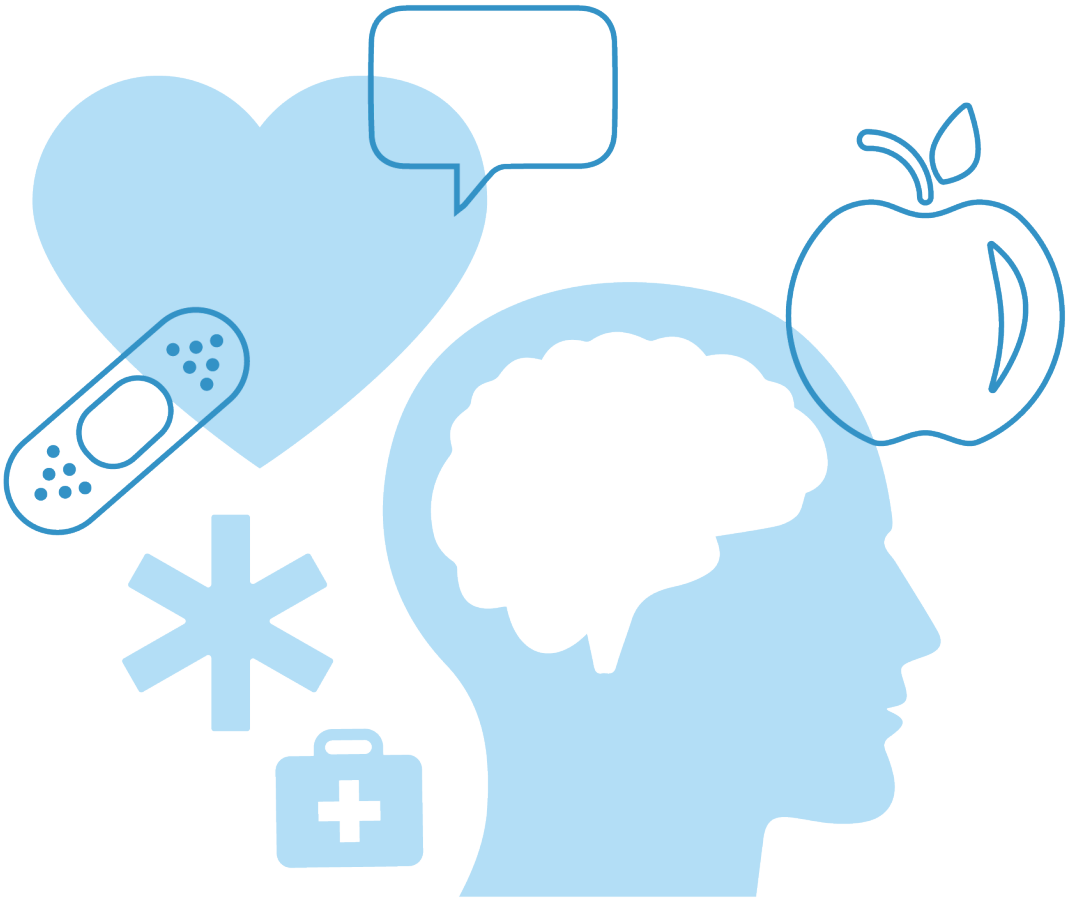
EUGENE S. FARLEY, JR.
HEALTH POLICY CENTER

CORE COMPETENCIES

for Behavioral Health Providers Working in Primary Care



The Colorado Health Foundation™
CO SIM State Innovation Model
CARING for COLORADO FOUNDATION A Health Grantmaker
The Ben and Lucy Ana Walton Fund of the WALTON FAMILY FOUNDATION
ROSE COMMUNITY FOUNDATION
THE PITON FOUNDATION at Gary Community Investments

Suggested Citation

Benjamin F. Miller, PsyD, Emma C. Gilchrist, MPH, Kaile M. Ross, MA, Shale L. Wong, MD, MSPH, Alexander Blount, EdD, C.J. Peek, PhD. Core Competencies for Behavioral Health Providers Working in Primary Care. Prepared from the Colorado Consensus Conference. February 2016.

Miller, Gilchrist, Ross, and Wong of the Eugene S. Farley, Jr. Health Policy Center, University of Colorado School of Medicine organized and led this project. Blount of Antioch University New England and University of Massachusetts served as consultant for behavioral health competencies and training. Peek of the University of Minnesota served as consultant to facilitate the consensus process and help synthesize the resulting content.

