"Where Do I Start?" Chronic Disease Management for Behavioral Health Consultants

Stacy Ogbeide, PsyD, ABPP, CSOWM

@DrStacyO1

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Presenter

- **Stacy Ogbeide, PsyD, ABPP**
- Clinical Health Psychologist
- Associate Professor/Clinical
- Long School of Medicine
- Family Medicine Residency – Director of BH Education
- Psychology Internship – PC Track Coordinator
- Passion for evidence-based practice and faculty/supervisor development in primary care!
- Lead TA Consultant, Primary Care Behavioral Health Strategies, LLC
- www.stacyogbeide.com

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Thank you!

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Objectives

Upon completion of this activity, learners will be able to:

1: Understand biological and physiological aspects of Hypertension and Obesity;

2: Identify the impact of implicit bias on the treatment of overweight and obesity; and

3: Understand how to make alterations to behavioral interventions for patients with Hypertension and Obesity in primary care.

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Schedule for today (CST)

- 1:45pm-1:55pm – Introductions
- Intro to topic – The why? – 1:55pm-2:05pm
- Role of the BHC in PC/Setting the Stage – 2:05pm-2:15pm
- Topic 1: Hypertension: 2:15pm-2:30pm
- Topic 2: Obesity: 2:30pm-2:45pm
- Small Group Case – 2:45pm-3:00pm
- Large Group Discussion/Q and A – 3:00pm-3:10pm
- Wrap-Up-Adjournment – 3:10pm-3:15pm

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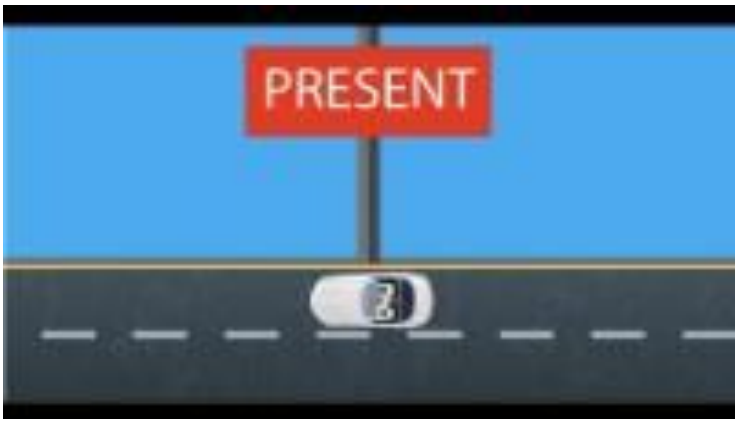
It has probably been a long morning…. Let's make the next 1.5 hours meaningful



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Introductions

- In the chat box…
- Name
- Role in the clinic (e.g., BHC)
- How long have you been a BHC in PC?
- 1 thing you hope to learn today?

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Text **STACYOGBEIDE135** to **37607** once to join

How confident are you in using psychological/behavioral intervention approaches for chronic disease management in primary care? (1 being low and 10 being high)

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How important is it for you to use psychological/behavioral intervention approaches for chronic disease management in primary care? (1 being low and 10 being high)

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The "Why"

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Why this topic?

- More than 45% of Americans have at least one chronic disease, with chronic disease also being a leading cause of the death in the United States.
- In primary care, about 75% of visits are for the management of multiple chronic diseases.
- Due to the increasing medical complexity of patients who present to primary care, these numbers make it more challenging for PCPs to manage these conditions alone.
- Team-Based Care needed to appropriately manage these conditions

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Who else is on your PC team?

- What other disciplines do you have on your PC team? Type in the chat box.
- Question to consider throughout the afternoon – **Who else can be brought in from your team to provide care for the patient?**

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Why these conditions?

- Hypertension occurrence in PC: 50% of visits/year (1/3 of patients with hypertension not controlled)
- Obesity occurrence in PC: 42% of patients in a given year
  - BMI screening increasing; PC visits focused on weight mgmt. continue to be sub-optimal (less than 20% of visits in PC)
  - Research shows that low intensity interventions by PCP only not sufficient and do not result in behavior/weight change

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Role of the BHC

- **GATHER** (Reiter, Dobmeyer, Hunter, 2018)
- Generalist
- Accessible
- Team-based
- High productivity
- Educator
- Routine (pathways, regular care component)
- Care structure
- Visits (typically 15-30minutes to mirror PCP schedules)
- Consultation model (episodes of care)

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Setting the stage for interventions

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Targeted Assessment in Primary Care - What do YOU use in your initial visits?

