
A PATH TO A PARADIGM SHIFT: NORTH CAROLINA'S JOURNEY TO WHOLE PERSON CARE



Foundation for Health
Leadership & Innovation

CENTER OF EXCELLENCE
FOR INTEGRATED CARE

TABLE OF CONTENTS

Introduction	4
History of Integrated Care in North Carolina	6
A Paradigm Shift Begins	12
Payment and Protocol	14
Integrated Care Spotlights	16
Integrated Care Workforce	22
Integrated Behavioral Healthcare Support	26
Summary	28
References	29
Appendix A	34

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INTRODUCTION

North Carolina has been a national leader in advancing integrated behavioral healthcare for the past several decades. The shift from siloed care to whole person care originally started as conversations and project partnerships among key health entities across the state. Our story begins with the North Carolina Foundation for Advanced Health Programs (NCFAHP), now known as the Foundation for Health Leadership & Innovation.

NCFAHP was created as an organization to seed and advance health innovation without the constraints that are inherent within government agencies. NCFAHP was the original home of Community Care of North Carolina (CCNC) and worked closely with the North Carolina Division of Health and Human Services (NC DHHS) Medicaid and the Office of Rural Health (ORH) to support CCNC in building networks for local primary care practices to manage the quality and utilization of their assigned Medicaid population.

Over time, the CCNC networks began to serve this population beyond traditional medical care, and momentum and interest in this expansion of care grew throughout the state.

Behavioral healthcare was soon included, and originated in a partnership with several professional associations and agencies. This work in behavioral health care was supported by grant funding from AstraZeneca, the Kate B. Reynolds Charitable Trust, and The Duke Endowment (Morrissey, Domino, Wicher, Kilany, & Gaynes, 2009), which collectively initiated the creation of ICARE [Integrated, Collaborative, Accessible, Respectful, and Evidence-Based] (later the Center of Excellence for Integrated Care), and the implementation of



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integrated behavioral healthcare in pilot sites across the state from 2006-2009 (Dickens, Lancaster, & Crosbie, 2012).

Most recently, North Carolina received governmental and legislative support for a full state-wide healthcare system change towards value-based care. This effort toward Medicaid transformation validates what providers of a variety of disciplines have known for quite some time: There is a strong connection between the mind and the body, and patients should be treated and cared for within the context of their lives.

A Review of the Literature

The purpose of this literature review is to track the progression and current state of integrated behavioral healthcare in North Carolina.

The literature reviewed included document types such as policy briefs, white papers, government bulletins, academic research, and website advertisements for various clinics, trainings, and healthcare entities, as well as personal conversations. The review process was completed with a final update in April 2020.

Themes from the review included: 1) increased government support for integrated care; 2) increased access to mental health through integrated care; 3) evidence of specific clinical examples in North Carolina; 4) preparing the workforce; 5) and a shift in financial structures.

It should be noted that this literature search is likely not exhaustive; however, it was conducted using a wide range of search terms listed in the appendix with the intent to better understand the shift of healthcare in North Carolina to the paradigm of integrated behavioral health and caring for the whole patient. Upon the conclusion of the final search, some events and literature were added from individual interviews and personal communication with those who had been involved in North Carolina's integrated care efforts for quite some time.

HISTORY OF INTEGRATED CARE IN NORTH CAROLINA

Some of the earliest efforts of integrated care in our state started in the West, through the North Carolina Area Health Education Center (NCAHEC) with Mountain Area Health Education Center's (MAHEC) women's clinic integrating substance use counselors and therapists in the 1990s.

This effort was closely followed by MAHEC family medicine practicing what began as co-located integrated care in 2005 and developed into a robust integrated care model, including same day access to behavioral health, a consulting psychiatrist, and a care manager (Landis, Barrett, & Galvin, 2013). The Western North Carolina CCNC Network replicated these models in additional participating primary care providers.

Beginning in 2005, integrated care began spreading across CCNC networks and their primary care providers statewide (Collins, Fernandez, Ruppenkamp, 2011). Around the same time frame, funding was granted to the North Carolina Foundation for Advanced Health Programs (NCFAHP) from AstraZeneca, the Kate B. Reynolds Charitable Trust, and The Duke Endowment to further explore the integration of behavioral health into primary care offices (Morrissey, Domino, Wicher, Kilany, & Gaynes, 2009).

