Whole Health in Populations Experiencing Mental Illness

Session 4: Sustaining clinician and clinic staff wellbeing when working with patients who have complex needs.

Session Goal: Offer both interpersonal and systems-level strategies for improving provider wellbeing when working with patients experiencing mental illness, physical co-morbidities, health-related social needs, and/or substance use disorders.

Speakers:

1. Lynnea Lindsey, PhD
2. Meg Devoe, MD
3. Heather Teters, LCSW, CADC

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Strategies for Clinician Wellness when Working with Patients who have Complex Needs

Whole Health for Populations Experiencing Mental Illness

Meg Devoe, MD and Heather Teters, LCSW CADC

Central City Concern

Portland, OR

May 22, 2019

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Strategies for Clinician Wellness when Working with Patients who have Complex Needs

- Introductions
- Why this is hard
- Why wellness matters and how leadership can support clinicians
- Our team, our work, our approach to wellness
- Present a difficult case of setting boundaries
- Talk population level data
- Discussion/Questions

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Who We Are…

We've worked together since 2015 in the development of an ambulatory ICU within a federally qualified health center

Meg Devoe, MD

- General internist and addiction medicine specialist
- Clinician at CCC and faculty at OHSU
- Doing this type of work since 2009

Heather Teters, LCSW, CADC

- Trauma and addiction specialist
- Central City Concern since 2015
- Doing this work for 15 years, in all types of roles

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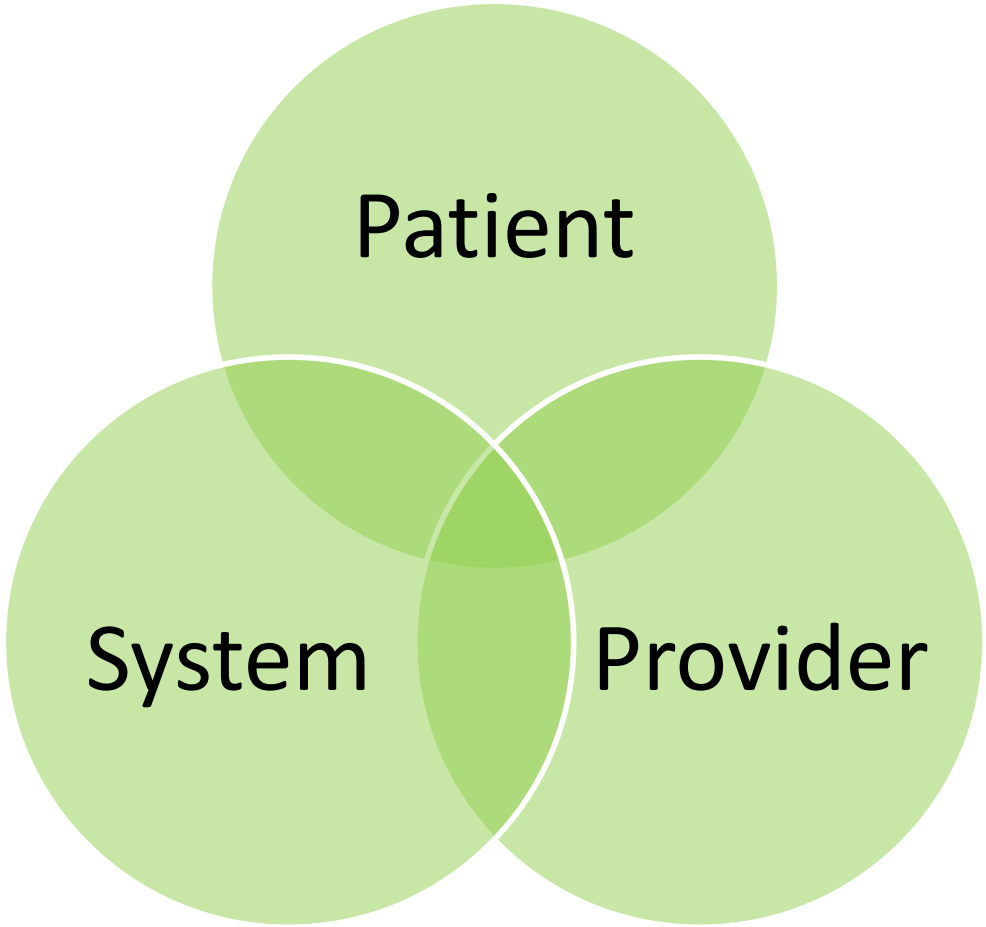
Why is this work so hard?

- Complex care coordination
- ACEs
- Poverty
- Racism
- Homelessness
- Stigma
- Insurance
- Literacy
- Disability
- Adverse environment
- Social isolation
- Lack of transportation
- Food insecurity
- Lack of resources
- Challenging behaviors
- Imperfect systems
- Power dynamics
- Generational trauma
- Shifting incentives
- Intimate partner violence

Why is this work so hard?



