TEAM UP | SCALING & SUSTAINABILITY CENTER™

Integrated Care Team Role Development Guide

TEAM UP Scaling and Sustainability Center
Boston Medical Center
960 Massachusetts Avenue
Boston, MA 02118

www.teamupcenter.org

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Introduction

Team-based care is core to the TEAM UP Model™. The model utilizes a multidisciplinary integrated care team consisting of three primary roles: primary care providers (PCPs), behavioral health clinicians (BHCs), and community health workers (CHWs). All three roles are fully embedded within the primary care clinic operating as part of the same care team, unlike other models that rely on coordinated or co-located behavioral health supports. The model's efficacy relies on the unique expertise of these three roles in providing coordinated, comprehensive integrated behavioral health care to address the developmental and behavioral health needs of children and adolescents within the clinic. This model emphasizes consultation between all three roles such that patient care is shared across the team versus other models that emphasize referral and handoff alone.

Table 1. Core Scope of Practice for each Member of the Integrated Care Team

PCPs	BHCs	CHWs
• Assessment with standardized screeners, e.g., SWYC, PSC • Anticipatory guidance relevant to age and visit • Identification of developmental or behavioral concerns • Diagnosis of common behavioral health conditions • Psychoeducation and treatment planning • Medication initiation and management • Consultation across the care team	• Assessment with standardized screeners, e.g., PHQ, GAD, SCARED • Identification of developmental, behavioral, or relational concerns • Diagnosis of common behavioral health conditions • Psychoeducation and treatment planning • Brief intervention and psychotherapy • Periodic reassessment of symptoms • Behavioral medicine • Consultation across the care team	• Child and caregiver engagement, including problem solving, parenting support, and coaching • Psychoeducation and advocacy • Care coordination and systems navigation with schools, Early Intervention, and other community agencies • Referrals to community-based services • Consultation across the care team

Staffing Plan Development

As practices begin their process to implement the TEAM UP model, they develop a staffing plan based on the size of their patient population to ensure that BHC and CHW roles are each staffed at a ratio of about 1 FTE to every ~3,000 patients. For example, a practice with 4,500 pediatric patients would develop a staffing plan with 1.5 FTE for the BHC role and 1.5 FTE for the CHW role. In cases where hiring staff at 0.5 FTE is a challenge, practices sometimes opt to hire 2 FTE CHWs and 1 FTE BHC or the inverse. Practices with patient populations of less than 3,000 hire a minimum of 1 FTE for each role.

Like all components of the model, staffing ratios have been developed in collaboration with partnering practices to ensure members of the team are able to accomplish their full scope of work. However, the level of need within the patient population and the availability of additional resources in the practice and community are important to consider when determining the exact staffing plan for each practice. Some practices need more BHC and/or CHW resources while others might be able to provide the same level of care with a different configuration.

Each practice develops BHC and CHW job descriptions that fit with their organization's needs and norms, while also maintaining that the job descriptions align with established TEAM UP role definitions. Practices also consider the role of the PCP on the care team to ensure that organizational expectations and job descriptions for this role align with the scope of work necessary to implement the TEAM UP model.

Additional Roles in Integrated Care

Other models or frameworks for integrated behavioral health care emphasize different or additional roles on the care team. These can include but are not limited to referral specialists, behavioral health specialists, and care managers. There is significant overlap between these roles and those defined within the TEAM UP model. Practices that have some of these roles already in place benefit from partnering with TEAM UP Center staff to consider how their existing roles will shift, evolve, or collaborate with those of the TEAM UP model.

Psychiatrists and psychiatric nurse practitioners are also common roles on integrated care teams. Their unique scope and expertise can support capacity building among the primary care team to address behavioral health issues within the medical home; however, they are not required roles within the TEAM UP model. When these positions are available within the practice at large or as additional members of the integrated care team, their role is often focused on education and consultation to primary care providers, diagnostic confirmation, and assessment and management of complex needs.

Utilizing this Guide

This guide includes detailed overviews for each of the three core roles within the TEAM UP model with a particular emphasis on the skills and responsibilities that are unique to delivering integrated care. These overviews provide guidance for practices to develop a staffing plan for implementing the model within their setting. Practices use these overviews to help define new roles on the integrated care team which may involve hiring new staff, transitioning existing roles from other areas of the practice, and/or re-setting expectations for staff and providers to be in alignment with the goals of the TEAM UP model.

Though practices solidify members of their integrated care team at the start of TEAM UP model implementation, development of these roles continues over time. To support these roles, the TEAM UP Center Learning Community provides role-focused trainings and consultation with the goal of increasing knowledge and skills in team-based assessment and management of developmental and behavioral concerns as outlined in each role overview.

Role Overview: Behavioral Health Clinician

Behavioral health clinicians (BHCs) on the integrated care team provide assessment, consultation, and therapeutic intervention to address mental and behavioral health needs within primary care. Integrated behavioral health clinicians share their expertise across the primary care team to build mental health awareness and capacity as part of standard practice. They are equipped to provide a range of therapeutic services from brief to longer-term interventions for children from birth to transitional age and their families.

Required Education/Experience

- Master's level degree in social work, mental health counseling, or marriage and family therapy, or doctoral-level training in psychology (e.g., PsyD, PhD, or EdD)
- Experience working in a behavioral health or medical setting with child clinical training
- Bilingual and/or bicultural preferred

Certification/Licensure

- Current state licensure (e.g., LCSW, LICSW, LMHC, LMFT, LPC) or planned pathway to licensure, with support from the practice where applicable

Core Competencies (Skills)

- Able to provide brief, evidence-based therapeutic interventions that adhere to the primary care model and support improved patient functioning
- Able to provide behavioral health services to patients with less complex presentations and accurately step up care/refer to specialty care for more complex cases
- Skilled in collaborating with specialty care in supporting children with complex needs in the medical home
- Able to make quick and accurate clinical assessments of mental and behavioral conditions
- Knowledge of common chronic conditions in pediatric primary care, including symptoms, mechanisms, common co-occurring behavioral health problems, and appropriate treatment
- Able to apply population health framework to patient care
- Comfortable functioning effectively as a member of an interdisciplinary team
- Possess strong communication and consultation skills
- Knowledge and comfort in using screening tools to assess for mental health conditions
- Strong documentation skills and ability to use electronic health records for team-based communication on behalf of patients
- Knowledge of culture's impact on health and the ability to incorporate patient beliefs into treatment planning
- Possess strong care management skills and knowledge of local resources for outside referrals

- Skilled in using a collaborative, culturally responsive, and trauma-informed approach in patient/family engagement
- Training or knowledge in the following topics:
    - Interaction between biology, health, and behavior
    - Biological components of health and disease
    - Common psychotropic medications and their uses and common side effects

Core Responsibilities

- Provide comprehensive assessment, confirmation of diagnosis, consultation, and brief intervention for less complex presentations of behavioral conditions
- Consult with integrated care team (PCP and CHW) to provide effective treatment planning and assist patients in successfully achieving goals
- Contribute to the development of care management processes such as the use of guidelines, disease management techniques, case management, and patient education to improve self-management of chronic disease
- Provide timely feedback to the PCP and others involved in patient care, both verbally and through documentation of patient progress and diagnostic information in the patient record
- Teach patients, families, and staff care, prevention, and treatment enhancement techniques
- Assist in the detection of “at risk” patients and development of plans to prevent further psychological or physical deterioration
- Actively participate in meetings to support implementation and improvement of practice’s integrated care model
- Monitor the practice’s behavioral health program, identifying problems related to patient services and making recommendations for improvement

References

- SAMHSA-HRSA Center for Integrated Health Solutions Core Competencies for Integrated Behavioral Health and Primary Care
- Agency for Healthcare Research and Quality (AHRQ) Provider- and Practice-Level Competencies for Integrated Behavioral Health in Primary Care
- Cherokee Health Systems Behavioral Health Consultant Job Description

Role Overview: Community Health Worker

Community Health Workers (CHW) are critical members of the integrated care team. Under the supervision of a licensed BHC, CHWs works alongside PCPs and BHCs to address the developmental and behavioral health needs of patients.

The CHW role is distinct from a Case Manager, Care Coordinator, or Resource Specialist in that the role is grounded in shared characteristics with the population served, e.g., language, race/ethnicity, experience, and community knowledge. In this role, the integrated CHW engages children and families, provides education and care coordination to address care gaps, and attends to medical, behavioral, and health-related social needs. Given this scope of work, some practices choose to operationalize the role as a Family Partner, further defining the position with an emphasis on lived experience as a parent, caregiver, or guardian.

The integrated CHW works with patients to improve overall health outcomes. They assess strengths, needs, and barriers to accessing care and often act as a primary point of contact for caregivers, providing mentorship and supporting access to care at various critical junctures. They also connect families facing economic and social challenges to community resources.

The integrated CHW adheres to high professional standards of conduct and maintains respectful and culturally responsive engagement with patients and colleagues. The integrated CHW effectively manages a caseload of patients with complex needs and communicates all service delivery by accurately documenting interventions and engagement activities within the patient record. As a core member of the integrated care team, the CHW attends and actively engages in all pertinent meetings, trainings, and supervision with their medical and behavioral health colleagues.

Required Education/Experience

- High school diploma or equivalent with a minimum of 2 years of experience in a community-based medical or behavioral health setting
- Bachelor's or associate degree in a human service-related field preferred
- Experience working with diverse populations and within the local community
- Experience as a parent/caregiver/guardian preferred
- Bilingual and/or bicultural strongly preferred

Certification/Licensure

- CHW certification varies by state and is strongly encouraged where applicable

Core Competencies (Skills)

The TEAM UP model promotes three core skill areas that build upon common CHW competencies to support the specialization of the integrated CHW role as an essential member of the integrated care team. These foundational competencies support CHWs in effectively bridging clinical and community services and contributing meaningfully to whole-person care in the context of integrated behavioral health.

- **Engagement**
  - Able to engage and maintain trusting relationships with patients and families
  - Competence in providing direct services, including but not limited to informal counseling, coaching, assessments, and facilitating connections to self-care and supportive resources
  - Knowledge of screening and assessments to identify needs, strengths, and barriers to accessing care
  - Comfort in evaluating readiness for change and identifying actionable steps and strategies to support change
  - Able to assist in the development and implementation of behavioral and care plans, ensuring the family's voice and autonomy are central to the planning process
- **Education**
  - Able to provide culturally responsive education and support to patients and families to deepen understanding of physical, developmental, and behavioral health needs, promote wellness, and encourage healthy behavior change
  - Skilled in acting as a cultural mediator between individuals, families, care teams, communities, and service providers by facilitating multidirectional learning and mutual understanding; this includes educating care teams about cultural factors that influence health beliefs and behaviors, while also supporting families in navigating expectations and practices across systems, e.g., health care and school
  - Competence in providing education on physical, developmental, and behavioral health information to children and families to foster resilience, support prevention, and reduce risk
  - Able to support the development of self-advocacy skills and informed decision-making abilities by strengthening patients' and families' knowledge, confidence, and capacity to navigate care and services with autonomy
- **Care Coordination**
  - Skilled in assisting patients and families in navigating various systems, including medical, behavioral health, and school, and accessing community resources and services
  - Able to collaborate with patients, families, and care teams to coordinate care across systems, including transitions, referrals, and scheduling or managing appointments
  - Comfort in utilizing data and evidence-informed practices to monitor care progress and improve coordination between patients, families, and care teams
  - Able to develop and maintain community partnerships to expand resource options and expedite seamless connection to services

Core Responsibilities

- Utilize evidence-based engagement strategies, such as motivational interviewing (MI) and problem-solving techniques, to engage and maintain trusting relationships with patients and caregivers, and to assess for and monitor emerging needs for prevention, wellness, medical, and behavioral health care
- Assist families in developing and implementing goal setting and action planning
- Partner with patients and caregivers to promote successful execution of treatment plans and ensure continuity of care by assessing readiness to change, identifying and addressing barriers, and assisting patients/families in taking action
- Provide education and information to caregivers to improve their knowledge and understanding of typical child development and mental and behavioral health issues, including symptoms, diagnosis, management strategies, and available resources and services to promote informed decision making
- Strengthen patients' and caregivers' self-management skills to anticipate and address barriers to accessing services and treatment, e.g., transportation, gathering supporting documents, and advocating
- Provide psychoeducation to strengthen patients' and caregivers' capacity for self-assessment, such as identifying escalating symptoms, the need for emergency services, etc.
- Ensure continuity of care through ongoing collaboration with patients, caregivers, PCPs, BHCs, and other care team members to provide comprehensive care coordination
- Support referral processes and assist families in accessing and connecting to appropriate services for behavioral and developmental health needs
- Identify and build relationships with community partners, such as Early Intervention, community behavioral health centers, schools, and other local service providers to increase capacity for collaboration

References

- Project Launch Family Partner Role
- Massachusetts Board of Certification of CHWs Core Competencies for CHWs
- Massachusetts Board of Certification of CHWs Privileges, scope of practice and responsibilities of a Certified CHW

Role Overview: Primary Care Provider

Primary Care Providers (PCPs) provide ongoing medical care for children and families. From birth to young adulthood PCPs provide routine and acute care to their patients. Routine care includes tracking social and emotional development and providing anticipatory guidance around normal development. When a problem or concern is noted, PCPs seek consultation by referring children for specialty evaluations and treatment. PCPs coordinate all services, including referrals to specialty care.

PCPs are often the first point contact within the integrated team. Well child visits include standardized screening tools to assess social and emotional concerns. When there is a positive screen or caregiver concern, the integrated team is available to help with the assessment and collaborate together and the family to put a plan in place. Once a diagnosis such as ADHD, depression, or anxiety is made, PCPs are able to discuss treatment options including medications to help support the patient.

Required Education/Experience

- Physician (MD or DO), nurse practitioner (NP), or physician assistant (PA)
- Completion of residency or training in pediatrics or family medicine
- Experience providing primary care to children and adolescents
- Bilingual and/or bicultural preferred

Certification/Licensure

- Valid state licensure and board certification equivalent to applicable credentials

Core Competencies (Skills)

- Understanding of screening tools recommended by the American Academy of Pediatrics to assess social and emotional development
- Strong clinical diagnostic skills and knowledge of evidence-based medicine, inclusive of child and adolescent development and mental and behavioral health
- Competence in the diagnosis and interventions for ADHD including medication management
- Competence in the diagnosis of depression and anxiety in children and adolescents with understanding of interventions including medication management in older children and adolescents
- Understanding of autism screening and diagnostic process
- Understanding the impact of learning disabilities, neurodevelopmental delays, and social emotional issues on educational success
- Understanding of team-based care model and roles of other members on the integrated care team
- Strong communication skills and commitment to team collaboration

Core Responsibilities

- PCPs provide a range of services for both physical and behavioral health needs, including:
    - Preventive care
    - Care for an acute illness
    - Care for chronic or ongoing conditions including neurodevelopmental and behavioral health problems
    - Skills to provide diagnosis and medications for ADHD
    - Collaboration with other members of the integrated care team, e.g., BHC and CHW, to establish diagnoses of depression and anxiety and consider medication management in addition to other interventions
    - Timely and thorough documentation and interdisciplinary communication within the standard electronic health record

References

- HealthCare.govCa-Glossary – primary-care-provider
- SAMHSA-HRSA Center for Integrated Health Solutions Core Competencies for Integrated Behavioral Health and Primary Care
- Agency for Healthcare Research and Quality (AHRQ) Provider- and Practice-Level Competencies for Integrated Behavioral Health in Primary Care