NATIONAL REGISTER
OF HEALTH SERVICE PSYCHOLOGISTS
Behavioral Health Consultation In Primary Care

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Paradigm Shift

Integrated practice in primary care is a qualitatively different clinical process than specialty mental health. It is not an abbreviated version of specialty mental healthcare.
Clinical Practice Framework

• Remember You Are A Team Member
• Be Guided By Principles Of Population Health
• Fulfill Functions Of Primary Care:
  ▪ Contact
  ▪ Continuity of Care
  ▪ Comprehensive Care
  ▪ Coordinated Care
The Warm Handoff & Functional Assessment
Availability for Warm Hand-off:

• Be available
• Be visible
• Be interruptible
• Say, “Yes, I can.”
Two “Customers”

1. Patients

2. Providers (and team)
Be a Container for Primary Care

- Energetic
- Eager to help
  - Patients and providers
- Calm, cool, and collected
Warm Handoff

• Clarify the referral question with referring provider
  ▪ “What would you like me to focus on with this patient?”
  ▪ “How can I be most helpful to you?”
  ▪ “What would you like me to accomplish with this patient today?”

• Expect that sometimes this won’t be possible
Warm Handoff

- When reason for referral is unclear, consider common reasons for referral
  - Diagnostic clarification
  - Adherence
  - Parenting skills
  - Anticipatory guidance
  - Poor/declining health status
  - Poor response to previous intervention
  - Provider feels overwhelmed
  - Provider isn’t sure what to do
Warm Handoff

• When reason for referral is unclear
  ▪ See the patient!
    • “Do you remember what you and Dr. Smith were talking about when she mentioned you meeting with me?”
  ▪ Look for a target during chart review
  ▪ Define a target. Consider:
    • Adherence
    • Diagnostic Clarification
    • Wellness Promotion
    • Coping and Self-care
  ▪ Learn about the providers
  ▪ Teach the providers—case by case by providing feedback and delivering results

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Behavioral Health Consultation: Initial

1. Introduction & Setting the Frame
2. Problem Identification & Clarification
3. Patient Engagement
4. Care Coordination & Treatment Planning
5. Documentation
Review The Chart

• If you skip the chart review because you’re running behind, you’ll fall further behind.

• Never, ever skip this step.
Functional Assessment:
Introduction (Minutes 1-2)

- **Introduce your role** using introductory script.
- **Explain care model** and role as member of primary care team.
- **Set the frame** for the visit.
  - Length of visit,
  - What will happen during visit,
  - Documentation in record,
  - Coordination with PCP

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Functional Assessment: Problem Identification & Clarification

• **Quickly reach agreement with the patient** on identification of primary problem

• **Provide focused assessment** of primary problem

• **Do not assess other areas** until assessment of initial referral question/primary problem has been completed and as time allows.

• **Keep the visit on track using the 3 Rs**
  • Restate, Reflect, and Redirect
Functional Assessment:
Problem Identification & Clarification (Minutes 3-15)

• **Assessment of Symptoms**
  • Onset, Triggers, and Course
  • Duration, Intensity, Frequency
  • What makes the problem better? Worse?
  • Assessment of Risk

• **Assessment of Functioning**
  • Home, Social, School, Recreational

• **What have they already tried to address the problem?**
Functional Assessment:
Engage the Patient & Family (Minutes 15-25)

- **Summarize** your understanding of the problem
- **Review** treatment recommendations and options
- **Express empathy** and provide validation
- **Offer a Strategic Reframe**
  - Simplify & reduce the magnitude of the problem
- **Create a “do-able” framework for change**
- **Offer a brief intervention**
Functional Assessment:
Coordination with PCP (Minutes 25-27)

- Verbal and/or electronic
  - Typically *not* your note
- Communicate diagnosis and plan
- Offer recommendations and collaborate on action steps
- Ask PCP to reinforce behavior change plan
- Consider scheduling conjoint visits
  - (lab, nurse, PCP, etc.)
Effective Feedback to PCP

- Be brief (1-2 minutes)
- Be mindful of primary care flow
- Be concise
- Speak in the vernacular
- Be confident and decisive
- Focus on:
  - Symptoms and Diagnosis
  - Treatment Plan
  - Needed Action Steps

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Do’s and Don’ts from a PCP

- Do communicate diagnosis and plan
- Don’t tie up an exam room for 30 minutes
- Do let me know if there is:
  - Drug abuse
  - Axis II pathology
  - Limited mental ability or illiteracy
  - *Add info the chart’s ALERT section
- Don’t refer a patient somewhere without letting me know (to ER or psychiatry)
- Do be decisive...you are the expert!
# Follow-up Plan Options

<table>
<thead>
<tr>
<th>Close (1-2 weeks)</th>
<th>Intermediate (1 month)</th>
<th>With PC Visits, PRN, or None</th>
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</table>
| • Severity & acuity of problem | • Clinical needs of patient  
• Overall primary care plan | • Level of motivation and engagement  
• Clinical needs of patient |

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Functional Assessment: Follow-Up Visits

- Frequency is clinically driven
  - Consider level of engagement and motivation
- Begin visit with a targeted question
  - “How did time-out go using the new techniques we discussed?”
- Review symptoms and functioning
- Review progress
- Reinforce any attempt at behavior change
- Troubleshoot barriers
- Introduce new skills and strategies if appropriate