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