MONTANA PRIMARY CARE ASSOCIATION

COMING OUT OF THE SILOS

The Integrated Behavioral Health (IBH) Implementation Guide

Purpose of this document

This document introduces Primary Care Behavioral Health (PCBH) services and the evidence for using this full integration approach in the primary care setting. It describes the rationales for implementing PCBH services and a brief and practical way to introduce this approach to staff members in the clinic. Additionally, the document describes the roles and responsibilities of all members of a PC team providing PCBH services. While traditional roles continue, there are new skills that Primary Care Providers (PCPs) and nurses (RNs) can develop to use Behavioral Health Consultants (BHCs), Behavioral Health Consultant Assistants (BHC-As) and Community Support Workers (SWs) services optimally to achieve improved outcomes. These demonstrated outcomes include better patient engagement, clinical outcomes, satisfaction among PCPs and nurses, and healthcare value.

Progress toward full integration of mental health and wellbeing services in the primary care setting begins with preparation and continues as clinics make incremental changes to further the effectiveness of integrated services over the first few years. It will not take anything away from what's already offered by the primary care clinic; it only adds to it. A self-assessment tool accompanies this guide. It offers a quick check for clinics concerning critical steps toward full integration. The over-arching aim of this document is to help your clinic prepare a fertile ground for integrated care and cultivate new and expanding services that will benefit the health of the entire community.

Commonly Used Abbreviations In This Document:

Abbreviation	Term
IBH	Integrated Behavioral Health
PCBH	Primary Care Behavioral Health
CC	Collaborative Care
PCP	Primary Care Provider (Physician, Advanced Nurse Practitioner, Physician's Assistant)
RN	Registered Nurse
BHC	Behavioral Health Consultant
BHC-A	Behavioral Health Consultant – Assistant
CSW	Community Support Worker
CC-RN	Collaborative Care Nurse

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Any queries related to this toolkit should be directed to Montana Primary Care Association.

TABLE OF CONTENTS

TABLE OF CONTENTS ii

INTRODUCTION 4

Primary Care Behavioral Health: A Team-based Approach to Integration 4

1. Preparation 7

1.1 Assessing Your Clinic's Resources and Needs 7

Resources and Needs 7

Integrated Behavioral Health: A Promise and An Ask 8

1.2 New Primary Care Team Members 8

Behavioral Health Consultant (BHC) 8

Behavioral Health Consultant Assistant (BHC-A) 8

Community Support Worker (CSW) 9

1.3 Your Leadership: The Key to Success 9

IBH Champion 9

Clinic Manager 9

Front Desk Lead 10

1.4 Preparing Your Clinic's IBH Operational Framework 10

1.5 New Ways of Working for PCPs and Nurses 11

Same day appointments with the IBH clinician 11

Workflow for warm handover 11

1.6 BHC and BHC-A Training 12

BHC Training 12

BHC-A and CSW Training 13

Community Support Worker 13

2. Implementing Integrated Behavioral Health Services: Months 1-6 13

2.1 Introducing the Service 13

2.2 Collaboration and Planning 14

IBH Group and Classroom services 14

Clinical Pathway Programs 14

Adapting IBH Services to the Needs of Your Clinic 14

2.3 Helpful Monthly Metrics 15

2.4 Identifying Barriers to Use of IBH Services 15

2.5 Celebrating Success 16

2.6 On-going Professional Development 16

2.7 Local BHC, BHC-A, and CSW Capability Development 16

3. Expansion of Integrated Services: Months 6-12 17

3.1 Use of IBH Services to Enhance Preventive Care 17

3.2 Routine Class/Group Services 17

3.3 Group Medical Visits **17**

3.4 Linkage with External Resources **17**

4. Evolution of Integrated Services: Year One and Beyond **18**

4.1 Helpful Quarterly and Annual Metrics **18**

4.2 Strategic Use of BHC, BHC-A and CSW Workforce **18**

4.3 Growth of the BHC, BHC-A, and CSW Workforce **18**

4.4 Leadership Roles for BHCs, BHC-A's and CSWs **19**

5. Appendices **20**

Appendix A: **20**

IBH IMPLEMENTATION CHECKLIST **20**

Appendix B: Resources and Needs Checklist **25**

Appendix C: Adapting IBH Services to the Needs of Your Clinic **26**

Appendix D: Barriers Surveys **27**

Appendix E: List of Potential Topics for On-Going Professional Development **32**

Appendix F: List of video clips illustrating IBH Implementation Guide ideas **33**

1. BHC USING GATHER HANDOUT TO INTRODUCE BHC ROLE TO A NURSING ASSISTANT NEW TO THE CLINIC ..... **Error! Bookmark not defined.**

INTRODUCTION

Primary Care Behavioral Health: A Team-based Approach to Integration

The purpose of Integrated Behavioral Health (IBH) services is to improve the overall health and wellbeing of all people seeking care at your clinic. It involves delivery of services from a variety of new team members; the exact composition of the *new* primary care team may vary from clinic to clinic and region to region in Montana. The IBH approach involves offering behavioral health services to any patient exhibiting a need for help during a primary care visit. This population-based care approach underlies the medical services delivered in the primary care setting.

IBH services delivered in primary care mirrors the care provided by PCPs and RNs in several ways. First, they are brief. Visits with the Behavioral Health Consultant (BHC), Behavioral Health Consultant Assistant (BHC-A) or Community Support Worker (CSW) may be as short as 15 minutes and rarely require more than 30 minutes. Shorter visits are preferred by many patients and the shortened length allows your new team members to see more patients. This is important because there are many people seen in primary care who would benefit from the services of a BHC or BHC-A, but are unlikely to seek out any type of counselling or specialty mental health care and/or addiction services.

Access to community based mental health care (such as that historically funded through the State of Montana Medicaid Program) and community based addiction services will also be important, as some people will continue to need this support. Creating an additional layer of primary care based behavioral health services should not only increase access to behavioral care for the mainstream members of a community, but it will also enable appropriate access to specialty mental health and addiction services. IBH also provides a layer of support for patients transitioning out of mental health or addictions care back into the primary care system for ongoing management. In most clinics, the BHC may identify a proportion (e.g., 10% - 20% of the people they see) as in need of specialty mental health care. While some patients will agree to a referral for traditional mental health care, others will not.

The **GATHER**[1] acronym provides a brief introduction to the key strategies used in Primary Care Behavioral Health (PCBH) services, a model of IBH that been widely adopted across the nations primary care system. The GATHER acronym was originally developed to describe the work of the BHC. Please read about these strategies in Tables 1 and 2. Table 1 describes how GATHER applies to the whole team and Table 2 explains its application in the HIP role.

The evidence for IBH services includes improved access to medical and behavioral health services, better clinical outcomes, and improved satisfaction for patients and general practitioners[2].

This guide provides a brief introduction to IBH program parameters for planners and decision makers in primary care clinics and other medical facilities spread across Montana. The Appendices provide more detailed information and tools to guide program planning and successful implementation.

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[1] Robinson, P. J. & Reiter, J. T. (2015). *Behavioral Consultation and Primary Care: A Guide to Integrating Services, 2nd Edition*. NY: Springer

[2] Robinson, P. J., Von Korff, M., Bush, T., Lin, E. H. B., & Ludman, E. J. (2020). The impact of Primary Care Behavioral Health services on patient behaviors: A randomized controlled trial. *Family Systems and Health, 38(1*), 6-15.

The IBH Self-Assessment Tool (see Appendix A) is a checklist for integration-related activities. It is divided into four areas:

(1) preparing for integrated services,
(2) starting services (months 1-6),
(3) expanding services (months 6-12), and
(4) evolving services after year one.

The companion readings provided with this toolkit provide additional information about integrated behavioral care generally, and the primary care behavior health model specifically.

Table 1: The GATHER approach to integrated primary mental health and addiction services.

