Getting Docs on Board — Expediting Triage of Mental Health Patients in Medical EDs

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Triage Begins At The Door

- Ambulance Turnaround Times for Patients
  - 30 minutes considered reasonable standard

- Understanding EMTALA for Mental Health Patients
  - Medical Screening Exam (MSE) required on all patients who seek assistance on the grounds of the hospital
  - Danger to Self, Danger to Others considered Emergency Medical Conditions (EMC) which trigger EMTALA

Hospitals Have Three Obligations Under EMTALA:

1. Individuals requesting emergency care, or those for whom a representative has made a request if the patient is unable, must receive a medical screening examination to determine whether an emergency medical condition (EMC) exists. The participating hospital cannot delay examination and treatment to inquire about methods of payment or insurance coverage, or a patient's citizenship or legal status. The hospital may only start the process of payment inquiry and billing once they have ensured that doing so will not interfere with or otherwise compromise patient care.
2. If the hospital does not have the capability to treat the condition, the hospital must make an "appropriate" transfer of the patient to another hospital with such capability. This includes a long-term care or rehabilitation facilities for patients unable to provide self-care. Hospitals with specialized capabilities must accept such transfers and may not discharge a patient until the condition is resolved and the patient is able to provide self-care or is transferred to another facility.

3. The emergency room (or other better equipped units within the hospital) must treat an individual with an EMC until the condition is resolved or stabilized and the patient is able to provide self-care following discharge, or if unable, can receive needed continual care. Inpatient care provided must be at an equal level for all patients, regardless of ability to pay. Hospitals may not discharge a patient prior to stabilization if the patient's insurance is canceled or otherwise discontinues payment during course of stay.
Screening for Mental Health Patients does not Need to be Over-exhaustive, but Should be Targeted

- Focus on the presenting problem
- Ensure that there are no causative or co-morbid serious medical issues (too often overlooked or ignored!)
- Help stabilize the psychiatric problem without over-sedating or restraining the patient
- Fulfill hospital EMTALA obligations

Zeller’s “Six Goals of Emergency Psychiatric Care”

- Exclude medical etiologies of symptoms
- Rapidly stabilize the acute crisis
- Avoid coercion
- Treat in the least restrictive setting
- Form a therapeutic alliance
- Formulate an appropriate disposition and aftercare plan

1. Zeller, Primary Psychiatry, 2010
Medical Evaluation of the Psychiatric Patient

Medical Clearance Algorithm for Emergency Psychiatric Presentations
Essential Parts of Triage of Emergency Psychiatric Patient

- Presenting problem (why are they here?)
- Pertinent history (more complete can come later)
- Vital signs
- Visual evaluation
- Rule out any serious medical issues
- Determination of risk, observation levels

Serious, Potentially Life-Threatening Symptoms in a Psychiatric Patient

- Loss of memory, disorientation
- Severe headache
- Extreme muscle stiffness or weakness
- Heat intolerance
- Unintentional weight loss
- Psychosis (new onset)
- Difficulty breathing
Serious, Potentially Life-Threatening Signs in a Psychiatric Patient

- Abnormal vital signs
- Overt trauma
- One pupil larger than the other
- Slurred speech
- Incoordination
- Seizures
- Hemiparesis

Factors That Can Indicate Serious, Possibly Life-Threatening Conditions

- New-onset psychiatric illness at age >45
- Abnormal vital signs
- Focal neurologic findings
- Evidence of head injury
- Substance intoxication or withdrawal
- Exposure to poisons/toxins/drug overdose
- Decreased awareness with attention problems
Medical Conditions that can Mimic Psychiatric Illness

- Head trauma
- Encephalitis/Meningitis/other infections
- Encephalopathy, esp. kidney/liver failure
- Metabolic (hypo-natremia, -glycemia, -calcemia)
- Hypoxia
- Thyroid disease
- Toxic level of meds (intentional OD or toxic buildup)
- Seizure
- Poisons

Psychiatric Screening Tools at Triage
Screening Tools at Triage

• Brief Suicide Screening for all patients
  o Replace basic questions such as “are you suicidal?” with higher-yield, 2-question risk assessment
  o Can lead to more detailed suicide assessment later for patients indicated from Brief Screening

• Brief Violence Screening for agitated patients
  o Broset Scale
  o BARS Scale

Suicide Screening Question #1

• “At some point everyone has felt hopeless. Do you currently feel hopeless about the future? Would you say you feel . . .”

1. Not particularly hopeless about the future
2. I feel hopeless about the future
3. I feel I have nothing to look forward to
4. The future is hopeless and things cannot improve.

• If patient indicates response # 1 to 3, they will be designated as low-risk. If patient indicates a response of #4, the Triage Nurse will initiate a psychiatry consultation for further assessment.
Suicide Screening Question #2

- “Many people have had thoughts about ending their lives. Do you currently have any thoughts about killing yourself?”

