Module 1

PROFESSIONAL PRACTICE AND ROLE Checklist	
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LEGAL CASES PERTAINING TO MENTAL HEALTH

***Tarasoff VS UC Regents* – TARAS**

Memory tip – "OFF" self/someone/DUTY TO WARN

- **T –** Tell
- **A –** About
- **R –** Risk or plan of
- **A –** Attack and
- **S –** Save

***Ford VS Wainwright* – FORD**

Memory tip – think FORD CRASH/NO DEATH penalty if legally insane during crime

- **F –** Found insane
- **O –** Or incompetent when committing crime, then
- **R –** Restriction on
- **D –** Death penalty (inhumane treatment)

***Durham VS King* – DUR**

Memory tip – DURHAM/INSAM – If insane, releases liability of crime

- **D –** Defense of Insanity
- **U –** Unarticulated actions during crime
- **R –** Releases liability of crime

Stark Law* – STARK** – ***Memory tip - think STORK, hidden baby/hidden incentives

- **S –** Self-referrals by providers prohibited
- **T –** Targets healthcare fraud and abuse
- **A –** Also known as Anti-kickback Law
- **R –** Referral that leads to financial gain
- **K –** Knowledge expectation of providers, punishable by penalties.

Dusky VS United States* – DUSKY** ***Memory tip -Think DUmb DUsky – no comprehension/no trial

- **D –** Defendant
- **U –** Unable to comprehend so unable to
- **S –** Stand trial
- **K –** Key witness forensic psychiatrist/psychologist
- **Y –** Yes, still committed to an institution to undergo assessment and treatment

***Rennie VS Klein* – RENNIE**

Memory tip – think RenNO – NO to Med unless due process

- **R –** Right to
- **E –** Express
- **N –** Not wanting meds
- **N –** Need to
- **I –** Initiate process and
- **E –** Explore court orders

Donaldson Vs O'Connor

Memory tip – think O'connIN – IN a facility for 15 years when no grave disability or danger S or O

- **O –** O'Connor
- **C–** Confined for 15 years
- **O –** Otherwise non-dangerous, could live independently
- **N –** Not constitutional because
- **N –** No danger to self
- **O –** Or others
- **R –** Right to liberty violated

***Roger VS Okin* – I C ROGER**

Memory tip – RO/G/ER – patient can Receive meds if Ok by Guardian or Emergency Rm or Court

- **I –** If legally competent
- **C –** Cannot be
- **R –** Required to be medicated
- **O –** Only if
- **G –** Given in
- **E –** Emergency OR
- **R –** Required court hearing

***Habeas Corpus* –**

Memory tip – think Habe a Cort Process to detain

Habeas Corpus – Unlawful to detain an individual without due process.

Writ of Habeas Corpus – If a patient believes they are being unlawfully committed in an inpatient facility, he/she can file a petition or legal request for release from an inpatient facility. This petition can be filed by the patient, or they can ask their attorney, advocate, or a facility staff member. If this petition is accepted, the patient is granted a hearing in court.

PROFESSIONAL PRACTICE AND ROLE

NP Role History

- First NP certificate program 1965 – University of Colorado
- Later, master's degree was required in 1970s
- First NPs = pediatric NPs in rural areas due to PCP shortages
- PMH-CNS exam offered 1974
- PMHNP exam offered 2000
- PMHNP competencies 2003
- Consensus model for APRN regulation, licensure, certification – 2008
- PMH-CNS exam not offered after 2017. Previous PMH-CNS to continue practice

PMHNP Regulations/State Legislature/Practice Organizations

- ***State Nurse Practice Act (NPA)*** sets minimal educational requirements
  - NPA made into law by **state** legislature

- ***State legislature*** gives the PMHNP right to practice in that state
  - NPA also dictates scope of practice of NPs/PMHNPs
  - State Board of Registered Nursing (BRN/BON) enforces NPA in that state
  - BRN/BON has legal authority to regulate practice, and give license, monitor, license, revoke licenses
  - Cannot use legal professional designations (RN, NP, PMHNP) unless you have valid license
  - BRN/BON ensures minimal educational and clinical requirements before granting license

- ***Scope of practice***
  - Defines NP roles and actions and can have broad variations from state to state
  - Identifies competencies/minimum requirements that are expected of all NPs
  - Although based on legislation, enforced by the State BRN

- ***Standards of professional nursing practice – professional organizations***
  - Developed by professional societies – ANA or other specialty organizations.
  - These are authoritative statements about quality and type of practice that should be provided by NP
  - Describe the standard of care that must be met by the provider
  - Way of judging the nature of care provided
  - Minimum level of acceptable performance, can be used to legally describe the standard of care, and precise or general guidelines can be used
  - Certification (ANCC/AANP) is through a voluntary process by going through non-governmental agency, although many state BRNs/BONs now require passing certification exam before granting licensure

PMHNP Roles & Responsibilities

- **Scholarly Activities –** research, publishing, continuing education, teaching others etc
- **Mentoring** – Based on mutual respect, supports PMHNP students and newly certified PMHNPs in acquisition of knowledge, skills, competencies
- ****Advocate**
  - Patient rights are supported and patients are encouraged to speak up for themselves
  - Responsible for ***reducing stigma related to MH – educate through presentations, larger platform if possible***
  - Promote MH by joining professional organizations like ANA, APNA etc.
- ****Health Policy**
  - Legal and ethical responsibility as an advocate for MH
  - Participate in local/national policy changes, best way to join professional orgs
  - Testify in public meetings, work or media as necessary to ***educate the public on MH issues – can also help by doing presentations***
  - **4 Component**s of Health Policy: Process, policy reform, policy environment, policy makers
  - **Policy formation stages**: Formulation, Implementation, Evaluation
  - Laws and regulations help shape and develop health policies: Executive branch implement laws, legislative branch help formulate initial laws, and judicial branch help interpret law.
- **Case Manager**
  - Review services provided and treatment plans of patients and coordinate care
- **Risk Assessor**
  - Monitor and identify high risk situations for patients and assess any risky behaviors
- **Risk Manager**
  - Mitigate high risk situations to reduce risk for injury, self-harm to patients.
- **Collaborator especially with PCP when needed**
  - PMHNP engages in interprofessional collaboration with other health care professionals to improve patient outcomes and to ensure patient has all the resources for their expanded care needs.
- **AUTHENTIC Working Relationship**
  - PMHNP is able to form a ***therapeutic relationship and alliance*** based on authenticity, genuineness, acceptance, respect, empathy, and nonjudgement.

