Mi-CCSI
Center for Clinical
Systems Improvement

Mi-CCSI

CoCM Training

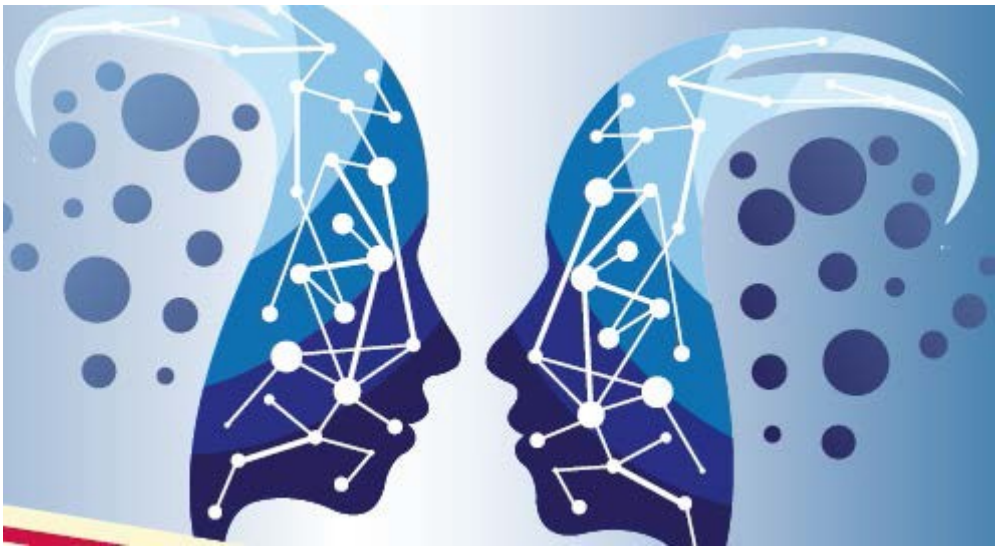
Day Two

Handouts

1. Motivational Interviewing GL MHTTC Workbook

Motivational Interviewing
Great Lakes ATTC
MI-CCSI

Fall 2020



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Motivational interviewing for helping professionals

The materials in this packet are designed to provide you with the knowledge and skills you need to deliver MI with integrity to the model. Through reading, didactic lecture, videos, small and large group practice, and individual performance feedback you'll be presented with opportunities to gain skill and confidence in the provision of this evidence- based practice.

GOAL: Systematically use MI in your work and move in the direction of fidelity to the practice.

Objectives

1. Be able to identify the key concepts of MI and how each relates to promoting positive behavior change.
2. Be able to describe each process of MI (Engaging, Focusing, Evoking, Planning) and how each contributes to promoting positive behavior change.
3. Apply MI skills for efficient and effective engagement (the Relational Foundation) and the elicitation of change talk (Technical skills).
4. Begin integrating MI into your patient change conversations.
5. Engage in an ongoing learning process to achieve fidelity.

Key Concepts in MI

1. Resist the righting reflex

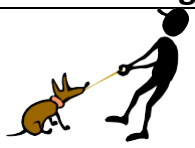
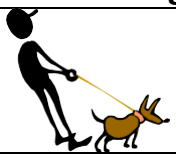
- The "righting reflex" is the practitioner desire to fix what seems wrong with people and to set them promptly on a better course.
- Expression of a directing communication style.
- How do people who are ambivalent about change respond to the righting reflex?

Activity: Just Do it!

- What comments did you notice from peers who participated in this exercise?

- What kind of situations trigger your own righting reflex?

2. Communication style matters

Directing	Guiding	Following
		
Administer Authorize Conduct Decide Determine Lead Manage Prescribe Steer Take charge Tell	Accompany Awaken Collaborate Elicit Encourage Inspire Lay before Look after Motivate Show Support	Attend Be responsive Be with Go along with Have faith in Listen Observe Shadow Stay with Take interest in Understand

Activity: Communication Style Switching

Instructions: Watch the video and for each communication style, note 1-2 observations of what the practitioner said/did and how the client responded.

- Following:

- Directing:

- Guiding:

3. Motivation is a key to change

- Motivation is a state of being ready, willing, and able; it is not a trait.
- Motivation is interpersonal; what the practitioner says and does matters.
- Motivation is a key to successful change.

Activity: Self-Reflect on Motivation
Instructions: Think of a behavior you've engaged in even though you knew it might lead to negative consequences. Ideally, this would be a behavior you have made past attempts to change. With this behavior in mind, consider the following questions with brief written response.

- How much time passed between when you began this behavior and when you were first aware that there was a potential problem with it?

- How much time passed between the moment you first noticed there was a potential problem with this behavior and the first time you made an earnest attempt to change it?

- Did you ever experience success in changing this behavior? ___Yes ___No

- Did you ever return to the behavior after initiating some change? ___Yes ___No

- How about the people in your life when you were attempting to change the behavior: Briefly describe (adjectives) how people were helpful.

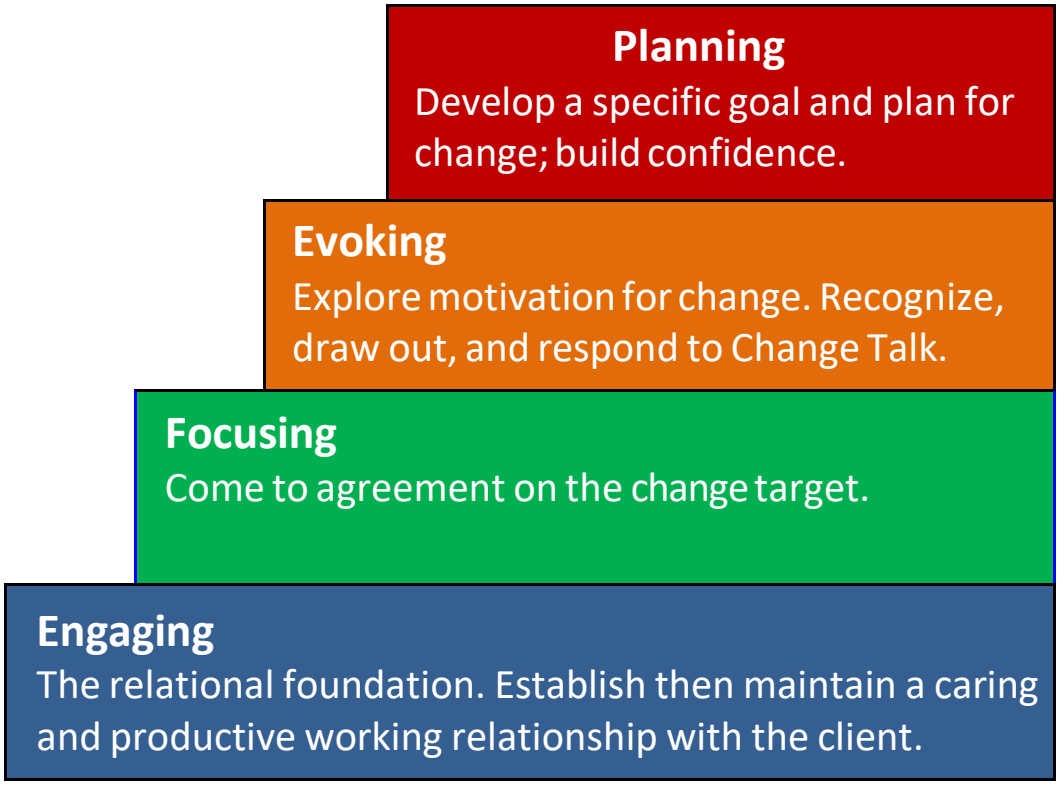
- Briefly describe (adjectives) how people were not helpful.

4. **Ambivalence about change is normal**
   - Ambivalence means feeling two ways about something.
   - Presents a significant barrier to change.
   - Must be explored and (hopefully) resolved.

NO CHANGE	
Pros	**Cons**
CHANGE	
Cons	**Pros**

MI Processes

(Miller & Rollnick, 2013, pp. 25-32)



Miller, Moyers, Rollnick (2013) DVD. Your take-aways:

MI Core Skills (OARS)

- Open questions
- Affirmation
- Reflective listening
- Summarizing

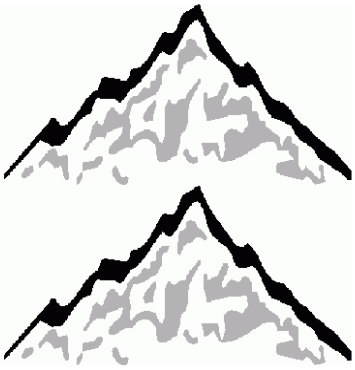
Core skills are applied within each process in unique and creative ways.

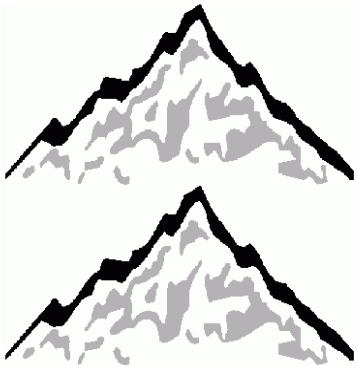
Climbing the Motivation Mountain

Adapted from Miller and Rollnick , 2013,

Engaging- Who are you and what's troubling you?
aka Where should we go on this journey? Shall we travel together?

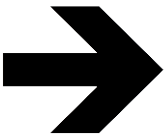
Focusing- Setting the agenda
aka Which mountain should we climb together? Where to?





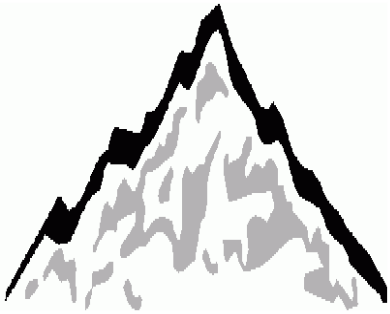
Evoking- Resolving client ambivalence, explore values, concerns, priorities, evoke change talk, importance and confidence
aka Whether or why?

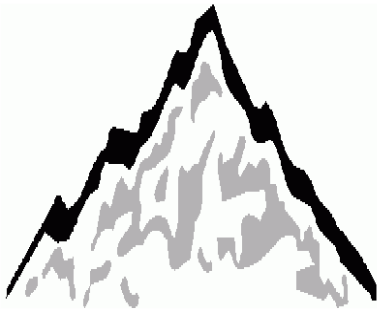
Slippery slope of ambivalence

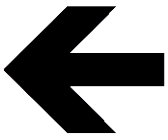


NOTE: This is hard work.

Testing the waters: Is the client ready for the down side of the mountain? Check it out!







NOTE: This feels easier. ☺
DOWNHILL

Planning: Identifying a change plan, addressing barriers, supporting change efforts
aka How? When?

Engaging

The relational foundation. Establish then maintain a caring and productive working relationship with the client.

Perspective Shifts

- Engaging is Task #1 – the first 20% of every encounter.
- Engaging in MI requires a way of being with people (the Spirit of MI).
- Develop a partnership with shared expertise.
- Rapid engagement is possible with MI skills.
- Let go of assessment-oriented, fact gathering questions.
- Competence vs. Deficit worldview – look for strengths.
- Replace questions with reflections.

The Spirit of MI is a way of being with people which sets the **PACE** of the conversation with these elements:

- **Partnership**. MI is a collaboration between experts.
  - People are the experts on their own lives.
  - MI is not done "to" or "on" someone, but "for" and "with" a person.
  - This includes both: Letting go of the expert role while being aware of the aspirations and convictions you bring to the conversation.

