Chapter 1
Integrated Behavioral Health Service Models and Core Competencies

1.1 Introduction to Integrated Behavioral Health Practice

The COVID-19 pandemic has demonstrated to the world the importance of health care systems that are adequately prepared to effectively provide universal, comprehensive health care to address co-morbid health and behavioral health disorders. The pandemic has also demonstrated the importance of maintaining a healthy population and the high cost of systemic health inequities that naturally lead to disparities in health. The implementation of the Patient Protection and Affordable Care Act (PPACA) spurred an increased focus on integrated behavioral health care (IBHC) and a promise to address disparities and other issues related to health care access (Andrews et al. 2013). Ten years since the passage of the Affordable Care Act that promise remains unfulfilled. COVID-19 has shown how disastrous the continued failure to fulfill that promise has been to millions of Americans, especially for Black, Indigenous and People of Color (BIPOC) who are more likely to be infected due to their employment as essential workers and difficulty to social distance and who are more likely to experience serious illness and death if infected due to a lack of access to adequate health care and other essential resources (Koma et al. 2020).

For instance, Black Americans are over 3.5 times more likely to die from COVID-19 than their white counterparts. For Latinx persons, the likelihood of death is almost twice that of whites. This, despite the fact that Black and Latinx populations are, on average, younger than the White population and should therefore experience lower rates of death due to COVID 19 (Gross et al. 2020). Currently, early evidence suggests that Indigenous communities with poor access to indoor plumbing combined with long histories of systemic poverty, high rates of comorbid conditions, and poor health care access also face a higher risk of infection, transmission, and death (Rodriguez-Lonebear et al. 2020). According to more recent data through late May 2020, obtained from the CDC and reported by the New York Times, Black and Latinx persons are three times more likely to contract COVID 19, and twice as likely to die from the virus, compared to their white counterparts. Native people are
also far more likely to contract the virus than white people (Oppel et al. 2020). This has been found throughout the United States and does not take into account the recent surge in cases that began in June, 2020.

These disparities are the direct result of racist policies and systems that have led to the inequitable access to health care, wealth, and basic resources such as food, adequate housing, clean air and water, and other social determinants of health (SDOH) for generations of BIPOC persons (Chowkwanyu and Reed 2020). In addition, the chronic daily stress caused by racism, discrimination, overcrowding, police violence, and intentional and unintentional racist insults and assaults experienced by Black and Brown people can lead to “weathering” or advanced aging that can increase the risk for disorders associated with higher rates of death from COVID-19 such as cardiovascular disease, high blood pressure and diabetes (Chowkwanyu and Reed 2020; Geronimus et al. 2006; Sue et al. 2007). The experience of racism has also been linked to higher rates of depression and suicide risk (O’Keefe et al. 2015).

From a behavioral health standpoint, the high stress caused by the pandemic, associated lockdowns, and related economic and educational impacts has placed large segments of the population at higher risk for high stress, addiction, complicated grief, trauma, loneliness, interpersonal violence, depression, and anxiety. Furthermore, the lockdown has prevented large segments of the population with preexisting behavioral issues from receiving adequate health and behavioral health care. The result is likely to be a precipitous rise in new cases of behavioral health disorders and a worsening in pre-existing conditions requiring increased capacity in behavioral health care that currently does not exist. The rising complexity of social and health-related challenges requires solutions that traverse the full range of health and behavioral health professions (Gehlert et al. 2017). The high prevalence of behavioral health problems experienced in the population (i.e., nearly 50% the US population will experience a behavioral health disorder in their lifetime) and the complexities of health and behavioral health require a health care workforce such as social workers and other professionals who can provide behavioral health care in a variety of multidisciplinary settings (Kessler et al. 2005).

1.2 Defining Integrated Behavioral Health Practice

In this book, I define behavioral health practice as care that addresses the needs of persons with co-occurring mental health and addiction issues as well as other behaviors impacting health. Figure 1.1 displays the domains of integrated behavioral health practice. I will address persons receiving care in a variety of settings and from multiple service professionals. As a result, I will use the terms “clients” and “providers” to refer to behavioral health service recipients and professionals, respectively. Behavioral health practice includes comprehensive screening, assessment, prevention, and treatment of the full range of mental health and addictions issues (Peek 2013). Integrated care is an effective means to provide people with access to a range of behavioral health professionals and interventions (Thota et al.
When behavioral health practice is fully *integrated* within health care settings, a team of multidisciplinary professionals provides holistic care for both medical and behavioral health issues. A comprehensive definition of integrated behavioral health and primary care was provided by the Agency for Health Care Research and Quality (2013):

“The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.” (Peek 2013; p. 2).

