Clinical Pathways

Somatic Symptom and Related Disorders (SSRD)

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What is a Clinical Pathway?

- An evidence-based guideline that decreases unnecessary variation and helps to promote safe, effective and consistent patient care.
- Clinical pathways are also associated with reduced hospital complications, decreased length of stay, and decreased hospital costs.

Pathway Objectives

- To standardize a treatment approach regardless of clinical service or presenting complaint
- To standardize the initial approach and diagnostic formulation provided to the patient and the family
- To focus the clinical care on recovery by emphasizing a functional approach rather than promoting the sick role
- To ensure that appropriate outpatient services have been set up

What is SSRD?

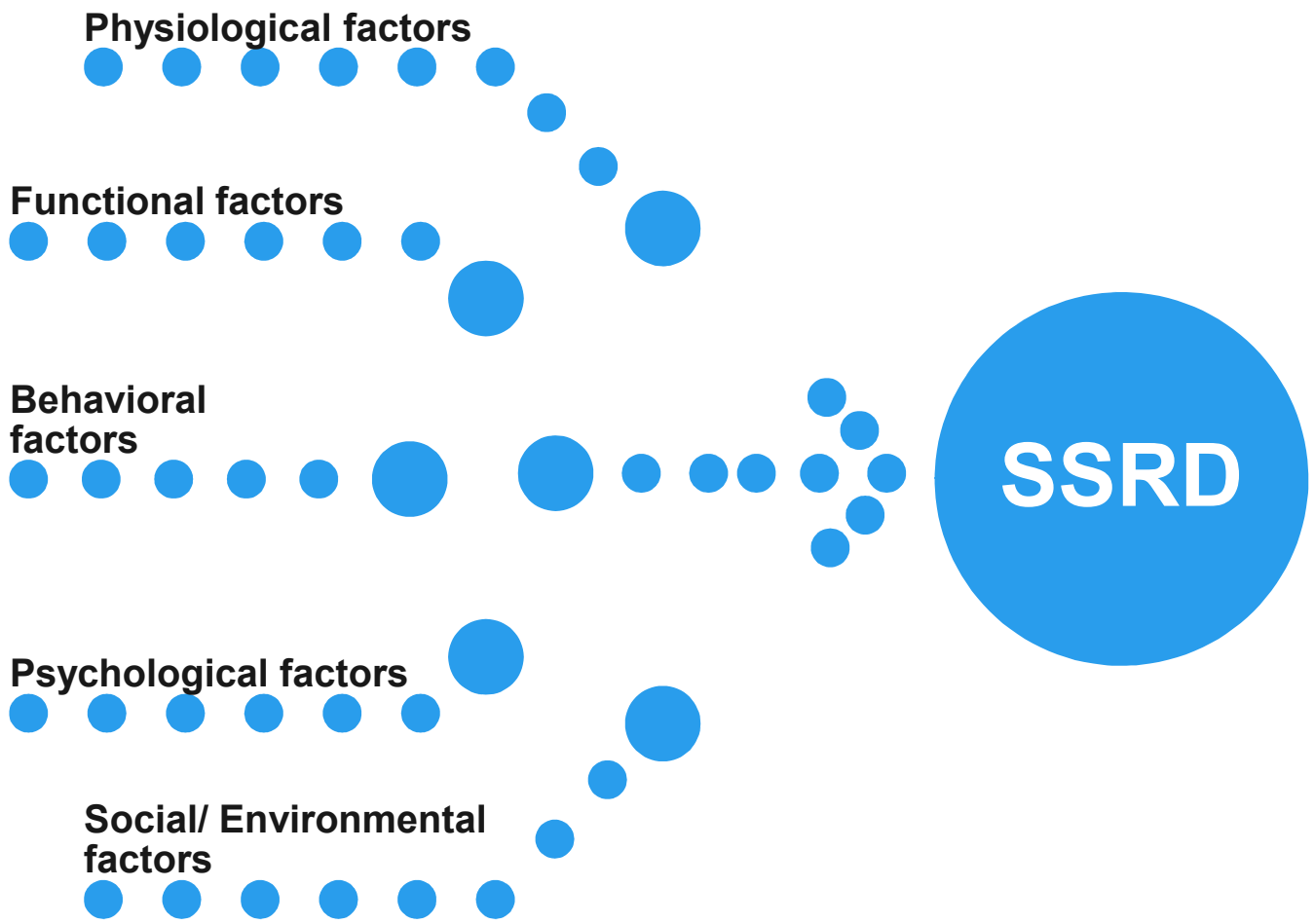
SSRD – formerly known as Medically Unexplained Physical Symptoms (MUPS) - is a clinical presentation where symptoms or impairment cannot be fully explained by an identifiable disease process given the current medical evidence. This pathway seeks to evaluate and ultimately **explain** to patients and their families the cause of these often debilitating symptoms.

Examples

Examples of diagnoses that can present as SSRD include:

- Conversion disorder (syncope, psychogenic nonepileptic seizures (PNES), gait disturbance, etc.)
- Other somatic symptom and related disorders (SSRDs), as per DSM-V
- Chronic pain syndromes
- Irritable Bowel Syndrome (IBS) and chronic abdominal pain
- Psychogenic nonepileptic seizures
- Chronic or daily headache
- Chronic fatigue syndrome
- The presence of SSRDs does not preclude comorbid medical illness

What causes SSRD?



Who are These Kids?

- Females > Males
- They often struggle to interact with teachers and engage with peers
- They tend to miss a lot of school, are often called to be picked up early, and are chronically behind in course work
- They frequently present to the hospital, subspecialty clinics and PCP
- They are medically time intensive, at times, demanding and difficult to assess and treat
- The families often deny any psychological factors and are wary of psychiatric services
- The families are often upset with the medical teams for failing to provide an explanation for their child's symptoms

Slide from Rome III research group

Slide from Rome III research group

Why is an SSRD Pathway Needed?

Historically there has been:

- Inconsistent Approach to these patients
- Exhaustive Medical Work Up – invasive, expensive
- Overuse of Pain Meds (with little benefit)
- Mid-stay pivot to Psychiatry Consult
- Family Dissatisfaction
- Provider Dissatisfaction
- Prolonged LOS

Goals of the SSRD Pathway

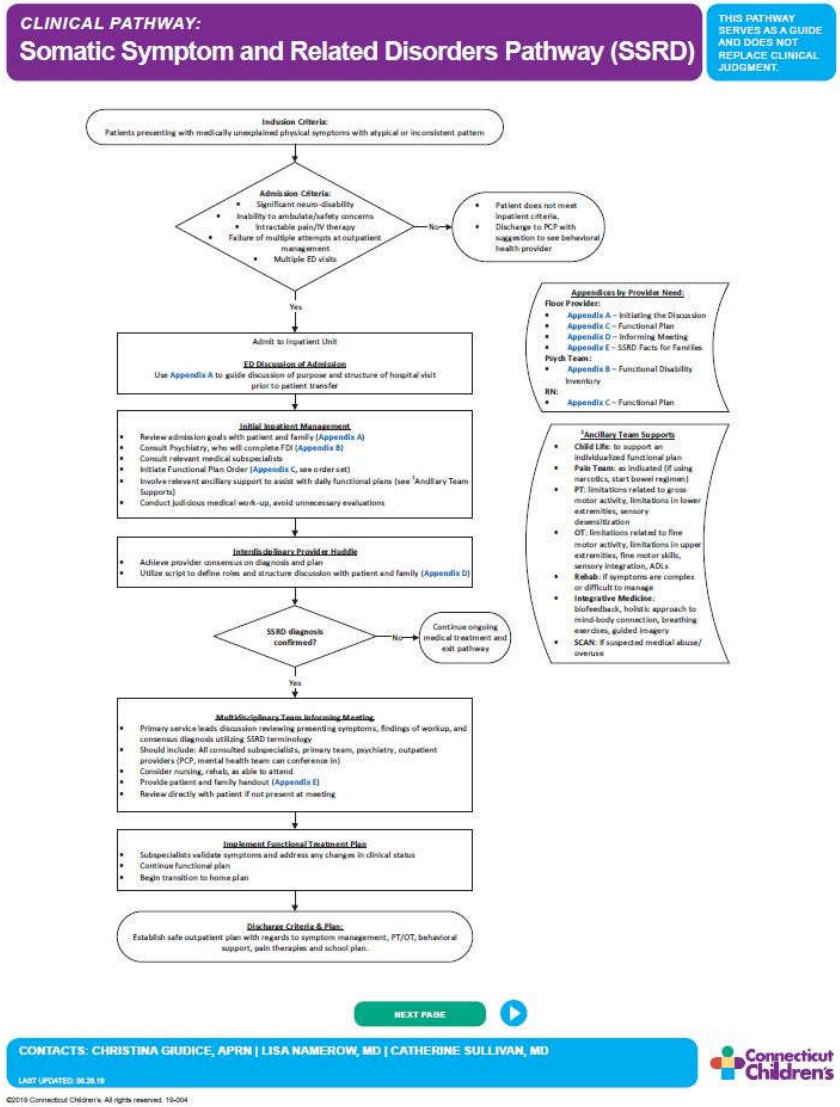
- Identify the patients
- Provide scripting to assist providers approach to patients and families
- Encourage concurrent medical and psychiatric evaluations – to avoid a sudden pivot to psych
- Establish a more structured, functional plan soon after admission
- Avoid having psychosomatic conditions be diagnoses of exclusion after exhaustive, costly, and invasive tests
- Engage the subspecialist and collaborate throughout the admission to support family “buy in” and their confidence in final diagnosis and treatment plan
- Avoid provider inconsistencies and improve the family-provider relationship
- Consistent approach to the Informing meeting
- Improve discharge planning

