

Primary Behavioral Health Care Services

Appendices to Practice Manual

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Behavioral Health Optimization Program

Air Force Medical Operations Agency (AFMOA)
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**Appendix 1:
Standard BHC Information Sheet**

Behavioral Health Consultation Service

WHAT Is The Behavioral Health Consultation Service?

We're making the Behavioral Health Consultation Service available to you in our primary care and family health clinics, as a part of your comprehensive health care benefit. The service offers help when stress, worry, or emotional concerns about physical or other life problems interfere with your daily life.

WHO Is The Behavioral Health Consultant (BHC)?

WHAT Problems Can the BHC Help Me With?

The BHC is a psychologist, social worker or nurse practitioner especially trained to work as a member of your primary care team. This team approach allows us to consider physical, behavioral, and emotional aspects of your health.

For example, the BHC can help you develop plans for smoking cessation or other lifestyle changes. He or she can also help you with emotional or behavioral problems such as difficulties with your family or relationships, grief, excess stress, depression, anxiety, or anger.

HOW is this Service Different from Mental Health?

The BHC simply adds another option for your complete health care. You are seen directly in the primary care or family health clinic. The BHC provides consultation and brief intervention, not traditional psychotherapy. If you request it, or the BHC thinks you would benefit from it, he or she will refer you to specialty mental health services. Another difference from specialty mental health care is that your BHC will document the assessment and recommendations in your outpatient medical record. He or she will not keep a separate mental health record.

WHAT Should I Expect When I See the BHC?

Your BHC will ask you specific questions about your physical symptoms, the emotional concerns you are experiencing, your behaviors, and how all of these might be related.

Communications with your BHC may not be entirely confidential. Your BHC will make every effort to protect your privacy. But, like *all* providers, they *must* report information from any active duty patient that could have a negative impact on our mission, or that involve UCMJ violations or other reportable events. There are also limits to confidentiality for *all* patients (active duty and non-active duty) to ensure safety in situations involving risk to self or others.

Your appointments should last about 30 minutes or less. Your BHC will provide brief, solution-focused skills and techniques. You can expect to be seen in this clinic. The BHC will have a close working relationship with your primary medical provider and keep them updated on how you are doing. Remember: Your primary care provider and you are still the leaders of your health care team. The BHC's main job is to help develop and implement the most helpful healthcare plan for YOU!

Appendix 2: BHC Disclosure Statement

The following is a prototype for a verbal, introductory script. Use this script, or something similar, to ensure that the nature of BHC services is clear to the primary care staff and all potential patients.

Behavioral Health Consultant Introductory Script

Hello, my name is _____.

Before we get started today, let me explain to you a little bit about who I am and what I do.

I'm the behavioral health consultant for the clinic and a (psychologist/social worker/nurse/psychiatrist) by training. I work with the primary care managers in situations where good health care involves paying attention not only to physical health, but also to emotional health, habits, behaviors, and how those things interact with each other. If your provider is concerned for any reason that any of these factors are affecting your health or functioning, they can call me in as a consultant.

My job as a consultant is very specific. It's to help you and your provider better target any problems that have come up for you at this point. To do this, I'm going to spend about 25 minutes with you to get a snap shot of your life—what's working well and what's not working so well. Then together we'll come up with a plan or set of recommendations that seems doable.

The recommendations might be things you try on your own, like reading some self-help material, practicing some skills on your own, and you might never see me again. Or, we may decide to have you come back to see me a couple times, if we think that would be helpful to get some positive momentum going on specific skills. We might also decide that you'd benefit from going to a more intensive specialty service. In that case, I'd talk with your primary provider and, if that was something they wanted for you, I'd help them arrange a referral, using the information you've given me today.

After we've finished meeting today, I'll meet with your provider to go over what we've talked about and what the plan is. This information will be integrated in your healthcare record. So, don't be surprised if your provider, or any other health care team member, asks you how parts of the plan are going.

My limits of confidentiality are the same as other providers in this clinic, which includes responsibility to report cases in which someone is a risk to themselves or others and cases of domestic abuse or violence. (For active duty members, I may also be required to report UCMJ violations.)

Do you have any questions about any of this before we begin?

If yes: Spend time needed to make sure the patient understands the purposes of this service. If no: “(medical provider’s name) is concerned about (referral reason). Is that your sense of what is going on here, or do you have another take on this?”

Appendix 3: Medication Consultation & Management

Recommendations and Procedures

Subject

Psychotropic medication consultation & management for patients

Definitions

Prescribers: Physicians, psychiatrists, family/women's health nurse practitioners, prescribing psychologists, and physician assistants.

Non-Prescribers: Psychologists, master's-level practitioners, and registered nurses.

Recommendations

The following principles will guide medication consultation and management practices:

- Practitioners licensed with prescriptive authority are responsible for recommendations on the selection of medication, dosage schedules, and length of treatment.
- The prescribing practitioner who requests the consultation is responsible for disposition of the advice and recommendations of a behavioral health consultant.
- In a consultation role, non-prescribers¹ may make suggestions about medication to the responsible prescriber, but they are not required to do so.
- Response to medication is as important a content issue in psychotherapy and case management as it is in medication management interviews. Therefore, in a consultation role, non-prescribers may include the following, or similar, medication-management issues in patient interviews and alert a prescriber to a patient's potential non-adherence and/or unwanted side effects.
 - Whether or not a patient is taking a prescribed medication
 - What taking a medication means to a patient
 - How a patient believes a medication is affecting her or him
 - Encouraging a patient to use a prescribed medication
 - Incorporating a patient's beliefs and attitudes regarding medication into a plan for psychotherapeutic treatment or case management
- Alternatively, non-prescribers may recommend that the Primary Care Manager (PCM) consult with a Consultation Liaison Psychiatrist (CLP).
- Record documentation will reflect these principles.

Background

Psychoactive medication has become a common element of the therapeutic armamentarium, in both specialty mental health and primary care. Practitioners with a wide variety of training and experience are responsible for mental health care. Some of these practitioners are licensed to prescribe medication, others are not.

One advantage of practicing in multidisciplinary mental health teams and integrating mental health with primary care is the ability to consult with colleagues. Consultation is generally

assumed to enhance quality of care by expanding the breadth and depth of training and experience that may be focused on a given clinical situation or problem.

Prescribing and non-prescribing practitioners increasingly interact with one another, and with one another's patients, in the modern mental health delivery system. It is important that we conduct these interactions so that we deliver the highest possible quality of care, while accommodating the law and adhering to ethical standards. While each clinical situation is unique to some extent, if we follow the recommendations delineated here when consulting, the result will be high-quality, efficient support of one another and our primary care provider colleagues.

Procedures

- Prescribers who request specific consultation with prescribing or non-prescribing consultants are responsible for the disposition of that advice to their patients.
- Non-prescribers will be knowledgeable about the commonly prescribed agents in each of the broad classes of psychoactive substances (i.e., anti-anxiety, anti-depressant, mood-stabilizers, anti-psychotic, sedative/hypnotic).
- When discussing medication with prescribers, non-prescribers will identify themselves as non-prescribers.
- When discussing medication-management issues with patients, non-prescribers will identify themselves as non-prescribers.
- Non-prescribers will suggest medication changes to patients only when prescribers request them to convey this information on their behalf. Non-prescribers may carry out these requests, but are not required to do so.
- In a consultation role, non-prescribers¹ may discuss medication issues with the responsible prescriber, but they are not required to do so.
- When documenting medication discussions with primary care providers, non-prescribers will preface their documentation with the following: "Recommended the following to Dr. X:..."
- When prescribing and non-prescribing mental-health providers consult with prescribing primary-care providers, all parties will be aware that practitioners licensed to prescribe are responsible for medication selection, dosage, and length of treatment. Mental health consultants will clearly differentiate their roles as prescribers or non-prescribers to primary care providers seeking consultation. Non-prescribing behavioral health consultants will remind primary care providers that they are offering their best information on psychopharmacology, but they do not have prescriptive authority. Primary care providers can then accept their recommendations, or request a consultation with a CLP.
- When a prescribing primary care provider requests consultation from a CLP, prescribing psychologist or psychiatric nurse practitioner, the responsible provider will be clearly identified. Clarification of the consultation relationship and ultimate responsibility for care will be addressed in each instance.
- BHCs can provide standard patient education and discuss adherence to medications directly with patients.

¹Non-prescribing BHC's assessment and intervention plans should not include recommendations on specific types and dosages of psychopharmacology. Non-prescribing BHCs can make recommendations about whether a patient may or may not be appropriate for pharmacological intervention.

Appendix 4: Behavioral Health Consultant Job Description

Duties and Responsibilities

A behavioral health consultant (BHC) is a member of the Primary Care Clinic's healthcare team who assists the primary care managers (PCMs) in managing the overall health of their enrolled population. The BHC's goals are to help improve recognition, treatment, and management of psychosocial/behavioral problems and medical conditions in the enrolled population. The BHC provides consultation services to all patients referred by the Primary Care team.

The BHC's role is limited to that of a consultant. Scope of care and responsibilities include:

- Targeted assessment and evaluation, including diagnostic impressions and functional status focused on the presenting problem
- Timely and succinct feedback to PCMs regarding consultation findings and recommendations
- Concise documentation in the patient's medical record
- Triage and referring patients to specialty mental health care when appropriate.
- Formulation of behavioral health interventions appropriate to the primary care setting, and assisting with implementation of PCM treatment plans
- Providing brief follow-up, including relapse-prevention education
- Developing, teaching, and/or providing oversight for classes that promote education and skill-building to enhance psychological and physical health
- Providing on-going consultation services for a sub-set of patients who require on-going monitoring and follow-up (i.e., continuity consultations)
- Sharing knowledge with other team members and patients, both formally (in-services, consult responses) and informally (hallway conversations)
- Working as a primary care team member to develop specific clinical pathways or best practice programs for targeted patient groups (e.g., patients with acute stress symptoms and PTSD)

Qualifications

BHCs are privileged providers¹ with advanced degrees in the mental health field who have received Air Force-recognized specialized training, including both didactic and clinical components, in the duties, responsibilities, and skills of a primary care BHC.

¹ Providers need not be privileged for independent practice; privileged providers can be supervised and still function as a BHC. However, we recommend that a BHC mentor supervise and mentor their BHC practice, while their regular, on-site supervisor performs overall supervision. Although there is no credentialing requirement at the time of this manual's release, it is expected that mental health providers will soon be required to obtain AFMS credentialing as a BHC prior to functioning in this capacity.

