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Psychosocial Management without Integrated Mental Health Support

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DISCLOSURES

- I have no conflicts of interest to disclose.

These are my slides for public distribution – they may differ slightly from what I present in person.

Don’t panic: I am not going to read through 77 slides in 50 minutes. They’re all here for reference, but we aren’t constrained by them.

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Learning Objectives

1. Participants will learn strategies to provide psychosocial management in the cardiopulmonary rehabilitation context that have limited to no integrated mental health support.
2. Participants will learn creative approaches to promote continuity of psychosocial care that do not require on-site mental health support from specialists.
3. Participants will be able to describe strategies for maximizing the quality of psychosocial management through both existing resources and care coordinated with outside resources.
4. Participants will develop at least one action item to implement upon returning to their cardiopulmonary rehabilitation site.

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Psychosocial management

- Psychosocial management is a core component of CVPR
  - This includes *treatment* for distressed CVPR patients
  - Not commonly integrated into CVPR or easily accessible
  - Depression and anxiety are commonly *assessed* in CVPR
    - But not *treated*
  - How many CVPR programs have integrated mental health support? *We don't even know.*
- Patients with psychosocial issues typically need additional help with "Behavioral Medicine"

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Does psychosocial management work?

- **Yes**. Surprisingly well. (And the whole is greater than the sum of the parts.)
- "The comprehensive delivery of the recommended core components is associated with reductions in mortality and morbidity." (Particularly exercise, **psychosocial management**, and patient education.)

Kabboul, N. N., Tomlinson, G., Francis, T. A., Grace, S. L., Chaves, G., Rac, V., ... & Krahn, M. (2018). Comparative effectiveness of the core components of cardiac rehabilitation on mortality and morbidity: a systematic review and network meta-analysis. *Journal of clinical medicine*, *7*(12), 514.

Example: Depression in CR

- Depression:
  - *Very* frequently comorbid with heart disease
  - Associated with worse prognosis, premature drop-out, lower quality of life, etc.

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Example: Depression and Anxiety in PR

- Anxiety and Depression:
  - *Very* frequently comorbid with COPD
  - Associated with poor prognosis, younger age, female sex, smoking, lower FEV1, cough, higher SGRQ score, and history of cardiovascular disease
  - COPD nearly doubles risk of suicide

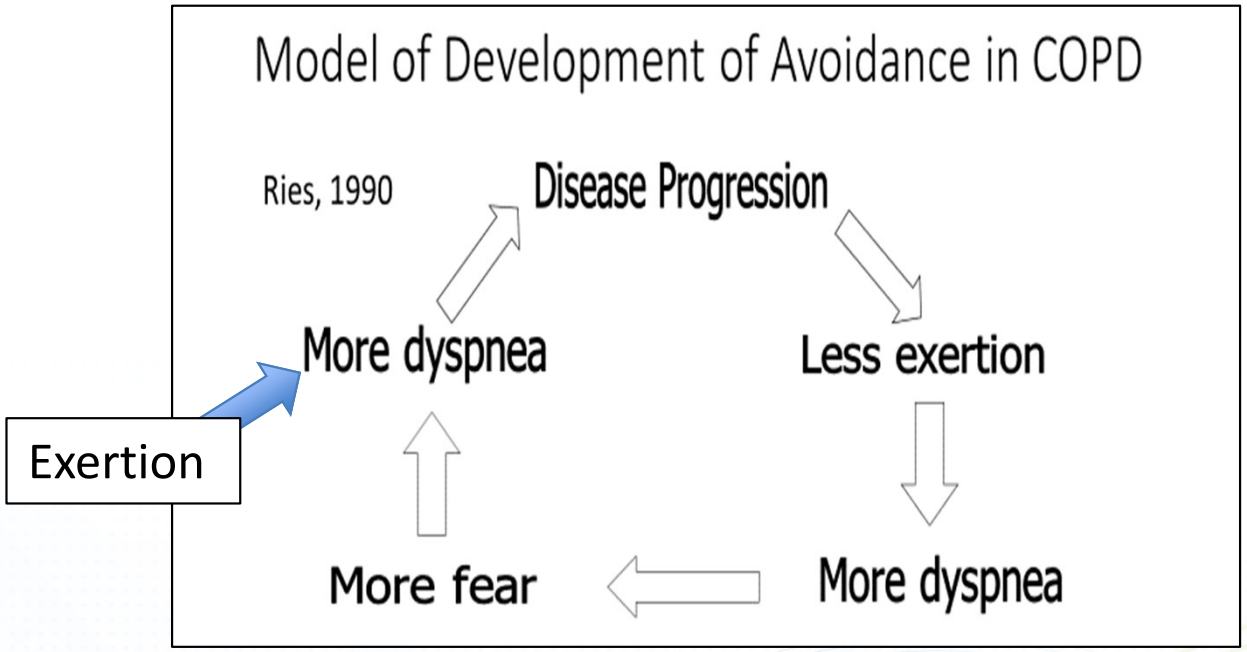
2020 GLOBAL STRATEGY FOR PREVENTION, DIAGNOSIS AND MANAGEMENT OF COPD

Anxiety

- For pulmonary diseases, anxiety is special…

Sanderson, R. E., Campbell, D., & Laverty, S. G. (1962). Traumatically conditioned responses acquired during respiratory paralysis. *Nature*, *196*(4860), 1235.

Anxiety



Ries (1990). Position paper of the American association of cardiovascular and pulmonary rehabilitation: Scientific basis of pulmonary rehabilitation. J Cardiopulmonary Rehabil 1990; 10: 418-441.

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Options:

1. Use your Integrated Mental Health Support!
2. Build a referral network
3. Provide Mental Health Support using existing staff

That is, use the “Core Competencies,” enriched with your ingenuity!

