Adventures in Integrated Care

This *Monitor on Psychology* series showcases psychology practitioners who work on a variety of health-care teams, reporting on what these practitioners do and how they got the education and training to do it.



AMERICAN PSYCHOLOGICAL ASSOCIATION

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DEAR MEMBER,

Improving the health of people requires that they have access to effective and efficient psychological services for the prevention and treatment of a wide range of emotional and behavioral conditions. Psychologists are actively involved in clinical treatment, health system design, and the implementation of innovative approaches to health care.

To illustrate this important connection and promote the valuable role psychology plays in health care, the *Monitor on Psychology* published Adventures in Integrated Care, a yearlong series of articles that showcase psychology practitioners who work on a variety of medical teams, reporting on what these practitioners do and how they got the education and training to do it.

Now we are making a collection of these articles available to you. In addition, we've included links to excellent APA resources, briefs, videos, CE classes and the APA Center for Psychology and Health, so you can take advantage of all that APA offers in this field.

Moving into the future, look for more collection booklets from APA as a basic part of your membership. In the interim, please enjoy these articles.

Best,



W. DOUGLAS TYNAN, PHD, ABPP
APA Director of Integrated Health Care and Acting Director, Center for Psychology and Health

A TRANSPLANT PSYCHOLOGIST

Jared L. Skillings is an integral part of an organ transplant team.

BY REBECCA A. CLAY

Jared L. Skillings, PhD, is a second-generation psychologist, but his practice couldn't be more different from his father Ralph's. While his dad owns a private practice in rural Ohio, Skillings spends his days with heart, lung and kidney transplant patients as part of a $5 billion health-care system with 2,075 beds and more than 23,000 employees. Skillings conducts presurgical psychological evaluations of adults who need heart or lung transplants and children who need kidney transplants at Spectrum Health System in Grand Rapids, Michigan. He's also director of behavioral medicine there, with a goal of getting a behavioral health professional into every department in the system.

That's starting to happen. In 2011, just before Skillings joined the system, Spectrum had just four psychologists, a social worker and a psychiatrist. By the end of 2016, the system expects to have 46 behavioral health providers, including 27 psychologists and psychology trainees. Some provide traditional psychological services, such as treatment of post-traumatic stress disorder, while others are embedded in various medical clinics — sleep, pain management, geriatrics, neurology and more.

Skillings wants patients to have the option to see a psychologist whether they enter the system for a mental health problem or a medical problem, be it a heart attack, diabetes or anything else. His dream is that behavioral health becomes as ubiquitous within the health system as Starbucks is everywhere else.

"If you go to the grocery store, Starbucks is there," says Skillings. "Is Starbucks the reason you go? No, but it adds huge value."

EVALUATING TRANSPLANT PATIENTS

Spectrum used to outsource its behavioral health care. "Then the organization started looking at the data and saw that integrated care was superior in terms of outcomes and cost savings," says Skillings, who became the system's inaugural director of behavioral medicine in 2012.

He trained as a generalist while earning his doctorate in clinical psychology at the University of Toledo. But while he was on internship at the Jackson Memorial Hospital/University of Miami Medical School, he fell in love with integrated care. "You don't have to become a specialist right out of the gate," he advises. "There's some benefit to having a broad range of experience before you get into one of the integrated-care specialties."

At Spectrum, Skillings's original one-day-a-week work with the transplant team has grown into a full-fledged specialty, thanks to the growing demand for organ transplants.

His goal is to gauge whether the patient is a good candidate for a transplant based on his or her psychosocial stability and how likely he or she is to adhere to medical directions. Transplant patients, for example, need to be able to comply with as many as 40 medical tests and appointments before a transplant and complex medication and lifestyle regimens afterward. Most transplant programs won't give transplants to nicotine users, so would-be patients must stop smoking and get themselves in shape. And because Spectrum requires transplant patients to have someone who can care for them at home 24/7 for at least a month after the operation, patients must also have good social support.



CRAIG VAN DER LENDE

Dr. Jared Skillings conducts presurgical psychological evaluations of adults who need heart or lung transplants and children who need kidney transplants.

Skillings also evaluates pediatric patients who need kidney transplants. With living donors, presurgical evaluations are even more complex as two different behavioral health providers must be involved — one to evaluate the child and the other to evaluate the would-be donor. It's just as important to take care of the living kidney donor as the child, says Skillings. "These kids are adorable; they're sick; and people feel bad for them," he says. "We need two providers so that the whole evaluation is objective."

Unlike many psychologists in integrated settings, whose work is fast-paced, Skillings has the luxury of spending a longer time with patients as he assesses whether they're appropriate candidates for transplants. "Unless it's a life-and-death situation, I have plenty of time to evaluate a patient and help him or her come to terms with the need for a transplant," he says.

Skillings also provides post-transplant support. "If the transplant doesn't go as well as expected or the patient is struggling to adjust after surgery, I go in and provide cognitive-behavioral therapy or other interventions," he says. Occasionally, a transplant patient will have concentration or memory problems and require cognitive screening or neuropsychological assessment.

The medical staff has reacted positively, says Skillings. "They're thrilled to have us there," he says.

That's because patient outcomes improve. In a 2015 article in the *Journal of Clinical Psychology in Medical Settings*, Skillings and co-author Amber N. Lewandowski presented a case study demonstrating how psychological assessment and interdisciplinary care helped a lung transplant patient thrive. Skillings helped the patient address the issues uncovered during his evaluation, including anxiety, marijuana use, problems with adhering to medical recommendations and the lack of a plan for postsurgical care. After his 2014 transplant, the patient was able to return to hiking and traveling, favorite activities he hadn't been able to enjoy for years.

As for Skillings's dad, he has been fascinated by how psychology has been transformed over the years, Skillings reports.

"Back in his day 40 years ago, you either went into academia or private practice," says Skillings. "These integrated care opportunities didn't really exist." ■

IMPROVING COMMUNICATION

Lauren N. DeCaporale-Ryan is embedded in the health-care team to interact among providers and patients

BY REBECCA A. CLAY

Geropsychologist Lauren N. DeCaporale-Ryan, PhD, works at the University of Rochester Medical Center, but her focus isn't on patients.

Instead, she focuses on the physicians, surgeons and other clinicians who care for them. As an assistant professor embedded in the psychiatry, medicine and surgery departments, her job is to improve care by helping health-care providers communicate more effectively with patients, families and each other.

"My role is different from that of anyone else I know in psychology," says DeCaporale-Ryan, who earned her clinical psychology doctorate from the University of Missouri–St. Louis in 2011.

DeCaporale-Ryan spends her day doing rounds with individual clinicians or teams, observing surgeons, physicians and other clinicians as they interact with patients. With each physician/patient encounter, she tracks a series of behaviors, such as how they greet patients and even whether they smile. She then provides immediate feedback or follows up one-on-one to tackle problems.

Interactions between surgeons and patients typically last less than three minutes, so DeCaporale-Ryan teaches surgeons how to be warmer so patients don't feel they're just a number to be checked off. With physicians, whose interactions last longer, the goal is to boost efficiency so they don't get burned out by day's end.