Figure 1.2 displays the central elements to integrated care. The National Integration Academy Council at the Agency for Health care Research and Quality identified five elements central to integrated care: (1) the deployment of collaborative, holistic, team-based health care designed to address the whole person (e.g., medical and behavioral health); (2) the implementation of universal screening and assessment protocols across health care settings; (3) the use of procedures designed to deliver efficacious, evidence-based treatments and interventions; (4) engaging in cross-disciplinary training and developing a workforce of health care professionals competent to practice integrated care; and (5) the coordination of organizational structures including communication systems, treatment plans, paperwork, records, and billing. Indeed, integrated care has also been defined as: “Tightly integrated, on-site teamwork with a unified care plan as a standard approach to care for designated populations. Connotes organizational integration as well, often involving social and other community services” (Peek 2013; p. 44). This includes the principles of multidisciplinary collaboration, and coordinated organizational practice structures, treatment plans, continuous quality improvement, training and payment, and billing systems (Peek 2013). Health and behavioral health organizations will need to implement professional development strategies that include coaching, alignment of organizational processes and procedures with integrated practices, and the establishment of communities of practice that can lead to organic and sustainable change across all levels of the organization (Mancini and Miner 2013). Achieving truly integrated care will also require a workforce capable of practicing in medical
and behavioral health realms and a health care system with the capacity to provide universal access to coordinated health care for all persons (Mancini et al. 2019).

1.2.1 The Need for Integrated Behavioral Health Practice

1.2.1.1 Comorbidity of Health and Behavioral Health Issues

Behavioral health conditions are common across populations. According to the 2018 National Survey on Drug Use and Health (NSDUH), almost a fifth of the US adult population had a mental illness in 2018 and over 21 million people over 12 years of age (1 in 13 people) needed treatment for either an alcohol or drug use (SAMHSA 2019). These stark numbers are almost certain to markedly rise considering that the long-term health and economic impact of the COVID-19 pandemic will be generational. While the current concern is focused on the capacity of
health care systems to serve clients with physical illnesses, the behavioral health care system also faces the potential to be overwhelmed in the near and distant future.

Behavioral health and physical health conditions are commonly comorbid. Two diseases are comorbid when they co-occur in the same person and impact each other such as mental illness, substance abuse disorders, and chronic disease conditions (Santucci 2012). In 2016, 8.2 million (3.4%) persons had a co-occurring mental illness and substance use disorder. Adolescents also have high rates of comorbid substance abuse and psychiatric disorders (Hser et al. 2001). About half of persons who experience a mental illness will have a comorbid substance use disorder (Kelly and Daley 2013; Ross and Peselow 2012) and almost 70% of adults with a mental illness have a co-occurring chronic physical health condition. Persons experiencing poverty have even higher rates of comorbidity. In the U.S., almost half (49%) of Medicaid beneficiaries have a mental health condition and 52% of those with both Medicare and Medicaid have a mental health condition (Kronick et al. 2009).

Behavioral health conditions such as depression, anxiety, substance use, bipolar disorder, and ADHD are commonly comorbid with physical health conditions such as diabetes, heart disease, hypertension, asthma, and obesity (Gerrity 2014; SAMHSA 2019; Young et al. 2015). For instance, Latinx persons with diabetes are more likely to experience comorbid depression than the broader population (Olvera et al. 2016). This co-occurrence of disorders leads to greater morbidity, mortality, functional impairment, and health care costs (Young et al. 2015).

1.2 Defining Integrated Behavioral Health Practice

1.2.1.2 Health care System Fragmentation

Health care consumers in the United States, particularly members of BIPOC communities and persons who are economically disadvantaged, receive inadequate access to behavioral health care due to the separation of behavioral and primary (physical) health care services and a limited number of providers of behavioral health services (CDC 2013; Cunningham 2009; Schoen et al. 2006). Less than half (41–43%) of persons with a mental health need over the age of 12 received mental health treatment in 2018, and only 11% who needed substance abuse treatment received care at a specialty facility (SAMHSA 2019). For persons with serious mental illnesses, a third did not receive any services (SAMHSA 2019). Further, adults and adolescents with mental health conditions are more likely to smoke, drink, and use substances than those without a mental health condition. Despite this, only a third of adolescents and almost half of adults with a co-occurring mental health and substance use issue received treatment for either disorder in 2018 (SAMHSA 2019).

