

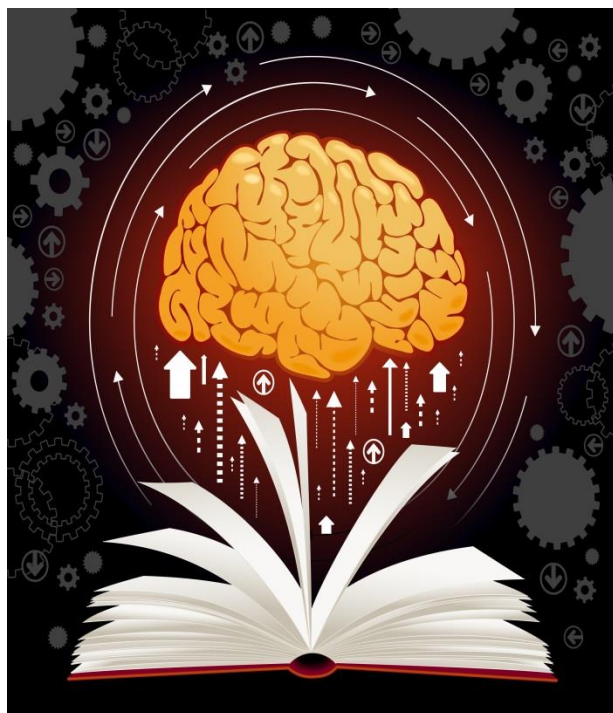


DPC

Psychiatry

Residents Journal

JAN, 2016



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Interview with Dr. Binder (President of APA)

Q: Personally, what made you choose psychiatry as a career? Did you think about any other specialties?

I chose psychiatry as a profession because when I was in medical school, I saw it as a specialty where doctors need to spend time with patients to know them and develop a physician-patient relationship. It is required to help patients through difficult times in their life. I think it is very rewarding.

I probably would have chosen internal medicine and one of its subspecialties. I liked medicine very much, and I also saw that people were coming with a problem and a physician needs to understand their differential and deal with chronic medical problems. In medicine, we also need to help patients through the various crises they encounter.

What is a good definition of mental illness?

The DSM-V definition is pretty good. I know that DSM-V committee struggled to define mental illness whether it should be the same as other DSMs. The definition is clinically significant disturbances in cognition, emotional regulation, and behavior.

Q: What are the most significant changes in the DSM-V?

One of the changes it will be easier to update it. There is a committee headed by Dr. Paul Applebaum that came up with a list of principles about when and if to make changes in DSM. Without looking at any particular diagnosis, we need to think about the principles that need to be accomplished to add any new diagnosis. It created a balance between a document that does not change very quickly because we all learn it and we all use it, on the other hand, there are constant research and new findings in the field to have a document that is flexible creating a mechanism to help changes as they arise in the field.

What is the position of the APA on the shortage of psychiatrist? Does the APA support increase funding of residency programs?

APA supports increase funding and GME slots. There as you mentioned a shortage of psychiatrist. It is very shortsighted to decrease the number of residency spots. In fact, we need to increase residency spots and GME funding. We are partnering with AMA and the AAMC to lobby to increase GME funding.

Q: Does the APA support prescription privileges to other healthcare providers?

Physician assistants and NP have significant medical training. Their training is not extensive to obtain a medical degree, but they do have a role in the delivery of health care services. They are part of the healthcare team with physicians. The physician is the leader of the team; we need to rely on other healthcare practitioners to deliver the services.

Physicians and NP are most helpful when they recognize their skills and limitations. In California where I live, an NP is often present in a pediatrician office. In a case of immunization or the mild cold, the NP can do fine, however if there is a more complicated medical problem the NP will bring the Pediatrician immediately. They need to know what they are qualified to do. That is very different than a psychologist; they have no medical training. They are not trained to prescribe medications

What is the APA position on gun regulation?

Gun Regulation we have a resource document on gun violence. It can be found on the APA website; there is a section of our position statements and resource materials. You can research under guns and understand the position of the APA.

The documents talk about suicide and gun possession. It is imperative when people are in times of crisis due to psychiatric disorders or other factors as DUI or legal issues, guns should be temporarily removed from people who are very angry or upset so that they don't have access to guns during those periods.

The gun ownership can be restored after going to the court and making an argument that they are much calmer and keep guns.

Q: Psychiatrist believed there are several stigmas in society against them, including lack of respect from other specialties. Is that still the case?

