



Virginia Department of  
Behavioral Health &  
Developmental Services

# State Hospital Census Management Information

SJ 47 System Structure and Finance Expert Panel

# Unsustainable Hospital Census

- The nine state mental health hospitals are weathering a 157% increase in TDO admissions and a 54% increase in total admissions since FY 2013 following the passage the General Assembly's last resort legislation.
- The hospitals are now consistently running at an unsustainable 95% occupancy or higher. Best practices show that occupancy over 85% is considered less safe for patients and staff.
- At times, several hospitals have been at 100% and occasionally a hospital has had to use a temporary bed.
- The hospitals have sustained an overall 17% (\$9.6 million) administrative services reduction to their budgets over the past decade.
- Direct care turnover rates across the state hospitals increased from FY 2014 to FY 2015 to 30%. The use of overtime has increased. In addition, the average salary across the hospitals trails the national market by 13%.

# Additional Hospital Pressures

- State hospitals maintain an extraordinary barriers to discharge list (EBL) for people who are clinically ready to discharge but cannot leave because the right community services, such as appropriate housing, are not available.
- In September 2016, there were 182 individuals on the statewide EBL.
- While costs may continue in the community for those eventually discharged from the EBL and some of the vacated hospital beds may be filled, individuals on the EBL in 2015 used bed days that equate to the operational budget of a 122-bed state hospital, or a cost of about \$30 million.

# May 10, 2016

**From:** Barber, Jack (DBHDS)  
**Sent:** Tuesday, May 10, 2016 1:14 PM  
**To:** # DBHDS Mental Health Facility Directors (DBHDS); [CSB Executive Directors]  
**Cc:** Herr, Daniel (DBHDS); Drumwright, Kathy (DBHDS); Darr, Don (DBHDS); 'Jennifer Faison'  
**Subject:** State Hospital Bed Utilization

I am writing to speak candidly about state hospital utilization, recognizing that there will be some divergent views.

The state hospitals and CSBs, as well as private hospitals, have done a *remarkable* job responding to the demand that can be associated with the “last resort” legislation. In FY15 there were 229 evaluations each day and 68 TDOs. 93% of the TDOs went to private hospitals, representing a 14% increase relative to FY13. While state hospitals received just 7% of the total number of TDOs this represented an increase of 39% over FY13 and featured increased numbers of individuals with primary substance use issues, TBI, and developmental disabilities. Medical co-morbidity also increased resulting in escalating medical costs.

While the response has been very effective we are beginning to receive more and more complaints from the CSBs about the difficulty of access for emergency evaluators and, indeed, access to CCCA has been extremely difficult of late (more on that later). Overtime, incidents, and staff attrition have been the consequences for the hospitals, some of which are too consistently running at 95-96% occupancy (well above the recommended “safe” level of 85%). Not surprisingly then we have emergency evaluators who are more frustrated and hospitals that are less safe.

While I do not think it would be too difficult to get the General Assembly to add beds, since there is some predilection for that already, I also do not think that there will be BOTH increased funding for beds and increased funding for improved community services. Rather, I think we would simply shift more toward hospitals and that, in some amount of time, will find that the added beds were not sufficient (since little or nothing would have been done to improve access and effectiveness of non-emergency services). In the meantime, the high use of crisis services will continue and we will continue to spending much time and effort in the highest risk piece of the system, where individuals are most likely to come to harm.

The only path through this is to operate the state hospitals at 90% or below occupancy. That will make them safer and will not add further pressure to the emergency response system. This is a complicated task since it involves a great many individually focused decisions to reach the aggregate result. While there may be some room for improved diversion the bulk of this effort will, I believe, have to come from aggressive, persistent, discharge aligned treatment in the hospitals and more expeditious discharge of individuals when clinically ready for discharge, especially for individuals not faced with “extraordinary barriers”. Whether there are processes that need to be adjusted on the part of either state hospitals or CSBs I do not know. What I do know is that utilization management performed at the point of a crisis situation is a much greater risk than staying on top of it during the course of treatment AND that it cannot be done unilaterally either by a hospital or a CSB. I also think that if we all treat 90% as the threshold for alert we are going to do better than waiting until we are at 95% or 100%.

