OPTUMHealth™ Education

Q&A Summary
The Impact of Behavioral Health Disorders on Chronic Medical Conditions

Responses completed by: Gary Rosenberg, MD, LFAACAP, DLFAPA, Behavior Health Medical Director, Optum Operations, Population Health Management; Thomas A. Blocher, MD, MBA, Medical Director, Optum, Population Health Solutions and Prevention

What do you think about eye movement desensitization and reprocessing (EMDR)? Will it be or is it recognized for UHC/insurance?

a. As indicated in the attached summary, EMDR has shown effectiveness in the treatment of anxiety and in particular PTSD. If provided by a trained and certified practitioner, a trial of six to eight sessions is indicated. One must check with his/her insurance provider to see if coverage for EMDR is included.

Is cognitive-behavioral therapy (CBT) used to treat opioid addiction now?

a. Because CBT takes on some of the negative or distorted thinking, it tackles cognition tendencies that are deeply ingrained in individuals struggling with addiction. By assisting clients to recognize the thinking that drives their addictive behavior, it can be an effective treatment modality for substance abuse. The treatment of opioid use disorder includes medication to address the physical addiction, like buprenorphine, and psychological therapies that address the psychosocial determinants of the disorder, which include CBT, family therapy, group therapy, and educational therapy often within the framework of Narcotics Anonymous support. In addition, therapy often includes specific physical and psychological modalities that address associated depression and anxiety disorders.

How do we get medical physicians and mental health physicians to work together?

a. Through the continuing efforts of medical associations and provider groups in association with the support of insurance companies and state and national organizations the goal of collaborative treatment can be achieved.

What are your thoughts on genetic testing being completed prior to beginning and/or changing prescription medication?

a. The conclusion of the American Psychiatric Association (APA) Task Force for Novel Biomarkers and Treatments, a component of the APA Council on Research, this spring was that there is insufficient data to support widespread use of pharmacogenomic tests in clinical practice to guide antidepressant treatment. Genetic

polymorphisms have been linked to antidepressant efficacy but many of these items are not included in commercially available tests.

I have noted a trend in behavioral health practices wherein patient must go through multiple visits, counseling and group therapies before seeing a psychiatrist. What is driving this?

a. Unfortunately, there is a shortage of psychiatrists based on the need demonstrated in most communities, so patients are often first evaluated and sometimes treated prior to the first session with a psychiatrist. In fact, as indicated in the presentation, most patients for a variety of reasons have their medications managed by their primary care physician (PCP).

I have a member that feels she is having some depression. She does not have a behavioral health provider. Her PCP does not feel she has depression. She has asked for Family and Medical Leave Act (FMLA) for a few weeks to help her with her emotional health, but her PCP will not complete the paper work and support her in the effort. What suggestions should I give this member?

a. The patient can ask her PCP for the names of psychiatrists in the community with whom her physician has a working relationship. In addition, the patient can find the names of psychiatrists in the community to seek an evaluation appointment.

How do you address stigma of seeing a psychiatrist, [in other words,] when a member wants to only see his/her PCP and declines need for other mental health professionals?

a. Most people have their psychiatric medications prescribed and managed by their PCP for various reasons including comfort, cost and lack of ready availability of psychiatrists in the community. The PCP will hopefully have a working relationship with psychiatrists in the community from whom he/she can seek support and guidance as needed. There are 30-plus states in the country that have a Child Psychiatry Access Program available that can provide telephone consultation with a child psychiatrist or social worker as needed as well as a one-time individual assessment if needed.

Would it be possible to add a template for RNs to send MDs referrals on mental health issues, just as we do for medical issues to the internal medicine director?

a. Please check with your supervisor, as there is now an active Behavioral Health Case Management Psychiatry team that is available for consultations every day of the week from nine to five.

What are your thoughts on functional and structural MRI studies on patients brains with chronic pain as a method to open the discussion of mental health wellbeing when the imaging results identify brain and peripheral nerve abnormalities—where there may be an alteration if from bottom-up pain to top-down pain?

a. There is no evidence now that supports MRI testing in this situation. However there is overwhelming evidence that supports the role of psychological issues in pain and therefore in the holistic treatment of pain.

Is there still a decrease in life expectancy with mental illness and/or chronic illness that is well managed?

a. The words "well managed" are the key to the answer, as we are not able to use the word "cured." As a result, there are still issues that impact the patient's physical and biological status that will impact both the quality and length of the individual's life.

