



DEFENSE
HEALTH AGENCY

National Capital Region
Medical Directorate
ADMINISTRATIVE INSTRUCTION



NUMBER 6493.01
JUL 07 2014

ClinOps

SUBJECT: Behavioral Health (BH) Services in the Patient-Centered Medical Home (PCMH)
Primary Care Service Settings

References: See Enclosure 1

1. **PURPOSE.** This Administrative Instruction (AI), under the authority of References (a) through (c) and in accordance with (IAW) References (d) through (q), establishes policy and responsibilities for the National Capital Region Medical Directorate (NCR MD) and subordinate organizations. Based primarily on the requirements of Reference (d), this AI is to implement BH Services in the PCMH (BH-PCMH) and other primary care service settings.

2. **APPLICABILITY.** This AI applies to:

a. The NCR MD, Walter Reed National Military Medical Center (WRNMMC) to include the DiLorenzo Clinic and the Tri-Service Dental Clinic, Fort Belvoir Community Hospital (FBCH) to include the Dumfries and Fairfax Clinics. These facilities are collectively referred to hereafter as Medical Treatment Facilities (MTFs). Any deviations or exceptions to this guidance are subject to the prior approval of the Director, NCR MD.

b. All other Tri-Service MTFs in the NCR enhanced Multi-Service Market (eMSM) are highly encouraged to adopt this AI and the associated handbook (Reference (h)) as a best practice. The eMSM includes the MTFs above and these additional facilities: 779th Medical Wing, Naval Health Clinic (NHC) Annapolis, NHC Quantico, Washington Navy Yard Clinic, Rader Army Health Clinic (AHC), Kimbrough Ambulatory Care Center, McNair AHC, Bolling Clinic, Malcolm Grow Medical Clinic, and the Pentagon Flight Clinic.

3. **POLICY.** It is NCR MD policy that MTFs implement the BH-PCMH program in PCMHs and/or other primary care clinics. These clinics, having adult, primary care clinic enrollment of at least 3,000 patients, will decrease overall health costs and improve patient access to behavioral healthcare, population health, readiness, physical and mental health outcomes, and patient and provider satisfaction by using the PCMH model.

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4. RESPONSIBILITIES. See Enclosure 2

5. PROCEDURES. See Enclosure 3

6. RELEASABILITY. **Unlimited**. This AI is approved for public release and is available on the NCR MD Website at www.capmed.mil.

7. EFFECTIVE DATE. This AI:

a. Is effective immediately upon publishing to the NCR MD Website; and

b. Must be reissued, cancelled, or certified current within 5 years of its publication IAW Reference (i). If not, it will expire effective 10 years from publication date and be removed from the NCR MD Website.



CHRISTINE M. BRUZEK-KOHLER
Director for Clinical Operations
By direction of the Director

Enclosures

1. References
2. Responsibilities
3. Procedures

Glossary

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ENCLOSURE 1REFERENCES

- (a) Deputy Secretary of Defense Action Memorandum, "Implementation of Military Health System Governance Reform," March 11, 2013
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) National Capital Region (NCR) Medical Directorate Concept of Operations, September 10, 2013
- (d) DoD Instruction 6490.15, "Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings," August 8, 2013
- (e) JTF CapMed Instruction 6025.05, "Patient-Centered Medical Home," July 2, 2012
- (f) Assistant Secretary of Defense (Health Affairs) Policy Memorandum 09-015, "Implementation of the 'Patient Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009
- (g) TMA/DoD(HA), Military Health System Patient Centered Medical Home Guide, June 2011
- (h) National Capital Region Medical Directorate (NCR MD) Behavioral Health in Patient Centered Medical Home Handbook of Best Practices, March 2014¹
- (i) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012
- (j) JTF CapMed Instruction 6025.04, "Medical Quality Assurance (MQA) and Clinical Quality Management," October 5, 2011 as amended
- (k) JTF CapMed Manual 6025.01, "Clinical Quality Management Manual," March 29, 2012 as amended
- (l) DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," August 17, 2011
- (m) Walter Reed National Military Medical Center Instruction 6010.17, "Medical Staff Policies," February 20, 2012²
- (n) Fort Belvoir Community Hospital Instruction 5100.02, "Bylaws, Rules and Regulations of the Medical Staff," February 27, 2012³
- (o) VA/DoD, Clinical Practice Guideline for Management of Post Traumatic Stress, Version 2.0, June 2010
- (p) VA/DoD, Clinical Practice Guideline for Management of Major Depressive Disorder, May 2009
- (q) VA/DoD, Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0, June 2013

¹ This reference is available through the Clinical Operations Directorate at 301-295-0669.

