

**ODMH Public Private Inpatient Psychiatric Services Leadership**  
**Project #1**

**AGENDA**

**February 27, 2013**

- A. History of November 2012 Conference
- B. Today's meeting
  - 1. Purpose / Task
    - a. Standardized guidelines
    - b. Get feedback – buy in
    - c. Try it out / pilot
- C. What we have to view / consider
- D. Challenges / barriers
  - 1. Cost
  - 2. Disgruntled – ER docs, hospital
- E. Right people at the table
  - 1. Have Boards help
  - 2. Have HBH help
  - 3. Get right people / everyone's job
- F. Time limited subgroup – 2 to 3 meetings
- G. Report out to region – April / May
- H. Statewide – reconvene in one year or less
- I. Support from Director of ODMH / ODADAS

## **ODMH Public Private Inpatient Psychiatric Services Leadership Project #1**

### **Project 1: Improving access through standardizing the medical clearance process**

**Issue:** In our region admissions periodically are delayed or denied based on interpretation, definition, and understanding of medical clearance

- *As is state:* Inconsistent, costly, rigid, and excessive testing
- *Desired state:* A consistent, cost effective, and uniformed clearance process
- *Leaders:* Dr. Bergman, Parma General Hospital, Dr. Emmanuel Nwajei, Heartland Behavioral Healthcare
- *Champions:* Gail Houk (Alternative Paths), Nancy Collier (Med Central Health System), Jeff Allen (Crisis Intervention & Recovery Center), Jeff Doig (Ten Lakes Center), and Dr. Joseph Varley (Summa Health System)
- *Outcomes:*
  - Uniform guidelines
  - Potential algorithm
  - Consider consistent clinician-to-clinician communication to head-off issues
  - Potentially expansion project to include unit to unit transfers, hospital to hospital, as well accepting readmissions that recently left the facility

# HEARTLAND BEHAVIORAL HEALTHCARE STANDARD ADMISSION MEDICAL CLEARANCE GUIDELINES

*\*Please fax all required/requested items in an effort to provide the best possible patient care. Thank you.\**

**Phone: (330) 833-3135, ext. 1301**

**Fax: (330) 833-6686**

(If no answer, Dial 0 and ask for the charge nursing supervisor)

Patient's name:	Patient's age:
Referring hospital/physician:	Phone:                      Fax:
Contact person:	Phone (if different than above):
Reason for psychiatric referral:	
DSM Axis I Diagnosis:	

**Please send the following information on all patients:**

Medical record/ED notes including ED physician & nursing records, V.S., x-ray results, labs, allergies & list of current meds.

Words "medically cleared" clearly printed or checked off in chart (no NG tube or IV's)

List of known Axis III Medical Conditions

Demographics sheet

Insurance card copy/insurance information

County pre-screening evaluation

Pink slip – both sides correctly completed

Psychiatric evaluation, if completed

This section contains the list of documents that should be faxed in with **every HBH referral**. Should be sent at the time of referral to ensure efficient processing.

**Minimum required lab work for all patients:**

CBC with Diff

CMP (or BMP with Hepatic Panel)

Blood ETOH < .08

Urine toxicology (9-panel test preferred)

EKG

HCG on females under age 60

if positive HCG, FHT if present

This section contains the list of tests that HBH suggests to ensure medical clearance on **all admission referrals**.

**If the patient regularly takes or has overdosed on any of the following meds, please send blood levels:**

ASA (salicylates)

Depakote(kene) valporic acid

Digoxin

Dilantin (phenytoin)

Lithium

Tegretol

Tylenol (acetaminophen)

Phenobarbital

Other

This section contains the list of blood/medication levels necessary to ensure medical clearance on admission referrals **where it is clinically appropriate**.