Core Competencies

To function as a BHC, you must demonstrate applied competency to a BHC mentor or AF/SGHW in the following areas:

Knowledge

- **Know the behavioral health consultant model**
Demonstrate a thorough understanding of the current *Primary Care Behavioral Health Services Practice Manual*, and be able to describe the BHC's role to primary care team members and patients
- **Understand the relationship between medical and psychological aspects of health and disease**
Apply the biopsychosocial model to the primary care setting, and demonstrate a basic knowledge of pharmacotherapy

Clinical

- **Apply population-based healthcare principles**
Provide services to *all* enrollees (not just those with diagnosable mental disorders)
- **Provide services appropriate to the primary care environment**
Perform focused assessment and rapid problem identification, use 15- to 30-minute visits, limit problem definition and address patients' needs with limited follow-up, and demonstrate knowledge of interventions that can be used by members of the primary care team
- **Employ empirically supported interventions**
Identify, adapt, and apply empirically supported interventions to the broad range of problems presenting in primary care
- **Identify functional outcomes**
Make recommendations that target occupational, social, and familial functioning; home activities; and recreation
- **Plan, develop, and provide lifestyle classes**
Offer educational and skill-building classes that enhance health and improve functioning, and teach group-facilitation skills to other primary care team members
- **Triage patients to specialty care services and community resources**
Demonstrate understanding of the scope of practice for primary care, provide care for all patients within that scope, and appropriately refer those who require alternative care

Administrative

- **Function as an interdisciplinary team member**
Work as a consultant to the PCM, who makes all patient care decisions; focus on the referral question; persistently follow up with PCMs; tailor recommendations to the pace of primary care; and devise services that reduce PCM workload
- **Use clear verbal and written communication**
Respond to any consultative question in language free of psychological jargon, and document services and recommendations in a concise, actionable manner

Hours

BHCs are available full-time or part-time in primary care. Part-time consultants should work at least 2 half-days per week and provide services on a predictable schedule (i.e., set days and times). When feasible, it is preferable for part-time consultants to work in primary care half-time (i.e., 20 hours per week).

BHCs will be reasonably available by pager or cell phone during duty hours, when not in the clinic.

Additional details on BHC core competencies can be found in Appendix 18, “Training Core Competency Tool.”

Appendix 5: Resources for Managing Depression in Primary Care

There are a number of good resources for treating depression in primary care. One highly recommended approach is the Integrated Care Program (ICP) for the Treatment of Depression, as outlined in the following materials (provider and patient manuals):

- Robinson, P., Wischman, C., & Del Vento, A. (1996). *Treating depression in primary care: A manual for primary care and mental health providers*. Reno, Nevada: Context Press.
- Robinson, P. (1996). *Living life well: New strategies for hard times*. Reno, Nevada: Context Press.

Other useful resources are available on-line. However, many existing clinical practice guidelines are designed with only primary care and specialty mental health care in mind; they were not developed for the clinics in which behavioral health care has been integrated. Therefore, you should closely evaluate their specific applicability to an integrated primary care approach. The idea behind treating depression in primary care is to use both the PCM and the BHC to optimize treatment, follow-up, patient adherence, and maintenance of change. You and the PCM, working conjointly, can handle most of these patients exclusively in the primary care environment. However, you should refer to specialty mental health the patient who has any of these symptoms or conditions:

- Imminent risk of suicidal behavior
- Psychotic symptoms
- Manic symptoms
- Complex psychotropic medication issues
- Incomplete response to adequate trial of one or two medications
- Alcohol dependence or other substance dependence
- A recent history of severe psychiatric problems or hospitalizations

One very useful site is “Partners in Care,” a project sponsored by the Agency for Healthcare Research and Quality, in cooperation with the RAND Corporation. It can be found at:

<http://www.rand.org/health/pic.products/>

You will find many helpful resources on this site; encourage PCMs to use them, too. Among them are the quick reference cards that provide a thumbnail sketch of assessment, differential diagnosis, treatment, care-management guidelines for depression, and useful tips for educating patients and dealing with common barriers to treatment.

In general, one way you can be most effective is to assess whether a patient truly needs pharmacotherapy and, for those who do, provide basic education about these medications. Another way you can be very helpful is to routinely schedule a two-week follow-up visit with patients after their PCM has prescribed an anti-depressant. Some will have difficulties with their medications and need to speak with their PCM, but many will not. By seeing these patients, the goal is for you to be able to significantly improve the quality of care and their adherence to the care plan, while decreasing the PCM’s overall time burden.

Examples of Basic Tips BHCs Can Offer Patients Prescribed Anti-depressant Medication

- Anti-depressant medications help restore a chemical balance in the brain.
- They are not addictive.
- Your response will be gradual, and the medication will take two to six weeks to work.
- If side effects occur early, they usually improve or can be treated.
- The first week, you may expect your sleep and appetite to improve. It may take a few weeks for mood and energy to improve and for negative thinking to decrease.
- Take your medication every day. Based on certain side effects, it may work better to take it in the morning or the evening, but generally, it is best to take it about the same time each day.
- Keep track of side effects and discuss them at your follow-up.
- Continue taking the medication, even if you feel better (unless otherwise directed by your physician).
- Don't stop taking the medication before talking with your PCM.
- Call if you have any questions.

Develop a Handout on Medications and Side Effects

Anti-depressant medications usually have some side effects. This means that in addition to helping, they also produce some undesirable effects. Typically, they are temporary, or at least diminish over the first few weeks of treatment. Some are common, and there are strategies to cope with these more effectively. Use existing resources to develop your own handout (see below) on common side effects and coping strategies.

If you experience.....

Nausea
Constipation
Dry mouth
Etc.

Try.....

An example of such a handout is included on the following pages.

Using Antidepressant Medications Successfully

A person's body, behavior, and thoughts interact continuously. Once depression becomes a problem, this interaction may lead to a "downward spiral" in mood and hopefulness. Two courses of action help reverse the downward direction and create a "positive spiral."

- 1. Use of medications.** Medications may help you feel better. Antidepressant medications restore the presence of neurotransmitter substances that become depleted by stress. Medications may work somewhat slowly. Therefore, it is best to use medications in combination with behavioral planning and use of coping strategies.
- 2. Strategic use of coping strategies.** Use of active coping strategies helps you reverse the downward spiral of depression. When you address life problems with effective strategies, you have more opportunities to create positive conditions in your life. Make a concerted effort to work with your health care provider in planning skillful use of coping strategies.

You are much more likely to succeed in antidepressant treatment when you have accurate information about all aspects of medication use. Please review the following details and discuss any questions you have with your healthcare providers.

- 1. Starting medication.** Start your medication as soon as it is prescribed. The sooner you start, the sooner you will experience the desired benefits.
 - a.** *Keep in mind that it generally takes 2 to 3 weeks before you will start noticing a reduction in symptoms and 4 to 8 weeks for symptoms to fully subside.*
 - b.** The first thing most people experience is improved sleep, decreased fatigue and some improvement in emotional control.
 - c.** Antidepressants mostly affect the physical symptoms of depression. Other symptoms, such as depressed mood and low sense of self-worth, may respond only partially to medication treatment. In other words, antidepressants are not "happy pills;" they do not totally erase feelings of sadness or emptiness.
- 2. Remembering to take medications.** Take your medication at a certain time every day. During the first several weeks, you may want to leave yourself several reminder notes. Some people use a behavioral hygiene task, such as teeth brushing, as a cue to take their medication. Also, some people may want to leave an extra bottle of medication in a desk drawer at work in the event that they forget to take the medicine at home.
- 3. Carrying on with other activities.** You may continue with your normal activities while taking antidepressant medications. If you do notice minor sedation or sleepiness in starting a medicine, avoid driving or carrying out hazardous activities. Sleepiness will usually diminish. If it does not, talk with your provider about a medication change.
- 4. Taking antidepressants with other medications.** You may take antidepressants with most other types of medications. However, do talk with your provider about the compatibility of antidepressant medications with other medications you are taking.
- 5. Taking antidepressants and consuming alcohol.** Do not drink alcohol while taking antidepressant medications. Alcohol can block the effects of the medication.
- 6. Addiction.** Antidepressants are not addictive.
- 7. Increasing medication dose.** Increase your medication dose according to the directions of your provider. In starting antidepressant medications, you start with small doses initially and increase gradually. Do not worry that you are "taking too many pills." Your provider is

prescribing a slow increase in dose in order to help you avoid side effects. After you reach your “therapeutic dose,” your provider will probably prescribe tablets that are larger in dosage, which then allows you to take fewer tablets.

- 8. Continuing to take the medication.** Take the medication until you and your provider decide that you are ready to stop the medicine. In most cases, your provider will ask you to take the medicine for at least 6 months after you reach a therapeutic dose. Do not stop taking the medicine because you feel better. Use this period of feeling better to work on developing coping skills that will help prevent relapse. The relapse rate when people discontinue medications too early is as high as 80%. Wait and plan how and when to stop with your provider.

Handling Side Effects

Most antidepressant medications have mild side effects. The side effects are usually temporary and diminish or disappear during the first few weeks of treatment. **If you experience side effects that are more severe, call your provider.** She or he will probably suggest one or more of the following strategies:

- Change the time that you take the medication
- Change the dose of the medicine
- Use a remedy for the side effect
- Change to a different medication

The following table summarizes common side effects and possible strategies for coping with side effects. Most medications have only one or two of the side effects listed in this table.

Common Side Effects	Remedies
Dry Mouth	Drink plenty of water. Chew sugarless gum or sugarless gum drops.
Constipation	Eat more fiber-rich foods. Take a stool softener.
Drowsiness	Get fresh air and take frequent walks. Try taking your medicine earlier in the evening, or if you are taking your medicine in the day ask your doctor if you can take it at night.
Wakefulness	Take medications early in the day. Learn more about behavioral changes that can reduce insomnia. Take a warm bath and have a light snack before bed. Avoid exercising vigorously late in the evening.
Blurred vision	Remind yourself that this will be a temporary difficulty. Talk with your doctor if it persists.
Dizziness	Stand up slowly. Drink plenty of fluids. If worried, call your PCM.
Feeling speeded up	Tell yourself, “This will go away within three to five days.” If it does not, call your doctor or nurse.
Sexual problem	Talk with your doctor. A change in medications or a medication holiday may help.
Nausea or Appetite Loss	Take the medicine with food. Prepare food so that it is appetizing and colorful. Eat small healthy meals.

Sources: Using Medications Successfully. An ICP Booklet. Reno: Context Press.
Preston, J. & Johnson, J. (2000) Clinical Psychopharmacology Made Ridiculously Simple, Edition 4. Miami: Medmaster.

**Appendix 6: Recommended
Screening Measures for Primary
Care**

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

Purpose

The Patient Health Questionnaire-9 (PHQ-9) facilitates the recognition and diagnosis of depressive disorders in primary care patients. It also includes a question about functional impairment. You can calculate a Depression Severity Index score and repeat it to monitor change.

Who Should Take the PHQ-9?

You should use the questionnaire with individuals suspected of having a depressive disorder.

Making a Diagnosis

Since the questionnaire relies on patient self-report, you must verify definitive diagnoses, taking into account how well they understood the questions and other relevant information from the patient, his or her family, or other sources. In addition, the diagnoses of Major Depressive ***Disorder*** (rather than *Syndrome*) and Other Depressive ***Disorder*** require you to rule out normal bereavement (mild symptoms, duration less than two months), a history of a manic episode (Bipolar Disorder), and a physical disorder, medication, or other drugs as a biological cause of the depressive symptoms.

Interpreting the PHQ-9

Criteria for the diagnoses assessed on each page are at the bottom of the page, in the notation that begins with “FOR OFFICE CODING” (in small type). Category names are abbreviated (e.g., Major Depressive Syndrome is Maj Dep Syn.)

Additional Clinical Considerations

After making a provisional diagnosis with the PHQ-9, additional clinical considerations may affect your decisions about management and treatment:

- *Have current symptoms been triggered by psychosocial **stressors**?*
- *What is the **duration** of the current disturbance and has the patient received any **treatment** for it?*
- *To what extent are the patient’s symptoms **impairing** his or her usual work and activities?*
- *Is there a **history** of similar episodes, and were they **treated**?*
- *Is there a **family history** of similar conditions?*

The PHQ-9 is less than one page long. The first nine questions assess depressive symptoms; the last question assesses functional impairment. All PHQ instruments can be downloaded at <http://phqscreeners.com/overview.aspx>. They have recently been placed in the public domain and no permission is required to reproduce, translate, display or distribute them. Translations, a bibliography, an instruction manual and other information are also provided on the website.

