Southwestern Virginia Mental Health Institute

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Hidden

There are fireworks on every page in this edition, just like the one pictured here. Can you find all 16 of them?

From the Director

I wanted to share with you the latest guidance and understanding about medical screening and assessment of individuals prior to admission, 2014 and 2015 mental health laws enacted by the Virginia General Assembly, and the efforts that SWVMHI has made to inform, educate, and give feedback to the healthcare partners in our region.

The Importance of Medical Screening and Assessment of Individuals Presenting with Psychiatric Symptoms

It is well documented that individuals who seem to have psychiatric symptoms may instead be suffering from the symptoms of acute medical syndromes or illnesses. Likewise, symptoms of mental illness can mask acute, undiagnosed and untreated medical illnesses. Further, individuals with psychiatric disorders have significantly more medical co-morbidities than the general population. In addition, individuals with serious mental illness have a life expectancy that is 15-25 years less than that of those without a serious mental illness. It is likely that this is due to a number of factors including lack of access to medical providers, a lack of ability to pay for care or medications, lack of good medical follow up, side effects of certain psychiatric medications, and other factors.

It is critical, therefore, that every effort be made to have a medical screening done for individuals being referred for inpatient psychiatric treatment. This screening is designed to rule out a serious medical condition and to decrease the likelihood that an individual with a serious, urgent, or emergent medical condition will be sent to a psychiatric hospital that cannot adequately manage the individual's condition. To not conduct an adequate medical screening is a serious issue and places the individual at risk to worsen during transportation to the facility and upon arrival to the facility.

Guidance is provided by DBHDS in the second edition of its *Medical Screening & Medical Assessment Guidance Materials,* issued January 1, 2014. SWVMHI was instrumental in the creation of the first edition of this document in 2007, and has been critically attuned to this issue since at least the 1990s. The issue is particularly important in southwest Virginia, which has higher than the average rates of poverty and unemployment, higher rates of those uninsured and underinsured, limited access to medical professionals (healthcare shortage region), and higher than expected rates of deaths from common medical causes. The Guidance Materials emphasize good communication, starting early in the process, between medical professionals at the psychiatric hospital and the community hospital and a clear understanding of the critical importance of the issue by all involved in the commitment process.

For years, the SWVMHI Director, Medical Director, Clinical Director, and other clinical leaders have been meeting with community hospitals, emergency room staff, CSB leadership, magistrates, and others to emphasize the importance of medical assessment and screening. Given the timeframes involved and the limited and variable resources in hospital emergency rooms, it remains a challenge to assure that the screening and assessment is completed in a timely manner, that is, before the Emergency Custody Order expires and while the individual is cooperative with the assessment process. Also a factor is that both the community hospital and the receiving psychiatric hospital must comply with the federal Emergency Medical Treatment and Active Labor Act (EMTALA, see below). Medical stability took on a new, critical importance with the passing of the "last resort" mental health law, effective July 1, 2014.

For a link to the DBHDS Medical Screening and Medical Assessment Guidance, see: http://www.dbhds.virginia.gov/library/document-library/140401medicalscreeningguidance%20(2).pdf

Mental Health Law Change July 1, 2014

Two areas relevant to this topic were revised in the Virginia Code by the 2014 session of the General Assembly. The first is that the time period of the Emergency Custody Order (ECO) was changed from four to eight hours, and the provision for an extension of the ECO time period was eliminated. The second change added specific language that a state psychiatric facility shall not refuse to admit an individual who meets the criteria for a TDO unless an alternative facility agrees to accept the individual, and an individual who meets the criteria for a TDO shall not be released by the CSB. In the year since this change, it has come to be referred to as the "last resort" legislation. That is, if there is no

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SWVMHI Values: Communication and Leadership

One of the SWVMHI Values is Communication. Another is Leadership. These two values, as one might imagine, are highly interrelated. One cannot easily be an effective leader without clearly communicating through words and deeds. In other words, effective communications help to make one an effective leader.

How do we know if we are effective communicators? The question seems simple enough, but a bit of thought (and a wealth of experience) reveals that what we say is often not what is heard. One CEO, Rob Cromer, recently wrote about three "magic questions" he asks himself every day to help him assess his effectiveness as a communicator and leader. Those magic questions are:

1. **What am I not saying that needs to be said?** "You forget to communicate to everyone around you and expect everybody to believe, understand, and know what you're thinking," explains Cromer. "The more you can communicate, the less confusion there will be."

2. **What am I saying that is not being heard?** "Sometimes you're saying things, but it's not actually translating to action or understanding," says Cromer. "It is important to present your vision in a way that people can get behind it, act upon it, and be empowered by it."

   If your goals are not being achieved, ask yourself whether or not you communicated clearly and whether they were *heard.*

3. **What is being said that I am not hearing?** This is the most important of the three questions, Cromer emphasizes. It is easy to get clouded by the day-to-day ruckus and forget to listen to the people surrounding us. However, people cannot *NOT* communicate. Communication is around us everywhere; all we need to do is listen and *hear.*

"If you're truly listening and having a conversation with somebody, you're going to get a lot of feedback out of it, even if they're not trying to outwardly give you feedback," he says. These are the people in place around us, depending on us, awaiting our leadership. They can be our teammates, our patients and other stakeholders, and, at home, our family members. Listen to what they are saying.

~ James Moon, Ph.D.
Psychology Supervisor

Chaplain's Corner

July is a great month for summer fun and celebrations. There is nothing like Fourth of July parades and picnics, as well as other notable days of the month. July is also National Dog House Repair month; Be Nice to New Jersey week (beginning July 5); Hemochromatosis (Iron Excess Disorder) Month; American Fancy Rat and Mouse Association week (July 26 – August 1); and the Hemingway Look Alike Days held the week of July 23 – 26 (I may give this one a try). I think my favorite day is July 2 – "I Forgot Day." Not a day to remember anything, just a day to forget.

I'm pretty good at that now with a lot of years of seasoned practice. I think it reminds me of my birthday at the end of the month and the Graham family motto, "Ne Oublie" (Do not forget). Problem is, no one in the Graham Clan can actually remember what it is we are supposed to not forget, so that explains a lot about me. Anyway, a day to forget can be a pretty good thing. Forgetting the things that irritate us about each other. Forgetting the scores we have to settle. Forgetting wrongs that others have done to us. A day to forget might offer us a much needed respite from all the stresses and conflicts we find ourselves mired in through family, work, and relationships.