Contextual Interview (Strosahl & Robinson)

Functional Assessment (Hunter et al.)

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Initial Visit

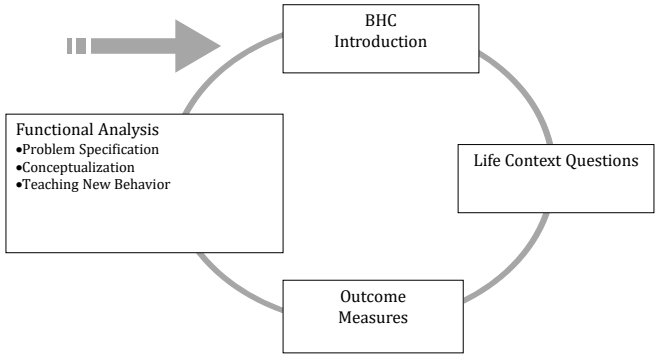

Figure 9.2. Components of a BHC initial visit.

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Follow-up Visit

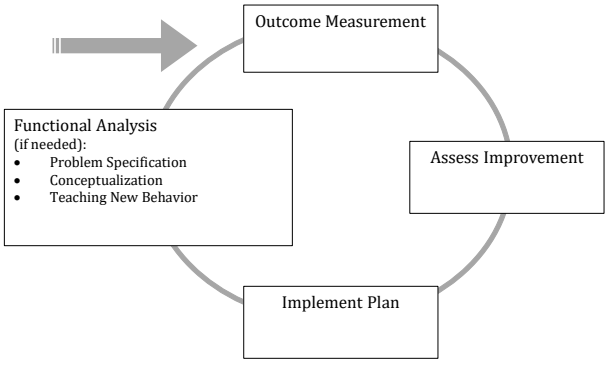

Figure 9.9. Components of a BHC follow-up visit.

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Assessment Examples

Contextual Interview

Functional Assessment

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Guiding conceptualization?

- **Guiding question: What is the function of the "problem"?**
- **Context matters**
- Cognitive-Behavioral (1st/2nd wave)
  - Problems
  - Mechanisms (A and C)
  - Origins (distal factors/predispositions)
  - Precipitants (proximal factors)
- Acceptance-Based (ACT/fACT)
  - Avoidance?
  - Rule-governed behavior?
  - Something else?

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Measurement-Based Care

- What are you/your clinic using to measure outcomes? (Outcome tools?) – Type in the chatbox
- How do you know what you're doing is effective?

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Measurement-Based Care

- Quality of Life tools (**Is their functioning improving? Important for mgmt. of chronic disease**)
  - Duke Health Profile
  - SF-36
  - Healthy Days (CDC)
  - Quality of Life Enjoyment and Satisfaction Questionnaire Short Form (Q-LES-Q-SF)
- Psychology Flexibility
  - AAQ-2 (Psychological Flexibility)

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Psychiatric Symptom Mimics

- Weight gain/polyphagia?
- Fatigue?
- Difficulty concentrating/confusion?

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Hypertension

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Hypertension – What is it?

High blood pressure (HBP or hypertension) is when your blood pressure, the force of your blood pushing against the walls of your blood vessels, is consistently too high.

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Biological and Physiological Aspects of Hypertension

Risk factors:

- Age*
- Obesity
- Family history*
- Race/Ethnicity*
- Reduced nephron number
- High-sodium diet
- Excessive alcohol consumption
- Physical inactivity

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Causes of Hypertension

- Primary Hypertension: (known as "Essential Hypertension): Most adults with hypertension have primary hypertension which means that the cause of the high blood pressure is not known.
- A small subset of adults has secondary hypertension, which means that there is an underlying and potentially correctable cause, usually a kidney or hormonal disorder

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Causes of Hypertension

- Secondary or Contributing causes of hypertension
  - Prescription or over-the-counter medications
  - Illicit drug use: amphetamine, cocaine
  - Other causes: Primary renal disease (chronic and acute kidney disease), Primary Aldosteronism, Renovascular Hypertension (fibromuscular dysplasia and atherosclerosis), Obstructive Sleep Apnea, Pheochromocytoma. Cushing's disease, Coarctation of Aorta, Endocrine disorders: hypo/ hyperthyroidism, hyperparathyroidism

