SMART Medical Clearance FAQs

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, 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.

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 conditions 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 is not always indicated and should be driven by the clinician's assessment with accompanying documentation of medical decision making.

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. 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 #4 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) **What is considered an "Abnormal Mental Status"?**
When performing a focused medical assessment such as we do with the SMART protocol, we are ***obligated*** to rule out delirium as a cause of our patient's presentation. At a bare minimum, to pass the mental status portion of the exam, the patient should be "A/O x 3" or be awake, alert and oriented to person, place and approximate time. However, we expect the clinician to have a longer conversation with the patient to allow them the opportunity to gather a history and evaluate their thought process. With a thorough history and adequate conversation with the patient, emergency providers typically perform well when identifying patients presenting with delirium as opposed to a psychiatric cause of their presentation. While abnormal, hallucinations alone are not necessarily enough for a patient to be considered as having an abnormal mental status. That being said, patients with ***new onset auditory hallucinations, visual hallucinations regardless of chronicity, disorientation, inability to concentrate or memory problems*** all warrant a diagnostic evaluation including basic labs and a urine toxicology screen (see #1).

7) **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 strongly 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).

8) **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.

9) **For chronic COPD patients (not in exacerbation or treated and back to baseline), is an O_2 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.

10) **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 in the SMART protocol even if they are asymptomatic.

11) **Is the HII score intended to replace obtaining blood alcohol levels (BALs)? If so, do you repeat the HII score if a patient initially scores 4 or greater or are you required to obtain a BAL?**
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. 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.