

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.

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Approach to the Physical Exam and Working With Psychiatric Providers

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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
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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

Darves-Bornoz, J.M., T. Lemperiere, A. Degiovanni, and P. Gaillard, Sexual victimization in women with schizophrenia and bipolar disease. *Social Psychiatry and Psychiatric Epidemiology* 30: 78-84 (1995)

Padgett, D.K., and E.L. Struening Victimization and traumatic injuries among the homeless: Associations with alcohol, drug, and mental problems. *American Journal of Orthopsychiatry* 62:525-34 (1992).

Leff, J. (1990) Depressive symptoms in the course of schizophrenia. In *Depression in Schizophrenia* (ed. L. E. DeLisi). Washington, DC: American Psychiatric Press

Comorbid Alcohol Disorders

Diagnosis	Lifetime Prevalence of Alcohol abuse or dependence
Bipolar I	46.2%
Bipolar II	39.2%
Schizophrenia	33.7%
Panic Disorder	28.7%
Unipolar Depression	16.5%
General Population	13.8%

Regier DA et al. JAMA, 1990

From: Cigarette Smoking Among Persons With Schizophrenia or Bipolar Disorder in Routine Clinical Settings, 1999–2011

Psychiatric Services. 2013;64(1):44-50. doi:10.1176/appi.ps.201200143

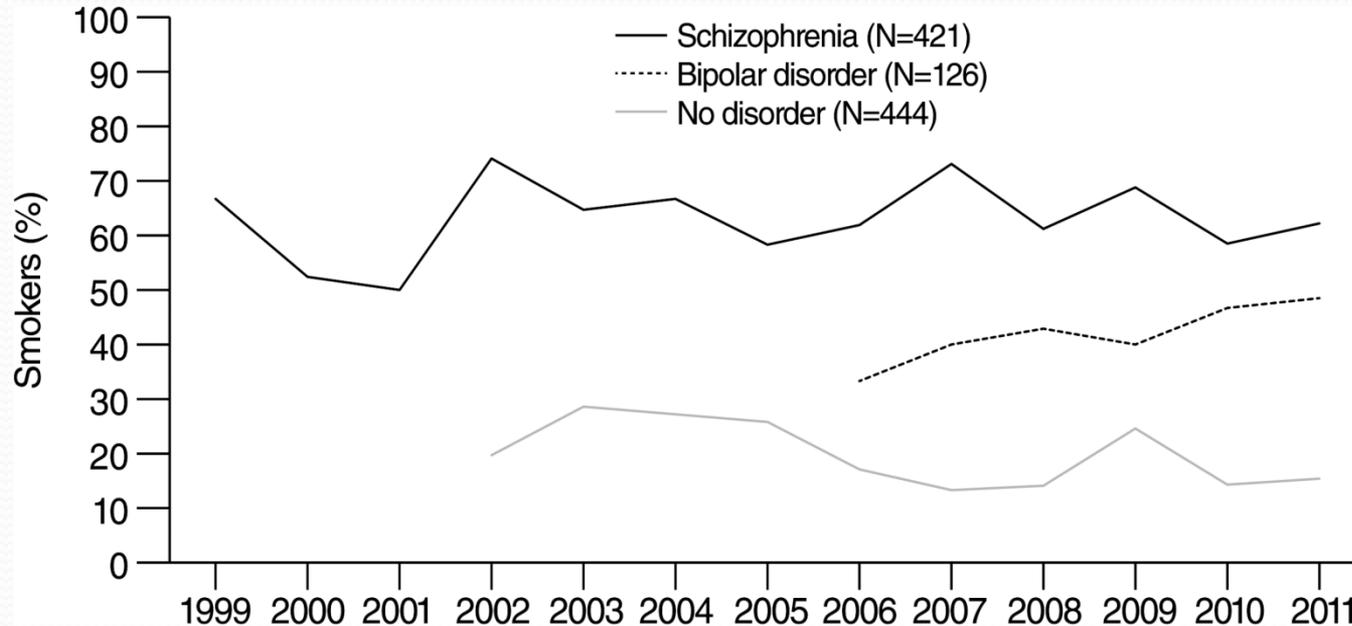


Figure Legend:

Percentage of smokers by diagnostic group and year of enrollment^{aa}Data are not shown for the bipolar disorder sample prior to 2007 or for the control group (no psychiatric illness) for 2004 because N<10 for each of these years for these groups. Number of persons in each of the other groups, by year, follows. For schizophrenia: 1999, 15; 2000, 21; 2001, 10; 2002, 27; 2003, 34; 2004, 15; 2005, 48; 2006, 21; 2007, 26; 2008, 49; 2009, 77; 2010, 41; 2011, 37. For bipolar disorder: 2007, 15; 2008, 14; 2009, 20; 2010, 30; 2011, 33. For the no-disorder control group: 2002, 71; 2003, 28; 2005, 66; 2006, 35; 2007, 45; 2008, 64; 2009, 61; 2010, 35; 2011, 39

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, 2nd 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[Cad Saude Publica](#). 2010 Mar;26(3):591-602

Pirl WF et al. Psych Serv 2005;56:1614.

²Freudenreich O et al. Psychosomatics 2007;48:405.

³Viron M et al. Comm Ment Health J (in press)

Kisely, et al, JAMA Psychiatry ,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

	Baseline	4 wks	8 wks	12 wks	Annually
Review Personal / Family history of illness	X				X
Weight [BMI]	X	X	X	X	X
Waist Circumference	X			X	X
Blood Pressure	X			X	X
Fasting Plasma Glucose	X			X	X
Fasting Lipid Profile	X			X	X

American Association of Clinical Endocrinologists, North American Association for the Study of Obesity: Consensus development conference on antipsychotic drugs and obesity and diabetes. Diabetes Care 2004; 27:596-601

Two Worlds

Primary Care

- Unconditional love
- Continuity is goal
- No Stigma
- No coercion
- Data shared
- Large panels
- Flexible scheduling
- Fast Paced
- Time is independent
- Flexible Boundaries
- Treatment External (labs, procedures)
- Patient not responsible for illness

Behavioral Health

- Conditional love
- Termination is goal
- Stigma common
- Coercion possible
- Data private
- Small panels
- Fixed scheduling
- Slower pace
- Time is dependent – “50 min hour”
- Firm Boundaries
- Relationship with provider IS tx
- Patient responsible for participating in tx

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
- Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. (2009). *Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual abuse*. Ottawa: Public Health Agency of Canada.
- http://www.phac-aspc.gc.ca/ncfv-cnivf/pdfs/nfntsx-handbook_e.pdf

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

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Common Medical Complaints

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

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?

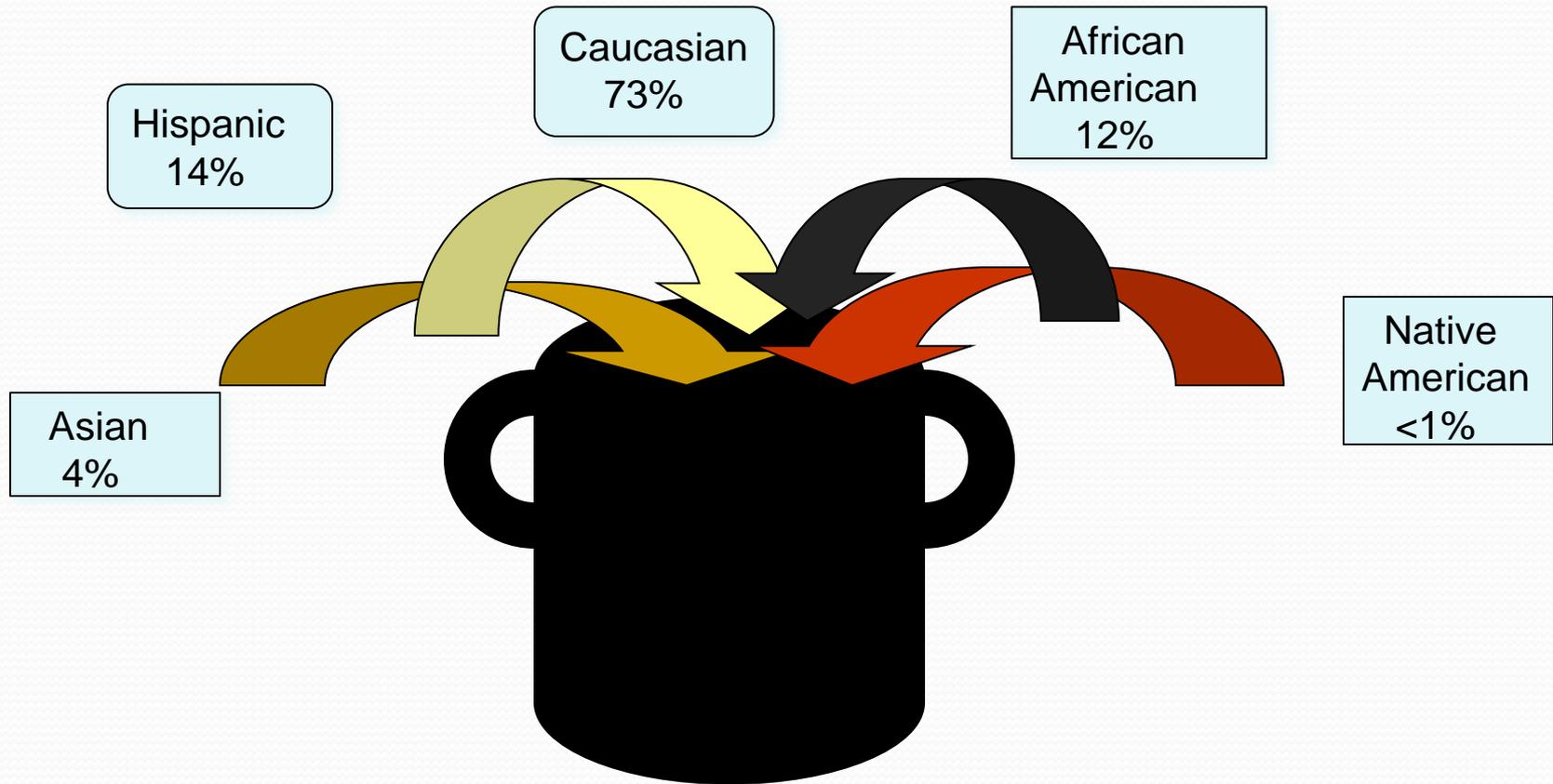
Other services to consider during the visit to PCP

- 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



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

Enzyme	Top 27 Drugs Causing ADRs in Literature Review	Poor Metabolizers %
CYP 1A2	<i>Carbamazepine, diltiazem, erythromycin, fluoxetine, imipramine, *isoniazid, naproxen, nortriptyline, phenytoin, rifampin, theophylline, *verapamil</i>	White 12
CYP 2C9	<i>Fluoxetine, *ibuprofen, *imipramine, isoniazid, naproxen, phenytoin, *piroxicam, *rifampin, verapamil, warfarin</i>	White 2-6
CYP 2C19	<i>Fluoxetine, imipramine, *isoniazid, nortriptyline, phenytoin, rifampin, warfarin</i>	White 2-6, Asian 15-23
CYP 2D6	<i>Diltiazem, fluoxetine, *imipramine, paroxetine*metoprolol, *nortriptyline, theophylline</i>	East Asian – 0-2% AA – 0-19% Caucasians – 3-10% (40% IM, only 50% "normal")

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 (HbA_{1c} > 7)
 - **1% point** ↓ HbA_{1c} = 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

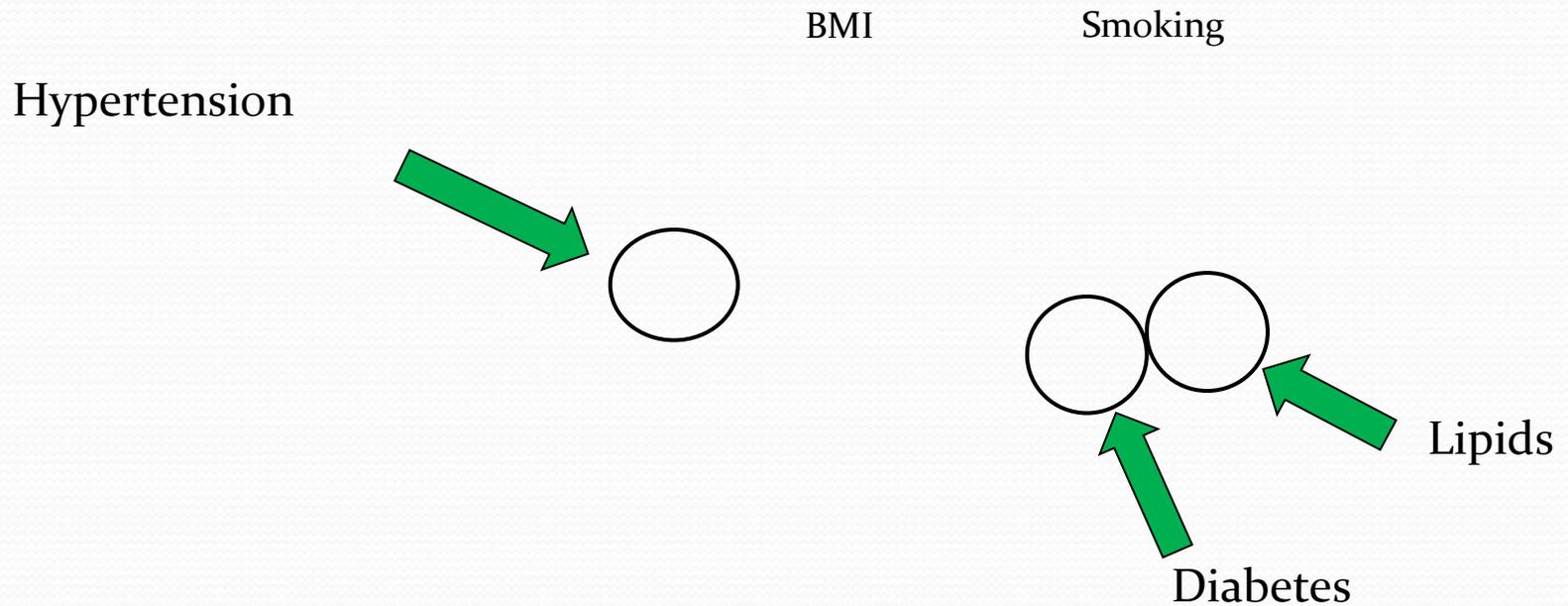
Stratton, et al, BMJ 2000

Hennekens CH. *Circulation* 1998;97:1095-1102.

Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.

Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

Low Hanging Fruit



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

Primary Care Settings – 4 – 6?

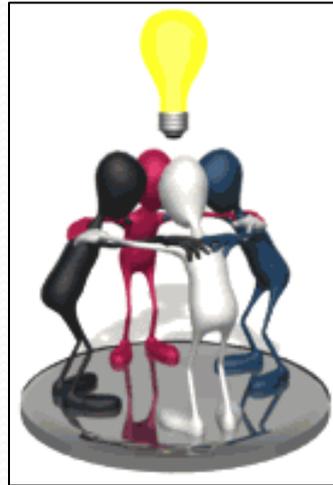
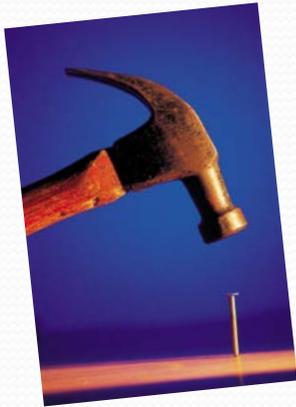
Mental Health Settings:

- Psychiatrist – 4
- Nurse – 4
- Case Manager – 20
- Therapist/Crisis – 5

30 – 40 Opportunities a Year?

“Force Multiplier Effect”

- Force multiplication refers to an trait or a combination of traits which make a given force more effective than that same force would be without it.





Case Manager



PCP



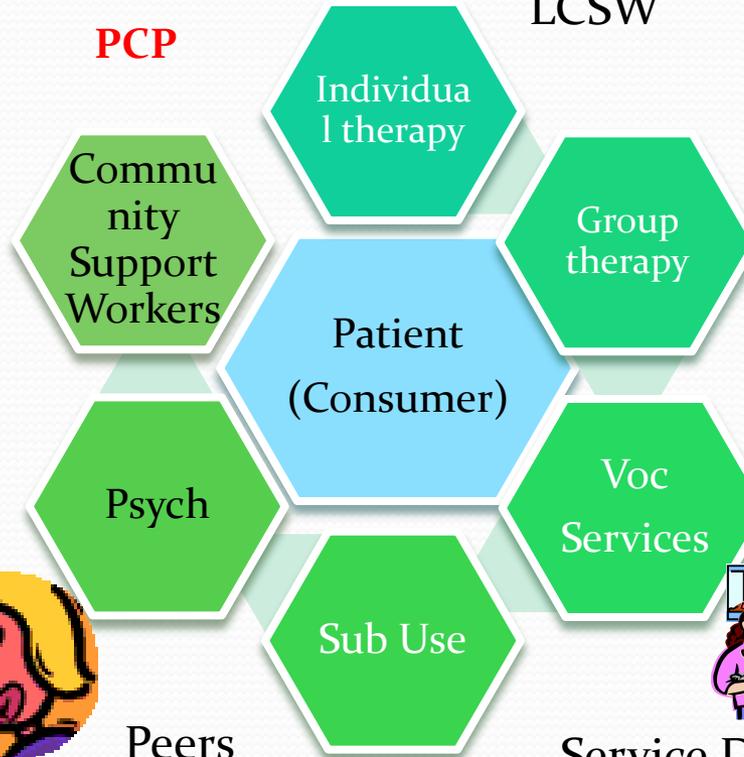
LCSW



Psychiatric Providers



Psychologist



Addictions Counselor



ADMIN



Nurse



Peers



Service Dog



Licensed therapist

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?
 - **Hypertension** – Systolic? Diastolic? Millimeters of Mercury? Stroke?
 - **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



Formula for Good Health

Place a ✓ for what you already do and an X for what you commit to working on.

<input type="checkbox"/>	0	Cigarettes	
<input type="checkbox"/>	5	Servings of fruits and vegetables per day	
<input type="checkbox"/>	10	Minutes of silence, relaxation, or meditation per day	
<input type="checkbox"/>	30	Body Mass Index < 30 kg/m²	
<input type="checkbox"/>	150	Minutes of exercise per week (e.g., brisk walking or equivalent)	

What Can A Healthy Lifestyle Do For You?

14 recent studies from the medical literature show that just these 5 simple habits can reduce your chance of developing...

Type 2 Diabetes by 93%
Hypertension by 78%
Heart Attacks by 83%
Strokes by 75%
Heart Failure by 47%
All Cancer by 36-64%
& reduce your overall chance of dying by 40-65%

This is the #1 way to stay healthy and prevent serious disease!

Kopes-Kerr, *Am Fam Physician*. 2010 Sep 15;82(6):610-614

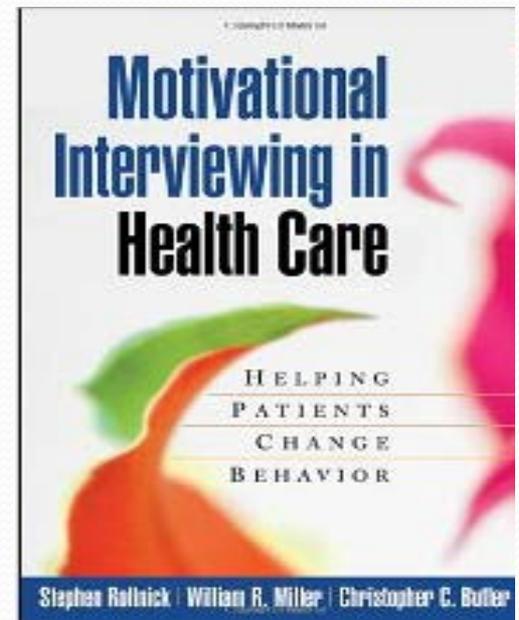
Example – psychiatric provider adjusting dose of statin between visits with PCP

