ROCKY MOUNTAIN HEALTH PLANS®

HIRING AND ONBOARDING INTEGRATED BEHAVIORAL HEALTH PROVIDERS IN PRIMARY CARE

June 2019

Table of Contents

Introduction

If you are reading this, chances are that your practice has committed to embedding a behavioral health provider (BHP) within your primary care office. You recognize the benefits of including a professional who can contribute to whole-person care, and you have obtained buy-in from administrative leadership in adding this professional to your care team. However, it can be a bit daunting to move from conceptualizing this job role to actually embedding this new team member. Although primary care offices are well experienced in hiring various types of medical providers, clinical staff, and administrative staff, it can feel like uncharted territory hiring a behavioral health provider.

Common questions often include:

- What licensure and training qualifications should I look for in order to bill for services?
- How do I make sure a BHP candidate is a good fit to work in primary care?
- How can I make my recruiting offer as attractive as possible?
- How do I prepare patients, providers, and staff for the behavioral health provider to join our team?
- What are key steps in onboarding the new BHP?

Although this guide cannot answer every question, it is designed to provide practical tips for you to consider as you work towards actively hiring and onboarding an integrated BHP. Throughout, there will be various links to peer-reviewed articles, examples from other practices, and additional resources.

As an additional note, this guide will be most applicable to practices who are planning to hire a fully embedded, integrated behavioral health provider as an employee of their clinic. Some sections (e.g. key personal qualities to look for, preparing patients and staff members for a new team member) may also apply to practices planning to contract with a local community mental health center or other mental health practice to offer co-located care.

Support from Rocky Mountain Health Plans (RMHP)

RMHP's Practice Transformation Team is here to help. The team includes Quality Improvement Advisors (QIAs), Clinical Informaticists (CIs), and an Integrated Behavioral Health Advisor (IBHA) who have expertise in helping practices understand how to prepare care teams for staffing and workflow changes, as well as how to set up processes to adapt to changing needs of practices and patients over time. We work with primary care and specialty practices in structured practice transformation programs, as well as flexible offerings of consultative services. All services are at no cost to your practice.

For more information, contact your assigned QIA, CI, or IBHA. To connect with Practice Transformation for the first time, email **practice.transformation3@rmhp.org**.

Planning Phase

As a first step, we recommend that your practice enlist the support of a multidisciplinary hiring committee for an integrated behavioral health provider (BHP). Seek input from a variety of staff members since their day-to-day functions will inevitably change by adding this new type of team member. Invite providers and staff to join who may have a valuable perspective on qualities and skillsets that would be most beneficial, as well as those who have the charisma and trustworthiness to advocate for the importance of this role with patients, families, and other staff members. Key roles to consider include office managers, nursing staff, medical providers, care managers, medical assistants, and patient navigators.

Proposing Integration to Medical Providers

Nothing triggers a revolt faster among primary care teams than to mandate processes, models, or tools without securing buy-in and input early on in the process (**Corso, Hunter, Dahl, Kallenberg, & Manson, 2016**). Some providers quickly see the value of adding an integrated behavioral health provider to the practice, and others have viewpoints along the lines of "We could never afford that" or "Mental health issues aren't my business." **Corso and colleagues (2016)** recommended excellent points to consider as a preparation checklist for PCPs, including questions such as:

- What are your most costly chronic diseases?
- How much is patient non-adherence costing you financially? How much damage is it doing to your patients' health?
- What aspects of your patients' health could receive more attention if you had a behavioral health resource immediately accessible daily?

Corso and colleagues (2016) also included a sample provider survey, which you can use to gather input and highlight areas of agreement and potential resistance to integration.

Core Competencies of Integrated Behavioral Health Providers

Once you have secured buy-in from providers and key staff members, you will begin the work of crafting the role of an integrated behavioral health provider. Not surprisingly, the day-to-day work of an integrated BHP in primary care is vastly different than any other setting, especially a private or agency-based outpatient mental health practice. Primary care has a distinct culture and patient population that requires most traditionally trained behavioral health providers to adapt in order to quickly earn the trust of patients, families, staff, and providers and demonstrate effective patient outcomes. **Bischoff, Springer, Reisbig, Lyons, and Likcani (2012)** described important indicators of success for a BHP working in primary care. Integrated BHPs must develop (1) skills for working in a medical setting, (2) skills for working with patients, and (3) skills for collaborating with healthcare providers.

In 2016, the Colorado Consensus Conference, sponsored by the Eugene S. Farley, Jr. Health Policy Center, developed a set of **core competencies** for behavioral health providers working in primary care (Miller et al., 2016). These eight core competencies consist of:

1. Identifying and assessing behavioral health needs as part of a primary care team
2. Engaging and activating patients in their care
3. Working as a primary care team member to create and implement care plans that address behavioral health factors
4. Observing and improving care team functions and relationships
5. Communicating effectively with other providers, staff, and patients
6. Providing effective and efficient care delivery that meets the needs of the population of the primary care setting
7. Providing culturally responsive, whole-person, and family oriented-care
8. Understanding, valuing, and adapting to the diverse professional cultures of an integrated care team

There are several additional guild-specific competencies for working in healthcare settings, such as **family therapists working in healthcare settings**, **psychology practice in primary care**, or **social work practice in healthcare settings**.

However, the strength of the Farley Center's core competencies is that they are not limited to a singular behavioral health discipline and cover more over-arching concepts. Within these competencies, behavioral health providers must be able to address the continuum of health spanning from prevention to illness and disability as it changes across the lifespan. BHPs must also attend to health across multiple generations and within multiple cultural contexts, accounting for socioeconomic and health disparities. Rather than presenting a single plan of care for all patients with a certain disease or in a certain demographic category, care must be tailored to account for patient values and preferences, as well as available community resources.

