

**Substance Abuse and Mental Health Services Administration
Wellness Initiative**

**Having the Conversation:
Speaking Wellness in Your Health Care Visit
Podcast**

Narrator: The Substance Abuse and Mental Health Services Administration, or SAMHSA, created the Wellness Initiative because people with mental and/or substance use disorders tend to die years earlier than the general population. Studies show this is mostly due to preventable and treatable conditions, such as diabetes, heart disease and cancer, which can be improved by healthy eating, increased physical activity and smoking cessation. Focusing on health and wellness is particularly important for people with/or at risk for mental and/or substance use disorders so they can live long and healthy lives. SAMHSA's goal is to help individuals, families, providers, and communities improve whole health outcomes. Keep listening to learn more about wellness and tips you can apply in your life.

Galbreath: Hello. Have you ever left a busy doctor's office only realizing that you forgot to ask something? Or maybe you feel a little unclear if the team was all on the same page. Maybe you're a health care professional, and you felt maybe a little rushed or didn't feel confident that your patient left with a clear understanding of the treatment plan that you both discussed. Well then, you're in the right place, as we dive into this and other topics on today's Blog Talk Radio show, "Having the Conversation: Speaking about Wellness in Health Care Visits."

Today's event, as you heard, is sponsored by SAMHSA's part of National Wellness Week. Well, we're going to be talking about messages and practicing wellness provides an essential foundation for good health and hopefully that we can [use to] eliminate the health disparities among people with serious mental illness and substance use disorders.

My name is Laura Galbreath. I direct the SAMHSA/HRSA Center for Integrated Health Solutions, through the National Council of Behavioral Health. CIHS is a technical assistance center offering training, consultation, resources, and support to mental health addiction and primary care provider organizations that are integrating care. I'm also a passionate mental health advocate and a big believer in a future where all people with mental illness and substance use disorders achieve a full and satisfying life in a community with access to effective services and support systems.

We've got three great guests with us today to bring their unique perspectives on today's conversation. First, we have Shannon Tyson Pilletti, who's a psychiatrist and assistant medical director at the Jefferson Center for Mental Health in Colorado, where she leads efforts to integrate primary care and behavioral health, both in the mental health clinic and at some of their partnering primary care sites in the community.

Next, we'll have John Holly, who is a peer support intern at Human Resources Center in Edgar and Clark County, in eastern Illinois, where he supports peers and their health and wellness goals. And Dr. Raymond Reeyon, a physician and executive director at Packard Health in Ann Arbor, Michigan, and a real leader in integrated care, both for primary care and behavioral health. So we're really excited to have all three with us today to talk about this important topic.

We know that the doctor-patient relationship has been and remains a keystone of care, and it's vital as individuals work to improve their mental and physical health. Also, you know, it's a reminder that this is a meeting in which data is gathered, diagnoses and plans are created, patients get activated in managing their whole health, and they get the support that they need. And, in addition, satisfaction with the doctor-patient relationship is a real critical factor when it comes to peoples' decisions about where they can seek their care and how to stay involved in that organization and provider.

And as a patient, it's also vital to help reduce the risk of errors, complications, and improper care that we could receive from multiple providers. So having these effective conversations are really key to ensuring whole health. And so, we're real excited to have this conversation, and we really look forward to some of these new ideas that we're going to have to support you as you think about yourself, how to support your peers and colleagues, and our broader health care community in having effective conversations and speaking about wellness in health care visits.

So first off, I'm going to ask each of our guests to share a few of their thoughts on the topic and then we're going to open it up to some, some discussion, some questions, and dialogue. So first I wanted to start off with Shannon to share some of her experience and perspective on the topic and share your thoughts.

Pilletti: Thank you, Laurie. You know, I think you mentioned several times whole health. Whole health is really about the entire person. It's about spiritual health, it's about physical health, it's about mental health, it's about behavioral health, which includes substance use disorders. And when we look at the whole person, it's important to be able to address any barriers to care to wellness that may occur.

We all have barriers to care. We have time pressures, we have financial pressures, we have social pressures, and in order for us to make changes to address our health, all of those things need to be addressed. In the busy lives of physicians, sometimes it's hard to make time for that. And that's where behavioral health professionals come in; that's where we try and teach physicians how to do things differently.

