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Maternal Maslow: Evaluating Patient Follow-Up and Treatment Goal Completion for Prenatal Referrals in a Women's Health Clinic

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Maternal Maslow: Evaluating Patient Follow-Up and Treatment Goal Completion
for Prenatal Referrals in a Women's Health Clinic

by

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Presented to the Faculty of the
Graduate Department of Clinical Psychology
George Fox University
in partial fulfillment
of the requirements for the degree of
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in Clinical Psychology

Newberg, Oregon

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Prenatal Referrals in a Women's Health Clinic.

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by the

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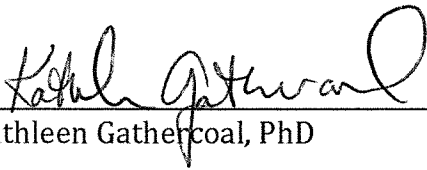
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Abstract

Prenatal screeners in Obstetrics (OB) clinics can quickly and accurately identify health risks such as nutrition, lack of dental care, depression, anxiety or financial issues that not only impact the health of the mother but of the baby as well. With appropriate referrals and follow-up by the patient, the health of the next generation can be greatly enhanced by a simple screen and referral to treatment programs, as long as the patient is following through with referrals. This research identified patient follow-up to referral and treatment goal completion rate through a standardized screen and referral process in a local OB population. Results found that women are more likely to follow through with referrals that do not require as much long-term commitment such as handouts or consulting with an RN versus going to a nutritionist or behavioral health consultant. Additional research found that women are more likely to prioritize practical treatment goals (i.e., transportation or childcare) over more preventative goals such as periodontal health. Overall,

there is still a great need to educate both patients and providers about preventative health in prenatal care.

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Chapter 1

Introduction

Heart disease is the leading cause of death in the United States according to the 2010 National Vital Statistics Reports (Heron, 2013). While heart disease is a terrible disease, it is also extremely preventable by maintaining a healthy diet and exercising regularly. Other diseases at the top of the list such as chronic lower respiratory failure, cerebrovascular disease, and lung cancer are equally as preventable and amenable to change because they are a result of behaviors. Healthy behavioral choices such as quitting smoking, a healthier diet, an increase in physical activity, and a decrease in alcohol consumption can contribute to the prevention of some of the most deadly diseases in the U.S. (Woolf, 2008). In other words, these diseases could be almost completely eliminated by simple behavioral health choices, which makes these diseases highly amenable to change both in regards to treatment and prevention.

The medical field is currently making a shift from reactive approaches of treating fully-fledged diseases to a more proactive approach to health (Snyderman & Yoediono, 2008) since many diseases can be avoided by behavioral choices. This proactive approach to health is called preventative care, which focuses on promoting health and disease prevention using behavior modification, screening, and vaccines (Woolf, 2008). Though preventative care could save millions of dollars in treatment health costs, only 1% - 3% of health care expenditures are put toward preventative health care measures (Woolf, 2008). Therefore, there is a need for not just efficacious designs but efficient and cost-effective ones as well. As health costs continue to

escalate there is a need for the medical field to move away from a treatment focus toward early prevention and identification. Preventative care emphasizes the need to identify patients with risk factors early so they can make healthy behavior choices to reduce their chance of developing certain avoidable diseases since the majority of the population only learns extensive health change information post diagnosis (Kelly, Eldredge, Dalton, & Miller, 2014). The term *P4 medicine* is a recently developed term used to describe a new approach to medicine, which moves from a disease-focused to patient-focused philosophy of healthcare. The 4 p's stand for predictive, preventative, personalized, and participatory with the overall goal of the interactions to be a team model between provider and patient (Lejbkowitz, Caspi, & Miller, 2012). The medical model is moving away from secondary or tertiary treatment toward primary prevention, including population-based interventions that are contextually based: integrating scientific interventions with community needs. This involves taking into account the needs, values, and preferences of the community such as which evidence-based interventions are most likely to cause change in the specific population (Brownson, Baker, Leet, Gillespie, & True, 2010).

The Affordable Care Act (U.S. Department of Health & Human Services, 2014) created a seismic shift in the healthcare strategy in the United States. The measurable goals underlying healthcare reform are commonly known as the "triple aim" and include simultaneously improving the health of the population, enhancing the experience of the patient, and reducing per capita cost of care for the benefit of communities (Institute for Healthcare Improvement, 2014). These goals have transformed the approach to patient care in primary care clinics (now termed Patient-Centered-Medical Homes, PCMH) and are being implemented in clinics and hospitals all across the country. Thus increasing the need for low cost, evidence-based, effective tools that

can be easily integrated into a primary care setting to assist in population-based care. The new expectation for patient-centered medical care also includes an integration of behavioral health services to address the emotional impact of health issues as well as the physical effects (Katon & Unutzer, 2013).

Screeners: Effective Tool for Population-Based Healthcare

Screeners are one of the most effective, evidence-based tools for identifying risk factors in patients. Screeners are routinely used in all kinds of primary care settings to “detect diseases and promote wellness such as internal medicine, pediatrics and gynecology” (Fuller & Cavanaugh, 1995, p.193). Primary care providers appreciate the efficiency of screeners. Using a screener they can quickly identify the issue and intervene with a brief intervention. For high acuity problems the patient can be referred to appropriate treatment (Bohman et al., 2008). One of the most powerful arguments for the use of screeners in primary care is that they are a broad assessment that has the potential to produce individualized results. Helping a patient to identify his or her specific needs and then establishing a corresponding treatment plan is an important step in the intervention process and more importantly in the activation process (Olin et al., 2010). If a patient does not feel confident that he or she can make the changes recommended then behavioral health interventions become ineffective. The patient needs to feel empowered to take control of the resources available to him or her. “People who believe they have the skill, knowledge, information or resources available to support their likelihood of success are more likely to follow through” (Olin et al., 2010, p. 467). This means patients not only need health/treatment information, they need information that is pertinent to their specific needs and presented in laymen’s terms that can be comprehended by the patient (Krist et al., 2012). With

conditions such as heart disease there are many lifestyle changes required to reduce risk, which can be overwhelming to a patient. However, it is important for patients to be reminded that change is not an all-or-nothing thing (Olin et al., 2010), rather it is a process which can occur in incremental steps. Helping patients to develop attainable intervention goals can greatly assist in their follow through and success.

The 5As model is one of the most up-to-date, efficient models for providing behavioral health services in a primary care setting (Hunter, Goodie, Oordt, & Dobmeyer, 2009). The 5As model starts with the *assess phase* where information about the problem is gathered such as symptoms and environmental factors and how much control the patient has over his/her symptoms is assessed. The next stage is the *advise phase* where the behavioral health consultant explains options for intervention with the patient based on the previous information gathered. During the *agree phase* the patient decides what intervention he/she would like to pursue. In the *assist phase* the behavioral health consultant helps the patient develop new skills so they can implement the behavioral intervention. Finally in the *arrange phase* the behavioral health consultant and the patient discuss when or if follow up is necessary either with the behavioral health consultant or another resources such as the PCP. The 5As model is a model that is to be conducted in the span of 15 to 30 minutes (Hunter et al., 2009). The use of a screener can facilitate the quick and effective focus of a 5As intervention by providing early identification of health issues. This integrated approach to behavioral interventions emphasizes the need for the individual to understand the problem, identify a reasonable solution or first-step and believe he/she has the ability to begin the change process. In summary, the appropriate use of screeners can facilitate the efficiency and effectiveness of the 5As intervention, after which the provider

can refer the patient back to the behavioral health provider. In the follow-up, the behavioral health provider can help the patient identify specific areas where he/she can start making behavioral changes and reinforce his/her progress toward a healthier lifestyle.

