Primary Care Mental Health for Veterans: Integrating Care

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We do not have any financial relationships with any commercial interests.

Learning Objectives

1. Describe the purpose of primary care mental health integration
2. List 5 benefits of the primary care mental health integration model
3. List 3 ways primary care mental health integration helps marginalized groups
4. Describe key components of effective primary care mental health integration

Patient Aligned Care Team (PACT)

Consists of: Primary Care Provider (MD, DO, NP, PA), RN, LVN, Medical Support Assistant (MSA)

Social Work, Pharmacy, Dietetics, Mental Health, etc. , are supporting disciplines

Principles of the VA Patient-Centered Medical Home

- Patient-driven
- Team-based
- Efficient
- Comprehensive
- Continuous
- Communication
- Coordinated

(Tew, Klaus, Oslin, 2010)

Rationale for the Development of Integrated Mental Health Care

- Nationally, up to 70% of all primary care visits include psychosocial concerns covering the full spectrum of psychiatric disorders and behavioral health concerns (e.g., medication adherence, insomnia, chronic pain management, lifestyle concerns, weight loss) .

  (Oslin et al., n.d., Foundations for integrated care, Vol. 1)

- MH concerns are 2 to 3 times more common in patients with chronic medical illnesses including diabetes, chronic pain, arthritis, headache, back and neck problems, and heart disease. (Katon, 2003; Katon, Lin, Kroenke, 2007; Scott et al. 2007)

- Untreated MH problems were found to be related to significant functional impairment, poor treatment adherence, adverse health behaviors that complicate physical health concerns, and excess health care costs.

  (Almeida and Pfaff, 2005; Anda et al., 1990; Cronin-Stubbs et al., 2000; DiMatteo, Lepper, and Croghan, 2000; Kessler et al., 2005; Kinnunen et al., 2006; Martini, Wagner, Anthony, 2002; Merikangas et al., 2007; Scott et al., 2009)

- Primary care is where many patients want their mental health care and where most of the mental health care is already happening (Stafford, Ausiello, Misra, Saglam, 2000)

- More mental health prescriptions are written by PCPs than mental health providers.

  (Burt & Schappert,

Rationale for Integrated MH Care (Cont'd)

- Despite interest and focus on enhancing PCP education regarding MH treatment (e.g., CME) , most MH treatment in the primary care setting has been shown to be suboptimal.

  (Gallo et al., 2002; Gallo, Ryan, Ford, 1999; U.S. Preventive Services Task Force, 1996)

  - Few receive adequate treatment course
  - Lack of resources for regular monitoring and overcoming treatment roadblocks
  - Only 1/4 to 1/3 achieve full symptom resolution, which is less than typically observed in psychiatric trials.

    (Callahan et al., 1996; Kamath, Finkel, Moran, 1996; Oslin et al, n.d., Foundations of integrated care Vol 1; Wells, Sherbourne, Schoenbaum, 2000; Tew et al., 2010)

- Referral to specialty mental health treatment is not always the most appropriate option
  - Most patients do not require specialty MH services
  - Most patients do not want specialty MH services (e.g., stigma, pre-contemplative) (Bartels et al., 2004)
- Co-location alone has not significantly impacted care delivery. (Tew et al., 2010)
- The most expensive 1% of health care consumers accounted for 27% of total health care costs in 1996. (Berk & Monheit, 2001)

Primary Care – Mental Health Integration (PC-MHI) in Veterans Affairs

"Since the 2008 release of the Uniform Mental Health Services Handbook (UMHSH), the Veterans Health Administration (VHA) has required all VA Medical Centers (VAMCs) and specified Community Based Outpatient Clinics (CBOCs) to implement Primary Care-Mental Health Integration (PC-MHI) programs."

(Beehler et al., 2015, p. 1)

"As the Nation's largest integrated healthcare system, Veterans Health Administration (VHA) of Department of Veterans Affairs has taken on this challenge of fielding the biggest program of primary care-mental health integration ever undertaken. The program has been a joint effort of VHA office of Mental Health services and VHA Primary Care services."

