Behavioral Health Competencies Knowledge, Skill, Attitudes

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NH BEHAVIORAL HEALTH SUMMIT

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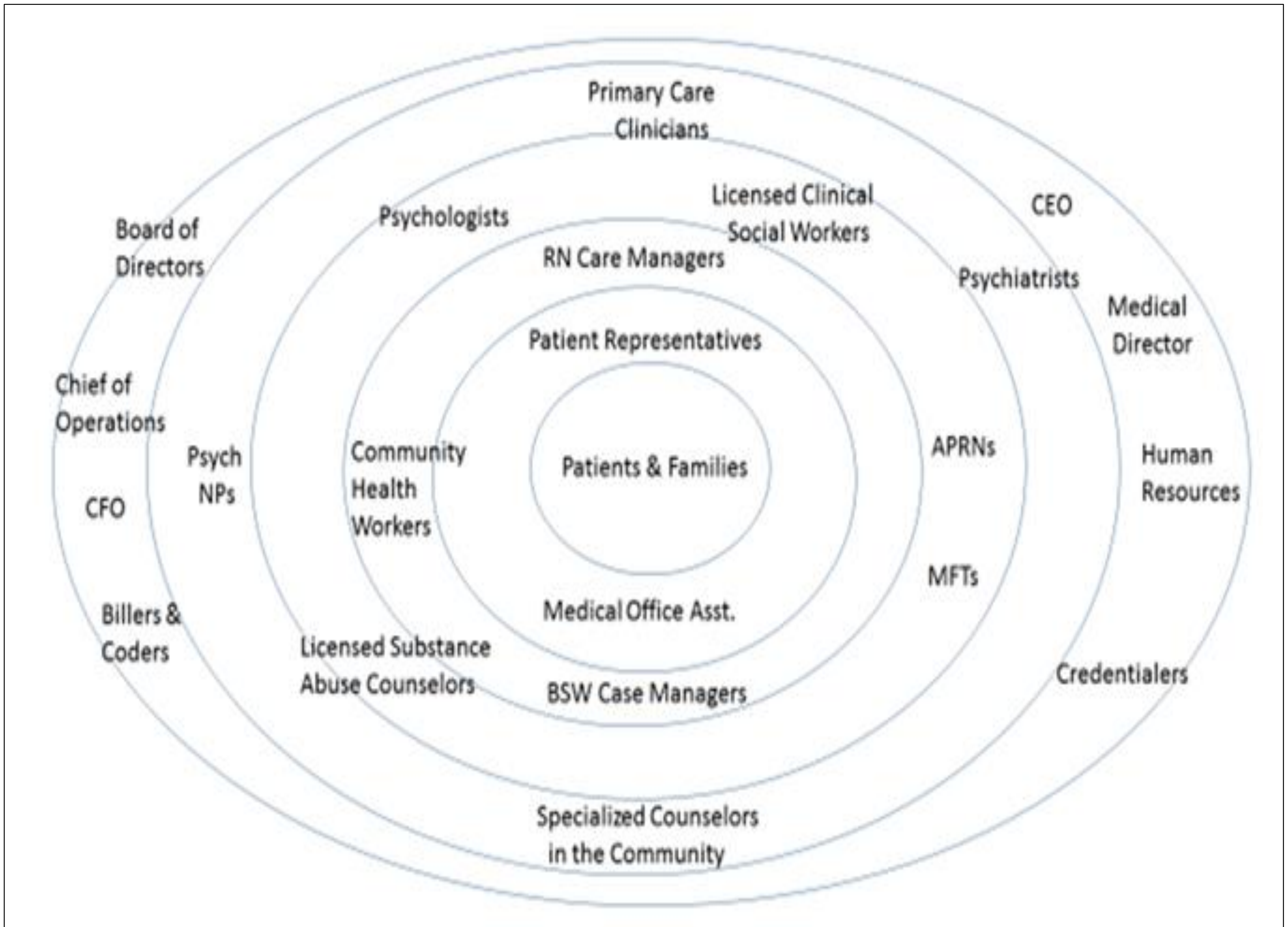
Goals

