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Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Advancing Team-Based Care: Optimizing the Role of Integrated Behavioral Health Providers in Health Centers

Tuesday April 29th, 2025

1:00 - 2:00pm Eastern / 10:00 - 11:00am Pacific

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- The views expressed in this presentation are those of the presenters and may not reflect official policy of Community Health Center, Inc. and its Weitzman Institute.
- We strive to create a respectful and welcoming learning environment. If anything in today's session makes you feel uncomfortable, please let us know via email at nca@chc1.com.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information hat we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.
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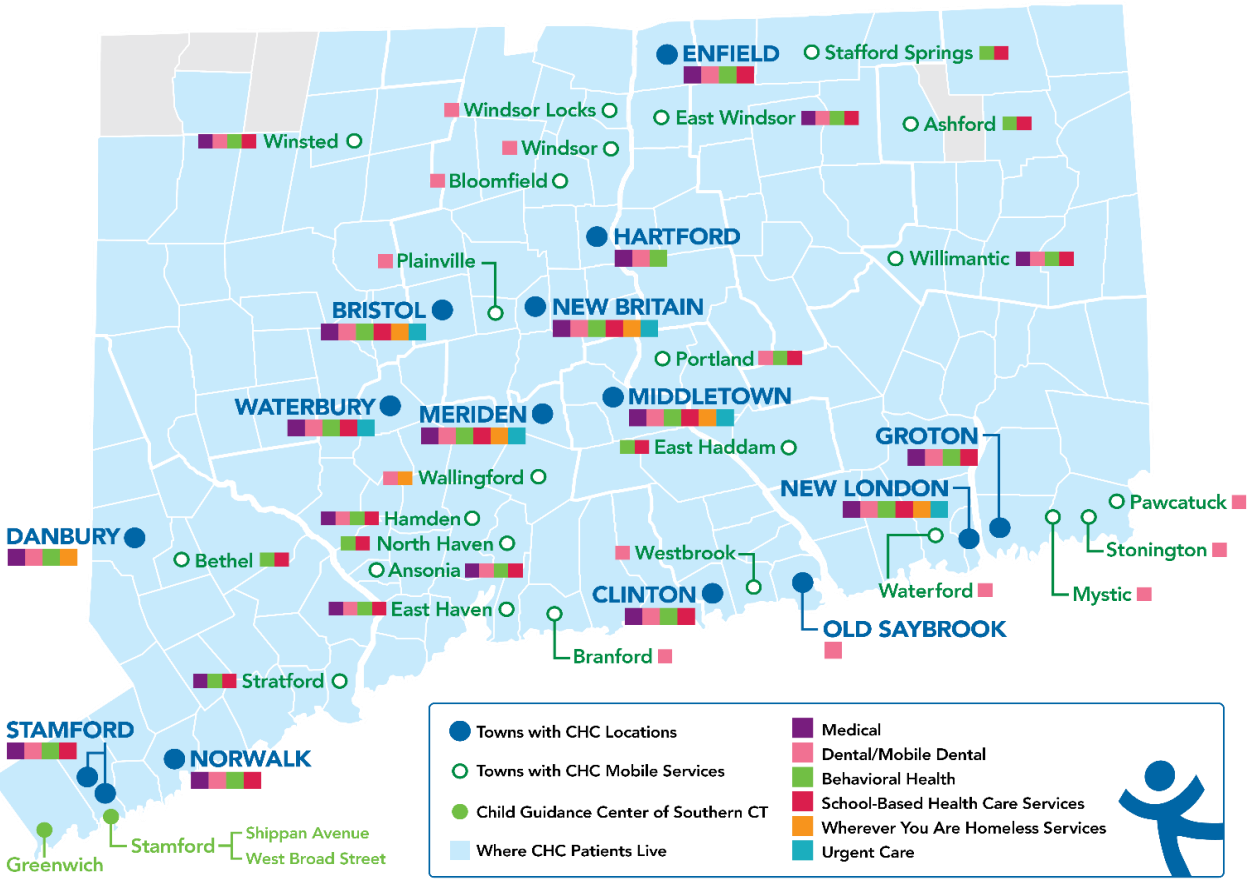
Locations & Service Sites



Community Health Center, Inc.

THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2021	2022	2023
Patients Seen	99,598	102,275	107,225

National Training and Technical Assistance Partners (NTTAP)
Clinical Workforce Development

Provides **free** training and technical assistance to health centers across the nation through national webinars, activity sessions, learning collaboratives, trainings, publications, and more!

