FIGURE 2.1. BHC Core Competencies (*continues*)

Dimension	Element	Attribute
I. Clinical practice knowledge and skills	1. Role definition	Says introductory script smoothly, conveys BHC role to all new patients, and answers patient's questions
	2. Problem identification	Identifies and defines presenting problem with patient within first half of initial 30-minute appointment
	3. Assessment	Focuses on current problem, functional impact, and environmental factors contributing to/maintaining problem; uses tools appropriate for primary care
	4. Problem focus	Explores whether additional problems exist, without excessive probing
	5. Population-based care	a. Understands difference between population-based and case-focused approach
		b. Provides care along a continuum from primary prevention to tertiary care; develops/uses pathways to routinely involve BHC in care of chronic conditions
	6. Biopsychosocial approach	Understands relationship of medical and psychological aspects of health
	7. Use of evidence-based interventions	Utilizes evidence-based recommendations/ interventions suitable for primary care for patients and PCPs
	8. Intervention design	a. Bases interventions on measurable, functional outcomes and symptom reduction
		b. Uses self-management, home-based practice
		c. Uses simple, concrete, practical strategies, based on empirically supported treatments for primary care

FIGURE 2.1. BHC Core Competencies (*continues*)

Dimension	Element	Attribute
I. Clinical practice knowledge and skills (*continued*)	9. Multipatient intervention skills	Works with PCPs to provide classes and/or groups in formats appropriate for primary care (e.g., drop-in stress management class, group medical visit for a chronic condition)
	10. Pharmacotherapy	Can name basic psychotropic medications; can discuss common side effects and common myths; abides by recommended limits for nonprescribers; consults psychopharmacology prescribing expert when needed
II. Practice management skills	1. Visit efficiency	Demonstrates adequate introduction, rapid problem identification and assessment, and development of intervention recommendations and a plan in 30-minute visits
	2. Time management	Stays on time when conducting consecutive appointments
	3. Follow-up planning	Plans follow-up for 2 weeks or 1 month, instead of every week (as appropriate); alternates follow-ups with PCPs for high-utilizing patients
	4. Intervention efficiency	Uses consultant approach to planning follow-up by working with patients only until symptoms or functioning begin to improve and there is a plan in place for continued improvement; structures behavioral change plans consistent with briefer courses of care
	5. Visit flexibility	Appropriately uses flexible strategies for visits: 15 minute, 30 minute, phone contacts, telehealth visits, secure messaging
	6. Triage	Attempts to manage most problems in primary care but does triage to mental health, unhealthy substance use, or other clinics or services when symptoms or functioning are not improving with PCBH services
	7. Case management	a. Uses patient registries (if they exist); takes load off of PCP (e.g., returns patient calls about behavioral issues); advocates for patients
		b. Communicates and coordinates care with care coordinators and case managers
	8. Community resource referrals	Is knowledgeable about and makes use of community resources (e.g., refers to community self-help groups)
III. Consultation skills	1. Referral clarity	Is clear on referral questions; focuses on and responds directly to referral questions in PCP feedback

FIGURE 2.1. BHC Core Competencies (*continued*)

