Partnerships in primary care

December 1, 2015
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• Promote effective communication with primary care audience
  • ‘Elevator speech’
  • SBAR
• Address HIPAA misconceptions
• Discuss the use of new tools and resources
• Introduce Collaborative-Integrative Models
Know your audience

• How do physician’s think?
• How do they prioritize information?
• How is their role unique?
What do they need?

- How will you know?
- Compelling, evidence-based information
- Immediately applicable
- Tangible services and products

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Nursing</th>
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<tbody>
<tr>
<td>American Psychiatric Association</td>
<td>Harford Center for Geriatric Nursing Excellence</td>
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<td>American Geriatrics Society</td>
<td>National Gerontological Nursing Association</td>
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<tr>
<td>Gerontological Society of America</td>
<td>ConsultgeriRN.org</td>
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<td>Portal for Online Geriatrics Education</td>
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**Concise** - 20 seconds or less

- Finish with a question:
  - Is there someone in your office that would be a good fit?
  - Do you think your providers would benefit from a discussion about…?
  - Could we schedule a time to talk further about this?

- Include: *What’s in it for them?*

- Practice, practice, practice!

**Elevator Speech**
Write your own
• Use Motivational Interviewing concepts and strategies
  • Express empathy
  • Weigh pros/cons
  • Prepare for resistance, meet with non-resistance
  • Foster self-efficacy
# NaRCAD Tip Sheet: Handling Objections & Obstacles

<table>
<thead>
<tr>
<th>If a Clinician:</th>
<th>Try Doing This:</th>
<th>While Considering:</th>
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<tbody>
<tr>
<td>Rejects your information without much consideration...</td>
<td>• Ask him/her to elaborate on the rejection&lt;br&gt;• Allay any fears by explaining exactly what the academic detailing service is attempting to accomplish, and your role in the project.</td>
<td>• It might be because of lack of time that day, in which case you should arrange for another time to meet.&lt;br&gt;• There may be misconceptions about the purpose of your visit or your program; He/she may believe you are there to restrict or report his/her practices.</td>
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<td>Is agitated or combative...</td>
<td>• Empathize with how the clinician feels&lt;br&gt;• Acknowledge concerns&lt;br&gt;• Present your point of view from a different angle</td>
<td>• Don’t become defensive or counterattack; such responses do not lead to a good working relationship.&lt;br&gt;• If you don’t know the answer to a question, say so and offer to get back to the clinician with an answer.</td>
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<tr>
<td>Is skeptical...</td>
<td>• Ask why s/he is skeptical and address those concerns. Explain that you are hearing that from other clinicians as well if that’s the case.</td>
<td>• Draw the clinician out by asking him/her to identify approaches that he/she stands by strongly and see if there are parallels to draw upon.</td>
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<td>Is indifferent...</td>
<td>• Make what you have to say relevant to his or her needs. Ask, “Is there any way you think I can be of service to you?”</td>
<td>• You might tactfully reflect the clinician’s apparent mood, e.g., “I’m getting the feeling that what I’m saying isn’t new to you—that you’ve heard all of this before. Is this right?”</td>
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<tr>
<td>Sees drawbacks to your approach or messages...</td>
<td>• Acknowledge those drawbacks if they seem valid; identify that the other approach being used by the clinician may also have drawbacks in terms of patient outcomes.</td>
<td>• If the evidence suggests that the proposed drawback is not an issue in this case, tactfully point out that although it is logical to think that what the clinician is suggesting would be a drawback, there is powerful research that demonstrates this is not the case.</td>
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• CMS’ Comprehensive Primary Care Initiative Participants
  • Screening for Clinical Depression and Follow Up Plan
  • https://data.cms.gov/dataset/CPC-Initiative-Participating-Primary-Care-Practice/k9im-rfs2

• Participants of OHSU-ECHO Psychiatric Medication Management Telehealth project 2014-2015-2016

Where the door may already be open
OHSU ECHO enhances the ability of primary care physicians to treat chronic and complex illnesses in their hometown clinic and increases patient access to care. It is modeled after the University of New Mexico’s Project ECHO \textsuperscript{\textregistered} (Extension for Community Healthcare Outcomes).

