



Project BLUE STREETS

Tulsa-Area Medical Clearance Protocol of Acute Psychiatric Patients

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Project Blue Streets Task Force

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DISCLOSURE STATEMENT

This protocol provides recommendations based on information collected in task force meetings and through research of evidence-based and peer reviewed medical literature. The goal is to provide MHTFs and EDs a common standard of efficient and evidence-based recommendations to better care for persons with psychiatric disorders, including emergency custody, voluntary, and involuntary civil admissions. This protocol was not created nor intended to supersede the independent judgement of the treating clinician.

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Executive Summary

The term ‘medical clearance’ is commonly used within the Tulsa area medical and mental health communities. However, it lacks a consistent definition among providers. Area mental health treatment facilities commonly request medical clearance of patients, sometimes out of concern and sometimes out of habit.

In order to help develop a standard around the term and process of medical clearance, Oklahoma State University Center for Health Sciences (OSU-CHS) formed a task force, Project Blue Streets. Project Blue Street meetings began in summer of 2018 and concluded in spring of 2019. Task force members included leaders in the area of law enforcement, health care, behavioral health care, and government services.

The mission of the Project Blue Streets task force was to improve the process of transferring people into an appropriate setting in an emergency situation. The role of the task force was to gather information, obtain stakeholder input, and develop a final protocol.

This protocol provides recommendations based on information collected in task force meetings and through research of evidence-based and peer reviewed medical literature. In addition to providing recommendations that standardize medical clearance in Tulsa, this protocol also provides guidance on special issues with medical clearance. Furthermore, it improves community-wide communication between Emergency Departments (EDs) and Mental Health Treatment Facilities (MHTFs).

The goal of the contents herein is to provide MHTFs and EDs a common standard of efficient and evidence-based recommendations to better care for persons with psychiatric disorders, including emergency custody, voluntary, and involuntary civil admissions. The Project Blue Streets task force will continue to monitor and re-assess the effectiveness of this protocol on a quarterly basis. Updates to ensure the protocol is working as intended and beneficial to EDs, MHTFs, and patients and their families will happen as needed.

Part 1: Background and Use

1.1 Why Is Medical Clearance of Psychiatric Patients Important?

Individuals needing psychiatric care enter the mental health system in different ways. When an individual is in a mental health crisis, entrance to the system often involves several points of contact within the community. The most common points of contact are law enforcement, emergency departments (ED), and mental health treatment facilities (MHTF). Proper care must be exercised at these three critical points, because individuals with psychiatric conditions often experience co-occurring medical conditions, which are often undiagnosed and contribute to a staggering life expectancy gap. In the Tulsa area those with mental health and substance use disorders have an average life expectancy gap of 27 years less than those without those conditions.¹ The process of addressing medical concerns is commonly referred to as medical clearance. Medical clearance should incorporate evidence-based medical practices to maximize effective utilization of resources, reduce the wait time for effective treatment, and improve patient care.

1.2 The Context of Medical Clearance Prior to this Protocol

The term ‘medical clearance’ is commonly used within the Tulsa area medical and mental health communities. However, it lacks a consistent definition amongst providers. MHTFs commonly request medical clearance of patients, sometimes out of concern and sometimes out of habit. Some of these concerns include the possibility that patients may have a medical problem that is more appropriately addressed in a medical facility or their facility lacking the resources to care for the patient. Further complicating legitimate MHTF concerns are ingrained historic practices (e.g. minimum Blood Alcohol Levels) that appear to override evidence-based medical research. In EDs, providers are often unaware of specific medical concerns or capabilities of the receiving MHTF. EDs frequently rely on non-medical personnel at MHTFs for determining whether a patient meets medical acceptance criteria. The lack of a consistent definition of medical clearance is not without consequences. Patients are needlessly shuffled within the medical system, causing additional stress and delaying treatment at their point of maximum acuity. They are often subjected to unnecessary tests and procedures that are without merit or purpose. At times, patients can be in the custody of local police departments who are charged with maintaining safety. Because of this, law enforcement can end up caught in an inefficient process which can significantly delay their ability to patrol. Such inconsistency and poor application of practices necessitated the creation of a commonly agreed upon protocol to establish standardized language and practice. The goal of the protocol is for patients to enter a therapeutic milieu quicker, for MHTFs to have confidence in their ability to provide appropriate care to the patient, for ED clinicians to experience less frustration, and for police officers to spend more time patrolling and less time in waiting rooms.

1.3 Definition of Medical Clearance

There is no one accepted definition of medical clearance. This definition may vary based on the education and background of the individual making the determination. For example, an ED physician may define medical clearance as lack of an acute medical condition. However, a

¹ Laudan Aron, et al., “Prevention, Treatment, and Recovery: Toward a 10-Year Plan for Improving Mental Health and Wellness in Tulsa,” Urban Institute, March 2018.

Licensed Practical Counselor (LPC) may define medical clearance as a mandatory procedure on all patients.

National definitions of medical clearance generally involve two commonly accepted thoughts:

1. The patient's psychiatric symptoms are not caused by an underlying medical problem² that should be addressed in a traditional medical setting (e.g. CVA or brain tumor).
2. The patient's medical status is such that they can be safely and appropriately managed in the outpatient setting.

It is well recognized that physicians cannot predict how a patient will do in the future, nor should they be expected to. Instead, physicians and other clinicians should make decisions with reasonable medical certainty.³ Physicians and other clinicians should be open to reconsidering a clinical scenario based on new information. Most importantly, EDs should be willing to discuss concerns with receiving or transferring facilities. Further, it should be noted that medical clearance does not exclude the patient's need to potentially return to an emergency room, urgent care, or other medical facility for future physical medical conditions.

