

# Primary Care and Behavioral Health Workforce Integration: Barriers and Best Practices

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## KEY FINDINGS

Prior research has highlighted the benefits of integrated care, which contribute to better care for individuals, better health for populations, and lower costs for healthcare. Integrated care improves patient outcomes, reduces reimbursement issues, increases employee productivity, boosts employee satisfaction, and decreases costs. It also increases access to behavioral health services and reduces patients' readmission rates. While the evidence supporting integrated primary and behavioral health care is strong and integrated care has been embraced by some care providers and health care administrators, the process of integrating care can nonetheless be challenging, specifically related to preparation of the workforce. To understand the barriers, challenges, and best practices of integrating care, a case study was conducted with eight key informants from organizations throughout the country that have successfully implemented integrated care models.

The study participants described a diverse workforce population involved in integrated care, including a team of physicians, nurses, psychologists, social workers, licensed professional counselors, marriage and family therapists, and peer support personnel. Models of integrating care ranged from the infusion of behavioral health professionals into primary care settings to the integration of basic primary care services into behavioral health clinics.

Five themes related to barriers of integration and three areas of best practices emerged from our interviews. Participants identified the following barriers: 1) insufficient number of staff, 2) disagreements about provider roles, 3) restrictions on sharing patient information, specifically for patients receiving treatment for substance use, 4) state and federal policies that hinder reimbursement for care, and 5) workflow and logistical obstacles. Study participants identified areas of best practice as 1) building a culture of collaboration within the organization, 2) engaging employees in orientation or training programs, and 3) utilizing a cooperative approach and fostering a system for "warm hand-offs" to improve patient care.

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## BACKGROUND

One in four Americans experience a behavioral health illness each year, and the majority of those individuals also suffer from a comorbid physical health condition (American Hospital Association, 2014). Moreover, between 30-80% of all primary care visits are driven, in part, by behavioral health issues, necessitating that primary care physicians (PCPs) provide mental health care and substance use disorder services (Wodarski, 2014). Overall, approximately 60% of mental health care visits are directed to a PCP (Wodarski, 2014) and almost half of patients do not follow through when referred to a mental health specialist (Grembowski et al., 2002). There are several reasons why a patient would prefer to see their PCP over a behavioral health specialist, including concerns about confidentiality, barriers to access, or the discrimination surrounding mental health care and/or substance use disorder treatment.

Integrating primary care and behavioral health care services through team-based care models is one strategy for improving health outcomes. The Agency for Healthcare Research and Quality's (AHRQ) defines integrated care as:

Care resulting from a practice team of primary and behavioral health clinicians, working together with patients and families, using a systemic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance use condition, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, physical symptoms, and ineffective patterns of healthcare utilization (AHRQ, 2013).

The push for integrated care is not new, predating health reform, though the addition of federal laws increases the urgency of implementing successful integrated care models. Research has borne out the benefits of integrated care, which contribute to the “triple aim” of better care for individuals, better health for populations, and lower healthcare costs (Addy et al., 2015). For example, integrated care improves patient outcomes, reduces reimbursement issues, increases employee productivity, boosts employee satisfaction, and decreases costs (O'Donnell et al., 2013). It also increases access to behavioral health services and reduces patients' readmissions rates (American Hospital Association, 2014). Finally, integrated care stabilizes PCP's workload, as they can refer patients with behavioral health concerns to a nearby colleague rather than provide care for those patients singlehandedly, likely lacking the sufficient expertise. Thus, the benefits of integrated primary and behavioral health care are substantial.