Galbreath: That's great, that's really helpful. I think we'd love to have some conversation about that in terms of that training and how do we support both individuals in, who are the patient if you would in this example, to have that conversation, but also how do we really help, clinicians and, colleagues in the field to participate in that. And with that, John, what are your thoughts?

—it's kind of, some of your work with peers and has had your own lived experience as to how to have those kinds of conversations.

Holly: Those were some really great points. One of the things that I do is I facilitate a group called Whole Health Action Management —it's a product of SAMHSA, and in it we talk about a lot of those things—everything from spirituality to physical activity and things like that. I've had diabetes for 44 years, and while I used to make out my doctor's notes on pen and paper, I now put it on my smart phone so if I happen to be in the kitchen and think "oh that's something I need to ask my doctor about." I've just got a real quick... that I can just make a note for it. I believe in really good communication with my doctor.

And I also believe that I am in charge of my own health care. That I'm the coach of a team, you know, and they're the players I depend on. And I depend on their expertise and their ideas and their opinions, but then I have to implement those into my own life.

I also believe that it's very important for the individual to get educated on whatever disease that they deal with most, whether it happens to be depression from the mental health side or diabetes in my case or whatever else you would, you would have to deal with. So that you can speak with them in a clear, and I use medical terms with my doctor, because he understands then exactly what I'm saying and I know the meanings of those words too, so we can communicate very effectively. And I think that effective communication with your doctor is very important. Thank you.

Galbreath: Thanks John. Just [tell us] what's an example of some of the language that you said that you use; you use the doctor's language.

Holly: Well, like one of the common tests for diabetes as far as how your control is doing, it's called an A1C. And that's an average of your blood sugar level for over a 2- or 3-month period. I'll talk about a TSA or things like that; I'll call the lab work by their specific names. So those kinds of things. Thank you.

Galbreath: That's great. That's really helpful. Ray, what are your perspectives as a physician kind of a leader and in seeing integration from both sides of this. What are your thoughts as you think about how to facilitate that conversation?

Reeyon: Yes, I think the when a patient and a doctor, nurse practitioner, or psychologist meet, you know, it's a very human interaction. And I think like all effective human interactions, it goes best if there's mutual respect and trust. And that it's easy to say but you know, getting there sometimes is harder. It's interesting to me with John that he'll use medical language, because I actually try to make sure I'm communicating not in medical language, so it's kind of funny. I think if both sides are doing it you can meet in the middle but it's... I've seen way too many times physicians lapse into medical language, and then a lot of meaning is lost.

And interestingly enough, you know, I had the experience as a really young child to have a lot of problems with my ears. I spent a lot of time with my ear nose and throat doctor's office. And that actually led to directly to me becoming a physician and I'll tell you why—the guy was very bright, he was friendly, he took time with me, he listened to what I said. And I think those are some of the real fundamental things that physicians and medical providers really have to give people for effective interaction. And I think that it's sometimes hard in a busy medical practice now in our current system.

Galbreath: It is. I think it's probably a pretty common question we hear a lot ... is while the conversation's great, we only have you know, 7 or 10 minutes together and even though there are a lot of efforts to integrate primary care practices into a community mental health setting where maybe you can have a little bit of extra time ... it still may not be enough given some of the complexity or multiple health challenges that someone maybe faced or their wellness goals. So, what do you guys think about that in terms of how do I have that conversation if you don't have a ton of time together?

Pilletti: This is Shannon. I think there are multiple ways to do that and I... often the pressure is on the primary care physician to do that, and they want to do that, they want to interact with their patients, they educate the patient. But more and more, with the time pressures, the expectation as to what needs to be done in a visit, the requirements of annual labs, monthly labs, whatever is required for that client for good care, those time pressures become more and more. That's where physician extenders can help: nurses, behavioral health professionals who are in the primary care setting.

Additionally, what we have found in our practices, that sometimes an initial time investment on the front end with the client, particularly somebody who either doesn't understand or may be frustrated with the medical process and so require more time from the physician, an initial investment of a 30-minute or a 45-minute appointment will pay off a month, 2 months, a year down the line, building that alliance, building that trust. And clients understand time pressures from physicians and so if you come in understanding what the time pressure is, and what the expectations are—and those are clearly stated and clearly communicated—and that there's compassion and understanding during the visit—things go smoother.

