Primary Care-Mental Health Integration

Co-Located, Collaborative Care:

An Operations Manual

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It should be noted that the U.S. Department of Veterans Affairs did not plan or authorize this manual. The guidance contained is not to be construed as official or reflecting the views of the U.S. Government or any other institution public or private. The authors have no financial or other conflicts of interest to disclose.

The Authors

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Executive Summary: Operations Manual
Primary Care-Mental Health Integration: Co-Located, Collaborative Care

The following manual is provided to the field as operational support in service of successful and sustainable Co-located, Collaborative Care (CCC) Primary Care-Mental Health Integration (PC-MHI). Truly integrated healthcare involves a radical shift in conceptualizing care and challenges providers to function in ways that often contrast sharply with how they were trained to work. In addition to training staff to function in new ways, shaped by a population-based approach, the transformation of care must be supported by infrastructure to be sustained. Dozens of staff have attended recent national trainings in PC-MHI, and many have been clamoring for systematic guidance for "how-to" develop a viable integration system. While this relatively new care structure is evolving rapidly and often uniquely across the national system, the collective wisdom of the pioneers in this transformation has been gathered together here. Hopefully, the manual will highlight helpful structures and best practices for success, alert staff to common pitfalls, and save many the time otherwise spend to "re-invent the wheel".

As defined and required by the Uniform Mental Health Services Handbook (VHA Handbook 1160.01), there are two main categories of PC-MHI services; CCC and Care Management (CM). VA medical centers and large CBOCs must have on-site integrated care clinics utilizing a blended model that includes co-located collaborative care and care management, using the Behavioral Health Laboratory system, TIDES, or other evidence-based models.

- **Co-located, Collaborative Care services offered by an embedded behavioral health provider:** This approach involves providing services to primary care patients in a collaborative framework within primary care teams. Behavioral health visits are brief (generally 20-30 minutes), limited in number (1-6 visits with an average of between 2 and 3), and are provided in the primary care practice area, structured so that the patient views meeting with the behavioral health provider as a routine primary care service and medical providers are supported across a broad scope of behavioral health concerns.

- **Care Management (often provided via telephone):** This approach includes mechanisms for systematic monitoring of symptoms and treatment emergent problems such as non-adherence or side effects; decision support; patient education and activation; and assistance in referral to specialty mental health care programs, when needed. CM services follow structured protocols designed around specific diagnostic entities such as depression and are generally implemented by behavioral health nurses or clinical social workers.

The differences between PC-MHI programs and traditional mental health are dramatic, and generally require a culture shift for all stakeholders, from PCPs to BHPs and leadership. The following chart summarizes some of the differences.

	Co-Located Collaborative MH Care	Mental Health Specialty Care
Location	On site, embedded in the primary care clinic	A different floor, a different building
Population	Most are healthy, mild to moderate symptoms, behaviorally influenced problems.	Most have mental health diagnoses, including serious mental illness
Provider Communication	Collaborative & on-going consultations via PCP's method of choice (phone, note, conversation). Focus within PACT.	Consult requests, CPRS notes, Focus within mental health treatment team.
Service Delivery Structure	Brief (20-40 min.) visits, limited number of encounters(avg. 2-3), same-day as PC visit.	Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.
Approach	Problem-focused, solution oriented, functional assessment. Focused on PCP question/concern and enhancing PCP care plan. Population health model.	Diagnostic assessment, psychotherapy and psychopharmacological , individual or group, recovery-oriented care. Broad scope that varies by diagnosis.

Major Recommendations: The areas of training, personnel management, program monitoring and workload comprise the infrastructure for sustainability. This manual attempts to summarize what is recommended within each area, and to provide examples of successful and productive tools in each.

1. **National PC-MHI Support**: Trainings are offered through the National PC-MHI Program Office directed by Dr. Edward Post and the leaders of the care management programs (TIDES and BHL) as well as the Center for Integrated Healthcare. The PC-MHI website can be found at: http://vaww4.va.gov/PCMHI/index.asp, and CIH SharePoint at https://vaww.visn2.portal.va.gov/sites/natl/cih/default.aspx. It is recommended that staff working in integrated roles attend the corresponding training for that role. In addition, higher levels of facility management need basic familiarity with these concepts in order to ensure effective decision-making that does not conflict with integrated care. Integration must occur at all levels within the system, such that mental health managers/supervisors and team leaders routinely consult with medical counterparts related to integration progress and barriers.
2. **Personnel Management**: Recruiting, hiring, and supervising co-located, collaborative care behavioral health providers (CCC BHPs) for PC-MHI programs is a complex process that is critical to sustainability. Guidance is delineated in the body of this manual. Administrators must have a clear understanding of the nature and expectations for successful functioning in PC-MHI programs as a CCC BHP. It is recommended that direct supervisors of these roles

attend the related trainings and/or read the full Operations Manual and consult with national experts as needed.

3. **Program Monitoring**: This process should be an on-going dialogue between the provider and local level supervisors rather than limited to formal annual or semi-annual evaluations. The following tools should be utilized:

    1. BHC Core Competencies Tool (Robinson & Reiter, 2007; See Appendix D): This rating scale describes six content domains and the specific skills required to master the competency. Providers should rate themselves and compare ratings with the review of the supervisor or trainer.

    2. Chart reviews: A random sample of charts should be reviewed to check for competency within administrative and documentation skills. Domains such as relevance, conciseness, brevity and evidence of consultation should be documented. This kind of monitoring is critical to ensure initial competency, and helpful to repeat periodically as a form of ongoing quality assurance.

    3. Observations: If possible direct clinic observation should occur. The trainer or program leader for PC-MHI can assist with this process by making site visits and observing direct interactions with patients as well as other clinical staff. Fidelity project is currently underway that will include the development of coding sheets to assist with this task.

    4. Input from other primary care team members: In order to gauge team skills and integration with other PC members, the supervisor should consult with other PC team members and ask specific questions about program integration episodically. PACT team input should routinely be included in performance appraisals of PC-MHI mental health staff.

    5. Dashboards: It is important to monitor trends in patients being seen by individual providers working within PC-MHI programs including the number of unique patients seen, the total number of encounters, the number of encounters per unique, the number of encounters per day, average session length, and the most common diagnoses seen in clinic. Most of these items are available through the national dashboard except the last two, which can be very good indicators of CCC implementation success. It is recommended that this function be delegated explicitly and time allotted to perform it, with routinely scheduled reports expected.

4. **Workload Capture**: The workload of BHPs (both CCC and CM) in a primary care setting is captured by using Clinic Stop Code 534, and 539 for group encounters. Detailed guidance on stop codes and CPT codes are available in Chapter 4 of the Operations Manual. Administrative Officers, supervisors, team leaders and front line PC-MHI staff need to be familiar with proper coding for this service.

Chapter One: Purpose, Background and Conceptual Framework

Purpose of this Manual:

This manual is provided to the field as operational support in service of successful and sustainable co-located, collaborative care (CCC) Primary Care-Mental Health Integration (PC-MHI). As defined and required by the Uniform Mental Health Services Handbook (VHA Handbook 1160.01), there are two components of PC-MHI services; CCC and Care Management (CM). This manual provides a detailed description of co-located, collaborative care behavioral health services integrated within primary care and some tools to support its implementation. Care management has been well described in other documents (e.g., Zanjani et al., 2008, Zeiss & Karlin, 2008) therefore we have not attempted to include more than a brief clarification here.

This manual is designed for administrators such as careline managers, supervisors, integrated behavioral health providers, primary care providers, and others who have responsibility for managing the implementation and operations of PC-MHI programs. The primary aim of this manual is to provide a reference summarizing key infrastructure considerations, clarifying roles and responsibilities, and highlighting core competencies for PC-MHI work. Samples of logistical tools such as service agreements, policy memos, personnel guidance, CPRS progress note templates and general program management strategies are also provided. Note that there is a companion Education Manual that delineates in greater detail the nuts and bolts of these concepts, with sample templates that are designed as a primer in PC-MHI work for the new co-located, collaborative care (CCC) behavioral health provider (BHP).

This manual is intended as guidance only. There has been and will continue to be considerable site-to-site variability in discipline-specific staffing levels, scopes of practice, skill sets, and access to specialty resources within primary care settings. Thus, any operational strategy must build in a degree of flexibility and fluidity to enable the behavioral and primary care partners to reach their own balance and share tasks commensurate with their particular circumstances. The need for local variability limits the degree of specificity within this manual, but also underscores the key principle that the charge of successful, real-time delivery of first level behavioral health care is really directed to the team and not the individual provider.

The purpose of this manual is to delineate the systems and helpful structures to support CCC functioning. While blending is discussed, and staff need to be familiar with both roles, this manual provides implementation guidance for the CCC role, just as the BHL manuals provide it for the BHL model of care management.

Primary Care Mental Health Integration Requirements:

The concept of PC-MHI is derived from the Institute of Medicine's description: "Primary Care is the provision of continuous, comprehensive, and coordinated care to populations undifferentiated by gender, disease, or organ system. Primary care is the provision of accessible, integrated, biopsychosocial health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community (emphasis added- IOM, 1996)." All 153 VA hospitals are required to provide access to mental health care in the context of primary care clinics as directed in the VHA Handbook 1160.01 of September 2008 titled *Uniform Mental Health Services in VA Medical Centers and Clinics."* This handbook outlines the essential elements of mental health programming, including integration within primary care clinics. The handbook states

that all medical centers and large CBOCs serving more than 5,000 patients must provide a blend of co-located, collaborative care and evidence-based care management services, such as those offered through the Behavioral Health Lab or TIDES models (VHA Handbook 1160.01, p. 35). This manual focuses on the co-located, collaborative care services, and addresses the concept of blending with care management services.

Co-located Collaborative Care: The Uniform Mental Health Services handbook states "the co-located, collaborative care (CCC) model involves one or more mental health professionals who are integral components of the primary care team and who can provide assessment and psychosocial treatment for a variety of mental health problems, which include depression and problem drinking" (VHA Handbook 1160.01, p. 35). Zeiss and Karlin (2008) note that the embedded provider is often a psychologist but could be a different mental health professional, and that these professionals provide "immediate follow-up of positive screens for mental health problems." In addition to follow-up assessments for positive screens, the co-located mental health provider "also can assess any Veterans who are identified by the PCP as likely to benefit from mental health services." Zeiss and Karlin go on to note that the provider also offers consultation to PCPs on strategies for managing challenging behaviors as well as to provide behavioral medicine services for broader health issues. The CCC model is said to emphasize "immediate face-to-face connection with patients identified with mental health needs in a primary care visit and the use of evidence-based psychotherapy and health behavior management" (Zeiss & Karlin, 2008).

The second component of integrated care delivery within the VA is care management, which, according to the Handbook "includes mechanisms for systematic monitoring of symptoms and treatment emergent problems such as non-adherence or side effects; decision support; patient education and activation; and assistance in referral to specialty mental health care programs, when needed. The care management component can be based on the Behavioral Health Laboratory, the Translating Initiatives for Depression into Effective Solutions (TIDES) model, or other evidence-based strategies approved by the Office of Mental Health Services."

These two categories of care are required offerings by all medical centers and large CBOCs, as is the blending of the two. Varied models of blending have evolved, including those that structure the CCC staff as "gatekeepers" of referrals and those that utilize health technicians and care managers to provide comprehensive follow-up to initial positive screens and refer patients with positive results directly to care management for further assessment and/or treatment. In addition to the need for thoughtful and purposeful blending of CCC and CM functions, the addition of Health Behavior Coordinators (HBC) throughout the system provides another opportunity for collaboration and challenge for coordination. While the HBC staff have limited clinical time allotment, they are central to training Patient Aligned Care Team (PACT) staff in behavior change techniques, and can complement the other PC-MHI staff in this process. It is recommended that staff in these three roles meet episodically (at least monthly initially and quarterly after roles are well-established) to ensure effective collaboration, clarify who will do what, and keep each other informed of various initiatives.

Co-Located, Collaborative Care Mission Statement:

Consistent with the service philosophy of primary care, the mission of the CCC component of integrated primary care is to detect and address the broad spectrum of behavioral health needs among primary care patients, with the aims of early identification, quick resolution of identified problems, long-term problem prevention, and healthy lifestyle support.

A major goal of this model is to support the primary care provider in identifying and treating patients with mental health diagnoses and/or need for behavioral interventions. This approach involves providing services to primary care patients in a collaborative framework with primary care team providers and staff. The focus is on resolving problems within the primary care service context. In this sense, the behavioral health provider is a key member of the primary care team. Behavioral health visits are brief (generally 20-30 minutes), limited in number (1-6 visits with an average of between 2 and 3 per VSSC dashboard), and are provided in the primary care practice area, structured so that the patient views meeting with the behavioral health provider as a routine primary care service. The referring primary care provider is the chief "customer" of the service and, at all times, remains the overall care leader. This model of co-located, collaborative care with embedded behavioral health providers in primary care clinics represents a main entry point in the continuum of care which should include "a range of effective delivery methods that are convenient to Veterans and their families" (VA Strategic Plan, 2010, p. 33).

Conceptual Framework:

In the Department of Veterans Affairs Strategic Plan for 2010-2014, Secretary Eric Shinseki writes "Our mission at VA is to serve Veterans by increasing their access to our benefits and services, to provide them the highest quality of health care available, and to control costs to the best of our abilities." Delivering mental health services embedded in the context of primary care clinics allows for highly accessible, evidence-based and cost-effective care. Added benefits include reduced stigma for services and a stepped care structure that facilitates smooth linkage with specialty services as needed. Further, a majority of the Mental Health Performance Measures outlined in the DVA Strategic Plan identify new cases of alcohol misuse, depression and PTSD, that can be addressed at least initially by staff working in PC-MHI clinics.

In response to such a dynamic mission and far-reaching set of expectations, primary care delivery within VHA both locally and nationally is evolving into an increasingly sophisticated interdisciplinary team based, patient-centered medical home approach known as the Patient Alliance Care Team (PACT). This model represents the next evolution of health care delivery that has been embraced by the VA. It aims to replace episodic illness and complaint- based care with coordinated, proactive, preventive care and a long term healing relationship with the healthcare team. The primary care team focuses on the whole person, including psychosocial aspects of functioning. One of the core features of patient centered team work is shifting healthcare services "away from the acute care model and toward a more patient-centered model that focuses on wellness and disease prevention" (VA Strategic Plan, 2010).

Well-designed and implemented Primary Care-Mental Health Integration (PC-MHI) supports this goal in part by addressing mental health concerns at the sub-clinical, minor or moderate levels before they escalate to full diagnostic level problems. It is the expectation that PC-MHI providers interact and blend services with other PACT members, as part of the extended team, providing services across multiple teamlets, typically consisting of a primary care provider, a RN, a LPN, and a PSA that function together as a team to meet the needs of a specified panel of patients. The emphasis in this model of integration is on life functioning, with the goal of early remediation of symptoms. For those patients who present with more serious psychosocial difficulties, effective integration allows for rapid, on-site assessment as needed and increased rates of successful linkage to specialty care. Specifically, there is evidence that patients in need of specialty services who receive motivational intervention are far more likely to keep their scheduled appointments than those who do not receive this intervention (Zanjani, Miller, Turiano, Ross, & Oslin, 2008). In addition to providing person-centered, accessible care in the medical clinic context as part of the

medical team for minor to moderate concerns, there is a subset of patients who meet mental health diagnostic criteria for more serious concerns but are unwilling to consider care in a specialty clinic setting, for whom integrated behavioral health services may be the only acceptable avenue of service.

In general, the approach of CCC providers is a stepped care, population-based model that strives to care for the health needs of the population by providing brief, structured, evidence-based care on a wide range of presenting concerns and facilitating linkage with more intensive specialty treatments as needed. Several sites tracking referral patterns related to integration services have demonstrated a reduction in referrals to specialty care as well as transformation of access from a system with long delays and waits to one of same-day service. This level of accessibility serves the needs of both good patient care and good medical provider support. In this model of embedded integration, the primary care provider (PCP) is a primary customer, and services from the behavioral health provider include consultation and close collaboration with the medical teams, including the PCPs, in the service of coordinated and comprehensive healthcare. Team members include staff from nursing, behavioral health, pharmacy, nutrition, health behavior coordinators, medical social workers and clerical staff. One well-known example of a site that has successfully implemented an open-access, co-located collaborative model of service delivery is the White River Junction VA. Led by Dr. Andrew Pomerantz, this site utilizes a uniquely efficient system of gathering screening responses via laptop computer prior to actually meeting with the patient to maximize the efficient use of time during the appointment (Pomerantz, 2007).