Collaborative Practice Agreements (CPA)

- Written agreement between a physician (can also be MD, DO, dentists) and NP outlining NP R&R in clinical practice.
  - Copy of CPA is kept at the facility, copy sent to BRN/BON.
  - CPA may need to be renewed annually with updated signatures, depending on BRN/BON requirements
  - Full, reduced, restricted practice authority depends on the state
  - Only physicians can sign a death certificate

Incident to Billing to get 100% Reimbursement (otherwise 85%)

- First visit is with Physician and Physician NPI # is used for all visits
- The following visits can be with NP at same or different location FOR THE SAME PROBLEM
- If you add additional assessment/treatment for DIFFERENT problem, then you can only bill 85%

ICD-10 + CPT Codes (American Medical Association owned 5-digit codes)

- Standard codes are used for billing, claim will be rejected if correct codes are not used.
- Many of these codes you have already encountered during your clinicals.
- Required for Medicare submission

Diagnosis Related Groups (DRGs) – groups related to specific diagnosis and tied to fixed reimbursement rates, although adjustments can be based on severity and locality service rates.

Contracted Service System – PMHNP signs a contract and agrees to provide care to a specific popul.

Restrictive Covenant Contract - includes a non-compete clauses that restricts an employee or contractor from practicing within a set number of miles from an employer business for a set period of time after the employee leaves the business or after the contract timeline expires. Restricted covenant contract includes the following 4 different types of promises. 1) a promise not to compete with the former employer 2) a promise not to solicit or accept business from patients of former employer 3) a promise not to recruit or hire away employees of former employer 4) a promise not to use or disclose former employer's confidential information or practices.

Medication Prescriptions and Controlled Meds

- Written practice protocol with supervising physician may be needed to prescribe meds
- In US- all 50 states give prescriptive authority to NPs + controlled substances
- Prescription pad – NP name, title, lic #, clinic name, address, phone num, all sites if NP practices at multiple sites. DEA – has state and federal oversight/authority, PMP/CURES verify use of controlled
- ***Controlled meds*** (morphine, hydrocodone, codeine, oxy, fentanyl, methadone, amphetamines)
  - Do NOT list DEA # freely to minimize fraud and diversion, required for narcotic prescription
  - Use tamper-resistant prescription pads (CMS requirement) and has to be hand signed on the same day it is issued (not applicable to EHRS linked directly with the pharmacy).
  - CMS prefers EHRS direct link methodology for sending and validating prescriptions.
  - Prescriber cannot call the narcotic prescription in, some may want form faxed in etc.
  - Strict rules to reduce diversion of controlled medications.

Controlled Substance Classes/Schedules – Schedule II – V

- ***Schedule I:*** No one can prescribe – Heroin, PCP, MDMA
- ***Schedule II:*** Significant abuse potential – Morphine, Methadone, Methylphenidate, Oxycodone, Fentanyl, Hydrocodone
- ***Schedule III:*** Moderate abuse potential – Ketamine, Anabolic steroids, Testosterone
- ***Schedule IV:*** Low abuse potential – Benzos, Ambien, Phentermine, Soma, Darvon, Tramadol
- ***Schedule V:*** Very low abuse potential – Antitussive with codeine, Lomotil, Lyrica, Motofen, Parepectolin

Significant Legislature related to PMHNPs

Budget Reconciliation Act of 1989 – HR 3299

- Medicare to reimburse all NPs directly (not only pediatric and FNPs in rural areas)

HIPAA Act of 1996 – HIPAA Administrative Simplification Standard

- Confidentiality requirements for medical records
- Required all providers including NPs to have NPI#s to be able to bill for their services

Balance Budget Act of 1997 & Primary Care Health Practitioner Incentive Act

- NPs reimbursed directly by Medicare Part B (outpatient), Medicaid, Tricare and insurance plans
- Reimbursement of 85% established per Medicare Physician Fee Schedule
- HIPPA Act of 1996 required all providers (also) NPs to have NPI#s to be able to bill for their services

HITEC Act – Health Information Technology for Economic and Clinical Health Act

- Signed into law in 2009 with incentives to providers for early adoption till 2015
- EHRS adoption and more strict enforcement of HIPPA laws and related penalties
- After 2015 penalties or reduced reimburse rates for providers not using EHRS
- Incentives for providers to use EHRS
- Improve quality by e-prescribing, computerized provider order set, and tracking care to avoid duplication of orders or health services

Mental Health Parity Act of 1996

- Emphasized on lifetime and annual dollar limits for mental health services.
- In 2008, Mental Health Parity and Addictions Equity Act (MHPAEA) and;
- In 2010, the Affordable Care Act (ACA), required comprehensive standards for equitable coverage of mental health and substance use disorder treatment and coverage of medical/surgical treatment.

TIGER (Technology Informatics Guiding Education Reform)

- Required technology curriculum for colleges and included a 10-year plan for nursing path towards computer and information literacy.
- It is PMHNP responsibility to understand and shape health care technology to improve access, quality and patient experience.

Emergency Medical Treatment and Labor Act (EMTALA)

- Law that requires hospitals to provide an exam and stabilizing treatment without consideration if insurance coverage or payment.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Continuation of health benefits after employee leaves the job under certain circumstances.

