Competencies for Family Therapists Working in Healthcare Settings

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Executive Summary

In 2013, a team of family therapists came together to initiate the design and development of core competencies for family therapists working in healthcare settings. They were responding to an increasing number of family therapists seeking and being sought after for positions in such settings. Family therapists expressed a desire to ensure their knowledge and skills were relevant for the particular contexts in which they were being employed. As the healthcare industry expands its interest in incorporating behavioral providers into conventionally-biomedical settings, it has compelled major changes in workforce training across all behavioral health disciplines. Several such disciplines have responded to this by creating competencies that guide their members in developing the knowledge, skills, and abilities necessary for delivering care. Family therapists are well-suited for working in primary, secondary, and tertiary healthcare settings because of their skills in psychological and relational assessment, diagnosis, and treatment. They are valuable members of healthcare teams because they understand the ways that systems best form and function, and they have a wide range of skills for working with one or more people in the room.

The following report includes competencies recommended for family therapists working in healthcare settings. The information presented should be considered on a continuum. This means that a family therapist working in a healthcare setting does not have to master all of the listed competencies. Rather, supervisors, educators, employers, and learners should use these as a guide based on the context(s) in which they are positioned. There are six broad domains anchoring the report. Under each domain are competencies broken down by: (a) clinical skills; (b) training and supervision; (c) healthcare management and policy; and (d) scholarship. Examples of target indicators are provided to illustrate the application of each competency.

Six Anchoring Competency Domains

1. **Systems:** integrating and implementing systems theory concepts and ideas.
2. **Biological, Psychological, Social, and Spiritual:** recognizing that health is comprised of all four areas of mutual influence.
3. **Collaboration:** working cooperatively with others to maximize the benefits of team-based care, research, policy work, and training.
4. **Leadership:** guiding systems toward a more collaborative and integrated approach to health care, as well as championing for resources so that healthcare systems function at their highest capacity.
5. **Ethics:** promoting the highest standard of work in accordance with the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics, in recognition of other healthcare team members' codes of ethics, and in accord with rules and laws governing one's profession and professional setting.
6. **Diversity:** recognizing various groups, communities, and cultural influences that impact the delivery, response, policies, and study of integrated behavioral health care.

The developers of these competencies strongly support the design of evaluation mechanisms and shared curriculum to help streamline the content, delivery, and measurement of the competencies outlined in this document. This report is designed to be a resource for family therapists, training programs, educators, supervisors, researchers, administrators, policy makers, and employers to ensure that those being considered for positions where these skills and knowledge are needed are using a similar lexicon and have consistent expectations for family therapists functioning within healthcare settings.

Introduction & Background

Growing numbers of providers, training programs, educators, supervisors, researchers, administrators, policy makers, employers, and even patients/clients and families have been advocating for mending the fragmentation of mental and physical health care. Their focus is geared toward designing a system of health care prepared to treat the whole health experience. Underlying this is the realization that at least 50% of patients continue to present in primary care offices with needs that are psychosocial in nature (Ansseau et al., 2004; Serrano-Blanco et al., 2010; Toft et al., 2005). They come hoping that their primary care providers will be able to treat these psychosocial conditions in synchrony with physical needs (Kessler & Stafford, 2008; Reiss-Brennan, 2010). Other times, patients may not realize that they are experiencing a physical manifestation of their psychosocial health, or that they are having a psychosocial response to a physical condition. Professionals trained in traditional methods are not equipped to function in the healthcare teams that can fully address these complex needs. Our system requires a new generation of behavioral health providers trained to work in healthcare settings.

Family therapists offer a unique skillset in healthcare contexts. As one of the five recognized core behavioral health professions by SAMSHA-HRSA, and through their extensive training in the principles of general systems theory and evidence-based models of care, they are well-equipped to function successfully in a wide range of healthcare settings. With this foundational understanding of systems, their skillset transitions readily into needed areas of competency to function successfully as behavioral health providers in a wide range of healthcare settings. However, an expanded skillset is needed for family therapists to function successfully in any healthcare environment. Those who apply these competencies may identify as family therapists who work in healthcare settings and/or as Medical Family Therapists (MedFT).

In 1992, Susan McDaniel, Jeri Hepworth, and Bill Doherty introduced how family therapists are important to advancing health in their seminal text, *"Medical Family Therapy: A Biopsychosocial Approach to Families with Health Problems,"* and there has been a continued growth in this area of family therapy ever since. They published a second edition of their book (McDaniel, Doherty & Hepworth, 2014) with an even stronger emphasis on the clinical skills needed for integration into healthcare settings. Their contemporaries Jennifer Hodgson, Angela Lamson, and Tai Mendenhall, along with co-author D. Russell Crane, published *"Medical Family Therapy: Advanced Applications"* in 2014 to further the success of family therapists in healthcare settings through training, research, policy, and finance. This text also included the Medical Family Therapy Healthcare Continuum (see Appendix A; Hodgson, Lamson, Mendenhall, & Tyndall, 2014), wherein general categories of skills and knowledge for those practicing MedFT are presented to highlight the variety of ways that the work can be implemented. However, while the concept of family therapists working with patients and families from a biopsychosocial (BPS) lens has been around since the field's inception in the 1970s (Engel 1977; 1980), with the addition of spirituality (i.e., BPSS) in the 1990s (Wright, Watson, & Bell, 1996), there has been an increasing need to articulate a skill set and competencies around the work done by family therapists in healthcare settings.

Development of the Competencies

The work of the current project (i.e., the development of MedFT competencies) began approximately 20 years after the term "Medical Family Therapy" was first coined by McDaniel et al. (1992). Results from a modified Delphi study highlighted that the scope of work by family therapists in healthcare settings was evolving and growing (Tyndall, Hodgson, Lamson, White, & Knight, 2010). The competencies created in 2010 began to touch on the educational infrastructure(s) needed to ensure professionalism by MedFTs in clinical contexts (Tyndall, Hodgson, Lamson, White, & Knight, 2012; Tyndall, Hodgson, Lamson, White, & Knight, 2014). In 2013, a group of interdisciplinary experts in

the field of MedFT (i.e., individuals who demonstrated professional expertise based on publications, presentations, teaching, or clinical experience in health care who also self-identified as licensed family therapists practicing in the field of MedFT) initiated a response to the following grand tour questions: (a) *What are the global domains that you believe are essential for family therapists working in a healthcare context?;* (b) *What competencies do you believe a family therapist working in a healthcare context should possess or demonstrate under [name of domain]?*

This process was facilitated by a scaffolding structure that was already used by sibling disciplines for a similar purpose, e.g., Psychology (American Psychological Association, 2015), Social Work (Council of Social Work Education, 2015). Over a period of four years, more than 30 volunteer expert participants from 23 unique healthcare settings and training contexts (ranging from newer to more experienced) convened through conference calls and emails. Methods used to recruit participants included purposive sampling grounded in a review of the academic literature and a review of individuals affiliated with institutions of higher education that offer academic courses or educational programs with a focus on family therapy in a healthcare context. Participants had to meet the following inclusion criteria, which included at least one of each of the following (one from A and one from B):

A. Professional expertise in the topic area evidenced by one of the following:

   a. More than five publications about or pertaining to healthcare research or intervention by the expert;

   b. Five or more years spent teaching or training family therapists to work in a healthcare context or conducting research in healthcare by the expert;

   c. Five or more professional presentations about or pertaining to healthcare research or intervention by the expert; or

   d. Active clinical license, and/or five or more years of clinical experience providing family therapy in a healthcare context.

B. Professional allegiance evidenced by one of the following:

   a. Self-identification as a family therapist in a healthcare context, or

   b. Current focus of professional work as a family therapist in a clinical, research, legislative, policy, or academic healthcare context.

Exclusion criterion were: mental health providers whose professional work involved engagement in collaborative healthcare or integrated care work, but who did not identify themselves as a family therapist in a healthcare context.

Participants worked in small and large groups to establish the domain areas, subsequent competency areas, and target indicators. In the winter of 2017, a group of eight were selected to carry out the final effort and met for two full days at the American Association for Marriage and Family Therapy (AAMFT) headquarters to create a final draft. This document was then returned to the other participants for member-checking and additional editing to ensure that the original intent of the domains and competencies were still intact. Lastly, the document was provided to additional stakeholders for their input and comments to inform the final editing.

These competencies stand on the foundation of competencies for the profession of marriage/couple and family therapy constructed by the American Association for Marriage and Family Therapy (2004). While those foundational

family therapy competencies, as well as the AAMFT Code of Ethics (2015), are designed for the general family therapy professional, this set is more specific for those family therapists choosing to work in a healthcare setting. These competencies were designed for use by educators, supervisors, and trainers to inform consistent training for family therapists who intend to work in a healthcare setting. While they share commonalities with competencies developed across sibling disciplines for healthcare settings, these competencies also demonstrate the unique skillsets and contributions of family therapists as a profession.

The following document is organized into six domains (systems, biopsychosocial-spiritual, collaboration, leadership, ethics, and diversity). Within each of those domains are four competency categories or areas of work in which a family therapist in a healthcare setting might engage: (a) clinical work; (b) healthcare management and policy; (c) scholarship; and (d) training and supervision. All family therapists working in a healthcare setting will not be expected to master each of these competency categories; however, this document is meant to be used as a reference point for skill development needed for a specific job and subsequent evaluation. For example, if a family therapist in a healthcare setting is hired to conduct research, the competency category named "scholarship" would be a critical competency category under each domain to direct one's professional skill development and be evaluated for success. Lastly, the target indicators are meant to be examples of tangible means of evaluation. In other words, the target indicators include ways in which the competency could be seen and demonstrated. Because the meaning and shared understanding of terms is critical to growing together, a glossary is also included at the end of this document.

Six Anchoring Competency Domains

1. **Systems:** integrating and implementing systems theory concepts and ideas.
2. **Biological, Psychological, Social, and Spiritual**: recognizing that health is comprised of all four areas of mutual influence.
3. **Collaboration:** working alongside and cooperatively with others with the intention to promote and provide a cooperative and organized approach to health care.
4. **Leadership:** guiding systems toward a more collaborative and integrated approach to health care, as well as championing for resources so that healthcare systems function at their highest capacity.
5. **Ethics:** promoting the highest standard of work in accordance with the American Association for Marriage and Family Therapy (AAMFT) Code of Ethics, in recognition of other healthcare team members' codes of ethics, and in accord with rules and laws governing one's profession and professional setting.
6. **Diversity:** recognizing various groups, communities, and cultural influences that impact the delivery, response, policies, and study of integrated behavioral health care.

It is the intention of the team preparing this document that it will be regularly reviewed and revised in accordance with our field's ongoing development and evolution. These competencies will be reviewed every five years to look for areas where more clarity and revisions are indicated. Questions, ideas, or concerns regarding this document are welcome and should be directed to Dr. Jennifer Hodgson (hodgsonj@ecu.edu).

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Domain 1: Systems

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
1.1 Clinical	1.1a Discerns within and between each of the BPSS dimensions relevant to health and wellness across levels of clinical care using a relational and systemic lens.	Explains and operationalizes appropriate literature to conceptualize systemic practice (e.g., Family Therapy, Medicine, Medical Family Therapy, Nursing, Psychology, Public Health, Social Work). Uses clinical models that promote relational and BPSS health and well-being in the care for patients, families, communities, physicians and/or physician extenders, and the healthcare team. Articulates and applies within and between each of the dimensions of the BPSS framework in their healthcare settings using a relational and systemic lens: (a) in the presence and absence of illness; (b) in traditional and integrated behavioral health sessions; (c) in clinical debriefing with the healthcare team on behalf of patient/family care; (d) across developmental stages and the lifespan. Describes the reciprocal interactions of BPSS dimensions amongst individuals, family, social support, and larger systems (e.g., healthcare team member self-care, healthcare team member self-reflections, healthcare team member-patient/family relationships, and supervisor-healthcare team member relationships).
	1.1b Recognizes the multi-directional influences between family/ support systems and healthcare systems.	Facilitates communication between and among patients/clients, families, healthcare team members, community partners, and payers from a systemic/relational perspective. Encourages healthcare team members and patients to balance conversations about illness/well-being, health/wellness, and deficits/resilience while considering relational health. Identifies and appropriately intervenes in issues that involve violence (e.g., domestic violence, adverse relational issues) and trauma (e.g., abuse, neglect, sexual violence, war). Considers family/support systems and healthcare team members in each treatment plan and involves them as appropriate in practice (e.g., organize family meetings to clarify agenda and increase support).

	1.1c Considers systemic/ relational challenges and resources when promoting health behavior change.	Encourages healthcare team members to engage the family/ support system, and in lifestyle and behavior modification (e.g., accessing social support, consultation and meetings, family meal planning). Develops and shares brief evidence-based references and resources (e.g., handouts, tip sheets) for team members on understanding importance of relationships on health and health outcomes.
	1.1d Demonstrates knowledge of systemic theoretical approaches as applied to BPSS and relational issues to treat patients and family/support systems.	Applies and adapts family/support systems theories and BPSS interventions to specific diagnoses (e.g., solution focused brief therapy for depression, emotionally focused therapy for couples facing trauma, structural family therapy for psychosomatic concerns, asthma and diabetes management). Develops standards of care protocols that reflect family/support systems involvement in treatment based on identified needs of the healthcare team and population trends (e.g., end of life discussions; advanced directives; large levels of prescriptions for ADHD; eating disorders; multiple family members with multiple chronic conditions / disease states).
1.2 Training and Supervision	1.2a Utilizes a systemic / relational and BPSS framework when mentoring, supervising, or teaching learners, behavioral health providers, healthcare providers, researchers, and administrators.	Ensures that BPSS and relational practice, research, and teaching activities are informed by evidence-based practices/research. Promotes proficiency in supervisees and learners' usage of family-oriented care tools and measures (e.g., genograms, five family-oriented questions). Links impacts of family systems and family behaviors to disease management and recovery process in discussions with medical/ healthcare team. Uses family systems concepts such as boundaries (rigid, open, enmeshed), structure (executive sub-system, parental sub-system, intergenerational coalitions), and relational processes (triangles, differentiation, family projection processes) to shape roles, learnings, and interactions with the healthcare team.

	1.2b Teaches about healthcare culture from a systemic/relational lens.	Develops and utilizes tools to orient and advance understanding regarding the healthcare culture (e.g., medical vocabulary tests, medical vs. behavioral health team member stereotypes, structural map of healthcare team and organization) and collaborative practices (e.g., guidelines for entering medical contexts, Peek's Three-World View). Aids learner in identification of key stakeholders and develops strategies to manage these relationships. Teaches reciprocal interactions and influences of the biopsychosocial-spiritual dimensions through self-reflexivity, individual and team level resilience training, self-of-the provider work, and team dynamics work.
	1.2c Facilitates opportunities for inter-professional collaboration and supervision for learners and supervisees.	Promotes and leads interdisciplinary learning opportunities (e.g., group supervision that includes MedFTs with Balint groups, didactics, precepting, morning rounds/huddles, palliative care team, pharmacy, and psychiatry residents). Develops and maintains relationships with community partners to provide training experiences. Identifies opportunities to develop services with other healthcare team members such as medical assistants, nurse practitioners, pharmacists, and case management staff. Develops and facilitates necessary support group services for learning with a special focus on healthcare team member-patient-system relationships.
	1.2d Exhibits responsiveness to intersecting needs of learners, patients, family members, and overall healthcare system.	Maintains an inviting and allied presence for all team members and attends to relationships that affect learners (e.g., frequently visits the practice floor and engages with patients, healthcare team members, allied professionals, and management). Identifies opportunities for relationship enhancement activities such as team building, community outreach, and community engagement to promote morale and relationship health.

