TEAM AND PRIMARY CARE PROVIDER CORE COMPETENCY TOOL (CCT)

Name: **Team role:** **Date of start of work in clinic with PCBH:**

This tool provides a structure for PCPs and PC team members to use in learning information and in developing new skills to assure their success in delivering Primary Care Behavioral Health (PCBH) services. These competencies will assist them in working optimally with a Behavioral Health Consultant (BHC) and PCBH Care Extender staff (e.g., Behavioral Health Assistant or BHA, Health Coach or HC, Community Support worker or CSW), if available. The competencies are sorted into 2 areas: Part A: Clinical Work (6 competencies) and Part B: Team-based Care (12 competencies). Note that most competencies apply to all team members; however, some apply uniquely to Primary Care Providers (PCPs), and these are shaded in grey.

This CCT is useful for self-assessment and for evaluation based on observation in practice. In using it on a regular basis, a team member or PCP can identify priorities for learning and thereby assure progress toward higher skill levels.

A rating of "1" means the PCP or team member is not demonstrating a competency; a "2" indicates that the competency is inconsistently or partially demonstrated; a "3" indicates that the person routinely demonstrates the competency but in just a rudimentary fashion, a rating of "4" indicates consistent and/or skillful demonstration of the competency; ratings of "5" are reserved for competencies that team members always demonstrate and/or demonstrate at a superior level (i.e., could teach other team members in their discipline this competency).

Chapter 6 of *Behavioral Consultation and Primary Care: A Guide to Integrating Services*, 3rd Ed. provides more information about each of these competencies and their potential use.

List of abbreviations

BHC – Behavioral Health Consultant	BHA – Behavioral Health Assistant	CSW – Community Support Worker
PC – Primary Care	PCP – Primary Care Provider	WHO – Warm handoff

Use of this form:

This form may be used by individual PCPs and team members, by the team as a group, and/or by a PCBH trainer assisting with PCBH implementation in a clinic/system.

It may also be used to identify people for career progression to advanced roles in all team positions, where they can assist with ongoing training needs. Ratings of 4 and 5 may signal good candidates for career progression (for more information, see Sec. 6.2.4 in Robinson & Reiter, 2024).

Part A: Clinical Work

Competency	*Minimal Demonstrated Benchmark Behaviors*	*Comments and Sample Behavioral Anchors*	*Rating*	*Comments*
1. Provides information about PCBH services.	1a. Routinely mentions PCBH services to new patients.	• Sample language: "We try to address all aspects of health at our clinic, including physical, mental, and social health. One of our team members is an expert on managing stress, which has a big impact on our health."		
	1b. Introduces start of PCBH services to established patients that might benefit from a BHC visit.	• Sample language: "We have some new services in the clinic, and many patients want to meet our Behavioral Health Consultant." "Their services are routinely helpful for a large number of our patients."		
	1c. Provides a brochure describing BHC services to patients, including the following. • Availability of same-day visits • Examples of problems BHC assists with. • Length of BHC visits (≤ 30 minutes) • Addresses cost of BHC services in a way that minimizes barriers to patient seeing BHC.	• Describes purpose in a way that lessens stigma; sample language: "BHCs help with stress and problems of living"; "BHCs help families live their best lives". • The BHC is a generalist; sample language: "BHCs see children, youth, adults, and families."; "They have great ideas for working with all types of life challenges, including physical as well as psychological problems." • Encourages patient engagement by indicating flexibility in visit length; sample language: "BHC visits are about 30 minutes long, but shorter is possible if your time is limited today." • For patients concerned about costs, informs them the BHC might be able to provide a non-billable same-day visit, after which the		

		patient can research cost through their insurance company.		
2. Identifies specific focus for BHC visit.	2. Works with patient to define a primary problem and/or goal for visit with BHC.	• Sample language: "I would like for you to talk with the BHC today about your family concerns"; "The BHC may give us some new ideas about how to work with your low energy."		
3. Understands and supports BHC assessment surveys.	3. Supports use of BHC screeners; understands scoring and can use in assessing patient status and progress.	• Offers patients opportunity to complete BHC screeners prior to BHC visits. • Understands scoring system of screeners used by BHC (e.g., quality of life measures, psychosocial stress measures, etc.). • Able to use scores to inform treatment plans. • Able to talk with patient about assessment findings: "I see that your social health score was improved in your follow-up with visit with the BHC – that's good news."		
4. Identifies and addresses risk, involving BHC as needed.	4. Appropriately identifies patients at risk of harm to self and others and involves BHC as needed.	• Is aware of risk factors for suicide/homicide. • Asks about suicidal ideation directly when risk factors are elevated, and conducts further risk assessment when needed. • Staffs about specific plan to address risk with BHC.		
5. Supports behavior change interventions.	5a. Has basic understanding of interventions commonly used by BHCs and able to support patient follow through on plans. Commonly used interventions include Focused Acceptance and Commitment (FACT), adapted cognitive interventions, adapted behavioral interventions and	• Supports patient in pursuing action plans that align with values, making choices with awareness. • Encourages patient to follow through on behavior change plans for mood, sleep, use of new social/communication skills, parenting strategies. • Notes value of continued practice of exercises targeting physiology and intentional choosing , such as breathing		

	adapted Motivational interviewing (MI).	exercises, muscle relaxation, distraction, urge surfing. • Able to provide continuity for patients preparing for behavior change by reviewing pros and cons of change, emphasizing personal choice, conceptualizing readiness, and adjusting plans to stage of readiness.		
	4b. Reviews chart notes about BHC interventions and plans prior to medical visit following a BHC visit.	• Specifically, asks about patient experience with plan made with BHC; sample language: "I see you worked on a Bull's-Eye Plan with the BHC – how's that going?"		
6. Encourages follow-up visits with BHC.	6. Encourages patient follow-up with BHC at medical visits as indicated by patient presentation.	• Offers same-day follow up with patients seen previously by BHC. • Attempts to enhance patient engagement in follow-up with BHC (when indicated) by scheduling medical and BHC follow-up appointments for the same day and in proximal appointments.		

Clinical Work (self-assessment)

Please complete a rating for each competency and note any details in the box to the right of the competency rating, for discussion with teammates and planning skill development. Note your questions, strengths, and learning priorities below.

A. Competencies that I have questions about:

B. Competencies that are strengths:

C. Competencies to prioritize for more development:

Part B: Teamwork

Competency	*Minimal Demonstrated Benchmark Behaviors*	*Comments and Sample Behavioral Anchors*	*Rating*	*Comments*
1. Supports PCBH integrated care culture.	1a. Uses language and practice habits suited to PCBH context.	• Avoids specialty MH language (e.g., “session”, “therapy”, “counseling”, “intake”) when talking about BHC service. Instead, uses terms such as “appointment”, “visit”, or “classes” to be consistent with PC/PCBH language.		
	1b. Relates to BHC as a consultant, rather than “therapist” or “counselor”.	• Supports idea that BHC provides recommendations to the PCP; that PCP remains in charge of patient care. • Helps patient anticipate that single visits with the BHC may be sufficient, based on patient desire and progress.		
2. Identifies patients for BHC service.	2a. Refers patients of all ages and with all behavioral concerns (medical, psychological, social).	• Understands that the BHC is a generalist and supports the reach of BHC services to many patients by referring all that would benefit from behavior change support (including patients with medical conditions, such as diabetes, high blood pressure, etc.)		
	2b. Prioritizes referral of patients with disparate health outcomes.	• Is especially sensitive to potential referral needs in patients from groups with known health inequities		
	2c. Identifies patients for BHC services in multiple contexts.	• Develops practice habits that support patient identification, such as reviewing daily schedule, planning BHC involvement during huddles with team. • Nursing staff collaborate with PCP in offering BHC service to patients calling with behavioral health concern.		

