

TRI-SERVICE BHCF CORE COMPETENCY TOOL

BHCF:

Date:

Trainer:

A certified BHCF Trainer rates the BHCF trainee skill level based on their observations of trainee performance of each dimension. Trainees must demonstrate ability to perform the minimal benchmark behaviors and/or demonstrate the clinical knowledge/skill that is consistent with minimal benchmark. **A "Pass" rating on every element is required to satisfactorily complete training.** During initial training, BHCF Trainees will be rated on the final training day with the core competency tool during role plays of a 7-10 day contact and a 4 week contact.

Dimension: I. Care Facilitation Specific Skills					
Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Role definition: <i>Says introductory script smoothly, conveys the BHCF role to all new patients.</i>	1a. Accurately describes per standardized script: i) Who they are and their role in the clinic ii) Estimated length of each contact iii) What will happen during the contact iv) What follow-up may occur v) That the note will go in the medical record vi) That the PCM/IBHC will receive feedback vii) Any reporting obligations				
	1b. Says the script in 2 minutes or less				
	1c. If interrupted by the patient during the introductory script, the BHCF answers questions and appropriately redirects to complete the introductory script				
2. Rapid Confirmation of Referral Diagnosis: <i>Rapidly assesses patient understanding of referral diagnosis.</i>	Assesses patient understanding of referral diagnosis within 60 seconds after completing introductory script	<ul style="list-style-type: none"> "It looks like Dr. Hunter would like me to assist so that we can better manage or target your depressed mood. Is that what you see as the main problem or is it something different?" 			

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
3. Patient Contact Protocol	3a. Conducts initial contact with patient 7-10 days from date of referral	During role play, accurately articulates the contact protocol and the modules appropriate for a 7-10 day call			
	3b. Conducts follow-up contacts with patient at four week intervals	During role play, accurately articulates the contact protocol and the modules appropriate for a monthly contact			
	3c. Schedules/completes PRN contacts in appropriate circumstances and with appropriate content	<ul style="list-style-type: none"> • During role play, articulates circumstances for which the BHCF would use a PRN call • Keeps PRN contacts appropriately brief • Does not administer assessment measurement tools during PRN contacts 			
	3d. Care facilitator follows DoD/VA CPGs regarding duration of care facilitation Reviews with PCM prior to removing patients from active caseload Removes patients from active caseload by closing the episode of care within one week when closure criteria is met using Service-specific guidelines Uses only the current date when closing an Episode of Care	Example criteria for considering case closure with PCM: <ul style="list-style-type: none"> • Depression: Patient has a severity score of <5 points on the PHQ-9 maintained over at least 8 consecutive weeks • PTSD: Patient has a minimum 10-20 point decrease in PCL score maintained over at least 8 consecutive weeks • Anxiety: Patient has a severity score of <5 points on the GAD-7 maintained over at least 8 consecutive weeks • Patient has never engaged in the program after weekly contact attempts over 6 weeks • Patient has quit the program • Relocation • Transfer to Specialty Care 			

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
4. Patient Contact Attempts	4a. Care Facilitator follows Service-specific guidance when attempting to contact patient	Able to articulate the following during role play: <ul style="list-style-type: none"> • Required number of contact attempts (lower and upper limits) per Service-specific guidelines • Attempt contacts only during clinic business hours, varying day and times of contact attempts. 			
	4b. Care Facilitator follows Service-specific guidance for mode of contact	<ul style="list-style-type: none"> • Attempts telephonic contacts using clinic/office phone. Does not use personal cell phone to call or text message patient. • Utilizes secure messaging system if patient consents. Does not use unsecure (e.g., Outlook) or personal email to contact patient 			
5. Content of Patient Contacts: <i>Conducts assessment, provides feedback and education to patient, and collaboratively problem-solves barriers to the treatment plan</i>	5a. Stays within scope of practice and BHCF role (e.g., does not provide therapy or make medication recommendations or dosage changes)	<ul style="list-style-type: none"> • Frames contact around questions in factor groups; does not provide therapy • Does not make medication recommendations or dosage changes 			

