OVERVIEW OF INITIAL AND FOLLOW-UP VISITS: INFUSING COMPASSION TO MAKE PCBH RADICAL

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AGENDA

Rationale for structure

Discussion of Compassionomics and Contextualism and why it matters for our visits…

Overview of initial visits

- Introduction
  - Role-plays
- Contextual Interview
  - Rationale
  - Love, work, play, health behaviors, three T's
  - Role-plays
- Intervention and follow up plan

Overview of follow-up visits

OUR JOURNEY TODAY…

Our ask of you today…

…be vulnerable…

…be curious…

…be open…

…be kind… be compassion… and, above all, be love…

Great special edition on PCBH from the Journal of Clinical Psychology in Medical Settings[1]

- If you haven't read, please do!

G – Generalist

A – Accessible

T – Team oriented

H – Highly productive

E – Educator

R – Routine

*Remember… *GATHER → Four C's*[2]

- *First Contact*
- *Continuity of care*
- *Comprehensive care*
- *Coordinate care when needed*

QUICK REVIEW…

EBT for mental health disorders:

- How long are typical visits?
- How frequently do patients meet with providers?
- How many visits do providers typically have with patients?
- Now…what about for primary care providers?

So, just taking our SMH approach to PC is not the answer… we not only need to BE in PC but we need to change HOW we practice

- Robust research base showing effectiveness of brief interventions[17]
  - Even for intense mental health conditions (e.g., PTSD)

*"To get population reach – we need a **philosophy** to improve access to help us work with everyone & everything that walks into PC…"*

CONTEXTUALISM/COMPASSION CAN FEEL LIKE…

This approach…

…protects us…

STRUCTURE OF PCBH VISITS…

So, what are the preconceived notions/assumptions of PCBH visits?

Gotta be less than 30 minutes

Gotta be directive

Gotta be focused on *one problem*

Gotta set SMART goals

…others? And, why are these preconceived notions?

We guarantee, unless you have done a training with us (or Patti/Kirk) before, this will be a different approach to PCBH visits… potentially, drastically different…

Again, not saying it is truth… just a different perspective

QUESTION FOR YOU ALL…

On your own and then we will pair up…

- How do you define what "good care" looks like? What are the components of "good care?" What are your relational fames?
- Where have these relational frames with good care come from? Who has taught you this? What research supports it?

FROM STANDPOINT… WE TRY…

We are radical, not superficial

- We couldn’t do this work daily and see the number of patients we do if it was superficial

We strive to know and to see the patient

We incorporate their context

We work with things like trauma, substance abuse, etc., that is still part of their context…

It means we are love/compassion…

ANOTHER PROMPTING QUESTION… WHAT IS YOUR WHY???

Partnering up…

What got you into healthcare/psychology?

- The five why's

How often do you live that value in your work?

If willing, please share

SO… WHY THIS FOCUS ON CONTEXT/LOVE/COMPASSION???

Our why…

COMPASSIONOMICS

Compassionate care defined:

- *Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective*

Research on Compassionomics – literally, related to every outcome we have researched

- Patients have lower A1Cs and cholesterol
- Patients have better controlled pain
- Have higher quality of life after being diagnosed with cancer
- One of, if not, the most predictive intervention for treatment adherence
- Significantly reduce health cost, lower referrals, lower diagnostic testing, lower hospital admissions, ER utilization, etc.
- After being discharged for HF and pneumonia, lower readmission rates
- Prompts patients to ask more questions, request clarification, and support from their medical team
- Prevents provider burnout… maybe, the most predictive intervention to prevent burnout…
  - Yes, *leaning in* rather than *leaning out* prevents burnout…
    - This is why PCBH isn't about being superficial… F*CK THAT NOISE!

COMPASSIONOMICS

So… pretty impressive and, yet, not so surprising, data… right?

Now the question turns to… are we?

Pause…

COMPASSIONOMICS

Is the US Health System compassionate:
- Patients – 53%
- Providers – 58%

Do providers provide compassionate healthcare:
- Providers – 78%
- Patients – 54%
  - You know something really interesting???

Honest question… this was for medical providers, right… do you think we are better?

We may be scared to find out…
- How would we know… come back to this later…

COMPASSIONOMICS

So… how we feeling?

Remember that definition of compassion:

- *Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective*

How do we do that?

How do we promote that?