1. I do not have any thoughts of killing myself
2. I have thoughts of killing myself, but I would not carry them out
3. I would like to kill myself
4. I would kill myself if I had the chance

- If patient indicates a response of #1, they will be designated as low-risk. If patient designates a response of #2, 3, or 4, patient will be placed on suicide precautions. A response of #2 indicates a moderate risk for suicide. A response of #3 or 4 indicates high-risk for suicide. A psychiatry consultation will be initiated by the Triage Nurse for further assessment.

Broset Violence Checklist

Broset scores will serve as a “6th vital sign” for ED patients that are combative, disruptive, agitated, hostile or suicidal. Obtain and document a Broset score upon patient arrival at Triage / Desk. Re-evaluate and document a Broset score every 2 hours. Obtain and document a Broset score on any existing ED patient that has a behavior change (e.g. new or escalating ED patient who has a behavior change) and re-evaluate/document every 2 hours thereafter.

<table>
<thead>
<tr>
<th>*Broset Violence Checklist</th>
<th>Interpretation</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confusion</td>
<td>Appears obviously confused &amp; disoriented. May be unaware of person, place, time.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Irritability</td>
<td>Easily agitated or angered. Unable to tolerate the presence of others.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Boisterousness</td>
<td>Behavior is overtly “loud” or noisy. For example screams, shouts out when talking, etc.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Threat</td>
<td>A verbal outburst which is more than just a raised voice and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Physical Attacks</td>
<td>Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance, the grabbing of another person’s clothing, the raising of an arm or leg, making of a fist or modeling of a head butt directed at another.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Attacks on Objects</td>
<td>An attack directed at an object and not an individual. For example the indiscriminate throwing of an object, banging or smashing windows, kicking, banging, or handing hitting an object, or the smashing of furniture.</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total Points</td>
<td>Low risk no violence, 1-2 moderate risk of violence and prevention measures should be taken. 3-6 high risk of violence and immediate prevention measures should be taken and plans about how to manage an attack made</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
### Behavioral Activity Rating Scale (BARS)

1 = difficult or unable to rouse  
2 = asleep but responds normally to verbal or physical contact  
3 = drowsy, appears sedated  
4 = quiet and awake (normal level of activity)  
5 = signs of overt (physical or verbal) activity, calms down with instructions  
6 = extremely or continuously active, not requiring restraint  
7 = violent, requires restraint

### Improving Throughput
Improving Throughput (cont.)

- Calming techniques and de-escalation can avoid need for restraints and oversedation, lead to more prompt disposition, well worth the short amount of time to attempt

- Can calming occur before moving patient into “psych area”?

- Beginning appropriate medications in ED – not “chemical restraints” – can facilitate discharge in appropriate patients, shorten hospital stay, make time in ED part of treatment rather than “caretaking”

Restraint use leads to a length of stay of psychiatric patients in EDs averaging 4.2 hours longer than that of patients not requiring restraints

Complications of Oversedation

- Prevents ability to do full medical/psychiatric evaluation, and can mask medical comorbidities
- Patients unable to answer questions
- Patients unable to keep self hydrated, other self care
- Psychiatric consultant will typically not come to evaluate until patient is awake
- Receiving hospitals/programs unwilling to consider patient transfers until alert, leading to boarding, dispositional delays
- Unconscious patient not receiving treatment but taking up vital space in ED – thus not helping patient while preventing other ED patients from treatment

Starting Psychiatric Meds in the ED – Most Useful for Acute Psychosis, Agitation, Anxiety

- Oral meds preferred
  - Less coercive, therapeutic alliance, reduced risk from needle use, easy to administer with cooperative patient

- Second Generation Antipsychotics preferred for both PO and IM when antipsychotics indicated
  - Calming is goal rather than heavy sedation

- Traditional haloperidol/lorazepam cocktail can lead to oversedation, serious side effects which can also seriously delay throughput
Laboratory Work?

Necessity Of Lab Testing?

- New-onset psychiatric symptoms, especially in age >45, should be presumed from a medical condition and have a full workup with labs, radiology

- Routine laboratory testing is not indicated; rather, directed testing should be based on most likely diagnosis and emergency medicine attending’s decision

- Routine labs without indication have very low yield and are unnecessary cost, should not prevent or delay psychiatric admission
Alcohol Level Issues

- No reason to get to .08 for transfer – patient isn’t going to be driving!
- If alcohol level is above certain range, should be alert, ambulatory, “able to eat a sandwich”
- Need to know patient is not showing evidence of serious alcohol withdrawal
- “Loaded” with “banana bag” and anti-seizure medications can facilitate transfer earlier

Collaboration With The Receiving End
Ideas for Improved Transfer to Psych

- Work with receiving units/outside hospitals on parameters for “medically stable”
  - Often unnecessarily strict vital signs ranges, alcohol level limits, medical condition exclusions
- Focus on admission criteria
  - Inclusion rather than exclusion – knowing what unit wants, what absolutely cannot be accepted – can help prevent confusion, hard feelings. Remember, you need them and they need you!
- Offering data which can be sent after transfer
  - Labs can be drawn to assist with further care, but need not have results prior to transfer to psych unit

Questions?
Thank you

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