		• Nursing assistants communicate with PCP about behavioral and emotional concerns noticed when rooming a patient.		
	2d. Supports development and refinement of PCBH pathways designed to improve patient access to BH services for patients experiencing problematic health outcomes (e.g., chronic pain, ADHD).	• Able to verbally describe principles of population-based care as the foundation of the PCBH model. • Can explain that PCBH pathways are important to the mission of PCBH (i.e., to address health disparities, to improve access to BH services for the entire clinic population). • Participates in pathway design, implementation, and evaluation work.		
	2e. Identifies barriers to use of BHC and seeks solutions to address identified barriers .	• Uses Referral Barriers Questionnaire to identify barriers; collaborates with team to address challenges (by using educational, technical, and other strategies).		
3. Uses warm handoff (WHO) skillfully.	3a. Referral for initial visits is most often WHO.	• Thinks of both short-term and long-term impact of methods for referring patient to BHC, avoiding scheduling future visits and choosing WHO whenever possible.		
	3b. Able to adjust description and length of initial WHO to match individual patient need.	• Matches conversation about BHC and WHO to patient needs, taking more time with reluctant patients and less with patients readily agreeing.		
	3c. Understands and uses different options for initiating WHO (e.g., via electronic health record, texting BHC, physically locating BHC, etc.).	• Chooses option for connecting patient with BHC that is most efficient at the moment of referral.		
	3d. Completes WHO workflow by staffing briefly with the BHC after their consultation.	• Sample language: “Thanks, I’m glad you were able to identify some ways to help them take their medication more consistently. I’ll		

		support your ideas when I see them next month."		
	3e. Uses WHO strategy to support same-day BHC follow-up visits, when indicated.	• Recommends same-day visit with BHC for patients returning for a medical visit and indicting interest in and/or need for follow-up with BHC.		
4. Uses BHC services to improve team efficiency.	4a. Asks BHC to complete limited focus visits with patients.	• Example: asks BHC to complete a brief review of barriers and facilitators to patient use of medications prescribed for a medical condition (e.g., gout).		
	4b. Uses BHC to save PCP time when PCP's schedule is over-booked or urgent care situations arise.	• Sample language: "Hello, before we start our visit today, I'd like for you to spend 10 minutes with our BHC. You can talk with them about the coping strategies you are using to manage diabetes and set an agenda for our visit. I'll join you shortly, sound good?"		
	4c. If team includes Behavioral Health Consultant Assistant (BHC-A), uses BHC-A optimally to extend BHC services.	• Uses BHC-A to facilitate WHOs, to pass communication to BHC, etc.		
5. Uses BHC to improve patient experience in clinic visits.	5a. Uses BHC to enhance patient experience in preventive care visits.	• Offers BHC when families identify behavioral health concerns in a prevention visit; sample language: "I'll ask our BHC to drop in now and explore this a bit more with you. My guess is that they will have some good ideas for us." • For families in prevention visits that do not identify a specific concern, uses BHC for more in-depth education about child development during the 15-minute wait period after a vaccination; sample language: "I'm going to ask our BHC to drop by while		

		you are waiting. They may be able to teach you a new social game to play with your little one."		
	5b. Offers patients options for visits with BHC.	• For patients who are unable to stay for a WHO (or patients phoning and unable to come for a clinic visit), offers telehealth option; sample language: "How about I ask the BHC to give you a call this afternoon, after you take your son home and put him down for his nap? Would that work?"		
6. Uses BHC to optimize outcomes associated with prescribing medications.	6a. Attempts to avoid over-prescribing by referring to the BHC for behavior change for conditions likely to improve with behavior change support (e.g., depression, anxiety, ADHD, and sleep problems).	• May have standing order for WHO to BHC for patients struggling with depression, anxiety, ADHD, sleep, etc.; monitors for response to BHC intervention and staffs with BHC regarding possible augmentation with medication if limited response to behavioral interventions is observed.		
	6b. Uses BHC to assist with start of new psychotropic medications.	• Asks BHCs to assist with start of psychotropic medications, such as medications for depression or ADHD (including identifying potential barriers to use, such as beliefs about medication use; also for on-going monitoring of beneficial and side effects).		
	6c. Uses BHC services for patients that face barriers to taking medications as prescribed.	• Asks BHC to assist with identifying specific barriers to use of psychotropic and medical conditions (e.g., cost, forgetting, lack of confidence in medication, fear of side effects).		
7. Uses stepped care approach in	7a. Uses BHC to support use of specialty mental health care.	• Possible reasons to consider specialty care include an emergency; patient not improving after a few visits; patient prefers specialty;		

