1-1-2010

Program evaluation of integrated primary care in two primary care clinics

Jeri Turgesen
George Fox University

This research is a product of the Doctor of Psychology (PsyD) program at George Fox University. Find out more about the program.

Recommended Citation
http://digitalcommons.georgefox.edu/psyd/95

This Dissertation is brought to you for free and open access by the Psychology at Digital Commons @ George Fox University. It has been accepted for inclusion in Doctor of Psychology (PsyD) by an authorized administrator of Digital Commons @ George Fox University.
Program Evaluation of Integrated Primary Care in Two Primary Care Clinics

by

Jeri Turgesen

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

Newberg, Oregon
May 3, 2010
Program Evaluation of Integrated Primary Care in Two Primary Care Clinics

Jeri Nicole Turgesen, MA

has been approved

at the

Graduate School of Clinical Psychology

George Fox University

As a Dissertation for the PsyD degree

Approval

Signatures:

Mary Peterson, PhD, Chair

Kathleen Gathercoal, PhD

Clark Campbell, PhD

Date: 5/3/2010
Primary care physicians are on the front line of patient intervention, and treat conditions ranging from the physical to the psychological on a daily basis. With their primary training focused on biological issues, physicians may be ill equipped when presented with psychological or mental health problems. The integration of a Behavioral Health Consultant (BHC) into the primary care setting can help to bridge the gap between the physical and the psychological, allowing for a more comprehensive biopsychosocial approach to patient treatment. Two primary care medical clinics have recently collaborated in the establishment of an integrative primary care program utilizing Behavioral Health Consultants. Based on the overall results it was found that brief short-term therapy within the medical setting is an effective method for providing services to patients. The results indicated a significant change and reduction in patients’ perceived level of distress, and significantly improved their global perception of overall wellbeing as well as high levels of both patient and physician satisfaction.
# Table of Contents

Approval Page ........................................................................................................... ii

Abstract ..................................................................................................................... iii

List of Tables ............................................................................................................. vi

Acknowledgments .................................................................................................... vii

Chapter 1: Introduction ............................................................................................ 1

Program Evaluation of Integrated Primary Care in Two Primary Care Clinics .......... 1

Models of Treatment ............................................................................................... 3

Benefits of the Behavioral Health Consultant ....................................................... 4

Initiation of Behavioral Health Consultation Services in Two Primary Care Clinics.... 7

Program Evaluation ............................................................................................... 8

Chapter 2: Methods ................................................................................................. 9

Procedures .............................................................................................................. 9

Measures ................................................................................................................. 10

Chapter 3: Results ................................................................................................ 12

Descriptive Statistics ............................................................................................. 12

Efficacy of Integrated Primary Care ....................................................................... 12

Patient Satisfaction ................................................................................................. 13

Physician Satisfaction ............................................................................................ 14

Chapter 4: Discussion ............................................................................................ 17

References ............................................................................................................. 21

Appendix A Instruments Utilized ........................................................................... 25
Appendix B  Curriculum Vita .............................................................. 33
Table of Tables

Table 1  Correlations Contributing to Total Patient Satisfaction ......................................................... 14

Table 2  Significant Predictors of Patient Satisfaction ............................................................................ 14
Acknowledgments

My hope and sincere goal is to adequately thank all of those who have been so willing to join with me and stand by my side throughout this journey of growth, development and self-discovery. To simply say thank you does not seem sufficient enough and I am not sure there are words to adequately express the deep appreciation I feel for each and every one of you. To all of my family, friends and those who have lent support in a variety of ways, I am truly grateful. Without you this process would not have been the rich experience of growth that it has been, I am so honored to have had all of you be a part of my process and thank you profusely for your unwavering support and encouragement throughout this journey.

Specifically to Dr. Mary Peterson I would like to express my upmost thanks and respect. Your guidance, support, mentorship and constructive feedback have resulted in the growth and development of the professional I am becoming. I have been honored to have your mentorship and encouragement throughout this journey and I can truly say I would not be where I am today were it not for your focus and emphasis on both my personal and professional growth and training, all of which has been invaluable.

To John, you more than anyone have sacrificed during this process. Thank you so much for your constant presence, support, encouragement and cheerleading as we have moved throughout this journey together. Your excitement and support for my ambitions combined with your unwavering love have kept me grounded while allowing me to simultaneously push forward and explore my passions. I love you and cannot thank you enough for the person you are and the partnership we have.
Chapter 1

Introduction

Program Evaluation of Integrated Primary Care in Two Primary Care Clinics

Primary care physicians are on the front line of patient intervention, and treat conditions ranging from the physical to the psychological on a daily basis. With their primary training focused on biological issues, physicians may be ill equipped when presented with psychological or mental health problems. However, up to 70% of the medical appointments made with a primary care physician are for problems stemming from psychosocial issues (Gatchel & Oordt, 2003). Additionally, primary care physicians provide 67% of all psychotropic medications and 90% of the 10 most common complaints in primary care have no organic basis (James, 2006).

Currently our health care system is arranged in such a manner that patients are required to go to one location to receive services for their physical problems and a separate location for their psychological, mental and behavioral problems. This dichotomy between mental and physical health can lead to sub-optimal treatment of either of these areas, both of which are integral to a patient’s well being and experience.

The physical split that exists between the locations for treatment of physical health and the treatment of mental health is a graphic representation of the Cartesian philosophy that underlies both previous and current methods of providing treatment. The belief maintained in the medical community is that the physical and the mental are two distinct entities of an individual. Physical problems are one realm of an individual’s health, and are treated by medical doctors
utilizing a biomedical approach. Alternatively, the patient’s psychological or mental issues are a distinct category and are treated by a mental health professional utilizing a psychosocial approach to health (McDaniel, Campbell, & Seaburn, 1995). These distinctions between physical and mental health have interfered with a holistic approach to patient treatment.