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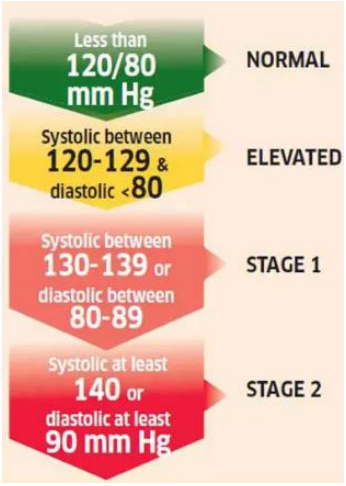
Stages of Hypertension

- Normal blood pressure – Systolic <120 mmHg and diastolic <80 mmHg
- Elevated blood pressure – Systolic 120 to 129 mmHg and diastolic <80 mmHg
- Hypertension:
  - Stage 1 – Systolic 130 to 139 mmHg or diastolic 80 to 89 mmHg
  - Stage 2 – Systolic at least 140 mmHg or diastolic at least 90 mmHg



HYPERTENSIVE CRISIS Systolic over 180 and/or diastolic over 120, with patients needing prompt changes in medication if there are no other indications of problems, or immediate hospitalisation if there are signs of organ damage

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Systolic Versus Diastolic

- Blood pressure reading is recorded as two numbers:
- **Systolic** blood pressure (the top number) — indicates how much pressure your blood is exerting against your artery walls during heartbeats.
- **Diastolic** blood pressure (the bottom number) — indicates how much pressure your blood is exerting against your artery walls while the heart is resting between beats.

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Signs and Symptoms

- Asymptomatic "silent killer"
- Focal neurologic symptoms could be due to ischemic or hemorrhagic stroke
- Nausea and vomiting, which may be a sign of increased intracranial pressure
- Chest discomfort, may be due to myocardial ischemia or aortic dissection
- Acute, severe back pain, which might be due to heart failure
- **Most patients with hypertension have no symptoms and no physical findings other than elevated BP**

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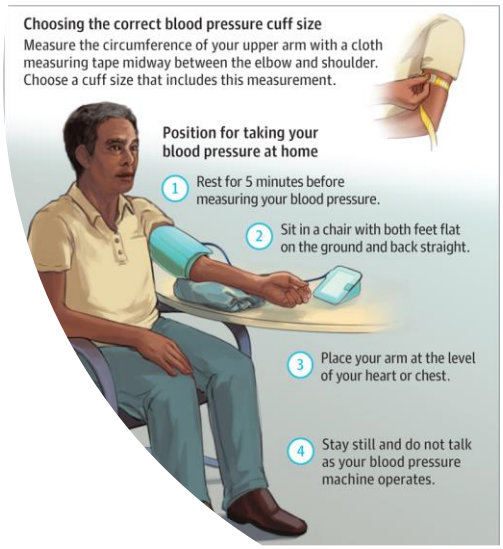
Diagnosing Hypertension

- The diagnosis of hypertension requires **integration** of home or ambulatory blood pressure monitoring (ABPM) in addition to measurements made in the clinical setting.
- Hypertension is defined when the average BP is greater than 130 mm Hg systolic or 80 mm Hg diastolic
- Since BP may be transiently elevated, the diagnosis of hypertension is based on the average of **two or more** properly measured seated readings on each of two or more office visits



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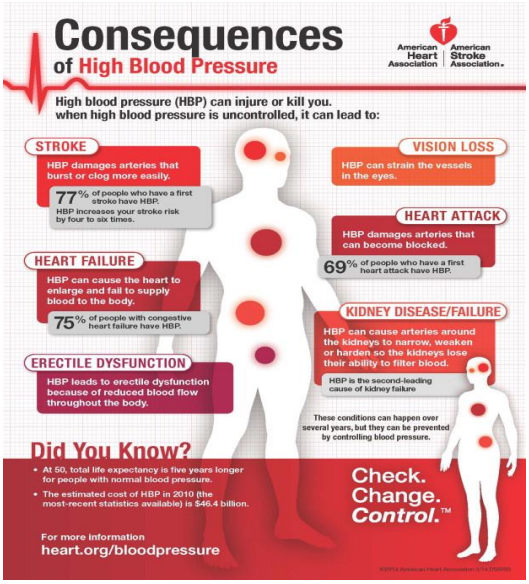
Complications of Hypertension



