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Q+A will open at the end of the presentation.

**Follow-up questions?**

**Contact**



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**PRESENTED BY:**  
**Marsha Johnson, LCSW**  
**Suzanne Daub, LCSW**

**Tuesday,**  
**May 16, 2023**  
**12:00 pm – 1:00 pm ET**

# NEW DIAGNOSIS OF A CHRONIC CONDITION

Integrated Care DC is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the U.S. Department of Health and Human Services (HHS). A total of \$3,500,365, or 81 percent, of the project is financed with federal funds, and \$810,022, or 19 percent, is funded by non-federal sources. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, HHS or the U.S. Government.

- » Integrated Care DC enhances Medicaid providers' capacity to deliver whole-person care for the physical, behavioral health, substance use disorder, and social needs of beneficiaries.
- » The technical assistance program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH).

To improve care and outcomes, the program focuses on three practice transformation core competencies:

- 1 Deliver **patient-centered care** across the care continuum
- 2 Use **population health analytics** to address complex needs
- 3 Engage **leadership** to support person-centered, value-based care

# WHY PARTICIPATE IN INTEGRATED CARE DC?

- » Integrated Care DC will help ensure you have the infrastructure, knowledge, and tools you need to deliver high-value care.
- » Our coaching team includes primary care, psychiatric, addiction medicine, and behavioral health clinicians with deep expertise in integrated care models.
- » Educational credit (CE/CME) is offered at no cost to attendees for live webinars.
- » All DC Medicaid providers are eligible.



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>> **Got ideas?**

**Take this short survey** to share suggestions and requests for trainings.  
[www.integratedcaredc.com/survey](http://www.integratedcaredc.com/survey)



# PRESENTERS



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<b>Company</b>	No financial disclosures	No financial disclosures	No financial disclosures	No financial disclosures
<b>Nature of relationship</b>	N/A	N/A	N/A	N/A

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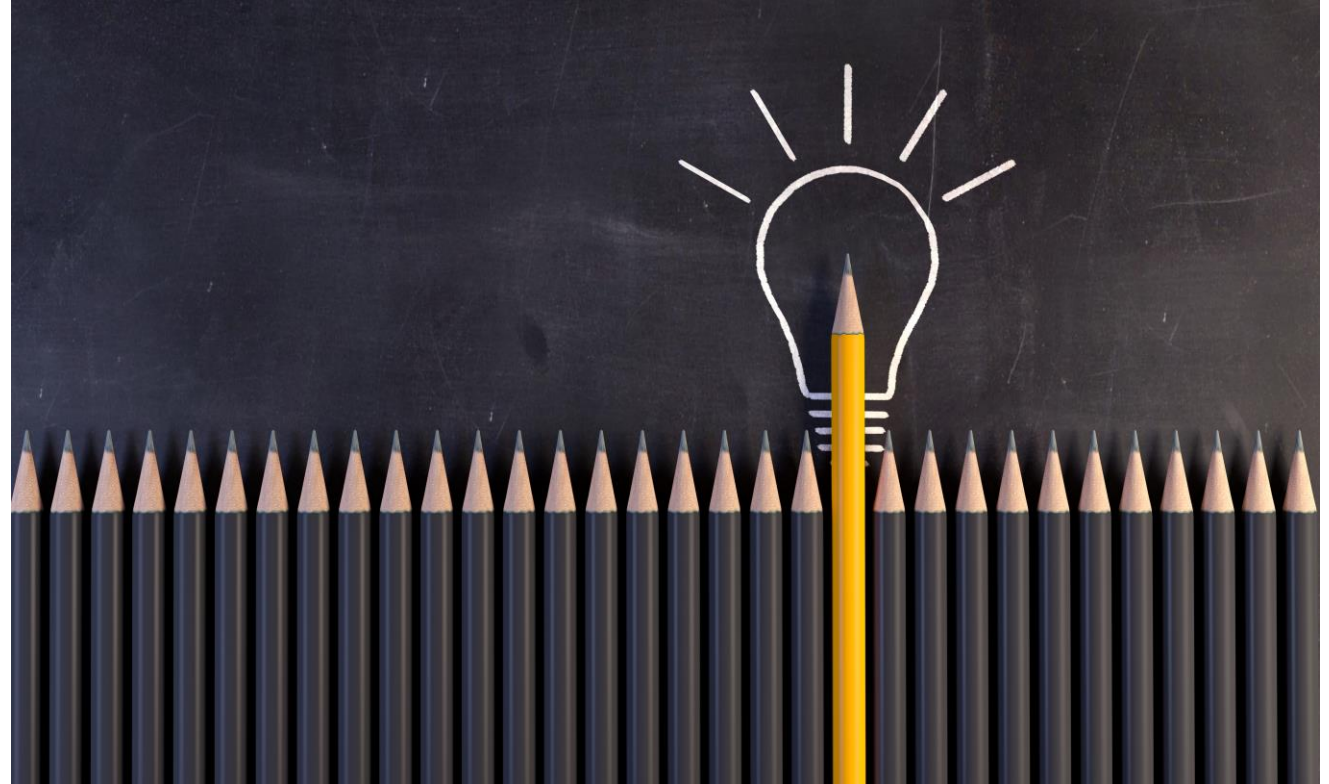
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## New Diagnosis of a Chronic Condition

- » Welcome and Program Announcements
- » PCBH Overview
- » Understanding Chronic Conditions
- » The 5 As
- » Discussion
- » Q&A



1. Describe two facts about chronic disease prevalence and/or cost.
2. Discuss the ideal position of a behavioral health consultant with respect to chronic conditions.
3. Apply the 5 As in working with a patient with a newly diagnosed chronic condition.



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# **PRIMARY CARE BEHAVIORAL HEALTH CONSULTATION MODEL**

- » The Primary Care Behavioral Health (PCBH) Consultation model is a psychological approach to **population-based clinical health care** that is simultaneously **co-located, collaborative, and integrated** within the primary care clinic
- » The goal of PCBH is to improve and promote **overall health within the general population**

# THE BEHAVIORAL HEALTH CONSULTANT (BHC) ROLE IN THE PCBH MODEL: GATHER



## Generalist

The goal is to have the BHC work with patients of any age and any behavioral concern, from anxiety or tobacco use to parenting strategies

## Accessible

The BHC should be available to help the primary care provider at all times during the workday

## Team-based

The BHC is part of the health care team and participates in meetings and huddles about patient care

## High Productivity

To make this model work financially, the BHC must be able to see many patients each day. Many of these visits are short

## Education

The BHC educates patients about health issues and the health care team about patients' psychosocial needs. The BHC supports the primary care provider in continued care of the patient

## Routine

When making referrals to the BHC becomes part of the clinic's normal daily workflow

# UNDERSTANDING CHRONIC CONDITIONS

A chronic disease is a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both

- 90% of the nation's \$4.1 trillion per year in healthcare costs can be attributed to people with chronic diseases and mental health conditions (CDC, 2021)
- 6 in 10 adults have one chronic disease and 4 in 10 adults have two or more chronic diseases (CDC, 2021)
- Chronic diseases are the leading causes of death and disability (CDC, n.d.)

# MOST COMMON CHRONIC CONDITIONS IN THE U.S.



Source: [Hush Naidoo Jade Photography](#) on [Unsplash](#)

1. Heart disease
2. Cancer
3. Diabetes



- » Chronic conditions are more prevalent in people from socioeconomically deprived backgrounds. (Mair et al, 2020)
- » Onset of a chronic disease reduces wages by 18%. (Thorpe et al, 2017)
- » Americans with just one or two chronic illnesses in 2014 paid double the out-of-pocket costs compared to Americans without chronic conditions. (Butorff et al, 2017)
- » People of color face higher rates of diabetes, obesity, stroke, heart disease, and cancer than whites. (Thorpe et al, 2017)

“People from socioeconomically deprived areas with chronic illness or multimorbidity have higher morbidity and mortality than their more affluent counterparts.”  
(Mair et al, 2020)



# INTERVENTION

A significant determinant of positive coping outcomes is the presence of therapeutic interventions

- » K. White et al. did a systematic review of the literature on chronic disease and coping
- » Therapeutic interventions include:
  - providing more knowledge about the chronic condition
  - teaching coping skills
  - improving adherence behavior
  - exploring ways to gain satisfaction in work or life
  - examining the emotional consequences of illness
  - incorporating new healthcare technologies

## » Therapeutic interventions drove positive outcomes:

- More positive moods
- Greater disease acceptance
- Increased quality of life
- Improvements in patient knowledge and self-care behaviors



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- » Therapeutic support for emotional response
- » Keen understanding of stages of change
- » Motivational interviewing skills to explore meaning and support self-management
- » Focused time

# THE FIVE As

» A health behavior change model designed for use with chronic illness care originally developed as part of the Chronic Care Model.

- Assess
- Advise
- Agree
- Assist
- Arrange

Symptoms

Risk factors

Behaviors

Attitudes

Preferences

## Knowledge and understanding

- Provide information about symptoms, treatments, long-term effects, and health behavior impact on disease progression

## Emotions

- Normalize range of emotional responses to new diagnosis

## Coping

- Discuss coping strategies that can be utilized

## Self-management

- Describe specific self-management strategies

## Life impact

- Share common impacts on life, relationships, functioning, and work

Specific, person-centered options for treatment, symptom reduction, and improvements to quality of life, health, and functioning





- » Use advise sparingly if you are using motivational interviewing
- » Ask permission before you advise
- » Be mindful of information overload
- » Consider impact of information
  - Too little anxiety can result in no sense of urgency to change
  - Too much anxiety can result in disengagement

- Collaboratively select goals based on patient interest and motivation to change
- Establishing stage of change will have a strong bearing on the “agree” step
- Motivational interviewing (MI) adherent strategies to strengthen commitment, assess readiness, and mitigate barriers are critical in this phase

## Knowledge and understanding

- Provide credible and evidence-based information and resources

## Emotions

- Provide information about common reactions to new diagnoses

## Coping

- Teach a coping strategy to mitigate stress of the diagnosis

## Self-management

- Refer patient to self-management classes, support groups or other approaches to support self-management

## Life impact

- Problem-solve impacts on life, relationships, work, and functioning

## >> Determine follow-up

- Visit with BHC
- Visit with PCP
- Refer to self-management or support groups
- Refer to specialty behavioral health
- Phone call



Source: Microsoft Stock Images

# DISCUSSION

# Q&A

- » About chronic diseases. (2021, April 28). Centers for Disease Control and Prevention. <https://www.cdc.gov/chronicdisease/about/costs/index.htm>.
- » Buttorff, C., Ruder, T., & Bauman, M. (2017). *Multiple chronic conditions in the United States*. RAND Corporation. <https://www.rand.org/pubs/tools/TL221.html>.
- » Health and economic costs of chronic disease. (n.d.). Centers for Disease Control and Prevention. <https://www.cdc.gov/chronicdisease/about/costs/index.htm>. Accessed April 30, 2023.
- » Hunter, C.L., Goodie, J.L., Oordt, M.S., Dobmeyer, A.S. (2022). Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention. (2<sup>nd</sup> ed.). American Psychological Society.
- » Mair, F.S., Jani, B.D. (2020). Emerging trends and future research on the role of socioeconomic status in chronic illness and multimorbidity. *The Lancet*, 5(3). pp. E128-E129. [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(20\)30001-3/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30001-3/fulltext).

- » Thorpe, K.E., DeMatteis, C. (2016, April 18). *Addressing health in America to build wealth*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/forefront.20160418.054518/full/>.
- » Thorpe, K.E., Ko Chin, K., Cruz, Y., Innocent, M.A., Singh, L. (2017, August 17). *The United States can reduce socioeconomic disparities by focusing on chronic diseases*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/forefront.20170817.061561/full/#:~:text=Chronic%20Disease%20Burden%20Among%20Communities,among%20Hispanics%2C%20than%20for%20whites.>
- » White, K., Issac, M.S., Kamoun, C., Leygues, J., Cohn, S. (2018). The THRIVE model: A framework and review of internal and external predictors of coping with chronic illness. *Health Psychology Open*, 5(2). doi: [10.1177/2055102918793552](https://doi.org/10.1177/2055102918793552)



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- » The webinar recording will be available within a few days at: [www.integratedcaredc.com/learning](http://www.integratedcaredc.com/learning)
- » **Upcoming Webinar:** *Engaging Families (PCBH Series Part 12)*, Tuesday, June 20, 2023, 12:00 pm – 1:00 pm ET
- » For more information about Integrated Care DC, please visit: [www.integratedcaredc.com](http://www.integratedcaredc.com)