The program born in NCFAHP from that funding, ICARE, and partners such as the North Carolina Psychiatric Association, the North Carolina Academy of Family Physicians, the Office of Rural

Health, and the North Carolina AHEC system, worked with practices and clinicians to begin transforming clinical work across the state (Morrissey et al., 2009).

ICARE worked at the clinical level, as well as advocated and advised on policy with documents such as the ICARE Policy Brief (2009). The work being done was a collaborative effort across agencies, for example with a publication in the North Carolina Medical Journal by Chris Collins (2009) that emphasized the importance of integrated care in North Carolina. Supporting statements in the ICARE policy brief, Collins referenced the financial hurdles and activities necessary to provide whole person care.

Evidenced in part by Collins referenced potential workflows for integrated care, evidence-based behavioral health screenings, and resources for practices trying to implement integrated care. Collins ended by calling on North Carolina to support integrated care by furthering the work of entities such as ICARE, its partners, and the practices attempting to provide this model of care. Despite a great deal of progress in some areas since these publications, much of what was referenced in 2009 was still applicable to the current state of integration as recent as a year ago.

In 2010, ICARE was reorganized into the Center of Excellence for Integrated Care (COE) (Stein, Lancaster, Yaggy, & Dickens, 2011), and the work of the Center included continuing to serve as an ambassador for integrated care, as evidenced by a presentation conducted by the then-President/CEO of the Foundation for Health Leadership & Innovation at the Rowland-Hite Health Planning Seminar (2011).

Evidence of agency teamwork across the state in the delivery of integrated behavioral health services to veterans and their families, as well as the general public, was highlighted around the work of the NCDHHS Division of Mental Health, Developmental Disabilities and Substance Abuse Services, COE, and CCNC. These agencies worked together with practices across the state to help them deliver

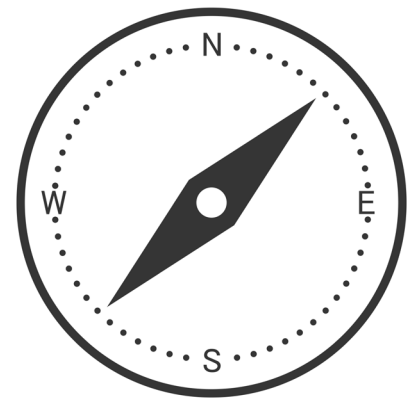


high-quality care with an emphasis on the mind-body connection (Stein, Lancaster, Yaggy, & Dickens, 2011). Citing the growing body of evidence for integrated care – especially for patients with both a physical chronic illness, as well as a mental health diagnosis, for example, depression, (Williams, 2012) – called for clinics in North Carolina to receive technical assistance to help improve integration efforts, as well as the continued need to address necessary financial hurdles to be overcome.

In some instances, the work around integrated behavioral healthcare became focused around certain populations. For example, focusing on the need for integrated care in the pediatric world, the North Carolina Institute of Medicine published a policy statement (2012) addressing children and the support of their social-emotional development and mental health. In this document, the authors state, “To improve the quality of care, the state should identify evidence-based screening tools, triage, assessment, referral protocols, and clinical treatment guidelines, and develop a system of value-based payments for women and young children with mental health needs” (NCIOM, 2012). Still calling for an “integrated system,” this document stops short of discussing integrated care as the placement of mental health within primary care as regular treatment.

Mount, Hairston, and Charles (2012) commented specifically for their work in the African America population to be used to spur the conversation further around the diabetes-mental health policy issues, and the goal to improve treatment for those living with Type 2 diabetes. For rural communities, mobilizing integrated care models and strategies was key to increasing the accessibility of mental health (NCIOM, 2014). While many were pushing the philosophy of the true integration of the mind and the body, others simply wanted mental/behavioral health to have a seat at the healthcare table.