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
<p>5. Content of Patient Contacts (continued) <i>Conducts assessment, provides feedback and education to patient, and collaboratively problem-solves barriers to the treatment plan</i></p>	<p>5b. Conducts assessment</p> <ul style="list-style-type: none"> i) Prior to contact, identifies current and potential problems by medical record review ii) Identifies correct question modules for baseline snapshot, 7-10 day contact, 4 week contacts, and PRN contacts iii) Conducts assessment using questions in FIRST-STEPS factor groups <ul style="list-style-type: none"> 1) Asks General Concern questions 2) Assesses adherence to the PCM/IBHC treatment plan <ul style="list-style-type: none"> a) Asks Medication Non-Adherence questions if applicable b) Asks Behavioral Health Services Non-Adherence questions if applicable 3) Administers evidence based assessment measurement relevant to the diagnosis at 4 week contacts and, if not done on the date of referral, at the 7-10 day contact <ul style="list-style-type: none"> a) Chooses correct assessment measure for the diagnosis 4) Administers AUDIT-C measurement at 7-10 day contacts and, when appropriate, monthly and PRN calls <ul style="list-style-type: none"> 1) Gives examples of when to use AUDIT-C on monthly or PRN calls 5) Asks about SI and violence/harm risk during each initial and monthly patient contact as well as, when appropriate, PRN contacts. iv) Looks for possible manic or hypomanic episodes or alcohol/substance abuse, especially when a medication has been prescribed, and consults with IBHC and/or PCM to determine appropriate disposition. v) Looks for possible signs or symptoms that patient is unable to function due to serious psychological health concerns, and consults with IBHC and/or PCM to determine appropriate disposition. 				

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
5. Content of Patient Contacts (continued) <i>Conducts assessment, provides feedback and education to patient, and collaboratively problem-solves barriers to the treatment plan</i>	5c. Reads assessment measure (e.g., PHQ-9, GAD-7, PCL, AUDIT-C, SI screening, and MDQ) questions and response items verbatim Gives an appropriate rationale to the patient before using an assessment measure; provides accurate feedback to patient on results of the assessment measurements	1) Gives appropriate rationale to the patient before using an assessment measure <ul style="list-style-type: none"> FIRST TIME “One thing we’ll do on each call is go through a series of questions that will help me and your PCM understand if our current plan of treatment is on track, or if it needs adjustment” FOLLOW ON CALLS “You may remember the series of questions we went through on our last call. These questions will help me and your PCM understand if our current plan of treatment is on track, or if it needs adjustment” Does not use terms such as “test” or “evaluation” 2) Provides accurate feedback to patient on results of the assessment measurements, providing correct interpretation of score value and change in score and in context of the patient’s reported symptoms. For example: <ul style="list-style-type: none"> Significant improvement: “Initially you scored a 17 on the PHQ-9 which is the series of questions we just did and eight weeks later you have now scored an 8. That is consistent with when you told me earlier that you are feeling a lot better. Over time, we would like to get to the point where the score is a 4 or below, and we are certainly moving in that direction. I’ll give all of this information to your PCM, but in the meantime it seems to me like we are on the right track. Would you agree with that assessment?” Improved score, but not clinically significant: “Initially you scored a 17 on the PHQ-9 which is the series of questions we just did and four weeks later you have now scored a 14. While the number is moving in the right direction, it isn’t enough change for me to think that we 			

