Launching Heart of the City Health Center: A Qualitative Study of Community-Driven Primary Care, Behavioral Health, and Substance Use Services Integration

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Integrated Primary Care and Behavioral Health Rationale

The prevalence of mental disorders and other chronic health conditions among US adults continues to rise, with recent estimates indicating that as many as one in five US adults has at least one mental disorder. In many cases, adults with mental disorders also experience other, interconnected chronic health conditions, such as diabetes or cardiovascular disease. However, given the wide spectrum of health care needs represented among populations with comorbid mental and other chronic health conditions, neither conventional primary care nor specialty behavioral health care alone provide the breadth of services necessary to maintain the health and well-being of these individuals. Therefore, to more holistically address the physical and behavioral health needs of populations with multiple chronic health conditions, a number of integrated primary care and behavioral health (PCBH) models have been developed and implemented throughout the US.

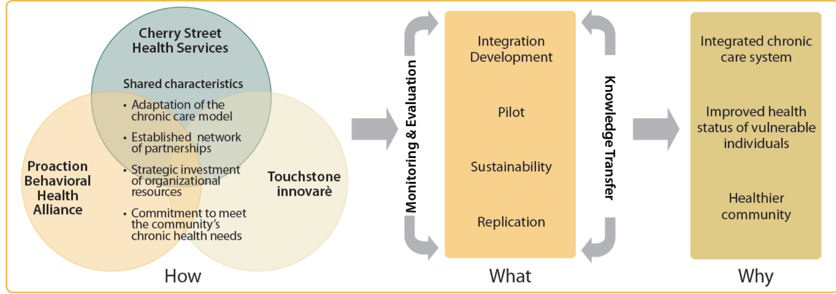
The four quadrant clinical integration framework (Table 1) demonstrates the type of health care settings best suited to meet patients' physical and behavioral health needs based on their level of risk for or the complexity of these needs. This framework has been extended to connect the type and complexity of patients' health care needs with the continuum of integrated care models, which are commonly segmented into three broad categories: coordinated, co-located, and integrated. Features of each model, such as the level of communication and collaboration among staff members, staffing structures, screening/assessment tools utilized, and the type of health services provided, may vary according to the level of health system integration. As such, integrated PCBH models may be further differentiated within the three broad model categories.

Table 1. Four Quadrants of Clinical Integration anchored to Patient Health Care Needs

(adopted from Collins et al., 2010)

Behavioral Health Risk/Complexity (Low → High)	Physical Health Risk/Complexity: Low	Physical Health Risk/Complexity: High
High	**QUADRANT II** Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: Patients with bipolar disorder and chronic pain) Note: When mental health needs are stable, often mental health care can be transitioned back to primary care.	**QUADRANT IV** Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: Patients with schizophrenia and metabolic syndrome or hepatitis C)
Low	**QUADRANT I** Patients with low behavioral health and low physical health needs Served in primary care settings (Example: Patients with moderate alcohol abuse and fibromyalgia)	**QUADRANT III** Patients with low behavioral health and high physical health needs Served in primary care settings (Example: Patients with moderate depression and uncontrolled diabetes)

Figure 1. Integrated Primary Care and Behavioral Health Initiative Theory of Change



Study Origins and Objective

In 2009, as part of the Community Health Center Innovation Mission Project, Altarum Institute established a two-year partnership with Cherry Street Health Services, a federally qualified health center based in Grand Rapids, MI. At this time, the health center was planning an integrated PCBH initiative with two other community-based health care safety net organizations, Touchstone *innovarè* and Proaction Behavioral Health Alliance, that focus on the delivery of mental health care and substance use services (Figure 1). To support the developmental phase of this initiative, which primarily consisted of planning the initiative and testing an integrated PCBH model with a small number of health professionals and patients, Altarum provided strategic planning and formative research support. The main formative research objective was to capture the developmental processes and initial experiences associated with the integration of primary care, behavioral health, and substance use services among the three community-based health care organizations while launching Heart of the City Health Center.