Providing integrated care can reduce inequities in behavioral health care access and the use of inefficient and costly emergency services because it can conveniently provide culturally competent behavioral health care in the same place as primary care. This reduces burdens on clients who lack child care services, transportation, or time and can increase overall access to services and needed referrals (Bridges et al. 2014; Corrigan et al. 2014; Mechanic and Olfson 2016; Reiss-Brennan et al. 2016; Woltmann et al. 2012),
The Institute of Medicine’s seminal report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* urged a redesign of health care in the United States and concluded that the current health care system in the United States was fundamentally inefficient, unsafe, fragmented, and unable to meet the health care needs of patients. The institute concluded that transformational change to the health care system was needed and, “that merely making incremental improvements in current systems of care will not suffice.” (IOM 2001; p. 2). The authors of the report identified six aims for health care improvement that included making health care systems safer, more effective, patient-centered, timely, efficient, and equitable across race, gender, ethnicity, socioeconomic status, and geographic location. To achieve these aims, the authors identified the need for health care to be provided by a collaborative team of multidisciplinary professionals that provide patient-centered, holistic care coordinated across patient conditions, settings, and services over time (2001).

In another seminal report, Berwick and colleagues (2008) also highlighted the need for health care service transformation. As part of the Institute for Health Care Improvement (IHI), they identified the “triple aim” of health care to: (1) improve the health of the population; (2) improve patients’ care experience (including quality, access, and reliability); and (3) reduce costs (Berwick et al. 2008; p. 760). Integrating health and behavioral health care can address these three aims (Mauer, 2009). Due to the lack of accessible, community-based behavioral health options, large numbers of people access behavioral health services through their primary care providers such as a family physician (Xierali et al. 2013). Co-locating primary care and behavioral health care professionals in the same setting can, therefore, increase access to behavioral health care and reduce the burdens that can interfere with patients’ ability to follow-up on treatment recommendations (Xierali et al. 2013).

Indeed, the integration of behavioral health and primary care services carries vast potential in the prevention, detection, early intervention, and effective management of chronic diseases for patients with co-occurring behavioral and physical health problems (Croft and Parish 2013; Druss and Mauer 2010; Mechanic 2012; Shim et al. 2012). Integration of behavioral health and primary care has been shown to reduce depression symptom severity, increase coping skills, and has been associated with positive experiences of behavioral health care clinicians (Balasubramanian et al. 2017). The use of integrated care teams has been shown to significantly reduce emergency room utilization for persons with serious mental illness (Kim et al. 2017). Providing evidence-based integrated behavioral health treatment in primary care settings can also increase the likelihood that substance use disorders will be detected and patients referred for treatment (Chan et al. 2013), reduce psychiatric symptoms, improve functioning, and increase quality of care (Roy-Byrne et al. 2010). Integrated behavioral health care is also associated with higher referral completion rates at specialty mental health centers (Davis et al. 2016).
1.2.1.3 Health Inequity and Social Determinants of Health

Unfortunately, the pursuit of the triple aim has been inconsistent across the service landscape (Obucina et al. 2018). Further, the exclusive focus of the triple aim on improving population health through more efficient health care and reducing health risk behaviors runs the risk of ignoring the social determinants of health (SDOH) (e.g., lack of basic resources, housing, safety, income, education, and occupational endeavors) that drive health inequities and lead to poor health, particularly for people with behavioral health disorders (Bryan and Donaldson 2016; Kerman and Kidd 2019). Health care, therefore, must move beyond focusing exclusively on health indicators and adequately address the social determinants of health. Increasing transdisciplinary collaboration and integration of health and behavioral health care through collaborative care models and medical homes represents a key way to achieve this goal (Whittington et al. 2015).

Social determinants of health are the socioeconomic contexts that impact health such as income, political power, and access to various resources such as employment opportunities, food, healthy environmental conditions, transportation, quality K-12 education, safety, affordable and stable housing, and health care. Having equitable access to these determinants shape the health and quality of life of individuals and communities (CSDH 2008). Braveman and Gruskin (2003) defined health equity as:

“the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage.” (p. 254)

Health inequity is the inequitable distribution of the conditions of health to groups that have differential access to wealth and power as the result of systemic issues such as racism, discrimination, income and wealth inequality, police violence and over-policing in BIPOC communities, unfair social policies, and environmental pollution among others that lead to health disparities in morbidity and mortality across race, gender, and class (Braveman and Gruskin 2003; Brennan Ramirez et al. 2008). We can improve health equity by reducing system fragmentation through transdisciplinary collaborations across health and behavioral health care organizations, communities, academic institutions, and local, state, and national governmental organizations. This requires community, policy, and system level change to improve the health of the community. (Braveman and Gruskin 2003; Brennan Ramirez et al. 2008; CSDH 2008). The impact of SDOH will be discussed in more detail in Chap. 2, and SDOH assessment practices will be discussed in Chap. 4.
1.3 Behavioral Health Care Integration

