beacon health options

Agenda

Meeting Title:	Clark County Crisis Collaborative
Date/Time:	August 17, 2017 3:00-4:30 PM
Location:	Children's Center, 13500 SE 7th St, Vancouver, WA 98683 phone 650-479-3208 pc: 7999-9944

3:00 – 3:10 Introductions

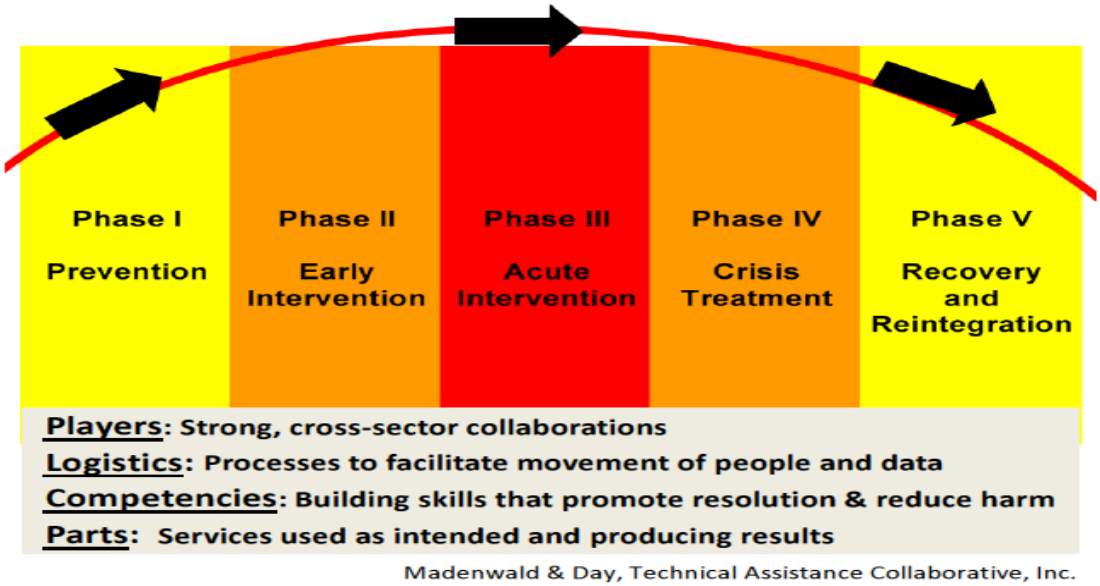
3:10 – 3:30 Follow up from last meeting, announcements and updates on recommended key action steps

- HW from last meeting:
  - Erin to re- send out survey to other providers in group
  - Daniel (ACH) follow up on feedback from lunch and learn meeting with public health
  - Medical clearance group- learn more from Unity model; approach units with recommendations
  - Aaron update medical clearance document
  - Data group schedule follow up meetings to figure out what to track and bring back to next meeting for review
- Updates from Group
- Youth Suicide (standing item)

3:30 – 4:00 Discuss next steps on medical clearance

4:00 - 4:20 Review data matrix draft 1 and identify priority metrics

4:20 - 4:30 Next steps for crisis collaborative efforts and focus



Madenwald & Day, Technical Assistance Collaborative, Inc.

Medical Clearance

1. Recommendation

Develop a task force to set a standard of care for medical clearance for the Clark County community that advances the dual goals of 1) patient safety and 2) patient centeredness. We recommend that the task force develop protocols and screening tools to determine if and when a medical clearance is necessary and in what setting (in the field by EMR, at an urgent care setting, a psychiatric facility or a hospital setting). For example, criteria for Psychiatric Patients with Low Medical Risk who could be evaluated by a nurse at the E&T or an individual with no clear medical emergency can be evaluated by an EMT in the community in accordance with SBH 721 or a psychiatric evaluation completed in the community by the mobile crisis team with a referral to Memorial Urgent Care for medical screening and admit to PHSMC-PSII which shares a building. Peer counselors could be enlisted to provide support during medical clearance process wherever it occurs.

Emergency physicians should be involved in the process, as well as the DMHPs, Emergency Medical Response (EMR) and Psychiatric Facilities.

