

Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)

Using PSYCKES in Emergency Settings: Guidelines for Policies and Procedures

Implementation of PSYCKES involves assigning the essential PSYCKES tasks listed below.

In order to promote successful adoption of PSYCKES, hospitals are advised to develop, document and implement policies and procedures for PSYCKES use. These should establish staff accountability and, ideally, integrate PSYCKES tasks into existing workflows. These guidelines provide a framework for that process.

Essential PSYCKES Tasks	Sample Procedures	Sample Policies
<p>1. Identify Potential PSYCKES Clients</p> <ul style="list-style-type: none"> • Identify potential PSYCKES clients, • Check if previously consented, • Obtain client's Medicaid identification (ID) number, and • Verify client's identity. 	<ul style="list-style-type: none"> • Designate staff responsible for this task • This staff member will: <ul style="list-style-type: none"> ○ Identify potential PSYCKES clients <ul style="list-style-type: none"> ▪ All Medicaid enrollees ▪ Had Medicaid within the past 5 years ○ Determine whether the client is already consented <ul style="list-style-type: none"> ▪ **if yes, skip to Step 6** ○ Obtain and document the client's Medicaid ID number (or can use Social Security number) ○ Verify client's identity <ul style="list-style-type: none"> ▪ 2 forms of ID, OR ▪ Staff can attest to client identity. • Consider a flag on client's medical record and/or "face sheet" to indicate whether the client <ul style="list-style-type: none"> ○ Is PSYCKES eligible ○ Has already signed a PSYCKES Consent Form 	<ul style="list-style-type: none"> • All clients should be screened upon arrival for PSYCKES eligibility. • Eligible clients should be consented at the earliest opportunity. • PSYCKES Clinical Summary should be obtained for all eligible individuals.
<p>2. Obtain Client Consent</p> <ul style="list-style-type: none"> • Obtain signature of PSYCKES-eligible client on PSYCKES Consent Form, and • Give a copy of the form to the client. 	<ul style="list-style-type: none"> • PSYCKES Consent Form is pre-printed and accessible to staff <ul style="list-style-type: none"> ○ Designate staff responsible for using Consent Module Administration function to set up Consent Form (fill in blanks) ○ Designate staff responsible for printing PSYCKES Consent • PSYCKES Consent Form is included in intake/admission package and signed by client routinely along with any other paperwork (e.g., receipt of Client Rights / HIPAA privacy notice) <ul style="list-style-type: none"> ○ Alternatively, specify where blank forms are maintained • Designate staff responsible for asking clients for consent and answering questions about PSYCKES, and when this will happen • Staff copy signed consent (front and back) and give copy to client • If client initially refuses consent, when will another effort be made? 	<ul style="list-style-type: none"> • Consent to view PSYCKES data should be requested of all eligible individuals with capacity to consent (unless clinically contra-indicated). • Only the PSYCKES Consent Form, printed from Consent Module, may be used. • A copy of the PSYCKES Consent Form (especially information on back) must be given to the client.

