AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Working with Clients with Serious Mental Illness to Improve Health Outcomes Workshop
November 14, 2019

Agenda

TIME	TOPIC
8:00-8:30	Sign-in and Breakfast
8:30 – 9:00	Welcome and Introductions
9:00 – 9:30	Team Approaches to Supporting Health Outcomes in a Behavioral Health Agency
9:30 – 10:15	Partnering with Primary Care
10:15 – 10:30	**BREAK**
10:30 – 11:30	Working with Medical Conditions Relevant to Health Risk in People with Serious Medical Illness
11:30 – 12:00	**Lunch**
12:00 – 1:15	Using Whole Person Care Tools to Improve Health Outcomes of Clients with Serious Mental Illness
1:15 – 1:30	Action Planning and Next Steps

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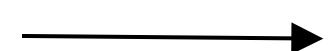
Action Planning Worksheet

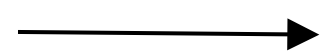
Instructions: After each session write down ideas, inspirations, or other things you want to take back to your organization to shape your work.

Team Approaches to Supporting Health Outcomes in a Behavioral Health Agency
Partnering with Primary Care
Working with Medical Conditions Relevant to Health Risk in People with Serious Medical Illness



Action Planning Worksheet

Using Whole Person Care Tools to Improve Health Outcomes of Clients with Serious Mental Illness



Working with Clients with Serious Mental Illness to Improve Health Outcomes Workshop Evaluation

Instructions: Please rate your agreement with the following statements based on your experience today.

Session 1: Team Approaches to Supporting Health Outcomes in a Behavioral Health Agency	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The presenter(s) were effective in delivering the information.				
2. The information and materials were relevant to my work and/or practice.				
3. Overall, I am satisfied with my time spent in this session.				

Session 2: Partnering with Primary Care	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The presenter(s) were effective in delivering the information.				
2. The information and materials were relevant to my work and/or practice.				
3. Overall, I am satisfied with my time spent in this session.				

Session 3: Working with Medical Conditions Relevant to Health Risk in People with Serious Medical Illness	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The presenter(s) were effective in delivering the information.				
2. The information and materials were relevant to my work and/or practice.				
3. Overall, I am satisfied with my time spent in this session.				

Session 4: Using Whole Person Care Tools to Improve Health Outcomes of Clients with Serious Mental Illness	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The presenter(s) were effective in delivering the information.				
2. The information and materials were relevant to my work and/or practice.				
3. Overall, I am satisfied with my time spent in this session.				

At the conclusion of this training you should be able to:

- Describe evidence and causes for reduced life expectancy in SMI populations
- Explain rationale for mental health providers accepting responsibility for improving health outcomes
- Illustrate the structure of an integrated care team, and the functions its members carry out
- Familiarize behavioral health agency staff with the medical office setting
- Describe steps to build relationships with primary care providers and teams
- Describe cultural differences between behavioral health and primary care
- Differentiate the team's role to monitor / support / intervene with medical conditions compared to "treating" them
- Describe key conditions affecting SMI populations

- Identify useful and appropriate sources of reference information on health conditions for staff
- List three health conditions likely to respond to simple interventions
- Demonstrate different interventions to try when working with clients to improve health outcomes
- Use AIMS Center tools to create plans with clients to address specific barriers to care

Considering the above learning objectives, please rate your agreement with the following statements:	Strongly Agree	Agree	Disagree	Strongly Disagree
4. The learning objectives were met.				
5. There was adequate opportunity to ask questions during the training.				
6. The information presented in this training enhanced my current knowledge.				
7. I will use the provided tools and/or handouts in my practice.				

8. If applicable, list one thing you intend to change and/or one lesson to apply to your practice and why.

9. What did you enjoy most about this training?

10. What could be improved in a future training?

11. What additional training and technical assistance would you like to receive in 2020 based on what you participated in today?

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Supporting Your Client in Calling Their PCP's Office: Vignette

Background

Crystal is a 50 year old woman with schizophrenia. She lives with her partner of many years. Due to her unremitting hallucinations, she has been unable to work since her teens, though can cook and take care of her house, and enjoy their cats. She has high blood pressure, is obese, largely from her medications, and has gastrointestinal difficulties related to very high doses of antipsychotic medication over many years.

