Primary Care in Behavioral Health

CPAA/AIMS Center Training Program
May 7, 2019

Welcome

• Cascade Pacific Action Alliance Welcome
• Work Accomplished to Date

AIMS Center Introductions

• John Kern, MD
• Sara Barker, MPH
• Olga Felton, RN, MSN, CENP

Housekeeping

• Training Folders
  – Action Items Worksheet
  – Other Materials/Handouts
  – Evaluation
  – CEUs
• Presentation Slides
Agenda

<table>
<thead>
<tr>
<th>TIME</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 – 8:30</td>
<td>Sign-in and refreshments</td>
</tr>
<tr>
<td>8:30 – 9:00</td>
<td>Welcome and introductions</td>
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<tr>
<td></td>
<td>Overview of the day</td>
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<tr>
<td>9:00 – 9:45</td>
<td>Core principles and team roles in whole person care</td>
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<tr>
<td>9:45 – 10:45</td>
<td>Partnering with primary care</td>
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<tr>
<td>10:45 – 11:00</td>
<td>BREAK</td>
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<tr>
<td>11:00 – 12:30</td>
<td>Supporting medical care of people with serious mental illness</td>
</tr>
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<td>12:30 – 1:30</td>
<td>LUNCH</td>
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<tr>
<td>1:30 – 2:15</td>
<td>Population health &amp; risk stratification</td>
</tr>
<tr>
<td>2:15 – 3:00</td>
<td>Measurement-based care</td>
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<td>Using a registry to improve client outcomes</td>
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<tr>
<td>3:00 – 3:15</td>
<td>BREAK</td>
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<tr>
<td>3:15 – 4:30</td>
<td>How do I help clients get healthy?</td>
</tr>
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<td></td>
<td>Evidence-based strategies</td>
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<tr>
<td>4:30 – 4:45</td>
<td>Action planning review of the day</td>
</tr>
<tr>
<td>4:45 – 5:00</td>
<td>FEEDBACK &amp; ADJOURN</td>
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CORE PRINCIPLES AND TEAM ROLES IN WHOLE PERSON CARE

Session 1

Audience Introductions

- Prompt(s):
  - Name
  - Organization
  - Role at Organization
  - What is one thing you hope to get out of today’s training?

Learning Objectives

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

- Describe evidence for reduced life expectancy in SMI populations
- List 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
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**

(Re)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

SMI Life Expectancy: Still Short and Still Not Improving

Prevalence of Current Smoking
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

Reflection & Discussion

Yes, but we’re different...

- **Prompt(s):**
  - How does your agency’s situation vary from the typical BHA model?
  - Do you have goals other than BP and BMI?

Principles for Evidence-Based Integration in Whole Person Care

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

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

**Population-Based**
A defined group of clients is tracked in a registry so that no one “falls through the cracks.”

Behavioral Health Home: A Picture Worth a Thousand Words
Team Strategies Across Settings

- **PCP**
- **Patient**
- **BHA or PC Team Members:** MA, BHP, RN, Navigators, CHW
- **Psych and/or Addictions Providers or Consultants**

Staff Assignment to Care Manager and Case Manager Functions

- **Licensed Behavioral Health Providers (LICSW, CDP, other BH licensures)**
  - Well suited to many functions
  - More expensive!
- **Case Managers and Navigators**
  - Used to coordinating care, interfacing with the outside world
  - Sometimes less medical background
- **Nurses**
  - More medical background, manage co-morbidities
  - [Sometimes] less comfort with SMI population
  - More expensive!
- **Peers**
  - The benefit of lived experience
  - Less medical background

Care Functions

- Screening Functions
- Psychiatric Prescriber 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
  - Peers
    - Primary role in supporting good health behaviors
  - Support staff
    - Clerical support of registry function
  - Have you figured out a novel solution?
Learning Activity

Instructions:
• Report out the following by agency:
  – Organization’s mission
  – Why whole person care?
  – Where are you headed

PARTNERING WITH PRIMARY CARE

Session 2

Action Planning

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
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 Include...