"In surgery, I'm encouraging people to slow down," says DeCaporale-Ryan. "In medicine, I'm encouraging them to speed up."

DeCaporale-Ryan suggests, for example, that physicians ask patients about their concerns at the beginning of sessions to avoid the common problem of patients bringing up new topics just as physicians head out the door. With a physician who never smiled, DeCaporale-Ryan suggested that he build on his natural tendency to incorporate touch — shaking hands or patting patients on the shoulder — in every encounter. "He observed for himself that this was quite effective," says DeCaporale-Ryan. "Patients were responding to him more warmly."

She also teaches physicians how to communicate with each other more effectively. With a grant from the Institute on Medicine as a Profession and the Josiah Macy Jr. Foundation, DeCaporale-Ryan, APA President Susan H. McDaniel, PhD, and an educational psychologist are helping surgical faculty give more constructive feedback to residents and to each other.

To go into the operating room and operate on another human being, you have to be able to separate yourself from your feelings, says DeCaporale-Ryan, adding that surgeons' focus has always been on technical expertise rather than interpersonal communication skills. Surgeons must often act quickly in the operating room, limiting the opportunity for constructive communication and occasionally resulting in their shouting directives at residents, she says. Residents sometimes express frustration that surgeons are inconsistent when it comes to following up with them about how they could or should have navigated something differently in the operating room or in patient care delivery. The new faculty development project will teach surgeons how to determine when and how feedback is best delivered to improve the learning environment.



STEPHEN S. FEARDON

Within integrated-care environments, there's not as much stigma against mental health care, says Dr. Lauren N. DeCaporale-Ryan.

DeCaporale-Ryan is also working to ensure that clinicians communicate with families, who are often ignored. "Ninety-nine percent of the time it's not on purpose," she says. "It's a sense of urgency, feeling rushed."

In another project, DeCaporale-Ryan and colleagues will help clinicians function better on teams. Funded by the university's Institute for Innovative Education, the project will feature a physician, social worker and nurse practitioner training interprofessional teams as they care for actors posing as patients.

Another priority for DeCaporale-Ryan is preventing burnout among residents. "If you have burned-out physicians, they're not effectively caring for patients," she says. She and her surgical colleagues are launching a wellness program that will offer social activities outside the hospital, information on financial planning and healthier snacks in resident lounges.

DeCaporale-Ryan also sees some patients of her own — primarily older adults — in the hospital's family medicine program, where she did a two-year postdoctoral fellowship. She doesn't just get referrals from this primary-care setting. Thanks to her work with the surgery department, many patients are referred to her by surgeons.

"What family medicine has long done quite well and surgery has begun to catch on to is that it's useful to have a team of people working with a patient or family rather than trying to take on all their needs alone," says DeCaporale-Ryan.

At Missouri, she says, older adults preferred to use primary-care clinicians, religious resources or support groups rather than the university's community clinic. DeCaporale-Ryan saw a different model during her internship at the Central Arkansas Veterans Healthcare System, which included a rotation in which an entire team provided home-based primary care.

"I recognized that to provide effective care for geriatric populations, the setting needed to be integrated," says DeCaporale-Ryan. "With integrated environments, there's not so much stigma and they can more easily access care." ■

A REHABILITATION PSYCHOLOGIST

Angela Kuemmel helps veterans with spinal cord injuries lead full lives.

BY REBECCA A. CLAY

Angela Kuemmel, PhD, has firsthand experience with the same kind of injuries her patients in a Veterans Affairs (VA) spinal cord injury center have. At a high school swim meet in 1996, she dove into a pool, injuring her spinal cord. She has used a wheelchair ever since.

Today, Kuemmel is a staff psychologist specializing in spinal cord injuries and disorders at the Louis Stokes Cleveland Veterans Affairs Medical Center. Like many rehabilitation psychologists, she does psychological evaluations, individual therapy and group therapy for both newly injured veterans — most of whom were injured stateside — and those with chronic problems.

But she also collaborates with VA physicians, physical therapists, nutritionists and other clinicians to ensure that her patients receive comprehensive care that addresses all their needs. When veterans with spinal cord problems come to the VA for their annual check-ups, for example, she is part of the team that assesses their overall well-being. She has also pioneered a telehealth program on pain management that involves an occupational therapist and a physical therapist, plus a weight-management program that involves a physical therapist and nutritionist.

"For people with spinal cord injuries to have a high quality of life, it takes a village of teamwork to make that happen," says Kuemmel, who received a 2014 APA presidential citation for her leadership of and advocacy for early career psychologists.

As part of the team approach to care, Kuemmel might consult with a physician and then help a patient understand his or her medical problems and how to manage them. Or she might tackle a medical problem directly by persuading patients with pressure ulcers to get out of their wheelchairs and into bed — something many are reluctant to do. "For some people, life stops if they can't be up in their wheelchair," she says.

She also serves as a liaison between her team and healthcare specialists. After a referral to a neuropsychologist, for example, she presents the results to her team and helps them interpret the recommendations.

"I feel very valued and very well-utilized," says Kuemmel, who works alongside another rehabilitation psychologist plus a psychology postdoc and intern. "Our input is highly sought after."

"For people with spinal cord injuries to have a high quality of life, it takes a village of teamwork to make that happen," says Dr. Angela Kuemmel, who received a 2014 APA presidential citation for her leadership of and advocacy for early career psychologists.

Kuemmel has launched some specialized interdisciplinary programs. One is the telehealth program on managing chronic pain. The 18-week program is designed for patients who have trouble getting to VA facilities because they live too far away. The program covers such topics as relaxation strategies and chronic pain's impact on relationships. A physical therapist talks about how pain affects participants' physical functioning, while an occupational therapist teaches the participants yoga.

Kuemmel also runs a weight-management program for patients with spinal cord injuries with a team that includes a nutritionist, physical therapist and recreational therapist. The 12-week program starts with the team evaluating patients, then providing individualized fitness and nutrition plans. Kuemmel helps participants set goals, curb emotional eating and overcome barriers to weight loss.

This kind of integrated care is nothing new for the VA, says Kuemmel, who points out that a psychologist has been part of the spinal injury center for decades. It's also familiar to Kuemmel.



LLOYD WOLF

"I feel very valued and well-utilized. Our input is highly sought after."

ANGELA KUEMMEL, PhD

While she earned her doctorate in clinical psychology from Nova Southeastern University in 2009, all her training in integrated care took place within the VA. She completed a rehabilitation psychology practicum at the Miami VA, her predoctoral internship in rehabilitation psychology at the VA Boston/Harvard Medical School and a postdoctoral fellowship in rehabilitation psychology at the James A. Haley VA in Tampa, Florida.

That training focused on team consultation, including building relationships with other kinds of providers, communicating effectively with those outside your discipline and sharing visits with patients. But another key skill is simply speaking up as a team member.

"Finding and using your voice in team meetings is important," says Kuemmel. "It's important to give both verbal reports to the team as well as documentation so they know what you're working on with a patient."

Kuemmel knows from her own experience that integrated care helps patients with spinal cord injuries. "I worked with a great team when I did my own spinal cord injury rehab 19 years ago," says Kuemmel, who also served as the public interest representative and chair for APA's Committee on Early Career Psychologists. "I definitely attribute that as one of the reasons why I am able to live successfully after my injury."

