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Core Competencies for Licensed Behavioral Health Providers Working in Integrated Ambulatory Settings

Adapted from Colorado's Core Competencies for Licensed Behavioral Health Providers Working in Primary Care

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Background

In 2015, the Farley Health Policy Center developed a process to establish a set of core competencies for licensed behavioral health providers working in primary care settings in the state of Colorado. At that time, Colorado was on the cusp of integrating behavioral health and primary care in hundreds of practice sites with its Center for Medicare and Medicaid Services' State Innovation Model grant. The intent of this process was to establish common competencies across health care delivery settings and training and education programs. The set of eight core competencies has been used to help practices recruit and set expectations for integrating behavioral health providers; used in education programs across the state, including development of e-learning modules; and most recently adopted as part of the curriculum for a training symposium focusing on state-wide best practices, led by the Colorado Office of Behavioral Health.

The Colorado core competencies consensus process began with a synthesis of the best available articles and resources on behavioral health competencies in primary care:

- **Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review**. Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality. March 2015.
- **Core competencies for integrated behavioral health and primary care**. Center for Integrated Health Solutions (CIHS); SAMHSA-HRSA and National Council for Behavioral Health. www.integration.samhsa.gov
- **Competencies for Psychology Practice in Primary Care**. McDaniel SH, Grus CL, Cubic BA, Hunter CL, Kearney LK, Schuman CC, Karel MJ, Kessler RS, Larkin KT, McCutcheon S, Miller BF. American Psychologist. 2014 May;69(4):409.
- **Training behavioral health and primary care providers for integrated care: A core competencies approach.** Chapter by Strosahl (2005) in *Behavioral Integrative Care: Treatments That Work in the Primary Care Setting*., pp. 53-71. W. O'Donohue, M. Byrd, N. Cummings, & D. Henderson (eds). New York: Brunner-Routledge.

A set of competencies was created after reviewing the literature and soliciting input from Colorado stakeholders to develop agreement upon final language for the set. Using a structured online survey, stakeholders offer suggestions for shaping individual competencies and defining the set as a whole. Edits and feedback were incorporated into the competencies. A consensus conference was subsequently held to discuss collected feedback, opinions and options for finalizing competency language. More substantive issues were discussed in facilitated small and large workgroups. The resulting feedback was incorporated into the next iteration of the competencies and tested for consensus through a final online survey. Final feedback was incorporated into the consensus product, *Core Competencies for Behavioral Health Providers Working in Primary Care.*

The Farley Health Policy Center supported the Oregon Health Authority's Behavioral Health Collaborative (BHC) to develop recommendations to "build a 21st century behavioral health system in Oregon. The BHC developed a series of high-level recommendations to OHA, and OHA responded by partnering with existing stakeholder groups to establish six workgroups (cite BHC recommendations reports; BHC implementation update):

- Governance and finance

- Standards of care and competencies
- Workforce
- Peer delivered services
- Data and outcomes
- Health information technology and exchange

The Standards of Care and Competencies workgroup recommended that OHA assess the minimum core competencies of behavioral health providers in Oregon: merits, gaps, and minimum training requirements for providers in various settings. OHA staff has completed a matrix to identify current requirements for licensed and unlicensed workforce. OHA staff have prioritized competencies for licensed behavioral health providers working in integrated ambulatory settings, and are now consulting with the Farley Health Policy Center to develop these competencies. The Oregon Health Policy Board's Healthcare Workforce Committee has identified a subgroup that will be dedicated to work with OHA and the Farley Health Policy Center to finalize a set of competencies.

The Farley Health Policy Center recommends that OHA follow a similar consensus process as Colorado to develop a core set of competencies for licensed behavioral health providers working in integrated ambulatory settings. The Healthcare Workforce Committee will serve as the initial stakeholder group and determine further stakeholder input is needed for future adoption in Oregon.

Methodology

A literature review was conducted to search for new resources or resources for the expanded setting, including primary care, outpatient mental health centers, and school-based health centers. Two additional resources were identified and incorporated into the set of competencies. The Colorado Core Competencies and the foundational references used to create the Colorado Core Competencies are the most cited literature on competencies for integrated care delivery. Since the intent of OHA is similar to the rationale for creating the Colorado Core Competencies, the Colorado Core Competencies were chosen as the set to adapt for Oregon's licensed behavioral health providers.

Preamble to the Competencies

Competence as a licensed behavioral health provider working in an integrated care delivery site refers to the ***knowledge, skills, and attitudes*—and their interconnectedness—that allow an individual to perform the tasks and roles in that setting** (adapted from Kaslow, Dunn, & Smith, 2008). These competencies are compatible with the five generic core competencies for healthcare professionals as articulated in the 2003 Institute of Medicine report, *Health Professions Education: A Bridge to Quality*. The goal for all members of the care team is to acquire and demonstrate competencies specific to their roles in integrated health care. The scope of this document is the desired competencies tailored for licensed behavioral health providers.

SAMHSA definitions of competencies and core competencies:

Competencies are defined as the integration of knowledge, skills, and attitudes that contribute to the quality of a person's work performance. Knowledge is information and understanding learned through experience or training. Skill is the result of applying knowledge or ability to a set of circumstances, and attitude is the way a behavior is performed. Attitudes often align with the principles or values of a practice.

Core competencies are the foundational and essential competencies required by anyone who provides behavioral health services. These competencies are common across a range of roles and

environments. Roles in some settings or program models may require advanced or specialized competencies in addition to these core competencies.

General Definition of Integrated Behavioral Health

The competencies relate to the OHA definition of integration and the Agency for Healthcare Research and Quality (AHRQ) definition of integrated behavioral health and primary care.