Her med list is

- Lisinopril 20 mg daily
- Hydrochlorothiazide 50 mg daily
- Clozapine 600 mg at bedtime
- Aripiprazole 10 mg at bedtime

She has a good relationship with her primary care provider, Dr. Desai, but feels that the front desk staff at the office thinks that she is a bad person and maybe can read her thoughts. She is reluctant to call the office for this reason and has lost her temper when on the phone with them. She thinks of getting another doctor but is quite attached to Dr. Desai and after discussing the options with her case manager, decides to try to continue to deal with the front desk people.

Today she needs to call the office because she needs a refill on her aripiprazole, but the insurance company has insisted on a prior authorization before they will fill it because she is on two antipsychotic medications.

Activity

You are Crystal's case manager and you are assisting her in calling Dr. Desai's office. Using the "Support Your Client with a Primary Care Provider (PCP) Call or Visit" tool pretend you are making the call with Crystal.

1) What would you do with Crystal before calling Dr. Desai's office?

2) Based on the role play you just saw, anything you would add?

3) After the call what would your next steps be? Anything else you would do to help build your clients skills and confidence?

Hypertension (HTN) – Commonly Asked Questions

This guide is designed to help case managers provide answers to common questions they may hear from clients about the chronic condition hypertension. It is helpful for case managers to keep this guide where they can refer to it quickly when they get questions from clients.

What do I need to know about hypertension?

What is hypertension?

A condition in which the pressure in the blood vessels is higher than normal.

Why is this a bad thing?

It increases the risk of heart attack and stroke.

Is this the same thing as "High Blood Pressure"?

Yes. You will also see it abbreviated as "HTN."

How is it detected?

Through measurement with a blood pressure cuff. Review this chart to understand which BP numbers might be a problem.

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and /or	HIGHER THAN 120

If my blood pressure is high in the clinic on a single measurement, does that mean I have hypertension?

Not necessarily – an actual diagnosis would require more than one measurement and a primary care visit.

If my blood pressure is elevated, but I feel fine, does that mean I shouldn't worry about it?

No – hypertension USUALLY has no symptoms unless very severe.

How is hypertension treated?

With medication and close follow-up with your PCP. Some people can make lifestyle improvements that will reduce need for medication. Some may need always to be on medication.

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So, I have hypertension - what do I do now?

What can I do to improve my blood pressure?

- Don't smoke and avoid secondhand smoke.
- Reach and maintain a healthy weight.
- Eat a healthy diet that is low in saturated and trans fats and rich in fruits, vegetables, whole grains, and low-fat dairy products.
- Consume less than 1,500 mg/day of sodium (salt). Even reducing daily intake by 1000 mg can help.
- Eat foods rich in potassium. Aim for 3,500 – 5,000 mg of dietary potassium per day.
- Limit alcohol to one drink per day if you're a woman or two drinks a day of you're a man.
- Be more physically active. Aim for at least 90 to 150 minutes of aerobic and/or dynamic resistance exercise per week, and/or three sessions of isometric resistance exercises per week.
- Take medicine the way your health care provider tells you.
- Know what your blood pressure should be and work to keep it at that level.

Where can I read more about hypertension?

- American Heart Association: https://www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure
- Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/bloodpressure/materials_for_patients.htm
- MedlinePlus: https://medlineplus.gov/highbloodpressure.html
- Resources for Integrated Care, *Hypertension and Serious Mental Illness: A Tip Sheet for Navigators*:https://www.resourcesforintegratedcare.com/behavioral_health/navigation_services/tip_sheets%20

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Diabetes - Commonly Asked Questions

This guide is designed to help case managers provide answers to common questions they may hear from clients about the chronic condition diabetes. It is helpful for case managers to keep this guide where they can refer to it quickly when they get questions from clients.

What do I need to know about diabetes?

What is diabetes?

A disease in which blood sugar is abnormally elevated.

Is it called by other names?

You may also hear it called diabetes mellitus. It is frequently abbreviated DM.

Why is elevated blood sugar bad?

