COBB COUNTY COMMUNITY SERVICES BOARD

Policy # 8152	Behavioral Health Crisis Center - Screening Protocol Crisis Receiving Center	Service Delivery
Origination Date: October 1, 2012		
Revision Date: July 1, 2015, July 30, 2015, December 28, 2015, December 19, 2016, January 31, 2019, June 28, 2019 **Reviewed Date: May 8, 2013**		
Approved: **Foster Norman, Executive Director**		

POLICY:

It is the policy of the Cobb County Community Services Board's Behavioral Health Crisis Unit (BHCC)'s Crisis Receiving Center to provide psychiatric stabilization, detoxification and stabilization of co-occurring illness. The expected outcome is to integrate individuals back into the community in as short a period of time required for optimal restoration and stabilization.

PROCEDURE:

1. The BHCC's Crisis Receiving Center does not refuse to receive any individuals presented for evaluation and or stabilization.
2. Individuals are checked in at the receiving area by a BHCC staff member. Self-referred individuals are triaged by the nursing staff:
    a. Vital signs and a
    b. Brief medical history is obtained to make sure the BHCC can accommodate any special medical issues and to ensure the individual's medical history does not include the state's exclusionary criteria (See Attachment A).
3. All individuals are assessed upon arrival to determine the necessary level of care. An initial screening for risk of suicide or harm to others is conducted for each individual presenting for evaluation. The assessment includes an interview by the Registered nurse, social worker or other clinical staff for identification, to obtain the chief complaint and to gather the individual's medical and psychiatric history.
4. A Release of Information, with the individual's approval, will be completed so designated people may be contacted for the individual.
5. If the individual does not meet criteria for admission to the Temporary Observation or Crisis Stabilization Units after the initial screening, an appointment or a referral will be made, with the individual's permission, for the appropriate service. Documentation of the rationale for the denial of services is recorded in the individual's medical record.
6. If it is decided that the individual meets criteria for the Temporary Observation or Crisis Stabilization Unit, staff conducts a pat-down search of each individual, her or his clothing, and all personal effects before admission to the units. (See Policy #8144).
7. The MD/APRN will write orders for care, including the level of observation, and order a body search with rationale, if needed (See Policy #8144)

8. Individuals participate in the development with an initial treatment plan/Individual Recovery Plan and a Discharge Plan delineating the next steps for treatment through the Crisis Receiving Center.
    a. If admitted to either to the Temporary Observation or Crisis Stabilization unit, and with the individual's participation, the following are created: a comprehensive treatment plan/Individual Recovery Plan, a safety plan a relapse prevention plan, as applicable and a Discharge Plan.
9. Clinical staff will begin discussing options for aftercare with the client, according to his/her preferences and the available options upon presentation to the Crisis Receiving Center.

This Policy is referred to in Policy #8154, #8151, #8153, #8149, #8155

DBHDD: Medical Guidelines and Exclusion Criteria

	EXCLUSION CRITERIA for Admission to State Hospitals & Crisis Stabilization Units *Version 8/13/2018*
1	Angina
2	Burns (severe) requiring acute care or physical therapy; if the burn could be cared for at home, it is not an exclusion.
3	Chronic Pain Coverage that includes IV opioid analgesia. All other chronic pain syndrome requires a Physician to Physician discussion
4	Delirium
5	Dementia *Crisis Stabilization Units (CSU) are not equipped to treat individuals with dementia as primary diagnosis. These individuals are also at risk of victimization.*
6	Dialysis
7	Unstable fractures, open or closed
8	GI bleed, active
9	Infectious disease requiring isolation and/or treatment by IV antibiotic
10	Intravenous fluids or IV antibiotics *CSUs are not a safe environment for managing intravenous fluids or IV antibiotics.*
11	Joint dislocations, acute, until reduced
12	Draining wound, open, requiring daily deep wound care.
13	Oxygen dependent (must be off of all supplemental 02 and O2 saturation greater than 90% with normal activity for CSU admission)
14	TB, active
15	Traumatic Brain Injury in the absence of a mental illness ((If individual was diagnosed with a mental illness prior to the TBI, the receiving facility will evaluate).
	Georgia Code - 37-3-1.16.1 - *"Traumatic brain injury" means a traumatic insult to the brain and its related parts resulting in organic damage thereto which may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but for the purposes of this chapter, traumatic brain injury shall not be considered mental illness.*
16	Tubes or drains, chest or abdominal, including ostomies
17	Individuals must be able to complete their ADLS independently to be admitted to a CSU facility.
18	Durable medical equipment that is not readily available or is required to be plugged in.
	MEDICAL EVALUATION GUIDELINES for Admission to State Hospitals & Crisis Stabilization Units *Version 8/13/2018*
1	**ALL patients presenting at the Emergency Department**
	a. CBC
	b. UA
	c. UDS
	d. Chemistry Panel
	e. Pregnancy test (if there is reason to believe a woman is pregnant, a pregnancy test is required.)
2	**VITAL SIGNS**
	a. BP acceptable range: <90/60; >170/110 must be evaluated and treated before transfer; or provide documentation why not clinically significant. Otherwise, physician-to-physician conversation is necessary. Stable chronic HTN does not need to be WNL.
	b. Pulse acceptable range: <110/minute; >60 minute. If outside this range, physician-to-physician conversation is necessary. Pulse >140 requires physician-to-physician.