I came across a poem I believe speaks to the importance of forgetting:

Two Important Things Never to Forget

Each day we face many mental perils, have to make many important decisions,
Like what color socks to wear. Some things must take priority, however,
It's important to keep them in mind. The first is to be comfortable with yourself;
You may not be perfect, but, darn, who is?
Be happy with yourself if you can truly say I did not intentionally hurt anyone today.
There's more than enough bad people out there to do that for you.
So pat yourself on the back for a day of sainthood!

The second thing is … uh … the second thing is … um … is … shoot, I don't remember!

May you forget something that causes you stress and anxiety. May you recall something that makes you grin!!

~ Timothy Graham, D. Min.
Chaplain

From the Director, *continued*

other willing facility, the state facility must be named on the TDO and may not refuse the admission.

During training for Community Services Board staff in 2014, several potentially problematic scenarios were discussed. These were also included in the Frequently Asked Section of the DBHDS website: http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/civil-commitment-changes#ECO_Timeframe

These FAQs, like the Medical Screening and Assessment Guidance, continue to emphasize direct communication between the state facility medical professional and the physician in the Emergency Department. The importance of this communication early and as needed assures that any concerns on the part of the receiving facility are noted. I encourage all those who are interested to read the guidance document and the FAQs for more information on this important topic. For instance, here is one question and response:

"What happens if the eight hour ECO period is coming to an end and the state hospital believes the person is not medically clear but the ER has medically cleared the person?

The new state law provisions require the state hospital to accept a patient for temporary detention if an alternative facility cannot be located by the expiration of the eight hour ECO period. If the state hospital physician believes the individual's needs exceed the capabilities of the state hospital, then that should be communicated to the ER physician. If the ER physician decides to send anyway, then the individual must come to the state hospital and the state hospital will need to plan what it will do. This may include immediate transport to the nearest ER or attempting to secure medical admission elsewhere. Even though the new law requires a state facility to accept an individual for temporary detention if an alternative facility cannot be found, the requirements of EMTALA, if applicable to the sending facility, must still be met by the sending facility. Transferring an individual to a facility that has stated it cannot safely manage the individual's medical condition is taking a risk on the part of the sending hospital, which could be liable under EMTALA for an inappropriate transfer. The best scenario for the individual in a situation where the state facility is not able to meet the individual's medical needs would likely be for the ER physician to keep and treat the individual until he is stable enough to be transferred to the TDO facility, though this will require collaboration

with law enforcement. Local stakeholders, including law enforcement, should discuss this scenario to ensure that plans are in place to best meet the needs of individuals. Regional protocols may also want to address this type of scenario."

Mental Health Law Change July 1, 2015

Virginia Code 37.2-1104 has long permitted a physician in an emergency department or a community hospital to obtain a Medical Temporary Detention Order to prevent a patient from leaving the hospital when immediate treatment or testing is needed and the patient is not capable or may not be capable of making a decision. The law in effect through June 30, 2015, requires that once the physician has found probable cause that the individual is incapable of making an informed decision regarding treatment or is incapable of communicating such a decision, and that the medical standard of care calls for testing, observation, or treatment of the disorder within the next 24 hours to prevent death, disability, or a serious irreversible condition, the court may issue an order authorizing such testing, observation, or treatment. A medical TDO is in effect for either 24 hours or until such time as the patient becomes capable of making and communicating an informed decision, whichever is shorter. A medical TDO may be renewed every 24 hours as needed.

As a result of feedback from many stakeholders, including SWVMHI, about the impact of the "last resort" legislation and concerns about medical stability, a change was enacted in the Medical TDO law which will go into effect July 1, 2015. The criteria for use has been loosened such that the "medical standard of care calls for testing, observation, or treatment within the next 24 hours to prevent, death, disability or to treat an emergency medical condition that requires immediate action to avoid harm, injury or death." We hope that by replacing the old language "serious irreversible condition" with "an emergency medical condition that requires immediate action to avoid harm" it will be easier to use.

We have begun efforts to educate hospitals and emergency departments about this change in the statue, and it is on our list of prompts when we receive calls.

SWVMHI Steps Up Efforts to Communicate about Medical Assessment Prior to Admission

As a result of long-standing and heightened concern about the medical status of individuals who are admitted to SWVMHI on Temporary Detention Orders, SWVMHI implements a number of strategies to inform, educate, and give feedback to our community healthcare partners.

Face to Face Meetings with Community Hospitals/Hospital Systems and local CSBs: Since January 1, 2014, SWVMHI has held twelve meetings with hospitals/hospital systems, including seven since July 1, 2014. Often these were problem-oriented meetings, but others were ongoing education/information sharing meetings. These meetings are attended generally by a combination of the Facility Director, Medical Director or Chief of General Medicine, Clinical Director, Unit Programs Director, Director of Community Services, and others as appropriate. Two meetings are planned for July.

Written Communication to Community Hospitals/Hospital Systems about Patient Care Issues: In addition to face to face meetings, since January 1, 2014, the SWVMHI Director or Assistant Director of Administration have written eleven letters or emails to hospital or hospital systems executives about patient care issues, including communication difficulties and/or quality of patient of care issues. There have been seven written communications since July 1, 2014.

EMTALA Complaints Filed: In addition to the above, since July 1, 2014, SWVMHI has filed, as required by Federal law, two EMTALA complaints involving patients who were admitted to SWVMHI on a TDO who we believed had emergency medical conditions and about whom we had clearly communicated our concerns. At least one of these complaints resulted in system-wide education of hospital

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From the Director, *continued*

administration and staff in the community hospitals. We believe this will improve patient care.

Emails to Dr. Barber, DBHDS Medical Director: Beginning July 1, 2014, SWVMHI has sent Dr. Barber information about each time we are concerned about the medical conditions of an individual who has been admitted to us. We believe these helped to inform DBHDS about the scope of the medical screening and assessment issue that southwest Virginia is facing. At least twelve emails have been sent.

Other communications about census and medical status:

- Attendance at Smyth County Community Hospital Medical Staff Liaison meetings by SWVMHI Medical Director.

