Session #B1

Translating Therapy Skills Into Integrated Behavioral Health in Primary Care

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- List how behavioral health providers can use systems theory and clinical skills to provide effective care in the Integrated Behavioral Health model.
- Identify understanding of theoretical models of treatment most appropriate for the fast-paced and diverse nature of Primary Care, including: Motivational Interviewing, Brief Solution-Focused Therapy, Cognitive Behavioral Therapy, and Crisis Intervention.
- Discuss practice skills to perform brief, effective functional assessments and interventions in a Primary Care setting.

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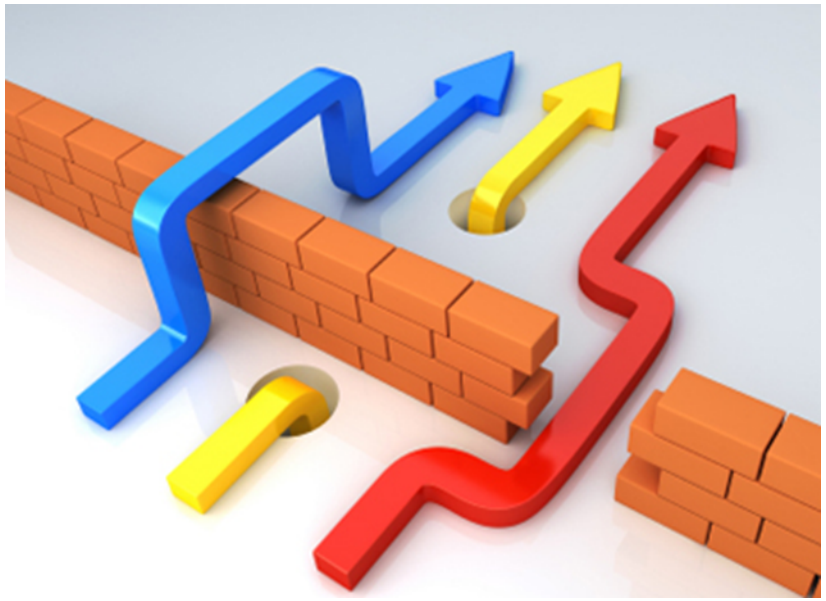
Integrated Behavioral Health



In Integrated Care, “behavioral health providers and Primary Care Providers (PCPs) work together in a shared system, and the behavioral health provider functions as a member of the primary care team to address the full spectrum of problems the patient brings to their PCP” (Hunter et. al, 2014).

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Levels of Integrated Care

- Level 1– Minimal Collaboration: Mental health and other healthcare providers work in separate facilities, have separate systems, and rarely communicate about cases.

- Level 2 – Basic Collaboration at a Distance: Providers have separate systems at separate sites, but engage in periodic communication about shared patients, mostly through telephone and letters. Providers view each other as resources.

- Level 3 – Basic Collaboration Onsite: Mental health and other healthcare professionals have separate systems, but share facilities. Proximity supports at least occasional face-to- face meetings and communication improves and is more regular.

- Level 4 – Close Collaboration in a Partly Integrated System: Mental health and other healthcare providers share the same sites and have some systems in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other's roles and cultures.

- Level 5 – Close Collaboration in a Fully Integrated System: Mental health and other healthcare professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other's roles and areas of expertise.

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How Did Integrated Behavioral Health Start at Legacy?

- Legacy was awarded a HRSA Grant to implement IBH at Legacy San Jacinto (Baytown) from November 2014 – October 2016.
- Allowed four staff members: Two Behavioral Health Consultants, an Integrated Behavioral Health Representative, and Project Coordinator.
- Areas of focus to screen and/or treat included: Depression, Substance Abuse, and Post-Partum Depression.
- A primary measure of the grant was to raise *Depression Screening and Follow Up* rates to 40% within the first year of funding and to 80% send of the second year of funding.

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Timeline: Growth of IBH at Legacy

Late 2014: Clinical Lead and BHC began educating clinic staff on IBH and establishing workflow for IBH.

Spring 2015: Two BHCs began working in the clinic alongside providers at clinic in Baytown.

2016: Adjusted workflow to better serve patients and clarify billing
Expanded IBH to Montrose Location; HRSA Grant Renewed through October 2018

2017: Increased utilization of IBH at both Baytown and Montrose Locations.
Awarded Episcopal Grant to add four additional BHC positions.

2018: Integrated Behavioral Health up and running at five Legacy clinics (Baytown, Montrose, Fifth Ward, Southwest, and Beaumont.

Fall 2019: Appointment of VP of Integrated Behavioral Health and 7 full-time BHC's.

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Patient Experience

Screenings Completed and Patient identified

Provider Initiated

- Positive PHQ-9, EDPS, GAD-7
- Unmanaged Health Condition*

Behavior Health Consultant (BHC) Initiated

- Pre-Screen

Patient Request

- Word of Mouth
- Exam Room Educational Materials

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Patient Experience

Provider and BHC discuss referral in the clinic to determine eligibility for BHC services based on behavioral health or health management need while patient remains in exam room.

Patient and BHC meet for initial evaluation (IBHA) in Assessment Room or Exam Room. If BHC unavailable, appointment will be scheduled by IBH Rep in real time.

Patient pre-contemplative: Psychoeducation provided. No further follow up at this time.

Patient shows readiness for change: treatment plan created.

Patient's case is not referable to BHC.

Patient referred for:

- Continued follow up with PCP
- ER or Psychiatric Inpatient
- Social Services

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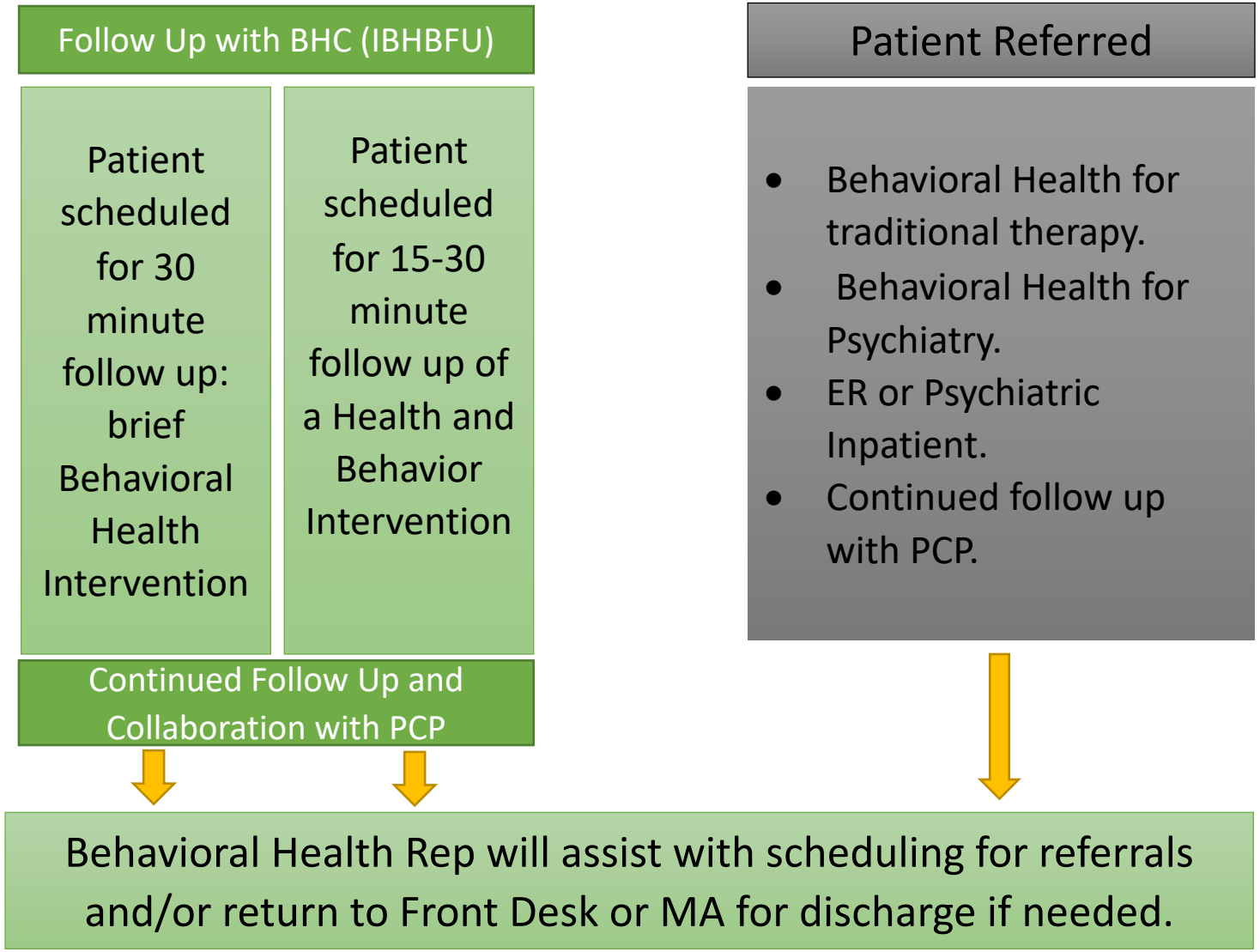
Patient Experience



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The Initial Assessment

- Introduction of the BHC
  - PCP to patient
  - BHC to patient

- Consult with PCP
  - What are your concerns?
  - What do you need from me with this patient?

- Focus on issue identified in referral
  - "Dr. Smith ask for me to talk with you more about the depression you have been experiencing."
  - NOT, "What brings you in today?"

- Clarify identified issue
  - What is the frequency, intensity, and duration of the problem?
  - Was there a triggering event?
  - What makes it worse? Better? Any previous treatment?

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The Initial Assessment

- Functional Assessment
  - Mood and Affect
  - Cognitive Functioning
  - Activity Level
  - Physical Functioning
  - Health Behaviors
  - Risk Assessment
  - What does a typical day look like?

- Engaging patient in change process
  - What do you want to be different right now?

- Treatment plan and follow up
  - Setting a specific goal
  - Referring to additional resources
  - Scheduling follow up visit
  - Closing the loop with PCP

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Common Screeners

- **Depression:** PHQ 2, PHQ 9, PHQ A
- **Anxiety:** GAD 2, GAD 7, Pediatric Anxiety Rating Scale (PARS), Health Anxiety Questionnaire
- **Pregnancy/Post-Partum Depression**: Edinburgh (EDPS)
- **Mood Disorders:** Mood Disorder Questionnaire (MDQ)
- **Substance Abuse:** SBIRT, CAGE
- **Disordered Eating:** SCOFF, Eating Disorder Screen for Primary Care (ESP)
- **Diabetes Distress:** Diabetes Distress Scale (DDS)

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Using Evidence Based Treatment Modalities

- Solution Focused Therapy
- Cognitive Behavioral Therapy
- Motivational Interviewing
- Crisis Intervention

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Solution Focused Therapy

Ask direct, thought provoking questions:

- If you could change one thing in your life right now, what would that be?
- You are excellent at taking care of others, how do you take care of yourself?
- What do you want your life to look like?

Help your patient focus on *one thing* to do differently.

- You're feeling depressed most of the day and when you're depressed you want to be in your room in the bed in the dark. I wonder how you would feel if you laid on the couch for part of the day instead of your bed?

As a provider, ask questions that assume positive changes.

- Tell me what is going well right now.
- What is better since that last time I saw you?

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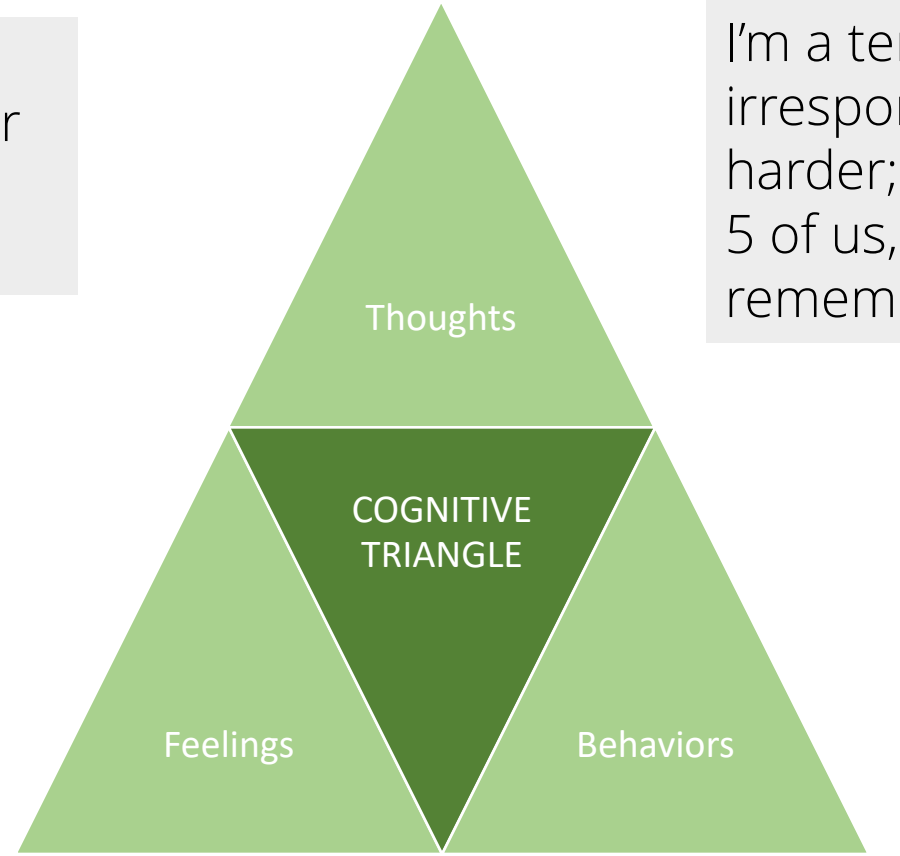
Cognitive Behavioral Therapy

Scenario:
Mom missed her child's 2 month well check.



I'm a terrible mother; I'm irresponsible; I need to work harder; My mom kept track of 5 of us, I should be able to remember one appointment

Guilty – 10
Angry – 8
Depresse d – 8

Cry; Negative self-talk; yell at toddler for making too much noise during the appointment

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Cognitive Behavioral Therapy

Make a list:

What would you tell a friend in the same scenario?

- ❑ It's one appointment
- ❑ You called and rescheduled as soon as you realized you missed it
- ❑ This is hard
- ❑ The phone reminder system is confusing
- ❑ Drop your toddler off with me before you go next time

Alternate lists might be: *What do you think you're doing well as a mom? What else was going on that day? What's the evidence that you're a terrible mom and what's the evidence that you're not?*

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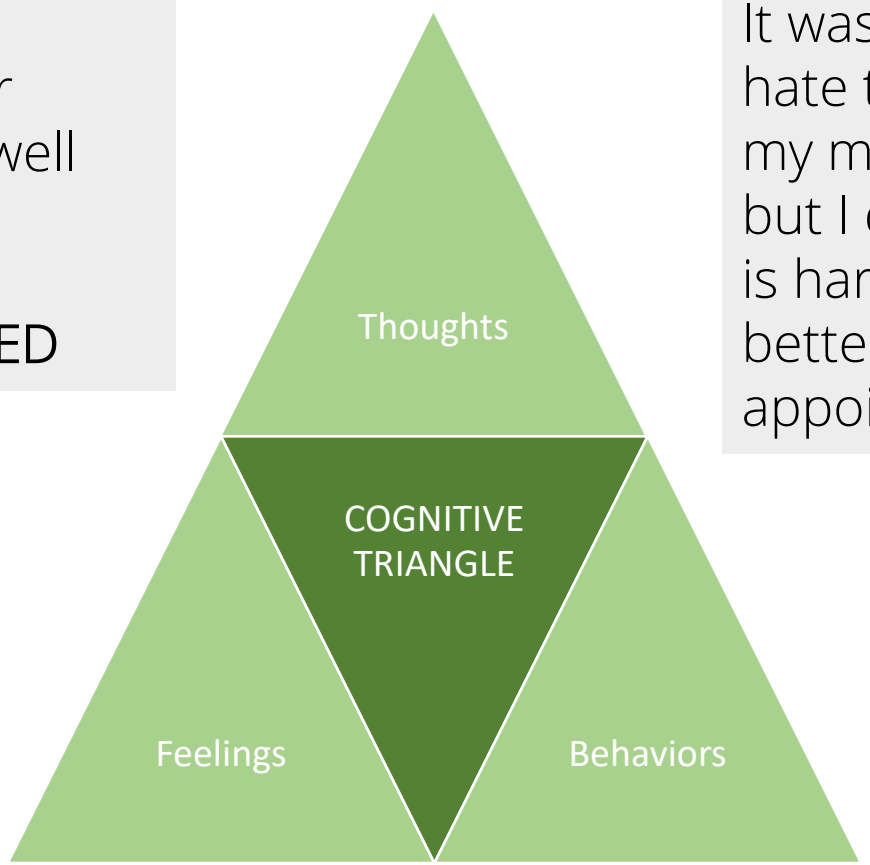
Cognitive Behavioral Therapy

Scenario:
Mom missed her child's 2 month well check.

REPROCESSED



It was one appointment. I hate that I missed it. I know my mom did this for 5 of us but I don't know how – this is hard! I need to find a better way to keep track of appointments.

Guilty – 5
Frustrated – 6
Depressed – 4
Determined - 7

Cry; Do a breathing exercise; Talk myself through it; Set a reminder in my phone for next time.

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Motivational Interviewing

Motivational Interviewing is a way professionals can talk to patients and ask them questions. This way of talking with patients helps them feel heard and cared for. It makes it smoother for the professional and the patient work together to figure out what the patient wants and needs and how to get it.

MI is not just a set of skills for how to help people move towards change. It is a **"way of being"** with patients.

The 5 general principals of MI are:

- Show empathy through reflective listening.
- Help patients see when their goals or values do not line up with how they are currently acting.
- Avoid arguing.
- Understand that change is hard.
- Support self-confidence and optimism.

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Using the Spirit of Motivational Interviewing

Motivational Interviewing is not just a set of skills for how to help people make positive changes. When we use MI, we must first thinking about creating a positive atmosphere for change by:

- Working together vs. telling people what they're doing wrong
- Asking questions vs. assuming you know the issue at hand
- Supporting patients vs. trying to convince them
- Hearing the patient's thoughts and ideas
- Using what motivates the patient
- Allowing people to decide for themselves
- Knowing change is connected to the patient's own goals and values
- Showing understanding that a patient's situation is not simple vs. judging their decisions

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Motivation to Change

Increasing motivation to change by using Evocative Questions:

- “How would you like for things to change?”
- “Of these options considered, what seems the most possible?”
- “How would things be better if you change?”
- “How would things be different?”
- “Why would you want to change?”
- “How serious is this to you?”
- “Given all of this, what’s your next step? What will you do now?”

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Crisis Intervention

- The goals are to lessen the intensity, duration, and presence of a crisis that is perceived as overwhelming and can lead to self-injury.
- The goal is also to protect the individual from self-harm, and in the process, identify the underlying disorder(s), dysfunction, or event that precipitated the crisis.
- The goal of crisis management is to re-establish equilibrium and restore the individual to a state of feeling in control in a safe, secure, and stable environment. Under certain circumstances this might require hospitalization.

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Crisis Intervention: Psychiatric Emergencies

Identify Chief Complaint

- Suicidality, homicidality, acute psychosis, behavioral/aggression
- Time of onset (acute, perpetuating)
- Duration
- Precipitants:
  - Biological (illness, drugs, injuries)
  - Social (moves, break-ups, loss, trauma)
- Predisposers
- Perpetuators
- Severity

Assess for Preventive and Protective Factors

- Support networks
- Coping mechanisms
- Management of past difficulties
- Future orientation
- Religious/spiritual faith
- Areas of Strength

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Patient Case

Robert is a 54 year old Hispanic male with a history of Hypertension, Diabetes – Type 2, Obesity. During a visit for medication refills, Robert tells his doctor he has been feeling more tired, a "little down", and is frustrated that he has gain 10 pounds since his visit 3 months ago. His sugars and blood pressure are in normal range at today's visit and Robert states he takes his medication "like clockwork". Robert's primary care doctor administered a PHQ-9 (score of 16) and is sending him for routine bloodwork.

List of things to watch for…

- ✓ Was the identified issue clarified?
- ✓ Did the BHC assess for mood, functionality, and risk level?
- ✓ What theoretical modalities were used? What skills did you identify?
- ✓ How did the BHC practice cultural sensitivity?

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Frequently Asked Questions

- How do you bill for this?
- What is the difference between a BHC and a therapist?
- How do you find space?
- How do you do this in a 15-30 minute visit?
- What do you do when patients decline services?
- How do you handle resistance from providers?
- How do you handle providers asking you to step outside of your scope of practice?

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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Join us next year in Philadelphia, Pennsylvania! Thank you!