Who will provide integrated care?

Assessing the workforce for the integration of behavioral health and primary care in New Hampshire

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Executive Summary

This study fills knowledge gaps about the integrated primary care workforce

The Cherokee (2014) report identified workforce as a primary barrier to the successful integration of behavioral health (IBH) in primary care settings in New Hampshire (NH). This study, conducted by the Center for Behavioral Health Innovation at Antioch University New England, picks up where the Cherokee report left off by filling knowledge gaps about workforce needs, assets, and potential directions. We hope to provide information and vision necessary to inform the development of a strategic and effective NH IBH workforce plan.

The IBH workforce in primary care was broadly defined

We defined the IBH workforce broadly to include the roles that serve a number of behavioral health-related functions, including prescribing and consulting about psychotropic medications, providing psychosocial interventions, enhancing patient engagement in care, supporting health literacy and adherence, addressing barriers to health and healthcare (i.e., social determinants of health), and keeping information flowing between the patient and the primary care team.

We assessed the IBH workforce from the perspectives of primary care practices and training programs

We assessed the perspectives of primary care practices – with an emphasis on safety net providers – and potential IBH training institutions and programs. We assessed primary care providers with an online survey; 71% of safety net clinics responded. We also reached out to all NH-based training programs that might conceivably contribute to the IBH workforce of the future. We assessed training institutions with a phone-based interview; 40% of the training programs participated.

Providers and training programs are enthusiastic, but in early stages of development

Safety net providers expressed broad interest in IBH. The current levels of integration and the organization of programs indicate a service system in the early stages of integrated care, while underestimating the progress yet to be made to realize that goal. Academic programs are not, as a rule, considering work in primary care as a primary destination for their students at the doctoral, master's, bachelor's or associate's level. Most training programs, however, are interested in learning more about how they might contribute to the IBH workforce of the future.

The most central IBH workforce roles are most difficult to fill

Four critical primary care behavioral health workforce roles emerged from the safety net provider input: 1) consulting psychiatrists and psychiatric prescribers, 2) behavioral health clinicians, 3) primary care clinicians (also called primary care providers), and 4) staff that augment care and communication between patients and providers, which we are calling "care enhancers." While we did not survey the primary care clinician workforce, the literature shows their contribution to be crucial to successful IBH. The most central roles in IBH – psychiatric consultants and behavioral health clinicians – are perceived as the most difficult positions to fill. A desire was expressed for more "substance abuse counselors." We believe substance-related interventions should be subsumed under the – generalist – "behavioral health clinician" role and that BHCs should be trained to be competent to perform this function at a generalist level.

Doorways and pathways towards the primary care IBH workforce of the future

The next step in developing the IBH workforce for the future of primary care is to bring primary care providers and training programs of academic and CME organizations together to create and implement a NH IBH workforce development plan. The plan should build on the "doorways and pathways" and pre- and/or post- graduate training models discussed in this report, to enhance the number, quality, and diversity of care enhancers, psychiatric consultants/prescribers, and behavioral health clinicians who are well prepared to deliver IBH in NH.

Introduction

Behavioral health conditions exact staggering burdens on individuals, families, and societies alike (Kessler et al., 2005; Kessler et al., 2009). Although effective treatments exist, most people with behavioral health conditions (mental health, substance abuse or serious health behavior change needs) neither seek nor receive adequate treatment (Kessler et al., 2005). Of those who do, most seek help in primary care settings that consistently under-detect and under-treat behavioral health conditions (Coyne, Thompson, Klinkman, & Nease, 2002; Mertens, Lu, Parthasarathy, Moore, & Weisner, 2003; Schulberg, Block, & Madonia, 1996). Experts have advocated for the integration of behavioral health (IBH) into primary care settings as the most effective way to close the behavioral health treatment gap (World Health Organization, 2008). Numerous randomized clinical trials indicate that IBH can enhance the detection, uptake, effectiveness, and cost effectiveness of behavioral health care in primary care settings (Butler et al., 2008; Blount, 2003).

Widespread, effective, and financially sustainable implementation of IBH has proven very challenging in settings of usual primary care (Alexander, Arnkoff, & Glass, 2010; Pincus, 2003). Among the barriers to successful dissemination and translation of IBH has been a limited and poorly equipped workforce. National estimates indicate that the behavioral health workforce is insufficient to meet the need of patients in our safety net primary care settings (Burke et al., 2013). The problem extends beyond the limited pool of behavioral health providers, to inadequate preparation of each group on an integrated health team. The current behavioral health and primary care workforce lacks the training, acculturation, skills, attitudes, and leadership qualities

necessary to successfully work as a team to enact IBH (Workforce / SAMHSA-HRSA, n.d.,). Limited didactic and experiential training opportunities continue to hamper the dissemination and implementation of IBH (Hall, Cohen, Davis et al., 2015).

For the population with serious mental illness or serious substance abuse disorders (SMI), it would seem that the problem to be addressed by integration is their physical health. People coping with SMI have health problems that parallel their SMI problems in intensity, making them extremely vulnerable to loss of function due to chronic illness and to early death (Coulton & Manderscheid, 2006). One approach to addressing this problem has been to bring primary care services into behavioral health centers. While the problems of "reverse integration" are somewhat different from primary care IBH, the training needs for staff are similar. Add the fact that almost 1/3 of people coping with SMI get all of their care, medical and behavioral, solely in primary care medical settings (Wang, et al, 2006), and it is clear that the training conclusions of the report, that IBH workers be trained in addressing chronic illness, health behavior issues, mental health and substance abuse needs can be applied to the entire workforce for integration.

A recent report commissioned by the Endowment for Health and conducted by Cherokee Health Systems highlighted the perception among key stakeholders that NH lacks an adequate IBH workforce (Cherokee Health Systems, 2014). Respondents highlighted a lack of qualified behavioral health clinicians, a confusing licensing environment, a shortage of psychiatry, and an overall aging workforce, as major impediments to IBH. Workforce shortages and inadequate preparation extended to the primary care/medical workforce as well. The aforementioned problems are further compounded by the lack of adequate specialty mental health care and the rural nature of many NH communities. The former places heavier behavioral health burdens on primary care practices, while the latter makes it difficult to recruit, train, and retain qualified professionals.

The Cherokee (2014) report advocated for a multi-pronged workforce development strategy, including but not limited to developing a statewide workforce plan that articulates the number and types of workforce needed, considering ways to expand the workforce pipeline, and advocating for policy changes to support workforce development. While the Cherokee (2014) study identified workforce, practice transformation, and payment reform as interlocking barriers to IBH, it stopped short of investigating and documenting workforce needs, assets, and potential role development in the depth necessary to inform effective strategic action.

This project was designed to fill IBH workforce-related knowledge gaps, to inform a NH IBH workforce development plan. First, we sought to better understand the current and future workforce needs of primary care settings, with a focus on safety net providers (i.e., Federally Qualified Health Centers, Rural Health Clinics). Second, we assessed the extent to which NH-based training institutions are preparing their students for IBH roles in primary care. Finally, we leveraged the scholarly literature, the Cherokee report, and our findings to develop a NH-based IBH workforce development plan.

Method

Stakeholder Engagement

The project was conducted by the Center for Behavioral Health Innovation (BHI) at Antioch University New England. BHI works shoulder-to-shoulder with community partners to improve behavioral health practice for underserved populations, through behavioral health integration, knowledge translation, evaluation, external facilitation, and technical assistance. The principal investigator for the project (Blount) is a nationally recognized IBH thought leader.

We developed a Workforce Advisory Team (WAT) to provide input and consultation to the project. It consisted of key IBH stakeholders, from a variety of roles within safety net settings, with the New Hampshire Behavioral Health Integration Learning Collaborative and training/academic programs represented, as well. See the beginning of this document for the members of our Workforce Advisory Team.

We met with the WAT twice, the first time for input into the survey methodology and the second time for help with data interpretation and reporting. At the first meeting, the WAT described the landscape of IBH in New Hampshire from their perspective, and the wide varieties of roles and staff that occupy a place within that landscape. We were told the following:

- Practices need information about how to select IBH staff
- Most IBH training is "on the job"
- Little career mobility exists between roles
- Few common standards exist for defining IBH roles across clinics

We met for the second time with the WAT after collecting and analyzing the data, to get their assistance with interpreting the data. The team confirmed our understanding of the data, that most primary care clinics are not as integrated as they think they are, although clinics have evolved somewhat in the two years since the "Cherokee Report" was released. The WAT validated our understanding of the basic IBH roles that we perceived in the data. WAT also supported, in broad strokes, a formative version of the conclusions and recommendations contained in this report.

Primary Care Needs Assessment

We conducted an IBH workforce needs assessment, via a brief online survey sent to NH primary care practices (with a focus on safety net providers). We did not assess the number or role of primary care clinicians (PCCs) in our survey; i.e., family medicine, internal medicine and pediatric physicians, nurse practitioners and physician assistants. The PCC workforce has been addressed by others and is tracked nationally.