Contents

Acknowledgements

The authors gratefully acknowledge the financial backing of the following foundations:

The Colorado Health Foundation
Caring for Colorado Foundation
The Ben and Lucy Ana Walton Fund of the Walton Family Foundation
Rose Community Foundation
The Piton Foundation at Gary Community Investments

The authors also wish to thank the Colorado State Innovation Model leadership for their support, Linda Niebauer and Larry Green for their help in planning the Colorado Consensus Conference and final product development, and the Colorado Consensus Conference participants (see appendix A) for their time and feedback to improve the competencies.

Preamble to the Competencies

Consensus on the eight core competencies for licensed behavioral health providers working in primary care was established at the Colorado Consensus Conference on November 17, 2015, with revisions called for at that meeting and subsequently reviewed by the participant group in December of 2015. This preamble sets the stage for understanding the eight competencies.

Competence as a licensed behavioral health provider working in primary care 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 completely 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 primary care team is to acquire and demonstrate competencies specific to their roles in integrated primary care. The scope of this document is the desired competencies tailored for licensed behavioral health providers.

General Definition of Integrated Behavioral Health

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

> "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 repeating themes were identified that 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 as applying across all the competencies.

The behavioral health provider competencies are written to apply broadly:

- Across a continuum from prevention to illness: to address prevention, wellness, mental health and substance use treatment, recovery, trauma, 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, 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 primary 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 Behavioral Health Practice in Primary Care

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 a team in primary care* that may or may not stand out beyond those expected of licensed behavioral health providers in general.

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 primary care 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 consensus starting point created among stakeholders on November 17, 2015, 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 primary 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 primary 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.

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

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

5. **Communicate effectively with other providers, staff, and patients**
   BH providers in primary care 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 build patient understanding, satisfaction, and the ability to participate in care.

6. **Provide efficient and effective care delivery that meets the needs of the population of the primary care setting**
   BH providers in primary care 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, whole-person and family-oriented care**
   BH providers in primary care 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 primary care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in primary care culture, with providers, and medical situations.

1. Identify and assess behavioral health needs as part of a primary 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 primary 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-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
    - Potentially 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

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.

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.

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 primary 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 primary 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 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
    - 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 primary care 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 primary care team member to create and implement care plans[1] that address behavioral health factors

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

a. Work from a recognized role to identify, assess, educate, and treat as a member of the primary 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 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, trauma or adverse childhood experiences on care and health, along with strategies to consider within care plans
   - 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
   - Recognition of when a BH problem is outside the scope of primary 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 primary 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 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 primary 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

---

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

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

e. 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.

f. 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.

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

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

[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 primary care 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, such as:

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, 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 primary 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.

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 primary care setting

BH providers in primary care 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 primary care 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.
- *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 PCPs and other team members to assess and develop 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 and orient patient to visit
- 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

---

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, whole-person and family-oriented care

BH providers in primary care 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.

Use the biopsychosocial model treating health, illness, assessment, and care as the product of intertwined biological, psychological, and social factors (social determinants of health). 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., economic, socioeconomic status, and other barriers to health and care such as residential safety and stability, level of social/vocational connectedness, level of distress and distraction, 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 patients communicate with healthcare professionals 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

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 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

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 primary care with an attitude of flexibility. BH providers adapt their work style to meet patient needs while building confidence and comfort in working in primary care culture, 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 primary 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 primary care to patients, families, and providers when it proves useful
- Develop comfort and confidence in working with PCPs 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 primary care team

- Recognize and manage the ethical issues common in integrated care and primary care in general, including 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

References

General definitions of competency:

Kaslow, N. J., Dunn, S. E., & Smith, C. O. (2008). Competencies for psychologists in academic health centers (AHCs). *Journal of Clinical Psychology in Medical Settings,* 15, 18–27. doi:10.1007/s10880-008- 9094-y

Institute of Medicine (2003). The Core Competencies Needed for Health Care Professionals. IOM Committee on the Health Professions Education Summit; Greiner AC, Knebel E, editors. *Health Professions Education: A Bridge to Quality. Washington (DC);* National Academies Press. Available from: http://www.ncbi.nlm.nih.gov/books/NBK221519/

Core Competencies for Collaborative Practice (2011). Report of an expert panel sponsored by the *Interprofessional Education Collaborative* that consists of organizations from nursing, medicine, pharmacy, dental, medical colleges, and schools of public health. http://www.aacn.nche.edu/education-resources/ipecreport.pdf

General definition of integrated behavioral health excerpted from:

Peek, C.J. and the National Integration Academy Council (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. *Agency for Healthcare Research and Quality*, Rockville MD. http://integrationacademy.ahrq.gov/lexicon

Main competency statements adapted from:

Kinman CR, Gilchrist EC, Payne-Murphy JC, Miller BF. Provider- and practice-level competencies for integrated behavioral health in primary care: a literature review. (Prepared by Westat under Contract No. HHSA 290-2009-00023I). Rockville, MD: Agency for Healthcare Research and Quality. March 2015. http://integrationacademy.ahrq.gov/sites/default/files/AHRQ_AcadLitReview.pdf

Specific examples or behaviors drawn or adapted from:

McDaniel SH, Grus CL, Cubic BA, Hunter CL, Kearney LK, Schuman CC, Karel MJ, Kessler RS, Larkin KT, McCutcheon S, Miller BF (2014). Competencies for psychology practice in primary care. *American Psychologist*. 69(4):409.

