CORE COMPETENCIES FOR INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE

SAMHSA-HRSA

Center for Integrated Health Solutions

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
MENTAL HEALTH FIRST AID
Healthy Minds. Strong Communities.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov 1-877-SAMHSA-7 (1-877-726-4727)

JANUARY 2014

www.integration.samhsa.gov

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first "national home" for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration, and run by the National Council for Behavioral Health, CIHS provides training and technical assistance to community behavioral health organizations that received SAMHSA Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS' wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

SAMHSA-HRSA
Center for Integrated Health Solutions

1701 K Street NW, Suite 400

Washington, DC 20006

202.684.7457

integration@theNationalCouncil.org

www.integration.samhsa.gov

RECOMMENDED CITATION

Hoge M.A., Morris J.A., Laraia M., Pomerantz A., & Farley, T. (2014). *Core Competencies for Integrated Behavioral Health and Primary Care*. Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions.

Prepared by the Annapolis Coalition on the Behavioral Health Workforce under contract to the HRSA-SAMHSA Center for Integrated Health Solutions at the National Council for Behavioral Health.

For further information contact Michael Hoge, Ph.D. at michael.hoge@yale.edu.

PROJECT TEAM

CIHS engaged the Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org) to lead and manage the competency development project. The Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field.

The core Annapolis Coalition team managing the project included:

Michael A. Hoge, PhD, Senior Science and Policy Advisor, The Annapolis Coalition

John A. Morris, MSW, Executive Director, The Annapolis Coalition

Michele Laraia, PhD, APRN, Project Consultant, The Annapolis Coalition

Ann McManis, Director of Operations, The Annapolis Coalition

SENIOR CONTENT ADVISORS

Andrew Pomerantz, MD, National Mental Health Director for Integrated Care, Veterans Administration and Associate Professor, Dartmouth Medical School

Tillman Farley, MD, Director of Medical Services, Salud Family Health Centers, Colorado

ACKNOWLEDGEMENTS

The project team is indebted to HRSA and SAMHSA for their support and guidance on this project; to Laura Galbreath and the CIHS team at the National Council; to our senior content advisors and key informants; and to our administrative team at The Annapolis Coalition.

While we are grateful for the input from the senior content advisors and all of the key informants listed in Appendix I, the final decisions on the content of this report were made by the project team. They alone are responsible for any errors or omissions.

TABLE OF CONTENTS

INTRODUCTION

Despite the increasing national focus on integrated care, there is no single, widely recognized set of competencies on this service approach for either the behavioral health or primary care workforce. To address this gap, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) charged the Center for Integrated Health Solutions (CIHS; www.integration.samhsa.gov) to identify and disseminate core competencies on integrated practice relevant to behavioral health and primary care providers. The development of these competencies was performed by the Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org) under the auspices of CIHS.

The core competencies developed through this project are intended to serve as a resource for provider organizations as they shape job descriptions, orientation programs, supervision, and performance reviews for workers delivering integrated care. Similarly, the competencies are to be a resource for educators as they shape curricula and training programs on integrated care. The charge was to develop a "core" or "common" set of competencies broadly relevant to working in diverse settings with diverse populations. The competency sets are not intended to be setting or population specific. Their principal relevance is to the integration of behavioral health with primary care as opposed to the integration of behavioral health with specialty medical care.

Workforce Sectors

Behavioral health encompasses prevention, intervention, and recovery from mental health and substance use conditions. Equally important, it focuses on promoting behaviors that support health and wellness. This workforce, which is described in a previous SAMHSA-funded report (www.annapoliscoalition.org/download_actionplan.aspx), is comprised of graduate trained professionals, direct care staff with on the job training and experience, and persons in recovery from behavioral health conditions. This includes, but is not limited to: psychiatrists, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, and peer support specialists and recovery coaches.

Primary care is a complex concept that focuses on the provision of "…comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern…" (American Academy of Family Practitioners, www.aafp.org). It includes health promotion, disease prevention, education, diagnosis and treatment. The primary care workforce includes, but is not limited to, physicians, physician assistants, advanced practice nurses, registered nurses, and a range of allied health professionals.

Types of "Integrated Care"

While the concept of integration, as used within this document, refers to collaboration between behavioral health and primary care providers, there are many forms and models of integrated care. CIHS developed a framework, which can be accessed online (www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare). The competencies reported are principally intended to address levels 4, 5, and 6 in that framework, which involve either close or full collaboration and one of three organizational models: some systems integration, integrated practice, or transformed/merged practice.

Finding Common Language

The competency set requires the use of consistent language to refer to the recipients of healthcare. The terms used by different professions/specialties and in different settings vary widely (i.e. patient, client, or consumer) and it is clear that no single term is preferred by, and perhaps even acceptable to, the many groups and individuals involved in the delivery of integrated care.

For this document, the term *healthcare consumer* or simply *consumer* has been selected as one that is understood, though perhaps not preferred, in primary care, mental health, and the field of addictions. As captured below in the competencies, it is generally recommended that providers adopt the language of the setting in which care is delivered. To the extent to which such language is unacceptable to providers, they are encouraged to educate others within their team and setting about their rationale for using alternative language.

Within this document, the term *behavioral health* is used to refer to mental health and addictions. Behavioral health is distinguished from "general health," recognizing the imperfections in the distinction and the language used to describe it. Behavioral health is also distinct from healthy or health behavior. Unless otherwise noted, the term *health conditions* refers to all health conditions and is not specific to behavioral health.

Guiding Assumptions

The development of this core competency set was guided by a series of assumptions that are articulated below.

1. It is crucial to stress that these competencies reinforce or enhance the basic competencies of each discipline and the specialty competencies that each provider must have to practice in his or her field. There is not a bright line between those competencies and many of the competencies that are essential for the provision of integrated care. Some competencies that are generic to most forms of healthcare, such as those related to *interpersonal communication*, are included in this set because they are *absolutely essential* to the effective delivery of integrated care.
2. In order for a core competency set to be practical and useful, it has to have a manageable number of competency categories and individual competencies. Long and detailed competency sets overwhelm the reader, the educator, the interprofessional team leader, and the direct care provider. Clarity and simplicity was the goal.
3. The competencies are optimally skill oriented, focusing on what the provider of integrated care can actually "do." Knowledge and attitudes make the desired behavior possible, but demonstration of an essential skill is the desired outcome.
4. The focus of integrated care and these workforce competencies is very broadly defined, not narrowly focused on particular diagnosable disorders. Similarly, the competencies are intended to be relevant to healthcare consumers across the lifespan from diverse populations, and are not specific to a particular age or population.
5. The competency set specifies skills such as the use of evidence-based treatments and tools, but generally does not identify specific treatments or tools. These will vary by setting and population and will change over time as the evidence base grows and prevention and treatment approaches evolve. Up-to-date information on evidence-based treatments and tools can be accessed at various websites including www.samsha.gov and www.hrsa.gov.
6. The competencies are premised on consumers and family members as partners in the healthcare process whose strengths, goals and preferences should drive healthcare decisions.
7. The issue of culture must be considered in all efforts to understand health, illness, treatment, resilience and recovery.
8. The effective delivery of integrated care requires system modifications to support changed practice. However, system design was outside of the scope of this project. Clearly the financing and organization of care delivery can have a major impact on the ultimate competence of the providers working in those delivery systems.
9. Core competencies are defined as those that apply to the *majority* of providers involved in integrated care. Each competency is not necessarily relevant to *every* provider. For example, more complex, clinically oriented competencies may not be applicable to care managers or navigators. Many of these competencies may be relevant to peer support roles. The employer must designate the competencies applicable to each position.

Long and detailed competency sets overwhelm the reader, the educator, the interprofessional team leader, and the direct care provider. Clarity and simplicity was the goal.

