



**MANUAL**  
**For**  
**INTEGRATED**  
**BEHAVIORAL**  
**HEALTH SERVICES**

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# Clinical Overview

## Categories of Behavioral Health Services

There are 3 basic categories of behavioral health services. These services are not necessarily separate; patients may participate in multiple behavioral health (BH) services concurrently. Similarly, the list of 5 BH consultation services are not discrete; as Primary Care Providers (PCPs) and behavioral health clinicians (BHCs) gain a clearer picture of patients' needs for care, the level of consultation services may change.

1. Behavioral Health Consultation Services
  - a. Assessment/Evaluation (20-30 minutes)
  - b. Brief General Consultation (1-3 visits, 20-30 minutes)
  - c. Consultative Co-Management (co-manage patient with PCP, 15-30 minutes, long term, infrequent intervals)
  - d. Brief Treatment Pathways (3-15 visits)
2. Psycho-educational Groups
3. Psychiatric consultation

### *1. Behavioral Health Consultation Services:*

These services are delivered within the primary care setting and are available for any patient referred by a primary care provider for any reason. The Behavioral Health Clinician, who is a member of the care team, delivers these services. The primary objectives of integrated behavioral health services are:

- to engage in population based education, prevention and early intervention with the patients of GVHC, as well as the community at large regarding behavioral health.
- work as a team with the PCP in the recognition, treatment and management of mental disorders and psychosocial issues,
- to provide assessment and diagnosis in order to assist PCP in treatment of BH problems
- to provide formal and informal training to PCP's in order to increase understanding and skill in intervening on behavioral health issues.
- To provide focused interventions to improve patient's functioning and well-being
- to engage patients in brief treatment pathways and/or brief psychotherapy when indicated
- to work with PCP's and consulting psychiatrist to manage chronically mentally ill patients who are otherwise without resource in the community

(a)Assessment/Evaluation Although all first visits will necessarily involve assessment, it is not infrequent that this consultation service is delivered alone. Common examples of the need for an assessment are: PCP's need for functional assessments for disability or related forms; PCPs may want a second opinion on provisional ADD assessments, or may want a BHC to rule-out bi-polar before beginning anti-depressant medication.

(b) Brief general consultation services form the core of the Primary Behavioral Health Program. Visits are limited in duration (20-30 minutes) and number (typically 1-3); included an initial assessment and intervention and brief follow up to insure improvements. These services are ordinarily appropriate for more functional primary care patients, those with natural support systems, and/or those who's functioning improves rapidly with intervention, and those who do not place high importance on the role of a counselor/therapist in recovery.

(c) Consultative Co-management is designed for those primary care patients who require more assistance over time but are best treated within the primary care clinic (due to patient preference, history of lack of follow through with off-site referrals or lack of resources in the community). These consultations are appropriate for patients with chronic medical and or psychiatric conditions who require a chronic intermittent consultative approach. While more visits may be involved, over a longer period of time, these visits remain short in duration (20-30 minutes) and at infrequent intervals. Visits focus on self management (of mental and physical conditions); sustaining or increasing support obtained from the community, and other life skills.

(c) Brief Treatment Pathways are similar to general consultation (still 20-30 minutes) but are typically longer in number of sessions (3-15) and involve more typical therapeutic techniques. These services are appropriate for patients who have higher levels of functional impairment, have little natural supports or resources outside of the PC setting, or do not improve after initial interventions, and/or place a high level of importance on the role of therapy/counseling in recovery.

For a discussion of appropriate evidence-based helping techniques utilized within these services, see **appendix D**.

## ***2. Psycho educational Groups***

Decades of research has shown groups are an effective, efficient mode of intervention for a multitude of behavioral health difficulties. For patients, typically groups would take the place of individual visits with the BHC; not be in addition to individual services. The focus of a psycho-educational group should be determined by the prevalence level of BH problems within the clinic, as well as BH conditions that have a high impact on overall patient health. For example, high incidence BH conditions such as stress, depression or obesity are appropriate subjects for group intervention.

While all types of groups have been shown to have good outcomes, psychotherapy groups, support groups and peer-led groups are not being used at GVHC for a variety of reasons. Psycho-educational groups are the most appropriate use of a BHC's (and a patient's) time. Groups should have a set curriculum focusing on education about the condition, treatment options, and self management strategies. Group facilitators are expected to have the knowledge

and skills to utilize motivational techniques (self change and motivational interviewing) in order to facilitate patient's readiness to engage in necessary behavior changes.

Please see **Appendix E** for sample scripts for PCP's to refer a patient to a group.

### **(c) Consultation Services: The Consulting Psychiatrist**

The primary responsibility of the Consulting Psychiatrist is to enhance the Medical Provider's psychoactive medication management for very complicated patients by providing written consultation on medication decisions. The Psychiatrist will also advise the Medical Provider regarding work-ups of neuro-psychiatric symptoms (e.g., need for neuro-imaging, lab testing, EEG, etc.) and ongoing management of psychotropic medications (e.g., drug level monitoring, chemistry/CBC/Urine testing, etc.) Behavioral Health Clinicians can and should also refer directly to the psychiatrist in approximately 10% of patients. The Psychiatrist's level of involvement with individual patients is almost always minimal; the Medical Provider is always the patients Primary Care Provider.

Similar to the role of BH Clinicians, part of the consulting psychiatrist role is to increase skill, knowledge, and level of comfort for PCPs in managing psychiatric conditions of their patients. One of the primary goals of having a consulting psychiatrist in an integrated behavioral health program is to increase the number of PCPs who have the ability and willingness to care for patients with complicated psychiatric conditions, without a psychiatrist's involvement.