Example of Diagnosing a Major Depressive Disorder and Calculating the Depression Severity Index

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month

Over the last 2 weeks, how often have you been bothered by any of the following:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Feeling down, depressed, or hopeless?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much?...	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Poor appetite or overeating?.....	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?.....	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For office coding: Total Score _____ = _____ + _____ + _____)

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

FOR OFFICE CODING:

Maj Dep Syn: If #1 or #2 and five or more of #1-9 are at least “More than half the days” (count #9 if present at all).

Other Dep Syn: If #1 or #2 and two, three, or four of #1-9 are at least “More than half the days” (count #9 if present at all).

Major Depressive Disorder Diagnosis

The criteria for Major Depressive *Syndrome* were met because she checked #1 as “Nearly every day,” and checked five of items 1 to 9 as “More than half the days” or “Nearly every day.”
NOTE: #9, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis was Major Depressive *Disorder* (not Syndrome), since questioning by a physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

Depression Severity Index

This is calculated by assigning scores of zero, 1, 2, and 3 to the response categories of “Not at all,” “Several days,” “More than half the days,” and “Nearly every day,” respectively. The index is the sum of the scores for the nine items, and ranges from 0 to 27. In the above case, the Depression Severity Index score is 16 (three items scored 1, two scored 2, and three scored 3).

In a study of 3000 primary care patients, the mean score for the Depression Severity Index was 5.0. The mean score for patients with Major Depressive Disorder (N=290) was 18.6. The mean score for patients with any mood disorder (N=473) was 15.1. Recommended descriptors for level of depression severity (Kroenke, Spitzer, & Williams, 2001) include:

Score	Level of Depression Severity
1-4	Minimal
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

Reference

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, 606-613.

Patient Health Questionnaire – 9 (PHQ-9)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name _____ Age _____ Sex: Female Male Today's Date _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For office coding: Total Score _____ = _____ + _____ + _____)

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

FOR OFFICE CODING:

Maj Dep Syn: If #1 or #2 and five or more of #1-9 are at least "More than half the days" (count #9 if present at all).

Other Dep Syn: If #1 or #2 and two, three, or four of #1-9 are at least "More than half the days" (count #9 if present at all).

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. © 1999, Pfizer Inc.

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

Purpose

The Patient Health Questionnaire-2 (PHQ-2) is designed as a brief screening for depression. It assesses the frequency that the patient experienced depressed mood and anhedonia over the prior two weeks. It consists of the first two questions of the PHQ-9.

Who Should Take the PHQ-2?

The PHQ-2 can be used as a screening for depression with all primary care patients.

Scoring and Interpreting the PHQ-2

Items marked “Not at all” receive a score of 0; “Several days” = 1 point; “More than half the days” = 2 points; “Nearly every day” = 3 points. Item scores are added together to produce a total score ranging from 0 to 6.

Using a cut-score of “2” is recommended to provide a balance between sensitivity and specificity (Kroenke, Spitzer, & Williams, 2003). Individuals who score “2” or higher should receive further assessment for depression. This could include administration of the PHQ-9, and/or interview assessment for depression.

Reference

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2003). The PHQ-2: Validity of a brief depression screener. *Medical Care, 41*, 1284-1292.

Patient Health Questionnaire – 2 (PHQ-2)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name _____ Date _____

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

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For office coding: Total Score _____ = _____ + _____ + _____)

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. © 1999, Pfizer Inc.

Quick Guide to the Duke Health Profile (DUKE)

Purpose

The Duke Health Profile (DUKE) is brief, 17 item assessment of health and quality of life. It assesses health in three broad domains: physical health, mental health, and social health. It is comprised of six health subscales (physical, mental, social, general, perceived health, self-esteem) and four dysfunction subscales (anxiety, depression, pain, disability).

Who Should Take the DUKE?

The DUKE can be used to screen for health problems and behavioral health concerns in primary care populations.

Scoring and Interpreting the DUKE

The DUKE can be hand-scored using a template for manual scoring. Scoring takes several minutes. Scores on subscales can range from 0 to 100. High scores on the health subscales indicate good health, while high scores on the dysfunction subscales represent high dysfunction or poor health.

Permission to use the DUKE

The Air Force has obtained written permission to use the DUKE in the BHOP program. This permission extends only to use of the DUKE Health Profile in US military medical facilities and only in connection with patients seeking treatment in those facilities. It does not allow use of the DUKE Health Profile for any commercial purpose, including in commercially-funded clinical trials. It does not allow use of the Duke Health Profile in circumstances where a subject is charged for use or administration of the Duke Health Profile. Duke University's copyright notice must be retained on all copies of the DUKE used under this grant of permission.

Reference

Parkerson, G. R., Broadhead, W. E., & Tse, C. J. (1990). The Duke Health Profile: A 17-item measure of health and dysfunction. *Medical Care*, 28, 1056-1072.

DUKE HEALTH PROFILE (The DUKE)

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Date Today: _____ Name: _____
Date of Birth : _____ Female _____ Male _____

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

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

TODAY would you have any physical trouble or difficulty:

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

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

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

DURING THE PAST WEEK: How often did you:

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

DURING THE PAST WEEK: How often did you:

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

MANUAL SCORING FOR THE DUKE HEALTH PROFILE

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PHYSICAL HEALTH SCORE

<u>Item</u>	<u>Raw Score*</u>
8 =	_____
9 =	_____
10 =	_____
11 =	_____
12 =	_____
Sum =	_____ x 10 = _____

MENTAL HEALTH SCORE

<u>Item</u>	<u>Raw Score*</u>
1 =	_____
4 =	_____
5 =	_____
13 =	_____
14 =	_____
Sum =	_____ x 10 = _____

SOCIAL HEALTH SCORE

<u>Item</u>	<u>Raw Score*</u>
2 =	_____
6 =	_____
7 =	_____
15 =	_____
16 =	_____
Sum =	_____ x 10 = _____

GENERAL HEALTH SCORE

Physical Health score =	_____
Mental Health score =	_____
Social Health score =	_____
Sum =	_____ ÷ 3 = _____

PERCEIVED HEALTH SCORE

<u>Item</u>	<u>Raw Score*</u>
3 =	_____ x 50 = _____

SELF ESTEEM SCORE

<u>Item</u>	<u>Raw Score*</u>
1 =	_____
2 =	_____
4 =	_____
6 =	_____
7 =	_____
Sum =	_____ x 10 = _____

To calculate the scores in this column the raw scores must be revised as follows: If 0, change to 2; if 2, change to 0; if 1, no change.

ANXIETY SCORE

<u>Item</u>	<u>Raw Score*</u>	<u>Revised</u>
2 =	_____	_____
5 =	_____	_____
7 =	_____	_____
10 =	_____	_____
12 =	_____	_____
14 =	_____	_____
Sum =	_____ x 8.333 = _____	

DEPRESSION SCORE

<u>Item</u>	<u>Raw Score*</u>	<u>Revised</u>
4 =	_____	_____
5 =	_____	_____
10 =	_____	_____
12 =	_____	_____
13 =	_____	_____
Sum =	_____ x 10 = _____	

ANXIETY-DEPRESSION (DUKE-AD) SCORE

<u>Item</u>	<u>Raw Score*</u>	<u>Revised</u>
4 =	_____	_____
5 =	_____	_____
7 =	_____	_____
10 =	_____	_____
12 =	_____	_____
13 =	_____	_____
14 =	_____	_____
Sum =	_____ x 7.143 = _____	

PAIN SCORE

<u>Item</u>	<u>Raw Score*</u>	<u>Revised</u>
11 =	_____	_____ x 50 = _____

DISABILITY SCORE

<u>Item</u>	<u>Raw Score*</u>	<u>Revised</u>
17 =	_____	_____ x 50 = _____

Raw Score = last digit of the numeral adjacent to the blank checked by the respondent for each item. For example, if the second blank is checked for item 10 (blank numeral = 101), then the raw score is "1," because 1 is the last digit of 101.

Final Score is calculated from the raw scores as shown and entered into the box for each scale. For physical health, mental health, social health, general health, self-esteem, and perceived health, 100 indicates the best health status, and 0 indicates the worst health status. For anxiety, depression, anxiety-depression, pain, and disability, 100 indicates the worst health status and 0 indicates the best health status.

Missing Values: If one or more responses is missing within one of the eleven scales, a score cannot be calculated for that particular scale.

**Appendix 7:
Executive Summary of Recommended Guidelines
for Air Force Behavioral Health Consultants in
Primary Care**

Executive Summary of Recommended Guidelines for Air Force Behavioral Health Consultants in Primary Care

We intend these guidelines to apply only to behavioral health care in the primary care setting and not to replace existing regulations (such as AFI 44-109 or AFI 44-102) for specialty mental health care. Behavioral health consultants (BHCs) shall refer to the appropriate guidelines and will be held accountable to individual clinic policies (operating instructions) while providing services in primary care.

NOTE: Services you provide in primary care are consultative only and do not include initiating a formal course of treatment with patients. The PCM always remains in charge of a patient's health care.

The following guidance only summarizes and supplements material described in detail in the manual.

Documentation

- Document the chief complaint, presenting symptoms, assessment, provision of care, and plan only in the outpatient medical record (i.e., a separate mental health record is not required).
- Be aware that medical records are fairly open and accessible files that many individuals of various backgrounds may access. Therefore, limit your documentation in the record to information that is highly pertinent to the referral question and your recommendations. Omit superfluous details and irrelevant, sensitive information.
- We recommend that you keep all documentation in the medical record succinct and free of psychological jargon, so that other healthcare providers in primary care can easily understand your assessment and treatment recommendations.

Treatment Plans

You are not required to create comprehensive treatment plans for patients whose psychological and psychosocial symptoms you treat exclusively in primary care, as is required by the Health Services Inspection (HSI) or The Joint Commission in specialty mental health clinics. However, you should routinely document assessment information and recommendations in the medical record.

Assessments

- Individual providers/clinics will decide whether to use formal assessments for patients in primary care. However, we recommend that such assessments be brief, symptom- or functionally focused, and consistent with the culture of primary care. After you document the assessment results and interpretation in the Subjective, Objective, Assessment, Plan (SOAP) note, shred all assessment instruments.
- The nature of clinical practice in primary care demands a brief, symptom-focused assessment, devoting less time to a thorough assessment of potential historical contributors.
- BHCs are now recommended to screen for the presence of SI/HI at each patient contact. You should assess, adequately document, appropriately triage, and treat the patient, in compliance with AFI 44-109, when such symptoms are clinically suspected or present. This version of the BHOP Practice Manual contains recommendations for the assessment of risk by the BHC. Furthermore, to comply with HSI standards, you must assess for suicidality at each appointment with a patient who has been prescribed antidepressant medication.

