AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

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

November 14, 2019

Welcome from Better Health Together

- Sarah Bollig Dorn
  - Senior Program Manager

AIMS Center Introductions

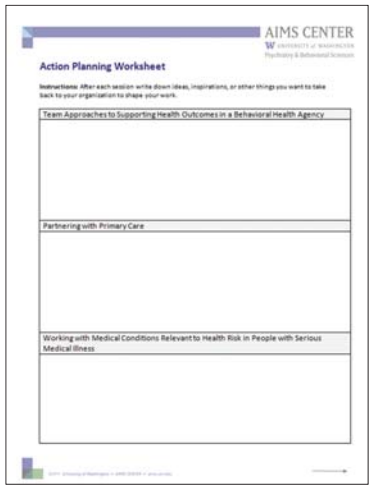
- John Kern, MD
  - Clinical Professor
- Milena Stott, LICSW, CMHS, CDP
  - Clinician Trainer

Introductions from Teams

- Clinic team
- Name
- What is your role?
- What is one thing you are hoping to gain from this training?

Setting the Stage

- Housekeeping
- Handouts and slides
- Action planning worksheet
- Evaluation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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

Overview of the Day

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

TEAM APPROACHES TO SUPPORTING HEALTH OUTCOMES IN A BEHAVIORAL HEALTH AGENCY

Session 1

Learning Objectives

By the end of this session, participants 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

What Motivates Us?

- Mission
  - Desire to take better care of individuals
    - What's your story?
- Financial sustainability
  - ACH payment
  - Eventual Value-Based Payment
  - Meeting payment metrics
- Other Reasons

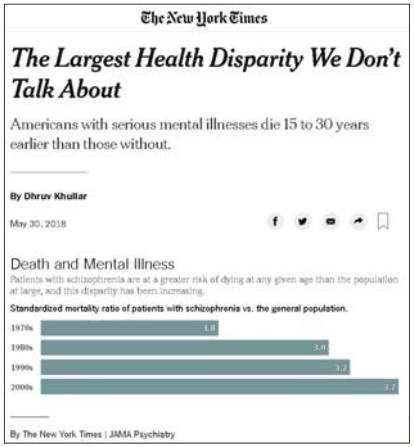
Introduction to the Mortality Gap

- Hard to pursue recovery goals when dead
- No one else is doing it
- Opportunity for frequent touches
- Now part of our mission

Reflection & Discussion

After reading the New York Times article….

- Any immediate reactions?
- How might you respond?


The New York Times

The Largest Health Disparity We Don't Talk About

Americans with serious mental illnesses die 15 to 30 years earlier than those without.

By Dhruv Khullar

May 30, 2018

Death and Mental Illness

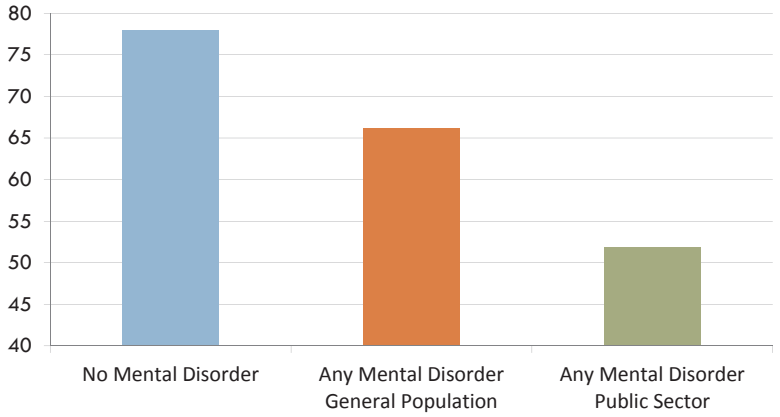
Patients with schizophrenia are at a greater risk of dying at any given age than the population at large, and this disparity has been increasing.

Standardized mortality ratio of patients with schizophrenia vs. the general population.

1970s 1.8
1980s 3.0
1990s 3.2
2000s 3.7

By The New York Times | JAMA Psychiatry

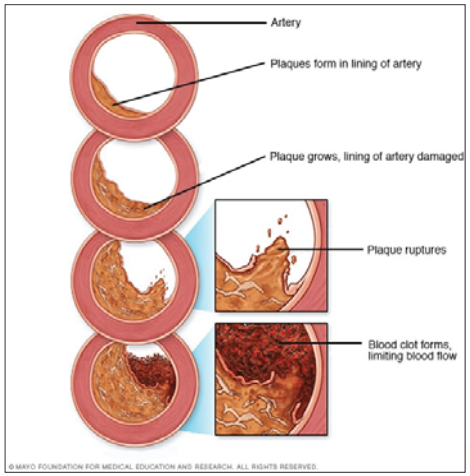
Life Expectancy of People with Symptoms of SMI: Still Short and Still Not Improving



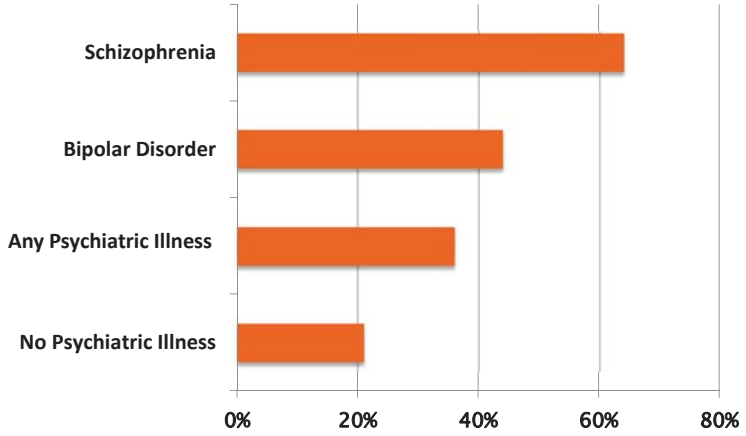
Bar 1 & 2: Druss BG, Zhao L, Von Esenwein S, Morrato EH, Marcus SC. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 June;49(6):599-604; Bar 3: Daumit GL, Anthony CB, Ford DE, Fahey M, Skinner EA, Lehman AF, Hwang W, Steinwachs DM. Pattern of mortality in a sample of Maryland residents with severe mental illness. Psychiatry Res. 2010 Apr 30;176(2-3):242-5