Please refer to **Appendix E** for a more thorough discussion of the Psychiatrist's role.

### **Referring**

The vast majority of referrals to behavioral health services should come from primary care providers. However, there is no 'wrong door' within GVHC to obtain BH services. The following is a non-exhaustive list of staff that might refer a patient for services:

- Health Educators
- Patient Care Coordinators
- Dentists
- CPSP workers
- Nurses

Referrals from outside sources, directly to behavioral health services, are strongly discouraged. By definition, GVHC's integrated behavioral health services are intended for current GVHC patients. The only exceptions to this are when a patient is referred from an outside source directly to GVHC's behavioral health services, and is in need of a primary care 'home'. After the initial appointment with the behavioral health clinician, the patient is then made an appointment to establish care with a GVHC primary care provider. However, no patient should be turned away without services. When this situation arises, a non-GVHC patient is mistakenly

referred to GVHC solely for mental health services, the BHC should meet with the patient, discuss the patient's needs and available community resources, and make appropriate referrals.

To lower barriers to referral, written referrals are not mandatory. Although there are cases where they are particularly helpful (PCP and therefore patient chart is not on site); all GVHC behavioral health clinicians are prepared for, and adept in, engaging patients in 'on-the-fly' assessment with little background information, and making rapid provisional diagnoses.

Since the preferred time of first behavioral health intervention is on the same day as the PCP appointment, attention must be paid to what has been called the 'warm hand-off'; which is the PCP's introduction of the BH clinician and/or BH services, to the patient. This is discussed at length from an administrative perspective under the administrative overview; for sample scripts for warm hand-offs (to a BHC and also to a psychiatrist) please see **appendix E**.

### **A word about Substance Abuse/Dependence Intervention and Treatment**

A clinical overview of BH services within a primary care setting would be remiss without a thorough discussion of substance abuse/dependence. However, although much is known about substance abuse/dependence treatment, little is known about its relationship to intervention in the primary care setting. Although GVHC does utilize screening tools (the adult health history form) for every patient to identify substance abuse problems (including tobacco dependence) and PCP's do refer (less commonly than MH referrals) to BHCs, there is little in place beyond this. Arguably, substance abuse/dependence is less understood by PCP's than mental health issues and (depending on the substance of abuse) still carries a stinging moral judgment. There is no better evidence for this than the common PCP request to discharge a patient because they are a 'drug seeker', instead of identifying this patient as a patient with a dangerous chronic disease and making appropriate treatment decisions

The role of the primary care system in substance abuse/dependence intervention is less clear than its role in the treatment of mental health conditions. There are many reasons for this. PCP's have a long history of treating mood and anxiety disorders with pharmacotherapy- the often quoted (replicated) research is 80% of psychotropic in the Nation are prescribed by PCP's; it is one of the reasons it is now conventional wisdom that the primary care system is the de-facto mental health system in the United States. Because there are no medications that are considered treatment for substance abuse (opiate antagonists and other 'anti-craving' medications are not considered treatment in and of themselves) PCP's have never had a major role in substance abuse intervention. In addition, integrated behavioral health programs have in large part grown in inverse proportion to the collapse of community mental health services. Informal, natural support systems are uncommon for those who suffer with mental health issue, leaving primary care systems and their integrated behavioral health programs frequently the sole providers of mental health care in a barren landscape. This is untrue of substance abuse. Not only have substance abuse/dependence treatment services managed to survive the decline of community mental health, private treatment providers have managed to thrive. In addition, the fascinating, 12-step community support groups (Alcoholics Anonymous, Narcotics Anonymous) which exist in almost every community are a non-professional natural support system that is effective for

many suffering from substance dependence. For these reasons, PCPs and their primary care systems have not had to 'fill the gap' in the same way they have had to for mental health. Lastly individual therapy has not been shown to be effective for substance dependence, leaving the role not only of the PCP, but of the BHC in question with substance dependence.

In 2008, GVHC has just begun system wide training for PCP's on substance abuse/dependence and promising practices for interventions in the primary care setting. Like all chronic diseases, motivational self-change strategies are particularly useful with substance abuse/dependence and this will be part of the training curriculum. In addition, GVHC will begin its first substance abuse psycho-educational group (not substance dependence treatment) in the spring of 2008.

Concurrently, GVHC is developing standardized clinical pathways for substance abuse/dependence. Generally, a PCP and BHC's role in substance dependence is education (written, verbal, or group) and brief motivational enhancement; with substance dependence, assessment, diagnosis, motivational interventions (which may take multiple sessions) and referral to an appropriate level of treatment or 12 step support groups.

# Administrative Overview

## Accessing the Behavioral Health Consultant

In integrated BH services, the focus will be on same-day access for patients being seen by primary care providers. Only by seeing a high percentage of same day referrals (a minimum of 20% of a day's visits should be same day) is the behavioral health program truly population based. Research informs us that men, the elderly, ethnic minorities and other groups have a higher level of stigma regarding mental health services, and are not likely to come to a BH appointment scheduled ahead. By seeing these patients as an extension of their visit with their PCP, the BHC is able to assess and intervene on a percentage of the population that would never normally have contact with a mental health clinician.

Cell phones are the primary means of alerting the Behavioral Health Consultant of the need for a consultation, although in smaller clinics it can be common for a PCP or their medical assistant to simply walk over to the BHC to request a consult.

