



SAMHSA-HRSA Center for Integrated Health Solutions

Bridging the Culture Gap: Approaches to Communications in an Integrated Setting

“Grand Rounds” - Sandy Stephenson, LPCC, LISW

(Director Integrated Health Care, Southeast, Inc. Columbus, OH)

**“Psychiatrist Consultation to a Collaborative Behavioral Health Program in Primary Care”
- John S. Kern, MD**

(Project Director, Regional Mental Health Center, Merrillville, IN)

“Morning Huddle” - Corey Lakins, MSW

(Project Director, Milestone Centers, Inc. (PA))



Webinar Objectives

- Identify three structured approaches to effective communication that close the culture gap between primary care and behavioral health providers
- Describe the application of these approaches in the integrated care setting, how they support improved care and better outcomes



Grand Rounds

Presenter: Sandy Stephenson, LPCC, LISW
Director Integrated Healthcare, Southeast Inc.
Columbus, OH



About Southeast, Inc. Healthcare Services

- Incorporated as a 501(c)3 Community Mental Health Center in 1978
- Services are Provided in 6 Ohio Counties with primary location in Franklin County (Columbus, OH)
- BH services initiated in 1978; PC Services initiated in 1995
- FQHC status as a New Access Point, Healthcare for the Homeless, 2011
- 5,653 people served in Franklin County in FY 2012
- 1,320 people received PC in FY 2012
- Certified by Ohio Department of Mental Health, Ohio Department of Drug, Alcohol and Addiction Services; Accredited by The Joint Commission
- In Process – TJC Ambulatory Care Accreditation; NCQA Recognition; ODMH Medicaid Health Home Certification



Integrated Healthcare Staff Consultation and Education Processes

- **Morning Huddles**
Occur Daily; Rapid Review of Critical Information;
Template Driven yet Informal
- **Case Consultation(s)**
Unscheduled and as Clinically Indicated
- **Grand Rounds**
Professional Education; Occur Monthly with Required
Attendance; Template Driven and
Formal; CEU's for Some Licensed Staff



Morning Huddle Template

Integrated Healthcare

1. Physical Health – Presenting and Critical Issues (Chronic Physical Health Diagnoses and Health Indicators)
2. Behavioral Health – Presenting and Critical Issues (BH DXs/Information on 5 Axes)
3. Cluster Assignment and Relevance to Treatment (If Staged, Stage of Readiness for Change)
4. High Risk Issues/Current Safety Issues and Triggers
5. Agreed Upon Tasks and Integrated Activities (Who is Going to do What?)
6. Agreed Upon Follow-Up and Communication
7. Other



Grand Rounds

- A “Ritual” of Medical Education
- Presentation of the Medical Problems and Treatment of a Patient or a Specific Clinical Issue to an Audience of Medical Professionals, Interns, Residents, Students
- Presents “The Bigger Picture” Using a Particular Patient Situation as Example
- Provides Exposure to Situations and Best Practices that Others may not have Experienced
- Provides a Forum for Discussion/Learning



Grand Rounds Template

Southeast, Inc. Clinical Grand Rounds Presentation Format

(Prepare answers for each of the questions for your team's presentation. Assure you prepare an integrated approach, including behavioral and physical health responses)

Introduction and History (10 Minutes)

Include only Information Relevant to the Learning Focus and Important for Understanding of the Clinical Issues)

History of Present Illness(es)/Episode(s)

1. Brief demographic description of the client
2. Current symptoms of the present illness(es): Include all co-morbid medical conditions
3. History of and Current Substance Use/Abuse
4. History of and Current S/I or H/I



Grand Rounds Template, Cont'd

Past Psychiatric and Other Medical History

5. Time when mental health symptoms were first experienced (note symptoms and possible contributing factors)
6. Time when chronic/co-morbid health conditions were first experienced or diagnosed (note symptoms and possible contributing factors)
7. Other past/significant physical health history
8. Past psychiatric and other medical hospitalizations (Where, When, Why)
9. Past suicidal or homicidal attempts (When, Where, Why)
10. History of Violence
11. Medications that have been tried, both successfully and unsuccessfully
12. Medication Adherence
13. History of abuse/trauma/post-traumatic stress disorder
14. History of traumatic brain injury