Oregon Health Authority [working definition]:

> "Creating a system that seeks to break down barriers among and collaborate with physical, behavioral, oral, and social health care providers to put patients at the center of comprehensive, cost-effective care that improves patient experience, population health, and individual health outcomes."

Agency for Health Care Research and Quality:

> "The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.
>
> This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of healthcare utilization." Peek, C.J. and the National Integration Academy Council (2013)

Cross-Cutting Themes for the Eight Competencies

Several tenets apply across all of the competencies. Rather than repeating them within each of the eight competencies, which leads to long, repetitive-sounding competency descriptions, these cross-cutting themes or tenets are listed here once, to apply across all the competencies.

The behavioral health provider competencies are expected to be applied using an equity, person-centered, and trauma informed lens and pertain to work:

- Across a continuum from prevention to recovery: to address mental health, substance use treatment, trauma, stress, adverse childhood experiences (ACEs), and quality of life
- Across the lifespan: from birth to end of life care
- Across the generations: children and elders in families or intergenerational relationships (that may involve guardians, family caregivers, or others), not only as individuals apart from such relationships
- Across a biopsychosocial continuum: integrating biological, psychological, social, and spiritual information and perspectives in evaluation and treatment
- Person-centered and culturally sensitive: tailoring care to patient values and preferences; language, culture and community; socioeconomics and health disparities; and religious, gender, sexual orientation or other important identifications

The Competencies Are Not Written for Any Particular Model or Type of Integration

Different clinics may employ different types of spatial arrangement, team structure, or styles of collaboration—sometimes known as "models," such as "co-location," "full-integration," "primary care behavioral health," or "collaborative care." These are often chosen on the basis of goals, stage of development, or what clinics find practical at any given time.

The eight competences are written to support highly integrated practices with on-site behavioral health providers as members of the health care team. Practices will vary in how they implement or carry out these competencies, depending not only on their "model" of integration, but on their patient population, spatial arrangement, and operational support. For example, some competencies may be used more routinely or intensively depending on the type of collaboration or integration being used in practice and patient populations involved. In addition, these competencies do not take into account the additional elements needed for successful integration at the practice level (e.g., electronic medical records, workflow, spatial arrangements, and competencies for integrated care necessary for other team members). Such "model" characterizations can be found in the AHRQ Lexicon and SAMHSA/HRSA CIHS

The Competencies Are Specific to Delivering Behavioral Health Services in an Ambulatory Integrated Care Setting

These competencies do not attempt to re-create the entire scope of competencies for licensed behavioral health providers acquired in their basic training—only those *specific to working on an integrated care team* that may or may not stand out beyond those expected of licensed behavioral health providers in general.

In Oregon, these competencies apply to:

- Medical or Osteopathic physician licensed by Board of Examiners for State of Oregon & board eligible for Psychiatry
- Psychologist licensed by State Board of Psychologist Examiners
- Registered nurse certified as Psychiatric NP by Oregon State Board of Nursing
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Marriage & Family Therapist

The competencies are written to optimize the overall functioning of the team, more so than any individual provider type. The competencies are most likely to be impactful when the BH service is not considered adjunctive, and what both providers have to offer is perceived as synergistic and complimentary of one another. At the same time, these competencies were designed with mental health and substance use disorders, as well as behavioral management of chronic illness as the primary reason for clinical presentation in mind. Therefore, the identified clinician likely to be viewed as "primary" from the patient perspective is the one that is perceived to have availability to listen, provide empathy and non-judgment, and allow the patient to prioritize aspects of their care. Such characteristics are not often found in physicians or prescribers operating in current systems of care. Additionally, the behavioral health provider, opposed to the prescriber, is likely to be less restricted as it relates to time and is trained with a skill set that meets such needs. Further, the behavioral health provider is likely to have more extensive availability as it relates to duration of a given clinical encounter as well as the overall course of treatment.

The process of developing the knowledge, skills and attitudes for realizing these core competencies should be considered an ongoing progression of implementation involving consistent practice, supervision or consultation, and feedback. These competencies are fluid, rather than linear. While advancements may be made in one competency area, progress in another competency may be stalled due to patient or setting need. The competencies are to be implemented across clinical presentations, across the developmental spectrum, in a variety of settings and models in a non-static, flexible manner, involving individual and team-based reflection on the extent and degree of quality in which the competencies have been implemented.

Further, it is assumed that such competencies may be distinct or incongruent with assessment and interventions skills taught in most graduate programs, in which a more "traditional" model of mental health care is most likely to be taught. Additionally, and of critical importance, is the potential differences in interpretation of ethical standards that may take place in integrated behavioral health models of care compared to more traditional settings. While theory-based interventions and factors contributing to psychotherapy outcomes must always be taken into account in any setting, the implementation of such ideals in an integrated setting is likely to be more brief and time-limited. As it relates to best practice and maintaining high ethical standards, unique and more broad-minded perspectives on matters such as space/setting, length of individual encounters and episodes of care, confidentiality and information sharing, being goal oriented vs. process oriented for individual outcomes, and inclusion of more than one care provider are important considerations.

Some competencies are learned through education in classes or on the job, while these and others may be developed and mastered as the behavioral health provider acquires experience in an integrated setting.

How to Read the Competencies

The eight competencies are written at three levels of detail:

1. *Competency name with a one- or two-sentence description:* a title and high-level statement of what is included in the competency
2. *Bullet point list with headings:* this "unpacks" the high-level description with specifics
3. *Examples of what you might see in action:* concrete and practical examples—"what you actually do"—adapted from the publications from which the eight competencies were originally drawn.