A FITTING FAREWELL

Kristen Dillon serves on an integrated-care team that provides veterans in hospice with a respectful, holistic and peaceful end of life.

BY REBECCA A. CLAY

When clinical psychologist Kristen Dillon, PsyD, learns about a behavioral or psychological issue faced by a veteran in the hospice unit, she checks in with the patient's integrated-care team. If someone is having trouble sleeping, for instance, the team will identify the most likely problems feeding the insomnia, which could be anxiety, symptoms of post-traumatic stress disorder (PTSD), family issues or the wrong dose or type of medication, to name just a few possibilities.

Then the team develops the treatment plan. Dillon might teach the veteran mindfulness and meditation techniques. The nurses might encourage him or her to be more active during the day and go to bed a little later at night, or to try reading or watching TV if he or she still can't sleep. The physician might check the medications to see if one or more might be provoking the sleeplessness.

"Everybody has a different piece of the puzzle, and we all have to put it together to benefit the veteran the best way we can," says Dillon. In addition to the psychologist, the team includes a physician, several kinds of nurses, a social worker, an occupational therapist, and a speech pathologist, as well as dieticians, documentation specialists, pharmacists, a chaplain and trainees.

Such teamwork is standard procedure for Dillon at the 14-patient hospice unit at the Edith Nourse Rogers Memorial Veterans Hospital in Bedford, Massachusetts. The hospital campus also includes several community living centers, some of which also have palliative and hospice care components. It's a great fit for her background, which includes a specialization in geropsychology from William James College, a research focus on alleviating caregiver stress, and a keen interest in the lives and stories of older people.

Veterans' challenges in the unit are, of course, significant. Medically, they may suffer from cancer, amyotrophic lateral sclerosis, the effects of Agent Orange or other serious conditions. Psychologically, they often face depression, anxiety and PTSD.

Team members create their own schedules based on team conferences and their individual professional roles. Dillon's schedule, for example, includes morning meetings with the team; psychosocial support meetings with veterans, their families and sometimes other team members; and individual therapy appointments with veterans or family members as needed. Similarly, nurses create their own schedules based on team discussions and on providing care related to veterans' activities of daily living, meals and medications, for example.

Dillon also leads the team in using STAR-VA, an interdisciplinary behavioral intervention used throughout the VA that is designed to help manage veterans' dementia-related behaviors. Features include minimizing the use of antipsychotic medications and using positive reinforcement and environmental and staff changes to make veterans' lives as comfortable as possible. For instance, Dillon might create a "pleasant events" schedule that involves supplying a veteran with relaxing music, arranging daily times for him or her to have conversations with staff, or even ensuring that favorite foods are a regular part of meals. With a veteran who is acting aggressively because of PTSD or dementia, she might discuss with staff the possibility of cutting down on the number of staff hovering around the patient or moving him or her to a quieter room.



Dr. Kristen Dillon is part of an integrated care team whose members also include a physician, several kinds of nurses, a social worker, an occupational therapist, a speech pathologist, dieticians, documentation specialists, pharmacists, a chaplain and trainees.

EVAN RICHMAN

In partnership with a social worker, Dillon also runs anticipatory grief and bereavement support groups for families and staff. And she oversees informal memorial services that allow staff to process their feelings about clients who have died in hospice — approximately 80 veterans in the 14 months since the unit opened in 2014.

Besides such structured activities, Dillon spends a lot of time fielding behavioral and psychological crises as they arise.

"I'm constantly on call," says Dillon, who also provides psychological services at several palliative care centers on the hospital campus. "I'll get a call from a physician or nurse in the hospice unit or one of the centers saying, 'This person is dying, can you come and be with their family?'"

Given the importance of teamwork with this population, one of her most important jobs is fostering relationships with and between team members, Dillon adds. In the beginning of her time at the hospital, for instance, she hung out in the nurses' station to learn about their rhythms, strengths and needs. Staff debriefings and memorial services for veterans who have died have also proven wonderful bonding opportunities, she has found.

Such activities are good for staff and especially good for those they serve, says Dillon.

"You're going to be working so closely together that you have to rely on each other," she says. "The only way to get a holistic view of the person, to have the greatest continuity of care, is to have everyone involved in discussing his or her needs and treatment. Our whole aim is to support veterans in having the best quality of life they can have at this time." ■

WORKING WITH AN ACCOUNTABLE CARE ORGANIZATION

Arnold D. Holzman and his practice are joining forces with hundreds of physicians.

BY REBECCA A. CLAY

Ask Arnold D. Holzman, PhD, how he sees the future of psychology, and he lays out a vision of psychologists working side by side with physicians in accountable care organizations — groups of health-care providers who come together to provide care for a particular patient population and enjoy bonuses for keeping their patients healthy. That's why Holzman quickly agreed when an accountable care organization called the Community Medical Group and asked his practice for help last year.

The idea behind the accountable care organization was to better serve patients in Connecticut's New Haven and Fairfield counties. But the several hundred physicians involved soon realized they couldn't go it alone.

"They kept coming back to the need for high-quality psychological intervention," says Holzman, co-founder and managing partner of Behavioral Health Consultants, LLC, in Hamden, Connecticut. "Many of the problems that bring individuals to physicians' offices, particularly primary-care offices, are psychologically based."

As a result, the accountable care organization turned for help to Behavioral Health Consultants, which has 11 psychologists and three master's-level clinicians on staff and subcontracts with other mental health professionals — about half of them psychologists — as needed.

Accountable care organizations are springing up in response to the Affordable Care Act, which is intended to improve care and reduce costs by encouraging reimbursement focused on the quality — not the number — of services provided. Physicians share accountability for the cost and quality of care delivered to a patient population, with insurers rewarding improved outcomes and lower costs. The organizations can not only develop their own treatment protocols but also share electronic medical records and back-office functions, such as billing and appointments.

Realizing that integrating medical and psychological services was key, Community Medical Group recruited Behavioral Health Consultants, whose providers already had relationships with many of the physicians in the organization, to provide the psychological services its patients need.

Behavioral Health Consultants and the accountable care organization are currently separate entities, but the two are discussing the possibility of co-located services. That way, says Holzman, patients will see psychologists as "a routine extension of their work with a doctor as opposed to something separate." He hopes that eventually his practice will be able to enjoy such benefits of integration as shared administrative and support services and electronic medical records, joint negotiations with payers, even profit-sharing. "This is a process that will take years," he predicts.

So far, the relationship consists of referrals.

"The problem with more traditional relationships, as many physicians have told us, is they'll often tell patients they should go see someone, but they don't know whom to refer them to," says Holzman. "And they don't know if they got there because there's no [follow-up] communication."

The physicians now tap Holzman and his colleagues when they suspect patients have emotional or behavioral problems that are impairing their health. One young man, for example, came to Holzman after tests could find no medical reason for his chest pain and other symptoms of a possible heart problem. The real issue turned out to be anxiety. "Once we reframed his symptoms as anxiety, we could approach the problem as a psychological one, not a medical one," says Holzman, who used cognitive-behavioral therapy to teach the man how to better manage the stressors in his life and the resulting anxiety.