- **Acceptance.** Expressing an attitude of unconditional positive regard.
  - Absolute Worth.
  - Accurate Empathy.
  - Autonomy Support.
  - Affirmation.

- **Compassion**. We conduct MI in the service of others.
  - Deliberate promotion of another's welfare.
  - Get ourselves out of the way.
  - Serve as a benevolent witness.
  - Distinguish this way of being with people from the tactics of a used car salesperson.

Engaging

The Spirit of MI (continued)

- **Evocation.** Motivation for change is not installed but is evoked.
  - Motivation for change already exists within people.
  - Perspective that people truly have the wisdom and resources within themselves to identify and move towards their goals.
  - Pragmatically, people are more likely to change if they themselves come up with the reasons versus being advised.

Discussion questions

- Which element(s) of MI spirit best fits with how you currently work?

- Which elements (s) might pose some challenge to how you currently work?

- Why might you be interested in bringing all MI spirit elements to the way you work?

MI Relational Foundation Measures (reproduced with permission from Moyers et al., 2015)

Partnership

1 (low)	**2**	**3**	**4**	**5** (high)
Clinician actively assumes the expert role for the majority of the interaction with the client. Collaboration or partnership is absent.	Clinician superficially responds to opportunities to collaborate.	Clinician incorporates client's contributions but does so in a lukewarm or erratic fashion.	Clinician fosters collaboration and power sharing so that client's contributions impact the session in ways that they otherwise would not.	Clinician actively fosters and encourages power sharing in the interaction in such a way that client's contributions substantially influence the nature of the session.

Empathy

1 (low)	**2**	**3**	**4**	**5** (high)
Clinician gives little or no attention to the client's perspective	Clinician makes sporadic efforts to explore the client's perspective. Clinician's understanding may be inaccurate or may detract from the client's true meaning.	Clinician is actively trying to understand the client's perspective with modest success.	Clinician makes active and repeated efforts to understand the client's point of view. Shows evidence of accurate understanding of the client's worldview, although mostly limited	Clinician shows evidence of deep understanding of client's point of view not just for what has been explicitly stated but what the client means but has not yet said.

Engaging

Core Skill: Open Questions

- Promote engagement by exploring the person's perspectives, experiences, and concerns.
- The perspective shift here is to refrain from fact gathering/assessment questions (typically Closed Questions) at hello.
- Use Open Question starters: What…? How…? Tell me about… Describe…

Activity: Questions at Hello

Instructions: Read each question and decide if it is Open or Closed and a Good ☺ or Not-so-Good ☹ engaging question. If Not-so-Good, construct a better engaging question.

Common Questions at hello	☺	☹
1. What brings you here today?		
2. Are you in a relationship?		
3. Can we talk about paying your restitution?		
4. How are you today?		
5. Did you do what you were supposed to do?		
6. Are you having a good day?		

Now, using the starters above, construct 2-3 more engaging Open Questions:

Engaging

Core Skill: Affirmation

- The perspective shift here is to actively look for, recognize, and affirm a person's inherent worth, strengths, positive attributes, or past efforts with change.
- Affirmation of strengths builds the relational foundation and promotes engagement.
- Affirmations should not be confused with praise. Construct affirmation using a "you" statement.

	We all need positive feedback. Affirmations promote partnership, self-efficacy, hope, and improved self-regard. **AFFIRMATIONS BUILD CONFIDENCE**

Activity: Mining for Affirmations

- Start by brainstorming: What strengths do you observe in the people you work with? What are their positive personal attributes or resources? Write down a list of 15-20 strengths.

- Once the person you're working with has identified some strengths, what affirmations can you offer in response to reinforce these positive self-perceptions?

Someone famous
Strengths/Values:

Affirmation:

Engaging

Core Skill: Reflective listening

- Accurate empathy or "reflective listening" is the most important skill in MI.
- The perspective shift here is to replace questions with reflections.
- Listen carefully to understand the person's perspective.

Steps to forming a Reflection:

1. Hear what the person is saying.

   Barriers: Strategies:

2. Make an educated guess about the person's underlying meaning.
   "You mean that you…"

3. Choose your direction.

4. Share your guess as a concise <u>statement</u> (not a question).

Engaging

Activity: Construct Simple and Complex Reflections.
"People I work with"= patients, clients, consumers, customers NOT co-workers.

I really like the work that I do. I feel like I am pretty good at what I do. I've helped a lot of people.

- Simple Reflection:

- Complex Reflection:

You know. There are some things I struggle with. I am not always 100% sure I am doing the best job I can with the people I work with.

- Simple Reflection:

- Complex Reflection:

Thinking about doing anything differently in my professional work life makes me uneasy.
I am not sure I really have the time or the energy for that.

- Simple Reflection:

- Complex Reflection:

I really value having productive relationships with the people I work with. Some of this MI stuff makes sense and seems like it would make things a bit easier for me.

- Simple Reflection:

- Complex Reflection:

It's really hard to constantly have the feeling that I am supposed to know all the answers and fix all the problems for the people I work with. I don't always have what I need to run my own life because I put so much of myself into my work.

- Simple Reflection:

- Complex Reflection

Engaging

Core Skill: Summarizing

- A summary is like a reflective listening paragraph and reflects back several things the person has shared. Summarizing can reinforce a person's values, strengths, and motivations.
- Three types:
    - *Collecting* summaries recall a series of items as they accumulate.
    - *Linking* summaries link the present conversation with something discussed before.
    - *Transitional* summaries bring it all together to wrap up a task, a process, or a session.
- Start summaries with a "check-in" followed by a "checking it out" and end with an open question.

Activity: Create a Summary
Instructions: Based on the dialogue (previous page), create a collecting summary.

Engaging

Other Skills: MI Adherent (MIA) Behaviors

- **Affirm:** Recall than an affirmation accentuates a person's inherent worth, strengths, positive attributes, or past efforts with change.
- **Seek collaboration:** The practitioner is explicitly attempting to share power or acknowledge the expertise of the client. Asking the client what they think about information or asking permission to give information.
- **Emphasize autonomy:** This code is assigned when the practitioner works to CLEARLY focuses the responsibility with the client highlighting their sense of control, freedom of choice, personal autonomy, or ability to decide about their own actions.

Activity: Making MIAs
Instructions: In the scenarios below, respond with MIAs.

Jim is a 34-year old man who has been living homeless for the last 5 years and has recently moved into a group home. Jim says, "I've been at this a long time, I know the deal. If you don't go with the rules they kick you out. I know that. It's either do the deal and stay in or don't do the deal and get kicked out and be on my own."

- **Affirm:**
- **Seek:**
- **Emphasize:**

Jacklyn is a 15-year old girl who's been truant for most of her sophomore year. She's been sick on and off and has some serious issues with anxiety. Jacklyn says, "I know I have to come to school. I don't want to be like those girls I see just hanging out on the street nothing to do, looking bored. It's just that I am bored here too. But I know I can't be sitting at home, missing school much more."

- **Affirm:**
- **Seek:**
- **Emphasize:**

Engaging

Traps that Promote Disengagement (Miller & Rollnick, 2013, pp. 40-45)

The "Chat" Trap

The Assessment (Question-Answer) Trap

The Expert Trap

The Premature Focus Trap

The Labeling Trap

Discord, not "Resistance"

When a client argues, interrupts, disagrees, ignores, or discounts you, this is viewed as discord in MI. "Discord is about you or more precisely about your relationship with the client… Discord is like a fire (or at least smoke) in the therapeutic relationship."
(Miller & Rollnick, 2013, p. 197)

Activity: Self-Reflection on Client Discord

1. What are statements and behaviors you've observed from clients that signal discord? Be specific.

2. What is your reaction to these statements and behaviors?

3. What part do you play in the dissonance? Specifically, what trap might you have fallen into?

4. What would be some of the good things about changing the way you respond to dissonance? What's the worst thing that could happen if you did nothing?

5. Pick a statement of discord from above and write out an MI consistent response.

Technical definition of MI:

"Motivational Interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." (Miller & Rollnick, 2013, p. 29)

MI Processes:

Skills:

- Core OARS Skills
- Informing (E-P-E), Seek Collaboration
- Emphasis on choice

Skills are applied within each process in unique and creative ways.

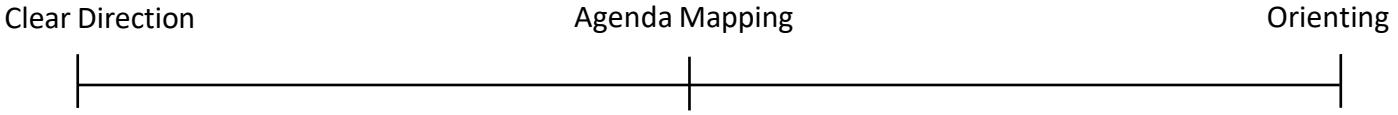
Focusing

Collaboratively come to agreement with the client on the change target. This could include: a specific behavior (engagement in services, medication adherence, parenting, completing school work, maintaining employment, high risk sexual behavior), substance (alcohol, illicit drug, tobacco), or condition (depression, anxiety, grief).

Perspective Shifts

- Focusing is a process with three possible scenarios
- Balance client and practitioner priorities for change
- Negotiation is often needed
- Once the focus for change target(s) is agreed upon, stick with it until transition to next change target

Three Scenarios (Miller & Rollnick, 2013, pp. 99-101; Rosengren, 2018, pp. 174-175)



Focus is clear. Client and practitioner are in agreement about the change target(s) for the session.

Focus is somewhat clear. Some client and practitioner priorities are known, but negotiation is needed to come to agreement on focus of change target(s) for the session.

Focus is unclear. Client and practitioner are not sure what the concerns or priorities are for the session. Exploration is needed to determine change target(s).

Focusing

Balance Priorities

Core Skill: Informing (Miller & Rollnick, 2013, pp. 131-154; Rosengren, 2018, pp. 212)

- First, find out about the person's priorities or concerns.
  - Then, share your priority or concern using the **E-P-E** procedure:
    - **E**licit client permission.
      "Would it be okay if I shared a perspective with you?"
    - **P**rovide the perspective on your priority or concern.
    - **E**licit the person's response.
      "What are your thoughts on this?"