Contrast with Specialty Mental Health:

There are several defining characteristics of CCC service delivery (e.g., brief, targeted assessment, consultation, intervention and triage) that differ substantially from the delivery of specialty mental health care service delivery as outlined in Table 1. It is critical for administrators, supervisors and clinicians to gain conceptual mastery of these features in order to make decisions in support of effective functioning for both specialty and integrated care services. When well understood, flow issues are more readily resolved, and resources appropriately allocated, and patients are most likely to be cared for in the appropriate setting. For the bulk of experienced mental health staff working in primary care clinics today, there was no academic training in this relatively new integrated approach. Few clinicians enter these roles with the practice management skills and core competencies to function optimally within the PACT service delivery structure. Simply assigning a traditionally trained clinician to work in the PC-MHI setting presents a challenge for successful implementation as often do not have the skills to succeed. Training through formal conferences, reading recommended texts, shadowing experienced PC-MHI staff, and consulting with clinical leaders in the system can be instrumental in developing the skills for success in PACT work. The practice differences are substantial and generally require a culture shift for all stakeholders, from PCPs to BHPs as well as local leadership. Specifically, it is important that CCC providers have offices within the PC clinic whenever possible. This allows for frequent team consultations, warm hand-offs, informal interactions, and decreased stigma for patients. Services provided in CCC should meet the needs of the population and be brief in nature (e.g., 20-30 minutes). If CCC providers do not understand this alternative practice management style and schedule patients for 50-60 minutes of repeated psychotherapy sessions, they quickly become inaccessible for warm hand-offs. The population served by CCC providers is typically high functioning with mild to moderate symptoms. Those with severe symptoms are generally not appropriate for continued mental health care with the primary care environment. However, treating

those with mild to moderate symptoms in primary care increases the access to specialty mental health services for those who need more intensive levels of care. The following chart summarizes some of the differences between CCC services and mental health specialty care.

	Co-Located Collaborative MH Care	Mental Health Specialty Care
Location	On site, embedded in the primary care clinic	A different floor, a different building
Population	Most are healthy, mild to moderate symptoms, behaviorally influenced problems.	Most have mental health diagnoses, including serious mental illness
Provider Communication	Collaborative & on-going consultations via PCP's method of choice (phone, note, conversation). Focus within PACT.	Consult requests, CPRS notes, Focus within mental health treatment team.
Service Delivery Structure	Brief (20-40 min.)visits, limited number of encounters(avg. 2-3), same-day as PC visit.	Comprehensive evaluation and treatment, 1 hour visits, scheduled in advance.
Approach	Problem-focused, solution oriented, functional assessment. Focused on PCP question/concern and enhancing PCP care plan. Population health model.	Diagnostic assessment, psychotherapy and psychopharmacotherapy, individual and group, recovery-oriented care. Broad scope that varies by diagnosis.

Integration Support Systems:

The VA has structured national support for integration efforts through The National Primary Care-Mental Health Integration (PC-MHI) Program Office, directed by Dr. Edward Post, the VISN 2 Center for Integrated Healthcare, Philadelphia Behavioral Health Lab (VISN 4 MIRECC), TIDES Care Management, and Mental Health QUERI. The PC-MHI office opened in 2008 and provides leadership to integration efforts in a variety of ways. They coordinate regular national trainings on PC-MHI, produce a quarterly newsletter, provide monthly educational conference calls, and provide evaluation of integration efforts. In conjunction with staff from the VSSC, they have developed a data cube to track related workload and diagnostic use in addition to data gathering from the annual staff survey. Trainings are offered several times a year that bring together top leaders in the field to teach staff from around the country the concepts and skills of successful care management, as well as leadership training for PC-MHI program management. Their website can be found at: http://vaww4.va.gov/PCMHI/index.asp.

The Center for Integrated Healthcare (CIH) is a VA Office of Mental Health Services funded Mental Health Center of Excellence which opened in November 2004 with a mission of improving the health of Veterans by integrating mental health services into the primary care setting, thus increasing both access and quality of care for Veterans. Further, consistent with the Department of Veterans Affairs FY 11-13 Mental Health Initiative Operating Plan: Improving Veterans' Mental Health, CIH supports the continued implementation of the Uniform Mental Health Services Handbook (VHA Handbook 1160.01) transformational initiatives, by conducting research, providing education and training to develop highly skilled CCC providers, and by serving as a clinical resource to the entire VA healthcare system for successful program implementation. CIH trainings in co-located, collaborative care are offered several times a year and bring together top leaders in the field to teach staff from around the country the concepts and skills of successful on-site integration. Given the lack of academic preparation for these relatively new roles, sending staff to either CIH training in CCC or PC-MHI training for care management and PC-MHI Program Leadership may be very helpful in shifting the care delivery culture from traditional care to integrated care.

Chapter Two: Roles and Responsibilities of Behavioral Health Providers within Primary Care-Mental Health Integration

Introduction

The literature states that up to 70% of primary care patient appointments include psychosocial concerns covering both the full spectrum of psychiatric disorders (from subclinical distress to serious mental health concerns) and a range of behavioral concerns from insomnia, adherence, and pain management to lifestyle issues such as weight management and tobacco dependence. The majority of psychotropic medications are written by PCPs, and the system's demands on the primary care providers have grown exponentially, limiting their ability to manage the volume of behavioral health issues they face. Most have neither the time nor the training to provide effective behavior management techniques. Thus, the Behavioral Health Provider's (BHP) role is critical to comprehensive healthcare. They are tasked with providing brief assessments, targeted treatment, triage, and management of primary care patients with medical and/or behavioral health problems.

Consequently, integrated primary care interventions focus on helping patients replace maladaptive behaviors with adaptive ones, provide skill training through psycho-education and patient education strategies, and focus on developing specific behavior change plans that fit the fast work pace of the primary care setting. These interventions are developed in collaboration with the patient and other PC providers and implemented within the primary care context.

Types of PC-MHI Behavioral Health Providers:

- **Co-Located, Collaborative (CCC) Behavioral Health Providers:**
  The CCC Behavioral Health Provider (BHP) is typically a social worker, a psychiatric nurse or a psychologist. The BHP's role is to provide support and assistance to both PCPs and their patients without engaging in any form of extended specialty behavioral health care. These disciplines will cover BHP responsibilities of triage and consultation at PCP request.

- **Care Managers (CM):**
  CM protocols are designed around specific diagnostic entities such as depression and anxiety and are generally implemented by behavioral health nurses or clinical social workers. Service delivery can be done via telephone in the CM model, so embedded location is not central to this role.

- **Prescribing Behavioral Health Providers:**
  In addition to behavioral interventions, all primary care settings should have access to a prescribing behavioral health provider. These providers include psychiatrists or psychiatric nurse practitioners with psychotropic prescription privileges, available on-site or via telepsychiatry.

Definition of Roles:

- **Co-located, Collaborative Care (CCC) Providers**
  The CCC provider refers to those mental health staff who are embedded in the Patient Aligned Care Teams (PACT) and focus on general service delivery for a wide range of concerns. While it is likely that the majority of presenting concerns addressed involve traditional mental health problems such as depression, anxiety, PTSD and substance misuse, the intended scope of these roles encompasses all behavioral issues that impact health, such as pain management, insomnia, tobacco dependence, weight management etc. A distinguishing feature of the general IPC approach is that it "casts a wide net" in terms of who is eligible. From a population based care perspective, the goal is to offer and provide brief, general behavioral health services to as many patients in need of care as possible. Traditional primary care medicine is largely based upon this approach. The idea is to "tend the flock" by providing a large volume of general health care services, none of which are highly specialized. Patients who truly require specialized expertise are usually referred into medical specialties, such as specialty mental health care. An additional distinguishing feature of the CCC role is to intervene with patient problems even when they are sub-syndromal, in hopes of averting progression to full diagnostic symptomatology. To this end, patient functioning is emphasized more than diagnostic criteria. For example, a brief intervention for alcohol misuse is likely to be appropriate for many patients whose drinking levels exceed healthy limits, and may prevent a progression to dependence, but may not meet criteria for abuse or dependence. Behavioral Health Providers working in this role are generalists with a wide range of skills and a willingness to work within available evidence-based protocols in support of their medical colleagues in busy clinic settings. At all times, care is coordinated by the PCP, who is still responsible for monitoring the results of interventions. Communicating back to PCPs on a daily basis is one of a BHP's highest priorities, even if it means handwritten notes, e-mail, or staying late to have a face-to-face conversation. BHPs will communicate with PC providers in both written and verbal form (i.e, face-to-face or over the telephone).

- **Care Managers**
  Care management services provide a consistent, protocol-based and empirically supported treatment package approach, and are available for particular diagnostic groups. Primary care patients in need of these services will include those with *high prevalence, high impact* (in terms of resource use) conditions such as uncomplicated depression, anxiety, PTSD, alcohol misuse, and chronic pain. According to the UMHS Handbook, CM "includes mechanisms for systematic monitoring of symptoms and treatment emergent problems such as non-adherence or side effects; decision support; patient education and activation; and assistance in referral to specialty mental health care programs, when needed." These interventions have historically been organized under two specific evidence-based models in the VA: TIDES and Behavioral Health Lab (BHL). These two models are in the process of merging at the time of this writing. The CM protocols are designed around specific diagnostic entities such as depression and anxiety and are generally implemented by behavioral health nurses or clinical social workers. Service delivery can be done via telephone in the CM model, so embedded location is not always central to this role.

- **Prescribing Behavioral Health Providers:**
  The primary responsibility of the prescribing behavioral health provider is to enhance the PCP's psychoactive medication management by providing verbal consultation on the PCP's initial medication decisions, medication changes, and the management of routine side effects. For more chronic, complicated, and/or refractory patients, the prescribing behavioral health provider may assess the patient directly to develop a medication regimen. In these instances, the PCP would take over renewal of prescriptions, once the patient is stabilized. If the patient does not stabilize, referral to behavioral health specialty care will be facilitated by BHPs. These functions are more fully described below and outlined in the sample Service Agreement attached in Appendix A:

- ***Initiation of pharmacotherapy:*** As PCPs develop assessment skills, routine initiation of anti-depressant treatment may not require consultation. Consultation may be indicated if prior psychiatric treatment history is unusually complex, there is suspicion of more complex psychiatric diagnosis (e.g., bipolar disorder, psychotic disorder, personality disorder), concern about lethality, or the choice of psychotropic treatment is complicated by co-morbid medical illness/other medications. For those sites with pharmacy support the clinical pharmacist in the primary care setting may be integrated into this process.
- ***Failure to respond to initial pharmacotherapy:*** This category accounts for the bulk of consultations to the prescribing behavioral health provider among patients with anxiety and mood disorders. Failure to respond to initial treatment may result from imprecise diagnosis, inadequate medication dosage, medication intolerance (e.g., side effects), co-morbid medical illness, substance abuse/dependence, poor treatment adherence, or refractory illness.
- ***Relapse on pharmacotherapy:*** Symptom relapse while receiving active psychotropic treatment often prompts a request for psychiatric consultation. In some cases, augmenting or switching medications may be necessary. Transfer of responsibility back to the primary care PCP (after stabilization) is often appropriate.

Defining Characteristics of Co-located, Collaborative Care

The delivery of CCC behavioral health services is, by necessity, very different than the delivery of behavioral health services in the traditional, specialty behavioral health clinic. Table 2 provides an overview of CCC service delivery characteristics structured by domains of core competencies (Robinson & Reiter, 2007).

Table 2: Defining Attributes and Core Competencies of CCC

Domain	Attribute
I. Clinical Practice Skills	1. Applies principles of population based care for everyone along a continuum from acute need, sub clinical problems & prevention, to those who are healthy.
	2. Defines CCC Role with patient before starting assessment (able to say intro accurately; e.g., deliver memorize script content in 2-minutes or less).
	3. Rapid problem identification (able to determine if referral problem is what the patient sees as the problem in the first minute after the intro script is finished for 90% of all first consultation appointments).
	4. Uses appropriate assessment questions (e.g., ask questions geared towards current problem referral and functioning & how the patient's physical condition, thoughts, emotions, behaviors, habits, and environment are impacting/influencing the identified problem and functioning).
	5. Limits problem definition/assessment (focuses on presenting problem). Does not assess other areas (except suicide and homicide as indicated for depressed and stressed individuals) until assessment of initial referral problem is complete and as time allows.

	6. Focuses recommendations and interventions on functional outcomes and symptom reduction (e.g., improve ability to work, improve performance on responsibilities at home, increase frequency or improve quality of social interactions [friends], increase intimate/familial interactions [spouse, children], increase exercise, enjoyable or spiritual activities, improved sleep, decreased autonomic arousal, decreased pain exacerbation, improved mood).
	7. Teaches self-management skills/home-based practice as the prime method for decreased patient symptoms and improved functioning (e.g., deep breathing, cue controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, eating behavior changes, increased physical activity, problem solving, and assertive communication). The majority of what the patient does to decrease symptoms and improve functioning is done outside of the consultation appointment.
	8. Interventions are specifically (operationally) defined and supportable by primary care team members (e.g., <u>increase fun activities</u> [read Mon, Wed, Fri from 1300-1330 in home office], <u>increase exercise</u> [Mon-Fri from 1700-1730, 30-minutes on stair-stepper], use relaxation skills).
	9. Shows understanding of relationship of medical and psychological systems (e.g., biopsychosocial model of physiological disorders, can describe to the patient the relevant factors, physical, behaviors, thoughts, environment, interactions with others, impacting symptoms and functional impairments).
	10. Shows basic knowledge of medicines (can name basic anxiety and antidepressant meds and what might be a first line recommendation for specific symptom presentation).

II. Practice Management Skills	1. Uses 30-minute appointment efficiently (e.g., identify problem, how functionally pt is impaired, symptoms, summarize to patient understanding of problem during at the 15 minute point, use next 10 minutes to develop and start a behavioral change plan).
	2. Stays on time when conducting consecutive appointments.
	3. Demonstrates capacity to consistently use intermittent visit strategy (e.g., see patient in 2 wks or in 1 month instead of every week), telephone visits, and secure messaging as available.
	4. Appropriately suggests the patient seek specialty behavioral health care when the intensity of service needed to adequately address the patient's problem is beyond what can be done in consultation appointments (e.g., PTSD, OCD, Marital Counseling, ETOH abuse/dependence).

	5. Uses community resources referral strategies (e.g., Military One Source, community retirement center for those using primary care for social contact, self-help divorce group, etc.).
III. Consultation Skills	1. Focuses on and responds to referral question (e.g., specifically talks about evaluation regarding initial referral question).
	2. Tailors recommendations to work pace of primary care (e.g., recommendations given to PCPs be done in 1-2 minutes by the PCM when/if they see the patient again).
	3. Conducts effective feedback consultations (e.g., when giving feedback keep to 1 minute or less and use specific straight-forward short explanations).
	4. Willing to aggressively follow up with providers, when indicated (e.g., medication recommendations for depression/anxiety, significant side effects for meds, alarming medical symptoms).
	5. Focuses on recommendations that reduce providers' visits and workload (e.g., recommend patient see you in two weeks to assess symptoms and functional changes and response to medications instead of seeing PCM).
IV. Documentation Skills	1. Writes clear, concise medical record notes (e.g., focus on referral problem, frequency, duration, acute or long-term, functional impairment, short specific recommendations).
	2. Notes are consistent with feedback to the PCM (e.g., note is a general outline of the verbal information or email you give/send the PCM).

In general, the integrated primary care model does not involve providing any type of extended behavioral health care to the patient. Some interventions are single session visits, with feedback about psychological intervention strategies made immediately available to the referring provider. Interventions with patients are simple, "bite-sized" and compatible with the types of interventions that can be provided in a 20-30-minute health care visit. It is also clear to the patient that the BHP is being used to help the PCP and patient come up with an effective "plan of attack" to target the patient's concerns. Follow-up consultations are choreographed to reinforce PCP generated interventions. The goal over time is to maximize what often amounts to a very limited number of visits to either the BHP or the PCP. Thus, the BHP is able to follow patients who need longer term surveillance "at arm's length," in a manner which is very consistent with how PCPs manage their at risk patients. The underlying philosophy is one of taking a Veteran-centric approach to enable long-term independent success in problem-solving. This style involves a focused, solution oriented approach to problem-solving that incorporates evidence-based interventions whenever possible.