There are overlapping and interdependent experiences of complexity

Why clinician wellness matters…

REFLECTION

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider

Thomas Bodenheimer, MD[1]

Christine Sinsky, MD[2,3]

[1]Center for Excellence in Primary Care, Department of Family and Community Medicine, University of California San Francisco, San Francisco, California

[2]Medical Associates Clinic and Health Plan, Dubuque, Iowa

[3]American Medical Association, Chicago, Illinois

ABSTRACT

The Triple Aim—enhancing patient experience, improving population health, and reducing costs—is widely accepted as a compass to optimize health system performance. Yet physicians and other members of the health care workforce report widespread burnout and dissatisfaction. Burnout is associated with lower patient satisfaction, reduced health outcomes, and it may increase costs. Burnout thus imperils the Triple Aim. This article recommends that the Triple Aim be expanded to a Quadruple Aim, adding the goal of improving the work life of health care providers, including clinicians and staff.

Ann Fam Med 2014;12:573-576. doi: 10.1370/afm.1713.

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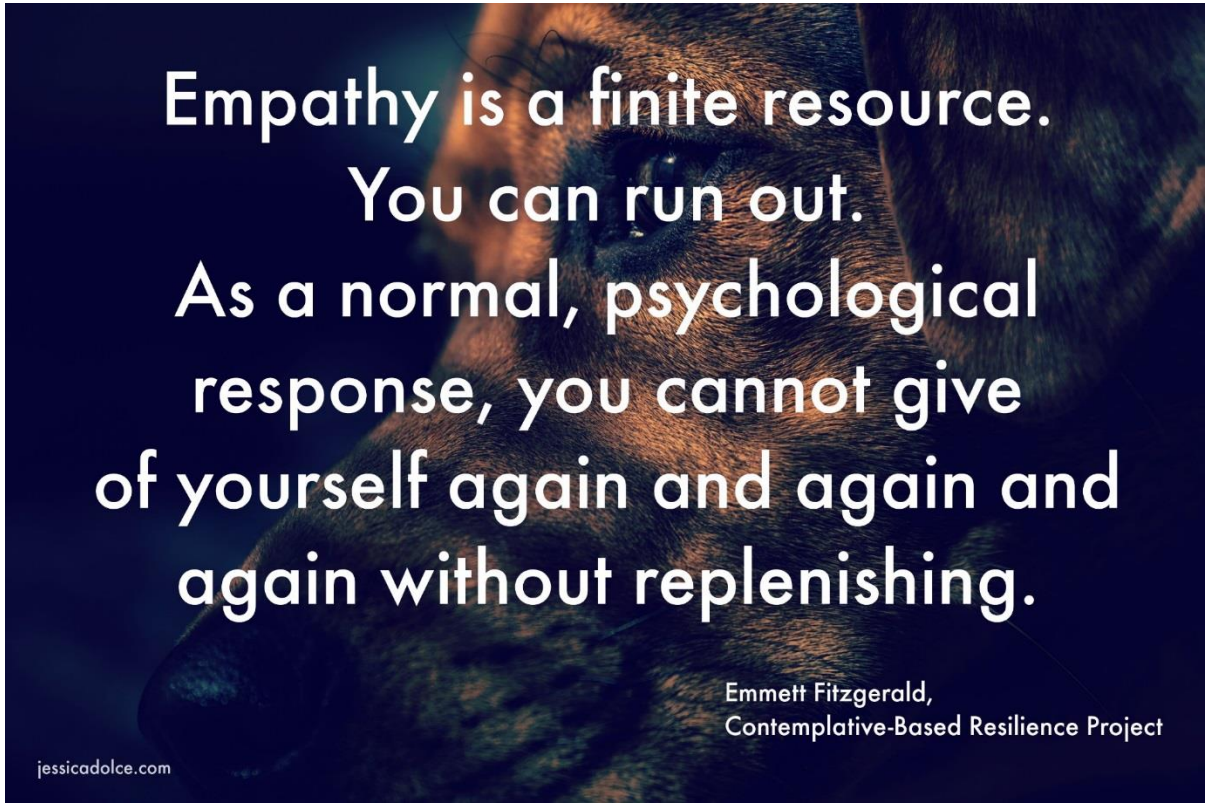