- Pace
- Model of care
- Environment 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
- Address top 1-3 concerns

Primary Care Team Model (Usually)

- Team may include Gatekeepers: Medical Assistant, Care Coordinator, LPN, RN, ARNP, MD
- Multiple contacts before seeing PCP at the office appointment
- Frequent interruptions
- Services involve touch
- Address top 1-3 concerns
- Follow up in 2 weeks to 3 months

Environment of Primary Care

- Busy, hectic, full waiting room
Environment of Primary Care

• Exam rooms with lots of gadgets

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
• Push a specific position
• Withhold information
• Let them take their lumps

Learning Activity: Developing Your Elevator Speech

• What might you say to engage a client with your whole health program?
• What might you say to introduce your program to a PCP or primary care staff member?
  – Example: “We are interested in helping you work more effectively and efficiently with us, not just this client but also others like him/her.”
• PRACTICE

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 (patient demographics, lab tests, insurance, medications, any other pertinent information)
• Make the call with the client if possible

Sample Case Presentation

“This is Olga calling from Dr. Kern’s office. I’m calling to make an appointment for a client that I’m working with. He hasn’t seen a provider since 1902. He states he is diabetic but is not taking medication. His HGBA1C is 12.”
Ask Me 3: Good Questions for Your Good Health

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Available at: http://www.ihi.org/resources/Pages/Tools/Ask-Me-3-Good-Questions-for-Your-Good-Health.aspx
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

Screening is Just the Start

You cannot fatten a cow by weighing it.
~ Chinese Proverb

Supporting vs. Treating

• Promoting basic health literacy “Know your numbers”
• Advocating for client
• Reducing health disparity
• Facilitating treatment goals
• Removing barriers to health care
• Preventing illness and complications

COMMON HIGH RISK CONDITIONS
Hypertension (High Blood Pressure)

- Not related to emotional distress
- Elevated pressure in the body’s blood vessels
- Common, but more common with age, obesity
- Related to risk of death by stroke or heart attack
- Treated with medication
- Weight management, exercise can help

Diabetes Mellitus (DM)

- A condition in which the body cannot make or cannot use insulin properly
- Types
  - Type 1
  - Type 2
    - Prediabetes
      - impaired fasting glucose
      - impaired glucose tolerance
    - Gestational DM
    - Other

What Happens in Type 2 Diabetes

Pancreas can't make enough insulin
Stomach empties 50% faster than normal
Liver puts too much sugar into the blood
Muscle cells and other tissues are resistant to insulin

Blood Sugar Ranges in Diabetes

<table>
<thead>
<tr>
<th>Range</th>
<th>Blood Sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>70 or less</td>
<td>Hypoglycemia (too low)</td>
</tr>
<tr>
<td>70 – 140</td>
<td>Acceptable</td>
</tr>
<tr>
<td>150 or more</td>
<td>Hyperglycemia (too high)</td>
</tr>
</tbody>
</table>
What is **Cholesterol**?

A fat-like substance in your blood. Cholesterol is a natural fat like substance found in your blood. It is a key component to cells. It also comes from foods we eat.

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**High Cholesterol - Hyperlipidemia**

- Hyperlipidemia
  - Too high levels of cholesterol in the blood
  - Related to death by stroke or heart attack
- Not usually caused by eating high cholesterol food
- Risk factors include obesity and genetics
- Treated successfully with medication

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**Side Effects of Psychiatric Medications**

- **Weight gain**
- **Diabetes**
- **High Cholesterol and abnormal triglycerides**
- **Insulin resistance**
- **Metabolic syndrome**
- **Additional problem:**
  - Polypharmacy

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**Obesity and Impact of Antipsychotic Medications**

![Graph showing Estimated Weight Change at 10 Weeks on "Standard" Dose](chart.png)
Screening: Treat to Target Goals

Weight/BMI Chart

Reliable Sources on Medical Conditions

- Primary care providers and nurses
- Use the internet with caution, including:
  - Medline Plus
  - WebMD
  - Mayo Clinic website
  - American Heart Association
  - American Academy of Family Physicians
- Don’t make treatment decisions based on what you read on the Internet

So What Do We Do?