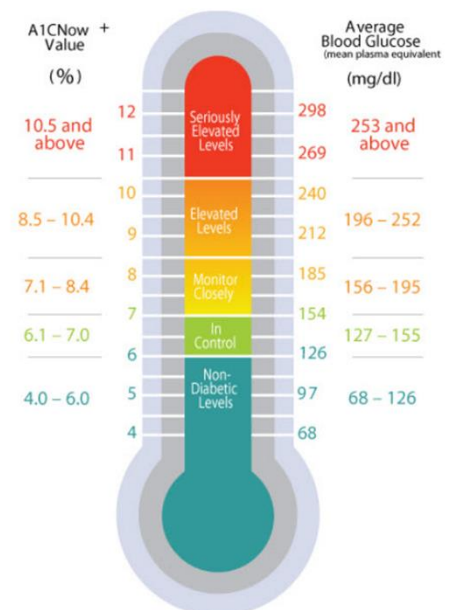
Elevated blood sugar causes severe damage over time to blood vessels, kidneys, nerves, eyes. It raises risk for heart attack and stroke. Getting it under control can reduce the risk of death by heart attack or stroke.

What causes diabetes?

It is mostly related to unhealthy weights. But it can also run in families.

How is diabetes diagnosed?

It is screened for in primary care clinics, and increasingly in behavioral health clinics, usually by use of blood tests such as HbA1c, pronounced "hemoglobin A one C." These are usually checked every 3 to 12 months, as the diabetes is monitored by the treatment team.



Is it important to know the numbers for these screening tests?

Yes – you will check your blood sugar daily or more often at home with the use of an instrument called a glucometer. This helps check how treatment is working, or if it needs adjusting. You will be asked to bring a record of these measurements to medical appointments.

How is diabetes treated?

There is no cure, but medications such as metformin and insulin, as well as healthy eating and attempts to maintain a healthy weight can control blood sugar levels and limit the damaging effects on organs.

So, I have diabetes - what do I do now?

What can I do to manage my diabetes?

Work together with your team and your primary care provider to:

- Measure and keep track of your blood sugar
- Use your medication regularly and share with your team how you think it is going
- Work with your case manager on healthy eating
- Get some exercise every day - even a little is better than nothing!

Can psychiatric medications make diabetes worse?

Yes – sometimes it will be possible to use medications that cause less weight gain and less risk of diabetes.

Can medications for diabetes cause side effects?

Yes – most importantly, blood sugar can be reduced to too low a level. You might experience the following symptoms: Fatigue, pale skin, shakiness, anxiety, sweating, confusion, abnormal behavior or both, such as the inability to complete routine tasks.

What should I do if I experience side effects from medications?

Eat something and then contact your case manager or health care provider – you made need to have your medication adjusted.

Where can I read more about diabetes?

- American Heart Association: https://www.heart.org/en/health-topics/diabetes/about-diabetes
- Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/diabetestv/managing-diabetes.html
- American Diabetes Association (ADA): https://www.diabetes.org
- MedlinePlus: https://medlineplus.gov/diabetes.html
- Resources for Integrated Care, *Type 2 Diabetes and Serious Mental Illness: A Tip Sheet for Navigators*: https://www.resourcesforintegratedcare.com/behavioral_health/navigation_services/tip_sheet/diabetes

Hyperlipidemia – Commonly Asked Questions

This guide is designed to help case managers provide answers to common questions they may hear from clients about the chronic condition hyperlipidemia. It is helpful for case managers to keep this guide where they can refer to it quickly when they get questions from clients.

What do I need to know about hyperlipidemia?

What is hyperlipidemia?

Hyperlipidemia is a condition in which cholesterol, a substance which normally circulates in the bloodstream, is present in excessive amounts.

Is this the same thing as "high cholesterol"?

Yes.

What is a "lipid"?

"Lipid" means "fat." hyperlipidemia means too much fat in the bloodstream, in the form of cholesterol.

Why is this a problem?

Hyperlipidemia (or "elevated cholesterol") increases the risk of heart attack and stroke.

If I am a vegetarian and eat no foods with cholesterol in them, does that mean I cannot have hyperlipidemia?

No, the body makes its own cholesterol in addition to that which a person eats. Reducing intake of especially saturated fats – those found in meat and dairy products – may reduce cholesterol to some degree. But vegetarians can have hyperlipidemia, too.

How is hyperlipidemia diagnosed?

With a simple blood test – people taking antipsychotic medication should have this done annually.

What are normal and abnormal cholesterol levels?

HDL is sometimes called "good cholesterol" – it has beneficial effects. HIGHER HDL levels are better - Think 'H' as in 'higher'. LDL is sometimes called "bad cholesterol." LOWER LDL levels are better. Total Cholesterol should also be LOWER.