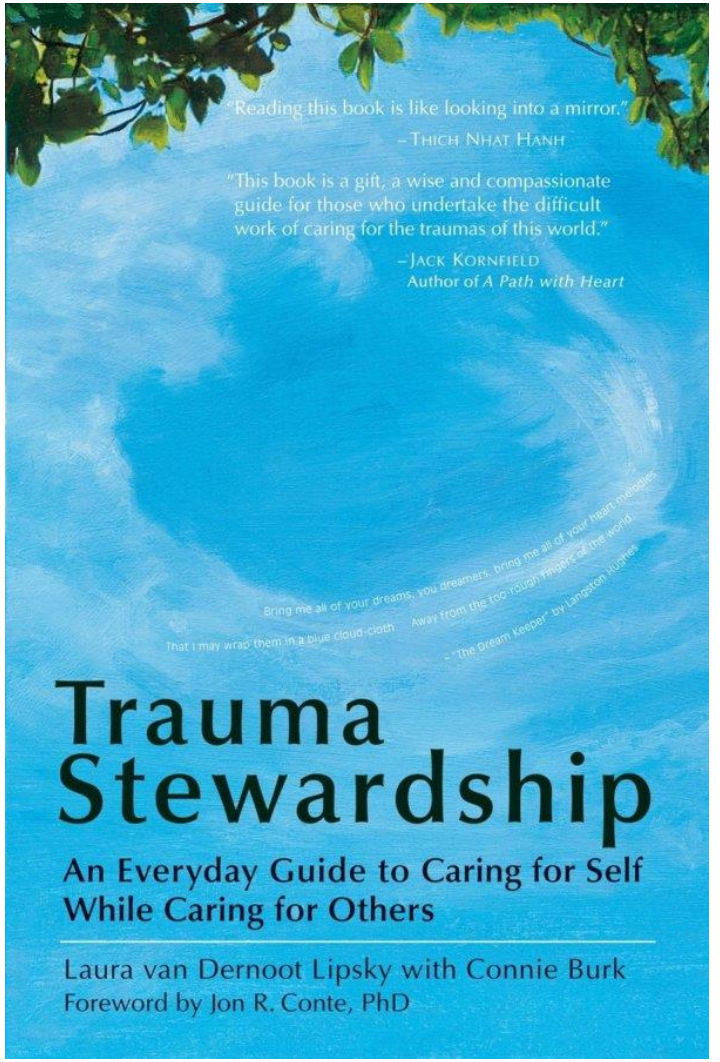

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Trauma Stewardship

The 16 Warning Signs of Trauma Exposure Response

Feeling Helpless and Hopeless

A Sense That One Can Never Do Enough

Hyper-vigilance

Diminished Creativity

Inability to Embrace Complexity

Minimizing

Chronic Exhaustion/Physical Ailments

Inability to Listen/Deliberate Avoidance

Dissociative Moments

Sense of Persecution

Guilt

Fear

Anger and Cynicism

Inability to Empathize/Numbing

Addictions

Grandiosity: An Inflated Sense of Importance Related to One's Work

-Laura van Dernoot Lipsky

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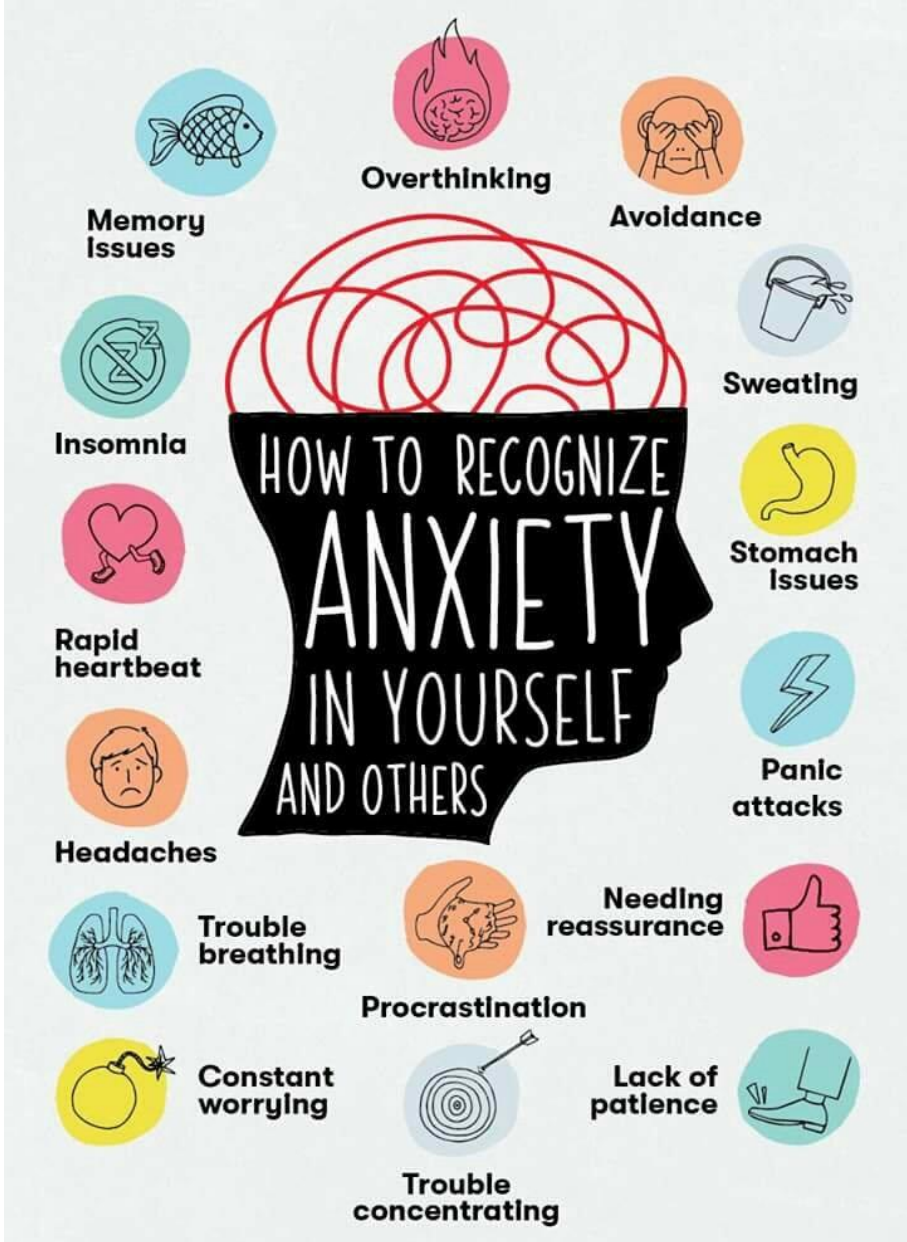
HOW TO RECOGNIZE
ANXIETY
IN YOURSELF
AND OTHERS
Memory Issues
Overthinking
Avoidance
Insomnia
Sweating
Rapid heartbeat
Stomach Issues
Headaches
Panic attacks
Trouble breathing
Needing reassurance
Procrastination
Constant worrying
Lack of patience
Trouble concentrating

