BHC CORE COMPETENCY TOOL (CCT)

BHC: **Date:** **Trainer:** **Phase:**

Recommended use of this form:

This form may be used by a qualified BHC Trainer to rate BHC trainees on each competency during BHC training. Supervisors may also rate BHC competency using this form as part of ongoing evaluation of BHC staff. BHCs may also rate themselves on this form, for periodic self-monitoring or as part of the training/supervision process.

A rating of "1" means the BHC is not demonstrating this competency; "3" is the expectation for new BHC's (< 3-4 months of experience); "5" indicates expert status.

Part A is mostly focused on the structure of clinical visits and is usually the only part used in Phase I training for BHCs who have had less than 3 months of PCBH exposure.

Part B is focused mostly on BHC competencies for team-based primary care. It is best used in Phase II training (along with Part A) with BHCs who have been in clinic for a month or more. Observation of team interactions and consultative interactions with PCPs, as well as review of BHC chart notes, is recommended for completion of Part B.

NOTE: BHCs are expected to have foundational skills in evidence-based assessment, treatment, consultation, documentation and ethical/legal practice through their graduate education and post-licensure work experience. This foundation is typically necessary for successful demonstration of competencies listed here.

Part A: Clinical Visit Structure								
Competency	Minimal Demonstrated Benchmark Behaviors	Comments and Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
1. Role definition: *Says introductory script smoothly; conveys the BHC role to all new patients.*	1a. Accurately describes the BHC role: i) Who they are, credential and title, ii) The BHC role in care, iii) How long the visit will be, iv) What will happen during the visit, v) The structure of follow-up, vi) That the visit note will go in medical record, vii) That the BHC will staff the patient's care with the PCP, viii) Notification of billing practices (if indicated)	• If interrupted by the patient, is able to gently refocus to complete the script • If ad-libbing, avoids words/phrases that minimize their value (e.g., "I *only* have 30 minutes," or "I have *short* visits," or "I can't do regular therapy," etc.)						
	1b. Delivers the script in 2 minutes or less.							

Part A: Clinical Visit Structure								
Competency	**Minimal Demonstrated Benchmark Behaviors**	**Comments and Sample Behavioral Anchors**	**Rating**					**Comments**
			1	2	3	4	5	
2. Rapid Agenda-Setting: *Rapidly reaches agreement with the patient on identifying the primary problem and/or goal for the visit.*	2. Confirms and clarifies consultation issue and obtains initial patient engagement in addressing consultation issue within 60 seconds after completing the introductory script.	• Sample language: - "My understanding is that Dr. Jones would like us to talk about your panic attacks, is that your understanding?" - "I believe Dr. Jones wants my help with this paperwork you brought in for your depression disability claim. Is that your understanding?" • When referral question is unclear, seeks clarification from referring medical note, PCP, and/or patient.						
3. Assessment: *Focuses on presenting problem/referral goal. Uses appropriate screeners. Uses a biopsychosocial assessment of the presenting problem and life functioning, with the goal of identifying intervention opportunities. Attends to risk.*	3a. Measure use: Uses assessment measure appropriate to primary care to assess and monitor outcome. If additional measures are administered, they are appropriate for primary care, scored, interpreted, and documented correctly. Measures are scored during/before the visit and discussed/used with the patient in a value-added manner.	• Administers the service's screening/monitoring tool at each visit (as feasible) • Only uses other tools if they have been approved by the service lead • Scores the tool during/before the visit • Utilizes the tool to aid clinical decision-making • Uses/Inquires about significant discrepancies between scores and self-report						
	3b. Appropriately assesses risk of harm to self and others	• Is aware of risk factors for suicide/homicide • Asks about suicidal ideation directly when risk factors are elevated, and conducts further risk assessment as needed						