A Single Integrated Set of Competencies

The initial project goal was to develop two competency sets: one for behavioral health practitioners and the other for primary care practitioners. However, the results of the data gathering process revealed that most competencies required for integrated care were common to behavioral health *and* primary care providers. The initial draft of competencies, which contained some distinctions between behavioral health and primary care skills, met with criticism from a number of key informant reviewers who argued that such separation would promote continued silos between disciplines and professions and foster an unnecessary interprofessional divide. Thus the competencies that appear below are structured as a single integrated set.

METHOD

The method for arriving at the core set of competencies involved three major activities: (1) structured interviews with the key informants; (2) review of the recent literature on integration, and (3) review and analysis of selected competency sets judged to have relevance to this process. Each of these sources yielded potential content for inclusion in the competency set. Using a qualitative and consensus driven process, the Project Team integrated and distilled the recommendations into a number of competency *categories* and then placed individual competencies within those categories. A draft competency set was reviewed by the Senior Content Advisors and Key Informants and revised based on the feedback received. A more detailed description of the methodology is contained in Appendix II.

USING THE CORE COMPETENCIES

The identification of core competencies creates an essential foundation for preparing and further developing a workforce to deliver integrated care. These competencies can be used to further that agenda in multiple ways.

Shaping Workforce Training

Competency sets are a reference point for educators who are designing and delivering a training curriculum. This set of competencies on integrated care can be used to identify the need for training courses and can shape the content of such courses. It can be used to update and expand the focus of existing courses, to design continuing education events, and to select topics for in-service education within healthcare organizations.

Informing Job Descriptions

The competencies can be used to develop or update job descriptions and duties for positions within settings where integrated care is delivered. Lack of role clarity is a prime driver of dissatisfaction with and turnover in healthcare positions. Greater clarity in job descriptions and job roles can help improve employee satisfaction and retention.

Employee Recruitment

These competencies in integrated care can be used in the recruitment process to educate prospective employees about the nature of the work, since “realistic job previews” tend to decrease the frequency with which candidates are offered and/or accept jobs for which they are not well suited. Similarly, the competencies can be used to assess the qualifications of job candidates, both during a review of applications and during the interview process.

A Guide to Orientation

The competencies can be used as a guide to orienting new employees to their role and responsibilities in the delivery of integrated care. Supervisors and employees can jointly review the competencies and discuss the employee’s perspective on areas where additional training and mentoring may be beneficial.

Performance Assessment

Competencies should be the foundation on which assessments of performance are based. These competencies on integrated care can be incorporated into employee self-assessment tools, 360-degree evaluations, and formal performance reviews used within healthcare organizations.

Shaping Existing & Future Competency Sets

There are many existing competency sets that have been developed for the health professions, for the direct care workforce, and for peer support workers. The integrated care competencies identified in this document can be used by the developers of existing competency sets as a benchmark for assessing the extent to which those other sets adequately incorporate content regarding integrated care. Those sets can be updated based on such a review and new competency sets under development can draw from the information within this report as well.

CORE COMPETENCY CATEGORIES

The competencies are organized into nine competency categories. These were not determined in advance, but emerged from the key informant interviews, the literature review, and examination of other competency sets. Some of the competencies could appear in more than one category, but were placed in the category deemed most relevant. The categories that emerged from the process are outlined in Table 1.

TABLE 1. SPECIFIC COMPETENCIES BY CATEGORY

I. INTERPERSONAL COMMUNICATION

The ability to establish rapport quickly and to communicate effectively with consumers of healthcare, their family members and other providers.

Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.

II. COLLABORATION & TEAMWORK

The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.

Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.

III. SCREENING & ASSESSMENT

The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.

Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.

IV. CARE PLANNING & CARE COORDINATION

The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.

Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.

V. INTERVENTION

The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.

Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.

VI. CULTURAL COMPETENCE & ADAPTATION

The ability to provide services that are relevant to the culture of the consumer and their family.

Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.

VII. SYSTEMS ORIENTED PRACTICE

The ability to function effectively within the organizational and financial structures of the local system of healthcare.

Examples include: understanding and educating consumers about healthcare benefits, navigating utilization management processes, and adjusting the delivery of care to emerging healthcare reforms.

VIII. PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT

The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.

Examples include: identifying and implementing evidence-based practices, assessing treatment fidelity, measuring consumer satisfaction and healthcare outcomes, recognizing and rapidly addressing errors in care, and collaborating with other team members on service improvement.

IX. INFORMATICS

The ability to use information technology to support and improve integrated healthcare.

Examples include: using electronic health records efficiently and effectively; employing computer and web-based screening, assessment, and intervention tools; utilizing telehealth applications; and safeguarding privacy and confidentiality.

I. INTERPERSONAL COMMUNICATION

1. Establish rapport, rapidly develop, and maintain effective working relationships with diverse individuals, including healthcare consumers, family members, and other providers.
2. Listen actively and effectively, as demonstrated by the ability to quickly grasp presenting problems, needs, and preferences as communicated by others, and reflect back that information to ensure that others have been accurately understood.
3. Clearly convey relevant information in a non-judgmental manner about behavioral health, general health, and health behaviors using person-centered concepts and terms that are free of jargon and acronyms and are easily understood by the listener.
4. Explain to the healthcare consumer and family the roles and responsibilities of each team member and how they will work together to provide services.
5. In speaking to healthcare consumers or professionals, use the terminology that is common to the setting in which care is delivered or advocate for and educate others about the rationale for using alternative language.
6. Use the primary language and preferred mode of communication of the healthcare consumer and family members or communicate through the use of qualified interpreters.
7. Adapt the style of communication to account for the impact of health conditions on a healthcare consumer's ability to process and understand information.
8. Provide health education materials that are appropriate to the communication style and literacy of the healthcare consumer and family and that reinforce information provided verbally during healthcare visits.
9. Recognize and manage personal biases related to healthcare consumers, families, health conditions and healthcare delivery.

II. COLLABORATION & TEAMWORK

1. Recognize, respect and value the role and expertise of healthcare consumers, family members, and both behavioral health and primary care providers in the process of healthcare delivery.
2. Develop a shared understanding of the respective roles and responsibilities of team members to ensure that collaboration is efficient.
3. Recognize the limits of one's knowledge and skills and seek assistance from other providers.
4. Serve as an effective member of an interprofessional team, helping other providers on the team to quickly conceptualize a healthcare consumer's strengths, healthcare problems, and an appropriate plan of care.
5. Exhibit leadership by directing, guiding, or influencing the collaboration and service delivery of the healthcare team.
6. Respect and respond to the leadership displayed by other providers in a healthcare setting or team.
7. Assertively represent one's professional opinions, encourage other team members to express opinions, and resolve differences of opinion or conflicts quickly and without acrimony.
8. Advocate within the healthcare setting or team for the role of the healthcare consumer and family member in healthcare decisions.
9. Facilitate collaborative care by actively sharing relevant information with others through communications that are authorized by the healthcare consumer and are permissible under HIPAA and related laws, regulations and policies.
10. Foster shared decision-making with healthcare consumers, family members, and other providers.
11. Respond to the expressed needs of healthcare consumers, family members, and other providers, while minimizing the extent to which provider preconceptions of illness and treatment obscure those expressed needs.
12. Demonstrate practicality, flexibility, and adaptability in the process of working with others, emphasizing the achievement of treatment goals as opposed to rigid adherence to treatment models.
13. Connect healthcare consumers and family members to other members of the healthcare team through face-to-face encounters known as "warm hand-offs."
14. Use behavioral health and general health interventions to support the work of the team and to enhance healthcare consumer outcomes.
15. Respond immediately, if at all possible, to requests for consultation or intervention from other providers.
16. Adapt health interventions to the work flow and pace that typically characterizes the provision of primary care, including rapid assessment, brief treatment, and a high daily volume of healthcare consumer contacts.
17. Advocate for, teach, and support illness and whole health self-management and recovery approaches to health conditions within the healthcare team and setting.
18. Advocate for and foster the use of peer support approaches and peer support providers in the healthcare setting as a component of healthcare delivery.