While practicing within PC-MHI programs and utilizing a CCC service delivery framework, the PCP ultimately remains in control over the plan of care for the patient. Thus, the CCC provider is functioning under the jurisdiction of the PCPs treatment plan for the patient. A separate behavioral health treatment plan is not needed because the CCC provider is considered an extension of primary care services.

A final notable aspect of the integrated primary care model is that it allows "*in vivo*" training to occur, built around specific casework. Over time, with feedback regarding hundreds of patients sent to the consultant, PCPs begin to see the same themes recur in their panel of patients and also gain firsthand experience using effective strategies, supported by the BHP. Eventually, the PCP and the BHP learn to integrate the skills over time and implement both psychological and medical interventions more effectively.

Services Included in Co-located, Collaborative Care

There are several different types of services that occur within CCC. These are described below:

- **CCC Initial Consult Visit:** Initial visit with a patient referred for a general evaluation or determination of level of care; focus on functional evaluation, recommendations for treatment and forming limited behavior change goals; involves assessing patients at risk because of some life stress event; may include identifying if a patient could benefit from existing specialty care or community resources; consultation with clinical pharmacist, or referral to medical social worker. (CPT code 90804 or 96150, infrequently 90801 coding is needed/appropriate. See chapter 4 for more details.)

- **CCC Follow-Up Visit:** Visits by a patient to support a behavior change plan or treatment target identified by the PCP on the basis of earlier consultation; often in tandem with planned PCP visits. (CPT code 90804 or 96152)

- **Treatment Adherence Enhancement Visit:** Visit designed to help patient adhere with intervention initiated by PCP; focus on education, motivational interviewing, addressing negative beliefs, or strategies for coping with side effects. (CPT code 90804 or 96152)

- **Relapse Prevention Visit:** Visit designed to maintain stable functioning in a patient who has responded to previous treatment; often spaced at long intervals. (CPT code 90804 or 96151)

- **Behavioral Medicine Visit:** Visit designed to assist patient in managing a chronic medical condition or to tolerate invasive or uncomfortable medical procedure; focus may be on lifestyle issues or health risk factors among patients at risk (*e.g.,* headache management, tobacco cessation, weight loss); may involve managing issues related to progressive illness such end-stage COPD, *etc.* (CPT code 96152)

- **Psycho-educational Group Visit:** Brief group interventions that either replace or supplement individual consultative treatment, designed to promote education and skill building/effective problem-solving. Often a psycho-educational group can and should serve as the primary psychological intervention as many behavioral health needs are best addressed in this type of group treatment. (CPT code 90853 or 96153)

- **Conjoint Consultation:** Visit with PCP and patient designed to address an issue of concern to both. (CPT code 90804 or 96152)

- **Telephone Consultation:** Intervention contacts or follow-ups with patients that are conducted by the BHP via telephone, rather than in-person. (CPT codes for Non-physicians: 98966 (5-10 min), 98967 (11-20 min), 98968 (21-30 min) and Physicians: 99441 (5-10 min), 99442 (11-20 min), 99443 (21-30 min)

- **"Walk-In" Behavioral Health Consultation:** Usually unscheduled staff- or patient-initiated contact with the BHP for an immediate problem-focused intervention (CPT code 90804 or

96152). The majority of initial visits should be in this category following a warm hand-off from the PCP to the BHP.

Additional, non-codable functions:

- **PCP Consultation:** Face-to-face discussion with PCP to discuss patient care issues; often involves "curbside" consultation (no CPT code used for these types of visits).

- **Collaboration between CCC and Care Manager or Health Behavior Coordinator:** There should be an on-going dialogue between the CCC provider, care manager, and the health behavior coordinator. This communication should not only include consultations about direct patient care, but should also include discussions about role expectations and the unique contributions that each position brings to the PACT. When each provider type is functioning well within their roles, all three positions compliment each and blend to provide exceptional patient care. It is recommended that initially formal meetings are scheduled, until collaborative roles, expectations, and processes for informal consultations are well established. For example, within this framework the health behavior coordinator can serve as an expert consultant on health behavior change to both the CCC and the CM. Further, CMs and CCC providers can be mutually refer to each other, depending on the needs of any given patient.

Services not available in PC-MHI programs by either CCC or CM

- Medical Social Work Services (These services are provided by the PACT Social Worker.)
- Specialty Mental Health services such as:
    - Outpatient psychotherapy for conditions requiring more than six visits
    - Day Treatment or Intensive Outpatient Services
    - Neuropsychological/Personality or other Psychological Testing
    - Case Management
    - EAP
    - Routine Crisis intervention services (i.e. PC-MHI staff cannot be the default first-line crisis responders for a facility, and remain available for warm hand-offs. They should, however, be available to PACT patients and teams as needed, and help to triage/facilitate linkage to appropriate care)

Note: Patients who are already in treatment with a specialty mental health provider will generally not be seen by the BHP in integrated primary care except under very circumscribed conditions.

Service Agreements:

The specific roles and practice expectations of providers within PC-MHI programs are distinct. As noted above there are specific services provided within PC-MHI programs and specific services that are incongruent and should not occur within this service delivery framework. However, when the defining role characteristics are not well understood by administrators, supervisors, and clinicians, it is likely that role boundaries will become blurred, threatening the sustainability and access of PC-MHI programs. Even when roles are clearly delineated, it is possible that confusion may occur about which services are provided within PC-MHI programs. Thus, it is important that the expectations of providers working in PC-MHI programs are clearly stated in formal written documents. Further, it is important that psychotropic prescribing expectations of PCPs and specialty mental health providers (i.e., non-PC-MHI) are clearly documented.

For example, some primary care providers are hesitant to prescribe first line antidepressant medications, perceiving that this should be a function of specialty psychiatric prescribers. Prescribing front-line medications is within in scope of practice for PCPs and this routine practice should be the expectation. Failure to apply this population- based service creates unnecessarily

long wait times for initial appointments with psychiatric prescribers and decreases access for Veterans with SMI, in need of intense services not appropriate to provide in primary care.

One method for clarifying role expectations among PCPs, CCC PC-MHI providers, and specialty mental health programs is the implementation of service agreements. These formal documents should specifically describe the expectations for each role. Such documents should be developed though collaborative initiatives including stakeholders in all relevant groups (e.g., both PC and mental health) and be crafted to meet local needs. The final document should be reviewed and receive approval from all stakeholder groups and leadership. Please see Appendix A for an example from VISN 2. Well-crafted service agreements will define the roles and service expectations of PC-MHI, PCPs, and specialty behavioral health providers, including expectations for return of stable patients to primary care. The ultimate purpose of these formal written documents is to improve efficiency and access to care.

Chapter 3: Program Management

Part 1: Personnel

Recruiting, hiring, and supervising co-located, collaborative care behavioral health providers (CCC BHPs) for PC-MHI programs is a complex process that is critical to sustainability. Thus, it is important that these factors are given intensive consideration. There are a few key principles that will help to ensure long-term PC-MHI program success by creating highly competent and skilled personnel invested in the continued implementation of PC-MHI programs.

First, it is critical that administrators have a clear understanding of the nature and expectations for successful functioning in PC-MHI programs as a CCC BHP. This information and understanding will guide the selection of an appropriate candidate, and help to ensure the success of the program. Unfortunately, there is a tendency for high staff turnover when careful selection and matching does not occur. This is costly for training and team functioning and decreases reciprocal trust with the medical providers.

It is important that all personnel documents reflect a consistent message. Thus, the recruitment advertisement should reflect the nature and demands of the position, which should be described by position descriptions, functional statements and performance plans.

Recruiting:

In order to create a PC-MHI integration program with a high likelihood of success, it is critical to recruit and hire the right individuals. Overlooking important considerations during this phase of program implementation, or rushing to fill a position quickly, may inadvertently have a negative impact on the successful implementation of an effective PC-MHI program. The first consideration during the recruitment phase is the advertisement of the position.

Advertisements for the recruitment of co-located, collaborative care providers should include detailed information about the position, the requirements, and the day to day job expectations. This will help to attract applicants well suited for this position. It is critically important that these positions are not advertised as traditional mental health positions. Thus, standard or generic behavioral health recruitment documents should not be used.

The advertisement should state that the provider will be expected to serve as a **consultant** to primary care staff, and that the focus of clinical interventions will be based on **brief, functional assessments** rather than traditional specialty mental health assessments and interventions. Providing detailed information about the nature of the position, the fast-paced environment, and day-to-day expectations, will help applicants to initially self-select to apply or to determine that the position may not be a good match for them.

Recruitment advertisements that are likely to attract exceptional candidates, should describe the role as functioning within an exciting and fast paced environment. In addition, recruitment documents should include the typical number of daily patients that are expected to be seen, the types of interventions that are expected to be provided and the minimal education and experience with evidenced based and behavioral medicine requirements.

Experts in the field (e.g., Robinson & Reiter, 2007) have developed sample recruitment advertisements that can be modified to meet local level needs. Please see the example below and additional samples are provided in Appendix B.

"Co-located, Collaborative Care Behavioral Health Provider in Primary Care-Mental Health Integration Program: Exciting new position as a primary care team member providing brief consultations to eight to fourteen patients per day and their primary care providers. Training and experience in evidenced based treatments and health psychology required. Most have Ph.D. in clinical or counseling psychology, or a LCSW" (Robinson & Reiter, 2007, p. 510).

Hiring

After the tailored recruitment advertisements have been posted and the pool of applicants has emerged, the next critical element is the selection and hiring of exceptional applicants. There are specific skills that you will want to identity in potential applicants.

Recently, a few doctoral psychology graduate training programs have added training opportunities in an integrated primary care setting and some pre-doctoral internships and a handful post-doctoral fellowships are also providing experiences in this area. Nonetheless, it is highly likely that psychology applicants who are not recent graduates will not have much prior experience working within a PC environment. Although some candidates with a social work background may have experience working in PC, especially those who have worked as a "medical social worker," only a few training programs within this discipline provide this experience. Thus, one should expect that most potential candidates will not have prior experience or training in PC. Even if a candidate has experience working in PC as part of an interdisciplinary team, he or she may not have previous experience functioning as a co-located, collaborative care provider. Further, some candidates may have worked in PC or other medical settings, but may lack the right background to function successfully as a CCC provider.

When selecting a candidate, prior work or training within an integrated primary care clinic as a co-located, collaborative provider is ideal. As aforementioned, this simply may not be possible. There are other factors that should be considered to help you identify the best applicant, who is the most likely to be successful. Please see appendix C for sample interview questions. PBI (problem based interview) items and non-PBI items are included. These are complex questions and most interviewees will find them difficult. Do not expect that any given applicant will answer all of them well. Regardless of the specific questions the interview panel selects, there are some specific characteristics and themes that you should consider important. These themes will emerge in exceptional applicant's responses:

- Possesses at least some of the core competencies (see Appendix D) or demonstrates potential for learning them
- Is interested in doing something different, as opposed to traditional mental health services
- Has a desire to see more patients and extend services to a greater percentage of the population
- Likes to be in the middle of the action
- Is flexible
- Able to function well in novel situations
- Interested in expanding outside of current practice patterns

- Interested in working with a variety of populations
- Familiar with motivational interviewing techniques
- Expresses interest in continuing to learn
- Recognizes the importance of behavior change interventions and view something that they can assist the medical providers with
- Possesses an out-going personality that will be well-suited to on-going program outreach to all team members.

Position Descriptions/Functional Statements

Before being hired potential candidates should be given the opportunity to review position descriptions/functional statements. These required documents differ by specific provider disciplines. However, the purpose and function of these documents is very similar. Both should accurately reflect the expectations and required tasks for the position. Sample elements that should be included for a CCC BHP position can be found below. Also, please see Appendix E for a sample position description/functional statement for a GS 13 CCC clinical psychologist. This document can easily be modified to meet local needs and can be edited to meet the requirements of position description for other professions.

A well-written document will include an overview of the position, such as the following:

> "The co-located, collaborative care behavioral health provider (CCC BHP) is a member of the primary care clinic's health care team who assists the primary care provider (PCP) in managing the overall health of their enrolled population. The BHP's goals are to help improve recognition, treatment, and management of psychosocial/behavioral problems and conditions in the enrolled population. The person will provide consultation services to all patients referred by the primary care team. The person in this position will deliver brief, consultation–based services in the primary care clinic to patients and PCPs using an integrated care model" (Robinson & Reiter, 2007).

This document should include the required personnel qualifications (e.g., degrees, licensure, prior experience, knowledge, as well as the following elements.

- Ability to apply the biopsychosocial model of assessment to the primary care setting.
- Ability to formulate diagnostic and treatment recommendations and present findings to treatment teams (i.e., physicians, social workers, psychologists, and nursing staff as appropriate, and Knowledge of and skill in the uses of psychological assessment, psycho-diagnostic evaluations, and psychotherapy.
- Possess specialized knowledge of evidence-based treatment for general behavioral health problems (e.g., depression and anxiety) and areas of behavioral medicine (e.g., chronic pain, obesity and sleep problems)

The description should also include information about the specific expected tasks that CCC BHPs will complete. The following are examples of tasks to be included.

- The scope and responsibilities include targeted assessment and evaluation, including diagnostic impressions and functional status focused on the presenting problem
- The provider will be expected to meet passing criteria of core competencies (see Appendix D) as assessed by program manager or other supervisor.
- Candidate shall provide timely and succinct feedback to primary care providers regarding consultation findings and recommendations.
- Candidate shall provide concise documentation of care and recommendations in patient's medical record.
- Candidate will determine the appropriateness of the patient receiving services in the primary care setting.
- Candidate will formulate behavioral health interventions appropriate to primary care setting, and assisting with implementation of primary care treatment plans.
- Candidate shall provide brief follow ups, including relapse –prevention education.
- Candidate will typically see 8-10 patients a day.

Performance Plans

It is also critical for the performance plans to reflect the expectations of the position and be consistent with the information contained in the position descriptions. Thus, the specific expectations of the position and the core competencies should be included within the performance plan. Behavioral health providers in PC settings should not be functioning under performance plans that are used in specialty mental health clinics. The performance plans must describe the unique position expectations of behavioral health providers in primary care.

In addition to standard VA requirements, the following content domains from the core competencies (Robinson & Reiter, 2007) must be included in the performance plan and should be used to guide the employee's evaluation process. These primary domains include clinical practice skills, practice management skills, consultation skills, documentation skills, team performance skills, administrative skills, and continuing education. Please see Appendix F for sample performance plans. Additionally, see Table 2 in chapter 1 for items identified as essential elements for a CCC provider.

Supervising:

Supervising CCC BHPs should be viewed as an on-going process that occurs at regular intervals. To ensure an effective, well-functioning program, professional development should combine processes and mentoring that are available at the local, VISN, and National levels.

Local supervision

It is critical that administrators and program leaders have a clear understanding of the nature and expectations of the roles of a PC-MHI provider. In order to provide appropriate supervision, ensuring on-going success of the program, the direct supervisors (or local trainer/champions) of PC-MHI clinicians must have an in-depth, meaningful understanding of the nuances and requirements of a PC-MHI program. This understanding must be more detailed and operational

than that required of administrators. It is recommended that the supervisor have experience functioning as a behavioral health consultant within a PC-MHI program. At the very least, those without direct experience should consult with experts, consider attending PC-MHI trainings, and shadow a staff person who has successfully adopted the model. Further, it is recommended that specific language detailing expected leadership and supervision tasks for high quality implementation and sustainability of PC-MHI programs be written into the performance plans of the local PC-MHI supervisors (see Appendix G for sample performance plan language for PC-MHI supervisors).

A local trainer/champion may be the administrative supervisor, but this does not always have to be the case. If the administrative supervisor does not have the expertise, time, or interest necessary to provide appropriate training, support, and supervision to the PC-MHI program, a local trainer/champion should be identified.
Below you will find recommended knowledge, skills, and experiences that should be expected of strong supervisors or local trainers/champions.

- Prior experience working in a CCC PC-MHI setting using a brief model of service delivery
- Demonstrated knowledge and understanding of PC-MHI programs (including fundamental elements of co-located, collaborative services and care management)
- Familiarity with National PC-MHI office mission and initiatives
- Familiarity with population based interventions, as well as consultation and liaison skills, and familiarity with evidenced based brief interventions such as cognitive-behavioral techniques.
- Demonstrated competency and experience in providing clinical services using behavioral medicine techniques (e.g., chronic disease management, weight management, tobacco cessation, stress management, etc.)
- Medical Literacy, as demonstrated by familiarity with common medical terms, front-line psychiatric medications, understanding of medical culture, and previous experience as part of interdisciplinary treatment teams.