Tulsa is not unique in the problems facing medical clearance and often communities have similar problems. In 2010, the Governor of New Jersey signed into law the creation of a standard protocol⁴ for medical clearance for acute psychiatric patients referred for inpatient admission. The following characteristics are also helpful to further clarify medical clearance and should be considered:

- Medical clearance does not indicate the absence of ongoing medical issues or treatments.
 - Medical clearance may be waived at the discretion of the admitting psychiatrist.
 - Clinical decisions are based on the medical examination needs of each individual patient
- The purpose of medical clearance is to provide an assessment of the patient's current medical condition and stability within the context of a transfer to a clinical treatment setting with appropriate resources to monitor and treat what has been currently diagnosed

1.4 Additional Protocol Definitions

For the purpose of this protocol, the following definitions will be used:

Mental Health System

² Thomas W. Lukens, MD, PhD, et al., "Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department," *Annals of Emergency Medicine* 47, no. 1 (January 2006): 79-99, accessed February 21, 2019, doi:10.1016/j.annemergmed.2005.10.002

³ Reasonable medical certainty, also termed "reasonable medical probability," is defined by Black's Law Dictionary as: "In providing cause of injury, a standard requiring a showing that injury was more likely than not caused by a particular stimulus, based on the general consensus of recognized medical thought." Bryan A. Garner, *Black's Law Dictionary*, 9th ed., (Toronto: Thomson Reuters, 2010).

⁴ New Jersey Chapter of American College of Emergency Physicians and New Jersey Hospital Association. "Consensus Statement: Medical Clearance Protocols for Acute Psychiatric Patients Referred for Inpatient Admission." March/April, 2011.

A Mental Health System represents the entirety of the treatment spectrum providing mental health resources. This continuum includes, but is not limited to, primary care clinics, therapists, Community Mental Health Centers (CMHC), non-CMHC outpatient clinics, Intensive Outpatient Treatment (IOP), partial hospitalization, substance abuse treatment, and inpatient hospitalization.

Medical personnel/clinician

Medical personnel and clinicians are those individuals with education, training, and licensure in a medical program. For the purpose of this protocol, these individuals include physicians, nurse practitioners, physician assistants, registered nurses, and licensed practical nurses.

Non-medical personnel/clinician

Non-medical personnel and clinicians are those individuals with education, training, and licensure in a therapeutic setting. For the purpose of this protocol, these individuals include Licensed Practical Counselor (LPC) and Licensed Clinical Social Worker (LCSW).

Mental Health Treatment Facility (MHTF)

Commonly referred to as a psychiatric facility, MHTFs represent the highest available level of care and most restrictive treatment setting for individuals in a mental health crisis. MHTFs have the ability to accept and treat voluntary and involuntary patients. Individuals admitted to a MHTF generally are a danger to themselves or others. An individual may be psychotic to the point of being gravely disabled. An individual may also be experiencing other symptoms that have caused them to destabilize and cause significant impairment with loss of functioning (although may not meet involuntary criteria). Most MHTF in the Tulsa area have a board-certified psychiatrist on staff that informs policies and procedures. A psychiatrist is a physician who has completed additional, specialized training and education in the medical specialty of psychiatry and should be considered the expert on the capabilities of a facility to treat an individual.

Assessment Department

Assessment Department refers to a department of a MHTF in charge of assessing individuals for appropriateness of admission. Assessment departments are generally staffed by non-medical personnel, such as an LPC. Often, admissions are discussed with medical personnel, such as a psychiatrist or registered nurse.

Emergency Department (ED)

Emergency Departments refers to an internal structure of a medical facility. It is often an entry point for both medical and mental health care. True for the Tulsa hospitals only (OSU Medical Center, Hillcrest Medical Center, St. Francis, St. Johns), all ED physicians are board certified in the medical specialty of Emergency Medicine. As such, they should be considered the expert in the medical clearance of a patient.

Licensed Mental Health Professional Statement

In the State of Oklahoma, an individual may be detained for mental health treatment for up to five business days (120 business hours). Such detainment requires the completion of a Licensed Mental Health Professional Statement (LMHP). Once an individual has an LMHP completed, they are considered “involuntary.” The LMHP requires that the person completing the LMHP certify the patient has been made aware of the treatment recommendation and is unwilling to accept it. An

individual can only be made involuntary if they are a danger to themselves or others, or gravely disabled. Individuals that agree to treatment should not be made involuntary.

Individuals may change their mind in the course of the medial clearance process. While they may agree to treatment in the beginning, they may change their mind once transportation is arranged. The decision to make a patient involuntary status should be individualized to the patient and treatment setting. It should not be based on lack of transportation or a fear (without evidence) that a patient may change their mind. If there is evidence that the patient may change their mind, then a LMHP should be considered.

Not all individuals are able to complete an LMHP. Oklahoma State Statute allows the following professions to certify a LMHP:

- A psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology
- A physician licensed pursuant to Section 480 et seq. or Section 620 et seq. of Title 59 of the Oklahoma State Statutes
- A clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists
- A professional counselor licensed pursuant to Section 1901 et seq. of Title 59 of the Oklahoma Statutes
- A person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act
- A licensed marital and family therapist as defined in Section 1925.1 et seq. of Title 59 of the Oklahoma Statutes
- A licensed behavioral practitioner as defined in Section 1930 et seq. of Title 59 of the Oklahoma Statutes
- An advanced practice nurse as defined in Section 567.1 et seq. of Title 59 of the Oklahoma Statutes specializing in mental health
- A physician's assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions

Abbreviated Lab Values

CBC: Complete Blood Count

CMP: Complete Metabolic Profile

UDS: Urine Drug Screen

ECG: Electrocardiogram

BAL: Blood Alcohol Level

1.5 Intended Use of Protocol

This protocol provides recommendations based on information collected in task force meetings and through research of evidence-based and peer reviewed medical literature. The goal is to provide MHTFs and EDs a common standard of efficient and evidence-based recommendations to better care for persons with psychiatric disorders, including emergency custody, voluntary, and involuntary civil admissions. This protocol was not created nor intended to supersede the independent judgement of the treating clinician.

This protocol was collaboratively created by medical and mental health professionals in Tulsa that work in these areas on a daily basis. The protocol supports a common understanding of medical clearance within the Tulsa community. To avoid variations in practice and provide necessary acute inpatient care, medical and psychiatric treatment facilities agree to the contents herein. As this protocol was created in Tulsa for Tulsa, caution should be utilized when applying to other communities.