**Please review the necessary info below and proceed accordingly only if it applies to your patient:**

CPK, if appropriate, i.e., if cocaine/PCP/hypothermia:

if < 500 unit/l, no 2<sup>nd</sup> level needed

if > 500 unit/l, need results showing downward trend

TSH – i.e., known thyroid diagnosis

UA – i.e., elderly, acute mental status changes/dementia/fever

Chest x-ray – i.e., SOB/HIV, fever, cough

CT of head (usually indicated for first psychosis in patients over age 40, or history of head trauma)

This section provides guidelines when medical clearance is more complex. **Used only when clinically appropriate.**

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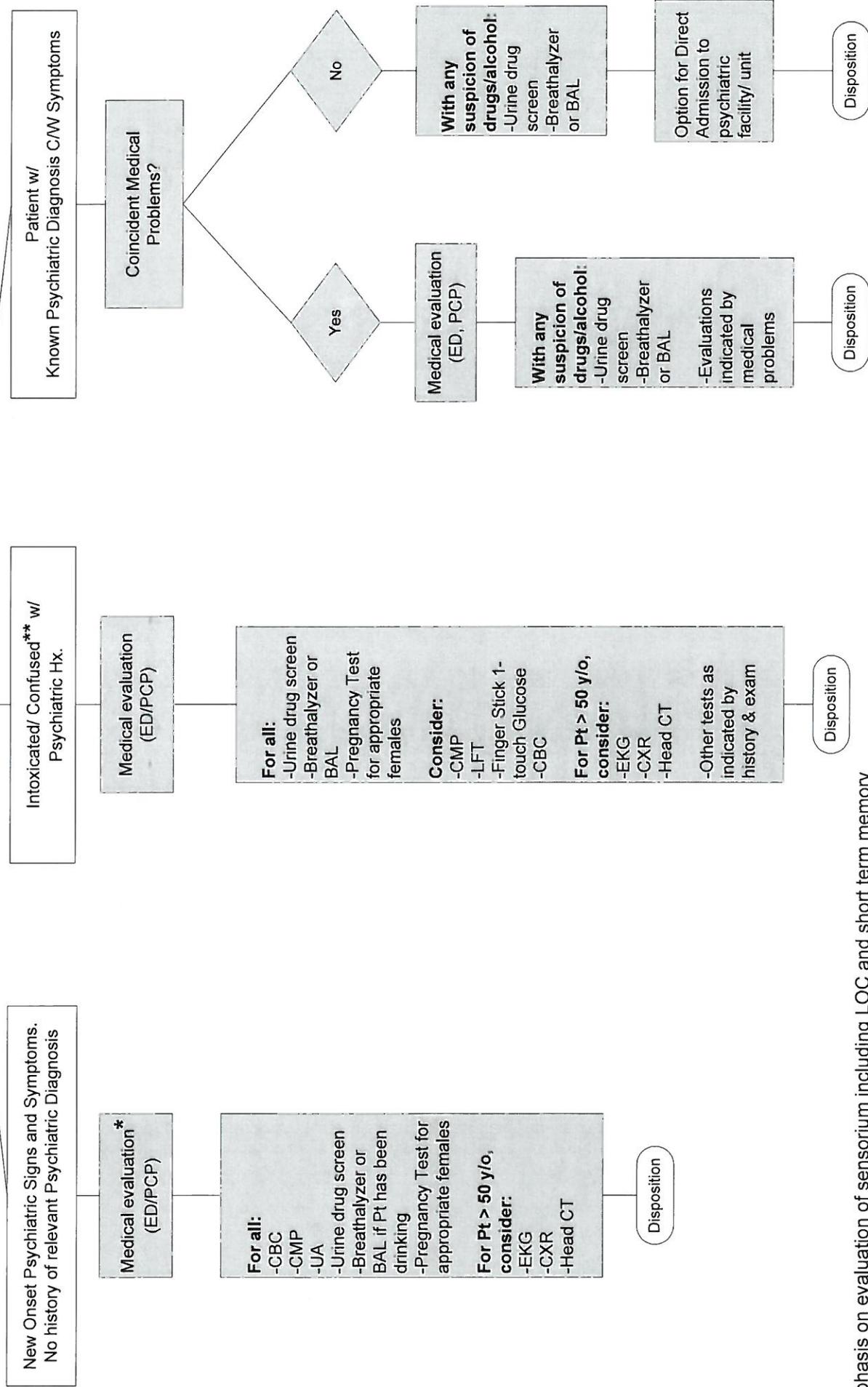
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# MaineHealth Medical Clearance Protocol: Acute Psychiatric Patient in the E.D. Presenting for IP Admission

