The Value of Cross-Training in the Collaborative Setting

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Disclosure

During the past 12 months, we have not had relevant financial relationships (in any amount) that present a conflict of interest with the material presented here.
Learning Objectives

By the end of the presentation, participants will:

- Understand how to frame behavioral health issues in a primary care setting
- Be able to identify the core competencies for behavioral health and physical health providers
- Learn how to integrate a psychiatrist into a primary care team
Mr. A is a 54 year old Caucasian man. He presents in crisis having recently lost his sales job, health insurance and car. He is fearful that he will lose his home as well. Mr. A has a BMI over 30; DM poorly controlled with Metformin (HbA1C >10) and has been hypertensive for 6 years.
Patient Centered--Patient Driven: The Priority in Cross Training

- Relationship building
- Patient driven - shared decision making
- Patient centered shared care plans
- Whole person perspective
- Whole life perspective
- Wellness oriented
- Recovery based Care
We train, hire and pay doctors to be cowboys. But it’s pit crews we need.... To function this way, however, you must cultivate certain skills which are uncommon in practice and often not taught.

Atul Gawande
This presentation is not about how to transform your system... but first you have to transform your system

Common Integration Needs:

- Defining & communicating the vision & business model
- Investigating best practices/strategies
- Developing policies & procedures
- Defining your population
- Clarify what data to collect
- Developing registries & data collection/sharing to support clinician/administrator decision making
And Then…

You have to commit to time & cost of training to make integrated care a reality

- Build a continuous learning culture
- Build a coalition
- Nurture champions
- Take the long view: change takes time
- Multi-task: work on all essential components concurrently
Supporting Cross Training Through Practice Based Learning (AKA: OTJT)

- Rolling Start – Identify and develop champions
- Seek/develop networks/learning collaborative/communities of practice
- Daily huddles
- Shadowing: [http://cirrus.mail-list.com/cfha/70412549.html](http://cirrus.mail-list.com/cfha/70412549.html)
Training For Teams

- Progress and Promise: Profiles in interprofessional health training to deliver Patient-Centered Primary Care (12/2014)
  - Report highlights seven exemplars: programs that work to develop the competencies required for work in advanced models of primary care
  - The profiles in this report include powerful practical strategies for developing interprofessional teams in PCMH settings
1. Alternate turns as team leaders

In clinical settings, many programs intentionally alternate leaders on teams, often based on a patient’s need for a given health profession’s expertise at a given time. This process helps break down traditional hierarchies, enriches team dynamics, and gives students valuable real-life practice.
Training For Teams

2. Invest time in developing team dynamics

Recognizing that teams work better if they truly coalesce as a group, some programs invest time in building the team itself. Program leaders at the San Francisco VAMC, for example, have published extensive guidelines on strategies that maximize the power of the team huddle.
Training For Teams

3. Consider varying communication Preferences

Working to improve interprofessional communication. One group taught behavioral health students, who tended toward longer narratives, to consolidate their notes into 30-second summaries that were more digestible for physicians accustomed to succinct opinions.
Primary Care Behavioral Health vs. Specialty Mental Health

“I’m afraid you’ve had a paradigm shift.”
<table>
<thead>
<tr>
<th>Dimension</th>
<th>PCBH</th>
<th>Specialty MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>Population-based</td>
<td>Individual participant-based</td>
</tr>
<tr>
<td>Primary Customer</td>
<td>PCP, then Individual</td>
<td>Individual, then others</td>
</tr>
<tr>
<td>Primary Goal</td>
<td>Improve individual participant’s functioning. Promote PCP effectiveness</td>
<td>Resolve individual participant’s mental health problem</td>
</tr>
<tr>
<td>Delivery structure</td>
<td>Part of PCMH team, fast pace, numerous contacts</td>
<td>Specialized service</td>
</tr>
<tr>
<td>Who is “responsible” for the treatment plan</td>
<td>PCP</td>
<td>Therapist</td>
</tr>
<tr>
<td>Primary Modality</td>
<td>Consultation model</td>
<td>Specialty Treatment Model</td>
</tr>
<tr>
<td>Team structure</td>
<td>Part of PC team</td>
<td>Part of specialty MH Team</td>
</tr>
<tr>
<td>Access standard</td>
<td>Determined by team preference</td>
<td>Determined by participant preference</td>
</tr>
<tr>
<td>Cost per episode of care</td>
<td>Potentially decreased</td>
<td>Highly variable, related to participant’s condition</td>
</tr>
</tbody>
</table>
What is ‘Primary Care Psychiatry’?

