Using Mindfulness to Improve Health Care Delivery

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Disclosures

Disclosure statement

- Susan Richardson has the following relevant financial relationship(s)with a commercial interest: She is an employee of Wellpath

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Objectives

- By the end of the presentation, participants will be able to explain the concept of mindfulness (definition, how it works, and common uses)
- By the end of the presentation, participants will be able to identify three barriers to great care (versus good care) in the prison setting
- By the end of the presentation, participants will be able to describe five strategies using mindfulness to assess, diagnose, and treat patients

God’s Hotel
Victoria Sweet

What is mindfulness?

- A skill that enables individuals to be more in charge of their physical, emotional, social and spiritual well being.
- Paying attention, in the moment, on purpose, without judgment
- Some may be more naturally inclined to it but anyone can learn it
- Practice will never make perfect but it will lead to improvement

Mindfulness: How does it work

- Brain has the capacity to create new pathways for neurotransmitters – this is called neuroplasticity.
- There are two separate nervous systems
  - Sympathetic (SNS) – involved in fight or flight or freeze – this is useful when we are in real danger but counter productive when we perceive threat where there is none. Our response to perceived danger (real or not) is reactivity – fight or flight or freeze. A history of trauma (primary or secondary) sets our default mode at fight, flight or freeze. Autonomic nervous system (ANS) – enables use of executive functioning and decision making, to act intentionally, rationally
  - Mindfulness boosts frontal lobe activity which over time bolsters our capacity for rational thought, and intentional planning which promotes executive functioning while modulating emotional awareness and impulse control
  - Mindfulness also gives us an awareness of which system we are using and enables us to switch between the two

Mindfulness: Common Uses

- Personal – self care
- A skill we teach our patients

My first encounter with mindfulness in practice

- God’s Hotel – by Victoria Sweet

How did we get here?

- Providers are unhappy, hate their jobs, burn out
  - Make mistakes
  - Choose the most likely/expedient answer then ignore anything that goes against it
  - Leave the profession
- Patients don’t feel heard or understood
  - Don’t “bother” going to the doctor
  - May seek “alternative” medicine (note this is not a bad thing in and of itself)
- The quality of care suffers

Why???????

Barriers in the community at large

- Insurance driven
  - Goal to minimize costs
    - Increased productivity demands
      - Shorter appointments
      - Larger case loads
      - Longer work hours
    - Forces provider to fight for better care
      - Prior authorization for treatments
      - Prior authorization for more expensive medications
      - Shorter stay at higher level of care (two edged sword)
      - Even patients can feel that they need to exaggerate symptoms to get the care they need

Barriers in the community at large (2)

- The Electronic Health Record (two edged sword)
  - Pay more attention to record than the patient

    Record becomes the expert, not the patient

    Record makes it almost impossible to do a chart review

    Record can be difficult to change

    multi tasking (typing while “listening” to patient)

    increased documentation demands

    problem oriented rather than patient (who has a problem) oriented

Barriers unique to correctional setting

- Provider bias towards inmates
  - Less “deserving” of care
  - Assumption that inmates have an agenda – colors provider perception
  - Prejudice (race, ethnicity, sexual orientation, poverty, education)
- Biases of collateral informants (Officers)
- The very real possibility that the patient is not telling the truth or has an “ulterior motive”
- Limited time patients can come to appointments
- Limited formulary
- Limited access to services outside the prison
- Difficulty getting outside records
- Restrictions in contacting the family

Key Principles

Attention

Curiosity

Beginner’s Mind

Presence

Attention – before the visit

- To the data – record, collateral information
- To yourself
- To the environment

Pay attention to any data available (take notes!)

- The record
  - What they were asking for at last visit
  - What happened the last time you met with patient. How did they present?
  - What you did: treatment started or changed
  - Anything that happened since you last saw them (eg. Went to court)
- Collateral information
  - Other members of treatment team
  - Officers
- After you have gathered data, put it aside

Paying attention to yourself

- Body scan – are you relaxed, tense (if yes, where in your body are you carrying the tension) THEN for five seconds relax the area(s)
- What are you thinking about – BE HONEST
  - (the patient, your problems, everything else you have to do today, your headache?)
  - Are you having racing thoughts
- Don’t judge – you are where you are and you are doing the best you can
- Use brief mindful activity - put hands behind your head and breathe (forces you to open up your diaphragm)

Paying attention to the environment

- Where is the exit, means of escape
- What things if any could be used as a weapon
- What things are confidential
- Anything going on outside that is concerning, dangerous
- Always pay attention to your “gut”

Paying Attention during the visit

- Paying attention to the patient and your interaction with the patient
- Paying attention to yourself
- Paying attention to the environment

Paying attention to the patient during the visit

- Focus on the patient (using central vision) and on yourself (peripheral vision)
- Acknowledge that this is an interaction between you and the patient at a point in time
  - Show up with undivided attention
  - Stay in the moment
  - If your attention wanders, gently bring your focus back, without judgment

When all else fails, examine the patient as if you had no other information available

- Observe when they walk into the room – keep mind open, non judgmental, expect the unexpected
  - Posture –erect, stooped
  - Gait – normal, limp, shuffling
  - Expression – do they make eye contact, do they appear to be in pain (physical or emotional), guarded, open
  - What does your “gut” tell you
    - Are they truly present
    - Do they “want to be there”
    - Do they want to share their story

Paying attention to the patient (2)

- Listen to the patient
    - Primary complaint
    - Anything else that attracts your attention
    - Avoid judgment/premature conclusions
    - Is there any contradiction between what they say and how they appear

Paying attention during the visit on the periphery

- Pay attention to yourself paying attention
  - To the patient
  - To the interaction between you and then patient
  - If your mind is wandering gently bring it back without judgment
  - To your body – where ever there is tension consciously relax
- Paying attention to your surroundings
  - Things going on outside the room that could be call for action on your part
    - A fight out side the door
    - A Fire alarm
    - Any other sign of danger or anything that requires you to refocus your attention

Curiosity – “the art and joy of observation”

- When we are curious we explore new things for their own sake irrespective of what we might get out of it
- “a wonderment”, “a realization there is always more”, “an openness to experience”
- In medicine – seeking to know what makes each person tick
- What blocks curiosity
  - – being afraid to say “I don’t know,” unwillingness/fear of uncertainty. (both a problem for the provider and the patient/family who “want answers” because we are always supposed to know everything right now.
  - An “unpleasant” encounter – patient not doing what I want, patient is being “difficult”, non compliant – “I just want this visit to be over.”
    - This is a good time to switch attention to yourself – irritability, symptoms of fight or flight
- What curiosity makes you want to do – dig further , explore archaeology of each person’s illness

Curiosity

- Ask the patients about who they were and what their lives were like prior to incarceration
- Ask about the patient's about their experience not just their symptoms
  - Symptoms more concrete – loss of appetite, can't sleep, pain, lack of mobility
  - Experience more abstract – how their condition effects them – relationships, ability to function (as a partner, as a parent, as an employee), mental health, level of suffering (physical, emotional, spiritual)
  - Use open ended questions and allow time for the patient to respond (do not finish the patient's sentences)
  - Are there differences between
    - What the patient is saying
    - How the patient appears
    - Collateral information

How curiosity is beneficial for us

- The more curious you are the less anxious, defensive and rigid you will be and reverse is also true
- Research showed people who were attentive and curious were less anxious and defensive when compared with those who were equally attentive but had a less curious disposition
- Curiosity is linked with release of neurotransmitter dopamine – people who are curious are genetically different from their peers. Their dopamine receptors are more numerous and their genetic coping mechanisms are different
- However, environment also plays a role – people tend to be more curious in supportive environments

Beginner's Mind

- Think about what you were like when you were a student or an intern
  - Different expectations
    - Not expected to know all the answers – "you don't have to know everything just enough to know that something might be worth pursing"
    - Could live with uncertainty
    - More time to spend with the patient
    - More time spent collaborating with supervisors and/or colleagues
    - Less pressure to quickly come up with a diagnosis

  Easier to believe that the body is amazing

  has the capacity to heal itself

  need to ask "what is in the way" of the person (body, mind, spirit) healing themselves?

Presence

- Showing up and entering the world of the patient
  - With compassion
  - Without judgment
- Our patients KNOW when we are really there
- Need ability to step outside of oneself and observe whether or not we are truly present
- When patient and provider are present to one another time stands still
  - Neither patients nor providers feel rushed
  - Patients feel heard and supported
  - Providers feel they have addressed the patients' needs

Unique opportunities in correctional setting

- Lower productivity expectations
- Longer appointment times
- Those who give prior authorization are part of the health care team, not a separate entity
- Interdisciplinary communication accessible
- Patients live in the same place they are seen
  - Can be observed and interacted with throughout situations/times of the day

Mindfulness in Practice

So, why don’t practice it?

A word about compassion fatigue

Secondary traumatic stress

+

Burnout

=

Compassion fatigue

Secondary Traumatic Stress

- Caused by witnessing/interacting with others who are traumatized or suffering
- In today's world we are trauma saturated before we even leave the house due to social media
- Mental health professionals experience STS by hearing the patient's story and experiencing it as though it were happening in real time
- STS builds over time
- People who have experienced past trauma have certain triggers which bring back the experience of the trauma as if it is happening right now
- When this happens a person stops interpreting their environment by what their senses tell them and begin interpreting it based on past painful experience
  - Perceived imminent danger when there is none
  - Switch to fight or flight

Burnout

Traditionally has been blamed on the work environment

- schedule
- certain patients (personality disorders, aggressive, hostile)
- certain coworkers
- supervisors/management
- correctional officers
- prison climate

BUT this makes us the victim – because we cannot change any of the above

Burnout (Gentry)

- The chronic condition of

- Perceived demands outweighing perceived resources
  - Gentry and Bernowsky, 1998

Therefore….

- Those of us who suffer from Compassion Fatigue have a very difficulty time treating our patients mindfully
  - Due to STS – we are emotionally reactive (fight or flight)
  - Due to our perception of our environment
    - We perceive a lack of choice
    - We perceive a lack of time/resources

BUT

- We do have choices
  - Choices have consequences and we will have to live with them and that's okay

    Be realistic about likelihood/severity of consequence

    Recognize there is no perfect solution and make the best decision you can

    Don't choose based on emotion (Remember: be aware of yourself, relax your body)
- We do have time/resources as long as we prioritize
  - What must be done
  - What should be done
  - What can be deferred to a later time

Take home

- Pay attention
- Be curious
- Use a Beginner’s Mind
- Be Present

- When you feel stressed take a 5 second break to relax your body

- When you feel traumatized , consciously use your senses to evaluate what is going on

- When you feel burned out, take time/space to recognize what you can do. Then thoughtfully make choices

God’s hotel

- Visits less rushed
- Seeing patients in their own environment/community
- Seeing patients over time
- An opportunity to ask questions
- what’s in the way?
- What’s really going on?
- What am I missing?

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