

# Strengthening the Behavioral Health Workforce: Spotlight on PITCH



The Professional Counselor™  
Volume 10, Issue 3, Pages 306–317  
<http://tpcjournal.nbcc.org>  
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doi:10.15241/jlh.10.3.306

Jessica Lloyd-Hazlett, Cory Knight, Stacy Ogbeide,  
Heather Trepal, Noel Blessing

The coordination of primary and behavioral health care that holistically targets clients' physical and mental needs is known as *integrated care*. Primary care is increasingly becoming a de facto mental health system because of behavioral health care shortages and patient preferences. Primary care behavioral health (PCBH) is a gold standard model used to assist in the integration process. Although counselor training addresses some aspects of integrated care, best practices for counselor education and supervision within the PCBH framework are underdeveloped. This article provides an overview of the Program for the Integrated Training of Counselors in Behavioral Health (PITCH). The authors discuss challenges in implementation; solutions; and implications for counselor training, clinical practice, and behavioral health workforce development.

**Keywords:** integrated care, primary care, counselor training, PITCH, behavioral health workforce development

In 2016, 18.3% of adults were diagnosed with a mental illness and 4.2% of adults were diagnosed with a *serious* mental illness (SMI; Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). Of those with a mental illness, only 41% received mental health services, leaving more than half unserved (SAMHSA, 2015). Many of these untreated adults turn to their primary care provider (PCP) for help and report preference for behavioral health services within primary care (Ogbeide et al., 2018). In fact, data show that primary care has become the de facto mental health system in the United States (Robinson & Reiter, 2016).

Although PCPs attempt to provide pharmacological interventions and appropriate behavioral health referrals, patients often return still experiencing distress because they are unable to follow through on referrals (Cunningham, 2009; Robinson & Reiter, 2016). On average, this circular process results in substantially longer medical visits (e.g., 20 minutes versus 8 minutes) and fewer billable services (e.g., one versus five or more; Meadows et al., 2011). This also results in a significant increase in health care spending, with patients incurring 30%–40% higher costs because of the presence of a mental health condition (de Oliveira et al., 2016; Wammes et al., 2018). There is a need for professionals trained in behavioral health care working within the primary care setting (Serrano et al., 2018).

Counselor training addresses some aspects of the role of behavioral health professionals in primary care. The most recent version of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) entry-level program standards mandates that all accredited programs, regardless of specialty, orient counseling students to “the multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation” (CACREP, 2016,

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Jessica Lloyd-Hazlett, PhD, NCC, LPC, is an associate professor at the University of Texas at San Antonio. Cory Knight, MS, is a master's student at the University of Texas at San Antonio. Stacy Ogbeide, PsyD, ABPP, is a behavioral health consultant, licensed psychologist, and associate professor at the University of Texas Health Sciences Center San Antonio. Heather Trepal, PhD, LPC-S, is a professor and coordinator of the Clinical Mental Health Counseling Program at the University of Texas at San Antonio. Noel Blessing, MS, is a doctoral student at the University of Texas at San Antonio. Correspondence may be addressed to Jessica Lloyd-Hazlett, 501 W. Cesar E. Chavez Blvd., DB 4.132, San Antonio, TX 78207, [Jessica.lloyd-hazlett@utsa.edu](mailto:Jessica.lloyd-hazlett@utsa.edu).

Standard F.1.b.). As patients' needs and training mandates increase, there is a demand for counselor training programs to respond with models and practices for counselor training in behavioral health in primary care settings.

The Program for the Integrated Training of Counselors in Behavioral Health (PITCH) is a 4-year project sponsored by a Health Resources and Services Administration (HRSA) Behavioral Health Workforce Education and Training (BHWET) grant received by the Department of Counseling at the University of Texas at San Antonio. The purpose of this article is to describe this innovative program. Toward this end, we briefly outline the Primary Care Behavioral Health (PCBH) consultation model undergirding PITCH. Next, we describe the need for behavioral health integration in primary care settings. Then, we delineate our implementation of PITCH to date, including specialized field placements, training curriculum, and program evaluation methodologies. Following, we discuss challenges and resolutions gleaned from the first 1.5 years of implementation. Finally, we explore implications for counselor education to further enhance counselor preparation and engagement in behavioral health care delivery in primary care settings.