The BHC will answer phone calls from a PCP, even while in session with another patient. The BHC will give an estimated wait time to the PCP, finish the current session, and proceed to the referred patient. Scheduled patients waiting in the waiting room (follow ups) must be balance with the need for timely response for same day referrals. Before interviewing the patient, it is usually helpful to have a short discussion with the PCP to obtain their assessment/pertinent patient history, and to elicit the PCP's goals for the consult. PCP's have a wide variation of goals for differing patients, and it is not beneficial for a BHC to assume they know what it is (for example, PCP desires an assessment to r/o bi-polar before starting an SSRI; BHC assumes goal is to provide support for bereavement. Although a BHC can and should do both, in this example, it is important to address the PCP's specific goal.

**Patient in crisis:** When a patient presents to the Behavioral Health Consultant in crisis (i.e., suicidal or homicidal ideation), the Behavioral Health Consultant will make every effort to see this patient and manage the crisis within the primary care clinic. The Behavioral Health Consultant should take this patient off the hands of the Medical Provider and attempt to manage the situation within the primary care environment utilizing the established protocols and system for handling patients in crisis (see GVHC protocols entitled *Danger to Self, Danger to Others, and Gravely Disabled*).

## Screening Protocol

The nature of screening (a large percentage of the target population, in this case GVHC patients) means that the BH program and its clinicians are not 'in charge' of this task. Screening is



integrated into the larger GVHC healthcare system in 2 ways: there are 7 behavioral health questions on the adult health history form (given at first visit, every 5 years, or at any major health change) that screen for mood/anxiety problems, substance abuse (including nicotine dependence) and domestic violence/abuse.

Second, GVHC screens every diabetic patient with the PHQ-9 depression screening tool, every month. In addition, GVHC is in the process of instituting universal depression screening for all post partum women.

See **appendix G** for the Adult Health History Form and the PHQ-9

### **Assessment Protocol**

Because consultation services are brief, it is not normally a good use of time to apply traditional clinical intake or outcome assessments. In addition, most research indicates a skilled clinical interview is more accurate than any screening tool for diagnostic purposes. However, brief, symptom-focused assessments as well as quality of life assessments can be used when appropriate, at a BH clinician's discretion.

Generally speaking, assessment tools must be the standardized tools, approved by GVHC. This is to ensure evidence-based practice materials are used, as well as avoid violation of copyright laws. At this time, there are 3 approved screening tools for the following conditions:

- Depression: The patient health questionnaire-9
- Bi-Polar: Mood Disorder Questionnaire
- Alcohol and other drug use: The CAGE-AID

See **Appendix G** for copies of these 3 forms

Although these screening tools are more typically used by PCP's (for the reasons stated above) the BH clinician should be familiar with them in order to better communicate with PCP's and also to interpret for patients when asked.

### **Providing Feedback to Medical Provider:**

Behavioral Health Consultants are expected to provide feedback **in-person** and on the **same day** as the patient contact occurs. In addition, formal written feedback will come in the form of the BH progress note filed in the chart. The Behavioral Health Consultant has several options for the same day feedback: verbal (in-person or voice mail), e-mail (outlook). IN the case of a patient who has been referred from another GVHC site, a copy of the BH progress note is to be faxed directly to the referring Medical Provider the same day the patient is seen. This faxing is Medical Records responsibility, but it is the BHC's responsibility to indicate to MR that the note needs to be faxed, and to whom. It is acceptable to use a sticky note, with the information on it, stuck to the BH progress note: (i.e. 'to be faxed to Dr. Simenson at N. Merced').

In practice, it is important to know which feedback option different PCP's prefer, and it is also important to ascertain if, in addition to the written note, a PCP needs feedback about the patient more immediately. For many patient visits, a written progress note, written on the same day, faxed if necessary and filed in the patient chart is sufficient. For other patient visits, especially those same-day, warm-hand offs from PCP's, the PCP is waiting for feedback from the BHC in order to make appropriate medical decisions. For example, PCP's may need feedback immediately from a BHC to rule out bi-polar, if they wish to start anti-depressant medication with the patient immediately. The same is true for any deferential diagnosis whereby the PCP waits for the BHC's assessment before making medication decisions.. It is critical BHC's build trust with PCPs by consistently providing relevant feedback, in the time period the PCP needs it, and in the form the PCP is most apt to use (i.e. never use email until you know the PCP prefers this method of communication).

Please see **Appendix G** for the Behavioral Health progress note

### **Scheduling**

All templates for services will be set up in 30 minute increments. Scheduling will be maintained on the GVHC computer system by front office staff, and will be accessible to professional staff as well. Appointments may be scheduled by front office staff or the Behavioral Health Consultant as needed. Although it is an option to leave approximately 50% of each hour unscheduled for same day warm hand-offs, most BHC's at GVHC do not find this necessary , but instead utilize no shows and good time management to accommodate same day referrals from PCP's.

Despite the financial loss (see billing below) every effort should be made to schedule follow up visits with the BHC and PCP on the same day for self pay and EAPC patients, in order to lower financial barriers for these patients to receive care. Same day scheduling for MediCal and other insured patients should always be a priority if the BHC and/or PCP suspect the patient may have barriers to receiving care (transportation or childcare issues, stigmatized beliefs about behavioral health, etc).

### **Documentation**

Consultation responses and follow-up notes are recorded chronological portion of the patient's medical chart on the Behavioral Health Progress Note. The most important factor regarding BHC notes is they must be general; only information pertaining to care is documented. Quotes (unless related to symptoms), specific thoughts and feelings (unless related to symptoms or diagnosis) specifics of past traumas, counter transference or transference are not appropriate for BHC notes.