Cardiovascular Disease Defined

- Blocks blood vessels to heart or brain
- Causes heart attack or stroke



Prevalence of Current Smoking



Dickerson F, et.al,. Psychiatr Serv 2013; 64 (1): 44

Small Changes » Big Difference

Cholesterol ↓10%	• 10% ↓ in cardiovascular disease
Blood Pressure ↓6mm/Hg	• 16% ↓ in cardiovascular disease • 42% ↓ in stroke
Triglycerides ↓10 mm/L	5% ↓ in cardiovascular disease
HbA1c ↓1 pt	21% ↓ in diabetes related deaths 14% ↓ in heart attacks 37% ↓ in microvascular complications

Principles for Evidence-Based Integration

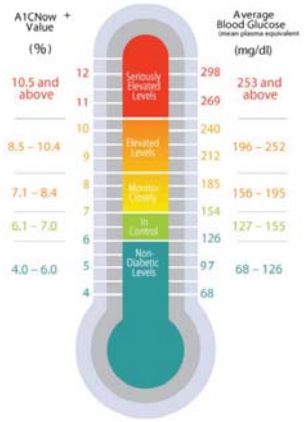
Team-Based and Person-Centered
Primary care and behavioral health providers collaborate effectively, using shared care plans.

Population-Based and Data-Driven
A defined group of patients or clients is tracked in a registry so that no one "falls through the cracks."

Measurement-Based Treatment to Target
Treatment goals clearly defined and tracked for every patient. Treatments actively changed until clinical goals are achieved.

Measurement-Based Care

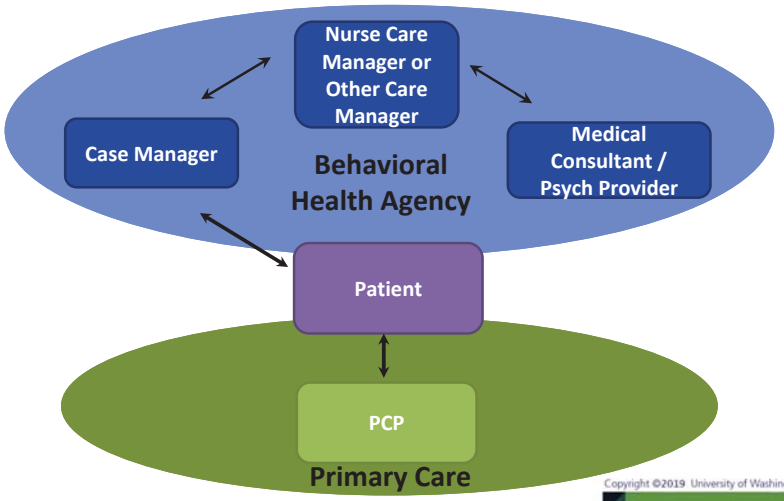
- **Systematic use of clinical data to drive clinical decision making**



Use of a Registry Supports Measurement-Based Care

Case Number	Active in Care Management Date	Primary Physician	RMHC Psychiatrist	Standard monitoring labs last done	BMI	LDL	HbA1c	Diastolic BP	Next PCP appt	Notes
943421	6/27/12	Dr. Carter	Chinweze	11/3/14	23	153	8.5	64	12.3.14	BPHC Client
1323163	9/4/13	Dr. Girn	Siegall		31					New PCP Referral Needed
1359811	2/23/11	Dr. Vavilala	Sandoval	7/16/14	34	148	4.2	97	12.3.14	Adult Case Manager: Jan Mueller
1373181	2/14/11	Dr. Ready	Ilyas	3/28/14	43	165	5.2	100	11.30.15	Adult Case Manager: William Whitely
1379191	10/2/13	Dr. Dobranski	Graham	5/24/10	32	162	5.4	70	12.1.15	
1386941	8/29/2011	Dr. Przeniczny	Lin	6/13/14	45	132	6.0	103	4.2.15	BPHC Client
1392941	4/7/14	Dr. Al-Kharrat	Ilyas	10/22/14	39	144	8.1	77	1.25.15	
1429731	5/21/14	Dr. Djurovic	Graham	9/26/14	42	127	4.9	105	12.10.14	BPHC Client
1456711	5/21/14		Yballe		33					BPHC Client
1478761	4/19/12	Dr. Przeniczny	Graham		25					Adult Case Manager: Jeanne Rearick
1500582	5/21/14	Dr. Simantarkis	Strayhorn		24					BPHC Client
1520511	3/10/11	Dr. Lucena	Ilyas		45					Adult Case Manager: Darcy Anderson
1522111	3/25/11		Lin	7/22/14	42	160	7.2	84	3.1.15	
1544892	5/21/14	Dr. Sandiford	Ilyas	1/13/14	32	160	4.9	74	11.14.14	BPHC Client
1564501	5/21/14	Dr. Djurovic	Siegall	9/26/14	41	120	8.0	76	4.1.15	BPHC Client
2031015	5/21/14	Dr. Sanchez	Dobransky	7/17/14	28	155	6.3	98	2.14.15	BPHC Client
2040722	3/18/11		Ramirez	6/12/14	32	152	6.9	102	3.12.15	Lake Park Residential
16200674	12/9/11		Lin		33					Lake Park Residential
16216393	2/27/14		Dobransky	2/27/14	44	147	7.7	78	11.20.14	Cholesterol issues and weight lose
16218469	3/5/12	No PCP	Kern	9/11/13	31	157	5.0	72	11.15.14	PCP Referral Needed
16220577	5/21/14	Dr. Ostrowski	Ramirez	2/11/14	45	120	8.1	76	12.1.15	BPHC Client
16223990	4/5/11	Dr. Vavilala	Ozoa	2/25/14	35	146	7.6	77	2.1.15	Adult Case Manager: Julie Peterson
16224462	5/21/14		Graham	6/24/14	42	149	4.5	96	12.10.14	BPHC Client
16228329	5/30/13	Dr. Girn	Lin	10.22.14	38	145	5.9	80	1.2.15	New PCP Referral Needed
16231478	12/2/14	Dr Ramirez	Ilyas		29					
16232096		Dr. Sandival	Siegall		26					
16238746	5/15/14		RHC	Lin	30					
16239558	5/21/14	Dr. Mac	Dobransky	6/12/14	40	180	5.7	110	4.1.15	BPHC Client
16240372	12/17/12		Dobransky		31					

