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| Scopes of Practice: Behavioral Health Care Facilitators |
| Task 3 Deliverable Draft |



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# Executive Summary

In August 2019, Atrius Health engaged healthcare consulting firm AHP to review and codify competencies, work standards, and best practices for three non-licensed paraprofessional roles in Atrius’s practices. Previously, AHP conducted a series of interviews and other assessment activities to establish the current state of responsibilities, functions, and competencies of these three staff roles—pediatric care facilitators (PCFs), behavioral health care facilitators (BHCFs), and population management coordinators (PMCs). This report recommends the next step in that process: a detailed scope of practice for each role to perform optimally in the Atrius Accountable Care Organization (ACO) environment.

PCFs, BHCFs, and PMCs at a Glance

***Pediatric Care Facilitators (PCFs)*** support pediatric patients, their families, and providers with care coordination and navigation around complex medical and social needs.

***Behavioral Health Care Facilitators (BHCFs)*** support adults and some children with behavioral health diagnoses from all payers but primarily a Medicaid population.

***Population Management Coordinators (PMCs)*** serve adult patients with chronic illnesses, address gaps in preventive care, and focus on quality metrics in the practices.

## Approach to Development of Scopes of Practice

A scope of practice describes the procedures, actions, and processes that an individual is permitted to undertake according to regulations and licensure, if applicable. Developing a scope of practice for a non-licensed paraprofessional like the PCF, BHCF, or PMC involves understanding how they can best contribute to the healthcare process and align that with activities that do not require licensure or other credentials that might be in the scope of a licensed colleague, such as a nurse or social worker, for instance.

In order to develop these scopes of practice, AHP conducted an environmental scan of evidence-based and best practices and competencies for same or comparable positions. In this report, those are presented as a detailed set of competencies and knowledge, skills, and abilities (KSAs) that will enable these paraprofessionals to optimally perform their jobs for the good of Atrius and its patients.

This report is organized to best outline competencies and how they apply to Atrius’s environment. Key points for each role include:

* highlights of the evidenced based and best practices for each facilitator role,
* the ideal competencies and related KSAs that should be associated with each role,
* how the role can be used within the context of the Atrius organization, and
* if there can be/should be any career ladders.

This version of the report focuses exclusively on the BHCF scope of practice.

# Behavioral Health Care Facilitators (BHCFs)

## Evidence-Based Practices and Best Practices

The environmental scan of evidence-based practices (EBPs) and best practices (BPs) focused on the three key areas of healthcare that BHCFs’ work touches on. These include:

1. Working effectively with persons with mental illness and substance use in a non-clinical setting to support clinical care.
2. Working in a primary care setting that integrates primary care and behavioral health through support and information-sharing.
3. Working as part of a team within behavioral health and across the primary care setting.

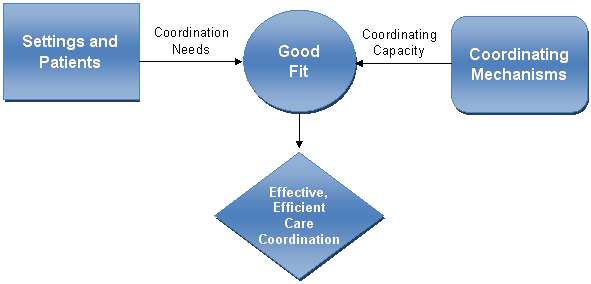
The environmental scan found these key areas of work to be tied to the best practice models outlined below.

**1. Illness Management and Recovery (IMR).** IMR is an EBP that has emerged for programs that serve persons with severe and persistent mental illness (SAMHSA, 2009). The highlight of this EBP is the emphasis on working with patients with mental illness to define their own goals for participation in treatment, to continually provide hope for recovery, to help the patient identify his/her strengths and preferences, and to help the patient advocate for his/her needs. The approach of this model helps to clarify how much the front-line staff should “do for” the patient versus encouraging the patient to advocate and do for him/herself. There are several key concepts that apply to the work of BHCFs:

* Recovery is more than coping
* Recovery is influenced by an individual’s “stress vulnerability”
* The staff can help the consumer identify his/her stress vulnerability
* Recovery is an ongoing process
* Consumer-directed care is a key aspiration
* Changing the consumer’s biochemistry is a way to reduce stress vulnerability

IMR is an important EBP because it is the best practice approach of the Massachusetts Department of Mental Health (DMH) for clients in the Adult Clinical Community Services (ACCS) program that serves ACO and dually-insured (Medicare and Medicaid) consumers.