1. In general, an **initial documentation** should contain the following information:
  - Who requested behavioral health involvement and the referral question, if applicable
  - A statement of pertinent assessment findings and findings from a mental status examination (*e.g.*, symptoms of mental disorder, life stresses, relevant psychosocial issues)

- Clinical impressions – Functional symptoms must be documented. A diagnostic formulation is not required; however, in cases where a diagnosis is suspected (R/O) or has been made, this should be included in the consultation response
- Level of functional impairment, if any
- A brief behavioral change plan to include:
  - An estimated number of future visits
  - Next follow up appointment with BHC
  - Next follow up appointment with PCP
  - Self management goals discussed with patient
  - Referrals

In addition, BHC's share the responsibility of maintaining an accurate master problem list in the chart. If the patient's behavioral health difficulty is chronic in nature, the BHC should transfer this condition, or diagnosis to the master problem list.

2. **Follow-up consultation notes** should be recorded in the medical chart. Follow-up notes should contain the following information:

- An assessment of the patient's adherence and response to interventions initiated previously by the consultant and/or health care provider;
- Recommendations regarding continuing or modifying intervention strategies;
- A statement of who is responsible for executing intervention strategies (*e.g.*, consultant, medical provider, patient);
- Level of functional impairment, if any
- A brief statement regarding the follow-up plan.

2. Primary Care providers need to document two things:

- Referral to a BH clinician, and the reason for the referral. This should be documented clearly in the medical progress note.
- PCP's need to share the responsibility of transferring any DSM-IV diagnosis, or other pertinent findings, from the behavioral health progress note to the master problem list in the chart.

See **appendix G** Behavioral Health Progress Note Form

### **Documentation of sensitive issues**

As medical records are fairly open and accessible products, the Behavioral Health Consultant must balance concerns about documenting a sensitive issue in the record with the need for other health care providers to know certain information. Information that is deemed to be sensitive can be communicated to the patient's Medical Provider in a variety of ways, including phone follow-ups, and need not always be documented within the medical record. Information that is directly pertinent to the provision of care should be documented in the medical record. Examples of

inappropriate documentation is the documentation of transference/counter-transference; specific details of traumatic history; HIV status; patient dreams, etc. It should be obvious from these examples that none of these things directly pertain to the care the patient is receiving.

Behavioral Health Consultants must comply with all regulations regarding reportable events, regardless of level of sensitivity of this information (for example, child or elder abuse). **It is the responsibility of the provider who identifies the reportable event to act on this information.** Behavioral Health Consultants should not push this responsibility onto the Medical Provider if the Behavioral Health Consultant identifies the event. Similarly, the Behavioral Health Consultant should not accept this responsibility from the Medical Provider if the Medical Provider identifies this information.

### **Informed Consent and Counselor Disclosure Statements**

Both individual visits with a BHC, consults with a psychiatrist, and psycho-educational groups are covered by the standard GVHC Consent to Treatment form as long as they are rendered within the context of primary care (patient referred by a PCP, PCP documents referral in the chart, BH clinician diagnosis is documented under Master Problem List).

It is the responsibility of the Behavioral Health Clinician to discuss the following for each patient served:

1. Inform the patient of who he/she is and that he/she is a behavioral health provider
2. Strive to develop trust and an open line of communication with the patient
3. Inform patient of limits of confidentiality (i.e. child abuse reporting, danger to self and others, etc.)

### **Staffing Guidelines**

Utilization will vary across sites. The general recommendation is to have a one full time Behavioral Health Clinician for every 4 medical providers. Although dental providers are not considered in this equation, it is expected other departments will utilize Behavioral Health Consultants at their sites to some degree.

### **Productivity Standards**

Productivity standards are under review at Golden Valley at this time. In the interest of the population based philosophy of an integrated behavioral health program, as well as the primary goal which is to help as many patients as possible, BHC's are expected to strive to see as many patients as is feasible, while still providing quality services. Although a BHC has only partial control of those numbers (since all referrals are PCP initiated) BHC should make every effort within their control to see between 8-16 patients a day.

## Billing/Payment

Just as PCP's, BHC's fill out their own 'scantron' or billing sheet (the BH billing forms are not yet computerized), for both same day and non-same day visits. All billing sheets for the days visits are expected to be done and left in the appropriate place (different at differing clinic sites) by the end of the day. If a patient has MediCal, and has been seen the same day as a PCP, the BHC handwrites 'integrated' or 'same-day' on the billing sheet, to flag the billing department not to bill both visits (MediCal will not pay for same day visits, billing this may put the organization at financial/legal risk). The following is a table of the code used to bill for BH services.

Psychiatric/Psychological Interview	90801
Individual Psychotherapy, 20-30 min	90804
Individual Psychotherapy, 45-50 min	90806
Family Psychotherapy (without patient present)	90846
Family Psychotherapy (with patient present)	90847

It is important to be aware of limitations of particular insurances regarding coverage for particular diagnosis (and not another) and frequency of visits. The front desk staff has the responsibility of pre-authorization for all insurance patients a BHC sees.

MediCal patients can only be seen two times a month by a BHC, regardless of necessity. Other MediCal limitations differ between Counties, and Site Administrators must explicitly discuss these limitations with the BHC.

If patient is self-pay or EAPC, they only pay one fee for seeing the BHC and the PCP on the same day. Even if a patient sees a BHC and a PCP at different GVHC clinic sites on the same day, they still pay only one fee.

If a PCP refers a self pay or EAPC patient to a BHC, and the BHC is unavailable, the patient may see the BHC up to 48 hours after the PCP appointment, and not pay another fee to see the BHC. Within 48 hours, the visit is still considered same-day, for payment purposes. After 48 hours, the patient will be charged their sliding fee discount rate (which is the same as the rate to see a PCP) to see the BHC.