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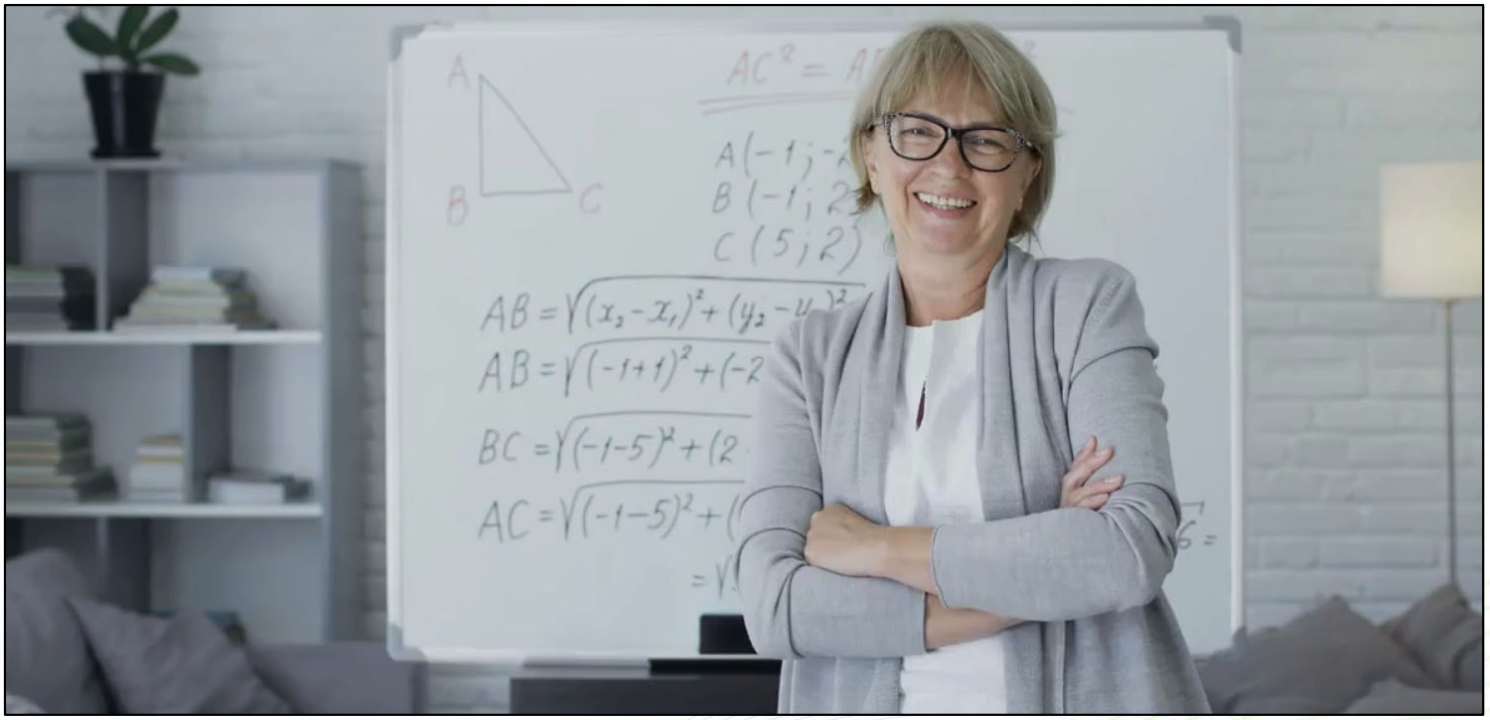
Meet Patricia



- Hughes, J., & Ede, D., (2019). Psychosocial risk factors as modulators of cardiovascular outcomes in secondary prevention. In Rippe, J. (Ed.), Lifestyle Medicine, Third Edition. Boca Raton: Taylor & Francis.

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Resources for Core Competencies

- Cardiac Resources
  - Core Competencies for Cardiac Rehabilitation/Secondary Professionals: 2010 Update, Position Statement of AACVPR. Hamm et al. Journal of Cardiopulmonary Rehabilitation and Prevention 2011; 31:2-10
  - Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs, 6th Edition. AACVPR. 2021
  - The Certified Cardiac Rehabilitation Professional CCRP Preparatory Study Guide.
- Pulmonary Resources
  - Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals: American Association of Cardiovascular and Pulmonary Rehabilitation Position Statement. Nici L et al. Journal of Cardiopulmonary Rehabilitation and Prevention 2007;27:355-358.
  - Guidelines for Pulmonary Rehabilitation Programs, 5th Edition

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2. Psychosocial management core competencies for CR/secondary prevention

Demonstrate an understanding of:

1. Influence of psychosocial factors on the pathophysiology of CVD and adherence to treatment
2. Depression and its major association with recurrent CAD events, poorer outcomes, and adherence to treatment
3. Other psychological indicators that may affect treatment response, such as anxiety, anger or hostility, and social isolation
4. Actions of pharmacologic and lifestyle interventions for psychological distress
5. Socioeconomic factors that may serve as barriers to treatment adherence, such as educational or income level, lack of resources or support
6. Available support services to augment psychological interventions (e.g., psychologists, counselors, social workers, clergy)
7. Effective behavior change strategies based on common theoretical models and adult learning strategies

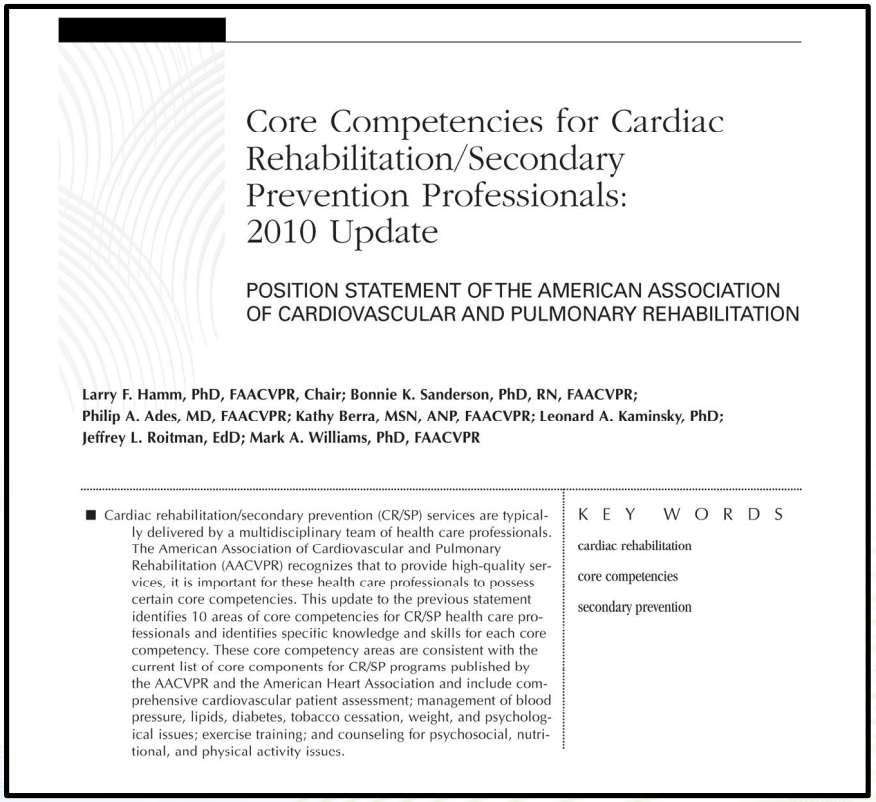
2. Psychosocial management core competencies for CR/secondary prevention