Instead, we inquired in the survey about all staff who were perceived by the WAT as contributing to the delivery of behavioral health services, broadly defined, in primary care. These contributions include:

- Prescribing and consulting about psychotropic medications
- Providing psychotherapeutic interventions
- Creating and maintaining patient engagement in care
- Addressing health literacy, adherence, and health barriers (i.e., "social determinants of illness")
- Keeping information about the patient's health needs and health behavior flowing between the patient and the health team

The survey inquired about current and projected staffing for behavioral health functions, the readiness of new and current staff to perform behavioral health aspects of their roles, and the difficulty of finding qualified persons to fill each role. The survey also asked respondents about the current level of integration at their site. See Appendix A for the full needs assessment survey.

We focused on surveying safety net providers, since they have the mandate – and access to additional resources – to care for our most vulnerable, underserved, and psychosocially challenged patients. As such, these health centers are likely to be early adopters of IBH and acutely aware of IBH-related workforce supply, demand, and quality issues.

While our sample is small and focused on one segment of the overall primary care patient population in New Hampshire, there has been enough experience in integrating care for all populations to be able to use our findings to get a picture of the needs statewide. The AIMS Center of the University of Washington, the leader in the development of the Collaborative Care Model of IBH, estimates that the staffing level for behavioral health clinicians for complex, multi-condition low income populations needs to be up to three times that required to serve populations with adequate incomes who have behavioral health or medical needs only.

We worked with the Endowment for Health, Bi-State Primary Care, and NH DHHS to identify safety net providers in the state (i.e., Federally Qualified Health Centers and Rural Health Clinics). The Executive Directors of each safety net provider clinic received an electronic cover letter and short questionnaire, and two weeks later a follow-up reminder if they had not yet completed the questionnaire. The Workforce Advisory Team members also reminded the Directors to participate. Of the 21 providers identified, 15 completed the survey, for a 71% response rate. We also identified nine Dartmouth-Hitchcock clinics that provide primary care and serve a large number of Medicaid patients. We telephoned and emailed the Practice Managers and/or Medical Directors, asking for their participation. After several follow-up attempts, only one of the 9 clinics completed the survey, so we restricted our analysis (and interpretation) to the data provided by the safety net providers. See Appendix B for the list of clinics.

Training Program Asset/Desire Assessment

In parallel with the needs assessment, we conducted a workforce asset/desire assessment, to identify NH's current and potential future IBH workforce training offerings. The search included both higher education institutions and other types of training programs that prepare individuals to enter the workforce with skills under a particular degree and/or certification. Because our definition of IBH was inclusive, we identified a wide range of potentially relevant academic and other training programs, including graduate level psychology and counseling programs; family medicine and psychiatry residencies; and associate's, bachelor's and master's programs in social work, nursing, physician assistant, medical assistant, occupational therapy, human services, community health worker and public health.

In total, we identified 30 training institutions, offering 95 academic degrees and/or programs. Emails and/or phone calls were made to a representative of each program, with a brief description of the project and an invitation for them to participate in the study by completing a short interview. Of the 95 training programs, 42 (44%) did not respond, 15 (16%) declined to participate or indicated that IBH was not relevant to their program, and 38 (40%) completed the phone-based interview protocol. See Appendix C for the list of training programs.

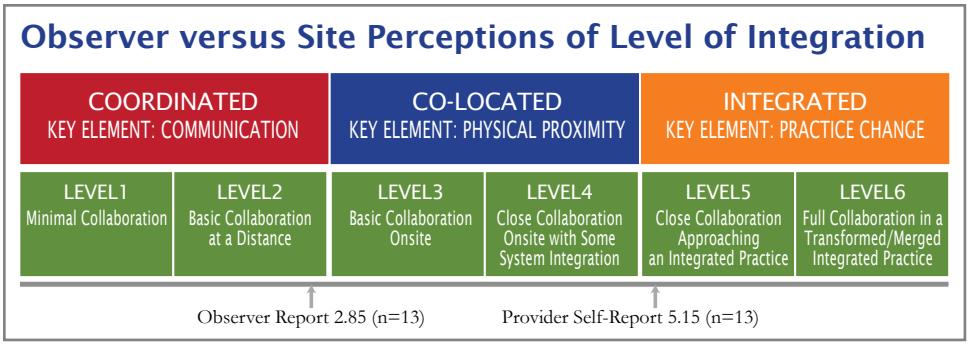
The interviews asked respondents about the settings in which their graduates have been placed, including primary care. The interviews also inquired about experiential and didactic training offerings specific to behavioral health in primary care. We asked each site about their interest in focusing more on this area of training in the future, and collected some basic information about each program. See Appendix D for the phone-based interview protocol.

Our research team (three Clinical Psychology faculty, one staff evaluator, one doctoral level Clinical Psychology student) quantified responses to four of the interview questions. Questions about program graduates' training and placement were scored on a three-point scale: 0 = No behavioral health or primary care training, 1 = behavioral health OR primary care training (but not both), and 2 = primary care behavioral health (i.e., IBH training). Questions about programs' interest and readiness to focus intentionally on primary care behavioral health training expansion in the future were also scored on a three-point scale: 0 = pre-contemplation (i.e., unaware of the opportunity or disinterested), 1 = contemplation (i.e., some awareness of the opportunity, willing to think more about it) and 2 = ready to act (i.e., aware of the opportunity and ready to take action). All five members of the research team read the interview transcripts and scored the responses using the aforementioned scales. The average score across all five raters was used in subsequent analyses.

Findings: Primary Care Needs Assessment

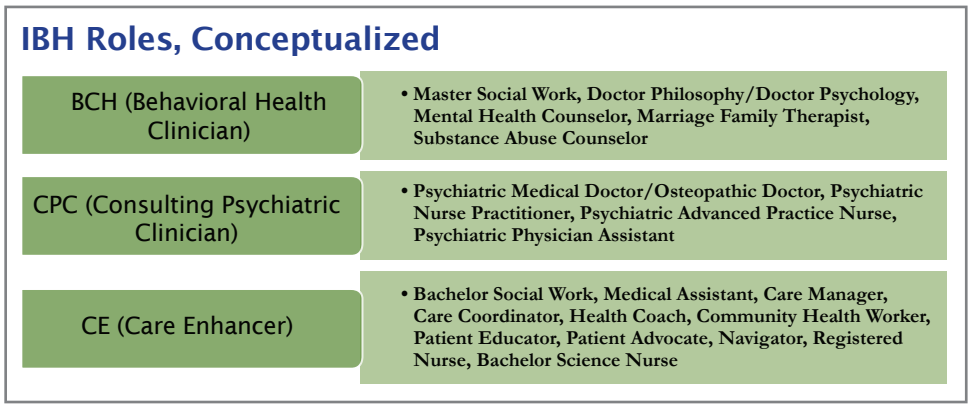
Safety Net Providers View Themselves as More Integrated than Observers

We asked respondents to self-report their level of integration on SAMHSA's six-point scale (see graphic, below). They rated themselves at about level 5 on average – the "close collaboration approaching integration" level. This finding stands in contrast to the independent ratings of Cherokee Health Systems a couple of years earlier, which would have placed these same practices somewhere between levels 2 (basic collaboration at a distance) and 3 (basic collaboration onsite). Consistent with research (Hall et al., 2015) and input from our Workforce Advisory Team, our impression is that the Cherokee assessment is probably the more accurate representation of the level of integration among our respondents. The tendency to overestimate one's degree of integration is almost universal, especially once a behavioral health clinician has been added.



From chaos, a few fundamental role categories emerge

A dizzying array of staff roles and titles are in use by our respondents, with considerable variation in how these roles and titles are perceived and filled across sites. Based on the scholarly literature and input from WAT – as well as our desire to bring more coherence to these data – we have conceptualized these roles as falling within four categories: behavioral health clinicians (BHCs), primary care clinicians (PCCs), consulting psychiatric clinicians (CPCs), and other members of the healthcare team which we are combining under the title of Care Enhancers (CEs). See the figure at left for how we operationalized these role categories. Note as well, that we use this categorization repeatedly, throughout the remainder of this report.



IBH staff perceived as corresponding to IBH roles; Most receive on-the-job training

We asked our safety net respondents about who actually fills various IBH-related roles now, and who they would like to fulfill those roles now and in the future. As reflected in the table below, most respondents are satisfied with how they fill the various IBH-related roles now. They don't anticipate drastic changes in who will make up the IBH workforce of the future. The exceptions to this rule are that respondents would like to have bachelor's level social workers (BSWs) filling the care manager role of the future, rather than the registered nurses (RNs) and bachelors of science in nursing (BSNs) that tend to occupy it now. Some of the Care Enhancer roles we assessed do not exist in most of the clinics surveyed. Depending on which role they were using, our respondents generally wished for their CE roles to be filled by registered nurses or BSN, or staff with other Bachelor's or Associate's degrees.