To report activity outside this protocol within the MaineHealth System please dial (207) 761-2322



\* Emphasis on evaluation of sensorium including LOC and short term memory

\*\*Evaluation for Delirium is an important part of medical evaluation

# MaineHealth®

## *A Consensus Approach to the Medical Clearance Process for Psychiatric Patients Referred for Inpatient Admission by MaineHealth Emergency Departments*

### **History of Workgroup**

In 2006, a MaineHealth ‘Mental Health Steering Committee’, with representatives from member and affiliate hospitals, recommended the adoption of standard protocols for diagnosing and treating psychiatric patients presenting in MaineHealth emergency departments (EDs). The **MaineHealth ED Psychiatric Care Workgroup** was formed to develop and implement the protocols. This document has been developed by the MaineHealth ED Psychiatric Care Workgroup to support this work.

### **MaineHealth Medical Clearance Guidelines for Acute Psychiatric Patients in the ED**

The following medical clearance guidelines are based on guidelines endorsed by the Maine Hospital Association (MHA) and updated January 23, 2007, in combination with guidelines used by MidCoast Hospital and by the Maine Medical Center (MMC) Emergency Department. They reflect an effort to: 1) decrease variation in practice among MaineHealth EDs; 2) standardize and streamline the process of patient assessment and referral; and 3) maintain high-quality of care for the presenting patient.

*As stated in the MHA Medical Clearance Guidelines, Tremendous variation in practice results in delays for patients, frustration for providers, and inefficient use of healthcare resources. Where possible, the use of evidence-based clinical guidelines may make this difficult experience better for all involved. This consensus document is meant to guide clinicians in patient care, not to replace judgment or the need for care adapted to the needs of the individual patient.*

### **Basic Principles**

- 1) ‘Medical clearance’ refers to medical evaluation of persons being considered for psychiatric admission. It screens for general medical problems that require medical admission or are responsible for the psychiatric problems and require medical rather than psychiatric treatment, or medical problems that need to be addressed in the course of the patient’s inpatient psychiatric care.
- 2) Medical clearance is indicated for many-but not all-patients being considered for psychiatric admission. Those with exacerbations of longstanding psychiatric disease who are otherwise well may not require medical clearance.
- 3) There should be a common standard for medical clearance across the state, as psychiatric units and hospitals draw patients from across the state.
- 4) Emergency departments and psychiatric facilities must communicate regularly and work to develop mutual trust.

### **Quality Improvement**

Since all psychiatric inpatient facilities and emergency departments have active quality improvement programs, any issue causing dissatisfaction for either the receiving hospital or the referring hospital will be referred back to that hospital for review and improvement. Performance will be tracked to demonstrate adherence to the guidelines.

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## *A Consensus Approach to the Medical Clearance Process for Psychiatric Patients Referred for Inpatient Admission by MaineHealth Emergency Departments*

### **PROPOSED GUIDELINES FOR THE MEDICAL CLEARANCE WORK-UP**

#### **Different Patients have Different Needs**

- The level of medical clearance required depends on the clinical situation. Four patient groups can be distinguished with different needs:
  - 1) New patients with unknown history or no prior history of medical or psychiatric illness. They need in depth medical evaluation. Up to 60% may have medical or toxic causes for their presentation.
  - 2) Known psychiatric patients with known major medical problems/medical complaints. Their known medical problems/complaints/confusion need medical evaluation appropriate to their medical condition. Drug screen and breathalyzer if any suspicion.
  - 3) Intoxicated or confused patients, whether new or known well. They need medical evaluation appropriate to their current medical condition.
  - 4) Known psychiatric patients with an exacerbation of a known problem, history of repeated psychiatric admissions including a recent admission, no history of major medical problems and no active medical complaint. These patients often require minimal medical clearance.