Dimension	Element	Attribute
III. Consultation skills (*continued*)	2. Curbside consultations	Successfully consults with PCPs on demand about a general issue or specific patient; uses clear, direct language in concise manner
	3. Assertive follow-up	Ensures PCPs receive verbal and/or written feedback on patients referred; interrupts PCP, if indicated, for urgent patient needs
	4. PCP education	Delivers brief presentations in primary care staff meetings (e.g., PCP audience; focus on what BHC can do for them, what PCPs can refer, what to expect, how to use BHC optimally)
	5. Recommendation usefulness	Tailors recommendations to the pace of primary care (e.g., interventions suggested for PCPs can be done in 1–3 minutes)
	6. Value-added orientation	Makes recommendations that are intended to reduce PCP visits and workload (e.g., follow-up with BHC instead of PCP)
	7. Clinical pathways	Participates in team efforts to develop, implement, evaluate, and revise pathway programs needed in the clinic
IV. Documentation skills	1. Concise, clear charting	Records clear, concise notes in detail: referral problem specifics, functional analysis, pertinent history, impression, specific recommendations, and follow-up plan
	2. Prompt PCP feedback	Provides written and/or verbal feedback to PCP on the day the patient was seen
	3. Appropriate format	Delivers chart notes that are consistent with expected clinic/system format
V. Administrative knowledge and skills	1. BHC policies and procedures	Understands scheduling, templates, codes for primary care work, criticality of accurate medical coding
	2. Risk-management protocols	Understands limits of existing BHC practices; can describe and discuss, for example, how and why informed consent procedures differ
	3. Coding documentation	Routinely and accurately completes coding documentation
VI. Team performance skills	1. Fit with primary care culture	Understands and operates comfortably in fast-paced, action-oriented, team-based culture
	2. Knows team members	Knows the roles of the various primary care team members; both assists and utilizes them
	3. Responsiveness	Readily provides unscheduled services when needed (e.g., sees patient during lunchtime or at the end of the day, if needed)
	4. Availability	Provides on-demand consultations via wireless communication when not in the clinic; keeps staff aware of whereabouts

Note. BHC = behavioral health consultant; PCP = primary care provider.

FIGURE 2.2. Marketing Survey

Providing the Right Care, for the Right People, at the Right Time

Family Medicine Behavioral Health Consultant

Services: Consultation (30 minutes) for assessment and behavioral health treatment planning, recommendations, and interventions.

Referrals: ANYTHING you think might be helped through habit, behavioral, cognitive, or emotional changes.

Goals of Service: To help you and your patients develop practical knowledge and skills to promote and improve physical and emotional health.

The following is a list of common problems for which I may be helpful.

General Mental Health Problems

❑ Stress
❑ Anxiety/fears
❑ Depression
❑ Anger
❑ Relationship problems
❑ Grief or bereavement
❑ Attention-deficit/hyperactivity disorder
❑ Posttraumatic stress disorder
❑ Suicidal thoughts
❑ Workplace stress
❑ Burnout
❑ Eating disorders
❑ Obsessive–compulsive disorder
❑ Memory concerns
❑ Parenting concerns

Clinical Health Problems

❑ Insomnia
❑ Chronic pain
❑ Headache
❑ Fibromyalgia
❑ Temporomandibular disorders
❑ Low back pain
❑ Tobacco use
❑ Alcohol use
❑ Diet (weight loss, dietary adherence)
❑ Exercise
❑ Diabetes
❑ Gastrointestinal problems
❑ Chronic obstructive pulmonary disease
❑ Medication adherence
❑ Chronic illness management

FIGURE 2.3. Consultation Request

Consultation Request

Patient Name and ID: _____ Referring PCP: _____

Circle Consult Problem: Anxiety, Panic, IBS, Hyperventilation, Depression, Stress, Insomnia, Chronic Pain, GERD, COPD, Diabetes, ETOH Problems, Adherence, Tobacco Cessation, Obesity, Anger, Relational Problems, Bereavement, Memory Problems, Other: _____

*Requesting Provider, please circle requested skills training/patient education:

Anxiety/Panic/IBS/Hyperventilation: 1. Deep Breathing Training; 2. Cue-Controlled Relaxation; 3. Modify Thoughts That ↑Sx; 4. Educate on Physiology of Autonomic Arousal; 5. Decrease Avoidance Behaviors That Maintain Problem; 6. Educate on Medication Side Effect

Depression: 1. Educate on Depression Cycle; 2. ↑Exercise; 3. ↑Social Support; 4. ↑Meaningful/Valued Activities; 5. ↑Medical Tx Adherence; 6. Education on Medication Side Effect

Stress Management: 1. Deep Breathing Training; 2. Cue-Controlled Relaxation; 3. Modify Thoughts That ↑Sx; 4. ↑Exercise; 5. ↑Social Support; 6. ↑Meaningful/Valued Activities; 7. Assertive Communication

