OFFICE OF THE STATE INSPECTOR GENERAL
Report to Governor McAuliffe and the Virginia General Assembly

Review of the Virginia Acute Psychiatric and Community Services Board Bed Registry

June W. Jennings, CPA
State Inspector General
Report No. 2016-BHDS-001

COMMONWEALTH OF VIRGINIA

Office of the State Inspector General

June W. Jennings
State Inspector General

Post Office Box 1151
Richmond, Virginia 23218

Telephone (804) 625-3255
Fax (804) 786-2341
www.osig.virginia.gov

January 28, 2016

The Honorable Terence R. McAuliffe
Governor of Virginia
Patrick Henry Building, Third Floor
1111 East Broad Street
Richmond, VA 23219

Members of the Virginia General Assembly
General Assembly Building
1000 Bank Street
Richmond, VA 23219

Dear Governor McAuliffe and Members of the General Assembly:

The Office of the State Inspector General (OSIG) conducted a review of the web-based Virginia Acute Psychiatric and Community Services Board Bed Registry (registry) pursuant to *Code of Virginia (Code)* § 2.2-313[D] and respectfully submits this report as required by *Code* § 2.2-313[E].

The purpose of the project was to review the following:

- Utility of the registry as a tool for Community Services Board (CSB) emergency services staff to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals including the registry's successes, challenges, and efficiencies.
- Impact of current registry-related operations on CSBs, state-operated facilities, private inpatient psychiatric facilities, public and private residential crisis-stabilization units, Department of Behavioral Health and Developmental Services (DBHDS), and individuals served.

Overall, OSIG found that the registry operates in substantial compliance with statutory requirements. However, registry updates are not always being made by providers in accordance with Code requirements. OSIG has included recommendations in this report to expand DBHDS oversight of this process.

By copy of this letter OSIG is requesting that agency management provide a corrective action plan within 30 days to address this report's recommendations.

On behalf of OSIG, I would like to express our appreciation for the assistance provided during this review by DBHDS, CSBs, and other registry users.

Sincerely,

June W. Jennings, CPA
State Inspector General

CC: Paul J. Reagan, Chief of Staff to Governor McAuliffe
William A. Hazel, Jr., M.D., Secretary of Health and Human Resources
Jack Barber, M.D., Interim Commissioner, DBHDS

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Executive Summary

The Office of the State Inspector General (OSIG) conducted a review of the web-based Virginia Acute Psychiatric and Community Services Board Bed Registry (registry) pursuant to *Code of Virginia (Code)* § 2.2-313[D] and submits this report as required by *Code* § 2.2-313[E].

The purpose of this project, conducted in October and November 2015, was to review the following:

- Utility of the registry as a tool for Community Services Board/Behavioral Health Authority (CSBs) emergency services staff to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals including the registry's successes, challenges, and efficiencies,
- Impact of current registry-related operations on CSBs, state-operated facilities, private inpatient psychiatric facilities, public and private residential crisis stabilization units (CSUs), Department of Behavioral Health and Developmental Services (DBHDS), and individuals served.

Overall, OSIG found that the registry operates in substantial compliance with statutory requirements. OSIG staff reached this conclusion after:

- Completing extensive background research including reviews of acute psychiatric bed registries used in other states, and reviewing 2014 and 2015 General Assembly mental health law changes;
- Administering a web-based survey to registry users;
- Conducting phone surveys with staff at public and private behavioral health facilities that admit individuals under Temporary Detention Orders (TDOs);
- Interviewing DBHDS Office of Behavioral Health Services (OBHS) staff providing registry oversight; and
- Reviewing November 2015 registry data.

To improve current processes and enhance future outcomes, OSIG recommends that:

- DBHDS ensure that all providers are in full compliance with *Code* § 37.2-308.1[D] by developing a system for monitoring providers' procedures for updating the registry whenever a change in bed availability has occurred. DBHDS leadership should also develop processes for addressing non-compliance.
- The DBHDS Behavioral Health Quality Subcommittee (BHQS) analyze all high risk cases since the registry's inception to identify trends and performance measures for ongoing tracking and performance improvement activities to be published in the quarterly Connections Newsletter.