COMPASSION IN ACTION

How can we engineer a context of compassion…

- It starts as soon as we walk into the room…
- How we greet the patient and pass patients in the hallways
- Our introduction
- The questions we ask
- What we do when vulnerability shows up
- How we *contextualize* the presenting concern
- How we express our own vulnerability
- How we intervene
- The words we use
- What we say to the team, both in person and in our documentation
- What we say when we huddle with our MAs and PCPs
- Handouts in exam rooms
- The way exam rooms look
- *Create frames of compassion*
  - *Be compassion…*

ENGINEERING A CONTEXT OF COMPASSION…

What if we asked ourselves before every visit, "how do I want this patient to feel when they leave today?"

- What would we do different?
- What would we focus on?
- What context would we want to create?

NOW… LET'S SHIFT TOWARDS CONTEXTUALISM…

"Never in human history has there been as many medications and technologies available to help people manage their diabetes (or other health care concerns), yet the sequelae of poorly managed diabetes continues to wreak havoc on patients and health care systems, alike…"[4]

We know what chronic conditions are…[5]

We know how they develop…

We know how to treat them…

Yet…[6-8]

A CONTEXTUAL APPROACH

Behaviors do not happen in vacuums

- Symptoms arise due to one's context, thus, for us to intervene appropriately we must understand the context

What happens when we start to do this?

- Disorders and pathologies make sense! And, we don't have to fix anyone!

To us, if what is showing up doesn't make sense, we are missing the context

- Everything the patient is doing has a **purpose/function**, if we can help identify that function, rapid change can occur
  - Simple but profound

"We are not interested in changing people… We are more interested in changing contexts (internal and external) so behaviors that are problematic no longer make sense"

A CONTEXTUAL APPROACH

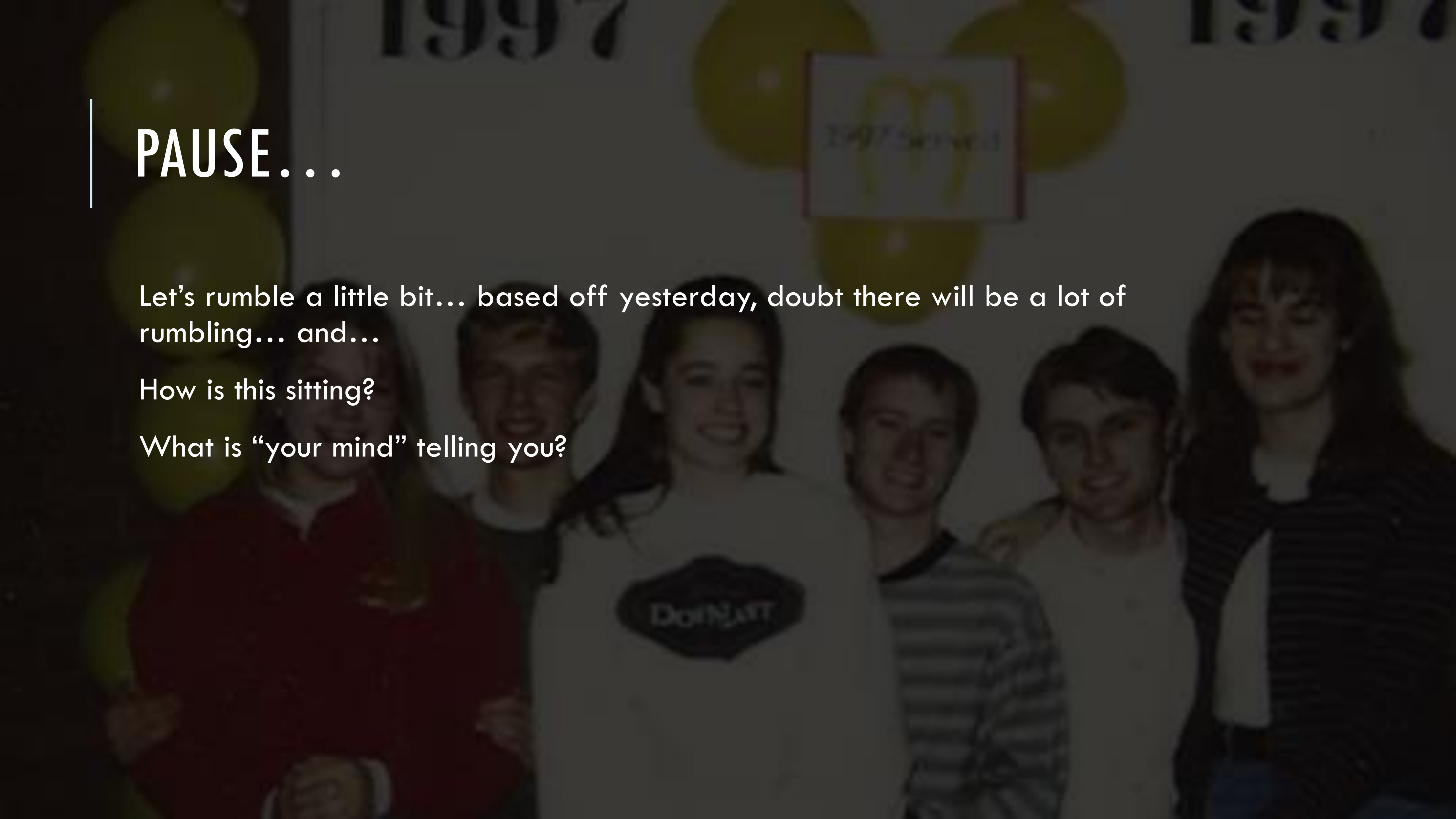
This isn't anything new… most of us agree with this, right?