Ability to perform the following:

1. Screening and assessment for psychological distress, especially depression, anxiety, anger or hostility; social isolation; marital/family distress; sexual dysfunction; and substance abuse
2. Appropriate referrals for psychiatric or psychological care when needs are recognized as beyond the scope of usual care
3. Individual and group education and counseling interventions that address stress management and coping strategies
4. Measure and report outcomes of psychosocial management at the conclusion of the program

2. Psychosocial management core competencies for CR/secondary prevention

- 7 Knowledge
- 4 Skill/Ability



Core Competencies for Cardiac Rehabilitation/Secondary Prevention Professionals: 2010 Update

POSITION STATEMENT OF THE AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION

Larry F. Hamm, PhD, FAACVPR, Chair; Bonnie K. Sanderson, PhD, RN, FAACVPR; Philip A. Ades, MD, FAACVPR; Kathy Berra, MSN, ANP, FAACVPR; Leonard A. Kaminsky, PhD; Jeffrey L. Roitman, EdD; Mark A. Williams, PhD, FAACVPR

■ Cardiac rehabilitation/secondary prevention (CR/SP) services are typically delivered by a multidisciplinary team of health care professionals. The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) recognizes that to provide high-quality services, it is important for these health care professionals to possess certain core competencies. This update to the previous statement identifies 10 areas of core competencies for CR/SP health care professionals and identifies specific knowledge and skills for each core competency. These core competency areas are consistent with the current list of core components for CR/SP programs published by the AACVPR and the American Heart Association and include comprehensive cardiovascular patient assessment; management of blood pressure, lipids, diabetes, tobacco cessation, weight, and psychological issues; exercise training; and counseling for psychosocial, nutritional, and physical activity issues.

KEY WORDS

cardiac rehabilitation

core competencies

secondary prevention

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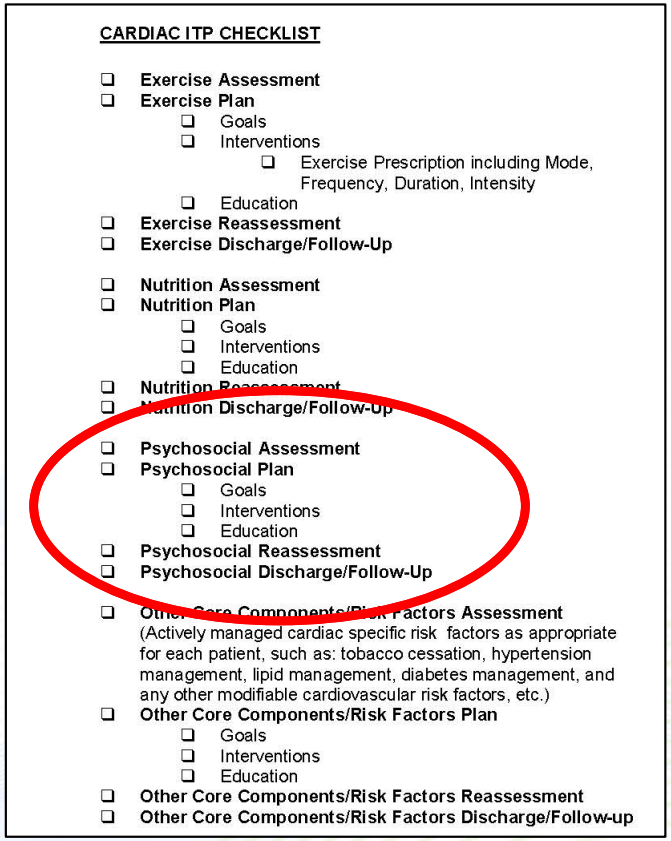
2. Psychosocial management core competencies for CR/secondary prevention

- They are implied in the ITP Checklist!



CARDIAC ITP CHECKLIST

- ❑ **Exercise Assessment**
- ❑ **Exercise Plan**
  - ❑ Goals
  - ❑ Interventions
    - ❑ Exercise Prescription including Mode, Frequency, Duration, Intensity
  - ❑ Education
- ❑ **Exercise Reassessment**
- ❑ **Exercise Discharge/Follow-Up**

- ❑ **Nutrition Assessment**
- ❑ **Nutrition Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Nutrition Reassessment**
- ❑ **Nutrition Discharge/Follow-Up**

- ❑ **Psychosocial Assessment**
- ❑ **Psychosocial Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Psychosocial Reassessment**
- ❑ **Psychosocial Discharge/Follow-Up**

- ❑ **Other Core Components/Risk Factors Assessment**
  (Actively managed cardiac specific risk factors as appropriate for each patient, such as: tobacco cessation, hypertension management, lipid management, diabetes management, and any other modifiable cardiovascular risk factors, etc.)
- ❑ **Other Core Components/Risk Factors Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Other Core Components/Risk Factors Reassessment**
- ❑ **Other Core Components/Risk Factors Discharge/Follow-up**