Purpose and Scope of the Review

OSIG conducted a review of the registry pursuant to *Code* § 2.2-313, whereby:

D. *"The State Inspector General may conduct such additional investigations and make such reports relating to the management and operation of state agencies as are, in the judgment of the State Inspector General, necessary or desirable."*

OSIG submits this report pursuant to *Code* § 2.2-313, that requires:

E. *"Notwithstanding any other provision of law, the reports, information, or documents required by or under this section shall be transmitted directly to the Governor's chief of staff and the General Assembly by the State Inspector General."*

The purpose and scope of this review was not to conduct a comprehensive review of the mental health laws enacted July 1, 2014. Instead, this review focused on the following:

- Objective 1: Assess the utility of the registry as a tool for CSB emergency services staff to facilitate the identification and designation of facilities for the temporary detention and treatment of individuals meeting the criteria for temporary detention by:
  a) Evaluating the registry to determine if key elements mandated under *Code* § 37.2-308.1 are present.
  b) Assessing the utilization of the registry by emergency services staff through review of data collected by DBHDS from CSBs and a survey of registry users.
  c) Evaluating successes, challenges, and efficiencies of the registry through interviews conducted with registry users and data reviews.
- Objective 2: Assess the impact of current registry-related operations on CSBs, state-operated facilities, private inpatient psychiatric facilities, public and private residential CSUs, DBHDS, and individuals served by:
  a) Determining the number of FY 2015 TDO admissions.
  b) Determining DBHDS staff resources dedicated to the registry and their responsibilities.
  c) Determining DBHDS processes for collecting, analyzing, and reporting registry data to DBHDS leadership.

Background

Virginia's statewide registry, launched in March 2014, was developed through a multi-year partnership between DBHDS, Virginia Hospital and Healthcare Association (VHHA), CSBs, and Virginia Health Information (VHI). According to DBHDS staff, the primary purpose of the registry is "to provide descriptive information about each public and private inpatient psychiatric facility and each CSB and private residential crisis stabilization unit, including their bed availability to CSB emergency services staff that need immediate access to inpatient or residential crisis services for individuals in crisis."

Code § 37.2-308.1[A] assigns the responsibility for the development and administration of the registry to DBHDS. The DBHDS Office of Behavioral Health Services (OBHS) has the responsibility for oversight and management of the registry. The primary staff person responsible has changed multiple times since its inception including several made during this review and report writing timeframe. OBHS registry responsibilities include:

- Developing and conducting web-based registry training;
- Publishing the quarterly Connections Newsletter;
- Monitoring registry data via a data dashboard and monthly report;
- Communicating with registry users and admitting facilities;
- Conducting an annual survey of registry users; and
- Participating in regional and stakeholder meetings.

Additional DBHDS responsibilities include:

- Ensuring individuals determined to meet TDO criteria have access to an acute care bed when needed;
- Ensuring facility or program updates regarding bed availability are made to the registry daily at a minimum, as required by *Code*; and
- Ensuring communication channels with users and stakeholders are effective and efficient.

In addition to its responsibility for administering the registry, DBHDS, in collaboration with the Community Services Boards and Behavioral Health Authorities, developed a reporting process to collect and aggregate monthly CSB data including the total number of prescreening evaluations, total number of TDOs, and number of TDOs that occurred under an emergency custody order (ECO). This process provides DBHDS with information about events involving individuals who were evaluated and determined to meet the criteria for a temporary detention order (TDO), but for whatever reason, the TDOs were not issued. This information is published monthly on the DBHDS website.

DBHDS staff emphasized to OSIG that the registry is only one tool used by CSB emergency services staff to locate an appropriate acute care bed for individuals meeting TDO criteria, and it is

not to be considered a substitute for sound clinical judgment or effective communication with providers and/or collateral contacts regarding a person's history and status during a crisis.