In a literature review of provider- and practice-level competencies for integrated behavioral health in primary care, **Kinman, Gilchrist, Payne-Murphy, and Miller (2015)** also identified some specific skills that BHPs need to be able to perform to work successfully in primary care. Selected skills include:

- Quickly and efficiently identifying and assessing behavioral health needs through the use of evidence-based, brief screening tools and further evaluation of comorbidities, functional impairment, and severity of symptoms
- Selecting and administering a wide variety of brief, evidence-based therapies in conjunction with medications as appropriate
- Monitoring patient progress, documenting progress in the health record, and recognizing when treatments need to be modified over time
- Facilitating referrals to other specialists or community-based resources
- Refraining from using therapy jargon to communicate with staff on the patient care team and contributing to a shared language and set of values

Key Personal Qualities to Seek

In order for integrated BHPs to succeed in demonstrating these core competencies over time, there are some personal qualities that are highly recommended to look for in potential candidates. One of the most important qualities to look for is a team-based care mindset. This is often a major adaptation that integrated BHPs have to make as they transition out of traditional mental health settings, since traditional therapy training tends to emphasize the sacredness of the patient-therapist relationship and does not often include tangible focus on collaboration with other healthcare providers or community resources. The training and experience offered in the mental health field has a gap in the philosophy underlying integrated care, population health management, the Quadruple Aim, and the medical home model (**Corso et al., 2016**). This skill can absolutely be taught and practiced, as long as the integrated BHP believes in the value of practicing as part of a team. Some things that integrated BHPs can do to demonstrate a commitment to teamwork include:

- Taking an active role in clinic-wide quality improvement efforts (e.g. looking for ways to help improve clinical quality measures with a behavioral health component, like diabetes),
- Recognizing the impact of behavioral health processes on the clinic as a whole (e.g. the impact of a new screening tool on workflows for the front desk), and
- Gaining knowledge about key aspects of other staff members' jobs.

Primary care requires a fast-paced, action-oriented culture, and it is essential for BHPs to manage their time well. The spectrum of integrated behavioral health services includes juggling brief encounters with patients, co-visits with medical providers, and longer behavioral health visits. Behavioral health providers in primary care must know how to introduce themselves quickly, succinctly describe their role in providing care for the patient, and obtain proper informed consent while building rapport with the patient to maintain engagement (**Dobmeyer, Rowan, Etherage, & Wilson, 2003**). This requires warmth, openness, and flexibility with where and how to conduct sessions with patients and their families. As **Corso and colleagues (2016)** wrote, "You want people in your medical home who have an internal compass consistent with medical home concepts."

It is also important to assess whether integrated BHP candidates have the ability to assert themselves as an important member of the team. Although it takes time to feel comfortable in a new environment, especially in a clinic system new to embedding a BHP within the team, an effective BHP needs to succinctly and confidently demonstrate his/her value to other care team members, as well as to patients and family members. This requires the courage to be present (both mentally and physically) and speak up when appropriate, as well as a strategic understanding of how behavioral health needs fit within the larger picture of whole-person care and sustainable business management in primary care.

Corso and colleagues (2016) also identified "red flags" to avoid, such as rigidity, overconfidence, insistence on being right, self-aggrandizing, needing excessive time to prepare to perform optimally, difficulty adapting, and easily becoming defensive. They also recommended staying away from people who are very sensitive to power and authority, as well as those who do not take feedback well or assume too much responsibility for their patients. Individuals with these types of characteristics will likely struggle to thrive in a team-based primary care setting.

Inquiring about Prior Work Experience

One of the most significant limitations to progress within the field of integrated behavioral health is the lack of a trained workforce with primary care training and practical experience (**Hall et al., 2015**). Although there are benefits of hiring a BHP who has previously worked in a primary care office, this should not be considered an absolute requirement. In fact, some of the foundational skills (such as multidisciplinary collaboration, flexible thinking, adaptive responses, etc.) that are necessary for successful work in a primary care setting translate well in other settings (e.g. residential treatment, school systems, crisis response teams, etc.), and vice versa. BHPs transitioning from specialty mental health agencies to primary care will quickly learn that there are differences in organizational culture, population demographics, and goals of treatment. Gaining skills to work in primary care requires training in brief interventions, time to reflect on what works well or poorly in communicating with team members, and ample opportunities to practice interventions with a variety of patients with a variety of presenting problems.

Fortunately, these skills can be taught to willing, motivated learners, and there are a variety of regional and nationally offered trainings that can support the development of primary care counseling skills. If you are considering hiring a BHP who has limited prior experience working within primary care settings, consider carefully whether (1) you believe their prior experiences have provided them a foundation for meeting the competencies recommended in the above section and (2) they appear open to receiving ongoing training in integrated behavioral health skills in primary care. If so, they could be a great candidate.

De-Mystifying Licensure Types

It is important to keep in mind that licensure status should only be used as an introductory guide to understand the basic, generalist training the person received in graduate school and what they are qualified to do within their scope of practice as determined by the Colorado **Department of Regulatory Affairs (DORA)**, the agency that oversees mental health licensing for psychologists, social workers, marriage and family therapists, professional counselors, and registered psychotherapists.

In general, you will need to (1) hire a masters- or doctoral-level licensed mental health professional or (2) contract with a provisionally licensed or graduate student who is in the internship phase of his/her training and can be clinically supervised by a licensed mental health professional already working in your office. A variety of mental health workers, such as psychologists, couple and family therapists, professional counselors, and social workers are qualified to coordinate biopsychosocial, team-based care; assess mental health symptoms and diagnose disorders; and deliver evidence-based treatment to enhance patient engagement and promote adjustment to disease. Furthermore, many of these fields even include subspecialties that include additional training for providing mental health services in a biomedical setting, such as **health psychology**, **medical family therapy**, and **medical social work**. Some candidates may have completed a specific track during school or pursued a post-graduate certificate with a specialization in one of these sub-fields; this is helpful but not required for working in primary care.