Prenatal Development: Uniquely Sensitive Risk

Screeners have been shown to be very effective in high-risk populations such as prenatal care. Many complications of pregnancy, such as low birth weight due to poor nutrition or smoking, or fetal alcohol syndrome due to high alcohol consumption, may be identified and addressed through early screening. Women who do not receive comprehensive prenatal care are three times more likely to deliver a low weight baby than women who received adequate prenatal care (Child Trends, 2015). Financially, for every \$1 spent on prenatal care, \$3.38 is saved the first year of the baby's life. The estimated cost to the US economy for maternal care, neonatal care and long-term services is \$26 billion per year (Loftin et al., 2010). Besides the financial cost, there are social costs as well; preterm delivery is the most common cause of infant death and disability in developed countries (Kiss, Petricevic, Martina, & Husslein, 2010). Also, low birth weight babies have a higher chance of medical issues later on in life such as heart disease, diabetes and high blood pressure. Thus, there is a compelling financial and emotional reason to make prenatal screening a priority, especially since simple prenatal screen and treat programs have been demonstrated to drastically reduce the incidence of preterm births (Kiss et al., 2010).

In 2010 researchers discovered that the number of low birth weight babies could be reduced through a simple screen and treat program for vaginal infections (Kiss et al., 2010). Poor periodontal health, poor nutrition, smoking, alcohol use and high stress have also all been strongly correlated with avoidable prenatal disorders.

Oral health is a little known risk factor for low birth weight babies. In a study conducted by Strafford, Shellhaas, and Hade (2008), 46% of women 18 or older have tooth decay and yet only 49% of obstetricians perform oral health screens. Studies have shown that there is a correlation between periodontal infection and low birth weight possibly because of the uncontrolled spread of bacteria and the inflammation of tissues that could result in structural damage to the placenta and contribute to the fetus contracting an infection (Bobetsis, Barros, & Offenbacher, 2006). Asking for the patient's dental history and giving her a referral to a dentist if she has not been to the dentist in over a year can easily address this health risk.

Nutrition is extremely important for a healthy pregnancy. A child's diet has the most profound impact on his or her physical and mental development between conception and 24 months (Roseboom, Painter, van Abeelen, Veenedaal, & Rooij, 2011). Chronic degenerative diseases, heart disease and even schizophrenia are correlated with poor prenatal nutrition especially in regards to a deficiency of vitamin A, vitamin B12, folic acid, iron and zinc (Bryce, Coitinho, Darnton-Hill, Pelletier, & Pinstруп-Andersen, 2008). Recent studies show that almost 18% of pregnant women suffer from an iron deficiency (Cantor, Bougatsos, Dana, Blazina, & McDonagh, 2015). If poor nutrition is flagged on a screener then psychoeducation on proper nutrition can be an effective intervention. Also a referral to Women, Infants and Children (WIC) can be helpful as well since it provides supplemental foods and nutrition information to low-income women.

When a pregnant women smokes, she is not only doing serious harm to her own body but jeopardizing the development of her baby. Smoking can cause growth retardation, premature rupture of membranes and spontaneous abortion (Surgeon General, 2014). Overall it has been

estimated that simply eliminating smoking during pregnancy would reduce infant deaths by 5% and low birth weight babies by 10% (Whitlock, Polen, Green, Orleans, & Klein, 2004). A reduction in smoking behaviors has been shown to increase birth weight even if the women only move from heavy to light cigarette smoke exposure before the third trimester (Benjamin-Garner & Stotts, 2012). However, pregnant women are less likely to self-report than non-pregnant women about their smoking behaviors (Mullen, Carbonari, Tabak, & Glenday, 1991) because they are afraid of having their baby taken away by Child Protective Services (Roberts & Pies, 2011). Therefore, if smoking is suspected it is wise to offer resources regardless of screener results or ask smoking questions in multiple choice format instead of a yes or no answer to help the patient avoid fear and shame (Mullen et al., 1991).

Prenatal alcohol use is the leading preventable cause of birth defects. Any consumption of alcohol during pregnancy can result in prenatal growth retardation, neurodevelopmental deficits such as intellectual disabilities and spontaneous abortion (Floyd et al., 2008). Brief interventions have proven to be effective in screening and reducing the risk of fetal alcohol syndrome (Babor & Higgins-Biddle, 2000). Questions on a screener need to differentiate between alcohol dependent and nondependent individuals. Interventions for nondependent individuals can be a simple psycho-education session about the effects of alcohol on the fetus (Manwell, Fleming, Mundt, Stauffacher, & Barry, 2000). Alcohol dependent individuals may need to be referred to an alcohol detoxification program (Floyd et al., 2008). Consistent use of SBIRT (screening, brief intervention, and referral to treatment) in primary health clinics can drastically reduce unhealthy alcohol consumption (Agerwala & McCanze-Katz, 2012) as well as fetal alcohol syndrome.

Research shows that 5% to 16% of women have an anxiety disorder during pregnancy (Wiegartz & Gyoerkoe, 2009), yet only about 20% of physicians routinely screen for anxiety during pregnancy (Coleman, Carter, Morgan, & Schulkin, 2008). Untreated anxiety during pregnancy can result in an increased risk of physical complaints during pregnancy (Wiegartz & Gyoerkoe, 2009). Untreated anxiety during pregnancy also makes a women three times more likely to suffer from postpartum depression (Sutter-Dallay, Giaccone-Marcésche, Glatigny-Dally, & Verdoux, 2004). Screeners can differentiate between pregnancy-specific stress and state anxiety caused from pregnancy. A study conducted by Lobel et al. (2008) showed that women with pregnancy-specific stress delivered nine days earlier than state anxiety. Researchers also discovered that women who suffered from pregnancy- specific stress versus state dependent stress were more likely to use unhealthy coping mechanisms such as smoking or poor nutrition, further increasing health risks. Pregnancy-specific stress may be more treatable because that specific type of stress is very context related. Studies have found that knowledge is associated with lower stress in pregnant women so simply educating women about symptoms and hormonal changes specific to stress in pregnancy may lower anxiety (Lobel et al., 2008).

All of these behaviors can be quickly and easily identified by screeners and then corrected through short-term behavioral health interventions. Prenatal complications can be minimized with the use of screeners and brief interventions. These tools not only enhance the health of the mother but also enhance the health of the next generation.

Research has shown that low income (i.e., low SES) women typically make more regular visits to their obstetrician than they do to their primary care provider (Scholle & Kelleher, 2003) possibly because of barriers such as transportation and childcare. Women tend to take initiative

in pursuing their own preventative health when they believe it is particularly salient to themselves (Kelly et al., 2014). Therefore, the use of a pre-natal screener could identify individual risk factors and potentially lead to brief interventions that may be extremely beneficial to both mother and developing fetus. The following specific hypotheses highlight the potential benefits of a population-based screener in a women's health setting,

Hypothesis 1: It was hypothesized that a screener administered during the intake assessment for pre-natal care would identify women at risk for physical and behavioral health problems.