- But, how often do we actually practice in this way?
- How often do we label things without taking in the context?
- How intentional are we with our visits to promote this?

How often do we reinforce to patients, "*you are broken?*"

How we ask questions, what we focus on, what does this create as far as relational frames?

How does that impact our duration and frequency of visits?



PAUSE…

Let’s rumble a little bit… based off yesterday, doubt there will be a lot of rumbling… and…

How is this sitting?

What is “your mind” telling you?

PCBH VISITS

For us to be ~~brief~~ radical, we need to be…

- Structured but flexible
- Intentional
- Psychoeducation focus
- Behavioral and contextual focus
- Transdiagnostic
- Focused on functional restoration rather than symptom reduction
- Work happens outside of the room, rather than inside

GENERAL OUTLINE OF INITIAL VISITS

Introduction (2 minutes)

Contextual Interview (10 minutes)

Conceptualization statement (2 minutes)

Psychoeducation (3-5 minutes)

Intervention (5-10 minutes)

Plan and follow-up (2 minutes)

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INITIAL VISIT: INTRODUCTION

Example

- https://www.youtube.com/watch?v=YzYh_uQtzZY&list=PLvLh_YdubBs4fm9u7Xgg1i5VKMMcmvt2f&index=2
- Rob's & Dave's

INITIAL VISIT: INTRODUCTION

Who you are

- A Behavioral Health Consultant (intern)
- Your profession (i.e., clinical psychologist, LCSW, LMHC, etc.)
  - Predoctoral intern, which means I am in my final year of my clinical/community psychology doctorate program. I am supervised by … you can contact them at any time by …

Part of the team

- Work closely with the medical providers

Focus on overall health improvement, including physical and mental health

Duration of appointments (15-25 minutes) and what will happen today

- Will ask you a number of questions to get to know you
- Come up with a game plan

Some people get what they need after one visit, others follow up

You document in their medical chart and will communicate back to the PCP

INITIAL VISIT: INTRODUCTION

Your thoughts?

What context does that establish?

What *don't* we say?

Our *introduction* to this introduction… need to practice…

Literally, we are going to write this out…

INITIAL VISIT: INTRODUCTION

Role play

- Write-out your introduction
- Pair up and practice

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*PRIMARY CARE CONTEXT

Fast paced

*Multimorbidity of patients

Biomedical focus of clinics

Interplay of BIO-PSYCHO-SOCIAL-SPIRITUAL/CULTURAL factors

Pressures to be accessible to medical team

Many patients weren’t seeking out mental health services – what’s this mean for stage of change?

THIS RESULTS IN A FC APPROACH MAKING A LOT OF SENSE… AS, WE NEED TO BE

*Transdiagnostic

Need organizing principles to translate complexity into parsimony

Basic idea of *contextualism (philosophy that underlies fACT)

- *There is a function to every behavior
- *We cannot focus on a single behavior w/o assessing the context in which the behavior occurs

KEY TAKEAWAY: What context is sustaining a particular behavior? In other words: What is helpful about a patient's behavior given their context?