The Competencies Are Expected to Evolve Over Time

These are not offered as a *final* product for all time, but as a starting point that can evolve through application in the field.

Abbreviations Used

behavioral health	BH	primary care provider	PCP
mental health	MH	electronic health record	EHR
substance abuse/use	SA		

Eight Competencies at a Glance

1. **Identify and assess behavioral health needs as part of a care team**
   BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health, MH, and medical conditions across the lifespan; and incorporate their clinical observations into an overall, team-based care assessment that may include identifying, screening, assessing, and diagnosing.

2. **Engage and activate patients in their care**
   BH providers engage patients in their care, helping them understand how their BH factors affect their health and illness, and how the BH aspects can be integrated in a team-based care plan. Provider-patient engagement is done in a culturally responsive and trauma-informed way that allows the client to have their own voice and choice and promotes individualistic planning and resiliency.

3. **Work as a care team member to create and implement care plans that address behavioral health factors and improve health outcomes**
   BH providers work as members of the care team to collaboratively create and implement care plans that address BH factors in practice. These factors may include mental illness, substance use disorders, childhood adversity, trauma, toxic stress, and physical health problems requiring psychosocial interventions.

4. **Help observe and improve care team function and relationships**
   BH providers help the care team monitor and improve team function and collaborative relationships. By knowing their own and others' roles, they help the team pool knowledge and experience to inform shared treatment planning, engage in shared decision-making with patients, and share power and responsibility for care and health outcomes.

5. **Communicate effectively with other providers, staff, and patients**
   BH providers communicate effectively with providers, patients, and the other members of the care team with a willingness to initiate patient or family contact outside routine face-to-face clinical work. BH providers communicate in ways that promote trust, patient choice and voice (through flexibility and patient participation in care), and build patient understanding, and satisfaction.

6. **Provide efficient and effective care delivery that meets the needs of the population of the care setting**
   BH providers use their available time and effort on behalf of the practice population, setting prioritized agendas (with roles and goals) with patients and the team, managing brief and longer patient encounters effectively, and identifying areas for immediate and future work with appropriate follow-up care for which BH availability is maintained.

7. **Provide culturally responsive, trauma-informed, whole-person and family-oriented care**
   BH providers employ the biopsychosocial model – approaching healthcare from biological, psychological, social, spiritual, and cultural aspects of whole-person care, including patient and family beliefs, values, culture, and preferences.

8. **Understand, value, and adapt to the diverse professional cultures of an integrated care team**
   BH providers act in ways consistent with the collaborative culture and mission of integrated care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in an integrated culture, with providers, and medical situations.

1. Identify and assess behavioral health needs as part of a care team

BH providers apply knowledge of cognitive, emotional, biological, behavioral, and social aspects of health, mental health, and medical conditions across the lifespan; and incorporate their clinical observations into an overall, team-based care assessment that may include identifying, screening, assessing, and diagnosing:

a. Mental illnesses, SA disorders, and adverse health behaviors commonly encountered in primary care —and the ways these often present in primary care practice
b. BH or psychosocial contributors to common physical health problems such as chronic illnesses and medically unexplained or stress and trauma-related physical symptoms
c. Complicated, unusual, or high-risk clinical situations with significant BH and social factors intertwined with medical care and/or barriers to care and patient self-management, using a broad range of information in medical record and PCP knowledge of patient history
d. Children, adolescents, and families with, or at risk for, psychosocial problems, further assessing:
    - Developmental problems and milestones
    - Social or structural determinants of health
    - Difficult situations in childcare, including bedtime, toileting, and feeding
    - Learning difficulties and attention deficit hyperactivity disorder
    - Psychosocial and environmental risk factors and stressors such as parental MH or family systems problems, adverse childhood experiences, and contextual factors affecting health and care such as home and school environments
    - How family, guardians, or caregivers can be part of overall care or health of the child, including potential parent training or coaching
e. Severe or persistent BH problems or psychiatric emergencies that require the assistance of specialized BH providers, services, or community-based resources

Use strengths-based wellness, resiliency, and recovery models.

Identification (and targeted BH screening) in the areas above may be focused on identifying either populations or individuals with BH needs, and may use practice-level and claims data to assist in such identification.

Screening and assessment are done in a trauma-informed manner that facilitates trust and predictability between the BH provider and patient.

Examples of "identify and assess" from McDaniel, et al., 2014:

- Identify behavioral or psychological factors in common primary care medical conditions (e.g., depression comorbid with diabetes and how blood sugar levels may affect cognition and mood)
- Interview effectively to identify problem, degree of functional impairment, and symptoms
- Conduct a suicide assessment on all patients identified with depressed mood
- Identify severe or treatment-resistant MH problems for triage to specialty MH, as available (e.g., psychotic and delusional disorders, complex trauma, severe personality disorders, eating disorders)
- Recognize names and purposes of medications for common medical and behavioral conditions (e.g., diabetes, hypertension, and depression) seen in primary care and the common side effects affecting mood or cognition
- Find out about support systems, spiritual resources, and connections to community resources
- Obtain information from caregivers and parents in the assessment process (e.g., help a caretaker identify health risks for a child with asthma residing with a smoker, and engage the parents in a conversation about change)
- Interview for health beliefs/attitudes that influence patient or family view of health, illness, and help-seeking
- Identify cognitive and emotional factors that influence a patient's or family's reaction to medical diagnoses, use of health information, and influence reactions to diagnoses, injury, and disability
- Recognize the effect of acute and chronic illness on physical and mental health of caregivers, parents, siblings, and other family members
- Assist primary care team in selecting measures to identify common problems (e.g., depression, anxiety, SA, sleep difficulties, disruptive child or adult behavior), and understand strengths and limitations of screening tools