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Learning Objectives

- Gain foundational knowledge on integrated behavioral health
- Understand the perspective of the interdisciplinary care team for integrated behavioral health
- Explore case studies that highlight the interdisciplinary care team

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Speakers

- Tim Kearney, Ph.D., Chief Behavioral Health Officer, CHCI
- Nicole Seagriff, DNP, APRN, FNP-BC, Vice President – Western Region, CHCI
- Chelsea McIntosh, PsyD, ABPP, Training Director – Postdoctoral Residency Program, CHCI
- Tichianaa Armah, MD, Chief Psychiatry Officer, CHCI

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Introduction to Integrated Behavioral Health

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Introductory Poll

- **Question #1:** Do you currently have integrated behavioral health?
- **Question #2:** What are your top challenges related to implementing integrated behavioral health at your site? (Pick 2):
    1. Finding staff
    2. Billing for services
    3. Territoriality of disciplines
    4. Challenging workflows
    5. Regulatory restrictions
    6. Space constraints

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What is Integrated Behavioral Health (BH)?

- Providers from across multiple disciplines working to deliver the best quality care to a shared patient panel.
- The tasks necessary to provide care are split between team members across disciplines and outcomes shared.
- Everyone works to the top of their license in their own areas, relying on team members for tasks outside their realms
- More efficient, effective, and elegant treatment.
- Will look different at different sites

Overview of BH Landscape

Clinical Providers:

- Therapists
  - Social worker, marriage and family therapist, counselor, psychologist, drug and alcohol counselor
- Medication providers:
  - Psychiatrist, psychiatric nurse practitioner, prescribing psychologists
- Level of licensure
  - Licensed Independent Practitioners (LIP)
  - Licensed to Practice Under Supervision
  - Student or Resident Under supervision of appropriately credentialed LIP

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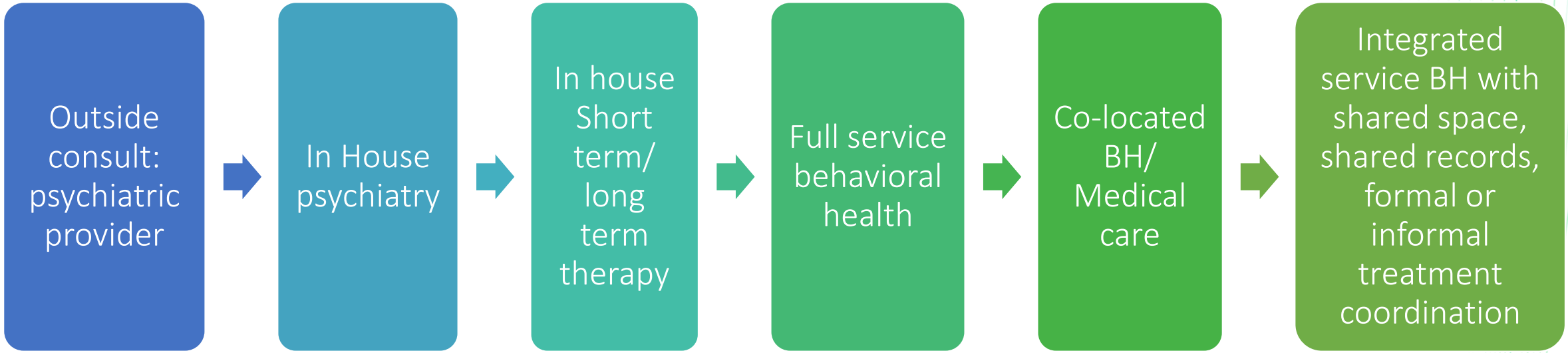
Continuum of Integrated BH Care



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Behavioral Integration & Primary Care Team

Screening for depression	Medical Assistant (MA), Medical Provider, Behavioral Health Provider
Care management	Registered Nurse (RN), Case Manager/Care Coordinator
Crisis management	Behavioral Health Provider
Brief Psychotherapy	Behavioral Health Provider
Referral for longer-term psychotherapy	Behavioral Health Provider, Referral Coordinator
Psychotropic Medication	Primary Care Provider (PCP) or PMHNP, Psychiatrist
Psychiatric Consultation	Consulting Psychiatrist, Psychiatric Mental Health Nurse Practitioner (PMHNP), Psychiatry
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Trained staff to screen, refer, and treat.

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Best Practices for Optimizing Integrated Behavioral Health

- **All patients are "Community Health Center, Inc. (CHCI) patients"**, not "medical patients" or "behavioral health patients" or "dental patients.
- Shared **Electronic Health Record** between all disciplines on the team to allow greater coordination of patient care.
- Physical and virtual **co-location** with the other disciplines to provide patient-centered care and communicate seamlessly.
- **Having the right people** and orienting them to an integrated model of care

All Patients are “CHCI Patients”

- In 2023, 12.0% of CHC Primary Care Patients were also CHC BH Patients, and 65.3% of CHC BH Patients were also CHC Primary Care Patients.
- All patients enter through the same doorway to be greeted by the same patient service associate, avoiding the stigma associated with seeing a therapist.
- Getting behavioral health care outside of our integrated team-based care system does not disqualify a patient from getting medical care at CHCI, though it makes coordination of services more difficult.
- Medical patients were more likely to keep initial appoints for behavioral health than those who had no previous connection to CHCI.