Essential PSYCKES Tasks	Sample Procedures	Sample Policies
<p>3. Determine Whether There Is A Clinical Emergency In a clinical emergency, the consent module may be used to obtain 72-hour emergency access for client information.</p>	<ul style="list-style-type: none"> • **Skip this step if client has consented.** • Designate staff responsible for determining that it is a clinical emergency. • Designate staff responsible for ensuring that the medical record supports emergency access by documenting why/how the client meets criteria for a clinical emergency. • Specify where in the record this is documented. • Emergency access expires in 72 hours, so another attempt should be made to obtain consent. How/when will that take place? (Before transfer to inpatient? On inpatient unit? Will inpatient staff have consent module access?) 	<ul style="list-style-type: none"> • Emergency access is available only in a clinical emergency. • Specify staff authorized to certify a clinical emergency. • Develop guidelines for what constitutes a clinical emergency (Hospital may use existing criteria; PSYCKES information is available.) • If the client refuses to sign the form but criteria for emergency access are met, provider may still access PSYCKES data (as stated on the Consent Form).
<p>4. Use Consent Module To Enable Access To Client's Clinical Summary In PSYCKES PSYCKES user with "Registrar access" uses Consent Module to:</p> <ul style="list-style-type: none"> • look up client, • verify client's identity, and • document the rationale for access to clinical data. 	<ul style="list-style-type: none"> • Designate staff responsible for this task • This staff member will: <ul style="list-style-type: none"> ○ Enter PSYCKES Consent Module ○ Search for client by <ul style="list-style-type: none"> ▪ Medicaid ID # or ▪ Social Security # ○ Specify the basis for accessing the client's information <ul style="list-style-type: none"> ▪ Client signed consent, or ▪ Clinical emergency ○ Verify client's identity and document: <ul style="list-style-type: none"> ▪ 2 forms of ID, or ▪ Staff attests to client's identity ○ May proceed directly to accessing/printing clinical summary <p>All PSYCKES users at the hospital now have access to the client's clinical information</p> 	<ul style="list-style-type: none"> • Designate which staff or categories of staff will have Consent Module access; could be some or all PSYCKES users. • Sharing of Office of Mental Health (OMH) User IDs and security tokens is prohibited. • Consider developing guidelines for when/why staff may attest to client identity.
<p>5. Retain PSYCKES Consent Form In Client's Medical Record</p>	<ul style="list-style-type: none"> • **Skip this step if emergency access was used.** • Designate staff responsible for this task • Specify how/when/where PSYCKES Consent Form will be filed: <ul style="list-style-type: none"> ○ Will paper Consent Form will be retained, or will it be scanned into electronic medical record (EMR)? ○ In which section of the record will it be kept? ○ When will it be filed / scanned in? <p>(Consider bar-coding PSYCKES Consent Form for inclusion in EMR)</p>	<ul style="list-style-type: none"> • The PSYCKES Consent Form (original or scanned) must be retained in the client's medical record.

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<p>6. Print Clinical Summary</p>	<ul style="list-style-type: none"> • Designate staff responsible for this task • The designated staff will: <ul style="list-style-type: none"> ○ Access client’s Clinical Summary via: <ul style="list-style-type: none"> ▪ Recipient Search, or ▪ Consent Module ○ Make selections for printing Clinical Summary <ul style="list-style-type: none"> ▪ Specify time period (up to 5 years is available) ▪ Specify which sections / details to print ○ Export Clinical summary to PDF, and print <ul style="list-style-type: none"> ▪ Or, if applicable, append PDF to EMR ○ Close PDF document without saving, or save only to secure server. 	<ul style="list-style-type: none"> • PSYCKES Clinical Summary should be obtained and reviewed for all eligible clients. • Designate which staff or categories of staff will have PSYCKES access. • Prohibit saving the printable Clinical Summary PDF document anywhere other than a secure server. (Hospital’s existing policies may be sufficient but should be reviewed in relation to PSYCKES.)
<p>7. Place Clinical Summary In Client’s Medical Record (This may be done before or after the clinical summary is reviewed by staff.)</p>	<ul style="list-style-type: none"> • Designate staff responsible for this task • Specify how/when Clinical Summary will be filed: <ul style="list-style-type: none"> ○ Will hard copy of Clinical Summary be retained? Will PDF document be appended to client’s EMR? Will printed summary be scanned into EMR (and hard copy shredded)? ○ In which section of the record will the PSYCKES Consent Form be filed? ○ When will the Clinical Summary be filed/scanned/appended to medical record? <p>Consider placing bar-coded Consent Form as cover sheet on Clinical Summary and scanning into EMR as a single document</p> 	<ul style="list-style-type: none"> • PSYCKES Clinical Summary should be obtained and retained in medical record for all eligible clients. • Redisclosure of confidential information is prohibited, and additional restrictions apply to health information with special protections (HIV, substance abuse, family planning, genetic), which may appear in the PSYCKES Clinical Summary. (Hospital’s existing policies may be sufficient but should be reviewed in relation to PSYCKES.)
<p>8. Review Clinical Summary</p>	<ul style="list-style-type: none"> • Designate categories of staff (which disciplines, settings, etc.) responsible for reviewing PSYCKES Clinical Summary • Specify when Clinical Summary will be reviewed <ul style="list-style-type: none"> ○ Prior to documenting psychiatric evaluation and psychosocial assessment? ○ Before deciding on disposition? ○ During discharge planning? <p>Clinical staff reviewing a printed summary should have access to PSYCKES in order to facilitate access to further detail.</p> 	<ul style="list-style-type: none"> • PSYCKES Clinical Summary should be obtained and reviewed for all eligible clients. • Designate which staff or categories of staff will have PSYCKES access. Consider including inpatient staff.

Please see also: PSYCKES Access and Training for Emergency Department Staff: Guidelines for Policies and Procedures