The end product should be a one to two-page document that has clear criteria, a defined screening process and is ratified by the relevant impacted entities.

2. Background

Many communities, including Southwest Washington, have grappled with this issue of requiring medical clearance prior to psychiatric hospitalization. The practice is time-consuming, costly, and generally is not patient-centric. From a patient-first lens, it is important to balance the potential health benefit that comes from the medical clearance with what potential harms it may introduce. This includes costs that the patient must bear, risk of unnecessary testing, discomfort, testing under coercive circumstances, delay in treatment of the crisis condition, and additional transportation.

The Clark County Crisis Collaborative, formed in April 2017, gathered initial information on medical clearance practices from four local acute behavioral health facilities focused on treatment for substance use and mental health. The discovery revealed that there are differences in medical clearance practices for substance use inpatient facilities versus psychiatric inpatient facilities, indicating inconsistency in the application of medical clearance practices and an opportunity for change.

Lifeline Connections (LLC) operates a detox facility for substance use and accepts clients directly after following a screening process, whereas admission to the three psychiatric facilities, Telecare's Evaluation and Treatment Facility (E&T), PeaceHealth Medical Center's Station Two (Station 2) and Elahan Place (EP) Crisis Stabilization Unit, requires medical clearance at a local emergency department before acceptance.

Lifeline utilizes clear criteria to determine when medical clearance is warranted including:

- Urine Drug Screen (UDS) over 0.35
- Potential fractures
- Lacerations less than 12 hours old and are more than 1.5 cm long or that may require suturing
- Significant complaints of shortness of breath, chest or abdominal pain
- Unable to provide coherent medical history or speak intelligibly (with some exception)
- Any patient with P < 48 or > 230; Temperature > 102 or < 95 degrees Fahrenheit; SBP > 180 or < 90; DBP > 120; R > 30 or < 10
- Unconscious

The intent of medical clearance practices at the three psychiatric facilities is to ensure patient safety, enhance admission processes and maintain an appropriate level of care. The lab work requested from the hospital emergency department

include a comprehensive metabolic panel (CMP), CBC, UDS, UA with microscopic, acetaminophen, salicylate, TSH and pregnancy.

In July 2016, the Washington State Legislature passed SHB 1721 which allows for ambulances to transport patients directly to facilities other than the emergency department, including psychiatric facilities for the purposes of hospital diversion. The bill has been implemented in Clark County for substance use services but not mental health. This bill allows for an opportunity to re-visit medical clearance practice for mental health facilities and implement patient-centric system service delivery. An example could be field clearance by an EMT while a crisis team is providing a service in the community and determines with the client that psychiatric hospitalization or crisis stabilization would be beneficial.

Currently, the most time consuming component process in the emergency department is waiting for a psychiatric evaluation, according to the DMHP.

SHB 721 allows for diversion to a psychiatric facility under these circumstances:

- Voluntary with mental health as the chief compliant
- Clear history of mental health problems
- Current condition cannot be explained by a medical issue
- Age 18-55
- Cooperative, non-combative
- Normal level of consciousness
- HR 50-110
- BP Systolic 100-190
- RR 12-24
- Temperature 97-100.3
- O2 RA above 92
- Blood sugar 70-300
- Can care for self
- Blood alcohol level below 0.3

3. Rationale for the recommendation

There seems to be no consensus in literature that delineates a proven, standardized approach to the evaluation and management of psychiatric patients requiring medical evaluation in the emergency department. Additionally, medical clearance in the emergency department often reference Emergency Medical Treatment and Labor Act (EMTALA), a federal law passed in 1986 that requires anyone coming into an emergency department to be stabilized and treated regardless of their insurance status including a physical exam and necessary testing.

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 treatment the diagnosis. Medical clearance for individuals with a primary psychiatric complaint is to determine within reasonable medical certainly that there is no medical emergency and the individual is medically stable enough to transfer to the intended setting.