Grand Rounds Template, Cont'd

Substance Use/Abuse History (note impact on MI and Physical Health Conditions)

15. Drugs and/or Alcohol past used and dates/age of 1'st use
16. AOD Treatment (When, Where, Outcome)

Family History

17. Current and/or past mental illness and/or AOD issues identified in parents/grandparents
18. Current and/or past mental illness and/or AOD issues identified in siblings or other family members
19. Current/Past additional/significant medical conditions identified in parents/grandparents
20. Current/Past additional/significant medical conditions identified in siblings or other family members

Additional Medical History

21. Other relevant current and/or past medical conditions with client
22. Any known allergies of client



Grand Rounds Template, Cont'd

Psychosocial History: Birth to Present

23. Early Childhood Development
24. Education
25. Employment
26. Legal History
27. Friendships/Relationships/Marriage or S/O
28. Religious/Spiritual Beliefs
29. Identified Race, Ethnicity and Culture
30. Family Involvement, including people the client identifies as his/her family
31. Sexual Orientation and Gender Identity
32. Current life style, behavioral and physical health high risk factors
33. Current medications and adherence
34. Current stressors
35. Current barriers for the client
36. Current strengths of the client
37. Behavioral Health Cluster Assignment (and implications for BH and PC Treatment)
38. Stage of Change/Readiness for Change (note if different across BH and PC health conditions)



Grand Rounds Template, Cont'd

Differential Diagnosis (15 Minutes)

Brainstorming session with audience: What diagnoses should be considered? Team Physician then presents the Multiaxial Diagnoses and Primary Care diagnoses, rationale, including current medications.

Where is the client is “stuck” presently?

Where is the team/other providers “stuck” presently?

Interventions & Treatment (20 minutes)

Interventions that have been successful in this type of clinical situation including Best Practices; Interventions that have not worked in this type of clinical situation; Ways client’s culture and family could be incorporated into client’s treatment & recovery plan.

Next Steps/Follow-Up (15 Minutes)

Suggestions from the audience for new interventions/approaches and rationale for these suggestions.

Suggestions from the audience regarding resources to access and/or recommendation for referrals.

Team will tell audience 3 new interventions they will attempt with the client and rationale. Evaluation for QI and for CEU’s



Integrated Learning Opportunities and Challenges Across Medical Cultures/Cultural Divide

- Implementing Staff Learning Experiences within Different PBHCI Models
- Selection of Presentations and PBHCI Application
 - Subject Specific: Trauma; TBI w/Substance Use and Co-Morbid Physical Health Issues; Atypical Antipsychotics and Metabolic Disorder/Diabetes Management
 - Case Specific: Patient with Major Unusual Incident; Patient Placed at High Risk; Patient with Differential Dx Considerations; Treatment is not Effective
- Role of Grand Rounds Facilitator
 - Interdisciplinary Learning Challenges
 - Hope Vs Frustration with Complexity of Patient Issues
 - MI/Substance Abuse/Physical Health “Balance”
 - Time well spent vs negative impact on productivity/bottom line



Questions?