Steps For Success

1. Identify a patient presenting with SSRD
2. Notify family of CT Children's approach to SSRD on admission (Appendix A)
3. Obtain consults specific to presenting symptom(s)
4. Always consult Psychiatry, consider Child Life (for functional plan), PT/OT, Pain, and SCAN services as appropriate
5. Scales/assessments
6. Complete any outlying medical work up
7. Patient/Family Informing meeting:
   - Provider meeting to formulate diagnosis
   - Family meeting, with patient if possible, to present diagnosis and treatment plan
   - Involvement of PCP in the meeting if possible
8. Initiation of treatment within hospital setting while working on clear discharge plan with behavioral and medical /PCP support/involvement during admission and upon discharge

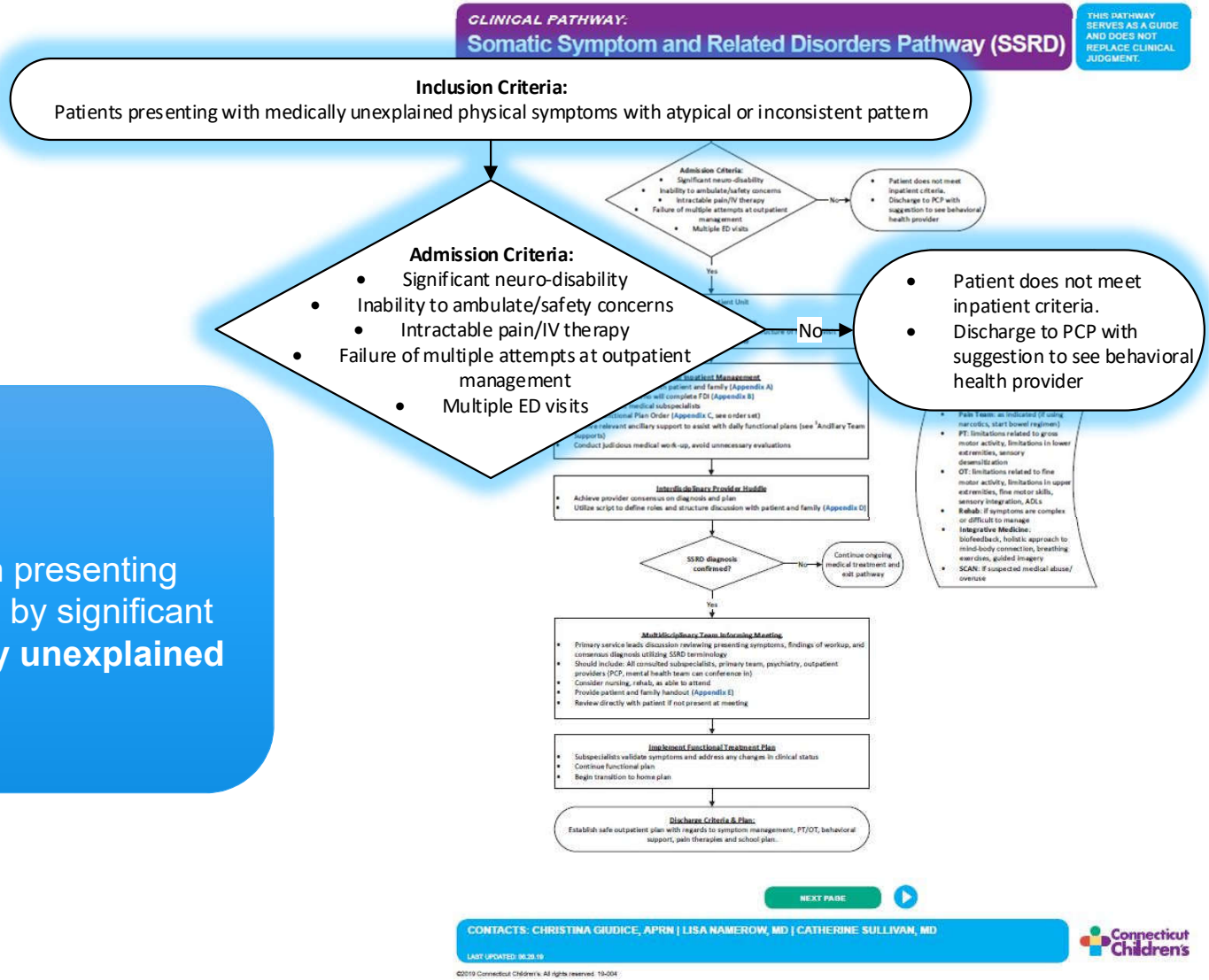
This is the Somatic Symptom and Related Disorder (SSRD) pathway.

We will discuss the key components in this module.



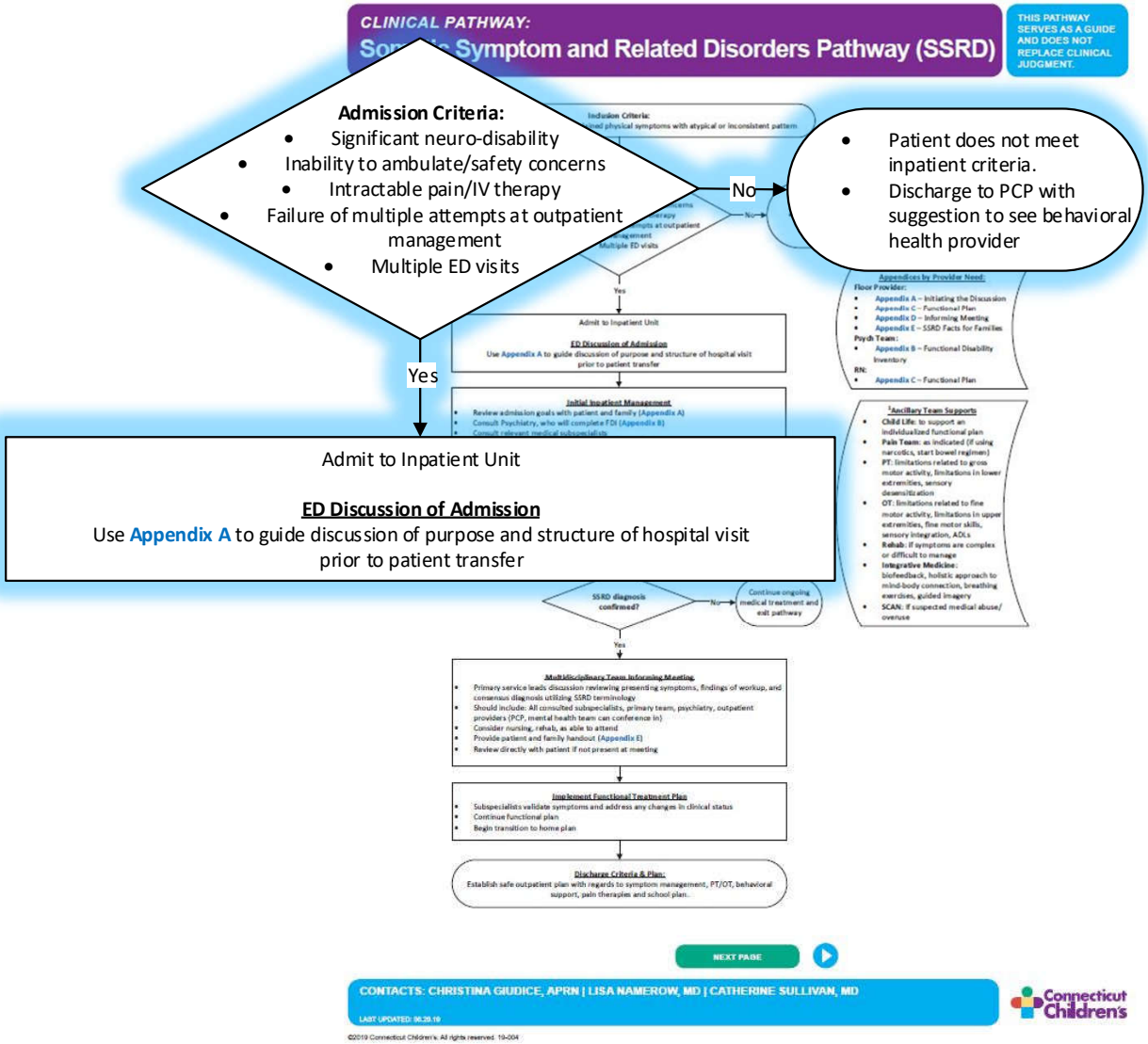
Inclusion Criteria:

When suspecting SSRD, common presenting symptoms are often accompanied by significant functional disability with **medically unexplained patterns**.



