Chapter 13
Medical Family Therapy in Community Health Centers

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Community health centers (CHCs) provide affordable, accessible care to patients in urban and rural areas across the nation. Health centers must be located in underserved locales, governed by a community-majority board, provide a core set of primary care services, and offer a sliding fee scale to patients under 200% of the federal poverty level (National Associations of Community Health Centers, 2017a). Based on most recent figures, health centers serve more than 25 million patients (1 out of every 15 Americans), 71% of whom are at the 100% federal poverty level and below and 83% are uninsured or publicly insured (NACHC, 2017a). Health centers employ over 8400 mental health and substance abuse staff and provide access to these services in the most underserved communities in the nation. In 2015, over 8.3 million clinic visits were provided for mental health or substance abuse issues; this represents a 56% growth in behavioral health visits since 2010 (NACHC, 2017b).

CHCs often operate as patient- and family-centered healthcare homes; they also function as community-centered healthcare homes due to their integration of behavioral health, oral care, and medical health services. CHCs often tend to (a) be culturally proficient; (b) offer team-based care; (c) provide enabling services, which offer enhanced access to care; and (d) be highly attuned to community accountability and governance. Many of the services provided through CHCs are not reimbursed at the same level as those in private primary care contexts, yet CHCs who engage in collaborative and integrated behavioral healthcare are able to highlight their cost-effectiveness, cost-offset, and positive effects on quality of care, patient satisfaction,

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and health outcomes (Mukamel et al., 2016), in part due to the four factors mentioned above.

Providers trained in Medical Family Therapy (MedFT) offer a unique lens in CHCs that bridges medical and behavioral health assessments, diagnoses, and treatment via a collaborative, transdisciplinary team and approach to care. In this context, MedFT is described as the practice of treating patients and their families (i.e., support persons) in relation to health, illness, loss, or trauma using a biopsychosocial-spiritual (BPSS; Engel, 1977, 1980; Wright, Watson & Bell, 1996) and systemic approach to care (Hodgson, Lamson, Mendenhall, & Crane, 2014). The BPSS framework is essential for MedFTs in CHCs because patients come from diverse social locations and are treated outside of a traditional medical model through an integration of biological, psychological, social, and spiritual components of their life. Patients in some healthcare contexts may not be asked how their health decisions are informed through their religious/spiritual beliefs. However, due to the cultural diversity reflected in CHC patient panels, MedFTs commonly consider the role of spirituality in tandem with physical and psychosocial health. Thus, in order for a MedFT to understand how a patient makes sense of health, the MedFT must also work to capture the way in which patients make sense of life (whether that is aligned with a higher power, nature, or freedom to have agency in decision-making).

In addition to MedFTs working from a BPSS approach to care, they are inclined to promote behavioral health to be just as important as physical health concerns and, furthermore, support the importance of relational health as a part of overall wellness. Unfortunately, across many healthcare systems, behavioral healthcare is underutilized, mental illnesses and behavioral health conditions are underdiagnosed, and patients are under-, over-, or mistreated for their complex diagnoses (Fagiolini & Goracci, 2009). Behavioral healthcare is often not well coordinated with medical care, especially for low-income populations. This is partly because providers and clinicians are not maximizing collaborative communication or treatment plans. As such, the window for BPSS care can become compromised, and the opportunity and accountability to work collaboratively with patients who are likely representative of underserved social locations (e.g., lower socioeconomic status, physical/mental ability challenges, ethnic minority) are minimized or closed. In addition, in disrupted or disjointed healthcare systems, there is little inclusion of the family as part of a patient's treatment process—despite the ravaging effects that an untreated or mistreated medical or behavioral health illness has on families (Rolland, Emanuel, & Torke, 2017). The literature is summarized well in several systematic reviews that show the reciprocal effects of family relations on health, both physical and behavioral (e.g., Hartmann, Bäzner, Wild, Eisler, & Herzog, 2010; Martire, Schulz, Helgeson, Small, & Saghafi, 2010), yet few healthcare systems aim to incorporate families as part of everyday healthcare practices.

MedFTs see these BPSS and relational complexities as an opportunity to work with patients and families while they are receiving care in CHCs. There are various ways that behavioral health has been received in medical contexts, including collaborative, colocated, and integrated care (Blount, 2003). Having behavioral and medical health providers colocated or, better yet, extending integrated behavioral

healthcare (IBHC) increases the likelihood that patients will attend their behavioral health visit and reduces patient barriers to healthcare treatment (Krupski et al., 2016). However, IBHC alone does not ensure that providers will communicate on a regular basis, construct collaborative patient-centered care plans, or safeguard that integration will occur beyond the clinical world (i.e., extend into the operational world (e.g., systemic procedures)) or the financial world (e.g., billing systems) (Peek, 2008). Moving toward integrated behavioral healthcare models with maximum collaboration between healthcare providers, operating officers, and billing specialist professionals must be purposeful. Assessments and treatment plans must be coordinated, medical records streamlined, and reimbursement for services conducted in a way that ensures that all patient needs are cared for with equity (i.e., that physical health needs are not perceived as more important than behavioral health needs).

CHCs across the nation have different methods for addressing the BPSS needs of their patients. Therefore, "if you have seen one health center, you have seen one health center" (National Association of Community Health Centers, 2011, p. iv). This chapter was prepared by a team of MedFTs who are all involved with behavioral health services within a CHC system. Throughout, we describe the model we use and our approach to addressing patients' health. The following vignette presents an example of high-level integration between behavioral and primary care providers, family members, and integrated procedures that helped to maximize care delivery.

Clinical Vignette

[Note: This vignette is a compilation of cases that represent treatment in a Community Health Center. All patients' names and/or identifying information have been changed to maintain confidentiality.]

In 2006, JH and AL designed and delivered integrated behavioral healthcare (IBHC) for a community health center (CHC) in eastern North Carolina. Since then, the CHC system has grown its IBHC program from 1 to all 5 medical clinics in the CHC system. Each of these locations included MedFT services integrated in tandem with medical health services. In 2013, additional funding allowed the IBHC service to start including health coaches (HC) along with MedFT services. This approach maximized the full extent of our MedFTs' clinical skill sets (e.g., *assessing, diagnosing, and intervening with severe mental health symptoms and concerns*) *while, at the same time, providing support and education to patients at risk for chronic health conditions* via *health coaching services.*

Our protocol for HCs and MedFTs was to prepare for each encounter before meeting the patient, including (a) reviewing the patient's medical chart to identify whether there was a history of a mental health diagnosis or symptoms based on a previous mental health assessment and, if indicated, the patient was to be seen by the on-site MedFT; (b) determining what chronic

*health concerns existed for the patients, given that most had at least one chronic health condition (*e.g., *diabetes, hypertension, hyperlipidemia, obesity), and any corresponding biomarkers on management of the condition (*e.g., *hemoglobin A1c, blood pressure, cholesterol levels, body mass index); and (c) evaluating progress made on a patient-constructed goal from a previous integrated care visit.*

In early 2013, a MedFT supervisor was scheduled to provide live supervision for a HC who was still in training. Together they reviewed the patient's chart and noted that he was a fairly new patient to the clinic. In the chart, they could see that Jamar self-reported and identified as a 19-year-old African American male. He was 5' 11" and weighed 386 pounds. His body mass index (BMI) was 53.8, meeting the criteria for severe obesity. He had not been previously seen by one of the clinic's HCs or MedFTs. The HC and supervisor knocked on the exam room door and entered together. Given that the HC was shadowing her that day, the HC supervisor modeled the introduction:

The HC supervisor opened the encounter stating, "Good morning Jamar. We are health coaches and a part of your health care team. We work with patients on ways to improve health by getting better sleep, changing eating or activity habits, reducing stress, working on smoking cessation, and finding ways to improve family support. We also try to set health goals with each patient and share this information in the same chart as the one kept by your primary care provider (PCP). Would it be okay if we talked for a bit today about your health?"

Jamar agreed, whereupon the supervisor had another question for him. "Jamar, who do you have with you today?"

Jamar pointed to his mother in the room. The HC supervisor asked if it would be okay for her to talk with him while his mother was in the room or if he preferred that she step out. He consented to have his mother present.

Behavioral health team members begin every health coaching and MedFT visit in the same way: by completing the Patient Health Questionnaire-3 (and PHQ-9 if necessary; Kroenke, Spitzer, & Williams, 2001*) and Generalized Anxiety Disorder-2 (and GAD-7 if necessary; Spitzer, Kroenke, Williams, & Lowe,* 2006*) to determine if there are any concerns related to mental health (*e.g., *symptoms of depression or anxiety). Jamar's score was a zero on both screeners.*

The HC trainee then asked Jamar if he had any concerns that he would like to give attention to in relation to his health. His mother quickly jumped in with a concern about his weight. Jamar quietly mentioned—under his breath—that he was not concerned with his weight.

"I wish I slept better," he said with confidence.

*Based on their approach of meeting patients where they are at, the HC supervisor and trainee began to assess Jamar's sleep through our screener and engaged his mother in the conversation as much as we could (*e.g. *"Do you remember Jamar having this concern when he was younger?"). Through*

that process, they learned that he drank four 2-liter bottles of a highly caffein-ated and sugary soda each day. The HC supervisor asked him if anyone had ever told him that caffeine can disrupt his sleep. He said that he started drink-ing a lot of soda while in high school and that he had never really thought about it in relation to his sleep. More recently, Jamar shared that he was real-izing that he was having a hard time getting to sleep and staying asleep.

Jamar's mother became tearful during the conversation as she heard about his struggles with sleep and, again, reiterated her concerns about his health. Jamar also talked about getting up in the middle of the night several times to use the restroom.

The HC supervisor asked Jamar what he thought he could do to improve his sleep that might also help him improve his overall health. Their discussion included conversations about behaviors that sometimes complicate sleep (e.g., screen time before bed, setting a regular sleep schedule, and caffeine intake). Jamar decided on a goal to cut back to one 2-liter bottle per day.

While the HC supervisor and trainee were excited by his motivation, they also understood the research about withdrawal from caffeine and wanted to set a more realistic goal that Jamar could sustain. His mother became pas-sionate about how to help him cut back on his soda intake, which was more related to her concomitant want for him to lose weight. Together, Jamar and his mother constructed a health goal that ultimately addressed his sleep hygiene concerns. Soon thereafter, the PCP entered the room and the HC supervisor and trainee shared Jamar's goal with her while also informing her of a concern that he shared about getting up to urinate several times through-out the night (which triggered the PCP's attention to check for diabetes).

Our primary concerns in CHC range from managing mental health presentations (e.g., depression and anxiety) and chronic health conditions (e.g., diabetes and hypertension education) to lifestyle issues (e.g., sleep and stress), all of which require consistent collaboration between medical and behavioral health providers (BHPs). Recently, services have ramped up even further as we have begun provid-ing care in the dental wings of these clinics as well as through the local school sys-tem. In every instance, we use motivational interviewing (MI; Rollnick, Miller, & Butler, 2007) as a framework for health coaching interactions and solution-focused care (e.g., De Shazer et al., 2007) when delivering MedFT (see more detailed dis-cussion below). All providers document care in the same electronic health record (EHR) to facilitate interdisciplinary collaboration and coordination of care. Inclusion of family members, as well as others from the patient's support system, is encouraged so as to maximize success with each patient's health goal(s). Respecting the support system and community that surround the patient, as well as delivering

the highest quality services to those who are underserved and underinsured, represents core values of CHCs (Taylor, 2014). While some providers may choose to take an aggressive approach to treatment for significant health concerns, our team is inclined to take a BPSS and systemic approach that is strength based, and through realistic goals, we move patients toward sustainable wellness.

What Are Community Health Centers?

CHCs serve as a laboratory for innovation. This innovation includes the integration of MedFT on-site, whereby patients are seen in the context of their families and treatment is offered in ways that are sensitive to diverse family and cultural belief systems. Including MedFTs in community health centers (e.g., Federally Qualified Health Centers) has resulted in positive outcomes for families and, perhaps as important, positive outcomes among providers (Aamar, Lamson, & Smith, 2015; Phelps, Hodgson, Lamson, Swanson & White, 2012; Phelps et al., 2009). And while some CHCs choose to contract with off-site behavioral health services (e.g., specialty mental health services such as psychiatry, psychotherapy, case management), in this chapter, we focus primarily on contexts that advance on-site integrated behavioral healthcare. Behavioral health providers (BHPs) working as members of an IBHC team may include any mental health professional with specialized training in IBHC. Herein MedFTs are featured in this role.

Community healthcare centers have a significant outreach potential that includes sending medical providers, nurses, BHPs, and specially trained lay persons (e.g., promotoras) into the community to work with patients in their homes and/or at their work settings. Some BHPs are colocated in a CHC clinic, which means that they are available on-site, but are not typically providing patient care in the exam rooms. Instead, they are seeing their own scheduled patients for traditional 45–50 minute psychotherapy sessions. Other BHPs in a CHC may help PCP care for patients who are experiencing mental health crises but primarily see their own scheduled patients a majority of the time. Lastly, some CHCs are advanced in their integration of behavioral health and have their BHPs go into the exam room before, during, or after the PCP to screen for and treat behavioral health issues related to wellness, mental illness, chronic illnesses/conditions, and/or an acute general medical condition. These BHPs typically carry smaller "traditional therapy" caseloads; the majority of their work in IBHC is in tandem with other healthcare providers (e.g., PCPs, nurses, dentists, hygienists, case managers, nutritionists). This permits them to see more patients and improve access to behavioral healthcare that is otherwise a challenge for patients with minimal financial resources, fear of stigma associated with seeing a behavioral health provider off-site, limited time, and/or transportation difficulties for additional doctor appointments.

