Six Federally Qualified Health Centers Integrating Oral Health, Behavioral Health, and Primary Care Services

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ABSTRACT

Purpose: The objective was to describe levels of integration of primary care, oral health, and mental/behavioral health services in Federally Qualified Health Centers (FQHCs).

Methods: The case studies included FQHCs in urban and rural areas in Colorado, Missouri, New Mexico, New York, Ohio, and Washington, DC. Site visits lasted approximately three hours and included interviews with multiple stakeholders using a 40-question protocol. The study population consisted of six FQHCs providing primary care, oral health, and behavioral health services to at least 20% of patients according to the Uniform Data System.

Results: The FQHCs exhibited structural characteristics and clinical and administrative processes indicative of integrated organizations when measured by the objective standards of integration in 2 published frameworks; Valentijn and co-authors designed the first and the US Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions constructed the second. The efforts of the FQHCs fit those described by Valentijn including using integrated electronic health records (functional integration); incorporating integration as a primary organizational goal (normative integration); having leadership that encouraged innovation (organizational integration); implementing hiring practices to assure identification with the organizational mission (system integration); encouraging communication across disciplines (professional integration); using team based care delivery (clinical integration); and engaging with the larger community to improve collective impact (vertical integration). The FQHCs also fit at the highest levels of the SAMSHA-HRSA framework exhibiting characteristics that corresponded with Level 5 or Level 6 as mostly or fully integrated organizations.

Discussion: While service co-location does not equate to service integration, it provides an organic path to interdisciplinary coordinated care that enables patients to improve health status and life outcomes. FQHCs have a unique opportunity to expand access to integrated primary care, oral health, and behavioral healthcare services for those with chronic illnesses, mental health diagnoses, or substance use disorders.

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BACKGROUND

- 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 understand:
  - System components of integration and referral
  - Organizational strategies used by safety net providers to integrate services
  - Impacts of co-location of services and clinical providers on integration
  - To define the importance of other factors (eg, integrated electronic health records) 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 2 developed structural frameworks describing integrated health care organizations (Figure 1, Table 3)
- 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] (Figure 1) and the US Substance Abuse and Mental Health Services Administration (SAMHSA)-Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (Table 3)

RESULTS

Figure 1. The Valentijn et al. Model

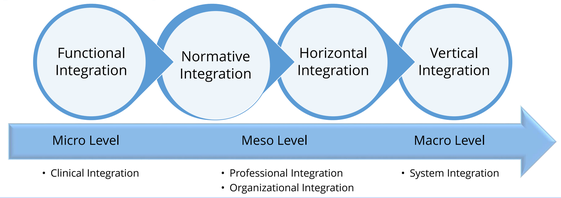

Table 1. Structural and Process Characteristics of the 6 FQHCs

Characteristics of the Health Centers	AHCH	BH	CCH	CHN	HPWO	WWHC	Valentijn et al. Framework Level
Structural Characteristics							
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
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
Engagement with external community-based organizations with mutual interests in patients	X	X	X	X	X	X	S,V
Process Characteristics							
Engagement with municipal programs benefitting target population	X	X	X	X		X	S,V
Fully or partially integrated electronic health record (EHR)	X	X	X	X	X	X	F,H
Organization-wide case management/treatment plan	X						C,F,H,O
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
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

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

Table 2. 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 3. 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

- 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/informal interactions among organizational staff
- Providers encounter various degrees of difficulty with integrating health services; difficulty increases when there are embedded structural barriers to bridge

SAMHSA-HRSA Key Element in Coordinated Care: Communication

- Integrated electronic health records are essential 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
- 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

- Evolving processes and programs that are responsive to individual patient needs
- Staff training in specialized approaches to care delivery to address characteristics of the patient population
- Team-based service delivery utilizing the full competencies of all members and team members must be open to new learning
- 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

DISCUSSION

- 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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