Behavioral Health Support for Hypertension Management

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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*

Purpose

- Hypertension ("high blood pressure") is a highly prevalent condition, affecting 25% of American adults
  - Uncontrolled blood pressure (50% of those with HTN) can contribute to significant morbidity and mortality related to cardiovascular, renal, subjective distress, and other health concerns
- The purpose of this talk is to increase awareness of how valuable behavioral health providers can be in helping hypertension
- Behavioral health providers can apply their clinical techniques and approaches to help psychological AND health conditions
- Application of these approaches, we will discuss, can improve patient outcomes, address the inequity in hypertension, reduce demand/frustration on care team, and contribute to financial incentives of meeting meaningful use measures

Overview

- Background
- Overview of the "Behavioral Health Consultant Hypertension Toolkit"
- Introduction of key components:
  - Levels of a Behavioral Health Hypertension Visit—Simple to Advanced
  - Structure of a Behavioral Health Hypertension Visit
  - Tools, Resources, and "Tricks of the Trade"
- Apply to a case: A walkthrough
- Discuss a second case
- Questions and Answers

Conflict of Interest Statement

- No conflict of interest. This presenter (TC) works as an independent contractor for Health Federation of Philadelphia, and is not receiving financial support from this organization for this presentation and the toolkit is freely accessed. This presenter is being paid a nominal stipend for sharing this information
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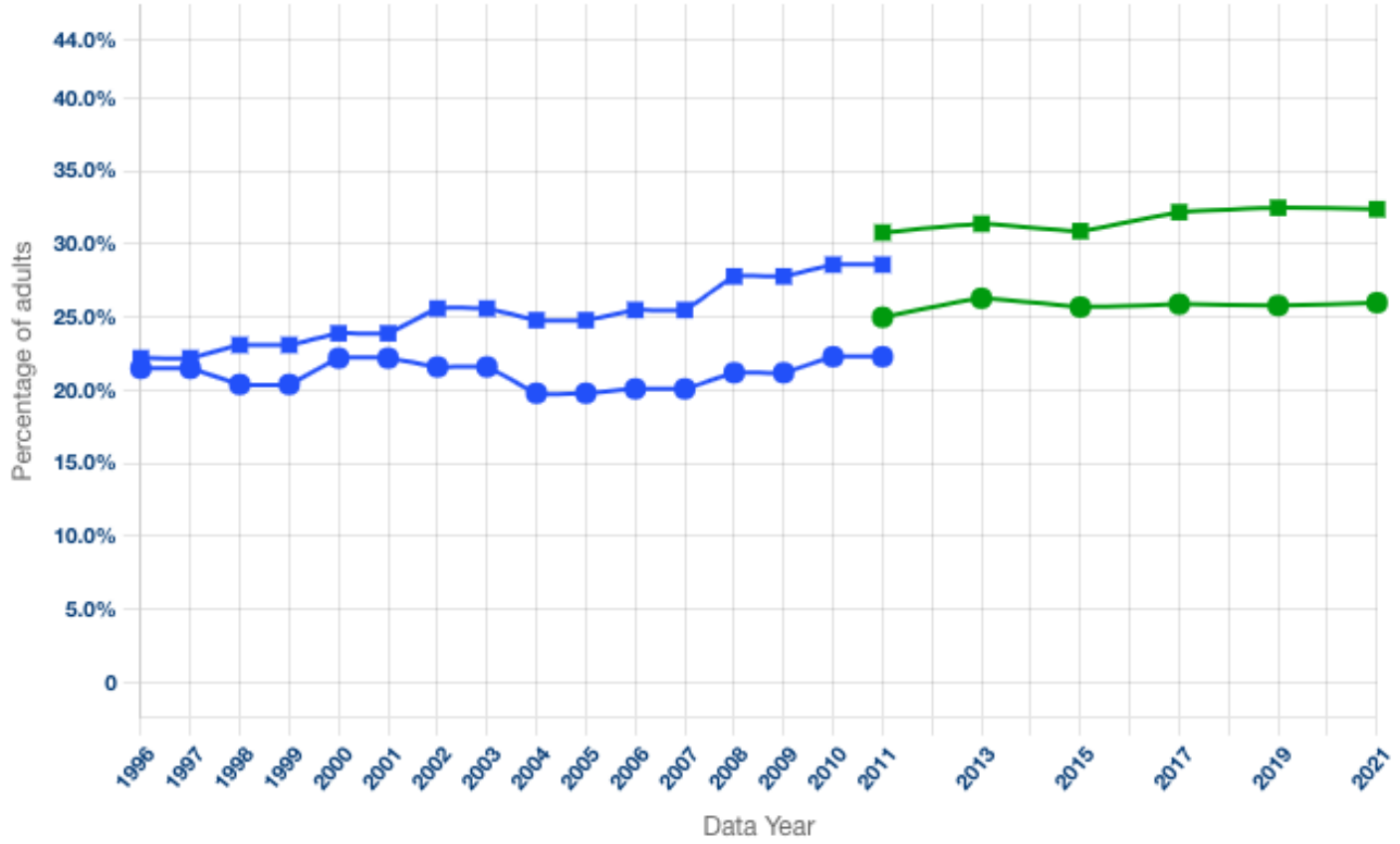
Background