Informed Consent

- The law governing informed consent for specialty mental health care usually defines mental health care as a series of psychotherapy contacts (individual, marital, group, or family), governed by a treatment plan, where the therapist is the primary provider. In primary behavioral health care, the mental health provider will provide consultation, triage, brief assessment, and intervention, and will not formally initiate a course of treatment (as legally defined). Thus, you are not required to have patients complete a separate Privacy Act/Informed Consent Document if you provide care exclusively in the primary care environment, including both individual services and psychoeducational classes.
- You are under the same reporting obligations as other primary care providers regarding confidentiality limits for active duty (AD) personnel, and the Privacy Act statement patients sign regarding provision of primary care services adequately covers this (see also AFI 44-102).
- Formal, written, informed consent procedures only apply in cases where a mental health provider is rendering specialty mental health treatment to a patient with a mental health diagnosis, *in a specialty mental health environment*. For example, if you see a patient in primary care that has depressive symptoms and refer them to a depression management group that occurs in the mental health clinic, the provider in the mental health clinic should give this patient appropriate informed consent for treatment in the mental health clinic.

Two distinguishing features determine whether informed consent is necessary:

1. Who provides the treatment, and

Informed consent is required if care is provided by a specialty mental health provider acting in a specialist non-BHC role.

2. Where the services are provided

If a specialty mental health clinic provides services (outpatient or inpatient mental health, ADAPT program), informed consent would be required. The same standard of care that applies to all patients in that clinic should be met, regardless of referral source.

Generally, we recommend delivering psychoeducational classes (life-skill building classes) outside the mental health clinic (preferably in primary care or other community/base locations). This will maximize participation, decrease stigma, and minimize paperwork (documentation would be required only in the medical record).

The classes offered in primary care should build skills and be psychoeducational, and you likely will have to develop new programs. ***Do not simply re-locate an existing depression-management group from the Outpatient Mental Health Clinic to the primary care clinic!*** Although you will see many patients in these primary care classes who meet diagnostic criteria for a mental disorder, such as depression, most existing depression-management group treatments have been developed for specialty care and not for managing depression in primary care. A new model of care for managing depression in primary care will be required.²

Treating Depression in Primary Care: A Manual for Primary Care and Mental Health Providers describes a cognitive behavioral intervention for depressed primary care patients. It's companion book, *Living Life Well: New Strategies for Hard Times*, was written for patients and contains many forms for patient use in behavior change efforts. *Living Life Well* can easily be used for primary care groups, as each chapter lends itself to a class meeting. Often, a primary care class is better attended when the BHC gives it a name other than a diagnosis (e.g., Life Satisfaction Class, Living Life Well Class, Quality of Life Class, Pain and Comfort Class, etc.).

- We expect all providers to inform patients of their degree (level of training), purpose of the visit, and potential dispositions. We encourage you to discuss the limits of confidentiality (refer to AFI 44-109 and AFI 44-102) with AD patients. The standard BHC information sheet adequately covers this.
- Pay special attention when there is clinical suspicion that discussion of a presenting problem may result in disclosure of information that requires you to act further (e.g., domestic violence; suicidal ideation/homicidal ideation; UCMJ violations). When patients disclose “reportable events,” you *must* act in accordance with the law and AF policies and procedures.

² Although no algorithm exists for determining which patients are optimally suited for depression management in primary care (versus specialty care), you must do so based on the symptom presentation, the patient's preference, and any history of prior treatments. Collecting data may help refine the criteria for making such determinations.

Appendix 8: Sample BHC Subjective, Objective, Assessment, Plan (SOAP) Notes and Ambulatory Data System (ADS) Coding

Sample 1: SOAP Note for Initial Encounter

S: 46 y/o female family member of ADAF E-8 referred by Dr. Jones for tension headaches seen for 30 minutes (25 minutes spent in counseling/coordination of care). Explained BHC role and gave pt BHC handout; pt expressed understanding. Frequency is most days of the week (more frequent the past month), duration is 5-6 hours, intensity usually 6/10. Analgesics give minimal relief. No other treatment modalities tried. The only consistent precipitant identified is disagreements with her husband or mother. Pt works full-time but has stayed home from work twice this month due to headaches. She has two children (9, 10 years old) and loses patience with them during headaches. She has 2 or 3 close friends but has started avoiding them because of increasingly depressed mood. Patient has stopped exercising during the last month. PCM given verbal feedback on consultation via voicemail.

O: Pt was pleasant and cooperative and displayed no pain behaviors. Ox4. Mood described as “okay.” Affect was mood congruent and appropriate. Thought processes were logical and linear. No SI/HI. PHQ-9=8 (mild depressive symptoms).

A: 784.0 Headache (Primary)
V62.81 Relational Problem NOS (Secondary)

P:

1. Recommend PCM ask about pt’s use and effectiveness of this plan, and encourage pt to increase social activity
2. Pt was taught Time-Out strategy to use when relationship conflicts escalate
3. Pt agreed to resume physical activity by walking 15 mins x 2/week
4. Follow-Up with BHC in 3-4 weeks

ADS Coding for Sample 1

Primary ICD 9 – CM Code:	784.0 (Headache)
Secondary ICD 9 – CM Code:	V62.81 (Relational Problem NOS)
Evaluation and Management Code:	99203 (Initial visit – 30 Minutes)
CPT Procedures Code:	None

Sample 2: SOAP Note for Initial Encounter

S: 26 y/o male ADAF E-6 referred by Dr Smith for increased stress seen for 30 minutes (30 minutes spent in counseling/care coordination). Explained BHC role and gave pt BHC handout; pt expressed understanding. He has been on Paxil in the past (2005) for 1 year, but no meds since. Pt believes stress began to increase six months ago and has gradually worsened. He PCS'd here 5 months ago and has no family or friends nearby. He had many friends at his last base. Pt reports increased irritability and verbal arguments with his spouse the past 3-4 months. Neither likes this duty location. Insomnia has been a problem the past month and he recently received a LOR for being late to work. He drinks 2-3 beers before bed to help with sleep; no recent alcohol-related incidents. Pt normally enjoys fishing, playing cards, dancing, but has not engaged in these since his PCS. He also stopped exercising a few months ago. PCM given feedback on consultation via copy of note left in their box.

O: Pt is cordial though somewhat guarded. Ox4. Mood is "frustrated," affect constricted. Thought processes were logical/linear. No SI/HI. PHQ-9=12 (moderate depressive symptoms).

A: 309.0 Adjustment disorder with depressed mood

P: 1. Recommendation for PCM: monitor depression sx w/ PHQ-9 each visit; reinforce any progress pt makes toward goals outlined above; assess alcohol use at each visit
2. Pt does not currently need antidepressant medication
3. Discussed how alcohol can affect sleep. Pt agrees to avoid evening use
4. Pt set goal of finding a co-worker who likes to fish (to potentially increase his activity level)
5. Pt to follow-up with BHC in 2 weeks

ADS Coding for Sample 2

Primary ICD 9-CM Code:	309.0 (Adjustment D/O w/ depressed mood)
Evaluation and Management Code:	99203 (Initial visit – 30 Minutes)
CPT Procedures Code:	None

Sample 3: SOAP Note for Initial Encounter

S: 20 y/o male ADAF E-2 referred by Dr Richards for possible depression seen for 30 minutes. Explained BHC role and gave pt BHC handout; pt expressed understanding. Pt reported sad mood, decreased sleep, irritability, frequent crying, lack of interest, poor concentration and decreased appetite; all with onset 3-4 weeks ago after breakup with girlfriend. No history of depression. He has not been able to find anything to improve his mood. Pt has decreased social interaction and no longer getting regular exercise. Has been more irritable at work and having difficulty accomplishing tasks. Supervisor has noticed reduced quality of work but not given official counseling statements. Patient reported SI 2-3 times daily, for no more than 10 minutes each time, since the breakup. No history of attempts. He has briefly thought of “ways people kill themselves,” but not for the purposes of choosing a method to kill himself. Thoughts are mostly related to wishing he didn’t have to feel “sad and lonely,” and wondering how ex-girlfriend would react to his death. Has only had thoughts of actual suicide “1-2 times” and easily dismissed them as not an option for him. Patient denied desire, intention or plans to kill himself and described the thoughts as “not like me.” He does not have access to means and has no sense of courage to attempt. No preparation or rehearsal. He frequently spends time alone, and thus has opportunity for an attempt. Barriers to self harm include religious prohibitions against suicide and the fact that he “couldn’t do that to my family.” Patient has access to social support here but has recently decreased his contact with them. Denied alcohol use. Unit perceived as supportive. Offered referral to MHC but patient declined stating he wanted to see if BHOP could help him. Patient agreed to exercise, listen to music and/or spend time with others when he has SI. Expressed understanding of how to access crisis services, and agreed to do so, if SI does not resolve or he has active SI. PCM given verbal feedback on consultation. 30 minutes spent in counseling and coordinating care.

O: Pt is cooperative. Ox4. Mood described as “I’m just here;” affect is flat. Motor movement appeared to be slow. Thought processes are logical/linear. Speech is somewhat slow and volume is soft. No HI. Pt having SI without planning, desire or intent. PHQ-9=14 (moderate depressive symptoms).

A: 309.0 Adjustment disorder with depressed mood
Risk Assessment: Mild. Patient appropriate for management in primary care.

P:

1. Recommendation for PCM: assess SI at each visit; monitor depression sx w/ PHQ-9 each visit; reinforce any progress pt makes toward goals outlined above
2. Pt does not currently need antidepressant medication
3. Discussed behavioral activation for depression.
4. Pt set goal of resuming regular exercise and spending more time with friends regardless of motivation/mood
5. Pt agreed to crisis response plan as described above.
6. Pt to follow-up with BHC in 1 week
7. BHC to make phone contact for status check on Friday.

ADS Coding for Sample 3

Primary ICD 9-CM Code:	309.0 (Adjustment D/O w/ depressed mood)
Evaluation and Management Code:	99203 (Initial visit – 30 Minutes)
CPT Procedures Code:	None

Sample 4: SOAP Note for Follow-up BHC Encounter

S: 30 minute follow-up for tension headaches; referred by Dr. Jones. She tried Time-Out during a recent conflict with her mother and thinks it helped. They were able later to talk calmly about their recent problems and pt has noticed a subsequent decrease in headache frequency (3 days last week). Pt did not do any of the planned walking, as she didn't feel she had time.

O: Pt was pleasant, smiled/joked often, and displayed no pain behaviors. O_x4. Mood described as "better." Affect was mood congruent and appropriate. Thought processes were logical and linear. No SI/HI. PHQ-9=4 (minimal depressive symptoms).

A: 784.0 Headache (Primary)
V62.81 Relational Problem NOS (Secondary)

P:

1. Recommend PCM reinforce changes and encourage increased social and physical activity
2. Pt plans to continue Time-Out and will try it w/ her husband and kids, as well
3. Pt does want to resume exercise, so we reset the goal to walking x 1/week for 10 minutes, which pt felt was more realistic. Increase as able.
4. No follow-up with BHC planned at this time. PCM may refer again in the future as appropriate.

ADS Coding for Sample 4

Primary ICD 9-CM Code:	784.0 (Headache)
Secondary ICD 9-CM Code:	V 62.81 (Relational Problem NOS)
Evaluation and Management Code:	99499 ("dummy" code)
CPT Procedures Code:	96152 Health and Behavior Intervention (2 units)

Sample 5: SOAP Note for Follow-Up BHC Encounter

S: Follow-up from 2 weeks ago with patient referred by Dr. Smith for stress, irritability, and insomnia. 30 minute appointment (25 minutes spent in counseling/care coordination). He has avoided evening alcohol use 2-3 nights per week and noticed improved sleep on nights he abstained. He did meet a co-worker who likes to fish but he's not certain he likes the co-worker. However, he has been to the gym x 3 in the past week and wants to focus on increasing this. He notices he is more patient with others the past two weeks.