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Some Ideas for Cultivating Self-Care

- Are my basic needs met? Am I eating regularly and sleeping enough?
- Have I moved my body in a nourishing way today?
- Are there places that feel tight and am I holding tension?
- How are my relationships? Do I feel connected?
- Am I engaging in real self-care? What might need to shift?
- Do I give myself time to do nothing? To sit? To be?
- How is my breath? Have I intentionally breathed today?
- When is the last time I got a checkup at the Doctor?
- Do I feel safe? Supported? Heard and Seen? Validated?
- How has my self-talk been lately? Could I be more kind?
- Do I feel fulfilled? Am I making time for creativity? Hobbies?
- Have I learned something new lately? Tried something different?
- Am I intentional about how I'm using my time and energy?

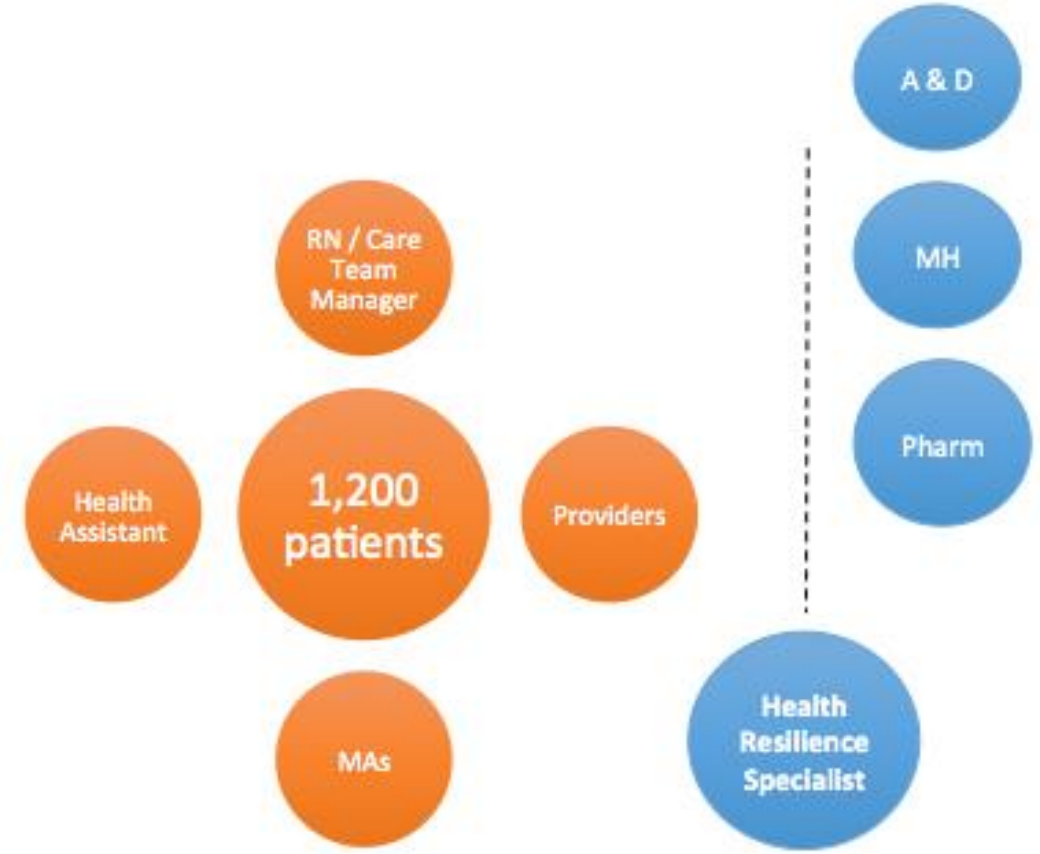
Our system…

Portland, OR

FQHC and designated Health Care for the Homeless program.