Affordable Care Act of 2010

- Extended insurance coverage under parent of adult children up to 26 years of age

Americans with Disabilities Act

- Access to employment and community resources for physically or mentally disabled patients

Healthy People 2020

- Goals over next 10 yrs – reduce rate of eating disorders, suicide rates and attempts by adolescents

National Alliance on Mental Illness (NAMI)

- Agency that helps families of mentally ill. Offers education, support groups & other outreach activities.

Sunset Legislation – Acts must be reviewed by a certain date, or it will be automatically rescinded
Sunrise Legislation – Legislation designed to increase transparency in governmental processes
Phases of Policy Making – Formulation + Implementation + Evaluation
Policy Reform – Changes in program and practices. Stakeholders: govt, organizations – become active
Health Care Policy Model = Access + Cost + Quality

Centers of Medicare and Medicaid Services (CMS)

- Federal program/health coverage for >65 years, or has disability, any age with renal disease
- Agency under US Dept of Health and Human Services (DHHS). Covers health care costs and reimbursements. Important to know what is covered so you can get paid and patients can get adequate care + meds.
- Medicare, Tricare, and Veteran's Health plans are funded by federal taxes

- **Medicare Part A – (Inpatient Services, SNF)**
  - Covers inpatient hospitalization (***includes psychiatric***) for anyone over age 65 who had Medicare deductions out of their paycheck.

- **Medicare Part B – (Outpatient Services)**
  - Outpatient appointments
  - Laboratory tests
  - Ambulance for emergency psychiatric care/transport
  - DME
  - Prevention services:
    - Screenings & Vaccines
    - Smoking-cessation counseling and treatment
    - Alcohol misuse screening and counseling
    - Also covers SBIRT (Screening, Brief Intervention, Referral to Treatment – see Nonpharm and Therapies section) reimbursements

- **Medicare Part C/Advantage Plans**
  - Covers both inpatient and outpatient care and some plans also cover prescription drugs
  - Administered by private insurance vendors – need approval by Medicare
  - Medicare Advantage – a program that allows eligible Medicare beneficiaries to choose where they receive their health care – through a qualified managed care plan, that in turn receives capitation payments from Medicare for each enrollee

- **Medicare Part D**
  - Prescription drugs (nonformulary may not be covered)
  - Must be Part A/B enrolled

Medicaid – Title XIX of the Social Security Act

- Federal and state funded program
- Must meet federal poverty level criteria
- Covers kids, pregnant women, adults, seniors, developmentally disabled
- How Medicare benefits are determined – *State* determines qualification
- Some elderly can have both Medicare and Medicaid, although Medicaid is payer of last resort
- **Single largest payer for MH services in the US
- **Also covers care for Substance Use Disorders (SUD)
- Is dental covered under Medicaid – yes, beneficiaries under 21 years get basic dental coverage.

CHIP – Children's Health Insurance Programs (Reauthorization Act) CHIPRA

- Covers kids + pregnant women

Payer Systems

First party payer – Fee for service– Patient pays directly
Second party payer – payments made through a legal guardian or grantor, hospitals, pharmaceuticals
Third party payer – payment by Medicare, Medicaid, Private insurance
Fourth party payer – Employers purchase health insurance for employees and have a deductible expense

Health Insurance Coverage and Cost

- Affordable Care Act of 2010
- Expansion of health insurance to the uninsured.
- Age for parental coverage until age 26.
- Prohibits insurance company to base coverage on preexisting conditions.
- Penalty for employers if not participate in national health plan.

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)

Managed Health care Plans

HMOs

- PCP is gatekeeper, PCP must refer to specialist
- Patient can only see providers within the network
- Copay per visit
- Provider paid specific salary or by patient

PPOs

- Patients are not assigned a PCP
- Patient can visit any provider in the network
- No referral needed for specialist
- Patient can select their PCP
- Usually more expensive than HMO

Other

PCC – Patient Centered Care Model

- Health Resources and Services Administration (HRSA) have several initiatives to expand mental health practices and provide patient centered EBP-based care.
- Focus on the following:
  - Welcoming environment
  - Respect for patient needs and values
  - Empowering patients
  - Sociocultural competence
  - Integration/coordination of care
  - Support for patients
  - Access to care
  - Community outreach

SAMHSA – Substance Abuse and Mental Health Services Administration

- **Health Care Home**
- Focus on:
  - Primary care to coordinate services for patients with multiple health concerns including MH and SUD concerns
  - Team-based care where there is collaboration to meet patient needs
  - Community supports are also critical for successful treatment

HIPAA - Health Insurance Portability and Accountability Act

- Passed by Congress 1996
- PHI – Protected health information cannot be disclosed without consent
- Applies to: HIPAA rules also apply to emails as well and 2-way encryption is required for emails
  - All providers
  - Health insurance companies
  - Labs
  - SNFs
  - Third Party Administrators (TPA)– process claims and handle admin actions (can be insurer, plan, retirement plan)

- ***What it includes:***
  - **H –** Health care providers to inform patients of HIPAA policy
  - **I –** Includes forms that need to be signed ANNUALY to be valid
  - **P –** Psychiatric/MH records – provider has right to refuse patients' request to view
  - **A –** Address the request within 30 days and keep identifying information private
  - **A –** Able to review and request corrections to medical records
  - **A –** Ask for consent when discussing Dx/condition with someone else or when someone else present

- Examples of ***OTHER EXCEPTIONS*** when HIPPA Consent NOT required. Can be sent to:
  - **M –** Mandatory reporting to the county/state dept of health – STD/communicable
  - **O –** Other providers for consults/treatment
  - **T –** TPA – Third party - billing, accounting, administrative, AND LEGAL
  - **H –** Healthcare operations such as review, audits, etc.
  - **E –** Enter default for collections/unpaid bills
  - **R –** Reporting abuse, assault, domestic violence, reporting intent to harm self/others
  - **S –** Share with insurance companies/entity paying for medical charges