Behavioral Health Home



Care Functions

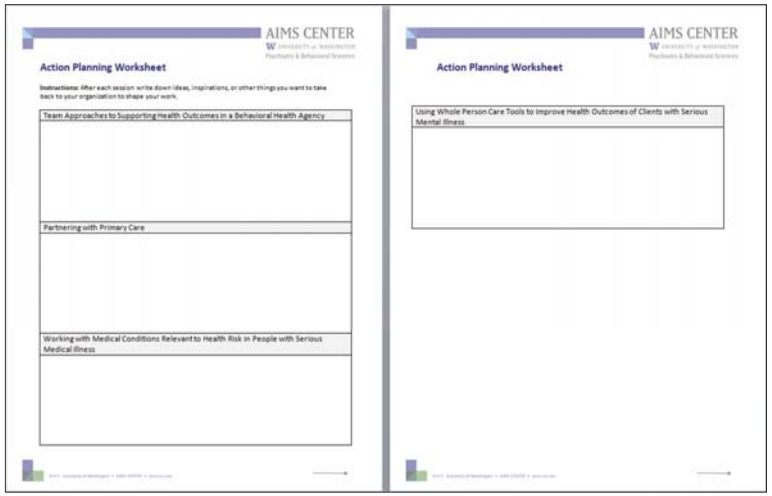
- Screening Functions
- Psychiatric Provider Functions
- Case Management Functions
- Registry Functions
- Medical Consultant Functions
- PCP Functions

New Ways to Perform Tasks

- **Changing roles of existing staff**
  - **OP nurses expanding into population health**
  - **Case managers expanding role definition into physical health.**
  - **Peers**
    - Primary role in supporting good health behaviors
  - **Support staff**
    - Clerical support of registry function

Have you figured out a novel solution?

Action Planning



PARTNERING WITH PRIMARY CARE

Session 2

Learning Objectives

By the end of this session, participants should be able to:

- **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**

Bridging the Cultural Divide

Behavioral Health

Primary Care

Primary Care Provider's View

- I don't understand patients with mental illness
- Their physical illness and symptoms are due to mental illness
- Treating people with mental illness takes more time

Client's View

- Doctors don't understand
- Doctors are incompetent
- Doctors are impatient
- Doctors are scary

Cultural Differences

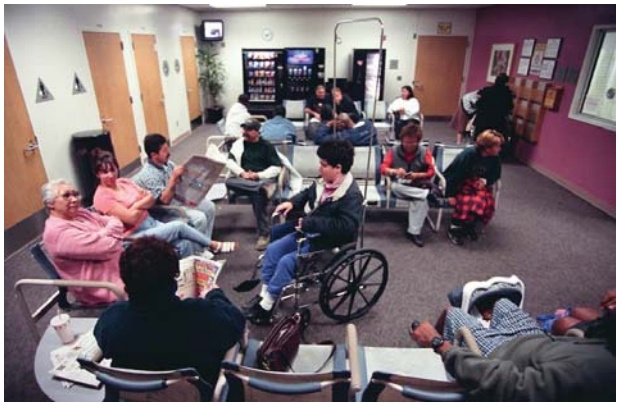
- Pace
- Environment
- Model of Care
- Jargon

Pace

- May be long wait in waiting room
- Appointment may be delayed
- Initial encounter with provider 15-30 minutes
- Follow up encounter 7-20 minutes
- Same day appointments possible
- Only possible to address top 1-3 concerns, at most, in any given appointment

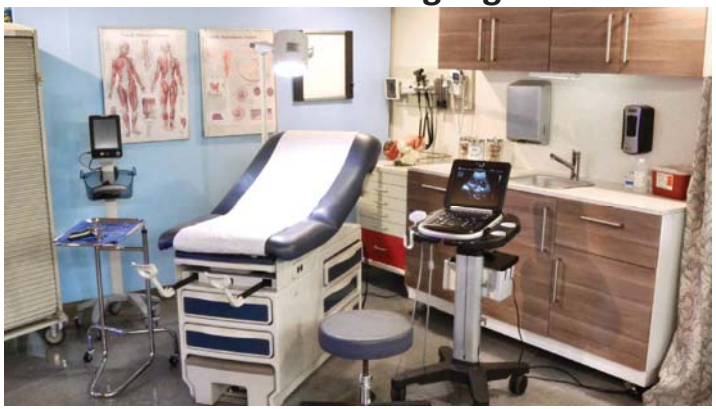
Environment of Primary Care

- Busy, hectic, full waiting room



Environment of Primary Care

- Exam rooms with lots of gadgets



Primary Care Visits Different from the Mental Health Environment

- Usually interact with several people before seeing PCP:
  - MA, Care Coordinator, LPN, RN, ARNP, Care managers….
- Frequent interruptions
- Services involve touch
- Address top 1-3 concerns

Primary Care Jargon

- "Patient" vs. "client" or "consumer"
- "Member" in a health plan
- Medical jargon (BP, BMI, HTN, DB, HGBA1C, etc.)

Reflection & Discussion

- What are your tips for developing a relationship with primary care?
  - What have you tried that worked? Didn't work?

Partnership Principles: Do!

- Tend to their needs
- Bring something to the table
- Assist whenever possible
- Make it about the next 10 encounters
- Find common ground and interest
- Reveal anything helpful
- Take one for the team

Partnership Principles: Don't!

- Bring your needs first
- Expect to "get" something
- Limit assistance to a project
- Make it about this single encounter

Tips for Communicating with Primary Care About a Client

- Quick identification of caller
- Quick identification of client
- Brief statement of reason for call
- Have information ready
  - i.e. patient demographics, lab tests, insurance, medications, any other pertinent information
- Make the call with the client if possible

Learning Activity: PCP Call Vignette

Prompt:

- You are Crystal's case manager and you want to help her communicate more effectively with the doctor's office

Instructions:

- Follow along with Crystal's case
- Use the 'Pocket Tool' to help us support Crystal during her PCP call
- Jot down ideas on the "Supporting Your Client in Calling Their PCP's Office: Vignette" handout

Client Case – "Crystal"

- 50 yo woman, schizophrenia. Lives with her long-term partner. Can't work due to hallucinations, but can take care of her house
- Medical conditions
  - High blood pressure
  - Obese, largely due to her medications
  - Gastrointestinal difficulties due to her medications
  - Lisinopril, 20mg/day
  - Hydrochlorothiazide 50mg/day
  - Clozapine 600mg/bedtime
  - Aripiprazole 10mg/day
- Receptive to treatment?
  - Good relationship with her PCP, Dr. Desai
  - Feels the front desk staff thinks she's a bad person/can read her thoughts
    - Reluctant to call the office for this reason and lost her temper on the phone with them
  - Thinking of finding a new doctor, but is attached to Dr. Desai
  - Discussed this with her case manger and decided to try to continue to deal with the front desk
- Today's call
  - 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

Before the Call

Support Your Client in Calling their PCP
Before the Call – Review reason for PCP call (i.e. lab results, check in, solve a problem) – With Client, determine 1 question to ask – Gather relevant information (i.e. client DOB, case numbers, insurance card, RX's) – Write down & practice the ONE question – Be prepared to take notes during the call

- Gather relevant info:
  - Clinic phone number
  - Name of the front desk staff person
  - Refill number on the pill bottle
  - Other paperwork from the prior auth. process
    - Help Crystal put all the info in one easy-to-find place – a little notebook?
- Write down and practice the question:
  - Exactly what to say when they answer
    - Brainstorm likely challenges:
      - Front desk is rushed and impatient
      - You get flustered and hang up
- Anything else you would do before the call?

