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**Merging Cultures in an
Integrated Clinic**

Susan B. Girois, MD, MPH
City of Norfolk Community Services Board
SAMHSA PBHCI Grantee Meeting
Phoenix, AZ September 23-25, 2013

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About the Speaker
**Susan B. Girois, MD, MPH, Primary Care Physician,
Norfolk Community Services Board**



Dr. Susan Girois is board certified in Internal Medicine with a Master's Degree in Public Health from the London School of Hygiene and Tropical Medicine. Following residency at the Hospital of the University of Pennsylvania, Dr. Girois worked as an HIV Primary Care Physician in the Philadelphia public health system. In 2001, she served as HIV Clinical Advisor to the Ministry of Health in Botswana for roll-out of the National ARV program. She subsequently joined Handicap International Federation, a specialized NGO that provides emergency services, health interventions, and rehabilitation in over 60 countries. Dr. Girois joined the Norfolk Community Services Board in December 2012 to implement integrated care delivery within the Adult Outpatient Psychiatric Clinic.

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Why a discussion on merging cultures?

- *Integration is a change process.*
- *Any change process must focus on awareness of changes in relationships.*
- *Culture is defined in relationships.*
- *Articulation of the "Culture of Integration" is essential to sustaining change.*

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Progress is made when a specialist in one field impinges on the specialty of another.
– G. H. Wells

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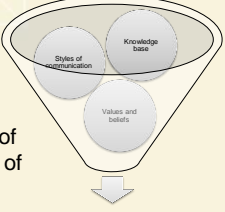
The purpose of this session is to start a dialogue.

The approach is scenario-based to highlight cultural challenges through real-life situations.

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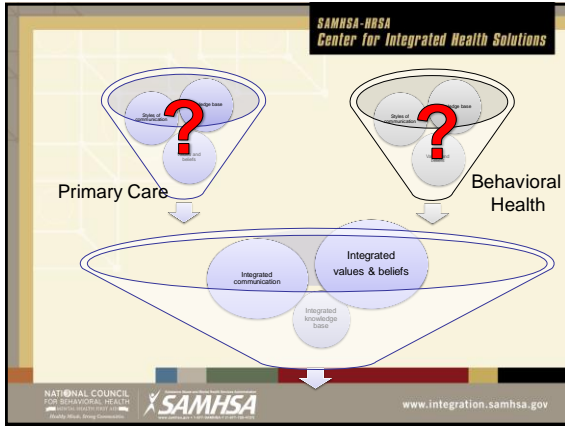
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Core perspectives that shape our understanding of our work, our patients and of ourselves.




Professional Culture

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Mr. W



* This man does not necessarily have a mental illness

Mr. W is a 46yo man with severe diabetes seen in the Integrated Clinic for schizophrenia. Each time he visits the Clinic he talks about his legal struggles to get visitation rights with his 2 year old daughter. There are also tensions with his manager on the job.

Source: footage.shutterstock.com

Mr. W

The PCP has tried for 6 months to initiate appropriate medical therapy to control the diabetes and reduce his cardiac risk. Results are disappointing.

The PCP calls the Case Manager to report non-compliance...

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Mr. W

PCP: *Mr. W worries me. He is at high risk for a heart attack. He should be on about 5 medicines, including an aspirin, to reduce his risk. It's been 6 months and he's STILL not taking even ONE medication regularly. Can you help get him on track?*

CM: *Mr. W says he's doing OK off medicines. He has a court date next week so that he can see his daughter. He's very worried about losing his job and not being able to pay child support. We discussed his treatment goals last week and 'preventing heart attack' is pretty low on his list of priorities.*

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Mr. W : What's at stake?

**EXPLANATORY MODEL
VALUE SYSTEM**

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Mr. W : Explanatory model / Value system

PC Lens	BH Lens
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Mr. W : Explanatory model / Value system

PC Lens	BH Lens
Disease management	Recovery model
Saved lives	Meaningful lives
Clear goals to	Lifelong aim toward
<ul style="list-style-type: none"> Reduce risk Prevent decline in function Minimize suffering 	<ul style="list-style-type: none"> Independence Community engagement Planning for relapse
Patient stays patient	Patient → Consumer

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Mr. W (cont.)

PCP: OK, so Mr. W has a lot on his plate... But, studies show that someone with his risk profile is highly likely to have a heart attack within 5 years! If he could get his A1c below 7 and his LDL cholesterol less than 100, we could halve that risk. I sure hope he doesn't end up in the ED!

CM: I think he'll be OK. He's come such a long way! Over the past 5 years he has stopped using cocaine, gotten a job and stayed on his medications! I remember when I visited him in Crisis after trying to fly off a bridge...