### Primary Care Behavioral Health

The coordination of primary and behavioral health care that holistically targets clients' physical and mental needs is known as *integrated care* (SAMHSA, 2015). One model used to assist in the integration process is the PCBH consultation model—a team-based and psychologically informed population health approach used to address physical and behavioral health concerns that arise in the primary care setting (Reiter et al., 2018). A hallmark of the PCBH model is integration of behavioral health consultants (BHCs), who dually function as generalist clinicians and as consultants to the primary care team (Serrano et al., 2018).

A BHC is different than a traditional counselor. In fulfilling their roles and functions, a BHC:

Assists in the care of patients of any age and with any health condition (Generalist); strives to intervene with all patients on the day they are referred (Accessible); shares clinic space and resources and assists the team in various ways (Team-based); engages with a large percentage of the clinic population (High volume); helps improve the team's biopsychosocial assessment and interventions skills and processes (Educator); and is a routine part of psychosocial care (Routine). (Reiter et al., 2018, p. 112)

BHCs conduct brief functional assessments, collaborate with patients on treatment goals, implement evidence-based treatment interventions, and provide PCPs with feedback and recommendations for future patient care and support (Hunter et al., 2018). In addition, BHCs see patients for approximately 15–30-minute visits, with an average range between two and six visits per episode of care (Ray-Sannerud et al., 2012). In many ways, the BHC role involves a new professional identity for mental health professionals (Serrano et al., 2018). To date, BHC training and employment has typically involved social workers and psychologists. However, the counseling profession is increasingly recognized and engaged in integrated PCBH (HRSA, 2017).

### Need for Integrated Services

Primary care settings must begin to consider behavioral health integration in order to increase the quality of life of their patients. Over recent years, there has been a significant increase in patients who receive psychotropic medication for mental health complaints in the primary care setting (Olfson et al., 2014). PCPs are managing increasingly complex diagnoses beyond anxiety and depression. These

include bipolar, disruptive, and other comorbid disorders (Olfson et al., 2014). Individuals diagnosed with an SMI such as these also show a high prevalence of chronic health conditions, including diabetes and cardiovascular disease. Untreated psychological symptoms can often present themselves in somatic forms and can have a strong impact on chronic health conditions (McGough et al., 2016). People with SMIs prefer behavioral health services from their PCP; however, treatment outcomes for those with SMIs that seek services from their PCP are generally of lesser quality (Viron & Stern, 2010). Patient, provider, and systemic-level factors influence this phenomenon. Relevant factors may include impacts of patients' mental health diagnoses on treatment adherence, misdiagnosis from PCPs, and minimal collaboration between medical and behavioral health providers (Viron & Stern, 2010).

The PITCH program addresses several critical needs of individuals seeking behavioral health services in the local community, where conditions that necessitate behavioral health services, including mental illness and substance use disorders, are common. In a focus group run in 2011 with members of the community, the group identified mental health as a key concern (Health Collaborative, 2013). Although mental health services were offered in a psychiatric facility for children, adolescents, and adults, members of the focus group reported that the demand for mental health providers and psychiatric beds exceeded the supply. The stigma associated with mental health also was seen as a barrier to care. As a result, many people go undiagnosed and untreated (SAMHSA, 2015).

PITCH also addresses the need for interdisciplinary approaches to behavioral health workforce development. The expansion of PCBH consultation services amplified this need (Robinson & Reiter, 2016). Unlike other models of integrated care (i.e., Collaborative Care Model, Chronic Care Model), the PCBH model makes available primary care-focused behavioral health services across an entire clinic population and across all possible patient presentations. This model also requires a skilled mental health professional adept at a variety of patient presentations and able to manage processes like clinic flow and a new role as consultant—skills and roles not commonly present in training for specialty mental health services (Robinson & Reiter, 2016).

## **PITCH: An Overview**

PITCH is housed within a CACREP-accredited master's-level clinical mental health counseling (CMHC) program enrolling more than 100 students each year. The principal investigator (PI) of PITCH is a professor specializing in clinical supervision, bilingual counselor education, and professional advocacy. Other PITCH team members include an assistant professor (Co-PI, university liaison) specializing in family counseling, program evaluation, and ethics; an assistant professor and board-certified clinical health psychologist (consultant); and an external project evaluator.