Part A: Clinical Visit Structure								
Competency	Minimal Demonstrated Benchmark Behaviors	Comments and Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
3. Assessment (continued)	3c. Assessment of presenting problem: Duration, frequency and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem. Assesses biopsychosocial factors that coincided with onset of or change in symptoms. Goal is to identify coping skills needs/strengths	• Sample questions: - "How long have you been feeling depressed?" - "How many days per week do you have a headache?" - "Is there anything that seems to make your sleep problems worse (or better)?" - "Have you been treated for panic attacks in the past?" (if so, "What kind of treatment did you receive, and was it helpful?")						
	3d. Assessment of functioning: Develops a "snapshot" of the patient's life context (family r/s, social r/s, recreational and physical activity, work/school). Assesses impact of the problem on these life domains, and vice-versa, to identify the patient's coping skills needs/strengths	• Uses mostly closed-ended questions to quickly develop a snapshot of life context • Asks questions that result in a holistic understanding of the referral concern's impact on functioning in at least 3 areas • Uses functional assessment to identify key coping skills needs/strengths						
4. Problem focus	4a. In initial visits, focuses assessment and intervention on the presenting problem. (Exceptions may be made when a patient clearly indicates a preference for talking about a different problem area, or if significant new concerns are identified during the visit.)	• After assessing the presenting problem, BHC might opt to assess other areas identified or suspected as problematic. • Remote history is utilized if directly and significantly relevant to the presenting problem; otherwise, the BHC attempts gentle redirection back to presenting problem						
	4b. In follow-up visits, maintains a focus on the original problem (unless exception criteria in 4a are met)	• Visit is focused on assessing for changes in status of problem and adherence to plan to determine need for follow-up and/or need for new plan						

Part A: Clinical Visit Structure								
Competency	Minimal Demonstrated Benchmark Behaviors	Comments and Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
5. Summary and formulation	5. Provides a succinct summary of the presenting problem and relevant history Highlights and explains the coping skills deficits/strengths affecting the problem Quickly checks with patient for accuracy	• Summary is used to ensure accurate understanding of the problem and relevant history • Example: "It sounds like alcohol use has been an off/on problem for 20 years, but was doing ok until 6 months ago when you lost your job…" • Formulation explains how biological, behavioral, cognitive, emotional, and/or environmental factors led to (or are maintaining) the problem. • Example: discuss how alcohol use is likely affecting sleep; how avoidance may be worsening anxiety; how reduced activity may be worsening depression • Both typically take 2-5 minutes (total) and are provided prior to discussion of intervention options						

Part A: Clinical Visit Structure								
Competency	Minimal Demonstrated Benchmark Behaviors	Comments and Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
6. Uses evidence-based recommendations and interventions suitable for primary care for patients and PCPs	6a. For Phase I evaluation, BHC can demonstrate **at least 2 of the following interventions** in the categories below. Phase II eval must demonstrate at **least 3 of the following** in the categories below. Categories: i) Adapted cognitive interventions, ii) Adapted behavioral interventions, iii) Adapted physiological management Interventions (e.g., relaxation training), iv) Adapted Motivational Interviewing (MI) interventions, v) FACT interventions	• Adapted cognitive interventions: e.g., increasing awareness of unhelpful beliefs/thoughts, developing more helpful beliefs/thoughts • Adapted behavioral interventions: e.g., behavioral activation, sleep strategies, self-guided exposure, communication skills training; self-management goals, parenting skills • Adapted physiological management interventions: e.g., relaxed breathing, cue-controlled relaxation, imagery, progressive muscle relaxation, distraction • Adapted MI interventions: e.g., using decisional balance, emphasizing personal choice, eliciting change talk, using readiness ruler, developing a change plan. • FACT interventions: e.g., setting goal to align values and actions; practicing mindfulness						
	6b. Interventions are collaboratively developed with the patient.	• Provides intervention options • If an option is more important than others, BHC recommends that • Ensures patient agreement with the recommended intervention(s) • Tailors interventions as needed using patient input						
7. Clear visit structure	7. Visits follow a clear structure (5 A's, FACT)	• Introduction is done at visit outset • Interventions are not recommended until assessment is complete • Follow-up (if any) is not planned until end of visit						

Part A: Clinical Visit Structure								
Competency	Minimal Demonstrated Benchmark Behaviors	Comments and Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
8. Intervention design	8a. Intervention goals are specific, realistic, and clearly related to the presenting problem	• Interventions follow the SMART format (Specific, Meaningful, Achievable, Relevant, Timed) • Typically just 1-2 intervention goals are planned						
	8b. Uses self-management, home-based practice as the prime method for intervention. Most interventions involve self-guided skill-building	• Interventions do not revolve primarily around visits with the BHC • If handouts/referrals are used, they usually supplement rather than replace behavioral interventions						
9. Intervention efficiency	9. Structures behavior change plans that are consistent with brief consultative care	• Does not plan extended follow-up with BHC						
10. Time management	10. Appointments are routinely kept to 30 minutes or less.							
11. Verbal consultative staffing	11. PCP staffing is concise, avoids jargon, and includes the BHC's assessment, behavior change plan, and recommendations for PCP's care of the patient.	• Staffing typically takes less than 1 minute						
12. Value-added PCP recommendations: *Recommendations are tailored to the pace of primary care.*	12. Recommendations that the BHC provides to the PCP are: i) Achievable for the patient, ii) Evidence-based, iii) Brief (PCP can describe/reinforce in less than 2 minutes), iv) Concrete, v) Designed to reduce PCP visits and workload when possible.	• Example of recommendation that PCP could reinforce: "I recommend that at the patient's next visit, you reassure him again that his symptoms are anxiety and not a cardiac problem." • Example of reducing PCP visits and workload: - Follow-up with BHC instead of PCP - BHC will complete patient paperwork and provide to PCP for review/signature						

Phase I Evaluation (Part A only)

These ratings were based on observation of ____ new and ____ follow-up patient appointments *(___ role play ___ in-vivo*)

Competency that are strengths:

Competencies to prioritize for more development:

Trainer's signature: _____ Date: _____

Supervisor's comments:

Supervisor's signature: _____ Date: _____

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
13. Clinical productivity behaviors	13. Regularly engages in behaviors to increase BHC utilization.	• Strives to achieve organization's BHC utilization goals using a diverse set of strategies, such as: • Daily scrubbing of PCP appointment lists to identify patients appropriate for BHC services, followed by coordination with PCPs/staff to link these patients with BHC. • Promoting PCP understanding of BHC services by providing information during new provider in-processing, briefings at huddles and provider meetings, and formal trainings. • Being visible in the clinic each day by circulating in the clinic, interacting with staff when not seeing patients, and encouraging consultations and handoffs. • Being vocal in huddles each day (including requesting to see specific patients by name and coordinating how handoff will occur). • Using strategies to decrease no-shows and cancellations (e.g., increased same-day visits, coordinating follow-up appointments with other PC appointments, reminder phone calls, etc.). • Working with clinic leadership to establish clinical pathways incorporating the BHC. • Working with clinic team to increase same-day warm handoffs and develop efficient handoff processes • Identifying which PCPs refer few patients and developing plan to decrease barriers to referral.						

