Referral Management Program

VOLUME 4

FOUNDATIONS FOR INTEGRATED CARE

Behavioral Health Solutions for Primary Care.

Foundations for Integrated Care

LEARNING MAP

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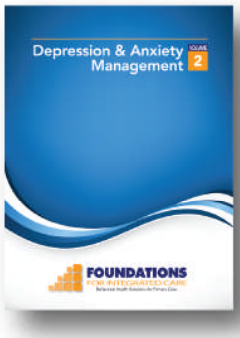
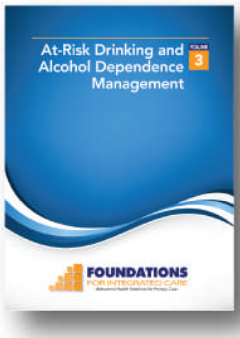
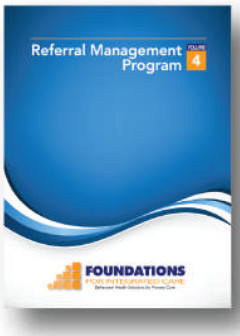
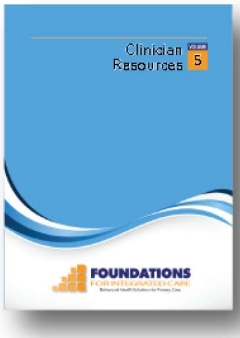
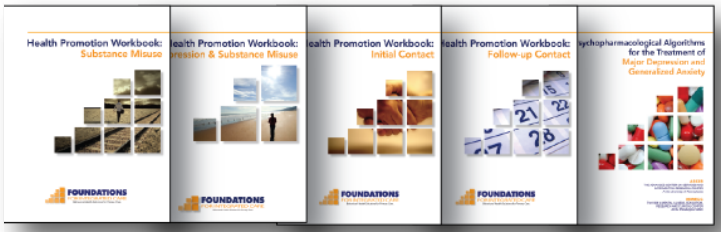


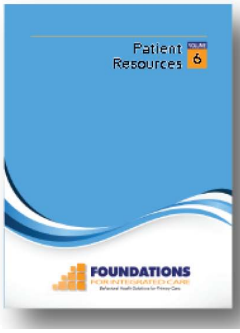




Additional Resource Materials







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CHAPTER 1

Using This Training Manual

This training program, entitled **Foundations for Integrated Care**, will assist you in expanding your knowledge and appreciation of integrated care, i.e., providing behavioral health care within primary care. In addition, the training manuals will serve as an ongoing reference guide. The current manual, *Referral Management*, will introduce you to an intervention intended for patients being referred to specialty Mental Health services with the goal of enhancing treatment engagement. If you are reading this manual, it is assumed that you have already completed Volume 1, Building a Strong Foundation. Volume 1 provides you with a strong foundation in the important components and practices within integrated care. In addition, Steps 1, 2, and 3 of the clinical program are outlined in much more detail than is found in this manual. Finally, the intervention described in this manual relies heavily on Motivational Interviewing, a clinical skill described in Volume 1.

The primary intended audience of this manual is behavioral health providers (BHPs) working or intending to work within an integrated primary care setting; however, other primary care team members as well as specialty mental health and addiction providers may find it useful to understand the rationale and components of the intervention. Alternatively, at sites without referral management, specialty mental health and addiction providers and staff may decided to implement the intervention on their own as an effective tool to increase initial treatment engagement for their patients. Behavioral health providers are strongly encouraged to supplement this training with additional training opportunities noted in Volume 1 and this manual, including training in Motivational Interviewing.

The following icons are used as visual guides throughout this manual:

Graphic Icons/Cues		
Key Points Course content that plays an important role in the overall learning experience.	**Practice Dialogue** Course content that contains dialog that is best practiced by speaking the text aloud.	**Check it Out** Course content specific to Health Technician level staff.
Practice Discussion Course content that depicts typical patient interactions, best practiced as a role-play.	**Procedure / Steps** Course content that illustrates step-by-step instructions, procedures, or protocols.	**Tips: Learning** Course content that provides useful tips for enhancing the overall learning experience.

CHAPTER 2

Referral Management

In Volumes 1 through 3 of this training program, you learned about how to provide mental and behavioral health treatment within the primary care setting. In this Volume, you will learn how to facilitate a smooth transition from primary care to specialty mental health care for those patients needing or requesting that level of care. Although many patients can, and prefer, to receive mental health and substance abuse treatment within primary care, patients with more severe or complicated symptoms are more effectively and safely treated within the specialty care clinic. Yet, there are substantial barriers that limit engagement in specialty mental health care. These barriers, including stigma, practical issues such as transportation, access issues, scheduling limitations, as well as patient ambivalence, commonly result in low rates of referral completion.

Referral Management (RM) is an evidence-based clinical program designed to increase engagement in mental health (MH) and substance abuse (SA) treatment for patients referred from primary care who have complex behavioral health care needs. The intervention utilizes a motivational interviewing style to help increase motivation and address any ambivalence about treatment, as well as, problem solving to identify and address any perceived treatment barriers.

While the focus is on those experiencing severe mental illnesses who are referred to specialty mental health and addiction services, this clinical program can be adapted to other types of medical specialty care referrals such as engagement of patients in cardiac rehabilitation or other types of chronic medical management program.

Learning Objectives

Completion of this training program will build clinical skills and achieve the following objectives:

- Understand the theoretical framework for assisting patients seen in primary care to achieve success in engaging and sustaining engagement in specialty care
- Review the basic skills in using motivational interviewing strategies
- Understand the utility of using structured assessments to facilitate triage decisions
- Learn the utility of a patient tracking registry to assure patients are not lost or forgotten
- Learn how to effectively use telephone visits to enhance engagement in treatment
- Learn how to integrate the use of support staff (ex. Health Technicians)

CHAPTER 3

Evidence Base

The treatment of patients with mental health or substance abuse problems is compounded not only by the complexity in tailoring effective treatments, but also by the difficultly in initiating patient engagement. There is substantial anecdotal and research evidence that shows many patients in need of specialty MH/SA care are not referred and when they are referred seldom engage. Many different approaches have been taken to try and enhance treatment engagement including phone call or mailed reminders, patient centered scheduling, or open access/walk-in clinics. Despite those efforts many patients still fail to engage. To improve engagement, research has demonstrated that using tailored feedback, motivational techniques, and tracking outcomes can lead to substantial improvement in treatment engagement. In one study that included 113 participants, 57 participants took part in a referral care management program and 56 participants were scheduled with a specialty care appointment.

