Strategies for Behavioral Health Integration

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Learning Objectives

List and define key components of behavioral health integration into primary care

Identify the differences between the collaborative care and primary care behavioral health models

Describe the potential clinical benefits and cost savings opportunities of behavioral health integration into primary care

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BH care is not accessible

<50% of people with diagnosed BH conditions receive treatment in a given year

<10% of people with substance use disorders

7400 additional BH providers needed to fill gaps in designated provider shortage areas

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“Traditional” BH care burdens the patient

BH care happens in a different setting from where the need is identified

Follow-up on referral becomes the responsibility of the patient

>50% of referrals to specialty mental health services do not result in service delivery

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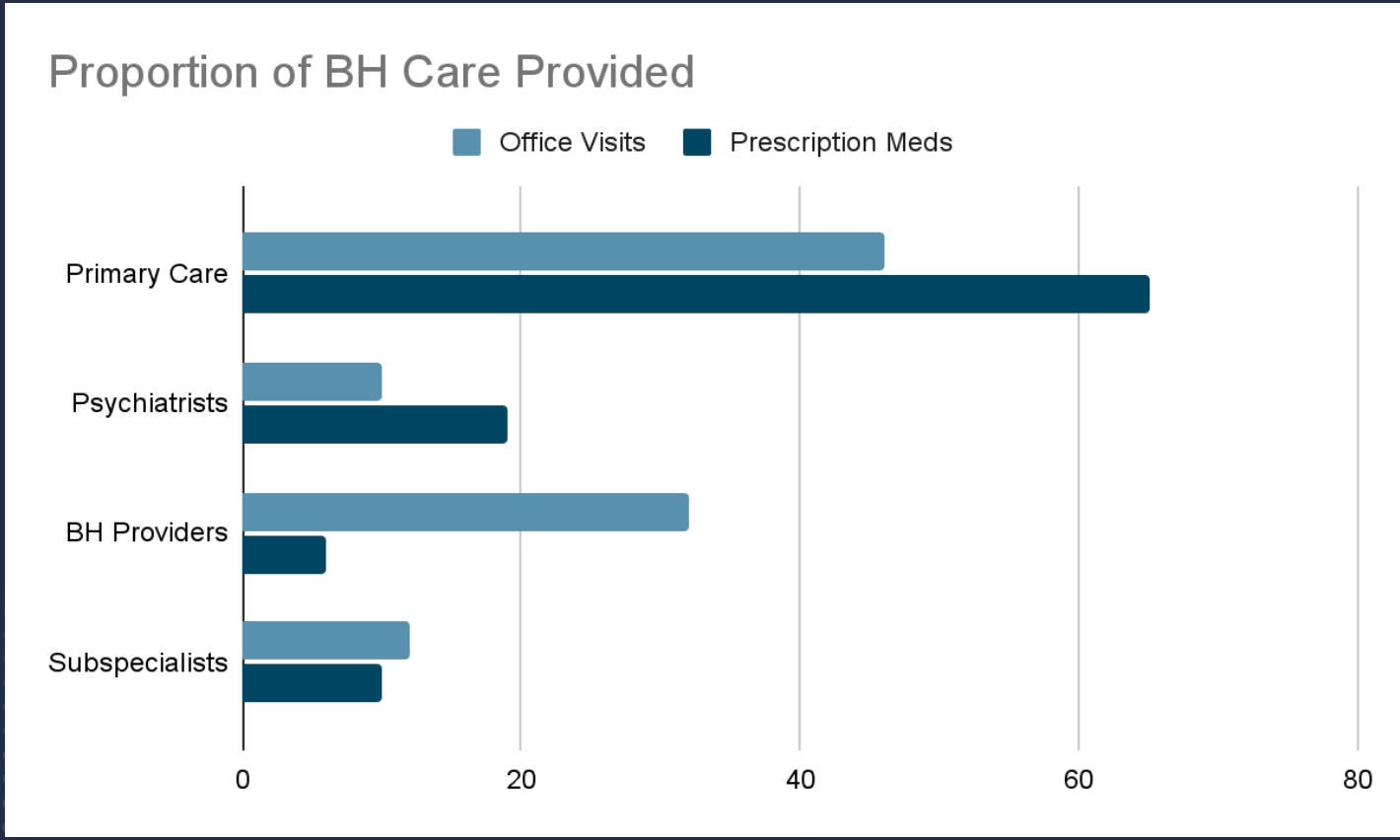
Primary care is where behavioral healthcare already happens



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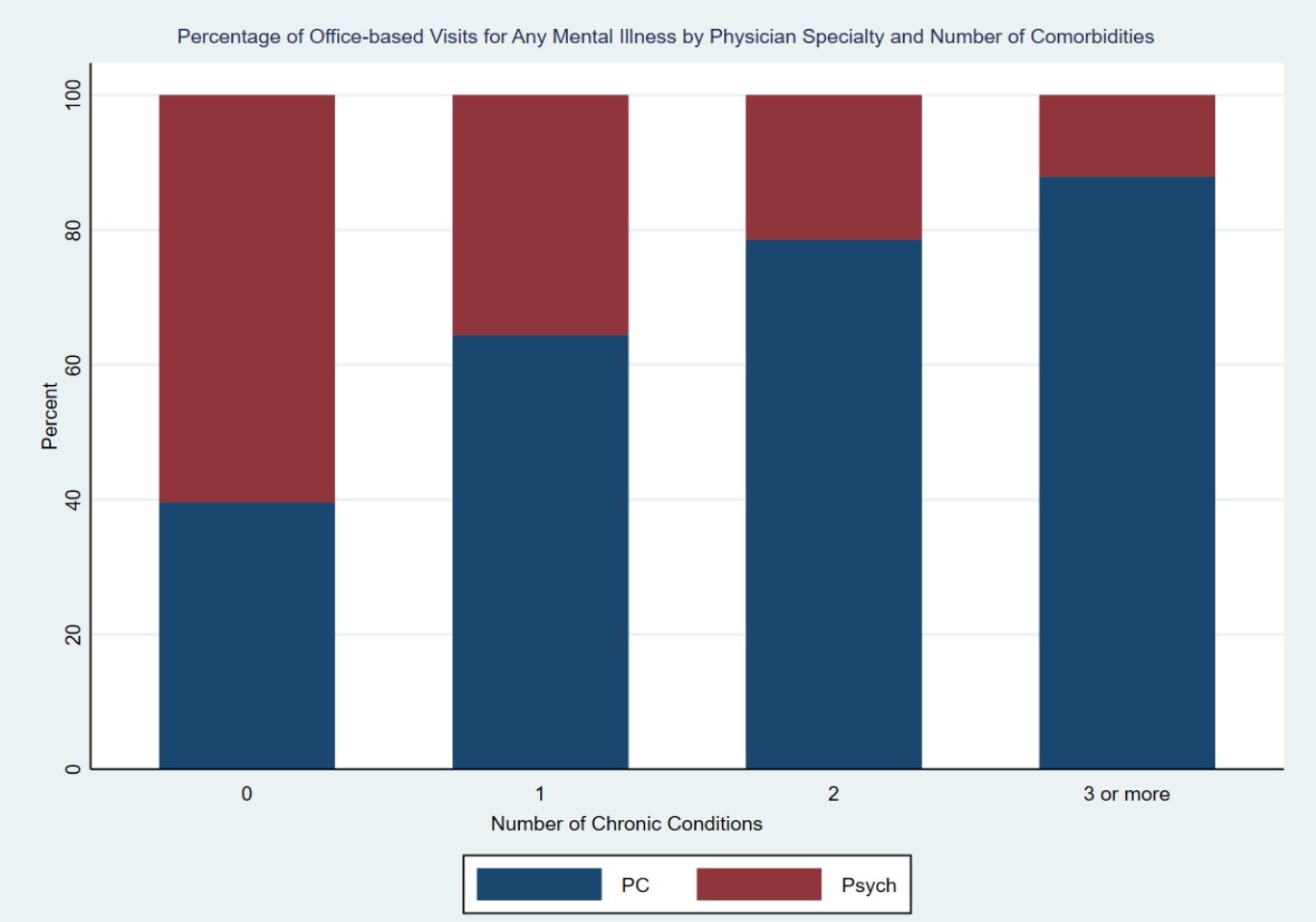
PCPs provide majority of BH care when chronic illness is involved