Providing psychiatric consultation **within** the primary care setting, working in collaboration with behavioral health consultants and other members of the PC team.
Possible Models for Primary Care Psychiatry

- Indirect consultation (education and supervision only)
- Co-location of specialty care; psychiatrist accumulates and follows a caseload
- **Consultation model**, combining direct and indirect consultation, curbsides, and in-service training
Roles for Primary Care Psychiatrists

**Caseload Consultant**
Consults indirectly through care team on defined caseload

**Direct Consultant**
Sees PC patients face to face and offers recommendations

**Clinical Educator**
Direct and indirect training of BHC’s and PCP’s

Adapted from Raney & Kern, CME course, APA Institute, October 2011
Primary Care Psychiatry: How to Behave

- **Be available and accessible**—curbsides ideally answered the same day
- Recommendations: **brief and focused**
- **Think beyond medication** recommendations
- Education best when it is patient-focused, or provided in digestible portions

*Adapted from Raney & Kern, CME course, APA Institute, October 2011*
Primary Care Psychiatry: How to Behave

- “Warm handoffs” are bi-directional
- Clarify your role to the patient
- Person-centered, recovery-oriented, engagement-first approach often helpful
The Successful Consulting Psychiatrist

- Flexible
- Adaptable
- Self-confident
- Outgoing
- Appreciates cadence of primary care setting
- Willing to learn more about primary care
- Willing to tolerate interruptions
- Likes to work in teams
- Can tolerate uncertainty
- Willing to consult on broad scope of patients
- Likes doing something more than ‘med checks’

Adapted from Raney & Kern, CME course, APA Institute, October 2011
<table>
<thead>
<tr>
<th>Situation</th>
<th>Example</th>
<th>Assessment and recommendations for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsure of Diagnosis or how to Rx</td>
<td>Soft signs of psychosis, Signs and symptoms don’t align, Atypical history</td>
<td>Clarification of diagnosis and preliminary treatment recommendations</td>
</tr>
<tr>
<td>Diagnosis irrelevant; level of care question</td>
<td>Vaguely suicidal, or claims attempt in recent past, Refractory psychosis</td>
<td>Should patient be referred to crisis center or psychiatric inpatient? Does patient require specialty (outpatient) behavioral healthcare?</td>
</tr>
<tr>
<td>Confident of Diagnosis: resuming prior Rx</td>
<td>New or established patient with credible history of past positive response to known regimen</td>
<td>Is dosage titration necessary? Is there any reason to use alternative/newer medication?</td>
</tr>
<tr>
<td>Confident of Diagnosis: unsure how to start Rx</td>
<td>New or established patient, no prior treatment history, OR severe co-morbidities, e.g., schizophrenia &amp; brittle diabetes</td>
<td>What are reasonable “first choices” for first episode of psychosis? What are alternatives to usual first choices?</td>
</tr>
<tr>
<td>PharmacoTx in place; no/minimal progress</td>
<td>Depressed patient, 3-4 wks in tx, still lethargic, anorectic: symptom or side-effect?</td>
<td>Can we distinguish symptom vs side-effect? Does pharmacotherapy need modification at this time?</td>
</tr>
<tr>
<td>PharmacoTx in place: incomplete response</td>
<td>Depressed patient, looks and feels better, but still can’t sleep or concentrate</td>
<td>How best to optimize response? Is it time to consider augmentation (potentiation) strategies?</td>
</tr>
<tr>
<td>PharmacoTx in place: complex regimen</td>
<td>New patient presumably stable psychiatrically, but on ≥4 psychotropics</td>
<td>Can regimen be simplified, and if so, where is safest place to begin?</td>
</tr>
<tr>
<td>PharmacoTx in place: discontinuation?</td>
<td>New or established patient with stable episodic illness, wants to discontinue psychotropic</td>
<td>What is safest way to discontinue the psychotropic? What to look for when med has already been discontinued?</td>
</tr>
</tbody>
</table>
SATURDAY, MAY 5, 9 AM - 4 PM
COURSE 04
INTEGRATING BEHAVIORAL HEALTH AND PRIMARY CARE: PRACTICAL SKILLS FOR THE CONSULTANT PSYCHIATRIST

Topic: Psychosomatic Medicine
Director: Lori Raney M.D.
Co-Director: Jurgen Unutzer
Faculty: John Kern, M.D., Anna Ratzliff, M.D.
Intended Benefits of Consultation Model

- Enhance individual and population health outcomes for those served in PC setting
- Enhance confidence and skill-set of primary care providers…and BHCs
- Assist PC setting in establishing protocols for specific clinical situations
- Facilitate linkage with specialty behavioral health care
# Two Different Worlds?