While only 32% (N=18) of those with the simple referral attended a specialty care appointment, 70% (N=40) of those in the referral care management program attended at least one specialty care appointment. There were no differences in appointment attendance when comparing diagnostic groups (Depressive Disorder, Substance Use Disorder, or Comorbid) or age groups (55 or younger, or older than 55). The referral management program outlined in this module is principally based on this research. These important findings support the use of the Referral Management program with patients identified for referral to specialty care. In the study, participants in referral care management were contacted prior to the specialty care appointment, which is also an option for programs with adequate available resources. The Referral Management program emphasizes contacts with the patient after the first missed appointment, thus focusing on the 68% of patients who do not attend their appointment based on simple referral techniques.

CHAPTER 4

Overview

Referral Management (RM) is a manualized clinical service that is based on Motivational Interviewing [12]. RM aims to increase motivation by addressing ambivalence associated with seeking MH/SA treatment as well as reduce barriers to treatment engagement. RM is often telephone based due to convenience for the patient and logistical reasons. However, it may also be done in person, particularly with a patient that you have been meeting with who you feel could benefit from stepping up to specialty care. Patients who are ambivalent about treatment will benefit from this intervention as well as patients who have barriers to accessing treatment.

The clinical intervention consists of telephone contact(s) made to patients to address, in a patient-centered way:

1. How the patient's emotional distress and/or substance misuse is affecting them
2. The potential benefits of symptom reduction/control
3. The possible benefits of attending treatment appointments
4. Problem solving any treatment barriers

The timing of the initial RM contact is anticipated to be site-specific, largely based on program resources and goals. Some Integrated Care programs conduct the initial RM patient contact prior to the first MH/SA appointment, while other programs reach out to the patient after the patient has failed to keep the MH/SA appointment. In general, the language in this manual and the accompanying materials describes the latter, where the patient has already missed a specialty care appointment. However, the intervention and materials can be easily adapted for either scenario. For example, you may decide to contact patients who need addiction services prior to the initial appointment, whereas patients with primary psychiatric illnesses you may contact only after an initial missed appointment.

The RM intervention is laid out in a workbook format. The BHP completes the workbooks with the patient, filling out appropriate sections and utilizing the workbook as a guide. The completed workbook is given to the patient to serve as a reminder of his/her reasons to attend treatment. Additional contacts from the behavioral health provider are dependent upon whether the patient successfully attends his/her MH/SA appointment.

PROGRAM ? DECISION

Staffing
RM services are appropriate to be delivered by the wide range of clinicians that serve in the BHP role. Based on site resources, RM services may also be effectively delivered by well-trained and actively supervised psychology/health technicians (HTs). While the use of HT staff allows for the opportunity to increase program outreach across all services, it is also likely that RM services delivered by HT staff will have a decreased clinically-driven component. HT delivered RM services are anticipated to be more scripted and structured, with emphasis on specific tasks such as problem solving around transportation barriers. If HTs are utilized as "front line" staff in the delivery of RM, the general HT training strategies outlined in Volume 1 should be completed before RM training is introduced. Training in the techniques of Motivational Interviewing outside of what if presented in Volume 1 should be incorporated into the RM training. Ongoing training and regular supervision from the BHP or other integrated care clinician should include the review of current cases.

CHAPTER 5

Motivational Interviewing Techniques

Referral Management Interviewing (MI) to help facilitate a constructive discussion around engaging in MH/SA treatment. This style is especially useful when someone is reluctant or ambivalent about engaging in treatment or changing their habits because it enables the patient to make a decision to change. It is a supportive and respectful approach that is persuasive without being coercive or cajoling. For example, rather than telling a patient why you think they should attend a mental health appointment, it is far more effective and empowering to ask the patient their own reasons for attending. An MI style involves remaining non-judgmental, and helping uses the effective communication style of Motivational to reflect back the patient's intrinsic motivation rather than confronting or giving advice.

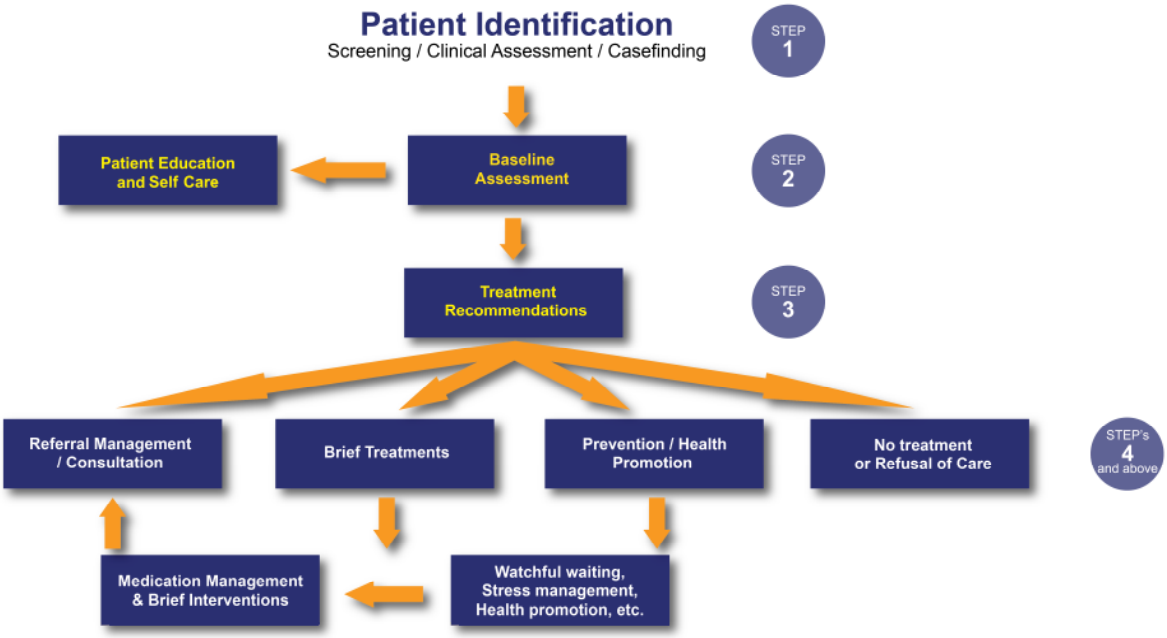
A simple definition of motivational interviewing is "...a constructive discussion about behavior change." Volume 1 provides an introductory overview of Motivational Interviewing principles and communication strategies. As noted in Volume 1, you are strongly encouraged to seek additional training in this technique as it will lead to increased effectiveness and success not only in delivering RM services but across all of your program's clinical services.