- A weekly Census and Review Team teleconference meeting is held between SWVMHI and the region's six CSBs. At this meeting, each instance of an unexecuted TDO, medical issue, referral to another state facility due to census, and over-census admission to SWVMHI is discussed. This has provided a learning opportunity for best practices throughout the region. At this meeting, we also review all medical issues and over-capacity issues to improve CSB, ED, and SWVMHI processes, and give feedback. The Team also advocated for additional LIPOS (Local Inpatient Purchase of Services) money. In addition, there is a monthly regional meeting to review individuals on Discharge Assistance Plans, those on the Ready for Discharge list, and individuals with long lengths of stay.

- Should SWVMHI be called for an admission, there is no other accepting facility, and we are at our operating capacity, the SWVMHI Director must call and speak to the Director of another state facility to ask if that facility can serve as back-up. **The contact must be director to director on each CSB referral due to the increase in admissions statewide.** These processes have been refined and improved over time, but at times, there is no backup facility.

- The Director of Community Services attends and disseminates information from the regional team charged with providing, developing and referring individuals with Intellectual/Developmental Disabilities for services. In addition, Central Office receives the name and admission date of all individuals with ID/DD who are admitted to state facilities so that they can ensure follow-up. SWVMHI is also present at meetings involving Training Center services.

- At an executive level, census and medical issues are discussed at the Southwest Board for Regional Planning, which meets every second month. The regional board also advocates for additional Discharge Assistance Plan money to assist with more complicated discharge needs and Local Inpatient Purchase of Services money to purchase beds in the region's private psychiatric hospitals.

- In an effort to avoid inpatient admissions for court-ordered forensic evaluations, SWVMHI psychologists provide approximately 100 outpatient evaluations for the region. Many of these individuals would have been admitted to SWVMHI. In addition, SWVMHI developed an innovative, targeted program of outpatient therapy in the regional jail in order decrease the repeated admission of an individual.

Efforts Will Continue

Individuals with medical disorders will continue to present challenges to the behavioral health system. It is important for us all to understand and communicate the risks of medical complications as well as our requirements under the law. It is also important for SWVMHI to demonstrate continued follow-up with our region's community hospitals and CSBs. Emergency department staff changes over time and new CSB prescreeners come on board. There will always be a need to inform, educate, and give feedback about these important issues.

We also see that continued education of SWVMHI staff, including medical professional, nursing, and Administrators on Call (AOCs), will be useful in the event of a difficult medical situation. We have begun the process of educating the region about the new Medical TDO law and frequent reminders of the capability may help to resolve some of the issues before the medically compromised person is sent to us.

In addition, Dr. Barber continues to solicit input and feedback on the impact of the mental health laws in an effort to address, or attempt to address, additional needed change through legislative action.

When situations arise in which a SWVMHI medical professional differs from the physician at the referring hospital about the medical condition of the patient, and when we in fact feel it is dangerous to transfer the individual from a medical to a psychiatric hospital, SWVMHI has provided guidance to our medical professionals who may find themselves in this situation. Here is the guidance for SWVMHI that should be discussed with the referring physician in the emergency room and documented:

"I have accepted the patient on behalf of Southwestern Virginia Mental Health Institute in Marion, Virginia. It is the policy of Southwestern Virginia Mental Health Institute to never refuse a mentally ill patient in jeopardy of being released from an emergency room.

I am completing this document to lodge a formal protest with regards to the medical stability of the individual being transferred, who may be medically unstable, and could suffer consequences related to the transfer, up to and including death.

Medical needs as represented in this individual's case may exceed the scope of services provided at Southwestern Virginia Mental Health Institute and could require immediate referral to another institution for further care.

Areas of my concern include, but may not be limited to the following: [list]."

What is EMTALA? A Quick Summary

The Emergency Medical Treatment and Active Labor Act is a statute that governs when and how a patient may be 1) refused treatment or 2) transferred from one hospital to another when in an unstable medical condition. EMTALA applies to "participating hospitals" -- i.e., to hospitals that accept payment from the Department of Health and Human Services, Centers

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Human Resources Corner

Excellence is doing ordinary things extraordinarily well. ~ John W. Gardner

What are Premium Rewards?

Premium Rewards is a way to reduce your monthly health insurance premium. Who doesn't want to do that? Participants of the Anthem COVA Care and Aetna COVA HealthAware Plans are eligible for Premium Rewards. For single health insurance coverage you can lower your monthly premium by $17.00. If you cover a spouse, the combined savings can be $34.00 per month.

What do you need to do to receive Premium Rewards?

Current user: If you are currently receiving Premium Rewards, then your only step is to re-take the health assessment. This can be done by one of two ways:

1. You can access the MyActiveHealth's website and answer questions in the on-line Health Assessment regarding your personal health at www.myactivehealth.com/cova, **or**

2. You can call MyActiveHealth's toll free number 1-866-938-0349 and answer the Health Assessment questions over the phone.

The employee, and if there is a covered spouse on the employee's plan who is already covered with Premium Rewards must complete the health assessment in order to continue with Premium Rewards into the upcoming plan year which begins July 1, 2015.

To continue your reward without a break, you and your covered spouse will need to have completed the on-line health assessment by June 30, 2015, for the July 1, 2015, new plan year effective date.

First time user: If you are not already receiving Premium Rewards, then your steps are to:

1. Take the health assessment either on-line or by phone as shown above, AND

2. Have a biometric screening done by your personal physician. To access the biometric screening form, the employee needs to create an account by using your Employee ID number with MyActiveHealth at www.myactivehealth.com/cova or you can phone MyActiveHealth at 1-866-938-0349. You then follow the instructions on the form to report your biometric screening results to MyActiveHealth. Please be sure to keep a copy of your confidential email or letter stating your form has been accepted by MyActiveHealth. Your spouse will need to call the toll-free number to complete the health assessment and subsequently obtain the biometric screening form.

If you did not complete the healthy actions (Health Assessment and if applicable the Biometric Screening) by June 30, 2015, eligible members can complete the health assessment and biometric screening during the plan year. The member's Premium Reward will be effective the first of the month after the requirement(s) are completed, submitted and accepted.

Security of your Information

Safeguards are in place to ensure that your personal information on the MyActiveHealth portal is not shared with your employer. The Active Health program will use this information to identify possible health issues to help you and your doctors track and improve your health. Participation is voluntary.

If you have any questions about Premium Rewards, or have other questions regarding your health coverage or other benefits, please contact any member of the Human Resources Office.

