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Geri Amori, PhD, DFASHRM: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I am joined by Kris McCarty, occupational therapist with a master's in physical therapy, who is an inspired and passionate advocate; David Miller, patient experience coach from Johns Hopkins Health System; and Carleigh Zahn, practicing board-certified internist and rheumatologist. Welcome. Today, we're talking about creating a safe space for patients receiving care, who also have behavioral health diagnosis with concurrent medical illness and how to support a positive patient-clinician relationship with these complex issues.

But before we begin discussing this very important topic, it's my pleasure to tell you about a comprehensive white paper that has been developed by Coverys, our parent company, that is available for a free download to anyone who listens to this podcast. The white paper details data gleaned from Coverys medical malpractice claims and offers risk management suggestions to increase your healthcare organization's patient engagement. There is a link right on the podcast landing page. We hope you'll take advantage of this resource. And now, let's begin today's discussion.

To set the stage for today's discussion, a literature meta-analysis published in 2019 found that mental disorders are often associated with 1 or more chronic physical diseases and leads to even more aggravated physical consequences for patient health. The care provided to people with mental disorders for their physical health problems is generally inferior to that received by persons without mental disorders. So I'd like to begin by asking Kris, while this is not surprising to many of us who have behavioral health backgrounds, the research further suggests that people who have depression and another medical illness tend to have more severe symptoms of both illnesses. How has this research been confirmed or refuted in your professional roles?

Kris McCarty, OTR/MPT: I, like you, am not surprised with this research, and it certainly is confirmed in my clinical experience. These blended relationships are complex. With either condition, you have the shared biological risk factors and the interplay between them. And as we recognize, you're not able to sequester psychological and social factors from any patient that we serve. So any of these factors are going to contribute to the overall burden or complexity for any condition.

Amori: It becomes sort of like how do you sort out what's what, in that situation. David, those of us who have worked with behavioral health patients may have encountered many patients with behavioral illness experiencing healthcare in a different way than compared to patients without a diagnosis. They, like all of us, perceive the system through the lens of their other encounters with the system, as well as any influence of their disorder on their perceptions. So, in your experience, do you see patients with coexisting behavioral health and medical conditions perceiving their hospitalizations in a less than positive light? Or have you just not noticed any sort of differences?

David Miller: We have noticed differences in some cases. But while each patient's case is, of course, unique, what remains in every case is the focus on maintaining that patient-centered care. And that care obviously pulls in a host of disciplines to provide service. For example, when there's a medical condition that presents pain for a patient with a coexisting behavioral health diagnosis, our treatment goal is to increase that function, including the reduction of that pain. And the only way we can accomplish this, across the board, is when the patient forms a collaborative relationship with a staff of experts. And we know all of those disciplines that come on board, PT, OT, VA, medical, etc., having an emphasis on promoting independence and making sure that each patient is treated wholly and equally, that's what nets the success.

Amori: Kris, there's a challenge within our system. A behavioral health diagnosis may feel discriminatory, even when there aren't outward demonstrations of the disorder. Like depression, even. You may not see someone's depression. It's a stigma in our system. People expect other people, humans, to control their depression or their anxiety. And there's no clean way to treat a person with behavioral disorders who also has a physical illness, especially when that disorder has been identified. Right? If the disorder hasn't been identified, and the person has anxiety, we just call them an anxious patient. And they actually seem to get less stigma than somebody who's got generalized anxiety disorder on their chart. I mean, it's tough, right?

What is the type of patient engagement that can be created to involve patients who have behavioral disorders, who may themselves feel—they discriminate against themselves, right—who likely may be quite nontrusting of healthcare in general? What do we do? How do we cross that barrier?

McCarty: I think that patient engagement, one, is patient-facing, but it's also caregiver-facing. We have gone through a pandemic, and during the pandemic, we were trying to get one foot in front of the other and just make it to the next day. And a lot of our traditional education and in-service or opportunity to offer support in different ways to help manage this patient presentation kind of fell off the wayside while it was concurrently growing in frequency. So I think, one, it's equipping our team with tools and helping to remind them each presentation is unique. So is the approach used. So helping our teams to recognize the key in reading patients and involving them, to the best of their ability, offering education, giving the patient's choice and verbal affirmation when possible, but I think it's multifactorial in supporting the patients but also supporting those who are supporting the patients with education and support as well.

Amori: And I think you brought up an important point that during the pandemic, so many of the infrastructures that we had built to do these things kind of fell apart. It all fell apart. The world fell apart. So now we have to rebuild and reidentify and restructure. Carleigh, when we talk about healthcare, the epitome of no engagement is to treat a person like a slab of meat. You know, like, there they are. They are the arm in room or emergency bay 3 or the whatever it is, right? It's a body with body systems and a human that's attached to it. It's been easy to forget. So fully engaged healthcare might be more like the med student approach. The patient is well informed, cares, and tries to participate fully. How

do you avoid a system-only or a disease-only approach to patient care? Because we know not all patients are med students, right? Especially when there are coexisting behavioral health issues that are present. What do you do? How do you do it?

Carleigh Zahn, DO: I am lucky, or I am challenged, depending on how you want to look at it, in that I work in a specialty where there is increased incidence of comorbid behavioral and mental health diagnoses. So I live this every workday. I can guarantee that if I don't approach the patient as a whole, if I only focus on the disease, even if I get their disease to be in remission, meaning disease is controlled and the symptoms are controlled, the patient may not feel like they're truly in remission because of those behavioral health comorbidities. So I have to make it a purposeful approach to just not treat the disease, and for some providers, that may be challenging. It may need to be something that's a focus and a change for them. It may not be inherent to them. Medicine is ever-changing, and that means the way we approach it should be too.

Amori: I can hear that, that it's hard, that it's a difficult thing you got to do and you can't take it one extreme or the other. David, let's face it, there's a whole continuum between the slab of meat and the medical student, right? There's a big place in there where we all fall somewhere in our ability to engage, in our knowledge and our desire, right? When someone has behavioral health illness, it simply affects where they fall on that continuum, in terms of their ability. That's all. We're all on there somewhere. And their ability to think through it because of their perspective, they're just in a different place than some of the rest of us. It doesn't push them off the scale. So the real question, in my mind, for the healthcare system is, how do you meet someone where they are on that continuum? How do you do that? How do you figure out where they are and meet them there?

Miller: I think it ties in to exactly what was just said. Not just looking at it as the disease. And, again, it's about that connection in that relationship. And yes, meeting them where they are. What that means is that balance between the physical and the mental health needs. A provider, again, needs to see each individual as a whole. That's what's going to lead to a more positive experience, obviously. It's interesting, one of the things that we typically share is a quote from William Osler, a founding member of Hopkins School of Medicine, and he said, “Care more particularly for the individual patient than for the special features of the disease.” And so I think that really is the key.

Amori: Actually seeing the person. Actually knowing what's going on for them individually. Of course, that's the hardest thing to do. It's much easier just to look at the disease, right? Carleigh, I know you studied everything in medical school because that's what happens in medical school. But the question our listeners wonder is whether we were taught how to treat hypomania, unrelenting grief, severe PTSD, internal, not necessarily in a veteran, who also has a body-system illness versus a standard patient with a standard typical behavioral health diagnosis or a standard typical nonbehavioral health diagnosis. Are you taught how to deal with these comorbidities?

Zahn: I'm going to say everything is a strong statement when you refer to learning everything in med school. But in my medical training, we acknowledged that comorbid diagnoses exist, but we honestly didn't spend a lot of time expanding on recognizing them or treating them. In the decade-plus years later, I can say with confidence that medical schools nowadays are focusing on this more, which I think is amazing. I am very lucky that I had a wonderful residency and fellowship, which did take these issues seriously and did help us grow and learn about these challenges. So while perhaps med school didn't, there are other parts of our medical training that can also build on this. So long story short, no, I didn't, but we're getting better at it.

Amori: Well, good. I'm glad to hear that. That makes all of us feel more secure and safer about it and happier. That's great. And I would say that medical schools are changing their approaches to teaching students now, too. Let's hope they're moving more in a way that really does address things like this. And Carleigh is giving me a thumbs up on that one, so good. As we come to the close of today's session, or today's episode, I'd like to know what the 1 thing each of you would like our listeners to take away from our discussion on patient engagement with those with behavioral health and other comorbidities. And I'd like to start with you, David, if I could.

Miller: Absolutely. In the relationship between provider and a patient who may be presenting a combination of physical and behavioral health needs, it's vital to approach and treat each equally, as they truly impact one another. And in that combination of care, respective providers in a multidisciplinary team can help people with chronic disease by providing that care for the whole person and assisting patients in their understanding and treatment of their needs. The focus remains on successfully treating both physical health problems and behavioral health problems.

Amori: Successfully treating them both. Thank you, David. Kris, what are your thoughts?

McCarty: I think, first and foremost, acknowledge it's real, it is prevalent, and it is challenging. And no matter where you are as a healthcare professional, look at what you can do in your circle of control. If you're an administrator, what can you do to equip the team that you support? If you are a clinician, every person has a different vantage point, and what is your circle of influence that you can impact by acknowledging it is real and it's something that everyone is dealing with every single day?

Amori: So from you two, thank you. From you two, I hear don't lose focus. Remember, we are treating a whole human, and they happen to have 2 diagnoses. Carleigh, would you like to bring us in home?

Zahn: Sure. I think both from the patient and the medical world side of things, we should highlight what you mentioned before about stigma. There's a stigma and bias to mental health. Patients can feel stigma about getting the diagnosis, medical professionals can have stigma about the diagnosis for a patient, definitely preconceived notions. So the takeaway should be that we need to be aware of our biases because if we're not inherently aware of our biases, we can't take care of the whole patient.

Amori: Being aware of our biases. Thank you, Carleigh. Carleigh, David, and Kris, thank you so much for joining us here today. And I'd also like to thank our participants for being here and listening to us. This has been a great conversation. And thank you, everyone, for sharing your thoughts and perspectives. And I look forward to seeing all of you again next time on *Perspectives 360.*

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