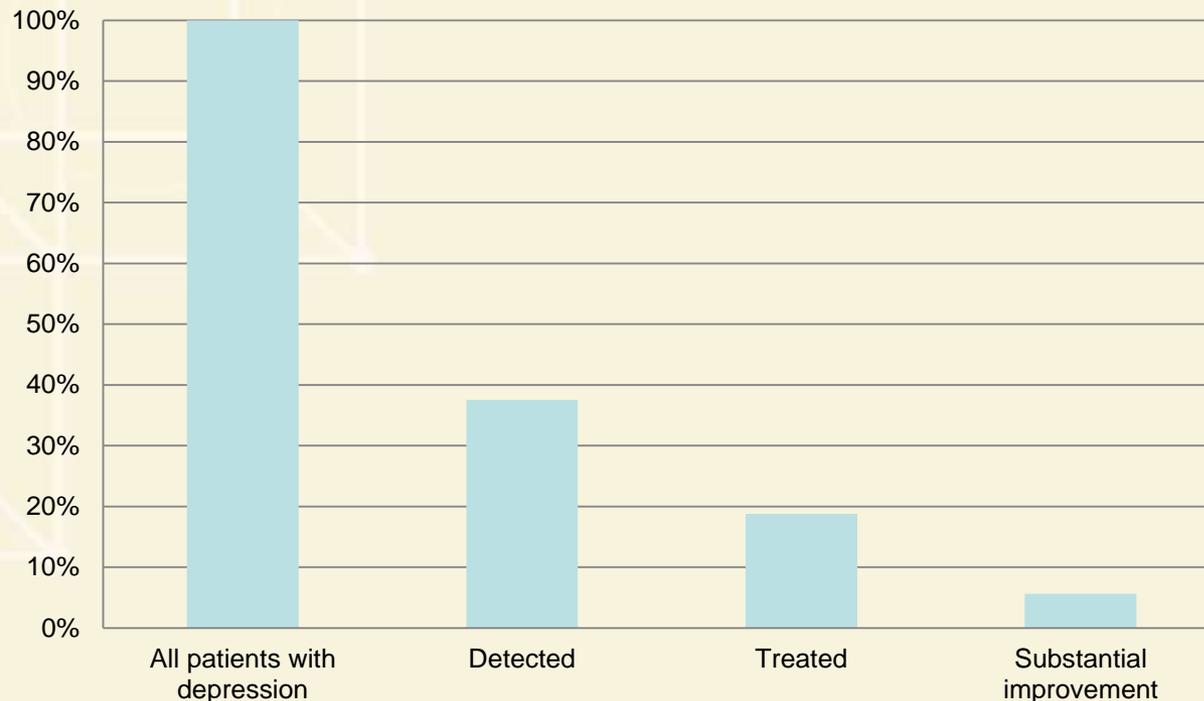
Psychiatrist Consultation to a Collaborative Behavioral Health Program in Primary Care

Presenter: John S. Kern, MD

Project Director, Regional Mental Health Center
Merrillville, IN



Depression Care in Primary Care as Usual



Kessler, RC, et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). JAMA, 2003. 289 (23): 3095-3105.



Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

Better access

- PCPs get input on their patients' behavioral health problems within a days /a week versus months
- Focuses in-person visits on the most challenging patients.

Regular Communication

- Psychiatrist has regular (weekly) meetings with a care manager
- Reviews all patients who are not improving and makes treatment recommendations

