



**North Carolina Department of Health and Human Services  
Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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**MEMORANDUM**

**TO:** Stakeholders and Workgroup Members  
Patient Transfer Guidelines

**FROM:** Michael S. Lancaster, M.D.  
Chief of Clinical Policy

Susan Saik, MD  
Medical Services Manager

**RE:** Patient Transfer Guidelines Feedback

Thank you for participating in the development of Patient Transfer Guidelines for individuals being transferred from Emergency Departments and State Operated Psychiatric Hospitals and Alcohol and Drug Treatment Centers (ADATCs).

I have listed below the feedback that was received and the determinations that were made.

Feedback submitted

1. Should we have a check-sheet for diagnostic labs/procedures needed for each patient risk category being considered for admission?

**Response -**

***These guidelines were based on the most common areas that come up in the medical clearance process, especially those where abnormal lab values may not mean that the patient is not medically stable to be received by an inpatient psychiatric/ADATC facility. Going to categories would be prescriptive, and it would not leave room for Emergency Department Physicians to use their professional judgment about what the patient needs. These guidelines are somewhat of a compromise between those 2 ends of the spectrum. It is thought that these guidelines will address 80% of the problems that arise in the transfer process. A check-sheet might be helpful, but it was felt that this should be considered in a "second phase" of implementation.***



2. Should there be MD to MD communication PRIOR to submitting medical information? If MDs agree on transfer, then the office staff work out the transfer of information, etc. Should MD to MD communication occur within one hour?

**Response -**

***Physician to physician communication before complete information has been submitted by the referring hospital may mean that the acceptance or denial is based on incomplete or inaccurate information.***

***In addition, physician to physician communication is probably not realistic in every case.***

***There should, however, be physician to physician communication if the receiving facility is declining a patient for medical reasons whom the ED physician has medically cleared.***

***These guidelines should decrease the frequency of needing to do so. Requiring***

***communication to occur within one hour may undermine the overall effectiveness of these guidelines since clinical emergencies may prevent a 1 hour time frame from being met.***

***The guidelines were edited to reflect the emphasis on physician to physician communication in certain circumstances.***

3. Will these guidelines be enforced? Will these guidelines apply to Community Hospitals who admit psychiatric patients?

**Response -**

***The NCHA, DSOHF, NCCEP, and DMH/DD/SAS support the attached guidelines and are committed to using them in an effort to improve the care of patients. It is recognized that dissemination, clarification and feedback by each of the entities supporting these guidelines will be essential to improving the process. Concerns with the implementation and/or interpretation of these guidelines will be solicited by DMH/DD/SAS (Office of Clinical Policy). Some concerns may fall into the larger state-wide medical clearance policy, and these will be addressed as well.***

***Concerns about adherence to these guidelines should be addressed first with the facility Clinical Director. If there are unresolved concerns, then a Division level staff member should be contacted.***

***The use of these guidelines for behavioral health patients transferred from EDs to psychiatric beds in Community Hospitals is under discussion, but a final determination has not been made at this time.***

4. Does a patient have to have a negative UDS for consideration for transfer? If so, it is unlikely that many patients at all would get transferred.

**Response -**

***No. Many patients admitted to the state facilities have a positive UDS. This section was reworded to indicate that intoxicated patients with any alcohol level should be able to walk safely, take p.o., and have had a UDS.***

5. Different entities responded saying that a variety of cut-off values for glucose, white blood cell counts, and vital signs were being used, and specific cases were presented. There have been poor patient outcomes in addition to denial of patients who should have been able to be transferred on one or more occasions in the past related to the use of stringent and artificial criteria. Some facility staff expressed concerns about whether the wider range of acceptable values contained in the guidelines would represent a problem.

**Response**

***Treatment of abnormal labs without taking the patient's overall needs into account can present a more dangerous situation for the receiving facility than accepting a wider range of values in a stable patient. The state facility medical directors were instrumental in***



*determining what values should be placed into these guidelines. The state facility medical directors acknowledge that some patients with values outside of the “acceptable” ranges are appropriate for transfer. These transfers require physician to physician communication and requires the state facility to get the input of their medical service. We will solicit feedback based on experiences and outcomes related to the use of these guidelines.*

6. Should a battery of tests be required for patients going to ADATCs? The patient may not really be medically stable enough to go home from the ED. If a patient is delirious and/or has DTs, the ADATC may not have the capability to care for that condition.

**Response -**

*These guidelines are not meant to be an all-inclusive listing of what medical conditions may or may not be able to be cared for by a state facility. These guidelines were based on the most common areas that come up in the medical clearance process, especially those where abnormal lab values may not mean that the patient is not medically stable to be received by an inpatient psychiatric/ADATC facility. Requiring the ordering of lab tests that are not clinically indicated may not be in the best interest of the patient, however, the ED physician is expected to acquire the information needed to determine that the patient is medically stable and have knowledge of the environment that the patient is going to. The State-wide Medical Clearance Policy still applies.*

7. There are an alarming number of requests for CT scans of the head in patients that otherwise have no such medical indication. This is an expensive test that has an associated risk of radiation exposure. I feel that it is inappropriate to demand that this is done before the patient will be considered for acceptance. If we do not meet these demands, then the State Facility simply stops considering the patient for transfer.

**Response**

*It is acknowledged that The Food and Drug Administration has announced an initiative to reduce unnecessary radiation exposure from certain medical imaging procedures including computed tomography, nuclear medicine studies, and fluoroscopy procedures, which use higher radiation doses than other radiographic procedures. All agencies endorsing these guidelines support the safe use of medical imaging devices, informed clinical decision-making, and increased patient awareness of their own exposure. The guidelines have been amended to recognize that the decision to perform major diagnostic imaging rests with the Emergency Department physician. Information is provided that State Operated Facilities do not have major diagnostic imaging capability, including computed tomography.*

8. Many respondents stated that these guidelines would be very helpful and that it is good to have clear guidelines for transfer of patients to mental health facilities.

**Response**

*Even if these guidelines do not resolve 100% of the issues related to transfers, the vast majority of respondents believe that these guidelines will significantly improve the current process. The Wake Crisis Collaborative has had a set of transfer guidelines with more stringent criteria in effect for about a year, and they estimate that it has resolved about 80% of problems related to transfers.*

