



# Medical Clearance for Psychiatric Hospitalization- Considerations with the COVID-19 Pandemic Emergency

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The current COVID-19 Pandemic Emergency in Ohio requires serious consideration of the best use of available medical resources. Hospital Emergency Departments (ED) are expected to see a very significant increase in service volume to meet the needs of those with suspected and confirmed COVID-19 infection as with the predicted upcoming “surge” in cases within the coming weeks. Persons in a behavioral health crisis and in need of psychiatric hospitalization have often received medical clearance using ED resources. Given the present circumstances, use of the ED for such patients may present risks for their health, as many with chronic and persistent mental health conditions have co-existing chronic medical conditions that place them at an increased risk for severe illness should they develop COVID-19.

There is no directive that requires that medical clearance for psychiatric hospitalization occur in an ED setting versus an ambulatory healthcare setting. Appropriate settings could include behavioral health crisis assessment centers, health (or integrated behavioral healthcare) clinics, Federally Qualified Health Centers (FQHC), urgent care clinics, or medical practices. Persons who are highly agitated, violent, or actively suicidal will continue to need assessment and medical clearance in high-intensity medical care settings such as EDs or a behavioral health crisis center designed for patients exhibiting these features, but for those without such features, medical clearance can be accomplished in an ambulatory setting. Use of such settings would alleviate overburdening ED resources and potentially provide a safer environment of care for persons in behavioral health crisis able to cooperate with medical clearance procedures.

Medical clearance is a function that allows for determination that a patient does not have acute medical issues that necessitate admission to an acute medical setting despite the presence of a psychiatric emergency. It is accomplished by qualified medical professional (physician, nurse practitioner) review of medical history, performance of physical assessment/examination, and review of any necessary laboratory/other medical studies (X-rays, CT scans, for example) necessary to establish the absence of acute medical issues that would preclude safe patient care delivery in a psychiatric setting.

Medical Clearance for psychiatric stabilization can be streamlined using focused screening tools such as the SMART Medical Clearance form (a non-copyrighted resource; attached along with FAQs). Use of the SMART Medical Clearance form (or similar instrument) and physical examination/assessment, may establish the stability of a patient without obtaining laboratory/additional medical studies.

In addition, with the current COVID-19 Pandemic Emergency situation, all healthcare providers are utilizing screening instruments to establish the presence of possible COVID-19 symptoms and/or exposure to persons known or suspected to have COVID-19 infection, to determine next steps. Examples of screening question (those in current use at State-Operated Regional Psychiatric Hospitals) are as follows:

1. Does the patient have symptoms of respiratory infection (fever, cough, or shortness of breath)?
2. Has the patient traveled outside of the United States within the past 14 days, or been exposed to someone with confirmed COVID-19?
3. Take the patient’s temperature to see if the patient has a temperature of 100.4 degrees Fahrenheit or greater.

Those persons screening negative for COVID-19 on such questionnaires would not require further medical testing while positive responses to any of these questions require further medical investigation and follow-up, including contact with local health department regarding the need for COVID-19 testing.

While this guidance is being offered to encourage utilization of ambulatory healthcare settings for performance of medical clearance for psychiatric hospitalization, we recognize that communities will require a planning and coordination process to move toward implementing this change, and that communities will differ in the resources available to devote to this work.

Given these considerations, community systems are strongly encouraged to explore the use of alternative sites and partnerships for the medical clearance work. Considerations that may be useful in this planning and coordination include:

Use existing forums to elevate and facilitate the discussion. Consider this as part of the local community planning and crisis response approach. Local conveners may include ADAMH Boards, federally qualified healthcare centers and providers, to name a few.

Build upon key partnerships in your local healthcare system and look for unique ways to partner with others in your community such as local DD boards, Area Agencies on Aging, home healthcare provider organizations, and transportation providers among others.

Review and become familiar with the admission protocols used by your local psychiatric hospital(s).

Develop triaging processes for those who need additional testing prior to inpatient psychiatric admission- those that are not able to be medically cleared through the tools described above. This includes further developing and/or extending your local network of providers who may have additional capacity to perform lab services, EKGs, or other testing that may be needed.

Consider any transportation needs as you are looking at alternative sites for medical clearance. Be sure to have a plan for transporting individuals between the site(s) and the hospital in a manner that is safe for both the individual being transported as well as the individual providing the transportation.

