Primary Care-Mental Health Integration (PC-MHI)
Functional Tool

The purpose of this tool is to outline the essential elements of a fully functional Primary Care-Mental Health Integration (PC-MHI) program within the VHA context.

The introductory section of this tool (pp. 1-3) provides an overview and orientation to PC-MHI services. The main section (pp. 4-10) presents in checklist form the six specific functions of a fully operational PC-MHI program and details the elements necessary to achieve basic functionality in each. Additional desirable and optimal elements based on current best practices are also included.

Definition

Primary Care-Mental Health Integration (PC-MHI) is the term VA uses to describe a set of mental and behavioral health care services that are provided to Veterans in collaboration with primary care providers. These services are fully integrated into the primary care setting (PACT), and support PACT-based treatment of both mental health conditions and behavioral aspects of chronic medical conditions. PC-MHI programs seamlessly combine evidence-based care management and co-located collaborative care services (see below).

Goal

The goal of PC-MHI is to provide high-quality, collaborative mental and behavioral health care to improve the health of both individual Veterans and the Veteran population as a whole.

Objectives

- To provide immediate access to clinical assessment and appropriate collaborative care and treatment for those experiencing mental health symptoms (either ad hoc or in response to screening).
- To practice collaborative, stepped and measurement-based care, including appropriate longitudinal follow-up, to address common mental health conditions for the primary care population.
- To enable optimal functioning of PACT teams through collaborative decision support and interdisciplinary consultation with co-located mental health providers.
- To prevent the development of more severe symptoms through early recognition and intervention.

Rationale

The integrated mental health services that PC-MHI programs provide were developed to address specific Veteran, provider, and health system needs and have a number of unique characteristics that differentiate them both from traditional specialty mental health services and from earlier efforts to address mental health concerns in primary care.

PC-MHI services are **population-based**; they are designed to attend to the mental health concerns of the broad population of Veterans in primary care, not just those who are eventually seen in specialty mental health. Emphasis is on common mental health conditions, early intervention, and behavioral health

concerns. As such these services broaden **access** to mental and behavioral health care; at the same time, they allow MH specialty resources to focus on more seriously ill Veterans with complex needs.

PC-MHI services are **patient-centered**. Through the use of co-located behavioral health providers who provide services directly in the primary care clinic, Veterans have improved **access** to more timely care. Studies also show that the perceived stigma associated with receiving mental health services is reduced, and patient satisfaction is higher. Convenience, through flexibility in how care is delivered, is another hallmark. In particular, telephone follow-up with patients is key to managing episodes of care effectively and efficiently.

Co-location in PACT also facilitates the high degree of **collaboration and communication** among providers that PC-MHI services necessitate, not only to accomplish the goals of decision support and joint treatment planning, but also to increase the capacity of primary care providers to address common mental health concerns. This close collaboration also engenders bi-directional learning between primary care and mental health staff.

PC-MHI services are **measurement-based**. Process and outcome data are collected according to protocols through the use of structured assessment tools and supportive software. These data are used both to monitor and guide care over time and to assess its effectiveness, ensuring higher quality care.

Finally, PC-MHI services are **evidence-based**, drawing on over 20 years of published studies showing that integrated mental health care improves or increases:

- access,
- treatment engagement and adherence,
- the probability of receiving higher quality, guideline-concordant care,
- clinical and functional outcomes, and
- patient satisfaction.

Strategy

To accomplish these objectives, PC-MHI providers are members of the PACT interdisciplinary team, where they collaborate on assessment, support or provide primary care-based treatment and brief therapy, and conduct follow-up over time. Thus, a PC-MHI program is of necessity co-located and collaborative, and coordinates even the services it may provide from other locations (e.g., telephone care) through this fundamental integration with PACT. PC-MHI programs are referred to as "blended" when they seamlessly incorporate evidence-based care management and co-located collaborative services, both of which are mandated in VHA. The requirement for blended programs is a recognition of the strong evidence base for depression care management, and the need for co-located mental health expertise to (1) provide immediate access in PACT, (2) address additional conditions beyond depression, (3) educate PACT staff, and (4) supervise those PC-MHI providers who are not independently licensed.

Co-located collaborative care includes consultation with other PACT staff providing care to the Veteran through "curb-side" discussions and in interdisciplinary team meetings, focused assessment, joint treatment planning, expertise in psychopharmacology, brief therapy, and complex behavioral health interventions. These services are provided by licensed independent mental health providers, largely in the form of face-to-face visits. Visits may be done individually by the co-located provider or in joint meetings with the Veteran and other PACT providers. In either case, the Veteran's care providers will develop a common conceptualization of the Veteran's health and mental health problems and their interrelationships, which all team members will incorporate into their individual assessment and treatment services.