The biopsychosocial model, developed by Engel (1977), was developed specifically to combat this separation, and aid treatment providers in viewing the individual as a whole entity. His work helped to move the medical field from the biomedical to the biopsychosocial. Each of these separate components can have an impact on the health and well being of the individual, and each should be taken into consideration when providing services and treatment. Miller, Hall, and Hunley (2004) described the importance of an integrative approach to health care and its necessity in providing comprehensive treatment for a client’s problems,

The health and mental health problems of our clients/patients cannot be understood separately or in parts. It is only through collaborative dialogue between physicians and mental health practitioners that a whole picture emerges and directions evolve for the most effective treatment of our clients/patients (p. 117).

Primary care physicians are trained to treat their patients’ medical disorders, although the fast-paced nature of primary care clinics provides limited opportunities to assess and treat mental health problems. There is even less opportunity to educate patients about the interaction between mental and physical health and the potential impact on their health and well-being. In order to successfully implement the biopsychosocial model of treatment and intervention full integration and collaboration are necessary (Gatchel & Oordt, 2003).
Models of Treatment

Models of treatment and intervention fall along a continuum, with separate specialty clinics on one end, and fully integrated models of treatment on the other. Traditional models of treatment and intervention for mental health problems have centered on the independent psychologist model. This model is the traditional model in which psychological services are provided independent of, and in a different location than, the physical health services. The mental health provider is able to provide services to a small percentage of clients and many clients who need services may never follow through on referrals or present for treatment, as they remain trapped in the belief that their psychological functioning has no impact on their physical health and well-being (Robinson & Reiter, 2007). Furthermore, treatment barriers including cost, location, and health plan coverage may limit access to mental health care.

A subtype of the Independent Practitioner model is the co-location model; psychologists and physicians provide distinct services while operating out of the same building or facility. Despite the close proximity, there is very little interaction in the provision of services. Similar to the independent model, physicians may refer clients to the psychologist, who takes over care for the client at that point. The client may choose not to follow through with the referral to the psychologist, again believing that they do not need to see someone independent of the physician for the treatment of their specific issue or problem (Gatchel & Oordt, 2003).

Similar to the co-location model is the Psychologist as Primary Care Provider Model (Gatchel & Oordt, 2003). This model places a psychologist within a primary care clinic operating within the same office; physicians are then able to refer their clients to the psychologist who takes over treatment at that point. The care received by patients is similar to the kind of care
received at an outpatient or health psychology center, as the psychologist is still an independent provider. Co-location without collaboration is not equivalent to integrated care, and is an insufficient model of care (James & Folen, 2005).

An alternative method for providing services is the primary care behavioral health model, utilizing a Behavioral Health Consultant (BHC). This model allows physicians and mental health providers to work side by side, often sharing an office or exam room, in order to provide comprehensive care for clients (Robinson & Reiter, 2007). The term BHC refers to any behavioral health provider who works in a consultative role with physicians, and provides recommendations and service support for both behavioral interventions and psychotropic medications. The BHC works to provide second-tier support to the physician providing more specialized knowledge and aiding in the development of a well-rounded treatment plan, ensuring the patient receives comprehensive biopsychosocial care (James & Folen, 2005). This co-location and high level of integration allows the physician to introduce the psychologist as an expert and colleague who can be vital in the treatment of the client. The strong reinforcement from the physician and treatment in a familiar facility may alleviate some hesitancy the client may have about seeing an individual for a problem related to their mental health (Gatchel & Oordt, 2003). Integrating mental health specialists into the primary care setting is an efficient and effective way for bridging the gap between the biomedical and psychosocial realms and effectively treating patients utilizing a biopsychosocial approach.

**Benefits of the Behavioral Health Consultant**

The primary care model utilizing a BHC is focused towards collaborative work, supporting the primary care physician. The goal is to intervene at an earlier point within the
mental health continuum. Having earlier contact with the patient in a location where they are familiar, allows for earlier recognition and treatment of mental health symptoms, thereby lessening the impact on an individual’s overall functioning. This early intervention can ultimately help reduce the duration and intensity of symptoms (James & Folen, 2005). By incorporating psychologists into the primary care setting the quality and overall coordination of services are greatly enhanced for the patient (James, 2006).

Developing effective collaboration between physicians and psychologists optimizes patient care. With the traditional approach to primary and specialty levels of care, physicians are often left frustrated by the lack of feedback and response regarding their patients and the services that are being received, in addition to the lack of follow through by patients in establishing appointments when referred to secondary levels of treatment. Effective collaboration and dialogue between physicians and psychologists is essential for a comprehensive approach to understanding the client’s problems and developing an effective treatment plan which will adequately direct the most effective treatment (Miller et al., 2004).

The integrated model of care has yielded a variety of positive outcomes for patients, physicians and mental health providers. Patients report greater levels of satisfaction with integrated models due to the decrease in stigma from receiving services at a medical center rather than a mental health clinic (Chen et al., 2006; Miller et al., 2004). Integration of a mental health provider in to the primary care setting allows the patient to receive all their treatment in one location, reduces the stigma of going to a separate facility for mental health treatment, and allows the physician to emphasize the role of mental health in the overall health and well-being for clients (Abrahams & Udwin, 2002). Additionally, the single location and collaboration
between health care providers dramatically increases the number of individuals who do receive the necessary mental health to nearly 90\% (Speer & Schneider, 2003).