In my medical school, we have a significant portion of the medical students who choose psychiatry, and that shows a lack of stigma against psychiatry. My medical colleagues respect my expertise and rely on my work. They always call a psychiatrist and ask for help. I don't see the stigma against psychiatrist.

In society, we know there are cartoons about the psychiatrist and the APA have been effective trying to de-stigmatize for all our patients and ourselves. We are attempting to make society understand the role of psychiatrist and it is an ongoing process. There is still a stigma against patients, and part of that is against psychiatrists who treat these patients.

Q: Where does the APA stand on psychiatrist safety?

First of all residents and medical students need to educate not to put a home address. Medical licenses are public information, so we instruct our residents to use a work address. It is critical to avoid having your home address on NPI or medical licenses. We are certain things that can be done to keep ourselves safer. This is imperative to instruct medical students and residents to avoid putting certain information on the internet. We talk to students to avoid uploading certain things on Facebook. College students usually don't think about these issues, and when you start treating patients, we should be more careful. We teach our residents where they should sit in the room and are aware of cues of violence. It is critical to talk to supervisors if residents have a concern.

Q: APA has recently re-designed its logo to reflect psychiatry as a brain science and branch/specialty of medicine. What was the reason?

Logo said medical leadership for the mind, brain, and body. We are physicians for a specialty that includes mind, brain, and body. There is no healthcare without mental health care. It is imperative for all healthcare professionals to acknowledge and pay attention to mental health needs of your patients. That is good medical care. When we tell a patient, they have MI we need to pay attention if they are anxious. This is critical to encourage patients to follow up.

Q: Will the ABPN support the creation of new sub-specialties as neuropsychiatry?

I have not heard any recent efforts to increase the number of sub-specialties. The accreditation of new subspecialties goes through the ABPN in conjunction with the ACGME. There are certain criteria for accrediting new subspecialties. This does not include only psychiatry but most fields.

For example, you had to show there are journals, treatments for a specified patient population and continue funding to train new fellows.

For example the fellowship of forensics, it used to be the forensic psychiatrist helps with the consultation in the medico-legal aspect but now it is defined as treating the correctional population as well.

Q: Are there any guidelines for telepsychiatry from the APA, and is the APA working on any initiative for telepsychiatry practice?

We believe at the APA that telepsychiatry will be very prominent in the future. It is considered a way of treating people who are unable to come to a psychiatrist office. It was initially promoted as a way of treating people in rural areas where there are not a lot of psychiatrists, now it is even expanding to include big cities. It can help the disabled or a young mother with children. It will make it easier to get help. We have put together a work group of experts in the field of telepsychiatry, they are developing teaching tools and presenting information at the APA annual meeting in Atlanta. This is an ongoing initiative, and it is also used now in integrated settings.

Q: We have covered a broad scope of various topics and issues facing psychiatry. Is there anything else you would like to add at this time?

A: No, I think you have covered most of the important topics and questions.

DPC's Evolving Utilization Review Program – An Update:

By Mari Fischer

Committee Chair:

Dr. Nathan Centers

Utilization Review Committee Members:

Mari Fischer, RN MS, CPHQ, ADON

Carolyn Allen MSW, RN

Lisa Kordowski, MA, LCC, NPC

Nancy Mirkovic, LPN

Preparing for a future that includes justification for inpatient stays is on the agenda for DPC's new Utilization Review Committee. In today's uncertain healthcare economic climate it is more important than ever that resource allocation be done with prudence, efficiency and based on necessity. DPC's inpatient beds are a particularly scarce and valuable resource and we are committed to ensuring that the use of this precious resource is reserved for those that may benefit most. To do this, we are aligning ourselves with industry standard guidelines, namely CMS and Joint Commission criteria, as we develop our program. The prospect of being required to perform concurrent reviews with the MCOs that manage our Medicaid population is on the horizon.

We have adopted same fundamental utilization review policy for inpatient stay justification as DSAMH. This is the same criteria set used by both the IMDs and the EEU. You can find this policy on the F Drive under DPC Utilization Review Folder.