O: O_x4. Pt is more talkative today, mood is "fine" and affect full. Thought processes are logical/linear. No SI/HI. PHQ-9=7 (mild depressive symptoms)

A: 309.0 Adjustment disorder with depressed mood

P: 1. Recommendation for PCM: monitor depression sx w/ PHQ-9 each visit; encourage pt to increase his social and recreational activities; assess alcohol use at each visit
2. Pt to continue to decrease evening alcohol use and continue increased physical activity
3. Pt to follow-up with BHC in 3 weeks

ADS Coding for Sample 5

Primary ICD 9-CM Code: 309.0 (Adjustment D/O w/ depressed mood)

Evaluation and Management Code: 99214 (Outpatient visit/ Established patient)

CPT Procedures Code: None

Sample 6: SOAP Note for Follow-Up BHC Encounter

S: 30-minute follow-up with 20 y/o male ADAF E-2 referred by Dr Richards for possible depression. Last seen 1 week ago. No change in concentration or appetite. Patient engaged in exercise 3 days and spent more time with friends since last contact; found he felt less sad and had more energy during and afterwards. Sleep has improved some but not back to normal. Pt has been crying and thinking about ex-girlfriend less. Unsure if duty performance has improved but noted that supervisor has not talked to him about this issue again. Has had SI only once since last contact. Followed crisis response plan as agreed and found that thoughts were dismissed quicker. No active SI or related planning, intent or desire since last contact. No preparation, rehearsal or courage to attempt. Patient expressed continued commitment to crisis response plan. Was offered referral to MHC but declined stating “I think I am starting to feel better.” Barriers to self-harm remain in place. Discussed further behavioral activation. Patient agreed to increase exercise to 4 days per week. He agreed to go by community center and inquire about guitar lessons that he and a friend want to take together. Has plans to spend the weekend with friends. 30 minutes spent in counseling and coordination of care.

O: Pt is cooperative. Ox4. Mood described as “feeling okay today;” affect is flat. Thought processes are logical/linear. Speech is still slow but volume is normal. Motor movement appeared to be WNL. No HI. Pt having SI without planning, desire or intent. PHQ-9=13 (moderate depressive symptoms).

A: 309.0 Adjustment disorder with depressed mood
Risk Assessment: Mild. Patient appropriate for management in primary care.

P:

1. Recommendation for PCM: assess SI at each visit; monitor depression sx w/ PHQ-9 each visit; reinforce any progress pt makes toward goals outlined above
2. Pt does not currently need antidepressant medication
3. Pt set goal of increasing exercise and inquiring about guitar lessons
4. Pt expressed continued commitment to crisis response plan
5. Pt to follow-up with BHC in 1 week

ADS Coding for Sample 6

Primary ICD 9-CM Code:	309.0 (Adjustment D/O w/ depressed mood)
Evaluation and Management Code:	99214 (Outpatient visit/Established patient)
CPT Procedures Code:	None

Appendix 9: Sample AHLTA Template

SOAP Note for Initial Encounter

Initial Eval

S: Pt is a y/o male / female AD member/ family member / retiree referred by Dr. for . The BHC handout was given to the patient by the PCM/BHC. BHC explained role and pt acknowledged understanding. Pt was seen for 30 minute appointment with 25 minutes spent in counseling/care coordination. Pt reported as the primary concern to be addressed today. Feedback provided to referring PCM.

During appt, pt discussed

Problem Definition:

Frequency:

Duration:

Better (Factors that improve symptoms):

Worse (Factors that exacerbate symptoms):

Functional Impact

Physical Activity:

Pleasurable/Valued Activity:

Work performance:

Marital/Reltnshp Satisfaction:

SLEEP:

TIB: SOL: Frequency & duration of awakenings: Wake up time: Time gets out of bed:

Naps: Change in sleep schedule on weekends:

INTEREST:

ENERGY:

CONCENTRATION:

APPETITE:

Caffeine:

ETOH:

Tobacco:

O: MSE:

Orientation: X4

Attention: good **Appearance:** well-kempt **Speech:** normal rate/rhythm

Eye Contact: Pt maintained good eye contact throughout entire appt.

Thought Content and Process: WNL, no A/V/T hallucinations, linear, goal-directed

Mood:

Affect: congruent

SI:

Psychomotor Activity: WNL

A: Axis I: See Above

Pt was given a BHC educational handout on:

P: Recommendations to PCM:

- 1.
- 2.
- 3.

Recommendations to Patient:

- 1.
- 2.
- 3.

BHC will:

- 1.
- 2.

Follow-Up Plan:

-No follow-up with BHC required.

-Pt will follow up in 4 weeks with BHC to address behavioral changes.

-At next appt,

SOAP Note for Follow-Up Encounter

S: Pt is a y/o male / female AD member/ family member / retiree referred by Dr. for . Pt last seen on . Pt seen today for 30 minutes with 25 minutes spent in counseling and coordination of care. Pt reported adherence to the following tx recommendations:

During appt, discussed:

SLEEP:

INTEREST:

ENERGY:

CONCENTRATION:

APPETITE:

Functional Impact:

Physical Activity:

Pleasurable/Valued Activity:

Work performance:

Marital/Relationship Satisfaction:

O: MSE:

Orientation: **X4**

Attention: good **Appearance:** well-kept **Speech:** normal rate/rhythm

Thought Content and Process: WNL, no A/V/T hallucinations, linear, goal-directed

Mood:

Affect: congruent with reported mood

SI:

A: Axis I: See Above

Pt educated

P: Recommendations to Pt:

Pt was given a BHC educational handout on:

P: Recommendations to PCM:

- 1.
- 2.
- 3.

Recommendations to Patient:

- 1.
- 2.
- 3.

BHC will:

- 1.
- 2.

Follow-Up Plan:

-No follow-up with BHC required.

-Pt will follow up in 4 weeks with BHC to address behavioral changes.

-At next appt,

Appendix 10: Ambulatory Data System (ADS) BHC Coding Guidelines

Application of General Coding Rules

Mental health providers in the AFMS should already be familiar with general mental health coding guidance. The information contained in this appendix will highlight and summarize only the coding guidance specific to services provided as a Behavioral Health Consultant (BHC). General coding guidance is available in a separate publication, *Mental Health Coding Handbook: Guidance on Air Force Coding Standards, Version 2.0* (Air Force Medical Operations Agency, 2010). The *Coding Handbook* also contains a section specific to coding BHC appointments. BHCs should review the *Coding Handbook* for topics such as:

- Understanding Evaluation and Management (E&M) and Procedure (CPT) codes
- Coding primary and secondary diagnoses
- Using military-unique codes
- When (and when not) to code “No Diagnosis”
- Using modifiers
- Coding units of service
- Coding telephone calls

The following sections describe recommended coding for BHC patient encounters (new and established patient visits), as well as coding for other (non-patient contact) activities. Other mental health codes (e.g., psychotherapy codes) can be used when appropriate; however, documentation must support the alternate coding. NOTE: These are guidelines that cannot capture every imaginable scenario. As you attempt to apply these guidelines to specific encounters, remember the most basic rule of coding: *Code based on what you do and ensure documentation supports the code.*

Coding for BHC Patient Encounters

Initial Encounter

Initial BHC visits should typically be coded using the E&M Outpatient Visit/New Patient series (99201-99205). No CPT code is used when an E&M code is used. Note that when a time-based E&M code is used, the note must include the total appointment time as well as the amount of time spent in counseling and coordination of care. The following summarizes the relevant codes:

E&M CODE	DESCRIPTION: OUTPATIENT ENCOUNTER/NEW PT	TIME
99201	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • A problem focused history; • A problem focused examination; • Straightforward medical decision making. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.</p>	10 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99202	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:</p> <ul style="list-style-type: none"> • An expanded problem-focused history; • An expanded problem-focused examination; • Straightforward medical decision-making. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are low to moderate severity.</p>	20 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99203	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:</p> <ul style="list-style-type: none"> • A detailed history; • A detailed examination; • Medical decision making of low complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.</p>	30 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99204	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • A comprehensive history; • A comprehensive examination; • Medical decision making of moderate complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. <u>This code would not typically be used by the BHC.</u></p>	45 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99205	<p>Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:</p> <ul style="list-style-type: none"> • A comprehensive history; 	60 minutes face-to-face with patient

	<ul style="list-style-type: none"> • A comprehensive examination; • Medical decision making of high complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. <u>This code would not typically be used by the BHC.</u></p>	<p>and/or family. Note must include required information for time-based codes.</p>
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90801 is the CPT code used for full psychiatric evaluations in the mental health clinic. It is typically not appropriate for BHC initial visits because the complexity and detail required in the assessment and documentation are beyond the scope of BHOP. However, there may be rare occasions in which the BHC performs a full psychiatric evaluation and this code is appropriate under that circumstance. E&M 99499 is used with CPT 90801.

CPT CODE	DESCRIPTION: INITIAL EVALUATION	TIME
90801	<p><u>This code would not typically be used by the BHC.</u> It would be used if the presenting problem is purely psychiatric in nature and a <u>full diagnostic interview</u> (i.e., comparable to what would be accomplished in the mental health clinic) is performed.</p>	Unspecified

Follow-up Encounter: Psychiatric Condition

BHC follow-up visits for patients with psychiatric/mental health conditions or problems will be coded in the Outpatient Visit/Established Patient code series (E&M 99212-99215). No CPT code is used. Note that when a time-based E&M code is used, the note must include the total appointment time as well as the amount of time spent in counseling and coordination of care. The following table summarizes these codes:

E&M CODE	DESCRIPTION: OUTPATIENT ENCOUNTER/ESTABLISHED PT	TIME
99212	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • A problem-focused history; • A problem-focused examination; • Straightforward medical decision making. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.</p>	10 minutes face-to-face with the patient and/or family. Note must include required information for time-based codes.
99213	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:</p> <ul style="list-style-type: none"> • An expanded problem-focused history; • An expanded problem-focused examination; • Medical decision making of low complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are low to moderate severity.</p>	15 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99214	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components:</p> <ul style="list-style-type: none"> • A detailed problem-focused history; • A detailed problem-focused examination; • Medical decision making of moderate complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity.</p>	25 minutes face-to-face with patient and/or family. Note must include required information for time-based codes.
99215	<p>Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:</p> <ul style="list-style-type: none"> • A comprehensive history; • A comprehensive examination; • Medical decision making of high complexity. <p>Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. <u>This code would not typically be used by the BHC.</u></p>	40 minutes face-to-face with the patient and/or family. Note must include required information for time-based codes.