As with any healthcare setting, membership of a CHC treatment team is critical to its success, insofar as each member fulfills an important role. The following represent key contributors in CHCs.

Treatment Teams in Community Health Centers

Teams in CHCs are charged with the task of meeting a wide variety of simple to complex healthcare needs. They treat pediatric to geriatric patients from a wide variety of socioeconomic, educational, and cultural/ethnic backgrounds. In addition, these teams function under tremendous pressure due to limited time, resources, and high patient volume. Therefore, they must function as a well-oiled machine with clear and effective leadership. In a CHC, too, it is beneficial to have team members who are bilingual and bicultural to help ensure patients' healthcare needs are addressed with minimal opportunities for misunderstandings secondary to language or cultural differences.

Behavioral health providers (BHPs). These professionals may provide 45–50 minute scheduled traditional mental health visits and/or integrated behavioral healthcare visits (15–30 minutes) working alongside PCPs. They may include providers who screen for mental health conditions and provide brief interventions and/or work with patients to set health goals toward optimizing health or managing a chronic illness(es) effectively. BHPs most common to CHC settings include health coaches and/or providers from a variety of mental health disciplines (e.g., medical family therapy, health psychology, clinical social work, psychiatric nursing, psychiatry).

Care managers/coordinators. Care managers are members of the team who assess, plan, organize, and monitor patients' health. They assess for particular challenges that the person is experiencing (e.g., access to food, medication, shelter), listen to patients'/families' concerns, and help problem-solve issues associated with basic needs. Among underserved and underinsured populations, these members of the team are critical because they reduce healthcare barriers common to the population(s) they serve and are prepared with resources from the community that may meet a range of bilingual and bicultural needs.

Diabetes health educators. Often certified, diabetes educators are healthcare professionals who are trained to have comprehensive knowledge of and experience in educating on the topics of (a) prediabetes, (b) diabetes prevention, and (c) diabetes management. Their role is to educate and support individuals and families who are affected by diabetes. They help patients and families understand and self-manage the disease through individualized treatment plans for health outcome promotion (National Certification Board for Diabetes Educators, 2017). They are prepared with educational materials available in the language (and at the literacy level) of the CHC patients served.

Front desk staff. These staff check patients in and out of the clinic, answer the phones, collect payments, and help to schedule appointments. They oftentimes serve as cultural brokers to ensure that patients and their support persons feel a sense of quality and safety provided within the CHC center. These individuals are frequently bilingual and bicultural (reflecting the more dominant languages and cultures in the community) to help communicate with patients and to ensure understanding about care offered and processes for being seen.

Health coaches (HCs). HCs work with the PCP and BHPs to provide coaching around common health behaviors that may lead to or lessen the impact of chronic

conditions (e.g., healthy eating, physical activity, stress management, sleep hygiene). They may help with basic screenings for mental health issues (e.g., depression, anxiety) and report to the PCP and BHPs on the team the results of any brief screens. HCs in a CHC are trained to assess and address health risk behaviors associated with toxic stress, too. They also are prepared to identify uncontrolled health behaviors common to uninsured and underinsured patients, as well as screen for stress and resources needed due to recent local traumas (e.g., floods, earthquakes, tornados).

Lab technicians. Lab techs work under the supervision of PCPs to conduct lab tests (e.g., strep, flu, exposure to common environmental toxins found in the fields where workers are exposed). They may also be trained as phlebotomists (i.e., to draw blood for analysis).

Medical office assistants (MOAs). MOAs are often the first and last point of contact after the patient checks in for an appointment. They perform a variety of administrative tasks, including (but not limited to) managing a patient's medical record, file insurance forms, schedule appointments, and arrange clinical procedures such as X-rays. MOAs sometimes gather patients' vital signs and record the data in medical records. At times, they will administer basic mental health screenings (e.g., depression, substance abuse) and pass that information onto the BHP or PCP treatment team member. They escort the patient to his or her exam room and notify the PCP that the patient is ready to be seen. At times, MOAs may be called upon by the PCP for other skills (e.g., translating).

Nurses. Nurses work alongside the PCP to assist with the collection of patient information and patient vitals (e.g., height, weight, blood pressure, blood glucose levels). Nurses perform diagnostic tests, interpret and/or report to the PCP in-house test results (e.g., strep, hearing, blood glucose, blood pressure), administer PCP-recommended medication/treatment, and interact with patients to help allay concerns during medical visits. They also answer the phones and relay information to and from the PCP to patients and other healthcare collaborators. They may administer vaccinations and other health screenings. In a CHC, nurses may be bilingual or bicultural to further ensure that patients' healthcare needs are addressed with minimal opportunities for misunderstandings.

Primary care providers (PCPs). This is a healthcare practitioner who sees people with common medical problems and is responsible for diagnosing and treating medical and mental health conditions. This person may be a medical doctor, nurse practitioner, or physician's assistant. He or she oversees the patient's medical care visit, prescribes any pharmaceutical treatment, orders necessary labs or tests, refers to specialists, and documents findings in the patient's medical record.

Referral specialists. These team members process referrals made by the PCP to other healthcare providers in the community. Some of the more common referrals include dental services, specialty medical and mental health services (not offered on-site), and lab and imaging services. Referral specialists' efforts may be particularly complicated due to a lack of bilingual and/or affordable services for underserved and uninsured patients commonly seen in a CHC.

X-ray technicians. These technicians use imaging methods to visualize the inside of the human body (e.g., bones, teeth). The pictures they create help PCPs diagnose and treat sundry illnesses or injuries.

Fundamentals of Care in Community Health Centers

Using a BPSS framework (Engel, 1977, 1980; Wright, Watson & Bell, 1996), MedFTs collaborate with medical and other healthcare professionals to improve patient outcomes and enhance patient satisfaction while addressing a variety of common behavioral and mental health topics. To address these concerns, MedFTs working in a CHC should be prepared to:

1. Join with patients, support persons, and the healthcare system in an ethical manner, especially given that the delivery of behavioral health via IBHC models is still relatively new.
2. Recognize and deliver a wide range of screenings and assessments across the lifespan, including for those associated with managing psychosocial crises (e.g., child or elder abuse, intimate partner violence, suicidal/homicidal ideation).
3. Formulate an accurate diagnosis for common DSM-5 psychiatric disorders (American Psychiatric Association, 2013) with knowledge about the International Classification of Disease coding system (World Health Organization, 1992).
4. Identify ways in which collaborative processes can be improved by the inclusion of MedFT in a CHC setting.
5. Extend research-informed and best practice interventions indicated for diverse populations and in the context of a variety of complex or chronic conditions.

While the information below may be applied to other primary care settings, we have found this content to be especially helpful when collaborating with patients and providers in CHCs. This is not a comprehensive map of services; it instead provides a general overview of the types of care and concerns that MedFTs may address at different phases of a CHC healthcare visit.

Pre-visit Work

Before entering the room, MedFTs should review the patient's EHR and consult with the PCP to become acquainted with the patient's health history. Reviewing the patient's vitals (e.g., blood pressure, blood glucose, weight, height, age), problem/diagnosis list, list of medications, and recent health visit treatment plans will assist with the MedFT's joining, assessing, and intervening accurately. It will also assist with promoting continuity of care. Please note, though, that there are

some scenarios in which it is not appropriate or advisable for a MedFT to enter the exam room. Examples include:

- If the patient has the flu, high fever, a quarantined contagious condition, is actively vomiting, or is unclothed
- If notes in the chart indicate that the patient has consistently declined MedFT interventions for non-circumstantial reasons
- If the PCP has requested that the MedFT wait to see the patient until after the PCP or another member of the team completes a task
- If the patient does not speak the same language as the MedFT and no translator is available at that time

Joining

Joining is an ongoing experience that starts from the beginning through the end of an encounter. When deemed appropriate to enter the patient's room, the MedFT should begin with (a) offering an introduction, (b) explaining one's role at the clinic with consideration for the patient's social location (e.g., age, ethnicity), (c) outlining the purpose of one's visit, (d) obtaining verbal consent from the patient, and (e) explaining the limits of confidentiality. Several of these factors are discussed in more detail below. Joining behaviors may include nonverbal interactions like maintaining direct eye contact and leaning forward slightly while the patient and any support persons are talking. Joining is also done through a variety of verbal interactions, including reflectively listening and repeating back what is heard throughout the encounter, being transparent with one's purpose and collaborative partnership with the healthcare team, and concluding the interview with a summary that acknowledges the patient's reason for the health visit, health goal(s), and any interventions or resources discussed.

Explaining One's Role with Consideration for Patient's Social Location

Joining, particularly in a CHC, should include acknowledgment of any factors (e.g., cultural, financial, housing, occupational) that the MedFT, additional healthcare team member, or the patient/support person(s) thinks may present a possible barrier to successfully carrying out a treatment plan. For example, if working in a CHC setting with a high percentage of Spanish-speaking patients, ask the patient if he or she is comfortable communicating in English before beginning the encounter. Some patients may be comfortable speaking English minimally but would prefer a translator or bilingual MedFT for this part of the visit. Acknowledging what may help the patient to be more comfortable is an important part of the joining process and in the patient understanding the MedFT's role as a part of his or her healthcare. Support persons may also help by explaining whether the patient hears better in one ear over another or can see best if the MedFT sits closer to him or her.

Joining with children is a separate skill to master; MedFTs should make sure to acknowledge children in the room and tailor their work and description of their role so that it is age appropriate. For example, joining aides with children may include puppets, magic markers, crayons, coloring books, etc. It is also helpful to modify one's voice, vocabulary, and location in the room (i.e., make yourself eye-level if the child is the patient), when joining with children.

Obtaining Consent

If there are support persons in the room, it is important to get permission from the adolescent or adult patient to include them in the encounter before moving to the assessment phase. On occasion, the person in the exam room is not someone that the patient wants to have heard his or her health history. That person should be asked to step out of the room for the visit, upon the patient's request.

Note that getting a child's assent is important to joining successfully, even if the adult in the room says that it is okay to talk to the child. With smaller children, the MedFT should make attempts to adjust one's position in the room to appear less intimidating. For example, sitting on the small step connected to the exam table will put the MedFT more at eye-level with a young patient who is seated on a chair.

Explaining the Limits of Confidentiality

Building a successful relationship with a patient in any IBHC context can be expedited when the primary care provider or another member of the healthcare team introduces the MedFT to the patient during a healthcare visit. Typically, the PCP and MedFT describe the limits of confidentiality pertaining to the patient's presenting concern (e.g., that the patient's concern will be discussed by the PCP and MedFT and that both providers document in the same charting system). While it is not always possible for a healthcare team member to stop workflow to do this, the MedFT can also borrow the rapport already established with the healthcare team by mentioning that he or she is also a member of the patient's healthcare team and works to see all patients coming into the CHC. This may help to reduce a patient's uncertainty or stigma about having a mental health professional on board his or her healthcare team. Once the MedFT has begun to join with the patient, he or she should then consider how to prioritize screening or assessment as a part of the visit.

Assessing

As a MedFT, you may deliver both behavioral and mental health services as part of a traditional therapy appointment or as an IBHC visit (i.e., in conjunction with a medical encounter). Priority should be given to IBHC visits and to behavioral health

issues, first and foremost. MedFTs use a variety of common adult and pediatric mental health screeners (see Table 13.1) to aid in assessment and diagnosis. MedFTs should be aware that screeners are not designed to be purely diagnostic but rather aid in assessment and determining symptom severity. For example, a clinically significant PHQ-9 (Kroenke, Spitzer, & Williams, 2001) score does not automatically mean that a patient has major depressive disorder. However, the information gathered from the PHQ-9 can assist in understanding which symptom(s) a patient is experiencing, the severity of specific symptoms, and severity of the overall depression. Depending on the patient's chief complaint, other brief mental health screenings may be indicated. All assessments/screeners should be documented in the patient's EHR and revisited to track changes in symptom severity. They serve as a secondary line of assessments to a more thorough mental health assessment in accordance with the DSM-5 (APA, 2013).

When an assessment suggests that mental health issues are not present, the MedFT should then assess for how patients are managing with any current and/or previously diagnosed chronic conditions (as seen in the patient's EHR or through prior consultation with the PCP). If everything is well managed, then the MedFT

Table 13.1 Examples of Behavioral Health Screening Tools

Adult		Pediatric	
Depression	PHQ-9 (Kroenke et al., 2001)	**Behavioral and emotional development**	ECSA—Early Childhood Screening Assessment (Gleason, Zeanah, & Dickstein, 2010)
Anxiety	GAD-7 (Spitzer et al., 2006)	**Behavioral and emotional health**	PSC—Pediatric Symptom Checklists (Jellinek et al., 1988)
Cognitive functioning	MoCA—Montreal Cognitive Assessment (Nasreddine et al., 2005)	**ADHD**	Vanderbilt-NICHQ Assessment for ADHD (Wolraich et al., 2003)
Bipolar disorder	MDQ—Mood Disorder Questionnaire (Hirschfeld et al., 2000)	**Pediatric development**	Ages and Stages Questionnaire (Squires, Bricker, & Potter, 1997)
PTSD	SPRINT—PTSD screener (Connor & Davidson, 2001)	**Trauma**	Adverse Childhood Experience (Felitti et al., 1998)
Alcohol use	AUDIT—Alcohol Use Disorder Identification Test (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001)	**Alcohol and drug use**	CRAFFT Screening Interview (Knight et al., 1999)
Substance use	DAST-10—Substance Use Screening Tool (Skinner, 1982)		
Domestic violence	AAS—Abuse Assessment Screen (Weiss, Ernst, Cham, & Nick, 2003)		

Table 13.2 Examples of Health Behavior Screeners

	Adult	Pediatric
Healthy eating	PAN—Physical Activity and Nutrition Behaviors Monitoring Form (Eat Smart, Move More NC, 2005)	PAN—Physical Activity and Nutrition Behaviors Monitoring Form (Eat Smart, Move More NC, 2005)
Sleep	ESS—Epworth Sleepiness Scale (Johns, 1991)	BEARS Sleep Interview (Owens & Dalzell, 2005)
Physical activity	RAPA—Rapid Assessment of Physical Activity (Topolski et al., 2006)	PAN—Physical Activity and Nutrition Behaviors Monitoring Form (Eat Smart, Move More NC, 2005)

will assess for opportunities for health behavior change. In the model that we use, every patient is supported in designing a health goal to promote his or her own health. For example, patients may want to modify/improve their eating, stress management, or sleeping patterns to prevent or lessen the effects of chronic health conditions (e.g., obesity, diabetes, hypertension, hyperlipidemia). Some patients also take this opportunity to engage in steps toward smoking cessation. All MedFTs (in our model) are trained in motivational interviewing (Rollnick et al., 2007) and on how to construct SMART (i.e., specific, measurable, assignable, realistic, and time related) goals (Doran, 1981). This helps to ensure that the process is patient centered and that the health goal is directly relevant to the patient's concern. These goals are documented in the patient's EHR so that they can be tracked in the system and followed up on by any member of the healthcare team.

The following tools are available for assessing specific patient health behavior issues and needs. They are not to be used as a first step in assessment, but rather as a means to gain more depth, when necessary. These instruments, like the ones in Table 13.1, can be found in English and Spanish and in some cases other languages as well. While Table 13.2 is not exhaustive, it reflects the screeners for some of the more commonly presented issues to the authors who work in the CHC setting.

Diagnosing

Working in a CHC setting affords MedFTs the opportunity to engage with patients who are managing acute and chronic conditions, as well as simple to complex mental and/or medical diagnoses. Each patient encounter should be coded by the MedFT with a mental health diagnosis and/or behavioral health screening/assessment code. The diagnosis should be based on information given during the patient interview, reviewed in the patient's EHR, discussions with support persons present, results of screening assessments, and conversations with the PCP. Not all mental health encounters will result in a DSM-5 (American Psychiatric Association, 2013) psychiatric diagnosis. In such cases, you may choose to give a provisional diagnosis or use the ICD-10 code (World Health Organization, 1992) when screening for

depression (Z13.89). Provisional diagnoses are used when a MedFT feels that he or she has insufficient data for determining a diagnosis. Codes are also available for instances when a behavioral health screening is done and no formal diagnosis is identified. It is advisable for MedFTs to secure training in coding and billing when working in a CHC, even if the MedFTs' services are not billed for directly (e.g., Medicare or Medicaid). Using the correct codes and tracking them are important to identifying trends in presenting concerns among the patient population and using that data to advocate for policy and training for the healthcare teams.

Intervening

When intervening in an IBHC model, MedFTs function as both mental and behavioral health specialists. In this capacity, they may offer traditional 45–50 minute therapy sessions to patients and families, but generally their interventions take place during brief 15–30 minute encounters. During these visits, MedFTs collaborate with patients, families, and healthcare providers in order to join, assess, diagnose, intervene, and/or initiate healthy lifestyle modifications through the use of health goals. MedFTs may make referrals to other specialty behavioral health interventionists and/or community resources when the patient's needs are outside of the CHC offerings (e.g., substance abuse treatment, severe mental health concerns). Outside referrals are made because not all behavioral health interventions are suitable, available, or manageable in a CHC or brief traditional therapy service. For example, treatment for schizophrenia and other psychotic disorders, feeding and eating disorders, substance use and addictive disorders, and/or other complex mental health issues may need longer-term evidence-based care off-site with continued collaboration involving members of the on-site CHC healthcare team.

The main objective of behavioral health interventions is to support and encourage patient health through lifestyle modification and research-informed treatment for acute and/or chronic conditions. Interventions may include (a) patient psychoeducation, (b) crisis interventions, and (c) interventions at the individual, family, and/or community system levels. Research-informed practices aimed at the individual, family, and/or community system levels are addressed later in this chapter. Here we focus on the psychoeducation and crisis intervention levels.

Patient Psychoeducation

Patient psychoeducation includes (a) ensuring that patients understand the implications of their chronic illness (if they have one) and/or (b) ensuring that patients understand how their own behaviors affect their health. Both of these factors are necessary requirements for developing and maintaining healthy lifestyle changes and lay the foundation for setting health goals with patients and their support person(s).

Patients must be aware of the implications of their health condition(s). MedFTs should initially spend time assessing the patient's/family's level of understanding of an illness. For example, a patient who has recently been diagnosed with diabetes may know very little about how stress, nutrition, sleep, physical activity, or medication management will affect insulin levels. In cases where patients have lower health literacy, less social support, and/or higher anxiety blocking their understanding and retention of information, it is paramount that MedFTs educate them on how health behaviors affect specific illnesses. Otherwise, there will be little success with health goals created at the visit. MedFTs should also become well informed of common major chronic diseases (e.g., diabetes, hypertension, obesity, asthma) seen and treatments delivered in their CHCs. This will help the MedFTs, in collaboration with the PCPs, prepare and/or disseminate educational materials that increase patients' and support persons' health literacy (and address areas where more psychoeducation is needed).

Crisis Interventions

MedFTs working in a CHC may encounter patients with severe mental health issues and/or who are living in dangerous settings (e.g., suicidal ideation, child abuse, domestic violence, substance abuse). For example, encountering suicidal ideation (SI) is not uncommon when working in a CHC setting. Researchers in one study found that approximately 64% of patients who had attempted suicide had visited their primary care provider within 1 month of their attempt (Ahmedani, 2015). MedFTs should be especially cognizant of populations who are at increased risk for SI; these may include American Indians (Middlebrook, LeMaster, Beals, Movins, & Manson, 2001), LGBTQ adolescents and young adults (Haas et al., 2010), men and women after a relationship breakup (Wyder, Ward, & De Leo, 2009), older men (over 80 years; Conwell, Duberstein & Caine, 2002), patients with history of a mood disorder (Tidemalm et al., 2011), and persons who are unemployed (Classen & Dunn, 2012). Understanding the context for any crisis, indicated screenings/assessments (e.g., Columbia Suicide Severity Rating Scale for suicidal ideation; Posner et al., 2011), and research-informed interventions pertaining to populations who experience said crisis is an incredibly important skill for MedFTs. Once screened, follow-up communication and visits are essential for those who have experienced a crisis. Further, adequate and accurate documentation is required to help reduce patients from falling through the cracks, especially those who are not seen often or routinely at the CHC.

Documentation

Once the MedFT has joined, assessed, diagnosed, and intervened, it is imperative that he or she clearly and thoroughly document the details of the encounter. Proper documentation of encounters is not only an essential part of patient care and ethical practice; it also enables CHCs to adequately assess patient needs, cost/outcome effectiveness,

and quality of care through quality improvement endeavors. Proper documentation ensures that the MedFT receives credit in the monthly encounter totals (see Glossary for more details). MedFTs working in a CHC should have awareness and knowledge of (a) the EHR system (where one records what happened during a patient visit), (b) patient management systems (where one enters the information needed to support the billable encounter charge slips, current procedural terminology (CPT) codes, etc.), and (c) any required documents that still exist in hard copy (i.e., paper forms).

The EHR is an electronic version of a patient's medical history that is maintained and managed by designated members of the treatment team (e.g., PCP, BHP, nurses). This record will contain information about a patient such as demographics, medical and mental health diagnoses, lab and test results, progress notes, and medication lists. MedFTs have access to patients' medical charts, thus ensuring that providers are accountable to using the EHR effectively and efficiently as they provide care and protect patients' privacy (i.e., only accessing data in private areas and logging off after each use). Table 13.3 includes information about the EHR and the fundamentals of its use that MedFTs should master.

Table 13.3 Fundamentals of EHR usage for MedFTs

MedFTs should know how to	Specific Tasks
Customize your EHR	It is recommended that MedFTs customize their EHR. In most EHRs they can do this by setting user preferences. Through this process, the MedFT will create an electronic signature, common lists for encounters, and access and import important documents to personal folders.
View the daily schedule	MedFTs should be able to view the daily appointment schedule by provider and/or by facility. This will help prepare for and target patients who would benefit most from MedFT services.
Send/receive internal mail	All non-face-to-face correspondence about patients must occur via the internal mail system. Through this system, MedFTs may collaborate with PCPs, nurses, and other BHPs.
Set reminders	MedFTs will want to set reminders about following up on patient's goals and needs. They may do this through setting reminders and deciding how often the reminder will pop up.
Practice with fake patient charts	If the MedFT does not feel confident documenting in the EHR, practice using fake patient charts that are often already created in the system provides training.
Document a behavioral health encounter	MedFTs should document a behavioral health encounter by using the behavioral health template. Recommended templates include those for patients managing blood pressure, cholesterol, diabetes, depression, stress, smoking, healthy eating, physical activity, family support, medication, and health promotion. MedFTs will want to record the scores of all assessments used, diagnoses given, and information relevant to the treatment and plan.
When a patient declines services and calls, contact the patient to follow-up	MedFTs should consider documenting in the EHR even when a patient declines services. All calls and attempts to contact the patient for follow-up should also be logged to track patient engagement attempts.

When working collaboratively with medical providers in CHCs, it is important to consider the type of information documented in the EHR. Documentation should be used to provide integrated healthcare providers with meaningful information about the patient's treatment plan. With that in mind, behavioral health providers should seek to include language about the patient's visit that is familiar to other providers on the team, as well as being consistent with the language that other providers use in treatment planning. Rather than solely focusing on building therapy narratives about the patient's behavioral health encounter, it is equally important to include adequate information about the diagnosis, including the status and severity of the diagnosis and the progress of the patient's treatment. Including information about relevant biomarkers, screening tools, and interventions implemented during the visit can also be helpful in bridging the treatment plans between the biomedical and behavioral/mental healthcare teams. Finally, behavioral health providers in CHCs should consider writing easy-to-understand goals in the EHR. Aforementioned SMART goals are frequently used across healthcare disciplines; they are an efficient way to streamline treatment planning efforts across a care team. It is thereby helpful to the collaborative process if these goals were easily accessible by (and visible to) other healthcare providers in the CHC.

Common Challenges and Considerations

Delivering IBHC services in a CHC setting has some unique challenges. In this section, we address time and space limitations, potential ethical issues, meeting the needs of minority and non-English-speaking patients, and challenges associated with the basics of collaboration.

Time and Space Limitations

To be able to work effectively with time and/or space limitations, it is important to know the environment and other members of the treatment team well. The CHC team is designed to work as efficiently as possible to maximize care for a high volume of patients every day. It is the MedFT's responsibility to understand and work in context of the patient flow. Working with time limitations requires awareness of how quickly the PCP is moving between patients and how many patients have been checked in and are waiting to be seen. Communicating with the PCP, the nurse, or a medical assistant before you begin a patient encounter may help maximize the workflow and ensure patients are seen in a logical order. Generally, providers see patients for 10–15 minutes and visit rooms based on check-in order. MedFTs should plan accordingly to strategize which rooms to visit and when (i.e., have reviewed their chart for signs of concern from previous visit or patient goal that deserves continuity in care).

Regarding space, it is important to know what other spaces around the clinic could be used to visit with patients if an exam room is not available. This is particularly important if the provider asks the MedFT to meet with the patient after the visit but needs the room for his or her next patient. MedFTs should ask the medical provider how much time is available to meet with the patient or if they would prefer that the patient be moved to another unused clinic room/office. It is important that the MedFT not delay clinic workflow, as this will be a deterrent for providers to use IBHC with their patients. However, sometimes patients need longer sessions with the MedFT, so communication with the PCP or nurse is important to resolving workflow challenges and achieving optimal patient care. In some clinics, there are designated spaces for the MedFT to meet with patients when there are longer IBHC or traditional sessions; these spaces are typically larger in size, too, so as to allow for caregivers or family members to be present.

Ethical Considerations

Navigating different codes of ethics in an IBHC setting, especially when it applies to confidentiality and obtaining patients' consent, can be especially complicated. The following discussion provides guidance on how to respect limits of confidentiality and obtaining consent while following established codes of ethics and meeting HIPAA (Health Insurance Portability and Accountability Act of 1996) requirements:

Confidentiality. Confidentiality of all patients' medical information must be protected. Fundamentally, confidentiality is achieved when a patient's private, personal medical information is guarded from disclosure to unauthorized individuals. As a general rule, all medical information for a given patient must remain private, unless (a) permission to share said information has been granted by the patient and/or (b) a compelling and legal reason to break confidentiality is extant (e.g., life-or-death emergency, imminent potential for self-harm via suicide or harm to others via homicide). Procedures for guarding confidentiality may include:

1. Making sure that doors are closed in exam rooms and that conversation volumes are kept low to prevent others from hearing private information.
2. Explaining to the patient during the encounter that his or her information will not be shared with anyone except for their PCP, nurse(s), or other CHC staff directly involved with the patient.
3. Securing the EHR and not leaving patients' records unattended on a computer or otherwise available for viewing on an unlocked device.
4. Sharing information with the PCP that is pertinent/relevant to the patient's situation.
5. Remaining cognizant of new or additional individuals (e.g., friends, family) who have joined the patient room and not disclosing information from current or previous visits without first receiving consent from the patient to proceed with visitor(s) present.

