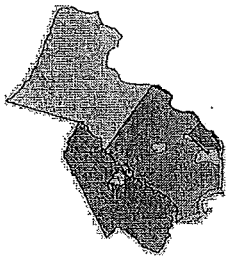

Northern Virginia Regional Management Group

Serving Alexandria, Arlington, Fairfax-Falls Church, Loudoun, and Prince William Community Services Boards

Regional Admission Procedures

Section I: No ECO: Procedures for Accessing Psychiatric Hospital Bed for Voluntary, TDO, CMA, and Commitment Admissions

Step 1: CSUs - If appropriate, contact the four regional Crisis Stabilization Units to determine bed availability and/or eligibility for admission. If no bed is available or appropriate, move to Step 2.

Step 2: Regional and Near-Regional Hospitals - Contact the following hospitals to determine bed availability and/or eligibility for admission:

- Dominion Hospital
- Inova Fairfax
- Inova Loudoun
- Inova Mt. Vernon
- Novant Prince William
- Virginia Hospital Center
- Spotsylvania Regional Medical Center
- Snowden Hospital
- The Pavilion at Williamsburg Place
- Poplar Springs

If no bed is available or appropriate, move to Step 3

Step 3: Solution Finders have been identified for all of our regional hospitals and all of our hospitals with whom we have a partnership. At hospitals where beds are available but could not be accessed with an initial telephone call, Emergency staff and/or Emergency Managers will discuss barriers and potential solutions with the Solution Finders. If no bed becomes available or appropriate, move to Step 4.

Step 4: State Hospitals - Contact NVMHI. If no bed is available at NVMHI or admission can't occur due to medical issues, move to Step 5.

Step 5: Psychiatric Bed Registry - Review the Psychiatric Bed Registry, and

14150 Parkeast Circle, Suite 275
Chantilly, Virginia 20151-2923
703-449-6303, Fax 703-968-4020
www.fairfaxcounty.gov/csb/region

contact hospitals that have beds for the age range of your individual.

Step 6: No available bed at any hospital - Alert NVMHI of need for bed. Keep individual in originating hospital (CMA or committed individual), Emergency Department, MH center or police station until bed is available at NVMHI or a private hospital.

- If week day hours, Emergency Services Managers will alert their own Aftercare Manager and the NVMHI Director of Clinical Social Work (in her absence, the NVMHI Social work secretary) that a bed cannot be located.
- If week day hours, NVMHI will identify individuals at NVMHI who may be able to be discharged. Potential options include: individuals identified for discharge for same or next day, individuals capable of being moved to CSU for temporary or step-down purposes; individuals who are NGRI and have passes as part of their treatment plan; review of bed holds.
- If week day hours, discharge planners will also review LIPOS and CSU individuals and determine whether LIPOS or CSU individuals can be discharged in order to create a bed in a private hospital
- Emergency staff will continue to contact private hospitals at regular intervals and/or get updates from the Psychiatric Bed Registry.

Step 7: Admission over capacity

- For TDO admissions, NVMHI is mandated to go over capacity or arrange an admission at another state facility. If no ECO is in place but a TDO is determined to be needed, Emergency staff will conduct a thorough bed search as described in Section I, Steps 1-6 of this document. If the CSB is unable to locate a TDO bed, NVMHI will be contacted, and they will accept the individual or facilitate an admission to another state hospital
- For non-TDO admissions, NVMHI can go over capacity if all other options have been reviewed and exhausted

Step 8: Post-Admission - Emergency staff will document responses on CSB Hospital Log. CSB Emergency Managers will send CSB Hospital Logs to the Regional Projects Office on a monthly basis for 1) TDO admissions to NVMHI, and 2) other admissions upon request.

If an admission results in **NVMHI exceeding its capacity**, the following will occur the next business day:

- The discharge planner of CSB that admitted this individual will work with NVMHI and other CSB discharge planners to bring NVMHI back to no more than their capacity as soon as possible.
- If the individual can be moved to a bed in a private hospital, Emergency staff will take the lead in locating that bed and arranging the transfer.
- Emergency staff will notify the Regional Office at 703 449-6303
- The Regional Office will conduct a review of the process with a focus on utilization management and quality clinical care.

Section II: Emergency Custody Orders (ECO): Procedures for Accessing Psychiatric Hospital Bed for TDOs

Step 1: Notification of State Facility - When an ECO is executed or when an individual has been taken into custody, law enforcement will contact their CSB Emergency Services, and that CSB will call NVMHI.

Note: Contact Piedmont Geriatric Hospital (PGH) for individuals ages 65 and over, and Commonwealth Center for Children and Adolescents (CCCA) for individuals under age 18.

> **Youth (under age 18):** Review Attachment A regarding admission procedures to the state facility, Commonwealth Center for Children and Adolescents (CCCA).
>
> **Older Adults (ages 65 and over):** Review Attachment B and C regarding admission procedures to the state facility serving our region, Piedmont Geriatric Hospital.

Step 2A: ECO evaluation is completed and no state hospital bed is needed - Contact NVMHI as soon as possible.

Step 2B: ECO evaluation is completed and TDO bed is needed

- Follow Section 1, Steps 1-5 to secure TDO bed. Notify NVMHI when a bed is secured.
- At 4 hours, if no bed has been located, move to Step 3.

Step 3: ECO in progress at 4 hours - If the ECO evaluation and/or bed search has not been completed after **4 hours** from being executed, the CSB will notify NVMHI and submit admission paperwork as described in pages 7-9 of this document. The following options may occur:

1. **No bed available except at NVMHI:** ECO evaluation has been completed and has resulted in the determination that a TDO is needed and no bed other than NVMHI has been located. At this time, the CSB arranges a last resort TDO bed. NVMHI reserves two beds for TDOs. A TDO request to NVMHI will only occur after a minimum of 8 hospitals have denied admission.
2. **No bed available at NVMHI:** ECO evaluation has been completed and resulted in the determination that a TDO is needed, no bed is available after contacting 8 hospitals, and no bed is available at NVMHI. At this time, the CSB proceeds to Psychiatric Bed Registry procedure as outlined in Section I, Steps 5-7 of this document.

Step 4: No bed after 7 hours - If no hospital bed has been located after **7 hours**, CSB notifies NVMHI, and one of two options will occur:

1. NVMHI will exceed its established capacity;
2. NVMHI Facility Director or designee will facilitate an admission to another state hospital.

Step 5: TDO prior to 8 hours - At **no later than 8 hours**, a TDO is issued with a location of NVMHI or other state facility as identified by the Director of NVMHI.

Step 6: Bed located after 8 hours - If a hospital bed is located after the individual is en route to NVMHI or another state facility, the CSB will:

1. Notify Law Enforcement;
2. Notify NVMHI;
3. Designate the alternative facility on the prescreening report
4. Send Notice of Alternative Facility of Temporary Detention (Form DC-4044) to the clerk of the issuing jurisdiction.

Step 7: Bed more appropriate (as determined by CSB and NVMHI) is located after admission - If a hospital bed is located after the individual has been taken to NVMHI or other state facility but prior to the TDO hearing, CSB will:

1. Obtain transportation order from their magistrate (Form DC-4046)
2. Send Notice of Alternative Facility of Temporary Detention (Form DC-4044) to the clerk of the issuing jurisdiction.
3. Designate the alternative facility on the prescreening report

Individual will be transported and admitted to the more appropriate placement.