- ***MH Records and HIPPA***
  - **M –** MH records treated differently
  - **H –** Have to keep separate from patient's other records
  - **R –** Records need separate consent
  - **E –** Exceptions – Duty to warn when patient threatens to harm self or others (Tarasoff)
  - **C –** Can discuss with family or others involved in care, for payment if patient is ok with it

- ***Minors and HIPPA***
  - **M –** Minor's consent is not required for <18 (only needed for abortion)
  - **I –** If releasing records, parents must sign consent
  - **N –** Not for emancipated minors – sign their own legal docs
    - Emancipated Minors
      - Declaration in legal court documents
      - If serving (active duty) in the US military
      - If in a legally binding marriage (or divorced)
  - **O –** Obtain consent from parent/guardian, but minors can ***assent* (7-17)** to participate in treatment/research
  - **R –** Requires parental permission to speak to minor to obtain assent (ex: research study)

Malpractice Related Nomenclature

Plaintiff

- Patient, representative, or family member who is claiming injury/damage/wrongdoing

Defendant

- Respondent to the lawsuit/NP/facility/clinic

Trial Steps

- Court filing
- Discovery phase – Medical records, interviews, expert testimony (NPs in the same specialty and location unless seeing patients virtually)
- Burden of proof on the plaintiff
- Court trial phase/or settlement/arbitration if no trial
- Judgement – dismissal of case or damages awarded if plaintiff able to prove injury/harm occurred

Thorough Documentation + Example

- Ensure all patient teaching is documented and also importance of medication compliance. Use templates as needed to give education and document.
- Ensure all consent forms are signed (review annual per facility policy etc) and document
- Example:
    - Patient with bipolar disorder filing a lawsuit for increase in seizure activity while patient on mood stabilizer/anticonvulsant despite being non-compliant. Your documentation will save you from a lot of stress. Document patient teaching each time you spoke to the patient. Lab results that may show non-compliance to treatment and remediation/teaching that was performed multiple times without indication of medication compliance.

Elements of Negligence

- **DO – Duty** is **O**wed or a legal duty exists to exercise reasonable care
- **B – B**reach in duty or standard of care was violated
- **I – I**njury caused by this breach - Proximate cause
- **D – D**amage occurred as a result of injury

Types of Malpractice Insurance

- Protects against claims of malpractice
- Agency might carry liability insurance, but it is very important for NPs to have their own.
- *Options: NSO, American Professional, Berxi, ProLiability, CMF, CM&F, Cinch, etc.*

Occurrence-Based Malpractice Insurance

- Not affected by changing jobs and the coverage remains even after retirement
- Coverage for any incident when the policy was still valid even if suit filed years later

Claims-Based Malpractice Insurance

- Only covers the time the premium was paid and only if the NP is currently still enrolled in the insurance plan.
- No future claims will be paid if a suit is filed by the patient in the future.
- Ensure you buy **TAIL COVERAGE** if you have claims-based policy especially if change jobs or retire
- If no tail coverage under this policy, you will not be covered by this malpractice after you retire or not have the policy anymore.

Health and Hospital Services

Patient-Centered Medical Home (PCMH) – health delivery model

- Patient and family are critical members of the interdisciplinary team (PCP, PA, NP, pharmacist, dietician, SW, case manager RNs…)
- Healthcare needs taken care in home setting
- Focus on coordination of care
- Patient/family has 24-7 access to a member of team

Accreditation

- Voluntary process for hospitals
- Usually nongovernmental agency offers the process to be accredited
- Gold Standards – accreditation denotes excellence in patient care by meeting requirements
- For hospitals/clinics:
    - TJC for hospitals or ambulatory or psychiatric facility accreditation types
        - Different chapters, requirements are outlined in EPs (elements of performance) for each chapter
    - Magnet designation through ANCC
- For Academic institutions
    - ANCC
    - NLNAC

Sentinel Event (SE)

- A major patient safety event resulting in death (unexpected and completed suicide), permanent harm, rape, assault, dismemberment, enucleation of the eye, or severe injury.
- Also facility or environmental occurrences such as fire, excessive heat, natural or unnatural calamity.
- Facility expected to conduct a **Root Cause Analysis (RCA)** to make improvements and reduce risk and harm.
- Follow-up meetings, intervention tracking and reporting is usually required to be submitted to accrediting body such as The Joint Commission (TJC) or Department of Public Health etc.
- Suicide is still counted against the facility by TJC even if it occurs within 3 days after discharge.

RCA - TIMS

- **T –** Team process to identify factors that resulted in harm or error
- **I –** Identify and correct system vulnerabilities
- **M –** Mandated TJC process for SEs
- **S –** System focused, not punitive towards staff

Just Culture

- ANA collaborated with State Boards of Nursing to establish Just Culture Initiatives in 2010
- Holds people accountable for lapses in care and behaviors, and release of investigative information
- Creation of learning environment with focus on designing safe work health care facilities
- Focus on improving work environment by looking at system vulnerabilities and ways to improve rather than only punitive actions

Quality Improvement & Risk Management

Quality Improvement (QM)

- **I –** Identifying problems, improve systems, productivity, and decrease cost
- **M –** Measuring Outcomes
- **P –** Parameters new ones established
- **R –** Reduce complications, errors, hospitalizations, mortality
- **O –** Overall patient satisfaction improved
- **V –** Various methods **PDSA (Plan-do-study-act)**, Lean six sigma elements etc.
    - Plan – Create action plan for change
    - Do – Do the intervention steps in the action plan
    - Study – Analyze results to see impact of change
    - Act – Choose what actions need to be implemented, sustained, and consistently evaluate
- Example: Problem is identified with increased catheter related urinary tract infections at the hospital. A work group is created to investigate causes and implement counter measures to decrease infection rates.
- Change Management – Change agent – person guiding change (administrator/executive)
- Assess and address organizational barriers first and identify facilitatiors for EBP to be successful.

