PCBH Overview: Tricks of the Trade and Beyond

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Beachy Bauman Consulting, PLLC

Friday, July 10th 2020

WHO WE ARE… ITS GOOD TO SEE YOU ALL AGAIN ☺

Bridget Beachy, PsyD
- Principal Member, Beachy Bauman Consulting
- Director of Behavioral Health, at a Community Health Center (CHC) in Central WA
  - **Roles:** BHC, administrator, primary supervisor for interns and fellows, faculty for FM residency

David Bauman, PsyD
- Principal Member, Beachy Bauman Consulting
- Behavioral Health Education Director at a CHC in Central WA
  - **Roles:** BHC, administrator, primary supervisor for interns and fellows, faculty for FM residency

We both live and breathe PCBH and contextual approaches (e.g., Acceptance and Commitment Therapy)

We value what we do… and… we get emotional… well, Dave does…

Our values live through our presentations… the people that mean the most to us are with us today…

OUR JOURNEY TODAY…

We have six+ hours… which sounds like a lot… and…

Logistics of Zoom

Introductions, wanting to hear where you all are heading!

Some *context*

Connecting to your why…

Broken up into three sections:

- Part I: PCBH overview (the why, primary care, and GATHER)
- Part II: Nuts and bolts of the role
- Part II: Becoming a director

LOGISTICS

Zoom format

- Chat box
- Keep self muted
- Breakout sessions

Our gratitude for you being here today…

WHERE ARE YOU ALL HEADED???

Name

Where you are going?

What you are hoping to get out of today?

Any successes/wins you would like to share?

BEFORE WE "JUMP INTO THE DEEP…"

We are passionate about integrated behavioral health in primary care

We ~~may~~ will most likely say things that challenge some assumptions…

…And that is okay… that is our hope… we are here with you…

Our perspectives aren't truths…

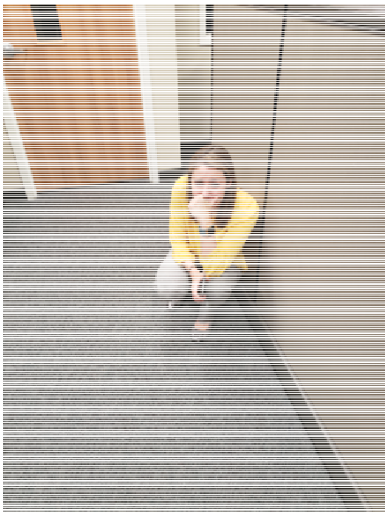
Integrated care, while great, is hard to do…

…Be kind on the journey…

INTEGRATED CARE CAN FEEL LIKE…

Anyone that says PCBH is *easy*…

…probably hasn't done it…



OUR WHY'S

To do this work, there has to be *a calling, a value, a why…*

What is your why? What drives you?

Retirement party exercise…

Anyone willing to share?

LET'S GO BACK TO THE BEGINNING…

Why have behavioral health in primary care in the first place?

Any thoughts?

Privilege of talking to the founders… (side note)

- PCBH Corner's - https://www.youtube.com/playlist?list=PLvLh_YdubBs5P-dv9IrSH7-TwTqM8fkqo

THE *WHY* OF PCBH

A lot of the stories (and accidents!)…

- Alexander Blount
- Neftali Serrano
- Kirk Strosahl and Patti Robinson
- Jeff Reiter

The biopsychosocial philosophy has been around for a while[1]

- Up-taken most by family medicine
- Influence on primary care

THE *WHY* OF PCBH

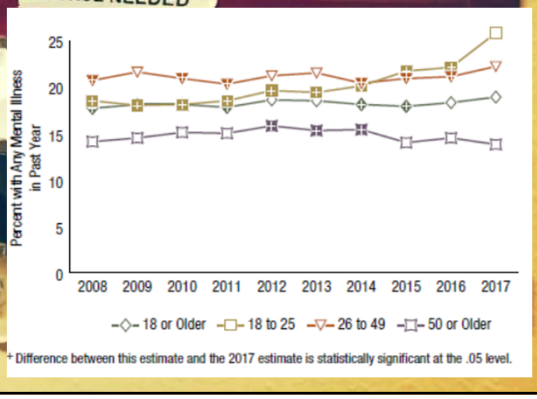
And… the data that you all are aware of…

What percent of adults have Any Mental Illness in a given year?

Figure 48 Table. Any Mental Illness in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	17.7+	18.1	18.1+	17.8+	18.6	18.5	18.1+	17.9+	18.3	18.9
18 to 25	18.5+	18.0+	18.1+	18.5+	19.6+	19.4+	20.1+	21.7+	22.1+	25.8
26 to 49	20.7+	21.6	20.9+	20.3+	21.2	21.5	20.4+	20.9+	21.1+	22.2
50 or Older	14.1	14.5	15.1	15.0	15.8+	15.3+	15.4+	14.0	14.5	13.8

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.



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THE *WHY* OF PCBH

But, where do they get treatment?

Figure 72 Table. Type of Mental Health Services Received in the Past Year among Adults Aged 18 or Older: Percentages, 2002-2017

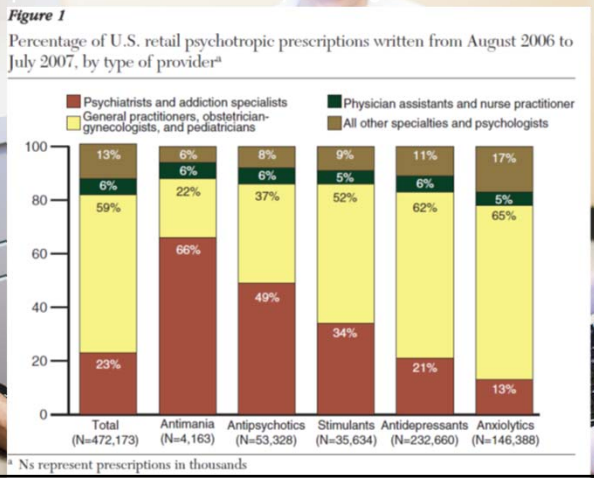
Service Type	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
Any Mental Health Services	13.0+	13.2+	12.8+	13.0+	12.9+	13.3+	13.5+	13.4+	13.8+	13.6+	14.5	14.6	14.8	14.2	14.4	14.8
Inpatient	0.7+	0.8	0.9	1.0	0.7+	1.0	0.9	0.8	0.8+	0.8+	0.8	0.9	1.0	0.9	0.9	1.0
Outpatient	7.4	7.1	7.1	6.8+	6.7+	7.0+	6.8+	6.4+	6.6+	6.7+	6.6+	6.6+	6.7+	7.1+	6.9+	7.5
Prescription Medication	10.5+	10.9+	10.5+	10.7+	10.9+	11.2+	11.4	11.3+	11.7	11.5	12.4	12.5	12.6	11.8	12.0	12.1

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Note: Mental health service is defined as having received inpatient care or outpatient care or having used prescription medication for problems with emotions, nerves, or mental health.

THE *WHY* OF PCBH

That 12.1% of prescriptions… where are they coming from?[3]



THE *WHY* OF PCBH

Well, just refer to SMH

- 20% of referred patients follow-through[4]

Why many don't go to specialty MH?[4]

- Lack of insurance
- Stigma
- View their problem as "physical"
- Inconvenience
- Better familiarity, comfort with PCP
- Prior negative experiences
- I don't want/need to go

THE *WHY* OF PCBH – LET'S DO IT!

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

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[6]

- Even for intense mental health conditions (e.g., PTSD)

THE *WHY* OF PCBH

And… that is usually where the story ends… its about mental health and substance abuse….

Yet, close to half of all Americans have a chronic health concern (e.g., HTN, DM, heart disease, etc.)[7]

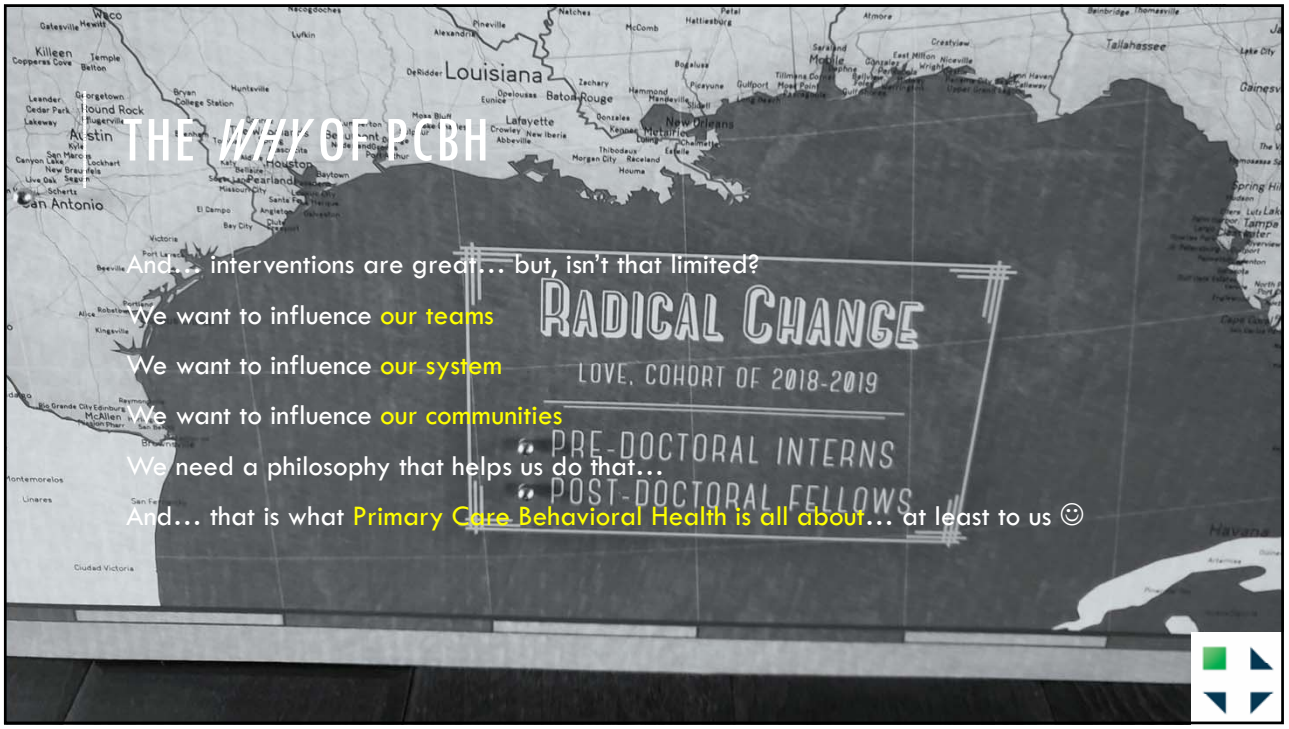
- Nearly two-thirds of all deaths in US are contributed to heart disease, cancer, stroke, COPD, & DM

What is one universal recommendation for chronic conditions?

What are the realities of treatment adherence in primary care?[8-9]

What does the research Adverse Childhood Events say?[10]

This isn't a mental health intervention… this is a healthcare intervention…



THE *WHY* OF PCBH

And… interventions are great… but, isn't that limited?

We want to influence our teams

We want to influence our system

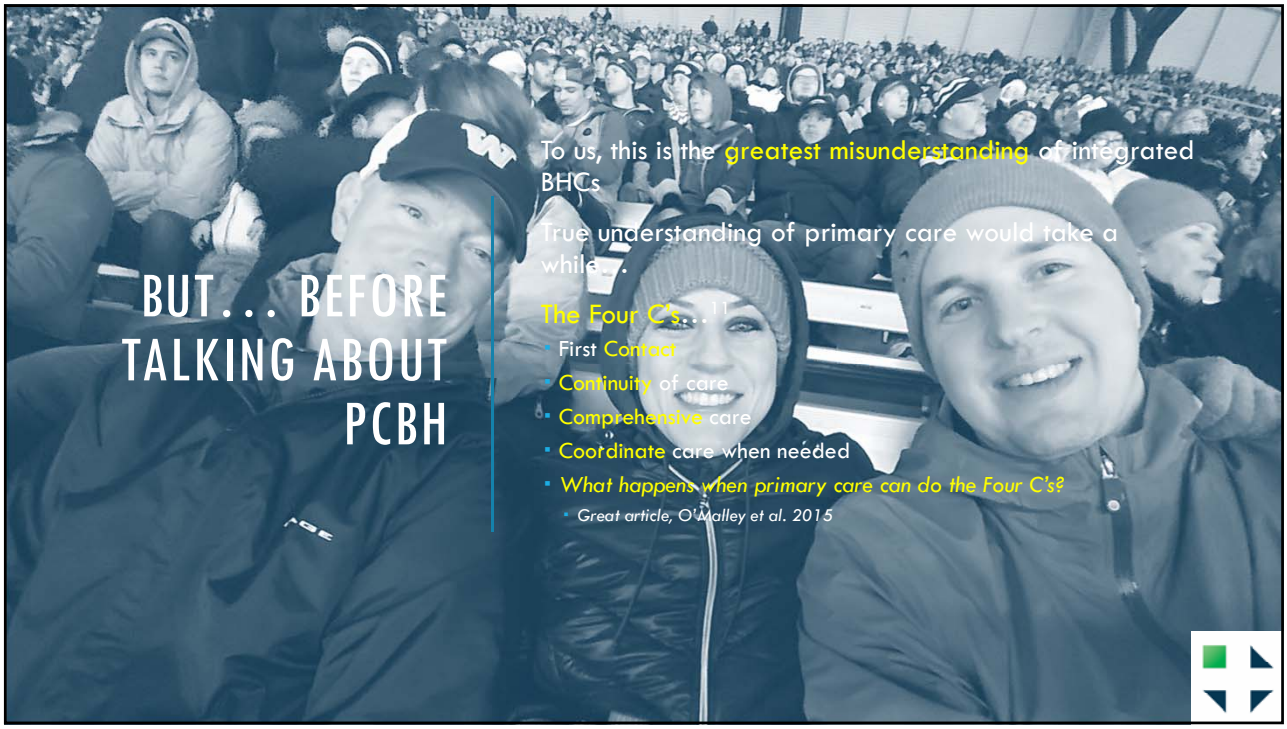
We want to influence our communities

We need a philosophy that helps us do that…

And… that is what Primary Care Behavioral Health is all about… at least to us ☺

GROUP DISCUSSION

Just what is primary care?