#### **Waiving Medical Clearance**

- Medical clearance may be waived at the discretion of the admitting psychiatrist for well-known psychiatric patients who do not have a significant medical history.
- Waiving medical clearance is the prerogative of the admitting psychiatrist and not the referring source.
- When an admitting psychiatrist has accepted a referral from a mental health clinician in the community pending medical clearance, he or she may call an ED to request medical clearance without further evaluation by a crisis worker to determine the need for admission. The decision to accept the patient for admission has already been made by the psychiatrist.

#### **Medical clearance should include a history, examination, and lab tests appropriate to the patient's condition and history.**

The history should include:

1. History of Present Illness (HPI), including psychiatric and medical complaints and events
2. History of Medical Problems
3. History of Psychiatric Problems, Substance Abuse, Allergies, and Current Medications.

The examination should include:

1. Physical Examination sufficient to screen for major medical problems
2. Mental Status Examination with a brief description of key abnormal findings and emphasis on evaluation of sensorium

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Ordering any laboratory tests is dependent upon the emergency provider's determination of the patient's clinical status as suggested by the patient group and findings on the history and examination. The following recommendations are intended to be guidelines and are not to be construed as being universally required for any group of patients:

1. Patients without a prior psychiatric history: CBC, comprehensive metabolic panel, UA, breathalyzer or BAL for patients who have been drinking, drug screen. For patients over 50 years old: CXR, EKG as appropriate. Head CT only with focal neurological findings or recent head trauma/injury.
2. Known psychiatric patient with medical complaint/known medical problems: as appropriate to known medical problem. Urine drug screen and breathalyzer if any suspicion.
3. Intoxicated/confused patient: breathalyzer or BAL and urine drug screen on all. Consider comprehensive metabolic panel, LFT, one-touch finger stick for glucose, CBC. For patients over 50 years old: consider EKG, CXR, Head CT and any other tests as indicated by history and exam.
4. Known patient with no medical complaint: None. Urine drug screen and breathalyzer if any suspicion.
5. Women of childbearing age: pregnancy test (allows initiation of therapy urgently on admission)

### **Requests for Additional Laboratory Testing from the Accepting Physician**

With regard to courtesy labs, it is important to note that ED's have better access to laboratories than most psychiatric hospitals and crisis residences. The accepting psychiatrist may ask that additional labs be drawn in the ED to establish a baseline before starting therapy (e.g., pregnancy test, other tests that were not needed for medical screening, etc); however the accepting psychiatrist should check for those results the next day. The transfer of the patient should not be delayed while waiting for the results of these lab tests.

The accepting psychiatrist/provider may have personal knowledge about the patient and may believe that further diagnostic evaluation is needed, including labs. In this instance, the accepting psychiatrist/provider should speak directly to the ED physician/provider. The two providers should then collaborate on an appropriate approach to further evaluate.

### **Notes Regarding Laboratory Tests**

A blood alcohol level (BAL) may be helpful in documenting recent alcohol ingestion; however, the results are not useful in determining whether a patient is clinically intoxicated. The diagnosis of intoxication (and conversely, the determination that the patient has the capacity to be evaluated for psychiatric admission) is a clinical decision, and no specific blood alcohol level should be used to determine sobriety and capacity to participate in a clinical evaluation. Components of making this clinical decision include that the patient is cooperative and does not exhibit evidence of intoxication (i.e., somnolence, slurring of words or ataxia). BALs are not indicated in patients who deny recent alcohol use and have no evidence (e.g., odor) of it on examination.