² This reference is available through the WRNMMC Executive Secretariat at 301-295-2027.

³ This reference is available through the FBCH Command Group at 571-231-3314.

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ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, NCR MD. Director, NCR MD, shall ensure implementation of this AI and compliance with these procedures within the NCR.

2. DIRECTOR, CLINICAL, BUSINESS, AND WARRIOR OPERATIONS. The Director shall:
 - a. Provide oversight of the implementation of BH-PCMH within the MTFs and support, as needed, to MTFs in the NCR eMSM as directed by the Director, NCR MD.
 - b. Identify a BH-PCMH Program Manager for the NCR MD IAW Reference (d).

3. PROGRAM MANAGER, BH-PCMH. The Program Manager shall:
 - a. Be a designated full-time position – not a set of additional duties IAW Reference (d).
 - b. Be the subject matter expert for program, design, implementation, and sustainment at the MTFs.
 - c. Collect metrics from MTFs on program standards and outcomes and report these to the Director, Clinical, Business, and Warrior Operations and the Chair, PCMH Work Group on a quarterly basis.
 - d. Serve as the expert trainer for Internal Behavioral Health Consultants (IBHCs), with technical expertise and support from the Deployment Health Clinical Center, approve the training of all Behavioral Health Care Facilitators (BHCFs); and provide training and coordination for the relevant staff of the MTFs.
 - e. Serve as a representative on the DoD Primary Care Behavioral Health Committee.
 - f. Review program productivity and quality metrics weekly.

4. CHAIR, PCMH WORK GROUP. The Chair of the PCMH Work Group shall:
 - a. Report BH-PCMH program metrics to the NCR MD Market Leadership Board IAW References (j) and (k).
 - b. Assist BH-PCMH Program Manager in regional efforts to implement and sustain the

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BH-PCMH program, including coordinating with MTF Directors and PCMH Provider Champions.

5. MTF DIRECTORS. The MTF Directors shall implement BH-PCMH in all applicable PCMH clinics:

- a. Provide the appropriate staff for the BH-PCMH IAW References (d) through (f).
- b. Provide administrative oversight for and administrative management of the IBHCs and BHCs, as they are defined in the Glossary, including professional affairs processes.
- c. Identify an appropriate External Behavioral Health Consultant (EBHC) and adjust the EBHC's workflow requirements to allow for participation in the BH-PCMH program.
- d. Coordinate all training with NCR MD for the IBHCs, BHCs, and EBHCs.
- e. Assist the coordination between the MTF PCMH Provider Champion and the NCR MD BH-PCMH Program Manager.
- f. Provide space and appropriate resources within the primary care clinic for the IBHCs and BHCs.
- g. Participate in the PCMH Work Group.

6. PCMH PROVIDER CHAMPION. The PCMH Provider Champion shall, IAW Reference (e):

- a. Attend the DoD Primary Care Behavioral Health (PCBH) Committee as an ad hoc member as needed or requested by the NCR MD BH-PCMH Program Manager
- b. Coordinate with the NCR MD BH-PCMH Program Manager to implement the BH-PCMH program at the MTFs.

7. PRIMARY CARE CLINIC CHIEF. The Primary Care Clinic Chief shall be responsible for the quality and performance of the IBHC and BHC, including peer review.

8. IBHC. The IBHC shall provide consultation, brief assessment, and intervention with patients (typically in the context of a 15 or 30 minute appointment) on behalf of the primary care team. These services are an adjunct to the primary care manager's (PCM's) treatment plan and help manage or improve a set of mental health or physical symptoms for the patient and the primary care team. The IBHC will implement the primary behavioral health model IAW References (d), (h), and (i).

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9. BHCF. The BHCF is a registered nurse who shall provide services that reinforce, encourage, check, and support the patient's adherence to the PCM's pharmacologic treatment plan and IBHC recommendations. The BHCF shall serve as a liaison between the EBHC and the primary care team. The BHCF will implement the care facilitation model IAW References (d), (h), and (l).

10. EBHC. The EBHC shall provide consultation about psychotropic medications to the PCM and BHCF at regular intervals and when requested more frequently by the primary care team. The EBHC will assist in implementing consultation as part of the care facilitation model IAW References (d), (h), and (l).

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ENCLOSURE 3PROCEDURES1. STAFFING

a. MTFs with 7,500 or more enrollees shall have at least one full-time IBHC, and one full-time BHCF in each primary care clinic (blended model).

b. MTFs with 3,000-7,499 enrollees shall have at least one full-time IBHC in each primary care clinic (PCBH model). These IBHCs shall also be required to implement a care management model in addition to the PCBH model. See the Glossary for further description of these.

c. All MTFs with a PCMH of 3,000 or more enrollees shall have a MTF-level designation of a specific physician, clinical psychologist, or advanced practice registered nurse with specialized training in prescribing psychotropic medications, irrespective of size or staffing of the MTF. This person shall serve as the EBHC and shall support the program through telephone consultation and must be able to respond to all IBHC or BHCF consultation requests within 24 hours.

2. TRAINING, CORE COMPETENCIES, AND CERTIFICATION

a. IBHCs, BHCFs, and EBHCs shall complete training approved by the NCR MD BH-PCMH Program Manager prior to providing these respective services within an NCR MD MTF.

b. IBHCs and BHCFs shall demonstrate the core competencies during initial training in order to perform their respective job duties. At 6-12 months after this initial training, core competency skills will be assessed again during an MTF site visit in order to confirm the maintenance and further development of the specialized skills required by the BH-PCMH Program. Failure to meet core competencies at the initial or follow-up evaluation precludes anyone from working within the NCR MD as an IBHC, BHCF or EBHC.

c. IBHCs, BHCFs, and EBHCs shall receive their training certifications from the NCR MD BH-PCMH Program Manager prior to providing these respective services in the NCR.

d. MTFs shall follow the guidelines in Reference (d) for expert trainers for IBHCs and BHCFs and may not utilize expert trainers without the explicit designation and approval of the NCR MD BH-PCMH Program Manager.

3. SERVICE DELIVERY MODEL

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a. BHCFs monitor patients in a manner consistent with the evidenced-based science for a care management model and will follow patients who are taking psychotropic medications IAW Reference (d) for the following diagnoses:

(1) Major Depressive Disorder (including other depressive disorders such as Dysthymic Disorder; Depressive Disorder NOS, Adjustment Disorder with Depressed Mood).

(2) Post Traumatic Stress Disorder (PTSD).

(3) Generalized Anxiety Disorder (including other anxiety disorders such as Panic Disorder, Obsessive-Compulsive Disorder, Anxiety Disorder NOS, Adjustment Disorder with Anxiety, Social Anxiety Disorder, Acute Stress Disorder).

b. IBHCs deliver services in a manner consistent with the evidence-based science for a PCBH model of service delivery. IBHCs can see any adult (i.e., the age of medical consent in that state) patient in the PCMH irrespective of the diagnosis providing there is some basis of evidence for addressing the patient's behaviors or lifestyle, as these may impact the patient's physical or mental health conditions.

c. IBHCs, EBHCs, and BHCFs are team-oriented roles, and these personnel shall use a team-oriented approach aimed at patient-centered care and population health.

