Table 5.1 Behavioral Health Consultant Core Competency Tool Abbreviated

BEHAVIORAL HEALTH CONSULTANT (BHC) CORE COMPETENCY TOOL (CCT)

Part A: Clinical Visit Structure

Competency	*Minimal Demonstrated Benchmark Behaviors*
1. Role definition	1a. Accurately describes the BHC role. • Name, title credential. • BHC role in care • Length of visit • What will happened during the visit. • The structure of follow-up. • That the visit note will go in medical record. • That the patient's care will be coordinated with the PCP. • Notification of billing practices.
2. Rapid agenda setting	2a. Confirms and clarifies consultation issue and obtains initial patient engagement in addressing consultation issue within 60 seconds after completing the introductory script.
3. Assessment	3a. Measure use. • Uses assessment measure appropriate to PC to assess and monitor outcome. • If additional measures are used, they are appropriate for PC, scored, interpreted, and documented correctly. • Measures are scored during/before the visit and discussed/used with the patient in a value-added manner.
	3b. Appropriately assesses risk of harm to self and others.
	3c. Assessment of functioning: Develops a "snapshot" of the patient's life context (family/friends, work/school, recreational/leisure/spirituality, health behavior). Notes patient's coping skills needs/ strengths.
	3d. Assessment of presenting problem. Explores duration, frequency and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem. Assessment of psychosocial factors that coincided with onset of or change in symptoms, with goal of identifying coping skills needs/strengths.
4. Problem-focus	4a. Within visits, focuses assessment and intervention on the presenting problem. (Exceptions may be made when a patient clearly indicates a preference for talking about a different problem or if significant new concerns are identified during the visit, or if the visit purpose is prevention.)

	4b. In follow-up visits, maintains a focus on the original problem (unless exception criteria in 4a are met)
5. **Summary and formulation**	5a. Provides a succinct summary of the presenting problem and relevant history.
	5b. Attempts to convey a relationship between a patient's values and their desire to make a change in behavior. Highlights and explains the coping skill deficits/strengths affecting the problem. Checks with patient for accuracy.
6. Evidence-based recommendations and interventions suitable for PC patients and PCPs	6a. Demonstrates at least 3 of the following in the categories below. • Focused Acceptance and Commitment (FACT). interventions • Adapted cognitive interventions. • Adapted behavioral interventions. • Adapted Motivational Interviewing (MI).
	6b. Interventions are collaboratively developed with the patient.
7. Clear visit structure	7a. Visits follow a clear structure (FACT, 5As).
8. Intervention design	8a. Intervention plans are specific, realistic, and clearly related to the presenting problem.
	8b. Uses self-management, home-based practice as the prime method for intervention. Most interventions involve self-guided skill-building.
	8c. Provides a written copy of plan or asks patient to write plan.
	8d. Uses confidence rating scale (1-10, 10= high confidence) to assess confidence in plan at all visits. If less than 7, adjusts plan to increase confidence rating.
9. Intervention efficiency	9a. Structures behavior change plans that are consistent with consultative care service.
10. Time management	10a. Appointments are routinely kept to 30 minutes or less.
11. Verbal consultative staffing (Part A)	11a. Staffing and other team members is concise, avoids jargon, and includes the BHC's impression, behavior change plan, and recommendations for PCP's care of the patient.
12. Value-added recommendations	12a. Recommendations that the BHC provides to the PCP and team are: • Achievable for the patient. • Evidence-based. • Brief (PCP can describe/reinforce in less than 2 minutes). • Designed to reduce PCP visits and workload when possible.

