Criteria for Medical Assessment Prior to Admission to a Psychiatric Hospital, Inpatient Psychiatric or Crisis Stabilization Unit (PEDS)

- **General Assumptions for Recommendations**
- **Standardized Exclusion Criteria for Pediatric Admission to State Hospitals and Crisis Stabilization Units**
- **Medical Assessment and Screening Guidelines for Pediatric Admissions**

General Assumptions

- The following guidelines are meant to supplement the Medical Screening & Medical Assessment Guidance Materials issued by the Department of Behavioral Health and Developmental Services (DBHDS) on April 1, 2014. This document does not supersede any Virginia or federal law.

- An individual who is actively violent may not be appropriate for admission to a Crisis Stabilization Unit.

- Doctor-to-doctor communication is requested to ensure continuity of care and is required to resolve disagreements in patient care.

- Doctor-to-doctor communication is required when there is a question about the medical stability of a patient.

- Whenever practical, individuals without acute exacerbation of co-morbid medical conditions can seek medical assessment through an emergency or non-emergency department setting. When these patients present on their own to the emergency department, appropriate examination and laboratory work will be offered. Wherever medical assessment occurs, these guidelines will apply. A more complex medical assessment may be clinically warranted for individuals with exacerbation of medical conditions or for whom there is concern that an underlying medical condition might be the cause of the behavioral, cognitive, or emotional presentation.

- Patients presenting with a primary medical need should be stabilized prior to referral for psychiatric treatment and considered for a medical temporary detention order (TDO) pursuant to Virginia Code §37.2-1104 (https://law.lis.virginia.gov/vacode/title37.2/chapter11/section37.2-1104/). Pursuant to Virginia Code §37.2-810 (https://law.lis.virginia.gov/vacode/title37.2/chapter8/section37.2810), when a patient is transported by law-enforcement or alternative transporter to a medical facility for medical evaluation or treatment, such medical evaluation or treatment shall be conducted immediately in accordance with state and federal law.

- Patients who are determined to need an acute level of medical care will be admitted medically and emergency departments will request a medical temporary detention order when this is appropriate.

- All receiving providers will evaluate medically stabilized patients for admission and pursuant to Virginia Code subsection B 20 of §32.1-127 (https://law.lis.virginia.gov/vacode/title32.1/chapter5/section32.1-127.1:03/), each hospital shall establish protocols authorizing doctor-to-doctor communication when there is a refusal to admit a medically stable patient and develop protocols that require verbal communication between the on-call receiving provider and a clinical toxicologist or other person who is a Certified Specialist in Poison Information, if requested by the referring provider, when there is a question about the medical stability or appropriateness of an admission due to a toxicology screening.

- Those under the age of 18 are referred to facilities serving children & adolescents. The exception is emancipated minors which a court may declare in the following circumstances: (i) the minor has entered into a valid marriage, whether or not that marriage has been terminated by dissolution; or (ii) the minor is on active duty with any of the armed forces of the United States of America; or (iii) the minor willingly lives separate and apart from his or her parents or guardians, with the consent or acquiescence of the parents or guardians, and that the minor is or is capable of supporting himself or herself and competently managing his or her own financial affairs; or (iv) the minor desires to enter into a valid
marriage and the requirements of Virginia Code § 16.1-331 (https://law.lis.virginia.gov/vacode/title16.1/chapter11/section16.1-331/) are met.

Doctor-to-Doctor Dispute Resolution Protocol

- Stage 1: When there is a disagreement between the referring provider and receiving provider about any requested laboratory work or evaluations, and/or admission, the providers should attempt to resolve the matter amicably.

- Stage 2: If such resolution cannot be reached between the providers, the referring provider may request that the dispute be escalated to the Medical Director (or designee) of the referring facility to initiate a discussion with the Medical Director (or designee) of the receiving facility for resolution.

- Stage 3: If the matter remains unresolved or the Medical Director is unavailable, the Medical Director (or designee) at the referring facility may request that the dispute be brought to the Chief Medical Officer (or equivalent) of the receiving facility for resolution. This discussion should be facilitated by either the referring facility's Medical Director (or designee) or the Chief Medical Officer (or equivalent).

  Note: When DBHDS state facilities are involved in a dispute, the chain of command should be followed with escalation after the CMO to the State Hospital Facility Director, and if not successful, escalation to the DBHDS Chief Clinical Officer and/or DBHDS Commissioner is appropriate.

Protocol Review and Monitoring Committee (PRMC)

- A Protocol Review and Monitoring Committee (PRMC) will be established to monitor providers' adherence to the medical assessment guidelines and ensure unified implementation. As needed, the PRMC will also review cases that were escalated to determine what steps can be taken to improve resolution earlier in the process and cases in which a significant medical condition was not identified or stabilized.

- The PRMC membership will consist of one representative from each of the following organizations; Department of Behavioral Health & Developmental Services, Psychiatric Society of Virginia, Virginia Association of Community Services Boards, Virginia College of Emergency Physicians, and Virginia Hospital & Healthcare Association. Each organization shall designate an alternate to attend meetings as necessary. Meetings will be held as necessary, but no fewer than twice a year. Members will serve for two years and may be reappointed for additional terms. In cases where specific facilities are being discussed, representatives from the facilities will be invited to attend the meeting.