- Health Behavior Change
- Supporting Medical Care
- Wise Prescribing

Modifiable Risk Factors

- Smoking
- Obesity
- Lack of Exercise
- Untreated medical illness
- Meds that cause weight gain
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

Supporting Health Behavior Change (2)

- But not too much or too fast...
- Suggest the simplest behavior change
- Help brainstorm to make change as effortless as possible
  - e.g., pills by the toothbrush, shoes by the bedside...
- Get an early win

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

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/HealthcareProfessionalsandFacilities/ProfessionalsResources/TobaccoCessationResources
Functional Support for Medical Care

- Appointments [making, keeping, using]
- Interacting, interpreting for the medical system
- Building relationships with primary care providers
- Reminding, encouraging, frequent touches
- Lessons from primary care case managers

Reflection & Discussion

- Prompt(s):
  - How might you support your clients in their interactions with medical providers?

Wise Prescribing

- Minimizing risk of obesity

Low Hanging Fruit

Hypertension

BMI

Smoking

Lipids

Diabetes

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

Round 1: Which is the Low-Hanging Fruit?

Restarting preventative asthma meds

Weekly Zumba class

Group education about diabetes

“...inhaled corticosteroids (ICS) decrease hospital admissions, ED visits, and even deaths in children with persistent asthma. Real-world patient adherence to ICS-Rx can be as low as 20%.”

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

Response to Blood Pressure Treatment

Round 3: Which is the Low-Hanging Fruit?

- 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.”
Learning Objectives
By the end of this session, participants will be able to:

• Describe methods to stratify clients with SMI
• List clinical information about clients that are most effective in risk stratification
• Identify a high risk population for tracking and intervention
Population Health Management
- Key to success in value based care
- Focus on the health of a defined client population - not individuals
- Utilize data to identify client that need specific interventions or additional services
  - Assessment, tracking and care management across the population – not just clients who actively seek care

What is Risk Stratification?
- Part of population health management
- A tool for identifying and predicting which clients are at high risk - or likely to be at high risk – for poor health outcomes
  
  Definition from Rocky Mountain Health Plans
- Many methods and approaches used to evaluate risks - no one right way

Checkpoint
- What indicators are you currently using to identify risk?

Ways to Think About Risk Categories
High Risk
- Potential for future high costs or physical, mental or functional decline

High Cost
- Past or current spending (inpatient stays, multiple ED visits)

High Need
- In need of more intense coordination and support due to multiple risk factors
Cost Curve for People with High Needs

![Cost Curve Graph]

- Top 1% account for 20% of health care spending
- Top 5% account for 50% of healthcare spending
- Top 10% of spenders account for 66% of healthcare spending
- Bottom 50% spenders account for 3% of healthcare spending

Strategy for Risk Stratification

Two Step Risk Assessment Process:
1. Stratify based on diagnosis, claims or algorithm
2. Add care team’s perception

Care Management: Implications for Medical Practice, Health Policy, and Health Services Research. (2015, April).  

American Academy of Family Physicians Care Management and Coordination Tool  
https://app.innovation.cms.gov/CPCPlusConnect/sfc/#version/069t0000000FrRB

Indicators of Risk for People with Serious Mental Illness

- Cardiovascular risk
- Blood pressure
- Body Mass Index (BMI)
- A1C and fasting blood sugar labs
  - Diabetes and pre-diabetes
- Cholesterol
- Smoking status
- Functional status

Reflection & Discussion

- Review ‘Risk-Stratified Care Management & Coordination’ handout
  - Risk Stratification Exercise
    - Describe your population by risk level?
    - Describe strategies you might use by risk level?
    - What population does your program target?
- Report Out
Where Do You Get Data?

- MCO diagnosis and claims data
- Shared EHR or other shared data arrangement with medical providers
- Screening/intake forms
- Collective Ambulatory (PreManage)
- Assessment on site
- Sending out for labs or sourcing lab info done elsewhere

Information in PreManage

- Admission dx and chief complaint
- Demographics
- Care team
- Disposition
- ED visit history
- Custom reports on ED utilization

Checkpoint

- What data sources are you currently using?
- Who is using (Collective Ambulatory) PreManage?
- Lessons learned?

Who Can Be On The Collective Ambulatory Network?