Galbreath: That's really helpful. You know, one of the really specific things that I think you, John, mentioned is you create a list and we know AHRQ (the Agency for Healthcare Research and Quality) has a really nice campaign on questions and the answers and how to write down those questions. And so obviously, making sure that you bring that list. ...

What about coming in with that one agenda item of saying you know, what is it that I'm most concerned about or ... thinking about my broader health and how do I communicate that? Would it be helpful to set the conversation up with the physician around one goal? Or sharing of my ultimate health goal, and maybe learning how to create or identify that health goal for a lot of folks as a need?

Holly: If there's one thing that is the most important to me on a single visit, I'll open with that. You know, right after we say hi to each other, say "this is this is my biggest thing today." And it might be in my case, for an appointment I'm going to make next week, that my insulin pump supplies are... "I'm out of refills on – that's kind of important to me you know," then I can work my way down the list to "would you check this mole, please," or you know, something else that is that is not as important to me, and certainly he's gonna make things that are on his agenda too.

Something that Shannon said is I usually know pretty close to when my my tests are due, lab work, because I have something that I keep track of as well. And what Ray had said about building that trust is and I agree I trust my my doctor and and he also knows that I'm paying attention to my own health so he trusts me too and that that's very important. Thank you.

Reeyon: Yeah, I think the clearer someone can be on what they hope to get out of the visit, the better and I think to do some like "gee this is most important, this is next important." I can tell you on the physician or provider side, you know, we've reviewed things before we walk in the door so we'll have a little mental checklist in our mind of things that we hope to get done from our perspective. And there may be you know, the two separate lists may align real tightly or they may not be related at all, but I think to have people think about, "gee this is what I really need." And then, from my perspective, is if folks have a list [of] the things that are important to them, I may have another list but I've got to address their list because ... you know, frankly it's not all about my agenda.

You know, that if people have things that are important in their mind, whether they're you know, medically important or not, it's important to them so you have to address them. So the clearer the goal of the patient the better. I'm OK with lists just as long as they're not 10 items long, because you know, I think there's a limit to what anyone can do in a visit.

Galbreath: Great, thanks. You know, we've been talking a lot about just the physician, or the provider if you will, with the patient. What about some of the role of the other folks? What might I share with a nurse and then or what might I take advantage of in terms of the opportunity or some follow-up education or support after the visit? So other people that people might want to think about when they go to the doctor's visit to get their support in their health and wellness.

Holly: This is John, and I think they are very important. I regularly will deal with my doctor's nurse, Carrie, and I make it a point of knowing her name so that I can address her that way. I also deal with my certified diabetes educator on a regular basis. And a lot of times, if there is something small that I need, I'll just deal with her and let her catch the doctor, instead of having to come in and have to eat more into his time. Thank you.

Reeyon: And then we've got different folks in our office. We actually have a diabetes educator and we have a social worker in our office. We have people who help with if people need social services, transportation, help with enrollment and food stamps. We have a food pantry, so I

think for complicated...people who have complex needs. You know, I sometimes I use the term you know, “doctors aren’t Marcus Welby” (for those of us old enough to remember the old TV show), that medicine is too complicated now, and many people have needs that far exceed what I can do by just by myself in the exam room, so I just think that’s a really critical point.

Pilletti: And we have very similar extenders or additional people in the practices that we work with who do similar things. We have health navigators who help people navigate health care systems ... make sure they get to the appointments, understand when is the convenient time is for the person. We have behavioral health professionals who break down barriers to change and barriers to care, be that financial ... you know, basic security issues, such as food security, housing security, and then health care coordinators who help the physicians talk to other physicians and make sure that everyone’s on the same page.

Galbreath: That’s great. It sounds like all three of your examples really show a team approach of different folks that might be able to help you...anybody in terms of their health and their wellness goals, and not to be afraid to just ask, “Hey, this is one of my goals; I really could use some help getting some services around getting my diabetes medication.” And then you know, asking that if there’s anybody there that can help them. It sounds like a good question that folks can ask.

You know, speaking of other people who come into the mix here..., a lot of folks sometimes will think about bringing a family member or a friend you know, somebody else with them into the exam or to the appointment. What has been your experience with that? Is that a good strategy to kind of, help make sure I leave with the right information or reduce some of my fear or anxiety that I might have about going to an appointment?

