Michigan's Medical Clearance MI-SMART Form
Frequently Asked Questions

Part 1 Questions (Adapted from Sierra Sacramento Valley Medical Society)

1. **How do you define a "New Onset Psychiatric Condition"?**
   Using common practice guided by literature, "new onset" typically refers to "new onset psychosis" especially in age extremes given the increased incidence and likelihood of medical etiologies causing their presentations. It is our recommendation that any patient presenting with signs or symptoms consistent with psychosis (hallucinations, delusions, catatonia, or thought disorders) without a prior documented history of the same, warrants a thorough medical assessment including laboratory diagnostics at a minimum to exclude causative organic etiologies. Comprehensive diagnostic testing is not necessarily indicated in patients with new onset depression or anxiety. In such cases, the clinician should rely on their training and exercise their best judgement in selecting appropriate testing.

2. **What satisfies the question "Possibility of pregnancy (age 12-50)"?**
   For females between the ages of 12 and 50 years, screening for pregnancy is required. However, the reliability of history of pregnancy alone is notoriously inaccurate in most emergency department settings. Therefore, only a urine (UPT) or serum beta-hCG test (qualitative or quantitative) will satisfy this question. Confirmed history of hysterectomy does not require testing.

3. **What is meant by "Other complaints that require screening"?**
   This question is meant to remind the provider to assess any other acute or chronic condition(s) that the patient may present with as they would do with any other individual presenting to the emergency department. Examples may include: shortness of breath, chest pain, or abdominal pain while chronic conditions may include asthma, chronic kidney disease, or seizure disorders. Full diagnostic testing of each of these conditions should be indicated in Part 2 of the form and should be driven by the clinician's assessment with accompanying documentation within Part 3 of the form.

4. **If the patient's vital signs are outside of the reference range, what diagnostic testing, if any, is required?**
   This depends on the specific vital sign in question and the circumstances surrounding the patient's presentation—this could range from thorough documentation of rationale in the provider's medical decision making to a full laboratory diagnostic evaluation. A list of commonly used diagnostic studies is listed in Part 2 of the form, with space for other studies.
   Most physicians are ordering a basic laboratory evaluation (CBC and CMP), +/- UA, urine tox screen, EKG and chest x-ray depending on the specific vital sign abnormality and the patient's signs/symptoms. For instance, in addition to basic labs, a patient with a fever may require a UA, chest x-ray, lactate or blood cultures to identify a source while a patient with isolated asymptomatic hypertension may only require a creatinine to evaluate renal function (end organ dysfunction). We do, however, strongly recommend that when the vital signs are compared to the SMART reference ranges (see timing in #5 below) that the clinician apply the reference ranges strictly and consistently (i.e., a blood pressure of 181/92 or a heart rate of 111 should be evaluated regardless of presentation).

5. **Regarding timing, which set of vital signs (arrival, evaluation, etc.) do you recommend we use to drive our diagnostic evaluation?**
   The specific vital signs that should be compared to the SMART reference ranges and ultimately drive the diagnostic evaluation are: 1) vital signs at the time of evaluation by a qualified provider (physician, PA, or NP) or 2) vital signs after evaluation by a qualified provider up to the time of transfer to a psychiatric facility. Vital signs at arrival can be problematic and deceiving given that patients typically are anxious, agitated, or were recently under the influence of drugs or alcohol. Vital signs that normalize shortly after ED arrival are reassuring and less concerning than those that are persistently abnormal or slowly deteriorate, either of which require thorough documentation of medical decision making, diagnostic testing, or both. To maintain a conservative lean, we recommend thorough evaluation based upon the vital signs at time of evaluation by a provider or when vital signs begin to fall outside the reference ranges (deteriorate) regardless of recent diagnostic evaluations.