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



Primary Care
Clinicians
Licensed Clinical
Social Workers
CEO
Psychologists
Board of
Directors
RN Care Managers
Psychiatrists
Medical
Director
Patient Representatives
Chief of
Operations
Psych
NPs
Community
Health
Workers
Patients & Families
APRNs
Human
Resources
CFO
MFTs
Medical Office Asst.
Billers &
Coders
Licensed Substance
Abuse Counselors
BSW Case Managers
Credentialers
Specialized Counselors
in the Community

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).

Dollar, K. M., Kearney, L. K., Pomerantz, A. S., & Wray, L. O. (2018). Achieving same-day access in integrated primary care. *Families, Systems, & Health*, *36*(1), 32-44. doi:10.1037/fsh0000327

Serrano, N., Cos, T. A., Daub, S., & Levkovich, N. (2017). Using standardized patients as a means of training and evaluating behavioral health consultants in primary care. *Families, Systems, & Health*, *35*(2), 174-183. doi:10.1037/fsh0000272

Is IPC Really That Different from Mental Health?

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

The Primary Care Consultant: the Next Frontier for Psychologists in Hospitals and Clinics, p. 9-27. American Psychological Association. Washington, DC.
Primary Behavioral Health Care Services Practice Manual 2.0, U.S. Air Force Medical Operations Agency, 2002.

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

McDaniel, S. H., Grus, C., Cubic, B., Hunter, C., Kearney, L. K.,. Schuman, C., ... Johnson, S., B. (2014). Competencies for psychology practice in primary care. *American Psychologist, 69* (4), 409-429

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 progres
Agree on goals and the process of supervision