Having a mental health professional collaborate in patient care helps to ensure that patients receive the proper diagnosis and treatment. The majority of individuals who present to primary care physicians have at least one diagnosable mental health problem. Limited training and time to assess mental health problems may lead to misdiagnosis or the attribution of psychiatric symptoms to physical conditions (Karin & Fuller, 2007). The combination of services in the integrated model leads to greater detection and diagnostic accuracy, allowing for proper treatment and patient care (Bartels et al, 2004). Physicians and behavioral health providers are able to share diagnostic impressions, collaborate on treatment goals and treatment planning, and ensure that a cohesive treatment plan is developed from multiple perspectives to ensure the patients’ overall health and improvement are reached. This model ensures that the interaction between physical and mental health is attended to, and the patient is treated from the comprehensive biopsychosocial model, shown to enhance clinical and functional outcomes (Hedrick et al., 2003).

Additionally, working from a comprehensive biopsychosocial model in which patients can receive all their care from one location may work to reduce the overall stigma in our society that is attributed to mental health concerns. In this model mental health is seen as an additional component that is valued by the primary care physician, and understood to be a contributor to overall health and wellbeing. With this model and attitude, patients are more likely to accept and understand that mental health is an integral part to overall health (Zeiss & Karlin, 2008).
Initiation of Behavioral Health Consultation Services in Two Primary Care Clinics

With the benefits that have been demonstrated through the integration of mental health providers into the field of primary care, two primary care clinics located in a rural area agreed to participate in a pilot project integrating advanced doctoral students in clinical psychology into the primary care centers at two outpatient clinics. These students worked collaboratively with primary care physicians to ensure that patients are receiving treatment for a variety of mental and behavioral health concerns. Descriptive data was collected during the initial four months of the program’s operation, and indicated that the BHCs are accessing patients at a variety of levels with a variety of treatment needs. During the program’s initial 4-month time of operation a total of 124 patients received consultation services, with each patient averaging 3.39 sessions, totaling 420 consultation appointments. Of those individuals referred for services, 37% were referred for anxiety, 38% for depression, 8% for pain and 17% for other reasons. Of those individuals referred for services the majority, 72%, were women and 28% were male. The average age range was between 4 and 93 years of age, with an average age of 42 (M. Peterson, personal communication, March 2009).

Given the limited time that the Behavioral Health Consultation Services program has been in operation, the focus has been on development and physician education in how the program can be utilized, and no outcome or satisfaction data has been collected. Now that the program has been well established and is running smoothly, it is time for a full program evaluation, including outcome and satisfaction of both patients and physicians.
Program Evaluation

The purpose of this study is to evaluate the Integrative Primary Care Behavioral Health Program at two private primary care clinics. The effectiveness and benefits of this model have been demonstrated in a variety of areas including patient benefits, physician benefits and service benefits, those three areas will be key areas of consideration in evaluating the programs movement towards an effective model for integrative health. Research has demonstrated that integrating psychologists into the primary care system is an effective method for bringing comprehensive biopsychosocial treatment planning and implementation to patients. It was hypothesized that the Integrative Behavioral Health Program in the primary care clinics would be an effective program resulting in an improved sense of global wellbeing for the patient. The patients’ satisfaction will be related to improved wellbeing, rapport with therapist, ease of scheduling appointments, understanding the nature of the relationship and care, as well as relevance to diagnosis and work with PCP. Finally, physician satisfaction with the integrated primary care program will depend on patient improvement, patient satisfaction, ease of referral, frequency of communication and relevancy to the physician treatment objectives. Physicians will also be surveyed as to their perceptions regarding potential barriers to referring their clients for integrated mental health services.
Chapter 2

Methods

Procedures

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. All participants were current, active patients within the primary care clinic’s Newberg and Sherwood centers. Participants were identified by their primary care physicians as individuals who were likely to benefit from behavioral health interventions and were provided with a referral for services. All individual’s received 30-minute sessions utilizing evidence based treatment practices, which were provided at no cost to patients. At the patients’ initial appointment with the BHC, the Outcome Rating Scale, Session Rating Scale and the informed consent document were completed. Those children younger than age 12 completed the Child Outcome Rating Scale in place of the Outcome Rating Scale. The BHC, a graduate student intern in clinical psychology, then provided the appropriate evidence based treatment for the prescribed number of sessions. At the final appointment, the patient again completed the Outcome Rating Scale, the Session Rating Scale and the Patient Satisfaction Survey; the Child Outcome Rating Scale was again substituted for those children younger than age 12.

Following patient data collection, the Physician Satisfaction Survey was distributed to the clinic primary care physicians during their weekly provider meetings. Following the meeting, the
surveys were collected and returned to the researcher by the clinic manager, allowing for anonymous responses by the PCPs.

**Measures**

The Talking Cure Outcome Rating Scale (ORS; Appendix A) and Session Rating Scale (SRS; Appendix A) are brief visual, analogue self-report surveys that were adapted for their use in this study. Developed as an alternative to the lengthy Outcome Questionnaire 45.2 (OQ-45.2; Lambert, Hansen, et al., 1996), the ORS draws from areas related to client functioning, specifically individual, relational and social functioning. The correlation between the ORS and the OQ-45.2 is .59 indicating a moderate level of concurrent validity. This modest correlation indicates the ORS is an acceptable ultra-brief alternative for assessing an individual’s global level of distress; similar to the results obtained in the full-scale score for the OQ-45.2 (Bringhurst, Watson, Miller, & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS has a test-retest reliability of .97 (Bringhurst et al., 2006).

