security cards, and other documents as necessary. Applications shall be initiated in a timely manner per federal and state regulations *State hospital will request that the CSB complete the SSA-1696.* To facilitate follow-up, if vital documents are not active at the time of discharge, the state hospital shall notify the CSB of the type of the vital documents still needed, as well as the date it was requested, and include a copy of any applications with the discharge documentation that is provided to the CSB	*Prior to discharge and per federal and state regulations* *When SSA benefits are being applied for*

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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.	*Prior to discharge* *At discharge* *At discharge*

		The state hospital medical director shall be responsible for ensuring that the physician's discharge summary is provided to the CSB responsible for discharge planning (and prison or jails, when appropriate)	

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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.	*Prior to discharge as soon as accepting placement is confirmed*	The state hospital social worker shall indicate in the discharge instructions the Case Management CSB and the Discharge CSB to indicate a change in CSB.	*At discharge*
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	*Prior to discharge as soon as accepting placement is confirmed*		
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			

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
decision maker wish to keep services at the original CSB, while living in a different CSB catchment area. For individuals who are enrolled in CSB DD services, please follow the *Transferring Support Coordination/DD Waiver Slots* policy.			
At a minimum, the CSB responsible for discharge and the CSB that serves the discharge catchment area shall collaborate prior to the actual discharge date. The CSB responsible for discharge planning is responsible for completing the discharge plan, conditional release plan, and safety and support plan (if indicated), and for the scheduling of follow up appointments. While not responsible for the development of the discharge plan and the safety and support plan, the CSB that serves the catchment area where the patient will be discharged should be	*Prior to discharge as soon as accepting placement is confirmed*		

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
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.	*Within two (2) business days of notification of intent to transfer*		
If the two CSBs cannot agree on the transfer at discharge, they shall seek resolution from the Director of Clinical Services (or designee). The CSB responsible for discharge planning shall initiate this contact.			

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

CSB responsibilities	Timeframe	State hospital responsibilities	Timeframe
NGRI Acquittees: The *Guidelines for the Management of Individuals Found Not Guilty by Reason of Insanity (Revised 2023)* indicate that individuals who have been found not guilty by reason of insanity may take up residence in any area of the state of their choosing. They are not required to return to the area from which they were originally acquitted by reason of insanity, nor to the jurisdiction where they lived prior to admission. All referrals for CSB case transfer of NGRI acquittee shall follow the standard transfer process as described above, including use of the Out of Catchment Notification/Referral Form (see appendix). CSBs shall not refuse to accept transfer of an NGRI case transfer unless they can clearly demonstrate that the necessary services or supports required to manage the acquittee's risk are unavailable through the CSB or private providers in the area and that the transfer would create increased risk to the community or the acquittee as a result. The CSB's current NGRI caseload size shall not be a reason for refusal to accept transfers. The court of jurisdiction MUST approve the placement for an insanity acquittee and their responsible CSB prior to placement in the community. This information will be identified in the proposed conditional release plan prepared by the referring CSB (with input from the receiving CSB).			

Exhibit K
Collaborative Discharge Requirements for Community Services Boards and State Hospitals

Contract No. P1636.CSBCode.3

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 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, 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 affect a smooth transition and discharge. The CSB responsible for discharge planning is ultimately responsible for the completion of the discharge plan. Reference in these protocols to CSB means CSB responsible for discharge planning, unless the context clearly indicates otherwise.

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

- When the individual's living situation is unknown or cannot be determined, or the individual lives outside of Virginia, the CSB responsible for discharge planning is the CSB which completed the pre-screening admission form.
- For individuals who are transient or homeless, the CSB serving the catchment area in which the individual is living or sheltered at the time of pre-screening is the CSB responsible for discharge planning.
- When a CSB other than the pre-screening CSB is continuing to provide services and supports to the individual, then the CSB responsible for discharge planning is the CSB providing those services and supports.

- For individuals in correctional facilities, in local hospitals, or Veteran's Administration facilities, or in regional treatment/detox programs, the CSB responsible for discharge planning is the CSB serving the catchment area in which the individual resided prior to incarceration, or admission to local hospitals, Veterans Administration facilities, or regional detox programs
- In instances in which there is a dispute related to which CSB is responsible for discharge planning, the state hospital will work collaboratively with the CSBs involved to determine which CSB is responsible within two business days. If resolution cannot be reached, the state hospital will contact their Community Transition Specialist who will make a determination based on the available information.

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

Comprehensive treatment planning meeting (CTP): 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, 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.

Extraordinary Barriers List (EBL):

- 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

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 fourth 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): (see *"DBHDS Forensic Discharge Planner Protocol for Community Service Boards & Local and Regional Jails," Revised 2023):* Refers to staff positions at the CSB that are funded by DBHDS to provide Forensic 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.

Forensic Evaluator: A licensed clinical psychologist or psychiatrist with specialized training, education, and experience in completing forensic evaluations.

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 developmental disability. This evaluation and determination are 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 (CSB):

Required knowledge:

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

Responsibilities:

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

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

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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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Forensic Coordinator (State Hospital):

Required knowledge:

- Understanding of the basic criminal justice process and the Virginia Code related to pretrial defendants
- Serves as a liaison between the jails, courts, the state hospital, the Office of Forensic Services, and the Forensic Review Panel
- Ability to work with an interdisciplinary team
- Ability to communicate well, particularly knowledge of how to write to the court and how to verbally present information in a courtroom setting
- Knowledge of person-centered planning practices that emphasizes recovery principals.

Responsibilities:

1. 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, and ethical and legal standards.
2. Ensures that patients transferred from 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 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 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.
9. Works closely with administrative assistant of forensic services 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.

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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Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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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 or psychosocial representative, 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
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.

Exhibit K

Collaborative Discharge Requirements for Community Services Boards and State Hospitals

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. Civil Patients followed by CSBs will have an average length of stay on the extraordinary barriers list (EBL) of 60 days or less. 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 or be offered as a dashboard.