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Common Treatment Approaches

- **Lifestyle/Behavioral Modifications!**
- Such as:
  - Dietary salt restriction
  - Potassium supplementation (as directed by PCP)
  - DASH diet
  - Exercise
  - Limited alcohol intake
  - Weight loss
  - Stress Management

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Pharmacologic Therapies

- One or more of these medications are initially used to treat high blood pressure:
- Thiazide Diuretics **— rid the body of excess sodium (salt) and water and help control blood pressure. These are sometimes called "water pills."**
- Angiotensin-Converting Enzyme (ACE) Inhibitors, Angiotensin II Receptor Blockers (ARBS) and Calcium Channel Blockers**— relax and open up the narrowed blood vessels and lower blood pressure.**

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Hypertension Interventions

- Focus is on changing specific health habits impacting heart health
- Options?
- Tobacco use, losing weight, changing eating habits (DASH diet), stress mgmt., improving medication adherence

Hunter et al, 2017

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Hypertension Interventions

- Brief Motivational Interviewing (BMI) to determine readiness and area of focus
- Providing education (depending on stage of change)
- Goal setting (SMART)
- Problem-solving treatment (medication adherence)
- CBT skills for tobacco cessation (4 visit protocol for primary care) – in tandem with NRTs
- Health Federation of Philadelphia – clinical pathway for HTN – contact me if you would like a copy!

Jakupcak et al., 2010; Hopko et al., 2005

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Obesity

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Food for thought

How comfortable are you in treating your patients with obesity/overweight concerns?

What would make you more comfortable?

How do you open up the conversation about weight?

Personal reflection: are you aware of your own bias related to weight?

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Research on Obesity Stigma

- Weight bias is expressed as early as age ___?
- Employment settings
  - Lower wages, fewer promotions, discrimination in hiring
- Educational settings
  - Lower educational attainment, negative comments/lower expectations by teachers
- Interpersonal Relationships
  - Bullying, ostracism, peers: negatively viewed from preschool to high school, less dating
- Media
  - Entertainment: fewer relationships, more ridicule, stereotypical eating, negatively portrayed
  - Advertising: unhappy, unattractive
  - News media: negative, unflattering and stereotypical portrayals

Friedman RR, Puhl RM. Yale Rudd Center for Food Policy & Obesity, 2012.
UCON Rudd Center for Food Policy & Obesity, http://www.uconnruddcenter.org/weight-bias-stigma

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Research on Obesity Stigma, cont'd

- **Health Care**
- Nurses
  - Report preferring not to care for or touch obese patients, "repulsed"
  - May view patients as lazy, lacking willpower, non-compliant
- Physicians
  - Report viewing patients as more non-compliant, lazy, weak-willed, unsuccessful, unintelligent, dishonest
  - Spend less time in visit, have less discussion, more reluctant to perform preventive health screenings
- Medical Students
  - Report believing obese patients to be non-adherent, sloppy, awkward, unpleasant, responsible for symptoms
- Psychologists
  - Attribute more pathology, severe symptoms, worse prognosis, negative attributes

Friedman RR, Puhl RM. Yale Rudd Center for Food Policy & Obesity, 2012.
Puhl, RM, http://www.uconnruddcenter.org/files/Pdfs/Clinical_Implications_of_Obesity_Stigma_Presentation_2013.pdf

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Impact of obesity stigma & discrimination

- Depression
- Low self-esteem
- Poor school performance
- Increased binge eating
- Avoidance of physical activity
- More likely to avoid/cancel/delay **preventive care**
  - Why? Disrespectful treatment, negative attitudes, unsolicited advice to lose weight, embarrassment about being weighed, bad experiences with too-small medical equipment
- Body image dissatisfaction***
  - *Body acceptance and/or self-compassion* → *he*althier behaviors

UCON Rudd Center for Food Policy & Obesity, http://uconnruddcenter.org/weight-bias-stigma-health-care

Courtesy of Kathryn Kanzler, PsyD, ABPP

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How you can help address bias