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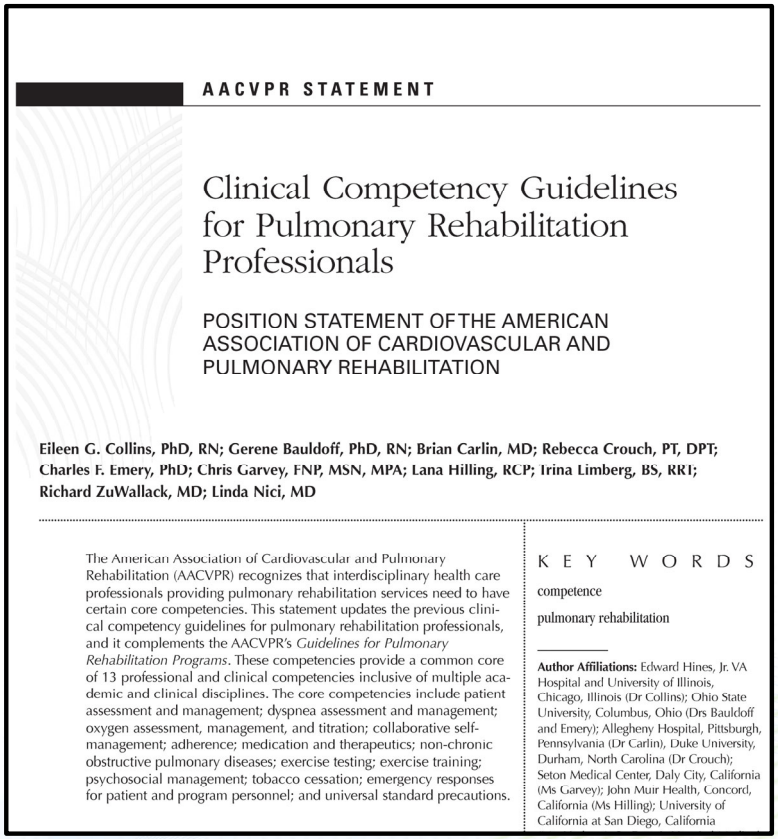
3. Psychosocial management core competencies for Pulmonary Rehabilitation



AACVPR STATEMENT

Clinical Competency Guidelines for Pulmonary Rehabilitation Professionals

POSITION STATEMENT OF THE AMERICAN ASSOCIATION OF CARDIOVASCULAR AND PULMONARY REHABILITATION

Eileen G. Collins, PhD, RN; Gerene Bauldoff, PhD, RN; Brian Carlin, MD; Rebecca Crouch, PT, DPT; Charles F. Emery, PhD; Chris Garvey, FNP, MSN, MPA; Lana Hilling, RCP; Irina Limberg, BS, RRT; Richard ZuWallack, MD; Linda Nici, MD

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) recognizes that interdisciplinary health care professionals providing pulmonary rehabilitation services need to have certain core competencies. This statement updates the previous clinical competency guidelines for pulmonary rehabilitation professionals, and it complements the AACVPR's *Guidelines for Pulmonary Rehabilitation Programs*. These competencies provide a common core of 13 professional and clinical competencies inclusive of multiple academic and clinical disciplines. The core competencies include patient assessment and management; dyspnea assessment and management; oxygen assessment, management, and titration; collaborative self-management; adherence; medication and therapeutics; non-chronic obstructive pulmonary diseases; exercise testing; exercise training; psychosocial management; tobacco cessation; emergency responses for patient and program personnel; and universal standard precautions.

KEY WORDS

competence

pulmonary rehabilitation

Author Affiliations: Edward Hines, Jr. VA Hospital and University of Illinois, Chicago, Illinois (Dr Collins); Ohio State University, Columbus, Ohio (Drs Bauldoff and Emery); Allegheny Hospital, Pittsburgh, Pennsylvania (Dr Carlin), Duke University, Durham, North Carolina (Dr Crouch); Seton Medical Center, Daly City, California (Ms Garvey); John Muir Health, Concord, California (Ms Hilling); University of California at San Diego, California

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3. Psychosocial management core competencies for Pulmonary Rehabilitation

Demonstrate an understanding of:

1. Influence of pulmonary disease processes on emotional functioning, especially depression and anxiety
2. Influence of pulmonary disease on social relationships (including family and friends) and quality of life
3. Influence of pulmonary disease and emotional distress on cognitive functioning, especially memory and problem-solving skills
4. Influence of socioeconomic factors (ie, work status, income level, educational attainment, and access to health care) on patient functioning
5. Influence of psychosocial factors on adherence to health behaviors (ie, smoking, diet, and exercise)
6. Pharmacologic agents that are commonly used to treat psychological distress
7. Available institutional/community resources (eg, psychologist, social worker, and clergy) to address psychosocial needs
8. Long-term planning needs of some patients, including advance directives, palliative care, and hospice information

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3. Psychosocial management core competencies for Pulmonary Rehabilitation

Ability to perform the following:

1. Screen for psychological symptom burden (especially depression and anxiety), substance abuse, and poor quality of life
2. Assessment of cognitive capacity for adequate participation in the rehabilitation program and adherence to medical recommendations
3. Individual and group education/therapy to address stress management and effective coping strategies
4. Referral to institutional/community resources to address psychosocial distress or cognitive concerns that are not otherwise addressed
5. Referral to the mental health specialist should screening suggests significant psychiatric disease
6. Measure and report outcomes of psychosocial functioning at the conclusion of the program

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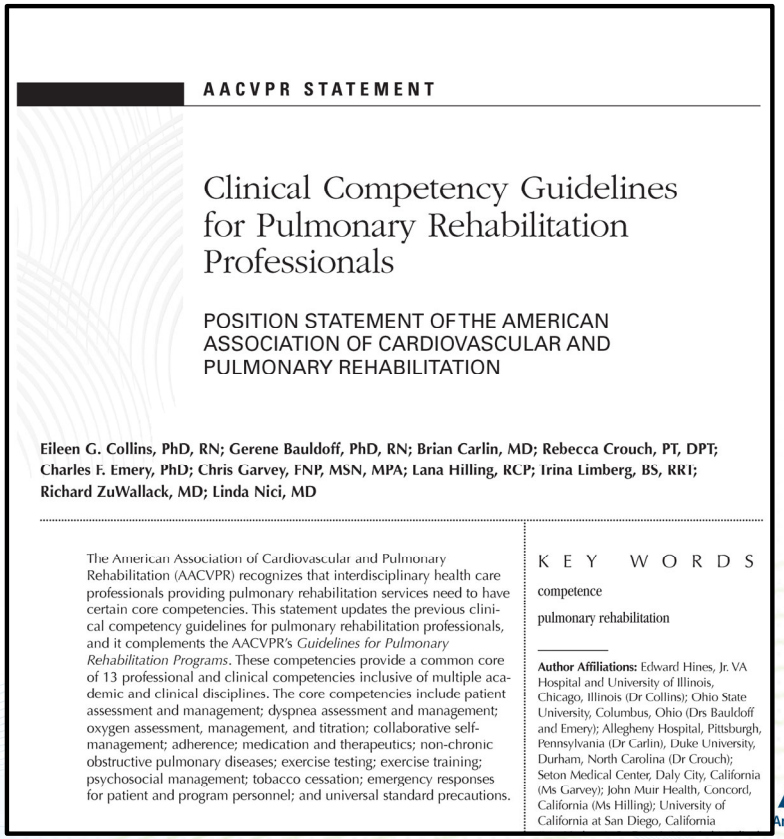
3. Psychosocial management core competencies for Pulmonary Rehabilitation