Part B: Team-Based Care								
Competency	**Minimal Demonstrated Benchmark Behaviors**	**Sample Behavioral Anchors**	**Rating**					**Comments**
			1	2	3	4	5	
14. Uses consultant care structure	14. Utilizes a "consultant" rather than "therapist" structure for planned follow-up	• BHC plans to follow patients until improvement begins and a clear plan is in place for continued improvement • Most patients are seen for ≤ 4 visits. Patients not improving after 3-4 visits are recommended for specialty care • Patients may be seen for > 4 appointments when clinically indicated (e.g., patients awaiting - or not accessing - recommended specialty care; 1-2 additional visits needed to solidify skills, etc.), but always maintaining the consultant structure (i.e., the BHC does not *plan* more than one follow-up at a time)						
15. Follow-up planning	15a. Appointments are spaced in a manner consistent with a population-health model as well as individual patient needs. Schedules follow-up for < 2 weeks only when clinically indicated	• Default follow-up interval is 2 weeks • Schedules less than 2-week follow-up as indicated; e.g., a depressed patient with elevated risk of self-harm; patient with daily panic attacks requests more support, etc.						
	15b. Coordinates follow-up visits with other primary care visits to maximize convenience to the patient, decrease the likelihood of no-shows, increase teamwork, and optimize value to the patient and team	• When planning follow-up, asks every patient, "Do you have any other visits here in the near future?" • Plans follow-up same day as a PCP, if possible and indicated. Utilizes good decision-making for whether to place these visits before/after the PCP visit. • Regularly coordinates with PCP for patients started on medications (e.g., follow-up with BHC at 2 weeks and PCP at 4 weeks)						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
16. Risk management	16. Appropriately manages patients assessed to be at high risk of harm to self or other	• Recommends (and facilitates) specialty care for high-risk patients; plans follow-up with these patients until engaged in specialty care (or, until improved) • Develops Crisis Response Plan for patients deemed moderate or high risk • Follows organization guidance for facilitating emergency care for patients at imminent risk of harm to self/other • Documents at each visit the recommendation for specialty care, for high-risk patients who do not access specialists						
17. Community resource referrals	17. Has information on community-based resources, and refers patients when indicated	• Knows/Finds support groups, legal aid, senior centers, domestic violence centers, housing resources, etc. • Referrals mostly used to supplement (not replace) self-management interventions						
18. Specialty mental health utilization	18a. Understands and follows specialty care referral criteria.	• Refers to specialty care if: emergency; patient not improving after a few visits; patient prefers specialty; requested by PCP; patient needs excluded service (e.g., forensic evaluation, detox)						
	18b. Uses specialty care episodically, as needed, while maintaining longitudinal care	• When patients are referred, the BHC plans continued follow-up until patient is engaged in specialty care and/or improves • If assisting a patient who is also seen in specialty care, BHC coordinates as needed with specialist(s)						
19. Class and group services	19. Provides / Participates in classes and/or group medical visits with a format and content appropriate for primary care.	• Can differentiate a class/workshop from a group medical visit • Participates in group medical visits • Offers classes / workshops in clinic						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
20. Pharmacotherapy	20a. Can identify common psychotropic medications, indications for the medication, and common side effects. Can address myths about psychotropic medication							
	20b. Can identify medications used for physical health conditions commonly treated in PC (e.g., DM)							
	20c. Is aware of medications prescribed for patient and checks adherence	• Checks EHR for prescribed psychotropics, assesses patient adherence						
	20d. Assists with medication adherence problems	• Assesses, addresses adherence barriers • Informs PCP (during BHC visit, if needed)						
	20e. Stays within scope of practice for non-prescribers							
21. Time management	21. Flexes schedule to meet patient and team needs while generally staying on time	• BHC flexes the length of visits (when indicated) in order to accommodate same-day visits and needs of the team • BHC generally sees patients at the appointed time, unless needs of the team or same-day patients interfere						
22. Concise, clear and timely charting using appropriate format	22a. BHC-specific EHR template is used.	• Uses the service's specified template for initial and follow-up appointments						
	22b. Documents in the medical record during the clinical encounter.	• At a minimum, key history and the plan is documented during the visit						
	22c. Clinical notes are written specifically for PCP and team members in a succinct and jargon-free manner.	• The BHC uses accessible descriptors like "taught healthy thinking" rather than "cognitive restructuring", or "relaxation" rather than "autogenic training"						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
22. Concise, clear charting using appropriate format (continued)	22d. Documentation includes pertinent history of presenting problem; MSE; functional and risk assessments; clear clinical impression with specific evidence-based recommendations and follow-up plan for patient; also recommendations for PCP.							
	22e. Ensures EHR notes are accessible to the PCMH team and maintained as part of the patient's medical record.	• Notes are not routinely marked "sensitive".						
23. Written recommendations to PCP	23a. Completes clinical notes within the organization's time limit.							
	23b. Written recommendations are actionable by PCP while not adding significantly to PCP's workload.							
24. Verbal consultative staffing	24. Completes same-day verbal staffing with PCPs for every initial appointment, and as-needed staffing at follow-ups. If unable to access PCP for same-day verbal staffing, BHC uses alternate staffing means.	• Alternate means for staffing could include secure email, secure messaging, copy of written note. • Staffing of follow-up is given if there is significant new information or a change the PCP should know about.						
25. Responsiveness and availability to PC team	25a. Maintains flexible attitude and openness in providing consultation: i) Readily provides unscheduled services when needed ii) Has an "open door" policy encouraging PCMH staff interruptions to promote same-day visits and urgent curbside consultations	• BHC works with the team to make warm handoffs routine • Door is fully open when not seeing patients • Does not use a "do not disturb' sign • When BHC is with a patient and PCMH team member knocks on door to speak about another patient, BHC briefly steps out of office to address the issues						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
25. Responsiveness and availability to PC team (continued)	25b. Conducts efficient warm handoffs: i) Responds promptly to warm handoff requests ii) Accepts brief overview of referral concern from PCP iii) Meets patient briefly and arranges a visit time, ideally same day iv) Visit with patient occurs in the PCP's exam room if possible	• Responds immediately to a request for a warm handoff, even if in a patient visit • Quickly clarifies with PCP key aspects of the patient's care (e.g., PCP's treatment plan, additional activities that should occur prior to the patient's departure, how long the PCP's exam room is available) • Briefly meets the patient in the PCP's exam room; rapidly identifies a visit time that will work for the patient and BHC • Conducts a same-day visit with patient in the PCP's exam room (if available) or the BHC's room, unless the patient must leave within five minutes						
26. Team-based care	26. Clarifies and reinforces other aspects of the primary care treatment plan: i) Is aware of key components of patient's care from primary care. ii) Reinforces the importance of all aspects of the plan (especially those related to the referral concern).	• Demonstrates awareness of key aspects of the patient's care plan from primary care (including areas that are directly, and not directly, related to the referral concern) • Reminds patients of those aspects of the care plan related to the referral concern • Provides problem-solving and/or motivational interviewing for key aspects of the care plan the patient is not engaging in						
27. Assertive follow-up with PCPs	27. Interrupts PCP/team member when needed to address urgent patient needs. Interruptions are kept as brief as possible to minimize impact on PCP workflow.	• Examples of urgent patient needs: Concerning medication side effects, urgent patient questions regarding medications or medical recommendations, safety concerns.						
28. PCBH care team coordination	28. Engages patients with other care team members, when indicated.	• BHC engages the DM educator, pharmacist, dietitian, care manager, community care worker or other team member (with the PCP's consent), when indicated • Utilizes triage nurse if unaddressed medical concerns arise during a BHC visit						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
29. PCMH team education	29. Provides at least quarterly training to PCMH team members on: i) strategies for optimal use of the PCBH service and/or; ii) basic behavior change information and/or strategies	• Educates the team via formal and informal avenues (e.g., meetings, huddles, curbside consultations, handouts) on a wide range of topics such as: - Behavior change topics (e.g., MI, BA) or information (e.g., diagnostics) staff can use with patients - Role of the BHC on the PCMH team - How to use the BHC to optimize team functioning						
30. Fit with primary care culture	30a. Knows the roles of the various primary care team members and articulates their roles/duties in the clinic.	• Knows the names of all team members • Can describe the basic role of each member of the PCMH team (clinical and non-clinical) • Articulates how each team member can support a PCBH service, and vice-versa						
	30b. Regularly attends and participates in PC team meetings, huddles, and events to stay a visible and active member of the team	• Regularly requests 3-5 minutes (or more) of speaking time at clinic meetings to discuss PCBH topics • Attends 90% of clinic meetings, events						
	30c. Uses language and practice habits appropriate for PC culture.	• Avoids specialty MH language (e.g., “session”, “therapy”, “intake”). Instead, uses terms such as “appointment,” “visit,” or “classes” to be consistent with PC language • Uses PC space for visits (e.g., exam room) • Clinical space, if not an exam room, mimics the exam room (e.g., similar patient education materials, furniture, lighting; avoids special furniture not in exam rooms, white noise machine, “do not disturb” sign, or other features not standard in the clinic)						
31. Understands population-based care	31. Able to verbally describe principles of population-based care as the foundation of the PCBH model	• Can explain that the goal of PCBH is to improve care for the entire primary care clinic population • Can explain the population-based strategy of providing small interventions to large numbers of people						

Part B: Team-Based Care								
Competency	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Rating					Comments
			1	2	3	4	5	
32. BHC policies and procedures	32a. Template meets requirements: i) Minimum of 12 visit slots per day, on average, for full-time BHC ii) All slots are 30 minutes iii) Classes are slotted for 30-60 minutes iv) Most or all slots can be scheduled in advance (some same-day slots may be used for newer BHCs or those doing more than 4-5 same-day visits per day, on average)	• If same-day slots are used, the BHC does not limit the timing or number of same-day visits to the number of same-day slots; these slots are used merely as a cushion that makes it easier to accommodate same-day visits						
	32b. Uses correct CPT codes (as specified by service)	• Codes typically used include: Health and Behavior, brief (30-min) Psychotherapy codes						
	32c. The service's BHC peer review items are used in regular peer review process.							

Phase II Evaluation (Parts A & B)

When used to determine readiness for BHC work, successful completion means ***the organization's required number of Part A/B items are rated at least 3***

These ratings were based on:
Observation of ___ new and ____ follow-up appointments
Observation of ____ PCP consultative staffings
Review of ____ chart notes of patients seen in Phase II training

Competencies that are strengths:

Competencies to prioritize for more development:

Trainer's signature: _____ BHC's signature: _____ Date: _____

Supervisor's comments:

Supervisor's signature: _____ BHC's signature: _____ Date: _____

ATTRIBUTIONS: This Core Competency Tool (CCT) from Whole Team, PLLC, is an adaptation of CCTs published in Behavioral Consultation and Primary Care: A Guide to Integrating Services (Robinson & Reiter, 2007; 2016) and CCTs offered for public use by the U.S. Department of Defense (https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/649015p.pdf) and Mountainview Consulting Group, Inc. (https://www.mtnviewconsulting.com).