Risk Management

- **R –** Reducing liability and adverse patient outcomes by
- **I –** identifying risky practices
- **S –** Systematic organizational process
- **K –** Kindle safe and effective care
- ***Failure Modes Risk Analysis (FMEA)*** – Facilities that are Joint Commission accredited, are required to do a Focused Self-Assessment FSA mid cycle (~18 months if the survey is every 3 years. Facilities are supposed to identify a vulnerable process and complete a FMEA to reduce associated risks at each step and system vulnerabilities. For example, the facility identifies medication administration as one of the risk prone areas in the FSA after they review med errors. The QM and nursing department are tasked to complete a FMEA on med management to address risks/vulnerabilities, and proactively correct risk/error-prone vulnerabilities

NCQA – National Committee of Quality Assurance developed

11 HEDIS (Health Effectiveness Data Information Sets) measures Mental Health health outcomes

- MH Utilization HEDIS Measures
    - A – Adherence to antipsychotic meds for schizophrenia patients
    - A – Antidepressant medication management
    - C – Children – Psychosocial care for patients on antipsychotics
    - C – Children – Proper follow-up for patients on MULTIPLE antipsychotics
    - C – Children – ADHD – Proper follow-up
    - C – CVD monitoring for patients with Schizophrenia diagnosis and meds
    - D – DM screening & monitoring for patients on antipsychotics (and also children)
    - D – Discharge – Proper follow-up post DC

Evidence-Based Practice and Nursing Research

Research Nomenclature

Evidence-Based Practice

- Best research evidence driving clinical practice, patient care, and decision making
- Critical for reducing practice chasms/gaps
- Driving force for evidence-based decision making
- Driving force for changes in previous practices
- ***Research utilization*** – Using research generated knowledge through the process of synthesizing and evaluate current research to make practice decisions. Developing practice guidelines and dissemination of information is equally as important.

PICOT Question

- **P –** Specific patient **Population** being studied or **Problem**
- **I –** Intervention (specific medication, therapy, tests)
- **C –** Comparison group (no treatment/placebo versus different treatment)
- **O –** Outcome (reduction in symptoms, no symptoms)
- **T –** Time Frame (what is the duration of the intervention)

Statistical Terms

- **Control group** – patient in this group do not receive intervention/treatment
- ***N*** – total size of sample
- ***n*** – number of patients in a group
- ***P* value** – also known as significance level. Level of significance is usually set at $p<0.05$ or $p<0.01$
- ***t*-test** – test to evaluate differences in means between two groups
- **Independent variable** – variable being manipulated
- **Dependent variable** – result seen as a result of the manipulation of the independent variable
- **Alternative Hypothesis (H_A)** – Assumption that is being tested. If Null hypothesis is rejected, there is difference and thus alternative hypothesis is true
- **Null hypothesis (H_0)**– Opposite of hypothesis being tested = No real difference between groups
    - Example: If Alternative Hypothesis is Med A treats depressive symptoms better than Med B. Null hypothesis is that Med A will not perform better than Med B for symptom reduction.
- **Mean** – Adding all values divided by number of values
- **Median** – the middle value when all values are lined up
- **Mode** – The most common value
- **Range** – difference between largest and smallest value
- **Reliability** – **Re**peatability. How often the instrument/tool gives the same measurement
- **Validity** – **V**alues **A**lign with what is intended to be measured.
- **Normal curve** – a bell-shaped curve where most of the values are included in 1-2 ***confidence interval***s as the curve flattens out at the edges. For example, a 95% confidence interval means that 95% of the values fall within the range of values and are closer to the mean. The fewer the values that fall beyond 1-2 confidence intervals (***outliers***), the higher the confidence level. ***Standard deviation (SD)*** – number of values falling outside of the mean. 95% of the values under a normal bell curve fall within 2 SDs of the mean.
- **Descriptive Statistics** – Describes data in the study from either quantitative or qualitative studies (mean, standard deviation, variance)
- **Inferential Statistics** – Used in Quantitative research to analyze data and test hypothesis (T-test, Analysis of Variance (ANOVA), Pearson's r correlation, probability, P value)

Evidence-Based Practice and Nursing Research

Research Nomenclature

- **Qualitative –** nonnumeric data, measures in natural settings, observations, opinions
- **Quantitative** – data that is numeric, and statistical tests can be done to validate the results
- **External Validity** – to what extent the sample is representative of the population and results can be generalized.
- **Internal Validity** – Extent to which we can draw cause and effect inferences from a study. The independent variable/treatment cause a change in the dependent variable/outcome.
- **Arbitrary Inference** – coming to incorrect conclusion based on previous experience
- **Deductive Reasoning** – top-down (D –Down) logic, making inference from broad to more specific.
    - Quantitative studies use this type of reasoning
    - Quantitative studies use numeric data that can be measured
    - Usually involve a larger number of patients
    - Randomization of patients can be done
    - Measurements, questionnaires, instruments are used to generate metric data
- **Inductive Reasoning** – bottom-up logic, making inferences going from specific to making generalizations.
    - Qualitative studies use this type of reasoning.
    - Qualitative studies usually involve interviews, focus groups, words, subjective opinions
    - Usually, a fewer patients are studied
    - Is not randomized
    - Statistics commonly not used

