

## Medical Clearance Evaluation in the ED for People with Mental Health Needs

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In 2018, MN Health Collaborative partners developed and adopted shared standards for medical clearance evaluation in Emergency Departments (EDs), including labs needed, to ensure a person is medically stable for transition to inpatient psychiatric facilities.

Implementing these medical clearance practices decreases wide local variation which at times results in unnecessary tests and delays in patients receiving needed treatment.

These recommendations are part of a larger effort of ICSI effort with MN Health Collaborative partners to develop and implement shared standards for patients with mental health needs in the ED. This set of standards currently has three parts; in addition to Medical Clearance Evaluation it also includes shared standards for Suicide Prevention and Intervention, and Agitation and Violence Prevention.

*“Our work to reduce unnecessary labs was a result of our collaboration made possible with ICSI and systems thinking. Thank you.”*

— KURT ISENBERGER, MD  
Medical Director of  
Regions Hospital  
Emergency Department

### May 2021 Update

An updated review of literature found additional evidence supporting reduction of routine laboratory testing in EDs. While the MN Collaborative recommendations herein remain unchanged, a brief evidence update follows, including a study conducted by HealthPartners, one of the participants in MN Health Collaborative.

1. Researchers at HealthPartners conducted a retrospective cohort study looking at the effect of a change in hospital policy that eliminated routine screening laboratory tests for psychiatric admission (Zwank, 2020). Prior policy included requiring standard admission order set for inpatient psychiatric admission, including orders for complete blood count (CBC), basic metabolic panel, urinalysis, basic urine drug screen, and urine pregnancy test when applicable. After the policy change, these lab tests were no longer routinely required and instead were ordered at the discretion of the ED provider or at the request of the admitting psychiatric service.

The study included 1,910 patients (886 pre-implementation and 1,024 post-implementation) and found:

- The median number of lab tests ordered during the hospital stay decreased.
  - A large decrease in lab ordering in the ED was somewhat offset by a less pronounced increase in lab ordering of nearly all the same lab tests during the inpatient stay. However, total overall lab ordering decreased significantly.
- The proportion of patients with no blood lab orders increased from 22% to 40% and the proportion of patients with no lab orders increased from 9% to 20%.

- The median total lab charges decreased from \$445 to \$312, resulting in a total cost savings of \$136,192.
  - Mean ED length of stay decreased by 5.5 hours.
  - No increases in consultations or transfers were noted.
  - No patients died or were transferred to the ICU during the hospital stay.
2. A 2018 systematic review of three observational studies including a total of 629 patients could not determine the clinical utility of protocolized laboratory screening tests for medical clearance of psychiatric patients in the ED. The prevalence of clinically significant results was low, that is, no patient's treatment plan or disposition was changed because of an individual laboratory test result (Conigliaro, 2018).

The following MN Health Collaborative recommendations for Medical Clearance Evaluation are based on evidence-based guidelines published by the American College of Emergency Medicine (ACEP) and the American Academy of Emergency Psychiatry (AAEP), as well as consensus recommendations by the expert working group based on local community context.

## Recommendations

### MN Health Collaborative partners are adopting the following:

1. For emergency department patients with primary psychiatric complaints, diagnostic evaluation should be directed by the patient's history and physical examination. Routine laboratory testing does not need to be performed. (ACEP)
2. *Routine* laboratory testing\* should not be required by facilities accepting patients for psychiatric treatment. Laboratory evaluation should be based on individual patient history and exam. (Collaborative Consensus)

(\*It is critical to distinguish between tests needed in the ED and tests that can be done at the inpatient facility. The ED is responsible for tests that assist in acute ED management as well as help determine patient disposition. If labs are already being obtained in the ED, the ED provider may choose to include labs that would be helpful for inpatient management. **However, these labs should not delay disposition.** Courtesy labs that may benefit an inpatient facility may include: 1) therapeutic drug levels of psychoactive agents 2) pregnancy test 3) ECG for patients on psychoactive agents with QTc implications 4) CBC/CMP)

3. Further medical evaluation should be considered for patients who have (1) new-onset psychiatric symptoms after the age of 45 years, (2) advanced age (65 years of age and older), (3) cognitive deficits or delirium, (4) positive review of systems indicative of a physical etiology, such as cough and fever, (5) focal neurological findings or evidence of head injury, (6) substance intoxication, withdrawal, or exposure to toxins/drugs, (7) decreased level of awareness, or (8) other indications, such as abnormal vital signs that direct further assessment. (AAEP)

*Note regarding age: There is no evidence on age as an independent risk factor. For organizations that wish to use the SMART tool (created by Sierra Sacramento Valley Medical Society), note that the tool uses >55 years of age and <12 years of age as warranting consideration.*

4. When Urine Drug Screen (UDS) is obtained for a psychiatric patient, it should not delay disposition. The patient may be transferred to another facility with a pending UDS. (Collaborative Consensus)

*Note: ACEP recommends that **routine** UDS should not be performed as part of the ED assessment of the psychiatric patient*

5. For patients with alcohol intoxication, the psychiatric assessment of the patient should be based on the patient's cognitive abilities, rather than a specific blood alcohol level. Clinicians should consider using a period of observation to determine if psychiatric symptoms resolve as the episode of intoxication resolves. (ACEP)
6. If there is disagreement between the receiving facility and ED on evaluation and/or disposition of the patient with psychiatric complaints, **the receiving psychiatry clinician and referring ED clinician should discuss the case** via phone. (Collaborative Consensus)

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## References

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### **ACEP guideline:**

American College of Emergency Physicians. Care of the psychiatric patient in the emergency department, a review of the literature. October 2014. Available at: <https://www.acep.org/how-we-serve/sections/emergency-medicine-practice-management--health-policy/news/september-2015/psychiatric-patients-in-the-emergency-department/>

### **AAEP guidelines:**

Anderson EL, Nordstrom K, Wilson MP, et al. American Association for Emergency Psychiatry Task Force on Medical Clearance of Adults Part I: Introduction, Review and Evidence-Based Guidelines. *Western J Emerg Med* 2017;18(2):235-242. doi:10.5811/westjem.2016.10.32258.

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