## Appendix A

### Key Principles in Integrated Behavioral Health Care

***Principle #1: The Behavioral Health Clinician provides the least intervention necessary to patients in order to improve well-being, increase adherence to PCP recommendations, and facilitate patient's willingness and ability to engage in self management strategies.***

There are a multitude of reasons to provide the least intervention necessary. First, access is a primary goal of not only of the IBH program, but one of GVHC's values. If patient cannot access BH services, the quality of services matters little. If PCP's cannot access the BH program for their patients, they will cease referrals. When access is poor, a BHC's schedule is booked out weeks ahead, and no-show rates hover at 50% due to gap between initial referral and appointment. BHC's are in large part responsible for their own access (see appendix for trouble shooting access problems). Using good clinical judgment, a BHC will continually make decisions about what the least intervention necessary is to help a patient. Many patients can be effectively assisted with one 30 minute visit of education and motivational enhancement; still more can be helped dramatically with 4 sessions of cognitive behavioral interventions, and insight oriented therapy. A BHC should guard against any tendency to 'hook' every patient for 10 sessions, without assessing first whether this is necessary.

Perhaps an even more compelling reason to provide the least intervention necessary is that it is, in fact, better for patients. In order to remain consistent with recovery principles, a strength-based and patient empowerment perspective, patients should spend as little time with a BHC as possible. To paraphrase Carl Rogers, a BH clinician's job is not to get people better; only to remove barriers to their growth. It is ill advised clinically to encourage dependence on paid professionals/formal systems; rather a BH clinician should utilize their skill to assist patients in developing self management strategies, increasing use of natural support systems, and increasing tolerance for feelings and behaviors that do not adversely impact functioning.

***Principle #2: Integrated Behavioral Health Services are grounded in a population based care philosophy that is consistent with the mission and goals of the primary health care.***

One of the distinguishing factors of an integrated behavioral health program from a traditional community mental health service delivery model is the population based perspective. Community mental health services are typically intensive and reserved for the most chronically and severely mentally ill in any given community. On the contrary, integrated behavioral health programs "cast a wide net" in terms of who is eligible; those who are severely mentally ill can obtain services, as well as those who do not meet any DSM-IV diagnostic criteria. Most members of the primary care patient population can benefit from behavioral health services delivered in this service delivery model. From a population based care perspective, the goal is to provide brief, general psychosocial services to as many patients as possible. Education, prevention and early intervention are thus common and important points of intervention. An effective BH program utilizes large scale

screening for BH conditions and tracks prevalence rates (and those who are at risk). For high prevalence conditions, useful, culturally competent educational and preventative information are disseminated through waiting room posters and videos, written materials given directly to the patient, and verbally from both the PCP and the BHC. In addition, An integrated behavioral health program is proactive regarding the behavioral health needs of current patients and should engage in outreach to the community at large as well.

***Principle #3: The line between physical and mental health is not clear; the distinction may be somewhat arbitrary. Patient care supersedes which 'category' the care falls into.***

The bio-chemical nature of behavioral health conditions, as well as the behavioral components of medical conditions, informs us that most problems patients are facing are not clearly distinguishable as purely medical, or purely mental health. In fact, it could be argued the historical split between these two types of care is the result of, and has worsened, the stigma surrounding mental health problems. Attempts to delineate which problems are 'mental' from which ones are 'physical' are not helpful to the patient, and may actually lower the quality of services they receive. One of the many benefits of having both PCP's and BHC's involved in a patient's care is a team approach, whereby each helping professional can treat the patient within their own scope of expertise; for example, with depression, PCP's can prescribe and manage psychotropic medications, BHC's can provide brief psycho-educational counseling. With diabetes, PCP's can diagnose and make recommendations for care; a BHC can intervene to enhance motivation for the necessary behavior changes. The underlying philosophy that all care is patient care is why communication between PCP and BHC is of the utmost importance; to insure both PCP and BHC are aligned in their goals for the patient. This is also the reason all behavioral health progress notes are filed within medical progress notes- the physical manifestation of 'integration'.

## Appendix B

# Access

Access is in large part the BHC's responsibility. The general guideline is that all same day referrals can be seen, and the wait is no longer than 3 days for a scheduled appointment. A BHC should monitor their own schedule for access; when or if this becomes a problem, the following is a list of potential problems and solutions:

- Problem: High percentage of first time appointments are booked ahead.
- Solution: Increase education/marketing to PCP's to increase number same day warm hand-offs for first appointments, instead of booking out.
- Problem: High percentage of chronically mentally ill patients 'clogging' the schedule
- Solution: Lower frequency of visits to once monthly for check-in on functioning; contract with patient to check in by phone weekly or bi-weekly; contract for increased support from group sources in the community (Wellness centers, etc)
- Problem: Patients who began in a brief treatment pathway are now long term therapy patients, despite sustained improvements.
- Solution: Consult with clinical supervisor for guidance on termination, and/or titration of frequency of visits (i.e. bi-monthly check ins)
- Problem: Patients who are being seen long term because of lack of improvement (i.e. patients who have been seen for more than 4 visits without improvement, or worsening)
- Solution: If a patient has not improved or worsened after 4 visits with BHC, this treatment pathway is not functional. Consult with PCP or psychiatrist regarding medication failures if appropriate; refer patient to alternative treatment options (community groups, etc); discuss with patient lack of improvement and involve patient in developing alternative plan.
- Problem: Patients who are able (MediCare, private insurance, self pay) prefer to come in weekly, although not clinically indicated
- Solution: utilize phone check-ins and structured behavioral change plans (i.e. 'homework') every other week, instead of appointments. Clinically intervened to increase patients utilization of natural, community support systems, and lower use of formal, paid, and professional support systems.