- 8 Knowledge
- 6 Skill/Ability



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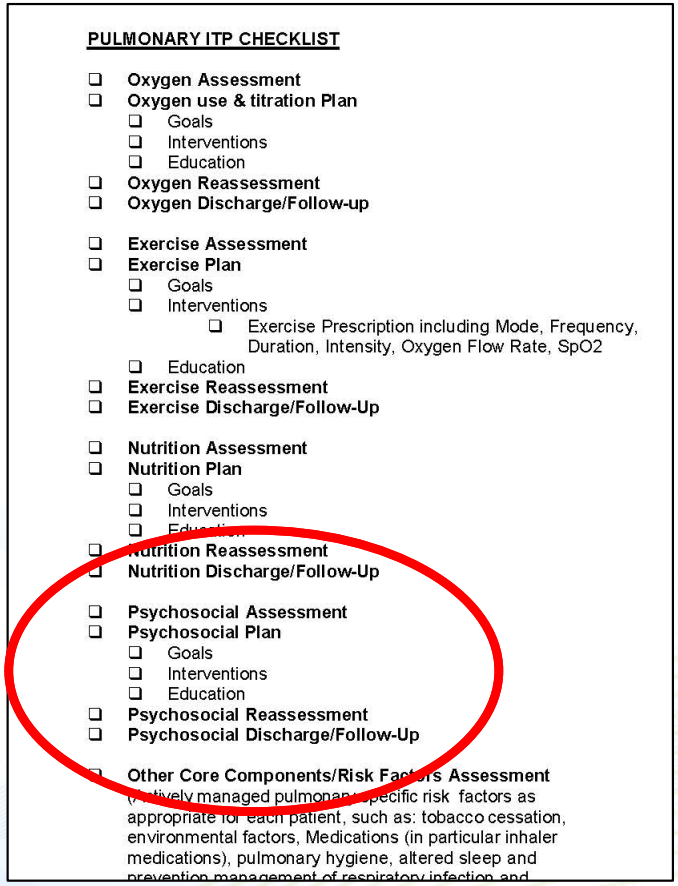
3. Psychosocial management core competencies for Pulmonary Rehabilitation

- They are implied in the ITP Checklist!



PULMONARY ITP CHECKLIST

- ❑ **Oxygen Assessment**
- ❑ **Oxygen use & titration Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Oxygen Reassessment**
- ❑ **Oxygen Discharge/Follow-up**

- ❑ **Exercise Assessment**
- ❑ **Exercise Plan**
  - ❑ Goals
  - ❑ Interventions
    - ❑ Exercise Prescription including Mode, Frequency, Duration, Intensity, Oxygen Flow Rate, SpO2
  - ❑ Education
- ❑ **Exercise Reassessment**
- ❑ **Exercise Discharge/Follow-Up**

- ❑ **Nutrition Assessment**
- ❑ **Nutrition Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Nutrition Reassessment**
- ❑ **Nutrition Discharge/Follow-Up**

- ❑ **Psychosocial Assessment**
- ❑ **Psychosocial Plan**
  - ❑ Goals
  - ❑ Interventions
  - ❑ Education
- ❑ **Psychosocial Reassessment**
- ❑ **Psychosocial Discharge/Follow-Up**

- ❑ **Other Core Components/Risk Factors Assessment**

(actively managed pulmonary specific risk factors as appropriate for each patient, such as: tobacco cessation, environmental factors, Medications (in particular inhaler medications), pulmonary hygiene, altered sleep and prevention management of respiratory infection and

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Providing Mental Health Support with existing staff

- A minimalist approach:
  - Stick to the Core Components/Competencies you can do:

1. Screening and assessment for psychological distress
2. Appropriate referrals for psychiatric or psychological care when needs are recognized as beyond the scope of usual care

You can do this!

When you have *nothing*, you'll refer the patient back to their PCP. (The "*de facto* mental health system" in America)

3. Individual and group education and counseling interventions that address stress management and coping strategies
4. Measure and report outcomes of psychosocial management at the conclusion of the program

You can do these!

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Providing Interventions in CR

1. Behavioral interventions that can be incorporated into the CR program by CR staff.
2. Psychological interventions, such as psychotherapy or counseling.
3. Pharmacological interventions, such as medications used to treat anxiety, depression, or sexual dysfunction.

- Patient education
- Small group stress management
- Exercise

Requires mental health professionals *integrated services* or a *referral*

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CVPR Knowledge Competencies

- Available support services to augment psychological interventions (*e.g.*, psychologists, counselors, social workers, clergy)

CR Skill Competencies

1. Screening and assessment for psychological distress, especially depression, anxiety, anger or hostility; social isolation; marital/family distress; sexual dysfunction; and substance abuse
2. Appropriate referrals for psychiatric or psychological care when needs are recognized as beyond the scope of usual care
3. Individual and group education and counseling interventions that address stress management and coping strategies
4. Measure and report outcomes of psychosocial management at the conclusion of the program

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Psychosocial Assessment

1. Screening using reliable and valid instruments
2. A broader evaluation of the patient's psychosocial concerns starting with the intake interview.
   - Core competency: Able to conduct a comprehensive evaluation that includes assessment of psychosocial concerns related to heart disease, such as depression, anxiety, social isolation, and anger or hostility.
3. Screening instruments should be administered at the beginning and end of CR

Depression

- The patient is screened for depression.
- If the patient is depressed, results are discussed with the patient and the health care provider is notified.
- The patient is re-screened for depression prior to completion of the program.
- If the patient is depressed, results are discussed with the patient and the health care provider is notified.

