Commentary on the Clinical PH-BH Curriculum slides

Some over-arching comments about the clinical curriculum. The slides, which are generally pretty good (and some modules are excellent), are primarily (a) solely informational, and (b) seemed to lack any reference to the context of the typical social work courses in which they might appear. These two issues are serious limitations.  Many curricula that have remained on the shelf because of these omissions.

WHERE/WHEN/FOR WHOM THE MODULES CAN BE USED.  This is important information for faculty.  Curricula designers need to be creative in suggesting to faculty which modules or module sections could be integrated into which courses.  Are these modules directed to BSW or MSW students and if MSW students, at what point in their education (first year required courses or second year electives).  Are they for students specializing in addiction work, students interested in careers in the health field, or all social work students.  Faculty perceive the curriculum to be crowded already and often do not want to include more unless curriculum designers can show them, “Here are ways you can meet the learning objectives of this particular course by teaching this particular material.”

Students also need to understand in what way this information fits into their overall learning or learning in a particular course.  The modules were lacking introductions that said, “Here is why this material is important to your learning in this particular social work course.”

CLASSROOM EXERCISES AND SKILL PRACTICE TO INTEGRATE AND APPLY KNOWLEDGE.  Curricula that address knowledge issues alone are much less effective than curricula that have frequent exercises and skill practice built in.  Many curricula designers say that they will rely on the skilled faculty who use the modules to build in these elements.  Faculty (except for a highly dedicated few), believe they do not have the time to develop creative ways to integrate interactive elements.  They need to be given specific classroom exercises and role-plays (client-worker scripts) which they can modify to meet the needs of their students. If these are lacking, the curriculum has very limited utility.  The authors might consider making less use of role play, the traditional social work "practical" learning activity. Medical education, nursing, physician assistants all learn through standardized or simulated patients. Integrating simulated/standardized patients into the clinical curriculum could make this the next 'up and coming'/innovative way to train our social work students on basic interaction skills and foundational therapeutic skills

I'm attaching an article that is being published in the forthcoming issue of CSWE's Journal of Social Work Education. This is a study of incoming and graduating MSW students in several NE schools (N>900 students; 78% of the student body) looking at their knowledge and attitudes concerning working with substance abusing clients. What's interesting and VERY DISCONCERTING is that graduating students who had not had a course on substance use/addiction or placement in this area, became LESS interested in working with this population, in comparison to incoming students. The importance of formal education on this topic in MSW programs cannot be overestimated.

"Special populations" are not described, the challenge of integrating care are profound and specific for women, people with disabilities, children and adolescents, and older adults. Adolescent substance use disorder is not addressed nor are other population groups that are also often overlooked. It is important to train students in best practices for groups that are often overlooked by the traditional medical establishment.  Given that addiction and mental illnesses generally develop/manifest in adolescence, it would be useful to have part of one section of the curriculum focused on prevention as well as early identification and treatment of adolescents.   It is very important to show the current state of evidence on prevalence, prevention, identification and treatment in adolescent substance use and mental health.   Mapping for students how as a society we are addressing and trying to reduce the burden of disease of adolescent substance use and mental is foundational.   The curriculum might speak to the gaps of evidence in the area of adolescent substance use.   The lack of randomized control trials on the association between screening and brief intervention and outcomes. The mixed evidence of the reduction in negative outcomes for adolescents (deaths from motor vehicle accidents, fewer days drinking or using drugs) except for the Stephens 2002 study.  A recent article by Mitchell, 2013 does a nice job of reviewing this literature. With regard to substance use issues, this is a problem to not address special populations. A huge issue in substance use integration is high risk substance use (not dependence or addiction) and misuse of psychoactive medications. There is little about prevention and wellness, health promotion that emphasizes risk and resiliency factors, the Adverse Childhood Events studies and other research on childhood, adolescent and adult traumas as contributors to increased risk of mental illnesses and addictions, and to a variety of medical conditions. There are many medical/behavioral health co-morbidities that could be addressed such as eating disorders, weight and nutrition/exercise management, domestic violence, and **tobacco**!!! The section on medication does not address agonist and/or antagonist drugs that are useful in the treatment of substance use disorder.  I would argue that integrated care settings are among the most appropriate settings to provide and monitor medication(s) for substance use disorder.  The relationship between chronic pain and opioid use disorder should also be addressed.   Case examples should explicitly include examples of substance use disorder as chronic with episodic relapse.

Module 1

Slide 4: Integration occurs as the capacity of primary care to seamlessly provide medical and behavioral health care as the patient needs, without setting up barriers that make it difficult for patients to get their needs met.