(Post, Metzger, Dumas, and Lehmann, 2010, p. 83)

Purpose of PC-MHI

- To promote the effective treatment of common mental health and substance use disorders in the primary care environment, hence improving access to care and treatment quality across the spectrum of mental illness severity.

- To be consistent with the New Freedom Commission on Mental Health (2003) which emphasized that mental and physical health are interrelated aspects of overall health and best treated in a coordinated system that elevates mental health care to the same level of urgency as medical health care.

(Post, Metzger, Dumas, & Lehmann, 2010; Veterans Health Administration, 2004)

Core Elements of PC-MHI

"A form of care where behavioral health and primary care providers interact in a systematic manner to meet the health needs of their patients."

- Patient-centered
- Co-located
- Collaborative
- Measurement-based
- Population-based
- Stepped
- Care Management

(Oslin et al., n.d., Foundations for integrated care, Vol. 1, p. 7)

Characterized by:

- Brief behavioral interventions
  - 30-minute visits
  - Brief functional assessment
  - 1-6 visits
  - Individual therapy, group therapy, care coordination
- Curbside consultation
- Medication consultation or management
- Open Access/Same Day Access
- Telephone encounters/visits
- Interdisciplinary team-based care lead by a Primary Care provider

Contrast with Specialty Mental Health Care

(Oslin et al., n.d., Foundations for Integrated Care, Vol. 1, p. 15)

	Integrated Care	Mental Health Specialty Care
Location	On site, embedded in the primary care clinic	A different floor, a different building
Population	Most are healthy, mild to moderate symptoms, behaviorally influenced problems.	Most have mental health diagnoses, including serious mental illness
Provider Communication	Collaborative & on-going consultations via PCP's method of choice (phone, note, conversation).	Consult requests, chart notes, Focus within mental health treatment team.
Service Delivery Structure	Brief (20-40min) visits, limited number of encounters, offer telephone follow-up	Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.
Approach	Problem-focused, first line psychopharmacotherapy, solution-oriented, functional assessment. Focused on PCP question/concern and enhancing PCP care plan. Population health model.	Diagnostic assessment, psychotherapy and advanced psychopharmacotherapy, individual and group, recovery-oriented care. Broad scope that varies by diagnosis.

Models of PCMHI

- Behavioral Health Laboratory – Care Management (CM) with VA integrated software, Philadelphia VA
- TIDES - Depression mgmt. by nursing, telephone-based, VA SACC
- White River Junction Model – Co-located, Collaborative Care (CCC)
- PACE – Provides CM for older adults in PA
- Kaiser Permanente – Offers disease mgmt. services for a variety of conditions including depression, utilizes depression screening, population-based care, decision-support to providers
- Diamond – Depression improvement access across Minnesota, since 2008 with participating insurance co, not co-located, provides evidence-based CM almost exclusively by telephone, high fidelity to model, informatics is key to program success

(Oslin et al., n.d., Foundations for Integrated Care, Vol. 1)

Evidence supporting the use of PC-MHI

Dozens of trials suggest that integrated and collaborative care have significant improvements compared to usual care, since frequent, ongoing monitoring of treatment adherence and symptom outcomes with feedback allows for PRN treatment modification.

- Depression care management - most evidence with mild depression
- Brief interventions for alcohol use – robust evidence base
- Anxiety and pain management – growing evidence

(Oslin et al., n.d., Foundations for Integrated Care, Vol. 1)

Benefits of PC-MHI

- Reduced mental health stigma (Beehler et al., 2015)
- Improved identification of mental health conditions and substance misuse (Nutting et al., 2005; Pomerantz et al., 2008; Oslin et al., 2006)
- Better access to appropriate MH evaluation and treatment (Pomerantz et al., 2008; Tutty, Simon, Ludman, 2000)
- Increased rates of MH engagement and treatment adherence (Wray et al., 2012; Zanjani, Miller, Turiano, Ross, Oslin, 2006b)
- Improved clinical and functional outcomes, including reduced mortality, with quicker response time (Alexopoulos, 2009)
- Increased PCP prescribing of antidepressants (Wray, Szymanski, Kearney, McCarthy, 2012)
- Decreased health care costs over 4 year period (Unutzer, 2008)
- Adding brief-CBT prolongs outcome effect (Alexopoulos, 2009)