We also asked our respondents where most of these staff get trained to fill the IBH aspects of their role – whether they perceive them as "ready to go" (i.e., not requiring any additional training once their graduate training is completed), whether they need to receive "on-the-job-training" (OJT) to meet the demands of their role, or whether they require substantive additional training from external sources. Most clinics perceive staff as either ready to go, or needing on the job training. Additional training from external sources for staff to fulfill their IBH role is rare, despite the findings in the literature that such training is necessary and can make the difference between success or failure of an IBH program (Hall, Cohen, Davis, et al., 2015). Our respondents' lack of exposure to IBH workforce members who have had specific training for primary care behavioral health, is consonant with our perception that most do not have highly specific conceptualization of the clinical roles and routines of IBH, and are therefore at risk of failing to appreciate the additional training needs of their current workforce.

Qualifications and Training of IBH Staff by Role and Role Category

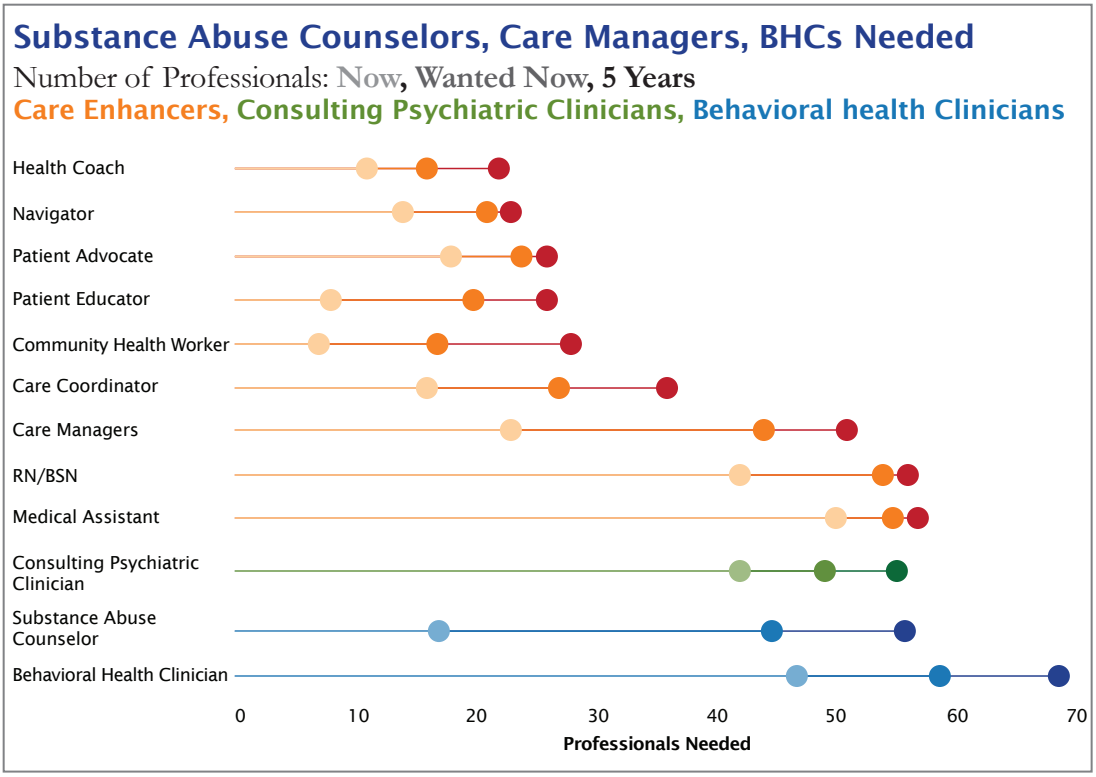
Role Category	Role	Who is filling the role now? (mode)	Who would you *like* to fill the role? (mode)	Where Trained? (mode)
Care Enhancers	Care Coordinators	RN/BSN	RN/BSN	OJT
	Care Managers	RN/BSN, followed by "*don't have this role*"	BSW	OJT
	Medical Assistants	Medical Assistant	Medical Assistant	OJT
	Patient Educators	"*don't have this role*," followed by RN/BSN	RN/BSN	OJT
	Health Coach	"*don't have this role*," followed by RN/BSN	RN/BSN	RTG=OJT
	Nurse	RN/BSN	RN/BSN	RTG
	Patient Advocate	Other Bachelor's	Other Bachelor's	OJT
	Navigator	"*don't have this role*," followed by Other Bachelor's	Other Bachelor's or Associate Debree	OJT
Behavioral Health Clinicians	Substance Abuse Counselors	MSW	MSW, followed closely by LMHC	RTG
	BH Clinicians	MSW	MSW	RTG
Consulting Psychiatric Clinicians	Psych Consultants & Prescribers	NP/APN, followed by MD/DO	NP/APN, followed closely by Psych MD/DO	RTG

Abbreviation Key: RN=registered nurse; BSN=bachelor of science in nursing; MSW=master of social work; LMHC=licensed mental health counselor; NP=nurse practitioner; APN=advanced practice nurse; MD=medical doctor; DO=osteopathic doctor; OJT=on the job training; RTG=ready to go

Substance abuse counselors, care managers, behavioral health clinicians in demand

Respondents were asked to report the number of staff in each of the various IBH roles now, as well as how many they would like to have now and in the future. The chart below reflects their answers. The color of the circle represents the role category (Care Enhancer, Consulting Psychiatric Clinician, or Behavioral Health Clinician). The dark, left-hand circle represents the current number of staff filling each role; the moderately shaded, middle circle represents the number they wish they had now; and the light, right-hand circle represents the number they wish to have in five years. The gap between the left-hand circle and the middle circle reflects current demand for that role, and the gap between the left- and right-hand circles reflects the projected "five-year" demand for that role.

Considerable variability exists in the current number and future demand for the various Care Enhancer roles. The current number and projected current/future demand for health coaches, patient navigators, and patient advocates are limited. The current number of patient educators, community health workers, care coordinators, and care managers is also relatively low, and substantially discrepant from anticipated future demand. Finally, registered nurses and medical assistants (who, with additional training, can be part of the IBH behavioral health workforce) are ubiquitous now, and are likely to remain so in the future. Respondents are currently most lacking in substance abuse counselors, wishing to have many more both now and in the future. Those professionals who more typically fill the behavioral health clinician role (psychologists, social workers, counselors) are more common, with moderate growth in demand projected into the future. The current number of consulting psychiatric clinicians is fairly high, with moderate projected growth in demand.



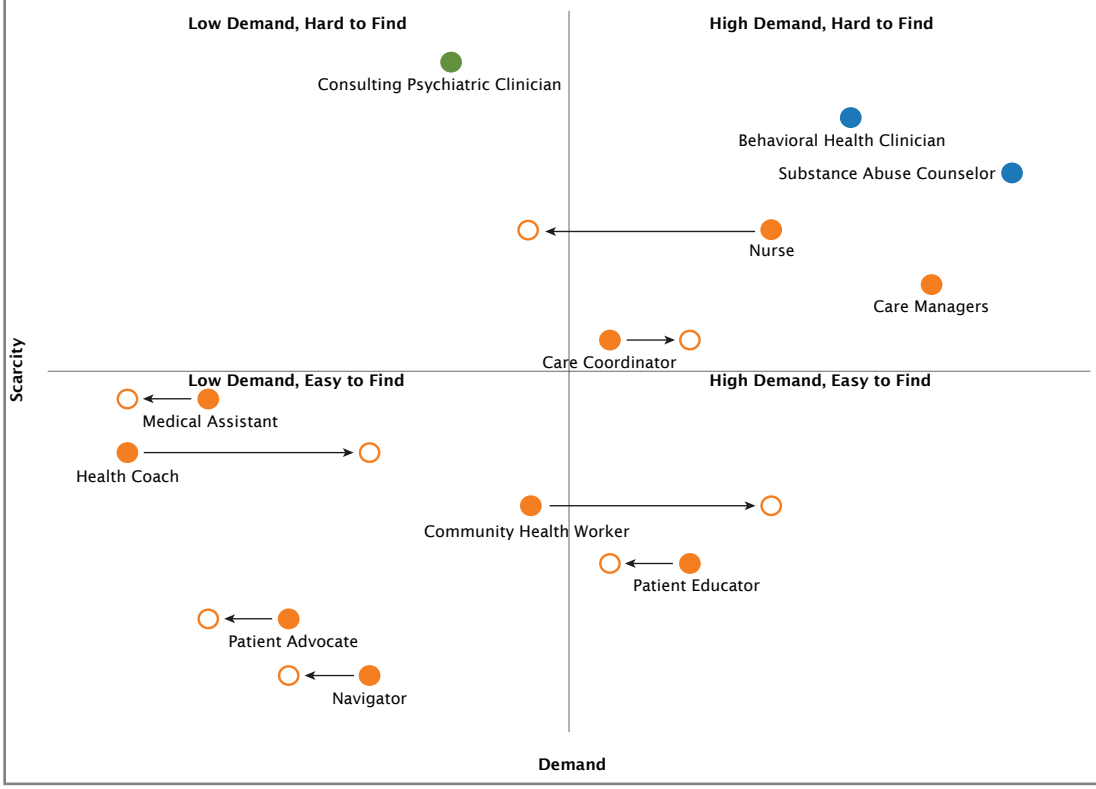
IBH roles most in demand are also hardest to find