Some states have created a standard of practice for medical clearance. For example, New Jersey did so at the direction of legislation passed in 2010 to standardize admission and medical clearance protocols due to a lack of uniform standards and duplicative processes. Massachusetts' task force developed criteria for psychiatric patients with low medical risk due to a lack of a standard. The criteria established was based on clinical experience, including:

- 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:
  normal vital signs (with oxygen saturation if available)
  normal (age appropriate) assessment of gait, strength and fluency of speech
  normal (age appropriate) assessment of memory and concentration

Locally, the Unity Center in Portland, Oregon does not require lab work, UDS and admits clients who are intoxicated as long as they are able to "walk, talk, able to eat a sandwich" if the UDS is over 0.25. Further learning and understanding is warranted.

4. Potential downsides but how they can be mitigated

There are downsides to changing medical clearances to consider and strategies to address them must be identified.

Concern	Mitigation strategy
Medical staffing at psychiatric facilities is limited and direct admissions of individuals who are medically acute could pose safety risks to the client, staff and other residents. Per WAC 246-337-080(2)(A), admissions are limited to patients for whom the facility is qualified to serve by staff, services, equipment, building design and occupancy to give safe care.	Identify clear criteria for when medical clearance is warranted to be applied. Assist facilities in identifying staffing and program design needs to provide safe care, including medical staff as part of the staffing pattern.
There have been times where seemingly healthy patients between the ages of 15-55 with chronic mental illness present with baseline symptoms that require medical admission. There are risks to having an EMT provide field clearance for patients rather than being screened by a MD in the emergency department. Delirium often mimics psychosis.	Audit historical data or charts to determine the circumstances and frequency in which this occurred. Identify clear criteria for field screening. Identify training needs of EMT to provide for field screening.
Threats to harm self and others often accompany substance use/abuse and symptoms clear upon sobriety. This can give the false presentation of symptoms that may be more appropriately treated in a substance use facility rather than inpatient psychiatric facility. ETOH level and UDS provide for benchmarks for psychiatric evaluation; starting the evaluation process prematurely could result in inappropriate use of resources.	Identify clear criteria and screening tools for diagnostic specificity that differentiates and directs to appropriate treatment.
With changes in admission criteria at health plans, there have been cases where clients were accepted quickly without authorization being obtained and the facility was not reimbursed for services. Direct admits could potentially leave a facility with unpaid services.	Engage health plans and providers on behavioral health medical necessity criteria and utilization management processes. Identify minimum criteria for entry.
Springstone (incoming psychiatric facility in Salmon Creek) has indicated that they will require medical clearance at an ED prior to admission.	Further conversation with Springstone to understand requirement and introduce recommendations developed.

Bed availability and access is limited in Clark County and there are individuals waiting in EDs for psychiatric beds that become available.	This concern is not directly related to medical clearance practices. Utilizing an alternative to current medical clearance will not impact the number of referrals to facilities however will reduce unnecessary waiting in the ED.
BHOs require the rule out of all possible medical causes for psychiatric symptoms at an ED prior to admission to psychiatric unit- "medicine trumps psychiatry". There could be potential liability on part of the accepting agency if medical concerns are later identified.	Clark County does not operate within the BHO structure and being an early adopter to integrated healthcare allows for practice improvement. Medical clearance can be established to be less invasive and more cost effective. We owe it to those we provide care for to make that change.
If direct admit occurs to an in-patient psychiatric facility and transfer is needed to the ED there may be EMTALA issues as this would be a transfer to a lower level of care since the ED is classified as outpatient services.	Clear criteria for direct admits need to be established in consultation with local EDs based on their historical experience.

5. Conclusion

The practice of medical clearance is time-consuming, costly, and generally is not patient-centric. Users of the crisis system in Clark County have reported that requiring medical clearance prior to admission delays treatment and often times is a traumatic experience. From a patient-first lens, it is important to balance the potential health benefit that comes from the medical clearance with what potential harms it may introduce. This includes costs that the patient must bear, risk of unnecessary testing, discomfort, testing under coercive circumstances, delay in treatment of the crisis condition, and additional transportation. Many states across of the country have re-examined and standardized medical clearance practices and Washington State allows for diversion to a psychiatric facility. It is recommended that a task force develops a standard of care for medical clearance for the Clark County community that advances the dual goals of 1) patient safety and 2) patient centeredness. We recommend that the task force help the community transition to a practice where a screening process can allow certain individuals to bypass the need to go first to an emergency department before receiving necessary mental health services.