Video better than audio better than case reports

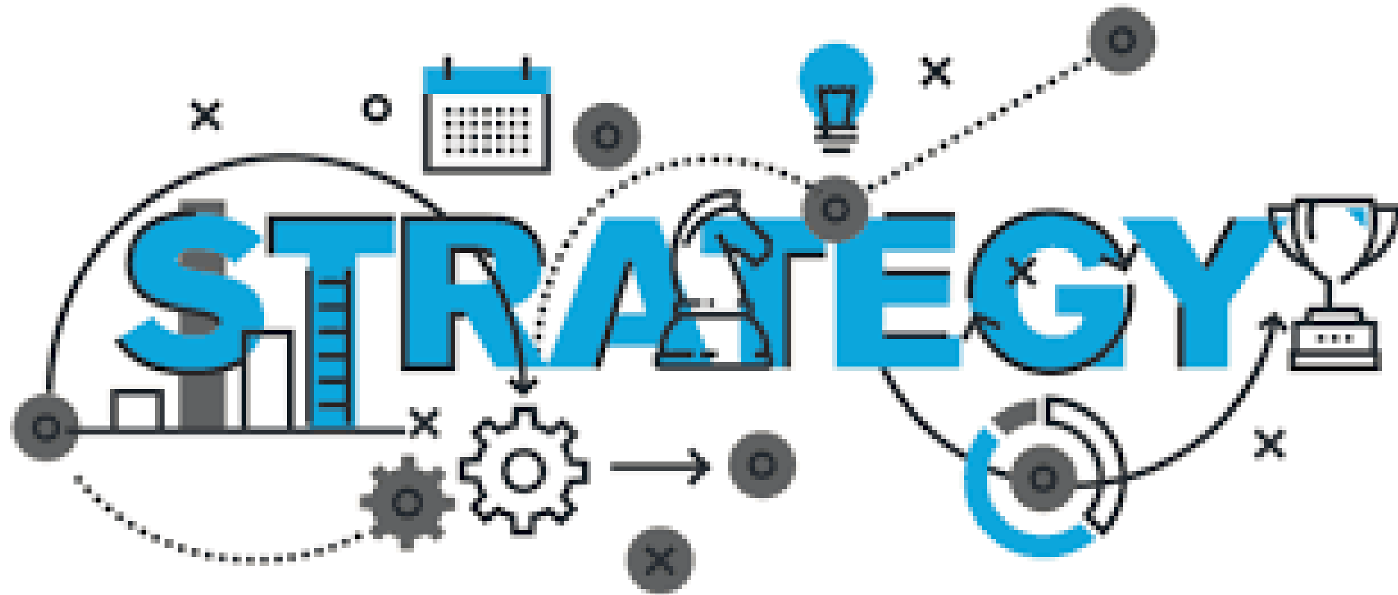
DIFFERENT

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

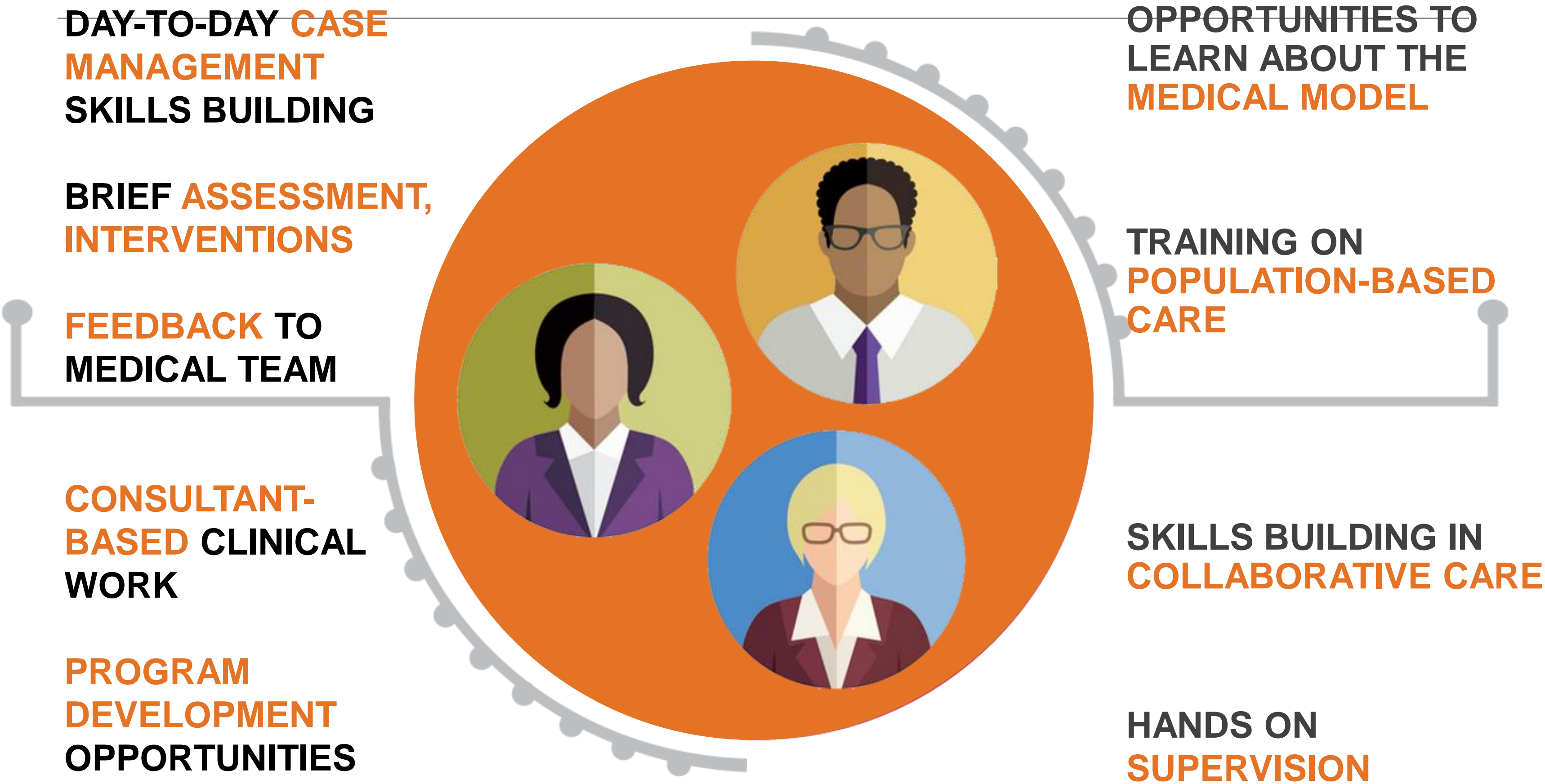
Be the water

- 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[1,2] AND THE FOLLOWING:



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

Center for
Behavioral Health
Innovation

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

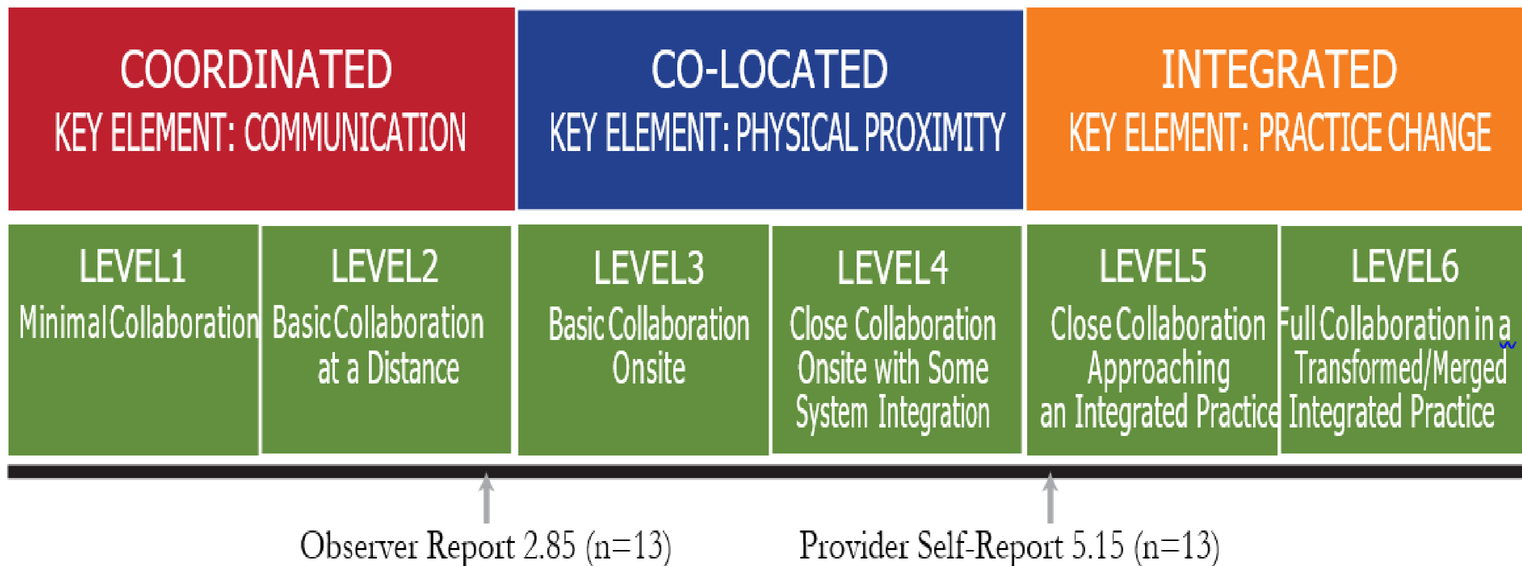
Focused only on primary care behavioral health workforce in New Hampshire

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.