BUT… BEFORE TALKING ABOUT PCBH

To us, this is the greatest misunderstanding of integrated BHCs

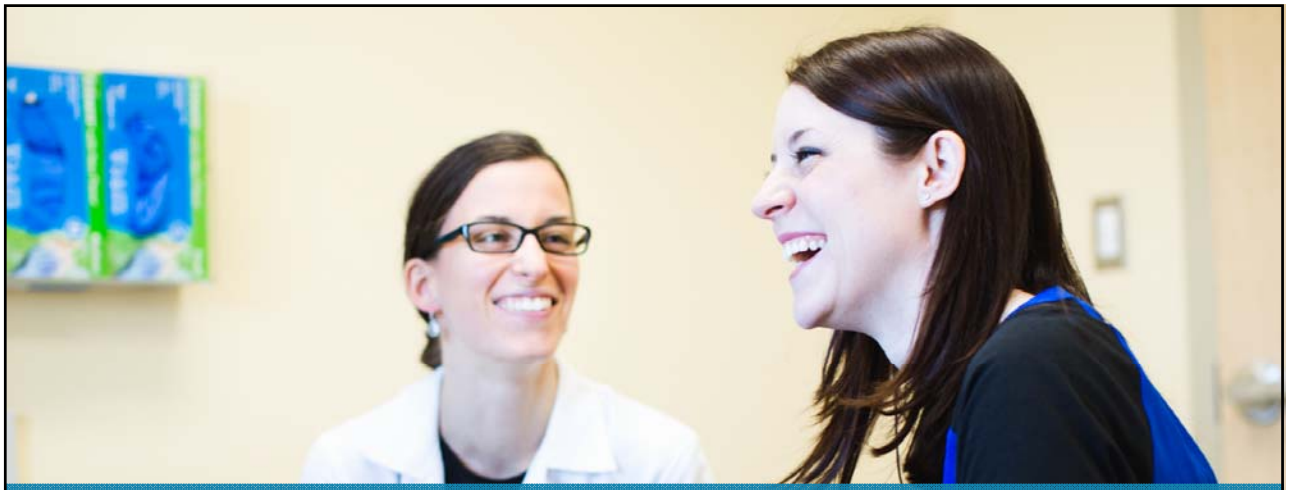
True understanding of primary care would take a while…

The Four C's…

- First Contact
- Continuity of care
- Comprehensive care
- Coordinate care when needed
- *What happens when primary care can do the Four C's?*
  - *Great article, O'Malley et al. 2015*

FIRST CONTACT

Primary Care's Four C's



CONTINUITY OF CARE

Primary Care's Four C's

COMPREHENSIVE CARE

Primary Care's Four C's

COORDINATE CARE WHEN NEEDED

Primary Care's Four C's

OKAY… SO… LET'S LOOK AT PCBH

Great special edition on PCBH from the Journal of Clinical Psychology in Medical Settings[1,2]

- If you haven't read, please do!

G – Generalist

A – Accessible

T – Team oriented

H – Highly productive

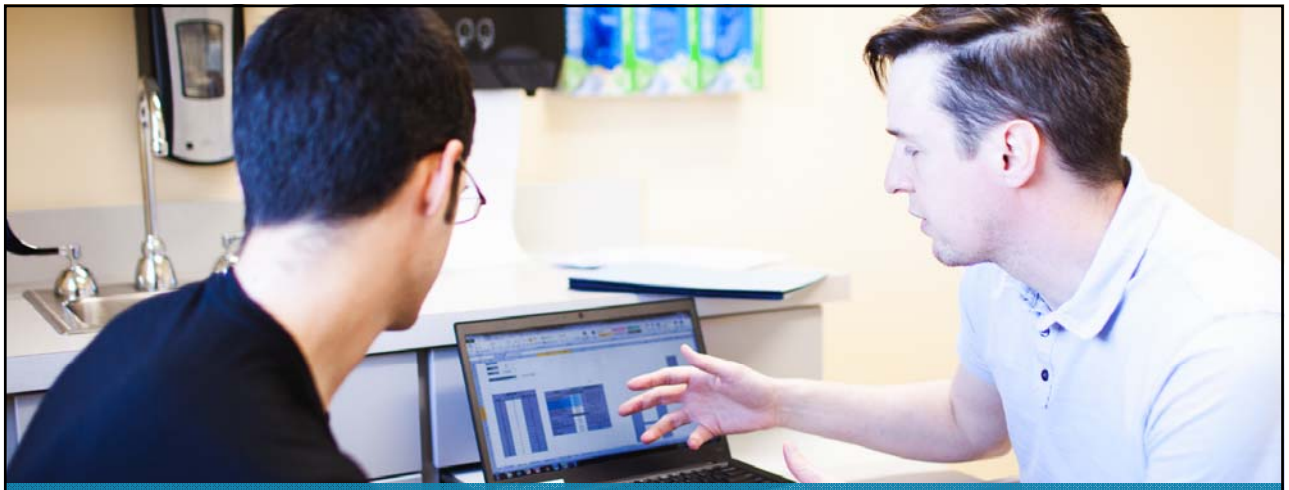
E – Educator

R – Routine

GENERALIST | GATHER

ACCESSIBLE | GATHER

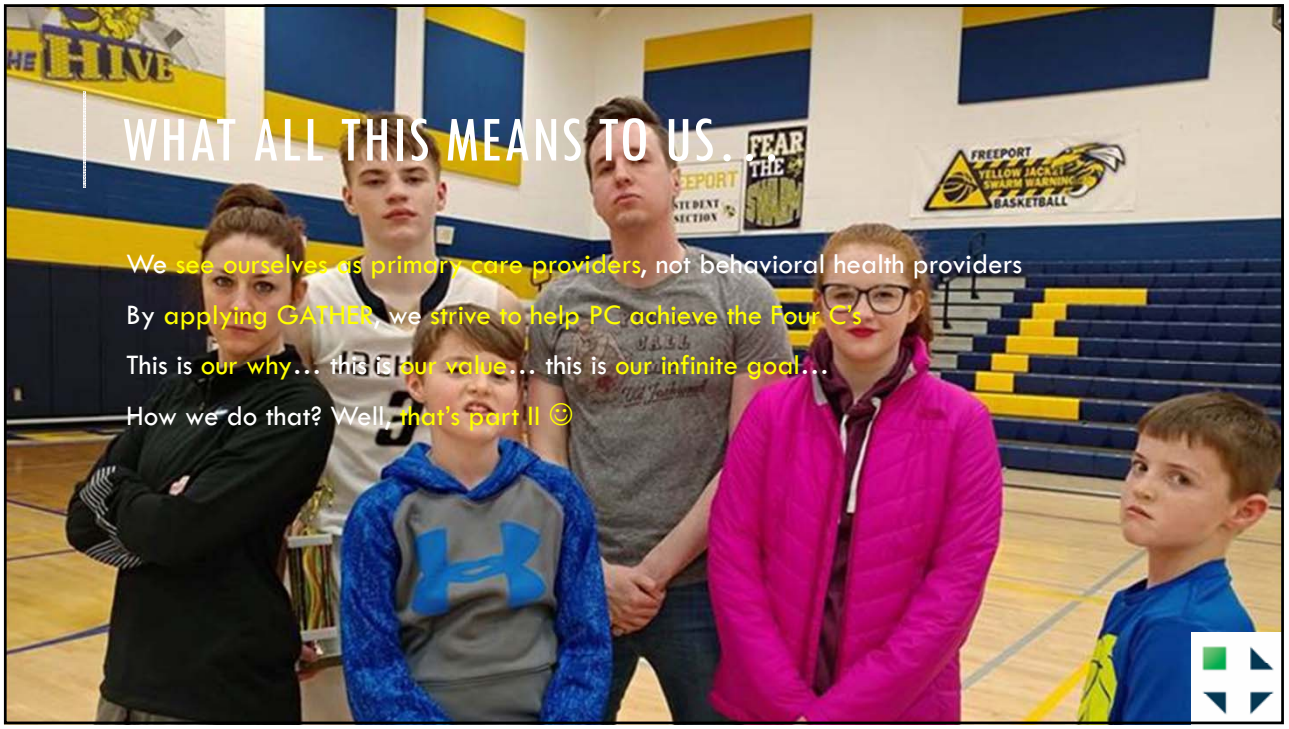
TEAM ORIENTED | GATHER



HIGH PRODUCTIVITY | GATHER

EDUCATOR | GATHER

ROUTINE | GATHER



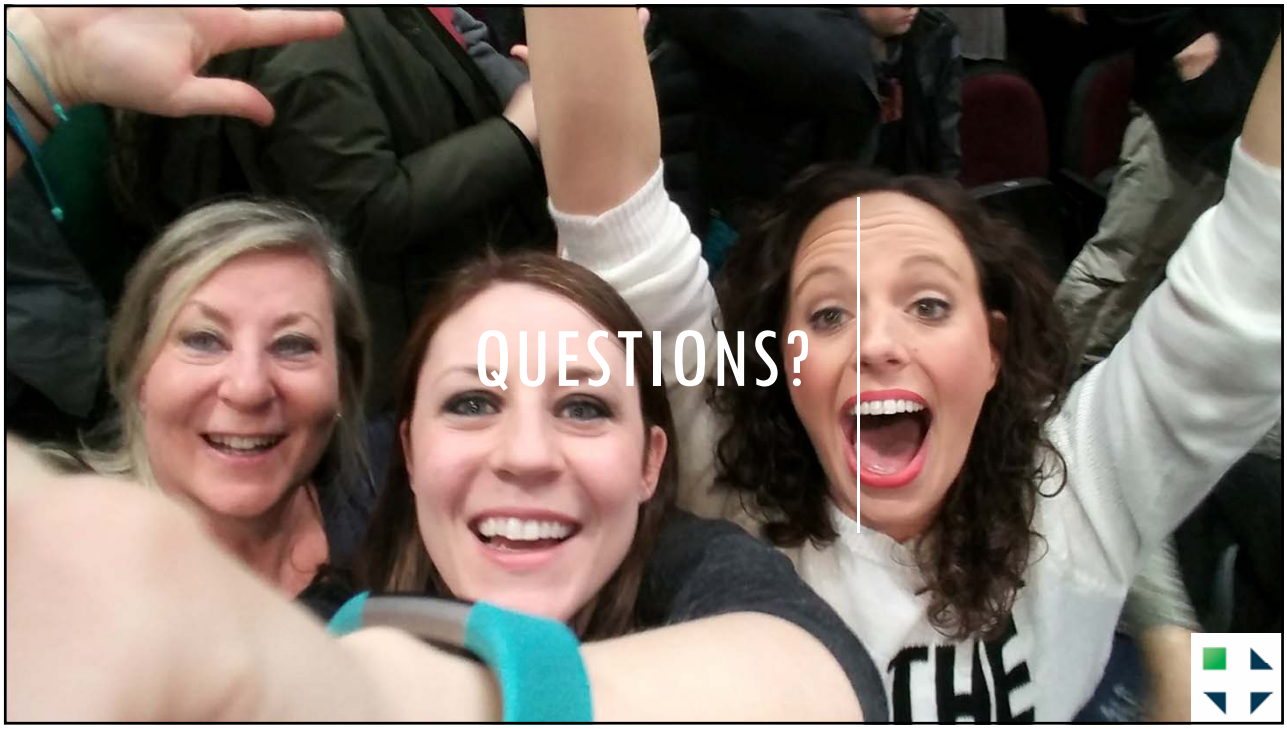
WHAT ALL THIS MEANS TO US…

We see ourselves as primary care providers, not behavioral health providers

By applying GATHER, we strive to help PC achieve the Four C's

This is our why… this is our value… this is our infinite goal…

How we do that? Well, that's part II ☺



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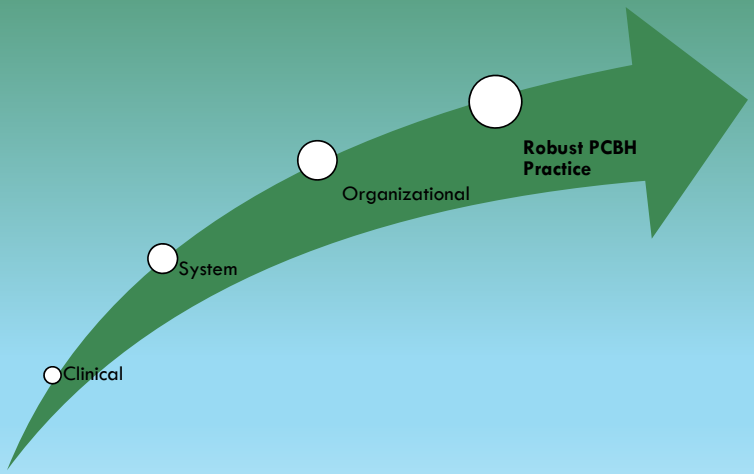
PART II: NUTS AND BOLTS OF THE ROLE


GROUP DISCUSSION
What are the common barriers you have seen in integrated care/PCBH?