INITIAL VISIT: CONTEXTUAL INTERVIEW

Our stories with the CI…

Every.Single.Time

- Depression – Yep, Anxiety – Yep, Treatment Adherence – Yep, DM – Yep… you get the point
- Need to practice

Same sequence and in the same order every time

- Why?

Not a checklist, but a story builder

- Symptoms/behaviors do not happen in vacuums, they happen in a **context**
- We cannot intervene without knowing the context
- While a sequence, questions derive from answers…
- Looking for gravitational pulls…

*ACCESS-V (INSTEAD OF DSM-V)

*ACEs

*Cultural considerations

*Context:Internal,TEAMS & External Context

***SDoH**

*Stages of change – Pros of avoidance

*Values

WHAT ALL THIS MEANS TO US...

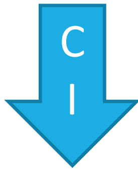
In order to work efficiently BHCs must have a broad knowledge of working “mental representations”

We build these mental representations over time & via our schooling/experiences/trainings

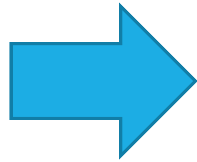
The Contextual Interview is a MAJOR mental representation that helps us gather a lot of information

We can filter our knowledge of conditions, evidenced based interventions and case conceptualizations through the patients’ context (organized by ACCESS-V)

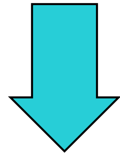
BHCS' CLINICAL ROLE



Knowledge of
*Conditions &
*evidenced based recs &
*Conceptualization CBT, MI, ACT, etc. skills



Patients'
*ACCESS-V



= *SMART GOALS

Specific, measurable, achievable, relevant, time oriented

*CONTEXTUAL INTERVIEW LOVE, WORK, PLAY & HEALTH BEHAVIORS

Love

- Living Situation
- Relationship
- Family
- Friends
- Spiritual, community life?

Work/School

- Work/school situation
- Income?

Play

- Fun/Hobbies
- Relaxation

Health Behaviors

- Exercise
- Sleep
- Diet
- Substance use (caffeine, cigs, alcohol, MJ, substances, etc.)

INITIAL VISIT: CONTEXTUAL INTERVIEW

Videos

Using your CI checklist, grade the contextual interview

- https://www.youtube.com/watch?v=TE2L66a3DUg&t=60s (begin at 0:36)
- https://www.youtube.com/watch?v=JKFWsb8RtW0&t=23s
- https://www.youtube.com/watch?v=vuTrmRFDt9s&t=149s
- https://www.youtube.com/watch?v=iHC-TkoUJsw&t=18s

Lol, trust us, we know a lot about what your minds are saying…

THIS WILL TAKE TOO LONG!!!

And, you know, you are right… it will at the beginning

IT FEELS TOO STRUCTURED, I CAN'T BE MYSELF!!!

And, you know, you are right… it does at the beginning

THIS WILL CAUSE US TO NOT FOCUS ON THE REFERRAL PROBLEM!!!

And, you know, you are right… it will cause you to focus on the *context* where that problem comes from

PATIENTS DON'T WANT TO BE ASKED THESE QUESTIONS!!!

And, you know, you are right… and, isn't that the point…

WELL, I'LL USE THIS SOMETIMES, BUT NOT FOR LIKE SMOKING CESSATION!!!

And, you know, smoking has a context as well… a story…

PAUSE

Let's rumble ☺

Definitely not saying this is the *only way*… and it is *our way*…

Definitely not saying you can't do PCBH unless you use the CI; lol, could you imagine

- Love all the double negatives ☺

What we are saying:

- This has helped us tremendously… saved our careers before they started…
- It makes us stay curious with patients
- It honors what is surrounding them and normalizes
- It creates obvious interventions and keeps us from doing algorithms that won't uptake
- This, in and of itself, is an intervention… it reflects the PCC, TIC and Compassionomics research[9-13]
- It allows us to be kind… it allows us to be compassion… it allows us to be love…
- Give it time, practice, practice, practice… and then practice some more…
- We will have future didactics on the CI/fACT in and of itself… brilliant tool ☺ Thanks Patti, Deb, and Kirk!