- Hypertension is widely prevalent (32% of adults, 50% have varying degrees of limited/uncontrolled blood pressure)
- Hypertension (HTN) is disproportionally experienced in those with increased impact of social determinants of health, those in BIPOC communities, and/or in those that are prescribed antipsychotic medications
- Colorado has one of the best rates in the country, yet 26% of Coloradoan adults have HTN and the rates have been increasing over the last decade
- Risk is higher in older those with lower incomes, males, and Black, Indigenous, and People of Colour (BIPOC) Coloradoans

America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, https://www.americashealthrankings.org/explore/annual/measure/Hypertension/state/CO . Accessed March 25, 2023

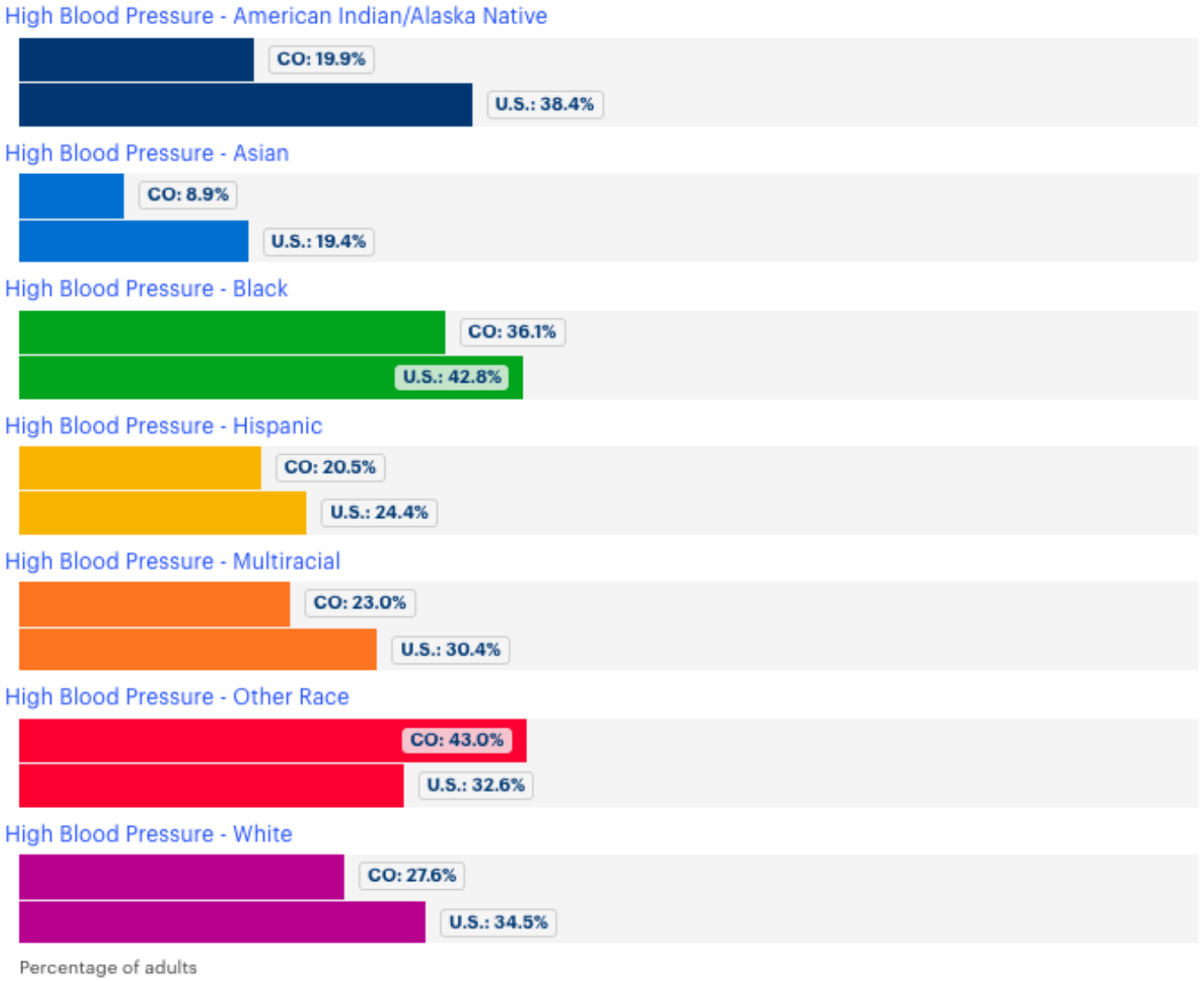
Trend: High Blood Pressure in Colorado, United States



