# Chronic Care and Behavioral Health

*Chronic Disease and Behavioral Health Management:*

*Addressing Behavioral Health To Improve All Health*

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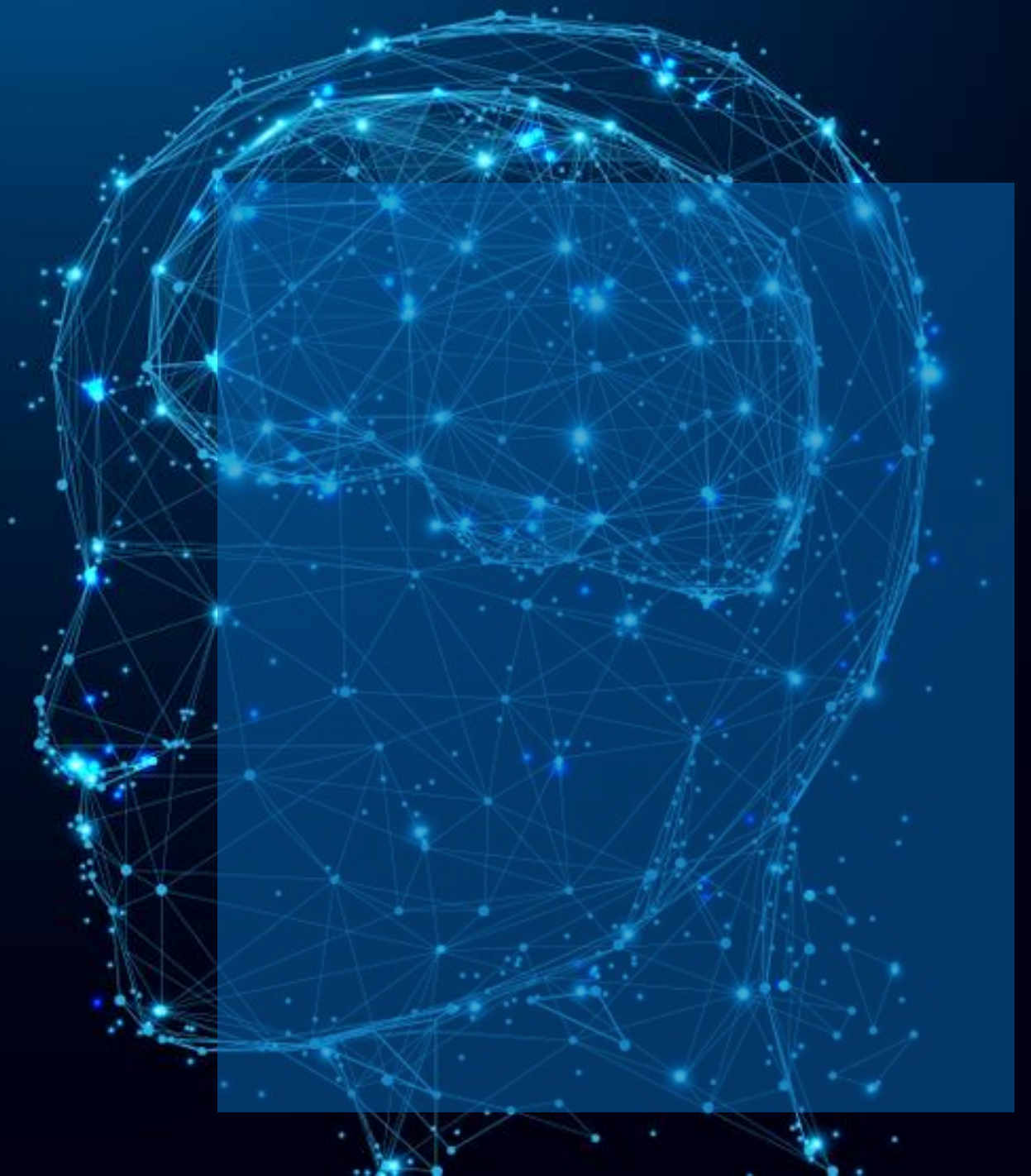
Capital Nursing Education

# Objectives

1. Describe why chronic disease management needs to be multidisciplinary.
2. Describe what behavioral health is.
3. Describe how behavioral health and chronic disease interact.
4. Identify at least three psychosocial barriers that may need addressed in treating chronic disease and behavioral health issues.
5. Demonstrate the use of open-ended questions.
6. Detail two strategies to improve patient self-management of chronic disease.

# What is Behavioral Health?

- Behavioral Health describes the connection between behavior and the health and well-being of the body, mind and spirit.
- Behavioral Health includes both mental health and substance use encompassing.
- Prevention, Intervention, treatment, and recovery services.



# *What is Chronic Illness?*

A human health condition or disease that is persistent or otherwise long lasting in its effects.

The term chronic is often applied when the condition lasts longer than 3 months.

Chronic conditions cannot be prevented by vaccines or cured by medication, nor do they disappear- per the U.S. National Center for Health Statistics.

Common Chronic Diseases include arthritis, asthma, Diabetes, Heart disease and viral diseases such as Hepatitis C and HIV/AIDs.

# *Centers for Disease Control and Prevention States*

*"Chronic diseases are the most common, costly and preventable of all heath problems"*

*Chronic diseases are the leading causes of death and disability in the United States.*

*Prevention is essential to addressing chronic disease as a public health challenge in the 21st century.*

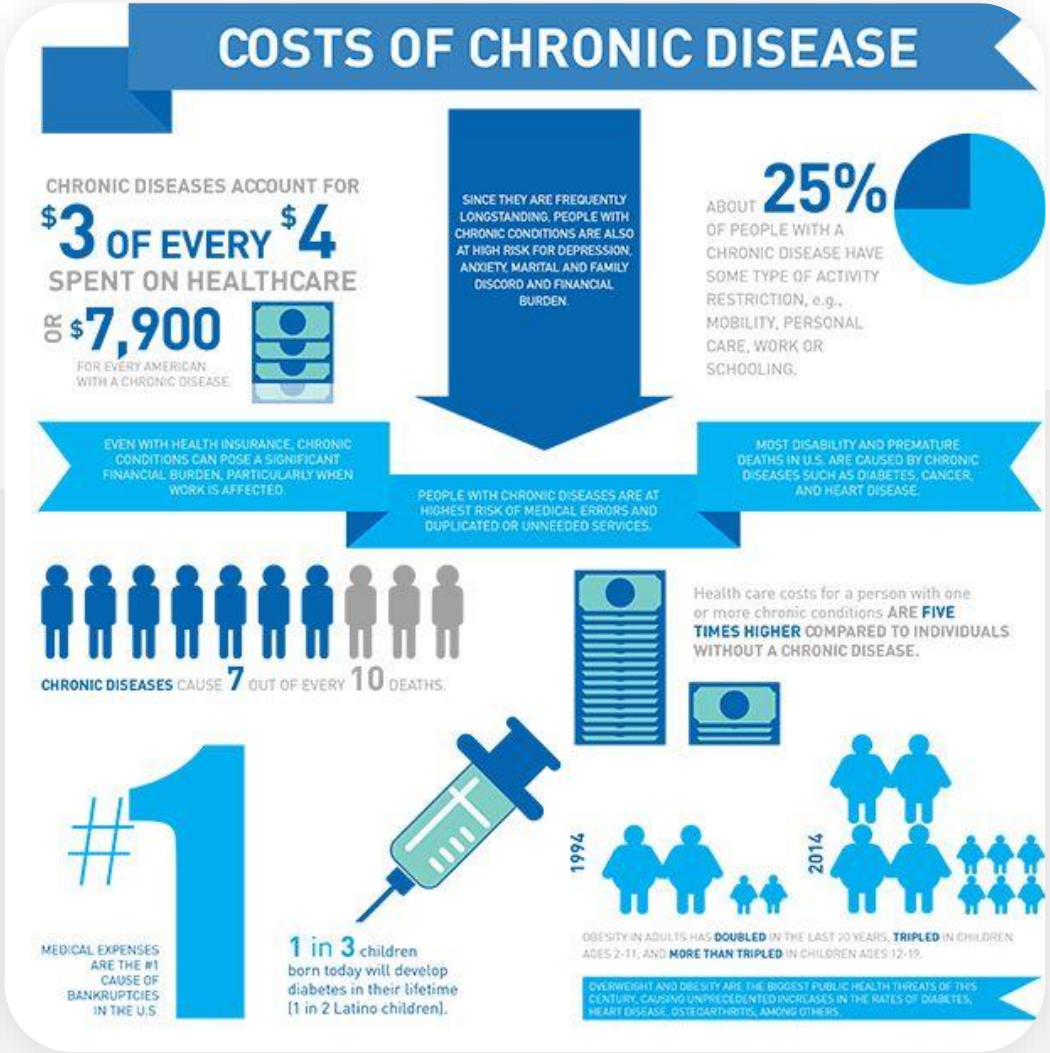
*Almost 50% of all adults over the age of 18 years have one or more chronic health conditions*

*25% of adults have two or more chronic health conditions.*

# *How do Chronic Disease and Behavioral Health Interact*

- *18-25% of patients suffer from depression following a myocardial infarction.*
- *Diabetics are 2x as likely to suffer from depression than non-diabetics.*
- *13% of cancer patients also suffer from depressive disorders.*
- *2.5x risk of suffering from depression in patients with severe Chronic Obstructive Pulmonary Disease (COPD).*
- *Anxiety and depression, among other behavioral health issues, typically act as a cost-multiplier to the expense of managing chronic diseases.*