## Appendix C

# Suggested Checklist for Getting Started

During the first three weeks of beginning at a GVHC health center, carry out the following:

- Work with your Site Administrator to monitor your scheduling template. 30-minute appointments slots are only one option; some BHC's are two 25 minute and one 10 minute slot (reserved for same day). Experiment with what works for access.
- Walk around the clinic on a daily basis to converse and remind providers you are there to provide services. Frame your services as something that will save them time.
- Provide same-day, legibly written and verbal feedback on all patients seen.
- State that you have an open-door policy (any concern, any patient, any time during the work day).
- Prepare a handout with your pager and voice mail numbers in large, bold print on the handout, to hang throughout the clinic; also give to the nurse and receptionist at your clinics. Send to outlying GVHC which do not have their own BHC.
- Directly contact the PCP's at outlying clinics; arrange a time to visit the clinic over a lunch hour to meet the staff and speak to the PCP in person about your services.
- Accept a call at the end of the day and work late.
- Attend all provider meetings; monthly provider meetings, organizational meetings, all trainings and lectures. Speak briefly at appropriate meetings to 'market' your services. Remember you may be the only advertisement for behavioral health services PCP's see.
- Observe PCP's common concerns and questions regarding behavioral health conditions. Present a requested talk and/or provide brief, practical, and instructional handouts for providers.
- Invest in developing relationships with your front desk staff. Make sure reception knows you will see any patient who needs services that same day, whether they walk-in, call, or a provider refers them.
- PCP's have a fairly traditional view of mental health and mental health clinicians. Continually look for opportunities to tactfully educate PCP's that you can treat those who are seriously impaired by their mental condition, but that you are just as happy to 'check on' a stressed caregiver, offer a second opinion on a differential diagnosis between ADD and ODD, and provide SSRI education for a patient.

## Appendix D

# Evidence-based helping techniques, appropriate for GVHC's integrated behavioral health services

The following list is not exhaustive. The guiding principle is that only evidence based interventions should be used. Each BH clinician has the individual responsibility to stay abreast of current research in the field, to obtain continuing education in necessary subjects, and to practice within his/her scope of expertise. BH clinicians and the BH program in general should be a shining example of adherence to effective, research-based services; most importantly to provide quality services to our patients, but also to provide accurate education to our PCP's regarding best practices for BH problems.

This list of helping techniques is not appropriate for every behavioral health problems, rather is a general list of strategies that are acceptable for a wide range of clinical conditions.

- Cognitive/Behavioral Therapies
- Motivational Interviewing and other self-change techniques
- Psycho-educational groups
- Bibliotherapy
- EMDR
- Brief psychotherapy (5-15sessions)
- Insight oriented therapy (can be used in any duration of intervention, i.e. first and only visit with patient, or brief treatment pathway)
- Humanistic helping techniques (philosophical, can and should be used with any and all interventions)

The following are techniques/services are generally not appropriate in the primary care setting; however, there may be exceptions within any of these, and a BHC should use their best clinical judgment, as well as consultation with a supervisor when making these decisions.

- Extensive testing for IQ, LD, etc. This is specialized testing that is sometimes not in the scope of practice of a BHC; even when it is, the fast pace, rapid assessment and intervention make specialized testing incompatible with integrated behavioral health programs. A need for these types of testing should be referred out to school psychologists, Regional Centers, private psychologists, etc.

- Hypnosis and/or regression therapies. Assuming the BH clinician has been trained and certified in these strategies, and although there is research that supports the effectiveness of some types of these strategies for particular BH problems, due to the need for uninterrupted time for these strategies, they are inappropriate for the PC setting.
- Treatment of Sexual Offenders or Batterers. These are specialized treatment pathways, may be outside the scope of expertise of the BH clinician, and are best served by referring to specialized providers of these treatments in the community.
- Treatment of personality disorders. Individual therapies for dependent, anti-social, and narcissistic Personality disorder have not been shown to be effective. Intensive, structured specific therapies have been shown to be effective for borderline personality disorder. However, because unless a BHC has been trained in these specialized modalities, treatment of BPD is outside the scope of expertise for a BHC. In addition, the intensity of treatment necessary (weekly team meetings, continued close self-harm/suicide assessments and plans) for BPD make it inappropriate in the primary care setting. Since a BHC should not refuse a PCP referral, if a patient is referred and diagnosed correctly with a personality disorder, the BHC should make every effort elicit PCP's goals, and develop a behavior change plan specifically around PCP's goals, not treatment of the PD. The BHC should communicate to the PCP the diagnosis, and share strategies with the PCP for management of the patient.
- Treatment of severely mentally ill children, moderate to severe autistic or mental retardation, or similar. Although many BH clinicians have the experience and expertise to engage in the above, the primary reason for not doing so is that in most communities, there are better resources. Most communities have a Central Valley Regional Center as well as a wrap-around service for very disturbed children, one which can provide in home support, parenting classes, extensive assessment and treatment. It is hard to argue that a 30 minute visit two times a month (MediCal restriction) could be as effective.

It is outside the scope of this manual to name all common helping strategies that have been shown to be ineffective. However, the following are some of the most common mistakes BH clinicians make in the use of ineffective treatments in the primary care setting:

- Harm Reduction techniques for Substance Dependent patients (moderation as opposed to abstinence): This is a highly controversial subject in the addictions treatment field, and to date, there is no conclusive research that harm reduction is helpful to those that are substance dependent (note that harm reduction may be helpful for substance abusers).
- Individual therapy exclusively for substance dependence. The most effective treatment for substance dependence involves community support groups and/or specialized addictions treatment (residential or out-patient, depending on the level of care needed). The role of a BH clinician in intervening on substance dependence is to

screen, assess, diagnose, educate, elicit motivation for change, and insure referral to services.