Follow-up Encounter: Medical Condition

Another option for coding follow-up BHC visits is to use the Health and Behavior Intervention CPT series (CPT 96152-96155). **Note: The E&M “dummy code” 99499 should be used in conjunction with the CPT code.** The Health and Behavior codes may *only* be used when the primary diagnosis is a *medical* condition or symptom (not a *psychiatric* condition or symptom). These codes capture a wide array of intervention with physical health issues, such as adherence to medical treatment, symptom management, health promoting behaviors, health related risk-taking behaviors, and overall adjustment to physical illness. In almost all of these cases, the physician will have diagnosed the physical health condition. The following table summarizes the Health and Behavior CPT code requirements:

CPT CODE	DESCRIPTION: HEALTH AND BEHAVIOR INTERVENTION	TIME
96152	The intervention service <i>provided to an individual</i> to modify the psychological, behavioral, cognitive, and social factors affecting the patient’s physical health and well-being. Examples include increasing awareness about his/her disease and using behavioral approaches to initiate physician prescribed diet/exercise programs.	One unit per 15 minutes
96153	The intervention service <i>provided to a group</i> . An example is a smoking cessation program that includes educational information, cognitive behavioral treatment, and social support.	One unit per 15 minutes
96154	The intervention service <i>provided to a family with the patient present</i> . For example, a psychologist could use relaxation techniques with both a diabetic child and his/her parents to reduce the child’s fear of receiving injections and the parent’s tension when administering the injections.	One unit per 15 minutes
96155	The intervention service <i>provided to a family without the patient present</i> . An example would be working with parents and siblings to shape the diabetic child’s behavior such as praising successful diabetic management behaviors and ignoring disruptive tactics.	One unit per 15 minutes

Follow-up Encounter: Biofeedback Services

A final option for coding BHC follow-up visits occurs when biofeedback interventions are used with established patients. Biofeedback requires specialized training and involves both assessment and treatment using biofeedback equipment. It may or may not include a psychosocial intervention. In the primary care setting, biofeedback interventions are brief in nature and are coded E&M 99499 (“dummy code”) and CPT 90901 without behavior modification strategies or CPT 90875 with behavior modification strategies (e.g. relaxation training).

CPT CODE	DESCRIPTION: BIOFEEDBACK ENCOUNTER/ESTABLISHED PT	TIME
90901	Biofeedback training using any modality	Unspecified
90875	Individual psychophysiological intervention incorporating biofeedback training by any modality (face-to-face with the patient) with a psychosocial intervention (e.g., insight oriented, behavior modifying or supportive intervention).	20 to 30 minutes

Shared Medical Appointments (SMA)

Shared Medical Appointments (SMAs; sometimes referred to as Drop-In Group Medical Appointments or DiGMAs) involve an individual encounter with a patient in a multiple patient format (group setting). The patient's individual needs are addressed in a group setting with the availability of a secluded individual appointment if necessary. The medical diagnosis of group members is diverse and can include diabetes, chronic pain, and hypertension to name a few. The focus is on biopsychosocial factors that are or could affect treatment of, or severity of, the patient's physical condition. The goal is to modify the psychological, mental, emotional, cognitive, and social factors that are identified directly affecting the patient's physiological functioning, disease status, health, and general well-being. These visits use the CPT Health and Behavior Intervention Codes. Coded E&M 99499 ("dummy code") and CPT 96153-one unit per 15 minutes.

Telephone Contacts by Credentialed Providers (calls must be initiated by the patient)

Telephone services are non-face-to-face evaluation and management (E&M) services provided to a patient using the telephone. These codes are used to report episodes of care by the provider initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment, the code is not reported and is considered part of the pre-service work of the subsequent E&M service, procedure, or visit. In addition, if the telephone call refers to a service performed and reported by the provider within the previous seven days, then the service is considered part of that previous E&M service or procedure.

E&M CODE	DESCRIPTION: TELEPHONE CONTACT (CREDENTIALLED PROVIDER)	TIME
99441	Telephone evaluation and management service provided by a credentialed provider to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.	5-10 minutes. Note must include amount of time spent with patient for time-based

		codes.
99442	Telephone evaluation and management service provided by a credentialed provider to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.	11-20 minutes. Note must include amount of time spent with patient for time-based codes.
99443	Telephone evaluation and management service provided by a credentialed provider to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment.	21-30 minutes Note must include amount of time spent with patient for time-based codes.

Telephone Contacts by Non-Credentialed Providers (calls must be initiated by the patient)

Non-credentialed providers (i.e. psychology residents and other BHCs not privileged for independent practice) should use the following CPT codes for telephone services. The 99499 “dummy” E&M code would be used.

CPT CODE	DESCRIPTION: TELEPHONE CONTACT (NON-CREDENTIALLED PROVIDER)	TIME
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment.	5-10 minut Note must include amount of time spent with patient for time-based codes.es.
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment.	11-20 minutes. Note must include amount of time spent with patient for time-based

		codes.
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment.	21-30 minutes. Note must include amount of time spent with patient for time-based codes.

Examples

New Patient

A PCM requests an initial visit for a 45-year-old female family member with panic-like symptoms. The patient is seen for a problem-focused assessment and targeted intervention of 30 minutes. This encounter includes an expanded problem focused history and exam and straightforward medical decision making. *This scenario is coded E&M 99203 (No CPT code is used).*

Established Patient –Psychiatric Diagnosis/Symptom

A 24-year-old active duty member is seen for a 30-minute face-to-face second visit to reinforce anxiety-management strategies taught to her on the first visit (e.g. relaxation and goal setting for increased exercise). Her primary diagnosis is Adjustment Disorder with Anxiety (ICD 309.24). *This visit is coded E&M 99214 (No CPT code is used).*

Established Patient –Medical Diagnosis

A 59-year-old male is seen for a 30-minute face-to-face third visit to teach and reinforce behavioral strategies for managing his weight. Intervention focuses on goal setting for increased exercise. His primary diagnosis is Obesity (ICD 278.00). *This visit is coded E&M 99499 (“dummy code”) with CPT 96152 (2 units).*

Established Patient – Biofeedback Encounter

A 47-year-old active duty pilot is referred for consultation for non-pharmacological strategies for managing hypertension. Relaxation is identified as a skill and a 30-minute biofeedback-assisted relaxation session is conducted. *This scenario is coded E&M 99499 (“dummy code”) and CPT 90875.*

Established Patient – Psychoeducational Class

A 60-minute psychoeducational class for patients with chronic pain conditions is provided. Primary diagnoses for patients are medical, such as Arthritis (ICD 715.90), Backache (ICD 724.5), or Fibromyalgia (ICD 729.1). *Each visit is coded E&M 99499 (“dummy code”) and CPT 96153-4 units.*

Established Patient – Shared Medical Appointment (SMA)

Ten patients are seen for a 90-minute SMA by both a PCM and a mental health provider. The patients have some or all of the following diagnoses: diabetes, chronic pain, hypertension, and dyslipidemia. Each person’s needs are addressed in the group. This session has a common theme of goal setting and sticking with lifestyle changes. The psychologist then talks for 30 minutes on the aspects of goal setting (e.g. setting reasonable goals and relapse prevention strategies). *This scenario is coded E&M 99499 (“dummy code”) and CPT 96153-6 units. Note: In SMAs, both the mental health provider and physical medicine provider document their encounter and code separately for each patient.*

Coding for Other (Non-Patient Contact) Activities

Environmental Intervention: Commander, First Sergeant, Supervisor

This intervention is usually to discuss job limitations and/or environmental changes that could help the patient in managing their mental health condition (e.g. shift changes). Topics discussed may include duty restriction, a safety concern, or other patient concern. It is also common for this intervention to occur following an inpatient hospitalization. Ideally, these conversations would be face-to-face but can be accomplished by phone. This code would be used for telephone consultations in which a true environmental intervention or change is discussed. Otherwise code as a telephone contact. Coded E&M 99499 (“dummy code”) and CPT 90882.

Interpretation and/or Explanation of Results with Family Members or Advising them on How to Assist Patient

This involvement of others (family members and/or other responsible persons) in the intervention process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient). Coded E&M 99499 (“dummy code”) and CPT 90887.

Medical Team Conferences

These medical conferences include an interdisciplinary team of health professionals or representatives of community agencies meeting to coordinate activities of patient care (patient not present). These conferences can last 30-60 minutes. Coded E&M 99366 (face-to-face, 30 min or more, non-physician), 99367 (not face-to-face, 30 min or more, physician) or 99368 (not face-to-face, 30 min or more, non-physician) with no CPT code. Each provider codes this encounter separately, but must document in separate notes (in S-O-A-P format) the nature of their work during this medical team conference.

ICD 9 Code	ICD 9-CM Diagnoses (Text)	Category
293.89	Anxiety disorder due to general medical condition	DSM-IV AXIS I CLINICAL DISORDERS
296.20	Major depressive disorder, single episode, unspecified degree	
296.30	Major depressive disorder, recurrent, unspecified degree	
300.00	Anxiety disorder not otherwise specified	
300.01	Panic disorder without agoraphobia	
300.02	Generalized anxiety disorder	
300.23	Social phobia	
300.29	Specific phobia	
300.3	Obsessive-compulsive disorder	
300.4	Dysthymic disorder	
300.81	Somatization disorder	
303.90	Alcohol dependence, unspecified	
305.00	Alcohol abuse, unspecified	
305.10	Nicotine dependence, unspecified	
307.42	Primary insomnia	
307.44	Primary hypersomnia	
307.89	Pain disorder w/psychological factors and general medical condition	
308.3	Acute stress disorder	
309.0	Adjustment disorder with depressed mood	
309.24	Adjustment disorder with anxiety	
309.28	Adjustment disorder with mixed anxiety depressed mood	
311	Depressive disorder not otherwise specified	OTHER CONDITIONS OF CLINICAL ATTENTION (DSM-IV V CODES)
316	Psychological factors affecting medical condition	
V15.81	Noncompliance with medical treatment	
V61.0	Family disruption	
V61.10	Marital problems, unspecified	
V61.20	Parent-child problems, unspecified	
V62.2	Occupational problem	
V62.4	Social maladjustment	
V62.81	Other psychological or physical stress, not elsewhere classified	
V62.82	Bereavement	
V62.89	Other (phase of life problem/life circumstances problem)	
V65.42	Counseling on substance use and abuse	
V68.9	Encounters for administrative purposes, unspecified	
V69.0	Problems related to lifestyle, lack of physical exercise	
V69.1	Inappropriate diet and eating habits	
V69.2	High risk sexual behavior	
V69.9	Problems related to lifestyle, unspecified	
715.90	Arthritis, site unspecified	
724.5	Backache, unspecified	
784.0	Headache	
401.9	Essential hypertension, unspecified	
564.1	Irritable bowel syndrome	
278.00	Obesity, unspecified	
729.1	Fibromyalgia, NOS	
ICD 9 Code	ICD 9-CM Diagnoses (Text)	Category

ICD 9 Code	ICD 9-CM Diagnoses (Text)	Category
780.50	Sleep disturbance, unspecified	PRESENTING COMPLAINT OR SYMPTOM
780.79	Other malaise & fatigue	
784.0	Headache	
799.2	Nervousness	
780.4	Dizziness & giddiness	
783.0	Anorexia	
783.1	Abnormal weight gain	
783.21	Abnormal weight loss	
785.1	Palpitations	
786.01	Hyperventilation	
786.50	Chest pain, unspecified	
787.01	Nausea with vomiting	
787.02	Nausea alone	
787.1	Heartburn	
789.00	Abdominal pain, unspecified site	