The primary purpose of PITCH is to develop a highly trained workforce of professional counselors to provide integrated behavioral health care (IBH) to rural, vulnerable, and underserved communities in primary care. Sub-goals of the PITCH program include establishing meaningful, longitudinal interdisciplinary partnerships as well as a graduate-level certificate in IBH to support sustainability. Toward this, 12 advanced counseling students enrolled in the aforementioned CMHC program are selected to participate each year from a competitive application pool. Selected trainees are required to complete two specialized IBH courses and two 300-hour clinical rotations in designated primary care settings. In exchange, trainees receive a \$5,000 stipend upon completion of each semester rotation. Additionally, PITCH staff coordinate quarterly interprofessional trainings, including workshops focused on primary care, behavioral health, supervision, funding, and policy.

## Specialized Field Placements

A unique feature of the PITCH program is the development of specialized field placement sites. Other behavioral health integration projects have relied on existing clinical placement sites (Sampson, 2017). Often these sites have low levels of existing integration, as well as underdeveloped infrastructure to support behavioral health delivery in primary care. When existing clinical site placements do have some integrated services, they are most often co-located services (Peek & the National Integration Academy Council, 2013). Instead of field site development, previous efforts have emphasized student training through workshops (Canada et al., 2018). These workshops are often open to community members. Individuals are then charged to bring knowledge back to extant clinical sites. Although this offers some positive benefits, it may not be as impactful. Further, this approach may fall short of establishing infrastructure to support longitudinal changes (Serrano et al., 2018).

To start development of specialized field placements, we identified potential sites interested in IBH delivery. We then set up initial meetings with sites to discuss the PITCH project and to determine the feasibility of placing a BHC trainee. If sites were amenable, we scheduled a series of follow-up visits to provide orientation to clinic staff on IBH, the PCBH model, and the role and scope of BHCs. During these visits, we also provided consultation on infrastructure components, such as electronic medical record documentation procedures, suggestions for clinic flow, and room spacing (Robinson & Reiter, 2016). Throughout the field placement, we remained active in checking with sites to make workflow adjustments as needed. Trainees complete certificate-based coursework prior to beginning field placements as well as during the clinical rotations.

## Trainee Curriculum

Selected trainees are required to complete two specialized courses in IBH, as well as two 300-hour clinical rotations at one of the specialized field placement sites discussed above. The PCBH model scaffolds all aspects of the PITCH training and delivery. We utilize this model to support conceptualization of the BHC role in primary care settings, interventions, and supervision.

As part of the PITCH program, two didactic courses were created to provide training in IBH and PCBH. The courses were developed and instructed by the PITCH IBH consultant. The first course, IBH-I, introduces students to the primary care setting (e.g., family medicine, pediatrics, geriatrics), the PCBH model of care, behavioral health consultation, health behavior change, and common mental and chronic health conditions encountered in primary care, and offers a basic understanding of brief, cognitive-behavioral-based and solution-focused interventions used in primary care (Reiter et al., 2018; Robinson & Reiter, 2016).

Students must complete the following assignments in the course: two exams, an IBH journal article review, a primary care clinic tour, an interview with a PCP, a presentation on one commonly seen problem in primary care (e.g., insomnia, chronic pain, depression), and a term paper highlighting treatment on a common problem in primary care using the 5A's model (Hunter & Goodie, 2010). The 5A's is a behavioral change model that includes assessing, advising, agreeing, assisting, and arranging. Upon demonstrating satisfactory performance, students may enroll in IBH-II.

The primary purpose of the second course is to begin applying foundational knowledge of PCBH as well as practice functional and contextual assessment and cognitive-behavioral intervention skills in the primary care setting. Trainees demonstrate their skills through a series of in-class role-plays, leading up to a final evaluation of their performance in a 30-minute initial consultation visit with a standardized

patient. Trainees must complete both courses to maintain their status in PITCH. Both courses are open as electives to students enrolled in the counseling program or a related discipline (e.g., social work).