Role Play and Discussion

Instructions:

1. **Have you assisted a client in calling a primary care office? Tell us about your experience**
2. **Observe the role play**
3. **As a case manager would you add anything else to the call you just observed?**

During the Call
- Remain cordial, even when frustrated
- Thank the staff you talk to by name
- Identify yourself & relation to client
- Give call reason in two sentences or less
- Ask for your clinic contact (if applicable)
- Take notes including: who was talked to, information received and next steps

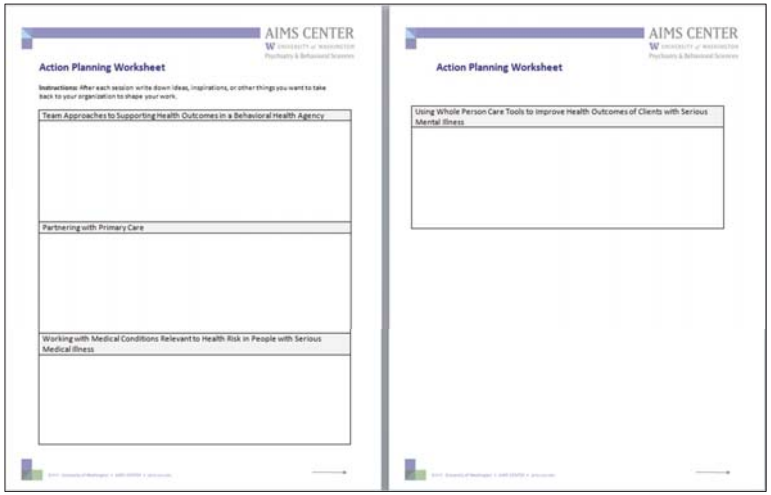
After the Call

After the Call
- Briefly summarize notes in chart
- Develop next steps with client

Case manager and Crystal write themselves a note:
- **Talked to Nancy on Tuesday at 2 pm**
- **She said they had prior authorization and doc would do it today**
- **Next Steps:**
  - **Planned for Crystal to call back tomorrow**
    - **Make sure you have your notes!**
  - **Crystal will let case manager know if any problems. They will meet next week at the same time.**
- **Case manager: "Hey, you're getting this prior authorization thing figured out!"**

Anything else you would do to help your client build skills and confidence?

Action Planning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Team Approaches to Supporting Health Outcomes in a Behavioral Health Agency

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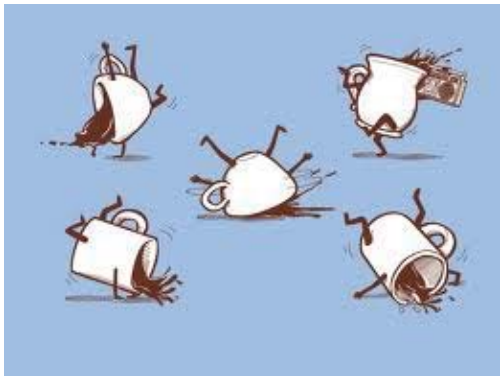
Action Planning Worksheet

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

BREAK



WORKING WITH MEDICAL CONDITIONS RELEVANT TO HEALTH RISK IN PEOPLE WITH SERIOUS MENTAL ILLNESS

Session 3

Learning Objectives

By the end of this session, participants should be able to:

- 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

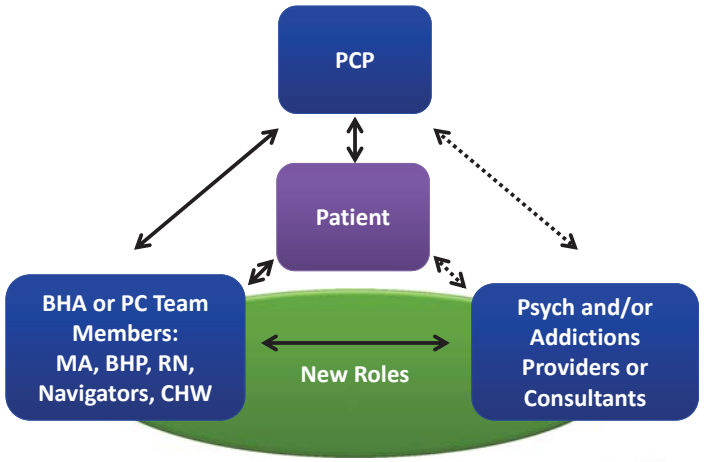
Supporting Client Medical Care

"All meaningful behavioral change occurs in the context of a personal relationship."

- Joe Parks, MD

Director, Missouri Health Homes Project

Behavioral Health Home Team

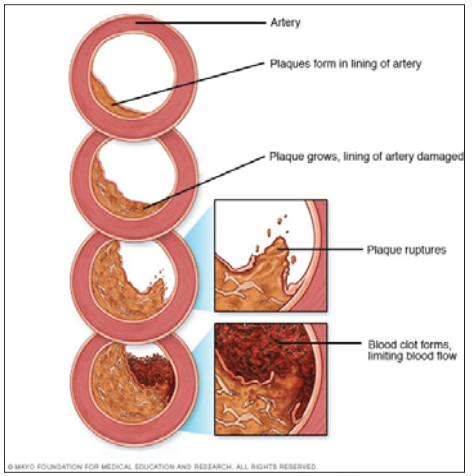


Supporting vs. Treating

- Promoting basic health literacy
- Advocating for client
- Reducing health disparity
- Facilitating treatment goals
- Removing barriers to health care
- Preventing illness and complications

Cardiovascular Disease Defined

- Blocks blood vessels to heart or brain
- Causes heart attack or stroke



FINDING AND USING GOOD INFORMATON ABOUT COMMON HIGH RISK CONDITIONS

What Should a Case Manager Know About Medical Conditions?

"Coaches working with patients with cardiovascular risk (i.e. diabetes, hypertension, and high LDL-cholesterol) need to know as much about these conditions as patients should know. It is important that coaches have easy access to patient education materials on these topics."