GATHER
The Essentials of BHC, BHC-A and CSW Collaboration
Here's how the BHC, BHC-A and CSW work together in the GATHER approach. **G**eneralist The BHC, BHC-A and CSW are generalists added to the clinic to help PCPs and RNs provide excellent care to all patients. While the BHC sees any patient trying to improve their health, the BHC-A focuses on helping patients self-manage their wellbeing, navigate the health care system and manage chronic diseases. The CSW focuses on supporting patients to address their social needs, access community resources and navigate the social support systems. **A**ccessible The BHC and BHC-A can see patients on the day a need is identified, most of the time and refer to the CSW as appropriate. **T**eam-based The BHC, BHC-A and CSW are core members of the primary care team and may help in a variety of ways, such as making calls, teaching classes, providing group medical visit services, and assisting with resources. **H**igh productivity The BHC and BHC-A attempt to help as many patients as possible, so they often provide very brief services at the time of need. **E**ducator The BHC teaches behavioral interventions to others on the primary care team; and the BHC-A, and CSW a teach patients new behavior change skills including self-management. **R**outine pathways The BHC, BHC-A and CSW work to complement each other's roles (e.g., the BHC may help a patient with low mood and then introduce them to the BHC-A for assistance with managing a chronic condition. The BHC-A may recognize a social need and refer them to the CSW).

*BHC, BHC-A, CSW **GATHER together!***

Table 2: The GATHER Approach to BHC Services

GATHER
The Essentials of the BHC role
Here's a way to remember the key features of BHC work: **G A T H E R**! **G**eneralist The BHC is a generalist who sees any behavioral issue and unexplained medical issue and all ages. **A**ccessible 50% of BHC services are available on a same-day basis. **T**eam-based The BHC is a core member of the primary care team and is ready to help in a variety of ways, such as pre-PCP visits, after-PCP visits, classes, group medical visits, and assisting with resources. **H**igh productivity The BHC sees 10 or more patients every day. **E**ducator The BHC teaches behavioral interventions to others on the primary care team. **R**outine pathways The BHC helps the team develop pathways or protocols that routinely involve BHC help in care for high-impact patient groups. *Let's **GATHER** at ….*

Reflecting on the how consistent your current IBH services are with GATHER can help to identify changes that would be beneficial to your clinic's medical providers and patients.

VIDEO CLIP: GATHER To Orient New PCP to PCBH
https://www.dropbox.com/s/1bv0dpnfa61u7b1/GATHER%20Orient%20New%20PCP_Recording_1760x900.mov?dl=0

1. Preparation

1.1 Assessing Your Clinic's Resources and Needs

The first step in preparing for the implementation of integrated services in your practice is to take stock of your resources and your needs. The leadership team may want to sit down and think through what resources are available and how the addition of BHC, BHC-A, and CSW services can meet the needs of your clinic. Please use the **Resources and Needs Checklist** (*see Appendix B*) as a starting point for your discussions and planning.

Resources and Needs

The Resources and Needs Checklist helps you plan ways to use integrated care to meet the unique needs of your clinic at this moment. Your total initial 'yes' responses provide a baseline. Over the course of the next 18 months, your level of integration and the success of working in new ways will increase. Using this brief checklist every 3-6 months will help you track your progress. You can record results in the table at the bottom of the page.

How IBH clinicians are utilized in clinics may vary depending on clinic resources. For example, a clinic that that is understaffed with PCPs may have the BHC involved in more pre-visit work to save the provider time in addressing patient medical needs and improve access to care for other patients. There are many adaptations a clinic might make at any point in time to address gaps in resources.

As you complete most of the steps suggested in the **IBH Self-Assessment Tool**, (Appendix A) you will see your 'yes' responses increasing on the Resources and Needs Checklist. You may even see resources improve. For example, full integration often helps a clinic optimize the use of available space, so that more services can be delivered even if you are unable to increase your space. Also, full integration has been associated with better retention of PCPs, so a resource problem like PCP shortage may improve over the course of the first few years of integrated care[3],[i].

By making behavioral health services more accessible, PCPs and RNs have more time to better meet the wider needs of their patients. Evidence tells us that patients, as well as PCPs and RNs, prefer integrated care to non-integrated care[4]. When IBH clinicians share in the responsibility of caring for patients with psychological and physical health problems, PCPs and RNs are more able to address preventive, acute

[3] English, C. I. (2021). Integrated Primary Care is Associated with Greater Job Satisfaction and Less Burnout Among Montana"s Medical and Behavioral Health Care Providers. Graduate Student Thesis. University of Montana. ScholarWorks at University of Montana. roi: https://scholarworks.umt.edu/cgi/viewcontent.cgi?article=12794&context=etd

[4] Hunter, C. L., Funerburk, Polaha, S., Bauman, J., Goodie, J. L., & Hunter, C. M. (2017). Primary care behavioral health (PCBH) model research: Current state of the science and a call to action. Journal of Clinical Psychology in Medical Settings. https://doi.org/10.1007//s10880-107-9512-0

and chronic care needs of many more patients and over time the health of the population served by your clinic will increase.

Integrated Behavioral Health: A Promise and An Ask

As might be obvious, IBH services come with a promise and an ask. Let's look at the promise first. The promise is to lessen stress on PCPs and RNs by facilitating easier and more successful delivery of services to patients. This allows your clinic to deliver a holistic package of healthcare services (psychological, social and medical) to more patients. The BHC, BHC-A and CSW infuse behavioral science into the primary care service mix by conducting brief visits to assist patients and families over the course of their lives. The promise is to improve clinical outcomes, including patient quality of life and patients skill in caring for their health. Lastly, the promise is that these services will work to strengthen the primary care team, as the BHC, BHC-A and CSW work to support optimal communication, collaboration, and linkage with external resources.

Now, for the ask.

The BHC, BHC-A and CSW will need your support in starting work in roles that are new to them. They will need your help in planning how they can best adapt their skills to the goal of helping your clinic grow stronger and more effective in its purpose.

1.2 New Primary Care Team Members

Your clinic might elect to add one or more IBH clinicians as primary care team members as you move toward integrated care. Often, a clinic will be involved in interviewing and selecting new team members. The new team members may not begin their service at the same time. When they do arrive, together or separately, it is a good idea to set aside time as a team to welcome them. Even a short celebration will help them feel like they are part of the team. Here are some brief descriptions of new team members that may join your practice soon.

Behavioral Health Consultant (BHC)

The GATHER acronym, which will be addressed later in this guide, describes the role of the BHC in depth. The BHC will be a licensed health care professional and will often have participated in intensive training in BHC work prior to arrival. The BHC sees patients of any age for brief appointments (15-30 minutes) and, not only accepts, but actually *prefers* same-day referrals from PCPs and RNs.

Behavioral Health Consultant Assistant (BHC-A)

The BHC-A works closely with a BHC to support the BHC's clinical practice. Tasks include greeting patients, responding to warm handovers or same-day referrals when the BHC is not available, completing outcome measures (e.g., Pediatric Symptom Checklist, Duke Health Profile), calling patients to deliver information from the BHC or other team member, and supporting patients in self-management plans developed by the team. The BHC-A is typically a non-licensed health care professional who is trained and

supervised by the BHC. At the request of the BHC, the BHC-A may deliver psychoeducational services consistent with brief handouts describing evidence-based interventions.

Community Support Worker (CSW)

CSWs are community based and may have specific cultural and/ or lived experience that assists them with engaging patients, many of whom may not have regular involvement with your clinic. While the CSW is typically not a licensed health care professional, many CSWs will have completed some college course work in mental health, addictions or social work. In some resource poor locations, the same person can fulfill both the BHC-A and the CSW role, flexing as necessary based on the patient's needs. In other areas the CSW may be part of a separate community based program or organization designed to link patients with specific community support functions.

1.3 Your Leadership: The Key to Success

The more your clinic leadership knows about IBH and the roles of the new team members, the more quickly members of the primary care team will experience the benefits of integrated primary behavioral health and addiction care. Here are some ideas about how various members of your leadership team may help support the implementation process in your clinic.

IBH Champion

It is best to identify a clinical team member who would like to champion the IBH program in your clinic. The 'IBH clinic champion' can be an RN or PCP. In addition to other vital functions, the IBH champion will, (1) partner with the BHC, BHC-A and/or CSW with the aim of facilitating their integration into clinic activities and (2) supports your clinic's on-going efforts to further evolve the integrated care program (such as designing and implementing clinical pathways that integrate IBH services as part of routine care).

Often, the IBH champion will be the first to try out new workflows involving IBH services. For example, the IBH champion and BHC might decide to pilot a routine practice of referring a patient diagnosed with diabetes to the BHC for a same day visit on the day of their diagnosis. This pilot would provide information about the relative value of helping the patient with their emotional response and their acceptance of the diagnosis and their subsequent ability to develop strong self-management habits.

There are many possible pathways (or workflows), and it is useful for the PCPs and RNs to collaborate with the IBH champion and IBH clinicians to identify groups of patients with particular needs and establish pathways.

VIDEO CLIP: Champion Orients Champion
https://www.dropbox.com/s/vq3g4385cn6g8yw/Champion%20Orients%20Champion.mov?dl=0

Clinic Manager

The clinic manager is key to successful integration and evolution of the IBH program and the services it provides. During the first 6 months, your clinic manager may want to check in with the new team members on a regular basis. The frequency of brief check-ins might start with once weekly and move to every other week after the first month. The clinic manager will also want to both support and organize training opportunities designed to increase the effectiveness of the BHC, BHC-A or CSW.

Front Desk Lead

The front desk lead will often help with the development of the BHC schedule template and will be important in preparing front desk workers for greeting and assisting patients that are receiving IBH services. The front desk lead needs to understand that all initial BHC appointments are 30 minutes in length and that every other appointment (50%) in the daily schedule template is held open for same-day visits. Patients scheduled for same-day visit appointments do not need to be urgent patients but can present with routine behavioral health needs. They may also be new patients or follow-up patients. The goal in scheduling patients for an IBH service is to offer them the first available appointment, including being seen on the same day as a PCP or RN referral. The front desk lead can also act as a first point of contact, making a quick recommendation to the RN or PCP for a BHC visit if behavioral health needs are identified when the patient checks in at the front desk.

1.4 Preparing Your Clinic's IBH Operational Framework

The BHC, BHC-A or CSW will need a range of support functions in place to do their job well. These include space to work from when they are seeing patients; access to the electronic medical record (EMR); a way to communicate with teammates; an appointment template or booking system; access to non-confidential medical documents to support their work; a section of a bulletin board to provide information and updates to teammates and a method for reporting activities and outcomes to your clinic's leadership team. Following are a few details to help you prepare for what your new primary care team members will need.

- Space for patient visits
    - It is critical to provide the BHC, BHC-A or CSW a place to work that is in the exam room area
    - This could be a station shared with a nurse; it does not need to be an exam room.
    - When seeing patients, the BHC and BHC-A can work in any available small space; it does not need to be the same space every day.
- Access to clinical records
    - The BHC, BHC-A or CSW will need to enter patient-related information into your electronic medical record (EMR). In most clinics, this will involve direct input into the chronological record of care while in others, information from a separate IBH database will be uploaded into the EMR.
    - The BHC and BHC-A need to be able to communicate with PCPs and RNs, using the EMR.
- Shared appointment booking system
    - The BHC appointment template needs to include 30 minutes appointments throughout the practice day, with every other appointment held open for use for same-day appointments.
    - The BHC appointment template needs to be accessible to PCPs and RNs, so that they can directly schedule appointments for patients who wish to receive IBH services.

- Immediate access to IBH services
    - It should be noted that the PCBH approach strongly emphasizes having the BHC see patients on the same day of their medical visit. This is called a **"warm-handover"**, which creates immediate access to care for patients that bring up or exhibit behavioral health concerns during a medical visit. In general, this emphasis on same day access is also true for the BHC-A and CSW.
    - It is important for your clinic to identify how the primary care team will complete warm hand-overs of patients for any type of IBH service.
- Interprofessional communication
    - Immediate access to computerized libraries of materials to support patient interventions delivered by the BHC, BHC-A or CSW (e.g., patient education handouts, computerized scoring programs for screening and outcome surveys)
    - A section of a bulletin board where IBH providers can share information with other team members.
    - Allowing the BHC, BHC-A and CSW to attend team huddles and clinic staff meetings
    - Inclusion on the internal email group distribution list for primary care team members
- Program level and client level outcome metrics
    - The BHC, BHC-A and CSW will need clinic level support for developing a system for reporting program and client level outcome metrics to your clinic's leadership team..
    - How you do this will vary from clinic to clinic, but it is advisable to try to link existing systems for reporting metrics to the new one for reporting IBH metrics.

VIDEO CLIP: HUDDLE (BHC and PCP Huddle at beginning of day)
https://www.dropbox.com/s/6tw5vhsp06jnu43/HUDDLE.MOV?dl=0

1.5 New Ways of Working for PCPs and Nurses

Same day appointments with the IBH clinician

Most of the time, patients prefer to see a BHC, BHC-A or CSW when they are already at the clinic for a medical visit. This is particularly so for an initial visit, but also true for follow-up visits as well. The PCP or RN is thus strongly encouraged to make a "warm handover" of the patient to the BHC, BHC-A or CSW. Warm handovers capitalize on the patient's motivation to change and reduce the "no show" rate to 0%. This has the effect of maximizing the clinical impact of a BHC, BHC-A or CSW visit and, by eliminating no shows, optimizes the clinic wide impact of IBH services in general.

VIDEO CLIP: Why BHC Prefers Same-Day (BHC Explains to Nurse Why Same-Days are Preferred)
https://www.dropbox.com/s/2zd8g6h0yww5y9r/Why%20BHC%20Prefers%20Same-Day.mov?dl=0

Workflow for warm handover

The warm handover begins with the PCP, RN or other referring staff member explaining what the BHC has to offer. Often, the referring PCP or RN will say something like this:

"I would like you to see our behavioral health consultant today. Our (BHCs) name is X, and he/she helps me work with patients that I see that are experiencing stress and everyday problems of living. These visits are

often short, 15- to 30-minutes, and there is no charge for you to see them. (BHC's name) is probably available right now or at most within the next half-hour. (BHCs name) has been very helpful to many of my patients with similar concerns. Would you like me to introduce you to X now?"

The other steps in a warm handover involve entering the patient into the appointment schedule for the IBH clinician and then bring them together in the exam room, providing a brief face to face introduction of the IBH clinician where possible. While many patients will prefer an in-person warm-handover, especially where there is a heightened level of immediate distress or a reluctance to engage with traditional mental health or addiction services in the community, some patients will not want to stay for an immediate appointment. In this case, sending a text to or calling the BHC, BHC-A or CSW and inviting them briefly to introduce themselves to the patient is important. Matching "a name and a face" also reduces the likelihood of a subsequent no show by the patient. The referring PCP or RN will have a sense of what is best clinically and culturally for each patient, in terms of the acceptability of using a warm handover or scheduling a patient for a visit with the BHC, BHC-A or CSW on another day.

VIDEO CLIP: PCP MAKING A WARM INTRODUCTION TO BHC
https://www.dropbox.com/s/kcbyrddzv8b39i6/Warm%20Handover.MOV?dl=0

1.6 BHC and BHC-A Training

All BHCs and BHC-As need to complete a training program designed to equip them with the knowledge and skills to undertake their role. Strategies for funding training vary and need to be explored in preparation of implementation of PCBH services. Training takes a few months to complete and there is an expectation that both roles need to successfully complete the training programs be able to succeed in their work in their role as a BHC, BHC-A, or CSW.

The training programs are intended to provide the foundation knowledge and skills to equip people to work in these roles. Employing organizations will need to continue to support ongoing individual professional development that reflects the persons experience, qualifications and needs of the local population.