Other than working with the parent/caregivers how can we best help our children?

a. There are significant psychosocial issues that can impact children that are outside of the control of the parents, caregivers and the child. We can all work together to make our world a safer and healthier place to live.

I don't know anyone with a perfect childhood. We all have had a poor situation in some aspect of our childhood. Are we all functioning with a mental illness? Or is the difference that some of us can function with our mental illness?

a. It is not that we all have mental illness but we all have issues and experiences that shape us and influence us on a daily basis in combination with our genetic and physical traits. Most people in fact deal with the issues effectively within the construct of their support system and their positive individual qualities and traits. It is a complex and multi-determined process that will result in the presence of mental illness in some of us.

How can we encourage members who obviously need intervention but who are not interested in employee assistance program (EAP) contact information?

a. Great question! Read the answer near the end of this Q&A about med resistance. We do not always know where people are coming from. Too often when we hit a "roadblock" we just let things drop and try another path. In order to make progress, we have to try to understand where these ideas are coming from! This is includes being able to let the member refuse the treatment that WE have determined to be the best for them.

Would CBT be an option for an adult with Asperger's and multiple medical conditions, who sees a psychiatrist and is taking lorazepam as his only therapy? He has social communication/isolation issues.

a. CBT is a good option for an adult with Asperger's. I am not an expert in this area, but we do have subject matter experts for ASD.
b. The recent genetic research update on ASD reveals that this is a highly genetic condition, with KNOWN biological defects.

How do you determine opioid addiction when a patient is in pain? Is it addiction if used for pain?

a. Opiates taken for acute pain (three–five days) does not seem to be the issue. It is its use for chronic pain where we get into trouble. These are different conditions with different pathophysiologies.
b. Chronic pain is more difficult and requires more in-depth knowledge than the average pain management physician has in his/her toolbox. Chronic pain often requires a specialist.
c. In phantom-limb pain, the individual experiences pain in extremities that are no longer there! In chronic pain, the individual can experience “central pain,” which is pain that is being generated in the brain, not the peripheral nerves (just like the phantom limb).
d. In chronic pain, the opiates are problematic. They are generally not effective for central pain, so what the member is seeking is actually sedation. After prolonged use, the brain can no longer tell the difference between pain and withdrawal. So when the meds wear off, the member screams that he/she is in PAIN, when he/she is actually in WITHDRAWAL. Paradoxical effects commonly occur, wherein the opiates are actually stimulating pain, and then the member has to take MUCH MORE opiate to sedate away this new substance-induced pain. Autonomic nerves and the adreno cortical axis are affected, making things REALLY complicated.

What is the United States’ incidence of depression compared to other countries?

a. The U.S. tracks with rest of the world. There used to be some increased incidence of depression in the Northern climates, but this is no longer thought to be valid.

Can CPT be taught in a 10–30 minutes session?

a. CPT = “Current Procedural Terminology.”
b. After many years, I am now sadly aware that learning about CBT and DBT does not mean that I know how to actually use these tools. This takes practice, and lots of clients!

CBT seems very helpful. How can I find more information on this?

a. There are programs available on the Internet.
b. Since these tools require a lot of practice, I have found that group learning is the very best. If you and your team could takes this on, you would be surprised how much fun it is to learn these skills. I am a pretty good supervisor and teacher on this subject, but my team regularly blows me out of the water with their remarkable insights, practical approached, and support!

How do we help improve behavioral health (BH) care coverage and make it more accessible?

a. We have created a false dichotomy between BH and medical care. When the skin turns yellow in hepatitis, is that a dermatology diagnosis? Is shortness of breath in congestive heart failure a lung disease? We have to stop thinking that BH can interfere with physical health, and see the two as parts of the overall condition. Therefore, we are ALL behavioral health providers!!!
b. I highly recommend the Motivational Interviewing text (Miller and Rollick) for everyone, especially primary care providers. Wait a minute, we are ALL primary providers.

How would address reluctance to take medications?

a. Medication resistance can be caused by a wide variety of conditions: thought disorder with paranoia (if you do not believe me on this, then just read the paper and watch the news!); PTSD from prior experience with healthcare providers; PTSD from the loss of a loved one (almost always blaming the doctor/meds); we ourselves have prejudices; many of our members suffer from poor health literacy and/or poor self-care skills; and more!

Was surprised drug addiction wasn't one of the listed risk actors in earlier slide. Can you please touch on working with drug-/heroine-addicted members?

a. I am surprised as well! Substance use disorder (SUD) is perhaps the greatest of all MBI issues. We have to be able to see the member as a prisoner of his/her addition instead of as a BAD patient.