E & M Code	Evaluation and Management
<i>Note: When using E&M codes, no CPT code is used</i>	
99201	Office or other outpatient visit (new patient) - 10 minutes
99202	Office or other outpatient visit (new patient) - 20 minutes
99203	Office or other outpatient visit (new patient) - 30 minutes
99204	Office or other outpatient visit (new patient) - 45 minutes
99205	Office or other outpatient visit (new patient) - 60 minutes
99212	Office or other outpatient visit (established patient) - 10 minutes
99213	Office or other outpatient visit (established patient) - 15 minutes
99214	Office or other outpatient visit (established patient) - 25 minutes
99215	Office or other outpatient visit (established patient) - 40 minutes
99366	Medical team conference, face-to-face, patient not present, non-physician, 30 minutes or more
99367	Medical team conference, not face-to-face, patient not present, physician, 30 minutes or more
99368	Medical team conference, not face-to-face, patient not present, non-physician, 30 min or more
99441	Telephone call - 5-10 minutes (credentialed provider)
99442	Telephone call – 11-20 minutes (credentialed provider)
99443	Telephone call – 21-30 minutes (credentialed provider)
99499	“Dummy code” used when CPT code is used

CPT Code	CPT Procedures
<i>Note: When using CPT codes, the E&M “dummy code” 99499 also should be used</i>	
90801	Comprehensive evaluation comparable to what is provided in the mental health clinic
90875	Individual psychophysiological treatment incorporating biofeedback and a psychosocial intervention, 20 to 30 minutes
90882	Environmental intervention: Commander, First Sergeant, supervisor
90887	Interpretation of results with family members; or How to assist patient (patient not present)
90901	Biofeedback training, any modality
96152	Health and behavior intervention, Established patient, One unit per 15 minutes
96153	Health and behavior intervention, Group visit, One unit per 15 minutes
96154	Health and behavior intervention, Patient and family present, One unit per 15 minutes
96155	Health and behavior intervention, Family (but not patient) present, One unit per 15 minutes
98966	Telephone call – 5-10 minutes (non-credentialed provider)
98967	Telephone call – 11-20 minutes (non-credentialed provider)
98968	Telephone call – 21-30 minutes (non-credentialed provider)

**Appendix 11:
Handout for the Primary Care Staff**

Roles and Responsibilities of the BHC

Behavioral health consultation (BHC) services support PCMs and improve the effectiveness of the health care provided by PCMs by using a team approach and addressing the entire range of the patient's presenting problems.

What is Expected of the BHC Practicing in the Primary Care Clinic

- At the PCM's request, they consult with patients in brief appointments (typically 30 minutes) and assist the PCM with assessment and co-management of target problems.
- BHC services are provided directly in the primary care clinic.
- They conduct assessments and brief, focused interventions, gearing their services toward early identification, triage, quick resolution, and long-term wellness.
- They encourage PCMs to refer any patient who may have biopsychosocial or behavioral difficulties, or factors affecting their health or functioning.
- They provide timely and succinct feedback to PCMs about all referred patients.
- They can address a wide range of health and behavioral health complaints, and engage in health promotion.
- When not in the primary care clinic, BHCs are readily available to the PCM by phone or beeper during usual duty hours. Although BHCs may not always be able to respond in person due to other duties, phone consultation, at a minimum, will be readily provided.
- They document findings and recommendations in the outpatient medical record only, not in a separate mental health record.

What the Primary Care Clinic and Staff Are Expected to Provide the BHC Practicing On-site

- They should include the BHC as a member and provider on the healthcare team.
- They should make available office space suitable for the BHC to see patients.
- They should provide the usual administrative and computer support given to providers (appointment booking, CHCS, pulling medical records, a computer terminal for AHLTA documentation, etc.)

PCMs always maintain ownership of their patient's health care plan, even when referred to the BHC.

**Appendix 12:
Patient Satisfaction and Provider
Satisfaction Questionnaires
Recommended for BHC Service
Evaluations**



**ANONYMOUS PROVIDER SATISFACTION SURVEY
FOR BEHAVIORAL HEALTH CONSULTANT (BHC) SERVICES**

**Please complete this survey, enclose it in the attached envelope, and mail to:
AFMOA/SGHW ATTN: Maj Robert Vanecek
2261 Hughes Ave, Ste 153
Lackland AFB, TX 78236**

1. How long have you been working in this clinic? _____ Months
2. How much have you referred patients to or consulted with the behavioral health consultant (BHC)?
- Not at All Very Little Some Quite A Bit A Lot

**IF YOU HAVE NOT USED THE BEHAVIORAL HEALTH CONSULTANT AT ALL,
STOP HERE, BUT STILL MAIL IN YOUR SURVEY.**

3. On average, how long does it take YOU to access the BHC?
- Same Day 1 Day 2-3 Days 4-7 Days 8-14 Days 15 Days or More
4. On average, how long does it take the PATIENTS you refer to access the BHC?
- Same Day 1 Day 2-3 Days 4-7 Days 8-14 Days 15 Days or More
5. How would you rate your satisfaction with YOUR access to the BHC?
- Poor Fair Neutral Good Very Good Excellent
6. How would you rate your satisfaction with your PATIENTS' access to the BHC?
- Poor Fair Neutral Good Very Good Excellent
7. Does the BHC provide the kinds of services you want for your patients?
- No, definitely not No, not really Neutral Yes, generally Yes, definitely
8. In your perception, how helpful is the BHC for your patients?
- Poor Fair Neutral Good Very Good Excellent

SURVEY CONTINUED ON REVERSE SIDE

9. Thinking about your interactions with the BHC, how would you rate the helpfulness of the BHC to you?

Poor Fair Neutral Good Very Good Excellent

10. How would you rate the timeliness of the BHC's clinical input?

Poor Fair Neutral Good Very Good Excellent

11. How would you rate the quality of the services the BHC provides?

Poor Fair Neutral Good Very Good Excellent

12. To what extent does having a BHC in the clinic meet your needs?

None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all of my needs have been met	All of my needs have been met
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13. To what extent does having a BHC in the clinic meet your clinic's needs?

None of the needs have been met	Only a few of the needs have been met	Most of the needs have been met	Almost all of the needs have been met	All of the needs have been met
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14. All things considered, how satisfied are you with having BHC services in your clinic?

Completely Dissatisfied	Very Dissatisfied	Somewhat Dissatisfied	Neither Dissatisfied Nor Satisfied	Somewhat Satisfied	Very Satisfied	Completely Satisfied
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15. Would you recommend other PCMs use a BHC for their patients?

Definitely Not Probably Not Neutral Probably Yes Definitely Yes

16. Do you think having a BHC in your clinic has improved recognition or treatment of the behavioral components of both physical and mental health problems?

Not at All A Little Bit Somewhat Quite a Bit A Lot

17. What is/are the most important and useful aspects of behavioral health consultant services?

18. Is there anything you think might improve the provision of behavioral health services in your clinic?



**ANONYMOUS PATIENT SATISFACTION SURVEY FOR
BEHAVIORAL HEALTH CONSULTANT SERVICES**

Please complete this survey following your visit with the Behavioral Health Consultant. Put the survey in the attached envelope and give it to someone at the front desk or place it in the mail.

1. Thinking about your visit today, how would you rate the behavioral health consultant (BHC) on each of the following:

a) Amount of time you had with the BHC during your visit? (circle one)

Poor Fair Neutral Good Very Good Excellent

b) How much you were helped by the care you received from the BHC? (circle one)

Poor Fair Neutral Good Very Good Excellent

c) How well the care met your needs? (circle one)

Poor Fair Neutral Good Very Good Excellent

d) Overall quality of care you received? (circle one)

Poor Fair Neutral Good Very Good Excellent

2. Would you recommend BHC services to your family or friends? (circle one)

Definitely Not Probably Not Probably Yes Definitely Yes

3. All things considered, how satisfied are you with the care you received from the BHC during this visit? (circle one)

Completely Very Somewhat Neither Somewhat Very Completely
Dissatisfied Dissatisfied Dissatisfied Dissatisfied Satisfied Satisfied Satisfied
Nor Satisfied

4. Did the BHC discuss options for different kinds of behavioral health care with you? (circle one)

Not at All Minimally Sufficiently Very Much Completely

5. Did the BHC involve you in making decisions about your specific behavioral health care plan? (circle one)

Not at All Minimally Sufficiently Very Much Completely

6. In general, would you say your health is: (circle one)

Excellent Very Good Good Fair Poor

7. How many times have you seen the BHC for your current concern? _____ Times

**Appendix 13:
Primary Care Behavioral Health Consultant,
Peer Records Review**

Primary Care Behavioral Health Consultant, Peer Records Review

Date: _____ Peer Reviewed By: _____

Provider Reviewed: _____ Provider Code: _____

____ Note for Initial Contact with Patient

	YES	NO	N/A
1. Is the name of the referring PCM and the referral question and/or chief complaint documented?			
2. Is a statement of assessment findings documented (life stresses, symptoms of mental disorder, relevant psychosocial issues)?			
3. Are functional symptoms and/or a diagnosis, if there is evidence to support one, documented (clinical impressions)?			
4. Is there a statement of recommended interventions and who is to execute them?			
5. Is there a statement of the follow-up plan (e.g., patient returned to care of PCM, no further consultation planned, patient will return in two weeks for consultative follow up)?			
6. Is there an appropriate SI/risk screening/assessment?			

Note for Follow-up Contact with Patient

	YES	NO	N/A
1. Is there a statement that provides the name of the referring PCM and that the visit was a follow-up?			
2. Is the patient's compliance with and response to interventions initiated by the consultant and/or PCM documented?			
3. Is any recommendation regarding continuing, modifying, or stopping intervention strategies documented?			
4. Is there a statement about who is responsible for executing follow-on intervention strategies?			
5. Is there a statement regarding the follow-up plan?			
6. If patient seen beyond 4 appointments, is a rationale for "continuity consultation" provided?			
7. Is there an appropriate SI/risk screening/assessment?			

ENCOUNTER MEETS STANDARD OF CARE: YES NO

Comments: _____

Appendix 14: Recommended Self-Audit for Primary Behavioral Health Care Services

Recommended Use

We recommend you use this self-audit tool within three months of starting your BHC service. You can also complete this audit in collaboration with your BHC mentor.

If any domain is rated a 3 or less at the initial self-audit, we strongly encourage you consult with a BHC mentor on those specific parameters. We also recommend re-audits as often as quarterly in start-up months, and if you are being trained and integrated into an existing BHC service. Once your service is well established, annual audits should be sufficient. However, this form should not replace systematic monitoring of the BHC service itself, to guide modifications in program delivery and ensure fidelity to the model (e.g., average number of sessions per patient, referrals to specialty care, etc.).

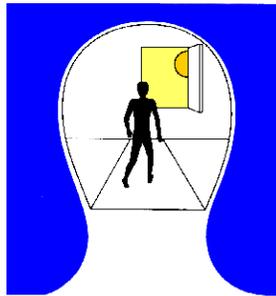
Domain	Rating (1= Poor; 4= Adequate; 7= Superior)						
	1	2	3	4	5	6	7
1. The BHC is a privileged provider who has received training and adequately demonstrated core competencies.							
2. Routine peer review is conducted on BHC records.							
3. The BHC is functioning only in a consultant role; PCMs always remain in charge of patient health care.							
4. The BHC ensures all patients receive the standard BHC service information sheet.							
5. The BHC adheres to the standard introductory script components, including their training, limits of care, and reporting obligations.							
6. The BHC does not manage patients that are at moderate or greater risk for suicide (except for initial triage).							
7. The BHC practices within their scope of service (i.e., no Command Directed Evaluations, long-term psychotherapy, or intensive psychological assessments).							
8. The BHC documents, in SOAP-note format, in patient medical records only (no separate record).							
9. The BHC documents recommended interventions, provides feedback to PCM, and documents follow-up plans.							
10. The BHC routinely sees patients in 15- to 30-minute visits.							
11. Most patients seen for 4 or fewer appointments.							