Research Design and Methods

A single-case study design was used with three embedded units of analysis: (1) top management staff involved with integration planning workgroups; (2) health professionals who comprised an integrated care team; and (3) adults with serious mental illness and other chronic health conditions who received integrated care. Six to 12 months into the initial phase of integrated care delivery, Altarum staff members conducted 25 semi-structured interviews with top management staff members and health professionals across the three partner organizations in addition to four focus groups, three with patients and one with the integrated care delivery team of health professionals. All interviews and focus groups were audio recorded for subsequent transcription by an independent consultant. An inductive content analysis approach with periodic inter-rater reliability checks was then used with NVivo 8 software to distill common themes.

Initial Integrated PCBH Patient Experiences

"I think I've become aware of how I can holistically approach … how to help myself." ~ Patient

Among patients who received integrated health care during the initiative's development phase, the following themes emerged:

- Satisfaction with the level of communication and coordination among the integrated care team;
- Increased self-awareness of their chronic health conditions and of ways to self-manage these conditions;
- Improved self-efficacy and activation related to chronic condition self-management;
- Increased adherence to medication regimens, healthy eating habits, and regular exercise.
- Attribution of improvement in physical health markers, such as blood pressure and hemoglobin A1C levels, to the receipt of integrated care.

Key Findings

Among top management and direct care staff, the following eight themes emerged as the most critical to the initial implementation of integrated care model: (1) investment of resources; (2) clarity of initiative purpose and vision; (3) leadership guiding staff roles and responsibilities; (4) ongoing staff education and training; (5) communication and collaboration; (6) staff buy-in; (7) adaptation of financing and technological mechanisms; and (8) standardization of clinical and operational processes (Table 2).

Table 2. Integrated PCBH Barriers and Facilitators

PCBH Integration Barriers	PCBH Integration Facilitators
Lack of awareness and understanding of integrated PCBH among organizational staff members	Awareness and understanding of integrated PCBH among organizational staff members
Cultural differences between primary care and behavioral health organizations and staff members (e.g., organizational processes, staff members' attitudes, and clinical orientations)	Buy in and positive attitudes toward integrated PCBH among organizational staff members
Limited leadership (i.e., lack of guidance concerning staff members' roles and responsibilities, lengthy or unclear decisionmaking processes)	Support from organizational leaders (i.e., the investment of organizational resources and guidance provided to those staff members involved with PCBH integration)
Lack of resources, including fiscal resources and protected or dedicated staff time, for integrated PCBH	Collaboration among staff members, regardless of their respective disciplines, to complete necessary tasks or duties related to PCBH integration
Competing priorities (i.e., other job responsibilities or involvement with other organizational initiatives constricting available time)	Standardization of clinical and operational processes related to integrated PCBH delivery
Difficulties standardizing operational and clinical processes, particularly those related to reimbursement, across organizations	Federal, state, and local governmental policies and programs supporting integrated PCBH (e.g., the health home provision of the health reform legislation)

The following three themes additionally emerged as most salient to the initial experiences of integrated care team members and patients: (1) cohesion and continuous improvement among health professionals delivering integrated care; (2) patient engagement in chronic condition self-management; and (3) aligned recognition of self-management goals among health professionals and patients.

Detailed study findings are available online at:
http://www.altarum.org/files/pub_resources/IntPrimaryCare-Report_FINAL_0.pdf.

Conclusion and Implications

Efforts to integrate PCBH may be best developed and implemented as a continuous transformation process wherein fundamental, iterative changes to many aspects of organizational administration and service delivery are ongoing. This study's findings informed the program's operational and clinical transformation into an integrated collaborative system of care currently serving 725 adults with chronic health conditions at Heart of the City Health Center within the Durham Clinic.

Collins C, Hewson DL, Munger R, & Wade T. Evolving models of behavioral health integration in primary care. 2010. New York: Milbank Memorial Fund.

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