**2. Care Coordination.** A care coordination best practice model has been established by the National Center for Excellence in Primary Care Research (NCEPCR) that includes a conceptual approach to care coordination in primary care, a catalogue of key functions and measures for effectiveness and quality. (NCEPCR, 2014). NCEPCR is part of the Agency for Health Research and Quality (AHRQ). One of the conceptual frameworks that applies to the work of the BHCFs is the following organizational design model:



**3. Patient Navigation.** The Institute for Healthcare Improvement’s (IHI) identified the following best practices, in addition to integrating primary care with behavioral health (IHI, 2012):

* Supporting self-management for adults with serious mental illness,
* Workforce development to support care management and
* Navigation services for individuals with severe mental illness[[1]](#footnote-2) (p. 2)

Other highlights of their best practice include:

* Wellness and “whole health” approach to patients;
* Coaching;
* Engagement through Motivational Interviewing;
* Recovery as a foundation for addressing mental illness;
* A focus on individual needs, strengths and preferences; and,
* Matching care coordination to individual needs.

**4. The Collaborative Care Model.** The five key principles of Collaborative Care (AIMS Center, 2014) include:

* Patient centered care
* Population-based care
* Measurement-based treatment to target
* Evidence-based care
* Accountable care

Underlying all of the work of the BHCFs are two fundamental evidence-based practices: Trauma-Informed Care and Motivational Interviewing.

**Trauma-Informed Care** is becoming a standard approach in almost all behavioral health settings and in many primary care settings. The federal government’s Substance Abuse and Mental Health Services Administration (SAMHSA) has committed significant resources to developing and supporting training for all levels of staff who are involved in behavioral health with the full age spectrum of clients (SAMHSA, 2014).

The most common associations with trauma are the post-traumatic stress of veterans returning from combat and the trauma of children who have been abused or neglected as documented in the Adverse Childhood Experiences Study (ACES). However, as the principles of Trauma-Informed Care have been more clearly delineated, they have been applied more broadly to many different patient populations as an evidence-based approach to engaging patients and delivering both care coordination services and clinical treatment.

The Trauma-Informed Approach by any person directly dealing with a client or family can be summarized with the “4 R’s”:

1. **R**ealizes the widespread impact of trauma and understands potential paths for recovery
2. **R**ecognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system
3. **R**esponds by fully integrating knowledge about trauma into policies, procedures, and practices
4. **R**esists re-traumatization

The approach in practice includes key program elements for staff competency that include:

* Become trauma aware and knowledgeable about the impact and consequences of traumatic experiences for individuals, families, and communities.
* Evaluate and initiate use of appropriate trauma-related screening and assessment tools.
* Implement interventions from a collaborative, strengths-based approach, appreciating the resilience of trauma survivors.
* Learn the core principles and practices that reflect TIC.
* Anticipate the need for specific trauma-informed treatment planning strategies that support the individual’s recovery.
* Decrease the inadvertent retraumatization that can occur from implementing standard organizational policies, procedures, and interventions with individuals, including clients and staff, who have experienced trauma or are exposed to secondary trauma.
* Evaluate and build a trauma-informed organization and workforce.

**Motivational interviewing (MI)** is an approach to engage consumer, patients, family members, and others into the stages of change to which there is initial “resistance.” MI focuses on the stages of change and skills and competencies of the staff person to engage the patient in “change talk” to build support for movement from “pre-contemplation” to “action” to “maintenance.”

The approach upholds four principles— expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy (client’s belief s/he can successfully make a change) (CWR, 2011).

Motivational Interviewing (MI) is an evidence-based treatment that addresses ambivalence to change. MI is a conversational approach designed to help people with the following:

* Discover their own interest in considering and/or making a change in their life (e.g., diet, exercise, managing symptoms of physical or mental illness, reducing and eliminating the use of alcohol, tobacco, and other drugs).

To remember the core counseling skills of MI, use the acronym OARS (Miller & Rollnick, 2013):

* Asking **O**pen questions
* **A**ffirming
* **R**eflective listening
* **S**ummarizing
* Express in their own words their desire for change (i.e., "change-talk").
* Examine their ambivalence about the change.
* Plan for and begin the process of change.
* Elicit and strengthen change-talk.
* Enhance their confidence in taking action and noticing that even small, incremental changes are important.
* Strengthen their commitment to change.