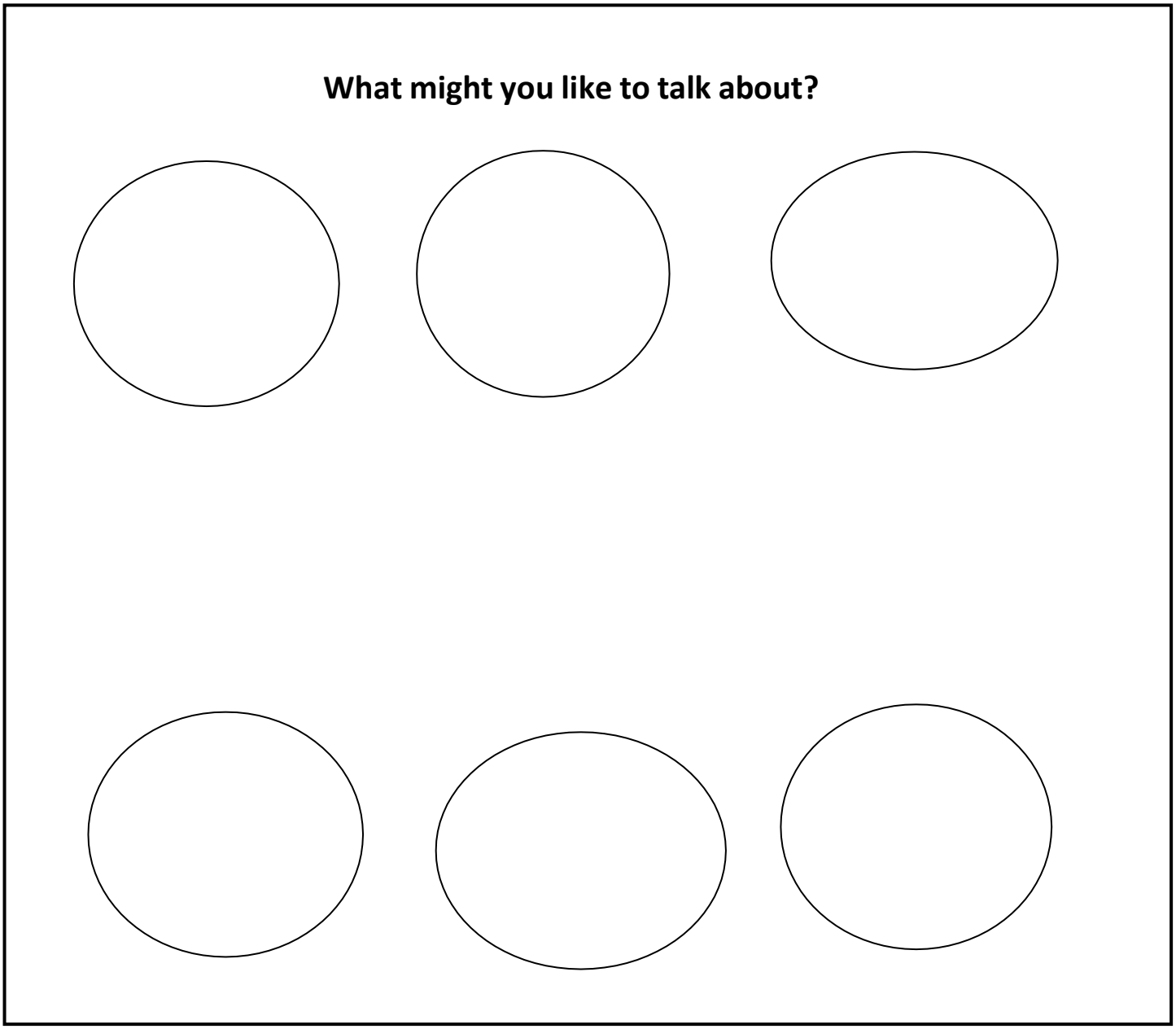
Listen carefully and Reflect.

Negotiate the agenda and come to agreement on the change target of focus

Focusing

Tool: Agenda Map

Instructions: Complete an agenda map thinking about the population you work with.



Once the change target is agreed upon, that becomes the focus of the change conversation until transition to the next one

Evoking

Once a change target is agreed upon and there is a clear, ethical direction for change transition to Evoking. Evoking explores the "why" of change. This process is the heart of MI during which the person's ideas and motivations for change are explored.

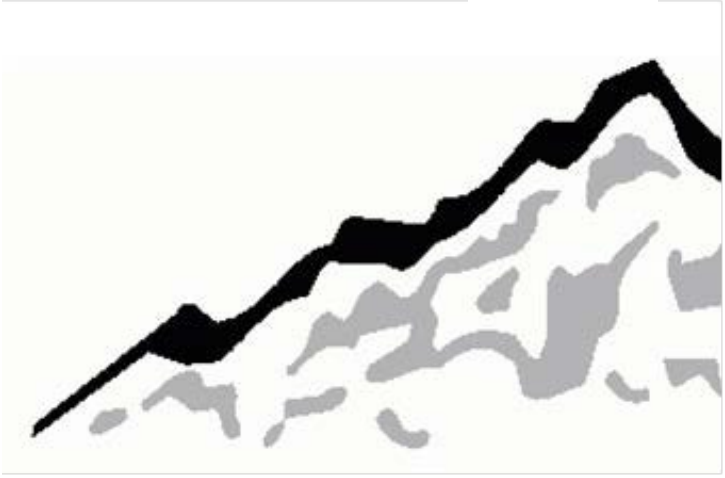
Perspective Shifts

- Motivation is a key to change
- Let go of assessment/fact gathering questions
- Resist your righting reflex
- Maintain focus on the change target, avoid tangents
- Listen for the language of change

Your Tasks

1) Recognize the language of change (Change Talk) and differentiate it from the language of no change (Sustain Talk) and Discord
2) Proactively draw out Change Talk
3) Strategically respond: cultivate change talk and soften sustain talk.

Begin climbing Motivation Mountain…



Evoking

Task #1: Recognize Language Cues

(Rosengren, 2018, pp. 269-275)

Change Talk is the language of change, that is, any client language in the direction of change regarding the change target. Types of Change Talk: **DARN CAT**

DESIRE: want, like, wish, hope to change
ABILITY: can, could, able to change
REASON: specific reason for change
NEED: need, have to, got to, must, it's important to change

* * * *

COMMITMENT: I will, I'm going to, I intend to change
ACTIVATION: ready to, willing, planning to change
TAKING STEPS: specific action or step toward change

Sustain Talk is any client language in the direction of no change or the status quo; the opposite of Change Talk. Sustain Talk is about the **change target**.

Discord signals dissonance and is about the **relationship**.

So what? Why are these language cues important?

(Miller & Rollnick, 2013, pp. 167-171; Rosengren, 2018, pp. 267-268)

Evoking

Task #2: Proactively draw out Change Talk

(Rosengren, 2018, pp. 302-309)

The core skill here is Open questions. Instruction: Call forth the **DARN CAT**. For each category of change talk, develop 2-3 Open questions.

DESIRE (want, like, wish, hope):

ABILITY (can, could, able to):

REASON (specific reason for change):

NEED (need, have to, got to, must, it's important to change):

* * * * * *

COMMITMENT (will, going to, intend to):

ACTIVATION (ready, willing, planning):

TAKING STEPS (specific step toward change recently taken):

Evoking

Task #2: Proactively draw out Change Talk (continued)

Querying Extremes

- What concerns you the most about_____in the long run?
- Suppose you continue on as you have been, without changing. What do you imagine are the worst things that could happen?
- From what you know, what might be some of the risks from continuing_____?
- What do you think could be the best results if you did make this change?
- If you were completely successful in making the changes you want, how would things be different?
- Imagine for a minute that you succeeded in changing_____. What are some good things that might happen?

Looking Back

- Do you remember a time when things were going well for you? What has changed?
- What were things like before_____? What were you like back then?
- How has_____changed you as a person or stopped you from growing, from moving forward?

Looking Forward

- If you did decide to make this change, what do you hope would be different in the future?
- How would you like things to turn out for you in____[months/years] or so?
- If you were to have a week off from your symptoms/problems, what would you do first?
- How would you like things to be in the future?
- What do you expect might happen if you don't make any changes?

Exploring Goals and Values

- Tell me what you care most about in life. What matters most to you?
- How do you hope your life will be different a few years from now?
- How does making a change with_____ fit with what you care most about, or your life goals or dreams?

Evoking

Task #2: Proactively draw out Change Talk (continued)

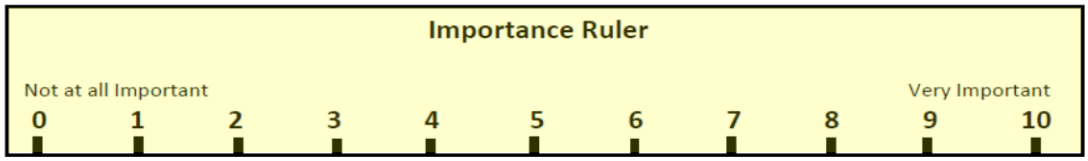
What is the problem?

(Miller & Rollnick, 2013, p. 213)

		Importance to change	
		Low	*High*
Confidence to change	*Low*	1	2
	High	3	4

Tool: Importance/Confidence Ruler (Miller & Rollnick, 2013, pp. 174-175)

On a scale of 0 to 10 where 0 is "not at all important" and 10 is "very important," how important is it for you to make a change with _(change target)_ ?



Ask the single follow up question:

- [0] What would it take to get to a 1 or 2?
- [1-4] Why this number and not a 0?
- [5-7] What would it take to go from this number to a [slightly higher #]?
- [8-10] Talk about why making this change is very important.

Evoking

Task #3: Strategically Respond
Cultivate Change Talk

When you hear Change Talk, don't just sit there! (Miller & Rollnick, 2013, pp. 183-188)

Use your OARS:

- **O**pen question to ask for elaboration
  Client: I need to cut down on the drinking. Practitioner: Tell me more.

- **A**ffirm an underlying strength
  Client: I'm going to take a break for a few weeks. Practitioner: You have a lot of will-power.

- **R**eflect
  - Simple Reflection to highlight the specific language cues
  - Complex Reflection to offer a guess in the direction of change

- **S**ummarize – collect the Change Talk flowers and offer back as a bouquet

Best practice:

- ❑ Start by briefly acknowledging any Sustain Talk/reasons for no change.
- ❑ Then, highlight Change Talk, motivations, and reasons for change.
- ❑ End with a question that moves the conversation forward.

Evoking

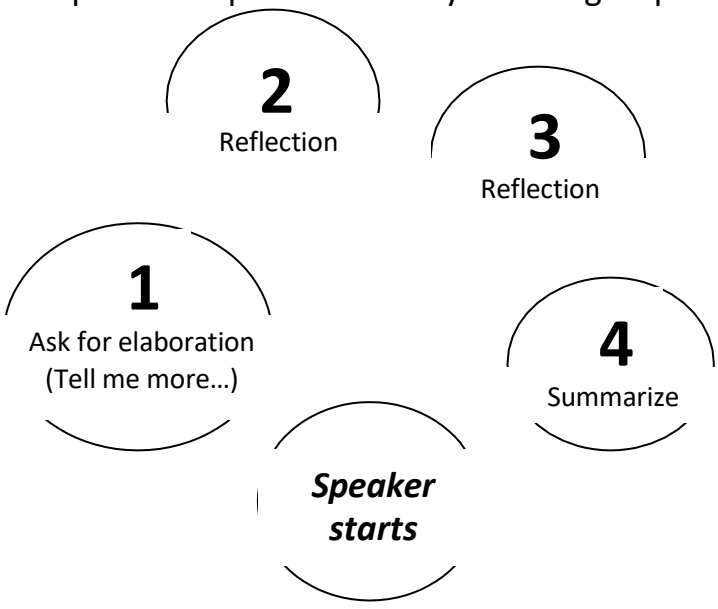
Activity: Cultivating Change Talk is Easy as 1-2-3-4

Moving from practice-as-usual to delivering MI with fidelity requires your own behavior change. With this change in mind, please note your response in the space provided below to <u>one</u> of the following questions:

- Why would you want to integrate MI into your services?
- What is one skill you could work on to develop your MI practice?
- What would be the best reason to get MI into routine practice with your clients?
- What would you need to do differently in order to deliver MI with fidelity?

Your response:

- Speaker starts by sharing the above written statement.
- Moving to the speaker's left, group members do 1-2-3-4 in turn.
- Speaker responds naturally to each group member.



Evoking

Evoking Task #3: Strategically Respond

Cultivate Change Talk

Instructions: Read the client narrative below, then work together as a group to create MI consistent responses.

Client: I have to do something about my drinking. I know it's really bad for me and I can't keep this up. I am going to lose everything.

