Primary Care Behavioral Health Toolkit

A public-private partnership
transforming primary care
www.pcpci.org

Provided as part of *Primary Care Behavioral Health (PCBH) Introduction and Foundations* training provided by Mountainview Consulting Group through the Patient-Centered Primary Care Institute

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A library of editable documents included in this implementation kit is available by clicking here, or by visiting our website: www.pcpci.org.

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Organizational Readiness Tool

Name: Date:

Implementing Primary Care Behavioral Health Services **Organizational Readiness Tool**						
Use a rating scale of 1 = low success and 5 = high success to assess your current level of success for resolving all issues within each of the 7 domains below. You can simply make a checkmark in the column corresponding to the skill rating that best describes your organization's current success level.						
Domain	**Issues**	**Success Rating** (*1 = low; 5 = high*)				
		1	**2**	**3**	**4**	**5**
I. Political and Organizational	1. Insure senior level management ratifies strategic vision					
	2. Involves key internal stakeholders (department heads, office managers)					
	3. Involve internal "opinion leaders" (team leads, vocal supporters)					
	4. Link with key external stakeholders (consumers, CMHC's, social service agencies, hospitals, CCOs, schools)					
	5. Hold staff/section discussions to create "buy in" for change					
	6. Address philosophical resistances to integration					
	7. Provide "preparatory" workshops/training to increase understanding of integration initiative					
	8. Identify teams/units most ready to change					
	9. Involve skeptics in design and development process					
Domain **I** total score: Add numbers associated with your checkmarks and divide by nine for average readiness rating. Any individual rating below 3 signifies a problem area.						

Domain	Issues	Success Rating (*1 = low; 5 = high*)				
		1	**2**	**3**	**4**	**5**
II. Core Program Philosophies	1. Adopt a population based care philosophy					
	2. Aim to create a seamless delivery system, high coordination					
	3. Emphasize consistent services across teams, clinics and sites					
	4. Develop both brief intervention and pathway services					
	5. Support cultural competence among services & clinicians					
	6. Base system of care in a well documented administrative process & structure					
	7. Adopt an evidence based care approach to developing clinical services					
	8. Develop a team-based sustainable clinical practice for BH and PC clinicians and other PCPCH team members					
	9. Design a service that is feasible to implement & operate					
	10. Embed integrated services in a team approach to healthcare					
Domain **II** total score: Add numbers associated with your checkmarks and divide by 10 for average readiness rating. Any individual rating below 3 signifies a problem area.						

Domain	Issues	Success Rating (*1 = low; 5 = high*)				
		1	**2**	**3**	**4**	**5**
III. Financing Strategies	1. Identify payment mechanism for BH providers					
	2. Evaluate benefit design and change as needed					
	3. Develop sustainable budget strategy					
	4. Create mechanisms for collecting insurance revenues					
	5. Identify methods for risk sharing with partners					
	6. Develop agreements for distribution of cost savings					
Domain **III** total score: Add numbers associated with your checkmarks and divide by 6 for average readiness rating. Any individual rating below 3 signifies a problem area.						
IV. Program Mission, Scope & Tactics	1. Create a written "service manual"					
	2. Define scope of services					
	3. Identify types of services provided					
	4. Describe clinical and team role expectations					
	5. Agree on the populations eligible to receive services					
	6. Detail excluded services					
	7. Generate triage and referral criteria for outside services					
	8. Define linkage protocols for working with CCOs and/or other community resources					
Domain **IV** total score: Add numbers associated with your checkmarks and divide by 8 for average readiness rating. Any individual rating below 3 signifies a problem area.						

Domain	Issues	Success Rating (*1 = low; 5 = high*)				
		1	**2**	**3**	**4**	**5**
V. Administrative Infrastructure	1. Create a policies and procedures "service" manual					
	2. Agree on reporting and supervisory relationships					
	3. Address administrative staffing requirements					
	4. Define charting and documentation requirements					
	5. Develop a workable service capture and billing system					
	6. Write core policies and procedures					
	7. Develop recommended schedule templates					
	8. Agree upon clinical staffing ratios					
	9. Identify roles and responsibilities of different disciplines					
Domain **V** total score: Add numbers associated with your checkmarks and divide by 9 for average readiness rating. Any individual rating below three signifies a problem area.						
VI. Staff Training	1. Agree to necessity of skill based training for BH providers, PCCs, RNs and CNAs					
	2. Offer workshops and training sessions					
	3. Use best practices approach to training targets					
	4. Use services manual as key training tool					
	5. Provide in vivo training and support using a local "champion"					
	6. Agree to make training and mentoring available over time					
	7. Employ structured case discussions					
Domain **VI** total score: Add numbers associated with your checkmarks and divide by 7 for average readiness rating. Any individual rating below 3 signifies a problem area.						

Domain	Issues	Success Rating (*1 = low; 5 = high*)				
		1	**2**	**3**	**4**	**5**
VII. Performance Indicators	1. Describe costs and outcomes of integrated services					
	2. Measure whether population care targets are met					
	3. Assess consumer and provider satisfaction with integrated services					
	4. Analyze program accessibility and penetration rates					
	5. Describe the problems/service needs of patients and the degree of match with services received					
	6. Develop practice profiles for individual clinicians and PC teams					
	7. Collect information at the level of clinicians, teams, sections and clinics					
	8. Adopt performance indicators as a "core" management tool					
Domain **VII** total score: Add numbers associated with your checkmarks and divide by 8 for average readiness rating. Any individual rating under 3 signifies a problem area.						

PCBH Sample Manual

Your Clinic

PRIMARY CARE BEHAVIORAL HEALTH

PROGRAM MANUAL

Date

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I. Acknowledgment

This provisional manual was developed as a result of the efforts of many pioneers in development of the Primary Care Behavioral Health (PCBH) model.

The manual describes basic features of the PCBH program and guidelines for day-to-day operations of the PCBH in primary care clinics.

Behavioral Consultation and Primary Care: A Guide to Integrating Services (Robinson & Reiter, 2007) provides additional information to support implementation and ongoing development of services.

The Department of Defense Instruction (DoDI) (August 8, 2013), *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings*, also provides additional guidance concerning the roles and responsibilities and training of providers working in the PCBH model.

References related to the PCBH model are also provided in Appendix J.

II. Vision and Mission

YOUR CLINIC has a long history of providing mental health (MH) and substance abuse (SA) services to primary care patients. Some patients receive additional services in the specialty MH and SA sector. Research and experience that an approach promoting separation of specialty and primary care services falls short in meeting the needs of primary care patients who need accessible and coordinated care.

YOUR CLINIC is pursuing two goals in an effort to improve primary care services to patients with behavioral health care needs:

1. To ensure that behavioral health clients have primary care homes.
2. To increase behavioral health services in primary care clinics.

The Primary Care Behavioral Health (PCBH) Model is being implemented in YOUR CLINIC to address Goal 2. Following are the key anticipated outcomes of the model:

- Improve system performance through increased access to behavioral health services for primary care patients.
- Increase satisfaction of patients, Primary Care Clinicians (PCCs), behavioral health providers, and other clinic staff by providing interventions that have proven to be successful in addressing specific problems and needs.
- Improve health-related quality of life by increasing clinical functions through evidence-based practices and interventions.
- Assist patients in addressing their behavioral health needs by increasing access to primary care services during primary care visits.

Purpose

The PCBH Model aims to improve overall health outcomes for patients by improving access to efficient and effective behavioral health services within the primary care clinics.

III. Guidelines, Goals, and Objectives

A. The Role of Behavioral Health in Primary Care

Approximately 28% of Americans experience a diagnosable psychiatric disorder in any given year. Half of this group receives no care at all. Of those that do, only about half get the care from a specialty MH clinic. Instead, most rely on other health care providers, especially PCCs (Narrow, Regier, Rae, Manderscheid, & Locke, 1993).

Up to 70% of primary care medical appointments are for problems stemming from psychosocial issues (Gatchel & Oordt, 2003). These concerns can take many forms; the most obvious being bona fide psychiatric disorders. For example, a survey of consecutively scheduled adult primary care patients found that 19% met criteria for major depression, 15% for generalized anxiety, 8% for panic, and another 8% for substance use. Between 36% and 77 % had more than one disorder (Olfson et al., 2000). During one week of practice, the average PCC will see the full spectrum of MH disorders, from depression and anxiety to SA and psychotic disorders. PCCs regularly handle care for chronic psychiatric problems, as well as acute flare-ups (e.g., a suicidal patient).

Because they provide care across the lifespan, many PCCs also treat child behavior problems, such as Attention Deficit Hyperactivity Disorder (ADHD), in addition to the problems of adults and older adults. Keep in mind that they do all of this while also tending to the medical needs of patients. Recalling our earlier comments that non-psychiatric physicians treat the majority of psychiatric patients and prescribe the majority of psychotropic medications in this country, it is no wonder that primary care has been labeled the country's "de facto mental health care system" (Regier et al., 1993).

PCCs do not have adequate time or training to address the behavioral health issues in a typical 15-minute encounter. PCCs find it difficult to keep pace with scheduled appointments when numerous high-need patients are awaiting care. Patients in need of care may leave without receiving care when wait times become too long to tolerate. When PCCs refer patients for specialty MH services, patients often have difficulty making or keeping those appointments. The mismatch between patient needs and availability of services results in unsatisfactory outcomes for both patients and PCCs.

Comprehensive Mental Health Service (CMHS) provides only a fraction of the services needed by this population: a FY01 overlap analysis showed that of the ? patients served in YOUR CLINIC clinics, ?% had a documented behavioral health issue. Of those, only ?% were seen by specialty behavioral health providers.

Patients may not access CMHS because they: 1) may not know about CMHS; 2) may not be willing to go to CMHS; 3) have tried CMHS services and may not perceive a benefit; 4) may

not qualify for access (i.e., does not meet serious mental illness criteria); or, 5) may face social barriers to accessing CMHS services (stigma, transportation, etc.).

YOUR CLINIC has made attempts to address the psycho-social needs of patients who are within the primary care system. The Behavioral Scientist at the YOUR CLINIC works diligently to teach residents and provide clinical services for patients at that clinic. Only a fraction of primary care patients will have access to the behavioral health provider at YOUR CLINIC and no patients; the remainder will be managed by their PCC who generally does not have the time to manage behavioral problems in the time allotted in the medical appointment. Patients seeking care at t YOUR CLINIC have had no access to on-site behavioral health services; until the past few months, the only care available was through their Primary Care Clinicians.

These findings make a compelling case for integrating behavioral interventions into the daily provision of primary care services.

B. Primary Care Behavioral Health Integration Model

After review and examination of several models of integration, YOUR CLINIC elected to implement the PCBH Integration Model as developed by Dr. Patricia Robinson and Dr. Kirk Strosahl in YOUR CLINIC. (A full description of the model can be found in Robinson and Reiter, 2007.) This approach is a shift from the traditional roles and responsibilities of a MH care provider. Instead, the PCBH provider functions as a consultant to, and core member of, the primary care team.

The term selected for this new type of provider is Behavioral Health Consultant (BHC). The most important conceptual characteristics that distinguish the PCBH approach from the traditional delivery of specialty behavioral health services (MH and SA treatment) can be seen below in Table 1.

Table 1: Conceptual Distinctions of the PCBH Model versus Specialty Behavioral Health Models

Dimension	PCBH	Specialty Behavioral Health (BH)
Model of Care	Population-based	Client-based
Primary Care Receivers	PCC, then patient	Client, then others
Key goals	1. Promotes PCC efficiency and increases impact on many patients. 2. Supports small change efforts in many patients. 3. Prevents morbidity in high risk patients. 4. Achieves medical cost savings.	1. Provides intensive services to fewer clients with high acuity in order to resolve MH and SA issues. 2. Less capacity to delegate resources to prevention in less acute clients.
Therapist model	Part of an array of primary care services to many clients.	A specialized and separate referral service available to few clients.
Care Manager	PCC	Specialty behavioral health provider
Dominant modality	Consultation	Specialty behavioral health treatment
Access to care	Same day, every day	Determined by resources, usually with some waiting periods.
Cost per episode of care	Potentially decreased	Highly variable, related to client condition.

C. Key Principles of the PCBH Integration Model

Principle #1:
The BHC's role is to identify, treat, triage, and manage primary care patients with medical and/or behavioral health problems.

The defining characteristics of the PCBH philosophy of care are that:

1. Maladaptive behaviors are learned and maintained by various external or internal rewards.
2. Many maladaptive behaviors occur as a result of skill deficits.
3. Direct behavior change is the most powerful form of human learning.

Consequently, consultative interventions focus upon:

1. Helping patients replace maladaptive behaviors with adaptive ones.
2. Providing skill training through psycho-education and patient education strategies.
3. Developing specific behavior change plans to fit the fast work pace of the primary care setting.

The PCC and Registered Nurse (RN) support interventions initiated by the PCB over time and involve the BHC in on-going care of the patient as needed.

The PCBH model can dramatically increase the quality of behavioral health care provided in the primary care setting.

1. The PCBH model delivers evidence-based interventions for a large variety of patients with emotional and behavioral problems commonly seen in primary care; for example, depression, panic disorder, generalized anxiety disorder, and chronic pain.
2. The PCBH model approach is equally facile at addressing illness and health promotion behaviors; for example, mitigating headaches and developing a healthy weight through diet and exercise.

Principle #2:
The BHC functions as a core member of the primary care team, providing consultative services.

The BHC provides behavioral health services to primary care patients as a consultant to the primary care team. While the BHC will see many patients for a single visit and provide recommendations to the PCC to enhance the patient's care plan, the BHC will see other patients for a longer time period, providing on-going skill training and coaching to help the patients improve their functioning in key life roles and improve or maintain health. The BHC does not have a caseload and supports the relationship between the PCC and patient.

1. The BHC's role is to enrich and support the ongoing relationship of the PCC and the patient by implementing behavioral health interventions generated by the referral of the PCC.
2. There is no attempt to take charge of the patient's care, as is the case in specialty MH and SA services.
3. The focus is on resolving problems within the primary care service context. In this sense, the behavioral health provider is a key member of the primary care team, providing needed expertise on behavioral health related matters to each team member.
4. Behavioral health interventions look like primary care visits (rather than specialty care visits). Visits are brief (15-30 minutes), limited in number (1-6 visits per patient with an average of between 2 and 3), and are provided in the primary care practice area so that the patient views meeting with the BHC as a routine primary care service.
5. The referring PCC is the chief "customer" of the BHC's consultative service and, at all times, remains the overall care manager.

Principle #3:
The PCBH Model is grounded in a population-based care philosophy.

The PCBH model uses a clinic-wide, population-based care perspective rather than a case focus perspective. The goal is to detect and address a broad spectrum of behavioral health needs in the primary care patient population with the aim of early identification, quick resolution, long-term prevention, and wellness for as many patients as possible. This perspective of delivering healthcare services is accomplished through brief interventions and pathway programs, which are described below.

Brief Interventions

Brief interventions are brief services delivered at the time of need for any patient with a psychosocial concern or a need for assistance with making a behavior change. Patients requiring complex MH and SA treatment are referred into the specialty behavioral health system, as requested by the PCC. See the Quick Guide in Appendix F for examples of specific interventions the BHC provides.

Pathway Programs

PCBH services are also delivered through pathway programs. A PCBH pathway describes specific assessment and intervention activities designed to improve outcomes for patients in a high impact group. A patient group may be considered high impact if there is a large number of patients in the group with a specific condition (e.g., overweight/obesity or depression) or if they have a higher pattern of using services and/or have less than adequate health care outcomes (e.g., patients with chronic pain).

PCBH pathway programs may involve a variety of service delivery formats, including individual visits, class visits, and group visits. Typically, class visits are time limited and focus on building specific skills, while group visits are on-going and focus on helping patients develop and apply skills consistently over an extended period of time. For example, a workshop on sleep hygiene or a series of classes on tobacco cessation are typically described as classes, while visits to a group that meets monthly to provide on-going support to chronic pain patients would be considered a group visit.

Pathway programs are developed at the clinic level using available information such as cost information, satisfaction data, and knowledge about available resources. In some cases, pathway programs will describe tasks to be completed by PCCs and RNs to improve patient clinical outcomes, use of clinic resources, and provider satisfaction. As clinics initiate pathways, they often start with piloting a few initial steps in the pathway. As corrections are made, the pathway will continue to develop guided by on-going evaluation and collection of outcome data.

Principle #4:
The BHC seeks to enhance delivery of behavioral health services at the primary care level and works to support a smooth interface between primary care and specialty services (MH and SA treatment).

The BHC promotes a link between medicine and a variety of behavioral health services provided in the community resources. The BHC works with the PCC team in an effort to match the patient's level of need to the appropriate level of care. The primary care team uses a standardized referral and coordination of care protocols so that patients easily flow to and from specialty MH and SA services.

In order to increase the number of eligible patients that receive appropriate behavioral health services, the BHC assists the PCCs to:

1. Recognize and treat behaviors related to mental disorders and psychosocial problems.
2. Detect "at risk" patients early with the aim of preventing further psychological or physical deterioration.
3. Prevent relapse or morbidity in conditions that tend to recur over time.
4. Prevent and manage addiction to pain medicine or tranquilizers.
5. Prevent and manage work and/or functional disability.
6. Identify appropriate interventions that will result in desirable clinical outcomes for patients with high prevalence mental disorders.
7. Promote efficient and effective treatment and management of patients with chronic emotional and/or health problems.
8. Use behavioral interventions to manage patients who use medical visits in order obtain needed social support.
9. Improve the quality of PCC interventions without the aid of behavioral health consultation.
10. Efficiently and effectively move patients into appropriate MH and SA specialty care when appropriate and available.

D. Program Goals and Evaluation Processes

Experience in other healthcare systems has shown that implementing an effective PCBH program improves clinical, satisfaction, and cost outcomes. (Katon, Robinson, et.al., 1996) YOUR CLINIC expects that integrating behavioral health providers into the primary care setting will result in the same outcomes.

Table 2 defines an overview of the goals and objectives of the performance review plan for monitoring and evaluating the PCBH program over time. Appendix A includes the measures that may be used in some or all YOUR CLINIC clinics to determine whether program goals and objectives are being met.

Table 2: YOUR CLINIC Performance Goals and Objectives

I. Patient Outcomes	**Objective**
1. Patients' health-related quality of life indicators improve through provision of PCBH model of care.	A. Adult primary care patients who receive services from a Behavioral Health Consultant show improvement in their health-related quality of life.
	B. Children/youth who receive services from a Behavioral Health Consultant show improvement in their psychosocial wellbeing.
	C. Patients participating in Pathways (self-care; self-management) show improvement in one or more areas of health.
	D. Patients who are identified as high risk/high cost patients who are only engaged in urgent/emergent services (e.g., high utilizers of multiple medical systems) are connected to a PCC.
II. Access	**Objective**
1. Access to PCCs improves.	A. PCCs demonstrate an increase in the average number of patient encounters per clinical hour.
	B. Wait times for PCC appointments decrease.
	C. High users of primary care visits who participate in Pathways demonstrate a reduction in PCC visits.
2. Access to behavioral health services for patients in the primary care setting improves.	A. Patients who have no histories in specialty BH / SA have their behavioral health issues detected and addressed in the PCBH model of care.
	B. Patients who have only urgent/emergent histories in specialty BH / SA have their behavioral health issues detected and addressed in the PCBH model of care.
	C. Patients in need of specialty behavioral health services are referred and connected.

III. Experience and Satisfaction	**Objective**
1. Patients experience the PCBH model of care as beneficial.	A. Patients (or their parents) express overall satisfaction with services provided in the PCBH program.
2. PCCs experience the PCBH model of care as beneficial.	A. Increasingly, PCCs report reduced barriers to use of PCBH services.
	B. Increasingly, PCCs indicate a stronger likelihood of working with the PCBH staff to develop and support a behavior change plans for their patients.
	C. Increasingly, PCCs indicate confidence in the PCBH program as beneficial to most of their patients.
	D. Increasingly, PCCs indicate belief that PCBH services help them provide better primary care to their patients.
3. PCBH staff experience the PCBH model of care as beneficial.	A. Increasingly, PCBH staff express satisfaction with providing PCBH services.
	B. Increasingly, PCBH staff indicate confidence that PCBH services are beneficial to their patients.
	C. Increasingly, PCBH staff indicate confidence that PCBH services are beneficial to PCCs.
IV. Fidelity to the Model	**Objective**
1. PCCs utilize the PCBH Program.	A. PCCs refer a minimum of 10% of their patients to the Behavioral Health Consultant.
2. BHCs demonstrate fidelity to the PCBH model.	A. Less than 5% of patients who see a BHC see the PCB for more than 11 individual visits / year.
	B. BHCs complete eight or more face-to-face patient visits/day in year one; and ten in year two.
	C. 50% of new referrals to BHCs receive a BHC visit on the same day of the medical visit (i.e., via a “warm hand-off”).
	D. On average, less than 15% of patients seen by the BHC are referred to specialty behavioral health services.

IV. Roles and Responsibilities of PCBH Team

There are a number of key players in the PCBH model. In this section, the roles and responsibilities for each of these positions as they related to the PCBH Program are described.

- PCBH Providers
    - A. Behavioral Health Consultant
    - B. Behavioral Health Consultant Assistant*
    - C. Behavioral Health Consultant Facilitator*
- PCBH Primary Care Team Members
    - D. Primary Care Clinician
    - E. Registered Nurse
    - F. Medical Assistant
- PCBH Leadership
    - G. Medical Director**
    - H. PCBH Lead
    - I. PCBH Supervisor
- PCBH Resources
    - J. PCBH Advisor
    - K. PCBH Clinic Committee

*Some clinics may not have Behavioral Health Consultant Assistants or Behavioral Health Consultant Facilitators, but may at some point in the future.

**Some clinics may not have a Medical Director. For those without a medical director, the leadership team will determine what member of the staff provides the tasks typically completed by the Medical Director.

A. PCBH Provider: Behavioral Health Consultant

The BHC role is a behavioral health provider who: 1) operates in a consultative role within a primary care team utilizing the PCBH Model; 2) provides recommendations regarding behavioral interventions to the referring PCC; and 3) conducts brief interventions with referred patients on behalf of the referring PCC.

The BHC role can be assumed by psychologists, psychiatric, and medical social workers; marriage and family therapists; and licensed master's level counselors.

The BHC responsibilities include the following:

1. Maintains a visible presence to the PCCs during clinic operating hours.
2. Is available for "curbside" consultation (a brief interaction between the PCB and a PCC) by being in the clinic or available by phone or pager.
3. Is available for same day and scheduled initial consultations with patients referred by PCCs.
4. Performs brief, limited follow-up visits for selected patients
5. Provides a range of services including screening for common conditions, assessments, and interventions related to chronic disease management programs.
6. Conducts risk assessments, as indicated.
7. Provides psycho-education for patients during individual and group visits.
8. Assists in the development of clinical pathway programs, group medical appointments, classes, and behavior focused practice protocols.
9. Maintains an up-to-date library of patient education materials for commonly seen problems.
10. Identifies, reviews, and modifies educational materials for literacy level and cultural appropriateness under the supervision of the PCBH Supervisor.
11. Provides brief behavioral and cognitive behavioral interventions for patients
12. Triages patients with severe or high-risk behavioral problems to CBHS or other community resources for specialty MH services consistent with Step-up/Step-down criteria.
13. Provides PCCs with same-day verbal feedback on client encounters either in person or by phone.
14. Facilitates and oversees referrals to specialty MH / SA services, and when appropriate, support a smooth transition from specialty MH / SA services to primary care.
15. Presents the PCBH model to private and public programs and agencies, in order to establish effective linkages and resources.
16. Prepares brief consultant notes for the medical chart that explain assessment findings, interventions delivered, and recommendations made to the PCC.
17. Maintains clinical records and other necessary paperwork in a timely manner to comply with all administrative regulations.

18. Educates PCCs in the basic principles of brief behavioral and cognitive behavioral interventions and reinforce their use in the medical visit.
19. Supports collaboration of PCCs and psychiatrists concerning medication protocols.
20. Provides assistance in capturing program evaluation and fidelity measures.
21. Attends clinic meetings, including all staff, PCC, Clinic Leadership, and Clinic PCBH Committee meetings as requested by Clinic Site Director and or PCBH Program Supervisor.
22. In primary care clinics with two or more BHCs, one BHC may be designated as the BHC Lead. The Clinic Site Director may appoint the lead; otherwise it will be based on seniority. A small amount of the BHC Lead's time may be shifted from clinical activities to administrative activities and attending meetings.

In general, the BHC does not provide time intensive case management and traditional medical social work services such as referral management and coordination, procuring durable medical goods, and patient advocacy. In the future, these services may be provided by BHC Assistant.

Core Competencies for the BHC are included in Appendix B.

B. PCBH Provider: Behavioral Health Consultant Assistant

In the future, YOUR CLINIC may employ staff members to work as BHC Assistants. The BHC Assistant role is to work as a member of the primary care team providing services to patients in medical clinics consistent with the PCBH Model. In general, the job of the BHC Assistant is to extend the services of the BHC and manage patient flow related to BHC patient contacts. The nature of interaction between BHC Assistants and the Medical Assistants (MAs) will vary from clinic to clinic.

The responsibilities of the BHC Assistant include the following:

1. Is accessible and visibly present to members of PCBH team during clinic hours.
2. Is available to primary care patients and health professionals on a same-day basis.
3. Provides triage and patient flow assistance to the BHC.
4. Administers standard screening and outcome measures instruments.
5. Facilitates PCC and patient requests for same-day and future consultations with the BHC.
6. Performs interpretation services for the BHC and supports the BHC in providing culturally sensitive services.
7. Provides requested interventions related to chronic disease management pathways.
8. Assists the BHC in delivery of group visits.

9. Provides support to the PCBH pathway program work (e.g., constructing and maintaining chronic disease management registries).
10. Assures availability of patient education and other materials related to PCBH work.
11. Manages and coordinates referrals to specialty behavioral health services including MH and SA services.
12. Assists patients in meeting basic needs such as food, shelter, clothing, benefits.
13. Maintains up-to-date contact information about commonly-used community resources.
14. Manages and coordinates referrals to community resources.
15. Supports patient in obtaining durable medical equipment.
16. Supports patient in obtaining legal services and benefits advocacy services as requested by the BHC, RN, or PCC.
17. Completes selected sections of commonly used forms.
18. Represents PCBH Program staff in meetings with local community groups and governmental and social agencies to provide information on the activities and goals of the PCBH program.

Core Competencies for the BHC Assistant are included in Appendix B.

C. PCBH Provider: Behavioral Health Consultant Facilitator

In the future, YOUR CLINIC may employ staff members to work as BHC Facilitators. The role of the BHC Facilitator is to assist the primary care home/medical home team with on-going care for patients who are most at risk for poor health outcomes. This may involve development of patient registries and initiation of on-going contact with identified patients until gains are made. In some cases, the BHC Facilitator will coordinate care with an external prescriber of psychotropic medications.

The responsibilities of the BHC Facilitator include the following:

1. Is accessible by phone or in person during all clinic hours.
2. Is available to primary care patients and health professionals on a same-day basis.
3. Responds to referrals from the BHC, PCC and RN.
4. Administers standard screening and outcome measures instruments.
5. Supports patient practice of skills learned in consults with the BHC.
6. Provides requested interventions related to management of serious mental illness and substance abuse problems.
7. Provides requested interventions related to chronic disease management pathways.
8. Assists the BHC in delivery of group visits, as able.

9. Provides support to the PCBH pathway program work (e.g., constructing and maintaining registries, preparing evaluation summaries).
10. Provides patient education and community resource materials to patients.
11. Manages and coordinates referrals to specialty behavioral health services including MH and SA services.
12. Assists patients in meeting basic needs such as food, shelter, clothing, benefits.
13. Maintains up-to-date contact information about commonly-used community resources.
14. Manages and coordinates referrals to community resources.
15. Supports patient in obtaining durable medical equipment.
16. Supports patient in obtaining legal services and benefits advocacy services as requested by the BHC, RN, or PCC.
17. Completes selected sections of commonly used forms.
18. Represents PCBH Program staff in meetings with local community groups and governmental and social agencies to provide information on the activities and goals of the PCBH program.

Core Competencies for the BHC Facilitator are included in Appendix B.

D. PCBH Primary Care Team Member: Primary Care Clinician

The PCC (here defined as an MD, Doctor of Osteopathy, Physician's Assistant, or Nurse Practitioner) is the focal point of the PCBH Model and the key player in making the model work. The productivity and impact of the BHC is completely tied to the flow of referrals from clinic PCCs.

The PCC's responsibilities include the following:

1. Refers patients with any type of behavioral health issue to see the BHC, preferably at the time the problem is identified during a medical visit.
2. Integrates the BHC into routine daily practice as a core primary care team member.
3. Integrates the skills of the BHC into ongoing primary care management of patients with behavioral health needs.
4. Works with the BHC to expand the impact of the BHC in the PCC's practice.
5. Adjusts exam practices and routines to anticipate that the BHC will be involved with a high percentage of patients over time.
6. Is receptive to consultative feedback from the BHC that may steer the PCC in a different direction than previously followed.
7. Maintains a fluid, real time communication link with the BHC throughout the practice day.

8. Works with clinic staff to identify, develop, and implement PCBH pathway programs.
9. Participates with the BHC in methods of service delivery such as group medical appointments, disease specific clinics, etc.

PCBH skills of the PCC are listed in the Core Competencies in Appendix B and in the PCC Self Assessment Tool in Appendix C.

E. PCBH Primary Care Team Member: Registered Nurse

The RN plays a critical role in the delivery of services under the PCBH Model. The RN's responsibilities include the following:

1. Identifies patients to refer to the BHC.
2. Arranges, and, when possible, makes needed exam room space available to the BHC.
3. Offers support during nursing visits to patients on behavior change goals initiated by the BHC.
4. Initiates registries used in the tracking of patients in PCBH pathway programs.
5. Participates with BHCs in co-teaching classes and group medical visits.
6. Addresses issues related to the interface of the BHCs, BHC ASSISTANTs, RNs, and MAs.
7. Problem solves patient flow issues as they relate to the BHCs and BHC ASSISTANTs.
8. Participates as a member of the Clinic PCBH Committee.

PCBH skills of the RN are listed in the Core Competencies in Appendix B and the RN Self Assessment Tool in Appendix C.

F. PCBH Primary Care Team Member: Medical Assistant

The MA, working under the supervision of the RN, supports the PCBH Model by identifying possible referrals to the BHC and attending to work flow issues.

MA responsibilities include the following:

1. Coordinates with the BHC and BHC ASSISTANT on the status of patients scheduled to see the PCC and BHC on the same day.
2. Works closely with BHC ASSISTANT on patient flow, space, and other issues.
3. Supports patients' pursuit of behavioral goals established in visits with the BHC.
4. Coordinates with the BHC and BHC Assistant on patient registries involving the delivery of behavioral health services.

PCBH skills for the MA are listed in the MA Self Assessment Tool in Appendix C.

G. PCBH Leadership: PCBH Program Lead

Under the direction of the Director of the CHCW Medical Director, the PCBH Program Lead is responsible for overseeing the implementation and on-going operation of the PCBH program at all YOUR CLINIC clinics.

The PCBH Program Lead is responsible for the initiation and development of the PCBH Program across all clinics.