Step 8: Post-Admission - Emergency staff will document responses on CSB Hospital Log. CSB Emergency Managers will send CSB Hospital Logs to the Regional Projects Office on a monthly basis for:

1. TDO admissions to NVMHI;
2. Other admissions upon request.

If an admission results in **NVMHI exceeding its capacity**, the following will occur the next business day:

- The discharge planner of CSB that admitted this individual will work with NVMHI and other CSB discharge planners to bring NVMHI back to no more than their capacity as soon as possible;
- If the individual can be moved to a bed in a private hospital, Emergency staff will take the lead in locating that bed and arranging the transfer;
- Emergency staff will notify the Regional Office;
- The Regional Office will conduct a review of the process with a focus on utilization management and quality clinical care.

Note: NVMHI will assure that Nursing Supervisors, PCPs, psychiatrists, and admission staff are familiar with responsibilities related to bed unavailability and time frames for contacting supervisors and other state hospitals. Emergency Managers will assure that their staff have current information regarding bed availability, bed registry access, contact information at relevant private facilities (CSB Hospital Log, Solution-Finders List, updated lists are on the web site at www.fairfaxcounty.gov/region), time frames for contacting and receiving responses from

private providers, and time frames for contacting supervisors regarding a potential inability to find a needed hospital bed for an individual.

Specialty Populations:

ID/DD: For adults who have ID or DD, consult with REACH staff to determine the need for their involvement.

Deaf: For adults who are deaf, hard of hearing, late deaf, or deafblind, consult with staff at Western State Hospital (WSH) if no beds are available in community hospitals or NVMHI. Only on rare occasions would a deaf individual be directly referred to WSH. As mandated by State Code, VDDHH (Virginia Department for the Deaf and Hard of Hearing) maintains a directory of Qualified Interpreter Services and works to remove communication barriers. DBHDS, in cooperation with the CSBs, provides comprehensive consultative services; contact Kathy Baker, Coordinator of Services at (540) 213-7527.

Contact Information:

- **NVMHI:**
  - 7am-4:45pm: Phone (703) 207-7170 and Fax (703) 207-7150
  - 4:45pm-6:59am, weekends, holidays: After-Hours pager (703) 719-8325 and Fax (703) 207-7304.

- **Piedmont Geriatric Hospital:**
  - Notification of ECO only (to include individual's initials, CSB, evaluator's name and phone number and ECO start time):
    1. Voicemail (434) 767-4926 **or**
    2. E-mail pghecoNotification@dbhds.virginia.gov.
  - 7:30 am-4:00 pm: Phone (434) 767-4926 and Fax (434) 767-2352
  - After 4:00 pm, weekends, holidays: Phone (434) 767-4401 and Fax will be designated by on-call admissions clinician

- **Commonwealth Center for Children and Adolescents:**
  - 24-7: Phone (540) 332-2120 and Fax (540) 332-2202

Section III: Bed Management at NVMHI

In an effort to manage regional inpatient resources so they are available throughout the fiscal year, the Regional Utilization Review and Consultation Team (RUG) reviews and modifies admission criteria for LIPOS, NVMHI, and CSUs on an as needed basis. Consistent with our mission of using least restrictive community resources, long-term inpatient psychiatric care is not available in our region. The below admission criteria reflect the decisions made by RUG.

Definitions:

- Insured individuals are those who have Medicaid, Medicare, and/or commercial insurance.
- Level I individuals are those who have high acuity/low complexity needs and require acute stabilization
- Level II individuals are those who have high acuity/high complexity needs and require intensive care

NVMHI Admissions of Uninsured Individual:

- Uninsured individuals will be referred to NVMHI. Admission to a private hospital using LIPOS funds will only occur if no beds are available at NVMHI.
- Uninsured individual with Level II inpatient clinical needs will be given priority admission to NVMHI over an uninsured individual with Level I needs.
- Regardless of Level, an individual must be medically cleared by NVMHI before an admission can occur.

NVMHI Voluntary Admission of Insured Individual:

- A voluntary admission with insurance will be directed to a private hospital.
- Exception: After regional private hospitals and partnership hospitals (Spotsylvania Regional Medical Center, Snowden Hospital, The Pavilion at Williamsburg Place, and Poplar Springs Hospitals) have denied admission, an insured voluntary individual may be admitted to NVMHI but only with CSB Emergency Manager approval. The Emergency Manager will notify NVMHI of their approval.

CSU Admissions:

- Insured individuals at NVMHI may be admitted to any of our regional CSUs (step-down admissions).
- Individuals can simultaneously be put in a LIPOS or NVMHI bed AND be put on the CSU referral list (so they can be moved to a CSU as soon as a bed becomes available).

NVMHI Post-hearing Admissions:

- Following designation of LIPOS funding for post-hearing placement, Emergency staff may continue to make efforts for transfer to NVMHI for 24 hours following the hearing. After that time, Emergency staff will turn over the transfer process to the CSB Discharge Planner.
- Level I uninsured individuals who are post-hearing may stay at the hospital where they were detained or be transferred to NVMHI; an individual who may complete their treatment episode quickly may be better served by remaining at the detention hospital.

Section IV: Transfers to NVMHI

<u>Regional Admissions Committee</u>

Background:

- Individuals who are recommended for transfer from a private hospital to NVMHI will continue to receive active treatment in the private hospital up until their transfer to NVMHI
- Transfers of Level II individuals are likely to occur because of their complex needs.
- Transfers of Level I individuals may be less likely if inpatient treatment can be completed in a brief episode
- An individual's treatment remains the responsibility of the admitting hospital if 1) insurance is either exhausted or denied during the course of the private inpatient treatment, or 2) the individual is uninsured and admitted directly to a hospital without CSB involvement.

  Exception: These individuals may be transferred to NVMHI only with the approval of the CSB Aftercare Manager (or designee) and the NVMHI Director of Clinical Social Work (or designee).
- If the insurance policy had expired before the course of private inpatient treatment began, the individual is considered to be uninsured.

Procedures

Step 1: Referral for transfer from a LIPOS hospital to NVMHI occurs after the CSB Discharge Planner determines that the transfer is clinically necessary and directly communicates that decision to NVMHI.

Note: Exceptions can be made in unusual circumstances as follows: CSB Emergency Manager has determined the need for transfer at the time of the LIPOS admission and has directly communicated that request to NVMHI, the CSB Discharge Planners, and the Regional Projects Office.

Step 2: Transfers of insured individuals from a private hospital to NVMHI will only occur after regional review. CSBs or hospitals can initiate the Regional Admissions Committee review process by contacting the Regional Office at 703 449-6303.

- Regional review involves participation by one person from each of the following: 1) NVMHI, 2) CSB, and 3) Regional Office. If one of those parties is not available, then the review defaults to two.
- This review will occur within one week of paperwork (identified below) being submitted to NVMHI and the Regional Office.
- Participants to this phone call have set aside the following times for the review: Tuesdays, 10-11 am (Loudoun and Alexandria CSBs) and Wednesdays, 2-3 pm (Prince William, Fairfax-Falls Church, and Arlington CSBs).
- If this review results in a finding that a transfer to NVMHI is needed, the CSB will provide that update to the private hospital.
- The individual will be transferred to NVMHI or put on the Ready for Transfer List on the date of that review and will be admitted pending bed availability.

Step 3: Records needed for transfers to NVMHI are listed in Section V.

Section V: Medical Assessments

NVMHI is a freestanding, psychiatric facility with limited medical care capability for individuals who require laboratory, x-ray or other diagnostic tests, therapeutics, oxygen or any kinds of drains or tubes. Stabilization of acute medical problems prior to admission is critical for the individual's safety. Medical stabilization without providing active treatment or diagnosis of underlying condition (i.e., transfusion, sodium supplementation, lowering of BP) for the sole purpose of transportation is not sufficient.