Examples from Strosahl, 2005:

- Identify problems quickly and incorporate the patient's point-of-view
- Apply patient's strengths and resources to identified problems; focus on functional outcomes
- Evaluate readiness-to-change, and emphasize patient-driven change

Examples from CIHS, 2014:

- Recognize signs, symptoms and treatments of the most common health conditions, crises, and comorbidities seen in the healthcare setting
- Assess the family and social support system and other socioeconomic resources that can impact health and care

2. Engage and activate patients in their care

BH providers engage patients in their care, helping them understand how their BH factors affect their health and illness, and how the BH aspects can be integrated in a team-based care plan, and empowering patients to be active partners in addressing their own health. Provider-patient engagement is done in a culturally responsive and trauma-informed way that allows the client to have their own voice and choice and promotes individualistic planning and resiliency.

a. Use strong interpersonal skills to help patients feel comfortable and motivated, and to help the patient build a therapeutic relationship with the BH provider and care team by using language and an approach that helps overcome barriers or stigma to access BH services.
b. Involve care managers or other team members when appropriate to help patients and families engage fully in their care.
c. Explain the "why and how" of integrated care:
    - Educate patients about the conditions and BH factors in their clinical situation and care involving parents, families, guardians, or caregivers as appropriate to age and situation
    - Help patients understand and work with the care team and plan that includes BH, while addressing any discomfort with their care or barriers to it; using language to introduce BH providers that helps address the patient's confusion or fears
    - Triage patients to the appropriate level of care while managing the patient's needs in the interim
d. Engage patients and families in collaborative planning and decision-making regarding their care (see competency 4). In particular, engage patients in a manner consistent with their health literacy:
    - Engage patients at times when patients need to understand their choices and take an active role to the extent they wish
    - Based on patient's presentation, goals, and wants, co-develop treatment goals and outcomes
    - Intentionally evaluate engagement (e.g., using measures such as no show rate; therapeutic alliance and progress towards shared goals; patient activities between encounters)
    - Engage patients and the team at times when there is a need to confirm a direction that is a good fit for the patient and the team—a plan that the patient understands and embraces
e. Set reasonable care team expectations, provide follow-up support for the patient, and promote care team transparency with the patient:
    - Work with healthcare colleagues to help set realistic expectations of patient engagement in care (e.g., in which areas, if any, a patient is ready to participate, competing demands in their larger life context, realistic timeframes for developing patient readiness, and how pushing something prematurely may generate resistance)
    - Provide follow-up support for the patient, including connecting the patient to appropriate resources within the clinic and within their community
    - Use practice routines transparent to the patient (e.g., have team conversations about the patient in the presence of the patient, and facilitate patient access to records and notes)

Examples of “engage and activate patients” from McDaniel, et al, 2014:

- Engage the broader team by co-interviewing a patient with diabetes with a dietician
- Work with the pediatrician and respiratory therapist in a joint effort to develop a plan to improve a child’s adherence to an asthma treatment regimen

Examples from Strosahl, 2005:

- Apply patient or family strengths and resources to identified problems
- Evaluate readiness-to-change, and emphasize patient-driven change

Examples from CIHS, 2014:

- Establish rapport and rapidly develop and maintain effective working relationships with diverse individuals, including healthcare consumers, family members, and other providers
- Listen actively and effectively—quickly grasp presenting problems, needs, and preferences as communicated by others and reiterate to ensure that it has been accurately understood
- Convey relevant information in a non-judgmental manner about BH, general health, and health behaviors using terms free of jargon and acronyms, and easily understood by the listener
- Explain to the patient and family the roles and responsibilities of each team member and how all will work together to provide services

3. Work as a care team member to create and implement care plans[1] that address behavioral health factors and improve health outcomes

BH providers work as members of the care team to collaboratively create and implement care plans that address BH factors in practice. These factors may include mental illness, substance use disorders, childhood adversity, trauma, toxic stress, and physical health problems requiring psychosocial interventions.

a. Work from a recognized role to identify, assess, educate, and treat as a member of the care team. This involves appropriate division of responsibility within the care team to help form care plans and carry out interventions that address the common clinical challenges (listed below—see competencies 1 and 2 for similar specifics reiterated here):
   - Mental illnesses, chronic stress, ACEs and SA disorders
   - Physical health problems requiring psychosocial interventions in the care plan, e.g., BH contributors to a wide range of primary care presentations such as common chronic illnesses (e.g., asthma, diabetes, heart disease, irritable bowel syndrome, childhood illnesses), and medically unexplained physical symptoms
   - Complicated or high-risk cases with BH and social factors at the root of the risk or complexity
   - Adverse health behaviors commonly seen in primary care, along with associated prevention and health promotion strategies

b. Bring particular BH knowledge and skill to bear, such as:
   - Knowledge of human development to tailor BH services to patients across the lifespan
   - Influence of family systems on care and health, along with strategies to consider within care plans
   - Impact of trauma and ACEs on physical and mental health, and trauma-informed guidelines for care
   - Early identification and intervention for children and others with symptoms or risks who may not have a diagnosable condition
   - General knowledge of how psychosocial and BH factors and conditions interact with common primary care problems and/or problems in educational settings
   - Recognition of when a BH problem is outside the scope of ambulatory care and needs other levels or types of care
   - Prevention, wellness, and health behavior interventions, e.g., sleep, parenting, healthy eating and exercise, self-regulation
   - Community resources, schools, agencies, home-based care programs

c. Help the care team negotiate care plans that are understood and embraced by patients, families, and caregivers, e.g., with:
   - Conversations and plans consistent with their health literacy
   - Shared treatment decisions that result in patients understanding their choices, and taking an active role to the extent they wish
   - A clinical team leader identified for each patient, based on the needs of the patient, and matching those needs with provider scope of practice, and relationship with the patient
   - Community resources and peer supports to be mobilized in support of the care plan or self-management support
   - Sufficient patient/family confidence in ability to carry out the patient's role in treatment or health behavior change

d. Help the care team monitor patient progress on BH factors in care to ensure that the level of treatment provided in primary care is resolving symptoms.
   - Employ other or higher levels of care, as appropriate, based on monitored outcomes
   - Use data to help monitor progress, e.g., practice-level data such as registries, EHR, appointments, referrals along with claims data (if available), to help monitor and identify the need to adjust care plans that are not working