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Available support services

- Do you have support services available?
  - Psychologists?
  - Counselors?
  - Social workers?
  - Psychiatrists?

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Utilizing Mental Health Providers

What is it really like?

Referral to Other Providers

1. Have clear guidelines about what warrants a referral,
2. The process for referring patients for additional evaluation and treatment, and
3. What local mental health infrastructure is available.

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When to Refer

- Patients should be referred for further evaluation and treatment for psychosocial considerations outside the scope of practice of CR professionals:
  1. Severe anxiety
  2. Severe depression
  3. Many other issues

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The Default: Primary Care Physician

- The PCP is the "*de facto* mental health system" in America.
- What are they gonna do?

Pharmacologic interventions

- Do antidepressants work for patients eligible for **CR**?
  - Not very well, for depression.
    - Hughes, J. W., Kuhn, T. A., Ede, D., Gathright, E. C., & Josephson, R. A. (2022). Meta-analysis of antidepressant pharmacotherapy in patients eligible for cardiac rehabilitation: Antidepressant Ambivalence. *Journal of Cardiopulmonary Rehabilitation and Prevention*.

Antidepressant ambivalence

- “Antidepressants reduced depressive symptoms (*g* = 0.17: 95% CI, 0.08-0.27), but the effect was small.” (Hughes et al., 2022)
- For patients with heart failure, antidepressants have not been effective in clinical trials.
- Maybe antidepressants are effective for anxiety and/or stress.

Pharmacologic agents for PR

- Antidepressants
  - SSRI's for depression *and/or* anxiety
- Anxiolytics – *Fall risk?*
  - Benzodiazepines
  - Barbiturates
  - Non-benzodiazepine drugs

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GOLD Guidelines for Antidepressants in COPD

- 2017 *None*
- 2018-2022 *Sidestep the issue!*
  - "There is no evidence that anxiety and depression should be treated differently in the presence of COPD."

Vogelmeier CF, Criner GJ, Martinez FJ, et al. Global strategy for the diagnosis, management and prevention of chronic obstructive lung disease 2017 report. *Respirology.* 2017;22(3):575-601.

2018-22 GLOBAL STRATEGY FOR PREVENTION, DIAGNOSIS AND MANAGEMENT OF COPD

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Antidepressants in COPD

- In real world settings, 1/3 of depressed patients with COPD receive antidepressants.
- Patients with COPD prefer behavioral treatments to antidepressants.
- Neither their depression nor clinical condition are likely to be helped by antidepressants alone.

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COPD

- Here I list all the **large** randomized clinical trials of antidepressants for depression in COPD:
  - (there aren't any…)

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Building a Psychosocial Provider Referral Network: A very brief overview

Acknowledgments: Matt Whited and Eva Serber

Where to look for Psychosocial Treatment Providers

Ask around

- Colleagues (where do they currently refer?)
- PCPs
- Patients
- Local University departments
  - *e.g.,* psychology, MFT, counseling, etc.
  - If they can't be a resource, they can often recommend resources in the community

Ready-Made Referral Sources

- Veteran's Admin. Hospital
- Local hospital system or medical center
- Other Departments within your institution
- Local university/college clinics

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Ready-Made Referral Sources

- **Managed Care Entities** (MCEs) or **Managed Care Organizations** (MCOs):
  - May help link patients with treatment providers in the community if they can't afford care.

Internet Search Resources

- Most are opt-in
- You get to see how the provider presents themselves to clients in their own words
- Some listings may be outdated

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Internet Search Resources

- General search engine (e.g. google)
  - May not be able to trust the reviews
  - Look for mental health providers co-located with physicians
- www.findapsychologist.org
- Find a therapist (Psychology Today Website)
  - There are others like this, you'll see them when you do a google search, in our area they are 100% redundant
- Health insurance provider website
  - good for an individual outside of your referral list area
- Licensing bodies (poor resource)

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What to look for in Psychosocial Treatment Providers

(How do I find the good ones!?)

Backgrounds

- Master's level licensure
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Professional Counselor (LPC)
  - Licensed Marriage and Family Therapist (LMFT)
  - Licensed Clinical Addiction Specialist (LCAS)
- PhD level licensure
  - Licensed Psychologist (PsyD, PhD)
- Medical Licensures
  - Psychiatry
  - Psychiatric Nurse Practitioners

Treatments and Orientation

- **Health or adjustment to health conditions**
- **Behavioral Medicine**
- General
  - Cognitive Behavioral Therapy (CBT)
  - Behavior Therapy
  - Dialectical Behavior Therapy (DBT)
  - Acceptance and Commitment Therapy (ACT)
- PTSD
  - “Exposure”, Prolonged Exposure, Cognitive Processing Therapy
- Substance abuse

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Red Lights/Flags

Lights (relative to our patients needs)

- Red – Probably not a good provider
  - Primary approach other than above
  - Pseudoscience or weird things (dilutes the dose of effective treatment) like herbal remedies, energy psychology (Emotional Freedom Technique), etc.
  - Too many specializations and approaches relative to experience and background

Yellow Lights

Lights (relative to our patients needs)

- Yellow
  - Primary focus/interest other than depression/anxiety/PTSD/substance use
    - *e.g.,* relationships/marital, children – unless that's what they are seeking help for.
  - Focused on a population that may not include all of our patients
    - *e.g.,* religious-based counseling – unless they have expressed an interest ("Can I see the hospital chaplain?" "I want a Christian counselor")

Green Lights

Accepting new clients & saturday appointments are available for established clients. At Faith Based Counseling Services, LLC, our mission is to provide quality therapeutic services that embody the whole you, mind, body and spirit. We believe that in order to have overall balance and healing, you must be able to tap into all parts of you , which include spiritual connection. Therapeutic services are not provided in the form of preaching, but incorporate your connection with God. We utilize Godly principles to assist in strengthening you in order to enhance your ability to cope, see hope and imagine a better life for yourself.

La'Neika Benbow is a Licensed Clinical Social Worker & Marriage & Family Therapist with over 17 years of experience. This includes work with veteran's, special needs, medical issues, family, pre-marital, marital & general couples issues, elderly/alzheimers), providing strategies for caretaker stress reduction, assisting those with history of trauma & more.