- Provide integrated primary and behavioral health care, pharmacy, and co-located specialty mental health and substance use disorder services.
- We serve 5,000 patients per year, who have a high degree of medical, behavioral and social needs:
  - 40% patients met “high-utilizer” criteria
  - > 90% coming out of homelessness or unstable housing
  - > 90% with mental illness or substance use disorder
- Robust team based care within PCMH model.
- Embedded within larger social services agency (Central City Concern).

“Usual Care” vs SUMMIT A-ICU



“It’s like riding out the chaos”: Perspectives of clinicians and staff on caring for high-utilizer patients in the SUMMIT intensive ambulatory. *(ICU trial 4/13/18)*

Target Conditions and Characteristics

Medical Condition	Percent
Chronic kidney disease	19.8%
CHF	42.9%
COPD	50.5%
Chronic/severe infections	53.8%
Diabetes	42.9%
End stage liver disease	24.2%

Characteristics	
Age, mean ±SD, years	57 ±11
Housing status:	
Homeless	23.4%
Low income housing	63.0%
Other or unknown	13.7%

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Behavioral Health and Medical Complexity

Behavioral Health Condition	Percent
Substance use disorder	80.2%
Anxiety disorder	33.0%
Bipolar disorder	19.8%
Depressive disorder	53.8%
Psychotic disorder	16.5%
Trauma-related disorder	38.5%

Selected Diagnoses	Percent
Any mental health diagnoses	87.3%
Any substance use disorder	79.7%
Medical Diagnosis Count	**Percent**
2 diagnoses	8.9%
3 diagnoses	27.8%
4 diagnoses	19.0%
5+ diagnoses	38.0%

87% have a mental health diagnosis

85% have 3+ medical diagnoses

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Team wellness in Summit

- Meditation
- Huddles
- Weekly reflection/QI
- Interdisciplinary staffing and supervision
- Objective risk management and support
- Grief processing
- Training opportunities driven by team
- Book club
- Team members have a say in metrics

A difficult case of boundary setting

Tony established with Summit at the age of 58.

He has a history of traumatic brain injury, congestive heart failure, impaired mobility due to infarcted bone in tibia and fibula, severe alcohol use disorder and chronic homelessness since 2013 with a pattern of explosive behaviors and unstable interpersonal relationships.

Tony

Over the course of 2 years, he cycled between hospitals, nursing homes, respite care, supportive low barrier independent housing and homelessness.

His physical health would improve during hospitalizations and nursing home stays often to the point where he would no longer meet ADL criteria to stay in long term care.

Tony

In other cases, he was discharged from supportive environments because of unsafe behaviors around substance use or verbal/physical abuse of staff and other residents

While he had a TBI with encephalomalacia, he never met the threshold for guardianship.