More patients covered by one psychiatrist

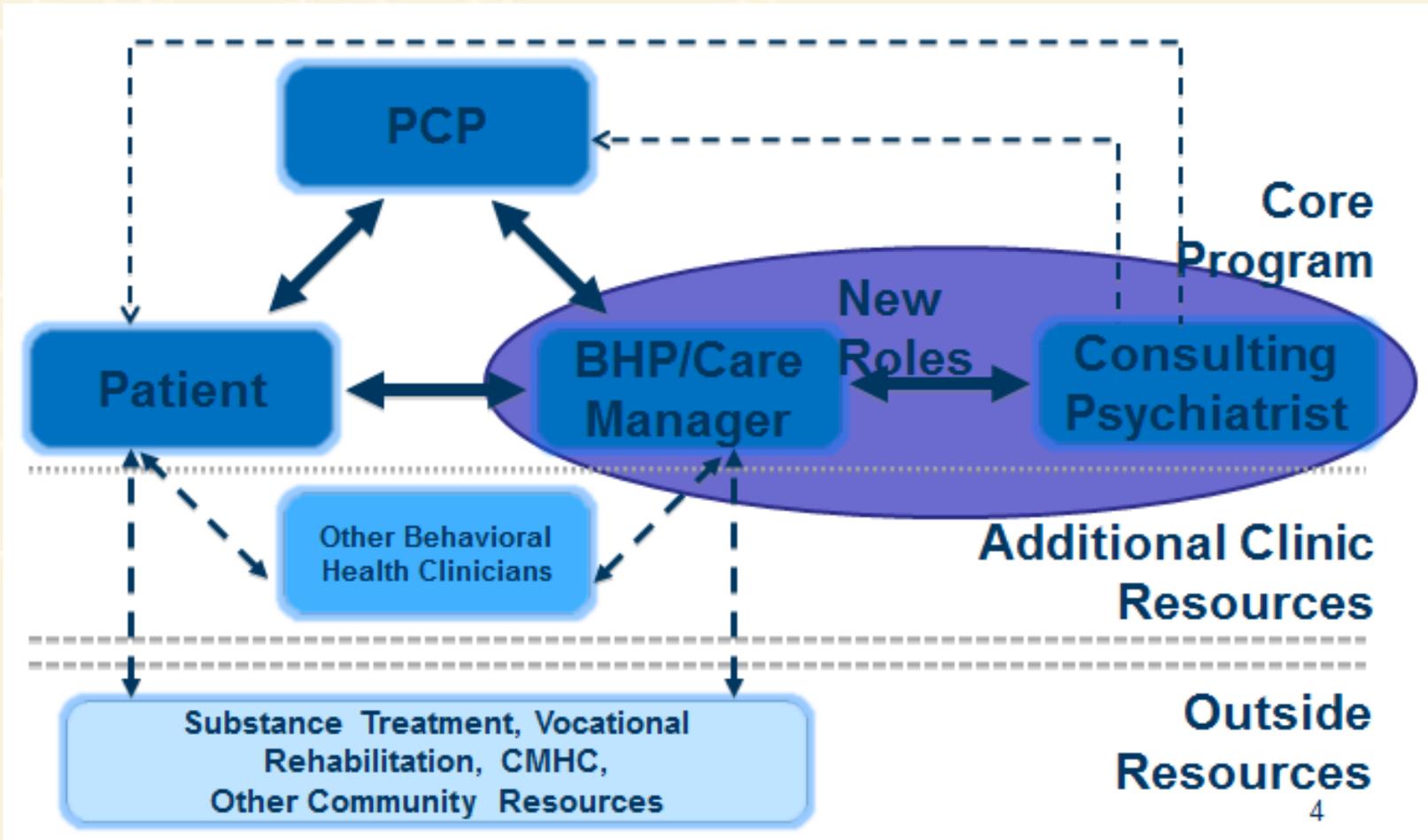
- Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients.

'Shaping over time'

- Multiple brief consultations
- More opportunity to 'correct the course' if patients are not improving



Collaborative Team Approach



Liability

PCP: Oversees overall care and retains overall liability AND prescribes all medications.
CM/BHP: Responsible for the care they provide within their scope of practice / license.

INFORMAL CONSULTATIVE
Curbsides, advice to PCP and BHP, no charting, and not supervisor of BHP, "take it or leave it"

COMBINED COLLABORATIVE
Curbside with PCP and BHP, could document recommendations in chart

FORMAL SUPERVISORY
Direct with patient after other steps unsuccessful, written opinion and paid
Psychiatric provider administrative and clinical supervisor of BHP → ultimately responsible

Collaborative care should reduce risk:

- Care manager supports the PCP
- Use of evidence-based tools
- Systematic, measurement-based follow-up
- Psychiatric consultant

Consulting psychiatrist moves between Informal and formal

•Olick et al, Fam Med 2003
•Sederer, et al, 1998
•Sterling v Johns Hopkins Hospital., 145 Md. App. 161, 169 (Md Ct. Spec. App. 2002)

BHP/Care Manager Toolkit

Clinical Skills

- Basic assessment skills
- Use of common screening tools
- Concise, organized presentations

Behavioral Medicine & Brief Psychotherapy

- Motivational interviewing
- Distress tolerance skills
- Behavioral activation
- Problem solving therapy

Other Skills

- Health Behavior Change
- Specific population skills (eg. Anticipatory Guidance for pediatrics)
- Referrals to other behavioral health providers and community Resources

Communication with BHPs/Care Managers

Method of Consultation

- Electronic communication (e-mail, instant messaging, cell phone, text)
- In person
- Tele-video

Consultation Schedule

- Regularly scheduled
- Frequency

Integrating Education

- Integrate education into consultations whenever possible.
- Scheduled trainings (CME, Brown Bag lunch, etc).
- Journal articles, handouts, protocols, etc (either in person or electronically).
- Encourage BHPs to attend educational meetings with you



Screening Tools as “Vital Signs”

Behavioral health screeners are like monitoring blood pressure!