Pilletti: This is Shannon and I think a family member or advocate is always another set of ears, [who] sometimes can bridge communication gaps. But additionally ... you know, family members—the biggest issue—the family members are advocates. And I know sometimes I’ve seen physicians and psychiatrists become frustrated with family members.

I’ve always taken it that they’re this patient’s advocate, when they cannot advocate for themselves or might be anxious to advocate for themselves. And if you understand family members from that perspective, it often helps bridge the communication with the patient themselves. Additionally, when there’s not a family member, I do think it’s important for a patient to have an advocate, whether we provide that or whether they bring a friend, whether they bring even their next-door neighbor who’s giving them a ride, having those advocates help us understand the patient better.

Reeyon: So I’m a family physician and I often will see you know, couples, so they’ll both be my patient, so I have to echo Shannon. In general I find it very helpful ... you know, the few handful of times, it’s not as really overwhelmed by the vast majority, where it’s very helpful to have a friend or family member in the visit.

Galbreath: That's great. So I really hear from somebody that yes, it's OK to think about inviting a family member, or an advocate as you were saying, Shannon, and that a great role that I could ask them to play would be to listen, help take notes, ... and then also provide some context if there are some other challenges that may come up, and that listening and that support is a good way to utilize them.

Pilletti: And yes, Laura, one other point I kind of agree on what Ray had said, often family physicians do treat entire families. That's why they're family physicians. And there was an interesting study by Weisner, who looked at the health of substance use disorder patients. And when the substance use disorder patient became sober or abstinent, the health of the entire family improved.

And often, particularly with substance use disorders but many illnesses, patients are hesitant to seek care for whatever reason, you know, pride, you know, often some patients don't think it's that much of a problem as it is, whether they have you know, diabetes and they don't think it's a problem or they may have substance use disorder and they don't think it's a problem. And it's often the family member who is better able to discuss how much of a problem it really is because it is affecting the entire family.

Galbreath: That's so helpful. Thank you.

Holly: This is John. I'd just like to throw in: Both being a support person to somebody else and having supporters for yourself are both independently good signs of wellness. And so yes, I think that's very healthy. Thank you.

Galbreath: Such a great point. And you know, ... another thing that I think we've become much more aware of lately is the role of trauma and how it affects our health and you know, upwards of 70 percent of Americans in the U.S. have expressed some type of traumatic event at least once in their life and so a lot of folks will come maybe with a history that really will impact their ability to become an active participant in that exam room.

How do you recommend somebody kind of advocate for ... if they have had a history of trauma? What are some of the things they could ask for to make that experience maybe a little bit more friendly and not triggering in terms of past traumatic experience that is still impacting them?

Pilletti: Laura, one thing that we do at Jefferson Center is we work with our SQHC to set up a trauma-informed care environment at each of the sites. What trauma-informed care basically means is treating each patient and each person that you work with with respect. It's very simply that. Each person's experience with trauma is different and so for us to predict what is going to trigger somebody is impossible.

We have to set up a communication and a sense of respect with the client so that they are able to easily say "This is overwhelming for me; this is retraumatizing for me, or that is

restigmatizing for me.” And if we start from that perspective and give them that voice, voices and choices. ... And then give them the choice as to how they want to handle that, it’s key to having a trauma-informed care perspective.

We know as you said, about 65, 70 percent of people throughout the United States have had some sort of trauma. About a quarter of those had significant trauma. ... Those are huge numbers. Those affect all physicians, not just in primary care, not just in psychiatry. We know that the risk for illnesses of all kinds, increases with trauma—diabetes, heart disease, cancers. And so it’s really important that we understand trauma as physicians.

Galbreath: Yeah that’s great. It really brings up a topic that we want to bring up around health care professionals. So, how do we help our field as we become more integrated? So you know, I’m coming in, I’m talking more freely about both my diabetes and my bipolar condition. How do we make sure that, be it primary care staff, we make them feel comfortable talking about my bipolar [condition], ... but also for the behavioral health providers, that we’re increasing their competency and comfort talking around ... somebody’s diabetes or other medical conditions that they may be working on as part of their health goals.

Reeyon: So for us we actually wind up doing a lot of co-visits with our mental health folks who actually set up a visit where we’ll actually see folks with both one of our primary care people and our mental health person at the same time. So we find that pretty helpful when folks have both things active simultaneously. We’ll also do that at times with our diabetes educators, so we even had some folks where we’ve had all three of us working with someone simultaneously.

So we’ve utilized a lot of co-visits here at Packard for really a number of years to help us with a little bit more complex folks.

Holly: This is John; those are really good ideas. I also think it’s important for you know, as part of my list of things just to say why “I’ve talked with doctor so-and-so about this and I’ve talked to doctor so-and-so about that,” so ... that just keeps all those lines of communication open. Thank you.

Galbreath: Definitely. Shannon, you’re doing a lot on integration. How much do we have to help our clinicians in feeling comfortable on topics that they [didn’t] necessarily have a higher level of training on?

Pilletti: That’s exactly it, Laura. Many physicians have not had extensive training in psychiatry and in mental health. Placing mental health professionals [and] behavioral health professionals in primary care is one way to deal with it. Educating our primary care doctors is another way to deal with it.

Often, [among] the most popular continuing medical education among primary care doctors is the psychiatry piece, because they don’t feel adequate or comfortable dealing with that. Assuring them that they are competent to deal with this is another piece to that. Teaching

them the basics of basic medications and helping them understand when they need to refer is another piece to that.

You know, many doctors are comfortable starting somebody on an antidepressant, but when one antidepressant doesn't work, they feel uncomfortable. And so, having consultants in the primary care clinics, having behavioral health professionals and health care coordinators that can link the primary care doctor to the psychiatrist is important, and there's all different ways to handle it. I think sometimes primary care docs feel like they need to be different than they are or be more than they are, but I think we really need to think of it as any other specialty. We don't expect primary care docs to be cardiologists, nor do we expect them to be psychiatrists, but we do expect them to have solid knowledge of both.

Reeyon: Yes, so a lot of what we do in primary care is we do a breadth of services, but they're a lot less deep than what specialists can provide. So what we are continually bouncing against is sort of the limits of our own capabilities. That's just something we deal with repeatedly throughout the day. ... so we have to be fairly comfortable [about] when to hand people off ... So I think it's a group, and different individuals will be stronger at different particular things, and then people... What you often see among primary care folks is that they'll develop interests over the course of their career that they'll get better at and then conversely, they'll have things where they're a little bit less comfortable at, so you'll often get ... a spectrum... of capabilities among folks.

Galbreath: So true. And you know, I think it's really exciting when we talk about ... integration of primary care, mental health, substance use ... It's a real opportunity so our health care field is changing fairly quickly. ... You know, I think we still come up with some barriers and challenges that we hear about.

One I'd really love to hear your thoughts on is you know, we still hear a lot about stigma, people with mental illness, maybe they have a health care professional who hasn't been as kind of, enlightened if you would around these issues. ... And so if somebody's feeling... and, let me add a side note on some research showing that when there is that stigma toward somebody with a mental health condition, that physicians or clinicians I should say, I don't want to just call it physicians, ... can be.. have a belief that maybe the individual because of their mental illness are less likely to adhere to the treatment and may not refer them to specialists for additional testing if need be.

So what are we recommending if I come into an exam room, and I do share and disclose about my mental illness, and I'm not feeling like I'm getting very good care, or not being listened to...? What do you guys think in terms of what to do in that situation, if somebody comes across that barrier?

Holly: This is John. As a patient-consumer, I would simply ask for a referral to somebody else on that issue. That's what I would do. Thank you.

Pilletti: Yes, I'd ask for another doctor.

Reeyon: I think you maybe try to state it differently but it's hard to... you know, the responsibilities in the visit are different. The patient's not really responsible for making the physician or nurse practitioner get it. If they don't have some either ability to listen or understanding of where people are coming from If patients help me understand when I don't understand, I'm pretty grateful, and I don't expect that of them, frankly.

