Magic and Marvel of Primary Care Behavioral Health Series:
An extended exploration of PCBH

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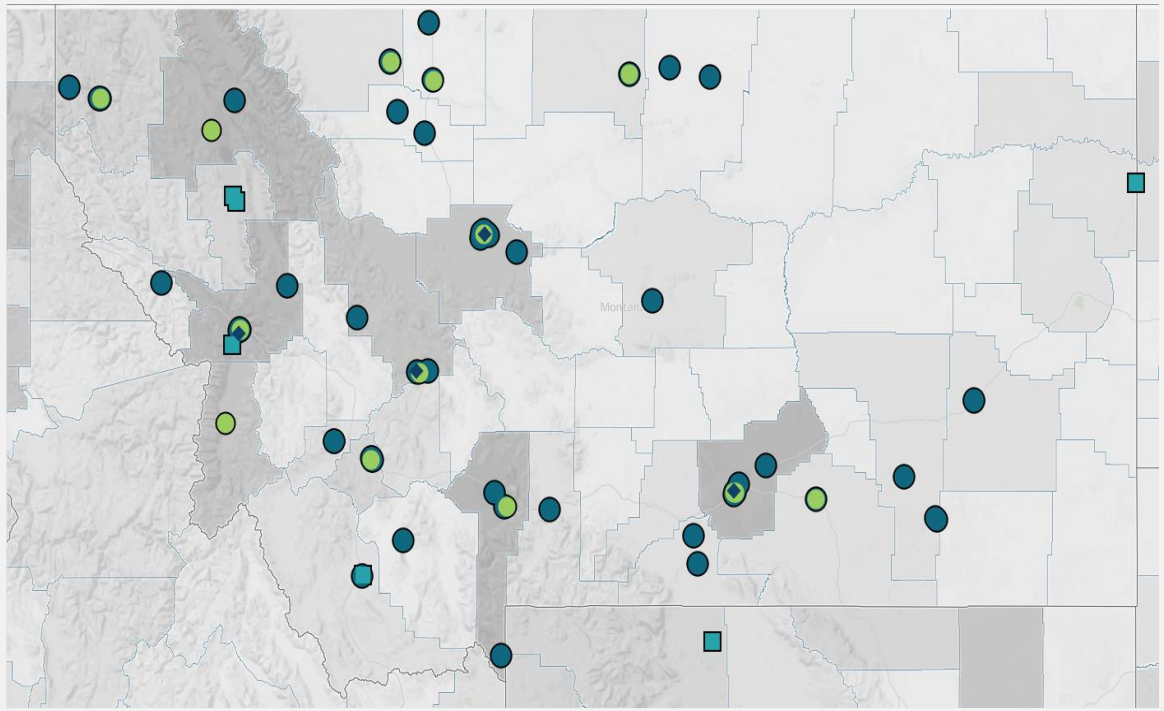
This is us: MPCA



- The **Mission** of the Montana Primary Care Association is to promote integrated primary healthcare to achieve health and well-being for Montana's most vulnerable populations.
- The **Vision** of MPCA is health equity for all Montanans

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- MPCA values integrity, collaborations, and innovation.
- The Montana Primary Care Association is the support organization for Montana's 14 Community Health Centers and 4 of our Urban Indian Centers. MPCA centers serve over 117,500 patients across Montana.

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Magic and Marvel of Primary Care Behavioral Health Series: Brief Intervention Series

Come join us for bi-weekly sessions from different experts in Montana to learn more about PCBH Brief Interventions. Topics will include advanced conceptions of diagnosis, treatment planning, intervention implementation, and continuing practice plans.

I. Magic of warmhand- off, structuring session
II. Marvel of Diagnosis and treatment
III. Life cycle of treatment, 4-parts to a treatment plan

- ☐ Warm Hand off and introduction explanation to tx and tx plans
- ☐ Skills based to interventions (session) 1 or 2 training (i.e. 12 sessions; teach skills towards dx, client centered, symptom-based interventions)
- ☐ CPT (continuing practice plan)
- ☐ Circling back: adjustments to previous treatments or new problems in new times

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Breakout Rooms
What Do We like About Brief Interventions?
What Don’t you like?

