Safe Prescribing Action Group:

Teaching residents basic behavioral health management in resource-poor settings

CALIFORNIA HEALTHCARE FOUNDATION

California Improvement Network

Better Ideas for Care Delivery

Agenda

- Housekeeping & Accreditation
- Key points for behavioral health management in primary care
- Q&A
- Calendar

Faculty

Sharone Abramowitz, MD
Director, Behavioral and Addiction Medicine
Highland Hospital

Kelly Pfeifer, MD
Director, High-Value Care CHCF

Diana Coffa, MD
Residency Director
UCSF/SFGH Family Medicine Residency Program

Housekeeping

- This session will be recorded
- Slides and recording will be posted on action group website (Basecamp) within a week
- To ask a question:
  - Logistical questions: Use CHAT to the Host
  - Questions for Speakers : Use CHAT to ALL
- Webinar Evaluation: please take a moment at the end of the webinar to give feedback

Accreditation Information

Physicians

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this live activity for a maximum of ***1.5 AMA PRA Category 1 Credits™***. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target audience: Residency Programs Across California

- **Educational Objectives:**
  - Learn how to integrate screening for behavioral health into primary care, in resource-poor settings
  - Understand alternatives to benzo treatment in chronic pain
  - Learn how to demonstrate and teach mindfulness techniques in brief visits

FOR CME CREDIT: Complete evaluation

Faculty

CME Course Director: Daniel Alford, MD, MPH, FACP, FASAM

- Dr. Alford has nothing to disclose with regard to commercial interests.

Sharone Abramowitz, MD

- Dr. Abramowitz has nothing to disclose with regard to commercial interests. She does not plan on discussing unlabeled/investigational uses of a commercial product.

Diana Coffa, MD

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Kelly Pfeifer, MD

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Key points:

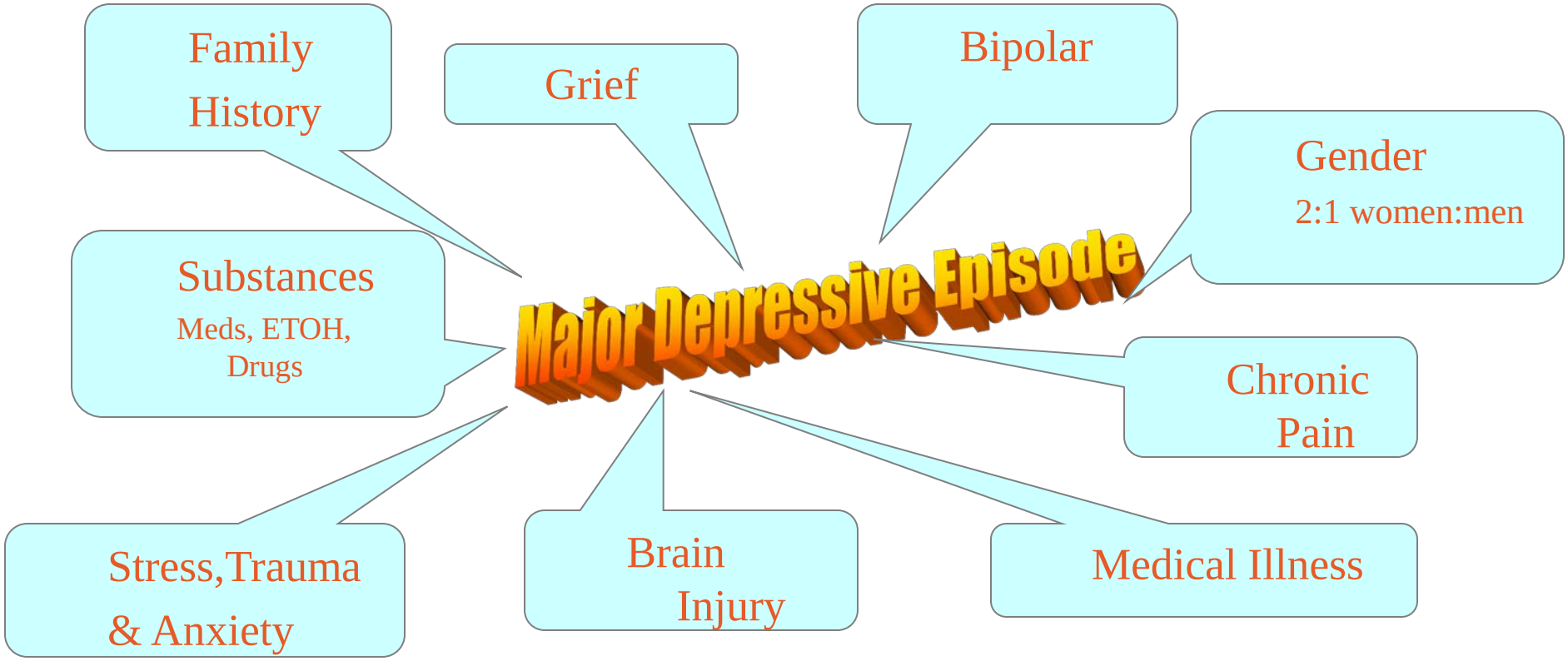
1) Understand comorbidities
   - Screen for depression and PTSD
2) Opioids and benzos
   - Alternatives for treating anxiety
   - Don’t create new starts
   - Teach how to wean
3) How to teach mindfulness during short visits

1. Chronic Pain is a Co-Morbid Condition

Condition	Prevalence in Patients with Chronic Pain
Major Depression	15% to 56%
Anxiety Disorders	17% to 50%
Somatization Disorder	20% to 31%
Personality Disorders	31% to 81%
PTSD	20% to 34%
Substance Use Disorders	15% to 28%

Dersh J et al. Spine 2006
Trescot AM et al. Pain Physician 2008

Multifactorial Etiologies



More low income people have depression in primary care settings

UCLA Study, J Affect Disord. 2000

PHQ-2

- "Over the past 2 weeks have you felt down, depressed, hopeless?"
- "Over the past 2 weeks have you felt little interest or pleasure in doing things?"
- PHQ-2= score 2 or higher
  - Good sensitivity, poor specificity
    - Validation of PHQ-2 and PHQ-9 to Screen for Major Depression in the Primary Care Population. Ann Fam Med 2010.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

California Improvement Network — Better Ideas for Care Delivery

Operationalizing PHQ-2 & 9

- Standardized check-in process:
  - Frequency: Every visit? Annually? Change in condition?
  - Who does it?
    - Patient: forms, tablets
    - EHR templates: MA, resident
- Standardized follow-up intervals – to measure impact and outcome:
  - PHQ-9 measures response to treatment
  - Treat to target
  - Standardized follow-up intervals:
    - Text, email, phone calls
    - Resident or team driven
- Think about your exit plan

Operationalizing PTSD screening: brief version

- Have you ever been harmed physically, sexually, emotionally as a child or an adult?
  - In the last week, do have thoughts or memories about what happened come up?
  - Do you have nightmares associated with what happened?

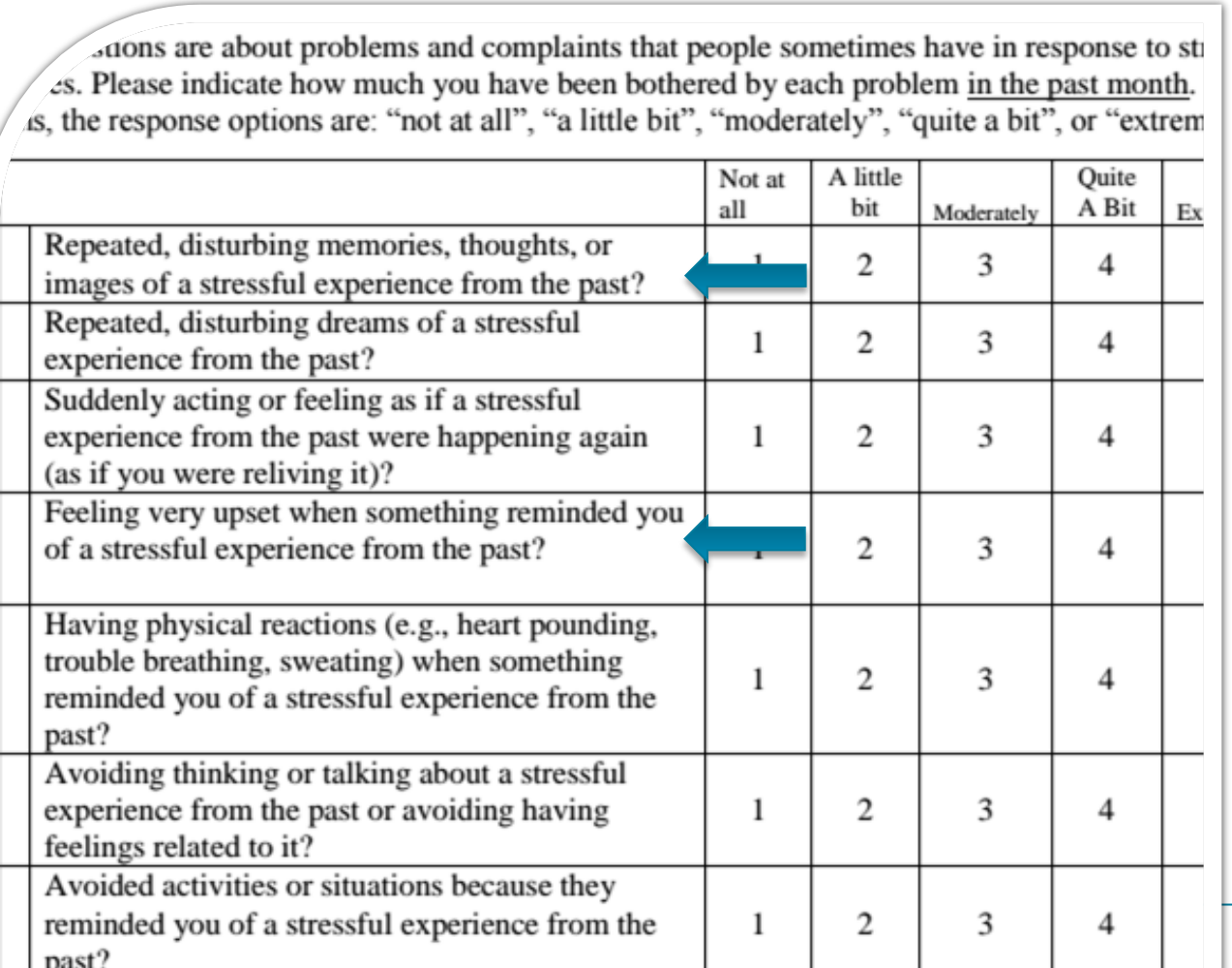
- If no to these questions – they do not have PTSD.

PTSD Checklist-Civilian Version (PCL-C)

Start with:

"Have you ever been harmed physically, sexually, emotionally as a child or an adult?"

- If positive, then do full or modified PCL-C



…uons are about problems and complaints that people sometimes have in response to st…
…es. Please indicate how much you have been bothered by each problem in the past month.
…s, the response options are: "not at all", "a little bit", "moderately", "quite a bit", or "extrem…

	Not at all	A little bit	Moderately	Quite A Bit	Ex
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	
Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	
Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	
Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	
Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	
Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	
Avoided activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	

4 categories of symptoms:

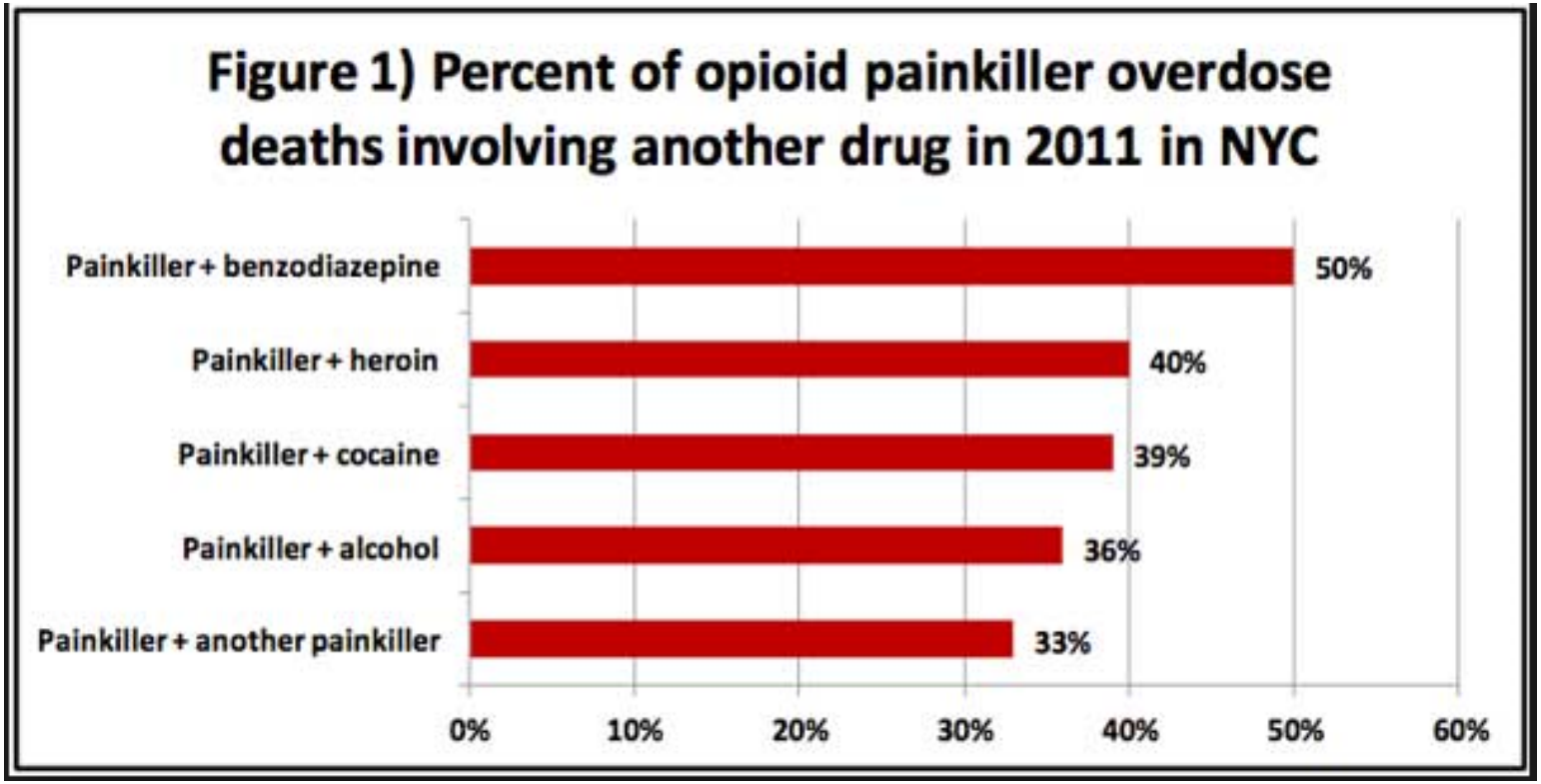
1. Intrusive
2. Avoidant
3. Negative alterations in mood & cognition
4. Hyperarousal

Lang, et al. Behav Research & Therapy, 2005.

PTSD Treatment

- **Referral** to treatment:
  - Warm hand-off, if available
  - Medi-Cal and insured: Referral to plan mental health line
- **Integrated treatment**:
  - **Group or Individual Counseling**:
    - Seeking Safety, Dialectical Behavioral Therapy, Recovery
  - **Mindfulness practices** (breathing, body scans)
    - http://www.freemindfulness.org/download
    - Headpace app
  - **Sleep hygiene** (Cognitive Behavioral Therapy for Insomnia)
    - https://stanfordhealthcare.org/medical-treatments/c/cognitive-behavioral-therapy-insomnia/procedures.html
  - **Psychopharmacology tips**
    - '2 for 1' meds: gabapentin (3:1), TCAs, SNRIs
    - Sleep meds: prazosin, trazadone, avoid Z-drugs
    - Go low and slow

2. Benzos And Opioids



Approach to benzos and opioids

1. Avoid new starts
2. Check CURES (commonly psychiatrist and PCP unaware they are co-prescribing)
3. Inheriting patients on benzos and opioids:
   - –Opioids easier to taper than benzos –
     - •Both take many months
     - •10% per month is reasonable
     - •If long-term chronic use – goals can be lowest dose with maximum functioning, or buprenorphine
   - –Tapering to zero may be not realistic

Benzo withdrawal

- Do not stop benzos abruptly, can be life threatening due to seizure risk
  - Looks like alcohol withdrawal
- Taper slowly
  - At 10-20 % of peak dose, typically will see WD – need to slow down taper
  - Often transient for 1-2 wks (symptom rebound)
- Opioids and benzos each can cause ‘protracted withdrawal syndrome’
  - Can drive illicit use
  - Anxiety, mood instability, insomnia, sometimes sensitivity to light, touch & paresthesias

Alternatives to benzos when treating anxiety

- Understand causes:
  - Chronic intermittent withdrawal? Consider slow opioid taper or buprenorphine
  - Caffeine, stimulant drugs?
  - Untreated PTSD?
- Treating anxiety in chronic pain:
  - Mindfulness practices
    - Yoga, Tai Chi, other mind-body practices
  - Exercise
  - Gabapentin
    - caution w/ low dose SSRI or TCA

Alternatives to Z-drugs and benzos for insomnia

- R/o other causes
  - SUD withdrawal,
  - Sleep apnea
  - Environmental,
  - Activating drugs or caffeine
- Sleep hygiene: Stanford CBT-I
- Progressive muscle relaxation
- Gabapentin, antihistamines or melatonin prn, prazosin in PTSD
- Caution with trazadone

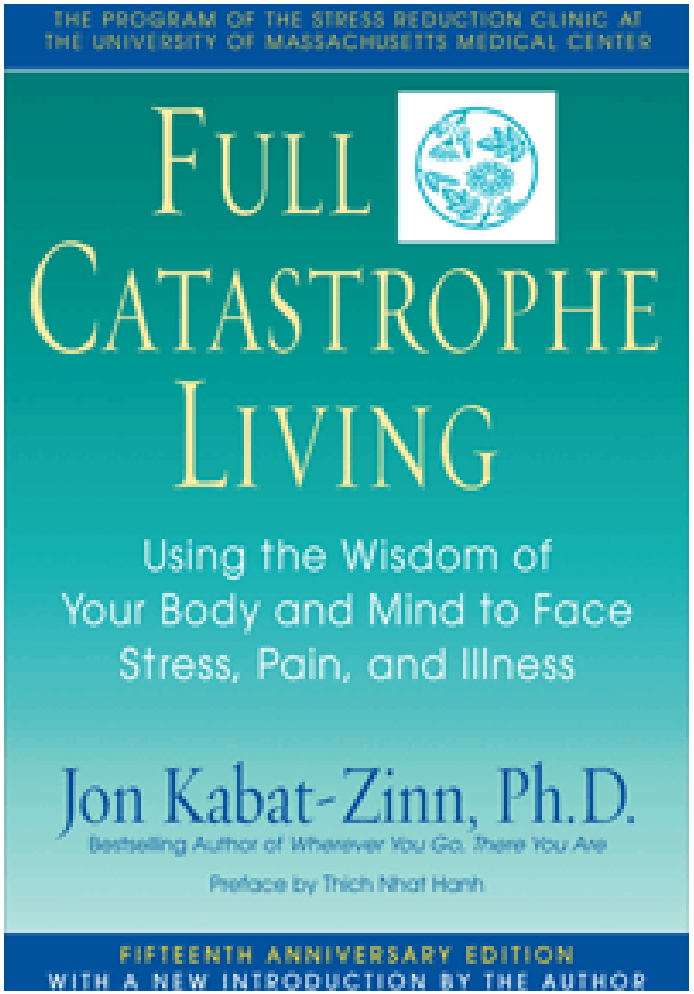
3. Mindfulness Approaches To Chronic Pain & Suds

Mindfulness Definition …

Like focusing a spotlight on the here-and-now:

Mindfulness practices intentionally attend in an open and discerning way to whatever is arising in the present moment., During mindfulness meditation (MM), all experience ('good' or 'bad') is observed and accepted without judgment, whether it be drug cravings or freedom from drug cravings, physical pain or being pain free, pessimism or optimism.

Shapiro, J of Clinical Psychology 2009
Kabat-Zinn, Full Catastrophe Living 1990



Mindfulness Based Stress Reduction (MBSR)

designed for chronic pain

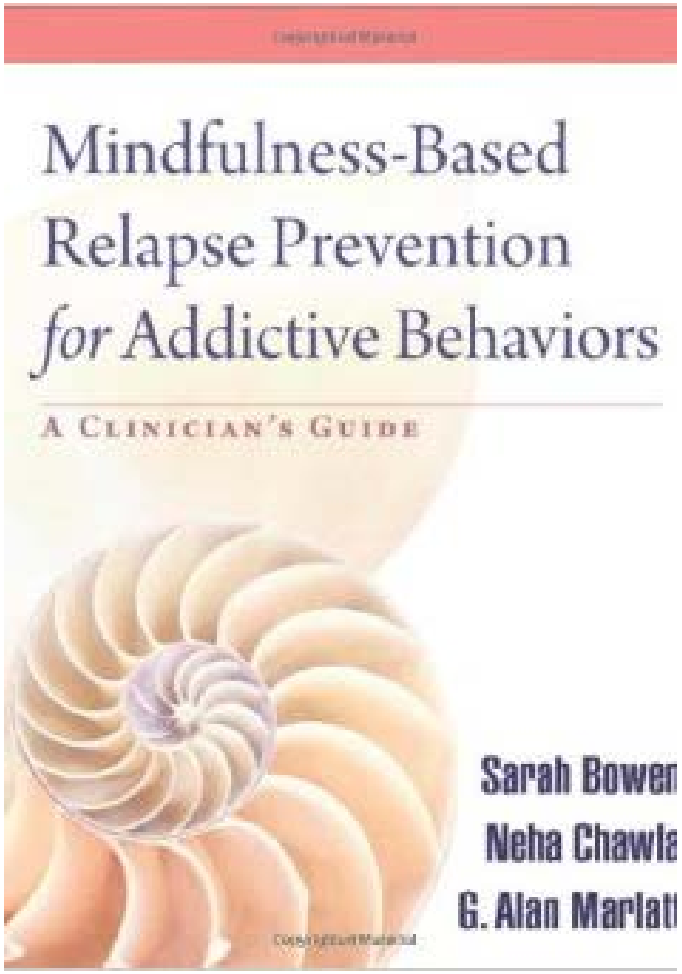
1) Theravada-style Buddhist sitting breath-based meditation
2) Body Scanning
3) Hatha Yoga postures

- 8 week standardized course with one day long class, offered in over 200 medical centers
- http://www.mindfullivingprograms.com/whatMBSR.php

Gu, et al. J Clin Psychol Rev 2015

Evidence for Mindfulness Based Interventions

- Early case series found over ½ of chronic pain pts had 33% or > reduction in current pain and body problems
  - Kabat-Zinn Gen Hosp Psychiatry, 1982
- May improve coping with stress & pain , with gains lasting up to 4 yrs
  - Kabat-Zinn et al Clin J Pain, 1986
- Compliance rate, despite promoting daily practice, compares favorably to other behavioral pain management approaches
  - Sturgeon Psychology Research & Behav Management, 2014
- Promising evidence for fibromyalgia and LBP
  - Lauche et al J Psychosom Res 2013, Cramer et al BMC Complement Alt Med 2012



Mindfulness- Based Relapse Prevention (MBRP)

designed for addiction

- 8 sessions: mindfulness practices in presence of relapse triggers and recognizing the role of thoughts in relapse.
- Also emphasizes balanced lifestyle, self-care and compassion, and social support.

Bowen S et al. *JAMA Psychiatry*. 2014

Mindfulness Oriented Recovery Enhancement Methodology (MORE)

designed for problem opioid use

Combines elements:

- Mindfulness-based stress reduction
- Cognitive behavioral therapy
- Positive psychology

<u>8 sessions</u>:

- Mindfulness training to target automatic habit behavior
- Foster non-reactivity
- Positive reappraisal training to regulate negative emotions
- Foster a sense of meaningfulness
- Training in savoring pleasant events and emotions

Galrland et al. J Consullt & Clin Psych 2014

Teaching mindfulness in short visits

- Teach ‘Soft Belly’ breathing in the office
  - James Gordon, Center for Mind-Body Medicine https://vimeo.com/37976492
- Know what is in your community
  - www.pcbehavioralhealth.com/relaxation-contemplative-practice for examples
- Offer patient menu of options:
  - Free HeadSpace app
  - If available: MBSR, MBRP, MORE
  - Local yoga, tai chi, qi quong, etc. classes
  - Local meditation center training (typically donation based)
  - Make action plan & check back with them

"Come back to me when the cup is empty. Come back to me with an empty mind."

Group Visits for Pain Management

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Better Ideas for Care Delivery

Why groups?

- Improve patient access
  - 8-10 patients in a 1.5 hour group
  - For some group models, even larger groups can work
- Chronic pain patients need time
  - 1.5 hours of being listened to and sharing experiences is incredibly therapeutic regardless of content
- Isolation is a defining feature of the chronic pain experience
  - Patients feel like nobody understands them
  - Family, friends are unable to relate
  - Unemployed and unable to engage in social activities

Possible purposes of a group visit

- Treat pain
- Treat suffering associated with pain
- Provide an alternative to medications
- Reduce opioid use
- Orient patients to clinic policies
- Provide opportunity to discuss pain agreements
- Prescribe opioids on a regular schedule
- Assess for signs of misuse
- Train residents and medical students

Three basic categories

- Orientation groups
- Medication groups
- Psycho-educational and therapeutic groups

Orientation Groups

- Meet once or twice
- Can be run by health worker, behavioral clinician, NP, PA, or physician
- Can be a large group, offered monthly, bimonthly, or quarterly

Orientation Groups

- Brief overview of chronic pain
  - How is it different than acute pain?
  - What are the various options for treatment?
- Discussion of benefits and risks of opioids
- Overview of clinic policy
  - UDS frequency, drop-in policy, etc.
- Review and signing of pain agreement

Model of Overview of Chronic Pain

	Acute Pain	Chronic Pain
Time course	Short term	Long term
Quality of Pain	Often sharp, some ache	Often aching, burning, tingling, shooting
Location	Often focal, easy to point to	Often vague, moving
Cause	Usually known cause	Often unknown or multiple causes
Treatment	Medication works great	Medication is not enough. Need a multi-modal approach

Pharmacologic	**Physical**
Complementary and Alternative Medicine	**Cognitive and Behavioral**

Pharmacologic

- Neuroleptics
- Antidepressants
- Anesthetics (lidocaine patch)
- Muscle relaxants
- Topicals (capsacin)
- Opioid medications/Tramadol
- Procedural pain clinic:
  - baclofen pumps, etc.
- Buprenorphine
- Naloxone

Physical

- Physical Therapy/Physiatry consults
- Joint injections
- Spine injections
- Surgery
- Exercise
- Stretching
- Paceing
- Heat or ice
- Trigger point injections

Complementary and Alternative Medicine

- Acupuncture
- Mindfulness Based Stress Reduction and meditation
- Yoga Classes
- Tai-chi classes
- Massage
- Manual Medicine
- Anti-inflammatory diets and herbs
- Supplements
- Guided imagery

Cognitive and Behavioral

- Pain Group
- Individual therapy
- Brief cognitive and behavioral interventions in clinic
- Visualization, deep breathing, meditation
- Sleep hygiene
- Gardening, being outdoors, going to church, spending time with friends and family, etc.

Three basic categories

- ✓Orientation groups
- Medication groups
- Psycho-educational and therapeutic groups

Medication Groups

- Monthly meetings for refills
- Provide brief support and treatment
  - Psychoeducation and self management
- Discuss pain, function, strategies for managing pain, and impact of medication in the group
- Provide brief individual visits
- Provide medication refill

Medication Group

- Assess the same items you would assess in regular pain visits
  - Pain level
  - Changes in functional status
  - Opioid side effects
  - Urine drug screen as indicated
  - Can use structured intake questionnaire with MA
- Offer the same treatments you would offer
  - Non-opioid medication options
  - Non-pharmacologic pain management options
  - Group setting can increase motivation to try new treatments

Many options for structure

Option 1

- Group meeting for 1-1.5 hours followed by brief individual visits for refill management
- Group can be lead by provider, health worker, behavioral clinician

Option 2

- Group meeting for 1.5 hours
- Concurrent individual meetings where patients step out of group for brief individual visits
- Group can be lead by provider, health worker, behavioral clinician

Three basic categories

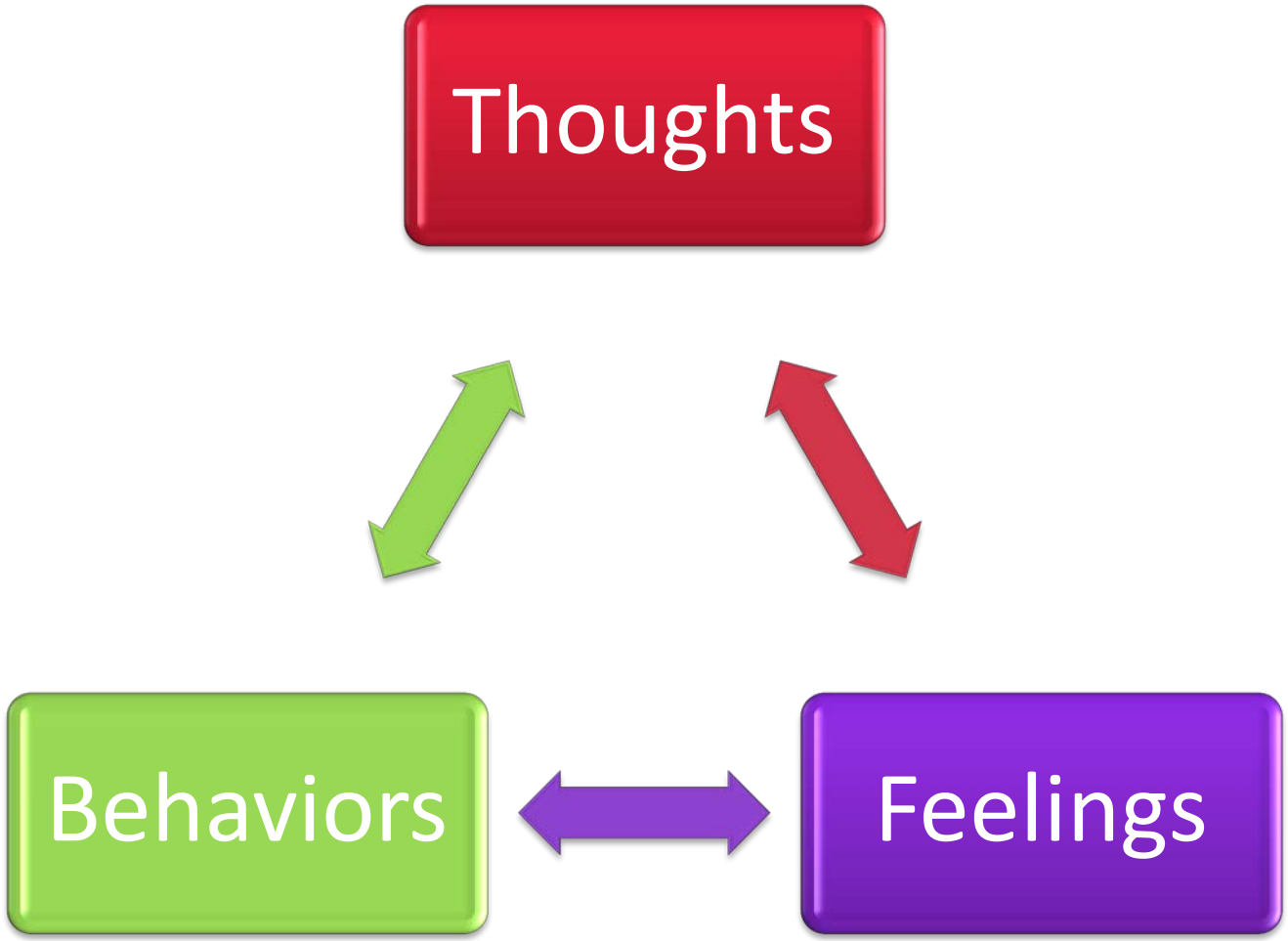
- ✓Orientation groups
- ✓Medication groups
- Psycho-educational and therapeutic groups

Therapeutic Groups

Therapeutic Groups

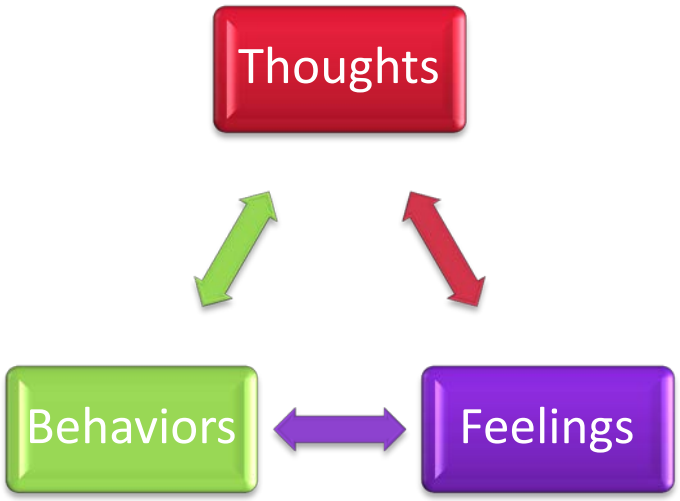
- Three models have been well studied:
  - Cognitive Behavioral Therapy (CBT)
  - Acceptance and Commitment Therapy (ACT)
  - Mindfulness Based Stress Reduction (MBSR)
- Most groups combine:
  - Formal therapeutic modality
  - Self management education
  - Social support

Cognitive Behavioral Therapy



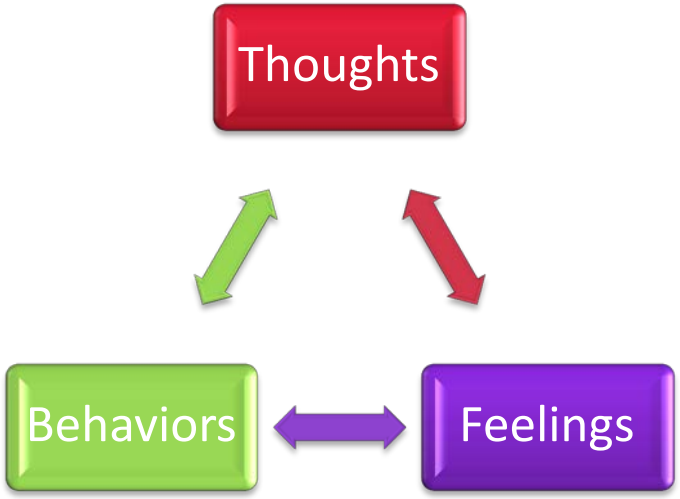
Cognitive Behavioral Therapy

- Teaches patients to intervene on their thoughts, feelings, and behaviors
- Involves homework and specific exercises
- Very amenable to manuals and protocols



CBT exercise

- Write down a thought you are having right now.
- Categorize it as
  - Helpful
  - Not helpful
  - Neutral
- If it is not helpful, can you re-write it so that it is helpful?

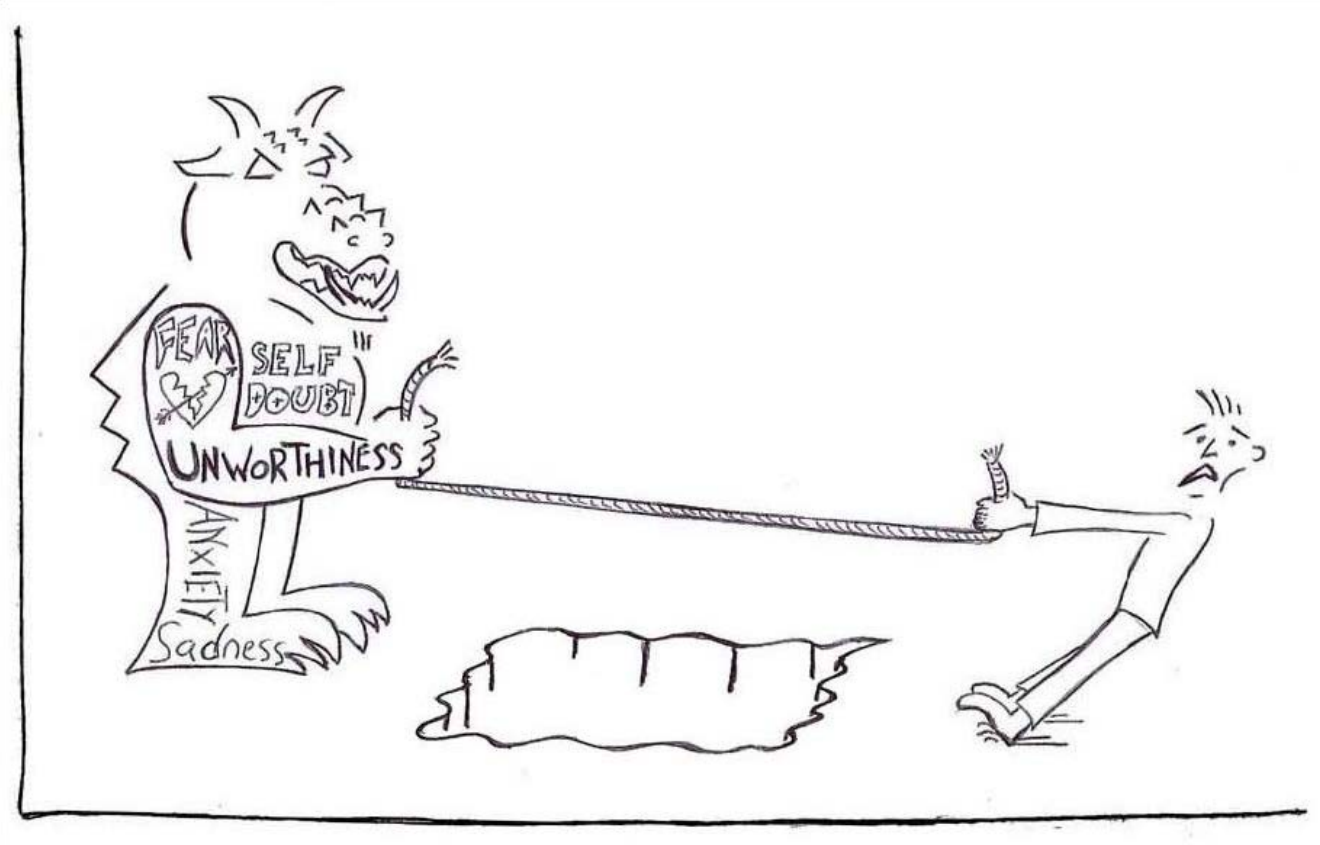


Acceptance and Commitment Therapy

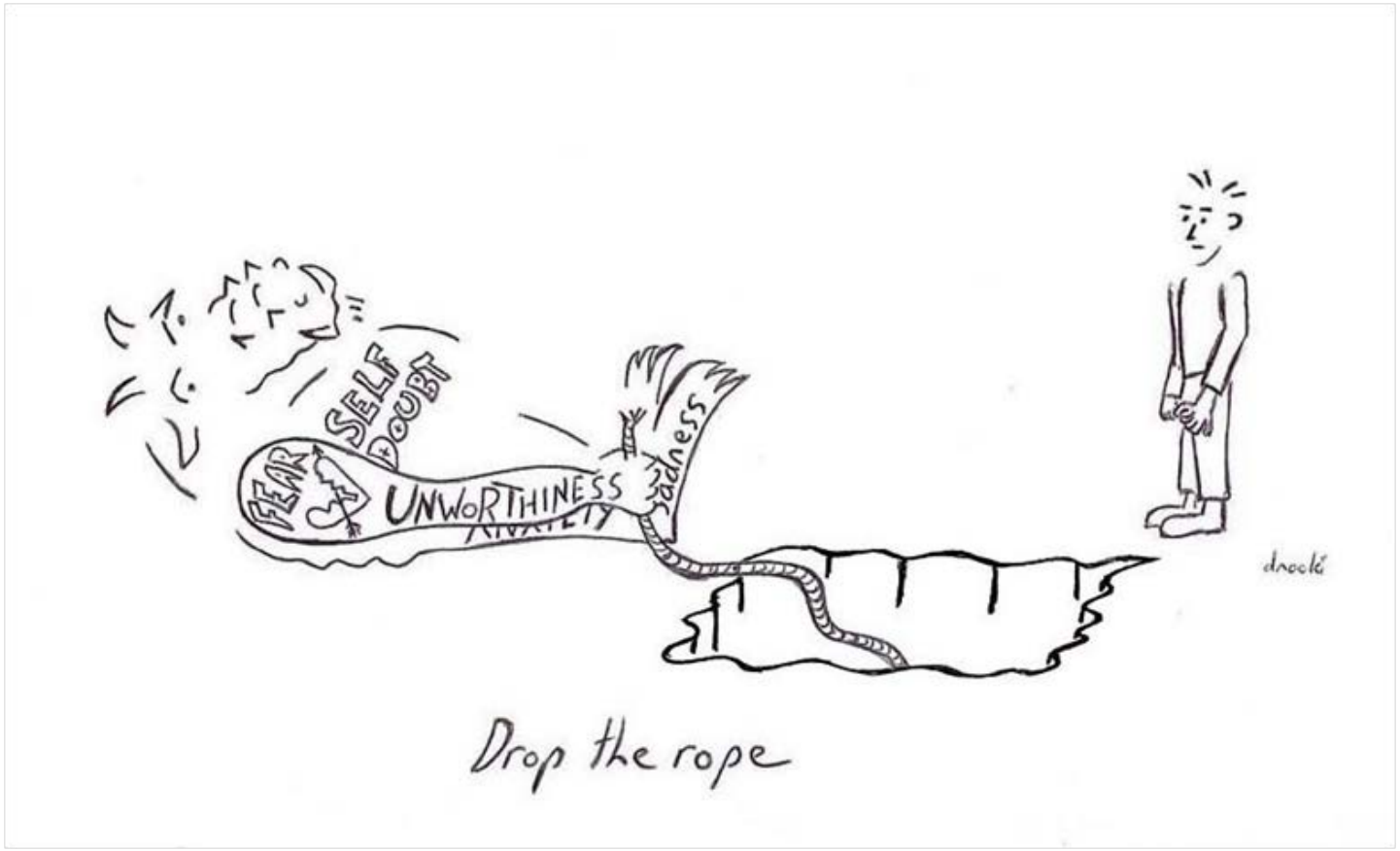
- Helps people genuinely accept the current state of things
- This acceptance allows them to commit to moving forward from where they are towards the things they value

- Rather than wasting energy fighting the present, use the energy to arrive in the present and befriend it.

Acceptance and Commitment Therapy



Acceptance and Commitment Therapy



Being Present
Focus on the here and now

Values
Discover what is truly important to you

Commitment
Take action to pursue the important things in your life

Self as Context
See yourself as unchanged by time and experience

Defusion
Observe your thoughts without being ruled by them

Acceptance
Be willing to experience difficult thoughts

How to Build a Therapeutic Group

A sample session

1:30 Three deep breaths
1:35 Check-in

1:50 Topic: Variable, e.g. Sleep hygiene

2:25 Stretch Break

2:30 Exercise: Variable, e.g. body scan

2:40 Personal Project: Variable, e.g. make one change to your sleep routine

2:50 Take home points

2:55 Three deep breaths

Example Topics

- Hope and acceptance
- Sleep hygiene and pain
- Communicating with your healthcare team
- Pain medications
- Thoughts and pain
- Anger and pain
- Emotional pain and physical pain
- Increasing your social support
- Learning to pace yourself
- Finding your inner strength

Impact on patients

- “I realized I’m not alone”
- “I still have pain, but now I can live with it. It doesn’t bother me the way it did”
- “After just the first session, everything changed. I have hope now”

Impact on Residents

- Increased interest in chronic pain patients
- Increased empathy
- Exposure to group visit model
- “I actually enjoyed working with chronic pain patients!”

Resources

- Managing Chronic Pain: a Cognitive-Behavioral Therapy Approach Workbook and Therapist Guide, by John Otis
- Literacy Adapted CBT Manual for Chronic Pain by Beverly Thorne, PhD
- Cognitive Therapy for Chronic Pain: A Step by Step Guide by Beverly Thorne, PhD
- We have a home-made manual and facilitator guide at SFGH. Email me diana.coffa@ucsf.edu for an electronic copy

Logistical tips

- Survey patients about ideal times
  - Afternoon typically better
- Establish a straightforward referral process
- Assign someone to call patients the morning of the group to remind and encourage them
- Consider pairing a provider with a health worker or MA to run the group

Discussion

- What are your biggest challenges around behavioral health management?
- What do you know about educational resources in your community?
- What experience do you have teaching behavioral techniques to residents?

Residency Action Group 2015-16 Calendar

	July	August	September	October	November	December	January	February	March
Webinars 90 min	7/22 12pm	8/28 12pm Password: chcf Code: 668 818 809	9/8 12:30pm Password: chcf Code: 668 610 299		11/9 12pm Password: chcf Code: 661 331 076	12/14 12pm Password: chcf Code: 665 897 286	1/11 12pm Password: chcf Code: 663 298 057	2/8 12pm Password: chcf Code: 669 393 250	
Office Hours			~~9/21 11am Password: chcf Code: 662 422 708~~	**New Time TBD**	11/23 12pm Password: chcf Code: 669 822 219		1/25 12pm Password: chcf Code: 669 860 079	2/29 12pm Password: chcf Code: 663 211 015	
In-person				10/1 9-5pm					3/24 9-5pm
Topics	Addiction and pain	QI and Change Mgmt	Behavioral Health	SCOPE, Team planning	Patient engagement, self-care, integrative medicine	Art and science of opioid tapering	Medication-assisted treatment	TBD	Harvest our learnings
Coaching	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly

Reminder to register for 10/1 SCOPE of Pain training.

https://www.scopeofpain.com/in-person-training/ choose Waterfront Hotel, Oakland, CA, Oct 1, 2015

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Please Fill Out the Evaluation (CME Credit)

http://goo.gl/forms/zS4EWOQLGX

Questions?

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