Part 2: Development of the Protocol

2.1 Development of Protocol

In September of 2018 Oklahoma State University Center for Health Sciences (OSU-CHS) formed a task force, Project Blue Streets (*See Table 1*). Project Blue Streets meetings took place beginning fall of 2018 through spring of 2019. Task force members included leaders in the area of law enforcement, health care, behavioral health care, and government services. The mission of the task force was to improve the process of transferring people into an appropriate setting in an emergency situation. The role of the task force was to gather information, obtain stakeholder input, and develop a final protocol.

Table 1: Taskforce Members

<p>Jason Beaman D.O., M.S., M.P.H., FAPA Task Force Chair Chair Department of Psychiatry and Behavioral Sciences OSU Center for Health Sciences</p>	
<p>Captain Shellie Seibert Mental Health Coordinator Tulsa Police Department</p>	<p>Deputy Chief Carrie Slatton-Hodges Oklahoma Department of Mental Health and Substance Abuse Services</p>
<p>Officer Demita Kinard Tulsa Police Department</p>	<p>Miranda Phillips D.O., FACEP, FAAEM System Medical Director Emergency Department Saint Francis Hospital</p>
<p>Chief Michael Baker Director of Emergency Medical Services Tulsa Fire Department</p>	<p>Dennis Blankenship D.O. Medical Director Emergency Department OSU Medical Center</p>
<p>Victoria Hui Holloman, M.P.A. Facilitator OSU Center for Health Sciences</p>	<p>Jake O’Meilia, M.D. Medical Director Laureate Psychiatric Hospital</p>
<p>Maggie den Harder, M.P.A. Mental Health Policy Fellow Oklahoma Policy Institute</p>	<p>Nicole Washington D.O. Tulsa Area Psychiatrist</p>

Stakeholders were identified through the task force and included regional MHTF, EDs, and other relevant agencies (*See Table 2*). Once a facility was identified, the head administrator and clinician (or other designated individuals) were invited to meet with the task force. During this meeting, an open discussion was held centered around nine different questions (*See section 2.2*).

Parallel to the stakeholder meetings, a literature search was performed. This search included reviewing relevant medical literature and analyzing other community protocols. Once the protocol was created, it was provided to stakeholders for review and agreement. This protocol represents a culmination of this information. The MHTF and EDs that agree to the practices and protocols herein are listed in Appendix A.

Table 2: Stakeholders (including representatives and titles)

Organization	Representative(s) and Title(s)
Tulsa Center for Behavioral Health (TCBH)	<ul style="list-style-type: none"> • Kevan Finley, Executive Director, Oklahoma Forensic Center • Leah Price, Executive Director, TCBH
Oklahoma State University Medical Center and Emergency Medicine and Psychiatry Residencies	<ul style="list-style-type: none"> • Matt Adams, Chief Administrative Officer • Dennis Blankenship, D.O., Chair of Emergency Medicine • Adam Lane, D.O., Emergency Medicine Residency Program Director • Jason Beaman, D.O., Chair of Psychiatry and Behavioral Sciences
OU-TU School of Community Medicine Psychiatry and Emergency Medicine Residencies	<ul style="list-style-type: none"> • Ashley Walker, M.D., Psychiatry Residency Training Director • Bo Burns, M.D., Chair, Department of Emergency Medicine
Parkside Psychiatric Hospital and Clinic	<ul style="list-style-type: none"> • Debra Jones, Ed.D., CEO • Virginia Heller, M.D., Medical Director
Saint Francis Hospital Emergency Department	<ul style="list-style-type: none"> • Miranda Phillips, D.O., System Medical Director
Laureate Psychiatric Clinic and Hospital	<ul style="list-style-type: none"> • Jake O’Meilia M.D., Medical Director • Debbie Davidson, Admissions Director
Mental Health Association of Oklahoma	<ul style="list-style-type: none"> • Mike Brose, Chief Executive Officer • Whitney Phillips, PA-C, OU School of Community Medicine • Jacki Sauter, LPN, Healthcare Outreach Coordinator
Tulsa Police Department	<ul style="list-style-type: none"> • Capt. Shellie Seibert, Mental Health Coordinator • Officer Susannah Ralston, Mental Health Liaison • Officer Demita Kinard
Hillcrest Medical Center	<ul style="list-style-type: none"> • Jeffrey Goodloe, M.D., Emergency Medicine Physician

St. John’s Medical Center Tulsa	<ul style="list-style-type: none"> • Chad Phillips, M.D., Co-Director
Medical Control Board, Emergency Medical Services System for Metropolitan Oklahoma City & Tulsa	<ul style="list-style-type: none"> • Jeffrey Goodloe, M.D., Medical Director • Duffy McAnallen, Law Enforcement Officer and Paramedic
Brookhaven Hospital	<ul style="list-style-type: none"> • Mark Gage, D.O., Medical Director
CREOKS Spring Creek Recovery Center	<ul style="list-style-type: none"> • Brian Ormsby, Director • Joyce Bumgardner, M.D., Medical Director
Crisis Response Team	<ul style="list-style-type: none"> • Chief Michael Baker, Tulsa Fire Department, Director of Emergency Medical Services • Captain Shellie Seibert, Tulsa Police Department, Mental Health Coordinator
Family and Children’s Services (F&CS) Crisis Care Center (CCC)	<ul style="list-style-type: none"> • Stevan Lahr, M.D., Medical Director, F&CS • Erica Starkey, D.O., Medical Director, CCC • Chris Perry, Director, CCC
Eastern Oklahoma Veteran’s Administration Hospital	<ul style="list-style-type: none"> • Doug Raymer, M.D., Lead ED Physician • John White, M.D., Psychiatrist
Wagoner Hospital	<ul style="list-style-type: none"> • Becky Campbell, Mental Health Unit Director

2.2 Project Blue Street Stakeholder Feedback

During the course of Project Blue Street meetings, stakeholders were asked nine different questions to guide the development of the recommendations within this protocol. Below is the feedback they provided:

1. *What is your definition of medical clearance?*

There were consistent answers from both EDs and MHTFs on what constituted medical clearance. Common answers included ensuring that there was not a non-psychiatric component causing a patient's symptoms and ensuring that the patient was medically stable enough to return home if not admitted to a MHTF. Other answers included ensuring that the patient did not have complications or conditions that the MHTF could not care for (such as IVs, CPAP, etc.). The last concern was noted as a common source of contention that could be easily solved by knowing the individual capabilities of each MHTF (*See Appendix B*). EDs consistently believed that they defined medical clearance meaning that if a doctor declared on his or her own medical license that the patient was stable, then that declaration should not be challenged without good reason.