Additionally the ORS is available in a young child format. The Child Outcome Rating Scale (CORS; Appendix A) was designed in a similar format to the ORS for children aged six to twelve. The CORS was correlated with the Youth Outcome Questionnaire 2.0 (YOQ-2.0) a widely used measure of global distress in youth with sound psychometric properties (Burlingame et al., 2001). Duncan, Sparks, Miller, Bohanske, and Claud (2006) found moderate concurrent validity between the CORS and the YOQ-2.0 and a Pearson product moment correlation of .61, indicating the CORS is an acceptable measure of global distress in youth. CORS has a strong internal reliability of .84 (Duncan, et al., 2006).
The SRS is seen as a global measure of patient therapist alliance (Duncan et al., 2003). The SRS was developed based on four theoretical tenets, three of which were derived from Bordin (1979, as cited in Duncan et al. 2003). These three tenets include the development of a relational bond between the therapist and client, agreement on therapeutic goals and agreements on the tasks to be completed in therapy. The fourth item reflects the results of a factor analysis of commonly utilized measures of therapeutic alliance; in the results of their study Hatcher and Barens (1996, as cited in Duncan et al., 2003) determined a common underlying factor of the client’s confidence in the therapist’s approach. Concurrent validity was established utilizing the Helping Alliance Questionnaire II (HAQ-II; Luborsky et al., 1996), a significant correlation of .48 was found. Although small, it indicates the SRS is a brief alternative for measuring global therapeutic alliance (Duncan et al., 2003). The SRS has a test-retest reliability of .64 (Duncan et al., 2003).

Similarly to the CORS, the SRS is available in a young child format. The Child Session Rating Scale (CSRS; Appendix A) was designed in a similar format to the SRS for children aged six to twelve. Despite its similarity to the SRS, the reliability and validity for CSRS has not yet been well established.

A Patient Satisfaction Survey (Appendix A) was developed to gain insight into the referred patients’ likes and dislikes with the Integrated Behavioral Health Program. Questions centered on the patient’s beliefs regarding treatment efficacy, the nature of their relationship with the BHC, and likelihood to utilize the services again. Similarly, a Physician Satisfaction Survey (Appendix A) was developed to gain insight into barriers of physician referral and beliefs regarding treatment efficacy and benefits seen from clients.
Chapter 3

Results

Descriptive Statistics

The first 20 patients referred to the Behavioral Health Consultation Program were included in this initial program evaluation. Participants included 9 males and 11 females ranging in age from 8 to 92 with a mean age of 48.3 ($sd = 24.4$). The number of sessions ranged from 2 sessions to 9 sessions with a mean 5.4 sessions ($sd = 1.9$). Patients were referred for a variety of reasons primarily depression ($n = 9$), anxiety ($n = 7$) and other ($n = 4$; including substance abuse, eating disorders and behavioral difficulties).

Efficacy of Integrated Primary Care

A paired samples t-test was conducted to compare patient means on the ORS conducted at the initial session with the ORS completed at the patients’ final session. The mean on the initial ORS was 14.9 ($sd = 9.5$) and the mean on the final ORS was 29.5 ($sd = 7.0$). A significant increase from the patients’ first session to final session was found [$t(19) = 6.5, p < .001$]. This calculation had an observed power of 1.0 and a Cohen’s $d$ effect size of 1.7. There was not a significant change between the initial SRS score and the Final SRS score ($p > .05$). Similar to previous studies (Kolbasovsky, Reich, Romano & Jaramillo, 2005; Felker et al., 2004), the results indicate that integrated primary care is an effective method for providing mental health services to patients, resulting in an improved sense of global wellbeing. The lack of change in SRS was expected due to the high ceiling on the measure (Miller & Duncan, 2004). It was
expected that a positive therapeutic rapport and relationship would be established with the patient during the initial session and maintained throughout treatment.

**Patient Satisfaction**

Patients completed the Patient Satisfaction Survey in the final session, yielding a response rate of 100%. Total scores on the Patient Satisfaction Scale ranged from 38 to 55 with a mean score of 50.1 ($sd = 5.0$), a maximum score of 55 was possible. A Pearson correlation coefficient was calculated to determine those factors correlated with the participant’s overall satisfaction with the program based on their total score for the patient satisfaction survey, see Table 1. A moderate positive relationship was found between an individual’s age and their overall level of satisfaction $[r(18) = .54, p < .05]$, indicating a significant linear relationship between the two variables. As a patient’s age increases, so does their satisfaction with the overall program.

Additionally a strong positive correlation was found between an individual’s overall satisfaction with the program and their total score on the SRS at both the first $[r(18) = .89, p < .001]$ and last session $[r(18) = .86, p < .001]$, indicating a significant linear relationship between the two variables. Those individual’s who experienced positive global therapeutic alliance indicated greater satisfaction with the program. These results replicate previous findings that general therapeutic factors have a greater impact on an individual’s satisfaction with treatment, more so than symptom reduction (Lambert & Barley, 2001; Norcross, 2002).

A stepwise linear regression was calculated to determine which of the variables that initially correlated with patient satisfaction yielded the best overall prediction. A significant regression model was found $[f(2, 15) = 38.65, p < .001]$ with an adjusted $R^2$ of .816. Both the
Table 1

**Correlations Contributing to Total Patient Satisfaction**

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Beta</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRS Total, First Session</td>
<td>.56</td>
<td>$p = .006$</td>
</tr>
<tr>
<td>SRS Total, Last Session</td>
<td>.40</td>
<td>$p = .035$</td>
</tr>
</tbody>
</table>

SRS score at the initial session and the SRS score at the final session were significant predictors of patient satisfaction, see Table 2. Indicating that patient perception of global therapeutic alliance at both the first and last session account for 81.6% of the variance in overall patient satisfaction.