3 MAJOR TYPES OF BARRIERS[1,3]



COMMON CLINICAL BARRIERS[1,3]

Narrow, specialized focus
- E.g., kids vs adults
- E.g., only MH or BH
- *Why a barrier?*

Difficulty managing time
- Too time intensive in duration
- *Why a barrier?*

Mismanagement of follow-up visits
- *Too frequent/ too infrequent*
- *Why a barrier?*

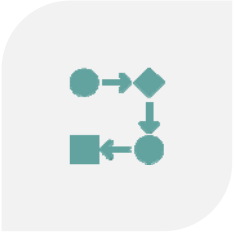
Focus on symptom reduction vs. functional restoration
- *Why a barrier?*

OVERCOMING CLINICAL BARRIERS:
NARROW/SPECIALIST → BE A TRUE GENERALIST

- PC has gamut of conditions/concerns and ages/populations
- Utilize your knowledge/skills and adapt to population
- Why we recommend a contextual/behavioral approach

OVERCOMING CLINICAL BARRIERS:
DIFFICULT TIME MANAGEMENT → INTENTIONAL STRUCTURE

SOUND INTRODUCTION



STRUCTURED VISITS

OVERCOMING CLINICAL BARRIERS:
TROUBLE WITH FOLLOW-UPS → UNDERSTAND PC CONTEXT

UNDERSTANDING PRIMARY CARE

RIGHT TRAJECTORY

PRAGMATIC – WHAT'S HELPFUL?

OVERCOMING CLINICAL BARRIERS:
FOCUS ON SYMPTOM REDUCTION → FOCUS ON FUNCTIONING

FUNCTIONAL RESTORATION

PHQ-9 VS DUKE HEALTH PROFILE

IF WE JUDGE SUCCESS BY HOW YOU ARE FEELING, WE WILL LOSE EVENTUALLY… HOWEVER, IF WE JUDGE SUCCESS BY YOUR BEHAVIORS, THAT IS A WINNABLE GAME."

OVERCOMING SYSTEM BARRIERS:
TRADITIONAL PACE → PRIMARY CARE PACE

PRIMARY CARE TIME

BIRD IN THE HAND

BUILD CLEAR PROCESS TO ASCERTAIN WHO

OVERCOMING SYSTEM BARRIERS:
PROVIDER RESISTANT → CREATE A CONTEXT OF BUY-IN

IF YOU HELP THEIR PATIENTS, THEY WILL USE YOU! LET YOUR WORK SPEAK FOR ITSELF

GET SOMETHING DONE, EFFECTIVE INTERVENTIONS

OVERCOMING SYSTEM BARRIERS:
PROVIDER RESISTANT → CREATE A CONTEXT OF BUY-IN

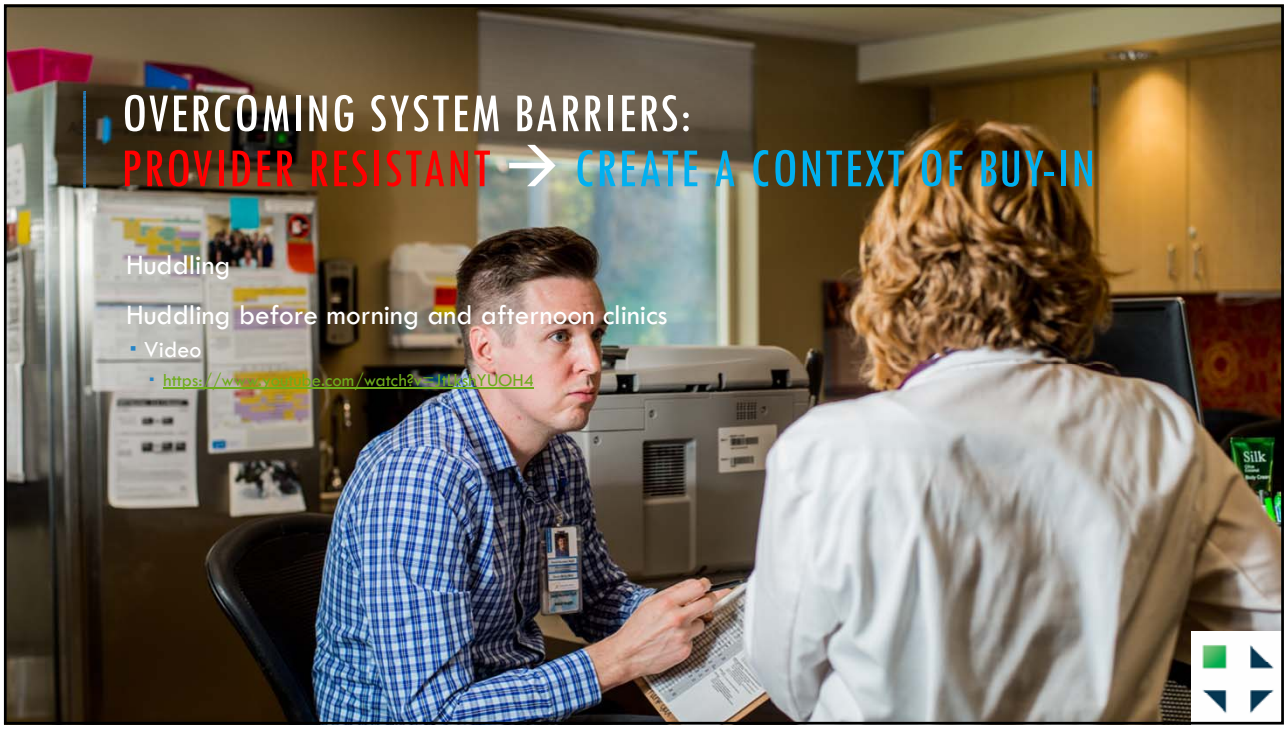
BE ASSERTIVE, YET PATIENT

INFUSE YOURSELF INTO ALL ASPECTS OF CLINIC OPERATIONS

GIVE BARRIER TO CLINICAL SERVICES QUESTIONNAIRE AND BHC SATISFACTION SURVEYS

PICK YOUR BATTLES

STRATEGIES
(NEXT SLIDES!)

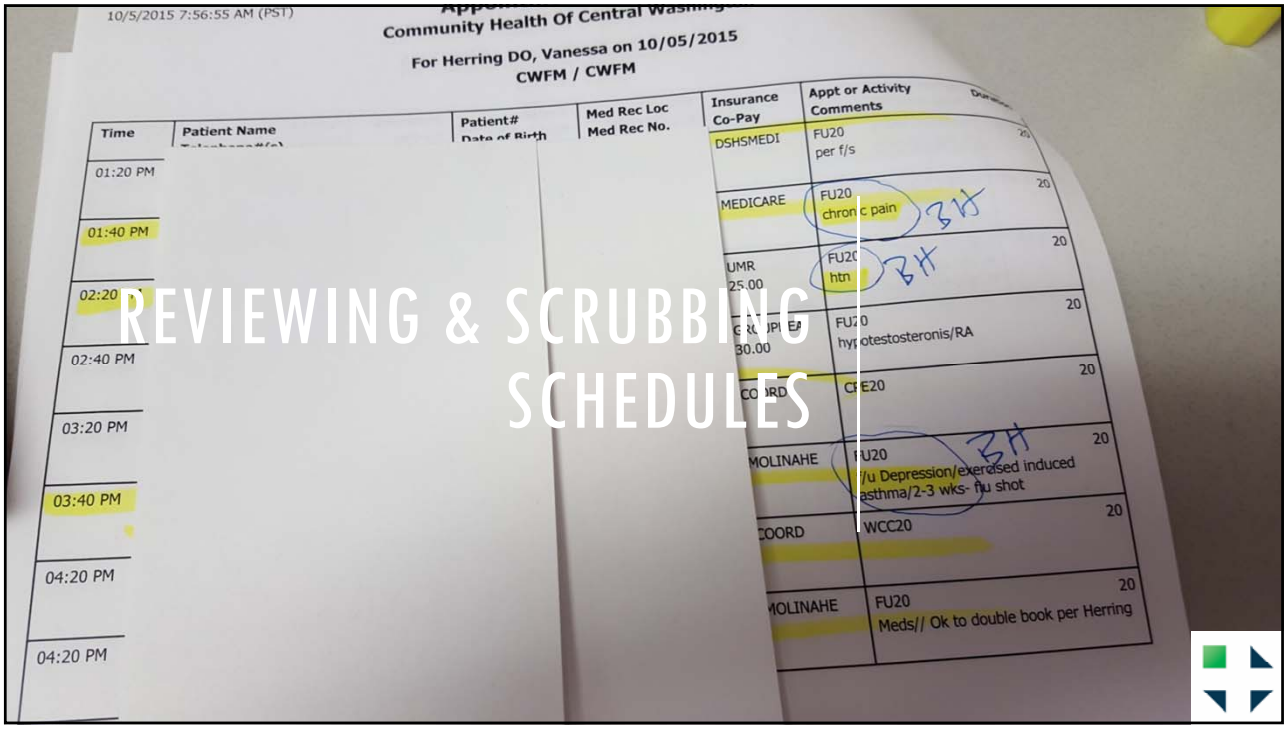


OVERCOMING SYSTEM BARRIERS:
PROVIDER RESISTANT → CREATE A CONTEXT OF BUY-IN

Huddling

Huddling before morning and afternoon clinics

- Video
  - https://www.youtube.com/watch?v=1tUsxYUOH4



REVIEWING & SCRUBBING SCHEDULES

YOU TRY!