- These guidelines are intended to provide consistency in evaluation of persons with mental illnesses and suspected comorbid medical conditions by emergency department providers and for referrals to all psychiatric hospitals, inpatient psychiatric units and CSUs in Virginia. The ultimate decision for admission is that of the receiving provider.

EXCLUSION CRITERIA: Pediatric Admission to State Hospitals & Crisis Stabilization Units

	Criteria for Exclusion
1	Burns (severe) requiring acute care; if the burn could be cared for at home, it is not an exclusion.
2	Acute Delirium.
3	Acute Head Trauma/Traumatic Brain Injury in absence of a mental illness.
4	Unstable fractures, open or closed and joint dislocations, acute, until reduced.
5	Unstable seizure disorders.
6	Bowel obstruction, requiring active treatment or medical observation.
7	Acute Respiratory Distress.
8	Acute drug intoxication, withdrawal, or high-risk for complicated withdrawal, including history of delirium tremens.
9	Active GI bleed and/or active bleeding from other unknown sites.
10	Active TB; other infectious disease requiring isolation and/or treatment by IV antibiotics to be discussed by providers based on facility's ability to provide.
11	Intravenous fluids or IV antibiotics *State Hospitals & CSUs are not a safe environment for managing intravenous fluids or IV antibiotics.*
12	Draining wound, open, requiring daily complex wound care.
13	Vent and Trach patients excluded; other oxygen dependent patients based on facility's ability to provide care (e.g. BiPAP, CPAP at night, Oxygen Concentrator).
14	Tubes or drains, chest or abdominal, including ostomies (unless the individual provides their own ostomy care).
15	Hemodialysis patients excluded. Peritoneal dialysis patients based on facility's ability to safely manage patient.
16	Individuals requiring hospice or end of life care.
17	*For Crisis Stabilization Units only:* Durable medical equipment that is not able to be secured by CSU.

MEDICAL EVALUATION GUIDELINES: Pediatric admission to All Psychiatric Hospitals and Units & Crisis Stabilization Units*

**Requests for further testing, without an agreement of medical necessity will require doctor-to doctor communication.*

	Guideline for Evaluation
1	Pediatric patients presenting at the emergency department for medical assessment prior to admission to a psychiatric service or crisis stabilization unit will receive an appropriate medical screening exam including a focused problem history, neurologic, and physical exam, as well as: a. UDS > 12 y/o (note that this doesn't screen for all drugs of abuse) b. Urine pregnancy test for females of child bearing age Consider if first episode or acute change in mental status and for all pediatric patients with an eating disorder concern: c. Basic Chemistry Panel d. CBC Notes: • Patients taking medications and symptomatic for toxicity should have levels drawn and checked in the emergency department. This includes: Dilantin, Lithium, Depakote, and Tegretol. Patients with a possible overdose of Acetaminophen or Salicylate should have those levels checked. • Patients with other medical issues should have focused workup done such as a glucometer blood glucose level or BMP in the setting of known diabetes. • Patients who are anuric (e.g. dialysis dependent and unable to produce urine) will not have a drug screen performed. • Patients who have the capacity to make informed decisions and do not consent to collection of a urine or blood specimen will not be forced, including under an emergency custody order (ECO). The provider or screener in the emergency department should relay this information to the facility considering admission.
2	Vital Signs: a. Within normal limits for age group, may require doctor to doctor communication if concern is expressed.
3	Psychiatric Disorders of thought, cognition, or mood: a. Basic neurological examination; rule out delirium. b. Explain any abnormalities. c. Consider Head CT – for acute behavioral changes out of the context of an identified mental health disorder with focal neurological deficit.
4	Alcohol Abuse, Dependency or Intoxication: a. Evaluation cannot take place until patient mental status is cleared and BAC = 0.0. *

5	Pregnancy: Provider discussion of current physical status of mother and fetus. Locales with OB consultation availability will accept. High risk pregnancies evaluated on a case-bycase basis.
6	Diabetes Mellitus: a. Blood sugar stabilized consistently below 250 mg/dl for a 2-hour period before approval and within one hour of transfer. Any requests outside this standard should be handled via doctor-to-doctor communication. b. Doctor-to-doctor communication is necessary for determination on patients with insulin pumps.
7	MRSA in the absence of complex wound care, notification to accepting facility and doctor-to-doctor communication is necessary.
8	Mechanical assistance or wheelchair: Patients able to move or transfer independently with mechanical assistance or wheelchair will be accepted – follow ADA Guidelines.

** A review of the appropriateness of the minimum blood alcohol concentration (BAC) of 0.0 will be reexamined in May of 2019 by representatives from the Virginia College of Emergency Physicians, the Department of Behavioral Health and Developmental Services, and the Virginia Hospital & Healthcare Association. If practical experience proves that the minimum BAC level should be increased, the representatives will collaboratively determine an appropriate level.*