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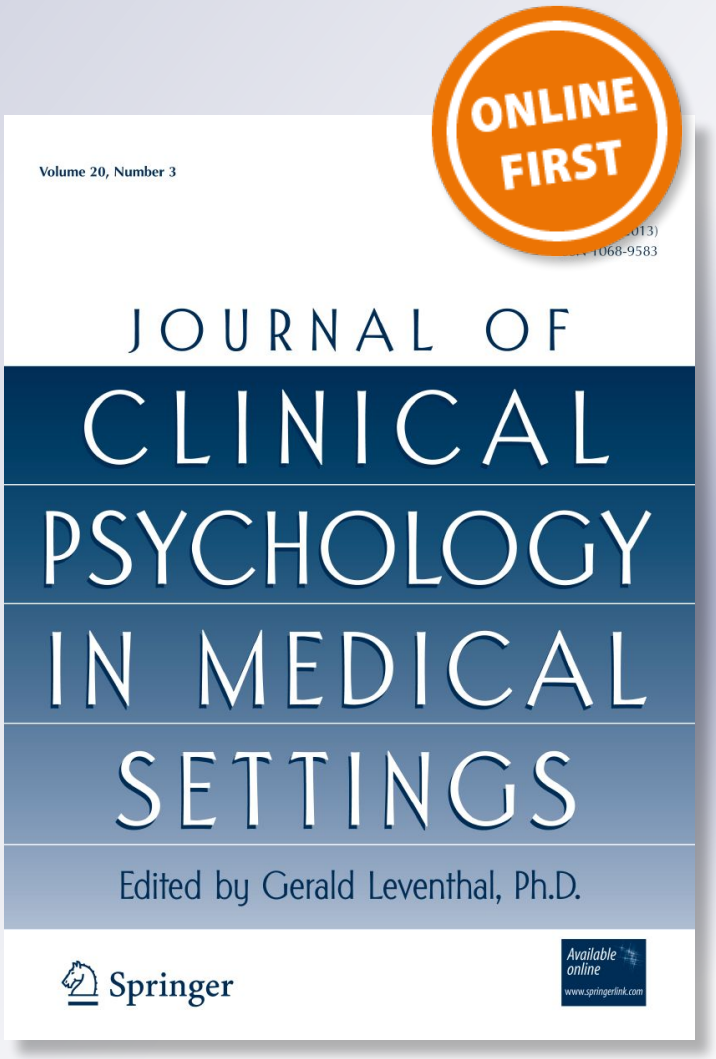

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Creating a Primary Care Workforce: Strategies for Leaders, Clinicians, and Nurses

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Abstract
Many primary care clinics struggle with rapid implementation and systematic expansion of primary care behavioral health (PCBH) services. Often, an uneven course of program development is due to lack of attention to preparing clinic leadership, addressing operational factors, and training primary care providers (PCPs) and nurses. This article offers competency tools for clinic leaders, PCPs, and nurses to use in assessing their status and setting change targets. These tools were developed by researchers working to disseminate evidence-based interventions in primary care clinics that included fully integrated behavioral health consultants and were then used by early adaptors of the PCBH model. By deploying these strategies, both practicing and teaching clinics will take a big step forward in developing the primary care workforce needed for primary care teams, where the behavioral health needs of a patient of any age can be addressed at the time of need.

Keywords Primary care behavioral health · Primary care leadership · Physician training · Nurse training · PCBH leadership competency · PCBH primary care provider and nurse competencies

Introduction

A sea change for the practice of primary care is occurring. On the horizon is a primary care system that includes behavioral health services as a part of routine good health care. In the primary care behavioral health (PCBH) model (Robinson & Reiter, 2007, 2015), the behavioral health consultant (BHC) is a fully integrated member of today's health care team. The BHC is optimally positioned within the healthcare landscape to deliver evidence-based behavioral health interventions to address the biological, psychological, and social needs of primary care patients of any age. The waves of this change have been rolling in for decades, first with the work of pioneers (Katon et al., 1996; Robinson, 1998; Strosahl, 1996a, b) and then later with the widespread implementation of the patient-centered medical home (PCMH) concept (Agency for Healthcare Research and Quality, 2014). Because of both the demonstrated and expected benefits of PCMH team inclusion of BHCs, healthcare funders are beginning to offer rich incentives to PCMH sites that offer BHC services (e.g., Health IT Analytics, 2016). Even as healthcare system, waters become favorable for BHC services, many primary care clinic leaders find the initiation and expansion of PCBH model services challenging. Clinic leaders may be confused about models of integration and may lack information about the impact of full behavioral health integration on patient outcomes. Developing a new business model is, of course, an on-going concern for leaders. Perhaps one of the greatest barriers to optimal integration is the lack of primary care providers (PCPs) and nursing staff who are trained to partner with a BHC.

This purpose of this article is to offer guidance to clinic leaders who are working to create a PCBH model-prepared

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workforce and to medical providers who want to develop their competencies for integrated care. Serrano, Cordes, Cubic, and Daub (2017) addressed behavioral health workforce development recently; therefore, we do not address this area in this article. We provide tools that define the new competencies that clinic leaders, PCPs, and nurses need to learn to practice effectively in a clinic implementing the PCBH model. Additionally, we suggest strategies for making operational changes and providing training necessary to build competence. We conclude with two brief reports from multi-site primary care systems that highlight lessons learned about workforce development.

The tools and strategies grow from our collective research, clinical work, management, leadership, consultation, and teaching experiences over the past 30 years. Throughout this article, we integrate the best scientific evidence with our combined practical clinical experience to ensure clinic leaders, PCPs and nurses have the knowledge and skills needed to push the wave of behavioral health integration forward. This wave can lead to primary care health services that routinely deliver evidence-based biopsychosocial interventions to primary care patients at the moment a need is identified. One of the best ways to ensure that those needs are met immediately is with the PCBH model of behavioral health integration.

The PCBH Model

The PCBH model defines the BHC as a fully integrated member of the primary care team. The model was originally defined by Robinson and Reiter (2007, 2015), and, for this special edition of the *Journal of Clinical Psychology in Medical Settings*, Reiter, Dobmeyer and Hunter (2017) created a definition, which is completely consistent with the more detailed definition offered by Robinson and Reiter. A recent review of 29 studies on the PCBH model found that it shows promise as an effective population health approach to behavioral health service delivery and that it is associated with positive patient and implementation outcomes (Hunter et al., 2017).

The BHC brings new services to primary care patients, PCPs, and nurses. In a variety of ways, BHC work mirrors that of the PCP's and nurse's, including accessibility, continuity, and coordination. BHC chart notes are considered as primary care notes and entered into the medical record. PCPs and nursing staff can easily see, support and eventually implement the basic interventions started in BHC visits. Evidence-based behavioral, cognitive, and motivational interventions figure prominently in BHC services. The design and delivery of BHC services are influenced by two over-arching goals. The first goal is to help patients learn to be more effective in managing and/or improving their biological, psychological, and social health. The second goal is to help PCPs and nurses learn to implement effective biopsychosocial assessments and interventions in primary care.

Improving Patient Functioning

Patients learn new skills from the BHC in individual or group visits. The BHC offers workshops, educational class series, and/or group medical services (e.g., group appointments led by the BHC alone or in co-leadership with another team member). BHCs may also initiate development of PCBH model pathways (i.e., standard integrated team-based workflows) that help make BHC services a routine part of primary care. The purpose of a PCBH model pathway is to improve outcomes for patients who are members of a specific group (e.g., patients experiencing chronic pain) by making delivery of evidence-based interventions more accessible for members of that group. Simple and complex pathway services are assessed and revised according to results achieved. An example of a simple pathway is automatic referral of a patient diagnosed with diabetes for a consult with the BHC on the same day of diagnosis. In that consultation appointment, the BHC engages in a focused biopsychosocial assessment to determine the patient's emotional response to receiving a diabetes diagnosis and identify what health behavior changes the patient might make for optimal diabetes management, given psychosocial resources and level of motivation. More complex clinical pathways may involve use of a patient tracking registry and delivery of group medical services in addition to individual BHC visits. This type of clinical pathway is useful for high-risk patients challenged with multiple chronic conditions. Complex pathways, such as those addressing chronic pain, increase opportunities for more efficient delivery of medical and behavioral services and improved social support.