A. Coordinates implementation efforts that encourage client use of services.
B. Problem-solves barriers to implementation and operational issues.
C. Participates in design of new PCBH programs, such as pathways.
D. Conducts Core Competency Training for newly hired BHC and BHA (if available in the future) staff
E. Conducts regular clinical quality review of individual BHCs for the purpose of improving core practice competencies and maintaining model of care fidelity, and provides summaries in support of BHC staff performance evaluation.
F. Provides corrective clinical training as indicated for all BHCs, including those under a formal performance improvement plan.
G. Acts with other personnel to complete PCBH evaluation activities as specified in the PCBH Program Manual.
H. Reviews PCBH program evaluation information and prepares clinic specific and system-wide reports for distribution to all stake holders on an annual basis.
I. Participates in Quality Improvement and relevant clinical research projects, as requested.
J. Participates in community meetings and serves on clinic committees as requested by Clinic Site Directors.
K. Attends YOUR CLINIC leadership group meetings and community groups meetings as requested by YOUR CLINIC leadership.
L. Completes updates to PCBH program manual on an annual basis.

H. PCBH Leadership: Clinic Site Director

Not all YOUR CLINIC clinics have Clinic Site Directors, and leadership in clinics without a Clinic Site Director may designate a staff member to perform the responsibilities of the Clinic Site Director, relative to the PCBH Program.

Clinic Site Director is responsible for planning and directing the PCBH Program at the clinic level and for administrative supervision of BHCs, including scheduling, approving leave requests, tracking productivity, and resolving patient and staff related issues. The Clinic Site Director may find it useful to request that the Clinic Manager assist with some of these tasks.

The Clinic Site Director responsibilities include the following:

1. Assists in the development of the BHC template.
2. Assures that BHC has support with scheduling issues.
3. Supports the BHC/BHC Assistant in scheduling of rooms for clinical services (group and individual).
4. Assures that BHCs attend PCC meetings.
5. Assures that BHC attends Clinic Leadership Team meetings.
6. Reviews BHC program data (including completed visits per day and ratios of new to follow-up and same-day to scheduled visits).
7. Engages BHCs (and BHC Assistants, when available) in discussion of solutions to resolve any variances from expected outcomes using monthly data summaries provided by the PCBH Supervisor.
8. Consults with the PCBH Clinical Supervisor concerning BHC performance problems, clinical training needs, and PCBH pathway program development.
9. Designates a PCC of the day who is responsible for responding to medical problems identified by the BHC when the patient's PCC is not available.
10. Monitors the rate of referrals of PCCs to BHCs and addresses issues related to low referrals.

I. PCBH Leadership: PCBH Clinical Supervisor

Under the direction of the Director of the YOUR CLINIC Residency Program Director, the PCBH Clinical Supervisor is responsible for system-wide and clinic-specific operation of the PCBH program.

The PCBH Clinical Supervisor responsibilities include the following:

1. Supervises the clinical aspects of Primary Care Behavioral Health Services delivered in all clinic sites by all BHCs and BHC assistants.
2. Orients BHCs and BHC Assistants to their roles and responsibilities as defined in the program manual.
3. Reviews and evaluates program level outcome data and individual BHC practice profile data in collaboration with the PCBH Lead.
4. Responsible for the design and conduct of PCBH-related staff training activities.
5. Provides corrective training to BHCs or BHC Assistants when requested to do so by the PCBH manager.
6. Works in collaboration with the PCBH Program Lead, Residency Director, CEO, COO, Nursing Manager, and Health Center Medical Directors and / or Clinic Managers to assure model fidelity and individual provider core practice competencies.
7. Works with CHCW Medical Director, Residency Program Director and/or Clinic Managers to address operational issues related to PCBH services

8. Works with CHCW Medical Director, Residency Director, Clinic Medical Directors, PCBH Program Lead and/or Clinic Managers and staff to support initiation of PCBH pathway programs.
9. Functions as a liaison between the PCBH Program and community behavioral health organizations.

J. PCBH Resources: PCBH Advisor

Each primary care clinic will have a PCBH Advisor designated by the Clinic Site Director or Clinic Manager. This role may be filled by a PCC or RN. Key qualities of a PCBH Advisor include: 1) enthusiasm about the PCBH model; 2) experience working in the clinic for a number of years; 3) an understanding of the cultural issues that need to be addressed to serve patients in the community optimally; and, 4) a reputation as opinion leader within the clinic. The time commitment of being a PCBH Advisor is 30-60 minutes per month and is a volunteer activity.

PCBH Advisor responsibilities include the following:

1. Serves as a member of the Clinic PCBH Committee.
2. Provides leadership concerning cultural sensitivity in delivery of primary care services.

K. PCBH Resources: PCBH Clinic Committee

Each primary care clinic will establish a PCBH Clinic Committee. The purpose of the Committee is to monitor and guide implementation of the PCBH Model. Committee members include the Clinic Site Director or Clinic Manager (or designee), Nurse Manager, the Clinic Operations Lead, a BHC, and one or more patients. The PCBH Clinic Committee will meet quarterly. The meeting agenda will include: 1) review of clinic PCBH performance measures and 2) development of action plans to address any variance from expected results of integration.

Additionally, members of the PCBH Clinic Committee will conduct continuous quality improvement projects, including use of the Quality Management Chart Tools (see Appendix I) to assure high quality charting by the BHC and BHC Assistant.

V. Training Program Overview

YOUR CLINIC recognizes that implementation of the PCBH model in new YOUR CLINIC clinics represents a paradigm change that affects every aspect of service delivery in the clinics. Medical and behavioral health staffs have never worked together in this way and, consequently, new skills will need to be developed. YOUR CLINIC is committed to providing high quality, high impact training to all staff in new positions and those who will work with them.

YOUR CLINIC has developed a core competencies-based training program for all staff to help develop the skills needed to assure the long term success of the PCBH model. A core competencies approach assumes that each staff member must acquire specific skills that, in interaction with others, optimize the impact of the PCBH model. This approach emphasizes that skills are best developed through on-site training. Core competency rating tools for BHCs and BHC Assistants (when and if available in the future) (see Appendix B) and self assessment tools for PCCs, RNs, and MAs (see Appendix C) will be used to support on-going skill development.

The PCBH training program involves several key components including Didactic Training, Core Competency Training, and Self Directed Learning.

A. Didactic Training

Didactic workshop trainings are available in a variety of venues, including the following:

1. Go Live In-Clinic Training
   Prior to the start of the PCBH model, the PCBH trainer will introduce the PCBH manual and provide 1-2 hours of training at each of the YOUR CLINIC clinics. The PCBH trainer will offer more didactic (as well as skill-based training during Core Competency trainings in the YOUR CLINIC clinics.

2. Go Live BHC / BHC Assistant Training
   All BHCs and BHC Assistants (if available in the future) will participate in training prior to beginning to deliver PCBH services.

3. Self-Assessment Tools
   PCCs, RNs, and MAs will use PCBH self-assessment tools (see Appendix C) to check their PCBH knowledge and skill level after each in-clinic training. Copies of self-assessment ratings will be provided to the clinic leadership and then used to plan follow-up training activities.

B. Core Competency Training

During in-clinic training, the PCBH trainer will focus on helping BHCs (and BHC Assistants, if available in the future) demonstrate competency in PCBH skills. During the initial days of training, BHCs and BHC Assistants will focus on development of basic skills. During a second wave of training (about six months after the initial training), BHCs and (BHC Assistants, if available in the future) will focus on developing greater skill and on developing and evaluating PCBH pathway programs in the clinic. Core Competency training involves the PCBH trainer modeling PCBH skills, observing the BHC (and BHC Assistant, if available) in patient care, and coaching BHCs (and BHC Assistants, if available) regarding PCBH skills. Core Competency tools will direct BHC's (and BHC Assistant's) training. Copies of these tools are available in Appendix C.

Expert trainers will also consult with clinic leadership to help identify and resolve gaps in clinic systems or processes that could influence the effectiveness of the PCBH model.

Between the two training visits, BHCs will participate in monthly practice review phone calls with their expert trainer. These phone consults are designed to help the BHC increase their skills and develop the PCBH program locally as well as to discuss clinical practice issues that are surfacing for the BHC.

C. Self Directed Learning

To develop strong skills in delivering PCBH services, providers will benefit from on-going reading and didactic training. To assist PCBH program staff with pursuing a personal course of learning, YOUR CLINIC is developing a PCBH Library. The library will be housed at the YOUR CLINIC/online here. Materials for check-out will include articles, books, and best practice videos. Potential areas of study will include:

1. Acceptance and Commitment Therapy
2. ADHD Assessment and Interventions
3. Behavioral Activation
4. Behavior Modification
5. Brief Interventions / Brief Therapy
6. Cognitive Behavioral Therapy
7. Communication Skill Training
8. Exposure
9. Family Therapy
10. Harm Reduction
11. Health Behavior Change
12. Mindfulness
13. Motivational Interviewing
14. Parent Skill Training
15. Problem Solving Therapy
16. Social Skill Training
17. Solution Focused Therapy
18. Values Clarification

VI. Clinical Activities

This section describes the clinical services provided by the PCBH Team, as well as some specific practice tools and processes that increase the effectiveness of the BHC (and BHC Assistant, if available in the future).

A. Clinical Services of PCBH Team

The BHC and BHC Assistant, when available, work as a team to provide several types of clinical services which are described below. BHC Assistant services may be provided by other disciplines and/or by the BHC.

1. Brief Interventions

Brief interventions are at the core of the PCBH model. PCCs, RNs, or other clinic staff members (MAs, registration staff, etc.) as designated by the Clinic Site Directors make referrals to the BHC.

The BHC then provides the brief intervention to the patient. The main objectives of brief interventions are to assist the PCC in the recognition, treatment, and management of mental and addictive disorders, chronic diseases, psychosocial issues, and health risk behaviors. Generally, the BHC will teach the patient one or more skills during a single or series of consultation visits and generate one or more recommendations for the PCC team concerning how to intervene with the referral problem on an-ongoing basis. Through consultation, the BHC transfers skills and knowledge about behavior change principles to the patient, as well as the referring PCC.

BHCs attempt to provide brief interventions to patients on a same-day basis. This allows for a “warm handoff” of the patient from the PCC to the BHC. The BHC spends between 15 and 30 minutes with a referred patient in initial and follow-up visits. The BHC services focus on the referral question or problem identified by the PCC and patient, and services are time limited.

On average, the BHC will see a patient one to four times, with a small percentage of patients requiring more than four visits. Most benefit from four or fewer visits and a significant number of patients benefit from a single contact. The goal of consultation is to help the patient and referring PCC develop a workable action plan and to build positive momentum for behavior change and a better quality of life.

The BHC and/or BHC Assistant may have on-going contact with a small number of patients who are in a chronic state of emotional turmoil, are using medical services primarily because of emotional health issues and/or psychological conditions, or are experiencing poor health outcomes due to psychosocial problems. Patients needing ongoing behavior

change support will often be served in PCBH Pathways involving monthly management groups.

2. Pathway Programs

PCBH pathway programs are developed at the clinic level as the result of quality improvement activities. Pathway programs are data based, involve a team approach, and change over time. They are designed to improve clinical outcomes, job satisfaction, and cost-efficiencies.

The Plan, Do, Study, Act (PDSA), or Deming cycle, developed by W. Edward Deming is useful method for developing PCBH Pathway programs.

This method involves the following steps:

1. Plan: After identifying a population of concern, the objectives and processes necessary to improve outcomes are identified.

Example: *Population of concern*: Patients identified by PCCs as being in need of specialty MH services and who do not follow up on referrals to specialty BH services. *Desired outcome*: Increase the percent of referred patients who attend a specialty MH appointment from approximately 50% to 70%. *New objectives/processes*: (1) PCC refers all patients identified as needing specialty MH to the BHC for a same-day visit; (2) BHC uses the Step-up/Step-down checklist (see Appendix E) to coordinate care; (3) BHC uses motivational interviewing protocol to enhance patient interest regarding referral; (4) patient initiates a behavior change to improve functioning; and, (5) a BHC follow-up visit is scheduled to support patient follow through.

2. Do: Implement the process.

Example: PCBH Step-up/Step-down Pathway Program

3. Study: Measure the new processes and compare the results against the expected results to determine any differences.

> Example: Conduct chart reviews to determine the percentage of patients referred to specialty MH who made contact with specialty MH provider and who had improvement in functioning (according to the Duke Health profile) in follow-up visit with BHC.

4. Act: Analyze the differences to determine causal factors. Decide where to apply changes.

> Example: In building a pathway program, clinics may plan to target one or more new objectives and processes. Additionally, the clinic may decide to try a pathway program using the PDSA cycle in one practice group prior to dissemination. This allows for more efficient change to plans and smoother clinic-wide implementation.

The Clinic PCBH committee will be involved in developing pathway programs using the PDSA method. Clinic PCBH committee members will develop names for pathway programs that are consistent with the cultural perspectives of patients attending that clinic. Two examples of PCBH Pathway Programs are included in Appendix D, tobacco cessation and chronic pain.

3. Step-up/Step-down Pathway Program

The BHC and BHC Assistants will follow the Step-up/Step-down Pathway Program when a patient is referred by a PCC to specialty MH/SA services. This protocol is currently under development and may involves the following steps:

a. Use a Step-up/Step-down Patient Referral Criteria protocols for adults and children/youth at the patient's initial BHC visit for referral to Specialty MH/SA services or for coordination of care back to primary care after the patient completes an episode of Specialty MH/SA care. An example is included in Appendix E.
b. Engage the patient in discussing the possible advantage of specialty MH/SA services.
c. Identify possible barriers to the patient's use of MH/SA services and explore strategies to address these barriers.
d. Develop a behavior change plan to help the patient improve health-related quality of life (e.g., increase social activity or improve diet or exercise).
e. Schedule a BHC follow-up appointment with the patient after the date of the patient's initial specialty MH/SA visit to discuss the patient's experience.

f. At patient's BHC follow-up appointment, assess the patient's success with implementing the behavior change plan and with attending the specialty MH/SA appointment. If the patient has not benefitted from the behavior change plan, is ambivalent about using specialty MH/SA services, and/or did not attend the specialty MH/SA appointment, continue with steps b, c, and d.

4. Excluded Services

The BHC does not provide the following services:

- Any form of psychotherapy
- Diagnostic procedures exceeding brief interventions or the scope of care of the consultant
- Long-term or short-term traditional group therapy services (psycho-education groups are appropriate)
- Specialized occupational health and/or disability management services
- Court-ordered evaluation or treatment
- Employee assistance program services to clinic employees
- Evaluation and intervention with an employee who is referred as part of a job performance improvement action.

If a BHC receives a request from a patient or a primary care team member for any excluded service, the BHC will link the patient or employee to the appropriate resource.

B. Practice Support Tools

The PCBH Model uses a variety of practice support tools to support both the growth of the PCBH program and the efficiency and effectiveness of BHC consultations. This section describes some of these practice supports.

1. Primary Care Clinician/Registered Nurse Referral Scripts

Few PCCs and RNs have practiced side-by-side with a BHC/BHC Assistant team. To help PCCs and RNs make referrals to BHC staff members, it is useful to give PCCs and RNs scripts for what to say to patients with different types of presenting problems. The goal of scripting is to accurately represent the role of the BHC/BHC Assistant team and to maximize the percentage of patients who accept the referral. Each BHC/BHC Assistant team is encouraged to distribute these scripts and to repeatedly role model them. Sample Referral Scripts can be found in Appendix F1.

2. Primary Care Clinician/Registered Nurse Referral Form

Not all clinics will use a referral form. However, an example form is provided in Appendix F2. Reasons for using a Referral Form include: (1) increasing efficiency in the referral process, (2) enhancing communication between the PCC and BHC as to the specific referral problem or question, (3) encouraging PCCs to refer a broad range of patients who need help with behavior change and (4) providing a basis for understanding referral information in aggregate reports and potentially generating reports on outcomes for specific referral groups.

A pad of Referral Forms may be placed in exam rooms. At the request of the PCC or RN, an MA may complete the checklist and take it, along with the patient, to the BHC to arrange for visit after the medical visit. Alternatively, the referral form may be added to the bottom of the patient discharge form.

3. Clinical Guides for the Primary Care Behavioral Health Consultant

Conducting a 15-30 minute visit is a big change for most behavioral health providers and requires a particular focus during the interaction with the patient. Frequently, novice BHCs find it challenging to remember to collect assessment information due to the new time frames associated with the PCBH Model.

To develop a comprehensive, fast psychosocial exam style it takes practice using practice tools to structure the interview, intervention process, and completion of chart notes. The BHC should use the clinical guides found in Appendix F to support delivery of PCBH services in a consistent manner.

Summary of the Three Clinical Guides

1. The "Interview Note Form" template, found in Appendix F3, is in a subjective, objective, assessment, and plan (SOAP) format that allows the BHC to organize patient assessment information in a structured way. The BHC uses this format in training to learn to conduct new, follow-up, group, and telephone visits in an consistent format and efficient manner.

   When charting follow-up visits, the BHC should focus notes in the subjective section on: 1) the patient's status in regard to the initial referral problem or question; 2) the patient's efforts to implement the plan resulting from the initial visit with the BHC; and, 3) the impact of the implementation of the plan on the patient's current status.

   The BHC should use this tool to assure that charting is completed in a consistent format. Charting should be completed within three to five minutes of the conclusion of the patient contact. Appendix F4 provides an example of a chart note.

2. The "PCBH Intervention Quick Guide" provides several interventions for each of the primary reasons for referrals listed on the PCBH Referral Form. A copy of the PCBH Intervention Quick Guide is available in Appendix F5.

3. Seven Ways to Respond to Common Referrals provides more detailed guidance for the most frequent referrals in most clinics. This tool, along with the PCBH Intervention Guide, helps the new BHC select an intervention with an evidence-base quickly. "Seven Ways to Respond to Common Referrals" is available in Appendix F6.

Each clinic, at its discretion, may develop written instructions to guide the PCBH staff in conducting assessments and identifying interventions when working with specific patient population groups.

C. Outcome Assessment Tools and Screeners

Systematically measuring clinical and functional outcomes is a basic characteristic of evidence-based practices. The PCBH program is deeply grounded in this approach. After reviewing the available literature for fast, yet informative, outcome measures, YOUR CLINIC elected to recommend a specific set of outcome assessment tools and screeners and to allow individual clinics to choose according to their needs. The Assessment and Screeners Reference Guide (ASRG) found in Appendix G provides a copy of recommended PCBH outcome assessment and screening tools, along with a description of the measure, the target audience, available languages, and scoring information. The following sections provide a brief description of the outcome assessment tools and screeners included in the ASRG.

1. Recommended Routine Outcome Tools

For each patient visit, the BHC may administer the appropriate outcome assessment tool based on the age of the patient. Recommended outcome tools include: 1) the Duke Health Profile; 2) the Pediatric Symptom Checklist (either the Parent completed version or the Youth Self-Report); or 3) the Infant-Toddler Assessment, which is currently under development. In addition, the Visit Rating Scale may be administered for each patient visit. Exceptions can be made for visits with children who are under four and/or are too young to respond to the Visit Rating Scale.

Additional outcome scales may be useful in class-based and group-based services. The Duke Anxiety-Depression Scale (for generic classes and workshops) and the Healthy Days Questionnaire (for chronic pain classes) are examples (see Appendix G).

2. Recommended As Indicated Screening Tools

Screening tools can speed-up BHC and BHC Assistant services and add precision. The BHC and/or BHC Assistant may use screening instruments when indicated by clinic protocols or as needed to provide more specific information about symptoms of concern. Information about recommended screening tools is available as part of the ASRG in Appendix G.

The BHC may elect to make these screeners available throughout the clinic in wall-hanging units to facilitate use by PCCs, RNs, MAs, and BHC Assistants. Some screeners may be administered repeatedly to track patient response to treatment. Since they are brief and evidence-based, screening tools may be helpful to PCCs to use to trigger referrals to the BHC and, in some cases, to evaluate patient response to treatment.

D. Clinical Policies and Procedures

1. Patient Access to the Primary Care Behavioral Health Consultant

As stated earlier, PCCs, RNs, or other clinic staff members (MAs, registration staff, etc.) can make referrals to the BHC, as designated by the individual Clinic Site Directors. There are several ways that a patient gains access to services from the BHC:

a. Same-day request ("warm handoff") from the PCC, RN or designee with or without a referral checklist, which is the recommended mode of referral
b. A written request to the BHC from the PCC, RN, or designee for a future appointment (for example by inclusion of BHC on a "Future Appointments Sheet" used in discharge planning)
c. Phone triage by a PCC or triage nurse
d. At the suggestion of the BHC as a result of a scheduled pre-screening
e. An established patient contract (such as a pain agreement requiring the patient to see the BHC)
f. As part of a PCBH pathway program
g. During huddle

Patients who are eligible to receive PCBH services are those assigned (or in the process of being assigned) to the BHC's clinic.

The BHC is expected to maintain schedule accessibility such that no patient must wait more than 48 hours to see the BHC.

All BHCs will use some form of real time communication device (i.e., smart phone, beeper, clinic cell phone) that ensures that PCCs and other clinic staff have immediate access to the BHC. The BHC will respond to each request for service immediately. This may require leaving an ongoing interview with another patient to receive the new referral and determine whether the new patient can wait until the existing interview is completed.

2. Informed Consent

When patients sign their consent to receive primary care treatment, they are also signing consent for PCBH services.

PCBH providers will provide a brief description of PCBH services at the first patient visit. This description will be consistent with the PCBH brochure. See Appendix H.

3. Clinical Assessment Standards

BHC consultation services are brief and PC-oriented. They are not a form of specialty MH care. Assessments should be focused on the primary reason for the referral.
There are several important implications of this clinical standard:

1. BHCs are required to inquire about suicidal or homicidal ideation when the patient's clinical presentation indicates the need for such, or when requested by the PCC.
2. BHCs are required to assess for safety issues and to develop appropriate safety plans when risks to safety are identified.
3. BHCs are not required to make a DSM-IV diagnosis and may make a diagnosis if it would contribute to the patient's subsequent treatment and the BHC has enough information and the appropriate training.
4. BHCs are not required to perform a mental status examination as part of their assessment, but may if this is requested by the PCC.
5. BHCs, even in their role as consultants, are still required to report high-risk situations to the appropriate state agency.

E. Quality Assurance of Charting and Documentation

BHCs and BHC Assistants will document PCBH visits in the progress note section of the paper chart and the electronic medical record (EMR). BHCs and BHC Assistants will use a SOAP format (or other format required by the Electronic Health Record) and complete chart notes for all patient contacts on the day of service. Chart notes will be made available to the referring PCC or RN on a same-day basis.

In general, consultation notes should be brief and highly focused and present only information that is directly relevant to the referral problem or question. An example chart note is included in Appendix F4.

Within each clinic, BHC charts will be reviewed on a scheduled basis using the Quality Management Chart Tool to assure high quality documentation. Typically, this review will include five records per month per BHC (and BHC Assistant, if available). Quality Management Chart Tools for the initial visit and the follow-up visit are included in the Appendix I.

Review elements for the initial visit include the following:

1. Is there documentation that the visit is an initial visit?
2. Is there documentation of the referring PCC/RN/Other?
3. Is there documentation of the referral problem or question?
4. Is there documentation of findings regarding patient life context (living situation, social support, financial/work situation, psychosocial stressors)?
5. Is there documentation of findings concerning the referral problem or question?
6. Is there a statement concerning assessment findings?
7. Is there documentation of one or more specific recommendations to patient (e.g., behavior change plan, behavior skill practice, follow-up regarding food, shelter, housing)?
8. Is there documentation of one or more specific recommendations to the referring PCC or RN?
9. Is there documentation of BHC's communication of findings and recommendations for referring PCC or RN?
10. Is there documentation of a specific follow-up plan (with whom and when)?
11. Is there documentation of completion of a risk assessment for patients whose presentation indicated the need for such?

Review elements for the follow-up visit include the following.

1. Is there documentation that the visit is a follow-up visit?
2. Is there documentation of the referring PCC/RN/Other and the referral problem or question?
3. Is there documentation of patient's status regarding referral problem or concern (improved, same, worse)?
4. Is there documentation about patient's attempt to implement recommendations generated in initial BHC visit and impact?
5. Is there documentation of one or more specific recommendations to patient (e.g., behavior change plan, behavior skill practice, follow-up regarding food, shelter, housing)?
6. Is there documentation of one or more specific recommendations to the referring PCC or RN?
7. Is there documentation of BHC's communication of findings and recommendations to referring PCC or RN?
8. Is there documentation of a specific follow-up plan (with whom and when)?
9. Is there documentation of completion of a risk assessment for patients whose presentation indicated the need for such?

All missed appointments with the BHC will be documented in the progress note section of the patient's medical record. Additionally, the BHC will attempt to telephone a patient who does not show for a scheduled follow-up visit and, if possible, provide services by phone

when the patient is reached. Charting ensures that the PCC knows that the patient did not follow through with a scheduled appointment or received BHC services by phone.

F. Providing Feedback to the Primary Care Clinician

BHCs will provide feedback to the PCC in person and/or by written note on the same day of the consultation visit. In addition, written feedback will come in the form of the consultation note, which should also be completed on the same day as the visit.

G. Medication Consultations with Primary Care Clinicians and Patients

The BHC and/or BHC Assistant will assist the PCC and patient with medication issues as requested by the PCC. Possible services include exploring patient preference for treatment, assessing symptom severity and adherence coaching.

Coaching involves exploring the patient's experience of beneficial and side effects; identifying barriers to adherence including personal beliefs, problems remembering to take the medication, cost of the medication, etc.; and, developing specific behavioral strategies to address barriers. These services may be helpful concerning patient use of all medications, not only psychotropic medicines.

H. Psychiatric Consultations with Primary Care Clinicians and Patients

The BHC and/or BHC Assistant may assist with PCC consultation with a Psychiatrist as requested. In addition, they will provide linkage to Psychiatric services as clinically indicated.

I. Telemedicine

To Be Included in the Future

VII. Administrative Procedures

Just as clinical procedures support efficient operation of the PCBH program, there are several administrative or system level components that must be in place to support the implementation of the PCBH Model.

A. Primary Care Behavioral Health Consultant Appointment Template

In general: 1) each clinic will create a template for their BHCs; 2) every patient seen by a BHC must be registered even if the patient was also seen and registered for a visit with the PCC; 3) every clinic will make sure appointments and registrations are done under a PCBH provider class identifier number; and 4) each clinic will develop their registration procedures.

Schedule templates will be maintained by clinic support staff and will be visible to all provider staff. The BHC template will include six 30-minute visits in morning and afternoon clinics, as indicated below. It is expected that charting by the BHC will take place within the 30-minute appointment structure.

Use a return appointment type (RT) to allow staff to schedule any patient in any slot.

Morning

Time	Activity Type
8:30	RT
9:00	RT
9:30	RT
10:00	Stop
10:30	RT
11:00	RT
11:30	RT

Afternoon

Time	Activity Type
1:30	RT
2:00	RT
2:30	RT
3:00	Stop
3:30	RT
4:00	RT
4:30	RT

Most patients will be warm-handoffs. Appointments may be scheduled by front office staff, PCCs, RNs, Medical Assistants or the BHC.

BHCs will receive monthly feedback similar to that provided to PCCs (for example, encounters per clinic hour).

B. Revenue/Billing

To Be Included in the Future

C. Performance Measures

See Appendix A.

D. Staffing Guidelines

Staffing guidelines are based on several factors and the most important is the overall health of the population served. For clinics serving homeless populations, the ratio of PCCs to BHCs is often 1:1. In other community clinics, the ratio might be 1 BHC for 3,500-5,000 patients. In many instances, the BHC will provide all services and there will be no BHC Facilitator. If the need for BHC services exceeds capacity, a clinic may hire a BHC Assistant complete components of BHC work and extend the number of patients a BHC can see.

Currently, the United States Air Force uses the following staffing guidelines: 1 BHC for 3,500 patients and 1 BHC Facilitator (RN) for 7,500 patients.

E. Productivity Standards

The following productivity standards will apply to the BHC:

- Ten average face-to-face encounters per day within 6 months of PCBH implementation.
- Ten average face-to-face encounters per day in subsequent years.

PCCs will refer between two and eight patients per day to the BHC.

F. Core Competencies

Core Competency Tools for the BHCs and BHC Assistants and Self Assessment forms for PCCs, RNs and MAs are included in Appendices B and C. These tools are important in evaluating the job performance of PCBH staff.

VIII. ACRONYMS

Acronym	Stands For:
ADHD	Attention Deficit Hyperactivity Disorder
ASRG	Assessment and Screeners Reference Guide
BHC	Behavioral Health Consultant
BHC Assistant	Behavioral Health Consultant Assistant
YOUR CLINIC	replace with the name of YOUR CLINIC
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
EMR	electronic medical record
LCSW	licensed clinical social worker
MA	Medical Assistant
MH	mental health
PC	primary care
PCBH	primary care behavioral health
PCC	primary care clinician
PDSA	Plan, Do, Study, Act
RN	Registered Nurse
SA	substance abuse
SOAP	subjective, objective, assessment, and plan

APPENDICES

Appendix A – Performance Measures

Domain	Indicator	Comments
1. Patient Outcomes	1a. Socio-Emotional Well-Being	Duke or other measure
	1b. Symptom Reduction (e.g., depression/anxiety)	PHQ-9, CESD-10, GAD, or other
	1c. Behavioral Health Goal Attainment	PCC, BHC, Patient rate achievement of specific goal identified for intervention

Goal	Objective	Evaluation Question	Measure
Health status Primary Care patients will improve	A. Improve the functional status of Primary Care patients who receive Behavioral Health services from a BHC in the Primary Care setting	A. Did the functional status of Primary Care patients who received behavioral health services in the Primary Care setting improve?	A. 4-week post- BHC visit telephone survey (6 items) of randomly selected group of patients (after implementation of Primary Care Behavioral Health (PCBH) model)
	B. Demonstrate improved health-related quality of life among adult patients who come for more than one BHC visit	B. Did the quality of life of patients who received more than one follow-up Behavioral Health service improve after their follow-up appointment within an "episode of care"? An episode of care equals 6 months, assuming that the treatment for which the referral was made is still the issue for which treatment is provided. An new episode is defined as one where the patient is referred for a new problem within 6 months of the initial referral for the initial presenting problem)	B. Duke Health Profile 4 scores: 3 Functioning Scale Scores (Mental Health, Physical Health, Social Health) and 1 Dysfunction Scale Score (Disability). Scores range 0-100. Higher is better for Function and worse for Dysfunction. Compare time 1 (initial BHC visit) and time 2 (last visit with BHC during 6-month period following initial visit)
	C. Demonstrate decreased psychosocial distress among children who come for one or more BHC visit	C. Are patients demonstrating decreased psychosocial distress at last follow-up with BHC in an episode of care as defined above	C. Pediatric Symptom Checklist total score (for patients ages 4-16) using procedure for Duke
	D. To support Primary Care Clinicians in their efforts to focus specifically on Primary Care delivery	D. Did the Primary Care Clinician enhance the quality of Primary Care delivered as a result of having the BHC as an additional resource (e.g. preventive care services)	D. Preventive service delivery rates among Primary Care patients for services (e.g. immunizations, pap smears and additional preventive measures for patients with chronic diseases)

Primary Care Behavioral Health Integration Program – Performance Measures

Domain	Indicator	Comments
2. Satisfaction	2a. PCC	
	2b. BHC	
	2c. Patient	

Goal	Objective	Evaluation Question	Measure
Primary Care Clinicians will express high level of satisfaction with BHC model of care	A. Improve Primary Care Clinician ability to care for patients with Behavioral Health issues B. Increase Primary Care Clinician satisfaction with system of care for Primary Care patients with Behavioral Health diagnoses who are seen by a BHC in the Primary Care setting	A. Did the ability of Primary Care Clinicians to care for patients with behavioral health issues improve as a result of the availability of the BHC? B. Did the satisfaction of the Primary Care Clinicians with the system of care for Primary Care patients with behavioral health diagnoses increase?	A. - B. Add survey questions per Patti PCC survey pre- and post-implementation
BHC will express high level of satisfaction with BHC model of care	A. Establish Satisfaction Level of BHCs with training on new model of care delivery B. Establish Satisfaction Level of BHCs with implementation of new model of care delivery	A. Are the BHCs satisfied with training and preparation received in new model of care delivery? B. Are the BHCs satisfied with implementation of new model of care delivery?	A. - B. Post-implementation BHCs Survey, 5-6 months post-initiation of intervention
Primary Care Patients receiving BHC services will express high level of satisfaction with BHC model of care	A. Establish high satisfaction level of Primary Care patients with BHC services	A. Are Primary Care patients who receive BHC services satisfied with the services?	A. 3-month post-intervention Patient Survey, six questions. Survey to be completed by patients who received services from BHC

Primary Care Behavioral Health Integration Program – Performance Measures

Domain	Indicator	Comments
3. Primary Care Clinician Productivity	3a. Number of Primary Care encounters per hour	Measure against standard, goal, self
	3b. Active panel size	Expect correlation between panel size and number of referrals to BHC
	3c. Relationship between cost of BHC and increased revenue by PCC	

Goal	Objective	Evaluation Question	Measure
To enhance Primary Care Clinician Productivity	A. To increase the number of patients seen by Primary Care Clinicians as a result of additional BHC resources in the clinic	A. Did the Primary Care Clinician increase the number of patient encounters as a result of having additional BHC resources?	A. The number or Primary Care encounters per hour relative to the average number of encounters in the clinic, the overall system, and the individual Primary Care Clinician's baseline productivity
	B. To increase the size of the active patient panel as a result of the Primary Care Clinicians' ability to refer patients to the BHC	B. Did the Primary Care Clinician increase size of their active patient panel as they increased the number and percentage of referrals to the BHC.	B. The percentage increase in the Primary Care Clinicians' active patient panel relative to the number of referrals to the BHC
	C. Decrease visits that are not medically necessary among patients with behavioral health problems	C. Did high utilizers of medical services who had one or more BHC visits decrease use of medical services in the 6-month period subsequent to the BHC series of visits, in comparison with the 6 months prior to the BHC visit(s)?	C. Account histories, pre-and post-intervention for a sample of patients who received behavioral health services in Primary Care. Compare the number of medical visits in 12-month period after visit with Behavioral Health Provider working in Primary Care for 2 groups: • Group 1: (pre-implementation): sample of patients that made 10+ medical visits in year prior to visit with Behavioral Health Provider claims • Group 2: (post- implementation): sample of patients that made 10+ medical visits in year prior to visit with trained BHC.