III. SCREENING & ASSESSMENT

1. Use strengths-based wellness, resilience, and recovery models in conceptualizing the health and healthcare of consumers.
2. Routinely conduct brief, evidence-based, and developmentally sensitive screens for the risky, harmful, or dependent use of substances, including alcohol, illicit drugs, and prescription medications, and appropriateness for agonist, antagonist, and anti-craving medications.
3. Routinely conduct brief, evidence-based, and developmentally appropriate screens for cognitive impairment, common mental health problems, and behaviors that compromise health.
4. Routinely conduct brief screens for risk related to self-harm, harm to others, impairments in functional self-care, and environmental safety.
5. Detect signs of abuse, neglect, domestic violence, and other trauma in individuals across the lifespan.
6. Conduct or have other team members conduct more detailed, yet efficient, assessments of healthcare consumers who screen positive for mental and substance use conditions, risk to self or others, or potential abuse and neglect.
7. Recognize and diagnose, using established classification criteria, the most common mental health and substance use conditions seen in the healthcare setting.
8. Recognize the signs, symptoms and treatments of the most common health conditions, health crises, and comorbidity seen in the healthcare setting.
9. Understand the symptoms and treatments for the major healthcare conditions of the consumers under the provider's care.
10. Briefly assess the nature of the consumer's family and social support system and other socio-economic resources that have an impact on health and healthcare.
11. Determine collaboratively the feasibility of providing effective treatment to the healthcare consumer and family within the context of the healthcare team and setting.

IV. CARE PLANNING & CARE COORDINATION

1. Create and periodically update integrated care plans in consultation with healthcare consumers, family members, and other providers, including individuals identified by consumers as part of their healthcare team.
2. Work with healthcare consumers to develop whole health and wellness recovery plans.
3. Match and adjust the type and intensity of services to the needs of the healthcare consumer, ensuring the timely and unduplicated provision of care.
4. Through the care plans, link multiple services, healthcare providers, and community resources to meet the healthcare consumers' needs.
5. Ensure the flow and exchange of information among the healthcare consumer, family members, and linked providers.
6. Work collaboratively to resolve differing perspectives, priorities and schedules among providers.

7. Provide or arrange access to "patient navigation" services that focus on benefits and financial counseling, transportation, home care, and access to social services, peer support, and treatment, including medications.
8. Establish and support systems and procedures within the team and healthcare setting for the use of agonist, antagonist, and anti-craving medications.
9. Coordinate with health plans in identifying and addressing individual consumer and population needs.
10. Implement disease management programs and strategies for selected health conditions, combining the use of engagement tools, health risk assessments, cognitive and behavioral interventions, medications, web-based tools, protocols and guidelines, formularies, monitoring devices, shared decision-making aides, illness and whole health self-management strategies, peer support and empowerment approaches, and call centers.
11. Effectively connect healthcare consumers who cannot be adequately treated by the team or within the setting to other appropriate services.

V. INTERVENTION

1. Demonstrate a fundamental belief in the value and effectiveness of brief interventions to improve health through practice patterns and communications with healthcare consumers, family members, and other providers.
2. Use focused interventions to engage healthcare consumers and increase their desire to improve health (e.g., motivational interviewing, motivational enhancement therapy).
3. Promote healthcare consumer and family adherence to care plans.
4. Educate healthcare consumers, family members, and other providers about healthcare conditions, prevention, available treatments, illness and whole health self-management, peer support and recovery.
5. Identify evidence-based interventions and best practices for integrated care settings.
6. Provide health promotion, wellness and prevention interventions.
7. Deliver brief, trauma-informed, problem-oriented treatment for mental conditions or problematic health behaviors.
8. Deliver brief, trauma-informed treatment for risky or harmful substance use conditions, including the misuse of prescription drugs.
9. Deliver brief, supportive interventions addressing the consequences of illness and injury.
10. Implement longer-term models of treatment and support for healthcare consumers with persistent illnesses that require follow-up over time.
11. Prescribe and manage medications for mental health and substance use conditions (appropriately licensed providers only), including Medically Assisted Treatments for addictions, with consultation, as needed, from other prescribing professionals.
12. Educate healthcare consumers and family members about the common effects, side effects, potential long-term adverse health effects, and interactions of pharmacological treatments for mental health and substance use conditions.
13. Recognize the primary indications, effects, and side effects of pharmacological agents used in the treatment setting for the most common health conditions.
14. Recognize the potential impact and interaction of over-the-counter medications and other non-prescription remedies on health and healthcare treatments.
15. Manage behavioral health crises through office and home-based interventions and linkage to treatment facilities.

16. Link healthcare consumers and family members with other resources, including but not limited to specialty healthcare, rehabilitation and social services, peer support, financial assistance, and transportation, following up to ensure that effective connections have been made.
17. Support healthcare consumers in considering and accessing complementary and alternative services designed to support health and wellness.
18. Provide information, education, guidance, and support to family members and other caregivers.

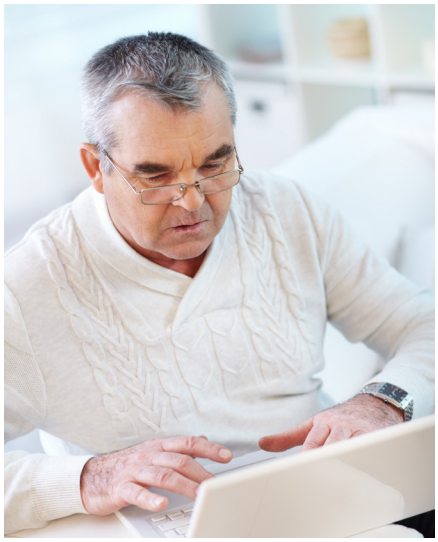
VI. CULTURAL COMPETENCE & ADAPTATION

1. Identify and address disparities in healthcare access and quality for diverse individuals and populations served.
2. Adapt services, including evidence-based interprofessional team approaches, to the language, cultural norms, and individual preferences of healthcare consumers and family members.
3. Develop collaborative relationships with providers of services tailored to the needs of culturally diverse healthcare consumers and family members.
4. Examine the experiences of culturally diverse healthcare consumers and family members with respect to quality of care and adjust the delivery of care as needed.
5. Educate members of the team about the characteristics, healthcare needs, health behaviors, and views toward illness and treatment of diverse populations served in the treatment setting.
6. Foster and value diversity in terms of the composition of the interprofessional team members in all roles, including, but not limited to, community health workers.

VII. SYSTEMS ORIENTED PRACTICE

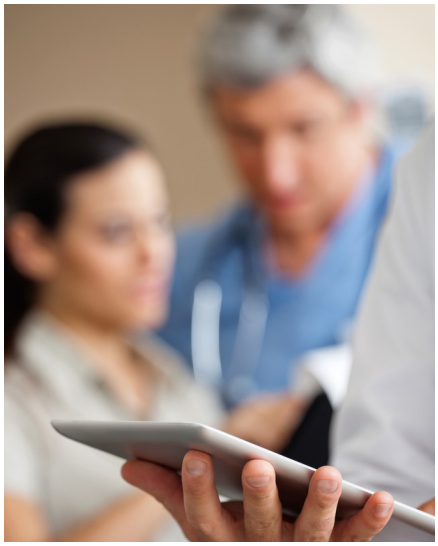
1. Understand and practice effectively within the organization and culture of the interprofessional team, practice setting, and local healthcare system.
2. Provide or arrange assistance to healthcare consumers, family members and other providers in understanding applicable healthcare benefits, coverage limits, and utilization management procedures.
3. Organize and deliver services with an understanding of the impact of team based care on billing, reimbursement, and healthcare coverage.
4. Consider both clinical and cost-effectiveness in decision-making about the organization and delivery of services.
5. Anticipate and adjust the delivery of care to emerging healthcare reforms and structures, such as accountable care organizations, medical homes, and health insurance exchanges.
6. Plan and deliver services with an understanding of the healthcare needs of the population being served.