IAN CHRISTMANN

Dr. Arnold D. Holzman is in discussions with insurers who may provide seed money for demonstration projects to show that adding psychologists' interventions keeps patients healthier. "They see our work as potentially reducing their financial exposure if patients get better sooner," he says.

But Holzman and his colleagues also assist patients with medical problems. In fact, they are developing the accountable care organization's protocol for treating patients who have diabetes along with depression, obesity or other problems, yet aren't following their physicians' recommendations. The protocol will lay out how referrals will be made, as well as guidelines for individual and group treatment and outcome measures so all of the providers can determine whether treatment is successful.

Holzman is also in discussions with insurers who may provide seed money for demonstration projects to show that adding psychologists' interventions keeps patients healthier. "They see our work as potentially reducing their financial exposure if patients get better sooner," he says.

He encourages other psychologists to get involved with accountable care organizations, either by developing relationships with physicians who are members of one or more organizations or by joining practices like his own that have already developed those relationships.

Holzman's background in pain management and health psychology prepared him well for working with an accountable care organization, he says. "When you're trained in pain management, communicating with physician referral sources is second nature," says Holzman, who earned a doctorate in clinical psychology from the State University of New York at Binghamton in 1981.

Such integrated care, he adds, is not only good for patients. It's also good for the bottom line. Because of the new relationship with the accountable care organization, Holzman anticipates substantial growth and expects to bring on many more clinicians and subcontractors.

"That's really the motivation here: to provide high quality service and be successful at the same time," he says. ■

A BARIATRIC PSYCHOLOGIST

Rachel Goldman helps patients understand that weight-loss surgery is only the first step toward a healthier life.

BY REBECCA A. CLAY

Psychologist Rachel L. Goldman, PhD, says she will never forget a young man who was so obese he couldn't even raise his leg a few inches off the chair while sitting in her office.

"The average person doesn't understand why people need bariatric surgery and thinks, 'Why can't they just go to the gym like I do?'" says Goldman, now the senior bariatric psychologist at the Bellevue Center for Obesity and Weight Management at New York's NYC Health + Hospitals/Bellevue and clinical assistant professor at New York University School of Medicine. "What I realized was that there really were morbidly obese people who couldn't take the usual recommendation of just walking to the mailbox."

That realization shaped Goldman's career. She got her first exposure to bariatric surgery during her internship at the Medical University of South Carolina (MUSC). After earning her doctorate in clinical psychology from Fairleigh Dickinson University in 2010, she did a postdoc specializing in obesity and bariatric surgery back at MUSC.

By restricting access to the stomach or simply removing most of the stomach altogether, gastric bypass and similar procedures help people lose weight by reducing the amount of food they can eat or how well they can absorb nutrients or both. According to the American Society for Metabolic and Bariatric Surgery, longitudinal research has found that most patients maintain significant weight loss — at least half of their "excess" body weight, or the difference between their current and ideal weights — over the long haul.

While any surgery entails some risk, for obese patients who haven't been able to lose weight through dieting and exercise it can be a medical necessity, says Goldman. In fact, bariatric surgery doesn't just help with obesity. According to a 2016 study in *Diabetologia*, bariatric surgery is a much more effective way to reverse Type 2 diabetes in patients with mild to moderate obesity than an intensive lifestyle intervention involving exercise, a dietician-directed diet and medication, for example.

The number of psychologists specializing in bariatric surgery is small, Goldman says, explaining that most hospitals simply refer patients to outside psychologists, who often lack specialized training. As in-house staff members, she and the center's other bariatric psychologist are part of a team that includes surgeons, physician assistants, nurse practitioners and nutritionists.

"Our work is very much built around the idea that we are a multidisciplinary team because we really need to all work together to get patients ready for surgery," she says.

Since joining Bellevue as its first specially trained bariatric psychologist in 2011, Goldman has spent her days evaluating patients planning surgery and helping to monitor their needs before and after procedures.

Goldman begins by going over patients' motives for having the procedure, their mental health histories and any symptoms, such as disordered eating. She checks whether cognitive deficits, behavioral issues or stressors in patients' lives might keep them from adhering to post-surgery lifestyle changes. She also assesses their social support. Spouses, for instance, can become jealous or feel neglected when patients want to exercise instead of watching television the way they used to.



ROBERT ADAM MAYER

Goldman also educates patients who view surgery as a quick fix. "Surgery is just a tool, not a cure for obesity," she tells her patients. "It's like we're giving you a prescription and you have to fill it."

She also helps patients understand the recommendations given by their physicians and other providers. "They might know they can't eat certain foods, but not understand the reason," says Goldman. Patients may think that chicken breasts and fruit are healthy, for example, but overly dry chicken and some fruit skins can get stuck in patients' rearranged digestive systems.

Goldman helps patients start breaking bad habits even before they have surgery, encouraging them to make small changes and helping them plan for such potential pitfalls as holiday parties. She may meet with patients a few times before or after surgery or invite them to join one of the center's support groups.

"The average person doesn't understand why people need bariatric surgery and thinks, 'Why can't they just go to the gym like I do?'" says Dr. Rachel Goldman.

Then she and the surgeons discuss whether patients are ready for surgery or whether they are depressed or have other psychological issues that could reduce their chances of success.

"I don't want to be the one deciding if a patient gets surgery or not," says Goldman. "But surgeons usually want a yes or no answer." While deciding whether patients' medical need for surgery outweighs their psychological issues was challenging at first, it has gotten easier after almost five years. "I hear all the time now, 'If you don't think this patient is ready or think he or she needs more help, we're going with it,'" says Goldman. "They really do appreciate my input."

Goldman also works closely with the nutritionists. She helps patients figure out how to make dietary guidelines work in their day-to-day lives and avoid overeating, which can cause nausea and vomiting. Goldman also finds herself fielding questions such as whether a particular brand of protein shake is safe for patients with diabetes. "I spend a lot of time with patients, so they feel comfortable coming to me," she says.

Goldman and her patients celebrate successes together, whether achieving a goal weight or simply reviewing food diaries to see how much better they're eating than three weeks earlier.

"I sometimes feel like a cheerleader at work," says Goldman, who encourages other psychologists to join a field that's growing along with the obesity epidemic. "I love seeing patients who were struggling before so successful and happy." ■

AN EMERGENCY CARE PSYCHOLOGIST

Sherman C. Slone assesses patients who have been involuntarily committed to emergency rooms and medical and mental health facilities.

BY REBECCA A. CLAY

Most psychologists in private practice keep regular office hours. Not Sherman C. Slone, PsyD, founding partner of Emergent Care Psychologists, PA, in Pinellas Park, Florida. The five psychologists in his practice — three full-time, two part-time — can find themselves working after normal business hours, on weekends or over holidays as they assess individuals who have been involuntarily committed to see if they're safe to release. Slone's practice also assists other patients in psychiatric, medical and rehabilitation hospitals, helping them manage anxiety, depression and other problems.

The bulk of Slone's work focuses on patients who have been involuntarily committed by emergency room physicians, police officers or even neighbors who have convinced judges someone is dangerous.