**Appendix 15:
Sample BHC Service Poster**

Opening the Door to a Healthier YOU

FACTS

- Symptoms of depression and anxiety are one of the most common problems among primary primary care patients
- Appropriate treatment improves daily functioning, overall health, and makes physical symptoms more bearable
- The majority of depressed patients in primary care respond to initial treatment



QUESTIONS

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2. During the past month, have you often been bothered by having little interest or pleasure in doing things?

If you answered YES to either of these questions talk with your provider

HELP is available TODAY in THIS CLINIC from a Behavioral Health Consultant!

From: Managing Depression in Medical Outpatients, The New England Journal of Medicine, 2000; 343:1942-1949

Appendix 16: Referral Barriers Questionnaire

Appendix 17: Behavioral Health Consultant Mentor Job Description

Duties and Responsibilities

A Behavioral Health Consultant Mentor (BHCM) provides clinical and didactic training to new Behavioral Health Consultants (BHCs) as well as follow-up consultation. BCHMs also serve as a consultative resource for other BHCs. As a mentor, the BCHM will help BHCs maintain consistency with the BHC service philosophy and work within the scope of practice for the primary care setting. Within these parameters, the BCHM will also encourage creativity within the BHC's local practice while maintaining consistency with the Behavioral Health Consultant service model.

BHCMs have previously fulfilled all core competencies necessary to work as a BHC. In addition, they provide the following as applicable:

- Training for new BHCs. BCHMs maintain a plan for training behavioral health providers in the skills and competencies necessary to perform as a BHC. This training may be part of a residency or internship, or it may be an independent externship. Training will be accomplished through directed reading of the practice manual, didactic instruction, demonstration by the BCHM, and direct observation and feedback of the BHC trainee by the BCHM. When training occurs outside of a residency or internship program, the BHC candidate will typically visit the BCHM's facility for training. Some facilities may prefer to bring the BCHM to their site to provide training.
- Feedback for BHC trainees. BCHMs will evaluate BHC candidates using the *Training Core Competency Tool* (found in Appendix 18). The core competencies will be used as criteria to provide performance-based feedback.
- Follow-up consultation with trainees. Following initial training, BCHMs will maintain contact with their newly trained BHCs by telephone (or other means if deemed appropriate) on a periodic basis for a period of at least 6 months. Frequency of follow-up during this time will vary; typically this will occur at least monthly, but may be more often if indicated. This contact will constitute a formal relationship *only to provide consultation and additional training*. The BCHM will **not** assume responsibility for the care provided by the BHC. In cases where the BHC is required to work under clinical supervision (e.g. unlicensed psychologists), the BHC will normally provide services under the license of a designated clinical supervisor (other than the BCHM, unless the BCHM is co-located with BHC and fulfills both roles). The BCHM may provide consultation to the BHC's clinical supervisor if necessary. If the BCHM becomes unavailable for mentoring (due to PCS, TDY, etc.), he or she will assist their designated BHCs in finding alternative mentors. Geographically separated BCHMs will not perform peer review.
- Follow-up consultation with alternatively trained BHCs. Some BHC trainees will have obtained initial training by means other than BCHM's training programs. BCHMs will also provide follow-up mentoring to these BHCs after their initial training in accord with the above description.

- Peer consultation to experienced BHCs. BHCMs will be available to provide consultation to experienced BHCs, as needed. This consultation may include discussion of complex cases, ethical issues, development of new services, or other topics related to provision of BHC services.
- Session reviews. BHCMs will be available to view and provide feedback on video- or audio-taped sessions provided by the BHCs.

Qualifications

BHCMs are privileged providers with advanced degrees in the mental health field (social workers, psychologists, psychiatrists, and psychiatric nurse practitioners [when privileged]) who have received clinical training in the duties, responsibilities, and skills of a primary care BHC. BHCMs will additionally have at least 100 BHC patient contacts and 6 months of experience working as a BHC under this model. They will have a BHCM's written recommendation for being a mentor based on their mastery of core competencies (rated as a "5" on 95% of items in the Training Core Competency Tool; see Appendix 18) and other competencies required for mentoring (see below). Observation of the BHCM candidate's teaching and mentoring skills is required before being designated as a BHCM.

Core Competencies Required

All core competencies necessary to perform the role of a BHC are required. In addition, a BHCM is required to have:

Knowledge Competencies

- Knowledge of performance criteria for BHC providers, such as would be applied in an on-site training program
- Comprehensive knowledge of the *Primary Behavioral Health Care Services Practice Manual* and all related policies and procedures related to practice, as reflected in the *Primary Behavioral Health Care Services Practice Manual*, workshop outlines and videotaped demonstrations
- Comprehensive knowledge of the *Behavioral Health Consultant Training Manual* and all related policies and procedures related to training, as reflected in the *Behavioral Health Consultant Training Manual*, workshop outlines and videotaped demonstrations

Clinical Competencies

- Demonstrated skill in applying the BHC service model with a wide variety of primary care patient problems using evidence-based interventions

Teaching Competencies

- Demonstrated understanding that the training will be criterion based with corresponding core competency areas and benchmarks for evaluating trainee performance.
-

- Demonstrated understanding of mentor roles and skills, including use of behaviorally-based feedback, modeling and guided rehearsal; willingness to provide negative feedback in a constructive skill-building manner

Administrative Competencies

- Demonstrated ability to contribute to program design based on population-based care principles, with the aim of targeting BHC services to population needs
- Ability to model the development of cooperative relationships with the local clinic chief, the physician team leader and other primary care staff
- Demonstrated understanding in how to assist BHCs in assessing customer satisfaction, clinical outcomes and other performance measures related to their service

Appendix 18: Training Core Competency Tool

Training Core Competency Tool

Name:

Date:

Rater:

Use a rating scale of 1 = low skills to 5 =high skills to assess current level of skill development for all attributes within each dimension. Check in the column corresponding to the rating that best describes the trainee’s current skill level. *Competency Tool:* BHC mentor rates the BHC trainee based on their observations for each dimension (verbal feedback is also strongly recommended). A rating of 3 or higher is considered satisfactory for training.

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
I. Clinical Practice Knowledge and Skills	1. Role definition	Says introductory script smoothly, conveys the BHC role to all new patients, and answers patient’s questions						
	2. Problem identification	Identifies and defines the presenting problem with the patient within the first half of the initial 30-minute appointment						
	3. Assessment	Focuses on current problem, functional impact, and environmental factors contributing to/maintaining the problem; uses tools appropriate for primary care						
	4. Problem focus	Explores whether additional problems exist, without excessive probing						
	5. Population-based care	Provides care along a continuum from primary prevention to tertiary care; develops pathways to routinely involve BHC in care of chronic conditions; understands the difference between population-based and case-focused approach						
	6. Biopsychosocial approach	Understands relationship of medical and psychological aspects of health						
	7. Use of empirically-supported interventions	Utilizes evidence-based recommendations/interventions suitable for primary care for patients and PCMs						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
I. Clinical Practice Knowledge and Skills (cont'd)	8. Intervention design	8.a. Bases interventions on measurable, functional outcomes and symptom reduction						
		8.b. Uses self-management, home-based practice						
		8.c. Uses simple, concrete, practical strategies, based on empirically supported treatments for primary care						
	9. Multi-patient intervention skills	Works with PCMs to provide classes and/or groups in format appropriate for primary care (e.g., drop-in stress management class, group medical visit for a chronic condition)						
	10. Pharmacotherapy	Can name basic psychotropic medications; can discuss common side-effects and common myths; abides by recommendation limits for non-prescribers						
II. Practice Management Skills	1. Visit Efficiency	30-minute visits demonstrate adequate introduction, rapid problem identification and assessment, and development of intervention recommendations and a plan						
	2. Time Management	Stays on time when conducting consecutive appointments.						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
II. Practice Management Skills (cont'd)	3. Follow-Up Planning	Plans follow-up for two weeks or one month, instead of every week (as appropriate); alternates follow-ups with PCMs for high-utilizer patients						
	4. Intervention Efficiency	Completes treatment episode in four or fewer sessions for 85% or more of patients; structures behavioral change plans consistent with time-limited treatment						
	5. Visit Flexibility	Appropriately uses flexible strategies for visits: 15 minutes, 30 minutes, phone contacts, secure messaging						
	6. Triage	Attempts to manage most problems in primary care, but does triage to mental health, chemical dependency, or other clinics or services when necessary						
	7. Case Management	Utilizes patient registries (if they exist); takes load off of PCM (e.g., returns patient calls about behavioral issues); advocates for patients						
	8. Community Resource Referrals	Is knowledgeable about and makes use of community resources (e.g., refers to community self-help groups, Airmen and Family Readiness Center resources).						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
III. Consultation Skills	1. Referral Clarity	Is clear on the referral questions; focuses on and responds directly to referral questions in PCM feedback						
	2. Curbside Consultations	Successfully consults with PCMs on-demand about a general issue or specific patient; uses clear, direct language in a concise manner						
	3. Assertive Follow-Up	Ensures PCMs receive verbal and/or written feedback on patients referred; interrupts PCM, if indicated, for urgent patient needs						
	4. PCM Education	Delivers brief presentations in primary-care staff meetings (PCM audience; focus on what you can do for them, what they can refer, what to expect, how to use BHC optimally, etc.)						
	5. Recommendation Usefulness	Recommendations are tailored to the pace of primary care (e.g., interventions suggested for PCMs can be done in one to three minutes)						
	6. Value-Added Orientation	Recommendations are intended to reduce physician visits and workload (e.g., follow-up with BHC instead of PCM)						
	7. Clinical Pathways	Participates in team efforts to develop, implement, evaluate, and revise pathway programs needed in the clinic						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
IV. Documentation Skills	1. Concise, Clear Charting	Clear, concise notes detail: <ul style="list-style-type: none"> • Referral problem specifics • Functional analysis • Pertinent history • Impression • Specific recommendations and follow-up plan 						
	2. Prompt PCM Feedback	Written and/or verbal feedback provided to PCM on the day the patient was seen						
	3. Appropriate Format	Chart notes use SOAP format						
V. Administrative Knowledge and Skills	1. BHOP policies and procedures	Understands scheduling, templates, MEPRS codes for PC work, criticality of accurate ADS coding						
	2. Risk-management protocols	Understands limits of existing BHOP practices; can describe and discuss how and why informed consent procedures differ, etc.						
	3. KG ADS (coding) documentation	Routinely and accurately completes coding documentation						

Dimension	Element	Attribute	Skill Rating (1 = low; 5 = high)					Comments
			1	2	3	4	5	
VI. Team Performance Skills	1. Fit with Primary Care Culture	Understands and operates comfortably in fast-paced, action-oriented, team-based culture						
	2. Knows Team Members	Knows the roles of the various primary care team members; both assists and utilizes them						
	3. Responsiveness	Readily provides unscheduled services when needed (e.g., sees patient during lunch time or at the end of the day, if needed)						
	4. Availability	Provides on-demand consultations by beeper or cell phone when not in the clinic; keeps staff aware of whereabouts						