 Suggest skipping slides 7 to 16. Clinical social work students should know what mental illness and addiction are.

Slide 17 -20 are very important, the crux of the whole module – that BH patients are coming into primary care, and are not getting treated.

Slides 21-28 are interesting, but they don’t specifically point to why PH-BH or the role of social work.

Slide 31 There is a statement that the model has to include a team approach. That’s the common model, but is there strong evidence that it must include team care? When a rural/frontier physician practices in a single practice but has telemedicine consults, isn’t that integrated? Or an internist or family practice physician or PA treats the patient and family. That could be integrated as well.

Module 2

Generally quite good, but there is an awful lot of material to cover in one session. Group activity (slide 47) may be difficult for students who have not had experience in medical settings to understand or appropriately respond.

Module 3

Generally quite good. Hard to imagine getting through all of this material in one class session. Take care in Slides 14, 15, 17 that you mention substance use, too. Or addiction or use the term “behavioral health” rather than mental health.

The process recording (slides 22 and 23) is the kind of case that comes into a university counseling office, maybe the student health clinic. It’s not all that much like the typical case that comes into primary care. Take, for example, a role play like this. With a partner, practice giving feedback, alcohol education, concern and advice and referral to treatment if necessary. One person will act as the health professional who has administered the AUDIT. Your partner will act as a patient in a primary care setting who scored a 7 on the AUDIT. Patient: You are a 35-year-old pregnant woman (or husband of a 35-year-old pregnant woman), who called the health professional with concerns about feelings of stress, depression. You are concerned about the financial stresses of the new baby, your 2 other young kids and child care. If asked about your alcohol use, you might say something like: “I stopped going out to drink with my friends as soon as I found out we were pregnant. Sometimes I will have a glass of wine, never more than 2 at night but not very often. I heard that wine is okay. I don’t smoke, I don’t do drugs, and I wouldn’t do anything that would harm the baby.”

In slide 71, it might be useful to have students observe a role play that shows patients in various stages of change and interactions with counselors. I’ve pointed to one, there are undoubtedly many others that are better. <http://www.youtube.com/watch?v=wcu8oqHIsbc>

Module 4

Very good, well designed presentation – but could not be given within one class session.

Module 5

Recommend use of the AUDIT and AUDIT-C (perhaps as supplement to the NIDA one question). Not clear that Assessment module fits the PH-BH – it does not talk sufficiently about how assessment in primare care practice is different from social work assessment in any other settings. What makes it integrated care? How is assessment different, reporting results different, time available and priorities are different? If included, Module 5 would go after Module 6, which is screening, which logically preceeds doing a full assessment.

Module 6:

Slide 4. Valid Reliable Brief Public domain Free Multiple languages Multiple ways to administer (verbally, in person or over the phone, on paper or online) Widely used in the U.S. and worldwide Identifies unhealthy and dependent drinking patterns Results guide treatment Monitors change in use Fits with other screeners

Slide 12. Don’t use the CAGE Aid, use AUDIT, DAST, CRAFFT. Also, what are you recommending for PTSD, IPV, tobacco?

Slide 15-28 Totally unclear why it is necessary to go into the DSM-IV TR when we have DSM V coming out, and whether this fits in a PH-BH course – isnt this basic material for a mental health or behavioral health survey course, not for a PH-BH course.

Slide 29 for the group exercise, it is probably more helpful to give students some roleplay. We use Role-play #1: Partner with someone to practice some of the techniques that you are learning. For this situation, one person will act as the health professional using the three questions of the AUDIT-C, and one person will act as the patient who has come to the clinic seeking help for some bothersome problems. Use the blank AUDIT-C on the following page to complete the role-play.

Patient: You are a 21-year-old woman being seen for an annual exam. You drink with your friends at parties and to socialize. If asked, you might say something like: “A lot of my friends and I go out and drink on the weekends, maybe on Thursday nights too. I don’t want to stop hanging out with my friends, but I have blacked out a couple times and am worried. My parents would kill me if they knew how much I am drinking

Module 7

Pretty good. Would be useful to describe how the SW would work with primary care with more of the common medical conditions (slide 3).

The 5As have been abbreviated by the tobacco guidelines people, now focusing just on Assess, Advise, and Arrange. Other parts take more time than typically available

Module 8

I have doubts about the specific utility of this module unless it is more specifically tied to PH-BH.

A bit jarring is the 5As showing up in slides 19 and 20. The examples do not specifically show the tie into culture and PH-BH.

