

CCC Functional Assessment: Training Tool

Introductory Script

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| 1–2
Minutes | <ul style="list-style-type: none"> • Describe who you are/role in the clinic* • How long visit will be • What will happen during the visit • Type of follow-up which may occur • Note from visit will go in medical record • PCP will get feedback • Reporting obligations* |
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Assess

10–60 Seconds	<p>Referral Problem <i>Identifies and/or clarifies the presenting problem*</i></p>
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12–15 Minutes	<p>History of Problem <i>Asks about duration, frequency, and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem.</i></p>
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Problem Hx (Duration/Frequency/Intensity)

Treatment Hx (Including Med Trials, Adherence, Adverse Reactions):

What Makes the Concern Better/Worse:

Other Problems of Concern to Veteran:

Functional Assessment/Typical Day

Evaluates how presenting problem impacts patient's functioning in all the below areas

Sleep:

Physical:

Work:

ETOH:

Close relationships:

Tobacco:

Family:

Drugs:

Friends:

Caffeine:

Recreation:

Additional Assessment

*Uses/references assessment measures appropriate to primary care (e.g., PHQ9, GAD-7, PCL)**

Clinical reminders:

Measurement-based care

PHQ-9:

GAD-7:

PCL:

BAM/AUDIT-C:

Other:

Pain (Source)

Today = ___/10, High = ___/10, Low = ___/10, Avg = ___/10

Risk Assessment (e.g., lethality, suicidality/homicidality):

*Appropriately assesses and manages risk of harm to self/others**

Additional Assessment Items for Prescribers

Review of Problem List and Pertinent Medical History:

Assessment of Drug Allergies and Adverse Reactions:

Review of Active Medication List:

Brief Review of Systems (If Indicated):

Assessment Summary

1–2 Minutes	<p><u>Impression/Diagnosis/Assessment Summary</u> <i>Provides patient succinct summary of assessment information and biopsychosocial impressions/formulation of problem. Integrates key biological, psychological, social or environmental factors in the formulation.</i></p>
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Advise

1–2 Minutes	<p><u>Share Options and Discuss Strengths/Needs</u> <i>Specific, personalized options for treatment that are based in the evidence; discussion of how symptoms can be decreased and functioning and quality of life/health improved. Review behavioral change options for addressing identified concerns and implementing next steps.*</i></p>
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Options:

Strengths/Needs:

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Personal Action Plan (Agree)

1–2 Minutes Patient’s goals for change:
(Based on treatment options reviewed in advise—the patient is interested in and willing/motivated to engage in these options)

PCP & PACT/or PC-MH Team Input:

Assist

5–10 Minutes Starting a Behavioral Change Plan and In Session Practice:

- *Begin to implement the specific behavioral change action plan, demonstrate relevant skills, and discuss specific options for homework practice. Focus on learning new information, developing new skills, overcoming barriers, solving problems, and/or developing confidence to make change.**
- *Uses evidence-based interventions for identified concerns**

Handouts Given (education/activation):

Reminder: CIH Patient Handouts [here](#)

Arrange

1–2 Minutes *Specify plans for follow-up (visits/calls)**
Provide patient with a written prescription of next steps

RTC Follow-Up Arrangements:

Additional Referrals (if indicated):

- Referral to Care Management (if indicated)
- Referral PACT Team Member (if indicated)
- Referral to Specialty Mental Health (if indicated)

Other :

- Give VCL number: 1-800-273-8255 (press 1)

Written Prescription of Next Steps:

Remember: Give feedback to the PCP/PACT that is brief and focused after seeing the Veteran!

**indicates critical items for inclusion in competency demonstrations and key areas in your work with Veterans*