



# ***SAMHSA-HRSA Center for Integrated Health Solutions***

## Primary and Behavioral Healthcare Integration

### **Guiding Principles for Workforce Development**



**NATIONAL COUNCIL**  
FOR COMMUNITY BEHAVIORAL HEALTHCARE



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## ABOUT THE SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in specialty behavioral health or primary care provider settings. CIHS is the first “national home” for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.

Jointly-funded by the Administration and the [Health Resources Services Administration](#), and run by the [National Council for Community Behavioral Healthcare](#), CIHS provides training and technical assistance to 56 community behavioral health organizations that collectively received more than \$26.2 million in Primary and Behavioral Health Care Integration grants, as well as to community health centers and other primary care and behavioral health organizations.

CIHS’s wide array of training and technical assistance helps improve the effectiveness, efficiency, and sustainability of integrated services, which ultimately improves the health and wellness of individuals living with behavioral health disorders.

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## EXECUTIVE SUMMARY

Recent healthcare reforms have stimulated increased interest in promoting the integrated delivery of behavioral health services with other forms of healthcare. However, workforce issues related to the provision of integrated behavioral health and general healthcare have been a longstanding concern and are widely identified as barriers to integration, including:

- Inadequate skills for integrated practice;
- Reluctance to change practice patterns;
- Negative attitudes about persons with mental health and substance use problems;
- Lack of financial incentives to reinforce the skills required to provide integrated care; and
- Shortage of leaders committed to and capable of managing the organizational change process required to achieve integration.

Workforce development is a key CIHS priority. To meet the seven core strategic goals identified in the [SAMHSA-sponsored Action Plan on Behavioral Health Workforce Development](#), the Center elicited the guidance of an array of experts and drew upon published literature. The goals identified include:

- Goal 1:** Expand the role of consumers and their families to participate in, direct, or accept responsibility for their own care
- Goal 2:** Expand the role and capacity of communities to identify local needs and promote health and wellness
- Goal 3:** Implement systematic federal, state, and local recruitment and retention strategies
- Goal 4:** Increase the relevance, effectiveness, and accessibility of training and education
- Goal 5:** Actively foster leadership development among all segments of the workforce
- Goal 6:** Enhance available infrastructure to support and coordinate workforce development effort
- Goal 7:** Implement a national research and evaluation agenda on workforce development

Addressing these behavioral healthcare workforce development needs will involve a multiyear effort. Over the next 3 years, CIHS will identify the highest priority action steps and develop targeted implementation plans, including items from a distinct substance use disorders effort. The following informing principles will guide both CIHS' planning and its efforts to strengthen the workforce:

- CIHS' efforts to address workforce development will continuously evolve and will be modified as the field provides feedback and additional information is gathered.
- Each strategy must explicitly examine the role of and effect on consumers of healthcare services, including the involvement of persons in recovery from mental or substance use disorders in the healthcare workforce. All training resulting from CIHS' work must be explicitly recovery-oriented, provide training jointly with consumers and providers, and include faculty who are persons in recovery.
- CIHS will make every effort to explore existing resources or initiatives on integration before creating something new. Avoiding duplication is essential in this era of scarce resources.
- Strategies must be identified and developed with an eye to sustainability, recognizing that the CIHS is a time-limited structure.
- The notion of "partnership" should underlie and drive all workforce strategies.



## RECOMMENDED STRATEGIES

### *Training & Education*

- A. Evidence-Based Training: Implement evidence-based teaching methods by creating a Learning Home on Integration that links individuals to sequenced educational opportunities that are reinforced through supervision.
- B. Faculty & Trainer Development: Foster the skills of teachers and trainers by creating the Faculty Forum on Integration to coordinate educational resource sharing, identification of educational best practices, and the continuing education and mentoring of educators (modeled after the Association for Medical Education and Research in Substance Abuse).
- C. Higher Education Curriculum Reform: Promote the adoption of curricula on integrated care in professional education programs by engaging educational leaders to develop and implement an action plan on curricula reform.
- D. Core Competency Development: Identify and disseminate three sets of core competencies on integrated practice tailored to: (1) general healthcare; (2) behavioral health; and (3) peer support.
- E. Core Curriculum Development: Facilitate workforce training by developing and disseminating portable curricula on a small number of high priority competencies, which would include data and interventions that hold promise for highly impacted communities with disparate mental health outcomes and access.