Men age 20 or older:

Type of Cholesterol	Healthy Level
Total Cholesterol	125 to 200mg/dL
Non-HDL	Less than 130mg/dL
LDL	Less than 100mg/dL
HDL	40mg/dL or higher

Women age 20 or older:

Type of Cholesterol	Healthy Level
Total Cholesterol	125 to 200mg/dL
Non-HDL	Less than 130mg/dL
LDL	Less than 100mg/dL
HDL	50mg/dL or higher

So, I have hyperlipidemia - what do I do now?

How can I lower my cholesterol?

- A heart-healthy eating plan limits the amount of saturated and trans fats that you eat, these are found in red meat and full-fat dairy products.
- Weight reduction can help lower your LDL (bad) cholesterol.
- Everyone should get regular physical activity (30 minutes on most, if not all days).
- Quitting smoking can raise your HDL (good) cholesterol. Since HDL (good) helps to remove LDL (bad) cholesterol from your arteries, having more HDL (good) can help to lower your LDL (bad) cholesterol.
- **Medications.** If lifestyle changes alone do not lower your cholesterol enough, you may also need to take medication. There are several types of cholesterol medicines available, including statins. While you are taking medicines to lower your cholesterol, you should continue with the lifestyle changes. Work with your primary care provider to find the right medications.

Where can I read more about hyperlipidemia?

- American Heart Association: https://www.heart.org/en/health-topics/cholesterol
- Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/cholesterol/
- MedlinePlus: https://medlineplus.gov/cholesterol.html

Treat to Target: Physical Health Measures

Measure	Value	Condition
BMI	> 25	Overweight
	> 30	Obese
Blood Pressure	> 130/80	Hypertension/High Blood Pressure
	> 180/120	Hypertensive crisis (see MD or ER immediately)
HbA1c	> 5.7	Prediabetes
	> 6.5	Diabetes
Lipids (LDL)	> 190	Hyperlipidemia/ High Cholesterol

Choosing Wisely®

An initiative of the ABIM Foundation

American Psychiatric Association

AMERICAN PSYCHIATRIC ASSOCIATION™

Five Things Physicians and Patients Should Question

1

Don't prescribe antipsychotic medications to patients for any indication without appropriate initial evaluation and appropriate ongoing monitoring.

Metabolic, neuromuscular and cardiovascular side effects are common in patients receiving antipsychotic medications for any indication, so thorough initial evaluation to ensure that their use is clinically warranted, and ongoing monitoring to ensure that side effects are identified, are essential. "Appropriate initial evaluation" includes the following: (a) thorough assessment of possible underlying causes of target symptoms including general medical, psychiatric, environmental or psychosocial problems; (b) consideration of general medical conditions; and (c) assessment of family history of general medical conditions, especially of metabolic and cardiovascular disorders. "Appropriate ongoing monitoring" includes re-evaluation and documentation of dose, efficacy and adverse effects; and targeted assessment, including assessment of movement disorder or neurological symptoms; weight, waist circumference and/or BMI; blood pressure; heart rate; blood glucose level; and lipid profile at periodic intervals.

2

Don't routinely prescribe two or more antipsychotic medications concurrently.

Research shows that use of two or more antipsychotic medications occurs in 4 to 35% of outpatients and 30 to 50% of inpatients. However, evidence for the efficacy and safety of using multiple antipsychotic medications is limited, and risk for drug interactions, noncompliance and medication errors is increased. Generally, the use of two or more antipsychotic medications concurrently should be avoided except in cases of three failed trials of monotherapy, which included one failed trial of Clozapine where possible, or where a second antipsychotic medication is added with a plan to cross-taper to monotherapy.

3

Don't routinely use antipsychotics as first choice to treat behavioral and psychological symptoms of dementia.

Behavioral and psychological symptoms of dementia are defined as the non-cognitive symptoms and behaviors, including agitation or aggression, anxiety, irritability, depression, apathy and psychosis. Evidence shows that risks (e.g., cerebrovascular effects, mortality, parkinsonism or extrapyramidal signs, sedation, confusion and other cognitive disturbances, and increased body weight) tend to outweigh the potential benefits of antipsychotic medications in this population. Clinicians should generally limit the use of antipsychotic medications to cases where non-pharmacologic measures have failed and the patients' symptoms may create a threat to themselves or others. This item is also included in the American Geriatric Society's list of recommendations for "*Choosing Wisely*."

4

Don't routinely prescribe antipsychotic medications as a first-line intervention for insomnia in adults.

There is inadequate evidence for the efficacy of antipsychotic medications to treat insomnia (primary or due to another psychiatric or medical condition), with the few studies that do exist showing mixed results.