Shared Electronic Health Record

- Patient signs an informed consent for behavioral health care treatment where they are informed that the shared EHR is a standard practice.
- BH Provider notes the type of session (individual, family, group) and whether the patient was seen in real life, via phone, or via video and gives a brief summary of the session including diagnosis.
- Screen for suicide at every session
- All providers treating the patient have access to records from all disciplines

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Co-Location

- Physical and virtual co-location with other clinical disciplines
- Move towards telehealth eliminated the greatest challenge – adequate physical space and introduced a new one – team based care when parts of the team are remote
- Offer a wide-range of life span behavioral health services: brief assessments; individual, family and group therapy; short-term and long term behavioral health care; psychiatric services, and Medication Assisted Treatment (MAT) programs with relapse prevention support groups

Warm Hand Off

Warm Hand Off can be maintained in a hybrid team:

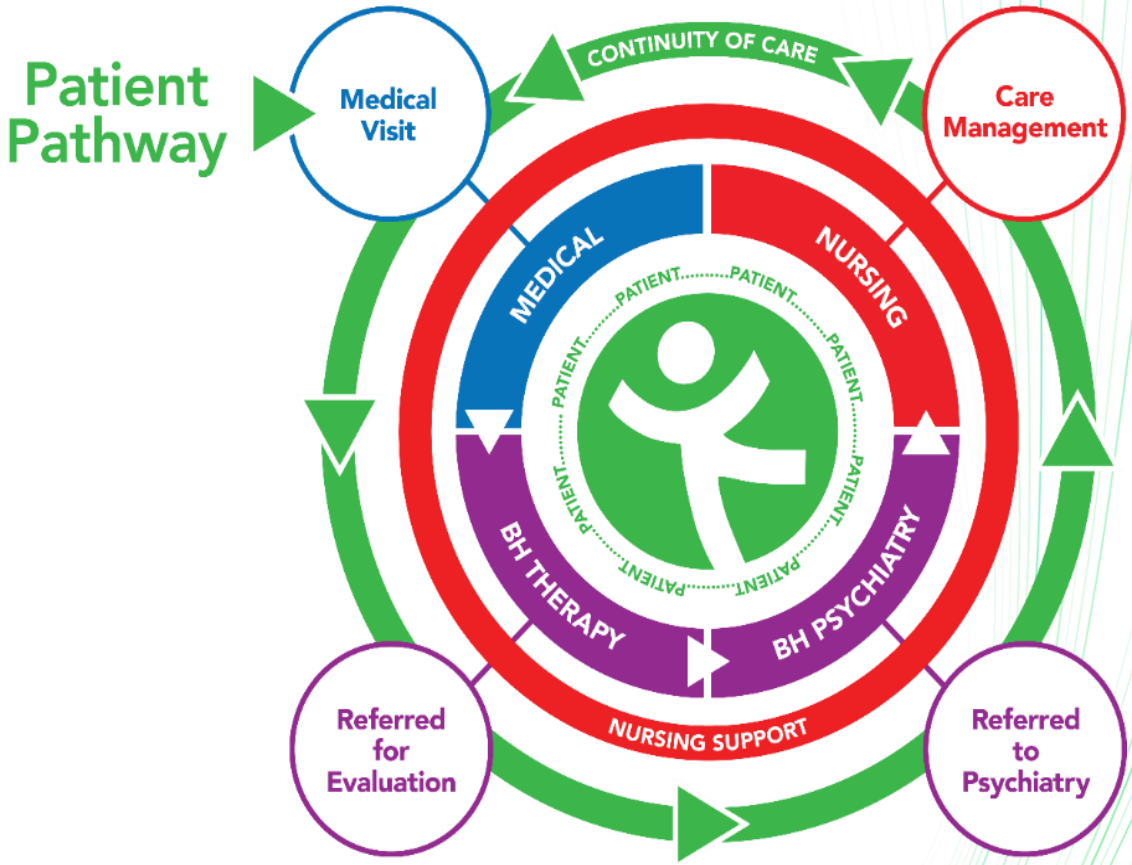
On Site:

- If a member of the team thinks a patient needs to see a behavioral health provider before leaving the appointment, it is flagged for the MA
- MA briefs the BH provider
- Every effort is made for patient to meet a BH provider before patient leaves

E-WHO (Electronic Warm Hand Off)

- Leverage EHR to do this virtually

Can BH send patients back to medical?