Module 9

Alternative case study of medication :

Mrs. R is 48 year old woman who presents to your office for an initial visit complaining of chronic low back pain and requesting an opioid pain medication refill. She has a history of lubosacral (LS) spine degenerative joint disease (DJD) and severe scoliosis/kyphosis for which she has been treated with long-acting oxycodone 40mg twice daily (BID) and oxycodone/acetaminophen 5/325mg (approx 4–6 tablets throughout the day as needed). She states that a pain management physician set the regimen, which improved her ability to take care of herself, although she still hasn't been able to reach her goal of returning to work. As per the patient, the pain management physician told her she should follow-up for continued medication with her primary care provider. She has had frequent visits with other providers at your clinic during the past several months, including walk-in visits for opioid medication refills. She states that she's "not an addict," and is quite upset that she's been sent from physician to physician who are reluctant to prescribe enough medication, giving her only 30 tablets of oxycodone/acetaminophen at the last visit which is running out. She is requesting 180 tablets to make it through the month. Without medication, her pain is 9/10 constant, sharp, and non-radiating. Currently her pain is 5/10, which she describes as tolerable. On physical exam, she is ambulating normally, but has some apparent discomfort when getting onto the exam table. She has point spinal tenderness and mild paraspinal tenderness without spasm around the LS region. She has moderate scoliosis/kyphosis, and a normal straight leg raise and neurological exam. A previous MRI 6 months ago demonstrates DJD in the LS region with foraminal narrowing at L1-2

Exert caution with using the term “mental health” exclusively, as in slide 3, slide 5, 20 – the co-occurrence of menta l illness, addiction, risky substance use, tobacco use, and misuse of prescription opioids and other psychoactive substances is endemic in primary care practice.

Slide 17-18 may be useful to mention children and adolescents frequently prescribed psychoactive medications, taking other drugs, alcohol, tobacco, etc. There is almost no attention to children and youth in the whole curriculum. Worth putting in something, especially around medications.

Slide 19 – include anticraving medications, opioids and other analygesics, psychostimulants such as amphetamine for ADHD.

Module 10

I found the entire module did not fit well into PH-BH. Fine for describing how to do care planning. But what’s unique to PH-BH. How to provide minimum necessary information that fits in the style and pace of PH electronic health records, HIPAA mental health notes exceptions – what to put in the medical chart and what to keep separate? Slide 42 is good on this issue.

Module 11

Pretty good, would benefit from IMPACT and SBIRT put earlier in slide deckk so that you are demonstrating these two evidence based practices, rather than burying them at number 12. Describe how to use the results from PHQ-9 and AUDIT for directing care and for monitoring impact of care.

Other examples of evidence informed treatments on slide 17 – include IPV, PTSD, adolescent substance use.

Module 12 and 13

Alternative Role Play:

**Role-play:** Partner with two other participants to practice some of the techniques that you are learning. For this situation, one person will act as the health professional who has administered the AUDIT and determined, based on an AUDIT score of 17, that the patient is at moderate risk of experiencing alcohol-related problems. One person will act as a patient who has come to the clinic seeking help for some neck pain. The health professional will practice providing a motivational brief intervention and referral to this patient. The third person will act as an observer and rate the health professional on the MI skills used. Refer to the completed AUDIT on the following page to learn more about the patient’s drinking patterns.

**Patient:** You are a 64-year-old x-ray technician who drove your car into a ditch over the weekend. You called the clinic because you are concerned that the crash could be causing you neck pain. You just recently moved to the area due to problems you have had in the past, some involving alcohol. If asked to talk about your life, you might say, *“I don’t really feel like talking about it. I’ve had a hard life, and I’ve had to fight hard for everything, and then I just lose*. *People keep taking things away from me.”* By that, you mean your kids. Your ex-husband took custody of your children when you got divorced 15 years ago, and ever since then, you have been in a downward spiral of mean men and little self-confidence. Although you are reluctant and do not think you drink a lot, you admitted during the screening that you drank two glasses of wine over a three hour period. You actually drank 2 glasses of wine and a ½ pint of gin.

**If Asked About Pros & Cons:**

**PROS:** It helps you escape and numbs the pain that you have to keep inside all day during your shift. Then at night, when you get home, *“I open up the cabinet and I feel the sadness lift as I pour my first glass and then another and another.”* It’s all you’ve got right now.

**CONS:** This accident is a bit of a wake-up call. You want to work at least a few more years before retiring and an injury would prevent this. **If pressed for more cons:** You know that alcohol has caused you some problems in the past, and you don’t want them repeated. You also lost your mother and father to alcoholism and you don’t want to die alone like them. You have some new friends from work and you want to make a good impression on them, which the alcohol does not help with.