Typically, the local supervisor will have the most direct and meaningful authority and responsibility for the front-line PC-MHI providers. Therefore, the process of on-going supervision at this level is a critical element for program effectiveness and sustainability. The following are specific recommended tasks that should be implemented by the local program supervisor/team lead:

- Ensure that CCC BHP expectations and competencies are written into all CCC BHP position descriptions and performance plans.
- Ensure that new providers receive adequate training to support attainment in all domains of core clinical competencies (i.e., clinical skills, practice management, consultation, documentation, teamwork, and administrative skills). Please see educational manual for additional information.
- Schedule and lead local learning collaborative calls with all CCC PC-MHI providers at least monthly (Bi-weekly would be better.)
- Review individual provider metrics (e.g., encounters per day, number of uniques seen…) monthly with each CCC BHP. This can occur during group phone calls using coded data reports. (Please see section below entitled monitoring for more information

about reports). Data can be presented in coded reports and used to facilitate group discussion about program quality improvement.

- Team leads should have monthly individual discussions with providers whose data consistently fails to suggest adequate utilization rates or adequate primary care mental health integration.
- Develop and implement action plans for areas of identified difficulty.
- Meet at least quarterly with local PC **medical team leads** to ensure on-going problem solving and collaborative communications.
- Link with national PC-MHI office and other national resources (e.g., consultation with CIH staff) by attending select calls and informational/educational offerings.
- Receive consultation and meta-supervision on monthly basis with either VISN PC-MHI leadership or national leaders in the field if VISN leadership is not available.

VISN Level Supervision

It is recommended that VISN leadership consider investing in PC-MHI programs by identifying a VISN level steering group or select staff who could be tasked with implementation and oversight of PC-MHI programs across the VISN. VISN level staff serve as expert consultants to all sites, link between the VISN and the National PC-MHI office, and as consultants for the facility level PC-MHI site leads and supervisors (or local champions). VISNs (e.g., 16, 12, 1, 2) who have adopted this structure have described this as an important element in successful implementation and program sustainability. A VISN-level leader should provide the facility level leaders with meta-supervision, by discussing program expectations, providing and interpreting site level data, as well as program improvement and sustainably via monthly group calls and individual consultations as needed. In addition, the VISN level leader functions as an internal facilitator and should use a variety of empirically derived strategies to facilitate implementation and program sustainability, including academic detailing, provider education, local change agent participation, stakeholder engagement at all levels of the organization, performance monitoring and feedback, formative evaluation, and marketing. This expert can assist the local champions/supervisors with hiring and interviewing new providers, training new staff, initiating program implementation, continued monitoring of program and individual provider outcomes. Please see monitoring section below for more information about specific techniques and tools that can be utilized.

National Resources

In addition to local and VISN level resources, there are also national resources and training that can be utilized to supplement the supervision process and can facilitate training and continued education. Trainings are offered via the National PC-MHI office several times a year. These trainings bring together top leaders in the field to teach staff from around the country the concepts and skills of successful care management, as well as leadership training for PC-MHI program management. Their website can be found at: http://vaww4.va.gov/PCMHI/index.asp. Further, the Center for Integrated Healthcare (CIH) provides quarterly training for CCC providers.

New CCC Provider Training:

It will be the rare candidate that has been trained and worked in an integrated model of care. As such most providers being hired will have to be trained. It should be the responsibility of the facility level supervisor to ensure that appropriate training occurs. It is recommended that new providers familiarize themselves with the primary care setting and the practice expectations of the PC-MHI

program. Reading core texts (e.g., Robinson & Reiter, 2007, Hunter et al., 2009) as well as additional resources recommended by the National PC-MHI office will facilitate this process. Training should be structured around attainment of the core competences described by Robinson and Reiter (2007; see Appendix D). The supervisor should ensure that adequate time for training is scheduled in advance of clinical service provision. Taking the time to ensure an appropriate training period and process will increase the likelihood of program success and sustainability, as well as decrease turn-over by supporting provider confidence and satisfaction.

Ideally, training should be conducted by someone who is an expert in integrated behavioral health in primary care services and who has experience training others to operate well within the model. Although current research about training models for behavioral health providers functioning within primary care environments is limited, one research team provided evidence that attendance at a 1-3 day workshop, with continued follow-up telephone consultation calls improved provider knowledge and skill acquisition related to a brief CBT intervention for the primary care environment (Cully et al., 2010). In addition to supporting attendance at relevant PC-MHI workshops, leaders should be actively involved and provide a supportive environment for successful training to occur (Martin, 2010). Other effective training techniques include implementation of action plans, performance assessments, and on-going supervisory consultation (e.g., Borrelli, Lee, & Novak, 2008; Martin, 2010). PC-MHI experts have also recommended shadowing current, successful CCC BHPs, shadowing PCPs, and on-going consultation from experts within the field (e.g., Robinson and Reiter, 2007; Hunter et al., 2009).

Part 2: Program Monitoring and Implementation

Program Monitoring

Systematic monitoring of outcome data and providing timely feedback to providers about this data is an important element of program monitoring and sustainability. The feedback process should be an on-going dialogue between the provider and local level supervisors rather than limited to formal annual or semi-annual evaluations.

The local supervisor should control this process. However, depending on network structure, this could reflect collaboration with the VISN PC-MHI consultant. The following tools are recommended for use:

1. Core Competencies Tool (Robinson & Reiter, 2007; See Appendix D): This rating scale describes six content domains and the specific skills required to master the competency. Each item is rated from 1 (low) to 5 (high), reflecting the level of skill development for each competency. Providers should rate themselves and compare ratings with the review of the supervisor.
2. Chart reviews: A few patient charts should be reviewed to check for competency within administrative and documentation skills. For example, are notes brief, concise, and relevant and are consultations with other PC team members documented?
3. Observations: If possible direct clinic observation should occur. This VISN level employee can assist with this process by making site visits and observing direct interactions with patients and other clinical staff.
4. Input from other primary care team members: In order to gauge team skills and integration with other PC members, the supervisory should consult with other PC team members and

ask specific questions about program integration (e.g., Does the provider have brief curb-side consults? Are they visible in the clinic? Do they keep the door open when not in session?)

5. Program fidelity measures: Although not available at this time for inclusion within this manual, there are CCC program fidelity measures currently being developed and will be available in the near future
6. Dashboards: It is important to monitor individual PC-MHI provider's practice management trends, including the number of unique patients seen, the total number of encounters, the number of encounters per unique, the number of encounters per day, average session length, and the most common diagnoses seen in clinic. This information should be viewed in relationship to the overall clinic population. These sorts of data, however, remain meaningless without direct provider feedback. Please see National Monitoring section below for more information on dashboards.

Using a combination of these methods, areas of deficiencies can easily be identified. Reports can be created that depict areas of strengths and deficiencies. Action plans should be created for areas of deficiencies.

National Monitoring:

In mid-2010, the National PC-MHI office established an on-line, national dashboard for tracking PC-MHI programs utilizing stop code 534. Via this website, anyone can select any facility and obtain information about the staffing, status, reach, and penetration of the program as well as the number of encounters and percent of common diagnoses seen within the program at any given site. This data can be used to guide local level discussions about on-going program implementation and sustainability. The dashboard is located at the following web address: http://reports2.vssc.med.va.gov/ReportServer/Pages/Reportviewer.aspx?%2fPC%2fPCMM%2fPC-MH+Integration%2fMainMenu.

Program Implementation:

Once the CCC provider has been hired, program implementation can begin. Ensuring appropriate program implementation is an important task. This should be approached using a theoretically driven, purposeful and well constructed implementation plan. All too frequently, programs are developed and staff is hired, with very little planning or time given to program implementation.

Implementation scientists have repeatedly demonstrated that top down initiatives, even when supplemented with academic detailing and training, are not sufficient to implement sustained clinical practice change (Parker, dePillis, Altschuler, Rubenstin, & Meredith, 2007; Grol, Wensing, & Eccles, 2005; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Shekelle, Kravitz, Beart, Marger, Wang & Lee 2000) This is particularly true when implementing complex programs, such as the PC-MHI initiative, that requires engagement and support from multiple care specialties, and requires changes in provider attitudes, organizational structures and processes, and clinical processes (Kilbourne, Schulberg, Post, Rollman, Belnap, & Pincus 2004).

As part of the implementation plan, it is important to engage top level VISN and facility leadership, from both behavioral health and primary care. As part of a parallel process it is important to engage clinic level leadership and front-line staff. One promising method of implementation involves meeting with all clinic staff and reviewing a program implementation checklist (Fortney et al., 2009, Kirchner et al., 2010). Please see Appendix H for a sample implementation checklist,

modified from Fortney and colleagues (2009) and Kirchner et al., (2010). The checklist includes all the program elements required by the Uniform Services Handbook for PC-MHI program. It also allows for variation to meet specific site level needs. All clinic members review the checklist and, through group discussion, reach consensus for the establishment of the required elements. The decisions and any required actions are documented on the checklist. This checklist is then translated into a site action plan for program implementation. The plan should be monitored and revised as necessary throughout the implementation process. The plan should be reviewed at formal meetings by all clinic staff at approximately 1 and 2 years after initial development and should be revised as needed to reflect changes in program or clinic level needs. This process is complex and time-consuming. Ideally the process will be facilitated by the VISN PC-MHI program lead in collaboration with facility level leadership.

The following tasks/domains are included within the checklist (please see appendix H).

- Specify pt identification procedures:
- Identify possible exclusion criteria and method for assessing criteria:
- Specify collaborative care team members:
- Specify clinical activities of collaborative care team members:
- Specify treatment guidelines:
- Specify suicide protocol:
- Identify or develop implementation tools:

Chapter 4: Logistics and Administrative Procedures

Space:
Co-located, collaborative BHPs, by definition, are co-located in primary care and provide service within this setting. In VA Medical Centers the provided space should be a dedicated office within the primary care clinic, centrally located, with ease of access to every provider. The embedded nature of the work space requires it to be "in the thick of things," where the core of the clinic activity occurs. Alternatively, a typical primary care exam room can be made available whenever the BHP is on site. This latter option underscores the notion of the BHP as another member of the PACT, but requires flexibility on the part of the BHP.

BHPs are explicitly discouraged from "removing" patients from the primary care clinic and "transporting" them to the specialty clinic area (i.e., the behavioral health section or floor in the medical center). In addition to the dedicated space for individual visits, psychoeducational space should also be available if at all possible. When this is not possible within the clinic space, the next preferred classroom location is neutral territory within the facility rather than mental health space per se.

Coding (Clinics and Encounters):

There are two types of services provided within PC-MHI programs. One is CCC and the other is Care management (CM). Both types of services function within the primary care clinic and must use the following clinic and coding procedures.

Stop Codes:

The workload of BHPs (both CCC and CM) in primary care settings is captured by using Clinic Stop Code 534, and 539 for group encounters. Thus, each BHP **must** have specific clinics created that use the 534 and 539 stop codes and patients seen in primary care **must** be scheduled in these clinics.

The formal name of a stop code is a DSS identifier. These are 3 digit, standardized codes, used to characterize outpatient clinics. These coding recommendations were developed by the National PC-MHI office and can also be found on their website, http://vaww4.va.gov/PCMHI/Resources.asp.

Service	Stop code	Recommended use	Acceptable use
CCC Individual (face to face)	534	• 534/[provider code**] • Example of 534/510: individual visit with PC-MHI psychologist	• 534/[clinic code] • Examples: ✓ 534 [alone] ✓ 534/420:individual visit with PC-MHI for pain management)
CCC Group Visit (face to face)	539	• 539/[group provider code] • Example of 539/558: PC-MHI psychologist- led depression self-management group)	• 539/[clinic code] • Examples ✓ 539/420: pain management group led by PC-MHI) ✓ 539 [alone]

CCC Telephone based care	527/534*	• 527/534*: PC-MHI telephone	• 527/534*: PC-MHI telephone
CM Individual (face-to-face)	534	• 534/[care/case manager**] • Example of 534/182: initial assessment by depression care manager	• 534/[provider code] • Example of 534/117: initial assessment by RN care manager
CM Individual Telephone based	182/534*	• 182/534 (telephone case management_ • Example of 182/534 follow-up monitoring by depression care management conducted over the telephone.	• 527/534/[mental health telephone] • Example of 527/534 follow-up assessment by PC-MHI personnel conducted over the telephone)

*Used in credit position only when combined with a telephone code. In this situation the telephone code must come first.
** Note that not all disciplines have group codes specifying provider type. Please note that use of discipline-specific provider type codes does not make it clear which encounters represent CM rather than CCC services.

Coding Encounters:

When completing the encounter form, the BHP should use the appropriate CPT Code and Diagnostic Code that represents the type of service provided in the specified period of time, and the diagnosis addressed, respectively.

Encounter information should also include appropriate use of International Classifications of Diseases (ICD) codes. ICD codes are commonly used codes developed for classification of diseases.

Current Procedure Terminology (CPT) codes are used to describe health care services. CPT, developed by the American Medical Association four decades ago, was originally adopted by Medicare and Medicaid and has been more recently adopted by private insurance and managed care companies. CPT codes can also be used as a system for classifying services for reimbursement. The following CPT codes are commonly used for PC-MHI purposes:

- Telephone:
    - Non-physicians: 98966 (5-10 min), 98967 (11-20 min), 98968 (21-30 min)
    - Physicians: 99441 (5-10 min), 99442 (11-20 min), 99443 (21-30 min)
- Face-to-Face:
    - Registered Nurse:
        - New Patient - Problem Focused Exam: 99201
        - Established Patient – Brief Exam: 99211
        - Established Patient – Problem Focused Exam: 99212
    - Psychologist, Social Worker, NP, CNS, etc.:
        - New Patient – Initial Psychiatric Interview: 90801. *Please note. Use this code only if a full psychiatric diagnostic interview was completed.
        - Established Patient: (time dependent)

- 90804: 20-30 minutes
- 90806 : 45-50 minutes

  - Health and Behavior Assessment (requires physical health diagnosis): 96150 (15 min increments)
  - Health and Behavior Intervention (requires physical health diagnosis): 96152 (15 min increments)
- Other:
  - Brief intervention for substance use (telephone or face-to-face): 99408, 99409 (time dependent)

Specific information for the Health and Behavior Codes

To correctly use the health and behavior codes documentation must show evidence of coordination of care with the patient's primary medical care providers or medical provider responsible for the medical management of the physical illness that the psychological assessment/intervention was meant to address.

- Evidence of a referral to the Clinical Psychologist by the medical provider responsible for the medical management of the patient's physical illness must be documented in the medical record for the initial assessment and for reassessment.
- Documentation in the medical record by the Clinical Psychologist (CP) *Specialty Code 68)*, must include:

1. For the *initial assessment (96150)*, evidence to support that the assessment is reasonable and necessary, and *must include, at a minimum, the following elements*:
   - Onset and history of initial diagnosis of physical illness, and
   - Clear rationale for why assessment is required, and
   - Assessment outcome including mental status and ability to understand or respond meaningfully, and
   - Goals and expected duration of specific psychological intervention(s), if recommended.
2. For reassessment (96151), evidence to support that the reassessment is reasonable and necessary must be documented in detailed progress notes. These *detailed progress notes must include the following elements*:
   - Date of change in psychological or medical status requiring reassessment, and
   - Clear rationale for why reassessment is required, and
   - Clear indication of the precipitating event that necessitates reassessment
3. For the intervention service (96152-96155), evidence to support that the intervention is reasonable and necessary must include, at a minimum, the following elements:
   - Evidence that the patient has the capacity to understand or to respond meaningfully, and
   - Clearly defined psychological intervention planned, and
   - The goals of the psychological intervention should be stated clearly
   - There should be documentation that the psychological intervention is expected to improve compliance with the medical treatment plan, and
   - The response to the intervention must be indicated, and
   - Rationale for frequency and duration of services
   - Time duration (stated in minutes) spent in the health and behavioral assessment or intervention encounter should be documented in the medical

record, and the quantity billed should reflect 1 unit for each 15 minutes, e.g., one hour equals 4 units of service.

- ICD-9-CM diagnosis code(s) reflecting the physical condition(s) being treated must be present as the primary diagnosis.