[1] Elements likely found in care plans involving integrated BH (excerpted from AHRQ Lexicon)

1. Team roles and goals—specific goals and team members responsible for specific goals or tasks.
2. Documentation of dialogue with the patient on why a shared record is an important component—the benefits (and any risks) to the patient—with exploration of any patient concerns about shared records and any precautions taken to protect the confidentiality of BH information.
3. Patient education about their conditions, treatments, and self-management.
4. Medical treatments, including pharmacologic treatment, a single shared medication list, and problem list.
5. Psychotherapy, community groups, or other non-pharmacologic BH or substance use therapy or support.
6. Counseling or coaching, e.g., motivational interviewing and behavioral activation.
7. How plan is tailored to patient/family context, e.g., cultural groups, language, schools, vocational, and community.
8. Expectation for implementation:
   - All involved providers read and work from the care plan—these are shared care plans
   - Likely indicators that improvement has begun are listed, along with who is most likely to notice the change first
   - Likely indicators that the care plan isn't working and may need to be revised, along with who should be informed that the care plan needs changing

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Examples of "create and implement care plans" from McDaniel, et al., 2014:

Generalist skills:

- Use interventions to improve function in areas such as school and work responsibilities, improving quality of social interactions, decreasing disruptive behaviors, improving sleep, decreasing pain, reducing anxiety, improving mood and improving exercise and nutrition
- Implement evidence-based interventions (e.g., cognitive behavior therapy, parent–child interaction therapy, motivational interviewing, family psychoeducation, and problem-solving therapy)
- Offer interventions for patient self-care, symptom reduction, and functional improvement--with self-regulation such as deep breathing, relaxation, sleep hygiene, increased exercise, problem solving, and assertive communication
- Employ methods such as "Teach Back" to assure patient understanding of healthcare plans, and the patient's role in his/her own care
- Bridge appropriately among behavioral services offered in primary care and specialty MH and community resources
- Assist the primary care team on when and how to incorporate integrated BH provider into the care process
- Help primary care team engage challenging patients in a manner that enhances care, e.g., BH provider readily available to primary care team to discuss ways to interact effectively with patients or families with challenging interpersonal styles and complicated medical or social situations

Common chronic illness:

- Plan care that takes into account relevant factors (physical, behavioral, cognitive, environmental, and social) that can affect pain (for example), and considering health literacy level and cultural beliefs so as to engage patients in care for chronic pain beyond medication
- Offer interventions that include the family system, e.g., involve spouse or parents in nutritional planning for a patient with diabetes
- Provide psychoeducation and supportive counseling to family caregivers or parents of a patient or child with a particular condition

Biologic components/interactions:

- Describe the actions taken while working with the PCP that help engage patients with medically unexplained symptoms in regular care

4. Help observe and improve care team function and relationships[2]

BH providers help the care team monitor and improve team function and collaborative relationships. By knowing their own and others' roles, they help the team pool knowledge and experience to inform shared treatment planning, engage in shared decision-making with patients, and share power and responsibility for care and health outcomes.

a. Know their own roles, contributions, and scope-of-practice (along with that of the other team members).

b. Be flexible in role and work style to best fit the needs of the patients and team members.

c. Help ensure each member is working at the "top of their license" and are viewed as having equal responsibility in the overall care and outcomes for the patients well-being.

d.

e. Help develop ways in which PCPs can introduce the BH provider that readily engage the patient and identify the BH provider as part of the care team, and clarify the kinds of situations for which the BH provider can be helpful with the clinic population.

f. Help the team pool the knowledge and experience of all members (and their patients) to inform and enhance treatment.

g. Use clinic-level data to help the team pool their knowledge to improve identification, plan care, evaluate efforts, and enhance integration strategies among the care team.

h. Help the primary care team (along with other team members) identify and respond to problems in teamwork and collaboration, and to further develop the team functions.

i. Empower each member of the team to maximize their contribution to the patient's behavioral health.

j. Share responsibility with PCPs for patient care and experience, total health outcomes, and cost/resource use (Triple Aim, Berwick et al, 2008).

k. In school-based health centers, identify, describe, and explain the differing roles and responsibilities of other helping professionals working in and with schools

l. Participate in process improvement methods to enhance teamwork and clinical care.

m. Help model workforce wellness and professional self-care for team.

[2] Care team function and relationships are often referred to as "inter-professional practice" because the teams are often comprised not only of PCPs and BH providers, but other professionals as well. These providers are to function as one team, rather than as "add-ons" who function more or less separately.

