

Dear Colleague:

The Massachusetts College of Emergency Physicians together with the Massachusetts Psychiatric Society announce their approval of the Joint Task Force Consensus Guidelines on The Medical Clearance Exam and The Use of Toxic Screens (previously released) for the evaluation and management of the psychiatric patient in the Emergency Department.

The Medical Clearance Exam

1. There was general agreement by task force members that the term medical clearance may convey unwarranted prospective security regarding the absence of any prospective medical risks. However, given the deeply ingrained use of the term, task force members felt it would not be possible to eliminate its use or introduce an alternative term.

2. Medical clearance reflects short term but not necessarily long term medical stability within the context of a transfer to a location with appropriate resources to monitor and treat what has been currently diagnosed.

3. Any patient with psychiatric complaints who is examined by the emergency physician should be assessed for significant contributing medical causes of those complaints. Medical clearance of patients with psychiatric complaints in an emergency facility should indicate that:

within reasonable medical certainty, there is no known contributory medical cause for the patient's presenting psychiatric complaints that requires acute intervention in a medical setting;

within reasonable medical certainty, there is no medical emergency;

within reasonable medical certainty, the patient is medically stable enough for the transfer to the intended dispositional setting (e.g. a general hospital, a psychiatric hospital, an out patient treatment setting or no follow-up treatment);

the emergency physician who has indicated medical clearance shall, based on his or her examination of the patient at that point in time, indicate in the patient's medical record the patient's foreseeable needs of medical supervision and treatment. This information will be used by the transferring physician who will make the eventual disposition of the patient (See item # 13).

4. Medical clearance does not indicate the absence of ongoing medical issues which may require further diagnostic assessment, monitoring and treatment. Neither does it guarantee that there are no as yet undiagnosed medical conditions.

5. Task force members agreed to make reference to and use of the EMTALA definition of the medical screening and stabilization exam. By that definition, transfer of a patient requires that the patient be medically stable for transfer or that the benefits of transfer outweigh the risks.

6. No consensus in the literature was found that delineated a proven, standardized approach to the evaluation and management of psychiatric patients requiring medical evaluation in the emergency department. There was general agreement, based on clinical experience, to establish Criteria for Psychiatric Patients with Low Medical Risk.

7. The Criteria for Psychiatric Patients with Low Medical Risk recommended by the task force included:

- Age between 15 and 55 years old
- No acute medical complaints
- No new psychiatric or physical symptoms
- No evidence of a pattern of substance (alcohol or drug) abuse
- Normal physical examination that includes, at the minimum:
 - a. normal vital signs (with oxygen saturation if available).
 - b. normal (age appropriate) assessment of gait, strength and fluency of speech
 - c. normal (age appropriate) assessment of memory and concentration

8. A typical physical examination in the emergency department is focal, driven by history, chief complaints and disposition, and is not a replacement for a general, multisystem physical examination. The extent of the physical examination performed on a psychiatric patient by the emergency physician should be documented in the patient's medical record.

9. It was agreed and recommended that routine diagnostic screening and application of medical technology for the patient who meets the above low medical risk criteria is of very low yield and therefore not recommended.

10. Patients who do not meet the low medical risk criteria are not automatically at high medical risk. For patients who do not meet the low medical risk criteria, selective diagnostic testing and application of medical technology should be guided by the patient's clinical presentation and physical findings.

11. Once a patient has been medically cleared and accepted by the receiving facility, the receiving facilities may nevertheless request that the emergency department initiate laboratory tests (e.g. drug levels, renal function etc.) only if such tests will facilitate the patient's immediate care at the receiving facility. However, awaiting the results of these lab tests should not delay the transfer process.

12. It was agreed that during a psychiatric patient's medical assessment, the decision of when to begin the patient's psychiatric evaluation should be a clinical judgment. The psychiatric component of a patient's emergency department evaluation should not be delayed solely because of the absence of abnormality of laboratory data.