"These patients may have tried to hurt themselves, taken an overdose or mentioned suicidal thoughts while intoxicated," says Slone, adding that many of these patients have substance use issues. He and his colleagues conduct "lethality" assessments to determine whether it's safe to release patients to a less restrictive level of care and also assess patients' wishes and competency to make decisions for themselves as they come up with alternative treatment plans.

While Slone typically doesn't have an ongoing relationship with patients, he says, "obviously, we want to do the assessment in a therapeutic manner." For patients with substance use problems, that could mean doing motivational interviewing, helping them set up a plan for staying clean and referring them to community agencies for further help.

Slone got his start in emergency care early in his career. After earning his doctorate in clinical psychology from the Illinois School of Professional Psychology in 1986, he spent almost a decade working at Magellan Behavioral Health in Tampa. Eventually, he became the area crisis director in charge of evaluating and treating patients whose psychiatric and substance use problems put them at risk of hospitalization.

In 1998, Slone and partner Emily J. Futch, PhD, founded Emergent Care Psychologists. The practice now contracts with half a dozen hospitals to provide care to all patients with psychological concerns in exchange for a per patient or capitated rate.

"As far as I know, we're the only group of psychologists in the private sector who are contracting with medical hospitals to provide psychological consultations," says Slone, adding that most local psychiatrists choose not to work with hospital patients because so many of them are either on Medicaid or lack insurance altogether.

What's in it for hospitals? Lowered costs and better care, says Slone. Take suicidal patients. Patients who have made suicidal gestures typically wind up in intensive care units or in beds with 24-hour "sitters" — both extremely expensive options. Bringing in Emergent Care Psychologists isn't just less expensive. Meeting patients' psychological needs also reduces what Slone calls "noise" on the wards — the agitation, combativeness and other behavior that make it difficult for nurses and other staff to do their jobs and other patients to rest and recover.

Slone, Futch and their colleagues also tackle such issues as anxiety, depression or grief in hospitalized patients. A physician in the intensive care unit, for example, might request a consult on how to help a patient who panics every time the physician tries to wean him off a ventilator. Slone might teach breathing techniques or provide cognitive-behavioral interventions to lessen the patient's anxiety.



STEVE NESIUS/SILVER IMAGE

Drs. Sherman C. Slone, Emily J. Futch and Lauren Berrios of Emergent Care Psychologists

And while Florida psychologists can't order, prescribe or dispense medication, Slone also consults with physicians and other prescribers about psychotropic medications.

"It could be that a patient has been on a psychiatric medication in the past, and the physician would like a mental health professional to review that medication and see if the patient needs to get back on it or continue on a medication," says Slone, who is board certified in psychopharmacology. "We have some credentials to recommend medications to the attending physicians or the neurologists or other physicians working with patients."

No matter what the problem, the process begins when a physician calls the practice's dispatch line to request a consult. During their assessments, the psychologists work with emergency room physicians, trauma surgeons, neurologists, infectious disease specialists and other types of physicians as well as nurses, trauma nurse practitioners, case managers and family members. There's also plenty of informal discussion with other professionals in the common "dictation rooms" where physicians and others write their consultation reports.

Working with hospitalized patients can be challenging, Slone admits. For one thing, most of his patients are in crisis.

"We sometimes see patients who have jumped off the Sunshine Skyway Bridge — the highest in the area — and survived or patients who have shot or stabbed themselves," he says.

He and his colleagues must also have the confidence to make decisions about releasing patients who have been involuntarily committed, with all the potential liability that involves. Plus, they must be willing to work very long hours, if necessary.

But this kind of work represents a big potential growth area for psychologists who can handle such pressures, says Slone, who hopes to expand his practice.

"We've been quite shorthanded," he says, adding that bringing more psychologists on board could allow the practice to do more psychological and behavioral interventions with patients. "Right now, we don't have time to do as much as we'd like." ■

INTEGRATED CARE IN REVERSE

Jon Marrelli is getting people with serious mental illness the physical health care they need.

BY REBECCA A. CLAY

A young man came to Sunset Terrace, a large Brooklyn outpatient mental health clinic, because he was depressed about his brother's death from diabetes. But that wasn't his only problem: His own blood sugar levels were dangerously high. He wasn't taking his insulin, a potentially life-threatening move. He had also stopped seeing his physician.

That's when psychologist Jon Marrelli, PsyD, stepped in. During the man's psychotherapy session with a staff social worker at the facility, which is part of the New York University Lutheran Family Health Centers, Marrelli and a nurse met with him to discuss his physical health. They convinced him to transfer his medical care to the clinic's own in-house physician. And they helped him understand the importance of taking his medication and getting his diabetes under control.

Stories like this illustrate how the Sunset Terrace Integration and Recovery (STIR) project Marrelli directs is enhancing the physical health of patients with schizophrenia, bipolar disorder, major depression and other serious mental illnesses. The program is funded by a four-year primary and behavioral health care integration grant from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The grant program helps mental health clinics embed medical professionals within mental health care settings as a way to improve physical health outcomes for adults with serious mental illness.

"People with serious mental illness die about 20 years earlier than the general population, for reasons that are often preventable if they only had access to medical care or someone who could teach them better self-management skills or improve their health literacy," says Marrelli, director of primary and behavioral health care integration grants. "It's a public health tragedy."

HEALTH-CARE CONNECTIONS

An example of what Marrelli calls "reverse integration," STIR has brought a physician, nurse and medical assistant together to work with more than 50 psychologists, social workers, psychiatrists and psychiatric nurses within the mental health center. If a mental health professional notices a patient has a physical health problem—or a patient hears about STIR—he or she is invited to join the program and get involved. Participants who don't have a primary-care provider get connected with the clinic's onsite physician. (If they already have a physician in the community, the program shares its assessments and coordinates care.) Participants are also invited to join the clinic's wellness classes, which focus on tobacco cessation, diabetes management, nutrition and chronic pain management. Over the 12-month program, Marrelli and his colleagues track participants' blood pressure, body mass index, waist circumference, smoking, cholesterol, blood sugar and other physical indicators.

The positive outcomes go far beyond the anecdotal. The 40 patients who have completed the program since it launched in 2015 have on average seen significant drops in their blood pressure, cholesterol levels and weight. The outcomes have been so positive the hospital system is exploring how to sustain the program after the SAMHSA grant ends.

Marrelli's efforts also include more traditional integration—placing psychologists and other mental health professionals directly into primary-care settings to fight stigma and ensure that those patients get the mental health services they need. That's because many people who need mental health services go to primary-care settings but avoid mental health clinics because of stigma, says Marrelli. As part of New York's Delivery System Reform Incentive Payment program, which is helping to redesign the state's Medicaid system, Marrelli is working to embed mental health professionals into all nine of NYU Lutheran's primary-care clinics as well as some of the system's community-based partners in the next 18 months.



Dr. Jon Marrelli at his Brooklyn, New York, clinic.