Improving PCP and Nursing Staff Functioning

Perhaps the most significant opportunities for BHCs to help PCPs and nursing staff enhance their skills for delivering effective biopsychosocial assessments and interventions occur while delivering daily services. In the PCBH model, the burden of biopsychosocial care is lessened on PCPs, as it is shifted to the BHC. Additionally, as PCPs and nurses see the effectiveness of biopsychosocial interventions implemented by the BHC, they may begin to implement those interventions with their patients without referral to the BHC. There are many opportunities for BHCs to reduce work-related stress on PCPs and nurses, as they are credentialed members of the team that can review records, initiate phone contacts, and assist with document production for PCPs and nurses.

Challenges for Clinic Leaders and Providers

To achieve the benefits of integrated behavioral health care, many clinics begin by identifying a behavioral health provider to work as a BHC. While they will likely seek training for BHCs hired without prior experience in the PCBH model, preparation of clinic leaders, PCPs and nursing staff may be an after-thought. Without properly trained clinic leaders and providers, the pace of implementation will be slower and proceeds unevenly. When clinic leaders are unable to anticipate necessary changes to clinic infra-structure, the newly hired and minimally trained BHC will lack the operational foundation for integrating fully. Similarly, PCPs and nursing staff who do not know how to interface with their new colleague may be hesitant to engage for concern about imposing or "doing the wrong thing." They may rely on old habits established in interactions with traditional mental health and substance abuse providers and reserve use of the new BHC for patients in crisis and those with more severe problems. Implementation of the PCBH model proceeds more optimally when attention is paid to preparing clinic leaders, PCPs, and nursing staff.

The Role of Clinic Leadership in PCBH Model Implementation

"Clinic leaders" include all members of the leadership team charged with oversight of implementing the PCBH model. The exact membership will vary depending on the size and structure of a healthcare clinic or system of clinics. The Chief Executive Officer (CEO), the Chief Officer of Operations, the Director of Primary Care Services, the Medical Director for a larger system, the Director of Nursing, the Chief of Information Technology, the Director of Human Resources, a designated Clinic Manager, and a designated Clinic PCP and/or nurse are all possible members of a PCBH model leadership group tasked with facilitating the substantial transformation occasioned by initiation of PCBH services. Most often, recruited leaders have little or no expertise in the PCBH model and so begin their learning by attending workshops or webinars on the PCBH model, along with other models of integration.

At some point, most implementation teams visit a clinic with PCBH services and request assistance from a consultant with expertise in the PCBH model. Often, a large system will begin with a pilot program to inform system-wide change at a future point in time. Smaller systems may start with implementation in one clinic and move quickly toward implementation in all clinics. From the beginning, leadership will need to ask the consultant to define a work plan that assures attainment of PCBH model sustainability by resources within the system in a short time period. The consultant will use standard implementation materials to assure model fidelity (see PCBH Tool Kit at Mtnview-consulting.com). Initially, the consultant will likely assist with selection and hiring of BHCs while simultaneously educating the leadership team about the PCBH model and assisting with development of a feasible program evaluation plan, a business plan, and specific implementation strategies. Once several BHCs are hired, the consultant will assist with core competency training for the BHCs, as well as nurses and PCPs. The consultant can usually implement a train-the-trainer strategy within 6–12 months of initiation of BHC services, wherein the most successful BHCs are trained to train future BHCs and take lead roles in development of PCBH model pathways and other innovations.

Because clinic leaders will be charged with making key decisions about implementation, it is important that they be the first "on board" with adoption of the PCBH model. Once briefed, a central project lead or a pair of co-leaders may focus on implementation in pilot sites. Clinic leaders need to attend clinic-specific all-staff meetings where the PCBH model is introduced to PCPs, nursing, management, and support staff. Such meetings provide a great venue for further understanding the questions and preferences of end-users. In our experience, making sure all staff members know what changes are taking place, why those changes are important, and how those changes are likely to improve workflow, care, and patient and provider satisfaction with services is a critical component of start-up of BHC services. As implementation proceeds, clinic leaders need to generate clinic-specific reports on PCBH model quality metrics (see Robinson and Reiter 2015, Chap. 8). In our experience, regular feedback to providers and other team members encourage efforts to meet expected metrics, timely identification of barriers and creative efforts to effectively address identified barriers.

Competencies for Clinic Leaders

The PCBH Clinic Leadership Competency Assessment Tool (CL CAT; Table 1) is a pragmatic tool based on our experience of what clinic leaders need to do to create a solid foundation for PCBH model services. It has 31 competencies, and they are organized into the same six domains that organize the competency tools for PCPs and nurses (see Table 2) and for BHCs (see Chap. 5 in Robinson and Reiter 2015). The CL CAT is not a formal measure with psychometric validation; however, research on its properties and contribution to efficient implementation should be a research priority. Below we provide a focused review of each competency domain with recommendations for efficient competency attainment.

Table 1 PCBH clinic leadership competency assessment tool (PCBH CL CAT)

PCBH clinic leadership competency assessment tool	
Competency	Rating 1 = low 5 = high
Domain 1: support of new clinical practices	
1. Accurately defines role of BHC	
2. Develops and maintains schedule template of 30-min visits for BHCs, with at least half designated as same-day	
3. Demonstrates understanding of a population-based care approach to BH problems and anticipates impact on clinic operations	
4. Supports BHC access to information needed to understand population served at clinic	
5. Works effectively to address scheduling and charting needs related to delivery of group medical visit services	
6. Works effectively to address scheduling and charting related to classes and workshops provided by BHC	
7. Promotes use of BHC clinical measures in practice evaluation reports	
Domain 2: practice management skills	
8. Assures optimal location of BHC in clinic (i.e., preferably in the team room with BHC use of exam rooms or consult rooms for patient visits)	
9. Advocates for optimal staffing of BHCs	
10. Supports huddles that involve all team members, including BHCs	
11. Identifies and addresses barriers to PCP and nurse use of BHC on a same-day basis	
12. Identifies and addresses barriers to patient scheduling of future BHC appointments	
Domain 3: consultation skills	
13. Develops electronic health record flags for routine delivery of BHC services to targeted patient groups	
14. Assures BHC has the resources to research questions about evidence-based treatment and training to use resources well	
15. Promotes collection and dissemination of data to team concerning BHC fidelity to consultation role	
Domain 4: documentation skills	
16. Makes adjustments to EHR to support BHC documentation of screening tool and assessment results	
17. Makes adjustments to EHR format for after visit summary to accommodate behavior change plan provided to patients by BHC	
18. Makes adjustments to EHR to support care plans informed by BHC	
19. Makes changes to EHR to support referral of patients to groups, classes and workshops lead by BHC	
20. Works with EHR to facilitate development of registries supportive of BHC work	
21. Works with EHR to enhance team linkage with emergency departments and hospitals	
22. Works with EHR and staff to enhance communication between BHC and external specialty providers, supporting continuity in stepping up/down	
Domain 5: team performance skills	
23. Assists with BHC assignment to one or more PCP patient panels	
24. Encourages PCPs to provide standing orders for delivery of BHC services to targeted patient groups	
25. Adjusts EHR to support PCBH pathway design and implementation	
Domain 6: administrative skills	
26. Has read a copy of PCBH program manual and appendix	
27. Knows and supports staff training from the BHC to optimize clinic response to patients presenting with urgent threats to safety	

Support of New Clinical Practices

The competencies in this area include fluency in describing PCBH model services and anticipating their impact on existing workflows. This area also includes making adjustments to EHRs to support PCP, BHC, and nursing documentation related to BHC services. Finally, this area includes defining the details concerning the interface between clinical staff and support staff related to the delivery of BHC services. For example, PCPs and nursing staff need workflows concerning referral to the BHC, for both same-day and future appointments. Front desk staff and appointment line staff need to be prepared to schedule return appointments for patients seeking BHC follow-up and for patients intending to participate in BHC-led group services. BHCs will require access to scheduling and charting systems, and all clinical staff will need be able to access the BHC's schedule and chart notes. It is incumbent on clinic leaders to make sure this access is available.

Table 2 PCBH primary care provider and nurse core competency tool

Primary care provider/nurse core competency tool	
Competency	Rating 1 = low 5 = high
Domain 1: clinical practice skills	
1. Applies principles of population-based care to preventive and chronic care services	
2. Applies principles of population-based care to MH problems	
3. Defines role accurately	
4. Shows understanding of relationship between medical and psychological systems	
5. Refers a broad range of patients to BHC	
6. Rapid problem identification for BHC referral	
7. Uses appropriate assessment tools	
8. Notes functional impact of problem	
9. Supports self-management, home-based practice	
10. Supports interventions recommended by BHC	
11. Demonstrates basic knowledge of best practice guidelines for common behavioral health problems	
12. Ready to work with BHC in group medical visits	
13. Ready to work with BHC in providing PC lifestyle groups or classes	
Domain 2: practice management skills	
14. Uses BHC referral to reduce length of medical visit	
15. Uses BHC visit to save a medical visit	
16. Shows capacity to use BHC for continuity visits	
17. Refers to BHC groups, classes and workshops	
18. Uses BHC to link with ACO, CCO, hospital, school or other staff not co-located	
19. Uses BHC to link patients with community resources	
20. Uses BHC to make phone contacts with patients	
21. Works effectively with PCBH registries	
22. Uses BHC to assess and as appropriate to triage to MH and chemical dependency	
Domain 3: consultation skills	
23. Understands consultative nature of BHC services	
24. Expects BHC consultation to focus on one problem or answer a question	
25. Seeks curbside consultations with BHC	
26. Willing to interrupt BHC visit, when indicated	
27. Asks BHC to research questions about patient care	
Domain 4: documentation skills	
28. Documents referral to BHC and referral problem in chart note	
29. Makes time for BHC to give 1-min feedback when needed	
30. Clarifies responsibilities for charting curbside conversation results	
Domain 5: team performance skills	
31. Provides/supports standing orders for BHC services	
32. Supports PCBH pathway design and implementation	
33. Knows multiple ways to access BHC services, both same-day and scheduled	
Domain 6: administrative skills	
34. Has copy of PCBH program manual and appendix	
35. Knows what services BHC does not provide	

Robinson and Reiter (2015). Used with permission

Preparation of BHC schedules will involve building a BHC patient appointment template and assuring it supports the core features of BHC practice. Specifically, the template will need to include 10–14 30-min appointments throughout the practice day. To assure same day access, every other appointment slot will need to be designated as "same-day

only." Leaders should identify optimal strategies for communicating the need for a same-day BHC visit, such as use of text messaging, pagers, or person-to-person interactions and offer teams options for completion of necessary tasks (e.g., creating an appointment, checking patient in, transporting patient, etc.). Highly innovative BHC services, such as the PCP preparation visit suggested by Robinson and Reiter (2015), will require more thought. This visit type involves the BHC completing part of the PCP visit prior to the start of the PCP visit (e.g., interviewing a new patient with a mental health history about their mental health history prior to the start of the PCP visit). This type of service can add quality and efficiency (i.e., save PCP time, particularly on a busy day); however, this option will be used only by the team that has worked out communication and workflow strategies.

To attain full population health impact of the PCBH model, it is important for BHCs to have access to demographic information about patients enrolled at the clinic. For example, it might be important to have information about a team's or PCP's panel, including the size, payer mix, age/race/ethnicity/language breakdowns and most frequent patient problem presentations or top ten diagnoses. It might also be useful for the BHC to have the relative standing of each panel on primary care quality metrics, such as diabetic control, colorectal screening, completion of adolescent Well Child visits, etc. Access to such information will assist the BHC in thinking through population-based care strategies for delivery of BHC services and in anticipating what evidence-based interventions she or he can add into the clinic's current efforts to attain primary care quality metrics. This type of information is also helpful to development of PCBH model pathways targeting the group of patients with greater complexity.

Support of BHC Practice Management

One of the PCBH model goals includes shifting some of the burden of biopsychosocial healthcare from PCPs to the BHC to increase efficiency in primary care service delivery. For example, PCPs often spend more time with depressed patients, so having a BHC assess and intervene prior to the PCP visit with patients presenting with depression can shorten the amount of time the PCP needs to spend. When BHCs are included in daily team huddles, PCPs can anticipate patient visits that might "run long" due to the complexity of the patient and request that the BHC handle part of the visit so that the PCP can remain on-time. To optimize practice management for PCPs and BHCs, each BHC in a clinic should work in the physical area of the clinic where their assigned teams work. This provides a visual reminder of BHC availability, promotes efficiency in team communication and coordination of care, and reinforces the perception of the BHC as an essential part of good health care.

Unlike most other members of the team, our experience suggests that up to 20% of BHC time may be spent in the delivery of group-based services. Group-based care allows for efficient delivery of services to large numbers of patients who could benefit from learning the same healthcare intervention or skill set. Clinic leaders can assist in determining group service location, supporting the creation of workflows for scheduling and multiple patient check in, and developing documentation templates that minimize length of time needed for BHC charting of group visits.

Support of BHC Consultation Role

The BHC is often one of the first members of the team to work in a consultant role; therefore, clinic leaders need to consider work processes designed to support this new role. Leaders may assist PCPs and nursing staff in using BHC services more broadly by identifying specific patients that might typically be sent to the BHC for a visit. For example, PCPs are typically good at referring patients with anxiety or depression but may not think to refer patients with other problems for which a BHC consultation could improve the treatment plan and/or treatment results (e.g., diabetes, hypertension, tobacco cessation, obesity, chronic pain). In our experience, reminding the primary care team to refer patients with these problem presentations or establishing a clinical pathway that identifies and makes referral a routine standard operating procedure can dramatically increase the referral rate.

Another aspect of the BHC consultation role is that of researching questions that PCPs and nurses may have about patients that they may or may not refer to the BHC for a direct service. For example, a PCP may have a question about the evidence for behavioral interventions for temporomandibular joint disorder or want an opinion on initiating an exercise program with an overweight adolescent with asthma. Sometimes the BHC will have the answer to questions like these, but other times, the BHC will need to access clinical decision support tools used by PCPs (i.e., Dynamed, up-to-date). Given the broad range of problems seen by the BHC and the rapid expansion of new scientific findings, the BHC needs to stay current with evidence-based assessments and treatments for behavioral health concerns.

One of the challenges for many BHCs new to the PCBH model is working as a consultant rather than a psychotherapist. Adherence to the consultation role may be estimated by the ratio of the BHC initial visits to the BHC follow-up visits. Generally, that will be in the range of 1:2 or 1:3. When ratios are as high as 1:5, this usually signals a problem with the BHC's adherence to the PCBH model and more training will be necessary. Clinic leaders can assist with timely corrections in BHC practice patterns and encourage practice in a consultant role by making certain that monthly

reports are available to the BHC and to the clinic manager for the BHC. Another important metric is the percentage of same-day visits the BHC completes on a daily basis. In our experience, optimal functioning occurs when about half of the BHC patients are seen in same-day, "warm hand off" encounters (i.e., a patient is seen by the BHC immediately after or before the medical visit and may be introduced to the BHC by the PCP). A same-day appointment also occurs when a patient calls the clinic requesting a same-day visit and is then seen by the BHC that day. Availability of BHC monthly metrics related to the ratio of initial and follow-up visits, and same day appointment frequency, provides the BHC and clinic leaders with actionable information to assist a new BHC in practicing with fidelity to the role of the BHC as a consultant.

Table 3 BHC SOAP notes for the initial visit

Subjective
Patient age and sex; referring provider and referral issue
Patient's responses to life context questions
Patient's responses to functional analysis questions
Objective
Behavioral observations of the patient and any others present
Pertinent mental status issues (e.g., affect, cognitive organization, suicidal ideation)
Test results (e.g., screener or health-related quality of life score)
Assessment and plan
Conceptualization from functional analysis/life context questions
Diagnosis (physical from the PCP; or other)
Recommendations for the patient and the PCP
Any further planned assessment or follow-up

Support of BHC Documentation

Although a challenge, efforts to improve the match between available electronic health record (EHR) templates for mental health and substance abuse and the charting needed to support BHC work can pay dividends, both immediate and long-term. An EHR template with prompts and data fields that align with the typical BHC focused assessment, interventions, and recommendations can support timely and accurate completion of visit documentation. Additionally, a well-developed BHC template highlights recommendations for PCPs and nurses concerning the possible focus for future visits with the PCP and nurse. It is important that BHC notes resemble PCP notes including a similar charting format (i.e., SOAP, DAP) completed in the primary care visit section of the EHR. In our experience, most EHR mental health note templates are designed for specialty mental health providers and offer mostly unnecessary and unhelpful structural components for BHC work. Therefore, it may be easier to create a BHC visit template rather than attempt to craft a BHC note from an existing template created to support a substantially different service.

Table 3 provides a listing of topics typically included in a chart note of an initial BHC visit. The note includes a brief contextual interview designed to provide an understanding of the referral problem in the context of the patient's life and a functional analysis of the referral problem. Both help to inform development of a behavioral or cognitive intervention. For new BHCs, it may be helpful to have questions that support timely assessment of life context and completion of functional analysis included within the EHR. This may be accomplished by creating .dot phrases for the question lists. Other .dot phrases may be used to assure that the BHC is using evidenced-based interviewing processes for risk situations, such as risk of suicidal behavior.

Assessments typically used by the BHC can be built into the EHR for easy access and, if possible, included in lab sections in a graph format to show change over time. It is also important for EHR/BHC templates to include clinical measures of health-related quality of life and links to quality patient education handouts for printing as a part of the "after-visit" summary (i.e., the summary and instruction sheet provided patients after a visit). Clinic leaders may encourage PCPs and nursing staff to consistently use BHC assessments and patient education handouts by making them accessible in the EHR. This will enhance patient experience of continuity and increase the likelihood of patient success in behavior change over time. There may also be adjustments that can be made to the after-visit summary sheet that increase its' usefulness to patients. For example, automated text may be added concerning the availability of the BHC for same-day follow-ups in the future (as this has the potential to reduce no-show and cancellation rates associated with scheduled follow-ups).

Clinic leaders need to also consider billing strategies and assure that EHR documentation supports billing. This may require that PCP chart notes include documentation of a referral problem for a BHC consult, as well as specification of the referral problem. It is helpful to have the flow of the BHC note mirror the flow of the PCP note, so that readers know where to find information quickly. Table 4 provides an example of a chart review tool. Clinic leaders can use this tool as a checklist to assure that essential elements of a BHC chart note are included in the EHR template.

A final detail concerning BHC documentation concerns trying to build key metrics of program evaluation in the chart note, to support development of monthly reports. Such elements might include documentation of referring PCP and referral problem, as this supports oversight of the number and breadth of referrals by individual PCPs. Other elements include whether the BHC visit is an initial or follow-up visit and whether it is a same-day visit or a future scheduled visit. Inclusion of outcome scores (e.g.,

Table 4 The primary care behavioral health chart review tool

The Primary Care Behavioral Health Chart Review Tool				
Confidential: The purpose of this tool is to assure quality in documentation by Behavioral Health Consultants working in the PCBH Model.				
BHC: MR#: Date of service:				
Date of review: Reviewer:				
	YES	NO	N/A	Comments:
Documentation in Medical Record				
1. Entries are brief, specific, and accurate.				
2. Each encounter contains written or electronic signature of the BHC.				
3. All entries are completed and signed within 3 working days. *				
Behavioral Health Documentation Content				
4. Includes name of referring provider and referral problem or question.				
5. Subjective includes life context assessment.				
6. Subjective includes functional analysis of target problem.				
7. Subjective includes suicide/homicide risk assessment as indicated.				
8. Follow-up notes assess change and patient experience with the initial consult plan.				
9. Objective includes description of patient behavior and/or outcomes instrument measure (e.g., Duke for adults, PSC-17 for children).				
10. Assessment includes medical diagnosis by referring PCP (as applicable) and/or other diagnosis by PCP or BHC.				
11. Functional analysis problem conceptualization is in the note. **				
12. Plan includes interventions for patient and follow-up plan.				
13. Plan includes recommendations for PCP.				
Feedback to BHC from Reviewer (including any corrective action needed):				

*This may vary depending on clinic policy

**Depending on note format, may be described in the plan, the assessment, or an open general comments field

quality of life scores) support creation of reports that provide feedback about the effectiveness of individual BHCs with all patients and, if a "target problem" list is included in the EHR, an estimate of BHC effectiveness with specific problems. Some systems may build in rating scale questions (using a 1–10 scale), such a problem severity,

patient confidence in behavioral experiment resulting from the visit, and patient evaluation of the helpfulness of the BHC visit (for more information see Robinson, Gould, & Strosahl, 2011). Robinson and Reiter (2015) provide more general information about PCBH model program evaluation, and clinic leaders will also need to think through possible additional metrics that support value-based payment calculations.

BHCs will need access to patient registries created by other team members and the ability to create their own registries as well. Regardless of who creates the registry, all team members should have access to registries involving delivery of BHC services. Registries may include lists of patients with recent emergency department visits, patients recently discharged from the hospital, patients at high risk for suicide, patients with medication agreements, or patients who are receiving BHC care management while initiating psychotropic medication treatment. Additionally, registries may track other at-risk groups, such as those with multiple chronic conditions. Registries may also be helpful in tracking the impact of BHC efforts to support patient referral to specialty mental health and substance misuse services and to promote continuity in primary care after speciality treatment is initiated or completed.

Supporting BHC Integration with the Team

As a new member of the team, the BHC will benefit from clinic leadership efforts to formally integrate the BHC as a team member. This may be accomplished in a variety of ways, including development of a poster with a picture of the BHC to introduce newly hired BHCs to staff and patients and developing a brochure and exam room poster that describes the role of the BHC and services provided by the BHC. Clinic leaders may also help by developing clear workflows and posting them in optimal locations in the clinic. Clinic leaders may also support BHC attendance at provider meetings and encourage the BHC to have and use a brief speaking time at every provider meeting. When there is more than one BHC in a clinic, clinic leadership may assign each BHC to certain teams so the BHC is responsible for providing care to a specific group of patients. Implementation of clinical pathways, in addition to improving population health impact as previously discussed, can also serve as a concrete way to involve the BHC in team-based care. In our experience, thoughtful efforts to make BHC services "routine" improve the frequency of team member use of BHCs by the team services. Increased team engagement creates the opportunity for team members to get to know the BHCs better, see the impact they can have, and more quickly view them as an important team asset.

Administrative Support

Finally, while we have discussed aspects of administrative support in several of the preceding sections, it is important to emphasize the importance of clinic leaders' on-going attention to administrative details, including developing appropriate policies and procedures. Table 5 offers a listing of PCBH model service delivery performance goals and objectives to support development of useful dashboards and program evaluation reports. Clinic leaders need to clarify responsibility regarding development of a manual to guide PCBH implementation and operations and a plan for updating annually as the program evolves. With PCBH model expansion, there may be a need to revise the roles and responsibilities of various team members and to add information on new PCBH model team members, such as Behavioral Health Assistants (see Robinson and Reiter 2015, Chap. 3).

PCBH Model Competencies for PCPs and Nurses

The Primary Care Provider and Nurse Core Competency Tool (PCP & Nurse CC Tool) (Table 2) lists 35 competencies in six domains for PCPs and nurses working in the PCBH model (Robinson & Reiter, 2015). More details about the meaning of each competency and examples of these competencies are described by Robinson and Reiter (2015, Chap. 6). This tool was developed based on observations of PCP and nurse clinical behaviors that seem to work effectively in a PCBH model of service delivery. It has not yet been formally assessed for psychometric properties or predictive outcomes. The PCP and nurse CC Tool provides a structure for self-assessment and practice improvement planning for PCPs and nurses preparing to work successfully in the PCBH model. Increasingly, PCPs and nurses will be able to attend workshops to learn fundamental skills for working in PCBH model clinics. Arizona State University is currently developing a series of webinars for PCPs focused on working with BHCs (see https://go.asuonline.asu.edu); however, many competencies are best mastered in the practice context while providing services with a BHC. In the following section, we provide a brief review of competencies listed in the 6 domains of the PCP and Nurse CC Tool.

Domain 1: Clinical Practice

Competencies in this domain focus on PCPs and nurses further developing their skill in talking with patients about a biopsychosocial approach to health and in delivery of brief evidence-based behavioral interventions. This area also includes the PCP and nurse pattern of routinely using the BHC to enhance care for patients with broad range of presenting problems. This requires a shift from referring to the BHC as "specialist," "psychotherapist," or "counselor"

Table 5 PCBH model performance goals and objectives

	Objective
I. Patient outcomes	
1. Patients' health-related quality of life indicators improve through provision of PCBH model of care	(A) Adult PC patients who receive services from a BHC show improvement in their health-related quality of life
	(B) Children/youth who receive services from a BHC show improvement in their psychosocial well-being
	(C) Patients participating in PCBH Pathways (self-care; self-management) show improvement in one or more areas of health
	(D) Patients who are identified as high-risk/high cost patients who are only engaged in urgent/emergent services (e.g., high utilizers) are connected to a PCP and BHC
II. Access	
1. Access to PCPs improves	(A) PCPs demonstrate an increase in the average number of patient encounters per clinical hour
	(B) Wait times for PCP appointments decrease
	(C) High users of PC visits who participate in Pathways demonstrate a reduction in PCP visits
2. Access to behavioral health services for patients in the PC setting improves	(A) Patients who have no histories in specialty BH/SA have their behavioral health issues detected and addressed in the PCBH model of care
	(B) Patients who have only urgent/emergent histories in specialty BH/SA have their behavioral health issues detected and addressed in the PCBH model of care
	(C) Patients in need of specialty behavioral health services are referred and connected
III. Experience and satisfaction	
1. Patients experience the PCBH model of care as beneficial	(A) Patients (or their parents) express overall satisfaction with services provided in the PCBH program
2. PCPs experience the PCBH model of care as beneficial	(A) Increasingly, PCPs report reduced barriers to use of PCBH services
	(B) Increasingly, PCPs indicate a stronger likelihood of working with the PCBH staff to develop and support a behavior change plans for their patients
	(C) Increasingly, PCPs indicate confidence in the PCBH program as beneficial to most of their patients
	(D) Increasingly, PCPs indicate belief that PCBH services help them provide better PC to their patients
3. PCBH staff experience the PCBH model of care as beneficial	(A) Increasingly, PCBH staff express satisfaction with providing PCBH services
	(B) Increasingly, PCBH staff indicate confidence that PCBH services are beneficial to their patients
	(C) Increasingly, PCBH staff indicate confidence that PCBH services are beneficial to PCPs
IV. Fidelity to the model	
1. PCPs utilize the PCBH Program	PCPs refer a minimum of 10% of their patients to the behavioral health consultant
2. BHCs demonstrate fidelity to the PCBH model	(A) Less than 5% of patients who see a BHC see the PCB for more than 11 individual visits/year
	(B) BHCs complete eight or more face-to-face patient visits/day in year one; and ten in year two
	(C) 50% of new referrals to BHCs receive a BHC visit on the same day of the medical visit (i.e., via a "warm hand-off")
	(D) On average, less than 15% of patients seen by the BHC are referred to specialty behavioral health services

to thinking of the BHC as a team member with expertise in biopsychosocial assessment and intervention. PCPs and nurses may also improve their skill in working with a patient to identify a specific problem for the focus of the BHC consult. This is an important aspect of making successful referrals, as patients are often more likely to agree to involve the BHC when the problem agreed upon with the PCP is of fundamental importance to the patient. Training in this area encourages the PCP and nurse to look at the functional impact of symptoms and the use the BHC to help a patient improve their functioning in key roles, such as parenting or being a loving partner. Other aspects of this domain focus on learning the most common interventions used by the BHC so that they can support these in medical visits, promoting patient experience of continuity in care. Finally, this competency involves partnering with the BHC in delivery of group medical services and encouraging patients to participate in workshops and class series offered by the BHC.

Domain 2: Practice Management

Competencies in this domain focus on use of the BHC to improve PCP and nurse efficiency in practice and, as a result, may improve patient access to both medical and behavioral health services. For example, PCPs learn to use BHC referrals to reduce the length of a medical visit and nurses learn to offer a BHC visit when it better meets the needs of a patient than a medical visit (e.g., when a patient calls indicating psychological distress over a stressful life circumstance). Another skill in this domain is using on-going BHC services to improve outcomes for patients with multiple medical and psychological problems. With continuous availability to BHC services, patients may learn skills to reduce stress, make gains in motivation for health behavior change, and more consistently engage in approach-oriented skills for managing chronic disease and emotional problems that often accompany illness. Finally, this area includes learning to use the BHC to help with tasks other than patient visits, such as reviewing records and making phone calls. Flexible use of the BHC in accomplishing the multiple tasks of serving the planned and unplanned needs of patients may reduce stress and time pressure for the entire team and enhance their overall experience of job control and job satisfaction.

Domain 3: Consultation

This domain focuses on fine-tuning skills for using the BHC as a consultant. A consultant provides a variety of services, all to enhance the team's ability to conceptualize and implement behaviorally informed treatment plans for patients. PCP and nurse mastery in this area involves routinely using the BHC to research needed information about evidence-based behavioral interventions and to assist with treatment planning for patients the PCP may manage without referring the patient for a face-to-face visit with the BHC. It is also learning to consistently access the BHC at the time of need of consultation in an efficient manner. This may involve interrupting a BHC during a visit, which is perfectly acceptable and expected in a PCBH model clinic. As PCPs and nurses gain fluidity in this area, their conversations about the BHC with patients come to more clearly reflect the importance of behavioral consultation to outcomes valued by the patient. Strong skills in using the BHC as a consultant also pave the way for PCP and nurses to make continuous gains in development of a broad repertoire of assessment, conceptualization, and interventions for patients with behavioral challenges.

Domain 4: Documentation

Although there are only a few skills in this area, they are important because they support inter-professional communication, billing procedures, and continuity for the patient. First, PCPs and nurses need to document their referral and specify the referral problem agreed upon with the patient. Most clinics have specific workflows designed to support BHC billing, such as specification of a medical problem in the referral for patients with chronic diseases who are experiencing biopsychosocial barriers to self-management. When PCPs and nurses follow up with a patient after a BHC consult, they will need to review the BHC note and support the behavior change plan as a part of their medical visit. This will include the PCP or nurse charting patient status relative to the referral problem for the BHC consult and the patient's experience with implementing the plan resulting from the BHC consult, as well as the behavioral plan resulting from the medical follow-up visit. While BHCs will typically complete progress notes on a same-day basis and notify PCPs of their availability in the EHR, most will want to make time to listen to brief verbal BHC feedback about a same-day consults (usually requiring less than a minute). Lastly, PCPs and nurses share the responsibility for clarifying charting responsibility associated with curbside conversations about a patient. Curbside conversations are those inter-professional interactions that occur separate from a patient visit and result in any type of modification to the treatment plan.

Domain 5: Team Performance

In this domain, the PCP is encouraged to consider what standing orders they might support for automatic BHC referrals. For example, many PCPs routinely refer any patient that uses tobacco products for a same-day BHC visit. This area also concerns PCP and nurse collaboration in developing, implementing and evaluating PCBH model pathways. Such may develop out of mutual interests or be associated with

participation in the clinic's quality improvement committee work. This domain highlights the importance of competency regarding knowledge and consistent adherence to workflows established for accessing BHC services, both for same-day and scheduled appointments. Finally, this area concerns PCP and nurse responsibility in identifying barriers to use of the BHC and to working toward resolution of identified barriers.

Domain 6: Administrative

PCPs and nurses need to review the PCBH model manual and be supported in discussing questions and ideas concerning the program and related policies. The manual describes the roles and responsibilities of PCPs and nurses, as well as practice management tools and risk management procedures. The manual also includes a listing of the services that BHCs do not provide, such as court-ordered services, and PCPs and nurses need to be aware of these. PCPs and nurses need access to the manual on a common drive so they can access it as needed. They also may contribute new ideas and suggest changes in annual updates to the manual.

Challenges to PCP and Nurse Competency Development

It has been our experience that most PCPs and nursing staff can easily master the competencies of working in a PCBH model clinic and will quickly experience the positive reinforcement for changes they make to practice habits. Unfortunately, there are a few, somewhat common barriers that may inhibit PCPs and nurses from acquiring some of the skills related to competent practice in the PCBH model. Barriers may include insufficient time for learning new skills, change fatigue, and strong habit strength for old patterns of working with behavioral health providers. In addition, a lack of confidence in the quality of BHC services, or a concern about overwhelming the BHC, may suppress demonstration of behaviors consistent with the PCBH model. Finally, lack of understanding of the benefit of BHC services to PCP and nursing practice and sense of job control may be a barrier.

Lack of Time and Change Fatigue or Burnout

Medical information grows daily, and PCPs are required to track new information about diagnosis and treatment in dozens of areas. As generalists, they need to stay abreast of findings related to preventive activities and treatment of acute and chronic conditions for infants, children, adolescents, adults and elders. Additionally, they work with EHRs that are imperfect, time consuming, do not necessarily support quality medicine, and are frequently changing. With such high demands for acquiring and generating information, some PCPs and nurses may come late for trainings on PCBH model skills and/or multi-task while in training. Strategies for addressing these challenges include shortening PCBH model trainings and assuring that they are highly interactive and even playful, and therefore engaging for busy PCPs and nurses. PCPs and nurses are also likely to be more involved when trainings are anchored to a case example or a quality issue and involve small group skill practices and discussions. In addition to group trainings, it is helpful to provide academic detailing to PCPs and nurses, often focusing on a competency area suggested to be problematic for a significant number of PCPs or nurses. Detail training can be supported by a half-page handout with three key points written to facilitate retention or by short video clips.

Additionally, the BHC may address the change fatigue or burnout directly by offering trainings that help PCPs and nurses identify sources of stress and develop plans to address stress effectively. In a recent study from the United States, 45.8% of physicians reported having at least one symptom of burnout (Shanafelt et al., 2012). Because physicians and nurses are not likely to seek help and about a quarter of doctors attempt to hide their symptoms of anxiety or stress from their colleagues (Rosvold & Bjertness, 2002), BHC services in the clinic may provide a new and needed support for improved attention to resiliency in the primary care team.

To address stress and burnout, the BHC may draw from empirically supported programs designed to improve the health and well-being of workers (Flaxman, Bond, & Livheim, 2013), as well as adaptations of the Acceptance and Commitment Therapy (ACT) model designed to address provider resiliency (Robinson et al., 2011). There are studies in progress assessing the impact of such programs on the health and well-being of health care workers (see for example, Baker, Beachy, & Bauman, 2016; Lee-Baggley, 2017). Lee-Baggley et al., in Halifax, Nova Scotia have discovered barriers to use of the program and experimented with offering different formats. Specifically, they report a tendency to under-report need for such programs and time constraints as barriers to participation. This research team has tried various delivery formats, including (1) a 1-day workshop with a half day follow-up; (2) 4 weekly 1-h sessions conducted during academic rounds; (3) 3 weekly 1.5-h sessions; and (4) a single 1.5-h awareness session. Currently, they are conducting a randomized trial using a 10-session telephone coaching program, as this format provides greater flexibility as well as anonymity. Initial data from the various formats suggest that the ability to foster practice of ACT skills is important to program effectiveness. Researchers working in this area will hopefully look at program impact on PCP development of PCBH model competencies and their related benefit to efficient and effective practice, job satisfaction and continuation in the field of primary care.

Strong Habit Strength

Some aspects of working with BHCs may conflict with previous PCP and nurse habits, including those developed in practice and those trained directly in traditional family practice residents. For example, some PCPs and nurses were trained to never interrupt a "therapist" and it seems wrong for them to do so, even after encouragement. They worry about having a negative impact on the patient and offending the BHC. Another example involves the ways that PCPs and nurses have learned to interact with patients about mental health and substance abuse services. Strong training produces robust patterns, and some PCPs and nurses may resort to referring to the BHC as a counselor, or in some other way imply a specialist role, even after skill-based training in the PCBH model. Practice patterns and beliefs that run counter to PCBH model practices can be addressed over time through re-education, encouragement, and persistence. Also, using physicians or nurses that are PCBH champions to share strategies in provider meetings may have a significant impact in modifying strong practice habits among their colleagues. Furthermore, PCPs and nurses learn from their experience and that experience includes what they see other staff do in day-to-day practice and what patients report in the way of benefit from focused, consultative interventions with a BHC.

Factors Related to the BHC Services

Barriers related to competent team-based practice with a BHC may also relate specifically to PCP and nurse beliefs about the BHC. For example, some believe that short-term work with patients with mental health problems is not helpful to patients. Other PCPs may have developed their own set of behavioral and medication interventions to use with patients with behavioral problems because they could not access specialty services for their patients. Among this group, some will be reluctant to change because they do experience success with their approach, although this may come at the cost of struggling with managing their schedule. For these barriers, the BHC will need to work to develop strong relationships and to continuously provide 5-min updates on the literature supporting the use of brief interventions at provider meetings.

A final barrier to competency development related to BHC services is a PCP or nurse's perception that the BHC is not competent in some ways. Early in the BHC's practice, a patient receiving a consult may have provided negative feedback to the referring PCP or nurse. As discussed earlier, there is a shortage of behavioral health providers trained to work in the PCBH model. Even if a BHC has a good clinical repertoire, he may not be effective in teaching or influencing the PCPs and nurses.

Clinic leaders may be able to assist if this appears to be an issue in PCBH model implementation by working to obtain further training for the new BHC, both as a competent provider of clinical services to a wide range of patients and as an educator for PCPs and nurses. If a BHC appears to be ineffective and not inspiring the confidence of his new colleagues, clinic leaders may need to look for a replacement and to attend closely to strategies used in recruiting and selecting the replacement. In general, a strong BHC candidate is one who wants to change from traditional mental health to primary care, likes the idea of being part of a team, voices confidence in being able to help a patient in a short visit, knows cognitive behavioral interventions, and likes a fast pace. A BHC with these qualities may be better able to embrace the role of teaching PCPs and nurses over time, including barriers that are sure to arise.

Lack of Perception of Benefit of BHC Services to PCP and Nurse Practice

PCPs and nurses may see BHC service as an additional cost in a tight budget and not clearly understand the potential for the BHC to support their billing and reimbursement. In medicine, as in other fields, professional behavior is shaped by a business plan and the business plan in medicine revolves around using codes that will be paid and paid well. Historically, clinics have experienced barriers to billing BHC services at a level that would allow their service to break-even. This is changing now, state-by-state, and the current move to explore combined fee-for-service and value-based payment models is creating the financial culture needed for PCBH model services to take hold in clinics with differing population risk levels and payer mixes.

Identifying Barriers

Of fundamental importance in addressing barriers to PCP and nurse development of competence in working in a PCBH model is identifying the specific barriers that appear to be influencing their practice at any given time. There are many potential barriers, some subtle and some obvious, and they may be effectively addressed but then re-appear in the context of provider turn-over and system changes in a clinic. From our clinical experience, we have found two brief questionnaires useful in "testing the waters" to identify emergence of barriers to optimal implementation, with PCP and nurse competence being only a subset of potential barriers. The PCBH barriers to use of BHC (BUB; Robinson & Reiter, 2015) may prove useful in the first 4–6 weeks of starting a BHC service. The barriers to same day use of BHC (BUS; Robinson & Reiter, 2015) is indicated after the program has been up and running for a few months, particularly when the BHC has not started to receive five or more

same-day referrals daily. Most PCPs can complete the BUB or BUS in 3–4 min, and results can suggest problems with barriers related to operational factors, as well as PCP and nurse knowledge and practice habits. Both questionnaires are readily available (see http://www.behavioralconsultationandprimarycare). Although neither have been psychometrically validated, clinic leaders and providers have found them useful in a large variety of primary care systems.

Case Studies

The final section of this article offers two case studies demonstrating how two very different healthcare systems addressed workforce development in PCBH model implementation and expansion. Multnomah County Health Department (MCHD) is an urban, safety net public health system, with many primary care sites that are designated as federally qualified health centers (FQHCs). In 2016, MCHD deployed BHCs in all primary care clinics and began a major initiative to transform to the PCBH model. The Department of Defense (DoD), a pioneer in integrated care, now mandates delivery of PCBH model services worldwide in all military adult primary care clinics with at least 3000 enrollees. These include services in both small and large clinics and in sites that train social work, psychology, physician assistant, and family medicine residents. This section describes the implementation strategies used in these system-wide initiatives. In addition, we will address the "lessons learned" by each of these systems, with a specific focus on addressing the barriers to workforce development and preparation.

