Behavioral Health Competencies
Knowledge, Skill, Attitudes

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Goals

Describe the activities needed to provide “biopsychosocial” care and services in the community

Describe behavioral health competencies for behavioral health providers in primary care

Describe the kinds of training and supervision needed to support these functions
Key Aspects of this Model

Patient and Family at the Center

**Everyone** involved has a role to play in addressing health including behavioral health

The **Coordination** between the roles as critical than the roles themselves

**Leadership** – Clinical, Operational and Financial
Emergency Room Utilization Project

Dr. Andy Valeras and team at the Family Health Center in Concord

How can we improve our care to reduce unnecessary ER visits?

Use of the “UPOC – urgent plan of care” – impact on patients, medical assistants and on call providers
The Need for Specific Training

Paucity of Training

Most mental health providers do not have background or specific training to practice in integrated settings (Serrano et al., 2018).

Impact of No Training

Untrained MHPs tend to develop traditional MH services in primary care, rather than truly integrated care practice.

Necessary Adjustments

Work in fast paced, team-based care settings

Develop new skills for successful collaboration & same-day access, (Dollar et al., 2018).


## Is IPC Really That Different from Mental Health?

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<thead>
<tr>
<th></th>
<th>IPC</th>
<th>MH Specialty</th>
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<tbody>
<tr>
<td><strong>Location</strong></td>
<td>PC Clinic</td>
<td>A different floor, building, site</td>
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<tr>
<td><strong>Population</strong></td>
<td>Full population in primary care</td>
<td>Most with moderate to severe MH concerns</td>
</tr>
<tr>
<td><strong>Inter-Provider</strong></td>
<td>Collaborative, ongoing, &amp; consultative</td>
<td>Consult reports</td>
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<tr>
<td><strong>Communication</strong></td>
<td>Using PCP method of choice</td>
<td>CPRS Notes</td>
</tr>
<tr>
<td><strong>Service Delivery</strong></td>
<td>20-30 minute appointments Limited number (mean: 2-3)</td>
<td>50-90 minute psychotherapy sessions; 14 weeks or more</td>
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<tr>
<td><strong>Structure</strong></td>
<td></td>
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<tr>
<td><strong>Approach</strong></td>
<td>Problem-focused Solution Oriented</td>
<td>Varies by therapy Diagnosis focused</td>
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<tr>
<td><strong>Treatment Plan</strong></td>
<td>PCP continues to lead</td>
<td>MH Provider is lead</td>
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<tr>
<td><strong>Primary Focus</strong></td>
<td>Support overall health of Veteran/Population Focus on function</td>
<td>Cure or ameliorate MH symptoms</td>
</tr>
<tr>
<td><strong>Termination and</strong></td>
<td>Responsibility remains with PACT/PCMH</td>
<td>MH Provider remains person to contact if needed</td>
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<tr>
<td><strong>Follow-Up</strong></td>
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American Psychological Association (McDaniel et al., 2014)

Science
- Science Related to the Biopsychosocial Approach
- Research/Evaluation

Systems
- Leadership/Administration
- Interdisciplinary Systems
- Advocacy

Professionalism
- Professional Values and Attitudes
- Diversity
- Ethics in Primary Care
- Reflective Practice/Self-assessment/Self-care

Relationships
- Interprofessionalism
- Building and Sustaining Relationships in Primary Care

Application
- Practice Management
- Assessment
- Intervention
- Clinical Consultation

Education
- Teaching
- Supervision

Science

Knowledge: “Recognizes names and appropriate doses of medications for commonly occurring medical and psychological behavioral conditions”

Research and Evaluation: “Engages in practice based improvement methods to both provide the care and improve the care”
Systems

**Leadership:** “Promotes effective communication and collaborative decision making in healthcare teams

**Interdisciplinary teams:** “Engages schools, community agencies and health care systems to support optimal patient care and functioning i.e. childhood obesity, substance use disorders”

**Advocacy:** Lots of possibilities here
Professionalism

**Attitudes:** “Adapts to IPC environment, including frequent interruptions, fast past pace of clinic and unpredictable access to space”

**Ethics:** “Demonstrates a commitment to ethical principles with particular attention to dual relationships, confidentiality, informed consent, boundary issues, and business practices”
Relationships

Interdisciplinary Teams: “Understands the roles of other team members, communicates those roles to patients and helps resolve difficulties in team functioning”

Attention to Process: “Manages power differentials between team members and between patients and providers”
Application

Practice Management: “Uses appointment time efficiently (e.g., in a 30 minute appointment identifies problem, degree of functional impairment and symptoms early in the visit”

Consultation, Assessment and Intervention: “Comfortable with the role of “expert” as a generalist behavioral primary care provider”
Education

**Coaching:** “Able to coach medical providers and staff in patient and family centered care communication and behaviors”

**Education:** “Develops educational materials, e.g., issues facing a patient and family with Type 1 diabetes”

**Supervision:** “Provides opportunities for other disciplines to learn from each other”
What is the Same and what is Unique about Supervision in Integrated Care
SAME