We asked respondents to rate how difficult it is to find adequately trained staff to fulfill the behavioral component of each of the IBH roles, from 1 (very easy) to 5 (very difficult). By layering that information with the information about current and future demand, we created an IBH workforce gap analysis chart. This chart places the perceived demand for each IBH role on the X-axis, and the difficulty filling each role on the Y-axis. Splitting each axis at its mid-point created four quadrants: 1) high demand, hard to find; 2) high demand, easy to find; 3) low demand, easy to find; and 4) low demand, hard to find. As in the previous chart, color-coding reflects roles, with Care Enhancers in orange, Behavioral Health Clinicians in blue, and Consulting Psychiatric Clinicians in green. The solid circles reflect the "wished for now" rank order placement on the Demand and Difficulty Finding dimensions, and the hollow circles reflect the "wished for in five years" placement. The arrows represent the direction and magnitude of change in demand, from now to five years. When no difference exists between the "wished for now" and "wished for in five years" rank order, only a single solid circle is visible.

IBH workforce development should focus on those roles in the "high demand, hard to find" quadrant: behavioral health clinicians, substance abuse counselors, case managers, care coordinators and nurses. All of these roles are in demand now, and expected to remain so in coming years, except for nurses, where demand is expected to drop a bit moving forward. Consulting psychiatric clinicians are also moderately in demand and very hard to find. This finding is also important, given the centrality of consulting psychiatric clinicians to successful IBH practice in primary care.

Gap Analysis of IBH Roles

Number of professionals wished for now and in 5 years, by level of demand and how hard they are to find
Care Enhancers, Consulting Psychiatric Clinician, Behavioral Health Clinicians



Findings: Training Program Asset/Desire Assessment

IBH-related training in New Hampshire is in its infancy

Many training programs expressed interest in preparing their graduates for relevant IBH roles, but most have not yet done so in a systematic or deliberate manner. As reflected in the first set of bars in the chart below, most programs offer either behavioral health training or primary care training, but not IBH training (0 = neither primary care nor behavioral health training; 1 = behavioral health or primary care training; 2 = IBH in primary care training). Nationally, the most advanced training programs for BHCs offer coursework and/or experiential IBH training opportunities in primary care. Graduates from these programs are prepared to assess patient behavioral health needs, develop plans of care, implement or augment medical regimens, evaluate the effectiveness of regimens and motivate individuals to change unhealthy habits. This sort of programming has not yet made it into the curriculum of the responding Master's degree programs. In NH, only one doctoral program in Clinical Psychology has recently developed a systematic – albeit optional – IBH-specific training sequence for their students.

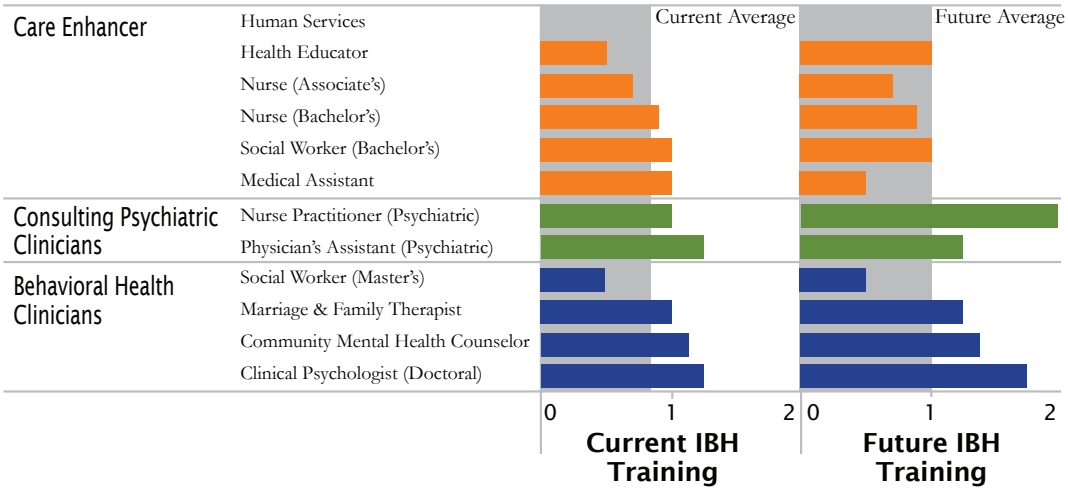
Most training programs are eager to partner, learn more about IBH workforce needs

Comparison of the "Current Average" and "Future Average" columns of the chart below shows that traiing program respondents are both fairly enthusiastic about and intending to expand their IBH training (0 = pre-contemplation, 1 = contemplation, 2 = ready to act). Responding social work programs were notably less ambitious in their future plans to prepare students for IBH, despite the strong current and future demand for BHCs (and specifically, MSWs) reflected in our needs assessment data. Programs that prepare future Care Enhancers were less uniformly ready to enhance IBH training in the future, because behavioral health was less likely to be perceived as a core element of their training missions. The lack of

Current and future training focus for integrated primary care

Average current (left column) and future (right column) training program scores

Care Enhancers, Prescribers, Behavioral Health Clinicians



discipline-specificity of CE roles complicates this picture: roles such as navigator, health coach, community health worker and patient advocate are not reliably linked to a particular training background, despite the presence of some targeted programs in the private sector (health coach) and public sector (community health worker). The programs that are poised and open to learning more about and offering more IBH training in the future, tended to already offer a behavioral health component to their training, albeit one that was not yet specifically tied to primary care or IBH.

Interpretation and Discussion

Characterizing the NH IBH workforce field: Nascent enthusiasm

Our respondents were enthusiastic about the future of IBH in primary care. The safety net providers perceive themselves as providing a high level of IBH, and seemingly view IBH – and the workforce associated with it – as increasingly central to their mission. Almost all of the training programs we talked to expressed interest in being part of a NH-based IBH workforce initiative.

Safety net providers had a more sophisticated view of IBH than did the training programs, although they probably overestimate their current level of integration and underestimate the training and preparation necessary for staff to become an effective part of a well-functioning IBH team. Training institutions are later adopters of IBH than the safety net providers, and many have not decided whether offering any training in behavioral health work in primary care is part of their mission. Relatively few of them recognize or prepare their students for this emerging job market. Some training programs were unaware of the demand for their graduates as part of IBH teams in primary care. Others seemed vaguely aware of the IBH-related job opportunities, but not well positioned to help graduates take advantage of them.

Conceptualizing and developing the workforce for the four core roles of IBH

These results, and the IBH workforce needs of New Hampshire, can be best understood and addressed by focusing not on the myriad specific degrees, roles, and labels currently in use in primary care settings, but on four basic role categories that together make up the IBH team in primary care: behavioral health clinicians (BHCs), primary care clinicians (PCCs), consulting psychiatric clinicians (CPCs), and Care Enhancers (CEs).

Train more behavioral health clinicians (BHCs) for a generalist IBH role in primary care

BHCs are licensed mental health or substance abuse therapists. They have Master's or Doctoral degrees. In some sites around the nation, nurses with additional behavioral health training also fill this role. In the clinics we surveyed, the BHC role is filled by Master's level social workers, marriage and family therapists, clinical mental health counselors, and Doctoral level psychologists.

BHCs in well-integrated primary care settings function quite differently from their colleagues in "specialty" mental health/substance settings or even "co-located" primary care. In fully integrated settings, BHCs are generalists. They provide mental health, substance abuse, and health behavior change services, plus behavioral health and behavior change consultation to other team members (primary care clinicians, CPCs, and CEs). These services are delivered as part of the routine care provided by the primary care healthcare team, rather than offered as a specialty service via referral. BHCs in well-integrated settings offer briefer, more goal-oriented, and more incremental interventions than their counterparts in co-located or specialty settings. BHCs in well-integrated primary care settings serve the entire primary care panel or designated populations of patients rather than a specific behavioral health caseload. BHCs in these settings do not open or close cases; rather, they add behavioral health expertise and sometimes direct service to the overall care of all patients.