# *Treatment of Chronic Disease is costly, Accounting for 86% of all Health Care Spending*



# *Medicare Embraces' Chronic Care Management and creates Opportunities*

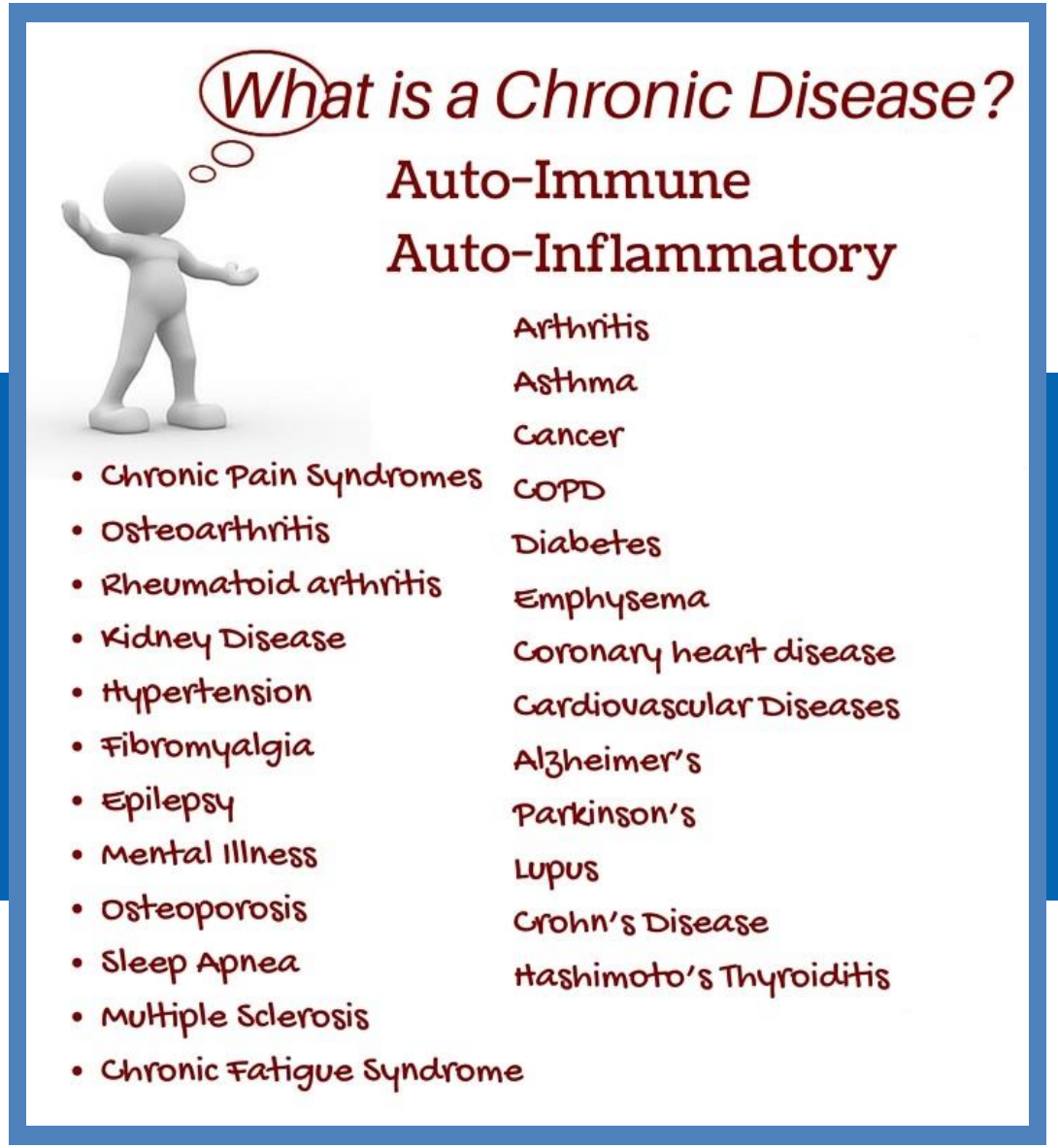
- *Centers for Medicare and Medicaid Services introduced expanded code set for Psychiatric Collaborative Care Model and Behavioral Health Integration programs.*
- *Medicare's Chronic Care Management program expanded in 2017 which presents unique and exciting opportunities for behavioral health providers.*
- *As of January 1, 2017 CMS began directly reimbursing clinicians who coordinate care for patients with behavioral health conditions.*

## *Medicare has recognized that both Chronic Care and Behavioral Health Require*

- *Goal directed care management.*
- *In-between care management.*
- *Patient centered care.*
- *Comprehensive care planning.*

# *Use your Words **Carefully***

*Within the professional community there is a wide variation in what diseases are included in chronic disease.*



# *Behavioral Health*

*The new Medicare BHI (Behavioral Health Integration) program is used to support patients in-between their visits with practitioners who are treating patients with conditions such as mood and anxiety disorders, cognitive disorders such as Alzheimer's and other dementias, psychotic disorders such as schizophrenia, as well as people with a variety of addictions – including drug and alcohol addiction.*

*The new benefit fosters goal-directed, comprehensive care planning, care coordination and monitoring by the care team, with an overall aim of fostering a continuous relationship between the patient and the care team.*

# *Population Management*

*American Journal of Health's definition of* ***Population Health Management*** *is that despite work in this area beginning more than a decade ago, the definition is still evolving.*

*Kindig and Stoddart define it as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group".*

*Each organization must evolve and find the best evidenced-based practices that effect the population served- either by disease or population.*

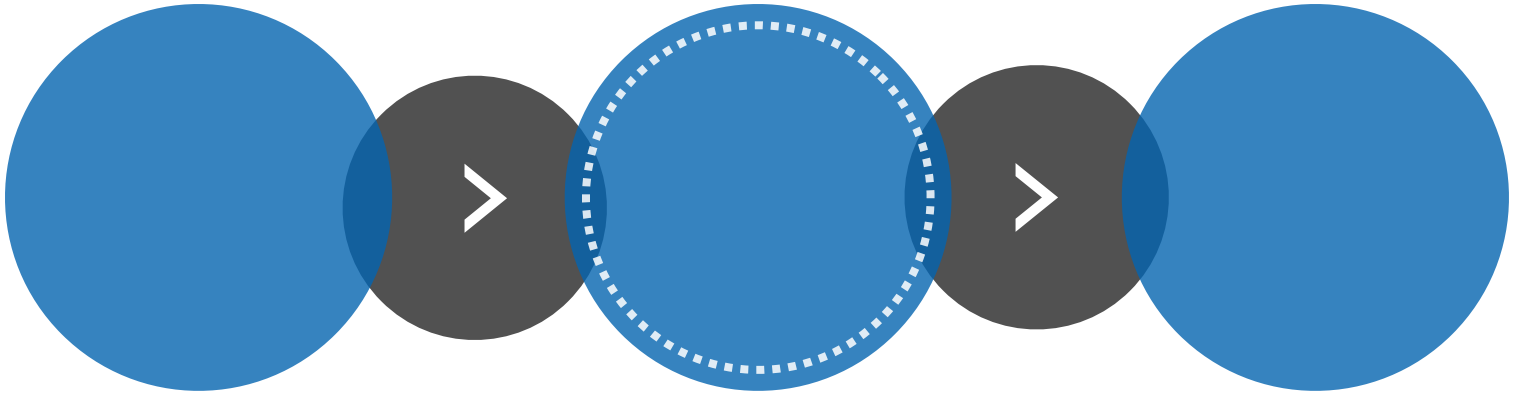
*Not one size fits all intervention.*

# *Disease Management*

*Disease management is a set of activities aimed at improving the health and clinical outcomes of a population of patients, defined by chronic disease.*

*Disease management is moving towards or including population management.*

# *Self Management*



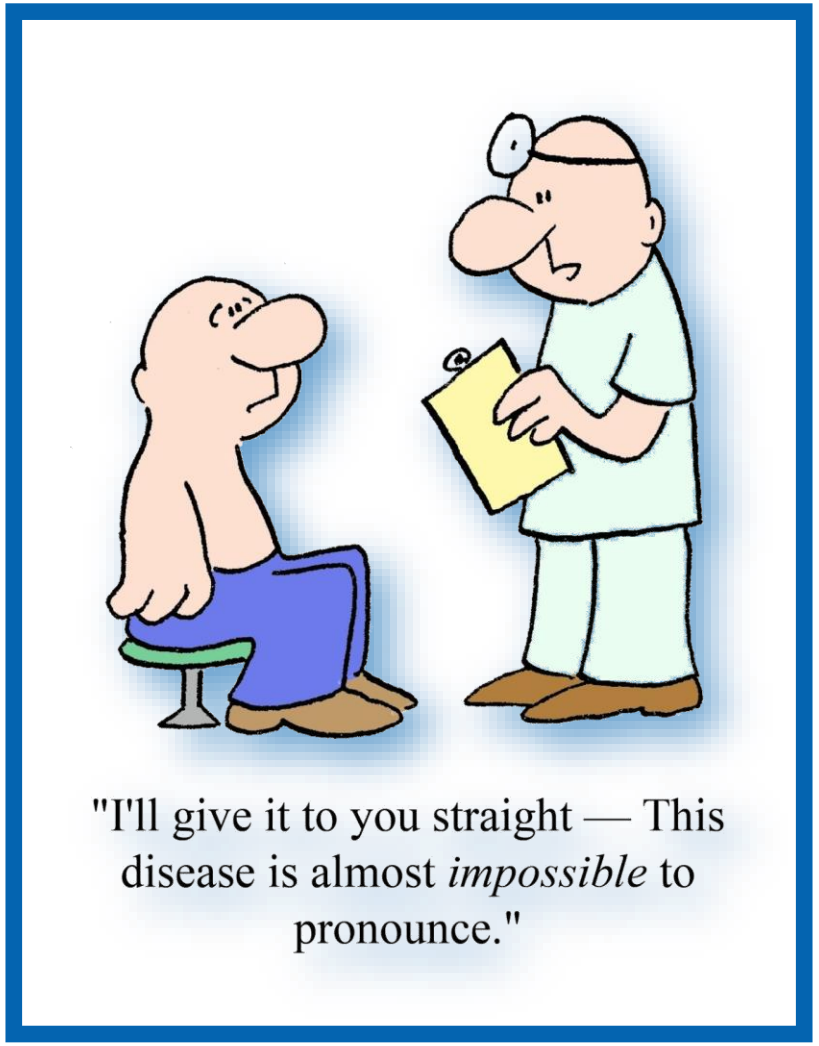
*Self management is the ability of the patients with their family, community and healthcare providers to learn to manage their symptoms and treatment and make life style changes.*

*Patients need to understand how cultural, socio economic and spiritual factors impact their management of disease.*

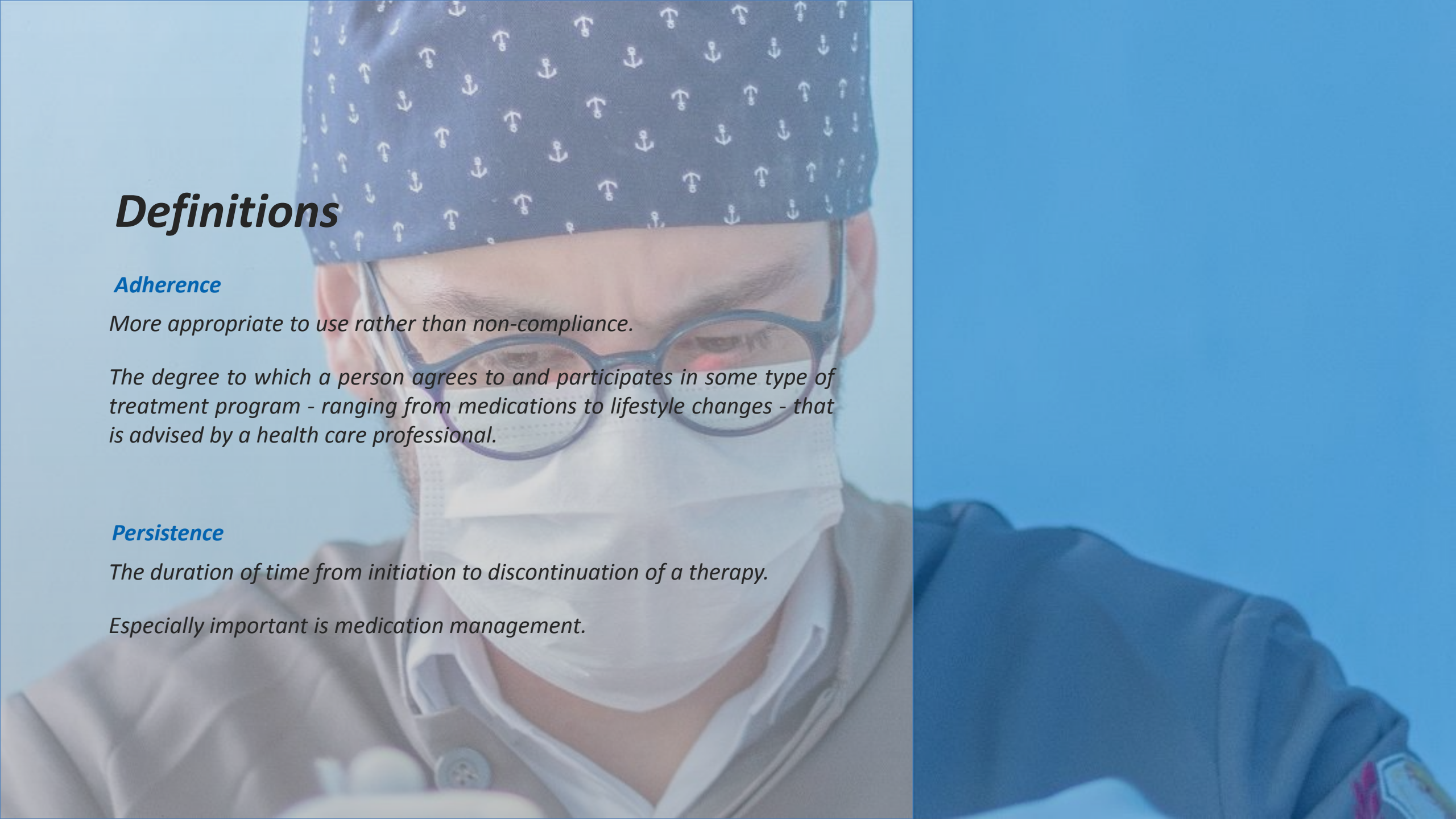
*Self management is all about the patient's ability to manage their disease or condition with support.*

# *Self Management Support*

- *Is what health care providers can do to facilitate the patients self management.*




- *Allows the patient to have control and educates the patient on their disease.*



# Definitions

## Adherence

*More appropriate to use rather than non-compliance.*

*The degree to which a person agrees to and participates in some type of treatment program - ranging from medications to lifestyle changes - that is advised by a health care professional.*

## Persistence

*The duration of time from initiation to discontinuation of a therapy.*

*Especially important is medication management.*

# *Aging Population*

*There are estimates that about two thirds of all older adults have more than two chronic conditions. Parkekh and associates cited several research studies in a 2011 article that show the number of chronic conditions relates to the risk of adverse outcomes including mortality, poor functional status, adverse drug events etc.*

# *Equip the Patients with Problem Solving Skills*

- *Daily challenges from living with chronic disease requires assisting the patient in learning what is critical to the patient.*
- *Prioritizing assists when organizing the education.*
- *Consider what is critical for the patient to know each day.*
- *Always factor in what is important to that particular patient.*

# *Mrs. Smith*

1. *Likes to know why something is happening with her COPD.*
2. *Teaching disease process is important to this patient.*
3. *Feels “knowledge is power”.*
4. *Very independent and likes to be in control.*
5. *What types of things need to be taken into consideration for the teaching plan?*
6. *Important for her to address actions and reduce exacerbations.*

# *Mr. Johnson*

1. *Just wants to feel better and “golf”.*
2. *Gets “anxious when I know too much”.*
3. *May come a point to give detailed disease progression knowledge, but would need to “take it slowly”.*
4. *Can utilize knowledge that crosses most disease processes, such as medication management, diet and exercise.*
5. *Equipping him with problem solving skills to keep disease more managed would be important for him.*

# *Chronic Care Management*

1

*Progresses from working in silos of care to holistic and everyday approach.*

2

*Disease management should be patient-centered and cross all settings of care.*

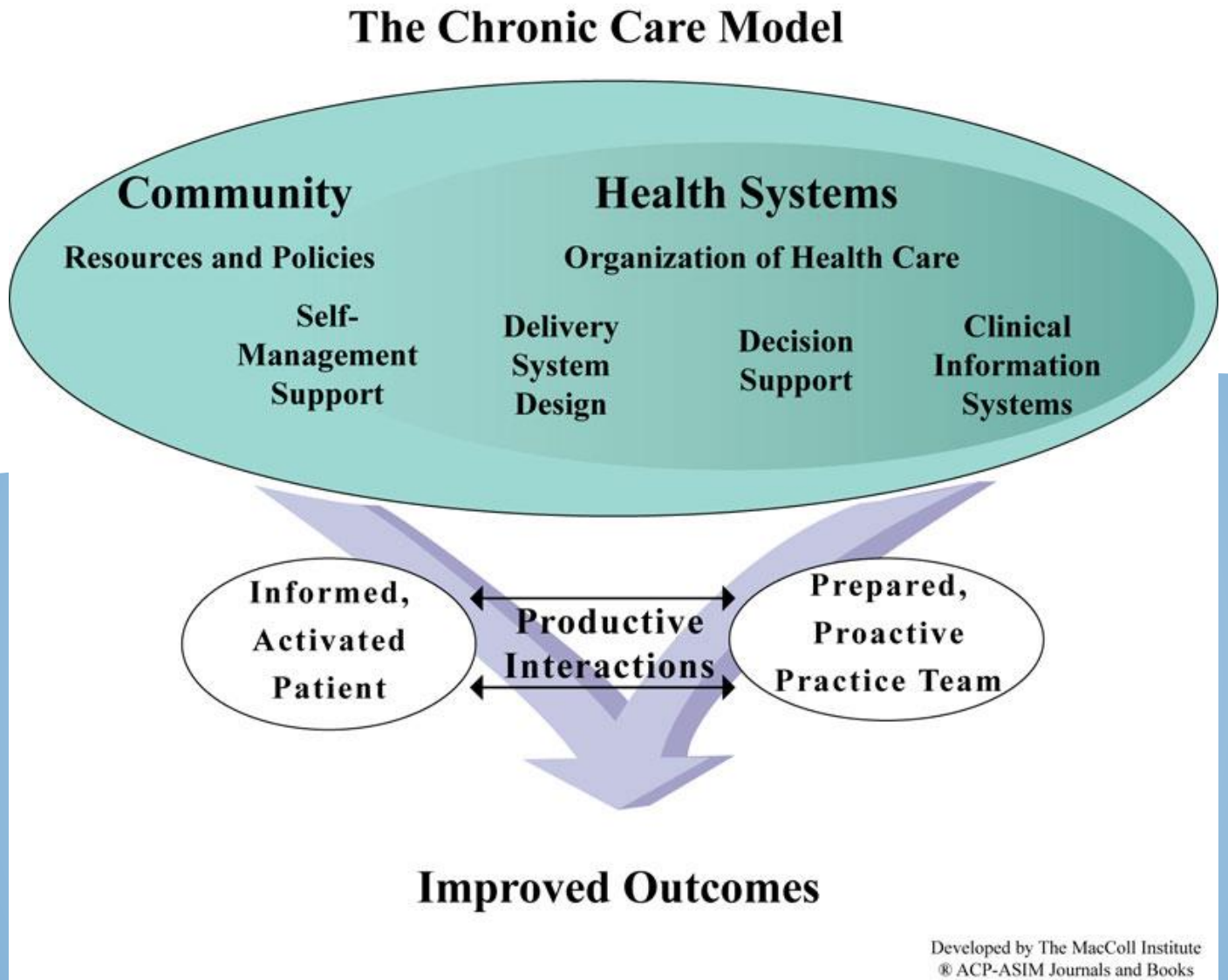
3

*Caregivers and supportive services need to be taken into consideration.*

4

*If it is important to the patient it is important to their care.*

# *The Wagner Model*



# *Elements of Wagner's Model*

1

*Productive interactions- both and informed patient and a prepared practice team Wagner describes this as "having the motivation, information, skills and confidence necessary to make decisions about their health and manage it.*

2

*Self-management support is the assistance provided for the patient to fell empowered and prepared to mange their health.*

4

*The patient is central to managing their health not the team. They may need to be coached or motivated.*

5

*Delivery system design, refers to assuring the delivery of effective, efficient clinical care and self-management support. This uses interdisciplinary roles using evidenced based care and case management.*

# *Elements of Wagner's Model Continued*

1

*Decision support- evidence-based guidelines embedded into daily practice. Patient education should be based upon proven educational strategies, patient centeredness, and communicated to patient in written form.*

2

*Embedded technology – an example would be patient education with embedded agency protocols or national guidelines for a specific diagnosis or condition that "pop up" as a "tickler" for the clinician to consider.*

4

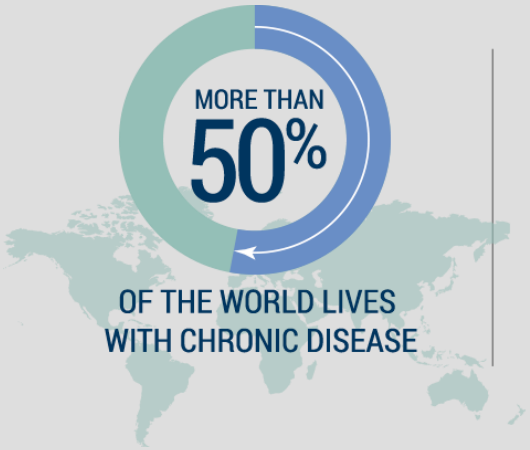
*Clinical information systems element revolves around the use of technology.*

5

*Community resources mobilizes resources to assist with meeting the needs of the patient.*

# *The Health Systems Element Focuses on the Organization of Healthcare*

*The culture, structure and mechanisms to promote safe, high quality care for patients. This starts from top down.*





# *Interdisciplinary support, it takes a Village*

# The Team

1. Physical Therapy
2. Occupational therapy
3. Nutritionist
4. Community
5. Spiritual
6. Whoever is important to the patient
7. The family support system
8. Counseling
9. Pharmacy


# *What came first, the Chicken or the Egg?*

*Does depression cause chronic disease or does chronic disease cause depression? Does it matter?*

# *Summary of the Chronic Care Model*

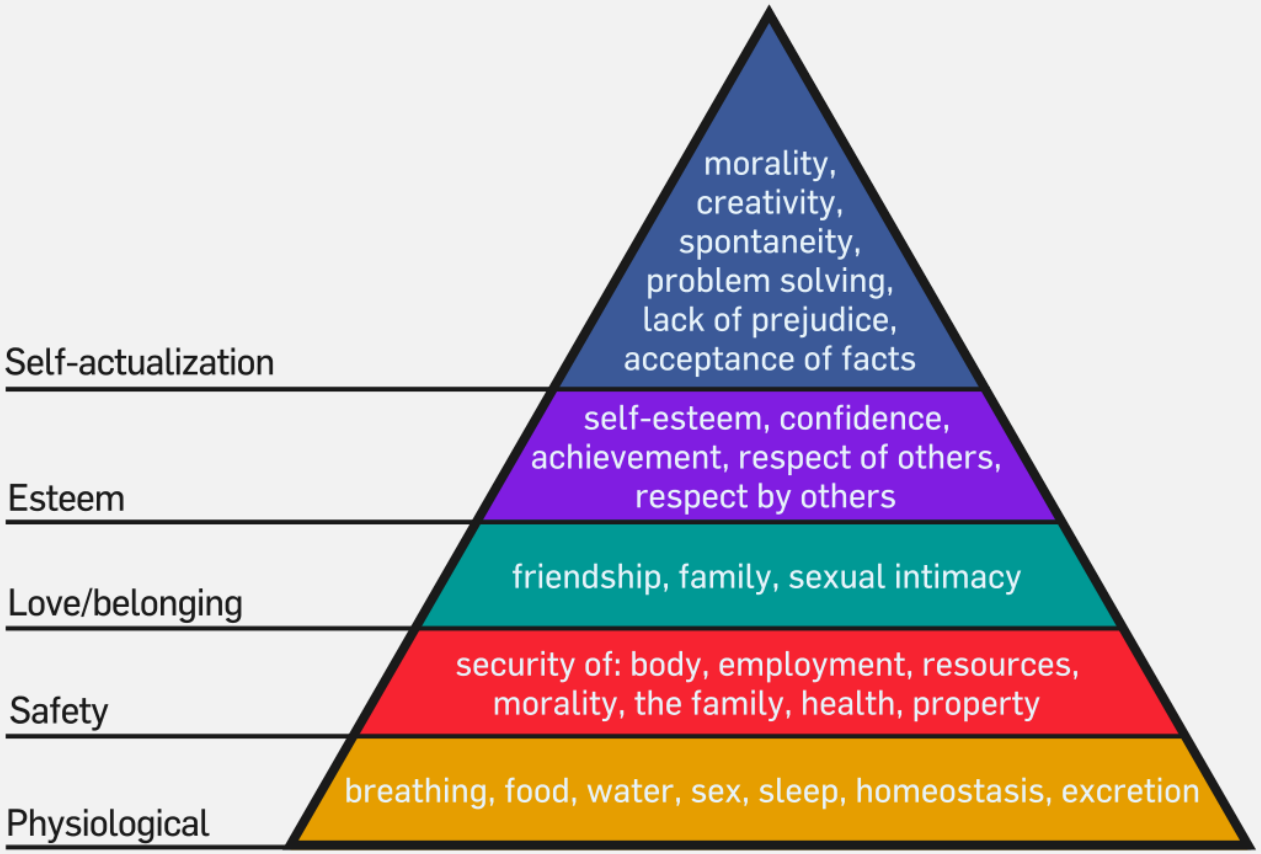
*The purpose is to align and integrate all the elements to improve patient outcomes related to management of chronic conditions.*

*You can visit the Improving Chronic Illness Care website (http://improvingchroniccare.org)*

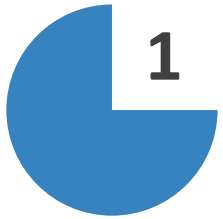
# *Maslow's Hierarchy of Needs*

- *Often used in chronic care in improving self-motivation to be a healthier individual.*
- *Maslow states that people are motivated to fulfill basic needs before moving on to other more advanced needs.*
- *Originally developed as a 5-stage model but has been expanded several times and is now an 8-stage model.*
- *Bottom levels must be met before successful teaching of self-management principles or disease management.*

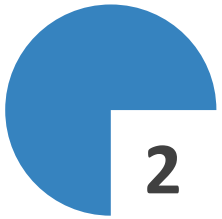
# *Maslow's Hierarchy*



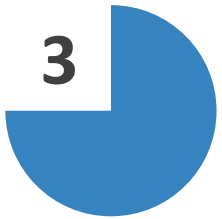
# ***Motivational Interviewing***



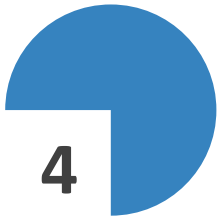

*Scientific, patient-centered approach to motivate and assist patients to resolve uncertainty about change.*




*MI is often considered a component of health coaching.*

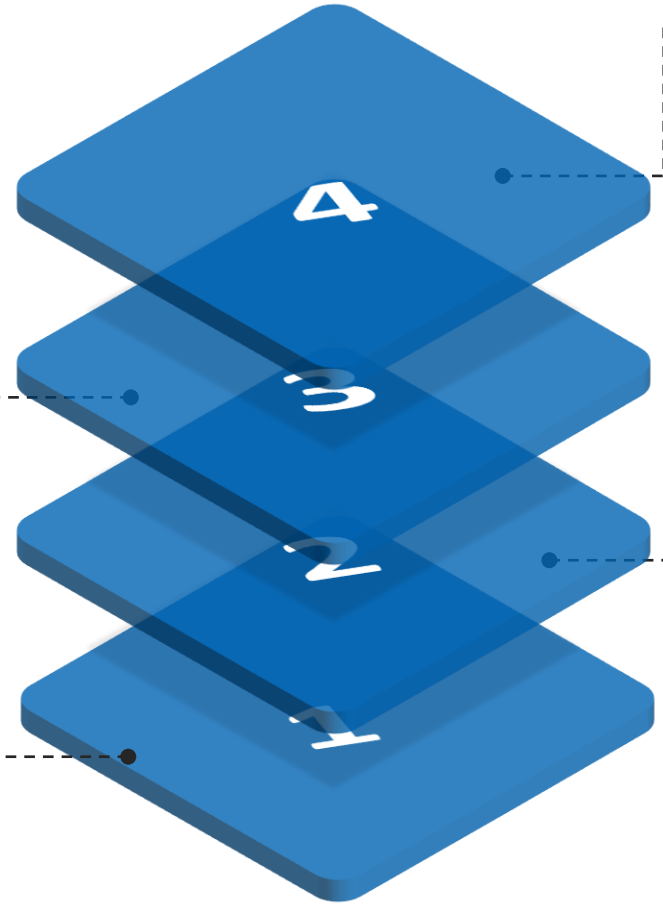



*When using MI you are guiding patients to tap into inner reasons for making a health change.*




*MI engages the patient in decision-making and honors patient autonomy.*

# *Guiding Principles for Motivational Interviewing*



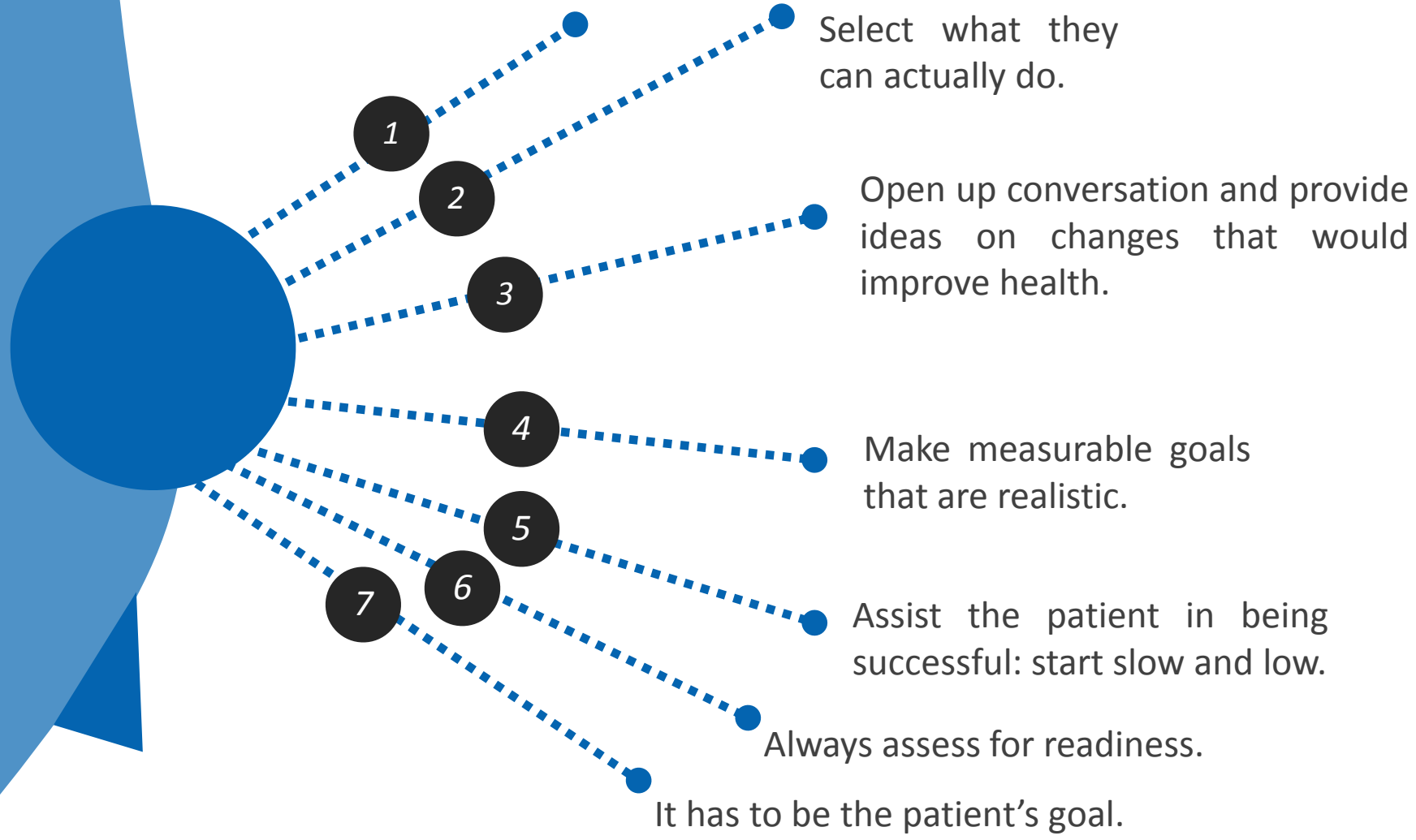

*Develop discrepancy – see where they are versus where they would like to be – see the gap.*

*Express empathy.*

*Roll with resistance – honor the patients autonomy – listen use open ended questions. Wait for readiness.*

*Support self efficacy – develop trust and rapport, support their goals and actions – find out their WHY. Work towards developing an action plan.*

# Action Plan


Decide what is important.
1
Select what they can actually do.
2
Open up conversation and provide ideas on changes that would improve health.
3
4
Make measurable goals that are realistic.
5
Assist the patient in being successful: start slow and low.
6
Always assess for readiness.
7
It has to be the patient's goal.

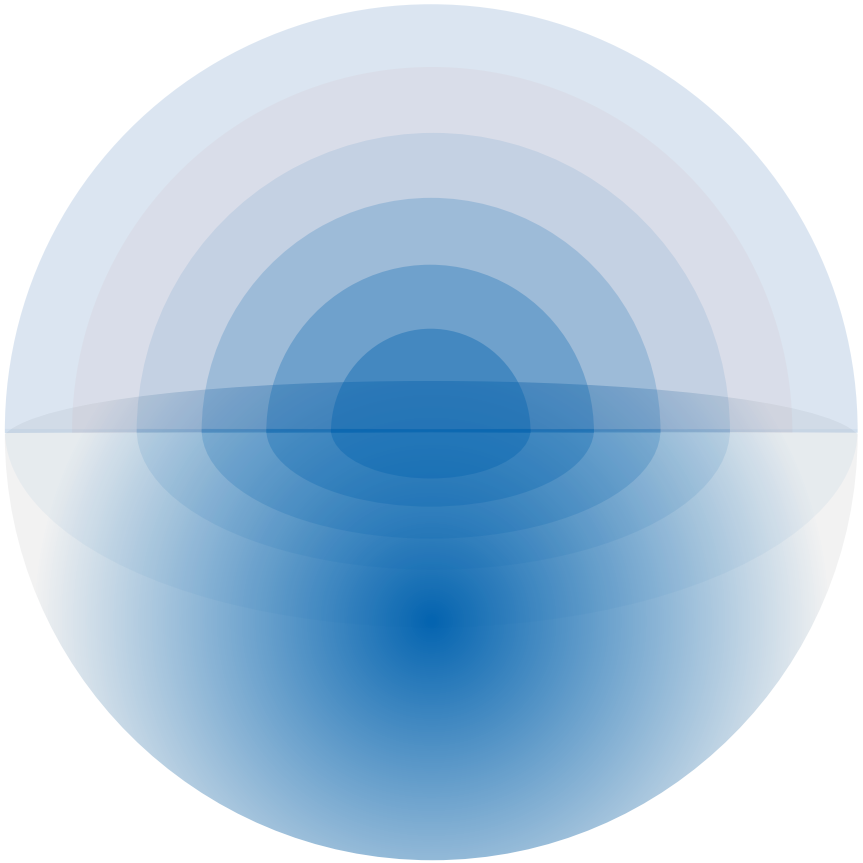
# Zone Or Stoplight Tools

1. *Colors of a stoplight to guide patients with monitoring and evaluating if their symptoms are beginning to exacerbate.*
2. *Simple guidance prompts the patient on actions to take, and who and when to call the health care team versus going into emergency.*
3. *Need to evaluate health literacy.*
4. *Never condescend to patient.*
5. *Should be included with emergency plan.*
6. *Provide problem solving tools and education to patient and family.*

# Tech Back

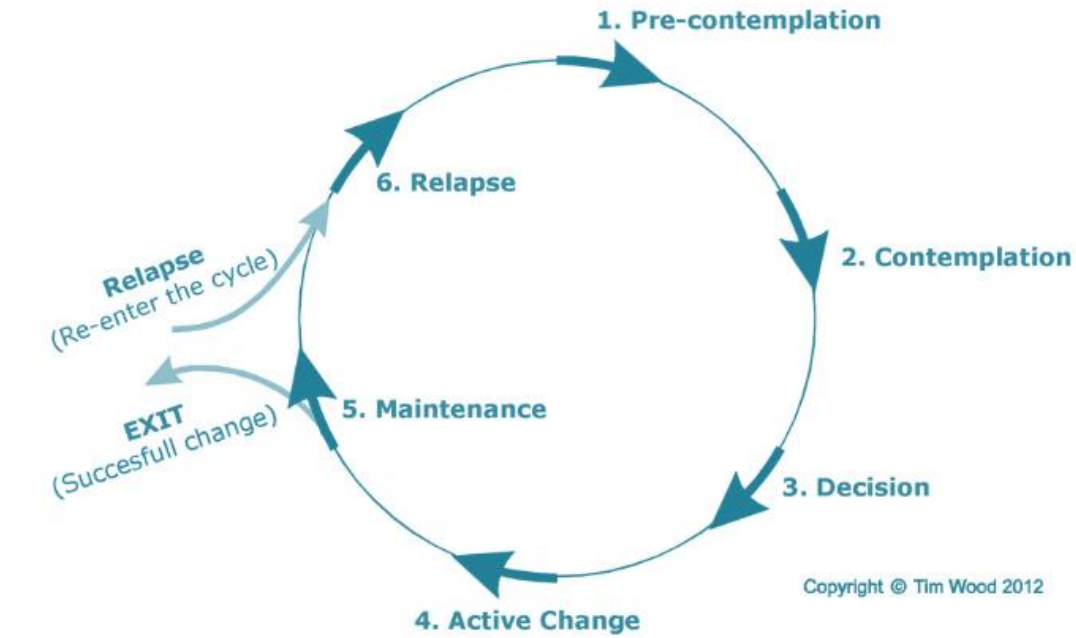
1. *Health literacy clinical tool.*
2. *Teach small amounts and have patient to teach it back before moving on.*
3. *Not a test of patient but a means of evaluating effectiveness of teaching..*
4. *Takes practice.*
5. *Smaller chunks are better.*
6. *Sometimes called chunk-check-chunk.*

# *Trans Theoretical Model of Change*



- *Also known as the stages of change model.*
- *Often used with alcohol and drug rehabilitation.*
- *Open ended questions.*
- *Pt moves through stages but can leave and "re-enter".*
- *Takes careful listening and patience.*
- *Avoid pushing.*

# *Stages of Change*




1. Pre-contemplation **(Why bother?)**
2. Contemplation **(Partly want to change)**
3. Decision **(Deciding to change)**
4. Active change **(Changing behaviour)**
5. Maintenance **(Keeping it going)**
6. Relapse **(Return to pre-contemplative behaviour)**

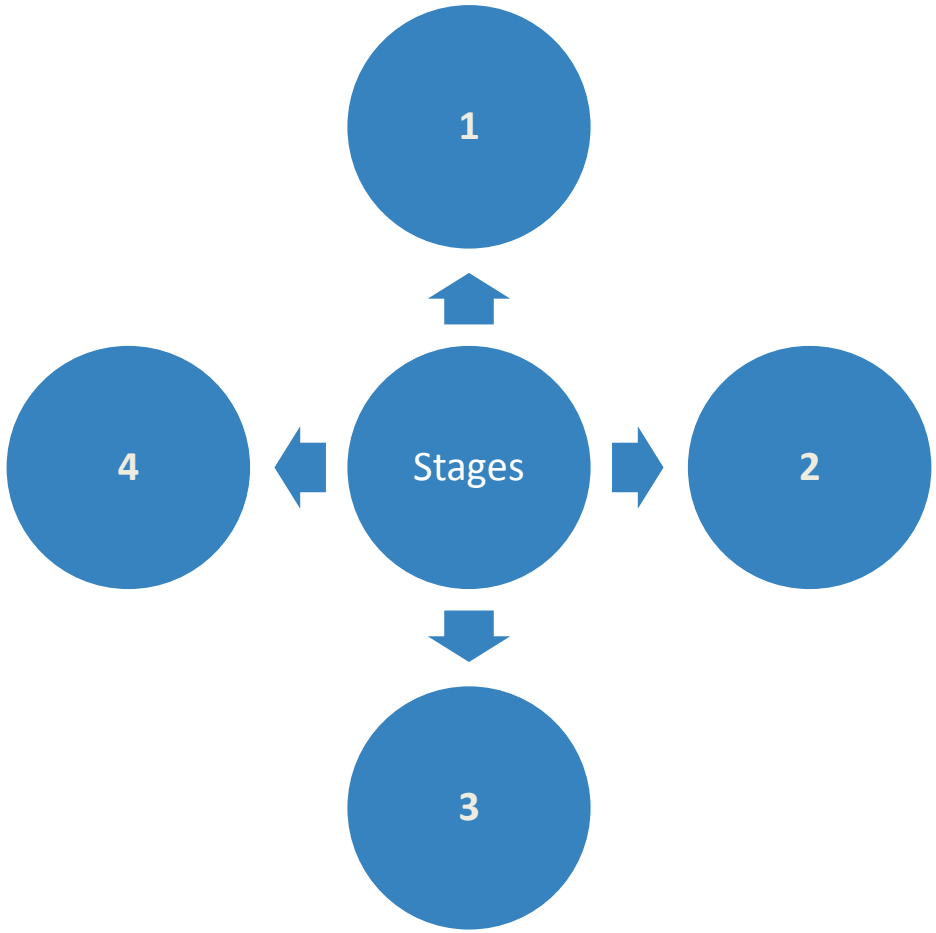
# Stages

***3***

*Preparation-assist in creating goals and a reasonable change plan.*

***4***

*Action-assist with problem-solving skills, modify the plan as needed, encourage.*



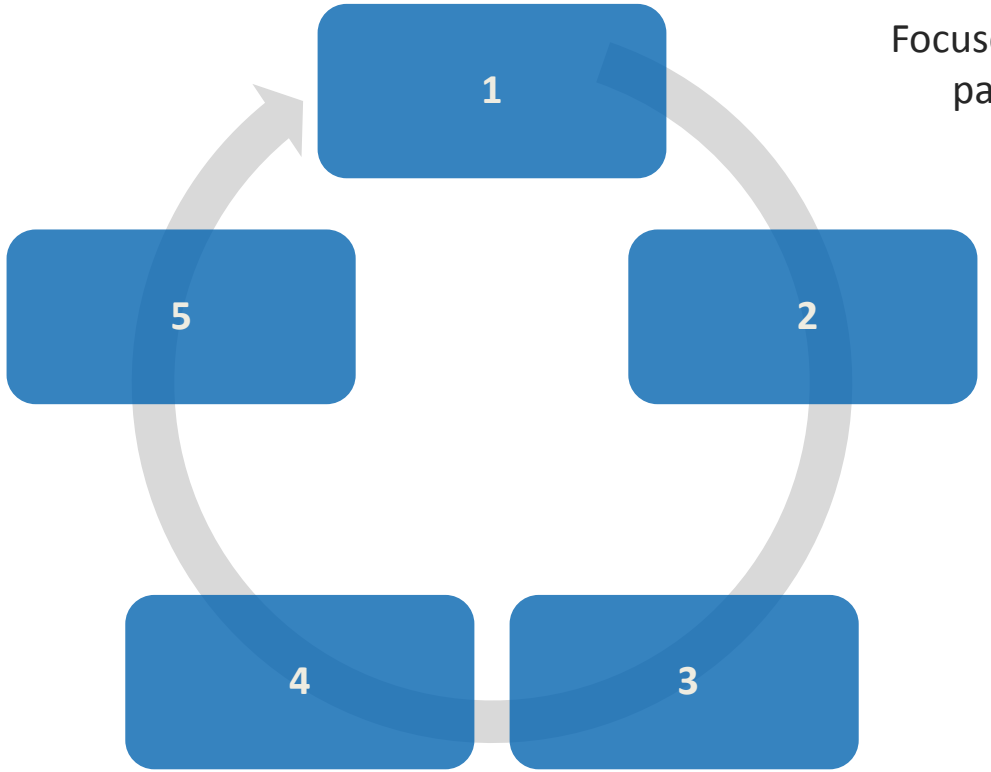

***1***

*Pre-contemplation: increase awareness of risk and problems - give educational feedback, provide encouragement.*

***2***

*Contemplation: remind of reason for wanting to change, discuss consequences of not changing – continue encouragement.*

# Oars Modal of Communicating



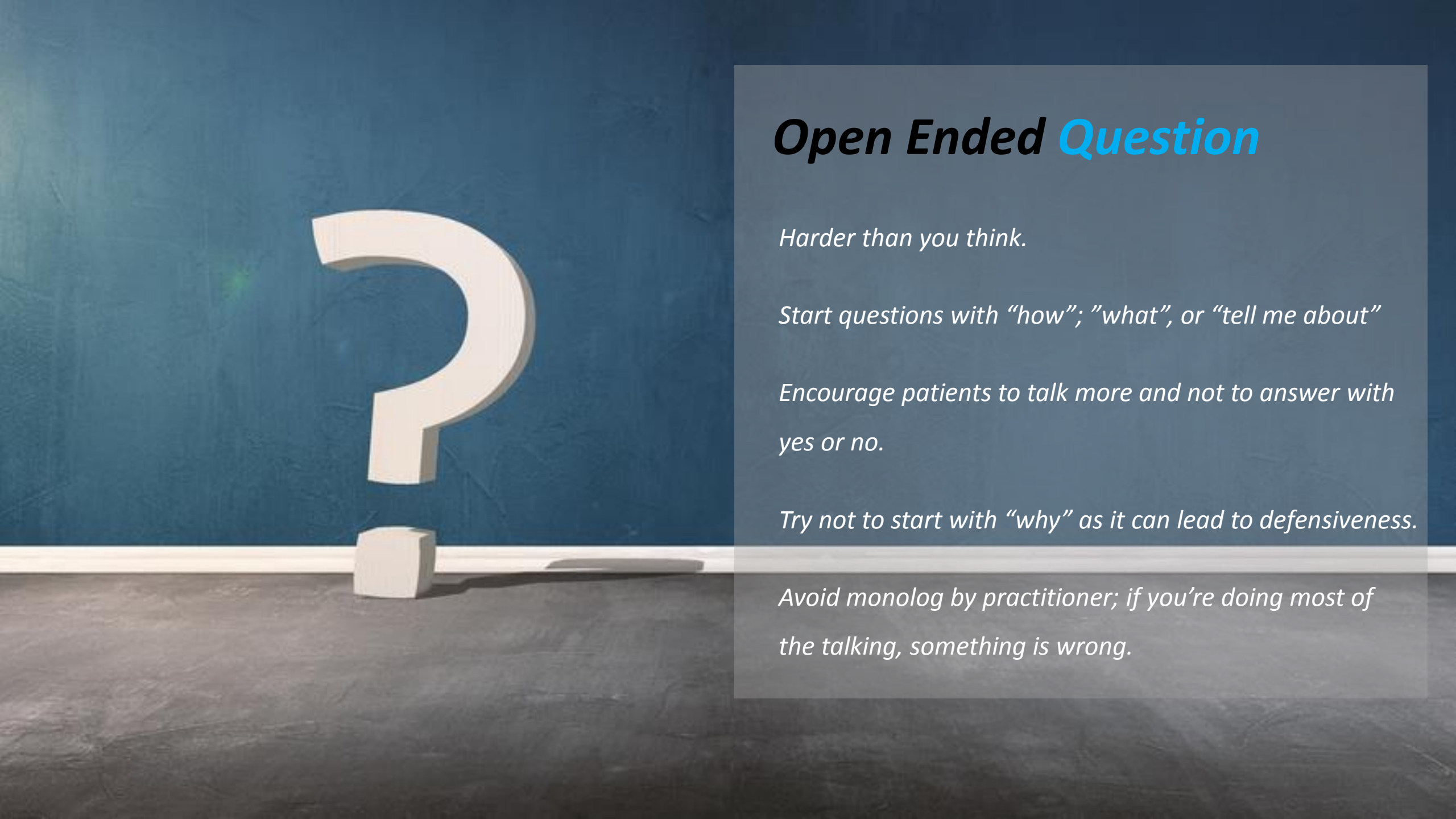

Focuses on the patient.

Acknowledge their feelings.

Build trust and rapport.

Explore and gain more information and truthful feelings.

Create opportunities to challenge the patient's view and encourage movement to make change.



# *Open Ended Question*

*Harder than you think.*

*Start questions with “how”; ”what”, or “tell me about”*

*Encourage patients to talk more and not to answer with yes or no.*

*Try not to start with “why” as it can lead to defensiveness.*

*Avoid monolog by practitioner; if you’re doing most of the talking, something is wrong.*

# Affirmation Statements

1

"I can tell you have been working hard on including exercise in your life"

2

"Your ideas for losing weight are really good"

3

"I can tell you've thought about this a lot"

4

"I think you've made some really good decisions this week"