~ Kim Sayers, PHR
Human Resource Consultant

Staff Development

Take advantage of the training Opportunities in July

When: July 7, 1330 - 1615
Where: Dogwood Classroom
What: Dealing with Difficult People

When: July 28, 1515 - 1615
Where: Dogwood Classroom
What: From a Negative You to Positive You

The Emergency Management CAI is due during the month of July.

Please log into the Knowledge Center and take your CAI today. Questions should be directed to any member of the Training Department.

I just want to thank everyone for all the prayers, cards, flowers, words of encouragement, visits, and for your friendship during the loss of my dad, Mont Shepherd.

May God bless each of you.

~ Paul Shepherd

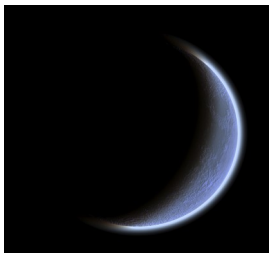
IT QUICK TIPS

Did you know?

- Computer running a bit sluggish? Sometime a reboot of the system might help; however be aware it might take awhile for the system to come back up.
- Holding the "Window Button" (shown below) and the "L" at the same time will quickly lock your computer.

July Lunar Phases

July 1
Full Moon, also called "Buck Moon" by Native Americans of New England and the Great Lakes because at this time of the year, the new antlers of the buck deer begin to appear. Also called the "Thunder Moon" due to all the summer storms.



July 8
Last Quarter Moon

July 15
New Moon

July 24
First Quarter Moon

July 31
Full Moon (Blue Moon)

Rehab Department News

Beautiful sunny days and quite hot days have arrived and seem be here to stay! Summer officially started June 21, but the heat came early. Groups continue to be held outdoors when possible to allow the individuals we serve to enjoy the weather.

The New Day Café continues coffee sales for the individuals we serve during morning break period. It still continues to be very popular with them.

The special activity for June, Splish Splash, was held on June 25. Various games were offered and included water games and slopes. A special snack of chocolate cake and ice cream was served.

The New Day Café will now be open before church services on Thursday evenings for the individuals we serve, and will offer snacks before services.

Work continues in the vegetable garden with involvement from the individuals we serve including planting, harvesting, and keeping a keen eye out for critters looking to get their crops. Please be on the lookout for upcoming vegetable sales.

Preparations continue in groups for items to be sold at this year's annual Arts and Crafts Festival at Hungry Mother Park. It will be held July 17 through July 19. The Rehab Department will have a tent at the park with our handcrafted items for sale. Please mark your calendars for this exciting weekend!

The R-CERC meeting was held June 17 at Hungry Mother State Park with staff and individuals served participating.

Departures: Mike Williams, P-14 Rehabilitation Specialist second shift, will be attending Chiropractic school in Spartanburg, SC. His last day was June 24, 2015.

The New Day Café continues coffee sales every morning for staff. Please come by and try our coffee. Hours of service are posted at the Café.

~ Sheila Thomas, Rehab Specialist

Kronos Workforce Dos and Don'ts

We still continue to receive questions regarding messages received from Payline about upcoming loss of leave. **PLEASE DISREGARD ANY MESSAGES YOU RECEIVE FROM PAYLINE PERTAINING TO LEAVE.** Payline leave balances are not accurate and therefore, should not be used when determining your current leave balances. Payline is still utilized to provide you with your W-2s and your paycheck information. To view your current leave balances, you should only use Kronos. Remember to put your cursor on today's date on your timecard to view today's leave balances.

Are you having issues clocking in and out? If the clock will not accept your punch when you swipe your ID badge, it could be the bar code located on the back of your badge. If there are any scratches or any parts of the bar code are missing, the clock will not be able to read it. If this happens, contact someone in Human Resources to make arrangements for a new ID badge.

Another common problem when clocking in and out that results in many missed punches is simply not paying attention. If you swipe your badge and hear the beep, you think your punch took and you are off, but please pause a moment to be sure that you name appears in the clock's window before moving on. If your name does not appear, your punch was not recorded. This momentary pause could save you the trouble of having to complete a missed punch form and also save your timekeeping from having to enter that missed punch as well.

What happens if you forget your ID badge? You can type in your ID number using the keypad on the clock, but this is not ideal — it is too easy to mistype your ID number (very common error) or to hit the "clear" button instead of the "enter" button when you are finished. If you forget your ID badge, the best thing to do is see your supervisor or timekeeper and complete a missed punch form. This form is also located on the forms directory.

Are you guilty of the "punch and park?" This is when you park your car at the entrance of a building, run in and swipe your ID badge, then get back in your car and park it. If you are guilty of this, **STOP**. Once you clock in, you are officially on the clock and you should be proceeding immediately to your work station. You should be parking your car and gathering the personal belongings you need before you clock in for the day. This action is subject to supervisory review and/or progressive disciplinary action, and will not be tolerated.

By now, you should be used to accessing Kronos to review your timecard and leave balances. You are encouraged to log in often, especially before taking leave to be sure you have appropriate leave balances before requesting time off.

If you see errors on your timecard, or you just don't understand what you are reading, be sure to contact your timekeeper or your supervisor.

If you have forgotten your password, please use the "forgot my password" link, which will prompt you to answer the security questions you set when you first logged into Kronos. If that still doesn't work, you can then contact Cheryl Veselik to reset your password for you. Just a word of caution — if she has to reset your password, the system will also require you to reset your questions as well.

~ Kronos Implementation Team

From the Director, *continued*

for Medicare and Medicaid Services (CMS). The purpose of the statute is to prevent hospitals from rejecting patients, refusing to treat them, or transferring them to "charity hospitals" or "county hospitals" because they are unable to pay or are covered under the Medicare or Medicaid programs. The essential provisions of the statute are as follows:

Any patient who "comes to the emergency department" requesting "examination or treatment for a medical condition" must be provided with "an appropriate medical screening examination" to determine if he is suffering from an "emergency medical condition." If he is, then the hospital is obligated to either provide him with treatment until he is stable or to transfer him to another hospital in conformance with the statute's directives. If the patient does not have an "emergency medical condition," the statute imposes no further obligation on the hospital.

What is an "emergency medical condition"?