Hypothesis 2: It was hypothesized that patients with identified risk factors would be referred to appropriate services and resources.

Hypothesis 3: It was hypothesized that patients receiving referrals would be sufficiently activated to follow-up and contact resources.

Hypothesis 4: Conditions identified by the screener and incorporated into individualized prenatal treatment goals would result in an increase in overall treatment goal completion.

Chapter 2

Methods

Participants

Approval was received from the University Human Subjects Research Committee prior to the initiation of this program evaluation, and ethical guidelines established by the American Psychological Association were followed (American Psychological Association, 2010). All participants were past patients of an obstetrician's office in a suburban and rural area for the past 1.5 years. Participants consisted of 247 pregnant women from a rural OB clinic (64 women) and a suburban OB clinic (183 women). The ages ranged from 15 to 44 with an average age of 26.72 ($SD = 5.93$). The participants were primarily European-American (64.8%), and also Hispanic (23.5%), Multiracial (2.4%), American Indian (.8%), Pacific Islander (2.4%), Asian (1.2%), African-American (1.6%), and Other (3.2%). The number of pregnancies ranged from 1-7 with an average pregnancy number of 1.82 ($SD = 1.62$). There were no significant differences in the population between clinics, so data was combined for additional analyses. There was an attrition rate of 9.7% from women who transferred care to another OB clinic or passed away from non-pregnancy related causes.

Instruments

Based on a literature review of prenatal risk factors a screener was constructed to identify risk for periodontal health, nutrition deficits, mental health issues, substance abuse issues, sleep troubles, financial stressors, lack of transportation and lack of childcare/ support. Screener questions were worded in a "yes" or "no" format, and were administered by a medical assistant

in a confidential, intake assessment. Care pathways were specified on the screener for potential risk so patients were initially referred in a reliable, uniform fashion across different nurse administrators. The screener was not developed to be a diagnostic tool but to highlight potential risks.

Procedure

Medical assistants were trained on the standardized screen and referral process when hired at the clinic. At the initial prenatal assessment the medical assistant verbally administered the behavioral health screener designed to identify pregnancy related health risks such as periodontal health, nutrition, mental health issues, substance abuse issues, sleep issues, financial issues, lack of transportation and lack of childcare or support. Patient responses were marked on the screener, which then identified referral pathways to appropriate referrals/ interventions based on patient responses to screener questions. Standardized interventions included psychoeducational materials, follow up with an integrated behavioral health provider and referrals to county health services, dental services and RN visits. Each referral was free for the patient and a specific provider name and phone number was provided to optimize follow through. Recommended referrals were recorded in the medical chart as Maternal Medical Home goals (MMH) and screeners were scanned into electronic medical record.

Every trimester the medical assistant would call the patient and track her progress on her maternal medical home goals. The progress and completion of treatment goals were entered in the patient's medical chart each trimester as *complete*, *in progress*, or *incomplete*. Once a treatment goal was accomplished it was removed from patient's treatment plan. Patient follow up was defined as the completion of the intervention referral. Treatment goal completion was

defined as the absence of symptoms in reference to the specific problem. For example, if a patient was no longer having problems sleeping the goal was marked as complete. Treatment goals were no longer tracked after the end of the third trimester.

De-identified demographic information, screener results, referrals given, referrals completed and treatment goal completion were collected from the patient's medical charts for analysis.

Data Analysis

Overall demographics of referral and treatment goal groups were collected and analyzed through SPSS. Frequencies and percentages for screener results, referrals, referral follow-up and treatment goal completion were conducted by SPSS. Statistical analysis was conducted through the use of a Test for Significance of Differences Between Two Proportions to evaluate significant differences between follow through in referrals. Statistical analysis was conducted through the use of a Test for Significance of Differences Between Two Proportions to evaluate significant differences between treatment goals. All analysis was completed by hand for test of significant differences between two proportions and calculations were reviewed to confirm accuracy. An alpha level of .05 was used for significance between proportions.

Chapter 3

Results

Screener Identification of Risk

Based on initial screener results 61.1% of patients screened positively for dental needs, 44.1% for sleep deficits, 40.1% for high levels of stress, 34.8% for nutrition deficits, 24.7% for depressive symptoms, 23.1% for financial issues, 9.3% for childcare issues, 8.9% for substance abuse and 8.5% for transportation issues. These percentages are similar to the percentages found in literature reviews on prenatal health risks demonstrating that this screener is able to assist in identifying women who may need a higher level of care.

Referral Rate by Providers

Of the total population of women screened, 84.6% of patients were referred to a dentist, 69.2% of patients were referred to county services, 58.3% of patients were referred to the behavioral health consultant, 44.1% of patients were given handouts, 15% of patients were referred to a nutritionist, 13.4% of patients were given a prescription for vitamins, and 9.7% were referred to a RN for additional consultation. Results show that the clinic tended to over-refer based on initial screener results.

Patient Referral Follow Through

A Test for Significance of Differences Between Two Proportions was conducted to evaluate patient follow through with referrals. The following results show the percentage of patient response to referrals: handouts (98%), prenatal vitamins (97%), meeting with an RN (92%), county resources (75%), dental (61%), behavioral health provider (47%), and nutritionist

(46%). Women were more likely to receive a handout, prescription for vitamins, visit a nurse or go to county for resources ($z = 1.63, p < .05$) than go to a dentist ($z = 2.89, p < .05$). Women were least likely to follow through with a referral to the behavioral health provider or nutritionist ($z = 2.59, p < .05$) than other referrals. Results showed that the rate of follow up depended on the specific referral. Women were much more likely to pursue a referral that would result in immediate results than a referral that could be considered more long-term and process oriented such as seeing a nutritionist or behavioral health consultant.

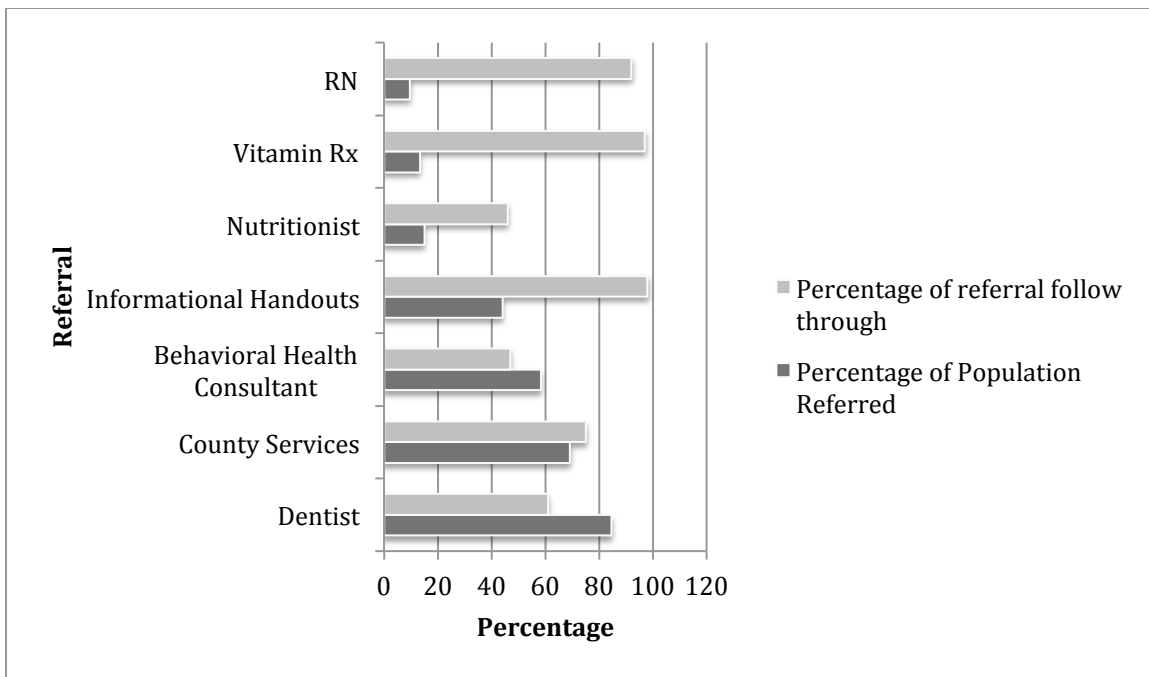


Figure 1. Comparison of the percentage of population referred to the percentage of population who followed through with referrals.