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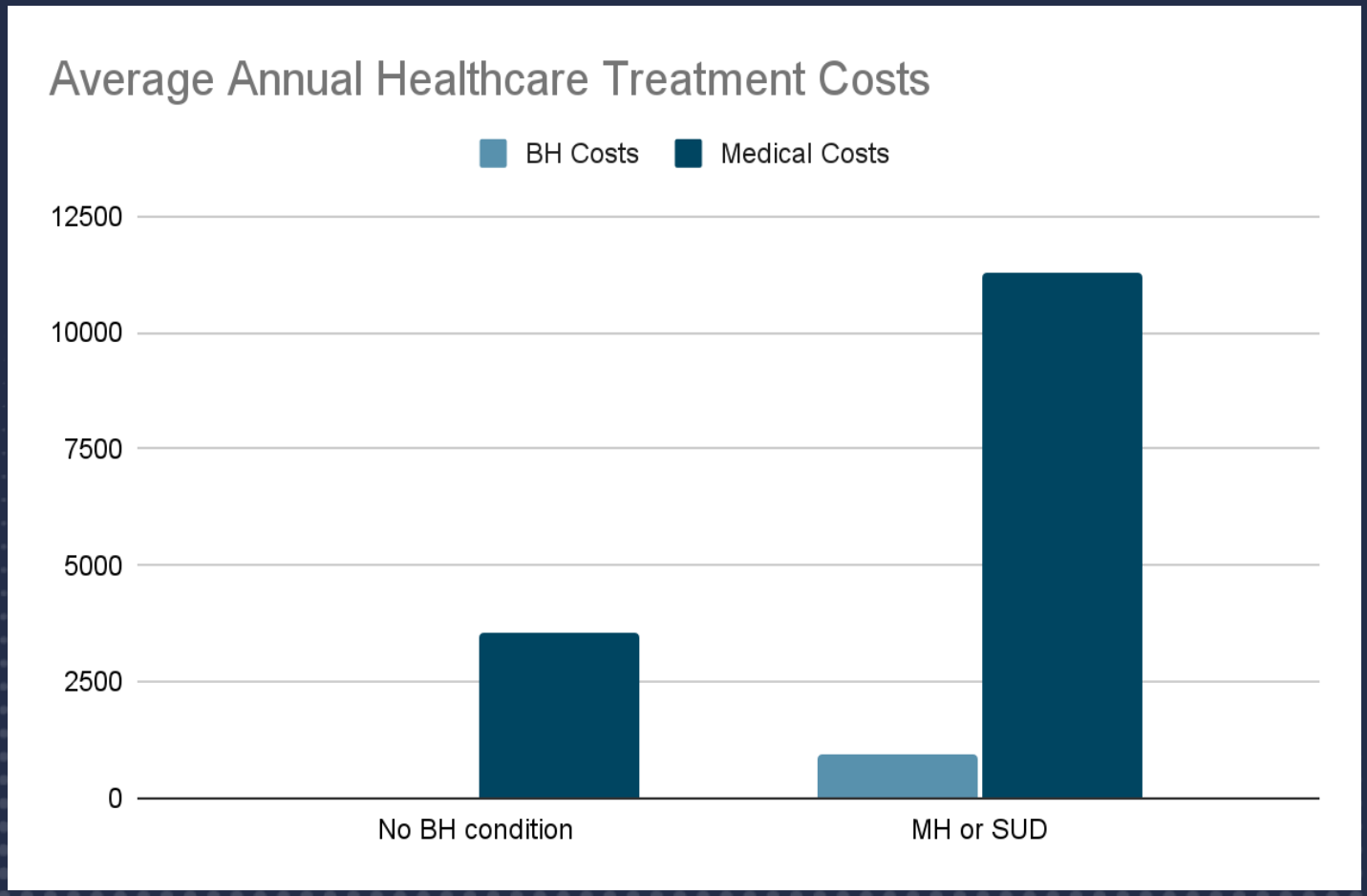
Patients with BH conditions have more costs of care due to higher medical costs, not BH costs



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How can we bring BH into primary care?

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UVA Family Medicine serves a diverse population in a training setting

Serve a diverse population of patients in a residency clinic

Typical clinic: 6 providers, 1 BH, PharmD, SW

BH services staffed by two psychologists, three graduate students, rotating medical learners

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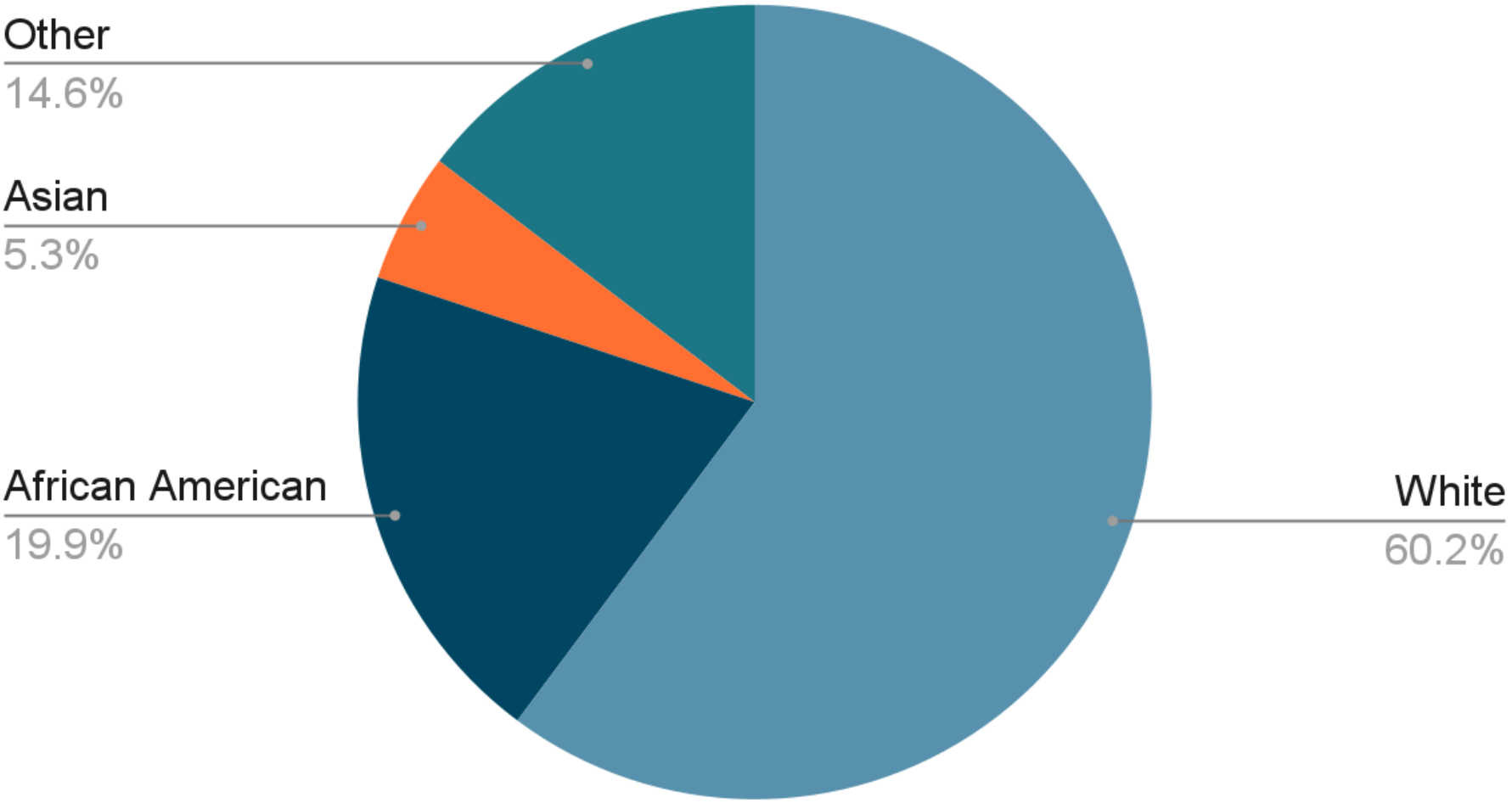
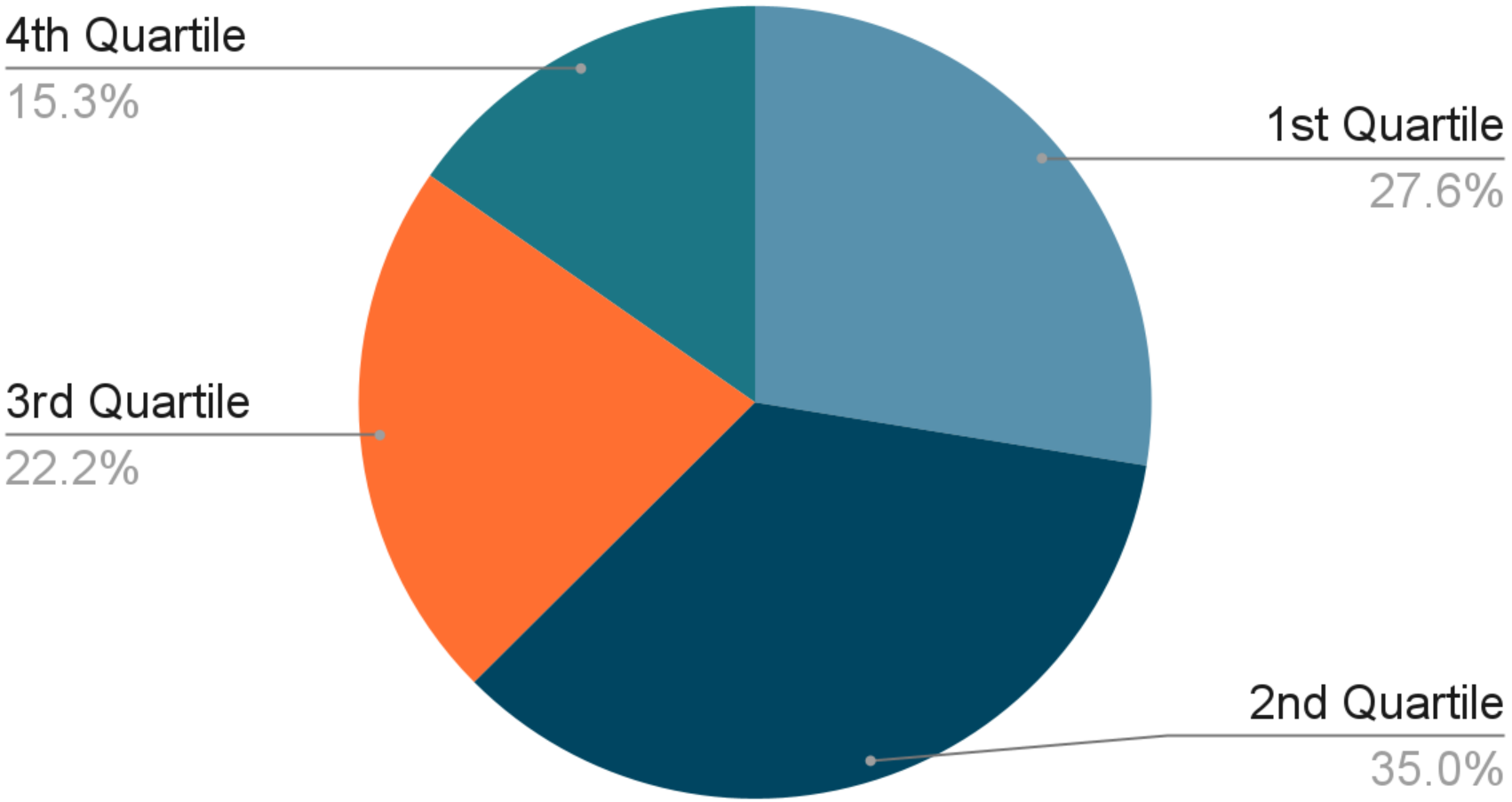
Patients by Race