		<p>have made a significant improvement. That said, you did mention that you are generally feeling better, and I'm glad of that. I will talk with your PCM about the scores and how you are feeling to see what he would like to do. Either he or I will give you a call in the next couple days to talk with you further after we know his thoughts. In the meantime, let's continue with our current plan, including your Zoloft at the same dose as your PCM prescribed. What are your thoughts on that?"</p> <ul style="list-style-type: none">• No change or worsening score: "Initially you scored a 17 on the PHQ-9 which is the series of questions we just did and four weeks later you have now scored a 20 which lets me know we haven't made an improvement. You also mentioned earlier that you aren't feeling any better which is consistent with that. I'm really glad we had this call today which allows me to take this information back to your PCM to see what he would like to do. In the meantime, I want to reiterate that treatment is often effective and improvement is the rule rather than the exception. Our goal remains complete remission, although successful treatment often entails medication and/or dosage adjustments in order to maximize response. For now, let's continue with your PCMs current plan, including your Zoloft at the same dose, and either Dr Jones or I will call you in the next couple days to talk with you further after we know his thoughts. Do you have any questions right now or is there anything you would like to add?"			
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Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
5. Content of Patient Contacts (continued) <i>Conducts assessment, provides feedback and education to patient, and collaboratively problem-solves barriers to the treatment plan</i>	5d. Delivers evidence-based patient education	1) Can demonstrate one or more web or mobile applications that provide evidence based psychopharmacology information 2) Provides patient education in accordance with the DoD/VA Clinical Practice Guidelines 3) Provides information about medications including common side effects and myths 4) Provides information about behavioral health services 5) Uses motivational interviewing strategies to discuss low-risk alcohol use Provides information about resources available to patients and beneficiaries			
	5e. Collaborates with patient in making decisions and encourages patient to participate in the treatment process, initiate self-management activities, and adhere to the treatment plan. Encourages and supports regular attendance for scheduled visits with medical or mental health care providers. <ul style="list-style-type: none"> i) Uses three or more motivational interviewing strategies to increase readiness to change ii) Supports self-management goals set by PCM/IBHC if applicable iii) Collaboratively problem solves ways to address barriers iv) Collaboratively develops self-management goal utilizing SMART goal format 	Uses three or more motivational interviewing strategies during each of final training day role-plays (i.e., 7-10 day and 4 week contacts). Examples include the following: <ul style="list-style-type: none"> • OARS <ul style="list-style-type: none"> ○ Open-ended questions ○ Affirmations ○ Reflective listening ○ Summarizing • Decisional Balance • Readiness Ruler 			
	5f. Follow-up <ul style="list-style-type: none"> i) Assesses barriers to continuity of care ii) Identifies patients who need a PCM appointment iii) Identifies patients to refer to an IBHC iv) Explains IBHC services and facilitates connecting the patient to IBHC v) Schedules appropriate follow-up BHCF appointments utilizing scheduling function in FIRST-STEPS 	Assesses barriers to continuity of care using questions in the correct Continuity of Care factor group			

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
6. Patient Safety: <i>Evaluates risk of harm to self/others</i>	6a. Evaluates for Suicidal Ideation (SI) and violence/harm risk verbally at every initial and monthly patient contact as well as PRN contacts when appropriate following Service-specific standards	<ol style="list-style-type: none"> 1) Asks about SI during the each initial and monthly patient contact as well as, when appropriate, PRN contacts by asking the SI and violence/harm risk screening questions and responses verbatim 2) Articulates examples of PRN contacts when SI and violence/harm risk screening questions would be appropriate to ask 3) If suicide screen question is positive, asks additional questions from Suicide Module verbatim 4) If violence/harm screening question is positive, asks additional questions to determine extent of the problem (e.g., target, plan, intent, past history) 			
	6b. When SI and/or violence/harm risk is identified, and in keeping with Service, MTF, or Clinic policies, initiates crisis assessment and intervention as needed	<p>Able to articulate an appropriate plan for further assessment and intervention. For example:</p> <ul style="list-style-type: none"> • Remains on the call with the patient while getting provider • Facilitates contact with a privileged provider for triage during the same patient contact 			
	6c. Is proficient with Service, MTF, and/or Clinic policies for emergency procedures for elevated SI/HI risk <ol style="list-style-type: none"> i) Brings Service, MTF, or Clinic standard operating procedures to Initial training ii) Understands and complies with emergency procedures for elevated SI/HI risk iii) Understands and complies with procedures for reporting events and/or patient incidents 	<ol style="list-style-type: none"> 1) Brings Service, MTF, and/or Clinic standard operating procedures to initial training 2) Correctly articulates steps to take when a patient is identified who has SI and/or risk of violence/harm. 			
	6d. Documents elevated SI/HI risk in AHLTA note Completes AHLTA note immediately (i.e., ASAP and within one hour of contact)				

Dimension: I. Care Facilitation Specific Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
7. Patient Staffing: <i>Facilitates communication with External Behavioral Health Consultant, Internal Behavioral Health Consultant, and PCM</i>	7a. Participates in routine clinical caseload review with the IBHC/EBHC. Using SBAR format, clearly and succinctly provides patient progress, symptoms, treatment plan, and self-management goals as well as relevant information from applicable Clinical Practice Guidelines (CPGs) during case staffing with the IBHC/EBHC.	Communicates with other providers using SBAR format: 1) Situation 2) Background 3) Assessment 4) Recommendation Examples of relevant information includes: <ul style="list-style-type: none"> • Elevated level of concern • Side effects from medications • Treatment non-responders • Change in case status • Non-adherence to treatment plan • Barriers to adherence with treatment plan • Inability to maintain contact (no contact despite weekly attempts for 6 weeks) • New patients • Reasons identified for potential case closure 			
	7b. Using SBAR format, clearly and succinctly communicates to the PCM relevant information from the patient contact as well as relevant information from applicable Clinical Practice Guidelines (CPGs). Facilitates feedback of IBHC/EBHC recommendations to the PCM.	Communicates with other providers using SBAR format: 1) Situation 2) Background 3) Assessment 4) Recommendation Examples of relevant information includes: <ul style="list-style-type: none"> • Elevated level of concern • Side effects from medications • Treatment non-responders • Change in case status • Non-adherence to treatment plan • Barriers to adherence with treatment plan • Recommendations from weekly staffing with IBHC or EBHC • Inability to maintain contact (three missed attempts over two weeks) • Reasons identified for potential case closure 			

Dimension: II. AHLTA Documentation Skills (Note: Additional AHLTA Documentation Skill Core Competencies will be assessed monthly during Peer Review)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Peer review	1. Routinely meets all requirements contained within the Service-specific peer review	Refer to Service-specific peer review			
2. Note format	2. Routinely and accurately documents notes in the patient's electronic medical record for each patient contact/attempt utilizing Service-specific template/format/guidelines	Enters accurate and complete AHLTA note within FIRST-STEPS for each patient contact when creating test cases			
3.T-Cons	3. Routinely and accurately sends T-Cons to PCM per Service-specific guidelines	Articulates requirement for communication with PCM via T-Con after each patient contact			
4. Coding	4. Routinely and accurately completes coding as per Service-specific guidelines	Articulates codes used appropriate for patient contact			

Dimension: III. Practice Management

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Time management	1a. For <u>role plays on final training day</u> : Completes each role play (i.e., 7-10 day and 4 week contacts) within one hour.				
	1b. For <u>patient encounters during site visit</u> : Completes 100% of patient encounters (including entering data in FIRST-STEPS and documenting in AHLTA) within 30 minutes				
	1c. Extends calls longer than 30 minutes only as required to appropriately manage patient safety issues (i.e., to bring licensed independent provider into the call for further evaluation and management) or if required due to a barrier or difficulty in communication. Call content must remain within scope of BHCF role (i.e., BHCF does not provide therapy).				
2. Caseload	2. Maintains target number of <u>ACTIVE</u> patients on caseload in accordance with SERVICE SPECIFIC guidelines <ul style="list-style-type: none"> • Air Force 60-80 • Army 60-80 • Navy 60-80 • NCR xx-xx 	Works with PCMs and IBHCs to identify and recruit patients appropriate for Care Facilitation Removes inactive patients from caseload according to Service-level policy			
3. Database Reports	3. Creates monthly database reports for clinic leadership	At a minimum, reports include the following: 1) # new referrals during calendar month 2) # active cases on last day of calendar month 3) # cases dis-enrolled (categorized) 4) # positive for SI/HI and disposition			