- "Health Coaching," the UCSF Center for Excellence in Primary Care

Chronic Health Condition Guides: Commonly Asked Client Questions

- Brief, to be used as reference tool
- Common conditions important for cardiovascular risk:
  - Hypertension
  - Diabetes
  - Hyperlipidemia

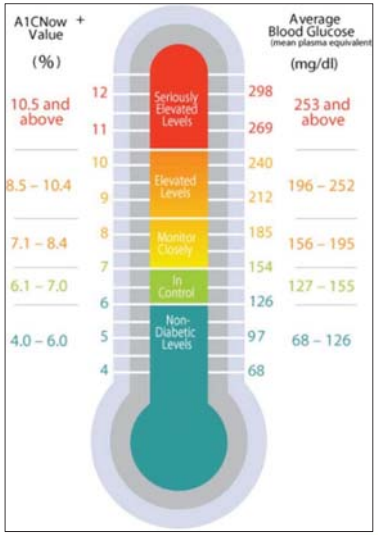
Hypertension (High Blood Pressure)

- Elevated pressure in blood vessels
- Increases the risk of death by stroke or heart attack
- Treating
  - Medication
  - Health behavior change
    - Weight management, exercise
    - Smoking cessation
    - Limiting alcohol

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

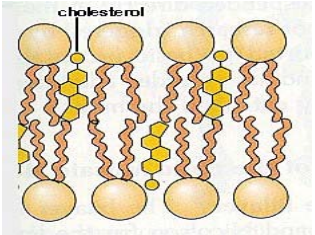
Diabetes Mellitus (DM)

- Condition in which blood sugar is abnormally elevated
- Damages eyes, kidneys, blood vessels
- Usually related to overweight
- Treated with dietary management, meds
- Measurements of blood sugar followed closely



Cholesterol

- A normal fat like substance found in your blood
- A key component to cells
- Comes from foods we eat



High Cholesterol - Hyperlipidemia

- **Hyperlipidemia**
  - **High levels of cholesterol in blood**
  - **Related to death by stroke or heart attack**
- **Risk factors include obesity and genetics**
- **Treated successfully with medication, weight reduction**

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

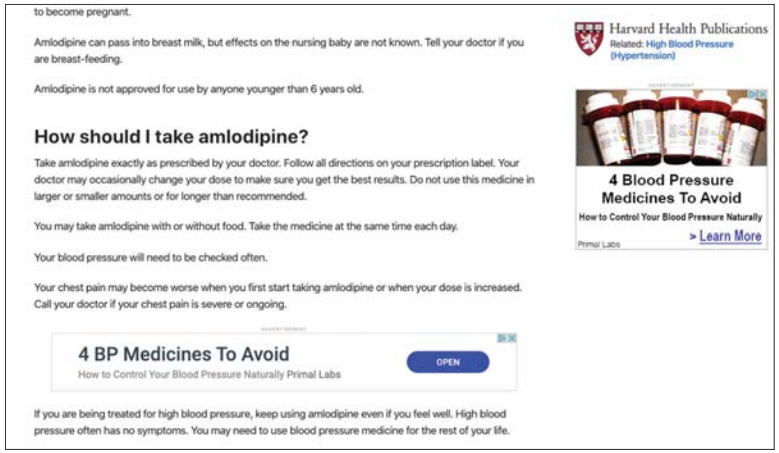
Women age 20 or older:

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

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

Unreliable Sources of Information on Medical Conditions


to become pregnant.

Amlodipine can pass into breast milk, but effects on the nursing baby are not known. Tell your doctor if you are breast-feeding.

Amlodipine is not approved for use by anyone younger than 6 years old.

How should I take amlodipine?

Take amlodipine exactly as prescribed by your doctor. Follow all directions on your prescription label. Your doctor may occasionally change your dose to make sure you get the best results. Do not use this medicine in larger or smaller amounts or for longer than recommended.

You may take amlodipine with or without food. Take the medicine at the same time each day.

Your blood pressure will need to be checked often.

Your chest pain may become worse when you first start taking amlodipine or when your dose is increased. Call your doctor if your chest pain is severe or ongoing.

4 BP Medicines To Avoid
How to Control Your Blood Pressure Naturally Primal Labs
OPEN

If you are being treated for high blood pressure, keep using amlodipine even if you feel well. High blood pressure often has no symptoms. You may need to use blood pressure medicine for the rest of your life.

Harvard Health Publications
Related: High Blood Pressure (Hypertension)

4 Blood Pressure Medicines To Avoid
How to Control Your Blood Pressure Naturally
> Learn More
Primal Labs

Reliable Sources of Information on Medical Conditions

- **AIMS training and support materials!**
- **Medical providers and nurses**
- **Use the Internet with caution**
- **Reliable sites include:**
  - **Medline Plus**
  - **WebMD**
  - **Mayo Clinic**
  - **American Heart Association**
  - **American Academy of Family Physicians**
  - **American Diabetes Association**

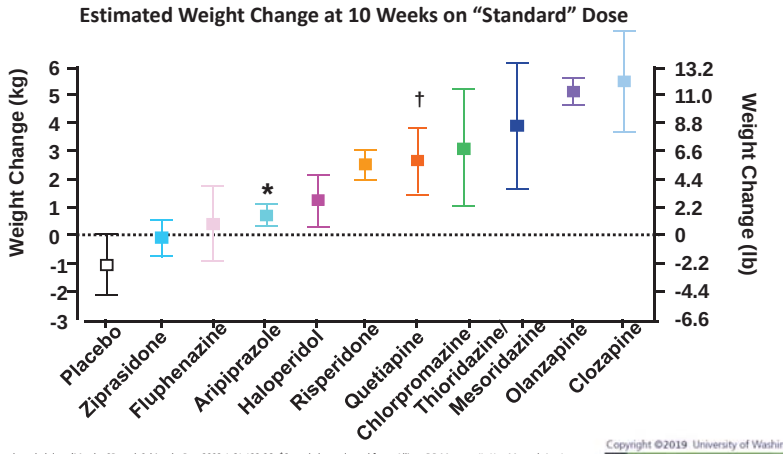
Case Managers Do Not Diagnose Chronic Health Conditions in Clients

- Will be identified by medical or psychiatric teams
- Once identified, case managers support a client in managing these conditions
- If a client shares information about a condition you think your team doesn't know about, let the team know

Side Effects of Psychiatric Medications

- Weight gain
- Diabetes
- High cholesterol and abnormal triglycerides
- Insulin resistance

Obesity and Impact of Antipsychotic Medications



*4–6 week pooled data (Marder SR et al. Schizophr Res. 2003;1;61:123-36; †6-week data adapted from Allison DB,Mentore JL, Heo M, et al. Am J Psychiatry. 1999;156:1686-1696; Jones AM et al. ACNP; 1999.