Why People In Distress Don't Seek Behavioral Health Services

1. **Lack of insurance**
2. **Stigma**
3. **View their problem as "physical"**
4. **Inconvenience (including long waitlists)**
5. **Transportation**
6. **Lack of child-care**
7. **Better familiarity, comfort with PCP**
8. **Prior negative experiences**

BUT, these same individuals will use TWICE the amount of primary care services as non-distressed people!

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IMAGINE

- No rules
- Gave patients
  - what they need
  - when they needed it
  - the amount they need
- Patient Centered
- Strength based
- Patient Self-Reliant (know when to let go)

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Primary Care Behavioral Health (PBCH)

1. ***It is*** the right treatment at the right time, with the appropriate level of care.

2. ***It is*** measurement-based care (MBC).

3. ***It is*** interprofessional, team-based relational community-based care given when needed as needed. It may be brief, sequential, or intermittent.

But Why?

- Primary Care Providers **(PCPs) prescribe 80% of antidepressants**, 67% of psychoactive agents, and 92% of elderly patients receive their mental health services in primary care
- High levels of stigma and discrimination against this population create lack of access to services.
- Around **50% of Americans** will experience a diagnosable Substance Use Disorder (SUD) or Mental Health (MH) disorder at some time in their life.
- Primary care clinics are a gateway for individuals with behavioral health and primary care needs.

- Montana's suicide rate is more than twice the national average.
- 45% of completed suicide patients had a PCP visit within one month, 20% of those had visited within **24 hours.**
- Alcohol was found in the bloodstream at a 2 times higher rate than national average for completed suicide patients.

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MENTAL HEALTH TREATMENT PATHWAYS

Findings from
109,593
respondents to the
2002-2009 Medical Expenditure
Panel Surveys (MEPS)

Peterson, S., Miller, B., Payne-Murphy, J., & Phillips, R. (2014). Mental health treatment in the primary care setting: patterns and pathways. Family, Systems, & Health.

Behavioral Primary Care Reduce ridge rules that make care less accessible

- When patients do access therapy in specialty MH, they **usually do not use it for long**.
- Average number of therapy vis**its is merely one** (Brown & Jones, 2005).
- Mean number of therapy visits per patient has decreased by about 20%
- Often patients complain of difficulty scheduling **follow-up appointments** that are convenient; worse yet, some patients are **terminated from care for missing too** many appointments or **failing to follow through on the recommendations** from the MH clinician.
- While the specialty MH care sector has the luxury of picking and choosing which patients to follow, the PC sector does not. This is particularly true for community health clinics, which are the safety net for the population. Thus, most patients spurned by the specialty MH system eventually end up back in PC.

- Patricia J. Robinson, Jeffrey T. Reiter. (2018). *Behavioral Consultation and Primary Care*(2nd ed.). Springer.

