Like the Eye of the Tiger: Inpatient Psychiatric Facility Exclusionary Criteria and Its “Knockout” of the Emergency Psychiatric Patient

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Abstract

Context: Over 6% of all emergency department (ED) visits in the United States involve primary mental health or behavioral issues. The patients are stabilized in the ED but frequently require admission to an inpatient psychiatric unit or institution for longer term treatment and management. To facilitate this process, an emergency physician (EP) must first “medically clear” the patient as stable for transfer. At present, there is no interdisciplinary consensus regarding the necessary elements of the medical clearance or stability assessment process. In addition to satisfy the vague requirement for medical clearance, the EP must abide by the rules of the inpatient facilities before his/her patient is accepted.

Settings and Design: This manuscript summarizes the admission exclusionary criteria of inpatient psychiatric units in the Houston–Galveston metro area. Subjects and Methods: we pooled the exclusionary criteria of all the facilities patients with mental illness can be sent to in the Houston–Galveston metropolitan area, and divided those criteria by categories. Results: Pooled exclusionary criteria congregate into 1. preexisting or current medical condition and capabilities (e.g. hypertensive urgency, pregnancy, acute alcohol intoxication), 2. exclusionary criteria related to administrative burdens that may impact staffing or require advanced equipment/training e.g. autism spectrum disorders, intellectual disabilities, respiratory isolation or daily hemodialysis, 3. laboratory and ancillary testing required by inpatient facilities before acceptance of the patient. Conclusions: Of the inpatient units in the Houston–Galveston area, facilities lack a unified staffing model, ancillary services, but the various challenges (e.g., limited staffing and ancillary services) and different skills offered (e.g., geriatric care) are reflected in exclusionary criteria in a partially overlapping, but not fully uniform, way. The variation in number and kinds of exclusionary criteria further complicate the admission process and often serve as a bottleneck in the securing an inpatient bed.

Keywords: Behavioral emergencies, inpatient psychiatric exclusionary criteria, medical clearance and stability examination, psychiatric emergencies

Introduction

“Let me tell you something you already know. The world ain’t all sunshine and rainbows. It is a very mean and nasty place and it will beat you to your knees and keep you there permanently if you let it. You, me, or nobody is gonna hit as hard as life. But it ain’t how hard you hit; it’s about how hard you can get hit, and keep moving forward. How much you can take, and keep moving forward. That’s how winning is done.” – Rocky Balboa.

In the Academy Award winning film, Rocky, the protagonist, is a southpaw club boxer from the slums of Philadelphia who, as part of a publicity stunt, is picked to fight against the world heavyweight champion, Apollo Creed.[1] Unfazed by seemingly insurmountable odds, Rocky displays an iron will to “go the distance.” Few films resonate more with Americans than Rocky. Its lessons of raw determination, sheer heart, and fighting against all odds in the face of overwhelming obstacles are applicable to modern emergency physicians (EPs) and psychiatrists who are tasked with treating and stabilizing patients in the ED.
patients suffering from behavioral emergencies and transferring them to inpatient psychiatric facilities.

Mental health-related visits account for approximately 6% of all emergency department (ED) visits in the United States.[2] From 1992 to 2001, there were 53 million of these visits in USA EDs. Mental health-related visits also represented 7% of all pediatric ED visits.[3] Psychiatric emergencies, defined by the American Psychiatric Association (APA) as “an acute disturbance in thought, behavior, mood, or social relationship, which requires immediate intervention as defined by the patient, family, or social unit,” constitute a large burden on the USA healthcare system, and EPs are often tasked with the initial evaluation and stabilization of the emergency psychiatric patient. Even after medically evaluating, stabilizing, and “clearing,” these patients, EPs, and emergency psychiatrists are at the mercy of the inpatient psychiatric facilities and patients are frequently denied admission for what may often appear to be arbitrary or solely administrative reasons. These denials contribute to ED boarding and burden ED staff.

In 2008, the American College of Emergency Physicians (ACEP) surveyed 1400 ED directors. A staggering 79% of the directors reported that emergency psychiatric patients were boarded in their EDs.[3] ACEP defines boarding when a patient remains in the ED after the patient has been admitted to the facility but has not been transferred to an inpatient unit.[6] Moreover, 62% of the directors responded that they had no psychiatric services for patients who are being boarded in the ED.[3] Ten percent of ED directors stating even reported having psychiatric patients boarded for a week or longer until they could be properly transferred to an inpatient facility. In 2010, the Schumacher group surveyed ED administrators and reported that more than 70% of respondents had patients with behavioral emergencies boarding for 24 h or longer.[7] The authors’ experience at their home institution, Ben Taub General Hospital (Houston, Texas, USA), mirrors this trend of boarding and extended lengths of stay: 7876 emergency psychiatric patients were seen and evaluated from January to October of 2014. Approximately one-quarter of patients were ultimately transferred to inpatient psychiatric facilities, with an average length of stay of 29.5 h (personal communication, Harris Health Leadership).