Insomnia: 1. Sleep Behavior Change, Stimulus Control, Sleep Restriction; 2. Relaxation Skills Training

Weight Management: 1. Improve Exercise Habits; 2. Eating Behavior Change; 3. Educate on Weight Management; 4. Modify Thoughts That Perpetuate Problem

Chronic Pain (Musculoskeletal/Headache): 1. Pace Activities; 2. Relaxation Training; 3. ↑Exercise; 4. ↑Social Support; 5. ↑Meaningful/Valued Activities; 6. Modify Thoughts; 7. Educate on Pain

Medical Illness Management: 1. Educate on Depression Cycle; 2. Relaxation Skills Training; 3. ↑Social Support; 4. ↑Pleasant Activities; 5. Modify Thoughts That Perpetuate Problem

Other: _____

Note. PCP = primary care provider; IBS = irritable bowel syndrome; GERD = gastroesophageal reflux disease; COPD = chronic obstructive pulmonary disease; ETOH = ethyl alcohol; Sx = symptoms; Tx = treatment.

FIGURE 2.4. Problem of the Week

Stress

Is STRESS a factor in your patients' well-being?

I can help your patients in the following ways:

- Recognizing the signs and symptoms of stress
- Identifying triggers for stress reactions
- Training in relaxation strategies
- Teaching healthy thinking strategies
- Improving balance between work and leisure
- Enhancing problem-solving skills

Patients can be scheduled for behavioral health consultation appointments at the reception desk or can be seen promptly on the day they have an appointment with you. I can be contacted at XXX-XXX-XXXX.

FIGURE 2.5. Appointment Template

BHC Schedule Template

- 7:30: Team huddle
- 8:00: Book
- 8:30: Book
- 9:00: Book
- 9:30: Open time
- 10:00: Book
- 10:30: Book
- 11:00: Book
- 11:30: Book

- 12:00: Lunch
- 12:30: Book
- 1:00: Book
- 1:30: Book
- 2:00: Open time
- 2:30 Book
- 3:00: Class (60 minutes)

A Day in the Life of a BHC

7:30: Attend huddle(s), touch base with PCP

8:00: Planned follow-up, diabetes self-management

8:30: Adult with depressed mood

9:00: Child with stomach pain who has had a full/clear medical workup

9:30: Slot not filled; complete remaining notes from earlier

9:45: Join PCP in exam room to assist patient in identifying support resources

10:00: (Started at 10:05): Initial appointment for stress related to work

10:30: Risk assessment for patient in acute distress

11:00: Initial appointment for pain

11:30: Adult with relationship concerns

12:00: Lunch

12:30: Planned follow-up, second appointment for insomnia

12:45: Interruption by medical administrative support regarding appointment scheduling for anxiety patient

1:00: Adult assessment to clarify attention problems in patient requesting ADHD medication

1:30: Planned follow-up on patient with PTSD

2:00: Warm handoff for anxiety symptoms

2:30: Planned follow-up for weight loss

3:00: Group: Living Well Class, teach and practice stress coping skills

4:00: PCP feedback, close out notes, and preappointment planning for next day

Note. BHC = behavioral health consultant; PCP = primary care provider; ADHD = attention-deficit/hyperactivity disorder; PTSD = posttraumatic stress disorder.

FIGURE 2.6. Provider Survey

A BHC can provide a broad range of services, including assessment, education, and brief intervention for your patients. To help ensure that I provide services that meet the needs of you and your patients, please complete the following survey.
In sections **B** and **C** below, use the following scale to rate your responses:

Never	Rarely	Sometimes	Often
1	2	3	4

	A. Please circle the number of any item below in which you are unclear on how a BHC can help or for which your confidence is low that a BHC can help.	B. How often in your practice do you see patients who present with the following problems?				C. When working with a patient with this problem, how often might you request assistance from a BHC?			
1	Mental health disorders (e.g., depression, anxiety/panic)	1	2	3	4	1	2	3	4
2	Subclinical emotional symptoms (e.g., sadness, worry, guilt)	1	2	3	4	1	2	3	4
3	Difficulties coping with stress	1	2	3	4	1	2	3	4
4	Marital problems	1	2	3	4	1	2	3	4
5	Child behavior problems	1	2	3	4	1	2	3	4
6	Other family problems	1	2	3	4	1	2	3	4
7	Chronic pain	1	2	3	4	1	2	3	4
8	Tension or migraine headache	1	2	3	4	1	2	3	4
9	Chronic insomnia	1	2	3	4	1	2	3	4
10	Grief and bereavement	1	2	3	4	1	2	3	4
11	Noncompliance with medication	1	2	3	4	1	2	3	4
12	Tobacco use (wanting to quit)	1	2	3	4	1	2	3	4
13	Tobacco use (not wanting to quit)	1	2	3	4	1	2	3	4
14	Overweight/obesity	1	2	3	4	1	2	3	4
15	Sedentary lifestyle impacting health	1	2	3	4	1	2	3	4
16	Stress-related medical conditions	1	2	3	4	1	2	3	4
17	Self-esteem issues	1	2	3	4	1	2	3	4
18	Unhealthy alcohol use	1	2	3	4	1	2	3	4
19	Drug abuse	1	2	3	4	1	2	3	4
20	Overutilization of health care	1	2	3	4	1	2	3	4
21	Coping with chronic/terminal illness	1	2	3	4	1	2	3	4
22	White-coat hypertension	1	2	3	4	1	2	3	4
23	Anxiety interfering with medical care	1	2	3	4	1	2	3	4

Please indicate by number the top five items or clinical areas above in which you would like to see services from the behavioral health consultant.

1. _____ 2. _____ 3. _____ 4. _____ 5. _____

Thank you for completing the survey. Please add any comments to the back of this form.

Note. BHC = behavioral health consultant.

FIGURE 2.7. Note Example (*continues*)

S/O

Chief Complaint: Depression
Referring Provider: Dr. Kevin Brown (PCP); feedback was provided to PCP.

History of Present Illness:

- Patient is a 32 y/o female. Source of information was self.
- Pt was given brochure describing PCBH services.
- Discussed with patient the PCBH model of service delivery including limits of confidentiality and the team-based, consultation approach to care. Pt indicated understanding and was seen in a 30-minute BHC appointment.

Health Habits:

OTC/Supplements/Vitamins: None
Medication Relevant to HPI: Prozac 20 mg
Caffeine: 24 ounces of coffee in AM
ETOH: 1 glass of wine 3 days a week
Nicotine: 1 pack of cigarettes a day; no desire to quit at this time
Physical Activity: Walks 30 minutes 2 days/week

Personal History: Social hx reviewed, med tech in hospital

Family History: Married 10 years, one child age 7 years

Description of Depressed Sx: Sad mood, tearfulness, trouble falling asleep, decreased interest, poor concentration, decreased libido

Duration of Depressed Mood: 2 years

Factors Related to Onset: Death of father, increased job stress

Frequency and Severity: Depressive sx daily, rated as a 6 (over last 2 weeks) on 0–10 scale with 0 being no sx and 10 being the most severe imaginable.

Course of Depression: Worse 2 years ago around time of father's illness and death. Sx improved a moderate amount after 6 months. Reported additional mild improvement since starting Prozac 6 months ago.

Hospitalized for Depression: No

Anyone suggested or you noticed mood seems unusually high at times? No

Psychosocial Factors: Death of father 2 years ago, work stress although resolving, supportive husband

Aggravating Factors: Worsened by staying in bed on weekends, withdrawing from friends/social activities

Alleviating Factors: Improved by doing fun activities with spouse and child

Current Tx: Prozac 20 mg for last 6 months

Past Tx: None
Review of Systems:

Systemic: Feeling tired (fatigued)
Gastrointestinal: Normal appetite
Neurological: No disorientation
Psychological: Sleep disturbance and loss of pleasure. A desire to continue living, not thinking about suicide, no plan or intent. No homicidal thoughts.

