Case Studies of 6 Safety Net Organizations that Integrate Oral and Mental/Behavioral Health Services with Primary Care Services

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ABSTRACT

Research Objective: The objective of this study was to describe levels of integration of primary care, oral health, and mental/behavioral health services in several Federally Qualified Health Centers (FQHCs). The goals were to understand systemic components of integration and referral, organizational strategies that enabled efforts to integrate, the impact of co-location of providers from different disciplines on care, the importance of other factors including the electronic health record on service coordination and integration, and to describe commonalities and differences among the FQHCs in systems and processes that enabled service integration.

Study Design: Project staff conducted case studies at 6 FQHCs providing integrated health services to mixed patient populations in urban and/or rural areas in Colorado, Missouri, New Mexico, New York, Ohio, and Washington, DC. Site visits lasted approximately 3 hours and included interviews with multiple stakeholders at each location using a 40-question protocol to guide informants to the main topics of interest.

Population Studied: The study population consisted of a sample of FQHCs providing primary care, oral health, and behavioral health services to a minimum threshold for each service of 20% of patients according to data extracted from the Uniform Data System maintained by the US Health Resources and Services Administration (HRSA).

Principal Findings: Integration is an ongoing process in organizations with broad scopes of services, complex patient populations, and growing size. These FQHCs exhibited structural characteristics and clinical and administrative processes indicative of integrated organizations and comprehensive health homes when measured by the objective standards of integrated organizations in two published frameworks on the subject. Valentijn and co-authors designed the first and the US Substance Abuse and Mental Health Services Administration (SAMHSA)-HRSA Center for Integrated Health Solutions constructed the second. The FQHCs exhibited many of the characteristics described by Valentijn et al including using integrated electronic health records (functional integration); incorporating integration as a primary organizational goal (normative integration); having leadership that encouraged engagement and innovation (organizational integration); implementing hiring practices to assure that employees identified with the organizational mission (system integration); encouraging formal and informal communication across disciplines (professional integration); using team based care delivery models (clinical integration); and engaging with the larger community to improve their collective impacts on patients (vertical integration). The FQHCs also fit at the highest levels of the SAMSHA-HRSA model framework exhibiting characteristics that corresponded with Level 5 or Level 6 as mostly or fully integrated organizations.

Conclusions: Integration is an ongoing process in organizations with broad scopes of services, complex patient populations, and growing size. FQHCs have a unique opportunity to expand access to needed primary care, oral health, and behavioral healthcare services for those with chronic illnesses, mental health diagnoses, or substance use disorders. While co-location does not equate to integration, it provides an organic path to interdisciplinary coordinated care thereby enabling patients to improve health status and life outcomes.

Implications for Policy or Practice: While efforts at integration might be more exigent in safety net organizations serving medically complex people, patients in any health care system would similarly benefit from integrated care.

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INTRODUCTION

- The systemic linkages between oral, physical, and mental health are receiving increased attention due to an increased emphasis on management of chronic disease
- FQHCs provide co-located primary care, oral health, mental/ behavioral health, and pharmacy services
- Co-location does not equate to integration but is an enabler of interdisciplinary, integrated care
- The objectives of this study were to:
  - To describe system components of integration and referral
  - To outline organizational strategies used by safety net providers to integrate services
  - To understand the impact of co-location of services and clinical providers on integration
  - To define the importance of other factors (eg, integrated electronic health record) to the effectiveness of integration

METHODS

- Qualitative study using a selective case study methodology conducted in 2018
- FQHCs that provided at least 20% of patients with each of primary care, oral health, and mental/behavioral health services (as described in the 2016 Uniform Data System) were solicited to participate
- Out of more than 1,400 FQHCs, approximately 30 met all criteria and 6 were solicited and agreed to participate:
  - Albuquerque Health Care for the Homeless (AHCH), Albuquerque, NM
  - HELP/PSI/Brightpoint Health (BH), New York, NY
  - Colorado Coalition for the Homeless (CCH), Denver, CO
  - Compass Health Network (CHN), Clinton, MO
  - Health Partners of Western Ohio (HPWO), Lima, OH
  - Whitman-Walker Health (WWH), Washington, DC
- Onsite interviews with:
  - Executive and administrative staff, clinical professionals, behavioral health providers
  - In individual or group sessions
- Formal protocol of questions asking about:
  - Importance of service integration
  - Critical elements of processes to achieve integration
  - Characteristics of programs that facilitate integration
- Analyses were accomplished in the context of two developed structural frameworks describing integrated health care organizations
- Structural characteristics, processes, and placements of clinicians in FQHCs were catalogued in terms of the different types of integration described by Valentijn and colleagues[1]

- This project was supported by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS). The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS, or the US Government.

RESULTS

Figure 1. The Valentijn et al. Model

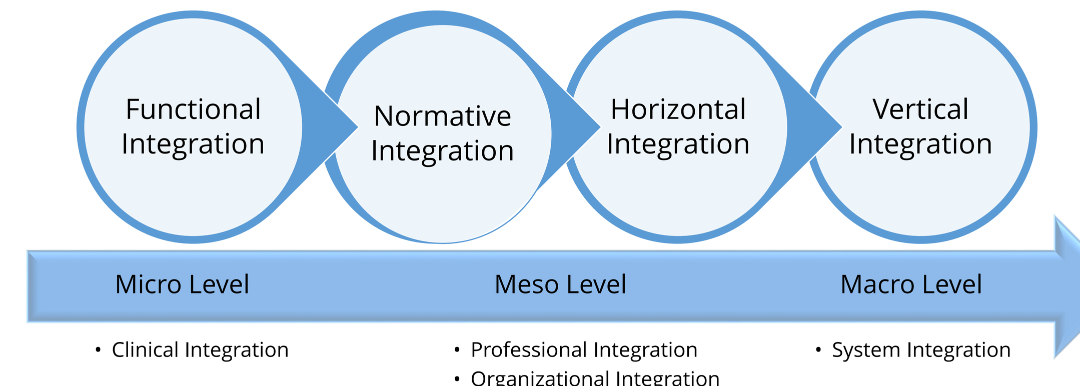

Table 2. Structural Characteristics of the 6 FQHCs

Structural Characteristics	AHCH	BH	CCH	CHN	HPWO	WWC	Valentijn Framework Level
Co-location of primary medical, behavioral health, and dental clinical services in a health center	X	X	X	X	X	X	F,H,O,V
Designation as a Primary Care Medical Home (PCMH)	X	X	X	X	X	X	H,O
Designation as a Health Home		X		X			H,O
Integrated clinical pods (services in same clinical area)			X	X	X		F,H,O
Dental operatory located in primary care clinic	X		X				F,H,O,V
Multiple clinic locations		X	X	X	X	X	F,H,O,V,S
Open office space/ not discipline specific	X		X		X		F,H,O,V
Common waiting areas	X	X	X	X	X		F,O
Service-specific waiting areas	X		X	X		X	F,O
Near public transportation	X	X	X	X	X	X	F,O
Engagement with external community-based organizations with mutual interests in patients	X	X	X	X	X	X	S,V
Engagement with municipal programs benefitting target	X	X	X	X		X	S,V

Type of Integration: C=clinical, F=functional, H= horizontal, N=normative, P=professional, O=organizational, S=system, V=vertical.

Table 3. Processes Enabling Integrated Service Delivery in the 6 FQHCs

Process	AHCH	BH	CCH	CHN	HPWO	WWC	Valentijn Framework Level
Fully or partially integrated electronic health record (EHR)	X	X	X	X	X	X	F,H
Programs/services to mediate social problems encountered by patients	X	X	X	X	X		F,H,O,S
Resources to address social determinants of health	X	X	X	X			F,H,O,S
Regular staff and/or committee meetings that include clinicians from a variety of disciplines	X		X	X	X	X	N,O,P
Efforts to recruit staff who identify with organizational mission	X	X	X	X	X	X	N,P,S
Orientation training includes training about all services at the FQHC	X	X	X	X	X	X	N,O
Training in the special characteristics of the targeted patient population	X	X	X	X		X	N,O,P
Efforts to introduce staff to differing clinical services		X		X	X	X	N,O,P
Staff training in harm reduction strategies	X	X	X	X		X	N,O,P
Staff training in trauma-informed care	X	X	X	X	X	X	N,O,P
Staff training in topics related to other health disciplines	X			X	X		N,O,P
Staff training in de-escalation techniques/anxiety reduction	X			X	X	X	N,O,P
Ongoing training opportunities	X		X	X	X	X	O

Type of Integration: C=clinical, F=functional, H= horizontal, N=normative, P=professional, O=organizational, S=system, V=vertical.

Table 4. Workforce Placement and Clinical Activities in the 6 FQHCs

Workforce Placement and Clinical Activities	AHCH	BH	CCH	CHN	HPWO	WWC	Valentijn Framework Level
Clinical Providers							
Behavioral health specialist embedded on clinical team	X		X	X	X	X	C,H,P
Oral health professional embedded on clinical team	X		X				C,H,P
Clinical pharmacists on site	X	X	X	X	X	X	C,H,P
Leadership involvement in integration activities	X	X	X	X	X	X	N,O,P
Medical history review by dentist	X	X	X	X	X	X	C,H,O,P
Medical services in dental clinic (eg, A1C testing)	X		X	X	X		C,H,O,P
Oral health assessment by primary care clinician	X	X	X	X		X	C,H,O,P
Primary care providers managing medication-assisted treatment	X	X	X	X	X	X	C,H,O,P
Primary care providers prescribing drugs for depression or anxiety	X	X	X	X	X	X	C,H,O,P
Access to staff psychiatrist for clinical consultations	X	X	X	X		X	C,O,P,V
Other Staff							
All staff is oriented to services available in the organization	X	X		X	X	X	F,N,O
Peer support workers or patient navigators on staff	X		X	X		X	F,N,O
Case management personnel on staff	X	X	X	X	X	X	F,N,O
Insurance navigators in health center	X	X	X	X	X	X	F,N,O

Type of Integration: C=clinical, F=functional, H= horizontal, N=normative, P=professional, O=organizational, S=system, V=vertical.

RESULTS (cont.)

Table 5. Six Levels of Integration in the SAMHSA-HRSA Framework[2]

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

SAMHSA-HRSA Key Element in Co-Located Care: Physical Proximity

- The philosophy of integrated service delivery is reflected in the physical design of the health centers, in the institutionalized patient management and administrative processes, and in the formal and informal interactions among organizational staff.

SAMHSA-HRSA Key Element in Coordinated Care: Communication

- An integrated electronic health record is an essential formal communication tool to assure that clinicians have access to the necessary information to provide comprehensive patient care and to communicate with other members of the care team about patient needs.
- The "language of integration" is evolving. The primacy of informal communication between providers from various disciplines is emerging as a key feature of successful efforts at integration.

SAMHSA-HRSA Key Element Integrated Care: Practice Change

- Integration of health services requires evolving processes and programs that are responsive to individual patient need.
- The characteristics of the patient population sometimes require staff training in specialized approaches to care delivery.
- Meeting the complex needs of patients in FQHCs requires engagement of skilled staff including medical and dental clinicians, social service and behavioral health providers, and other support professionals.
- Service delivery must be team based; teams must utilize the full competencies of all members and team members must be open to new learning.
- Providers encounter various degrees of difficulty with integrating health services; difficulty increases when there are embedded structural barriers to bridge.
- Engagement with other community based organizations and inpatient or specialty health care providers to meet the needs of their patients increases the collective impact of an integrated organization.
- Public programs and funding streams have encouraged comprehensive services for particular populations revealing the value of integrated, coordinated service delivery.

CONCLUSIONS AND IMPLICATIONS

- Integration is an ongoing process in organizations with broad scopes of services, complex patient populations, and growing size.
- FQHCs have a unique opportunity to expand access to needed primary care, oral health, and behavioral healthcare services for those with chronic illnesses, mental health diagnoses, or substance use disorders.
- Although efforts at integration might be more exigent in safety net organizations serving medically complex people, patients in any health care system would similarly benefit from integrated care.

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