In contrast with the perceptions of our NH safety net clinic responders, BHCs require special training to be successful in well-integrated primary care settings. Clinicians trained only in specialty mental health often fail in IBH settings. Hall, Cohen, Davis and their colleagues (2015) reported a study of 19 sites around the country, many of which were selected as exemplars of integrated care. The study found that "Practices [that] were newer to integration underestimated the time and resources needed to train and organizationally socialize (onboard) new clinicians. This underestimating of the necessity of targeted training for integrated practice for behavioral health clinicians was the source of several failures of early program iterations" (p.S41).

Only one doctoral program is explicitly and systematically preparing graduates for the BHC role in primary care. The other relevant programs were generally not aware of whether their graduates worked in primary care. Yet, all of these programs were interested in learning more about how to expand the IBH workforce statewide. Our safety net clinics expressed a great desire for clinicians to fill the role of "substance abuse counselor." This seems to be a direct and logical response to the opioid crisis. The default to a specialist provider, however, is generally inconsistent with the core tenets of IBH specifically and primary care generally, and may reflect limited exposure to the roles that more generalist-trained BHCs take in opioid and other substance misuse treatment programs in primary care nationally.

Separating the role of substance abuse counselor from BHC creates several problems. The strength of primary care is to engage patients in a generalist approach to care. Adding multiple specialized BH clinicians to a primary care practice would replicate inside the primary care setting the problems endemic in the currently bifurcated mental health/substance abuse treatment systems. Mental disorders, substance misuse, and chronic illness are highly comorbid. To engage patients in care for all their issues requires a service that can offer care for whichever problem the patient is willing to address first and clinicians who can leverage a longitudinal relationship to start where the patient is willing to start when they are ready.

A more immediate argument for BHC generalists has to do with the strictures of the 42CFR regulations on sharing information about substance abuse diagnoses and treatments. The regulations permit sharing of information about substance abuse problems under the following conditions: the setting holds itself out as a general medical service, the substance use and treatment information was not generated by a sub-unit identified with substance abuse diagnosis and treatment, and substance abuse diagnosis and treatment is not the primary function of the provider. In other words, having a specialty Substance Abuse Counselor in a primary care practice would disallow sharing of information without an additional patient release, which would undercut the premise and practice of a team approach.

IBH works best with a generalist BHC, who is equipped to address mental health, substance abuse, and health behavior issues together or separately, as they arise. In the long run, training BHCs to adequately address the whole array of concerns common to primary care – and to make enhanced referrals to specialty care when warranted – is crucial. Doing so would not prevent primary care practices from dealing with the substance misuse problem head on. It could well be that the first population addressed by the BHC in a primary care practice would be patients with substance use disorders. We need to train generalist BHCs to competence in addressing opioid use, problem drinking, and other common substance misuse conditions in the state. To do this will require educating Masters and Doctoral degree programs about necessary training and documentation of experience needed so that graduates can meet qualifications for the NH MLADC certification. This will prevent a needless internal struggle about whether generalist BHCs are able to deliver the care the state is currently committed to enhancing.

New Hampshire is well supplied with programs that could produce excellent BHCs. Currently, none of the relevant Master's level clinical training programs offer a course that is equivalent to the training programs available in the private sector to prepare mental health clinicians to succeed in primary care. The practices that are in need of BHCs currently prefer MSWs for this role, but other Master's degree or Doctoral programs (Doctor of Psychology, Licensed Mental Health Counselor and Marriage and Family Therapist) could be equally good sources of BHCs.

Rather than expect each individual Master's program to create and insert a new course focused on IBH into their already overcrowded curricula, it may make more sense to develop or contract for a course or certificate program that is equivalent to those offered in the private sector. This course or sequence could be accepted for credit by individual Master's programs, or it could be taken post-degree by students in programs without the latitude to accept it for academic credit.

Experiential training opportunities must go hand in hand with coursework to adequately prepare the BHCs of the future to contribute clinically and programmatically upon graduation. Primary care sites, especially safety net settings, will need adequate support and resources to provide experiential training grounds for BHCs. A doctoral program in Clinical Psychology recently received a grant from the Agency for Healthcare Resources and Services to expand the experiential component of their IBH-specific training program. The best source of sustainable support for experiential training would be to allow sites hosting qualified trainees to bill under Medicaid for their services, as is done in many states. Students in training can also provide a significant service resource if support for supervisory time can be made available.

The quality of the future BHC workforce would be improved if behavioral health profession trainees (psychologists, social workers, counselors) were socialized to primary care through a "ground floor" experience as a Care Enhancer, as part of the experiential component of training. Devoting part of their placement time to Care Enhancer-related work, provides important resources to the primary care practice, trains the student in foundational skills and functions such as patient engagement, and gives them the experience of working within an IBH team.

Expand the reach of the existing consulting psychiatric clinician (CPCs) workforce

The majority of our clinics are using psychiatrically trained nurse practitioners and advanced practice nurses (53%) rather than psychiatrists (27%) to fill the role of CPC. Practices seem to be using psychiatrists and psychiatric advanced practice nurses largely in a consulting role, supporting the prescribing and care of the PCCs. Access to psychiatric expertise is critical not only to patient care, but also to the care and support of PCCs in IBH settings. Primary care clinicians are comfortable prescribing the medication therapies for a broader array of patients if they have readily accessible consultation with BHCs or CPCs about diagnosis, and with CPCs about prescribing regimens.

New Hampshire has one psychiatry training program, operated by Dartmouth-Hitchcock in Lebanon. The program trains seven general adult residents per year, three child fellows in each of the two years of training, and two sleep medicine fellows, two addiction psychiatry fellows, and one geriatric psychiatry fellow per year. Dartmouth-Hitchcock has a collaborative care program in their primary care clinics in Lebanon (adult and child) and these are active training sites for medical students, adult psychiatry residents, and child fellows. Medical students and psychiatry trainees at Dartmouth are very interested in collaborative care. Residents are exposed to this kind of care in their outpatient training and many focus on it during their elective time in their fourth year of training. Child fellows also are exposed in their outpatient work and there is significant interest in opportunities for this kind of work. Dartmouth-Hitchcock is actively honing the Dartmouth model of collaborative care to address and support anxiety, depression, and substance use disorder care in primary care and anticipates growing training opportunities as this work progresses. Generally speaking, adult and child psychiatrists express considerable interest in providing collaborative care in primary care and would welcome job opportunities in this kind of practice. Many trainees seek to remain in New Hampshire once they complete their training.

We were unable to assess how much of the cause of psychiatrists being in the minority in the CPC workforce is related to the differential cost of a psychiatrist versus an advanced practice nurse, rather than a scarcity of interested psychiatrists. The interest expressed in IBH by members of the Dartmouth psychiatry residency would seem to argue that economics is a factor. Recent proposed changes by Medicare in payment for psychiatric consultation in primary care should be kept in sight as a possible support for engaging psychiatrists more fully in IBH in NH.

Because small, rural practices will probably never be able to employ their own CPCs, and NH-based programs do not have the capacity to solve the national shortage of psychiatric providers, re-education and redeployment of the existing psychiatric resource, in addition to enhanced recruitment of new psychiatrists to the State, may be the best bet to address this part of the workforce challenge. A NH-based statewide psychiatric consultation service modeled after the Massachusetts Child Psychiatry Access Project could provide an important solution. This service averted a psychiatric access crisis in pediatric primary care in Massachusetts, without adding significantly to the overall workforce.

Retraining psychiatrists currently in practice may offer a short-term approach to improving the workforce of CPCs. The American Psychiatric Association makes available a full day of training in consulting as a psychiatrist in primary care at each of its annual meetings. The curriculum from this course is in the public domain and could be taught through an online or in person format by current experts in primary care psychiatry in the State.

Help primary care clinicians (PCCs) adapt to IBH

We did not assess the number or role of primary care clinicians (PCCs) (family medicine, internal medicine and pediatric physicians, nurse practitioners and physician assistants) in our survey, because PCC workforce issues have been addressed by other investigators and tracked nationally. We did, however, investigate the role of PCCs in the delivery of IBH and the training of a competent workforce.

Hall, Cohen, Davis, et al, (2015) found that IBH requires primary care clinicians to adapt their practice in several ways. They need to accept and utilize new expertise on the team, review screenings and identify patients needing BHC services, communicate with patients about their behavioral health needs and how the BHC can help, and discuss patient behavioral health needs with the BHC so they (PCC) can guide development of an overall plan of care. This is in addition to their current work diagnosing and prescribing medications for common mental health conditions, such as depression, anxiety, alcohol and opioid use, and ADHD.

While the integration of BHCs and CPCs into primary care is designed to take some of these responsibilities off the shoulders of PCCs, in addition to improving the care they deliver, the process of integration is not without stress. Many will experience the transformation to integrated primary care and concomitant modifications in their role as challenging, even as they often report enjoying their work more. Learning when and how to introduce BHCs into the flow of care, into workflows that the PCCs have developed over many patient care episodes, is often disconcerting. While some experience immediate relief with the additional support, for others it takes many iterations of sharing care of patients with BHCs for PCCs to develop enough trust in their colleagues' skills to become comfortable with this aspect of team care.