Primary Care Behavioral Health Integration Program – Performance Measures

Domain	Indicator	Comments
4. Access to BH Services	4a. Number of consultations and referrals to or with the BHC	
	4b. Proportion of active patient panel linked to group services (pathways)	
	4c. Proportion of patients linked by BHC to specialty care	

Goal	Objective	Evaluation Question	Measure
Access to behavioral health services for patients in the Primary Care setting will improve	A. Increase the number of Primary Care patients screened, referred, and treated for behavioral health conditions in the designated measurement period	A. Did the % of Primary Care patients who were screened, referred or treated for behavioral health issues increase from pre- to post- implementation? (same for engagement in Pathways)	A. The number and percentage of Primary Care patients newly screened, referred, and treated for behavioral health conditions compared over time
	B. Decrease appointment and temporal wait times for patients to receive an initial behavioral health service in the Primary Care setting	B. Did the average wait time for start of a behavioral health service decrease from pre- to post-implementation?	B. Appointment and Temporal Wait Times: The amount of time a patient waited to see the BHC following a referral to the BHC from a Primary Care Clinician
	C. Decrease the "no connect" rate for specialty behavioral health services for patients who receive initial behavioral health treatment from the BHC in the Primary Care setting	C. Did patient "connect" rate for follow-up specialty behavioral health services increase pre- to post implementation?	C. The number of clients who are referred by the BHC to specialty Behavioral Health treatment and receive services relative to the number of individuals who are referred for additional Behavioral Health treatment but do not receive additional services.

Primary Care Behavioral Health Integration Program – Performance Measures

Domain	Indicator	Comments
5. Fidelity to Model	5a. Proportion of PCC referrals seen by BHC in same day	
	5b. Availability of BHC when needed by PCC	Use e-referral to track to track wait time for BHC
	5c. Length of BHC appts (how frequently going beyond 15 min appt)	

PCG Note: There is measure included in the DPH set for percentage screened. This may be an important measure to consider until "Fidelity to the Model". DPH list includes proportion of PCC referrals seen by BHC in the same day and availability of BHC when needed by a PCC (as well as length of BHC appointments (e.g. how frequently appointments go beyond 15 minute segments).

Goal	Objective	Evaluation Question	Measure
Detection of behavioral health conditions in Primary Care will improve	A. Initiate use of Primary Care screeners (e.g., PHQ-9, PTSD-4, GAD-7, Pain Dysfunction Questionnaire)	A. Did PCC use of screeners increase pre- to post-intervention?	A. Based on the PCC survey, how many and what % of providers perform screening for Behavioral Health conditions in the Primary Care setting? (Pre and post?)
Primary Care Clinicians and BHCs will demonstrate fidelity to the BHC model	A. Establish BHC practice that has high fidelity to model B. Establish BHC optimal productivity C. Maintain 48 hour access for BHC visits	A. Are ratios after implementation improved from baseline? Ratio of new to follow-up (1:2) Ratio of same day to scheduled (1:1) B. Does BHC complete an average of 10 patient encounters per day? C. Do BHCs maintain 48-hour access for BHC visit?	A. – B. BHC contact sheet (on back of Duke or PSC) Ratios of new to follow-up and same-day to scheduled for each BHC on a monthly basis Encounters per day (Billing data may not be reliable) C. Periodic sampling of BHCs access (sample 5 days for 5 BHCs every month)

Appendix B – Core Competency Tools

Behavioral Health Consultant (BHC) Core Competency Tool

Name of BHC:	Clinic:
EVALUATION CONDUCTED BY	
❑ **SELF PRE**-TRAINING DATE ADMINISTERED:	❑ BY TRAINER (NAME):
❑ **SELF POST**-TRAINING DATE ADMINISTERED:	DATE ADMINISTERED:

This tool is used to evaluate the core competencies of the Behavioral Health Consultant (BHC). The BHC Core Competency Form will be used as follows:

1. You will evaluate and rate yourself before and after core competency training.
2. Your PCBH trainer will rate your skills at the conclusion of core competency training. Your goal is an average score of 2.0 or better on scored items in each of the seven competency areas at the end of the week. Some areas will be "N/A" or "not applicable," as you generally can't attain competence in some areas without practicing PCBH skills for 4-6 months.
3. Your PCBH trainer(s) will re-rate your skills after you have been in practice for 6 months.
4. We encourage you to review this list of competencies and to set your own learning objectives. Your pre-training ratings will help your trainer plan strategies for addressing your individual training needs optimally
5. This tool will also be used for input on your annual performance appraisal.

Core Competency Assessment Schedule			
Before 1st Full-Week Training	After 1st Full-Week Training	After 6 Months of Practice	Annual Performance Appraisal
Evaluate Self	Evaluate Self Trainer Evaluates	Evaluate Self Trainer Evaluates	Supervisor Evaluates

The BHC-A Core Competency Tool includes seven basic areas of knowledge and skill development	**Competency is assessed using a rating scale of 1 to 3**
I. Clinical Domain: Brief Interventions Skills II. Clinical Domain: Pathway Services Skills III. Documentation Skills IV. Consultation Skills V. Team Performance Skills VI. Practice Management Skills VII. Administrative Knowledge and Skills	1. Needs further training 2. Achieves objectives 3. Excels

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING: Needs Further Training (1 point) Achieves Objectives (2 points) Excels (3 points)

Name of BHC-A:	**Clinic:**

SUMMARY OF DOMAIN RATINGS	**SELF Pre-Training Average Rating**	**SELF Post-Training Average Rating**	**TRAINER Post-Training Average Rating**
I. Clinical Domain: Brief Interventions Skills			
II. Clinical Domain: Pathway Services Skills			
III. Documentation Skills			
IV. Consultation Skills			
V. Team Performance Skills			
VI. Practice Management Skills			
VII. Administrative Knowledge and Skills			

TRAINEE SIGNATURE	DATE
TRAINER SIGNATURE	DATE

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Role Definition	1. Gives PCBH brochure to patient to all new patients			
Role Definition	2. Says PCBH introductory script accurately and smoothly			
Role Definition	3. Answers patient questions about PCBH services accurately			
Bio-psycho-social Perspective	4. Conveys an understanding of the connection between biological, psychological, and social health			
Use of Assessments	5. Completes outcome measures in a timely manner; Scores accurately; Uses results to assess treatment response			
Use of Screeners	6. Completes screeners as requested; Scores accurately; Uses screeners to help assess treatment response			
Life Context Interview	7. Uses life context questions to obtain a snapshot of patient's life in initial contact (5-10 minutes)			
Health Risk Questions	8. Asks health / health risk questions			
Identification of Factors Affecting Healthcare Use	9. Asks questions, as indicated, to identify factors that might impede patient use of healthcare services (e.g., head injury, learning disability, health literacy limitations)			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Target Problem Identification	10. Identifies referral problem; Uses scaling question to quantify level of patient concern			
Three Ts	11. Uses Three Ts / target problem analysis questions to formulate possible interventions			
Problem Summary	12. Makes problem summary statement and asks for patient verification			
Intervention Development	13. Links recommended interventions to results of analysis			
Evidence-based Interventions	14. Uses evidence-based interventions suited to primary care (and, as indicated, briefly cites and explains evidence to patient)			
Patient Engagement	15. Asks patient to choose among possible interventions			
Behavioral RX Pad	16. Uses behavioral prescription pad or equivalent to note intervention (or supports patient in noting)			
Patient Confidence	17. Uses scaling questions to assess patient confidence in behavioral plan			
Helpfulness	18. At end of visit, asks patient to respond to scaling question regarding helpfulness of visit			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Patient Education	19. Uses patient education materials as appropriate			
Target Problem Follow-up	20. Uses scaling question to assess level of patient concern about referral problem in follow-up visits			
Patient Adherence	21. In follow-up visits, asks patient about implementation of behavior change plan			
Support of Behavior Change Plans	22. Provides face-to-face and/or telephone call support to patients concerning implementation of behavior change plans			
Cultural Competence	23. Attempts to understand the patient's cultural perspective on health and health problems and/or seeks resources as needed			
Cultural Competence	24. Uses information about patient's culture to understand patient's expression of psychological distress and/or seeks resources as needed			
Cultural Competence	25. Adapts assessments, screeners, and interventions to patient's cultural perspective and/or seeks resources as needed			
	I. CLINICAL DOMAIN: BRIEF INTERVENTIONS – Total Points:			
	Average (divide by 25, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Trainer Comments / Recommendations				

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Population-based Care	26. Can state the difference between a case-focused approach and a population-based approach to patient care			
Population-based Care	27. Able to identify opportunities for providing care along a continuum from primary prevention to tertiary care			
Quality Improvement Methods	28. Can briefly describe ways to measure clinical performance and assess quality of care (e.g., Find, Organize, Clarify, Understand, Select, Plan, Do, Study, Act or FOCUS-PDSA)			
Population-based Care	29. Participates in development of pathways intended to promote health / prevent health decline			
Pathway Activities	30. Participates in development of pathways for chronic conditions			
Pathway Activities	31. Participates in development of pathways for high impact / high prevalence conditions other than chronic disease			
Pathway Activities	32. Provides assessment and intervention activities according to pathway instructions			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Pathway Activities	33. Participates in evaluation of pathway programs (for example, providing documentation and summarizing information)			
Multi-patient Intervention Skills	34. Works with PCCs, RNs, MAs, and BHC-As to provide primary care class services (e.g., drop-in stress management class, group medical visits for chronic pain patients)			
II. CLINICAL DOMAIN: PATHWAY SERVICES – Total Points:				
Average (divide by 9, or the number of skills rated if fewer):				
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Concise, Clear Charting	35. Completes brief, specific, accurate notes that enhance team-based care			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Prompt Charting	36. Completes notes immediately following clinical activity / patient service			
SOAP Format	37. Uses SOAP format or other format expected in Electronic Health Record for all patient visits			
Same-day or Scheduled	38. Documents that visit is same-day or scheduled			
Visit Context	39. Documents visit type: Individual, group, couple, family, telephone			
Initial or Follow-up	40. Documents that visit is initial or follow-up			
Service explained, patient consent	41. If initial visit, documents that PCBH services explained and patient gave verbal consent			
Follow-up Visit #	42. If follow-up visit, documents # of follow-up visit (1st, 2nd, etc.) and date of last visit with patient			
Brief Interventions	43. Documents brief interventions used in visit			
Pathway Services	44. Documents that services were related to a pathway and names pathway			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Recommendations to Patient	45. Documents specific recommendations to patient			
Recommendations to PCC	46. Documents that visit summary was provided to PCC / RN (e.g., copy of chart note or verbal summary)			
Signature	47. Signs chart note			
Future Appointment	48. Documents plan for future appointment with BHC-A (or indicates no plan of future)			
Future Appointment with PCC	49. Documents plan for future appointment with PCC (or indicates no plan of future)			
Referrals	50. Documents referrals facilitated in patient visits (including MH clinic or SA program)			
	III. DOCUMENTATION SKILLS - Total Points:			
	Average (divide by 16, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Trainer Comments / Recommendations				

IV. CONSULTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Referral Clarity	51. Listens carefully to PCC or RN regarding specific referral concern and / or uses Referral Checklist to specify referral concern for BHC-A visit			
Response to Referral	52. Responds directly to referral question in chart note and in feedback			
Assertive Follow-Up	53. Ensures PCCs receive feedback on patients; Interrupts PCC, when indicated, for urgent patient needs			
Feasible Recommendations	54. Provides recommendations tailored to the pace of primary care (e.g., PCC can implement recommended strategy in 5 minutes or less)			
Participation in Meetings	55. Regularly attends clinical team meetings (based upon clinic standards)			
Brief Presentations	56. Effectively delivers pertinent brief presentations in staff meetings (for example, on evidence for behavioral treatments)			
Provides PCBH Orientation	57. Provides orientation on PCBH program to all new clinic employees			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

IV. CONSULTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Curbside Consultations	58. Offers productive, on-demand, and concise consults to PCCs and RNs on both general and patient specific issues, using clear, direct language			
Value-Added Orientation	59. Effectively utilizes downtime by collaborating in PC team activities; such as working on projects/products that improve the PCBH program.			
	IV. CONSULTATION SKILLS – Total Points:			
	Average (divide by 9, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

V. TEAM PERFORMANCE SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Fit with Primary Care Culture	60. Understands and operates comfortably in fast-paced, action-oriented, team-based culture of primary care			
Knows Team Member Roles	61. Knows the roles and functions of primary care team members and both assists and uses other team members			
Responsiveness	62. Readily responds to PCC, RN, MA, and BHC-A requests			
Availability	63. Is available during all hours worked in clinic; Uses white board to communicate whereabouts when appropriate; Uses pager to enhance accessibility			
	V. TEAM PERFORMANCE SKILLS – Total Points:			
	Average (divide by 4, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Triage Efficiency	64. Demonstrates efficiency in triage of patients			
Telephone Visit Efficiency	65. Adheres to a protocol that supports efficient coverage of planned topics and notes start and stop times			
Patient Visit Efficiency	66. Adheres to a protocol that supports efficient coverage of planned topics; Notes start and stop times			
Timely Response to PCC / RN Requests	67. Uses logs to track progress in addressing PCC / RN PCBH program requests			
Guided by Outcomes	68. Uses outcomes to identify strategies for improving PCBH practice (for example, ratio of same-day to scheduled, initial to follow-up, non-pathway to pathway visits)			
Patient Registries	69. Uses patient registries as planned by PC team			
Collaborates on Registries	70. Collaborates on data entry on registries worked by multiple team members			
Community Referrals	71. Makes use of community resources			
Maintains resource lists	72. Develop and maintain up-to-date lists of patient resources (co-located and community)			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Seeks Assistance	73. Seeks assistance from PCBH Advisor or Program Committee concerning practice management concerns			
	VI. PRACTICE MANAGEMENT SKILLS – Total Points:			
	Average (divide by 10, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Template	74. Assures that schedule supports appropriate same-day to scheduled visits ratio (usually 1:1 ratio)			
Adheres to CLINIC Policies and Procedures	75. Adheres to all CLINIC policies and procedures			
Risk Management Protocols	76. Able to describe and discuss how and why informed consent procedures for MH and SA differ from PCBH services; Understands limits of PCBH services			

Behavioral Health Consultant (BHC) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Risk and Safety	77. Provides risk assessments as indicated by patient presentation; Develops appropriate safety plans			
Documentation	78. Routinely and accurately completes documentation on the same-day of service delivery			
	VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS – Total Points:			
	Average (divide by 5, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

Behavioral Health Consultant – Assistant (BHC-A) Core Competency Tool

Name of BHC-A:	Clinic:

EVALUATION CONDUCTED BY	
❑ **SELF PRE**-TRAINING DATE ADMINISTERED:	❑ BY TRAINER (NAME):
❑ **SELF POST**-TRAINING DATE ADMINISTERED:	DATE ADMINISTERED:

This tool is used to evaluate the core competencies of the BHC-A). The BHC-A Core Competency Form will be used as follows:

1. You will evaluate and rate yourself before and after core competency training.
2. Your PCBH trainer(s) will rate your skills at the conclusion of your core competency training. Your goal is an average score of 2.0 or better on scored items in each of the seven competency areas at the end of the week. Some areas will be "N/A" or "not applicable," as you generally can't attain competence without practicing PCBH skills for 4-6 months.
3. Your PCBH trainer will re-rate your skills at the conclusion of your first 6 months of work as a BHC-A. Your goal then will be a minimal average score of 2.0 in all domains.
4. We encourage you to review this list of competencies and to set your own learning objectives. Your pre-training ratings will help your trainer plan strategies for addressing your individual training needs optimally.
5. This tool will also be used for input on your annual performance appraisal.

Core Competency Assessment Schedule			
Before 1st Full-Week Training	After 1st Full-Week Training	After 2nd Full-Week Training	Annual Performance Appraisal

The BHC-A Core Competency Tool includes seven BHC-Asic areas of knowledge and skill development	**Competency is assessed using a rating scale of 1 to 3**
I. Clinical Domain: Brief Interventions Skills II. Clinical Domain: Pathway Services Skills III. Documentation Skills IV. Consultation Skills V. Team Performance Skills VI. Practice Management Skills VII. Administrative Knowledge and Skills	1. Needs further training 2. Achieves objectives 3. Excels

Evaluate Self	Evaluate Self Trainer Evaluates	Evaluate Self Trainer Evaluates	Supervisor Evaluates

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

Name of BHC-A:	Clinic:

SUMMARY OF DOMAIN RATINGS	SELF Pre-Training Average Rating	SELF Post-Training Average Rating	TRAINER Post-Training Average Rating
I. Clinical Domain: Brief Interventions Skills			
II. Clinical Domain: Pathway Services Skills			
III. Documentation Skills			
IV. Consultation Skills			
V. Team Performance Skills			
VI. Practice Management Skills			
VII. Administrative Knowledge and Skills			

TRAINEE SIGNATURE	DATE
TRAINER SIGNATURE	DATE

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Role Definition	1. Gives PCBH brochure to patient to all new patients			
Role Definition	2. Says PCBH introductory script accurately and smoothly			
Role Definition	3. Answers patient questions about PCBH services accurately			
Bio-psycho-social Perspective	4. Conveys an understanding of the connection between biological, psychological, and social health			
Use of Assessments	5. Completes outcome measures in a timely manner; Scores accurately; Uses results to assess treatment response			
Use of Screeners	6. Completes screeners as requested; Scores accurately; Uses screeners to help assess treatment response			
Identification of Factors Affecting Healthcare Use	7. Asks questions, as indicated, to identify factors that might impede patient use of healthcare services (e.g., head injury, learning disability, health literacy limitations)			
Target Problem Identification	8. Identifies referral problem; Uses scaling question to quantify level of patient concern			
Helpfulness	9. At end of visit, asks patient to respond to scaling question regarding helpfulness of visit			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Patient Education	10. Uses patient education materials as appropriate			
Target Problem Follow-up	11. Uses scaling question to assess level of patient concern about referral problem in follow-up visits			
Patient Adherence	12. In follow-up visits, asks patient about implementation of behavior change plan			
Support of Behavior Change Plans	13. Provides face-to-face and/or telephone call support to patients concerning implementation of behavior change plans			
Cultural Competence	14. Attempts to understand the patient's cultural perspective on health and health problems and/or seeks resources as needed			
Cultural Competence	15. Uses information about patient's culture to understand patient's expression of psychological distress and/or seeks resources as needed			
Cultural Competence	16. Adapts assessments, screeners, and interventions to patient's cultural perspective and/or seeks resources as needed			
	I. CLINICAL DOMAIN: BRIEF INTERVENTIONS – Total Points:			
	Average (divide by 16, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Trainer Comments / Recommendations				

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Population-BHC-Ased Care	17. Can state the difference between a case-focused approach and a population-BHC-Ased approach to patient care			
Population-BHC-Ased Care	18. Able to identify opportunities for providing care along a continuum from primary prevention to tertiary care			
Pathway Activities	19. Participates in pathways for chronic conditions			
Pathway Activities	20. Assists in pathways intended to promote health / prevent health decline			
Pathway Activities	21. Assists in evaluation of pathway programs (for example, providing documentation and summarizing information)			
Multi-patient Intervention Skills	22. Works with PCCs, RNs, MEAs, and PCBs to provide primary care class services (e.g., drop-in stress management class, group medical visits for chronic pain patients)			
II. CLINICAL DOMAIN: PATHWAY SERVICES – Total Points:				

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
	Average (divide by 6, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Concise, Clear Charting	23. Completes brief, specific, accurate notes that enhance team-BHC-Ased care			
Prompt Charting	24. Completes notes immediately following clinical activity / patient service			
SOAP Format	25. Uses SOAP format for all patient visits			
Same-day or Scheduled	26. Documents that visit is same-day or scheduled			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Visit Context	27. Documents visit type: Individual, group, couple, family, telephone			
Initial or Follow-up	28. Documents that visit is initial or follow-up			
Service explained, patient consent	29. If initial visit, documents that PCBH services explained and patient gave verBHC-Al consent			
Follow-up Visit #	30. If follow-up visit, documents # of follow-up visit (1st, 2nd, etc.) and date of last visit with patient			
Brief Interventions	31. Documents brief interventions used in visit			
Pathway Services	32. Documents that services were related to a pathway and names pathway			
Recommendations to Patient	33. Documents specific recommendations to patient			
Recommendations to PCC	34. Documents that visit summary was provided to PCC / RN (e.g., copy of chart note or verBHC-Al summary)			
Signature	35. Signs chart note			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Future Appointment	36. Documents plan for future appointment with PCB or BHC-A (or indicates no plan of future)			
Future Appointment with PCC	37. Documents plan for future appointment with PCC (or indicates no plan of future)			
Referrals	38. Documents referrals facilitated in patient visits (including MH clinic or SA program)			
	III. DOCUMENTATION SKILLS - Total Points:			
	Average (divide by 16, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

IV. CONSULTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Referral Clarity	39. Listens carefully to PCC or RN regarding specific referral concern and / or uses Referral Checklist to specify referral concern for PCB or BHC-A visit			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

IV. CONSULTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Response to Referral	40. Responds directly to referral question in chart note and in feedBHC-Ack			
Value-Added Orientation	41. Effectively utilizes downtime by collaborating in PC team activities; such as working on projects/products that improve the PCBH program.			
	IV. CONSULTATION SKILLS – Total Points:			
	Average (divide by 3, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

V. TEAM PERFORMANCE SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Fit with Primary Care Culture	42. Understands and operates comfortably in fast-paced, action-oriented, team-BHC-Ased culture of primary care			
Knows Team Member Roles	43. Knows the roles and functions of primary care team members and both assists and uses other team members			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

V. TEAM PERFORMANCE SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Responsiveness	44. Readily responds to PCC, RN, MEA, and PCB requests			
Availability	45. Is available during all hours worked in clinic; Uses white board to communicate whereabouts when appropriate; Uses pager to enhance accessibility			
	V. TEAM PERFORMANCE SKILLS – Total Points:			
	Average (divide by 4, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Triage Efficiency	46. Demonstrates efficiency in triage of patients			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Telephone Visit Efficiency	47. Adheres to a protocol that supports efficient coverage of planned topics and notes start and stop times			
Patient Visit Efficiency	48. Adheres to a protocol that supports efficient coverage of planned topics; Notes start and stop times			
Timely Response to PCC / RN Requests	49. Uses logs to track progress in addressing PCC / RN PCBH program requests			
Data Entry	50. Enters data, as requested, on same-day of request			
Patient Registries	51. Uses patient registries as planned by PC team			
Collaborates on Registries	52. Collaborates on data entry on registries worked by multiple team members			
Community Referrals	53. Makes use of community resources			
Maintains resource lists	54. Develops and maintains responsible up-to-date lists of patient resources (co-located and community)			
Food Resources	55. Is aware of and skillful in referring patients to food resources			

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Clothing	56. Is aware of and skillful in referring patients to clothing resources			
Shelter	57. Is aware of and skillful in referring patients to shelter / housing resources			
Equipment	58. Is aware of and skillful in referring patients to equipment resources			
Form Completion	59. Is aware of most common forms and skillful in assisting patients in completing forms			
Seeks Assistance	60. Seeks assistance from PCBH Advisor or Program Committee concerning practice management concerns			
	VI. PRACTICE MANAGEMENT SKILLS – Total Points:			
	Average (divide by 15, or the number of skills rated if fewer):			
BHC-A Comments / Concerns				

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Trainer Comments / Recommendations				

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Template	61. Assures that schedule supports appropriate same-day to scheduled visits ratio (usually 1:1 ratio)			
Adheres to CLINIC Policies and Procedures	62. Adheres to all CLINIC policies and procedures			
Risk Management Protocols	63. Able to describe and discuss how and why informed consent procedures for MH and SA differ from PCBH services; Understands limits of PCBH services			
Documentation	64. Routinely and accurately completes documentation on the same-day of service delivery			
VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS – Total Points:				
Average (divide by 4, or the number of skills rated if fewer):				

PCBH – Behaviorist Assistant (BHC-A) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
BHC-A Comments / Concerns				
Trainer Comments / Recommendations				

Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

Name of BHC-F:	Clinic:
EVALUATION CONDUCTED BY	
❑ **SELF PRE**-TRAINING DATE ADMINISTERED:	❑ BY TRAINER (NAME):
❑ **SELF POST**-TRAINING DATE ADMINISTERED:	DATE ADMINISTERED:

This tool is used to evaluate the core competencies of the BHC-F. The BHC-F Core Competency Form will be used as follows:

1. You will evaluate and rate yourself before and after core competency training.
2. Your PCBH trainer(s) will rate your skills at the conclusion of your core competency training. Your goal is an average score of 2.0 or better on scored items in each of the seven competency areas at the end of the week. Some areas will be "N/A" or "not applicable," as you generally can't attain competence without practicing PCBH skills for 4-6 months.
3. Your PCBH trainer will re-rate your skills at the conclusion of your first 6 months of work as a BHC-F. Your goal then will be a minimal average score of 2.0 in all domains.
4. We encourage you to review this list of competencies and to set your own learning objectives. Your pre-training ratings will help your trainer plan strategies for addressing your individual training needs optimally.
5. This tool will also be used for input on your annual performance appraisal.

