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Incorporating Change 2, Effective November 20, 2014

USD(P&R)

SUBJECT: Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive 5124.02 (Reference (a)), this instruction:

a. Establishes policy, assigns responsibilities, and prescribes procedures for attainment of inter-Service standards for developing, initiating, and maintaining adult behavioral health services in primary care.

b. Establishes:

(1) BHP staffing requirements and behavioral health models of service delivery for primary care.

(2) BHP competency training and clinical and administrative BHP standards required for the delivery of these services in primary care.

(3) Service and DoD-level structures for planning and evaluating primary care behavioral health services.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense in direct care, non-deployed settings.

3. POLICY. It is DoD policy that behavioral health services are provided in primary care settings to decrease overall health costs and to improve patient access to behavioral health care,

population health, readiness, physical and mental health outcomes, and patient and provider satisfaction. To meet these goals:

- a. Sufficient BHP staffing levels will be met and maintained.
 - b. Standards will be in place for implementing and maintaining quality in the delivery of behavioral health services in primary care.
 - c. Training standards, core competencies, and clinical and administrative standards will be established for, and met by, BHP.
4. RESPONSIBILITIES. See Enclosure 2.
 5. PROCEDURES. See Enclosure 3.
 6. RELEASABILITY. **Cleared for public release**. This instruction is available on the Internet from the DoD Issuances Website at <http://www.dtic.mil/whs/directives>.
 7. EFFECTIVE DATE. This instruction is effective August 8, 2013.


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Personnel and Readiness

Enclosures

1. References
2. Responsibilities
3. Procedures
4. DoD Primary Care Behavioral Health Committee Governance
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Glossary

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
- (b) Kroenke, K., Spitzer, R. L., and Williams, J. B., "The PHQ-9: Validity of a brief depression severity measure," *Journal of General Internal Medicine* 2001; 16: 606-613
- (c) Weathers, F., Litz, B., Herman, D., Huska, J., and Keane, T., "The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility," Paper presented at the Annual Convention of the International Society for Traumatic Stress Studies, October, 1993
- (d) Management of MDD Working Group, Department of Veterans Affairs & Department of Defense, "VA/DoD depression practice guideline provider care card, VA/DoD clinical practice guideline of major depressive disorder," May 2009
- (e) Kroenke K., Spitzer, R. L., and Williams, J. B., "The Patient Health Questionnaire-2: Validity of a two-item depression screener," *Medical Care* 2003; 41: 1284-1294

ENCLOSURE 2

RESPONSIBILITIES

1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), the ASD(HA):

- a. Oversees DoD compliance with this instruction.
- b. Ensures funds for BHP in primary care are used for personnel, resources, and training-related activities.
- c. Establishes a DoD Primary Care Behavioral Health Committee. Committee governance will be in accordance with Enclosure 4 of this instruction.
- d. Designates the DoD Program Manager for Behavioral Health in Primary Care as the chair of the DoD Primary Care Behavioral Health Committee.
- e. Designates a representative to serve on the DoD Primary Care Behavioral Health Committee from:

(1) ~~Joint Task Force National Capital Region Medical Command~~ *National Capital Region Medical Directorate*.

(2) Deputy Assistant Secretary of Defense, Clinical and Program Policy (DASD(C&PP)).

2. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

- a. Establish a comprehensive BHP in primary care services program in accordance with this instruction within 12 months of this instruction's effective date.
- b. Ensure that existing BHP resources are not available to be reallocated to primary care to meet the staffing requirements of this instruction before new Defense Health Program resources are allocated to meet BHP staffing requirements.
- c. Designate a primary care behavioral health program manager for each Service.
- d. Designate representatives for the DoD Primary Care Behavioral Health Committee for each Service to include:

(1) The primary care behavioral health program manager.

(2) A primary care representative (e.g., a family medicine physician, internal medicine physician, physician assistant, nurse practitioner).

