# PRIMARY *CARE BEHAVIORAL HEALTH* PROVIDER ADHERENCE QUESTIONNAIRE-2 (PPAQ-2)

**Provider:**

**Date:**

**Clinic and Location:**

**Description:** The PPAQ-2 is a self-report instrument completed by integrated behavioral health providers to assess adherence to key features of health services delivery when working in Primary Care Behavioral Health (PCBH) or Collaborative Care Management (CCM) settings.

**Instructions:** Indicate the frequency with which you typically engage in the behavior described *while providing behavioral health services in primary care in the corresponding model*. Complete items 1 through 42 for PCBH, items 43 through 93 for CCM, or the full set of items for both models.

## Primary Care Behavioral Health

| Question | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| 1. During clinical encounters with patients, I see patients for 30 minutes or less. | 1 | 2 | 3 | 4 | 5 |
| 2. I manage patients reporting mild and moderate symptoms in primary care, and I refer those with more severe symptoms to specialty mental health services when possible. | 1 | 2 | 3 | 4 | 5 |
| 3. During patient appointments, I discuss barriers to implementing a plan or adhering to treatment recommendations. | 1 | 2 | 3 | 4 | 5 |
| 4. I accept referrals for patients with common mental health problems (i.e., depression, anxiety, etc.). | 1 | 2 | 3 | 4 | 5 |
| 5. During clinical encounters with a patient, I implement behavioral and/or cognitive interventions. | 1 | 2 | 3 | 4 | 5 |
| 6. In introducing my role in the clinic to patients, I explain that I want to get an idea of what is and what is not working for the patient and then together develop a plan to help them manage their concerns. | 1 | 2 | 3 | 4 | 5 |
| 7. During clinical encounters with patients, I triage patients to determine if they can be treated in primary care or should be referred to a specialty mental health or a community agency. | 1 | 2 | 3 | 4 | 5 |
| 8. I accept referrals for patients who might benefit from brief, targeted behavioral health interventions for chronic pain. | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
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| 9. I accept referrals for patients who might benefit from brief, targeted behavioral health interventions for adjustment to illness (e.g., diabetes, heart disease, spinal cord injury, TBI, etc.). | 1 | 2 | 3 | 4 | 5 |
| 10. My progress notes in the shared medical record include focused recommendations for the Primary Care Provider and/or primary care team. | 1 | 2 | 3 | 4 | 5 |
| 11. I meet briefly with primary care staff as a team to provide both a behavioral health perspective and behavioral data. | 1 | 2 | 3 | 4 | 5 |
| 12. My progress notes include focused recommendations for the patient. | 1 | 2 | 3 | 4 | 5 |
| 13. I consult with various members of the primary care team (e.g., pharmacist, dietician) in addition to the Primary Care Provider about behavioral aspects of medical conditions (e.g., medications that cause nightmares.) | 1 | 2 | 3 | 4 | 5 |
| 14. At follow-up encounters with patients, I inquire about progress on goals or action plans set at the previous appointment. | 1 | 2 | 3 | 4 | 5 |
| 15. I administer one or more brief validated measures (e.g., Patient Health Questionnaire-9, or PHQ-9) for an **initial screening** of symptoms of interest, or I review these findings if measures were administered by other primary care staff. | 1 | 2 | 3 | 4 | 5 |
| 16. It takes 30 minutes or more for me to complete all documentation following the initial appointment. | 1 | 2 | 3 | 4 | 5 |
| 17. Following patient appointments, I provide feedback to Primary Care Providers (based on their preferred method of communication) within 1 business day of an initial appointment. | 1 | 2 | 3 | 4 | 5 |
| 18. During clinical encounters with patients, I clarify, confirm, and discuss the patient's concerns. | 1 | 2 | 3 | 4 | 5 |
| 19. My progress notes include brief clinical impressions of the patient's presenting problem(s). | 1 | 2 | 3 | 4 | 5 |