Community agencies requested all parties involved make the process of medical clearance patient centric. They believed the process could potentially be traumatic and all parties involved in the process should be cautious. Specific concern was noted for the use of over

stigmatizing and minimizing language in the ED. Several agencies had experiences in which patients felt burdensome to the ED and that their mental health crisis was frustrating to the ED because of system issues.

2. *How do you handle medical clearance in acceptance of psychiatric patients?*

Overall, wide variety was seen in the process of acceptance from the ED to the MHTF. Some MHTFs have standardized admittance procedures, while other facilities remarked that admittance was dependent on the comfort level and judgement of the on-call physician. As a general rule, EDs would call the MHTF, notify them of a possible transfer and the MHTF would require paperwork be transmitted, usually by facsimile. Once information was available to the MHTF in paper form, it would be presented to the physician (or sometimes a nurse). Some facilities have the paperwork reviewed by non-medical staff (such as an LPC) who would request lab tests or procedures or decline the patient based on certain information (e.g. BAL too high). EDs reported that it was difficult to talk to the on-call physician.

3. *What is your targeted time to respond to the psychiatric hospitals with a new patient? Do you track this?*

Facilities ranged in their reported desired response times. Some facilities require an immediate response while others work to provide a response within an hour. Most MHTF tracked the amount of time it took to provide a call back to a waiting ED. All admitting psychiatric facilities agreed that they should let an ED know within 15 minutes or less whether or not they had an available inpatient psychiatric bed.

EDs preferred to have an immediate answer. They stated that based on their experience some psych facilities provide an immediate response while others can take multiple hours to provide a response.

4. *What lab values are important to you and why in clearing a psychiatric patient?*

This question elicited a variety of responses. Every ED stated that labs should be dependent on the individual patient and there should not be a blanket policy on required labs. EDs noted that there was a standard “psych workup” that was performed, despite knowing that it was not best evidenced practices. The EDs stated that this workup was performed because they believed they would be denied transfer without them. They provided several examples of MHTFs not providing the patient’s information to the on-call physician because the patient did not have the labs that the non-medical clinician believed were important. Some EDs believed that MHTFs were attempting to pass routine lab costs to the ED under the guise of medical clearance. EDs stated that often a UDS is required on a patient that is not showing any signs of substance intoxication or a patient that has admitted to drug use. The EDs stated that there were significant problems with this decision as they would spend hours (often with police) waiting for a patient to urinate. The EDs stated that the results of the UDS were not relevant and did not change their course of action most of the time. They believed the decision to obtain a UDS should be decided on a patient-by-patient basis and not by a non-medical clinician.

The EDs believed that labs were often unnecessarily requested on suicidal patients. They noted that individuals who arrived voluntarily at the ED with suicidal thoughts were required to have labs to determine if whether they had attempted suicide. The ED believed that this mandate was true regardless of whether the patient had any physical signs of a toxidrome or was gauged to be honest and cooperative.

Some MHTFs believed that routine labs were required on every patient (CBC, CMP, UDS, ECG, BAL). The MHTF had different reasons for why they believed the labs were necessary. One MHTF stated that a UDS is required in order to determine if a patient came upon “their psychosis honestly.” All MHTFs, except one, stated that they would be open to reevaluate their need and desire for labs pending the outcome of this report. All MHTFs stated that they had the ability to obtain labs but noted that the turnaround time could be as long as 48 hours in some cases.

One laboratory test that was identified in almost all conversations was the BAL. EDs believed that BAL had little clinical value in determining whether a patient was medically stable or not. The EDs stated that the different MHTFs in Tulsa had different requirements for BALs. For example, most MHTFs required that patient’s BAL be below 250. If it was not, the ED was required to recheck the level in four hours and attempt transfer again. The EDs noted that most levels were mandated by non-medical clinicians and appeared arbitrary. The EDs noted that rarely were they asked about the clinical status (mentation, ambulation etc.) of the intoxicated patient.

5. *Can you provide examples of bad outcomes because of the medical clearance issue? Please do not name specific individuals/facilities.*

No EDs or MHTFs could recall a bad outcome that occurred because of poor medical clearance. Both entities recognized that previous bad relationships dictated a current defensive strategy. All EDs stated that if they had made an error in misjudging the stability of a patient, they would immediately take the patient back without hesitation. MHTFs noted that when “clearance” had not been performed to their satisfaction, they would send the patient to another ED.

There were no recognized instances of Tulsa EDs being dishonest on the stability of a patient. Some MHTFs serving surrounding counties mentioned they had past negative experiences with rural hospitals. However, no MHTF could recall an event in which a Tulsa ED was dishonest about the stability of a patient or dishonest about vital signs or lab values.

6. *What do you think is the appropriate concept for transferring a psychiatric patient?*

All EDs believed that a process that minimized answer time was preferred. They believed that one phone call should be required. Some EDs did not believe that they should be questioned on lab values or vital signs and that merely stating the patient was “clear” should be enough. Most EDs requested that their word be taken as honest unless there was a reason otherwise. They did not believe it was necessary to be asked what lab values were and then told they would have to fax labs before a decision could be made.

EDs believed that patients should start at MHTF. They should be transferred to an ED only if there is a specific concern. If the ED acknowledges that concern, then the MHTF should accept the patient back. The EDs believed that if any labs/testing/paperwork was requested, it should come in the form of a physician to physician conversation. Further the EDs believed that if they had a concern, they should have quick access to the on-call physician. EDs believed that avoiding facsimiles was important and that all paperwork could be provided upon transport of the patient.

