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
(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
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

Collaborative Care

Caseload-focused psychiatric consultation supported by a care manager

Better access
- PCPs get input on their patients’ behavioral health problems within a day /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

- PCP
- Patient
- BHP/Care Manager
- Consulting Psychiatrist
- Other Behavioral Health Clinicians
- Substance Treatment, Vocational Rehabilitation, CMHC, Other Community Resources

Core Program
New Roles
Additional Clinic Resources
Outside Resources
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.

INAORMAL CONSULTATIVE
Curbside, 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
Direct with patient after other steps unsuccessful, written opinion and paid.

SUPERVISORY
Psychiatric provider administrative and clinical supervisor of BHP → ultimately responsible.

Consulting psychiatrist moves between informal and formal.

Collaborative care should reduce risk:
- Care manager supports the PCP
- Use of evidence-based tools
- Systematic, measurement-based follow-up
- Psychiatric consultant

Olick et al, Fam Med 2003
Sederer et al, 1998
**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 (e.g., 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

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**Notes:**
- Yellow: Shows a 3-point improvement from the initial assessment score. Or if initial assessment is the only assessed score and is above 10.
- Green: Most recent score is below 10.
- Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10.
- Green: Most recent score is below 10.
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

Minutes per psychiatric phone consult 2008-2012: mean 5.6 mins

www.integration.samhsa.gov
## Consult Examples

<table>
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<tr>
<th>Reason for Consult</th>
<th>Diagnosis</th>
<th>Recommendation</th>
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<tr>
<td>Med SE from lithium</td>
<td>BP 1</td>
<td>Switch to VA</td>
</tr>
<tr>
<td>SE from Vyvanse</td>
<td>ADHD</td>
<td>Try another per protocol</td>
</tr>
<tr>
<td>Li level is 1.2</td>
<td>BP 1</td>
<td>Cont unless having SE</td>
</tr>
<tr>
<td>Inc depression sx</td>
<td>MDNOS</td>
<td>TSH, if nl start Lamictal</td>
</tr>
<tr>
<td>Poss SE from Seroquel</td>
<td>BP 1/PD</td>
<td>Dec Seroquel to 100 mg</td>
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<tr>
<td>Paxil not effective</td>
<td>MDD</td>
<td>Add Wellbutrin</td>
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<td>Req Lamictal or XR?</td>
<td>BP 2</td>
<td>No difference</td>
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<tr>
<td>SE from Celexa</td>
<td>MDD</td>
<td>Switch to Wellbutrin</td>
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<tr>
<td>Depression sx inc</td>
<td>BP1</td>
<td>Check lithium level</td>
</tr>
<tr>
<td>Suicidal, acute distress</td>
<td>PD</td>
<td>Safety plan, therapy</td>
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<tr>
<td>High doses of meds, confused</td>
<td>MDD</td>
<td>Stop Vistaril, reduce Ativan, call collateral</td>
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<tr>
<td>Anxious, wants Xanax, nipple pain</td>
<td>GAD</td>
<td>No xanax, inc Zoloft, 15 coping skills</td>
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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 meet 10-15 minutes with the PCP prior to patient encounter.
- Report the medication changes or additions.
- Report 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
Wilkinsburg – Every Thursday, except 2nd Thursday Monthly
Wood Street – Every 2nd Tuesday Monthly

www.integration.samhsa.gov
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
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<td>Integrated Health Services Director</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Southeast, Inc. (Columbus, OH)</td>
<td>Project Director</td>
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<td><a href="mailto:stephensons@southeastinc.com">stephensons@southeastinc.com</a></td>
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