The Indiana Division of Mental Health and Addiction (DMHA) in collaboration with its integration stakeholder cross agency partners submitted a Technical Transfer Initiative (TTI) grant proposal and was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Association of State Mental Health Program Directors (NASMHPD). That grant is supporting today’s training activities.

www.indianaintegration.org
Approach to the Physical Exam and Working With Psychiatric Providers

Lori Raney, MD
Collaborative Care Consulting
Dolores, CO
Module 3
Approach to the Physical Exam and Health Behavior Change

- Learning Objectives:
  - Understand the prevalence of comorbid behavioral health and medical conditions
  - Describe the best approach to the physical exam
  - List medical conditions that may mimic psychiatric disorders
  - Discuss health behavior change approaches
Pre Course Questions

1. What comorbid behavioral health diagnosis are common in the SMI population?
   1. Trauma related disorders
   2. Simple phobia
   3. Adjustment Disorders
   4. Paraphilias

2. To reduce anxiety, the purpose of the first appointment could be to
   1. Gather information
   2. Make the next appointment
   3. Introduce staff
   4. All of the above

3. Common reasons for medical visits in the SMI population include all except
   1. Abdominal pain
   2. Chest Pain
   3. Well visit
   4. Headache
Overview

- Comorbidities
- Screening Guidelines and Preventive Care
- Approach to the Exam
- Cultural Considerations
- Health Behavior Change in SMI population
Psychiatric Comorbidity in SMI Patients

1. Depression – 15%
   - suicide 10%

2. Trauma –
   1. 22% women reported rape
   2. 12% homeless men reported assault

3. Substance Abuse
   1. 40% of SMI population use alcohol
   2. 50 – 80 % use tobacco products


### Comorbid Alcohol Disorders

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Lifetime Prevalence of Alcohol abuse or dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar I</td>
<td>46.2%</td>
</tr>
<tr>
<td>Bipolar II</td>
<td>39.2%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>33.7%</td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>28.7%</td>
</tr>
<tr>
<td>Unipolar Depression</td>
<td>16.5%</td>
</tr>
<tr>
<td>General Population</td>
<td>13.8%</td>
</tr>
</tbody>
</table>

Regier DA et al. JAMA, 1990
Medical Comorbidity

- **CVD** - Leading Cause of Death Diabetes, Hypertension, Dyslipidemias, Obesity, Smoking, Metabolic Syndrome – Discussed Earlier –

- **Cancers** – same rate as general population, just dx late, 2\textsuperscript{nd} leading cause of death. Cancer incidence:
  - Men – lung, stomach/pancreatic/esophageal, kidney
  - Women – lung, kidney, breast

- **Infectious Diseases** – limited data
  - HCV – 4-10\% outpatients – growing concern
  - HIV - 2.7 \% outpt, 17\% homeless population
  - TB – 17\% - (inpatient sample)

- **Chronic Pain** – 36.6\% Schizophrenia

\(^1\textit{Cad Saude Publica},\ 2010\ Mar;26(3):591-602\)
\(^2\textit{Pirl WF et al. Psych Serv} 2005;56:1614.\)
\(^3\textit{Freudenreich O et al. Psychosomatics} 2007;48:405.\)
\(^3\textit{Viron M et al. Comm Ment Health J} (in press)\)
\(^3\textit{Kisely, et al, JAMA Psychiatry} ,\textit{Vol 70 (no.2) Feb 2013}\)
Screening/Preventive Services Essential

- ADA/APA guidelines for SGAs – Psychiatric providers
- HIV, TB, HCV
- USPSTF recommendations – age recommended - cancers
- Substance Use, Smoking, “Medical” marijuana, meth
- Prevention – flu shots, immunizations, etc
ADA/APA Screening Guidelines for Second Generation Antipsychotics

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>4 wks</th>
<th>8 wks</th>
<th>12 wks</th>
<th>Annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review Personal /</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Family history of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>illness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight [BMI]</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waist Circumference</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting Plasma Glucose</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fasting Lipid Profile</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

## Two Worlds

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Unconditional love</td>
<td>- Conditional love</td>
</tr>
<tr>
<td>- Continuity is goal</td>
<td>- Termination is goal</td>
</tr>
<tr>
<td>- No Stigma</td>
<td>- Stigma common</td>
</tr>
<tr>
<td>- No coercion</td>
<td>- Coercion possible</td>
</tr>
<tr>
<td>- Data shared</td>
<td>- Data private</td>
</tr>
<tr>
<td>- Large panels</td>
<td>- Small panels</td>
</tr>
<tr>
<td>- Flexible scheduling</td>
<td>- Fixed scheduling</td>
</tr>
<tr>
<td>- Fast Paced</td>
<td>- Slower pace</td>
</tr>
<tr>
<td>- Time is independent</td>
<td>- Time is dependent – “50 min hour”</td>
</tr>
<tr>
<td>- Flexible Boundaries</td>
<td>- Firm Boundaries</td>
</tr>
<tr>
<td>- Treatment External (labs, procedures)</td>
<td>- Relationship with provider IS tx</td>
</tr>
<tr>
<td>- Patient not responsible for illness</td>
<td>- Patient responsible for participating in tx</td>
</tr>
</tbody>
</table>
## Approaching the Exam

### Providers View
- WE DON’T UNDERSTAND THEM
- THEY ARE MENTALLY ILL
- THEY TAKE TOO LONG
- THEY DON’T DO WHAT WE SAY
- THEY SCARE ME

### Patients View
- THEY DON’T UNDERSTAND ME
- THEY ARE INCOMPETENT
- THEY AREN’T PATIENT WITH ME
- THEY WANT TO CONTROL ME
- THEY SCARE ME
Example

- Mr. X, I can tell that you are very frustrated and you must feel like all the doctors think that your symptoms are not real... you probably also feel that the doctors don't really know what they are doing since they have not been able to make a proper diagnosis for you.
Approach to the Exam – Reset Expectations

**Longer appointment**
due to aspects of illness
such as poverty of speech,
Apathy, disorganization,
Positive symptoms make
It harder to get accurate
history. 2-3 appts per hour,
smaller panel size - half

**Sensitive to Trauma**
Especially sexual trauma
In women. Be ready for
emotional response to exam,
Take time to explain and go
slow

**Avoid Bombardment**
Start with one or two
goals and move
through the list over
the course of multiple
appointments -
plenty of pent up
need has to be
managed carefully
Approach to the Exam - Tips

• Calm demeanor - don’t challenge delusions – reassurance and understanding, work around the positive symptoms
• Correct misinformation about medical care
• Understand you may get a lot or most of your information from staff rather than the patient.
• Purpose of first visit could be introductions, tour, gather information, make the next appointment and no PE
• Maintain appropriate boundaries
• This is team-based care, so use the resources of the team
  • Co-visits with other staff, huddles
• Slower pace
• Be willing to cut the visit short and try another day!
Positive Symptoms that may Interfere with Exam

- Delusions
  - Paranoid – someone is out to get me
  - Somatic – have cancer, guts are rotting, bug eggs in my scalp
- Disorganization
  - Dress
  - Language
  - Hygiene
- Hallucinations – especially auditory-
  - Could say provider is going to “harm”
  - Could say provider is “good”
  - Could say patient is “stupid” to be here
Positive symptoms: example

- Patient with Bipolar DO, currently manic, refusing medication except for Valium. C/O vaginal discharge. PCP enters room to do pelvic exam and patient found naked, scrubbing the sink. She is smiling, has rapid speech and states she is not ashamed to be seen in her “birthday suit”. PCP calmly gets her to the exam table, diagnoses STD and patient gets appropriate treatment.
Negative Symptoms – Absence of ....

- Poverty of Speech
  - Monosyllabic Speech
  - Monotone Speech
- Lack of Motivation
- Apathy – disinterest in things
- Inexpressive Face – flat affect
- Few gestures
- Lack of ability to experience joy or act spontaneously

- 25% have “deficit syndrome” – severe negative symptoms
Negative Symptoms: Example

- Difficult to assess patients pain. He does not volunteer any information. However, his counselor did send him in for visit given this has apparently been going on for some time. Will get a KUB to start and check for constipation.
- Trial of Lansoprazole and close follow up.
- He was not able to get a urine sample for us today. Refused to even try.

PCP note in EMR 2013
Trauma
May negatively influence access to and engagement in primary care:

1. Avoidance of medical and dental services
2. Non-adherence to treatment
3. Postponing medical and dental services until things get very bad
4. Misuse of medical treatment services – ex. over use of ER Services and misuse of pain meds
Why medical settings may be distressing for people with trauma experiences:

- Invasive procedures
- Removal of clothing
- Physical touch
- Personal questions that may be embarrassing/distressing
- Power dynamics of relationship
- Gender of healthcare provider
- Vulnerable physical position
- Loss of and lack of privacy
Signs that a person may be feeling distressed:

- **Emotional reactions** – anxiety, fear, powerlessness, helplessness, worry, anger
- **Physical or somatic reactions** – nausea, light headedness, increase in BP, headaches, stomach aches, increase in heart rate and, respiration or holding breath
- **Behavioral reactions** – crying, uncooperative, argumentative, unresponsive, restlessness
- **Cognitive reactions** – memory impairment or forgetfulness, inability to give adequate history
Physical Exam of Traumatized Patient

- Chaperone
- Explain what you are going to do “You need a breast exam”
- Let them know when you are going to touch them and where “I am going to touch your left breast now”
- Ask if it’s ok to proceed “Ready?”
- Check in from time to time “Are you doing ok?”
Resource

- **Handbook of Sensitive Practices for HealthCare Providers**
  

Example – first visit

- H. B. is a 57 yr old AA female with Schizoaffective DO who presents with Case Management staff. She has been to the office before just to stand in the waiting room and come back and "check out" the exam room. Last week, I was able to talk to her briefly between patients and she said that her toe nails were too long. Maybe I could help with that. This week she comes to the exam room with staff and allows a check of her BP and after cutting one toe nail, tell me that hurt and she will think about cutting the rest, despite the fact that her feet look like bird claws. Eventually, we may be able to further exam the patient and even get blood work. This may take several months.

Todd Wahrenberger, MD
Suicidal Patients

- Rare events are very difficult to predict
- Previous suicide attempt history somewhat helpful
- Take them seriously –
  - 15% Bipolar DO attempt suicide
  - 10% Schizophrenia attempt suicide
- Ask about command hallucinations (voices) telling to do this
- Ask how they would do it
- Ask if they have means to carry out the plan – pills, firearms, rope
- Get help from your team!
- **Have a written, well thought out plan for emergencies – who to call**
Controlled Substances

- Definitely an issue – chronic pain common (36%)
- Many patients feel narcotics beneficial for their mental health
- Like any other patient use sparingly and for short duration if possible
- Prevents antidepressants from working (*anti – depressant* vs. *depressant*)
- Contracts helpful – close ALL loopholes (esp. patients Borderline Personality DO)
- Methadone and Suboxone useful
- Pregabalin (Lyrica), gabapentin, SNRIs - duloxetine (Cymbalta) and venlafaxine (Effexor) can be helpful for pain
Belligerent Patients – De-Escalation

- Appear calm, centered, self-assured (even if you aren’t)
- Limited Eye Contact – not too much, not too little
- Neutral facial expression, eye level, monotone voice
- Minimize body movements, relaxed and alert posture
- Position yourself for safety
- Don’t point or shake finger, do not touch
- Do not get defensive, be respectful while setting limits
- Be honest
- Empathize with feelings but not behavior
- Trust your instincts

www.citinternational.org
Common Medical Complaints

- **PAIN**
  - abdominal (30.7%),
  - head,
  - mouth (24%),
  - back (14.7%)
- Insomnia
- Cough, Sore Throat, Headache