Review Methodology

This review was conducted in keeping with the Association of Inspectors General Principles and Standards for Offices of Inspector General: Quality Standards for Inspections, Evaluations, and Reviews (May 2014). In preparation for this review, OSIG conducted the following procedures:

- Researched acute psychiatric bed registries in Maryland, New York, Texas, Alabama, and Massachusetts.
- Reviewed 2014 and 2015 Virginia General Assembly mental health law changes.
- Interviewed DBHDS Central Office staff including:
    - Assistant Commissioner for Behavioral Health Services,
    - Acting Director, Office of Licensure,
    - Director of Acute Care Services,
    - Acute Care Services Consultant, and
    - Crisis Intervention Community Support Specialist.

After completing background research, OSIG developed a detailed work plan to guide the review. Review procedures included:

1. Conducting an anonymous web-based survey with registry users and analyzing results from 353 respondents.
2. Matching the 73 registry registered admitting facilities with the list of DBHDS-operated or licensed inpatient hospitals and residential CSUs.
3. Conducting phone surveys with staff from 19 randomly selected public and private facilities across all five Health Planning Regions (HPR) that accept temporary detention admissions.
4. Review of November 2015 registry data.
5. Review of FY 2015 DBHDS TDO Exception Reports.
6. Review of FY 2015 high risk cases.

Review Results

Overall, OSIG found that the registry operates in substantial compliance with its statutory mandates. However, beyond the required elements of the registry itself OSIG provides the following observations and recommendations that, if addressed, will enhance the operations and success of the registry.

Objective 1A – Evaluating Code-Mandated Registry Elements

OSIG review of *Code* § 37.2-308.1 registry requirements follow:

- *The bed registry shall include descriptive information for every public and private inpatient psychiatric facility and every public and private residential crisis stabilization unit in the Commonwealth, including contact information for the facility or unit;*

  A review of the registry confirmed that descriptive information for every public and private inpatient psychiatric facility and every public and private residential CSU in the Commonwealth contained the name of the facility; primary contact person's name and phone number; number of available beds by gender and age; Partnership Planning Region (PPR) in which the facility is located; level of security provided; types of special payer sources accepted; and date and time the bed availability information was last updated.

- *The bed registry shall allow employees and designees of community services boards, employees of inpatient psychiatric facilities or public and private residential crisis stabilization units, and health care providers as defined in Code § 8.01-581.1 working in an emergency room of a hospital or clinic or other facility rendering emergency medical care to perform searches of the registry to identify available beds that are appropriate for the detention and treatment of individuals who meet the criteria for temporary detention.*

  Interviews with DBHDS staff indicated that CSB and licensed inpatient facility personnel are identified by their respective organizations and granted search privileges by request to VHI. Other interested health care providers such as emergency room or clinic staff are provided access to the registry upon request to DBHDS.

- *The legislation requires that every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department shall participate in the acute psychiatric bed registry established pursuant to subsection A and shall designate such employees as may be necessary to submit information for inclusion in the acute psychiatric bed registry and serve as a point of contact for addressing requests for information related to data reported to the acute psychiatric bed registry.*

  OSIG staff matched the 73 public and private inpatient facilities and CSUs registered in the registry with the list of public and licensed inpatient facilities and CSUs provided by DBHDS to ensure all required programs were registered. In addition, OSIG conducted phone surveys with 19 (27 percent) of the 73 admitting facilities registered in the registry, validating the accuracy of contact information. These randomly selected programs from each PPR reported having an average of four designated staff responsible for updating the registry and addressing information requests.