Core Competency Assessment Schedule			
Before 1st Full-Week Training	After 1st Full-Week Training	After 2nd Full-Week Training	Annual Performance Appraisal
Evaluate Self	Evaluate Self Trainer Evaluates	Evaluate Self Trainer Evaluates	Supervisor Evaluates

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

The BHC-F Core Competency Tool includes seven BHC-Fsic areas of knowledge and skill development	Competency is assessed using a rating scale of 1 to 3
I. Clinical Domain: Brief Interventions / Case Management Skills II. Clinical Domain: Pathway Services Skills III. Documentation Skills IV. Consultation Skills V. Team Performance Skills VI. Practice Management Skills VII. Administrative Knowledge and Skills	1. Needs further training 2. Achieves objectives 3. Excels

Name of BHC-F:	Clinic:

SUMMARY OF DOMAIN RATINGS	SELF Pre-Training Average Rating	SELF Post-Training Average Rating	TRAINER Post-Training Average Rating
I. Clinical Domain: Brief Interventions / Case Management Skills			
II. Clinical Domain: Pathway Services Skills			
III. Documentation Skills			
IV. Consultation Skills			
V. Team Performance Skills			
VI. Practice Management Skills			
VII. Administrative Knowledge and Skills			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	**Needs Further Training (1 point)**	**Achieves Objectives (2 points)**	**Excels (3 points)**

TRAINEE SIGNATURE	DATE
TRAINER SIGNATURE	DATE

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS / CASE MANAGEMENT		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Role Definition	1. Gives PCBH brochure to patient to all new patients			
Role Definition	2. Says PCBH Facilitator introductory script accurately and smoothly			
Role Definition	3. Answers patient questions about PCBH services accurately			
Bio-psycho-social Perspective	4. Conveys an understanding of the connection between biological, psychological, and social health			
Use of Assessments	5. Completes outcome measures in a timely manner; Scores accurately; Uses results to assess treatment response			
Use of Screeners	6. Completes screeners as requested; Scores accurately; Uses screeners to help assess treatment response			
Identification of Factors Affecting Healthcare Use	7. Asks questions, as indicated, to identify factors that might impede patient use of healthcare services (e.g., head injury, learning disability, health literacy limitations)			
Target Problem Identification	8. Identifies referral problem; Uses scaling question to quantify level of patient concern			
Helpfulness	9. At end of visit, asks patient to respond to scaling question regarding helpfulness of visit			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS / CASE MANAGEMENT		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Patient Education	10. Uses patient education materials as appropriate			
Target Problem Follow-up	11. Uses scaling question to assess level of patient concern about referral problem in follow-up visits			
Patient Adherence	12. In follow-up visits, asks patient about implementation of behavior change plan, use of psychotropic medications and participation in recommended specialty services			
Support of Behavior Change Plans	13. Provides face-to-face and/or telephone call support to patients concerning implementation of behavior change plans, including use of psychotropic medications and participation in recommended specialty services			
Cultural Competence	14. Attempts to understand the patient's cultural perspective on health and health problems and/or seeks resources as needed			
Cultural Competence	15. Uses information about patient's culture to understand patient's expression of psychological distress and/or seeks resources as needed			
Cultural Competence	16. Adapts assessments, screeners, and interventions to patient's cultural perspective and/or seeks resources as needed			
I. CLINICAL DOMAIN: BRIEF INTERVENTIONS / CASE MANAGEMENT – Total Points:				
Average (divide by 16, or the number of skills rated if fewer):				

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

I. CLINICAL DOMAIN: BRIEF INTERVENTIONS / CASE MANAGEMENT		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Population-based Care	17. Can state the difference between a case-focused approach and a population-based approach to patient care			
Population-based Care	18. Able to identify opportunities for providing care along a continuum from primary prevention to tertiary care; able to transition patients to/from different levels of care			
Pathway Activities	19. Participates in pathways for chronic conditions			
Pathway Activities	20. Assists in pathways intended to promote health / prevent health decline			
Pathway Activities	21. Assists in evaluation of pathway programs (for example, providing documentation and summarizing information)			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

II. CLINICAL DOMAIN: PATHWAY SERVICES		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Multi-patient Intervention Skills	22. Works with BHC, BHC-A, PCCs, RNs, and MEAs to provide primary care class services (in primary or in backfill position)			
II. CLINICAL DOMAIN: PATHWAY SERVICES – Total Points:				
Average (divide by 6, or the number of skills rated if fewer):				
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Concise, Clear Charting	23. Completes brief, specific, accurate notes that enhance team-based care			
Prompt Charting	24. Completes notes immediately following clinical activity / patient service			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
SOAP Format	25. Uses SOAP format for all patient visits			
Same-day or Scheduled	26. Documents that visit is same-day or scheduled			
Visit Context	27. Documents visit type: telephone, Individual, group, couple, family			
Initial or Follow-up	28. Documents that visit is initial or follow-up			
Service explained, patient consent	29. If initial visit, documents that PCBH services explained and patient gave verbal consent			
Follow-up Visit #	30. If follow-up visit, documents # of follow-up visit (1st, 2nd, etc.) and date of last visit with patient			
Brief Interventions	31. Documents brief interventions used in visit			
Pathway Services	32. Documents that services were related to a pathway and names pathway			
Recommendations to Patient	33. Documents specific recommendations to patient			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

III. DOCUMENTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Recommendations to PCC	34. Documents that visit summary was provided to PCC / RN (e.g., copy of chart note or verbal summary)			
Signature	35. Signs chart note			
Future Appointment	36. Documents plan for future appointment with BHC-F, BHC, PCC or RN (or indicates no plan of future)			
Future Appointment with PCC	37. Documents plan for future appointment with PCC (or indicates no plan of future)			
Referrals	38. Documents referrals facilitated in patient visits (including MH clinic or SA program)			
	III. DOCUMENTATION SKILLS - Total Points:			
	Average (divide by 16, or the number of skills rated if fewer):			
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

IV. CONSULTATION SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Referral Clarity	39. Listens carefully to PCC or RN regarding specific referral concern and / or uses Referral Checklist to specify referral concern for PCB or BHC-F visit			
Response to Referral	40. Responds directly to referral question in chart note and in verbal feedback			
Value-Added Orientation	41. Effectively utilizes downtime by collaborating in PC team activities; such as working on projects/products that improve the PCBH program.			
	IV. CONSULTATION SKILLS – Total Points:			
	Average (divide by 3, or the number of skills rated if fewer):			
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

V. TEAM PERFORMANCE SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Fit with Primary Care Culture	42. Understands and operates comfortably in fast-paced, action-oriented, team-based culture of primary care			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

V. TEAM PERFORMANCE SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Knows Team Member Roles	43. Knows the roles and functions of primary care team members and community providers and both assists and uses other PC and community team members			
Responsiveness	44. Readily responds to PCC, RN, MEA, and BHC requests			
Availability	45. Is available during all hours worked in clinic; Uses white board to communicate whereabouts when appropriate; Uses pager to enhance accessibility			
	V. TEAM PERFORMANCE SKILLS – Total Points:			
	Average (divide by 4, or the number of skills rated if fewer):			
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Triage Efficiency	46. Demonstrates efficiency in triage of patients			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Telephone Visit Efficiency	47. Adheres to a protocol that supports efficient coverage of planned topics and notes start and stop times			
Patient Visit Efficiency	48. Adheres to a protocol that supports efficient coverage of planned topics; Notes start and stop times			
Timely Response to PCC / RN Requests	49. Uses logs to track progress in addressing PCC / RN PCBH program requests			
Data Entry	50. Enters data, as requested, on same-day of request			
Patient Registries	51. Uses patient registries as planned by PC team			
Collaborates on Registries	52. Collaborates on data entry on registries worked by multiple team members			
Community Referrals	53. Makes use of community resources			
Maintains resource lists	54. Develops and maintains responsible up-to-date lists of patient resources (co-located and community)			
Food Resources	55. Is aware of and skillful in referring patients to food resources			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Clothing	56. Is aware of and skillful in referring patients to clothing resources			
Shelter	57. Is aware of and skillful in referring patients to shelter / housing resources			
Equipment	58. Is aware of and skillful in referring patients to equipment resources			
Form Completion	59. Is aware of most common forms and skillful in assisting patients in completing forms			
Seeks Assistance	60. Seeks assistance from PCBH Advisor or Program Committee concerning practice management concerns			
	VI. PRACTICE MANAGEMENT SKILLS – Total Points:			
	Average (divide by 15, or the number of skills rated if fewer):			
BHC-F Comments / Concerns				

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VI. PRACTICE MANAGEMENT SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Trainer Comments / Recommendations				

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
Template	61. Assures that schedule supports appropriate same-day to scheduled visits ratio (usually 1:1 ratio)			
Adheres to CLINIC Policies and Procedures	62. Adheres to all CLINIC policies and procedures			
Risk Management Protocols	63. Able to describe and discuss how and why informed consent procedures for MH and SA differ from PCBH services; Understands limits of PCBH services			
Documentation	64. Routinely and accurately completes documentation on the same-day of service delivery			
	VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS – Total Points:			
	Average (divide by 4, or the number of skills rated if fewer):			

PCBH – Behavioral Health Consultant – Facilitator (BHC-F) Core Competency Tool

ENTER RATING:	Needs Further Training (1 point)	Achieves Objectives (2 points)	Excels (3 points)

VII. ADMINISTRATIVE KNOWLEDGE AND SKILLS		SELF Pre-Training	SELF Post-Training	TRAINER Rating and Comments
Skill Area	**Skill**			
BHC-F Comments / Concerns				
Trainer Comments / Recommendations				

BEHAVIORAL HEALTH CONSULTANT CORE COMPETENCY TOOL						
Use a rating scale of 1 = low skills and 5 = high skills to assess the BHC's (your) current level of skill development for all attributes within each of the following 6 domains. Place a checkmark in the column corresponding to the skill rating that best describes the BHC's (your) current skill level.*						
DOMAIN	ATTRIBUTES	SKILL RATING (1 = LOW; 5 = HIGH)				
		1	**2**	**3**	**4**	**5**
I. Clinical Practice Skills	1. Applies principles of population-based care to preventive and chronic care					
	2. Applies principles of population-based care to mental health problems					
	3. Defines role accurately					
	4. Shows understanding of relationship of medical and psychological systems					
	5. Uses appropriate assessments					
	6. Identifies problem rapidly					
	7. Limits assessment to one problem					
	8. Identifies functional impact of problem					
	9. Conducts thorough analysis of target problem efficiently					
	10. Uses target problem analysis to conceptualize possible interventions					
	11. Shows knowledge of best practice guidelines, ESTs					
	12. Matches interventions to patient's strengths and deficits					
	13. Offers patient a choice among interventions					
	14. Describes interventions in transparent language so PC team can support					
	15. Uses self-management, home-based practice					
	16. Records collaboratively developed plan on behavioral RX pad					
	17. Assesses patient confidence in behavior change plan					
	18. Shows basic knowledge of medicines					
	19. Ready to provide primary care groups or classes for a variety of problems (sleep, stress, lifestyle)					
	20. Ready to provide group medical visit services					
	21. Participates in development and implementation of PCBH pathways					

II. Practice Management Skills	1. Uses 30 minute visits efficiently					
	2. Stays on time when conducting consecutive appointments					
	3. Completes treatment episode in 4 visits or less					
	4. Uses continuity visits					
	5. Uses flexible patient contact strategies					
	6. Uses intermittent visit strategies					
	7. Refers appropriately to groups and classes in PC clinic					
	8. Uses primary care mental health case management strategies (e.g., registries)					
	9. Coordinates care with ACO, CCO, school, hospital or other staff not co-located					
	10. Uses community resources					
	11. Appropriately triages to mental health and chemical dependency					
	12. Thoughtfully markets BHC services					
III. Consultation Skills	1. Focuses on and responds to referral question					
	2. Conducts effective curbside consultations					
	3. Focuses on recommendations that reduce PCC/RN visits and workload					
	4. Tailors recommendations to work pace of primary care					
	5. Provides presentations to PCCs, RNs, CNAs					
	6. Provides exam room posters that educate patients and / or trigger self or PCC/RN referral to BHC					
	7. Provides brief ½ page handouts to PCCs & RNs concerning evidence for BH interventions					
	8. Able to Research BH Intervention Questions					
	9. Willing to assertively follow up with PCCs, when indicated					

IV. Documentation Skills	1. Writes clear, concise chart notes					
	2. Gets chart notes and feedback to PCC/RN on same day basis					
	3. Chart notes are consistent with curbside conversation results					
V. Team Performance Skills	1. Understands and operates comfortably within primary care culture					
	2. Shows awareness of team roles					
	3. When away from station, leaves information as to location and time of return					
	4. Readily provides unscheduled services when needed					
	5. Is available for on-demand consultations					
VI. Administrative Skills	1. Understands relevant policies and procedures					
	2. Understands and applies risk management protocols					
	3. Routinely completes all billing activities					

*Note: This tool can be used by an expert trainer or clinical supervisor as part of a training and evaluation process and/or by the BHC for self-assessment and career development planning.

PCC AND RN CORE COMPETENCY TOOL						
Use a rating scale of 1 = low skills and 5 = high skills to assess the PCC's or RN's (your) current level of skill development for all attributes within each of the following 6 domains. Place a checkmark in the column corresponding to the skill rating that best describes the PCC's or RN's (your) current skill level.*						
DOMAIN	ATTRIBUTES	SKILL RATING (1 = LOW; 5 = HIGH)				
		1	**2**	**3**	**4**	**5**
I. Clinical Practice Skills	1. Applies principles of population-based care to preventive and chronic care services					
	2. Applies principles of population-based care to mental health problems					
	3. Defines role accurately					
	4. Shows understanding of relationship of medical and psychological systems					
	5. Refers a broad range of patients to BHC					
	6. Rapid problem identification for BHC referral					
	7. Uses appropriate assessments					
	8. Notes functional impact of problem					
	9. Supports self-management, home-based practice					
	10. Supports interventions recommended by BHC					
	11. Demonstrates basic knowledge of best practice guidelines for common BH problems					
	12. Ready to work with BHC in group medical visits					
	13. Ready to work with BHC in providing primary care lifestyle groups or classes					
II. Practice Management Skills	1. Uses BHC referral to reduce length of medical visit					
	2. Uses BHC visit to save a medical visit					
	3. Shows capacity to use BHC for continuity visits					
	4. Refers to BHC groups, classes and workshops					

	5. Uses BHC to link with ACO, CCO, hospital, school or other staff not co-located					
	6. Uses BHC to link patients with community resources					
	7. Uses BHC to make phone contacts with patients					
	8. Works effectively with PCBH registries					
	9. Uses BHC to assess and as appropriate to triage to mental health and chemical dependency					
III. Consultation Skills	1. Understands consultative nature of BHC services					
	2. Expects BHC consultation to focus on one problem or answer a question					
	3. Seeks curbside consultations with BHC					
	4. Willing to interrupt BHC visit, when indicated					
	5. Asks BHC to research questions about patient care					
IV. Documentation Skills	1. Documents referral to BHC and referral problem in chart note					
	2. Makes time for BHC to give 1-minute feedback on same day of BHC consult					
	3. Clarifies responsibility for charting curbside conversation results					
V. Team Performance Skills	1. Provides or supports standing orders for BHC					
	2. Assures that team members know who is covering when PCC or RN is out of clinic					
	3. Participates in PCBH pathway design and implementation					
VI. Administrative Skills	1. Knows multiple ways to access BHC services, both same-day and scheduled					
	2. Has copy of PCBH program manual and appendix					
	3. Knows what services BHC does not provide					

*Note: This tool can be used by an expert trainer or clinical supervisor as part of a training and evaluation process and/or by the PCC or RN for self-assessment and career development planning.

Appendix C – Self-Assessment Tools

Name of PCC:	Clinic:	
Name of Trainer:	Type of Review: ❑ ORIENTATION ❑ TRAINING ❑ SKILL CHECK	Date Administered:

This tool offers you, as a PCC, an opportunity to self-asses your knowledge and skills related to successful use of the Primary Care Behavioral Health (PCBH) services in your clinic. PCBH staff members include the Behavioral Health Consultant (BHC) and, in the future, may include a Behaviorist Assistant (BA). Your responses will also help your medical director develop plans for on-going training.

When first beginning to work with a BHC, PCCs need information about how to interface with the new team members. After an initial period of practice, most PCCs are ready to learn new clinical skills. This tool helps you navigate this learning process with intention and focus.

The PCC Self-Assessment Tool includes six knowledge / skill development areas. We recommend that you focus on the first four immediately after you begin to practice in the PCBH program and save areas five and six for when you have a solid foundation in the basics. The six areas are:

I. Interface with BHC
II. Value-Added Use of BHC
III. Use of Assessment and Screening Tools
IV. Documentation Skills
V. Clinical Skills: Brief Behavioral Interventions
VI. Clinical Skills: Pathways

A PCBH trainer will teach you the basic skills (areas one through five) when you begin to practice in a PCBH clinic setting. Four to six months later, the trainer will return and provide information and skill practice opportunities for areas five and six.

This is how we recommend that you use this tool.

1. Use it first during your initial training as a check on what you understand and what you still have questions about in areas 1-4. Make a check in the column that describes your situation at the end of training. The column options are:

Untrained: "I have not been trained to do this."
Trained: "I have been trained to do this."
Skillful: "I have the skill to do this consistently with confidence."

2. Use this tool again as a check on what you understand about areas 5-6 after your second training with the PCBH trainer. Indicate your training experience by making a mark in the column that describes your level after training.

Provide your medical director with a copy of your responses at time one and time two. At your request, the BHC and / or medical director will be able to provide you additional reading materials on the PCBH Program. A copy of the PCBH Program manual is available from the Medical Director or the BHC.

PCBH – Primary Care Clinician (PCC) Self-Assessment Tool

I. **BHC Interface**	Un-trained	Trained	Skillful
1. Understands the roles and responsibilities of BHC			
2. Understands process for having patients triaged and scheduled for same-day visits with the PCB and /or BA			
3. Understands how to direct patients to obtain a future scheduled appointment with a BHC			
4. Provides an accurate verbal description of PCBH services to patients and/or provides patient with the program brochure (for example, says "The BA will help you with housing").			
5. Understands difference between "warm handoff" and cold handoff			
6. Describes PCBH services including information about the connection between biological, psychological, and social health			
7. Uses PCBH referral script language to lessen stigma and enhance patient acceptance of service			
8. Consistently offers all patients option of same-day (rather than scheduled) visit with BHC			
9. Identifies a primary target problem for BHC visit and obtains patient agreement on target problem focus			
10. Uses Referral Form or equivalent to enhance communication between PCC, patient, and BHC and clarity of target problem			
11. Refers a broad range of referral target problems to BHC (reflective of patients served at clinic), including patients with:			
a. chronic disease(s)			
b. common psychological problems; e.g., depression, anxiety			
c. complaints of family and relationship problems			
d. complaints of stress			
e. health risk behaviors; e.g., tobacco, alcohol, drugs, unsafe sex			
f. needs for skill building; e.g., parenting skills, social skills			
g. problems that interfere with successful medical visits; e.g., learning disability, health literacy limitations			
11. Uses BHC to improve patient use of medications (for example, requests BHC to explore barriers to patient adherence)			
12. Refers and / or co-teaches classes lead by BHC			
13. Understands the basic components of a BHC visit			
14. When seeing a patient after a BH visit, is able to:			
a. ask patient about implementation of behavior change plan			
b. ask patient how helpful BHC was			

PCBH – Primary Care Clinician (PCC) Self-Assessment Tool

I. **BHC Interface**	**Un-trained**	**Trained**	**Skillful**
c. support patient in practicing skills learned in BHC visit(s)			
d. use scaling question that quantifies level of patient concern about target problem when seeing patient after a visit with a BHC			
15. Understands how the BHC fits into the primary care model and able to advocate for their integration with other staff			
16. Provides information to PCBH Advisor regarding successes in integrating PCBH services into practice			
17. Seeks assistance from and provides information to the PCBH Advisor (a PCC or RN colleague) regarding how to integrate the BHC into patient care activities and / or PCBH Committee when unsure of interface of PBHC, PCC and RN			
18. Responds to surveys concerning PCBH services in a timely manner (e.g., Referral Barriers Questionnaire)			

VI. **Value-Added Use of BHC**	**Un-trained**	**Trained**	**Skillful**
22. Consistently uses BHC to enhance patient outcomes (a minimum of 15% of your panel)			
23. Uses BHC to make telephone calls to patients and to connect them to resources, as appropriate			
24. Uses BHC to complete parts of PCC and RN visits with patients (for example, provide care instructions, assess treatment response, support treatment adherence)			
25. Uses information about your use of BHC services to identify opportunities for new ways to use this resource to enhance your practice			
26. Uses BHC to reduce burden on you and other staff and, at the same time, enhance patient outcomes (for example, satisfaction, development of needed skills). Example: Ask BHC to assess and advise when you see patients with chronic pain, depression, school problems, etc.			

III. **Use of Assessment and Screening Tools**	**Un-trained**	**Trained**	**Skillful**
19. Understands Duke Health Profile and uses results to assess and plan treatment for adults			
20. Understands Pediatric Symptom Checklist and uses results to assess and plan treatment for children			
21. Understands screener associated with a specific clinic pathway and is able to use it to initiate BHC services and to evaluate treatment response			

PCBH – Primary Care Clinician (PCC) Self-Assessment Tool

IV. **Documentation Skills**	**Un-trained**	**Trained**	**Skillful**
22. Documents referral to BHC in chart note			
23. At follow-up visit with patient after initial BHC visit, documents patient response to BHC recommendations			
32. Documents brief interventions used / supported in visit			
33. Documents when visit services were related to a pathway and names pathway			
34. Routinely asks the BHC questions about behavioral interventions that might be useful to specific patients (for example, a patient you plan to see in a few minutes) and general conditions (for example, behavioral interventions for patients with sleep problems).			

V. **Clinical Skills: Brief Behavioral Interventions**	**Un-trained**	**Trained**	**Skillful**
31. Uses brief 5-minute behavior change interventions that are helpful to primary care patients, including:			
a. behavior modification			
b. clarifying values			
c. goal setting and action step planning			
a. mindfulness			
b. motivational interviewing			
c. problem-solving			
d. relapse prevention planning			
e. relaxation skill			
f. scheduling social activities			
32. Uses patient education materials as appropriate			
33. Communicates needs for patient education materials to BHC			

VII. **Clinical Skills: PCBH Pathway Services**	**Un-trained**	**Trained**	**Skillful**
24. Supports clinic leaders in developing PCBH pathways or planned approaches to care that address gaps and deploy BHC to improve outcomes for high impact patient groups (e.g., chronic pain, ADHD, depression/anxiety)			

PCBH – Primary Care Clinician (PCC) Self-Assessment Tool

VII.	**Clinical Skills: PCBH Pathway Services**	**Un-trained**	**Trained**	**Skillful**
25.	Provides patients with accurate descriptions of how BHC working in pathway programs will assist the PCC / RN team and patient in obtaining better outcomes			
26.	Participates consistently in PCBH pilots and programs			
27.	Provides needed PCBH pathway evaluation information			
28.	Able to shift smoothly from focus on individual care to pathway care			

Name of RN:		Clinic:
Name of Trainer:	Type of Review: ❑ ORIENTATION ❑ TRAINING ❑ SKILL CHECK	Date Administered:

This tool offers you, as a Nurse, an opportunity to self-asses your knowledge and skills related to successful use of the Primary Care Behavioral Health (PCBH) services in your clinic. PCBH staff members include the Behavioral Health Consultant (BHC) and, in the future, may include a Behavioral Health Consultant Assistant (BHC Assistant). Your responses will also help your nursing director develop plans for on-going training.

When first beginning to work with a BHC, nurses need information about how to interface with the new team members. After an initial period of practice, most nurses are ready to learn new clinical skills. This tool helps you navigate this learning process with intention and focus.

The RN Self-Assessment Tool includes six knowledge / skill development areas. We recommend that you focus on the first four immediately after you begin to practice in the PCBH program and save areas five and six for when you have a solid foundation in the basics. The six areas are:

I. Nurse / BHC Interface
II. Value-Added Use of BHC
III. Use of Assessment and Screening Tools
IV. Documentation Skills
V. Clinical Skills: Brief Behavioral Interventions
VI. Clinical Skills: Pathways

A PCBH trainer will teach you the basic skills (areas one through four) when you begin to practice in a PCBH clinic setting. Four to six months later, the trainer will return and provide information and skill practice opportunities for areas five and six.

This is how we recommend that you use this tool.

1. Use it first <u>during your initial training</u> as a check on what you understand and what you still have questions about <u>in areas 1-4</u>. Make a check in the column that describes your situation at the end of training. The column options are:
   Untrained: "I have not been trained to do this."
   Trained: "I have been trained to do this."
   Skillful: "I have the skill to do this consistently with confidence."

2. Use this tool again <u>after your second training with the PCBH trainer</u> as a check on what you understand about <u>areas 5-6</u>. Make a check in the column that describes your situation at the end of training. Options are same as those noted above.

Provide your nursing director with a copy of your responses after each training. At your request, the BHC and / or medical director will provide you additional reading materials on the PCBH Program. A copy of the PCBH Program manual is available from the Nursing Director or the PCB.

PCBH – Nurse (RN) Self-Assessment Tool

I. **RN / BHC Interface**	**Un-trained**	**Trained**	**Skillful**
1. Understands the roles and responsibilities of BHC			
2. Understands process for having patients triaged and scheduled for same-day visits with the BHC			
3. Understands how to direct patients to obtain a future scheduled appointment with a BHC			
4. Provides an accurate verbal description of PCBH services to patients and/or provides patient with the program brochure (for example, says "The BHC will help you with housing").			
5. Understands difference between "warm handoff" and cold handoff			
6. Describes PCBH services including information about the connection between biological, psychological, and social health			
7. Uses PCBH referral script language to lessen stigma and enhance patient acceptance of service			
8. Consistently offers all patients option of same-day (rather than scheduled) visit with BHC			
9. Identifies a primary target problem for BHC visit and obtains patient agreement on target problem focus			
10. Uses Referral Form or equivalent to enhance communication between PCC, patient, and BHC and clarity of target problem			
11. Refers a broad range of referral target problems to BHC (reflective of patients served at clinic), including patients with:			
a. chronic disease(s)			
b. common psychological problems; e.g., depression, anxiety			
c. complaints of family and relationship problems			
d. complaints of stress			
e. health risk behaviors; e.g., tobacco, alcohol, drugs, unsafe sex			
f. needs for skill building; e.g., parenting skills, social skills			
g. problems that interfere with successful medical visits; e.g., learning disability, health literacy limitations			
12. Uses BHC to improve patient use of medications (for example, requests PCB to explore barriers to patient adherence)			
13. Refers and / or co-teaches classes lead by BHC			
14. Understands the basic components of a BHC visit			
15. When seeing a patient after a BHC visit, is able to:			
a. ask patient about implementation of behavior change plan			
b. ask patient how helpful BHC was			

PCBH – Nurse (RN) Self-Assessment Tool

I. **RN / BHC Interface**	**Un-trained**	**Trained**	**Skillful**
c. support patient in practicing skills learned in BHC visit(s)			
d. use scaling question that quantifies level of patient concern about target problem when seeing patient after a visit with a BHC			
16. Understands how the BHC fits into the primary care model and able to advocate for their integration with other staff			
17. Provides information to PCBH Advisor regarding successes in integrating PCBH services into practice			
18. Seeks assistance from and provides information to the PCBH Advisor (a PCC or RN colleague) regarding how to integrate PCBH team members into patient care activities and / or PCBH Committee when unsure of interface of BHC, PCC and RN			
19. Responds to surveys concerning PCBH services in a timely manner (e.g., Referral Barriers Questionnaire)			

II. **Value-Added Use of PCB-BA**	**Un-trained**	**Trained**	**Skillful**
20. Uses BHC to make telephone calls to patients and to connect them to resources, as appropriate			
21. Uses BHC to complete parts of PCC and RN visits with patients (for example, provide care instructions, assess treatment response, support treatment adherence)			
22. Uses BHC to reduce burden on PCC and other staff and, at the same time, enhance patient outcomes (for example, satisfaction, development of needed skills). Example: Ask BHC to assess and advise when you see patients with chronic pain, depression, school problems, etc.			

III. **Use of Assessment and Screening Tools**	**Un-trained**	**Trained**	**Skillful**
23. Understands Duke Health Profile and uses results to assess and plan treatment for adults			
24. Understands Pediatric Symptom Checklist and uses results to assess and plan treatment for children			
25. Understands screener associated with a specific clinic pathway and is able to use it to initiate BHC services and to evaluate treatment response			

IV. **Documentation Skills**	**Un-trained**	**Trained**	**Skillful**
26. Documents referral to BHC in chart note			

PCBH – Nurse (RN) Self-Assessment Tool

IV. **Documentation Skills**	**Un-trained**	**Trained**	**Skillful**
27. At follow-up visit with patient after initial BHC visit, documents patient response to PCB recommendations			
28. Documents brief interventions used / supported in visit			
29. Documents when visit services were related to a pathway and names pathway			
30. Routinely asks the BHC questions about behavioral interventions that might be useful to specific patients (for example, a patient you plan to see in a few minutes) and general conditions (for example, behavioral interventions for patients with sleep problems).			

V. **Clinical Skills: Brief Behavioral Interventions**	**Un-trained**	**Trained**	**Skillful**
31. Uses brief 5-minute behavior change interventions that are helpful to primary care patients, including:			
a. behavior modification			
b. clarifying values			
c. goal setting and action step planning			
d. mindfulness			
e. motivational interviewing			
f. problem-solving			
g. relapse prevention planning			
h. relaxation skill			
i. scheduling social activities			
32. Uses patient education materials as appropriate			
33. Communicates needs for patient education materials to BHC			

VI. **Clinical Skills: PCBH Pathway Services**	**Un-trained**	**Trained**	**Skillful**
34. Supports clinic leaders in developing PCBH pathways or planned approaches to care that address gaps and deploy PCBH staff to improve outcomes for high impact patient groups (e.g., chronic pain, ADHD, depression/anxiety)			
35. Provides patients with accurate descriptions of how PCBH staff working in pathway programs will assist the PCC / RN team and patient in obtaining better outcomes			

PCBH – Nurse (RN) Self-Assessment Tool

VI. **Clinical Skills: PCBH Pathway Services**	**Un-trained**	**Trained**	**Skillful**
36. Participates consistently in PCBH pilots and programs			
37. Provides needed PCBH pathway evaluation information			
38. Able to shift smoothly from focus on individual care to pathway care			

Name of MA:		Clinic:
Name of Trainer:	Type of Review: ❑ ORIENTATION ❑ TRAINING ❑ SKILL CHECK	Date Administered:

This tool offers you, as a MA, an opportunity to self-asses your knowledge and skills related to successful use of the Primary Care Behavioral Health (PCBH) services in your clinic. PCBH staff members include the Behavioral Health Consultant (BHC) and, in the future, may include the Behavioral Health Consultant Assistant (BHC Assistant). Your responses will also help your Nurse Manager develop plans for on-going training.

When first beginning to work with PCBH staff, MAs need information about how to interface with the new team members. After an initial period of practice, most MAs are ready to learn new clinical skills. This tool helps you navigate this learning process with intention and focus.

The MA Self-Assessment Tool includes five knowledge / skill development areas. We recommend that you focus on the first four immediately after you begin to practice in the PCBH program and save areas five and six for when you have a solid foundation in the basics. The six areas are:

I. MA / RN, PCC, & BHC Interface
II. Value-Added Use of BHC
III. Use of Assessment and Screening Tools
IV. Clinical Skills: Brief Behavioral Interventions
V. Clinical Skills: Pathways

A PCBH trainer will teach you the basic skills (areas one through three) when you begin to practice in a PCBH clinic setting. Six months later, the trainer will return and provide information and skill practice opportunities for areas four and five.

This is how we recommend that you use this tool.

1. Use it first during your initial training as a check on what you understand and what you still have questions about in areas 1-3. Make a check in the column that describes your situation at the end of training. The column options are:
   Untrained: "I have not been trained to do this."
   Trained: "I have been trained to do this."
   Skillful: "I have the skill to do this consistently with confidence."

2. Use this tool again after your second training with the PCBH trainer as a check on what you understand about areas 4-5. Make a check in the column that describes your situation at the end of training. Options are same as those noted above.

Provide your Nurse Manager with a copy of your responses after each training. At your request, the BHC and / or medical director will provide you additional reading materials on the PCBH Program. A copy of the PCBH Program manual is available from the Medical Director, Nurse Manager, or the BHC.

PCBH – Medical Assistant (MA) Self-Assessment Tool

I. **RN / PCB-BA Interface**	**Un-trained**	**Trained**	**Skillful**
1. Understands the roles and responsibilities of BHC			
2. Understands process for having patients triaged and scheduled for same-day visits with the BHC			
3. Understands how to direct patients to obtain a future scheduled appointment with a BHC			
4. Provides an accurate verbal description of PCBH services to patients and/or provides patient with the program brochure (for example, says "The BHC will help you learn to sleep better").			
5. Uses PCBH referral script language to lessen stigma and enhance patient acceptance of service			
6. Notifies PCC or RN when signs of psychological distress are noted in rooming a patient			
7. Stocks BHC Referral Forms and PCBH brochures (if used) for PCCs and RNs			
8. Uses Referral Form or equivalent to enhance communication between PCC, patient, and BHC and clarity of target problem			
9. Collaborates with BHC to improve patient use of medications (for example, requests BHC to explore barriers to patient adherence)			
10. Promotes and supports patient attendance of classes lead by BHC			
11. Understands the basic components of a BHC visit			
12. Supports BHC communication with PCC and / or RN before and after patient visits with the BHC			
13. Understands how the PCBH team fits into the primary care model and able to advocate for their integration with other staff			
14. Seeks assistance from and provides information to the PCBH Advisor (a PCC or RN colleague) regarding integration of PCBH team members into patient care activities and / or PCBH Committee			

II. **Value-Added Use of PCB-BA**	**Un-trained**	**Trained**	**Skillful**
15. Identifies opportunities for using the BHC to reduce burden on PCC and other staff that will, at the same time, enhance patient outcomes. For example, let the PCC or RN know when you room a patient that might benefit from skill training from PCB and shorten the time the PCC needs to spend with the patient and focus more on medical issues.			