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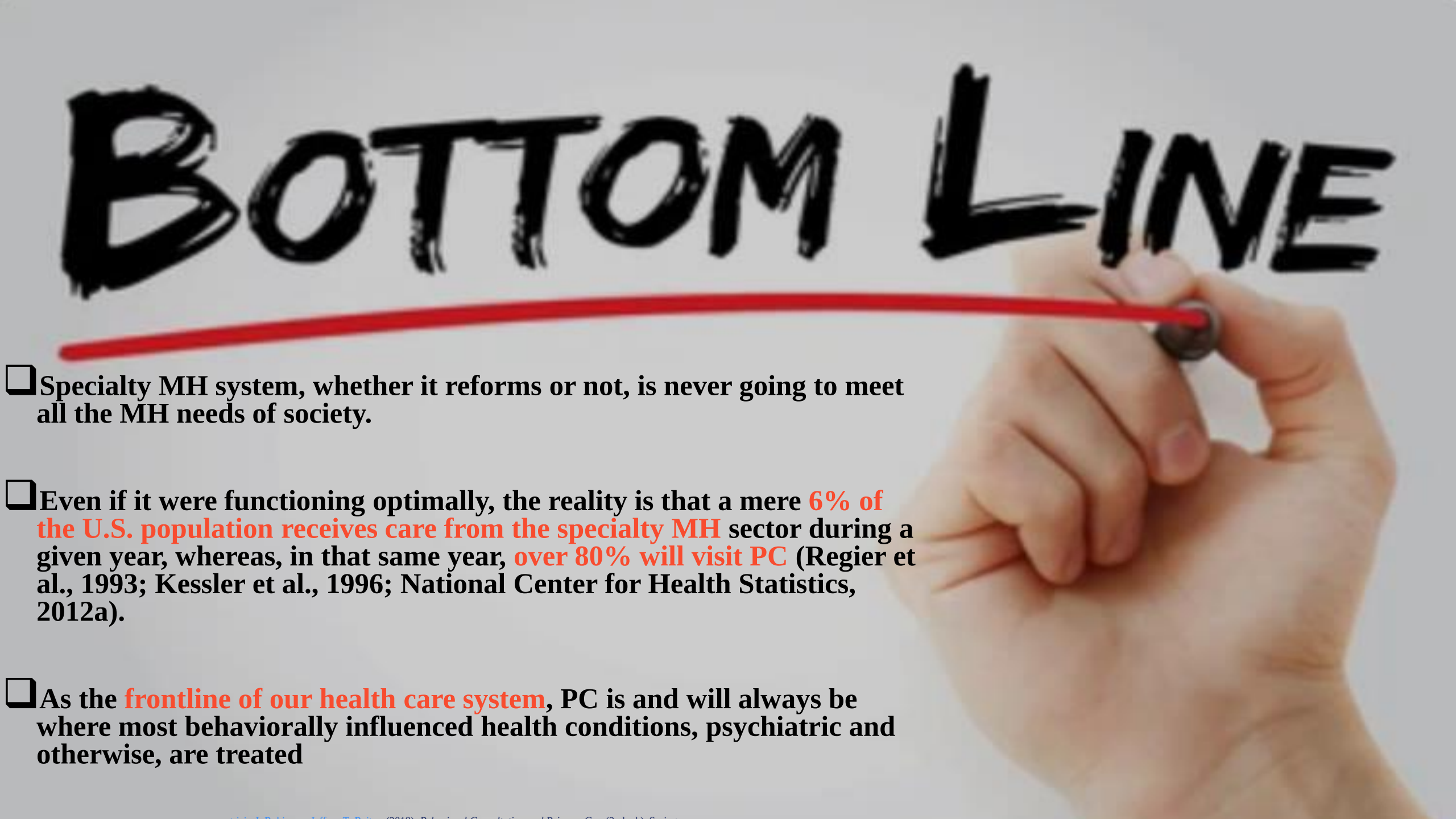
BOTTOM LINE

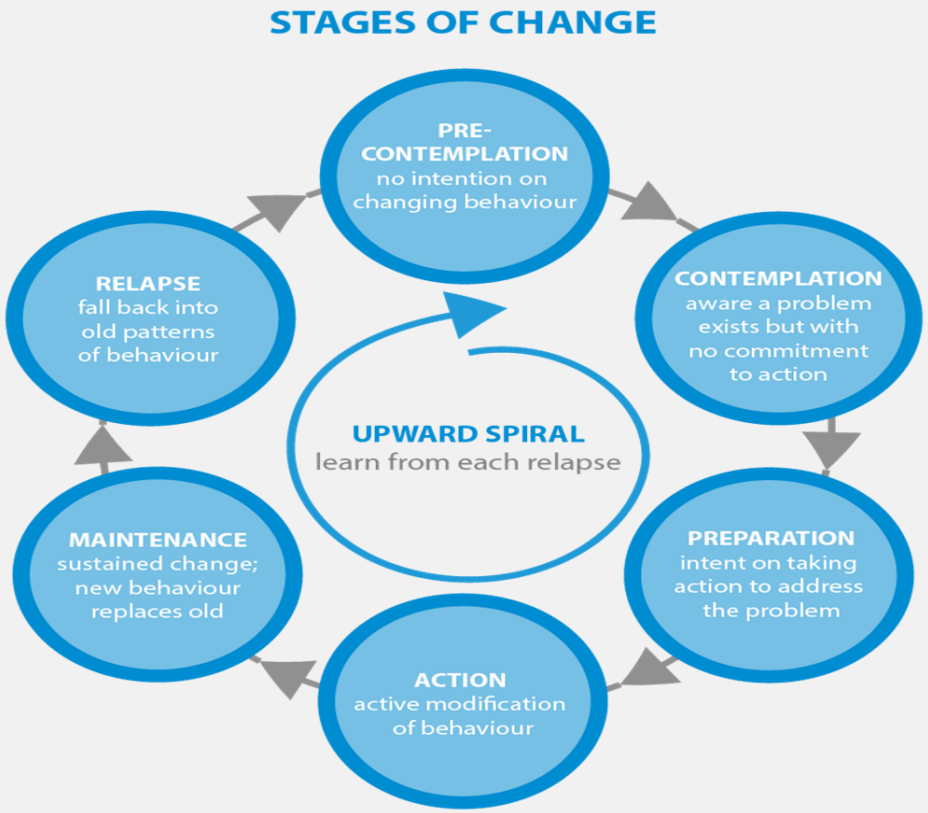


- Specialty MH system, whether it reforms or not, is never going to meet all the MH needs of society.

- Even if it were functioning optimally, the reality is that a mere 6% of the U.S. population receives care from the specialty MH sector during a given year, whereas, in that same year, over 80% will visit PC (Regier et al., 1993; Kessler et al., 1996; National Center for Health Statistics, 2012a).

- As the frontline of our health care system, PC is and will always be where most behaviorally influenced health conditions, psychiatric and otherwise, are treated

Basics Understanding of Brief Intervention



- ✓ MH must be seen as routine care
- ✓ Overall attitude of understanding and acceptance Active listening skills
- ✓ Focus on immediate goals
- ✓ Working knowledge of motivational interviewing and stages of change
- ✓ Working knowledge of cognitive behavioral and solution-oriented approaches

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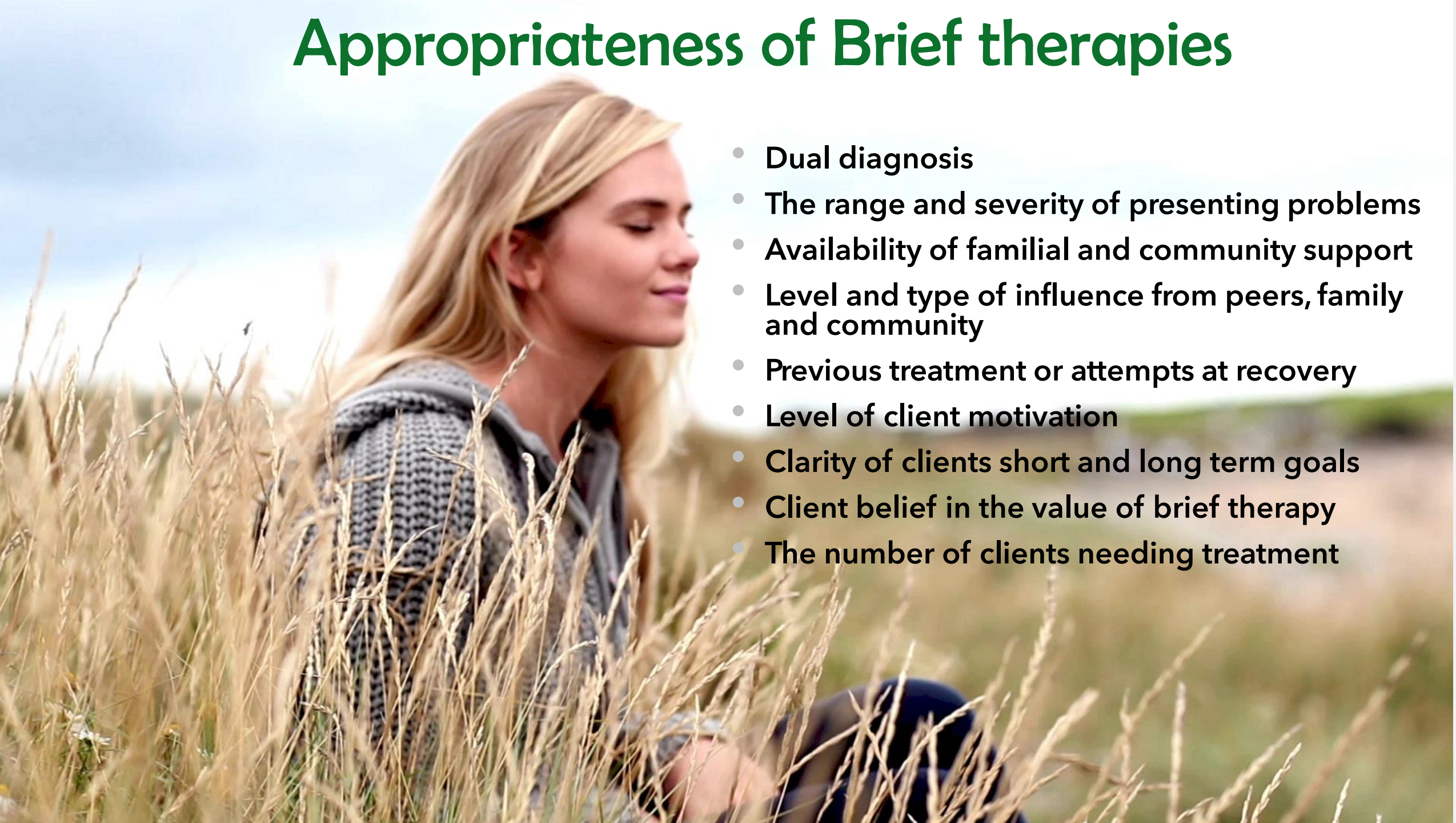
Benefits

- ✓ Reduce no-show
- ✓ Increase treatment engagement
- ✓ Increase compliance
- ✓ Increase self-efficacy
- ✓ Reduce aggression and isolation

Appropriateness of Brief therapies



- Dual diagnosis
- The range and severity of presenting problems
- Availability of familial and community support
- Level and type of influence from peers, family and community
- Previous treatment or attempts at recovery
- Level of client motivation
- Clarity of clients short and long term goals
- Client belief in the value of brief therapy
- The number of clients needing treatment

What are the Characteristics Of Brief Interventions?

Characteristics of Brief Therapies

- Problem focused
- Target the symptoms not what is behind it
- Clearly define goals related to specific behavior
- Understandable to both client and clinician
- Produce immediate results
- Rapid establishment of working relationship
- Highly active, empathic, and sometimes directive
- Responsibility for change is placed clearly on the client
- Experiences enhanced self-efficacy/confidence that change is possible
- Termination is discussion from the beginning
- Outcomes are measurable

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Goals of Brief Interventions

Specific

Measurable

Achievable in 6-10 weeks

If not return to team

Realistic

Time limited

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Use at least one measurable change in the client's behavior

- Time management
- Expanding support
- Improving social skills
- Changing unhelpful thoughts
- Improving health behaviors
- Vulnerability awareness and prevention
- Vocational issues
- Support group attendance
- Forgiveness and acceptance
- Staying in the “hear and now”
- Identifying triggers for the mood or behavioral
- Coping with high risk or triggering situation

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Recommended Frequency of Contact with Patients

Active Treatment

- ✓ Until patient significantly improved/stable
- ✓ Relapse Prevention Plan from start of tx
- ✓ Typically, 2 contacts per month
  - Mix of phone and in-person

Monitoring

- ✓ 1 Contact per month
  - After 50% decrease in PHQ
  - Monitor for ~3 months to ensure patient stable
  - Complete relapse prevention

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Session:

- **Educate the why and what is happening**
- **Pick one thing to work on and problem solve**
- **Small Small Goals**
- **Praise and Reinforce**
- **Track progress/symptoms**

Treat to Target

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Problem Solving Process

3 Assessment Questions:

1. trigger?
2. Response
3. What made it worse?

Warm Hand-Off

Assessment teach, practice, homework

Assessment teach, practice, homework

Assessment teach, practice, homework

Assessment teach, practice, homework

Assessment teach, practice, homework

Relapse Prevention toolbox

Building Therapeutic Alliance

Relapse Prevention Plan

Patient Name:_____

Maintenance medications: Date: _____

1. _____;_____ Tablet(s) of_____mg._____Take at least until_____
2. _____;_____ Tablet(s) of_____mg._____Take at least until_____
3. _____;_____ Tablet(s) of_____mg._____Take at least until_____
4. _____;_____ Tablet(s) of_____mg._____Take at least until_____

Call your primary care provider or care manager with any questions (contact isbelow)

Other Treatments:

1. _____
2. _____
3. _____

Personal Warnings:

1. _____
2. _____
3. _____
4. _____

Things that help me feel better:

1. _____
2. _____
3. _____
4. _____

If symptoms return, contact:_____

Primary Care Provider:_____ Phone:_____

Care Manager:_____ Phone:_____

Next appointment: Date:_____Time:_____

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End of Session Remember:

Helpfulness question:

“To what extent has this visit been helpful? Use a scale of one = not helpful to 10 = very helpful to let me know.”

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Thank You!!

See You in 2 Weeks