3	**Psychiatric Disorders of thought or mood**
	a. Normal **physical** and neurological examination; rule out delirium.
	b. Consider CT or MRI of brain or provide documentation why not clinically indicated
4	**Alcohol Abuse, Dependency or Intoxication**
	a. C I W A -Ar (Clinical Institute Withdrawal Assessment of Alcohol Scale Revised). A CIWA Score of 15 or Lower is required. If CIWA Score is higher than 15, wait and redo CIWA. (See attached CIWA-AR information.)
	b. BAL. A specific BAL is not required. Calculate future BAL based on knowledge that BAL will drop by 25 per hour. A BAL above 200 requires a MD to MD consultation
	c. Lever Function Test if indicated with clinical symptoms (i.e. jaundice, bruising etc).
	d. M a y request CT of brain if subdural is suspected.
5	**Acetaminophen overdose.** Follow ACE Toxicity guidelines. Repeat levels until below risk for possible hepatotoxicity. Referral acceptable after ACE falls below .10 and a Physician to Physician consultation. Patients on Mucomyst must complete entire course of treatment prior to transfer.
	a. Initial level >1.2 at 4 hrs
	b. 0 . 6 at 8 hrs.
	c. 0.3 at 12 hours
	d. Repeat after 4 hour interval
6	**Other Overdoses**
	Follow recommendations of GEORGIA POISON CONTROL regarding observation period. Call 1-800-222-1222 or www.georgiapoisoncenter.org and have Physician to Physician conversation as needed.
7	**AIDS:** Subject to ability to provide appropriate treatment (i.e. availability of medications, etc.)
	a. Labs as indicated in # 1 above
	b. Additional test as indicated, such as CT of brain if pathology suspected.
	c. End stage AIDS patients should not be referred for psychiatric care in crisis stabilization units
8	**Anemia:** Any value outside of those listed below require a physician-to-physician conversation
	a. Symptomatic anemia consisting of low O2, Shortness of Breath, hypoxia, fatigue with effort.
	b. Hgb < 7 requires physician to physician conversation or provide documentation why not clinically stable for transfer prior to transfer
9	**Diabetes Mellitus**
	a. Accucheck less than 250 -- no additional work up, unless other associated conditions or issues require any other labs
	b. Accucheck more than 250- requires labs (CBC and BMP – including Electrolytes, Creatine, BUN and Glucose)
	c. Blood sugar stabilized consistently below 250 mg % for a 2-hour period before approval and within one hour of transfer. Any requests outside this standard should be handled via physician to physician conversation.
10	**Febrile** patients
	a. T >101.5 requires explanation provide documentation why not clinically significant
	b. Chest X-ray if indicated
11	**Hypokalemia / Hyperkalemia**
	a. If below 3.0 or above 5.0, determine etiology and/or have physician to physician conversation.
12	**Hyponatremia / Hypernatremia**
	If below 130 or above 145, have physician to physician conversation. Acceptable range between 130-145
13	**MRSA**
	Physician to physician communication is expected, with Infectious Diseases consult if needed.

14	**Pregnancy: Evidence of High Risk Pregnancy** (Including, but not limited to, diabetes, abnormal GFR, BMI > 35, multiple gestation, polycystic ovaries, hypertension, HIV/AIDS, history of Autoimmune diseases, abnormal TFTs, acute abdominal pain/ vaginal spotting, preeclampsia/ eclampsia, history of genetic disorder) **requires Physician to Physician discussion**
	Assessment of current physical status of mother and fetus.
15	**WBC**
	Values outside of this range requires comment about medical stability on PARF and physician-to-physician conversation: >10,000 or <3000. Range between 3000 -10, 000 is acceptable.
16	**Mechanical assistance or wheelchair**
	Patients able to move or transfer independently with mechanical assistance or wheelchair may be accepted
17	**Patient refusal to cooperate with lab testing**
	Decision regarding acceptance must be made on the basis of the information available and with a Physician to Physician conversation.

ADDITIONAL INFORMATION

→	An individual who is actively violent is not appropriate for admission to a Crisis Stabilization Unit: • If an individual continues to need seclusion and or restraint afterthe administration of PRN medication or • If the patient cannot be safely managed at the CSU because of current acuity already on the unit.
→	Physician to Physician communication is requested to ensure continuity of care, and is required in cases of differences of opinion. Physician to Physician communication is required when there is any unstable medical condition.
→	In cases where the referring physician believes the receiving physician is requesting inappropriate labs or Evaluations or denying acceptance inappropriately, the referring physician may request to discuss the case with the Hospital or CSU Medical Director (or designee) at any time.
→	In cases where the referring physician believes the receiving physician is requesting inappropriate labs or evaluations or denying acceptance inappropriately, the referring physician may request to discuss the case with the CSU Medical Director (or designee) at any time.
→	These guidelines are intended to provide consistency for referrals into CSUs in Georgia. However the ultimate decision to admit or not admit is that of the receiving physician.
→	Those under the age of 18 are referred to CSUs serving children & adolescents. The exception is emancipated minors which are defined in Georgia as follows: Emancipation may occur by operation of law when a minor is validly married, reaches the age of 18 years, or during the period when the minor is on active duty with the armed forces of the United States. Emancipation may also occur by court order pursuant to a petition filed by a minor with the Juvenile Court.