As for CCCA, this is a different animal really. Its census goes up when all other child/adolescent options are up, always during the school year, and in waves. Last week we had 51 kids in the hospital while purchasing 18 beds at Poplar Springs as a rather typical example of such a situation. In the summer the census will be down dramatically, typically into the 20s and occasionally even lower. The hospital features a mixture of adolescents (and younger kids) with autism spectrum disorders, psychosis, DJJ involved behavioral issues, other conduct disorders, adjustment disorders, intellectual disabilities, and so forth. When that disparate cohort of kids gets crowded into the units the risks become very high, especially for the less physically or intellectually robust. We cannot do more than fight our way through it this spring, but will engage a review process with CCCA over the summer to assure that the clinical and discharge processes are well aligned with what has become their new “mission”, that we identify any consistent reasons for delaying discharges (e.g. DSS placements), and basically try to be sure the operation is lined up the best we can to move kids through and avoid the kinds of situations like we had last week and are still on the edge of today.

I look forward to hearing any thoughts you may have and to discussing further with you. In the meantime, I encourage you to discuss in your regions and hospitals.

# June 27, 2016

**From:** Barber, Jack (DBHDS)

**Sent:** Monday, June 27, 2016 10:09 AM

**To:** Barber, Jack (DBHDS); # DBHDS Mental Health Facility Directors (DBHDS); [CSB Executive Directors]

**Cc:** Herr, Daniel (DBHDS); Drumwright, Kathy (DBHDS); Darr, Don (DBHDS); 'Jennifer Faison'

**Subject:** RE: State Hospital Bed Utilization

- In May, TDOs to private hospitals declined further to 81.1%. The state hospital TDOs increased to 444, 68 more than any prior month (April, which was 79 higher than any prior month) and 3.5 times the FY15 monthly average. This past weekend we were diverting from four facilities to other state hospitals, complicating DC planning and creating multiple operational problems.
- For FY16 TDO admissions to private hospitals have increased 4.9%, but TDO admissions to state hospitals have increased **116.9%**. The EBL list continues to run at 160 or so.
- Any efforts to mitigate this situation are best developed locally and regionally. Hopefully, we are already discharging faster when individuals have a place to go, trying to engage private hospitals, expediting returning jail patients back to jail, and so forth, but I am too far away from it to know what all has been and what the next steps would be. It is an extremely difficult situation.

# August 2, 2016

**From:** Barber, Jack (DBHDS)  
**Sent:** Tuesday, August 02, 2016 5:00 PM  
**To: Subject:** RE: State Hospital Bed Utilization

Since the “last resort” legislation took effect in July, 2014 admissions to state hospitals have increased 42% (4275 in FY14 to 6082 in FY16). TDO admissions to state hospitals have increased 164% (1319 in FY14 to 3477 in FY16). Starting in January, 2016 the TDOs to state hospitals progressed as follows: 263 > 278 > 297 > 376 > 444 > 413 . We have continued to divert from one state hospital to another intermittently. The EBL continues to run in the 150 range and, as you know, does not capture everyone who is clinically ready for discharge. Virginia has 17.3 state beds per 100,000 compared to a national average of 15, a difference that amounts to about 165 beds or so. Building on the prior two emails, the plain fact of the matter is that state hospital utilization must go down in order for the hospitals to operate safely and have beds within the correct catchment area when they are needed.

Since I believe that we will produce better, more cost effective services and be stronger if we are a more integrated system I believe we need an integrated approach to this problem, an approach that better distributes to current tension and makes all of us more accountable for how we use this most expensive resource. In my mind I believe we will need to deliver some funds to CSBs up front in order to add capacity and add performance targets with cost consequences for state hospital utilization. For this to be effective it is going to need to be something we work out together so that we set the best parameters possible. Someone may, of course, have a better idea and, if so, I would be very happy to hear it.

While private hospitals continue to take the great majority of TDO admissions, the percentage has dropped. From their report the issue is behavioral or medical acuity, but it may be we need to think about other ways to purchase the beds. Not sure. I also have questions about whether this issue is best addressed on the front door when there is evidence of a crisis and risk.

My deep concern as legislators see the state hospital census rapidly increasing is the application of a seemingly quick and easy solution to add more beds. We will be back to building a hospital system instead of building a community system. Adding beds will take the system in the wrong direction, basically adding beds for individuals who do not clinically need them, and that the current trajectory we are on, which has resulted in the problem being worse now than when I wrote to you in May, is not tenable. It has reached the point that substantive attention is needed sooner than later.