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Having the Right People on the Team

- Behavioral health clinicians continue to focus on the interplay between a patient's inner world and social reality.
- The 45 minute session or weekly sessions that are often the norm in free standing BH programs are often not needed, and the opportunity to have other team members provide parts of the care that the BH provider would need to do if they were a solo practitioner can lead to more effective and efficient care.
- Strong pod identify to build camaraderie
- Inform candidates of unique opportunities, responsibilities, and obstacles of integrated care at time of hire
- Training opportunities

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Interdisciplinary Team Panel

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Nicole Seagriff
DNP, APRN, FNP-BC

Chelsea McIntosh
PsyD, ABPP

Tichianaa Armah
MD

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Case Study Examples

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Case Study #1

About the Patient

- 22 year old Mexican American female, seen for frequent concerns with physical health amplified by chronic health conditions, history of sexual abuse, and multiple guardian changes.

Patient Goals

- Understand emotional health conditions and ways to address them.
- Understand how to best respond to ongoing negative family dynamics

Provider Goals

- Accurately diagnose underlying health issues
- Join client in developing more confidence in expressing herself and her needs
- Increase insight in role of relationships and identifying healthy needs in relationships

Patient Needs

- Coordination of care related to reporting and experiencing multiple physical health concerns
- Coordination between psychiatry and BH for diagnostic clarification to inform medication management.

Challenges

- Underreported suicidal ideation because she was worried this would result in hospitalization
- Her report of symptoms were conflicting at times and so as noted collaboration was needed to conceptualize and address inconsistencies

Key Strategies Implemented

- Routine collaboration
- Review of record from other providers

Results

- Increased insight
- Stability of mood
- Improved response to interpersonal relationships
- Less “ worried well” visits

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Case Study #2

About the Patient

- 45 year old Caucasian male, seeking treatment for depression and PTSD based symptoms after experiencing significant physical illness affecting his ability to work.

Patient Goals

- "Feel better and be less depressed"

Provider Goals

- Process PTSD
- Increase regulatory strategies for experience of anger
- Improve ability to communicate with others to reduce interpersonal conflict.
- Identify source of pain
- Successful referral for surgery

Patient Needs

- Coordination of care with case management
- Nursing support to problem solve following up with treatment recommendation
- Obtaining resources
- Building trusting relationships with providers over time.

Challenges

- When client experiences difficulty understanding, will become frustrated and presents with anger. He may shut down a conversation or not continue with a provider.
- Client experiences significant difficulty with memory and focus resulting in difficulty following through with treatment recommendations.

Key Strategies Implemented

- Communication in writing
- Pacing and explaining interventions
- Collaboration with external partners
- Care management by nurse including frequent reminder phone calls and check ins
- Consistency of providers that patient was comfortable with and had already “told his story to”

Results

- Improved insight
- Ongoing work in terms of improving ability to communicate with providers and work towards self-defined goals
- Hip replacement!

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Key Takeaways

- Cross-disciplinary collaboration and review of the patient's full record leads to better understanding and more accurate assessments, targeted and effective care and treatment planning, and improved health outcomes.
- Consistent provider relationships builds patient trust, reduces the need to repeat the patient's history, and enhances continuity of care.
- Proactive care management, including nurse-led follow-ups and reminders, supported patient engagement and follow-through.

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Questions?

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Wrap-Up

Webinar: Integration of Oral Health in Team-Based Care Settings

- Join CHCI and the National Network for Oral Health Access (NNOHA) for a 60-minute webinar on integrating oral health into primary care, including the history of integration in health centers, best practices, and resources. Additionally, participants will gain foundational knowledge on the clinical care team's perspective, and review real-world case studies showcasing effective team-based approaches.
- **When**: Wednesday, May 21, 2025
- **Time**: 2:00 - 3:00pm Eastern / 11:00am - 12:00pm Pacific
- **To register, click here!**

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2025 Health Center Workforce Summit

- The **2025 Health Center Workforce Summit** is presented by CHCI, the Association of Clinicians for the Underserved (ACU) STAR² Center, and the National Association of Community Health Centers (NACHC).
- The **2025 Health Center Workforce Summit**, *Building a Workforce for 2025 and Beyond*, is an opportunity for health centers, look-alikes, health center-controlled networks (HCCNs), primary care associations (PCAs), and other partners to come together to share and elevate best practices that address workforce challenges and needs. The focus of the **2025 Health Center Workforce Summit** will seek to improve workforce well-being; support recruitment, and retention; enhance and implement sustainable workforce pathways to train the next generation of professionals; and strengthen emergency preparedness. A combination of presentations, large group discussions, and break out groups will be used to share innovative workforce models and practices, build community, and leverage resources that contribute to successful workforce strategies.
- **When:** Wednesday May 7th and Thursday May 8th from 12:00 - 5:00pm Eastern / 9:00am - 2:00pm Pacific

Register Here:

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Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development

https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

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Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca