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A little about me

- I am a Clinical Assistant Professor for the Doctor of Behavioral Health Program at Arizona State University
- The focus of our program is educating graduate students from many professional backgrounds (including OT ©️) in the provision of behavioral health in an integrated medical setting, with a focus on primary care
- I presented on this topic with a team at the AOTA annual conference this year
What is Primary Care:

- **Primary care** is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (Institute of Medicine [IOM], 1994; Patient Protection and Affordable Care Act [ACA], 2010).

Triple Aim

The Triple Aim is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. This is reflected in the move to improve primary care. The tenets are:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of healthcare.

[http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)
Philosophy of OT lends itself to facilitate the triple aim

- There is evidence to support the cost effectiveness of OT in primary care
- Our use of groups is a strategy for management of populations (chronic diseases, depression, pain management, lifestyle modification, etc.) and can be a cost-containment strategy
- Our interventions are chosen based on patient goals
- Our interventions focus on improving self-efficacy, self-management of conditions, and overall quality of life

What can OT do in Primary Care?

- OTs receive ‘whole person’ training, but traditionally work in Mental/Behavioral Health or Physical Disabilities – Adult or Pediatric populations
- We are all trained to use our full skill set, we just tend to focus on specialized areas
- **Primary care is NOT specialized!!**

*The current movement within healthcare is toward integrated primary care…there is room for us there. We need to address the physical and behavioral health needs of the patients. When we do this, we are working at the ‘top of our license’ (a current term to ensure all professionals are using their full skillsets)*
But WHY Primary Care?

“In 2008 the costliest 5% of Medicare beneficiaries accounted for 38% of the annual Medicare fee-for-services spending” (MedPac, 2012)

“66% of Medicare spending is on patients with 5 or more chronic diseases” (Hastings Center)

“Eighty percent of the health care dollars are spent by 20 percent of the population” (http://www.politifact.com)

The largest percent of frequent ED users present with mental health issues

In a nutshell: A small percentage of the population uses MOST of our healthcare dollars

Chronic Disease in Primary Care

Chronic diseases have overtaken infectious diseases as the leading cause of death and disability

Almost half of all adults have one chronic condition

Chronic diseases account for 7/10 deaths in US (including heart disease, cancer and stroke which account for 50% deaths)

25% of people with chronic conditions have difficulty with daily activities such as walking, bathing, etc.

Chronic diseases share common risk factors which are modifiable.

(CDC, 2013; Fryer et al., 2010; IDF Diabetes Atlas, 2008; MOH, 2007; Union for International Cancer Control World Cancer Congress 2012; WHO, 2005)
Why primary care?

- As many as 70% of patients presenting to primary care have behavioral health needs (Hunter, Goodie, Ordt, & Obermeyer, 2009)
- These patients with chronic disease tend to present to primary care
- They have impaired function, and often multiple co-morbidities including co-morbid chronic illnesses and/or co-morbid behavioral health conditions

Chronic Disease in Primary Care with Behavioral Issues

- Chronic Medical Conditions with Co-morbid Behavioral Health Conditions

- Cost the healthcare system 2x as much

- Compared to Medical Only
More on the subject…

- Sixty percent (60%) of individuals with depression go undetected in primary care. (Bland, 2007)

- As much as 85% of physician visits are for problems that have a significant psychological and/or behavioral component, such as chronic illnesses (Stress Found to Weaken Resistance to Illness Washington Post, Dec. 22, 2003)

- Individuals with diabetes are twice as likely as individuals without diabetes to have serious psychological distress (McVeight, et al, 2003).

- Patients and physicians don’t recognize symptoms as behavioral diagnoses...so conditions are not effectively treated!! (Croghan & Brown, 2010)

Why is this important?

- Mental and behavioral health care plays a significant role in the prevention, diagnosis and/or treatment of the 15 leading causes of death in the United States. They are: heart disease, cancer, stroke, chronic lower respiratory disease, accidents, diabetes, Alzheimer’s disease, Influenza/Pneumonia, kidney disease, Septicemia, suicide, chronic liver disease, hypertension, Parkinson’s Disease, assault/homicide. (Center for Disease Control, 2005).

- These are some of the many reasons OT should be in primary care!!
This means…

**Patients with mental health needs are more likely to present to their primary care provider than to any other setting!!**

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**Behavioral health definition**

- Behavioral health encompasses behavioral factors in medical care. This includes mental health related issues (depression, anxiety, etc.) as well as behaviors that affect health (non-adherence to medical instruction, unhealthy lifestyle/habits, etc.)
Treating the ‘whole person’ in primary care results in:

- Increased patient satisfaction as there is more engagement when patient issues are recognized (better patient experience)
- More collaboration with multiple professionals results in increased patient access to care and services (better patient experience and health of the population)
- Identifying patients early in the disease process and addressing their needs will decrease the overutilization of medical services (improved population health and cost containment)

Evidence Based Assessments

- These are some examples of assessments that work well in the primary care setting. There are many assessments and interventions available to you, I will cover a few here:
  - MMAS (Morisky Medication Adherence Scale)
  - COPM (Canadian Occupational Performance Measure)
  - FOTO (Focus On Therapeutic Outcomes – specific body part assessment related to function)
  - PHQ-9 (Patient Health Questionnaire -9)
  - GAD-7 (General Anxiety Disorder – 7)
  - The DUKE (General Health Profile)
Evidence Based Assessments

- MMAS
  - 4 question scale to determine medication history – quick and simple
- COPM
- FOTO
  - Functional assessment specific to body part. Quick and easy for pt to complete
- PHQ-9
  - 9 item depression screen quick
- GAD-7
  - 7 item assessment for determining severity of anxiety
- The DUKE
  - Assesses physical, mental, social, and general health, includes depression and anxiety

This is one website with many assessments:
http://www.rehabmeasures.org/default.aspx

More on EVB assessments

- These are examples of good assessments to establish baseline status, and assess effectiveness of treatment (administered pre and post intervention)
- They are brief, so they work well in a fast paced primary care setting
- There are many many more! (The DUKE has multiple versions for many different patient issues)
- Based on the patients diagnosis and presentation, you can choose which assessments you will use.
More on EVB assessments

- Assessment findings are used to place patients in appropriate levels of care, with the appropriate professional (i.e. refer out or deal immediately with issues identified)

- The lack of open-ended questions in some of these assessments allows them to be completed quickly, with very useful information obtained (appropriate for a fast paced primary care setting)

- You may do one or more of these in addition to your general OT evaluation (ROM, strength, pain, functional assessment, etc.)

You have assessed the patient...now what??

- Once you determine the patient deficits or problem areas, you provide your intervention

- This is what we all do regularly!! This is not new!!

- In primary care, we just have a wider range of issues we must address.
Examples
• Here are some common diagnoses and issues you will see in primary care...with suggested treatment options

### Chronic Obstructive Pulmonary Disease (COPD)
• COPD has medical and behavioral health implications. It can result in:
• Loss of function (the more advanced the COPD, the worse the impairment)
  • Ltd tolerance for physical activity (self-perpetuating cycle)
  • Poor endurance for ADLs and IADLs, work, recreation, family routines, etc.
• Impaired quality of life
  • Due to alterations in mood
  • Change in economic status due to loss of employment or increase in medical costs
  • Anxiety or depression that can result from condition
What can you do?

- Begin to address any unhealthy behaviors (smoking, alcohol use/abuse, diet issues – discuss with PCP for consistency with plan)

- Be aware that anxiety can occur due to dyspnea, resulting in a progressive cycle (dyspnea worsens anxiety, which worsens dyspnea, and so on) – educate patient in strategies to gradually increase activity tolerance while changing dysfunctional thinking that leads to panic/anxiety (a CBT approach)

What else can you do?

- Provide strategies to cope with SOB (relaxation techniques, controlled breathing strategies)
- Educate patient in technique to monitor air flow (spirometer) increasing patient self-efficacy for self-management
- Educate the patient in activity modification strategies to maximize function
- If there are many patients with this diagnosis, provide groups for coping strategies, relaxation training, etc. (anxiety/depression), activity modification, paced and graded physical activity to improve general health and activity tolerance, medication adherence strategies, breathing monitoring, etc.

Can you think of more? Does this discussion spark ideas?
Whole-person care

- Do you see how we are addressing the whole person in the primary care setting...where they come for care?
- Do you see how increasing patient self-management and self-activation will result in:
  - Improved quality of life
  - Fewer visits to the ED due to exacerbation of symptoms or anxiety due to SOB
  - Improved general health and patient perception of their health

Diabetes

- This condition is very common in primary care (5th most common diagnosis in outpatient settings)
- When diabetes is poorly controlled, the risk for medical complications significantly increases (obesity, heart disease, stroke, HTN, blindness, kidney failure, neuropathy, amputation)
- Patients with diabetes are at higher risk for depressive symptoms, which reduces the likelihood of patient self-management of disease (physical activity, diet, medication adherence)
- There is also a link between anxiety and stress in diabetic control
What can you do?

- Begin to address any unhealthy behaviors (poor diet, poor blood monitoring, low activity levels, poor medication management)
- Educate patient in strategies to:
  - Modify diet
  - Increase activity level (appropriate to their level of fitness and disease, as increased activity affects insulin levels)
  - Adhere to medication instructions
  - Modify faulty thinking (i.e. “I already blew it by eating that cake, I’ll get back on my diet tomorrow” or depressive thoughts)

*These interventions can be provided individually or in groups!*

What can you do?

- When patients are not adhering to medical instructions, ask them what difficulties they are having taking their medication. You may find out that:
  - Pills are too big and difficult to swallow
    - Teach them how to break them (if possible) and take them with food
    - Discuss with PCP alternate medication possibilities
  - It is embarrassing to monitor blood sugar or take medications at work
    - Determine a strategy (i.e. take during a 15 minute break, discuss with boss to briefly leave work station, etc.)
    - Educate the patient how common this disease is so they don’t feel they are abnormal
  - Medications are too expensive
    - Explore options (many pharmaceutical companies will give coupons, discounts, or free medications)
  - They don’t know really understand what to do or how to use their glucose monitor or when to take medication
    - Teach them how
    - Provide a schedule to help them develop a habit/routine of self-monitoring
Cont.

- These are just some of the reasons patients give for non-adherence, there are many reasons given...explore barriers as medication adherence is an ADL for this patient! This habit/routine of non-adherence is negatively affecting the patient’s health!

What other questions can you ask?

- How often do you measure your blood levels in a typical day?
- How many times per week do your blood sugar levels run high or low?
- Do you carry your medication with you?
- Do you carry something with sugar (sugar packet, candy bar, applesauce, etc.)?
- Have you had any serious problems due to low blood pressure (i.e., passing out, car accident, vision changes, lethargy, etc.)?

As the patient answers your questions, you will think of solutions based on your occupational therapy perspective!! This is a perspective that is unique to our profession and our unique contribution to primary care!
Related issues...

- As this diagnosis commonly co-occurs with depression, or results in distress, be sure to assess the patient about these issues.
- Ask the patient if they are experiencing signs of depression, worry, anxiety, stress, or anger.
- If you determine further assessment is indicated, you can use assessments (as we discussed earlier) for specific conditions (i.e. PHQ-2 or 9, GAD-7, DDS2 or 17 diabetes distress scale, etc.).

Whole-person care

- As with COPD, we are addressing medical and behavioral health issues (health related behaviors as well as mental health) as they relate to health and function.
- Do you see how increasing patient self-management and self-activation will result in:
  - Improved quality of life?
  - Fewer visits to the PCP and ED due to issues and symptoms related to poor glucose control?
  - Fewer problems related to depression, stress/distress or anxiety?
  - Improved general health and patient perception and control of their health?
Irritable Bowel Syndrome

- One of the most common functional gastrointestinal disorders (FGID).
- Commonly seen in primary care
- Diagnosis made when symptoms cannot be explained by structural issues, infection, etc.
- Treating the underlying psychosocial aspects of the condition (behavioral health issues) significantly helps this population

IBS - mild

- When symptoms are mild (about 70% of the time), treatment may not be indicated. If these patients present to you:
  - Educate patient regarding the relationship between stress and their symptoms
  - Provide stress coping strategies (avoid stressful situations when possible, relaxation strategies, modify thought process, etc.)
  - Recommend changes in diet (i.e. decrease fat, caffeine, alcohol, gas-producing foods, etc.)
  - Discuss recommended diet with PCP as patient may benefit from fiber supplements

If these patients present for treatment, it is usually brief, and if they use these techniques, they can avoid worsening of symptoms and independently manage their condition
IBS - moderate

- When symptoms are moderate (about 25% of the time), patients will benefit from behavioral intervention. If these patients present to you:
  - Educate patient regarding the relationship between stress and their symptoms
  - Help patients identify exacerbating factors and modify their behavior accordingly
  - Provide stress coping strategies (avoid stressful situations when possible, relaxation strategies, modify dysfunctional thought processes, etc.)
  - Recommend changes in diet (i.e. decrease fat, caffeine, alcohol, gas-producing foods, etc.)
  - Discuss any pharmacotherapy (anti-anxiety, anti-depressant) that the physician prescribes with the patient
  - These patients may benefit from a stress management group

IBS - Severe

- About 5% of patients have severe IBS. These patients will usually require a referral out for specialty mental health care
- These patients benefit from re-assurance that their physical symptoms are not being dismissed as imaginary, and that the provider has more expertise in dealing with their specific condition
- These patients get frustrated when they feel their physician thinks their symptoms are ‘in their heads’ – you can educate them regarding the relationship between stress and IBS.
Cardiovascular diseases (CVD)

- These conditions are also quite common in primary care (CAD, cardiomyopathy, valvular heart disease, HTN, pericardial disease, arteriosclerosis, atherosclerosis, AAA, PVD)

- These conditions can increase risk of other chronic diseases (i.e. diabetes, hypercholesterolemia)

- These diseases have risk factors that are non-modifiable (age, heredity, gender, race), and modifiable (diet, activity level, tobacco, drug, alcohol use/abuse, emotional issues, etc.)

What can you do?

- You can address the modifiable risk factors by educating the patient in:
  - Medication adherence strategies
  - Diet modification strategies
  - Developing schedules and habits to improve likelihood of adherence
  - Providing activity/exercise programs that are consistent with patient goals and interests
  - Benefits of self-management and strategies to achieve self-management (i.e., activity journal, medication schedule, meal plan, food intake journal, ...)

  (we covered these in detail above, you can use some of the same strategies and techniques across conditions)
What else can you do?

- Emotional issues, including: stressors (chronic and acute), depression, anxiety, anger, and hostility contribute to the development of CVD.
- Modifying diet, activity, tobacco, and alcohol use can help with both the physical and emotional issues associated with CVD.
- You can also provide individual or group interventions to specifically address:
  - Depression
  - Anxiety
  - Coping strategies
  - Adjustment to illness
  - Family education around what to expect and how to help family member succeed with plan
  - Education regarding community resources

Musculoskeletal Issues in primary care:

- LBP, shoulder pain, knee pain, tendinitis are also common issues presenting to primary care.
- For all of these issues, posture and activity modification are key issues that OT can address. You can provide:
  - Education regarding proper postures (i.e. lumbar curve maintenance, shoulder retraction, depression, 90/90/90 positioning at work stations, forearm and support, etc.)
  - Activity modification education
  - General exercise education and education for exercises for specific condition:
    - Shoulder isometrics (IR/ER; flex/ext; abd/add with scapulae retracted/depressed)
    - Forearm stretching and light UE strengthening
    - Proper sitting/bending postures for LBP
Additional things you can do

- Adaptive equipment for LBP (sock aid, long handled sponge, shower/tub chairs, reacher, etc.)
- Recommend or fabricate wrist extension orthotic (formerly called a ‘cock-up’)
- Educate patients to rest, pace activities, identify which activities provoke symptoms and modify accordingly

Other issues to address related to musculoskeletal problems

- Depression
- Anxiety
- Coping strategies around:
  - Loss of function
  - Loss of meaningful recreation
  - Change in family roles
  - Chronic pain

Many of these issues can be addressed individually or in groups.
These are just a few examples of diagnoses you will see in primary care.

- The OT in primary care is a generalist and will see patients of all ages and multiple diagnoses, many with several co-morbid diagnoses.
- The OT in primary care will see patients for brief visits, but throughout the course of their lifespan.
- In this setting, collaboration and communication with the other team members is critical for optimal patient care.

With these conditions...

- Do you see how you are using your full skillset?
- Do you see how you are addressing the needs of the ‘whole person’?

*OT, with our training in physical and mental health, are uniquely prepared to work in this setting!*
Group Interventions in Primary Care

- As occupational therapists, we are well educated in the therapeutic use of groups and group dynamics.
- In primary care, for many of the common chronic illnesses, groups allow you to effectively treat a large number of people in a short period of time.
- Once you have identified patients who are at risk for worsening of symptoms (through: diagnosis, your assessments, and interactions), you can stratify them into an appropriate level group to lower the risk of their symptoms worsening.
- Groups can also be used to facilitate population health management and cost containment, while giving the patient a positive experience. These are the 3 tenets of the triple aim!!

Determining which resources to use for primary care

- There are many assessments and interventions that have been shown to be effective for specific conditions.
- Some have been researched in primary care, some, due to their brevity and effectiveness with intermittent encounters, are reasonable to use in primary care.
- Discuss with the team if there are assessments they regularly use.
- Google assessments for: function, quality of life, stress, anxiety, depression, self-efficacy, or anything else you would like to measure.
Determining which resources to use for primary care

- Research effective interventions in primary care (i.e. SBIRT for substance abuse and smoking, CBT, ACT, MI for mood issues, posture improvement strategies, tendinitis interventions, diet and lifestyle modification for obesity and cardiac issues, etc.)

- In the reference list, the book *Integrated Behavioral Health in Primary Care* has suggestions for assessments, and has extensive forms and handouts for your reference for each condition discussed. I covered a few here.

This is a new setting for OT so you will have to look up tools that will help you...you will be surprised how much information is out there!!

Questions??

- Questions??
- Comments??
- Thoughts??
References

- [http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx](http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx)
- [http://www.rehabmeasures.org/default.aspx](http://www.rehabmeasures.org/default.aspx)