Beginning in 2015, and over the next several years, publications with a North Carolina focus began to highlight the broad recommendations and needs of the state for a paradigm shift. One provider wrote specifically about a clinic’s treatment of the



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whole person and the integration of behavioral health into primary care (Freeman, 2015). The author emphasized the importance and connection of the mind and the body, "...At XXX, we bear this in mind and do not arbitrarily differentiate between medical and mental illness: Illness is illness, and we treat it from the same whole-person paradigm."

This clinic started in 2007 with just one behavioral health provider for one day a week, with a model similar to the primary care behavioral health model (PCBH; Robinson & Strosahl, 2009), where behavioral health consultants were extremely accessible and meeting on the same day as the appointment with the primary care provider, in the exam room, and offering brief interventions. An increased number of North Carolina clinic systems have worked to adopt models such as the PCBH model and the Collaborative Care model as a way of integrating behavioral health into the state's primary care system (Kelley, 2019; Tilson, Muse, Colville, Cole, & Keller, 2020).

Over the next few years, momentum toward and awareness of integrated care continued to build (NCIOM, 2016; NCCCN, 2017; Richard, 2017; Eugene, 2016). In fact, within the span of 10 years, North Carolina hosted the national conference for the professional home of integrated care, the Collaborative Family Healthcare Association, twice.

The 2007 conference was held in Asheville, and the 2016 conference was held in Charlotte, with both being preceded by a policy summit. These conferences and summits brought together some of the foremost experts in integrated care, as well as leaders in North Carolina government (E. Christian, personal communication, July 27, 2020). The result of the 2016 policy summit was a document entitled, "*Scaling Integration Through Health Policy*," which addressed the structural changes needed in North Carolina to bring about the same paradigm shift to whole person care.

Soon after the 2016 conference, the North Carolina Institute of Medicine published an issue brief, "Transforming North Carolina's

Mental Health and Substance Use Systems,” whose authors called for several recommendations to improve the North Carolina system (2018). At least two of these recommendations spoke directly to the shift towards whole person-integrated care:

Recommendation 3.9: Support practice and system transformation towards integrated care.

Recommendation 5.4: Improve capacity of primary care practices to screen, treat, and refer older adults to treatment for behavioral health needs.

In an updated version of “*The North Carolina Rural Health Action Plan: A Report of the NCIOM Task Force on Rural Health*,” the authors noted the progress made through Medicaid transformation for the availability of treatment of mild to moderate mental health needs in integrated primary care settings (Zolotor & Yorkery, 2018).

Changes in policy and payment structures soon became realities. For example, North Carolina Community Care Network, Inc. (2017) published a document for the Division of Medical Assistance centered around the newly endorsed G-Codes. The G-codes — specifically designed to reimburse for the collaborative care model treatment for depression in Medicare patients — were subsequently endorsed for the treatment of behavioral health concerns in primary care for Medicaid beneficiaries in North Carolina.

Also in 2017, Dave Richard, the Deputy Secretary for the North Carolina Division of Medical Assistance, authored a commentary in the North Carolina Medical Journal discussing the vision for the management of physical and behavioral health in North Carolina, specifically what the management of behavioral health in managed care might look like for North Carolina. Richard introduced the ideas of prepaid health plans (PHPs), the importance of patient choice within these PHPs, and made a case to improve healthcare by examining the siloed funding streams of physical and behavioral health. Ultimately, this article helped pave the way for the changes soon to come to healthcare in North Carolina in the next few years.

Two articles in 2018 highlighted the importance of integrated behavioral health for both addressing the health of patients, and the quadruple aim of healthcare, but also simply increasing access to behavioral/mental health care for populations in need.

Authors Christian, Krall, Hulkower and Stigleman (2018) outlined integrated care models and programs in their article, *“Primary Care Behavioral Health Integration: Promoting the Quadruple Aim.”* Christian et al. discussed elements of the primary care behavioral health model (PCBH; Robinson & Strosahl, 2009), Screening Brief Intervention and Referral to Treatment (SBIRT; Del Boca, McRee, Vendetti, & Damon, 2017), and the Collaborative Care Management model (CoCM; Unutzer et al., 2002), while acknowledging that clinics may have to make allowances for what resources they have available to implement the models to fidelity. The authors mentioned work being done in North Carolina with a variety of efforts being conducted to change the way healthcare is practiced, and the positive impact on the quadruple aim of healthcare when integrated care is practiced effectively. While achieving the quadruple aim is surely desirable, the authors articulated that integrated care was a fit for North Carolina simply due to the need for accessibility to mental/behavioral health services in the many rural counties in the state.

