

*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**

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## ***Acknowledgements***

This *Medical Screening and Medical Assessment Guidance, Second Edition*, was produced by a workgroup representing the Virginia Department of Behavioral Health and Developmental Services (DBHDS), the Virginia Association of Community Services Boards (VACSB), the Virginia Hospital & Healthcare Association (VHHA), the Virginia College of Emergency Physicians (VaCEP), the Psychiatric Society of Virginia (PSV), the Medical Society of Virginia (MSV), and the Virginia Department of Medical Assistance Services (DMAS). Special appreciation is given to the individuals listed in Appendix A.

## **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.<sup>1</sup>

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

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<sup>1</sup> 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<sup>2</sup> 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<sup>3</sup> (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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<sup>2</sup> See Chapter 8 of Title §37.2 of the *Code of Virginia*

<sup>3</sup> 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<sup>4</sup>, 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.

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<sup>4</sup> 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.viriniamedicaid.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.viriniamedicaid.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.

## **Appendix A**

### ***Medical Screening and Medical Assessment Workgroup Participants***

#### Virginia DBHDS

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#### Virginia Department of Medical Assistance Services

Bonnie Winn, DMAS

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Additional Participants

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Karen Taylor, Special Counsel, DBHDS

## **Psychiatric Unit or State Facility Medical Care Capabilities and Typical Exclusion Criteria**

**The purposes of the medical screening is to attempt to make sure that the individual is not experiencing a serious medical event that is masquerading as a psychiatric disorder or being concealed by a psychiatric disorder and that the receiving facility can provide the medical care the individual needs.**

This document will serve as an Appendix to the forthcoming, updated "*DBHDS Medical Screening and Medical Assessment: Guidance Materials,*" developed in joint fashion with the key stakeholders.

Psychiatric hospitals and units typically have fewer medical and medical nursing resources than hospital medical and surgical units. These free standing psychiatric hospitals and psychiatric units may lack access to immediate labs or other tests (especially on a STAT basis), have no electronic monitoring capability, may not be able to provide IV fluids or medications, and may have less clinical experience on hand at both the Nursing and Physician level.

Examples of conditions which typically cannot be managed safely in these psychiatric settings include acute delirium, head trauma, unstable fractures, unstable seizure disorders, active GI bleeding, bowel obstruction, acute respiratory distress, sepsis, overdoses, open wounds, surgical drains, severe burns, intracranial bleeds, pulmonary embolus, acute drug withdrawal with autonomic instability, active labor, major serum electrolyte abnormalities, and so forth.

A typical psychiatric unit can monitor vital signs non-invasively, provide oral medications, monitor fluid "input and output," monitor pulse oximetry intermittently, institute common preventative actions, and observe for signs of distress. Units that are part of general hospitals have more immediate access to emergency medical care, STAT labs and other tests, but typically no more capacity to provide more intensive medical treatment.

Preventative monitoring and management of some drug or alcohol withdrawals can typically be done. Pregnant patients (other than high risk), individuals with HIV, individuals with type I diabetes, individuals with PEG tube feedings, and those requiring a wheelchair can typically be managed safely. Physical therapy may be available. Nursing interventions to prevent decubitus ulcers, oropharyngeal aspiration, bowel obstruction, and transmission of most communicable diseases are generally possible.

Given the complexity of both human illness and health care systems, it is frequently difficult to provide absolute exclusion criteria. As such, each case is reviewed with consideration of the individuals needs, the resources of the accepting facility and the resources of the local medical community.

Facility:	
<b>CAPABILITIES</b>	
<b><u>Physician</u></b>	<u>YES, NO, or Comment this column</u>
Primary Care Physician in house 24/7	
Psychiatrist in house 24/7	
Physician on call by phone only after hours/weekends	
<b><u>Nursing</u></b>	
RN on unit 24/7	
RN on site 24/7, but not on each unit	
<b><u>Nursing Services</u></b>	
Frequent vital signs, q 2 hours or less	
Intake and output monitoring	
Weights (b.i.d. or less)	
Accuchecks for blood glucose monitoring	
O2 Saturation	
<b><u>Diagnostic Testing</u></b>	
STAT labs on site regular working hours	
STAT labs on site 24/7	
Routine X Rays on site regular working hours	
STAT X Rays on site 24/7	
EKG/STAT EKG regular working hours	
STAT EKG 24/7	
Arterial blood gas	
Venous Doppler	
Bladder Ultrasound	
Swallow Studies on site regular work hours	
Percutaneous procedures (drain fluids, biopsy, etc.)	
<b><u>Interventions</u></b>	
Continuous electronic monitoring (VSs, O2, etc.)	

IV Fluids	
IV Antibiotics or other medications	
Indwelling urinary catheter management	
PICC Management	
Total Parenteral Nutrition (TPN)	
Feeding through G or J tube Isolation	
Decubitus management Stage 1 – 2	
Decubitus Management Stage 3 – 4	
Surgical Drain Management	
Tracheostomy Management	
In and Out Urinary Catheterization	
Analgesic Pumps	
Methadone Maintenance for SA	
Chemotherapy	
Basic CPR plus AED	
Advanced CPR (ACLS)	
<b><u>Emergency Treatment</u></b>	
Immediate: In house	
Call 911 only	
Time from 911 call to ER	