## Ideal Competencies and Associated KSAs

A brief environmental scan of care coordination and patient navigation practices was conducted with the goal of identifying a set of competencies specific to BHCFs. The method for conducting an environmental scan and arriving at a core set of competencies included a review of the literature on working with persons with mental illness, providing behavioral health in a primary care setting, collaborative and team-based care in primary care settings, survey results from paraprofessionals in the field, SAMHSA best practice case studies, and job descriptions and competencies from state licensing bodies for similar position. The literature review included journal articles, white papers, research reports, government and private sector documents, guides, “tool kits” and competency sets relevant to this process. Each of these sources yielded potential content for inclusion in the below BHCF competency which includes:

1. Using Independent Judgement
2. Facilitating Patient-Centered Care
3. Linkages to Health System and Community Resources
4. Health Education, Coaching and Wellness Planning
5. Facilitate Transitions
6. Advocacy
7. Relapse Prevention

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| Competency: Using Independent Judgement and Professionalism  While working under the general supervision of an independently licensed behavioral health clinician, acts autonomously and discerns when to involve his/her supervisor. Acts with integrity, politeness, confidence, and humility and demonstrates self-awareness and a willingness to accept and resolve mistakes in a mutually agreeable manner. |
| **Demonstrates knowledge of:**   * Scope of practice of the behavioral health clinician and prescriber. * The role of the primary care clinician. * Ethical and professional obligations, including confidentiality and requirements of 42 CFR, Part 2. * Patient rights. * Emotional Intelligence. * Organizational and time management tools. * Department and organization policies and procedures. * Professional etiquette and attitudes. |
| **Demonstrates the skill & ability to:** |
| * Exhibit the emotional intelligence needed to positively impact desired healthcare outcomes. * Show sensitivity and responsiveness to a diverse patient population including but not limited to gender, age, culture, race, religion, abilities, and sexual orientation. * Build trust by being accessible, reliable, accurate, and supportive. * Demonstrate accountability to patients, members of the primary care team, and others. * Apply knowledge of and act within professional boundaries and scope of practice. * Use organizational skills, time management, problem solving, and critical thinking to assist patients efficiently and effectively. * Assist in developing and implementing care plans, in cooperation with clients and professional colleagues. (Care plans should be based on needs and resource assessments. Plans should describe how each party involved will help meet the goals and priorities defined in collaboration with clients.) * Assess and evaluate BHCF outcome measures across the healthcare continuum, such as decreasing barriers to care and population health disparities, while improving patient encounters, resource provision, and collaborative relationships. * Respond to patient needs over personal self-interests. * Use tact and a cooperative attitude in all forms of communication. * Promote BHCF role, responsibilities, and value to patients, providers, and the larger community. * Adhere to ethical principles of healthcare including patient confidentiality. * Actively participate in professional growth and learning activities. * Employ self-care strategies and healthy coping mechanisms. * Perform duties accurately and efficiently. * Incorporate feedback from supervisor and team members to improve daily performance. * Have awareness of the things one doesn’t know and seek out consultation and learning opportunities to fill the gaps. * Practice speaking with both confidence and humility. * Maintain composure and politeness even in the face of a difficult or tense situation. * Reliably act with integrity and take responsibility for one’s own actions. * Work to resolve mistakes as soon as possible. * Assertively express one’s professional opinions, encourage and actively listen to other team members opinions. * Resolve differences of opinion or conflicts quickly and without acrimony. * Respectfully respond to others. * Accept and give feedback discreetly. * Know and support National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. * Apply insight and understanding about human emotions and responses to create and maintain positive interpersonal interactions. |

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| Competency: Facilitates Patient-Centered Care That is Compassionate, Appropriate, and Effective for The Treatment of Disease And Illness And For The Promotion of Health  Establishes rapport quickly, identifies the presenting problem from the patient’s perspective, establishes a goal based on the patient’s needs, and develops a follow up plan that draws on the patient’s strengths and preferences. |
| **Demonstrates knowledge of:**   * Active listening skills. * Motivational Interviewing and stages of change. * Trauma-Informed Care. * Basic understanding of behavioral health and substance use disorders. * The general impact of Social Determinant of Health on (SDOH) on patient health. |
| **Demonstrates the skill & ability to:** |
| * Interview the patient using open-ended questions. * Listen actively, paraphrase, or repeat key points back to demonstrate understanding. * Ask open ended questions to gain additional information. * Obtain information necessary to provide the resource requested by the patient. * Convey information to patients in a polite, jargon-free, non-judgmental manner. * Adapt to the preferred mode of communication of the patient. * Demonstrate concern and a desire to help. * Express openness to the ideas, opinions, and feedback of others. * Use language that is appropriate to the patient’s racial, ethnic, and cultural background. * Clearly convey relevant information in a nonjudgmental manner about behavioral health, general health and socioeconomic concerns. * Effectively exchange information with patients, behavioral health clinician, and prescriber. |