Part B: Team-based Care

Competency	*Minimal Demonstrated Benchmark Behaviors*
1. Clinical productivity behaviors	1a. Uses multiple strategies to optimize use of BHC clinical services.
2. Consultant care structure	2a. Uses consultant framework in conceptualizing and planning follow-up with patient. Uses a "consultant" rather than "therapist" structure for planned follow-up.
3. Follow-up planning	3a. Plans follow-up strategically and only when indicated. Appointments are spaced in a manner consistent with a population-health model, as well as individual patient needs.
	3b. Coordinates follow-up visits with other PC visits to maximize convenience to the patient, decrease the likelihood of no-shows, increase teamwork, and optimize value to the patient and team.
4. Risk management	4a. Appropriately manages patients assessed to be at high risk of harm to self or other. Attentive to employer policy regarding management of patients at risk of harm to self or other.
5. Community resource referrals	5a. Has information on community-based resources, refers patients when indicated.
6. Task-sharing	6a. Routinely offers to complete tasks (within scope) to share workload of PCPs and RNs.
7. Specialty mental health utilization	7a. Understands and follows specialty care and referral criteria.
	7b. Uses specialty care episodically, as needed, while maintaining longitudinal care.
8. Class-based services	8a. Provides/participates in class-based services, using a format and content appropriate to PC.
9. Pharmacotherapy	9a. Can identify common psychotropic medications, indications for the medication, and common side effects. Can address incorrect beliefs about psychotropic medications.
	9b. Can identify medications used for physical health conditions commonly treated in PC (e.g., diabetes).
	9c. Stays within scope of practice for non-prescribers.
10. Schedule management	10a. Makes decisions about BHC schedule that promote helpful contact with as many patients as feasible within the context of time and space availability.
11. Concise, clear, and timely charting using	11a. BHC-specific EHR template is used.
	11b. Documents in the medical record during the clinical encounter.
	11c. Clinical notes are written specifically for PCP, team members, and patients in a succinct and jargon-free manner.

appropriate format	11d. Initial visit documentation includes assessment of the presenting problem, functioning/context, risk and habits; brief mental status exam; a clear clinical impression; evidence-based interventions in the form of a SMART goal; follow-up plan, if any; recommendations for the PCP.
	11e. Ensures EHR notes are accessible to the PC team and maintained as part of the patient's medical record.
	11f. Completes clinical notes within the organization's time limit.
12. Verbal consultative staffing (Part B)	12a. Staffs patients verbally with PCPs for every initial appointment, and as needed at follow-ups. If unable to access PCP for same-day verbal staffing, BHC uses alternate means of staffing.
13. Responsiveness and availability to PC team	13a. Maintains flexible attitude and openness in providing consultation. • Readily provides unscheduled services when needed. • Has an "open door" policy encouraging PC staff interruptions to promote same-day visits and urgent curbside consultation. If away from station, ensures team know location and time of return.
	13b. Conducts regular and efficient warm handoffs. • Warm handoffs are the default means of engaging the BHC with patients. • Responds promptly to warm handoff requests. • Accepts brief overview of referral concern from PCP. • Meets patient briefly and arranges a visit time, ideally same day. • Visit with patient occurs in the PCP's exam room if possible.
14. Team-based care plan assistance	14a. Clarifies and reinforces other aspects of the treatment plan. • Is aware of key components of care from PC. • Reinforces the importance of all aspects of the plan (especially those related to the referral concern).
15. Care team coordination	15a. Engages patients with other care team members, when indicated.
	15b. If working with Behavioral Health Assistant (BHA), maximizes care extender benefits to PC team and to patients.
	15c. Maintains contact with Care Extenders (CEs) located in the community (e.g., Community Support Workers [CSWs]).
16. PC team education	16a. Provides at least quarterly training to PC team members on: • Strategies for optimal use of the PCBH service and/or • Basic behavior change information and/or strategies.
	16b. Researches questions about behavioral health topics for team.
	16c. Explores assessment and intervention options for PCBH pathway development.
17. Fit with primary care culture	17a. Knows the roles of the various PC team members and articulates their roles/duties in the clinic.
	17b. Regularly attends and participates in PC team meetings, huddles, and events to stay in visible and active member of the team.

	17c. Uses language and practice habits appropriate for PC culture.
18. Population-based care	18a. Articulates population based care mission of BHC work; is attentive to daily practice choices as they pertain to population-based care perspective.
19. PCBH policies and procedures	19a. Uses a balance of same-day and preschedule slots that promotes fidelity. • Template meets requirement of minimum of 12 visit slots per day, on average, for full-time BHC. • All slots are 30 minutes. • Classes are scheduled according to length/purpose.
	19b. Uses correct CPT codes (as specified by service)
	19c. The service's BHC peer review items are used in regular peer review processes.