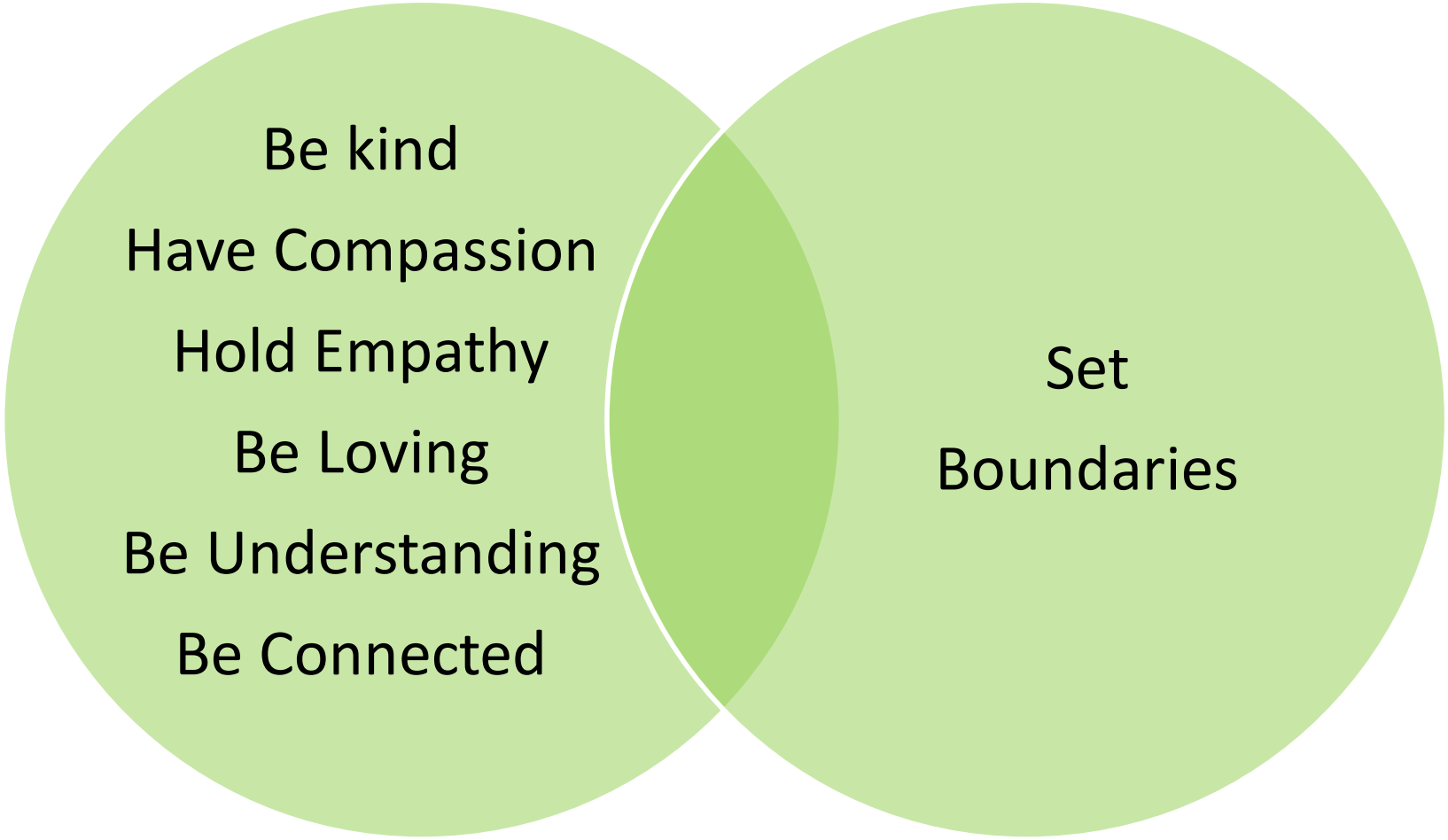
Tony

He would often present to clinic intoxicated, in crisis or sometimes in a place of clarity (sometimes all 3).

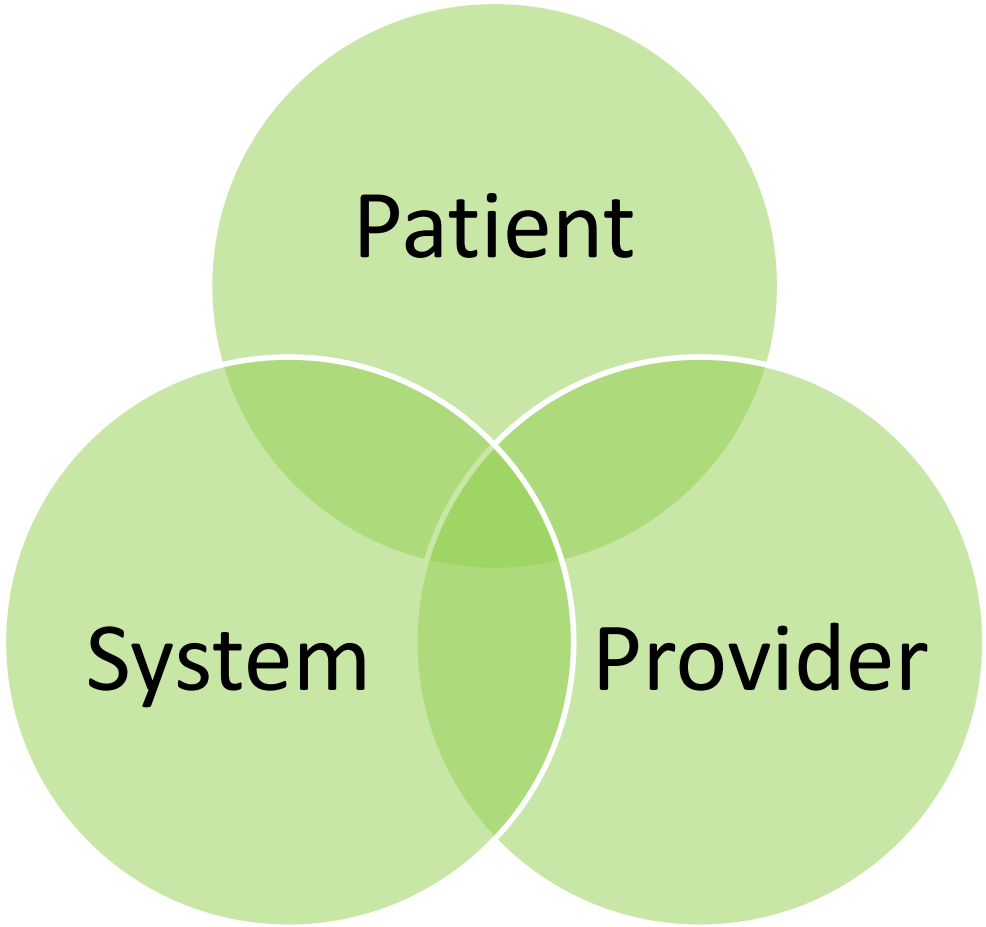
He was often disruptive, demanding, agitated, loud, suspicious and impulsive. His behaviors affected the sense of safety and well-being of our other clients.

He had 5 behavioral agreements with our clinic, a 30 day exclusion, a 90 day exclusion and a 6 month exclusion

Things You Can Do at the Same Time…



What is happening when Tony seeks care?



There are overlapping and interdependent experiences of complexity

Tony's brain injury limits his ability to actually engage in substance use treatment or reliable behavioral modification.