- Open question: (shift focus or reframe)

- Affirmation: (find an underlying strength)

- Reflection: (construct two concise reflections using strategic complex types)
  a)

  b)

Soften Sustain Talk/Discord

(Miller & Rollnick, 2013, pp. 200-210; Rosengren, 2018, pp. 360-364, 374)

Instructions: Read the client narrative below, then work together as a group to create MI consistent responses.

Client: I already told you I don't have a problem with drinking and so what if I smoke some weed? Everyone I know smokes. Why do you care what I do? I've been to treatment before so I know all about the risks. There's nothing you can tell me that I don't already know.

- Open question: (shift focus or reframe)

- Affirmation: (find an underlying strength)

- Reflection: (construct two concise reflections using strategic complex types)
  a)

  b)

- Emphasize choice/personal control:

Evoking

Activity: Rowing with OARS for Evoking

Roles:

- Speaker – real play. Consider talking about continuing to learn MI: What changes will you need to make to get MI into routine practice? What will you need to work on to reach fidelity?
- Practitioner – go right into Evoking. Use your OARS to explore the Speaker's motivation for change.
- Observer – listen carefully to the Practitioner and use the observer sheet provided to note skills.

Debrief:

1. *Practitioner starts by sharing what she/he liked about the interview and what could have been different, then*

2. *Observer shares feedback using Elicit-Provide-El*

MI References

- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd edition). New York, NY: Guilford Press.

- Miller, W. R., Moyers, T. B., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* [training DVD]. From https://www.changecompanies.net/products/motivational-interviewing/

- Moyers, T. B., Manuel, J. K., & Ernst, D. (2015). *Motivational Interviewing Treatment Integrity coding manual 4.2.1*. Unpublished manual, University of New Mexico, Center on Alcoholism, Substance Abuse, and Addiction. Retrieved from https://casaa.unm.edu/download/MITI4_2.pdf

- Rosengren, D. (2018). *Building motivational interviewing skills: A practitioner workbook* (2nd edition). New York, NY: Guilford Press.

Closing Review

- Something I learned or relearned…

_____
_____
_____

- From this course I gained…

_____
_____
_____

- One thing I learned about myself as a practitioner…

_____
_____
_____

- I am more confident now that I can…

_____
_____
_____

- I'm going to integrate MI into practice by…

_____
_____
_____

2. MHTTC SBIRT Screening & Brief Assessment Questionnaires

Great Lakes (HHS Region 5)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SBIRTScreening and Brief Assessment Questionnaires

1. **Brief Screens:**
   NIAAA quantity and frequency
   Single alcohol screening question (plus alternative)
   Single drug screening question (plus alternatives)
   Conjoint screening questions

2. **Full Screens and scoring algorithms**

   AUDIT- Alcohol use disorders identification test
   DAST- Drug abuse screening test
   CRAFFT- Adolescent screening tool

3. **Downloadable person friendly versions**

   AUDIT
   ENGLISH: **https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf**
   SPANISH: **https://pubs.niaaa.nih.gov/publications/AuditSP.pdf**

   DAST
   ENGLISH: **http://www.sbirtoregon.org/wp-content/uploads/DAST-English-pdf.pdf**
   SPANISH: **https://www.communitycarenc.org/sites/default/files/sbirt-dast-10-forms.pdf**

   CRAFFT
   ENGLISH: http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_SA_English.pdf
   SPANISH: **http://www.ceasar-boston.org/CRAFFT/pdf/CRAFFT_SA_Spanish.pdf**

Accuracy of Alcohol and Drug Screens

	Sensitivity	Specificity
	Of those **with** the condition, what proportion screen **positive**?	Of those **without** the condition, what proportion screen **negative**?
	True positive vs. false negative	True negative vs. false positive
Single Alcohol Screening Question	82%	79%
AUDIT-C	♂: 79% ♀: 80%	♂: 56% ♀: 87%
NIAAA Quantity- Frequency Questions	83%	84%
Single Drug Screening Question	83%	94%
Two-Item Conjoint Screen (TICS)*	79%	77%

*Screens for problem use and dependence, not risky use

Smith, Journal of General Internal Medicine, 2009; http://www.integration.samhsa.gov/images/res/tool_auditc.pdf; Friedmann, Journal of Studies on Alcohol, 2001; Smith, Journal of General Internal Medicine, 2009; Brown, Journal of the American Board of Family Practice, 2001

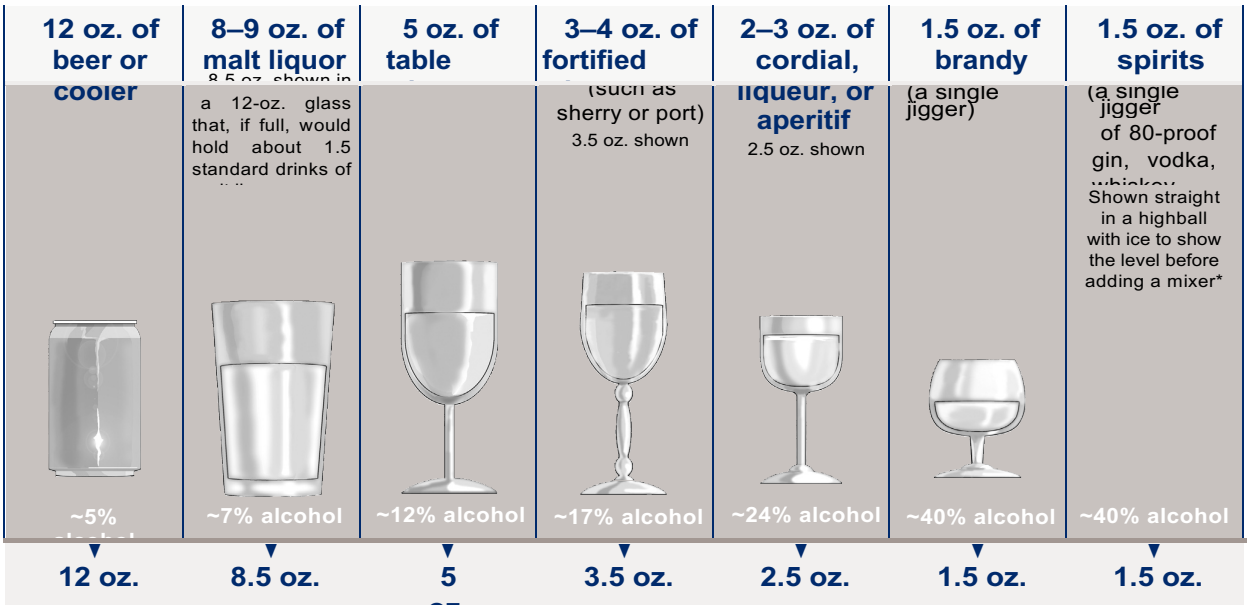
Interpreting Screen Results

- Screens identify most risky users, problem users and dependent individuals
- False-positives and false-negatives are not unusual
- **Because of false-positives …**
  - Positive screens are not definite indicators of risky use, problem use or dependence
  - Screens merely indicate which asymptomatic individuals should undergo further assessment
- **Because of false-negatives …**
- Screens should not be administered to individuals with symptoms of disorders
- Those individuals should undergo more in-depth assessment

NIAAA Questions on Quantity and Frequency of Drinking

1. In the past three months, how many days a week did you have some alcohol?

Please use the following definition of "standard drink" for questions 2 and 3.



2. On days that you did drink in the past three months, how many standard drinks did you typically have?

3. During the past three months, what's the largest number of standard drinks you had in any day or night?

Interpretation:

For items 1 and 2, multiply the responses to compute the average number of standard drinks per week.

A number greater than 14 suggests risky drinking on a weekly basis for men.
A number greater than 7 suggests risky drinking on a weekly basis for women.

For item 3:

A number greater than 4 suggests risky drinking on an episodic basis for men.
A number greater than 3 suggests risky drinking on an episodic basis for women.

Risky drinking on either a weekly or episodic basis or both qualifies an individual to be at least a risky drinker

AUDIT-C

How often do you have a drink containing alcohol?

a. Never
b. Monthly or less
c. 2-4 times a month
d. 2 or 3 times a week
e. Daily or almost daily

How many standard drinks to you have on a typical day when you drink?

a. 1 or 2
b. 3 or 4
c. 5 or 6
d. 7 to 9
e. 10 or more

MEN: X=5
WOMEN: X=4

How often do you have X or more drinks on one occasion?

a. Never
b. Monthly or less
c. 2-4 times a month
d. 2 or 3 times a week
e. Daily or almost daily

Single alcohol screening question:

How many times in the past year have you had X or more drinks in a day?

a. Never
b. Monthly or less
c. 2-4 times a month
d. 2 or 3 times a week
e. Daily or almost daily

A version to track outcomes over time:

In the last month, how many days a week or month did you have more than X standard drinks? (X = 3 for women, 4 for men). Response = number of days AND “week" or “month.”

Single drug screening question

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?

Circle the best response:

1. None
2. 1
3. 2-5
4. 6-10
5. 11-20
6. More than 20

In the last month, how many days a week or month did you use marijuana?

Circle the best response:

1. None
2. 1
3. 2-5
4. 6-10
5. 11-20
6. More than 20

In the last month, how many days a week or month did you use another drug, including heroin, other recreational drugs, and pain pills, uppers/stimulants, or downers/sedatives beyond what was prescribed for you?

Circle the best response:

1. None
2. 1
3. 2-5
4. 6-10
5. 11-20
6. More than 20

Interpretation for single alcohol and drug questions: Positive response: Greater than none

Two- item Conjoint screening questionnaire

(May be added to 2 single screening questions to identify more drug disorders. Does not identify at-risk alcohol or drug use)

1. In the last year, have you ever drunk alcohol or used drugs more than you meant to?
2. In the last year, have you felt you wanted or needed to cut down on your drinking or drug use?

Interpretation: Positive response: Yes to either or both questions

.

Alcohol Use Disorders Identification Test (AUDIT)

In the past 12 months…	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
3. How often do you have 3 or more drinks on one occasion? *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
				Total score =	

Interpretation: To compute the total score, add the number at the top of the column for each response.

Risk Category	Total Score		Management
	Females	Males	
Low risk	0 to 6	0 to 7	Education, affirmation
At risk	7 to 15	8 to 15	Brief intervention
Problem use	16 to 19		Brief intervention + F/U
Likely dependent	20 to 40		Referral

Drug Abuse Screening Test-10 (DAST-10)

In the past 12 months …	Yes	No
1. Have you used drugs other than those required for medical reasons?		
2. Do you use more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you ever had blackouts or flashbacks as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Do people in your life ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs (other than possession)?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?		
Total score =		

Interpretation:

For item 3, “yes” scores 0 points, and “no” scores 1 point.
For all other items, “yes” scores 1 point, and “no” scores 0 points.
Add up all the points to computer the total score.