VIII. PRACTICE-BASED LEARNING & QUALITY IMPROVEMENT



1. Search and evaluate the literature for evidence of the most effective interventions for specific health conditions.
2. Apply relevant practice guidelines to the delivery of care.
3. Deliver evidence-based, integrated approaches to the treatment of health conditions, adapting them to the population, treatment setting, and local system of care.
4. Assess the fidelity of team-based care to evidence-based treatment models.
5. Identify and rapidly address errors in care and assist in implementing policies and procedures to reduce future errors.
6. Measure and monitor individual health outcomes in collaboration with the consumer, adjusting care plans based on outcome data.
7. Monitor healthcare consumer and family satisfaction with care on multiple dimensions and adjust care and practice patterns based on the feedback.
8. Recognize the importance of monitoring client outcomes in the aggregate and demonstrate an ability to read and interpret outcomes monitoring reports.
9. Monitor aggregate consumer health care outcomes and collaborate with the team in improving the process of care based on the data.
10. Collaborate with the healthcare organization and other local healthcare agencies to continuously assess and improve service system design.
11. Establish and pursue individual and team-based learning and improvement goals.

IX. INFORMATICS



1. Use an electronic health record to retrieve relevant information and to document care concisely.
2. Screen, assess and provide services to healthcare consumers using computer-based and web-based tools.
3. Employ telehealth applications to ensure consumer access to appropriate care and to deliver healthcare.
4. Assist healthcare consumers in using web-based tools as part of their personal healthcare plan.
5. Communicate with healthcare consumers and family members using secure online, mobile, and “smart” technology and devices.
6. Safeguard healthcare consumer privacy and confidentiality with respect to communication, documentation, and data.

REFERENCES

Air Force Medical Operations Agency, Behavioral Health Optimization Program, Mental Health Division/SGHW. (2011, April). *Primary behavioral health care services practice manual, version 2.0*. Lackland AFB, TX: Author.

Alakeson, V., Frank, R. G., & Katz, R. E. (2010). Specialty care medical homes for people with severe, persistent mental disorders. *Health Affairs, 29*(5), 867-873. doi: 10.1377/hlthaff.2010.0080

Alexander, L., Quintanilla, R., Schlesinger, B., & Goldstein, B. (2010, June 3). *Addressing mental health problems in primary care: IMPACT and other approaches* [Webinar series]. California Institute for Mental Health, Alcohol & Drug Policy Institute, Integrated Behavioral Health Project. Retrieved from http://www.cimh.org/post/integration-initiatives-webinars

Anastasi, J. K., Capili, B., & Schenkman, F. (2009). Developing an integrative therapies in primary care program. *Nurse Educator, 34*(6), 271-275. doi:10.1097/NNE.0b013e3181bc747a

Bascetta, C. A. (2010). *Healthcare delivery: Features of integrated systems support patient care strategies and access to care, but systems face challenges* (GAO-11-49). Washington, DC: United States Government Accountability Office.

Bjerkan, J., & Alonso, A. (2010). Patients and professionals in collaborative testing. *Studies in Health Technology and Informatics, 157*, 66-71. Retrieved from http://www.ebooks.iospress.nl/bookseries/studies-in-health-technology-and-informatics

Blount, A. F., & Miller, B. F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings, 16*(1), 113-119. doi: 10.1007/s10880-008-9142-7

Bluestein, D., & Cubic, B. A. (2009). Psychologists and primary care physicians: A training model for creating collaborative relationships. *Journal of Clinical Psychology in Medical Settings, 16*(1), 101-112. doi:10.1007/s10880-009-9156-9

Brawer, P. A., Martielli, M., Patrice, P. L., Manwaring, J., & Tierney, A. (2010). St. Louis initiative for integrated care excellence (SLI2CE): Integrated-collaborative care on a large scale model. *Families, Systems & Health, 28*(2), 175-187. doi:10.1037/A0020342

Bryan, C. J., Morrow, C., & Appolonio, K. K. (2009). Impact of behavioral health consultant interventions on patient symptoms and functioning in an integrated family medicine clinic. *Journal of Clinical Psychology, 65*(3), 281-293. doi:10.1002/jclp.20539

Chalk, M., Dilonardo, J., Gelber Rinaldo, S. G, & Oehlmann, P. (2010, July). *Integrating appropriate services for substance use conditions in health care settings: An issue brief on lessons learned and challenges ahead*. Forum on Integration: A collaborative for States. Retrieved from http://www.tresearch.org/download/policy_briefs/LessonsLearned.pdf

Chang-Quan, H., Bi-Rong, D., Zhen-Chan, L., Yuan, Z., Yu-Sheng, P., & Qing-Xiu, L. (2009). Collaborative care interventions for depression in the elderly: A systematic review of randomized controlled trials. *Journal of Investigative Medicine, 57*(2), 446-455. doi: 10.231/JIM.0b013e3181954c2f

Cummings, N. A., O'Donohue, W. T., & Cummings, J. L. (2009). The financial dimension of integrated behavioral/primary care. *Journal of Clinical Psychological Medical Settings, 16*(1), 31-39. doi:10.1007/s10880-008-9139-2

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs*, 28(3), w490-w501. doi:10.1377/hlthaff.28.3.w490

Daniels, A. S., Adams, A., Carroll, C., & Beinecke, R. H. (2009). A conceptual model for behavioral health and primary care integration. *International Journal of Mental Health, 38*(1), 100-112. doi:10.2753,imh0020-7411380109

Druss, B. G., & Walker, E. R. (2011, February). *Mental disorders and medical comorbidity*. (Research Synthesis Report No. 21). Retrieved from Robert Wood Johnson website: http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html

Easterly, L. (2009). An educational model for workforce development: Dissemination of evidence-based practices. *Community Mental Health Journal, 45*, 199-208. doi: 10.1007/s10597-008-9170-7

Eichbaum, Q., Grennan, T., Young, H., & Hurt, M. (2010). An alternative model for medical education: Longitudinal medical education within an integrated health care organization - a vision of a model for the future? *The Permanente Journal, 14*(3), 44-49. Retrieved from http://www.thepermanentejournal.org

Fielding, S. (2010). *Integrative medicine: Improving health care for patients and health care delivery for providers and payors.* Minneapolis, MN: The Bravewell Collaborative.