ROBERT ADAM MAYER

'INEXTRICABLY LINKED'

While administrative tasks consume about 90 percent of Marrelli's time, he still carries a caseload of patients, most of whom have been diagnosed with schizophrenia. He co-chairs the Health Care Reform Task Force for APA's Div. 31 (State, Provincial and Territorial Affairs). And he's helping to train the next generation of integrated-care providers by supervising psychology externs. "Many mental health training programs have not yet caught up to teaching the important, emerging area of integrated care," says Marrelli, who prepared by supplementing his 2007 doctorate from the University of Hartford with the University of Massachusetts Medical School's certificate program in primary-care behavioral health. He also obtained a mentor from APA's Div. 18 (Psychologists in Public Service) and resources from Div. 38 (Society for Health Psychology).

In addition to helping mental health staff understand the importance of attending to their patients' physical health, Marrelli also works with medical staff to help them adjust to this often-unfamiliar patient population. The staff leading the health education classes, for instance, must learn how to adapt their teaching styles and materials to be appropriate for people with serious mental illness. That could mean understanding that classroom disruptions, such as standing up in class, may be a symptom of paranoia or the onset of mania rather than rudeness. Marrelli also encourages class facilitators to incorporate stretching breaks to boost concentration in participants with medication-induced grogginess.

"Some people joke that the medical side is only concerned with the neck down and the mental health side is only concerned with the neck up," says Marrelli. "What I'm trying to teach the staff is that the two are really inextricably linked." ■

WHY FOCUS ON INTEGRATED CARE?

1
Aspects of overall health are missed by a sole focus on physical or mental health.

2
Behavioral factors are leading causes of chronic illness and mortality.

3
Chronic illness accounts for 75 percent of the nation's health spending.

Source: APA Practice Organization

PSYCHOLOGIST-DELIVERED, PHYSICIAN-APPROVED

Primary-care practices appreciate having integrated behavioral health consultants, Mercy Health has found.

BY REBECCA A. CLAY

When a new patient burst into tears in his office at Mercy Heath's Springfield Family Medicine Clinic in Cincinnati, physician Douglas L. Hancher, MD, suspected she needed more help than she would admit, even though she denied she was suicidal.

"In the old days, we would have had to look at her insurance, check who was in her plan and seeing new patients and refer her to someone who might have been 20 miles on the other side of town," says Hancher. "Then it could take six weeks to get an appointment."

Not anymore. Thanks to Mercy Health's commitment to embedding behavioral health consultants in primary-care practices, psychologist Leslie Instone, PhD, was just across the hall and able to see the patient immediately. She discovered that the woman had tried to kill herself before and had a plan to try again soon. She sent the patient to the psychiatric emergency room, where she got the help she needed.

"I would have felt terrible if I had missed someone who was suicidal and she went on to commit suicide," says Hancher. "Having a back-up is good."

Stories like that are one reason why Mercy Health—one of the nation's 10 largest nonprofit health systems—is moving aggressively to integrate behavioral health consultants into its family medicine, internal medicine and pediatric clinics in Ohio and Kentucky. The goal is to achieve the triple aim of better health, lower costs and enhanced patient satisfaction, says Martyn Whittingham, PhD, the psychologist who launched the initiative in 2014 as chief of clinical integration and research at Mercy's Behavioral Health Institute. (Whittingham has since left the organization.)

According to Mercy Health's preliminary data, Hancher isn't the only physician who appreciates having a behavioral health consultant as part of the team. In a survey of 100 physicians and staff members at seven Cincinnati practices involved in the integration project, participants gave almost everything at least four points on a five-point scale:

■ **Access to care.** Providers and practice staff, such as practice managers and care coordinators, gave an average rating of 4.7 when asked how helpful integration has been for patients and how it has increased ease of access to behavioral health services for patients. That's an especially important figure given Mercy's mission of serving the underserved, says Whittingham.

■ **Helpfulness.** The survey also asked questions aimed specifically at providers. When asked how helpful having a behavioral health consultant was in terms of providers' ability to do their own jobs, for example, the average rating was 4.5.

■ **Improved work flow.** Providers gave a 4.2 average response when asked how much the integrated behavioral health model improved the work flow in their day-to-day practice. "The behavioral health consultant could have been seen as invasive or blocking work flow," says Whittingham. "Instead, they improve work flow, even in this really early stage."

■ **Satisfaction.** The 4.7 average score for a question about how likely providers are to recommend behavioral health integration to their colleagues is a key indicator of success, says Whittingham. "That's the final test," he says, adding that momentum is building as participating physicians like Hancher share their experiences with behavioral health consultants with their colleagues. "Physicians are coming to us and asking, 'When am I getting mine?'"

There are already 14 behavioral health consultants—primarily psychologists, plus a couple of social workers—in 24 of the system's 150-plus primary-care clinics. Another three are under contract but haven't yet started. And the system plans to hire many more this year. About 25 percent of the system's 600,000 patients already have access to a behavioral health consultant. It has been a challenge to find enough psychologists ready and willing to work in these fast-paced, integrated settings. "There aren't enough people trained in primary-care integration," says Whittingham, who earned his doctorate in counseling psychology from Indiana University in 2006. "I've visited multiple universities and told deans, 'If you train them, we have positions they can apply for.'"

To make up for that lack of preparation, Mercy Health has developed an intensive training regimen for new hires. In addition to watching training videos, new behavioral health consultants "shadow" more seasoned consultants in their own practices for a week. Then they flip positions, moving into their new settings with their colleagues alongside them to supervise them for a week.

On the medical side, physicians are discovering that behavioral health consultants can help not just with psychological problems but with physical problems, too, including medication adherence, exercise and smoking cessation, says Mbonu N. Ikezuagu, MD, MBA, the attending physician for the internal medicine residency program at Mercy St. Vincent Medical Center in Toledo.

"Integrating a behavioral health consultant into our office has moved us closer to achieving our goal of delivering amazing patient care," says Ikezuagu, adding that both the attending physicians and 36 residents use the service on a daily basis. "This is the wave of the future." ■

HOW AN INTEGRATED APPROACH HELPED MERCY HEALTH

1 **Increased access to care**

2 **Improved work flow**

3 **Boosted colleague satisfaction**



JEREMY KRAMER

"There aren't enough people trained in primary-care integration," says Mercy psychologist Dr. Martyn Whittingham. "I've visited multiple universities and told deans, 'If you train them, we have positions they can apply for.'"

EXPANDING OPPORTUNITIES IN WOMEN'S SPECIALTY CARE

Meet three practitioners who work hand-in-hand with medical professionals to keep new mothers, military veterans and other women healthy.

BY REBECCA A. CLAY

The expectant mothers at Denver's Presbyterian/St. Luke's Hospital—a regional center for high-risk pregnancies—often have such high blood pressure that both they and their babies are at risk of complications or even death. On bed rest at the hospital for weeks or even months, they have little to do but worry—which can send their blood pressure soaring even higher.

That's where consulting psychologist Jennifer Harned Adams, PhD, comes in. She teaches the women visualization, breathing exercises, progressive muscle relaxation and other strategies they can use while they're stuck in bed. She'll also help them find relaxation apps on their cellphones or tablets so they can use the techniques whenever they need them.

"These moms are facing all these potentially scary outcomes for themselves and their babies, but can't do a whole lot physically to manage that anxiety," says Adams. "Being a part of the team is great so we can think about these moms in a more holistic fashion."