- *The legislation requires that every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department shall update information included in the acute psychiatric bed registry whenever there is a change in bed availability for the facility, board, authority, or provider or, if no change in bed availability has occurred, at least daily.*

  The registry is designed to allow every state facility, community services board, behavioral health authority, and private inpatient provider licensed by the Department to update their bed availability whenever they are able. The registry is designed to enable DBHDS to determine the number of times per day the registry has been updated by any facility. It also has the capacity to provide reports of updates by facility, including the date and time updates were made, individual updating the registry, and the details of the bed status change. An automatic email notifies a facility when their bed availability has not been updated at least once in a 24-hour period. A registry data dashboard contains a listing of facilities that have not updated their bed availability within the 24-hour requirement but does not include information regarding facilities' compliance with the first part of the *Code* requirement, "whenever there is a change in bed availability." The DBHDS Acute Care Services Consultant reviews the data dashboard daily. A random check on November 27, 2015, revealed four facilities that had not updated the registry as required in the preceding 24 hours.

OBSERVATION NO. 1A — COMPLIANCE WITH CODE MANDATES

The registry is in substantial compliance with the core elements mandated by *Code* § 37.2-308.1[B-E] and is able to capture and report on these core elements.

Objective1B — Utilization of the Registry by Emergency Services Staff

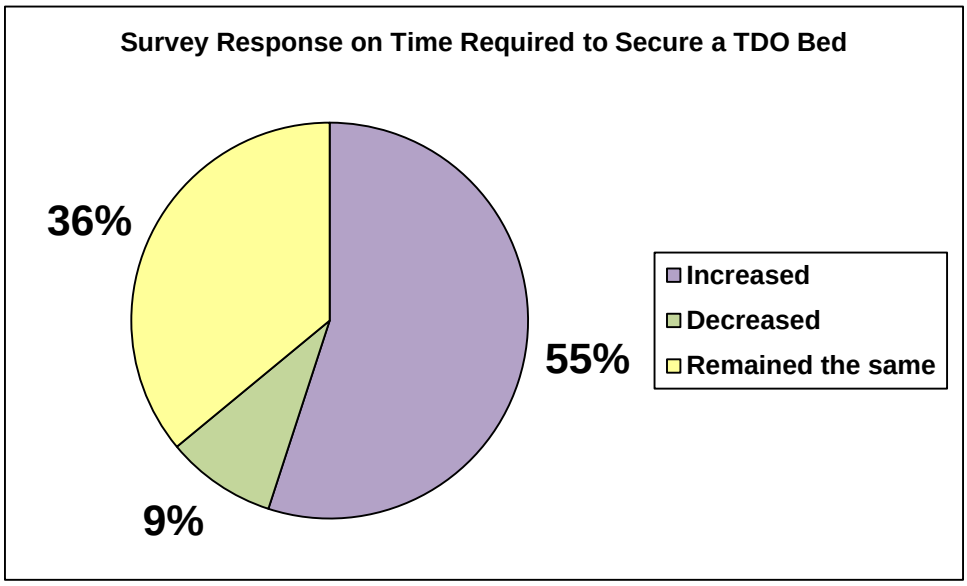
DBHDS reported that between March 2014 and June 2015, approximately 27,000 registry searches were performed. Registry bed searches in the 30 days prior to and including November 27, 2015, by PPR are listed below (See Appendix I — Partnership Planning Regions):

- Region 1 (Northwestern) – 741
- Region 2 (Northern) – 347
- Region 3 (Southwestern) – 562
- Region 4 (Central) – 175
- Region 5 (Eastern) – 372
- Region 6 (Southern) – 31
- Region 7 (Catawba) – 93

Of the 353 web-based registry user-survey respondents, 193 (54.7 percent) reported that it was currently taking more time to locate a willing facility than prior to the implementation of the registry. Survey respondents attributed this to two factors:

1.) State hospitals request emergency services staff contact all community-based facilities with registry-identified available beds before the expiration of the Emergency Custody Order (ECO) in order to preserve state hospital safety-net beds; and
2.) Facilities, CSB, and/or providers are not uniformly updating the registry whenever there is a change in bed availability requiring emergency services staff to make additional calls to facilities or programs to confirm bed availability.

The chart below shows the distribution of the survey responses.