While many of the aforementioned articles were found in journals and policy documents, integrated care was also on the move in media formats easily digestible to both consumer, as well as clinician. For example, entities such as the i2i Center for Integrative Health hosted a policy exchange series (<https://i2icenter.org/pxintegrated/>) which sought to clarify ideas around integrated care, especially with regard to the MH/IDD/SUD population. Of particular importance in this piece was the renewed emphasis on the role of patient/consumer voice in the healthcare process.

As the literature is tracked over the years, authors have highlighted the philosophical need for, as well as the challenges in delivering, integrated whole person care.



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A PARADIGM SHIFT BEGINS

The ICARE policy brief (2009) mentioned previously outlined then-Governor Perdue's integrated healthcare agenda, the successes and role of ICARE itself, while also suggesting a statewide action agenda to tackle the obstacles still facing the healthcare system.

In addition to the reimbursement barriers frequently cited in this brief, as well as the workforce shortage for clinicians to do integrated care work, the authors of the document emphasized one of the most significant challenges to be the lack of a group specifically designed to focus on integrated care in DHHS leadership. The authors called for an extension of the quality improvement work of CCNC to focus around behavioral health, as well as a more efficient way for healthcare providers to exchange patient information relevant to their whole person care.

Ten years later, with much work being done in between, several of the recommendations presented in this document are currently being undertaken.

In 2017, North Carolina proposed a program re-design of Medicaid Managed Care, including a November 2017 letter from Governor Cooper to The Honorable Eric D. Hargan, Acting Secretary of the U.S. Department of Health and Human Services, requesting to amend its original waiver application to, "...enhance the managed care program's ability to advance integrated high-value care, improve population health, engage and support providers, and establish a sustainable program with more predictable costs."

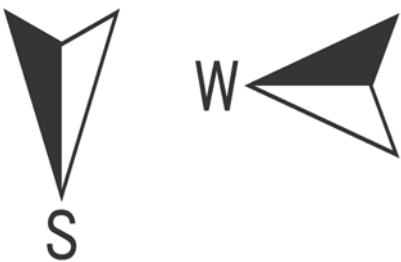
This letter of request highlighted specific needs, similar to the ones outlined by ICARE policy brief (2009), including strengthening the provider workforce. It also mentioned needs such as addressing social determinants of health through public-private pilots.

At the federal level, Medicare opened up codes to allow practices to bill for integrated care in the form of the Collaborative Care model (CoCM). Soon after, in the fall of 2018, NC Medicaid published their September 2018 bulletin indicating that it would now allow for reimbursement for psychiatric Collaborative Care management.

As much work continued being done behind the scenes, Secretary Mandy Cohen and Deputy Secretary Dave Richard took the move towards integrated care to the masses with an article in The News & Observer (2018).

For those who might not have been paying attention to the healthcare landscape, this perspective on whole person care was relatively new. However, for those who had been working on this change in healthcare for several years, the federal government’s approval to changes that the General Assembly handed down regarding the Medicaid program was cause for cautious optimistic celebration. North Carolina’s Medicaid program would be run by managed care prepaid health plans (PHP) in a way that the authors stated, “...will prioritize the health of the whole person to make North Carolinians healthier overall.”

In 2019, several government and non-governmental entities (NC Tracks, NCDHHS) sent out support and reminders for accurate billing and coverage of CoCM codes in an effort to help providers ensure success and sustainability of this effort. Shortly thereafter, in February 2019, NC DHHS announced their five-year, \$10-million federal grant to focus on social determinants of health via the Healthy Opportunities pilots to further whole person care (NCDHHS, 2019; i2i, 2019). Many of the systems needed were coming into place, and the recognition of the many elements of a person’s healthcare were being acknowledged with a plan to support those elements.