The lack of consistent exclusionary criteria and interdisciplinary consensus on medical clearance leaves emergency providers feeling like Rocky Balboa, perpetual underdogs in a never-ending fight against a mammoth bureaucracy, against a health care system that has stripped resources from community outpatient treatment centers and even at times, literally and figuratively, against the emergency psychiatric patients themselves. Rocky is knocked down time and time again but comes back swinging and so should we.

**Exclusionary criteria**

Exclusionary criteria are rules set forth by individual psychiatric facilities regarding what individual patient factors exclude someone from admission. These exclusionary criteria range from requirements for basic laboratory studies to the functional capacity of patients. Most psychiatric facilities will not accept patients with certain laboratory abnormalities, which by extension, means many patients will have to undergo routine testing regardless of their status as “medically cleared.” Psychiatric facilities often have the same standard set of requirements and exclusionary criteria regardless of patient presentation (i.e., otherwise healthy patient with known underlying psychiatric condition who presents with suicidal ideation versus the older patient without known psychiatric history presenting with altered mental status or psychosis).

**METHODS**

All area psychiatric inpatient facilities provided their exclusionary criteria to Ben Taub Psychiatric Emergency Center as part of their normal administrative clearance process. The authors reviewed each of the subject facilities’ criteria and divided them into categories based on whether the criteria addressed pre-existing medical conditions, therapies that required certain staffing models or specialized equipment or lastly, if the facility merely required other testing prior to...
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The results were then tallied and the percentages of each type of exclusionary criteria for the entire Houston-Galveston metro area are listed on Figures 1-5.

Figures 1-5 represent the various exclusionary criteria from inpatient psychiatric facilities from the Houston metro area. We have organized the criteria into three categories. The first category, summarized in Figures 1 and 2, captures exclusionary criteria based on patient’s preexisting or current medical condition and capabilities ranging from hypertensive urgency to pregnancy and acute alcohol intoxication. The second category, summarized in Figures 3 and 4, encompasses exclusionary criteria based largely on administrative burdens that may impact staffing or require advanced equipment or training including patients that require respiratory isolation or daily hemodialysis.

The third and final category depicted in Figure 5 details the laboratory and ancillary testing required by inpatient facilities before acceptance of the patient.

Discussion

Physicians who need to transfer a patient to psychiatric facility for stabilization and treatment must abide by that institution’s specific admission requirements. These admission requirements, known also as exclusionary criteria, are distinct from the medical clearance and assessment process, which is designed to uncover any medical explanations for the patient’s psychiatric pathology. Exclusionary criteria, on the other hand, often address institutional limitations (e.g., staff shortages and training limitations) and serve to limit the number and kinds of patients, for which an individual facility may care.

As seen in Figures 1 and 2, psychiatric patients with complicated preexisting medical conditions such as end-stage renal disease requiring hemodialysis or chronic obstructive pulmonary disease requiring home oxygen, even when chronic or stable, are denied admission to many inpatient treatment facilities. Almost universally, these facilities exclude patients that have cognitive dysfunction, intellectual disability (previously referred to as mental retardation), or autism or those who are unable to independently attend to their activities of daily living. Abnormal vital signs can include systolic blood pressure >180 regardless of whether the patient is symptomatic or at their baseline. Indeed, 93.75% of patients with dementia and 93.75% of those patients who cannot perform their own activities of daily living are excluded from inpatient psychiatric facilities and are only admitted to one facility that specializes in geriatric psychiatry. Similarly, 100% of patients who require intravenous medications or therapies are denied admission.

Patients who are not accepted by inpatient facilities based on exclusionary criteria are left to linger in the ED until a bed in a facility becomes available for the patient or the patient becomes appropriate for an admission to a medical ward at the attached hospital. The general hustle and bustle of the ED can be detrimental to the stabilization and treatment of psychiatric patients, worsening both their neuropsychiatric condition and their comorbid medical illnesses.

As most EDs do not have the benefit of on-site emergency psychiatry, if psychiatric patients require medications, they will more commonly receive stabilizing medications and cocktails (e.g., haloperidol, lorazepam, diphenhydramine) designed to treat acute decompensations instead of longer term agents such as extended release or depot medications, which may be more appropriate for the recovery of the patient. This reliance on shorter acting agents is likely due to the comfort and familiarity of emergency providers in prescribing psychotropic medications.