- Hospitals
- Managed care organizations
- Providers – BH and primary care
- Risk-carrying organizations (ACOs, etc.)
- Long term care and post-acute care facilities
Online Resources

National Council Webinar on Risk Stratification, 2018

Care Transitions for People with Serious Mental Illness

Quick Reference Guide to Promising Care Models for Patients with Complex Needs, Commonwealth Fund 2019

Blueprint for Complex Care, Center for Health Care Strategies, December 2018
http://www.chcs.org/media/Blueprint-for-Complex-Care_UPDATED_030119.pdf

Action Planning

MEASUREMENT-BASED CARE: WORKING WITH A REGISTRY
Session 5
Learning Objectives

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

• Describe how a registry facilitates successful caseload management
• Recognize how physical health metrics are used to drive treatment to target
• List treat to target goals for common medical conditions
• Recall how a registry is used to prioritize clients

Why Use Data? Why a Registry?

• Track treatment engagement and adherence
• Prioritize clients on caseload for intervention
• Identify clients who are disengaged or lost to follow up
• Track key client symptoms and conditions with tools like BP or BMI
• Prepare for today’s work

Population Health vs. Caseload Management

• Population Health
  – The health outcomes of a group of individuals, including the distribution of such outcomes within the group, system, or region
• Caseload Management
  – Monitoring and managing health outcomes, individual treatment and access to care, for a group of patients assigned to a team

Actionable Data in a Registry

• Care team must have readily available data on client status and outcomes to drive changes in treatment
  – In any measurement-based model, it is difficult to achieve improvement in outcomes without regular review of data
• Workflow should prompt this
  – For example a care manager would review the registry to find clients that need a follow-up call or you might need to call the primary care office for lab results
**Treat to Target: Physical Health Measures**

**Blood Pressure**

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

**Blood Glucose and A1c**

- **Blood Glucose**:
  - Less than 100 mg/dL
- **A1c**:
  - Less than 5.7%

**Cholesterol**

- **Total Cholesterol** = Less than 200
- **LDL** = Less than 100
- **HDL** = Greater than 60
- **Triglycerides** = Less than 150

**BMI**

- Overweight: > 25
- Obese: > 30

**Blood Pressure**

- Hypertension: > 130/80
- Hypertensive crisis: > 180/120

**HbA1c**

- Prediabetes: > 5.7
- Diabetes: > 6.5

**Lipids [LDH]**

- Hyperlipidemia: > 190

Threshold for treatment in absence of other risk factors: clinical CV disease, DM.
**Treat to Target: Physical Health Measures**

**Weight/BMI**

**BMI Chart**

**APA Metabolic Monitoring Guidelines**

**Table 1 - Metabolic monitoring parameters based on American Diabetes Association/American Psychiatric Association consensus guidelines**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>Week 4</th>
<th>Week 8</th>
<th>Week 12</th>
<th>Every 3 months thereafter</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical history</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist circumference</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting glucose/ hemoglobin A1c</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting lipids</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* Personal and family history of obesity, diabetes, hypertension, and cardiovascular disease.

**AIMS Center Patient Tracking Spreadsheet: “Patient Tracking” Tab Demo**

**AIMS Center Patient Tracking Spreadsheet: “Caseload Overview” Tab demo**
How Does This Actually Work?

• How does that data get in there?
• Who puts it there?
• How do we sort it for maximal clinical impact?
• At what point do I need medical oversight?
• Who can do all of these tasks? Which staff?
• What data do I already have that I can use?

Learning Activity
Step 1 - Prioritize Clients on Practice Caseload tab
Instructions:
• Review practice caseload, then:
  – Identify clients who are most in need
  – Identify clients who will most likely benefit
• How did you decide?
• What might you do for these clients, with what you know so far?

Learning Activity
Step 2 – Working With More Detailed Info
Instructions:
• Review Patient Tracking tab for our two clients, then:
  – Would you change your management plan?
  – What would you do differently?
  – Which data did you find useful?

