

Data verification and Hypothesis-driven care Overview 2-26-2013

A.M.B.E.R. clinic
Albuquerque Multidisciplinary Behavioral Evaluation for Recovery and Resiliency

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Overview

- **14-session clinical seminar**
 - **I/DD and TBI focus**
- **Certificate will be recognized within IHS clinical services**
- **Participation demonstrates breadth of clinical challenges**
- **Expertise & collegial relationships**

Overview

- **Create a book of teaching cases**
- **Have an outline of basic materials**
- **Establish and support open inquiry to patient symptoms**
- **Foster intellectual curiosity**

Sources of data

- **Patient complaint**
- **Caregivers' complaint**
- **Social transgressions**

Sources of data

- **Behavioral dysfunction has meaning**
 - **Pain**
 - **Habit**
 - **New conscious response or automatic response?**
- **When in doubt, try it out...**

Sources of data

- **Challenges of getting corroborative data**
 - reports from caregivers
 - written reports and medical notes
 - brain imaging films v. written notes
 - work settings, school, neighbors, extended family

Sources of data

- **Does a brain injury always cause new deficits and personality change?**
 - **When was the injury?**
 - **police report or insurance claim**
 - **How many TBIs**
 - **LOC – duration, repeats**
 - **Amnesia: retrograde, anterograde, duration, density**

Mental work

- **Rarely does a person with I/DD or TBI follow a predictable pattern**
- **Creating an individualized empirical dataset of responses**
- **Build a partnership with the patient/care team**

Mental work

- **Prioritization: safety, health, prevention**
- **Sort data – generate hypothesis**
- **Commit to treatment**
- **Record response**
- **Revise treatment**
- **Revise hypothesis**
 - **REPEAT.....**

Hypothesis

- **Preferably visible in your diagnosis, for communication**
- **Re-consider, integrating pharmacologic and behavioral results**
 - **partial responses may need to be tracked**
- **Keep observable symptoms separated from diagnostic conclusions or theories**

Person-First Language

- **Patients are fellow humans**
- **Treating the person, not the disease/syndrome**
- **Examples:**
 - **person with epilepsy --- epileptic**
 - **schizophrenic --- someone w/ scz**
 - **survivor of BI --- a TBI**
 - **people w/ I/DD --- “retard” or the developmentally disabled**

Notes

- **EHR**
 - **Rxs: doses, duration**
 - **Diagnostic formulation**
- **systematic**
 - **return to Sx and CC over time**
- **comprehensible**
 - **rationale for medication changes**
 - **re-thinking diagnoses**
 - **additional testing requested**

Challenges

- **Feeling off-balance**
- **Create partnership with patient**
 - **welcome all activities they are pursuing, to assess additive value and contribution**
- **Realize you are conveying and containing the hope for patient and their support team**

Summary

- **Have fun learning who your patients are**
- **Make a habit of documenting changes**
- **Monitor effects of medications/changes**
- **Use body and space indicators of sense of self, energy, engagement, purpose and experience (NVMSE – 2-12-13)**
- **Being wrong is useful data**