- Identify that there is a problem
- Need further assessment to understand the cause of the “abnormality”
- Help with ongoing monitoring to measure response to treatment



Registries

Patient Caseload Program Tools Logout Search Patient: Hello, Jurgen (nutzer)

MHITS ID	POPULATION	DATE ENROLLED	STATUS	DATE	PHQ -9	GAD -7	# OF SESSIONS	WKS IN TX	DATE	PHQ -9	DEP IMPR	GAD -7	ANX IMPR	MED	CONTINUED CARE PLAN	PSYCH. NOTE	PSYCH. EVAL.	NEXT APPT.
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1 - 24 of 24

Population: G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, H - Home, C - Children, O - Older Adults, I - CMI
 * - score is last available but not from the last F/U.
 L1: Patient has been graduated from L2.
 L2: Patient is still not taken by a Case Manager after 14 days.
 Red: Most recent score is above 10 and has not improved by 3 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10.
 Yellow: Show a 3 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10.
 Green: Most recent score is below 10.

Population(s) included: GA-U Uninsured Veterans Veteran Family Members Home Children Older Adults CMI

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Assessment and Diagnosis in the Primary Care Clinic



- Diagnosis can require multiple iterations of assessment and intervention
- Advantage of population based care is longitudinal observation and objective data
- Start with diagnosis that is your 'best understanding'