Clinic Scheduling Standards:

All clinics for the CCC BHP in primary care should be set up in **15-minute increments.** Scheduling will be done by clerks and not by the individual providers. However, schedules should be accessible to all professional staff as well. Initial contacts should be booked to fill two appointment slots (i.e., 30 minutes), whereas routine follow-ups should be booked as one or two appointment slots, as needed. If it is anticipated that a particular patient will require more than 15 minutes at a follow-up, two appointment slots should be allocated for that patient's follow-up.

The templates will reflect a similar time commitment as the primary care provider templates. In order to be readily available for walk-ins, it is recommended that CCC BHPs alternate 30-minute bookings with 30-minute open slots. For example:

8:15 am:	New /follow-up patient
8:45 am:	Walk-in /consultation
9:15 am:	New/ Follow-up patient
9:45 am:	Walk-in/consultation
10:15 am:	New/Follow-up patient
10:45 am:	Admin time
11:15 am:	New/ Follow-up patient
12:00 noon:	Lunch
12:45 pm:	Admin time
1:15 pm:	Open for walk-ins or consultations
1:45 pm:	New/Follow-up patient
2:15 pm:	Open for walk-ins or consultations
2:45 pm:	New/Follow-up patient
3:15 pm:	Open for walk-ins or consultations

More experienced BHPs may elect to shorten their appointment slots (e.g., only 20 minutes to complete a new patient intake). The open slots may be used for other activities (e.g., computer work, care management) if no walk-ins appear. In addition, BHPs with other routinely occurring meeting obligations will need to carve out those times from schedule access.

Some PC-MHI providers (CCC, CM, and prescribing providers) have completely open grids, meaning that there are no scheduled appointments. Patients are seen on a first come, first serve

basis. This provides open access and availability to see warm-hand offs from primary care providers. Although this option may not be successful in every clinic, it has been highly successful in some locations (Pomerantz, 2007). The most import aspect is to consider your local needs regarding follow-up, and clinic flow.

Some clinics have opted to scheduled open access slots based on clinic flow. For example, the CCC BHP would have open access appointments at peak clinic times, to allow for quick access for warm hand-offs from PCPs. For example:

8:00 am: New /follow-up patient

8:30 am: New /follow-up patient

9:00 am: Walk-in/consultation

9:30 am: Walk-in/consultation

10:00 am: New /follow-up patient

10:30 am: Admin time

11:00 am: Walk-in/consultation

11:30 am: Walk-in/consultation

12:00 noon: Lunch (and so on throughout the day, based on clinic flow)

Staffing Guidelines:

The Mental Health Uniform Service Handbook put forth the following expectations for staffing PC-MHI programs.

a. VA medical centers and very large CBOCs, those seeing more than 10,000 unique Veterans each year must have integrated mental health services that operate in their primary care clinics on a full-time basis. These services need to utilize a blended model that includes collocated collaborative care and care management.

b. Large CBOCs, those seeing between 5,000 and 10,000 unique Veterans each year, must have on-site integrated care clinics utilizing a blended model that includes co-located collaborative care and care management, using the Behavioral Health Laboratory, TIDES, or other evidence-based models. The hours and days of availability of integrated care services can vary depending upon the clinical needs of the patient population.

c. Mid-sized CBOCs, those seeing between 1,500 and 5,000 unique Veterans, must have an on-site presence of mental health services available to primary care patients who need them. The distribution of services between integrated care and mental health clinics can vary depending upon the clinical needs of the patient population.

d. Smaller CBOCs must provide access to general and specialty mental health services for those who require them.

In addition to the specific PC-MHI staffing guidelines provided by the Mental Health Uniform Service Handbook, the recent implementation of PACT has provided staffing recommendations for the core teamlet as well as recommendations for other team members. Other team members were

included in these ratios, because they were perceived to be critical to the daily provision of primary care services. However, PACT is currently in early stages of implementation and overall primary care staffing will continue to be monitored. It is also important to interpret these recommendations with flexibility to allow for variation that reflects local level needs, Veteran population, and available resources.

Current PACT guidance recommends that the core teamlet (PCP, RN, MSA, and LPN or health tech) serve a panel of ± 1200 patients. The recommendations for integrated behavioral health are as follows (Schectman et al., 2010)

- Psychologist ± 3 panels
- Social Worker ± 5 panels
- Care Manager ± 5 panels
- Psychiatrist ± 10 panels

These guidelines should be interpreted as early recommendations rather than firm expectations, and will need to be evaluated and modified based on local area needs and resources. In many CBOCs, staffing patterns do not permit separate staffing for both integrated primary care services and specialty behavioral health services. At these sites, integrated primary care services will typically be delivered by the same provider who also delivers specialty behavioral health interventions. This "hybrid" situation can be confusing for both the primary care provider and the behavioral health provider, but it is an important distinction to keep in mind when implementing PC-MHI programs in CBOCs.

It is recommended that providers functioning in these hybrid roles make clear distinctions to PCPs, patients, and even themselves regarding which role they are functioning in at any point in time. Specifically, it is recommended that providers largely function within the CCC framework. For example, they should continue to accept warm hand-offs and frequently consult with PACT team members. Further, all new patients should be seen using CCC service delivery patterns (e.g., functionally based, 20-30 minutes, etc.) until/unless it becomes evident that additional services from a specialty approach are needed. The majority (estimates of 75-80%; Robinson and Reiter, 2007) of presentations can be treated using CCC practices, and the provider in a hybrid role should attempt to do so whenever possible. Providers should consider whether they would refer this patient to specialty mental health, before "switching hats" and providing services using standard behavioral health practice patterns. It is essential that patients are fully informed of such a switch prior to the provider's change in role and that the provider negotiate with the patient for a specific number of therapy sessions to attain a specific goal. Further, CCC practice management strategies can, be incorporated into more intensive and specialized services. For example, limiting sessions to 30 or 45 minutes, allows more time to consult with PCPs. It is recommended that only a limited number of specialty sessions be available and it is wise to schedule this during times when the PC clinic is not as busy (early morning or late afternoon). This scheduling will allow more time for consultations and open access. Another option for providing mental health services in CBOCs is through Care Management (CM) interventions. Using a stepped-care format, CM services may allow the CCC provider to offer increased access and provide services for patients with more complicated concerns.

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Appendix A

DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CENTERS
VISN 2
PRIMARY CARE / BEHAVIORAL HEALTH
PROVIDER AGREEMENT

Purpose: To develop a seamless consultation process in the VA Healthcare Network Upstate New York (VISN 2) system to ensure appropriate referrals, delivery of safe, effective and timely care to Veteran patients, and to improve clinic efficiency. The overall goal of this agreement is to decrease referral delay from primary care (PC) to specialty mental health (MH) services, to enhance co-located, collaborative healthcare delivery, to increase specialty MH capacity, and to increase the graduation rate of Veterans back to primary care from specialty mental health services. This agreement will improve efficiency and access to care, thereby improving overall health outcomes in our Veteran population.

Consistent with principles of the Patient Centered Medical Home (PCMH) and to assist primary care providers with the treatment of behavioral health concerns in PC, VISN 2 will continue to implement and expand the co-located, collaborative care model of integrated primary care (IPC) throughout the network. Staffing for these programs will vary based on clinic size. Co-located, collaborative care behavioral health providers (CCC BHPs) will support PCMH initiatives and will assist PCPs in providing brief behavioral interventions and monitoring Veteran responses to newly initiated medication trials. It is the expectation that PCPs will work in collaboration with CCC BHPs for these purposes. If a PCP is unsure whether medication is needed or if a referral to specialty services is warranted, the CCC BHP can provide a more thorough assessment and brief behavioral interventions. Further expanding the model of collaborative care, VISN 2 will be gradually implementing a blended model, including specific care management programs as required by the Uniform Mental Health Services Handbook.

Outline and Structure of Agreement:

This service agreement is designed to implement a stepped-care treatment approach based on best practice models of service delivery. This approach allows Veterans to obtain mental health treatment services that are appropriate to their individual level of functioning and provides opportunities to receive high quality care while remaining in the primary care setting when appropriate. Many behavioral health concerns can be managed within the primary care clinic by the primary care team through collaborations between PCPs and integrated behavioral health providers.

Options for treatment of mental health symptoms:

Utilizing the stepped-care approach, there are several options for the treatment of mental health symptoms, ranging from least intensive and restrictive to highly intensive specialty services. Each level is further detailed below in individual sections.

- **Level 1:** Primary care provider with as needed (curbside) consultation from a psychiatric prescriber or the CCC BHP either in-person, via telephone, or though chart review consult process.
- **Level 2:** Co-located, Collaborative Care Behavioral Health Provider (CCC BHP): Typically a non-prescriber (social worker or psychologist) embedded within primary care clinics in collaboration with PC team. Listing of CCC BHPs for VISN 2 can be found at: Listing of VISN 2 CCC BHPs.

- **Level 3:** Veteran appointment with a psychiatric prescriber in the primary care environment, in person or via telemedicine or telemental Health, defined as the use of telecommunications technology to provide mental health services to individuals. Link to the following site for additional information: http://vaww.telehealth.va.gov/telehealth/cvt/tmh/index.asp
- **Level 4:** Intensive specialty care (e.g., mental health providers within specialty behavioral health services).

PRIMARY CARE / BEHAVIORAL HEALTH
PROVIDER AGREEMENT

LEVEL 1: Primary care provider with as needed (curbside) consultation from a psychiatric prescriber or the CCC BHP either in-person or via telephone.

Within the least restrictive level of care, the Primary Care Provider (PCP) manages the treatment of behavioral health concerns and consults with psychiatric prescribers and the CCC BHP as needed. This level of care is best suited for uncomplicated mental health concerns that are best treated within the PC setting, allowing the Veteran to maintain a high level of functioning without use of specialty services. Primary care providers will utilize this treatment option as a front line approach for medication.

PCPs will manage uncomplicated mental health concerns in conjunction with collaborative, consulting behavioral health providers (prescribers and non):

1. PCPs are expected to manage uncomplicated depression and anxiety following recommended clinical practice guidelines. As noted in 2009 VA/DOD CPG, selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), bupropion, and mirtazapine are considered first-line treatment options for adults with Major Depressive Disorder (MDD). No particular antidepressant agent is superior to another in efficacy or time to response. Choice can be guided by matching Veteran's symptoms to side effect profile, presence of medical and psychiatric co-morbidity, and prior response (see Appendix A). **VA/DOD Clinical practice guidelines for depression and anxiety can be found at the following web address: http://www.healthquality.va.gov/mdd/mdd_full09_c.pdf. Medication recommendations can be found within Appendix A of the current document.**

   Specifically, for example:

   - Uncomplicated depression/anxiety is generally treated with a Selective Serotonin Reuptake Inhibitor (SSRI) at an appropriate dose, for a sufficient length of time (Please see Appendix A).
   - If adverse drug reaction or side effects to the SSRI occur, either alone or in as needed consultation with a psychiatric prescriber, PCPs may choose to initiate a second anti-depressant trial at an appropriate dose for a sufficient length of time. If adverse effects, side effects, or inadequate response continue, the PCP is advised to refer the Veteran to the psychiatric prescriber in primary care clinics in person or via telemedicine (level 3).
   - As further detailed in level 2, it is the expectation that when initiating psychotropic medications, PCPs will offer brief interventions by CCC BHPs to support cognitive-behavioral strategies for improved mood. See appendix B for effective referral scripts.

2. PCPs are expected to resume care of stable non-psychotic disorders once maintenance established in mental health specialty clinics or by psychiatric prescribers in primary care. (This process is further described within level 4)

Additional Resources and Team Members

There are additional staff that serve as valuable team members to support the PCP. The availability and proximity of these resources will vary by clinic size and location. PCPs are encouraged to consult as needed, especially when prescribing for populations with unique medical concerns (e.g., elderly, women who may be pregnant or breastfeeding, poly-pharmacy, etc.)

1. Psychiatric medication chart review consult option**:** This option is being established in some locations where staffing permits as a pathway for PCPs to seek assistance in the management of Veterans with common behavioral health concerns, but who may not require a formal face-to-face encounter for evaluation. (For example, a PCP may wish to have a specialty provider's medication recommendations, based on information available within the chart.)
2. Clinical Pharmacy: Clinical pharmacists can provide valuable information about contraindications, dosing, side effects, and other frequent concerns. In many PC settings, clinical pharmacists are available to provide same day information to patients and providers. In other clinics a consult will need to be placed.
3. Co-located, Collaborative Care Behavioral Health Provider (CCC BHP): (typically- non-prescriber): To assist PCPs with the treatment of behavioral health concerns within the primary care environment, VISN 2 will continue to implement and expand the co-located collaborative model of integrated primary care (IPC) throughout the network. It is the expectation that when initiating psychotropic medications, PCPs will offer brief interventions by CCC BHPs to support cognitive-behavioral strategies for improved mood. Please see Level 2 for detailed description of program and services provided.
4. Behavioral Health Assessment Center (BHAC): PCPs and BHPs may also consider screening and support services available through the Behavioral Health Assessment Call Center (BHAC) such as depression monitoring for Veterans new to medication, and more thorough telephone screening for those Veterans who cannot or will not meet with the CCC BHP. BHAC services can be accessed via consult (found under behavioral health consult menu, listed as Behavioral Health Assessment Call Center). CCC BHPs may be called upon to offer clinical intervention for those Veterans who are identified as needing service following Behavioral Health Assessment Center (BHAC) screening.
5. Education: In addition to these staff resources, education about the appropriate medication management of uncomplicated and common mental health concerns in primary care (that do not warrant referral to specialty services) will be provided to primary care providers by experts, specialty psychiatric prescribers, and primary care leadership. (Please see above link to clinical practice guidelines and appendix A for specific prescribing information).

LEVEL 2: Co-located, Collaborative Care Behavioral Health Provider (CCC BHP): Typically non-prescriber (social worker or psychologist) embedded within primary care clinics. Listing of CCC BHPs for VISN 2 can be found at: Listing of VISN 2 CCC BHPs

It is the expectation that PCPs offer brief intervention by the CCC BHP to support cognitive-behavioral strategies for improved mood and functionality. This provides the Veteran with brief, behavioral health interventions while remaining within the primary care environment. See appendix B for effective referral scripts. Warm hand-offs to BHPs are utilized 90% of the time, and formal consults are rare, to be used only when BHP is not available to insure future linkage. Even when consults are used, PCP will arrange for the Veteran to be scheduled at their convenience before leaving clinic if same day direct hand-off is not possible.

The CCC BHP will have daily advanced access slots, and Veterans should be seen at least for a brief appointment on the same day as their primary medical appointment.

Integrated BHPs will assist PCPs in monitoring Veteran responses to newly initiated medication trials and provide brief behavioral interventions. PCPs also can contact the CCC BHP to assist with lethality

assessments, diagnostic clarification, determining appropriateness of medication trial, further assessment, and follow up. If a PCP is unsure whether medication is needed, the CCC BHP can provide more thorough assessment and brief behavioral interventions. BHPs can also provide education, prevention, and adherence, and are developing expertise in health behavior change as well. They may be excellent resources for Veterans in managing issues such as insomnia, pain, lifestyle issues, adjusting to illness or adherence concerns.

In addition, services provided by the CCC BHP, include, but are not limited to, the following

- Tobacco cessation
- MOVE!/Weight Management (enrollments, group classes and individual consultations)
- Brief interventions for alcohol misuse
- Interventions for coping with chronic medical conditions (e.g., diabetes management)
- Interventions for sleep difficulties such as insomnia
- Adherence to medical recommendations
- Pain management interventions
- Brief cognitive screening
- Brief interventions for common behavioral health concerns (e.g., depression, anxiety, grief and loss)
- Care facilitation

CCC BHPs **facilitate referrals to more intensive levels of care.** When considering referral for specialty behavioral health services it is highly recommended and expected that PCPs contact the CCC BHP. The CCC BHP will be familiar with the behavioral health resources within the specific area of the network, and will have the necessary knowledge and resources to ensure linkage to the most appropriate services (e.g., PRRC, group, evening services, etc.).

Due to variability across the network, unless the PCP is familiar with the standard local process, the CCC BHP should be consulted to facilitate referrals including, but not limited to, the following considerations.