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| Competency: Linkages to Health System and Community Services  Identifies appropriate community resources that match the needs of the patient. Promotes timely access for the patient with the patient’s active participation to reach his/her defined goals. Clarifies the requirements for the community resources and sets expectations for the time to obtain access to those resources based on experience. Develops a follow up plan that draws on the patient’s strengths and preferences. |
| **Demonstrates knowledge of:**   * Community resources within the local area served by the Atrius clinic. * Criteria for acceptance into clinical programs. * Limitations or restrictions for entitlements and community supports. * The general impact of SDOH on patient health. * Principles of advocacy for patients in need |
| **Demonstrates the skill & ability to:** |
| * Develop collaborative relationship with other healthcare team members in order to reduce patient care barriers. * Coordinate care with various service providers. * Schedule appointments. * Assist with housing * Support referrals. * Provide employment support, * Provide and/or coordinate transportation services. * Assess and maintain insurance coverage. * Arrange or provide language translation services. * Effectively exchange information with patients, behavioral health clinician, and prescriber. * Establish accountability or negotiate responsibility**.** Make clear the responsibility of participants in a patient's care for a particular aspect of that care. The accountable entity (whether a health care professional, care team, or health care organization) will be expected to answer for failures in the aspect(s) of care for which it is accountable. Specify who is primarily responsible for key care and coordination activities, the extent of that responsibility, and when that responsibility will be transferred to other care participants. |

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| Competency: Health Education, Coaching and Wellness Planning  Establishes understanding of patient’s health status and interest and motivation to address health issues. Explains health issues in terms the patient can understand. Supports and encourages the patient through coaching rather than didactic approaches. Establishes goals based on the patient’s needs. Develops a follow up plan that draws on the patient’s strengths and preferences to promote wellness. |
| **Demonstrates knowledge of:**   * Active listening skills. * Motivational Interviewing and stages of change. * Basic health issues and solutions for persons with mental illness, especially side effects of psychotropic medication. * Basic understanding of behavioral health and substance use disorders and impacts on health and wellness. |
| **Demonstrates the skill & ability to:** |
| * Goal setting with consumers. * Personalized wellness planning based on individual needs and preferences and readiness to address identified issues. * Obtain and record accurate information from patients and educate them and caregivers on the process of managing their personal medical records including schedules, reports, treatment plans, bills, and prescriptions. * Tailor education and support to align with patients' capacity for and preferences about involvement in their own care. Education and support include information, training, or coaching provided to patients or their informal caregivers to promote patient understanding of and ability to carry out self-care tasks, including support for navigating their care transitions, self-efficacy, and behavior change. * Empower patients to communicate their preferences and treatment priorities to their healthcare team and participate in decision-making. * Empower patients to participate in wellness by providing self-management assistance and health promotion resources and referrals. * Interpret instructions from PCP and specialists. * Provide education to promote health literacy. * Increase patient skills for self-management and wellness. * Adjust plan on an ongoing basis based on patient’s changing needs. * Apply multiple techniques for helping people understand and feel empowered to address health risks for themselves, their family members, or their communities. (Examples may include informal counseling, motivational interviewing, active listening, harm reduction, community-based participatory research, group work, policy change, and other strategies.) |

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| Competency: Facilitate Transitions  Facilitate specific transitions, which occur when information about or accountability for some aspect of a patient's care is transferred between two or more health care entities or is maintained over time by one entity. Facilitation may be achieved through activities designed to ensure timely and complete transmission of information or accountability. |
| **Demonstrates knowledge of:**   * Behavioral health system of care and clinical components of each. * Information required to facilitate effective and efficient communication among facilities involved in the transition. * Intake and discharge protocols for psychiatric hospitals, detoxification programs, medical surgical units, and emergency rooms. * Referrals for specialty care within Atrius * Basic understanding of behavioral health and substance use disorders and impacts on health and wellness. |
| **Demonstrates the skill & ability to:** |
| * Obtain key clinical information on patients’ needs for follow up treatment in the Atrius clinical system. * Establish clear communication for follow up or transfer appointments with the designated Atrius personnel. * Advocate for timely access for follow up services within Atrius and in the community to meet patient needs, maintain treatment gains of the prior level of care, and reduce risk of readmission. * Provide education to promote health literacy for the patient regarding the transition. * Assess and support patient skills for self-management and wellness. |