Perhaps the most significant aspect of this program's implementation to this point is noted in the definition of psychiatric stability. For our purposes, psychiatric stability is the pivotal point at which a client is no longer in need of acute inpatient services. Doctor Nathan Centers, the UR Committee Chair, would like our psychiatrists and residents to ask themselves the following question when determining psychiatric stability: "Is the patient acutely dangerous to self or others based on a mental illness? If not, why hasn't a 48 hour note been written?" This notion is particularly important in light of DPC CEO, Greg Valentine's recent announcement that moving forward, 48 hour notes will be issued across the board amongst all levels of care. This is a

decision the DSAMH administrative team put into play earlier this week. It is the committee's intent to use industry benchmarks for common diagnosis as a gauge to measure against DPC's Lengths of Stay. To begin, we will be looking at clients whose LOS is greater than 14 days but we will move toward matching psychiatric diagnosis with industry average LOS for that specific diagnosis. We will be identifying outliers and will perform in depth case reviews as warranted.

You may have noticed that some new discharge focused audits are being done by Lisa Kordowski and Nancy Mirkovic. These audits are picking up psychiatric stability dates, behaviors/symptoms, medication changes and diagnosis as well as items that relate to a client's readiness for discharge. In addition, Lisa and Nancy will be routinely meeting with psychiatrists and residents to obtain weekly updates. This information is then compiled and used during the UR Committee meeting held on Thursday mornings. Cases will be reviewed by Dr. Centers and the UR Committee; recommendations will be sent back to teams as action items. We are trying to use the information we gather not only as a means to monitor resource use, but also to support our clinical staff so that optimal client outcomes can be obtained. Eventually, we will extend our scope to include looking at appropriateness of admissions and ensuring optimal use of professional services within the hospital.

The involvement of the immune system and psychiatric diseases- Part 1

Sehba Hussain-Krautter, MD

The biological basis of psychiatric disorders such as schizophrenia and bipolar disorder is complex and reflects dysfunction in various biological systems that are closely interlinked such as gene expression, cellular pathways, neurotransmitter system, and immune regulation. The involvement of some facets of the immune system in the mechanisms that underlie psychiatric disorders is inevitable as the immune system is an integral part of the biological network. The aim of this short review series is to delineate the involvement of the immune system via published research studies and peer-reviewed scientific articles.

It is well recognized that in schizophrenia N-methyl-D-aspartate receptors (NMDAR) are involved since antagonists to these receptors lead to the induction of psychotic symptoms [1] and studies have indicated that in acutely ill patients with an initial diagnosis of schizophrenia there is an increase prevalence of NMDA-R antibodies [2]. Another well-documented example of involvement of autoantibodies in psychiatric illness is the presence of anti-DNA antibodies that cross blood-brain barrier in the neuropsychiatric manifestations of systemic lupus erythematosus. B cells, which are part of the immune cell repertoire make these antibodies and are proof of direct involvement of the immune system in these conditions.

Other aspects of the immune system such as pro-inflammatory cytokines have also been shown to be involved as well. Studies have shown increased levels of IL-1, sIL-2R, IL-6, TNF- α -2, CRP and low IL-4 in different phases of bipolar disease and schizophrenia. Moreover, this profile is only partially ameliorated by medication [3]. Majority of studies comparing cytokines across different mood states are comprised of cross sectional studies. The few longitudinal studies available are of short duration, and only evaluate changes from mania to euthymia. Evaluating the relationship between the natural course of the illness (changes in mood state) and potential changes in cytokine levels might help to address the role of these changes in the etiology of diseases such as bipolar disorder [4].

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Joint Commission Documentation standards

Abdelrahman Abdelaziz M.D.

Documentation should be precise, accurate and complete (and yes, timed/dated), the new healthcare system puts a lot of weight on documentation for either quality or reimbursement purposes. We all heard this before **“If it’s not documented in the medical record then it didn’t happen.”** How many times have plaintiff’s counsel used this in the court room. Today we are listing the **“Do not Use” abbreviations recommended by JCAHO**

Official “Do Not Use” List¹

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO ₄ and MgSO ₄	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Reference:

Facts about the Official “Do Not Use” List of Abbreviations:

http://www.jointcommission.org/facts_about_do_not_use_list

Rhetorical Analysis of Unrecognized physical illness prompting psychiatric admission

Lee Berman, M.D.

DO and PhD, Roy R. Reeves, et al, in their research article, “Unrecognized physical illness prompting psychiatric admission”, analyze the causes that might contribute the misdiagnoses of patients with psychiatry like symptoms with mental illness. Reeves’, et al, research purpose is to “assess the factors that contribute to clinicians’ erroneously attributing alteration of mental status to psychiatric illness when the patient has an actual medical disorder.”(181) It seems that the intended audience for this paper is medical professionals as well as those in medical administration that make decisions on patient care and how to improve outcomes. The researchers in this article use a dispassionate tone but one that uses evidence to show that there are poor outcomes that occur because of the misdiagnosis of medical illness with psychiatric illness.