Medical Screening:
For an individual at a CSB, the following information is needed:

- Vital signs
- Urine dipstick
- Breathalyzer
- CSB Preadmission Screening From

For an individual in a hospital, the above information and the following additional information are needed:

- Physical Exam
- CBC
- Urinalysis
- Comprehensive Metabolic Panel
- Urine drug screen and blood alcohol level

If the results of the tests/assessments listed above and/or the described presentation of individual being assessed suggest a potential medical issue, additional tests may be required (i.e., Medical Clearance) to assure an individual's safety at NVMHI.

Medical Clearance:
Acute medical problems or intoxication may mimic psychiatric symptoms and may be suspected in individuals who have no previous psychiatric history. Frequent causes of acute delirium include: pneumonia, infections, dehydration, organ failure, some cancers and CVA. These individuals need to be treated in an acute care facility prior to admission to NVMHI. **To rule out medically induced psychiatric symptoms and to ascertain whether this individual can be appropriately treated at NVMHI, the following are essential for individuals with a suspected medical issue:**

- Physical examination
- CBC
- Urinalysis
- Comprehensive Metabolic Panel
- Urine drug screen & Blood alcohol level

Additional tests may be recommended depending on results to assure that this individual can be cared for at NVMHI.

A Primary Care Physician (PCP) is on call 24/7 and works as follows:

- PCP is available for MD to MD communication to clarify what is needed for NVMHI to medically clear the individual.
- PCP reviews the test results
- NVMHI PCP medically clears the individual for admission as appropriate,
- NVMHI admission staff or Nursing Supervisor (after 4:45PM) informs the CSB that NVMHI is ready to accept the individual. Only at this point should individuals be transported to NVMHI.
- If NVMHI does not medically clear the individual, reasons will be provided to the CSB staff person whom will need that information as they search for beds at other hospitals.
- Medical assessments are described in Medical Screening and Medical Assessment Guidance Materials issued by DBHDS on April 1, 2014 (Attachment D).

Substance Abuse Issues

NVMHI does not admit individuals who are intoxicated **and** have a history of significant withdrawal symptoms (i.e., seizures, DT's). NVMHI does not have the capability for intubation or providing ventilator support or inserting IV's if the need should arise. There is no specific cut-off point for BAL. An individual cannot be admitted if he/she is obtunded or is having difficulty breathing or regulating their airway or have an underlying medical condition that cannot be appropriately treated at NVMHI. Methadone is not available after 4:45PM; NVMHI cannot conduct an after-hours admission for individuals who will require Methadone upon admission.

Records

- Records needed for transfers to NVMHI:
  - CSB Prescreening Form
  - Medical History & Physical Exam
  - CBC
  - Urinalysis
  - Comprehensive Metabolic Panel
  - Urine Drug Screen
  - Blood Alcohol Level
  - Medication Administration Record
  - Admission Psychiatric Assessment
  - Psychiatry Progress Notes
  - Nursing Progress Notes
- The following, only if performed:
  - CIWA
  - List of Vaccines given
  - Radiological Studies
  - Consultation Reports/Notes
  - Result of PPD

- Medical information should be faxed to NVMHI using the Medical Clearance FAX Form (Attachment E).
- Transfers from a private hospital to NVMHI must include a sufficient exchange of verbal and written communication so that clinical/medical information is clear prior to NVMHI admission
- Note: In rare circumstances, some of these procedures may be waived, such as in the situation where the individual just recently left NVMHI.

ECOs

- As described in Section II, individuals under an ECO who need a TDO bed and no bed is available will be admitted to a state facility.
- If the state facility physician believes the individual's medical needs exceed the capabilities of the state facility, the state hospital physician will communicate that information to the ER physician.
- If the ER physician sends the individual anyway, the state hospital will respond accordingly, including the possibility of immediate transport to the nearest ER or attempting to secure medical admission elsewhere.
- The requirements of EMTALA must be met by the sending facility and sending an individual to a hospital that cannot safely manage the individual's medical condition is taking a risk on the part of the sending hospital.
- An optimal option would be for ER physician to keep and treat the individual until he is stable enough to be transferred to the TDO facility and/or consider the appropriateness of a Medical TDO.

Section V: Quality Improvement Procedures

In an effort to manage regional inpatient resources so they are available throughout the fiscal year, the Regional Utilization Review and Consultation Team (RUG) reviews and modifies admission criteria for LIPOS, NVMHI, and CSUs on an as needed basis.

- RUG meets monthly and includes members from NVMHI, CSB Emergency Managers, CSB Aftercare Managers, CSB Youth Managers, and the Northern Virginia Regional Projects Office.
- Private hospital partners join this RUG meeting on a quarterly basis.
- RUG agenda items are also addressed at monthly meetings for CSB Emergency Managers and CSB Aftercare Managers.
- Recommendations about policies and significant procedures are forwarded to the Regional Management Group (RMG), comprised of the five CSB Executive Directors and the two Facility Directors in Region II, for their final decision.

Information from the following sources will be summarized monthly (if available) by the Regional Projects Office and submitted for review to the RUG and RMG:

- LIPOS, NVMHI, Piedmont Geriatric Hospital (PGH), and CSU utilization, including utilization per 100,00, and occupancy

- TDO analyses
- Insured admissions to NVMHI
- Extraordinary Barriers List
- Hospital logs for NVMHI TDOs and other logs as requested
- Bed Registry Summary
- Number of contacts to NVMHI or PGH for assistance with bed finding
- Detailed review of Reportable Events (ECOs beyond 8 hours, difficulty obtaining TDO beds

These groups will review data and make recommendations for improvements as needed.

CSB Emergency and Aftercare Managers and NVMHI Supervisors will assure that their staff read these Regional Admission Procedures and that they receive updates to these procedures as they occur.

Effective: June 13, 2014

Joseph Wilson by Margaret Graham 6/27/14

Joseph Wilson, Chair, Executive Director — Date
Loudoun County Community Services Board

Suzanne Chis by Carl Ager 6/27/14

Suzanne Chis, Executive Director — Date
City of Alexandria Community Services Board

Anita E. Friedman 6/27/14

Anita Friedman, Acting Executive Director — Date
Arlington County Community Services Board

6-27-14

Daryl Washington, Deputy Executive Director — Date
Fairfax-Falls Church Community Services Board

6/27/14

Alan Wooten, Executive Director — Date
Prince William County Community Services Board

6/27/2014

Jim Newton, Director — Date
Northern Virginia Mental Health Institute

Mark Diorio, Director — Date
Northern Virginia Training Center

COMMONWEALTH CENTER FOR CHILDREN & ADOLESCENTS

Bed Management Plan
June 2014

DBHDS maintains only 48 acute inpatient psychiatric hospital beds for Virginians who are under 18 years of age. These beds are at the Commonwealth Center for Children & Adolescents (CCCA) in Stanton, which serves the entire commonwealth. With this 48-bed limit, CCCA and its community partners, including private hospitals, juvenile detention and correctional centers, and community services boards (CSBs), have been successful in meeting all emergency hospitalization needs utilizing the plan below.

CCCA serves as the safety net for children and adolescents who require acute inpatient psychiatric care and cannot be admitted to or remain in any other child/adolescent psychiatric hospital in Virginia. All valid referrals are accepted for admission assuming adequate exploration of alternative placements, medical clearance, and available bed space. To date the system has been able to meet the emergency placement needs of all children and adolescents through appropriate diversions and bed management at CCCA through discharge planning.