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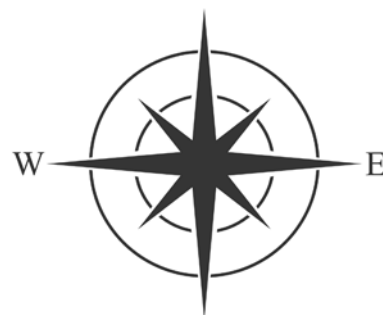
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PAYMENT AND PROTOCOL

Woes regarding the fiscal sustainability in integrated whole person care are not new, nor are they limited to North Carolina.

In 2009 (Collins, Fernandez, & Ruppenkamp, 2012), DMA opened billing codes to increase opportunities for integrated care. “In 2009 and as a result of a perceived need to support integrated care among Medicaid patients, several new billing codes were introduced by DMA that permitted primary care providers to conduct assessments for BH, to provide counseling on alcohol and substance abuse, and to administer and interpret BH screening tests.”

While still governed by federal regulations, Session Law 2011-314 (S 607), effective January 2012, reduced state barriers by allowing for the exchange of information between mental health and other health care providers to improve the quality and the coordination of care (Botts, n.d.).



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Progress toward integrated care was slowed when S.L. 2011-264 instructed NC DHHS to proceed with the statewide restructuring of the mental health, developmental disabilities, and substance abuse services system by implementing the 1915 (b)(c) Waiver Program statewide by July 1, 2013 (HB 916). While this waiver was beneficial in many ways for outpatient mental health services, the payment for mental health services was now capitated through the LME/MCOs requiring primary care practices to get credentialed and bill for mental health services separate from the physical health services.

As previously stated, in the fall of 2018 NC Medicaid joined Medicare in covering versions of integrated care that resemble the CoCM codes with specific team members (e.g., behavioral health care manager, physician, and psychiatric consultant) and required elements such as a patient registry and stepped care entitled, *"Psychiatric Collaborative Care Management."*

These changes in payment policies and emphasis on collaborative care were announced in the fall, with additional promotion from NC Division of Health Benefits (formerly NC Division of Medical Assistance), NC Tracks, North Carolina Academy of Family Physicians, NC Psychiatric Association, and NC Medical Society. The financial side of the house seemed to be catching up to the clinical practice of integrated care, potentially resulting in sustainable models of whole person care (McClellan, Alexander, Japinga, & Saunders, 2019).

INTEGRATED CARE SPOTLIGHTS

North Carolina has received attention at the national level with examples of the integrated care work being practiced in the state for quite some time (Collins, Hewson, Munger, & Wade, 2010; Mauer, 2006; Rath, 2020; Williams, Shore, & Foy, 2006).

A 2006 national publication by the National Council for Community Behavioral Healthcare cited North Carolina as hosting three pilot sites, supported by grant funding, with the goal of evaluating outcomes and potentially influencing Medicaid policy and reimbursement. Findings were supportive of integrated care and indicated outcomes such as decreased overall health care costs and decreased mental healthcare costs (Mauer, 2006).

Initiatives in the Veteran's Affairs (VA) system in North Carolina were also part of a larger VA Primary-Care Mental Health Integration initiative, where additional outcomes were tracked, including patient-centered outcomes such as risk assessment for suicidality, clinic follow up on PHQ-2 screening for depression, follow-up for PTSD screenings, and positive substance use screenings. It is clear from this report (Post & Van Stone, 2008) that the VA was working towards integration throughout its system nationwide, including North Carolina, and determining how to achieve the best outcomes both clinically, operationally, and financially.

CCNC funded a Mental Health Integration project in 2005 to help facilitate behavioral health in primary care with a focus on screenings and a reduction in emergency department visits and

inpatient admissions (Collins, Fernandez, & Ruppenkamp, 2011). From those results, a larger scaled project was initiated by the Office of Rural Health and CCNC — with the support of the Center of Excellence for Integrated Care — in an effort to facilitate co-location of providers. The focus was primarily on reverse co-location (i.e., primary care services located in behavioral health clinics) (Collins, Fernandez, & Ruppenkamp, 2011). As a result of the support of resources from the NC General Assembly, 53 practices participated in co-location, and six practices participated in reverse co-location. While limited, the results did indicate initial positive feedback and results in the information that was collected.