Behavioral health care integration exists along a continuum. Early work by Doherty (1995) and Doherty et al. (1996) conceptualized behavioral health care integration as existing across five levels of integration. These levels correspond to the amount of contact and collaboration between professionals. The levels range from complete separation of behavioral health and primary care services to full integration in which professionals work closely as part of a multidisciplinary team with a shared treatment plan, billing, and records system (Doherty 1995; Doherty et al. 1996). The Substance Abuse and Mental Health Services Administration later revised these levels to include six levels of integration (Heath et al. 2013).

Figure 1.3 displays the levels of integration for primary care and behavioral health. In Level 1, there is minimal or no collaboration between behavioral health and primary care services or systems. This level is characterized by a lack of communication or information sharing. In Level 2, behavioral health and primary care services are provided in separate settings and utilize separate professional staff and systems. At this level, professionals occasionally communicate or share information with one another on an as needed basis. In Level 3, behavioral health and primary care services are co-located in the same setting or facility. The co-location of care and familiarity of providers increases the likelihood of referral acceptance and follow-through. However, while behavioral health and primary care providers may occasionally communicate and share information on some patients, these providers make their own decisions regarding patient care, track and evaluate their own outcomes, and utilize separate care plans, billing systems, training schedules, and record systems. In Level 4, services are co-located and there is closer collaboration between behavioral health and primary care providers in the form of shared communication, records, and billing systems as well as cross-training opportunities.

![Fig. 1.3 Levels of integration](image-url)
In this level, behavioral health specialists may be embedded within the primary care team or a behavioral health team may employ a nurse practitioner (Heath et al. 2013). Level four is where true integration begins.

Levels 5 and 6 demonstrate higher levels of collaboration. In Level 5, multidisciplinary teams of behavioral health and primary care professionals engage in team-based care. Providers clearly understand the roles of other professions and work together to design collaborative care plans for each patient. Communication, billing, and records systems may be partially integrated. The sixth and final level of integration indicates full collaborative care in a multidisciplinary team. The boundaries of practice for behavioral health and primary care professionals begin to fade as professionals begin to engage in shared practices that focus on holistic care. For instance, primary care professionals begin to provide brief screening and interventions for behavioral health issues, and behavioral health practitioners may screen for health conditions and assist in the management of chronic disease. Behavioral health and primary care practitioners work as a single health care team designed to address the whole person and this practice is applied to all patient populations. Records, communication, and billing systems are completely or almost completely integrated (Heath et al. 2013).

### 1.3.1 Common Integrated Behavioral Health Practices and Models

There are four practices that are crucial to providing quality integrative care. First, universal screening of all patients is a basic requirement for integrated behavioral health care. All clients should be screened in three areas: (1) common behavioral health concerns such as depressed and anxious mood, adverse events and traumatic stress, community and interpersonal violence, and alcohol and drug use; (2) common health indicators such as stress, heart rate, cholesterol, blood pressure, weight, BMI, and health risk behaviors (e.g., smoking, drinking, substance use, sedentary lifestyle, overeating, unprotected sex); and (3) social determinants of health (e.g., access to basic resources such as safe and secure housing, adequate food, childcare, transportation, safety, employment, and adequate income). In fully integrated behavioral health care settings, screening is a shared responsibility across team members. In partially integrated settings, the addition of a primary care provider (e.g., nurse practitioner) in behavioral health care settings, and/or a behavioral health care provider (e.g., social worker) in a primary care setting can be used to conduct screenings, assessments, counseling, and referrals.

Second, the deployment of peer providers that help people navigate the health care system and access and utilize services across medical and behavioral health systems is another important form of integrated practice. These providers may be health navigators, community health workers, peer specialists, or promotoras. Peer providers provide a range of important, culturally and linguistically inclusive services
that include: (1) promoting wellness; (2) increasing service access through client advocacy; and (3) engaging clients and keeping them connected to treatment through a robust therapeutic relationship.

Third, co-location of behavioral health and primary care services can reduce barriers to treatment. These barriers include poor transportation access, lack of trust, demands of family care obligations, and work schedules that often limit the ability of persons, particularly poor and BIPOC persons, to access health or behavioral health services. Short of utilizing fully integrated teams, co-location of services can be accomplished by employing or contracting with licensed behavioral health practitioners to provide culturally affirming and responsive services at health care sites or employing or contracting health care providers to provide health screening and intervention services at behavioral health sites. Co-location and coordination of behavioral health and primary care enhance access to both services by reducing or eliminating the need to travel long distances to multiple locations at different times. Case study 1.1 provides a descriptive example of how collaborative care can improve access to care and improve health outcomes.

**Case Study 1.1: Inés and El Centro de Salud**

Inés, 33, emigrated to the United States from Central Mexico when she was 15 with her mother. She is married to Carlos, 36, and they have 2 young children, Carlos, Jr., 6, and Ana, 8. They currently live in a neighborhood with many other Latinx immigrants in a medium-sized Midwestern city. She works as a receptionist in a local community service agency for Latinx youth. She is also a volunteer counselor and runs a dance group for local children. Inés receives her health care from a local health clinic serving the Latinx community. She is able to walk to this clinic. The agency provides primary care services via a team of volunteer and paid physicians, nurses, social workers, and peer counselors. The agency is affiliated with a local university medical school and is a training site for social work, psychology, nursing, and medical students. All staff are bilingual. The agency provides primary care services seven days a week that include family medicine, wellness and prevention screening, vaccinations, diabetic and nutritional counseling, wellness services such as yoga, exercise and relaxation groups, a food pantry, and support groups for stress reduction, exercise, and developing wellness plans.

In order to provide behavioral health services to its clients and promote the mental health of its community, the clinic developed a collaborative with local mental health professionals providing child, youth, and adult mental health services for problems such as depression, intimate partner violence (IPV), anxiety, stress, PTSD, and addiction. The clinic has formal referral relationships with several mental health clinicians and agencies in the local community that provide bilingual and culturally competent care. The clinic also provides free office space to several bilingual counselors and social workers in exchange for providing individual and group counseling to the clients of the clinic. The clinic and providers within the collaborative also

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1 All names and other identifiers of this case have been changed to protect privacy and confidentiality.
engage in routine cross-training activities in order that clinic staff can implement more routine behavioral health practices (e.g., screening, assessment) in their work, while mental health providers can learn how to be more culturally fluent with the persons they serve. This promotes and ensures a pipeline of competent, culturally affirming behavioral health practitioners in the community. The clinic provides transportation, interpreter scheduling services, appointment reminder calls, and other administrative tasks in order to facilitate mental health care with collaborative providers. The clinic also conducts routine behavioral health screening, assessment, and brief interventions with patients. Those patients needing more intensive services are then referred to the collaborative for more advanced care.

The clinic also employs community health workers and peer counselors to provide system navigation services for persons needing referrals to community agencies. These “Guía’s” or guides (1) provide transportation and interpretation services for clients, (2) accompany clients to health-related appointments outside the clinic, (3) help clients navigate payment and insurance forms and processes, (4) help clients get access to and navigate social services, and (5) provide wellness services by helping people develop wellness action plans around stress reduction, education about healthy relationships and parenting, diet and exercises, and how to maintain a healthy lifestyle.

Inés has several co-occurring health and behavioral health conditions that she has successfully controlled. She has diabetes and has a history of mild-to-moderate depressive episodes. She has also experienced several adverse childhood events (ACE’s) (n = 5) that place her at an increased risk of several health conditions. Her ACEs include witnessing interpersonal violence, having a family member with a mental health and addiction disorder in the home, and experiencing sexual assault as a minor from a family member, which precipitated their leaving Mexico. She experienced partial PTSD symptoms for 15 years including hypervigilance, negative alterations in cognitions in mood (e.g., shame, guilt, anger, dissociation) and intrusive memories (e.g., flashbacks and nightmares). She also currently experiences occasional panic attacks when she is stressed. Inés receives comprehensive medical care from the clinic for a co-pay of $35. She does not have health insurance from her employment. During a visit 2 years ago she was screened for behavioral health symptoms as part of the clinic’s initiative to provide more comprehensive behavioral health care “check-ups.” It was at this screening that she realized she suffered from several mental health symptoms (e.g., depression, anxiety, and PTSD). She reports, “I thought everyone felt like I did. Tired, sad, nervous all the time. I thought this was normal. I figured, ‘well, I went through a lot so I’m supposed to have these nightmares and anxious thoughts.’ I thought what I went through was my fault and that I just shouldn’t talk about it. My family certainly didn’t want to discuss it. It was too hard for them to hear. So I just said to myself, ‘Push it out of your mind, Inés, it’s the past, it’s over, get on with your life. Stop dwelling on it.’”