INITIAL VISIT: CONTEXTUAL INTERVIEW

Let’s role-plays

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INITIAL VISIT: CONCEPTUALIZATION STATEMENT

Reflect back to the patient your understanding of their context

Ask if this sounds right

Reframe the patient's problem as a response to their individual context

- Even for things such as obesity, DM, HTN… these are still showing up in the individual's context

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INITIAL VISIT: PSYCHOEDUCATION AND INTERVENTIONS

DO NOT underestimate psychoeducation

- These things may seem basic to us, but this could not be further from the truth

Interventions

- Didactics throughout the year
- Behaviorally focused
  - Sorry… but yes, they do
- Utilize handouts
- Set SMART goals
- Remember, the work is done OUTSIDE of the visit, not inside

GENERAL OUTLINE OF INITIAL VISITS

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Plan and follow-up (2 minutes)

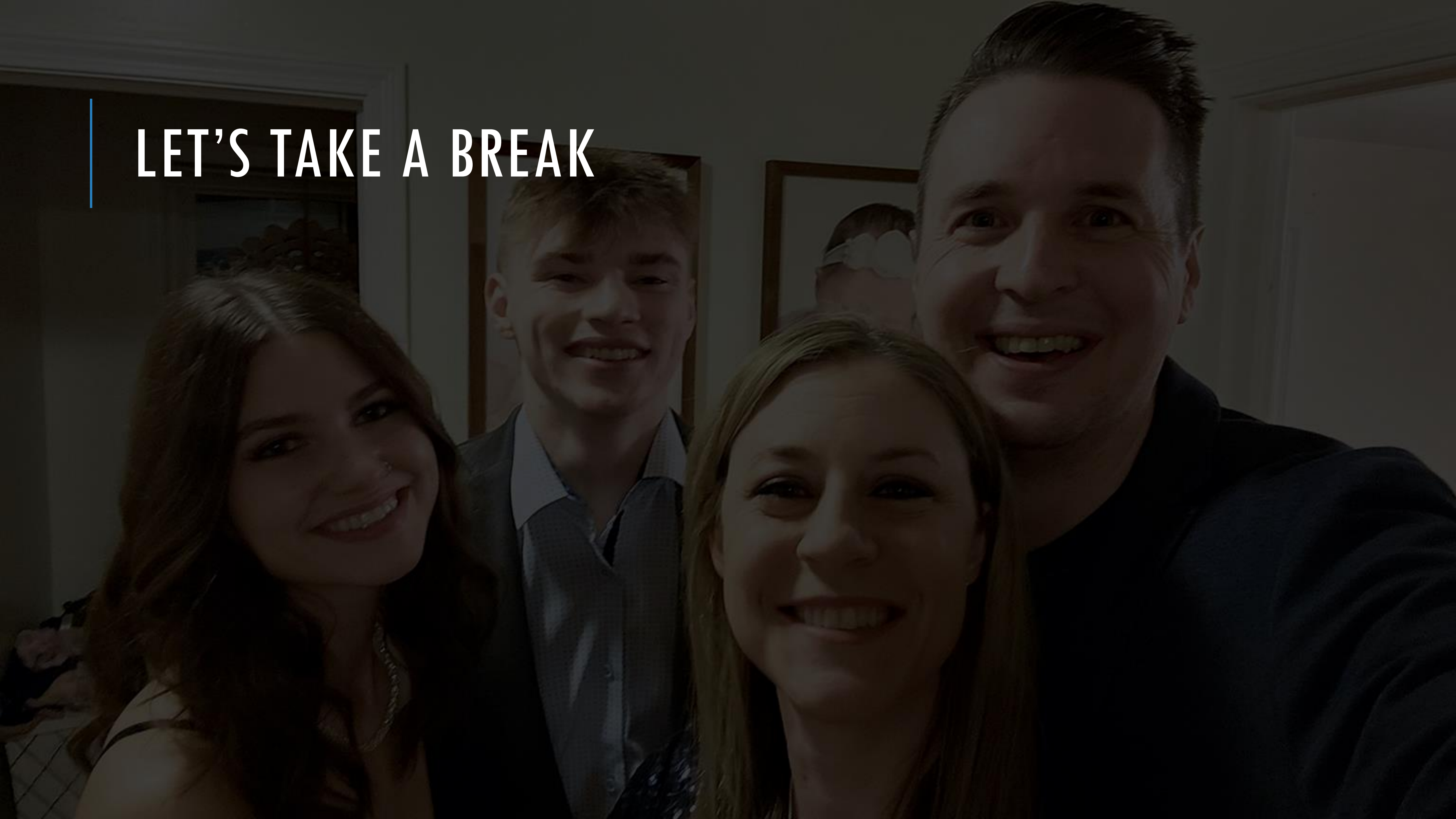
INITIAL VISIT: PLAN AND FOLLOW-UP

Plan

- SMART and written out
  - Prescription pads

Follow-up

- Do they need to follow up?
- Suggesting a follow up or asking?
  - Pros and cons to both
- Only for extreme reasons should it be in a week
- Earliest, two weeks, need to give time for it to work
- Can they follow up at next PCP visit?
  - Can you take the place of a PCP visit?


LET'S TAKE A BREAK

FOLLOW-UP VISITS: STRUCTURE

Set an agenda (1-2 min)

Assess progress (5-10 min)

Psychoeducation/intervention (5-10 min)

Set SMART goals (2-5 min)

Establish follow-up (2 min)

FOLLOW-UP VISITS: STRUCTURE

Set an agenda (1-2 min)

Assess progress (5-10 min)

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Set SMART goals (2-5 min)

Establish follow-up (2 min)

FOLLOW-UP VISITS: SET AN AGENDA

Purpose

- Conduct a visit that balances patient and provider needs

Structure

- Provider needs:
  - "I want to follow-up on the goals we set last time…"
- Patient needs:
  - "…what else would you like to discuss today?"
  - "something else?" until complete list is developed
- Prioritize:
  - "Okay, we may have time to get to two or three of those items, what would be most important to you?"

FOLLOW-UP VISITS

Role play: agenda setting

- Now let's make it trickier….

FOLLOW-UP VISITS: STRUCTURE

Set an agenda (1-2 min)

Assess progress (5-10 min)

Psychoeducation/intervention (5-10 min)