Determining applicable licensure options for your behavioral health providers can seem confusing. There are many similarities between mental health professions. However, there are some differences between professional groups in terms of training emphasis, state requirements for number of direct patient contact hours accrued post-graduation, conceptualization of the change process and goals of treatment, and billing and reimbursement. In Appendix A, you will find a table with information to help you begin to consider which types of licenses may be most helpful to meet your patients' needs. For comparison, information including non-licensed health and wellness coaches and medical professionals such as psychiatric nurse practitioners is also included.

Selecting a Job Title

You have many options when determining the name for the position of a behavioral health provider. There is no standardized name for a professional who works in primary care to manage mental health disorders, helps patients make behavioral changes to better manage chronic disease across the biopsychosocial spectrum, and supports patients and families during acute illnesses. Common options for job titles include:

- Behavioral Health Provider (BHP)
- Behavioral Health Clinician/Consultant/Counselor (BHC)
- Behavioral Health Specialist (BHS)
- Behavioral Health Therapist (BHT)
- Integrated Health Counselor (IHC)
- Integrated Behavioral Health Specialist (IBHS)

As you are determining the best name for this new team member, you should consider your community culture and how that influences your patients' openness to discussing mental and behavioral health concerns in the context of primary care. For example, including the term "therapist" in the title may lead some patients to make an uncomfortable association between the role of your integrated behavioral health provider and a traditional community-based mental health therapist, so you may opt instead for a term including "consultant" to emphasize the role of this professional consulting with the rest of the team to contribute to comprehensive patient care or "provider" to emphasize that they are providing health services to patients and carry equal weight as medical providers in supporting whole-person care.

Crafting a Job Description

Many practices find it helpful to rely on tools such as core competencies and standards for clinical practice in healthcare settings (see prior section) to craft key functions to include in a job description. Your clinic is likely skilled at creating job descriptions for various primary care positions, so this serves as a good foundation. A few BHP-specific recommendations are included below.

Many practices are tempted to limit the applicant pool based on licensure type to ones they are more familiar with (often a licensed social worker (LCSW) or psychologist). Unless you have a very clear reason why you wish to limit accepted licensure types (e.g. majority of patients at practice covered by Medicare), we recommend remaining open to all types of licensure available for reimbursement in primary care (e.g. LCSW, psychologist, licensed professional counselor (LPC), and licensed marriage and family therapist (LMFT)) so you have the biggest pool of applicants from whom you can choose for interviews. This is especially important in rural communities with a greater shortage of licensed mental health providers.

It can also be helpful to review samples from other clinics for inspiration; examples include positions at the **Hope Clinic** and **Clinica Tepeyac**. The AIMS Center at the University of Washington also provides a **sample job description for a behavioral health care manager**, which could be an important support staff member to include on your integrated care team. **Corso and colleagues (2016)** also provided sample job descriptions for behavioral health providers and behavioral health directors. You can also ask RMHP's Practice Transformation Team (**practice.transformation3@rmhp.org**) for more local and regional examples.

Determining Staffing Ratios

One question practices often ask is "How big can a caseload be for an integrated behavioral health provider?" Due to the significant variation in program development – as well as financial and geographic recruiting limitations – practices utilize a wide array of staffing arrangements to meet their needs. In general, integrated BHPs who see patients less often (e.g. monthly as opposed to weekly) and for briefer interventions (e.g. 30 minute visits or during medical encounters as opposed to 60 minute visits) can carry a larger caseload of active patients, whereas those who offer more intensive services often have a reduced caseload capacity. Another factor that influences caseload capacity is the acuity of symptoms your integrated BHP will be targeting for treatment; BHPs who treat patients with higher acuity symptoms (thus, offering more frequent and intensive services) carry a smaller caseload than those who focus on preventive care and treating primarily patients with mild to moderate symptoms. This is a key decision point for your practice to consider in your planning efforts for hiring one or multiple integrated behavioral health providers.

There is no standard ratio of how many behavioral health providers to include in a system compared to the number of patients or providers. For example, one VA system recommended 1.0 full-time equivalent (FTE) BHP for every 2 medical providers, or 0.6 FTE BHP for every 1200 patients. Other clinics, perhaps with lower acuity of behavioral health symptoms in the patient population, find it preferable to aim for 1.0 FTE BHP for every 3 or 4 medical providers. **Corso and colleagues (2016)** suggested an integrated BHP can see up to 16 patients/day in a population ranging from 3000-10,000 patients.

Recruiting Phase

Now that you have planned your strategy, you are ready to begin sharing your job posting with others and conducting interviews to find the best candidate for the job.

Options for Job Postings

Your practice may already have a process in place to solicit applications from professionals using a variety of methods, such as an online job posting system where individuals can search for open positions and submit an application. These are reasonable options to post positions for behavioral health providers, and there are some additional ways to target specific groups that may work well for your practice in terms of recent training. One idea is to work with RMHP's Practice Transformation Team (**practice.transformation3@rmhp.org**) to establish contact with a university-based mental health counseling, social work, or psychology program in Colorado and ask them to share the link to the job posting with their alumni. Many universities maintain contact with their students and alumni through email in order to help connect them with jobs.