Patient may meet admission criteria due to severity of symptoms, failure of outpatient management or a combination of reasons

If they do not meet admission criteria, good communication with the pediatricians office to involve outpatient subspecialties is imperative.

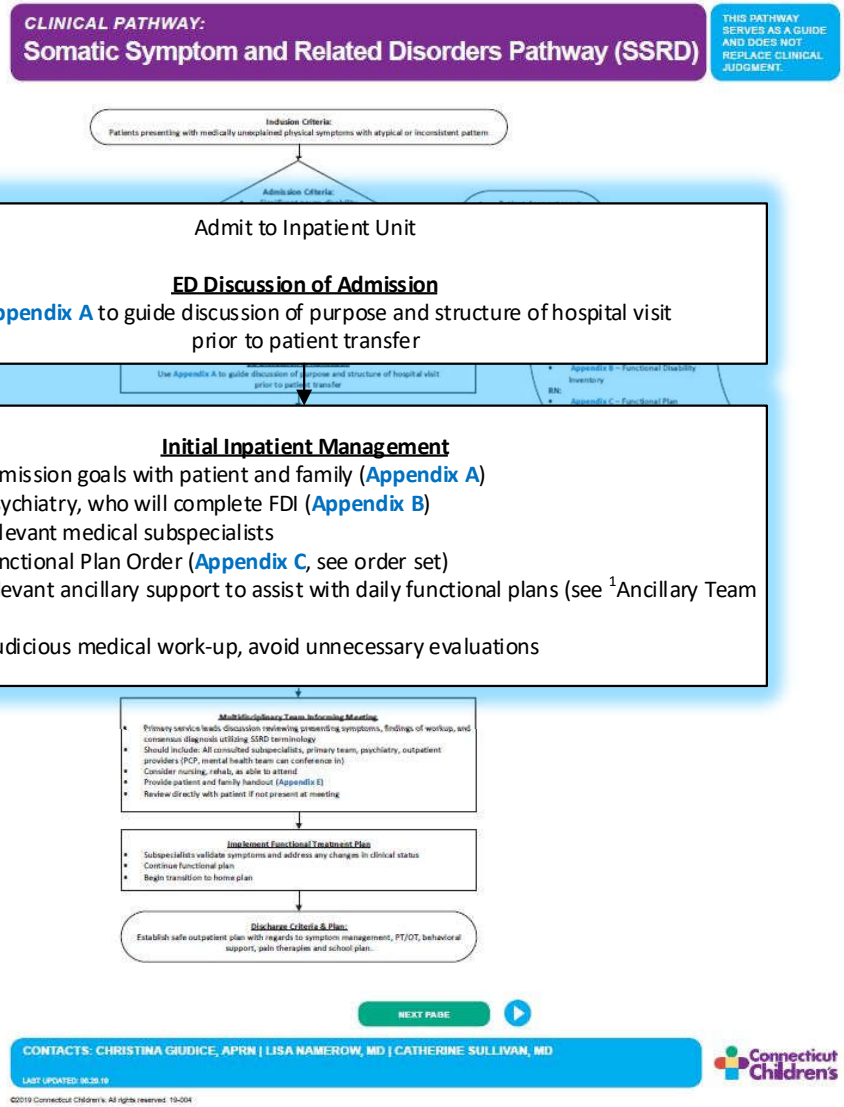


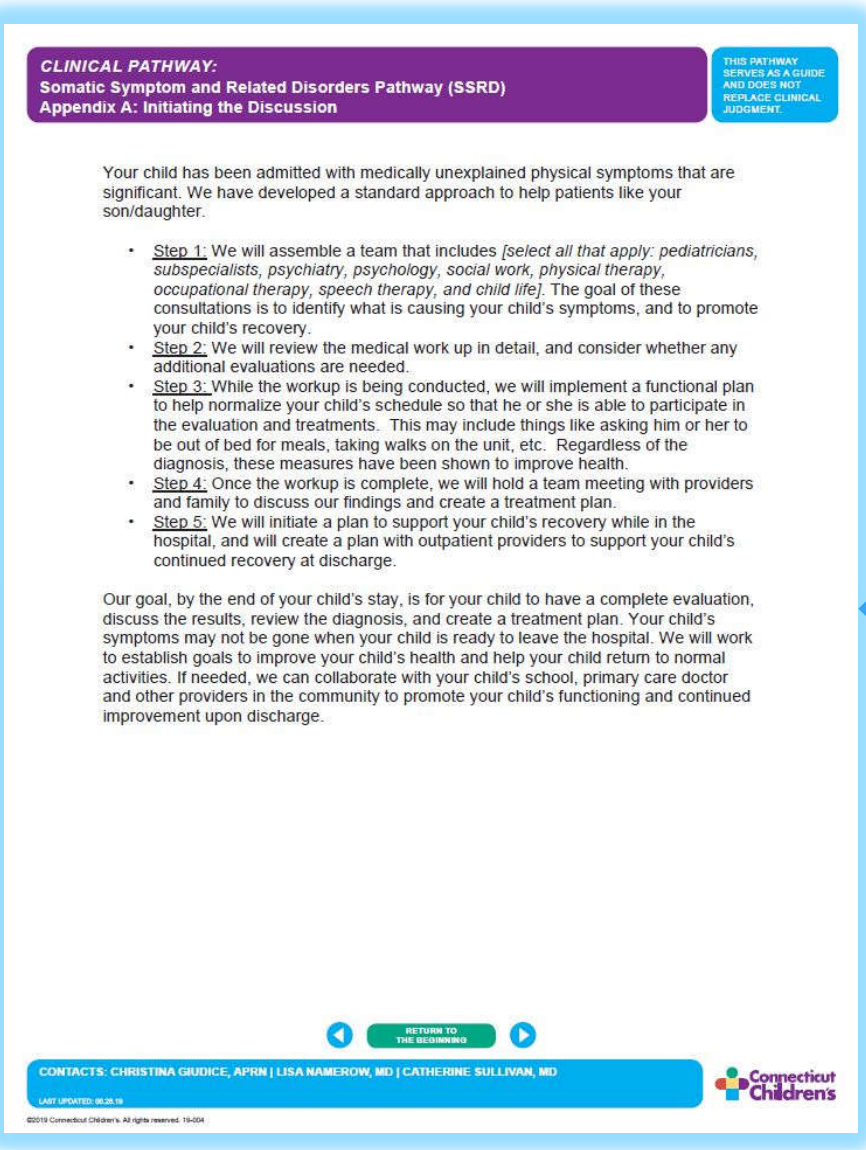
Initial Management:

Early communication is imperative:

- Patients and families should be made aware that the goal of the admission is to clarify what is causing these symptoms.
- Developing an open relationship with the family early on may help prevent discord and misunderstandings down the road.

See Appendix A on the following slide.





CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)
Appendix A: Initiating the Discussion

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Your child has been admitted with medically unexplained physical symptoms that are significant. We have developed a standard approach to help patients like your son/daughter.

- Step 1: We will assemble a team that includes *[select all that apply: pediatricians, subspecialists, psychiatry, psychology, social work, physical therapy, occupational therapy, speech therapy, and child life]*. The goal of these consultations is to identify what is causing your child's symptoms, and to promote your child's recovery.
- Step 2: We will review the medical work up in detail, and consider whether any additional evaluations are needed.
- Step 3: While the workup is being conducted, we will implement a functional plan to help normalize your child's schedule so that he or she is able to participate in the evaluation and treatments. This may include things like asking him or her to be out of bed for meals, taking walks on the unit, etc. Regardless of the diagnosis, these measures have been shown to improve health.
- Step 4: Once the workup is complete, we will hold a team meeting with providers and family to discuss our findings and create a treatment plan.
- Step 5: We will initiate a plan to support your child's recovery while in the hospital, and will create a plan with outpatient providers to support your child's continued recovery at discharge.

Our goal, by the end of your child's stay, is for your child to have a complete evaluation, discuss the results, review the diagnosis, and create a treatment plan. Your child's symptoms may not be gone when your child is ready to leave the hospital. We will work to establish goals to improve your child's health and help your child return to normal activities. If needed, we can collaborate with your child's school, primary care doctor and other providers in the community to promote your child's functioning and continued improvement upon discharge.