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.

Category	Disciplines
Care Enhancer (CE)	• BSW, Med Asst, Care Manager/Coord, Health Coach, CHW, Pt. Educator, Navigator, Reg. Nurse, BS Nurse
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. The is an important workforce intervention.

Role of "Care Enhancers"

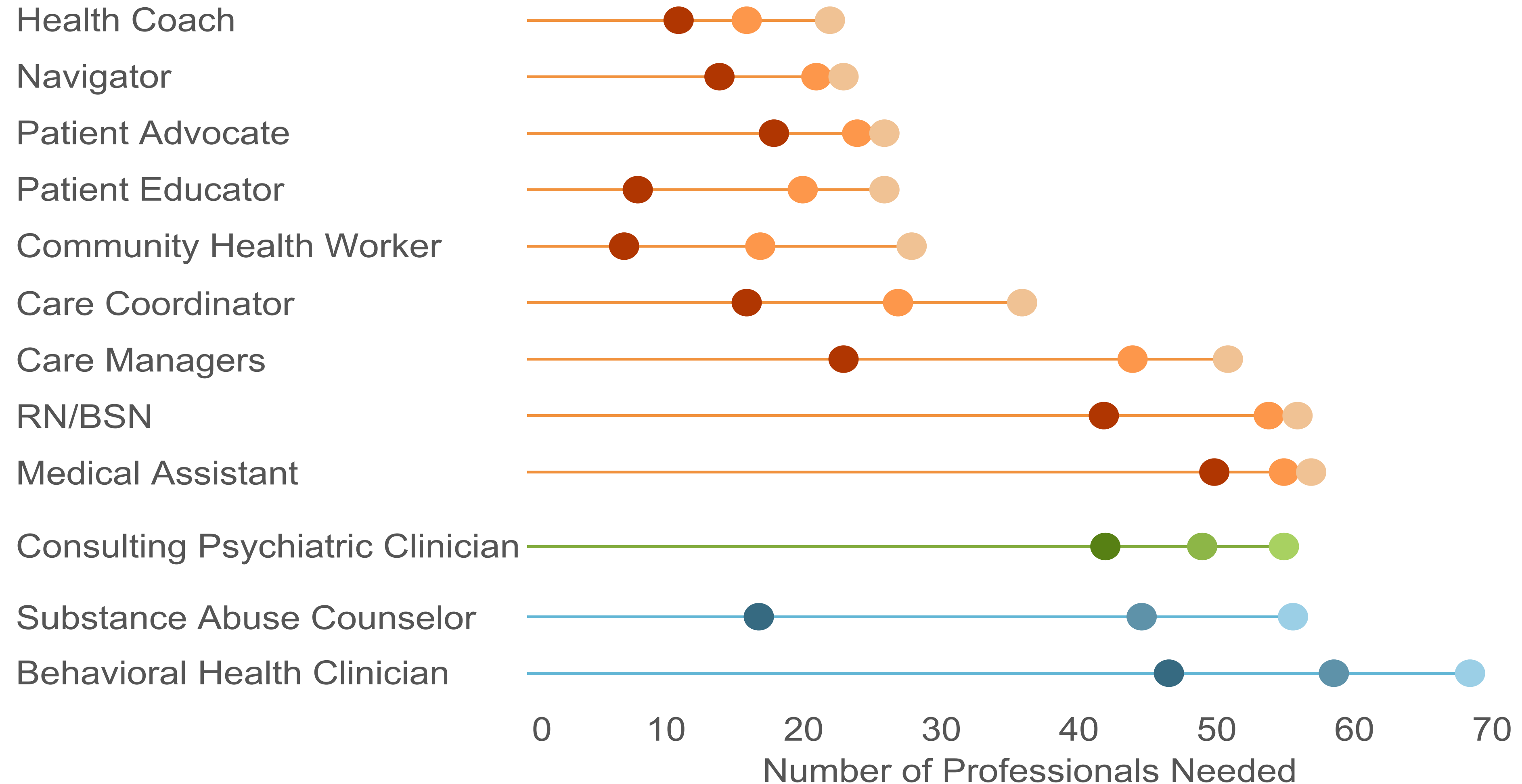
Lots of roles being added:

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.