1.3 Healthcare Management and Policy	1.3a Understands the management of systems integral to the provision of BPSS and relationally-oriented health care.	Identifies and convenes teams of systems facilitators to promote and circulate BPSS and relationally-oriented health care (e.g., advisory boards, implementation teams). Articulates historical and current collaborative relationships between care sites (e.g., community collaborations) in order to align the respective mission and vision statements of care contexts. Applies critical research and updates regarding practice-related changes that influence BPSS and relationally oriented policies.
	1.3b Educates healthcare team members, alongside policy- and decision- makers, about the benefits of systemic interventions and research.	Articulates and promotes BPSS and relationally-oriented research (evidence-based) to construct healthcare policy (e.g., leadership presentations, policy briefs). Influences practice patterns within the clinic by aligning to national and other standards as appropriate.
	1.3c Advocates for the inclusion and sustainability of family therapists in health care.	Creates a business model for sustaining family therapists in a healthcare setting (e.g., billing structure, overhead costs, productivity, salary). Designs, tests, and stabilizes multiple income generation methods (e.g., classes, group visits, special trainings, trainings for professionals). Advocates for accurate information in job-postings and training opportunities for family therapists in healthcare settings.
1.4 Scholarship Competency	1.4a Designs, evaluates, and disseminates systemic and relational programs of research with inter-professional colleagues.	Designs studies that highlight the systemic nature of health to further advance relational and dyadic research (e.g., BPSS dependent variables). Surveys and critiques existing literature to identify gaps and limitations in the implementation of team-based models. Develops and regularly communicates evidence-based findings to stakeholders who can advance systems' relational health. Identifies key performance indicators as evidence of outcome achievement (e.g., five consults per half day; two family meetings in a week).

	1.4b Understands the integration of research and practice through systematic applications of research to clinical work.	Articulates and justifies the importance of systemic and relational research in the practice system. Understands principles of dissemination and implementation science prior to selecting population specific intervention for targeted clinical research. Works with healthcare information technology to develop appropriate methods of capturing systemic data for clinical research and investigation.

Domain 2: Biopsychosocial-spiritual

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
2.1 Clinical Skills	2.1a Understands and applies ways to integrate the BPSS framework with health and family therapy theories and models.	Applies a broad range of evidence-based family therapy and health behavior theories and interventions in tandem with the BPSS framework with individuals, couples, families, and groups in healthcare systems.
	2.1b Identifies and applies BPSS framework in relation to diseases and conditions common to the setting.	Demonstrates integration of BPSS framework into: (a) direct care (i.e., assessment, diagnoses, treatment/intervention, monitoring/ follow-up); (b) treatment team collaboration; (c) development/ coordination of a comprehensive treatment plan; (d) clinical documentation and provision of resources with awareness of research and culturally informed practice for common diseases and conditions. Demonstrates knowledge of epidemiology, human anatomy, behavioral health, pathophysiology, physiology, and relational diagnoses in the context of cultural and spiritual beliefs and practices.
	2.1c Possesses a basic knowledge of psychopharmacology and pharmacology relevant to the target clinical population and any BPSS effects of these drugs.	Outlines the basic classes of psychotropic drugs, common uses, and potential BPSS side effects across the lifespan. Outlines the common medications prescribed in one's clinical practice setting, common uses, and potential BPSS side effects.

	2.1d Understands common biological and mental/behavioral comorbidities of various health conditions (e.g., chronic pain, depression) with consideration of cultural and spiritual beliefs and practices.	Describes major health conditions treated in one's clinical context and potential BPSS comorbidities in relation to patients' social locations, health histories, and social networks.
	2.1e Recognizes BPSS terminology and abbreviations in discussions, consultations, and documentation.	Communicates with consideration for the recipient's healthcare literacy, appropriate terminology and abbreviations in oral and written communication within biological, mental, relational and spiritual health (e.g., ADHD, BID, enmeshment, HEENT, hematoma, HNT, parentified child, triangulation).
	2.1f Distinguishes time, need, and content for consult using a BPSS framework with a variety of patients, families, healthcare team members, and community partners.	Inquires about multiple BPSS dimensions when consulting with patients, families, healthcare team members, community partners, and others relevant to care. Articulates how the BPSS dimensions interact with each other and/or influence care. Conducts a BPSS assessment with patients and families in preventing or dealing with health conditions. Refers to specialists with expertise in each of the BPSS dimensions when content or need for further evaluation/treatment falls outside the family therapist's scope of practice. Identifies the intersection of BPSS framework with diverse social locations and social determinants of health. Identifies patient/family centered care and population health factors through a BPSS framework.
2.2 Training and Supervision	2.2a Uses BPSS framework during administrative tasks, consultation, supervision, and training in a healthcare context (e.g., primary, secondary, and tertiary care systems) or other settings that incorporate the BPSS framework into traditional and integrated care models.	Evaluates supervisees' and learners' knowledge and application of the BPSS framework through a relational and systemic lens. Provides instruction, consultation, and mentorship on BPSS dimensions as they relate to ethical clinical care, research, policy, leadership, and collaboration with interdisciplinary professionals/teams in health care or other settings.

	2.2b Illustrates the historical foundation of the BPSS framework and current trends of its use.	Delivers training regarding the historical foundation of the BPSS framework and theoretical implications for BPSS practice, education, and research. Describes current trends regarding the BPSS framework and its influence on individual, relational, and domestic/global health.
2.3 Healthcare Management and Policy	2.3a Applies the BPSS framework through a relational lens to healthcare management and policy.	Creates and articulates healthcare protocols and policies that (a) integrate the BPSS framework; (b) are relationally oriented; (c) promote workflow organizational patterns that are efficient and sustainable; (d) honor the patient and healthcare teams' social locations. Contributes to the development of local, state/regional, national, and/or global healthcare policies that advance research, training, and treatment of BPSS concerns, evidence-based approaches, and practice-based evidence.
	2.3b Understands healthcare policies that advance BPSS and relational care.	Identifies BPSS polices and protocols that are indicated for clinical, research, and/or training healthcare contexts or populations. Articulates the benefits of BPSS and relational healthcare policies (when available) and constraints (when absent) to a wide range of audiences, from direct consumers to administrators, legislators, and/or researchers.
	2.3c Leads healthcare teams in adopting and maintaining BPSS informed protocols and policies.	Trains healthcare team members on how to execute BPSS informed protocol and policies. Implements processes that assist a team in reaching consensus regarding the utilization of the BPSS framework in the healthcare context. Evaluates protocols and quality improvement strategies for the inclusion of BPSS in practice, research, and/or training.
2.4 Scholarship	2.4a Utilizes contemporary literature and evidence-based models that integrate the BPSS framework into health care and health services research, practice, program development, and evaluation and/or policies.	Identifies seminal and current resources and empirical support for implementing and sustaining BPSS care and policies in the family therapist's professional setting. Applies qualitative, quantitative, and mixed-methods BPSS research and program evaluation into practice.

	2.4b Conducts BPSS research, program evaluation, and/or grant writing in healthcare settings with interdisciplinary teams.	Designs and participates in BPSS research, program evaluation, and/or grant writing (e.g., big data, clinical trials, dissemination and implementation studies, practice-based networks, qualitative inquiry). Maximizes use of statistical analyses, health informatics, content analyses, and health engineering to analyze BPSS patient/family centered data and population health data from Electronic Health Record (EHR). Complies with IRB and/or each setting's research approval processes, HIPAA, ethical and professional standards associated with data collection and research implementation/dissemination. Collaborates and consults with interdisciplinary teams, recognizing the needs from, and of, the community in relation to implementation and dissemination of BPSS research. Designs and conducts evaluations or research studies that include or recognize the involvement and integration of all BPSS dimensions into interventions and protocols in a healthcare setting.