- 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

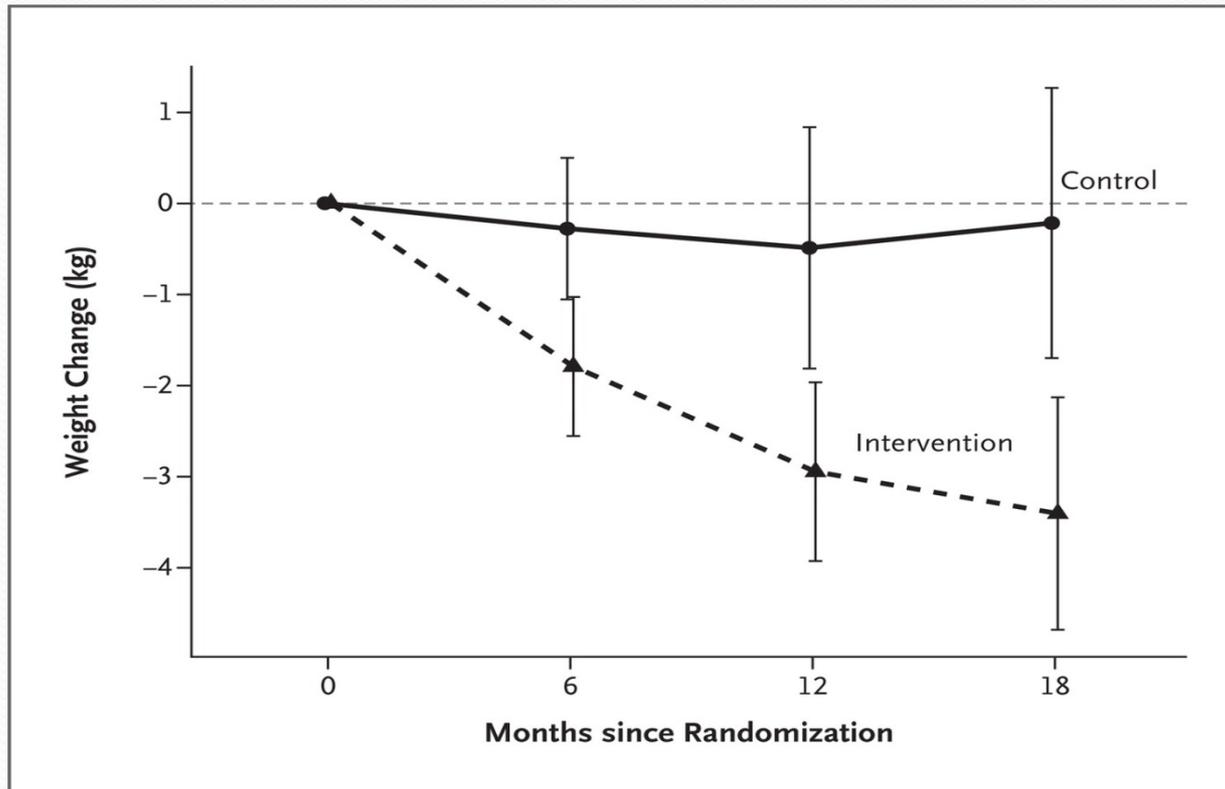
Health Promotion Implementation Resource Guide: Implementation Ready Health Promotion Programs