## Behavioral Health World
- We have *people in recovery*
- We emphasize *engagement* first
- We focus on *personal goals* and strengths
- We’re looking for ways to *spend more time* with those we serve
- We’re into *collaborative* approaches, and *shared decision making*

## Physical Health World
- They have *patients*
- They have tests to get done
- They focus on *symptoms* and *pathology*
- They’re looking to be more *efficient*
- They’re into *hierarchical* relationships, and instructing patients what to do
Tell me and I forget
Teach me and I remember
Involve me and I learn
Benjamin Franklin
Train to Core Competencies

1. Interpersonal Communication
2. Collaboration and Teamwork
3. Screening and Assessment
4. Care Planning and Care Coordination
5. Brief Intervention
6. Cultural Competence and Adaptation
7. Systems Oriented Practice
8. Practice-Based Learning and Quality Improvement
9. Population-Based Care Management

Adapted from SAMHSA-HRSA Center for Integrated Health Solutions
Competency: Interpersonal Communication

“I was able to get in one last lecture about diet and exercise.”
Interpersonal Communication

The ability to establish rapport quickly and to communicate effectively

Examples include:

- Active listening
- Conveying information in a jargon-free, non-judgmental manner
- Using terminology common to the setting in which care is delivered
- Adapting to the preferred mode of communication of the consumers and families served
Ms. T is a 73 year old African American woman. She is a retired teacher with chronic back pain, HTN, and a history of multiple hospitalizations for CAD. She is depressed, has stopped going to church, misses her PCP appointments and takes her HTN medications “on my own terms.”
Professional Strengths

Behavioral Health
- Strong engagement skills
- Trained in active listening
- Person-centered perspective
- Comfort with uncomfortable Emotions
- Psychiatrist offers integration of BH and PH

Primary Care
- Long history of delivering complex news in a brief/succinct format
- Team communication skills: Experience delegating and coordinating care with PC team members
- Decisive communication
# Cross Training Opportunities

<table>
<thead>
<tr>
<th>PC to BH</th>
<th>BH to PC</th>
<th>Psychiatry to Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertiveness</td>
<td>Master the effective “warm hand off”</td>
<td>Receptive to both</td>
</tr>
<tr>
<td>Rapid assessment, brief treatment, and a high daily volume of visits</td>
<td>Active listening and motivation enhancement strategies</td>
<td>Rapid assessment and consultation</td>
</tr>
<tr>
<td>Medical terminology</td>
<td>Plain language</td>
<td>Shared language</td>
</tr>
<tr>
<td>Communicate in bullet points vs. paragraphs</td>
<td>Reflective, expressed understanding</td>
<td>Responsiveness</td>
</tr>
<tr>
<td>Express opinions with confidence</td>
<td>Suspending judgment</td>
<td>Decisive in face of ambiguity</td>
</tr>
<tr>
<td>Curbside Consultation</td>
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</tr>
</tbody>
</table>
Collaboration and Teamwork

The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.

“My physical therapist says this is the worst possible position you can lie in.”
Collaboration and Teamwork

Examples include:

- **Understanding and valuing** the roles and responsibilities of other team members
- **Expressing professional opinions** and resolving differences of opinion quickly
- **Providing and seeking consultation**, and fostering shared decision-making
- **Developing a shared understanding** of the respective roles and responsibilities of team members to ensure that collaboration is efficient
- **Exhibiting leadership** by supporting collaborative care
Samantha is a 17 year old girl who presented to her primary care provider for a wart removal. The practice had just initiated depression and suicide screening. Samantha screened positive for suicidal ideation.

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture
### Professional Strengths

<table>
<thead>
<tr>
<th>Behavioral Health</th>
<th>Primary Care</th>
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<tbody>
<tr>
<td>- History of interdisciplinary teamwork</td>
<td>- Master of the workflow behind the PC visit</td>
</tr>
<tr>
<td>- History of high level systems work</td>
<td>- Collaborative work with multiple specialists</td>
</tr>
<tr>
<td>- Used to “blurred roles”</td>
<td>- Team leadership skills</td>
</tr>
<tr>
<td>- Work with peer support approaches and peer support providers</td>
<td>- Ability to absorb and implement recommendations</td>
</tr>
</tbody>
</table>
## Cross Training Opportunities

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<tr>
<td>Efficient workflow</td>
<td>Use behavioral health interventions to support the work of the team and to enhance healthcare outcomes.</td>
<td>Case sharing and involvement</td>
</tr>
<tr>
<td>Visit focus (goal of visit)</td>
<td>Effective use consulting psychiatrist</td>
<td>Answer question: interplay of physical and psychiatric aspects of patients health</td>
</tr>
<tr>
<td>Outcome focused</td>
<td>Shared decision-making</td>
<td>Person driven-outcome focus</td>
</tr>
</tbody>
</table>

"I HAVE YOUR BACK"
“Have you tried taking long walks?”
Brief Interventions

The ability to conduct brief, evidence-based and developmentally appropriate screening with standardized measurement tools. Conduct brief interventions or arrange for more detailed assessments when indicated.

