DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: June 28, 2022

From: Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) (11)

Subj: Expanded Implementation of Outpatient Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Team-Based Care (VIEWS 7302913)

To: Veterans Integrated Services Network (VISN) Director (10N1-23)
VISN CMOs (10N1-23)
VISN Chief Nursing Officers (10N-23)
VISN Chief Mental Health Officers (CMHO) (10N1-23)

1. The purpose of this memorandum is to provide information regarding continuation of the Veterans Health Administration's (VHA) planned national implementation of the BHIP-CCM model at all Department of Veterans Affairs (VA) medical centers and all Community Based Outpatient Clinics (CBOC) nationwide over the next 5 years. BHIP teams are interdisciplinary teams of outpatient mental health providers and administrative support staff who provide and coordinate care for Veterans in general mental health (GMH) clinics.

2. BHIP teams have an evidence-informed staffing model and an evidence-based clinical practice model, the CCM, which aims to facilitate coordinated, proactive, population-based care. Consistent with previous data showing positive Veteran and staff impact, a recent VHA study demonstrated that BHIP-CCM team-based care promotes improved team function, decreased hospitalizations, and improved health outcomes for Veterans with complex mental health conditions[1], and this care was associated with substantial cost savings to VHA.[2] Supported by this evidence, the current national expansion promotes: 1) VHA's Modernization Plan which aims to fully deploy an integrated, team-based Whole Health approach to mental health care across the enterprise; 2) a high reliability organization in which standardization of key principles leads to cost savings and satisfaction; and 3) adequate mental health staffing, as higher mental health staffing to mental health patients is associated with lower Veteran VHA patient suicide rates.[3,4,5]

[1] Bauer MS, Miller CJ, Kim B, Lew R, Stolzmann K, Sullivan J, Riendeau R, Pitcock J, Williamson A, Connolly S, Elwy AR, Weaver K. 2019. Effectiveness of Implementing a Collaborative Chronic Care Model for Clinician Teams on Patient Outcomes and Health Status in Mental Health: A Randomized Clinical Trial. JAMA Network Open, 2(3):e190230.
[2] Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, & Bauer MS. 2020. An Economic Analysis of the Implementation of Team-based Collaborative Care in Outpatient General Mental Health Clinics. Medical Care, 58(10):874-880.
[3] Katz IR, Kemp JE, Blow FC, McCarthy JF, Bossarte RM. 2013. Changes in Suicide Rates and in Mental Health Staffing in the Veterans Health Administration: 2005 to 2009. Psychiatric Services, 64(7):620-625.
[4] Richardson JS, McCarthy JF, Katz IR. August 2017. Applying Machine Learning Techniques to Identify Quality and Staffing Measures Associated with VHA Facility Suicide Rates in 2013-2014. Biannual Department of Defense / Department of Veterans Affairs Suicide Prevention Conference.
[5] Griffin C, Palframan K, Katz IR, McCarthy JF. November 2019. Associations between Mental Health Staff-to-Patient Ratios and Suicide Rates, by Facility and VISN, 2014 to 2017. Unpublished Report, Department of Veterans Affairs, Office of Mental Health and Suicide Prevention.

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3. Over the next 5 years, all facilities must transition their outpatient GMH level of care to BHIP-CCM care at all VA medical centers and CBOCs. This effort continues the iterative national rollout in which facilities create appropriately staffed teams, develop standard CCM-based procedures, evaluate those processes for their intended outcomes, and share strong practices. Within the 5-year timeframe, all facilities should develop and execute a plan to ensure BHIP-CCM integration. In the first year, each VISN should choose, at minimum, one facility to fully implement BHIP-CCM care, with the expectation that all facilities will begin planning (i.e., complete assessments and develop implementation plan). The rollout across a VISN's facilities may be staggered, taking into account the flexible multi-year process outlined above. Please refer to the BHIP policy resource page for memo instructions, timeline, deliverables and other resources.

4. Should you have any questions concerning this memorandum, please contact BHIPresources@va.gov.

Erica Scavella, M.D., FACP, FACHE

Attachments

Attachment A –
Behavioral Health Interdisciplinary Program (BHIP) Staffing Ratio & Resources

***BHIP Staffing Ratio:**

Employee Category	Recommended Minimum FTEE for Mental Health Team Panel Size of 1,000
Total MH Clinician: Licensed Independent Providers (LIPs) and Advanced Practice Providers	6.0 (e.g., pharmacotherapy & psychotherapy providers for the full range of disorders, with specialty/expertise in mood disorders, PTSD and other anxiety disorders, SUD, SMI, pain management, medical issues, etc.)
Administrative Support	1 (e.g., medical support assistant, program support assistant)
Non-LIPs	1 (e.g., nurse, peer specialist, addiction therapist)
**Care Coordination	1 (e.g., RN/SW/LPMHC care coordinator)
Total FTEE (minimum)	**9.0 (8.0 clinical)**

Note: PTSD=Posttraumatic Stress Disorder; SUD=Substance Use Disorders; SMI=Serious Mental Illness; RN=Registered Nurse; SW=Social Worker; LPMHC=Licensed Professional Mental Health Counselor.

BHIP-Collaborative Chronic Care Model (BHIP-CCM) Resources:

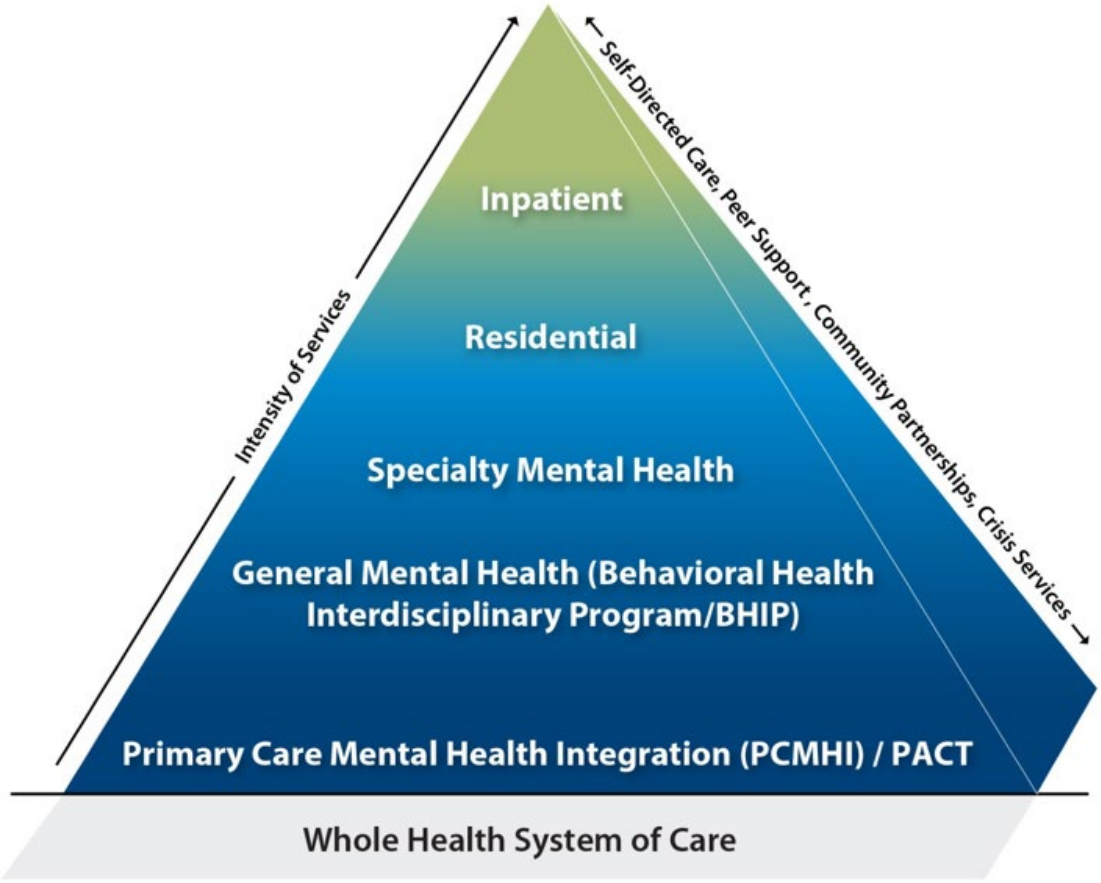
a. The BHIP SharePoint, with all BHIP-CCM team materials.
b. The BHIP-CCM Enhancement Guide, a step-by-step guide for self-assessment and moving care processes into alignment with the CCM. Teams can work through the 8 modules and 27 associated processes to define necessary clinical and administrative procedures.
c. The BHIP Team Workbook introduces basic tools to guide BHIP teams on how to work together and how to identify and carry out improvement projects.
d. Talent Management System (TMS) offers three BHIP Team Simulation Courses: BHIP Strategies for Team Role Clarity (Course #35656), BHIP Team Communication Strategies (Course #35657), and BHIP Within the VHA Mental Health Continuum of Care (Course #35658).
e. Regular technical assistance calls, facility consultations, and trainings.
    i. Second Thursday monthly national BHIP call (see SharePoint)
    ii. Individual facility and network consultations and trainings
f. BHIP Panel Management Tool, a tool that pulls teams, FTEE, and patient assignments from Patient Centered Management Module (PCMM) and can be used to monitor the team's panel.

*The BHIP staffing ratio applies to BHIP teams and is different from the overall outpatient mental health staffing ratio of 7.72 FTEE per 1000 patients treated in all of outpatient mental health. The overall outpatient staffing ratio covers staffing for all outpatient mental health programs [e.g., Primary Care Mental Health Integration

(PCMHI), general mental health (GMH)/BHIP, and specialty programs such as Substance Use Disorder Intensive Outpatient Programs, PTSD Clinical Teams, Intensive Community Mental Health Recovery (ICMHR), etc.], and the denominator for this metric is all patients treated within those programs at the facility. Here 7.72 is considered a minimum level of staffing needed to provide the full continuum of outpatient MH services for all patients treated in VA mental health programs at the facility. The BHIP staffing ratio describes the number of staff needed on a BHIP team for an assigned panel of 1000 mental health patients. Mental health patients managed in Patient Aligned Care Team (PACT)/PCMHI are not included on BHIP panels, and thus are not included in the BHIP staffing ratio denominator. Because BHIP is designed to provide core treatment services for patients with mental health conditions too complex to be managed in PACT/PCMHI, the staffing ratio needed for these teams is higher than for outpatient mental health patients overall.

** All Veterans receiving MH care, who do not receive their MH care through the collaborative care model in PACT/PCMHI, should be assigned to a BHIP team home, with rare exceptions (e.g., ICMHR). To fully implement BHIP, 1) all BHIP teams should align with the recommended staffing model and must integrate the CCM clinical practice model to provide all core BHIP-CCM services for Veterans in GMH; 2) all BHIP teams (staff and Veterans) are entered into PCMM; and 3) all Veterans with a BHIP team home are assigned a Mental Health Treatment Coordinator (MHTC) in PCMM. Typically (and especially for new BHIP patients and new episodes of care), this would be a Registered Nurse, Social Worker, or Licensed Professional MH Counselor care coordinator who oversees the care coordination for the Veteran, based on individual clinical needs and consistent with national guidance regarding care coordination (e.g., VHA Directive 1110.04). Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services. It can include, but is not limited to, care management and case management. For existing BHIP patients, the BHIP team should review existing MHTC assignments and consider whether these assignments best meet the Veteran's *current* needs or whether the Veteran would be better served with a new MHTC assignment. Changes in MHTC assignments should be accomplished in collaboration with the Veteran and at an appropriate juncture in treatment to promote seamless and coordinated care (e.g., a new episode of care). Additionally, the assigned MHTC will collaborate and coordinate with the Lead Coordinator (LC; per VHA Directive 1110.04) who oversees implementation of the Veteran's whole health care plan. Note, the VSSC List of Coordinators has the staff listed who can enter data into PCMM for MH. Where more than one name appears for a facility, the first person is considered to be the primary MH PCMM Coordinator. If you see errors in this list, please email Julie.Wildman@va.gov. ***Note, original MHTC guidance remains in effect until new, updated national guidance is disseminated; guidance is located at the MHTC policy resource page.***

Attachment B – BHIP's Role in VA's Stepped Mental Health Continuum of Care



Background:

The Veterans Health Administration (VHA) is updating VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (to be recertified as a directive with future publication date), to require full implementation of Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) team-based care. That is, facilities must convert all outpatient general mental health (GMH) care to BHIP-CCM care at all Department of Veterans Affairs (VA) medical centers and Community Based Outpatient Clinics (CBOC). The GMH level of care is, when appropriate, generally defined by Stop Code 502 in the existing electronic health record and by the use of GMH charge orders in Cerner Millennium. Fully implementing BHIP-CCM care means having one sufficiently staffed BHIP team for every approximately 1000 GMH unique Veterans served by the facility where each team 1) meets the recommended staffing model and 2) incorporates CCM as the team's practice model. Consistent with the current recommended minimum staffing for outpatient mental health, the BHIP model's updated staffing ratio expands the original 2013 BHIP guidance and includes additional FTEE to support treatment, care coordination, and proactive population management.

VHA Handbook 1160.01 requires facilities to support a full continuum of care, including Primary Care Mental Health Integration (PCMHI), general outpatient (BHIP), specialty outpatient, residential, and inpatient mental health services. Optimal team-based care requires all parts of

the continuum to be staffed appropriately and function effectively. Strong team-based care throughout the continuum will help ensure that 1) evidence-based treatments are considered for Veterans with mental health conditions to facilitate episodic, recovery-oriented care; and 2) Veterans will be transferred to less intensive levels of care when appropriate.

1. Consistent with the CCM and Whole Health model, the mental health continuum of care begins with self-directed care, typically done by Veterans on their own without clinician involvement or supported by clinicians in the Patient Aligned Care Team (PACT). In addition to primary care providers, nurses and ancillary staff, PACT includes integrated mental health services and care coordination or care management provided by the PCMHI staff. Most individuals with mental health conditions and health behavior needs can be managed within PACT, which is their medical "home." PCMHI staff are embedded in the PACT to provide consultation, brief assessments, time-limited evidence-based interventions suitable for primary care, longitudinal follow-up as needed, referral management and decision support for the team, etc.

2. Generally, BHIP teams are the 'home' for all mental health patients whose mental health care needs cannot be managed in PACT and require treatment at a higher intensity of care (i.e., general or specialty mental health services); exceptions to this are Intensive Community Mental Health Recovery (ICMHR) patients. BHIP teams are a crucial part of VA's stepped mental health continuum of care model as they provide necessary care coordination (or care management when indicated) for all Veterans receiving mental health services in general or specialty care. BHIP teams provide complete courses of evidence-based psychotherapy and behavioral interventions, medication management, care coordination or care management and access to Whole Health services for the full range of patients seen in GMH clinics (e.g., mood disorders, PTSD and other anxiety disorders, substance use disorders (SUD), serious mental illness, pain, etc.). BHIP teams must have processes to ensure access to the full array of evidence-based therapies (e.g., by engaging within and across BHIP teams and with specialty MH care). This stepped approach reserves mental health specialty care [e.g., PTSD Clinical Team (PCT), ICMHR, etc.] for more intensive, time-limited services (adjunctive to BHIP team services and BHIP care coordination or care management) to advance stabilization or recovery or for ongoing specialist interventions that address more complex treatment needs.

3. All levels of the mental health continuum of care are necessary for Veterans to get the services they need. Nationwide establishment of BHIP teams does not entail eliminating specialty mental health services, such as ICMHR, PCT, or SUD intensive outpatient programs (SUD IOP), etc. Specialty teams are essential for those who need services beyond the core services they receive from their PACT/PCMHI or BHIP teams. In many instances, specialty providers will work collaboratively with providers and patients on PACT or BHIP teams, and it is essential to ensure such care is carefully coordinated and is consistent with requirements for specialty care. Depending on where the Veteran's mental health 'home' is (i.e., PACT or BHIP), that team will assume ownership of the Veteran's overall mental health care and ensure care coordination for all mental health services being provided at the time (e.g., if the Veteran is on a BHIP team, there would be Mental Health Treatment Coordinator (MHTC) and BHIP team assignment, with BHIP team-based care and adjunctive, time-limited specialty MH care as needed). The assigned MHTC will collaborate and coordinate with the Lead Coordinator, as applicable, (per VHA Directive 1110.04, Integrated Case Management Standards of Practice) who oversees the Veteran's care coordination needs and planning along the system-wide continuum of care.

4. BHIP team-based mental health care is the provision of comprehensive, accessible, Veteran-centered mental health care by interdisciplinary providers and support staff in partnership with Veterans and their supportive others. Similar to one primary care clinic having multiple PACTs within the clinic, an outpatient GMH clinic will likely have multiple BHIP teams within that clinic. BHIP teams have several important team member roles including: 1) an identified team leader, 2) an MHTC assigned to each Veteran, and 3) multiple professional disciplines and administrative staff. Team members communicate, coordinate, and work collaboratively with all care team members, including Veterans, to accomplish shared goals within and across settings and achieve coordinated, high-quality care. Effective teams have a set of defining characteristics: leadership support, appropriate staffing levels and mix, co-located space (or virtual space options to promote team communication and collaboration), shared goals, team member role clarity, regular communication strategies (within the team, with mental health colleagues across the continuum of care, and with Veterans), team building opportunities, and a focus on process definition and continuous process improvement.

5. The evidence-based CCM is the practice model for BHIP teams (see BHIP-CCM Enhancement Guide).

***CCM Goal:* Anticipatory, Continuous, Evidence-Based, Collaborative Care via…**				
CCM-2: Work Role Redesign	**CCM-3: Veteran Self-Management Support**	**CCM-4: Provider Decision Support**	**CCM-5: Information Management**	**CCM-6: Community Linkages**
• **Care management** • **Need-driven access** • **Activated follow-up**	• **Focus on the individual's values and skills** • **Shared decision-making** • **Self-mgt skills** • **Recovery-orientation**	• **Provider education** • **Practice guidelines** • **Specialty consultation**	***Population*:** • **Registry** ***Provider:*** • **Feedback** ***Patient:*** • **Outcome tracking** • **Measurement-based care**	• **Additional resources** • **Peer-based support**
CCM-1: Organizational Leadership and Support				

6. The CCM is based on the original design for chronic disease management, published by Wagner, et al. (1996)[1]. It is distinct from the Collaborative Care Model (CoCM) that provides patient monitoring and decision support to primary care teams primarily via telephone which, in VA, is provided by PCMHI's care management function. The CCM requires BHIP teams to establish processes to incorporate six necessary elements: organizational leadership and support; work role redesign; Veteran self-management support; provider decision support;

[1] Wagner EH, Austin BT and Von Korff M. Organizing Care for Patients with Chronic Illness. Millbank Quarterly 1996;74: 511-545

information management; and community linkages. To optimally promote CCM-based care, BHIP teams should engage in the following steps:

- Obtain leadership support (VISN, facility, and facility mental health);
- Establish team membership (e.g., clearly defined team member roles and shared team purpose and goals);
- Identify Veterans on the team's panel (e.g., plan for assigning Veterans to the team and assigning an MHTC);
- Develop within team procedures (e.g., provision of evidence-based therapies; patient flow, including measurement-based care; process improvement activities, clinical case reviews, and care coordination, including access to Whole Health and other services);
- Develop liaison procedures with other parts of the continuum of care (e.g., PCMHI, specialty outpatient, residential, inpatient, emergent/urgent care, and community care);
- Develop procedures for Veteran engagement and input;
- Identify relevant team measures and evaluation plan; and
- Implement process for ongoing review and updating of team procedures.

As BHIP team-based care requires an increased focus on communication, collaboration, and care coordination, it is critical that teams have protected time for regular team communication strategies (e.g., huddles, team meetings, interdisciplinary team meetings with other services, retreats, etc.). Time should also be protected for the MHTC to participate in care coordination review team meetings.

Table 1. Stepped Care Model of Outpatient Mental Health Services

***Abbreviations in Notes section below table.**
This table is NOT an exhaustive list of services.

PACT/PCMHI	• **Foundational: Self-management support**
	  • Self-directed activities that can include many options (e.g., mobile apps, community resources, etc.)
	  • Peer support including Whole Health and Mental Health peers
	  • Rehabilitation therapies (e.g., occupational therapy, recreation and creative arts therapy, kinesiotherapy and physical therapy, blind rehabilitation)
	  • Complementary and Integrative Health Interventions (e.g., acupuncture, massage and chiropractic care) and active self-care training (e.g., yoga, Tai Chi, biofeedback, etc.)
	• **Brief psychotherapies & behavioral interventions for the full range of mental and behavioral health conditions**
	  • E.g.: Brief versions of EBPs developed specifically for primary care, including ACT, Brief CBT-D, Brief CBT-CP, Brief counseling for SUD, app-based CBT-I, Motivational Interviewing, Brief exposure for PTSD, PST
	• **Medication management (for patients capable of a substantial level of self-management)**
	  • Psychotropic prescribing for stable or less complex patients (including M-OUD with appropriate DEA X waiver)
	  • Controlled substance risk mitigation and management, including urine drug testing (UDT and PDMP), informed consent, data-based risk reviews, etc. UDT inclusion of alcohol metabolites and availability of gas or liquid chromatography/mass spectroscopy (GC-LC/MS) should be in place and routinely used as a component of risk mitigation.
	  • Pain Management (PM) integration by providers with specialty pain training, such as Clinical Pharmacist Practitioners (CPP) providing comprehensive medication management and NP, PA, MD or DO capable of providing specialized pain exam. Providers triage to specialty Pain Clinics when appropriate, and coordinate services.
	• **Care coordination/care management/case management**

BHIP/GMH	**Stay until Stabilized/Recovered**

	• **Foundational: Self-management support**
	  • Self-directed activities that can include many options (e.g., mobile apps, community resources, etc.)
	  • Peer support including Whole Health and Mental Health peers
	  • Rehabilitation therapies (e.g., occupational therapy, recreation and creative arts therapy, kinesiotherapy and physical therapy, blind rehabilitation)
	  • Complementary and Integrative Health Interventions (e.g., acupuncture, massage and chiropractic care) and active self-care training (e.g., yoga, Tai Chi, biofeedback, etc.)
	• **Full courses of common evidence-based psychotherapy and behavioral interventions for the full range of mental and behavioral health conditions**
	  • E.g.: ACT, BFT, CBT-D, CBT-CP, CBT-SUD, CBT-I, Motivational Interviewing, MET, SBIRT, CPT, PE, IPT, PST, SST, IDDT, Family/Couple Services, etc.
	• **Medication management for the full range of mental and behavioral health conditions**
	  • Psychotropic and pain prescribing for mild, moderate and complex patient presentations, or patients undergoing transitions in treatment plans (e.g., medication changes, dose increases, tapering); including access to M-OUD with appropriate DEA X waiver and management of controlled substances
	  • Controlled substance risk mitigation and management, including random UDT, pill counts (for controlled medications), PDMP, informed consent, data-based risk reviews, etc. UDT inclusion of alcohol metabolites and availability of GC-LC/MS testing should be in place and routinely used as a component of risk mitigation.
	  • Pain Management (PM) integration by providers with specialty pain training, such as Clinical Pharmacist Practitioners (CPP) providing comprehensive medication management and NP, PA, MD or DO capable of providing specialized pain physical exam. Providers triage to specialty Pain Clinics when appropriate, and coordinate services.
	• **Care coordination/care management/case management**

Specialty	• **Foundational: Self-management support**

	• Self-directed activities that can include many options (e.g., mobile apps, community resources, etc.) • Peer support including Whole Health and Mental Health peers • Rehabilitation therapies (e.g., occupational therapy, recreation and creative arts therapy, kinesiotherapy and physical therapy, blind rehabilitation) • Complementary and Integrative Health Interventions (e.g., acupuncture, massage and chiropractic care) and active self-care training (e.g., yoga, Tai Chi, biofeedback, etc.) • **PTSD Clinical Teams (Intensive Outpatient PTSD)** • PTSD specialty teams to address patients with complex and/or comorbid conditions or those with more acute and/or chronic needs, typically including mental health and Substance Use Disorder (SUD) comorbidity, and/or those not responding to EBPs delivered in BHIP. Primary services include provision of VA/DoD clinical practice guideline recommended treatments, including trauma-focused psychotherapies primarily provided on an individual basis (e.g., CPT, PE). Skills based interventions for severe symptoms of PTSD (e.g., dissociation) provided on a time-limited basis. PTSD Clinical team members provide consultation and support for care transitions with BHIP. • **Outpatient Substance Use Disorder (SUD)** • Intensive, specialized SUD services that may include intensive outpatient programs, accredited opioid treatment programs (methadone programs), and continuing care. Outpatient specialty SUD programs address patients with complex and/or co-occurring conditions or those with more acute and/or chronic needs, typically including mental health and SUD comorbidity. Outpatient specialty SUD programs provide intensive services to stabilize patients and start them on a path to recovery. Services include M-OUD and medication for alcohol use disorder, intensive evidence-based treatments including CBT-SUD, contingency management, TSF, MET and incorporate principles of motivational interviewing and case management. • **Other specialty mental health outpatient services**—PRRC, ICMHR, Family Services, VHA Vocational Rehabilitation Service, RANGE and E-RANGE, etc. • **Pain Specialty Clinic/CARA Pain Management Team**

	• Specialized pain teams to address patients with complex and/or comorbid conditions or those with more acute and/or chronic needs, typically including mental health and SUD comorbidity and rehabilitation (e.g., Physical Therapy/Occupational Therapy/Recreation and Creative Arts Therapy/Kinesiotherapy) expertise; providing intensive services to stabilize patients and start them on a path to recovery, includes M-OUD, intensive psychosocial treatment and case management • Psychological approaches such as CBT-CP and less common psychotherapy (e.g., exposure therapy, etc.). These services are typically provided in the context of interprofessional teams but may also be provided as part of BHIP care • Non-interventional pain management: 1) Optimization of complex medication regimens; 2) Specialist interprofessional pain management teams to address complex, treatment resistant or unstable patient cases, typically including mental health and SUD comorbidity co-occurring with chronic pain • Interventional pain management: Injections and surgical interventions • **Interdisciplinary High-Risk Review Team Regarding Pain** • Performs data-based risk reviews per Notice 2018-08. • **Care coordination/care management/case management**

*Notes: Acceptance and Commitment Therapy (ACT); Behavioral Family Therapy (BFT); Cognitive Behavioral Conjoint Therapy for Posttraumatic Stress Disorder (CBCT-PTSD); Cognitive Behavioral Therapy for Chronic Pain (CBT-CP); Cognitive Behavioral Therapy for Depression (CBT-D); Cognitive Behavioral Therapy for Insomnia (CBT-I); Cognitive Behavioral Therapy for Substance Use Disorders (CBT-SUD); Cognitive Processing Therapy (CPT); Doctor of Medicine (MD); Doctor of Osteopathic Medicine (DO); Enhanced Rural Access Network for Growth Enhancement (E-RANGE); Evidence-Based Psychotherapy (EBP); General Mental Health (GMH); Integrated Dual Diagnosis Treatment (IDDT); Intensive Community Mental Health Recovery (ICMHR); Interpersonal Therapy (IPT); Motivational Enhancement Therapy (MET); Medication for Opioid Use Disorder (M-OUD); Nurse Practitioner (NP); Physician Assistant (PA); Posttraumatic Stress Disorder (PTSD); Prescription Drug Monitoring Program (PDMP); Prolonged Exposure (PE); Problem Solving Training (PST); Psychosocial Rehabilitation and Recovery Center (PRRC); Rural Access Network for Growth Enhancement (RANGE); Screening, Brief Intervention, and Referral to Treatment (SBIRT); Social Skills Training (SST); Urine Drug Testing (UDT)

Attachment C – Guidance for Understanding BHIP Team & Staffing Data in Attachment D

Implementing the Behavioral Health Interdisciplinary Program (BHIP) team model across your health care system will require substantial planning to ensure that teams are adequately and appropriately staffed to provide all the services expected at this level of care per **Attachment B**. In Attachment D and below, we provide data and tools to guide your design and staffing of your BHIP teams.

Attachment D, Table 1:

Table 1 describes the number of Primary Care Mental Health Integration (PCMHI) full-time equivalent (FTE) staff (Column B) and the number of BHIP teams (Column C), as defined by the staffing model in Attachment A, needed at each health care system. The number of clinical FTE needed for PCMHI in Column B is estimated as .67 FTE for every 1200 facility uniques. The number of BHIP teams needed in Column C is defined as 1 BHIP team per 5 Patient Aligned Care Teams (PACT), operationalized as 1 BHIP team per 6000 facility uniques. This estimate is based on a general assumption of current MH utilization rates and a stepped MH care model that includes PCMHI.

Based on the number of BHIP teams needed, recommendations for total number of FTE needed at the health care system to staff the overall BHIP program are provided in Column D [i.e., VA medical center and associated Community Based Outpatient Clinics (CBOC)]. These are divided into sub-classes of Licensed Independent Provider/Advanced Practice Provider FTE [e.g., psychiatrists, psychologists, nurse practitioners, clinical pharmacist practitioners (CPP), social workers (SW), licensed professional mental health counselors (LPMHC), marriage and family therapists, etc.]; Administrative FTE (e.g., medical support assistants, etc.); Non-Licensed Independent Provider FTE (e.g., peer support specialists, addiction therapists, etc.); and Care Coordination FTE [e.g., registered nurse (RN), SW, LPMHC, etc.].

We recommend that you consider current general mental health (GMH) staffing in relationship to these recommendations. Strategic planning should aim towards full staffing of BHIP teams and continued staffing of the entire MH continuum of care, including PCMHI and specialty care [e.g., Posttraumatic Stress Disorder Clinical Teams (PCT), Substance Use Disorder Intensive Outpatient Programs (SUD IOP), and Intensive Community Mental Health Recovery (ICMHR) Services], residential and inpatient mental health.

To facilitate hiring and/or reorganization plans to implement BHIP teams to meet patient needs, Table 1 provides an interactive worksheet to summarize gaps between current staffing and BHIP team staffing recommendations. **Column D summarizes the total FTE needed for BHIP teams at your health care system to meet the recommended BHIP staffing model; this total FTE is simply what is recommended to meet the model and does NOT take into account existing FTE already in GMH or on BHIP teams and/or other existing staff that may be available for realignment.** Columns

E-H break those total model FTE into subcategories as defined in Attachment A. These are provided as goals based on local health care utilization in Fiscal Year 2020 Quarter 2 (FY20 Q2). This timeframe was chosen because it represents the latest period that was not impacted by the COVID-19 pandemic. Pandemic-related challenges reduced primary care utilization. We considered using Office of Policy and Planning (OPP) FY22 projections, which would account for expected growth in primary care utilization based on pre-pandemic trajectories. These data would likely make estimates higher, suggesting a greater need for additional mental health staff. Using FY20 Q2 (pre-pandemic) actual utilization data provides a compromise between FY20-21 pandemic-related underutilization of services and FY22 projected need. Facilities anticipating rapid growth in mental health patient numbers or with highly dispersed patient populations may want to increase these goals to address local context.

To determine if and where staffing gaps exist, facilities should self-report current GMH FTE available for assignment to BHIP teams (including FTE already assigned to BHIP teams) in columns I-M. After reviewing staffing requirements for MH outpatient specialty and residential programs (if requirements exist), any excess FTE available for reassignment to BHIP should be entered in columns N-R. FTE entered in these columns (I-M and N-R) will be subtracted from the required FTE in Columns D-H to auto-calculate the number of additional FTE needed to meet the recommended staffing model, represented in Columns S-W. Outpatient specialty mental health or residential FTE should only be reassigned if there is excess capacity in these areas. Facilities must still be able to provide outpatient specialty mental health and residential care as required by VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (i.e., to be recertified as a directive with future publication date). Plans to hire or reorganize staff should be developed to ensure that additional FTE in the appropriate categories are available and assigned to the BHIP teams. Plans to reorganize must ensure that team-based care remains intact throughout the MH continuum of care (e.g., PCMHI, specialty care, etc.). When FTE are to be reorganized from specialty teams to BHIP teams, total FTE to be reorganized should be documented in Column X, along with information regarding the number of staff remaining in the relevant specialty program.

To optimally reach patients, BHIP teams should be logistically accessible to patients. Placing BHIP teams at CBOCs or linking BHIP teams to CBOCs by clinical video telehealth may improve accessibility, and thus treatment engagement, for patients. We recommend that you review patient location data as you plan your BHIP teams, considering where teams might be best located and where robust clinical video telehealth or other options to address logistical barriers to care (e.g., mobile clinics) may be needed.

Please direct questions regarding Attachments C or D to Matthew.Boden@va.gov.

Attachment E – Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Fidelity Self-Assessment Instructions

Overview & Instructions:

The Office of Mental Health and Suicide Prevention (OMHSP) seeks to learn about ongoing facility BHIP implementation to 1) understand the self-reported integration of CCM elements within BHIP teams and 2) provide useful education, tools, and support for the field. This self-assessment is critical to those efforts. It will also help to inform future OMHSP consultations with your BHIP team.

You may open the self-assessment in your web browser by clicking this link:

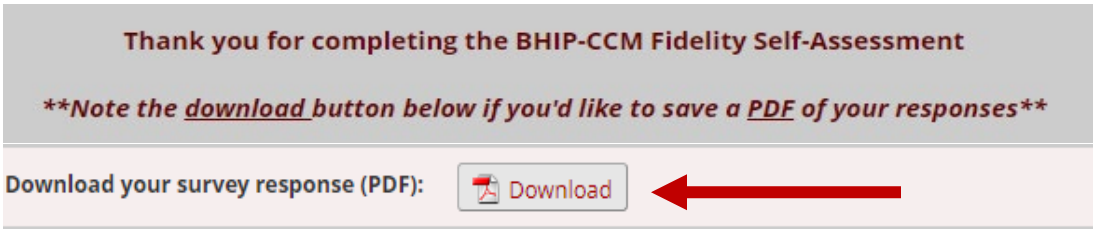
BHIP-CCM Fidelity Self-Assessment

If you wish to preview the questions, please click here: BHIP-CCM Fidelity Self-Assessment.pdf

Each BHIP team lead/coordinator should complete this team self-assessment for each BHIP team.

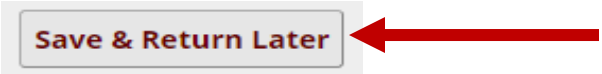
- Data collection is **open for 90 calendar days** following release of the national BHIP memorandum.
- Please submit **one** self-assessment for **each** BHIP team at your facility.
- We estimate this self-assessment will take **30-45 minutes** to complete per team.
- To submit the questionnaire for only one BHIP team, respond to all questions and click the 'Submit' button at the bottom of the screen.
- If submitting for more than one BHIP team, then click on 'Add Information for another BHIP Team' on the last page of the self-assessment.
- Once you have entered information for all BHIP teams, click the 'Submit' button at the bottom of the screen. You must submit the self-assessment in order for it to be counted.

- You will then have the option to download a copy of your self-assessment.

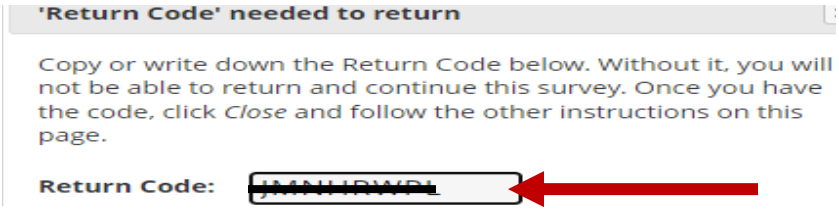


If you are unable to complete the self-assessment in one session, you may save & return later to complete.

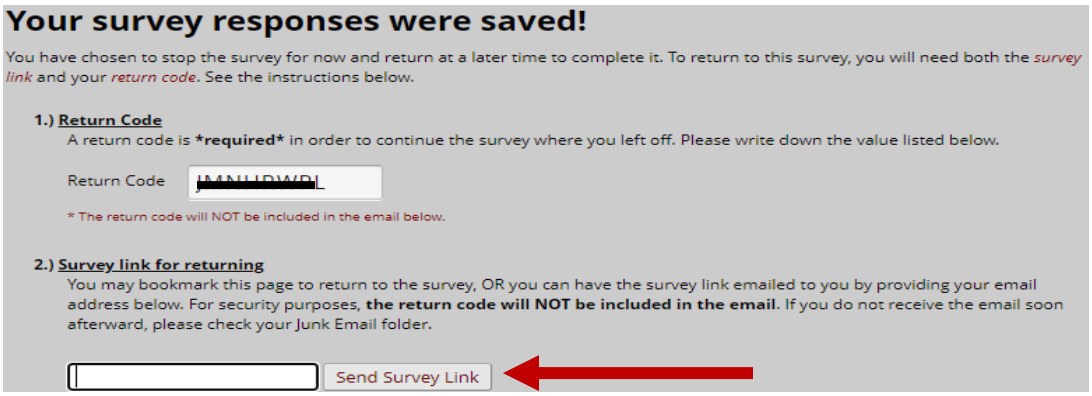
At the bottom of each page is the "Save & Return Later" button, please click on that button and follow the prompts to write down the return code and e-mail yourself the self-assessment link.



a. **You must write down the return code.**

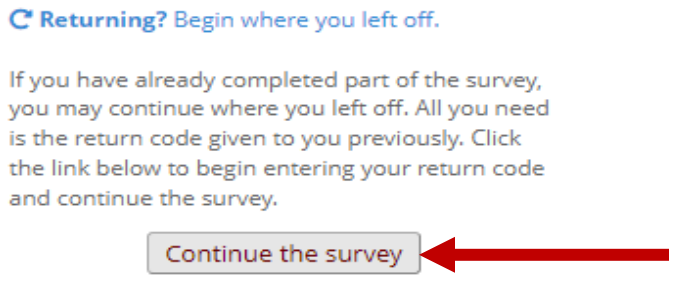


b. **And send yourself the link**



If you have forgotten to email yourself the link you can access the self-assessment via the original link: BHIP-CCM Fidelity Self-Assessment and move your mouse over the word "Returning" at the top of the self-assessment.

c. **The following box will pop up - click on "continue the survey"**



d. And enter in your 'return code" to continue with the self-assessment

You will NOT be able to retrieve your incomplete questionnaire without a Return Code. If you misplace your Return Code, you will need assistance to retrieve the questionnaire. Contact Leslie Parillo at Leslie.Parillo@va.gov.