Unlike the eight regional DBHDS psychiatric hospitals serving adults, CCCA does not have a back-up hospital within the system to accept patients if full. This, along with a high volume of admissions and a short average length of stay, intensifies the need for active and effective bed management at the facility and community levels. In addition to the steps taken by CCCA and community partners related to admissions and discharges described below, it is of course the case that adequate support for community-based crisis management services, as well as those services providing pre-crisis interventions, will both prevent hospitalizations that would otherwise be necessary and aid in more rapid discharges, thus preserving space at CCCA for necessary admissions and maximizing the number of children and adolescents who can be served close to home.

Admissions Process

- CCCA accepts referrals of young people up to 18 years of age who are in need of inpatient psychiatric hospitalization from the entire Commonwealth
- Our Intake/Admissions Office is staffed 24 hours a day, 7 days a week, and we accept admissions 24 hours a day, 7 days a week (540-332-2120)
- The CCCA Admissions Coordinator or designee receives all referral calls for potential admissions. The Admissions Coordinator reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act (see §16.1-335 *et seq.*)
- Other than admissions ordered pursuant to VA§ 16.1-275 or 16.1-356 (court-ordered evaluations), all admissions must first be prescreened by a CSB
- Any calls not from CSBs (other than in cases of VA§ 16.1-275, in which we still request though cannot require a CSB prescreen), are referred to the CSB for appropriate pre-admission prescreening

- Our Intake/Admission Specialist consults in every referred case with the CSB Emergency Services Prescreener to
    - Gather information about the reasons hospitalization is being considered and alternatives that have been tried and that may be available
    - Reviews all referrals for appropriateness for admission based on criteria set in the Psychiatric Treatment of Minor's Act
    - Consider the need for hospitalization, and if hospitalization is needed the availability of other options, particularly those that keep the child or adolescent close to home
- While the Intake/Admission Specialist may encourage the prescreener to explore options not considered, including providing names of alternative hospitals, we will accept any child/adolescent who is ultimately determined by the CSB to need emergency hospitalization and has no other option
- There is no minimum number of other hospitals that must be called; admission elsewhere will be encouraged if possible, with greater emphasis if the child/adolescent is from far away and/or we have fewer available beds
- The Uniform Prescreening Report must be received prior to acceptance for admission
- If there are active medical issues, the Intake/Admission Specialist will consult with our on-call physician to determine if medical clearance is necessary
- The specific process (method of transport, ways of obtaining consent, etc.) is dependent on the type of admission (e.g., Voluntary, Involuntary, Objecting Minor, TDO) and the specific needs of the child/family
- In cases in which we believe an admission to be inappropriate, we may exert considerable pressure on the community to identify alternatives. Assuring the appropriateness of admissions serves to prevent unnecessary and possibly distressing separation of the child/adolescent from his/her community, avoid unnecessary resource utilization, and maintain available bed space for appropriate admissions

<u>Bed Management</u>

A. Diversion

The only time CCCA would defer a valid admission is if it is at or near capacity. Because the 48 beds are the only public acute psychiatric beds for the entire Commonwealth, and because admissions are unpredictable and may be heavy (e.g., 20 or more admissions in a week or 5 or more admissions in a day) there are times when capacity becomes an issue. When we are near or at capacity,

- We contact CSB Emergency Services Departments and inform them, noting our available beds at the time and requesting that they divert if at all possible;
- Forensic admission referrals for Court Ordered Evaluation pursuant to §16.1-275 of the Code of Virginia will be placed on a waiting list and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Court Ordered Evaluations are ordered for children not in psychiatric crisis, but for whom an evaluation of treatment needs is warranted. These children are most often in detention centers and therefore in a safe place to await admission to CCCA;
- Forensic admission referrals for Evaluation of Competency to Stand Trial pursuant to §16.1-356 will be placed on a waiting list and will be admitted as bed space allows in the order in which the referral was received or as otherwise determined appropriate. Such children are in juvenile detention

centers or in the community as determined appropriate by a judge and will remain in that setting to await admission;

- When CCCA is full and a child who has been prescreened by a CSB and found to meet criteria for emergency civil voluntary or involuntary admission per the Code of Virginia cannot be safely admitted, the CSB will be notified and encouraged to implement a crisis/safety management plan and maintain the child in the community or in the present placement until bed space at CCCA is available if that is determined to be a safe option;
- If diversion strategies are unsuccessful, attempts will be made to have the child admitted to a private inpatient facility utilizing TDO admission, Medicaid, or other third party means;
- Admission may be deferred for patients who are in a safe place (e.g., another facility or detention) until space becomes available
- If attempts to find an alternative bed are not successful and a community safety plan is not a safe option, the child will be accepted for admission as soon as s/he can be safely admitted. If there is more than one such child, pending admissions will be prioritized in consultation with CSB referral staff, taking into account acuity of the situation and safety of the child.

B. Discharge

The availability of beds for admission is dependent on patients being discharged when clinically appropriate. Clinical teams always work closely with families and communities to facilitate timely discharge, working together to manage challenges that include delays before desired community-based resources become available or the absence of such resources, differences of opinion about clinical readiness for discharge or discharge placement options, transportation availability, etc. When CCCA nears capacity, we also

- Encourage families and communities to rapidly identify and develop discharge options and support plans
- Discharge any patients who may be safely discharged but remain in the hospital based on clinical discretion

PIEDMONT GERIATRIC HOSPITAL
Medical Information Needed for a TDO Admission

REMINDER TO ED PHYSICIAN: **Your physician-to-physician telephone conversation with the PGH physician is a mandatory element of an appropriate transfer. As a final step before you discharge an accepted pt, the PGH clinician will provide the PGH physician's name & phone number so you can call them.**

Brief Description of Piedmont Geriatric Hospital:

PGH is a 123-bed, freestanding, long term geropsychiatric facility. It has limited medical care capability for acute cases that require immediate laboratory, x-ray, or other diagnostic tests. To maximize patient safety, we encourage stabilization of acute medical problems prior to admission.

TDO Admission to PGH:

The TDO process requires admission candidate screening by CSB (Community Service Board) Emergency Services staff to determine that the individual suffers from mental illness requiring inpatient care and that there is no less restrictive alternative available. Once it is determined that a bed is available, the next step is to assess per DBHDS' *Medical Screening and Medical Assessment Guidance, Second Edition*, effective 4/1/2014.

The CSB is requested to fully complete the Uniform Pre-admission Screening form to include:
- all medications (including psychotropics)
- known allergies

If the individual is known to the CSB or if there are records available from a community living situation, please fax the most recent psychiatric evaluations and general treatment information. Please ensure that family/emergency contact persons are made aware of the pending admission to Piedmont and provide contact information to PGH. **If an individual on TDO is not committed at the hearing, CSB staff are expected to facilitate appropriate discharge from PGH, including transportation.**

Medical Clearance:

Behavioral symptoms such as confusion, agitation, and aggression are frequently caused by acute medical problems in the geriatric population. This is particularly probable in persons who have no previous psychiatric history. Frequent causes of acute delirium in the elderly include: pneumonia, urinary tract infection, dehydration, organ failure, and CVA. These individuals are best served in an acute care facility prior to referral to PGH. **To rule out medically induced psychiatric symptoms, the following are essential:**

- Physical examination
- CBC
- Urinalysis
- Chest X-ray
- EKG
- Comprehensive Metabolic Panel (Chem. 20)
- Current medications

The following tests are recommended, based on the physician's assessment:
- CT Scan and MRI of the head, as clinically appropriate
- Urine drug screen & Blood alcohol level, if clinically indicated
- Cardiac enzymes, based on the individual's medical history and current cardiac condition

A member of our medical staff is on call to consult with ER, Hospital, and Community Physicians regarding any issues/problems identified. Please contact us early in the process so we may assist in expediting the screening process.