Patients by Social Vulnerability Index



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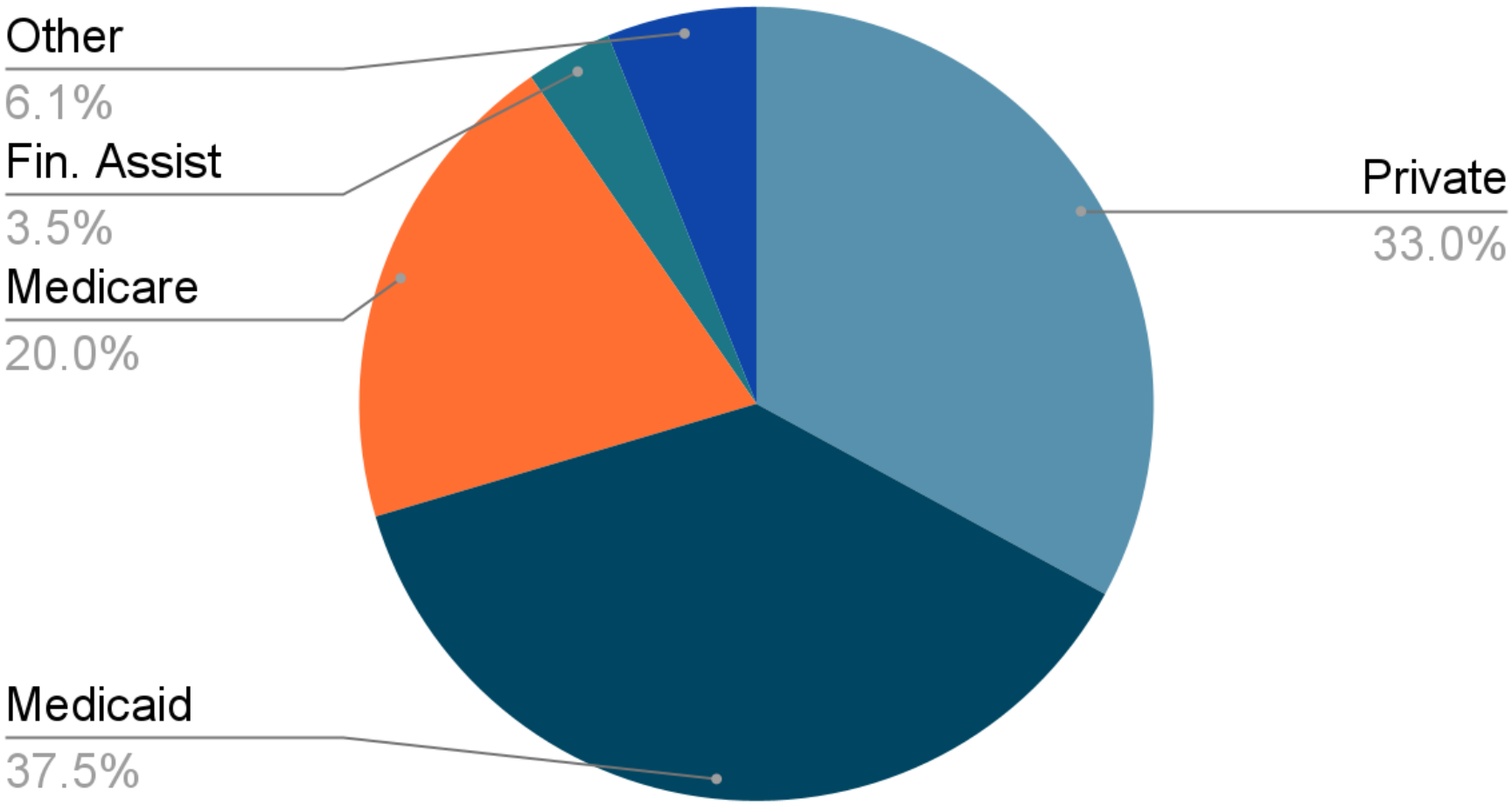
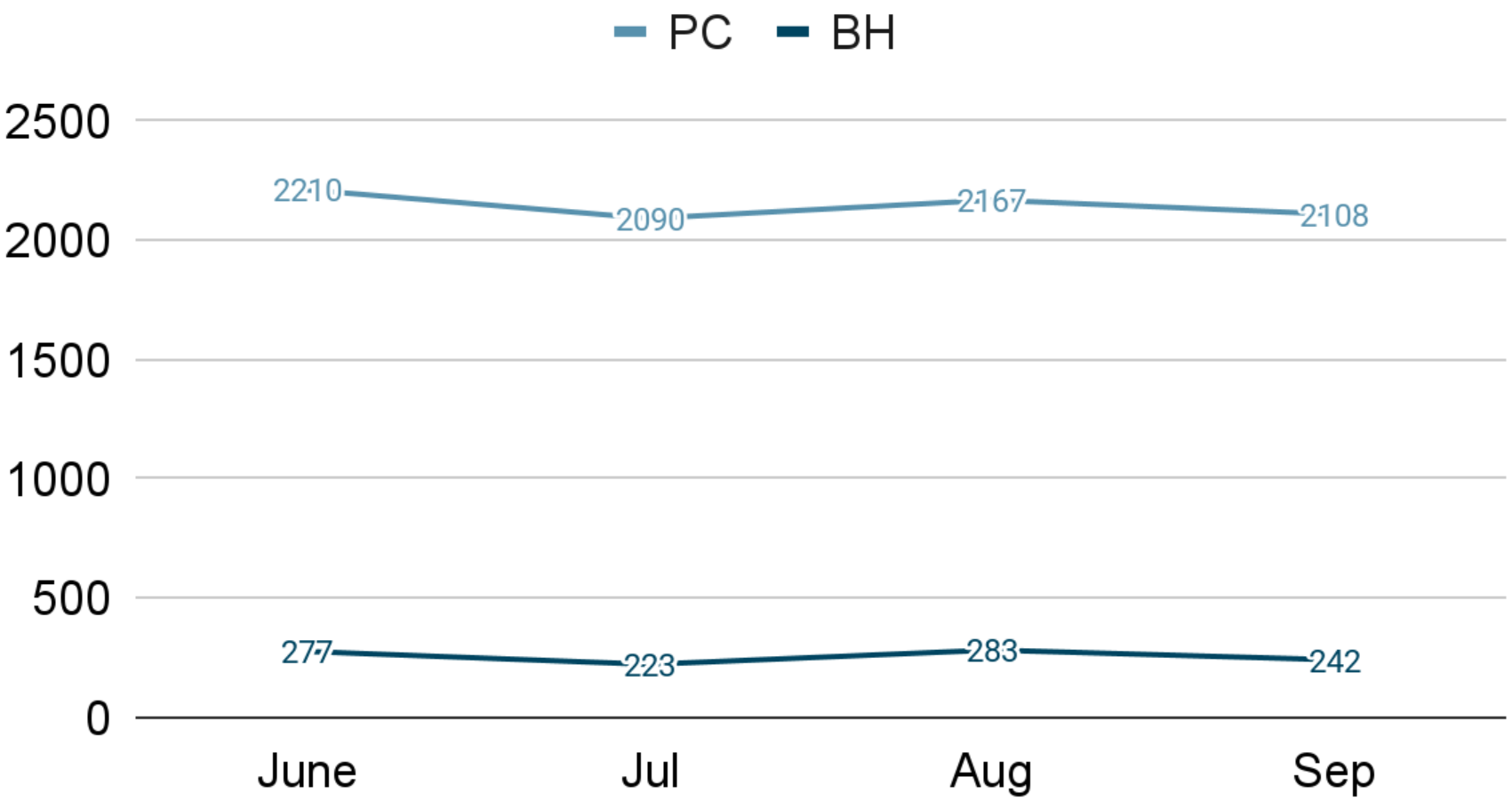
Visits by Primary Payer