CHAPTER 6

Steps of Referral Management

This section outlines the steps of the Referral Management clinical intervention, starting with entry into the Integrated Care Program. In Volume 1, “Building a Strong Foundation, you learned about identifying patients for your program, conducting an initial assessment and treatment recommendations (steps 1 to 3 of the clinical program). Steps 1 to 2 are briefly reviewed below and Step 3 is tailored to those patients appropriate for RM. The remainder of this section describes the steps of the RM intervention. Keep in mind; this intervention can be used whenever patients are referred to specialty care. Many times it will be as a result of your initial assessment (step 2), but this intervention may also be useful when you have been treating a patient in integrated care and then decide to “step up” the level of treatment to specialty services.

The figure below depicts the clinical process for integrated care. This manual focuses on the referral to specialty care – the treatment recommendation shown on the far left of the figure.



STEP 1 Identifying Patients on the Primary Care Team

As a review, mechanisms for patient identification or referral that have been successful for integrated programs include:

- Primary care provider identification (via telephone, walking the patient down the hall to you, consult, fax, etc.)
- Patient self-identification
- Identification based on positive standardized screens, such as the PHQ-2 for depression or AUDIT-C for alcohol use.
- Routine review of available records

For a complete discussion on how to identify patients on the primary care team, as well as a discussion on marketing to primary care staff, please refer to Volume 1, “Building a Strong Foundation.”

STEP 2 Initial Patient Contact and Baseline Assessment

For a complete discussion on the Baseline Assessment, please refer to “Building a For a complete discussion on the Baseline Assessment, please refer to “Building a Strong Foundation.” The goals in Step 2 are to:

- Confirm with the patient the reason for the referral
- Build rapport with the patient
- Complete a baseline assessment utilizing standardized questionnaires

Remember, your initial contact should be brief (20-30 minutes) with the focus being to make an appropriate triage decision. An appointment with you that is similar in content and length to a specialty care provider does not serve the patient’s needs or your own.

STEP 3 Determining who is Appropriate for Specialty Care

The information gathered in Step 2 is used to make a triage decision to determine the best service or treatment setting for the patient. The goals in step 3 are to:

- Make a triage decision based on the baseline assessment/initial contact (Step 2)
- Communicate the findings and the plan to the PCP

For many patients, the treatment plan is to engage in care with you or a BHP colleague in the primary care setting. RM is intended for patients whose needs are best served in specialty MH/SA settings and the goal of the intervention is to assist those patients with engaging or re-engaging in care. As you recall from Volume 1, integrated care is a population based, stepped care approach that utilizes brief treatments to serve a large number of patients. Those patients with more severe symptoms are better served in the specialty care setting where more intensive treatments are available. Deciding on a triage algorithm is a local decision, but specialty MH services are likely appropriate for patients with severe or complex depression, addiction, psychosis, and other serious mental health issues.

Once you determine that specialty MH care is appropriate, discuss the treatment recommendation with the patient and PCP.

> *"Mr. Jones, based on what we discussed today, I would like to offer you an appointment to see one of the clinicians in the Mental Health clinic. Our MH clinic has a variety of services and treatments available, including individual therapy, group therapy and medications. When you meet with the MH provider, they will talk with you in more detail and discuss the different treatment options with you. How does this sound to you? What questions do you have?"*

Some patients may be hesitant to schedule an appointment in Mental Health and it may help to provide more information and talk about their concerns as well as elicit from them how treatment may be beneficial. Volume 3, Depression and Anxiety Management, **Patient Education for Treatment Choice** section, provides information that may be helpful to you in discussing expectations as well as the nature of treatment options available in specialty care.

PROGRAM ? DECISION

Prior to implementing the Referral Management Program, your program, in consultation with specialty care and primary care leadership, will need to collaboratively decide the threshold for when a patient should be referred for specialty care. Case identification can vary for each site. The threshold can be a positive screen for certain symptoms (such as psychosis or mania) and/or symptom severity based on a scale such as the PHQ9 for depression. Research has shown that patients with more severe depression and those with complex presentations including possible psychosis, drug addiction, mania, etc., will have better outcomes in specialty care settings (Krahn, et al., 2006). This finding is likely related to specialty care's ability to provide a broader spectrum of care, more complex pharmacotherapy, and greater availability of evidence-based psychotherapies.

Facilitating the appointment

Once you and the patient have agreed upon a referral to specialty care, you should try to facilitate the appointment for the patient. If the patient can leave the visit with you with a specialty care appointment scheduled, it greatly streamlines services and may improve patient satisfaction.

If MH services are available within your facility or system, contact the MH clinic or someone with the ability to schedule the appointment while the patient is with you or on the phone. Better yet, ask for scheduling access so that you or a team member may schedule the appointment yourselves. Be sure to ask the patient about their availability and appointment times that would be most convenient for them.

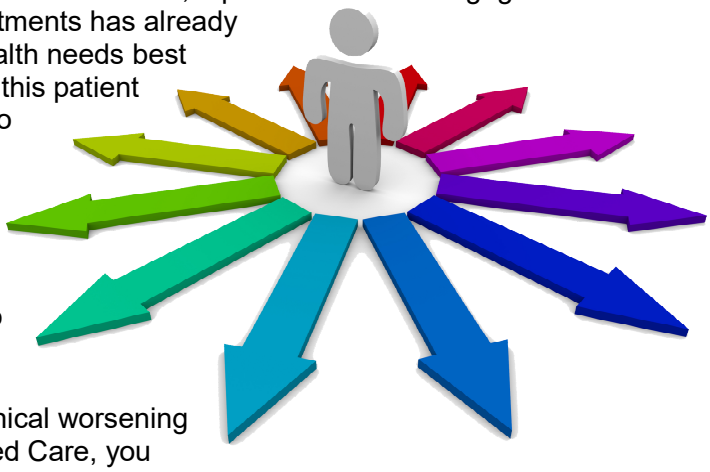
In the community and other settings, it is likely that you will not have the capability to directly schedule appointments in specialty MH/SA care. Your efforts should be directed toward facilitating engagement and empowering the patient to seek out specialty care. These efforts may include facilitating any needed referrals from the primary care provider (PCP), providing information about the MH/SA services that are available in the community, empowering the patient to re-engage with a previously established MH provider or to seek out a new provider, etc. If you are meeting with the patient face to face, you may encourage the patient to call and schedule the MH visit while still in your office. Providing information about available MH/SA services necessarily implies that you are knowledgeable about potential resources specific to the location and other individual circumstances of your RM patients. Keeping track of these resources may be especially challenging if your RM caseload includes patients across a variety of settings, income levels, etc.

Finalizing the treatment plan
Communicate to the patient that you will be following-up with him/her and ask for the best phone number and time to reach the patient. Depending on your program and the patient's needs, the timing of your follow-up will vary (i.e., after a missed appointment, before the initial appointment, or simply for you to be informed of the visit date). If the patient will be independently scheduling the visit, be sure to ask the patient to call you once it is scheduled. Set up the expectation that you will call if you have not heard from him or her.

Communicate the plan to the PCP and document your time with patient. If the appointment information is available to you, send the patient a letter in the mail as a reminder (see Patient Resources for a sample appointment letter).

Entry into Referral Management—Other Potential Pathways
Referral Management, as described in most of this manual's text, follows a very linear process in which patients are identified (Step1), assessed (Step 2), and triaged to specialty care (Step 3), resulting in enrollment into RM. However, there are other potential pathways that can lead to enrolling patients into RM that can be considered by your program.

A baseline assessment may not always be necessary to determine if a patient should be triaged to specialty care and enrolled in RM. For instance, a patient who was engaged in specialty care but missed follow-up appointments has already been identified as a patient with mental health needs best addressed in specialty care. It is likely that this patient may also benefit from enrollment into RM to facilitate treatment re-engagement. On the other hand, even in such cases when a referral is clear, conducting an initial assessment with structured assessments provides clinical data that can easily be shared among providers and contributes to program level data and outcomes.



In addition, for patients who experience clinical worsening while engaged in treatment within Integrated Care, you may decide to step up their level of care by offering specialty care. These patients may also benefit from the RM intervention to make that transition smooth. This includes patients who are currently being managed in primary care by a BHP for depression, anxiety or alcohol misuse.

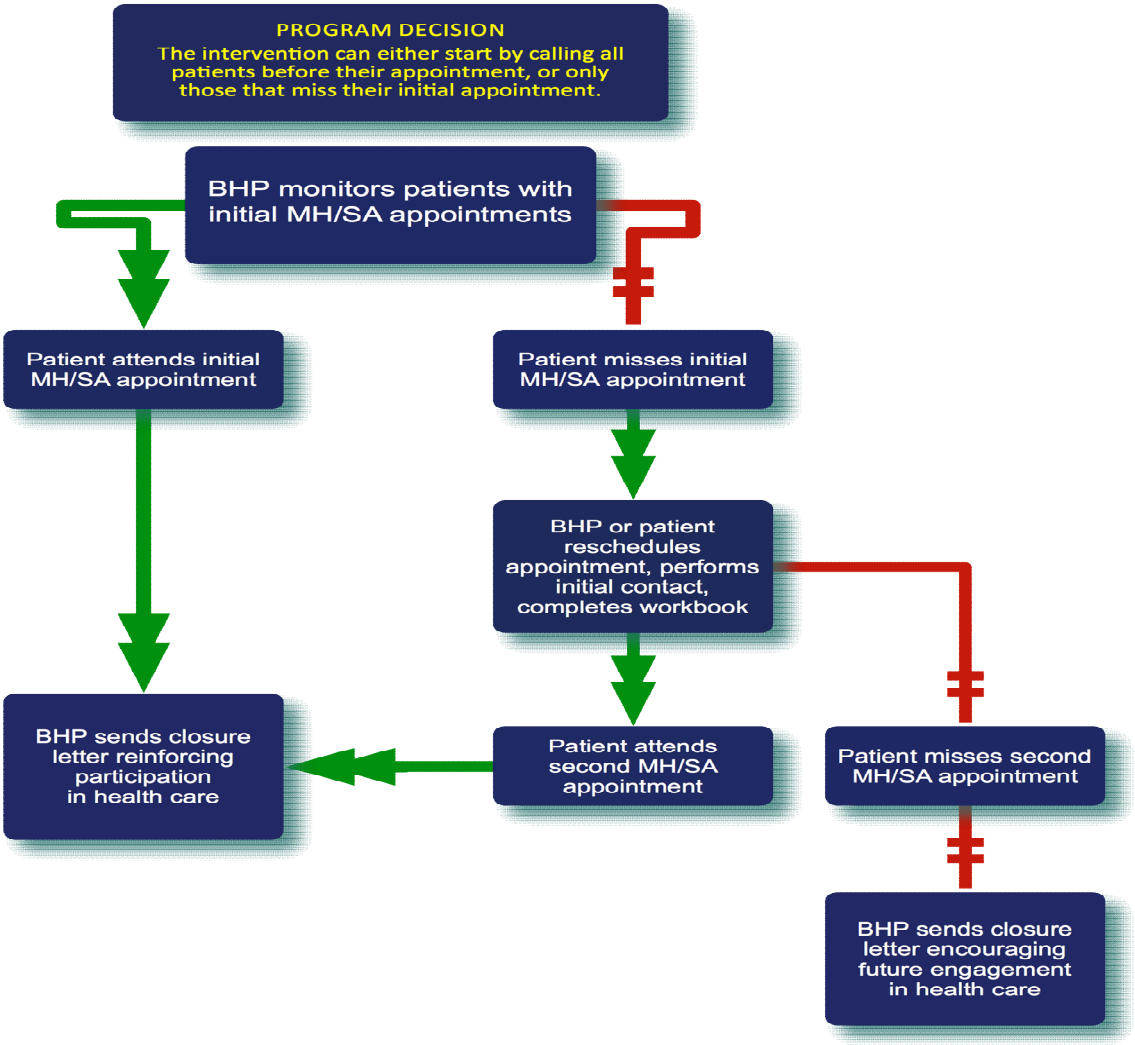
Other patients who may be appropriate for enrollment into RM are those patients who request an appointment with a MH/SA provider. Though not always the case, patients who specifically request specialty care may be more motivated to attend and less likely to need an RM intervention.

STEP 4 Following up on missed appointments – engaging in Referral Management

At this point, you have enrolled the patient into RM. As a reminder, the target population for the RM intervention is any patient that you see in the context of integrated care that you have collaboratively decided, along with the patient and PCP, will be best served in specialty care. The goal of the intervention is facilitate attendance to an MH/SA visit.