Ability to offer opportunities for those whom we serve to incorporate their belief in God into treatment, allows ability to gain insight, hope & additional support needed for change to occur. The hope is that all will be empowered in a way that

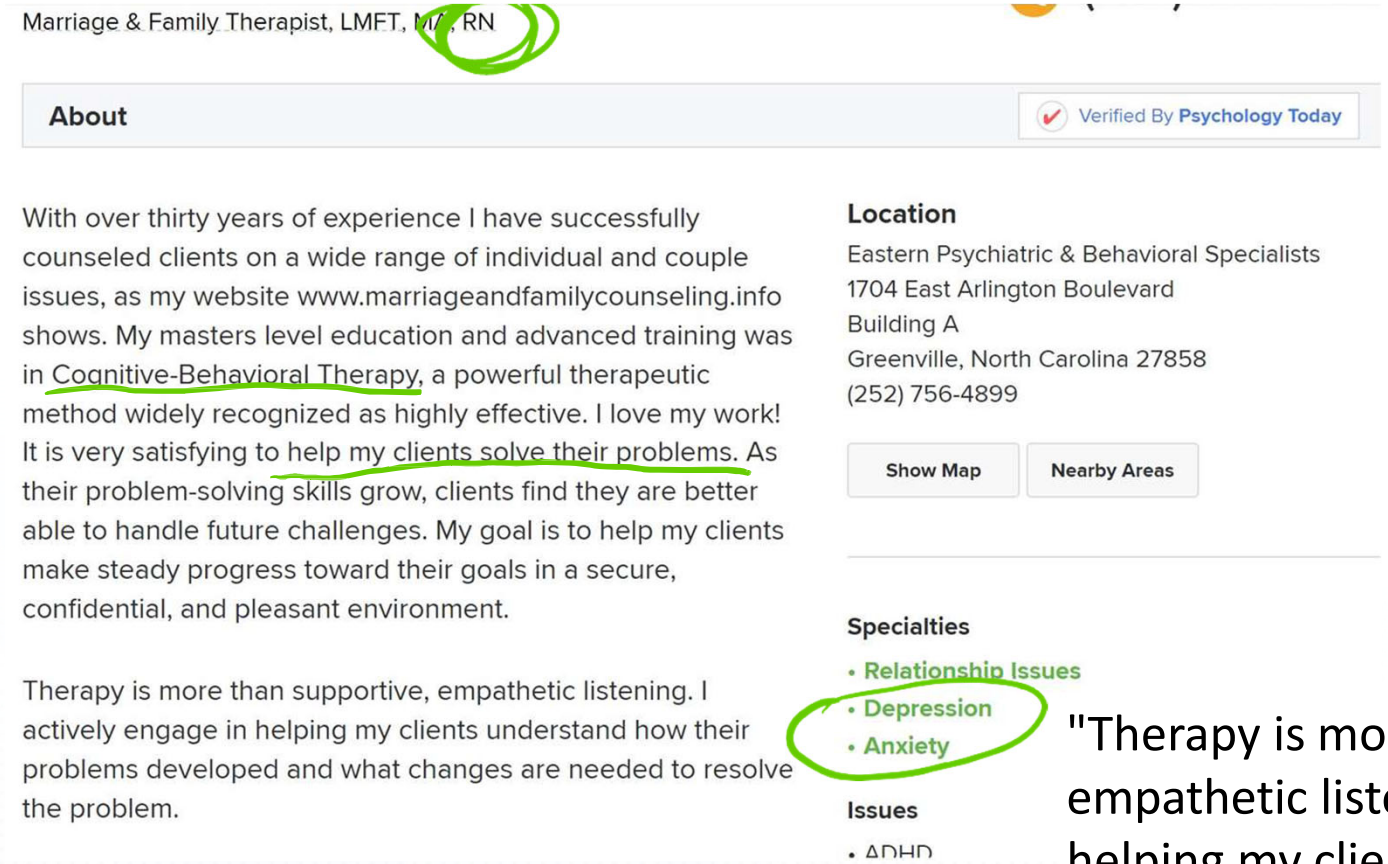
Email Us | Nearby Areas

Specialties

- Relationship Issues
- Depression
- Life Coaching

Issues

- Anxiety
- Coping Skills
- Domestic Violence
- Family Conflict
- Grief
- Life Transitions
- Marital and Premarital
- Parenting
- Self Esteem
- Spirituality
- Stress
- Trauma and PTSD
- Women's Issues



"Therapy is more than supportive, empathetic listening. I actively engage in helping my clients understand how their problems developed and what changes are needed to resolve the problem."

Some favored providers cluster within clinics

- You'll notice this when you see a clinic listed on a directory website, or when you see a few good providers at the same location.

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Another Example of a Behavioral Medicine Clinic in a Medical Center

Behavioral Medicine Clinic

Division of Bio-Behavioral Medicine

The Behavioral Medicine Clinic offers a broad range of behavioral medicine ("BMED") clinical services to patients with medical conditions, with an emphasis on coping and adjustment to chronic & complex health conditions, health behavior change, adherence behaviors and management of co-morbid psychiatric conditions.

We serve patient groups including Transplant surgery, GI/Metabolic and bariatric surgery, Psycho-oncology at Hollings Cancer Center, cardiovascular diseases, pulmonary diseases, and chronic pain. We primarily serve adults, though we occasionally see pediatric and adolescent patients for select services.

Pulmonary Behavioral Medicine

- Integrated behavioral medicine services within the MUSC Cystic Fibrosis Center for adult and pediatric patients
- Integrated behavioral medicine services within the MUSC nontuberculous mycobacteria (NTM) Program
- Outpatient therapeutic services including psychological intervention and pharmacotherapies for patients with a wide range of pulmonary and advanced lung diseases

Cardiology and Cardiac Rehab

- Outpatient therapeutic services including psychotherapies and pharmacotherapies for patients with a wide range of cardiovascular conditions, including adult congenital heart disease, arrhythmias and implantable cardioverter defibrillators, patients with mechanical cardiac support
- Integrated behavioral medicine clinic focused on brief, solution-focused interventions for cardiac and pulmonary rehabilitation (integrated clinic on hold with Covid-19 restrictions)

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Example of Community Clinic with Green “go” Flags

Coping With Medical Illness

I have a special interest in the relationship between emotional well-being and physical health and illness. Prior to beginning private practice, I served as an Assistant Professor and Director of Psycho-oncology Services at the Hollings Cancer Center at the Medical University of South Carolina

When someone is diagnosed with a medical condition, there is often a period of adjustment: to the diagnosis, treatment recommendations and control of symptoms and side effects of treatment. Significant worries, distress, sadness, difficulties with relationships as a result of changing roles and concerns about the future can be common struggles. Together, we can help you cope effectively as you navigate these health-related concerns.

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Contacting your short list: What to ask potential providers

Email or Phone Content

- Tell them a bit about our patient population, what challenges they face, and why you are contacting them
- Ask about
  - Comfort with patients with health issues and helping them improve their health behavior along with their mental health
  - Experience with helping people cope with physical illness
  - Accessibility of their office
  - Availability of appointments; waitlist; caseload
  - General strategies they may use with patients referred from CVPR*

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Email or Phone Content

- Ask about (cont'd)
  - Insurance accepted?
    - Medicare/Medicaid may be toughest (LME's more likely to accept in our experience)
  - Medication management – provided in house or is it referred out?

The final referral list

Making the Referral

https://www.aacvpr.org/resources-for-professionals#BMNR

1. Providing the list to anyone who screens positive or expresses difficulty
2. Fact sheet for the patient to take to the provider that details their exercise (or other health behavior) prescription and other relevant information
3. CVPR provider-initiated referral

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Update the Referral List Annually

- Add/remove providers
- Update contact information
- This is especially important if CVPR providers are not initiating the referral themselves

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Provide Mental Health Support using existing staff

Lifestyle interventions For CR and PR

- Is exercise an effective lifestyle intervention for depression, anxiety, and distress?
  - Yes

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CVPR Is FULL of behavioral interventions!

- Education and normalization
  - Specific conditions and expectations for symptoms, treatment, and recovery
- Engaging in exercise sessions
  - Successful experience – “I can do this.”
  - See improvements
- Social support – fellow pts and CR staff
- Gives direction, purpose

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CVPR Is FULL of behavioral interventions!

- Telemetry
  - perceived vs actual HR
- Supervised exercise
  - exposure to HR and exertion
  - physical sxs
- Relaxation and breathing exercises
- Pre- and post- observed outcomes

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Effective Behavioral Interventions

- Behavioral interventions “built into” CVPR
- Motivational interviewing
- Create a “therapeutic milieu”
- “Nudge:” Create a positive culture

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Create a therapeutic milieu

- A “therapeutic milieu” is a safe, structured group setting with a “culture” that is positive, hopeful, and supportive.
- “Culture eats strategy for breakfast.” (Peter Drucker, sort of).
- Much of our work happens in “micro interventions” (*e.g.,* brief patient encounters).

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“Nudge:” Create a positive culture

- “Culture eats strategy for breakfast.”
- Nudge theory from behavioral economics proposes that positive reinforcement and indirect suggestions influence behavior and decision-making in contrast with education, legislation or enforcement (Thaler and Sunstein, 2008).

Providing Interventions in CR

1. Behavioral interventions, such as psychotherapy or counseling.
2. Pharmacological interventions, such as medications used to treat anxiety, depression, or sexual dysfunction.
3. Behavioral interventions that can be incorporated into the CR program.

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Providing Interventions in CR

1. Behavioral interventions, such as psychotherapy or counseling
   - This is *probably* beyond the scope of what can be provided by CR staff
   - Do you have mental health referrals? Do they provide telepsychology?

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Providing Interventions in CR

1. Behavioral interventions, such as psychotherapy or counseling
2. Pharmacological interventions, such as medications used to treat anxiety, depression, or sexual dysfunction
3. Behavioral interventions that can be incorporated into the CR program
    1. Patient education
    2. Small group supportive counseling or stress management
    3. Exercise

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Discussion

- What has been your experience with mental health providers for your CR patients?
- What questions or concerns come up for you regarding your patient's psychosocial needs?
- What about patient's functioning gives you most concerns or discomfort?
- In what would you like to feel more confident when working with pt's psychosocial or behavioral needs?

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More References

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Psychosocial management in cardiac rehabilitation: Current practices, recommendations, and opportunities

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ABSTRACT

Psychosocial management is a core component of outpatient Phase-II cardiac rehabilitation (CR) and includes psychosocial assessment, providing interventions, measuring outcomes, and care coordination. Psychosocial management contributes to the effectiveness of comprehensive CR, but the implementation is not always consistent or clearly described in the literature, in part due to the availability of behavioral health specialists. Patients in CR have many psychosocial needs including anxiety, depression, substance use disorders, sleep problems, psychosocial stress, and cognitive impairment. Behavioral considerations are inherent in many other aspects of CR, such as participation in CR, health behaviors, adherence, and tobacco cessation. Evaluation, or psychosocial assessment, should identify significant issues, record related medications, and incorporate findings in the individual treatment plan. Some patients require further evaluation and treatment by a qualified behavioral health specialist. Psychosocial interventions provided to all patients include patient education, counseling, stress-management, a supportive environment, and exercise. Measuring outcomes entails repeating the psychosocial assessment when patients finish CR and documenting changes. Coordinating care requires understanding available local mental health infrastructure and procedures for making referrals, and may entail identifying additional resources. Interventions provided concurrently with CR to a subset of patients with more extensive needs are typically pharmacotherapy, psychotherapy, or addictions counseling, which are beyond the scope of practice for most CR professionals. The way psychosocial management is implemented suggests clinical and research opportunities. For example, the combined effects of antidepressants and CR on depression and anxiety are not known. A prominent *clinical opportunity* is to fully implement psychosocial assessment, as required by statute and the core components. This could involve referring patients for whom clinically significant psychosocial concerns are identified during the evaluation for a more thorough assessment by a behavioral health specialist using an appropriate billing model. A *research* priority is a contemporary description of behavioral health services available to CR programs, including how psychosocial management is implemented. As delivery of CR comes to include more alternative models (e.g., home-based), research is needed on how that affects the delivery of psychosocial management. Increased use of telehealth may broaden clinical opportunities for psychosocial management.

Contents

Abbreviations: AACVPR, American Association of Cardiovascular and Pulmonary Rehabilitation; CMS, Center for Medicare and Medicaid Service; CR, Cardiac rehabilitation; CPT, Current Procedural Terminology; RVU, Relative Value Unit.

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Thank you!

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