Another way to target trained mental health professionals is through various national professional organizations. There are a wide variety of organizations that provide professional development and networking opportunities for mental health professionals who wish to work in primary care. Many of these groups maintain an online discussion board where jobs can be posted, and some also have a regularly maintained listserv where jobs are shared within the group. Some of these organizations include:

- **Collaborative Family Healthcare Association (CFHA)**
- **Society of Teachers in Family Medicine (STFM) – Group on Family and Behavioral Health**
- **American Association for Marriage and Family Therapy (AAMFT)**
- **American Psychological Association (APA) – Society for Health Psychology (Division 38)**
- **National Association of Social Workers (NASW)**
- **American Counseling Association (ACA)**

Sample Interview Questions

Your practice likely already has a method for interviewing and selecting candidates to perform a wide variety of jobs within the primary care team. The following questions are not intended to replace those already included in your interview process to verify educational backgrounds and credentialing and determine fit for your organization. Rather, these can act as supplemental options to target core competencies of BHPs working in primary care. The language in most of the questions is drawn from behavioral interviewing techniques, which assumes that the best predictor of future behavior is past behavior in similar situations. The idea is to ask for specific examples demonstrating a quality or characteristic, which prevents the interviewee from just telling the interviewer what he/she wants to hear in a high-level, philosophical way. As the interviewee responds to questions, you can probe further for more depth by asking questions like, "Walk me through your decision process" or "Tell me more about that conversation the two of you had." The key is listening for details that add clarity to the story and support its accuracy.

Robinson and Reiter (2015) provided an excellent list of interview questions to consider. Appendix B includes an additional rubric for sample interview questions, which can help standardize scoring across potential job candidates and reduce unconscious bias when evaluating candidates' abilities to meet needs within primary care. Each question is linked to some of the core competencies for behavioral health providers working in primary care described briefly in the first section of this guide. This list is not exhaustive and is simply meant to provide your practice some initial ideas for interviewing questions. We recommend you consult a team of staff from all levels (medical providers, front and back office staff, other behavioral health staff if applicable, etc.) in finalizing your own interview guide and rubric as you search for the BHP who demonstrates the best fit for your office needs. In addition to using the rubric as a guide for determining the quality of interviewees' answers, we also recommend taking qualitative notes to support your assessment of responses.

Sample questions include:

- Tell me about a time when you worked with a team of providers and staff from various backgrounds to care for a patient. Provide a description of the team, your role, and the outcome.
- If you only had 15 minutes to spend with a patient with diabetes and marital problems, what would you do?
- Imagine that you are working with a Latino male patient in his 40s. His health history includes hypertension and type 2 diabetes. He recently lost his job as a mechanic, and he reports feeling depressed most of the time and having racing thoughts when he tries to sleep at night. He and his wife are arguing more than usual about how to care for their aging parents. How you would assess the symptoms and needs of this patient and craft a care plan to intervene?
- Imagine you are working with a patient who is in her late twenties with no chronic medical conditions. She lives alone and holds a full-time job at a restaurant. During her annual well woman exam, she disclosed to her physician that she has a history of childhood physical and sexual abuse and consumes 4-5 alcoholic drinks most nights and smokes marijuana regularly "to chill out." The physician has asked you to meet with the patient and recommend a treatment plan. What factors would you consider in deciding what services you and/or your team members could provide in the primary care office and what might be better to refer out to a community partner?
- Tell me about a time when you worked with a patient who was previously unengaged in his/her health care. What strategies did you use to help him/her understand how behavioral health factors contribute to overall health and elicit motivation from him/her to make changes.
- Provide an example of a time when you and another team member disagreed about the best course of action in caring for a patient. What did you do to resolve the situation, and what outcome did this have for the patient and your relationship with the team member?
- *(Optional question if interviewee does not have prior experience working in primary care)* Transitioning into working in a primary care setting can be challenging in many ways. How do you anticipate preparing yourself to adapt to this new environment?

Creating an Offer Package

A careful financial analysis of expected revenue and costs associated with an integrated BHP position – as well as a market analysis of similar roles in the region –can support you in determining an appropriate starting salary range.

Additional factors to consider that could enhance the attractiveness of your offer include:

- Funding and time away from work to support continuing education (e.g. conferences, specialized certification) since licensed behavioral health providers have requirements for ongoing education tied to their licensure
- Funding to support membership in high-quality professional organizations of the BHP's choosing
- Opportunities to earn additional financial incentives based on performance towards specified metrics (e.g. clinical quality measures (CQMs), productivity)
- Benefits such as health insurance, paid time off work, sick time, retirement savings, etc.

Onboarding Phase

Once you have successfully recruited the candidate you determine to be the best fit for your clinic, many clinics wonder what they can do (a) before the integrated BHP arrives for their first day and (b) how to provide on-the-job training, especially if this is going to be the only integrated BHP onsite. As **Corso and colleagues (2016)** wrote, "Your BHPs need what your PCPs need, not in terms of equipment, but in terms of leadership support, inclusion in all clinic issues and priorities, and administrative support at the clinical level" (p. 26-27). In the following sections, you will find options to consider related to a variety of topics, as well as a sample onboarding checklist in Appendix C.

Preparing Patients for IBH

It will take time for the integrated BHP to fill their schedule, so marketing on the front end is important to ensure patients know about this important clinic change. How do you plan to let patients know you have added this service (or a new provider, if integrated behavioral health has been an existing service)? Ideas include:

- Updating your website
- Sending out a letter to patients through the postal mail, email, or patient portal (see **example** from Western Medical Associates)
- Including a flyer in exam rooms and the check-out area (see **example** from Western Medical Associates)
- Updating advertisements in the waiting room (e.g. flyer, television ad, etc.)

Another idea is to discuss the topic of integrated behavioral health at a patient family advisory council (PFAC) meeting. It would be ideal to have the integrated behavioral health provider join for this PFAC meeting, but it also could be done in preparation for the behavioral health provider arriving. This serves the purpose of soliciting feedback from patients and families engaged with the practice. Some sample questions for PFAC members could include:

- What are the best methods for us to advertise this new service?
- Our initial plan for scheduling appointments with the integrated BHP is _____. How does that sound to you?
- What tips do you have for providers and staff as they introduce the availability of our integrated BHP to patients? Any wording you would recommend using or not using?
- What tips do you have for how our integrated BHP can help coordinate referrals to other behavioral health providers in the community when that is needed?

