BEHAVIORAL HEALTH CONSULTANT HYPERTENSION TOOLKIT

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Uncontrolled Hypertension and the Integrated Primary Care Behavioral Health Provider

Welcome: A Primer on the BHC Hypertension Toolkit

The Health Federation of Philadelphia is glad to present this integrated behavioral health toolkit. The toolkit's goal is to support behavioral health consultants (BHCs) in contributing to the treatment of uncontrolled hypertension.

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For some BHCs, there are a number of questions and concerns that arise when it comes to supporting chronic health needs in primary care. These include:

- How can my skills help someone with hypertension?
- I wasn't trained on hypertension, does this mean I am not qualified to help?
- Aren't medical conditions outside scope of competence?
- I don't know much about hypertension, and I am worried my provider may judge me or I may look uninformed to my patient.
- I am much more interested in supporting people with depression, trauma, anxiety, and stress. I am not sure if assisting with hypertension is for me.

These concerns are common, especially in newer BHCs/Integrated Behavioral Health Professionals (IBHPs) or clinicians whose training programs and previous job experience did not include chronic health disorders. This toolkit seeks to provide an easy on-ramp to help BHCs assist with uncontrolled hypertension by providing BHC decisional aids, clinical tools, instructions, background information, videos, and a podcast series. There are seven distinct parts:

1. *Background information on uncontrolled hypertension*
    - Summary of evidence for behavioral health interventions in improving high blood pressure
    - Instructional brief videos on important information to know about hypertension, assessment, and intervention

2. *Podcast series, Minding the Heart, of four short episodes that discuss behavioral health interventions and other consideration in providing clinical support for someone with hypertension*

3. Levels of Intervention for a Hypertension Visit

4. Structure of a BHC Hypertension Visit

- ♥ Decisional aid on how to shape an initial warm-handoff or visit for hypertension

5. *Clinical tools*

- ♥ High Blood Pressure Confidence scale
- ♥ Card Sort for Managing Hypertension, a tool to assist with determining clinical priorities
- ♥ Distress Scale for Diabetes & Hypertension: helps identify mood symptoms related to the health challenges of these disorders

6. *Billing considerations for reimbursement of behavioral health interventions for hypertension*

7. *Ideas for generating referrals for uncontrolled hypertension to the BHC*

We hope you enjoy this toolkit and find it useful in preparing yourself to best address the hypertensive needs of your health setting's panel.

Background Information on Uncontrolled Hypertension

HYPERTENSION AND BEHAVIORAL HEALTH FACT SHEET

This section will provide information on general and specific approaches IBHPs can take to add value to the care of individuals with uncontrolled hypertension.

The first part will define the terms and risk factors for uncontrolled hypertension. The second part will provide a broad overview of the integrated behavioral strategies for hypertensive care. The third part will provide the supporting evidence showing the impact behavioral health strategies can have on supporting hypertension management. The literature demonstrates the intersection between degree of hypertension control and psychological variables (e.g., depression, anxiety, substance use), and the positive direct benefit of behavioral health intervention on systolic and diastolic blood pressure.

"I'm going to take your blood pressure, so try to relax and not think about what a high reading might mean for your chances of living a long, healthy life."

We regularly joke about how work, life, stress, diet, and significant other factors are contributing to our high blood pressure, but do we take enough time clinically to address that linkage and that intuitive connection?

Photo Credit: David Sipress, 1/4/2020 *The New Yorker*

SUMMARY OF EVIDENCE

Part 1: Orientation

Uncontrolled hypertension occurs when systolic blood pressure is consistently ≥140 mmHg and/or diastolic blood pressure is consistently ≥90 mmHg. Consistent high blood pressure increases "wear and tear" on the heart and circulatory system. Elevated blood pressure increases the risk of kidney damage, heart attack (myocardial infarction), congestive heart failure, and stroke. Factors such as inconsistently taking hypertensive medications, cigarette smoking, sedentary lifestyle, dietary factors, alcohol and drug use, and stress can negatively impact hypertension.

Part 2: Effective Behavioral Health Strategies

As a BHC or IBHP, there are a variety of strategies to best support individuals living with chronic health diagnoses. It is important to remember the three fundamental skills that a BHC or IBHP can provide in any situation:

1. *Listen, validate, and support* the concerns a person endorses about managing their chronic health symptoms. Utilize open-ended questions, affirmations, reflections, and summaries.

2. *Address coexisting symptoms* of anxiety, depression, tobacco use, and substance use.

3. *SMART goals:* Addressing chronic health can feel like untangling an impossible knot, with multiple things to work on at once. An integrated behavioral health provider can help to deconstruct a large health target by breaking each goal into smaller behavioral steps via SMART goals (specific, measurable, attainable, realistic, and timely). Involving the health provider, to clarify one's goals, can be useful.

Key Interventions to Address Hypertension

- Address gaps in medication adherence.
- Assist with cigarette smoking reduction / cessation.
- Promote increased exercise.
- Reduce salt and fat, increase fresh vegetables, fruit, and low-salt food (DASH diet).
- Reduce problematic alcohol and drug use .
- Mindfulness and behavioral stress management techniques.

Part 3: Evidence Base: Why refer individuals with elevated hypertension to BHC/IBHP?

Impact of Psychological Conditions on Hypertension

- *Persistent anxiety* increases the sympathetic nervous system, activation of HPA axis, cardiovascular reactivity to stress, and long-term risk for CHD, MI, health-related death odds (1.25-2.5 O.R.) (Cohen, Edmondson, & Kronish, 2015).
    - Anxiety increases blood pressure, systemic vascular resistance, plasma renin activity, and blood lipids (Pan, Cai, Cheng, Dong, An, & Yan, 2015).
    - Persistent anxiety is associated with increased likelihood of cigarette smoking, excess alcohol use, and lower physical activity, further increasing the risk for cardiovascular effects. However, anxiety has not been associated with medication nonadherence (Cohen et al, 2015).
    - Anxiety can be substantially reduced through evidence-based therapies, especially cognitive-behavioral treatment and exposure-oriented approaches. Stress management and mindfulness techniques can also help incrementally reduce anxiety symptoms.
- *Depression* increases sympathetic nervous system, increases blood pressure, alters blood clotting, modifies heart rhythms, and elevates cholesterol and insulin levels (Rumsfeld & Ho, 2005).
    - A study providing psychoeducation on depression, support for concurrent depression, and helping enhance antidepressant medication adherence, boosted antihypertensive medication adherence (Bogner and de Vries, 2008).
- *Tobacco use* contributes to mitochondrial oxidative stress, endothelial dysfunction in the vascular system, and hypertension and cardiovascular diseases (Dikalov et al, 2019).
- *Substance use:*
    - Reductions in blood pressure are “modest” when addressing problematic alcohol use (Al’Absi and Hoffman, 2003), but this may also have the secondary effect of improving antihypertensive adherence and potentially increase engagement in positive lifestyle changes (e.g., engagement in exercise).

Valuable Clinical Expertise to Assist Hypertension is Part of the BHC/IBHP Skillset

- *IBHPS have considerable expertise and daily use of strategies that promote behavioral changes and engagement in health goals.*
    - Applicable techniques: motivational interviewing, cognitive behavioral therapy, functional assessment of behavior, education, and tailoring interventions to individual stage of readiness, knowledge, and contextual circumstances (Robinson & Reiter, 2016).

- Behavioral health providers *are experts in biopsychosocial assessment, and can develop a case conceptualization of what factors contribute to and impede effective hypertension management.*
    - IBHPs provide expertise in case conceptualization and interventions that can address behavioral health and physical health considerations simultaneously (Ward et al, 2016).
- *Elevated rates of psychological disorders and adverse social determinants of health are observed in those with chronic health conditions, especially insufficiently maintained hypertension* (Matei et al, 2018).

Health Behavior Changes

- *BHC/ IBHP can help improve adherence to antihypertensive medication.*
    - Behavioral interventions offer flexible, tailored strategies to help with blood pressure medicine adherence. Effective strategies include taking time to link medication-taking to existing daily activities/habits, providing positive adherence-oriented feedback, teaching self-monitoring strategies (including use of handouts), use of pill boxes, and motivational interviewing (Conn, Ruppar, Chase, Enriquez, & Cooper, 2015).
    - The best approaches often combined interventions and extended over multiple days of intervention.
    - Motivational interviewing can be a useful tool to help improve engagement in pro-health behaviors and yield better hypertensive control (VanBuskirk & Wetherell, 2014).
- *Effective smoking cessation interventions can be delivered briefly, cost-effectively, and with individualized-tailoring by BHC/IBHP.*
    - Smoking has a direct effect on elevating blood pressure (Journath et al, 2005).
    - "Behavioral and pharmacotherapy interventions improve rates of smoking cessation among the general adult population, alone or in combination… Combined behavioral and pharmacotherapy interventions increased cessation by 82% compared with minimal intervention or usual care (RR, 1.82 [CI, 1.66 to 2.00])" (Patnode et al, 2015).
- *Weight-loss can lower blood pressure from 3.0-6.8 mmHg / 2.9-5.7mg (Al'Absi & Hoffman, 2003)*
    - Behavioral therapy is the gold-standard intervention for weight loss, averaging a maintained loss of 5-8% of body weight 12 months later (Butryn, Webb & Wadden, 2011).

- Advances in behavioral health therapies, notably augmenting with acceptance-oriented approaches, seems to further optimize and improve weight loss relative to standard behavioral therapy interventions (Forman et al., 2016). Acceptance-oriented approaches seem to increase mindfulness during eating, reduce additional snacking, and seem to yield greater weight loss and a higher percentage of maintainers.

- *BHC and IBHP help promote exercise and activity*

  - Consultation on structured exercise can reduce anxiety, depression, and adverse cardiovascular syndromes, and can have interactive effects across these problem areas (Pratt et al., 2016; Reinhart et al, 2017). The Reinhart and colleagues book chapter also is informative on strategies to effectively improve physical exercise.

- *Support for dietary changes*

  - DASH diet can yield blood pressure reduction of 7-12 mmhg/ 5mmHg (Vollmer et al, 2001).

  - BHC/IBHP can help reinforce and troubleshoot dietary change strategies, using social problem-solving interventions (Lesley, 2007).

Stress Management Effectiveness for HTN

- *Stress reduction strategies can significantly reduce blood pressure, especially meditation.*

  - A review article showed a mean decrease in systolic/diastolic blood pressure from a variety of stress management techniques: (a) biofeedback (-0.8/-2.0 mm Hg), (b) progressive muscle relaxation (-1.9/-1.4 mm Hg), (c) stress management training (-2.3/-1.3 mm Hg), and (d) Transcendental Meditation (-5.0/-2.8 mm Hg). (Rainforth, Schneider, Nidich, Gaylord-King, Salerno, & Anderson, 2007).

  - This compares to systolic decreases of weight-reducing diet (-5.0 mg Hg), aerobic exercise (-4.6 mm Hg), alcohol restriction (-3.8 mm Hg), and sodium restriction (-3.6 mm Hg) (Rainforth et al, 2007).

Final Thoughts

- "Behavioral treatments produce moderately reliable effects, in the neighborhood of 6-10 mmHg BP reduction for pre-post comparisons" (Linden & Chambers, 1994)... and this can increase (7-15 mmHg reductions) as part of an individually tailored or multi-component approach (Linden & Moseley, 2006).

  - "The relatively largest BP changes were seen in those patients who showed stress reduction and more adaptive anger coping styles."

  - Behavioral interventions are recommended when: medication side effects are severe; "Lifestyle changes (weight loss, exercise uptake) alone are not enough to lower the BP to the normotensive range, and/or the patient needs psychological support to implement and maintain these changes"; patient prefers non-drug treatment or self-management approaches; patient has family history of HTN and CVD and is seeking preventive approaches; or patient has a stressful life style.

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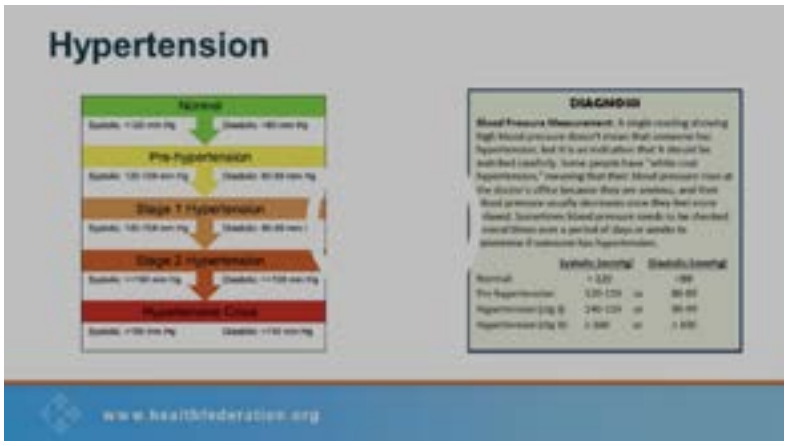
INSTRUCTIONAL BRIEF VIDEOS (BHC MICRO TRAINING SERIES)

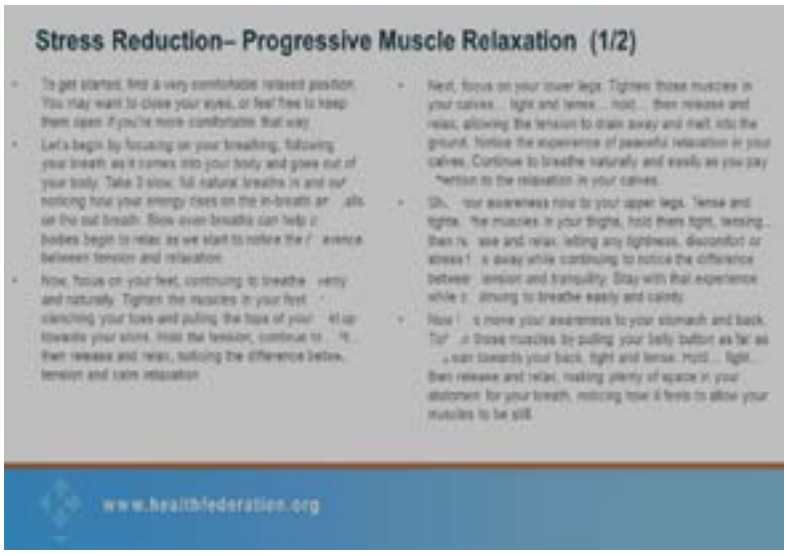
Welcome to the BHC Micro-Training Series. The focus is to quickly build knowledge and skills for highly effective BHC visits. The first training is on Uncontrolled Hypertension, and has two parts: Module 1--- background and mitigating factors (5 minutes); and Module 2--- assessment and intervention strategies (~6:30 minutes).

These modules, along with the remainder of this toolkit, will help you master the uncontrolled hypertension visit. Hopefully, you will enjoy this mini-series.

Hypertension for integrated Care Pt 1—Background & Mitigating Factors



Hypertension for Integrated Care Pt 2- Assessment & Interventions



Podcast Series:
Minding the Heart

HYPERTENSION PODCAST: *MINDING THE HEART*

The Health Federation of Philadelphia has created a series of short podcasts to discuss strategies, experiences, and perspectives on integrated behavioral health and uncontrolled hypertension. The Four podcasts review real-life Behavioral Health Consultant experience in treating hypertension and also bring a primary care perspective to the discussion. The podcast is hosted by Travis Cos, PhD.

Number	Co-Host(s)	Theme/Topic
1	**Roberta Vena, LCSW** Philadelphia Department of Health, Ambulatory Health Centers	**Progressive Muscle Relaxation**
2	**Meridith Kim, PsyD** Esperanza Health Center	**Autogenic Training**
3	**Vincent Lamont, LPC** Delaware Valley Community Health	**Mindfulness**
4	**Lacondria Simmons, PsyD, Joel McIntosh, LCSW** Philadelphia Department of Health, Ambulatory Health Centers	**Readiness Ruler for Hypertension**

Levels of Intervention

LEVELS OF INTERVENTION WITH HYPERTENSION

Intervening with hypertension can be daunting at first for a BHC. The podcasts and tools we are providing seek to help ease your transition into assisting with hypertension and help you master success with the individuals you will be working with. You can think about your intervention using three levels as outlined in the chart below.

Level 1: Listen, Support, Validate, & Clarify Concerns/ Barriers ***(Supportive & Motivational Interviewing MI)***

Level 2: Address Comorbid Psychological Conditions ***(Brief Standard Interventions)***

- **Cigarette Smoking**---Functional Analysis, Urge Surfing/Coping Skills, Reduction, NRT interest
- **Depression/ Anxiety**---Standard BHC Interventions
- **Alcohol Use**--- SBIRT, Harm Reduction, Substance Use Interventions

Level 3: Address Health Behaviors & SMART Goals. ***(MI & Problem-Solving)***

- **Medication Adherence**--- Barriers, Chaining to Daily Activities/ Reminders, Values
- **Dietary Changes**--- Education on High Fat/High Sodium Foods, Gradual Substitution of Healthy Foods
- **Physical Activity Changes**---Barriers, Values, Pacing/Graduated Activity, SMART Goals

Level 1---Beginner/ Introduction: Listen, Support, Validate, & Clarify Concerns/ Barriers

- Uncontrolled hypertension can be quite challenging for both the patient and the provider.
  - On the primary care provider end, it can be frustrating when a patient does not seem to be complying or does not heed warnings about harmful long term impacts of uncontrolled hypertension.
  - On the patient side, behavioral change is not easy, or would be done simply. Changing diet, medication adherence, sleep, physical activity, weight, smoking, alcohol consumption, stress, depression, anxiety, and/or anger can involve a lot of starts and stops. Support, guidance, coaching, and ultimately a number of tries may be needed. It can be much harder when family members do not need to make the same changes, which can add stress and additional cost in meal preparation.
- Therefore, you can do a lot of good by helping providers outsource their stress, and helping individuals explore what they know about hypertension, what their strengths and successful changes have been so far, and looking at the barriers and stuck points they are facing.

- Just having a fresh conversation sometimes can provide new perspective that yields new changes and can help patient outcomes, increase patient satisfaction, reduce health costs and morbidity, and lower provider stress.

Level 2---Intermediate: Addressing Psychological Conditions and Stressors.

- As BHCs, we are quite familiar with depression, anxiety, trauma, alcohol use, and tobacco.
  - We know these conditions or unsuccessful quit attempts can cause distress and change someone's typical behavior.
  - The distraction and impact of these psychological conditions can interfere with the engagement in wellness and healthy behaviors.
  - Also, as covered in other sections of this toolkit, these conditions can influence overall health, including through the sympathetic nervous system and immune system, that can worsen hypertension.
- Core BHC interventions can be significantly beneficial in reducing psychological distress and helping address substance use behaviors, often in a limited number of visits.
  - Adressing Anxiety and Depression (and Anger) can yield symptomatic change through a host of evidence-based techniques such as:
    - Cognitive-Behavioral Therapy
    - Solution-Focused Therapy
    - Third Wave Approaches (ACT, DBT, MBCT)
    - Problem-Solving Therapy
    - Stress Management and/or Behavioral Activation
    - Brief Dynamic Therapy
  - Smoking cessation or reduction can benefit from a variety of behavioral, cognitive, and mindfulness strategies, often coupled with psychoeducation, motivational interviewing, and goal-setting.

- Functional analysis involves looking at the frequency, intensity, duration, triggers, and outcomes of behaviors. With smoking, it can be highly important to look at baseline smoking and what increases or decreases smoking in an individual.

- Stress reduction techniques, in advance, can help cope with cravings and triggers, such as stress, when the person begins to reduce smoking.

- "Urge surfing" and/or "snoozing a cigarette" involve trying to systematically and gradually increase the time from craving to smoking, using metacognitive and distraction strategies. As someone gets in the "habit" of waiting longer and longer to smoke from environmental and physiological cues, they are eventually able to decrease cigarette smoking and ride out cravings as they seek to stop.

- Behavioral strategies seek to limit access to cigarettes, reduce common distractors and reinforcers that come with smoking (e.g., looking at phone, socializing), and barring smoking from certain areas (e.g. someone's home).

- Nicotine replacement therapies (NRT), such as medication and the suite of nicotine patches, lozenges, gum, and inhalers can help to reduce nicotine cravings and help breakthrough the "trampoline" floor most smokers hit (and bounce back up) with a reduction to around 3-7 cigarettes. Best practice guidelines recommend a long-acting (e.g. medication or patch) and a short-acting (e.g., inhaler or lozenges or gum) can be used in combination to help reduce and cope with cravings to smoke.

    - [Article]: Effectiveness of different forms of nicotine replacement therapy in helping people give up smoking

- Problematic alcohol use also responds to core BHC interventions that you may commonly use at your health setting.

    - Universal screening of alcohol use to identify problematic or risky use.

    - Screening, Brief Intervention, and Referral to Treatment (SBIRT).

    - Motivational Interviewing and Motivational Enhancement approaches to explore motivation to utilize alcohol, stage of change, consciousness raising, and help guide toward change when the person is ready.

    - Behavioral and cognitive strategies that can reduce alcohol use or enhance sobriety, including change planning, functional analysis, trigger awareness, alternating alcohol and other beverages, and planning schedules.

    - Helping to explore peer-guided supports for problematic alcohol use.

Level 3---Advanced: Addressing Health Behaviors & SMART Goals

- Medication adherence is one of the core pillars of working toward controlled hypertension.
    - Insufficient medication engagement can occur for a number of reasons, including perceived side-effects, low perceived sense of needs, or challenges in forming a new habit of regularly taking a medication.
    - Side-effects can often be discussed with the primary care provider, and some may be transient, or a medication substitution can occur to reduce that specific concerning side-effect.
    - Motivational interviewing, values inventory, and psychoeducation/"teach back" can be useful in exploring low perceived value of anti-hypertensive medication for a given patient.
    - BHCs can be very helpful in the behavioral change of starting a daily routine of taking medication.
        - Assessment of barriers to taking medication, and motivational interviewing to explore readiness and desire can be useful
        - Using behavioral strategies such as chaining to an existing, consistent part of the person's day (e.g. toothbrushing or meals), reminders (e.g., cell phone alarm or pop-up reminder in your calendar), and engaging social support to encourage and remind can be useful. That can eventually be phased out to simply placing medication out or a picture on the refrigerator that serves as a symbolic trigger not to forget to take medication.
- Dietary changes can often be useful for hypertension. Behavioral, cognitive, mindfulness, and motivational interventions can be useful.
    - The DASH diet (Dietary Approaches to Stop Hypertension) can be helpful in reducing high-fat and high-sodium foods. As you can imagine, these are often comfort foods and may be well ingrained in your individual's life. Psychoeducation, motivational interviewing, goal setting, and self-driven reinforcement can help work toward building healthy habits.
    - Portioning and food substitution can be helpful to reduce food intake and help aid weight management (in combination with activity). It also can help with achieving reduced sodium and fat. Assisting with education, changes, cravings, and assisting to get to habit instillation can be useful by a BHC.
    - Seeking to do gradual substitutions (one preferred item at a time, or slowly reducing added salts or sodas) can be helpful as well.

- Increasing physical activity is another positive approach for many people with uncontrolled hypertension. However, we know this is often not a preferred wish by many individuals and can be challenging to start and maintain.

    - Once again, values assessment, exploring personal history of activity and exercise, functional assessment, and motivational interviewing can be useful to enhance understanding and work toward shared goals.

    - SMART goals, gradual activity pacing, and adding in reinforcers for hitting goals and/or milestones can be ways to increase activity, as well as the additive benefit of your support and encouragement, as a BHC, and also enlisting the health care team in this activity.

    - Also looking to "gamify" activity, whether through a personal accelerometer (e.g., Fitbit or step counter), a video game system that uses movement (e.g. Wii), or competitions with family, friends, or peers, can also yield positive results.

As your comfort with assisting individuals with uncontrolled hypertension grows, there are several additional resources in this toolkit section that can guide you.

- "The Goals for a BHC Hypertension Visit" provides a step-by-step guide, using the 5As approach to integrated care to assist with hypertension in a BHC visit (i.e., Ask, Assess, Advise, Assist, Arrange). It provides different levels of intervention starting with the basics above.

- "High Blood Pressure Confidence Scale" helps guide psychoeducation to a patient on hypertension and reviews a patient's readiness and perceived importance to tackle five factors that can adversely impact blood pressure management: weight management; dietary changes; physical activity; medication adherence; stress management. This worksheet can help frame the beginning of SMART goal development and determining the best fit intervention.

- "Hypertension Card Sort" is another approach to help prioritize concerns. It is an approach in which a low importance card is placed to the far left, and a high importance card is placed to the far right. Then the person is able to place a number of hypertension reduction strategies on this continuum, to help the BHC/IBHP and patient collaboratively develop the most logical starting point, given their readiness.

- "Distress Scale for Diabetes & Hypertension" is a brief tool that can assess the degree to which some experience distress secondary to their chronic health concerns. These subjective distress symptoms can act as barriers to effective self-management or making personal health changes.

Structure of a BHC Hypertension Visit

GOALS FOR A BHC HYPERTENSION VISIT: DECISIONAL AID

Build rapport.

Understand what may be getting in the way of the person achieving blood pressure control.

Think in terms of stages of change and readiness.

Collaboratively determine 1-2 targets to address.

Develop an action plan.

A couple of reminders for the visit

- Let Motivational Interviewing guide your intervention.

MI Skills: Elicit-Provide-Elicit, Reflecting meaning/feeling, Open-ended questions, Clarifying questions, Stages of Changes, Importance/Confidence Ruler

- Review the "If you are stuck" box below to help you in case you are having trouble getting the visit focused on the visit's goals.

If You Are Stuck: Blood pressure is influenced by a lot of things and can be hard to manage. I hope we can find one thing that you can address simply in your (busy) life that may help your overall health.

How does that sound?

Greeting and BHC Introduction

Make sure to include health concerns in your BHC introduction.

ASK Quickly frame the agenda for today's visit.

- o Your care team indicated your blood pressure has been high, would it be okay if we take a few moments to review this?

ASSESS Learn more about hypertension in their life.

- o See what they understand about hypertension/ high blood pressure.
- o Does Depression, Anxiety, Substance Use seem to be in play? Feel free to screen.
- o Do they have a sense of what strategies they can take to manage their blood pressure?
- o (OPTIONAL): Utilize (a) Hypertension and/or Diabetes Distress Scale; (b) Readiness Scale; and/or (c) HTN Importance Scale or HTN Decisional Aid Card Sort (see accompanying podcasts).

ADVISE Review factors that can affect blood pressure

- o Discuss how cigarette smoking, medication non-adherence, alcohol use, limited physical activity, high sodium/high fat food, high stress, high anxiety, and high depression can affect blood pressure.
- o Can use priority cards to have them sort the main issues from low to high importance

ASSIST Address underlying concern (pick level based on assessment & BHC skill)

Level 1: Listen, Support, Validate, & Clarify Concerns/ Barriers (Supportive & Motivational Interviewing MI)

Level 2: Address comorbid psychological conditions (Brief Standard Interventions)

- o Cigarette Smoking---Functional Analysis, Urge Surfing/Coping Skills, Reduction, NRT interest
- o Depression/ Anxiety---Standard BHC Interventions
- o Alcohol Use--- SBIRT, Harm Reduction, Substance Use Interventions

Level 3: Address Health Behaviors & SMART Goals. (MI & Problem-Solving)

- o Medication Adherence--- Barriers, Chaining to Daily Activities/ Reminders, Values
- o Dietary Changes--- Education on High Fat/High Sodium Foods, Gradual Substitution of Healthy Foods
- o Physical Activity Changes---Barriers, Values, Pacing/Gradual, SMART Goals

ARRANGE Self-Management, Follow-Up?, Referral???

Clinical Tools

USEFUL TOOLS FOR A BHC VISIT ON HYPERTENSION

(1) HIGH BLOOD PRESSURE CONFIDENCE SCALE

Blood pressure is defined by two numbers, your systolic blood pressure and your diastolic blood pressure. Your systolic blood pressure is the pressure in your arteries when your heart is squeezing blood out to your body. The systolic blood pressure is represented by the top number of your blood pressure reading. Your diastolic blood pressure is the pressure in your arteries when your heart is relaxed; it is represented by the bottom number of your blood pressure reading.

What was your last blood pressure reading? Systolic = _____ Diastolic = _____
Often, you don't feel sick when you have high blood pressure. Except for the numbers on the blood pressure monitor, there may not be any other indication your blood pressure is high. Below is a table we can use to classify your blood pressure. How would you classify your blood pressure?

Blood Pressure Classification	SBP mm Hg	DBP mm Hg
Normal	<120	and < 80
Elevated	120-129	and < 80
Stage 1 Hypertension	130-139	or 80-89
Stage 2 Hypertension	at least 140	or at least 90

SBP = systolic blood pressure; DBP = diastolic blood pressure.

Source: American College of Cardiology, November 13, 2017
Hypertension Staging

Making Changes

Many different factors affect your blood pressure. Some of these factors you may be able to change, other factors you can't change. By making changes where you can, you can lower your blood pressure. The following is a listing of some of the factors that you can change.

How important is it to you to make these changes? If it doesn't apply or if it is not important, rate it a zero (0). If it is important, what steps can you take to make changes?

Tobacco Use

Quitting tobacco use is one of the most important health behavior changes you can make. If you are a nonsmoker, great! If you currently smoke, have you considered quitting?

How important to you is it to quit smoking?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If tobacco cessation is important to you, what is your plan to quit tobacco?

_____

_____

Weight Management

If you are overweight or obese, even small reductions in your weight (e.g., 10 pounds) can have a significant impact on your blood pressure. Weight loss requires a reduction in the number of calories you eat or drink and an increase in your physical activity.

How important is it to you to lose weight?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If weight loss is important to you, what can you do to start making changes in your eating, drinking, and physical activity habits?

_____

_____

Dietary Changes

Beyond weight loss, it is important to consider changing what you eat to reduce your blood pressure. A special diet called the DASH diet is often encouraged for individuals with high blood pressure. The DASH diet encourages you to decrease the amount of salt and fat in your diet while increasing the amount of potassium and fiber you consume. Often these changes require simple substitutions in your diet, such as replacing salt with other spices and choosing lower fat alternatives to your typical foods.

How important is it to you to change your diet?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If dietary changes are important to you, what are some of the foods that you are willing to substitute or eliminate from your diet?

_____

_____

Physical Activity

To improve cardiovascular health, it is recommended that you engage in 30 minutes of moderate intensity activity at least 5 days a week or vigorous intensity activity for 20 minutes at least 3 days a week.

How important is it for you to meet these activity recommendations?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If physical activity changes are important to you, how can you incorporate moderate or vigorous activities into your daily life?

_____

_____

Medication Adherence

If your blood pressure is in the hypertensive range, you may have been prescribed one or more medications to help you lower your blood pressure. However, the effectiveness of the medications depends on individuals taking them as they were prescribed.

How important is it for you to change the way you take your medications?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If medication adherence is important to you, what are some of the techniques you can use to manage your medications more effectively?

_____

_____

Stress Management

The stressors that you experience can contribute to higher blood pressure levels. You can manage stressors differently by changing the way you think or what you do and by using relaxation techniques.

How important is it for you to manage your stress response?

0-------1-------2-------3-------4-------5-------6-------7------8-------9-------10 N/A

Not important *Most Important*

If stress management is important to you, what are some of the techniques you can use to manage stressors more effectively?

_____

_____

(2) Instructions for Card Sort for Managing Hypertension

Similar to the High Blood Pressure Confidence Scale, this is a tool to help you work collaboratively with your person with uncontrolled hypertension to identify targets, and subsequent strategies.

You can print out the next two sheets and cut out the individual cards (See Card Sort for Managing Hypertension). Use the low importance and high importance cards as anchors for the continuum. You can then instruct the patient to sort out the following strategies, which are all effective approaches to address hypertension.

A video is included to help guide you through the easy use of the card sort.

Key tenets

1. Ask permission to do a quick exercise.

2. Discussion: We look at several strategies to help you best manage hypertension. The goal is to find the approaches that seem most relevant to your life and that you are most ready to do. Some strategies may not apply to you. Some strategies may apply to your life, but you might not be ready to start those yet. Others will seem very do-able and we can start to work on them today.

3. Discuss the continuum, putting low importance on the patient's left, and high importance on the patient's right, with enough space to put various cards in between.

4. Provide each card one by one and ask the person to place it on the continuum for how much it fits with their readiness and their needs.

5. Review the top 2-3 cards with the highest importance to the person and identify those as potential starting places to effectively intervene in controlling hypertension. Confirm those are indeed important and doable.

6. Discuss the interventions you might be able to do to address their top concerns. (Pro-Tip, ask them first what do they currently do or could do to address each of their top concerns, before providing your thoughts).

7. Take a moment to note the next few ranked options (#3-6) in your chart, as future targets.

8. Review how helpful this exercise was with the patient.

Reduce Cigarette Smoking
Reducir Fumar Cigarrillos

Take Hypertension Medicine
Tomar Medicamentos Para la Hipertension

Reduce Substance Use
Reducir el Consumo de Sustancias

Increase Physical Activity
Aumentar la Actividad Fisica

Reduce High Sodium / High Fat Foods
Reducir los Allimentos con Alto Contenido de Sodio / Grasa

Reduce Anxiety
Reducir Ansiedad

Reduce Depression
Reducir Depresion

Reduce Stress
Reducir el Estres

Low Importance
Baja Importancia

High Importance
Alto Importancia

(3) Distress Scale for Diabetes & Hypertension 2 Potential Problem Areas (DSDH2M)

The following tools have been validated for use with patients diagnosed with both diabetes and hypertension and to address adjustment to both conditions.

DIRECTIONS: Living with hypertension and/or diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and/or hypertension, and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 2 potential problem areas that people with diabetes and/or hypertension may experience. Consider the degree to which each of the 2 items may have distressed or bothered you *DURING THE PAST MONTH* and circle the appropriate number.

Please note that we are asking you to indicate the degree to which the item may be bothering you in your life, NOT whether the item is merely true for you. If you feel that a particular item is not a bother or a problem for you, you would circle "1". If it is very bothersome to you, you might circle "6".

	Not a Problem	A Slight Problem	Moderate Problem	Somewhat Serious Problem	Serious Problem	Very Serious Problem
1. Feeling overwhelmed by the demands of living with diabetes and/or hypertension	1	2	3	4	5	6
2. Feeling that I am often failing with my diabetes and/or hypertension routine	1	2	3	4	5	6

(4) Distress Scale for Diabetes & Hypertension 17 Potential Problem Areas (DSDH17M)

DIRECTIONS: Living with hypertension and/or diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and/or hypertension, and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 17 potential problem areas that people with diabetes and/or hypertension may experience. Consider the degree to which each of the 17 items may have distressed or bothered you *DURING THE PAST MONTH* and circle the appropriate number.

Please note that we are asking you to indicate the degree to which the item may be bothering you in your life, NOT whether the item is merely true for you. If you feel that a particular item is not a bother or a problem for you, you would circle "1". If it is very bothersome to you, you might circle "6".

	Not a Problem	A Slight Problem	Moderate Problem	Somewhat Serious Problem	Serious Problem	Very Serious Problem
1. Feeling that diabetes and/or hypertension is taking up too much of my mental and physical energy every day.	1	2	3	4	5	6
2. Feeling that my health provider doesn't know enough about diabetes and/or hypertension.	1	2	3	4	5	6

	Not a Problem	A Slight Problem	Moderate Problem	Somewhat Serious Problem	Serious Problem	Very Serious Problem
3. Feeling angry, scared, and/ or depressed when I think about living with diabetes and/or hypertension	1	2	3	4	5	6
4. Feeling that my health provider doesn't give me clear enough directions on how to manage my diabetes and/or hypertension	1	2	3	4	5	6
5. Feeling that I am often failing with my diabetes and/or hypertension routine	1	2	3	4	5	6
6. Feeling that I am not testing any blood sugars and/or blood pressure frequently enough.	1	2	3	4	5	6
7. Feeling that friends or family are not supportive enough of self-care efforts (e.g., planning activities that conflict with my schedule, enouraging me to eat the "wrong" foods)	1	2	3	4	5	6
8. Feeling that diabetes and/or hypertension control my life.	1	2	3	4	5	6
9. Feeling that my health provider doesn't take my concerns seriously enough.	1	2	3	4	5	6
10. Not feeling confident in my day-to-day ability to manage diabetes and/or hypertension.	1	2	3	4	5	6
11. Feeling that I will end up with serious long-term complications, no matter what I do.	1	2	3	4	5	6
12. Feeling that I am not sticking closely enough to a good meal plan.	1	2	3	4	5	6
13. Feeling that friends or family don't appreciate how difficult living with diabetes and/or hypertension can be.	1	2	3	4	5	6
14. Feeling overwhelmed by the demands of living with diabetes and/or hypertension.	1	2	3	4	5	6
15. Feeling that I don't have a health provider who I can see regularly enough about my diabetes and/or hypertension.	1	2	3	4	5	6
16. Not feeling motivated to keep up my diabetes and/or hypertension self-management	1	2	3	4	5	6
17. Feeling that friends or family don't give me the emotional support that I would like.	1	2	3	4	5	6

INSTRUCTIONS FOR SCORING:

The DSDH2M is a screener to identify possible diabetes- and/or hypertension-related distress. A total score of ≥ 6 warrants the utilization of the DSDH17M with an individual.

The DSDH17M yields a total distress scale score plus 4 subscale scores, each addressing a different kind of distress. To score, simply sum the patient's responses to the appropriate items and divide by the number of items in that scale. The letter in the far-right margin corresponds to that item's subscale as listed below. We consider a mean item score of 3 or higher (moderate distress) as a level of distress worthy of clinical attention. Place a check on that line to the far right if the mean item score is ≥ 3 to highlight an above-range value.

We also suggest reviewing the patient's responses across all items, regardless of mean item scores. It may be helpful to inquire further or to begin a conversation about any single item scored 3 or higher.

Total DSDH Score:

a. Sum of 17 item scores. _____

b. Divide by: 17

c. Mean item score: _____ ≥ 3 _____

A. Emotional Burden:

a. Sum of 5 items (1, 3, 8, 11, 14) _____

b. Divide by: 5

c. Mean item score: _____ ≥ 3 _____

B. Physician-related Distress:

a. Sum of 4 items (2, 4, 9, 15) _____

b. Divide by: 4

c. Mean item score: _____ > 3 _____

C. Regimen-related Distress:

a. Sum of 5 items (5,6,10,12,16) _____

b. Divide by: 5

c. Mean item score: _____ ≥ 3 _____

D. Interpersonal Distress:

a. Sum of 3 items (7,13,17) _____

b. Divide by: 3

c. Mean item score: _____ ≥ 3 _____

Billing Considerations for Reimbursement of Behavioral Health Interventions for Hypertension

BILLING FOR UNCOTROLLED HYPERTENSION IN BEHAVIORAL HEALTH INTERVENTIONS

One of the fundamental questions in integrated primary care is whether any given intervention is billable, and under what mechanism. These questions have varying answers, depending on the individual patient's insurance status, insurance type, and the local behavioral health reimbursement policies.

Medicaid. It is important to determine whether your agency has established reimbursement for integrated behavioral health with your regional payer, whether that is an accountable care organization (ACO), behavioral health managed care organization under PA Health Choices (BH MCO), or a commercial insurance payer. A second question is whether behavioral health reimbursement is available for addressing behavioral or psychological factors related to hypertension without a behavioral health diagnosis.

For example, in Pennsylvania, the BH-MCOs are required to contract with FQHCs for the provision of integrated BH services. Integrated behavioral health providers can bill for addressing the behavioral and psychological factors associated with uncontrolled hypertension (i.e., DSM-5 code: F54) or via associated comorbid psychological disorders (e.g., major depression, anxiety, tobacco dependence, substance use). The standard integrated billing code, CPT code 90832 is used for this type of intervention, especially when the duration of the visit is 16 minutes or longer and can be billed by a licensed mental health provider (e.g., professional counselor, marriage and family therapists, clinical social workers, and psychologists).

The F54 diagnostic code may be utilized when the patient has been diagnosed with hypertension and it is (a) temporally linked to psychological factors in the development, exacerbation, or delayed recovery of the condition (e.g., apathy reduced engagement in care); (b) impacted by behavioral factors that interfere with treatment of medical condition (i.e., low adherence to care); (c) present with other well-established health risks for the individual (i.e., sedentary lifestyle); and/or (d) contextual psychological and behavioral factors can impact the presentation of the symptoms (e.g., daily stress and anxiety dysregulates hypertension).

Health & Behavior Codes (Medicaid and Medicare). Another option for reimbursement is the CMS Health & Behavior Assessment and Intervention codes (HABI), that allow for billable reimbursement for assessment and intervention on a health behavior (https://www.apaservices.org/practice/reimbursement/health-codes/billing-guide.pdf). These are likely to be reimbursed at a lower rate than standard behavioral health intervention codes (e.g. 90832) and are useful when there is not necessarily a direct behavioral/ psychological link to the health concern, or existing reimbursement does not apply to F54 codes. The following table provides the initial 30 minutes and the subsequent modifier code for each additional 15 minutes.

CPT ® Codes, Effective January 1, 2020

Category	Initial Code (Initial 30 minutes)	Descriptor	Each Additional 15 Minute Code
Assessment (or reassessment)	96156	Health behavior assessment or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)	N/A
Individual Intervention	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	96159
Group Intervention	96164	Health behavior intervention, group (with the patient present), face-to-face; initial 30 minutes	96165
Family Intervention WITH Identified Patient Present	96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	96168
Family Intervention WITHOUT Identified Patient Present	96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	96171

https://www.apaservices.org/practice/reimbursement/health-codes/descriptors.pdf

Codes are intended to be used in combination. If a provider does an initial health assessment and a subsequent 30-minute intervention, the encounter would be coded with and billed for both a 96156 and 96158. If a provider does an hour-long health group, they would bill the encounter as 96164, 96165, and 96165, or in other words, one 96164 code for the initial group half hour, and two 96165 codes for each additional 15 minutes. HABI Codes can be used by state-licensed psychologists and licensed clinical social workers. Further advocacy is being sought for licensed professional counselors and marriage & family therapists at this time, but these professionals are not able to use Health & Behavioral CPT codes, as of July 2020 with Medicare.

Examples of Appropriate & Inappropriate Use of HABI

Allowable use of HABI	Not Allowable
• Hypertension with health behavior factors • New diagnosis of a chronic condition • Preparing patients for a new procedure • Prehypertensive/ Prediabetes • Medication adherence • Preparing for labor and delivery • Pregnancy loss • Cancer	• To provide personal, social, recreation and general support services (including case management) • Update family on patient's condition • Treatment planning with staff • Maintaining wellness and good health • Tobacco or caffeine withdrawal / stop • Medical family therapy

•Courtesy of Suzanne Daub (2020)

Private Insurance. Many private insurance carriers are reimbursing for the CPT Health & Behavior Codes. Please consult with your billing officer / department or the specific insurance carrier to determine if these codes are part of the reimbursable services.

Additional Resources. Codes have also been established for Psychiatric Collaborative Care Model. If your practice is working out of this model, or you are interested in more information, please reference the following link: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Ideas for Generating Referrals for Uncontrolled Hypertension to the BHC

Techniques to increase BHC Uncontrolled Hypertension Referrals

In this section, you will be provided with a quick overview of strategies to increase BHC referrals from the primary care provider.

Curbside Consultations and EHR Messages to Providers: Include Hypertension

A simple and effective way to increase uncontrolled hypertension referrals is to show your awareness and willingness to take on the referrals. Our BHCs have found that asking about hypertension and other chronic diseases in patient consultations, and sharing with the primary care provider that this was addressed in the consultation, can reveal BHC interest and capability. Sharing positive success stories from BHC work in provider curbsides or during interdisciplinary meetings can pique primary care provider interest and be seen as an exciting opportunity to address individuals that aren't progressing.

A more introductory way is to simply ask your provider about the medical and physiological science behind hypertension. In general, health providers like to teach, so if you are willing to show courage in admitting your naivete or limited knowledge, and clearly indicate you are interested in doing more, they can reward you with valuable education. If providers are skeptical of the value of BHC involvement in hypertension, consider sharing the evidence section of this toolkit that lays out the research base for the BHC role.

Outreach Materials

Pamphlets about behavioral health consultation can include a number of chief concerns that a BHC can address. Including high blood pressure in these materials can potentially increase interest from patients. Similarly, putting fliers in patient care rooms or the waiting room (with health center permission), can also be a way to increase health behavior referrals.

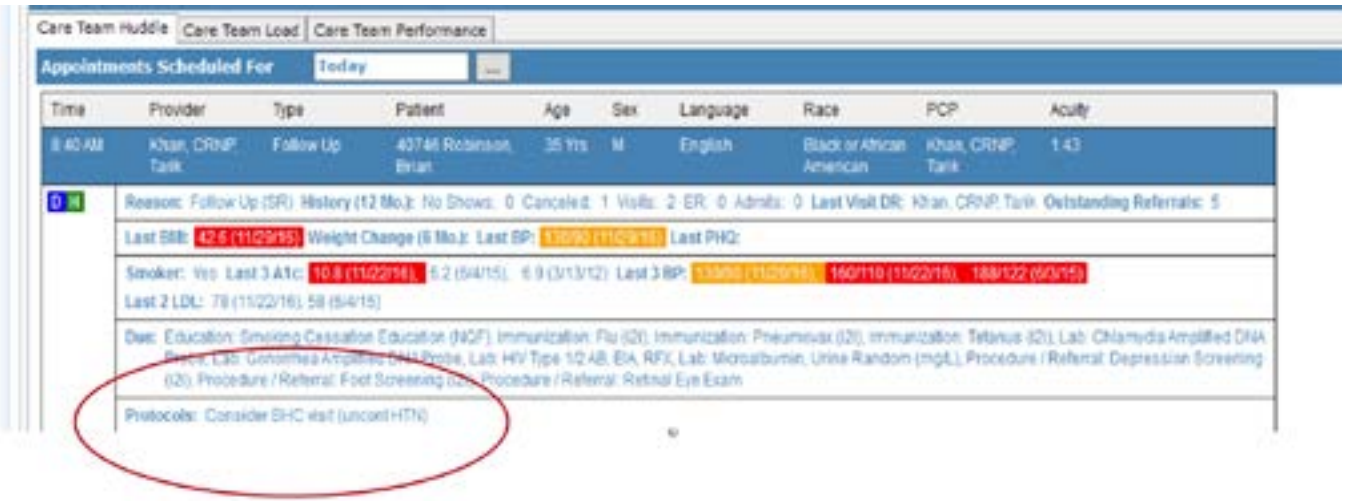
Outreach to Other Care Team Members

A variety of approaches can be useful to increase the health care team's awareness. The topic of assisting with uncontrolled health conditions, like hypertension, can be part of new primary care provider and health care team onboarding. It can also be important to do a booster training when that health care team member has been in their position for 3-6 months and has become more settled in their role. At that point, you can remind that person of some of the additional options for referral to a BHC. Also, if you regularly send out emails, newsletters, or reminders to staff members, mention that you are interested in receiving referrals for hypertension.

Using Population Management Tools: Adding Uncontrolled Hypertension to Huddle Sheets and Flagging for BHC Referral

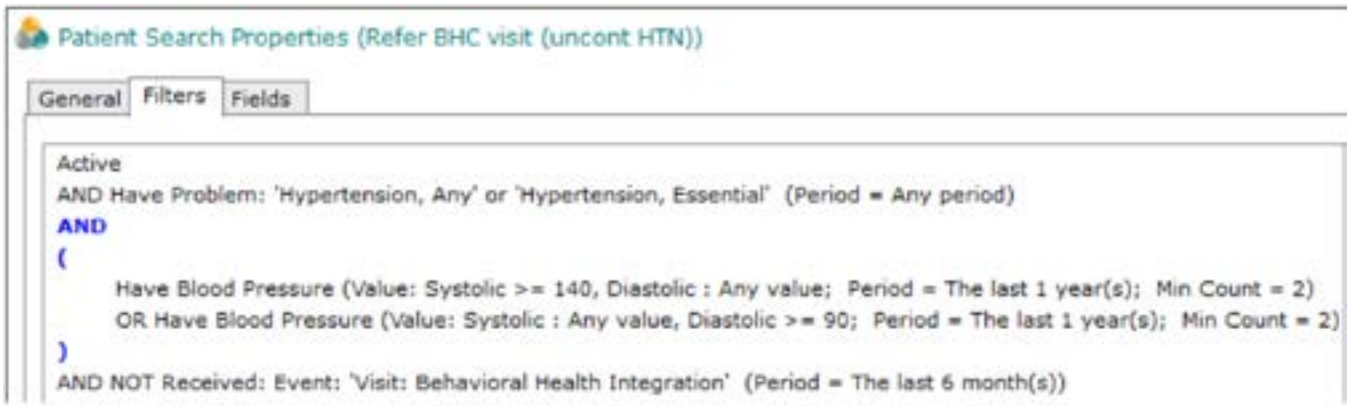
One way that some health centers have supported referrals to behavioral health consultants is through protocols on i2i huddle sheets. If a health center is using i2i huddle sheets, or another comparable pre-visit planning tool, these can serve as a prompt to members of the care team to engage the BHC when certain health conditions are present.

For example, a protocol might prompt the Medical Assistant to engage the BHC when a patient has a diagnosis of hypertension and has had two uncontrolled blood pressures over the past six months. Below is an example of a huddle sheet that has a protocol to refer to the BHC for uncontrolled hypertension:



Protocols are set up as "searches" in i2i based on the patient characteristics that should trigger the action. When these searches are placed in the "protocols" search category, they will appear on the huddle sheet. The title of the search is the text that appears on the huddle sheet. Below is an example of a search definition that would trigger the protocol above to appear on the huddle sheet:

Refer BHC visit – uncontrolled Hypertension



Thank you for utilizing our **Behavioral Health Consultant Hypertension Toolkit**!

The Health Federation of Philadelphia thanks you for what you do and wishes you well in your important work. If you have questions, input, or suggestions regarding this toolkit, **please contact Modupeola Dovi, MPH, Project Manager: mdovi@healthfederation.org or 215-567-8001, ext. 3038**.

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The keystone of community health since 1983