OBSERVATION NO. 1B –REGISTRY UPDATES BY PROVIDERS

Facilities, CSB, and/or providers are not uniformly updating the registry as required in the first part of the *Code*, "whenever there is a change in bed availability" requiring emergency services staff to make additional calls to facilities or programs to confirm bed availability, wasting limited time and resources, preventing individuals from placement in an appropriate bed in the most efficient manner, and preventing emergency services staff from proceeding to other emergencies. DBHDS operates the state behavioral health facilities and, thus, is responsible for ensuring their full compliance with *Code* requirements. DBHDS also has CSB and licensed provider oversight responsibilities enforced through performance contracts and licensure regulations.

OBSERVATION NO. 1B RECOMMENDATION:

DBHDS ensure that all providers are in full compliance with *Code* § 37.2-308.1.[D] by developing a system for monitoring providers' procedures for updating the registry whenever a change in bed availability has occurred. DBHDS leadership should also develop processes for addressing non-compliance.

Objective 1C – Registry Successes, Efficiencies, and Challenges

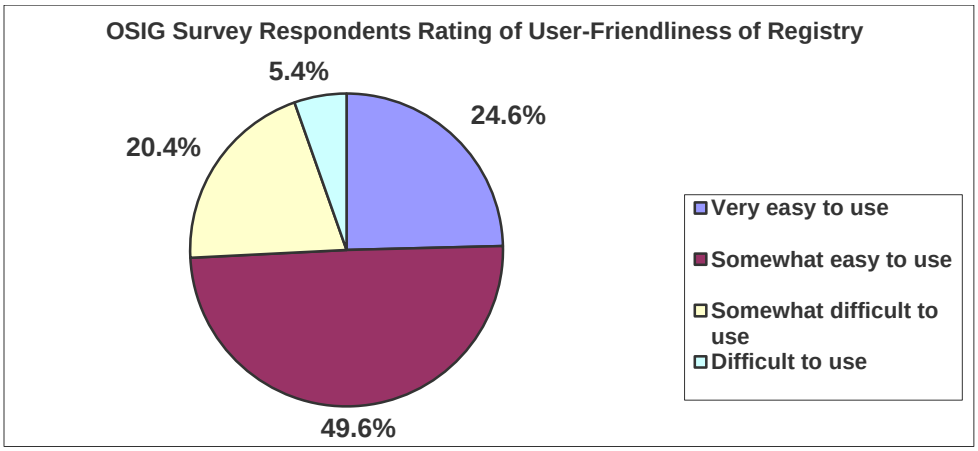
SUCCESSES/EFFICIENCIES

During the course of the review, the following strengths of the registry were identified:

A. The registry is a 24-hour centralized resource for emergency services staff to identify potential available beds for individuals in crisis who are in need of an inpatient psychiatric or crisis stabilization bed.

B. Registry queries can be tailored by region, security level, age, and gender.

C. The majority (74.2 percent) of survey participants (262 of 353) responded positively to the question regarding user friendliness of the bed registry. The following chart shows the distribution of responses to the survey question in percentages.



D. Private acute psychiatric facilities reported that the bed registry has been a valuable tool for obtaining a broader view of admitting facilities across the Commonwealth. The private acute care facilities also reported that the bed registry enables them to actively conduct outreach with regional CSBs to let emergency services staff know of bed availability when their census is low.

E. Residential CSUs reported that the bed registry is helpful when an individual receiving services in their programs needs a higher level of care.