working with BHC.		patient needs excluded service (e.g., forensic evaluation, detox). • Refers patients in need of specialty care to BHC on same-day as need identified, so that they receive immediate care and so that BHC can assist with referral.		
	7b. Uses BHC to support patients waiting for specialty care or returning from an episode of specialty care.	• When patients are referred, expects BHC to continue to follow-up until patient is engaged in specialty care and/or improves. • For patient who is already seen in specialty care, can use BHC to coordinate care as needed with specialist(s) or to see patient for a different concern. • For patients refusing specialty care, expects BHC to provide on-going care until the patient starts to improve		
8. Uses task sharing strategies with BHC.	8a. Routinely asks BHC to complete tasks within their scope to reduce workload of PCPs and RNs.	• Asks BHC to complete FMLA paperwork, call school to coordinate a child's care, or complete disability paperwork (assuming for all that the focus of the task involves a behavior concern).		
	8b. If available to service, uses BHC-A and/or Community Support Worker (CSW) to complete tasks that may improve patient experience and healthcare outcomes.	• For example, may ask BHC-A to work with CSW in completing a home visit or facilitating a referral to a community resource.		
9. Supports class services that address behavior change.	9a. Encourages patient to participate in workshops and class series offered by BHC.	• Monitors BHC bulletin board for updates on group services. • Provides BHC handouts about group services to patients.		

	9b. Supports patient participation in class-based medical services (e.g., for diabetes).	• Able to discuss the potential benefits of class-based medical services with patients (e.g., consistent appointment time, more time for education, social interactions, etc.)		
	9c. Offers to participate in delivery of class-based services with BHC.	• Willingness to co-lead or assist with class-based services with BHC (e.g., for children and families with ADHD or adults with chronic pain).		
10. Uses PCBH metrics to improve outcomes of integrated care.	10a. Understands BHC metrics (e.g., visits completed, # of follow-ups patient, % of patients recommended for secondary care, etc.) and supports BHC success in meeting key metrics.	• Reviews BHC graphs of metrics posted in staff room. • Discusses strategies for improving use of BHC services for a broad range of patient presentations.		
	10b. Understands team metrics (e.g., PCP referrals of all ethnicities, races, ages to BHC; PCP referral to BHC for medical problems as well as psychological and social problems; PCP initiation of WHOs versus future scheduled patients).	• Reviews graphs that depict team behavior mapping to equity in access to behavioral health services for all patients enrolled in clinic.		
11. Participates in professional development to broaden BH knowledge and skills.	11. Challenges self to learn more about use of behavioral assessment and intervention techniques adapted for PC.	• Initiates curbside consults with BHC to learn more about assessment and intervention. for behavioral issues. • Asks BHC to research questions about behavioral health topics for team. • Attends presentations by BHC. • Completes reading suggested by BHC. • Co-presents with BHC. • Co-leads groups with BHC. • Mentors new staff in PCBH Team Competencies.		

12. Follows policies and procedures related to PCBH.	12a. Skillful in use of scheduling software and electronic medical record actions related to BHC services.	• Able to quickly determine if patient has had a prior BHC visit. • Able to access BHC chart notes and use to support patient experience of continuity in care.		
	12b. Provides support to BHC billing codes, if advised to.	• Uses information provided in coding training as it relates to BHC services.		

Teamwork (self-assessment)

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ATTRIBUTIONS: This Core Competency Tool (CCT) was published in *Behavioral Consultation and Primary Care: A Guide to Integrating Services, 3rd Edition* (Robinson & Reiter, 2024).