Table 2

**Significant Predictors of Patient Satisfaction**

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Beta</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRS Total, First Session</td>
<td>.56</td>
<td>.006</td>
</tr>
<tr>
<td>SRS Total, Last Session</td>
<td>.40</td>
<td>.035</td>
</tr>
</tbody>
</table>

**Physician Satisfaction**

Nineteen out of 21 physicians responded to the Physician Satisfaction Survey, resulting in a response rate of 90.5%. Total scores on the Physician Satisfaction Surveys ranged from 28 to
35 with a mean score of 32.89 (sd = 1.97), a maximum score of 35 was possible. Descriptive statistics were calculated for each of the questions related to physician satisfaction. One hundred percent of physicians were satisfied or very satisfied with their overall experience integrating behavioral health services into the medical setting. One hundred percent of physicians agreed or strongly agreed that the services their patients received through the behavioral health program were beneficial, supported their treatment plans and that they received timely follow-up from the BHC. One hundred percent of physicians agreed or strongly agreed that their patients believe the services are beneficial. Fifty-eight percent of physicians agreed or strongly agreed that they had learned new treatment techniques through their work with the behavioral health consultants and 100% of physicians agreed or strongly agreed that they would recommend having behavioral health consultation services to their colleagues. These initial results indicate that overall physicians find the behavioral health services to be practical and beneficial to their patients and that this community of physicians is open to the continued integration of mental health into the medical setting, resulting in comprehensive biopsychosocial treatment for patients.

Physicians were also surveyed to determine potential barriers that may occur when referring their clients for integrated behavioral health services. Few potential barriers were identified. Specifically, 100% of physicians endorsed that finding a BHC at the time of referral was not a barrier, all physicians reported being comfortable with the referral process, and none of the physicians were concerned that they would alienate their patients by providing a referral to the BHC. A minority of physicians (15.8%) reported that having a therapist outside the clinic, or making multiple referrals for the same problem would be a barrier to their referring a patient. These results indicate that physicians are open and interested in referring their patients for
additional help and services, and based on the items surveyed, do not see barriers to referring their patients or encouraging their patients to utilize the mental health services available within the clinic.
Chapter 4

Discussion

This study was designed as a program evaluation to examine the effectiveness of integrating behavioral health consultants into the medical setting at two private primary care clinics. Based on the overall results it was found that brief short-term therapy within the medical setting is an effective method for providing services to patients. The results indicated a significant change and reduction in patients’ perceived level of distress, and significantly improved their global perception of overall wellbeing, as well as demonstrated high levels of global therapeutic alliance and patient satisfaction. This study has helped to further validate previous findings indicating that an integrated setting allows for the interaction between physical and mental health resulting in a comprehensive biopsychosocial model, which has been shown to enhance clinical and functional outcomes (Hedrick et al., 2003). Also, the incorporation of psychologists into the primary care setting improves the quality of services, and greatly enhances the overall coordination of services for the patient (James, 2006).

Patients reported high levels of satisfaction with the program, as measured by the Patient Satisfaction Survey, and a strong sense of global therapeutic alliance, as measured by the SRS. Overall, patient perception of their level of rapport and relationship with the therapist had the greatest impact on patient satisfaction. These findings are consistent with other literature, which has indicated that the global therapeutic factors are the greatest predictors of therapeutic
outcome, rather than symptom reduction as may typically be expected. Lambert and Barley (2001) outlined those variables that have been found to contribute to overall outcome in therapy, including techniques (accounting for approximately 15%), common factors (approximately 30%), expectancy effects (approximately 15%) and extratherapeutic change (approximately 40%). Of those factors that are within the control of the therapist, the common factors including the therapeutic relationship have the greatest impact on overall outcome. The high ratings on the SRS also indicate that it is possible to develop and maintain a strong therapeutic alliance despite the fast-paced nature of the medical setting and shortened clinical contact time of 30 minutes. A therapist’s ability to develop and maintain a positive alliance with their client throughout the therapeutic relationship has been found to be the primary component to therapy resulting in improved outcome for the client. It also forms the foundation in which one is able to effectively utilize those therapeutic techniques to further promote the overall wellbeing of the client (Lambert & Barley, 2001; Norcross, 2002).

The primary care physicians also demonstrated a high level of satisfaction with the integration of care and the benefits they are seeing in their patients’ overall wellbeing and the relevance behavioral health services have to their treatment plans. Their response related to overall satisfaction with the program and the strong recommendation that their colleagues work with an integrated mental health provider, further indicates that this group of primary care physicians are satisfied with the provision of services. The results suggest the primary care physicians are comfortable overcoming the Cartesian philosophy and mind/body split that has typically dominated the medical field, resulting in the relative isolation of mental health services outside of the medial model. These findings are similar to previous results found by Miller et al.
in which physicians and psychologists were surveyed in regards to their beliefs surrounding the need to integrate mental health and medical services. Their results found a high percentage of both physicians and psychologists believed regular collaboration between the professions to be positive.

The positive implications of this study are further highlighted by the use of supervised graduate level students currently training within the field of psychology, as opposed to the use of seasoned professionals with multiple years of experience in assessment and intervention. Despite the student status of the BHCs in this study, they were able to establish and maintain strong therapeutic alliances with the patients and utilize effective evidence based interventions, which ultimately contributed to an improvement in the patients’ global perception of wellbeing and a high level of overall patient satisfaction. The effectiveness that has been demonstrated by this study, through the use of graduate students works to further contribute to the pool of psychologists trained to work effectively within the primary care setting.