*Cad Saude Publica.* 2010 Mar;26(3):591-602
Coordinating Care with Specialists

- Using care managers to facilitate referrals and get info back to care team
- Referral form to take with them
- Fax copy of your notes in EMR
- Using Case Managers to encourage, get them there – “activation” crucial
- Find specialists that work well with your patients
Daily Huddles

• Allow the practice to plan for changes in the workflow, manage crises before they arise, make adjustments to improve access and staff member’s quality of life
• Share details of care being provided by individual members so you have a more comprehensive picture of the patient
• Huddle length – 7-10 min, stand up
• Huddle leader
• Bring your laptop – separate EMRs
• Decide if labs, reports, etc are available
• Check for openings - might be able to get someone in?
Other services to consider during the visit to PCP

- Medical – MD, DO, APN, PA
- Vocational
- Therapies
- ACT
- Housing
- Day treatment
- Crisis services

- Case management
- Supported employment
- Clubhouses
- Peer services
- Substance use services
America The Beautiful

- Caucasian: 73%
- African American: 12%
- Hispanic: 14%
- Asian: 4%
- Native American: <1%
Cultural Considerations

- Cultures other than Caucasian tend to have stronger family ties and more family involvement so need to be included in treatment planning.
- Somatic distress often expressed instead of emotional distress.
- Different beliefs about healing.
# Drugs with Increase ADRs and Their P450 Enzymes – JAMA 2001

<table>
<thead>
<tr>
<th>Enzyme</th>
<th>Top 27 Drugs Causing ADRs in Literature Review</th>
<th>Poor Metabolizers %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CYP 1A2</strong></td>
<td>Carbemazepine, diltiazem, erythromycin, fluoxetine, imipramine, *isoniazid, naproxen, nortriptyline, phenytoin, rifampin, theophylline, *verapamil</td>
<td>White 12</td>
</tr>
<tr>
<td><strong>CYP 2C9</strong></td>
<td>Fluoxetine, *ibuprofen, *imipramine, isoniazid, naproxen, phenytoin, *piroxicam, *rifampin, verapamil, warfarin</td>
<td>White 2-6</td>
</tr>
<tr>
<td><strong>CYP 2C19</strong></td>
<td>Fluoxetine, imipramine, *isoniazid, nortriptyline, phenytoin, rifampin, warfarin</td>
<td>White 2-6, Asian 15-23</td>
</tr>
<tr>
<td><strong>CYP 2D6</strong></td>
<td>Diltiazem, fluoxetine, <em>imipramine, paroxetine</em>metoprolol, *nortriptyline, theophylline</td>
<td>East Asian = 0-2% AA = 0-19% Caucasians = 3-10% (40% IM, only 50% “normal”)</td>
</tr>
</tbody>
</table>
Beneficial Effects of Interventions to Reduce Risks of CVD

- **Blood cholesterol**
  - 10% ↓ = 30% ↓ in CVD (200-180)

- **High blood pressure** (> 140 SBP or 90 DBP)
  - ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke

- **Diabetes** (HbA1c > 7)
  - 1% point ↓ HbA1c = 21% dec in DM related deaths, 14% decrease in MI, 37% dec in microvascular complications

- **Cigarette smoking cessation**
  - ~ 50% ↓ in CVD

- **Maintenance of ideal body weight** (BMI = 18.5-25)
  - 35%-55% ↓ in CVD

- **Maintenance of active lifestyle** (~30-min walk daily)
  - 35%-55% ↓ in CVD

Hennekens CH. Circulation 1998;97:1095-1102.
Low Hanging Fruit

Hypertension

BMI

Smoking

Lipids

Diabetes
How Many Interactions With Patients in Different Settings During a Year?

Primary Care Settings – 4 – 6?