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Mr. W (cont.) : What's at stake?

TREATMENT FOCUS

RISK

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Mr. W (cont.): Treatment focus & Risk

PC Lens	BH Lens

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Mr. W (cont.): Treatment focus & Risk


PC Lens	BH Lens
Focused Clinical guidelines Professional standards Research-based Quantitative outcomes Reputation Liability	Broad Individual Treatment Plan Consumer-driven Experience-based Qualitative outcomes Social determinants Suicide

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Ms. Y

Ms. Y is a 42 year old G5P2, unemployed woman seen in the Integrated Clinic for major depression and PTSD. She tells the triage nurse that she has been having pelvic pain for 2 weeks.



*This lady does not necessarily have a mental illness

Source: www.photocase.com

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Ms. Y

The PCP instructs the nurse to ask Ms. Y to disrobe and prepare for a pelvic exam.

The head nurse stops the PCP at the door of the examination room...

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Ms. Y

Nurse: Doc, you can't just go in there and examine her! The nurses haven't been trained. There's no policy.

PCP: #!\$%# The nurse just needs to hand me the instruments I ask for. I'll walk her and Ms. Y through it.

Nurse: Doc, you're going to penetrate her body. We don't know where she's been, what she's experienced, how this could make her re-live that experience! And, Doc, that nurse has been giving Ms. Y injections for 6 years and has never seen her undressed.

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Ms. Y: What's at stake?

GUIDING PRINCIPLE:
First, do no harm

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Ms. Y : First, do no harm

PC Lens	BH Lens
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Ms. Y : First, do no harm

<p>PC Lens</p> <p>Physical exam is essential Physical exam is a ritual Touch is part of healing Standard approach Facilitates documentation Defensible in a court of law</p>	<p>BH Lens</p> <p>Physical touch crosses boundaries Physical touch carries risk Avoid re-traumatization Sensitive to triggers Adapt to consumer</p>
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Ms. Z

Ms. Z is a 68 year old woman with bipolar disorder, depressed type, and anxiety disorder.

She also has diabetes and Hepatitis C and has been followed by the PCP in the Integrated Clinic for over one year.



*This lady does not necessarily have a mental illness

Source: OLLYSHUTTERSTOCK.COM

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Ms. Z

At her initial visit with the PCP, Ms. Z complained of new-onset tearing chest pain while mowing the lawn. The PCP sent her urgently to the ED to rule out aortic dissection. Work-up was negative.

Over the next 12 months, Ms. Z developed numerous symptoms suggestive of life-threatening medical emergencies. Each time the PCP would respond immediately and aggressively pursue work-up, ... which was always negative.

Over the same period, Ms. Z's mental health also declined, resulting in multiple voluntary psychiatric admissions.

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Ms. Z

PCP: *She's got medical problems, but they're not going to kill her. This downward spiral is clearly psychiatric!*

Psychiatrist: *She calls you because you react.*

PCP: *Right. Well, maybe I'll schedule her out 3-6 months instead of monthly, as I have been doing.*

Psychiatrist: *She may think you have abandoned her...*

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Ms. Z : What's at stake?

CLINICIAN'S ROLE

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Ms. Z : Clinician's role

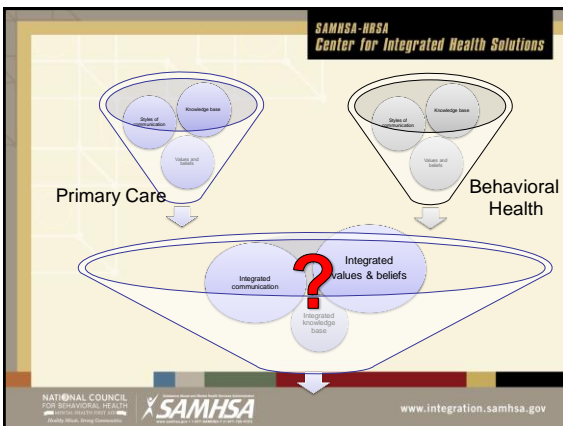
FLEXIBLE BOUNDARIES	FIRM BOUNDARIES
Empathy, compassion	Professional distance
Open access	Neutrality
24-h communication	Mutual accountability
Shifting roles	Consistent role
Self-knowledge	Self-reflection
Overwhelming	Exhausting

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HOW TO DESCRIBE AN INTEGRATED PROFESSIONAL CULTURE?

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Integrated Professional Culture

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Discussion and Q&A

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Headline goes here

Subhead

- Bullet Point 1
- Bullet Point 2
 - Line 1
 - Line 2
 - Line 3

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Opening statement, Line 1



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