Learning Activity
Step 3 – More About the Clinical Situation
Backstory for Sidney Abel:
• 32 yo man with Schizophrenia - has HTN & obesity, smokes, not making many improvements. Team needs to decide what to do next.
• Does this story change our interventions?
Learning Activity Step 3 – More About the Clinical Situation

• Backstory for Howie Morenz:
  – 47 yo man with bipolar illness and alcohol use disorder, was doing fine, but stopped taking meds a few months ago when got more depressed.

• Does this story change our interventions?

Tracking Clinical Outcomes

• Facilitates treatment planning and adjustment
  – Combats clinical inertia: where clients stay on ineffective or partially effective treatments

Action Planning

What are one or two ways to use a registry tool to improve the effectiveness of your care?

HOW DO I HELP CLIENTS GET HEALTHY? EVIDENCE-BASED STRATEGIES

Session 6
Learning Objectives

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

• List obstacles to treatment adherence with medications
• List behavioral activation techniques
• Describe motivational interviewing approaches to health behavior change

Evidence-Based Interventions

• Smoking Cessation Medications
  – Nicotine replacement therapy [NRT]
  – Bupropion [Wellbutrin, Zyban]
  – Varenicline [Chantix]
  – Safe to use with active psychiatric disorder & psychiatric medication
  – Increase success of quit attempts from 4% to 22%

• Weight Management
  – Only if very structured

MEDICATION ADHERENCE

Approaches to Medication Nonadherence

Rates of Non-adherence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>13.0%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19.0%</td>
</tr>
<tr>
<td>Alcohol Abuse/Dependence</td>
<td>35.0%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>35.5%</td>
</tr>
<tr>
<td>Diabetes: oral meds</td>
<td>35.5%</td>
</tr>
<tr>
<td>ADHD</td>
<td>37.0%</td>
</tr>
<tr>
<td>Diabetes: insulin</td>
<td>37.0%</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>45.0%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>45.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>50.0%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>57.0%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>60.0%</td>
</tr>
</tbody>
</table>
Clinician Factors & Communication Support Adherence

- Clinician-Client relationship may impart the most value in improving adherence
- Key elements are trust and caring
- “Health behavior change takes place in the context of a personal relationship.”

Shared Decision Making

Moving from medication ‘compliance’
*Patients’ passive following of provider orders*
Making collaborative treatment decisions jointly based on client lived experience and choice

Discussing Prescription and Non-Prescription Drug Use

- Most combinations of prescription medication and alcohol or drugs are not dangerous
  – With the exception of benzodiazepines
- Overemphasizing dangers of combining will seem naïve to clients
  – Many clients will have used both concurrently in the past
- Many clients will prefer to stop prescription medication than address their Substance Use Disorder [SUD]
- Addressing psychosis is critical even if ongoing SUD is a factor

Working with Clients to Support Treatment Adherence

- Match medication regimen to client’s individual abilities and needs
- Simplify medication regimens at least annually
- Maximize use of supportive tools
  – Ex) bubble pack dispensing or pillboxes
- Medication reconciliation after discharge
Maximizing Activation: Simple but Powerful

• Goals
  – Re-establish routines
  – Distract from problems or unpleasant events
  – Increase positively reinforcing experiences
  – Reduce avoidant patterns
  – Increase critical thinking
  – Decrease negative emotional response

3 Goals of Behavioral Activation

1. Increase mastery and pleasure
2. Decrease depressive activities
3. Remove barriers to rewarding things

Process of Behavioral Activation

• Education
• Encourage an experiment with self attitude
• Choose activities
• Practice new skills
• Evaluate the outcome
• Plan again - continue or change plans
Strategies

• Validating
  – Understanding their concerns/issues and holding hope for them
• Collaborative
  – What changes do they want to make
• Non-judgmental
  – We are learning together what helps them - experiment

Activation Ideas

• Household activities/projects
  – One pile at a time
• Pleasant and rewarding events
  – What did you used to enjoy doing?
• Self care activities

Maximizing Activation

Approach: Outside ➔ In

Typically we think of acting from the “inside ➔ out”
(e.g., we wait to feel motivated before completing tasks)

In BA, we ask people to act according to a plan or goal rather than a feeling or internal state

Activation Ideas

• Anxiety regulation
  – Activities with high engagement
  – Relaxation techniques
• Physical Activity
  – Exercise, movement- creative ways with children
• Social Interaction
  – Church, clubs, groups, family, friends
  – Quality vs. quantity
Make a SPECIFIC Plan

• The more detailed the plan, the more likely it will be followed
• In the plan, consider
  – Date or days of the week
  – What time of day
  – How long
  – With whom
  – Other aspects that need to be planned
• Ask client
  – How likely are you to do this?