Phases of Research

- ***Phase I*** – Conception, literature review is done, hypothesis is developed
- ***Phase II*** – Design and Planning, patient selection identified, IRB approval sought, selecting study design
    - Institutional Review Board (IRB) ensures safety and rights of patients and approves or rejects research studies. Committee members cannot have conflict of interest when voting
    - Stringent guidelines for vulnerable populations (children, pregnant women, prisoners, minorities, refugees, patients with MH, developmental, visual, hearing disability/impairment, patients of low Socio-economic status (SES)
- ***Phase III*** – Implementation, patients selected, INFORMED CONSENT signed, actions implemented
    - *Informed Consent* – includes all pertinent details – actions required, risks, benefits, compensation, confidentiality and data, contact info of the investigator
- ***Phase IV*** – Analysis, data is analyzed
- ***Phase V*** – Dissemination, final report prepared, published
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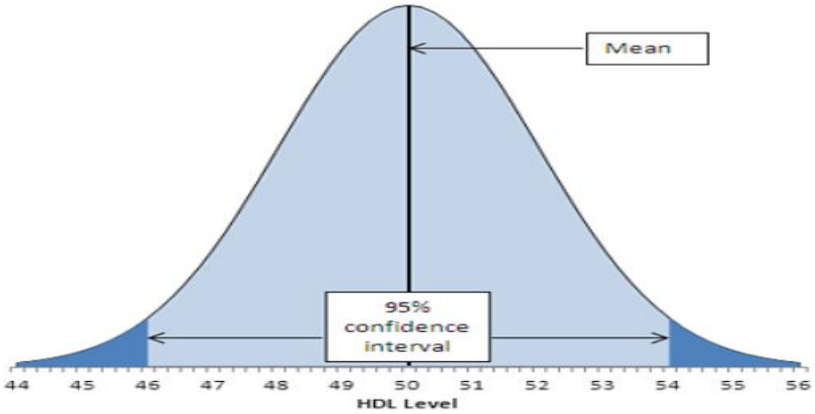
- ***Belmont Report*** – ethical principles to be followed when doing research with human subjects. Training and certificate requirements for different IRBs before beginning or submitting proposals.
- ***Tuskegee Syphilis Experiment*** – From 1932-1972, 600 African American patients tested for syphilis, and were positive, yet treatment was withheld to see progression of diseases. Many safeguards are now in place to ensure nothing like this every happens again.



Normal Curve

Evidence Strength Hierarchy

ANCC may have 1-2 drag and drop types of questions regarding the Evidence Strength Hierarchy for the FNP exam and standard multiple choice questions for the ANCC PMHNP exam.

** While answering these questions - just remember **Meta-analysis, Systematic Reviews**, **Randomized Controlled Studies or Experiments** are considered to be BETTER than the rest. Lowest levels are Ideas, Quotes, Editorials and Opinions, and the rest are in the middle.

Research Study Types

Case Studies
- Investigation of a single patient, case, situation, or a group

Cohort Studies
- Groups of patients who share common characteristic such as ethnic background, sex, age etc.
- Can help shed light on causative/risk factors for conditions

Correlational Studies
- Relationships between variables is explored.
- Positive correlation (two variables change together) or Negative correlation (if one variable increases, the other decreases)
- No correlation (variables are not related)
- When comparison of factors/characteristics of 3 or variables or groups is conducted, analysis of variance (ANOVA) can be used to check the differences in the means

Cross-sectional Studies
- Differences and similarities among groups or patients are compared as one point in time

Descriptive/Observational Studies
Information is collected through observation, without any changes in outside environment or variables

Experimental Studies – can be used to show causality
- Includes a control groups, and at least one intervention/treatment group for comparison
- Random sampling and random assignments are used to increase the strength of the study
- ***Quasi Experimental Study*** – similar to experimental but a convenience sampling is used instead of randomization
- ***Randomized controlled "double-blind" experiment*** are considered better experimental design than the ***randomized control experiment***

Longitudinal Studies
- Same patients are followed over years to compare the changes in the same variables being studied
- Also considered observational studies when there is no manipulation or intervention
- Goal is to learn more information on risk factors or progression
- ***Prospective Studies*** – Data is collected in the present time, and patients are followed over time
- ***Retrospective/Ex Post Facto Studies*** – Studies that focus on criteria that have already occurred in the past and variables can be compared. Usually utilizes chart reviews, interviews etc., after selection through research criteria

Meta-Analysis
- Data combined from multiple studies and systematic reviews and statistics analysis is applied.
- Gold standard for EBP

Systematic Review
- Summary of all literature or experiments that meet strictly defined criteria
- Various plausible and scientific databases used - Cochrane Reviews, Medline, PubMed, CINAHL
- Studies are graded from A to D
- Studies that are Gold Standard for conducting Systematic Reviews is by doing review of:
  Randomized Controlled Double-Blind Studies – Grade A or Level 1 - SUPERIOR
  Randomized Controlled Studies – Grade A or Level 1

Longitudinal Studies
- Same patients are followed over years to compare the changes in the same variables being studied

Research Related Terms

SAMPLING

- **Stratified Sampling** – proportion of the study population belonging to each of the group of interest is known.
- **Cluster Sampling** – selection of the study groups is random, rather than the selection of study units. Usually, cluster sampling is geographic or organizational units.
- **Systemic Sampling** – choosing individuals at a regular interval from a sampling frame by selecting a number to determine where to begin selecting individual subjects.
- **Simple Random Sampling** – making a numbered list of all subjects in a population from which you want to draw a sample, deciding on the sample size and selecting the required number of subjects using a table of random numbers or a lottery method.
- **Statistical POWER** – likelihood of hypothesis truly detecting an effect if there is one. It helps you determine if your sample size is large enough. To increase power, increase sample size.

PLACEBO AFFECT AND BIAS

- **Placebo Affect** – The beneficial effect that is reported for a placebo drug/null treatment that cannot be attributed to the chemical attributes of the placebo itself, and therefore may be due to a patient's belief in that treatment. Placebo effect in children is much higher – and due to this not too many medications are FDA approved for children/adolescents when it is difficult to decipher the results and show effectiveness when compared to the medication group.
- **Sampling Bias** – may occur in a study that recruits volunteers, as the group of volunteers may not be representative of the population that is being studied. Example: impact of exercise and those volunteers who are already physically active. Random Sampling reduces expectancy bias in a DOUBLE-BLIND study and RANDOMIZATION.
- **Expectancy Bias** – When researcher knows which patient is distributed in each group.
- **Proficiency Bias** – When treatments administered at different sites are compared if the site has greater proficiency in administering tests/treatments/interventions producing better results.

RESEARCH EFFECTS

- **Hawthorne Effect** – Study participants change their behavior for no other reason expect the knowledge that they are being studied.
- **Pygmalion Effect** – People tend to perform to the expectations placed on them, higher expectations = performs better.
- **Novelty Effect** – Individual responds most strongly to a seemingly dangerous experience when faced with it for the first time (roller coaster, bungee jumping), until novelty wears off over time.
- **Halo Effect** – Occurs when a researcher's evaluation of a subject's current performance is altered based on opinion of the previous performance of the subject
- **Simpson's Paradox** – Two studies with similar correlations can be combined to exhibit the opposite trend.
-

Other

- **Factor Analysis** – statistics method to describe variability among correlated variables. Example – General intelligence factor can be inferred, not measured.
- ***ANOVA*** – Analysis of Variance – inferential statistics test to compare 3 or more group means.

Prevention

• Primary Prevention

- **PRI** – **P**reventing **R**isk of **I**llness, decreasing # of new cases from devp
- Preventing disease or injury from even developing. Eliminating risk of developing an illness.
- Examples:
  - Low salt diet and daily exercise to prevent hypertension for those who have a family history of HTN
  - Never starting to smoke to avoid lung cancer
  - Using condoms to prevent acquisition of STDs
  - Polio vaccines to prevent polio
  - Stress management apps and classes
  - Drug abuse prevention classes in Elem/Middle Schools
  - Vaccine campaigns

• Secondary Prevention

- **SEC** – **S**topping **E**arly by **C**atching, decreasing # of existing cases
- Stopping disease or damage through early detection.
- Examples:
  - Screening for depression
  - Screening for alcohol use (CAGE questionnaire) or other substances
  - Screening for Hep C and HIV for patients getting treatment in addiction treatment centers
  - Screening tests such as PAP, mammograms
  - Screening for STDs when doing PAPs
  - Crisis intervention
  - Telephone hotlines

• Tertiary Prevention

- **TER** – **T**reatment, **E**ducation (for those already diagnosed), **R**ehabilitation
- Reducing damage by treating disease, rehabilitation, support, equipment
- For MH, decreasing disability and severity of SSx of psychiatric disorders
- Examples:
  - Cancer survivor support groups
  - HIV support groups
  - Education on medications for patients with multiple diagnosis to avoid drug interactions
  - Physical/Occupational therapy for patients with paralysis
  - Prosthetics for patient with BLE amputations to maintain functionality, physical activity, and independence
  - Social skills training for patients
  - Case management and taking care of housing and vocational needs of patients
  - Day treatment programs, or care programs to increase social interaction for patients with schizophrenia

Epidemiology

- **Incidence**
  - Number of **NEW CASES** (of a disease, condition) over a specified period of time.
  - Usually measured as a rate for 100,000 of the population
  - Example: How many new diabetes diagnosis in County X during year 2023
- **Prevalence**
  - Number of **ALL PRESENT cases** (of disease, condition) during a specified period of time
  - Usually measured as a rate for 100,000 of the population
  - Example: How many existing patients with diabetes in County X during year 2023
- **Mortality**
  - Death. Mortality rate = death rate
  - Example: Death rates and reasons are tracked by the county/health department/department of vital statistics.
- **Morbidity**
  - Physical or mental illness, disease state. Morbidity rates = Disease rates
  - Example: Morbidity rates of some of the reportable diseases is tracked by the county/health departments.
- **Sensitivity**
  - **SIN** – **Se**nsitivity Rule-**IN –** identify patients with the disease (true positive)
- **Specificity**
  - **SPOUT** – **Sp**ecificity = Rule-**OUT –** identify patients without disease (true negative)

Health Literacy

- Health literacy is a person's capacity to learn about and understand basic health information and have knowledge of basic health services to be able to utilize available resources to promote their own health and wellness.
- Health directly impacted by Health Literacy Levels
- Priority for patients who may be recent immigrants, and lower SES or education level
- Check literacy level before providing education/instruction. Example, man taking insulin, ask him how to read blood glucose levels and what values are too high.
- Assess learning needs, assess belief systems and identify misconceptions so you can utilized this information when educating.

Peer Review/Consulatation

- Peer review may be required by some employers – reviewer usually is NOT the supervisor
- Mutual benefit – critical yet supportive
- Shared discussion and accountability
- Regular engagement of two or more colleagues to give and receive feedback

TeleHealth

- Can be delivered through phone or video conferencing, same standard of care given to patients.
- Must meet state/federal/international standards.
- NP must ensure that HIPPA guidelines regarding confidentiality are still followed during all visits
- Telecare is outcome-based, and quality measures can be checked at intervals.
- Ability to reach patients in rural or underserved areas
- Licensing standards still apply for the PMHNP for that particular state – BRN jurisdiction stands.

Patient Commitment

- Court Cases (See attachment "Legal Cases Pertaining to Mental Health"
- Over the last few decades, more and more laws to protect patient rights, right to be in the *LEAST restrictive environment*
- ***Habeas Corpus*** – Unlawful to detain an individual without due process.
- ***Writ of Habeas Corpus*** – If a patient believes they are being unlawfully committed in an inpatient facility, he/she can file a petition or legal request for release from an inpatient facility. This petition can be filed by the patient, or they can ask their attorney, advocate, or a facility staff member. If this petition is accepted, the patient is granted a hearing in court.
- Forcibly engaging patient in involuntary evaluation or treatment (Involuntary) is illegal
- State laws regarding timelines may differ according to the sate the patient is committed. For example, in California, 5150: California Welfare and Institutions Code # 5150 allows a person with mental challenge to be involuntarily detained for a 72-hr psychiatric hospitalization (evaluation and treatment). Does not need to stay full 72-hrs if stabilizes. 5250 and other types of holds if 5150 can't be renewed. Terms and timelines may vary by State. ***Criteria:*** Dx of psychiatric disorder, danger to self/others due to Dx, grave disability, patient unaware/unwilling to accept Dx. Be able to assert that treatment likely to improve level of functioning
- ***INVOLUNTARY Commitment*** – Patient admitted against will, patient maintains liberties except leaving the premises, # days may vary by state
- ***Voluntary Commitment*** – Patient agrees to treatment, patient maintains all civil liberties, patient consents to commitment in a locked unit

Legal Terms/Living Will

Living Will – LIVI

- **L –** Legal document containing
- **I –** Instructions and Preferences in case patient is
- **V –** Very ill or dying
- **I –** Include in patient chart

Power of Attorney – POWER

- **P –** Patient chooses person/Agent who has
- **O –** Ownership/legal authority to make ALL decisions
- **W –** When patient becomes mentally incompetent or incapacitated
- **E –** Extends to other areas besides healthcare like financial
- **R –** Requires signature and notary

(Durable) Healthcare Power of Attorney/Healthcare Proxy/Healthcare Surrogate - HPOWER

- **H –** Healthcare decisions **ONLY**
- **P –** Patient chooses a person/Surrogate who has
- **O –** Ownership/legal authority to make decisions
- **W –** When patient becomes mentally incompetent or incapacitated
- **E –** Effect only when Pt provider determines incapacity
- **R –** Requires signature of **two witnesses** (excluding the surrogate making the decisions)

Ombudsman – liaison between patient and facility who investigates and mediates for resolution

Guardian Ad Litem – court assigned person who has legal authority to act in best interest of ward (child, fail elderly, developmentally disabled…)

ANA Code of Ethics

- ***9 provisions include***
  - Practice with compassion and respect
  - Primary commitment to patient
  - ***Advocates*** and protects patient rights, health, and safety
  - Provide optimal care with accountability & responsibility
  - Responsibility to promote health and safety, maintaining the integrity of the profession
  - Improves and maintains ethical environment
  - Advances the profession by research and EBP
  - **Collaborates** with other professionals to protect human rights, promote health diplomacy, and improve patient care outcomes
  - Know nursing values and maintain integrity

****Important Ethical Principles**

- Client is involved in decision making to their full capacity unless unable to
- Least restrictive setting
- Patients have a right to refuse treatment (legal process may allow to give meds)

Collaboration

- **Collaboration to improve patient care outcomes or improve services.**
  Examples:
  - Patient with frequent hospitalizations and an extensive comorbidity history of mental health not getting psychiatric evaluations upon every admission, especially medical related.
  - Collaborating with Ob/Gyn in the area to ensure that women are screened for post-partum depression or mood changes during pregnancy and receive adequate information and resources to seek treatment if necessary.
  - Collaborating with the Inpatient MH unit staff to help decrease seclusion and restraint episodes.
  - Patient with uncontrolled DM, HTN, collaborating with PCP especially prescribing medications that place patient at further risk of metabolic syndrome.
-

Ethical Decision Making

- **Deontological Theory – "Dent – Intent"**
  Action is bad or good based on **Intent**/Act regardless of consequence

- **Teleological Theory – "TeleOut"**
  Action is bad or good based on **outcome**

- **Virtue Ethics** – Virtues (honesty, integrity, compassion) lead to actions

Ethical Principles

Autonomy – AUTO

- **A –** Able to make own health decisions
- **U –** Unable to make decision (advance directives and designated decision maker)
- **T –** Treatment can be refused by competent patients
- **O –** Obligated to advocate for autonomy

Example: Patient has right to request/refuse Tx even though family members may not agree.

Justice - JUST

- **J –** Just and fair
- **U –** Unaffected by bias
- **S –** Societal resources are equally distributed
- **T –** Treatment of all is equal

Example: Patient who arrives in the emergency room of a hospital with a life threatening conditions receives treatment despite not having money for the treatment.

Fidelity – FIDEL

- **F –** Fulfilling promises
- **I –** Instilling trust in relationships
- **De – De**dication
- **L –** Loyalty to patients

Examples: PMHNP develop a rapport by building a trusting relationship with a patient. The relationship between a patient and all members of the MH interdisciplinary team (not only the PMHNP)

Nonmaleficence - NO

- **N –** No harm to patient
- **O –** Offer protection from harm

Example: PMHNP recognizes that patient has a long history of substance abuse with multiple relapses for a patient with general anxiety disorder. PMHNP decides not to prescribe the patient any benzodiazepines

Dignity

- **D –** Deserving ethical and respectful Tx
- **I –** Important in medical ethics
- **G –** guided by beliefs (religious, cultural etc. What does the patient consider dignified treatment)?

Examples: hospital gowns for privacy, foley catheter/urine bags not visible.

Beneficence - BENEF

- **B –** Benefit of patient drives action
- **E –** Decisions in patient's best interest
- **N –** No harm to patient
- **E –** Engage in compassionate care
- **F –** Function as patient advocate

Example: PMHNP prescribes antidepressants so MH can improve.

Veracity - VER

- **V –** Verify patient receives truthful information
- **E –** Ensure no withholding of information
- **R –** Right to make informed decisions

Example: Providers have responsibility to discuss results with patients – labs/diagnostic workup.

Utilitarianism - UTI

- **U –** Ultimate benefit for all as an obligation
- **T –** Target is the outcome of action
- **I –** Insure resources/benefits for all (eg taxes help build schools)

Example: Everyone in the county/state pays taxes even those without school-age children.

Confidentiality – CONFI

- **C –** Consent before sharing documents
- **O –** Obligation to protect under HIPPA principles
- **N –** NOT one consent (need separate for MH or additional meds)
- **F –** Formats – All
- **I –** Identity and medical information of patient to be protected

Accountability

- PMHNPs are responsible for actions and care decisions they make for their patients and are liable for any mistakes.
- Example: PMHNP diagnosed patient with panic attack after patient admitted with symptoms of chest pain and feeling of impending doom. Patient is later discharged with Benzos and later dies of a myocardial infarction.