- Bariatric Surgery evaluations
- Pre-Transplant evaluations
- Veterans requiring evaluation for interferon therapy for Hepatitis C
- Neuropsychology
- Substance abuse
- Post Traumatic Stress Disorder (PTSD)
- Veterans specifically interested in group therapy

For many diagnoses (e.g., PTSD, substance abuse) the most appropriate treatments and level of care will vary depending on symptom presentation, history, and Veteran preference. Primary care providers should contact the integrated CCC BHP; utilizing warm-hand offs whenever feasible. The BHP will conduct an initial assessment and make treatment recommendations, which may include brief behavioral interventions in primary care (e.g., empirically-supported brief interventions for alcohol use), a medication consultation by a psychiatric prescriber in primary care or via telemedicine, or a referral to specialty care for medication and/or behavioral interventions (including referrals to specialty PTSD or substance abuse treatment programs.) The BHP will also provide care facilitation to ensure linkage with specialty care, ranging from direct appointment arrangement to “bridge” contact, to direct escort to specialty staff if circumstances warrant. They will keep the PCP apprised of disposition and outcome in such cases.

The following are situations when PCPs should consider referring directly to specialty services, by-passing the CCC BHP. In these circumstances, PCPs should follow local policies for referral to specialty care.

- Immediate crisis situation and the CCC BHP is not available for warm hand-off
- The CCC BHP is only available to the clinic part time and referral to this provider would delay needed treatment process
- Veterans transferred from other medical centers previously receiving intensive MH services and specialty services are determined to be most appropriate form of continued care

LEVEL 3: Veteran appointment with a psychiatric prescriber in the primary care environment, in person or via telemedicine.

The primary role of psychiatric providers in primary care is to serve a consultation/liaison function to primary care providers within the least intensive level of care. However, at times Veterans will need more intensive care than available through this level of care, but may not require specialty mental health services. Although the extent of availability varies across the network according to clinic size and location, psychiatric prescribers work within many primary care clinics throughout VISN 2. In some CBOCs across the network, these services are provided via telemedicine, rather than through on-site providers. This serves as a middle level of care. At this level of care, Veterans will be scheduled with the psychiatric prescriber within primary care for diagnostic assessment, treatment initiation, and appropriate treatment planning. Within this level of care, the Veteran has at least one appointment with a specialty mental health prescriber for evaluation and medication initiation, but care is not transferred to specialty services. Once maintenance is established for stable non-psychotic disorders by the psychiatric prescriber, the PCP will resume care of the Veteran, including refill maintenance. Thus, the Veteran will remain within the least restrictive level of care.

The following are examples of appropriate use of consultation with a psychiatric prescriber to assist the PCP; however, this is not an exhaustive list. Note that, often, these needs can be met through non-visit consultation with the psychiatric prescriber (see level 1, including medication chart review consultation).

- Diagnostic clarification
- Concerns about choosing the best SSRI for an individual Veteran
- Concerns about lethality (may also refer to CCC BHP, non-prescriber)
- Concerns about appropriate dosing
- Contraindications
- Concerns about age and medical co-morbidities
- Concerns about side effects
- Complicated cases until stable (e.g., Depression and/or anxiety refractory to two different antidepressant trials adequately dosed)

LEVEL 4: Intensive specialty care (e.g., referral for medication and/or psychotherapy within specialty behavioral health programs).

The most intensive level of care is a referral to specialty mental health services outside of primary care. Some Veterans, because of their risk of lethality, medical/psychiatric complexity, or diminished coping capacity cannot be safely or effectively managed in the PC setting. The availability of and referral criteria for specific specialty behavioral health services vary across the network. Given the remote nature of some CBOCs, these CCC BHPs function in a dual role, 1) as the behavioral health consultant and 2) as the

behavioral health specialist (i.e., a small portion of their panel may consist of Veterans receiving longer-term psychotherapy services). It will increasingly become the expectation that specialty therapy for PTSD and substance abuse be provided via telemedicine to Veterans receiving care in rural CBOCs. The following information should be used as guidelines for referral to specialty services.

When referrals for behavioral health specialty care are placed, primary care providers will inform the Veteran of the indication for referral and obtain his/her verbal consent/agreement to be seen in mental health specialty care. This is the **only** level of care that will utilize formal computerized consults for routine practice. When considering referral to specialty care, level of risk, complexity, and functioning should be the primary guidelines rather than being dictated by specific diagnoses.

As aforementioned, when considering referral for specialty behavioral health services it is highly recommended that primary care providers contact the CCC BHP for additional consultation concerning appropriate referrals. This provider will be familiar with the programs offered within the particular region and can facilitate referral to these services as warranted. In particular, this provider will be the most familiar with the options for empirically based specialty mental health therapy (e.g., availability of Cognitive Processing Therapy (CPT) for PTSD, or Cognitive Behavioral Therapy (CBT) for depression as well as appropriate group options).

Veterans with the following conditions or needs are appropriate for referral to specialty behavioral health care for medication management or psychotherapy.

1. Complicated depression and/or anxiety:
   Complicated depression/anxiety is defined:
   - As depression/anxiety accompanied by psychosis and/or thoughts of self or other harm with intent to act. Psychiatry will also manage chronic thoughts of death without intent to act.
   - Depression and/or anxiety refractory to two different antidepressant trials adequately dosed.
   - Depression and/or anxiety complicated by adverse or serious side effects to medication after attempting to establish pharmacotherapy with at least two different first line medications.
2. Unstable Bipolar Disorder complicated by the following:
   - Thoughts of self or other harm.
   - Depressive episode with prior history of manic episodes.
   - Acute manic episodes.
   - Concomitant substance abuse.
3. Active schizophrenia (all types), schizoaffective and other psychotic disorders:
   - Thoughts of self or other harm.
   - Acute episode of hallucinations, thought disorder, and/or delusions.
4. Severe, chronic post-traumatic stress disorder (PTSD):**
5. Personality disorders requiring specialty behavioral health care.
6. Dementia**: Where available, these individuals should be referred to Geriatric services (e.g., GEM Clinic, Geropsychology, or Neuropsychology). When specialty geriatric services are not available or Veteran does not meet criteria, after delirium has been ruled out, dementia, complicated by behavioral problems or psychosis should be referred to psychiatry for medication management.
7. Substance abuse or misuse.**
8. Individuals, regardless of diagnosis, who have high levels of risk, complexity, or limited coping capacity.

9. Veteran request.

** Please note that for many diagnoses (e.g., PTSD, substance abuse) the most appropriate treatments and level of care will vary depending on symptom presentation, history, and Veteran preference. Although intensive specialty services will likely be the primary treatment modality, primary care providers should contact the integrated CCC BHP; utilizing warm hand-offs. The BHP will conduct an initial assessment and make treatment recommendations, which may include brief behavioral interventions in primary care (e.g., empirically-supported brief interventions for alcohol use), or a referral to specialty care for medication and/or behavioral interventions (including referrals to specialty PTSD or substance abuse treatment programs).

TIME FRAME:

It is expected that the CCC BHP will have daily advanced access slots, and Veterans should be seen for at least a brief appointment, on the same day as their primary medical appointment. Before placing a formal consult, please contact the CCC BHP to determine availability for same day, warm hand-off appointments.

Urgency:

When a CCC BHP is present, referrals should be made via warm hand-off, eliminating the need for formal consults and decreasing appointment wait times.

1. For emergent situations (reserved ***for acute emergencies***, such as severely depressed with suicidal/homicidal thoughts and intent) the VISN policy for management of suicidal patients and local SOPs should be employed. If the CCC BHP is not available, depending in the clinic setting, this may involve contacting the specialty behavioral health **"on-call"** provider or contacting local Emergency Department. **Veterans with active suicidal ideations must immediately be placed on 1:1 supervision until evaluated.**
2. **NEXT AVAILABLE:** moderately depressed or confused Veterans; non-suicidal Veterans; Veterans who are not responding to treatment for their mood or anxiety disorders; chronically psychotic Veterans, etc.
3. **ROUTINE:** Veterans with depression or anxiety not responding to two antidepressants; assessments for PTSD; etc.

Suicidal/Homicidal Ideation

Primary care staff and CCC BHPs will follow local clinic procedures and the VISN 2 policy for managing patients at risk for suicide when handling emergency situations. In CBOCs when the CCC BHPs are not on site, the covering clinician should be contacted for guidance or to work with local 911 in transporting Veterans to the nearest emergency department for evaluation. Primary care staff are encouraged to consult with their facility suicide prevention coordinator and the CCC BHP for matters pertaining to suicide ideation, risk, means restriction, and in regard to Veterans who have high risk for suicide as indentified by a patient red flag.

RETURN OF STABLE VETERANS TO CARE OF PRIMARY CARE

Once a Veteran becomes psychiatrically stable and remains on commonly prescribed psychiatric medications, the psychiatric clinic will have the option of referring the Veteran to his or her primary care provider for ongoing medication management (Veterans requiring ongoing counseling services will

continue to obtain those services in specialty care). A psychiatrically stable Veteran will be defined as follows:

- The Veteran should generally not be on more than two psychotropic medications.
- The Veteran should not be on formulary agents restricted to behavioral health.
- There should be no change in medication during the past six months.
- Relationship with the psychiatrist is not essential to the stability of the Veteran.

After obtaining agreement from the Veteran, the behavioral health provider will contact the primary care provider and the CCC BHP to discuss the case and finalize the transfer of care. A discharge note will be written by the behavioral health provider and will include a plan for future care including discussion of any medication monitoring needed, as well as indications for referral back to specialty behavioral health services.

To evaluate the effectiveness of this process the following items will be monitored:

- Number of new consults to specialty mental health services: as these should decrease over time.
- The number of Veterans seen by the CCC BHPs: expected to increase over time
- The number of Veterans with specific diagnoses (e.g., uncomplicated depression, anxiety, etc.) who are being seen in PC, in specialty mental health, and by the integrated behavioral health providers based on expected clinic population.
- Time to next available new appointment for specialty mental health providers: This should decrease as Veterans with uncomplicated depression/anxiety remain in primary care.
- Number of consults to BHAC for screening and monitoring of depression

Document Approval and Acknowledgements

This document was developed with extensive input from all stakeholder groups, reviewed and approved for VISN wide implementation by stakeholders and VISN 2 Network Primary Care and Behavioral Health leadership July 8th, 2010.

Portions of this document were based on existing service agreements solicited from the Bay Pines VA Medical Center, the West Palm Beach VA Medical Center, the Veterans Health Care System of the Ozarks, and the Albany VA Medical Center. These documents were compiled and modified to address the specific needs and structure of VISN 2. The committee members gratefully acknowledge the contributions from these facilities.

Appendix B

Sample Recruitment Advertisements

Advertising for a Co-located Collaborative Care Behavioral Health Provider (BHC) to Work in Primary Care-Mental Health Integration Program

The BHC position requires and independent license to practice in a healthcare setting, such as a Ph.D. or Psy.D. in psychology, an MSW (masters in social work). The individual in this position works as a primary care team member and delivers brief, consultation-based services to patients and PCMs in an integrated care model. The person adheres to the core competencies outlined in the integrated behavioral health in primary care practice manual. (Robinson & Reiter, 2007)

Appendix C

Sample CCC Interview Items PBI and Non PBI

Question (PBI)	Strong Response
1. Describe a time when you worked as a member of a clinical team in service to clients. Describe how the team worked together. What role did you play? What was your most valuable contribution	• Strong responses should respond to all elements of the item • Describe functioning as an informal team leader. • Look for candidates that emphasize role as the behavior change expert.
2. Describe your greatest a) challenges and b) successes in working with allied health providers multidisciplinary setting. What are your greatest strengths and weaknesses in this area? What factors do you see as carrying the greatest impact systemically in whether a multidisciplinary treatment program will function well or poorly?	• Look for clear examples that include both successes and challenges • Value the process and diversity of multidisciplinary teams • Describes positive collaborations with diverse provider types
3. In what evidence-based treatment approaches are you well versed? What do you see as the chief advantages and drawbacks of evidence based therapies?	• Motivational interviewing • Cognitive behavioral interventions
4. What have been your greatest challenges in time management and prioritizing competing demands, and how have you resolved them?	• Strong responses should reflect exceptional organizational skills and the ability to triage demands, and specific steps for resolving
5. Give us an example to illustrate how you have monitored and met the needs of health care providers as your customers. How did you assess their needs, and how did you determine that your efforts in support of them were effective?	• Some applicants may be confused by this item, and request additional clarification. • Strong responses will reflect an understanding of the importance of positive relationships with other providers and "internal customers" • Responses should include specific actions, such as asking providers what is working and what is not meeting their needs or conducting quick surveys to understand providers needs • Strong responses will reflect adaptability and the willingness to vary practice patterns based on feedback from other team members
6. Describe a time when you consulted with a	• Responses should reflect understanding of

PCP about helping a patient to make a health behavior change. What techniques did you describe and what communication strategies did you use?	fast-paced medical environment • The need to provide, quick, concise feedback • Adaptability to use multiple communication mechanism based on the team member's preferences
7. For the following items, on a scale of 0-10, with 0 indicating no knowledge/skill, 5 indicating an average level of knowledge/skill, and 10 indicating exceptional knowledge/skill, rate yourself in the following areas and give a brief example of each to demonstrate your skill level: • DSM diagnostic interviewing/ differential diagnosis • Triage and care coordination • Brief psychological intervention • Working within an interdisciplinary medical team • Motivational interviewing, treatment adherence, health behavior change • Crisis intervention • Population based integrated primary care_____	• Strong responses, should reflect accurate individual evaluation, rather than overstated responses. • Each of these items reflect important skills for functioning in PC • If rates a particular low, a strong response should include interest and willingness to learn and improve these skills.

Question (Non PBI)	Strong response
1. What are your thoughts about mental health care in general at the present time?	• Look for someone who sees problems with the specialty model of care and wants to do something different • Look for those who say would like to see more patients and extend services to a greater percentage of the population.
2. Describe your ideal work situation, including the room and area of a building where you would like to work and the types of patients you would ideally see.	• Behavioral health providers are usually taught to keep private, quiet offices, so don't expect a candidate to suggest otherwise. • The ideal candidate says he or she likes to be in the middle of the action and that variety in patient and problem types are what he or she is looking to work with. • Be skeptical of candidates that want a narrow specialty, non-clinical activities or a predictable practice schedule. Avoid

	candidates who would refuse to treat certain problems
3. If you only had 15 minutes with a patient who had marital difficulties who was referred to you for insomnia what would you do?	• Most candidates will express surprise and maybe uncertainty when asked to describe a 15-minute intervention. • Look for answers that stick to the problems at hand and end with a clear patient self-management plan. A sound answer might suggest screening for common causes of insomnia, like depression, anxiety and sleep behaviors (e.g., getting into bed when not sleepy) and should also include some kind of intervention (a referral for counseling is not a sufficient answer)
4. If you were asked to consult with a PCM about an obese patient with diabetes who is non-compliant with treatment, what would you do?	• Most candidates will not have experience or expertise with this type of patient, however, they should show some basic familiarity with both and a willingness to engage with the patient. • Ideal responses will mention approaches with motivational interviewing or acceptance of chronic disease, collaborative goal-setting, assessment of depression, and some type of patient plan to decrease calorie intake, increase physical activity or both.
5. If a clinic manager came to you and asked you to be the lead for the clinic in developing a clinical pathway for chronic pain, what would you do?	• Most candidates will not be familiar with the term clinical pathway, so one who is might be a strong candidate. If not familiar with the term, the candidate should express an interest in learning about it. • An ideal answer would include something about improving quality of life and functioning.
6. If a clinic manager came to you and asked you to be the lead for the clinic in developing a clinical pathway for substance abuse, what would you do?	• Most candidates will not be familiar with the term clinical pathway, so one who is might be a strong candidate. If not familiar with the term, the candidate should express an interest in learning about it. • Ideal response--listen for an awareness of the prevalence of substance abuse problems and a willingness to engage with

	them, some. A response suggesting motivational interviewing procedures, getting other staffed involved and screening would be an impressive answer.