3. SECRETARY OF THE ARMY. In addition to the responsibilities listed in section 2 of this enclosure, the Secretary of the Army through the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury's patient-centered medical home behavioral health implementation team:

a. Supports the work of the DoD Primary Care Behavioral Health Committee.

b. Assists the Services with implementation of behavioral health elements of the patient-centered medical home including program design, management, and program metrics.

ENCLOSURE 3

PROCEDURES

1. SERVICE PROGRAM STANDARDS. Each Service will:

a. Publish comprehensive Service practice standards detailing the clinical and administrative guidance for internal behavioral health consultants (IBHCs), as defined in the Glossary, and behavioral health care facilitators (BHCFs), as they are defined in the Glossary, and primary care managers (PCMs) to include the content areas detailed in Enclosures 3, 5, 6, 8, and 9.

b. Develop a Service-wide training program that:

(1) Employs expert interdisciplinary trainers that meet the standards listed in Enclosures 7 and 10 and are available to meet the interdisciplinary training needs required in paragraphs 1b(5) through 1b(6) of this enclosure.

(2) Trains IBHCs and BHCFs in the clinical and administrative standards necessary to operate efficiently and effectively in primary care.

(3) Has training and ongoing oversight plans and programs for IBHCs and BHCFs. Training will include Service-specific instructions, administrative and clinical standards of care, and core interdisciplinary competencies. Enclosures 5 and 8 list minimum BHCF and IBHC core competency areas that will be incorporated into Service practice standards.

(4) Uses core competencies and administrative and clinical standards as content areas to develop benchmark criteria for achieving IBHC and BHCF training goals.

(5) Requires that IBHCs and BHCFs understand Service instructions and can practice in accordance with expected core discipline-specific competencies (listed in Enclosure 5 and 8) and clinical and administrative standards (listed in Enclosure 6 and 9), as evaluated by an expert trainer, before seeing patients in the primary care clinic.

(6) Requires the expert trainer to teach administrative and clinical core competencies using in-person, live online or video expert trainer demonstration in the training of IBHCs and BHCFs prior to IBHCs and BHCFs seeing primary care patients.

2. SERVICE PRIMARY CARE BEHAVIORAL HEALTH PROGRAM MANAGER. The Service program manager:

a. Is a full-time position.

b. Serves as a representative on the DoD Primary Care Behavioral Health Committee.

c. Provides guidance and advice to the Service regarding the programs required to carry out and sustain Service-wide BHP services in primary care.

d. Provides oversight and management of Service BHP in primary care program rollout and sustainment.

e. Carries out Service program evaluation plans for BHP in primary care to include:

(1) Strategic plans for installing BHP in PCMH primary care clinics within 6 months of this instruction's issuance. The strategic plan will:

(a) Include timelines, milestones, and a plan for reporting progress towards meeting the responsibilities and guidelines in this instruction to the DoD Program Manager for Behavioral Health in Primary Care.

(b) Be reviewed and updated as necessary every 2 years.

(2) Installation-level compliance evaluation with the requirements of this instruction described in Enclosures 3 and 5 through 10.

3. SERVICE PERSONNEL. The IBHC and BHCF billets may reside within primary care clinics.

a. Staffing

(1) At least one full-time IBHC, and one full-time BHCF at each primary care clinic with 7,500 or more enrollees.

(2) At least one full-time IBHC at each primary care clinic with 3,000-7,499 enrollees.

(3) Installation-level support from a designated behavioral health prescription specialist, as defined in Glossary, irrespective of size or staffing of an installation. This support can be met through telephone consultation or telehealth applications and must be able to respond to all IBHC and BHCF consultation requests within 24 hours.

b. Staff Competencies, Standards, and Training

(1) BHCF

(a) Core Competencies (See Enclosure 5 for core competency specifics).

(b) Service Delivery Model and Clinical and Administrative Standards (see Enclosure 6 for delivery model, and clinical and administrative specifics).

(c) Expert Trainers (See Enclosure 7 for expert trainer specifics).

(2) IBHC

(a) Core Competencies (See Enclosure 8 for core competency specifics).

(b) Service Delivery Model and Clinical and Administrative Standards (See Enclosure 9 for delivery model, and clinical and administrative specifics).