BHC Training

The BHC training program has three components:

- Classroom -based training (live or virtual)
- Pre practicum – two days of in practice training, one day shadowing an experienced BHC and one day with a BHC trainer establishing relationships with the primary care team (live or virtual)
- Practicum – supported learning through mentoring groups, webinars, tutorials and assessments over six months

Learning outcomes for the program are as follows:
The BHC. . .

- Consistently practices within the primary care behavioral health model
- Uses behavioral health techniques and tools to intervene with diverse people's health situations and progress them towards improved health

- Works collaboratively to offer and promote integrated care within a primary care context

The classroom training introduces the scope and purpose of the BHC role, learning new skills and tools to use in practice.

BHC-A and CSW Training

Behavioral Health Consultant-Assistants and CSWs participate in training on PCBH delivered by a BHC just prior to their start of work. This training involves a wide range of learning activities and prepares them for their work in their new role. Some BHC-As and CSWs have worked in similar roles, such as nursing or medical assistant or community service positions. When they arrive at their clinic, they will collaborate with a BHC trainer and the clinic IBH champion. Together, they will begin to define ways in which the BHC, BHC-A, and CSW can partner with the team.

The training has several components including classroom-based learning (either in person or virtual), coaching and webinars.
The learning outcome for the training program are:
Behavioral Health Consultant - Assistant…

- Extends the work of the BHC (e.g., administering outcome surveys, facilitating warm hand-overs, calls to patients, assisting with group services, facilitating telehealth visits, etc.)
- Works in partnership with people from diverse backgrounds and health contexts to improve their emotional and physical wellbeing
- Works collaboratively within the primary care team

Community Support Worker

- Connects people with services and resources to support their emotional and physical wellbeing
- Maintains wellbeing and safety.

The programs are designed to reflect the behavioral health assistant and community support worker roles regardless of how these are configured in your area - whether based within the primary care practice or within a community organization. Prior to attending a training it is useful to meet with the training provider to provide an overview of the context of how the BHC-A and CSW roles are working in your area. Please speak to your regional leadership regarding an opportunity to participate in a discussion with a training provider.

2. Implementing Integrated Behavioral Health Services: Months 1-6

2.1 Introducing the Service

As mentioned previously, a warm clinic welcoming process empowers a strong start. It is also useful to "pass the word" about the availability of the IBH service. For example, create and distribute posters with a photo of the new BHC, BHC-A or CSW in the clinic for a few weeks prior to start up. A poster might include the work schedule for the BHC and guidance on how to make same-day referrals, and methods for contacting them. The new team member (s) should be given a 15-30 minute slot in an all staff

meeting during first week of start-up. Allowing the BHC and IBH champion to provide regular "program updates" at clinic staff meetings allows the whole staff to celebrate "wins" and "challenges". Depending upon your clinic practices, the best format for such "program updates" might be an all-staff gathering or meetings of health care providers. During these meeting, the BHC and IBH champion will work to get an understanding of the needs of the clinic for IBH services, brainstorm helpful ways of working together, and address questions.

VIDEO CLIPS: PCBH Flow - WHO and Initial Consult.mov, PCBH Flow - BHC Provides Feedback.mov

PCBH Flow - WHO and Initial Consult.mov
https://www.dropbox.com/s/1i9x8671rrl9cj5/PCBH%20Flow%20-%20WHO%20and%20Initial%20Consult.mov?dl=0

PCBH Flow - BHC Provides Feedback.mov
https://www.dropbox.com/s/ul0q0q6zf79o397/PCBH%20Flow%20BHC%20Provides%20FB.mov?dl=0

2.2 Collaboration and Planning

IBH Group and Classroom services

Group or 'classroom-type' services are often helpful for several reasons. First, groups provide a helpful format for patients to learn new skills and receive and give emotional and social support. Second, by working in groups, IBH clinicians can serve more patients. Group-based services may address preventive care needs or supplement efforts to meet the biopsychosocial needs of patients with chronic conditions. These groups may be led by the BHC, BHC-A or co-led with a member of the medical team.

Clinical Pathway Programs

A clinical pathway is an organized clinic process involving PCPs, RNs, IBH providers, and other team members working together to improve the services offered to a specific group of patients. For example, a simple pathway might be that PCPs will offer all parents of young children concerned about their child's behavior a same-day appointment with a BHC; or patients with diabetes a same-day appointment with a BHC-A for more extended review of the patient's self-management goals. Pathways help PCPs and RNs incorporate IBH clinicians and services into the routine delivery of clinical services, with an intention to improve outcomes.

Pathways may or may not involve group or classroom services. An example of a group pathway might be PCPs referring patients with low mood and low motivation to the BHC for behavior activation interventions prior to prescribing a psychotropic medication. The BHC or BHC-A would offer the patient assistance with behavior change to improve mood and energy and invite them to participate in a 4-class series designed to help improve quality of life (Life Path Class).

Adapting IBH Services to the Needs of Your Clinic

Every clinic setting is different and IBH services need to be shaped to meet the unique features of a clinic. Features to be analyzed and addressed include the community and cultural context, the attitudes of individual staff members, the ways staff members work together as a team, and the patients served by your clinic. ***Appendix C*** provides a survey for your clinic to use in taking stock of your practice resources, your patient demographics and vulnerabilities for the purpose of identifying priorities for your IBH program to address. Ideally, most members of the clinic staff will respond to this brief survey and your new BHC will summarize the results and present them to the staff. This will begin an on-going process for adapting, refining, expanding, and evolving IBH services in your clinic.

2.3 Helpful Monthly Metrics

Measurement-based care is used routinely in primary care and a few select measures will help you asses your progress with integrating behavioral health services into your practice. The following table provides a list of recommended metrics and related information.

Metric	*Frequency of Review*	*Goal*
1. Mean number BHC visits completed per day	Monthly	8+
2. Mean number of BHC-A visits completed per day	Monthly	8+
3. Mean number of CSW visits per day if also doing home or community visits	Monthly	6+
4. PCP/RN referrals to BHC, BHC-A, CSW per week	Monthly	3-15*
5. Referral for more intensive therapeutic intervention/package or to specialty mental health and addiction services	Monthly	10% - 20% of those referred to BHC or BHC-A
6. Patient satisfaction with BHC, BHC-A and CSW visits (1-10, asked in all visits)	Monthly	7 or above

*Number of PCP/RN referrals depends on staffing ratio of PCPs/RNs and BHCs, BHC-As on any particular day in a practice. On a day when a practice has fewer PCPs/RNs, the expectation is that the PCPs/RNs working will make more same-day referrals to the BHC and BHC-A.

VIDEO: Clinic Leadership Using Metrics
https://www.dropbox.com/s/yzieh4x3283gig5/Clinic%20Leadership%20Using%20Metrics.mp4?dl=0

2.4 Identifying Barriers to Use of IBH Services

Appendix 4 contains 4 surveys for identifying barriers to PCP and RN use of BHC and BHC-A services: two surveys attempts to identify *general barriers* to PCP and RN use of BHC or BHC-A services; two surveys attempt to identify specific barriers to use of BHCs and BHC-As for *same-day* services (meaning the same day as the patient's concern is identified or request is made). Your clinic leadership can decide which survey to use and when. It is good to assess barriers every 3-6 months during the start-up phase of your clinic's IBH program. If the BHC or BHC-A is not receiving 4 or more same-day referrals on an on-going basis, it is probably best to use the same-day version of the barriers survey. Following is a list of the Barriers Survey by name (See Appendix D for the surveys.).

- Barriers to Use of BHC (BUB) Survey
- Barriers to Use of BHC on Same-Day (BUB-SD) Survey
- Barriers to Use of BHC-A (BUBA) Survey
- Barriers to Us of BHC-A on Same-Day (BUBA-SD) Survey

The Barriers surveys are brief, and PCPs and RNs can complete any of them in under 5 minutes. It is best to have the surveys completed anonymously and returned to the BHC, BHC-A or clinic director for scoring and developing a written summary of results and recommendations.. The BHC or BHC-A will often discuss results with the IBH champion or clinic supervisor to generate more ideas for effectively addressing the barriers. Then, the BHC can make a brief report to implementation leadership and staff and seek their input on strategies to address any identified barriers.