This study has limitations in design, primarily related to the use of a pre/post model as opposed to utilizing a separate control group with random assignment. The use of a control group in further research would help to further establish the overall effectiveness of the integrated model and decrease the self-selection bias with those patients who are interested in BHC services being the most likely to follow-up with the referral, treatment and interventions.

Further research within the area of integrated primary care should continue to look at firm markers of overall improvement for both the patient and the medical setting. Patient improvement could be monitored by the measurement of physiological markers in order to empirically track a patient’s symptom reduction as the result of the treatment intervention and
use of a behavioral health consultant. At an institutional level, measuring areas of cost offset that are present as a result of the integrated model and increased comprehensive care that patients are receiving could further the evidence and support for this model to be incorporated into increased treatment centers and facilities. Additionally, longitudinal research is an important area to consider in order to evaluate the long-term effects this model of treatment and intervention may have for patients.

Integrative mental health services is a new and rapidly growing area within the field of psychology that is working to extend services to a greater number of patients who might not normally receive services. This study corroborates other research, indicating that there is an opening for psychologists to enter into the medical field and assist with the shift towards a truly biopsychosocial approach and model of treatment, providing short-term, effective services within the medical setting while simultaneously still being able to develop a positive connection and relationship with both the patients who are being served and the physicians who are caring for them.
References


Appendix A

Instruments Utilized
**Outcome Rating Scale (ORS)**

<table>
<thead>
<tr>
<th>Name ________________________</th>
<th>Age (Yrs):____</th>
<th>Sex: M / F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session # ____</td>
<td>Date: ________________________</td>
<td></td>
</tr>
<tr>
<td>If other, what is your relationship to this person? ____________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**Individually**
(Personal well-being)

| I-------------------------------I |

**Interpersonally**
(Family, close relationships)

| I-------------------------------I |

**Socially**
(Work, school, friendships)

| I-------------------------------I |

**Overall**
(General sense of well-being)

| I-------------------------------I |

Institute for the Study of Therapeutic Change

www.talkingcure.com

© 2000, Scott D. Miller and Barry L. Duncan
Session Rating Scale (SRS V.3.0)

Name ________________________ Age (Yrs):____
ID# _________________________ Sex:  M / F
Session # ____  Date: ________________________

Please rate today’s session by placing a mark on the line nearest to the description that best fits your experience.

**Relationship**

I did not feel heard, understood, and respected. I---------------------------------------------I
I felt heard, understood, and respected.

**Goals and Topics**

We did not work on or talk about what I wanted to work on and I---------------------------------------------I
We worked on and talked about what I wanted to work on and talk about.

**Approach or Method**

The therapist’s approach is not a good fit for me. I---------------------------------------------I
The therapist’s approach is a good fit for me.

**Overall**

There was something missing in the session today. I---------------------------------------------I
Overall, today’s session was right for me.

Institute for the Study of Therapeutic Change

www.talkingcure.com

© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson
Child Outcome Rating Scale (CORS)

Name ________________________ Age (Yrs):____

Sex:  M / F_____________

Session # ___  Date: ________________________

Who is filling out this form? Please check one:   Child______ Caretaker_______

If caretaker, what is your relationship to this child? ____________________________

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

Me
(How am I doing?)

I-----------------------------------------------------------------------I

Family
(How are things in my family?)

I-----------------------------------------------------------------------I

School
(How am I doing at school?)

I-----------------------------------------------------------------------I

Everything
(How is everything going?)

I-----------------------------------------------------------------------I

Institute for the Study of Therapeutic Change

www.talkingcure.com

© 2003, Barry L. Duncan, Scott D. Miller, & Jacqueline A. Sparks
Child Session Rating Scale (CSRS)

Name ________________________ Age (Yrs): ____
Sex: M / F
Session # ____ Date: ________________________

How was our time together today? Please put a mark on the lines below to let us know how you feel.

---

Listening
---

I---------------------------------------------------------------I

I listened to me.

I---------------------------------------------------------------I

I did not always listen to me.

How Important
---

I---------------------------------------------------------------I

What we did and talked about were important to me.

I---------------------------------------------------------------I

What we did and talked about was not really that important to me.

What We Did
---

I---------------------------------------------------------------I

I liked what we did today.

I---------------------------------------------------------------I

I did not like what we did today.

Overall
---

I---------------------------------------------------------------I

I hope we do the same kind of things next time.

I wish we could do something different.

Institute for the Study of Therapeutic Change

www.talkingcure.com

© 2003, Barry L. Duncan, Scott D. Miller, Jacqueline A. Sparks
### Patient Satisfaction Survey

1. The BHC seemed warm, supportive, and caring
   
<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. The BHC treated me with respect

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. The BHC did a good job of listening

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. I discussed problems that bother me

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. I felt comfortable discussing those areas of my life that bother me

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. The approach we used made sense to me

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. BHC’s explanation of my care was understandable

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. I learned new ways to deal with my problems

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. I believe the BHC has good ideas for me

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. I intend to use what I learned in the visit

    | 1 | 2 | 3 | 4 | 5 |
    |---|---|---|---|---|
    | Strongly Disagree | Neutral | Strongly Agree |

11. Overall I would rate my experience with the BHC

    | 1 | 2 | 3 | 4 | 5 |
    |---|---|---|---|---|
    | Very Negative | Neutral | Very Positive |

Questions adapted from Lang et al., 2005 and Robinson & Reiter, 2007
Physician Satisfaction Survey

1. Rate your overall experience with the Integrated Primary Care program at Providence

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Dissatisfied</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. I believe the Behavioral Health Consultation (BHC) services provided are beneficial to my patients

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. My patients believe the BHC services are beneficial

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. I believe the BHC has good ideas to support my treatment plan

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. I received timely follow up and consultation from the BHC regarding my patient

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. I have learned new treatment techniques from working with the BHC

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. I would recommend having integrated behavioral health consultation services to my colleagues

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. I have found the following areas to be potential barriers to my referring patients to BHC services

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Neutral</td>
<td>Strongly Agree</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Some questions taken from *Behavioral Consultation and Primary Care A Guide to Integrating Services*, Robinson & Reiter 2007
Informed Consent for Participation

The BHC program is a new service offered by PMG. We are asking you to fill out this survey because we would like your feedback about this service.