Visual Overview of the Referral Management Intervention

The graph below provides a visual overview of the design of the Referral Management service. You will note that the diagram begins with monitoring the patient's attendance at the initial specialty care appointment, with specific actions to be taken based on whether or not the patient attends the scheduled appointment. See the program decision box for the pros and cons of delivering the intervention before the visit versus after a patient has missed their appointment.



PROGRAM ? DECISION

Programs with sufficient resources may elect to engage all patients referred to specialty care in RM activities (initial contact/workbook completion) prior to the scheduled appointment, rather than waiting for the patient to miss his/her specialty care appointment. Offering RM services prior to the appointment allows for the greatest opportunity to lower the overall incidence of missed MH/SA appointments in patients referred through your Integrated Care program. On the other hand, 30-50% of patients will attend the visit regardless of the intervention. Delivering the intervention to all patients means you will inevitably be delivering an intervention to a group of patient not in need. By delivering the intervention after a missed visit, you save your integrated care program resources. However, unattended MH/SA visits utilize specialty care resources

Monitoring Engagement

The first step in the RM diagram is to monitor attendance at the initial MH/SA appointment. For sites with shared electronic medical records, such as the VA system, this is as simple as a quick look in the chart after the appointment date.

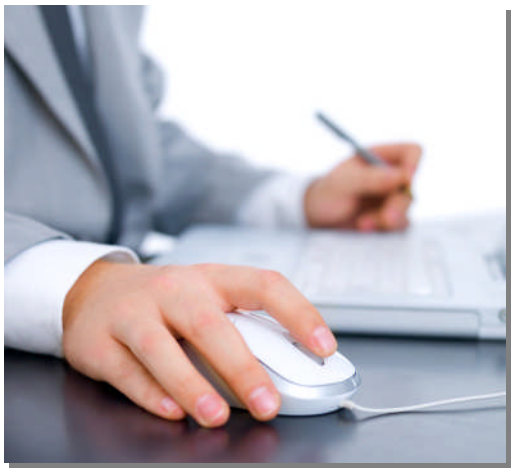
In other settings you will need to contact the patient to find out if they attended. In Step 3, you asked the patient to give you a call and let you know when the visit was scheduled. Follow-up with the patient in the few days following the date of the visit to see if he/she attended.

> *"Hello, Mr. Jones. I am calling to follow-up on our recent phone conversation to see how your MH appointment went."*
>
> Attended: *"I am so glad you were able to attend the appointment. I hope you enjoy working with (provider name). Feel free to contact me in the future if there is something I can do for you."*
>
> Missed: Try to complete the RM intervention at this time. Ask the patient if they have about 15 minutes to talk with you. If not, ask for a better time to reach them.

Health Technician Tip: For sites with health technician staff, a health technician can be assigned the role of tracking and monitoring attendance to the specialty care appointments and alerting the BHS when a patient does not attend the appointment.

To be effective in delivering the RM intervention, you need a system for tracking the patients that you are following and their appointment dates. As such, you are strongly encouraged to develop and use a tracking database. This will help organize your efforts, ensure appropriate and timely patient contact, and significantly decrease the likelihood of a patient becoming inadvertently "lost." At a minimum, information in your tracking database should include patient name and contact information, date of entry into RM, date of MH/SA appointment and whether or not the patient attended. Your tracking database should also allow for expansion to include any rescheduled appointments in those patients who missed their first appointment and the outcome.

Other information that may be helpful includes: dates of attempted and completed patient contacts, name of the provider/clinic with whom the patient has an appointment, dates of mailings to patients, etc. If you are utilizing support staff (such as health technicians (HTs)) to monitor appointment attendance, this database is a great tool for the HT to use to alert you of patients that need to be contacted for the RM intervention. In addition to helping you deliver effective RM services, the development and use of a tracking d atabase also allows the opportunity to provide valuable information to your program administrators about both your efforts as well as overall programs services. It is important to remember that any tracking database that contains patient identifiers needs to be secured and protected according to local guidelines as well as adherent to federal and state privacy and confidentiality requirements. At minimum, the tracking database needs to be stored in a secure setting to which access is limited to appropriate program staff. If stored electronically, the file needs to be on a secure computer and password protected.



The RM Intervention

At this point, you have identified that the patient did not attend the MH/SA appointment and you are ready to deliver the RM intervention.

The RM intervention focuses on the reasons why the patient did not attend the MH/SA appointment and aims to overcome barriers and problem solve with the patient to prevent missing the second appointment. It uses a workbook format to guide the interaction and to serve as a resource for the patient. The intervention takes about 15 minutes, but no more than 20 minutes. The next chapter walks you through each section of the workbook.

The main components of the workbook are to use a motivational interviewing style to engage the patient in discussion about:

- How the patient's emotional distress and/or substance misuse is affecting them
- The potential benefits of symptom reduction/control
- The possible benefits of attending treatment appointments
- Problem solving any treatment barriers

Once you've identified a patient as needing the RM intervention, follow these steps:

1. Reach out to the patient by telephone, making several attempts if necessary. Track all contacts or contact attempts. If you plan on offering the intervention before the first MH/SA appointment, then reach out to the patient 3-5 days before the MH/SA appointment to allow for rescheduling if necessary. If you are following up after a missed visit, start trying to reach the patient the day after their visit. If you are unable to contact the patient, send a letter encouraging him/her to call you.

2. Once you reach the patient, complete the referral management session with the patient utilizing the relevant RM workbook. Step by step instructions on completing the workbook can be found below. Sample workbooks can be found in the Patient Resources volume. Remember that the workbook is meant to guide the conversation, and you may not fill it out in its entirety. Even if the patient agrees to a rescheduled visit at the beginning of the call, we encourage you to complete the workbook. There may be some underlying ambivalence, fears about engaging in treatment, or treatment barriers that that patient may not spontaneously mention at the beginning of the contact.

3. If the patient agrees to attend a new appointment, assist the patient in getting the visit scheduled (see step 3 for a discussion on scheduling visits).

4. Mail the patient the completed workbook. Include a cover letter with either the appointment information, or information on how to schedule the visit (see the Patient Resources Volume for a sample workbook cover letter). Include in the letter any negotiations or expectations that you and the patient agreed to such as the patient calling you with appointment times/appointment attendance or the timeline for you to re-contact the patient.

Second MH/SA Appointment Monitoring
After the RM contact, monitor the patient's attendance to the second MH/SA appointment. Again, the exact mechanism for tracking attendance will be dependent upon access to local records and may require a brief follow-up call to the patient.