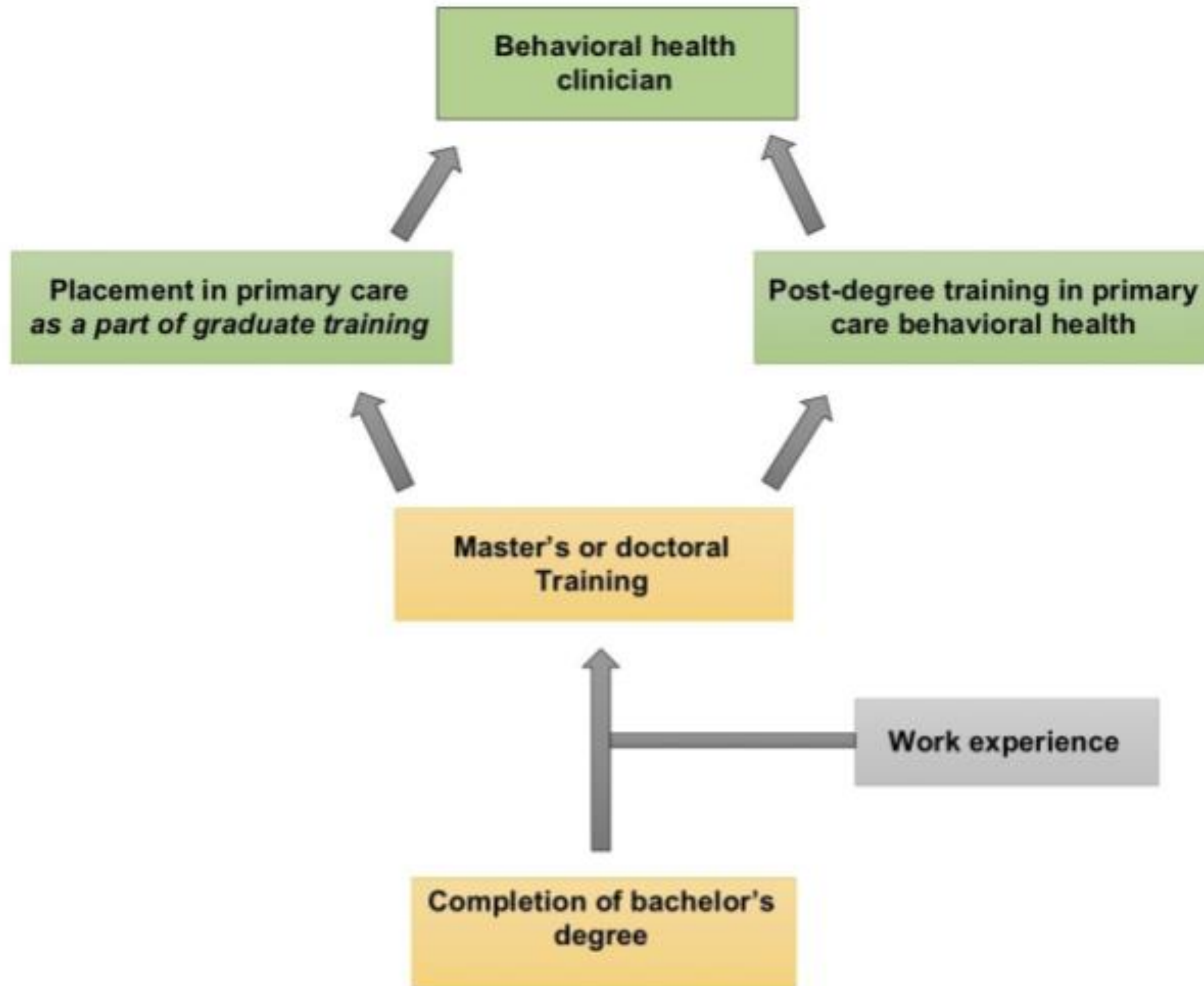


We believe "substance abuse counselors" should be identified and trained as "behavioral health clinicians."