I feel pretty fortunate if I run into someone like that, you know. In some ways, the responsibility is really on the professional to try and make sure they're in a place in their own mind where they're open in trying to understand. So I don't see the responsibilities are different. I think patients have a responsibility to try to communicate as clearly as they're capable ... but they don't have a responsibility necessarily to move the medical professional on the other side ... If anything, that's asking too much of them. So I tend to be like John you know, I'm a physician and I've run into some physicians that don't listen well. And I've talked to them and if they still don't get it, I'll start to look elsewhere actually. I don't necessarily think that's a bad response.

Holly: This is John, and yes, let me clarify: Before I ask for a referral to somebody else, I would certainly try to get their attention and be clear ... I think you know, being open and honest is part of my responsibility but you know, ultimately if I don't get the the service that I need, then yes, I need to find somebody who will. Thank you.

Pilletti: You know, Laura, I think this is an issue. As a psychiatrist it's very near and dear to my heart. ... And there have been multiple times in the past when I've had to argue with emergency room physicians over a client's having very severe medical symptoms that have not been worked up that they're seeing as psychiatric—ear pain or chest pain or whatever and there hasn't been a clear workup or there hasn't been a trail... and I think it is ... Sometimes, some physicians (and I want to be clear: It's not most physicians) some physicians hear “mental illness” and then attribute all physical symptoms to mental illness. That can be hugely problematic.

We know that clients with mental health disorders have chronic illness about 50 percent of the time. We know that clients with mental health disorders die 25 years earlier than other people in the general population. We know that clients with mental health disorders see primary care physicians less often, I think, because they do feel dismissed or rebuffed. And so on the one hand, it is not their responsibility. However, we do need to teach them how to, as I've hear the term, “manage up” or educate the physicians that “My knee hurting” does not have to do with my mental illness. You know? Or “my knee buckling” doesn't have to do with my mental illness.

We know that women are often, their illnesses are more often blamed on anxiety and depression than at you know, than the underlying physiology. And so it's OK to talk to your physician. My fear is that if clients ... when they... It's OK to talk to your physician and educate your physician, and let them know that this is real pain and they want the testing done. And if

that doesn't happen, it's OK to move on. However, moving on also can sometimes delay the symptoms and the treatment.

And so, it's always a balance about how much do you educate, versus how much do you move on. And, again, for physicians who may struggle with knowing how to handle mental illness, those are excellent opportunities to place a behavioral health professional, or a health care coordinator, or a nurse coordinator in your office to kind of mediate or to help educate yourself.

Galbreath: Thank you guys, that's such a great response. You know, really hearing about ... how to have that conversation when you can, and ... to kind of get to your health goals and your needs met but then eventually you know exploring the opportunity that you can try and find another provider either at that clinic or maybe elsewhere. So thank you all for that. It was very helpful and hopefully we're getting to a day where there's much better understanding and appreciation for you know, the complexities of ... our bodies and our minds so it's really helpful.

You know, I want to talk a little bit about some of the domains of wellness but before I do, do you guys have any other thoughts about kind of ... challenges that people might face that we can just touch on having those kind of effective conversations?

Reeyon: Can I bring up a challenge that I face? It's [that] the federal government has mandated fairly complex, computerized medical records. Honestly, those in my mind have actually made the work more difficult, particularly if you're working with a group that maybe has put in a new one of these systems. I guess I would ask people to be ... a little bit more understanding, if they're learning a new system because these systems can be really, really clunky.

And I'll be frank we put one in about a year ago and I just absolutely hated the thing for 5 and a half months. It was just it was like water torture. So I think these are being mandated. Actually if people don't put them in, the federal government is now fining people, so just if you're whoever you're working with is used to punching a lot of buttons on the computer, that isn't necessarily their idea; that's sort of being forced on the system right now.

You know, I'm optimistic enough to think in the future that it will get better but right now that's a system that we all have to kind of, live through, so I would just say that's a challenge that none of us can solve immediately, but it's out there and I think people adjust to it but it does change behavior.

Holly: This is John, and I would just like to say that about probably 6 to 9 months ago my doctor did exactly that and said "we're going through this new process and I've got lots more paperwork and bear with me" ... And in the "I feel his pain" department, literally this week we had to rollout all our electronic health care records in our mental health agency and we officially go live with it in 2 weeks. And so now we're all trying to debug and see what how each of us individually is affected. So yes, there's going to be a glitch as changes take place but I think

your solution of just being up front and honest about it, and say “hey, this is something I’m struggling with” is a really good solution to that. Thank you.