7. *Are there specific emergency departments/MHTFs that are easier to work with than others?*

8. *Are there specific emergency departments/MHTFs that are harder to work with than others?*

Both questions seven and eight elicited similar responses from stakeholders. Most EDs noted that there was one MHTF that was difficult to work with and contentious. Most of the contention was due to the fact that EDs had to wait for significant amounts of time (greater than four hours), only to find out that no beds were available at the MHTF. Many EDs stated there were several MHTF that were easy to work with. EDs further noted they regularly utilize the easier facilities more often as they were perceived as the path of least resistance.

MHTFs identified two specific EDs that were difficult. One ED was noted to often cite medical literature as a reason for not ordering tests that the MHTF stakeholder believed were necessary. Another ED was thought to be selective in where they sent patients with insurance and where they sent those without.

9. *Would you agree to follow a city-wide protocol regarding this issue?*

All EDs and all MHTFs except one agreed to follow the protocol. A list of participants who have agreed to and endorsed this protocol is in Appendix A. The MHTF that declined to agree to the protocol stated BALs were necessary and would not utilize any medical clearance guidance that dictated otherwise. This MHTF recognized, though, that there was no medical evidence to support the use of mandatory BALs.

Part 3: Literature Review

3.1 Discussion

The Journal of Emergency Medicine published a paper in 1999 titled, “Medical Clearance of Psychiatric Patients without Medical Complaints in the Emergency Department.” This article⁵ was a collaboration of ED medical personnel and psychiatrists. This article noted, approximately twenty years ago, that “current studies indicate that blanket screening of all patients is a prohibitive and unnecessary investment of time, money, and personnel.”⁶ This article did note that certain individuals may be at higher risk for medical complications than others. High risk cohorts included substance abusers, homeless, elderly, and individuals exhibiting new onset psychiatric symptoms. For this study, 212 were studied, ranging in ages from seventeen to eighty-three. Of study participants, 38 percent presented with psychiatric complaints only. All 38.0 percent had laboratory testing that was within normal limits (except for one pregnancy test that did not alter disposition and one mild leukocytosis). Of the 212 patients, 62 percent presented with medical complaints or had a significant medical history. The conclusion of the authors was that a workup could be performed by appropriately utilized triage and ED admission nurses. Furthermore, the authors believed that their study supported the conclusion against routine laboratory evaluations on all psychiatric patients.

The New Jersey Hospital Association collaborated with the New Jersey Chapter of the American College of Emergency Physicians. This collaboration produced a document similar to this protocol. The New Jersey document defined the general principles of medical clearance and the exam process. Of note was the recognition that EDs have an increased ability to obtain diagnostic information when compared to an MHTF. This protocol also recognized the value of communication. The protocol acknowledged that patient refusal for a diagnostic procedure should not be utilized as a refusal for acceptance to an MHTF. Finally, this protocol states that diagnostic testing should be guided by the ED physician’s “determination of need.”⁷

A study published in the *Western Journal of Emergency Medicine* in 2012 determined the value of mandatory screening in psychiatric patients in the ED. This study examined 598 patients. ED physicians ordered testing on 25.9 percent of these patients. The psychiatric service ordered laboratory testing on 44.0 percent of patients (who had previously been determined by the ED to need no further testing). Of this 44.0 percent that had further testing, only one patient (0.5 percent) had an abnormal lab value that would have changed disposition. This article also concluded that

5 Carrie S. Korn, Glenn W. Currier, and Sean O. Henderson, “Medical Clearance of Psychiatric Patients Without Medical Complaints in the Emergency Department” *The Journal of Emergency Medicine* 18, no. 2 (October, 1999): 173-176, Accessed December 10, 2018.

6 Korn et al., found this supported by JS Olshaker, et al., “Medical Clearance and Screening of Psychiatric Patients in the Emergency Department” *Academy of Emergency Medicine*, 4 (1997): 124-128., and JG Dolan et al., “Routine Laboratory Testing for Medical Disorders in Psychiatric Patients” *JAMA Internal Medicine, formerly Archives of Internal Medicine*, (1985): 2085-2088.

7 New Jersey Chapter of American College of Emergency Physicians and New Jersey Hospital Association. “Consensus Statement: Medical Clearance Protocols for Acute Psychiatric Patients Referred for Inpatient Admission.” March/April, 2011.

the additional testing of 191 patients amounted to utilization of \$37,682 of Medicare funds, on average costing an additional \$197.29 per patient.⁸

A study published in *Prehospital Emergency Care* described a one-year retrospective cohort study of North Carolina patients during 2013-2014. Of the 226 EMS patients brought to a CMHC (Wakebrook), only 5 percent required transfer to an ED. The conclusion of this study was, “A dedicated community mental health center is able to treat patients experiencing acute mental health crisis. Length of Stay (LOS) times were significantly shorter compared to regional EDs.”⁹

The American College of Emergency Physicians reviewed the medical literature in regard to “Care of the Psychiatric Patient in the Emergency Department” in 2014. This review noted that there has been a previous recommendation to avoid routine laboratory testing of all patients. Further, the review noted that urine toxicology for drugs of abuse in non-symptomatic patients should not be performed in the ED. Finally, this review noted that BALs were of little value and that clinicians should focus on the clinical status of the patient instead.¹⁰

A study published in *Annals of Emergency Medicine* in 2018 evaluated the issue of medical clearance utilizing a standardized screening protocol. This study evaluated 541,731 Emergency Medical Services (EMS) encounters. Of the nearly half million encounters, sixty (0.3 percent) failed transport to a psychiatric facility and required transport to an emergency department.¹¹

3.2 Research-Supported Conclusions

The literature reviewed as part of the development of this protocol provides further evidence-based research applicable to Tulsa EDs and MHTFs. The following conclusions are supported by medical literature:

- Community protocols can be developed to avoid de facto use of the ED for all patients;
- Patients with an acute mental health crisis (approximately 95 percent) do not need to be seen in the ED;
- The ED always remains an option if the medical stability of a patient’s status deteriorates;
- Length of stay (and thereby stress on the system) is much less when use of the ED is minimized;
- ED physicians can determine the necessity of testing;

8 Parveen Parmar, Craig A. Goolsby, Kavid Udompanyanan, et al., “Value of Mandatory Screening Studies in Emergency Department Patients Cleared for Psychiatric Admission” *Western Journal of Emergency Medicine* 13, no. 5 (November, 2012):388-393, Accessed December 10, 2018.