Note that the Barrier surveys do include 2 questions about satisfaction with the services of the BHC or BHC-A. If the mean ratings for satisfaction are less than 7, the BHC or BHC-A will need to seek assistance from leadership to identify and support changes needed.

2.5 Celebrating Success

While change is the way to better outcomes, including higher job satisfaction for all members of the primary care team, change is also challenging. It is important for a clinic to find a way to celebrate their success with integrated behavioral health care. Perhaps your clinical leadership and primary care team (s) will develop feasible ways of acknowledging progress. This might include celebrating a high number of referrals per day, sharing the outcomes of an IBH group or classroom program at team meetings or celebrating positive case studies / stories where the patient is now successfully managing their health themselves.

2.6 On-going Professional Development

Your BHC, BHC-A or CSW will definitely benefit from professional development activities that enhance their clinical skills for assisting patients with a wide range of psychological and medical problems. Others on your primary care team (s) may also benefit from accessing professional development activities on how to intervene with common behavioral health problems.

Your BHC and BHC-A work as generalists and provide services to patients of all ages and address all issues adversely affecting wellbeing including alcohol and other drug issues. Depending upon their prior training and work experience, they may need assistance with accessing professional training to enhance their skills for working effectively in their generalist role. See Appendix E for a List of Topics for on-going professional development for BHCs, BHC-As and other team members. Collecting encounter level data identifying the most common diagnostic codes used will help refine this list in future.

Often, providers or professional support organizations such as the Montana PCA may be able to join together to arrange professional develop activities for new BHCs, BHC-As or CSWs. Some of these activities may be specific to the BHC or BHC-A role, the CSW role, and some may be relevant to both.

2.7 Local BHC, BHC-A, and CSW Capability Development

Learning does not stop with the completion of formal training. Over time, it is hoped that every region will develop clinical leadership to support continued development for new IBH staff, to enable effective use of these new roles by clinics in the region. This is necessary for this new way of working to become sustainable. In addition, some BHCs may develop an interest in qualifying to train to become a BHC trainer. While this will require use of BHC locum's to cover while BHCs are away training, it is a strong asset for maintaining a consistent workforce and sustaining high level integration in your local region. Information about the training curriculum for BHC trainers is available from your primary care association.

3. Expansion of Integrated Services: Months 6-12

3.1 Use of IBH Services to Enhance Preventive Care

The BHC and BHC-A can assist with preventive care activities in a variety of ways. For example, BHCs can ask a series of questions on social and developmental milestones during pediatric well child visits or serve as an immediate follow-up resource when well child exams identify a need for care (e.g., an over-weight 4 year old). Additionally, the BHC and BHC-A can contribute to preventive care by consulting with patients with chronic conditions on an annual basis, looking for life stressors that might challenge stable and successful self-management.

3.2 Routine Class/Group Services

As your IBH program evolves, the BHC and/or BHC-A may be in a position to spend 10-20% of their clinical time in group or classroom-based care. The group-based care services will address the unique needs of your clinic. For example, a clinic serving a large group of older adults, may have several groups providing skill training and support in weekly or bi-weekly sessions for adults 65+ (Life Satisfaction Class). A clinic serving a younger group of patients might have weekly classes / groups focused on eating well, eating together as a family, and use of traditional recipes with local fresh ingredients. Weekly walking groups, involving discussion of a healthy lifestyle topic with a partner and with the large group at the end of session, are well-attended in many different practice settings.

3.3 Group Medical Visits

The IBH clinician may lead or co-lead group medical visits serving a variety of patient needs. For example, a BHC might offer a monthly group medical visit for patients with chronic pain, where patients learn or receive support for maintaining skills for pursuing a high quality of life, even while living with on-going pain. A CSW might co-lead a monthly group session for patients with diabetes with a diabetes educator RN.

3.4 Linkage with External Resources

As your IBH program grows strong roots, IBH providers can strengthen the linkage with community resources, including connections with community support agencies. The BHC can form strong relationships with local specialty mental health providers, mental health and addiction services clinics., The goal is to develop a stepped care continuum where patients can step up easily for more intensive

therapy or a brief episode of specialty mental health or addictions care and then step-down to primary care in order to stabilize any gains achieved in more intensive care.

4. Evolution of Integrated Services: Year One and Beyond

After a year of mindful attention, your PCPs and RNs may have difficulties imagining doing their work without the assistance of team based IBH clinicians. Now is a good time to look at a few more metrics, to anticipate workforce development needs, and to support the development of leadership in your area.

4.1 Helpful Quarterly and Annual Metrics

Your BHC will be able to suggest measurement strategies for looking at sources of stress for staff. Additionally, your BHC will be able to provide brief workshops on resilience and mindfulness. Another important metric to look at on a quarterly basis is that of staff satisfaction. On an annual basis, you may want to look at staff retention, as impacted by the frequency of IBH service utilization. Ideally, your BHC and BHC-A will have contact with 8 - 15% of the patients at your clinic on an annual basis.

4.2 Strategic Use of BHC, BHC-A and CSW Workforce

Most often, rates of using the BHC, BHC-A or CSW will be high and stable after a year of practice guided by metrics and thoughtful quality improvement efforts. There may be times when referral rates drop due to PCP and RN vacations, but those times are opportunities for BHCs and BHC-As to deliver more preventive care and develop or revise educational materials for patients and colleagues. There may also be times when, due to heavy demand from their primary care team members, BHCs and BHC-As are unable to accommodate all the requests for their services. When immediate access to behavioral healthcare of any kind is limited, your IBH providers will review strategies they can use to (when appropriate) 'keep the door open'.

The same-day service standard is critical to the success of the PCBH approach, so BHCs and BHC-As need to assure that about half of their visits remain open each day. PCPs may help by instructing patients who are not seen by an IBH clinician on a same-day basis to call on the day they would like to be seen rather than scheduling the patient out weeks in advance, as attendance rates are less high.

During busy times, the BHC and BHC-A will want to collaborate with the IBH champion to discuss strategic use of their services. Sometimes, it is very helpful for a BHC or BHC-A to begin a new group-based service that accommodates the needs of a group of patients that they may be seeing individually on a more or less regular basis. It is important to keep in mind that most patients benefit from a few appointments with the BHC and those that need more sustained contact may benefit from briefer BHC contacts (15 minutes) and/or drop-in group sessions where they can learn new skills over an extended period of time.

4.3 Growth of the BHC, BHC-A, and CSW Workforce

It is wise to always be thinking about growing your IBH workforce, as the need for this type of health care professional is undoubtedly going to increase with time. Strategies for workforce development should be

discussed with your local IBH Implementation team. Your clinic might be able to offer interns a learning experience or, for more advanced students, a practicum, internship or post-doctoral learning experience. There is a huge need for BHCs, BHC-As and CSWs from diverse ethnic and cultural backgrounds and it is wise to consider opportunities to work with the local implementation team to look at how to grow a more diverse workforce in your region.

4.4 Leadership Roles for BHCs, BHC-A's and CSWs

It is important to think about ways in which your workforce can grow both in capacity and capability. One way of doing this is to enlist a particularly experienced BHC or BHC-A to become a IBH program lead. This role often supports the overall rollout of the services, taking a lead in the practice of other BHCs and BHC-As, particularly in relation to maintaining model fidelity and ensuring that the workforce has the appropriate skills and learning to support their roles. Likewise, CSWs may progress towards being best practice workers and advance professionally to a role that includes training new CSWs.

As previously discussed, identifying a proficient BHC who may be interested in becoming a trainer for your local area is something to keep in mind. It's important also that this person can demonstrate best practices in BHC work, but also has an affinity for acting as a trainer and coach for the new workforce. Where possible, experience in teaching or training is a good basis for this role.