Benefits of PC-MHI

- Similar remission rates compared to specialty care (Krahn et al., 2006)
- Higher integrated care model adherence led to better response and remission rates (Oxman, Schunemann, Fretheim, 2006)
- Decreased wait times and reduced no-shows (Pomerantz et al., 2008; Zanjani et al., 2008)
- Decreased high medical utilization including use of ER and inpatient care (Gilbody et al., 2006; Oslin et al., n.d., Foundations for integrated Care, Vol. 1)
- Improved chance of guideline-based care (Watts et al., 2007)
- Improved patient satisfaction and perception of care quality (Hunkeler, 2006; Katon et al., 2001 ; Pomerantz, 2008)

Benefits for Marginalized Groups

- Decreases mental health stigma for those who have less acculturation towards mental health services, including but not limited to those who identify with being a cultural minority, person of color, Gender & Sexual Minority (GSM), Veteran, person with disability, and those with lower SES who have limited access (financially or mobility-wise to specialty MH services).
- Increases access to MH care (e.g., telephone evaluations, care management, brief behavioral interventions)
- Improves overall health outcomes and decreases medical costs

Example Clinic Grids for PCMHI

- Full Open Access
- Alternating Scheduled/Unscheduled 30 minute slots
- Open Access based upon clinic flow
- Open Access Pager
- Care Management Access

Phases of a 30-Minute Appointment

1. Introduction of behavioral health consultation service (1-2 minutes)
2. Identifying/Clarifying consultation problem (10-60 seconds)
3. Conducting functional analysis of the problem (12-15 minutes)
4. Summarizing your understanding of the problem (1-2 minutes)