Appointment Schedule
Community Health of Central Washington

For Doe, MD, Joe on 01/16/2018

Time	Patient Name	Age	Appt or Activity Comments
8:20 AM	Patient 1 Male	15 years	NEWPT Aneurysm
8:40 AM	Patient 2 Female	35 years	DM/Obesity
9:00 AM	Patient 3 Male	46 years	Smoking/lice
9:20 AM	Patient 4 Male	30 years	CPE
9:40 AM	Patient 5 Male	2 years	WCC
10:00 AM	Patient 6 Female	39 years	Med review
10:20 AM	Patient 7 Female	25 years	WWE
11:00 AM	Patient 8 Female	89 years	Memory concerns
11:20 AM	Patient 9 Female	26 years	Substance use
1:20 PM	Patient 10 Male	52 years	BP
1:40 PM	Patient 11 Male	21 years	Concentration
2:00 PM	Patient 12 Female	18 years	INITIAL OB
2:20 PM	Patient 13 Female	50 years	HTN
3:00 PM	Patient 14 Male	78 years	Cough/DM
3:20 PM	Patient 15 Female	45 years	Chronic pain
4:00 PM	Patient 16 Female	33 years	Palpitations/anxiety

ACCURATE INTRODUCTION

EFFECTIVE INTRODUCTION

HTTPS://WWW.YOUTUBE.COM/WATCH?V=W4ODCOOGZL0&LIST=PLVLH_YDUBBS5OTVVEIC1ADRDEVPLVDZT0

PROVIDE HAND OUT

OVERCOMING SYSTEM BARRIERS:
CONFUSION OF ROLE → INTENTIONAL STANDARDIZATION OF BHC ROLE

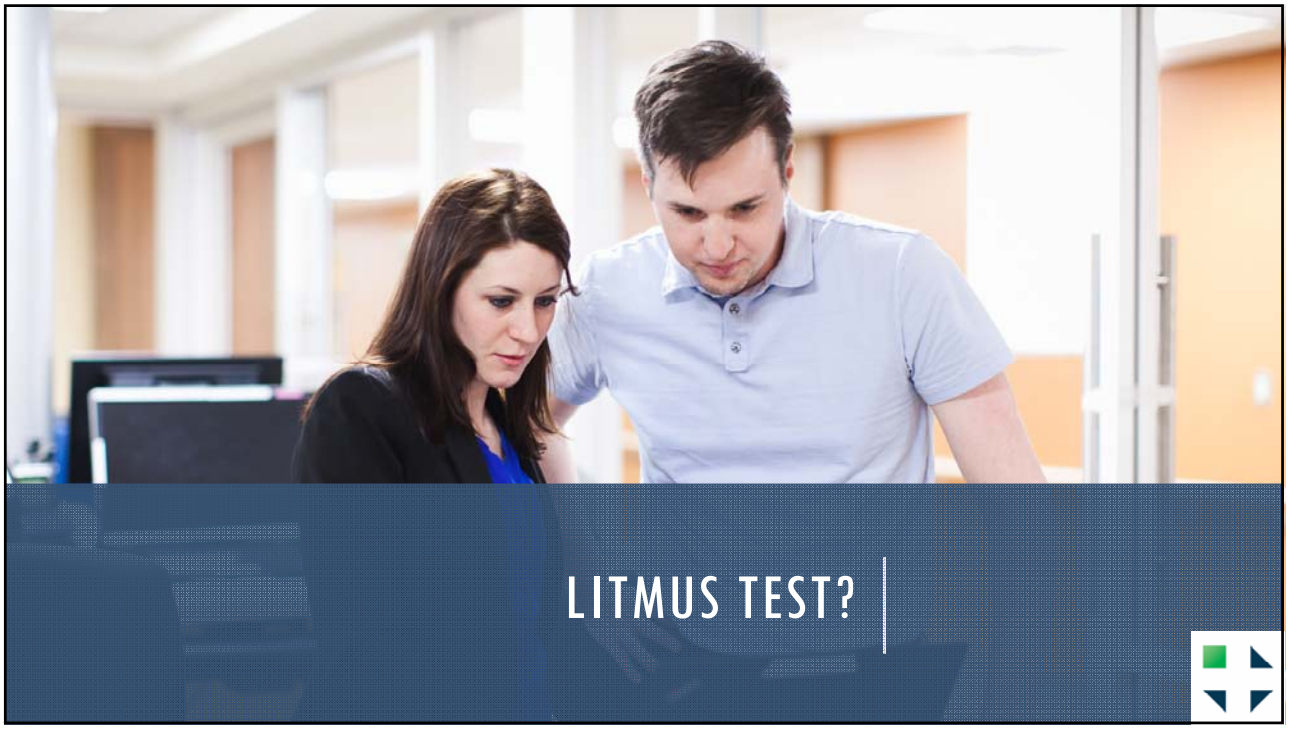
OVERCOMING SYSTEM BARRIERS:
CONFUSION OF ROLE → INTENTIONAL STANDARDIZATION OF BHC ROLE

- Refer to BHC as a "team member" instead of counselor or therapist
- The BHC is an "expert" to help with this condition
- Emphasize to the patient that you routinely involve the BHC in the care of a specific problem
- Inform the patient that BHC is flexible with the amount of time the BHC spends with them
- Let the patient know that this will help you (the PCP) help them (the patient) better

OVERCOMING SYSTEM BARRIERS:
LACK OF COMMUNICATION → UTILIZE ALL FORMS OF COMMUNICATION… INTENTIONALLY

- Direct vs indirect communication
- EHR
- Okay to be interrupted


COMMON ORGANIZATIONAL BARRIERS[1,3]
Space
Why a barrier?
Operations
Why a barrier?
"Provider" Status
Why a barrier?
Leadership Representation
Why a barrier?


LITMUS TEST?

OVERCOMING ORGANIZATIONAL BARRIERS: SILOED SPACE → INTEGRATED SPACE

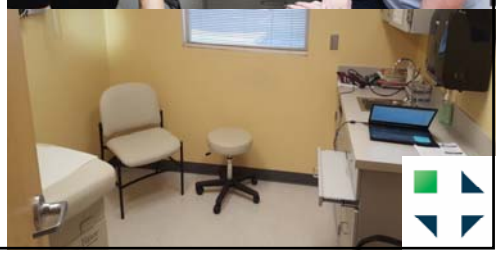
Where should the BHCs sit and see patients?
- Think of the context that one creates…

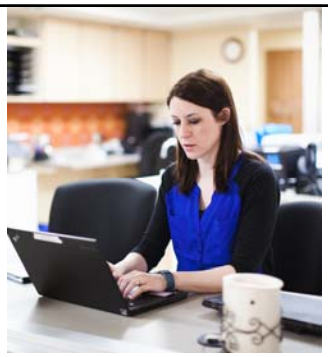
See patients in exam rooms
- Offices should match the primary care setting

Sit in provider pods

BE VISIBLE!
- Cool article about the impact of "bumpability"[4]

…Pause… Be kind… some stories…





OVERCOMING ORGANIZATIONAL BARRIERS: SILOED OPERATIONS → INTEGRATED OPERATIONS

Think of the context…

Same processes for operations
- Check-in/out
- Scheduling follow-ups
- Triage
- Phone calls/voicemails
- Faxing
- ROIs

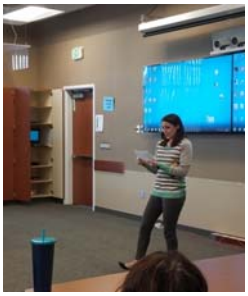
…Pause… Be kind… some stories…

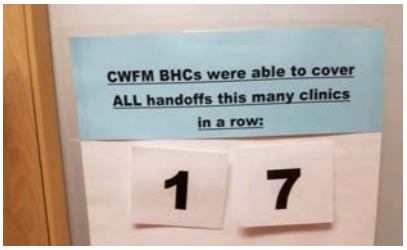
OVERCOMING ORGANIZATIONAL BARRIERS: BHCS? → PROVIDERS

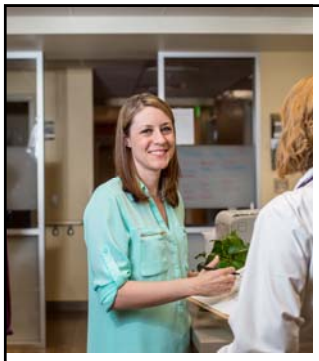
Change the culture!

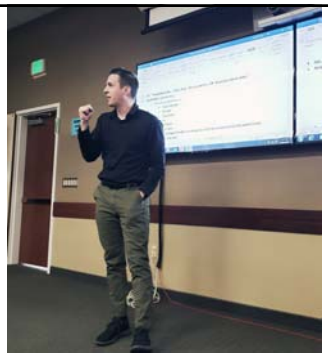
- All staff
- Committees
- Provider engagement
- Provider appreciation
- All provider meetings should include BHCs

…Dare we say… think of the context









OVERCOMING ORGANIZATIONAL BARRIERS: BHC BEING A "PROGRAM" → BEING PART OF THE CULTURE

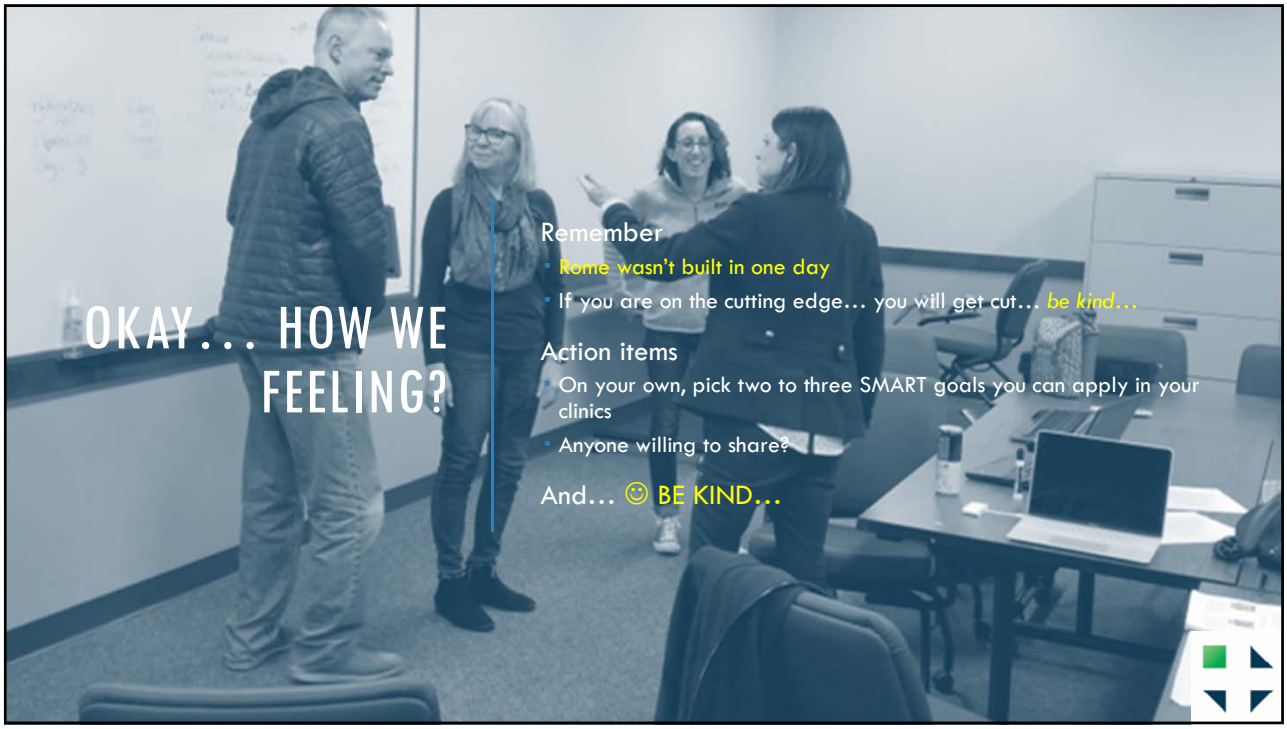
Change the context!

- Meetings, interview processes, representation at the leadership BHC level
- BHCs should be involved in all interviews that the medical providers are included in
- Need representation at the leadership level to prevent "drift"
  - MOST IMPORTANT… develop relationships!!!

…Pause… Be kind… some stories…

What you can do?	Barriers?	GATHER
Seeing all ages, conditions	Limited scope	G
Be visible	Can't find you	A
Be available	Too long of visits, working on non-productive tasks, investing on activities with low return on investment (e.g., lengthy notes)	A
Be accessible	Subtle deterrents (slow to respond, slow to get in the room, etc.)	A
Market yourself	Isolating self, lost in obscurity	T, E, R
Interruptions	Insisting on a different set of rules from what the team practices	A, T, R
Get something done! Helping many patients	Turning down visits, automatically having patients schedule, etc.	H
Asking the team for help	Doing everything "on your own"	T
Offering the team help	Operating independently	T
Again, match the culture of the team for work patterns	Also, insisting on different set of rules, leaving early, not helping during lunch, etc.	T, H
Being a team player, especially regarding work flow	Frequent call outs, not communicating absences in advance, taking patients without talking with the medical team	T

Summary of Barriers? Flip these…



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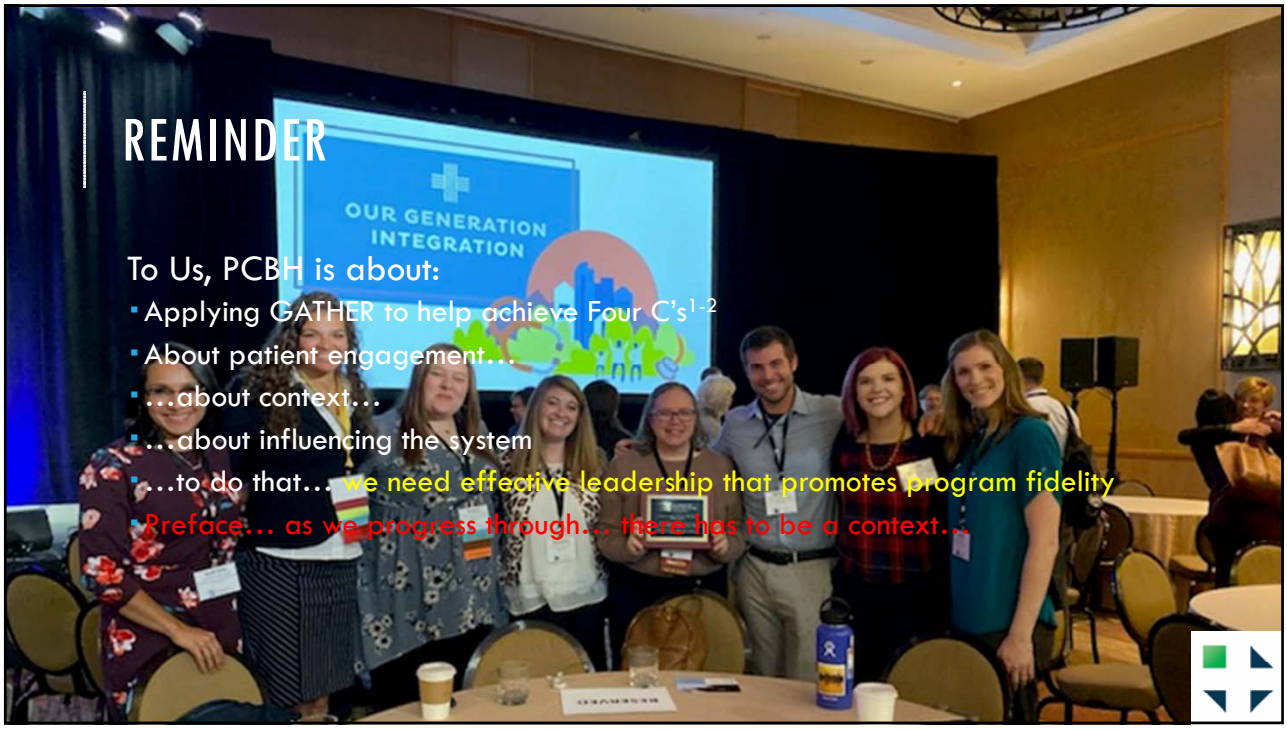
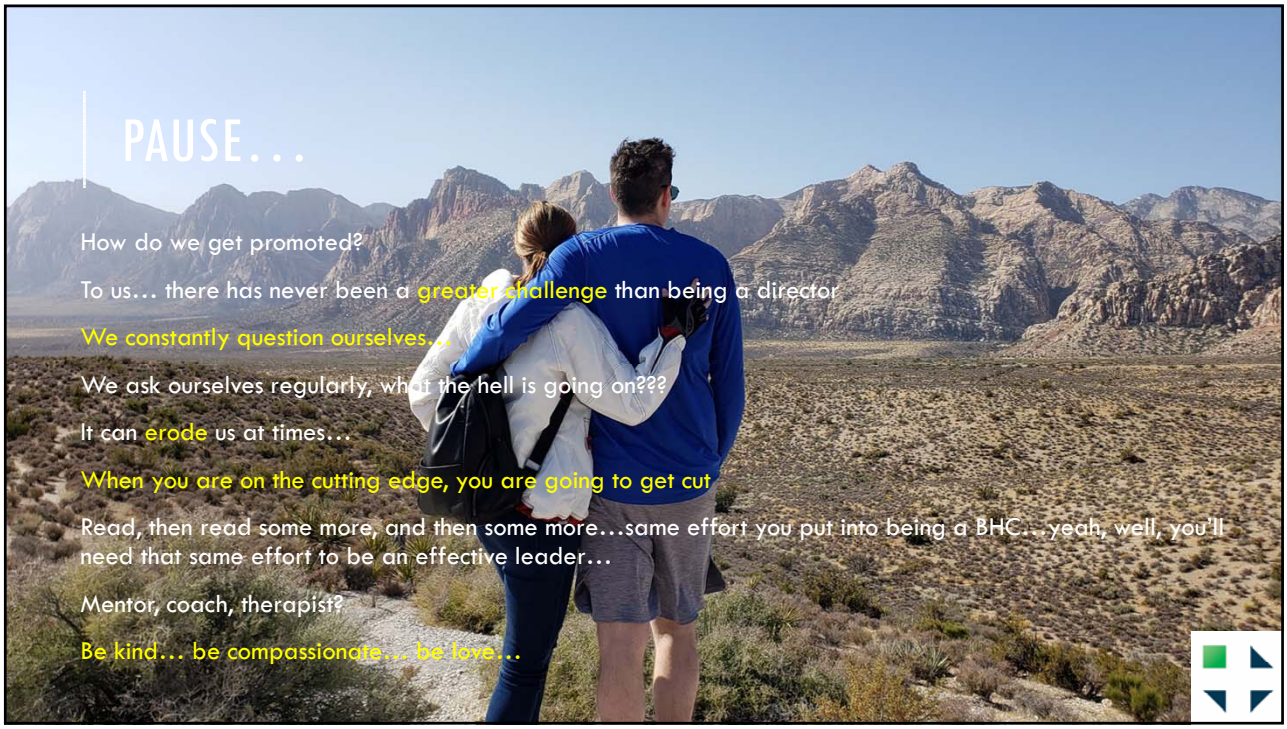
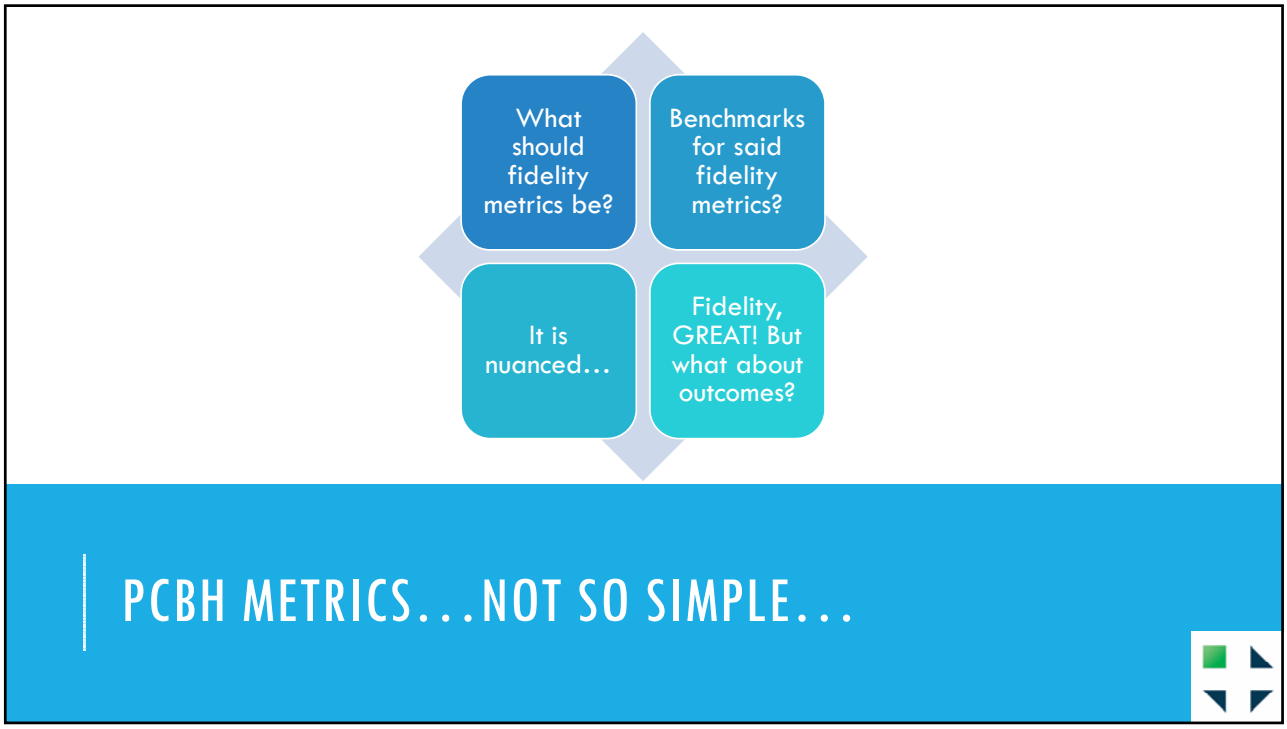
PART III: BECOMING AN EFFECTIVE LEADER/DIRECTOR

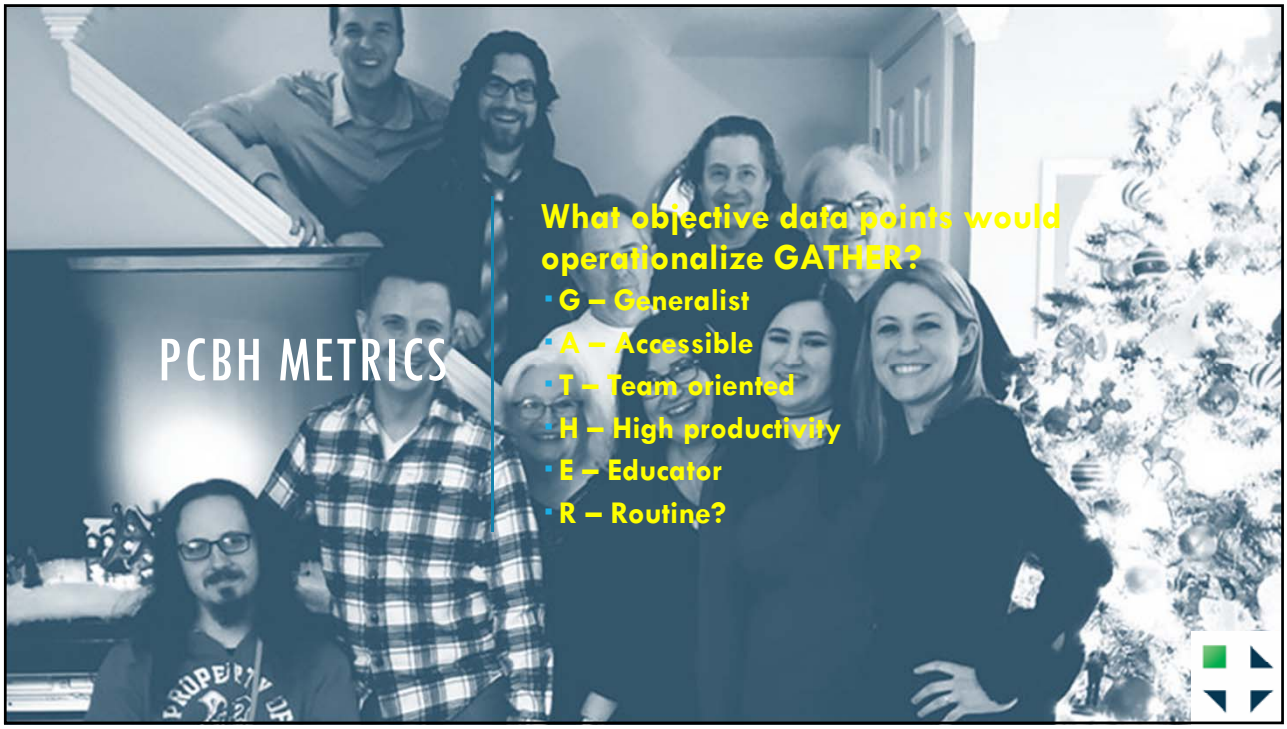

REMINDER
OUR GENERATION INTEGRATION
To Us, PCBH is about:
Applying GATHER to help achieve Four C's[1-2]
About patient engagement…
…about context…
…about influencing the system
…to do that… we need effective leadership that promotes program fidelity
Preface… as we progress through… there has to be a context…


PAUSE…
How do we get promoted?
To us… there has never been a greater challenge than being a director
We constantly question ourselves…
We ask ourselves regularly, what the hell is going on???
It can erode us at times…
When you are on the cutting edge, you are going to get cut
Read, then read some more, and then some more…same effort you put into being a BHC…yeah, well, you'll need that same effort to be an effective leader…
Mentor, coach, therapist?
Be kind… be compassionate… be love…


What should fidelity metrics be?
Benchmarks for said fidelity metrics?
It is nuanced…
Fidelity, GREAT! But what about outcomes?
PCBH METRICS…NOT SO SIMPLE…

GROUP DISCUSSION

What are fidelity metrics to PCBH?



PCBH METRICS

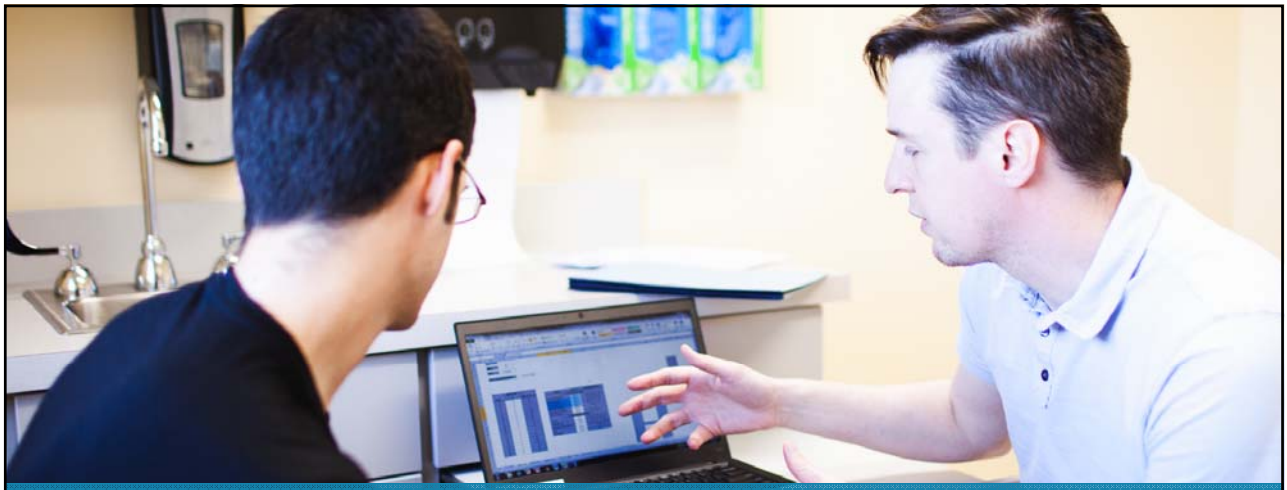
What objective data points would operationalize GATHER?

- **G – Generalist**
- **A – Accessible**
- **T – Team oriented**
- **H – High productivity**
- **E – Educator**
- **R – Routine?**

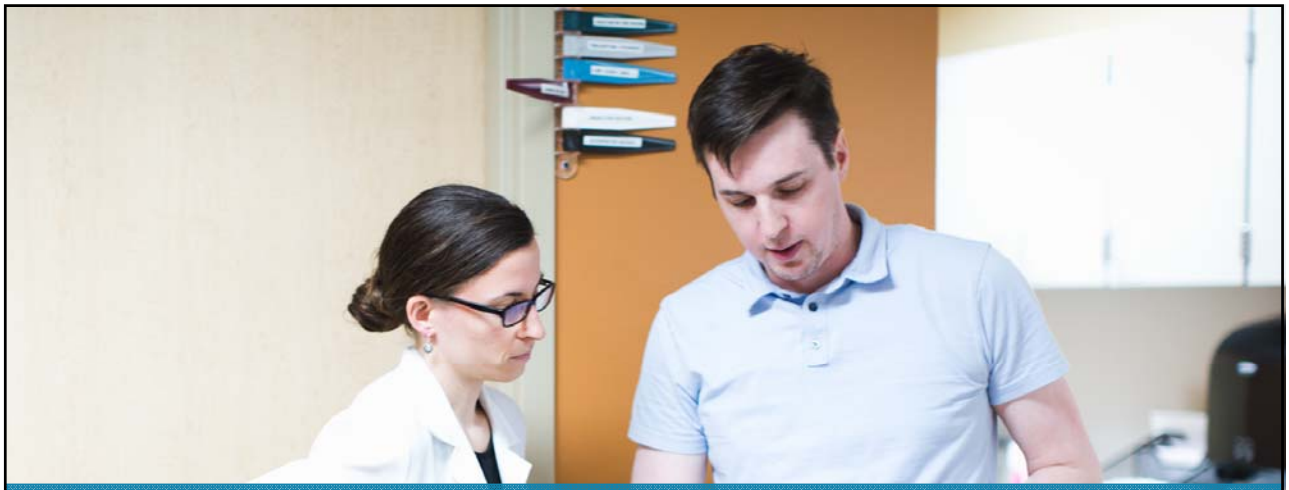
GATHER	Description of behaviors	Metric/Data Point	~ Benchmark
Generalist	Seeing pts of all ages, conditions, etc. in house Working with wide ranging patients	**Referral Reason** **Patient Satisfaction / Engagement**	Medical conditions, behavioral, cognitive, mental health, phase of life, etc. Regional and national benchmarks; Year to year
Accessible	Seeing pts on demand, same day Most visits <30 minutes	**WHO / Day** **Same day vs Solo scheduled**	3+ / Day 50 – 50
Team Oriented	Same operations as medical team Medical Provider Satisfaction	**Difficult for a metric…** **Where BHC sees pts, sits?** **Work flows?** **Track messages to team?**	Same reception, EHR, budget, etc. Year to year comparison
High Productivity	Aiming for high pt volume	**Visits / Day** **Unique patients**	Average 8+ per Day / about ½ of medical providers'
Educator	Available for curbside consultation Patient education materials Presentations Recommendations in chart notes	**Difficult for a metric…** **Pull from EHR data?** **Track messages to team?** **Track meetings / presentations**	More hard to define… Every patient encounter…
Routine	Routine part of PC services	**Unique Patients** **Initial vs Follows ups** **Total Vts/Unique Pts**	600+ 50 – 50 2-3 visits per patient

"KISS" METHOD FOR SUPPORTING FIDELITY

- Visits per clinic or day
- Warm handoffs per clinic or day
- Unique patients
- Patient satisfaction
- Medical provider satisfaction



VISITS PER DAY/CLINIC



WARM HANDOFFS PER CLINIC/DAY

UNIQUE PATIENTS/PENETRATION RATE

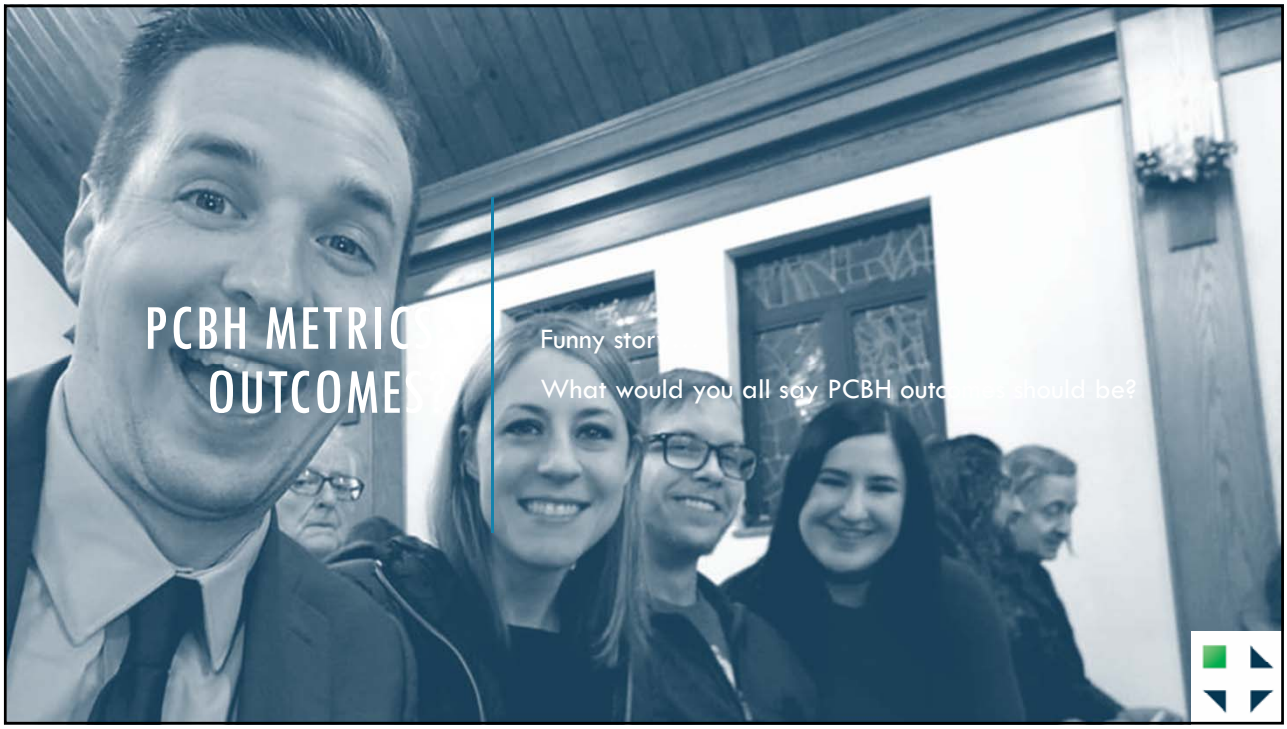
PATIENT SATISFACTION

PCP SATISFACTION

REMEMBER THOUGH…

The metric isn't the goal… that is finite…

The metric represents our value, our mission, our infinite goal…



PCBH METRICS

HTTPS://YOUTU.BE/43JP2SUJ4HW
HTTPS://WWW.YOUTUBE.COM/WATCH?V=LEMZZEVJEQM

If we focus on depression scores, is that measuring PCBH?

If we focus on DM scores, does that maybe do it?

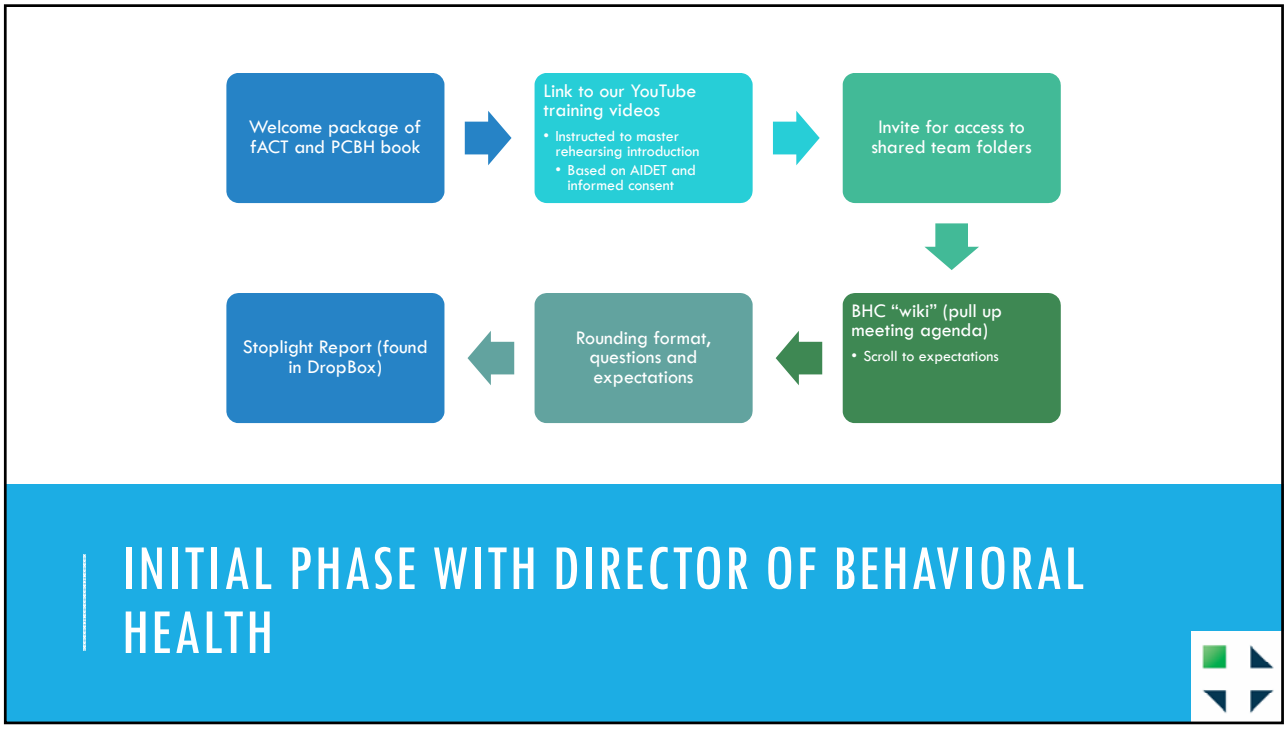
To us, KISS for PCBH outcome measures:

Patient engagement	Provider satisfaction
• Why?	• Why?

ONBOARDING BHCS

- Most BHCs are in same situation – brand new position!
- Major changes from graduate school and training
- And, yeah, those with "experience"…yeah, that doesn't mean anything
- Therefore, we need an intensive onboarding!
- Know your BHCs' "why?"/Supervision moving forward


SUGGESTED ONBOARDING PHASES
Initial phase
First month, 30 day review
90 day review
Ongoing


Welcome package of fACT and PCBH book
Link to our YouTube training videos
• Instructed to master rehearsing introduction
• Based on AIDET and informed consent
Invite for access to shared team folders
BHC "wiki" (pull up meeting agenda)
• Scroll to expectations
Rounding format, questions and expectations
Stoplight Report (found in DropBox)
INITIAL PHASE WITH DIRECTOR OF BEHAVIORAL HEALTH

INITIAL PHASE

Re-orientation to PCBH model/framework

Hand out of our services

Behavioral Health Consulting Services, provided by Behavioral Health Consultants (BHCs)

BHCs can help patients with:

- Quitting smoking
- Healthy living/ Weight management
  - Exercise plans
  - Healthy eating
- Diabetes
- "Nerves" or anxiety
- Stress
- "Blues" or depression
- Panic, chest pain
- Alcohol and drug problems
- Sleeping/insomnia
- High blood pressure
- Relationship problems
- Domestic violence
- ADHD
- Taking medications as prescribed
- Parenting tips
- Behavioral problems
- Chronic or persistent pain

Who are BHCs?

BHCs may be clinical psychologists with a doctorate degree or clinicians with a master's degree in Social Work, Marriage & Family, Psych, or Counseling.

Our BHC Team:

*James Jones, PsyD, Sally Smith, PsyD, Tom Jones, LCSW

What do BHC services look like?

*BHCs have unscheduled, same day visits (i.e., warm handoffs) as well as scheduled visits. PCP or patient self-referral.

*BHCs visits are usually about **30** minutes. Some patients come for a single visit; others have more visits to learn new skills.

*BHCs can help patients to do more things in their day-to-day lives that are important to them, even when not feeling well.
*Explore patients' values
*Teach mindfulness/relaxation
*Help with goal setting

*BHCs do **NOT** prescribe meds, but do assist with medication adherence plans

Possible Patient Benefits:
Improved holistic healthcare
Support in making lifestyle changes
Skills for managing life stresses

Services are for:
All ages. Children, teens, adults, and older adults. All problems.

Cost:
Check with patient's insurance cc
for co-pay cost
Sliding scale available

INITIAL PHASE

Hand out of "How BHCs are introduced"

Introducing & Involving BHCs in Visits

Please introduce BHCs as: **Behavioral Health Consultants**

Other names may include: team member, colleague, or behavioral health provider

*Do **NOT** describe a referral reason as: "counseling," "therapy," or "psych issues" as this can prompt unwanted, preconceived notions

To describe what BHCs "do," you can use phrases/words such as, BHCs help with:
- "lifestyle change"
- "stress management"
- "healthy living"

BHC involvement same day can be described as:
- "Our BHC is a **team member** whose role is to help patients improve their overall health" {reassure patients that the visit will be brief and quite possibly available right away}

If a patient is resistant to meeting with a BHC, you can approach it as you would for other referrals. Most PCPs have few problems asserting a referral to a cardiologist, and involving a BHC is no different

You can say something such as, *"I'd like you to see our BHC…*
- *… to learn relaxation strategies for managing your headaches"*
- *…to make a plan for improving your blood pressure"*

It's helpful to frame BHC visits as **routine or a standard part of care** that helps the PCP…

- "I refer all of my patients with _____, and it would help us get other ideas for improving your _____"

My BHC is always **busy** with patients, what should I do? Regarding interrupting BHCs:
- "BHCs **prefer interruptions** as it helps them be team players and to provide services/consultations at the time of need!" You can also contact a fellow BHC in clinic

What if my **patient already has a counselor, psychiatrist or therapist?**
- Often specialty counselors have a completely different role, if the patient could improve her/his health by engaging in behavior change, a BHC may still be useful in helping you provide care

While a BHC may be highly involved in the patient's care, ultimately, the PCP r primary caretaker

INITIAL PHASE

Review contextual interview – give laminated hard copy

Review EHR templates (also created based on contextual interview)

Contextual Interview

- **Love – Work – Play**
  - ☐ Living situation
  - ☐ Relationship status & sex
  - ☐ Family
  - ☐ Friends
  - ☐ Spiritual life
  - ☐ Work
  - ☐ Income
  - ☐ Fun/hobbies
- **Health Risk & Behaviors**
  - ☐ Caffeine
  - ☐ Tobacco
  - ☐ Alcohol
  - ☐ Marijuana
  - ☐ Street drugs
  - ☐ Diet
  - ☐ Exercise
  - ☐ Sleep
- **Time – Trigger – Trajectory of problem**
  - ☐ Onset of problem?
  - ☐ Recent change, why now?
  - ☐ Triggers?
  - ☐ Things that make it better, worse?
  - ☐ Effect on love – work – play?

*adapted from Robinson, P., Gould, D., & Strosahl, K. (2010). *Real behavior change in primary care: Improving patient outcomes & increasing job satisfaction.* Oakland, CA: New Harbinger Publications, Inc.

INITIAL PHASE

Review core competency tool

Behavioral Health Consultant Core Competency Tool	
Competency	**Rating** 1=low 5=high
Domain 1: Clinical Practice Skills	
1. Attends to entire clinic population.	
2. Participates in preventative care.	
3. Promotes small changes in a large number of patients.	
4. Participates in development and implementation of PCBH pathways.	
5. Describes services accurately to new patients.	
6. Understands the relationship of medical and psychological systems.	
7. Uses appropriate assessment tools.	
8. Clarifies referral problem with patient and PCP.	
9. Limits assessment focus to one referral problem.	
10. Conducts brief life context interview.	
11. Conducts effective functional analysis of target problem.	
12. Combines information from life context and functional analysis interviews to create effective interventions.	
13. Offers patient a choice among interventions.	
14. Shows knowledge of best practice guidelines, ESTs.	
15. Matches interventions to patient's strengths and deficits.	
16. Uses self-management, home-based practice.	
17. Provides patient with written or printed copy of plan.	
18. Assesses patient confidence in behavior change plan.	
19. Demonstrates basic knowledge of medications.	
20. Provides groups or classes for a variety of problems (sleep, stress, lifestyle).	
21. Provides group medical visits.	

Meet with HR, Organization orientation → Introduction to Electronic Medical Record → 1-2 weeks after starting, re-check with IT personnel

1ST MONTH

1ST MONTH: WEEK 1~

Shadow veteran BHCs

"Grade" veteran using CIOF-A

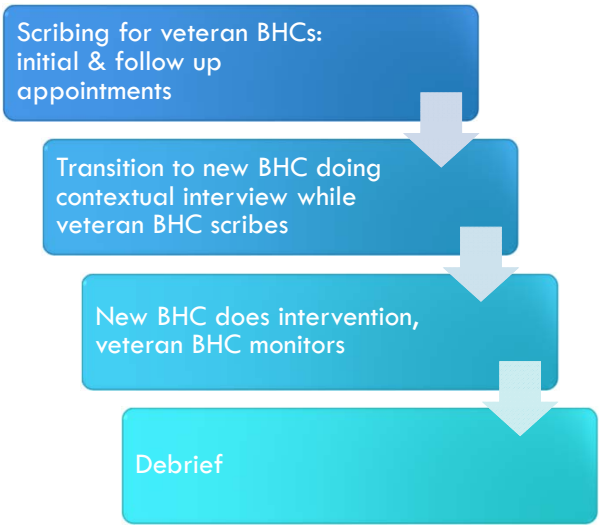
Towards end of week, new BHC will start to scribe for veteran BHC

Debrief

Contextual Interview Observation Form - Adult (CIOF-A)

Introduction	Circle
Introduces self to patient and any other person/people in the exam room in a friendly manner (i.e., greeting, smile, eye contact, etc.)	Yes No
Establishes relationship of other person/people in exam room to the patient	Yes No
Elicits patient's presenting problems and negotiates agenda for the visit	Yes No
Explains s/he will ask a series of questions before diving into presenting problem	Yes No
Love – Work – Play:	
Establishes patient's living situation (i.e., who is in the home?)	Yes No
Establishes patient's relationship status (i.e., dating, married, single, etc.)	Yes No
Asks which family members are important in his/her life	Yes No
Asks who, if anyone, is a close friend (i.e., best friend, distant, online, etc.)	Yes No
Asks if any spiritual beliefs, practices, or philosophies impact his/her life	Yes No
Establishes source(s) of income (i.e., employment, student loans, SSI, etc.)	Yes No
Discovers at least one pleasurable or fun activity for the patient, present or past	Yes No
Health Behaviors:	
Asks patient about their sleep habits and sleep quality	Yes No
Asks patient about their diet (i.e., home-cooked, fast food, fresh produce, etc.)	Yes No
Asks patient about their exercise habits	Yes No
Health Risk:	
Asks if patient ingests caffeine? If so, the interviewer asks how much?	Yes No
Asks if the patient uses any tobacco products? If so, asks how much?	Yes No
Asks if the patient uses alcohol? If so, asks how much?	Yes No
Asks if the patient uses marijuana? If so, asks how much?	Yes No
Asks if patient uses street drugs (i.e., illegal rxs, cocaine, meth, etc.)? If so, what kind and how much?	Yes

1ST MONTH: WEEK 2~



1ST MONTH: WEEK 3~

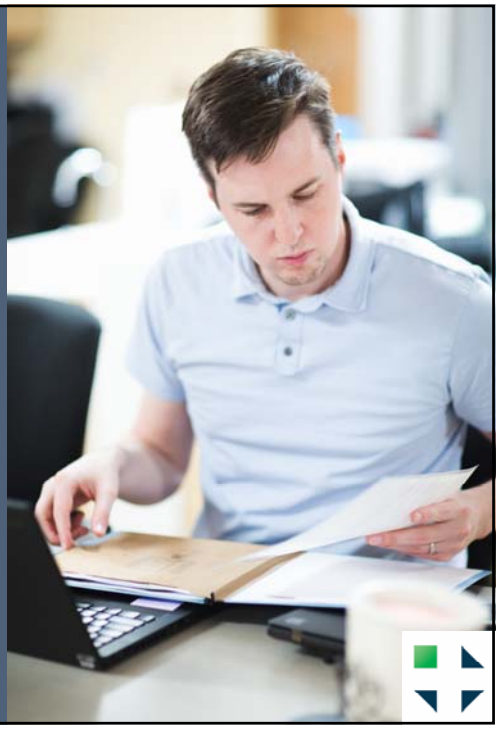
Putting it all together – new visits new BHC does full visit & scribes

Follow up visits – new BHC & veteran BHC do co-visits

- Veteran BHC "grades" using BH observation tools
- Feedback & debrief

1ST MONTH: WEEK 4~

- Transition to new clinic – open reduced schedule
- Intermittent shadowing throughout week by DoBH
- Troubleshooting with DoBH – 30 day review?
- End of week: Discuss adjusted schedule timeline



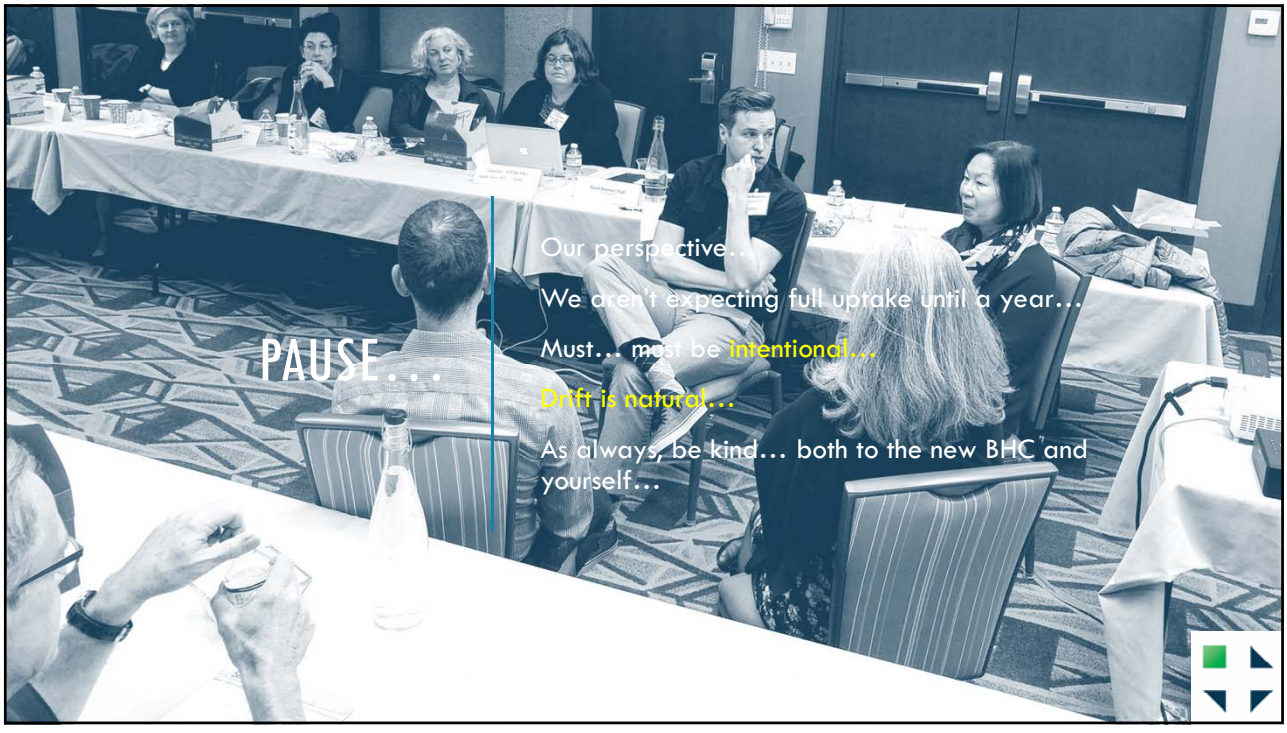
Standardization?