Physical Findings:
General Appearance:

Alert, well developed, well nourished, in no acute distress

Neurological:

OX4, no hallucinations, memory did not appear to be impaired, judgment seemed good
Speech: normal rate, appropriate tone and volume

FIGURE 2.7. Note Example (*continued*)

Psychiatric:

Demonstrated behavior: Good eye contact
Mood: Depressed
Affect: Constricted and congruent with mood
Thought process: linear, logical, and goal directed

BHM-20 Measure Scores:

Global Mental Health	2.80: Mild Distress
Well-Being Scale	1.33: Moderate Distress
Life Functioning Scale	2.00: Mild Distress
Symptoms Scale	3.38: Within Normal Limits
Anxiety Subscale	3.25: Within Normal Limits
Depression Subscale	2.33: Mild Distress
Alcohol/Drug Use Subscale	4.00: Within Normal Limits
Bipolar Subscale	4.00: Within Normal Limits
Eating Disorders Subscale	4.00: Within Normal Limits
Harm to Others Subscale	4.00: Within Normal Limits
Suicide Monitoring Scale	4.00: No Indication of Risk

PHQ-9 Measure Score: 16 Moderate Severity Level

Functional Impact: Accomplishing less at home (housework, yard work). Spending less time with family. Stopped seeing friends. Spending more time in bed on weekend. Denies significant impact on work functioning.

Depression Intervention:

[X] Provided patient education handout on depression
[X] Provided education on use of medications to treat depression
[X] Discussed factors related to development and maintenance of depression
[X] Discussed and set plan for behavioral activation

A/P

Depression: 32 y/o WF with depressive sx that started 2 years ago around time of father's death and increased work stress. Although grief response has improved and job stress is lower, pt continues to have sig sx of depression. Reports some improvement since starting Prozac 6 mos ago. Pt's sx likely maintained by social withdrawal and decreased rewarding activities. Pt interested in learning self-management skills for improving mood.
Depression recommendations for pt:

1. Continue Prozac as rx by PCP. Pt not interested in change/increase right now.
2. Read handout on increasing rewarding activities for mood management. Plan and do one enjoyable and one mastery activity per day; keep record on monitoring form.
3. Plan one social activity with friends each weekend.
4. On weekends get out of bed at 8 a.m. Eliminate naps.
5. F/u with BHC in 2 weeks.

Depression recommendations to PCP and team:

1. Encourage pt to follow plan above.
2. If sx do not improve in 6–8 wks discuss with pt whether modification in psychotropic meds is indicated.

Note. S/O = subjective and objective; PCP = primary care provider; Pt = patient; PCBH = primary care behavioral health; BHC = behavioral health care; OTC = over the counter; HPI = history of present illness; ETOH = ethyl alcohol; Hx = history; Sx = symptoms; Tx = treatment; OX4 = alert and oriented; BHM-20 = Behavioral Health Measure; PHQ-9 = Patient Health Questionnaire; A/P = assessment and plan; WF = White female; Rx = prescription; F/u = follow-up.

FIGURE 2.8. Additional Training (*continues*)

University of Massachusetts Certificate Course in Primary Care Behavioral Health (https://www.umassmed.edu/cipc/continuing-education/pcbh-certificate-course/)	"This course acknowledges the skills of specialty mental health clinicians and helps to translate prior knowledge and experience to the fast-paced, evidence-based, generalist culture of primary care. PCBH includes a range of topics from orientation to integrated behavioral health models, to specific health care issues like substance use and depression to cultural influences on health care. . . . The program consists of 22 pre-recorded e-learning modules that can be watched at any time and at your own pace; each takes about 1.5–2 hours to view and engage. PCBH is given four times each academic year, we collect completion data for CE/CME at the end of each session; you must finish the requirements of the course during the session you have registered for in order to receive CE/CME credit, you have access to all materials for one month after the semester deadline date." (paras. 1, 5–6)
University of Michigan Certificate in Integrated Behavioral Health and Primary Care (https://interprofessional.umich.edu/faculty/integrated-health-certificate-program/)	"This web-based interdisciplinary certificate is designed for clinicians—social workers, nurses, care managers, psychologists, and physicians—who deliver or plan to deliver integrated health services. Participants will gain assessment, intervention, and consultation skills; will learn how to apply these skills in the workplace; and will engage with a peer distance-learning community to practice new skills and share ideas." (para. 1) They offer a pediatric track, adult track, and combined pediatric adult track.
National Register of Health Service Psychologists (https://www.nationalregister.org/education-training/ihts/)	"The National Register created a training series to help position Health Service Psychologists as essential team members in integrated healthcare. There are 42 videos (more than 11 total hours) available on the National Register's continuing education site, CE.NationalRegister.org. These videos cover theory, models, and implementation as well as discussion of the medical, pharmacological, and psychosocial management of conditions that commonly present in integrated settings. Continuing education is awarded as the videos are completed. This training series includes a comprehensive review of clinical and administrative facets of integrated care: • **Key concepts** such as the behavioral healthcare consultation, the Triple Aim, reverse integration, and collaborating with medical personnel. • **Medical conditions** including hypertension, diabetes, cardiovascular disease, respiratory disease, arthritis, and obesity. • **Psychosocial conditions** including depression, ADHD, insomnia, chronic pain, trauma, and substance abuse. • **Healthcare overview** such as establishing and financing integrated care, EHRs and privacy, billing and coding." (paras. 1–6)

FIGURE 2.8. Additional Training (*continued*)

Society for Health Psychology (https://societyforhealthpsychology.org/training/integrated-primary-care-psychology-curriculum/)	"The course modules can be used/reviewed as a collection or separately depending on program needs or self-study participant interest. There are four foundation modules that set the stage for working in primary care. Eighteen topic modules related to specific patient behavioral health challenges and physical health conditions and the varied roles of integrated primary care psychologists along the prevention to intervention continuum, complete the curriculum. Each module includes PowerPoint lectures, notes, exercises, illustrative videos, resources, and references. Supplementary training manuals that elucidate key concepts and offer additional readings and resources accompany the modules. The curriculum was developed by a core group of nine primary care psychologists with vast experience working and training in integrated primary care. Some of the topic modules, such as working with older adults and managing chronic pain, were written by experts in particular subject areas in collaboration with the core team to ensure that they retained a foundation in primary care." (para. 2)
Collaborative Family Healthcare Association (https://www.cfha.net/about-us/)	"The Collaborative Family Healthcare Association (CFHA) is a multi-guild member association whose goal is to make integrated care the standard of care across the United States and beyond. For us, collaboration is not just a word in our name; it defines who we are, how we interact with each other and other organizations. We believe deeply that collaboration across professions is an essential element necessary for revisioning healthcare." (para. 1) Their annual conference offers a number of workshops and presentations focused on improving integrated behavioral health care skills. In addition, there is a Primary Care Behavioral Health Special Interest Group that offers year-round webinars.
Society of Behavioral Medicine (https://www.sbm.org/about)	"SBM is a nonprofit organization composed of researchers, clinicians, educators, industry professionals, and policy-makers from more than 20 healthcare disciplines. They focus on behavioral, psychosocial, environmental, and biomedical theory, knowledge, and interventions relevant to health and disease. SBM members conduct research on conditions such as cardiovascular diseases, respiratory diseases, obesity, diabetes, chronic pain, and cancer. They conduct research on specialty populations like children, women, veterans, aging adults, and minority groups. And they conduct research on clinical care and healthcare delivery, from in-person appointments to telemedicine and health apps. SBM members then use research findings to improve their own clinical practice and the lives of their patients. They also use research findings to improve public health policies and to make healthcare cheaper and fairer. They do this through individual work and in strategic partnerships with community groups, corporations, government entities, legislators, and other professional organizations." (paras. 3–5) There is an Integrated Primary Care Special Interest Group, which sponsors preconference and conference training on integrated behavioral health services.

Note. PCBH = primary care behavioral health; CE/CME = continuing education/continuing medical education; ADHD = attention-deficit/hyperactivity disorder; EHRs = electronic health records; SBM = Society of Behavioral Medicine.