- Practice being aware of your own bias
- Change your language
  - Use desired terms, such as *Weight, Excess Weight, BMI, Weight Management*
  - Don't use terms like, *Fatness, Excess Fat, Obesity, Large Size, Heaviness, Unhealthy BMI, Unhealthy Body Weight, Weight Problem*
  - Avoid language that places blame on patients
- Promote a positive office environment
  - Make it accessible
  - Use appropriate medical equipment
  - Reduce patient fears about weighing
  - Encourage healthy behaviors & promote self-acceptance
- Learn more about preventing weight bias
  - Toolkit, Preventing Weight Bias: http://biastoolkit.uconnruddcenter.org/
  - Examining Obesity Bias - training: https://www.unmc.edu/elearning/egallery/obesity-bias/

SCAN ME

Courtesy of Kathryn Kanzler, PsyD, ABPP

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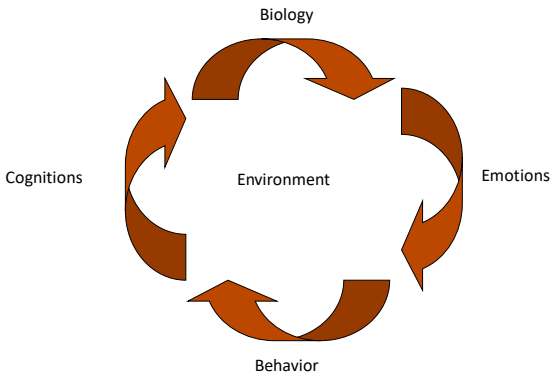
Why are people obese and/or overweight?



Courtesy of Kathryn Kanzler, PsyD, ABPP

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Biology

- Genetics
- Energy expenditure
- Fuel utilization
- Size & number of fat cells
- Metabolism efficiency

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Behaviors

- Energy In > Energy Out ?
- Habits
- Mindless eating
- Activity levels

Courtesy of Kathryn Kanzler, PsyD, ABPP

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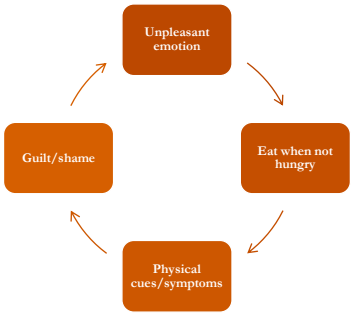
Emotions

- Emotional eating
- Stress eating
- Bored eating
- Bi-directional relationships



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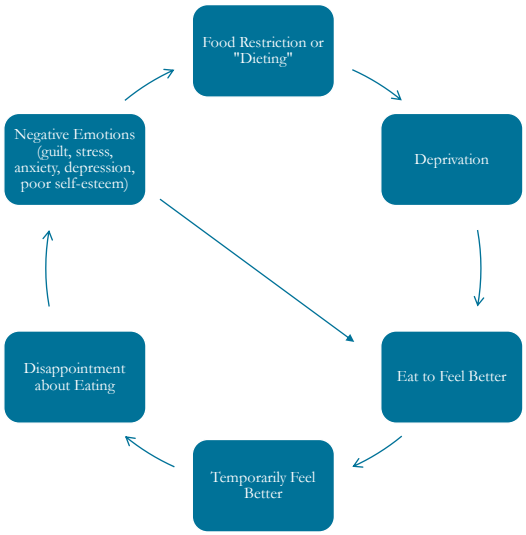
Restriction/Binge Cycle



(Ryan, J., 2018)

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Cognitions

- Perceptions of food amounts
- Perception of weight
- Beliefs about food (cultural considerations)
  - Food as comfort
  - Food as celebratory
  - Food as fuel?
- Knowledge levels
- Internalized Weight Stigma (e.g., Weight Bias Internalization Scale-Revised)

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Environment

- "Obesogenic environment"
- Cultural influences
  - Family attitudes/perceptions
  - Traditional diets
- Cues to eat
- Advertising: marketing unhealthy foods/beverages is targeted to communities of color[1]
  - Especially children & adolescents

1. Harris J, Shehan C, Gross R, Kumanyika S, Lassiter V, Ramirez A, et al.. UCONN Rudd Center Policy Report, 2015 August, 2015.

Courtesy of Kathryn Kanzler, PsyD, ABPP

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What about BMI?

