Behavioral Consultation In Primary Care: Principles, Competencies and Clinical Strategies

Kirk Strosahl, Ph.D.

kirk@heartmattersconsulting.com

HEART MATTERS CONSULTING

Winner of the 2009 APA Practice Innovation Award

Objectives

Examine the core features of the PCBH model

Discuss the evidence regarding brief interventions

Appreciate the rapid response effect in psychotherapy

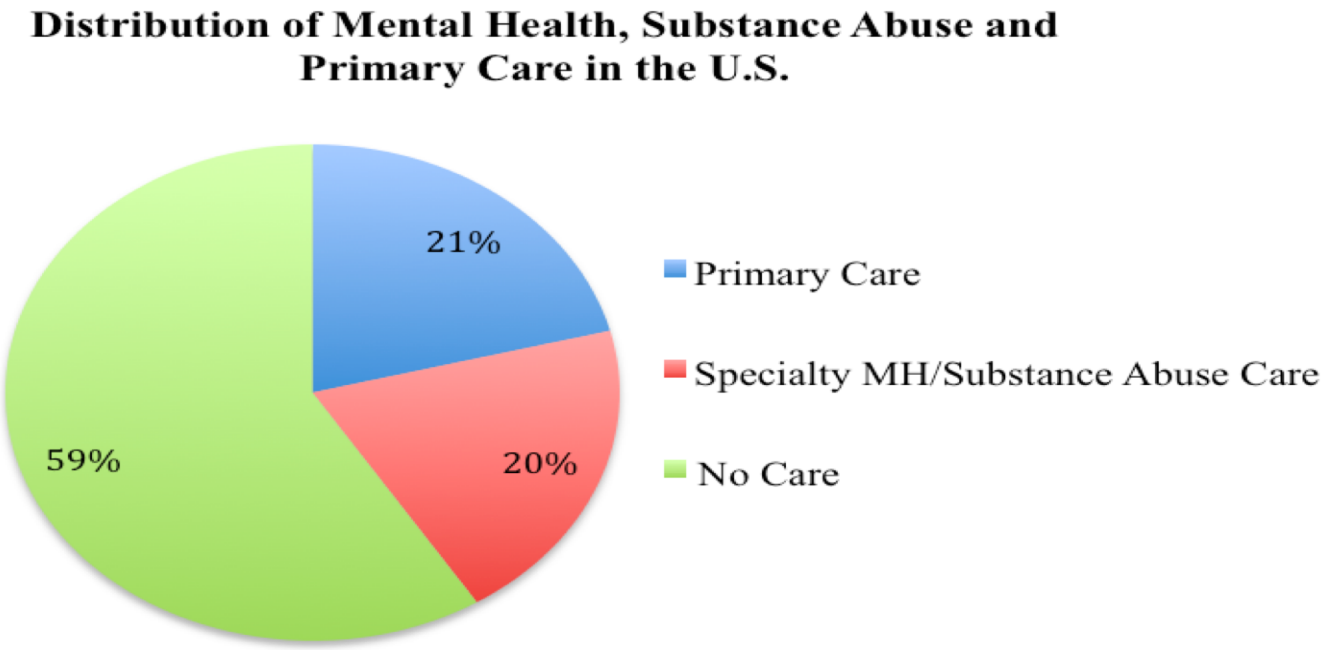
Learn the basic skills required for efficient and effective 30 minute consults

Demonstrate a contextual model of human suffering and dysfunction

Apply this approach to common clinical and behavioral problems seen in primary care

Why PCBH?

Distribution of Mental Health/Substance Abuse Care in the US



Why Don't People See A Therapist?

- Lack of insurance
- Stigma
- View their problem as "physical"
- Inconvenience (including long waitlists)
- Better familiarity, comfort with PCP
- Prior negative experiences

Why PCBH?

- Wide range of behavioral issues, ages
  - Living with chronic disease
  - Somatic complaints with lifestyle/stress component
  - Sub-threshold problems in living
  - Preventive health
  - All kinds of mental health/substance abuse problems
  - Infants through older adults

Why PCBH?

- Patients with psychosocial issues are high utilizers
  - Of 14 most common complaints in primary care, only 16% had organic etiology (Kroenke 1989)
  - Anxiety, loneliness drive visits (Fries, 1993)
  - Half of high-utilizers have a psych or CD problem (Friedman, 1995)
  - Patients with psych disorder utilize 50% more primary care services (Simon et al, 1995)

Why PCBH?

- Primary care providers can't do it alone
  - 15-20 minutes per visit
  - 3 complaints on average/visit
  - Insufficient training in behavioral interventions
  - Over 3 dozen urgent but unpaid tasks everyday
  - 52,000 new PCPs needed to meet new demand from the ACA
  - Overworked, underpaid—stressed!

Step 1: Appreciate the PC Mission

- Characteristics of primary care:
  - Integrated care
  - Accessible
  - Addresses a large majority of personal health needs
  - Continuous care across the life span
  - Practiced in the context of family and community
- Benefits of well designed primary care:
  - Better health outcomes
  - More equitable distribution of care
  - Lower health care spending

The Goal of PCBH

To improve and promote overall health within the general population

Step 2: Build a Model That "Maps"

Be a GATHERer:

Generalist

Accessible

Team-based

High productivity

Educator

Routine care component

Integration Models Differ in How Well They Do This

- WA State IMPACT project (co-located therapy)
  - Started in 2007 in 2 counties
  - Expanded to 100 CHCs and 30 CMHCS state-wide in 2009
  - 25,000 pts total (all years, all 130 clinics) as of 2012
- PCBH model
  - 8,000 pts in 2012 alone at HealthPoint's 11 clinics

Core Characteristics of PCBH Approach

- Consultant model
- Member of primary care team, work side-by-side
- Goal is to improve PCP mgmt of behavioral issues
  - Wide variety of interventions and goals
  - Brief visits, limited follow-up
  - Immediate feedback to PCP
  - Any behaviorally-based problem, any age
- Aim for immediate access, minimal barriers
- Rooted in population health principles

Ways to Connect Patients with PCBH Staff

- Warm Handoff
- Future Appointment
- Easiest Process – Instant message, text

SAME DAY PREFERRED

PCBH Service Array

- Brief Interventions
  - Directive 15-30 minute visits
  - Most same day of medical visit
  - Usually complete episode in 4 or less visits
  - Continuity visits for more at risk patients (1:1, T/C)
  - Workshops, classes (10-20%)
- Pathway Services
  - Assess and intervene with members of high impact group

Sample Clinic Day: What to Look For

- Variety of methods for getting pt to the BHC
  - Before PCP
  - PCP and BHC in room together
  - After PCP
- Variety of problems and ages
  - Clinical (MH, SA, Beh Med, all ages)
  - Case management/Care coordination
- Variety in the goals of visits
  - PCP-prep
  - Care augmentation
  - Medication assistance planning

The Behavioral Health Consultant (BHC)

Dimension	*Consultant*	*Therapist*
Primary consumer	PCP	Patient/Client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	PCP	Therapist
Referral generation	Results-based	Independent of outcome
Productivity	High	Low
Problem scope	Wide	Narrow/Specialized
Termination of care	Patient progressing toward goals	Patient has met goals

EVIDENCE FOR BRIEF INTERVENTIONS

Some Interesting Facts About Change

- Modal number of psychotherapy visits is . . .?
- Average number of psychotherapy visits is . . . ?
- The two biggest reasons clients seek help is . . . ?
- What is the trajectory of change/benefit in psychotherapy . . . ?
- What is the “rapid response” phenomenon . . . ?
- What percentage of clients exhibit this phenomenon . . . ?
- What is the long term outcome of clients showing rapid response?

Clinical Outcomes

- 71% of patients improved, even the most severe patients with more severe impairment at baseline improved faster than less severe

(Bryan et al., 2012)

- Patients receiving just 2-3 visits showed broad improvement in sx, functioning, well-being. These changes were robust and stable during 2-year follow-up

(Ray-Sannarud et al., 2012; Bryan et al., 2009)

- Most patients who attend 2, 3 or > 4 visits show clinically significant change

(Cigrang et al., 2006)

Symptom Reduction

- BHC patients (N=495) demonstrated significant improvements in clinical status (as assessed by BHM-20).
  - 72% of pts improved across appointments
  - 57% of pts demonstrated clinically meaningful & reliable improvement
  - Improvements also seen in those with most severe levels of distress at baseline

Bryan, C.J., Corso, M.L., Corso, K.A., Morrow, C.E., Kanzler, K.E., & Ray-Sannerud, B. (2012). Severity of mental health impairment and trajectories of improvement in an integrated primary care clinic. *Journal of Consulting & Clinical Psychology. 80 (3*), 396-403

Decreased Psychological Distress

- Patients (N=234) demonstrated statistically significant decrease in psychological distress over from first to last BHC appointment
  - Measure: Outcomes Questionnaire-45 (OQ-45)
  - Most common diagnoses: depression, anxiety, marital problems, chronic pain
  - 51% had 1 appt; 25% had 2 appts, 12% had 3 appts, 7% had 4 appts, 5% had > 4 appts

Cigrang, J. A., Dobmeyer, A. C., Becknell, M. E., Roa-Navarette, R. A., & Yerian, S. R. (2006). Evaluation of a collaborative mental health program in primary care: effects on patient distress and healthcare utilization. *Primary Care and Community Psychiatry, 11*, 121-127

Therapeutic Alliance

- Patients rated their therapeutic alliance following a first appointment with an BHC as statistically stronger than alliance ratings from a previously reported sample of outpatient psychotherapy patients
- Therapeutic alliance assessed after the first BHC appointment was not associated with eventual clinical change in mental health symptoms and functioning

Corso, K.A. Bryan, C.J., Corso, M.L, Kanzler, K.E., Houghton, D.C., Morrow, C.E. & Ray-Sannerud, B. (2012).Therapeutic alliance and treatment outcome in integrated primary care. *Families, Systems, & Health, 30 (2*), 87-100

Long Term Clinical Benefits

- Patients improved from their first to last BHC appointment, with gains being maintained an average of 2 years after intervention
  - Measure: Behavioral Health Measure (BHM) – 20
  - N = 70

Ray-Sannerud, B., Dolan, D., Morrow, C.E., Corso, K.A., Kanzler, K.E., Corso, M.L., & Bryan, C.J. (2012). Longitudinal outcomes after brief behavioral health intervention in an integrated primary care clinic. *Families, Systems & Health, 30*, 60-71.

Insomnia

- Brief behavioral intervention with BHC associated with decreased severity of insomnia

  Goodie, J., Isler, W., Hunter, C., & Peterson, A. (2009). Using behavioral health consultants to treat insomnia in primary care: A clinical case series. *Journal of Clinical Psychology, 65*, 294-304

Detection of Suicidality

- 338 patients referred to BHCs by their PCPs in the course of routine
- Treatment
  - Suicidal ideation reported to BHC by 12.4% (N=42) via routine screening with BHM-20
  - Only 2.1% (N=7) actually reported suicidal ideation to their PCP
  - Applicability for PCBH: routine screening via written methods yields higher identification of suicidal patients in PCBH
  - The "as indicated" approach is less effective as a population health screening method

Bryan CJ, Corso KA, Rudd MD, Cordero L. Improving identification of suicidal patients in primary care through routine screening. *Primary Care and Community Psychiatry. 2008; 13(4)*: 143-147.

Impact on Suicidality

- Suicidal ideation generally improved over the course of several BHC appointments
  - 497 primary care patients who kept 2 to 8 appointments with BHC
  - Therapeutic alliance was rated very high by patients
  - Alliance was ***not*** related to positive clinical outcomes

Bryan, C.J., Corso, K.A., Corso, M.L., Kanzler, K.E, Ray-Sannerud, B., & Morrow, C.E. (2012). Therapeutic alliance and change in suicidal ideation during treatment in integrated primary care settings. *Archives of Suicide Research, 16,* 316-323.

Impact on PTSD Symptoms

Pilot study of 15 active duty military members with deployment-related posttraumatic stress disorder (PTSD)

- Used Prolonged Exposure and some optional theme processing elements from CPT
- Patients attended an average of 4.5 30-minute appointments
- 50% of tx completers did not meet criteria for PTSD at the 1-month follow-up assessment.
- No SI thoughts, behaviors or plans

Cigrang, J. A., Rauch, S. A. M., Avila, L. L., Bryan, C. J., Goodie, J. L., Hryshko-Mullen, A., Peterson, A. L. (2011). Treatment of active-duty military with PTSD in primary care: Early findings. *Psychological Services, 8(2*), 104-113.

PCBH Evidence: Depression

Review of 12 RCTs (Schulbert 2002)

- Evidence-based psychotherapies adapted for PC are comparable to RX alone (supported by Psych) and superior to UC

Impact of embedded BHCs (Serano, 2011)

- Reduced referrals to MH (only 8% referred)
- Improved adherence to evidence-based guidelines
- Reduced RX for anti-depressants

Complex Patients

- Among patients with suicidal symptoms, depression, and PTSD, BHCs provided treatment
  - No direct relationship found between PTSD and suicide
  - Suicidal symptoms explained exclusively by depression
  - Applicability for PCBH: if patients with trauma, depression, and suicide present in primary care, do NOT begin treating PTSD – depression symptoms should be treated first providing suicide risk has already been assessed and addressed

Bryan CJ, Corso KA. Depression, PTSD, and suicidal ideation among active duty veterans in an integrated primary care clinic. *Psychological Services. 2011; 8(2*): 94-103.