PCCs are accustomed to getting on-the-job training through the Continuing Medical Education process. For the last six years, the Department of Psychiatry at Dartmouth has offered a continuing medical education course on mental health and substance use care in primary care for non-psychiatric physicians and nurses, training hundreds of clinicians. This is an important part of preparing PCCs for a transition to integration. We know of no organized programs available at present that train PCCs in the specific dispositions, skills, and techniques that will help them transition effectively and comfortably to the team aspects of IBH practice. Such programs are in development in New England, and at least one will be available by early 2017. Here again, the State might choose to replicate or contract for such a program to make it available as part of the transformation to IBH.

A modular, functional, and practical approach to expanding Care Enhancers (CEs)

We have chosen to include many roles and labels under the banner of Care Enhancer (navigators, community health workers, care managers, care coordinators, health coaches, patient educators, patient advocates, and there are probably others we couldn't identify). Our survey and discussions find that little standardization in function or title exists for the myriad labels given to the various types of Care Enhancers; a "patient advocate" might do in one practice what a "care coordinator" does in another, and so forth. While the labels vary, the commonalities in the functions they serve within the primary care team are striking. In general, Care Enhancers do one or more of the following:

1) create and maintain patient engagement in care within and across health settings,
2) address issues of health literacy, adherence and healthy living,
3) address social and economic barriers patients face in caring for their health ("social determinants of health")
4) keep information flowing between the patient and the rest of the healthcare team.

NH practices expect Care Enhancers to be Bachelor's or Master's prepared, with a preference for some medical and behavioral health training. In other states, practices have tended to default to nurses for many of these roles, only to broaden the acceptable training background as the crucial behavioral elements of the work became apparent. We included medical assistants and registered nurses/bachelor of science nurses in this category because they can also be trained to play a care enhancement role, such as managing depression registries or serving as care managers, as they have in other successful IBH settings nationally, e.g. in Minnesota. Indeed, staff with a wide variety of academic backgrounds and degrees can be successfully trained to handle one or more care enhancer functions.

Care Enhancers are critical to successfully enacting the behavioral and medical aspects of the care of high need populations. Currently, some CEs are trained in the private sector (health coaches), others in the public sector (community health workers), and others through augmentation of more traditional disciplinary training (nurse navigators). Moving forward, we should think of Care Enhancers in terms of the four functions, rather than the dizzying array of academic backgrounds, credentials, and labels applied to the staff that can fill those roles. Thinking in terms of care enhancer functions will provide coherence and conceptual clarity about the nature of the role, as well as more flexibility in how to staff it, while avoiding interdisciplinary conflicts over resources between advocates of one disciplinary background or another.

In "reverse integration" settings, where primary care is brought into specialty behavioral health centers, the CE role of medical care manager has been added resulting in significant effects in improving the delivery of preventive and chronic illness care (Druss, et al, 2010). Training case managers who have worked in behavioral

health settings in chronic illness care and wellness coaching is similar to training nurse care managers who have been working in medical settings in depression monitoring and patient activation techniques – each needs targeted training to be able to do the whole CE job in IBH.

Because the background of staff filling CE roles is so varied, their training should be modular rather than discipline-specific. Such training should be focused on training Care Enhancers, regardless of background, to competence in the four core functions, allowing for customization that fits with the particular programming of a particular population/primary care practice.

Based on our survey results, the supply of medical assistants in NH may well exceed the demand in the coming years. Medical assistant training could be considered a gateway to the CE role, thus filling a critical IBH workforce need. Medical assistants typically receive two years of post high school training orienting them to the medical setting, the basics of healthcare, and to professionalism as a key part of practice. Medical assistant training could be augmented by modular, post-degree competency-based education in one or many of the CE functions. This strategy could, quite quickly produce a high quality, flexible, and more socioeconomically and racially/ethnically diverse Care Enhancer workforce. Indeed, in some settings, medical assistants have been successfully trained to serve as depression care managers, to assist physicians and BHCs in opioid treatment programs (Mullin, 2016), and to regularly help patients identify and reach their individual health goals as part of a regular primary care visit (Mauksch and Blount, 2014). While the current training structures for health coaches, community health workers, care coordinators, and navigators are likely to continue to develop organically, we believe that retraining existing medical assistants for additional CE responsibilities in any of these roles should also be explored as an additional means for enhancing the IBH workforce.

Set the stage for an IBH-specific practice facilitator workforce

Another workforce role that may become important as the IBH expands, is the role of the IBH-specific practice facilitator. Practice facilitation is an approach to helping primary care practices innovate and improve. The practice facilitation approach has been widely – and effectively – used within the Patient Centered Medical Home movement (Baskerville, Liddy, Hogg, 2012; Nagykaldi, Mold and Aspy, 2005).

Statewide programs aimed at fostering the development of IBH often take a "learning community" approach, with webinars from experts and information exchanged between practices. An excellent example of this sort of programming has been offered by the New Hampshire Citizens Health Initiative over the past year. Perhaps the most sophisticated new resource in this space at the present time is the "Playbook" and "Integration Community" offered by the Integration Academy of the Agency for Healthcare Research and Quality. But the consensus of experts currently leans away from using learning communities as the only resource for helping practices make these changes. Additional time and energy, tailored to specific primary care practices, by practice facilitators is thought to be a necessary part of the resources required to help many practices make the substantial change in mind set as well as clinical routines required to offer successful IBH (Dickinson, 2015).

Practice facilitation has not yet been widely implemented or studied in the transformation of practices to IBH (Dickinson, 2015). Yet the experience of one author (AB) indicates that Patient Centered Medical

Home (PCMH) practice facilitators – who can be quite successful in helping practices adopt PCMH as a new model – tend to be less successful in facilitating the change to IBH. This could be because the medical expertise, so critical to facilitating the change to PCMH, already exists in abundance in the typical primary care setting, and thus, does not need to be added by the practice facilitator. The expertise critical to the transformation to IBH, however, tends to be thinly supplied in most primary care settings, such that the practice facilitator needs to bring both practice change and behavioral health integration expertise to the table. Planning for the development of an IBH practice facilitation workforce in the state should be part of long range planning. This model has been successful in Maine, and the Center for Behavioral Health Innovation at Antioch also has experience providing technical assistance to IBH practice transformation.

Leverage and infuse the highest levels of IBH expertise, across the workforce

Maximizing the supply of well trained BHCs and CPCs is a good and necessary step in New Hampshire. It is unlikely, however, to completely meet the IBH workforce needs of the future. As more practices venture more substantially into IBH, behavioral health will become a part of more of the array of primary care services (Cohen, Davis, Hall, et al, 2015). This increased need can be partially addressed by increasing the behavioral health expertise of other team members. Some "expertise transfer" is a natural byproduct when IBH team members work together with the same patient (Blount, 1998) and can be amplified when behavioral health experts offer targeted training and regular consultation on cases. Just as psychiatrists have leveraged their expertise in diagnosis and prescribing across a larger front line workforce of PCCs, well-trained BHCs such as psychologists and experienced social workers can leverage their expertise through regular consultation with CEs and PCCs. This allows CEs to be more broadly engaged in BHI when they have easy access to BHCs for difficult patient situations and treatment plans that are not progressing.

Toward a "doorways and pathways" model to enlarge, diversify the IBH workforce

Two approaches to developing a skilled professional workforce in healthcare have emerged: 1) traditional academic training supplemented by (unpaid or low paid) experiential training in practice settings; and 2) training on the job while collecting a salary, sometimes with the help of an academic setting. For the behavioral health workforce in primary care, the former typically precedes the latter. People train as social workers, psychologists, psychiatrists or other counselors, and then receive additional post degree training specific to primary care. This system privileges students with greater access to funds for tuition, who can endure longer periods without an income, and who can take on greater amounts of debt. Despite the best efforts of academic settings to attract and retain diverse student bodies, the resulting workforce tends to reflect the current ethnic and racial distribution of students with greater economic resources in the culture at large.

Academic programs that train behavioral health clinicians do not generally consider themselves a front door to work in primary care. Instead, they generally view and market themselves as the front door to the many possible roles or practice settings afforded by their discipline. Thus, the gulf between traditional disciplinary training and the specific needs for IBH practice in primary care is wide enough that specific post degree training has been necessary in many cases.

In primary care, new niche roles and the augmentation of old medical roles to include behavioral health components have undercut the traditional hegemony of academic disciplines. Social workers are being transformed into successful care managers, a role that was once the sole province of nurses. Associate's and Bachelor's level staff are succeeding in behavioral health roles that once required a graduate degree, such as functioning as depression clinical specialist or providing behavioral activation for patients with depression. In some places, even peers, fellow patients providing natural support, support are being enlisted and trained to effectively provide psychosocial interventions (Patel, Chowdhary, Rahman, & Verdeli, 2011).