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.



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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

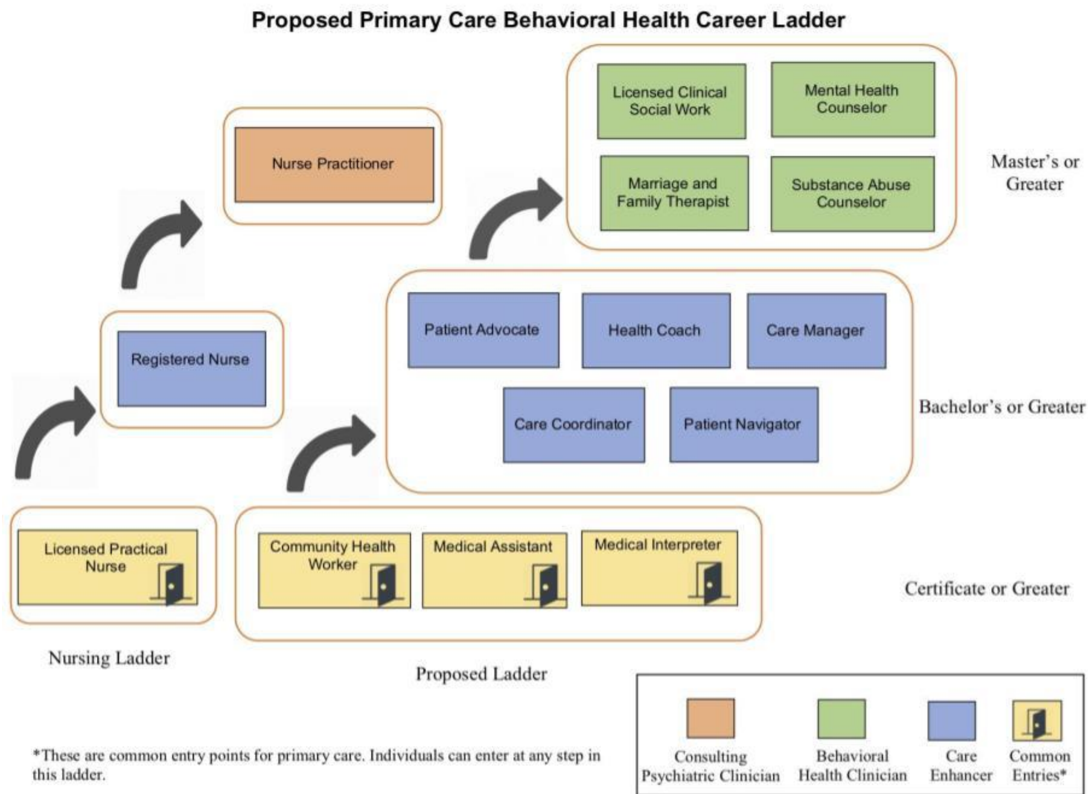
Care enhancers become more involved in formal BH programming, eg, teaching behavior activation, using MI, monitoring adherence and side effects in population programs for depression, each supported by evidence.

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



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

https://www.aaacn.org/sites/default/files/documents/DN_JF14_CCTM%20article.pdf

Patient Advocate

The Domains of Patient Advocacy

1. Scope of Practice and Transparency
2. Empowerment, Autonomy, Rights, and Equity
3. Communication and Interpersonal Relationships
4. Healthcare Access, Finance, and Management
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.

https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf

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