OHSU ECHO connects primary care providers with OHSU specialists for live, weekly video teleconferences. These one-hour virtual clinics give primary care physicians real-time reviews of complex cases. OHSU specialists provide written treatment recommendations. Each session also includes a 15- to 20-minute didactic presentation. CME is provided.

Primary care physicians are expected to present cases up to six times a year and share patient outcome data.

OHSU provides ongoing IT hardware and software support.

OHSU’s first Project ECHO \textsuperscript{\textregistered} Initiative, a Psychiatric Medication Management pilot program, was launched in September 2014 in conjunction with and support from Health Share. This pilot is focused on primary care providers in counties surrounding the Portland metropolitan area. If successful, OHSU hopes to expand Project ECHO \textsuperscript{\textregistered} to include other clinical disciplines throughout the region.
Know your allies

- Coordinated Care Organizations
- Oregon State University, College of Pharmacy, Department of Drug Use Research and Management
- Acumentra Health
For more information

• See printed materials for details

• **Acumentra Health Contacts:**
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• Making the case for integrated care
• Aging Demographics

**Talking Points**

1. Behavioral Health Integration with Primary Care is preferred by older adults
   - Because of their coexisting physical health conditions, older adults with behavioral health and substance use disorders are frequently seen in medical care settings, such as primary care offices, hospitals, and emergency departments (Wang, 2011; Institute of Medicine, 2012).
   - Given the stigma often connected with seeking behavioral health treatment and the relative shortage of behavioral health providers to refer to, older adults are more likely to seek care from a PCP (Rybarczyk et al., 2013).
   - No more than half of older adults referred to a mental health specialist followed through with the referral (Callahan et al, 1994).
   - Many older adults prefer to receive their depression treatment in primary care, where providers can address not only behavioral health problems, but also acute and chronic medical conditions that are often comorbid with depression (Park & Unutzer, 2011).
   - Older adults are receptive to screenings of anxiety and depression by their PCPs. In a recent study, 95% of older adults reported not being uncomfortable at all in being asked questions about depression and anxiety by PCPs; 99% reported not being embarrassed at all by being asked questions about depression and anxiety by PCPs (Samuels et al., 2014).
Standardizing Communication

- Situation
- Background
- Assessment or Analysis
- Recommendation

LEARN & ADOPT SBAR
**S: Situation**

**Concise overview of why you’re calling**

- Identify yourself and your role
- Identify patient information
- Describe the issue
Brief report of pertinent background information

May include
- Primary physical diagnoses or physical symptoms
- Medications and recent changes
- Primary behavioral symptoms
- Pertinent housing issues
- ADL function
- Social network issues
- What’s been done recently
- Who’s involved

B: Background
In your professional opinion, what do you think is going on?

What is missing?

What is the problem?

A: Assessment/Analysis
• What would you like to see happen next?
• What do you need from the person you’re talking to?

R: Recommendation
NANCY, I'M NOT SURE THAT'S WHAT HIPAA HAD IN MIND.
JANUARY 2014

Integrating Physical and Behavioral Health
Strategies for Overcoming Legal Barriers to Health Information Exchange


Executive Summary

This brief explores the strategies states use to address barriers that impede data-sharing efforts among providers to integrate physical and behavioral health care. The first step for states interested in more and better data exchange is to understand legal barriers to sharing such data and to directly confront misperceptions about those barriers with providers, health plans, and other stakeholders.

There is no single obstacle to data-sharing between physical and behavioral health care providers. Federal and state health information privacy laws create a complex network of requirements governing the use and disclosure of health information. The Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule restricts the use and disclosure of protected health information. Due in part to broad exceptions

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409991
“HIPAA typically should not serve as a legal impediment to robust health information exchange among physical and behavioral health providers.”
(RWJF brief, 2014)
“Thus, records relating to substance abuse diagnosis or treatment provided in a ... mental health facility, or in a primary care physician’s office, are not subject to the Part 2 regulations.”