6. **Is the Hack's Impairment Index (HII) score intended to replace obtaining blood alcohol levels (BALs)?**
   When performed in conjunction with screening for the potential for alcohol withdrawal (frequency and quantity of consumption), the HII score is intended to supersede the need for BALs. Given the unpredictable response of individual patients to identical quantities of alcohol consumption, the HII score was developed as an objective assessment of functional capacity in the setting of acute alcohol use and to allow the clinician to determine the degree to which the patient is under the influence. However, the MI-SMART form does not require the use of HII, but rather offers it as a starting point when alcohol intoxication is suspected. Each clinician is encouraged to perform other assessments in conjunction with HII to determine clinical intoxication.

7. **What is HII and when should it be performed?**
   HII stands for Hack's Impairment Index and is a tool to asses clinical intoxication. Blood Alcohol Concentration levels has been shown to be poorly correlated with intoxication levels. Therefore, HII is a quantitative tool that measures intoxication reliably and sensitively. It should be completed on all patients who are clinically intoxicated and/or who provide history of recent alcohol or drug use. If a patient initially scores 4 or greater, the patient is determined to be significantly under the influence of alcohol and the test should be repeated until the score is less than 4. The recommended testing interval is 2 hours. If administered regularly by a trained examiner (physician, PA, NP, or nurse) there is no indication for obtaining BALs. Furthermore, a HII score of 4 or more should not necessarily delay the mental health assessment by qualified personnel. However, this may need to be repeated as impairment improves. Visit here for more information: https://www.mpcip.org/mpcip/michigan-psychiatric-medical-clearance/hii-score/

8. **Are labs required for patients outside of the specified age range (<12 or >55)? If so, which ones?**
   Age extremes present a special challenge. While the literature is clear that patients greater than 55 require some degree of diagnostic evaluation, there is a paucity of evidence to suggest the right approach in children. Therefore, at a minimum, we recommend obtaining basic labs (CBC and CMP) on patients older than 55 years and conditionally recommend basic labs on patients less than 12 years old. Further diagnostic considerations should depend on the patient's presentation (history and physical) and advanced age should prompt the clinician to strongly consider obtaining more comprehensive diagnostic testing (i.e., UA, imaging). This should all be noted in Part 3 of the form.

9. **What does "Possibility of ingestion" refer to and which patients need screening for ingestions?**
   This is an area that the SMART protocol encourages all clinicians to lean heavily toward the conservative side given the risk of missing a lethal ingestion. Therefore, we strongly recommend obtaining, at a minimum, screening acetaminophen and salicylate levels on patients being evaluated for suicidal ideation, suicide attempts, major depression, or in patients reporting a history of overdose. Patients with mild to moderate depressive symptoms are not required to be screened. In otherwise healthy patients who pass the SMART protocol, other screening labs are not necessarily required. Caution should be exercised in patients who are suspected to have taken an ingestion. Comprehensive diagnostic testing should be obtained in those cases.

10. **For chronic COPD patients (not in exacerbation or treated and back to baseline), is an O2 saturation <95% considered abnormal? If so, what diagnostic evaluation is required?**
    Oxygen saturations of <95% are considered abnormal according to the SMART protocol regardless of whether the patient is in an acute or chronic state. Therefore, at a minimum, we recommend a basic diagnostic evaluation (CBC and CMP) in addition to a chest x-ray. Further

clinical explanation in Part 3 should be provided for patients with chronic hypoxia and/or on home oxygen.

11. **Are screening drug levels necessary if patients are taking one of the listed medications in SMART but are asymptomatic?**
    Yes, please obtain a screening drug level for patients taking one of the medications listed in the SMART protocol even if they are asymptomatic. This information can be valuable for the accepting clinician.

Part 2 Questions

12. **What does "abnormal" in Part 2 of the MI-SMART form mean?**
    Abnormal is intended to indicate a clinically significant abnormality. Clinicians are encouraged to use their judgement and expertise when completing this section of the form. In general, a clinically significant abnormality would be considered something that would warrant immediate further work-up and/or treatment if the patient would otherwise be discharged from the emergency department. For example, a female patient with a hemoglobin of 11.9 gm/dL might technically be just below the "normal" laboratory range but in most clinical settings this would not be considered "clinically significant". On the other hand, the same patient with a hemoglobin of 12.0 (technically "normal") might be considered inappropriate for in-patient psychiatric admission if it reflects an acute decrease from a hemoglobin 1 month earlier that was 13.8 AND associated with signs or symptoms of acute blood loss (e.g., orthostasis, melanotic stool, hematemesis, etc.).