Although the evidence supporting the positive impact of integrated primary and behavioral health care is strong and integrated care has been embraced by some care providers and health care administrators, the

process of integrating care can nonetheless be challenging, particularly for providers. To understand the barriers, challenges, and best practices for implementing integrated care on the workforce we conducted a qualitative case study consisting of eight interviews with representatives of organizations throughout the country that are providing integrated care. The purpose of this study is to identify workforce factors associated with integrated care provision and focused on collecting and summarizing the following information:

- A summary profile of the workforce engaged in integrated care at each site, including occupations, number of FTEs, number of patients served, and education/training background of the workforce;
- Workforce development initiatives for facilitating an integrated care model: methods used to introduce integrated care protocols to the workforce, ongoing training or other workforce development efforts;
- Evaluation of workforce outcomes: methods for determining whether workers are complying with new protocols or needs for corrective action;
- Feedback from the workforce: barriers to adoption from a worker perspective, resolution of challenges, positive feedback from workers; and
- Best practices or lessons learned for readying the workforce for a transition to integrated care

By documenting best practices and challenges to readying the workforce for care delivery in different types of team-based care models, the findings of this study can assist other organizations in carrying out a smooth transition into integrated care delivery.

## METHODS

This study was conducted by the Behavioral Health Workforce Research Center (BHWRC) at the University of Michigan. To begin, members of the BHWRC and its consortium of partners identified ten potential study participants representing large healthcare systems, Academic Medical Centers, clinics, community organizations, and the Department of Veterans Affairs. Organization representatives were sent a recruitment email, providing them with an overview of BHWRC's activities, summary of the study, and an invitation to serve as a key informant for a one-hour interview. Representatives from eight health care organizations agreed to participate in the interview; participants were geographically diverse, located in Maine, New York, Tennessee, Virginia, Georgia, Michigan, California, and Utah.

The BHWRC developed an interview guide that included questions based on their literature review in PubMed. The interview guide that included the following topics: workforce characteristics, workforce development initiatives, evaluation of workforce outcomes, workforce feedback, and best practices. Prior

to initiating the interviews, questions were piloted with BHWRC researchers who have expertise in qualitative research and integrated care. Semi-structured interviews were conducted with key informants in the spring of 2016 by two BHWRC researchers. Seven interviews were conducted via conference call and one was conducted at the office of the participant. Each interview lasted between one and one-and-a-half hours in length and was audio recorded with the participant's consent. All interview recordings were transcribed. This study was reviewed by the University of Michigan Institutional Review Board and deemed exempt from ongoing review.

BHWRC researchers employed the following research methods as part of their analysis of the interviews. First, the audio tapes were transcribed. Then, BHWRC researchers developed a codebook for summarizing key findings from the interviews, including definitions for each code and examples from the interviews. Next, three BHWRC researchers were randomly assigned interviews for review, after which they compared the results of their initial analysis refined the coding structure as necessary. Finally, they identified 12 common themes covered by the informants (Table 1).

**Table 1.** Themes from key informant interviews

Organizational Description	Reason for Integration	Background of Integration Efforts	Components of Integrated Care
Services Provided in Integrated Care Model	Workforce Involved in Integrated Care	Workforce Training to Integrated Care	Workforce Response to Integrated Care
Workforce Barriers to Integrated Care	Resolution to Barriers	Workforce Feedback on Integrated Care	Best Practices and Important Lessons

To ensure the quality of our coding and findings, each interview followed a cyclical coding process. Each interview was initially coded by two BHWRC researchers. Discrepancies between coders were assessed by a third BHWRC researcher. After the initial coding was completed, BHWRC researchers discussed and resolved all coding disagreements. BHWRC researchers used NVivo 11 for all coding.

## Study Participants

### ***Intermountain Healthcare – Utah***

Intermountain Healthcare is a large, not-for-profit healthcare system, headquartered in Salt Lake City, Utah. Intermountain Healthcare is the largest healthcare provider in the state, with 22 hospitals, 185 clinics, and 1,400 employed physicians. Intermountain Healthcare hospitals serve residents in urban, suburban, and rural areas in the Intermountain West. The organization developed a mental health integration (MHI) program in 2001 that incorporates health care into the primary care process. MHI has been implemented in over 90 of the Intermountain Healthcare clinics within the Intermountain Healthcare system and by community clinics in four other states

### ***Community Caring Collaborative –Maine***

Community Caring Collaborative was formed in 2006 and is located in rural Washington County, Maine. The organization provides integrated care in rural Washington County, Maine and serves populations in their communities, including at-risk infants and young children, families, elders, individuals challenged by substance use disorders, and individuals and families living in crisis or poverty. Community Caring Collaborative also serves as a forum for collaboration, communication, education, and training among local primary, behavioral, and integrated care providers.

### ***Veterans Affairs - Ann Arbor Healthcare System, Michigan; Veterans Affairs - Durham Health Care System, North Carolina***

Veterans Affairs is a government run health system serving military veterans. There are 168 Veterans Affairs hospitals and 1,053 outpatient clinics and offices in the United States, serving nearly nine million Veterans each year. The Veterans Affairs handbook requires that hospitals and outpatient clinics provide integrated mental health services. In support of these efforts, Veterans Affairs has developed their Primary Care Mental Health Integration (PC-MHI) program. BHWRC researchers interviewed providers at two Veterans Affairs sites.

### ***Morehouse School of Medicine – Georgia***

The National Center for Primary Care at Morehouse School of Medicine is a training-based organization that provides resources for the primary care system. The organization conducts both research and training, with a focus on community health, eliminating health disparities, and health information technology.

### ***Cherokee Health Systems - Tennessee***

Cherokee Health Systems is a regional health system, comprised of 45 clinical sites in 13 Tennessee counties. Cherokee health has been providing behavioral, physical, and dental health care for children and adults in their communities since the 1980's.

### ***Northwell Health - New York***

Northwell Health is the 14th largest health system in the country. Northwell services a high diverse population and consists of 21 hospitals, 10 behavioral health hospitals, 400 ambulatory practices, and 4,000 ambulatory providers. Their workforce includes MBAs, MSWs, LMSWs, psychologists, nurse practitioners, licensed psychologists, licensed professional counselors, marriage and family therapists, and peer paraprofessionals, among others.

### ***County of San Mateo Health System - California***

The Behavioral Health and Recovery Services (BHRS) for the County of San Mateo Health Systems provides services for children, youth, families, adults, and older adults for the prevention, early intervention, and treatment of mental health, substance use, and physical health conditions.

## **RESULTS**

Study findings indicated that participating organizations implemented a variety of integrated care models ranging from the infusion of behavioral health professionals into primary care settings to the integration of basic primary care services into behavioral health clinics. Seven organizations provided the number of full-time employees engaged in integrated care, approximate number of patients served annually by integrated care, and occupations employed in integrated care, which can be found in Table 2. The most frequently reported barriers to providing integrated care and best practices for implementing team-based care models are summarized below.

**Table 2.** Study participant information

Organization	Full-time Employees	Approximate Patients Served Annually	Occupations
Intermountain Healthcare	N/A	80,000	Primary Care Physicians Registered Nurses Nurse Practitioners Psychiatrists Psychiatric Nurse Practitioners Psychologists Licensed Clinical Social Workers Care Managers Peer Mentors Nutritionists Pharmacists
Community Caring Collaborative	1	150 families per year	Registered Nurse Social Worker Certified Parent Education Specialist
Veterans Affairs: Ann Arbor Healthcare System (MI)	1,200	1.1 million integrated care encounters serving 386,000 veterans	Primary care providers Social workers Psychologists Nurses Nurse practitioners Health technicians (peers) Clinical pharmacists
Veterans Affairs: Durham Health Care System (NC)	17	46,000	Psychiatrist Psychologists Social Workers Registered Nurse Care Managers Nurse Practitioners
Cherokee Health Systems	732	65,355	Psychologists Primary Care Providers Nurse Practitioners Physician Assistants Community Workers Cardiologists Nephrologists Pharmacists Dentists Psychiatrists Psychiatric Nurse Practitioners Licensed Clinical Social Workers
Northwell Health	3	200	Licensed Mental Health Counselor Licensed Clinical Social Worker Psychiatrist
County of San Mateo Health System	25	1500	Licensed Clinical Social Workers Marriage and Family Therapists Substance Use Counselors Case Managers

## Barriers to Providing Integrated Care

Five major barriers to providing integrated care were identified in the data from the interviews: 1) insufficient number of staff; 2) disagreements about provider roles; 3) restrictions on sharing patient information, specifically for patients receiving treatment for substance use; 4) state and federal policies that hinder reimbursement for care; and 5) workflow and logistical obstacles.

### *Insufficient Number of Staff*

Key informants noted that the integrated health care system lacks sufficient number of staff to effectively deliver integrated care, producing a major barrier in the implementation of integration. This barrier was particularly acute in the delivery of integrated care in primary care and community health settings. One interviewee stated,

“There aren’t enough family practice doctors anymore. There aren’t enough psychiatrists and child psychiatrists, nationally. There’s just not enough people going into the workforce that we’re trying to redesign and improve upon.”

Further exacerbating the challenges of recruiting insufficient number of staff are the difficulty of recruiting a workforce willing to work in a community health or primary care setting. While not unique to organizations which provide care in community health and primary care settings, it was a commonly stated barrier from informant interviews:

“Do we have enough psychiatrists, therapists, psychologists, primary care physicians? Never. We are constantly recruiting. We are constantly trying to get the right person that will work in that [integrated care] setting...”

The demands placed on providers working in primary care and community health setting also intensify the barriers to implementing integrated care. Informants identified that with a greater emphasis on improving population health, the primary care workforce has taken on responsibility for non-health related challenges, including housing and financial concerns. By expanding the role of primary care and community health organizations, this workforce needs experience in a wider set of skills. By adding integrated care to the mix, it can increase the workforce challenges for these organizations.



## ***Disagreements about Provider Roles***

In addition to workforce shortages, disagreements about roles of various providers (i.e., “turf issues”) can be a barrier to delivering integrated care. Regarding professional roles, one interviewee articulated that poorly defined roles can lead to discontinuous patient care:

“There is a professional desire to have some degree of exclusivity, some clarity, some pride or ownership, and that can be really good. At the same time, having overlapping roles or responsibilities becomes difficult. There are bureaucracy challenges with that; to say that something can be everyone’s role means that no one takes central ownership to do it.”

In addition, professionals may be defensive of their scopes of practice or traditional roles of care that are less conducive to integrated care. As one participant states,

“People get a little protective sometimes of their own turf and feel sometimes they hold the burden [of their professional role].”

The desire to protect professional scopes of practice and continue practicing what has traditionally been seen as behavioral health care versus primary care has the potential to hinder the integrated care delivery.

## ***Restrictions on Sharing Patient Information***

The provision of integrated health care is challenged by restrictions on sharing patient information, which is particularly sensitive to patients engaged in substance use disorder treatment. HIPAA laws and regulations, particularly provision 42 CFR Part 2, regulates the disclosure of information to protect patient privacy; however, the rule is unfortunately seen as an impediment to sharing patient information in a collaborative health care environment. As one interviewee explains, the inability to share this patient information is “one of the biggest challenges right now;” this “really interferes with data sharing for clinical purposes. You have to do these workarounds and it is very inconsistent with good care coordination.”

## ***Reimbursement Restrictions***

In addition to regulations that obstruct patient information sharing, state and federal policies have created a reimbursement structure that, according to one key informant, “is not built to value team-based care.” For example, Medicaid restrictions often prohibit billing for physical and mental health services on the same day. One informant remarked:

“This is a consultation-based model. The behaviorist may talk to the primary care provider about a patient, but not see them. The psychiatrist may consult but not see the patient. Even though there is really good outcome data, there often isn’t a billing system in place.”

While states vary in their allowable billing practices, one informant who works in a state which restricts billing to multiple providers in the same day found that it not only hinders continuation of care for patients, but also creates a workforce challenges.

“...it (billing restrictions) makes it really difficult to bring in a provider when they are not always going to get paid when they see a patient.”

Organizations located in states with these billing restrictions face a paradox. By pushing patients to make multiple appointments over different days, the number of patient no-shows can increase. However, challenges to getting proper reimbursements strain organizational finances and make workforce retention more difficult.

### ***Workflow and Logistical Obstacles***

Development of efficient workflow for team-based care coordination is a challenge for many organizations. As one participant states:

“[Workflow] is still a challenge for all specialty care and trying to coordinate that with a medical home...there’s a lack of coordination to specialty care interactions and barriers to organizing data so that you can get the same data to the specialist and primary care doctor and show the patient’s through their entire care continuum.”

Logistical obstacles, such as physical space constraints and lack of financial support for initiation and continuation of care integration add to the challenge of coordinating care. Another key informant described a particular logistical barrier to providing co-located integrated care:

“...the clinic recently asked if we could be flexible in not necessarily having a room designated for us, but potentially be located within a shared work room and then float to an exam room office when a patient need arises. That’s concerning for us, but we do recognize that space is a concern and thinking flexibly and working with our primary care collaborators would be very important

because they are trying to get [patients] in and out [of the clinic] as quickly and efficiently as possible and we have to be mindful of that.”

Another participant spoke of logistical issues when consulting for a community-based integrated care clinic. While organizational leadership embraced the new collaboration with behavioral health clinicians and specialists, the individuals at the community clinic itself did not make space for them. The participant stated, “I wouldn’t say we even integrated, because I think we got to that point where if [they are] not going to have a space for us, we can’t [provide integrated care for patients].”

Additionally, a participant noted physical barriers to effectively providing integrated care, stating that even the location of physical and behavioral health exam rooms has a role in delivery of care. Behavioral and physical health exam rooms are often located at the opposite ends of the building or floor, intersected by long hallways, and crowded patient waiting rooms. These obstacles, however negligible they may seem, are often perceived as “barriers to conducting warm hand-offs,” between primary care providers and behavioral health specialists.

### **Best Practices for Providing Integrated Care**

Three thematic areas of best practice emerged from the interviews: 1) creating a culture of collaboration within the organization, 2) engaging employees in orientation or training programs, and 3) utilizing a cooperative approach and fostering a system for “warm hand-offs” to improve patient care.

#### ***Creating a Culture of Collaboration***

A culture of collaboration within the organization is noted as a prerequisite for building a successful integrated care model. Communication and buy-in provides the base for integrated care delivery. One participant spoke of the workforce collectively holding the same values:

“I believe that the biggest thing is that really good integrated care, just like any good care, comes down to also finding out if people are on the same page in terms of values. Do people really believe in things like building relationships? What we found is that before you do the integrated care, there’s a lot of work [in aligning values] that is often missed.”

Likewise, another key informant emphasized the importance of aligning values, especially when integrated care teams are newly formed, stating,

“Most people dive into [forming integrated care teams] as though it is business as usual. It’s not business as usual at all. Frequently, you’ve got [behavioral and physical health care units] that have not typically meshed very well, or even understood each other very well.”

In addition to aligning core values, participants also emphasized that importance of teamwork when trying to identify the essential elements of providing comprehensive integrated care:

“Teamwork is very important in the whole process. Cultivating your teams, developing [the workforce], and choosing the right people to be on the team – because not everybody can do this model – is essential. Then, the ongoing cultivation of the team is very important...”

The importance of teamwork was also highlighted from the perspective of shared responsibilities among members of the integrated care team. As one interviewee maintained, “if you can’t create a sense of shared responsibility [among the team], you are going to have a really tough time of making [integrated care] work.” When there is crossover between behavioral health and primary care, it is important to create a sense of “togetherness.” In turn, that comradery will create a more productive team and higher quality of care for patients.

### ***Integrated Care Training and Orientation***

Orientation and training programs for workers emerged as critical components of integrated care. Orientation and training help the workforce understand their roles in integrated care, align their core values in patient care, and help foster a sense of teamwork. What is more, formal, on-the-job training has proven essential, as preparation in integrated care is often not occurring in schools. As an interviewee noted:

“Unless you take time to do pre-training, to hold an orientation, and to clear up [any confusion about provider roles], it is going to trip you up. We were willing to invest a lot of time [in training] and building relationships...because we found that when you just ‘showed up,’ it did not work.”

Another participant reflected on a lack of formal workforce training mechanisms that turned into a learning opportunity:

“One thing that we need to do much better is to do training that we did not do initially. We must do it in a more formal way so that it helps the services get integrated much smoother and easier. I

have noticed some of the bumps in the road with some of the clinics we have helped integrate, that we failed to [train]. You have your buy-in from administration, and that's helpful, but you have to lay out the processes for the staff, you have to address potential workflow issues, and begin to solidify the integrated care teams in the clinics so that they actually work together. Then, you can set up continuous communication and feedback, both at the clinical and administrative level so you can constantly evaluate your level of care."

While many organizations engaged the workforce in orientation and training during initial integration of behavioral health and primary care, some found it useful to maintain quarterly and monthly training sessions, often specializing them by position. As one participant explained:

"We pivoted into more of a virtual role with our training. It's become very clear that we need to have much more of a dedicated focus for our care management teams. Over the last three years we've trained several cohorts of 20-25 care managers. It's a virtual care management training series of 12 sessions."

In addition to formalized training for the entire workforce and specialized training by position, some participants found it useful to pair staff with veteran members of the integrated care teams.

### ***Warm Hand-offs***

Co-location of workers alone is insufficient for effective integrated care. As noted, logistical barriers can hinder the continuum of integrated care. Gaps in communication caused by difficulty in patient information sharing can further exacerbate these issues. Thus, a system for "warm hand-offs" – defined by participants as a physical health provider identifying a behavioral health need of a patient (or vice versa), and introducing the patient to the behavioral health specialist in real time – should be utilized to improve patient care. As one participant states:

"We will walk a patient over [to a behavioral health clinician] after a primary care visit and describe [the patient's symptoms]. We'll talk a little bit as a group. I'll then move onto my next patient. [The behavioral health clinician] will work with the patient and support staff members will report back to me, in person or electronically to coordinate a care plan."

Warm hand-offs, especially at the beginning of an episode of care, is extremely important to providing comprehensive integrated care.

## DISCUSSION

There are many advantages to integrated primary and behavioral health care. Integrated care contributes to better care for individuals, improving patient outcomes, increasing access to behavioral health services, and reducing patient readmission rates. Further, integrated care increases employee productivity, boosts employee satisfaction, and decreases costs associated with providing care. Evidence supports integrated care and has it has been embraced by many providers and health care administrators. However, integrated care is not achieved without challenges, especially for the workforce involved. This study identified five barriers to providing integrated care: 1) insufficient number of staff, 2) restrictions on sharing patient information, specifically for patients receiving treatment for substance use, 3) state and federal policies that hinder reimbursement for care, 4) workflow and logistical obstacles, and 5) disagreements about provider roles.

Our interviews also identified three areas of best practice in integrated care: 1) building a culture of collaboration within the organization, 2) engaging employees in orientation or training programs, and 3) utilizing a cooperative approach and fostering a system for “warm hand-offs” to improve patient care. Collectively, these barriers and best practices identify the workforce factors associated with the integration of behavioral health and primary care.

Less information is available on employee job satisfaction and worker retention in integrated care. The same can be said for the effectiveness of integrated care training. As integrated health care continues to mature, this may become an opportunity for future research.

## CONCLUSIONS AND POLICY CONSIDERATIONS

There is a great deal of evidence supporting the positive impact of integrated primary and behavioral health care. Integrated care improves patient outcomes (O’Donnell) and reduces patient’s readmission rates (American Hospital Association, 2014). Further, integrated care can reduce reimbursement issues and decrease costs (O’Donnell). Integrated care can also have a positive impact on the workforce, increasing employee productivity, boosting employee satisfaction, and stabilizing primary care physicians’ workload, enabling them to easily refer patients to other specialties where they might lack expertise.

While the argument for expanding the use of integrated care is strong and has been embraced by many care providers and health care administrators, the process of integrating care can be challenging, and

state and federal policies may obstruct the delivery of comprehensive care. However, there are some signs of positive change. With regard to restrictions related to sharing patient information, 42 CFR part 2 regulations were substantively amended in 2017 after this study was conducted. The final rule makes policy changes to the regulations to better align them with advances in the U.S. health care delivery system. Such enhancements to the rule include new provisions that coincide with the new models of integrated care that are built on a foundation of information sharing to support coordination of patient care, the development of an electronic infrastructure for managing and exchanging patient information, and a new focus on performance measurement within the health care system. Patients with substance use disorders should have the ability to participate in, and benefit from health system delivery improvements, including from new integrated health care models while providing appropriate privacy safeguards. One example of the new provisions includes a change to Consent requirements (§2.31). In certain circumstances, a patient can include a general designation in the “To Whom” section of the consent form, in conjunction with requirements that the consent form include an explicit description of the amount and kind of substance use disorder treatment information that may be disclosed, to facilitate the exchange of health information and through organizations that coordinate care.

Other suggested strategies for improving care coordination focus on federal and state efforts as well as programs from institutions such as universities, organizations, and credentialing agencies that may help streamline education and training for integrated care, thus, providing a better-prepared workforce. When the workforce, financial, and logistical needs of an organization are met in an integrated fashion, patients receive more comprehensive care and the workforce feels supported.

The following considerations may inform state and federal policies that could improve organizational and workforce capacity to integrate primary and behavioral health care:

1. Provide additional support for the creation of workforce pipelines to help address workforce shortages.
2. Expand integrated care in academic curricula in order to help better prepare the workforce for a model of care that is moving towards integration.
3. Highlight the need for integrated care buy-in from leadership, necessitating mechanisms that establish a culture of coordination in organizations.
4. Remove existing federal and state billing structures that hinder coordination of care.

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## REFERENCES

- Addy, C. L., Browne, T., Blake, E. W., & Bailey, J. (2015). Enhancing interprofessional education: Integrating public health and social work perspectives. *American Journal of Public Health, 105*, S106-S108. Retrieved from <http://proxy.lib.umich.edu/login?url=http://search.proquest.com/docview/1660149517?accountid=14667>
- American Hospital Association (2014, February). *Integrating behavioral health across the continuum of care*. Chicago, IL: Health Research & Educational Trust. Retrieved from [www.hpoe.org/integratingbehavioralhealth](http://www.hpoe.org/integratingbehavioralhealth)
- Grembowski, D.E., Martin, D., & Patrick, D.L., Diehr, P., Katon, W., Williams, B., ... Goldberg, H.I. (2002). Managed care, access to mental health specialists, and outcomes among primary care patients with depressive symptoms. *Journal of General Internal Medicine 17(4)*, 258-269.
- O'Donnell, A. N., Williams, M., & Kilbourne, A. M. (2013). Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care. *Journal of General Internal Medicine, 28(12)*, 1667–1672. <http://doi.org/10.1007/s11606-013-2496-z>
- Peek, C.J. & the National Integration Academy Council. (2013). *Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus*. AHRQ Publication No.13-IP001-EF. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf>
- Wodarski, J. S. (2014). The Integrated Behavioral Health Service Delivery System Model. *Social Work in Public Health, 29(4)*, 301-317. doi:10.1080/19371918.2011.622243