9 Jamie O. Creed, Julianne M. Cyr, Hillary Owino, et al. “Acute Crisis Care for Patients with Mental Health Crises: Initial Assessment of an Innovative Prehospital Alternative Destination Program in North Carolina,” *Prehospital Emergency Care*. 22, no. 5 (February, 2018): 555-564, Accessed December 10, 2018, doi: 10.1080/10903127.2018.1428840.

10 American College of Emergency Physicians, “Care of the Psychiatric Patient in the Emergency Department - A Review of the Literature,” (October, 2014) Accessed December 10, 2018.

11 Tarak K. Trivedi, Melody Glenn, Gene Hern, et al., “Emergency Medical Services Use Among Patients Receiving Involuntary Psychiatric Holds and the Safety of an Out-of-Hospital Screening Protocol to “Medically Clear” Psychiatric Emergencies in the Field, 2011 to 2016,” *Annals of Emergency Medicine*, (September, 2018): 1-10, Accessed December 10, 2018, doi: 10.1016/j.annemergmed.2018.08.422.

- Extra testing is unlikely to alter outcomes in 99 percent of patients. As noted above, in the 1 percent of patients that perhaps would benefit for more testing or alternate disposition, they can always be transported back to the ED; and
- Ancillary lab testing, beyond what the ED physician believes to be necessary, is expensive.

Part 4: Medical Clearance Process

4.1 Medical Clearance Includes:

After a review of the medical literature and completion of stakeholder meetings, the following process for medical clearance was developed.

A patient in a mental health crisis can enter the mental health system in primarily three ways:

- Independently arrive in the ED/MHTF by him or herself or with a family member;
- Transported by law enforcement; or
- Transported by EMS.

4.1.1 Protocol for Independent Arrival in the ED

If a patient arrives in the ED with a mental health complaint, the ED clinician should utilize best evidenced practices to determine whether the patient may require inpatient psychiatric hospitalization. Further, the physician should utilize reasonable and sound judgement to determine the extent of medical clearance that is required. All patients in the ED receive a History and Physical examination. This examination alone could suffice for medical clearance. Such an exam requires vital signs, an account as to the nature and extent of the psychiatric complaint and a focused physical exam. Specific care of the physical exam should focus on toxidrome and substance intoxication. Further testing should be justified based on patient-specific requirements. General conclusions of the exam in the ED include: EDs adherence to the protocol means the ED will comply with the following principles:

- ED clinicians shall only perform laboratory tests based on the clinical indication of the specific patient.¹² ED clinicians **do not** need to run a standard set of ‘psych’ tests.
- ED clinicians shall **not** routinely obtain BALs unless there is a clinical indication specific to the patient. For patients suspected of having alcohol ingestion, care should be focused on the clinical status of that patient such as the ability to ambulate safely and conversate.¹³ Patients who cannot ambulate, conversate, or are in stupor/coma are inappropriate for transfer to a MHTF.
- ED clinicians shall not routinely obtain UDSs in the medical clearance of psychiatric patients, unless the ED clinician feels it is appropriate. UDSs can be a useful diagnostic tool but should be utilized at the discretion of the ED. UDSs can be useful for an MHTF but rarely are required for stabilization.¹⁴ UDSs should not be utilized to confirm or deny drug use in a patient as the validity is often questionable. UDSs should not be utilized as a determination of need for psychiatric placement as it is difficult to determine what symptoms preceded the substance use.

¹² Thomas W. Lukens, MD, PhD, et al., “Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department,” *Annals of Emergency Medicine* 47, no. 1 (January 2006): 79-99, accessed February 21, 2019, doi:10.1016/j.annemergmed.2005.10.002

¹³ *Ibid.*

¹⁴ *Ibid.*

- EDs should send the complete medical record with the patient when he/she is being transported to the MHTF, not just discharge instructions.

Once the ED clinician determines that a patient requires inpatient hospitalization, a phone call to the MHTF is placed. The ED clinician should be aware that most MHTF in the Tulsa area are staffed with non-medical clinicians. The MHTF may request any information to the ED, such as labs, vital signs and clinical status. It is prudent for the MHTF to know any and all information that exists on the patient. However, the MHTF shall not request any further workup be performed (such as labs, alcohol level, UDS). If the MHTF requires any information that does not yet exist from the ED, that request should be made physician to physician. Non-medical clinicians are outside of their scope of practice when requesting further medical workup and interventions.

4.1.2 Protocol for Law Enforcement Assisted Arrival

If law enforcement is transporting the individual in a mental health crisis, then they should transport directly to the MHTF. If the law enforcement officer has a medical concern, then they should transport to the ED on their merit. Law enforcement should not be transporting directly to the ED out of fear that the MHTF will subsequently request it. MHTFs shall only request medical clearance on patients if there is a specific concern that the patient is medically unstable after an appropriate EMTALA defined evaluation.¹⁵ When such a concern arises, the MHTF shall call the ED clinician to alert them as to the nature of their concern. The ED clinician can discuss the concern but should not deny/refuse the MHTF's request for a medical clearance evaluation. As such, it does not demonstrate sound judgement to place a medically unstable patient into a patrol vehicle with non-medically trained law enforcement.

The MHTF should request all information over the phone. Transmission of medical information via facsimile is not reliable and causes delay in information conveyance. MHTFs can request that all medical documentation arrive with the patient. Ideally, if the ED states that the patient is "medically cleared," the patient will automatically be accepted to the MHTF. If the MHTF declines to accept the patient, they should do so with a physician to physician phone call.

4.1.3 Protocol for Independent Arrival in the MHTF

If the patient enters the system by directly arriving at the MHTF (either by self or via EMS), then the MHTF must provide EMTALA defined evaluation. If the MHTF determines that the patient requires a higher level of care, then appropriate transfer procedures should be implemented and executed as described above. The MHTF should have a valid specific medical concern and should call the ED clinician to alert them to such. Requesting blanket "medical clearance" is inappropriate for a hospital to hospital transfer. An appropriate example would be a suicidal patient who complains of chest pain. The hospital should arrange transfer of the patient to the ED and then call the ED clinician, stating their concern for chest pain. This information is vital to the ED clinician being able to address the concerns of the MHTF. Once the patient has been evaluated and disposition determined, the ED clinician shall call the MHTF and discuss clinical status. If the ED clinician states that the patient is now "medically stable/clear" then this assessment shall be

¹⁵ Electronic Code of Federal Regulations, 42 CFR § 489.24, "Special Responsibilities of Medicare Hospitals in Emergency Cases," Accessed April 29, 2019 at <https://www.law.cornell.edu/cfr/text/42/489.24>

accepted by the MHTF. If the MHTF disagrees with the ED clinician, then a physician to physician phone call shall be performed.

- MHTFs should provide an immediate “yes” or “no” answer on whether there are available beds. If a bed is available, then the conversation can proceed with whether the patient is appropriate for the facility. If they are concerned about potential admissions based on volume in the assessment department, then they should say “no” with the option to call back later.
- MHTFs should provide an answer on acceptance within 30 minutes of the first call from the ED.
- MHTFs shall not require ED clinicians to run a standard set of ‘psych’ tests. ED clinicians shall perform laboratory tests based on the clinical indication of the specific patient¹⁶ and not at the request of the MHTF.
- MHTFs shall not require ED clinicians routinely obtain BALs. If the ED clinician believes there is a clinical indication specific to the patient, then a BAL shall be performed. For patients suspected of having alcohol ingestion, care should be focused on the clinical status of that patient such as the ability to ambulate safely and conversate.¹⁷ ED clinicians shall recognize that intoxicated patients who cannot ambulate, conversate, or are in stupor/coma are inappropriate for transfer to a MHTF.
- MHTFs shall not routinely require UDSs. UDSs can be a useful diagnostic tool but should be utilized at the discretion of the ED. UDSs can be useful for an MHTF but rarely are required for stabilization. UDSs should not be utilized to confirm or deny drug use in a patient as the validity is often questionable.¹⁸ UDSs should not be utilized as a determination of return to the MHTF as it is difficult to determine what symptoms preceded the substance use.

¹⁶ Thomas W. Lukens, MD, PhD, et al., “Clinical Policy: Critical Issues in the Diagnosis and Management of the Adult Psychiatric Patient in the Emergency Department,” *Annals of Emergency Medicine* 47, no. 1 (January 2006): 79-99, accessed February 21, 2019, doi:10.1016/j.annemergmed.2005.10.002

¹⁷ *Ibid.*

¹⁸ *Ibid.*

Part 5: Special Issues in Medical Clearance

5.1 Medical Clearance of Pregnant Patients

All MHTFs have the ability to care for women who are pregnant, with more restrictive parameters than non-pregnant women. ED clinicians should recognize that patients admitted to an MHTF may be there for 7-14 days. As such, any testing or follow-up is difficult to obtain while admitted. If frequent evaluation is required, a MHTF may not be the most appropriate placement. The workup required to medically evaluate a pregnant patient may involve more/different types of tests.¹⁹ This evaluation is determined by the ED clinician, not the MHTF. The presence of psychiatric symptoms in pregnancy does not necessarily warrant extensive lab testing, UDS or a BAL.²⁰ If the patient is deemed stable for discharge home, then they should be deemed stable for transfer to a MHTF.

5.2 Transport of Psychiatric Patients

Psychiatric patients should be transported from hospital to hospital the same way other medical patients are transferred. An ideal goal is to avoid transportation by law enforcement. Involving law enforcement in transport increases the risk for a bad outcome and significantly affects the availability of officers to patrol.

Psychiatric patients transported to the hospital who were involuntary, or upon completion of medical clearance are rendered involuntary because of an LMHP, should be transported by a peace officer pursuant to 43A O.S. § 5-207(d-e). If the ED determines that the patient requires psychiatric hospitalization, and the patient agrees to treatment, then the ED may rely on the patient's family, friend, or other acquaintance to transport the patient to the appropriate MHTF. The ED clinician should consider the risks and reliability of private transportation in their decision to utilize this as an option. As a last resort for a voluntary patient without other acquaintance, a hospital shall request transportation for a patient to a MHTF from Emergency Medical Service Authority (EMSA).

The statutory language pertaining to the transportation of a mental health patient is stated in 43A O.S. § 5-207²¹ and contained below:

D. If the person is medically stable, the officer shall immediately transport the person to the nearest facility designated by the Commissioner of Mental Health and Substance Abuse Services as an appropriate facility for an initial assessment. If, subsequent to an initial assessment, it is determined that emergency detention is warranted, the officer shall transport the person to the nearest facility, designated

19 Michael P. Wilson, MD, PhD, et al., "Psychiatric Emergencies in Pregnant Women," *Emergency Medical Clinics of North America*. 33. (2015): 841-851, accessed February 20, 2019, doi: 10.1016/j.emc.2015.07.010

20 Andrew Carlin and Zarko Alfirevic, "Physiological Changes of Pregnancy and Monitoring," *Best Practice & Research Clinical Obstetrics and Gynecology* 22, no. 5 (2008): 801-823, Accessed November 29, 2018, doi: 10.1016/j.bpobgyn.2008.06.005.

21 Oklahoma State Statutes, Title 43A O.S. § 5-207 (OSCN 2019) accessed February 20, 2019, <https://www.oscn.net/applications/oscn/DeliverDocument.asp?CiteID=84186>

by the Commissioner as appropriate for such detention, that has bed space available. If it is determined by the facility director or designee that the person is not medically stable, the officer shall transport the person to the nearest hospital or other appropriate treatment facility.

E. If the person is medically unstable, the person may be transported to an appropriate medical facility for medical treatment. A treating physician may authorize that the person be detained until the person becomes medically stable. When the person becomes medically stable, if in the opinion of the treating or discharging physician, the patient is still a person requiring treatment as defined in Section 1-103 of this title, the physician shall authorize detention of the patient for transportation as provided in subsection D of this section by an appropriate law enforcement agency.

5.3 Consent for Medical Clearance

If there are tests needed during the medical clearance process requiring consent, those tests shall not be performed unless consent is given. If the individual lacks the capacity to provide consent, consent must be obtained from the properly appointed substitute decision-maker. If there is no designated substitute decision maker, then the facility should follow standard procedures.

5.4 Resolution of Disagreements

Disagreements over medical clearance or the contents of this protocol should be resolved with direct, physician to physician or task force member to stakeholder communication. Regular and immediate dialogue between parties involved in disagreements arising out of the medical clearance process is necessary to create and sustain the framework of this Tulsa-wide protocol.

5.5 Routine System-level Sharing

State and private MHTFs should routinely share information with each other, hospital emergency departments, law enforcement agencies, and courts about their medical treatment capabilities.²² Communicating this information on a regular basis, outside of individual cases or crises will continue to foster the collaboration and communication that began as part of Project Blue Streets and the development of this protocol. While the protocol will be updated on a regular basis, psychiatric facilities may experience changes in capacity that could cause a change in the capabilities of the MHTF. Continuous communication between the aforementioned parties will improve admittance efficiency and the referral process across the Tulsa area.

5.6 Systematic Quality Improvement

Tulsa-wide collaboration is needed in order to implement the medical clearance protocol developed by the Project Blue Streets task force. To ensure its effectiveness, the task force will reconvene on a quarterly basis to discuss any issues that have arisen, making amendments as needed, and update the protocol on a yearly basis to include feedback from stakeholders.

²² Similar, standard language was used in Virginia Department of Behavioral Health and Developmental Services document. See Virginia Department of Behavioral Health and Developmental Services, “Medical Screening and Medical Assessment Guidance Materials,” 2nd ed., (Effective date: April 1, 2014), Accessed November 29, 2018.

Appendix A

Project Blue Streets Protocol Adhering Facilities

At the end of each stakeholder interview, stakeholders were asked if they would be willing to adhere to a Tulsa-wide protocol. Most answered, “yes”. Stakeholders have had the opportunity to review the protocol and its contents. Below is the list of stakeholders, both EDs and MHTFs, that have agreed to the protocol contents.

Tulsa Emergency Departments	Tulsa Mental Health Treatment Facilities
<ul style="list-style-type: none"> ● Oklahoma State University Hospital ● Saint Francis Hospital ● St. John’s Medical Center 	<ul style="list-style-type: none"> ● Brookhaven Hospital ● CREOKS Spring Creek Recovery Center ● Family and Children’s Services Crisis Care Center ● Laureate Psychiatric Clinic and Hospital ● Parkside Psychiatric Hospital & Clinic ● Tulsa Center for Behavioral Health ● Wagoner Hospital

Appendix B Exclusion Criteria

Psychiatric hospitals and units typically have fewer medical and nursing resources than hospital and surgical units. Free-standing psychiatric hospitals and psychiatric units may lack access to immediate labs or other tests, or electronic monitoring capabilities, may not be able to provide IV fluids or medications, and may have less clinical experience on hand at both the nursing and physician level.

A typical psychiatric hospital can monitor vital signs, provide oral medications, monitor fluid “input and output”, monitor pulse, and observe for signs of distress. Psychiatric hospitals or units that are part of general hospitals may have more readily available access to emergency medical care, STAT labs and other tests, but typically no greater capacity to provide intensive medical care or treatment.

The following table contains the exclusionary criteria for Tulsa-area psychiatric hospitals and units. The exclusions reflect the treatment capacity and capabilities of the MHTF and its staff.

Psychiatric Hospital or Unit	Will Accept	Exclusion(s)
Brookhaven Hospital	<ul style="list-style-type: none"> ● Assistance level ● Bed bugs ● C Diff ● CPAP ● Oxygen ● Staph ● Wheelchair 	<ul style="list-style-type: none"> ● IV Line
Family and Children’s Services Crisis Care Center	<ul style="list-style-type: none"> ● Bed bugs ● Wheelchair 	<ul style="list-style-type: none"> ● Assistance level ● C Diff ● CPAP ● IV Line ● Oxygen ● Staph ● Unable to feed or use restroom by self

<p>Laureate Psychiatric Clinic and Hospital</p>	<ul style="list-style-type: none"> ● Assistance level ● CPAP ● Oxygen (in geriatric units and special cases in adult acute unit) ● Wheelchair 	<ul style="list-style-type: none"> ● Bed bugs ● C Diff ● Dialysis ● Inability to eat, drink, or swallow ● IV Line ● Staph ● Wound VAC
<p>Parkside Psychiatric Care and Hospital</p>	<ul style="list-style-type: none"> ● Assistance Level ● Bed bugs ● Wheelchair 	<ul style="list-style-type: none"> ● Anything requiring an electrical outlet in patient room ● C Diff ● CPAP ● Insulin pump ● IV Line ● Oxygen ● StaphIV Line ● Infectious Diseases requiring isolation
<p>CREOKS Spring Creek Recovery Center</p>	<ul style="list-style-type: none"> ● Wheelchair 	<ul style="list-style-type: none"> ● Assistance level ● Bed Bugs ● BIPAP ● C Diff ● CPAP ● Dialysis ● Incontinence ● Insulin pump ● IV Line ● Nebulizer ● Oxygen ● Staph ● Wound VAC
<p>Tulsa Center for Behavioral Health</p>	<ul style="list-style-type: none"> ● Staph ● Wheelchair 	<ul style="list-style-type: none"> ● Assistance level (no lifting) ● Bed bugs (can take after treatment and belongings are double bagged and sealed) ● C Diff (can take after full dose of antibiotics) ● CPAP machine (can take if portable machine) ● IV Line ● Oxygen

Wagoner Hospital	<ul style="list-style-type: none">● Assistance level● CPAP● Oxygen● Staph● Wheelchair	<ul style="list-style-type: none">● Bed bugs● C Diff● IV Line
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