Health Workforce Policy Brief

Feburary 2019

OHWRC
Oral Health Workforce Research Center

www.oralhealthworkforce.org

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

Margaret Langelier, MSHSA, Simona Surdu, MD, PhD, and Nubia Goodwin, MPH

Introduction

At a time when access to high-quality, low-cost health services is a concern, many studies have focused on identifying barriers and facilitators to availability and affordability of services for currently underserved populations or those at risk for diminished access. One strategy recognized as a probable facilitator to access is integrating service delivery for patients in a comprehensive health home. Safety net provider organizations, especially Federally Qualified Health Centers (FQHCs), appear to be key to providing integrated health care services for many. This project sought to identify critical components for integration of services within FQHCs in order to help other providers in their service integration efforts.

Methods

Project staff of the Oral Health Workforce Research Center (OHWRC) at the Center for Health Workforce Studies (CHWS), University at Albany used a selective case study methodology to conduct 6 case studies of FQHCs across the US. The following FQHCs participated in the project: Albuquerque Health Care for the Homeless (NM), HELP/Project Samaritan Services (PSI)/Brightpoint Health (NY), Colorado Coalition for the Homeless (CO), Compass Health Network (MO), Health Partners of Western Ohio (OH) and Whitman-Walker Health (DC). Case studies were conducted on-location using a standardized 40-question interview protocol. Case study visits and interviews lasted about 3 hours at each FQHC. Researchers reviewed and compared all interview notes to extract common strategies that affect service integration for patients in participating organizations. Researchers used 2 standard integration frameworks to describe findings from the study. The first framework, developed by Valentijn and colleagues, discusses the integrative functions of primary care.[1] The second framework, designed conjointly by the US Substance Abuse and Mental Health Services Administration (SAMHSA) and the US Health Resources and Services Administration (HRSA), describes the stages and steps involved in primary-care behavioral health collaboration and integration.[2] The final project report is a narrative summary of programs and strategies that enable effective service integration.

Conclusions and Policy Implications

1) The research revealed some critical components of successful integration in these organizations including:
   - Inclusion of service integration as a primary goal
   - Leadership and provider engagement with the goal of integration
   - Employees who identify with the organizational mission
   - Opportunities for training in specialized approaches to care delivery to gain an understanding of the characteristics of the patient population
   - Formal communication processes that enable referral and information sharing
   - An enviornment that encourages innovation and frequent, informal communications
   - Organizational engagement with a community of internal and external providers to improve collective impact on patients
2) This case study report provides an organized guide of benchmark characteristics of integrated organizations to enable internal evaluation of efforts at integration.
3) The final technical report provides case study examples that may help FQHCs and other types of service organizations in their efforts to provide integrated health care services.

Findings

The FQHCs that participated in these case studies served patients with complex health and social needs. All of the organizations in the case studies provided physically proximate/co-located services and all were using an integrated service delivery paradigm. Case

This work is funded through HRSA Cooperative Agreement U81HP27843: Health Workforce Research Centers Program.

study organizations exhibited many commonalities related to services offered, complexity of patient caseloads, hiring practices, and training of staff in specialized approaches to care delivery. The goal of service integration was manifest in the structural characteristics of the various health centers, in the formal and informal care processes that had developed and in the commitment of organizational leadership, clinical professionals and affiliated staff to the missions of the FQHCs. The study found various common themes and strategies to enable integration among the FQHCs in the case studies:

- The philosophy of integrated service delivery is reflected in the physical design of these health centers, in the institutionalized patient management and administrative processes, and in the formal and informal interactions among organizational staff.
- 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.
- Integration of health services requires evolving processes and programs that are responsive to individual patient needs.
- The characteristics of the patient population sometimes requires staff training in specialized approaches to care delivery.
- Service delivery must be team based; teams must utilize the full competencies of all members and team members must be open to new learning.
- Meeting the complex needs of patients in these FQHCs requires the engagement of skilled staff including medical and dental clinicians, social service and behavioral health providers, and other support professionals.
- 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 speciality health care providers to meet the needs of 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 the integrated, coordinated service delivery.

Conclusions

The 6 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 2 published frameworks on the subject. Each organization displayed multiple aspects of clinical, organizational, professional, functional, and normative integration as described by Valentijn and colleagues. All exhibited horizontal and vertical integration in their service menus. The FQHCs would also be placed at either Level 5, described as approaching integrated practice, or Level 6, defined as integrated/transformed practice, on the SAMHSA-HRSA framework.

FQHCs have a unique opportunity to expand access to include needed primary care, oral health, and behavioral health care services for patients with complex health needs. This study identified various themes and best practices shared among the case study participants, which are instructive for other organizations interested in service integration.

References

1. Valentijn PP SM, Opheij W, Bruijnzeels MA. Understanding integrated care: a comprehensive conceptual framework based on the integrative functions of primary care. *Int J Integr Care*. 2013:13e010.
2. Heath B, Wise Romero P, Reynolds K. *A Review and Proposed Standard Framework for Levels of Integrated Healthcare*. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions; March 2013. https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf. Accessed November 6, 2018.

This work is funded through HRSA Cooperative Agreement U81HP27843: Health Workforce Research Centers Program.