Monthly Office Visits



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PCBH and CoCM models have been prominent in BH integration

PCBH: Primary Care Behavioral Health Model

PCBH embeds a behavioral health consultant (BHC) in the primary care team to provide patient care

CoCM: Collaborative Care Model

CoCM takes a chronic illness approach that relies on care management and consultation

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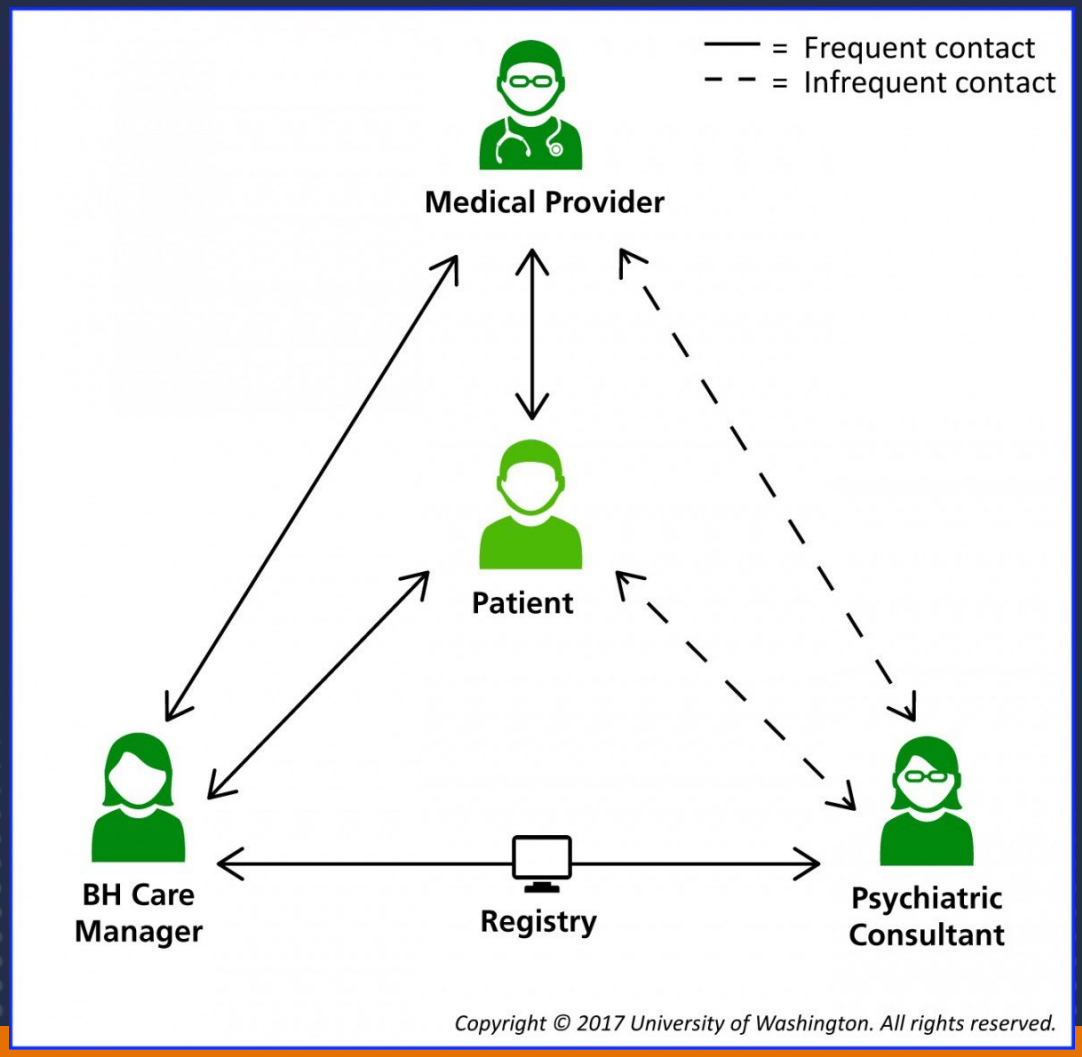
CoCM takes a chronic illness approach to BH integration



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UVA Family Medicine has implemented PCBH model

PCBH primarily with co -located psychiatric care, limited continuity psychotherapy

BHC provides direct patient care in coordination with PCP

Brief visits, often provided same-day on the PCP's schedule

BHC aims to extend the functionality of the primary care team

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The warm handoff links the PCP to the BHC in PCBH

BH need identified	Warm handoff to BHC	Close loop with PCP
Screening	Consult question and introduction	Summary of interaction, action plan, recommendations
Clinical interview	Brief assessment and intervention	PCP incorporates into treatment plan
Care coordination before visit	Action plan and PCP recommendations	

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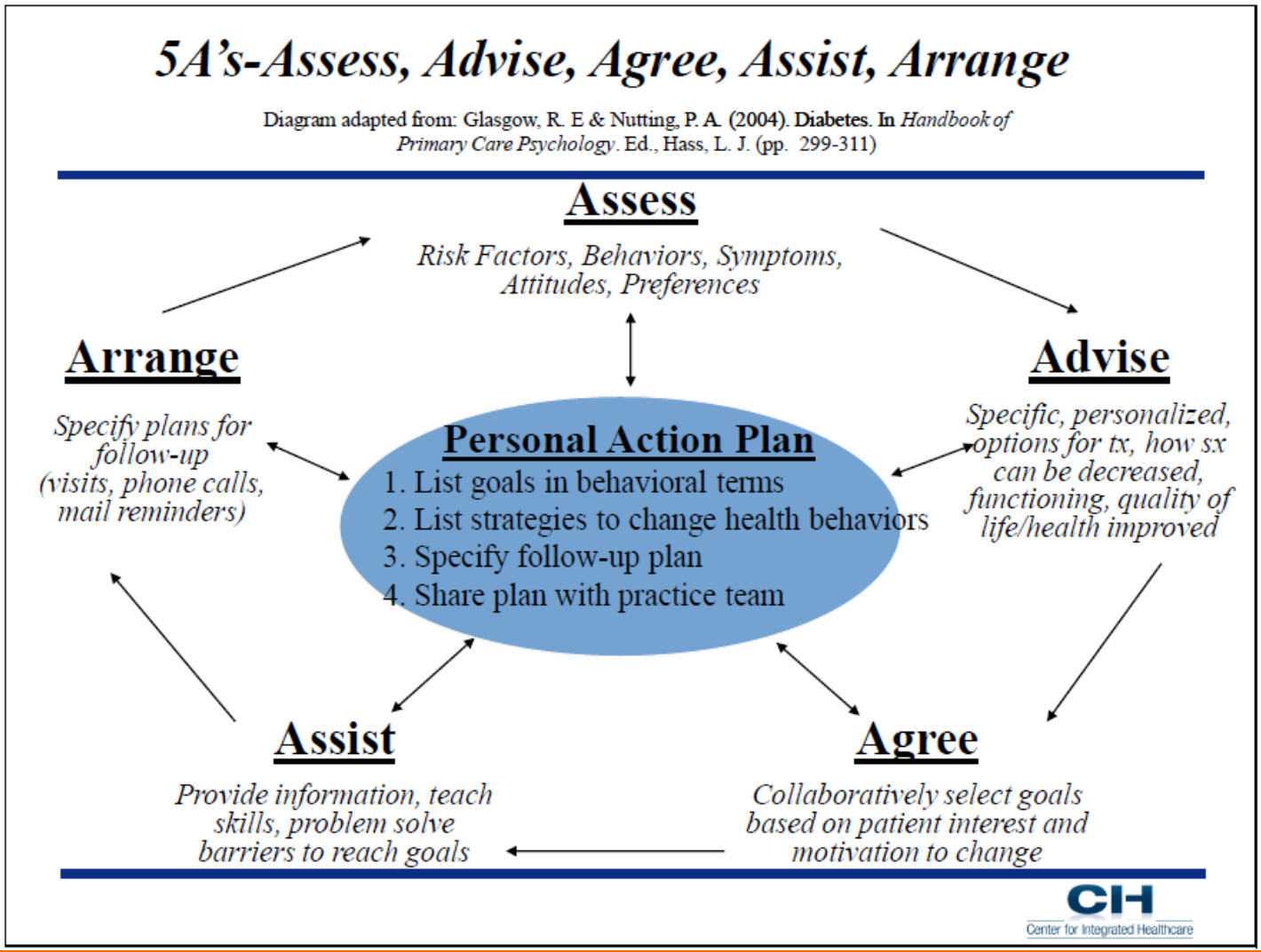
PCBH visits are nimble



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PCBH and CoCM have key trade-offs

Chronic vs. acute focus

Diagnosis-specific vs. broad spectrum

Balance of medication vs. behavioral intervention

However, models could complement each other (50% of VA is blended care)

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How does BH integration actually happen?