(c) Expert Trainers (See Enclosure 10 for expert trainer specifics).

4. SERVICE DELIVERY

a. Model

(1) IBHCs and BHCFs will deliver services using a blended model of care, as defined in Glossary, in primary care clinics with 7,500 or more enrollees. IBHCs and BHCFs will adhere to the service delivery model activities and clinical and administrative standards for work in primary care clinics outlined in Enclosures 6 and 9.

(2) IBHCs will deliver Primary Care Behavioral Health (PCBH) model services, as defined in Glossary, that incorporate BHCF activities for major depressive disorder and at least one anxiety disorder, in primary care clinics with 3,000-7,499 enrollees.

(3) Local or remote behavioral health prescription specialist, will provide clinical decision support, as defined in Glossary, and advice as needed to PCMs for patients regarding psychopharmacologic agents for a behavioral health indication.

b. Screening Standards for PCMs

(1) Screening for major depressive disorder will use evidence-based screening instruments designated by the Primary Care Behavioral Health Committee, designed for primary care. Screening will be conducted at a minimum:

(a) Annually.

(b) For all new patients.

(c) In patients at particularly higher risk for depression, based on medical illness per most recent Department of Veterans Affairs and Department of Defense (VA/DoD) clinical practice guidelines on major depressive disorder (e.g., diabetes, chronic pain conditions, or post-myocardial infarction).

(2) Screening for posttraumatic stress disorder (PTSD) will use evidence-based screening instruments designated by the Primary Care Behavioral Health Committee, designed for primary care. Screening will be conducted at a minimum:

- (a) Annually.
- (b) For all new patients.
- (c) If clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster, sexual trauma, combat), or history of PTSD.

5. DoD PRIMARY CARE BEHAVIORAL HEALTH COMMITTEE. See Enclosure 4 for governance and responsibilities.

ENCLOSURE 4

DoD PRIMARY CARE BEHAVIORAL HEALTH COMMITTEE GOVERNANCE

1. COMMITTEE MEMBERSHIP. Committee membership will include:
 - a. Chair as designated by the ASD(HA).
 - b. Primary care representative (e.g., a family medicine physician, internal medicine physician, physician assistant, nurse practitioner) who has knowledge of the Service's primary care delivery system and can represent the interest of their respective Service.
 - c. Primary care behavioral health program manager from each Military Service.
 - d. ~~Joint Task Force National Capital Region representative~~ *National Capital Region Medical Directorate representative.*
 - e. Representatives from:
 - (1) DCoE for Psychological Health and Traumatic Brain Injury.
 - (2) DASD(C&PP).
2. OTHER ADVISORY RESOURCES. Other government or non-government consultants may, at the discretion of the DoD Primary Care Behavioral Health Committee, be asked to provide issue-specific consultation as needed.
3. SCOPE. The DoD Primary Care Behavioral Health Committee will:
 - a. Meet no less than quarterly, commencing within 90 days following the issuance of this instruction.
 - b. Carry out the coordination of clinical and administrative processes, procedures, and protocols for consistent evidence-based behavioral health services in primary care. This will include:
 - (1) Evaluating and assisting in cross-Service execution of the requirements of this instruction and providing technical guidance and assistance.
 - (2) Development of specific behaviorally-defined competency benchmarks for minimum BHCF and IBHC providers as well as objective training standards that will be used by each Service for training to an objective benchmark that is consistent across the Services.

c. Develop and adopt a standardized set of quality and clinical performance indicators and the frequency of quality and clinical performance assessment in the areas of readiness, health behaviors, and outcomes; population health; patient and provider satisfaction; and health care cost to facilitate inter-Service assessments of quality and clinical performance.

d. Coordinate and facilitate inter-Service and intra-Service efforts to create and maintain Service data bases, reporting procedures, and data displays that permit the integration of Service-level data and permit cross-service comparisons of programs.

e. Deliver DoD informational or decisional briefs as needed to the PCMH Advisory Board.

f. Provide policy recommendations regarding provision of behavioral health services in primary care to the ASD(HA) and the Military Services via the PCMH Advisory Board.