To contact the Admissions Clinician call 434-294-0112; fax 434-767-2352, 7:30am-4pm weekdays.

After 4pm, weekends, or holidays, call 434-767-4401; fax number will be designated by the On-Call Admissions Clinician.

C

Piedmont Geriatric Hospital

A LEADER IN GERIATRIC PSYCHIATRY

Burkeville, Virginia

434-767-4401

Capabilities List

Piedmont Geriatric Hospital (PGH) is a long-term geropsychiatric facility, operated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS). It is the only Virginia state facility that exclusively treats elderly persons (65+ years of age) who are in need of inpatient treatment for mental illness, meet the requirements for voluntary or involuntary admission as determined by their mental health center (CSB) and do not have a medical condition that requires priority treatment in an acute care hospital.

Capabilities	Yes/No
Primary Care Clinician Services	
Physicians/Psychiatrist on-site M-F, 8:30 a.m. to 5:00 p.m.	Yes
Physician/Psychiatrist on-call after-hours/weekends/holidays	Yes
RN on unit 24/7	Yes
Diagnostic Testing	
Stat labs with turnaround less than 2 hours	Yes
Routine X-rays on site M-F, 8:30 a.m. to 5:00 p.m.	Yes
Stat X-rays – Outside labs	No
EKG/Stat EKG 24/7	Yes
Bladder Ultrasound	No
Venous Doppler	No
Arterial Blood Gas	No
Therapies on Site	
Occupational	Yes
Physical	Yes
Respiratory	No
Speech – part-time	Yes
Nursing Services	
Frequent vital signs (e.g. every 2 hours)	Yes
Intake and Output monitoring	Yes
Weights	Yes
Accuchecks for blood glucose monitoring	Yes
O2 saturation	Yes
Nebulizer treatments	Yes
INR –Labs sent out	Yes

Capabilities	Yes/No
Interventions	
Isolation – contact isolation	Yes
IV Fluids – short term	Yes
IV Antibiotics/Medications – short term, limited medications	Yes
Continuous electronic monitoring (VS, O2 sat, etc)	No
PICC Insertion	No
PICC Management	Yes
Wound Care – MWP	Yes
Surgical Drain Management	No
Tracheostomy Management	Yes
Analgestic Pumps	No
Dialysis	No
Chemotherapy	No
Feed through G or J tube	Yes
Medical Detox	No
Basic CPR plus AED	Yes
Advanced CPR (ACLS)	No
Social and Psychology Services	
Licensed Social Worker	Yes
Psychological Evaluation and Counseling	Yes
Pharmacy Services	
Emergency kit with common medications for acute conditions available	Yes
New medications filled within 8 hours	Yes
Emergency Services	
911 to ED in 20 min.	Yes

5/12/2014

Medical Screening
&
Medical Assessment

Guidance Materials

Issued by

Virginia Department of Behavioral Health and Developmental Services

with the support of

Virginia Association of Community Services Boards

Virginia Hospital & Healthcare Association

Virginia College of Emergency Physicians

Psychiatric Society of Virginia

Medical Society of Virginia

Virginia Department of Medical Assistance Services

SECOND EDITION
Effective date: April 1, 2014

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PART 1: INTRODUCTION

1.1 Why Is Medical Screening and Medical Assessment of Individuals in the Behavioral Health System Important?

An individual can enter the health care system with what appears to be a psychiatric disorder, when the true cause of the problem may be an underlying (and potentially life-threatening) primary medical or surgical problem masking itself as a disturbance of affect, cognition or behavior. Treatment may need to be medical in focus, and not involve admission to a psychiatric setting. In addition, individuals with psychiatric disorders frequently enter the health care system with undiagnosed medical conditions. The medical literature documents that individuals with psychiatric disorders have significantly more medical comorbidities than the general population. In addition, life expectancy for individuals with serious mental illness in the public system is estimated to be 15-25 years less than for other Americans, a result of many factors including a lack of access to primary health care, inadequate medical follow up, poor coordination between psychiatric and primary care providers, effects of psychiatric medications on certain health conditions, and other factors.[1]

Individuals with psychiatric disorders can present major challenges in terms of assessment and disposition. Many medical illnesses, whether acute or chronic in nature, can create or exacerbate psychiatric symptoms, as well as complicate the clinical presentation of the individual. For these and other reasons, including resource and clinical provider capacity, psychiatric hospitals emphasize the importance of careful medical screening and assessment prior to the admission of any individual. Most psychiatric inpatient facilities will not admit a person unless such screening has been completed and relevant information is available to support the appropriate level of care to meet the individual's needs safely.

1.2 The Current Context of Medical Screening and Medical Assessment in the Emergency Disposition of Individuals with Psychiatric Disorders

Given the multitude of conflicting priorities and resource availability, medical screening and medical assessment are often difficult to accomplish in a timely and thorough manner in the emergency disposition of individuals with psychiatric disorders, including individuals in emergency custody as well as voluntary and involuntary civil admissions. There are a number of inter-related underlying factors contributing to this situation, including the following:

- In general, emergency health and behavioral health care systems in Virginia are straining to meet current demands for service;
- There are significant variations among practitioners and facilities regarding what constitutes appropriate or adequate medical screening and medical assessment prior to

[1] J.Parks, MD (ed.), et al, *Morbidity and Mortality in People With Serious Mental Illness*, National Association of State Mental Health Program Directors Medical Directors Council, October 2006

admission to a psychiatric inpatient facility. Different psychiatric inpatient facilities may also have different requirements based on their ability to thoroughly assess and safely provide or coordinate care for medical issues;

- Medical and psychiatric screening and assessment resources vary considerably among facilities and communities across Virginia;
- The capacity of many inpatient psychiatric facilities, including state hospitals, to provide medical treatment is limited;
- Hospitals and Emergency Departments may be unaware of each others' ability (or limited ability) to meet the medical needs of individuals;
- Virginia statutes governing emergency custody, temporary detention, and involuntary commitment of persons with mental illness[2] authorize medical screening and medical assessment, but contain no explicit standards and procedures for carrying out these processes;
- There are no specific guidance or recommendations from any professional or governmental group describing who is responsible for which components of the medical screening and medical assessment process in every case;
- Medical screening and medical assessment, when completed, can be time-consuming. The time available to complete medical screening and medical assessments may be affected by statutory limitations affecting law enforcement's ability to maintain custody of the individual, provide transportation, and safeguard the individual, providers, and community members;
- Hospitals must also comply with the federal Emergency Medical Treatment and Active Labor Act[3] (EMTALA) governing screening and stabilization of emergency medical conditions, including emergency psychiatric conditions, and related transfers. [Note: these requirements are not addressed in this document]

1.3 Development of This Guidance

The above-referenced issues have been well documented. In 2005, the Office of the Inspector General (OIG) report, titled *Review of the Virginia CSB Emergency Services Programs*, found that "*the delays, costs, legality and inconsistency among hospitals of* [medical screening and medical assessment] *practices are a major source of concern among stakeholders, hospital medical emergency rooms, and consumers.*" In response to this finding, the Office of the Inspector General (OIG) recommended that "...[DBHDS] *develop and implement clear and consistent standards regarding medical clearance for all state hospitals and work with the Virginia Hospital and Health Care Association, and other appropriate bodies, to achieve a similar outcome for private hospitals.*" In response to the above recommendation, DBHDS convened a stakeholder workgroup in 2006 that developed and disseminated the first edition of the *Medical Screening and Medical Assessment Guidance Materials*, dated March 13, 2007.