An attempt is made by the statute to provide a definition, but the determination is ultimately a medical one rather than a legal one. As is the case with any medical decision, it must often be made quickly, with such information as is available, and is subject to critical retrospective review.

The definition provided under the statute is: "A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part, or
- With respect to a pregnant woman who is having contractions -- that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- that the transfer may pose a threat to the health or safety of the woman or her unborn child."

What is an appropriate transfer?

An "appropriate transfer" (a transfer before stabilization which is legal under EMTALA) is one in which all of the following occur:

- The patient has been treated at the transferring hospital, and stabilized as far as possible within the limits of its capabilities,
- The patient needs treatment at the receiving facility, and the medical risks of transfer are outweighed by the medical benefits of the transfer,
- The receiving hospital has been contacted and agrees to accept the transfer, and has the capability to provide the necessary treatment to him,
- The patient is accompanied by copies of the medical records from the transferring hospital, and
- The transfer is effected with the use of qualified personnel and transportation equipment, as required by the circumstances, including the use of necessary and medically appropriate life support measures during the transfer.

The statute provides that, if a physician is not physically present in the emergency room, the written certification in support of transfer may be signed by a "qualified medical person" in consultation with the physician, provided that the physician agrees with the certification and subsequently countersigns it.

What if an emergency medical condition is not properly diagnosed at the transferring hospital?

If the patient is erroneously diagnosed, and the physician mistakenly believes that he does not have an "emergency medical condition," when in fact he does, several courts have held that the statute does not apply to that case. There could, of course, be a claim for professional negligence for failure to make a diagnosis under State malpractice law in this situation.

However, some of the cases have suggested otherwise, with statements to the effect that a hospital could be found to be in violation of EMTALA for failure to diagnose an emergency medical condition through an inadequate screening procedure.

Does EMTALA apply only to E.R. patients?

At locations on the hospital campus and not at a Dedicated Emergency Department, the obligation under EMTALA arises only if 1) a request for emergency services is made, or if 2) a reasonably prudent layperson would conclude, based on the person's appearance or behavior, that he is in need of emergency treatment. This will include new conditions which arise for visitors or employees.

What obligations are imposed on receiving hospitals?

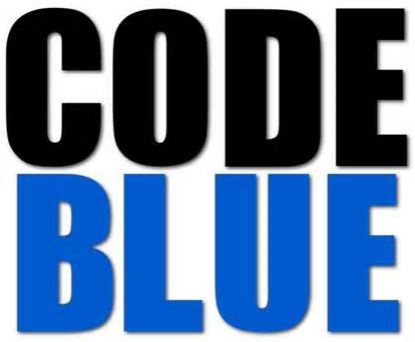
Most of the obligations under EMTALA are imposed on the transferring hospital. There are a couple of significant obligations imposed on the receiving hospital as well. The statute and the regulations provide that any participating hospital that has "specialized capabilities or facilities" such as burn units, shock-trauma units, or neonatal intensive care units, or which is a "regional referral center" in a rural area, may not refuse to accept a patient in transfer, if it has the capacity to treat the individual. The regulations do include a provision that imposes a very significant obligation on receiving hospitals. The regulation, at 42 CFR 489.20(m), obligates a participating hospital "to report to [CMS] or the State survey agency any time it has reason to believe it may have received an individual who has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of Section 489.24(d)." This regulation became effective on September 29, 1995. Note that it requires reporting only when a patient has been improperly transferred; it does not require reporting other known or suspected violations.

Information from http://www.emtala.com

Also see http://www.dbhds.virginia.gov/professionals-and-service-providers/mental-health-practices-procedures-and-law/emtala

~ Cynthia McClaskey, Ph.D.
Director

Code Blue Update



As many of you know, The Joint Commission (TJC) visited us last year and as always, here were several opportunities found for improvement. After getting our feelings hurt and recovering, we agreed that we did have several areas where we could improve. We knew we were doing the job well but we had no way to show it. So several of us in the areas involved started work on Performance Improvement strategies in certain categories.

Even before TJC findings, through my involvement in Code Blue Drills, and with input from staff, we gleaned several things we felt could make real and mock codes run more smoothly. We revised the Code Blue Order and Flow Sheet to better reflect what staff were doing, and to "jog" their memory for things that needed to be done or were done but there was no area to document this. It was renamed the Code Blue Order and Flow Sheet/ Medical Emergency Response, which is the title of Policy 3022 for Medical Emergency Response (Code Blue).

Also, we realized that for Code Blues, unlike behavioral codes, there was no After Code Processing Form to let us know what went well and what needed improving. So based upon the behavioral code After Code Processing Form, a committee was formed to develop an After Code Processing Form for all code blue events, real and mock. This has been very helpful in determining opportunities for improvement. Then, all the written information, Code Blue Order and Flow Sheet, Code Blue After Processing Form, and Code Blue Evaluation Form comes to the CPR coordinator for analysis.

From this information and other information gleaned through mock codes, we developed a CAI to help staff understand the workings and mechanisms of our Stryker Stretcher Cot and the use of Spyder Straps for a back board.

Through mock and real codes we also learned several things including, but not limited, to:

- ⋆ Making sure the scene is safe
- ⋆ Evaluating patient's need for first aid vs. medical emergency care
- ⋆ Protecting the airway
- ⋆ Obtaining vital signs and communicating them loudly
- ⋆ Adding finger stick blood sugar to the vital sign category
- ⋆ Getting the patient's chart
- ⋆ Controlling traffic
- ⋆ Opening ward doors for the crash cart and incoming staff
- ⋆ Having a staff person direct incoming staff to the emergency
- ⋆ Documenting on the flow sheet, completely and accurately
- ⋆ Educating staff on equipment
- ⋆ Updating equipment for better, easier use

Then coincidentally with TJC's standard regarding "how to identify early warning signs of a change in a patient's condition and how to respond to a deteriorating patient, including how and when to contact responsible clinicians," we targeted that statement in our CPR Competency to help staff know to call a code early in an event and to "know the individual you serve" to make sure staff can detect even minute changes in medical or mental behavior.

Additionally, during our Competency year trainings, instructors review Policy 3022 to ensure staff are familiar with the policy, their roles, the roles of others, and what tasks are expected to be performed. Then participating staff perform a mock CPR scenario, finding the victim, assessing the victim, calling a code, and then starting CPR all based upon the AHA BLS CPR criteria.