5. Appendices

Appendix A:

IBH IMPLEMENTATION CHECKLIST

Instructions
This tool is for clinics to use in (1) preparing for integrated services, (2) starting services (months 1-6), (3) expanding services (months 6-12), (4) and evolving services after year one. The items are organized into these four sections, and, within each section, there are both critically important items (non-shaded) and recommended items (with shading). The items are presented in question form, and you are asked to answer, 'yes' or 'no'. Of course, sometimes you may want to say 'in between' and that's fine, just think through what might help you move toward 'yes'.

The purpose of this tool is to guide you in identifying specific actions that can help you efficiently develop integrated mental health and addiction services and to experience the improved outcomes associated with integrated care. In using this tool, you can better anticipate and address changes in your clinic and you can better define adaptations to IBH services to meet the needs of your unique clinic.

If you have not yet read the IBH Implementation Guide, take a moment to scan it as it provides more information about the four phases of implementing integrated services in your clinic. The IBH Implementation Guide also has links to short video clips that may bring life to some of the new ways of working involved in integrated care.

When you have questions about specific steps or about general concepts in this tool, please refer to the IBH Implementation Guide and /or reach out to a clinic with more experience in your region.

A. Preparation for Integrated Services	**YES**	**NO**
1. Has your leadership team read Robinson & Reiter,2016, Chapter 1[1] and Robinson, et al., 2018[2]? (See Companion Reading Series)		
2. Has your leadership team read Bodenheimer & Laing (2007)[3] and Chen, et al., 2010[4]? (See IBH Companion Reader)		
3. Does your leadership team understand the purpose of integrated primary behavioral health and addiction services?		
4. Does your leadership team understand the GATHER model for BHCs, -BHC-As, and CSWs*?		
5. Does your leadership team understand the evidence for a full integration approach (improved patient engagement and satisfaction, better value, better PCP satisfaction, etc.)?		
6. Has your leadership team completed the Resources and Needs Checklist in order to strategize ways to adapt the PCBH/GATHER approach to your practice? (See Appendix B)		

7. Has your leadership team arranged to visit a clinic that has had PCBH (BHC/ BHC-A/ Community Support Worker[5]) services for more than a year?		
8. Has your PCA provided you with a job description and job advertisement for a Behavioral Health Consultant (BHC)?		
9. Has your PCA provided you with a job description and job advertisement for a Behavioral Health Consultant-Assistant (BHC-A) and Community Support Worker (CSW)?		
10. Does your clinic have a representative involved in the shortlisting and or interviewing of BHCs and other possible new IBH positions?		
11. Does the interview panel for BHC and other possible new IBH positions have a copy of interview questions and examples of optimal answers to use in the interview?		
12. Has your leadership team discussed ways to support collaboration between BHC, BHC-A, CSW, and CC RN (Collaborative Care Nurse) (e.g., having BHC-A provide "meet and greet" for BHC same-day referrals when BHC is not in the clinic, etc.)		
13. Does your clinic have an IBH Clinic Champion?		
14. Can the Practice Manager or IBH Clinic Champion clearly describe the IBH services to new clinic staff?		
15. Is the Practice Manager prepared to make changes to operations to prepare for BHC services (and services of other new IBH staff) (e.g., creating a schedule template that allows for 30-minute appointments with every other appointment same-day, etc.)?		
16. Does your front desk administrator understand services provided by BHCs and BHC-As and know to offer same-day appointments to patients seen by BHC or BHC-As that are calling to book a follow-up appointment?		
17. Has your leadership team decided who refers to the BHC, BHC-A, CSW/or CC RN, and to maximize patient access (e.g., PCP, nurse, administrator, front desk, HC BHC-As / CSW, self-referral, etc.)?		
18. Has your leadership team determined a location where the BHC and BHC-A can sit in a central location where they can be easily accessed by PCPs and nurses?		
19. Has your leadership team provided BHC, BHC-A, and CSW access to the EMR and arranged for BHC and BHC-A training in use of the appointment and EMR systems in your clinic?		
20. Are PCPs and nurses ready to communicate in multiple ways in real time with BHC and BHC-A (e.g., text, instant messaging, phone, e-mail, etc.)?		
21. Have you discussed how your IBH data will be collected and / or piloted a system for collecting, analyzing, and displaying BHC, BHC-A and CSW data for on-going program evaluation?		

[5] The Community Support Worker (CSW) role can be flexible to reflect the specific needs of your clinic. This includes a Support Worker, Cultural Support, Peer Support.

22. Has your leadership team created an appointment template for the BHC, BHC-A and CSW that allows for 30-minute appointments, alternating between same-day and future throughout the clinic day?		
23. Has your leadership team trained clinic staff on the procedure used in scheduling same-day appointments with BHCs, BHC-As, and CSWs?		
24. Has your leadership team trained clinic staff on the procedure used to schedule future appointments with BHCs, BHC-A, and CSWs?		
25. Do all PCP and nursing staff know that referring to BHCs and CSW on the same day as their medical visit improves patient access and engagement?		
26. Have all PCP and nursing staff received orientation on what to say to a patient when they are referring the patient to a BHC?		
27. Have all PCP and nursing staff received orientation on what to say to a patient when they are referring the patient to a BHC-A?		
28. Have all PCP and nursing staff received orientation on what to say to a patient when they are referring the patient to a CSW?		
B. Start of Integrated Services (months 1-6)	**YES**	**NO**
1. Is there a time scheduled for staff to meet the new BHC and/or other new IBH staff on their first or second day of work?		
2. Is there a plan for the new BHC and/or other new IBH staff to shadow the IBH Clinic Champion in practice?		
3. Have PCPs and nurses completed the "Resources and Needs Checklist"? (See Appendix B)		
4. Has the BHC provided feedback to PCPs and nurses on their responses to the "Adapting PCBH to the Needs of Your Clinic" Survey and started a planning process for optimal use of BHCs and/or other new IBH staff?		
5. Is there consensus in the clinic about the start of initial BHC classes or groups?		
6. Has the BHC and/or CSW started to offer group sessions?		
7. Is there consensus in the Clinic on the start of a BHC pathway (e.g., referral of patients with low mood/low motivation to the BHC prior to start of medication treatment)?		
8. Are most PCPs/nurses participating in a BHC pathway service?		
9. Is there consensus in the clinic about the start of a BHC-A/CSW pathway (e.g., same day meet and greet visit with the BHC-A for patients needing assistance with management of chronic conditions)?		
10. Are most PCPs/nurses participating in a BHC-A/CSW pathway service?		
11. Does your clinic have one or more ways of celebrating integration (e.g., "Warm Handover Trophy")?		
12. Do you post graphs in the staff room indicating number of visits completed by BHC's weekly?		
13. Do you post graphs in the staff room indicating number of visits completed by BHC-AS/ CSWs weekly?		
14. Do you post graphs in the staff room indicating number of referrals by PCP (without name, only Dr. A, B, etc.)?		

15. Has the BHC asked PCPs and RNs to complete one or more of the Barriers to Referral Survey(s)? (See Appendix D for all 4 versions)		
16. Have the BHC, PCPs, and RNs discussed Barrier Survey results and agreed to a plan to lessen any identified barriers to use of BHC, BHC-A or CSW?		
17. Do the IBH Clinic Champion and BHC meet monthly to discuss Professional Development topics for expansion of evidence-based treatments in an integrated treatment setting (e.g., interventions for young children, assessments and interventions for older adults with cognitive impairment, etc.)? (See Appendix E for a list of potential topics for On-going Professional Development learning).		
18. Does clinic management support staff participation in Professional Development trainings needed to enhance the effectiveness of integrated services?		
C. Expansion of Integrated Services (months 6-12)	**YES**	**NO**
1. Does your clinic have more than one BHC pathway?		
2. Does your clinic have more than one BHC-A or CSW pathway?		
3. Do your PCPs involve BHCs in preventive services (e.g., 4-year-old well child visit when child is overweight, adolescent well child visit when parent-child communication problems are identified)?		
4. Do most PCPs and RNs refer patients to class or group services provided by the BHC and BHC-As/ CSWs?		
5. Does your clinic offer patients one or more group medical services option?		
6. Does your clinic have a strong relationship with local mental health services?		
7. Does your clinic have a strong relationships with local addiction services?		
8. Are your BHC and/or BHC-As/CSWs able to meet the behavioral health needs of about 90% of the patients referred to them by PCPs and RNs (without referring to specialty care)?		
D. Evolution of Integrated Services (after year one)	**YES**	**NO**
1. Does your clinic assess staff resilience and/or team health on a regular basis?		
2. Does your BHC offer brief trainings on stress management, team-based practice, resilience, etc.?		
3. Does your leadership team strategize about how to use available BHC/BHC-A/CSW resources to meet patient needs for IBH services?		
4. Does the leadership team understand options for BHCs to grow professionally into mentor, training, and other leadership roles?		
5. Does the leadership team allow visits from clinics that are at the preparation phase of transitioning to integrated services?		

