“Using a standardized transfer form to decrease routine laboratory testing for psychiatric medical clearance: A San Antonio experience”

Megan O’Brien, MD Asst Professor, Baylor College of Medicine, Christus Children’s Hospital, Emergency Department

Background: The American College of Emergency Physicians (ACEP) and American Psychiatric Association (APA) both have policy statements against the use of routine testing of psychiatric patients as part of the medical clearance process for patients presenting with psychiatric complaints. Despite this, all psychiatric facilities in the San Antonio area required this on all patients as part of the process before acceptance for a psychiatric admission. This unduly stressed Emergency departments (ED) with increased utilization of resources, longer lengths of stay (LOS), and increased overall healthcare costs.

Aim Statement: To eliminate routine laboratory testing on psychiatric patients who present to Emergency Departments for medical clearance prior to a psychiatric admission.

Methods: A psychiatric/emergency medicine committee was formed by the Southwest Texas Regional Advisory Council (STRAC) covering this area of the state. Barriers preventing the adoption of a simplified medical clearance process were identified and a streamline system created. “Low Risk” patient criteria were delineated using literature and best practice recommendations using advisory statements from both ACEP and APA. For patients meeting this criteria minimum testing requirement of HCG for females ages 12-50 was agreed upon. A screening testing form with cognitive aids delineating qualification for minimum testing was created and included in paperwork sent to psychiatric facilities with admission requests. The psychiatric hospitals communicated with STRAC Behavior Health Coordinator any issues with inappropriate transfers, need for return to ED, or form utilization failure. Implementation of this process started 1Oct2024. Charts for patients discharged to psychiatric facilities from Christus Children’s Main ED three months prior (1July-30Sept) and three months after (1Oct-31Dec) implementation were queried and data was collected for patients meeting low risk criteria. ED Length of stay (LOS), Arrival to Behavior Hold (AD-BH) and Behavior hold to Discharge (BH-DC) were calculated and laboratory studies performed were recorded. The STRAC Behavior health coordinator was queried for fall outs.

Results: Pre-implementation there were 82 total psych patients, 55 who met low risk criteria (67%), post-implementation there were 96 total psych patients, 48 who met low risk criteria (50%) (Figure 1). Pre and post implementation, total ED LOS averaged 401 minutes and 233 minutes, a 42% decrease, AD-BH averaged 257 minutes and 128 minutes, a 51% decrease, BH-DC averaged 160 minutes and 147 minutes, a 9% decrease (Fig 2 and Fig 3). 100% of psychiatric patients pre-implementation had full testing (complete blood count, chemistry panel, urinalysis, urine toxicology screen, urine HCG for females, and EKG), post implementation only urine HCG on age appropriate female patients was performed on patients meeting low risk criteria. There were no reports of patients with inappropriate transfers or need for return to ED for medical concerns. Five patients had non-utilization of the form, none met low risk criteria.

Discussion: Eliminating routine testing for appropriate patient significantly decreases LOS for psychiatric patients without compromising medical clearance. The difference between total LOS change and the AD-BH was due to the lack of this data in all patients. However, using AD-BH is a better measure of the effect of this policy change as this accurately reflects the time the provider has finished medical clearance and is not related to factors of either psychiatric hospital response time/bed capacity or availability of psychiatric transport service. The small change in BH-DC is due to these factors, however the fact that this metric decreased as well may be due to a more streamlined process that the form enables for the reviewers at the psychiatric hospitals which leads. to faster acceptance times. Importantly, no patients were miscategorized or required ED return for further medical evaluation after admission to the psychiatric facility. This process successfully identified patients eligible for limited testing. Utilization of STRAC was a novel tool to facilitate stakeholder collaboration. This process could be adopted in other areas of Texas.

Figure 1

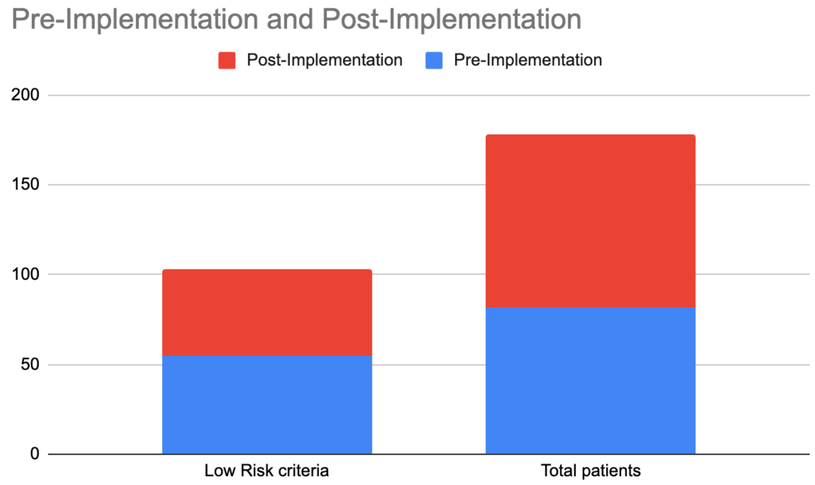

Figure 2

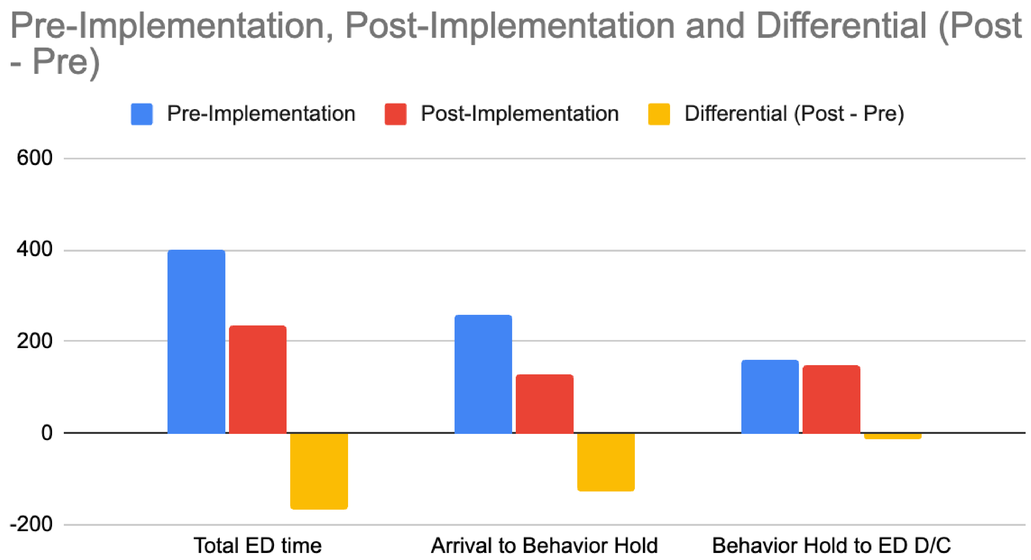

Figure 3