**When Asked About Your Readiness:** You think that your readiness is about 3 out of 10. It’s not a 1 or a 2 because you don’t want to jeopardize your remaining work years, and you know it’s holding you back from hanging out with your new friends when they invite you out.

**If the Health Professional suggests Plan/Next Steps:** You feel like you can cut back whenever you want. You’ve already made several changes in your life, and you’re not sure making any more at this point in time will help. **If pressed:** You have a history of depression and talking to the health professional reminded you of your old therapist back when you were going through the divorce. Getting all this stuff off your chest has helped a little. You ask the health professional if there’s anybody you can get in touch with to arrange an appointment with a therapist.

Alternative role play for Rolling with Resistance:

Partner with two other participants to practice some of the techniques that you are learning. For this situation, one person will act as the health professional who has administered the AUDIT and determined, based on an AUDIT score of 16, that the patient is at moderate risk of experiencing alcohol-related problems. One person will act as a patient who has come to the emergency department seeking help for some bothersome problems. The health professional will practice providing a cognitive behavioral brief intervention with this patient. The third person will act as an observer and rate the health professional on the CBT skills used. Refer to the completed AUDIT on the following page to learn more about the patient’s drinking patterns.

**Patient:** You are a 26-year-old in the emergency department because you recently injured your arm. You work as a customer service representative at a bank, and your performance has been slipping over the last 3 or 4 months. You were living with your boyfriend/girlfriend, but caught him/her cheating on you. So, you moved in with your mother and father, who are not too happy about you being there. You were blowing off some steam with friends a few nights ago, and when they found you, they insisted you come to the hospital. You drink 1 to 2 beers during the week and up to 4 drinks on most weekend nights. You also sometimes smoke pot on the weekends too but only if a friend has some. You think this kind of drinking is the “norm” for most people your age.

**If Provider Asks About Pros & Cons:**

**PROS:** Everyone you know drinks like you do; it is a part of your social life. You enjoy the slight buzz you get when you drink, and it especially feels good after a long week of work. It helps you to have fun and forget about all your work.

**CONS:** At first, nothing you can think of. **If provider prompts you about regrets:** You admit that you blacked out when you injured your arm and are not quite sure what happened. You are lucky you did not hit your head. You concede that it was probably the alcohol that made you black out.

**When Asked About Your Readiness:** You identify yourself as a 2 on the Readiness Scale and feel that there is not really a need to change your behavior. **If provider asks “why not 1?”**: You do not want to black out again. You are pretty confident that if you want to change in the future, you will be able to do it on your own.

**If the Health Professional suggests a Plan/Next Steps:** You do not really feel that drinking is a problem, but you agree that maybe drinking so much that you black out is not a good thing. So you agree to try to drink less,

These are good. I am unsure whether this emphasis on MI specifically fits with PH-BH. I realize that we use it a lot in IMPACT and SBIRT, but it does not seem restricted to PH settings. Are these two modules better fit into a clinical social work class rather than in PH-BH, or could examples be made specific, referencing PH conditions and situations.

Module 14

Interesting, but really need to show how this fits into PH practice. Especially, how does it fit with patient flow, medical model of care, billing and coding. How is it going to be paid?

Module 15

Very important module. Should include more on the principles and examples of medical record entry principles. Separate medical records for behvioral health or integrated. Examples of charting and performance measurement for evidence based practices such as IMPACT and SBIRT. Privacy and confidentialiity are very important but not well discussed (they are well discussed in module 3 of the policy course slide 31 and after). More needed on the specific measure (meaningful use) used in PH – PCPI, HEDIS, P4P, and how to move the measures. More on billing and reimbursement for services – how do you code and what is the likelihood of reimbursement.

Alternative class assignment:

The current assisgnment is not directly relevant to PH-BH integration. Better to give the social worker the challenge, if you want to stay with HEDIS, that the primary care group practice in which she is working has had consistently poor HEDIS scores on antidepressant medication management. They do a good job getting patients to start using, but are not doing well on continuity of medication use and having sufficient number of visits. How would the social worker change practices so that the HEDIS numbers improve rapidly? This would be a real world problem with some real world applicability -- not pretending to be a CEO of an MCO. The MCOs have not been very successful in moving the HEDIS numbers, so what could the student expect to do? But moving the numbers at a clinic level, that's possible. Alternatively, what could be done at the clinic level to improve the substance use initiation and engagement measures?