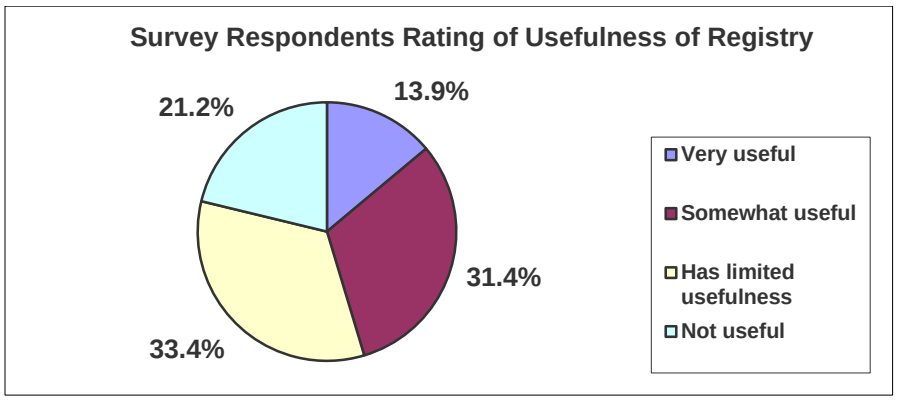
F. State facilities reported the registry has provided them with a greater understanding of the available private and CSB-operated facilities both within their defined catchment area and other regions.

CHALLENGES

Of the 163 unsolicited comments on the web-based survey conducted with registry users, 79 (48 percent) pointed to a lack of confidence in the accuracy of bed availability reported in the registry because of the number of calls made in which the bed status identified was inaccurate. CSB pre-screeners searching for available beds reported that this results in them making additional calls based on faulty information and absorbing already limited time, particularly for those individuals being evaluated under the eight-hour time limit for an ECO.

Additional challenges identified are listed below:

- The majority (54.6 percent) of participants (193 of 353) responded in the negative to the question regarding the usefulness of the bed registry in completing their job.



Note: Due to rounding, percentages in chart do not equal 100 percent.

- The majority (10 of 12) of private psychiatric facilities reported that updating bed availability, particularly when at capacity or near capacity was challenging.
- The challenge of remembering to update the registry was echoed by CSUs.
- State-operated facilities contacted did not identify any current challenges.

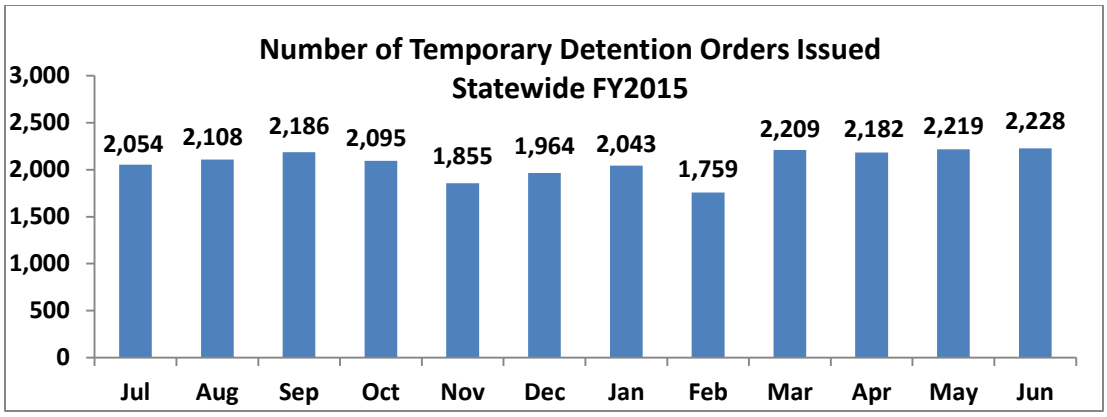
OBSERVATION NO. 1C – (SEE OBSERVATION NO. 1B)

OBSERVATION NO. 1C RECOMMENDATION:
(See Observation No. 1B Recommendation)

Objective 2A – FY 2015 Temporary Detention Orders

According to information provided by DBHDS, "A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under *Code* § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order."

The registry records 24,902 TDOs issued in FY 2015. The chart below shows the number of TDOs issued by month for FY2015.



Data Provided by DBHDS

Objective 2B – DBHDS Resources Devoted to the Registry

Although DBHDS hired an individual to serve as the lead to manage oversight of the registry at its inception, multiple personnel changes and restructuring in Central Office have resulted in several different members of the DBHDS OBHS possessing this responsibility. Responsibilities associated with oversight of the registry at DBHDS include the following:

- Ensuring individuals determined to meet TDO criteria have access to an inpatient or crisis stabilization bed when needed;
- Ensuring registry updates occur every 24 hours, as required by *Code*;
- Attendance at Registry Stakeholder Meetings;
- Training of new users as needed;
- Completion of a web-based survey with registry users annually;
- Publishing a quarterly newsletter, Connections; and
- Ensuring communication with users and stakeholders is effective and efficient.