Your participation in this survey is voluntary. You can stop taking the survey at any time. If you stop, you will still receive BHC services. We are asking you to take two short surveys at your first session and three at your last session. The surveys will give us information that will help us to improve the service.

Your name won’t be on this survey and any other information (age, gender, race) will not be associated with you. All of the survey responses will be kept confidential. The information will be stored in an electronic file. The survey responses will be used as part of a Doctoral Dissertation for a student in the GDCP at George Fox University. The survey is looking at the helpfulness of BHC services. These results may be published in an academic journal or used in further academic research. The only descriptive information that may be reported will be gender, age, reason for referral and referral source.

Your signature will show your agreement to fill out the surveys for this research project. We appreciate your participation. If you would like a copy of the final results, please let us know how you would like to receive the information (postal service or email.) If you have any questions, please contact me, Jeri Turgesen M.A. at 503-554-2370 or my dissertation research advisor, Dr. Mary Peterson, PhD at 503-554-2377.

Jeri Turgesen, MA
Doctoral Candidate

Mary Peterson, PhD
Associate Professor of Clinical Psychology

Signature of participant: ___________________ Date ____________
Appendix B

Curriculum Vita
EDUCATION

2007-present George Fox University Newberg, OR
- Graduate Department of Clinical Psychology: APA Accredited
- Currently a student in a Doctorate of Clinical Psychology program
  - GPA 3.94 on a 4.0 scale
  - Masters Conferred May 2009
  - Doctorate expected 2012

2006-2007 Lewis and Clark College Portland, OR
- Took classes towards a Masters in Counseling Psychology with an emphasis in psychological and cultural studies
  - Took part in a cultural exchange program for three weeks in Oaxaca, Mexico.
    - Lived with a host family, took advanced classes at a language institute and visited different social service organizations.
  - GPA 3.91 on a 4.0 scale.

2002-2006 Oregon State University Corvallis, OR
- Bachelor of Arts in Psychology and Spanish
- Graduated Summa Cum Laude June 2006
  - GPA 3.86 on a 4.0 scale.

September-December 2004 Universidad de Cantabria Santander, Spain
- Completed advanced Spanish intensive language courses.
- Gained cultural experience through living with a Spanish host family.

SUPERVISED CLINICAL EXPERIENCE

May 2009-present Providence Newberg Medical Center Newberg, OR
Consultation Team Behavioral Health Intern Consultation Team Coordinator
- Provide 24 hour on call physician consultation and patient assessment services in the Emergency Department, Medical Surgical Unit and the Intensive Care Unit.
- Conduct risk assessments to determine patient safety, risk of self-harm and need for possible psychiatric hospitalization.
June 2009-present Consultation Team Coordinator
- Student coordinator for team, liaison with hospital staff and supervisors. Assist in training for new team members. Provide oversight and additional support as needed.
- Supervisors: Drs. William Buhrow, PhD., Joel Gregor, Psy.D, and Mary Peterson, Ph.D.

April 2009-present Providence Newberg Medical Group Newberg, OR
Behavioral Health Consultant—Primary Care
- Provide individual therapy and behavioral health consultation to patients within an integrated primary care setting.
- Consult with physicians regarding diagnosis, treatment planning, and therapeutic strategies.
- Conduct comprehensive evaluations and assessments.
- Provide long-term outpatient therapy as needed for patients.
- Provide oversight and additional support, as needed for new team members.
- Supervisor: Dr. Mary Peterson, Ph.D.

April 2008-present Salem Hospital Bariatric Surgery Program Salem, OR
Bariatric Support Group Leader
- Provide twice-monthly group therapy for a group of pre and post-operative Bariatric surgery and Lap-band patients.
- Provide psychoeducation and opportunities to process in a supportive a therapeutic setting for individuals regarding their experiences surrounding weight, weight loss, and surgery procedures as well as related lifestyle changes and changes related to psychological and social factors.
- Develop curriculum and support group materials to use in sessions.
- Participate in weekly multidisciplinary meetings with surgeons, dieticians, nurses, and other Salem Hospital Bariatric Program staff to discuss patients’ status, needs, surgery risks and other program related topics.
- Assisted with program coordination and development of documentation to meet certification requirements for Center of Excellence designation.
- Supervisor: Dr. Dale Veith Ph.D.

September 2009-present Providence Newberg Medical Center Newberg, OR
Coordinator of the Providence Newberg Medical Center Pain Management Program
- Facilitate coordination of services and patient referrals between Providence Newberg Medical Center and affiliated George Fox Behavioral Health Services for individual therapy.
- Track utilization of emergency department services by patients presenting for chronic pain.
- Consultation with emergency department physicians regarding chronic pain patients and treatment referrals.
- Continued program development.
- Supervisor: Dr. Mary Peterson, Ph.D.
June 2009-September 2009
- Provided individual therapy for patients with chronic pain.
- Tracked high utilization of emergency department services by individuals with chronic pain.
- Consulted with emergency department physicians regarding diagnosis and treatment strategies for patients with chronic pain.
- Continued program development and streamlined to better track and provide appropriate interventions for those individuals with chronic pain.
- Supervisor: Dr. Mary Peterson, Ph.D.