Our analysis shows that Code Blue events are running more smoothly and properly.

Code Blue events are inherently scary, but with training, prompts, and practice, all staff know how to respond quickly and appropriately. Being confident that each person who participates in a Code Blue knows his or her role lets us focus on our own role in such an event. This can save lives.

~ Rebecca Sparger, RN, BSN
Training Coordinator

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

~Thomas Jefferson, Declaration of Independence: July 4, 1776

Welcome Aboard!

Please welcome the newest additions to the SWVMHI team!

Left to right: Corey Lester, Elizabeth "Katie" Smith, Jeremy Lampkins, Wendy Dolinger, and Kristin Epperson

SWVMHI is pleased to welcome **Kristen Epperson,** CNA to our team. Kristen will be working on Geriatrics, Wards E/F, on third shift. She has been a CNA for one year and lives in Wytheville, Virginia, with her husband. Kristen graduated from George Wythe High School and has some college courses to her credit. She previously worked at Edgemont Nursing Home in Wytheville and has done home health work.

Wendy Dolinger enjoys horseback riding. She received a B.S. from Old Dominion University. Currently, Wendy lives in Troutdale, Virginia. She previously worked at River North Correctional Center, Med-Fit Systems, and at Grayson Highlands State Park. Wendy will be working as a Fiscal Tech Senior in the Henderson Building. She has two relatives who work at SWVMHI. Her sister-in-law, Ashley Privett, who works in Rehab Services, and her cousin, Karen works in HIM.

Jeremy Lampkins likes to fish and hunt. He is single and lives in Chilhowie, Virginia. Jeremy graduated from Chilhowie High School. Previously he worked at Food City. Jeremy has accepted a position in housekeeping as a seasonal employee and hopes to eventually move into a full time position. His mother is Candy Lampkins, LPN on Ward E/F first shift.

Katherine (Katie) Smith is a new RN graduate and just recently passed her boards. Way to go Katie! Katie will be working on Geriatrics, Wards E/F on third shift. She graduated from Northwood High School and obtained her AS in Nursing from Wytheville Community College. Katie currently lives in Blacksburg, Virginia, but plans to move to this area soon. She has worked at Maxim Healthcare, County Retreat, and BrightStar Homecare.

Corey Tremayne Lester comes to us from Lumberton, North Carolina, where he graduated from Lumberton High School. Currently Corey resides in Marion, Virginia. He has worked at Mt. Rogers IDC and Monarch. Corey will be working as a psychiatric aide on Ward A/B on third shift.

Regina Hawkins, LPN, returns to SWVMHI after a 5 month hiatus. Welcome back Regina! She loves going to her grandson's ballgames and spending time with her family. Regina previously worked at SWVMHI part time and returns to work full time. She started out as a CNA and earned her LPN degree in 2011 from Wytheville Community College while working here. Regina and her husband of ten years, John Hawkins, live in Rural Retreat, Virginia, and they have two adult children and five grandchildren. She previously worked at Carrington Place in Wytheville, Virginia. Regina will be a float on second shift.

Left to right: Jessica M. Cumbee, Nicole MGrady

Continued on page 13

Recovery Hero

A Spotlight on Our Employees Using TOVA Skills and Assisting People with Their Recovery

Recently, on Ward AB, Pam St. John, Psychiatric Aide, was sitting with an individual on constant observation during meal time. The individual ate very quickly using her hands, putting herself at risk of choking. Pam quickly realized the risk to the individual and called for help. Then she moved the tray out of reach of the individual and assisted her with eating.

Pam was monitoring the individual closely and reacted quickly, realizing the individual could be at risk for choking if she continued to eat so quickly. Pam began talking to the individual, coaching her to use appropriate utensils, and to slow down between bites. Because she reacted quickly and possibly prevented an individual from choking, Pam is our Recovery Hero this month. She has been employed at SWVMHI since March 10, 2003, and we are glad that she is a part of our team. Please remember to congratulate Pam when you see her.

~ Robin Poe, MSN, RN-BC
Coordinator for Nursing Development

PERSONNEL CHANGES*

New Employees

Katherine "Katie" Smith, RN In Training	Jun 10
Corey Lester, Psychiatric Aide	Jun 10
Wendy Dolinger, Fiscal Technician Sr.	Jun 10
Regina Hawkins, LPN	Jun 10
Jeremy Lampkins, P14 Seasonal Housekeeping Worker	Jun 10
Kristin Epperson , Psychiatric Aide	Jun 10
Nicole McGrady, Patient Registrar	Jun 15
Jessica Cumbee, P14 Patient Registrar	Jun 15
Angelia Farmer Campbell, P14 RN	Jun 25
Morgan Kimberlin, P14 Seasonal Housekeeping Worker	Jun 25
Scott Graham, P14 Seasonal Housekeeping Worker	Jun 25
Constance Owens, P14 Seasonal Housekeeping Worker	Jun 25

Promotions/Role Changes

Mary Chandler, P14 to full time LPN	Jun 10
Connie Blizzard, P14 to full time LPN	Jun 10

Service Retirements

Katherine Hogston	Jun 26

MONTHLY PATIENT CENSUS

May 2015

Admissions 76

Discharges 65

Passes 20

Average Daily Census 156

* As of the time the newsletter was printed for distribution

Have you recently changed your phone number? Policy 2011, *Current Telephone Listing*, states, "Each employee is also responsible for immediately notifying his or her supervisor regarding a change in the phone number given in order to maintain a current listing. Failure to do so will result in performance counseling and possible disciplinary action if the problem is not promptly corrected." Phone numbers are kept confidential; however, the facility needs to be able to reach you in the event of an emergency.

Special Gym/Game Room Activities

Consumer Empowerment Recovery Council (CERC)
July 23, 2015
1515 - 1545

Patient Activity Council (PAC)
July 23, 2015
1545 - 1615

Movie Nights
July 6, 7, 13, 14, 20, and 21, 2015

Birthday Party
July 28, 2015
1800 - 2000
No Café

Freedom Day Celebration
July 23, 2015
1330 - 1500

Church Services held each Thursday from 1830 - 1930. New Day Café open prior to Church Services **except on July 2 when it is closed**.