Examples include:

- Screening, assessment, brief interventions for depression, anxiety, trauma; risky, harmful or dependent use of substances; cognitive impairment; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.
Comprehensive Vital Signs

- Temperature
- Pulse
- Respirations
- Blood pressure
- Body Mass Index
- PHQ-9
- GAD-7
- Audit
- Trauma Screen (THS, PC-PTSD)
Mr. Jones is 65 years old and has smoked for 40 years. He is chronically depressed. He is five years clean from drug and alcohol addiction and is finally welcomed back into his family and is getting to know his grandchildren for the first time in their lives. His doctor has told him that if he doesn’t quit smoking, he will die. He is certain that if he gives up cigarettes, he’ll pick up drugs.
Professional Strengths

Behavorial Health

- Training in evidence based brief treatment models
- Use of strengths-based wellness, resilience, and recovery models
- Specialized knowledge of abuse, neglect, domestic violence, and other trauma in individuals across the lifespan
- Knowledge of social determinants of health

Primary Care

- Years of working within the 15 minute time frame
- Stepped Care
- Ability to deliver “bad news” with competence and compassion in a brief time frame
- Understand importance of screening and prevention
# Cross Training Opportunities

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<tr>
<td>Understand the symptoms and treatments for the major healthcare conditions</td>
<td>Recognize and understand the most common mental health and substance use conditions seen in primary care</td>
<td>Diagnostic expertise in mental health; sustained physician-hood</td>
</tr>
<tr>
<td>Knowledge of PH medications and side effects</td>
<td>Working knowledge of psychopharmacology</td>
<td>Knowledge of state-of-the-art psychopharmacology</td>
</tr>
<tr>
<td>Treat to Target</td>
<td>Interventions in health promotion, wellness and prevention, trauma-informed, problem-oriented treatment</td>
<td>Treatment algorithms and experience with refractory conditions</td>
</tr>
</tbody>
</table>
Competency: Population-Based Care
Population-Based Care

The ability to systematically and proactively attend to the health outcomes of a group of individuals, including the distribution of outcomes within the group.

Examples include:

- Behavioral health consumers being tracked in a registry so that no one ‘falls through the cracks’
- The PCP, BHP and consulting psychiatrist regularly review the registry to change or adjust treatments if consumers do not meet treatment targets
Professional Strengths

Behavioral Health
- Case management skills can be transferred to care management
- Systems thinking and roots in addressing social determinants of health
- Value Peer Specialists

Primary Care
- Use of population based care strategies with other diseases (e.g., diabetes, asthma)
- Use of rapid PDSA cycles to improve population outcomes
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<tbody>
<tr>
<td>Consider whole population health outcomes (vs. 1:1 clinical outcomes)</td>
<td>Treatment targets for common behavioral health conditions</td>
<td>Support psychiatric screening and intervention with evidence based care</td>
</tr>
<tr>
<td>Registry Management</td>
<td>Care management with consulting psychiatrist (to inform next steps with consumers are not improving)</td>
<td>Consultation</td>
</tr>
<tr>
<td>Disease pathway development</td>
<td>Recognition of culture in engagement in care</td>
<td>Use of clinical guidelines with refinement for population</td>
</tr>
</tbody>
</table>
Patient Centered--Patient Driven: The Priority in Cross Training

- Relationship building
- Patient driven - shared decision making
- Patient centered shared care plans
- Whole person perspective
- Whole life perspective
- Wellness oriented
- Recovery based Care
To keep the body in good health is a duty... otherwise we shall not be able to keep our mind strong and clear Buddha
"Instead of waiting for the next big thing to transform our lives, why don’t we give it a shot ourselves?"
Questions?

What resources have you put into place to support the orientation and training of PCPs and BH providers in your practice?

Are there other competencies that we did not cover?

How have you addressed the challenges in staying current with curriculum development?

What are the barriers to implementing integrated care in non-FQHC settings?
Resources

- [www.primarycareshrink.com](http://www.primarycareshrink.com) Neftali Serrano, PsyD, Access Community Health Centers, Madison WI
- [www.integration.samhsa.gov](http://www.integration.samhsa.gov) Center for Integrated Health Care Solutions
- [www.uwaims.org](http://www.uwaims.org) University of Washington, AIMS Center, Advancing Integrated Mental Health Solutions
- Progress and Promise: Profiles in interprofessional health training to deliver Patient-Centered Primary Care. Patient-Centered Primary Care Collaborative (PCPCC). December 2014. [www.pcpcc.org](http://www.pcpcc.org)
- Collins et al, “Evolving Models of Behavioral Health Integration in Primary Care”, Milbank Foundation, 2010