“After the screening and the talk with the social worker, who I love, she is the best, I realized that this wasn’t normal and that I could get help. I went to a local social work provider who specializes in depression and trauma treatment. She provided me with education. She taught me relaxation skills. And after a while we did some cognitive processing therapy
where I talked about what I went through and we examined my thoughts about it. I think differently now and I don’t have the jumpiness and the nightmares anymore. She helped me realize it wasn’t my fault. That I didn’t deserve what happened to me. She is also Latina and we did therapy in Spanish, which was so, so helpful. I don’t think I could have opened up with just anyone. She saved my life. I feel so much better now and my diabetes is under control. I have more energy. I sleep better. I’m a better Mom. I can’t thank her and the clinic enough. They gave me transportation to therapy sessions and back to work. The therapy was not very expensive because of the collaborative. I could afford it. If it was expensive and I couldn’t get a ride to the clinic I probably would have just gave up on it. That clinic is amazing and I hope to do some dance groups for the kids there soon.”

The above example demonstrates the power of integrated care. While not completely integrated, the clinic in the example provided Inés with behavioral health and physical health services and were (1) culturally-tailored to her needs, (2) comprehensive, (3) coordinated, and (4) person-centered. The clinic also provided care that was inexpensive, easily accessible, and accommodated Inés’s transportation needs. The clinic addressed her needs in relation to trauma, depression, and anxiety resulting in improved health and well-being. The agency also facilitated the development of a community of providers that are more person-centered and culturally competent.

**Analysis**

Contrast the above case example to what Inés could expect in a more usual care scenario where care is not integrated, but separate, uncoordinated, and fragmented.

How likely would it be that Inés would be able to become aware and develop an understanding of her behavioral health symptoms and get access culturally competent, affordable and accessible behavioral health care?

What level or stage (e.g., 1–6) of integrated care would you place El Centro de Salud (See Fig. 1.3)?

How likely would it be that Inés would just continue on as she was and think, “Hey, just get over it and move on”?

And what would Inés’s health look like over the long term as a result of not getting the care she needed and deserved?

### 1.3.2 Two Integrative Practice Models: Health Homes and Collaborative Care

#### 1.3.2.1 Health Homes

Approximately 68% of persons with a behavioral health condition also have one or more chronic health conditions (Alegria et al. 2003). The Health Home Model is defined explicitly in Section 2703 of the Affordable Care Act (ACA). Health homes are designed for recipients of Medicaid with two or more chronic health conditions. These conditions usually include a behavioral health condition (e.g., serious mental illness and/or addiction disorder) and one or more chronic health conditions (e.g., diabetes, cardiovascular disease, hypertension). The model is designed to serve
persons with complex behavioral and physical health care needs by providing comprehensive care and case management through a multidisciplinary team of health care professionals (Alexander and Druss 2012; Mauer 2009). Health homes provide collaborative, person-centered care based on clients’ preferences, needs, and values. Clinical decisions are based on objective screening, assessment, and monitoring data that are routinely collected on clients receiving services. Health home professionals rely on a shared care plan and integrated records and billing systems. Interventions that are provided are evidence-based. Health homes also routinely monitor outcomes and treatment responses in order to adjust care as needed and maximize effectiveness (Alexander and Druss 2012). Health homes focus on holistic health, or whole health, which include addressing health/primary care needs, mental health, substance use, and social support and other social determinants of health such as housing, nutrition, accessing basic needs, and income support through the provision of case management services.

1.3.2.2 Collaborative Care

The collaborative care model represents an effective means of providing high-quality integrated care in order to systematically manage chronic, complex comorbid health conditions (Katon et al. 1995, 1996). This model is based on the chronic care model developed by Wagner et al. (1996, 2001). In this model, care is provided by a multidisciplinary team of primary care providers that include a team leader or care manager (i.e., usually a nurse or social worker), psychiatrist, and a range of behavioral health professionals including social workers, counselors, psychologists, community health workers, and peers (Butler et al. 2009; Bower et al. 2006; Thielke et al. 2007). Team members provide consultations and work collaboratively to meet the individual needs of patients through case management and stepped care (i.e., providing treatments such as psychotherapy or medications of increasing intensity or dosage slowly to meet patient needs with the least amount of intervention). For instance, in stepped care a person with depression may first receive cognitive behavioral therapy. If symptoms persist, a low-dose antidepressant medication may be added in order to achieve additional treatment response. Ongoing screening and assessment measures are used to inform clinical decisions. Interventions are evidence-based and treatment outcomes are identified and systematically reviewed through a process of continuous quality improvement in order to optimize performance, increase accountability and enhance patient care. To implement this model effectively requires system and organizational integration that includes data sharing, cross-training, and professional development opportunities and ongoing performance review.