- Traditional individual or group therapy for bereavement. Both modalities have been found generally ineffective. Self help strategies for bereavement have also been found ineffective. A focus on emotions associated with the loss by the BH clinician is associated with worse outcomes.
- Insight oriented/interpersonal therapies for enuresis or encopresis. Evidence suggests there is no abherent psychological problems associated with either of these problems, making traditional therapies ineffective. The most effective treatments are medical; the BHC can and should intervene to educate patient and family on the nature of the problem, assist family in ceasing discipline for such problems, assist patient with subsequent problems, i.e. feelings of shame, being teased, etc; and assist family with positive reinforcement techniques.

## Appendix E

# Sample Scripts

The following are two examples of possible ‘warm hand off’ (PCP to BHC) scripts. Of course PCP’s have their own style of communicating, and will have different relationships with different patients; these and other factors (especially cultural considerations) will make each ‘warm hand off’ individualized to best help the patient overcome any barriers to seeing a BHC. However, some general principles can be articulated:

- The referral to a BHC should be as directive as a PCP would normally make a referral to any other service. There should not be a discernable difference in content or tone between a referral to a BHC and a referral to a cardiologist. Patients will pick up the importance a provider implies regarding a referral, and respond accordingly.
- Unless a patient has used a diagnostic term themselves (“I feel depressed”; “I had a panic attack”; “I’m addicted”) it is more effective to use general terms like ‘stress’ to refer to behavioral health problems. BHC have the time and the skill to assess patients readiness to identify themselves as having particular problems, and can work with patients on de-stigmatizing these terms when necessary
- Similarly, it is more effective to use general terms such as ‘colleague’ or ‘someone who specializes’ instead of ‘counselor’ or ‘therapist’ or ‘social worker’. For many patients these terms evoke stigma, fear, and misunderstanding, and may keep a patient from seeing the BHC. A skilled BHC can identify themselves and intervene to address any of these apparent issues. Along the same lines, a PCP asking or offering a patient ‘counseling’ is less effective than offering them ‘education’ or ‘ideas’ or even ‘support’.

**Example 1:** It sounds like you might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you. Is it alright with you if I introduce you to her/him?

**Example 2:** From some of your answers on this questionnaire, it looks as if you may be feeling down lately. I have a colleague who I work with who can give you some ideas of ways to help with this. Her/His office is just down the hall, is it okay with you if my MA walks you there after we are done so you can talk for a minute?

The following are two sample scripts for referring to a psychiatrist. Both address the major barriers in psychiatric consultation, which are stigma and fear regarding the implications of seeing a psychiatrist, and misunderstanding about the role of a psychiatrist. Because of their history, and an almost archetypical stereotype, patients commonly assume a psychiatrist is a super competent, specialized analyst, who will engage them in intensive therapy. Many patients feel disgruntled, ignored, and even angry by very competent and kind psychiatrists, because they ‘only’ received an assessment and a prescription.

**Example 1 (high levels of stigma):** We have already tried 3 medications that have not worked for you, and I know that has been frustrating for you. We have a specialist here who is a doctor for anxiety/depression/voices, who may be able to change your medicine and find something that works for you. He/She is right here at GVHC, and could see you next week, is that okay?

**Example 2 (previous history with mental health services):** You have a long history of struggles with this problem, and since you are a new patient to me, I am wondering if you would be willing to see our specialist to make some recommendations about medicine. She/He is just a doctor, so they don't do counseling; however we do have a counselor that I think could be helpful to you. Is it okay with you for me to make you two appointments, one for medications, and one for counseling? I will follow up with you in two weeks.....

## Appendix F

# ROLE OF THE CONSULTING PSYCHIATRIST

## A. Levels of Consultation

1. *Telephone or “Curbside” Consultation:* These contacts are typically requests for specific information or advice about patient management, and are almost exclusively initiated by the PCP.
2. *In-Person Evaluation:* The central component of consultation is the initial in-person assessment. The goals of this evaluation include:
  - Rapid diagnostic assessment
  - Initiation, or change in medication regimen
3. *Follow-Up Support:* In most cases, Psychiatrists maintain some responsibility following the initial contact. The level of involvement can vary widely from as-needed contact with the Medical Provider to ongoing treatment until the patient is stabilized. An important goal of the initial evaluation is to determine the most effective and efficient level of Psychiatrist involvement in follow-up care.

It is important to note psychotherapy is not in the above list. Although some psychiatrists are trained and interested in providing psychotherapy, it is not an efficient use of the psychiatrist’s time. Care should be taken to shape PCP’s and patient’s expectations regarding this.

## B. Consultation Questions

1. *Initiation of pharmacotherapy:* Routine initiation of antidepressant or anxiolytic treatment should not prompt consultation. Consultation may be indicated if prior psychiatric treatment history is unusually complex, the choice of psychotropic treatment is complicated by co-morbid medical illness or other medications, or if the patient has had treatment failures on multiple medications.
2. *Failure to respond to at least 2 trials of pharmacotherapy:* This category accounts for the bulk of consultations to the Psychiatrist among patients with anxiety and mood disorders.
3. *Relapse on pharmacotherapy:* Symptom relapse while receiving active psychotropic treatment often prompts a request for psychiatric consultation. In some cases, augmenting or switching medications may be necessary.

## C. Consultant Tasks

1. *Assessment:* Assessment should focus on immediate needs and short-term treatment planning. The Psychiatrist’s involvement is likely to be brief (1 to 3 sessions).
2. *Triage/Treatment Planning:* By the end of the initial visit, the Psychiatrist should arrive at a tentative plan regarding level of care (one-time consultation vs. co-management). While eventual disposition will be determined by response to treatment, establishing an initial plan is necessary to create appropriate expectations (for patient, referring Medical Provider, and Psychiatrist).
3. *Prescribing:* The Psychiatrist will not take responsibility for prescription refills. If a new prescription is necessary, the Psychiatrist should indicate that refills will be managed by the referring Medical Provider.