[1]Robinson, P. J. & Reiter, J. (2015). Behavioral Consultation and Primary Care: A Guide to Integrating Services, NY: Springer.

[2]Robinson, P. J., Oyemaja, J., Beachy, B., Goodie, J., Bell, J., Sprague, L., Maples, M. & Ward, C. (2018). Creating a primary care workforce: Strategies for leaders, clinicians, and nurses. *Journal of Clinical Psychology in Medical Settings*, 20 (3). DOI 10.1007/s10880-017-9530-y

[3]Bodenheimer T, Laing B. (2007). The Teamlet Model of Primary Care. *Annals of Family Medicine*, Sept-Oct; 5(5), 457-461.

[4]Chen EH, Thom DH, Hessler DM, La Phengrasamy, Hammer H, Saba G, Bodenheimer T. (2010). Using the teamlet model to improve chronic care in an academic primary care Practice. *Journal of General Internal Medicine,* September (Suppl 4), 610-614.

Appendix B: Resources and Needs Checklist

This checklist helps you take stock of your resources and identify needs that may be better addressed in a fully integrated care approach. Use your total 'yes' responses today as your baseline and repeat this brief checklist every 3-6 months during your first 18 months of integrated services. You can track your progress in the table at the bottom of the page.

To the extent that you are able to complete most of the steps suggested in the IBH Self-Assessment Tool, you will see yes responses increase on the Resources and Needs Checklist. You may even see resources improve. For example, full integration often helps practices optimize space, so that it works better, and implementation of full integration is associated with better retention of PCPs and RNs.

Fully integrated care can also address many of the pressures felt by clinics and medical facilities across the country. By making mental health and addiction services more accessible, PCPs and RNs have more time to better meet the medical needs of their patients. In this team approach, there is more time for supporting patients with chronic conditions and addressing preventative care needs as well. Patients as well as PCPs and RNs consistently report being more satisfied with fully integrated care than with previous approaches to care.

Resources	**Yes**	**No**
1. Do you have adequate space for providing care?		
2. Are you fully staffed with PCPs?		
3. Are you fully staffed with RNs?		
4. Are you fully staffed with other practitioners?		
5. Do you have a BHC?		
6. Do you have a BHC-A?		
7. Do you have a CSW or direct access to community support		
Total		
Needs	**Yes**	**No**
1. Are you able to see your patients in a timely fashion?		
2. Are you able to access community based specialty mental health services in a timely fashion?		
3. Are you able to access community based addiction services in a timely fashion?		
4. Do you want to improve outcomes for your patients with chronic conditions?		
5. Are you able to meet the preventative care needs of your patients?		
6. Would you like to feel more satisfaction in doing the work you do?		
7. Would you like your patients to feel more satisfied with the care they receive at your clinic?		
Total		

Scores	**Baseline (today)**	**6-months**	**12-months**	**18-months**
Resources				
Needs				

Appendix C: Adapting IBH Services to the Needs of Your Clinic

(Adapted with permission from Robinson & Reiter, 2015[ii])

Every practice is unique. IBH services need to be shaped to meet the unique needs of a practice, reflecting the community and cultural context, the individual staff members, the ways staff members work together as a team and the patients served in the practice. Ideally, most of the practice staff will respond to this brief survey and the BHC or BHC-A will summarize the results and present them to the staff. This will begin an on-going process for adapting, refining, expanding, and evolving IBH Services in your clinic.

Question	*Answer(s)*	
Clinic Resources		
1. How many PCPs work in your clinic?		
2. How many PCPs are part-time?		
3. How many RNs work in your clinic?		
4. Do you have other potential IBH staff working in your clinic? (CC Nurse, Social Worker etc.)		If yes, who?
Patients		
5. How many patients come to your practice?		
6. How many patients are 60 years or older?		
7. How many patients are under 24 years?		
8. How many patients are under 18 years?		
9. How many patients are under 7 years?		
10. How many patients have chronic conditions?		
11. What is the breakdown for ethnicity/culture in your practice?		
12. What percent of your patients are high needs?		
Priorities for Use of BHC and BHC-A Provider		
13. What groups of patients would you most like to receive BHC and BHC-A services? Indicate level of priority using numbers 1-10, with 1 low priority and 10 high priority.		
Patients with…	Low to medium priority (1-6)	High priority (7-10)
a) Alcohol and Substance Abuse		
b) Stress and / or Anxiety		
c) Attention and learning problems		
d) Cognitive impairments		
e) Depression		
f) Family problems		
g) Relationship problems		
h) Work problems		
i) Weight management/obesity		
j) Sleep issues		
k) Trauma		
l) Other		
What **group sessions** would you like the BHC and/or BHC-A and/ or CSW to offer in your practice (e.g., sleep workshop, walking group, stress management, diabetes prevention etc.)?		

Appendix D: Barriers Surveys

There are four surveys assessing barriers to use of BHC and BHC-A services: two for BHCs and two for BHC-As.

For BHCs and BHC-As, one survey attempts to identify general barriers to PCP and RN use of BHCs and BHC-As and the other attempts to identify specific barriers to use of BHCs and BHC-As for same-day services (meaning same day as the patient's concern is identified). These are the names of the survey, and the surveys follow. Typically, only one survey is completed at a time. *Most often, PCPs and RNs can complete the survey of interest in 3-5 minutes*.

BHC Barriers Survey

1. Barriers to Use of BHC (BUB) Survey
2. Barriers to Use of BHC on Same-Day (BUB-SD) Survey

BHC-A / CSW Barriers Survey

3. Barriers to Use of BHC-A (BUBA) Survey
4. Barriers to Use of BHC-A on Same-Day (BUBA-SD) Survey

1. Barriers to Use of BHC (BUB) Survey
(Adapted with permission from Robinson & Reiter, 2015)

PART A: In your practice, when you consider using any BHC service (a class, warm-handoff, consult, etc.), how often do these factors <u>deter</u> you?	*Almost Never (0)*	*Occasionally (1)*	*Frequently (2)*
1. Patient is already seeing a therapist/counselor.			
2. I run out of time.			
3. Other needs/tasks distract me.			
4. Patient refuses the referral.			
5. Patient has seen HIP before for same problem, doesn't want to see again.			
6. Worry about alienating patient by recommending a HIP visit.			
7. Not sure how to refer to BHC.			
8. Not sure how to have patient schedule an appointment.			
9. HIP is unavailable or seems busy.			
10. HIP doesn't speak patient's primary language.			
11. Patient is responding well to medications alone; no need for HIP.			
12. Don't want to overwhelm the BHC.			
13. Not sure what to say about cost of HIP visit.			
14. Not sure which patients to send to BHC.			
15. Patient needs secondary MH or Addictions treatment.			
16. Unlikely BHC could help with this type of problem.			

If you answered "occasionally" or "frequently to 16, what was/were the problem(s)?

Other barrier(s)? Please explain:

PART B: Overall, how helpful is the BHC service **<u>for your patients</u>**? *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

No benefit *Extremely beneficial (good patient feedback)*

PART C: Overall, how helpful is the BHC service **<u>to you</u> (i.e., helps you better serve patients, etc.)?** *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

Not helpful *Extremely helpful*

PART D*:* If a 6 or below is indicated for PART B and/or PART C, what changes could be made to improve the helpfulness of the BHC service for both you and your patients? Use the backside of this paper to answer if needed.