PITCH trainees also complete two semester-long clinical rotations in primary care. Trainees are assigned to one of the specialized field placement sites based on availability, interest, and anticipated fit. Trainees are required to clock 300 hours each semester, 120 of which must represent direct clinical engagement. Direct clinical engagement time includes patient visits, consultation with the primary care team, and facilitating psychoeducational groups tailored to unique clinical populations. Trainees are required to participate in at least 1 hour of clinical supervision with an on-site supervisor each week. Additionally, trainees attend a bi-weekly group supervision course on campus instructed by a CMHC faculty member. After successful completion of didactic and clinical courses of the PITCH program, trainees are eligible to earn a graduate certificate in IBH. Adjustments to specialized field placement sites and the trainee curriculum are made as needed based on ongoing informal and formal evaluation of the program.

### **Program Evaluation**

The HRSA BHWET grant supporting PITCH prioritizes evaluation activities related to workforce training and development effectiveness (HRSA, 2017). In partnership with our external evaluator, we are conducting program evaluation across several domains of PITCH, including evaluations focused on trainees and clinical sites (e.g., level of integration).

### ***Trainee-Focused Metrics***

We have several evaluation metrics that are focused on trainees. Trainees complete the Behavioral Health Consultant Core Competency Tool (BHC CC Tool; Robinson & Reiter, 2016) and the Primary Care Brief Intervention Competency Assessment Tool (BI-CAT; Robinson, 2015) at the beginning, midpoint, and conclusion of clinical rotations. The BHC CC Tool measures and tracks skill development across four domains of BHC practice: clinical practice, practice management, consultation, and documentation. The BI-CAT includes domains of practice context, intervention design, intervention delivery, and outcomes-based practice. On-site observations of trainees also are conducted using the PCBH Observation Tool as part of the certificate coursework. These competency tools were developed based on observations of BHC clinical behaviors likely to work effectively in a PCBH model of service delivery. These measures have not yet been formally assessed for psychometric properties or predictive outcomes (Robinson et al., 2018).

In addition to tools that target individual trainee development, program evaluation efforts also attend to the macro experiences of trainees in the program. Specifically, trainees participate in focus groups facilitated by the external evaluator at the end of each semester. Focus groups provide the opportunity to understand pathways and barriers to program development. We also have developed an online database to track trainees' postgraduation employment trajectories and sustained engagement in PCBH.

### ***Site-Focused Metrics***

Although this particular HRSA grant is primarily concerned with trainee-focused outcomes (e.g., employment), we also ask identified clinical site liaisons to complete the Integrated Practice Assessment Tool (IPAT; Waxmonsky et al., 2013) at the start and finish of each rotation. Scores on the IPAT provide a snapshot estimation of the level of integration of clinical sites. Levels of integration correspond to those identified by *A Standard Framework for Levels of Integrated Healthcare* (Heath et al., 2013) and range from 1–6. Levels 1 and 2 are indicative of minimal, coordinated collaboration, with behavioral health and PCPs maintaining separate facilities and systems. Levels 3 and 4 reflect shared physical space

and enhanced communication among behavioral health and PCPs; however, practice change toward system-level integration is underdeveloped. Finally, Levels 5 and 6 are indicative of transformed, team-based approaches in which both “providers and patients view the operation as a single health system treating the whole person” (Heath et al., 2013, p. 6). Focus groups also were conducted with members of selected clinical training sites to explore barriers and pathways to PCBH delivery as a function of level of integration. At this time, the IPAT has not yet been formally assessed for psychometric properties.

### ***Rapid Cycle Quality Improvement***

Finally, program evaluation efforts include ongoing rapid cycle quality improvement (RCQI), a quality-improvement method that identifies, implements, and measures changes to improve a process or a system (Center for Health Workforce Studies, 2016). RCQI can be targeted at different aspects of the program. To date, RCQI has targeted trainee competencies related to functional assessment interviews, breadth of referrals concerns, and patient visit length. For example, after tracking trends in daily activity logs submitted by trainees, we noted a majority of referrals centered on anxiety and depression. We then provided supplemental training on identifying behavioral health concerns related to chronic health conditions, such as diabetes and asthma. Following this instruction, we reviewed the daily activity logs and noted greater breadth of referral concerns.

## **Challenges and Solutions**

Best practices for PCBH implementation within the context of workforce development are still developing. Further, available guidelines do not speak to counselor training programs specifically. In the section below, we discuss challenges we have encountered in the first 1.5 years of implementation of the PITCH program. We also share solutions we have generated to support optimal training experiences.