Multnomah County Health Department

Multnomah County Health Department (MCHD) in Portland, Oregon comprises three divisions: Mental Health and Addictions, Public Health, and Integrated Clinical Services (ICS). ICS provides medical, behavioral, pharmacy, laboratory, and dental care services to over 70,000 patients in primary care practices, a specialty HIV clinic, school-based health centers, dental clinics, and jails. MCHDs seven primary care practices, specialty HIV clinic, and 13 school-based health centers adopted a team-based primary care model that included co-located mental health services in 2007.

As a part of continuous quality improvement, the PCBH model was fully implemented in all MCHD primary care clinics in 2016. While the PCBH model was implemented in 2016, organizational preparation for this practice transformation began in 2012. At that time, due to MCHDs desire to enhance behavioral health integration, an expert in the PCBH model (with strong connections to the local mental health and addiction community) was hired as the PCBH program manager. The PCBH program manager's role was to advise senior leadership, be a member of the primary care leadership team, and serve as an ambassador creating a strategic link between MCHD primary care clinics and the local mental health and addiction provider community. MCHD senior primary care leadership and the PCBH program manager convened and supported a multi-session work-group in early 2012 to develop a strategic integration plan. This collaborative work-group included leadership from the health department's Mental Health and Addiction's division and MCHD primary care practice representation. The goal of this multi-session work-group was to conceptualize an "ideal" system of care for MCHD primary care patients who have behavioral health concerns. As a result of this collaborative effort, a visual-model was created that depicted a BHC assigned to every primary care team (and therefore to every patient) and strategic connections between MCHDs integrated primary care teams and the secondary and tertiary mental health and addictions services in the local community. In 2016 (after successive and exhaustive internal clinical and operational efforts), this once "ideal" system of care was achieved in full with the PCBH model initiative. The PCBH model initiative focused on hiring, core-competency training, and strategically assigning BHCs to every primary care team. Additionally, culturally responsive community health workers were paired with each BHC to support each primary care team.

Currently, all MCHD primary care patients can receive an equitable biopsychosocial primary care service. Each full-time BHC works with their teammates in caring for a specific set of around 3000–5000 patients. BHCs are assigned more or fewer patients depending on the complexity of patients in the practices they support. For example, as is typically the case for PCP practice, BHCs have fewer patient assignments working in an HIV clinic as compared to working in a pediatric clinic.

It is worth mentioning; when the PCBH model was initially implemented MCHD used the title "behavioral health consultant" to describe the licensed clinical social worker or psychologist primary care team member. This title was soon changed to "behavioral health provider." This new title supported PCBH model implementation in several ways. It promoted (1) the concept of "shared biopsychosocial care" between the PCP and assigned behavioral health provider; (2) an equitable relationship between the primary care provider and the behavioral health provider; (3) an understanding that the behavioral health provider was a clinician like the PCP and (4) the important longitudinal and relational care aspects of the behavioral health provider's practice.

In regard to the last point, in our experience, the longitudinal and relational care aspects of the PCBH model are unfortunately often overlooked and underappreciated. MCHD primary care found that changing from "consultant"

to "provider" ensured that the longitudinal and relational care aspect was fully appreciated. One of the most rewarding aspects of BHC work is the opportunity to be a life-long, consistent, and ever-ready support to team assigned patients. The goal of primary care is to provide a continuity relationship to patients, as such; this is also the goal of the BHC. BHCs, like PCPs, at MCHD can see a patient in childhood for school avoidance then again in adolescence for depression and then again in adulthood for chronic disease and, eventually, perhaps for end of life care. In close collaboration with PCPs, BHCs at MCHD can support the identification of severe mental illness early in life, ensure coordination of the patient to comprehensive care, keep abreast of treatment progress, and support the patient throughout their life in a biopsychosocial way.

To support this new and sizeable BHC workforce, and to develop a PCP and nurse workforce to partner with them, MCHD initiated a core competency training program in their clinics for BHCs and a structured PCBH model orientation program for PCPs and nurses. To prepare the clinics for PCBH model practice transformation, leadership and primary care teams received extensive training on the skill sets of BHCs (who were licensed clinical social workers and psychologists) and the impact of these skills on PCP and nurse practices, team effectiveness and patient outcomes. Leadership, PCPs, and nurses learned about the extensive training received by BHCs and the level of comparability between BHCs and PCPs regarding educational attainment and clinical preparation. Primary care teams also received training in a variety of behavioral interventions for common primary care problems. The overall training approach validated the use of psychiatric medications as a treatment option, but encouraged widespread use of focused cognitive-behavioral interventions for many problems. Teams came to understand that these interventions would be widely available to MCHD patients because of BHC staffing. They also learned that focused cognitive-behavioral interventions can be clinically and cost-effective treatments for many problems. Lastly, teams learned that focused cognitive-behavioral interventions provide the additional benefit of having few or no side effects and, because these interventions help patients learn new skills, their benefits can be more durable than medications which are eventually discontinued placing the patient at risk for relapse.

MCHD also developed a three-phase competency-based training program to support BHCs in their clinical practices. This training included (1) didactic training both in live and video formats, (2) shadowing of BHCs on-the-job by an expert trainer and expert trainer coaching for BHCs using the PCBH model core competency tool, and (3) a focus in clinic on retooling the primary care team for integrated team-based care. The purpose of this training program was to promote integrated team-based competencies for all clinic staff, with a focus on clinic leadership, PCPs, nurses, and BHCs.

To sustain integrated team-based training goals over time, an additional 8-h didactic training was created by MCHD BHCs and was reviewed and approved by MCHD senior leadership. This training is now an ongoing regular training for all MCHD primary care providers and nurses. It is a respected training that is attaining interest from various divisions within this health department and from external organizations. The training reviews the following: integrated team-based care concepts and workflows; how to access and engage with the local mental health and addiction system of care; how to effectively use psychiatric consultation and psychiatric care management; basic motivational interviewing skills; basic suicide prevention skills; biopsychosocial care for patients who have chronic pain; the impact of adverse childhood experiences on health outcomes; what is posttraumatic stress disorder, trauma-informed and trauma-specific care; biopsychosocial care for patients who have depression and/or anxiety, and MCHDs standard team-based Screening, brief intervention, and referral to treatment (SBIRT) workflow for substance use concerns.

Additionally, MCHD continues to develop standard integrated team-based workflows with cross-functional workgroups (these are like PCBH model pathways described earlier in this article). An integrated team-based workflow was implemented as part of a suicide prevention initiative and another for the detection and management of depression and anxiety in primary care. Workflows are being developed to improve supports for patients with chronic pain and to improve early detection and treatment of behavioral concerns in children. These new integrated care team workflows typically include standardized screening and then referral to the patient's BHC for focused clinical assessment and cognitive and behavioral interventions. The referring PCP and BHC then develop a team-based care plan for management of the patient's concerns over time.

The healthcare reimbursement system is a significant barrier to integrated primary care in Oregon, as it is across the United States. To address this external barrier, MCHD primary care and other local integrated care advocates educated local medical plans about the population health benefits of integrated primary care teams. MCHD explained that current fee-for-service payment did not incentivize BHC practice and suggested that medical plans consider alternative payment methods (APM) to promote widespread adoption of integrated primary care teams. MCHD also made it clear that earlier initiatives to co-locate traditional mental health providers in primary care clinics were not able to address the extensive demand for behavioral services of all kinds, and only a population-focused, high-capacity, immediate access-driven approach like the PCBH model could dramatically improve the psychosocial health of the MCHD population.

Because of these communications and other factors, a large local payer developed a unique per member per month payment rate for local primary care clinics who adopted the PCBH model. This new payment strategy, in concert with an overall blended payment structure for primary care, is ensuring the fiscal sustainability of the PCBH model at MCHD. The MCHD blended primary care payment structure that sustains integrated primary care includes (1) a unique BHC per member per month rate from a local payer; (2) fee-for-service billing by BHCs; (3) primary care APM that pays per member per month for most comprehensive biopsychosocial primary care service; and (4) team-based workflows that capitalize on the BHC to help teams meet local payer quality incentive metrics, such as metrics that incentivize SBIRT and universal depression screening and follow-up.

Lessons Learned

Throughout the evolution of integrated services, attention was paid to empowering PCPs and nurses to function competently in the new model of care. The strategies that proved most useful included (1) initial introduction of the PCBH model; (2) facilitated discussions among discipline-specific groups (PCPs, nurses) focused on the benefits and challenges of implementation; (3) development of well-documented workflows related to BHC services; (4) team meetings including BHCs and all other members focused on optimizing workflows; (5) BHC shadowing of PCPs and nurses; (6) BHC presentations on evidence for behavioral interventions at provider meetings; (7) information boards in clinics maintained by BHCs; (8) patient education handouts addressing the 10 most common behaviorally influenced problems stocked in accessible areas of the clinics; (9) initiation of a system-wide training for new employees that included instruction in PCBH model competencies; and (10) pursuit of a collective effort to reform payment for biopsychosocial primary care.

Plans for the Future

Next steps for integrated primary care teams at MCHD include continued re-development of all workflows that could benefit from routine BHC support. Now that BHC services are rapidly available to patients, there is an opportunity to shift work previously done by PCPs that may be more effectively addressed by a BHC. For example, MCHD primary care clinics have the capacity to offer a visit with the patient's BHC instead of the PCP for common issues within the BHC's areas of competence (depression, anxiety, weight loss, smoking cessation, behavioral problems in children, etc.). In this way, MCHD primary care plans to use the BHC as a PCP extender.

Losing providers because of professional burn-out is a concern for MCHD primary care and for primary care practices across the country. MCHD BHCs are focused on supporting efforts that have promised to decrease MCHD provider burn-out. It is hoped that as PCPs are supported with a BHC that this in and of itself will help to reduce provider burn-out. In our experience, many PCPs report that patients with complex behavioral health concerns tend to bring challenge to their practices. PCP access to a BHC (who is extensively trained to assess and treat behavioral concerns) could potentially mitigate some factors associated with PCP burn-out. As an example, a team-based workflow is being created at MCHD primary care that would ensure a shared BHC and PCP approach to the care of patients who have chronic pain. It is hoped that this new approach could result in the PCP feeling more supported when caring for these patients whose concerns often persist and continue to be presented by the patient well-after the PCP has exhausted viable medical options. Another current initiative intended to reduce provider burn-out is a current pilot of BHC and PCP facilitated Balint groups. Balint groups are usually closed-groups of providers that meet regularly to review challenging patient cases for the purpose of exploring patient–provider relational dynamics. MCHD primary care has hopes that this offering will provide unique support to providers and help them leverage the patient-provider relationship to promote provider professional resilience as well as healing in the patient. In preparation for implementing this service, MCHD primary care determined that BHCs tend to have unique knowledge, skills, and abilities that often make them particularly strong Balint group facilitators. As such, BHCs have been paired with PCP leaders to facilitate these groups.

The United States Department of Defense

A history of the implementation of the PCBH model in the DoD is described elsewhere (Hunter & Goodie, 2012; Hunter Goodie, Dobmeyer & Dorrance, 2014). A 2013 DoD policy (DoD Instruction 6490.15) established policy, staffing requirements, behavioral health models of service delivery for primary care, and procedures for attainment of DoD required core competency standards for developing, initiating, and maintaining adult behavioral health services in primary care (U.S. Department of Defense, 2013). This instruction also described the training standards for BHCs and care facilitators in primary care (nursing staff members working with registries of patients, such as those with depression), but did not specifically address training standards for PCPs and nurses that would now work with integrated BHCs.

A working group which included representatives from each branch of the military developed a PCBH model competency-based, phased training and evaluation approach for BHCs in 2012 (Dobmeyer et al., 2016). This training

was significantly expanded in 2016–2017. Currently, newly hired BHCs complete a 3-week distance learning orientation phase of training consisting of self-guided learning activities as well as online webinars. BHCs then attend a 5-day Phase 1 centralized classroom training and skills evaluation. Phase 1 classroom training consists of didactics, demonstrations and role-plays of patient encounters, and BHCs are required to demonstrate a set of core competencies in simulations of events likely to occur in real world practice settings. After Phase 1 training, BHCs begin seeing patients in their primary care clinics. For the first 3 months of their new practice, they receive bi-weekly phone mentoring from an IBHC trainer. 3–6 months after Phase 1 training, BHCs participate in Phase 2 training, where they are observed during live patient appointments and real-time consultation with PCPs. During this phase of training, the BHCs are again required to demonstrate core competencies, but in a context of delivering services in primary care.

Although comprehensive training for new BHCs yielded positive outcomes, an equivalent training approach for PCPs and nurses was not available. As a result, the responsibility for training PCPs, nurses, and other staff became the responsibility of the clinic's BHCs and care facilitator. BHCs have a standardized clinical practice manual and other specific instructional materials which they can use to assist staff in developing new clinical, practice management, and team-based care skills. The DoD has continued to evolve trainings and practice skills for the primary care team. For example, in 2014, they provided informational documents for teams to use in developing clinical pathways for eight specific, common conditions (i.e., depression, anxiety, diabetes, obesity, alcohol use, tobacco use, chronic pain, and insomnia). The pathways included methods for identifying patients and connecting them with primary care services, BHC interventions, and outcome monitoring strategies. In 2015, the DoD developed a 1-day training for clinic leaders to prepare them to function as subject matter experts on the PCBH and collaborative care models of service delivery. Participants learned to identify and address PCBH model implementation challenges; design a PCBH model evaluation plan for their clinic and monitor results; facilitate effective multi-disciplinary teamwork; and provide effective training on PCBH model competencies for PCPs in the clinic.

Lessons Learned

Over the past 5 years, DoD experts on the PCBH model have developed a better appreciation of the difficulties that many BHCs experience in mastering the skills required to succeed in the face-paced, multi-disciplinary team setting and to function as effective teachers for PCP and nurse colleagues. To develop a strong BHC workforce, the DoD revised the Core Competency Tools for BHCs, as well as BHC mentors/trainers. Additionally, there have been efforts to make the BHC training more robust (e.g., increasing active learning, using standardized patients in role plays with BHCs). On-going mentoring has helped BHCs be more effective in assisting PCP and nurse colleagues with learning new competencies for delivering services consistent with the PCBH model.

Plans for Future

All behavioral health staff working as faculty members in residencies are now trained in the PCBH model, and some provide BHC services in the residency clinics they serve. In the United States Air Force psychology residency training programs, all residents are trained in the PCBH model. Discussions are underway concerning methods for integrating PCBH model training into medical residencies, physician assistant (PA) residencies, and social work (SW) residencies in military primary care clinics.

Summary

There is a well-worn saying that states, "Be careful of what you wish for; you just might get it." This saying sums up the conundrum of workforce development, as PCBH model integration becomes the "new normal." PCPs and nurses have advocated for their patients to have better access to behavioral health services, and now this is increasingly possible. The PCBH model provides a needed structure to guide delivery of highly integrated behavioral health services, as well as new strategies for the new team to work together to improve outcomes. The initial concerns for most healthcare systems are with finding and training competent behavioral health providers to deliver BHC services. However, it is increasingly clear to systems transforming to the PCBH model that preparation of clinic leaders, PCPs and nursing staff are of equal importance to both short-term and long-term success. When prepared, clinic leaders can build a strong foundation for evaluation of the PCBH model, prepare for efficient implementation, and promote expansion and evolution of services over time. Clinic leaders can also promote competent PCBH model practice among members of the primary care team by supporting training. This article offers tools to help clinic leaders, PCPs, and nurses be fastidious and effective in transforming to the PCBH model. Use of recommended tools and strategies in practice and training venues is of paramount importance to the goal of creating a workforce for today and tomorrow, one with PCPs and nurses ready to partner with BHCs and address the behavioral health needs of patients of any age at the time a need is identified.

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Compliance with Ethical Standards

Conflict of interest The authors Patricia Robinson, Julie Oyemaja, Bridget Beachy, Jeff Goodie, Lisa Sprague, Jennifer Bell, Mike Maples, and Christy Ward declare that they do not have any conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human participants or animals performed by any of the authors.

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