

**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 Patient Aligned Care Teams (PACT) 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 PACT 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 through 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. (Telemental Health is defined as the use of telecommunications technology to provide mental health services to individuals. Link to TMH site: <http://vaww.carecoordination.va.gov/general-telehealth/telemental/>).
- **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](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 Telephone Call Center (BTC): PCPs and BHPs may also consider screening and support services available through the Behavioral Health Assessment Telephone Call Center (BTC) 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. BTC services can be accessed via consult (found under behavioral health consult menu, listed as Behavioral Health Assessment

Center). CCC BHPs may be called upon to offer clinical intervention for those Veterans who are identified as needing service following BTC 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 Behavioral Health Assessment Center 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 8<sup>th</sup>, 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 A**  
**Insert medication treatment recommendations (please see attached document entitled**  
**Appendix A)**

## APPENDIX B

### Sample Referral Script

When referring Veterans to the co-located, collaborative behavioral health provider, primary care providers, should consider languages similar to the following.

Example 1:

"I would like you to meet with a colleague of mine, whose office is just down the hall. She/he is an expert in \_\_\_\_\_(condition X). She/he often sees my Veterans right away and provides ideas that we can work on together to improve your \_\_\_\_\_(condition X). "

Example 2:

"Our clinic is fortunate to have an onsite consultant who specializes in working with Veterans who are experiencing difficulties with \_\_\_\_\_. She/he is our consultant and we work together as a team to address many types of conditions. I would like to introduce you to her/him. Would that be ok? Her/his name is \_\_\_\_\_." (Invite the BHP into the room (if available) and explain concern, in the Veteran's words, and in front of the Veteran. This provides the Veteran with an opportunity to see the teamwork and communication between providers, correct any misinformation, and participate in the decisions made about their treatment.

- Modified from Robinson, P.J., & Reiter, J. T. (2007). Behavioral Consultation in Primary Care: A Guide to Integrating Services. New York, NY: Springer.