### **Challenge: On-Site Clinical Supervision**

A significant challenge we encountered was related to on-site clinical supervision for the PITCH trainees. National accreditation standards require trainees to participate in regular supervision with both an on-site and university supervisor (CACREP, 2016). The on-site supervisor must have at least 2 years of postgraduate experience, as well as hold a master’s degree in counseling or a related field (e.g., psychology, social work). Furthermore, best practices for BHC training support a scaffolded supervision approach (Dobmeyer et al., 2003), wherein trainees’ initial time is spent completing 360 clinic shadowing visits with an experienced BHC. As trainee skills develop, leadership within patient visits transitions from co-visits to visits. In time, the trainee leads the visits, with an experienced BHC in independent practice shadowing. Additionally, the PCBH model emphasizes preceptor-style supervision, where the supervisor is readily available on-site for patient consultation as needed (Dobmeyer et al., 2003).

### **Solution: Changes to Specialized Field Placement Sites**

During Year 1 of PITCH, almost two thirds of the specialized field placement sites we partnered with did not employ the PCBH model at the time, and thus did not have a BHC available to provide on-site clinical supervision. To meet this need, we provided intensive PCBH and supervision training to four doctoral students enrolled in our counselor education and supervision program. Doctoral student supervisors were asked to spend at least half a day on-site with trainees with this amount tapering off with time and experience.

Although this solution met national accreditation requirements for supervision (CACREP, 2016), we noticed stark differences between the clinical experiences of trainees placed at field sites with an on-site BHC versus doctoral student supervisors. As such, we made the difficult decision in Year 2

to separate from all but two field placement sites that lacked an on-site BHC to provide supervision. The inclusion of a BHC to supervise became a requirement for all the new sites we partnered with in Year 2. Additionally, we made modifications to our grant funding allocations to support graduate assistantships focused on supervision for two of the four doctoral supervisors utilized in Year 1.

### **Challenge: Knowledge About PCBH and the BHC Role**

We encountered internal and external gaps in knowledge about the PCBH model, the BHC role, and the general culture of primary care settings. Internally, members of our faculty less connected to PITCH expressed support but also concern about alignment of PITCH training experiences and the experiences of other counseling students. Specific points of concern related to the brevity of visits, frequency of single encounters with patients, and the underpinning medical model. Additionally, because of patient privacy restrictions, PITCH field placement sites do not permit audio or video recording of clinical work, which is a typical supervision practice for counseling trainees. PITCH trainees also expressed some tension between the professional identity and skills training obtained in the CMHC program to date with the PCBH model and BHC role. Externally, we observed varying degrees of provider knowledge and buy-in about the PCBH approach to integrated practice. Areas of provider disconnect were more prominent at placement sites without existing integrated primary care services.

### **Solution: Ongoing Education and Advocacy**

At the internal level, we provided a brief educational session about the PCBH model at regular faculty meetings. It was important to emphasize PCBH as a different context of practice that, similar to school counseling, requires modes of practice outside of traditional 50-minute sessions. We also sought faculty consultation related to curriculum and structure for our specialized coursework. For example, faculty members expressed concern about missing opportunities for recorded patient visits, so we developed two assignments for the clinical courses that could meet this need. The first was a mock visit with a classmate that was video recorded and transcribed. Students then analyzed micro-skills and reflected. The second assignment consisted of a live observation by the university- or site-based supervisors of the trainee's work on-site with a patient.

We also encountered various levels of provider buy-in at our different sites. We encouraged students to reframe this resistance as an opportunity for learning and advocacy. As students gained knowledge about what we call the *primary care way*, students could better contextualize the questions or concerns of providers. For example, students could understand the premiums placed on time and space. From this position, students could tailor their approach to PCPs to enhance the PCP workflow. Additionally, faculty and supervisors emphasized the importance of ongoing psychoeducation about the PCBH model to their teams. Students are encouraged to be proactive in reviewing daily patient schedules for prospective services (i.e., *scrubbing the schedule*) and educating providers about how BHC services can augment patient care. The use of the BHC competency tools also facilitated this process, which encouraged students to consistently engage in behaviors conducive to BHC practice.

### **Challenge: Shortage of Spanish-Speaking Service Providers**

A final challenge we faced related to a shortage of Spanish-speaking service providers. Some sites offered formal translation services (i.e., in-person medical translator, phone- or tablet-based translators), while others utilized informal resources (i.e., other staff members). When placing students, we prioritized placement of bilingual trainees at locations with the greatest number of Spanish-speaking patients. However, we were not able to accommodate all sites.

## **Solution: Recruitment and Resources**

We have implemented several solutions to address this challenge. Among these, we have moved to weighing Spanish language fluency more heavily in PITCH selection criteria. We also are exploring future partnerships with the bilingual counseling certificate program that is housed in the University of Texas at San Antonio Department of Counseling. Additionally, we provide basic training and support to trainees related to the use of translators (in-person and virtual), and we have employed Spanish-speaking doctoral graduate assistant supervisors where possible for extra support.

## **Discussion**

The implementation of PITCH provides challenges but also solutions to the growing need for counselor education to focus on training in primary care. Patients prefer behavioral health services in primary care (Ogbeide et al., 2018). Thus, equipping the behavioral health workforce to provide services in this setting has proved to be imperative. Although primary care and interprofessional education is relatively new to counselor education, other behaviorally inclined disciplines (e.g., psychology, social work, nursing) have provided a training blueprint for counselor education programs to use and continue developing a place for themselves in primary care (Hooper, 2014; Vogel et al., 2014).

Serrano and colleagues (2018) shared recommendations for PCBH workforce development. These recommendations include: (a) development of an interprofessional certification body; (b) PCBH-specific curricula in graduate studies, including both skills and program development; (c) a national employment clearinghouse; and finally, (d) coalescing knowledge around provision of technical assistance sites. Below we discuss the implications of counselor education programs seeking to advance PCBH workforce development.

## **Standardized Training Models**

An important implication for training future counselors is the use of standardized training models (Tang et al., 2004). Throughout this article, much of the focus has centered on the PCBH consultation model (Reiter et al., 2018). In recent years, training standards have emerged for BHCs in primary care. These standards focus on a psychologically informed, population-based approach to treatment, in which BHCs are trained to create clinical pathways, collaborate with medical providers, conduct a brief functional assessment, and provide a brief behavioral intervention, mostly consisting of skills training and self-management (Reiter et al., 2018)—all of which is done in under 30 minutes. This clinical practice approach has become the de facto model in most BHC preparation programs throughout the United States (Hunter et al., 2018) and is currently endorsed by the Veterans Administration and the Department of Defense for integrated primary care (Funderburk et al., 2013). However, inconsistencies exist in how the PCBH model is taught, and there is a lack of available internship opportunities for master's-prepared behavioral health providers to receive clinical training (Hall et al., 2015). This challenge is especially relevant to future counselors, who lack a standardized model of training for primary care (Hooper, 2014). Our experience suggests that programs such as PITCH accomplish the joint goals of focusing on instruction and supervised practice in PCBH, developing BHC competencies, and meeting accreditation standards of orienting counselors to their role in integrated care settings (CACREP, 2016).

## **Behavioral Health Integration**

One of the largest challenges facing the PCBH model is behavioral health integration (Hunter & Goodie, 2010). Moreover, the PCBH model requires full integration (e.g., Level 5–6 integration) to be



maximally effective. Traditionally, PCPs would refer patients to a local mental health practitioner for issues related to depression or anxiety (Cunningham, 2009). However, these referrals would result in a low rate of success and deter many individuals from seeking out mental health services in the future (Davis et al., 2016). Co-located care (an in-house mental health practitioner conducting traditional psychotherapy or counseling) became the logical next step. This level of integration resulted in quicker referrals but led to poor communication and confidentiality issues between PCPs and mental health providers. This also left out other common, behaviorally influenced conditions in primary care such as diabetes, chronic pain, hypertension, and tobacco cessation (which are not routinely addressed or treated by mental health providers). Full integration (in which PCPs and mental health providers work collaboratively in the same setting) has become the ideal standard for the integration of behavioral health services in primary care (Heath et al., 2013).