Foy, J. M., Kelleher, K. J., & Laraque, D. (2010). Enhancing pediatric mental health care: Strategies for preparing a primary care practice. *Pediatrics, 125*, S87-S108. doi: 10.1542/peds.2010-0788E

Funderbunk, J. S., Sugarman, D. E., Maisto, A. M., Ouimette, P., Schohn, M., Lantinga, L.,... Strutynski, K. (2010). The description and evaluation of the implementation of an integrated health care model. *Families, Systems & Health, 28*(2), 146-160. doi:10.1037/a0020223

Gaboury, I., Lapierre, L. M., Boon, H., & Moher, D. (2011). Interprofessional collaboration within integrative healthcare clinics through the lens of the relationship-centered care model. *Journal of Interprofessional Care, 25*, 124-130. doi:10.3109/13561820.2010.523654

Goodell, S., Druss, B. G., & Walker, E. R. (2011, February). *Mental disorders and medical comorbidity* (Policy Brief No. 21). Retrieved from Robert Wood Johnson website: http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html

Haggerty, J. M., Ryan-Nicholls, K. D., & Jarva, J. A. (2010). Mental health collaborative care: A synopsis of the rural and isolated toolkit. *Rural and Remote Health, 10*(1), 1-10. Retrieved from http://www.rrh.org.au

Hawkes, N. (2009). Joined up thinking: The government hopes that integration of services will improve care, but as Nigel Hawkes reports the pilot schemes have a lot to prove. *British Medical Journal, 338*, 1238-1239. Retrieved from http://www.bmj.com

Hoge, M. A., Morris, J. A., Stuart, G. W., Leighton, Y. H., Bergeson, S., Flaherty, M.,... Madenwald, K. (2009). A national action plan for workforce development in behavioral health. *Psychiatric Services, 60*(7), 883-887. doi:10.1176/appi.ps.60.7.883

Hogg Foundation for Mental Health & Methodist Healthcare Ministries. (2011). Crisis point: Mental health workforce shortages in Texas. Austin, TX: Author.

Homer, C. J. (2009). Health disparities and the primary care medical home: Could it be that simple? *Academic Pediatrics, 9*(4), 203-205. doi:10.1016/j.acap.2009.06.001

Humphreys, J., Wakerman, J., Kuipers, P., Wells, B., Russell, P., Siegloff, S., & Homer, K. (2009). *Improving workforce retention: Developing an integrated logic to maximise sustainability of small rural & remote healthcare services*. Acton ACT, Australia: The Australian National University.

Hunter, C. L., Goodie , J. L., Oordt, M. S., & Dobmeyer, A. C. (2009). *Integrated behavioral health in primary care*. Washington, DC: American Psychological Association.

Integrated Behavioral Health Project. (2009, October). *Partners in Health – primary care / county mental health collaboration toolkit*. Retrieved from http://www.ibhp.org/uploads/file/IBHP%20Collaborative%20Tool%20Kit%20final.pdf

James L. C., & O'Donohue, W. T. (2010). *The primary care toolkit: Practical resources for the integrated behavioral care provider.* New York, NY: Springer.

Katon, W. J. (2009). Collaborative care: Evidence-based models that improve primary care depressive outcomes. *CNS Spectrums, 14*(12 Suppl 14), 10-13. Retrieved from http://journals.cambridge.org/action/displayJournal?jid=CNS

Kessler, W., & Cubic, B. (2009). The train is leaving the station: Is psychology aboard? *Journal of Clinical Psychology in Medical Settings, 16*, 1-3. doi:10.1007/s10880-009-9157-8

Kessler, W., Stafford, D., & Messier, R. (2009). The problem of integrating behavioral health in the medical home and the question it leads to. *Journal of Clinical Psychology in Medical Settings, 16*(1), 4-12. doi:10.1007/s10880-009-9146-y

Kilbourne, A. M., Greenwald, D. E., Hermann, R. C., Charns, M. P., McCarthy, J. F., & Yano, E. M. (2010). Financial incentives and accountability for integrated medical care in department of veteran affairs mental health programs. *Psychiatric Services, 61*(1), 38-44. doi:10.1176/appi.ps.61.1.38

Kirchner, J., Edlund, C. N., Haenderson, K., Daily, L., Parker, L. E., & Fortney, J. C. (2010). Using a multi-level approach to implement a primary care mental health (pcmh) program. *Families, Systems & Health, 28*(2), 161-174. doi:10.1037/a0020250

Knowles, P. (2009). Collaborative communication between psychologists and primary care providers. *Journal of Clinical Psychology in Medical Settings, 16*, 72-76. doi: 10.1007/s10880-009-9151-1

Kodner, D. (2009). All together now: A conceptual exploration of integrated care. *Healthcare Quarterly, 13*, 6-15. doi:10.12927/hcq.2009.21091

Koo, D., & Miner, K. (2010). Outcome-based workforce development and education in public health. *Annual Review of Public Health, 31*, 253-269. doi: 10.1146/annurev.publhealth.012809.103705

Lardiere, M. R., Jones, E., & Perez, M. (2011). *NACHC 2010 assessment of behavioral health services in federally qualified health centers*. Bethesda, MD: National Association of Community Health Centers.

Mathematica Policy Research. (2010). *Integrating mental health treatment into the patient centered medical home* (AHRQ Publication No. 10-0084-EF). Retrieved from http://pcmh.ahrq.gov/page/integrating-mental-health-treatment-patient-centered-medical-home

Mauer, B. J. (2009). *Behavioral health / primary care integration and the person-centered healthcare home*. Washington, DC: National Council for Community Behavioral Healthcare.

Mauer, B. J. (2010). *Substance use disorders and the person-centered healthcare home*. Washington, DC: National Council for Community Behavioral Healthcare.

Mauer, B. J., & Jarvis, D. (2010). *The business case for bidirectional integrated care: Mental health and substance use services in primary care settings and primary care services in specialty mental health and substance use settings*. Seattle, WA: MCPP Healthcare Consulting.

Maxwell, W. A., Alexander, K. P., & Ratliff, R. E. (2009, April). Reorganizing to provide integrated care. *Behavioral healthcare, 29*, 5. Retrieved from http://www.behavioral.net/article/reorganizing-provide-integrated-care

McColl, M. A., Shortt, S., Godwin, M., Smith, K., Rowe, K., O'Brien, P., & Donnelly, C. (2009). Models for integrating rehabilitation and primary care: A scoping study. *Archives of Physical Medicine and Rehabilitation, 90*(9), 1523-1531. doi: 10.1016/j.apmr.2009.03.017

Meyer, F., Peteet, J., & Joseph, R. (2009). Models of care for co-occurring mental and medical disorders. *Harvard Review of Psychiatry, 17*(6), 353-360. doi:10.3109/10673220903463325

Miller, B. F., Mendenhall, T. J., & Malik, A. D. (2008). Integrated primary care: An inclusive three-world view through process metrics and empirical discrimination. *Journal of Clinical Psychology in Medical Settings, 16*(1), 21-30. doi:10.1007/s10880-008-9137-4

Ministry of Health. (2009). *Towards optimal primary mental health care in the new primary care environment: A draft guidance paper.* Wellington: Author.

Morgan, M., Dunbar, J., Reddy, P., Coates, M., & Leahy, R. (2009). The true blue story: Is practice nurse-led collaborative care effective in the management of depression for patients with heart disease or diabetes? *BMC Family Practice, 10*(46), doi:10.1186/1471-2296-10-46

Morrow, C. E., Mansoor, E., Hanson, K. L., Vogel, A. L., Rose-Jacobs, R., Genatossio, C. S.,... Bandstra, E. S. (2009). The starting early starting smart integrated services model: Improving access to behavioral health services in the pediatric health care setting for at-risk families with young children. *Journal of Child and Family Studies, 19*(1), 42-56. doi: 10.1007/s10826-009-9280-z

Murphy, M. K., Chabon, B., Delgado, A., Newville, H., & Nicolson, S. E. (2009). Development of a substance abuse consultation and referral service in an academic medical center: Challenges, achievements and dissemination. *Journal of Clinical Psychology in Medical Settings, 16*(1), 77-86. doi:10.1007/s10880-009-9149-8

O'Donohue, W. T., Cummings, N. A., & Cummings, J. L. (2009). The unmet educational agenda in integrated care. *Journal of Clinical Psychology in Medical Settings, 16*(1), 94-100. doi: 10.1007/s10880-008-9138-3

Patel, K. J., & Dwamena, F. (2009). Impact of collaborative care management of depression among patients with cancer. *Journal of Clinical Oncology, 27*(10), 1730. doi: 10.1200/JCO.2008.21.1094

Peek, C. J. (2009). Integrating care for persons, not only diseases. *Journal of Clinical Psychology in Medical Settings, 16*(1), 13-20. doi:10.1007/s10880-009-9154-y

Pisani, A. R., leRoux, P., Phil, D., & Siegel, D. M. (2011). Educating residents in behavioral health care and collaboration: Integrated clinical training of pediatric residents and psychology fellows. *Academic Medicine, 86*(2), 166-173. doi: 10.1097/ACM.0b013e318204fd94

Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings, 16*(1), 40-46. doi:10.1007/s10880-009-9147-x

Pomerantz, A. S., & Sayers, S. L. (2010). Primary care-mental health integration in healthcare in the department of veteran affairs. *Families, Systems & Health, 28*(2), 78-82. doi: 10.1037/a0020341

Pomerantz, A. S., Shiner, B., Watts, B. V., Detzer, M. J., Kutter, C., Street, B., & Scott, D. (2010). The white river model of colocated collaborative care: A platform for mental and behavioral health care in the medical home. *Families, Systems & Health, 28*(2), 114-129. doi:10.1037/a0020261

Post, E. P., Metzger, M., Dumas, P., & Lehmann, L. (2010). Integrating mental health into primary care within the veterans health administration. *Families, Systems & Health, 28*(2), 83-90. doi:10.1037/a0020130

Protti, D. (2009). Integrated care needs integrated information management and technology. *Healthcare Quarterly, 13*, 24-29. Retrieved from http://www.longwoods.com/publications/healthcare-quarterly

Pyne, J. M., Fortney, J. C., Curran, G. M., Tripathi, S., Atkinson, J. H., Kilbourne, A. M.,...Gifford, A. L. (2011). Effectiveness of collaborative care for depression in human immunodeficiency virus clinics. *Archives of Internal Medicine, 171*(1), 23-31. doi:10.1001/archinternmed.2010.395

Ring, J. M. (2009). Psychology and medical education: Collaborations for culturally responsive care. *Journal of Clinical Psychology in Medical Settings, 16*(1), 120-126. doi: 10.1007/s10880-008-9141-8

Robinson, P. J., & Strosahl, K. D. (2009). Behavioral health consultation and primary care: Lessons learned. *Journal of Clinical Psychology in Medical Settings, 16*(1), 58-71. doi: 10.1007/s10880-009-9145-z

Roche, A. M., Pidd, K., & Freeman, T. (2009). Achieving professional practice change: From training to workforce development. *Drug and Alcohol Review, 28*(5), 550-557. doi: 10.1111/j.1465-3362.2009.00111.x

Rosenthal, E. L., Brownstein, J. N., Rush, C. H., Hirsch, G. R., Willaert, A. M., Scott, J. R.,...Fox, D. J. (2010). Community health workers: Part of the solution. *Health Affairs, 29*(7), 1338-1342. doi:10.1377/hlthaff.2010.0081

RTI–UNC Evidence-Based Practice Center. (2010). *Future research needs for the integration of mental health/substance abuse and primary care* (AHRQ Publication No. 10-EHC069-EF). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK51247

Russell, L. (2010). *Mental health care services in primary care tackling the issues in the context of health care reform*. Washington, DC: Center for American Progress.

Ruston, A., & Tavabie, A. (2010). Fostering clinical engagement and medical leadership and aligning cultural values: An evaluation of a general practice specialty trainee integrated training placement in a primary care trust. *Quality in Primary Care, 18*(4), 263-268. Retrieved from http://www.ingentaconnect.com/content/rmp/qpc

Sanchez, K., Thompson, S., & Alexander, L. (2010). Current strategies and barriers in integrated health care: A survey of publicly funded providers in Texas. *General Hospital Psychiatry, 32*(1), 26-32. doi:10.1016/j.genhosppsych.2009.10.007

Schmied, V., Mills, A., Kruske, S., Kemp, L., Fowler, C., & Homer, C. (2010). Understanding the needs and experiences of families: The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing, 19*, 3516–3526. doi:10.1111/j.1365-2702.2010.03321.x

Schoen, C., Osborn, R., Doty, M. M., Squires, D., Peugh, J., & Applebaum, S. (2009). A survey of primary care physicians in eleven countries, 2009: Perspectives on care, costs, and experiences. *Health Affairs, 28*(6), w1171-w1183. doi:10.1377/hlthaff.28.6.w1171

Schoenwald, S. K., Hoagwood, K. E., Atkins, M. S., Evans, M. E., & Ringeisen, H. (2010). Workforce development and the organization of work: The science we need. *Administration and Policy in Mental Health, 37*(1-2), 71–80. doi:10.1007/s10488-010-0278-z

Schuffman, D., Druss, B. G., & Parks, J. J. (2009). State mental health policy: Mending Missouri's safety net: Transforming systems of care by integrating primary and behavioral health care. *Psychiatric Services, 60*(5), 585-588. doi: 10.1176/appi.ps.60.5.585

Sevin, C., Moore, G., Shepherd, J., Jacobs, T., & Hupke, C. (2009). Transforming care teams to provide the best possible patient-centered, collaborative care. *Journal of Ambulatory Care Management, 32*(1), 24-31. doi:10.1097/01.JAC.0000343121.07844.e0

Smith, M. (2010). Collaborative care models for late-life depression and anxiety: Roles for nurses. *Journal of Gerontological Nursing, 36*(9), 3-4. doi:10.3928/00989134-20100803-01

Strandberg-Larsen, M., & Krasnik, A. (2009). Measurement of integrated healthcare delivery: A systematic review of methods and future research directions. *International Journal of Integrated Care, 9*(4), 1-10. Retrieved from http://www.ijic.org/index.php/ijic

Summerfelt, W. T., Tilson, H. H., & Crawford, C. A. (2009). Moving forward with workforce development research in public health. *Journal of Public Health Management Practice, 15*(6 Suppl), 1-2. doi:10.1097/PHH.0b013e3181c5c050

Sved-Williams, A., & Poulton, J. (2010). Primary care mental health consultation-liaison: A connecting system for private psychiatrists and general practitioners. *Australasian Psychiatry, 18*(2), 125-129. doi:10.3109/10398560903469783

Thacker, S. B. (2009). Guide for applied public health workforce research: An evidence-based approach to workforce development. *Journal of Public Health Management Practice, 15*(6 Suppl), S109-112. doi:10.1097/PHH.0b013e3181b1eb85

The Commonwealth Fund. (2010). *Quality matters: A bimonthly report on innovations in health care quality improvement*. Washington, DC: Author.

Thombs, B. D., Adeponle, A. B., Kirmayer, L. J., & Morgan, J. F. (2010). A brief scale to assess hospital doctors' attitudes toward collaborative care for mental health. *Canadian Journal of Psychiatry, 55*(4), 264-267. Retrieved from http://publications.cpa-apc.org/browse/documents/2

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2008). *Integration of mental health/substance abuse and primary care* (AHRQ Publication No. 09-E003). Retrieved from http://www.ahrg.gov

van Orden, M., Hoffman, T., Haffmans, J., Spinhoven, P., & Hoencamp, E. (2009). Collaborative mental health care versus care as usual in a primary care setting: A randomized controlled trial. *Psychiatric Services, 60*(1), 74-79. doi: 10.1176/appi.ps.60.1.74

Walker, B. B., & Collins, C. A. (2009). Developing an integrated primary care practice: Strategies, techniques, and a case illustration. *Journal of Clinical Psychology, 65*(3), 268-280. doi:10.1002/jclp.20552

Weiss, S. J., Haber, J., Horowitz, J. A., Stuart, G. W., & Wolfe, B. (2009). The inextricable nature of mental and physical health: Implications for integrative care. *Journal of the American Psychiatric Nurses Association, 15*(6), 371-382. doi: 10.1177/1078390309352513

Wu, M. P., Lin, P. F., Lin, K. J., Sun, R. S., Yu, W. R,, Peng, L. N., & Chen, L. K. (2010). Integrated care for severely disabled long-term care facility residents: Is it better? *Archives of Gerontology and Geriatrics, 50*(3), 315-318. doi: 10.1016/j.archger.2009.05.004

Wylie, L. W. J. (2010). Assessing user perceptions of staff training requirements in the substance use workforce: A review of the literature. *Drugs: Education, Prevention, and Policy, 17*(5), 618-631. doi: 10.3109/09687631003705538

Zismer, D. K., McCullough, J., & Person, P. E. (2009). Integrated health care economics part 2: Understanding the revenue drivers in fully integrated community health systems. *Physician Executive, 35*(4), 26-28. Retrieved from http://www.acpe.org/publications/pej

Zismer, D. K., McCullough, J., Person, P. E., & Renier, C., & Knutson, D. (2009). Integrated health care economics part 1: Are specialty physician services revenues reliable predictors of community health system financial performance? *Physician Executive, 35*(3), 26-31. Retrieved from http://www.acpe.org/publications/pej

Zivin, K., Pfeiffer, P. N., Szymanski, B. R., Valenstein, M., Post, E. P., Miller, E. M., & McCarthy, J. F. (2010). Initiation of primary care-mental health integration programs in the VA health system: Associations with psychiatric diagnoses in primary care. *Medical Care, 48*(9), 843-851. doi:10.1097/MLR.0b013e3181e5792b

APPENDIX I: CONTRIBUTORS

PROJECT TEAM

CIHS engaged the Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org) to lead and manage the competency development project. The Coalition is a non-profit organization dedicated to improving the recruitment, retention, training and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field.

The core Annapolis Coalition team managing the project included:

Michael A. Hoge, PhD, Senior Science and Policy Advisor, The Annapolis Coalition
John A. Morris, MSW, Executive Director, The Annapolis Coalition
Michele Laraia, PhD, APRN, Project Consultant, The Annapolis Coalition
Ann McManis, Director of Operations, The Annapolis Coalition

Senior Content Experts

Two individuals with nationally recognized expertise in this field were engaged as Senior Content Experts to provide a broad and high-level review of the product.

Andrew Pomerantz, M.D. is the National Mental Health Director for Integrated Services in the Veterans Health Administration and Associate Professor of Psychiatry at Dartmouth Medical School. His "White River" model of primary care – mental health integration, developed over a 15-year period, became a national model for the Veterans Administration in 2004. He is currently engaged in development of the VA's Patient Centered Medical Home.

Tillman Farley, M.D. is the Medical Services Director of Salud Family Health Centers, a migrant / federally qualified community health center with clinics across north and northeast Colorado. He completed his residency in family medicine in Rochester, New York and now serves as an Associate Professor in the Department of Family Medicine at the University of Colorado School of Medicine. He moved to Colorado from far west Texas where he spent three years directing a federally qualified rural health clinic. Dr. Farley has a strong interest in integrated primary care and health disparities, particularly as these apply to immigrant populations.

Expert Key Informants

The selection process and expertise of key informants is described in the Detailed Method section below.

Marty Adelman, MA, CRP
Mental Health Coordinator
Community Clinics Health Network
San Diego, CA

Sergio Aguilar-Gaxiola, MD, PhD
Professor & Director of the Center for Reducing Health Disparities
University of California at Davis
Davis, CA

Stephen J. Bartels, MD, MS
Professor of Psychiatry, Community & Family Medicine
Director, Center on Aging Research
Dartmouth University
Hanover, NH

Sue Bergeson
Vice President
Optum Health
Chicago, IL

Richard Brown, MD, MPH
Professor
Department of Family Medicine
University of Wisconsin
Madison, WI

Kathleen Buckwalter, RN, PhD, FAAN
Professor Emeritus, Sally Mathis Hartwig
Professor in Gerontological Nursing
University of Iowa College of Nursing
Iowa City, IA

Elisabeth Cannata, PhD
Vice President of Community-Based Family Services and Practice Innovation
Wheeler Clinic
Plainville, CT

Jeff Capobianco, PhD
Director of Practice Improvement
SAMHSA-HRSA Center for Integrated Health Solutions, National Council for Behavioral Health
Washington, DC

Mady Chalk, PhD, MSW
Director
Center for Performance-Based Policy
Treatment Research Institute
Philadelphia, PA

Kathleen R. Delaney, PhD, PMH-NP, FAAN
Professor and Specialty Coordinator
Rush College of Nursing
Chicago, IL

Guillermo Diaz, Jr, MD, CPHIMS
Chief Medical Information Director
QueensCare Family Clinics
Los Angeles, CA

Tillman Farley, MD
Director of Medical Services
Salud Family Health Center
Fort Lupton, CO

Michael Flaherty, PhD
Consultant
Former Director, NE Addiction Technology Transfer Center
Pittsburgh, PA

Dennis Freeman
CEO
Cherokee Health Systems
Knoxville, TN

Larry Fricks
Deputy Director
SAMHSA-HRSA Center for Integrated Health Solutions, National Council for Behavioral Health
Washington, DC

Steven L. Gallon, PhD
Chair, Blending Team
Northwest Frontier ATTC
Oregon Health & Science University
Portland, OR

Eric Goplerud, PhD
Vice President for Mental Health, Substance Use and Justice
NORC at University of Chicago
Washington, DC

Catherine Grus, PhD
Deputy Executive Director, Education Directorate
American Psychological Association
Washington, DC

Judith Haber, PhD, APRN, BC FAAN
Interim Dean
NYU College of Nursing
New York, NY

Nancy P. Hanrahan, PhD, RN
Psychiatric MH Nursing Center for Health Outcomes and Policy Research
University of Pennsylvania, School of Nursing
Philadelphia, PA

Tom Hill, MSW
Policy Director
Faces and Voices of Recovery
Washington, DC

Joseph Holshoe, PMHNP
Commander, US Public Health Service
Behavioral Health Consultant
Primary Care Clinic
Naval Health Center New England
Newport, RI

Leighton Huey, MD
Professor of Psychiatry
University of Connecticut
Farmington, CT

DJ Ida, PhD
Executive Director
National Asian American Pacific Islander Mental Health Association
Denver, CO

Brain Kaskie, MD, PhD
Associate Professor
Dept. of Health Management and Policy
College of Public Health
University of Iowa
Iowa City, IA

Kelly J. Kelleher, MD, MPH, FAAP
Director, Center for Innovation in Pediatric Practice
Nationwide Children's Hospital
Professor of Pediatrics
Ohio State University
Columbus, OH

Michael R. Lardieri, MSW
Vice President, Health Information Technology
National Council for Behavioral Health
Washington, DC

Virna Little, PsyD, LCSW
Senior Vice President for Psychosocial Services and Community Affairs
The Institute for Family Health
New York, NY

Amy Brock Martin, DrPH
Deputy Director
SC Rural Health Research Center
University of South Carolina School of Public Health
Columbia, SC

Dennis McCarty, PhD
Professor
Department of Public Health and Preventive Medicine
Oregon Health & Science University
Portland, OR

Mimi McFaul, PsyD
Deputy Director, Mental Health Program
Western Interstate Commission on Higher Education (WICHE)
Boulder, CO

Bill McFeature, PhD
Director of Integrative Behavioral Health
Southwest Virginia Community Health Center
Bristol, VA

Oscar Morgan, MHSA
Vice President
Magna Systems, Inc.
Annapolis, MD

Rich Munger, PhD
Planner/Evaluator
Buncombe County Human Service Support Team
Asheville, NC

Phyllis Panzano, PhD
Founder and President
Decision Support Services, Inc.
Columbus, OH

Beth Phoenix, RN, PhD
Health Sciences Clinical Professor
Director, Psychiatric Nursing Graduate Program
UCSF School of Nursing
San Francisco, CA

Andrew Pomerantz, MD
National Mental Health Director for Integrated Care
Veterans Health Administration
White River Junction VA Medical Center
White River Junction, VT

Richard A. Rawson, PhD
Associate Director
UCLA Integrated Substance Abuse Programs
Los Angeles, CA

Katherine Reynolds, MSW
Vice President, Health Integration and Wellness Promotion
National Council for Behavioral Health
Washington, DC

Ruth Shim, MD
Assistant Professor, Department of Psychiatry and Behavioral Sciences
Associate Director of Behavioral Health
National Center for Primary Care
Morehouse School of Medicine
Atlanta, GA

Tony Salerno, PhD
Practice and Policy Scholar
McSilver Institute for Poverty Policy & Research
Silver School of Social Work
New York University
Senior Consultant, CIHS
New York, NY

Kim Schwartz, MSW
CEO
Roanoke Chowan Community Health Center
Ahoskie, NC

Margaret Sharf, DNP
PMHNP Program Director
Oregon Health & Science University
School of Nursing
Portland, OR

Diane Snow, PhD, APRN, BC, CARN, PMHNP
Clinical Professor and Director
PMHNP Program
University of Texas at Arlington
Hurst, TX

Mark B. Snowden, MD, MPH
Associate Professor
University of Washington
Seattle, WA

Gail Stern, MSN, PMHCNS-BS
Administrator
Department of Psychiatry
Lehigh Valley Health Network
Coopersburg, PA

Gail Stuart, PhD, RN, FAAN
Dean
College of Nursing
Medical University of South Carolina
Charleston, SC

Michael Terry, DNP, APRN-PMH/FNP
Associate Clinical Professor
Nurse Practitioner Program
University of San Diego
Hahn School of Nursing & Health Sciences
San Diego, CA

Roberta Waite, EdD, APRN, CNS-BC, FAAN
Assistant Dean of Integration
Division of Graduate Nursing
Drexel University
Philadelphia, PA

Karen Williams, MS
VP for Programs
West End Medical Centers
Atlanta, GA

Beth Wrobel
CEO
Healthlinc Community Health Center,
Michigan City, IN

APPENDIX II: DETAILED METHOD

Overview

The method for arriving at the core set of competencies involved three major activities: (1) structured interviews with the key informants; (2) review of the recent literature on integration; and (3) review and analysis of selected competency sets judged to have relevance to this process.

Key Informants

The foundation of the core competencies rests on recommendations from 50 key informants who were selected because of their expertise on integrated care. They were identified in multiple ways, including: authorship of articles and other resources on the topic of integration, nomination by other experts, nomination by the SAMHSA-HRSA Center for Integrated Health Solutions, leadership within a HRSA-supported FQHC, leadership role in a community behavioral health organization that is a grantee within the SAMHSA-sponsored Primary and Behavioral Health Care Integration (PBHCI) program, and national leadership in peer support and recovery.

Special efforts were made to ensure that the key informant pool included individuals whose expertise reflected knowledge of and practice in the following: integration of primary care and behavioral healthcare; development of professional competencies; the unique needs of children, adults, and older adults; urban and rural healthcare; cultural competence, diversity, and disparities; and healthcare financing and managed care. Experts were drawn from varied disciplines and specialties, including: internal medicine and family medicine, public health, addictions, psychiatry, social work, nursing and peer support and recovery. The list of key informants is contained in Appendix I.

Key informants were interviewed by project team members using a semi-structured format. With respect to integration, they were asked to identify published works, other resources, and additional key informants. Their most important task was to recommend specific competencies for inclusion in the competency set. All recommended competencies were distilled into a single set, condensed to eliminate redundancy, and organized into categories in an iterative qualitative process managed by the project team.

Literature Review

A review of the relevant literature pertaining to workforce factors in integrated health care from 2008 through 2011 was conducted using a dozen databases. In addition, bibliographies in selected articles and reports were reviewed to identify other articles that may not have surfaced in the electronic subject search or that were not catalogued in the bibliographic databases. Titles and abstracts from the various database searches were reviewed and full articles were retrieved for those that met inclusion criteria. A total of 120 resources were retrieved, including: published articles; federal, state, and non-governmental reports; and book chapters. These works were supplemented through the key informant process, which identified new resources recommended by informants that were not covered in the initial search.

The literature on integration is predominantly composed of journal articles that represent opinion papers, literature reviews, and research reports, as well as a number of government and private sector documents, guides, books, and "tool kits." Most of this literature focuses on the U.S. health care system, although there are significant contributions from several international sources. Regardless of the country of origin of these works, there was agreement within them that, in integrated settings, practitioner roles and responsibilities are often dramatically different from the content of what is currently taught across traditional educational programs or the nature of the roles and responsibilities in traditional clinical settings (see, for example: O'Donohue, Cummings, & Cummings, 2009; Pomerantz, Corson & Detzer, 2009).

The literature reviewed was, by and large, very descriptive and very general about the nature of integration. A very small portion of the literature specifically discussed workforce competencies, which were distilled and added to the list identified through the key informant process.

Review of Other Competency Sets

While there are no widely recognized competency sets on integrated care, the project team members reviewed general competency sets to gather additional input regarding the structure and content of the set of competencies under development. This review generated information regarding the most common approaches to identifying categories of competencies and yielded suggestions for content related to integration. The competency sets reviewed and analyzed were:

Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, & attitudes of professional practice* (DHHS Publication No. (SMA) 06-4171). Technical Assistance Publication (TAP) Series 21. Rockville, MD.

> The original version of this document was authored by the National Addiction Technology Transfer Center (ATTC) and was updated in 2005 through the work of a committee of experts.

Psychiatric, Mental Health and Substance Abuse Essential Competencies Task Force. (2012). Essential psychiatric, mental health and substance use competencies for the registered nurse. *Archives of Psychiatric Nursing*, 26(2), 80-110.

National Panel for Psychiatric-Mental Health NP Competencies, National Organization of Nurse Practitioner Faculties. (2003, September). *Psychiatric-mental health nurse practitioner competencies*. Retrieved from www.aacn.nche.edu/leading-initiatives/education-resources/PMHNP.pdf

This document is currently under revision.

Note that this competency project is distinct from another federally sponsored effort funded by the Agency for Healthcare Research and Quality (AHRQ). The two projects could be viewed as complementary since the competencies described in this report are drawn principally from expert opinion, while the competencies in the AHRQ-funded project are drawn largely from observation of providers delivering integrated care. Both works will contribute useful information to the ongoing effort to define competencies for integration.

Development of the Competency Set

Three senior project team members, working independently, reviewed the comprehensive list of potential competencies identified through the three sources listed above and identified proposed competency categories. Differences were resolved through a consensus process that produced a working set of competency categories and tentative titles for the categories. A senior project team member placed individual competencies from the comprehensive list into competency categories. Other team members then proposed modifications to the placement and organization of competencies and achieved a complete set through a consensus process. Category titles were modified to fit the content of competencies within the categories.

The resulting competency set was circulated electronically to the senior content experts and all key informants. They were asked to respond to the set and recommend any additions or edits to the proposed competency categories or individual competencies. The competency sets were revised based on the recommendations received, some of which were contradictory in nature. Approximately 80% of recommended changes were incorporated into a revised competency set. The revised competency set was reviewed and approved by the Senior Content Advisors.