Promoting change in primary Care

(and other brief settings)

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Workshop Outline

- Our goal is to teach
  - Principles for successful implementation of the Psychological Flexibility model
  - Case conceptualization and intervention methods
  - Ways to promote resiliency in providers who work in brief treatment settings
- Tools for Patients: TEAMS, Hexaflex of Resilency, CPAT, Quick Guide, Bulls Eye Plan
- Tools for Providers: Personal / Professional Bulls Eye, Burnout Prevention Plan

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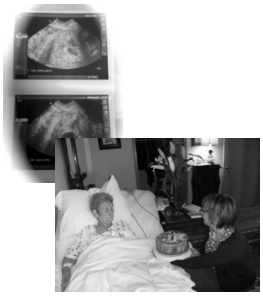
WHy Be Brief?

- Patient Access is Needed by Many and Difficult for Most
  - From before birth to preparation for death)
  - Access is haphazard at best
  - Pills in PC, Jails, ERs, Hospitals



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What Do Patients Want?

- Patient Preference
  - "I want to be seen when I want help, not later"
- Reduce stigma
  - "I don't want to be seen as crazy or needing pills or having to go for a lot of appointments"
  - Brief approaches emphasize patient's strengths; normalize suffering

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Why PC?

- Patients want primary care
  - . . . increase in use of PC as the chief source of MH tx across the US has occurred across all levels of psychiatric severity, not just milder forms
  - . . . use of PC has outpaced increases in specialty MH care access (Wang et al., 2006)
  - . . . and, by the way, research suggests equivalent levels of psychopathology and likelihood of psychiatric diagnosis across both specialty mental health and PC settings (Tata, Eagle, & Green, 1996)

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Resources are limited and . . .

- Access to MH services is very limited, particularly for underserved and in rural areas and particularly for economically challenged people
- Greatest amount of improvement occurs very early in treatment with diminishing returns of benefit over time. (Kopta ea al.; Ilardi & Craighead, 1994)
- Lengthier, time-unlimited therapies do not always demonstrate incremental efficacy compared to brief therapies (Knekt et al., 2008; see also Steenbarger, 1994 for a review)

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Bottom Line:
PC is the De-Facto MH System

- PCP is first medical professional with whom a patient discusses MH or behavioral difficulties
- 70-85% of PC visits are attributable to psychosocial or behavioral causes (Gatchel & Oordt, 2003; Kroenke & Mangelsdorf, 1989)
- So, the push is on to integrate BH services into PC
- The barriers:
  - A model for providing BH services
  - Translation of the most potent and user-friendly psychotherapy interventions to the demands of brief tx

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The Primary Care Behavioral Health (PCBH) Model *

- Embeds MH professionals within PC clinics to serve as BHCs to the PC team
- Goal is to improve detection, diagnosis and treatment of psychosocial health issuess
- Brief appointments (typically 15 to 30 minutes in length), time-limited contact with patients (frequently only 1-2 appoints) and collaborative decision-making with PCPs
- PCPs refer patients to BHCs, who conduct assessments and provide interventions in support of the PCP's tx plan, then provide recommendations and feedback to the PCP to further augment overall tx plan
- PCP retains full responsibility for patient care decisions

*Robinson & Reiter, 2007; Strosahl, 1996, 1997, 1998

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Clinical Features of BHC work

- Focus on rapid problem identification with active involvement of clinician and patient in stills training, with emphasis on self-management
- BHCs are directive (e.g., set an agenda, ask for specific examples of problems, educate patients, teaching and practice skills in-session, assign between appointment skill practice, monitor adherence and acquisition of skill mastery)
- "Concrete" clinical actions have been shown to significantly predict early clinic improvment (DeRubeis & Feeley, 1990)

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Clinical Features of BHC work

- BHC's routine practice of assigning "behavioral prescriptions" (called homework in psychotherapy) for skill practice and monitoring at follow-up is also associated with improved outcomes (Detweiler & Whisman, 1999)
- BHC uses empirically supported treatments that have been shown to contribute to improved clinical outcomes in fewer tx sessions across a diverse outpatient population without exclusion (Cukrowicz et al., 2005)

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What are the Benefits of PCBH Care?

- **Improved patient SXS** and functioning (Asarnow et al., ppolonio, 2009; Cigrang, Dobmeyer, Beckness, Roa-Navarrete, & Yerian, 2006; Corso et al., 2009; Davis, Corrin-Pendry, & Savill, 2008; Katon et al., 2002; RoyBryne, Katon, Cowley, & Russo, 2001; Simon et al., 2001; Unutzer et al., 2002)
- **Improved Patient Retention** (Katon, et al., 1996)
- **Reduced HC costs** (Katon, Roy-Byrne, Russo, & Cowley, 2002)
- **Reduction of PCP workload** (Davis et al., 2008; Spitzer et al., 1994)

Strengthened doctor-patient relationships (Simon, 1992)

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More specifics

- Patients improve across tx sessions (Bryan et al., 2009; Brian et al., 2010; Cigrang et al., 2006)
- Patterns of improvement mirror the earliest stages of traditional outpatient psychotherapy (e.g., Howard, Kopta, Krause, & Orlinsky, 1986; Kadera, Lambery, & Andrews, 1996)
- Recovery typically occurs within 4 PCBH appointments (Bryan et al., 2010)

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But does It work for People with severe problems? and do People sustain their gains?

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More severe improve

- Patient-focused method of outcomes research suggests a "dosage model of psychotherapy" (Kopta, Howard, Lowry, & Buetler, 194) rather than the traditional efficacy and effectiveness outcomes methodology to answer questions about which patients will respond to which treatments (Kopta et al., 1994)
- Bryan, Corso, Kanzler, Corso, Morrow, & Ray-Sannerud (2012) took this approach, studying 495 PC patients and creating 3 models to identify clinical improvement in terms of # appts attended, baseline impairment severity level, and interaction of these 2. The results:
  - 71.5% improved across appts
  - Patients with more severe impairment at BQ improved faster than patients with less severe BQ impairment
  - 495 PC patients

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Is the dose sufficient for sustained improvements over time?*

- 664 patients who received BHC care in large family medicine clinic, completed BHM (20-item self-report) at all visits and by mail 1.5 to 3 years after end of care; 70 returned (63% female, mean age 43, 47% Caucsian, 13% African American, 21% Hispanic / Latino, 3% Asian / Pac Islander, 10% other); Mixed effects modeling
- Results:
  - Patients improved from 1st to last BHC appointment
  - **Gains maintained on average of 2 years after care**
  - Patterns of results remained significant even when accounting for the receipt of additional MH tx subsequent to BHC care

*Ray-Sannerud, Morrow, Kanzler, Dolan, Corso, & Corso, 2012

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ACT "Fits" PC
(and other Brief TX settings)

- Better diabetes management and significant improvement in Hemoglobin A1C measurement (Gregg, et al, 2007)
- Improved rates of smoking cessation (Gifford, et al., 2004)
- Powerful treatment for chronic pain and disability behavior (McCracken et al., 2004)
- Reduced rates of seizures and improved QOL in patients with uncontrolled seizure disorder (Lundgren, et al., 2008)
- Helpful to depressed patients (Zettle & Hayes, 1986) and polysubstance abusing methadone-maintained opiate addicts (Hayes, et al., 2004)
- Better than usual care or waiting lists and as effective as other CB or psychotherapies in tx of many traditional mental health problems commonly seen in primary care (Powers, et al, 2009), including anxiety (Hayes, et al, 2006)

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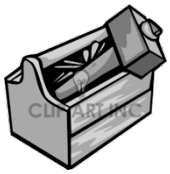

Tools for Promoting Change in Patients

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Mindfulness
TEAMS (Private Experience)

TEAMS Exercise

TEAMS Exercise:

Imagine going having a concern about your health, mental or physical or both, and deciding to ask someone for help

Private Event Element	Your observations
Thoughts	
Emotions	
Associations	
Memories	
Sensations	

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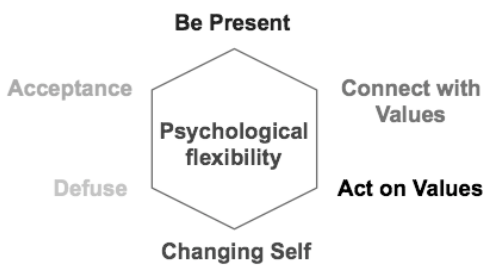
Resiliency in Aging: 6 Core Processes



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Core Process Assessment Tool (CPAT)

Inflexibility Points	Rating (0-10)	Flexibility
Stuck TEAM/Rules		Step Back
In past or future		Present Moment
Stuck / self story		Observer sees
Values disconnect		Values Connect
Impulsive, passive, self-defeating		Sustain Valued Action
Total Score:		(Range = 0-60)

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Real Behavior Change Quick Guide

- 1 page pocket guide (put in on your wall, in your clip board or in your pocket)
- 3+ interventions for each of the 6 Processes / Points of Psychological Flexibility
- Categorized by Process / Point
- Bulls Eye involves multiple processes, as do several others

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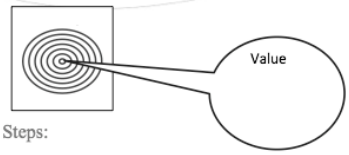
Bulls Eye Plan



Action Steps:

1.

Relates to which core process(es)?

2.

Relates to which core process(es)?

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Tools for Interviewing Briefly

- Love, Work, Play & Health
- Three Ts (Time, Trigger, Trajectory) and WORKABILITY
- Brief Assessments (0-10, all visits): Problem severity, confidence and helpfulness

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The Health context

- Experiential avoidance is a common response to lifestyle and health concerns
- The culture in the US doesn't promote a strong value connection with health
- PC Providers are challenged to the max!

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Burnout Rates

- **Medical Students – 45%**
- **Residents – 27% FP to 75% OB-GYN**
- **Attendings – 20% - 65%**

Limitations of studies – poor response rates, definition of burn-out (EE, DP, PA).

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Burnout

- **Over-eat, drink, work**
- **Substance abuse**
- **Isolation**
- **Depression, Suicide**
- **Leave Profession**
- **Relationship Problems**

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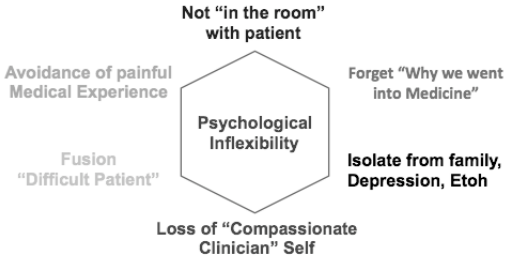
Burnout - Core Processes



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Burnout – Factors/Consequences

Adverse workflow
Low control
Unfavorable culture

⟷

Low MD satisfaction
High Stress/Burnout
Intent to leave

MD stress/burn-out ⟷ **Quality of care errors**

Linzer et.al, Working Conditions in Primary Care: Physician Reactions and Care Quality. Ann Inter Med 2009;151:28-36.

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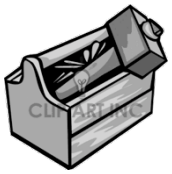

Tools for Promoting Provider Resilience

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Graduation/Retirement Party Worksheet

Instructions:
*For each of the four life areas listed below, please describe your core **values**. For example, if you were at your own graduation/ retirement party, what would you like to hear other people say about what you "stood for", the mark you had left . . . generally, what your behavior over the years demonstrated about your personal beliefs.*

1. **Studying/Practicing Medicine:**
2. **Relationships with Colleagues:**
3. **Relationships with Family/Friends:**
4. **Personal Health & Well-being:**

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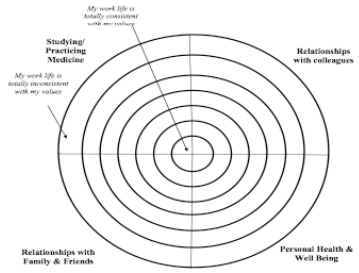
Name: _____

Professional/Personal Values Assessment



Instructions: Place an "X" in each of the four quadrants above to represent the degree to which you are currently living according to the values you've just described.

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Burnout Prevention and Recovery Plan

To help reduce your risk of burnout, please describe specific behaviors you intend to use, when you will use them, and how often for each of the four following skill areas. Try to respond to at least two areas initially and add in more plans later. The more specific is your plan, the more likely it is that you will follow it!

Practice of Acceptance:

Practice of Mindfulness (i.e., present moment awareness, contacting transcendent of self):

Practice of Contact with Personal Values:

Practice of Value Consistent Daily Actions:

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Passengers on the Bus

Exercise

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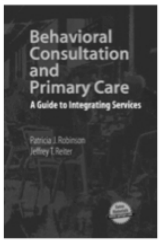
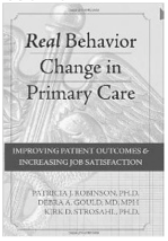
Resources

System Change: PCMH
Primary Care Behavioral Health **Model**



Patient and Provider Change
Acceptance and Commitment Therapy (ACT)



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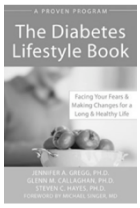
And More Resources



Out this month: *Brief Interventions for Radical Change: Principles and Practice Of Focused Acceptance and Commitment Therapy*Strosahl, Robinson &GustavssonNew Harbinger

http://www.contextualpsychology.org/ http://www.newharbingeronline.com/

real-behavior-change-in-primary-care.html

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Stay in touch . . .

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