5

Don't routinely prescribe an antipsychotic medication to treat behavioral and emotional symptoms of childhood mental disorders in the absence of approved or evidence supported indications.

There are both on and off label clinical indications for antipsychotic use in children and adolescents. FDA approved and/or evidence supported indications for antipsychotic medications in children and adolescents include psychotic disorders, bipolar disorder, tic disorders, and severe irritability in children with autism spectrum disorders; there is increasing evidence that antipsychotic medication may be useful for some disruptive behavior disorders. Children and adolescents should be prescribed antipsychotic medications only after having had a careful diagnostic assessment with attention to comorbid medical conditions and a review of the patient's prior treatments. Efforts should be made to combine both evidence-based pharmacological and psychosocial interventions and support. Limited availability of evidence based psychosocial interventions may make it difficult for every child to receive this ideal combination. Discussion of potential risks and benefits of medication treatment with the child and their guardian is critical. A short and long term treatment and monitoring plan to assess outcome, side effects, metabolic status and discontinuation, if appropriate, is also critical. The evidence base for use of atypical antipsychotics in preschool and younger children is limited and therefore further caution is warranted in prescribing in this population.

These items are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about the items on this list or their individual situation should consult their physician.

Released September 20, 2013; recommendation #5 updated August 21, 2014; recommendation #3 updated April 22, 2015

How This List Was Created

The American Psychiatric Association (APA) created a work group of members from the Council on Research and Quality Care (CRQC) to identify, refine and ascertain the degree of consensus for five proposed items. Two rounds of surveys were used to arrive at the final list: the first round narrowed the list from more than 20 potential items by inquiring about the extent of overuse, the impact on patients' health, the associated costs of care and the level of evidence for each treatment or procedure; and the second gauged membership support for the top five and asked for suggested revisions and comments. The surveys targeted the CRQC; the Council on Geriatric Psychiatry; the Council on Children, Adolescents, and Their Families; and the Assembly, which is the APA's governing body consisting of representative psychiatrists from around the country. After the work group incorporated feedback from the two large surveys, the APA's Board of Trustees Executive Committee reviewed and unanimously approved the final list.

On April 22, 2015, APA revised item 3. Read more about these changes and rationale.

For APA disclosure and conflict of interest policy please visit www.psychiatry.org.

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About the ABIM Foundation

The mission of the ABIM Foundation is to advance medical professionalism to improve the health care system. We achieve this by collaborating with physicians and physician leaders, medical trainees, health care delivery systems, payers, policymakers, consumer organizations and patients to foster a shared understanding of professionalism and how they can adopt the tenets of professionalism in practice.

To learn more about the ABIM Foundation, visit www.abimfoundation.org.

About the American Psychiatric Association

The American Psychiatric Association (APA), founded in 1844, is the world's largest psychiatric organization. It is a medical specialty society representing more than 33,000 psychiatric physicians from the United States and around the world. Its member physicians work together to ensure humane care and effective treatment for all persons with mental disorders, including intellectual disabilities and substance use disorders. APA is the voice and conscience of modern psychiatry. Participating in the *Choosing Wisely®* campaign furthers APA's mission to promote the highest quality care for individuals with mental disorders (including intellectual disabilities and substance use disorders) and their families.

For more information, visit www.psychiatry.org.

For more information or to see other lists of Five Things Physicians and Patients Should Question, visit www.choosingwisely.org.

Vignette: PCP Visit with Jeff

Instructions: Using the 'Pocket Tool' and this worksheet, jot down your ideas for supporting Jeff during his PCP visit in the space provided below.

Client Case – Jeff

- 45 yo man. Schizoaffective – no hospital >10 years. Lives in supported apt. Some cognitive limitations.
- Medical situation
  - Obese; BMI >35
  - Pre-diabetic
  - Hypertension
  - Lipids high
  - Takes clozapine
  - Pizza 2x/day
- Receptive to intervention?
  - Wants to be pleasant
  - Nervous if thinks he is "in trouble"
  - Easily flustered when asked questions
- Strengths
  - Likes to exercise
    - Very active in Special Olympics
- Provider
  - Outside PCP
    - Not onsite or formally integrated
    - No shared EMR
    - Motivated to help

Before the Office Visit

During the Office Visit

At the End of the Office Visit

After the Office Visit

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What to Do When Your Client is Not Getting Healthier

It is often complicated to know how to even start to identify the barriers preventing our clients' health from improving. However, it is important to identify barriers as it allows us more effectively support our clients with their treatment plans. This tool is an organizing frame for case managers to help with this process. It is useful to keep this tool where it can be referred to quickly.