ENCLOSURE 5

BHCF CORE COMPETENCIES

The BHCF will provide services that reinforce, encourage, check, and support the patient's adherence to the PCM's treatment plan and IBHC recommendations. Contacts with patients may be telephonic, through written electronic communication, video teleconference, face-to-face, or a combination of these means. BHCFs will possess clinical and administrative competencies to enhance patient follow-through with treatment plans prescribed by their PCM.

a. Clinical Competencies

- (1) Ability to check the patient's level of adherence to the treatment plan.
- (2) Support adherence to the PCM or IBHC's plan and aid in problem solving to overcome barriers to adherence.
- (3) Use evidence-based instruments to assess symptoms severity and treatment response.
- (4) Educate patients on strategies to maintain the treatment plan or sustain adoption of healthy behaviors.

b. Administrative Competencies

- (1) Communicate information regarding patient progress and adherence to the PCM or IBHC plan.
- (2) Document interactions with or about patients in the electronic medical record (EMR) that occur:
 - (a) Following each patient contact and will include services rendered, patient status and progress including any significant new symptoms reported by the patient.
 - (b) When there is information to communicate from a prescribing provider assisting with clinical decision support.

ENCLOSURE 6

BHCF SERVICE DELIVERY MODEL AND CLINICAL AND ADMINISTRATIVE STANDARDS

1. SERVICE DELIVERY MODEL. BHCFs monitor patients in a manner consistent with the evidenced-based science for a care management model of service delivery, as defined in the Glossary. PCMs may refer patients with major depressive disorder, an anxiety disorder, or other behavioral health or substance misuse problems to the BHCF within the scope of the BHCF's training and program requirements for follow-up care based on the PCMs prescribed treatment plan. Services will be in accordance with and in support of the overall goals of the PCM for that individual patient. As needed, the BHCF will take part in collaboration and team consultation with the PCM, IBHC, and the behavioral health prescription specialist.

2. BHCF SERVICES. BHCFs will:

a. Provide education on depression, anxiety, or other behavioral health, or substance misuse topics to patients if it is within the scope of their training and program requirements.

b. Monitor patients predominantly via telephonic means but will have availability to meet on a face-to-face basis or may use email or video teleconference as required to enhance adherence to the treatment plan.

c. Complete and document initial patient contacts within 10 days of the PCM referral. A contact is a clinical meeting between the BHCF and the patient in which one or more of the following activities take place:

(1) Administration of appropriate standardized measurement tools (e.g., Patient Health Questionnaire-9 (Reference (c)) or Post Traumatic Stress Disorder Checklist (Reference (d))) to evaluate symptom severity.

(2) Discussion with patients on adherence to medication or counseling recommendations.

(3) Educate and problem-solve with patients to enhance adherence to treatment.

d. Regularly, and as needed, review patient progress with the PCM, IBHC, and the behavioral health prescription specialist. This review should occur within 24 hours if deterioration in clinical condition should occur.

e. Facilitate ongoing depression and anxiety problem assessment and tracking, and may engage in other behavioral health, or substance misuse problem assessment and tracking if it falls within the scope of their training and program requirements for patients under the treatment guidance of the PCM.

- f. Provide psychoeducation for patients to encourage healthy habits and prevent decline in functioning.
- g. In accordance with standard procedures, manage and track the use of medication for the treatment of major depressive disorder, anxiety disorders, or other behavioral health or substance misuse problems within the scope of their training and program requirements.
- h. When clinically indicated, aid PCMs in referring patients into appropriate specialty mental health care.
- i. Provide suicide screening and assessment within primary care per Service directives and as delineated in the most recent VA/DoD clinical practice guidelines (e.g., major depressive disorder (Reference (e)) for suicide risk assessment) and connect at-risk individuals, with the appropriate credentialed provider immediately.

3. DOCUMENTATION

- a. The BHCF will document interactions with or about patients in accordance with Service standard operating procedure in the outpatient EMR.
- b. Clinical services will be documented within and not separate from the health record of each patient. A separate mental health record for patients will not be created.
- c. BHCF notes will have succinct summaries of the information gathered through patient contacts to support PCM clinical assessment and decision making.