RETURN TO THE BEGINNING

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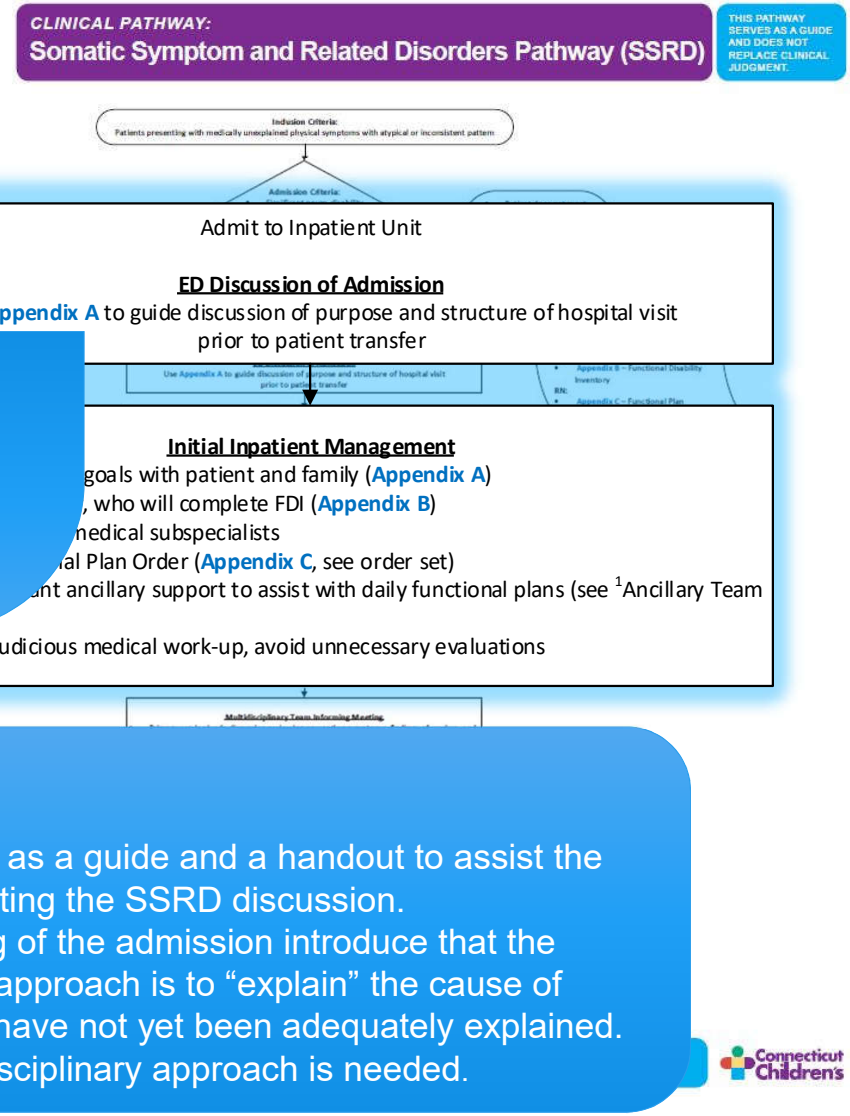

CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

Admit to Inpatient Unit

ED Discussion of Admission

Use **Appendix A** to guide discussion of purpose and structure of hospital visit prior to patient transfer

Initial Inpatient Management

- Review a goals with patient and family (**Appendix A**)
- Consult P , who will complete FDI (**Appendix B**)
- Consul medical subspecialists
- al Plan Order (**Appendix C**, see order set)
- nt ancillary support to assist with daily functional plans (see [1]Ancillary Team
- Conduct judicious medical work-up, avoid unnecessary evaluations

Appendix A:

- Should be used as a guide and a handout to assist the provider in initiating the SSRD discussion.
- At the beginning of the admission introduce that the purpose of this approach is to "explain" the cause of symptoms that have not yet been adequately explained. Thus, an interdisciplinary approach is needed.

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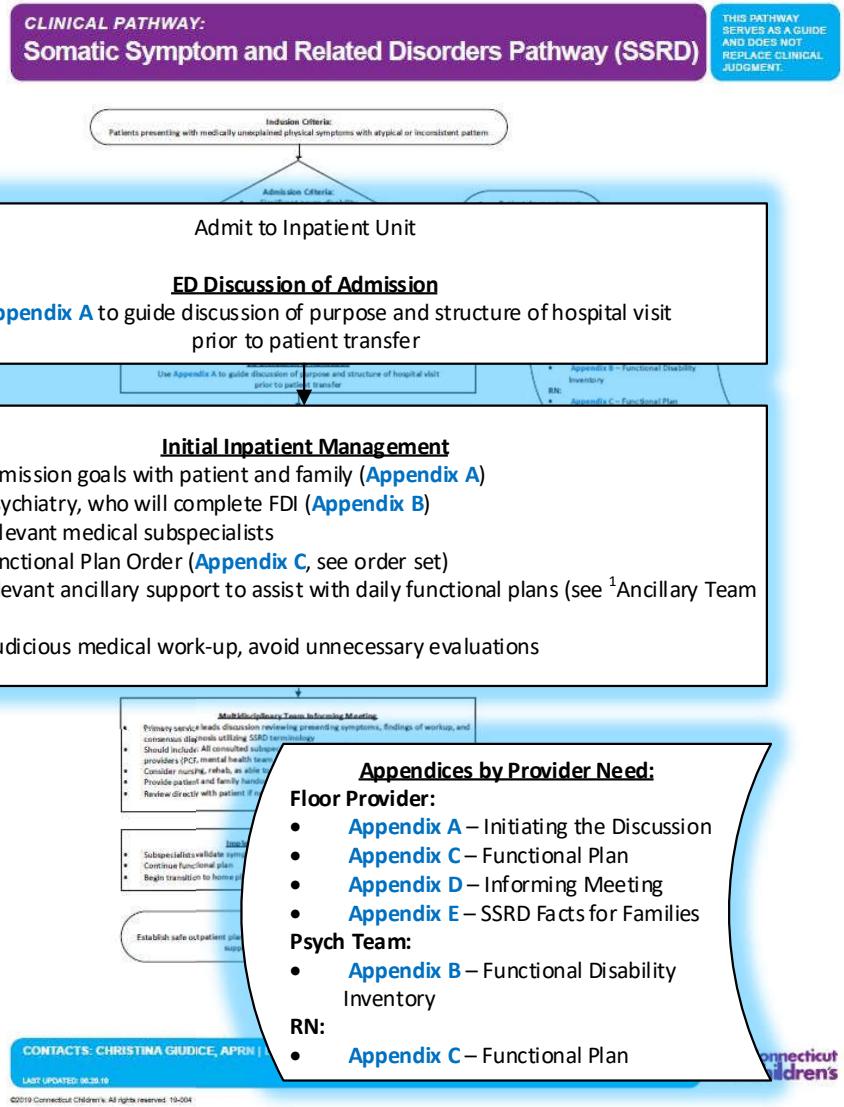
Initial Management:

Several tools are used to help guide care during admission: (See slides below for appendices)

- Functional Disability Inventory (FDI) (Appendix B)
- Individualized Functional Plan (Appendix C)
- Guide for the Informing meeting (Appendix D)
- SSRD Facts for Families (Appendix E)



CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)
Appendix B: Functional Disability Inventory

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

ID_____ Date_____

Functional Disability Inventory

Parent Form

When people are sick or not feeling well it is sometimes difficult for them to do their regular activities. In the past two weeks, would your child have had any physical trouble or difficulty doing these activities?

	No Trouble	A Little Trouble	Some Trouble	A Lot of Trouble	Impossible
1. Walking to the bathroom.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. Walking up stairs.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. Doing something with a friend. (For example, playing a game.)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. Doing chores at home.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. Eating regular meals.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. Being up all day without a nap or rest.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. Riding the school bus or traveling in the car.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Remember, you are being asked about difficulty due to physical health.

	No Trouble	A Little Trouble	Some Trouble	A Lot of Trouble	Impossible
8. Being at school all day.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. Doing the activities in gym class (or playing sports).	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. Reading or doing homework.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. Watching TV.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. Walking the length of a football field.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. Running the length of a football field.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14. Going shopping.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15. Getting to sleep at night and staying asleep.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