Appendix D

Core Competencies Checklist (Robinson & Reiter, 2007)

Dimension	GOALS	Does Not Meet Standard	Meets Standard
I. Clinical Practice Skills	1. Applies principles of population based care for everyone along a continuum from acute need, sub clinical problems & prevention to those who are healthy.)	◯	◯
	2. Defines Behavioral Health Consultant Role with patient before starting assessment. (Able to say intro accurately; e.g., deliver memorize script content in 2-minutes or less)	◯	◯
	3. Rapid problem identification (Able to determine if referral problem is what the patient sees as the problem in the first minute after the intro script is finished for 90% of all first consultation appointments.)	◯	◯
	4. Uses appropriate assessment questions (e.g. Ask questions geared towards current problem referral and functioning & how the patient's physical condition, thoughts, emotions, behaviors, habits, and environment are impacting/influencing the identified problem and functioning.)	◯	◯
	5. Limits problem definition/assessment (focuses on presenting problem). Does not assess other areas (except suicide and homicide as indicated for depressed and stressed individuals) until assessment of initial referral problem is complete and as time allows.)	◯	◯
	6. Focuses recommendations and interventions on functional outcomes and symptom reduction. [e.g., Improve ability to work, improve performance on responsibilities at home, increase frequency or improve quality of social interactions (friends), increase intimate/familial interactions (spouse, children), increase exercise, enjoyable or spiritual activities, improved sleep, decreased autonomic arousal, decreased pain exacerbation, improved mood.]	◯	◯
	7. Teaches self-management skills/home-based practice as the prime method for decreased patient symptoms and improved functioning. (e.g., deep breathing, cue controlled relaxation, cognitive disputation, sleep hygiene, stimulus control, eating behavior changes, increased physical activity, problem solving, and assertive communication) The majority of what the patient does to decrease symptoms and improve functioning is done outside of the consultation appointment.	◯	◯
	8. Interventions are specifically (operationally) defined and supportable by primary care team members (e.g., increase fun activities [read mon, wed, fri from 1300-1330 in home office], increase exercise [mon-fri from 1700-1730, 30-minutes on stair-stepper], use relaxation skills)	◯	◯

	9. Shows understanding of relationship of medical and psychological systems (e.g. biopsychosocial model of physiological disorders, can describe to the patient the relevant factors, physical, behaviors, thoughts, environment, interactions with others, impacting symptoms and functional impairments)	◯	◯
	10. Shows basic knowledge of medicines (Can name basic anxiety and antidepressant meds and what might be a first line recommendation for specific symptom presentation)	◯	◯

Dimension	**GOALS**		
		Does Not Meet Standard	**Meets Standard**
II. Practice Management Skills	1. Uses 30-minute appointment efficiently (e.g., identify problem, how functionally pt is impaired, symptoms, summarize to patient understanding of problem during at the 15 minute point, use next 10 minutes to develop and start a behavioral change plan)	◯	◯
	2. Stays on time when conducting consecutive appointments	◯	◯
	3. Demonstrates capacity to consistently use intermittent visit strategy (e.g., see patient in 2 wks or in 1 month instead of every week)	◯	◯
	4. Appropriately suggests the patient seek specialty behavioral health care when the intensity of service needed to adequately address the patient's problem is beyond what can be done in consultation appointments. (e.g., PTSD, OCD, Marital Counseling, ETOH abuse/dependence)	◯	◯
	5. Uses community resources referral strategies (e.g., Military One Source, community retirement center for those using primary care for social contact, self-help divorce group, etc.)	◯	◯
III. Consultation Skills with PCMs	1. Focuses on and responds to referral question (e.g., specifically talks about evaluation regarding initial referral question)	◯	◯
	2. Tailors recommendations to work pace of primary care (e.g., recommendations given to PCMs be done in 1-2 minutes by the PCM when/if they see the patient again)	◯	◯
	3. Conducts effective feedback consultations (e.g., when giving feedback keep to 1 minute or less and use specific straight-forward short explanations)	◯	◯
	4. Willing to aggressively follow up with providers, when indicated (e.g., medication recommendations for depression/anxiety, significant side effects for meds, alarming medical symptoms)	◯	◯

	5. Focuses on recommendations that reduce providers ' visits and workload (e.g., recommend patient see you in two weeks to assess symptoms and functional changes and response to medications instead of seeing PCM)	◯	◯
IV. Documentation Skills	1. Writes clear, concise medical record notes (e.g., focus on referral problem, frequency, duration, acute or long-term, functional impairment, short specific recommendations)	◯	◯
	2. Notes are consistent with feedback to the PCP (e.g., note is a general outline of the verbal information or email you give/send the PCP)	◯	◯

Appendix E

Functional Statement

Staff Psychologist, Co-located, Collaborative Care, PC-MHI Program

Series: GS-0180

Position grade: GS-13

Full performance level of position: GS-13

1. QUALIFICATIONS:

a. Doctoral degree in Clinical/Counseling Psychology (American Psychological Association accredited)

b. Internship in Psychology (American Psychological Association accredited)

c. Psychology Licensure

d. One year of experience as a professional psychologist equivalent to the GS-12 level.

2. GENERAL DESCRIPTION: This co-located, collaborative care (CCC) psychologist position is administratively within the Behavioral VA Care Line, with primary assignment to the Primary Care- Mental Health Integration (PC-MHI) program, located within primary care. The CCC behavioral health provider (psychologist) functions as part of multidisciplinary primary care teams, and delivers brief, consultation-based services to Veterans, primary care providers, and allied Patient Alliance Care Team (PACT) members. The focus is on general service delivery for a wide range of concerns and resolving problems within the primary care service context. Behavioral health visits are brief (generally 20--30 minutes), limited in number (1-6 visits), and are provided in the primary care practice area, structured so that the patient views meeting with the behavioral health provider as a routine primary care service. CCC BHPs function within fast-paced primary care teams and can expect to consult with 8-10 patients per day with the primary goals of assisting PACT members with identification, treatment, and management of mental health and behavioral medicine conditions in the enrolled population.

3. FUNCTIONS:

a. PC-MHI Clinical Practice:

The CCC PC-MHI psychologist provides functional assessment, triage, brief intervention, education and consultative services regarding a wide range of mental health and behavioral medicine concerns, on referral from primary care providers and allied PACT members. The PC-MHI psychologist uses population based practice management strategies and maintains competences in the following core domains.

1. **CCC PC-MHI Clinical Practice Management:** Conduct functional assessments, based on 30 minute appointments and will triage/refer to specialty care services as appropriate.

    - Applies principals of population based care (defines role and identifies problems rapidly)
    - ___percentage of all appointments are 30 minutes (will vary by setting)
    - Uses brief assessments routinely (e.g., PHQ-9, PCL, AUDIT C, etc)
    - Initial consultation appointment are based on functional assessments and treatment focuses on functional outcomes
    - Maintains daily open access slots
    - Next available "scheduled" appointment is within two weeks
    - Provides brief mental health and behavioral interventions (e.g., 1-5 sessions for broad range of concerns)

- Uses time-limited, evidence based, interventions that are simple and concrete
- Uses self-management/home-based practice interventions
- Uses intermittent visit strategy and flexible patient contact strategies
- Triages appropriately and efficiently to specialty mental health services
- Provide behavioral medicine interventions (including but not limited to stepped care level 2 tobacco cessation, alcohol misuse, weight management, and coping with chronic illness)
    - Stress management
    - Sleep hygiene
    - Relaxation training
    - Other interventions will be provided as clinically appropriate, based on patient need.
    - Leads MOVE! Group, or co-leads with other team members
        - Conducts individual MOVE! appointments
        - Uses behavioral health principles, and behavioral health intervention strategies to support patients in weight loss and other health concerns.
        - Collaborates with other members of the multi-disciplinary MOVE! Team and defers to their expertise on matters of nutrition or exercise

2. <u>Documentation skills</u>

- Writes clear concise notes, generally ½-1 page long, with explicit impression, recommendations and plan for PCP use
- Notes document curbside consultation results
- Notes are completed within 24 hours

3. <u>Consultation Skills</u>

- Routinely Consults with PCPs and other PACT team members about plan of care for patients
- Conducts effective curbside consultations
- Integrates within primary care team and works closely in collaboration with PACT team
- Attends PACT meetings and daily huddles
- Routinely provides feedback (verbal and/or written) to PCP and other PACT members same day as referral
- Uses warm-hand off strategy,
- Provides education to PACT on BH issues as well as consultation on tips for successful care management and patient facilitation, even when no direct patient contact.

b. Administration:

- Serves on Medical Center or Healthcare System, VISN, and/or National VA committees or task forces, as endorsed by supervisors.
- Participates in Psychology privileging, educational and peer review activities, in accord with Psychology and medical center policies.
- Participates as a non-voting member of the medical staff, in accord with medical staff by-laws.
- Participates in support of BVAC and Psychology administrative and performance improvement activities, e.g., by taking on assigned projects and serving on committees.
- Completes required clinical and administrative documentation in a timely manner and in accord with governing regulations.

c. Academic/Teaching/Training

- Supervises psychology predoctoral interns, practicum students and post-doctoral fellows in accord with training program policies and accrediting agency requirements.
- Provides staff and student didactic training and consultation as requested in content areas of scholarly and/or clinical expertise.
- May supervise or train allied health providers in accord with facility and regulatory standards regarding such training.

d. Research / Program evaluation

- May participate in program evaluation and/or research activities.

4. SUPERVISORY CONTROLS: The psychologist practices independently, using professional judgment and data-based expertise to make decisions about services and treatment provided to Veterans and their significant others. The incumbent works within a matrix management model and is responsible to
a) the Primary Care Director and team as a team member and participant in daily clinical activities,
b) the Behavioral Health Care Line and Program Manager for administrative oversight, and
c) the Lead Psychologist for oversight of professional practice.
The psychologist consults with respective supervisors as needed and with colleagues to develop knowledge and to apply agency policies and practices to new matters. The supervisory or local champion who oversees PC-MHI programs will complete performance evaluations with input from PCPs and other PACT team members.

5. KNOWLEDGE, SKILLS & ABILITIES: The following knowledge, skills and abilities are minimally required for psychologists practicing in the primary care environment at a GS-13 level:

- Knowledge of, and ability to apply, a wide range of psychological theories, evidence based practice and targeted assessment methods to a variety of patient concerns.
- Possess specialized knowledge of evidence-based treatment for general behavioral health problems (e.g., depression and anxiety) and areas of behavioral medicine (e.g., chronic pain, obesity and sleep problems).

- Demonstrated knowledge and understanding of PC-MHI programs (including CCC and CM)

- Familiarity with population based interventions, as well as consultation and liaison skills, and familiarity with evidenced based brief interventions such as cognitive-behavioral techniques
- Demonstrated competency and experience in providing clinical services using behavioral medicine techniques (e.g., chronic disease management, weight management, tobacco cessation, stress management, etc.)
- Medical Literacy, as demonstrated by familiarity with common medical terms, front-line psychiatric medications, understanding of medical culture, and previous experience as part of interdisciplinary treatment teams.
- Ability to develop coherent treatment strategies that are problem-focused and solution oriented.
- Ability to integrate, collaborate, and communicate diagnostic and treatment recommendations with PACT members.

Appendix F

Sample Performance Plan Content PC-MHI CCC Psychologist

Department of Veterans Affairs

PERFORMANCE APPRAISAL PROGRAM

***IMPORTANT**: For additional information see VA Handbook 5013/1, Part 1. If additional space is needed for any item on this form, use page 6.*

PERFORMANCE PLAN AND APPRAISAL OF

EMPLOYEE'S NAME *(Last, First, Middle Initial)*	POSITION TITLE, SERIES AND NUMBER	GRADE/SALARY
	Psychologist	GS-13

DATE ASSIGNED PRESENT POSITION	DUE DATE OF WITHIN-GRADE INCREASE	PERIOD COVERED BY THIS APPRAISAL FROM TO

SIGNATURE AND TITLE OF RATER PREPARING THIS PERFORMANCE PLAN	DATE	SIGNATURE OF EMPLOYEE	DATE

SECTION A - PERFORMANCE PLAN

Reflect the performance elements for the position to be rated. An element is defined as a component of a position that is sufficiently important to warrant written appraisal. Normally each position has four or five elements. Designate with an asterisk the element(s) considered critical. Specific performance standards must be written for each element. There are usually three to five performance standards for each element. When writing performance standards, only the fully successful level of achievement need be defined.

PERFORMANCE ELEMENTS/ STANDARDS

The following have been indentified as essential elements of clinical duties for a CCC PC-MHI provider. The CCC PC-MHI is expected to obtain and maintain mastery within the following domains of core competency developed by Robinson and Reiter (2007)

***CCC PC-MHI Clinical Practice Skills:**

Conduct functional assessments, based on 30 minute appointments and will triage/refer to specialty care services as appropriate. Service provided include, but are not limited to,

- Applies principals of population based care (defines role and identifies problems rapidly)
- ___percentage of all appointments are 30 minutes (will vary by setting)
- Uses brief assessments routinely (e.g., PHQ-9, PCL, AUDIT C, etc.)
- Initial consultation appointment are based on functional assessments and treatment focuses on functional outcomes
- Maintains daily open access slots
- Next available "scheduled" appointment is within two weeks
- Provides brief mental health and behavioral interventions (e.g., 1-5 sessions for broad range of concerns)
- Uses time-limited, evidence based, interventions that are simple and concrete
- Uses self-management/home-based practice interventions
- Uses intermittent visit strategy and flexible patient contact strategies

PERFORMANCE ELEMENTS/ STANDARDS

- Uses intermittent visit strategy and flexible patient contact strategies
- Triages appropriately and efficiently to specialty mental health services
- Provide behavioral medicine interventions (including but not limited to- stepped care level 2 tobacco cessation, alcohol misuse, weight management, coping with chronic illness) Stress management, Sleep hygiene, Relaxation training.

Other interventions will be provided as clinically appropriate, based on patient need.

- Leads MOVE! Group, or co-leads with other team members
- Conducts individual MOVE! appointments
- Uses behavioral health principles, and behavioral health intervention strategies to support patients in weight loss and other health concerns.
- Collaborates with other members of the multi-disciplinary MOVE! Team and defers to their expertise on matters of nutrition or exercise

Documentation Skills:

- Writes clear concise notes, generally ½-1 page long, with explicit impression, recommendations and plan for PCP use
- Notes document curbside consultation results
- Notes are completed within 24 hours

***Consultation Skills**

- Routinely Consults with PCPs and other PACT team members about plan of care for patients
- Conducts effective curbside consultations
- Integrates within primary care team and works closely in collaboration with PACT team
- Attends PACT meetings and daily huddles
- Routinely provides feedback (verbal and/or written) to PCP and other PACT members same day as referral
- Uses warm-hand off strategy,
- Provides education to PACT on BH issues as well as consultation on tips for successful care management and patient facilitation, even when no direct patient contact.

***Continued Education:**

- Participates in monthly PC-MHI learning collaborative phone calls
- Attends trainings in EBP for brief therapies
- Maintains knowledge based of IPC literature
- Conducts self-assessment using Robinson and Reiter (2007) core competency checklist and seeks additional training as needed

***Other duties as assigned:**

***ADP Security**

- Protects printed and electronic files containing sensitive data in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, federal regulations, VA statutes and policy.
- Protects data from unauthorized release or from loss, alteration, or unauthorized deletion. Follows applicable regulations and instructions regarding access to computerized files, release of access codes.

* **Customer Service**

- Meets the needs of customers while supporting VA missions.
- Consistently communicates and treats customers (Veterans, their representative, visitors, and all VA staff) in a courteous, tactful and respectful manner.
- Provides customers with consistent, responsive information.
- Handles conflict and problems in dealing with customers constructively and appropriately.

SECTION C-1 - ACTUAL ACHIEVEMENT

Indicate the single, overall level of achievement that best describes the employee's performance for each ELEMENT shown in Section A. Do not

indicate achievement for each individual standard. Specific examples of performance must be provided in the space below for each element

where a level of achievement other than Fully Successful has been assigned. Assignment of the Exceptional

ELEMENTS *(Use the same keyword description for each element as in Section A)*	LEVELS OF ACHIEVEMENT EXCEPTIONAL	FULLY SUCCESSFUL	LESS THAN FULLY SUCCESSFUL
CCC PC-MHI Clinical Practice Skills:	☐	☐	☐
Documentation Skills	☐	☐	☐
Consultation skills	☐	☐	☐
Continuing Education	☐	☐	☐
Other Duties as assigned	☐	☐	☐
ADP Security	☐	☐	☐
Customer Service	☐	☐	☐

Describe specific examples of performance for each element where a level of achievement other than Fully Successful has been assigned above. Specific achievements at the Fully Successful level may be described

Appendix G

Sample Language for Local CCC PC-MHI Supervisors or Team Lead/Champions Performance Plans

- **Supervision of CCC PC-MHI staff:**
    - Ensures all CCC BHP supervisees have tailored performance plans and position descriptions/functional statements that detail specific CCC PC-MHI expectations and competencies.
    - Ensures all CCC PC-MHI staff receive adequate training to support core competency skill acquisition and maintenance, (i.e., clinical skills, practice management, consultation, documentation, teamwork, and administrative skills) as detailed by Robinson & Reiter, 2007.
        - New providers have at least one week orientation time shadowing successful CCC BHPs and PCPs in primacy care, prior to assuming active clinical responsibilities,
        - Ensures all CCC BHP supervisees have completed recommended readings (e.g., VISN 2 Integrated Primary Care Behavioral Health Services Operations Manual and other PC-MHI literature. Readings and checklist with provider sign-off for reading completion provided by CIH.)
        - Ensures new providers attend a CIH CCC National training program or provide comparable, intensive training on-site.
    - Conducts monthly local call with all CCC PC-MHI supervisees. Goals are to provide supervision, consultation, peer support, and problem solving within a collaborative setting.