Examples of "help monitor and improve teamwork" from McDaniel et al, 2014:

- Promote effective collaborative decision-making in care teams, including the facilitation of team members communicating their own observations and perspectives
- Regard patient care as the responsibility of a team of professionals, not that of a single provider
- Consider the patient/parents/family to be key members of the healthcare team—who also need to understand team roles and functions. Recognize, respect, and support activities of other primary care team members to provide BH services—it is not all up to the BH provider
- Clarify the various roles of the BH provider to team members, recognizing when and how to use other team members' specific disciplinary expertise
- Give PCPs actionable recommendations that are brief, concrete, and evidence-based
- Provide immediate (e.g., same day) brief, feedback to a consulting PCP, avoiding psychological jargon
- Convey and receive both urgent and routine clinical information to primary care team members, using appropriate infrastructure (e.g., face-to-face, phone, e-mail, EHR tasks, consults, and chart notes)
- Lead or participate in staff, clinical, and organizational meetings.
- Work with clinical leaders and care team to design, implement, and evaluate quality improvement initiatives regarding integrated BH

Examples from Strosahl, 2005:

- Distinguish between a consultation/teamwork model and an individual psychotherapy model
- Explain the team role of the BH provider accurately to the patient, parent, or family
- Operate comfortably within the primary care extended team culture
- Frequently circulate through the medical practice area to create top-of-mind awareness among primary care team members
- Readily provide unscheduled services when needed
- Be available for on-demand consultations by pager or cellphone

Examples from CIHS, 2014:

- Recognize, respect and value the role and expertise of patients, family members, BH providers, and PCPs
- Serve as a member of an inter-professional team, helping other members quickly conceptualize a patient's strengths, problems, and appropriate plan of care
- Foster shared decision-making with patients, family members, and other providers
- Demonstrate practicality, flexibility, and adaptability in working with others, emphasizing the achievement of treatment goals as opposed to rigid adherence to treatment models

5. Communicate effectively with other providers, staff, and patients

BH providers in integrated care settings communicate effectively with providers, patients, and the primary care team with a willingness to initiate patient or family contact outside routine face-to-face clinical work. BH providers communicate in ways that promote trust, patient choice and voice (through flexibility and patient participation in care), and build patient understanding and satisfaction.

a. Communicate frequently with (and facilitate communication among) PCPs, BH providers, and other team members. "Frequent" is a large part of "effective." Other aspects of "effective" include being clear, concise, timely, respectful, and relevant to the situation at hand and in language others can readily understand. (See competency 8 for additional information).
b. Contact patients/families outside of face-to-face clinical work, as needed, in accordance with practice policies and patient/family preferences, e.g., brief calls, approved forms of email, texts, etc.
c. Facilitate communication among providers and between providers and patients in ways that increase transparency and build patient understanding, satisfaction, and ability to participate in care. Examples include:
    - Weekly or other regular team meetings regarding patient care
    - Brief daily meetings, "huddles," or case reviews
    - "Warm handoffs" between providers and patients
    - "Curbside consultations" between providers—including communication and teamwork issues
    - Consultations about patients for whom the BH provider is not (or will not be) providing direct care, e.g., consulting or coaching a PCP on a clinical question
    - Telephone follow-ups with patients or other providers
    - BH connections in the medical neighborhood with outside providers, case managers, specialists, community-based people who are involved with the patient or family but not part of the clinic team, etc.
    - Formal communications, e.g., case presentations that serve as vehicles for communication, consultation, or education
d. Communicate with health care colleagues in a professional and ethical manner consistent with the medical culture or methods that enhance the integrated care delivery. (For more, see competency 8.)
e. Be aware of the broad range of needs for communication tailored to the situation, e,g., regarding individual patients, populations or panels of patients, high-risk or high-cost situations, care coordination, specialty providers, and community organizations.
f. Communicating through documentation and shared health records in a manner accessible and clear to the rest of the integrated team and to patients.
g. In school-based health centers, communicate effectively with school personnel, families, and other stakeholder in the community.

Examples of "communicate effectively" from McDaniel et al., 2014:

- Proactively help team members better understand their interpersonal and communication styles, and how to work together more effectively
- Communicate effectively with team members and patients or families in a manner that is sensitive to power differentials present in a clinical setting
- Facilitate team process when there are professional disagreements by focusing on shared goals
- Use systems thinking and relationship skills typical of BH providers to address malfunctioning team behavior
- Write clear, concise EHR notes with key information and short, specific recommendations and plan
- Ensure EHR notes are accessible to the primary care team, knowing they may be accessible to the patient
- Encourage patients and families to use the patient portal of the EHR

Examples from Strosahl, 2005:

- Provide feedback to referring providers on the same day when there is a consultation question
- Tailor team recommendations at the pace and flow of the medical clinic
- Conduct effective curbside consultations
- Give recommendations that are concrete and easily understood by all primary care team members
- Write clear, concise chart notes indicating BH treatment plan, treatment response, and patient adherence to self-management—protecting sensitive and confidential information.
- Be knowledgeable of mandated reporting requirements on abuse and neglect

6. Provide efficient and effective care delivery that meets the needs of the population of the healthcare setting

BH providers in integrated care settings use their available time and effort on behalf of the practice population, setting prioritized agendas (with roles and goals) with patients and the team, managing brief (as well as longer) patient encounters effectively, and identifying areas for immediate and future work with appropriate follow-up care for which BH availability is maintained.

Key distinctions to be mastered:

- *Clinic panel vs. caseload:* BH provider's time in integrated care settings is focused on serving the entire clinic panel consistent with "panel (or population) management". In some cases this focus may be on a designated subpopulation (e.g., diabetes and depression). In either case, the BH provider's time is focused on serving an identified population rather than only on patients who happen to find their way onto a BH provider's "caseload."
    - Primary care practices may define their practice panels differently, and hence the patient population for BH providers may differ (e.g., the boundary practices set between primary care and specialty care or whether to provide complete care for patients with serious and persistent MH or SA problems). Clinics may decide to focus their BH on a subset of its total population, e.g., children with special needs, SA, depression, high risk or chronically ill, "super-utilizers," or other such subset. The "population" that the BH provider will care for will depend on how the clinic defines its population or target sub-population for BH integration.
    - Within school-based health centers, know and facilitate the role of schools in promoting and supporting mental health of all students
- *Efficient and effective:* There is no such thing as efficient care that is ineffective; therefore, efficient doesn't mean merely "fast" or "short." "Efficient and effective" means care is clinically effective at the same time it is done with a minimum of wasted motion, rework, delay, or cumbersome method. Analogy: "Concise" means all the necessary information with no wasted words. This competency is about "concise" in this sense – not only about time spent, but including time spent.
- *Brief vs. long visits:* The "right" appointment length depends on what the patient needs at that time—and can range from a 5-minute introduction or warm handoff to a 15- or 30-minute return visit for monitoring and coaching, to a 45- or 60-minute (or longer) evaluation visit. This competency involves flexibility to consciously match visit time to patient need, not to assume a "default" or habitual 50 minutes (or 15 minutes) for all visits.
- *Brief vs. longitudinal:* Much BH in primary care is done using brief, therapeutic approaches that fit the presenting problem and patient goals for progress with that problem. Mastery of such practical approaches is essential; however, in the primary care setting patients may return for care periodically over their lifespan rather than receiving one, short episode of BH care at the outset.

Examples of areas for effective-efficient practice management for BH providers:

a. Flexibility

- Be available in person and by phone or email, interruptible, and willing to improvise in scheduling and how patient contact is made
- Use physical space to increase visibility and presence in the midst of the primary care "traffic"

b. Know when to employ coordination, consultation, and collaboration (from Cohen et al, 2015)

- Coordination:

  - Coordinate BH care with other providers whose care has similar goals but is being done more or less independently
  - Steps may include contacting the other clinician, rapid briefing about patient situation and the issues to coordinate, and agreement on how to do so
  - Know when to triage, refer, or navigate to specialties or community referral instead of coordinating with the primary care team
- Consultation:
  - Share information, diagnoses, and impressions with primary care team members that add to the pool of important information, while making efficient use of their time
  - Seek input/consultation from other providers with different expertise in ways that are succinct, and respect their workflows and sense of time while getting the needed consultation
- Collaboration:
  - Work jointly with other team members to assess and develop individualistic care plans with patients and families
  - Ask for a consultation or initiate a change in care when the BH/team care isn't working

c. High-value use of appointment time

- Introduce self clearly and quickly, describing BH's role on the team and services available, to build rapport, orient patient to visit, and set up predictability off staff-client relationship that promotes safety and trust.
- Identify problems, functional impairments, symptoms, patient concerns, and reason for referral early in initial visit. Summarize your understanding of problem(s) at appropriate level for patient and family, and check for accuracy.
- Further assess symptoms, BH concerns, other concerns, patient story, and family history, paying attention to:
  - Crisis assessment and triage—need for ongoing care and/or referrals to specialists and community resources
  - Use of screening or assessment tools, whether universal or targeted
  - Health behavior change, which may include prevention and early intervention
- Select appointment time and length, when possible, based on patient needs

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Examples of "provide efficient and effective care" from McDaniel et al., 2014:

- Use appointment time efficiently (e.g., in a 30-minute appointment, identify problem(s), degree of functional impairment, and symptoms early in the visit)
- Summarize for patient and family or parents, when possible, an understanding of the problem (e.g., in 2–3 minutes) at the appropriate level, depth, and specificity for each patient in the context of their cultural beliefs

Examples from Strosahl, 2005:

- Use 30-minute sessions effectively
- Measure outcomes of behavior change or goals at every visit, developing alternative treatments when indicated
- Stay on time when conducting consecutive appointments
- Use community resource and social support strategies
- Use intermittent visit strategy to support home-based practice model/self-management
- Choreograph BH visits within existing medical services, appointments and processes

- Use flexible patient contact strategies, e.g., visits, phone, letter, email, and portals
- Coordinate triage of patients to and from external BH specialty services

7. Provide culturally responsive, trauma-informed, whole-person and family-oriented care

BH providers in integrated care settings employ the biopsychosocial model – approaching healthcare from biological, psychological, social, spiritual, and cultural aspects of whole-person care, including patient and family beliefs, values, culture, language and preferences. Practice cultural agility though recognition of own unconscious bias and assumptions.

Use the biopsychosocial model treating health, illness, assessment, and care as the product of intertwined biological, psychological, and social factors (social determinants of health). Respectfully recognize and address these perspectives in whole-person care.

Note: Biological and psychological factors are described in competencies 1 and 3. This competency emphasizes culturally responsive, whole person care:

a. Social factors

- Take into account the role of social functioning and relationships in health, illness, health practices, health beliefs, and participation in treatment including economic and other barriers to care
- Take into account the role of social determinants of health, e.g., a patient's socioeconomic status, employment, immigration status, and other factors impact health and wellbeing
- Understand how past experiences influence care patient care experience, e.g., level of trust in providers
- Identify and integrate individual, family, and cultural strengths in supportive patient care—making use of these assets, with family broadly defined to fit the patient's concept of his/her family
- Understand the impact of stigma related to BH problems. Work toward de-stigmatization of BH problems and treatment, using terminology that is appropriate to the culture of the patient and to the primary care setting where BH care is part of general healthcare
- Develop relationships with community organizations, agencies or schools that offer resources to more fully meet patients' needs, including non-medical resources addressing needs across the lifespan. Identify those with which the patient or family is already familiar or comfortable as part of their own community

b. Cultural and spiritual factors

- Take into account gender, gender identity, sexual orientation, disability, ethnicity/race, age, and other distinctive cultural or personal identifications while planning and providing care
- Tailor care plans to reported patient or family beliefs about health, illness, health practices, and how they are accustomed to participating in treatment (e.g., a refugee accustomed to specialist-based systems and work-ups)
- Quickly adapt treatment approaches based on cultural factors to help make care more acceptable or successful
- While planning and implementing care plans, use knowledge of health disparities to proactively address access, economic, and cultural factors such as language and any need for interpreters
- Inquire about and consider how spirituality and religion shapes the patient and family's responses to illness, care, and recovery

Examples of "culturally responsive, whole person care" from McDaniel et al., 2014:

- Ask patients, families, and team members about cultural identities, health beliefs, and illness history that affect health behaviors
- Demonstrate sensitivity to a variety of factors that influence healthcare (e.g., developmental, cultural, socioeconomic, religious, sexual orientation)
- Modify interventions for BH change in response to social and cultural factors
- Use culturally sensitive measures and procedures when conducting research, evaluation or quality improvement projects
- Help healthcare professionals communicate with patients who have cultural backgrounds different from their own (and vice-versa)
- Use language appropriate to the patient's education and culture
- Recognize the relationships among ethnicity, race, gender, age/cohort, religion, sexual orientation, culture, disability, and health behavior in primary care
- Engage schools, community agencies, or healthcare systems (that the patient or family can relate to) that support patient care and function
- Demonstrate knowledge and familiarity with local environment, including school locations and personnel, places of employment and hiring practices, affordable housing locations, parks, walking trails, recreational outlets that patients and families can realistically engage in.

Examples from CIHS, 2014:

- Use the primary language and preferred mode of communication of the patient and family members or communicate through the use of qualified interpreters
- Adapt style of communication to ensure a patient's ability to process and understand information
- Provide health education materials appropriate to the communication style and literacy level of the patient and family, and that reinforce information provided verbally during healthcare visits
- Recognize and manage personal biases related to patients, families, health conditions and healthcare delivery

Examples from Ball et al., 2010:

- Applies culturally competent and ethical practices to differing cultural perceptions of education and mental health, and how those perceptions influence mental health
- Develop strategies for students and families to overcome racial and ethnic barriers within the education system

8. Understand, value, and adapt to the diverse professional cultures of an integrated team

BH providers act in ways consistent with the collaborative culture and mission of integrated care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in other professional cultures, with providers, and medical situations.

Note: Much of this is implicit in other competencies, but is brought together here explicitly for the benefit of the entire care team, including the BH providers.

a. Evolve and reinforce values and attitudes consistent with the team-based culture and population health mission of primary care and the role of BH providers in it, modifying personal habits or behavior accordingly

- Cite evidence for the value of incorporating BH services into healthcare to patients, families, and providers when it proves useful
- Develop comfort and confidence in working with PCPs, other healthcare professionals, and in medical situations, adopting an attitude of flexibility; and adapting work content and style as needed to serve the best interest of patients, parents, families, or the patient's caregivers
- Ensure with the primary care team that high patient care volume is accompanied by tools and methods to provide quality BH care to populations and individuals, e.g., tools to track high-risk patients until stabilized or engaged in higher level of care
- Understand the local organizational mission, structure, and historical factors supporting the role of BH providers in integrated care

b. Understand and respect different team roles and scope of practice

- Communicate BH providers' professional scope of practice (and limitations) in context of the primary care team and across the patient lifespan
- Know the particular roles, values, cultures, scope of practice, and expertise of each team member so that trust and ability to depend on each other is enhanced by mutual understanding among physicians, nurse practitioners, physician assistants, BH providers, care managers, pharmacists, nurses, social workers, or others on the practice or extended team

c. Recognize ethical issues and code of conduct values across the care team

- Recognize and manage the ethical issues common in integrated care and primary care in general, including equity, trauma, and social determinants of health, and differences and similarities in concepts of confidentiality for BH in the team-based primary care setting and specialty MH settings
- Acknowledge and become familiar with the various codes of ethics and conduct among different disciplines on the healthcare team, including the common themes and differences
- Adhere to the code of ethics, conduct, and licensure of your particular discipline with an awareness of how these may or may not be applied differently in different work settings such as MH clinics, primary care clinics, hospitals or community organizations
- Practice appropriate documentation and business practices such as credentialing

Examples of “understand and adapt to diverse professional cultures” from McDaniel et al., 2014:

- Convey to other team members and patients the typical roles, skills and activities of BH providers in primary care across populations such as children, adults, and elderly
- Adapt role and activities in the best interest of patient care (e.g., serving as treating provider, consultant, team leader, advocate, care manager, health educator, or community liaison—depending on situation and need)
- Participate in professional or other learning groups on integrated BH as a professional activity
- Demonstrate a commitment to ethical principles regarding dual relationships, confidentiality, informed consent, boundary issues, team functioning, and others
- Manage stress associated with primary care practice via a consultation network with other integrated BH providers
- Evaluate own competencies and determine need for continuing education
- Act in best interest of the patient by seeking consultation or professional support in situations when needed
- Make use of supervisory or peer consultation support for BH providers within the organization
- Practice appropriate documentation, billing, and reimbursement procedures
- Follow laws on abuse reporting, adolescent reproductive health, and determination of decision-making capacity
- Demonstrate familiarity with hospital/medical setting bylaws, credentialing, privileges, and staffing responsibilities, and standards set forth by national accrediting bodies
- Engage the organization and its leaders at key times in making change that promotes integrated BH and ensure necessary resources for effective integrated BH practice

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