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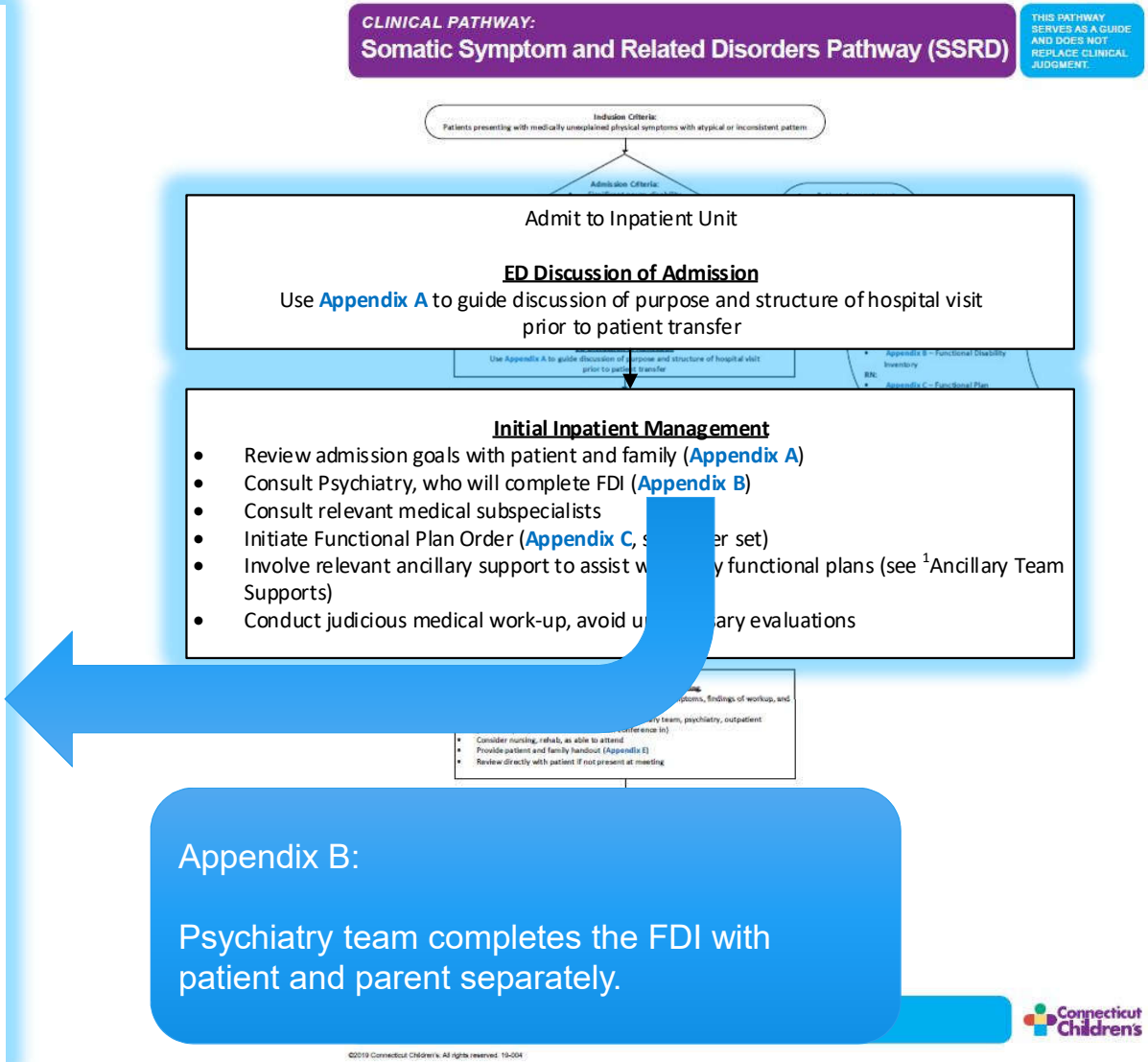

Appendix B:

Psychiatry team completes the FDI with patient and parent separately.

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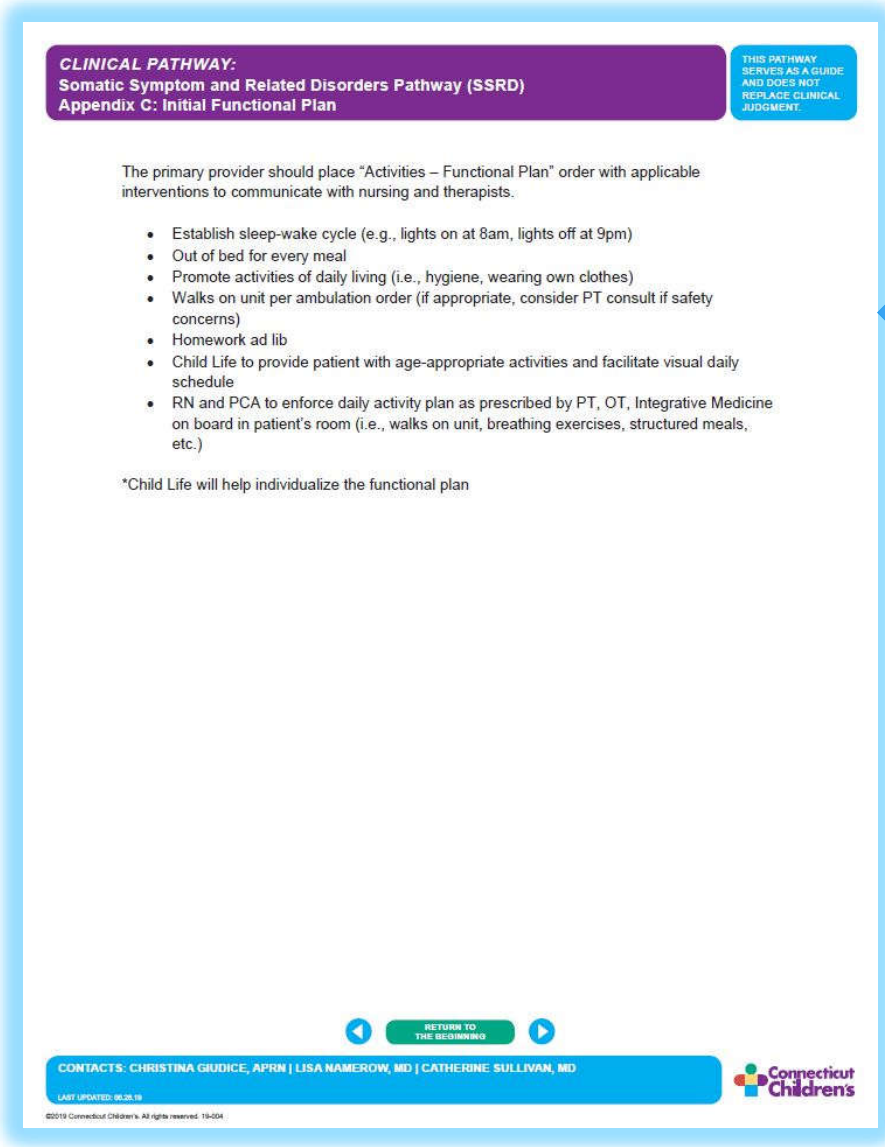


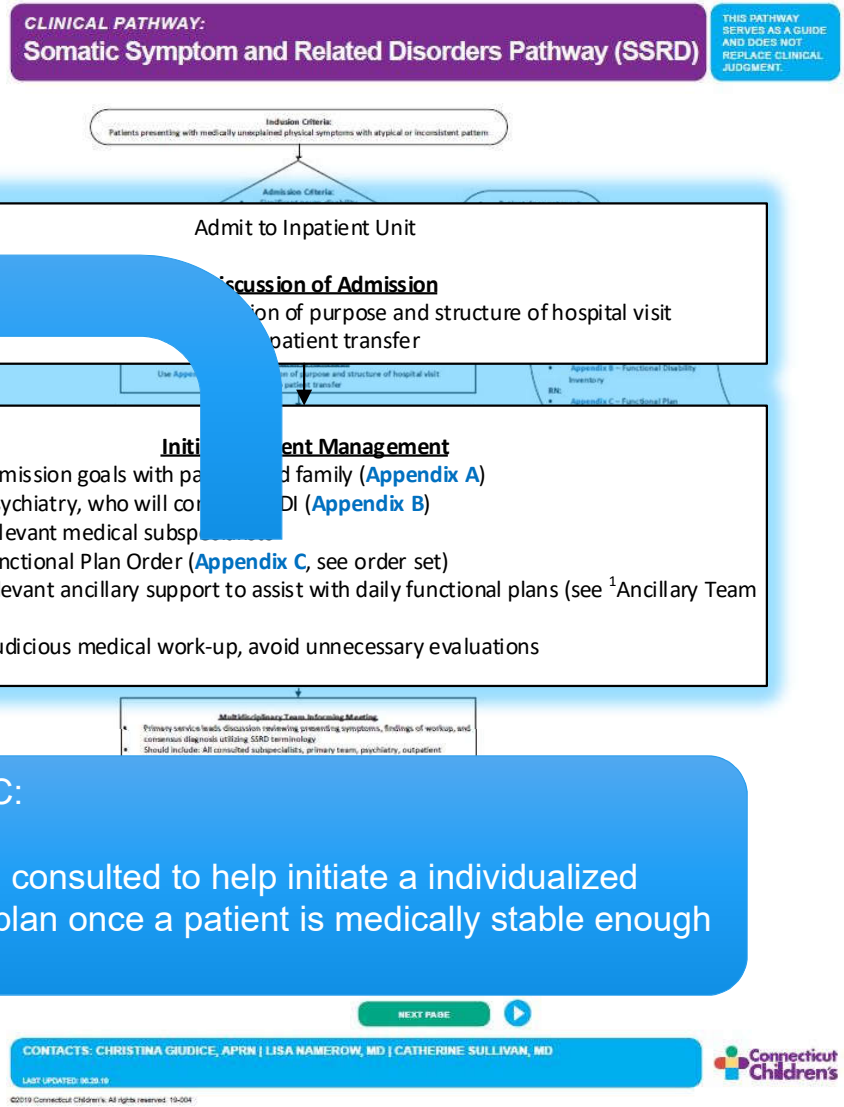
CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)
Appendix C: Initial Functional Plan

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

The primary provider should place "Activities – Functional Plan" order with applicable interventions to communicate with nursing and therapists.

- Establish sleep-wake cycle (e.g., lights on at 8am, lights off at 9pm)
- Out of bed for every meal
- Promote activities of daily living (i.e., hygiene, wearing own clothes)
- Walks on unit per ambulation order (if appropriate, consider PT consult if safety concerns)
- Homework ad lib
- Child Life to provide patient with age-appropriate activities and facilitate visual daily schedule
- RN and PCA to enforce daily activity plan as prescribed by PT, OT, Integrative Medicine on board in patient's room (i.e., walks on unit, breathing exercises, structured meals, etc.)