• One hour of dedicated individual time a week
Focus on quality of patient care
Excited volunteers usually do better
Developmental assessment of the learner – knowledge, skills, attitudes, prior personal experience,

DIFFERENT

Hour + Ongoing “real time” supervision to match IPC pace – “precepting” model
Focus on patient care AND interdisciplinary team function
May encounter resistance to brief assessment & intervention
Need to assess for different competencies, learners may be even more “green”
SAME

Establishing goals for experience

Disciplines provide supervision to “their own”

Frequent check in on progress
Agree on goals and the process of supervision

Video better than audio
better than case reports

DIFFERENT

Recognize students may not be aware of what the opportunities will be

Supervisors must address cross discipline work & competencies

Check ins even more important – keep “honest” about the model

May be challenging in typical (non training) PC environment
Supervisory Strategies to Promote Integrated Care
Shadow Providers & Staff
- Learn Roles
- Develop relationships
- Identify opportunities

Be the water
- Don’t expect the site to make big changes
- Work with those who want to work with you

“Perching”
- Be in the clinical space
- Be in the mix w/o being in the way
- Listen for ways to be helpful
TRAINING IN IPC SHOULD CONSIST OF TRAINING WITH OTHER MEDICAL PROFESSIONALS\textsuperscript{1,2} AND THE FOLLOWING:

- **Day-to-Day Case Management Skills Building**
- **Brief Assessment, Interventions**
- **Feedback to Medical Team**
- **Consultant-Based Clinical Work**
- **Program Development Opportunities**

**Opportunities to Learn About the Medical Model**

**Training on Population-Based Care**

**Skills Building in Collaborative Care**

**Hands On Supervision**
Specific Challenges
Prevent “creep” back to traditional MH services
Emphasize “primary care” level of care; facilitate referrals to specialty care as needed
Address documentation differences
Help students with challenging team members
Overtly discuss each students’ pros and cons re: IPC. Is this “their cup of tea?”
Note that students have opportunity to lead – IPC is a young field
BUILDING THE COMPETENCIES OF THE PRIMARY CARE BEHAVIORAL HEALTH WORKFORCE OF TOMORROW

ALEXANDER BLOUNT, ED.D.
Colorado Consensus Competencies for BHC’s

1. Identify and assess behavioral health needs as part of a primary care team
2. Engage and activate patients in their care
3. Work as a primary care team member to create and implement care plans that address behavioral health factors
4. Help observe and improve care team function and relationships
5. Communicate effectively with other providers, staff, and patients
6. Provide efficient and effective care delivery that meets the needs of the population of the primary care setting
7. Provide culturally responsive, whole-person and family-oriented care
8. Understand, value, and adapt to the diverse professional cultures of an integrated care team
For more the full report and much more information:

https://makehealthwhole.org/implementation/8-core-competencies/
NH PCBH Workforce Assessment funded by the Endowment for Health of NH carried out by the Center for BH Innovation

Focused only on primary care behavioral health workforce in New Hampshire

Assessing how behavioral health care is delivered to the most “stressed” populations

Studied the “safety net” clinics (FQHCs and look-alikes plus RHCs)

Looked at how well the training infrastructure of the state is poised to produce the workforce needed to supply these sites and by extension, the state.
The practices perceived themselves as more integrated than we suspect they are.

**Observer versus Site Perceptions of Level of Integration**

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<tr>
<th>COORDINATED</th>
<th>CO-LOCATED</th>
<th>INTEGRATED</th>
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<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
<tr>
<td>LEVEL 1: Minimal Collaboration</td>
<td>LEVEL 2: Basic Collaboration at a Distance</td>
<td>LEVEL 5: Close Collaboration Approaching an Integrated Practice</td>
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<tr>
<td>LEVEL 3: Basic Collaboration Onsite</td>
<td>LEVEL 4: Close Collaboration Onsite with Some System Integration</td>
<td>LEVEL 6: Full Collaboration in a Transformed/Merged Integrated Practice</td>
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Observer Report 2.85 (n=13)  Provider Self-Report 5.15 (n=13)
We defined behavioral health broadly.

1. Prescribing and consulting about psychotropic medications
2. Consulting with PCPs and other team members about patient BH needs and treatment.
3. Providing behavioral interventions or therapies for mental health and substance abuse needs and health behavior change
4. Creating and maintaining patient engagement in care
5. Addressing health literacy, adherence, and healthy living
6. Keeping information about the patient’s health needs and health behavior flowing between the patient and the health team
7. Addressing social and economic barriers patients face in caring for their health (“social determinants of health”)
We conceptualized the workforce by categories of function rather than discipline.

- **Care Enhancer (CE)**

- **Consulting Psychiatric Clinician (CPC)**
  - Psychiatrist (MD, DO), Psych Nurse Practitioner, Psych Advanced Practice Nurse, Psych Physician Assistant

- **Behavioral Health Clinician (BHC)**
  - Psychologist (PsyD, Phd), Marriage & Family Therapist, Substance Abuse Counselor, Mental Health Counselor, MSW
The Fourth Core Role in BHI

Primary Care Clinicians – (MD/DOs, APRNs, PAs working in Family Medicine, General Internal Medicine, Pediatrics, and sometimes OB/GYN)

We did not study this workforce because a number of federal and state agencies already do so.