For EPs and personnel, exclusionary criteria entail unnecessary and potentially expensive testing and substantial delays in admitting patients that the physician has already examined and deemed “medically clear” or stable for transfer. An anonymous mail survey of 500 EPs revealed that 35% of respondents stated that laboratory testing of psychiatric patients was “mandatory,” regardless of patient presentation. Sixteen percent of the required testing was mandated by ED protocol while the remaining 84% was dictated either by the psychiatrist or psychiatric facility. Few respondents of the survey believed that the testing was necessary or added clinical value. Another retrospective study analyzed patients presenting with psychiatric symptoms based off of their International Classification of Diseases, Ninth Edition codes and found that there was a large discrepancy from facility to facility in the number of laboratory tests used in the medical clearance of a patient. One facility may order up to four times as many laboratory tests as another.

![Exclusionary criteria based on required therapy continued](image)

![Exclusionary criteria based on laboratory/ancillary testing](image)
Our research also shows wide variation in required tests. The reason for this is likely multifactorial, reflecting the rising use of exclusionary criteria by psychiatric facilities, lack of traction in implementing ACEP’s policy statement as a more widespread practice, and the provider-to-provider difference in knowledge regarding the literature involving medical clearance. Although some facilities have less onerous requirements than others, emergency personnel are generally not aware of the bed availability at each facility every day. As a result, the facility with the most extensive exclusion criteria in the local area is the one that dictates the workup for each emergency psychiatric patient because if providers do not order all “mandatory” testing up front, patients may be excluded from one institution and then another. This can result in a piecemeal system of adding laboratories or addressing other requirements after the fact and markedly delays the patient’s stay in the ED.

One would wonder how the discrepancy in defining need for laboratory testing can be resolved: ACEP has made a clear recommendation against routine laboratory testing in awake and alert patients with normal vital signs and a noncontributory history and physical. Furthermore, ACEP has stated in a position statement that urine toxicology screens for drugs of abuse, which are often requested by treating psychiatric facilities and obtained in the ED, should “not delay patient evaluation or transfer.”[13] Despite a policy statement from the largest emergency medicine professional organization in the United States advocating against routine laboratory screening in psychiatric patients, and a large body of evidence to support this position,[14,15] as shown in Figure 5, over one-third of facilities require acetaminophen levels even in the absence of altered mental status, abdominal pain, or planned suicide by ingestion/overdose. Similarly, almost two-third of our local facilities require serum alcohol levels regardless of clinical sobriety.

Moreover, the APA does not share ACEP’s policy regarding laboratory testing in the medical clearance of psychiatric patients, and indeed, from the psychiatrist’s point of view, coexisting substance disorders direct placement in specific inpatient psychiatric facilities also capable of providing rehabilitation. Neither organization has a policy with respect to exclusionary criteria. In the absence of a consensus, inpatient facilities have their own exclusionary lists which rely on convenience rather than hard science. The inpatient administrative view is that patients who are poorly worked up medically, or who evolve into a more complicated medical picture, cannot be managed in a free-standing psychiatric facility. However, delaying admission only serves to worsen EC boarding and does not necessarily serve individual patient interests. The lack of interdisciplinary cooperation and coordination is crippling the system as a whole.

The authors at Ben Taub have also developed a collaborative model for the medical clearance process as shown in Figure 6.

Figure 7 demonstrates the three sides to the medical clearance and exclusionary triangle. Each specialty plays a key role in the stabilization, treatment, and ultimate disposition of patients with behavioral emergencies, and until we develop interdisciplinary guidelines and consensus, patients and staff will suffer due to an inherently unstable construct.

We recognize that not all EDs are fortunate enough to have access to psychiatric providers who can provide real-time evaluation and co-management of psychiatric patients. Technological developments including telemedicine may provide future alternatives for adopting a dynamic and collaborate during the medical clearance and assessment process as well as long-term patient management.

CONCLUSION

Psychiatric emergencies constitute a large burden on the healthcare system. Mental health-related visits now represent 6% of all ED visits in the United States. EPs are often tasked with the initial assessment of the patient with psychiatric symptoms and are frequently asked to “medically clear” a patient for psychiatric care. Based on an examination of the existing medical literature, ACEP released a clinical policy statement in 2006 that “routine laboratory testing of all patients is of very low yield and need not be performed as part of the ED assessment.”[13] Despite this statement, further work
is required for the clinical policy to be adopted into actual practice as most psychiatric facilities employ exclusionary criteria requiring all patients to receive routine testing before admission. This change may need to come at the state and local level first. A future protocol based on a prospective study that represents a higher level of evidence would be ideal in driving future policy.

We, therefore, urge ACEP, APA, and the American Academy of Emergency Psychiatry to adopt consensus guidelines for the medical clearance/assessment process and provide more specific guidance for uniform exclusionary criteria for inpatient hospitalization.

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Conflicts of interest
There are no conflicts of interest.

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