Reeves et al, opens with stating that “Psychiatric symptoms are not illness specific and may be caused by a variety of both medical and psychiatric disorders.” This is important in their argument because it shows what specifically they are trying to prove. Another important part early in the paper begins by showing other terms for what could look like psychiatric symptoms such as altered mental status, delirium, encephalopathy, and acute confusional state. They state that many studies show that altered mental status many times can be confused for psychiatric illness. They show that this occurs in approximately 9.1% of cases and give references to show this is true. The same paragraph also describes a study done on 100 state hospital patients which were screened for medical illness and 46% of these patients were found to have an unrecognized physical ailment that caused or worsened their psychiatric symptoms. They use this information in order to prove their point that many psychiatric illnesses are actually unrecognized medical problems. They then show another study that further shows that this is true. They use an example of an emergency department which was reviewed that sent patients with psychiatric symptoms to a psych ward. 4% of these patients needed immediate medical care 24 hours after admission because they had an acute medical problem that was missed.

The methods used in Reeves et al. mostly involved studies that were reviewed by physicians. They studied individual cases as well as the larger groups of patients. “Each case was retrospectively analyzed by 2 independent physicians, who used a checklist to determine whether elements of the initial assessment that would have identified or addressed the underlying medical disorder prior to admission, were performed.”(182) Cases were reviewed to determine whether the correct records were sent to the admitting psychiatric physician received all of the pertinent information before making a decision to admit that patient. Several cases were also studied that showed that patients with altered mental status secondary to medical illness were appropriately admitted to medical units. Statistical analysis was then performed and conducted by using the Statistical Package for Social Services.

In the results section of Reeves et al., they demonstrate that a good portion of psychiatric patient admitted were actually misdiagnosed and had a medical condition that caused their psychiatric symptoms. “Of the 1953 patients admitted to psychiatric units, 55

(2.8%) had a medical disorder that, during their hospitalization, was ultimately determined to have caused or significantly exacerbated the altered mental status for which they had been admitted”(183). In each of these cases the diagnosis was made on the medical unit within several hours. Fortunately none of these patients had a serious consequence after the delay in correct diagnosis. A review of patients with psychiatric misdiagnosis was also reviewed and showed that most of these patients had a history of mental illness which could have contributed to their misdiagnosis. These patients also received a lower rate of performance when it came to performance of appropriate medical histories, physicals, assessment of neurological function, vital signs, and review of radiological studies.

The discussion section of Reeves et al. opens with, “The results obtained in this study are consistent with previous findings that common causes of misdiagnosis in this population include lack of an appropriate assessment of cognition, inadequate physical examination, failure to obtain indicated laboratory studies, failure to obtain available patient history, and failure to address abnormal vital signs. The results also demonstrate that these factors are significantly less likely to have been addressed in patients with mental status changes admitted to psychiatric units than those admitted to medical units, and that patients with a history of mental illness are more likely to have their symptoms attributed to their psychiatric illness than are those without such a history” (184). They state that the clinical part most often contributing to neglect was appropriate review of cognitive function. The mini mental status exam is often the tool used to measure this. The Confusion Assessment method is also used to measure risk for delirium, is often missed, and can be performed in less than 5 minutes. Patients with psychiatric illness often have many other medical comorbidities, and in many times are in worse health than mentally healthy patients. They also state that they feel that psychiatric symptoms often may be associated with perceived barriers to both medical and mental health treatment. They conclude their discussion with the statement the misdiagnosis of medical problems in psychiatric patients continues to be an issue. “Clinicians should be able to recognize the signs of altered mental status and initiate an appropriate evaluation to assess the etiology.” (185).

They conclude by arguing that patients with mental status changes admitted to psychiatric units are less likely to have been evaluated correctly than those who are admitted to medical units. They continue to state that patient with a history of mental illness are more likely to be misdiagnosed with psychiatric illness compared to patients without such a history. The end with the suggestion that, “It is vital that physicians carefully evaluate all patients with mental status changes using the latest guidelines, such as the ACEP protocol, to ensure that all such patients receive appropriate medical care”(185).

References:

https://www.aacp.com/pdf%2F0810%2F0810ACP_Reeves.pdf

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