September 2008-May 2009 New Urban High School Milwaukie, OR
Practicum Student
- Provide individual therapy for adolescents aged 14-21.
- Provide group therapy utilizing Evidence Based Treatment Protocols.
  - Coping and Support Training (CAST)
  - Adolescent Coping With Depression Course
- Participate in multidisciplinary meetings to design Individualized Education Plans, 504 Plans, Functional Behavior Assessments and Behavior Support Plans.
- Provide assessments to determine students’ levels of functioning and their eligibility for special education.
- Supervisors: Dr. Fiorella Kassab Ph.D. and Stacy Rager, M.S.

January 2007-April 2008 George Fox University Newberg, OR
Pre-Practicum Student, Department of Clinical Psychology
- Provided weekly therapy for two undergraduate students.
- Conducted intake interviews, developed treatment plans, wrote formal intake and termination summaries.
- Supervisors: Mary Peterson, Ph.D. and Meg Boden-Alvey, M.A.

RELEVANT TEACHING & ACADEMIC APPOINTMENTS

Fall Semester 2010-present George Fox University Newberg, OR
Teaching Assistant—Clinical Foundations
- Provide individual instructions for three first-year graduate students in the development of clinical skills.
- Review videotapes of simulated psychotherapy sessions.
- Discuss clinical skills, therapeutic responses and role-play in both small group and individual settings.

Spring Semester 2010 George Fox University Newberg, OR
Teaching Assistant—Advanced Statistics and Research Design
- Edited and provided feedback on student research papers including introduction sections and the development of methods sections.
Met with students individually to discuss research projects and fine-tuning of documents.
Guest lectured on ethical guidelines of research established by the American Psychological Association and the development of informed consent documents.

Fall Semester 2009  George Fox University  Newberg, OR
*Teaching Assistant—Health Psychology*
- Assisted with administration of classroom assignments.
- Guest lectured on use of outcome measures in the primary care setting.

May 2009  Providence Newberg Medical Center  Newberg, OR
*Lecturer—Recognition of Abuse in the Healthcare Setting*
- Required Continuing Education Seminar for all nursing staff
- Educational Seminar provided on 3 occasions.
- Discussed recognition, identification, risk factors and interventions for Child Abuse, Elder Abuse, Domestic Violence and Horizontal Violence.

**TRAINING IN SUPERVISION**

Fall 2010-present  George Fox University  Newberg, OR
*TA Clinical Foundations*
- Provide formative feedback for students on the development of therapy skills.
- Discuss clinical skills, therapeutic responses and role-play in both small group and individual settings.

Fall 2010-present  George Fox University  Newberg, OR
*Mentor—Second Year Practicum Student*
- Provide one-on-one mentoring for a second year student.
- Facilitation of development of clinical skills.
- Work regarding self-awareness and professional development.

Fall 2009, Fall 2010  Providence Newberg Medical Center  Newberg, OR
*Supervisor—Depression Recovery Group*
- Supervised four first year graduate students in the provision of an 8-week psychoeducational group for depression.
- Instruction in group dynamics, group management and appropriate self-disclosure.

**RESEARCH**

*Dissertation*
- Final defense completed May 3, 2010.
Publications


Symposium Presentation

Poster Presentations


Richter Grant
Support Group as a mediator for psychosocial variables pre-Bariatric surgery
- Grant awarded spring 2009
- Study continues to be under review at Salem Hospital Human Subjects Review Board.

ADDITIONAL EDUCATIONAL EXPERIENCES

<table>
<thead>
<tr>
<th>January-June 2010</th>
<th>University of Massachusetts Medical School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate Program: Primary Care Behavioral Health</td>
<td></td>
</tr>
</tbody>
</table>
  - A training program through the University of Massachusetts Medical School designed to train behavioral health professionals to work in primary care settings, utilizing the Patient Centered Medical Home model.
  - 36 hours of didactic and interactive training delivered in 6 full-day workshops through an interactive web-portal. |
Coursework includes: Primary Care Culture and Needs; Evidence-based Therapies and Substance Abuse in Primary Care; Child Development and Collaborative Pediatric Practice; Behavioral Health Care for Chronic Illnesses, Care Management and An Overview of Psychotropic Medication in Primary Care; Behavioral Medicine Techniques; Families and Culture in Primary Care

PROFESSIONAL AFFILIATIONS

<table>
<thead>
<tr>
<th>Year</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-present</td>
<td>American Psychological Association—Student Affiliate</td>
</tr>
<tr>
<td>2007-present</td>
<td>Oregon Psychological Association—Student Affiliate</td>
</tr>
<tr>
<td>2008-present</td>
<td>APA Division 38—Health Psychology</td>
</tr>
<tr>
<td>2008-present</td>
<td>APA Division 45—Ethnic and Minority Issues</td>
</tr>
</tbody>
</table>

OTHER EXPERIENCE


College Intern, Migrant Summer School

- Utilized my Spanish skills to communicate effectively with students and parents.
- Frequently worked with and encountered children who suffered from both emotional and social distress.
- Connected with families to develop relationships and work with the children in a family systems context.
- Engaged in opportunity to work closely with an ethnically diverse staff, further enhancing my Spanish skills and cultural sensitivity.