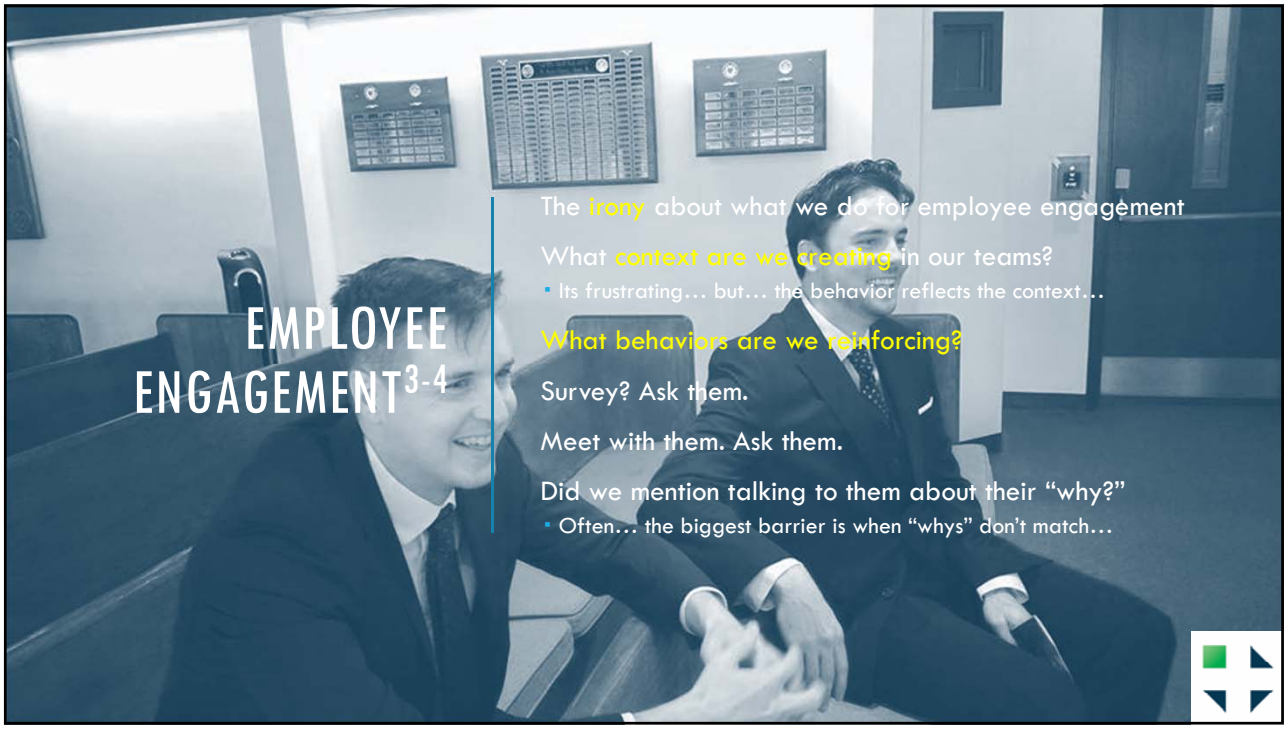
THE FLY-WHEEL STARTS TO SPIN!

ALL BHCS USING A SIMILAR FRAMEWORK…

1. Review of metrics to ensure increase
2. Discuss next steps w/opening more slots
3. BHC Core Competency Tool
4. Feedback from peers/colleagues; BHC's "why?" – In person, via email

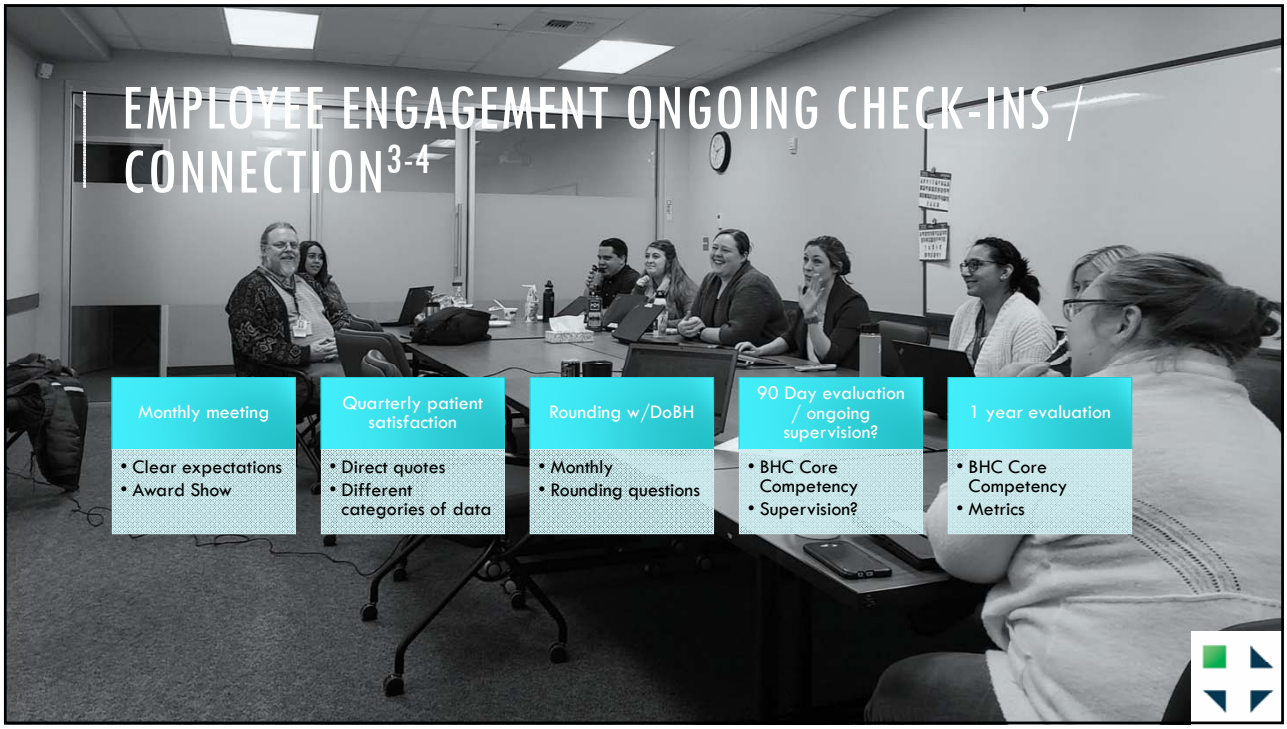
90 DAY REVIEW




EMPLOYEE ENGAGEMENT[3-4]
The irony about what we do for employee engagement
What context are we creating in our teams?
Its frustrating… but… the behavior reflects the context…
What behaviors are we reinforcing?
Survey? Ask them.
Meet with them. Ask them.
Did we mention talking to them about their "why?"
Often… the biggest barrier is when "whys" don't match…

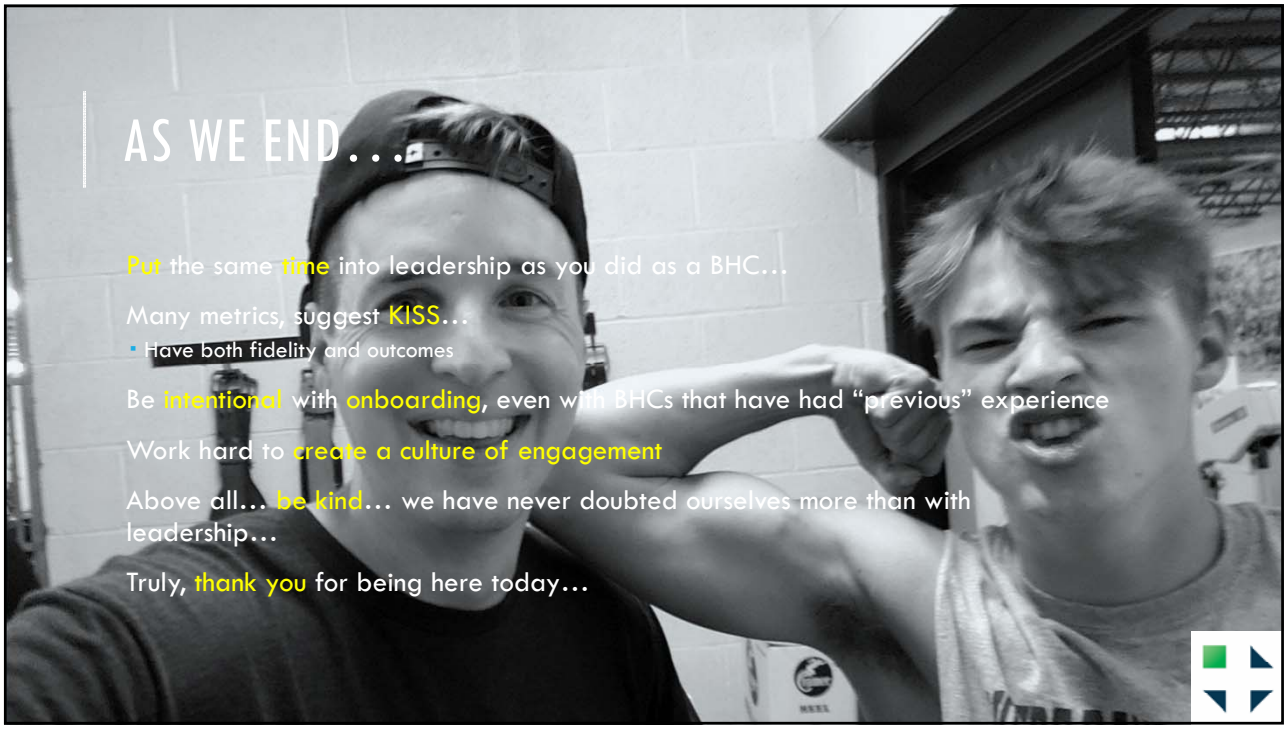

EMPLOYEE ENGAGEMENT – INDUSTRIAL ORGANIZATIONAL PSYCHOLOGY SUGGESTS
Flex time[5]
20% Passion time[5]
Productivity for 5 days versus 4 days[6]
Regular check-ins[3-4]
Connecting on a personal level
"Clear is kind"[7]
You Promote what you Permit[4]


CREATE A CONTEXT THAT BHCS *WANT* TO BE APART OF…
Advice from Kirk… share what your team is doing…
Share wins and successes…
Start meetings out with kudos
Interesting research on feedback…[8]
…and, at times… Clear is Kind…


EMPLOYEE ENGAGEMENT ONGOING CHECK-INS / CONNECTION[3-4]
Monthly meeting
• Clear expectations
• Award Show
Quarterly patient satisfaction
• Direct quotes
• Different categories of data
Rounding w/DoBH
• Monthly
• Rounding questions
90 Day evaluation / ongoing supervision?
• BHC Core Competency
• Supervision?
1 year evaluation
• BHC Core Competency
• Metrics


OTHER LEADERSHIP THOUGHTS…
Become friends with…
IT and EHR team
Billing and coding
Others?
Approach conversations…
Watch your mind filling in information…
Like with patients, the behavior has a function and is coming from a context…
Watch out for "us vs. them"


OUR SUGGESTED LEADERSHIP READINGS
Anything Studer Group related
https://publishing.studergroup.com/books/individual-books
…re of High Performance – Quint Studer
…E-Factor – Craig Deao
…ight A Leadership – Quint Studer
Compassionomics – Stephen Trzeciak, An…
Dare to Lead – Brene Brown
The Infinite Game – Simon Sinek
Start with Why – Simon Sinek
Radical Candor – Kim Scott
Nine Lies About Work – Macus Buckingham, Ashley Goodall
…there are millions out there… share what you find is helpful…
…seek out books that challenge your assumptions…


AS WE END…
Put the same time into leadership as you did as a BHC…
Many metrics, suggest KISS…
Have both fidelity and outcomes
Be intentional with onboarding, even with BHCs that have had "previous" experience
Work hard to create a culture of engagement
Above all… be kind… we have never doubted ourselves more than with leadership…
Truly, thank you for being here today…


QUESTIONS???

ONTACT US!

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www.beachybauman.com

https://www.facebook.com/PCBHLife/

https://www.linkedin.com/company/beachy-bauman-consulting-pllc

https://twitter.com/pcbhlife

https://www.youtube.com/channel/UCR_hf_LGVtUOoLa_KFvqvtQ

https://www.youtube.com/user/commhealthcw/videos

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