13. When crisis or inpatient psychiatric treatment is recommended for a patient who has been cleared by an emergency physician, the transferring physician should consider:

- a. the patient's anticipated needs for medical supervision and treatment as outlined in the medical record by the examining emergency physician and

b. the medical resources available at an intended receiving psychiatric facility. The receiving facility's medical resources should be accurately represented to the transferring physician by a qualified professional of the receiving facility.

14. To facilitate the transferring physician's choice of an appropriate inpatient psychiatric facility, the task force recommends the development of a list of New England psychiatric units indicating the respective availability of concurrent medical care, nighttime and weekend medical coverage, locked and unlocked beds and separate and concurrent substance abuse treatment.

15. In the event that transfer to a crisis or inpatient psychiatric facility is recommended, it is often desirable to have direct communication between the transferring physician and the psychiatrist accepting the transfer at the receiving facility.

a. Prior to having accepted a medically cleared patient for transfer, a potential receiving facility's request for additional diagnostic testing of the patient should be guided by that individual patient's clinical presentation and physical findings and should not be based on a receiving facility's screening protocol. (See paragraphs 6 - 10)

b. After having accepted a medically cleared patient for transfer, a receiving facility may request that the emergency department initiate laboratory tests (e.g. drug levels, renal function etc.) only if such tests will facilitate the immediate care at the receiving facility. Awaiting the results of these laboratory tests should not delay the transfer process.

16. Task force members felt that direct physician to physician communication was required to resolve concerns arising between the transferring physician and the receiving facility regarding:

- a. the need for an inpatient psychiatric hospitalization;
- b. the appropriateness of one facility versus another;
- c. a request for certain diagnostic testing;
- d. any general clinical disagreement;
- e. significant ongoing medical issues or treatment recommendations.

17. In view of the focal nature of the emergency physician's medical assessment and clearance, task force members strongly recommend that all psychiatric patients transferred to an inpatient facility be considered for a timely, comprehensive medical evaluation during the course of their hospitalization.

These guidelines will be distributed to members of both professional societies, and anyone else wishing to use this information. Please feel free to contact either organization for further information.

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Dear Colleague:

The Massachusetts College of Emergency Physicians together with the Massachusetts Psychiatric Society have jointly convened a task force to address the issue of use of toxic screens in the evaluation and management of the psychiatric patient in the emergency department. The joint recommendations are summarized below:

What constitutes a toxic screen?

The term toxic screen is generally defined as a laboratory test for common drugs of abuse and potential medication overdose. Toxic screens can be either urine and/or serum tests.

Should absolute levels preclude transfers (i.e. ETOH levels above 100)?

Neither the determination that the patient can be psychiatrically evaluated nor the determination that a patient can be transferred from the emergency department to a hospital or home should be based on a particular serum level of alcohol or another drug. These determinations should be made based on the overall clinical state of the patient.

Which psychiatric patients require a toxic screen?

Psychiatric patients that exhibit signs or symptoms of toxic ingestion or present with a history suggestive of a drug overdose may require a toxic screen and/or specific drug levels in addition to an appropriate medical examination.

Should courtesy toxic screens or drug levels for the receiving institution be drawn on patients before a transfer to an inpatient psychiatric unit?

Receiving institutions sometime request that emergency departments provide serum levels for currently prescribed medications. These "courtesy" drug levels may be drawn at the discretion of the sending institution but are not required for an otherwise medically stable psychiatric patient. Should these levels be drawn, the patient may be transferred before the results of the drug level are known.

The above guidelines have recently been incorporated into the Massachusetts Behavioral Partnership's Mobile Psychiatric Teams operational protocols for Medicaid and uninsured patients. In the next few weeks, our professional societies will reconvene to explore the broader issue of what constitutes a medical clearance exam as well as medical and psychiatric stabilization within the confines of the federal EMTALA regulations.

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