III. **Use of Assessment and Screening Tools**	**Un-trained**	**Trained**	**Skillful**

16. Understands Duke Health Profile			
17. Understands Pediatric Symptom Checklist			
18. Understands screener associated with a specific clinic pathways and learn to use screeners when asked by PCC or RN			

IV. **Clinical Skills: Brief Behavioral Interventions**	**Un-trained**	**Trained**	**Skillful**
32. Makes PCBH patient education materials available to patients at PCC or RN request			
33. Communicates information to BHC as requested by PCC or RN			

V. **Clinical Skills: PCBH Pathway Services**	**Un-trained**	**Trained**	**Skillful**
34. Participates consistently in PCBH pilots and programs			
35. Provides requested PCBH pathway activities			

Appendix D – Pathway Program Examples for Chronic Pain and Tobacco Cessation

PCBH Pathway Examples

Pathway Population: CHRONIC PAIN "Pain and Quality of Life Pathway"

Method of Identification: PCP: yes Screener: yes Other: none

PCP Role	BHC Role	RN Role
Complete Pt Agreement ***Yes***	Assessment Instrument ***Duke at initial BHC visit***	Refer to BHC ***Yes****
Refer to BHC ***Same Day***	Frequency of Assessment ***Monthly***	Registry Tracking ***Yes***
Plan Treatment ***Monthly QOL** Class (and medication, yes/no)***	Brief Intervention ***1. Describe pacing;*** ***2. Describe bull's eye values identification***	Registry Parameters ***1. Agreement signed*** ***2. Assigned to class*** ***3. UA frequency/status*** ***4. Date of Agreement Violation*** ***5. Three Chances start / stop***
Monitor Outcomes ***Monthly QOL; pain agreement compliance***	Psycho-education Material ***Bull's-Eye Worksheet***	Other
	Orientation to Class ***Yes***	
	Psycho-educational Class ***No***	
	Monthly Management Class ***Yes, QOL Class (with PCP in some cases), required by Pain Agreement***	

*at request of the PCP

**Quality of Life Class

Pathway Population: TOBACCO CESSATION "Tobacco Free"

Method of Identification PCP: yes Screener: no Other: none

PCP Role	BHC Role	RN Role
Complete Pt Agreement ***No***	Assessment Instrument ***Duke at initial BHC visit***	Refer to BHC ***Yes****
Refer to BHC ***Yes, Same Day***	Frequency of Assessment ***N/A***	Registry Tracking ***No***
Plan Treatment ***1. Assess Readiness Level*** ***2. Provide Support to Tobacco Users***	Brief Intervention** ***Provide Cognitive Behavioral Therapy (CBT) consistent with other evidence and other initiatives (e.g., stages of change, harm reduction, adds CBT to nicotine replacement / suppression products)*** ***Screens at all patient visits*** ***Provides relapse prevention support ("urge surf", how to avoid "abstinence violation effect"***	Registry Parameters ***None***
Monitor Outcomes ***Assess and document tobacco use***	Psycho-education Material ***Smoker's Helpline (1-800-662-8866 and ?website)***	Other
	Exam room posters ***Post exam room posters***	
	Orientation to Class ***Yes***	
	Psycho-educational Class ***Freedom from Smoking***	
	Monthly Management Class ***NO***	

***a**t request of the PCP

Appendix E – Step-Up/Step-Down Pathway Program: Patient Referral Criteria

Pt. Name: _____ DOB: _____Today's DATE: _____

This is an example of a document that your clinic could develop to enhance coordination between primary care behavioral health and specialty mental health / substance abuse services.

PRIMARY CARE / BEHAVIORAL HEALTH ADULT REFERRAL CRITERIA

PURPOSE: This protocol is intended to set criteria for the referral of Adults and Older Adults from the Primary Care setting to the Behavioral Health setting and vice versa.

I. PC to BH Referral: (check one or more)

These are persons in the primary care setting who have serious mental illness requiring extended specialized behavioral health treatment that is more than can be provided at the primary care site.

[*These persons should have an Initial Risk Assessment (form MRD03) performed by the Behaviorist at Primary Care site.]

- ☐ Persons with SMI & moderate to severe chronic impairment in functioning areas (independent living, self-care, vocational skills, social relations) that require specialized BH tx to maintain adequate functioning & prevent decompensation.
- ☐ Persons with SMI & at high risk for harm to self or others.
- ☐ Persons with severe psychotic disorders or primary disorders with psychotic features who are disorganized and are severely impaired in functioning.
- ☐ Persons with severe Axis II personality disorders which severely impairs functioning.
- ☐ Persons with complex PTSD which severely impairs functioning.
- ☐ Persons with repeated psychiatric hospitalizations or psychiatric emergency room visits in the past year.
- ☐ Persons who are high users of multiple emergent/urgent systems of care.
- ☐ Other Special Circumstances (describe):

II. BH to PC Referral: Persons may be from 1 of 2 groups:

1) CBHS clients who have attained the following stability criteria & can be managed in Primary Care setting:

- ☐ Mental health stability as defined by the following:
  - -No acute psychiatric symptoms or severe impairments in functioning
  - -No high suicide/violence risk or safety issues
  - -No multiple inpatient hospitalizations or multiple PES visits in the past year
  - -Compliance with psychiatric medications
  - -Activities of Daily Living: able to maintain self-care (food, shelter, clothing, personal hygiene, etc.)
- ☐ Housing: psychiatric symptoms not impairing ability to obtain or maintain housing.
- ☐ Substance abuse harm reduced: has minimal impact on psychiatric symptoms and functioning.
- ☐ Entitlements in place: or at least documentation in place for entitlement applications (i.e. SSI if eligible)
- ☐ Able to make appointments. PC does not provide outreach or home visits (except w/some Older Adults).

2) Non-SMI persons who can be managed in the Primary Care setting by behaviorist interventions and/or medication. These persons may be new to CBHS or may have received some prior CBHS treatment. (These are often diagnoses such as Generalized Anxiety, Panic Disorder, Social Phobia, Mild to Moderate Depression, Axis II Personality Disorder, Substance Use Disorder, Adjustment Disorder, Somatoform Disorders, etc.)

[*These persons should have an Initial Risk Assessment (form MRD03) performed by CBHS for referral to PC.]

*** Serious Mental Illness (SMI)** refers to a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation (for a long or indefinite period of time). Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders.

As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

"Functional impairment" means being substantially impaired as the result of a mental disorder in areas of independent living, social relationships, vocational skills or physical condition. [This form is on reverse side of PCBH Referral form]

Pt. Name: _____ DOB: _____Today's DATE: _____

This is an example of a document that your clinic could develop to enhance coordination between primary care behavioral health and specialty mental health / substance abuse services.

PRIMARY CARE / BEHAVIORAL HEALTH
CHILDREN AND YOUTH REFERRAL CRITERIA

PURPOSE: This protocol is intended to set criteria for the referral of Children and Adolescents from the Primary Care setting to the Behavioral Health setting and vice versa.

I. Primary Care to Behavioral Health Referral (check one or more):

These are persons in the primary care setting who have serious behavioral health needs requiring extended specialized behavioral health treatment that is more than can be provided at the primary care site.

[*These persons should have a Single Contact Episode Assessment performed by the Behaviorist at the primary care site.]

☐ Persons with an intensive or immediate care Behavioral / Emotional Need **and** an intensive or immediate care need impacting her/his Functioning. *This means persons with an item or items rated as a '3' in **either** Sections I and II of the Single Contact Assessment.*

☐ Persons with 1 or more hospitalizations or psychiatric emergency room visits in the past year.

☐ Persons who are currently involved in multiple systems of care (including children or youth receiving behavioral health services at school, within the Juvenile Justice system, and / or while involved with Child Protective Services).

☐ Other Special Circumstances (describe): _____

_____

II. Behavioral Health to Primary Care Referral (check **one**):

☐ Persons with a single, Moderate Behavioral / Emotional Need (a single item in Section I rated as a '2') and no severe impairments in Functioning (no items rated higher than a '2' in Section II).

☐ Persons with up to two Moderate Behavioral / Emotional Needs (up to two items in Section I rated as a '2') and no severe impairments in Functioning (no items rated higher than a '2' in Section II), whose primary mode of care is Medication Management, and the dosage has not changed for one month and ongoing medication management can be provided by primary care providers.

☐ Persons whose Primary Presenting Problem is Physical Health Needs / Physical Health Treatment (either the Medical or Physical item in Section II is rated as a '2' or '3') with a single, Moderate Behavioral / Emotional Need (a single item in Section I rated as a '2'). Persons must also have *no other severe impairments in Functioning* (no other items rated higher than a '2' in Section II)

Appendix F – Practice Supports

PCBH Program Tips for the PCC and RN
How to Introduce Primary Care Behavioral Health Services to Patients

Suggestion No. 1

"We have a team member here I'd like you to see. She/He is the _____ (Behavioral Health Consultant may have a different name in different clinics, e.g., BHC) for the clinic and I would like to see if she/he can help us develop a plan to help manage _____."

Suggestion No. 2

"I have a colleague, _____, who is part of our team that I 'd like you to see. She/He provides primary care behavioral health services for our clinic and I would like to see if she/he has any suggestions on additional things **we** can do to help manage _____."

Suggestion No. 3

For the PCP or RN:
"Our clinic is taking a new approach to help us improve the care we deliver. In the past, you saw X (name of BHC) for a variety of services. She is now able to provide additional services, as she has had additional training. I think she could help us with X (target problem). I think you'll be able to see her today. How does that sound to you?

Things to Emphasize

The idea is that your patient knows:

1) I'm part of the Team.

2) I teach skills that help patients improve their health and the quality of their life.

3) I'm there to help the two of you develop a stronger health care plan.

4) I may provide coaching for the patient and consultation for you for an extended period of time, but you as the PCP are still in charge of the patient's care and they are not being shifted to another provider.

PCBH Program - Referral Form (All ages)

Rev 1-17-2012

REFERRING PROVIDER	PATIENT LAST NAME	PATIENT FIRST NAME
DATE OF REFERRAL	CLINIC	MRN

PRIMARY REASON FOR REFERRAL (If more than one reason, please circle primary reason)

1. ❑ Abuse/Violence/ Neglect
2. ❑ Atten/Focus/Hyper
3. ❑ Alcohol / Drug
4. ❑ Anger
5. ❑ Anxiety
6. ❑ Behavior Problem
7. ❑ Chronic Pain
8. ❑ Cog. Impairment
9. ❑ Depression
10. ❑ Dev. Disability
11. ❑ Diabetes
12. ❑ Exercise
13. ❑ Family Health
14. ❑ Fatigue
15. ❑ Gender Identity
16. ❑ Grief
17. ❑ Headaches
18. ❑ Healthy Eating
19. ❑ Hi Risk Behaviors
20. ❑ Hypertension
21. ❑ Occupational
22. ❑ Parenting
23. ❑ Relationships
24. ❑ School
25. ❑ Sexual Function
26. ❑ Sleep Hygiene
27. ❑ Social Skills
28. ❑ Stress
29. ❑ Tobacco
30. ❑ Treatment Plan Adherence
31. ❑ Other: _____

PLEASE ARRANGE FOLLOW-UP VISIT WITH ME: ❑ **TODAY** ❑ **IN _____ DAYS** ❑ **IN _____ WKS** ❑ **NO FOLLOW-UP**

NOTE:

PCBH Program - Referral Form (All ages)

Rev 1-17-2012

REFERRING PROVIDER	PATIENT LAST NAME	PATIENT FIRST NAME
DATE OF REFERRAL	CLINIC	MRN

PRIMARY REASON FOR REFERRAL (If more than one reason, please circle primary reason)

1. ❑ Abuse/Violence/ Neglect
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6. ❑ Behavior Problem
7. ❑ Chronic Pain
8. ❑ Cog. Impairment
9. ❑ Depression
10. ❑ Dev. Disability
11. ❑ Diabetes
12. ❑ Exercise
13. ❑ Family Health
14. ❑ Fatigue
15. ❑ Gender Identity
16. ❑ Grief
17. ❑ Headaches
18. ❑ Healthy Eating
19. ❑ Hi Risk Behaviors
20. ❑ Hypertension
21. ❑ Occupational
22. ❑ Parenting
23. ❑ Relationships
24. ❑ School
25. ❑ Sexual Function
26. ❑ Sleep Hygiene
27. ❑ Social Skills
28. ❑ Stress
29. ❑ Tobacco
30. ❑ Treatment Plan Adherence

❑ Other: _____

PLEASE ARRANGE FOLLOW-UP VISIT WITH ME: ❑ **TODAY** ❑ **IN _____ DAYS** ❑ **IN _____ WKS** ❑ **NO FOLLOW-UP**

NOTE:

PCBH Program Chart Note

PCBH PROVIDER (PRINT)	DATE	TIME

CAUTION: Federal and State laws protecting confidential patient information apply to patient information contained in this completed form.

PATIENT INFORMATION (sticker may be affixed)

LAST NAME	FIRST NAME	M.I.

ALIASES	SSN	DOB	MRN

REFERRAL

REFERRING PROVIDER	PC CLINIC	DATE OF REFERRAL

PRIMARY REASONS FOR REFERRAL	ASSIGNED PCP, IF DIFFERENT

TYPE OF PCBH VISIT

❑ SAME DAY ❑ SCHEDULED	❑ INITIAL VISIT ❑ FOLLOW-UP	LAST VISIT (date):	❑ INDIVIDUAL ❑ GROUP/CLASS ❑ COUPLE ❑ FAMILY ❑ PHONE

FIRST TIME SEEN BY PCBH PROGRAM: ❑ NO ❑ YES, THEN: ❑ PCBH SERVICES EXPLAINED ❑ PATIENT GAVE VERBAL CONSENT	IF PATHWAY, FOCUS IS:

1. SUBJECTIVE NOTES

LIFE CONTEXT:
- ✓ LIVES WHERE? HOW LONG? WITH WHOM?
- ✓ IF HOMELESS, HOW LONG SINCE PERM HSD?
- ✓ LEGAL / CRIMINAL?
- ✓ WORKS / OBTAINS ECONOMIC SUPPORT?
- ✓ FAMILY? FRIENDS?
- ✓ RELAXATION?
- ✓ EXERCISE?
- ✓ FUN?
- ✓ SOCIAL / COMMUNITY?

HEALTH / HEALTH RISK:
- ✓ CHRONIC DISEASE(S)?
- ✓ ADHERENCE TO MEDICATIONS
- ✓ ADHERENCE TO OTHER TREATMENT?
- ✓ ETOH / DRUGS?
- ✓ TOBACCO?
- ✓ RISK AND SAFETY?

OTHER FACTORS IMPACTING HEALTH AND USE OF HEALTH CARE SERVICES:
- ✓ HISTORY OF HEAD INJURY
- ✓ LEARNING DISABILITY / ADHD
- ✓ ACCULTURATION STRESS
- ✓ HEALTH LITERACY CONCERNS
- ✓ CHRONIC DISEASE

To what extent is (reason for referral) a problem for you?

Scale 1-10: _____

- ✓ TIME?
- ✓ TRIGGERS?
- ✓ TRAJECTORY?
- ✓ WHAT MAKES BETTER?
- ✓ WHAT MAKES WORSE?
- ✓ SOLUTIONS TRIED?
- ✓ RESULTS?

2. OBJECTIVE NOTES

DUKE	**TOTAL SCORE**	**PHYSICAL HLTH**	**MENTAL HLTH**	**SOCIAL HLTH**	APPEARANCE ❑ WNL ❑ OTHER:
PSC-17 PARENT	**TOTAL SCORE**	**INTERNALIZING**	**ATTENTION**	**EXTERNALIZING**	BEHAVIOR ❑ WNL ❑ OTHER:
PSC-17 YOUTH	COMPARISON TO PRIOR SUGGESTS: ❑ IMPROVEMENT	**INTERNALIZING**	**ATTENTION**	**EXTERNALIZING**	MOOD ❑ WNL ❑ OTHER:

PRIOR SURVEY DATE	COMPARISON TO PRIOR SUGGESTS: ❑ IMPROVEMENT ❑ STABILIZED ❑ DECLINE ❑ N/A

3. ASSESSMENT

BRIEF INTERVENTIONS PROVIDED (reference checklist):	1.
	2.
	3.

4. PLAN

RECS TO PATIENT	1.
	2.
	1.
RECS TO PCP Communicated directly to referring provider? ❑ Yes ❑ No	2.
	3.
	IF INDICATED, FOLLOW-UP APPOINTMENT WITH **PCP** (date)

FOLLOW-UP APPOINTMENT WITH **PCBH PROVIDER** (date)	IF INDICATED, FOLLOW-UP APPOINTMENT WITH **PCP** (date)

REFERRAL MADE TO

❑ MH CLINIC: _____ APPT:_____

❑ SA PROGRAM: _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

VISIT SCALING ANSWERS	How confident are you that you can carry out the plan we've made: Scale 1-10: _____	How helpful was this visit? Scale 1-10: _____

PCBH Program Chart Note

Draft 10-01-10 pr 415-255-3706, Page 1

DATE	TIME
9-27-2010	10:00 AM
PCBH PROVIDER	
SMITH	

CAUTION: Federal and State laws protecting confidential patient information apply to patient information contained in this completed form.

PATIENT INFORMATION (sticker may be affixed)

LAST NAME	FIRST NAME	M.I.
Jones	Sam	L.

ALIASES	SSN	DOB	MRN
None	456-78-910	5-21-80	276514

CONTACT INFORMATION

2007 Turk #42D

REFERRAL

REFERRING PROVIDER	PC CLINIC	DATE OF REFERRAL
Jones	CHC	29 Sept 2010

PRIMARY REASONS FOR REFERRAL: Chronic Pain

ASSIGNED PCP, IF DIFFERENT: Same

TYPE OF PCBH VISIT

X SAME DAY X INITIAL VISIT X INDIVIDUAL ❑ GROUP/CLASS

❑ SCHEDULED ❑ FOLLOW-UP / LAST VISIT (date): ❑ COUPLE ❑ FAMILY ❑ PHONE

FIRST TIME SEEN BY PCBH PROGRAM: X NO X YES, THEN:

X PCBH SERVICES EXPLAINED X PATIENT GAVE VERBAL CONSENT

IF PATHWAY, FOCUS IS: Chronic Pain

1. SUBJECTIVE NOTES

LIFE CONTEXT:
- ✓ LIVES WHERE? HOW LONG? WITH WHOM?
- ✓ IF HOMELESS, HOW LONG SINCE PERM HSD?
- ✓ LEGAL / CRIMINAL?
- ✓ WORKS / OBTAINS ECONOMIC SUPPORT?
- ✓ FAMILY? FRIENDS?
- ✓ RELAXATION?
- ✓ EXERCISE?
- ✓ FUN?
- ✓ SOCIAL / COMMUNITY?

HEALTH / HEALTH RISK:
- ✓ CHRONIC DISEASE(S)?
- ✓ ADHERENCE TO MEDICATIONS
- ✓ ADHERENCE TO OTHER TREATMENT?
- ✓ ETOH / DRUGS?
- ✓ TOBACCO?
- ✓ RISK AND SAFETY?

OTHER FACTORS IMPACTING HEALTH AND USE OF HEALTH CARE SERVICES:
- ✓ HISTORY OF HEAD INJURY
- ✓ LEARNING DISABILITY / ADHD
- ✓ ACCULTURATION STRESS
- ✓ HEALTH LITERACY CONCERNS
- ✓ CHRONIC DISEASE

To what extent is (reason for referral) a problem for you? Scale 1-10: 10

- ✓ TIME?
- ✓ TRIGGERS?
- ✓ TRAJECTORY?
- ✓ WHAT MAKES BETTER?
- ✓ WHAT MAKES WORSE?
- ✓ SOLUTIONS TRIED?
- ✓ RESULTS?

Lives alone, receives disability. Did well in high school. Moved to SF and got a job as a waiter after graduation- "I was good at it". No legal problems.

No connection to his family.

Has two friends in his building.

Likes to go to the park and listen to music. To relax, watches TV, movies. Does not exercise.

No chronic disease(s). Drinks a few beers daily. Denies use of drugs except pot occasionally. No SI / HI, "but I get the blues sometimes can't get out much any more, I hurt and really don't have the money". Smokes 10 cigarettes / day – "don't want to quit".

"Pain today in right ankle (rated as 10, 1-10 scale and 10 = extreme). Pain as a problem in his life, rated as 10 (a big problem). Started 9 years ago after motorcycle accident--"Crushed my ankle."

Present daily, increases with walking. Interferes with many activities. Gets out several times a week, tends to "over do it and then pays". Medications help, but "need more".

2. OBJECTIVE NOTES

DUKE		PHYSICAL HLTH	MENTAL HLTH	SOCIAL HLTH	APPEARANCE
		20	40	60	X WNL ❑ OTHER:
PSC-17 PARENT	TOTAL SCORE	INTERNALIZING	ATTENTION	EXTERNALIZING	BEHAVIOR X WNL ❑ OTHER:
PSC-17 YOUTH	TOTAL SCORE	INTERNALIZING	ATTENTION	EXTERNALIZING	MOOD X WNL ❑ OTHER:

PRIOR SURVEY DATE:

COMPARISON TO PRIOR SUGGESTS:
❑ IMPROVEMENT ❑ STABILIZED ❑ DECLINE ❑ N/A

3. ASSESSMENT

Chronic pain with some symptoms of depression, secondary to isolation and financial constraints

BRIEF INTERVENTIONS PROVIDED (reference checklist):

1. Discussed pacing and learning to "check-in" and adjust level of activity and effort
2. Discussed importance of scheduling social activities (seeing friends) and pleasurable activities (park)
3. Provided information about the Quality of Life Class

4. PLAN

RECS TO PATIENT

1. Practice noticing pain level once per hour and making a choice about level of effort
2. Schedule 2 pleasurable activities/day, go to park on Sundays
3. Attend Quality of Life Class (1st Mon, 1 - 2)

RECS TO PCP

Communicated directly to referring provider?

❑ Yes ❑ No

1. Use Duke scores to monitor treatment impact
2. Support above behavioral changes
3. Encourage attendance of Quality of Life Class

FOLLOW-UP APPOINTMENT, if indicated

WITH PCBH PROVIDER (date) 2 weeks

APPOINTMENT WITH PCP (date) as planned

VISIT SCALING ANSWERS

How confident are you that you can carry out the plan we've made: Scale 1-10: 7

How helpful was this visit? Scale 1-10: 6

REFERRAL MADE TO NONE

❑ MH CLINIC: _____ APPT:_____

❑ SA PROGRAM: _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

❑ OTHER (specify): _____ APPT:_____

SIGNATURE: Leslie Smith, LCSW DATE: 9-20-2010 TIME: 10:30

PCBH Intervention Quick Guide

This list includes a variety of evidence-based interventions for common psychological problems. It is intended to give PCBs ideas for intervening with problems on the Referral Checklist, but not to include all possible interventions.

Referral Problem	Possible Interventions
1. Attn-Focus-Hyper	❑ With PCP, assess using Vanderbilt system ❑ Address social skill deficits ❑ Address parenting issues ❑ Homework plan ❑ Address related behavioral problems ❑ Teach focusing skills
2. Adherence Handout: Using Medications Successfully	❑ Functional Analysis (Three T's) ❑ Explore beliefs, world view regarding treatment plan ❑ Address barriers ❑ Build in social support, if possible
3. Alcohol / Drug	❑ Motivational interviewing ❑ Harm reduction strategies ❑ Mindfulness and value-based behavior change planning
4. Anger	❑ Functional Analysis (Three T's) ❑ Teach present moment skills ❑ Explore triggers and address ❑ Teach strategies for low cost / no cost expression of anger ❑ Explore possible deficits in assertion skills and address ❑ Explore cost / benefits of angry expressions ❑ Explore values as they relate to others impacted by angry behavior
5. Anxiety	❑ Functional Analysis (Three T's) ❑ Teach present moment skills ❑ Teach relaxation skills ❑ Develop exposure plan based on pursuit of valued actions ❑ Explore cognitions (catastrophizing)
6. Behavior Problem	❑ Behavior Modification
7. Chronic Pain	❑ Shift focus from pain avoidance to pain acceptance ❑ Shift focus from pain elimination to pursuit of a higher quality of life ❑ Values Clarification ❑ Skills for pain management (for example, pacing) ❑ On-going support of behavior change directed by patient's values

8. Cognitive Impairment	❑ Assessment ❑ Safety and social support planning ❑ Health care access and support plan ❑ Support and planning with caregiver(s)
9. Depression Symptoms	❑ Behavior Activation Plan ❑ Social Plan ❑ Exercise Plan ❑ Active (vs. avoidant) problem solving
10. Develop. Disability	❑ Planning consistent with outcome tool results (Duke or PSC) ❑ Coordination with resources (schools, voc training, case managers, etc.) ❑ Health care access and support plan ❑ Support and planning with caregivers
11. Diabetes	❑ Assess strengths and weaknesses in regards to self-management ❑ Target area where patient has greater level of readiness for change ❑ Address psychosocial stressors ❑ Address barriers to adherence to treatment
12. Eating	❑ Functional Analysis (Three T's) ❑ Behavior Modification ❑ Healthy Lifestyle Coaching
13. Exercise	❑ Functional Analysis (Three T's) ❑ Behavior Modification
14. Family Health	❑ Relationship strengthening plan (for example, play time, Caring Days, parent skill training) ❑ Behavior Modification (Star Chart) ❑ Listening skills ❑ Mindfulness skills
15. Fatigue	❑ Functional Analysis (Three Ts) ❑ Behavioral Modification ❑ Assess sleep, relaxation skills
16. Gambling	❑ Values Clarification ❑ Behavior Modification ❑ Harm Reduction
17. Gender Identity	❑ Functional analysis (Three Ts) ❑ Values clarification ❑ Problem solving ❑ Lifestyle planning ❑ Social skill training / social support planning

18. Grief	❑ Listening and support ❑ Information ❑ Encouragement of active experience of grief ❑ Connection with others (for example, grief group or friends and family members)
19. Headaches	❑ Functional Analysis (Three T's) ❑ Address contributing factors (for example, hydration, high stress, poor sleep, inadequate relaxation skills)
20. High Risk Behaviors	❑ Follow protocols of Your Clinic
21. Hypertension	❑ Teach relaxation skills (particularly progressive muscle relaxation) ❑ Encourage increase in playful and restorative activities ❑ Problem solve barriers to improved diet ❑ Support gradual support of an exercise program, as approved by PCP ❑ Explore barriers to medication adherence
22. Occupational	❑ Functional Analysis (Three T's) ❑ Problem solving ❑ Skill training as indicated
23. Parenting	❑ Functional Analysis (Three T's) ❑ Teach relationship building skills ❑ Teach stress reduction activities ❑ Assist with creation of daily schedules ❑ Teach behavior modification skills ❑ Teach mindfulness skills ❑ Teach communication skills
24. Relationship	❑ Functional Analysis (Three T's) ❑ (see Parenting Stress) ❑ Caring Days Plan ❑ Train on steps of effective problem solving
25. Safety	❑ Follow protocols of Your Clinic
26. School	❑ Functional Analysis (Three T's) ❑ Coordination with teacher (special programs) ❑ Explore homework, tutoring, social concerns ❑ Enhance motivation (e.g., career direction, tour of clinic)
27. Sleep Problem	❑ Functional Analysis (Three T's) ❑ Address identified sleep hygiene problems ❑ Stimulus control ❑ Relaxation training
28. Social Problem	❑ Functional Analysis (Three T's) ❑ Address social skill deficits (for example, effective assertion, playful interactions, guides for productive disagreements, optimal rate of engagement in social activities)

29. Stress-related Illness	❑ Functional Analysis (Three T's) ❑ Stress reduction training ❑ Relaxation training ❑ Active approach to solving life problems
30. Tobacco Cessation	❑ Functional Analysis (Three T's) ❑ Motivational Interviewing ❑ Cognitive behavioral interventions one-to-one or in groups ❑ Quit Line
31. Substance Misuse	❑ Functional Analysis (Three T's) ❑ Motivational Interviewing ❑ Harm reduction ❑ Cognitive behavioral interventions ❑ Values clarification
32. Weight Management	❑ Functional Analysis (Three T's) ❑ Address identified unhealthy lifestyle habits (including diet, exercise, and restful/restorative activities) ❑ Cognitive behavioral interventions one-to-one or in groups

Interventions for Seven Common Referrals to the BHC

I. Stress

1. Give patient a handout on Stress and explain typical emotional, behavioral, and physical symptoms.

2. Help patient identify sources of stress and plan specific stress reduction strategies for the most troubling sources of stress.

3. Review deep breathing and explain how it would be useful to help decrease their physical stress response.

4. Show patient how to do deep breathing & take patient through a 2-3 minute deep breathing exercise.

5. Review cue-controlled relaxation and explain how to get started and why it would be useful.

6. Help patient develop a plan to practice relaxation activities throughout the day to keep stress levels down.

7. Recommend starting physical activity program. Explain how exercise might decrease some of their symptoms and improve daily functioning. Help the patient plan specific days, times, and activities.

8. Explain how increasing enjoyable activities may help them to enjoy their current situation despite stressors that are beyond their control. Help patient develop several fun or enjoyable activities they will start. Write them on a piece of paper and write specific days and times to start and finish.

II. Depression

1. Give patient depression handout and explain avoidance and lethargy cycles promote symptoms of depression. Discuss how learning to accept negative feelings and change behavior helps a person to feel better and have more meaning in life.

2. Explain to the patient that as people become more depressed they generally cut out fun and enjoyable activities. Help the patient develop several fun or enjoyable activities they will start. Write them on a piece of paper and write specific days and times to start and finish.

3. Explain that increased physical activity can play a significant role in improving concentration, sleep and energy. Help the patient set goals for a physical activity program. Have them pick specific days, times and what they will do (walking is usually a good activity to start with).

4. Explain the role of thinking as it relates to depressed mood and decreased activities. Review ways the patient can start to separate from depressing thoughts and take action even while having sad or angry thoughts.

5. Help the patient identify specific social activities and make a plan to engage in social activities on a daily basis.

III. Anxiety

1. Give patient a handout on physiology of anxiety and explain what may be happening to their body when anxiety increases.

2. Explain that anxiety is a signal and explore triggers, looking for a specific problem(s) that the patient is having trouble solving.

3. Review deep breathing and explain how it would be useful to help decrease sympathetic arousal.

4. Show patient how to do deep breathing & take patient through a 2-3 minute deep breathing exercise.

5. Review cue-controlled relaxation and explain how to get started and why it would be useful.

6. Teach an autogenic relaxation exercise (for example, the CALM exercise).

7. Review handout on cognitive distortions (for example, catastrophizing) and how to ask questions to challenge anxious thinking.

8. If anxiety seems mixed with a stress component recommend starting physical activity program. Help patient specify days, times, and activities.

IV. Insomnia

1. Give patient a handout on insomnia. Review Stimulus Control Procedures. Make sure patient understands reasons for using stimulus control and how that will make their sleep better.

2. Review Sleep Hygiene Guidelines. Make sure patient understands reasons for following these guidelines.

3. Develop a specific plan to improve sleep efficiency and ask the patient to keep a sleep diary and follow-up with you in 2 weeks to assess progress.

4. Give patient a handout on sleep restriction, have them read it, then explain verbally what it is and why you want them to start it. Set new sleep and/or awaking time. Have patient follow-up in 2 weeks to assess progress.

V. Chronic Pain

1. Give patient handout on the Gate Control Theory of pain. Discuss how pain gate is influenced by attention, mood, thoughts, environment, physical processes and behavior. Discuss how the main focus with most people who have chronic pain is to keep the gate closed as much as possible (minimize pain), but a more important goal is to increase functioning and quality of life, despite pain.

2. Engage patient in a discussion about pain acceptance and explore patient's ability to be present and experience pain.

3. Engage patient in a discussion about important life values and explore the patient's consistency between current behavior patterns and patient's valued directions.

4. Discuss possibly increasing physical activity. Set plan if applicable.

5. Discuss possibly increasing pleasurable activities. Set plan if applicable.

6. Discuss use of relaxation to decrease muscle tension and how this might be helpful.

VI. Headache

1. If diet is implicated in HA give handout on possible foods to avoid in the short term to see if HA decrease.

2. Check on patient's daily water intake and address if problematic.

3. Check on quality of sleep and address if problematic.

4. Review the association between sympathetic nervous system arousal (stress), and how that might be impacting HA. Review common stress symptoms, paying attention to those stated by patient.

5. Encourage patient to recognize symptoms early and teach deep breathing and cue controlled relaxation to help manage physiological arousal.

6. Review brief strategies to help decrease stressful thinking.

7. Possibly, take patient through a brief autogenic relaxation exercise focused on hand-warming and have patient use thermometer at home to measure hand temp before and after exercise.

VII. Weight Management

1. Review with the patient specific eating behaviors (e.g. eating quickly, eating in front of TV) they can change that will allow them to still eat the foods they like, but potentially consume fewer calories and still feel full.

2. Review key areas of a healthy lifestyle (healthful eating, daily exercise, restorative sleep and leisure activities). Help the patient identify an initial area for change and continue small changes in a series of follow-up visit.