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| Competency: Advocacy  Supports patient in obtaining needed services within Atrius and in the community. Identify patient needs and coach patient on how to express needs to providers. Coach the patient on self-advocacy. |
| **Demonstrates knowledge of:**   * Motivational Interviewing. * Trauma-Informed Care. * Presence of stigma against persons with behavioral health and substance use disorders in the health care and social service delivery system. * Basic understanding of behavioral health and substance use disorders and impacts on health and wellness. |
| **Demonstrates the skill & ability to:** |
| * Assist patient with self-management and self-identification of needs. * Coach patients on how to express needs to other providers and community supports. * Empower patients to communicate their preferences and treatment priorities to their healthcare team and participate in decision-making. * Encourage clients to identify and prioritize their personal, family, and community needs. * Communicate with providers and service organizations to help them understand community and individual conditions, culture, and behavior to improve the effectiveness of services they provide. * Provide social support and informal counseling. * Attend visits and meetings with consumers. * Provide culturally appropriate support. * Increase self-advocacy. |

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| Competency: Relapse Prevention Planning  Works with patient on their understanding of behavioral health conditions and the risk of relapse. Engage the patient at their level of participation in planning for recovery that includes relapse, relapse prevention, and continued recovery. |
| **Demonstrates knowledge of:**   * Motivational Interviewing. * Trauma-Informed Care. * Recovery-oriented, strength-based approach to patients with behavioral health and substance use conditions. * The Stress vulnerability model for persons with mental illness. * Basic understanding of behavioral health and substance use disorders and impacts on health and wellness. |
| **Demonstrates the skill & ability to:** |
| * Assist patient with self-management and self-identification of needs. * Assess the patient’s readiness for change. * Develop an individualized plan for relapse prevention that the patient establishes. * Assess the patient’s stress vulnerability and methods to address the vulnerability. |

### How competencies tie to quality metrics

There are direct connections between the competencies and skills of the BHCF and the quality metrics of the Behavioral Health Service lines and the Atrius ACO overall.

* **Mass ACO Quality Metrics.** The Transitions of Care competency relates directly to both ACO and Behavioral Health Community Partner (BH CP) quality metrics that include timely follow up after discharge. The BHCFs can greatly improve the scoring on these metrics with timely follow up and transition. The transitions include discharge from inpatient psychiatric care, ED, and medical surgical discharge. Effective, timely, and accurate information exchange with a patient-centered approach will help Atrius to score high on these measures that include pay-for-performance provisions beginning in 2020.

Another metric is the reduction in use of Emergency Departments. By incorporating more robust wellness plans and relapse prevention plans the BHCFs can contribute to a proactive approach to the population with behavioral health and substance use diagnoses in reducing unnecessary use of the ED.

* **Behavioral Health Service Line Metrics.** The primary metric for the BHCF function is reduction of total medical expense (TME). The reports have indicated savings from the work of the BHCFs when measuring the patient’s TME from the three-month period before referral to the three-month period after engagement. There is emerging evidence that addressing SDOH in the linkages to community resources competency area is likely to be one of the sources of reduction in TME.
* **Compliance with MassHealth ACO Contract Requirements.** The competency areas involving motivational interviewing, trauma-informed care, and illness, management and recovery all underscore the person-centered approach to this population that is contained in the ACO and CP contracts.

### The context in which this role is performed

The role of the BHCF continues to evolve across other Atrius service lines and programs. For example, the team-based pilot in the Chelmsford office offers an opportunity to apply the team-based approach of the Collaborative Care Model and underscore the competencies of the BHCFs in team participation. The principles such as assigning responsibility, applying evidence base, measuring success and population-based care come into sharper focus in such a format.

There are other settings where the BHCFs partner with the pediatric care facilitators to help families access community resources. The strong skill set in MI and trauma-informed care provide an underpinning to working across departments with a focus on patient strengths and preferences in engaging children and families.

