BUILDING an Integrated Care System Within the Health Center FRAMEWORK
CHF: How do you define integrated health care in the context of the health center model?

Yee: Integrated health care in a health center has both operational (how it’s done) and cultural (why it’s done) aspects. Operationally, it might look like being able to share medical, dental and behavioral health patient records among the different clinicians providing care to an individual patient. It would enable each discipline (medical, dental and behavioral health) to be aware of and understand the complexity of each patient and how one condition might affect another. It might include team meetings to discuss patient cases/situations and how to best align, support and optimize care and outcomes.

From the cultural aspect, integrated care is a mindset, or a wholistic approach to comprehensive health care. A clinician might see a patient for the first time and, if practicing in an integrated manner, may have had all of the preventive health measures discussed prior to even seeing the patient (immunizations up to date; cancer and depression screening either done or planned for the visit; oral health/dental status reviewed and appointments updated; medications reviewed for possible negative interactions, duplication or need to stop refills, such as opiates previously prescribed for an acute pain situation). The patient visit would then be conducted with a broader approach, taking into consideration all aspects of the person’s care and interacting with the different disciplines to address issues in a wholistic/interdisciplinary manner.

So, integrated care includes both the philosophy, culture or approach to patient care, as well as setting up the practice processes that address the specific elements of accomplishing wholistic comprehensive care.

CHF: How does the health center model lend itself to creating or strengthening an integrated primary care system?

Yee: The health center model lends itself to creating and strengthening an integrated primary care system due to the fact that health centers are rooted in Community Oriented Primary Care (COPC). COPC is a continuous process by which primary health care is provided to a defined community on the basis of its assessed health needs by the planned integration of public health with primary care. Primary care for an individual can be defined as a person’s main source for regular medical care, ideally providing continuity and integration of health care services (medical, dental and behavioral health).

The country’s earliest health centers were adapted by Dr. Jack Geiger from the South African model over 50 years ago. Since then the U.S. health center model has been nurtured and strengthened. Today over 1,300 health center organizations with over 9,000 sites all over the country serve 25 million people. Based on their roots and foundation, health centers are positioned to optimally impact the further development and strengthening of an integrated primary care system.
**CHF:** What kinds of challenges do health centers face in recruiting and training the type of workforce needed to enhance integration with primary care and behavioral health?

**Yee:** The two primary challenges deal primarily with competition and the changing workforce pool. Since health care is a growing industry, especially with the implementation of the Affordable Care Act, staffing health centers, including clinical, administrative, operational and even facility maintenance staff, has become a challenge.

Local hospitals, private practices, rural health centers, corrections facilities and even academic ambulatory care centers are competing for the same pool of possible health center employees. I’ve seen medical assistants, who are single parents, leave a health center for a dollar an hour more to work with a local competitor.

Also, hospitals, rural health centers and corrections facilities are hiring physicians who are just completing their residency training at an average of 20-30% additional base salary than health centers. On top of that, they are also offering hefty signing bonuses ranging from $20,000-$30,000, with loan repayment assurances.

If we drill down to the specifics of recruiting the workforce needed to enhance the integration of primary care with behavioral health, on top of the challenges I just mentioned, hiring behavioral health staff is in itself challenging. There are very few psychiatrists, psychologists and social workers who are seeking employment with health care providers who work with underserved health center populations, many of whom don’t have health insurance coverage. Additionally, most behavioral health professionals have not been trained to work within an integrated care model (though there are some emerging models).

The training aspect poses additional challenges. Though training in health centers is beneficial for both recruitment and retention, it does hinder the productivity and efficiency of full time staff providing the training. Health center leadership must look at training as part of the health center mission — “to grow our own.” An investment must be made in the upcoming generations to help provide the necessary skills to mission-driven employees who want to serve health center populations, but who just need training. At NACHC, we are currently looking to experienced health centers that do training well and that can provide at least a break-even business model for training that can be documented and replicated.

**CHF:** Can you give examples of some of the common barriers health centers regularly confront in care integration — for instance, financing, capital improvements or regulatory burdens?

**Yee:** Many health centers encounter financial challenges, especially the more rural or frontier health centers. Behavioral health and oral health professionals are often hard to recruit, necessitating higher starting salaries or signing bonuses that many health centers can’t afford. This creates a huge barrier to getting the staffing needed to even consider care integration. Other challenges include finding bricks and mortar financing for facility expansion, or to purchase dental chairs and equipment if starting dental services from scratch.
Also, federally funded health centers must be mindful of the rules pertaining to changing or adding activities under their Section 330 grant (i.e., Scope of Project) and state licensing issues that may affect the ability of health centers to hire and get paid for behavioral health or dental services. Most states cover pediatric dental services, but fewer provide payment for adult dental services.

**CHF:** How do the barriers to care that health center patients commonly experience affect care integration at health centers?

**Yee:** Patients must first be able to overcome access barriers to care. These can include lack of transportation, need for interpretation services, lack of insurance coverage or not knowing how to navigate the local health care system (i.e., making appointments, obtaining medications, testing and specialty care). Many health centers do care integration well, but there are others that are struggling due to the patient barriers and limitations previously noted.

Once a patient does get access to a health center that provides integrated care, he or she still needs to respond and work with the care integration that is offered. Self-monitoring, follow-up and attending specialty care appointments are critical to integrated chronic condition management. There must be the right mix of health center staff assistance and community partnership with patient motivation and activation to affect positive health outcomes.

**CHF:** How important are partnerships/collaborations in building integration models at health centers? Can you provide some examples?

**Yee:** Local partnerships/collaborations are critical to establishing and sustaining integrated models of care in health centers. All parts of the local health care system must transform to support the efficient movement of patients within the system, including communication among organizations in the continuum. From transportation, to making appointments, to arranging payment, job placement, housing or legal services - these are all necessary parts that may be provided through local partnerships and collaborations.

Integration not only pertains to the medical disciplines, but also to integration with the local community. For example, NACHC is working with the Centers for Disease Control and Prevention (CDC), the YMCA of America, and the Association of State and Territorial Health Officials (ASTHO, or health departments) to address hypertension control. The three agencies, representing primary care, public health and local community partners, comprise a great collaborative model that is addressing population health issues such as uncontrolled high blood pressure, which can lead to a heart attack or stroke. This model includes the health center primary care continuum (care, testing, medication, education and follow up), exercise, education and monitoring from the YMCA and local epidemiologic surveillance and support from the local health department. When local systems and partners work in concert, individuals improve their care outcomes, entire populations get and stay healthier and fewer dollars are spent.◆