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System design facilitates BH integration

Development of clinical pathways and routine BH screening can shape use of integrated BH services

Examples:

Routine depression screening, including perinatal screening

Developmental screening for non-English speaking children

Non-pharmacological support around controlled medication prescribing

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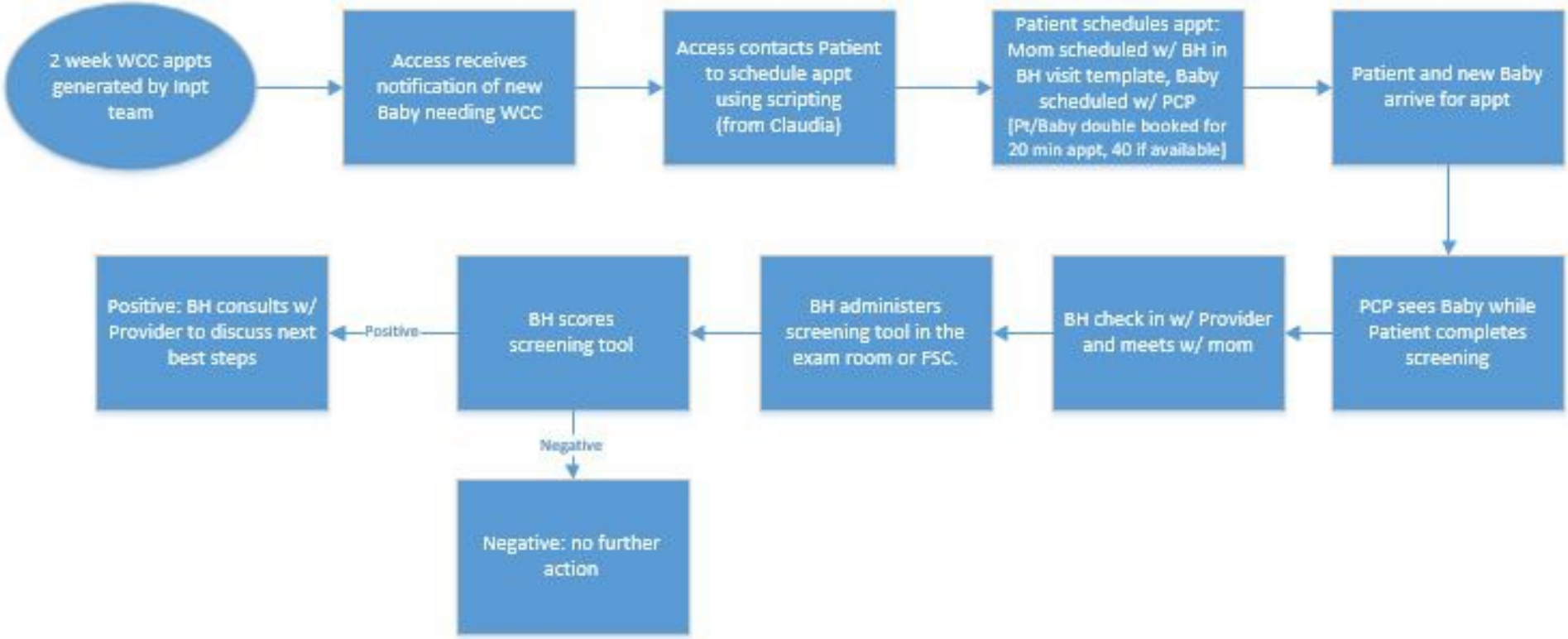
Example- Postpartum Depression



System design reflects attitude shifts in BH integration

Being flexible and willing are non-negotiable for seeing patients on the PCP's schedule

"Just schedule it!" and "no wrong door"

BHC = Clinician + care navigator

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System design facilitates attitude shifts

Open-access slots that require minimal -to-no review

Designated unscheduled time for warm handoffs, maintain visible presence in the clinic

	Monday
Pre-clinic	
AM	Warm handoff
	Warm handoff
	Warm handoff
	Warm handoff
Lunch	
PM	Open Access
	Open Access
	Continuity
	Continuity

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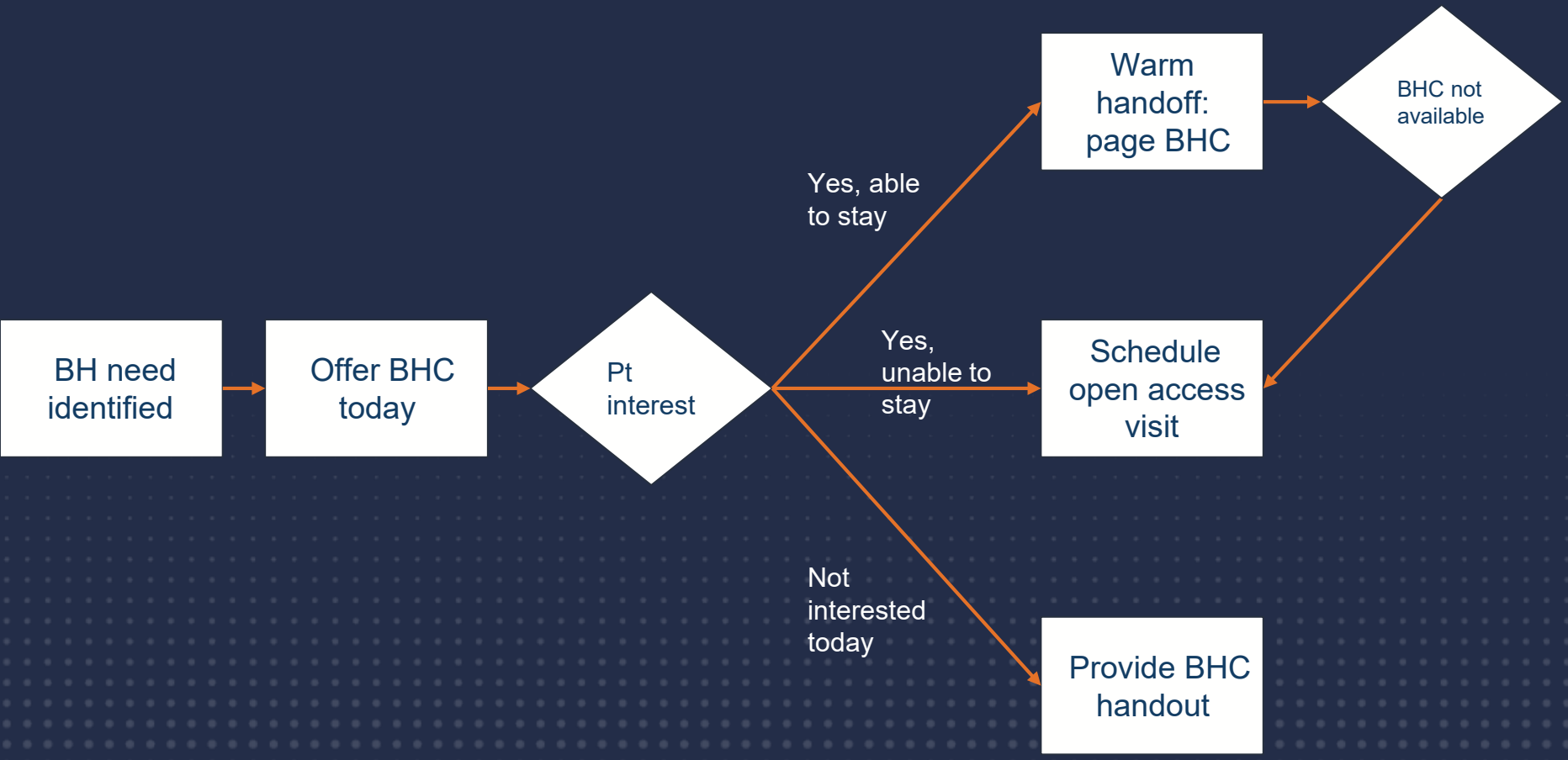
Example flow in our clinic



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BH integration needs setting-specific intervention

Interventions need to fit the brief (<30 min) visit setting

Menu of skills/strategies for patients to learn that can be easily taught and applied

Semi-structured intervention packages for our clinical pathways

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Behavioral Activation

You can begin to decrease depression by engaging in activities you find enjoyable, taking care of responsibilities that you have been neglecting, and pursuing activities that are in line with your values.

List three activities you enjoy:

1.

2.

3.

List three responsibilities you need to take care of:

1.

2.

3.

List three activities that are important to how you see yourself as a person (i.e. your values):

1.

2.

3.