We will start with your leadership to determine the best way to begin our work on this.

Thank you.

# Community Services Boards

- Meet with ES staff: what would allow you to comfortably not admit some of the people now being sent to SH, what resources or options are missing?
- Training in clinical risk mgt and avoiding lawsuits: it is bad feeling rather than bad outcomes that lead to almost all suits
- Review data re releases at hearing
- Meet with private hospitals re capacity and willingness
- Weekly meeting to review SH cases: who can we get out?
- Daily notice of diversions with weekly review of status

# State Hospitals

- Impressing on all teams the necessity of discharge as soon as safe/ready, especially those with a place to go
- Mechanism to transfer individuals post hearing to private hospital when have benefits
- Keeping good data on admissions: TDOs, SUDs, diversions, medical , DC at hearing, and trending. Communicate to region's CSBs monthly
- Bed utilization/100,000 presented monthly to CSBs in regional meeting along with admissions and discharge data
- Monthly CM meeting with SWs and CSB liaisons reviewing cases rated 1 and 2. Follow-up as indicated by SW Director, Clinical Director, or Director to commensurate person in CSB
- Local discharge assistance fund to assist or expedite discharges
- Provisions for prompt transportation when needed to effect DC
- Join CSBs for discussions with private hospitals



# DBHDS Actions: May 2016 to Date

CSB	Source	Amount	Purpose	Email Date
Fairfax	PGH	750,000	EBL/Incentives	5/11/2016
Hampton	ESH	875,000	EBL/Incentives	5/11/2016
Rapp. Area	PGH	860,000	DAP	
Rapp. Area	WSH	1,540,000	DAP	
Rapp. Area	WSH	1,300,000	EBL/Incentives	5/11/2016
Danville	SVMHI	400,000	EBL/Incentives	5/11/2016
Danville-Pitt	SVMHI	68,400	DAP	4/22/2016
Danville-Pitt	SVMHI	14,500	DAP	
Danville	SVMHI	350,000	LIPOS	
Mount Rogers	SWVMHI	263,500	Census Reduction	
RBHA	CSH	1,175,000	EBL/Incentives Strengthen Medical Services	5/11/2016
Region Ten	WSH	1,100,000	for Detox	
Region 1	WSH	<u>25,000</u>	EBL Reduction	
	<b>Total</b>	<b>8,721,400</b>		

*Also included:*

- *Gateway Homes, Williamsburg*
- *Contract for ten beds: Poplar Springs Hospital*

# Region I (October 2016 – March 2017)

CSB	Proposed Use of Funds	Targeted Census Reduction
<b>Region I</b>	For SUD residential, detox, CSU. Transportation costs for these admissions as needed.	<b>10%</b>
<b>Alleghany-Highlands</b>	Expand New Beginnings Transitional Housing to include 3 transitional long or short terms beds	<b>10%</b>
<b>Horizon</b>	<ol style="list-style-type: none"> <li>1. Support for Suboxone Clinic</li> <li>2. Expand Medical Detox program from 6 to 10 beds</li> <li>3. Expand CSU from 10 to 16 beds</li> <li>4. Lease medication dispensers to allow for 24 hour medication administration</li> <li>5. Hire FT peer position to provide transportation</li> </ol>	<b>10%</b>
<b>Rockbridge</b>	Establish forensic psychiatric services at Rockbridge Regional Jail	<b>10%</b>

# Region II (October 2016 – March 2017)

Proposed Use of Funds	Targeted Census Reduction
<ol style="list-style-type: none"><li>1. Start up a 6 bed ALF for geriatric discharges and diversions</li><li>2. LIPOS funding to divert geriatric admits</li><li>3. DAP funding to expedite geriatric discharges</li><li>4. CSB bonuses in December 2016 and June 2017 if region meets reduction goal</li></ol>	<b>10%</b>

# Region III (October 2016 – March 2017)

Proposed Use of Funds	Targeted Census Reduction
<ol style="list-style-type: none"><li>1. Extend the capacity of services provided by licensed SA providers</li><li>2. Fund transportation vouchers to/from SA treatment</li><li>3. Provide vouchers to individuals at high risk of homelessness related to their SA and psychiatric crises</li><li>4. Mt. Rogers CSB to assist them in pursuing portable auxiliary grant funding options</li></ol>	<b>10%</b>