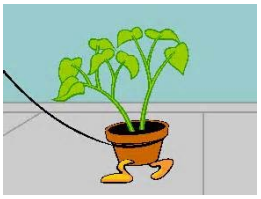
Please note that game room activities, in addition to those listed here, are held every weeknight, except as otherwise noted, from 1830 - 2000. New Day Café hours are from 1800 - 1830 unless otherwise noted as well. ***NOTE: No groups or evening Game room on Friday, July 3, 2015, are scheduled.***

July Days to Celebrate

"Off the cuff" July holidays to celebrate:

July 7
Chocolate Day
July 10
Teddy Bears' Picnic Day
July 11
Slurpee Day
July 13
National French Fries Day

July 18
National Hot Dog Day
July 23
Batman Day
July 27
Take Your House-plants for a Walk Day
July 29
National Chicken Wing Day
July 30
National Chili Dog Day



Welcome Aboard, *continued*

Jessica M. Cumbee is a P-14 Patient Registrar for HIM. Jessica has been a full time mom homeschooling her three children. She and her husband Nathan and their children live in Speedwell, Virginia. Previously, Jessica worked at Wythe County Community Hospital. In her spare time, Jessica is a fiber artist.

Nicole McGrady enjoys gardening and reading. She and her husband Stacey have five children total, of whom two are hers and three are her husband's. Nicole graduated from Wytheville Community College and worked for 13 years at Merillat and one year at Smyth County School Board. She and her family live in Marion, Virginia. Her mother, Linda Anderson, also works at SWVMHI.

Left to right: Morgan Kimberlin, Constance Owens, Scott Graham, Angie (Farmer) Campbell

Morgan Kimberlin is a recent graduate of Marion Senior High School (MSHS) and loves to play soccer. She lives in Atkins, Virginia, and is planning to attend Virginia Highlands Community College in the fall working towards her RN degree. Morgan worked at Food City while in high school. Her great uncle Wayne VanHoy works in Housekeeping where Morgan will be working as a P-14. Morgan hopes to one day become a full time employee at SWVMHI.

Constance Owens works a lot and goes to school. Constance has two young children and lives in Marion, Virginia. She is working several jobs while attending Virginia Highlands Community College for work in Substance Abuse. Constance also graduated from MSHS. Previously she worked at Hardee's as a manager, Walmart as a photo lab specialist, and the ABC store as lead sales/manager. Constance will be working as a P-14 in housekeeping. Constance also hopes to one day become a full time employee at SWVMHI.

Scott Graham also will be working as a P-14 in housekeeping and he is also a recent graduate of MSHS. This fall, Scott will be attending Pensacola Christian College with a goal of becoming a missionary to Thailand. Scott lives in Marion and received an Associate Degree from Wytheville Community College in general studies. Previously he worked at Environmental Enterprises, Inc. located in Marion.

Angelia (Angie) Farmer Campbell is a re-hire. Angie previously worked here from 1998 to 2001. She re-married last month so congratulations to the newlywed. Angie loves spending time with her grandchildren. She and her new husband have two children each and seven grandchildren combined. They live in Bristol, Virginia. Angie received her nursing degree from Virginia Highlands Community College and King College. Previously she worked at Quintiles in Raleigh, North Carolina, and Chiltern International in Bristol, Tennessee, both of which are pharmaceutical research facilities. For leisure Angie enjoys camping and boating. She will be working first shift as a P-14 RN.

Please give our newest employees a warm welcome to the SWVMHI family.

~ Training Department

Fun Facts about George Washington

Everyone in America knows that George Washington was the Father of our Nation and our first President. But did you know these things about our first leader?

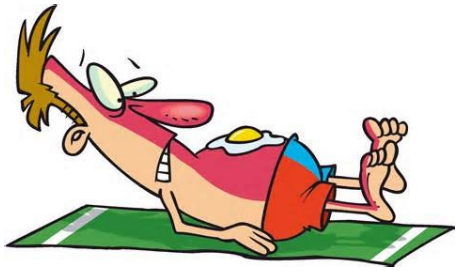
- He was not born on February 22, 1732. He was actually born February 11, 1731, but when the colonies switched to the Gregorian from the Julian calendar, his birthday was moved eleven days.
- The hair that is pictured in all portraits was his own and not a wig. It looks white because he powdered it.
- No one will ever rank higher than him in the U.S. military. In 1976, Washington was posthumously awarded the highest rank of "General of the Armies of the United States," because he established the framework for the American military and almost every big decision he made set a precedent.
- For a time, he was a non-President Commander-in-Chief. In 1798, when fears were growing of a French invasion, John Adams named Washington Commander-in-Chief of the U.S. Military, even though he was quite old and no longer president because his name was well known and it was thought this would help with recruitment of solders.
- He never chopped down that cherry tree. Parsons Weems, who wrote a myth-filled biography of Washington shortly after his death, made up the cherry tree story.
- Before becoming Father of the Nation, Washington was a master surveyor. He spent the early part of his career as a professional surveyor and created some 199 land surveys over the course of his life.
- He didn't have wooden teeth. But he did have teeth problems. When he attended his first inauguration, he only had one tooth left.
- He is the only president to actually go into battle while serving as president.

~ http://mentalfloss.com

First Aid Tips: Sunburns

Yeah! Summer is essential with vacations, and who doesn't like to go to the beach?!? When we think of beach vacations we think of "beach reads," eating out, sleeping late, lazy days, family, fun activities and sunburns.

Sunburns are so avoidable, yet when we get to the beach, we want to feel the sun, be out in the sun, and see our skin being "sun kissed." Yet sun kissed can and often does mean sunburned. Folks don't think of sunburns as burns from radiation like nuclear accidents, but sunburns are a form of radiation burn that affects living tissue -- the skin. This type of burn generally comes from increased exposure to Ultraviolet (UV) radiation, which is usually from the sun, but may be a result of tanning beds. (Just when you thought it was safe to take a nap.)



Skin symptoms of sunburn are reddened skin, skin that feels hot, and is painful to touch. General symptoms can include weakness, general fatigue, and mild dizziness. More severe symptoms can include edema, itching, nausea, fever, chills, and fainting. The burns can be first degree (redness) or second degree that include blistering. Some severe sunburns can be life threatening.

Excessive UV radiation is the leading cause of primarily non-malignant skin tumors. Sunscreen is widely agreed upon to prevent sunburn and some types of skin cancers. Sun damaged skin is evident in people in the form of accelerated aging of skin such as excessive wrinkling and sagging skin; age spots; uneven skin tone; and, actinic keratosis that often progresses to squamous cell carcinoma.