Pilletti: You know, and I think that brings up some interesting topics in terms of patients and their relationship with the physician. Some patients feel very anxious about having their information in electronic medical records. The other piece to electronic medical records is the hope of sharing information over time with other physicians and making an ease of information sharing, which can be threatening and anxiety-provoking to patients, particularly [those with] mental health and behavioral health/substance use disorders.

And I want clients/patients to understand that they have the ability to share what they choose to share and that there’s a bit of a movement right now to share all information but I want to give clients the empowerment to say “No, I don’t want to share that with everybody,” “I don’t want to share that with my primary care physician,” or “I don’t want to share that with the cardiologist. There’s just no reason for them to know whatever.” You know, ideally, sharing more information improves our health, but we all need to be very sensitive as to what we share.

Galbreath: That’s such a great point. You know, we do want good care coordination for our providers, so that we don’t have medical errors and risk, but how much information and how do we protect some of that? And for a lot of providers are trying to protect or maybe there’s a diagnosis recorded, but the details of that diagnosis are only limited to certain professionals in the EHR (electronic health record). And so I think from a consumer/patient perspective, just having that conversation, either when you’re filling out that paperwork on the privacy front or any member of that team just getting some clarity about what information is being shared and what do we want to share for good care coordination and what are some of those details that we’d like to keep private.

And also a quick sidebar related to technology: This came up for my mother actually recently was this issue of: “Now the doctor has a computer and instead of talking to me, he’s just sitting there talking to the computer and typing away.” And I said “Well, you know, Mom, that’s just concurrent documentation. They’re trying to take notes real-time, instead of waiting till later to capture that information.”

So you know, I think that part of that training that we made them think about to is that as we go through the struggles of these new systems and technology, how do we make sure to still have some of that eye-to-eye contact, and that conversation piece around “Here’s what I’m thinking, what are your thoughts, or what do you think about this treatment plan?”

Pilletti: It’s funny because I did a Google search on myself one time, Laura, and I think I got 4 stars, because it said “all she did was look at her computer and type.” And that’s again when our computer system was new. It made me more aware of that, and it made me stop typing at moments and look the person in the eye and explain to them what I’m doing. “I need to stop for a moment and record some of this,” you know, have those conversations as I’m going.. be

able to type and look at the person... I'm not a natural typist I always say if I had to be a secretary, I would starve because I would [laughter] so knowing how... knowing those nuances.

Galbreath: Yes, and I think, for patients and for consumers to understand that they're just trying to record information and get it all down. We're all trying to work through this technology and there are some really good pieces. You know, we're having conversations about how to be... what happens if you leave and forgot some information? How are people accessing patient portals now for their health care provider to see their lab work, or get a trigger about an appointment or a prescription or a text message as a reminder that I've got an appointment coming up? So there are some really good ways, I think, that will to help support all of us as professionals and as individual patients of health care.

So I want to talk a little bit about you know, certainly the goal here is the timing is around Wellness Week. And Wellness Week being a recognition that somebody's health is certainly part of their behavioral health recovery and vice versa and so when we think about some of the domains of wellness ... how does... what do you guys think, when thinking about some of these things that relate to our health but it's not taking a prescription or getting a test done? It's around managing my stress it's around exercising more, building social support, the power of financial security, spirituality, all these kind of, elements of wellness how do we bring that into the conversation? And it not just be about lab results ... how to have that bigger conversation?

Holly: This is John and that's the group I mentioned earlier—the Whole Health Action Management. We actually discuss virtually every one of those briefly and then ask the members of the group to select one, just one, that we're going to work on for eight weeks. It needs to be positively stated, and it needs to be time-bound and measurable.

So if somebody says that they want to increase their social activity, so it might be OK so we would... I would explore with them what they would like to do, so maybe for example let's says "I'd like to join a bowling league but I really don't know where to do that" then that person would as their weekly individual goal leading toward the larger goal of being on a team would be to find different bowling alleys they could go to where they have leagues then maybe visiting those individually to see you know, whether they like the atmosphere at those places, different steps like that towards meeting that goal of being more social.

Or if physical activity is their goal, finding a good place that they could go walking or that sort of thing and then increasing their distance and time as the eight weeks go by. So that's what exactly what I do, is to help people pick one of those and meet it. Thank you.

