Session # F3

It Takes a Village: Utilizing the Whole Primary Care Team to Take your IBH Practice to the Next Level

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- David Bauman, PsyD, Behavioral Health Education Director, Central Washington Family Medicine
- Patrick Vigil, MD, PhD, Family Medicine Faculty at Pacific Northwest University
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CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

OR

The presenters of this session currently have or have had the following relevant financial relationships (in any amount) during the past 12 months.

(BB + DB) Beachy Bauman Consulting

(BB + DB) Associates of Mountainview Consulting Group

Conference Resources

Slides and handouts shared in advance by our Conference Presenters are available on the CFHA website at http://www.cfha.net/?page=Resources_2018

Slides and handouts are also available on the mobile app.

Learning Objectives

At the conclusion of this session, the participant will be able to:

- Name at least three strategies that nursing, medical assistants, and other clinic support staff can do to promote behavioral health in the clinic.
- Identify at least three trainings that BHPs can give at either/both formal and informal meetings.
- Describe at least two possible benefits of engaging nursing, medical assistants and other clinic support staff early and often.

Bibliography / Reference

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Who we are

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Learning Assessment

A learning assessment is required for CE credit.

A question and answer period will be conducted at the end of this presentation.

PCBH tenets

G – Generalist – help all patients in clinic

A – Accessible – strives to intervene with patients on the same day

T – Team-based – shared clinic space and resources

H – High volume – engages with a large percentage of the clinic population

E – Educator – help improve team's biopsychosocial assessment and intervention skills/processes

R – Routine – continuous part of biopsychosocial care

Whole team approach

Entire clinic needs to buy in

- BHC isn't a "discrete" field or pathway
- Everything we do for patients is centered around behaviors
- Human focused not diagnostic focused
- Pragmatic

Team

- Reception
- Scheduling
- Nursing
- Pharmacy
- Lab
- BHC
- PCP
- Care coordinators (case managers, social workers, etc.)
- Who else?

This is a broader goal than just co-located services - Where can the whole team help out to make this happen?

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Strategies – empowering your staff and harnessing innovation

Strategy	MAs	Nurse	BHCs	PCPs	Rec./ sched.	Pharm, lab, OT, etc.	CC, SW
Orientation (intro BHC services)	X	X	X	X	X	X	X
Huddling	X	X	X	X			X
Scrubbing	X	X	X	X			X
Triaging	X	X			X		X
Marketing materials			X				
Introducing BHC to patients	X	X	X	X	X	X	X
Scheduling (for WHO, calls, etc.)	X	X			X		
Health promotion	X	X	X	X	X	X	X
Health bx change/adherence	X	X	X	X	X	X	X
Competitions (clinic counter, BHC quotient, WHO of month, etc.)	X	X	X	X	X	X	X
Skill shares/intra-organizational trainings	X	X	X	X	X	X	X

BHC Trainings/Initiatives

Trainings on suicide for clinicians	Adverse Childhood Experiences (ACEs) training for support staff
Wellness workshops/classes for all employees (e.g., yoga, Piyo, meditation, etc.)	De-Escalation/Dealing with difficult patient interactions
Burn out/resiliency	Agenda setting
Vicarious trauma	Patient centered communication
Motivational interviewing	Warm-handoff trophy

MA perspective

https://www.youtube.com/watch?v=318fZdZ6dGQ&feature=youtu.be

https://www.youtube.com/watch?v=nEMJ7_1CbxM&feature=youtu.be

https://www.youtube.com/watch?v=-z_84fuXtsk&feature=youtu.be

Penetration rates for BHCs

PROVIDER	CWFM	EMC	HIGHLAND	NMC	YPA	CHCW
All BHC Providers	2,321	587	176	320	1,335	**4,691**
All Providers	10,242	3,297	672	1,750	8,764	**24,473**
Penetration Rate	**22.662%**	**17.804%**	**26.190%**	**18.286%**	**15.233%**	**19.168%**

- 12 BHCs (8 core, 1 MAT, 1 post doc, 2 interns) with various amounts of clinical FTE
- 1/5 patients at CHCW have seen a BHC in the past 12 months
- At CWFM where we are fully staffed – 22.7%

“Real world” example

Patient calls into scheduling late in the afternoon on a Friday and tells them they are depressed and suicidal and they want to see a medical doctor. Scheduling contacts nursing, and the nurse asks the PCP, “can we put one more person on your schedule, it’s a crisis?” PCP says, “I’d also like a BHC appointment if I’m going to see that patient.” Nursing contacts the BHC and she agrees. Both the PCP and the BHC focused on finishing their “regular” visits while nursing was talking with patient for 20 minutes before coming in to the clinic. When the patient arrived, both the PCP and the BHC conducted co-visit and found out that suicidal thoughts were related to polypharmacy. No one in the family knew what she was taking. They find out that the 17 y/o grand child was giving her insulin. She was on very high levels of gabapentin. Patient is essentially “doped up” on multiple medications…so…PCP and BHC call pharmacy. We need help. We need to reduce her medications and send her home with a few days of a “bubble pack” to essentially re-set her medications. Reduce what we can. She’ll come back in a few days, through the weekend, and the PCP will go back through this. This worked great, and she was able to reduce her medications. Full team effort. Nursing. BHC. PCP. Pharmacy.

PCP perspective

- Clinic “getting blown up”
- “Solo” approach to problem would have been ineffective
- Co-located approach inappropriate for problem
- Fully integrated provided time and efficiency benefits, better utilization of team members’ abilities, and better patient care

Summary/Questions

To achieve GATHER and allow primary care to operate the way we want…

- IT TAKES A VILLAGE

Questions/comments?

Session Evaluation

Use the CFHA mobile app to complete the evaluation for this session.

Thank you!