4. *Records/Communication:* An initial consultation visit should always be followed by a consultation note and a verbal communication to the referring Medical Provider (either directly or by voice mail). Psychiatric notes are also filed within the medical progress notes, and for this reason need to consider the same care discussed in the administrative section 'sensitive issues'.



Please check the box for your best response after each question

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all <b>0</b>	Several days <b>1</b>	More than half the days <b>2</b>	Nearly every day <b>3</b>
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself; or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. 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				
i. Thoughts that you would be better off dead or of hurting yourself in some way				

2. 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? (circle)

Not difficult at all (1) Somewhat Difficult (3) Very Difficult (2) Extremely Difficult (4)

**PHQ Score:** \_\_\_\_\_ (range: 0-27)

- 0-4 no depression detected
- 5-9 watchful waiting and self-monitoring for any worsening symptoms
- 10-14 education on depression and self management tools
- 15+ further assessment necessary

**List any medical conditions or operations you have had in your lifetime**

Date	Medical conditions/operations	Date	Medical conditions/operations

What doctors have you seen in the past year? \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

List any medications, foods, animals or plants which you are allergic \_\_\_\_\_

Have you or any of your blood relatives had any of these problems listed below?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer/ tumors  | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizures        | <input type="checkbox"/> Hepatitis       |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Blood disorders |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Migraines       | <input type="checkbox"/> Birth defects   |

Who do you live with? \_\_\_\_\_

What kind of work do you do or have you done in the past? \_\_\_\_\_

Have you been exposed to chemicals, pesticides, loud noise, dust or gas?  No  Yes \_\_\_\_\_

Do you exercise regularly?  Yes  No If yes, what type of exercise? \_\_\_\_\_

Have you had a blood transfusion?  Yes  No

Have you had more than one sexual partner in the last six months?  Yes  No

Have you or a sexual partner been an IV drug user?  Yes  No

What was the last grade you completed in school? \_\_\_\_\_

Have you received vaccination against: Tetanus  yes  No When? \_\_\_/\_\_\_/\_\_\_

Flu  Yes  No When? \_\_\_/\_\_\_/\_\_\_

Pneumonia  Yes  No When? \_\_\_/\_\_\_/\_\_\_

**Circle all problems which you have had recently:**

Back pain	Difficulty breathing	Vomiting blood	Easy bruising/bleeding	Sleeping too much
chest pain	Coughing up blood	Painful urination	Excessive thirst	Insomnia
Joint pain	Irregular heart beat	Frequent urination	Impotence/Frigidity	Lack of appetite
Weakness	Swollen ankles	Slow urination	Loss of memory	Depressed, hopeless
Unsteadiness	Calf pain when walking	Blood in urine	Skin/nail conditions	No interest in things
Loss of sensation	Upper abdominal	Vaginal Bleeding	Black or bloody stools	Can't stop worrying
Eye problems	Lower abdominal	Genital Infection	Dizziness pressure	Use illegal drugs
Ear problems	Abnormal breast lumps	Loss of consciousness	Physical abuse	Trying to stop drinking
Diarrhea	Constipation	Severe headaches	Partner insults you	Smoke cigarettes

**For women only:** My last period started on \_\_\_/\_\_\_/\_\_\_ Do you examine your breasts every month for cancer  yes  no

When was your last pap smear performed? \_\_\_/\_\_\_/\_\_\_ I have been pregnant \_\_\_ times

When was your last mammogram x-ray performed? \_\_\_/\_\_\_/\_\_\_ My periods come every \_\_\_ days and last \_\_\_ days

Do you have accidental loss of urine or stool?  Yes  No

**FOR THOSE 65 AND OLDER:**

Do you prepare your own meals each day?  Yes  No Do you need help out of bed?  Yes  No

Do you do all your own shopping?  Yes  No Do you need help getting dressed?  Yes  No

Reason for your visit today: \_\_\_\_\_



Patient Label

# BEHAVIORAL HEALTH CONSULTANT (BCH) PROGRESS NOTE

Date: \_\_\_\_\_

Referred To: \_\_\_\_\_

Referred By: \_\_\_\_\_

Reason for Referral:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## CLINICIAN REPORT

Initial Visit

Follow Up Visit

Duration of Encounter: \_\_\_\_\_ Minutes

Type of Contact:

Face-to-Face

Group/Class

Phone

Other:

Assessment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Diagnosis: \_\_\_\_\_

Recommendations/Behavioral Change Plan:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Visits Recommended/Interval \_\_\_\_\_

BHC Signature \_\_\_\_\_

\_\_\_\_\_ Original to Chart

**TO BE FILED CHRONOLOGICALLY WITH MEDICAL PROGRESS NOTES**

Patient Label



**PSYCHIATRIC CONSULTATION NOTE**

Date: \_\_\_\_\_

Initial Visit

Follow Up Visit

**Vital Signs:** BP: \_\_\_\_\_ Weight: \_\_\_\_\_ T: \_\_\_\_\_ P: \_\_\_\_\_ R: \_\_\_\_\_

Medical Assistant Signature \_\_\_\_\_

Pertinent History/Findings: \_\_\_\_\_

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Assessment/Diagnosis: \_\_\_\_\_

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**Plan:** \_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_

Follow up: With PCP in \_\_\_\_\_ With Psychiatrist in: \_\_\_\_\_

Signature: \_\_\_\_\_

\_\_\_\_\_ Original to Chart