Consider the timeliness of completing the medical clearance review- getting the patient to the alternate site, evaluating the patient, communicating with the psychiatric hospital, getting the acceptance from the hospital to admit the patient. How can any of these steps be streamlined? What partnerships are needed to decrease wait times?

Be sure to include local law enforcement and first responders in your planning process. They will be key to getting patients to designated alternative sites for medical clearance. Communication of these changes in the behavior health crisis response approach and referral patterns will need to be clearly communicated to their colleagues in the field.

# SMART Medical Clearance Form

	No*	Yes	Time Resolved
<b>S</b> uspect <u>New Onset</u> Psychiatric Condition? .....	1		
<b>M</b> edical Conditions that Require Screening? .....	2		
Diabetes (FSBS less than 60 or greater than 250) .....			
Possibility of pregnancy (age 12-50) .....			
Other complaints that require screening .....			
<b>A</b> bnormal: .....	3		
<b>Vital Signs?</b>			
Temp: greater than 38.0°C (100.4°F) .....			
HR: less than 50 or greater than 110 .....			
BP: less than 100 systolic or greater than 180/110 (2 consecutive readings 15 min apart) .....			
RR: less than 8 or greater than 22 .....			
O <sub>2</sub> Sat: less than 95% on room air .....			
<b>Mental Status?</b>			
Cannot answer name, month/year and location (minimum A/O x 3) .....			
If clinically intoxicated, HII score 4 or more? (next page) .....			
<b>Physical Exam (unclothed)?</b> .....			
<b>R</b> isky Presentation? .....	4		
Age less than 12 or greater than 55 .....			
Possibility of ingestion (screen all suicidal patients) .....			
Eating disorders .....			
Potential for alcohol withdrawal (daily use equal to or greater than 2 weeks) .....			
Ill-appearing, significant injury, prolonged struggle or "found down" .....			
<b>T</b> herapeutic Levels Needed? .....	5		
Phenytoin .....			
Valproic acid .....			
Lithium .....			
Digoxin .....			
Warfarin (INR) .....			

\* If ALL five SMART categories are checked "NO" then the patient is considered medically cleared and no testing is indicated. If ANY category is checked "YES" then appropriate testing and/or documentation of rationale must be reflected in the medical record and time resolved must be documented above.

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Completed by: \_\_\_\_\_, MD/DO

Signature

Print



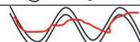
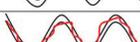
## List of Abbreviations

A/O x 3 .....	Alert and Oriented x 3 (person, place and time)
FSBS .....	Finger Stick Blood Sugar
HII Score .....	H-Impairment Index Score
INR .....	International Normalized Ratio
O <sub>2</sub> Sat .....	blood oxygen saturation

# H-Impairment Index (HII Score)

Time	0)	1)	2)	3)	4)
<b>Gross Motor Function</b>					
Unable to cooperate; cannot sit up	4	4	4	4	4
Can sit up, but unsteady	3	3	3	3	3
Can sit up steadily	2	2	2	2	2
Can stand and walk, but unsteady	1	1	1	1	1
Can stand and walk steadily	0	0	0	0	0
<b>Mentation and Speech</b>					
Unable to cooperate; unintelligible speech/moans	4	4	4	4	4
Slurred speech; does not make sense	3	3	3	3	3
Slurred speech; answers some questions	2	2	2	2	2
Imperfect speech; answers most questions	1	1	1	1	1
Baseline speech; lucid and appropriate	0	0	0	0	0
<b>Tracing Curve</b>					
Unable to participate	4	4	4	4	4
Makes mark on paper	3	3	3	3	3
Traces mostly out side of line	2	2	2	2	2
Traces mostly inside lines	1	1	1	1	1
Traces curve perfectly	0	0	0	0	0
<b>Nystagmus</b>					
Unable to participate	4	4	4	4	4
Profound nystagmus / can't follow finger with eyes	3	3	3	3	3
Moderate nystagmus/ follows finger for short distance only	2	2	2	2	2
Minimal nystagmus/follows finger with eyes whole time	1	1	1	1	1
No nystagmus/ follows finger with eyes whole time	0	0	0	0	0
<b>Finger to Nose Testing</b>					
Unable to participate	4	4	4	4	4
Grossly unsteady/misses targets	3	3	3	3	3
Unsteady and inaccurate/barely touches targets	2	2	2	2	2
Steady/ touches targets, but inaccurate	1	1	1	1	1
Steady/ accurately touches targets	0	0	0	0	0
<b>Total Score</b>					
<b>Health Care Provider Initials</b>					

## Scoring Reference

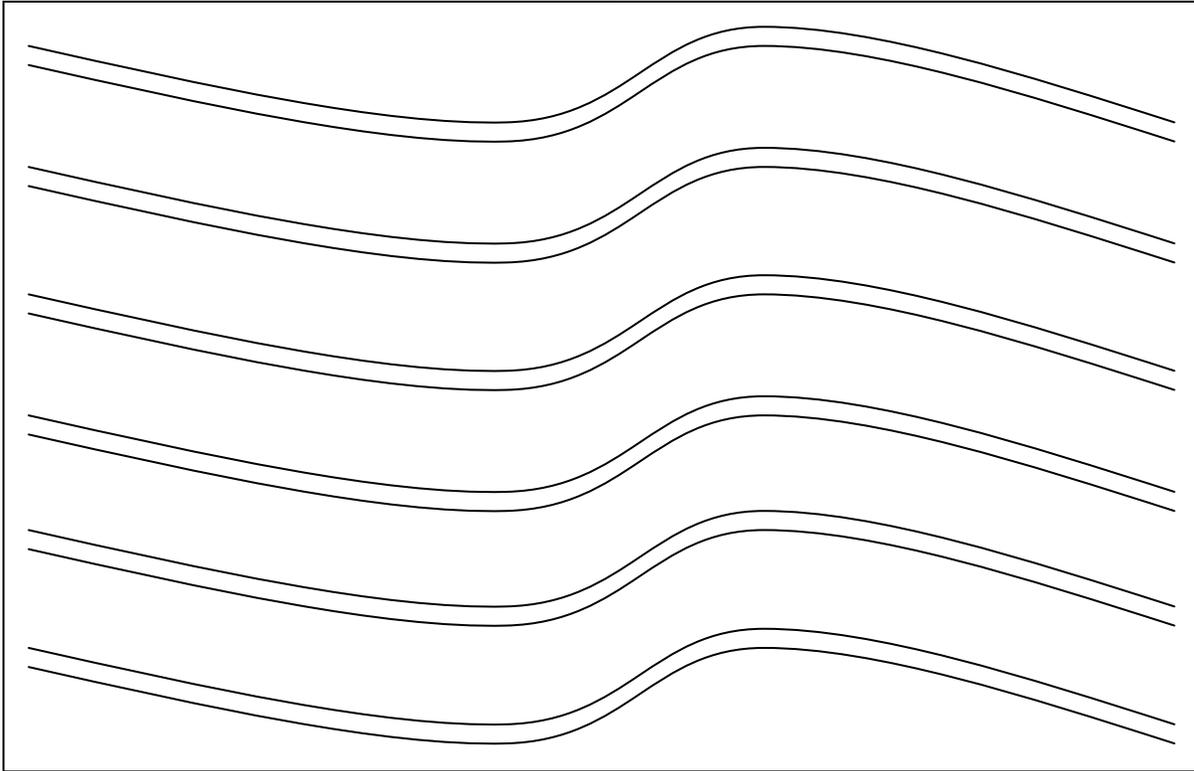
Gross Motor Function			Mentation and Speech			Tracing Curve		
Unable to cooperate; cannot sit up		4	Unable to cooperate; unintelligible speech or only moans	4	4	Unable to participate		4
Can sit up, but is unsteady		3	Slurred speech; does not make sense	3	3	Makes mark on paper		3
Can sit up and is steady, but cannot stand		2	Slurred speech; answers few questions appropriately	2	2	Traces mostly out side of line		2
Can stand or walk, but is unsteady		1	Imperfect speech; answers most questions appropriately	1	1	Traces mostly inside lines		1
Can stand and walk and is steady		0	Normal or Baseline speech; Conversive and appropriate	0	0	Traces curve perfectly		0

Nystagmus			Finger to Nose Testing		
Unable to participate		4	Unable to participate		4
Profound nystagmus; unable to follow finger with eyes		3	Grossly unsteady; Misses finger to target		3
Moderate nystagmus; only follows finger with eyes for short distance		2	Unsteady; Inaccurate/barely touches target		2
Minimal nystagmus; follows finger with eyes whole time		1	Steady; Inaccurate but touches target		1
No nystagmus; Follows finger with eyes whole time		0	Steady; Accurate finger to target		0

# Tracing Curve

Time:



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## 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<sub>2</sub> 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.