Intervention

nos Treated in the Heights

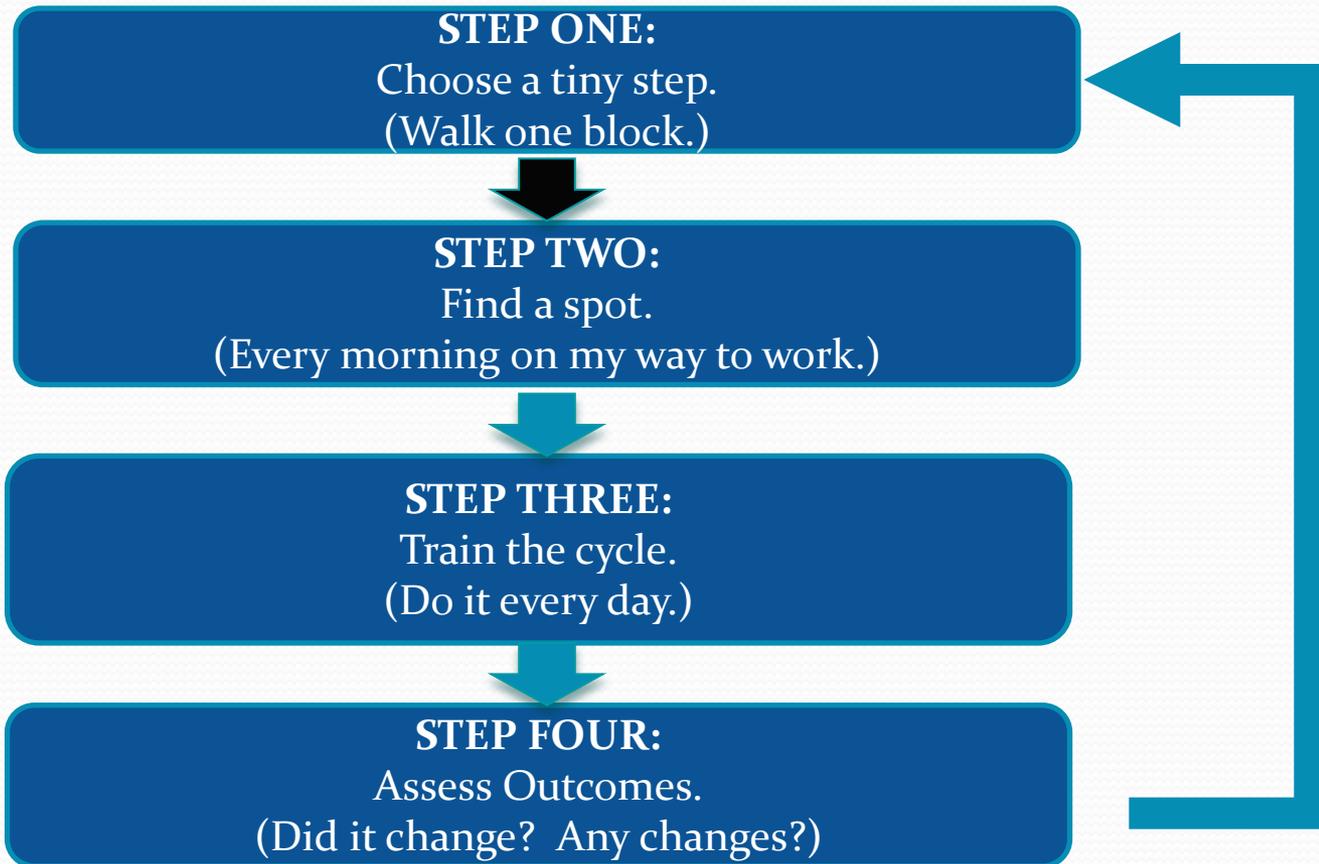
Bartels, 2012

ACHIEVE: Mean Weight Change, According to Study Group

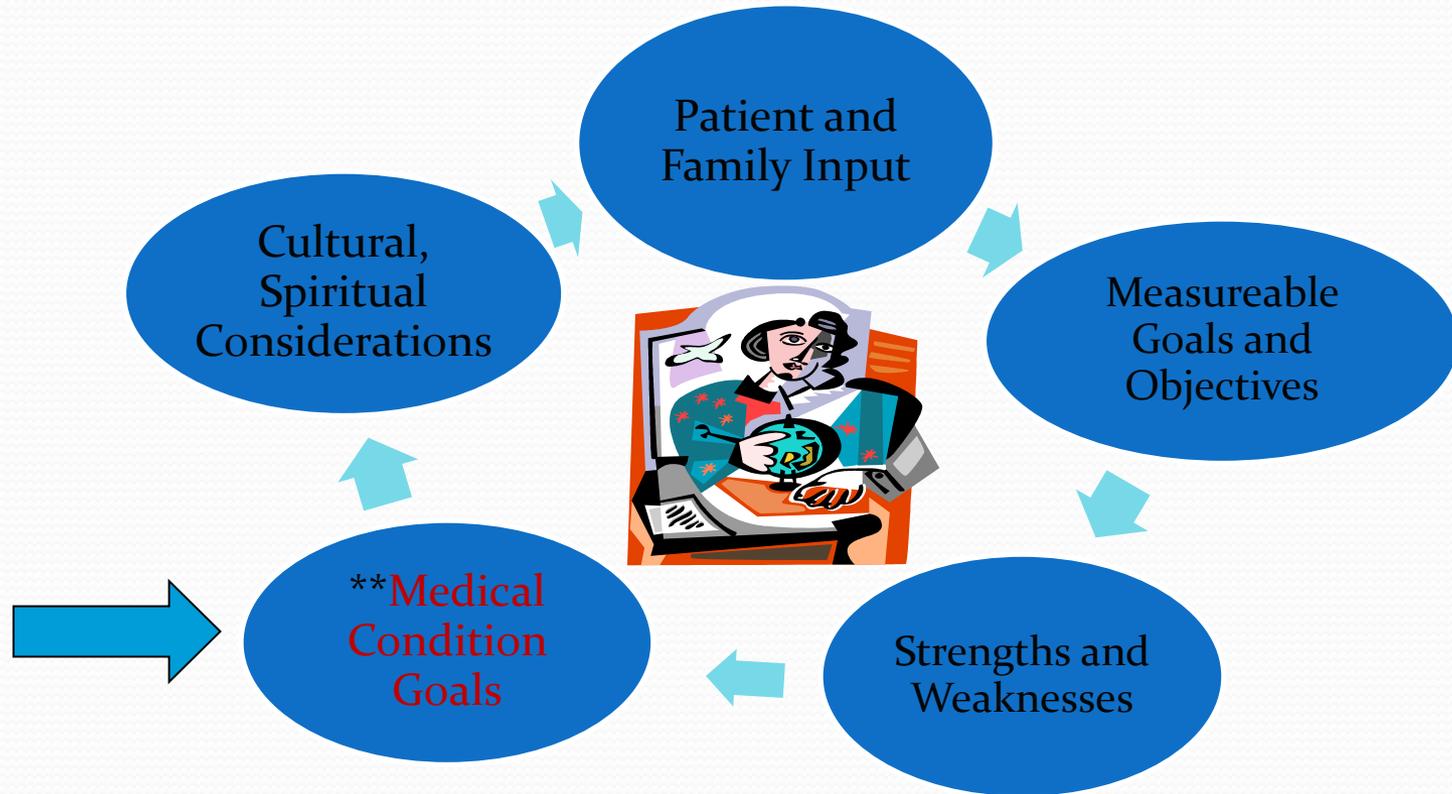


Daumit GL et al. N Engl J Med 2013. DOI: 10.1056/NEJMoa1214530

Simple Behavior Change Plan



Integrated Treatment Plans (MH, SUD, Physical Health)



Reflections

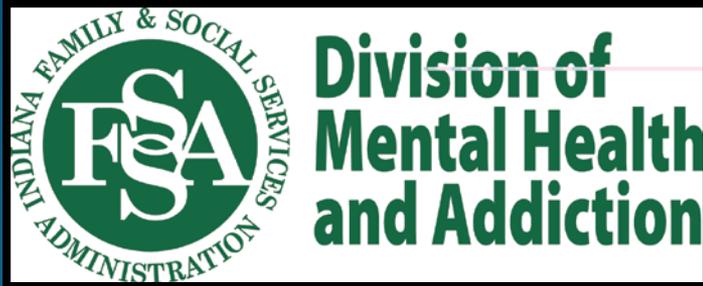
- How might you approach patients differently given the information you have received?
- What staff education do you think would be beneficial to maximize the “force multiplier effect”?

Post Course Questions

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 2. Simple phobia
 3. Adjustment Disorders
 4. Paraphilias
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Resources and additional training tools will be available on an elearning system at:

www.indianaintegration.org