- BMI most common measure – linked to health outcomes
- Can also use:
  - Waist-Hip Ratio
  - Waist circumference
  - Neck circumference
  - 2-minute walk test

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BMI Categories

Obesity Class	BMI Range
Class 1	30.0-35.0
Class 2	35.1-39.9
Class 3	40.0 and higher (sometimes categorized as "severe" obesity)

From https://www.cdc.gov/obesity/adult/defining.html

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Calorie Underestimation

- Research has shown differences in accuracy based on BMI category… BUT
  - All participants "strongly underestimated" calories in larger meals
- No statistical differences based on body size alone…

Wansink B, Chandon P. *Ann Intern Med*. 2006;145(5):326-32.

Courtesy of Kathryn Kanzler, PsyD, ABPP

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Obesity Interventions

- **Evidence-based recommendations:**
- Reducing caloric intake, increase exercise (at least 150 minutes of moderate/intense exercise/week for weight maintenance; 210 minutes moderate/intense exercise/week for weight loss), and behavioral strategies such as self-monitoring, stimulus control, and problem solving
- Interventions with high (14 or more) or moderate intensity (6-13) contacts in 6 months are more effective for weight loss

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Obesity Interventions - Assessment

- **Assessment in Primary Care:**
- Assessing BMI
- Weight loss history (attempts)
- Assessing eating habits/exercise habits
- Goal is 1-2 pounds/week (5-10% loss of weight has significant impact on overall health)*

Hunter et al, 2017

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Obesity Interventions

- **Interventions:**
- Brief MI
- Goal setting (SMART)
- Self-monitoring
- CAMES (Cut, Add, Move, Eliminate, Substitute)
- Behavior Modification (*changing how one eats*; AAT specific for stress/emotional eating)
- Weight maintenance (Brief MI can help)

Hunter et al, 2017

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Obesity Interventions

myfitnesspal

Lose It!

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Small Group Discussion!

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Questions to address in your small group

- **As you review your case…**
- What else would you assess for? To better inform your intervention?
- How would you explain the patient's condition (to the patient) in layperson's terms?
- Top 2 intervention options and why? (contextually, why are you selecting the intervention?)
- Cultural factors to consider? Social determinants of health?
- Who on your healthcare team would you involve in the patient's care?
- **Select a speaker for your group!**

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What did your group discuss?

- What else would you assess for? To better inform your intervention?
- How would you explain the patient's condition (to the patient) in layperson's terms?
- Top 2 intervention options and why? (contextually, why are you selecting the intervention?)
- Cultural factors to consider? Social determinants of health?
- Who on your healthcare team would you involve in the patient's care?

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Wrap-Up/Q & A

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Post-Test: How confident are you in using psychological/behavioral intervention approaches for chronic disease management in primary care? (1 being low and 10 being high)

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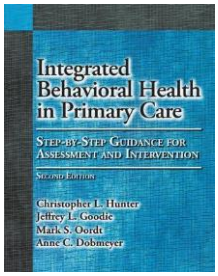

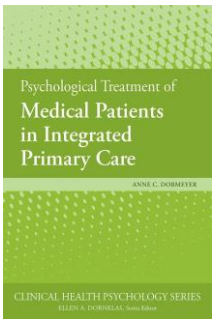

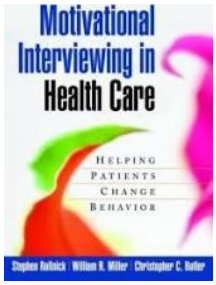

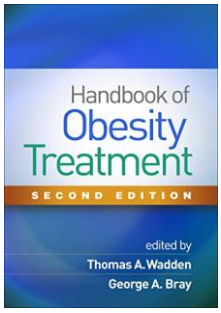

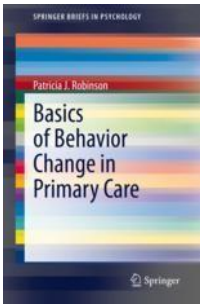

Book Resources

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Thank you!

You made it!

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Questions?

Please complete your workshop evaluations!

Contact Me:

- Stacy Ogbeide, PsyD, ABPP, CSOWM
- Email: pcbhtx@gmail.com
- Website: www.stacyogbeide.com
- References available upon request

@DrStacyO1

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65