Further reading and additional information:
Massachusetts task force:
https://www.acep.org/WorkArea/DownloadAsset.aspx?id=45190

New Jersey task force:
http://www.njha.com/media/33107/ClearanceProtocolsforAcutePsyPatients.pdf

American Association for Emergency Psychiatry task force on medical clearance of adults part 1: introduction, review and evidence-based guidelines

Eric L. Anderson, MD, Kimberly Nordstrom, MD, JD, Michael P. Wilson, MD, Ph.D., Jennifer M. Peltzer-Jones, RN, PsyD, Leslie Zun, MD, MBA, Anthony Ng, MD, and Michael H. Allen, MD; West J Emerg Med. 2017 Feb; 18(2): 235-242. Published online 2017 Jan 19. DOI: 10.5811/Westjem.2016.10.32258

Medical clearance in the emergency department: is testing indicated?
Feyi N. Emembolu, MD and Leslie S. Zun, MD, MBA. Primary psychiatry. 2010;17(6):29-34

Additional information on medical clearance in other states:

	Clearance?	Labs	Should not admit	BAL/UDS	Special notes
University of Connecticut	Performed by ED	Per HPI/physical exam; some labs required for patients presenting for detox, overdose, or eating disorders	Patients on O2 therapy; who require IVs; who have high acuity; who require telemetry	BAL on all patients for detox; UDS on patients with overdose	Patients with BAL > 100 should stay in the ED
Massachusetts College of Emergency Physicians	Reflects short-term but not long-term medical stability. Does not indicate the absence of ongoing medical issues	Not required for low-risk patients (age 15–55, no acute complaints, no new psychiatric or physical symptoms, no substance use, normal physical exam, normal vitals)	Not specified	Neither the determination that the patient can be psychiatrically evaluated nor the determination that a patient can be transferred should be based on a specific level of alcohol	ED exam is focal and not a replacement for a general multisystem physical exam after transfer. Additional testing may be performed if receiving facility asks for it, but should not delay transfer.
Best practices report/Illinois Hospital Association	Focused medical assessment by ED preferred over term “medical clearance”	Not required if patient has no new psychiatric condition, no hx of active medical illness, normal vitals, normal physical exam, normal mental status	Not specified	Patient cannot be assessed psychiatrically if intoxicated, but cognitive abilities rather than absolute level should guide assessment.	If intoxicated, patient should remain in the ED. This is not a function of a specific alcohol level.
North Carolina	Performed by ED	Not required for low-risk patients	NC psych facilities cannot safely manage serious medical conditions, such as (see report for full list): transfusions; recent head injury without workup; CVA; recent MI requiring telemetry; hypertensive crisis; acute drug intoxication; acute fracture; unexplained fever; DKA	BAL should be <300	Pay special attention to elderly patients, as medications may be causing their symptoms

- *ED,* emergency department; *HPI,* history of present illness; *BAL,* blood alcohol level; *UDS,* urine drug screen; *NC,* North Carolina; *CVA,* cerebrovascular accident; *MI,* myocardial infarction; *DKA,* diabetic ketoacidosis

Types of Measures[1]

Structure Measures- refer to the environment in which care is delivered, a facility's organization and resources

- What do you HAVE?
  - Is there a psychiatrist co-located in a clinic?
  - Staff to patient ratios

Process Measures- refer to the techniques and processes used to treat patients.

- What do you DO?
  - % patients screened for depression
  - Turnaround time for evaluation

Outcome Measures- refer to the consequences of the patient's interaction with the healthcare system

- Does it WORK?
  - Mortality
  - Patient satisfaction
  - Improvement in rating scales
  - Readmissions