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[2] See Chapter 8 of Title §37.2 of the *Code of Virginia*

[3] *42 USC § 1395dd*

Since that time, Virginia has established regional hospital utilization management structures in each of the seven DBHDS Partnership Planning regions; enacted significant mental health law reforms; refined the billing processes for medical screening and assessment of persons under emergency custody orders; and provided statewide and regional training as well as other support resources for behavioral health providers, emergency room personnel, law enforcement officers, judicial officials and other stakeholders.

Despite these actions, hospital admission practices continue to vary across regions, CSBs and facilities. Policy-makers, public and private providers, and other stakeholders are unified in supporting updating and reissuing the medical screening and medical assessment guidance to minimize these variations to the extent possible. This was underscored most recently in another report of the OIG, #206-11[4], and a stakeholder workgroup was reconvened in 2012. This guidance document emerged from that process.

1.4 Intended Use of This Guidance

This guidance is intended for use by state and private psychiatric inpatient facilities, hospital emergency departments, CSB providers and others involved in the emergency disposition of persons with psychiatric disorders, including emergency custody and voluntary and involuntary civil admissions. This guidance is intended to support a common understanding of medical screening and medical assessment, to delineate clearly the responsibilities and expectations for medical screening and medical assessment among key partners and to support consistent application of medical screening and medical assessment procedures by all parties in responding to persons with psychiatric disorders in emergency situations. This guidance applies only to the medical screening and medical assessment components of the evaluation process that occurs prior to admission of an individual to a psychiatric inpatient hospital or unit (unless a person is in a hospital emergency department, in which case EMTALA regulations regarding medical screening, stabilization and transfer will apply).

The terms "sending facility" and "receiving facility", as used in this guidance, mean the following:

- The "sending facility" is the hospital or emergency department in which the person who is undergoing medical screening and medical assessment is located and from which the person is being referred to another facility. The sending facility initiates and completes the referral of the person to the "receiving facility" for admission and continuing care.
- The "receiving facility" is the hospital to which the person who has undergone medical screening and medical assessment is being referred for admission and continuing care. The receiving facility assumes care of the person upon admission if the patient is accepted.

[4] Report #206-11. *OIG Review of Emergency Services: Individuals meeting statutory criteria for temporary detention not admitted to a psychiatric facility for further evaluation and treatment* (February 28, 2012).

PART 2: MEDICAL SCREENING AND MEDICAL ASSESSMENT: GENERAL INFORMATION

2.1 Purpose of Medical Screening and Medical Assessment

The primary purpose of medical screening and medical assessment is safety, i.e., to prevent someone with an illness or medical condition from being sent to a treatment facility that cannot adequately manage the person's illness or condition, thereby exposing the person and the system to the risk of a medical condition going undiagnosed and undertreated or untreated. Failure to adequately detect, diagnose, and treat medical conditions may result in significant and unnecessary morbidity and mortality, the advance of certain illnesses, and increased liability for providers across the system. Effectiveness, efficiency, and timeliness are also important dimensions of the medical screening and medical assessment process that are necessary to ensure safety and quality.

2.2 What are Medical Screening and Medical Assessment?

Medical screening and *medical assessment* are distinct terms that describe two different levels of inquiry about a person's health or medical condition:

2.2.1 Definition of Medical Screening - For the purpose of this *Guidance* document (as distinct from the meaning of this term in EMTALA), *medical screening* is the collection of information about the non-psychiatric medical condition of an individual in order to determine, or to help determine, whether there is a need for a further *medical assessment* before a decision is made regarding appropriateness of transfer to an inpatient psychiatric facility. In practice, this information gathering (i.e., medical screening) may be performed by a licensed physician, certain non-physician clinical personnel, or appropriately trained CSB staff (see Section 4.1).

2.2.2 Definition of Medical Assessment - For the purpose of this document, *medical assessment* is an in-depth assessment of an individual's non-psychiatric medical condition that occurs as needed, based on *medical screening*, and is only performed by a licensed physician or by another licensed practitioner (e.g., nurse practitioner, physician assistant) to the extent he/she is qualified and authorized to do so (see Section 4.2).

Medical screening and medical assessment, for the purpose of this *Guidance* document, are ongoing until it has been determined that the individual is stabilized, or until the individual is discharged or transferred to the care of another provider(s). This process, and the results, must be clearly and completely documented in the individual's record and should be incorporated into the referral information communicated to the next provider(s).

2.3 Medical Screening and Medical Assessment vs. "Medical Clearance"

The terms *"medical clearance"* and *"medical clearance for admission"* are often used by providers to describe the evaluation process by which a receiving facility obtains sufficient medical information about a patient to determine whether the receiving facility can meet the patient's needs. Providers should be aware, however, that the term *medical clearance* is inexact and may create or contribute to misunderstanding and/or confusion about a person's condition. The term *medical clearance* is not a substitute for a complete and detailed description of the person's actual medical condition, which is always more informative than saying, for example, "this person has *medical clearance*" or "this person is *medically clear*."

PART 3: ELEMENTS OF THE MEDICAL SCREENING AND MEDICAL ASSESSMENT PROCESSES

3.1 Medical Screening and Medical Assessment Domains

Comprehensive medical screening and medical assessment of persons with psychiatric disorders in emergencies involves collecting, developing and collating information in four domains:

- The individual's history,
- A mental status exam,
- A physical exam (including neurological exam, if clinically indicated), and
- Laboratory and other diagnostic testing and radiological studies (if clinically indicated).

Medical screening and medical assessment should be performed with a holistic view of the individual being examined rather than in terms of *either* psychiatric *or* medical conditions alone. The goal is to complete an adequate overall evaluation to discover the true clinical presentation of the individual, and to determine the best way and the most appropriate location to treat the individual.

3.2 The Importance of Individualized Medical Screening and Medical Assessment

Medical screening and medical assessment start with the assumption that each individual is or may be suffering from an underlying medical condition. Medical screening and medical assessment must also take into account multiple variables including the severity of psychiatric symptoms, the risks associated with whatever medical condition(s) may exist or be suspected, the medical treatment capacity and resources of the receiving facility, and issues related to transporting the individual to another facility.

Notwithstanding the above, standardized diagnostic testing applied to all persons can be wasteful and inefficient and should be avoided. This is true whether the standardized testing is initiated and performed by the sending facility or required or requested by a receiving facility. Rather, the performance of specific diagnostic and laboratory testing should be based on the person and the availability and reliability of other sources of information.

EMTALA regulations regarding medical screening and stabilization will apply whenever a person is seen in a hospital emergency department.

The individualized medical screening and medical assessment processes include the steps described in the following sections.

3.3 Medical Screening

3.3.1 Medical Screening Steps

Medical screening occurs in conjunction with a complete mental status examination (MSE). With the person's consent as set forth in *Section 4.2 Consent for Medical Screening and Medical Assessment*, the *medical screening* process follows these steps (though not necessarily in this order):

1. A screener (see Section 3.3.2) obtains information about the individual's past medical illnesses and conditions, previous psychiatric and medical hospitalizations, psychoactive and other medications used, and substance use or dependence.