Progressive Muscle Relaxation

This exercise involves systematically tensing and relaxing different muscle groups. This is a good relaxation exercise for those who have trouble concentrating, or experience racing thoughts or other mental distractions. You may leave your eyes open or close them, as you prefer. Experiment with how much you tense your target muscles: some find tensing tightly is most helpful, while others use “threshold tensing,” just tightening enough to barely sense the tension.

Start out by taking a few deep breaths into the abdomen. Just notice the breath.

Do a simple check-in of your emotional state, your thoughts, and what you are feeling in your body. Just notice what is happening, without judgment or expectation.

Make a fist with your right hand, and tense the muscles in your right forearm, allowing the rest of the arm to remain relaxed.
Study the sensations of tension.
Compare the tensed muscles to the relaxed ones in the opposite arm, and in the rest of the body.
When you’re ready, take a deep breath in, and, as you exhale, slowly, gradually release all of the tension, until every last bit has left the tensed muscles. You may imagine it’s like a fire hose that was rigid and becomes more flexible as the water drains out, or a any image that works for you.
Spend a few moments studying and appreciating the sensations in the muscles once they are relaxed.

Motivational Interviewing Toolkit – Building Healthy Habits

Check in

1. Would you be interested in / I understand you are interested in talking about x (identified health behavior)?
2. How do you feel talking about x with me today?

Positives/ Negatives

1. What are the positives of x?
2. What are the negatives of x?

WOOP Method

Wish – In an ideal world, what would x look like?

Outcome – How does changing x fit with your goals, values, and the type of person you'd like to become?

Obstacles – On a scale of 1-10, how confident are you that you can change x? What would make that number even higher?

Plan – SMART (Specific, Meaningful, Assessable, Realistic, Time-Oriented) goal → keeping the strategies to overcome identified obstacles in mind, what are three concrete steps that can be taken towards changing x?

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Strategies for Managing "Hot Spots"

Being on time/Managing time

- Do things in the same order every day.
  - Write out the routine and keep it where you can see it easily.
  - Keep the written routine in multiple places that you encounter during your day *(e.g., by your bed, in the bathroom, and on the fridge).*
  - Routine, routine, routine!!
- Create a cheat sheet to help you get through the routine (e.g. things you need for different tasks on your schedule)
- Add times to your routine schedule to help you know how long you need and have for each task
- Set alarms during the day for each step on your list *(e.g., when you need to start getting ready; when you need to leave)*

Remembering tasks

- Keep a running to-do list
- Keep a small notebook or list on your phone with you,
- Write out your task list each day.
  - Keep it on you or where you can see it easily *(e.g., near the front door).*

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ADHD Strategy Worksheet

Hot Spot #1: _____

1. WHEN? _____
2. WHERE? _____
3. HOW OFTEN? _____

Measurable goal _____

Strategy for goal 1: _____

1. When and where will you do this (e.g., tonight at my desk I will create a calendar)?

_____

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LESS PAIN – MORE GAIN

Individualized Pain Treatment Plan

For UVA Family Medicine Patients with Chronic Pain

STEP 1: SET GOALS

Here at UVA Family Medicine we want to help you feel better and do more of what you want to do. The scientific evidence tells us that setting specific goals helps people do that.

What is one specific way that you would like to feel better? (i.e. reduce pain from level 8 to 6; or reduce headaches from 4x to 2x/wk.) _____

What is one specific thing that you would like to be able to do more often or more easily? (i.e., walk dog around block; or play with child on floor)_____

The scientific evidence also tells us that management of chronic pain is most successful when it includes both pharmacological (medicine) and non-pharmacological treatments.

STEP 2: PICK TWO

To best treat your pain, we ask that you choose at least two of the following treatments in addition to any pain medication that you have been prescribed.

Free and Moderate Cost Resources

Low to moderate intensity exercise

- ACAC PHYSICIAN REFERRED EXERCISE PROGRAM (60 days for $60). Free childcare available during program participation. 434.984.3800 (physician must fax in form) http://www.acac.com/charlottesville/p-r-e-p/
- CARVER REC CENTER: (434) 970-3053; cost $19-$39/mo.; scholarships for city residents: http://www.charlottesville.org/Index.aspx?page=3070 (many group classes)
- SMITH AQUATIC & FITNESS CENTER: (434) 970-3072; $19-$39/mo.; scholarships for city residents at http://www.charlottesville.org/Index.aspx?page=3070
- YOGA at Common Ground Healing Arts: 434-218-7677, http://commongroundcville.org/our-services/outreach/. At various community spaces, some in Spanish, some for people w/ physical limitations.

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BH integration relies on interprofessional relationships

Education on the BH care model and specific BH topics can happen informally or formally

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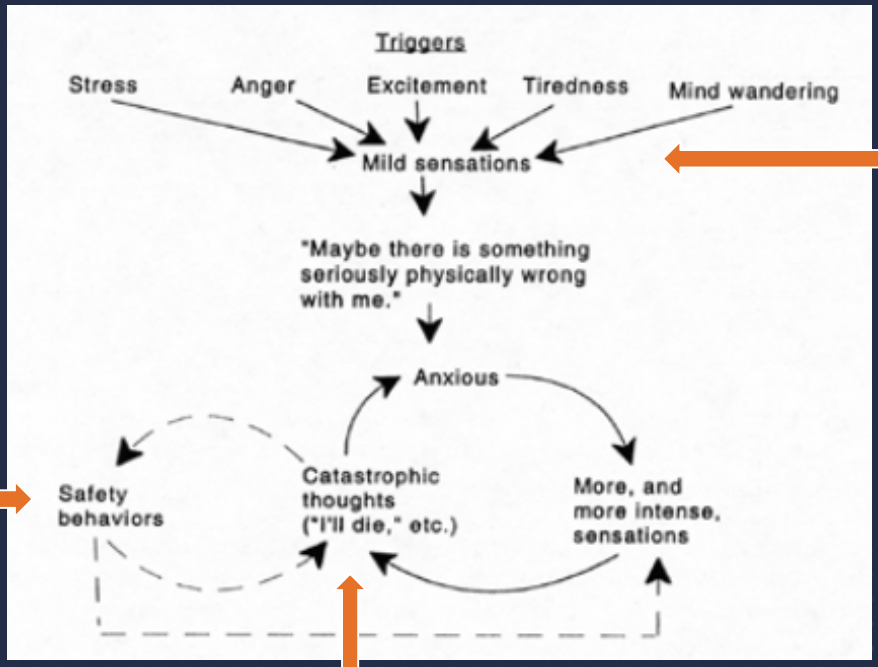
CBT for panic overview



Reduce fear of body sensations

Fade safety behaviors

Restructure catastrophic thoughts

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Sleep schedule: Track with a sleep diary

Sleep Diary

ID/NAME: ____________________

	Sample							
Today's Date	4/5/08							
1a. How many times did you nap or doze?	2 times							
1b. In total, how long did you nap or doze?	1 hour 10 min.							
2. What time did you get into bed?	10:15 p.m.							
3. What time did you try to go to sleep?	11:30 p.m.							
4. How long did it take you to fall asleep?	55 min.							
5. How many times did you wake up, not counting your final awakening?	6 times							
6. In total, how long did these awakenings last?	2 hours 5 min.							
7. What time was your final awakening?	6:35 a.m.							
8. What time did you get out of bed for the day?	7:20 a.m.							
9. Did you take any over-the-counter or prescription medication(s) to help you sleep?	☑ Yes ☐ No Medication(s): Relaxo-Herb Dose: 50 mg Time(s) taken: 11 pm	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:	◯ Yes ◯ No Medication(s): Dose: Time(s) taken:
10. How would you rate the quality of your sleep?	☐ Very poor ☑ Poor ☐ Fair ☐ Good ☐ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good	◯ Very poor ◯ Poor ◯ Fair ◯ Good ◯ Very good
11. Comments (if applicable)	I have a cold							

Jack D. Edinger, Colleen E. Carney
Overcoming Insomnia: Is This Book Right for Me. Copyright © 2015 by Oxford University Press

Oxford Clinical Psychology | Oxford University Press

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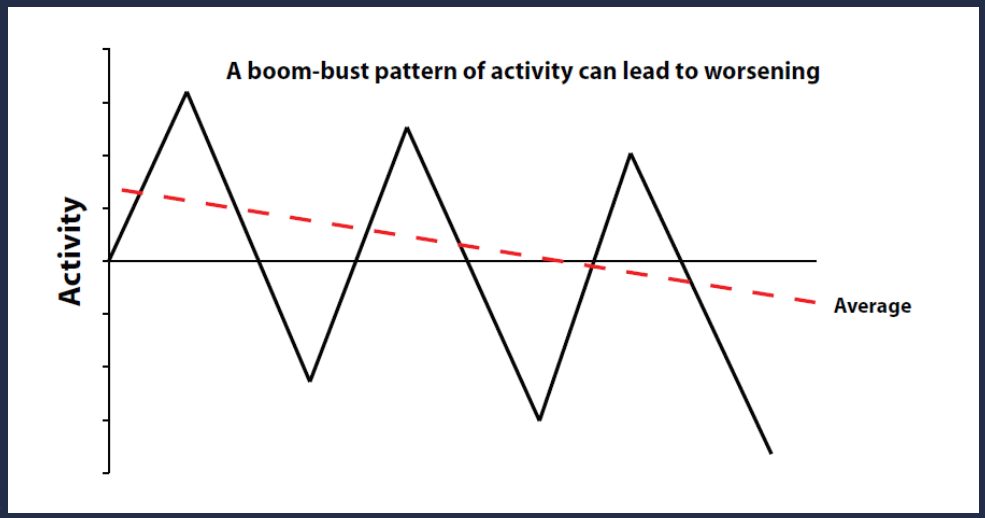
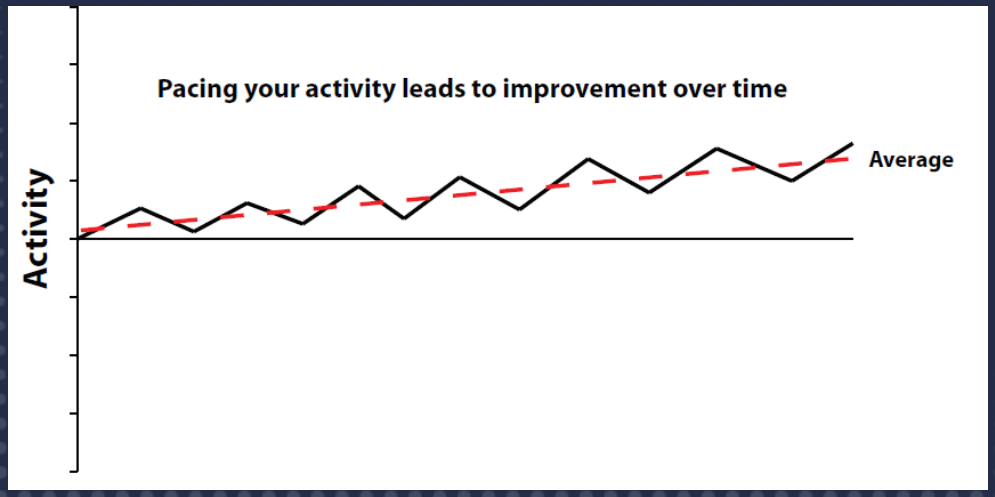
Pacing for chronic pain Boom-Bust Cycle





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BH integration relies on interprofessional relationships

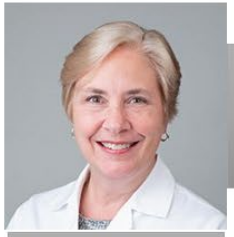
Who might I reach?

Shannon Savell, M.A

Precept room: Monday AM

Joey Tan, Ph.D.

Precept room: Wednesday AM

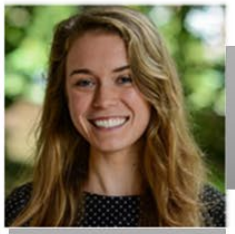


Claudia Allen, Ph.D.

Precept room: Friday AM

Sarah Kassabian M.Ed

Precept room: Tuesday AM



Meghan Costello, M.A.

Precept room: Thursday AM

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BH integration still faces significant barriers

Payment models are not fully aligned with integrated BH care processes

Initial implementation has a cost, not always reimbursed

Workforce challenges include inadequate training opportunities, uneven geographic distribution

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Our challenges

Getting beyond mood -only: Depression/anxiety/PTSD currently 80% of visits

Scheduled vs. unscheduled balance: 23% cancellation and no -show rate for scheduled visits

Reimbursement models: Value -based care still on its way

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How well do BH integration models work?

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BH integration is becoming more widespread

20% of primary care practices have co - located behavioral health providers

Large systems like the VA, DoD have integrated BH care models incorporated into their standard primary care model

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PCBH is a core feature of VA BH integration

J Clin Psychol Med Settings (2012) 19:105–116
DOI 10.1007/s10880-011-9285-9

Implementation of Primary Care-Mental Health Integration Services in the Veterans Health Administration: Program Activity and Associations with Engagement in Specialty Mental Health Services

Laura O. Wray · Benjamin R. Szymanski · Lisa K. Kearney · John F. McCarthy

	N	%
Sites with PC-MHI Programs	160	100
Co-located collaborative care (CCC) only	70	44
Care management (CM) only	6	4
Blended CCC and CM	74	46
No model reported	10	6

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BH integration models have emerging evidence on patient outcomes

2012 Cochrane review of 79 RCTs concluded CoCM effective for depression and anxiety

PCBH's strongest evidence is around access and patient engagement, RCTs less prevalent for patient health outcomes

Existing non -RCT PCBH outcome studies positive for depression, anxiety improvements

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Broader evidence on brief interventions supportive of PCBH approach

Table 1. Evidence for Efficacy of Brief Behavioral Interventions

Strength of Evidence	Intervention Target	Findings
High Level of Certainty	Depression	These efficacious interventions typically target a range of symptoms from depressed mood to Major Depressive Disorder and often involve cognitive-behavioral or problem solving strategies.
	Alcohol Use	These efficacious interventions target hazardous alcohol use and typically involve elements of motivational interviewing and personalized normative feedback.
	Tobacco Use	These efficacious interventions target cigarette smoking and typically involve motivational interviewing, brief advice using the 5A's framework[63,64††] (Ask, Advise, Assess, Assist, Arrange) and cognitive and/or behavioral strategies.
	Insomnia	These efficacious interventions target insomnia and typically involve cognitive-behavioral interventions or elements, such as stimulus control and sleep restriction.
Moderate Level of Certainty	Anxiety	Preliminary evidence suggests that brief cognitive-behavioral interventions are generally effective in reducing anxiety symptoms; however, many of the treatments may not be feasible to administer in primary care.

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Integrated BH cost savings come from better physical health

Intermountain Healthcare study (~100,000 patients in 100 practices) found cost savings of $113/person over 3 years , at implementation cost of $10/person

Nationally, potential savings opportunity of treating co -occuring behavioral health conditions estimated as $27 -$48 billion/year

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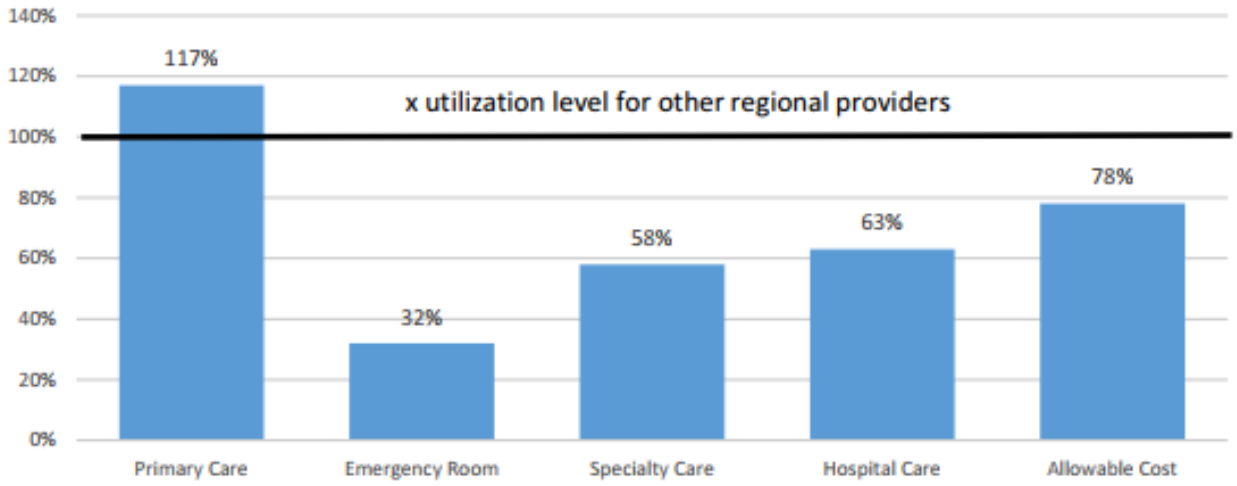
Integrated BH shifts around care utilization patterns

Tends to reduce emergency and inpatient medical care and increase primary care utilization

Fig. 1 Comparison of Cherokee Health Systems utilization with Regional Providers



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Integrated BH shifts around care utilization patterns

By Lucinda B. Leung, Lisa V. Rubenstein, Jean Yoon, Edward P. Post, Erin Jaske, Kenneth B. Wells, and Ranak B. Trivedi

DOI: 10.1377/hlthaff.2019.00270
HEALTH AFFAIRS 38,
NO. 8 (2019): 1281–1288
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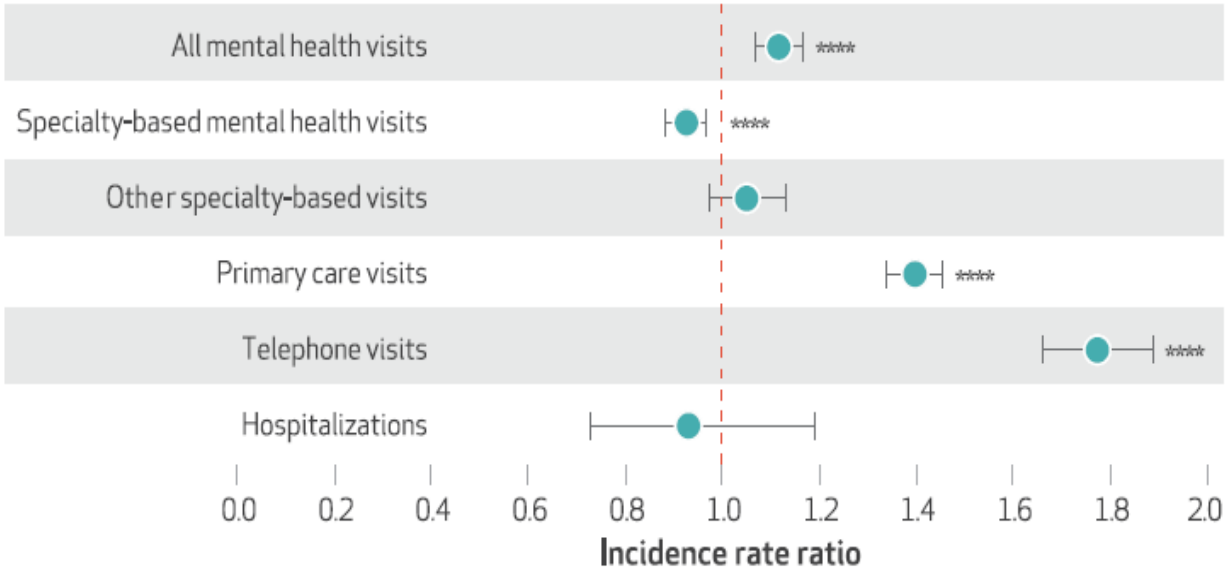
Veterans Health Administration Investments In Primary Care And Mental Health Integration Improved Care Access

Effect on Veterans Health Administration (VHA) health care utilization of each percentage-point increase in the proportion of primary care patients who received integrated mental health care, 2013–16



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Patient stories - PCBH facilitating better sleep

Case: 37 y/o F with chronic insomnia (4 -5 hrs awake in middle of night), tapering off psychiatric medication ahead of pregnancy

PCP role: Identified insomnia and preference for behavioral intervention

BHC role: Delivered short course of CBT for insomnia

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Patient stories - Facilitating better sleep

Stimulus control : Strengthen the bed as a cue for sleep

Sleep restriction therapy : Compress the window for sleep to consolidate it

Cognitive restructuring : Address thoughts about sleep that lead to anxiety, unhelpful sleep behaviors

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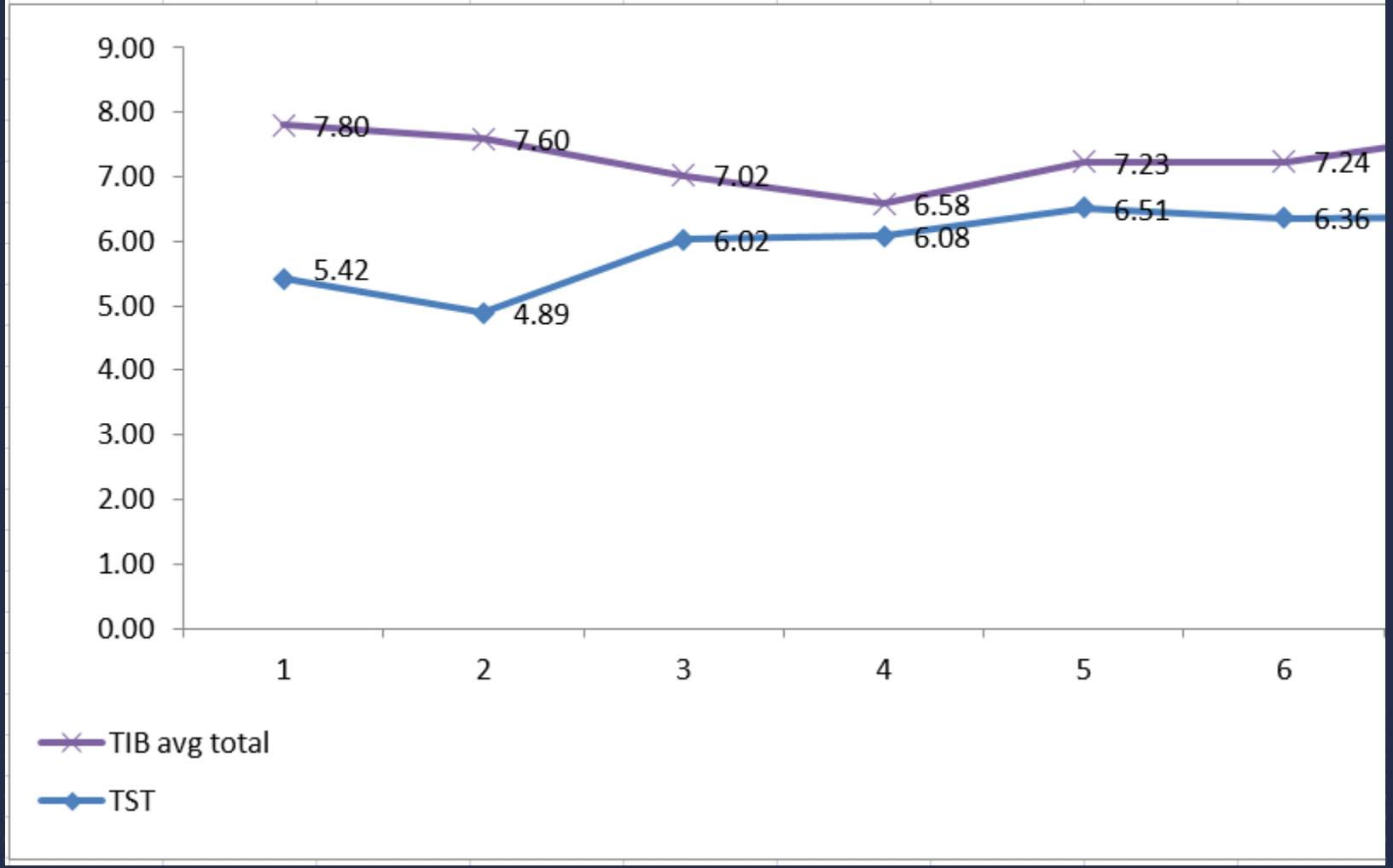
Time in Bed Average and Total Sleep Time Average



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Patient stories - Delivering brief evidence-based care for PTSD

Case: 57 y/o Arabic -speaking F, refugee, presenting to PCP with “1 yr hx progressive fatigue”

PCP role: Worked up metabolic, anemia, identified likely role of mood or primary insomnia

BHC role: Elicited trauma history, clarified conceptualization towards PTSD

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Patient stories - Delivering brief evidence-based care for PTSD

JAMA Network | Open

RCT: Effect of Written Exposure Therapy vs Cognitive Processing Therapy on Increasing Treatment Efficiency Among Military Service Members With PTSD

POPULATION

136 Men, 33 Women

Adults diagnosed with posttraumatic stress disorder (PTSD)

Mean (SD) age, 24 (8) y

INTERVENTION

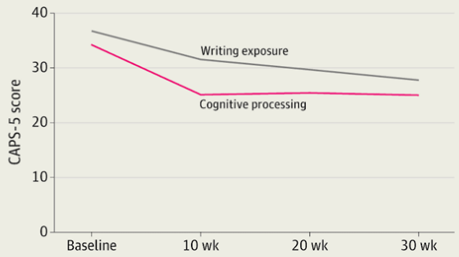
169 Patients randomized

85 Written exposure therapy
5 Weekly sessions of exposure-based treatment

84 Cognitive processing therapy
12 Twice-weekly sessions of trauma-focused cognitive behavioral therapy

FINDINGS

Written exposure therapy was noninferior to cognitive processing therapy at all assessment periods



Mean (SE) change from baseline to 10 wk
Written exposure therapy: −5.16 (1.17) points
Cognitive processing therapy: −9.12 (1.28) points
Difference (SE): 3.96 (1.73) points

SETTINGS / LOCATIONS

Outpatient clinics in Texas, United States

PRIMARY OUTCOME

Total PTSD symptom severity score, assessed with the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5), with a noninferiority margin of a 10-point difference at the 10-, 20-, and 30-wk assessments

Sloan DM, Marx BP, Resick PA; STRONG STAR Consortium. Effect of written exposure therapy vs cognitive processing therapy on increasing treatment efficiency among military service members with posttraumatic stress disorder: a randomized noninferiority trial. *JAMA Netw Open*. 2022;5(1):e2140911. doi:10.1001/jamanetworkopen.2021.40911

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Patient stories - Delivering brief evidence-based care for PTSD

BHC facilitated patient writing for 30 minutes at a time in native language

PCP started patient on low -dose melatonin, sertraline

After four sessions, patient reported less distress while writing, reductions in anxiety, headaches, and improved sleep

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Takeaways

BH integration into primary care helps us shift the burden of seeking BH care off of the patient.

Design the system and prepare care providers to facilitate responsive, tailored BH care.

BH integration has the potential to provide lasting shifts in how patients utilize health care.

Thank you!

jtan@virginia.edu

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