So What Do We Do?

- Health Behavior Change
- Supporting Medical Care
- Wise Prescribing

Modifiable Risk Factors

- Obesity

- Meds that cause weight gain

- Smoking

- Lack of exercise

- Untreated medical illness

Supporting Health Behavior Change

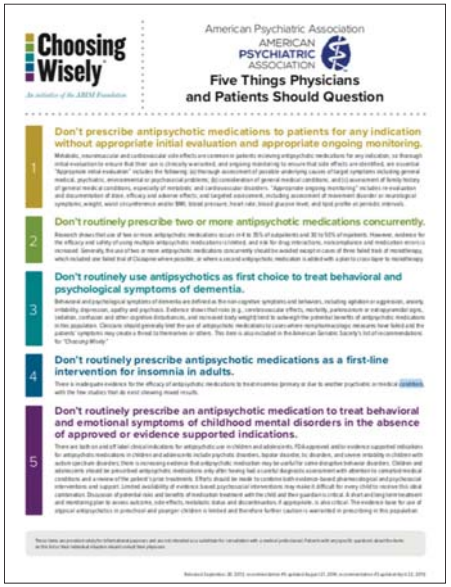
- Not too much or too fast… you are in for the long run
- Suggest the simplest behavior change
- Help brainstorm to make change as effortless as possible
  - e.g. pills by the toothbrush or shoes by the bedside
- Get an early win
  - Think of something that will make the client feel better soon i.e. a short walk together

Obesity Management

- A reasonable goal may be to reduce weight by 10% in 6 months. This can be achieved by the following:
  - Exercise
  - Dietary Change
  - Behavioral therapy
  - Medication
- STRIDE program
  - A 30-Session group-based Weight Loss and Weight Maintenance Program for People who live with Mental Illness
  - Kaiser and NWMHTTC – coming soon!

Wise Prescribing

- Minimizing risk of obesity



http://www.choosingwisely.org/wp-content/uploads/2015/02/APA-Choosing-Wisely-List.pdf

Tobacco Cessation

Ask	• About tobacco use
Advise	• To quit
Assess	• Readiness to make a quit attempt
Assist	• With making a quit attempt
Arrange	• A follow-up plan

Resource:
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/ProfessionalResources/TobaccoCessationResources

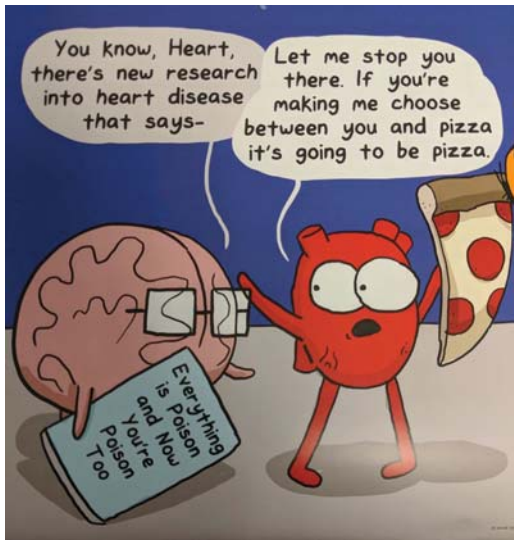
Smoking Cessation in SMI

- **Smoking prevalence has *not* decreased in SMI**
- **50% of deaths in SMI attributable to tobacco**
- **Cessation improves cognition and mental health outcomes**
- **Chantix *not* associated with poor mental health outcomes**

(Taylor et al. BMJ, 2014; Am J Psychiatry 2013; 170:1460–1467)

Supporting Health Behavior Change

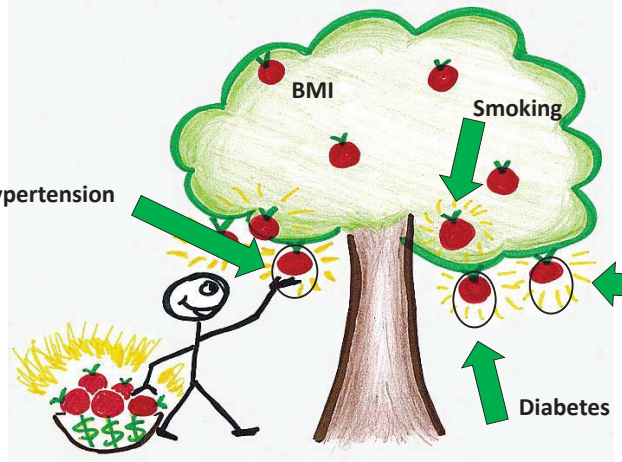
- **Motivational Interviewing**
- **Educating clients and staff**
- **Why we are doing this?**
  - **Remember your elevator speech?**
  - **Taking care of the whole person**
- **High level issues**
  - **Antipsychotic effects on weight**
  - **Major metabolic problems – Diabetes, Hypertension**
  - **Top 10 meds**



Case Manager Role in Client Medical Care

- Appointments
  - Making, keeping, using
- Building relationships
  - With client, caregivers and primary care providers/teams
- Healthy living
  - Reminding, encouraging, frequent contacts
- Navigating Medical System
  - Interacting and interpreting
  - Advocating for your client

Low Hanging Fruit



Learning Activity: Choose the Low-Hanging Fruit! Win Fabulous Prizes!

Round 1: Which is the Low-Hanging Fruit?

- Restarting preventative COPD meds
- Weekly Zumba class
- Group education about diabetes

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- Restarting preventative COPD meds
- Weekly Zumba class
- Group education about diabetes

"…inhaled corticosteroids (ICS) decrease hospital admissions, ED visits, and even deaths in children with persistent asthma. "

Popul Health Manag. 2015 Feb 1; 18(1): 54–60.

Round 2: Which is the Low-Hanging Fruit?

- Healthy Workplace initiative at BHA
- Ensuring blood pressure meds adherence
- Searching clients apartment for frozen pizza collection

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- Healthy Workplace initiative at BHA
- Ensuring blood pressure meds adherence
- Searching clients apartment for frozen pizza collection

Cholesterol ↓10%
- **10%** ↓ in **cardiovascular disease**

Blood Pressure ↓6mm/Hg
- **16%** ↓ in **cardiovascular disease**
- **42%** ↓ in **stroke**

Round 3: Which is the Low-Hanging Fruit?