2. The screener obtains information about the following:
    a. presently diagnosed medical illnesses (including in particular such diagnoses as stroke, diabetes, cardiac disorders including hypertension, seizure disorders),
    b. medical symptoms (such as respiratory distress, pain, bleeding, blurring of vision, trouble urinating, recent falls, etc.),
    c. psychoactive and other medications currently being used, including recent increases, decreases and/or discontinuation, misuse, or overdose of prescription medication, and
    d. recent or current substance use or dependence (including alcohol, cocaine, cannabis, opiates, etc) including risk for intoxication and/or substance withdrawal.

3. The screener observes:
    a. the person's overall physical condition and behaviors (e.g., sweating, redness in the face, inability to stand, slumped posture, drowsiness, overactive or agitated behavior, etc.), and
    b. signs and symptoms which may be related to delirium or substance use or withdrawal (e.g., sudden onset of symptoms, irrationality, fluctuating consciousness, disturbance of cognition or perception, significant tremors, etc).

4. The screener, to the extent he or she is trained, capable and responsible for doing so, obtains basic vital signs including pulse, temperature, blood pressure, and respiration.

5. The screener may need to review or obtain information from outside sources to complete the screening, in accordance with Section 3.5 (below) Sources of Information for Medical Screening and Medical Assessment.

6. The screener contacts the receiving facility and reviews the screening results and findings from steps 1-4 above with the admitting physician on duty or his designee. If the screening results are reviewed with such designee, the designee must review the findings with the admitting physician. If the admitting physician determines that further medical assessment is clinically indicated, then this determination must be communicated by the physician or his designee to the sending facility so that the sending facility may refer the individual to a physician or to another licensed practitioner who is qualified to perform the further *medical assessment*.

When the individual is transferred to the receiving facility, the medical screening process, findings, and conclusions must be clearly and completely documented in the consumer's record and communicated to the appropriate personnel at the receiving facility to ensure that there is continuity of care and a smooth transition for further treatment.

3.3.2 Who Performs Medical Screening?

Medical screening may be performed by a physician, non-physician clinical personnel qualified and authorized to perform medical screening or appropriately trained CSB staff.

If, at the time of referral to an inpatient psychiatric hospital, medical screening of the individual has been performed by personnel other than CSB staff (e.g., staff of an emergency department, inpatient facility of nursing facility) then CSB emergency services staff should confirm the completeness of the information, gather any necessary updates, and communicate this medical screening information to the receiving inpatient psychiatric facility.

If the person is not in a hospital emergency department, inpatient facility or nursing facility when the decision is made to pursue psychiatric hospitalization, then CSB emergency services staff should carry out as much of the medical screening process as possible and appropriate (see medical screening steps, above) given the specific qualifications of the CSB evaluator who is conducting the examination and other relevant considerations. CSB staff should collect as much medical screening information as possible from all available sources as efficiently as possible (see Section 3.5, *Sources of Information for Medical Screening and Medical Assessment*, below). These CSB responsibilities should be fulfilled regardless of the person's legal status at the time of the examination and medical screening (i.e., whether under voluntary circumstances, under an ECO, or otherwise in law enforcement custody).

It should also be emphasized that the responsibility of CSB emergency service staff regarding the medical screening process outlined above is to *gather* and *report* medical information, not to *evaluate* and *interpret* this information.

3.3.3 Where Does Medical Screening Occur?

Medical screening may occur in many settings. *Medical screening* may be done in a person's home, in a health or behavioral health clinic or outpatient program, in an emergency department of a hospital, or any other setting in the community.

Notwithstanding the above, EMTALA regulations regarding medical screening and stabilization will apply whenever a person is seen in a hospital emergency department.

3.4 Medical Assessment

3.4.1. Medical Assessment Steps:

If further *medical assessment* is indicated based on the observations and findings from the medical screening process detailed above or at the request of the receiving facility, then, with the consent of the individual as set forth in Section 4.2, *Consent for Medical Screening and*

Medical Assessment, the following steps are completed by a physician, or by another licensed practitioner to the extent he/she is qualified to do so (see Section 4.2). Such physician and licensed practitioner are referred to in this section as "clinician.

1. The clinician obtains a medical history.

2. The clinician performs a general physical exam, including mental status and neurologic exams.

3. The clinician obtains appropriate laboratory and other diagnostic tests, as clinically indicated.

4. The clinician consults with pertinent on-call physicians, psychiatrists, and/or other health care providers as needed.

5. The clinician re-assesses the individual prior to discharge or transfer if necessary.

When the individual is transferred to the receiving facility, the medical assessment must be clearly and completely documented in the individual's record and communicated clearly and completely to the appropriate personnel at the receiving facility to ensure that there is continuity of care and a smooth transition for any further treatment.

3.4.2 Who Performs Medical Assessment?
Medical assessment, as described above, may only be performed by a licensed physician or by a nurse practitioner or physician assistant or other licensed practitioner within the scope of his education and training, his authority under federal and state law, and his individual practice protocol or written supervision agreement.

3.4.3 Where Does Medical Assessment Occur? *Medical assessment* may be done in an ambulatory or outpatient health, urgent care or behavioral health clinic, but is most often accomplished in an emergency department of a hospital or an inpatient setting.

3.5 Sources of Information for Medical Screening and Medical Assessment

Providers performing medical screening and medical assessment should gather medical information about a person from all available, appropriate, and relevant sources, including

- The individual;
- The individual's family, friends and others;
- CSB staff and other care providers;
- CSB and other care provider records;
- Law enforcement officers who may be involved.

3.6 Application of HIPAA Privacy Rule

In accordance with the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164 (see http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html) health care providers may use or disclose protected health information without an individual's authorization for the purposes of treatment, payment, or health care operations. The minimum necessary rule does not apply to disclosures to or requests by a health care provider for treatment of an individual (see 45 CFR § 164.502(b)(2)(i)).

PART 4: ISSUES IN MEDICAL SCREENING AND MEDICAL ASSESSMENT

4.1 Communicating Individual Medical Screening and Medical Assessment Information

When a person experiencing a psychiatric emergency is in a hospital emergency department, EMTALA regulations governing screening and stabilization will apply. Many emergency interventions by CSB providers take place in non-medical settings as well. In any case, decisions about performing specific diagnostic tests and other medical assessments should be based on an understanding of each person's specific medical situation and his/her clinical needs at that time. Thus, timely and effective communication among CSB emergency providers, hospital Emergency Department medical staff, and receiving facility medical staff is essential to facilitate the decision-making and disposition process. Key elements of this communication include:

- *Communication should start immediately:* Communication between sending and receiving facilities should be initiated immediately by CSB staff, at the beginning of the screening process, so that the receiving facility can evaluate the significance of any findings in terms of its ability to safely manage and treat the person's presenting symptoms and condition.

- *Communication should be as direct as possible between key persons involved in the screening and assessment process and in referral and admission decisions:* All findings from the person's history and clinical examinations that are identified during the medical screening and medical assessment processes should be reported directly to the admitting physician or his designee (see Section 3.3, item 6, above).

- *The need for specific additional diagnostic tests and/or laboratory work should be decided through communication between physicians or clinicians on a case-specific basis:* Any diagnostic testing and laboratory work performed as part of medical assessment should be based on clinical need determined through direct communication and consultation between the sending and receiving physicians or designees.

- *Communication should be person-specific and detailed:* Communications to receiving inpatient psychiatric facilities should clearly describe the person's actual condition and needs. Similarly, sending and receiving facilities should clearly articulate their ability to meet these needs. Sending and receiving facilities should exercise extreme caution in using the term "*medical clearance*" in these communications (see section 2.3, above), as this term does not describe the person's actual condition.