Assess

5. Listing out possible change plan options (**selling it**) (1-2 minutes)

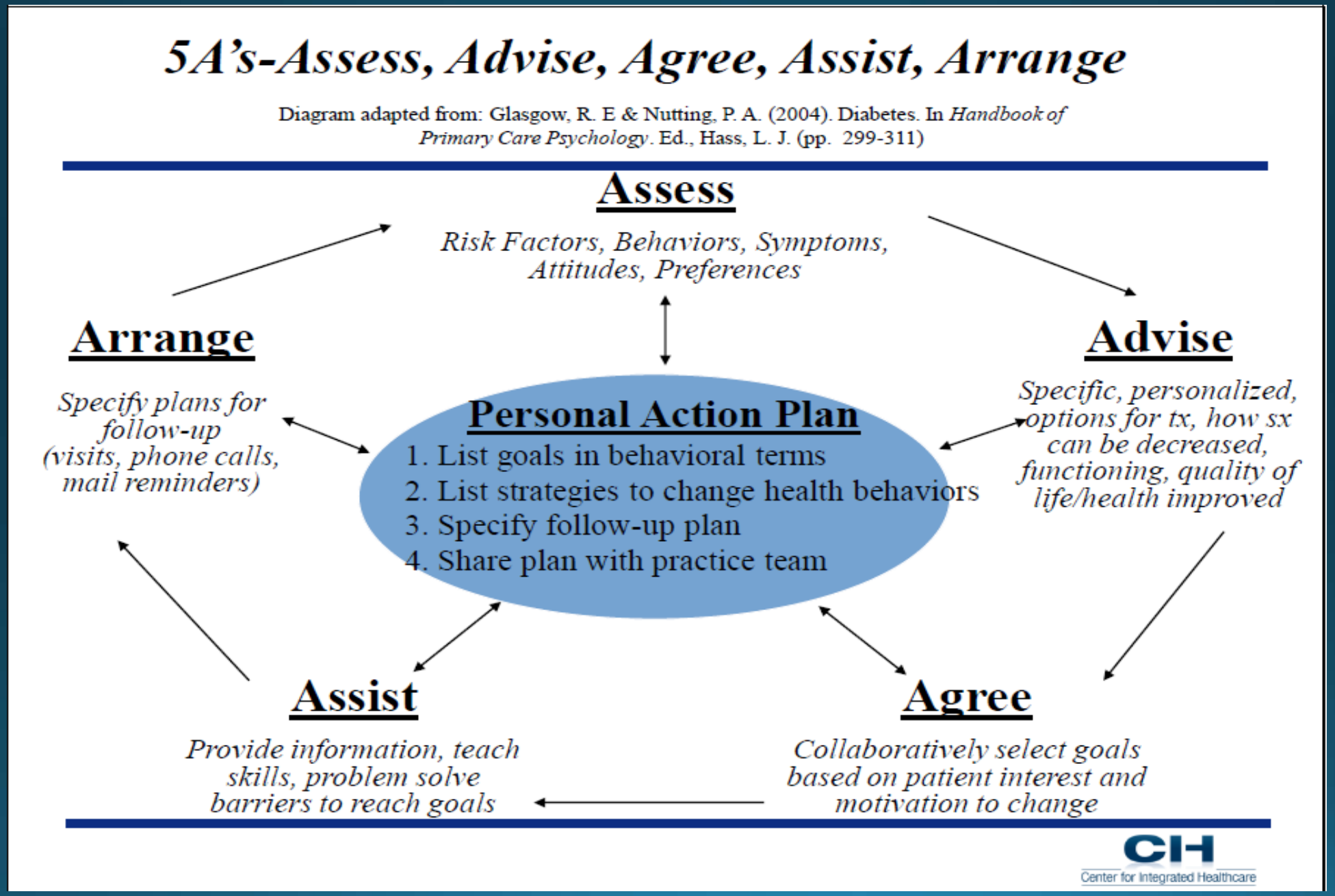
Advise
Agree

6. Starting a behavioral change plan (5-10 minutes)

Assist
Arrange

CIH
Center for Integrated Healthcare

The Brief Interview



The Functional Assessment

(Developed by the Center for Integrated Healthcare)

- Clarify presenting problem(s)
- Brief history of problem (duration, frequency, severity of symptoms, triggers, coping mechanisms ,treatment history)
- Evaluate how presenting problem impacts functioning in all below areas:
  - Sleep
  - Work
  - Close relationships
  - Family
  - Friends
  - Recreation
  - Physical
  - ETOH
  - Tobacco
  - Drugs
  - Caffeine
  - Pain
- Additional Assessment (e.g., PHQ-9, GAD-7, PCL, AUDIT-C)
- Risk Assessment (e.g., suicidality/homicidality, mandated reporting concerns)
  - Assessment of SI is critical in PCMHI - 45% of individuals who die by suicide have contact with a PCP in the month prior to their death. (Luoma, Martin, & Pearson, 2002)

The Brief Interview: Additional considerations for prescribers

- Review of problem list and pertinent medical history
- Drug allergies and adverse reactions
- Review of active medication list
- Brief ROS (if indicated)

(Oslin et al., n.d., Foundations for integrated care, Vol. 1)

Tips for Non-professional staff (e.g., Health or Psychology Technicians)

- Examine and practice the structured and standardized interview extensively before beginning the assessment
- Ask questions exactly as worded.
- Use probes on patients as a non-directive way to clarify answers (e.g., if you ask a patient a True or False question and they cannot decide on an answer, probe them with, "What would be your best guess?" or "Which answer comes closest to how you feel?")
- Never paraphrase a response in your own words
- Never diagnose patients during the interview or use language such as "Those symptoms are signs or symptoms of X."
- Never give any suggestions within the baseline interview (e.g., it may be helpful if you do this or try that")

(Oslin et al., n.d., Foundations for integrated care, Vol. 1, p. 34)

Measurement-Based Care: Screening Measures/Patient Identification

- **PHQ-2**: 2 items; anhedonia, feeling down, depressed, or hopeless
  If positive PHQ-2, then conduct suicide risk screening.
- **AUDIT-C**: 3 items: frequency, volume, and frequency of binge drinking
- **PC-PTSD** screening: 4 questions; potential index trauma plus re-experiencing, avoidance, hyperarousal, emotional detachment/numbing

Measurement-Based Care: Outcome Measures

- PHQ-9
- GAD-7
- PCL-5
- Mood Disorders Questionnaire
- Audit-C/Brief Addiction Monitor
- Blessed Orientation Memory Concentration (BOMC)
- Montreal Cognitive Assessment (MoCA)

➢ The use of structured questionnaires is important but does not replace good clinical judgment.