Within the Behavioral Health Service line, the competencies in relapse prevention and wellness planning may be limited by the lack of licensure. However, the principle can be applied in conjunction with the licensed clinicians to add support for a person at risk, one who is frequently relapsing, or an individual who is a high user of the ED. The underpinning of MI competencies provides the best chance to engage these patients in readiness for change and active engagement in their care.

### How the scope of practice can be optimally used

The BHCF scope of practice has been effective at engaging and supporting patients who pose great challenges to the BH service line and to Atrius as a whole. The participation of the BHCFs in other departments upon invitation and collaboration is a testament to their skill and value for any patient with a behavioral health issue even if they are not in active treatment. Engagement using MI, matching the patient to community resources that address SDoH, and helping non-BH staff understand mental illness and substance use disorders can have a positive impact on overall utilization.

But for these pilots and even the work of the BHCF within the BH Service line to be optimally used, data collection, measurement of outcomes, and problem-solving with data need to become part of the operation. With robust reporting, the BH Service Line managers can better identify accomplishments and opportunities for improvement. A tool such as a data dashboard (i.e., an information management tool that visually tracks, analyzes and displays key performance indicators (KPI), metrics and key data points) can provide timely measures of activity, profile the population more accurately, and inform opportunities for more effective interventions.

The core competency set listed previously can be used in the following ways:

1. **Employee recruitment:** The competencies can be used in the development of advertisements and other materials to help target the recruitment of prospective employees.
2. **Onboarding and ongoing supervision:** The competencies can be used by supervisors as a guide to orient new employees to their role and responsibilities. Additionally, supervisors and employees can jointly review the competencies, identify proficiencies and areas for additional training, mentoring, and coaching.
3. **Job descriptions:** The competencies can be used in the development of BHCF job descriptions for internal human resource purposes. Additionally, they can be used to create a description for disseminating to patients and their families in an effort to promote greater engagement with and clarity regarding how BHCF can help.
4. **Workforce training:** The competencies can be used to shape content for training BHCF and orienting BH Service Line members to the work of BHCF. It can be used to develop staff curriculum, training manuals, workshops, and in-service events.
5. **Performance appraisal:** The competencies can be a foundation upon which performance is assessed. To this end, the competencies can be incorporated into employee self-assessment tools and formal performance reviews.

## Possible Career Ladder

Several of the BHCFs were promoted into the position after starting out as Medical Assistants (MAs) within Atrius, so the position does offer some opportunities for line staff across Atrius. However, according to the supervisor of BHCFs, there are very limited opportunities within Atrius for promotion without an advanced clinical degree. The pursuit of a graduate degree in Social Work, Licensed Mental Health Counseling, or Counseling Psychology is the career path that Atrius supports. One BHCF is currently in a Master’s in Social Work (MSW) program and Atrius has a robust Fellows program for graduate interns in Psychology and Social Work. We propose a career ladder that supports this path, with tuition reimbursement and fellowship opportunities allowing BHCHs to advance within the BH service line.

**BHCF Career Ladder**

As part of developing the career ladder, we recommend that Atrius review retention methods and evaluate and reevaluate standard hiring criteria to align these with the competencies outlined in the previous section. If Atrius commits to retention, career development, and advancement for BHCFs, key elements to incorporate include:

* **Recognition programs,** i.e., motivating and rewarding individuals and groups for excellence in support of the organizational mission and goals with the outcome of increased job performance and staff retention.
* **Training,** i.e., enhancing existing skills, knowledge, and experience of employees and providing hands-on education to develop competency in areas of identified weakness. (These will be identified during the AHP gap analysis process that results in the Task 4 deliverable.)
* **Professional development,** i.e., supporting employees, through time, logistical support, or dedicated funds for instance, as they work toward credentials, degrees, or other educational opportunities that support their career advancement.

# Next Steps

Upon Atrius review of the findings in this report, the AHP team will use this information, along with that obtained in Task 2: Summary of Responsibilities, to conduct a gap analysis and develop a plan for building capacity and further developing this workforce. The team will:

* Compare ideal scope of practice with current state defined in this report to identify gaps for each role.
* Develop a plan for how Atrius can train the three roles to be able to meet the competencies necessary for the ideal scopes of practice.
* Develop a plan for how Atrius can measure the performance of the three roles to confirm compliance with scopes of practice and ensure continuous quality improvement in the roles.

# Appendix A: Literature Review Citations

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1. See page 2 of citation [↑](#footnote-ref-2)