13. **Why does the Corrected QT interval on an EKG need to be reported?**
    If an EKG is obtained, the corrected QT interval should be recorded in Part 2. This may be helpful in avoiding medications that might prolong the QT interval. An EKG should be obtained when clinically indicated (e.g., chest pain, syncope, etc.) and the corrected QT interval documented in Part 2.

Part 3 Questions

14. **If my Medical Clearance Explanation/Plan is well documented under the Medical Decision-Making (MDM) part of our electronic medical record (EMR), do I still need to complete Part 3?**
    Provided that there is sufficient documentation in the MDM section of the EMR and that this is included with the MI-SMART Form, Part 3 does not need additional explanation. The box referring to the EMR should be checked.

15. **Why would I document in Part 3 instead of simply referring to the Medical Decision-Making (MDM) section of the electronic medical record (EMR)?**
    For many clinicians using the MDM section of the EMR will be the most efficient and effective way to provide the medical explanation/plan. However, there may be occasions in a busy clinical setting where it may not be feasible for the clinician to complete documentation in the EMR prior to pursuing transfer. In such cases, it may be more efficient to document the explanation/plan in Part 3 prior to being able to complete the formal emergency department EMR.

16. **What should happen if the admitting/accepting clinician disagrees with my Part 3 explanation/plan and/or wants additional diagnostic studies?**
    Historically, such concerns were often conveyed through others involved in the admitting/transferring process (e.g., medical social workers). Concerns from the admitting/accepting clinician may occasionally occur. However, we believe that the best course in such occasions is for a direct clinician to clinician, patient-focused discussion to take place to better clarify the positions of both clinicians. It is anticipated that the receiving clinician is receptive to the medical explanation and plan provided by the transferring clinician. Similarly, the transferring clinician should be receptive to requests for clarification and/or reasonable additional diagnostic studies when clinically indicated.

Part 4 Questions

17. **Patient care was handed off to me at shift change, do I need to repeat the Medical Clearance Attestation?**
    The Medical Clearance Attestation (and appropriate clinical reassessment) should be completed every 24 hours until the patient is admitted/transferred. If it has been less than 24 hours since Part 4 was completed, you do not need to repeat this. However, although you do not need to complete Part 4, you should assure there has not been any significant change in the clinical status in the interval period, including review of recently acquired vital signs.

18. **If I sign Part 4 and the patient subsequently needs further acute medical evaluation/care will I be held responsible?**
    The MI-SMART process is intended to provide a standardized approach to the medical clearance of a patient in need of in-patient psychiatric hospitalization. Just as occasionally patients discharged from the emergency department will return, it is understood that, similarly, patients admitted/transferred for in-patient psychiatric care may occasionally need further acute medical care. This does not at all mean that the clinician completing the MI-SMART form provided an inadequate medical workup or care. However, it is expected that the clinician used good professional judgement in assessing and addressing any medical conditions and that a good faith, patient-focused effort was used throughout.

Drug Testing Questions

19. **Is mandatory drug testing/screening required for medical clearance?**
    Mandatory drug/testing is not required as part of the medical clearance process. However, whenever possible, referring facilities should attempt to obtain drug screens on patients to facilitate the transition to in-patient care. This should not impact the medical clearance process nor delay acceptance for in-patient admission.

20. **I thought that the Michigan Mental Health Code requires mandatory drug and alcohol testing/screening before a patient can be involuntarily admitted to an in-patient psychiatric unit?**
    This is not required under the Michigan Mental Health Code.

Additional questions may be directed to our contact page: https://www.mpcip.org/mpcip/contact/