BEHAVIORAL HEALTH CONSULTANT (BHC) CORE COMPETENCY TOOL (CCT)

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

This tool is useful in teaching new Behavioral Health Consultants (BHCs) and formulating plans to support their development of higher levels of skills and knowledge consistent with the BHC role.

A qualified BHC Trainer may use the tool to rate BHC trainees on each competency during a Phase 2 (on-the-job) training. A rating of "1" is used when a BHC does not demonstrate the competency; a "2" is given if the competency is inconsistently or partially demonstrated by the BHC; a "3" is given if the BHC routinely demonstrates the competency but in just a rudimentary fashion; a rating of "4" indicates the BHC consistently and/or skillfully demonstrates the competency; ratings of "5" are reserved for competencies the BHC always demonstrates and/or demonstrates at a superior level (i.e., could teach other BHCs this competency).

A supervisor may also use this tool as part of annual BHC evaluation. Finally, BHCs may also rate themselves on this form, for periodic self-monitoring or as part of the training/supervision process.

This tool is also useful for BHCs with interests in career progression to leadership and training roles. Specifically, these BHCs will be aiming for 4 and 5 ratings on all competencies, consistent with attainment of excellence.

Part A is mostly focused on the structure of clinical visits. Classroom training and skill practice is recommended for completion of Part A. Part B is focused mostly on BHC competencies for team-based primary care. Observation of team interactions and consultative interactions with PCPs, as well as review of BHC chart notes, is recommended for completion of Part B.

The trainer's recommendations at the conclusion of Parts A and B are based on observation in classroom and practice settings.

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 on the BHC CCT.

List of abbreviations
BHC – Behavioral Health Consultant PC – Primary Care PCP – Primary Care Provider Warm Handoff (WHO)

Part A: Clinical Visit Structure

Competency	*Minimal Demonstrated Benchmark Behaviors*	*Comments and Sample Behavioral Anchors*	*Rating*	*Comments*
1. Role definition	1a. Accurately describes the BHC role. • Name, title credential. • BHC role in care • Length of visit • What will happened during the visit. • The structure of follow-up. • That the visit note will go in medical record. • That the patient's care will be coordinated with the PCP. • Notification of billing practices.	• If interrupted by the patient, can gently refocus to complete the script. • If ad-libbing, uses words/phrases that promote hopefulness (e.g., Many people benefit from a single BHC visit."). • 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.")		
2. Rapid agenda setting	2a. 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 panic attacks, is that your understanding?" "I'm here to share a little information about some of the challenging behaviors parents often see in their 2-year-olds." "I believe Dr. Jones wants my help with this paperwork you brought in for a		

		disability claim. Is that your understanding?" • When unclear, seeks clarification from referring medical note, PCP, and/or patient.		
3. Assessment	3a. Measure use. • Uses assessment measure appropriate to PC to assess and monitor outcome. • If additional measures are used, they are appropriate for PC, 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. • Explores 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 when needed.		
	3c. Assessment of functioning: Develops a "snapshot" of the patient's life context (family/friends, work/school, recreational/leisure/spirituality, health behavior).	• Uses mostly closed-ended questions to quickly develop a snapshot of life context. • Uses functional assessment to identify key coping skills needs/strengths.		

	Notes patient's coping skills needs/ strengths.	• Uses answers to construct a holistic understanding of the patient's life and the impact on the problem.		
	3d. Assessment of presenting problem. Explores duration, frequency and intensity of physical sensations, behaviors/habits, thoughts, and emotions, as appropriate to presenting problem. Assessment of psychosocial factors that coincided with onset of or change in symptoms, with goal of identifying coping skills needs/strengths.	• Sample questions. • "How long have you been feeling depressed?" • "How many days per week do you have a headaches?" • "Is there anything that seems to make your sleep problems worse (or better)?" • "What have you tried to do to help with our nervousness? Was that helpful?"		
4. Problem-focus	4a. Within 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 or if significant new concerns are identified during the visit, or if the visit purpose is prevention.)	• 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	• Visit is focused on assessing for changes in status of problem and adherence to plan to determine need for		

	exception criteria in 4a are met)	follow-up and/or need for new plan.		
5. **Summary and formulation**	5a. Provides a succinct summary of the presenting problem and relevant history.	Summary is used to ensure accurate understanding of the problem and relevant history. • Example: "It sounds like alcohol use has been a concern off and on for 20 years, but was better until 6 months ago when you lost your job. . ."		
	5b. Attempts to convey a relationship between a patient's values and their desire to make a change in behavior. Highlights and explains the coping skill deficits/strengths affecting the problem. Checks with patient for accuracy.	• Formulation explains how biological, cognitive, emotional, and/or environmental factors led to (or are maintaining) the problem. • Example: "Alcohol may be affecting sleep"; "Avoidance may be worsening anxiety"' "Reducing activity may cause symptoms of depression to worsen". • Formulation explains how caring about people, self or important ideas is helpful to deciding to change unhelpful behaviors. • Example: "You love your children and how they see you responding to stress is important to you, do I have that right?"		

		• Formulation including both the factors leading to the problem and values related to decision to change typically takes 2-5 minutes (total) and are provided prior to discussion of intervention options and behavior change planning.		
6. Evidence-based recommendations and interventions suitable for PC patients and PCPs	6a. Demonstrates <u>at least 3 of the following</u> in the categories below. • Focused Acceptance and Commitment (FACT). interventions • Adapted cognitive interventions. • Adapted behavioral interventions. • Adapted Motivational Interviewing (MI).	• FACT examples: developing action plans that align with values; learning mindfulness. • Adapted cognitive examples: increasing awareness of unhelpful beliefs/thoughts, working toward clear value statements. • Adapted behavioral examples: behavioral activation, sleep strategies, self-guided exposure, communication skills training, self-management goals, parenting goals. • Adapted physiological management examples: relaxed breathing, cue-controlled relaxation, imagery, progressive muscle relaxation, distraction. • Adapted MI examples: using decisional balance, emphasizing personal choice,		

		eliciting change talk, using readiness ruler, developing a change plan.		
	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	7a. Visits follow a clear structure (FACT, 5As).	• 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.		
8. Intervention design	8a. Intervention plans are specific, realistic, and clearly related to the presenting problem.	• Interventions follow the SMART format (Specific, Meaningful, Achievable, Related to values, Time-bound). • Typically, just 1-2 intervention plans are stated.		
	8b. Uses self-management, home-based practice as the prime method for intervention. Most interventions involve self-guided skill-building.	• Interventions involve behavioral experiments and learning direct experience with implementation. • If handouts/referrals are used, they usually		

		supplement rather than replace behavioral interventions.		
	8c. Provides a written copy of plan or asks patient to write plan.	• Uses business card, behavioral prescription pad, or after visit summary to note plan.		
	8d. Uses confidence rating scale (1-10, 10= high confidence) to assess confidence in plan at all visits. If less than 7, adjusts plan to increase confidence rating.	• Avoids using labels other than "small problem", "very big problem. • Also, consistently states confidence as "low" or "high", helpfulness as "not very helpful" and "very helpful". • Uses response ruler with rating scale labels to accommodate responding based on individual/cultural preferences.		
9. Intervention efficiency	9a. Structures behavior change plans that are consistent with consultative care service.	• Does not plan extended follow-up. • Voices confidence in patient's ability to learn from experimentation.		
10. Time management	10a. Appointments are routinely kept to 30 minutes or less.	• May refer to time to support optimal flow through all visit activities. • Example: "I'd like to shift now to talking about the problem of irritability, so that we have time to explore it fully."		

11. Verbal consultative staffing (Part A)	11a. Staffing and other team members is concise, avoids jargon, and includes the BHC's impression, behavior change plan, and recommendations for PCP's care of the patient.	• Staffing typically takes less than 1 minute.		
12. Value-added recommendations	12a. Recommendations that the BHC provides to the PCP and team are: • Achievable for the patient. • Evidence-based. • Brief (PCP can describe/reinforce in less than 2 minutes). • 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 them again that their symptoms are anxiety / stress related and not a cardiac problem." • Example of reducing PCP visits and workload: follow-up with BHC instead of PCP; BHC offers to complete patient paperwork at follow-up with patient and present 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/virtual*).

Competency that are strengths:

Competencies to prioritize for more development:

Learning Plan:

Trainer's signature: _____ Date: _____

Supervisor's comments:

Supervisor's signature: _____ Date: _____

Trainer's signature: _____ Date: _____

Supervisor's comments:

Part B: Team-based Care

Competency	*Minimal Demonstrated Benchmark Behaviors*	*Comments and Sample Behavioral Anchors*	*Rating*	*Comments*
1. Clinical productivity behaviors	1a. Uses multiple strategies to optimize use of BHC clinical services.	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. • 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 team to increase same-day warm handoffs and develop efficient handoff processes. • Working with clinic leadership to establish clinical pathways incorporating the BHC. • Identifying which PCPs refer few patients and developing plan to decrease barriers to referral. • Reviewing PCBH metrics regularly with clinic leadership and team to identify new strategies for growing visit volume.		
2. Consultant care structure	2a. Uses consultant framework in conceptualizing and planning follow-up with patient. Uses a "consultant" rather than "therapist" structure for planned follow-up.	• Before planning follow-up, the BHC asks the patient if follow-up is desired. • If follow-up is planned, the BHC plans to follow patients until improvement begins and a clear plan is in place for continued improvement. • Follow-up is planned one visit at a time, based on patient desire and progress. • Patients not improving after 3-4 visits are recommended for specialty care.		

		• Patients may be seen for >3-4 visits while awaiting – or not accessing- recommended specialty care, but always maintaining the consult care structure.		
3. Follow-up planning	3a. Plans follow-up strategically and only when indicated. Appointments are spaced in a manner consistent with a population-health model, as well as individual patient needs.	• If follow-up is planned, 2-week interval between visits is most common interval. • Schedules less than 2-week follow-up as indicated, e.g., a patient with elevated risk of self-harm; patient with daily panic attacks requesting more support.		
	3b. Coordinates follow-up visits with other PC 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. Uses good decision-making for whether to place these visits before/after the PCP visit. • Regularly coordinates with PCP for patients started on medications and patients wanting more support (e.g., follow with BHC at 2 weeks and PCP at 4-weeks).		
4. Risk management	4a. Appropriately manages patients assessed to be at high	• Recommends (and facilitates) specialty care for		

	risk of harm to self or other. Attentive to employer policy regarding management of patients at risk of harm to self or other.	high-risk patients; plans follow-up with these patients until engaged in specialty care (or, until improved). • Documents 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.		
5. Community resource referrals	5a. Has information on community-based resources, 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.		
6. Task-sharing	6a. Routinely offers to complete tasks (within scope) to share workload of PCPs and RNs.	• Offers to complete Family Medical Leave Application (FMLA) paperwork, call school to coordinate a child's care, or complete disability paperwork (assuming for all that the focus of the task		

		involves a behavior concern).		
7. Specialty mental health utilization	7a. Understands and follows specialty care and referral criteria.	• Refers to specialty care if: emergency; patient not improving after a few visits; patient prefers specialty; requested by PCP; patients needs excluded service (e.g., forensic evaluation, detox).		
	7b. 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).		
8. Class-based services	8a. Provides/participates in class-based services, using a format and content appropriate to PC.	• Can differentiate a class/workshop from a from a monthly class-based medical service. • Participates in monthly class-based medical services to increase BHC reach and improve outcomes for groups of concern in clinic. • Offers classes/workshops.		
9. Pharmacotherapy	9a. Can identify common psychotropic medications, indications for the medication, and common side effects. Can	• Consults with PCP and/or clinical pharmacist to learn more about medications as needed.		

	address incorrect beliefs about psychotropic medications.			
	9b. Can identify medications used for physical health conditions commonly treated in PC (e.g., diabetes).	• Recognizes medications that may alter mental status significantly.		
	9c. Stays within scope of practice for non-prescribers.	• Avoids answering questions asking for recommendation of specific medication or specific dosage.		
10. Schedule management	10a. Makes decisions about BHC schedule that promote helpful contact with as many patients as feasible within the context of time and space availability.	• Uses BHC Practice Management sheet to optimize schedule adjustments. • BHC flexes the length of visits (when indicated) to accommodate same day requests and team needs. • BHC generally sees patients at the appointed time, unless needs of the team or same-day patients interfere.		
11. Concise, clear, and timely charting using appropriate format	11a. BHC-specific EHR template is used.	• Uses the service's specified template for initial and follow-up appointments.		
	11b. Documents in the medical record during the clinical encounter.	• At a minimum, key history and the plan is documented during the visit.		
	11c. Clinical notes are written specifically for PCP, team members, and patients in a succinct and jargon-free manner.	• The BHC uses accessible descriptors like "taught technique for being curious about thoughts" rather than "mindfulness" or		

		"relaxation" rather than "autogenic training".		
	11d. Initial visit documentation includes assessment of the presenting problem, functioning/context, risk and habits; brief mental status exam; a clear clinical impression; evidence-based interventions in the form of a SMART goal; follow-up plan, if any; recommendations for the PCP.	• In brief visits (≥16 minutes), can prioritize areas explored and charted. • Prioritizes documentation of intervention and behavior change experiment in language used with patient in all visits.		
	11e. Ensures EHR notes are accessible to the PC team and maintained as part of the patient's medical record.	• Notes are not routinely marked "sensitive".		
	11f. Completes clinical notes within the organization's time limit.	• Notes are more specific, accurate, and brief when completed within 3 minutes of the end of a BHC visit.		
12. Verbal consultative staffing (Part B)	12a. Staffs patients verbally with PCPs for every initial appointment, and as needed at follow-ups. If unable to access PCP for same-day verbal staffing, BHC uses alternate means of staffing.	• Alternate means for staffing could include secure email, secure messaging, copy of written note. • Staffing at follow-up is given if there is significant new information or change the PCP should know about.		
13. Responsiveness and availability to PC team	13a. Maintains flexible attitude and openness in providing consultation.	• BHC works with the team to make warm handoffs routine. • Door is fully open when not seeing patients.		

	• Readily provides unscheduled services when needed. • Has an "open door" policy encouraging PC staff interruptions to promote same-day visits and urgent curbside consultation. If away from station, ensures team know location and time of return.	• Does not use a "do not disturb" sign. • When BHC is with a patient and PC team member knocks on door to speak about another patient, BHC briefly steps out of office to address the issues.		
	13b. Conducts regular and efficient warm handoffs. • Warm handoffs are the default means of engaging the BHC with patients. • Responds promptly to warm handoff requests. • Accepts brief overview of referral concern from PCP. • Meets patient briefly and arranges a visit time, ideally same day. • 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 with the goal of identifying a same-day visit time. • Warm handoffs typically result in a same day visit, in any available clinical space.		
14. Team-based care plan assistance	14a. Clarifies and reinforces other aspects of the treatment plan.	• Demonstrates awareness of key aspects of the patient's care plan from PC (including areas that are directly, and		

	• Is aware of key components of care from PC. • Reinforces the importance of all aspects of the plan (especially those related to the referral concern).	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 MI for key aspects of the care plan the patient is not engaging in.		
15. Care team coordination	15a. Engages patients with other care team members, when indicated.	• BHC engages the DM educator, pharmacist, dietitian, care manager or other team member (with the PCP's agreement), when indicated. • Utilizes triage nurse if unaddressed medical concerns arise during a BHC visit. • Mostly uses team members to add to the BHC's care, rather than shifting care from the BHC to the team member.		
	15b. If working with Behavioral Health Assistant (BHA), maximizes care extender benefits to PC team and to patients.	• Conducts regular check-ins about workflows. • Provides on-going training/consultation to BHA.		
	15c. Maintains contact with Care Extenders (CEs) located in the community (e.g.,	• Knows CEs by name and understands their role.		

	Community Support Workers [CSWs]).	• Invites CEs regularly to PCBH team check-ins.		
16. PC team education	16a. Provides at least quarterly training to PC team members on: • Strategies for optimal use of the PCBH service and/or • 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 PC team • Uses the PCP/RN CC Tool systematically to advances skillfulness of team members in using the BHC to optimize team functioning.		
	16b. Researches questions about behavioral health topics for team.	• Understands how to use UPToDate and/or other credible search engines for information.		
	16c. Explores assessment and intervention options for PCBH pathway development.	• Prepares and provides information summary to promote pathway development.		
17. Fit with primary care culture	17a. Knows the roles of the various PC 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 PC team (clinic and non-clinical).		

		• Articulates how each team member can support a PCBH service, and vice-versa.		
	17b. Regularly attends and participates in PC team meetings, huddles, and events to stay in 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, huddles, events.		
	17c. 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).		
18. Population-based care	18a. Articulates population based care mission of BHC work; is attentive to daily practice choices as they	• Can explain that the goal of PCBH is to improve care for the entire PC clinic population.		

	pertain to population-based care perspective.	• Can explain the population-based strategy of reaching large numbers of people.		
19. PCBH policies and procedures	19a. Uses a balance of same-day and preschedule slots that promotes fidelity. • Template meets requirement of minimum of 12 visit slots per day, on average, for full-time BHC. • All slots are 30 minutes. • Classes are scheduled according to length/purpose.	• Makes changes to template to address barriers to optimal use of BHC. • With assistance from supervisor, makes changes to template to address BHC resilience.		
	19b. Uses correct CPT codes (as specified by service)	• Codes typically used include Health and Behavior, 30-minute Psychotherapy codes. • Bills for all billable services.		
	19c. The service's BHC peer review items are used in regular peer review processes.	• Participates in regular peer review as required by the organization. • Uses the correct peer review form.		

Phase II Evaluation (Parts A & B)

When used to determine readiness for BHC work, successful completion means the BHC demonstrated ratings of 3 or higher on competencies required by the BHC employer.

Performance ratings were based on:
Observation of ___ new and ____ follow-up appointments
Observation of ____ PCP consultative staffings
Review of ____ chart notes of patients seen

Competencies that are strengths:

Competencies to prioritize for more development:

Learning Plan:

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

Supervisor's comments:

Supervisor's signature: _____BHC's signature: _____ Date: _____

ATTRIBUTIONS: This Core Competency Tool (CCT) was published in the *Behavioral Consultation and Primary Care: A Guide to Integrating Services, 3rd Edition* (Robinson & Reiter, 2024). It is an adaption of CCT the CCT published in earlier editions (2007, 2016), as well as adaptations developed and offered for public use by Mountainview Consulting Group, Inc., (https://www.mtnviewconsulting.com), Whole Team, PLLC, and the U.S. Department of Defense (https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/649015p.pdf).