GETTING STARTED

Consultant Vs. Therapist

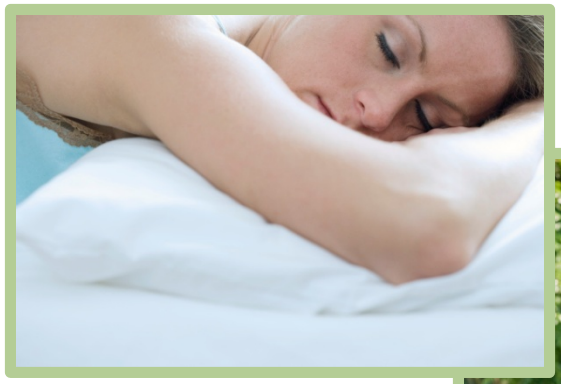
- Consultants answer a specific referral question
- Job is to help the referring medical provider with decision making and picking effective strategies
- Consultant has to answer the referral question first and foremost
- Medical provider is the primary customer, client is a secondary customer
- Ownership of care planning stays with medical provider
- Consultant has to build the practice by selling the service!

Orient Your New Colleagues (PCPs, RNs, Medical Assistants, Front Desk)

- Who to refer
- How to refer
- What to say
- What to do when someone is ambivalent
- How to involve the BHC in follow up medical visits

BHC Practice Habits Based on Evidence

- Provides “behavioral prescriptions” for skill practice and monitoring at follow-up (associated with improved outcomes)
- Uses empirically supported treatments that have been shown to contribute to **improved clinical outcomes in fewer treatment sessions across a diverse outpatient population without exclusion**



Basic BHC Behaviors

- Hang out in the heart of the clinic (nurses area)
- Schmooze, schmooze, schmooze!
- Portable computer allows concordant charting
- Access to printer and library of patient education materials
- Real time communication system with providers
- Use exam rooms if available but be sensitive to clinic flow

CLINICAL PRACTICE COMPETENCIES

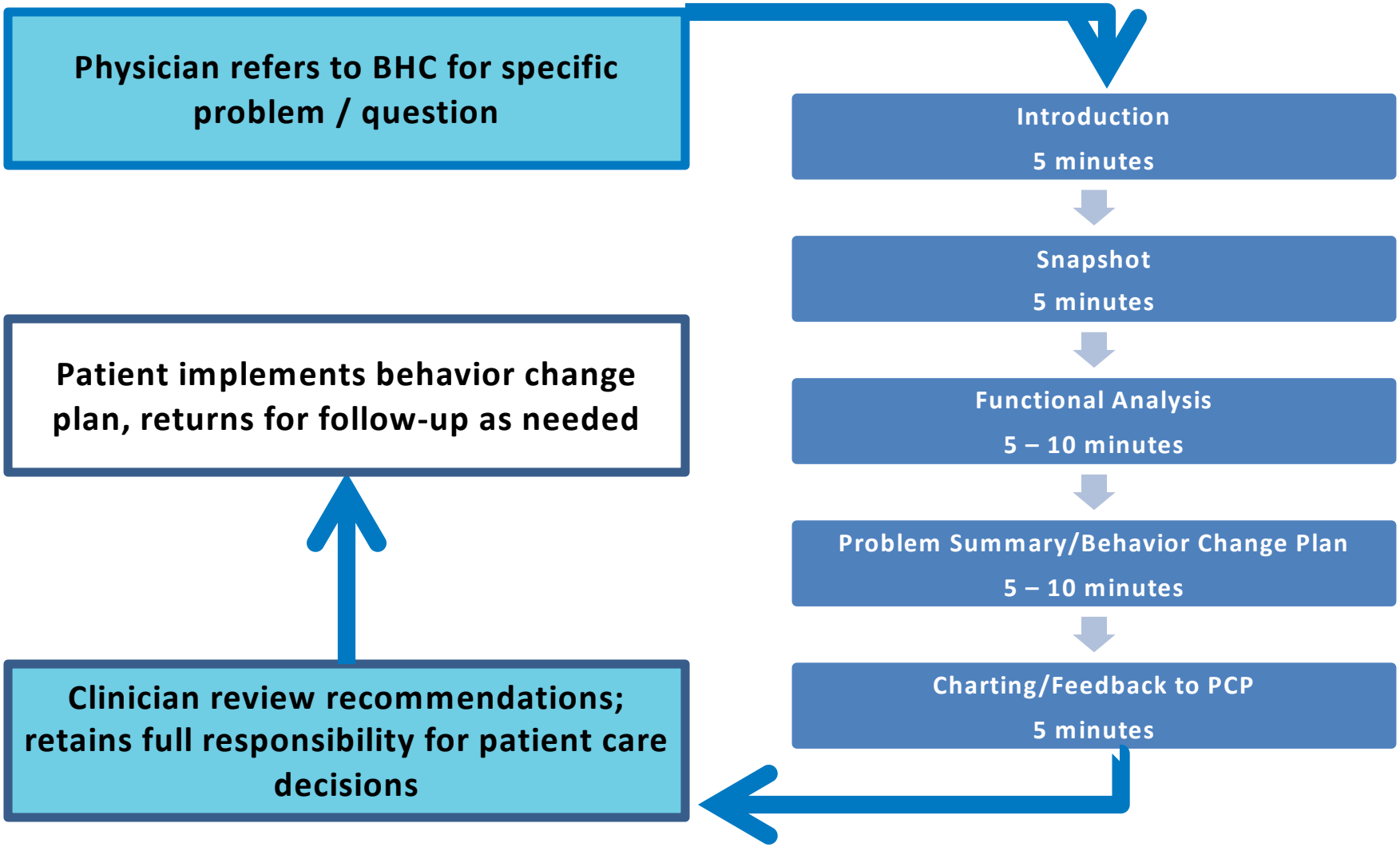
Starting Assumptions

- Assumptions about suffering
  - Symptoms are the “output”, not the “input”
  - Emotions are results of daily inputs, not problems to be solved or eliminated
  - There is a dynamic balance between life stress and positive coping behaviors
  - Little changes in this dynamic can produce big symptom displays
  - The goal is to understand the clients life context, within which the “problem” is nestled

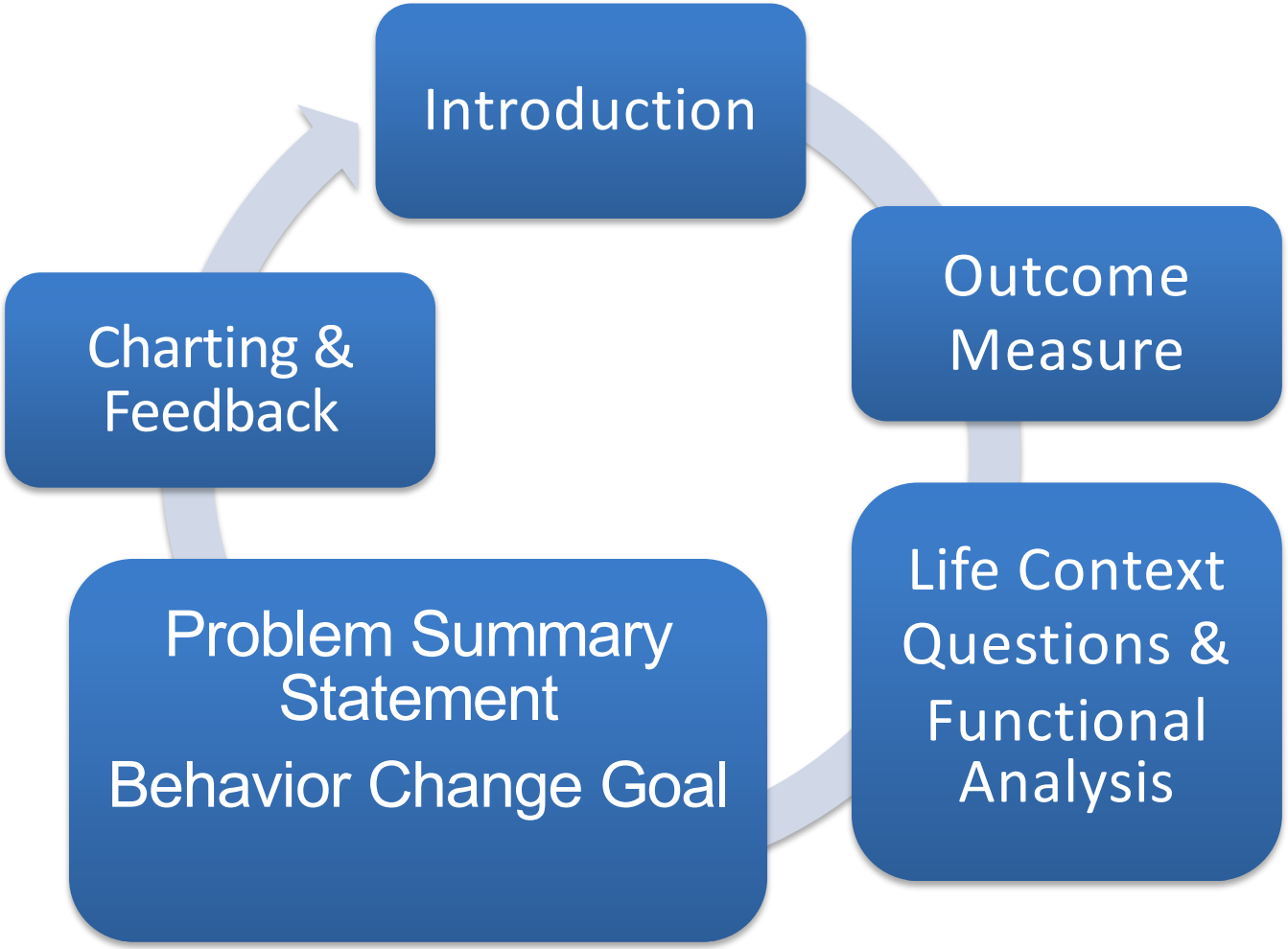
Starting Assumptions

- Assumptions about Behavior Change
  - Maladaptive behaviors are learned and maintained by various external and internal factors
  - Many maladaptive behaviors occur as a result of skill deficits
  - Direct behavior change is the most powerful form of human learning
  - Small behavior changes can have a dramatic effect on life context and symptom distress

Core Competencies: Initial Consult



Clinical Skills: Initial Visit



The Most Important Two Minutes is the First Two: Hi! I am Mary Virginia

- To help your PCP help you
- Your PCP calls me in to help when there's a concern about mental, physical or social health
- My job as a consultant to you and your PCP is quite specific
- We will spend about a 20-25 minutes today . . .

The Most Important Two Minutes: Cont.

- We will come up with a plan and I'll share that with your PCP
- Some people come back to see me to learn more skills and address other concerns; some only see me one time
- Okay, let's start with this brief survey; it will give us some numbers about your overall quality of life over the past week

The Love, Work, Play & Health Questions

Love	Where do you live? With whom? How long have you been there? Are things okay at your home? Do you have loving relationships with your family or friends?
Work	Do you work? Study? If yes, what is your work? Do you enjoy it? If no, are you looking for work? If no, how do your support yourself?
Play	What do you do for fun? For relaxation? For connecting with people in your neighborhood or community?
Health	Do you use tobacco products, alcohol, illegal drugs? Do you exercise on a regular basis for your health? Do you eat well? Sleep well?

The Three T & Workability Questions

Time	When did this start? How often does it happen? What happens immediately before / after the problem? Why do you think it is a problem now?
Trigger	Is there anything--a situation or a person--that seems to set it off?
Trajectory	What's this problem been like over time? Have there been times when it was less of a concern? More of a concern?
Workability	What have you tried (to address the problem)? How has that worked in the short run? In the long run or in the sense of being consistent with what really matters to you?

Problem Summary

- Express empathy / engage the patient (“This sounds very difficult and I can see that you’ve tried . . .)
- Strategic Reframe: Simplify and reduce the magnitude of the problem (“So, you’ ve bee feeling a lot of stress since loosing your job and it appears to affecting your ability to relax and to sleep at night.”)
- Help patient generate new strategies (“If a miracle happened . . . “)
- Create a do-able framework for change (“Let’ s take it one step at a time. I think the first step could be x or y; what makes sense to you?”)

In Session Rating Scales

1. How big of a problem is this for you? On a scale of 0 = “not a problem” and 10 = “a very big problem”, how would you rate it?
2. How confident are you that you will follow through with our plan? Use a scale where 0 = “no confidence” and 10 = “very confident”.
3. How helpful was this visit? Use a scale where 0 = “not helpful” and 10 = “very helpful”.

Behavior Change Basics

- Focus on function, not cure ("My job is to help you and your doctor improve your overall quality of life; often one or two small changes in our daily routine can make a big difference over time.")
- Process Check ("So at this point you are interested in . . . ?)
- Assess patient values related to problem ("In terms of what you think is really important in life--your core values--why does this change seem important at this time?")

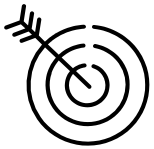
Behavior Change Plan

- Look for patient strengths to use in plan
- Emphasize idea of small positives
- Use external supports to promote success
- Frame plan as an “experiment”; collect data
- Assess patient confidence in plan
- Predict imperfection
- Provide a written copy of plan (on RX pad)

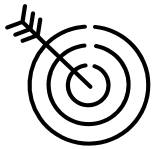
Team-Based Behavior Change Intervention: The Bulls Eye Plan

Your Clinic

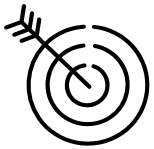
Your Phone Number



Love



Work



Play

Plan: _____

_____

_____

Interventions: General

- Basic behavior change (self-reinforcement)
- Build social support
- Suggest pamphlet or hand out
- Suggest book (Living with Children, I Can If I Want To, Living Life Well)
- Refer to community resources
- Suggest Internet programs (Insomnia, UCANPOOP 2, mild depression)

Interventions for Common Problems

- Eating, Sleeping, Engaging in Social Activities, Engaging in Exercise
- Medical Problems: Basic Interventions (Addressing stigma, creating a values context, recognizing primacy of psychosocial stresses; one step at a time)
- Overweight / obesity; diabetes; hypertension; ADHD
- Substance Abuse
- PTSD
- Medication Issues

Interventions: Depression

- (or Fatigue, Insomnia, loss of interest)
- Demystify depression, focus on symptom of concern
- Ask about patient's world view
- Explain the "lethargy cycle"
- Make behavioral activation plan, particularly social activities
- Problem solving

Interventions: Anxiety

- Teach relaxation / mindfulness / acceptance strategies
- Square breathing for panic
- CALM or diaphragmatic breathing
- Set up self-guided exposure (based on values)

Interventions: Sleep

- Use Handouts
- Review Sleep Hygiene Guidelines
- Coach on mindfulness and relaxation in bed
- Maintain sleep schedule
- Morning exercise
- Very common and high impact problem, so offer monthly workshops

Interventions:
Chronic Disease / Lifestyle

- Motivational Interviewing (Decisional Balance Sheet)
- Team-based support of specific goals (Bulls-Eye or SMART goals)
- Classes and workshops, group medical visits
- Internet-based with BHC phone call support
- Bibliotherapy (The Diabetes Lifestyle Book by Gregg)

Interventions: Relationship Problems

- Parenting Stress
  - Parenting Protocol (play, positive and descriptive praise, ignoring)
  - Enuresis (The Good Kid Book)
  - Overweight / obesity prevention
- Marital Satisfaction
  - See Relationship Couples Handout
  - Use Problem Solving
  - Caring Bank Account
  - Marital Check-up

Practice Management Skills

- Staying on-time, adjust time (10-15 minute sessions if needed)
- Keeping apt open, use classes/groups to increase your capacity
- Pair follow up visit with a PCP appt to reduce no shows
- Utilize alternative patient contact methods (phone follow ups, patient portal)

Schedule Template

Time	Activity Type
8:30	RT
9:00	SD
9:30	RT
10:00	SD
10:30	RT
11:00	SD
11:30	RT

Time	Activity Type
1:30	SD
2:00	RT
2:30	SD
3:00	RT
3:30	SD
4:00	RT
4:30	SD

Curbside Consults

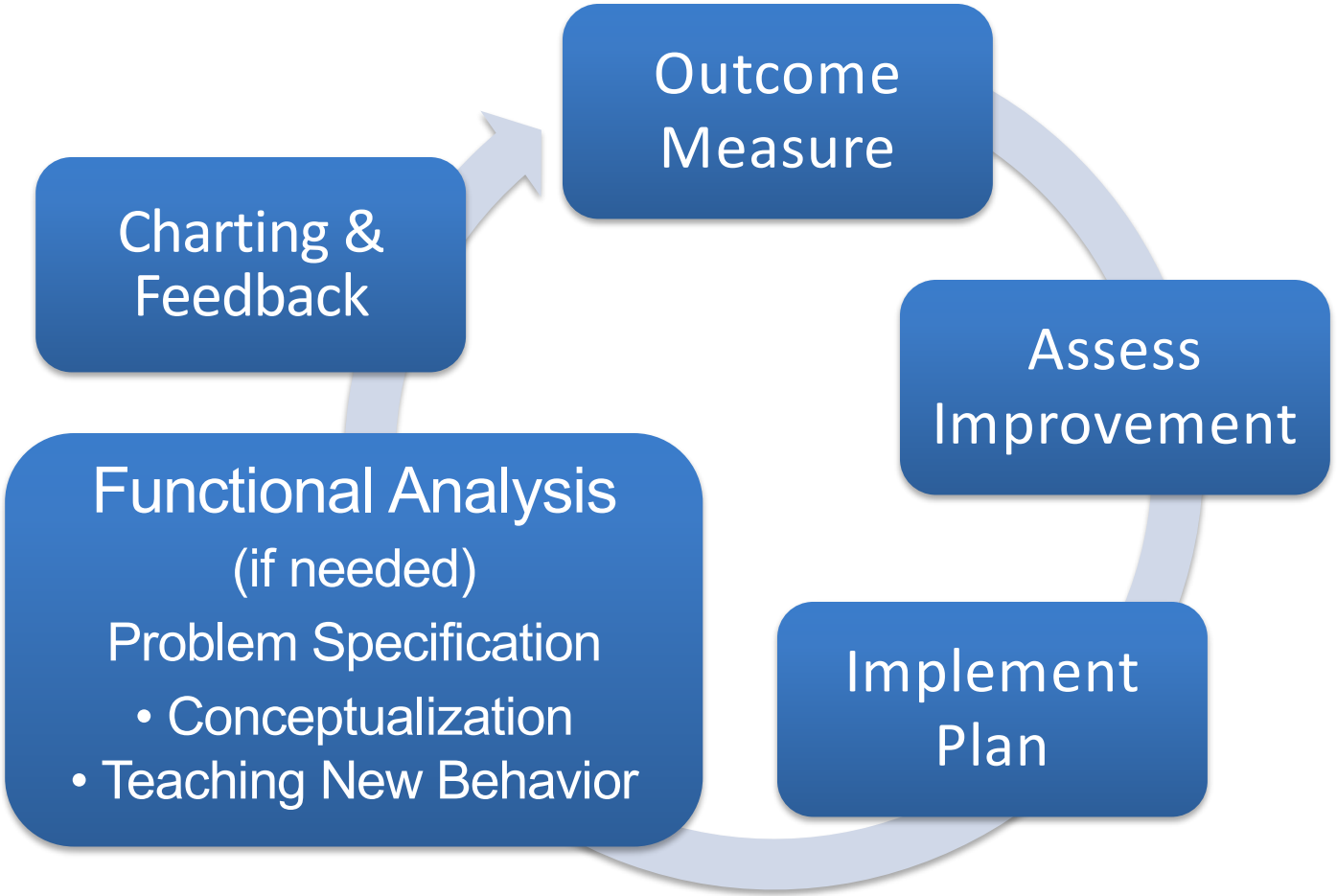
- In person for initial, same-day
- Be brief, get to the point and avoid jargon
- OK to interrupt PCP if you need immediate action
- Make sure to clearly answer the referral question and state your recommendations