3. Explore the role emotions play in unhealthy eating patterns.

4. Teach patient mindful eating skills.

5. Discuss the importance of increasing physical activity and help patient set specific goals for a physical activity program specifying days, times and activity to be performed.

6. Ask patient if interested in setting a calorie goal, if they are interested multiply current weight by 12 to get an estimate of calories they need to consume to maintain there current weight. Share this info with them. Then subtract at least 500 calories from the total they need to maintain current weight and this will give a reasonable target calorie goal that will allow them to lose approximately 1 pound per week.

PCBH Introduction Scripts

BHC Introduction

Hello, I would like to introduce myself and tell you a little bit about what I do at (clinic name). I am a Behavioral Health Consultant and a (your credential). This is a brochure that describes our services.

I work as a part of the primary care team here. At our clinic, we pay attention to the whole person -- physical, mental, and social health. My job is to help when your doctor has a concern about any area of your health.

I'd like to tell you about our visit today. We have about 20 minutes together today. I will be asking a lot of questions to get a snapshot of your life right now and to better understand the problem you and your doctor are concerned about. I may make a few notes while we talk.

After about 15 minutes, we'll start developing a plan to improve your quality of life, starting today. I'll discuss this with your doctor after our visit.

My chart note will go into your medical record. I have the same reporting responsibility as other team members regarding danger and safety issues.

Do you have any questions? If not, let's get started with my asking you a few questions from this survey. This will take about 3 minutes, and I'll give you the results when we finish. This will be a baseline, and, if you come back to see me, I'll ask these questions again and we can see if our plan is working and the scores are changing.

BHC Assistant Introduction

Hello, I would like to introduce myself and tell you a little bit about what I do at (clinic name). I am a Behavioral Health Consultant Assistant and I work closely with the doctors and with the Behavioral Health Consultant, (name). This is a brochure that describes Primary Care Behavioral Health services at our clinic.

The Behavioral Health Consultant and I are part of the primary care team here. At our clinic, we pay attention to the whole person -- physical, mental, and social health. The Behavioral Health Consultant's job is to help when your doctor has a concern about any area of your health.

I'd like to tell you what to expect in your visit with the BHC today. It will take about 20 minutes. S/he will be asking a lot of questions to get a snapshot of your life right now and to better understand the problem you and your doctor are concerned about. Together, you will come up with a plan to improve your quality of life. S/he discuss this with your doctor after the visit.

Her/his chart note will go into your medical record and she/he has the same reporting responsibility as other team members regarding danger and safety issues.

Do you have any questions? If not, let's get started with my asking you a few questions from this survey. This will take about 3 minutes, and I'll give you the results when we finish. This will be a baseline, and, if you come back to see the BHC, I'll ask these questions again and to help us see if the plan is working and the scores are changing.

BHC-Facilitator

Hello, I would like to introduce myself and tell you a little bit about what I do at (clinic name). I am a Behavioral Health Consultant Facilitator and a (your credential). Your doctor or nurse probably gave you a brochure that describes our services.

I with the primary care team here. At our clinic, we pay attention to the whole person -- physical, mental, and social health. My job is to help when your doctor has a concern about any area of your health.

I'd like to talk with you today for about 10-15 minutes. I will be asking a lot of questions to get to get information about how your life is going and how you are feeling right now. I will also be checking on the extent to which you have been able to follow through on plans you have made with your PC team, things like making small changes in your life and in some cases taking medications to help you.

After about 10 minutes, we'll start developing a plan. It may be that you will just continue doing what you are doing because it is helpful. If not, we will come up with something new. I'll let your doctor know about our visit.

My chart note will go into your medical record and I have the same reporting responsibility as other team members regarding danger and safety issues.

Do you have any questions? If not, let's get started with my asking you a few questions from this survey. This will take about 3 minutes, and I'll give you the results when we finish. I'll ask these questions at all our visits and tell you the results; your answers provide a way to measure your progress.

Appendix G – Assessment and Screeners Reference Guide

List of Recommended Instruments and Screeners

Recommended for ROUTINE USE – Assessment / Outcome Tools

1) Visit Rating Scale
2) Age appropriate assessment
    a) Duke Health Profile
    b) Pediatric Symptom Checklist
        i) Parent completed version
        ii) Youth Self-Report
        iii) Infant-Toddler Assessment (under development)

Recommended for AS INDICATED Use – Screening Tools

Domestic Violence

1) IPV Screen

Depression

2) PHQ-2 (Patient Health Questionnaire-2)
3) PHQ-9 (Patient Health Questionnaire-9)
4) Duke Anxiety Depression Scale (DUKE-AD)
5) Geriatric Depression Scale

Anxiety

6) GAD-7 (Generalized Anxiety Disorder-7)
7) Duke Anxiety Depression Scale (DUKE-AD) (listed also under "Depression")

ADHD

8) Vanderbilt Tool Kit
    a) Parent version
    b) Teacher version

PTSD

9) PC-PTSD
10) PTSD-16
    a) Civilian version
    b) Military version

Cognitive Impairment

11) Clock Drawing Test (CDT)
12) IQ Code
13) MMSE

Substance Abuse

14) Alcohol and Drug Audit C and D

Pain

15) Wong-Baker FACES pain scale

Overall Health

16) Healthy Days Measure

Quick Guide to the Visit Rating Scale

Description:	The Visit Rating Scale contains questions about the patient's perception of the problem severity, confidence in carrying out the (proposed) plan, and how helpful the visit was with the Behaviorist.
Target Population:	Ages 10 and over
Languages:	Still in development, will be translated as needed once finalized.

PROBLEM SEVERITY RATING: To what extent is (target problem) a problem for you?

Purpose:	The Problem Severity Rating question is intended to assess the patient's perception of severity of the presenting problem.
Scoring and Interpreting:	Problem severity is rated on a likert scale from 1 "*Not a problem*" to 10 "*A very big problem*".
When to use:	The Behaviorist should ask the Problem Severity Rating question at the beginning of each visit.
Recommended Interventions:	At initial visits, explain to patient that you will help with developing a plan to solve the problem or make it less troubling. At follow-up, compare rating with initial rating and share result with patient.

CONFIDENCE IN PLAN: How confident are you that you can carry out the plan we've made?

Purpose:	The Confidence in Plan question is intended to assess the patient's level of confidence in carrying out the plan that the Behaviorist is recommending.
Scoring and Interpreting:	Confidence in the plan is rated on a likert scale from 1 "*Not at all confident*" to 10 "*Very confident*".
When to use:	The Behaviorist should ask the Confidence in Plan question at the end of each visit.
Recommended Interventions:	If patient is confident, affirm their confidence and link plan back to problems: "Great, you sound confident. Let's see if our plan makes a difference in terms of X (target problem)". If patient is not confident (less than 5), ask patient if she would be more confident implementing only a part of the plan, and, if so, what part. If this doesn't improve patient confidence, ask what plan would make more sense at this point. Note that patients who lack confidence in a plan may lack skills for implementing a part of the plan. Think through skills required for implementation (for example, self-organization skills, personal assertion skills, etc.).

HELPFULNESS OF VISIT: How helpful was this visit to you?

Purpose:	The Helpfulness of Visit question is intended to assess the patient's perception of how helpful the visit was with the Behaviorist.
Scoring and Interpreting:	Helpfulness of Visit is rated on a likert scale from 1 "*Not helpful*" to 10 "V*ery helpful*".
When to use:	The Behaviorist should ask the Helpfulness of Visit question at the end of each visit.
Recommended Interventions:	If patient reports the visit was more helpful than not (rating of 6 or greater), thank them for the information, affirm that most patients find

	this “coaching” approach helpful, and end the visit. If patient reports a 5, briefly ask about what was helpful and what was not helpful and assure patient that you will try to do more of what was helpful in the follow-up (if planned). If patient reports the visit was not more helpful than not (rating of less than 5), ask patient what would have made the visit more helpful and agree to provide more of that in follow-up. You might also assure the patient that you will think more about the visit and try to come up with new ideas for the follow-up visit (if planned).

Visit Rating Scale

Circle number that most closely reflects your viewpoint.

A. To what extent is (target problem) a problem for you? (Not a problem) 1 2 3 4 5 6 7 8 9 10 (A very big problem)
B. How confident are you that you can carry out the plan we’ve made? (Not at all confident) 1 2 3 4 5 6 7 8 9 10 (Very confident)
C. How helpful was this visit to you? (Not helpful) 1 2 3 4 5 6 7 8 9 10 (Very helpful)
COMMENTS

Quick Guide to the Duke Health Profile (Duke)

<table>
<tr><td>Description:</td><td>The Duke is a well-validated 17-item self-report questionnaire with 11 subscales that measure functional health status and health-related quality of life during a 1-week period. The subscales are: physical health, mental health, social health, perceived health, disability, anxiety, depression, anxiety-depression, self-esteem, pain, and general health.</td></tr>
<tr><td>Purpose:</td><td>The Duke is used to assess and monitor change in functional health status and health-related quality of life.</td></tr>
<tr><td>Target Population:</td><td>Adults 18 & over</td></tr>
<tr><td>Languages:</td><td>The Duke has been translated into Spanish, Russian, French, German, Italian, Korean, Polish, Portuguese, Dutch, Afrikaans, and Taiwanese</td></tr>
<tr><td>Scoring and Interpreting:</td><td>Raw Score: This is the score in the last digit of the numeral next to the blank checked by the patient for each item. For example, if the second blank is checked for item 10 (blank numeral = 101), then the raw score is “1”, because 1 is the last digit of 101.
Final score: The final score is the sum of the raw scores multiplied by 10. Total final scores for physical, mental and social health range from 0 to 100, with 0 indicating the worst possible health status and 100 indicating the best possible health status.
<table>
<tr><th colspan="3">SOCIAL HEALTH</th></tr>
<tr><td>Item #</td><td>Raw Score</td><td>Final Score (raw x 10)</td></tr>
<tr><td>2</td><td></td><td></td></tr>
<tr><td>6</td><td></td><td></td></tr>
<tr><td>7</td><td></td><td></td></tr>
<tr><td>15</td><td></td><td></td></tr>
<tr><td>16</td><td></td><td></td></tr>
<tr><td colspan="2">Sum of Final Scores</td><td></td></tr>
<tr><th colspan="3">PHYSICAL HEALTH</th></tr>
<tr><td>Item #</td><td>Raw Score</td><td>Final Score (raw x 10)</td></tr>
<tr><td>8</td><td></td><td></td></tr>
<tr><td>9</td><td></td><td></td></tr>
<tr><td>10</td><td></td><td></td></tr>
<tr><td>11</td><td></td><td></td></tr>
<tr><td>12</td><td></td><td></td></tr>
<tr><td colspan="2">Sum of Final Scores</td><td></td></tr>
<tr><th colspan="3">MENTAL HEALTH</th></tr>
<tr><td>Item #</td><td>Raw Score</td><td>Final Score (raw x 10)</td></tr>
<tr><td>1</td><td></td><td></td></tr>
<tr><td>4</td><td></td><td></td></tr>
<tr><td>5</td><td></td><td></td></tr>
<tr><td>13</td><td></td><td></td></tr>
<tr><td>14</td><td></td><td></td></tr>
<tr><td colspan="2">Sum of Final Scores</td><td></td></tr>
</table></td></tr>
<tr><td>When to use:</td><td>The Duke will be used to track change in patients’ symptoms over time. The Behaviorist should complete and score the Duke at every visit with patients 18 years of age and older.</td></tr>
<tr><td>Recommended Interventions:</td><td>Pay particular attention to social health. When low, consider including an intervention to improve the patient’s rate of engaging in social activities.</td></tr>
</table>

Duke Health Profile (The DUKE)

INSTRUCTIONS:

Here are a number of questions about your health and feelings. Please read each question carefully and check (X) your best answer. You should answer the questions in your own way. There are no right or wrong answers. (Please ignore the small scoring numbers next to each blank.)

	Yes, describes me exactly		Somewhat describes me		No, doesn't describe me at all	
1. I like who I am		12		11		10
2. I am not an easy person to get along with		20		21		22
3. I am basically a healthy person		32		31		30
4. I give up too easily		40		41		42
5. I have difficulty concentrating		50		51		52
6. I am happy with my family relationships		62		61		60
7. I am comfortable being around people		72		71		70

TODAY, would you have any physical trouble or difficulty:

	None		Some		A Lot	
8. Walking up a flight of stairs		82		81		80
9. Running the length of a football field		92		91		90

DURING THE <u>PAST WEEK</u>: How much trouble have you had with:

	None		Some		A Lot	
10. Sleeping		102		101		100
11. Hurting or aching in any part of your body		112		111		110
12. Getting tired easily		122		121		120
13. Feeling depressed or sad		132		131		130
14. Nervousness		142		141		140

DURING THE PAST WEEK, How often did you:

	None		Some		A Lot	
15. Socialize with other people (talk or visit with friends or relatives)		150		151		152
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties)		160		161		162

DURING THE PAST WEEK: How often did you:

	None		1-4 Days		5-7 Days	
17. Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem		172		171		170

Quick Guide to the Pediatric Symptom Checklist-17 (PSC-17)

Description:	The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing. The PSC-17 Parent is used for children and youth between the ages of 3 and 17, and is completed by the parent. The PSC-17 Youth is a self-report measure completed by youth 12-17 years old.
Purpose:	The PSC-17 is used to facilitate the recognition of psychosocial dysfunction in a major area of daily life such as home, school, friends, activities, mood, or self-esteem.
Target Population:	PSC-17 Parent: Ages 3 to 17 PSC-17 Youth self-report: Ages 12-17
Languages:	The English, Spanish, and Chinese versions of the PSC-17 Parent are available on the PSC website: www2.massgeneral.org/allpsych/psc/psc_forms.htm
Scoring and Interpreting:	The PSC-17 total score is calculated by adding together the score for each of the 17 items. If 4 or more items are left blank, the questionnaire is considered invalid. A PSC-17 score of ≥15 suggests the presence of significant behavioral or emotional problems. Below are the items contained within the internalizing, conduct, and attention subscales and their cutoff scores: **The PSC-17 Internalizing Subscale (Cutoff ≥5):** 1. Feels sad, unhappy 2. Feels hopeless 3. Is down on self 4. Worries a lot 5. Seems to be having less fun **The PSC-17 Attention Subscale (Cutoff ≥7):** 6. Fidgety, unable to sit still 7. Daydreams too much 8. Distracted easily 9. Has trouble concentrating 10. Acts as if driven by a motor **The PSC-17 Externalizing Subscale (Cutoff ≥7):** 11. Fights with other children 12. Does not listen to rules 13. Does not understand other people's feelings 14. Teases others 15. Blames others for his/her troubles 16. Refuses to share 17. Takes things that do not belong to him/her
When to use:	The PSC-17 will be used to track change in patients' symptoms over time. The Behaviorist should give the PSC-17 to parents to complete at the beginning of every visit with a child aged 3 to 17 years. Youth ages 12 and over should complete the PSC-17 Youth self-report at the beginning of each visit.
Recommended Interventions:	Match behavioral interventions to the highest priority subscale that is elevated: Elevated Internalizing Subscale⇒ behavioral activation Elevated Attention Subscale⇒ provide Vanderbilt Tool Kit educational handouts Elevated Externalizing Subscale⇒ social skills training

PEDIATRIC SYMPTOM CHECKLIST (PSC-17)

PARENT

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions.

Please mark under the heading that best describes your child:

	(0) NEVER	(1) SOMETIMES	(2) OFTEN
1. Feels sad, unhappy	☐	☐	☐
2. Feels hopeless	☐	☐	☐
3. Is down on self	☐	☐	☐
4. Worries a lot	☐	☐	☐
5. Seems to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydreams too much	☐	☐	☐
8. Distracted easily	☐	☐	☐
9. Has trouble concentrating	☐	☐	☐
10. Acts as if driven by a motor	☐	☐	☐
11. Fights with other children	☐	☐	☐
12. Does not listen to rules	☐	☐	☐
13. Does not understand other people's feelings	☐	☐	☐
14. Teases others	☐	☐	☐
15. Blames others for his/her troubles	☐	☐	☐
16. Refuses to share	☐	☐	☐
17. Takes things that do not belong to him/her	☐	☐	☐

Does your child have any emotional or behavioral problems for which she/he needs help?
__No __Yes

PEDIATRIC SYMPTOM CHECKLIST (PSC-17)

YOUTH

Please mark under the heading that best fits you:

	(0) NEVER	(1) SOMETIMES	(2) OFTEN
1. Feel sad, unhappy	☐	☐	☐
2. Feel hopeless	☐	☐	☐
3. Down on yourself	☐	☐	☐
4. Worry a lot	☐	☐	☐
5. Seem to be having less fun	☐	☐	☐
6. Fidgety, unable to sit still	☐	☐	☐
7. Daydream too much	☐	☐	☐
8. Distract easily	☐	☐	☐
9. Have trouble concentrating	☐	☐	☐
10. Act as if driven by a motor	☐	☐	☐
11. Fight with other children	☐	☐	☐
12. Do not listen to rules	☐	☐	☐
13. Do not understand other people's feelings	☐	☐	☐
14. Tease others	☐	☐	☐
15. Blame others for his/her troubles	☐	☐	☐
16. Refuse to share	☐	☐	☐
17. Take things that do not belong to you	☐	☐	☐

Quick Guide to Intimate Partner Violence (IPV) Screening & Assessment

Description:	The Intimate Partner Violence (IPV) Screening Tool and guidelines described here were developed by Dr Leigh Kimberg of Maxine Hall Health Center. The questions in the IPV tool were designed to directly assess patients' past and current exposure to violent, threatening, or exploitative behavior by a partner. In addition, there are a series of questions to determine the potential threats to safety for the patient and any children in the household. Comprehensive information on screening, assessment, intervention, documentation, and reporting of IPV can be found on the Look to End Abuse Permanently (LEAP) at www.leapsf.org. **IPV Screening Procedures:** A. Screen for domestic violence in a safe environment. • Use your own words in a non-threatening, non-judgmental manner. • Ask the patient about domestic violence in a private place. • Separate any accompanying person or child from the patient while screening for domestic violence. • If it is not possible to screen for domestic violence safely do not screen patient. Arrange for return visit. B. Use questions that are direct, specific, and easy to understand (see IPV Screening and Assessment questions). C. When unable to converse fluently in the patient's primary language: • Use a professional interpreter or another health care provider fluent in the patient's language. • The patient's family, friends or children should not be used as interpreters when asking about domestic violence. D. Screen verbally, in addition to any written questionnaire forms used. E. Document that screening for domestic violence was done. • Document that domestic violence is or has been present, has never occurred, or is suspected even though the patient denies it. • Document the date and the results of the screening in the life record of the patient's chart as well as in the progress notes. F. Routinely discuss confidentiality limits with patients, mandatory reporting, and the requirement to report child abuse.
Purpose:	IPV screening is used to screen for current, past, or potential IPV and threats to safety.
Target Population:	Ages 13 and over
Languages:	Has not been translated yet
Scoring and Interpreting:	N/A
When to use:	Routine IPV screening should be done with all patients every 1-2 years. IPV screening should also be done with all new patients, when there are any signs of IPV, when patients begin a new relationship, and when patients are pregnant.
Recommended Interventions:	Assist patient with developing safety plans and link patient to appropriate resources. Request follow-up visit with patient.

INTIMATE PARTNER VIOLENCE (IPV) SCREENING AND ASSESSMENT

Screening

1. Ask indirect questions:
   a. How does your partner treat you?
   b. Do you feel safe at home?
2. Ask direct questions:
   a. Has your partner ever hit you, hurt you, or threatened you?
   b. Does your partner make you feel afraid?
   c. Has your partner ever forced you to have sex when you didn't want to?
3. Also ask about past history of IPV:
   a. Have you ever had a partner who hit you, hurt you, or threatened you?
   b. Have you ever had a partner who treated you badly?
   c. Have you ever had a partner who forced you to have sex when you didn't want to?

Assessment

1. Assessment of current IPV
   a. Assess for safety in clinic
      i. Is perpetrator with patient?
   b. Assess for current safety
      i. Threats of homicide
      ii. Weapons involved
      iii. History of strangulation or stalking
   c. Assess for suicidality and homicidality
   d. Assess for safety of children
2. Assessment of history of IPV
   a. Patterns of abuse
   b. History of effects of abuse
   c. Injuries/hospitalizations
   d. Physical and psychological health effects; economic, social, or other effects
   e. Support and coping strategies
   f. Readiness for change

Quick Guide to the Patient Health Questionnaire - 2 (PHQ-2)

Description:	The PHQ-2 is a brief screening instrument for depression, comprised of the first 2 questions from the PHQ-9. These questions assess the frequency of feelings of depression and anhedonia during the past 2 weeks on a scale of 0 "*Not at all*" to 3 "*Nearly every day*". The PHQ-2 is not meant to be used as a diagnostic tool or to monitor change in depressive symptoms over time.
Purpose:	The PHQ-2 is used as an initial screening for depression to determine whether further assessment is needed.
Target Population:	Adolescents, adults, older adults
Languages:	The PHQ-2 items can be taken from the full version of the PHQ-9, which has been translated into over 30 languages and can be freely downloaded from the PHQ website (www.phqscreeners.com).
Scoring and Interpreting:	Scores on the PHQ-2 range from 0 to 6. The authors of the PHQ-2 recommend a cutoff score of 3 as the optimal cut point, and state that a score of 2 would provide greater sensitivity and a score of 4 would provide greater specificity in terms of detecting or diagnosing depression[1].
When to use:	As indicated to screen for depression
Recommended Interventions:	Coach patient on mood improvement strategies, such as scheduling pleasurable activities, social contacts, and regular exercise.

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

[1] *Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-item Depression Screener. Medical Care 2003, (41), 1284-1294.*

Quick Guide to the Patient Health Questionnaire - 9 (PHQ-9)

Description:	The items on the PHQ-9 follow the criteria for a Major Depressive Episode listed in the DSM-IV. Symptom severity is rated by indicating the frequency that depressive symptoms have been experienced during the last 2 weeks on a scale of 0 "*Not at all*" to 3 "*Nearly every day*". An additional single item is rated to determine the impact of depressive symptoms on psycho, social, and occupational functioning.
Purpose:	The PHQ-9 is used to screen for depression, aid in diagnosis[2], and monitor change in symptoms over time.
Target Population:	Adolescents, adults, older adults
Languages:	The PHQ-9 has been translated into over 30 languages and can be downloaded from the PHQ website: www.phqscreeners.com
Scoring and Interpreting:	The total score is computed by first producing a sum for each column (e.g. each item chosen in column "*More than half the days*" = 2), then summing the column totals. Total Scores range from 0 to 27, and indicate the following levels of depression severity: **Total Score** — **Depression Severity** 0-4 None 5-9 Mild depression 10-14 Moderate depression 15-19 Moderately severe depression 20-27 Severe depression In addition to the patient's Total Score, the responses to Question #9 (suicidality) and Question #10 (the impact of symptoms on the patient's daily functioning) should be reviewed to determine appropriate treatment interventions.
When to use:	As indicated to screen for depression
Recommended Interventions:	Ask patient about preferences for addressing troubling symptoms. Offer behavioral strategies (for example, planning and engaging in more pleasurable, social, and mastery activities as well as exercise) and cognitive behavioral strategies (for example, taking a systematic approach to solving life problems). For patients with higher levels of severity and/ or with greater negative impact on ability to function, explore patient interest in combined treatment.

[2] Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. A diagnosis of any Depressive Disorder requires impairment of social, occupational, or other important areas of functioning (Question #10). A definitive diagnosis should not be made without taking a thorough history of the patient's depressive symptoms (as well as any Manic or Hypomanic Episodes) and contributing factors and considering all relevant differential diagnoses.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite, weight loss, or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns:		+	+	
TOTAL:				

10. If you checked of any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

ZT274388

Quick Guide to the Duke Anxiety-Depression Scale (Duke-AD)

Description:	The Duke Anxiety-Depression Scale (Duke-AD) is the 7-item anxiety-depression subscale of the DUKE Health Profile that has been validated separately as a screening instrument for anxiety and depression. The items inquire about nervousness, feeling depressed or sad, getting tired easily, trouble sleeping, being comfortable around people, difficulty concentrating, and giving up too easily.
Purpose:	The Duke-AD is used as a screening tool for anxiety and depression.
Target Population:	Adults
Languages:	The Duke has been translated into Spanish, Russian, French, German, Italian, Korean, Polish, Portuguese, Dutch, Afrikaans, and Taiwanese.
Scoring and Interpreting:	A raw score of 5 or greater (out of a possible 14) indicates high risk for anxiety or depression.
When to use:	As indicated to screen for anxiety and depression
Recommended Interventions:	This tool can be useful to patients who are considering attending a PCBH workshop or workshop series concerning strategies for coping with fear and sadness. It is also a useful measure in class visits designed to improve skills for coping with fear and sadness.

DUKE ANXIETY-DEPRESSION SCALE (DUKE-AD)

INSTRUCTIONS: Here are some questions about your health and feelings. Please read each question carefully and check (✓) your best answer. You should answer the questions in your own way. There are no right or wrong answers.

	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all
1. I give up too easily.....	_____2	_____1	_____0
2. I have difficulty concentrating.....	_____2	_____1	_____0
3. I am comfortable being around people.....	_____0	_____1	_____2

DURING THE PAST WEEK:
How much trouble have you had with:

	None	Some	A Lot
4. Sleeping.....	_____0	_____1	_____2
5. Getting tired easily.....	_____0	_____1	_____2
6. Feeling depressed or sad.....	_____0	_____1	_____2
7. Nervousness.....	_____0	_____1	_____2

Quick Guide to the Generalized Anxiety Disorder-7 (GAD-7)

Description:	The GAD-7 contains 7 items which assess the frequency of anxiety related symptoms over the past 2 weeks. The GAD-7 can be used as a self-report tool or as an interview.
Purpose:	The GAD-7 is used to screen for anxiety and measure the severity of symptoms.
Target Population:	Adults
Languages:	The GAD-7 has been translated into over 30 languages and can be downloaded from the PHQ website: www.phqscreeners.com
Scoring and Interpreting:	Each question has a number value (0-3). The total score is computed by adding the values endorsed for each item. Total Scores range from 0 to 21, and indicate the following levels of anxiety severity: **Total Score** — **Anxiety Severity** 0-5 — None or mild 6-10 — Moderate anxiety 11-15 — Moderately severe anxiety 16-21 — Severe anxiety A recommended cut-point for further evaluation is a score of 10 or greater.
When to use:	As indicated to screen for anxiety
Recommended Interventions:	Use this screener to help patients assess skill development in relaxation classes and workshops. It is also sometimes helpful in individual PCBH visits when patients are working on anxiety management skills.

Generalized Anxiety Disorder GAD-7

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? (Circle the number to indicate your answer.)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Quick Guide to the Geriatric Depression Scale (GDS)

Description:	The Geriatric Depression Scale is a 15-question screening tool for depression which was developed specifically for older adults. The Yes/No response format makes the questions easy to comprehend, and the time of administration is only 5-7 minutes. The GDS can be filled out by the patient or administered by a provider with minimal training in its use.
Purpose:	The GDS is used to screen for depression in older adults
Target Population:	Adults 60 and over
Languages:	The GDS has been translated into over 20 languages and can be downloaded from: http://www.stanford.edu/~yesavage/GDS.html
Scoring and Interpreting:	The questions contained in the measures are listed below. Answers in **bold** indicate depression. Although differing sensitivities and specificities have been obtained across studies, for clinical purposes a score >6 points is suggestive of depression and should warrant a follow-up interview. Scores > 10 are almost always depression. 1. Are you basically satisfied with your life? YES / **NO** 2. Have you dropped many of your activities and interests? **YES** / NO 3. Do you feel that your life is empty? **YES** / NO 4. Do you often get bored? **YES** / NO 5. Are you in good spirits most of the time? YES / **NO** 6. Are you afraid that something bad is going to happen to you? **YES** / NO 7. Do you feel happy most of the time? YES / **NO** 8. Do you often feel helpless? **YES** / NO 9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO 10. Do you feel you have more problems with memory than most? **YES** / NO 11. Do you think it is wonderful to be alive now? YES / **NO** 12. Do you feel pretty worthless the way you are now? **YES** / NO 13. Do you feel full of energy? YES / **NO** 14. Do you feel that your situation is hopeless? **YES** / NO 15. Do you think that most people are better off than you are? **YES** / NO
When to use:	As indicated to screen for depression in older adults
Recommended Interventions:	Often, older patients are more able to respond to this screener than more general screeners. Responses may help you identify targets for behavior change (e.g., increasing re-engagement in meaningful life activities, strategies for dealing with worry) and, later, to assess response to behavioral skill training or combined treatment.

Geriatric Depression Scale

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / NO

2. Have you dropped many of your activities and interests? YES / NO

3. Do you feel that your life is empty? YES / NO

4. Do you often get bored? YES / NO

5. Are you in good spirits most of the time? YES / NO

6. Are you afraid that something bad is going to happen to you? YES / NO

7. Do you feel happy most of the time? YES / NO

8. Do you often feel helpless? YES / NO

9. Do you prefer to stay at home, rather than going out and doing new things? YES / NO

10. Do you feel you have more problems with memory than most? YES / NO

11. Do you think it is wonderful to be alive now? YES / NO

12. Do you feel pretty worthless the way you are now? YES / NO

13. Do you feel full of energy? YES / NO

14. Do you feel that your situation is hopeless? YES / NO

15. Do you think that most people are better off than you are? YES / NO

Quick Guide to the Vanderbilt Tool Kit

Description:	The Vanderbilt Parent and Teacher Assessment Scales contain items measuring symptoms and impairment in academic and behavioral performance. Although this tool is not intended for diagnosis, it is widely used to provide information about symptom presence and severity, and performance in the classroom, home, and social settings. The Vanderbilt Scale takes 10 minutes to complete (Parent Form has 55 items and Teacher Form has 43 items).
Purpose:	The Vanderbilt Assessment Scales are used to screen for Attention Deficit Hyperactivity Disorder (ADHD). The follow-up scales can be used to measure change in symptoms over time.
Target Population:	Ages 6 to 12
Languages:	The Vanderbilt scales have been translated into Spanish, .
Scoring and Interpreting:	The parent and teacher initial assessment scales have 2 components: symptom assessment and impairment in performance. The symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18). The symptom measures are scored 1 to 3; scores of 2 or 3 on a single symptom question reflect *often-occurring* behaviors. The performance measures are scored 1 to 5; scores of 4 or 5 on performance questions reflect problems in performance. These scales should not be used alone to make a diagnosis. Additional scoring instructions are included on the following page.
When to use:	As indicated to screen for ADHD
Recommended Interventions:	Use these tools to assist PCPs in evaluating children for ADHD. They are recommended by the American Academy of Pediatrics. The Vanderbilt Toolkit is available on the Internet, and it includes patient education pamphlets (such as, Parenting Tips, Homework, etc.). When you screen for symptoms of ADHD, ask about the relationship between the parent and child, homework completion, and the child's level of success in social and academic activities at school.

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	**ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D6 **NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant**

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0353

Quick Guide to the Clock-Drawing Test (CDT)

Description:	The clock-drawing test (CDT) is a screening test for dementia and cognitive dysfunction. The test has a high correlation with the MMSE and other tests of cognitive dysfunction. It can be used to document deterioration over time in dementia patients. Clients are given a sheet of paper with a circle and instructed to draw in the numbers shown on a clock, and then asked to draw the hands of the clock to read "10 after 11".
Purpose:	The CDT is used to screen for dementia and cognitive dysfunction
Target Population:	All ages
Languages:	N/A
Scoring and Interpreting:	Administration and scoring instructions are contained on the following page. Cognitive impairment can usually be ruled out when the clock-drawing results are normal. Education, age and mood can influence the test results, with subjects of low education, advanced age and depression performing more poorly.
When to use:	The CDT should be used as an initial screening when cognitive impairment is suspected.
Recommended Interventions:	When results suggest problems, identify the patient's primary support person(s) and began planning with them to assure patient safety, adjust communication strategies, and implement changes that support optimal quality of life.

Instructions for the Clock Drawing Test:

Step 1: Give patient a sheet of paper with a large (relative to the size of handwritten numbers) predrawn circle on it. Indicate the top of the page.

Step 2: Instruct patient to draw numbers in the circle to make the circle look like the face of a clock and then draw the hands of the clock to read "10 after 11."

Scoring:

Score the clock based on the following six-point scoring system:

Score	Error(s)	Examples
1	"Perfect"	No errors in the task
2	Minor visuospatial errors	a) Mildly impaired spacing of times b) Draws times outside circle c) Turns page while writing so that some numbers appear upside down d) Draws in lines (spokes) to orient spacing
3	Inaccurate representation of 10 after 11 when visuospatial organization is perfect or shows only minor deviations	a) Minute hand points to 10 b) Writes "10 after 11" c) Unable to make any denotation of time
4	Moderate visuospatial disorganization of times such that accurate denotation of 10 after 11 is impossible	a) Moderately poor spacing b) Omits numbers c) Perseveration: repeats circle or continues on past 12 to 13, 14, 15, etc. d) Right-left reversal: numbers drawn counterclockwise e) Dysgraphia: unable to write numbers accurately
5	Severe level of disorganization as described in scoring of 4	See examples for scoring of 4
6	No reasonable representation of a clock	a) No attempt at all b) No semblance of a clock at all c) Writes a word or name

(Shulman et al., 1993)

Higher scores reflect a greater number of errors and more impairment. A score of ≤3 represents a cognitive deficit.

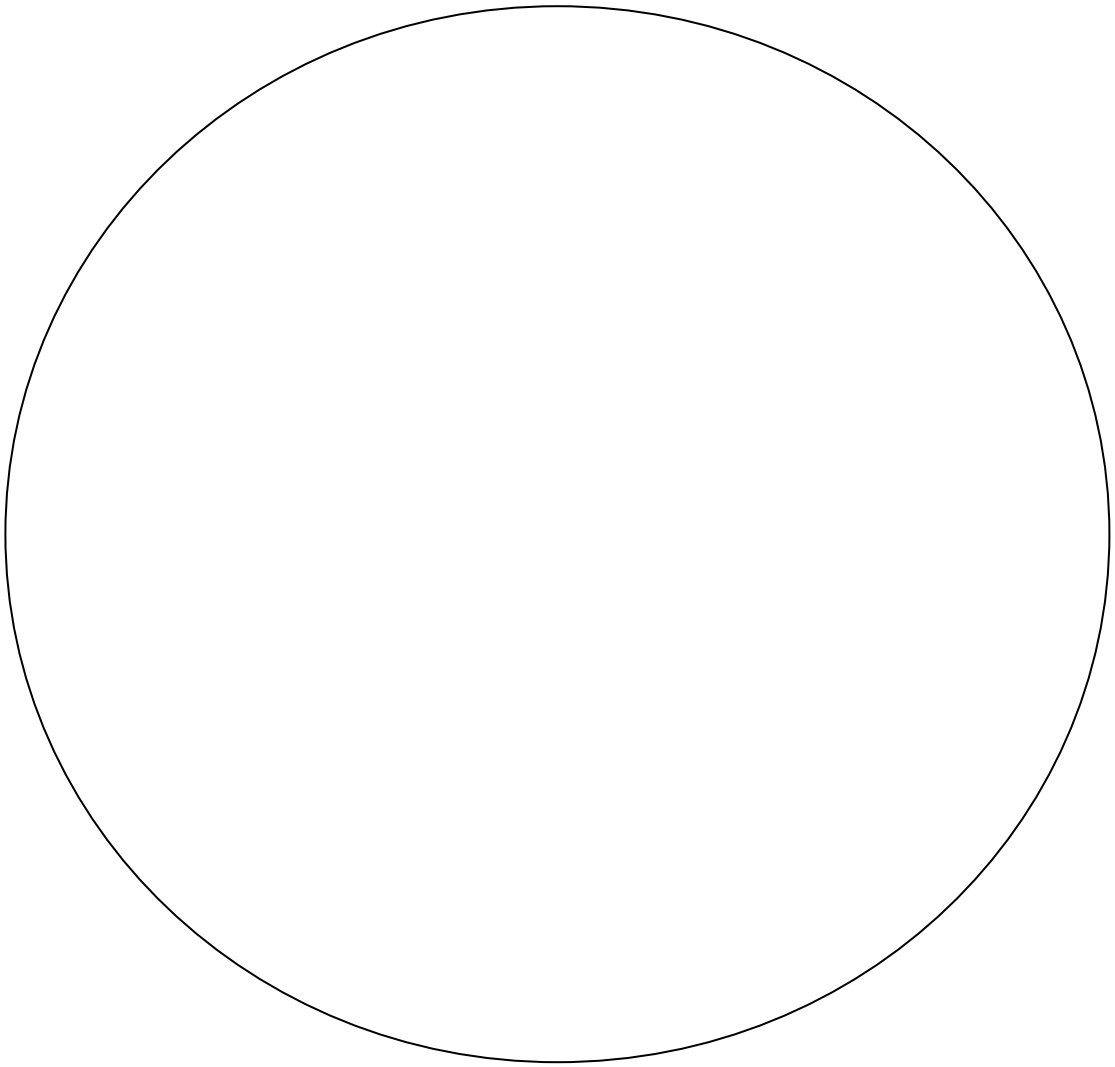
Sources:

- Kirby M, Denihan A, Bruce I, Coakley D, Lawlor BA. The clock drawing test in primary care: sensitivity in dementia detection and specificity against normal and depressed elderly. *Int J Geriatr Psychiatry*. 2001;16:935-940.
- Richardson HE, Glass JN. A comparison of scoring protocols on the clock drawing test in relation to ease of use, diagnostic group, and correlations with Mini-Mental State Examination. *J Am Geriatr Soc*. 2002;50:169-173.
- Shulman KI, Gold DP, Cohen CA, Zucchero CA. Clock drawing and dementia in the community: a longitudinal study. *Int J Geriatr Psychiatry*. 1993;8:487-496.

CLOCK DRAWING TEST

Patient name_____
Patient ID #_____
Date__/__/__

1) Inside the circle, please draw the hours of a clock as they normally appear
2) Place the hands of the clock to represent the time: “ten minutes after eleven o’clock”



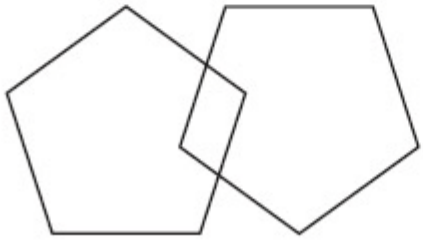
Quick Guide to the Mini Mental State Exam (MMSE)

Description:	The Mini Mental State Examination (MMSE) is a tool that can be used to systematically and thoroughly assess mental status. It is an 11-question measure that tests five areas of cognitive function: orientation, registration, attention and calculation, recall, and language. The MMSE takes 5-10 minutes to administer.
Purpose:	The MMSE is a screening instrument for cognitive impairment. When used repeatedly the instrument is able to measure changes in cognitive status.
Target Population:	Adults
Languages:	
Scoring and Interpreting:	The maximum score on the MMSE is 30. A score of 23 or lower is indicative of cognitive impairment. The MMSE relies heavily on verbal response and reading and writing. Therefore, patients that are hearing or visually impaired, have low English literacy, or those with other communication disorders may perform poorly even when cognitively intact.
When to use:	As indicated to assess mental status.
Recommended Interventions:	When results suggest problems, identify the patient's primary support person(s) and began planning with them to assure patient safety, adjust communication strategies, and implement changes that support optimal quality of life. Offer on-going re-assessment to the PCP, who may plan additional interventions and benefit from on-going assessment information.

The Mini-Mental State Exam

Patient_____ Examiner _____ Date_____

Maximum	Score	
		Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (country) (town) (hospital) (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he/she learns all 3. Count trials and record. Trials _____
		Attention and Calculation
5	( )	Serial 7's. 1 point for each correct answer. Stop after 5 answers. Alternatively spell "world" backward.
		Recall
3	( )	Ask for the 3 objects repeated above. Give 1 point for each correct answer.
		Language
2	( )	Name a pencil and watch.
1	( )	Repeat the following "No ifs, ands, or buts"
3	( )	Follow a 3-stage command: "Take a paper in your hand, fold it in half, and put it on the floor."
1	( )	Read and obey the following: CLOSE YOUR EYES
1	( )	Write a sentence.
1	( )	Copy the design shown.



_____ Total Score

ASSESS level of consciousness along a continuum _____

Alert Drowsy Stupor Coma

Quick Guide to the Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

Description:	The Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE) is a questionnaire that can be filled out by a relative or other supporter (the informant) of an older person to determine whether that person has declined in cognitive functioning. The IQCODE is often used as a screening test for dementia. The IQCODE lists 26 everyday situations where a person has to use their memory or intelligence. Examples of such situations include: "Remembering where to find things which have been put in a different place from usual" and "Handling money for shopping". Each situation is rated by the informant for amount of change over the previous 10 years, on a scale from 1 "*Much improved"* to 5 "*Much worse"*.
Purpose:	The IQCODE is used to screen for cognitive decline.
Target Population:	Adults
Languages:	The IQCODE has been translated into Chinese, Danish, Dutch, Finnish, French, Canadian French, German, Italian, Japanese, Korean, Norwegian, Polish, Portuguese, Spanish and Thai, and can be downloaded from: http://cmhr.anu.edu.au/ageing/Iqcode/
Scoring and Interpreting:	A person who has no cognitive decline will have an average score of 3, while scores of greater than 3 indicate that some decline has occurred. Various cutoff scores have been used to distinguish dementia from normality, the lowest being 3.3. To improve the detection of dementia, the IQCODE can be used in combination with the Mini-Mental State Examination and/or the Clock Drawing Test.
When to use:	As indicated to screen for cognitive decline when a family member or caregiver is available.
Recommended Interventions:	When results suggest problems, identify the patient's primary support person(s) and began planning with them to assure patient safety, adjust communication strategies, and implement changes that support optimal quality of life.

IQ CODE

Now we want you to remember what your friend or relative was like 10 years ago and to compare it with what he/she is like now. 10 years ago was in 20__. Below are situations where this person has to use his/her memory or intelligence and we want you to indicate whether this has improved, stayed the same or got worse in that situation over the past 10 years. Note the importance of comparing his/her present performance with 10 years ago. So if 10 years ago this person always forgot where he/she had left things, and he/she still does, then this would be considered "Hasn't changed much". Please indicate the changes you have observed by circling the appropriate answer.

Compared with 10 years ago how is this person at:

	1	2	3	4	5
1. Remembering things about family and friends e.g. occupations, birthdays, addresses	Much improved	A bit improved	Not much change	A bit worse	Much worse
2. Remembering things that have happened recently	Much improved	A bit improved	Not much change	A bit worse	Much worse
3. Recalling conversations a few days later	Much improved	A bit improved	Not much change	A bit worse	Much worse
4. Remembering his/her address and telephone number	Much improved	A bit improved	Not much change	A bit worse	Much worse
5. Remembering what day and month it is	Much improved	A bit improved	Not much change	A bit worse	Much worse
6. Remembering where things are usually kept	Much improved	A bit improved	Not much change	A bit worse	Much worse
7. Remembering where to find things which have been put in a different place from usual	Much improved	A bit improved	Not much change	A bit worse	Much worse
8. Knowing how to work familiar machines around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
9. Learning to use a new gadget or machine around the house	Much improved	A bit improved	Not much change	A bit worse	Much worse
10. Learning new things in general	Much improved	A bit improved	Not much change	A bit worse	Much worse
11. Following a story in a book or on TV	Much improved	A bit improved	Not much change	A bit worse	Much worse
12. Making decisions on everyday matters	Much improved	A bit improved	Not much change	A bit worse	Much worse
13. Handling money for shopping	Much improved	A bit improved	Not much change	A bit worse	Much worse
14. Handling financial matters e.g. the pension, dealing with the bank	Much improved	A bit improved	Not much change	A bit worse	Much worse
15. Handling other everyday arithmetic problems e.g. knowing how much food to buy, knowing how long between visits from family or friends	Much improved	A bit improved	Not much change	A bit worse	Much worse
16. Using his/her intelligence to understand what's going on and to reason things through	Much improved	A bit improved	Not much change	A bit worse	Much worse

Quick Guide to the Alcohol and Drug Use Disorders Identification Test (AUDIT C & D)

Description:	The AUDIT C & D is a comprehensive brief screening device, providing information on hazardous, harmful use, abuse and dependence of alcohol or drugs. It is designed as a self-report measure.
Purpose:	The AUDIT C & D is used to screen for drug and alcohol abuse or dependence, and can be used to monitor change in severity and frequency of use over time.
Target Population:	Adolescents and adults
Languages:	
Scoring and Interpreting:	**Alcohol Use Disorders Identification Test-Consumption Items (AUDIT C)** To score the AUDIT C, add up the numerical score for each of the three items. ***A score of 4 or higher*** detects 86% of patients with alcohol abuse, dependence and addiction disorders, with a specificity of 72% **Drug Use Disorders Identification Test-Consumption Items (D-AUDIT C)** To score the D-AUDIT C, add up the numerical scores for each of the three items. ***A score of 4 or higher*** is likely to identify patients with substance abuse, dependence or addiction.
When to use:	The AUDIT C & D should be routinely used to screen for alcohol or drug use. For patients who screen positive, the tool should be re-administered at subsequent visits to monitor change in use over time.
Recommended Interventions:	Use motivational interviewing strategies for patients who are misusing alcohol.

Alcohol & Drug Use Survey

Directions: For each question, mark and "X" in the box that best describes your alcohol use over the last month. One drink equals **one** shot of hard liquor, a **small can** of beer, or a **glass** of wine.

Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
					Total:

Directions: For each question, mark and "X" in the box that best describes your drug use over the last month. Drug use is one or more puffs of a joint; snorting, free-basing or injecting cocaine, heroine or methamphetamine; ingesting a recreational drug such as Ecstasy, LSD or Mescaline, Mushrooms; using vicodin, oxycontin, or other narcotics **without a doctor's prescription.**

5. How often do you use drugs?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
6. Typically, when you use, how many hours will you be under the influence of drugs?	Less than 2 hours	2 to 4 hours	5-6 hours	7-9 hours	10 hours or more
7. How often are you under the influence of drugs for 7 or more hours?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
					Total:

Quick Guide to the Primary Care Post-Traumatic Stress Disorder Screening (PC-PTSD)

Description:	The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings. The 4-items address the underlying characteristics specific to PTSD: re-experiencing, numbing, avoidance, and hyperarousal. The PC-PTSD is designed to be understandable to patients with an eighth-grade reading level.
Purpose:	The PC-PTSD is used to screen for PTSD.
Target Population:	Adults
Languages:	
Scoring and Interpreting:	Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to three of the items. A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder. However, a positive response does indicate that a patient *may* have PTSD or trauma-related symptoms and that further investigation is warranted.
When to use:	As indicated to screen for PTSD
Recommended Interventions:	PCPs and/or RNs or staff completing screening questions might use this tool to identify patients that would benefit from a visit with the PCB.

Primary Care PTSD Screen (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you…

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three (3) items.

Quick Guide to the Post-Traumatic Stress Disorder Screening (PCL)

Description:	The PCL is a 17-item self-report measure of the 17 DSM-IV symptoms of PTSD. There are military and civilian versions of the PCL. **PCL-M** (military) The PCL-M asks about symptoms in response to "stressful military experiences." It is used with active service members and Veterans. **PCL-C** (civilian) The PCL-C asks about symptoms in relation to "stressful experiences." The symptoms endorsed may be specific to just one event, or to multiple events.
Purpose:	The PCL is used to screen for and diagnose PTSD, and to monitor change in symptoms of PTSD during treatment.
Target Population:	PCL-M: Active service members and veterans; PCL-C: Civilians
Languages:	
Scoring and Interpreting:	Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to three of the items. A positive response to the screen does not necessarily indicate that a patient has Posttraumatic Stress Disorder. However, a positive response does indicate that a patient *may* have PTSD or trauma-related symptoms and that further investigation is warranted.
When to use:	As indicated to screen for PTSD
Recommended Interventions:	PCBs may use these screeners to better understand a patient's symptoms and develop interventions that target the most troubling symptoms. The screeners may also help the PCB assess patient's response to interventions designed to improve the patient's skills.

PTSD Checklist – Civilian Version (PCL-C)

Patient's Name: _____

Instruction to patient: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

#	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PTSD Checklist – Military Version (PCL-M)

Patient's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

#	Response:	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing memories, thoughts, or images of a stressful military experience?					
2.	Repeated, disturbing dreams of a stressful military experience?					
3.	Suddenly acting or feeling as if a stressful military experience were happening again (as if you were reliving it)?					
4.	Feeling very upset when something reminded you of a stressful military experience?					
5.	Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful military experience?					
6.	Avoid thinking about or talking about a stressful military experience or avoid having feelings related to it?					
7.	Avoid activities or situations because they remind you of a stressful military experience?					
8.	Trouble remembering important parts of a stressful military experience?					
9.	Loss of interest in things that you used to enjoy?					
10.	Feeling distant or cut off from other people?					
11.	Feeling emotionally numb or being unable to have loving feelings for those close to you?					
12.	Feeling as if your future will somehow be cut short?					
13.	Trouble falling or staying asleep?					
14.	Feeling irritable or having angry outbursts?					
15.	Having difficulty concentrating?					
16.	Being "super alert" or watchful on guard?					
17.	Feeling jumpy or easily startled?					

Quick Guide to the Wong-Baker FACES Pain Rating Scale (FACES)

Description:	The FACES is a pain rating scale for children. It has 6 faces to indicate the appropriate pain level, from "*No hurt*" to "*Hurts worst*".
Purpose:	The FACES is used to assess pain level in children.
Target Population:	3 and younger
Languages:	
Scoring and Interpreting:	N/A
When to use:	As indicated to assess pain level in children with injuries or chronic pain.
Recommended Interventions:	It is useful to have this scale in laminated form to use with children with pain complaints. The PCB might have it at the back of their clip board or, alternatively, hang it in exam rooms for easy reference.

Wong-Baker FACES Pain Rating Scale

No Hurt | Hurts Little Bit | Hurts Little More | Hurts Even More | Hurts Whole Lot | Hurts Worst

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can image, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling.

Rating scale is recommended for persons age 3 years and older.

Brief word instructions: Point to each face using the words to describe the pain intensity. Ask the child to choose face that best describes own pain and record the appropriate number.

Quick Guide to the CDC Core Health Days Measure

Description:	The Health Days Measure is used to assess the number of "healthy" and "unhealthy" days during the last month. Unhealthy days are an estimate of the overall number of days during the previous 30 days when the respondent felt that either his or her physical or mental health was not good. Healthy days are an estimate of the number of days during the last 30 when the person's physical and mental health were good
Purpose:	The Health Days Measure is used to assess overall physical and mental health, and to measure change over time.
Target Population:	Age 12 and over
Languages:	
Scoring and Interpreting:	Questions 2 and 3 are combined to calculate a summary index of overall unhealthy days, with a maximum of 30 unhealthy days. Healthy Days are calculated by subtracting the number of unhealthy days from 30.
When to use:	
Recommended Interventions:	This measure is often useful in monthly classes for patients in a chronic pain pathway. It is brief, so supports both the need for assessment and for efficiency in assessment. Patients often are interested in their progress, and the simplicity of this assessment helps them track their progress.

CDC Core Healthy Days Measure

1. Would you say that in general your health is
   a. Excellent
   b. Very good
   c. Good
   d. Fair
   e. Poor

3. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

4. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

5. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Appendix H – Patient Brochure Example

BEHAVIORAL HEALTH CONSULTANT:

PHONE NUMBER:

CONTACT INFORMATION:

ACTION PLAN:

_____

_____

_____

_____

NEXT APPOINTMENT:

Your Clinic

Provides quality health care through service and education.

Your Clinic

Address

Address

Clinic Hours

Contact Phone Number

Your clinic's web address

Your clinic's portal information, Facebook Page

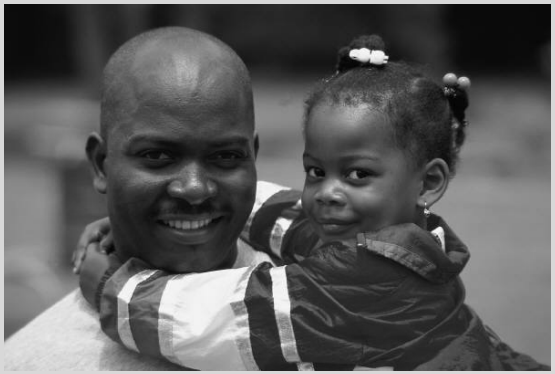
Your Primary Care Home

What is my primary care home?

Your primary care home is where you can see your primary care provider who can help you be healthy. This is where you go for yearly check-ups or when you feel sick or sad.

Does my primary care home offer behavior change services?

Yes, they offer care for the whole person, mind and body. Your primary care provider and primary care team work together to teach you the skills you need to lead a healthier life. This also requires you to take an active role in your own healthcare



Your Primary Care Team

Key members of your team include:

Primary Care Clinician (PCC)

Your primary care clinician helps you with your physical and mental health so overall you are feeling well. Your primary care provider will help you think through important health decisions and may connect you with another member of the primary care team to make sure that you are getting the best care.

Behavioral Health Consultant (BHC)

Your primary care provider may refer you to a BHC for a 15-30 minute visit.

The BHC will focus on a particular problem.

After talking to you, the BHC will help you make any changes you want to make.

The BHC may also help with stress or problems at home or school.

Nurse and Medical Assistant

Nurses and Medical Assistants play many roles on your primary care team. They will be the first person you talk to when you have a health concern. They work closely with the PCP and BHC. They also arrange referrals. In some clinics, BHC Facilitators provide case management services.

Your BHC can help you . . .

Create a healthy lifestyle by changing eating and exercise habits, or learning relaxation skills, ways to sleep better and have good friends.

- **Reflect on harmful habits** like using alcohol, tobacco and drugs, or getting angry easily and hurting people's feelings. The BHC can help you make changes for the better, even if they are small.
- **Cope** with stress, including loss and sadness.
- **Apply self-care techniques** to manage pain, diabetes, medications, and other issues.

Appendix I – Quality Management Chart Tools

Primary Care Behavioral Health Program

Quality Management Chart Tool – Initial Visit

Date: _____ Reviewed By: _____

Provider Reviewed: _____ Provider Code: _____

Initial Contact with Patient

	YES	NO	N/A
1. Is there documentation that the visit is an initial visit?			
2. Is there documentation of the referring PCP / RN?			
3. Is there documentation of the referral problem or question?			
4. Is there documentation of findings regarding patient life context (living situation, social support, financial / work situation, psychosocial stressors)?			
5. Is there documentation of findings concerning the referral problem or question?			
6. Is there a statement concerning assessment findings?			
7. Is there documentation of one or more specific recommendations to patient (e.g., behavior change plan, behavior skill practice, follow-up regarding food, shelter, housing)?			
8. Is there documentation of one or more specific recommendations to the referring PCP or RN?			
9. Is there documentation of BHC's communication of findings and recommendations to referring PCP or RN?			
10. Is there documentation of a specific follow-up plan (with whom and when)?			
11. Is there documentation of completion of a risk assessment for patients whose presentation indicated the need for such?			

Notes

_____

_____

_____

_____

If chart note does not meet standards, who will provide feedback to BHC and what corrective actions are recommended?

_____

_____

_____

_____

Primary Care Behavioral Health Program

Quality Management Chart Tool – Follow-Up Visit

Date: _____ Reviewed By: _____

Provider Reviewed: _____ Provider Code: _____

Follow-Up Contact with Patient

	YES	NO	N/A
1. Is there documentation that the visit is a follow-up visit?			
1. Is there documentation of the referring PCP / RN and the referral problem or question?			
2. Is there documentation of patient's status regarding referral problem or concern (improved, same, worse)?			
3. Is there documentation about patient's attempt to implement recommendations generated in initial BHC visit and impact?			
4. Is there documentation of one or more specific recommendations to patient (e.g., behavior change plan, behavior skill practice, follow-up regarding food, shelter, housing)?			
5. Is there documentation of one or more specific recommendations to the referring PCP or RN?			
6. Is there documentation of BHC's communication of findings and recommendations to referring PCP or RN?			
7. Is there documentation of a specific follow-up plan (with whom and when)?			
8. Is there documentation of completion of a risk assessment for patients whose presentation indicated the need for such?			

Notes

_____

_____

_____

_____

If chart note does not meet standards, who will provide feedback to BHC and what corrective actions are recommended?

_____

_____

_____

_____

Appendix J – PCBH Integration Model References

PCBH Integration Model References

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PCBH Referral Barriers Questionnaire

Referral Barriers Questionnaire

We are interested in learning what factors may deter you as a primary care provider or nurse, from referring to primary care behavioral health services. Please rate how frequently each of the referral barriers listed below occur for you, using a 1-5 rating. Please record the number in the "Response" column on the left.

Never or Rarely a Barrier		***Sometimes a Barrier***		***Frequently or Very Frequently a Barrier***
1	2	3	4	5

Response	
	1. Do you have behavioral health services in your clinic? Yes / No
If "No", what are your barriers to referral?	
	2. Behavioral health services in community difficult to reach by phone.
	3. Most patients don't want to go to specialty mental health or substance abuse services . . . feel stigmatized when I bring it up with them.
	4. Patients often refuse.
	5. Don't hear back from off-site services when I do refer.
	6. Not confident that they can help.
Other barriers:	
If "Yes", you do have behavioral health services in your clinic, what are your barriers to referral?	
	7. Unsure what to say to the patient about the behavioral health provider's service.
	8. Unclear on the process of referral.
	9. Not sure about how to arrange same-day visits with behavioral health provider.
	10. Not sure who to send to my clinic BH provider and who to send to specialty MH / SA provider
	11. Behavioral health provider is part-time, don't know when s/he is there.
	12. Don't have time to talk to the patient about a referral, make the referral, etc.
	13. Worry about alienating the patient by recommending an appointment with the BHC.
	14. Don't want to refer too many difficult and complex patients to the clinic behavioral health provider.
	15. Patient is already seeing a therapist; they should be addressing everything.
	16. Patient has seen the BHC before for the same problem, isn't likely to benefit from another referral.
	17. Patient is responding well to medications alone; no need for referral to clinic behavioral health provider.
	18. Concerned the patient might have a negative experience seeing the behavioral health provider.
	19. Patient isn't likely to benefit from a BHC referral (too complicated/severe/etc.)
	20. Referral process takes too long.
	21. Don't want to interrupt the behavioral health provider and request same-day visit for patient when s/he is with a patient.
	22. The behavioral health provider seems very busy; I don't want to add to his/her workload.
	23. Patient refused to see the BHC.
	24. Forget by the end of the visit.
25. Other Barrier (Please explain):	

Referral Barriers Questionnaire

A. Overall, how helpful are available behavioral health services **<u>for your patients?</u> (Circle the number.)**

0 1 2 3 4 5 6 7 8 9 10

no apparent benefit — extremely helpful, excellent patient feedback

B. Overall, how helpful behavioral health services <u>to you (i.e., helps you better serve patients, etc.)?</u> (Circle the number.)

0 1 2 3 4 5 6 7 8 9 10

not helpful — extremely helpful

What change(s) could result in higher ratings from you?

Your Philosophy Versus PCBH Philosophy

Your Philosophy vs PCBH Philosophy

PCBH Philosophy	Your Philosophy
Maladaptive behaviors are learned and maintained by various external and internal factors	
Many maladaptive behaviors occur as a result of skill deficits	
Direct behavior change is the most powerful form of human learning	

Ethical Issues Documents

Ethical Issues Facing Providers in Collaborative Primary Care Settings:

Do Current Guidelines Suffice to Guide the Future of Team Based Primary Care?

Christine Runyan, PhD, ABPP
Associate Clinical Professor
Dept. Family Medicine and Community Health
University of Massachusetts Medical School

Patti Robinson, PhD
Trainer and Health Care Consultant
Mountainview Consulting Group, Inc.
Zillah, WA

Debra A. Gould, MD, MPH
Associate Clinical Professor
Dept. of Family Medicine, University of Washington
Central Washington Family Medicine Residency Program

Ethical Issues Facing Providers in Collaborative Primary Care Settings: Do Current Guidelines Suffice to Guide the Future of Team Based Primary Care?

The elemental role of behavioral health clinicians (BHCs) in the implementation of Patient Centered Medical Home (PCMH) goals and standards is being iteratively and organically defined in primary care settings across the country. Ethical challenges intrinsic to the services BHCs will provide in the PCMH will undoubtedly emerge with greater frequency. To date, little has been written about the numerous and varied ethical issues and dilemmas that perplex behavioral health providers in primary care work. The default approach of primary care behavioral health providers facing potential ethical quandaries is to consult discipline specific guidelines (such as the American Psychological Association's Ethical Principles). Discipline-specific ethical guidelines have for the most part assumed delivery of services in models typical of specialty mental healthcare. While there is some published information on shared record keeping and limits of confidentiality, little has been written on other scenarios BHCs face. For example, family medicine physicians often provide care to an entire family. How should BHCs ethically, yet strategically, treat several family members simultaneously when family issues are the presenting problem? In the primary care setting, BHCs are more also delivering more preventive services as well as highly coordinated care to patient panels. From this context, concerns about implicit and explicit informed consent surface. Another burgeoning conundrum revolves around electronic communication with patients, as many primary care providers (PCP) use technology to effectively manage patient

panels. These are only a few of the potential ethical issues BHCs confront with limited guidance of from their respective professional organizations.

At the 2011 annual Collaborative Family Healthcare Association's Conference (CFHA), participants packed a room to participate with a group of professionals presenting case presentations illustrative of common ethical dilemmas in collaborative care. The dialogue about various ethical conundrums and the paucity of relevant setting specific guidance continued among various participants and lead to the creation of this special issue. Evolution of a new model of healthcare delivery has appropriately provoked discussion and action regarding training and clinical competence. The extant literature addresses models of collaborative care, condition specific interventions, requisite provider training, clinic based operational changes and financial sustainability. However, attention to professional and ethical challenges has lagged behind. The timeliness of eliciting information from providers working in collaborative settings and wrestling with nascent ethical issues is undeniable, and the necessity for a special issue of *Family Systems and Health* (FSH), is evident to the editors of this special issue and the FSH Editor and Editorial Board. A publication focused on identifying gaps in ethical standards for BHCs and their PCP colleagues is an important step in advancing the field and developing reflective guidance on interdisciplinary team-based primary care.

This special issue started with an invitation to a group of colleagues working in collaborative care[1]. With a plan of creating central themes and common threads for our readers, we provided specific instructions to potential contributors. We asked contributors to (a) use case examples to illustrate ethical dilemmas; (b) describe professional ethical

[1] The terms collaborative care and integrated care are used interchangeably throughout this special issue and do not imply different constructs.

standards pertinent to the case; (c) identify gaps in available guidance and how guidelines might be elucidated in state statues (without going into detail about specific states); (d) offer feasible recommendations to BHCs for deciding an ethical course when extant guidance was lacking; and (e) then demonstrate apply the recommendations to achieve an ethical resolution to the case example.

This special issue is the result of a year-long collaboration. This introduction offers an overview of the issue; a description of the Primary Care Behavioral Health (PCBH) model; highlights features of the model that seem to push the limits of available guidance; introduces a tool--the Four Boxes Approach--for analyzing ethical quandaries; and finally, several general recommendations for informal and formal methods of applying the Four Boxes Approach in team-based collaborative primary care settings.

The issue is organized in three sections: (1) Common Themes; (2) Context-Specific Quandaries; and (3) Research and Training. In section one, the first article by Cathy Hudgins and her colleagues, *Navigating the Legal and Ethical Foundations of Informed Consent and Confidentiality in Integrated Primary Care,* take the reader through a systematic examination of regulations and state laws about informed consent and confidentiality in integrated primary care. The authors make explicit recommendations about patients' informed consent, release of information, documentation, agreements with other providers, and billing. In the second paper, Jennifer Hodgson and colleagues use case examples to further elucidate the issues surrounding informed consent and confidentiality. In their paper entitled *Patient and Provider Relationships: Consent, Confidentiality, and Mistakes in Integrated Primary Care Settings,* the authors take on the complexities of a situation involving patients

voicing strongly negative opinions about one provider to another provider in the same clinic, introducing the challenges of dealing with potential mistakes in team-based care. Jeff Reiter, in the third article of this section, *The Ethics of Complex Relationships in Primary Care Behavioral Health,* describes the attributes of primary care that make it ripe for complex relationships and then provides suggestions for response and management. Reiter also presents a cogent argument for why and how the American Psychological Association's Ethical Standard 10.02 concerning Therapy Involving Couples or Families should be revised for primary care psychologists. This section concludes with an article that explores a scenario in which a behavioral health provider is faced with a colleague-physician seeking assistance for emotional distress. In *From Colleague to Patient: Ethical Challenges in Integrated Primary Care,* Kanzler and her colleagues artfully address questions about multiple relationships, conflict of interest, impaired colleagues, informed consent, and confidentiality.

Section two of the issue concerns ethical dilemmas that arise in delivery of care to specific populations and in specific primary care clinic contexts. Robinson and Rickard present several case examples involving team-based care to patients with chronic pain in their paper, *Ethical Quandaries in Caring for Primary Care Patients with Chronic Pain*. In this paper, the authors call out the challenges of communication between patients, BHCs, PCPs and medical specialists outside of the primary care clinic. They suggest that behavioral health providers need to develop more competence in regards to medical treatments and identify patient autonomy as an important trump card in delivery of services to primary care patients with chronic pain. In *Primary Care Behavioral Health: Ethical Issues in Military Settings,* Ann Dobmeyer explores the truly unique and layered

challenges of providing collaborative primary care in the US military health system which operates according to a specific set of rules and regulations, in addition to discipline specific guidelines for providers. In military medical treatment, providers often wear multiple hats and in so doing come into contact with quandaries about competence for delivery of primary care behavioral health services and boundaries concerning delivery of care to co-workers. In the third article of the section, *Ethical Matters In Rural Integrated Primary Care Settings,* Mullin and Stenger shed light on unique features of rural primary care practice. In rural settings, providers often interface more closely with patients and other providers in community activities which create situations that are ripe for unintended exchanges of information. The authors comment on how well existing ethical standards for psychologists and physicians encompass the realities of rural collaborative primary care and make a few recommendations to assist providers and advance the dialogue in the field. This section concludes with an article addressing the challenges of providing ethical care to patients at the end of life entitled, *Integrating Care When the End is Near: Ethical Dilemmas in End of Life Care.* Rosenberg and Speice aptly describe a BHC's appropriate and thoughtful, but at times unsettling, experience in delivering services at the end of life. They highlight the unique dilemmas that may arise in this circumstance, identify the relevant ethical standards across disciplines and discuss to what extent they provide adequate guidance. The article concludes with insightful suggestions to BHCs in collaborative primary care settings who will certainly need to navigate this difficult, but not uncommon experience.

All of the contributions in section three concern research and training in collaborative primary care settings. Jeff Goodie and his colleagues identify unique issues

of concern when conducting research in primary care. In their article, *Ethical and Effectiveness Considerations with Primary Care Behavioral Health Research in the Medical Home,* they use a case example to illustrate the tension between research and clinical care and provide the reader with a solid primer on federal and professional research guidelines. They conclude the manuscript with a series of recommendations for how best to balance the sometimes competing demands of ethical and effective research and clinical care within in collaborative primary care settings. The final article, *Multiple Role Relationships in Healthcare Education,* Reitz and his colleagues delve into the intricacies of advancing interdisciplinary training in order to optimize effective interdisciplinary practice. However, without adequate guidance, today's teachers and learners from various disciplines are left swimming in an educational pool without lifeguards. Reitz and colleagues offer a model for conceptualizing multiple roles and guiding use of appropriate boundaries within multiple roles.

Debra Gould, MD, MPH, is a primary care physician, educator, and scholar who helped edit this special issue. She also provides a brief commentary from the PCP perspective at the conclusion of each article.

The Primary Care Behavioral Health (PCBH) Model

Most of the authors contributing to this special issue deliver behavioral health services consistent with the Primary Care Behavioral Health (PCBH) model (Robinson & Reiter, 2007; Strosahl, 1994a, 1994b). We describe this model in our introduction so that readers are familiar with it and the description is then not repeated again in the individual submissions. This saves redundancy for our readers, as well as page length for the issue.

A few authors are working in a different collaborative care model, where they function less as fully integrated members of the primary care team, and they describe their approach in the beginning of their article.

The PCBH model evolved from early randomized control trials demonstrating improved clinical, satisfaction and cost outcomes for integrated behavioral health care relative to the usual practice of primary care providers referring patients to outpatient mental health clinics (see for example, e.g., Katon, Robinson, Von Korff, Lin, Bush, et al., 1996). Large health care organizations, such as the United States Air Force, and numerous Federally Qualified Health Centers have implemented this model. A procedural manual is fundamental to PCBH dissemination efforts and to realization of anticipated outcomes. With increasing frequency, research findings indicate that behavioral health services delivered in the context of the PCBH model result in improved symptoms, better quality of life and higher life satisfaction for most patients; that most patients benefit from an average of four or less visits; that gains made by patients are maintained for several years, and that patients and primary care providers prefer this model to usual care (Bryan, Corso, Corso, Morrow, Kanzler, et al., 2012; Bryan, Morrow, & Appolonio, 2008; Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006; Corso, Bryan, Corso, Kanzler, Houghton, et al., 2012; Ray-Sannerud, Dolan, Morrow, Corso, Kanzler, et al., 2012; Simon, Katon, Rutter, VonKorff, Lin, Robinson, et al., 1998; Smith, Rost, & Kashner, 1995). Numerous resources are now available to support behavioral health and primary care providers in implementing the model (Hunter, Goodie, Oordt, & Dobmeyer, 2009;; O'Donohue, Byrd, Cummings, & Henderson, 2005; Oordt & Gatchel, 2003; Robinson, 1996; Robinson, Del Vento, & Wischman, 1998;

Robinson, Gould, & Strosahl, 2010; Robinson & Reiter, 2007; Robinson, Wischman, & Del Vento, 1996; Runyan, Fonseca, & Hunter, 2003; Rowan & Runyan, 2005; Strosahl, 1997; Strosahl, Robinson, & Gustavvson, 2012).

The PCBH model describes the role and responsibilities of BHC, PCPs and nursing staff working together in the context of the PCMH. The BHC functions as a consultant to patients and providers and delivers brief intervention services and PCBH pathway services. The BHC offers brief intervention services to children, youth and adults, often on the same day of the patient's visit with the referring PCP or nurse. The BHC uses evidence-based interventions adapted to the brief context of primary care (see for example, Robinson, 2005; 2008; Robinson, Bush, Von Korff, Katon, Lin, et al., 1995; Goodie, Isler, Hunter, & Peterson, 2009) and translates these to even briefer versions that BHCs can teach PCPs. This allows the PCP, the BHC's primary customer, to support patient efforts to practice new strategies and skills over time and in this way sustain gains in functioning. The BHC is considered to be a primary care provider rather than a specialist and charts in the medical record rather than a separate mental health record. The BHC does not have a caseload, does not "open" or "close" cases and is easily accessed by patients and family members on an intermittent basis over the course of their lifetime.

BHC pathway services involve consistent involvement of the BHC with specific members of a specific patient population. Clinics develop PCBH pathways in order to improve outcomes to high impact patient groups. The targeted group may be that of a healthy population (such as children coming for well child visits) and the focus may be primary prevention (for example, discussing colic behaviors and strategies for parents to

use in responding). Alternatively, pathway services may target patients with mental and/or physical health problems (such as depression, diabetes or chronic pain) and the focus is on teaching self-management skills. Whatever the target, the goal of pathway services is to increase the healthy lifespan of members of the targeted group by consistently adding the expertise of the BHC to patient care. Specific BHC pathway services may include assessment and intervention visits in individual, family or group contexts. In some cases, services may involve delivery of monthly group services to patients (for example those with chronic disease) for as long as they receive care at the clinic.

Table 1 depicts differences between the PCBH model and delivery of traditional mental health services. Dr. Reiter, in his article for this special issue, defines areas of the PCBH model that tend to provoke new ethical quandaries for the BHC. We include Dr. Reiter's ideas, along with a few of our own, in the "Ethical Quandary" column of Table 1 and encourage you to make Dr. Reiter's article one of your first reads to help you conceptualize the interface of model of services and use of extant ethical guidance.

Ethical questions centering on competence arise in many areas of PCBH work, including recognizing the PCP as the primary customer, providing day-to-day support of the primary goals of the PCBH model, working as a team member and staying within the boundaries of the consultant role. Teaching PCPs, adapting empirically supported treatments to the brief treatment context, managing a fast paced high contact practice, providing care in novel group contexts (such as group medical visits), understanding the potential functional impact of a plethora of medical problems and coordinating care with the PCP as well as specialists outside the clinic require new skill sets. Most health care

organizations invest in a great deal of core competency-based training for BHCs and this helps to prepare them for effective and ethical practice. Indeed, one of the ethical dilemmas presented in Dr. Dobmeyer's article on PCBH services in military medical treatment facilities concerns the question of whether it is ethical for a behavioral health provider to offer BHC services without core competency training.

Ethical questions related to beneficence and patient autonomy arise in regards to the delivery structure of PCBH work and honoring the PCP as the provider "in charge" of the patient. For a more informed perspective, BHCs often need to look beyond their respective ethical codes to the American Medical Association code in order to better address subtle questions arising from work in the PCBH context. Quandaries related to confidentiality and multiple relationships are pervasive in PCBH work. A focus on community and provision of health care services to families results in a variety of questions about how to apply the extant guides of all disciplines to multiple relationships with patients and providers as well, particularly in rural clinics. Finally, the PCBH model is the dominant model in delivery of primary care based services in clinics serving uninsured and minimally insured patients, many of whom have disparate health outcomes and bring the complexities of language and culture at variance with providers. Collaborative care, in general, and collaborative care as practiced by highly integrated team members, such as BHCs, provides many rich opportunities to identify ethical quandaries. In looking at the cases that generate concerns about ethical action, many turn out to be problems arising from communication, lack of resources or knowledge deficits. We offer readers a tool for sorting these out in informal and formal case reviews.

The Four Box Method.

As clinicians, difficult or complicated clinical situations can feel like an ethical dilemma, when in fact, it could be solved by such things as improved communication between providers and patients, or by accessing resources that families didn't know existed. This is the contention of Jonsen, Siegler and Winslade (2010) who describe the Four Boxes Approach in *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. The editors of this issue believe that this model is a useful heuristic and introduces an approach to sorting out possible ethical issues other than simply consulting one's discipline specific ethical code. This model guides team members through a series of questions and considerations to reach an effective and ethical course of action. It provides a structure that focuses on the facts of the clinical situation and their relationship to relevant ethical principles as opposed to a dogmatic interpretation of the principles themselves.

The Four Boxes are: 1. Medical Indications (Beneficence, Non-maleficence), 2. Patient Preference (Autonomy), 3. Quality of Life (Beneficence/Non-maleficence and Autonomy) and 4. Contextual Features (Justice and Fairness).

Medical Indications The Principle of Beneficence and Nonmaleficence	**Patient Preference** The Principle of Respect for Autonomy
Quality of Life The Principles of Beneficence and Nonmaleficence and Patient Autonomy	**Contextual Features** The Principle of Justice and Fairness

This model helps a clinician identify whether a dilemma is the result of a communication problem, lack of knowledge or resources, or truly an ethical problem. When a dilemma is decidedly an ethical quandary, providers are then able to weigh relevant ethical principles and decide which takes precedence for the particular dilemma.

On a Final Note

We want to end our introduction with a few recommendations and a plea to our readers, as you are the pioneers who will experience the ethical quandaries of providing day-to-day integrated care in the PCMH and you will write the casebooks that guide others in the future. Our recommendations concern both informal and formal practices. First, for the informal: *When you don't know, ask someone!* Again and again, solutions come when we follow the principle of *"communicate, communicate, communicate"* – whether with a BHC mentor or PCP mentor. Express your concerns clearly, state your boundaries, and form your questions thoughtfully as they arise. Remember, co-workers (and patients, too!) are operating in a new paradigm and rigid application of rules from the former paradigm may lead to communication problems and weaken team relationships. Our next informal guidance is to *"learn, learn, learn"*. Read and discus the AMA code of ethics with other BHCs and with PCPs to familiarize yourself with the prevailing standards guiding primary care providers and practice. With many practices still in the throes of transformation to a PCMH, internal and external education and training abounds, webinars are often free, learning communities are more and more common and numerous on-going and co-training opportunities exist. So avail yourself of them and encourage your colleagues to do the same. If we are all exit the historical silos

of our own discipline and meet in the common hallways of collaborative team-based practice, not only will mind body dualism dissolve but patient outcomes will improve. Primary care will be redefined in a way that necessitates interdisciplinary training and service delivery.

Our more formal recommendations concern the start of systematic changes that can guide providers and patients toward ethical courses of action. For example, as recommended by Robinson and Reiter, clinics are wise to start a monthly meeting for reviewing cases that provoke ethical quandaries. The Four Boxes Approach offers a strong structure for such reviews. Sometimes, these reviews may suggest a need for small changes to the system of care. We encourage you to take the time to make and refine changes that support ethical and effective practice.

And on a final note, we ask our readers to promote acceptance of mental health and substance abuse as a part of legitimate primary care health issues. The mind and body are connected and we best serve our patients and our community when this is our assumption. We will work increasingly within multi-disciplinary teams and our care will come closer to the bar of compassion when the patient (rather than our disciplines) is the focus of care.

Table 1. PCBH model and traditional mental health services

Dimension	PCBH	Specialty MH	Ethical Quandary
Model	Population-based	Patient-based	
Primary Customer	PCP, then patient	Patient, then others	Competence in consultation role
Primary Goal	• Improve patient functioning / assist with specific behavior change activities • Promote PCP effectiveness • Prevent morbidity in high-risk patients • Achieve medical cost offset	Resolve patient's mental health problem	• Beneficence, brief treatment for many • Confidentiality and Multiple Relationship issues (related to BHC involvement with patient and others known to patient over decades
Delivery structure	Part of PCMH team, fast pace, numerous contacts	Specialized service, in or out of the PC clinic	• Beneficence • Patient autonomy
Who is "in charge" of patient	PCP	Therapist	• Confidentiality (patient requests may conflict with model) • Patient autonomy (primary of patient relationship with PCP)
Primary Modality	Consultation model	Specialty Treatment model	Competence, new skills needed to work with PCP and multiple specialists
Team structure	Part of PC team	Part of specialty MH team	Responsibility for learning about medical treatments
Access standard	Determined by PCP preference	Determined by patient preference	Health Disparities
Cost per episode of care	Potentially decreased	Highly variable, related to patient condition	Health Disparities

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Session # F1a
Friday, October 11, 2013 – 10:30-12:00 (40 minutes)

The Four Box Approach to Resolving Ethical Dilemmas in Primary Care Behavioral Health Practice

Christine Nicole Runyan, Ph.D., ABPP,
University of Massachusetts Medical School
Jeffrey T. Reiter, Ph.D., ABPP,
Health Point Clinics, Seattle, WA
Patricia Robinson, Ph.D.
Mountainview Consulting Group, Inc., Zillah, WA

Collaborative Family Healthcare Association 15th Annual Conference
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Faculty Disclosure

- I/We **currently have or have had** the following relevant financial relationships (in any amount) during the past 12 months:
  - Book royalties: New Harbinger
  - Book royalties: Gilford
  - Book royalties: Springer

Objectives

- Participants will be able to
  - Name ethical dilemmas that occur somewhat often in delivery of PCBH services
  - Describe and apply the four box method as a model for considering ethical dilemmas using case studies
  - Practice using the four box model in small groups with their own ethical scenarios

Common Ethical Dilemmas in Delivery of Primary Care Behavioral Health Services

- The Context makes a difference: Specialty vs PC
- The Model makes a difference: Specialty Psychotherapy vs PCBH
- See Handout: Table 1

Ethical Guidance

- AMA
- APA, AASW
- *Family Systems and Health Special Issue*, March 2013
- Jonsen, Siegler, & Winslade (2002). *Clinical Ethics, Fifth Edition*

The Four Boxes or Four Topics Method: Case Analysis / Four Topics

I. Medical Indications	II. Patient Preference
III. Quality of Life	IV. Contextual Features

See Handout: Table 2

Skill Practice

- Review Case
- Use Four Boxes / Topics to assess for ethical issues and identify a course of action
- Report to large group in 10 minutes:
  1. Case description
  2. Key Box / Topic
  3. Ethical Issue(s)
  4. Recommended Course of Action

Learning Assessment

What is the name of a practical tool that members of the PCMH may use in making ethical decisions arising in the course of delivery of PBCH services?

The Four Box Tool (or Four Topics Method)
(Jonsen, Siegler, & Winslade)

Name one common ethical quandary in primary care behavioral health practice.

Multiple relationships, patient autonomy, confidentiality

Session Evaluation

Please complete and return the evaluation form to the classroom monitor before leaving this session.

Thank you!

CFHA COLLABORATIVE FAMILY HEALTHCARE ASSOCIATION

Table 1. PCBH model and traditional mental health services

Dimension	PCBH	Specialty MH	Ethical Quandary
Model	Population-based	Patient-based	
Primary Customer	PCP, then patient	Patient, then others	Competence in consultation role
Primary Goal	Improve patient functioning / assist with specific behavior change activities Promote PCP effectiveness Prevent morbidity in high risk patients Achieve medical cost offset	Resolve patient's mental health problem	Beneficence, brief treatment for many Confidentiality and Multiple Relationship issues (related to BHC involvement with patient and others known to patient over decades)
Delivery structure	Part of PCMH team, fast pace, numerous contacts	Specialized service, in or out of the PC clinic	Beneficence Patient autonomy
Who is "in charge" of patient	PCP	Therapist	Confidentiality (patient requests may conflict with model) Patient autonomy (primary of patient relationship with PCP)
Primary Modality	Consultation model	Specialty Treatment model	Competence, new skills needed to work with PCP and multiple specialists
Team structure	Part of PC team	Part of specialty MH team	Responsibility for learning about medical treatments
Access standard	Determined by PCP preference	Determined by patient preference	Health Disparities
Cost per episode of care	Potentially decreased	Highly variable, related to patient condition	Health Disparities

Runyan, C., Robinson, P. J., & Gould, D. A. (2013). Ethical Issues Facing Providers in Collaborative Primary Care Settings: Do Current Guidelines Suffice to Guide the Future of Team Based Primary Care? *Family Systems and Health*.

Table 2. The Four Boxes or Four Topics Method: Case Analysis / Four Topics

I. Medical Indications **Principles of Beneficence and Nonmaleficence** • What is the patient's medical problem? History? Diagnosis? Progrnosis? • Is the problem acute? Chronic? critica;l? emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • *In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?*	II. Patient Preference **Principle of Respect for Autonomy** • Is the patient mentally capable and legally competent? • If competent, what is the patient sating about preferences for tx? • Has the patient been informed of benefits and risks, voiced understanding and given consent? • If incapacitated, who is the surrogate and how are they functioning? • Has the patient expressed prior preferences (AD)? • Is the patient unwilling or unable to cooperate with medical tx? If so, why? *In sum, is the patient's right to choose being respected to the extent possible in ethics and law?*
III. Quality of Life **Principles of Beneficence and Nonmaleficence and Respect for Authonomy** – What are the prospects, with or without tx, for a return to normal life? – What physical, mental and social deficits is the patient likely to experience if treatment succeeds? – Are there biases that might prejudice the provider's evaluation of the patient's QOL? – Is the patient's present or future condition such that his or her continued life might be judged undesirable? – Is there a plan oand rational to forgo tx? – Are there plans for comfort and palliative care?	IV. Contextual Features **Principles of Loyalty and Fairness** – Are there family issues that might influence treatment decisions? – Are there provider issues that might influence treatment decisions? – Are there financial and economic factors? – Are there religious or cultural factors? – Are there limits on confidentiality? – Are there problems of allocation of resources? – How does the law affect tx decisions/ – Is clinical research or teaching involved? – Is there any conflict of interest on the part of the providers or the institution?

PCBH Mission and Job Description

3. PCBH MISSION AND BHC JOB DESCRIPTION

Note: From Robinson, P. J. and Reiter, J. T. (2006). *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. Springer. A second edition of this book is in process and will be available Fall, 2014.

The PCBH mission is quite similar to the mission of primary care. As you may recall, the mission of primary care is to provide high quality medical care to the ill and to prevent illness among the well. The PCBH mission also includes preventive services, as well as services to patients with acute and chronic problems. The difference is in the types of services provided and the provider. Pursuit of PCBH mission requires trained behavioral health providers ready to deliver brief, evidence-based services in a consultative model. BHCs are generalists and they address the needs of patients from birth to death. BHCs are also system thinkers who work to improve the delivery system and to train their new colleagues (and learn from them). Increasingly, training programs across the United States and in other countries as well are gearing up to prepare behavioral health providers to succeed in this endeavor. This chapter provides guidance to clinic staff seeking to find a clinician capable of providing PCBH services.

HIRING A BHC

With increasing frequency, PCPs are reaching out to their communities to find a BHC to join the PC team. They are seeking to improve the quality of care they deliver to patients and to improve their satisfaction with their work. PCPs are learning about the PCBH model and its fit with medical home, team-based care principles and its fundamental value in achieving better

communication and greater coordination of care. Evidence suggests that the PCBH model is superior to enhanced-referral models of care, and in part, the superiority is due to improved communication between PCPs, RNs, and BHCs. Gallo and colleagues (2004) compared the PCBH model to an enhanced-referral to MH model and found that 80% of PCPs rated communication between themselves and the BHC as occurring "frequently" in the PCBH model, relative to the less than 50% in the enhanced-referral. Another recent study found that embedding BHCs resulted in reduced referrals to specialty mental health (only 8% of depressed patients were referred), improved adherence to evidence-based guidelines for the care of depression, and reduced prescriptions for antidepressants (Serrano & Monden, 2011). Additionally, a Canadian review found that collaboration and co-location of PCP and behavioral health providers was one of several factors that improved overall outcomes in mental health care (Craven & Bland, 2006). The growing body of evidence, the requirements of healthcare reform, the shortage of PCPs and the move toward team-based care are powerful forces converging to support integration efforts. And, integration usually starts with advertising and interviewing identified candidates.

Job Description

Creating a job description is an important part of launching a new BHC service. The title "Behavioral Health Consultant (BHC)" fits the position best, as it distinguishes this work from that of a therapist. However, some behavioral providers working in primary care use other titles, such as "Primary Care Psychologist" or "Primary Care Behaviorist" or simply "Behaviorist". A basic job description is as follows:

"The Behavioral Health Consultant position requires an independent license to practice in a healthcare setting, such as a PhD in psychology, a masters in social work, or a masters in

counseling. The person in this position works as a primary care team member and delivers brief, consultation-based services to patients and PCPs using an integrated care model. This person adheres to the core competencies outlined in the PCBH program manual."

We highly recommend that you endorse a specific list of competencies for a BHC, such as those provided in Chapter 5. Making a list of these competencies available to behavioral health providers inquiring about a job posting may help make a more certain decision about whether to apply or not. The competencies also need to be linked to annual job evaluation processes.

Clinics often have questions about what type of provider to hire. They may wonder if they can get the same services from a masters level provider and pay less for the BHC salary. In our experience, the success of the BHC depends more on skills than on discipline. That being said, doctoral-level providers typically have training in areas that masters level providers do not, including program development and evaluation, as well as in research. Doctoral level providers typically lead the BHC service if the service includes more than one professional. If you need a BHC to provide training, program evaluation, and supervision skills, include this in the job description.

Suggestions for Recruiting and Interviewing

For recruiting purposes the following description is recommended. It provides more detail to help the recruiting group attract the most viable candidates:

> "Behavioral Health Consultant: Exciting new position as a primary care team member providing brief consultative visits to 8-12 patients per day and their primary care providers. Training and experience in evidence-based interventions and health

psychology required. Must have a PhD in psychology, a masters of social work, or a master's in counseling, and be licensed or license-eligible in X state."

Hiring a BHC for the first time can be very challenging. Primary care administrators typically do not have a clear understanding of the mental health world or a clear idea of what to look for in a candidate. At the same time, most applicants probably will have little or no training or experience working in the PCBH model. There will likely be a deluge of applicants with a wide variety of backgrounds, which can all be very confusing to wade through. To complicate matters more, many applicants will have worked in medical settings in some fashion, yet lack the right background to fill a BHC position. The questions in Table 3.1 may help interview committees identify strong candidates, but we also recommend consulting with an experienced BHC—in another clinic or health care system if need be—regarding ideas for sorting the wheat from the chaff.

Table 3.1

Interview Questions (and Desired Answers) for BHC Position Applicants

WHAT ARE YOUR THOUGHTS ABOUT MENTAL HEALTH CARE IN GENERAL AT THE PRESENT TIME? In the answer to this question, look for someone who sees problems with the specialty model of care and wants to do something different (though might have only a vague idea of what that would be). Candidates who say they want to see more patients or extend services to a greater percentage of the population are on the right track. On the other hand, candidates who complain about not getting reimbursed well or about restrictions from managed care might not possess the vision that helps one succeed as a BHC.

DESCRIBE YOUR IDEAL WORK SITUATION, INCLUDING THE ROOM AND AREA OF A BUILDING WHERE YOU WOULD LIKE TO WORK AND THE TYPES OF PATIENTS YOU WOULD IDEALLY SEE.

MH providers are typically taught to maintain private, quiet offices, so don't be surprised to hear this. However, the ideal candidate will say he or she likes to be in the middle of the action and to think that variety is the spice of life. Be skeptical of candidates who yearn for a narrow specialty practice or for non-clinical activities (e.g., research or administration) or for a predictable practice schedule. Also avoid candidates who would refuse to treat certain problems. All providers have a comfort zone clinically, but those with the widest zone and a willingness to expand it will work best.

IF YOU ONLY HAD 15 MINUTES TO SPEND WITH A PATIENT REFERRED TO YOU FOR INSOMNIA AND DESCRIBING MARITAL PROBLEMS, WHAT WOULD YOU DO?

Most interviewees will express surprise and perhaps uncertainty when asked to describe a 15-minute intervention, but nonetheless some answers are better than others. Look for answers that stick to the problems at hand and that end up with a reasonably clear self-management plan. A sound answer might suggest screening for common causes of insomnia, such as problematic work schedules or poor sleep hygiene habits, and development of an intervention that addresses the insomnia. Marital problems might be conceptualized as a stressor that perhaps links to sleep problems and a strong candidate might suggest that this could be explored further in a follow-up brief visit. Suggesting a referral for counseling is an insufficient answer.

IF YOU WERE ASKED TO CONSULT WITH A PCP ABOUT AN 8 YEAR-OLD

CHILD WITH ATTENTION PROBLEMS AND BEHAVIOR PROBLEMS AT SCHOOL, WHAT WOULD YOU DO?

Many mental health professionals have led a fairly specialized existence so those who have worked primarily with adults might express unease when asked about working with children. However, strong candidates will be open to working with new populations and problems and will have at least a basic idea of how to help. For example, the applicant might identify ways he or she can help the PCP (e.g., contacting the child's teachers, recommending brief standardized assessment tools, and meeting with parents), demonstrate an awareness of diagnostic criteria for child behavior problems, and/or show some familiarity with behavior modification techniques. A good follow-up question could be to ask the applicant what he or she would say to a PCP who believed the child had Attention Deficit Hyperactivity Disorder, Combined Type. Again, look for answers that display an eagerness to help, a familiarity with basic behavior change techniques, and that ideally also recognize the time limitations in primary care. Simply suggesting a referral for counseling is again an insufficient answer.

IF YOU WERE ASKED TO CONSULT WITH A PCP ABOUT AN OBESE, ADULT PATIENT WITH DIABETES WHO IS NON-COMPLIANT WITH TREATMENT, WHAT WOULD YOU DO?

As with previous questions, many candidates will issue a disclaimer that obesity and diabetes have not been mainstays of their past work, yet they should show some basic familiarity with both and a willingness to engage with the patient. Ideal answers will mention approaches such as motivational interviewing or psychological acceptance of chronic disease, or may reference collaborative goal-setting approaches. Exploration of

the patient's mood (e.g., to assess for depression) would also be a reasonable part of the plan. Detailed understanding of the medical aspects of obesity and diabetes should not be expected.

IF THE CLINIC MANAGER CAME TO YOU AND ASKED YOU TO BE THE LEAD FOR THE CLINIC IN DEVELOPING A CLINICAL PATHWAY FOR CHRONIC PAIN, WHAT WOULD YOU DO?

Few candidates will be familiar with the term "clinical pathway', which means that one who is may be a strong candidate. If unfamiliar with the concept, a candidate should at least express an interest in learning about it. An impressive answer would include the importance of focusing on quality of life and functioning (in addition to pain intensity), and/or an awareness of the potential pitfalls of narcotic analgesics. Applicants who express an interest in or knowledge of novel interventions such as group visits will also likely be keepers. At a minimum, candidates should recognize chronic pain as something they can help with and be willing to work on issues at the systems level. Candidates who say they would not feel able to take on such a task should lose favor.

IF THE CLINIC MANAGER CAME TO YOU AND ASKED YOU TO BE THE LEAD FOR THE CLINIC IN DEVELOPING A CLINICAL PATHWAY FOR SUBSTANCE ABUSE, WHAT WOULD YOU DO?

Again, many applicants will be unfamiliar with the concept of a clinical pathway, but should at least be open to the idea once it has been explained to them. Listen for an awareness of the prevalence of substance abuse problems, a willingness to engage with them (even if lacking a strong experience base in the area), and some knowledge of empirically-supported procedures for substance abuse. A promising applicant may

suggest using a validated tool for screening and integrating motivational interviewing into assessment, or at least to show familiarity with these approaches in follow-up questioning. Very impressive would be ideas about how to get other staff involved in care, such as a mention of potential screening strategies at visit check-in or an interest in teaching providers and staff ways to intervene. Applicants who primarily focus on ways to refer patients out for specialized care may lack the creativity or flexibility desired in a BHC.

These are difficult questions and rare will be the candidate who provides impressive answers to all. The vast majority of candidates will have difficulty conceptualizing how to do abbreviated visits, will lack a clear understanding of the primary care environment, and will have limited familiarity with some conditions commonly encountered in primary care. However, asking these questions can help interviewers gain a clear feel for which candidates are the best qualified and the best fit, and sometimes the questions prompt candidates who lack the basic preparation and interest to withdraw their application. These questions are best used as an addition to any standard interview questions.