# Region 3.b (October 2016 – March 2017)

Proposed Use of Funds	Targeted Census Reduction
<ol style="list-style-type: none"><li>1. PCPs for telepsychiatry options;</li><li>2. staff support and peer volunteers to provide one on one care, support, and assistance to families;</li><li>3. incentives to private hospitals with psychiatric units to accept geriatric patients;</li><li>4. geriatric guardianship and legal consultation team</li><li>5. obtain regional training related to entitlements, waivers, and additional geriatric programs;</li><li>6. assist with training and arrange for consultation of a geriatric specialist;</li><li>7. fund a regional case manager position</li></ol> <p>CSB incentives: January-April 2017 May-October 2017</p>	<b>10%</b>

# Region IV (October 2016 – March 2017)

Proposed Use of Funds	Targeted Census Reduction
<ol style="list-style-type: none"><li>1. Incentives to private hospitals to admit challenging patients</li><li>2. Start up mobile crisis stabilization services</li><li>3. Individualized Services Fund that would be accessed through the RAC process to address specific one-time needs that would divert an admission.</li><li>4. Start up funding for transitional beds</li><li>5. Funding for Regional Housing Specialist position</li><li>6. Implementation of a new data management system</li></ol>	<b>10%</b>

# Region V (October 2016 – March 2017)

CSB	Proposed Use of Funds	Targeted Census Reduction
<b>Chesapeake</b>	<ol style="list-style-type: none"> <li>1. Fund a Peer Bridger program.</li> <li>2. Divert emergency contacts and engage individual's pre and post admissions to ESH.</li> </ol>	<b>10%</b>
<b>Colonial</b>	<ol style="list-style-type: none"> <li>1. Supplement a team based approach to local diversion by providing short term community support to the adult and geriatric populations.</li> <li>2. Provide various types of respite options with "close" wraparound services at ALFs and others to avoid hospitalization.</li> </ol>	<b>Supp</b>
<b>Eastern Shore</b>	<ol style="list-style-type: none"> <li>1. Fund a specialized special project position.</li> <li>2. Provide more complex geriatric and adult discharge planning and advocacy to geriatrics and adults.</li> <li>3. Provide necessary intensive level of services to divert individuals identified by ESH that are at risk of hospitalization and use of safety net bed.</li> </ol>	<b>10%</b>
<b>Hampton-Newport News</b>	<ol style="list-style-type: none"> <li>1. Fund an additional staff to the hospital liaison/discharge planning team that will focus toward more timely discharge and transfer.</li> <li>2. Provide a more active working relationship with ESH staff.</li> <li>3. Provide case specific work with designated identified persons.</li> </ol>	<b>10%</b>
<b>Middle Peninsula-Northern Neck</b>	<ol style="list-style-type: none"> <li>1. Fund increased staff levels at Discovery 1 and Discovery 2 utilized for individuals requiring more intensive services.</li> <li>2. Divert individuals from having to be admitted to acute care.</li> <li>3. Assist in discharging persons from ESH.</li> </ol>	<b>10%</b>
<b>Portsmouth</b>	<ol style="list-style-type: none"> <li>1. Fund an emergency service/hospital discharge clinician to assist in screening of individuals in the community to divert them from a psychiatric admission to ESH.</li> <li>2. Fund an emergency services/hospital discharge clinician to focus on aggressive discharge planning for the geriatric population at ESH.</li> <li>3. Complete applications for entitlements for individuals residing at ESH.</li> <li>4. Coordinate enhanced wrap-around services for individuals that have a high rate of using state and local facilities.</li> </ol>	<b>10%</b>