Treatment Goal Completion

A Test for Significance of Differences Between Two Proportions was conducted to evaluate patient completion of treatment goals. Women were most likely to meet treatment goals that involved childcare/support (98.6%), finances (96.4%), and transportation (96.4%) ($z = 3.95$, $p < .05$). Women were more likely to meet goals for depression (89.6%), substance abuse (86.4%), sleep (85.5%) and anxiety (85%) than they were to meet treatment goals for nutrition (74.2%) ($z=3.95$, $p<.05$). Women were least likely to meet treatment goals for dental (54.3%) ($z = 6.23$, $p < .05$). Results showed that the treatment goal completion rate depended specifically on the treatment goal itself. Women were more likely to complete practical treatment goals such as improving access to childcare and transportation than they were to complete treatment goals that could be viewed as more preventative such as eating well and going to the dentist.

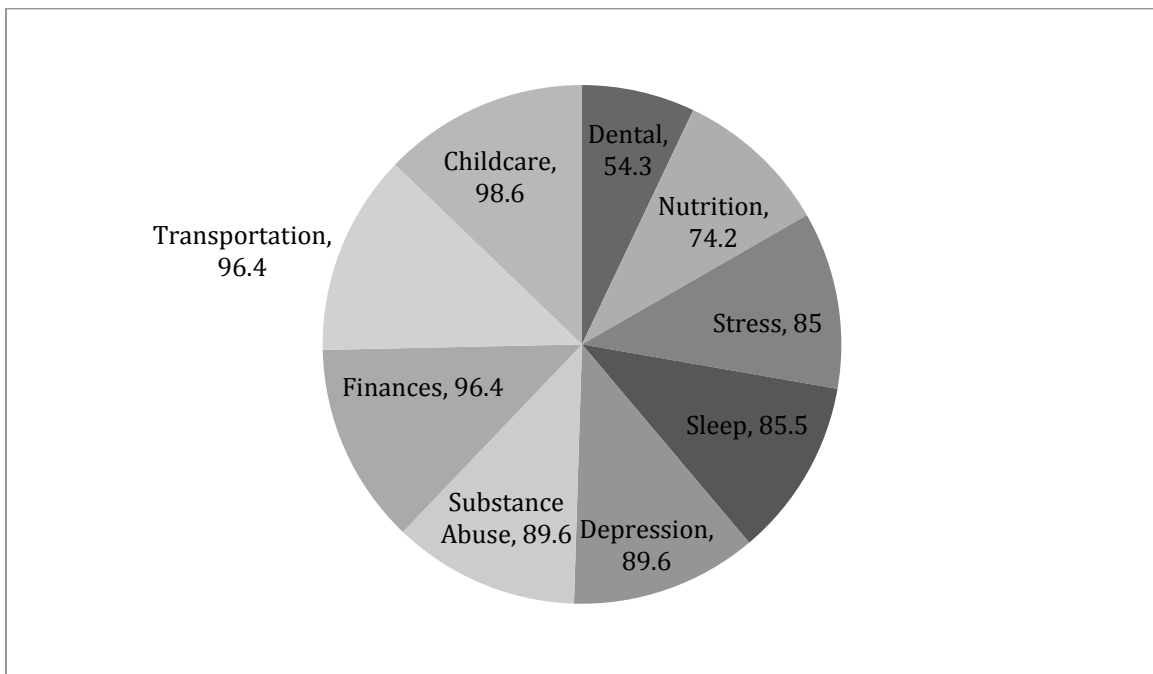


Figure 2. Percentage of overall population treatment goal completion.

Chapter 4

Discussion

This study was a program evaluation of the implementation of a prenatal screener in an OB clinic and its effect on patient follow-up and treatment goal completion. Results showed this screener was able to identify patients who may suffer from dental problems, nutritional deficits, mental health issues, substance abuse and financial issues as well as provide appropriate referrals.

Results showed that patient activation and follow-up depended on the type of referral given. Patients were most likely to accept an informational handout, receive a prescription for vitamins, visit the nurse or go to the local county for additional resources. Patients were more likely to go to the dentist than to follow through with a referral to the behavioral health consultant or nutritionist at the clinic. Based on the results of this study there may be a medically-oriented culture of care where both patients and providers are more comfortable prioritizing medical based interventions such as prenatal vitamins, self-education through handouts and practical resources related to basic needs such as food, childcare and transportation resources than periodontal or mental health.

Vitamins, RN consultation and county resources are all immediate response, “quick fix” interventions while seeing a behavioral health provider or nutritionist involves long-term behavioral activation. Some additional barriers to care may be a perceived level of vulnerability in consulting with a behavioral health provider related to a continuing stigma held by both providers and patients around mental illness.

Results showed that patients were most likely to accomplish treatment goals that involved financial issues, transportation, and childcare/support. Women were more likely to meet goals for substance abuse, depression, sleep and anxiety than they were to meet nutrition treatment goals. Women were the least likely to meet treatment goals for periodontal health. Based on the results of this study, women are most likely to accomplish practical, immediate treatment goals such as obtaining assistance with transportation, finances and childcare. They were less likely to accomplish goals that were viewed as more preventative in nature such as nutrition and dental. The disregard for periodontal health is consistent with previous literature in regards to lack of education around possible infections (Strafford et al., 2008). Goals such as dealing with depression, sleep and anxiety are more transient goals during pregnancy and may resolve through time and life circumstances and may not require specific action by the patient. It is notable that women had greatest success with those goals representing foundational, essential needs and were less likely to achieve those goals that were less essential for day-to-day functioning such as periodontal health or nutrition.

Overall, there is still a great deal of work to be done with regard to patient education around preventative health. Follow-up with referrals and accomplishment of treatment goals line up clearly with Maslow's hierarchy of needs where immediate needs such as finances, transportation and medical care are met first. The answer may not be upending Maslow's hierarchy of needs but encouraging patients to include periodontal health, nutrition and mental health as important factors in the hierarchy. These needs are most clearly defined by the medical provider since most patients are highly reliant on their provider's recommendations. Adherence to medical recommendations is strongly mediated by a patient's perception of her risk. High-risk

patients tend to receive more information about their care and therefore may be more motivated to follow-up (Headley & Harrigan, 2009). Patients and the healthcare system benefit from raising awareness of the impact of dental and nutrition on the birth weight of the baby. Therefore, it is important that patients are consistently receiving individualized and appropriate information regarding the importance of periodontal health, nutrition and behavioral health from their OB doctor.

Limitations

There were several limitations to this study. A marked limitation is that only women who reached their third trimester were included in the study. Therefore, anyone who had a miscarriage, switched care to another clinic or did not participate in care (i.e., answering phone calls) were not included in the study because of incomplete data. Therefore, the data only reflects women who carried their babies to term and stayed at the same OB clinic for the duration of their pregnancy.

Another possible limitation is under-reporting by patients with regard to symptoms and over-reporting with regard to behavioral changes. In most studies, women were filling out their answers on confidential screeners while our initial prenatal screen was conducted face to face with the Medical Assistant. The awareness that the information would be entered into a shared medical record could cause women to feel guilt or shame about behavioral issues, which could result in under-reporting by patients. This impact of under or over-reporting is important to be noted since the data relied mainly on patient report.

Another limitation is the absence of nationally, established norms that allow a comparison of the impact of this screener implementation versus expected impacted. However,

this study establishes a solid baseline for additional studies to be conducted with this OB clinic and their associates, and perhaps adds to the emerging national data regarding the impact of screeners.

Suggestions for Future Research

The continued integration of technology could further research by exploring the impact of introducing an online prenatal screener the patient could complete from home. This convenience could reduce patient discomfort about personal questions and raise response rate since they can complete it on their own time. Additional research could also be conducted on the impact of having the behavioral health consultant making the referral calls after receiving the screener versus relying on provider or MA follow up.

Summary

The implementation of a comprehensive screen and referral to treat program highlights the importance of early screening in order to assist with treatment planning and referral to essential services. Additional work is needed in maximizing the potential of the behavioral health consultant in an OB clinic. This will require additional provider education in extending the behavioral health roles outside of pure mental health, particularly in regards to periodontal health and nutrition in the hopes of an increased emphasis on preventative care in both patients and providers. Holistic goal setting can facilitate the importance of a multidisciplinary approach to treatment in an OB population. It is important to continue emphasizing preventative health for the sake our generation and even the next.

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Appendix A
WHA Wellness Assessment

We care about you and your family:		
Primary Care Provider:		ACTION: If none, refer to a PCP or Insurance for PCP
Pediatrician:	Name:	
Physically inactive for extended periods of time while at work:		ACTION: YES to inactive work + NO exercise = handout from CN
Exercises how many times per week: Type of exercise:		ACTION: YES to inactive work + NO exercise = handout from CN
Highest level of education:		
Using birth control when became pregnant:		ACTION: If YES- discuss alternative options
Pre-pregnancy weight in pounds:		
Housing situation:		ACTION: If Somewhat or Not - refer to CN or Ref. N
Financial concerns:		ACTION: If YES - refer to appropriate county services
Requests public transportation assistance:		ACTION: If YES - refer to CN or Ref. N
Number of children at home:		
Number of children at home under the age of 5:		
How many children with special needs:		
Difficulty finding childcare:		ACTION: refer to CN or Ref. N
Name of the father of baby/Partner:		
Occupation of the father of baby/Partner:		
Partner has a problem with alcohol or other drug abuse:		ACTION: If yes - alert behaviorist
Father of the baby/partner lives in the home:		
Father of the baby/partner plans to parent/share custody:		
We care about your dental and nutritional health:		
Do you have a dentist?	Name:	ACTION: If NO, refer to a Dentist or Insurance for Dental provider
Have you seen a dentist in the last year?		ACTION: IF NO, refer to a Dentist or Insurance for Dental provider - refer to CN or Ref. N
Do you have dental pain?		ACTION: IF YES, refer for immediate dental services
Do you run out of food because you don't have enough money?		ACTION: IF YES, refer to CN or Ref. N
Do you eat 1+ serving/day of each food group?		ACTION: IF NO, refer to Behaviorist
Do you take prenatal vitamins daily?		ACTION: IF NO, send prescription

We care about your mood:		
In the past two weeks have you had little interest or pleasure in doing things?		ACTION: If YES, refer to behaviorist for PHQ-9 screen
In the past two weeks have you felt down, depressed, or hopeless?		ACTION: If YES, refer to behaviorist for PHQ-9 screen
In the past two weeks have you felt that your stress level has impacted your daily functioning?		ACTION: If YES, refer to behaviorist for PHQ-9 screen
In the past week have you blamed yourself unnecessarily when things went wrong?		ACTION: If YES, refer to behaviorist for PHQ-15 screen for anxiety
Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with other people, or take care of things at home?		ACTION: If YES, refer to behaviorist for PHQ-15 screen for anxiety
In the past week have you felt scared or panicky for no good reason?		ACTION: If YES, refer to behaviorist for PHQ-15 screen for anxiety
Do you have difficulty falling asleep or staying asleep?		ACTION: If YES, give handout on sleep hygiene and refer to behaviorist if needed
Have you ever seen a mental health provider for how you have been feeling?	Reason List:	
Do you have a mental health provider?	Name:	
We care about how you feel about this pregnancy:		
Did you use medications or infertility treatments to become pregnant?		
Were you trying to get pregnant?		
If no, is this pregnancy desired?		ACTION: If NO, trigger to CN
If no, do you plan to continue the pregnancy?		ACTION: If NO or unsure, trigger to CN
We care about your safety:		
How many times in the past year have you had four or more drinks in a day?		ACTION: If "1 or more times", refer to behaviorist
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?		ACTION: If "1 or more times", refer to behaviorist
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?		ACTION: If YES, refer to behaviorist
Did any of your parents have a problem with alcohol or other drug use?		ACTION: If YES, refer to behaviorist

Did you use tobacco products in the three months prior to pregnancy?		ACTION: If YES, refer to behaviorist
What is your current smoking status?		ACTION: If CURRENT, refer to behaviorist
Are you exposed to second hand smoke?		
Have you experienced sexual violence?		ACTION: If YES, CN put pop up alert in chart
Do you have family members or friends who will help you in times of need?		ACTION: If NO, refer to CN
Do you feel safe at home?		ACTION: If NO, refer to appropriate county services
Are you currently being hit, punched, kicked or slapped by anyone?		ACTION: If YES, refer to appropriate county services
Do you need to discuss violence at home with your provider?		ACTION: If YES, refer to appropriate county services

Appendix B

Curriculum Vitae

Julia L. Terman

2239 Sam Parrett Dr Newberg, OR 97132
425-478-5286 julia.terman@gmail.com

EDUCATION

- Doctor of Psychology, Clinical Psychology** *Expected May 2017*
Health Psychology Emphasis
 George Fox University – *Newberg, OR*
 Graduate Department of Clinical Psychology: APA Accredited
 Cumulative GPA: 3.9
- Master of Arts, Clinical Psychology** May 2014
 George Fox University – *Newberg, OR*
 Graduate Department of Clinical Psychology: APA Accredited
- Bachelor of Arts, Psychology** May 2011
 Biola University – *La Mirada, CA*
 Torrey Honors Program

HONORS AND AWARDS

- Magna Cum Laude** May 2011
 Biola University – *La Mirada, CA*
- Graduate of Torrey Honors Program** May 2011
 Biola University – *La Mirada, CA*
- Induction into Psi Chi International Honor Society in Psychology** April 2009
 Biola University – *La Mirada, CA*
- Dean's List** January 2008 – May 2011

SUPERVISED CLINICAL EXPERIENCE

- Cherokee Health Services – Knoxville, TN** July 2016 – July 2017
Title: Intern
Description: Working within an integrated behavioral health primary care setting as well as a traditional outpatient mental health treatment setting to provide holistic care for patients.

Providence Medical Group Sherwood – Sherwood, OR

January 2015 – June 2016

Title: Behavioral Health Intern

Description: Worked within an integrated behavioral health primary care setting and within a multidisciplinary team comprised of physicians and medical personnel to provide holistic health care treatment for patients with mental illness, chronic pain, and health issues.

Population: Entire lifespan, pediatrics through geriatrics

Hours per Week: 16-20 hrs/week

Duties:

- Provided short-term, solution-focused CBT and person-centered therapy for individuals, couples, and families of varying age, sexual orientation, ethnicity, and socioeconomic status, including those with Medicaid/Medicare and the uninsured.
- Provided psychodiagnostic test administration and screening, including ADHD screenings, dementia screenings, learning disability evaluations, neuropsychological evaluations, personality assessments, and comprehensive psychological assessments.
- Provided consultation services for medical personnel, including psychodiagnostic clarity, referrals for long-term therapy, suggestions for behavioral interventions, training in motivational interviewing, crisis consultation, and risk evaluations.
- Attended weekly didactics on pertinent mental health issues, ethical issues, and effective systems navigation.

Supervisor: Jeri Terguson, PsyD.

Total Intervention Hours: 255 hrs

Total Assessment Hours: 160hrs

Behavioral Health Crisis Consultation Team – Yamhill County, OR

March 2014 – May 2016

Title: Behavioral Health Intern, QMHP

Description: A two-year on-call position providing crisis consultation, assessment, and intervention for two major medical centers (emergency department, intensive care unit, labor and delivery unit, and medical/surgical unit), law enforcement, and mental health agencies within Yamhill County.

Population: Children, adolescents, and adults often with severe mental health issues such as schizophrenia, bipolar disorder, severe depression, and dementia. Most patients have typically attempted to come close to attempting suicide, harming others or are experiencing psychosis or delirium.

Hours per Week: 12 hr shift bi-monthly

Duties:

- Completed hospital risk assessments, cognitive evaluations, and other assessments of patients of varying age, gender, sexual orientation, ethnicity, and socioeconomic status.
- Provided consultation for medical personnel pertaining to psychodiagnostic clarity, mental status, and level of risk.
- Provided phone consultation for law enforcement personnel who are in the field trying to diffuse or manage someone who is mentally ill and a danger to self or others.
- Worked collaboratively with medical personnel and Yamhill County staff to develop appropriate discharge plans for patients as well as to find appropriate placement for at-risk individuals while working within the broader Providence and Willamette Valley medical systems and county services.

- Implemented psychiatric hospitalization, respite care, sub-acute psychiatric placement, or alternative intervention placements for high-risk, suicidal, or cognitively decompensated patients under supervision of a licensed psychologist.
- Attended weekly trainings to consult and discuss cases.

Supervisors: Mary Peterson, PhD., ABPP, William Buhrow, PsyD., & Joel Gregor, PsyD.

Total Intervention Hours: 126 hrs

Women's Healthcare Associates, LLC – Newberg, OR

May 2014 – May 2015

Title: Behavioral Health Consultant

Description: A one-year position at an OB/GYN clinic providing short-term therapy for women who were struggling with behavioral health issues. Assisted in program development to help foster an integrated health care model.

Population: Adolescent and adult females, variation in ethnicity and SES

Hours Per Week: 9-18hrs/wk

Duties:

- Provided short-term behavioral health services within a primary care/maternal medical home model for female patients of varying age, sexual orientation, ethnicity, and socioeconomic status, including those with Medicaid/Medicare and the uninsured.
- Common presenting problems included depression, anxiety, postpartum depression, insomnia, stress, menopause, infertility, miscarriages, bipolar disorder, adjustment to life transitions, obesity, and bereavement.
- Administered and interpreted brief screeners and assessments, assisted with crisis management, and participated in warm handoffs.
- Engaged in consultation and care coordination as part of a multidisciplinary team of physicians, nurse practitioners, and nurses.
- Developed and implemented a treatment manual specific to working with women in healthcare settings.
- Assisted in program development for integrated primary care.
- Attended weekly didactics on pertinent mental health issues in healthcare.

Supervisor: Jeri Turgesen, PsyD.

Total Intervention Hours: 165 hrs

Total Assessment Hours: 20hrs

Sundstrom Clinical Services – Clackamas, OR

December 2014 – April 2015

Title: Assessment Intern

Description: A supplemental practicum one day a month at a private counseling center.

Population: Pediatrics and adolescents

Hours Per Week: 5 hrs per month

Duties:

- Administered cognitive assessments
- Wrote assessment reports

Supervisor: Celeste Flaschbart, PsyD.

Total Assessment Hours: 15 hrs

George Fox Counseling Center – Newberg, OR

August 2013 – December 2014

Title: Graduate Counseling InternDescription: A one-year position at the counseling center of a college campusPopulation: Undergraduate studentsHours Per Week: 18hrs/ wkDuties:

- Provided weekly individual psychotherapy to students of varying gender, sexual orientation, and ethnicity in a college counseling setting, utilizing person-centered and cognitive behavioral techniques.
- Conducted diagnostic intake interviews, developed treatment plans, and dictated formal intake and progress reports.
- Administered cognitive assessments and personality assessments.
- Attended weekly didactics on mental health issues specific to an undergraduate population.

Supervisor: Bill Buhrow, PsyD. & Kristina Kays, PsyD.Total Intervention Hours: 192 hrsTotal Assessment Hours: 7hrs**GFU Graduate Department of Clinical Psychology – Newberg, OR**

January 2013 – April 2013

Title: Pre-Practicum II TherapistDescription: Provided 10 therapy sessions as part of clinical foundations course to two undergraduate students who volunteered for course credit.Population: Undergraduate studentsHours Per Week: 2 hrs/ wkDuties:

- Provided weekly individual psychotherapy in a counseling setting, utilizing person-centered therapeutic techniques.
- Conducted diagnostic intake interviews, developed treatment plans, and wrote formal intake and progress reports.
- Attended weekly group and individual supervision with an advanced graduate student supervised by a licensed clinical psychologist.
- Reviewed videotaped sessions and presented cases.

Supervisors: Carlos Taloyo, PsyD. & Jenae Ulrich, MA.Total Intervention Hours: 20 hrs

SUPERVISORY EXPERIENCE

Fourth Year Oversight

August 2015 – Present

*George Fox University Graduate Department of Clinical Psychology – Newberg, OR*Faculty: Bill Buhrow, PsyD. & Rodger Bufford, PhD.Duties:

- Oversight of a second year student
- Helped second year student develop their clinical and assessment skills
- Helped second year with development of theoretical orientation

- Provided both formative and summative feedback of second year student's clinical and professional skills

Clinical Foundations Graduate Assistant

August 2015 – Present

*George Fox University Graduate Department of Clinical Psychology- Newberg, OR*Faculty: Glena Andrews, PhD.Duties:

- Supervised and taught 1st year PsyD students client-centered therapy concepts and skills
- Led weekly small groups to facilitate skill development
- Evaluated therapy video submissions and provided feedback on student papers
- Received weekly group supervision to facilitate supervision skills

Cognitive Assessment Graduate Assistant

August 2014 – December 2014

*George Fox University Graduate Department of Clinical Psychology – Newberg, OR*Faculty: Celeste Flaschbart, PsyD.Duties:

- Provided weekly lab demonstrations and instruction of various cognitive assessment instruments.
- Was responsible for evaluation of six graduate students' progress as they learned to administer, score, and interpret cognitive assessment instruments by reviewing videotapes, protocols, and written assessment reports.
- Met weekly with other TAs and faculty to discuss student progress and course requirements.
- Met individually with students to provide further instruction and support.

SUPERVISED ASSESSMENT EXPERIENCE

*16 Personality Factor Questionnaire, Fifth Edition (16 PF Fifth Edition)**Adult ADHD Self-Report Scale (ASRS v1.1)**Alcohol Use Disorders Identification Test (AUDIT)**Beck Anxiety Inventory (BAI)**Beck Depression Inventory – II (BDI-II)**Behavior Assessment System for Children and Adolescents, Second Edition (BASC-2)**Boston Naming Test**Brief Rating Inventory of Executive Function (BRIEF)**California Verbal Learning Test, Second Edition (CVLT-II)**Center for Epidemiological Studies Depression Scale for Children (CES-DC)**Comprehensive Trail Making Test**Conners Continuous Performance Test II (CPT-II)**Conners 3rd Edition**Conners Adult ADHD Rating Scales (CAARS)**Delis-Kaplan Executive Function System (D-KEFS)**Denver Developmental Screening Test II**Diagnostic Interview for ADHD in Adults (DIVA)**Edinburgh Postnatal Depression Scale (EPDS)*

Family Adaptability and Cohesiveness Scale – Fourth Edition (FACES IV)
Finger Tapping Test
Generalized Anxiety Disorder Screener (GAD-7)
Geriatric Depression Scale
Grip Strength Test
Grooved Pegboard Test
Halstead Category Test
Millon Adolescent Clinical Inventory (MACI)
Millon Behavioral Medicine Diagnostic (MBMD)
Millon Clinical Multiaxial Inventory – Third Edition (MCMI-III)
Mini-Mental State Examination – Second Edition (MMSE-2)
Minnesota Multiphasic Personality Inventory – Second Edition (MMPI-II)
Minnesota Personality Inventory – Second Edition RF (MMPI-II RF)
Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)
Montreal Cognitive Assessment (MoCA)
Mood Disorder Questionnaire
Outcome Rating Scale (ORS)
Patient Activation Measure (PAM)
Patient Health Questionnaire (PHQ)
Patient Health Questionnaire for Depression (PHQ-9)
Peabody Picture Vocabulary Test – Fourth Edition (PPVT-4)
Personality Assessment Inventory (PAI)
PTSD Symptom Checklist – Civilian (PCL-C)
PTSD Symptom Scale
Rey-Osterrieth Complex Figure Test
Seashore Rhythm Test
Session Rating Scale (SRS V.3.0)
Screen for Childhood Anxiety Related Emotional Disorders (SCARED)
Tactual Performance Test
Test of Memory Malingering (TOMM)
Trail Making Test A&B
Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV)
Wechsler Individual Achievement Test – Third Edition (WIAT-III)
Wechsler Intelligence Scale for Children – Fourth Edition (WISC-IV)
Wechsler Memory Scale – Fourth Edition (WMS-IV)
Wide Range Achievement Test 4 (WRAT4)
Wide Range Assessment of Memory and Learning – Second Edition (WRAML-2)
Wide Range Intelligence Test (WRIT)
Wisconsin Card Sorting Test (WCST)
Woodcock Johnson Academic Test – Fourth Edition (WJ-IV)

TOTAL SUPERVISED TRAINING CLINICAL HOURS

Clinical Intervention Hours: 928
Assessment Hours: 212

Supervision Hours: 318
Support Hours: 270

RESEARCH EXPERIENCE AND PROFESSIONAL PRESENTATIONS

Doctoral Dissertation Research

August 2012 – August 2015

George Fox University Graduate Department of Clinical Psychology – Newberg, OR

Topic: *Maternal Maslow: Evaluating Patient Follow Up and Treatment Goal Completion for Prenatal Referrals in a Women's Health Clinic*

Proposal Defended: May 2014

Dissertation Defended: August 2015

Dissertation Chair: Mary Person, PhD., ABPP

Research Vertical Team

January 2013 – Present

George Fox University Graduate Department of Clinical Psychology – Newberg, OR

Description: A research team focused on health psychology consisting of graduate students from each year of the program led by a faculty member.

Duties:

- Worked on personal dissertation
- Assisted peers with various aspects of their dissertations, such as proofreading chapters and entering data
- Developed supplemental research projects

Supervisor: Mary Peterson, PhD., ABPP

Infant Learning Laboratory

August 2009 – May 2011

Biola University – La Mirada, CA

Title: Undergraduate Research Assistant

Duties:

- Recruited 500+ research participants via phone
- Received coding training and coded videotaped experimental sessions
- Attended weekly supervision meetings and trainings

Supervisor: Jason Brunt, PhD.

RESEARCH PRESENTATIONS

Davis, S., **Terman, J.**, Speck, C., Malone, M., Goins, N., Terguson, J. (October 2015). *Integrating behavioral health services in a pediatric primary care setting*. To be submitted as poster presentation at Oregon Psychological Association Conference, Portland.

Terman, J., Terguson, J., Peterson, M. Gathercoal, K., & Buhrow, B. (October 2015). *Maternal Maslow: Self-prioritization of goal completion in an OB population*. Poster presented at annual meeting of the Collaborative Family Healthcare Association, Portland, OR.

Terman, J., Gathercoal, K., Turgesen, J., Peterson, M., & Buhrow, B. (August, 2015). *Help me help you: Looking at patient response to referrals in an OB population.* Poster presented at annual meeting of the American Psychological Association, Toronto.

Kang, T., Song, C., **Terman, J.,** Hartman, T., Fish, R., Goldberg, E. & Peterson, M. (2015, August). *Same time next week: Reducing the frequency of non-emergent patient visits in the ED.* Poster presented at annual meeting of the American Psychological Association, Toronto.

Terman, J., Ambrosion, H., Hartman, T., & Peterson, M. (2014, August). *Prenatal care: Getting her the help she needs.* Poster presented at annual meeting of the American Psychological Association, Washington, DC.

PROFESSIONAL PRESENTATIONS

Tips for Weight Management from a Behavioral Health Consultant June 2015

Presented to: Patients in weight management group at Providence Sherwood

Description: Conducted psycho-education on simple behavioral strategies to help lose weight.

Diabetes Management and Behavioral Health June 2015

Presented to: Physicians at Providence Sherwood

Description: Discussed referral pathways for physicians in regards to diabetes management.

Conducted psycho-education on the role of behavioral health in diabetes management.

From Anxiety to Zaines: Maximizing your Behavioral Health Consultant March 2015

Presented to: Physicians at Women's Health Care Associates

Description: Conducted psycho-education on ways to expand behavioral health care consultant's role in the clinic beyond pure mental health.

Managing Stress in a Healthcare Setting September 2014

Presented to: Women's Health Care Associates Staff

Description: Discussed ways to manage stress in the workplace and at home. Taught anxiety reduction exercises to staff.

GRANTS

Perioperative Persistent Pain Program May 2014

Funded by: Providence Newberg Medical Center

Description: Assisted with the writing and development of a proposal for evidence-based interventions for perioperative joint replacement patients with persistent pain.

PROFESSIONAL AFFILIATIONS

APA: Division 35, Society for the Psychology of Women*Graduate Student Affiliate***APA: Division 38, Health Psychology***Graduate Student Affiliate***Collaborative Family Healthcare Association***Student Member***Clinical Health Psychology Network***Student Member***American Psychology Association***Graduate Student Affiliate***Psi Chi International Honor Society in Psychology***Student Member*

TEACHING EXPERIENCE

Teaching Assistant for Health Psychology

June 2015 - July 2015

*George Fox University Graduate Department of Clinical Psychology – Newberg, OR*Faculty: Jeri Terguson, PsyD.Duties:

- Corresponded with students about class information and schedule
- Was responsible for grading assignments, providing specific feedback and helping develop criteria for course projects.
- **Guest Lecturer: The OB Population**

Teaching Assistant for Social Psychology

May 2015

*George Fox University Graduate Department of Clinical Psychology – Newberg, OR*Faculty: Joel Gregor, PsyD.Duties:

- Corresponded with students about class information and schedule
- Graded and provided feedback on paper and exams
- **Guest Lecturer: Pro-Social Behaviors**

Teaching Assistant for History and Systems

August 2014 – December 2014

*George Fox University Graduate Department of Clinical Psychology – Newberg, OR*Faculty: Kathleen Gathercoal, PhD.Duties:

- Was responsible for grading assignments and providing specific feedback on the interaction of philosophical ideas

ACADEMIC SERVICE AND LEADERSHIP

Clinical Advisory Council

September 2014 – Present

*George Fox University Graduate Department of Clinical Psychology*Duties:

- Met with the Director of Clinical Training regularly to plan Grand Rounds and Colloquium
- Evaluated new practicum placements for the next year.
- Created and reviewed surveys of student feedback about school events and implemented feedback.

Admissions Committee Student Member

October 2013 – March 2014

*George Fox University Graduate Department of Clinical Psychology*Duties:

- Participated in the admission of new students by assisting in reviewing and rating prospective student applications
- Attended weekly meeting to discuss applicants
- Helped facilitate interview days and interview applicants.

Peer Mentor

August 2013 – May 2014

*George Fox University Graduate Department of Clinical Psychology*Duties:

- Assisted incoming graduate students in transitioning to the program by providing personal and professional mentorship during their entire first year.

RELEVANT EMPLOYMENT HISTORY

CollegePlus! – La Mirada, CA

August 2011 – December 2012

Title: Academic CoachPopulation: Adolescents and adultsHours Per week: 20 hrs per weekDuties:

- Conducted bi-monthly calls with 30 students to monitor progress and inspire morale
- Empowered students to set and meet their academic, personal and spiritual goals
- Facilitated goal setting with students through active listening and open-ended questions

Supervisor: Brittany Crist**Learning Rx – Orange, CA**

August 2011 – May 2012

Title: Cognitive TrainerPopulation: Children and adolescents

Hours Per Week: 15 hours per week

Duties:

- Worked one-on-one with clients doing individualized “brain training” activities bi-weekly
- Created treatment plans for each client
- Tracked and recorded cognitive improvements of clients

Supervisor: Martin Eaton, PhD.

VOLUNTEER EXPERIENCE

Backpack Ministry

August 2009 – Present

Calvin Presbyterian Church – Shoreline, WA

Description: Helped pack backpacks with food for underprivileged children.

Serve Day

September 2012 – Present

George Fox University – Newberg, OR

Description: Served one day yearly at a women’s shelter. Tasks involved washing windows, stuffing envelopes and yard work.

EXTENDED CLINICAL TRAININGS AND EDUCATION

Primary Care and Health Psychology Training

- Integrated and Collaborative Care Practices for Teaching Pain Management Treatment
Emilee Delbridge, PhD October 2015
- Group Prenatal Care: A Pilot Project Aimed to Reduce Health Disparities in an Urban Medical Residency Program Utilizing an Interdisciplinary Care Model
Jerica Berge, PhD October 2015
- Fathers Matter: The Financial, Operational, and Clinical Implications of Paternal Peripartum Depression
Cassidy Freitas, MFT October 2015
- Brief Couple-Based Interventions: Getting to the Heart of Coping with Chronic Illness
Jennifer Harsh, PhD October 2015
- Effective Consultation with Medical Staff – Considerations for Integrated Health Care Delivery Models
Kimberly Monden, PhD. August 2015
- Negotiating Funding for Psychologist Positions in Primary Care and Specialty Medical Settings
Parinda Khatri, PhD. August 2015

- Working Therapeutically with Women who are Childless-Not-by-Choice –
Special Treatment Considerations August 2015
Vula Baliotis, PhD.
- Perinatal Mood Disorders – Supporting High Risk Women and Infants August 2015
Joanna Cole, PhD.
- Working With Suicidal Patients – Practical, Legal, and Ethical Considerations August 2014
Robert Meyers, PsyD.
- Challenges to Women’s Behavioral and Psychosocial Wellness During the
Perinatal Period August 2014
Pamela Geller, PhD.
- Peer Consultation and Mentoring in the Professional Development of Integrated
Care Psychologists August 2014
Helen Coons, PhD.
- The Interplay Between Psychology and Reproductive Health – Implications for
Policy and Practice August 2014
Antonia Biggs, PhD.
- Improving Outcomes for the Underserved – The Role of Integrated Primary Care August 2014
Dennis Freeman, PhD.
- Cannabis, Prescription Drugs, and Legal Highs – Research on Drugs of
Evolving or Mixed Legal Status August 2014
Matthew Johnson, PhD.
- Evidence-Based Treatments for PTSD in Veteran Populations: Clinical
and Integrative Perspectives March 2014
David Beil-Adaskin, PsyD.
- Primary Care Behavioral Health September 2013
Brian Sandoval, PsyD. & Juliette Cutts, PsyD.

Diversity Training

- African American History, Culture, and Addictions & Mental
Health Treatment January 2013
Danette Haynes, LCSW and Marcus Sharpe, PsyD.
- Afrocentric Approaches to Clinical Practice January 2013
Danette C. Haynes, LCSW and Marcus Sharpe, PsyD.

Assessment Training

- Learning Disabilities: A Neuropsychological Perspective
Tabitha Becker, PsyD. October 2014
- Understanding, Assessing, and Treating ADHD in Children
Erika Doty, PsyD. October 2014
- Using Tests of Effort in Psychological Assessment
Paul Green, PhD. May 2013
- Assessing Mild Cognitive Impairment and Dementia
Mark Bondi, PhD., ABPP May 2013

Other Related Trainings

- Managing Emerging Sexuality in Therapy
Joy Mauldin, PsyD. October 2015
- The Benefits of a Grief and Loss Program With a Unique Technological Intervention
Elizabeth Hamilton, PhD. August 2015
- “Face Time” in an Age of Technological Attachment
Doreen Dodgen-Magee, PsyD. November 2014
- Religion – Boon or Bane for Women?
Louise Silverstein, PhD. August 2014
- DSM 5: Essential Changes in Form & Function
Jeri Turgesen, PsyD. and Mary Peterson, PhD., ABPP January 2014
- The Person of the Therapist
Brooke Kuhnhausen, PsyD. March 2013

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