4. EXCLUDED SERVICES. BHCFs will not provide services:

- a. For which they are not trained.
- b. That are not part of their professional scope of practice.
- c. That are prohibited by operating procedures under which they work.

ENCLOSURE 7

STANDARDS FOR BHCF EXPERT TRAINERS

1. BHCF EXPERT TRAINER PREREQUISITES. Has met the following criteria:
 - a. Successfully completed BHCF training and meet all core BHCF core competencies as described in Enclosure 5.
 - b. Has 3 years of full-time clinical experience in a primary care setting.
 - c. Is designated as an expert trainer by his or her Service designation authority.

2. KNOWLEDGE COMPETENCIES. Shows factual knowledge of:
 - a. Performance criteria for BHCF competencies and administrative and clinical standards.
 - b. Service practice standards and all related policies and procedures related to training.

3. TEACHING COMPETENCIES. Shows factual knowledge and ability to:
 - a. Train to criterion-based core competency benchmarks for evaluating trainee performance.
 - b. Use behaviorally-based feedback and modeling.
 - c. Provide corrective feedback in a constructive skill-building manner.

4. ADMINISTRATIVE COMPETENCIES. Shows ability to:
 - a. Model the development of cooperative relationships with the local PCMs, IBHCs, and patients.
 - b. Aid BHCFs in assessing customer satisfaction, clinical outcomes and other performance measures related to their service.

ENCLOSURE 8

IBHC CORE COMPETENCIES

1. CLINICAL PRACTICE KNOWLEDGE AND SKILLS. The IBHC:

a. Explains the role of the IBHC in primary care to the patient before starting assessment (e.g., able to accurately deliver memorized introductory script content in 2-minutes or less).

b. Rapidly identifies the problem for which the patient is seeing the IBHC (e.g., after explaining the IBHC role, determine if the PCM and patient agree on the referral problem within the first minute, for 90% of all first consultation appointments).

c. Uses evidence-based screening and assessment appropriate for a primary care setting (e.g., Patient Health Questionnaire-2 (Reference (f)), Reference (c)).

d. Provides care for everyone along a continuum from prevention to acute and chronic problems within the structure of the PCBH model of service delivery.

e. Uses a biopsychosocial approach to assessment, intervention and primary care team feedback (e.g., how patient's physical condition, thoughts, emotions, behaviors, and environment are impacting or influencing the identified problem and functioning).

f. Uses evidence-based interventions appropriate for a primary care setting (e.g., self-management skills or home-based practice for relaxed breathing and eating behavior changes).

g. Bases interventions on measurable, functional outcomes and symptom reduction (e.g., improved ability to work, improved performance on responsibilities at home, increased frequency or improved quality of social interactions).

h. Teaches patient self-management skills as a primary strategy to decrease symptoms and improved function (e.g., activity pacing to manage chronic pain exacerbation).

i. Can provide psychoeducational classes or chronic disease management groups in a format appropriate for primary care setting (e.g., 2 one-hour classes on managing depressed mood).

j. Has basic knowledge of psychopharmacological agents (e.g., can name commonly used anxiety and antidepressant medication, appropriate dose and first line recommendations for a specific symptom presentation).

2. PRACTICE MANAGEMENT SKILLS. The IBHC:

- a. Efficiently manages appointments with most appointments lasting 30 minutes or less (e.g., identifies problem, how patient is functionally impaired, symptoms, and summarizes to patient understanding of problem by the 15 minute mark and uses the next 10 minutes to develop and start a behavioral change plan).
- b. Stays on time when conducting consecutive appointments.
- c. Uses follow-up intervals that are appropriate for a primary care setting (e.g., every 2-4 weeks).
- d. Completes intervention for majority of patients in 4 or fewer appointments.
- e. Uses flexible strategies for appointments (e.g., 15 and 30-minute scheduled appointments, walk-in appointments, phone contact and secure messaging).
- f. Uses patient registries if they exist and as applicable to role in primary care.
- g. Makes use of community resources (e.g., Military OneSource).

3. CONSULTATION SKILLS. The IBHC:

- a. Focuses on and responds to PCM referral requests when providing PCM feedback (e.g., specifically discusses the results and recommendation regarding the initial referral question or request).
- b. Provides on demand verbal consultation avoiding the use of psychological or psychiatric jargon, using clear, direct language in a concise time frame.
- c. Provides feedback to the PCM on all patients via verbal or written format.
- d. Consults with PCM as soon as possible for urgent patient needs when indicated (e.g., medication recommendations for major depressive disorder, significant medication side effects or alarming medical symptoms).
- e. Provides recommendations to PCM for patient care that are tailored to the pace of primary care (e.g., recommending the PCM ask the patient if he or she is engaging in enjoyable activities per plan to treat depressed mood).

4. DOCUMENTATION SKILLS. The IBHC:

- a. Provides concise, clear notes in the EMR free of psychological or psychiatric jargon. Focus on referral problem, frequency, duration, functional impairment and specific recommendations for change.

b. Documents interactions with or about the patient in the EMR by the end of the clinic day on which the patient is seen and no later than Service directives governing the completion of medical record notes.

c. Provides patient feedback to the PCM on same day as the patient visit for a majority of appointments when PCM is in the clinic on that day.

d. Uses Service note format for IBHC services in primary care.

5. ADMINISTRATIVE KNOWLEDGE AND SKILLS. The IBHC:

a. Understands IBHC program policies and procedures.

b. Understands risk-management protocols.

c. Codes appointment in EMR per Service standards.

6. TEAM PERFORMANCE AND SKILLS. The IBHC:

a. Knows the roles of primary care team members, how to aid them, and how each can be engaged to facilitate patient care.

b. Is available to aid with PCM requests or needs that are not scheduled.

c. Engages with staff when not seeing patients.

d. Participates in PCMH team huddles.

ENCLOSURE 9

IBHC SERVICE DELIVERY MODEL AND
CLINICAL AND ADMINISTRATIVE STANDARDS

1. SERVICE DELIVERY MODEL. The PCM typically consults with the IBHC to assist with managing the patient's health care, is aware of the IBHC assessment and intervention, as well as patient response. IBHCs deliver services in a manner consistent with the evidence-based science for a PCBH model of service delivery, as defined in Glossary, in support the overall health care goals of the PCM and the patient. In this role the IBHC can initiate follow-up appointments and see the patient for an initial appointment without the PCM initiating a request for IBHC assistance.

2. IBHC SERVICES. IBHCs will provide services within the primary care clinic to include:

a. Helping patients replace maladaptive behaviors with adaptive ones, providing skill training through patient education strategies and developing specific behavior-change plans that fit the fast pace of primary care.

b. Focused assessment and intervention with patients (typically in the context of a 15 or 30 minute appointment) geared to aid the patient and team with managing or improving a presenting problem.

c. Screening and assessment of patients who have or are at-risk for developing physical or mental health conditions, with the aim of enhancing resilience by preventing further psychological or physical deterioration.

d. Same-day services for patients who are suspected of having behavioral health symptoms that put them at risk of harming others or themselves.

e. Preventing relapse or morbidity in conditions that recur.

f. Preventing and managing addiction to prescription medications such as pain medicine or tranquilizers.

g. Preventing, reducing, and managing work and other functional limitations among primary care patients with chronic disease or persistent physical symptoms.

h. Helping reduce symptoms and maximizing social and work function for those with high-prevalence mental disorders.

i. Treating and managing patients with chronic emotional and health problems.

j. Treating and managing patients with high frequency medical appointments.

k. Helping patients transition to specialty mental health care.

l. Providing suicide screening, assessment and management within primary care per Service directives.

3. DOCUMENTATION

a. The IBHC will document:

(1) Interactions with or about patients per Service standard operating procedure in the outpatient EMR.

(2) Services within and not separate from the health record of each patient. A separate mental health record for patients will not be created.

b. IBHC notes will have succinct information free of psychological or psychiatric jargon with a primary goal of aiding in clinical decision making by the PCM.

4. IBHC DISCLOSURE STATEMENT. A formal, written, informed-consent document is not required for IBHC services. IBHCs will inform the patient of their role in providing care and inform the patient of the limits of care the IBHC can provide. Such disclosures will include:

a. Informing the patient that the IBHC has the same reporting obligations per Service instruction and state and federal law as any other medical provider.

b. Informing the patient that the IBHC will communicate their findings and recommendations to other members of the patient's health care team and document the appointment in the EMR.

c. Giving the patient the standard IBHC information sheet listing what was discussed verbally in paragraph 4a and 4b of this enclosure, and addresses any questions.

5. EXCLUDED SERVICES. The IBHC will not engage in:

a. Medical social work services (other than routine, community-resource referrals), specialized case-management services or psychological testing that goes beyond screening and assessment designed or adapted for use in primary care.

b. Group psychotherapy services (although educational classes and time-limited, focused group interventions offered in primary care are appropriate).

c. Specialized occupational health or disability-management services, command-directed evaluations, or mental health screens for security clearances.

d. Recurring, scheduled individual psychotherapy, that is modeled on outpatient specialty care (i.e., patients seen in 45 to 60 minute appointments, based on treatment plan and intervention that is independent of assisting the PCM in managing the patient's care).

e. Medication management (prescribing, altering, or stopping a medication). PCMs remain responsible for medication decisions.

ENCLOSURE 10

STANDARDS FOR IBHC EXPERT TRAINERS

1. LICENSURE AND EXPERIENCE. IBHC expert trainers:
 - a. Will hold a professional mental health-related license, have successfully completed the initial IBHC training and met all core IBHC competencies.
 - b. Will have accrued at least 200 clinical IBHC patient contacts in primary care and have at least 3 months of full-time equivalent IBHC primary care clinic experience.

2. KNOWLEDGE COMPETENCIES. IBHC expert trainers will demonstrate factual knowledge of:
 - a. Performance criteria for IBHC competencies and administrative and clinical standards.
 - b. Service practice standards and all policies and procedures related to training.

3. CLINICAL COMPETENCIES. IBHC expert trainers will demonstrate skill in applying the PCBH model of service delivery with a wide variety of primary care patient problems using evidence-based interventions.

4. TEACHING COMPETENCIES. IBHC expert trainers will demonstrate factual knowledge and ability to:
 - a. Train criterion-based core competency areas and benchmarks for evaluating trainee performance.
 - b. Use behaviorally-based feedback, modeling, and guided rehearsal.
 - c. Provide corrective feedback in a constructive skill-building manner.

5. ADMINISTRATIVE COMPETENCIES. IBHC expert trainers will demonstrate ability to:
 - a. Contribute to program design built on population-based care principles, with the aim of targeting IBHC services to population needs.
 - b. Model the development of cooperative relationships with the local clinic chief, the primary care team leader, and other primary care staff.

c. Aid IBHCs in assessing customer satisfaction, clinical outcomes and other performance measures related to their service.

6. EXPERT TRAINER DESIGNATION. The Service will designate individuals as expert trainers. Individuals recognized as expert trainers by a Service before the publication of this instruction may continue in that role.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ASD(HA)	Assistant Secretary of Defense for Health Affairs
BHCF	behavioral health care facilitator
BHP	behavioral health personnel
DASD(C&PP)	Deputy Assistant Secretary of Defense for Clinical and Program Policy
DCoE	Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
EMR	electronic medical record
FTE	full-time equivalent
IBHC	internal behavioral health consultant
PCBH	primary care behavioral health
PCMH	patient-centered medical home
PCM	primary care manager
PTSD	posttraumatic stress disorder
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VA/DoD	Department of Veterans Affairs and Department of Defense

PART II. DEFINITIONS

These terms and their definitions are for the purpose of this instruction.

behavioral health prescription specialist. A psychiatrist, psychiatric nurse practitioner, prescribing psychologist, or another provider credentialed for independent practice who can prescribe medication and has specialty training in the use of psychotropics. The behavioral health specialist with prescription privileges is typically a psychiatrist.

BHCF. A registered nurse (alternatively, a licensed vocational nurse, medical technician, licensed mental health counselor, psychologist, social worker, or psychiatric nurse practitioner) delivering services in a care management model of service delivery.

BHP. A generic term for IBHCs, BHCFs and behavioral health providers with prescription privileges.

biopsychosocial approach. A general model that posits that biological, psychological (to include thoughts, emotions, and behaviors), and social factors, all play a role in human functioning in the context of disease or illness.

blended model. Joins the care management and PCBH models of care so that BHCFs (typically a nurse) and IBHCs work together to provide behavioral health services as members of the primary care team.

care management model. A population-based model of care focused on a discrete clinical problem (e.g., depression). It incorporates specific pathways using a variety of components that systematically and comprehensively address how behavioral health problems are managed in the primary care setting. PCMs and BHCFs share information regarding patients and there is a shared medical record, treatment plan, and standard of care. Typically, there is some form of systematic interface with specialty care (e.g. weekly case review and treatment change recommendations).

clinical decision support. Support provided through a variety of means including, but not limited to, informal provider-to-provider consultation, structured informal consultation through the BHCF, and formal consultation with behavioral health prescription specialists (e.g., psychiatrists, prescribing psychologists, psychiatric nurse practitioners).

core competency. Minimum knowledge, skills, and abilities that are required to perform assigned duties.

full-time. An individual who works in primary care forty-hours per week on average with the capacity for 37.5 hours of clinical service delivery a week in that setting. Clinical service delivery is composed of a variety of activities to include, but not limited to, clinic appointments and telephone contacts with patients, multidisciplinary treatment planning, coordination of care, intervention and general consultation with primary care providers, nurses and staff. Additional clinical service delivery activities include charting, educational presentations, program development, and attending primary care staff meetings. Individuals cannot be assigned other duties outside of their primary care work.

IBHC. A psychologist, social worker, psychiatric nurse practitioner, or psychiatrist credentialed for independent practice or a psychology, social work, psychiatric nurse practitioner or psychiatry trainee being clinically supervised by a behavioral health provider who is credentialed for independent practice. IBHCs work in a PCBH model of service delivery.

Military OneSource. Military OneSource is a free service provided by the DoD to Service members and their families to assist with a range of concerns including money management, spouse employment and education, parenting and child care, relocation, deployment, reunion, stress and grief.

PCBH model. A population health-based model of care focused on all patient populations, where the medical and behavioral health providers share information regarding patients and there is a shared medical record, treatment plan, and standard of care. The behavioral health provider

is embedded with the primary care team and serves as a consultant and co-implementer with the PCM in the assessment, intervention and health care management of the patient. Consistent with a consultation model, the IBHC operates within a scope of practice and a standard of care that is consistent with primary care and differs from the scope of practice and standard of care in a specialty outpatient mental health clinic.

PCMH. The PCMH is a team-based model of primary care service delivery, led by a PCM, which provides continuous, accessible, family-centered, comprehensive, compassionate, and culturally-sensitive health care in order to achieve the best outcomes. The model is based on the concept that the best healthcare has a strong primary care foundation with quality and resource efficiency incentives. The PCMH focuses on providing or arranging for all the patient's health care needs for all stages of life to include, acute care, chronic care, preventive services, and end of life care. A PCMH practice is responsible for all of a patient's healthcare needs and for coordinating or integrating specialty healthcare and other professional services.

primary care clinic. A military treatment facility where patients are enrolled to a primary care manager (e.g., physician assistant, nurse practitioner, family medicine physician, internal medicine physician) who is designated as the patient's primary medical provider.

psychoeducation. Education offered to people with behavioral health and physical conditions about the causes of their condition, and the reasons why a particular treatment might be effective for reducing their symptoms.

telehealth applications. Equipment used for communication between individuals that are not in the same physical location (e.g., audio and video link through a webcam).