Yet PCCs play a core role in the success of BHI.

They are already treating depression, anxiety, SA, ADHD, chronic pain, Medically Unexplained Symptoms, and non-adherence, usually presenting in multiples along with chronic illnesses.

Members of other roles who are skilled in behavioral health, at working on a team, and at supporting team members make a crucial difference for PCCs.

When co-location and integration are done well, PCCs’ job satisfaction goes up and (anecdotally) so does provider retention. This is an important workforce intervention.
Role of “Care Enhancers”

Lots of roles being added:

Care Manager
Care Coordinator
Navigator
Health Coach
Patient Advocate
Community Health Worker
Patient Educators
(and on and on)

Some are new types of training and some are new roles for existing disciplines (RNs, LPNs, MAs, MSWs)

Whatever their training, these roles require behavioral skills.
BHCs, PCCs, & some forms of CE’s will be in great demand.

Substance Abuse Counselors, Care Managers, BHCs Needed
Number of Professionals: Now, Wanted Now, Wanted in 5 years
Care Enhancers, Consulting Psychiatric Clinicians, Behavioral Health Clinicians

Health Coach
Navigator
Patient Advocate
Patient Educator
Community Health Worker
Care Coordinator
Care Managers
RN/BSN
Medical Assistant
Consulting Psychiatric Clinician
Substance Abuse Counselor
Behavioral Health Clinician

Number of Professionals Needed
We believe “substance abuse counselors” should be identified and trained as “behavioral health clinicians.”

Primary care patients usually present substance use problems as part of larger arrays of concerns. Treating the “whole person” doesn’t mean treatment for only a particular BH problem any more than treating only physical problems.

The BHC who engages them in working on their behavioral health issues has to be defined as a generalist who can competently address unhealthy habits or depression or substance use, depending on where the patient is ready to work.

The 42 CFR permits generalist behavioral health and medical professionals in general medical settings to communicate about substance abuse diagnoses and treatment without additional permission from the patient.
Traditional Pathways to Becoming a Behavioral Health Clinician in Primary Care

Behavioral health clinician

Placement in primary care as a part of graduate training

Post-degree training in primary care behavioral health

Master’s or doctoral Training

Work experience

Completion of bachelor’s degree
Training needs identified by the PCBH Workforce Assessment:

Targeted training for licensed MH professionals to become Primary Care Behavioral Health Clinicians. (links to programs on the website).

Modules to introduce students to the field of Primary Care Behavioral Health. (Video modules on website)

Programs to become a licensed MH professional that can be taken while maintaining a full time job. (Links on the website)

Specialized training modules for APRNs and BHCs in pediatric settings. (Under development for the website.)

Experiential placements for BHCs in training in primary care sites. New grant programs funded by HRSA for psychologists (Antioch), social workers (UNH),
As BHI matures, the workforce needs to evolve

Care enhancers become more involved in formal BH programming, eg, teaching behavior activation, using MI, monitoring adherence and side effects in population programs for depression, each supported by evidence.

The more teams work together in the flow of care, (using huddles, programming for complex patients, implementing PDSA cycles), the more the expertise of each is contributed to the expertise of all.

The integration that occurs is not an integration of BH and medical roles, it is an integration of medical and psychosocial expertise.

I call it “meta-integration.”
Primary Care Behavioral Health Career Ladder

*These are common entry points for primary care. Individuals can enter at any step in this ladder.*
If we think of Care Enhancers as part of the BH services of primary care, and we respect licensing and ethical boundaries, what might be the basic competencies we would develop for these positions? The current workforce literature is not much help.
Care Coordinator

Advocacy for patients
Education and engagement of patients and families
Coaching and counseling of patients and families
Patient-centered care planning
Support for self-management
Monitoring and evaluation
Teamwork and collaboration
Cross-setting communications and care transitions
Population health management

Patient Advocate

The Domains of Patient Advocacy
1. Scope of Practice and Transparency
2. Empowerment, Autonomy, Rights, and Equity
3. Communication and Interpersonal Relationships
5. Medical Knowledge and the Healthcare System
6. Professionalism, Professional Development, and Practice

https://pacboard.org/documents/PACB-Competencies-final-10.10.17.pdf
Navigator

Effective communication
Enabling access to services
Personalization
Coordination and integration
Building and sustaining professional relationships
Knowledge for practice
Personal development and learning
Handling data and information
Professionalism.

Health Coach

Active Listening
Transtheoretical Model of Change / Change Readiness
Societal Influences on Behavior Change
Cultural Competence
Goal-setting
Guiding the Agenda
Use of Evidence-based Practice Interventions
Motivational Interviewing (MI)
  Open-ended questions
  Affirmation
  Reflection
  Summary
  Managing resistance
Empowering
Telephonic Coaching

https://www.nshcoa.com/core-competencies
Questions and Discussion

If we have time, we would like to have groups discuss the issue of BH competencies for Care Enhancers. Then we can summarize what they decided.

New Hampshire Primary Care Behavioral Health Workforce Portal

www.NHPCBHWorkforce.org