Closure

Patients who attend a MH/SA appointment: Send a closure letter acknowledging their attendance, encouraging their future treatment adherence, and stating that you will no longer be contacting them (for sample see Patient Resources). Include a statement making patients aware that they may contact you in the future. At this time referral management is completed.

Patients who do not attend the second MH/SA appointment: After the second missed visit, the RM protocol is complete. Send a closure letter reinforcing your recommendation to pursue treatment and provide appropriate contact information should the patient wish to engage in the future.

Of course, site procedures as well as clinical judgment will determine how many visits you reschedule for a patient. Keep in mind, a patient may agree to a new appointment several times to be agreeable, but never show up in the clinic. In this scenario, the MH/SA clinic's resources are not being used efficiently. Alternatively, the patient's psychiatric symptoms may be affecting their attendance, for example low motivation or avoidance, or the patient may have significant logistical barriers to treatment.

These cases may be appropriate to bring to supervision or consultation, and a decision made as to how to best proceed. If you are facilitating the appointment for the patient, at some point, you may decide to give that responsibility to the patient. In that case, inquire briefly about why they missed the visit, provide the contact information for the MH/SA clinic and let them know that while you will not be contacting them again, they may call you should they choose to seek out care in the future.

Patients who are not interested in specialty MH/SA treatment: Some patients when contacted will state that they are no longer interested in specialty MH/SA treatment. If the patient is willing, it may be helpful to complete part or all of the RM intervention, as the intervention is designed to address treatment ambivalence. Asking about the patient's future goals and how treatment may help to meet these goals, for example, can be useful. However, if a patient is clearly not interested in treatment, it is important to remain non-judgmental and respectful of their decision. Remind them that they can always follow-up with you or their primary care provider in the future if they change their mind. In some instances you may ask if you can touch base one more time in few weeks to see if they have changed their mind.

It is important, however, not to engage patients in integrated care as a substitute for specialty care. This would not be in the best interest of your program, where the goal is to provide brief treatments to the population of primary care patients, and primary care providers are not going to want to manage complicated mental health disorders. It is also not in the best interest of the patient who you have already deemed as needing specialty care services. By agreeing to follow the patient in integrated care, you may be communicating that this is an acceptable level of care for the patient. It may be helpful to bring these cases to supervision or consultation to determine the best course of action for the individual patient while keeping in mind the goals of your program

CHAPTER 7 Step-by-Step Instructions for the Health Promotion Workbooks

This section walks you through the Referral Management workbooks, providing step by step instruction on each section. There are 3 workbooks tailored to the patient's presenting symptoms: Health Promotion Workbook: Emotional Distress (for patients with depression, anxiety, or other primary mental health concerns), Health Promotion Workbook: Substance Misuse (for patients with a primary substance use disorder) and Health Promotion Workbook: Emotional Distress and Substance Misuse (for patients with comorbid mental health and substance use problems). As you read this section, please follow along in one of the 3 workbooks.

This contact is conducted by the BHP and incorporates the basic tenets of Motivational Interviewing (referenced earlier in this manual; see "Building a Strong Foundation" for more detail). Due to the uniqueness of each patient and his/her reactions to the materials covered, it is necessary for you to deal with responses in a flexible manner. Throughout the instructions, there are some general reminders or suggestions for ways to deal with some of the more frequent patient responses. It is important to review the entire workbook in depth in order to be familiar with all aspects of it. Remember, this workbook is a guide for the interaction and should not take you more than 20 minutes to complete. Keep each section brief, focusing on what is most important to the patient and do not feel that you must complete each section. If you happen to be filling this workbook out face to face with a patient, you should take the role of recorder to keep the interaction moving. You are more familiar with the content of workbook than the patient and it will likely take more time for him/her to take notes. The language of the workbooks assumes that the RM intervention is being conducted after the patient has missed their first appointment. If your program conducts RM prior to the initial appointment, the language may be modified accordingly.

PART 1. Seeking Treatment: This is the first section in all three workbooks (Emotional Distress, Substance Abuse, Comorbid Emotional Distress and Substance Misuse) and is an opportunity for you to learn the patient's reasons for not attending the appointment and thoughts about attending future appointments.

- **Key Points:**
  - Ask the patient about reasons for not attending the initial treatment session.
  - Encourage the patient to discuss feelings about attending a future treatment session.

Dialogue Example:

"Can you tell me what got in the way of attending your recent mental health appointment?"

Mr. Thomas is a 65-year-old patient who missed his scheduled substance abuse appointment for his cocaine use. You give him a call to follow-up:

You: "Hi Mr. Thomas, I am just calling as I noticed that you were not able to make your appointment yesterday."

Mr. Thomas "Oh, I forgot all about it. Just schedule me another one and send me a letter with the information."

You: "Great, we will do that. I would like to spend a few minutes on the phone today to discuss the appointment in order to help you feel prepared."

Mr. Thomas: I don't think we need to do that, I just forgot.

You: If you have the time, I would really like to talk with you a little more. I have a workbook that we can walk through that may be helpful. When we are done, I can send it in the mail for you to look through.

Mr. Thomas: Okay, I do have some time.

You go through the workbook with Mr. Thomas. When you ask for reasons not to attend the appointment, Mr. Thomas admits that he is worried that he will have t o go to group treatment. He has done that before and really did not like it. You talk about other options available in the clinic that he will be attending. When you check in his chart later, you see that Mr. Thomas ended up attending the scheduled substan ce abuse clinic appointment.

Reflecting on the Case: It would be easy to take Mr.Thomas's comment that he just missed the visit at face value, reschedule the visit, and skip the workbook. However, that would have been a missed opportunity to talk about the ambivalence that Mr. Thomas was feeling

PART 2. Identifying Future Goals:
Talking about the patient's goals is important for several reasons. First, it helps establish rapport with the patient. Second, it helps you understand what is important to the patient and establishes a context for thinking about the role of MH problems or SA in the patient's life. In addition, having the patient voice current goals helps orient his or her attention to the future and to possible positive changes, which sets the stage for a conversation about the potential benefits of engaging in treatment.

- **Key Points:**
    - Discuss how the patient would like his/her life to improve and be different in the future. This helps develop an awareness of the discrepancy between what the patient desires and how his/her current emotional distress/substance abuse may negatively impact those goals.
    - It is important to elicit from patients the goals that are most important to them rather than covering all areas listed in the workbook. You are listening for what it is they value, what is meaningful for them. Thus, starting with an open-ended question may be helpful initially to understand what is most relevant for the patient. Further querying may help generate additional goals in other domains that the patient did not think of right away. For example, a patient may say right away that they want to find a better job, but also mention that they would like to lose weight when asked if they have any goals around their health.
    - When patients respond by stating they have no goals, then you may give some examples, such as improving a chronic health problem, maintaining or building relationships, or maintaining their current health/independence.