Homelessness perpetuates a sense of crisis and dysfunction.

Our systems value autonomy with little support for patients like Tony (concept of "Spin, Float, Integrate").

Summit Population Data

What do we think population health looks like?

Enhanced primary care engagement with reduced* acute care utilization?

Better advanced care planning?

Improved transitions of care?

Better patient experience (reduced re-traumatization)?

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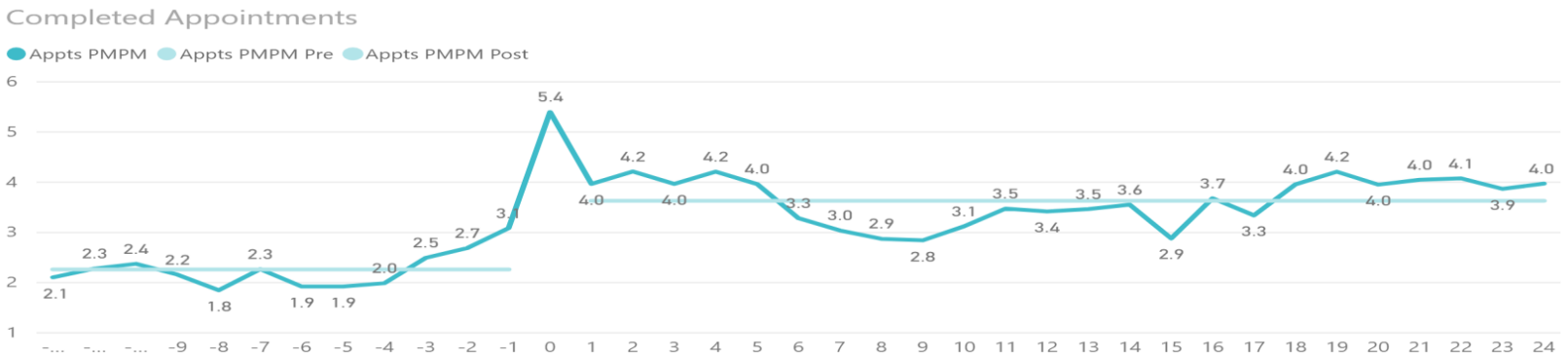
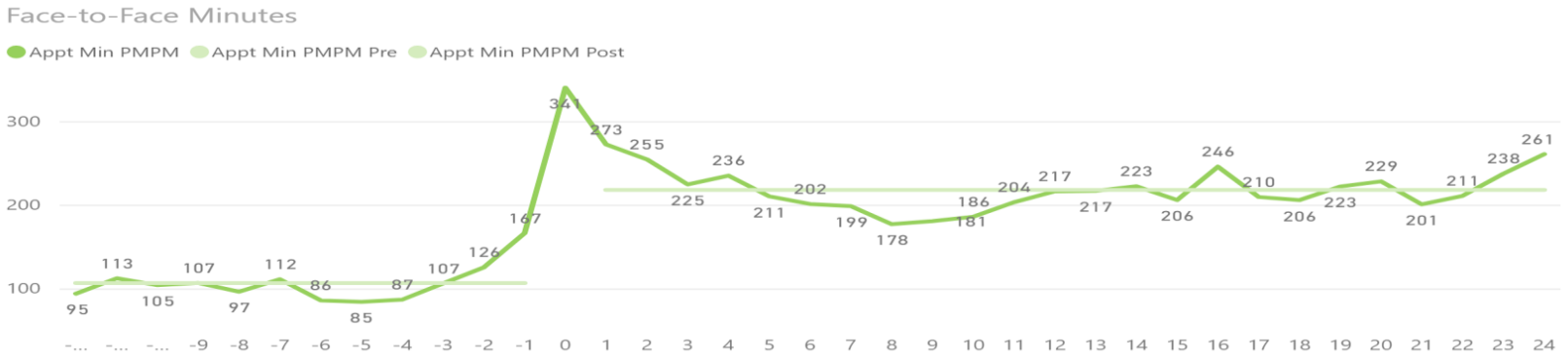
Summit Engagement

Impact on OTC Outpatient Utilization

60%
Appts % Change



104%
Appt Min % Change

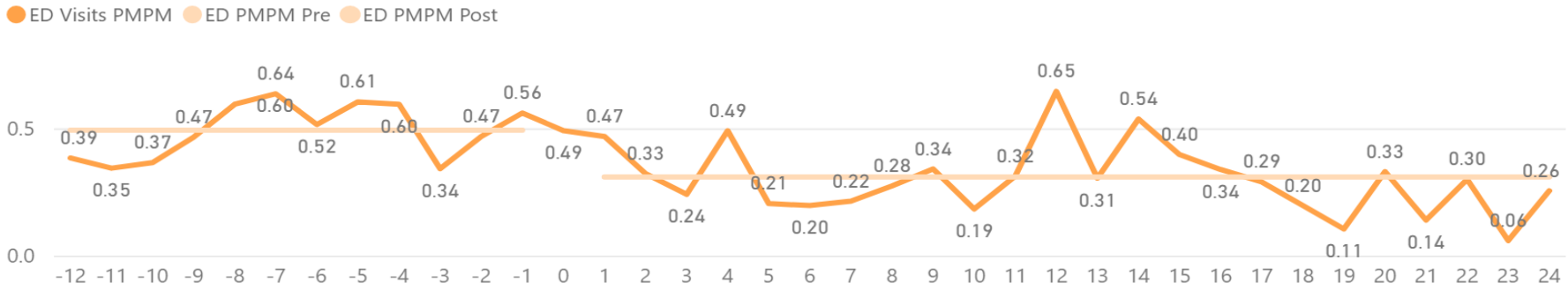


Impact on Hospital Utilization

87
Unique Patients

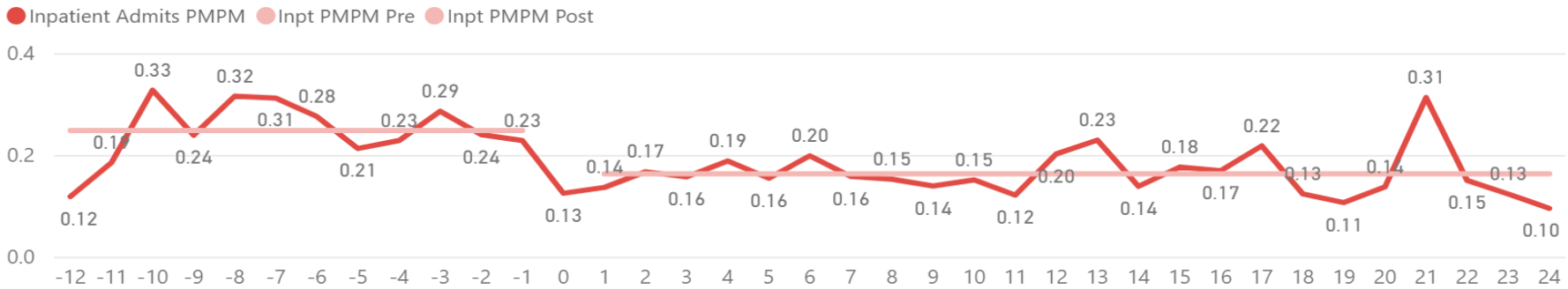
-37%
ED % Change

Emergency Department Utilization



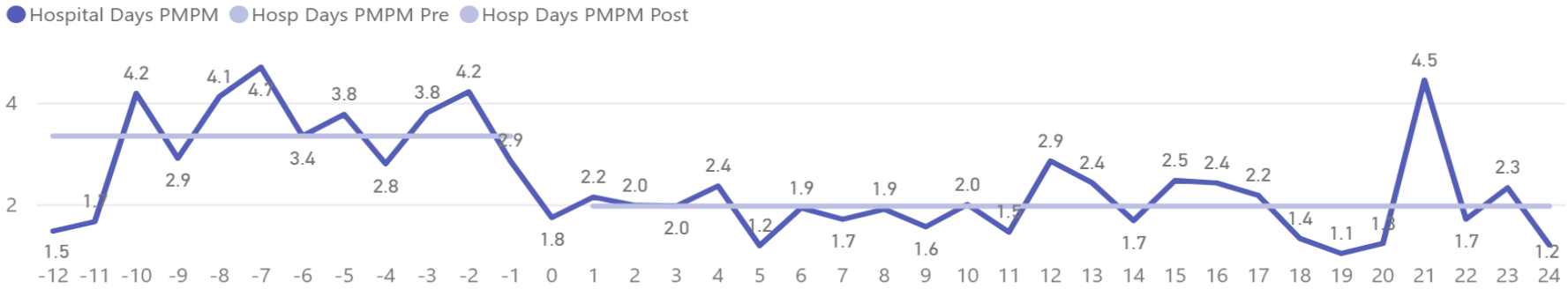
-34%
Inpatient % Change

Inpatient Utilization



-41%
Hosp Days % Change

Total Hospital Days



@cccportland

Summit = Better Patient Experience?

Patient Experience (HCAHP composite)

		Immediate	Waitlist		
		% Top Box	% Top Box	p-value	
Baseline	Access	53%	40%	0.0539	
	Communication	68%	74%	0.2877	
	Care Coordination	53%	56%	0.7025	
Follow-up	Access	57%	48%	0.1882	
	Communication	**81%**	**63%**	**0.0006**	
	Care Coordination	**60%**	**43%**	**0.0152**	

The Quadruple Aim Asks Us To…

- Improve population health
- Enhance patient experience of care
- Reduce per capita cost of health care
- Improve the work life of health care providers including clinicians and staff

Individual cases will challenge us. Knowing our population means knowing ourselves and working together across disciplines. Being trauma informed will help us sustain difficult work in broken systems as we work toward improving population health.

Strategies for Clinician Wellness when Working with Patients who have Complex Needs

Questions/Comments

Thank you!

Please complete the post-session evaluation.

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For more information on ED MI metrics support, visit

www.TransformationCenter.org