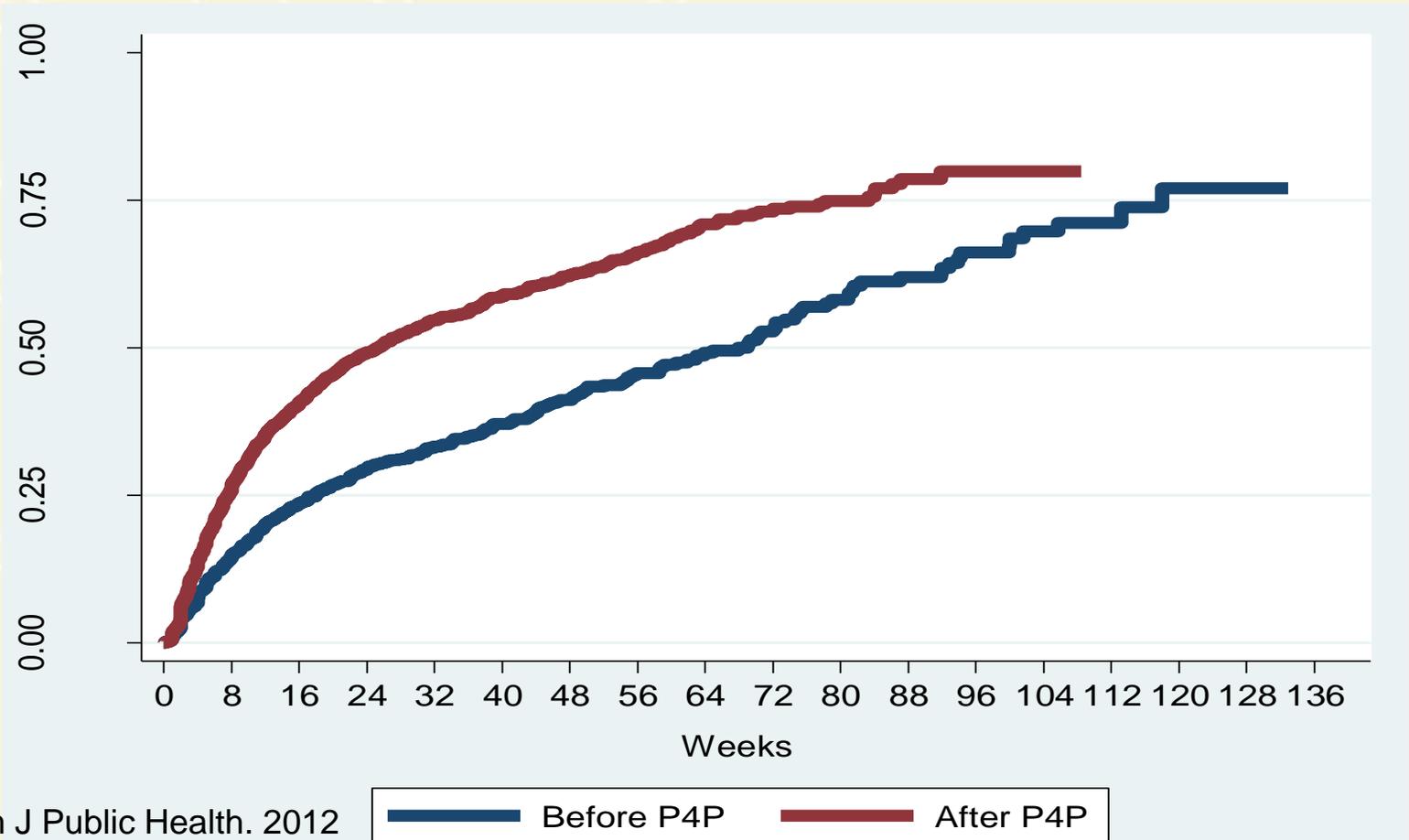
Caseload Review

If patients do not improve, consider

- Wrong diagnosis?
- Need different medication?
- Problems with treatment adherence?
- Insufficient dose / duration of treatment?
- Side effects?
- Other complicating factors?
 - psychosocial stressors / barriers
 - medical problems / medications
 - ‘psychological’ barriers
 - substance abuse
 - other psychiatric problems