Care management is a package of protocol-based services that support primary care-based prescribing of psychotropic medications, longitudinal follow-up, and behavioral health interventions. The package includes patient education, activation, monitoring of medication adherence and structured, measurement-based assessment of progress over time, with facilitation of changes in treatment when necessary. These services are usually provided over the telephone, often by staff who are not independently licensed, in close collaboration with PACT team members and with supervision by licensed independent mental health providers.

Like other primary care services, PC-MHI services are intended to identify and attend to the broad spectrum of mental and behavioral health needs presenting in the primary care population. Also like primary care, there is an expectation that some Veterans will have needs more appropriately addressed by specialty care. PC-MHI facilitates access to and collaboration with specialty mental health for Veterans with more complex needs. For those for whom specialized services are not necessary, PC-MHI offers timely, often immediate, access to high-quality, evidence-based care delivered in a convenient, familiar location: the primary care clinic.

The Uniform Mental Health Services Handbook (VHA 1160.01, September 2008) stipulates that PC-MHI services be available in larger primary care venues (at VAMCs, and at CBOCs that serve at least 5,000 unique Veterans per year). Both evidence-based care management and co-located collaborative functions are required; see the handbook for exact requirements. Consistent excellent implementation of that requirement is a VHA priority and this tool is intended to support and guide such implementation efforts.

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Identification of Patients

Clear guidelines are in place for identification of mental health needs to be addressed in primary care. These guidelines set out procedures for follow-up of positive screens (role of primary care provider, role of PC-MHI provider), as well as other appropriate means of identification and communication of needs to the PC-MHI provider.

Basic level of programmatic competency

- ☐ Policies and procedures specify how to connect primary care patients to PC-MHI services (warm handoff, consult, etc.), who may initiate involvement of the PC-MHI providers (e.g., primary care physicians, APNs, and PAs), and for what purpose.
    - ☐ PCPs demonstrate (through use) their understanding of procedures to request in-person collaborative care services within PACT clinics.
    - ☐ PCPs demonstrate (through use) their understanding of procedures to request PC-MHI care management services.
- ☐ Screening policies and procedures specify appropriate follow-up to be taken for positive screens for depression, PTSD, and alcohol abuse.
- ☐ Screening policies and procedures specify role expectations and processes for primary care provider (PCP) notification of positive PTSD and depression screens and for completion of suicide risk evaluation.

Additional elements: Desirable level of programmatic competency

- ☐ There are well-delineated, well-communicated points of access to the PC-MHI team, who further coordinate services amongst themselves and other extended PACT team members.
- ☐ Most patients are connected to in-person PC-MHI services via "warm handoff" (i.e., direct hand-off of the patient from the PC provider to the PC-MHI provider).
- ☐ PC-MHI staff routinely participate in PACT team meetings to anticipate or identify mental health needs and behavioral health components of health conditions.

Additional elements: Markers of optimal practice

- ☐ PC-MHI staff participate in PACT team huddles, as needed, to anticipate or identify mental health needs and behavioral health components of health conditions.
- ☐ Registry-based or other methods of enhancing case identification (e.g., automated case finder) are used.

Initial Assessment

Clear guidelines are in place for assessment of mental health needs, including biopsychosocial assessment and crisis management when appropriate, and protocols exist and are used for assignment of patients to the appropriate level of care. These adhere to established clinical practice guidelines. There is a crisis intervention protocol, which also addresses providers who are not independently licensed.

Basic level of programmatic competency

- ☐ PC-MHI providers primarily address mental health issues: depression, anxiety, alcohol misuse (abuse, heavy drinking, problem drinking), and trauma (screening).

- ☐ Direct referral and/or transfer to mental health specialty care is available for those patients whose needs cannot be met in the primary care setting.

- ☐ Consultation, in person or via video telehealth, with a psychiatrist or mental health APN/PA is available to PCPs whenever the primary care clinic is open to see patients. (Provider is not necessarily a PC-MHI staff person).

- ☐ Assessment by a PC-MHI behavioral health provider (psychologist/SW/licensed counselor) is available whenever the primary care clinic is open to see patients.
    - ☐ Provider is co-located in clinic.
    - ☐ Patient is seen on a timely, same day basis.
    - ☐ Structured assessment tools (e.g., PHQ-9) are used for initial assessment.
    - ☐ Initial assessment is brief.
    - ☐ Initial assessment focuses on the patient's goals, not just the presenting problem.
    - ☐ Initial assessment focuses on functioning.
    - ☐ Assessment may include the patient's family member or other personal support person, when that is acceptable to the patient.

- ☐ Upon enrollment into care management services, initial assessment is conducted according to established protocol, if not already completed.
    - ☐ Structured assessment tools (e.g., PHQ-9) are used for initial assessment.
    - ☐ Initial assessment is brief.
    - ☐ Initial assessment focuses on symptoms and functioning.