Follow-Up

If goal was not accomplished, ask 3 questions:

- Do they have buy in to the treatment?
- Did they simply forget?
- Was it a Mt Everest?

Reframing “Failure” is Essential

• Wrong plan, pick another...learning what worked and what didn’t work
• “Mistakes are portals of discovery.” – James Joyce

Building Success

• It’s an experiment, a trial, it’s not forever
• Suggest clients act first and see what happens
• Praise any success they make, even a small success
• Go slow and start small
Learning Activity

Instructions:
• Review the Behavioral Activation Activity Options and Behavioral Activation Action Plan
• Create an action plan for your partner

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI)

• A critical skill

Three Essential MI Elements

1. A particular kind of conversation about change
2. Collaborative
   – Not expert-recipient
   – Client-centered
   – Partnership
   – Honors autonomy
3. Evocative
   – Seeks to call forth the person’s own motivation and commitment
MI Assumptions

- It is a myth that clients are unmotivated
- Motivation is formed best in the context of relationship
- People usually feel ambivalent about change

CHECKPOINT
Motivational Interviewing

- Prompt
  - Describe your familiarity using Motivational Interviewing
- Video
  - Ineffective Provider

Guiding MI Principles – “RULE”

- Resist the righting reflex
- Understand your client’s motivations
- Listen to your client
- Empower your client

Communication Styles (Mix & Match!)

- Following
  - Suspending own “stuff,” giving full attention, predominantly listening
- Directing
  - Taking charge, communicating solutions, overseeing, usually the cornerstone of health care providers
- Guiding
  - Tutoring, assisting in client’s self-directed learning, helping clients solve a problem
Reflection & Discussion

• Prompt(s):
  – What communication style do you find yourself using?
    • Following?
    • Directing?
    • Guiding?

Core Communication Skills

• Asking
  – Intent to develop understanding of client’s problem (rather than just getting a list of symptoms)

• Listening
  – Active process, checking if you understand meaning correctly, encouraging client to reveal more

• Informing
  – Conveying knowledge to client about condition, reason for treatment, diagnoses, recommendations, etc

Change Talk in MI – “DARN”

• Listen for commitment and taking steps toward behavior change

• Desire
  – Client’s use of words like “want”, “like”, and “wish”

• Ability
  – Client’s use of words like “can” and “could”

• Reasons
  – Listen for specifics, which can occur with “desire” verbs

• Need
  – Client’s use of words “need”, “have to”, “got to”, “should”, “ought”, “must”

Client Engagement
Motivational Interviewing (MI)

• VIDEO
  – Effective Provider

• Nuggets of Wisdom
  – Use open questions
  – Open the door (invite client to share)
  – Use agenda setting, allow client to decide what to work on
  – Silence inner chatter
  – Reflect back to client
  – Summarize (bouquet of client’s change talk)
Additional MI Tips

• Use open questions
• Open the door (invite client to share)
• Use agenda setting, allow client to decide what to work on
• Silence inner chatter
• Reflect back to client
• Summarize (bouquet of client’s change talk)

Role Play: Motivational Interviewing

• Prompts:
  – How did the presenters use the client’s words?
  – What additional motivational interviewing tips were highlighted?

Team Building and Psychological Safety

• This is hard work, and many clients won’t progress
• The learning curve is very steep for team members to this work
• Psychological Safety
  – Team members feel they can speak up, ask questions and offer ideas

Action Planning
Wrap Up Reflection & Discussion

- Did we make progress on your goals for this training?
- What is one thing that you are going to change after the training today?
- What would you like to know more about now?

What is Coming

- 1:1 Team Calls with Sara Barker and John Kern
- Coaching calls by role
- Skill building and topic specific webinars
- What else would be helpful? Let us know on the evaluation

Evaluations & CEU

THANK YOU