Preparing Providers and Staff for IBH

It is also an essential step to train providers and staff members. Some will be familiar with what "integrating behavioral health into primary care" means, and others may have a very limited understanding of behavioral health beyond well-known mental health conditions like depression and anxiety. There may be biases and assumptions that need to be addressed, and training should be sensitive to the likelihood of behavioral health issues having a personal connection to staff members and providers.

Buy-in from providers and staff for integrated behavioral health is absolutely essential to the success of the integrated BHP in your practice. It cannot be bypassed for long-term success and sustainability. Take a moment to consider:

- Who are the providers and staff who are likely to be champions for this cause? How can you leverage their support in getting others on board?
- Who are the providers and staff who may be hesitant about this change? What are the reasons for their hesitation? (If you don't know…ask!) How can you frame integrated behavioral health in terms of what they value?

It is likely that the team will have many questions about how adding an integrated BHP will change their workflows. Provide ongoing opportunities to discuss these changes, solicit feedback from the team on what is working and what is not, and celebrate small wins along the way. Consider the following ways to provide training for providers and staff members:

- A lunch-and-learn for providers on the generalist role of integrated BHPs, best practices for conducting warm hand-offs and co-visits, and the referral process
  - Examples of helpful handouts could include a **PCP's Guide to Using a BHC** or **Grand River's MA/Provider Cheat Sheet**
- A lunch-and-learn or breakfast for staff members on their role in advocating for integrated BH in the practice, responding to common questions patients may have, and
  - Examples of helpful handouts could include this **sample FAQ guide** for staff from Western Medical Associates or this **handout** for staff education on the role of the BHP
- Including the integrated BHP in Quality Improvement (QI) team meetings
- Inviting the BHP to shadow various staff members (e.g. front desk, MAs, medical records, call center) and providers for a few hours at a time to learn what a "day in the life" looks like for each role

We recommend providing a regular forum for providers and staff to receive education about integrated behavioral health concepts and give feedback on the process so adjustments can be made, as opposed to a one-time event when the BHP is first hired. Consider inviting the BHP to host lunch-and-learns on requested topics such as diffusing difficult situations with patients in exam rooms, quick tips for anxiety management, working with patients with personality disorders, recommendations for managing chronic pain, and more.

Updating Clinic Documents & Processes

There are several documents you will want to make sure you have up-to-date and ready to implement before the integrated behavioral health provider begins seeing patients, including adjusting your general consent to treat paperwork for the clinic to reflect the fact that you have a multidisciplinary team and patients may be referred to an integrated behavioral health provider. Your practice may find it beneficial to review samples of integrated behavioral health policies, such as those from the **Department of Defense (DOD)**, in order to adapt them to your own needs. Standard operating procedures (SOPs) for integrated behavioral health, or a clinical practice manual, is an important structural document for IBH service delivery in primary care (**Corso et al., 2016**). According to **Corso and colleagues (2016)**, a comprehensive SOP would include the following:

- Guidelines, goals, and objectives
- Roles and responsibilities of the integrated care team
- Training program overview
- Clinical activities
- Administrative procedures

A more detailed list of subsections is available in the book **Integrating Behavioral health into the Medical Home: A Rapid Implementation Guide**. An easily modifiable sample practice manual is available from the **Patient Centered Primary Care Institute** (PCPCI).

In addition, it is important to have a clear process documented for identifying patients that could benefit from behavioral health intervention and streamlining the referral process. Many practices choose to use their referral tracking system in the electronic health record (EHR) to ensure they "close the loop" when the referral has been completed and are able to track metrics related to related. Furthermore, licensed BHPs are required to complete a mandatory disclosure statement when they provide integrated behavioral health services; see this **example** from Western Medical Associates.

You will also need to decide how closely you will align no-show penalties, cancellations, and payment for services with those expectations for medical services at the clinic. This varies practice by practice and should be communicated clearly to patients.

Supporting Professional Development & Networking

Professional development is an essential component in ensuring the success of your integrated BHP. Particularly if he/she is the only integrated BHP in the clinic, interaction with other integrated BHPs is essential in offering support, troubleshooting, and connection to practical resources (e.g. sharing workflows).

RMHP is deeply invested in professional development for integrated BHPs, and sponsored opportunities include:

- Regional networking meetings for integrated BHPs in primary care that meet once/quarter in Grand Junction, Durango, Glenwood Springs, and Montrose
- Annual behavioral health skills training
- Additional advanced practice conferences including topics related to integrated behavioral health
- Face-to-face and virtual access to an Integrated Behavioral Health Advisor who has years of experience providing integrated behavioral health services and has coached over 40 practices in Western Colorado
- Resource guides & toolkits on a variety of topics related to IBH

A few additional opportunities for training and professional development include:

- **The Collaborative Family Healthcare Association (CFHA)**
- **Denver Health Integrated Behavioral Health (IBH) Academy**
- **Primary Care Shrink YouTube channel**
- **Community Health of Central Washington YouTube channel**
- **PCPCI's Primary Care Behavioral Health (PCBH) Implementation Kit Library**
- **University of Massachusetts Medical School Center for Integrated Primary Care**

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Appendix A: Comparison of Licensure Types

Job Role	License	Training/Education	Typical Job Functions	Practice & Billing Notes
Psychiatric Medication Prescribers	Psychiatrist	Medical school, residency in psychiatry **Licensed medical doctor, board certified in psychiatry*	• Assessing & diagnosing mental health conditions & neuropsychological disorders • Prescribing & managing psychiatric medications • Collaborating with other healthcare professionals	Generally eligible for reimbursement from: • Medicare • Medicaid • Private insurers
	Advanced Practice Registered Nurse (APRN) – Psychiatric/ Mental Health Focus	Masters degree (MSN) or doctoral degree (DNP) in Nursing **Nurse practitioner or clinical nurse specialist*	• Taking health histories & completing physical exams • Diagnosing & treating acute & chronic illnesses • Prescribing & managing psychiatric medications • Providing health teaching & supportive counseling	Generally eligible for reimbursement from: • Medicare • Medicaid • Private insurers
Behavioral Health Provider (BHP) / Behavioral Health Consultant (BHC)	Licensed Psychologist (PSY)	Doctoral degree (PhD, PsyD, EdD) in Clinical Psychology or Counseling Psychology	• Assessing & diagnosing mental health conditions & neuropsychological disorders • Non-prescription therapeutic interventions • Coordinating with community partners	Generally eligible for reimbursement from: • Medicare • Medicaid • Private insurers
	Psychologist Candidate (PSYC)	Doctoral degree (PhD, PsyD, EdD) in Clinical Psychology or Counseling Psychology **Post-graduation, working towards full PSY licensure*	• Providing PSY services (see above) under clinical supervision	
	Licensed Clinical Social Worker (LCSW)	Masters (MSW) or doctoral degree (DSW, PhD) in Social Work	• Assessing & diagnosing mental health conditions • Non-prescription therapeutic interventions • Case management services • Discharges, referrals, & continuity of care planning	Generally eligible for reimbursement from: • Medicare • Medicaid • Private insurers
	Marriage & Family Therapist (MFT)	Masters (MA, MS) or doctoral degree (PhD) in Marriage & Family Therapy	• Assessing & diagnosing mental health conditions • Non-prescription therapeutic interventions • Unique focus on engagement with community & family systems	Generally eligible for reimbursement from: • Medicaid (including SBIRT) • Private insurers

Job Role	License	Training/Education	Typical Job Functions	Practice & Billing Notes
Behavioral Health Provider (BHP) / Behavioral Health Consultant (BHC)	*Marriage & Family Therapist Candidate (MFTC)*	Masters (MA, MS) or doctoral degree (PhD, DMFT) in Marriage & Family Therapy **Post-graduation, working towards full MFT licensure*	• Providing MFT services (see above) under clinical supervision	
	Licensed Professional Counselor (LPC)	Masters (MA, MS) or doctoral degree (PhD, EdD) in Counseling	• Assessing & diagnosing mental health conditions • Non-prescription therapeutic interventions • Coordinating with community partners	Generally eligible for reimbursement from: • Medicaid • Private insurers
	Licensed Professional Counselor Candidate (LPCC)	Masters (MA, MS) or doctoral degree (PhD, EdD) in Counseling **Post-graduation, working towards full LPC licensure*	• Providing LPC services (see above) under clinical supervision	
	Licensed Addiction Counselor (LAC)	Addiction counseling training OR masters or doctoral degree in behavioral health discipline	• Perform services for non-prescription treatment of primary SUD diagnosis (clinical evaluation, treatment planning, service coordination with other providers, case management, etc.) • Independently conduct individual or group counseling sessions • Provide clinical supervision for LACs, CACs, or other mental health professionals in area of SUD	** Few practice in primary care setting (due to **42 CFR Part 2**) unless dually credentialed but likely to see credentials when coordinating care with specialty mental health treatment for substance use disorders (SUD)*

Job Role	License	Training/Education	Typical Job Functions	Practice & Billing Notes
Behavioral Health Provider (BHP) / Behavioral Health Consultant (BHC)	*Certified Addiction Counselor I*	CAC training OR masters or doctoral degree in behavioral health discipline **may be working towards CAC II, CAC III, or LAC*	• Perform services for treatment of primary SUD diagnosis (see above) • Co-facilitate individual or group counseling with CACII, CACIII, or LAC	• Must practice in facility licensed by Office of Behavioral Health to provide SUD treatment & under supervision of physician or other licensed practitioner with addiction treatment credentials ** Unlikely to practice in primary care setting (due to **42 CFR Part 2**) unless dually credentialed but likely to see credentials when coordinating care with specialty mental health treatment for substance use disorders (SUD)*
	Certified Addiction Counselor II	CAC training OR masters or doctoral degree in behavioral health discipline **may be working towards CAC III or LAC*	• Perform services for treatment of primary SUD diagnosis (see above) • Independently conduct individual or group counseling sessions	
	Certified Addiction Counselor III	CAC training OR masters or doctoral degree in behavioral health discipline **may be working towards LAC*	• Perform services for treatment of primary SUD diagnosis (see above) • Independently conduct individual or group counseling sessions • Provide clinical supervision for ACAs & ACBs	
	Registered Psychotherapist	*Unlicensed person whose primary practice is psychotherapy (may be a student in internship phase for a graduate degree or someone who does not plan to pursue licensure but wishes to offer basic counseling)*	• Non-prescription therapeutic interventions • Referrals with community partners	
Health Educator / Health Coach / Wellness Specialist	*No license required, but there are certifications available (e.g. **National Society for Health Coaches**)*	Variety of backgrounds, including RN, LPN, MAs, etc	• Individualized coaching to promote self-management • Managing care for lower-risk patients with chronic conditions • Facilitating groups & classes for wellness & prevention of health problems	

NOTE: This information is intended to be general in nature & to help differentiate between major skill sets, educational experiences, & revenue generating capabilities of various licensed mental health providers. Beyond credentialing, strong consideration should be given to individuals' unique clinical experiences & personal strengths when hiring a new provider & integrating them into the practice organization. Questions about billing should be directed to payers.

Appendix B: Sample Interview Guide

Question: Tell me about a time when you worked well with a team of providers and staff from various backgrounds to care for a patient. Provide a description of the team, your role on the team, and the outcome.

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 3, 4, 5, 8).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Communicated answer in a scripted way and/or failed to provide a clear example demonstrating a time when he/she worked as a team to provide patient care.		Described a clear story related to team-based care, but the story focused on the efforts of one or two individuals as opposed to an entire care team.		Described a clear story related to team-based care, and the telling of the story demonstrated a clear respect for the skills and contributions of each team member.	
Did not actively seek or inappropriately sought support and input from team members concerning how to address behavioral health needs of patient as part of comprehensive treatment plan.		Actively and appropriately sought support and input from team members concerning how to address behavioral health needs of patient as part of comprehensive treatment plan.		Sought input from multiple team members and demonstrated a sincere belief that quality patient care requires coordination and teamwork. Recognized team processes that contributed to the outcome.	
Demonstrated a prioritization of his/her own goals over those of the team.		Prioritized teams' goals and patients' goals over personal goals and used shared decision-making.		Demonstrated an understanding that effective, flexible team-based care plays a role in patient satisfaction and safety, as well as the personal and professional wellbeing of the care team.	
				Total in this Section:	

Qualitative Notes:

Question: Imagine that you are working with a Latino male patient in his 40s. His health history includes hypertension and type 2 diabetes. He recently lost his job as a mechanic, and he reports feeling depressed most of the time and having racing thoughts when he tries to sleep at night. He and his wife are arguing more than usual about how to care for their aging parents. How you would assess the symptoms and needs of this patient and craft a care plan to intervene?

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 1, 6, 7).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Primarily focused on conditions and risk factors either primarily biomedical or psychological in nature, or he/she failed to demonstrate an understanding of factors typically addressed in primary care.		Recognized a variety of biomedical and psychological conditions and risk factors relevant within primary care, but he/she neglected to mention social and cultural components contributing to patient care.		Presented a clear understanding of the ways in which biomedical, psychological, and social health are intertwined within relational and cultural context.	
Seemed unsure of his/her role in meeting these needs OR recognized ways in which he/she could use traditional therapy skills in meeting patients' needs but did not emphasize the need to tailor these skills to a primary care setting.		Demonstrated basic understanding of how therapeutic skills must be adjusted for work within primary care but did not describe how to tailor to patients' cultural and sociodemographic needs.		Clearly described his/her role in helping to work with a team of practitioners to meet patients' needs across the biopsychosocial spectrum, within the context of culturally informed and family-centered care.	
Demonstrated lack of knowledge about specific measurements to identify common problems in primary care (e.g. depression, anxiety, suicidal ideation, disruptive child behaviors, etc.)		Demonstrated awareness of evidence-based measurements to identify common problems in primary care but did not describe how to intertwine with other forms of data.		Identified a comprehensive, ongoing approach to assessment that incorporates evidence-based measurements across the biopsychosocial spectrum with clinical interviews.	
				Total in this Section:	

Qualitative Notes:

Question: Imagine you are working with a patient who is in her late twenties with no chronic medical conditions. She lives alone and holds a full-time job at a restaurant. During her annual well woman exam, she disclosed to her physician that she has a history of childhood physical and sexual abuse and consumes 4-5 alcoholic drinks most nights and smokes marijuana regularly "to chill out." The physician has asked you to meet with the patient and recommend a treatment plan. What factors would you consider in deciding what services you and/or your team members could provide in the primary care office and what might be better to refer out to a community partner?

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 1, 3).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Conveyed a sense of "black and white" thinking without an appreciation for the nuances of emergent situations.		Displayed a limited understanding of unique circumstances (related to patients, resources, setting, etc.) which may change the course of action on a case-by-case basis.		Demonstrated significant awareness of times in which a specific protocol is useful and times in which contextual factors must be taken into account.	
Described either a scope of practice that was either too broad (indicating a lack of professional humility and knowledge of scope of practice) or too narrow (indicating a lack of confidence in one's abilities).		Demonstrated basic awareness of his/her own skillset and how to apply that to patients but did not always demonstrate accurate awareness of others' roles in order to make the most appropriate referrals.		Clearly described the general services able to be delivered by professionals from a wide variety of backgrounds, including him/herself and others within and outside clinic staff.	
				Total in this Section:	

Qualitative Notes:

Question: Tell me about a time when you worked with a patient who was previously unengaged in his/her healthcare and how you were able to help them understand behavioral health factors contributing to their health and elicit motivation from them to make changes.

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 2, 3, 7).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Did not provide a clear description of the purpose and process of behavioral health involvement or an assessment of factors contributing to this lack of engagement.		Described the rationale and process for behavioral health in patient-friendly language but did not address how interventions targeted specific patient fears or hesitations.		Conveyed a clear description of the "what and how" of integrated care and provided clear education about behavioral health conditions in a way that accounted for the patient's age and cultural background and was tailored to specific concerns of the patient.	
Maintained unrealistic expectations, either too high or too low, of the patient.		Established clear and realistic expectations for the patient's change process, based upon the patient's initial readiness to change.		Maintained personal realistic expectations for the patient and worked with other members of the care team to do the same.	
Failed to address contextual factors beyond those of traditional mental health influencing the patient's lack of engagement.		Described biomedical, psychological, and social problems contributing to the patient's lack of engagement, but did not specifically address the interrelationships between these factors.		Conveyed a deep, compassionate understanding of how biomedical, psychological, and social components were intertwined in preventing this patient from engaging in his/her own healthcare more.	
				Total in this Section:	

Qualitative Notes:

Question: Provide an example of a time when you and another team member disagreed about the best course of action in caring for a patient. What did you do to resolve the situation, and what outcome did this have for the patient and your relationship with the team member?

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 3, 4, 5, 8).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Demonstrated avoidance of discussing the problem with the team member or if communication did occur, it was unclear, lengthy, vaguely worded, or poorly timed.		Demonstrated effective and respectful communication techniques (clear, concise, timely, focused on relevant issues) with team member.		Demonstrated effective and respectful communication techniques by using communication resources most appropriate to the situation (e.g. face-to-face communication, shared health records, etc.)	
Used disrespectful words or body language to describe points of agreement or interactions with the team member.		Conveyed points of disagreement in a respectful manner.		Clearly described points of disagreement and respectfully acknowledged both parties' perspectives, being sensitive to power differentials in a clinical setting.	
Demonstrated lack of regard for differences in professional training or ethical standards across various disciplines		Conveyed baseline knowledge of ethical standards and areas of emphasis in training from multiple disciplines.		Conveyed an understanding of the nuances of professional roles and responsibilities in a multidisciplinary team and how that contributed to areas of disagreement.	
				Total in this Section:	

Qualitative Notes:

<u>Optional question if interviewee does not have prior experience working in primary care</u>: Transitioning into working in a primary care setting can be challenging in many ways. How do you anticipate preparing yourself to adapt to this new environment?

This question assesses skills related to Core Competencies for BHPs working in Primary Care, prepared from the Colorado Consensus Conference (competencies 4, 8).

Below Expectation	Slightly Below Expectation	Meets Expectation	Slightly Above Expectation	Exceeds Expectation	Score
0	1	2	3	4	
Demonstrated lack of interest in adapting personal style to working in primary care or belief that no skills from previous training or positions are transferable to work in primary care.		Recognized need to adapt work style to meet patient needs while building confidence and comfort in working in primary care culture with medical providers.		Conveyed willingness to adapt work style to primary care culture and communication with medical providers and expressed plan to engage fellow team members at the clinic in learning more about clinic culture.	
Presented poorly defined areas of primary care-relevant content requiring additional or did not mention a plan for gaining knowledge about these topics.		Identified clear areas of growth and learning that primarily focused on clinical conditions commonly treated in primary care and specified a broad plan for gaining knowledge in these areas.		Presented a clear, proactive plan (e.g. seeking mentorship, self-learning opportunities, continuing education courses, regional or national training programs, etc.) to increase knowledge of clinical, operational, and financial components of primary care.	
				Total in this Section:	

Qualitative Notes:

Appendix C: Sample Onboarding Checklist

Developing Program Vision

- ☐ Solicit feedback from providers and staff
- ☐ Solicit feedback from Patient and Family Advisory Council (PFAC), if applicable

Advertising Integrated Behavioral Health (IBH) Program

- ☐ Update website
- ☐ Create flyers to post in waiting room and exam rooms
- ☐ Send out letter to patients about new behavioral health provider (BHP)

BHP Credentialing and Contracting

- ☐ Contact payers to begin credentialing process for integrated BHP
- ☐ Contact payers to ensure behavioral health codes are in contract

Consent Paperwork

- ☐ Update clinic consent-to-treat paperwork to mention multidisciplinary team including integrated BHP
- ☐ Create/update mandatory disclosure form for IBH visits
- ☐ Determine process for completing mandatory disclosure forms and train staff accordingly

Behavioral Health Documentation

- ☐ Create templates in electronic health record (EHR) for behavioral health visits, warm hand-offs, and co-visits
- ☐ Train BHP on factors distinguishing between progress notes and psychotherapy notes

Behavioral Health Scheduling

- ☐ Determine appropriate mix of scheduled vs. unscheduled time to allow for warm hand-offs and care coordination duties
- ☐ Determine who will be responsible for scheduling BH appointments (BHP vs. front office staff)
- ☐ Ensure patients are receiving reminder phone calls for BH appointments

Adjusting Clinic Space

- ☐ Determine where behavioral health visits will be conducted and how this will affect clinic flow
- ☐ Make adjustments to physical space, as needed

Embedding the BHP in Clinic Culture

- ☐ Schedule time for BHP to shadow staff members and provider in clinic
- ☐ Schedule time for BHP to meet with staff to answer questions about role
- ☐ Schedule time for BHP to meet with providers to answer questions about role
- ☐ Include the BHP in Quality Improvement (QI) team meetings, as applicable
- ☐ Include the BHP in daily huddles & routine care management meetings
- ☐ Determine in-office communication strategies (e.g. instant messaging, text messaging, pagers, etc.) for quick access to BHP during medical encounters

Behavioral Health Resources

- ☐ Schedule time for BHP to gather knowledge about key referral partners & social service agencies (especially if new to local area)
- ☐ Schedule time for BHP to build “toolbox” of common screeners, handouts, etc.

Behavioral Health Referral Tracking

- ☐ Determine process for referring to integrated BHP & train staff accordingly
- ☐ Develop method for determining when to offer integrated BH services vs. when to refer out to specialty behavioral health provider
- ☐ Gather data on behavioral health referrals & track gaps

Program Monitoring

- ☐ Determine what types of process and outcome metrics are helpful and feasible to track for program evaluation purposes

BHP Professional Development

- ☐ Consider online formal and informal training options in integrated behavioral health
- ☐ Consider local, regional, and national training options in integrated behavioral health
- ☐ Connect BHP with RMHP's Integrated Behavioral Health Advisor by emailing your Quality Improvement Advisor, Clinical Informaticist, or practice.transformation3@rmhp.org
- ☐ Support BHP in attending quarterly networking meetings sponsored by RMHP's Practice Transformation Team
- ☐ Support BHP in attending relevant learning collaboratives sponsored by RMHP's Practice Transformation Team (e.g. Behavioral Health Skills Training, Advanced Practice Conference, etc.)

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