4. DOCUMENTATION/ADMINISTRATION

a. IBHCs must complete and sign all documentation of all clinical contacts in the behavioral health primary care Tri-Service Workflow Form (TSWF) in the electronic medical record (i.e., AHLTA) by the end of the clinic day on which the patient receives IBHC services, and in exceptional circumstances, within 3 days IAW References (m) and (o).

b. BHCFs and EBHCs must document clinical contacts in the electronic medical record (i.e., AHLTA) within ten days of the PCM referral IAW Reference (d).

c. BHCFs must also document in a care management database that is used throughout the DoD BH-PCMH program (e.g., FIRST Steps).

d. IBHCs, EBHCs, and BHCFs will follow coding guidelines pertinent to this model of care.

e. Documentation will be succinct and completed IAW the specifications of Reference (d).

5. SCREENING REQUIREMENTS. Primary care managers shall conduct screening for suicide, depression, anxiety, and PTSD during new patient encounters. Thereafter, annual screenings will implement care IAW References (d), (h), and (l) as indicated, and in accordance

with any forthcoming determinations of the Department of Defense Primary Care Behavioral Health Committee.

6. PROGRAM STANDARDS AND METRICS

a. IAW Reference (d), IBHCs and BHCFs shall utilize evidence-based outcome tools for all patients, and at every clinical contact evaluate clinical progress and outcomes on an ongoing basis. These tools (Appendices 1 through 5 to Enclosure 3) will be standardized across the NCR and may include the following:

- (1) Duke Health Profile.
- (2) Behavioral Health Measure-20.
- (3) Patient Health Questionnaire -9.
- (4) Post Traumatic Stress Disorder Checklist.
- (5) Generalized Anxiety Disorder Seven-Item Scale.

b. IBHCs and BHCFs shall report productivity metrics (number of patients seen per day) every two weeks, and provider and patient satisfaction metrics monthly. These will be reported to their chain of command and submitted to the NCR MD BH-PCMH Program Manager at these intervals and upon request. The NCR MD will also generate the following metrics annually:

- (1) Change in patient's score on an industry standard general measure of health (e.g., Duke Health Profile or Behavioral Health Measure-20).
- (2) Change in patient's score on an industry standard measure of depression (i.e., PH-9).
- (3) Change in patient's score on an industry standard measure of anxiety (i.e., GAD-7).
- (4) Change in patient's score on an industry standard measure of post traumatic stress disorder (i.e., PCL).
- (5) Decrease in leakage of behavioral health patients to purchased care network by 10% over one calendar year.
- (6) Minimum RVU production in direct care network of at least 10 RVUs per day per 1.0 full time equivalent IBHC.

c. Program standards for this service model require that IBHCs shall provide services for a minimum of ten patients per day, and an average of twelve patients per day. Program standards for this service model also require that BHCFs shall carry a caseload of no less than 150 patients and an average of 300 patients.

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- d. Peer review shall be conducted monthly by the MTF.
- e. These procedures will be carried out IAW References (j) and (k), and any subsequent determinations of the DoD Primary Care Behavioral Health Committee.

7. APPOINTING AND ACCESS TO CARE

- a. Because the IBHC, EBHC, and BHCF function as health extenders to the primary care providers, the MTF may elect to use electronic or paper-and-pencil appointing procedures, and the primary care clinic shall conduct the appointing from within.
- b. PCMs shall refer all patients who present depressive or anxiety symptoms (including stress) to the IBHC unless there is a medical contraindication for referring to the IBHC.
- c. The IBHCs shall provide care for all referrals on the same day as the referral from the primary care team, unless the patient declines same-day care.
- d. The BHCFs shall contact all referrals for care facilitation services within 7 business days of a referral from the primary care team.
- e. The EBHCs shall respond to consultation requests within 24 hours of being contacted by the IBHC, BHCF or primary care team.

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APPENDIX 1 TO ENCLOSURE 3

Duke Health Profile (The DUKE)

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INSTRUCTIONS:

Here are a number of questions about your health and feelings. Please read each question carefully and check (X) your best answer. You should answer the questions in your own way. There are no right or wrong answers. (Please ignore the small scoring numbers next to each blank.)

	Yes, describes me exactly	Somewhat describes me	No, doesn't describe me at all	
1. I like who I am	12	11	10	
2. I am not an easy person to get along with	20	21	22	
3. I am basically a healthy person	32	31	30	
4. I give up too easily	40	41	42	
5. I have difficulty concentrating	50	51	52	
6. I am happy with my family relationships	62	61	60	
7. I am comfortable being around people	72	71	70	

TODAY, would you have any physical trouble or difficulty:

	None	Some	A Lot	
8. Walking up a flight of stairs	82	81	80	
9. Running the length of a football field	92	91	90	

DURING THE PAST WEEK: How much trouble have you had with:

	None	Some	A Lot	
10. Sleeping	102	101	100	
11. Hurting or aching in any part of your body	112	111	110	
12. Getting tired easily	122	121	120	
13. Feeling depressed or sad	132	131	130	
14. Nervousness	142	141	140	

DURING THE PAST WEEK, How often did you:

	None	Some	A Lot	
15. Socialize with other people (talk or visit with friends or relatives)	150	151	152	
16. Take part in social, religious, or recreation activities (meetings, church, movies, sports, parties)	160	161	162	

DURING THE PAST WEEK: How often did you:

	None	1-4 Days	5-7 Days	
17. Stay in your home, a nursing home, or hospital because of sickness, injury, or other health problem	172	171	170	

APPENDIX 2 TO ENCLOSURE 3

Behavioral Health Measure-20 (BHM-20)

NOTE: The BHM-20 is a proprietary instrument. Below includes the items, which are rated by the patient on a five-point Likert Scale. This is not the actual instrument.

- 1) How distressed have you been?
- 2) How satisfied have you been with your life?
- 3) How energetic and motivated have you been feeling?
- 4) How much have you been distressed by feeling fearful, scared?
- 5) How much have you been distressed by alcohol/drug use interfering with your performance at school or work?
- 6) How much have you been distressed by wanting to harm someone? (Including Sometimes and A Little Bit)
- 7) How much have you been distressed by not liking yourself?
- 8) How much have you been distressed by difficulty concentrating?
- 9) How much have you been distressed by eating problems interfering with relationships with family and or friends?
- 10) How much have you been distressed by thoughts of ending your life?
- 11) How much have you been distressed by feeling sad most of the time?
- 12) How much have you been distressed by feeling hopeless about the future?
- 13) How much have you been distressed by powerful, intense mood swings (highs and lows)?
- 14) How much have you been distressed by alcohol / drug use interfering with your relationships with family and/or friends?
- 15) How much have you been distressed by feeling nervous?
- 16) How much have you been distressed by your heart pounding or racing?
- 17) Getting along poorly or terribly over the past two weeks: work/school (for example, support, communication, closeness).
- 18) Getting along poorly or terribly over the past two weeks: Intimate relationships (for example: support, communication, closeness).
- 19) Getting along poorly or terribly over the past two weeks: Non-family social relationships (for example: communication, closeness, level of activity).
- 20) Getting along poorly or terribly over the past two weeks: Life enjoyment (for example: recreation, life appreciation, leisure activities).

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APPENDIX 3 TO ENCLOSURE 3

Patient Health Questionnaire-9 (PHQ-9)

1	<i>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your response)</i>	Not at all	Several days	More than half the days	Nearly every day
a	Little interest or pleasure in doing things	0	1	2	3
b	Feeling down, depressed, or hopeless	0	1	2	3
c	Trouble falling/staying asleep, sleeping too much	0	1	2	3
d	Feeling tired or having little energy	0	1	2	3
e	Poor appetite or overeating	0	1	2	3
f	Feeling bad about yourself; or that you are a failure or have let yourself or your family down	0	1	2	3
g	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h	Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
<u>Total</u>					

2 *If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Circle your response.)*

Not difficult at all	Somewhat Difficult	Very Difficult	Extremely Difficult
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Question 1 (Symptom Severity Score): _____

Question 2 (Impact of Symptoms on Ability to Function in Major Life Roles): _____

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APPENDIX 4 TO ENCLOSURE 3PTSD Checklist – Civilian Version (PCL-C)⁴

Patient's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

	Do you have this typical problem or complaint	Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing <i>memories, thoughts, or images</i> of a stressful experience from the past?					
2.	Repeated, disturbing <i>dreams</i> of a stressful experience from the past?					
3.	Suddenly <i>acting or feeling</i> as if a stressful experience <i>were happening again</i> (as if you were reliving it)?					
4.	Feeling <i>very upset</i> when <i>something reminded</i> you of a stressful experience from the past?					
5.	Having <i>physical reactions</i> (e.g., heart pounding, trouble breathing, or sweating) when <i>something reminded</i> you of a stressful experience from the past?					
6.	Avoid <i>thinking about or talking about</i> a stressful experience from the past or avoid <i>having feelings</i> related to it?					
7.	Avoid <i>activities or situations</i> because <i>they remind you</i> of a stressful experience from the past?					
8.	Trouble <i>remembering important parts</i> of a stressful experience from the past?					
9.	Loss of <i>interest in things that you used to enjoy</i> ?					
10.	Feeling <i>distant or cut off</i> from other people?					
11.	Feeling <i>emotionally numb</i> or being unable to have loving feelings for those close to you?					
12.	Feeling as if your <i>future</i> will somehow be <i>cut short</i> ?					
13.	Trouble <i>falling or staying asleep</i> ?					
14.	Feeling <i>irritable</i> or having <i>angry outbursts</i> ?					
15.	Having <i>difficulty concentrating</i> ?					
16.	Being " <i>super alert</i> " or watchful on guard?					
17.	Feeling <i>jumpy</i> or easily startled?					

⁴ Weathers, F.W., Huska, J.A., Keane, T.M. *PCL-C for DSM-IV*. Boston: National Center for PTSD – Behavioral Science Division, 1991.

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APPENDIX 5 TO ENCLOSURE 3

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

⁵ Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

GLOSSARYPART I. ABBREVIATIONS AND ACRONYMS

AHLTA	Armed Forces Health Longitudinal Technology Application
BHCF	behavioral health care facilitator
EBHC	external behavioral health consultant
eMSM	enhanced Multi-Service Market
FBCH	Fort Belvoir Community Hospital
IBHC	internal behavioral health consultant
MTF(s)	medical treatment facility/facilities
NCR MD	National Capital Region Medical Directorate
PCBH	primary care behavioral health
PCMH	patient-centered medical home
TSWF	tri-service workflow
WRNMMC	Walter Reed National Military Medical Center

PART II. DEFINITIONS

These terms are for the purpose of this AI.

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.

blended model. Joins the care management and PCBH models of care so that BHCF (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).

DoD Primary Care Behavioral Health Committee. This committee is chaired by a designee of the Assistant Secretary of Defense for Health Affairs and comprised of these representatives from the following areas of each Service and the NCR MD: primary care, primary care behavioral health program manager, Defense Centers of Excellence and Traumatic Brain Injury, Deputy Assistant Secretary of Defense for Clinical and Program Policy, Deputy Assistant Secretary of Defense for Force Health Protection and Readiness. Other advisory members may be included at the discretion of the Primary Care Behavioral Health Committee in accordance with Reference (d).

EBHC. 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 who consults with the PCM.

eMSM. An enhanced multi-service market is a market where more than one Military Department delivers health care services to the entire population. There are six including the NCR MD.

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.

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

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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.

PCMH Provider Champion. The PCMH Team Leader/PCMH Provider Champion is a provider who leads a team of individuals at the practice level. The PCMH Provider Champion develops action plans that anticipate short- and long-term provider and clinic support staff shortages (i.e., TDY, leave, illness and deployments). The PCMH Provider Champion identifies opportunities to maximize patient continuity and through scheduling offloaters, non-empanelled medical officers/providers, and individual mobilization augmentees, as available. See Reference (e) for additional duties of the PCMH Provider Champion.

TSWF. This is a standard template in the electronic medical record (currently AHLTA), that is specifically tailored so that PCMs and behavioral health providers within the PCMH can document the patient's care in a clear and understandable way, including the shared treatment plan. This is not to be confused with the TSWF template utilized in outpatient (tertiary) behavioral health care settings.