Degree of Problems	Total Score	Management
None	0	Education, affirmation
Low	1	Education, affirmation
Low	2	Brief intervention
Moderate	3 to 5	Brief intervention + F/U
Substantial	6 to 8	Intervention or referral
Severe	9 to 10	Referral

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

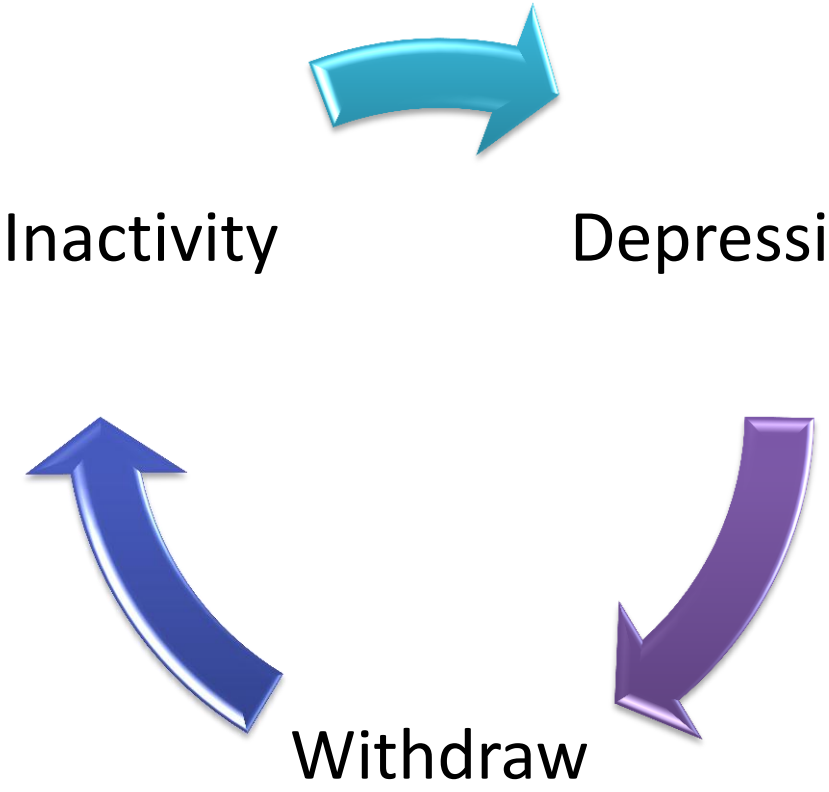
Yes ☐ → **Ask all 6 CRAFFT questions**

Part B	**No**	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

Interpretation:
Any "yes" is 1 point.

Degree of Problems	Total Score	Management
None	0	Education, affirmation
Low	1	Education, affirmation
High risk	2+	Brief intervention, Extended Brief intervention, Referral to specialist

3. Cycle of Depression



The Cycle of Depression

Content used with permission from Institute for Clinical Systems Improvement 2012

4. Activity Log

Month: _____

Activity Log

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Notes:

_____

_____

_____

_____

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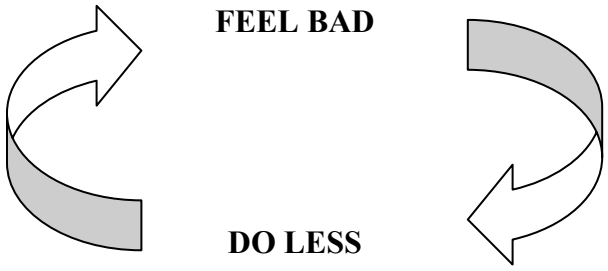
5. Problem Solving Therapy Tool

APPENDIX 4

PATIENT HANDOUT

Why is it Important to Do More Pleasurable Activities?

When people get depressed they don't feel up to doing the kinds of things they typically enjoy. By doing fewer enjoyable things they begin to feel even worse. As they feel worse, they do even less, and get caught up in a vicious cycle of doing less and less and feeling worse and worse.



As part of problem solving treatment we will help you set a goal of doing at least one pleasurable activity each day. In other words, arranging to provide yourself with a "treat" each day. Sometimes working on the problem of too few pleasant activities can be a simple and effective way to start to learn problem solving skills.

The positive benefits are:

(a) You can use problem-solving steps to help with pleasurable activities;

(b) You will start to assert control over your life in a positive and beneficial way; and

(c) Your success with doing pleasurable things will give you motivation to tackle some of the more difficult problems in your life.

Appendix 5

PROBLEM SOLVING TREATMENT FOR DEPRESSION
PROBLEM LIST

1. Problems with relationships: **Spouse or partner** **Family members: children, grandchildren, other family members** **Friends** **Other:**	**8. Problems with having a daily pleasant activity:**
2. Problems with work or volunteer activities:	**9. Problems with sexual activity:**
3. Problems with money and finances:	**10. Problems with religion or moral values:**
4. Problems with living arrangements:	**11. Problems with self-image:**
5. Problems with transportation:	**12. Problems with aging:**
6. Problems with health:	**13. Problems with loneliness:**

Appendix 6
PROBLEM-SOLVING WORKSHEET

Name:_____ Date: _____ Visit #:_____

Review of progress during previous week:

Rate how satisfied you feel with your effort (0 – 10) (0 = Not at all; 10 = Extremely): ___

Mood (0-10): ___

1. **Problem:**

2. **Goal:**

3. **Solutions:**

4. **Pros vs. Cons (Effort, Time, Money, Emotional Impact, Involving Others)**

a)	a) Pros (+)	a) Cons (-)
b)	b) Pros (+)	b) Cons (-)
c)	c) Pros (+)	c) Cons (-)
d)	d) Pros (+)	d) Cons (-)
e)	e) Pros (+)	e) Cons (-)

5. Choice of solution:	
6. Action Plan (Steps to achieve solution):	**Write down the tasks you completed.**
a)	
b)	
c)	
d)	
Pleasant Daily Activities. **Date Activity**	**Rate how Satisfied it made you feel (0 – 10)** **(0 = Not at all; 10 = Extremely)**

Version 9/24/02

Next appointment: _____

Appendix 7

PST-PC Maintenance Class Guidelines

Because we meet only once a month, and the time we have together is short, it's important to come to every class and to be on time. Give it your best shot even if you don't feel at your best.

If you know you will be late or can't make it, please call me at XXX-XXXX.

No one is forced to participate in class but your participation is important. You can learn by just listening but you will learn more by sharing and doing.

Remember everyone needs a chance to talk. The team that works together works the best.

Give others a chance to speak.

Please reserve judgment or negative criticisms.

Please speak your mind but be respectful.

Everything discussed is confidential! Please do not discuss what we talk about in here outside. If you must discuss, don't use other people's names.

If you are unhappy with the class or just think it's not for you, please let me know. You have the power to change and improve the classes.

Important phone numbers:

- If you have a question or you can't make a class: XXX-XXXX.
- If you have an emergency and you can't reach me, call XXX-XXXX.

6. Resources Related to Medications

Resources Related to Medications

ICSI (Institute for Clinical Systems Improvement), Depression, Adult in primary care depression	https://www.icsi.org/guideline/depression/
APA (American Psychiatric Association) Practice Guidelines	https://psychiatryonline.org/guidelines
American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults	https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.15767
Mayo antidepressant shared decision aid	https://depressiondecisionaid.mayoclinic.org/index
Psychopharmacology and Psychiatry Updates Psychopharmacology Institute (Podcasts)	https://podcasts.apple.com/us/podcast/psychopharmacology-and-psychiatry-updates/id1425185370 (free access to short and preview podcasts)

7. Mental Health Apps

Mental Health Topic		Website	iTunes App Link	Google Play App Link
Reviews for Mental Health Apps	Psyberguide	https://psyberguide.org/apps/	Resource: N/A	Resource: N/A
	ADAA (Anxiety & Depression Association of America	https://adaa.org/finding-help/mobile-apps	Resource: N/A	Resource: N/A
Anxiety and Depression	PTSD Coach	https://www.psyberguide.org/apps/ptsd-coach/	https://apps.apple.com/us/app/ptsd-coach/id430646302	https://play.google.com/store/apps/details?id=is.vertical.ptsdcoach&hl=en
	CPT Coach	https://www.psyberguide.org/apps/cpt-coach/	https://apps.apple.com/us/app/cpt-coach/id804271492?ign-mpt=uo%3D4	https://play.google.com/store/apps/details?id=gov.va.mobilehealth.ncptsd.cptcoach&hl=en
	PE Coach 2	https://www.psyberguide.org/apps/pe-coach/	https://apps.apple.com/us/app/pe-coach-2/id1281266434	https://play.google.com/store/apps/details?id=gov.va.mobilehealth.ncptsd.pecoach&hl=en_US
	Mindshift CBT (Anxiety Canada)	https://www.psyberguide.org/apps/mindshift/	https://apps.apple.com/ca/app/mindshift/id634684825	https://play.google.com/store/apps/details?id=com.bstro.MindShift&hl=en
	Thought Challenger	https://www.psyberguide.org/apps/thought-challenger/	https://apps.apple.com/us/app/thought-challenger/id1250196640	N
	Mood Mission	https://www.psyberguide.org/apps/moodmission/	https://apps.apple.com/au/app/moodmission/id1140332763	https://play.google.com/store/apps/details?id=com.moodmission.moodmissionapp
Resilience and Mindfulness				
	Mindfulness Coach	https://www.psyberguide.org/apps/mindfulness-coach/	https://apps.apple.com/us/app/mindfulness-coach/id804284729	N
	SuperBetter	https://www.psyberguide.org/apps/superbetter/	https://apps.apple.com/us/app/superbetter/id536634968	https://play.google.com/store/apps/details?id=com.superbetter.paid&hl=en
	Happify	https://www.psyberguide.org/apps/happify/	https://apps.apple.com/us/app/happify-activities-games-for-stress-anxiety/id730601963	https://play.google.com/store/apps/details?id=com.happify.happifyinc&hl=en
	Personal Zen	https://www.psyberguide.org/apps/personal-zen/	https://apps.apple.com/us/app/personal-zen/id689013447?ls=1&mt=8%3B	N
	Breathe2Relax	https://www.psyberguide.org/apps/breathe2relax/	https://apps.apple.com/us/app/breathe2relax/id425720246	https://play.google.com/store/apps/details?id=org.t2health.breathe2relax&hl=en
	Headspace	https://www.psyberguide.org/apps/headspace/	https://apps.apple.com/us/app/headspace-com-meditation-mindfulness/id493145008	https://play.google.com/store/apps/details?id=com.getsomeheadspace.android&hl=en
	Sanvello	https://www.psyberguide.org/apps/sanvello/	https://apps.apple.com/us/app/sanvello-stress-anxiety-help/id922968861	https://play.google.com/store/apps/details?id=com.pacificalabs.pacifica&hl=en_US
Insomnia				
	CBT-i Coach	https://www.psyberguide.org/apps/cbt-i-coach/	https://apps.apple.com/us/app/cbt-i-coach/id655918660	https://play.google.com/store/apps/details?id=gov.va.mobilehealth.ncptsd.cbti
Artificial Intelligence/ChatBots				
	Woebot	https://www.psyberguide.org/apps/woebot/	https://apps.apple.com/us/app/woebot/id1305375832	https://play.google.com/store/apps/details?id=com.woebot
Self-Monitoring				
	T2 Mood Tracker	https://www.psyberguide.org/apps/t2-mood-tracker/	https://apps.apple.com/us/app/t2-mood-tracker/id428373825	https://play.google.com/store/apps/details?id=com.t2.vas&hl=en
	CBT Thought Diary	https://www.psyberguide.org/apps/cognitive-diary-cbt-self-help/	N	https://play.google.com/store/apps/details?id=com.excelatlife.cbtdiary&hl=en
	Youper	https://www.psyberguide.org/apps/youper/	https://apps.apple.com/us/app/youper/id1060691513?ign-mpt=uo%3D4	https://play.google.com/store/apps/details?id=br.com.youper
No Longer Available (or we could not locate them)				
	This Way Up	https://www.psyberguide.org/apps/this-way-up/	WEB BASE ONLY	
	Worry Knot, Thought Challenger, Social Force (IntelliCare)	www.psyberguide.org/apps/worry-knot/	N	N
	Social Force	https://www.psyberguide.org/apps/social-force/	N	N
	Slumber Time	https://www.psyberguide.org/apps/slumber-time/	N	N
	Koko (is the kik by chance??)	says the App is no longer available	N	N

8. Patient Introduction to CoCM Scripting

Introduction of CoCare to Patient following warm handover by PCP

Hello, Mrs Smith-what do you prefer I call you? (smile, eye contact, welcoming)
As Dr Wilson just explained, my name is Robin and I am a nurse. They call me a Behavioral Health Care Manager and I work right here in Dr Wilson's office. I am a member of Dr Wilson's team.

What is your understanding of why Dr Wilson referred you to me today?

Would it be ok if I took 10 or so to explain how this might work for you?

Dr Wilson is concerned about the depression you are experiencing and how it seems to be worsening. The best way he and our team can support you and help you feel better is with what we call CoCare. In CoCare, there is a whole treatment team working on your behalf--some directly and some indirectly. I would work closely with you to learn how depression is effecting you day to day. Together we can discover actions and skills that you can use that will help you feel better. We also have a psychiatrist working in the background to be a resource to Dr Wilson in considering treatment choices such as medication or other therapies. We will review your progress periodically and suggest adjustments to further progress. We can also bring in other team members such as the pharmacist or social worker or make referrals if needed. Dr Wilson is still your Primary Physician, he leads the team and you will still have office visits with him as usual.

You are the most important team member. You are the expert on your life so your participation is key. One way is that we will monitor your symptoms periodically asking you the depression questions like we did today. This helps us know what to focus on and what is working. Another way is that you and I will meet together by phone, video or in person to see if skills and actions you are trying out are working and problem solve together.

If you chose to participate in CoCare-our first visit will be around 1 hour long so that I can get to know you better. After that our contacts will be shorter-often weekly at first and then less frequently as your symptoms improve and you begin to feel better. Our work in between office visits with Dr Wilson helps you make progress more quickly. The goal of CoCare treatment is to get your depression into remission and this often takes 6-12 months.

I know this is a lot. What questions do you have? It is your choice to participate and you don't have decide now. You can think about it and I can call you in a few days if you'd like.

Thank you for taking the time to meet with me today.

9. Introduction of BHCM to CoCM Breakout Session

Enter your breakout room (accept "join" breakout room)

Facilitator for each group

- **Each group will create an introduction to the CoCM program to a patient via round robin**
- **Assign a scribe to capture the introduction and share with the large group**

- **Include key talking points**
    - **Warmly greet**
    - **Ask permission**
    - **Understanding of the reason for the referral and with permission fill in gaps**
    - **BHCM relationship with the patient's primary care provider team and team concepts to include the psychiatrist role**
    - **Value to the patient and their role**
    - **What to expect ie frequency and timelines**
    - **Open communication to encourage questions**
    - **Identify someone in the group to share with the group at large**

****Allot 30 minutes total for this exercise**

10. PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=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**
☐	☐	☐	☐

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11. GAD-7

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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12. EPIC Care Coordination Intake Template

@SUBJECTIVEBEGIN@

REASON FOR VISIT

Integrated Behavioral Health (IBH) Care Coordination **Enrollment**

HISTORY OF PRESENT ILLNESS

@PREFERREDNAME@ is a @age@ @sex@, with a history of *** who is referred to IBH Care Coordination for ***.

Primary symptoms of concern: ***

Current stressors: ***

The following patient reported outcomes were completed:

{IBH Reported Outcomes:71872}

Current psychiatric pharmacological interventions: ***
Current nonpharmacological interventions: ***
Current psychotherapist: ***
Current psychiatric prescribing provider: ***

Suicidal Ideations: ***
Non-suicidal self-injury: ***
Homicidal ideations: ***
Access to firearms: ***

Sleep: ***
Pain interference: ***

PAST MEDICAL HISTORY

Medical History: ***

@LASTTSH@

Mental Health History: ***

Past medication trials: ***
Mental Health Hospitalizations: ***
Mental Health ED Visits: ***

Past psychotherapists: ***
Past psychiatric prescribing provider: ***
Past ECT/TMS/Ketamine: ***
Genomic testing: ***

Past suicide attempts: ***
Past non-suicidal self-injury: ***

Past homicidal ideations: ***

FAMILY HISTORY

***

SOCIAL HISTORY

***
History of trauma/abuse/neglect: ***
Learning: ***
Military history: ***
Legal history: ***

Current support: ***
Patient reports the following leisure activities: ***
Patient reports the following stress reductions activities: ***

Social Determinants of Health:
{SDOH assessment:78746}

Substance abuse: ***
Nicotine use: ***
Supplement use: ***
Caffeine use: ***
Physical activity: ***

Past chemical dependency treatments: ***

@ASSESSMENTPLANBEGIN@

The following program goals were identified:

Patient goals for care coordination:

1. ***

Healthcare team goals for care coordination:

1. ***

Referrals: {IBH CC referrals:73568}

Next contact: {numbers 0-10:5044} {DAYS/WEEKS/MONTHS:21172} by {MC AMB HP NEXT CONTACT TYPE:39416}.

Discussion items for next contact include ***.

The following emergency resources were reviewed with the patient: {MC CARE COORD MH RESOURCES:43699}.

The {Persons; family members:60370} was instructed to contact the care coordinator with any questions or concerns and stated understanding of the information provided.

{Complete all 4 sections if encounter is over the phone (Optional):71765}

RECOMMENDATIONS

Please see associated supervising psychiatrist note for additional recommendations for consideration by the Primary Care Provider.

13. Suicide Policy-Protocol Template

TITLE: SUICIDAL OR POTENTIALLY SUICIDAL PATIENT CARE IN PHYSICIANS OFFICE PRACTICES

POLICY OWNER: Quality Improvement Committee Chair
APPROVAL: _____

President & Chief Medical Officer,
POLICY STATEMENT/SCOPE: Encounters with patients who have thoughts of suicide can occur within the physician office setting. It is the responsibility of the health care team to provide support and assistance for maintaining the safety of patients who experience suicidal thoughts or behaviors.
PURPOSE: To outline the process for maintaining the safety of patients who are exhibiting suicidal thoughts and behaviors during an ambulatory care setting encounter.

RESPONSIBILTY: Physicians, Advanced Practice Providers, Clinical staff, Practice Leaders with entire office staff to provide support and assistance.

PROCESS / PROCEDURE:
I. Patient shows signs or symptoms of suicidality
1. Business Office associate

a. Phone
i. Remain on the phone with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. When transferring the call, remain on the call until they are transferred to physician/designee clinical care team

b. In person
i. Remain with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. Handoff to clinical team member who takes over.

2. Physician/Clinical Care Team/Designee
a. Determine risk level (**imminent/acute, moderate to high, chronic/lower)**
 Have you thought about hurting yourself?
 Sometimes others in situations similar to yours think about hurting themselves. Have you ever thought that way?
 I'm concerned about you and wonder if you sometimes wish you were dead or have ever thought about killing yourself. That is, patient's **intent, plans, and means.**

i. **Imminent/Acute Risk -Intent with lethal plan - This level always requires immediate action.**
1) On the phone
a. Confirm the patient's current phone number and location.
b. Instant message to practice/clinical leader who will notify/consult immediately with physician/designee.
c. Ask patient if they are currently safe while you complete an assessment.
i. If patient is unsafe, call 9-1-1. Attempt to keep patient on the line until police arrive.
1. If patient's support person is known, it is appropriate to contact the support person with or without patient's consent.
ii. If currently safe
1. Identify a family or friend in order to further assess risk level/strength of support system.
2. If patient and support person states they are safe, arrange for an appointment or send to hospital Emergency Department.

2) Patient present in the office
a. Nurse or physician/designee stays in room with patient sending an instant message to practice/clinical leader, provider and fellow care team members who will:
b. **Off campus offices/clinics:** Activate 9-1-1 to bring patient to emergency room via ambulance.
c. **On campus offices/clinics:** Utilize office Social Worker, if available, or call Security if necessary to keep patient safe, then escort to the hospital Emergency Department.
d. Contact hospital Emergency Room, (**SM Express at 685-4800**) with pertinent Hand Off information and for further evaluation/disposition.

ii. **Moderate to High Risk - Current/acute thoughts with plan but no means or intent.** This risk level may not require immediate hospitalization but should be addressed clearly and specifically including statements such as: What keeps you from attempting to harm yourself? Substantiate that it is a good reason to live.
1) Patient makes threat on the phone
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient/support person information contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department
2) Patient present in the office
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient information about contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department

iii. **Chronic/Lower Risk -Chronic thoughts with no intent, plan, or means**
1) Patient makes threat on the phone
a. Discuss with designated provider within 24 hours;
b. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to ER
2) Patient Present in the office
a. Notify/consult with patient's physician/designee within 24 hours
i. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
a) Suicide Hotline 1-800-273 TALK or 1-800-784.2433
b) Proceed to ER
iv. **Follow up and Documentation**
1) Following contact with the patient
a. Confirm all plans are in place and responsible parties have been notified
b. Determine next steps
i. Follow up with patient/family
ii. Follow up with facility/provider
iii. Provide any additional necessary information as necessary (medications, current plan of care, contact information, certification actions)
2) Documentation
a. Document in patient record
b. Documentation should include but is not limited to:
i. Assessment
ii. Screening tool (PHQ-9)
iii. Interventions and actions taken
iv. Follow up plan

REFERENCES: 2012 National Strategy for Suicide Prevention; Goals and Objectives for Action, Washington, DC: HHS, September 2012
Telephone Triage Protocols for Nurses, 4th Edition, Briggs, JK, Lippincott, Williams & Wilkins, 2012
CONCURRENT REVIEW:
Clinical Integration & Quality Improvement Date
Committee Chair
VP, Chief Nursing Officer, MHSM Date

14. Safety Plan Template

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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The one thing that is most important to me and worth living for is:

_____

15. Self-Management Goals Menu

Goals Important to You

-
-
-
-

Healthy Lifestyle

- Exercise regularly
- Avoid addictive substances
- Make healthy food choices and eat at a regular time in a comfortable space
- Get regular sleep

Relationships

- Spend time with others
- Go to social events or get coffee with friends
- Build supportive relationships

Stick With Your Plan

- Take medications as directed
- Keep appointments
- Participate in groups/counseling
- Stay in touch with your care manager
- Work on your goals

Productivity

- Get involved in workplace projects or community events
- Start or keep working on a regular basis
- Get involved in personal or family activities

Self-Reward

- Plan weekly activities that are relaxing or that you have enjoyed in the past like reading or listening to music
- Take up an old hobby or attend a special event

Spiritual

- Connect with a spiritual community
- Look for ways to meet your spiritual needs such as quiet study, meditation, services/ceremonies

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16. Self-Management Action Plan

SELF-MANAGEMENT ACTION PLAN

Patient Name:	**Date:**

Staff Name:	**Staff Role:**	**Staff Contact Info:**

Goal: *What is something you WANT to work on?*

1.

2.

Goal Description: *What am I going to do?*

How:

Where:

When:	**Frequency:**

How ready/confident am I to work on this goal? (Circle number below)

Not Ready 1 2 3 4 5 6 7 8 9 10 Very Ready

Challenges: *What are barriers that could get in the way & how will I overcome them?*

1.

2.

3.

What Supports do I need?

1.

2.

3.

Follow-up & Next Steps (Summary):

1.

2.

3.

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17. Care Manager Follow-up Guide

COMPASS

Care Management Phases & Follow-up Guide

This tool provides recommended guidance for the COMPASS team assisting a patient through the phases of care. Each system has to determine the tailoring needed within their own processes to operationalize this guide to its fullest. Above all, remember the patient is fluid and not a referral to be "handed off" to any one team member and then "given back". Communication leading up to and following each transition is critical to ensure all members of the team including the patient are aligned with the same goals. Stages of change and readiness are parallel aspects of this flow and may resonate with some users in applicability.

Active Engagement Phase

1st & 2nd contacts

- Determine eligibility & appropriateness
- Introduce COMPASS & set the roadmap for care
- Start building relationship with patient to identify preferences, strengths and challenges
- Establish primary care team communication strategy, engagement plans, caseload impact & understanding of patient care needs

Active Management Phase

Weekly contacts in the first month
Every other week over the next 2-3 months

- Clinical prioritization, assessment of red flag risks and identify patient preferences
- Establish care plan including both short & long term goals for optimal improvement
- Purposeful care management using Motivational Interviewing, Behavioral Activation & goal setting that links treat-to-target clinical plan including med intensification with personal health goals by developing strategies for self-monitoring, treatment (including medications) adherence and problem solving skills
- Shared understanding of working toward optimal maintenance of the chronic conditions and the organic but intentional process of outcome oriented care management

Active Transition Phase

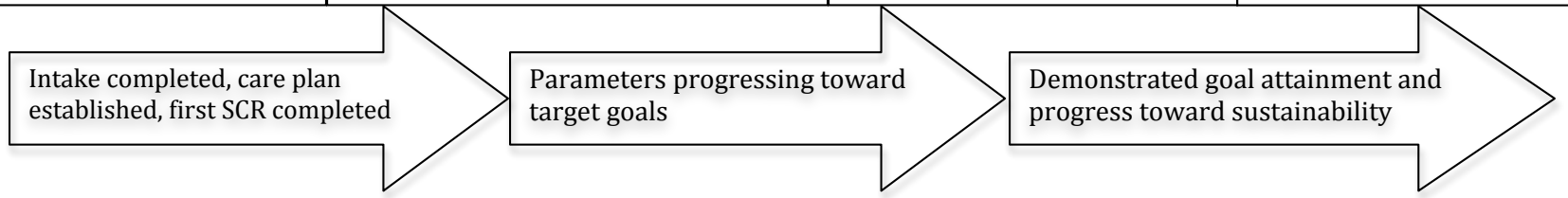
Frequency gradually extended
Average duration 5-18 weeks

- Based on pt's progress with clinical and personal goals and agreement that significant improvement has been made.
- Less frequent contacts as an opportunity for pt to practice identifying triggers, problem solve and self-monitor.
- Duration may need to be variable based on pt readiness, unanticipated pitfalls and ongoing coaching needs but overall becomes longer periods of self-management success.
- Starting to build maintenance plan using pts own words for what has contributed to improvement & problem solve obstacles

Maintenance Phase

Monthly to every 3 mo
Average duration 6-12 months

- Patient has been practicing and more consistently demonstrating self-management including ability to identify triggers, setbacks and opportunities
- Maintenance Plan has been developing along the way and patient can now articulate and complete own written plan for sustainment (example: own personal "yellow zone" and when to contact clinic when things come up and assistance is needed)
- Schedule established for PCP follow-up and lab/clinical monitoring intervals
- Primary care team understanding of maintenance plan including support role and and routine follow up expectations



18. Mi-CCSI Relapse Prevention Plan

Relapse Prevention Plan

A Relapse Prevention Plan focuses on stress reduction and self-monitoring and can help you to recognize depression early.

Patient Name: **Today's Date:**

Program activation date:

Contact/Appointment information

Primary Care Provider:_____

Next appointment: Date:_____Time:____

Care Manager:_____ Telephone number:_____

Next Appointment:_____ (circle one-6 mo/12mo follow up call)

**Use the depression-fighting strategies that have worked for you in the past, including taking your antidepressant medication regularly, increasing your pleasurable activities and maintaining a healthy lifestyle.

Maintenance Antidepressant Medications

Diagnosis:_____

1.

2.

You will need to stay on your medications to avoid relapse of depressive symptoms. If you feel you need to change or stops medications-please call your Primary Care Team. Your Physician can help you decide the safest options for medication changes.

Other Treatments

**Write down the problems that can trigger your depression and strategies that have helped you in the past.

• What are some of my everyday stressors?

• What coping strategies have worked for me in the past?

• Are these skills I can use every day or every week?

• How can I remind myself to use these skills daily?

**Watch for warning signs by regular self monitoring. You can check routinely for personal warning signs or telltale patterns of thought or behavior. You may want to ask a partner or friend to let you know if they notice any warning signs

**Use the PHQ test to check your depression score. If your score goes up over 10, it's time to get help again.

Triggers for my depression:

1.

Personal Warning Signs

1.

Coping strategies:

1.

Goals/Actions: How to minimize Stress from Depression

**Try to identify three or four specific actions that will help you. Be realistic about what you can and will do.

**Prepare yourself for high-risk situations.

• What are some problems or predictable stressors that might affect you in the future?

• Can you do anything to make a particular event less likely or less stressful?

• If you can't avoid a stressful situation: can you avoid negative reactions (like criticizing yourself) or react in a more positive way?

1.

2.

3.

4.

When we've made changes in our behavior, there's always a tendency to drift back towards old habits. How can you stop the backward drift?

****Put drift into perspective. We all make plans, but all of us drift away. The key is catching yourself and getting back on track.**

If symptoms return, contact:_____

Patient Signiture_____**Date**_____

Thank you very much for participating in the CoCM at _____!

19. AIMS Relapse Prevention Plan

Relapse Prevention Plan

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Date: _____

Purpose: Depression can occur multiple times during a person's lifetime. The purpose of a relapse prevention plan is to help you understand your own personal warning signs. These warning signs are specific to each person and can help you identify when depression may be starting to return so you can get help sooner – before the symptoms get bad. The other purpose of a relapse prevention plan is to help remind you what has worked for you to feel better. Both of these put YOU in charge!

Instructions: 1. Fill out this form with your care manager. 2. Put it where you'll come across it on a regular basis. 3. Use the PHQ-9 on the back to self-assess yourself. 4. If you see signs of returning depression, use your prevention plan.

Maintenance medications

1. _____; _____tablet(s) of _____mg _____Take at least until_____
2. _____; _____tablet(s) of _____mg _____Take at least until_____
3. _____; _____tablet(s) of _____mg _____Take at least until_____
4. _____; _____tablet(s) of _____mg _____Take at least until_____

Call your primary care provider or your care manager with any questions (see contact information below).

Other treatments

1. _____
2. _____
3. _____

Personal warning signs

1. _____
2. _____
3. _____
4. _____

Things that help me feel better

1. _____
2. _____
3. _____
4. _____

If symptoms return, contact: _____

Primary Care Provider: _____ Phone: _____ Email: _____
Care Manager: _____ Phone: _____ Email: _____

Next appointment: Date: _____ Time: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
		add columns:	+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)		**TOTAL:**		

10. 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 _____

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at *http://www.pfizer.com*. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

ZT242043

20. Case Studies

EXAMPLE 2: Good as it gets

Care Manager Note Feb 5, 2021

SUMMARY/UPDATES FROM LAST MONTH:
37 y.o. female with a history of Depression and PTSD who is referred to IBH Care Coordination for management of depressive symptoms. Over time in care coordination it has become clear that she has many of the characteristics of borderline personality disorder.

Date of enrollment: 2/1/2/20

PHQ-9 at enrollment: 12

PHQ9 Score	11/12/2020	12/31/2020	2/5/2021
PHQ-9 Total Score (max 27)	10	13	12

GAD7 Score	11/12/2020	12/31/2020	2/5/2021
GAD-7 Total Score (max 21)	9	12	15

Hospitalizations since enrollment: 0
ED visits since enrollment: 0

Current pharmacological interventions:
Duloxetine 60 mg
Abilify 7.5mg since 1/14/21

Pharmacological interventions since enrollment:
Abilify 2.5 mg added 7/22/20 - Increased to 5 mg 11/1/6/20 - Increased to 7.5 1/14/21
Seroquel 25 mg started 9/1/20 - denied any benefit, felt too drowsy. Stopped 9/21/20
Abilify 1 mg added 9/21/20 titrated to 2 mg approx. 10/12/20, back to 2.5 mg
On 11/2/20. Was on lamotrigine and fluoxetine on enrollment.

Current nonpharmacological interventions: Agreed to enter therapy and has shown evidence of following up with DBT through local psychologist

Past medication trials:
Wellbutrin. Effexor. Zoloft. Celexa. Lexapro. Lamictal.

Current Outpatient Medications:

- **ARIPiprazole** (ABILIFY) 5 mg tablet, Take 1.5 tablets (7.5 mg total) by mouth daily.
- calcium carbonate (TUMS) 500 mg (200 mg calcium) chewable tablet, Chew 2 tablets 3 (three) times a day as needed for indigestion or heartburn.,
- **DULoxetine** (CYMBALTA) 60 mg DR capsule, Take 1 capsule (60 mg total) by mouth every evening., Disp: 90 capsule, Rfl: 3
- loratadine (CLARITIN) 10 mg tablet, Take 10 mg by mouth daily., Disp: , Rfl:

Previous recommendations

1. The patient is coming up on a year in care coordination and her symptoms that remain elevated, appear to be at least in part, related to learning new coping skills in DBT. She is not routinely connecting with care coordination towards any particular goal, but rather uses care coordination more when in a crisis. Would move towards discharge and review crisis management plans.

Updates since last monthly SCR:

Prior to this contact, the patient had a pattern of not responding to calls and only reaching out when she was having a crisis. On this occasion, she responded to a call and states increased anxiety, describing a clock watching feeling and reports feeling like her anxiety is on the verge of panic at times, but is able to work through it. Aripiprazole only partly helpful.
States is doing group DBT, individual therapy, exercising regularly, staying busy around the house, and taking her meds regularly.

I have informed patient that we are at year mark for care coordination and at this point we do typically discharge patients from the program and have encouraged her in connecting with a psychiatric provider in the community and continuing to utilize all aspects of her individual and DBT program and resources within these two.

FEBRUARY 7, 2021 – PSYCHIATRY SCR NOTE

PATIENT WAS NOT SEEN and information was gathered by the care coordinator, Florence Nightingale, RN. See care coordinator notes for additional details. Care coordinator documentation associated with these recommendations can be accessed by clicking the hyperlink below.

RECOMMENDATIONS:

1. Residual symptoms on the PHQ-9 are in fatigue and sleep. concentration as well as feeling bad about herself (9 out of 12 points). She has been on bupropion in the past as an augmentation agent but also has a history of bulimia. Would need to explore her anxiety management before adding this option as a future consideration.
2. She has made progress in care coordination related to coming to the understanding that many of her symptoms are related to her personality and coping style. She is working hard to address them in therapy.
3. Would suggest she be discharged from care coordination given inconsistent follow up on behavioral activation or medication options and she has a good therapy plan. In regards to another medication change, if she would be open to scheduling an intake in the community with a psychiatric prescriber, we may be able to follow as a bridge to that visit but would hesitate to make medication changes without follow up with someone.

PATIENT WAS NOT SEEN and information was gathered by the care coordinator. Recommendations are based on chart review and discussion with the care coordination team. The intention is for these recommendations to be seen as options/suggestions by the care coordination team. The application of these or other clinical recommendations are subject to PCP's discretion and clinical discussions with the patient.