Set SMART goals (2-5 min)

Establish follow-up (2 min)

FOLLOW-UP VISITS: ASSESS PROGRESS

Completion of previous goals

- Completed
  - Reinforce any step in the desired direction
  - Assess impact on functioning
- Not completed
  - Brainstorm barriers
  - May need to revisit CI questions

Alternative gauge of progress

- "Since our last visit, has (insert presenting concern) been the same, worse, or better?"
- Explore response
  - "What do you think is made it better?"

FOLLOW-UP VISITS

Role play

- Assessing goals/progress
- Combine agenda setting and assessing goals/progress

FOLLOW-UP VISITS: STRUCTURE

Set an agenda (1-2 min)

Assess progress (5-10 min)

Psychoeducation/intervention (5-10 min)

Set SMART goals (2-5 min)

Establish follow-up (2 min)

FOLLOW-UP VISITS: PSYCHOEDUCATION/INTERVENTION

Build off of previous visit

- Refer back to Initial visit Psychoeducation/Intervention slide

FOLLOW-UP VISITS: STRUCTURE

Set an agenda (1-2 min)

Assess progress (5-10 min)

Psychoeducation/intervention (5-10 min)

Set SMART goals (2-5 min)

Establish follow-up (2 min)

FOLLOW-UP: GOALS AND FOLLOW-UP

Goals

- Take into account previous and completion
- SMART and written out

Follow-up

- Do they need to follow up?
- Can they follow up at next PCP visit?
  - Can you take the place of a PCP visit?
- Consider extending the time btw visits

FOLLOW-UP

Role-play

- Practice leaving follow-up PRN

SO…

How you feeling?

Again, to us… approaching patients from this perspective:

- Keeps us curious
- Allows the interventions to uptake
- …allows patients to engage with us…

What if we asked ourselves before every visit:

- How do I want this patient to feel when they leave the room?

… what would happen if healthcare became just 5% more curious, more compassionate, more loving…

Be kind, be compassion, and, above all, be love

- Allow your visit structure to reflect this…

AS WE END…

Even with these techniques, strategies, skills… we will still fail…

- And, maybe that is the point

Be kind, be compassionate, be **LOVE…**

…never underestimate how you can create a context…

- Just like with pictures in a presentation…

…and create contexts that allow patients to thrive and move towards their values

…We so appreciate you all… thank you for being vulnerable today…

QUESTIONS???

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