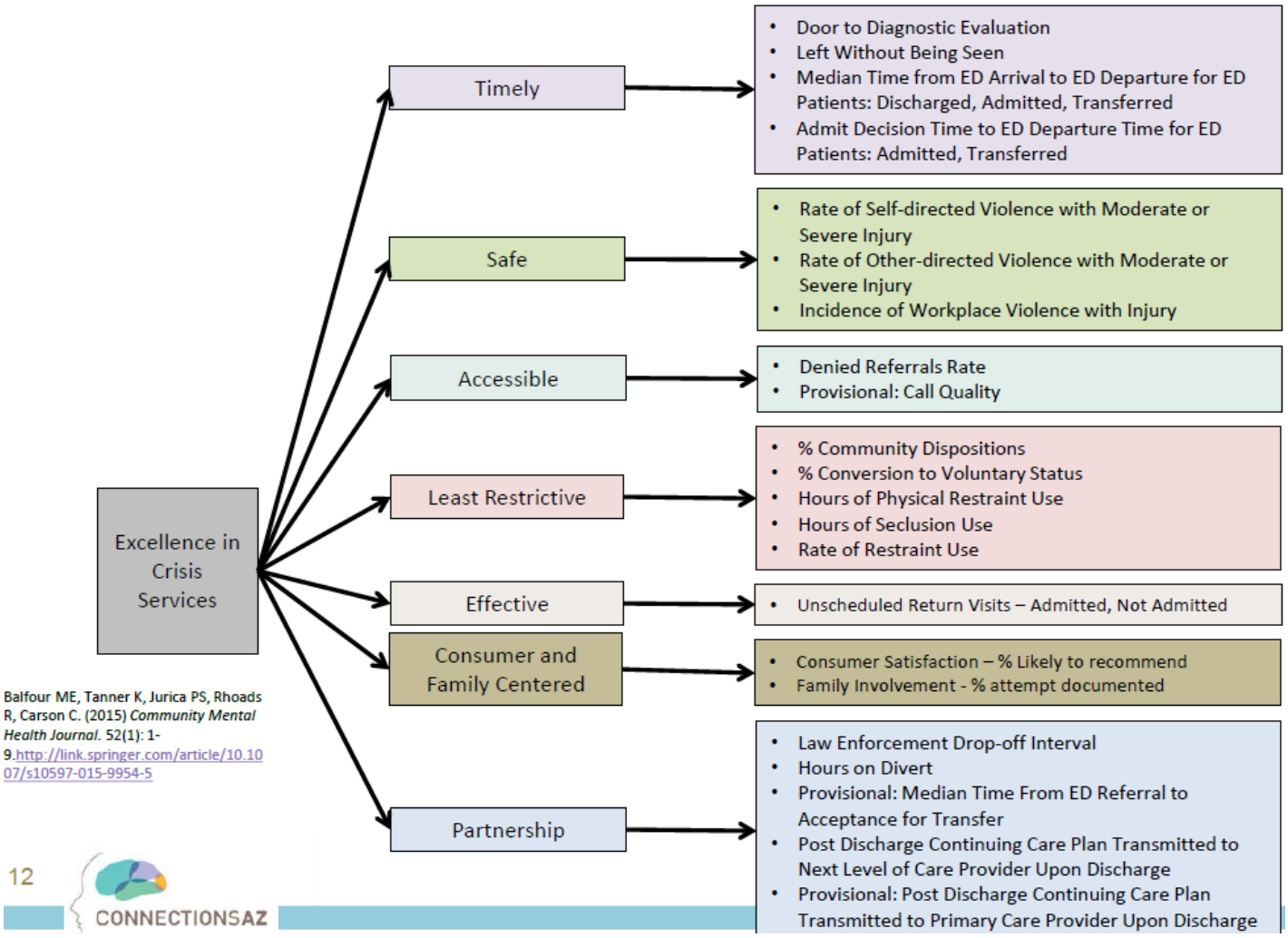
Measure Selection

1) Is it meaningful? Does it reflect a process that is clinically important and is there evidence supporting the measure?
2) Is it feasible? Is it possible to collect the data and can it be done accurately, quickly and easily?
3) Is it actionable? Do the measures provide direction for quality improvement activities?

[1] Margaret Balfour, slide deck: "Measuring Success: Development and Implementation of Values-Based Performance Measures for Behavioral Health Crisis Services"

CRISES- Crisis Reliability Indicators Supporting Emergency Services[2]

Sample of Value Based Performance Metrics (for facility-based psychiatric emergency services and 23-hour observation



[2] Balfour, Margaret E., et al. "Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatry Emergency Programs." Community Mental Health J (2016) 52:1-9