# *Reflective Listening*

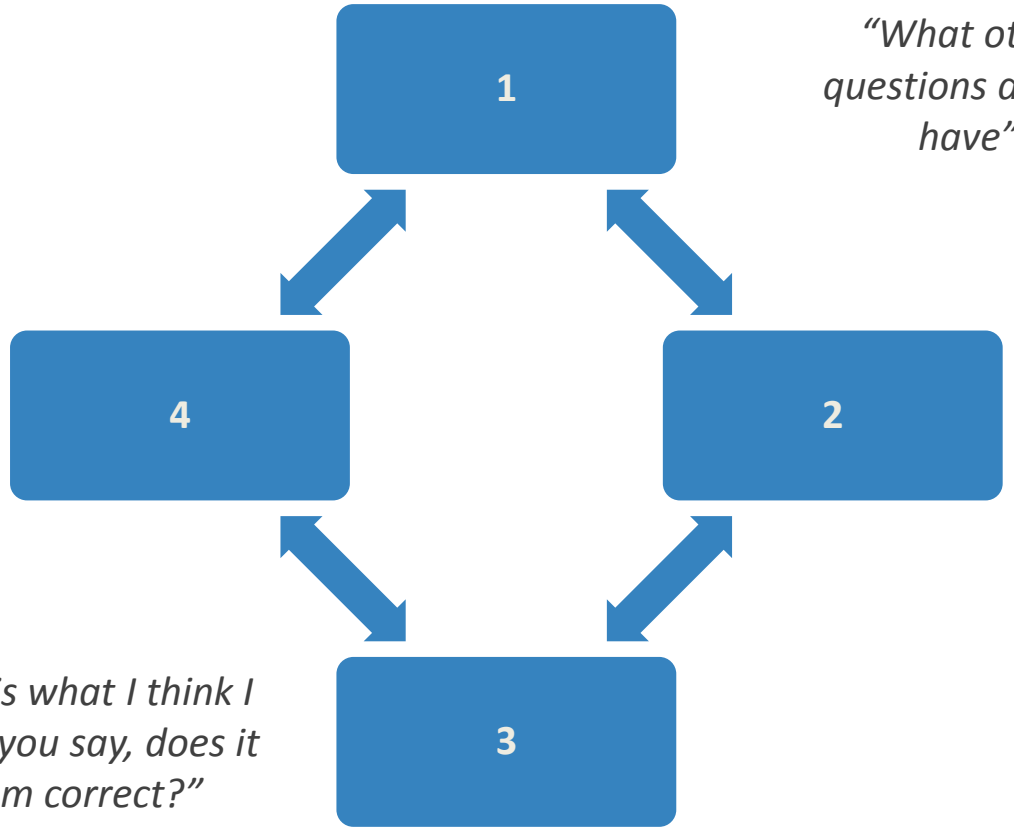
*“You seem very quiet today”*

*“It sounds like this illness makes you angry”*

*“It sounds like so much information is overwhelming”*

*“It seems as if you feel you are not ready for this”*

# Restating or Summarizing




*"What other questions do you have"*

*"Is there anything you want to add or correct"*

*"This is what I think I heard you say, does it seem correct?"*

*"Is there something we didn't talk about that you want to discuss?"*

# *Chronic Care Management*

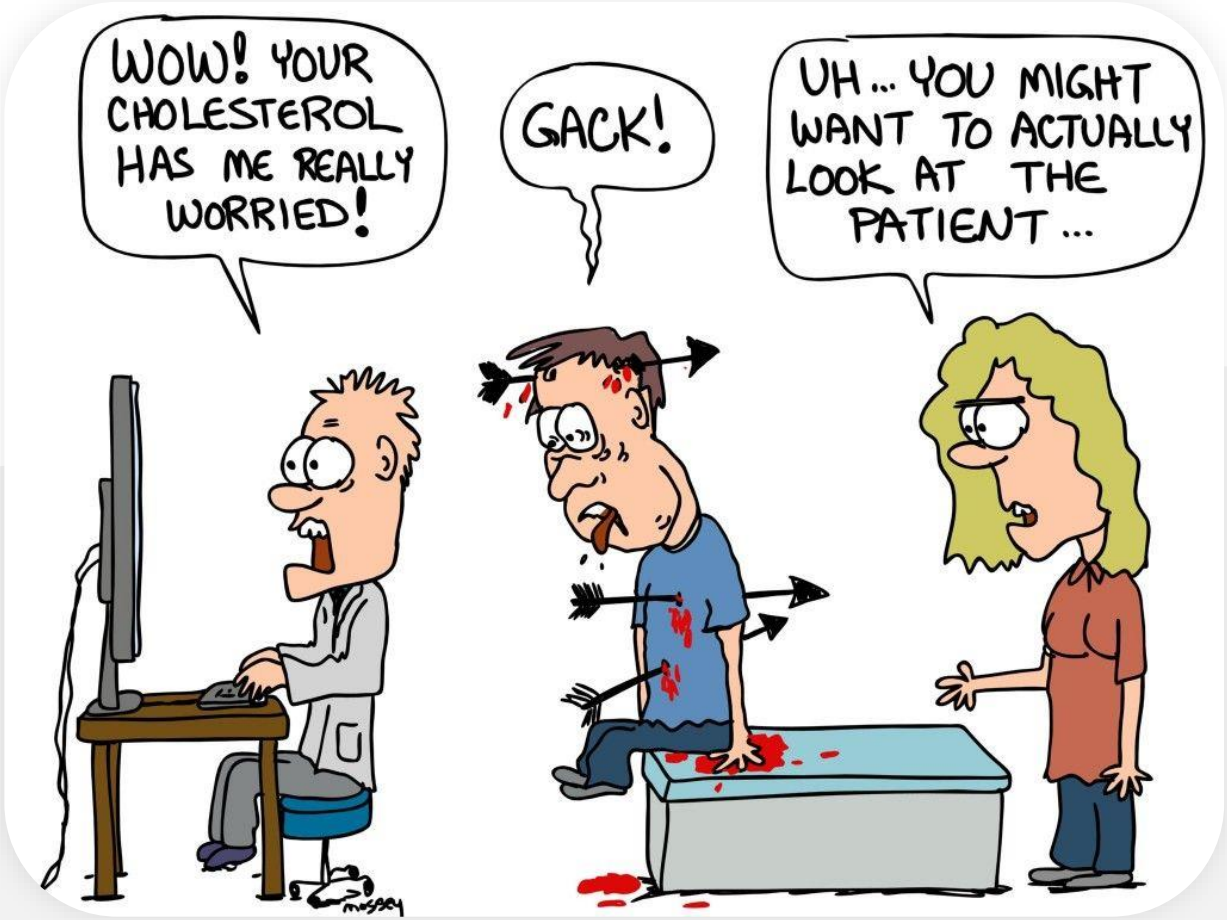
*Principles of teaching chronic care are primarily respect - good communication, being non judgmental and allowing the patient to "row his boat"*

*Chronic care will always be with us, in many ways aging is a chronic disease.*

# *Effects of Interaction Changes between Chronic Care and Behavioral Health*

- *Better care for patients.*
- *More support for behavioral health inclusions.*
- *Better screening for behavioral health issues with chronic disease, i.e. depression, anxiety, substance abuse issues.*
- *Better reimbursement for counseling and recovery for behavioral health issues.*
- *It takes a village.*

# Patient Centered Care



# *Objectives: Review*

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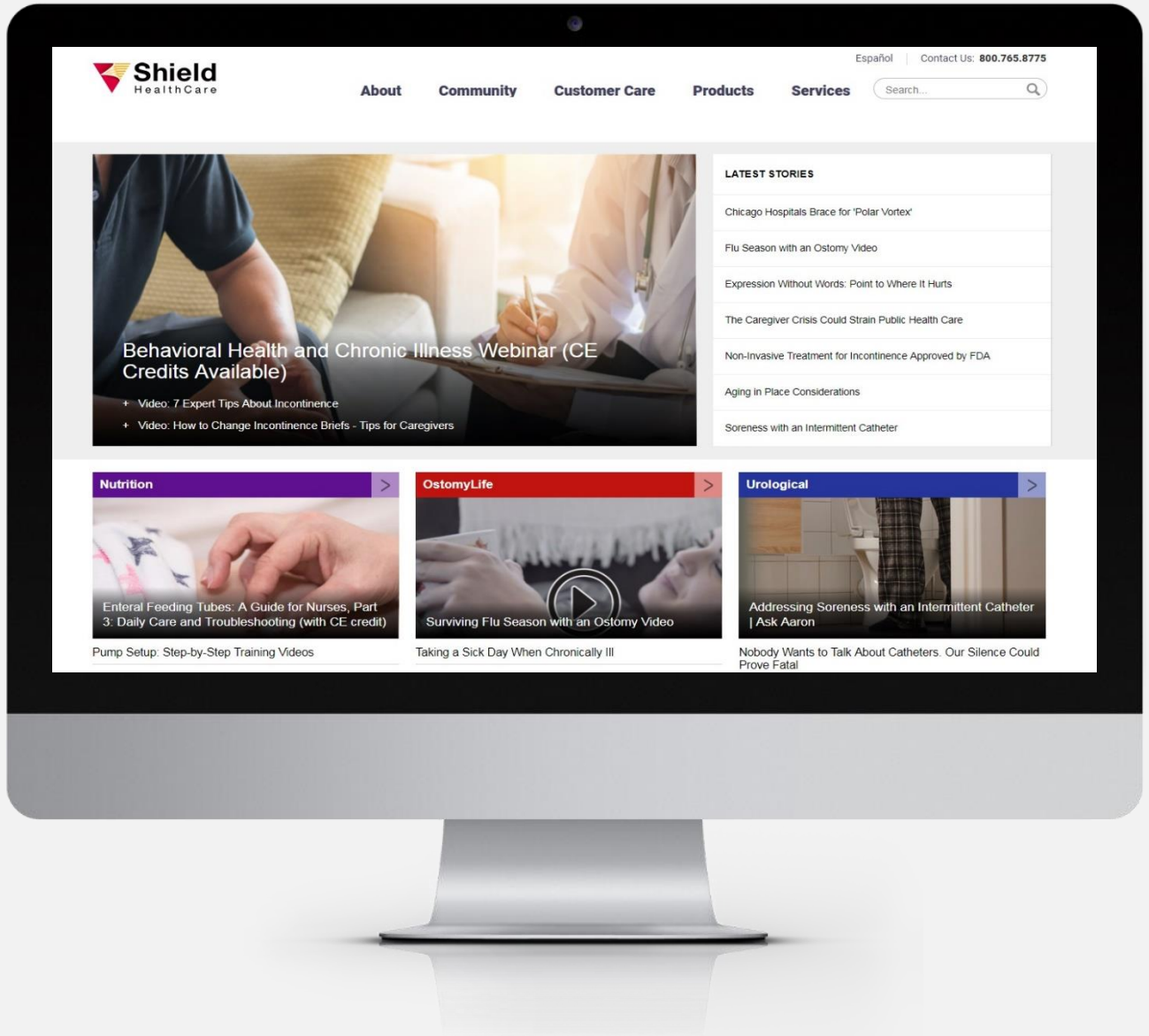

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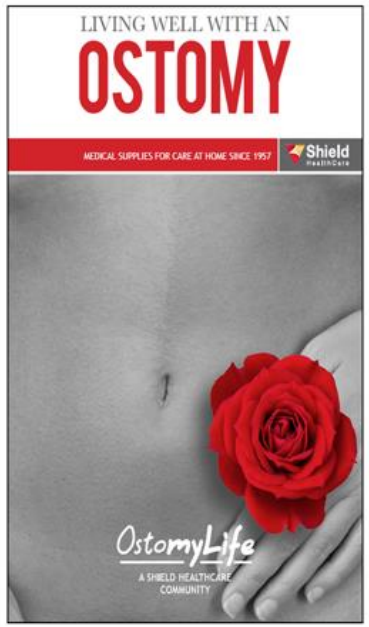


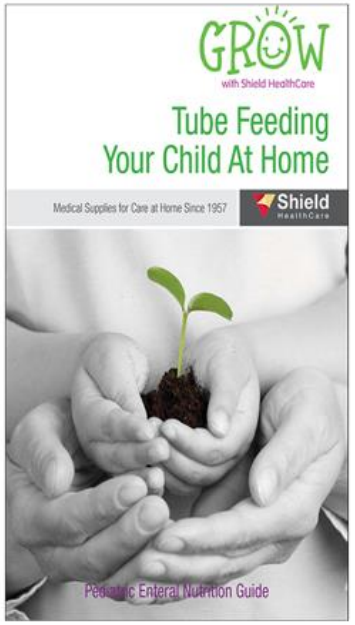


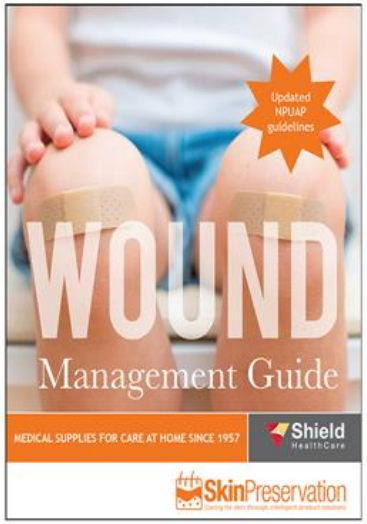




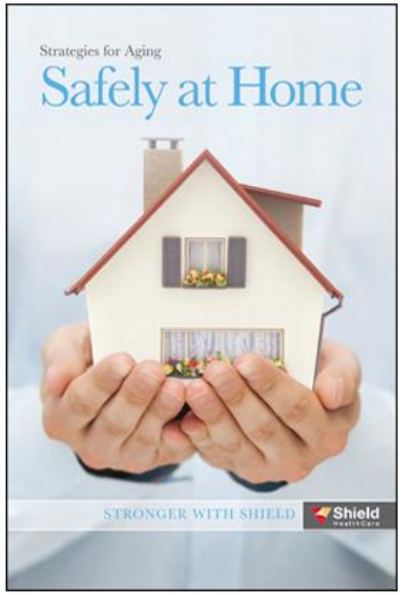


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