4.2 Consent for Medical Screening and Medical Assessment

Medical examinations or tests for which the individual's consent is required shall not be performed over the person's objections or, if he lacks the capacity to provide consent, until

consent is obtained from a properly appointed substitute decision-maker. Thus, if the individual is incapable of consenting, the examination or tests shall not be performed except in accordance with the applicable provisions of the Health Care Decisions Act including

- § 54.1-2981 et seq. (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2981)
- § 54.1-2970 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+54.1-2970),

or under a court order obtained in accordance with

- § 37.2-1101 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-1101) or
- §37.2-1104 (http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+37.2-1104),

or in accordance with other applicable provisions of law.

4.3 Resolution of Disagreements, Clarifications, etc.

The decision by a receiving hospital to admit an individual will be based on several factors including:

- The individual's need for the services available at the hospital;
- The individual's current status (medical/surgical, mental status, behavioral factors);
- The expected clinical course of treatment;
- The level of medical/surgical need; and
- The capacity of the hospital to meet that medical/surgical need.

Sending and receiving facilities may not always agree on the level of medical risk associated with a person's condition and/or on the action that should be taken to provide safe, effective, and timely care. When disagreements occur, sending and receiving facilities must work to resolve them quickly in the interests of the person needing care. When cases of disagreement cannot be resolved by others, the attending physician from the sending facility and the attending physician from the receiving facility must engage in direct physician-to-physician communication. Once requested, due to the legal time constraints surrounding ECO's and TDO's, this conversation should occur as soon as possible and include discussion of the case in question, clarification of medical or procedural issues and a quick resolution to the disagreement.

Ongoing regional collaboration between stakeholders (including CSBs, emergency departments of local hospitals, state and private psychiatric hospitals, etc) is strongly encouraged to ensure open lines of communication and to have a structure and forum to discuss best practices, logistical issues, and the most appropriate level of care for patients suffering from mental illness. By the same token, regular dialogue and collaboration at the state level between representatives of these stakeholder groups helps create and sustain a framework for strong communication, collaboration and problem-solving.

4.4 Disposition of Individuals with Acute or Unstable Medical Conditions

Individuals who are experiencing acute or unstable medical conditions may not be appropriate for admission to a DBHDS or private psychiatric facility. CSBs and sending facilities should have procedures in place to divert individuals to appropriate medical facilities when such individuals cannot be admitted to psychiatric hospitals due to an acute

or unstable medical condition. If an individual is referred whose medical condition has not been satisfactorily assessed, stabilized or treated, the receiving facility should care for the individual first and then provide constructive feedback to the sending facility with the aim of improving the referral process for the future. The CSB regional management infrastructure offers another avenue for improving the referral process among partner entities.

4.4 Reimbursement for Medically Necessary Medical Screening and Medical Assessment

Sections 37.2-808 and 37.2-809 of the *Code of Virginia* authorize reimbursement for medically necessary medical screening and medical assessment services provided to individuals during the period of emergency custody or temporary detention through the Involuntary Mental Commitment Fund administered by the Department of Medical Assistance Services. Specific procedures for reimbursement for medical screening and medical assessment services are found in Appendix B of the *Hospital Provider Manual* published by the Virginia Department of Medical Assistance Services(see https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={DA29CE06-C099-4F0B-93BF-E042070F2D61}&impersonate=true&objectType=document&id={DDC960C2-A548-4E21-8781-150B936EA527}&objectStoreName=VAPRODOS1)

The reimbursement procedure for medical screening and medical assessment provided to an individual under emergency custody in an "officer-initiated" or "paperless" ECO situation is described in the Medicaid Memo dated October 30, 2009 (see https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?vsId={1FC7C4AF-2B45-4A15-8416-8C535F4EE074}&impersonate=true&objectType=document&id={DBA26AE4-485F-4DA2-8A2C-CC372DECA51E}&objectStoreName=VAPRODOS1)

4.6 Routine System-level Information-Sharing

State and private inpatient psychiatric facilities should routinely share information with each other and with CSBs, hospital emergency departments, regional CSB utilization management committees, law enforcement agencies, and courts about their medical treatment capabilities. Communicating this information on a regular basis, outside the context of individual cases or crises, will foster understanding and collaboration, and improve the efficiency with which individual cases are handled. The CSB regional management infrastructure should incorporate this function into its ongoing operations by working with stakeholders within the respective regions.

In particular, each inpatient hospital and crisis stabilization unit should document and publish its specific medical capabilities and limitations, and disseminate this information to referral sources. Such information should also be posted on the Virginia Psychiatric Bed Registry.

4.7 Systematic Quality Improvement

Local and regional collaboration among many agencies and organizations is needed to implement an effective emergency and crisis response system for individuals with psychiatric disorders. In addition, medical screening and medical assessments are only two of many procedures and processes that must be efficiently implemented to have an effective "safety net" in place. Involved entities include state and private inpatient psychiatric facilities and emergency rooms, CSBs and other behavioral health service providers as well as police and sheriffs, courts, and others. These stakeholders are strongly encouraged to periodically assess their local emergency and crisis response system capacity and performance, and implement improvements when necessary to improve service delivery. The CSB regional management infrastructure offers a useful framework to support this effort, and regions are encouraged to use these mechanisms for this purpose.

E

MEDICAL CLEARANCE OF REFERRALS FOR ADMISSION TO NVMHI

Date _____ Time _____ Request for Medical Clearance

Individual's Name _____

Individual's Legal Status ☐ TDO ☐ CMA ☐ INVOLUNTARY ☐ VOLUNTARY

Date of Legal Status: _____ Date of Expiration of Legal Status: _____

CSB _____ Transferring Hospital _____

Primary Contact at Transferring Hospital _____

Phone Number: _____ Fax Number: _____

Required Information for Medical Clearance:

- ☐ CSB Pre-Screen
- ☐ Vital Signs
- ☐ Medical History & Physical Exam
- ☐ CBC
- ☐ Urinalysis
- ☐ Comprehensive Metabolic Panel
- ☐ Urine Drug Screen
- ☐ Blood Alcohol Level

Please note that additional tests may be recommended depending on results to assure that the individual can be cared for at NVMHI.

Required information to comply with Joint Commission standard for Continuity of Care and Handoff Communication between healthcare providers.

- ☐ MD Admission Psychiatric Assessment
- ☐ MD Progress Notes – last two weeks of hospitalization or from admission to date of request if Length of Stay less than two weeks.
- ☐ Nursing Progress Notes – last two weeks hospitalization or from admission to date of request if Length of Stay less than two weeks.
- ☐ Medication Reconciliation Record

Instructions:

1. Please check off boxes for information being sent.
2. Please fax all information at one time. Incomplete information cannot be processed for medical clearance and delays the process. Fax to: **Admissions Office (703) 207-7150**

NVMHI Admissions Staff Use Only

MEDICAL CLEARANCE OF REFERRALS FOR ADMISSION TO NVMHI

Individual's Name: _____ CSB: _____ Transfer Endorsed by: _____

All Information Requested Received: Yes ☐ No ☐

Missing Information:

_____

_____

_____

_____

Facility Notified of Missing information :
Date: ____ Time _____ Name of Person Notified: _____:

Request for Medical Clearance Date: _____ Time: _____
Reviewed by: _____ Date: _____ Time:____ Individual is medically cleared

Date: _____ Time:____ Individual is not medically cleared

AREAS OF CONCERN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTIFICATION RE: Area(s) of Concern(S):

1. CSB _____ Name_____ Date Notified _____ Time:_____
2. Facility _____ Name _____ Date Notified _____ Time: _____

DISPOSITION:
Is Individual Accepted? YES ☐ NO ☐ Not at this time ☐

Signed _____ Date _____