Galbreath: That's great. Sounds like you're really using other members of the team to kind of help with some of those health and wellness goals.

Reeyon: One of the other things I've found ... the importance of sleep and the interference in a good sort of sleep schedule of a variety of things—from too much eating or exercising too late in the day, honestly using too much technology late at night, people with TVs in their bedroom.

There's this whole panoply of things that go with on our society that really interfere with people establishing—they call it "sleep hygiene." It's just you go to bed around the same time, and you get up around the same time, you don't watch TV in the bedroom, you don't play computer video games until the moment you try to go to sleep, so that's actually something I wind up working with people fairly regularly on. And I'm always impressed how little people know about this stuff. I think everyone knows no, don't smoke, don't drink or drink in real moderation, but some of the information around sleep hygiene I think is relatively unknown in our society right now.

Galbreath: I know a consumer who shared with me that it's key to their recovery in terms of helping with their relapse prevention is making sure that they get plenty of sleep and a good balance and a good quality of sleep so that's key. Shannon, I was wondering, as I think about a mental health professional—a case manager or other professional that might be working with me at a mental health site or even at a primary care clinic... How could I think about how they can help a person around their wellness goals?

Pilletti: Well I think recovery is key—and you mentioned the word, recovery. That we don't think of mental health, we don't think of chronic illness as defining us anymore, or we try not to think that it's defining us anymore. We are not diabetes, we are not bipolar illness, we are not schizophrenia. Each individual is an individual who happens to have certain illnesses or certain challenges. Even trauma may be one of the challenges, but it does not need to define the person, so that we can recover and we can live a full life.

Now maybe the fullness of our life is not the same as it was six months ago before a certain illness was developed. However, we can still live a full life. Maybe we can't go backcountry hiking and camping, but we can still camp in a camper. So we look at how can we modify our life, given our current restraints, and how can we work toward improving that?

We also look at resiliency. And resiliency is the ability to overcome stresses. We all have stress every day. We know this; this isn't news. However, having the coping skills to deal with the stress is hugely important. And so whether it's mental illness or diabetes or smoking cessation, how are we going to change our coping mechanisms towards/for stress and improve how we handle it so that those stressors, be they illness, be they financial stressors, whatever, become a smaller part of our life and just a problem to solve rather than an overwhelming issue that stops us dead in our tracks.

Galbreath: That's great, so really thinking about ... the change process and how there's a whole team really focused on bringing themselves to help you through that change process around your behavioral health team as they support your recovery and your health goals, you know, peers that can offer some great support ... and friendship as you try to achieve goals and then certainly your team in terms of your physician, nurse, and other staff that are working on the medical condition.

And one of the pieces of recovery as our final closing is hope. And hope is a real principle of recovery and I think as we think about folks that are managing pretty complex medical conditions and also trying to deal with, you know, what's going on with their lives in terms of their relationships, jobs, housing and then certainly on top of that a mental illness or an addiction that they're trying to manage ... that sense of hope is so key and something that everybody can easily support. So anybody have any thoughts about that? Or any closing remarks they want to make sure that they share before we wrap up?

Reeyon: Well, I think you really hit it there at the end you know. All of us have problems, and we usually have no choice in some of the problems that we encounter in our lives. And we would like to give those problems away, but really all we can do is try to respond to those problems in the best way that we can. And then closely linked to that is to try and respond in a way that helps you get to your hopes. That's the purpose –we try to respond in a productive fashion to get to things that matter to us, whatever that may be.

Galbreath: Thank you, that's so helpful. [For] some of these topics that we've talked about today, there are some great tools and resources out there. SAMHSA's Wellness Campaign, you were talking about sleep; there are some good tools out there; also. When it comes to these things around integration and wellness, we've got a lot of great resources on the integration website: integration.SAMHSA.gov.

And feel free to e-mail us at integration@thenationalcouncil.org for any individual questions that you may have in terms of accessing some resources.

Thank you so much to John Holly, Dr. Ray Reeyon, and Dr. Shannon Pilletti for your time and this conversation today. I think what we learned is good health supports one's recovery and improving that conversation between the patient/consumer and the provider will only grow to help us through that change process in achieving whole health and wellness. And with that, thank you very much and have a great day.