Adams's work with pregnant women is just one example of how psychologists are working with physicians and other medical providers to improve women's overall health. Adams and other psychologists are helping women transition to motherhood, overcome chronic pain, heal from sexual assault and explore their gender identities.

The *Monitor* spoke to Adams and two other psychologists working in integrated settings focused on women's health.



ROGER MASTROIANNI

Dr. Kelly Huffman (below) specializes in treating pelvic pain, which can leave women depressed or anxious, as well as lead to sexual and relationship problems.

JENNIFER HARNED ADAMS

Assisting New Mothers

Presbyterian/St. Luke's and the affiliated Rocky Mountain Hospital for Children brought Adams on two years ago, and she spends a quarter of her time consulting with patients at the hospitals. "They were seeing the need for greater support for families," says Adams, who spends the rest of her work week at her private practice. "They saw how having a psychologist would help improve the quality of the hospital stay and the transition into parenthood."

Her training prepared her well. After earning her doctorate in clinical psychology from the University of Houston in 2003 and doing an internship at the University of Texas-Houston Health Sciences Center, she had three years of postdoctoral training in reproductive health and psychosocial oncology at The University of Texas-MD Anderson Cancer Center.

On the antenatal side, Adams now spends most of her time helping women cope with extended bed rest. In addition to boredom, they're facing worries about their babies, the work they're missing and their families back home. They may be mourning past miscarriages or—in the case of multiple babies—the death of a twin or triplet. "Of course, they're also bringing in whatever was going on with their lives to begin with—relationship or financial difficulties or previous histories of depression, anxiety or substance abuse," says Adams.



REBECCA STUMPF

Dr. Jennifer Harned Adams (above) specializes in treating pregnant women on hospital bed rest. In addition to boredom, these women face worries about their babies, the work they're missing and their families back home.

And since patients come from as far away as Wyoming and Nebraska, many are also isolated. Adams helps the women problem-solve and helps prepare them and their families for potentially bad outcomes. If their stay is long enough, she might even delve into more traditional psychotherapy.

Adams also works with mothers and other family members in the neonatal intensive care unit. For many patients, ending up in the unit is a traumatic surprise following an unexpectedly premature birth or delivery complication. "Women and families can be overwhelmed," says Adams. "It can be very unsettling to feel out of control." Adams helps them find a sense of control where they can, settle into a routine and work through the trauma.

The work is fluid and fast-paced, says Adams. "I love being able to walk down a hall and have a nurse tell me she's feeling worried about a mom and being able to troubleshoot or help make a plan," she says, adding that rounds and case planning meetings offer more formal collaboration opportunities.

Adams also helps educate nurses and other health-care professionals, offering trainings on understanding grief and loss in their patients and themselves and on preventing compassion fatigue and burnout in their professional roles. "I urge them to look for opportunities for self-care for themselves and others just in the course of their day and also to make aggressive self-care—exercise, massage or other practices—a regular part of their lives," says Adams, who has also worked with the Wishbone Foundation to train more

than 300 nurses in nine hospital systems how to support families who've lost their babies.

The training also helps nurses work more effectively with patients, adds Adams. Often, she says, there are communication problems because patients and their families are interacting angrily with nurses and other providers. "I help providers reframe that anger as fear, which helps them respond differently," she says.

KELLY HUFFMAN

Overcoming Pelvic Pain

Kelly Huffman, PhD, specializes in another type of care for women: treating pelvic pain. "Women are overrepresented in chronic pain populations," says Huffman, a psychologist at a pelvic pain clinic "by and for women" within the Cleveland Clinic's Center for Neurological Restoration.

Pelvic pain can have many causes. No matter what the etiology, it can leave women depressed or anxious about what's wrong with them. Pelvic pain can also cause sexual dysfunction and thus relationship problems.

And psychological distress can make pain worse, says Huffman, who did a postdoctoral fellowship in psychology and pain medicine at the Cleveland Clinic after earning her doctorate from the University of Wisconsin–Madison in 2008.

"If you have a lot of stress, depression, anxiety and other things going on in your life, it can amplify pain perception," she says. The opposite is true, too. "If you don't have a lot going on in your life, pain can become front and center in your life because you have nothing else to focus on."

When patients with pelvic pain come to the clinic, they consult with Huffman, plus a physician, physical therapist, occupational therapist and other team members who create individualized treatment plans. For some, that might mean surgery; for others, pelvic floor therapy, a type of physical therapy designed to rehabilitate pelvic floor muscles. The clinic also weans patients off opioid analgesics, if necessary. For patients who need more help, the clinic runs a three-week, full-time rehabilitation program.

Huffman's role on the team is to address any psychological issues. She might counsel couples on relaxation techniques they can use to enhance sexual functioning, for instance. Or she might help a sexual assault survivor work through the trauma that's contributing to her pain.

Working collaboratively can prevent unnecessary medical interventions, says Huffman. One patient, for example, had such severe pain with intercourse that she was scheduled for a vestibulectomy—surgical removal of some flesh at the vagina's opening. When Huffman talked with the patient, however, it turned out that it wasn't a physical problem that was holding her back but instead uncertainty about her sexual orientation. "If you don't have a partner you're attracted to, of course it would make intercourse difficult," says Huffman. The surgery was canceled.

Because many patients are convinced they need opioids to manage their pain, Huffman also provides psycho-education. "The common perception is, 'If I have pain, the answer is to take opioid analgesics,'" says Huffman. Addiction isn't the only danger of opioid use: Opioids can also make pain worse. "Most patients don't know about acute versus chronic pain," says Huffman. "Opioids are actually contraindicated for chronic pain."

This kind of integrated approach works, Huffman and her colleagues have found. In a study of 36 patients with pelvic pain, Huffman and co-authors found that interdisciplinary treatment including medication management; occupational and physical therapy; and individual, group and family therapy significantly improved pain severity, disability, depression, anxiety and "catastrophizing" (*Journal of Pain*, 2016).

And word is getting out, says Huffman. "The pelvic pain clinic has only been open for about a year," she says. "At this time, we have more volume than we can handle."

ROSALIE C. DIAZ

Helping Veterans Heal

In the military, seeking mental health care can be especially stigmatizing. That's one reason why psychologist Rosalie C. Diaz, PsyD, is happy to be treating female veterans in a stand-alone women's clinic at the Louis Stokes Cleveland Veterans Affairs (VA) Medical Center. "Having a psychologist be part of their primary-care team isn't seen as stigmatizing by our veterans," says Diaz. "I'm just part of the team."

The VA began emphasizing coordinated, co-located care in 2010 as a way of decreasing stigma and improving access to care, says Diaz, who did her predoctoral internship at Louis Stokes in 2003 and started her current position in 2013. "It's also seen as cost-effective because you're being more preventive," she says. A physician or other provider might be worried about a patient's depression, substance use or cognitive capacity, for example, so Diaz meets with the patient, screens for the problem and works with the provider on treatment recommendations. Other patients may have mood disorders, insomnia or difficulties with medical compliance. Infertility, pregnancy loss and post-traumatic stress disorder are also common.



REBECCA STUMPF

Dr. Rosalie C. Diaz treats female veterans in a women's health-care clinic. "Having a psychologist be part of their primary-care team isn't as stigmatizing by our veterans," she says.

Military sexual trauma—and the wide range of psychological emotions that often accompany it—is another big issue. "If you review their records before they see you, they'll sometimes deny to a provider that there has been any assault," says Diaz. "Then you're seeing them for therapy, and they'll share something that they've never confided before."

On an individual level, a veteran might also need Diaz to accompany her to gynecological exams to help her cope and avoid panic, for example. More broadly, Diaz and others are also working to raise awareness of military sexual trauma among patients and providers alike with an annual monthlong education campaign. For the veterans, she says, the campaign emphasizes that they're not alone and that there's an advocate for them. For providers, the message is that trauma is often hidden. "The provider might see anger in the forefront, but underneath there's fear or vulnerability," says Diaz. By working alongside the physician or other provider, Diaz can help ensure the patient gets the care she needs.

Diaz also works with the center's transgender clinic, which addresses physical, social and mental health issues. As part of that interdisciplinary team, she helps patients manage their transitions and explore their gender identity. She also helps screen patients to see if they're candidates for hormone therapy. Many of these patients have experienced bullying and harassment and may feel depressed, anxious or just uncertain. "We're looking at stability, support and their use of coping skills," says Diaz, who works alongside a primary-care physician, a psychiatrist, nurses, a social worker and another psychologist.

The biggest challenge with providing collaborative, multidisciplinary care that involves so many specialty providers in the same place at the same time is that it requires a good amount of time and space for them to collaborate on the best plans of care for their patients, says Diaz. "We have a lot of providers ready and willing to see veterans, but sometimes it's hard to coordinate with all the different disciplines and find rooms because we're growing," she says. "That's probably a good problem to have." ■

WHEN DELIRIUM TAKES OVER, SO DOES THE PSYCHOLOGIST

Nancy Ciccolella helps critical care patients emerge from the extreme confusion known as intensive care unit delirium.

BY REBECCA A. CLAY

While recovering from a lung transplant at Philadelphia's Temple University Hospital, a patient became irritable and difficult to work with. She wouldn't follow directions. She banged on the furniture if nurses didn't respond immediately when she pressed her call button. And her respiratory therapists were unable to wean her off her ventilator even though she no longer needed it.

"The staff was fed up," says Nancy Ciccolella, PsyD, who has been a psychologist in Temple's department of physical medicine and rehabilitation since 1992 and a clinical assistant professor there since 2002.

When Ciccolella assessed the woman, it turned out she didn't have behavioral issues: She was suffering from intensive care unit (ICU) delirium. According to the ICU Delirium and Cognitive Impairment Study Group at Vanderbilt University Medical Center, about two-thirds of ICU patients experience this extreme confusion. These patients may have trouble paying attention, thinking clearly or even understanding where they are; some hallucinate. ICU delirium not only increases the chances of longer hospital stays and higher costs but also months-long cognitive problems and death, the study group says.

Once Ciccolella explained to the medical staff that the patient had delirium rather than behavioral problems, their attitude toward her changed. "It was mostly a matter of making the team feel they got help," she says. "I de-escalated the situation."

As part of the heart and lung transplant team, Ciccolella spends much of her time on cases of ICU delirium like this one. "Delirium by definition waxes and wanes," she says. "One moment they're fine; the next they think it's 1948 and they're at church." Delirium can go undetected until nurses, therapists or other medical staff realize a patient isn't cooperating with requests to get out of bed or participate in respiratory therapy.

When that happens, Ciccolella begins by supporting the medical team and soothing frayed tempers. "The team might feel like someone's a problem patient and not listen to the person anymore," she says. "I go in and try to calm everything down." Next, she advises the medical team to address possible causes of delirium. Often, it's medications—particularly pain medications—that are the problem. Lab work can detect metabolic issues that might induce confusion, while CAT scans can reveal whether the delirium has been prompted by a stroke.

"Sometimes, patients are just confused by anesthesia," says Ciccolella, explaining that it can take weeks for the effects to wear off in older patients.

She also works with the medical team and patient to set two or three simple goals, such as getting out of bed once a day. Or if a patient isn't adhering to medical recommendations, she works with the patient and medical team to simplify protocols and enlists the family's help in achieving compliance.

Prevention is key, adds Ciccolella. She advises medical staff to help patients avoid delirium with such simple steps as making sure patients wear their glasses when they're awake and having night-lights so patients can re-orient themselves if they wake up. Patients should also be able to see a clock and a whiteboard explaining where they are, the date and the name of the nurse on duty. Such tactics can also help prevent post-traumatic stress disorder (PTSD), says Ciccolella. "People can have terrifying delusions when they're delirious in the ICU," she says. "Fifteen years after they've left the ICU, those delusions can still be clear as a bell." PTSD after a critical illness differs from PTSD following combat or an assault, Ciccolella and colleagues explained in a paper in *Rehabilitation Psychology* earlier this year. The hallmark of this under-recognized, under-treated form of PTSD is future-oriented worries about having a recurrence of the illness and winding up in the ICU again, they explain. The result? Patients don't follow up well when it comes to medications or doctor visits.

In addition to detecting and intervening with delirium, Ciccolella also helps the medical staff address other psychological problems that can crop up in a busy transplant unit. One frequent request is help getting patients—whether they have delirium or not—off their ventilators. "The respiratory therapists sometimes have trouble figuring out why patients are having trouble weaning," she says.

Once Ciccolella and the team have ruled out physical reasons, she helps patients manage anxiety with cognitive restructuring. Patients who may be thinking, "I can't breathe. What if no one answers the call bell? I'm going to die!" for example, learn to tell themselves that their monitors are working, nurses can see them and that they will be OK. Ciccolella also teaches patients to use music, imagery and other distractions, although the usual emphasis on deep breathing is a no-no. "We want them to think about anything but breathing," says Ciccolella. ■



COLIN LENTON

Dr. Nancy Ciccolella works to identify and treat intensive care unit delirium.

RESOURCES

APA has a wealth of information and resources on integrated health care.

• **The APA Center for Psychology and Health** engages in a variety of cross-association and organizational collaborations to apply psychology's expertise to increase access to quality health care at a reduced cost.

• **Division 38: Society for Health Psychology** seeks to advance contributions of psychology to the understanding of health and illness through basic and clinical research, education and service activities and encourages the integration of biomedical information about health and illness with current psychological knowledge. The division has a nursing and health group and special interest groups in aging, women and minority health issues.

• The Psychologists in Integrated Health Care **video series** provides a behind-the-scenes look at how psychologists in integrated health contribute to improved patient satisfaction and better health by working collaboratively with physicians, patients and families.

• This **health briefing series** focuses on a wide range of health conditions to further highlight psychology's vital roles, including and beyond assessment and treatment, in primary care and other health-care settings.

• The APA Office of Continuing Education in Psychology has a catalog of video on-demand continuing education **(CE) programs**. Search for courses on integrated care.

• **Search for jobs in integrated care** using APA's career search tool, PsycCareers.