- **PC-MHI program monitoring :**
    - Monitors individual CCC PC-MHI provider's practice management trends, including the number of unique patients seen, the total number of encounters, the number of encounters per unique, the number of encounters per day, and the most common diagnoses seen in clinic, using data available on the National PC-MHI dashboard http://reports2.vssc.med.va.gov/ReportServer/Pages/Reportviewer.aspx?%2fPC%2fPCMM%2fPC-MH+Integration%2fMainMenu .
    - Reviews PC-MHI monitored metrics quarterly with each CCC BHP. (CIH staff will provide consultation as part of this process for first quarter of implementation and as needed thereafter)
    - Conducts monthly individual discussions with providers whose data consistently fails to suggest adequate utilization rates or adequate primary care mental health integration and/or seeks consultations from facilitation experts as needed.
    - Develops and implements action plans for areas of identified difficulty

- **PC-MHI Collaboration**
    - BH leadership meets at least quarterly with local PC medical team leads to ensure on-going problem solving and collaborative communications

- **Continuing Education:**
    - Maintains knowledge of IPC literature and expectations of National PC-MHI office
    - Receives consultation, meta-supervision, and support at least quarterly with either CIH staff or other national PC-MHI leaders via national calls.

Appendix H

Steps for Implementing Collaborative Care Models

(Modified from Fortney et al., 2009 and Kirchner et al., 2010)

Implementation Step		Decision	Action Item
Step 1	**Specify possible target patients and identification procedures:** • Patients referred by PCP(warm hand offs) • Patients referred for brief interventions (approximately 1-4 sessions) for stress management, tobacco and alcohol misuse, chronic pain, sleep hygiene, lifestyle changes and coping with chronic illness • Patients referred for brief interventions for anxiety and depression • Patients referred for skill building (relaxation training, goal setting) • Patients screening positive for one or more of the following conditions, e.g., depression, alcohol dependence, anxiety and PTSD • Patients with target condition • Patients targeted by performance measures • Other		
Step 2	**Identify possible exclusion criteria and method for assessing criteria:** • Patients currently enrolled in specialty mental health • Schizophrenia • Bipolar Disorder • Severe substance misuse • Severe anxiety • Severe PTSD • High risk suicide ideation • No exclusion for initial consultation and triage visit or skill building and coping with chronic disease interventions but ultimately will not see the following for on-going services		

	• Other		
Step 3	**Specify collaborative care team members:** • Behavioral health provider (e.g., psychologist, masters level social worker, licensed counselor) • Primary care providers (physician, physician assistant, nurse practitioner) • Care manager (e.g., nurse, social worker) • Co-located Prescribing Provider • Clinical supervisor (e.g., psychiatrist) • OEF/OIF Care Coordinator • Other		
Step 4	**Specify clinical activities of collaborative care team members:** • Behavioral health providers o Functional assessment o Triage and consultation o Brief interventions (e.g., 1-4 sessions for multiple concerns) o Behavioral medicine interventions(e.g., tobacco cessation, alcohol misuse, weight management) o Stress management o Sleep hygiene o Behavioral interventions for chronic pain o Lifestyle interventions for chronic conditions (e.g., diabetes) o Relaxation training o Other • Primary Care Providers: o Screen for target condition o Diagnose target condition o Prescribe medication o Refer to collaborative care team o Refer to specialty mental health o Educate PCPs o Participate in education activities o Other • Co-located prescribing provider: o Train collaborative care team o Supervise collaborative care team o Educate PCPs o Provide treatment recommendations to PCPs o Provide consultations (by appointment and/or curbside) o Accepts referrals o Other		

	• Care Managers:
	  ○ Symptom assessment of target condition
	  ○ Education and activation
	  ○ Treatment preference assessment
	  ○ Treatment barriers assessment
	  ○ Psychosocial assessment
	  ○ Self-management goal and activity setting
	  ○ Brief counseling (e.g., problem solving therapy)
	  ○ Psychiatric comorbidity assessment:
	  – Schizophrenia
	  – Bipolar Disorder
	  – Substance misuse
	  – PTSD
	  – Panic Disorder
	  – Generalized Anxiety Disorder
	  – Sleep Disorders
	  – Pain
	  – Other
	  ○ Management of comorbid conditions:
	  – Substance misuse (mild, moderate)
	  – PTSD (mild, moderate)
	  – Panic Disorder
	  – Generalized Anxiety Disorder
	  – Sleep Disorders
	  – Pain
	  – Other
	  ○ Symptom monitoring for target conditions
	  ○ Medication adherence monitoring
	  ○ Side-effects monitoring
	  ○ Counseling adherence monitoring
	  ○ Self-management monitoring
	  ○ Other
	• Care Manager Psychiatric Supervisor:
	  ○ Train collaborative care team
	  ○ Supervise collaborative care team
	  ○ Educate PCPs
	  ○ Assess difficult cases presented by collaborative care manager
	  ○ Provide treatment recommendations to PCPs
	  ○ Provide consultations (by appointment and/or curbside)
	  ○ Accepts referrals
	  ○ Other		

Step 5	**Specify treatment guidelines:** • Specify protocols for stepping up the		

	intensity of care for patients failing treatment. • Guidelines for referral to specialty mental health: o Patient preference o Treatment resistant o Severity of illness o Suicide risk o Psychiatric comorbidity o Non-response o Non-adherence • Guidelines for disenrolling patients: o Length of time enrolled o Number of failed trials o Increases in symptom severity or comorbidity o Treatment response • Medication management algorithm (formulary adjustments)		
Step 6	**Specify suicide protocol:** • Protocol for assessing suicide risk • Protocol for ensuring safety of high risk patients		
Step 7	**Identify or develop implementation tools:** • Decision support system • Clinical assessment tools: o Symptom severity for target condition o Suicide risk o Psychiatric comorbidity o Adherence o Side-effects • Brochures and educational materials for PCPs • Brochures and educational materials for patients • Training materials for collaborative care team • Job descriptions and scope of practices for depression care team members • Establish clinic names and codes • Standards for assigning diagnoses, CPT codes, etc. • Consult forms/procedures • Other		

Appendix I

IPC BHP Initial Appointment Note Template – (Includes all expanded CPRS drop-down menus. Actual note is brief in length)

- Date:
- Visit Duration:
  - ◯ 15 minutes
  - ◯ 30 minutes
  - ◯ 45 minutes
  - ◯ 60 minutes
- Type:
  - ☐ Individual
  - ☐ Family
  - ☐ Conjoint (e.g., with PCP)
  - ☐ Group
  - ☐ Other: Specify _____
  - ☐ Scheduled
  - ☐ Walk in
  - ☐ Warm hand-off
- Reason for referral/Chief complaint:
  - ☐ Anxiety/PTSD
  - ☐ Bereavement/grief
  - ☐ Chronic illness management
    - ◯ Adjustment to medical condition: Specify_____
    - ◯ Diabetes
    - ◯ Pain
    - ◯ Other: Specify_____
  - ☐ Depression
  - ☐ Positive depression screen
  - ☐ Positive PTSD screen
  - ☐ Positive AUDIT C screen
  - ☐ Relapse prevention
  - ☐ Relationship/marital concern
  - ☐ Sleep concerns: Specify_____
  - ☐ Stress: Specify_____ ____
  - ☐ Substance misuse
  - ☐ Tobacco use cessation
  - ☐ Weight management
  - ☐ Wellness intervention
  - ☐ Other: Specify _____
- Referred by:
  - ◯ PCP
  - ◯ Self
  - ◯ Other: Specify _____
- PCP's concern:
- IPC BHP's role explained to Vet:
  - ◯ Yes
  - ◯ No
- Screening:
  - ☐ PCL (Post Traumatic Stress Disorder Checklist)
  - ☐ PHQ-9 (Patient Questionnaire- Nine Symptom Checklist)
  - ☐ AUDIT-C (Alcohol Use Disorders Identification Test)

- ☐ Other: Specify _____
- Session Focus: (free text, with prompts)
  - ☐ *Prompt:* Vet's statement of goal and concerns in his/her own words: *(free text)*
  - ☐ *Prompt:* Problem, noting frequency, intensity, duration, and history
  - ☐ *Prompt:* Past behavioral health treatment
- Functional Assessment (checkboxes, providing details as indicated)
  - ☐ Caffeine:
  - ☐ Close relationships:
  - ☐ ETOH:
  - ☐ Health and medical concerns:
  - ☐ Mood:
  - ☐ Non prescription drugs:
  - ☐ Pain (0-10)
    - ◯ Current:
    - ◯ Usual:
    - ◯ Best:
    - ◯ Worst:
  - ☐ Physical Activity:
  - ☐ Recreation :
  - ☐ Sleep:
  - ☐ Tobacco:
  - ☐ Work:
- Intervention:
  - Behavioral self-management
    - ☐ Anger management
    - ☐ Chronic illness management
      - ◯ Pain
      - ◯ Diabetes
      - ◯ Other: Specify _____
    - ☐ Communication skills
    - ☐ Healthy lifestyle behaviors
    - ☐ Insomnia intervention
    - ☐ Relapse prevention
    - ☐ Relaxation
      - ◯ Deep breathing
      - ◯ PMR
      - ◯ Stimulus control
      - ◯ Visualization
      - ◯ Other: Specify _____
    - ☐ Social support facilitation
    - ☐ Other: Specify_____
  - Care facilitation: (e.g., arranged medical appointments, facilitated linkage with other programs or services) Specify

    _____
  - Cognitive intervention
  - Goal setting (S.M.A.R.T.)
  - Medication support
  - Motivational interviewing
  - Supportive intervention
  - WRAP/Recovery support
- Patient education

- Verbal
- Written handouts
  - Specific handout:_____
    Link to CIH share point site containing educational materials = http://vaww.visn2.portal.va.gov/sites/natl/cih/default.aspx

- Diagnostic Impressions
  - Summary statement from Functional Assessment: *(free text)*
- Lethality
  - Behavioral Health Suicide Risk Assessment Note Completed today. See separate note dated (today's date).
  - Behavioral Health Suicide Risk Assessment Note Completed previously (within the past year) by _____ . See note dated _____ .
  - Pt. reports suicidal or homicidal *ideations.*
    - Yes: Specify _____
    - No
  - Pt. reports suicidal or homicidal *plans.*
    - Yes: Specify_____
    - No
  - Pt. reports suicidal or homicidal *intentions.*
    - Yes: Specify
    - No:

Risk level impression

- High risk: requires psychiatric stabilization at an increased frequency or level of care
- Intermediate risk: significant ongoing suicide risk but pt stable under current circumstances
- Low risk: presence of risk minimal but ongoing monitoring is warranted,
- Minimal risk: inconsequential level of risk
  Justification: _____

- Plan for management of lethality concerns
  - ☐ No treatment indicated at present,
  - ☐ Outpatient
  - ☐ Inpatient
  - ☐ Triage/ED
  - ☐ Other: Specify _____
- Patient Provided with:
  - ☐ Clinic and hotline contact information,
  - ☐ Appointment card and next step details
  - ☐ Managing risks/seeking help information and literature
- Pt. self management plan *(free text)*
  - Encourage patient specific "SMART" goals
    Specify: _____

Interdisciplinary treatment planning involving

- ☐ PCP
- ☐ Nurse
- ☐ Dietician
- ☐ Pharmacy
- ☐ Medical social work
- ☐ Psychiatric prescriber
- ☐ Other PCP team member: Specify _____

- ☐ Non-IPC provider: (e.g., specialty medical or MH clinician) Specify: _____

- Follow-up
  - BHP to consult with PCP about medications or other management suggestions
  - No follow-up needed
  - Patient already seeing specialty mental health provider; no further IPC behavioral health treatment planned
  - Referral to Behavioral Health Assessment Call Center (link to CPRS consult) for:
    - ☐ Core Assessment (additional screening)
    - ☐ Depression monitoring
    - ☐ Referral management program
    - ☐ Phone support when referring clinician not available
    - ☐ Other: Specify:_____
  - Facilitated linkage to specialty mental health provider/program
    - Appointment scheduled with _____on _____
    - Consult for _____ placed
  - Facilitated linkage for medication appointment with psychiatric prescriber
    - ☐ In PC
    - ☐ In specialty mental health program
    - ☐ Via telemedicine
    - ☐ Appointment scheduled with _____on _____
    - ☐ Consult for _____ placed
  - Referral to community resource/agency
  - Referral to other VA services:_____
  - Refused follow-up
  - Return for IPC BHP follow-up
    - ☐ 1 week: Date _____
    - ☐ 2 weeks: Date _____
    - ☐ 3 weeks: Date _____
    - ☐ 4 weeks: Date _____
    - ☐ > 4 weeks: Date _____
  - BHP telephone follow up: Date _____
- Clinical reminders completed
- PCP provided with feedback (multiple routes)
  - ☐ View alert/Additional signer
  - ☐ In person
  - ☐ By phone
  - ☐ VISTA, GUI, or Secured Messaging
  - ☐ Written note

Appendix J
DISSEMINATION GUIDANCE

Department of Veterans Affairs

Memorandum

Date: September 29, 2010

From: PC-MHI Team Leader for Behavioral Health

Subj: Operations Manual for Co-Located, Collaborative Care

To: Behavioral Health Careline Manager, Primary Care Manager, Mental Health Clinic Director

1. I am writing to share a newly released, comprehensive resource for Primary Care-Mental Health Integration. The attached Operations Manual, developed by staff from the Center for Integrated Healthcare, with input from national leaders in integration. It is a detailed "How-To" guide to implementing successful, sustainable integration of a Co-Located, Collaborative Care approach in the Patient Aligned Care Team (PACT).

2. Data from best practice sites across the system, such as _. _ . __consistently show that careful implementation of this model leads to reduced referrals to specialty care, relieving the stress on those systems and allowing them to serve seriously ill patients in a more accessible way as well as improved patient and provider satisfaction.

3. The manual is designed to delineate critical tasks from targeted recruitment, training and core competency development, to personnel management, program monitoring and workload capture. It is intended to support both the embedded integrated behavioral health providers in very practical ways, and the team leaders/supervisors and managers responsible for overseeing these programs.

4. The Executive Summary from the beginning of the manual is attached, along with the Table of Contents. I believe this tool has the potential to save a great deal of time and missed opportunities for facilitating implementation success, and hope that we can review it and determine how best to make use of this resource.

5. As Team Leader for this program, I am willing to oversee dissemination of the key elements we identify as helpful additions to our management strategies. I look forward to working with you on making use of this tool to improve our current systems. Please contact me at 716-862-8595 to arrange a time to discuss further. Thank you for your support of integrated/collaborative care on behalf of our Veterans.

Appendix K

ADDITIONAL RESOURCES

Reference Books

Hunter, C. L., Goodie, J. L., Oordt, M. S., & Dobmeyer, A. C. (2009). *Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention*, American Psychological Association.

Gatchel, R. J. & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration*: Washington, DC; American Psychological Association.

P. Robinson & J. Reiter (2007) Behavioral consultation and primary care: A guide to integrating services. New York: Springer Science-Media.

W. O'Donohoe, M. Byrd, N. Cummings, D. Henderson (2005). Behavioral integrative care: Treatments that work in the primary care setting. New York: Brunner-Routledge.

Websites

http://www.mentalhealth.va.gov/coe/cih-visn2/ (VA Center for Integrated Healthcare's website)

http://vaww4.va.gov/pcmhi (Website of VA's Primary Care-Mental Health Integration (PC-MHI) program, a shared responsibility of the Office of Mental Health Services and the National Primary Care Program.)

http://www.pcpcc.net (Patient Centered Primary Care Collaborative's website)

http://www.cfha.net (Collaborative Family Healthcare Association's website)

http://www.umassmed.edu/FMCH/PCBH/Welcome.aspx (Website of the University of Massachusetts Medical School's Primary Care Behavioral Health program)

http://www.behavioral-health-integration.com/news.php (Website of Dr. Kirk Strosahl's Mountainview Consulting Group)