| 20. In introducing my role in the clinic to patients, I explain that our appointments typically will be 30 minutes or less. | 1 | 2 | 3 | 4 | 5 |
| 21. I provide suicide risk assessment for primary care patients in crisis and refer to a higher level of care as indicated. | 1 | 2 | 3 | 4 | 5 |
| 22. I typically see patients for 50-minute appointments. | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
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| 23. During patient appointments, I use local community resources to assist me in meeting the behavioral health needs of patients. | 1 | 2 | 3 | 4 | 5 |
| 24. I provide education to the primary care team on behavioral health issues (e.g., presentations and handouts). | 1 | 2 | 3 | 4 | 5 |
| 25. I provide advice to the primary care team about appropriate referrals to specialty behavioral health services. | 1 | 2 | 3 | 4 | 5 |
| 26. My progress notes include findings from functional assessments and brief screening. | 1 | 2 | 3 | 4 | 5 |
| 27. I administer one or more brief validated measures (e.g., Patient Health Questionnaire-9, or PHQ-9) for **follow up screening** of symptoms of interest, or I review these findings if measures were administered by other primary care staff. | 1 | 2 | 3 | 4 | 5 |
| 28. I routinely consult with Primary Care Providers to increase my knowledge about behavioral aspects of medical conditions, such as the role of anxiety in cardiac distress. | 1 | 2 | 3 | 4 | 5 |
| 29. Following clinical encounters with patients, I continue to provide feedback to the Primary Care Provider about follow-up appointments, when needed. | 1 | 2 | 3 | 4 | 5 |
| 30. During clinical encounters with patients, I work with the patient to develop a specific plan to address their presenting problem and document this plan. | 1 | 2 | 3 | 4 | 5 |
| 31. I accept referrals for patients who need lifestyle interventions (e.g., tobacco cessation, weight control, stress management). | 1 | 2 | 3 | 4 | 5 |
| 32. I accept referrals for patients in need of behavioral health interventions for medication issues (e.g., adherence). | 1 | 2 | 3 | 4 | 5 |
| 33. I typically see patients for 10 or more appointments per episode of care. | 1 | 2 | 3 | 4 | 5 |
| 34. I accept referrals for patients in need of behavioral health interventions for adjustment to aging and issues specific to older patients. | 1 | 2 | 3 | 4 | 5 |
| 35. During a patient appointment, I provide functional assessment, focused intervention, and address disposition. | 1 | 2 | 3 | 4 | 5 |
| 36. I accept referrals for patients from Primary Care Providers as a warm hand off (i.e., the Primary Care Provider introduces me to the patient). | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
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| 37. In introducing my role in the clinic to patients, I explain that I work with the Primary Care Providers in situations where good health care involves paying attention to physical health, habits, behaviors, emotional health and how those things interact. | 1 | 2 | 3 | 4 | 5 |
| 38. I meet with a patient for greater than 50 minutes to gather a full psycho-social history and comprehensive psychiatric interview. | 1 | 2 | 3 | 4 | 5 |
| 39. During clinical encounters with patients, I address the Primary Care Provider's reason for referral. | 1 | 2 | 3 | 4 | 5 |
| 40. I employ strategies to identify and prevent exacerbation of at-risk, sub-syndromal behaviors and symptoms. | 1 | 2 | 3 | 4 | 5 |
| 41. I provide information regarding a patient's symptoms and functioning to assist Primary Care Providers (and/or clinical pharmacists, primary care psychiatrists, psychiatric nurse practitioners) in initiating or modifying common psychotropic medications, such as antidepressants. | 1 | 2 | 3 | 4 | 5 |
| 42. I participate in primary care based clinical pathways for common health conditions, such as chronic pain or comorbid depression and cardiovascular disease. | 1 | 2 | 3 | 4 | 5 |
| ***Collaborative Care Management items begin on the next page*** | | | | | |

| Collaborative Care Management | | | | | |
|---|---|---|---|---|---|
| **Question** | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| 43. I accept referrals from primary care providers or other team members when patients screen positive on routine screening measures (e.g., Patient Health Questionnaire-2). | 1 | 2 | 3 | 4 | 5 |
| 44. I actively reach out to patients by making multiple attempts to contact those individuals who might benefit from treatment. | 1 | 2 | 3 | 4 | 5 |
| 45. I offer patients the option of receiving care by telephone or face-to-face. | 1 | 2 | 3 | 4 | 5 |
| 46. I provide educational materials (e.g., handouts, action planning worksheets, videos, CDs, etc.) to patients in person or by mail. | 1 | 2 | 3 | 4 | 5 |
| 47. I provide psychoeducation to patients about the nature of their mental health condition or problem behavior (e.g., alcohol use concern) | 1 | 2 | 3 | 4 | 5 |
| 48. I provide psychoeducation to patients about their psychotropic medications (e.g., potential side effects, time required to see symptom improvement, etc.). | 1 | 2 | 3 | 4 | 5 |
| 49. I collaborate with patients to develop and update treatment plans | 1 | 2 | 3 | 4 | 5 |
| 50. I work with patients to identify and resolve barriers to treatment adherence. | 1 | 2 | 3 | 4 | 5 |
| 51. I help patients identify treatment preferences (i.e., pharmacological and non-pharmacological) for their primary concern. | 1 | 2 | 3 | 4 | 5 |
| 52. I address relapse prevention with patients, when indicated. | 1 | 2 | 3 | 4 | 5 |
| 53. I collaborate with patients to develop specific treatment goals (e.g., SMART goals). | 1 | 2 | 3 | 4 | 5 |
| 54. I use a motivational interviewing style to address behavior change with patients. | 1 | 2 | 3 | 4 | 5 |
| 55. I provide interventions focused on behavioral activation. | 1 | 2 | 3 | 4 | 5 |
| 56. I help patients develop and use self-management skills. | 1 | 2 | 3 | 4 | 5 |
| 57. I facilitate transitions in care when referral is indicated. | 1 | 2 | 3 | 4 | 5 |
| 58. I bridge communication between the primary care provider and supervising/consulting mental health specialist (e.g., psychiatrist) to improve care coordination. | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
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| 59. I document the results of validated mental health measures (e.g., Patient Health Questionnaire-9) in the electronic medical record and forward them to the primary care provider. | 1 | 2 | 3 | 4 | 5 |
| 60. I engage in regularly scheduled supervision with the supervising/consulting mental health specialist (e.g., psychiatrist) to guide treatment decisions. | 1 | 2 | 3 | 4 | 5 |
| 61. I review cases that are of concern with the supervising/consulting mental health specialist (e.g., psychiatrist) when indicated, even if outside of regularly scheduled supervision. | 1 | 2 | 3 | 4 | 5 |
| 62. I discuss the patient's treatment preferences, including medication options, with the supervising/consulting mental health specialist (e.g., psychiatrist) and the primary care provider. | 1 | 2 | 3 | 4 | 5 |
| 63. I routinely communicate pertinent patient information to the primary care provider and supervising/consulting mental health specialist (e.g., psychiatrist). | 1 | 2 | 3 | 4 | 5 |
| 64. I explain the care manager role in monitoring patient follow-up to the primary care provider. | 1 | 2 | 3 | 4 | 5 |
| 65. I join brief meetings of the primary care team(s) to communicate information about patient care. | 1 | 2 | 3 | 4 | 5 |
| 66. I collaborate with other mental health staff assigned to my primary care team(s). | 1 | 2 | 3 | 4 | 5 |
| 67. I use results from validated mental health measures (e.g., PHQ-9) with the primary care provider or supervising /consulting mental health specialist (e.g., psychiatrist) to help guide treatment decisions. | 1 | 2 | 3 | 4 | 5 |
| 68. I use the information from a standardized set of questions and/or validated mental health measures to collect baseline information about distress symptoms (e.g., depression) or problem behaviors (e.g., alcohol use concerns). | 1 | 2 | 3 | 4 | 5 |
| 69. I use the information from a standardized set of questions and/or validated measures to assess problem severity (e.g., depression v. dysthymia v. sub-syndromal depression). | 1 | 2 | 3 | 4 | 5 |
| 70. I assess comorbid mental health concerns and prior history of mental health concerns at baseline. | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
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| 71. I use the information from a validated mental health measure to conduct follow-up monitoring of symptoms (e.g., depression) and problem behaviors (e.g., alcohol use concerns). | 1 | 2 | 3 | 4 | 5 |
| 72. I use the information from a validated mental health measure during follow-up to guide treatment decisions (e.g., treatment modification, referral to other care). | 1 | 2 | 3 | 4 | 5 |
| 73. I provide a rationale to patients about why validated measures will be used routinely in their care. | 1 | 2 | 3 | 4 | 5 |
| 74. I share the results of measurement with patients throughout the course of care. | 1 | 2 | 3 | 4 | 5 |
| 75. I share the results of measurement (e.g., Patient Health Questionnaire-9) with patients at the end of treatment as part of relapse prevention. | 1 | 2 | 3 | 4 | 5 |
| 76. I review the purpose of contact or reason for referral at patient follow-up. | 1 | 2 | 3 | 4 | 5 |
| 77. I briefly assess patients at follow-up for any significant medical or health changes in a problem-focused manner. | 1 | 2 | 3 | 4 | 5 |
| 78. I conduct follow-up monitoring of patient adherence to psychotropic medication as prescribed by their primary care provider or other prescriber. | 1 | 2 | 3 | 4 | 5 |
| 79. I conduct follow-up monitoring of patient adherence to behavioral goals or self-management plans. | 1 | 2 | 3 | 4 | 5 |
| 80. I conduct follow-up monitoring of patients for side effects from psychotropic medications prescribed by the primary care provider or other prescriber. | 1 | 2 | 3 | 4 | 5 |
| 81. I conduct follow-up monitoring of patients with sub-syndromal presentations using a validated mental health measure and modify treatment when indicated based on patient preference. | 1 | 2 | 3 | 4 | 5 |
| 82. I refer complex or highly symptomatic patients to a higher level of care as indicated through treatment protocol, or standardized care process. | 1 | 2 | 3 | 4 | 5 |
| 83. I administer validated mental health measures using standardized language. | 1 | 2 | 3 | 4 | 5 |
| 84. I convey essential components of care to patients, referencing scripted or standardized language as needed. | 1 | 2 | 3 | 4 | 5 |

| Question | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| 85. I use a treatment protocol, or standardized care process, that is problem-specific (e.g., depression). | 1 | 2 | 3 | 4 | 5 |
| 86. I use a treatment protocol, or standardized care process, to guide initial treatment recommendations (e.g., identifying the level of intensity). | 1 | 2 | 3 | 4 | 5 |
| 87. I use a treatment protocol, or standardized care process, to direct a schedule for frequency and timing of follow-up contacts. | 1 | 2 | 3 | 4 | 5 |
| 88. When indicated, I make suggestions to the primary care provider to modify treatment following discussion with the supervising/consulting mental health specialist (e.g., psychiatrist). | 1 | 2 | 3 | 4 | 5 |
| 89. I adjust behavioral treatment if patient's symptoms do not remit within the time frame specified in the treatment protocol, or standardized care process. | 1 | 2 | 3 | 4 | 5 |
| 90. I use a treatment protocol, or standardized care process, to guide the frequency and timing of follow-up care. | 1 | 2 | 3 | 4 | 5 |
| 91. When available, I use software or other tools (e.g., databases or electronic spreadsheets) to support my care management functions focused on patient care, such as tracking individual patient outcomes. | 1 | 2 | 3 | 4 | 5 |
| 92. I use software or other tools (e.g., databases or electronic spreadsheets) for panel management, such as tracking my patient panel throughout the course of treatment. | 1 | 2 | 3 | 4 | 5 |
| 93. I convey reports of aggregate patient outcomes to referring primary care providers and clinic managers. | 1 | 2 | 3 | 4 | 5 |