Domain 3: Collaboration

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
3.1 Clinical Skills	3.1a Employs evidence-based models that promote inter-professional collaboration and relational care across clinical settings.	Articulates strengths, limitations, and potential biases of evidence-based integrated behavioral healthcare models. Incorporates evidence-based approaches while providing individual patient, couple, and/or family assessments, diagnoses, and treatment planning.
	3.1b Works effectively and efficiently across levels of integrated behavioral health care utilized by the system.	Identifies the level of integration appropriate to a healthcare context or healthcare team members (e.g., strengths/limitations of level of integration). Elicits and integrates feedback from patients, families, healthcare teams, support staff, and community partners to improve service delivery. Identifies and utilizes resources (e.g., clinic champions, community services) while providing integrated behavioral health services. Resolves workflow challenges to remove obstacles to care and maximize service to the population. Communicates openly with team members around power differentials and other aspects of diversity (e.g., race, gender, class) that may be present.
	3.1c Communicates individual and relational BPSS information collaboratively with the healthcare team.	Provides timely verbal and/or written communication directly to the healthcare team regarding each patient's assessment, diagnosis, care, and plan for treatment. Documents BPSS and relational healthcare information important to the patient's treatment plan in the EHR. Adopts medical terminology and communication to improve collaboration (e.g., Situation-Background-Assessment-Recommendation [SBAR]).
	3.1d Exhibits approachability and flexibility when collaborating with healthcare team members.	Maintains visibility and accessibility to increase opportunities for collaboration. Exhibits flexibility in integrated behavioral healthcare environment (e.g., open to interruptions by, and interrupting, healthcare team members).

	3.1e Develops a respectful working alliance to achieve shared treatment goals with other healthcare team members, the patient, and their family.	Builds working relationships with all members of the healthcare team, including clinical support and administrative staff through formal and informal work-related activities (e.g., team huddles, staff meetings, after-work activities). Introduces self to new and existing healthcare team members and gains and understanding of basic information about each member of the healthcare team. Engages in the mutual exchange of professional opinions about clinical, operational, and financial decisions. Participates as an active and valued member of the healthcare team (e.g., approaches healthcare team members to discuss patient's BPSS and relational care). Collaborates with healthcare team members before, during, and/or after the patient encounter.
3.2 Training and Supervision	3.2a Assesses each supervisee's/learner's knowledge and skills in inter-professional collaboration.	Measures competencies in inter-professional collaboration and engages the learner/supervisee in identifying areas of strength and potential for growth through use of case consultation and/or supervision with raw data (e.g., video, audio-recording). Assists learners in establishing developmentally appropriate goals related to participating in integrated behavioral healthcare teams. Elicits feedback from the learner's patients, patients' partners/ spouses and family members, and healthcare team members regarding collaboration skills.
	3.2b Develops the supervisee's/learner's collaborative skills with the inter-professional team.	Provides oral and written feedback regarding functioning collaboratively as a member of an inter-professional team. Assists the learner in receiving and assimilating feedback regarding inter-professional training and/or supervisory opportunities. Trains others in designing collaborative research projects.

	3.2c Teaches and models collaborative skills appropriate for the healthcare setting.	Teaches effective, brief communication methods appropriate for clinical setting (e.g., SBAR). Teaches how to articulate assessment outcomes and family therapy interventions with collaborative team. Instructs learners on how to construct and implement a collaborative treatment plan. Seeks opportunities to enhance collaborative skills (e.g., attending a noon conference lecture about medical issues and other healthcare professional conferences).
3.3 Healthcare Management and Policy	3.3a Develops policies and procedures to enhance collaboration.	Advocates for and/or writes policies that promote integration of family therapists into the relevant healthcare context (e.g., submits and/or presents white papers). Participates in continuing education related to management and advocacy of integrated care. Identifies healthcare policies that facilitate collaboration among inter-professional integrated behavioral healthcare teams and advocate for parity among them (e.g., office space, reimbursement). Consults with healthcare team to evaluate clinical, operational, and financial needs to enhance collaborative partnerships.
3.4 Scholarship	3.4a Demonstrates ability to engage in scholarly projects within an interdisciplinary team.	Involves and/or joins other healthcare team members in research initiatives (e.g., clinic quality improvement projects, research articles, presentations, and trainings). Reviews and submits grant opportunities/proposals pertaining to integrated care.
	3.4b Implements, evaluates, and disseminates research that demonstrates interdisciplinary collaboration.	Analyzes empirical research literature published about interdisciplinary collaboration. Studies impact of interdisciplinary collaboration on clinical, operational, and financial outcomes (e.g., Plan-Do-Study-Act [PDSA] cycles). Disseminates the outcomes of program evaluation studies and/or research that reflect collaborative designs, analyses, and implications.

Domain 4: Leadership

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
4.1 Clinical Skills	4.1a Promotes and creates current evidence-based knowledge and skills regarding inter-professional collaboration and integrated behavioral healthcare models.	Demonstrates command of evidence-based literature regarding inter-professional collaboration and integrated behavioral healthcare models. Promotes and expands upon models of family-centered and integrated behavioral health care in collaboration with patients, families, community partners, healthcare teams, administrators, researchers, policy makers, legislators, learners, and/or supervisees. Constructs and advances innovative models of integrated care in a variety of contexts (e.g., medical settings, schools, churches, behavioral health agencies, employee assistance programs) following recommended implementation and dissemination guidelines.
	4.1b Conveys clinical/research expertise with a variety of psychological, behavioral, and relational health diagnoses and interventions to patients, families, learners/ supervisees, healthcare teams, administrators, community partners, and/ or researchers.	Advocates for psychological, behavioral, and relational health diagnoses and interventions for patients and families. Educates on use of ICD and DSM (i.e., procedural and diagnostic codes) in clinical and research applications. Models a variety of psychological, behavioral, and relational health interventions in collaboration with members of the patient's family/support system and healthcare team to: (a) maximize patient care; (b) promote system efficiency; (c) train or mentor developing professionals. Achieves recognition for local/community, state/regional, national, and/or global contributions in clinical practice/research of psychological, behavioral, and relational health within one's area of specialty (e.g., identified as a content expert, receiving an award).
	4.1c Identifies own and other's role(s) within the hierarchy of leadership in the healthcare context.	Constructs a philosophy of leadership, including but not limited to: one's role as an advocate, clinical researcher, clinical supervisor, community liaison, health educator, team leader, and/or trainer. Disseminates integrated behavioral healthcare knowledge and skills at clinical, organizational, and staff team meetings (e.g., with patients, families, healthcare team members, staff, administration). Acquires advanced credentialing or certification in leadership, training, and/or supervision.

4.2 Training and Supervision	4.2a Understands and exemplifies the role and responsibilities of an effective, mentor, administrator, primary investigator, supervisor, and/or trainer.	Models professionalism for learners through timely and culturally appropriate (inclusive of full range of social location elements) feedback, ethical decision-making, responsiveness to questions/concerns, and attention to self-of the trainer matters that may impact the training and supervision process. Completes professional development training in leadership. Advocates for and encourages learners seeking internships or jobs in preparation for the workforce that advances their skills and practice of integrated behavioral health care and inter-professional collaboration.
	4.2b Recognizes areas of growth and strength in learners' clinical, operational, and financial practice and performance.	Identifies and implements evaluation instruments, with written and oral feedback, to learners or supervisees regarding strengths and areas of growth in integrated behavioral health model fidelity and inter-professional collaboration. Gives timely, clear, and respectful feedback about duties, roles, and performance on practice, research, and/or teaching of inter-professional collaboration, relationally-based interventions, and integrated behavioral health care models. Supervises healthcare teams' execution of individual, couple, and relationally-based psychological, behavioral, and relational health interventions/clinical research. Investigates billing and reimbursement practices to sustain integrated behavioral health care. Recommends work flow improvements to streamline the provision of integrated behavioral health care.
	4.2c Trains/educates and supervises healthcare team members who may come from a variety of disciplines and educational backgrounds to practice from a BPSS relationally-based integrated behavioral healthcare approach.	Prepares and conducts educational/training opportunities in various formats (e.g., hallway conversations, noon conferences, precepting, and workshops) about topics relevant to inter-professional collaboration and integrated behavioral health care that are BPSS-based, grounded in empirical evidence, and considerate of the laws, ethics, rules, and policies governing different disciplines.

	4.2d Advances training opportunities to expand relationally-based integrated behavioral health care with and for community partners and communities of interest.	Presents at local, state/regional, national, or global levels on relationally-based care and integrated behavioral health to audiences of community partners, and developing professionals. Receives recognition as a role model and ambassador among mentees and supervisees.
	4.2e Mentors learners and healthcare team members about their interpersonal communication and team-based processes.	Delivers recommendations to learners and healthcare team members in ways that reduce complex systemic concepts into basic terminology and avoid professional jargon when discussing relational processes. Offers examples to learners and the healthcare team about how to communicate effectively and ethically with patients, families, community partners, colleagues and other healthcare team members. Employs strategies with learners and healthcare team members for sharing and receiving feedback with patients, families, team members, and/or community partners. Identifies areas of improvement and strength with learners and healthcare team members in their delivery of BPSS and relationally-based care (e.g., 360-degree annual performance evaluations).
4.3 Healthcare Management and Policy	4.3a Utilizes management and/or administrator roles in executing inter-professional collaboration and integrated behavioral healthcare models and policies that impact: (a) healthcare teams; (b) clinical, financial, and operational systems of health care; (c) psychological, behavioral, and relational practice and research for patients and families.	Creates and/or expands care models and/or policies based on current trends in integrated behavioral health care that lead to improvements in inter-professional team functioning and sustainable patient/relationally-based care. Articulates current rules, regulations and guidelines for primary care (e.g., value based care, financial incentives, affordable care, and public and private insurance reimbursement, and alternative payment methods).

	4.3b Fosters engagement of all stakeholders in a healthcare system impacted by policies and procedures.	Conducts meetings and creates oral and written procedures with key stakeholders (e.g., administrators of healthcare delivery, billing specialists, Health Information Technology (HIT) directors, privacy/compliance officers, community partners, and representatives from external organizations). Surveys the community regularly for other potential stakeholders who share a similar mission/vision and/or should be part of the system's referral or collaborative network.
	4.3c Influences legislation and policies around the practice of integrated behavioral health care and family therapy.	Advocates for legislation that promotes parity with reimbursement and relationally-based practice privileges for all licensed behavioral health professionals with training in family therapy and behavioral health integration. Advocates for existing health policies to: (a) remove barriers and language that inhibits/discourages healthcare team members and family member/support system communications; (b) require healthcare systems to have someone trained to provide evidence-based family therapy services on staff; (c) support reimbursement for family-centered care. Demonstrates skill in preparing presentations/webinars, professional papers, policy briefs, and/or white papers on integrated behavioral health care, inter-professional collaboration/education, and/or family centered-care.
	4.3d Elicits a wide range of perspectives from members of the healthcare team and data sources.	Gathers perspectives from patients and families, members of the healthcare team/system, and other members of the community, as well as data from the EHR and other potential sources, to advance best practices and/or policies on inter-professional collaboration and/or integrated behavioral health care. Exhibits sensitivity and diplomacy while developing inter-professional collaboration and/or integrated behavioral healthcare programs, protocols, and policies within the context of specific organizational cultures, social determinants of health, and social locations. Collects, analyzes, and interprets patient/family centered information and population health data in relation to patient/family outcomes and quality improvement.

4.4 Scholarship	4.4a Contributes to knowledge regarding current empirical trends and current policies relevant to interdisciplinary collaboration and integrated behavioral health care.	Contributes to empirical literature, program evaluation, grants, or contracts as it pertains to interdisciplinary collaboration and integrated behavioral healthcare practices, management systems, billing processes, leadership, and advocacy. Recognizes the role of system delivery reform in healthcare delivery, research, and administration (i.e., contemporary policies around healthcare delivery and Patient Centered Medical Homes [PCMHs]). Holds leadership or has a contributing role in organizations recognized for advancements in health care and delivery system reform associated with integrated behavioral health care, interdisciplinary collaboration, education, and/or family centered-care (e.g., AAMFT, AHRQ, CFHA, HRSA, SAMHSA, WHO).
	4.4b Leads research teams studying interdisciplinary collaboration and/or integrated behavioral health care.	Designs and/or collaborates with the development, implementation, and/or dissemination of scholarship (e.g., CBPR, population health studies, program evaluation, quality improvement, RCTs) toward sustainable and efficient family-centered and integrated behavioral healthcare models.
	4.4c Serves as a leader in writing, submitting, and implementing grants or contracts on BPSS and relational health and health care.	Assembles a team of inter-professional collaborators and community members to develop and submit a BPSS informed grant proposal. Manages a funded grant or contract adhering to research and budget rules and guidelines (e.g., professional standards, HIPAA, IRB, regulatory boards, funders) and the expected processes agreed upon by all parties signing off on the submitted grant application. Serves as a grant reviewer for integrated behavioral health care, family-centered health care, and other BPSS-oriented proposals.
	4.4d Mentors in research planning, methodology, evidence-based outcomes, program evaluation, and quality improvement in the context of integrated behavioral health care.	Guides interdisciplinary research teams to impact healthcare management and policy and foster greater knowledge about BPSS, family-centered care, and integrated behavioral health care (e.g., patient/family centered research, PDSA cycles, population health studies, program evaluation, and research programs). Ensures that quantitative, qualitative, and mixed method designs are accurately and ethically implemented in integrated behavioral healthcare contexts.
	4.4e Embodies the role of relationally-oriented researcher and research mentor	Articulates a personal self of the researcher statement that includes an understanding of one's values and biases as a relational researcher. Serves as a mentor to an early career researcher.

Domain 5: Ethics

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
5.1 Clinical	5.1a Demonstrates adherence to ethical practice when engaged in therapeutic and consulting services with individuals, couples, families/ social supports, secondary supports, healthcare teams, community partners and any others directly involved in helping patients, families, and organizations.	Adheres to the current ethics and values of family therapists (AAMFT Code of Ethics). Acquires and maintains appropriate licensure or certifications and liability coverage. Adheres to supervision requirements for family therapists as outlined by the relevant licensure board(s) and/or clinical setting(s). Abides by scope of practice as defined by the family therapist's applicable laws and regulations, job description, and AAMFT Code of Ethics. Complies with appropriate institution, state/regional, and federal/ provincial regulations related to ethical and legal issues regarding assessment, diagnosis, treatment, collaboration, consulting, integrated behavioral health care, and case management activities. Demonstrates knowledge about healthcare standards defined by applicable laws or governing authority bodies (e.g., accrediting bodies, CMS, HIPAA, 42CFR Part 2, JCAHO, national boards). Ensures that policies and procedures are in place for ethical, confidential, and secure use of technology including telehealth, social media, and electronic communications between client/ patient, family/support member(s), supervisee, supervisor, community partner, and/or team member. Articulates and adheres to distinct settings' ethical policies regarding the delivery of integrated care/integrated behavioral healthcare services (e.g., churches, employee assistance programs, medical, behavioral health, school-based health clinics). Adheres to institutional, state, and federal regulations related to billing and reimbursement and seeks counsel from the regulator prior to implementing new models of integrated behavioral healthcare delivery. Stays current on the AAMFT Code of Ethics and other interdisciplinary codes of ethics, policies, and best practice guidelines to promote ethical inter-professional collaboration/shared-decision making and integrated behavioral healthcare services.

	5.1b Recognizes ethical issues faced by family therapists that are unique to delivering integrated behavioral health care.	Responds in a timely way to ethical challenges and liability issues related to being a family therapist in an integrated behavioral healthcare setting (e.g., confidentiality, documentation, dual/multiple relationships, and informed consent) and medical ethical decisions (e.g., advance care planning, issues of reproduction, parental rights). Demonstrates knowledge of other healthcare team members' professional codes of ethics and where differences may exist with the AAMFT Code of Ethics. Identifies specific ethical principles or codes that may be compromised in the delivery of integrated behavioral health care. Upholds the rights and privileges of individuals, couples, and families across the lifespan receiving care in healthcare settings (e.g., churches, employee assistance programs, medical, behavioral health, substance use disorder treatment, school-based health clinics).
	5.1c Employs appropriate actions to resolve ethical dilemmas unique to integrated behavioral health care.	Follows rules and policies adopted by the clinical setting, as well as each team member's regulatory body(ies), and professional associations for addressing ethical issues, violations, and grievances. Seeks input and support in a timely manner from colleagues, supervisors, site administrators, and/or legal counsel when resolving ethical dilemmas.

5.2 Training and Supervision	5.2a Knows the legal standards, ethical guidelines, and accreditation standards, governing each supervisee and learner's clinical decision making and research.	Demonstrates understanding of professional ethical codes, domestic/international laws, and accreditation standards of each supervisee and learner's professional discipline and those of the other members of the team. Conducts trainings to help inter-professional and integrated behavioral healthcare teams provide care and carry out research that is respectful and reflective of the ethical codes and domestic/international laws that govern each member's discipline(s). Educates each member of the interdisciplinary team on the scope of practice for family therapists and other supervisees and learners.
	5.2b Ensures that integrated behavioral health and relational care provided by learners are conducted in a competent manner in which ethical and legal practices are maintained.	Verifies that supervisees and learners understand and adhere to applicable laws, policies, and codes of ethics relevant to clinical practice and research. Helps learners differentiate between ethical issues common in integrated care and traditional mental health and substance use disorder treatment settings. Tailors learning strategies to enhance supervisees and learners' knowledge and skills in the conduct of ethical research and practice. Ensures that learners adhere to policies and procedures in place for ethical, confidential, and secure use of technology including but not limited to telehealth, social media, research involving, and electronic communications between the client/patient, family/support member(s), supervisee, supervisor, team member(s), and/or community partner(s). Participates in timely evaluation of supervisees' performance (e.g., clinical work, documentation, reporting, research activity). Ensures ethical representation of self, including professional identity, scope of practice, and training, among learners seeking internships or entrance into the workforce.
	5.2c Develops and maintains a supervisory relationship that fosters ethical treatment and research involving patients, families, team members, and other relevant partners.	Trains supervisees and learners on how to have ethical relationships with patients/participants, families/support systems, team members, administrators, and community partners. Models ethical behavior in the care and discussion of others. Engages learners and collaborators to resolve ethical dilemmas.

5.3 Healthcare Management and Policy	5.3a Advocates for the improvement of policies regarding the ethical practice of inter-professional collaboration, integrated behavioral health care, and family-centered care.	Attends to and researches the ethical impact of healthcare delivery models on patients, family/support system members, team members, community partners, and healthcare systems. Addresses workplace issues related to variances in ethical guidelines among disciplines in integrated care (e.g., encourages dialogue between team members on how to resolve differences).
5.4 Scholarship	5.4a Conducts and promotes ethical and systemic research.	Adheres to IRB/Human Research requirements as they apply to research conducted in healthcare settings (e.g., appropriate consent, reporting privacy or protocol breaches). Demonstrates an awareness of technical/ethical/legal issues that arise when conducting and reporting on research using patient health data and EHR. Identifies and attempts to resolve potential ethical challenges or negative consequences to the research population and community that are not addressed by the IRB process (e.g., enduring impacts, sustainability of initiative). Adheres to the AAMFT Code of Ethics when conducting research, writing, and/or determining authorship.

Domain 6: Diversity

COMPETENCIES	KNOWLEDGE/ABILITIES/ PERSONAL CHARACTERISTICS	TARGET INDICATORS
6.1 Clinical	6.1a Demonstrates understanding of different sociocultural and socioeconomic beliefs, practice, and traditions regarding health and health care (including diverse views regarding health disparities and healing across all BPSS dimensions).	Identifies specific healthcare beliefs, practices, and/or traditions that are unique to the populations they serve. Engages in conversations with patients, families, available communities of interest, and other healthcare team members that reflect curiosity, humility, and sensitivity about health and health care (e.g., gathers information about illness narratives/beliefs alongside culturally-informed preferences). Assesses cultural factors prior to making a diagnosis, collaborating, intervening, and/or implementing clinical research. Assesses for healthcare- and language- literacy throughout care processes using multi-modal methods (e.g., confirming patients' understanding of care plans with interpreters or cultural brokers, healthcare literacy screening, iterative "teach-back" sequences, visual aids).

	6.1b Demonstrates awareness of and sensitivity to social locations (e.g., ability, age, citizenship, geographic location, race/ethnicity, sexual/gender identity and orientation, socioeconomic status) in relation to assessment, diagnoses, and treatment options.	Responds to unique needs that reflect social locations (e.g., ensuring physical spaces are handicap accessible). Tailors care plans and interventions to specific cultural needs, available resources, and social locations of a patient and family in the context(s) of their community. Facilitates patient's and family's communication with inter-professional healthcare team members and/or community partners (e.g., local churches, events, leaders, schools) from backgrounds different than their own to develop and implement a treatment plan that respects varied social locations that impact the care process or outcomes. Attends to strengths and limitations of diagnostic and screening tools with different populations (e.g., using assessments with sensitivity to available data regarding cultural adaptation/norming). Engages team members, patients, families, and community partners with specialized knowledge/skills to identify unique characteristics of the patient population and community that need to be addressed in applying culturally appropriate and integrated behavioral health care.
	6.1c Designs, implements, and evaluates integrated behavioral healthcare treatment plans that are based on best-practice guidelines recognizing diverse social locations; these are dynamic, flexible, and adaptive enough to treat diverse patients/families.	Facilitates meetings with patient/family advocates, community partners, administrators, staff, and/or healthcare team members to develop and implement a treatment plan that respects varied social locations that impact the care process or outcomes. Modifies interventions that consider the unique social locations and needs of the patients and families being cared for by the healthcare team. Communicates with team members in a manner sensitive to power differentials and other aspects of diversity that may be present. Demonstrates the capacity to discern between personal identity, power dynamics, social context, sociocultural backgrounds, and socioeconomic status in healthcare team members' and patients' constructions and experiences of health, health care, and illness.

	6.1d Demonstrates respect, curiosity, and humility for learning about health and healthcare perspectives of diverse populations.	Inquires about cultural identities, health behaviors, health beliefs, and illness histories as well as traditions of the individual, family, and community. Demonstrates sensitivity to others' beliefs and experiences regarding BPSS health and health care.
	6.1e Demonstrates recognition of one's own personal biases and beliefs about diverse patient populations, healthcare disciplines, or settings and openness to seek support/ training/supervision to improve clinical practice/ clinical research.	Develops awareness regarding personal biases and beliefs through ongoing healthcare diversity training and exposure to and participation in culturally diverse events/contexts. Demonstrates the capacity to discern between personal identity, power dynamics, social context, sociocultural backgrounds, and socioeconomic status in healthcare team members' and patients' constructions and experiences of health, health care, and illness. Articulates personal beliefs, difficulties, and biases through self-reflective exercises, collegial conversations/supervision, and other activities. Encourages constructive performance feedback about self and all other team members (e.g., 360-degree annual performance evaluations) in relation to providing a culturally aware context and delivery of care.
6.2 Training and Supervision	6.2a Develops instructional methods that build learners' and supervisees' confidence and competence in areas of clinical services, research, and/or teaching with diverse patient/learner/participant populations and diverse inter-professional collaborators.	Provides learners with appropriate materials (e.g., key literature, popular media), examples, and experiences (e.g., introductions to community leaders and cultural events) to understand how to collaborate with diverse groups. Promotes use of evidence-based practice and research and culturally-sensitive measures, assessments, and interventions in clinical, research, supervision, and teaching. Educates and engages learners and integrated healthcare team members in providing care that honors the diversity of patients and members of the healthcare team. Seeks ongoing education to improve supervisory methods and understanding of diverse populations and the influence of social locations on healthcare practice, research, and training.

	6.2b Trains others in conducting diagnostic assessments and providing interventions using theories and methods that are respectful of patients'/ families' healthcare beliefs and cultural practices.	Teaches theories and methods that are oriented toward diverse samples or populations. Mentors learners to use cultural sensitivity when interpreting and applying theories and research (e.g., ensuring that theories or interventions tested only with majority populations are scrutinized before applying with minority populations).
	6.2c Promotes learners and supervisees' cultural humility in relational and BPSS practice, research, and teaching initiatives.	Provides learners with individual and/or group reflective exercises to examine personal biases and raise awareness impacting the therapeutic relationship and inter-professional collaboration. Encourages discussion about social locations of self and others among learners and healthcare team members. Models cultural humility for relational and BPSS learners (e.g., engages in regular peer-to-peer supervision, shares personal statements regarding biases that influence clinical practice, research, teaching, and receives continuing education).
6.3 Healthcare Management and Policy	6.3a Recognizes and mitigates the impacts of policies and laws have on diverse populations.	Calls and leads meetings to discuss family-centered policy changes to benefit diverse populations and social locations. Articulates the value of family-centered treatment policies that respect social locations and promote improved access to care for all. Advocates for policies that are inclusive and culturally informed within the healthcare system to reduce health disparities. Promotes policy that supports marginalized populations and reduces health disparities (e.g., tracking healthcare utilization, measuring cost-offset, determining cost-effectiveness).

	6.3b Demonstrates cultural sensitivity and humility as an integrated behavioral health care and relational researcher.	Engages with communities of interest, elders, mentors, cultural gatekeepers, and others regarding study design (e.g., developing appropriate methods for consent and data collection), interpreting findings, and dissemination (e.g., publications and presentations across professional- and lay- arenas). Conducts research (e.g., program evaluation, quality improvement, CBPR) recognizing BPSS dimensions and diverse social locations and subcultures. Utilizes tools and data collection methods that are accessible to people of different abilities and backgrounds (e.g., screen for health literacy prior to administering self-report measures, use psychometrically sound measures in participants' native language). Applies best-practice guidelines based on empirical research and customized guidelines for different diverse populations.
	6.3c Addresses ethical dilemmas pertaining to implementation of research studies with vulnerable populations and minority groups.	Engages in process of reflexivity when conducting research (e.g., audit-trails, reporting violations to an IRB or regulatory body). Adheres to guidelines for conducting research including informed consent and right to withdraw. Meets IRB standards of instituted safeguards when working with vulnerable populations and minority groups.

Glossary

42 CFR Part 2: Federal regulations governing the privacy of drug and alcohol abuse prevention and treatment records. These provisions were stimulated by the knowledge that stigma and fear of prosecution might discourage persons with substance use disorders from seeking care.

360-degree annual performance evaluations: A system or process in which an employee or learner receives private, anonymous feedback from people they work with. This may include administrators, managers, colleagues, and peers. Feedback is used for development across both personal and professional arenas.

Affordable Care Act (ACA): Also known as the Patient Protection and Affordable Care Act (PPACA) or "Obamacare"; the landmark health reform legislation was passed by the 111th Congress, and signed into law during March 2010.

Agency for Healthcare Research and Quality's (AHRQ): A U.S. government agency that functions as a part of the Department of Health and Human Services (HHS); its mission is to support research that leads to health care that is safe, of high quality, accessible, equitable, and affordable – and to work within HHS and other partners to make sure that the evidence is understood, disseminated, and used.

Balint group: A group of physicians or other providers who meet recurrently and present clinical cases in order to improve and better comprehend the provider-patient relationship. The group usually has two leaders (e.g., a physician and a behavioral health provider) who facilitate its process.

Biopsychosocial-spiritual (BPSS) framework: This framework expands upon the biopsychosocial model to include spirituality. It is grounded in the notion that an individual's or family's spiritual belief system can impact treatment and healthcare outcomes.

BPSS assessment: An integration of measures and instruments used to identify simultaneous and multi-directional influences of a patient's biological, psychological, social/familial, and spiritual functioning.

Centers for Medicare & Medicaid Services (CMS): Part of the U.S. Department of Health and Human Services; oversees numerous healthcare programs that are funded by the federal government, including those that involve health information technology.

Clinic champion: An existing member(s) of a healthcare system who is capable of moving innovative ideas through phases of initiation, development, implementation, and evaluation. This professional is also engaged in education and advocacy.

Collaborative Family Healthcare Association (CFHA): A member-based, member-driven collaborative organization that promotes comprehensive and cost-effective models of health care delivery that integrate BPSS foci when working with individual patients, families, providers, and communities.

Communities of interest: A unified body of people who share a common interest or passion. They exchange ideas, thoughts, and actions directed toward a common cause (e.g., social, historical, economic, political).

Community-based participatory research (CBPR): An approach to research that equitably involves community members, organizational representatives, care providers, and health researchers across all aspects/stages of the investigative process. All partners contribute unique expertise and share decision-making and project ownership.

Cultural broker: A person who facilitates the exchange of information, norms, and traditions from one group or person's culture to another.

Cultural gatekeepers: Indigenous members of a community who are equipped with informal or formal influence with the group(s) that they represent. These persons serve to define, translate, and inform information exchange/dissemination and/or behavioral practices that are advanced by outsiders working to learn about, engage with, and/or assist said community.

Cultural humility: Ability to maintain a non-ethnocentric stance that is open to others in relation to aspects of cultural identity (i.e., foci that are important to persons of differing cultures).

Dissemination and Implementation Science (D&I): A science that addresses gaps between what we scientifically know can optimize health and health care and what actually gets implemented in everyday clinical practice. Its aim is to use controlled processes to comprehend how to best ensure that evidence-based care is effectively delivered in clinical and public health practice.

Electronic Health Record (EHR): Also referred to as Electronic Medical Record (EMR); an electronic record of a patient's paper chart. EHRs are real-time, patient-centered accounts that include protected health information. Data are available instantly and securely by healthcare providers.

Evidence-based approaches/practice: The integration of clinical expertise, patient values, and the best research evidence into decision making processes for patient care.

Evidence-based integrated behavioral healthcare models: A broad spectrum of services that integrate behavioral health interventions with biomedical interventions in medical settings; methods employed have shown efficiency and effectiveness through formal research.

Federal/Provincial regulations: Laws and regulations at the federal and provincial (state) level that guide the practice of care; examples include the Health Insurance Accountability and Affordability Act (HIPAA), Stark, and Emergency Medical Treatment and Labor Act (EMTALA).

Financial incentives: Methods that encourage and motivate providers to perform well in the work that they do (e.g., provide effective and quality clinical care, improve patient outcomes).

Health behavior theories: A group of theories aimed at both the determinants of health behaviors and the processes of health behavior change. Examples include the Transtheoretical Model, Social Cognitive Theory, and Health Belief Model.

Health informatics: Also known as Health Information Technology (HIT); the interdisciplinary study of the design, development, adoption, and application of information technology innovations in healthcare services delivery, management, and planning.

Health Insurance Portability and Accountability Act (HIPAA): A United States law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other healthcare providers.

Health literacy: The degree to which a patient can obtain, process, and understand basic health information and services needed to make appropriate health decisions.

Health Resources and Services Administration (HRSA): An agency of the U.S. Department of Health and Human Services that is charged with improving health care to patients who are geographically isolated and/or economically or medically vulnerable. HRSA programs also support the training of care providers, the distribution of providers to areas where they are most needed, and improvements in health care delivery.

Healthcare diversity training: A structured program designed to facilitate positive intergroup interactions, reduce conscious and unconscious prejudices and discrimination, and teach individuals who are different from each other about how to work together effectively.

Healthcare system: An organization of people, institutions, and resources that deliver healthcare services to meet the health needs of targeted populations.

Healthcare team: A group directly employed by a healthcare setting or working in collaboration with the primary team that is consulted on a consistent basis to help shape delivered care.

Institutional Review Board: Also known as an "independent ethics committee" (IEC), "ethics review board" (ERB), or "research ethics board" (REB); a committee used in research to formally review, approve, monitor, and track biomedical and behavioral investigations involving human subjects. The purpose of the IRB is to assure that appropriate steps are taken to protect the rights and welfare ofhuman subjects.

Inter-professional collaboration: When learners/practitioners, patients/clients/families, and communities develop and maintain inter-professional working relationships with the goal of optimal health outcomes.

Inter-professional healthcare team: A group of professionals with complementary skills committed to a shared purpose, performance goals, and approach(es) to which they hold themselves mutually accountable.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): An independent organization that develops the standards and guidelines to improve the safety, effectiveness, and quality of health care. It also accredits medical providers and programs.

Levels of integrated behavioral health care: A classification system of integrated behavioral health care, including: Level 1: minimal collaboration; Level 2: basic collaboration at a distance; Level 3: basic collaboration onsite; Level 4: close collaboration in a partly integrated system; and Level 5: close collaboration in a fully integrated system.

Marginalized populations: Those excluded from mainstream social, economic, cultural, or political life. Examples include, but are not limited to, groups often excluded due to race, religion, political or cultural affiliation, age, gender, or financial status.

Medical terminology: Language (often based on Latin-roots and/or acronyms that simplify otherwise complex words/labels) that is used to describe physiological foci, processes, conditions, care practices, interventions/procedures, medications, etc., in healthcare practice.

Patient Centered Medical Home (PCMH): A model for the delivery of primary care; it ensures that high quality services are comprehensive, patient-centered, coordinated, accessible, and safe.

Performance indicators: Metrics used to quantify key business or organizational processes that reflect strategic performance (e.g., patient satisfaction, hospital re-admission rates, average length of stay).

Personal identity: The concept that a person develops about oneself over the life-course. This includes aspects of one's life that are both controllable (e.g., how to spend leisure time) and not controllable (e.g., skin color).

Plan-Do-Study-Act (PDSA) cycle: A systematic series of steps for gaining valuable learning and knowledge for the ongoing improvement of a product or process.

Population health: An approach to health that aims to improve the health of an entire human population.

Power dynamics: Levels of power, how power works, and/or how people use their power in the workplace.

Practice-based evidence: The practice of measuring and tracking real world clinical practice as it occurs (i.e., not controlled, as in evidence-based approaches).

Primary care systems: The first, and most generalized basic, healthcare stop for a wide variety of symptoms and concerns. Primary care providers (PCPs) may be physicians, nurse practitioners, or physician assistants.

Private insurance: A health insurance policy that is purchased by an employer or an individual from a private insurance company.

Program evaluation: A systematic method for collecting, analyzing, and using information to answer questions about projects, policies, and programs, particularly about their effectiveness and efficiency.

Psychotropic drugs: Medications (e.g., stimulants, antidepressants, anti-anxiety agents, antipsychotics, mood stabilizers) prescribed to treat a variety of behavioral health issues (e.g., depression, anxiety). They generally work by altering or balancing neurotransmitters in the brain.

Public insurance: An insurance plan or policy that is subsidized by federal or state funds such as Medicaid or Medicare.

Randomized Control Trials (RCT): Studies wherein participants are assigned at random to receive one (of up to several) clinical interventions. At least one of these interventions is designated as the "standard" of comparison or "control" group (e.g., standard care, placebo care, no care / wait-list).

Relational care: Care that focuses on the relationships between patients, their families and/or friendship supports, community members, healthcare providers, and healthcare administration during the provision of services for health and wellness, treatment, and disease prevention.

Scope of practice: The procedures, actions, and processes that a healthcare practitioner is permitted to undertake while staying within the terms and latitude of one's professional license.

Secondary care systems: Care sites staffed by providers with specific expertise with a presenting problem. Specialists focus either on a specific body system (e.g., endocrinology) or on a specific disease or condition (e.g., oncology).

Situation-Background-Assessment-Recommendation (SBAR): A communication technique used as an effective and efficient way to impart important information between healthcare providers. S = Situation, B = Background, A = Assessment, and R = recommendation.

Social context: Also known as "social environment"; the immediate setting in which people reside. Includes elements of culture, social class, geography, etc.

Social location: The group or groups that people belong to by nature of their place or position in history and society; includes gender, race, social class, age, ability, religion, sexual orientation, and geographic whereabouts.

Sociocultural: Signifies the combination or interaction of social and cultural elements such as habits, traditions, and beliefs.

Socioeconomic status (SES): A group's or individual's position within a within a hierarchical social structure that is organized by a combination of variables, including occupation, education, income, wealth, and place of residence.

Stakeholders: Persons or groups that have vested interest in – and can affect, or be affected by – decisions and outcomes in health care. May include patients, family members, providers, researchers, advocacy groups, professional societies, community members, policymakers, or others. Key stakeholders may have additional interest and influence into important decisions and practices.

Substance Abuse and Mental Health Services Administration (SAMHSA): An agency within the U.S. Department of Health and Human Services; it leads efforts in public health to advance the behavioral well-being of all United States inhabitants.

Teach-back: A communication method used to confirm whether a patient (or anybody else who is receiving information) understands what is being explained to them. If patients understand what they are receiving, then they are able to "teach-back" the information accurately.

Team huddles: Daily meetings in which all healthcare team members and staff meet to review and discuss their patients for the day. Short in duration, these meetings enable team members to anticipate care needs and special situations by gaining information from all providers involved.

Telehealth: The provision of health care remotely by means of telecommunications technology (e.g., telephone, internet).

Tertiary care systems: Care sites staffed by specialized consultants that advance personalized assessments and/or treatments. Usually accessed upon the recommendation and/or referral of primary or secondary providers.

Value based care: A model of healthcare delivery where physicians, physician extenders, and hospitals are paid for keeping people healthy and for improving the health of those who have chronic conditions in an evidence-based, cost-effective way. This contrasts with fee-for-service models of health care, wherein doctors and hospitals are paid based on the number of care services delivered.

Vulnerable populations: Certain populations whose access and range of options for health care are considered more limited because of because of their particular conditions or situations in life.

Working alliance: A collaborative and consensus-driven relationship between a provider(s) and a patient wherein both are working toward improving the patient's health and well-being.

World Health Organization (WHO): An agency of the United Nations that was established to promote and improve the health of the world's people and preventing or controlling communicable diseases through various technical projects and programs.

Appendix: Medical Family Therapy Continuum

MEDICAL FAMILY THERAPY HEALTH CARE CONTINUUM				
Level 1	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Rarely… 1) Applies a relational and/or biopsychosocial-spiritual (BPSS) lens in practice, research, and/or policy/advocacy work. 2) Conducts research on healthcare topics including relational and/or BPSS aspects of health, and writes in collaboration with other healthcare researchers. 3) Includes individuals, couples, families, AND healthcare professionals into their work. 4) Advocates and advances clinical models and policies that promote relational or BPSS health and well-being.	*Occasionally …*	*Usually…*	*Consistently…*	*Proficiently…*
		5) Trained to apply a broad range of family therapy and BPSS interventions and conduct family therapy.	6) Experienced in conducting BPSS research across traditional and integrated care practice contexts. 7) Integrated in outpatient and/or inpatient healthcare teams, attends to the needs of healthcare team members, is a part of healthcare team meetings, and/or practices conjointly with diverse healthcare professionals. 8) Identified as a MedFT clinician or MedFT researcher and integrates in/with healthcare contexts/professionals into most of their work.	
				9) Experienced at administrating, supervising in diverse medical contexts (i.e., primary, secondary, and tertiary care systems) incorporating both traditional and integrated care models. 10) Experienced in training healthcare professionals in family therapy and MedFT practice, research, policy, and/or administration.

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