Despite the many benefits, full integration might be impractical for clinics just beginning PCBH services. Clinics may not have the staff support, leadership support, and organizational buy-in to be successful because “successful integration is really hard” (deGruy, 2015). Integration, in a sense, causes a necessary disruption in how a clinic functions and serves patients. Although necessary, it is still a disruption and it can take time for a team to normalize their new way of practicing primary care. Clinics may need specific support to help establish pathways for behavioral health referrals (Landis et al., 2013), allow clinic staff more time to adjust to integrated services, and provide a pathway for the development of fully integrated services (Reiter et al., 2018). Investing in technical assistance experts can aid in integration efforts (Serrano et al., 2018). Additionally, clinics that already offer co-located services might benefit from a quality-improvement plan (Wagner et al., 2001) such as a plan-do-study-act model (PDSA; Speroff & O’Connor, 2004) to move to a higher level of integration. A sample PDSA cycle might consist of identifying barriers to improved patient care, creating a team-based plan for addressing barriers, designating a project overseer, tracking outcomes across time, and evaluating project success (Speroff & O’Connor, 2004). Both suggestions are great steps toward full integration and can be performed by counselors and counselor educators with training in PCBH and program evaluation (Newcomer et al., 2015). Funding for counselors in BHC roles would assist in meeting the aforementioned goals.

### **Funding for Counselors in PCBH**

One of the greatest barriers to providing accessible behavioral health services in primary care is funding (Robinson & Reiter, 2016). Insurers are just beginning to reimburse for same-day services (both a PCP and BHC visit; Robinson & Reiter, 2016). However, this recent development has primarily benefited psychologists and social workers in primary care and excludes licensed counselors, who account for 14%–25% of the mental health labor force (U.S. Department of Health and Human Services, 2016). Licensed counselors are a crucial part of the growing behavioral health workforce (Vogel et al., 2014) and bring a strong wellness and systems-based perspective to primary care (Sheperis & Sheperis, 2015). Furthermore, licensed counselors, along with other behavioral health providers, can help in a variety of ways such as reducing patient costs in the medical system (Berwick et al., 2008), reducing patient emergency room visits (Kwan et al., 2015), and implementing continuous quality improvement (Wagner et al., 2001).

Robinson and Reiter (2016) offered several suggestions regarding funding for BHCs unable to conduct same-day billing. The first is for BHCs to understand that PCPs will always be the main source of clinic revenue. Therefore, BHCs can provide support to the primary care team through behavioral consultation; improve screening and clinical pathway procedures; provide support for difficult patients and frequent visitors; and reduce PCP visit time through *warm handoffs*, with the patient witnessing the transfer of their care between PCP and BHC. Second, BHCs can secure bottom-up support from PCPs by providing “curbside” consultation services (consulting face-to-face with PCPs about a patient without directly

treating the patient). It comes as no surprise that PCPs feel more supported when BHCs are an available part of the medical team. Third, BHCs can generate top-down support through billing for group visits such as drop-in group medical appointments and 30-minute follow-up visits (Robinson & Reiter, 2016). Finally, grants represent another potential source of funding for behavioral health implementation (HRSA, 2017, 2018). HRSA and SAMHSA have been a tremendous resource in providing training grants specifically aimed at increasing the BHC workforce (e.g., HRSA, 2017) and addressing the nation's opioid epidemic (e.g., HRSA, 2018). In Texas, the Hogg Foundation has provided training grants for training future BHCs. Finally, the counseling profession must continue advocacy efforts toward establishing licensed counselors as Medicare providers. With this key change, licensed counselors would be more readily employable in medical settings (Dormond & Afayee, 2016).

## Conclusion

Primary care has been the de facto mental health system in the United States for decades. Providing comprehensive primary care to patients is imperative, and in order to do this well, our workforce needs to be equipped to meet the growing behavioral health needs where patients show up to receive care. Given clinical measures such as successful patient outcomes and CACREP accreditation standards targeting integrated health care knowledge, it behooves counselor training programs to consider developing models for BHC training. This article presents the key aspects of the PITCH program in the hopes that our model will be useful to other counselor education programs as the profession moves toward integrated practice models in order to meet the ever-changing needs of the health care landscape.

### *Conflict of Interest and Funding Disclosure*

PITCH is funded by a Behavioral Health Workforce Education and Training grant from the Health Resources and Services Administration. There is no known conflict of interest.

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