Dimension: IV. Team Performance Skills

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Fit with primary care culture	1a. Knows the roles of the various primary care team members and articulates their roles/duties in the clinic	Describes the role and duty of the following, including: 1) Group practice manager 2) PCMs (i.e., physicians, PAs, NPs) 3) Nurses 4) Internal Behavioral Health Consultant 5) Nutritionist 6) Pharmacist 7) Social Workers 8) Physical Therapists 9) Corpsman/Medics/Medical Techs 10) Administrative staff 11) Clinic Chain of Command 12) Other PCMH Staff not listed above			
	1b. Regularly (90% of clinic meetings) participates in PC staff meetings, huddles, and appropriate events to stay a visible and active member of the team, providing ongoing consultation and education about PCBH services Actively engages in marketing PCBH services for program development				
	1c. Uses language and practice habits appropriate for PC culture	Examples: <ul style="list-style-type: none"> When discussing Primary Care Behavioral Health, avoids specialty mental health jargon (e.g., terms like “intake,” “session,” “therapy,” “processing,” or “group” which are more indicative of specialty mental health care); Instead, use terms such as “appointment,” “visit,” or “classes” to be consistent with consultation in PC 			
	1d. Communicates with colleagues, other healthcare providers, and patients in a courteous, professional, and approachable manner	Uses appropriate greetings, courtesies, and salutations in written and verbal communication			

Dimension: IV. Team Performance Skills(continued)

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
2. Responsiveness and availability to PC team	<p>Maintains flexible attitude and openness in responding to PC team</p> <p>Has an “open door” policy encouraging warm hand-offs between BHCF and other PCMH staff</p> <p>Articulates role of the IBHC to the patient</p>	<ul style="list-style-type: none"> • When not seeing patients, actively engages with PCMH team members to encourage referrals • Door is literally open when not talking with patients • Does not use a “do not disturb” sign • Meets with patients when IBHC is not available to introduce role of IBHC and schedule the appointment with the IBHC 			
3. PCMH education: <i>Educates primary care staff and patients on how to optimally use BHCF and IBHC services.</i>	<p>Clearly articulates the following via formal and informal avenues:</p> <ul style="list-style-type: none"> i) BHCF contact expectations (25 minute contacts, continuity of care) ii) Referrals to the BHCF and/or IBHC (emphasizing what conditions and when to refer) iii) Accurately introduces the role of the IBHC to PC staff and patients 	<p>Examples of formal avenues: PCMH staff meetings/briefings, EMR notes.</p> <p>Example of informal avenues: Introduces self and role to PCMH staff on individual basis</p>			
3. Provides support to the greater PCBH team	<p>Facilitates use of IBHC by PCMs and patients:</p> <ul style="list-style-type: none"> i) Helps PCM identify patients to refer to an IBHC ii) Facilitates connecting the patient to IBHC for warm hand-off; accurately explains IBHC services and facilitates connecting the patient to IBHC when warm hand-off not possible iii) Assists patient in scheduling appointments with IBHC 				
5. Utilizing additional resources	<p>Appropriately assist patients with additional utilization of resources.</p>	<ul style="list-style-type: none"> • Identifies resources appropriate to meet the patient's needs • Utilizes follow-up or PRN contacts when appropriate to ensure need was met and/or identify and problem-solve barriers 			

Dimension: V. FIRST-STEPS Test Cases

Element	Minimal Demonstrated Benchmark Behaviors	Sample Behavioral Anchors	Skill Rating		Comments
			Fail	Pass	
1. Uses FIRST-STEPS for case tracking and clinical decision support	Independently completes two FIRST-STEPS test cases during final training day role plays (i.e., 7-10 day and 4 week contacts) without assistance other than screen shots.	Accurately completes each step on the FIRST-STEPS test case check list.			

BHCF Evaluation: Successful completion requires all items rated as "Pass"

CIRCLE: PASS / FAIL - (Provide rationale in comments.) Date of completion: _____

Trainer's signature: _____ BHCF's signature: _____ Date: _____

COMMENTS: