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Physical and Behavioral Healthcare Integration
Workforce Development Issue Research Brief

The integration of physical and behavioral health care, which is the systematic coordination of the broad range of primary care, mental health, and substance use services, is a growing trend across healthcare systems and settings. This is in large part due to the growing number of studies that have identified correlations between physical and behavioral health outcomes across age groups, and research identifying integrated healthcare leading to improved quality of care, outcomes, access, reduced costs, reduced provider burnout, and reduced stigma and discrimination of people with mental health and substance use problems.[i, ii] Additionally, recent healthcare policy reforms and funding incentives at the federal and state levels have stimulated the movement towards integration.

Although the movement towards integration of physical and behavioral health care is accelerating, there remain numerous barriers to full implementation of integrated healthcare systems. The key barriers to integration include:[iii, iv]

- o Lack of information technology and information sharing;
- o Lack of physical infrastructure;
- o Policy and regulatory challenges;
- o Financing mechanism; and
- o Workforce development.

This issue brief will focus on the workforce development barriers to integration. This brief will first provide an overview of the framework for types of integration and the need for integration. Furthermore, this brief will focus on healthcare workforce development barriers and provide recommendations for the implementation of integrated care. Finally, this brief will provide a summary of different resources to address healthcare workforce development integration barriers and a list of research and published studies on integration.

What is integration?

In general terms, physical and behavioral healthcare integration is the systematic coordination of the broad range of primary care, mental health, and substance use services.[v] Although there have been many research articles and studies outlining different types and models of integration, there is currently not one defined model or framework for the meaning of integration (Appendix A- Research on Integration). In order to provide a standard understanding of different types of integration/collaboration, the Substance Abuse Mental Health Services Administration (SAMHSA) - Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) released a report providing a standard framework for the different levels of integrated healthcare. This framework is intended to provide a common understanding

of integration to assist organizations that are developing initiatives towards implementing various degrees of integration. The framework has three overarching categories which include coordinated care, co-located care, and integrated care. Within each overarching category, there are two levels providing different degrees of integration for each respective category. The table below provides a definition for each level of integration as outlined in the SAMHSA-HRSA-CIHS report.[vi]

Standard Framework for Levels of Integration	
Coordinated Care	
Level 1 — *Minimal Collaboration*	Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient.
Level 2 — *Basic Collaboration at a Distance*	Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.
Co-Located Care	
Level 3 — *Basic Collaboration Onsite*	Behavioral health and primary care providers co-located in the same facility, but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers
Level 4 — *Close Collaboration with Some System Integration*	There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.
Integrated Care	
Level 5 — *Close Collaboration*	There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function

Approaching an Integrated Practice	as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.
Level 6 — *Full Collaboration in a Transformed/Merged Practice*	The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Table Reference: A Standard Framework for Levels of Integrated Health. SAMHSA-HRSA- Center for Integrated Health Solutions. April 2013.

<u>Why is Integration Needed?</u>

Many studies have identified correlations between physical and behavioral health outcomes across age groups. Increased physical symptoms often lead to increased psychological symptoms, especially for those with chronic medical illnesses and with the worst medical outcomes. For example, one study identified that as many as 70 percent of primary care visits originate from psychological issues[vii] and up to 60 percent of individuals that visit a primary care clinic also have a diagnosable mental disorder.[viii] Additionally, children and youth are experiencing increased behavioral health conditions at an alarming rate leading to poorer health outcomes that increase mortality rates and, as a result, impact their growth and development.[ix]

One of the keys to addressing the aforementioned issues is the integration of physical and behavioral health care. Research has identified integration as an effective approach to preventing the development of health care conditions and providing care for people with multiple health care needs.[x] Integrated physical and behavioral healthcare has been recognized to produce better outcomes, improve quality of care, increased access, reduced costs, and reduced stigma and discrimination of people with mental health and/or substance use problems.[xi] [xii] The integration of substance use services with primary care and behavioral health also provides an opportunity for earlier intervention in the course of a life for individuals suffering from addiction disorders.[xiii] Additionally, physical and behavioral healthcare integration has been shown to lead to reduced healthcare provider burnout and work silos as it allows providers to work together in collaboration and learn from each other on a wide array of health issues.[xiv]

<u>Healthcare Workforce Development Barriers to Integration</u>

Although there are many barriers to physical and behavioral healthcare integration, some of the key barriers revolve around issues pertaining to the healthcare workforce. To successfully implement integration initiatives, the following healthcare workforce issues may require an additional focus:

- *Shortages of physical and behavioral healthcare providers:[xv]*

  Recent health workforce studies reveal that health professional shortage and distribution issues impact access to primary and behavioral healthcare. As of November 2013, California has 182 primary care health profession shortage areas (HPSA) and 153 mental health HPSAs.[xvi] The high volume of shortage areas demonstrates the lack of healthcare providers throughout California which is a barrier to integration.

- *Providers lacking diversity and competencies to care for culturally diverse communities:[xvii]*

  According to 2013 estimates from the US Census, California is the most populous and diverse State in the nation with over 38.3 million residents, accounting for 12 percent of the nation's population.[xviii] A 2009 report titled "California Speaks: Language Diversity and English Proficiency by Legislative District" from the Asian Pacific American Legal Center of Southern California and the Asian & Pacific Islander American Health Forum states that more than 12 million (approximately 40 percent) Californians speak a language other than English in the home: 8.1 million speak Spanish and more than 2.7 million speak an Asian or Pacific Islander language.[xix] The increased diversity in languages spoken in California demonstrates the need for culturally competent healthcare professionals. As illustrated below, California's current healthcare workforce does not reflect the State's demographics with respect to racial and ethnic composition.

	California Population[xx]	Nurses[xxi]	Physicians[xxii]	Dentists[xxiii]
African American	6.6%	5%	3%	3%
Asian/Pacific Islander	13.9%	31%	21%	32%
Latino/Hispanic	38.2%	7%	4%	7%
Other	1.9%	3%	7%	1%
White	39.4%	53%	52%	57%

With the exception of Whites, California's racial and ethnic populations are projected to continue growing over the next several decades. These figures demonstrate there is a lack of diversity within our current healthcare providers to care for California's growing culturally diverse communities as compared to our population.

- *Providers lacking competencies and skills to work in and provide integrated/coordinated care:[xxiv]*

  Most physical and behavioral healthcare providers currently work and have been working in a traditional healthcare setting for their entire careers. Physical and Behavioral healthcare integration, regardless of the level of integration, will bring change to the traditional methods of providing care. This lack of experience of working in integrated/coordinated care models creates a barrier to integration as current providers do not currently have the competencies to easily transition into integrated systems which will require providers to adapt their traditional methods and work collaboratively within a team environment, and use evidenced-based and recovery-oriented approaches for integrated settings.

- *Cultural differences between physical and behavioral healthcare providers:[xxv]*

  Physical and behavioral healthcare providers have distinct ways of looking at issues and providing care to patients based on their different types of training, experience, and work settings. There are also differences with primary care and behavioral health providers' treatment philosophies, working styles, and patient communication practices.[xxvi] These differences create cultural barriers between the two types of providers. As integration will require physical and behavioral healthcare providers to work collaboratively and in team settings, these cultural differences may cause a barrier as the providers will need to work together with other providers that have methods different than their own.

- *Providers' reluctance to change practice patterns:[xxvii]*

  Integration will require physical and behavioral healthcare providers to transition from traditional practice patterns to integrated model practice patterns. As most providers have been working in traditional healthcare settings for most of their careers, some providers may be reluctant to change their traditional practice patterns which can cause a major barrier to full integration of physical and behavioral healthcare integration.

- *Providers stigma towards persons with mental health and/or substance use problems:[xxviii]*

  Most physical healthcare providers have not had adequate training on providing care to persons with mental health and/or substance use problems. Oftentimes the lack of training and experiences with this population leads to these providers having negative stigma about persons with mental health and substance use problems. Integrated systems will require physical healthcare providers to treat more patients with mental health and substance use problems and the negative stigma due to lack of training can be a barrier to providing competent care.

- *Lack of financial incentives to reinforce the skills required to provide integrated care:[xxix]*

  Physical and behavioral healthcare providers will require training to acquire the skills required to provide integrated care. There are few financial incentives for organizations to train providers, and few financial incentives for providers to attend the training to reinforce

their skills. The lack of financial incentives may be a barrier as there will not be a motive for providers to seek training to acquire additional skills.

- *Shortage of leaders committed to and capable of managing the organizational change process to achieve integration:[xxx]*

  Physical and behavioral healthcare integration will require a commitment to organizational change to help further integration efforts. To successfully implement organizational change there will be a need for leaders who are committed to and have the experience and the skills to manage these organizational changes. The shortage of these types of leaders can cause a barrier to the successful integration of physical and behavioral healthcare.

<u>Healthcare Workforce Development Recommendations for Integration</u>

To successfully address the aforementioned healthcare workforce barriers to integration, researchers have identified multi-pronged approaches to tackle the various issues. This section provides an overview of healthcare workforce development recommendations that have been outlined throughout various reports. This section groups the recommendations by the organization that developed the recommendations and the report that contains the information. There are several organizations that focus on developing resources, research, and analysis on integration, and have developed multiple sets of recommendations. Although all the sets of recommendations found for those organizations are listed in this report, it is not the intention to place a greater priority on the recommendations of those organizations. The following are recommendations from reports that were identified during the research process.

California Department of Healthcare Services Needs Assessment Recommendations[xxxi]

In 2012, the California Department of Healthcare Services conducted a needs assessment which included key findings for integration. Among the key findings were several recommendations that were specific to healthcare workforce issues including:

- To prepare for integration of services into primary care, cross train between the substance use disorder (SUD), primary care, and mental health workforce to understand the basics of substance abuse, mental health issues, and physical ailments that mimic alcohol and other drug abuse (AOD).
- All practitioners of the healing arts, including doctors, nurses, physicians assistants, licensed clinical social workers (LCSWs), marriage and family therapists (MFTs), and others, must expand their skillset to recognize AOD and co-occurring disorders (COD)
- COD affects a large portion of those seeking treatment. Core competency standards and training should address this.
- Sharing information among providers will be a key element to creating one problem list, one drug list, and one care plan. This collaboration between providers can be aided by the use of electronic health records, electronic billing, care management, and the concept of individual wellness.
- The workforce must be trained in the use of, and adopt evidence-based practices.
- Acknowledge that some areas of the state may have very limited access to SUD workforce. Address the influx of underserved populations.
- Identify how cultural competency will be addressed.

- All services delivered are not considered insurance billable services. Build a business case for reimbursement and provide input to SAMHSA.
- Universal screening could pave the way for a newly designated category of SUD credential.
- Ensure the workforce is trained and prepared to deliver all SUD related services identified for the expansion population and the Health Insurance Exchange.
- The private healthcare workforce will also expand and enhance its skillset to stay competitive and able to meet the increased demand for service. To augment the private workforce, county-level workforce may be enticed to the private healthcare market by better wages, benefits, and educational opportunities. This will further add to the public sector workforce shortage.

Integrated Behavioral Health Project (IBHP) Recommendations[xxxii]

In 2012 the Integrated Behavioral Health Project (IBHP) conducted a statewide needs assessment of integrated behavioral healthcare training and activities in California. Among the key findings were two recommendations that were specific to healthcare workforce development including:

- The need to train staff and providers within California's community clinics and health centers on how to be sensitive to individuals seeking behavioral health services. Additionally, there was a need for training on creating an environment that is free of stigma and discrimination.
- The need to have California's community clinics and health centers team members understand each other' roles in an integrated system including the roles of mental health and substance use staff.

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) Recommendations

The SAMHSA-HRSA, CIHS serves to promote the development of integrated primary and behavioral health services. As such, they have developed several reports that provide recommendations on different aspects of integration. The following five sets of recommendations were found throughout various SAMHSA-HRSA, CIHS reports and were specific to workforce.

To address healthcare workforce development barrier to primary and behavioral healthcare integration, the SAMHSA-HRSA CIHS developed 22 recommendations around seven themes. The themes included: training and education; recruitment and retention; leadership; persons in recovery; community; infrastructure development; and research and evaluation. Below is a table outlining the recommendations developed for each theme:[xxxiii]

SAMHSA-HRSA CIHS Recommendations for Integration Healthcare Workforce Barriers
Training and Education
A. Evidence-Based Training: Implement evidence-based teaching methods by creating a Learning Home on Integration that links individuals to sequenced educational opportunities that are reinforced through supervision.
B. Faculty & Trainer Development: Foster the skills of teachers and trainers by creating the

Faculty Forum on Integration to coordinate educational resource sharing, identification of educational best practices, and the continuing education and mentoring of educators (modeled after the Association for Medical Education and Research in Substance Abuse).

C. Higher Education Curriculum Reform: Promote the adoption of curricula on integrated care in professional education programs by engaging educational leaders to develop and implement an action plan on curricula reform.

D. Core Competency Development: Identify and disseminate three sets of core competencies on integrated practice tailored to: (1) general healthcare; (2) behavioral health; and (3) peer support.

E. Core Curriculum Development: Facilitate workforce training by developing and disseminating portable curricula on a small number of high priority competencies, which would include data and interventions that hold promise for highly impacted communities with disparate mental health outcomes and access.

Recruitment and Retention

A. Quality Improvement Collaboratives: Promote the development, implementation, and evaluation of recruitment and retention strategies in integrated care, drawing on quality improvement models employed by the Institute for Healthcare Improvement and NIATx and as called for in Health and Human Services Secretary Kathleen Sebelius' "National Strategy for Quality Improvement in Healthcare."

B. Cultural and Linguistic Diversity: Through a quality improvement collaborative focused specifically on diversity, foster the adoption of recruitment and retention strategies, including "grow your own" models for a range of health professions, expanded roles for community health workers, social marketing with young students, and student exposure to minority faculty members, as well as link with community-based participatory research and comparative effectiveness initiatives that look to identify different models' efficacy in subpopulations based on race, ethnicity, and language proficiency.

C. Realistic Job Previews and Selection Tools: Create video previews of integrated care workforce roles and a toolkit on selection procedures and criteria to promote recruitment and retention for these roles.

D. Rural and Underserved Areas: Identify and address behavioral health workforce shortages in integrated care by using HRSA, SAMHSA, and National Association of Community Health Centers (NACHC data to identify specific needs and the existing behavioral health services that can be better linked to the general healthcare system to address unmet need.) Build on the resources of the National Health Service Corps (NHSC).

Leadership

A. Leadership Development: Create the Leadership Program in Integrated Health as a permanent learning home for professionals and peers on bidirectional integration administration and change management.

B. Supervision Development: Develop and deliver a curriculum on best practices in integrated care that combines basic training, access to additional educational resources, and experiential learning.

Persons in Recovery

A. Competency Development: Develop a set of core competencies for peer roles in integrated care that will guide future curriculum development, training, and assessment

of peers addressing whole health.
  B. Shared Decision-Making: Foster patient- and family-driven care by identifying competencies and developing or refining model curricula on shared decision making in integrated healthcare.
  C. Education Regarding Peer Roles in Integration: Strengthen the roles of consumers by developing curricula and organizing training experiences that (1) educate persons in recovery about the nature of non-psychiatric work settings and (2) educate providers about the potential roles and contributions of peers in these settings.

Community
A. Community Capacity Building: Help community groups and coalitions, through technical assistance, to adopt a "whole health" approach as they provide prevention, health promotion, and early intervention with identified community health needs.

Infrastructure Development
A. Technical Assistance: Provide an essential infrastructure through CIHS for delivering technical assistance on workforce development in integrated care to the field. B. Structures for Continuous Learning: Create structures through the strategies identified above for organized and continuous workforce development, including the Learning Home for providers; the Faculty Forum for teachers; the Leadership Program for managers and executives; and the Quality Improvement Collaboratives on recruitment and retention. C. Financing: Identify and disseminate information on the workforce-related financing barriers to integration, including: prohibitions on same day billing; exclusion of selected behavioral health professions in federal and state funded insurance plans; and the absence of Medicaid coverage for peer support services in numerous states. D. Telemedicine and Telepsychiatry: Promote the use of these technologies by identifying early adopters and best practices in telemedicine and telepsychiatry and assembling an expert panel to provide technical assistance on these methods. (Note: this effort will be informed by HRSA's two offices on telehealth: the National Telehealth Resource Center and the American Telemedicine Association.) E. Accountable Care Organizations: Work closely with SAMHSA, HRSA, and CMS to promote the inclusion of behavioral health and the delivery of integrated care.

Research and Evaluation
A. Logic Models: Establish routine use of logic models for all CIHS workforce interventions on integration to make explicit the assumptions about the potential impact of interventions prior to their adoption. B. Program Evaluation: Support (within the limited resources available) the use of basic program evaluation strategies as part of a continuous quality improvement effort to strengthen the effect of workforce interventions.

Table Reference: Primary and Behavioral Healthcare Integration: Guiding Principles for Workforce Development. SAMHSA-HRSA Center for Integrated Health Solutions

SAMHSA-HRSA-CIHS also developed a report on workforce issues related to bi-directional physical and behavioral healthcare integration. The report outlined a great need for continuing education and organizational commitment in order to adopt best practices for integrated care. Specifically, the report outlined the need for the following:[xxxiv]

- Continuing education and training which includes post training evaluation, mentoring or supervision is more likely to be effective; training best practices should be adopted.
- Specific programs to support the broad adoption of both medication assisted treatment and screening, brief intervention and referral to treatment need to be identified and implemented.
- Effective training is accompanied by ongoing monitoring, supervision, mentoring, and other quality improvement activities, if innovations are to be adopted with fidelity; and
- Training to work in teams will be essential for integration; such programs can be adapted from other fields, but will need some tailoring specific to healthcare and substance abuse treatment.

SAMHSA-HRSA CIHS additionally developed a set of key elements that are needed to have successful integrated care for substance use conditions which included the need to:[xxxv]

- Ensure that the core behavioral health disciplines have adequate training in the disease of addiction, the nature of substance use conditions and treatment, and how to work in a complex team as part of their basic educational program.
- Ensure that counselors who are the backbone of the substance abuse treatment workforce have the necessary competencies and are certified to provide high quality care in an integrated healthcare system.
- Ensure the full adoption and integration of, at minimum, two specific evidenced based practices: 1) screening, brief intervention and referral to treatment in primary care and other healthcare settings and 2) medication-assisted treatment in both primary care and specialty care settings.
- Substantial training in team competencies will be essential for success in integrated care.

In a report developed by the Community Anti-Drug Coalition of America for SAMHSA-HRSA-CIHS titled: "Coalitions and Community Health: Integration of Behavioral Health and Primary Care", the authors identified workforce development as one of the key roles for coalitions. Specifically, the report identified the need for coalitions to support training and professional skills development in order to strengthen the implementation and sustainability of integrated care. The report outlined various examples of how coalitions have supported integrated healthcare workforce development strategies including:[xxxvi]

- Sharing templates used to identify training needs;
- Sharing paid evaluators in survey development and using low cost web based platforms;
- Mobilizing community stakeholders to jointly sponsor trainings;
- Developing and sharing resources and tools to support providers; and
- Educating primary care and mental health providers on prevention of substance use issues.

One key element to integration is having a set of core competencies that appropriately prepare and develop the healthcare workforce to work in integrated/coordinated care settings. The SAMHSA-HRSA CIHS developed a set of core competencies that, if implemented, can further the integration agenda in multiple ways including: shaping workforce training; informing job description; employee recruitment; guiding orientation; assessing performance; and shaping

existing and future competency sets. There are a total of nine core competencies including: Interpersonal communication, collaboration and teamwork, screening and assessment, care planning and care coordination, intervention, cultural competence and adaption, systems oriented practice, practice based learning and quality improvement, and informatics. The following table provides a brief description of each core competency as outlined in the SAMHSA-HRSA CIHS report: [xxxvii]

I. INTERPERSONAL COMMUNICATION
The ability to establish rapport quickly and to communicate effectively with consumers of health care, their family members and other providers.
Examples include: active listening; conveying information in a jargon-free, non-judgmental manner; using terminology common to the setting in which care is delivered; and adapting to the preferred mode of communication of the consumers and families served.
II. COLLABORATION AND TEAMWORK
The ability to function effectively as a member of an interprofessional team that includes behavioral health and primary care providers, consumers and family members.
Examples include: understanding and valuing the roles and responsibilities of other team members, expressing professional opinions and resolving differences of opinion quickly, providing and seeking consultation, and fostering shared decision-making.
III. SCREENING AND ASSESSMENT
The ability to conduct brief, evidence-based and developmentally appropriate screening and to conduct or arrange for more detailed assessments when indicated.
Examples include screening and assessment for: risky, harmful or dependent use of substances; cognitive impairment; mental health problems; behaviors that compromise health; harm to self or others; and abuse, neglect, and domestic violence.
IV. CARE PLANNING AND CARE COORDINATION
The ability to create and implement integrated care plans, ensuring access to an array of linked services, and the exchange of information among consumers, family members, and providers.
Examples include: assisting in the development of care plans, whole health, and wellness recovery plans; matching the type and intensity of services to consumers' needs; providing patient navigation services; and implementing disease management programs.
V. INTERVENTION
The ability to provide a range of brief, focused prevention, treatment and recovery services, as well as longer-term treatment and support for consumers with persistent illnesses.
Examples include: motivational interventions, health promotion and wellness services, health education, crisis intervention, brief treatments for mental health and substance use problems, and medication assisted treatments.
VI. CULTURAL COMPETENCE AND ADAPTATION
The ability to provide services that are relevant to the culture of the consumer and their family.
Examples include: identifying and addressing disparities in healthcare access and quality, adapting services to language preferences and cultural norms, and promoting diversity among the providers working in interprofessional teams.
VII. SYSTEMS ORIENTED PRACTICE
The ability to function effectively within the organizational and financial structures of the local system of healthcare.

Examples include: understanding and educating consumers about healthcare benefits, navigating utilization management processes, and adjusting the delivery of care to emerging healthcare reforms.
VIII. PRACTICE-BASED LEARNING AND QUALITY IMPROVEMENT
The ability to assess and continually improve the services delivered as an individual provider and as an interprofessional team.
Examples include: identifying and implementing evidence-based practices, assessing treatment fidelity, measuring consumer satisfaction and healthcare outcomes, recognizing and rapidly addressing errors in care, and collaborating with other team members on service improvement.
IX. INFORMATICS
The ability to use information technology to support and improve integrated healthcare.
Examples include: using electronic health records efficiently and effectively; employing computer and web-based screening, assessment, and intervention tools; utilizing telehealth applications; and safeguarding privacy and confidentiality

Table Reference: Core Competencies for Integrated Behavioral Health and Primary Care. SAMHSA-HRSA Center for Integrated Health Solutions. January 2014.

Substance Abuse and Mental Health Services Administration Recommendations

A SAMHSA report described the need for retooling and repurposing existing workforce to support integration. The SAMHSA report outlined new types of workforce that can support substance use disorders in integrated care settings which include: health educator, primary care behavioral health specialist, expanded care managers, and consultation-liaison clinician. The new types of workforce are defined below: [xxxviii]

- Health Educator is a type of workforce with evolving functions across different models of integration that would generally screen patients for risky health behaviors and provide feedback and/or brief intervention for appropriate patients.
- Primary Care Behavioral Health Specialist (PCBH Specialist) is a new type of worker needed for integration. The PCBH Specialist would work with those that have mental and substance use conditions and assist other patients whose behavior changes are keeping them from improved health. There would be various competencies the PCBH Specialist would need to have including assessment and treatment of services planning of individuals with mental and substance use disorders, consultation, communication, care management, team collaboration and an understanding of chronic disease and self-care requirements.
- Expanded Care Manager is a type of worker that would assist patients in managing both medical conditions and related psychological problems. Care Manager is more appropriate with patients that have multiple chronic conditions and patients that have a significantly high cost of care.
- Consultation-liaison Clinician is a traditional type of workforce that SAMHSA suggest the need for restructuring to deal with both the diagnosis and treatment of physically ill patients, and to work collaboratively with primary care givers including mentoring other clinicians in the application of new practices.

From 2009 to 2013, SAMHSA provided funding via the Primary and Behavioral Health Care Integration Program to support communities with the integration of primary care services into publicly-funded community-based behavioral health settings. Various grantees came together to develop keys to successful integration two of which were workforce related recommendations which include:[xxxix]

- Hiring peers for both the whole health and wellness sides of the clinics; and
- Addressing cultural and linguistic competencies to ensure best communication and understanding of clients' cultural, values, and actions.

California Institute for Mental Health[xl]

The California Institute for Mental Health developed core values to guide and shape integrated care. One element outlined in this report as being critical to implementing integration was the need for cross training all staff including primary care, mental health, and substance use on integrated care. The cross training would be intended to develop basic understanding and awareness of the interaction between health and behavioral health conditions, risk screening, and other basic integration approaches. This report also supports the inclusion of peers, health navigators, and family members as part of the integrated system and outlines the contributions they can bring to an integrated healthcare system.

National Committee for Quality Assurance

In 2013, the National Committee for Quality Assurance developed a report on integrated care for people with Medicare and Medicaid. One critical element they highlight is the need for better relationships and complementary skills of providers within and across healthcare systems while providers who have extensive experience with Medicare and Medicaid beneficiaries others do not which can hinder delivery of adequate care.

National Institute for Health Care Management [xli]

The National Institute for Health Care Management developed a report outlining strategies to support the integration of mental health into pediatric primary care. Two key recommendations within the report specific to healthcare workforce development included:

- Addressing workforce competency issues by changing health profession education curricula and increasing continuing education for current providers; and
- Education and training curricula should include cross-training primary care and mental health providers; mental health curricula for primary care residencies, and training on family-driven care across primary care and behavioral health professions.

Other Research Completed by Individuals

Dr. Dilonardo (2011) developed a report outlining integration challenges specific to addiction providers and primary care provider's networks. The report illustrated key recommendations that will drive a successful integration of substance use disorder into primary care which included:[xlii]

- Adequate training in substance use disorders and complex teamwork;
- Necessary competence and certification/licensure for substance abuse counselors;
- Broad and high quality adoption of SBIRT and MAT;
- Use of evidence-based training methods for evidence-based practices; and
- Team competencies with follow-up.

Dundon, Dollar, Schohn, and Latinga (2011) developed an operations manual for primary care-mental health integration and stated that recruiting, hiring, and supervising providers is a complex process. One key recommendation in the report was that administrators should have a clear understanding of roles or expectations of a provider when hiring in order to select the most appropriate candidate. The report outlined the importance of training providers to work within integrated environments in order to familiarize themselves with new settings and expectations. Additionally, the report specified various curricula elements that should be included in the training including:[xliii]

- Expanded clinical practice skills;
- Practice management skills;
- Consultation skills; and
- Documentation skills.

Resources to Address Healthcare Workforce Development Barrier to Integration

There are many organizations that have developed resources and that provide technical assistance to advance physical and behavioral healthcare integration. This section provides an overview of those organizations and contains links to their websites where additional resources can be located.

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)

The Substance Abuse Mental Health Service Administration (SAMHSA) and Health Resources and Services Administration (HRSA) funded the creation of the Center for Integrated Health Solutions (CIHS) which serves to promote the development of integrated primary and behavioral health services. CIHS supports both organizational and system reform and provides resources and expertise in the clinical "What" and operational "How" to address several critical issues including: bidirectional integration training, aging workforce, evidenced-based practice adoption, licensure support, credentialing, curriculum development, and accreditation. CIHS aims to increase the number of:

- Individuals trained in specific behavioral health related practices;
- Organizations using integrated healthcare service delivery approaches;
- Consumers credentialed to provide behavioral health related practices;
- Model curriculums developed for bidirectional primary and behavioral health integrated practice; and,
- Health providers trained in the concepts of wellness and behavioral health recovery.

To learn more about CIHS and view all the resources they have to offer, please visit their webpage at: http://www.integration.samhsa.gov/workforce/list

Worker Education and Resource Center (WERC)

The Worker Education and Resource Center is a non-profit organization that has programs geared toward high demand careers in the healthcare safety net. They provide comprehensive training courses for community health outreach workers to be part of multidisciplinary teams and include integrated curriculum that includes: mental and physical health concepts; basic anatomy, biology, and life science; vocabulary; math; soft skills; and computer skills. To learn more about WERC and the resources they offer, please visit their webpage at: http://www.we-rc.org/

Integrating Mental Health and Pediatric Primary Care Resource Center

The National Alliance on Mental Illness (NAMI) developed the Integrating Mental Health and Pediatric Primary Care Resource Center which provides resources for primary care providers engaging in integration initiatives. To view the resources page please visit the following link: http://www.nami.org/Template.cfm?Section=child_and_teen_support&Template=/ContentManagement/ContentDisplay.cfm&ContentID=120673

Center for Integrated Primary Care

The University of Massachusetts (UMass) Medical Schools developed the Center for Integrated Primary Care whose mission is to:

- Workforce - to develop, synthesize and disseminate skills for best practices in integrated primary care (IPC) so as to become a national leader in workforce development.
- Technical assistance - to support and showcase the development of IPC across UMass memorial departments, regionally and nationally.
- Evaluation - to serve as a center of excellence in the evaluation of programs that integrate behavioral health and primary care services.

The Center for Integrated Primary Care has various resources to support integration which can be located via the following link: http://www.umassmed.edu/cipc/index.aspx

Integrated Behavioral Health Project

The Integrated Behavioral Health Project (IBHP) identifies and disseminates effective, culturally-relevant strategies for integration, including approaches to recognize and treat physical and behavioral health care needs. IBHP provides tools, technical assistance, and information to providers so they can work collaboratively and effectively. To view IBHP resources, visit the following webpage: http://www.ibhp.org/index.php?section=pages&cid=73

Affordable Care Act (ACA)

The ACA has also appropriated funds that support and enhance workforce development efforts related to integration of primary care and mental health. These efforts have been critical in moving integration forward and more funding may be appropriate in the future. To view current federal funding opportunities on integration, please visit the following webpage: http://www.integration.samhsa.gov/financing/grant-opportunities

The Affordable Care Act Resources website provides resources on workforce development issues for integration including: training curricula and products; PowerPoint presentations, and reports/toolkits that provide information on implementing integration. The resources can be located via the following link: http://www.uclaisap.org/affordable-care-act/html/workforce-development.html

Conclusion

Physical and behavioral healthcare integration, although not yet fully defined has been identified as a model that improves overall health outcomes across age groups and populations. While healthcare workforce development remains a fundamental barrier to physical and behavioral healthcare integration, many organizations have developed broad-based recommendations that aim to address the varying healthcare workforce development issues. Additionally, many organizations have taken a proactive role in providing resources and technical assistance to providers and healthcare systems in order to facilitate the implementation of integration. To further integration efforts, organizations throughout California should work collaboratively to consider and implement all appropriate identified recommendations, and leverage existing resources in order to ensure a successful physical and behavioral healthcare integration.

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