Consent. Before beginning an IBHC or colocated traditional mental health encounter, consent must be obtained from each patient. Adult patients may give their own consent, whereas minors (or others who are incapable of giving consent) must receive consent from a legal guardian (know state law exceptions to providing emergency care to minors). At some healthcare settings, wherein IBHC has been offered previously and consent is embedded in the initial registration paperwork, patients are often unfamiliar with all the stipulations of receiving behavioral health services. As such, it is important to have a clear conversation with each patient to ensure understanding of what may result from an encounter (e.g., a mental health diagnosis from MedFTs) and to explain the limits of confidentiality. Once this has been explained, it is also part of the consent process to let the patient know that the information from the encounter will be documented in the EHR to be shared with the patient's PCP.

Serving Minority and Non-English-Speaking Patients

One major issue that CHCs were designed to address is combatting health disparities in medically underserved areas, many of which tend to serve ethnic minority and non-English-speaking populations (Geiger, 1984; Taylor, 2014). These populations also tend to be more vulnerable to the social, cultural, psychological, financial issues related to health, including lower socioeconomic status, fewer opportunities for consistent employment, limited proficiency with the English language, issues related to immigration status, and social marginalization (Derose, Escarce, & Lurie, 2007). Ultimately, these issues can result in seeking out healthcare services less often, lower compliance with and adherence to medical recommendations, less trust in the healthcare team, and poorer treatment outcomes. Attentiveness to these issues is crucial to providing quality care for all patients in CHCs, and healthcare providers can better attend to this by engaging minority and non-English-speaking patients through culturally sensitive healthcare practices (Brach & Fraserirector, 2000).

Culturally sensitive healthcare practices should include learning about (and educating other members of the treatment team about) how chronic illnesses and behavioral health needs might differ for ethnic minority populations (e.g., implications, indications, and contraindications of treatment may vary based on the cultural practices and identities of patients). One of the foremost culturally sensitive practices healthcare providers can use to attend to the needs of non-English-speaking populations is to make sure that handouts and resources about behavioral health and chronic illnesses are available in multiple languages (Israel et al., 2005). This can help to ensure that information about a patient's health or condition is available in a language that the patient is comfortable with. Also, learning key medical or treatment terminology in other languages may help healthcare providers to bridge language barriers and provide better overall care (Derose, Escarce, & Lurie, 2007). One of the most helpful resources that CHCs can implement to better serve minority and non-English-speaking patients is to include staff members who represent the

target patient population (Cabral & Smith, 2011; Wu & Windle, 1980). For example, Spanish-speaking physicians, medical assistants, receptionists, behavioral health providers, etc. should be present in a clinic that serves a predominantly Latino community. There is also some evidence to suggest that matching the staffing of clinics to the patient population (e.g., hiring bilingual and bicultural staff members) can promote better health outcomes (Cabral & Smith, 2011).

Finally, with populations served by CHCs (e.g., highly uninsured or underinsured), it is important to consider the impact of limited literacy skills when exploring culturally sensitive practices, particularly because low literacy skills have been found to be associated with significantly higher healthcare costs among underserved populations (Weiss & Palmer, 2004) and health disparities in geriatric populations (Sudore et al., 2006). Assessing for literacy level is an important culturally sensitive practice because individuals with limited literacy might use coping tools to show comprehension of the handouts, pamphlets, or information sheets provided, despite having limited reading abilities (Cowan, 2004). Literacy is not an indication of high intelligence; it is thereby important to not assume that a patient with lower literacy skills is less intelligent and/or less capable of compliance. Once assessment has been completed, healthcare providers can teach patients with low literacy skills by using techniques such as (a) providing verbal instructions, (b) teaching information using only a few sentences at a time and then repeating or reviewing instructions, and (c) using demonstrations. Also, for patients with low literacy skills, written materials should be avoided unless the materials are at the patient's reading level (Cowan, 2004).

Engaging in Collaboration

Engaging in effective collaboration means contributing to all parts and members of the system. The information below includes methods for engaging the support systems of both patients and members of the patients' healthcare team. Not all patients, support persons, or healthcare team members were socialized or trained to work alongside behavioral health professionals in a healthcare setting. This requires the MedFT to lean heavily on his or her relational skills to help build trust in the system while at the same time respecting the learning curves of those who are not as familiar with IBHC.

Family Collaboration

Family members, support persons, and other caretakers are important in the work that MedFTs do in a CHC setting. Because of their unique training, MedFTs excel at working with patients and their support persons. The challenge, though, is oftentimes getting said support persons to attend a healthcare visit. Asking patients if anyone accompanied them to a visit is a common way to begin. Many family

members/support persons wait in the car or waiting room to give the patient privacy. Sometimes the patient does not know that it is okay or beneficial to invite support persons into the exam room. Oftentimes just asking if the patient would or could invite a partner or support person in, when appropriate, is a quick process with tremendous gains. Another way to engage with support persons is to have the patient call or text the individual to communicate his or her health status and components of the treatment plan (including ways in which the support person can help to meet needs or extend support). Lastly, inviting the patient to bring in his or her primary support person to the next visit is an important strategy for expanding the system and inviting support persons to be a continuous part of the patient's healthcare team.

It is important that any family member/support person attending the appointment with the patient be acknowledged and engaged at the start of the visit. Tips for ethically engaging family members into visits include the following:

1. Obtain consent from the patient to discuss the patient's issues in front of others in the room.
2. Ask the patient to introduce you to each person in the room, and ask why he or she accompanied the patient to the visit.
3. Seek information from the visitor about the chief complaint (e.g., family members can help clarify the patient's story, add valuable information, and will tell you things that the patient may omit).
4. View the visitor(s) as collaborators in your work vs. impediments (e.g., parents can help children with emotional self-regulation).
5. Ask the patient to identify how the visitor can support him or her in achieving his or her health goals.
6. Encourage the patient and the visitor to summarize the next steps that will be taken to continue progress on the treatment plan.

Provider Collaboration

Primary care providers generally serve as patient gatekeepers. If a provider is not comfortable with a MedFT or IBHC, it is unlikely that the MedFT will be able to access the patient. MedFTs should, therefore, cultivate relationships with providers if they are interested in increasing their interactions with patients. Building relationships with support staff can also help increase patient encounters. This is particularly useful when each provider works with a designated medical assistant (MA) or registered nurse (RN). Being able to communicate well with MAs/RNs will help MedFTs to determine the best time(s) to enter a room and to be aware of the provider's timeline and approach to care for each visit.

Typically when MedFTs begin in a new work context, one of their roles is to respectfully introduce other providers to IBHC and the BPSS framework. Providers may not be accustomed to planning patient care and treatment planning with other clinicians. It is therefore important that MedFTs be aware of the level of integrated care (e.g., Doherty, McDaniel, & Baird, 1996) established at the CHC site and also

of the level of integration that respective providers are comfortable with (this often varies from provider to provider, even at the same location). Engaging providers in interactions around patient care begins with MedFTs modeling said interactions. This can begin with MedFTs initiating conversations with providers about shared patients.

After each encounter, MedFTs should follow up with the PCP to relay pertinent information about the visit and overall treatment planning. MedFTs should be aware that providers often have limited time for conversations between patients, so this may be a brief transfer of information. The following are some useful guidelines for follow-up: (a) keep it brief (15–30 seconds), (b) report salient information only (e.g., assessment scores, psychological, social, and spiritual issues—including financial and access to care issues—impacting treatment planning), (c) address red flag issues (e.g., suicidality, homicidality, child abuse, interpersonal violence), (d) design and deliver appropriate interventions (e.g., briefly explain mindfulness exercises, brief evidence-based psychotherapy or family therapy, interviewing strategies for motivating change), and (e) offer modified and/or additional treatment recommendations.

If a MedFT is having difficulty joining with a particular healthcare team member, he or she should consider finding a time to speak with the said team member to build more of a relationship (e.g., after patient appointments or during a lull in patient flow). In this conversation, the MedFT may consider (a) explaining to the provider the types of services that MedFTs offer, (b) asking the provider if there are particular services that he or she would like the MedFT to extend, (c) asking the provider if there are any particular patients with whom the MedFT could assist, (d) asking the provider how he or she would like the MedFT to follow up after patient care (including the type of information to be relayed), and (e) getting to know the provider better by asking about things that the team member enjoys and values as a way to develop a successful partnership. Afterward, MedFTs should be consistent in following up with providers about MedFT-patient interactions. It is important that MedFTs show an appreciation for the opportunity to collaborate and occasionally check in with providers about the collaborative process and how it may be improved—all the while maintaining an appropriate demonstration of confidence and competence. This will help MedFTs to increase rapport and build ongoing trust.

Community Health Centers Across the MedFT Healthcare Continuum

Skills and knowledge in medical family therapy can extend from primarily focusing on psychosocial issues presented by an individual or family with very limited integration of BPSS or systemic factors in the sessions to advanced relational and BPSS skills and knowledge who function as a part of collaborative teams in diverse CHC contexts. Tables 13.4 and 13.5 highlight specific knowledge and skills that

Table 13.4 MedFTs in Community Healthcare Centers: Basic Knowledge and Skills

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Knowledge	Familiar with CHC as a system of care beneficial to the community but rarely engages in opportunities to collaborate with healthcare team members about patients' BPSS health. Limited knowledge about BPSS impacts of a few common population health conditions seen at CHC clinics. Rarely engages professional members, patients, and support system members collaboratively in joining, assessing, diagnosing, planning, and/or intervening. Basic understanding regarding strategies for a healthy lifestyle when living with and/or with someone who has a health condition. If conducting research and/or policy/advocacy work, on rare occasions will collaborate with other disciplines related to CHC care and consider relational and/or BPSS aspects of health and well-being.	Can recognize the disease processes and differentiate between some of the more common ones and other comorbid BPSS health conditions and impacts on the CHC population served. Familiar with benefits of couple and family engagement in health-related adjustments and/or lifestyle maintenance but tends to refer more than provide this service. Knowledgeable about how to use the electronic health record system or other forms of secured communication to collaborate with various team members. Is an occasional contributor to discussions about research design and policy/advocacy work that include relational and/or BPSS aspects of health and well-being.	Working knowledge of specific team members (e.g., allopathic and osteopathic physicians, nurse practitioners, physicians, assistants, nurses, medical office assistants, phlebotomists, pharmacists, nutritionists, physical therapists, other behavioral health disciplines), medical terminology with regard to medications and EHR charting (e.g., prn, qd, BGL, TSH), and common comorbid medical conditions to commonly seen illnesses in a CHC (e.g., anxiety, asthma, depression, diabetes mellitus, hypertension, hyperlipidemia, substance use disorders). Broad range of knowledge about research-informed family therapy and BPSS interventions; able to and usually will conduct couple and family therapy and incorporate BPSS health factors into treatment with minimal need to refer out due to limited expertise. When work permits, is knowledgeable and consistency committed to conducting research and constructing policy/advocacy work that identifies and intervenes on behalf of individuals, couples, families, and healthcare teams toward the advancement of BPSS health and well-being.

(continued)

Table 13.4 (continued)

MedFT Healthcare Continuum Level	Level 1	Level 2	Level 3
Skills	Able to recognize at a basic level the BPSS dimensions of health and apply a BPSS lens to CHC practice, research, and/or policy/advocacy work. Can discuss (and psychoeducate) basic relationships between biological processes, personal well-being, and interpersonal functioning. Demonstrates minimal collaborative skills with CHC and other related healthcare providers; prefers to work independently, but when care is complex enough will contact/refer to other providers on- or off-site about additional services.	Knowledgeable about how to apply systemic interventions in practice but does it occasionally; capable of assessing patients and support system members present for background health issues such as family history and risk-related factors. Demonstrates adequate and occasional collaborative skills through (a) written and verbal communication mediums that are understandable to all team members and (b) coordination of referrals to specialty behavioral health providers and communication with the patient's CHC primary care provider. Conducts separate treatment plan from other providers involved in the patient's care; goals and interventions can overlap with—or be informed by—a CHC team member, but BPSS goals and collaboration with the team are not consistently done.	Able to and usually will integrate respective CHC team members' expertise and counsel into treatment planning. When done can successfully conduct a systemic assessment of a patient and family with competencies in assessing for BPSS aspects of illnesses and/or comorbid diseases and resources within the family. Usually engages other professionals within and outside of the CHC center who are actively involved in the patient's care. Skilled with standardized measures to track patients' individual and relational strengths and challenges, and makes them available in the patient's dominant language. Attends and contributes to team meetings to help shape BPSS treatment plans for patients.

characterize MedFTs' involvement in CHC contexts across Hodgson, Lamson, Mendenhall, and Tyndall's (2014) MedFT Healthcare Continuum.

MedFTs at *Level 1* rarely apply relational or biopsychosocial-spiritual (BPSS) practices and/or include partners, families, or healthcare systems into their work. This level often includes professionals from many different disciplines who recognize that working from a relational perspective is beneficial, although they might only take a relational perspective in certain settings (e.g., hospice, pediatrics) or

situations (e.g., when needing to make a referral, when one family member is the healthcare proxy for another family member). In CHCs, the range of skills or desire for collaboration with providers from other disciplines can be quite diverse. In this instance, a MedFT at *Level 1* may focus on a health concern and rely on BPSS only when its systemic nature drives the need to consider all of the BPSS domains, as can be the case with health coaching. In other instances, a MedFT at this level may consider the BPSS strengths and consequences associated with a diagnosis, but not attend well to the systemic relationships that can benefit or be influenced by the diagnosis. A strength at this level could be that attention is given with precision to the presenting concern. The vignette in this chapter illustrates a MedFT who moved

Table 13.5   MedFTs in Community Healthcare Centers: Advanced Knowledge and Skills

MedFT Healthcare Continuum Level	Level 4	Level 5
Knowledge	Consistently applies understanding of the more commonly treated health conditions and BPSS impacts in CHC centers. Knowledgeable about BPSS benefits and risks of associated treatments of the more commonly seen biological and mental health conditions across the lifespan in CHC centers (e.g., anxiety, asthma, depression, diabetes mellitus, hypertension, hyperlipidemia, substance use disorders). Understands how to implement and collaborate with other disciplines to implement evidence-based BPSS and family therapy protocols in traditional and integrated behavioral healthcare contexts. Identifies self as a medical family therapist. Knowledgeable about designing and advocating for policies that govern BPSS-oriented CHC services.	Understands and educates others about treatment and care sequences for unique and/or challenging topics in CHC practice (e.g., trauma, citizenship issues, geographic separation from family, unfamiliar cultural beliefs/practices); can consult proficiently with professionals about BPSS topics from other fields. Proficient at explaining evidence-based treatments regarding most mental health disorders and their role(s) in the family; has background to provide psychoeducation to patients and families about a variety of symptoms, medications, and behavioral health management. Very knowledgeable about BPSS research designs and execution, policies, and advocacy needs as relevant to CHC care. Proficient in developing a curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc. to mental health and other health professionals. Understands leadership and supervision strategies for building integrated behavioral healthcare teams in CHC settings.

(continued)

Table 13.5 (continued)

MedFT Healthcare Continuum Level	Level 4	Level 5
Skills	Able to deliver seminars and workshops to a variety of professional types (e.g., mental health, biomedical) about the BPSS complexities of a variety of commonly reported health and wellness topics found in CHC settings.	Proficient in nearly all aspects of commonly seen presenting problems in a CHC setting; able to synthesize and conduct research and clinical work; engages in community-oriented projects outside of the CHC center.
	Can apply several BPSS interventions in care (including most types of brief interventions); can administer mood- and disease-specific assessment tools as the CHC context requires.	Goes beyond intervention routine for this population; can integrate specific models of integrated behavioral healthcare into routine practice (e.g., PCBH, chronic care model).
	Consistently collaborates with key CHC team members (e.g., primary care providers, nurses, medical assistants, behavioral health providers, pharmacists, dieticians); initiates and facilitates team visits with multiple providers when working with patients and families.	Works proficiently as a MedFT and collaborates with other providers from a variety of disciples serving within the CHC center.
	Can independently and collaboratively construct research and program evaluation studies that study the impact of BPSS interventions with a variety of diagnoses and patient/family units of care.	Leads, supervises, and/or studies success of the implementation and dissemination of BPSS curriculum on integrated behavioral healthcare, BPSS applications, MedFT, etc.
		Explains at a high level of skill evidence-based treatments regarding most commonly seen CHC presenting problems and their impact on family systems; has background to provide psychoeducation to patients and families about a variety of symptoms, medications, and behavioral health management techniques that facilitate managing chronic illnesses well, returning to optimal health, or managing one's health successfully.

well past *Level 1* by demonstrating value in exploring the patient's BPSS health and constructing a treatment plan accordingly.

Level 2 does not deviate dramatically from the skills in *Level 1*, except in the frequency that BPSS or relational health is addressed as a part of each encounter. In our vignette, Jamar is a 19-year-old patient accompanied by his mother to a healthcare visit. The MedFT supervisor and trainee work from the start of the visit to explain the model of care adopted at the CHC and how it may benefit his goals for

care at that visit. It is clear that the supervisor and trainee share the value of BPSS health and skills in explaining and engaging the patient and his mother in discussing it. They also have collaborative skills in communicating with the patient, family member, and PCP to help construct a BPSS treatment plan.

At *Level 3*, the MedFT is usually applying a relational and BPSS practice in each encounter, as well as through conversations with other providers or collaborators. At this level, the MedFT can showcase that he or she is specifically trained to apply a broad range of family therapy interventions and conduct family therapy in the healthcare context. MedFTs at this level are providing care with consideration of data-driven or research-based information on relational and/or BPSS care. Given the frequency of using BPSS and relational healthcare at this level, a growing competence in diverse uses of MedFT is apparent to the supervisor's eye (similar to what was encountered by the supervisor described in the vignette). The MedFT is able to easily weave comments pertaining to biological health into concerns related to social stressors or psychological challenges. Furthermore, the MedFT is able to justify choices in care due to evidence-based research knowledge. In the vignette, the MedFTs are highlighting how effective they are in joining, assessing, and treating from a family-centered intervention level. They work to set a health goal that is not only identified as important to the patient, in this instance sleep patterns, but is also supported through a goal that was constructed in collaboration with the patient's mother. Not all family members share the same concern about weight or sleeping habits, so encouraging change and intervening in this type of conversation are something that one needs specialized training in order to deliver successfully. At *Level 3,* MedFTs will have had some of this training, alongside more extensive family therapy intervention skills.

Level 4 represents the MedFT who is consistently applying relational and/or BPSS knowledge and skills into his or her practice, research, policy, and/or advocacy work. The MedFT is experienced in using his or her knowledge and skills in both traditional mental health (i.e., the typical 50 minute couple/family or larger system session) and integrated behavioral healthcare contexts (i.e., MedFTs who work in tandem with biomedical and spiritual health providers when extending care/research/training). *Level 4* MedFTs in CHCs are recognized as part of the healthcare team, attend conjoint meetings and trainings, and are clearly identified as a MedFT in their work context. The medical assistants, dental team, or other medical providers know that the MedFT is a strong collaborator and contributor in addressing social determinants that may disrupt continuous care. The MedFT is recognized for attending to behavioral health concerns, symptoms, and diagnoses, along with stressors associated with a new diagnosis and/or anxiety associated with a medical procedure (e.g., a tooth extraction or receiving an injection). In these instances, the MedFT is able to extend evidence-based knowledge by providing a relaxation technique or determining whether brief therapy is a good option for the patient and his or her partner/family.

Finally, *Level 5* represents proficiency as a MedFT. At this level, the MedFT is able to serve as an administrator, supervisor, educator, researcher, and trainer in either a behavioral health or healthcare context and is trained and experienced

in family therapy and MedFT practice, research, policy, and/or administration (including the interface with diverse healthcare providers and staff, diagnoses, research, complications across BPSS domains, and ethical standards). At this level, MedFTs have the knowledge and skills to mentor new MedFT, healthcare, and IBHC providers on models of integrated behavioral healthcare. They are also able to ensure that the level of collaboration is held to the highest standard by integrating care at the clinical, operational, and financial levels (e.g., attending to quality care, shared documentation processes, and working to improve cost-effectiveness and cost-offset). The vignette showcases a MedFT supervisor functioning at this level on the continuum.

Research-Informed Practices

CHCs generally serve populations who have less access to healthcare options (Taylor, 2014). These populations often include racially and ethnically diverse patients or those with less access to educational and financial resources (Derose, Escarce, & Lurie, 2007). Therefore, behavioral health models used in CHCs should be appropriate for and empirically validated with populations from diverse social locations.

Individual Approaches

Given that CHCs offer a variety of healthcare services, with primary care services being a priority, BHPs working in CHC settings need to be prepared to help patients within the context of infrequent and brief interviews that typically last between 15 and 30 minutes (McDaniel, Doherty, & Hepworth, 2014). To effectively address the mental health needs and health behaviors of patients in CHCs, BHPs need to work from a theoretical approach that can effectively help individuals in the context of brief and infrequent face-to-face interactions with patients. Fortunately, there is a growing body of scientific evidence that supports the use of several clinical approaches within the context of primary care settings.

Motivational Interviewing

Motivational interviewing (MI) has been recognized as an effective approach to health behavior management for use in healthcare settings (Rollnick et al., 2007). It is also widely recognized as being a patient-centered approach to healthcare and has shown higher rates of success in promoting health behavior changes among patients in comparison to the traditional "recommendation-giving" practices of healthcare providers (Britt, Hudson & Blampied, 2004). The basic principles of MI suggest

that individuals are more likely to change when they can associate the desired change to something of intrinsic value and that the motivation to engage in behavior change grows when people feel safe to explore their reasons for change in the context(s) of what they value (Hecht et al., 2005; Miller & Rollnick, 2002).

Motivational interviewing can be a particularly useful intervention for patients served by CHCs because its principles are centered on assessing patients' current level of motivation, access to resources, willingness to make actionable change, and feasibility of the change (Emmons & Rollnick, 2001). MI's techniques encourage healthcare providers to take into account patient factors that may promote or limit change and thereby offer MedFTs and other providers the opportunity to explore social locations and cultural influences that have a role in shaping the patient's engagement in treatment. Lundahl et al. (2010) also found that MI was effective in increasing patients' engagement in treatment and promoting healthy behaviors. Finally, an additional advantage of MI is that it has been studied for use with mental health illness (e.g., Miller & Rose, 2009; Schoener, Madeja, Henderson, Ondersma, & Janisse, 2006) and chronic illness (e.g., Spencer et al., 2011). Therefore, a variety of healthcare providers can apply MI practices to their areas of focus to build collaborative treatment plans with consistent treatment approaches.

Transtheoretical Model for Change

A complementary tool that MedFTs might consider using in conjunction with motivational interviewing are the stages of change captured in the transtheoretical model for change (DiClemente, & Prochaska, 1998; Prochaska, Diclemente, & Norcross, 1992); after all, the two models are well-known for "growing up together" in the 1980s (Miller & Rollnick, 2009). The transtheoretical model for change presents five stages of change that a patient might move through during treatment: *precontemplation*, *contemplation*, *planning*, *action*, and *maintenance*. By assessing a patient's readiness to change, healthcare providers in CHCs are better able to identify how concerning the presenting problem is to the patient and whether the patient is interested in making changes to address his or her presenting problem. It can also be used to ensure that healthcare providers are appropriately engaging patients in the treatment process. When used along with MI, the transtheoretical model for change can be beneficial to populations served by CHCs because it allows for patient agency in the treatment process while encouraging providers to work from patients' respective stages of change (DiClemente & Velasquez, 2002; Norcross, Krebs, & Prochaska, 2011). This model has been found to be effective at increasing physical activity in adults with diabetes (e.g., Avery, Flynn, Wersch, Sniehotta, & Trenell, 2012), reducing dietary fat intake in underserved patients (e.g., Parra-Medina et al., 2011), and reducing substance use and other addictive behaviors (e.g., alcohol, tobacco, marijuana, gambling) (e.g., Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010). Along with being an effective tool for individual treatment, the transtheoretical model can be used to engage partners and families of the patient in the treatment process (Tambling & Johnson, 2008).

Cognitive Behavioral Therapy

In mental health fields, cognitive behavioral therapy (CBT) is hailed as the gold standard for behavioral health interventions. The body of empirical evidence in support of CBT as an effective treatment option for an array of mental illnesses is vast (e.g., Fischer, Baucom, & Cohen, 2016; Otte, 2011; Safren et al., 2010). While CBT is easily recognizable to multidisciplinary healthcare providers, it is still more commonly regarded as a psychological approach for mental health treatment, rather than a behavioral health treatment option. Emergent literature suggests that CBT is effective in the treatment of chronic illness (e.g., Katon et al., 2010) and lifestyle changes (e.g., Trockel, Manber, Chang, Thurston, & Taylor, 2011); however, this body of literature is young, and the treatment of chronic illness using CBT is frequently studied along with a comorbid mental illness.

Cognitive behavioral therapy was designed to be a brief approach for symptom resolution, which makes it appropriate for individual patients at CHCs who may have few, sporadic appointments. Furthermore, evidence of CBT's effectiveness in primary care settings is beginning to emerge, showing CBT to be effective with anxiety disorders, depression, medication adherence, chronic illness management, and parent management skills for parents of children with externalizing symptoms (e.g., Weisberg & Magidson, 2014), depression, anxiety, and physical health quality of life in primary care patients (e.g., Cully et al., 2010), chronic obstructive pulmonary disease, chronic heart failure, depression, and anxiety (e.g., Mignogna et al., 2014). However, there remains some concern that CBT-effectiveness researchers have not investigated the model's adequacy for use with diverse patients, such as those presenting to community healthcare centers (CHCs). For example, while Serfaty and colleagues (2009) found that CBT was effective in reducing depression scores in older adults treated in primary care, only 6% of their sample was non-White and no sample socioeconomic factors (SES) were reported. Therefore, MedFTs in CHCs should actively implore a culturally sensitive and patient-centered lens when engaging patients in CBT treatment techniques.

Family Approaches

Engaging families of underserved patients in treatment at CHCs can help to expand resources available to the patient, encourage shared responsibility for management of the presenting problem, and educate healthcare providers about the meaning of the presenting illness for the patient and family (Hu, Amirehsani, Wallace, McCoy, & Silva, 2016). While opportunities for traditional family therapy services may be available in some CHC settings, the primary focus of MedFTs in CHCs should be to engage available family members during IBHC visits while working collaboratively with other healthcare providers (Marlowe, Hodgson, Lamson, White, & Irons, 2012). Each of the approaches suggested for family-based intervention is used to offer support to patients by engaging their family or social support system in the treatment process.

Solution-Focused Therapy

Solution-focused therapy (SFT) is a strength-based approach to behavior change that focuses on solutions rather than deficits (Gingerich & Peterson, 2013). And while there is value to more frequent sessions (as is the case with any treatment), even a single session of SFT can assist in getting a patient and family engaged in care and thinking about change (Bloom, 2001; Lamprecht et al., 2007; Perkins, 2006). Additionally, a main assumption in SFT is that patients are the experts of and in their own lives. This assumption is instrumental to engaging marginalized individuals and families in treatment, thereby making SFT a valuable clinical model in CHCs.

Another major advantage of using SFT with families in CHCs is that its proponents assume competence and strength in the patient's and family's skill sets to address presenting illnesses (Berg, & De Jong, 1996; Grant, 2012). There are several reports of SFT being used to address lifestyle foci, chronic illness, and mental illness—including physical activity, diet, sleep hygiene (Valve et al., 2013), diabetes and obesity (Rudolf, Hunt, George, Hajibagheri, & Blair, 2010; Viner, Christie, Taylor, & Hey, 2003), and depression and anxiety disorders (Gingerich & Peterson, 2013; Grant, 2012). SFT has also been shown to be effective in engaging families and caregivers in the treatment of pediatric diabetes management (Christie, 2008), stroke survivors (Plosker & Chang, 2014), patients with psychosis (Priebe et al., 2015), and mothers with postpartum depression (Ramezani, Khosravi, Motaghi, Hamidzadeh, & Mousavi, 2017).

Patient-Centered Communication

Narrative approaches, specifically patient-centered communication, have been found to promote the development of shared meaning between providers, patients, and families about the presenting illness and the role of the said illness in the patient's and family's lives (Charon, 2001; Sakalys, 2003). There is evidence to suggest that patient-centered communication in family treatment promotes motivational enhancement and family engagement to reduce mental health symptoms of underserved parents and children in primary care settings (Cooper et al., 2011; Wissow et al., 2008).

Patient-centered communication may be particularly valuable in addressing the spiritual domain of the BPSS—i.e., the meaning-making domain of health (Sulmasy, 2002). By helping families make meaning about a presenting illness, providers can be more attuned to patients' and families' needs and limitations (Street, Makoul, Arora, & Epstein, 2009). Engaging in meaning-making communication can also help providers develop treatment plans that are aligned with unique values, needs, concerns, and resources.

With the diverse and often marginalized populations served in CHCs, the importance of allowing families and patients to explain the significance and impact of illness on their individual and shared lives cannot be understated. Underserved

groups often have a different lived experience than as compared to their healthcare providers (Rao, Anderson, Inui, & Frankel, 2007), not to mention different access to information about and resources to treat their illness (Nam, Chesla, Stotts, Kroon, & Janson, 2011). Patient-centered communication can be used to develop a relationship between healthcare providers, patients, and families that strengthens alliance, creates meaning about the illness, and encourages more active participation from families in care.

Community Approaches

Community health centers grew out the Civil Rights Movement and the War on Poverty (Taylor, 2014). They were designed with the intent of bringing services to impoverished communities, especially inner cities and rural communities. A primary goal of CHCs was (is) to promote community-oriented care, wherein members of the community simultaneously access and shape the services that they engage with (Geiger, 1984; Gibson, 1968). CHCs were developed to be a community resource for populations with limited access to and options for healthcare; this highlights how CHCs lend themselves naturally to community-based approaches to care.

Community Involvement

Health and illness narratives are a collective endeavor. Patients do not exist in isolation; their health and illness thereby have significance across personal levels and with those whom they interact with across friendship, family, and professional spheres and within the communities they inhabit (Murphy, 2015). Institutions in and surrounding the communities that CHCs serve can be another source of intervention. These community resources might include schools, churches, banks, local businesses/companies, and universities that have a vested interest in the health of their community population. Banks and local businesses/companies can be engaged to provide financial support for community health initiatives, particularly if the community is struggling with or at risk for a health disparity (Horowitz & Lawlor, 2008). Schools may be the next frontier in connecting potential patients to CHCs, encouraging the consistent practice of health behaviors, and providing space for behavioral health services in nonclinical settings (Keeton, Soleimanpour, & Brindis, 2012; Rosenthal et al., 2010). Universities have a long history of being strong supporters of CHCs. From providing the research expertise to engage CHCs in community-based participatory research (Wallerstein & Duran, 2006) to extending clinical support to patients and CHCs through providers in training (Cashman & Seifer, 2008; Seifer, 1998), the relationship between CHCs and local universities is one of the longest-standing and mutually beneficial community resources.

Community-Based Participatory Research

Community health centers are particularly well-suited for community-based partici-patory research (CBPR)—a collaborative research approach in which local organi-zations and residents are directly involved in the design and implementation of investigative pursuits (Israel et al., 2005; Wallerstein & Duran, 2006). These studies are designed to address concerns that are important to—and support initiatives that will—directly benefit community members (AHRQ, 2003; Rhodes, Malow, & Jolly, 2010). A strength of CBPR is its focus on building sustainable community partnerships to increase capacity of community organizations to better serve their constituents (Dulmus & Cristalli, 2012; Minkler & Wallerstein, 2011). CBPR can be particularly valuable when the research is service oriented, providing not only an opportunity for knowledge about the population through research but also providing the patients with access to additional healthcare services and options for treatment.

For example, Mendenhall et al. (2010) used CBPR to provide better quality dia-betes education and treatment to urban-dwelling American Indian (AI) populations. By engaging the AI community in and throughout the research and treatment pro-cess, the healthcare team was able to move away from conventional top-down mod-els of providing care toward an approach where healthcare providers and researchers were learning from and responding to the needs of the target population as co-owners and coproducers of the work. This included facilitating and empowering the target population's involvement in the design of the research, advancing the intervention(s), and even writing and publishing the results. Ultimately, the use of CBPR improved the health outcomes for the AI community across several diabetes-relevant indicators (Berge, Mendenhall, & Doherty, 2009; Mendenhall et al., 2012; Seal et al., 2016). When implemented with the support and interest of the target population in mind, CBPR—and/or any of the aforementioned treatment approaches—can be used by healthcare teams to provide more patient-centered and culturally aware care to (and indeed, with) those who are often marginalized and overlooked in the healthcare system.

Conclusion

Community health centers are incubators for innovation in healthcare delivery, including the integration of primary medical treatment with oral care, care manage-ment, substance use/abuse, and behavioral health services. They have been shown to be cost-effective and are designed to serve the needs of underserved families and individuals. Furthermore, CHCs are ideal for integrating MedFTs, as they are trained to treat patients and their families in relation to health, illness, loss, or trauma using a biopsychosocial-spiritual (BPSS) and systemic approach to treatment. MedFTs are trained to assess, diagnose, and treat a wide array of concerns that patients bring to primary care, ranging from lifestyle issues, chronic mental health conditions, and other health concerns in concert with the primary care team.

Common evidence-based interventions embraced by MedFTs include motivational interviewing, transtheoretical model/stages of change, cognitive behavior therapy, family (support system) engagement, solution-focused therapy, narrative approaches, and interventions developed from community-based participatory research. MedFTs embrace intervention models that honor patients' cultural values, beliefs, and preferences as they engage with the healthcare team through their illness and recovery/management processes.

Reflection Questions
1. What are some ways that MedFTs are able to deliver culturally appropriate services to underserved families and individuals?
2. Identify some of the challenges that MedFTs might experience (and possible solutions) when delivering services in a community health center context.
3. What are some of the research-informed approaches that MedFTs may want to practice when working in community health centers?

Glossary of Important Terms for Care in Community Health Centers

Collaborative care The process of working with healthcare providers across disciplines to discuss patient's diagnoses, treatment options, and interventions and to develop a treatment plan.

Cost report Often used for Medicaid and Medicare reimbursements, a report that includes information about the provider system (e.g., an FQHC), including utilization of services, charges to patients, and cost of services.

Encounters A face-to-face visit between a patient and healthcare provider that must include a treatment intervention and proper documentation.

Encounter rate A facility-specific rate that is paid to an FQHC to cover the cost of services for each valid encounter.

Federally Qualified Health Center (FQHC) A comprehensive healthcare center designed to service underserved populations, typically in areas with limited health resources. FQHCs must offer a sliding fee option to patients without insurance and are eligible for enhanced reimbursement from Medicare and Medicaid.

Health behaviors Practices, habits, and knowledge that can improve a patient's health.

Health disparities The differences in health status that socially disadvantaged populations experience. Factors that contribute to health disparities include access to healthcare, socioeconomic status, geographic location, race/ethnicity, and gender.

Population health Factors contributing to the health of (and the health outcomes of) a group of individuals who share a common illness, environment, or social identity.

Promotora A Hispanic/Latino community member who provides basic health education to the population as a trained lay person (not as a professional healthcare worker).

Rural health clinics Public, profit, or nonprofit clinics located in rural, underserved areas to provide primary care services to rural populations.

Social determinants of health The social, cultural, economic, and environmental factors that contribute to an individual's health status, including marital status, education, socioeconomic status, and immigration (see PRAPARE in Resources for more details).

Additional Resources

Literature

Engel, J. (2006). *Poor people's medicine: Medicaid and American charity care since 1965*. Durham, NC: Duke University Press.

Hoffman, B. (2012). *Health care for some: Rights and rationing in the United States since 1930*. Chicago, IL: University of Chicago Press.

Lefkowitz, B. (2007). *Community health centers: A movement and the people who made it happen*. New Brunswick, NJ: Rutgers University Press.

Minkler, M., & Wallerstein, N. (Eds.). (2011). *Community-based participatory research for health: From process to outcomes*. San Francisco, CA: Wiley.

Ward Jr., T. J., & Geiger, H. J. (2016). *Out in the rural: A Mississippi health center and its war on poverty*. New York, NY: Oxford University Press.

Electronic Resources

Agency for Healthcare Research and Quality: The Role of Community-Based Participatory Research. https://archive.ahrq.gov/research/cbprrole.htm

Community-Campus Partnerships for Health: Community-Based Participatory Research. https://depts.washington.edu/ccph/commbas.html

Health Resources Services Administration: Federal Office of Rural Health Policy. https://www.hrsa.gov/ruralhealth

Measures/Instruments

Alcohol Use Disorders Identification Test (AUDIT). https://www.drugabuse.gov/sites/default/files/files/AUDIT.pdf

Anxiety: Generalized Anxiety Disorder 7-Item Scale (GAD-7). http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/GAD-7_English.pdf

CAGE AID Questionnaire. http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

Depression: Patient Health Questionnaire 9 (PHQ-9). http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Drug Abuse Screen Test (DAST—10). https://www.drugabuse.gov/sites/default/files/dast-10.pdf

Duke Population Health Profile (Duke-PH). http://www.integration.samhsa.gov/clinical-practice/DukeForm.pdf

Social Determinants of Health/Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE). http://www.nachc.org/research-and-data/prapare/

Suicide Risk: Columbia-Suicide Severity Rating Scale (C-SSRS). http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/, http://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Trauma: PTSD Checklist—Civilian version (PCL-C). https://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf

Organizations/Associations

Health Resources Services Administration: Health Center Program. https://bphc.hrsa.gov

National Association of Community Health Centers. www.nachc.org

National Institute on Minority Health and Health Disparities. https://www.nimhd.nih.gov

RCHN Community Health Foundation. http://www.rchnfoundation.org

The Community Health Center Story. http://www.chcchronicles.org

References[1]

Aamar, R., Lamson, A., & Smith, D. (2015). Qualitative trends in psychosocial treatment for underserved patients with type 2 diabetes. *Contemporary Family Therapy*, *37*, 33–44. https://doi.org/10.1007/s10591-015-9326-x

Agency for Healthcare Research and Quality. (2003). *The role of community-based participatory research: Creating partnerships, improving health*. Retrieved from https://archive.ahrq.gov/research/cbprrole.htm

Ahmedani, B. K. (2015). Racial/ethnic differences in health care visits made before suicide attempt across the United States. *Medical Care*, *53*, 430–435. https://doi.org/10.1097/MLR.0000000000000335

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[1] Note: References that are prefaced with an asterisk are recommended readings.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Avery, L., Flynn, D., Van Wersch, A., Sniehotta, F. F., & Trenell, M. I. (2012). Changing physical activity behavior in type 2 diabetes: A systematic review and meta-analysis of behavioral interventions. *Diabetes Care*, *35*, 2681–2689. https://doi.org/10.2337/dc11-2452

Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *The alcohol use disorders identification test: Guidelines for use in primary care*. Geneva, Switzerland: World Health Organization.

Berg, I. K., & De Jong, P. (1996). Solution-building conversations: Co-constructing a sense of competence with clients. *Families in Society*, *77*, 376–391. https://doi.org/10.1606/1044-3894.934

Berge, J. M., Mendenhall, T. J., & Doherty, W. J. (2009). Using community-based participatory research (CBPR) to target health disparities in families. *Family Relations*, *58*, 475–488. https://doi.org/10.1111/j.1741-3729.2009.00567.x

Bloom, B. L. (2001). Focused single-session psychotherapy: A review of the clinical and research literature. *Brief Treatment and Crisis Intervention*, *1*, 75–86. https://doi.org/10.1093/brief-treatment/1.1.75

Blount, A. (2003). Integrated primary care: Organizing the evidence. *Families, Systems, & Health*, *21*, 121–133. https://doi.org/10.1037/1091-7527.21.2.121

Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, *57*(1_suppl), 181–217. https://doi.org/10.1177/1077558700057001S09

Britt, E., Hudson, S. M., & Blampied, N. M. (2004). Motivational interviewing in health settings: A review. *Patient Education and Counseling*, *53*, 147–155. https://doi.org/10.1016/S0738-3991(03)00141-1

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*, 537. https://doi.org/10.1037/a0025266

Cashman, S. B., & Seifer, S. D. (2008). Service-learning: An integral part of undergraduate public health. *American Journal of Preventive Medicine*, *35*, 273–278. https://doi.org/10.1016/j.amepre.2008.06.012

Charon, R. (2001). Narrative medicine: A model for empathy, reflection, profession, and trust. *Journal of the American Medical Association*, *286*, 1897–1902. https://doi.org/10.1001/jama.286.15.1897

Christie, D. (2008). Dancing with diabetes: Brief therapy conversations with children, young people and families living with diabetes. *European Diabetes Nursing, 5*, 28–32. https://doi.org/10.1002/edn.99

Classen, T. J., & Dunn, R. A. (2012). The effect of job loss and unemployment duration on suicide risk in the United States: A new look using mass-layoffs and unemployment duration. *Health Economics*, *21*, 338–350. https://doi.org/10.1002/hec.1719

Connor, K. M., & Davidson, J. R. T. (2001). SPRINT: A brief global assessment of post-traumatic stress disorder. *International Clinical Psychopharmacology*, *16*, 279–284. https://doi.org/10.1097/00004850-200109000-00005

Conwell, Y., Duberstein, P. R., & Caine, E. D. (2002). Risk factors for suicide in later life. *Biological Psychiatry*, *52*, 193–204. https://doi.org/10.1016/S0006-3223(02)01347-1

Cooper, L. A., Roter, D. L., Carson, K. A., Bone, L. R., Larson, S. M., Miller, E. R., … Levine, D. M. (2011). A randomized trial to improve patient-centered care and hypertension control in underserved primary care patients. *Journal of General Internal Medicine*, *26*, 1297–1304. https://doi.org/10.1007/s11606-011-1794-6

Cowan, C. F. (2004). Teaching patients with low literacy skills. In A. Lowenstein and M. Bradshaw (Eds.), *Fuszard's innovative teaching strategies in nursing* (3rd ed.). Sudbury, MA: Jones and Bartlett Publishers.

Cully, J. A., Teten, A. L., Benge, J. F., Sorocco, K. H., & Kauth, M. R. (2010). Multidisciplinary cognitive-behavioral therapy training for the veteran's affairs primary care setting. *The Primary*

Care Companion to the Journal of Clinical Psychiatry, *12*, e1–e8. https://doi.org/10.4088/PCC.09m00838blu

Derose, K. P., Escarce, J. J., & Lurie, N. (2007). Immigrants and health care: Sources of vulnerability. *Health Affairs*, *26*, 1258–1268. https://doi.org/10.1377/hlthaff.26.5.1258

De Shazer, S., Dolan, Y., Korman, H., Trepper, T. S., McCollom, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. Binghamton, NY: Haworth Press. https://doi.org/10.1111/j.1467-6427.2008.00419_4.x

*DiClemente, C. C., & Prochaska, J. O. (1998). *Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors*. New York, NY: Plenum Press. https://doi.org/10.1007/978-1-4899-1934-2_1.

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. In W. R. Miller and S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (pp. 201–216). New York, NY: Guilford Press.

Doherty, W., McDaniel, S., & Baird, M. (1996). Five levels of primary care/behavioral healthcare collaboration. *Behavioral Healthcare Tomorrow*, *5*, 25–28. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/10161572

Doran, G. T. (1981). There's a S.M.A.R.T. way to write management's goals and objectives. *Management Review*, *70*, 35–36. Retrieved from http://community.mis.temple.edu/mis-0855002fall2015/files/2015/10/S.M.A.R.T-Way-Management-Review.pdf

Dulmus, C. N., & Cristalli, M. E. (2012). A university–community partnership to advance research in practice settings: The HUB research model. *Research on Social Work Practice*, *22*, 195–202. https://doi.org/10.1177/1049731511423026

Eat Smart, Move More NC (2005). *Physical activity and nutrition behaviors monitoring form*. Retrieved from http://www.eatsmartmovemorenc.com/BehaviorsForm/BehaviorsForm.html

Emmons, K. M., & Rollnick, S. (2001). Motivational interviewing in health care settings: Opportunities and limitations. *American Journal of Preventive Medicine*, *20*, 68–74. https://doi.org/10.1016/S0749-3797(00)00254-3

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, *196*, 129–136. https://doi.org/10.1016/b978-0-409-95009-0.50006-1

*Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Family Medicine, 137*, 535–544. https://doi.org/10.1176/ajp.137.5.535.

*Engel, J. (2006). *Poor people's medicine: Medicaid and American charity care since 1965*. Durham, NC: Duke University Press.

Fagiolini, A., & Goracci, A. (2009). The effects of undertreated chronic medical illnesses in patients with severe mental disorders. *Journal of Clinical Psychiatry*, *3*, 22–29. https://doi.org/10.4088/JCP.7075su1c.04.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., … Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*, 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fischer, M. S., Baucom, D. H., & Cohen, M. J. (2016). Cognitive-behavioral couple therapies: Review of the evidence for the treatment of relationship distress, psychopathology, and chronic health conditions. *Family Process*, *55*, 423–442. https://doi.org/10.1111/famp.12227

*Geiger, H. J. (1984). Community health centers: Health care as an instrument of social change. In V. W. Sidel and R. Sidel (Eds.), *Reforming medicine: Lessons of the last quarter century* (pp. 11–32). New York, NY: Pantheon Books.

Gibson, C. D., Jr. (1968). The neighborhood health center: The primary unit of health care. *American Journal of Public Health and the Nation's Health*, *58*, 1188–1191. https://doi.org/10.2105/AJPH.58.7.1188

Gingerich, W. J., & Peterson, L. T. (2013). Effectiveness of solution-focused brief therapy: A systematic qualitative review of controlled outcome studies. *Research on Social Work Practice*, *23*, 266–283. https://doi.org/10.1177/1049731512470859

Gleason, M. M., Zeanah, C. H., & Dickstein, S. (2010). Recognizing young children in need of mental health assessment: Development and preliminary validity of the early childhood screening assessment. *Infant Mental Health Journal*, *31*, 335–357. https://doi.org/10.1002/imhj.20259

Grant, A. M. (2012). Making positive change: A randomized study comparing solution-focused vs. problem-focused coaching questions. *Journal of Systemic Therapies*, *31*, 21–35. https://doi.org/10.1521/jsyt.2012.31.2.21

Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., … Clayton, P. J. (2010). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, *58*, 10–51. https://doi.org/10.1080/00918369.2011.534038

Hartmann, M., Bäzner, E., Wild, B., Eisler, I., & Herzog, W. (2010). Effects of interventions involving the family in the treatment of adult patients with chronic physical diseases: A metaanalysis. *Psychotherapy and Psychosomatics*, *79*, 136–148. https://doi.org/10.1159/000286958

Hecht, J., Borrelli, B., Breger, R. K., DeFrancesco, C., Ernst, D., & Resnicow, K. (2005). Motivational interviewing in community-based research: Experiences from the field. *Annals of Behavioral Medicine*, *29*, 29–34. https://doi.org/10.1207/s15324796abm2902s_6

Hirschfeld, R. M. A., Williams, J. B. W., Spitzer, R. L., Calabrese, J. R., Flynn, L., Keck, P. E., … Zajecka, J. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The mood disorder questionnaire. *American Journal of Psychiatry*, *157*, 1873–1875. https://doi.org/10.1176/appi.ajp.157.11.1873

Hodgson, J., Lamson, A., Mendenhall, T., & Crane, D. (Eds.). (2014). *Medical family therapy: Advanced applications*. New York, NY: Springer.

*Hodgson, J., Lamson, A., Mendenhall, T., & Tyndall, L. (2014). Introduction to medical family therapy: Advanced applications. In J. Hodgson, A. Lamson, T. Mendenhall, and D. Crane, (Eds.) *Medical family therapy: Advanced applications* (pp. 1-9). New York, NY: Springer.

*Hoffman, B. (2012). *Health care for some: Rights and rationing in the United States since 1930*. Chicago, IL: University of Chicago Press.

Horowitz, C., & Lawlor, E.F. (2008). *Challenges and successes in reducing health disparities: Workshop summary*. Washington, DC: The National Academies Press. https://doi.org/10.17226/12154

Hu, J., Amirehsani, K. A., Wallace, D. C., McCoy, T. P., & Silva, Z. (2016). A family-based, culturally tailored diabetes intervention for Hispanics and their family members. *Diabetes Educator*, *42*, 299–314. https://doi.org/10.1177/0145721716636961

Israel, B. A., Parker, E. A., Rowe, Z., Salvatore, A., Minkler, M., López, J., … Potito, P. A. (2005). Community-based participatory research: Lessons learned from the centers for Children's environmental health and disease prevention research. *Environmental Health Perspectives*, *113*, 1463–1471. https://doi.org/10.1289/ehp.7675

Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). Pediatric symptom checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics*, *112*, 201–209. https://doi.org/10.1016/S0022-3476(88)80056-8

Johns, M. W. (1991). A new method for measuring daytime sleepiness: The Epworth sleepiness scale. *Sleep*, *14*, 540–545. https://doi.org/10.1093/sleep/14.6.540

Katon, W. J., Lin, E. H., Von Korff, M., Ciechanowski, P., Ludman, E. J., Young, B., … McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *New England Journal of Medicine*, *363*, 2611–2620. https://doi.org/10.1056/NEJMoa1003955

Keeton, V., Soleimanpour, S., & Brindis, C. D. (2012). School-based health centers in an era of health care reform: Building on history. *Current Problems in Pediatric and Adolescent Health Care*, *42*, 132–156. https://doi.org/10.1016/j.cppeds.2012.03.002

Knight, J. R., Shrier, L. A., Bravender, T. D., Farrell, M., Vander Bilt, J., & Shaffer, H. J. (1999). A new brief screen for adolescent substance abuse. *Archives of Pediatrics & Adolescent Medicine*, *153*, 591–596. https://doi.org/10.1001/archpedi.153.6.591

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Krupski, A., West, I. I., Scharf, D. M., Hopfenbeck, J., Andrus, G., Joesch, J. M., & Snowden, M. (2016). Integrating primary care into community mental health centers: Impact on utilization and costs of health care. *Psychiatric Services*, *67*, 1233–1239. https://doi.org/10.1176/appi.ps.201500424

Lamprecht, H., Laydon, C., McQuillan, C., Wiseman, S., Williams, L., Gash, A., & Reilly, J. (2007). Single-session solution-focused brief therapy and self-harm: A pilot study. *Journal of Psychiatric and Mental Health Nursing*, *14*, 601–602. https://doi.org/10.1111/j.1365-2850.2007.01105.x

*Lefkowitz, B. (2007). *Community health centers: A movement and the people who made it happen*. New Brunswick, NJ: Rutgers University Press.

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice*, *20*, 137–160. https://doi.org/10.1177/1049731509347850

Marlowe, D., Hodgson, J., Lamson, A., White, M., & Irons, T. (2012). Medical family therapy in a primary care setting: A framework for integration. *Contemporary Family Therapy*, *34*, 244–258. https://doi.org/10.1007/s10591-012-9195-5

Martire, L. M., Schulz, R., Helgeson, V. S., Small, B. J., & Saghafi, E. M. (2010). Review and meta-analysis of couple-oriented interventions for chronic illness. *Annals of Behavioral Medicine*, *40*, 325–342. https://doi.org/10.1007/s12160-010-9216-2

*McDaniel, S. H., Doherty, W. J., & Hepworth, J. (2014). *Medical family therapy and integrated care (2nd ed.)*. Washington, DC: American Psychological Association.

*Mendenhall, T. J., Berge, J. M., Harper, P., GreenCrow, B., LittleWalker, N., WhiteEagle, S., & BrownOwl, S. (2010). The family education diabetes series (FEDS): Community-based participatory research with a Midwestern American Indian community. *Nursing Inquiry, 17*, 359–372. https://doi.org/10.1111/j.1440-1800.2010.00508.x.

Mendenhall, T., Seal, K., GreenCrow, B., LittleWalker, K., & BrownOwl, S. (2012). The family education diabetes series (FEDS): Improving health in an urban-dwelling American Indian community. *Qualitative Health Research*, *22*, 1524–1534. https://doi.org/10.1177/1049732312457469

Middlebrook, D. L., LeMaster, P. L., Beals, J., Novins, D. K., & Manson, S. M. (2001). Suicide prevention in American Indian and Alaska native communities: A critical review of programs. *Suicide and Life-threatening Behavior*, *31*, 132–149. https://doi.org/10.1521/suli.31.1.5.132.24225

Mignogna, J., Hundt, N. E., Kauth, M. R., Kunik, M. E., Sorocco, K. H., Naik, A. D., … Cully, J. A. (2014). Implementing brief cognitive behavioral therapy in primary care: A pilot study. *Translational Behavioral Medicine*, *4*, 175–183. https://doi.org/10.1007/s13142-013-0248-6

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: preparing people for change*. New York, NY: Guilford Press.

Miller, W. R., & Rollnick, S. (2009). Ten things that motivational interviewing is not. *Behavioral and Cognitive Psychotherapy*, *37*, 129–140. https://doi.org/10.1017/S1352465809005128

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, *64*, 527–537. https://doi.org/10.1037/a0016830

*Minkler, M., & Wallerstein, N. (Eds.). (2011). *Community-based participatory research for health: From process to outcomes*. San Francisco, CA: Wiley.

Mukamel, D. B., White, L. M., Nocon, R. S., Huang, E. S., Sharma, R., Shi, L., & Ngo-Metzger, Q. (2016). Comparing the cost of caring for Medicare beneficiaries in federally funded health centers to other care settings. *Health Services Research*, *51*, 625–644. https://doi.org/10.1111/1475-6773.12339

Murphy, J. W. (2015). Primary health care and narrative medicine. *The Permanente Journal*, *19*, 90–94. https://doi.org/10.7812/TPP/14-206

Nam, S., Chesla, C., Stotts, N. A., Kroon, L., & Janson, S. L. (2011). Barriers to diabetes management: Patient and provider factors. *Diabetes Research and Clinical Practice*, *93*, 1–9. https://doi.org/10.1016/j.diabres.2011.02.002

Nasreddine, Z. S., Phillips, N. A., Bédirian, V., Charbonneau, S., Whitehead, V., Collin, I., … Chertkow, H. (2005). The Montreal cognitive assessment, MoCA: A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, *53*, 695–699. https://doi.org/10.1111/j.1532-5415.2005.53221.x

*National Associations of Community Health Centers. (2011). *So you want to start a health center…?: A practical guide for starting a federally qualified health center*. Retrieved from http://iweb.nachc.com/Downloads/Products/11_START_CHC.pdf

*National Associations of Community Health Centers. (2017a). *America's health centers: What are health centers and who do they serve*. Retrieved from http://www.nachc.org/wp-content/uploads/2017/03/Americas-Health-Centers_2017.pdf

*National Associations of Community Health Centers. (2017b). *Health centers expanding reach*. Retrieved from http://www.nachc.org/wp-content/uploads/2017/02/HCs-Expanding-Reach_Feb17.pdf

National Certification Board for Diabetes Educators. (2017). *Welcome to the National Certification Board for Diabetes Educators*. Retrieved from https://www.ncbde.org/

Norcross, J. C., Krebs, P. M., & Prochaska, J. O. (2011). Stages of change. *Journal of Clinical Psychology*, *67*, 143–154. https://doi.org/10.1002/jclp.20758

Otte, C. (2011). Cognitive behavioral therapy in anxiety disorders: Current state of the evidence. *Dialogues of Clinical Neuroscience*, *13*, 413–421. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3263389/pdf/DialoguesClinNeurosci-13-413.pdf

Owens, J. A., & Dalzell, V. (2005). Use of the "BEARS" sleep screening tool in a pediatric residents' continuity clinic: A pilot study. *Sleep Medicine*, *6*, 63–69. https://doi.org/10.1016/j.sleep.2004.07.015

Parra-Medina, D., Wilcox, S., Salinas, J., Addy, C., Fore, E., Poston, M., & Wilson, D. K. (2011). Results of the heart healthy and ethnically relevant lifestyle trial: A cardiovascular risk reduction intervention for African American women attending community health centers. *American Journal of Public Health*, *101*, 1914–1921. https://doi.org/10.2105/AJPH.2011.300151

Peek, C. J. (2008). Planning care in the clinical, operational, and financial worlds. In R. Kessler and D. Stafford (Eds.), *Collaborative medicine case studies* (pp. 25–38). New York, NY: Springer.

Perkins, R. (2006). The effectiveness of one session of therapy using a single-session therapy approach for children and adolescents with mental health problems. *Psychology and Psychotherapy: Theory, Research and Practice*, *79*, 215–227. https://doi.org/10.1348/147608305X60523

*Phelps, K., Hodgson, J., Lamson, A., Swanson, M., & White, M. (2012). Satisfaction with life and psychosocial factors among underserved minorities with type 2 diabetes. *Social Indicators Research, 106*, 359–370. https://doi.org/10.1007/s11205-011-9811-z.

*Phelps, K., Howell, C., Hill, S., Seeman, T., Lamson, A., Hodgson, J., & Smith, D. (2009). A collaborative care model for patients with type II diabetes. *Families, Systems, & Health, 27*, 131–140. doi: https://doi.org/10.1037/a0015027.

Plosker, R., & Chang, J. (2014). A solution-focused therapy group designed for caregivers of stroke survivors. *Journal of Systemic Therapies*, *33*, 35–49. https://doi.org/10.1521/jsyt.2014.33.2.35

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., … Mann, J. J. (2011). The Columbia–suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, *168*, 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Priebe, S., Kelley, L., Omer, S., Golden, E., Walsh, S., Khanom, H., … McCabe, R. (2015). The effectiveness of a patient-centered assessment with a solution-focused approach (DIALOG+) for patients with psychosis: A pragmatic cluster-randomized controlled trial in community care. *Psychotherapy and Psychosomatics*, *84*, 304–313. https://doi.org/10.1159/000430991

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to the addictive behaviors. *American Psychologist*, *47*, 1102–1114. https://doi.org/10.1037/0003-066X.47.9.1102

Ramezani, S., Khosravi, A., Motaghi, Z., Hamidzadeh, A., & Mousavi, S. A. (2017). The effect of cognitive-behavioural and solution-focused counselling on prevention of postpartum depression in nulliparous pregnant women. *Journal of Reproductive and Infant Psychology*, *35*, 172–182. https://doi.org/10.1080/02646838.2016.1266470

Rao, J. K., Anderson, L. A., Inui, T. S., & Frankel, R. M. (2007). Communication interventions make a difference in conversations between physicians and patients: A systematic review of the evidence. *Medical Care*, *45*, 340–349. https://doi.org/10.1097/01.mlr.0000254516.04961.d5

Rhodes, S. D., Malow, R. M., & Jolly, C. (2010). Community-based participatory research: A new and not-so-new approach to HIV/AIDS prevention, care, and treatment. *AIDS Education and Prevention*, *22*, 173–183. https://doi.org/10.1521/aeap.2010.22.3.173

Rolland, J. S., Emanuel, L. L., & Torke, A. M. (2017). Applying a family systems lens to proxy decision making in clinical practice and research. *Families, Systems, & Health*, *35*, 7–17. https://doi.org/10.1037/fsh0000250

*Rollnick, S., Miller, W. R., & Butler, C. (2007). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: Guilford Press.

Rosenthal, E. L., Brownstein, J. N., Rush, C. H., Hirsch, G. R., Willaert, A. M., Scott, J. R., … Fox, D. J. (2010). Community health workers: Part of the solution. *Health Affairs*, *29*, 1338–1342. https://doi.org/10.1377/hlthaff.2010.0081

Rudolf, M. C. J., Hunt, C., George, J., Hajibagheri, K., & Blair, M. (2010). HENRY: Development, pilot and long-term evaluation of a programme to help practitioners work more effectively with parents of babies and pre-school children to prevent childhood obesity. *Child: Care, Health and Development*, *36*, 850–857. https://doi.org/10.1111/j.1365-2214.2010.01116.x

Safren, S. A., Sprich, S., Mimiaga, M. J., Surman, C., Knouse, L., Groves, M., & Otto, M. W. (2010). Cognitive behavioral therapy vs relaxation with educational support for medication-treated adults with ADHD and persistent symptoms: A randomized controlled trial. *Journal of the American Medical Association*, *304*, 875–880. https://doi.org/10.1001/jama.2010.1192

Sakalys, J. A. (2003). Restoring the patient's voice: The therapeutics of illness narratives. *Journal of Holistic Nursing*, *21*, 228–241. https://doi.org/10.1177/0898010103256204

Schoener, E. P., Madeja, C. L., Henderson, M. J., Ondersma, S. J., & Janisse, J. J. (2006). Effects of motivational interviewing training on mental health therapist behavior. *Drug and Alcohol Dependence*, *82*, 269–275. https://doi.org/10.1016/j.drugalcdep.2005.10.003

Seal, K., Blum, M., Didericksen, K., Mendenhall, T., Gagner, N., GreenCrow, B., … Benton, K. (2016). The east metro American Indian diabetes initiative: Engaging indigenous men in the reclaiming of health and spirituality through community-based participatory research. *Health Education Research & Development*, *4*, 1–8. https://doi.org/10.4172/2380-5439.1000152

Seifer, S. D. (1998). Service-learning: Community-campus partnerships for health professions education. *Academic Medicine*, *73*, 273–277. https://doi.org/10.1097/00001888-199803000-00015

Serfaty, M. A., Haworth, D., Blanchard, M., Buszewicz, M., Murad, S., & King, M. (2009). Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: A randomized controlled trial. *Archives of General Psychiatry, 66*, 1332–1340. https://doi.org/10.1001/archgenpsychiatry.2009.165

Skinner, H. A. (1982). The drug abuse screening test. *Addictive Behaviors*, *7*, 363–371. https://doi.org/10.1016/0306-4603(82)90005-3

Spencer, M. S., Rosland, A. M., Kieffer, E. C., Sinco, B. R., Valerio, M., Palmisano, G., … Heisler, M. (2011). Effectiveness of a community health worker intervention among African American and Latino adults with type 2 diabetes: A randomized controlled trial. *American Journal of Public Health*, *101*, 2253–2260. https://doi.org/10.2105/AJPH.2010.300106

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder. *Archives of Internal Medicine*, *166*, 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Squires, J., Bricker, D., & Potter, L. (1997). Revision of a parent-completed developmental screening tool: Ages and stages questionnaires. *Journal of Pediatric Psychology*, *22*, 313–328. https://doi.org/10.1093/jpepsy/22.3.313

Street, R. L., Makoul, G., Arora, N. K., & Epstein, R. M. (2009). How does communication heal? Pathways linking clinician–patient communication to health outcomes. *Patient Education and Counseling*, *74*, 295–301. https://doi.org/10.1016/j.pec.2008.11.015

Sudore, R. L., Mehta, K. M., Simonsick, E. M., Harris, T. B., Newman, A. B., Satterfield, S., … Yaffe, K. (2006). Limited literacy in older people and disparities in health and healthcare access. *Journal of the American Geriatrics Society*, *54*, 770–776. https://doi.org/10.1111/j.1532-5415.2006.00691.x

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, *42*, 24–33. https://doi.org/10.1093/geront/42.suppl_3.24

Tambling, R. B., & Johnson, L. N. (2008). The relationship between stages of change and outcome in couple therapy. *American Journal of Family Therapy*, *36*, 229–241. https://doi.org/10.1080/01926180701290941

Taylor, J. (2014). The fundamentals of community health centers. In *National health policy forum: Background paper*. Washington, DC: George Washington University.

Tidemalm, D., Runeson, B., Waern, M., Frisell, T., Carlström, E., Lichtenstein, P., & Långström, N. (2011). Familial clustering of suicide risk: A total population study of 11.4 million individuals. *Psychological Medicine*, *41*, 2527–2534. https://doi.org/10.1017/S0033291711000833

Topolski, T. D., LoGerfo, J., Patrick, D. L., Williams, B., Walwick, J., & Patrick, M. B. (2006). The rapid assessment of physical activity (RAPA) among older adults. *Preventing Chronic Disease*, *3*, A118–A125. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/16978493

Trockel, M., Manber, R., Chang, V., Thurston, A., & Taylor, C. B. (2011). An e-mail delivered CBT for sleep-health program for college students: Effects on sleep quality and depression symptoms. *Journal of Clinical Sleep Medicine*, *7*, 276–281. https://doi.org/10.5664/JCSM.1072

Valve, P., Lehtinen-Jacks, S., Eriksson, T., Lehtinen, M., Lindfors, P., Saha, M. T., … Anglé, S. (2013). A solution-focused low-intensity intervention aimed at improving health behaviors of young females: A cluster-randomized controlled trial. *BMC Public Health*, *13*, 1044–1056. https://doi.org/10.1186/1471-2458-13-1044

Viner, R. M., Christie, D., Taylor, V., & Hey, S. (2003). Motivational/solution-focused intervention improves HbA1c in adolescents with type 1 diabetes: A pilot study. *Diabetic Medicine*, *20*, 739–742. https://doi.org/10.1046/j.1464-5491.2003.00995.x

*Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice, 7*, 312–323. https://doi.org/10.1177/1524839906289376.

*Ward Jr, T. J., & Geiger, H. J. (2016). *Out in the rural: A Mississippi health center and its war on poverty*. New York, NY: Oxford University Press.

Weisberg, R. B., & Magidson, J. F. (2014). Integrating cognitive behavioral therapy into primary care settings. *Cognitive and Behavioral Practice*, *21*, 247–251. https://doi.org/10.1016/j.cbpra.2014.04.002

Weiss, S. J., Ernst, A. A., Cham, E., & Nick, T. G. (2003). Development of a screen for ongoing intimate partner violence. *Violence and Victims*, *18*, 131–141. https://doi.org/10.1891/vivi.2003.18.2.131

Weiss, B. D., & Palmer, R. (2004). Relationship between health care costs and very low literacy skills in a medically needy and indigent Medicaid population. *Journal of the American Board of Family Practice*, *17*, 44–47. https://doi.org/10.3122/jabfm.17.1.44

Wissow, L. S., Gadomski, A., Roter, D., Larson, S., Brown, J., Zachary, C., … Wang, M. C. (2008). Improving child and parent mental health in primary care: A cluster-randomized trial of communication skills training. *Pediatrics*, *121*, 266–275. https://doi.org/10.1542/peds.2007-0418

Wolraich, M. L., Lambert, W., Doffing, M. A., Bickman, L., Simmons, T., & Worley, K. (2003). Psychometric properties of the Vanderbilt ADHD diagnostic parent rating scale in a referred

population. *Journal of Pediatric Psychology*, *28*, 559–568. https://doi.org/10.1093/jpepsy/jsg046

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: World Health Organization.

Wright, L. M., Watson, W. L., & Bell, J. M. (1996). *Beliefs: The heart of healing in families and illness*. New York, NY: Basic Books.

Wyder, M., Ward, P., & De Leo, D. (2009). Separation as a suicide risk factor. *Journal of Affective Disorders*, *116*, 208–213. https://doi.org/10.1016/j.jad.2008.11.007

Wu, I. H., & Windle, C. (1980). Ethnic specificity in the relative minority use and staffing of community mental health centers. *Community Mental Health Journal*, *16*, 156–168. https://doi.org/10.1007/BF00778587