Dialogue Example

"What are some of your goals right now for the next three months to a year?"

"What goals do you have in terms of your physical and emotional health, your activities and hobbies your relationships and social life, your financial situation, or other parts of your life?

"How would you like your life to improve?"

Mr. Green is a 26-year-old Veteran who missed his scheduled appointment in the Mental Health Clinic for depression. You call to follow-up and he states that he isn't sure if he would like to reschedule, but he agrees to complete the workbook with you. You ask about his future goals, and he states, "I don't know, that's part of my problem. I don't know what to do with myself." You probe further, asking "how would you like things to change?" He expresses a desire to change, but he is unable to articulate what that change would look like. You inquire about the last time he felt happy about his life and what things looked like for him then. He notes that before he was in the military, he had a lot of friends and he enjoyed playing baseball. You ask him what changes he would like to see in his social life now? Mr. Green states, "I would like to spend more time with my friends and family and get some help with my depression."

Reflecting on the Case: Patients may have trouble identifying future goals. Don't spend too much time around this, but do try to get the patient to come up with a goal that is important to him/her.

Review of Health Habits and Psychoeducation on Substance Misuse (NOT included in Emotional Distress only Workbook)

For individuals with substance misuse (the Substance Abuse and comorbid Emotional Distress and Substance Abuse workbook) the next section of the workbook includes a brief review of their current substance use as well as a section to prompt feedback and education on the potential consequence of abuse and dependence. This is meant to be done in a non-judgmental, conversational way - providing information rather than lecturing or giving advice. It may help to ask questions about what the patient already knows/understands and then reinforcing and filling in gaps.

Summary of Health Habits: This section allows you to learn about the patient's health behaviors, in particular alcohol consumption and drug use.

- **Key Points:**
  - Confirm regular drinking habits with patient, including number of drinks per week and number of drinking binges in the past 3 months. Be sure to ask in a way that will provide you information on standards drinks rather than information reflective of what the patient considers a drink. The patient's idea of a drink may be very different from an actual standard drinks size. Standard drink information is also provided at the end of the workbook.
  - Confirm any drugs currently being used by patient.

- **Dialogue Examples:**

  "Let's review some of the information about your health behaviors and habits. When we spoke initially, you indicated that you had about # drinks in past week. Is that still about right"?

Consequences of Substance Misuse: In this section, discuss patterns and consequences of substance use/abuse. This includes providing feedback on national averages for patterns of drinking (including abstainers, light drinkers, moderate drinkers, at-risk drinkers, and alcohol abusers) and providing brief psychoeducation on the common consequences of substance misuse.

- **Key Points:**

  - Ask the patient to identify his/her pattern of substance use/abuse.

  - Highlight the information provided in the chart on the negative outcomes of substance use and national averages for alcohol use patterns as appropriate. It may be helpful to first ask what the patient understands the negative consequences can be for their level of use. You can then reinforce what knowledge they already have and add any additional information to help put their alcohol or substance misuse into context.

- **Dialogue Examples:**

  "This chart talks about the different types of drinkers. There are 4 types of drinkers: abstainers or light drinkers, moderate drinkers, at-risk drinkers and those that have alcohol abuse or dependence. Most people, over 80%, are abstainers/light drinkers or moderate drinkers. Another 10% or so are drinking above the recommended limits, which we talked about, putting them at risk for negative health outcomes, and then about 5% or so have problems around their drinking and they are also at risk for negative health outcomes. Based on what we have talked about, where would you say you best fit in these categories? What do you know about the possible negative effects of that level of drinking? Is it okay if I tell you about some other common health consequences you may or may not have known about?"

Mr. Day is a 34-year-old male who missed his MH appointment for depression and alcohol misuse. He reports drinking 2-3 drinks each night during the week and 5-8 drinks on the weekends. When you talk about types and patterns of drinkers he is very surprised to hear that most people do not drink like he does saying, "Most of my friends actually drink more than I do."

> ***You**: "Usually people hang out with other people who have similar hobbies and interests. So if you are going out and drinking, it makes sense that you spend time with other people who enjoy that activity too. Because of that, it may appear that drinking those amounts is common; however, looking at the statistics of the entire population, in fact only 15% of the population drinks at levels that put them at risk for negative health effects.*
>
> ***Mr. Day:** "Wow, I didn't realize that and I had not really thought about how it could affect my health"*

Reflecting on the case: It makes sense that patients would think that the drinking patterns of their social circle are the norm. Pointing out that this is not the case can be powerful information.

PART 3. Effects of Emotional Distress/Substance Misuse
This section addresses the patient's own experience with the negative effects of Emotional Distress/substance abuse on his/her physical health, emotional/social well being, and relationships.

- **Key Points:**
  - Substance misuse workbook only) Ask the patient to indicate positive effects of his/her substance misuse and to identify the top 3 (Think MI – acknowledge the reasons for the status quo).
  - Ask the patient to identify the top three negative effects of Emotional Distress/substance misuse on his/her physical health, emotional social/well being and relationships. Try to use the patient's own words for their distress, for example they may say they are depressed, stressed out, emotionally overwhelmed, etc.
  - If the patient has difficulty coming up with negative effects, ask if you can mention some common effects of distress/substance misuse that other people sometimes experience.

- **Dialogue Example:**

  "What are some of the things you like about drinking? And what are some of the negative experiences that you have had as a result of your drinking/drug use?"

  "Can you tell me what have been the negative effects you have experienced due to your distress/depression/anxiety (use patient's own words when possible)? How has your distress impacted your life?"

  Again, it is much more powerful if these examples come from the patient, but if they are unable to articulate any, you may provide some examples:

  "Have you had any difficulty with..."

PART 4. Benefits of Reducing and Controlling Emotional Distress/Substance Abuse

This section addresses the possible positive effects on physical health, emotional and social wellbeing, and relationships when Emotional Distress/substance abuse is reduced or controlled. This is a way for you to learn about what the patient hopes to gain from seeking treatment. This is important information for you to use in MI reflections back to the patient.

- **Key Points:**

  - Patients identify the top three positive effects of controlling emotional distress/substance abuse.

  - If the patient can't identify positive effects, ask if you can provide examples of common positive effects that other people mention.

  - It is helpful to think back to what the patient identified as important to them or as their future goals, and tie in how they could better reach these goals via symptoms control/reduction.

Dialogue Example:

"What do you think might be some of the positive effects if you were able to reduce your emotional distress/depression or if you were able to stop drinking/using cocaine?"

Tie it in to future goals that were discussed: "You mentioned that you really wanted to develop better relationships with your kids. Do you think reducing your depression would help with this goal? How so?"

Give examples from the list of common benefits if the patient is unable to identify multiple benefits: "Do you think you may (sleep better, be happier, see improvement in your job performance etc.)"

"Of the benefits we talked about, what would you say are your top 3?"

In the Substance Misuse workbook only, prior to asking about the negative effects you first ask about the positive effects of substance misuse. This helps acknowledge to the patient that you understand there may be some benefits, and makes it easier to then address the negative consequences.

PART 5. Reasons for Getting Treatment

In this section, you can really help the patient tie it all together. You may remind the patient of the negative effects of emotional distress/substance abuse he/she identified and the potential benefits of reducing his/her symptoms and/or substance use that the patient discussed. You then ask the patient to now identify reasons for attending treatment. Next you discuss and help problem-solve any possible barriers to attending the appointment.

- **Key Points:**
  - Patient identifies the top three reasons to attend treatment.
  - Engage the patient in problem solving in order to overcome difficulties associated with attending treatment.
  - For problem-solving, continue to try to use a motivational interviewing style and rather than immediately giving advice and trying to solve the problem, start by asking the patient how they have approached this barrier in the past. Ask what has worked before and what they think might help for this appointment.

Dialogue Example:

"Based on our conversation this afternoon, what are your reasons for attending this upcoming MHC appointment? How do you think it will benefit you personally?"

"What might get in the way of you coming in to this next appointment? How have you handled that in the past?"

PART 6. Treatment Agreement

In this section, you ask about the patient's confidence that he/she will attend the upcoming appointment. Then ask if he/she is willing to make a verbal agreement/commitment to attending the upcoming treatment appointment. This agreement may strengthen the patient's resolve to attend treatment.

- **Key Points:**
  - Ask the patient to rate his/her confidence that he/she will attend the visit on a scale from 0 to 10. Ask why the patient is at that number rather than a 0. This will elicit from the patient a positive respons e on why they will be able or want to attend. You can then strengthen/highlight those reasons when reflecting it back.
  - Remind the patient to keep in mind the negative consequences of emotional distress/substance misuse, the benefits of controlling emotional distress/substance misuse, and the reasons they identified for attending treatment.
  - Remind the patient of the date, time, and location of the appointment.
  - Ask the patient to give verbal agreement via the telephone. Sign the agreement.

Dialogue Example:

"What I would like to do now is to ask you to verbally agree to attend your appointment on --/--/----?" I will sign my name on the agreement, and send the workbook and agreement in the mail along with appointment date and time. If you'd like, you can also sign the agreement when you get the workbook."

Ms. Hart is a 36-year-old woman who has been using alcohol excessively to help with sleep and stress at work. You contact Ms. Hart after she misses her appointment. Ms. Hart states that she was aware the night before about the appointment and planned to attend, however she was swamped all day and did not realize she missed the appointment until she got into bed that night. She agreed for the appointment to be rescheduled and you complete the Referral Management Intervention with her. At the conclusion of the call you briefly summarize the phone call and remind her of the appointment date and time. You explain the treatment agreement to her, saying…

> *"At the end of the booklet, here is a treatment agreement where I am writing down your appointment information. I'm going to sign it and ask that you sign the agreement when you receive the workbook. Signing an agreement will serve as a reminder and as a commitment that you will attend the appointment.*
>
> *Ms. Hart: "Do I have to sign it?"*
>
> *You: "We've found that most people who agree to this part of the workbook and sign the agreement are much more likely to attend their appointment so, that's why we ask you to do it."*

You ask her to put the booklet in a place that will remind her of the appointment and/or cut out the treatment agreement and put it in a place she will see. You call Ms. Hart back to see if she attended the MH appointment. She did attend and tells you: "I wasn't going to sign the treatment agreement – it seemed kind of hokey to me. When I got the workbook in the mail, I looked it over and decided to go ahead and sign it. When I woke up the day of the visit, I really did not feel like going, but thinking about the commitment I made helped."

Reflecting on the Case: Think about ways to make workbook and/or the treatment agreement powerful tools for a patient.

PART 7. Contact Summary
This section reviews the material covered in the workbook and allows you to give the patient tips and encouragement for attending treatment.

- **Key Points:**

  - Tell the patient to expect hard days during treatment and encourage him/her not to give up.

  - Give the patient instructions to call his/her PCP for assistance or in case of emergency. o Remind the patient that you will be sending the workbook to him/her. Let them know that you will not be keeping a copy.

  - Ask the patient to read the workbook frequently.

  - Suggest placing the agreement in a visible place, like the fridge, as a reminder of his/her commitment to attend the appointment.

  - Encourage the patient to bring the workbook to the MH appointment

  - For those patients misusing alcohol; Let the patient know that the workbook includes pictures of what standard drink sizes look like. Tell him/her that patients who are monitoring their drinking find this to be a helpful tool.

Dialogue Example:

"If you need to contact me for any reason before your appointment I can be reached at (your phone number)."

"I will be sending you the workbook that we just completed together. I would like you to look through it and use it to help you get through hard days during treatment so you can keep your goals in mind."

CHAPTER 8

Program Evaluation/Monitoring

Program level monitoring is just as important as patient level monitoring. Program level monitoring facilitates quality measurement, the ability to adjust and improve the program, and communication with all stakeholders including hospital administrators, insurance companies or others responsible for budgeting of the program. A successful program needs to be able to demonstrate success over many patients. This is only done with appropriate informatics.

For the referral management program key parameters to monitor include:

- Number of referrals
- Proportion of referrals assessed or pending an assessment
- Proportion of referrals assessed as needing specialty care
- Number of patients who accept an appointment
- Number of patients who engage in treatment

In addition, to improve the triage decision process, having patient level data available to model engagement will improve the ability to conduct the triage step.

Tracking these outcomes can be accomplished in a number of ways. There is commercially available software that facilitates the baseline assessment, progress note creation and the program level evaluation. There is an available software program that facilitates tracking patient attendance. Tracking facilitates monitoring for the individual patient but also for the program. For a further discussion on program monitoring, see Volume 1, Building a Strong Foundation.

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