Potential interventions

- Behavioral activation
- Motivational Interviewing
- Problem solving therapy
- Image Rehearsal Therapy
- PTSD prep
- Brief CBT
- CBT-Insomnia
- Mindfulness
- Medication Management
- Brief AUD
- Psychoeducation
- Relaxation training
- Chronic pain
- Brief exposure
- ACT in primary care
- SMART goals (specific, measurable, attainable, realistic, time-based)

Commonly prescribed psychotropic meds supported by PCMHI/Primary Care

- Bupropion
- Citalopram
- Escitalopram
- Duloxetine
- Fluoxetine
- Mirtazapine
- Sertraline
- Trazodone
- Hydroxyzine
- Prazosin
- Zolpidem
- Buspirone

Common Barriers to Implementation

- Medical team and mental health buy-in
- Space limitations
- Culture of care
  - Siloed care v. Integrated
  - Traditional care training models (60-min MH appts, treatment duration, belief that Primary care does not prescribe psychotropics)
- Lack of/limited training in providing integrated mental health care

Implementation Considerations

Conduct a needs assessment:

- Consult stakeholders
  - What organizational changes are required?
  - What is the goal and structure of the program?
- How big your population
- What services provided (e.g., just to Primary Care or all clinics)
- Anticipated patient flow
- Hiring new staff or retraining existing staff
- Space issues (renovation, consultation, etc.)
- Electronic medical record system
- Coverage and backup for high risk patients
- Disciplines needed (e.g., psychiatry, psychology, social work, RN/LVN, mental health techs, other providers etc.)
- Local model vs. regional model (PCMHI staff at remote site and all contacts by phone)
- Threshold for specialty care (resources, scope of practice issues, etc.)

(Oslin et al., n.d., Foundations for integrated care, Vol. 1)

Recommended PC-MHI Staffing

- 0.67 clinical PC-MHI FTEEs per PACT team (approximated by the number of PACT uniques / 1200)
- National VHA target penetration rate for FY17 is 10%.
- National VHA target Same Day access through December 2017 is 40% (for 2018 is 75%)

CPT/ HCPCS	Description	2016 wRVU	Provider approved**
	Assessment		
90791	Psychiatric diagnostic evaluation	3.00	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
90792	Psychiatric diagnostic evaluation with medical services	3.25	MD, DO, CNS, ANP, PA
H0001	Alcohol and/or Drug Assessment	0.5*	All within scope of practice
	Individual Psychotherapy		
90832	Psychotherapy face-to-face with patient and/or family member.; 16-37 minutes	1.50	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
90834	*Psychotherapy face-to-face with patient and/or family member. 38-52 minutes	2.00	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
	Individual Psychotherapy with E&M		
+90833	Psychotherapy face-to-face with patient and/or family member.; 16-37 minutes First code Evaluation & Management (E&M) service.	1.50	MD, DO, CNS, ANP, PA
+90836	Psychotherapy face-to-face with patient and/or family member.; 38-52 minutes First code E&M service.	1.90	MD, DO, CNS, ANP, PA
	Crisis Intervention Codes		
90839	Psychotherapy for crisis first 60 minutes	3.13	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+90840	Psychotherapy for crisis; use in conjunction with 90839 for each additional 30 minutes after 60 minutes	1.5	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
H2011	Crisis intervention service, per 15 minutes	0.5	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
S9484	Crisis Intervention, per hour	0.5	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT

	Outpatient Prolonged Service Codes		
+99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	1.77	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+99355	Outpatient prolonged service; use in conjunction with +99354 for each additional 30 minutes	1.77	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Inpatient Prolonged Service Codes		
+99356	Prolonged service in the inpatient or observation setting requiring unit/floor time with direct face-to-face patient contact beyond the usual service, first hour	1.71	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
+99357	Inpatient prolonged service; use in conjunction with +99356 for each additional 30 minutes	1.71	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Group Psychotherapy and Interventions		
90853	Group psychotherapy other than of a multifamily group.	0.59	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
	Family Services		
90846	Family psychotherapy (without the patient present)	2.4	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90847	Family psychotherapy (conjoint psychotherapy with patient present)	2.5	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90849	Multiple Family psychotherapy	.59	MD, DO, CNS, ANP, PA CP, SW, LPMHC, MFT
90887	Consultation with Family. Family Feedback/Education. Explanation of results of examination, procedures, data, to family or other responsible person.	1.48	All within scope of practice