Identifying Barriers and Strategizing Intervention

Ask your client how they feel about improving their health	1. Consider Possible Barriers	2. Explore Further	3. Initiate intervention strategy
	Does not care or is apathetic	N/A	Motivational Interviewing
	Is hopeless or distracted by active psychiatric symptoms	N/A	Consult with psychiatric provider
	Might not fully understand medical conditions and/ or treatment plan	Find out what they already know.	Share patient education materials about medical conditions E.g., Hypertension, Diabetes, Smoking cessation

Asses Adherence	1. Consider Possible Barriers	2. Explore Further	3. Initiate intervention strategy
	Inconsistent with medication	Find out why. – Too complicated or expensive? – Something else unpleasant? – Tactfully inquire about literacy	Make medications simpler. – Use med boxes, set alarms – Advocate for your client with the medical team.
	Inconsistent with diet	Find out why. – Too complicated or expensive? – Something else unpleasant?	– Provide dietary teaching and support. – Advocate for your client with the medical team.
	Inconsistent with activity plan	Find out why they are inconsistent. – Too complicated? – Too expensive? – Something else unpleasant?	– Behavioral activation – Advocate for your client with the medical team.
	Inconsistent with another aspect of treatment plan, eg. CPAP machine	Find out why they are inconsistent.	eg. Fitting of CPAP machine Advocate for your client with the medical team.

Assess outside barriers	1. Consider Possible Barriers	2. Explore Further	3. Initiate intervention strategy
	Knowledge	Find out what they already know.	Share patient education materials about medical conditions E.g., Hypertension, Diabetes, Hyperlipidemia
	Money is tight	Clarify insurance in place.	– Help with insurance if needed – Support re-evaluation for cheaper meds – Build a relationship with the pharmacy.
	Transportation is unreliable.	Explore transport mode and needs.	– Maintain [and update!] a list of inexpensive options. – Assist with paperwork, if needed.
	Cultural attitudes about illness that may discourage treatment	Discuss with client and family.	– Try to negotiate solution, – Engage support from someone in social system who is supportive
	Other Social Determinants of Health, e.g., housing stability, food security, disability payments…	Explore with client.	– Maintain list of social services resources, assist client in accessing them.
	Need for more support in dealing with the medical system.	Lots of barriers here for any person!	– Consider visit with client to PCP to see first-hand what barriers might be. – See *"PCP Visit or Call Pocket Tool"*

Assess additional barriers related to healthcare providers (us!)	1. Consider Possible Barriers	2. Explore Further	3. Initiate intervention strategy
	Improved coordination with primary care? Do primary care providers interact effectively with us?	Our team may need to build a closer working relationship.	– Talk to your team. – Find someone in the primary care clinic who you can work with. – Find a way to make yourself useful to the primary care team: what kind of help can they use with improving the outcome of your clients?
	Support of mental health staff or organizational culture supporting integration	Find out what your colleagues think and feel about having to work in this area.	– Education re high medical risks to our clients
	Do we understand what the client is being asked to do and why?	Sometimes the number of treatments and tests and appointments can be overwhelming.	– Find out what the client knows. – Advocate for a simpler and more convenient treatment plan

Working with Clients Who Are Not Improving: Vignettes

1. Pills are a mess

You go to visit your client, Roger. You notice that he has some of his pill bottles on the coffee table, and some next to the sink, and that while last time you brought him a pill box, it is still in the wrapping. You say "Would it be ok if I helped you get started with the pill box?"

Roger says, "No, I got it covered, I just have my own system, I don't need you to do it for me."

You are concerned that he is not getting his meds.

What would you think about finding out next?

2. Client agrees, but doesn't function

You are with your client, Gail. You go over the directions for her CPAP machine with her for the third or fourth time. "Look right here," you say, "it shows how to adjust the strap…" You notice she is looking over your shoulder at something else. She says "Sure, I can do that!" and she seems to mean it, but it never seems to happen. You are having trouble accounting for the difference between what she says she can do, and what she actually does.

What would you think about finding out next?

3. Family opposed

Your client, Matilda, has had her blood pressure rising with each of her psychiatric appointments, in spite of being prescribed antihypertensive medication. You ask her if she has any idea why this might be. She says she has stopped taking it every day, because her mother told her that taking such strong medication every day must be bad for her, and she doesn't want to make her mom mad.

What would you do next?

4. Active psychiatric illness

Steven announces that he is not having his blood pressure done any more, being weighed, going to the PCP, or for that matter, taking his antipsychotic injections, which are "poison." He clarifies that he is being advised about this by God, who is talking to him. This is a change for Steven, who previously had been quite interested in his health, and proud of the progress he was making.

What would you do next?

5. Leveraging the relationship

You are working with Jeff. He is obese and has pre-diabetes. His PCP told him that he could forestall the onset of actual diabetes by exercising and losing some weight. He is fine with exercising, but struggles with the eating part. He lives mostly on frozen pizzas, and may eat 3-4 in a day – they are his idea of something good to eat, and he has never learned how to prepare any other kind of food, though he is over 40. You make clear to him that you think he should start eating other kinds of food. He says that he will do this for you, as you have been working with him for years, and he feels terrible when he thinks you are disappointed with him. But now he starts eating pizzas on the sly, and hiding the evidence.

How could you work with Jeff to help him make change at a rate he can manage?

6. Non-symptomatic client

Susie has high blood pressure, diagnosed by her PCP, and has been prescribed medication for this. She will take it for a few days, and then stop, because she feels fine. Why should she be taking medication?

How would you answer this question? Or find someone to answer it? How could you talk with Susie about this from a Motivational Interviewing point of view?

7. Other BH staff disparaging

William has bipolar disorder and a borderline personality disorder. He has worked for years with a therapist at your agency, who has helped him stabilize and develop skills for managing his emotional reactivity. He shares with you that his therapist has told him that she thinks that the agency's work on physical health is silly, a waste of time, and "the latest fad." He thinks that he should concentrate on his mental health, and let his diabetes work itself out.

What kind of inquiry could clarify what is really happening in this situation?

8. PCP not welcoming

Your client, Louise, has seen Dr. Bob ever since he delivered her in 1971. He is the doctor for her whole family. In addition to schizophrenia, she has an inherited form of hyperlipidemia that needs to be treated. She frequently forgets appointments, what she is supposed to do with her medication and diet, and to get her lab tests done that Dr. Bob orders. Your team decides that you should offer support to her medical care, and you arrive with Louise at her next appointment with Dr. Bob. He says that he has no idea why you are there, or why you should be in the exam room, and asks you to leave – he can manage Louise's care perfectly competently just the way he always has.

How can your team build a working relationship with Dr. Bob?

9. Client adherent, but still not getting better

Caroline came to your program at a late stage – she has a number of conditions in addition to her hypertension, diabetes, and hyperlipidemia: she has had a heart attack, breast cancer, which is presently in remission, and colitis. She is an enthusiastic participant in your program – she is motivated to eat thoughtfully, make sure she gets some exercise, and she has even assigned herself as an ambassador to other clients who are reluctant to engage with your program. In spite of all this, her blood pressure is still high when measured at her psychiatric appointments. This makes her sad and frustrated.

What should we do next?

10. Child with diabetes and adherence problems

Ramon is 15 years old and is being treated at your center with risperidone for autism with agitation. While this has helped him return to school, he has gained a great deal of weight, and now actually meets criteria for type II diabetes. He has been started on metformin by his pediatrician, but doesn't get it regularly, because he and his family think that he has got into enough trouble with medication side effects already.

How could we engage Ramon and his folks in his medical care in a way that will be sustainable and productive in the long haul?

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Psychiatry & Behavioral Sciences

Vignette Review Template

1. What is the problem?

2. Barrier[s] considered:

    1.
    2.
    3.
    4.

3. Next steps
    a. What more information might we need to clarify the situation?

b. How might you intervene?

i. In an ideal world?

ii. In your agency and with your resources?

PC in BH Intervention Plan Date_______________ Page _____/______

Client	Date of next meeting with case manager	Coordination with outside provider	Assistance with meds	Health behavior support plans ☐ Shopping ☐ Cooking ☐ Activity ☐ Smoking cessation	Date of next appt with psych provider	Documents needed: ☐ Discharge summary ☐ Old charts ☐ Last PCP ☐ Labs from outside	Labs needed: ☐ HbA1c ☐ Lipid profile ☐ TSH ☐ Levels ☐ LFT ☐ other	Other

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