SKILL PRACTICE: With partner, give FB on initial visit; follow-up visit (role play demonstration)

Charting

- This is a consult note, not a progress note
- Be brief and highlight core findings
- Avoid use of jargon
- Chart concordantly to save time
- Three main components:
  - Restate the referral question
  - Core assessment findings and problem impression
  - Recommendations to patient/provider and actions you took with patient today

Clinical Skills: Follow-up



Follow-Up Appointments

- Often more brief (15-20 minutes)
- No introduction or life context questions; allows more time for focus on reviewing success of interventions / teaching new skills
- Begins with outcome questions (Duke or PSC, Visit Rating Scale)
- Review progress with behavior change plan; trouble shoot problems with follow through, reinforce any attempt at change, normalize lack of success
- If making progress, cease planned f-u; leave door open for easy access

Classes

- Generic
- Open Access
- Psycho-educational
- Continuity statements
- Usually 1 hour
- Use feasible assessment and chart
- Announce in Exam Room Posters

Groups

- Monthly
- On-going management
- On-going skill training
- Measurement of outcomes over time
- Often related to pathway
- May be drop-in or required
- May be lead by BHC / BA alone or co-led with PC Team members

Interventions: Depression/Anxiety

Quality of Life Classes with Dr. Byrnes on Mondays 4-5
Let your provider know if you want to come for 1 (or more) classes.

Date	Class Name	Topics
4 Oct	Behavior Change Basics	Learn to create more hopefulness about behavior change and the tricks of planning and implementing change plans
11 Oct	Acceptance & Values	Learn to accept what you cannot change and clarify what is most important to you
18 Oct	The Body-Mind: An Owner's Guide	Learn to create sensations of relaxation and wellness quickly and reliably
25 Oct	Effective Problem Solving	Review the steps to take to approach problems, even difficult ones, and solve them one step at a time
1 Nov	Healthy Arguments	Learn how to stand up for yourself, disagree, and negotiate respectively
8 Nov	Play and Creativity	Learn how to "not do" and take stock of your creativity activities
15 Nov	Lifestyle Planning	Learn to use the Bull's Eye Tool to plan and pursue a lifestyle consistent with your values

Example of a Exam Room Poster Advertising A Generic BHOP Class

PCBH Pathway Services

- **Targets a patient population** that has high impact (by numbers or by way of presentation)
- **Applies the evidence** for the care of the targeted population
- Respectful of **local resources**
- Seeks to **improve efficiencies**
- Measurement of **outcomes** planned

PCBH Pathway Services May Include…

- Screening Processes
  - Neurodevelopmental screening at 18- and 24-month well-child visits and exam room posters
- One-on-One Interventions
  - BHC consult at any 2-year old well-child where child is overweight
- Classes or workshops . . . Or ultra-brief checks
  - Sleep hygiene, smoking cessation
  - Visit check-in screen: Do You Want to Make A Lifestyle Change?

PCBH Pathway Services May Include…

- Group medical visits
  - Chronic pain
  - Unstable diabetes
  - Weight control

Questions, Evaluations

Thank you for your precious time!

Please complete a session evaluation.