- ☐ Appropriately qualified PC-MHI staff are available for crisis/emergency intervention (e.g., suicide intervention) during PC clinic hours.
    - ☐ If a provider who is not independently licensed (e.g., health technician, RN, psychology trainee, etc.) determines that a patient is at risk for suicide, he/she always has a protocol for and means to contact appropriate back-up personnel (e.g., two phone lines; direct access to curbside consultation).

Additional elements: Desirable level of programmatic competency

- ☐ Program policies are in place regarding who is appropriate to refer to specialty mental health, based upon consultation, initial assessment, failure to progress, and/or other locally developed criteria.

☐ In addition to the behavioral health provider assessment mentioned above, assessment by a PC-MHI psychiatrist or PC-MHI mental health APN/PA is available whenever the primary care clinic is open to see patients.
    - ☐ Provider is co-located in clinic.
    - ☐ Patient is seen on a timely, same day basis.

☐ If a patient must wait to see a PC-MHI provider (whether a psychiatrist/APN/PA *or* a behavioral health provider), on average wait time is 20 minutes or less.

☐ Behavioral health concerns are also addressed (e.g., smoking, weight management).

Additional elements: Markers of optimal practice

☐ Most patients typically do not have to wait more than 5 minutes to see a PC-MHI provider (whether a psychiatrist/APN/PA *or* a behavioral health provider)**.**

☐ Electronic structured assessment tools are used.

Clinical Services

The following categories of clinical services are routinely available through the PC-MHI program.

Basic level of programmatic competency

Consultation

☐ PC-MHI staff advise PCPs regarding which patients may be more appropriately served by mental health specialty care.

☐ Education of PCPs is an explicit goal of the PC-MHI program.

☐ Psychiatric providers (psychiatrist/APN/PA) are available to advise PCPs on prescribing psychiatric medications, as appropriate.

☐ Mental health curbside consultation is available for PCPs and other PACT team members.

Brief Interventions

☐ Brief Problem Solving Therapy is provided by qualified PC-MHI staff.

☐ Brief Cognitive Behavioral Therapy is provided by qualified PC-MHI staff.

☐ Brief alcohol interventions are provided by qualified PACT and PC-MHI staff.

Joint Treatment Planning/Collaboration

☐ Ensuring continuity of care through inter-professional communication is an explicit goal of the program.

☐ PC-MHI providers and primary care providers communicate actively and extensively to incorporate patient preferences into treatment plans.

☐ PC-MHI providers work together with PACT staff to make appropriate treatment decisions.

Patient Education and Activation

☐ PC-MHI staff routinely use Motivational Interviewing techniques.

☐ PC-MHI staff have education-focused discussions with patients and/or provide education materials to patients.

☐ PC-MHI staff help patients to become informed and active in their own care (patient activation).

Care Management, Monitoring and Tracking

A number of supportive services are available as a bundled package to support primary care-based mental health treatment (including prescribing of psychotropic medication), comprised of patient education, activation, and monitoring of adherence and progress over time.

- ☐ Services are primarily telephone-based.
- ☐ Services follow established protocols and scripts.
- ☐ Structured assessment tools are used for both initial and periodic re-assessment.
- ☐ Periodicity of re-assessment of patients enrolled in care management services is specified in and done according to established protocols.

☐ Progress and adherence of *all* PC-MHI patients is routinely monitored over time through periodic re-assessment.

- ☐ Follow-up assessments are prompted through use of a registry.
- ☐ Structured assessment tools are used for both initial and periodic re-assessment.

Clinical Supervision and Case Review

☐ Providers who are not independently licensed (e.g., RN, social work or psychology trainee) receive routine case supervision that meets the guidelines established by OAA.

- ☐ Supervision is from a psychiatrist, APN-MH, psychologist, and/or social worker and meets the licensing requirements of the specific trainee as well as OAA standards.
- ☐ Supervision occurs at least weekly and meets requirements of local policies that have additional criteria for supervision.

<u>Additional elements: Desirable level of programmatic competency</u>

Brief Interventions

☐ The typical amount of time patients spend in-person with a PC-MHI provider is 30 minutes or less.

☐ Policies provide guidance on limits to PC-MHI services, adapted to local criteria (e.g., number of sessions, weeks of PC-MHI service, etc.).

Joint Treatment Planning/Collaboration

☐ PC-MHI staff routinely participate in PACT team huddles and other team meetings.

☐ Policies and procedures specify frequency and content of re-assessment of patients.

Care Management, Monitoring and Tracking

- ☐ Watchful waiting and monitoring of sub-syndromal symptoms is routinely available.

- ☐ Watchful waiting and monitoring of individuals who initially resist engagement in treatment is routinely available.

- ☐ Scope and intensity of services are specified by algorithms which are informed by initial assessment and treatment plan.

- ☐ Follow-up of PC patients' missed referral appointments to specialty mental health is routinely accomplished.

Clinical Supervision and Case Review

- ☐ PC-MHI providers meet regularly to review the population of cases (this may occur within the context of supervision).
  - ☐ These meetings include at minimum *both* a behavioral health provider *and* a psychiatrist, APN-MH, or other independent provider with prescriptive authority.
  - ☐ These meetings include reviews of progress of current cases as well as potentially problematic new consults/referrals.
  - ☐ Cases not demonstrating improvement are discussed and treatment modifications are proposed to meet care needs.

- ☐ PC-MHI providers without prescriptive authority have supervision from a psychiatrist, APN-MH, or other independent provider with prescriptive authority for timely review and subsequent action of cases requiring psychotropic management.

Additional elements: Markers of optimal practice

- ☐ All PC-MHI patients are tracked over time (e.g., using a registry or panel management software) for purposes of monitoring clinical and administrative outcomes.

- ☐ Behavioral health concerns are treated.

Staffing

The PC-MH program is staffed to meet demand for services, and program staff have appropriate training for the services they provide.

Basic level of programmatic competency

- ☐ PC-MHI program is staffed appropriately to meet the demand for PC-based psychiatric assessment and consultation.

- ☐ PC-MHI program is staffed appropriately to meet the demand for PC-based, brief mental health assessment and therapy services.

- ☐ PC-MHI program is staffed appropriately to meet the demand for PC-based mental health care management services.

- ☐ PC-MHI program receives adequate clerical support.

- ☐ Staff have appropriate qualifications for the services they provide (e.g., prescribers, therapists, nurses, etc.).

- ☐ There is active communication among all PC-MHI staff.

- ☐ PC-MHI staff hold team meetings.

- ☐ PC-MHI staff providing in-person services receive training in brief models of practice.

- ☐ PC-MHI staff providing care management services receive formal training in care management protocols and skills.

Additional elements: Desirable level of programmatic competency

- ☐ PC-MHI staff have early morning, evening, and/or weekend hours as determined to be most appropriate for Veteran needs.

- ☐ Co-located PC-MHI providers' offices are interspersed with PCPs (e.g., in same hallway).

- ☐ All PC-MHI providers receive formal skills updates/ongoing continuing education.

- ☐ PC-MHI clerical support is fully integrated with PACT clerical support.

Additional elements: Markers of optimal practice

- ☐ Facility leadership demonstrates support of program staff involvement in regional and/or national PC-MHI conferences and activities.

Program Implementation

Program staff ensure that the PC-MHI program has leadership support and is implemented in accordance with best practices.

Basic level of programmatic competency

- ☐ Policies and Procedures Manual for PC-MHI is in place.
  - ☐ Policies and procedures manual is developed with joint input from both Primary Care and Mental Health service lines.
  - ☐ Content of policies and procedures manual includes:
    - ☐ Hours of clinic operation
    - ☐ Process of handoff
    - ☐ Communication
    - ☐ Roles and responsibilities
    - ☐ Relationship to PACT
    - ☐ Methods of assessment
    - ☐ Scope of work

☐ PC-MHI providers periodically conduct an orientation/training for primary care providers regarding the PC-MHI program.

☐ PC-MHI providers periodically conduct an orientation/training for specialty MH providers regarding the PC-MHI program.

☐ PC-MHI providers champion/market the program to PC staff.

Additional elements: Desirable level of programmatic competency

☐ PC and MH directors engage in activities that promote effective and on-going two-way communication about PC-MHI operations.

☐ PC-MHI staff routinely participate in PACT team meetings to discuss program operations.

Program Monitoring and Evaluation

PC-MHI program routinely carries out monitoring, evaluation and quality improvement activities.

Basic level of programmatic competency

☐ PC-MHI program seeks out provider feedback about the program and makes appropriate changes.

☐ Program leadership engages in at least one active quality improvement project.

Additional elements: Desirable level of programmatic competency

☐ Patient wait times to see a PC-MHI provider are monitored and necessary staffing adjustments are made.

☐ Veterans treated by PC-MHI providers are routinely monitored (as a part of program QI) on clinical outcomes related to their individual goals, and feedback is provided to primary care providers.

☐ PC-MHI services utilization and outputs are routinely assessed (e.g., encounter volumes, referral patterns, etc.).

Additional elements: Markers of optimal practice

☐ PCP performance is assessed (e.g., number and appropriateness of referrals) and feedback is provided.

☐ Effectiveness of communication between the PC-MHI provider and the PCP is assessed (e.g., appropriately acknowledging and responding to each other; ensuring that contact lists are up-to-date, etc.).

☐ Patient feedback about the PC-MHI program is sought out and appropriate changes are made.

☐ Specific consultation occurs with experts and/or larger community of practice.