# Region V (October 2016 – March 2017)

CSB	Proposed Use of Funds	Targeted Census Reduction
<b>Norfolk</b>	<ol style="list-style-type: none"> <li>1. Fund a special project position or a temporary agency staff position for the Community Integration Team.</li> <li>2. Provide intensive work with case specific support that could include four specific populations.</li> </ol>	<b>10%</b>
<b>Virginia Beach</b>	<ol style="list-style-type: none"> <li>1. Divert older individuals (65 years old and above) from state inpatient hospitalization or expedite discharges from the state facility safety net bed and promote community based solutions.</li> <li>2. 1:1 support either during the crisis episode or as part of the discharge plan to encourage local facilities to accept these individuals into their facilities.</li> <li>3. Flag geriatric evaluations for ES leadership by scheduling a clinical staffing on the next business day.</li> <li>4. Review by Senior Services staff on older individual cases and provide recommendations for discharge plans.</li> <li>5. LIPOS funding to divert adult civil and NGRI admissions.</li> </ol>	<b>10%</b>
<b>Western Tidewater</b>	<ol style="list-style-type: none"> <li>1. Divert geriatric individuals (defined as 65 and older) and adults from state inpatient hospitalization or expedite discharges from the state facility safety net bed.</li> <li>2. Fund state hospital discharge and diversion liaison services specifically for these populations.</li> <li>3. 1:1 support for the geriatric individuals and adults either during a crisis episode or as part of the discharge plan to encourage local facilities to accept these populations into their facility.</li> <li>4. Flag geriatric and state hospital evaluations for the ES leadership team by scheduling a clinical staffing on the next business day.</li> <li>5. Coordinate with crisis service staff to ensure 1:1 community based supports for Ambulatory Crisis Stabilization are available upon discharge.</li> <li>6. Ensure same day access to community based treatment and supports including rehabilitation services such as PSR and MHSS where appropriate.</li> <li>7. Partner with The Road2Home project at Norfolk CSB under the CABHI Initiative to secure stable housing.</li> </ol>	<b>10%</b>



# Recent DAP Plan Successes

- Region I received \$1,540,000 in additional DAP to bridge funding until new DAP from the GA was available and to support additional plans for people who were discharge ready but needed funding.
- 39 individuals were discharge from WSH using the funds (24 with ongoing DAP, 15 with one-time DAP). 2 individuals on NGRI status are using the funds to support community transition passes. There are funds remaining that will be assigned to new DAP plans.
- Region I received \$860,000 of additional DAP to support individuals discharged from state geriatric facilities. 5 individuals have been discharged using the funds and 5 more plans are approved for geriatric individuals approaching discharge.
- Region 3.b. was given \$14,500 for DAP to support 2 geriatric discharges and \$68,400 to support an NGRI transition and discharge. 2 geriatric individuals were discharged and the NGRI is utilizing the funds for community transition passes. Some funds remain because the geriatric plans did not require the full amount that was anticipated.

# Services to Improve State Hospital Census

Service	Description
<b>Performance-based contracts with select private hospitals (across the life span)</b>	Ease the front door pressure on state hospitals by purchasing beds in private hospitals for acute psychiatric treatment, especially TDOs.
<b>Community detox and sobriety services for individuals in crisis</b>	Detoxification is the medical process of withdrawing a person from drugs or alcohol on which he or she had become dependent. It is considered the first step in rehabilitation. Establish minimum level of detox capacity for each region based upon population and prevalence rates and would develop crisis capacity for detoxification at private hospitals or crisis stabilization units.
<b>Housing</b>	The availability of housing is one of the most significant issues for people with serious mental illness. The lack of adequate housing may lead to a mental health crisis or interaction with the criminal justice system, and it may lead to the inability of state hospitals to safely discharge individuals. Expand transitional housing through DBHDS-licensed group homes in each region, transitional and supervised apartments and supportive housing programs. Increase permanent supportive housing and contract to purchase assisted living facility and appropriate nursing home beds.

# Services to Improve State Hospital Census

Service	Description
<b>Children's crisis response</b>	The goal of children's crisis services is to respond immediately to crises and maintain children with or as close to their families as possible. Fund uniformly across all regions a core set of required services, including ambulatory and residential crisis stabilization, access to psychiatric services, and full integration with respite services.
<b>Discharge Assistance Program (DAP)</b>	DAP provides funds to pay for the specific community services that a specific individual would need to be discharged successfully from a hospital. Identify areas to develop individual and system capacity across the lifespan, establish transitional housing, lease apartments and establish day support funding for rehabilitative services for individuals with specialized needs across the lifespan. This would help address the EBL.
<b>Multi-disciplinary regional support teams</b>	Provide expert assistance to assisted living facilities and nursing homes to manage individuals with challenging behaviors and complex medical/clinical conditions and help enable them to stay in the community.