The Collaborative Care Model represents the highest level of integrated care and has shown positive outcomes for primary care patients with depression and anxiety problems in a range of settings compared to usual care (Archer et al. 2012; Thota et al. 2012; Unützer 2002; Unützer and Park 2012). A systematic review found robust evidence that collaborative care reduces depressive symptoms, increases
adherence and response to treatment, improves remission and recovery, and improves quality of life and satisfaction with care (Thota et al. 2012). Collaborative care models have also been found to be cost-effective (Katon et al. 2005; Schoenbaum et al. 2001).

1.4 Developing Integrated Behavioral Health Professionals

1.4.1 Core Competencies for Integrated Behavioral Health Practice

Several core competencies have been identified for integrated behavioral health practice. Professional competencies for Integrated Behavioral Health and Primary Care (IBHPC) have been identified by the SAMHSA-HRSA Center for Integrated Care (Hoge et al. 2014) and include nine core competencies routinely practiced by social workers and other behavioral health professionals (Fraher et al. 2018; Stanhope et al. 2015). These competencies are listed in Table 1.1. Integrated behavioral health competencies focus on several important areas of practice. First, these competencies require providers to be able to collaborate across disciplines and understand how to work together as part of a multidisciplinary team that uses a shared care plan to address the full range of health and behavioral health needs of clients. Second, providers are required to understand the intersections of health, mental health, and addiction and be prepared to screen and assess for health and behavioral health issues. Based on the results, providers engage and motivate clients to identify and achieve health and behavioral health goals through person-centered care plans (Stanhope et al. 2015). Third, providers are required to be competent in delivering culturally and linguistically relevant interventions that address health and behavioral health concerns. Fourth, providers must be able to assess and intervene competently to address social determinants of health such as housing, safety, food, income, transportation, and other socio-economic concerns of clients. Fifth, relevant providers and organizations across service systems need to effectively communicate and coordinate care to address the needs of clients within the population. And lastly, providers and organizations need to be engaged in a process of continuous quality improvement that involves monitoring and evaluating performance in order to adjust practices to improve targeted outcomes (Hoge et al. 2014).

1.4.2 Developing an Integrated Behavioral Health Workforce

Effective interprofessional and integrated behavioral health practice requires effective communication and collaboration skills (Sangaleti et al. 2017). There are many barriers to effective integrated behavior health practice. For instance, high caseloads...
### Table 1.1 Integrated behavioral health competencies and practices

| Competency category                      | Competency                                                                                                                                                                                                 | Practices and principles                                                                                                                                                                                                 |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Interpersonal communication              | Providers are able to engage clients, build rapport, answer questions, provide information, and communicate clearly and effectively with clients, family, and other health care providers | Clear communication  
Engagement  
Empathic listening  
Acceptance, nonjudgmental attitude  
Culturally and linguistically tailored                                                                                                                                                                                    |
| Collaboration and teamwork               | Providers are to effectively participate and function as a member of a multidisciplinary team of health and behavioral health professionals, clients, and family members | Understanding and respecting disciplines and roles of other team members  
Use shared decision-making                                                                                                                                                                                                 |
| Screening and assessment                 | Providers are able to effectively screen and assess for a range of health-related issues                                                                                                                    | Screen and assess for health risk behaviors, suicidality, harmful substance use, psychosocial functioning, psychiatric symptoms, trauma, violence, and social determinants of health |
| Care planning and coordination           | Providers are able to develop holistic treatment plans that address health, behavioral health, and social determinants of health. Creating and utilizing a shared treatment plan that takes a holistic view of the person and deploys strategies such as patient service navigation, developing wellness plans, supporting consumers in effectively managing chronic disease conditions | Person-centered goals  
Whole health  
Coordinating evidence-based treatments  
Wellness recovery plans  
Navigating service systems  
Accessing resources  
Addressing systemic barriers  
Enhancing social determinants of health                                                                                                                                                                                   |
| Evidence-based interventions             | Providers are able to utilize evidence-based interventions that are recovery-oriented to address a range of short- and long-term health and behavioral health issues | Motivational interviewing  
Cognitive behavioral therapies to address trauma, mental health, and substance use issues  
Case management  
Crisis intervention and safety planning  
Health promotion and illness prevention                                                                                                                                                                                  |
### Table 1.1 (continued)

| Competency category       | Competency                                                                 | Practices and principles                                                                                                                                                                                                 |
|---------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cultural competence       | Providers utilize services that are culturally and linguistically competent and tailored to meet the unique needs of the individual and are inclusive, equitable, and high quality | Identifying and dismantling racist structures and policies that contribute health inequities that drive health disparities  
Ensure equitable access to high-quality care  
Addressing social determinants of health  
Ensuring providers are diverse and reflective of the community they serve  
Training to identify and eliminate implicit and explicit biases  
Adapting services to cultural norms of client community |
| System-oriented practice  | Providers are able to operate effectively within the organizational structures of the health care system and setting | Effectively navigating the organization and system health care landscape  
Informing clients about how to access benefits and resources within the system  
Staying up-to-date with changing health care policy and practices |
| Practice-based learning and quality improvement | Providers are able to continually evaluate practice and engage in a process of continuous quality improvement to provide effective care that achieves positive health outcomes | Identify and implement evidence-based practices with fidelity  
Evaluating outcomes and client satisfaction with care.  
Using data to reduce errors and provide high-quality care  
Working with other team members to continually improve care |
| Informatics               | Providers enhance and improve health care through the use of information technology | Integrated electronic records and billing  
Using telehealth technologies  
Application and/or web-based screening, assessment, intervention, and monitoring  
Ensuring confidentiality and privacy |
and paperwork demands limit the time and energy providers have to listen, understand and respond to the needs and concerns of clients and their families. Fragmented billing, records, communication, and data sharing systems interfere with the ability of providers to communicate and coordinate care across client problems. A lack of understanding and respect for the roles of other professionals interfere with effective assessment and treatment of health and behavioral health issues in multidisciplinary settings (Ambrose-Miller and Ashcroft 2016). These barriers make it difficult for primary care and behavioral health care providers to provide holistic, person-centered care (Kathol et al. 2010; Miller et al. 2011). For instance, simple depression screenings in primary care sites continue to remain low (Akincigil and Matthews 2017), and recent data have demonstrated that a significant barrier to IBHC implementation is a lack of professionals competent in providing integrated care (Hall et al. 2015).

Over 110 million people in the United States live in one of the over 5000 designated areas with a shortage of behavioral health professionals (HRSA 2018). Currently, it would take an estimated 6628 professional to close this shortage (HRSA 2018). Addressing this need requires an increase in new and retrained behavioral health workers competent in transdisciplinary communication and collaboration (Cohen et al. 2015; Hall et al. 2015; Horevitz and Manoleas 2013; HRSA 2014). Enhancing the behavioral health workforce will require education and training initiatives that integrate primary care and behavioral health services within a framework that is collaborative and interprofessional, person-centered, strength-based, trauma-informed, and evidence-based, (Davis et al. 2015; Hoge and Morris 2004). It will also require the development of professional identities of primary care and behavioral health providers that are more open to transdisciplinary practice (Forenza and Eckert 2018; Gehlert et al. 2017). Professional education settings can contribute to more effective interprofessional education for primary care and behavioral health providers through a combination of clear roles and effective leadership (Jones and Phillips 2016). Early learning experiences that expose preservice providers to positive behavioral health role models can improve quality care (Lee and Del Carmen Montiel 2010). Mentoring relationships formed early in social work training through service-learning and clinical shadowing can also enable students to form relationships that help guide them through their postgraduation career choices (Allen et al. 2004; Mancini et al. 2019).

1.4 Developing Integrated Behavioral Health Professionals

1.5 Summary and Conclusion

The current health care policy and practice landscapes are fragmented, inefficient, and inequitable, leading to disparities in health and well-being. The ongoing COVID-19 pandemic has laid bare the devastating impact of health and wealth inequities in BIPOC communities. The behavioral health needs of these communities and others in the coming years due to the pandemic and its economic and social effects will be enormous. Anything short of a revolution in how behavioral health
care is provided will be inadequate. In order to meet the demand, behavioral health screening, assessment, and treatments must be fully integrated into primary care services in order to efficiently provide high-quality mental health and addiction services to persons in need. Collaborative care models represent one way forward. These models co-locate health and behavioral services and provide care through a team of multidisciplinary professionals who collaboratively coordinate and monitor care through shared treatment plans and records systems. These models currently exist, but are not sufficiently available to serve the needs of the population. We are past due on our promise of the Affordable Care Act to end health disparities caused by inequitable access to care. Integrated practice modalities such as the collaborative care model represent a commonsense way forward. But to provide these services at a scale adequate to the needs and demands of the population will require national policies that provide full, universal access to high-quality health care for all Americans.

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