On the job training to increase skill and add credentials could be a more robust pathway than traditional academic training alone toward a larger and more diverse workforce that is specifically trained in and socialized to primary care. Workers become competent in various aspects of functioning in primary care and then get the academic training and credentials to be able to do more complex and more professional roles. This "doorways and pathways" model would offer targeted training, in both academic and post-degree settings, that leverages the existing skills, credentials, and experience of the current healthcare workforce, into ever increasing levels of competence, credentials, and salaries, to satisfy the IBH workforce needs.

Nursing has had success with something approximating this approach. Pathways from licensed practical nurse to registered nurse to bachelor of science nurse to nurse practitioner and to doctor of nursing practice are reasonably well articulated. These pathways are often structured to allow students to continue working as they move up the ladder, interspersed at times with brief periods of full time engagement in an academic program. Theoretically, one could begin as a licensed practical nurse and, while maintaining an income for most of the journey, achieve the status of doctor of nursing practice and primary care provider.

The same sort of ladder could be articulated, probably without great change in existing academic programming, for the behavioral health workforce. Someone could begin as a community health worker and add training as a health coach or experience as a patient advocate, on the way to a degree as a clinical social worker, marriage and family therapist, or certified mental health counselor. Probably because, unlike nursing, each of these roles is viewed as a distinct discipline, the motivation and vision necessary for articulating such a ladder has been lacking. No effort has gone into orienting academic training programs to their possible roles in such a ladder. And most importantly, there has been no effort to recruit students to the doorway positions and articulate the net of pathways that could lead to a career of advancement within primary care or other medical settings. These tasks, articulating the vision of primary care as the central setting for generating its own behavioral health workforce, recruiting willing academic institutions as partners in building a network of ways for workers to improve skills and increase credentialing, and recruiting students to a clear structure of positions and opportunities for advancement, would form an agenda for the building of a long term self-renewing primary care behavioral health workforce.

Articulating the current network of possibilities, along with the employment opportunities and salary levels that are available to be achieved, is the job of an entity with statewide reach, committed to the building of the whole primary care behavioral health workforce, not to one program or discipline. The more clearly this network is articulated, and the more work in primary care is marketed, the more the market will put pressure on training programs to cooperate and support the endeavor. The program that is best at providing training that allows students who are already working at one role to keep working and move to a more complex higher paid role will hold a competitive advantage in the primary care workforce marketplace.

A robust plan will also consider the role of interpreter as one doorway into the workforce system we are envisioning. The role of professional interpreter in healthcare brings in a wide array of bright bi-lingual and bi-cultural workers who become oriented – through their work – to every aspect of practice in the settings in which they serve. Their skills with language and culture make them uniquely attractive candidates for roles such as navigator or health coach, which can then make some of them good candidates for training to fulfill more complex and professional roles, down the line. This would infuse the IBH workforce with staff who are competent in the languages and cultures the healthcare system now serves poorly, and hungry to refine their skills and credentials to take on increasingly sophisticated clinical duties and improved salaries, while remaining connected to – and hopefully loyal to – the primary care patients they serve.

Remove regulatory and payment barriers to the IBH workforce of tomorrow

Barriers currently impede the use of Master's level BHCs – other than social workers – in a fee for service environment. Since other Master's level behavioral health clinicians (e.g., clinical mental health counselors, marriage and family therapists) start at about the same place as clinical social workers in relation to primary care practice (needing a rigorous orientation to primary care and retraining for primary care behavioral health practice), payment barriers that effectively exclude them from the BHC role only serve to limit the potential IBH workforce.

Payment reform offers an opportunity for taking positive steps to expand the workforce in thoughtful ways. It is crucial that regulators and policy formulators be aware of training and workforce issues and that they allow and support the full array of behavioral health clinicians and the full array of trainees for behavioral heath clinician to be able to provide services in primary care under payment transformation whether or not they can be recognized under fee for service plans as eligible to bill. In Massachusetts, the explicit inclusion of trainees in approved training programs and any licensed behavioral health clinician as providers of behavioral health services in primary care made integrated care financially viable for many primary care practices serving Medicaid patients in Mass Health's 2014 Primary Care Payment Reform program.

Keep in mind our limited focus and sample, when considering these conclusions

We have chosen to assess the workforce needed for the level of integration that is recommended by accreditation agencies such as NCQA, and state plans such as the 1115 Medicaid Waiver. We assessed the workforce needs of safety net clinics practicing a fairly rudimentary form of integration, within the current – not future – regulatory and payment environment. As IBH practice in these clinics matures, in concert with a change to bundled payments of some sort, there will be an increasing need for Behavioral Health Clinicians and Care Enhancers in particular. Our recommendations anticipate some of these changes.

Our primary care sample consisted of 71% of the primary care safety net settings in NH. We should not generalize these findings to other providers that serve a substantial portion of the Medicaid-eligible patients in the state (e.g., Dartmouth-Hitchcock clinics). Likewise, only 40% of the training programs we contacted completed the interview, so these findings do not represent all relevant NH training programs.

Recommendations and Next Steps

Increase training-practice collaboration and communication

Our data, in combination with the national literature, points to gaps in the present and future IBH workforce. These gaps are perpetuated by the lack of contact between primary care settings and academic training programs. Primary care has not yet invested in developing its own workforce, and academic programs are not yet aware of the IBH workforce needs. To create an environment that can produce the BH workforce of the future, regular contact and communication between primary care, academic programs, and post degree training services is needed. Each has important needs to express and lessons to teach, in generating IBH workforce solutions.

Launch NH IBH workforce development network through one-day summit

One of the first tasks in building NH's workforce development capacity is to bring together primary care sites, academic programs, and post degree training services, along with health systems, policy leaders, and national experts, in a one-day IBH workforce summit. Other key NH IBH workforce stakeholders should be invited as well. The purpose of the summit would be to:

1) Initiate contact and communication among IBH workforce stakeholders
2) Develop shared understanding of NH's IBH workforce needs in light of the national literature
3) Sketch a shared vision of the NH workforce development network of the future
4) Identify representatives and institutions that are willing to invest time and effort to move the IBH vision

Develop an IBH workforce advisory group (IWAG)

By the end of the summit, a representative mix of primary care, training institution, and other key stakeholders should be identified to serve as potential members of a NH IBH workforce advisory group (IWAG). The IWAG should also be in contact with national experts and out of state IBH training programs, such as the Center for Integrated Primary Care at the University of Massachusetts Medical School. The IWAG would meet monthly, by conference call or in person, to 1) foster the ongoing education and communication between key IBH workforce stakeholders; and 2) develop a NH IBH workforce development strategic plan.

Create an IBH workforce development strategic plan

The NH IBH workforce development strategic plan should address a minimum of four priority areas.

- Marketing and recruitment of current and future students into IBH careers, particularly through the participating academic and training programs.
- Strengthening NH's IBH leadership, infrastructure, regulatory, and policy environment. For instance, the plan might call for advocacy for primary care settings to receive reimbursement for the services provided by supervised BHC trainees.
- Bulding out the "doorways and pathways" model discussed earlier in this report
- Designing and identifying an IBH workforce backbone structure/entity

Backbone entity implements plan, supports ongoing improvement of IBH in NH

The process of developing and implementing a long-term primary care behavioral health workforce plan for New Hampshire will be accomplished with the cooperation of many stakeholders. Those stakeholders will need an organization that convenes, facilitates, guides and expedites all along the way. This backbone entity would be charged with educating, marketing, and advocating for IBH among key constituencies; convening and coordinating key players; implementing, evaluating, and modifying the strategic plan over time; and providing access to IBH-related training, technical assistance, and practice facilitation resources to training institutions, primary care practices, and other key IBH stakeholders throughout the state (e.g., Integrated Delivery Networks, under NH's 1115 Medicaid waiver). It should have access to broad and deep knowledge about the natural history of IBH and the intricacies of the clinical routines and staff roles through which it is carried out. Whether in the information clearinghouse, technical assistance, or training and consulting role, the skills and knowledge of the backbone entity will be crucial to the development of IBH in New Hampshire.

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Appendix A. Primary Care Needs Assessment Survey

FQHC and RHC Clinic Survey

Integrated Behavioral Health Workforce Survey

1. Please tell us about the academic background of staff who contribute to Behavioral Health care in your practice. Please indicate all backgrounds if multiple staff members fill the same role.