Mental Health Settings:
- Psychiatrist – 4
- Nurse – 4
- Case Manager – 20
- Therapist/Crisis – 5

30 – 40 Opportunities a Year?
“Force Multiplier Effect”

- Force multiplication refers to a trait or a combination of traits which make a *given force more effective* than that same force would be without it.
A Shared Base of Health Literacy: Medical Knowledge for Non-Medical Staff

- What are the illnesses and why should I care? What does it have to do with mental illness anyway?
  - **Diabetes** – what is that Hemoglobin A one C and why does the abbreviation HbA1c look so weird, foot exams?
  - **Dyslipidemias** – Ok – I’ve heard of “good” and “bad” cholesterol but what’s the ratio business?
  - **Asthma** – inhaled corticosteroids? How do you use that thing?
  - **Smoking** – OK – I know this is bad for you but what does NRT stand for?
  - **Obesity** – Got it – this is bad and diet and exercise treat but what is this BMI thingy?
  - **Health Maintenance** – You mean you want me to encourage my female patients to get PAP smears?
Staff Training – Get Creative

- Brown bag lunch
- One pagers – Diabetes, Hypertension
- Education to give to patients
- E-mail blasts to all staff – latest news
- Articles/websites
- “Med Spots” at staff meeting (15 minutes)
- Case – To – Care Training, National Council

Example – psychiatric provider adjusting dose of statin between visits with PCP

- 43 yo male with Schizoaffective DO. LDL 185. I referred to PCP who started pravostatin 40 mg Jan 2013. She repeated Lipid panel Mar, labs reviewed by me one week later during my psych appt (PCP had not seen the results). LDL still high at 174. Called PCP – she suggested “something stronger like Lipitor” so I was able to get this started at my appointment with her consultation and patient scheduled to PCP in 2 weeks.
Health Behavior Change

Many opportunities in mental health settings!

• A huge body of knowledge and expertise in behavior change
• A few examples of health behavior change models:
  • Health Belief/Health Action Model
  • Relapse Prevention Model
  • Health Action Process Approach
  • Motivational Interviewing
Health behavior coaching if you only have 5 minutes... the **Why?** and the **How?**

- Motivational interviewing –
  - *Why do you think* you need to......lose weight, stop smoking, lower your blood pressure, lower your cholesterol, lower your blood sugar?
  - *How do you want* to do it?

Rollnick and Miller, MI in Healthcare
Self Management

- Programs designed to help people gain self-confidence in their ability to control their symptoms and how their health problems affect their lives
- Stanford Self-Management Program
  - 6 weeks
- Topics: dealing with emotions, exercise, nutrition, medications, communication, decision making
- WHAM – Whole Health Action Management, HARP – Health and Recovery Peer Program
- Peer led programs!
Intervention

Bartels, 2012

tos Treated in the Heights
ACHIEVE: Mean Weight Change, According to Study Group

Simple Behavior Change Plan

**STEP ONE:**
Choose a tiny step.
(Walk one block.)

**STEP TWO:**
Find a spot.
(Every morning on my way to work.)

**STEP THREE:**
Train the cycle.
(Do it every day.)

**STEP FOUR:**
Assess Outcomes.
(Did it change? Any changes?)
Integrated Treatment Plans (MH, SUD, Physical Health)

- Patient and Family Input
- Measureable Goals and Objectives
- Cultural, Spiritual Considerations
- Strengths and Weaknesses
- **Medical Condition Goals**
Reflections

• How might you approach patients differently given the information you have received?

• What staff education do you think would be beneficial to maximize the “force multiplier effect”?
1. What comorbid behavioral health diagnosis are common in the SMI population?
   1. Trauma related disorders
   2. Simple phobia
   3. Adjustment Disorders
   4. Paraphilias

2. To reduce anxiety, the purpose of the first appointment could be to
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   2. Make the next appointment
   3. Introduce staff
   4. All of the above

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   1. Abdominal pain
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Resources and additional training tools will be available on an elearning system at:

www.indianaintegration.org