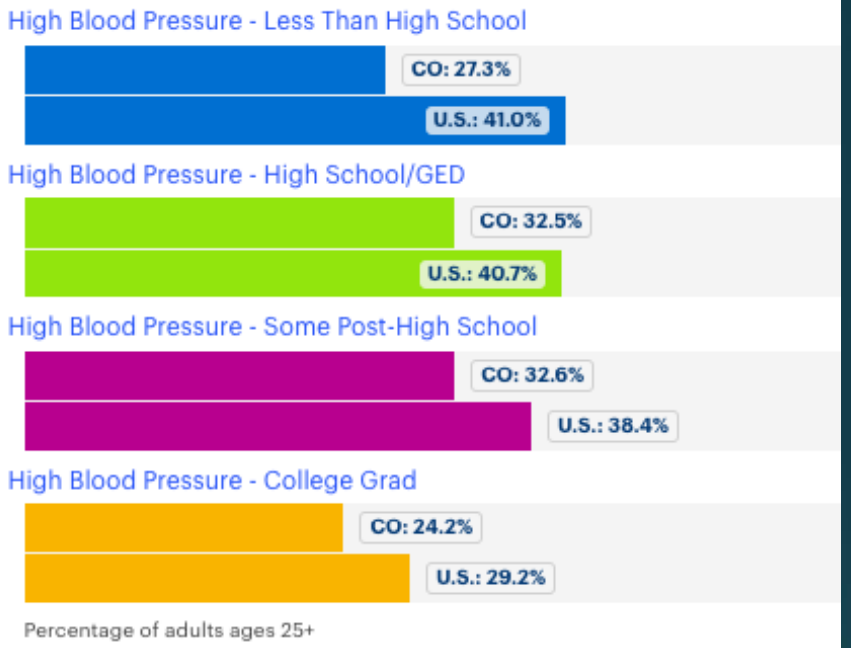
Percentage of adults who reported being told by a health professional that they had high blood pressure

● Colorado ■ United States

RACE/ETHNICITY



EDUCATION

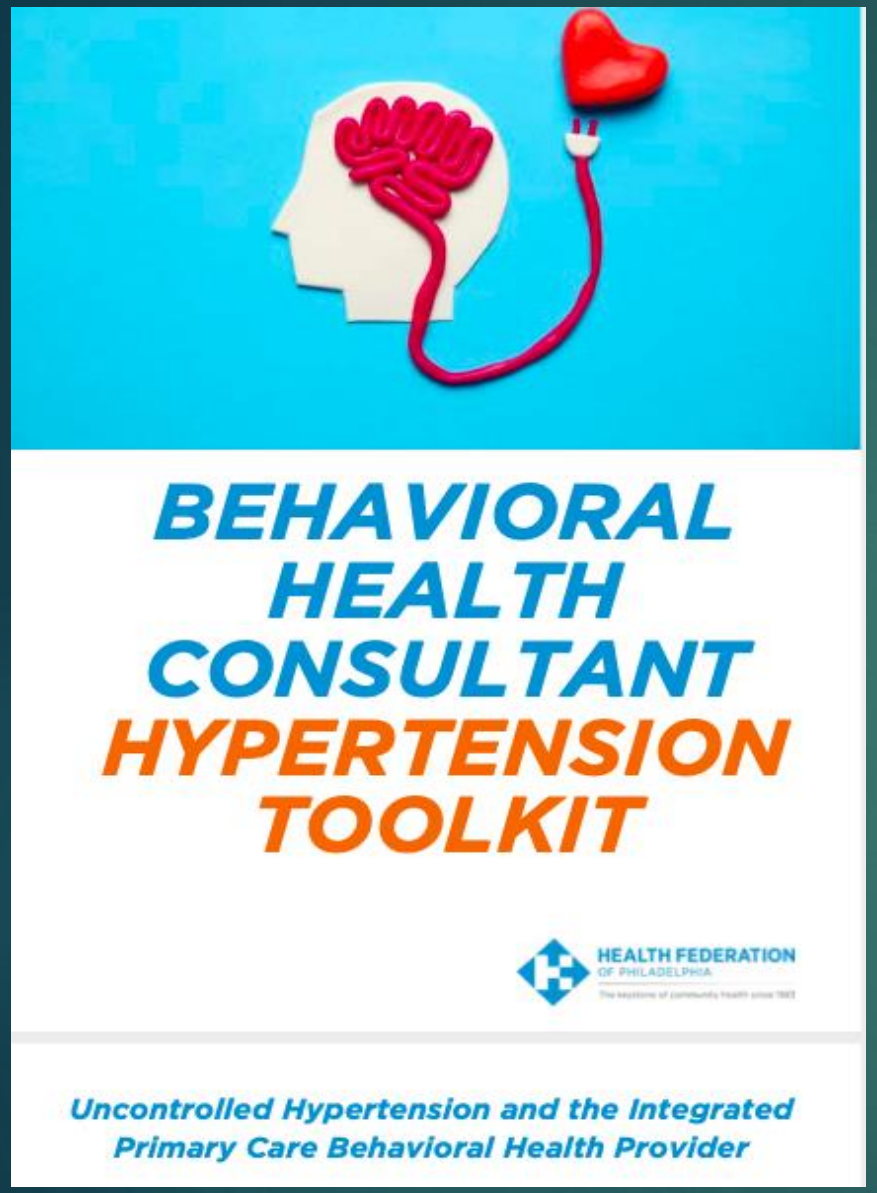


How Do We Help Those with Hypertension or Risk of Heightened Blood Pressure

- "Once diagnosed, however, it can be controlled through a combination of diet, exercise and medication. High blood pressure is influenced by risk factors that can be modified, such as smoking, obesity, physical inactivity, poor diet (eating foods high in sodium and low in potassium), (medication adherence) and excessive alcohol use." (American Health Rankings, 2022).
- Anxiety, depression, and trauma can affect blood pressure through its disruptive effect on nervous system, immune system, and other feedback systems within the body, that in turn affect our daily activities and behaviors.
- These are behavioral targets that can be addressed through common tools of behavioral health: psychoeducation, motivational interviewing, SMART goals, skill training, self-monitoring progress, and use of troubleshooting clinical interventions

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.



The Toolkit was developed as an activity of the Health Federation of Philadelphia, a nonprofit public health organization that works with a network of Federally Qualified Health Centers to advance access to high-quality, integrated, and comprehensive health and human services.

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"I don't know this seems out of my scope of competence, I don't know much about Hypertension"

- Options for Education
- https://healthfederation.org/behavioral-health-consultant-hypertension-tookit
- https://healthfederation.us14.list-manage.com/track/click?u=b6ca2b398ce57a160b425f7c5&id=7ea416a0b7&e=43b0dc1449
- https://www.youtube.com/watch?v=kxJVyR0OB6E&feature=youtu.be
-

Levels of a Behavioral Health Hypertension Visit—Simple to Advanced

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

These are nestled within an attitude of:

- Support
- Appreciation of the Individual's Life Context, Values, and Stage of Change
- Permission-Seeking and Collaboration
- Innovation and Creativity
  - (e.g., Gamifying with personal accelerometers; Use of Apps; Involving Family Systems)

Structure of a Behavioral Health Hypertension Visit

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?

Structure of a Behavioral Health Hypertension Visit

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).

Structure of a Behavioral Health Hypertension Visit

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

https://lasalle.zoom.us/rec/play/BsQbcaZAFPy09ANabiOBrpS9LmiCNikb-UauNg1LezbtHtcX-xuMAzHGni52H0BBarPsdHFxQyVv2bGN.TARCd91v9R5EZIDg?startTime=1611274791000&_x_zm_rtaid=ZljFMhj9S12ahJymhGBtaA.1679764095215.b42eb6891ac7e48d1cde2658c58c30e4&_x_zm_rhtaid=52 **(1:45)**

Structure of a Behavioral Health Hypertension Visit

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

Tools, Resources, and "Tricks of the Trade"

- "Teach Back"/ Psychoeducation
- Supportive Listening Pivot Stage of Change relevant Motivational Interviewing
  - Nope vs "Yes--BUT" vs "Maybe/Soon" vs "I can do" vs "I am doing!!!"
- Menu of Options
- Determine a Plan
  - Consider stress management techniques (see podcasts), mitigating depression/ anxiety/ trauma, smoking and/or substance use, and/or healthy behavior change (e.g. medication adherence, physical activity, diet substitutions)
- Make SMART
- Chance/ Check/ Celebrate/ Change

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.

Before we get into the cases---how do we make the fiscal dots-connect

- **Every Coloradan with Medicaid gets 6 integrated behavioral health visits w/o diagnosis using psychotherapy visit code**
- **Increase referrals of hypertension to integrated behavioral health**: Curbside Consultations, Huddles and EHR Messages to Providers: Include Hypertension as a referral reason
- **Check medical conditions when meeting with a patient---** is hypertension something that can be rolled into your plan of care, or can your treatment target also go toward helping global wellness for person
- **Using Population Management Tools:** Adding Uncontrolled Hypertension to Huddle Sheets and **Flagging for BHC Referral**
  - Look for patients with uncontrolled hypertension and see which ones haven't seen a BHC or mental health provider
- **Meaningful Use Metrics---** performance-improvement plan/ PDSA--- does referring to integrated behavioral health provider help contribute to meaning meaningful use metrics for uncontrolled hypertension

Case 1: Maria, 52 year-old, female, identifies at Southern Ute Tribe and Mexican-American, lives near Cortez.

- Blood pressure today is 157/112, hypertension for 5 years. She had two recent emergency room visits for high blood pressure in last six months
- Married, has two children, one is a young daughter, who splits time at her girlfriend's and at home, a teenage son at home. Husband long-haul trucker. She works in food preparation and calls her finance "a struggle." She regularly goes without blood pressure medication, worries about its side-effects, especially urinating at night, and tries herbal remedies
- She describes her diet as "traditional" but also notes significant soda and fast food/snack consumption, but has made changes. She smokes cigarettes (1ppd), she engages in alcohol use sparingly, regular marijuana use, and no other drug use.
- PHQ-2 reflexed into a PHQ-9, administered by MA—15, moderate depression; GAD-7 = 14, moderately severe anxiety. Denies trauma/ IPV.

Case 1: Maria, 52 year-old, female, identifies at Southern Ute Tribe and Mexican-American, lives near Cortez.

INITIAL ASK/ ASSESSMENT

- Nice, friendly, open to talk about her struggles with blood pressure
- Completed "Distress Scale for Diabetes & Hypertension 2" and reported elevated scores on emotional burden, physician-related stress, and regiment-related stress
- Importance to address hypertension. 8/10.----value was being here for kids, not missing work for ED visits, and not having a compromised later life,
- Confidence was 4/10---what I've tried hasn't worked, not sure what to do

Case 1: Maria, 52 year-old, female, identifies at Southern Ute Tribe and Mexican-American, lives near Cortez.

- ASSESS
- ADVISE
- ASSIST
- ARRANGE

- Assess ---Stage of Change /Did Card Sort Task---- high readiness on physical activity and learning some calming skills, low readiness on diet and smoking now
- Psychoeducation/ Advise--- reviewed cards and options
- Assist--- SMART goal for walking, taught diaphragmatic breathing,
- Arrange---review and made a plan to do another relaxation exercise over phone in 2 weeks

Your Turn: Case 2--- Carl, 39, male, White male, Army Veteran in community primary care.

- Blood pressure is regularly over 150/100---concerned about sexual functioning and has been "battling taking the meds"
- Was very active in service---loss of structure and back injuries in military (and in construction job), led to diminished physical activity, significant weight gain
- Retrained in career, has a sedentary desk job. Reports poor sleep from nightmares and sleep apnea. Often has to have a lot of caffeinated soft drinks and snacks to get through the work day and drive home.
- Unmarried--- "I'm not a good cook, I do a lot of ramen, take-out, and delivery." Drinks above recommended limits--- a six-pack a night, case on weekend days. Diabetes II is also a concern, a1c = 8.5.
- PHQ-9= 19, GAD-7 =18, PC-PTSD-5 = 4/5
- Identifies as born again, prays through troubles at nights. Feels connected to faith community, enjoys college/pro football, finds he drinks more when those aren't on, but does drink a bit to those. Video games help with stress.

Your Turn: Case 2--- Carl, 39, male, White male, Army Veteran in community primary care.

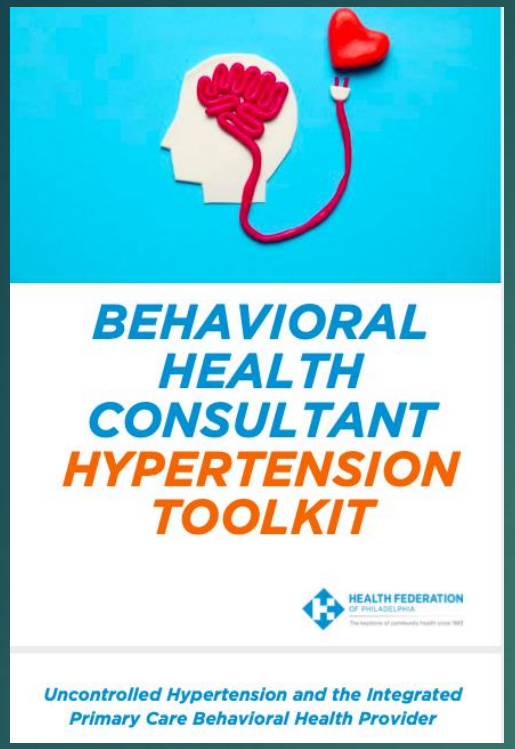
- Assess---
  - Where do we start?
  - What do you want to know?
  - CHATTERFALL TIME!!!

- What is he feeling and know about hypertension?
- What has he tried/ what is he doing now?
- What is important to him--- what is readiness to address HTN
- How about possible PTSD?
- Tools--- Screening measure? Card Sort? Other?

Your Turn: Case 2--- Carl, 39, male, White male, Army Veteran in community primary care.

- ADVISE--What info would you want to give him with what you know?
- ASSIST
- ARRANGE

- **Psychoeducation/ Advise**---Willingness to address PTSD and link with HTN/DM, via sleep, fatigue-related behaviors, and activation of alarm system
- **Assist**---What's the best target to focus on with him? How do you figure that out?
- **Arrange**---How might you shape your care plan?



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