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 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?

- Physiological factors
- Functional factors
- Behavioral factors
- Psychological factors
- Social/Environmental factors

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
Pediatrics
Mother’s / Child’s Agenda

She loves school and has many friends
I hope he finds something
I hope it is not cancer
It is not in her head!
I want some tests!
I hope he does not find anything
No tests please!
I do not know why I’m here
Pediatrics

Doctor's Incorrect Agenda

Not another one, please

These people are crazy!

How can I get rid of them?

Could it be porphyria?

It does not look like she is in pain

This is going to take too long

Should I treat her for H pylori?
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

Why is an SSRD Pathway Needed?
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
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.
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.
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)

FD Discussion of Admission

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

Initial Inpatient Management

- Review admission goals with patient and family (Appendix A)
- Consult Psychiatry, who will complete FDI (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 Ancillary Team Supports)
- Conduct judicious medical work-up, avoid unnecessary evaluations

Appendices by Provider Need:

Floor Provider:
- Appendix A – Initiating the Discussion
- Appendix C – Functional Plan
- Appendix D – Informing Meeting
- Appendix E – SSRD Facts for Families

Psych Team:
- Appendix B – Functional Disability Inventory

RN:
- Appendix C – Functional Plan
Appendix B: Psychiatry team completes the FDI with patient and parent separately.
Appendix C: Initial Functional Plan

Child life is consulted to help initiate an 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.
Appendix D:
Provides a script for the lead provider to help focus this informing meeting.
Appendix E:
Is a 3 page handout for the family that provides information on SSRD

Interdisciplinary Provider Huddle
- Achieve provider consensus on diagnosis and plan
- Utilize script to define roles and structure discussion with patient and family (Appendix D)

Multidisciplinary 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 providers (PCP, mental health team can conference in)
- Consider nursing, rehab, as able to attend
- Provide patient and family handout (Appendix E)
- Review directly with patient if not present at meeting

SSRD diagnosis confirmed?

No
Continue ongoing medical treatment and exit pathway

Yes

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 indicating 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 "jump" 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.

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.

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Implement Functional Treatment Plan

- Subspecialists validate symptoms and address any changes in clinical status
- Continue functional plan
- Begin transition to home plan

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Discharge Criteria & Plan:

Establish safe outpatient plan with regards to symptom management, PT/OT, behavioral support, pain therapies and school plan.
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.

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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References


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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