Objective 2C – DBHDS Process for Collecting, Analyzing, and Reporting Registry Data

DBHDS process for registry data management includes:

- Daily data monitoring of 24-hour updates, number of registry searches associated with securing a bed, and the number of adult and child beds available by region.
- The Assistant Commissioner for Behavioral Health Services is briefed on the utilization of the registry at least quarterly and also serves on the BHQS.
- A registry data dashboard contains a listing of facilities that have not updated their bed availability within 24 hours, but does not include information regarding facilities compliance with the first arm of the *Code* requirement, "whenever there is a change in bed availability."

OBSERVATION NO. 2C – DATA REPORTING

At this time, registry data reporting does not contain a process for collecting, analyzing, or reporting data relevant to compliance with all elements of *Code* § 37.2-308.1. In the absence of this it is not

possible to rely solely on the registry to ensure accountability and optimal use of the registry to fulfill its intended purpose of locating and securing appropriate beds for those in need and lessen the burden on CSB emergency services workers.

OBSERVATION NO. 2C RECOMMENDATION:

(See Observation No. 1B Recommendation)

Objective 2D – FY 2015 High Risk Cases

The DBHDS June 2015 Report on the Implementation of Senate Bill 260 to the Governor and the Chairs of the Senate Finance and House Appropriations Committees maintains that high risk cases are reported by CSB Executive Directors to the DBHDS Central Office Quality Review Team (QRT) within 24 hours of occurrence. At that time, QRT composition included the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of the Office of Behavioral Health Services, and the Crisis Intervention Community Support Specialist.

OSIG reviewed 10 percent of the 61 FY 2015 high risk cases. Each case was thoroughly reviewed by the Crisis Intervention Community Support Specialist or the Director of Behavioral Health Services and referred to the QRT. Summaries of high risk cases are published in the monthly TDO Exception Report.

A sample of case narratives for July 2015 follows:

1. The individual was evaluated while on a law enforcement-initiated ECO and determined to not meet criteria for a TDO. Within several hours, law enforcement was dispatched to the individual's home, and the individual was taken back into custody under a magistrate-issued ECO. The individual, aggressive and uncooperative in his home with his parents, warranting another evaluation based on the additional information. During the re-evaluation, it was determined the individual met criteria for a TDO; however the individual was in need of a medical evaluation prior to any hospital being willing to accept the individual for a TDO. While the medical clearance was being completed and the search for an appropriate bed was being conducted, the magistrate called to state the ECO had expired as it had been more than eight hours since the initial law enforcement-initiated ECO began. The evaluator obtained a bed at the regional state hospital and no loss of custody occurred.
2. An individual was evaluated while under a magistrate-issued ECO and was determined to be willing to seek voluntary hospitalization and deemed to have the capacity to admit himself to a hospital. Law enforcement and the evaluator left the individual in the emergency room while the transfer was being arranged by the emergency department staff. The individual left and the CSB was notified of the individual's absence. The CSB notified local law enforcement and obtained a TDO from the magistrate. However, the TDO was never executed because the individual's whereabouts were unknown. Both law enforcement and the evaluator made multiple attempts to locate the individual, and this culminated in reaching the individual by phone and the individual denying the need for treatment and

refusing to disclose his current location. The individual was willing to accept referrals to local, private community resources.

3. After evaluation but prior to the TDO issuance and execution, an individual not under an ECO left an emergency department. An ECO was sought and obtained from the magistrate; however, the individual was not located. The address provided to the emergency department was no longer the individual's address. The CSB notified local hospitals and CSBs of the individual's need for services. However, no contact was made with the individual. The CSB met with the emergency department administrators to discuss this event and to identify where the protocols for the hospital did not effectively provide for the safety of the individual under evaluation in the emergency department. As a result of the meeting, the hospital instituted stricter protocols, and the CSB will support the hospital with these protocols by notifying hospital administration when the protocols are not being followed.