Example 3: Partial improvement

NOTE BY CARE MANAGER

PATIENT WAS NOT SEEN and information was gathered by the care coordinator, Florence Nightingale, RN. See care coordinator notes for additional details. Care coordinator documentation associated with these recommendations can be accessed by clicking the hyperlink below.

SUMMARY/UPDATES FROM LAST MONTH:
45 y.o. female with a history of Depression and Anxiety who is referred to IBH Care Coordination for help in management of mood symptoms. Several life situations appear to have been involved in her presentation (loss of her father and the pandemic).

Date of enrollment: 9/17/20

PHQ-9 at enrollment: 24

PHQ9 Score	11/13/2020	11/27/2020	12/28/2020
PHQ-9 Total Score (max 27)	10	12	12

GAD7 Score	11/13/2020	11/27/2020	12/28/2020
GAD-7 Total Score (max 21)	7	14	10

Goals unique to this patient:
1. Connect with therapy
2. Identify more time to spend with husband

Mental Health hospitalizations since last SCR: 0
Mental Health ED visits since last SCR 0

Current Psychotropic Medications (including date of last dose change:)
Lexapro 15 mg

Pharmacological interventions since enrollment (including failed medication trials):
Lexapro 10 mg increased to 15mg on 12/28/20

Current Psychotherapy relationship:
IBH - appointment with therapist -11/27/20

Current Outpatient Medications:
• clonazePAM (KlonoPIN) 0.5 mg tablet, Take 1 tablet (0.5 mg total) by mouth daily as needed for anxiety., Disp: 10 tablet, Rfl: 0
• escitalopram (LEXAPRO) 10 mg tablet, Take 1.5 tablets (15 mg total) by mouth daily., Disp: 135 tablets, Rfl: 3
• Tri-Sprintec, 28, 0.18/0.215/0.25 mg-35 mcg (28) per tablet, TAKE 1 TABLET BY MOUTH DAILY AS DIRECTED, Disp: 84 tablet, Rfl: 3

Previous SCR recommendations:
1. Continue Lexapro 15 mg/day.
2. Continue therapy with Social worker. CBT workbook.

Updates since last SCR (Medications, non-pharmacologic interventions, progress towards previous recommendations):

Reports feeling about the same. States has had some increased anxiety in terms of return to school and feeling like the school she works in is not following the Governors order. Susan states she has felt an increase in her anxiety related to this and feels like this is the main thing driving her anxiety. Susan states she has been getting out of the house, forcing self to do things, and got together with brother who she had a fall out with after her father's death.

Susan has previously said that after some thought she would like to go ahead and go up on her Lexapro dose to 15 mg. We discussed this and agreed that this would be a good addition to helping to get some relief from her mood symptoms. Susan and I both also discussed nonpharmacological approach to her mood and working with a social worker in IBH to help with a cognitive approach for her anxiety.

Unfortunately, Susan canceled and no showed her last 2 appointments with the CBT provider and when talking with Susan about rescheduling these she stated she would like to consider waiting until the spring or summer to do appointments like this. Susan and I discussed this together and I challenged Susan in not working on skills currently to address challenges that are going on currently. We discussed that with the pandemic if we were to find a positive in this, maybe it would be that therapy appointments are often being done virtually which can increased flexibility for this. Susan remained resistive to this and stated she was unsure. I did describe a CBT and mindfulness app with her and encouraged her to explore this as it has some beneficial tools for building and maintaining resiliency and is something she can do on her own time. Susan acknowledged this and stated she would look into this.

From SCR: RECOMMENDATIONS BY SCR PSYCHIATRIST

RECOMMENDATIONS:

1. Outside of medications, the patient is not open to changes and wants to wait until the situation (pandemic) changes. She can get what she seeks outside of care coordination. We have not seen a new PHQ-9 since her last dose increase of escitalopram but she has not sent them in. We can pass the next steps to her PCP and back up her PCP outside of care coordination. Would move towards discharge.

PATIENT WAS NOT SEEN and information was gathered by the care coordinator. Recommendations are based on chart review and discussion with the care coordination team. The intention is for these recommendations to be seen as options/suggestions by the care coordination team. The application of these or other clinical recommendations are subject to PCP's discretion and clinical discussions with the patient.

21. Initial Care Manager Note Example

Florence Nightingale is a 73 y.o. female, with a history of Depression and Anxiety who is referred to IBH Care Coordination for help in management of mood symptoms.

Primary symptoms of concern: Increased irritability

Current stressors: Physical health, increased difficulties with memory

The following patient reported outcomes were completed:

PHQ9 Score	11/2/2016	6/15/2020	7/13/2020
PHQ-9 Total Score (max 27)	1	6	11

GAD7 Score	6/15/2020	7/13/2020
GAD-7 Total Score (max 21)	5	5

Current psychiatric pharmacological interventions: nothing currently - Patient states she would prefer not to take psychotropic drugs, but states they also have not been offered. States her personal reason is history of seeing people "get really messed up".

Does have prescription for amitriptyline 10 mg for sleep, states does not taking regular. States has fear of falling when getting up in the night.
Current nonpharmacological interventions: Meditation, prayer, exercise (2-3 times a week)
Current psychotherapist: denies
Current psychiatric prescribing provider: denies

Suicidal Ideations: denies
Non-suicidal self-injury: denies
Homicidal ideations: denies
Access to firearms: denies

Sleep: Reports sleeps in 2 hour periods of time, notes getting up to go to the bathroom, occasional GI distress, reports this is fairly regular. No difficulty with falling asleep. Amitriptyline, does not take regular basis, states fear of falling when getting up. Does endorse slightly better sleep when using, NO CPAP, getting overnight oximetry test.

Pain interference: Some chronic abdominal pain following Whipple procedure in Oct 2019. Reports pain is most noticeable in the evening when lying down

PAST MEDICAL HISTORY

Medical History:
Patient Active Problem List
Diagnosis
- Hyperlipidemia
- Hypertension Essential Primary
- Diverticulitis Colon
- Breathing Related Sleep Disorder
- Personal History Of Other Malignant Neoplasm Of Skin
- Gastroesophageal Reflux Disease NOS
- Hypothyroidism Primary
- Implant Breast Status Post
- Insufficiency Venous

- Neuropathy Peripheral
- Osteopenia
- Tremor Essential
- Varicose Vein Lower Extremity With Pain Bilateral
- Other Specified Diseases Of Biliary Tract
- Cancer Breast Personal History
- Overgrowth Bacterial Small Bowel (HCC)
- Fever Of Unknown Origin
- Depression Major Recurrent Moderate (HCC)
- Anxiety
- Irritable Bowel Syndrome With Diarrhea

Lab Results

Component	Value	Date
TSH	7.6 (H)	07/10/2020

Mental Health History:
Reports onset of depression after Whipple procedure (Oct 2019), denies any other treatment for depression. Husband reports a different person since surgery. States she was very positive, happy, smiling, did a fair amount of volunteer work, and feels she has lost all of that

Past medication trials: denies
Mental Health Hospitalizations: Denies
Mental Health ED Visits: Denies

Past psychotherapists: Denies
Past psychiatric prescribing provider: Denies
Past ECT/TMS/Ketamine: Denies
Genomic testing: Denies

Past suicide attempts: Denies
Past non-suicidal self-injury: Denies
Past homicidal ideations: Denies

FAMILY HISTORY

Sister - Depression - unsure of treatment method

SOCIAL HISTORY

Born and raised in Iowa by Mom and Dad is oldest in a sib ship of 6. Reports overall good childhood and was raised by "good parents". Reports a good relationship with all of her siblings and has regular contact with all of her sisters and brothers. States between her and her husband they have 8 children, states 2 children that live close by and others are somewhat scattered and 6 grandchildren in Owatonna

History of trauma/abuse/neglect: denies
Learning: denies
Military history: denies
Legal history: denies

Current support: Husband, sisters, multiple friends

Patient reports the following leisure activities: Walking, reading, used to volunteer (not currently), puzzles, video games on computer

Social Determinants of Health:
No categories of concern noted by patient.

Substance abuse: denies
Nicotine use: denies
Supplement use: Women's multi vitamins
Caffeine use: Minimal caffeine
Physical activity: Walking 2-3 times a week

Past chemical dependency treatments: denies

ASSESSMENT / PLAN

The following program goals were identified:

Patient goals for care coordination:

1. Work on establishing a schedule for walking 15 minutes a day
2. .Would be open to listening to medication options
3. Identify strategies for maintaining mood despite and resilience

Referrals: No additional referrals needed at this time

Next contact: 1 week(s) by Phone Call.

22. Follow-up Care Manager Note Example

Care manager monthly note:

SUBJECTIVE

REASON FOR VISIT

Integrated Behavioral Health (IBH) Care Coordination Monthly Systematic Case Review (SCR)

ASSESSMENT

Florence Nightingale is a 73 y.o. female with a history of Depression who is referred to IBH Care Coordination for help in mood management

Date of enrollment: 7/14/20

PHQ-9 at enrollment: 11

The following patient reported outcomes were completed:

PHQ9 Score	6/15/2020	7/13/2020	8/5/2020
PHQ-9 Total Score (max 27)	6	11	0

GAD7 Score	6/15/2020	7/13/2020	8/5/2020
GAD-7 Total Score (max 21)	5	5	0

Goals unique to Florence Nightingale, RN:

1. Work on establishing a schedule for walking 15 minutes a day
2. Would be open to listening to medication options
3. Identify strategies for maintaining mood despite and resilience

Mental Health hospitalizations since last SCR: 0
Mental Health ED visits since last SCR 0

Current Psychotropic Medications (including date of last dose change:)
Mirtazapine 15 mg

Pharmacological interventions since enrollment (including failed medication trials):
Amitriptyline discontinued

Current Psychotherapy relationship:
N/A

Previous SCR recommendations:

1. She has recently had her thyroid medication increased (this month) and she has been describing sleep issues as primary with fears about falling from amitriptyline (given per records for bowel issues). No other trials. Will need a follow up TSH in the fall.
2. With memory concerns and worries about a fall, amitriptyline is not ideal. Could test out a low dose of mirtazapine to see if she sleeps better without any dizziness but she should still get up carefully.

3. She may be having some challenges related to medical issues and stress. Therapy could look at CBT for insomnia and resilience support.

Updates since last SCR (Medications, non-pharmacologic interventions, progress towards previous recommendations):
Doing well, just recently spent some time in northern Minnesota. Reports has also been spending time in the garden and this has been enjoyable. Continues to spend time talking with sister and friends and finds this helpful. Denies any specific difficulties with her mood. In terms of Mirtazapine, Florence does feel this has been an improvement from the Amitriptyline. I did ask if I could check in with her husband to get his perspective on overall improvement given history of some mild memory concerns, but he was unavailable and so I will check in with him later.

23. SBAR Care Review Tool

Mi-CCSI Center for Clinical Systems Improvement

SBAR Case Review Tool

Patient Name: Date: PCP:

Situation (brief, 2 sentences)

Age Race Care Management start:

Main Care concern(s) (behavioral/medical/physical:

Background

Tobacco/Substance use:
Diagnoses:
Living situation/support system:
Health Literacy:
Adherence barriers/concerns:
Key leverage point: (pt. values/strengths etc…)

PHQ(9) latest:
BP latest:
A1c latest:
LDL latest:
HF Classification/EF:
MMSE latest:
eGFR

PHQ(9) previous:
BP previous:
A1c previous:
LDL previous:

Other Provider specific information:

Medications:

Allergies and Medications tried:

Imaging:

Consultants:

Assessment

Successes: Challenges: Prioritize care issues:

Recommendations

Behavioral:

Medical:

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