### *Recruitment and Retention*

- A. Quality Improvement Collaboratives: Promote the development, implementation, and evaluation of recruitment and retention strategies in integrated care, drawing on quality improvement models employed by the Institute for Healthcare Improvement and NIATx and as called for in Health and Human Services Secretary Kathleen Sebelius' "National Strategy for Quality Improvement in Healthcare."
- B. Cultural & Linguistic Diversity: Through a quality improvement collaborative focused specifically on diversity, foster the adoption of recruitment and retention strategies, including "grow your own" models for a range of health professions, expanded roles for community health workers, social marketing with young students, and student exposure to minority faculty members, as well as link with community-based participatory research and comparative effectiveness initiatives that look to identify different models' efficacy in subpopulations based on race, ethnicity, and language proficiency.
- C. Realistic Job Previews and Selection Tools: Create video previews of integrated care workforce roles and a toolkit on selection procedures and criteria to promote recruitment and retention for these roles.
- D. Rural and Underserved Areas: Identify and address behavioral health workforce shortages in integrated care by using HRSA, SAMHSA, and NACHC data to identify specific needs and the existing behavioral health services that can be better linked to the general healthcare system to address unmet need. Build on the resources of the National Health Service Corps.





### **Leadership**

- A. Leadership Development: Create the Leadership Program in Integrated Health as a permanent learning home for professionals and peers on bidirectional integration administration and change management.
- B. Supervision Development: Develop and deliver a curriculum on best practices in integrated care that combines basic training, access to additional educational resources, and experiential learning.

### **Persons in Recovery**

- A. Competency Development: Develop a set of core competencies for peer roles in integrated care that will guide future curriculum development, training, and assessment of peers addressing whole health.
- B. Shared Decision-Making: Foster patient- and family-driven care by identifying competencies and developing or refining model curricula on shared decision making in integrated healthcare.
- C. Education Regarding Peer Roles in Integration: Strengthen the roles of consumers by developing curricula and organizing training experiences that (1) educate persons in recovery about the nature of non-psychiatric work settings and (2) educate providers about the potential roles and contributions of peers in these settings.

### **Community**

- A. Community Capacity Building: Help community groups and coalitions, through technical assistance, to adopt a “whole health” approach as they provide prevention, health promotion, and early intervention with identified community health needs.

### **Infrastructure Development**

- A. Technical Assistance: Provide an essential infrastructure through CIHS for delivering technical assistance on workforce development in integrated care to the field.
- B. Structures for Continuous Learning: Create structures through the strategies identified above for organized and continuous workforce development, including the Learning Home for providers; the Faculty Forum for teachers; the Leadership Program for managers and executives; and the Quality Improvement Collaboratives on recruitment and retention.
- C. Financing: Identify and disseminate information on the workforce-related financing barriers to integration, including: prohibitions on same day billing; exclusion of selected behavioral health professions in federal and state funded insurance plans; and the absence of Medicaid coverage for peer support services in numerous states.
- D. Telemedicine and Telepsychiatry: Promote the use of these technologies by identifying early adopters and best practices in telemedicine and telepsychiatry and assembling an expert panel to provide technical assistance on these methods. (Note: this effort will be informed by HRSA’s two offices on telehealth: the National Telehealth Resource Center and the American Telemedicine Association.)
- E. Accountable Care Organizations: Work closely with SAMHSA, HRSA, and CMS to promote the inclusion of behavioral health and the delivery of integrated care.



**Research & Evaluation**

- A. Logic Models: Establish routine use of logic models for all CIHS workforce interventions on integration to make explicit the assumptions about the potential impact of interventions prior to their adoption.
- B. Program Evaluation: Support (within the limited resources available) the use of basic program evaluation strategies as part of a continuous quality improvement effort to strengthen the effect of workforce interventions.



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