	Health and Behavior (Family) Education		
96154	H/B Family (with the patient present) intervention (e.g. stress management/coping strategies), each 15 min	.45	All within scope of practice
96155	H/B Family (without the patient present) intervention (e.g. stress management/coping strategies), each 15 min	.44	All within scope of practice
H2027	Family with Veteran, psychoeducational service. Activities to provide information and education to clients, families, and significant others regarding mental disorders and their treatment. Each 15 minutes.	.5*	All within scope of practice
	Health and Behavior (Individual) Education		
96150	Initial H/B assessment (e.g. Health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	.5	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
96151	Assessment, health and behavior subsequent (per 15 minutes)	.48	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT
96152	Intervention, health and behavior, individual (per 15 minutes)	.46	MD, DO, CNS, ANP, PA, CP, SW, LPMHC, MFT

	Health and Behavior (Group) Education		
96153	H/B Group (2 + patients) intervention (e.g. stress management/coping strategies), each 15 min	0.1	All within scope of practice
98961	Self-Management education and training (2-4 patients) with standardized curriculum. May include caregiver/family. Each 30 minutes	0	All non-prescriptive within scope of practice
98962	Self-Management education and training (5-8 patients) with standardized curriculum. May include caregiver/family. Each 30 minutes	0	All non-prescriptive within scope of practice
99078	Group health educational/counseling services	0.4*	All within scope of practice
S9446	Group educational services not otherwise classified	0.4*	All non-prescriptive within scope of practice
S9449	Weight Management Class Non-MD Per Session	0.2*	All within scope of practice
S9452	Nutrition Classes Non-MD Per Session	0.2*	All within scope of practice
S9453	Smoking Cessation Class Non-MD Per Session	0.5*	All within scope of practice
S9454	Class for stress management	0.2*	All non-prescriptive within scope of practice

	Team Conference with Veteran/Family		
99366	Team conference (minimum 3 different disciplines) with participation by qualified non-prescriptive provider, face-to-face with patient and/or family, 30 minutes or more	0.82	All non-prescriptive within scope of practice
	Team Conference without Veteran/Family		
99367	Team conference (minimum 3 different disciplines) with participation by prescriptive provider. Patient and/or family not present, 30 minutes or more devoted to the same patient	1.1	MD, DO, CNS, ANP, PA and all others within scope of practice
99368	Team conference (minimum 3 different disciplines) with participation by qualified non-prescriptive provider. Patient and/or family not present, 30 minutes or more devoted to the same patient	0.72	All non-prescriptive within scope of practice
	Telephone		
98966	5-10 minutes of medical discussion.	0.25	All non-prescriptive within scope of practice
98967	11-20 minutes of medical discussion.	0.5	All non-prescriptive within scope of practice
98968	21-30 minutes of medical discussion.	0.75	All non-prescriptive within scope of practice
99441	5-10 minutes of medical discussion.	0.25	MD, DO, CNS, ANP, PA
99442	11-20 minutes of medical discussion.	0.5	MD, DO, CNS, ANP, PA
99443	21-30 minutes of medical discussion.	0.75	MD, DO, CNS, ANP, PA

	Other		
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes.	0.97	All within scope of practice
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers.	0.57	All within scope of practice
H0038	Self-Help/Peer Services, each 15 minutes	0.0	Peer Support Specialist
H0004	Behavioral health counseling and therapy, per 15 minutes	0.5*	All within scope of practice
H0007	Alcohol and/or drug services; crisis intervention (outpatient)	1.2*	All within scope of practice
H0014	Alcohol and/or drug services; ambulatory detoxification	0.95*	All within scope of practice
H2027	Psychoeducational Service, per 15 minutes	0.5	All Scope of Practice