- Instruction in Mindfulness meditation
- Regular visits to local farmer's market
- Successful engagement with case manager

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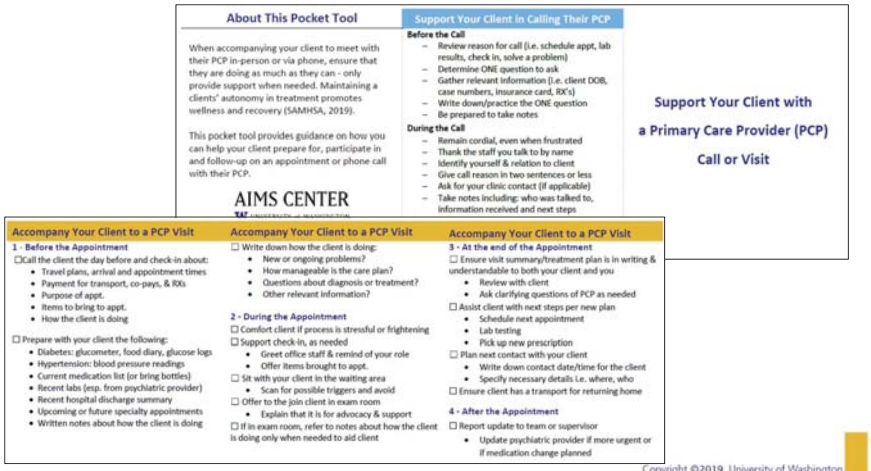
- Instruction in mindfulness meditation
- Regular visits to local farmer's market
- Successful engagement with case manager

"Meaningful behavioral change always happens in the context of a personal relationship."

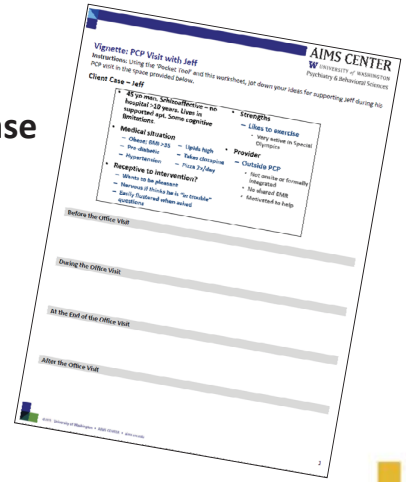
Pocket Tool: Support Your Client With a Primary Care Provider Call or Visit



Learning Activity: PCP Visit Vignette

Instructions:

- Follow along with Jeff's case
- Use the 'Pocket Tool' to help us support Jeff during his PCP visit
- Jot down ideas on the "Vignette: PCP Visit with Jeff" handout



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 with Jeff

Accompany Your Client to a PCP Visit

1 - Before the Appointment

☐ Call the client the day before and check-in about:
- Travel plans, arrival and appt. times
- Payment for transport, co-pays, & RXs
- Purpose of appt.
- Items to bring to appt.
- How the client is doing

☐ Prepare with your client the following:
- Diabetes: glucometer, food diary, glucose logs
- Hypertension: blood pressure readings
- Current medication list (or bring bottles)
- Recent labs (esp. from psychiatric provider)
- Recent hospital discharge summary
- Upcoming or future specialty appointments
- Written notes about how the client is doing

☐ Write down how the client is doing:
- New or ongoing problems?
- How manageable is the care plan?
- Questions about diagnosis or treatment?
- Other relevant information?

- **Reminder call**
  - Jeff does not have a transport plan
    - Help Jeff arrange w/ community transit
- **Check-in & discuss**
  - Jeff wonders about his diabetes
    - Use diabetes guide to explain; write down that may want to discuss further with PCP
- **Plan to Bring**
  - Jeff will bring his:
    - Blood sugar records
    - Blood pressure records
    - Medication box
  - You will bring
    - Jeff's most recent labs
- **Ensure all concerns are addressed**
  - "Anything else before we go?"

During the Office Visit with Jeff

2 - During the Appointment

☐ Comfort client if process is stressful or frightening
☐ Support check-in, as needed
- Greet office staff & remind of your role
- Offer items brought to appt.

☐ Sit with your client in the waiting area
- Scan for possible triggers and avoid

☐ Offer to the join client in exam room
- Explain that it is for advocacy & support

☐ If in exam room, refer to notes about how the client is doing only when needed to aid client

- **Support client with logistics**
  - Jeff is nervous and doesn't want to bother front office staff
  - Kindly remind Jeff to check-in
  - You ask to join in exam room
  - Jeff agrees
- **In exam room with PCP**
  - Jeff explains he's been exercising and is trying to cut back on pizza
  - PCP advises
    - ADA plate
    - One pizza-free day possible?
    - Simplify med regimen to once daily
  - PCP points out that Jeff's #'s are better, if not normal
  - Remind Jeff of his question about his diabetes, referring to written notes

At the End of the Office Visit

Accompany Your Client to a PCP Visit

3 - At the end of the Appointment

☐ Ensure visit summary/treatment plan is in writing & understandable to both your client and you
- Review with client
- Ask clarifying questions of PCP as needed

☐ Assist client with next steps per new plan
- Schedule next appointment
- Lab testing
- Pick up new prescription

☐ Plan next contact with your client
- Write down contact date/time for the client
- Specify necessary details i.e. where, who

☐ Ensure client has transport for returning home

- **Assist with Next Steps**
  - Jeff re-arranges med box
  - Both identify which day he will try to not eat pizza; write down
- **Plan Next Contact**
  - Also write down & share all notes with Jeff
  - Affirm and encourage again, "What a long day!"
- **Debrief visit with PCP**
  - Affirm Jeff for improved #s; acknowledge hard work!
  - Write down summary

After the Office Visit with Jeff

Accompany Your Client to a PCP Visit

3 - At the end of the Appointment

☐ Ensure visit summary/treatment plan is in writing & understandable to both your client and you
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☐ Plan next contact with your client
- Write down contact date/time for the client
- Specify necessary details i.e. where, who