(RWJF brief, 2014)
HIPAA Privacy Rule and Sharing Information Related to Mental Health

Background

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals’ trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information. At the same time, the Privacy Rule recognizes circumstances arise where health information may need to be shared to ensure the patient receives the best treatment and for other important purposes, such as for the health and safety of the patient or others. The Rule is carefully balanced to allow uses and disclosures of information—including mental health information—for treatment and these other purposes with appropriate protections.

In this guidance, we address some of the more frequently asked questions about
For Information regarding the Behavioral Health Information Sharing Advisory Group or its efforts:

Veronica Guerra, policy analyst, Office of Health Policy and Research  
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Visit the advisory group website –  
http://www.oregon.gov/oha/amh/Pages/bh-information.aspx

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Oregon Health Authority: Behavioral Health Information Sharing Advisory Group
Tangible Tools
Geriatric Substance Use Module
Serving Older Adults with Behavioral Health Needs

*Geriatric Substance Use Disorders: An Invisible Epidemic*

Presented by Oregon Health Authority, Health Systems Division and Portland State University Institute on Aging
• Alternatives to the 2015 Beers Criteria medications
  • Potentially high-risk drugs
  • Drug-disease interaction
• Medications that cause Anxiety
• Medications that cause Depression
• Differential Diagnosis in Geriatric Behavioral Health
• Physical conditions and Depression
• Components of Geriatric Brief Intervention Table
  /Alcohol and Drug Interaction Table

Tools and Resources
Serving Older Adults with Behavioral Health Needs

Toward Integrated Care: Anxiety

Presented by Oregon Health Authority, Health Systems Division and Portland State University Institute on Aging
Serving Older Adults with Behavioral Health Needs

Toward Integrated Care: Anxiety

Presented by Oregon Health Authority, Health Systems Division and Portland State University Institute on Aging

Geriatric Anxiety Module
Modules to come

- Suicide Prevention
- Geriatric Depression
- Bipolar Disorder or Severe Mental Illness
Resources to consider

- *Geriatrics At Your Fingertips, 2015*
  - Hard copy
  - Mobile app
- AGS app - iGeriatrics
Collaborative Care
<table>
<thead>
<tr>
<th>LEVEL 1</th>
<th>LEVEL 2</th>
<th>LEVEL 3</th>
<th>LEVEL 4</th>
<th>LEVEL 5</th>
<th>LEVEL 6</th>
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<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
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**COORDINATED**

**KEY ELEMENT: COMMUNICATION**

- In separate facilities, where they:
  - Have separate systems
  - Communicate about cases only rarely and under compelling circumstances
  - Communicate, driven by provider need
  - May never meet in person
  - Have limited understanding of each other’s roles

**CO-LOCATED**

**KEY ELEMENT: PHYSICAL PROXIMITY**

- In same facility not necessarily same offices, where they:
  - Have separate systems
  - Communicate regularly about shared patients
  - Communicate, driven by specific patient issues
  - May meet as part of larger community
  - Appreciate each other’s roles as resources

**INTEGRATED**

**KEY ELEMENT: PRACTICE CHANGE**

- In same space within the same facility, where they:
  - Share some systems, like scheduling or medical records
  - Communicate in person as needed
  - Collaborate, driven by need for each other’s services and more reliable referral
  - Meet occasionally to discuss cases due to close proximity
  - Feel part of a larger yet ill-defined team

- In same space within the same facility (some shared space), where they:
  - Actively seek system solutions together or develop work-a-rounds
  - Communicate frequently in person
  - Collaborate, driven by need for consultation and coordinated plans for difficult patients
  - Have regular face-to-face interactions about some patients
  - Have a basic understanding of roles and culture

- In same space within the same facility, sharing all practice space, where they:
  - Have resolved most or all system issues, functioning as one integrated system
  - Communicate consistently at the system, team and individual levels
  - Collaborate, driven by shared concept of team care
  - Have formal and informal meetings to support integrated model of care
  - Have roles and cultures that blur or blend

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• Become familiar with evidence based models in primary care-behavioral health integration
  • IMPACT (Unutzer, 2008)
  • PROSPECT (Unutzer, 2006)
• Where to find more information:
  • nrepp.samhsa.gov
  • integration.samhsa.gov
  • Integrationacademy.ahrq.gov
Thank you


References
Images credits