*** These are imputed wRVU values; codes with imputed wRVU values are not billed**

+ These are add-on codes; report in addition to the primary service

****MD and DO= Physician, CNS=Clinical Nurse Specialist, ANP=Advanced Nurse Practitioner, PA=Physician Assistant, CP=Clinical/Counseling Psychologist, SW=Social Worker, LPMHC=Licensed Professional Mental Health Counselor, MFT=Marital and Family Therapist;**

"All within scope of practice" includes Addiction Therapists, Registered Nurses; other Therapists

How to Conduct a Warm Handoff

The secret to the warm handoff for the PACT team member is:

STRAWS

Spot the problem for your patient
Translate the problem in destigmatizing terms
Relate the role of the PCMHI Provider
Ask for permission to conduct the handoff
Walk the patient over
State the problem and goal for the PCMHI Provider

(Developed by Joseph Grasso, PhD)

Sample script: Introduction of Integrated MH services by PCP to patient:

"I'd like you to meet with a colleague of mine, Dr. X, to talk a little bit more about your current stress. He is a psychologist on our team, and he can help us come up with a treatment plan for addressing your current stress and difficulty sleeping. He is just down the hall, and I trust that he will be able to help us."

(Adapted from Oslin et al., n.d., Foundations for Integrated Care, Vol. 1)

The secret to the warm handoff for the Behavioral Health Consultant (BHC) provider is:

TIES

Thank provider for warm handoff

Introduce self (Name, Title, Profession)

Explain role of PCMHI Provider

Set expectations for patient

(Developed by Joseph Grasso, PhD)

BHP Sample Introductory Script

"I'd like to begin by explaining who I am and what I do in this clinic. I'm one of the behavioral health consultants for the clinic and I'm a (psychologist, social worker, psych NP). I work with the primary care providers in situations where good health care involves paying attention to physical health, habits, behaviors, emotional health and how these things interact with each other. Anytime (referring provider) want, he/she can call me in as a consultant to help the two of you better manage the difficulties you're currently having. I'll spend about 25-minutes with you to get a good idea of what's working well, what's not working so well, and we'll come up with a plan to help you best manage your current problems or concerns.

Just as with your PCP, our visits are confidential. However, there are some reporting requirements for providers which may limit confidentiality (review limits of confidentiality). Additionally, I'll be writing a note that will go into your electronic medical record and I'll be giving your PCP some feedback on whatever plan we come up with.

Do you have any questions about who I am, my role in the clinic, or confidentiality?"

(Adapted from Hunter, Goodie, Oordt, & Dobmeyer, 2009)

Sample Script: Reaching out to patient by telephone after PCP visit

"Hello Mr./Mrs./Ms ____. My name is _____ and I work with your primary care provider, Dr. Bones. She asked that I give you a call today to follow up on some of the concerns you spoke about at your appointment yesterday (e.g., depressive symptoms, sleep problems, etc.). What I would like to do is ask you some questions to get a better idea of how you are feeling. It would take about 20-30 minutes and would only be shared with those involved in your health care. Would you have the time to do that today? Afterwards, we could talk about some options that might best fit your needs and get you feeling better. (If it is not a good time for the patient ask when a good time would be to call back.)"

(Adapted from Oslin et al., n.d., Foundations for integrated Care, Vol. 1)

Sample Script: Engaging a patient that is hesitant to participate in baseline interview

"Mr./Ms. X, even if you are feeling fine, your provider would still like us to do this follow-up interview to make sure you are doing well. Sometimes there is a misunderstanding and this interview would help to clear things up and give your provider a more detailed description of how you are feeling. I can assure you that this is a confidential conversation and will only be shared with those involved in your care."

(Adapted from Oslin et al., n.d., Foundations for Integrated Care, Vol. 1)

Interactive exercise

1. PCP intro speech to pt. and warm-handoff to BHP (1-2 min)
2. BHP intro to purpose of visit (1-2 min)
3. BHP Functional assessment (for c/o depressed mood, no SI) (10 min)
4. BHP recap of session to PCP (1-2 min)

Questions or comments?

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