2. Barriers to Use of BHC on Same-Day (BUB-SD) Survey
(Adapted with permission from Robinson & Reiter, 2015)

An important part of a BHC's job is providing warm-handover services (e.g., seeing a patient just before or just after you). HIPs also help with other same-day work (e.g., helping you with needs that arise during your visit such as writing a letter for you or exploring resources, etc.).

PART A: Please rate how often each of the below stops you from using these same-day BHC services.	*Almost Never (0)*	*Occasionally (1)*	*Frequently (2)*
1. Unsure about how to make a request for warm handovers.			
2. Didn't want to interrupt the BHC when he is in with a patient.			
3. Can't tell if the BHC is available.			
4. Forgot by the end of my visit.			
5. Didn't have time to involve the BHC.			
6. When the BHC seems busy, I don't like to add to their workload.			
7. I saw the BHC's schedule was full, so same day help was likely impossible.			
8. Couldn't find the BHC.			
9. The BHC was in a meeting when I needed them.			
10. The patient seemed busy, was unlikely to stay for another appointment.			
11. The patient told me she was too busy to stay for another appointment.			
12. Patient refused to see the BHC, for some other reason.			
13. I don't know what same-day services the BHC offers.			
14. I didn't know the BHC prefers same-day patient visits.			

Other barrier(s)? Please explain:

PART B: Overall, how helpful is the BHC service **for your patients**? *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

No benefit *Extremely beneficial (good patient feedback)*

PART C: Overall, how helpful is the BHC service **to you (i.e., helps you better serve patients, etc.)?** *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

Not helpful *Extremely helpful*

PART D*:* If a 6 or below is indicated for PART B and/or PART C, what changes could be made to improve the helpfulness of the BHC service for both you and your patients? Use the backside of this paper to answer if needed.

3. Barriers to Use of BHC-A/CSW (BUBA) Survey
(Adapted with permission from Robinson & Reiter, 2015)

PART A: In your practice, when you consider using a BHC-A/CSW service (a class, warm-handoff, consult, etc.), how often do these factors <u>deter</u> you?	*Almost Never (0)*	*Occasionally (1)*	*Frequently (2)*
1. Patient is already a therapist.			
2. I run out of time.			
3. Other needs/tasks distract me.			
4. Patient refuses the referral.			
5. Patient has seen BHC-A/CSW before for same problem, doesn't want to see again.			
6. Worry about alienating patient by recommending a BHC-A/CSW visit.			
7. Not sure how to refer to BHC-A/CSW.			
8. Not sure how to have patient schedule an appointment.			
9. BHC-A/CSW is unavailable or seems busy.			
10. BHC-A/CSW doesn't speak patient's primary language.			
11. BHC-A is not located in the clinic.			
12. Don't want to overwhelm the BHC-A/CSW.			
13. Not sure what to say about cost of a BHC-A/CSW visit.			
14. Not sure which patients to send to the BHC-A./CSW			
15. Patient needs BHC.			
16. Unlikely BHC-A/CSW could help with this type of problem.			

Other barrier(s)? Please explain:

PART B: Overall, how helpful is the BHC-A/CSW service **<u>for your patients</u>**? *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

No benefit *Extremely beneficial (good patient feedback)*

PART C: Overall, how helpful is the BHC-A/CSW service **<u>to you</u> (i.e., helps you better serve patients, etc.)?** *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

Not helpful *Extremely helpful*

PART D*:* If a 6 or below is indicated for PART B and/or PART C, what changes could be made to improve the helpfulness of the BHC-A/CSW service for both you and your patients? Use the backside of this paper to answer if needed.

4. Barriers to Use of BHC-A/CSW (BUBA) Survey
(Adapted with permission from Robinson & Reiter, 2015)

An important part of the BHC-A/CSW role is providing warm handovers (e.g., seeing a patient just before or just after you). The BHC-A/CSW also is available to help with other same-day work (e.g., exploring resources, phoning patients about resources, etc.).

PART A: Please rate how often each of the below stops you from using same-day BHC-A/CSW services.	*Almost Never (0)*	*Occasionally (1)*	*Frequently (2)*
1. Unsure about how to request for warm-handover services.			
2. Didn't want to interrupt the BHC-A /CSW when he is in with a patient.			
3. Can't tell if the BHC-A / CSW is available.			
4. Forgot by the end of my visit.			
5. Didn't have time to involve the BHC-A / CSW.			
6. When the BHC-A or CSW is off-site, I don't have time to contact them.			
7. BHC-A or CSW is part-time; unsure of their schedule.			
8. Couldn't find the BHC-A or CSW.			
9. The BHC-A or CSW was in a meeting when I needed them.			
10. The patient seemed unmotivated, was unlikely to engage with the BHC-A or CSW.			
11. The patient told me they were too busy to meet the BHC-A or CSW.			
12. Patient refused to see the BHC-A or CSW, for some other reason.			
13. I don't know what same-day services the BHC-A or CSW offers.			

Other barrier(s)? Please explain:

PART B: Overall, how helpful is the BHC-A/ CSW service **for your patients**? *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

No benefit *Extremely beneficial (good patient feedback)*

PART C: Overall, how helpful is the BHC-A/CSW service **to you (i.e., helps you better serve patients, etc.)?** *Please circle a number below.*

0 1 2 3 4 5 6 7 8 9 10

Not helpful *Extremely helpful*

PART D*:* If a 6 or below is indicated for PART B and/or PART C, what changes could be made to improve the helpfulness of the BHC-A/CSW service for both you and your patients? Use the backside of this paper to answer if needed.

Appendix E: List of Potential Topics for On-Going Professional Development

Below is a list of common patient presentations that many BHCs, BHC-As, and CSWs might benefit from learning more about. This can be used as a guide for ensuring that training and professional development equips your workforce to respond to each of these behavioral health concerns.

1. Anxiety/panic
2. Alcohol and drugs
3. Anger
4. ADHD
5. Child/adolescent behavior problem
6. Chronic pain
7. Cognitive impairment
8. Depression
9. Family/parenting/relationships
10. Grief
11. Lifestyle choices (eating exercise tobacco)
12. Chronic or Long-term condition
13. Medically unexplained symptoms
14. Occupation/school
15. Opioid use
16. Risk and safety
17. Sleep
18. Social issues
19. Stress
20. Treatment adherence
21. Trauma
22. Other

Appendix F: List of video clips illustrating IBH Implementation Guide ideas

To locate the place suggested for viewing in the Guide, readers can search for “video clip”.

Clinic Leadership Using Metrics.mp4
https://www.dropbox.com/s/yzieh4x3283gig5/Clinic%20Leadership%20Using%20Metrics.mp4?dl=0

Champion Orients Champion.mov
https://www.dropbox.com/s/vq3g4385cn6g8yw/Champion%20Orients%20Champion.mov?dl=0

GATHER Orient New PCP_Recording_1760x900.mov
https://www.dropbox.com/s/1bv0dpnfa61u7b1/GATHER%20Orient%20New%20PCP_Recording_1760x900.mov?dl=0

HUDDLE.MOV
https://www.dropbox.com/s/6tw5vhsp06jnu43/HUDDLE.MOV?dl=0

PCBH Flow - BHC Provides Feedback.mov
https://www.dropbox.com/s/ul0q0q6zf79o397/PCBH%20Flow%20BHC%20Provides%20FB.mov?dl=0

PCBH Flow - WHO and Initial Consult.mov
https://www.dropbox.com/s/1i9x8671rrl9cj5/PCBH%20Flow%20-%20WHO%20and%20Initial%20Consult.mov?dl=0

Warm Handover.MOV
https://www.dropbox.com/s/kcbyrddzv8b39i6/Warm%20Handover.MOV?dl=0

Why BHC Prefers Same-Day.mov
https://www.dropbox.com/s/2zd8g6h0yww5y9r/Why%20BHC%20Prefers%20Same-Day.mov?dl=0

Additional References

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