The difference treat-to-target can make

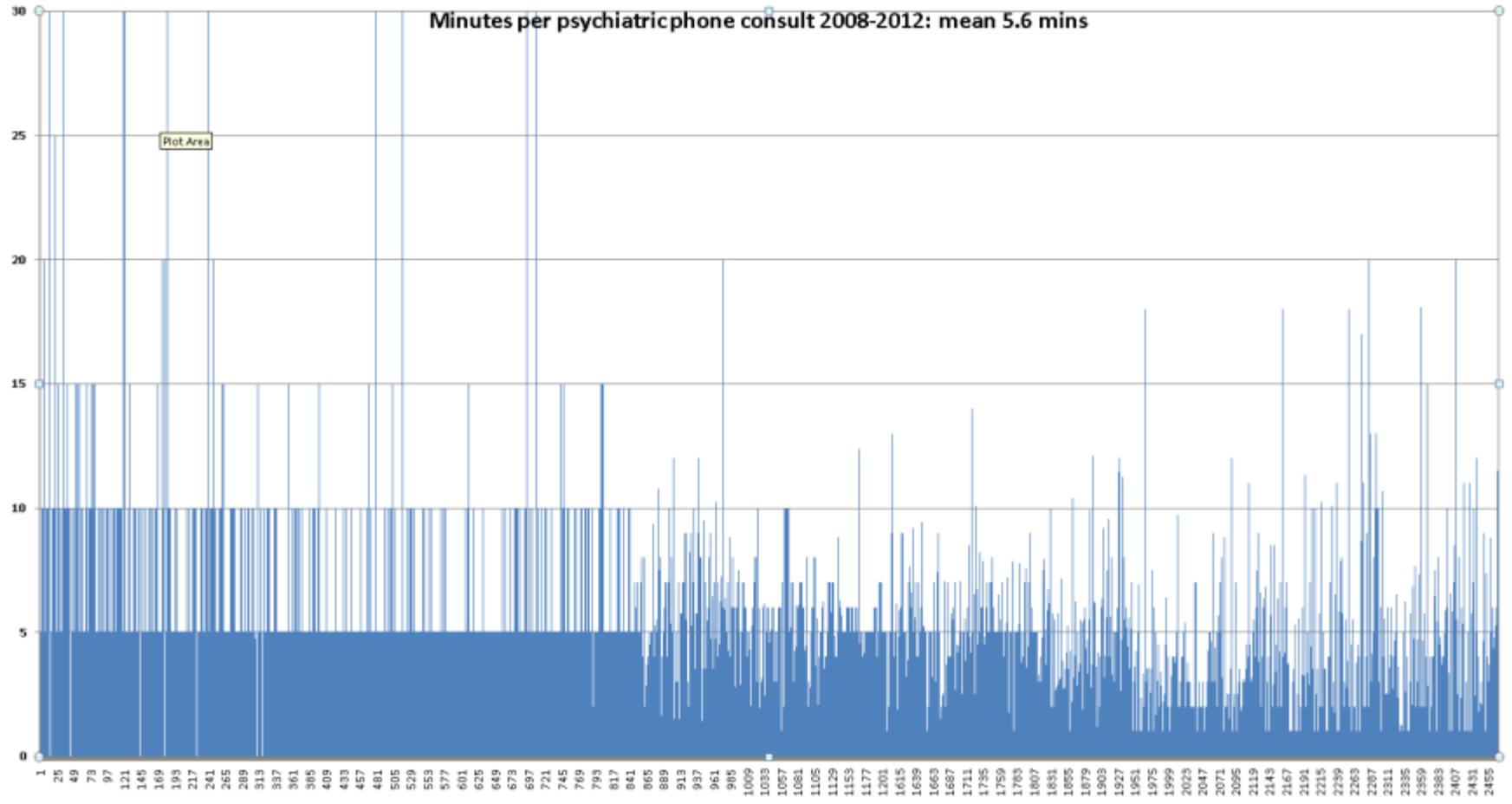


How Many Providers can be Supported by 5-hr Psychiatric Consultant?

- Peds - 3 FTE
- OB/Gyne - 3.6 FTE
- Midwives - 2.5 FTE
- Family Practice – 6.7 FTE
- Total: 15.8 [but almost all the business is from the FP's]



Curbsides to Behavioral Health Consultants

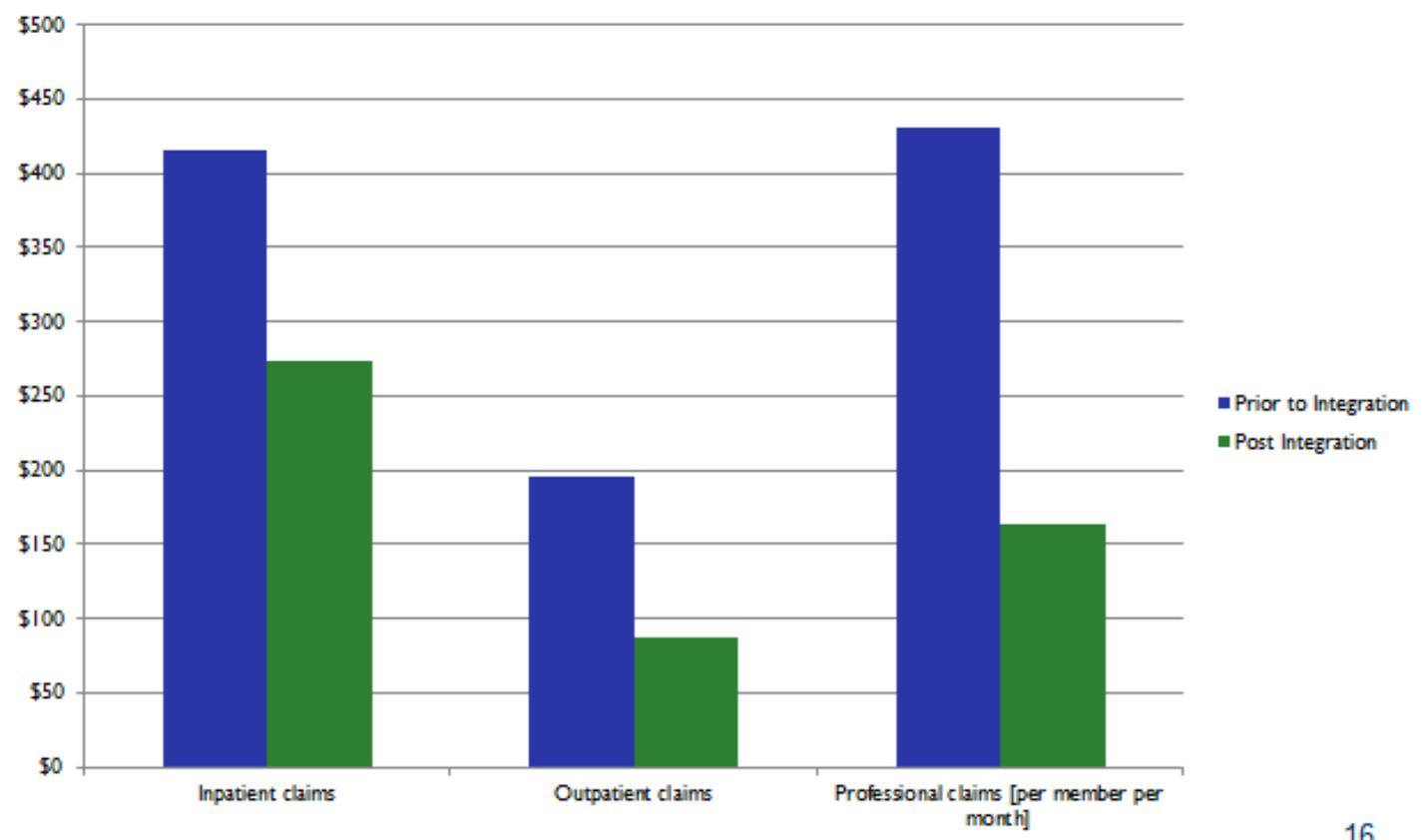


Consult Examples

REASON FOR CONSULT	DIAGNOSIS	RECOMMENDATION
Med SE from lithium	BP 1	Switch to VA
SE from <u>Vyvanse</u>	ADHD	Try another per protocol
Li level is 1.2	BP 1	<u>Cont</u> unless having SE
<u>Inc</u> depression <u>sx</u>	MDNOS	TSH, if <u>nl</u> start <u>Lamictal</u>
<u>Poss</u> SE from Seroquel	BP 1/PD	Dec Seroquel to 100 mg
Paxil not effective	MDD	Add <u>Wellbutrin</u>
<u>Req</u> <u>Lamictal</u> or XR?	BP 2	No difference
SE from <u>Celexa</u>	MDD	Switch to <u>Wellbutrin</u>
Depression <u>sx</u> <u>inc</u>	BP1	Check lithium level
Suicidal, acute distress	PD	Safety plan, therapy
High doses of meds, confused	MDD	Stop <u>Vistaril</u> , reduce Ativan, call collateral
Anxious, wants Xanax, nipple pain	GAD	No <u>xanax</u> , <u>inc</u> Zoloft, 15 coping skills



Midtown and North Shore Integrated Care: Significantly Reduced Overall Healthcare Costs in MDwise Study



Questions?



Morning Huddle

Presenter: Corey Lakin, MSW
Project Director, Milestone Centers, Inc.
Pittsburg, PA



Difference Between Morning Huddle and Case Conference?

- Morning huddle is reporting
- Case conference is discussion



Milestone's Preparation and Structure for Case Conference

- Therapist, CRNP and Psychiatrist BH client report form
- MD and RN clinical report
- Care Navigator's report



Milestone's Preparation and Structure for the Morning Huddle

- One or two Behavioral Health clinicians meets 10-15 minutes with the PCP prior to patient encounter
- Report the medication changes or additions
- Reports the mental health diagnosis and manifestation of symptoms



THERAPIST/CRNP/DOCTOR CLIENT REPORT

Client Name _____ **Date** _____

1) Medication updates/changes: Yes or No, if yes, what _____

2) Report of hospitalization: Yes or No, if yes, when _____,
and why _____
|

3) If hospitalized and discharged, were records requested: Yes or No

4) Has the client made any reports of physical symptoms or complaints:
Yes or No, if yes, what was reported: _____

5) Other reports _____

Thank you and please turn your report into your supervisor or HCH nurse
prior to the consumer's appointment with Dr. Fox and/or Gilboa.

Mobile Medical Van Schedule:

Penn Center – Every 2nd Thursday Monthly

Wilksburg – Every Thursday, except 2nd Thursday Monthly

Wood Street – Every 2nd Tuesday Monthly



Systemic Approaches

- The consumer belongs to one professional
- The recovery is in the hands of the one who best knows the consumer
- The information shared goes in separate treatment plans
- One discipline being the expert on the consumer
- Discussion with Psychiatrist between treatment team isn't necessary



What to Avoid

- Having a treatment team without both the MD and Psychiatrist
- A treatment team without clinical staff that works close with the consumer
- Starting an integrated treatment team without a list of priority consumers



Questions?



“Grand Rounds”

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**“Psychiatrist Consultation to a
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