Prevention is the key to not getting sunburned. Ways to prevent sunburns are to limit exposure to tanning beds and direct sunlight. Stay out of the sun, if possible between the hours of 1000 and 1600. If you must (or want to) be out in the sun, then protect yourself by wearing a hat to protect your head, neck, ears, and face. Wear light colored, long sleeved shirts. Wear sunglasses with UV protection, as sun damage can occur in the eyes and cause cataracts. Also, sunlight is reflective, so be aware of where you are such as near water, metal, white sand, etc.

Most importantly, protect your skin by wearing a high numbered (at least 30 or greater) broad spectrum SPF sunscreen to limit DNA damage to the skin. An average adult male should apply an amount equal to one ounce, which is two tablespoons. Apply the sunscreen about 15-30 minutes prior to sun exposure and then reapply 15-30 minutes after exposure. Depending upon the directions, reapply after swimming, sweating, or rubbing the skin.

Without protection the skin can burn in less than 15 minutes or in seconds from intense UV light. The harm is not always so readily apparent. The harm or burn (skin damage) appears from 30 minutes after exposure to up to 2-6 hours. The pain from sunburns is most apparent 6-48 hours after the exposure, and the burn may continue to develop for 1-3 days longer. Peeling skin may start anywhere from 3-8 days after exposure and up to three weeks. But again, long lasting damage can occur and not be evident for years, way too late to do anything about it, except see the dermatologist and have the skin cancers removed, and wish you were 16 again and knew then what you know now.

Getting increased UV radiation increases the risk of getting three types of skin cancers: melanoma, the most serious; basal cell, the least serious and most common; and squamous cell, which can grow aggressively and spread. The risk for melanoma increases with the number of lifetime cumulative sunburns. Prevention is the key, and early detection can be the cure.

People at higher risk for getting sunburns are those six and younger and 60 and older, since their skin is more fragile. Additionally, some antibiotics, oral contraceptives, tranquilizers, and some over the counter medicines increase the sensitivity of the skin to sun exposure. Read the labels and take precautions.

People get suntans and there is some protective factor in that. Suntans increase melanin production causing a darkening of the skin, and are a natural defense against sunburn overexposure. However, both sunburns and suntans are triggered by direct DNA damage to the skin cells from UV light.

Treatment of sunburns consists of applying cooling gels with aloe vera, menthol, or camphor that have been refrigerated, cool running water, soaking in a cool bath, NSAIDs for pain and swelling, and drinking plenty of water to rehydrate. Also, stay out of the sun until the burn is gone. Remember prevention is the best cure!

Source: www.WebMD.com

~ Rebecca Sparger, RN, BSN
Training Coordinator

Oh, say does that star-spangled banner yet wave
O'er the land of the free and the home of the brave?

Word Search

Just for fun, how many of the following words can you find related to the Fourth of July ?

Q	W	E	R	T	Y	U	I	O	B	Y	P	A	S	D	F	G	H
M	O	N	T	H	J	K	L	Z	L	X	C	V	B	N	D	M	P
O	I	U	C	Y	T	R	E	U	U	W	Q	L	K	E	E	J	H
G	F	D	O	S	A	M	J	N	E	B	V	C	L	X	C	Z	J
A	H	F	N	S	A	Z	X	C	V	B	N	E	G	F	L	D	S
M	Q	W	T	E	G	R	T	Y	U	I	G	S	O	P	A	K	H
E	C	G	I	F	R	D	A	Z	X	A	I	C	V	B	R	N	M
R	A	T	N	G	E	E	F	D	T	G	F	G	H	J	A	X	C
I	N	D	E	P	E	N	D	E	N	C	E	R	E	W	T	C	V
C	N	V	N	D	N	E	S	E	V	E	C	V	B	B	I	N	S
A	O	D	T	R	E	B	D	X	V	L	Q	W	E	R	O	T	K
F	N	V	A	H	R	V	B	N	M	E	H	G	F	D	N	S	R
E	S	N	L	V	Y	V	B	N	M	B	U	T	R	E	W	Q	O
X	C	O	G	H	J	K	F	O	U	R	T	H	F	S	R	V	W
I	U	I	T	R	E	W	Q	A	D	A	C	V	B	A	N	M	E
F	D	T	G	H	J	K	L	M	E	T	I	H	W	B	V	C	R
R	T	A	C	A	R	T	I	L	L	E	R	Y	V	B	N	M	I
H	A	N	C	O	C	K	P	O	I	U	Y	T	R	E	W	Q	F

July Fourth — American Independence Day. A day to celebrate with picnics, hot dogs, apple pie, and fireworks, all decked out in red, white, and blue. But did you know that America did not actually declare its independence on July Fourth? The actual vote by the first Continental Congress took place on July 2 but was not published in the newspapers until July 4. The Declaration of Independence was also not fully signed on July 4 either. John Hancock was the first signer of the document, and he signed it on July 4, but it took a full month for all 56 delegates to sign. Did you also know that July 4 was originally celebrated with lots of greenery? The traditional red, white, and blue colors were not widely available at the time of our nation's birth, nor were fireworks. Artillery that were used during battle were used as part of the July Fourth celebration following the war, but the practice dissipated as the cannons fell apart over time and were slowly replaced with fireworks.

Southwestern Virginia Mental Health Institute

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Comments, Suggestions or Ideas?

SHARE THEM!

Please send any comments, suggestions, or ideas you have regarding the newsletter to the Office of the Director.

View the news in FULL COLOR at www.swvmhi.dbhds.virginia.gov/swvmhi/news/newsletter.asp

This Month's Word Search Answer Key

									B	Y							
M	O	N	T	H					L						D		
			C					U	U					E	E		
			O				J		E				L		C		
A			N									E			L		
M			T		G						G	S			A		
E	C		I		R					A	I				R		
R	A		N		E	E			T	G					A		
I	N	D	E	P	E	N	D	E	N	C	E				T		
C	N		N		N		S	E		E					I		S
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		A		A	R	T	I	L	L	E	R	Y					I
H	A	N	C	O	C	K											F

Please submit articles for the next newsletter to Cheryl Veselik by July 20, 2015.

The next newsletter will be published August 1, 2015.