Objective 2E – DBHDS Behavioral Health Quality Subcommittee Review of High Risk Cases

Outcomes of the QRT's reviews of high risk cases through November 2015 could not be verified because team meeting minutes were not documented. Case documents were kept in individual folders and contained a description of events, supporting documents, and event summaries. During interviews with DBHDS Central Office staff, OSIG was informed that each case was reviewed independent of others. Data was not collected or presented in aggregate, a process that would have allowed for analysis and trending, identification of potential areas of systemic risk, or development of performance improvement activities.

The DBHDS Assistant Commissioner for Behavioral Health Services reported to OSIG that plans to change oversight responsibility for the high risk cases began in July 2015 and became fully operational in November 2015. Currently, the Crisis Intervention Community Support Specialist serves as the primary reviewer of high risk cases and quality oversight is provided by the BHQS, a subcommittee of the DBHDS Central Office Quality Improvement Committee. The QRT disbanded following the BHQS assumption of their responsibilities. Subcommittee membership includes the Director of Clinical Quality and Risk Management; Clinical Quality and Risk Management Program Manager; Director of Community Services; Director of Acute Care Services; and Assistant Commissioner for Behavioral Health Services.

DBHDS reports the following relevant to the BHQS:

1. The BHQS will develop and oversee a planned and systematic approach to the monitoring, analysis, and performance improvement in high-risk, high-impact services provided by state hospitals and CSBs to include:
    a. Prioritizing identified problems and setting goals for their resolution;
    b. Achieving measurable improvement in the highest priority areas; and
    c. Developing or adopting necessary tools, such as practice guidelines, consumer surveys, and quality indicators.

OBSERVATION NO. 2E – REVIEW OF HIGH RISK CASES

The DBHDS process for reviewing high risk cases in FY 2014 and FY 2015 did not include the collection and review of data in aggregate to support a process of analysis, trending, or development of performance measures to support system-wide performance improvement.

OBSERVATION NO. 2E RECOMMENDATION:

DBHDS develop a consistent data management process for high risk cases that includes reporting relevant data in aggregate to the BHQS. As a first step, this process should be completed for all high risk cases in FY 2014, FY 2015, and FY 2016 through November 2015. The BHQS should then develop a consistent process for reviewing and analyzing the data, identifying key performance measures, systemic risk factors, and areas for performance improvement. This process should also include the dissemination of outcomes in the published quarterly Connections Newsletter.

Appendix I– Partnership Planning Regions

Partnership Planning Region	Community Services Board
1: Northwestern Virginia	Alleghany Highlands CSB Harrisonburg-Rockingham CSB Horizon Behavioral Health Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2: Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church Loudon County Prince William County CSB
3: Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4: Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Richmond Behavioral Health Authority
5: Eastern Virginia	Chesapeake Integrated Behavioral Healthcare Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6: Southern Region	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7: Catawba Region	Blue Ridge Behavioral Healthcare

Appendix II— Management's Response

To: June Jennings
Inspector General
Office of the State Inspector General

From: Jack Barber, M.D.
DBHDS Interim Commissioner

Subject: DBHDS Response to Draft OSIG Report: Review of Virginia Acute Psychiatric and Community Services Board Bed Registry

Date January 7, 2016

Thank you for the opportunity to review the OSIG's Draft Report: Review of the Virginia Acute Psychiatric and Community Services Board Bed Registry. I appreciate the OSIG's thorough review of the important role of the Registry in ensuring that individuals in behavioral health crisis receive the care they need and recognition of DBHDS' ongoing efforts to insure maximum benefits are obtained with use of the tool. DBHDS is also committed to evolving its oversight of the crisis response system through enhanced quality review and improvement strategies.