Strosahl K. (2005). Training behavioral health and primary care providers for integrated care: A core competencies approach. Chapter 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

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

Other references

Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. Health Affairs. 2008 May 1;27(3):759-69.

Cohen DJ, Davis M, Balasubramanian BA, Gunn R, Hall J, Peek CJ, Green LA, Stange KC, Pallares C, Levy S, Pollack D. Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. *The Journal of the American Board of Family Medicine.* 2015 Sep 1;28(Supplement 1):S21-31.

Appendix A. Colorado Consensus Conference Participants

Sarah Barnes, Colorado Children's Campaign
Alexander Blount, EdD, University of Massachusetts Medical School
Shandra Brown Levey, PhD, University of Colorado Department of Family Medicine
Adam Burstein, DO, Children's Hospital Colorado
JC Carrica, EdD, CAC, Southeast Health Group
Marceil Case, Health Care, Policy and Financing
Colleen Casper, RN, MS, DNP, Colorado Nursing Association
Colleen Church, MPA, Caring for Colorado Foundation
Maribel Cifuentes, RN, The Colorado Health Foundation
Whitney Connor, Rose Community Foundation
Laura Cote Gonzalez, PhD, Denver Health
Perry Dickinson, MD, University of Colorado Department of Family Medicine
Andrea Dwyer, Colorado School of Public Health
Caitlin Evrard, MPH, Colorado Department of Public Health and Environment
Jessica Fern, MPP, Colorado Health Institute
Emma Gilchrist, MPH, Eugene S. Farley, Jr. Health Policy Center
Stephanie Gold, MD, Eugene S. Farley, Jr. Health Policy Center
Kim Gorgens, PhD, ABPP, University of Denver
Larry Green, MD, Eugene S. Farley, Jr. Health Policy Center
Jennifer Grote, PhD, Denver Health
Patrece Hairston-Peetz, PsyD, Colorado Children's Healthcare Access Program
Emily Haller, BA, Colorado Behavioral Healthcare Council
William Heller, Colorado Department of Health Care, Policy and Financing
Aubrey Hill, Colorado Coalition for the Medically Underserved
Steve Holloway, Colorado Department of Public Health and Environment
Laurie Ivey, PsyD, Swedish Family Medicine Residency
Emily Johnson, Colorado Health Institute
Mita Johnson, Walden University
Mindy Klowden, MNM, Jefferson Center for Mental Health
Kyle Knierim, MD, University of Colorado Department of Family Medicine
Marilyn Krajicek, EdD, RN, FAAN, CU College of Nursing
Erin Lantz, Colorado Community Health Network
Nadine Lund, BS, CPCC, Colorado Department of Public Health and Environment
Kevin Masters, PhD, University of Colorado Denver Department of Psychology
Lorez Meinhold, Keystone Policy Center
Mary Kay Meintzer, LPC, CACII, Sheridan Health Services
Benjamin Miller, PsyD, Eugene S. Farley Jr., Health Policy Center
Sam Monson, PsyD, Denver Health
Linda Niebauer, Eugene S. Farley, Jr. Health Policy Center
Sydney Oelerich, SIM Workforce Program Manager
Mike Olson, PhD, LMFT, St. Mary's Family Medicine Residency
Linda Osterland, PhD, Regis University
CJ Peek, PhD, University of Minnesota Medical School
Mark Queirolo, MPA, Colorado Department of Health Care Policy & Financing
Alex Reed, PsyD, MPH, University of Colorado Department of Family Medicine
Lenya Robinson, MA, LPC, Colorado Department of Health Care Policy and Financing
Kaile Ross, Eugene S. Farley, Jr. Health Policy Center
Don Sutton, PhD, Colorado Department of Public Health and Environment
Michael Talamantes, LCSW, University of Denver
Brian Turner, MPH, Colorado Behavioral Health Council

Patricia Uris, PhD, Colorado Department of Public Health and Environment
Alice Vienneau, LCSW, Denver Health
Robyn Wearner, MA, RD, University of Colorado Department of Family Medicine
Mary Weber, PhD, PMHNP-BC, University of Colorado College of Nursing
Tanya Weinberg, The Colorado Health Foundation
Shale Wong, MD, MSPH, Eugene S. Farley, Jr. Health Policy Center