☐ Ensure client has transport for returning home

4 - After the Appointment

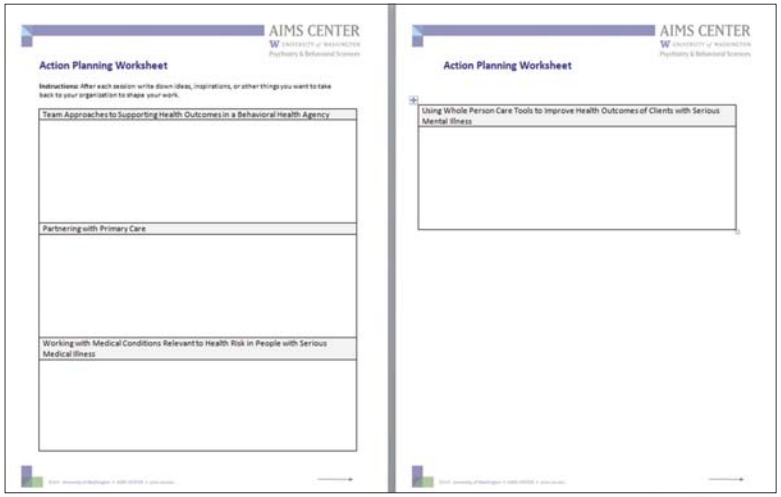
☐ Report update to team or supervisor
- Update psychiatric provider if more urgent or if medication change planned

- **Update team**
  - Document and share plans
  - Update psychiatric provider about medication change

Reflection & Discussion

- **Remember a time you accompanied someone to a doctor's appointment…**
  - **What was challenging?**
  - **How did it go?**
    - What did you do that was effective?
    - What did you do that was not as effective?

Action Planning



LUNCH

USING WHOLE PERSON CARE TOOLS TO IMPROVE HEALTH OUTCOMES FOR PEOPLE WITH SERIOUS MENTAL ILLNESS

Session 4

Learning Objectives

By the end of this session, participants should be able to:

- 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

What Do I Do When My Client Isn't Getting Healthier?

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

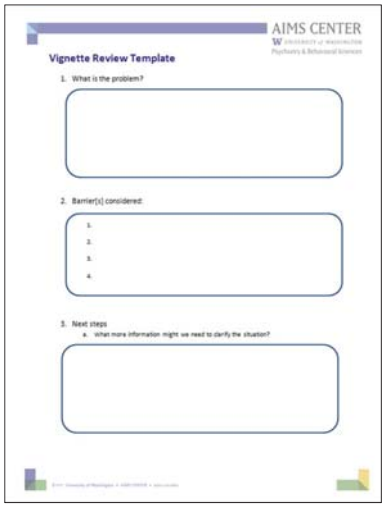
Asses Adherence	1. Consider Barriers	2. Explore Further	3. Initiate intervention strategy
	Inconsistent with medication	Find out why. – Too complicated or expensive? – Something else unpleasant? – Tactfully inquire about literacy	Make medications simpler. – Use med boxes, set alarms – Advocate for your 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.

Exercise: Generate Case Management Ideas

1. Pills are a mess
2. Client agrees, but doesn't function
3. Family opposed
4. Active psychiatric illness
5. Over-leveraging the relationship
6. Non-symptomatic client
7. Other BH staff disparaging
8. PCP not welcoming
9. Client adherent, but still not getting better
10. Child with diabetes and adherence problems

Directions

1. Read the vignettes
2. Talk to your team
3. What might barriers be?
4. What more information do we need?
5. Look at the intervention handout– are there ideas there?
6. Would this work back at your place?


AIMS CENTER
Vignette Review Template
1. What is the problem?
2. Barrier(s) considered:
3. Next steps

Plans for Your "Vignette" Clients

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

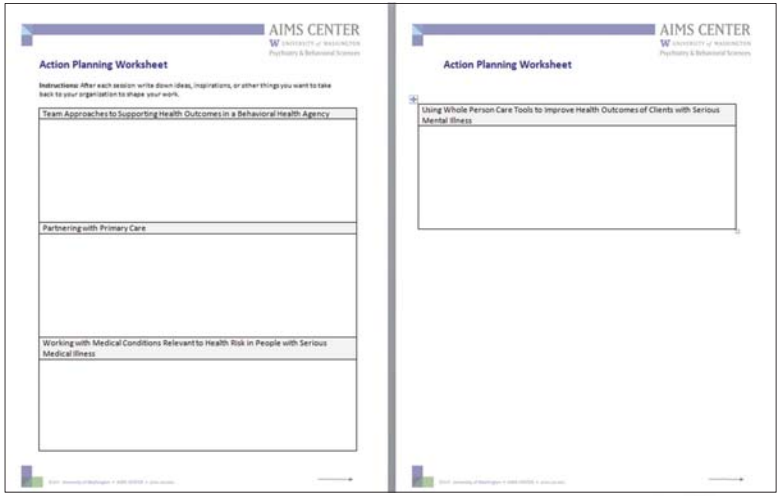
Now: Using the Tools for Your Challenging Client

- Challenging client you work with
  - Can you use the tools for ideas?
- Share with a partner
- Report out

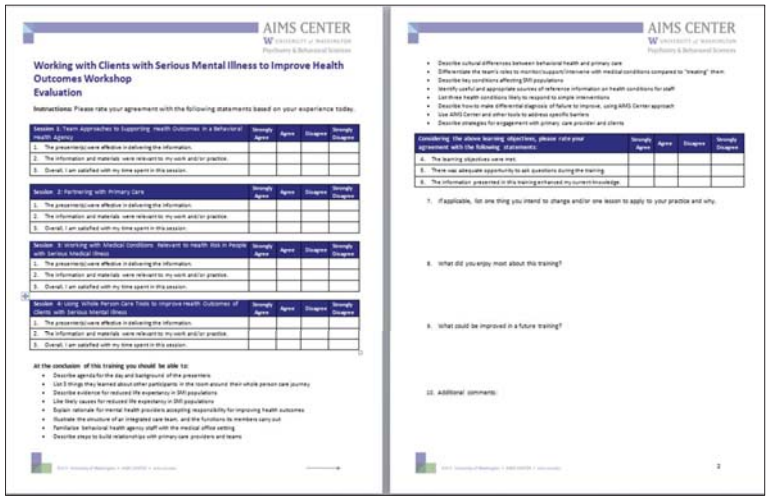
Reflections

- List one thing you intend to change or bring back to your agency?
- What would you change or add to the AIMS Center tools?

Action Planning



Evaluation



AIMS CENTER

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 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.				

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 agenda for the day and background of the presenters
- List 3 things they learned about other participants in the room around their whole person care journey
- Describe evidence for reduced life expectancy in SMI populations
- Like likely 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

AIMS CENTER

- Describe cultural differences between behavioral health and primary care
- Differentiate the team's roles 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
- Describe how to make differential diagnosis of failure to improve, using AIMS Center approach
- Use AIMS Center and other tools to address specific barriers
- Describe strategies for engagement with primary care provider and clients

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

8. What did you enjoy most about this training?

9. What could be improved in a future training?

10. Additional comments:

2

THANK YOU