Please choose from this list:

Behavioral Health role	**How many staff now in this role?**	MD/DO Psychiatrist MD/DO NP/APN PA (Physician Asst.) RN/BSN LPN MA (Medical Asst.)	Psychologist MSW MFT LMHC BSW Other Bachelor's Associate's Degree Other Degree (list)
Prescriber of Psychotropic Meds *(e.g. PCP, Psych MD, Psych APN)*			
Behavioral Health Clinician *(e.g. Psychologist, Social Worker, Counselor)*			
Care Manager			
Health Coach			
Substance Abuse Counselor			
Nurse			
Medical Assistant			
Community Health Worker			
Patient Advocate			
Care Coordinator			
Patient Educator			
Navigator			
Other (Please list)			

2. This is a 2-part question: To what extent do people hired for this role enter the job with the competencies necessary to perform the behavioral health aspects of it well? How much specific training is required to fill the Behavioral Health portion of each role?

RTG = *Ready to go (usually) in the role when they completed training for the discipline*
OJT = *On the job training needed for the behavioral health part of their role (done at your practice)*
STN = *Substantive additional training from external sources needed for the behavioral health part of their role*

Behavioral Health role	Ready to Go	On the Job Training Needed	Substantive Additional Training Needed	Amount of Specific Training Needed to Fill Behavioral Health portion of the role 0 = None 1= A Little 2 = Some 3 = Moderate Amount 4 = Great Amount
Prescriber of Psychotropic Meds *(e.g. PCP, Psych MD, Psych APN)*				
Behavioral Health Clinician *(e.g. Psychologist, Social Worker, Counselor)*				
Care Manager				
Health Coach				
Substance Abuse Counselor				
Nurse				
Medical Assistant				
Community Health Worker				
Patient Advocate				
Care Coordinator				
Patient Educator				
Navigator				
Other (Please list)				

3. Please tell us how many workers who contribute to Behavioral Health care in the practice you WISH you had now and how many you want FIVE years from now. Tell us also which discipline you would hire to fill this role.

Ideal Academic Discipline to fill the role

Behavioral Health role	**# you wish for NOW**	**# you want in 5 years**	MD/DO Psychiatrist MD/DO NP/APN PA (Physician Asst.) RN/BSN LPN MA (Medical Asst.)	Psychologist MSW MFT LMHC BSW Other Bachelor's Associate's Degree Other Degree (list)
Prescriber of Psychotropic Meds *(e.g. PCP, Psych MD, Psych APN)*				
Behavioral Health Clinician *(e.g. Psychologist, Social Worker, Counselor)*				
Care Manager				
Health Coach				
Substance Abuse Counselor				
Nurse				
Medical Assistant				
Community Health Worker				
Patient Advocate				
Care Coordinator				
Patient Educator				
Navigator				
Other (Please list)				

4. Please tell us how difficult it is to fill the Behavioral Health portion of each role, by checking the best box.

Level of Difficulty in finding adequately prepared staff for the BH part of the role

Behavioral Health role	Very Easy	Fairly Easy	Same as Non-BH roles	Fairly Difficult	Very Difficult
Prescriber of Psychotropic Meds *(e.g. PCP, Psych MD, Psych APN)*					
Behavioral Health Clinician *(e.g. Psychologist, Social Worker, Counselor)*					
Care Manager					
Health Coach					
Substance Abuse Counselor					
Nurse					
Medical Assistant					
Community Health Worker					
Patient Advocate					
Care Coordinator					
Patient Educator					
Navigator					
Other (Please list)					

5. At what level of behavioral health integration is your practice right now? (Check the one closest to your level) Please see www.integration.samhsa.gov if you would like more description about these models.

Coordinated, Level 1: Minimal Collaboration	
Coordinated, Level 2: Basic Collaboration at a Distance	
Co-Located, Level 3: Basic Collaboration Onsite between medical and BH services	
Co-Located, Level 4: Close Collaboration Onsite with some System Integration	
Integrated, Level 5: Close Collaboration Approaching an Integrated Practice	
Integrated, Level 6: Full Collaboration in a Transformed/Merged Integrated Practice	
Don't Know	

THANKS FOR YOUR PARTICIPATION!!

Appendix B. List of Clinics

Organization	Site type
Ammonoosuc Community Health Services, Inc.	Federally Qualified Health Center
Antrim Medical Group	Rural Health Clinic
Coos County Family Health Services, Inc.	Federally Qualified Health Center
Rowe Health Center (Cottage Hospital)	Rural Health Clinic
Families First Health and Support Center	Federally Qualified Health Center
Goodwin Community Health	Federally Qualified Health Center
Harbor Care Health and Wellness Center (Harbor Homes)	Federally Qualified Health Center
Health Care for the Homeless Program	Federally Qualified Health Center
HealthFirst Family Care Center	Federally Qualified Health Center
Indian Stream Health Center	Federally Qualified Health Center
Lamprey Health Care	Federally Qualified Health Center
Manchester Community Health Center and Child Health Services	Federally Qualified Health Center
Mid-State Health Center	Federally Qualified Health Center
Newfound Family practice	Rural Health Clinic
Newport Health Center	Rural Health Clinic
North Country Primary Care	Rural Health Clinic
Saco River Medical Associates	Rural Health Clinic
Speare Primary Care	Rural Health Clinic
Weeks Medical Center	Rural Health Clinic
White Mountain Community Health Center	Community Health Center
Concord Family Health Center	Community Health Center

Appendix C. List of Training Programs

Degree	Program	Institution
Consulting Psychiatric Clinicians		
M.D.	Family Medicine Residency	Dartmouth College
M.D.	Psychiatry Residency	
MS Familly Nurse Practitioner	Nursing	Massachusetts College of Pharmacy and Health Sciences (MCPHS) - Manchester
		University of NH
		Rivier University
MS Psychiatric/Mental Health Nurse Practitioner	Nursing	Rivier University
MA	Physician Assistant	Massachusetts College of Pharmacy and Health Sciences (MCPHS) - Manchester
Behavioral Health Clinicians		
PsyD	Clinical Psychology	Antioch University New England
PsyD	Counseling & School Psychology	Rivier University
MA	Clinical Mental Health Counseling	Antioch University New England
MS	Clinical Mental Health Counseling	Rivier University
MA, PhD	Marriage and Family Therapy	New England College
		Plymouth State University
		Southern NH University
MS	Couples and Family Therapy	Plymouth State University
MS	Psychology/Clinical Psychology	Hellenic American University
		Rivier University
MSW	Social Work	University of NH
N/A	Predoctoral Psychology Internship	Dartmouth College
N/A	Concord Hospital Internship Program	Concord Hospital
Care Enhancers		
BS	Health Science	New England College
		Keene State College
AS	Health Science	Manchester Community College
		Concord Community College
		White Mountains Community College
BS or Undergraduate Major	Health Education and Promotion/Health and Wellness	Plymouth State University
		Southern NH University
		Granite State College
		Colby-Sawyer College
AS	Health Education and Promotion/Health and Wellness	White MOuntains Community College

Degree	Program	Institution
BS or Undergraduate Major	Public Health	Rivier University
		Franklin Pierce University
		Colby-Sawyer College
LPN to RN	Nursing	Concord Community College
Licensed Nursing Assistant	Nursing	Salter School of Nursing
Patient Care Technician	Nursing	Salter School of Nursing
MS	Nursing	Franklin Pierce University
		Southern NH University
MS Clinical Nurse Leader	Nursing	Southern NH University
MS Nursing Patient Safety and Quality	Nursing	Southern NH University
AS	Medical Assistant	Manchester Community College
		White Mountains Community College
Certificate	Medical Assistant	Rivier Valley Community College
N/A	Eating Disorders Institute	Plymouth State University
Cmmunity Health Worker Training/Other Trainings	Southern Area Health Education Center	
Various Trainings	Northern Area Health Education Center	
N/A	NH Children's Behavioral Health Network	
N/A	NH Training Instituite on Addictive Disorders	
Degree Key: Degree Key: BA=bachelor of arts; BS=bachelor of science; AS=associate of science; MA=master of arts; MS=master of science; BSW=bachelor of social work; MSW=master of social work; LPN=licensed practical nurse; RN=registered nurse; MD=medical doctor; PsyD=doctor of psychology; PhD=doctor of philosophy		

Appendix D. Training Program Interview Protocol

1. Do you know of graduates doing work in primary care related to behavioral health? By primary care, we mean family medicine, general internal medicine, or general pediatrics.

2. What parts of your program, either academic or experiential, do you see intentionally focused on training in working in primary care and working as part of an interdisciplinary integrated primary care team?

3. Is your program interested in focusing more on this area of training in the future? If so, what do you envision your program doing to make this happen?

4. We're interested in the potential of bringing together multiple training programs to organize and expand the state's ability to produce or develop a behavioral health workforce for primary care. Would you be interested in being part of a larger workforce initiative focused on this type of training expansion, including in inter-institutional, interdisciplinary kind of ways?

5. Who else or what other programs in the state do you know of that are doing similar training?

Notes

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