*Child Life will help individualize the functional plan



CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)

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Admit to Inpatient Unit

Discussion of Admission
- Discussion of purpose and structure of hospital visit
- Discuss patient transfer

Initial Management
- Review admission goals with patient and family (**Appendix A**)
- Consult Psychiatry, who will complete MDI (**Appendix B**)
- Consult relevant medical subspecialists
- Initiate Functional Plan Order (**Appendix C**, see order set)
- Involve relevant ancillary support to assist with daily functional plans (see [1]Ancillary Team Supports)
- Conduct judicious medical work-up, avoid unnecessary evaluations

Multidisciplinary Team Informing Meeting
- Primary service leads discussion reviewing presenting symptoms, findings of workup, and consensus diagnosis utilizing SSRD terminology
- Should include: All consulted subspecialists, primary team, psychiatry, outpatient

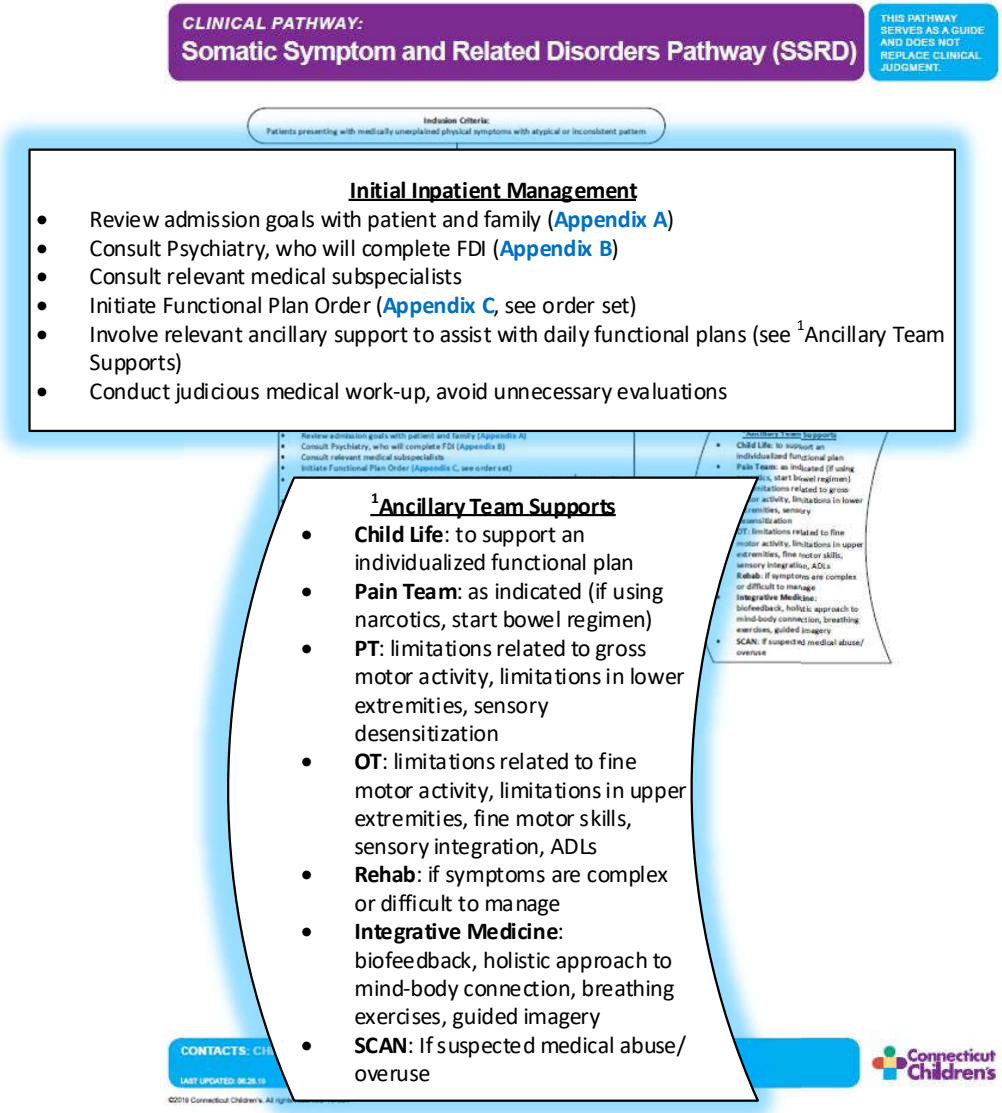
Appendix C:

Child life is consulted to help initiate a individualized functional plan once a patient is medically stable enough to do so.

Ongoing Medical Work-Up:

- Medical work up is dependent upon the chief complaint
  - As appropriate specialty consults can include: gastroenterology, neurology, rheumatology, cardiology, endocrinology, etc.

Medical work up occurs concurrently with early introduction Psychiatry and Child Life, as well as, Pain Team, PT/OT, and SCAN teams as indicated



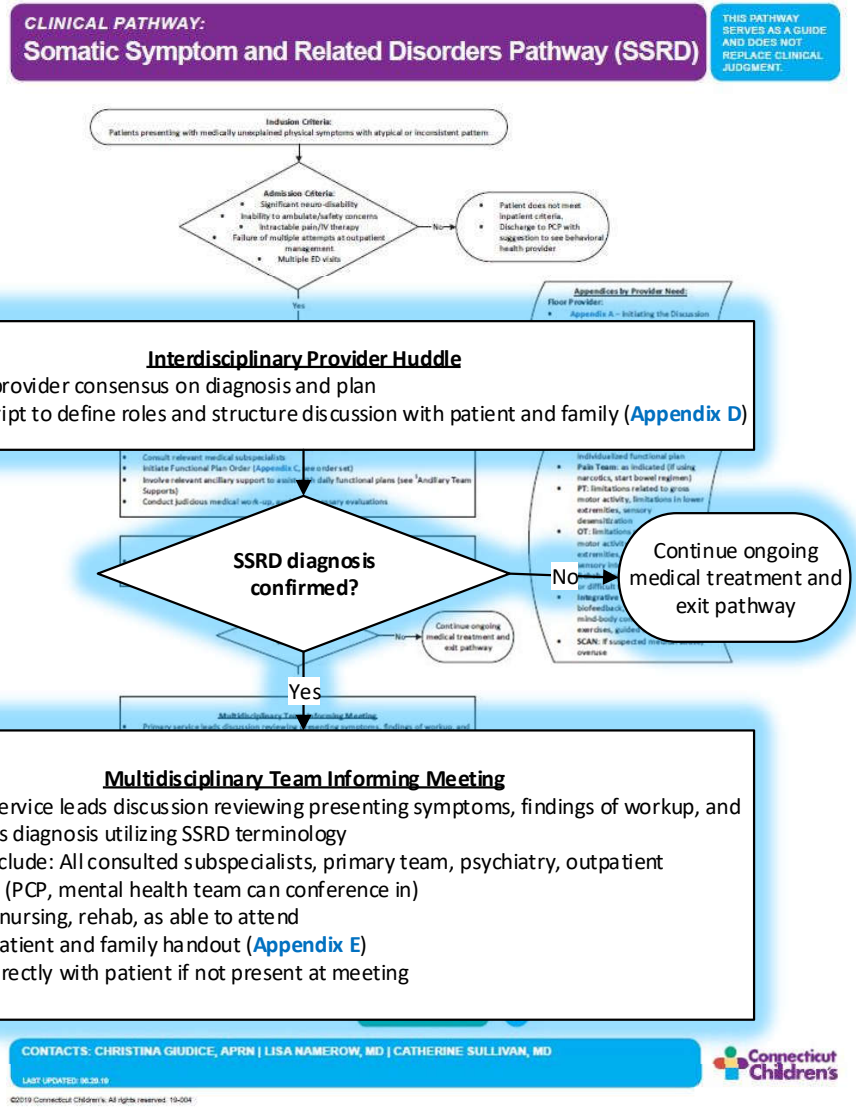
Next Steps:

Communication amongst team members and with family is imperative:

- Multidisciplinary team informing meeting should be used to establish understanding of the condition, treatment goals, and plan going forward

➡ See Appendix D on the following slide

➡ Any subspecialists that have been involved should continue to follow the patient throughout the admission, even if a medical diagnosis has been ruled out.



CLINICAL PATHWAY:
Somatic Symptom and Related Disorders Pathway (SSRD)
Appendix D: Script for the Informing Meeting

THIS PATHWAY SERVES AS A GUIDE AND DOES NOT REPLACE CLINICAL JUDGMENT.

It is key to have representation from every subspecialty participate in the informing meeting, including primary team, psychiatry, and each subspecialty service that was consulted on the case or saw the patient as an outpatient in the context of the patient's presenting symptoms. It is helpful to review or bring records of completed and pending diagnostic studies completed inpatient/outpatient/outside facilities, including lab studies and imaging.

As we said at the beginning of your son/daughter's admission, after all of the specialists have consulted and completed your child's medical workup, we come together as a multidisciplinary team to discuss what we have found to be contributing to your child's symptoms, and what the evidence-based treatment is for the condition. We want to give you a chance to ask questions and to be sure that you feel comfortable about our assessment and treatment plan.

We want to share with you a summary of your child's symptoms, why we consulted with these specialists, what diagnoses we were considering, and what our findings did or did not support. Please tell us along the way if we have any part of the history wrong, or if there is anything you do not understand. And please let us know if there is any particular medical condition or diagnosis that you feel we have not adequately addressed.

Primary Team review:

Your child first presented with: ___
Prior work-up included: ___

Each subspecialist review:

The differential diagnoses that are consistent with your child's symptoms include: ___
The workup that we performed included ____, and revealed ___.
Therefore, the following diagnoses were ruled in/out: ___

Given these findings and with the input from our specialists, we think your child's symptoms are best understood as___*:

In our experience, symptoms due to___ respond best to the following treatment approach: *(specify as applicable)*

- Cognitive behavioral therapy
- Medication management: ___
- Behavioral management: ___
- Outpatient support (PT, OT, Integrative Medicine, Psychiatry)
- Close follow up with your pediatrician to continue following your symptoms
- Continued follow up with relevant subspecialists

*If a psychosomatic or somatic symptom disorder is being considered, the attending leading the meeting should use the actual term (i.e., conversion rather than "stress") and ask Psychiatry to give a formulation of potential contributors.

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Somatic Symptom and Related Disorders Pathway (SSRD)

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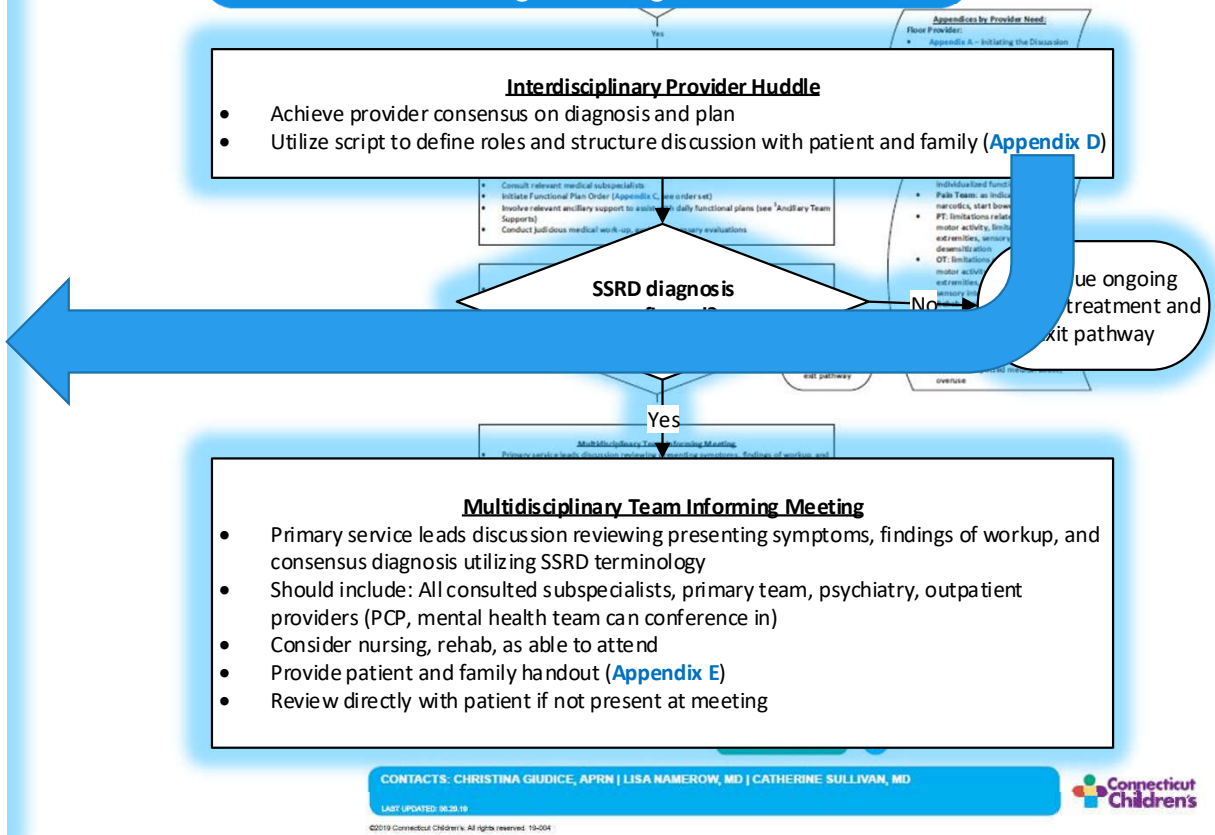
Appendix D:

Provides a script for the lead provider to help focus this informing meeting.



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Physical Symptoms of Emotional Distress: Somatic Symptoms and Related Disorders

Adapted from the American Academy of Child and Adolescent Psychiatry

What are Somatic Symptoms?
Physical complaints are common in children. As many as 1 in 10 children will complain of an ache, pain, or worry about their body on any given day. Sometimes when there is no medical illness that fully explains the complaint, it may be that emotions are being felt as physical symptoms. Physical symptoms of emotional distress are called **somatic symptoms**. **Somatization** is the name used when emotional distress is expressed by physical symptoms. Everyone experiences somatization at times. Examples include your heart beating fast or butterflies in your stomach when you feel nervous or muscles becoming tense and sore when you feel angry or under stress. These symptoms are very real to your child; they are not "faking it."

What are Somatic Symptoms and Related Disorders?
A Somatic Symptom and Related Disorder (SSRD) is diagnosed when your child has physical symptoms that are not explained by a medical illness or when symptoms of a known illness affect your child much more than expected and these symptoms interfere with daily life such as missing school, not wanting to play with friends, or avoiding fun activities.

SSRD Symptoms may include:

- body pains including headaches, joint pains
- stomach aches, nausea, vomiting
- fatigue, dizziness, memory problems
- weakness, numbness
- trouble breathing, shortness of breath
- changes in vision or hearing including sudden blindness
- a "stuck" feeling or a "lump" in the throat
- seizure-like episodes, fainting, abnormal movements

There are different types of SSRDs. Your child may be diagnosed with: Psychological Factors Affecting a Medical Condition, Somatic Symptom Disorder, or Conversion Disorder (Functional Neurological Symptom Disorder). Terms like "functional," "nonorganic," "psychogenic," "psychosomatic," "pseudo seizures," "amplified," and "medically unexplained" are also sometimes used.

Why does my child have an SSRD?
A child may have an SSRD for many reasons. Sometimes it starts with an illness, injury, or infection, but the symptoms do not go away after the illness has been treated. Other times somatic symptoms start without any prior illness or injury. Somatic symptoms may also be strong feelings or struggles that a child has not been able to share in words.

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Appendix E:

Is a 3 page handout for the family that provides information on SSRD

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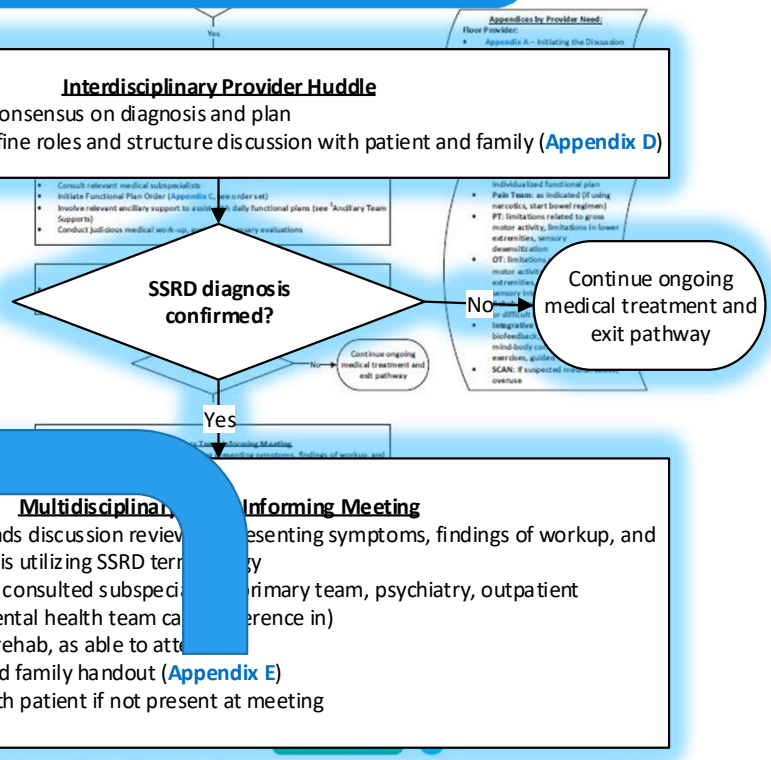

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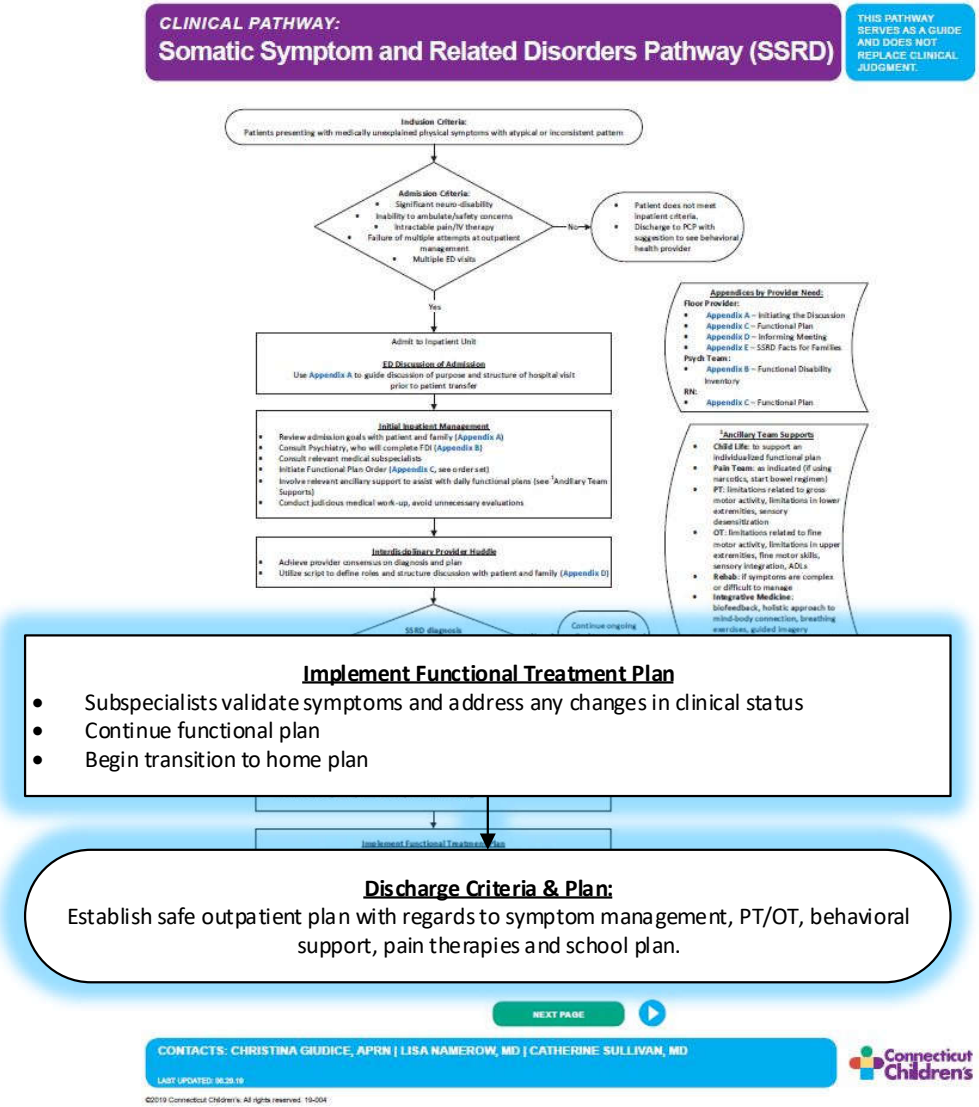
Discharge Criteria & Plan:

Communication and subspecialist involvement continues after the informing meeting.

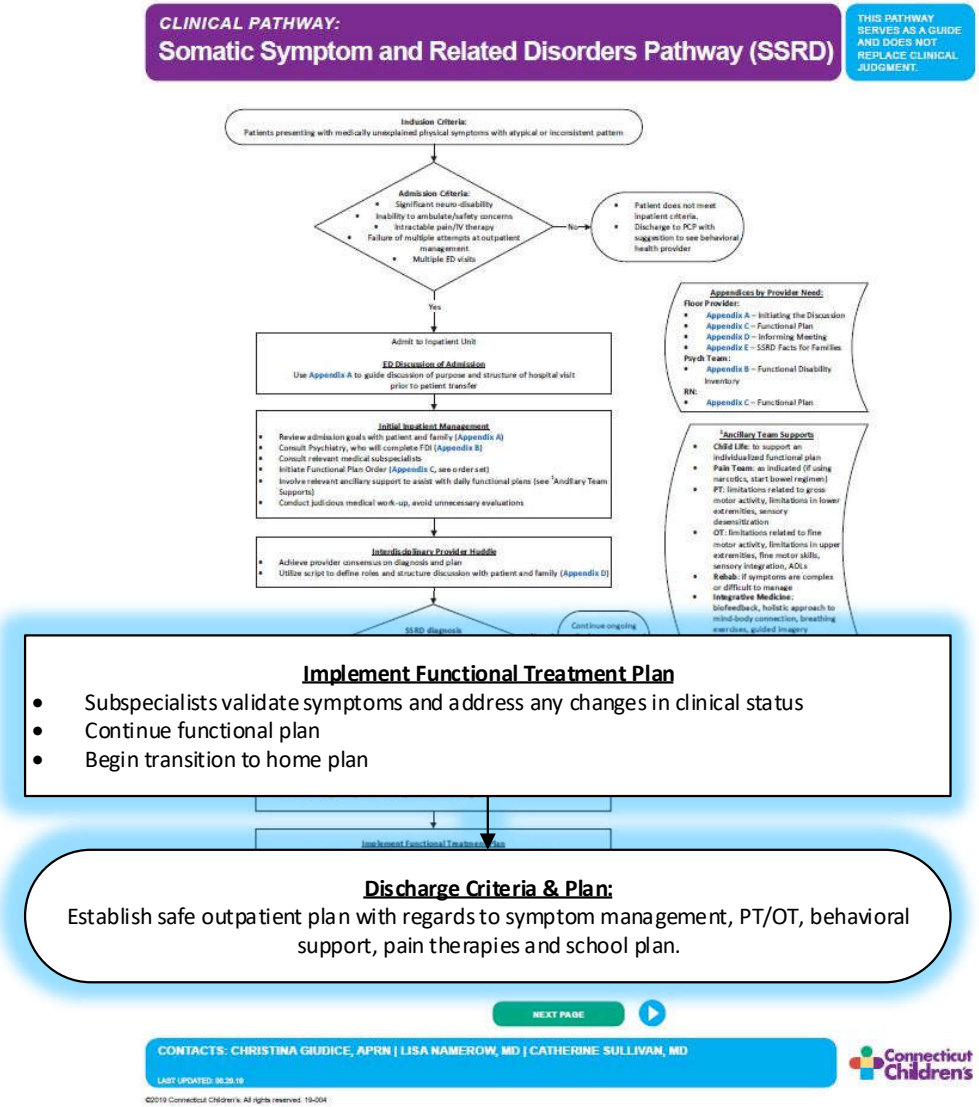
Plan shifts from medical work up to improving function and beginning the transition to home.



Discharge Criteria & Plan:

A safe outpatient plan should be established with input from all providers with regards to:

- symptom management
- PT/OT referrals
- behavioral support
- pain therapies
- and a school plan



Nursing Key Points

1. Nursing will be responsible for printing the SSRD pathway and placing appendix B and E in the thin chart for the appropriate services.
2. Review appendix A and E – it includes the language and the approach we will use. Understand that the hospital setting may worsen the symptoms for some patients
3. Facilitate a daily functional plan/schedule early in the hospital stay by:
   a. Encouraging ADLs
   b. Supporting ambulation
   c. OOB to chair for meals
   d. Sleep wake cycle with lights and meals
   e. Child Life involvement to assist, if needed
4. Psychiatry will administer the Functional Disability Index (appendix B) within 12 hours of admission
5. Participate in the Informing meeting with the family
6. Support ongoing behavior and functional recovery plan

Review of Key Points

- Combined Medical/Psychiatric/Rehabilitation Approach
  - Introduce this concept early to family and demystify process
- Symptom specific specialty consults
- Informing Meeting to increase family understanding of contributors to the physical symptoms and to promote family “buy in”
- More structured functional recovery plan soon after admission
- Improve discharge planning – support and plans to avoid readmission

Quality Metrics

- Percentage of patients with use of the SSRD order set
- Percentage of patients with documentation of informing meeting
  - Percentage of meetings led by primary service
  - Percentage of meetings where SSRD diagnosis is shared
  - Percentage of meetings where treatment plan is reviewed
  - Percentage of meetings where clarification of information is documented
  - Percentage of meetings where patient is present
  - Percentage of meetings where contact with patient's PCP is documented
- Average length of stay (days)
- Average time from admission to informing meeting (hours)
- Average time from informing meeting to discharge (hours)
- Number of readmissions within 30 days

Contact information

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  - Division of Child Psychiatry
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References

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Thank You!

About Connecticut Children's Clinical Pathways Program

Clinical pathways guide the management of patients to optimize consistent use of evidence-based practice. Clinical pathways have been shown to improve guideline adherence and quality outcomes, while decreasing length of stay and cost. Here at Connecticut Children's, our Clinical Pathways Program aims to deliver evidence-based, high value care to the greatest number of children in a diversity of patient settings. These pathways serve as a guide for providers and do not replace clinical judgment

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