Patient-centered and Team-based Care

Clinics and researchers across the state continued working and refining the processes, not only on the implementation of a variety of models of integrated care, but also with disease/condition-specific needs. There was a need for a shift in the models from the traditional medical model to a more team-based and patient-focused model of care (Phelps, et al., 2009; Bray, Cummings, & Thompson, 2012).

For example, in a rural Eastern North Carolina clinic, Phelps et al. focused on an integrated model of care in the treatment of Type-2 diabetes, including specifics on team member roles, a biopsychosocial assessment, and also noted the challenges encountered in delivering treatment, including sustainability past grant funding.

Bray, Cummings, and Thompson (2012) also highlighted the management of diabetes with the ECARE-Diabetes program for enhanced diabetes care. However, the population served in the ECARE program did not appear to be suffering from co-morbid diagnoses of diabetes and mental/behavioral health, which resulted in an absence of a behavioral/mental health professional on the healthcare team. The ECARE program cited similar improvements in patient results as the IMPACT project, a well-known integrated care study for patients with diabetes and depression.



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The authors make the argument for an enhanced treatment protocol with a physician and non-physician team members specializing in diabetes education, as well as the ability to have same-day appointments. Concerns for the financial sustainability of this type of integrated practice — even without a direct behavioral health component — continued to be expressed.

In a similar study, conducted in eastern North Carolina, Cummings et al. (2019) focused on patients with diabetes. However, these patients did have a co-morbid diagnosis of depression/depressive symptoms and experienced treatment with a clear behavioral health component. The intervention and study design was fully integrated with outcomes that reflected such, both medical (HbA1c) and behavioral health (depressive symptoms).

Operationalizing Integrated Care for Special Populations

While integrated behavioral healthcare is often focused on treating mild to moderate mental/behavioral health, North Carolina authors have also highlighted the use of mental health professionals in the treatment of trauma in primary care, pediatrics, and the treatment of those with serious mental illness.

When preventing, identifying, and addressing trauma-related concerns, Dr. Marian Earls (2018) wrote of the inclusion of mental health professionals in the pediatric medical home, with, “...primary care and mental health clinicians working together to care for the whole child in the context of the family, school, and community” (p.111) as a critical piece of the puzzle.



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Areas in the state like Carolinas Healthcare (Hollowell, 2020) — and in the Triangle area, with partnerships among and between Duke, UNC-Chapel Hill and NC DHHS — have received grant funding to further integrate behavioral health into primary care settings and increase accessibility of services (Gabryel, 2019; Duke, 2019).

Part of the discussion among integrated care practices of patients of all ages and diagnoses is what patient needs can be handled “in house” and what constitutes a need to refer out for specialty mental health.

WakeBrook Primary Care worked to create a model for integrated care for those with serious mental illness (SMI) to help address this unmet need in the SMI population, under the auspices of a SAMHSA PBHCI grant. This model included the components of a patient-centered medical home with additional time for appointments, specialized training for their provider team, and regular and structured communication with patients’ psychiatrists.

Perrin et al. (2018) stated that as a result of their model, patients experienced improvements in all 10 of their UNC Healthcare System Primary Care Improvement Collaborative (PCIC) quality indicators (e.g., depression screen, breast cancer screen, A1c in DM etc.). Considering the reported decreased life expectancy for those with severe mental illness, the indicators for the physical health screens in this population are extremely important. The authors acknowledge that this model is not financially suited to pay for itself in a fee-for-service model and, once the grant ran out, they reported anticipated running at a deficit of \$200,000.

Integrating Care Using Available Resources

North Carolina researchers also continued to look at the models and programs of integrated care that fit best in clinics across the state with the resources they have available (Daniels, Dixon, & Campbell, 2014; Howard, Laramée, & Byrne, 2019; Landis, Barrett, & Galvin, 2013).

For example, if done with fidelity, the CoCM out of AIMS Washington requires a registry, a behavioral health care manager, a primary care provider, and a consulting psychiatrist all working together with a common treatment algorithm. However, in deciding what is possible for their practice, North Carolina clinics have considered the availability of community resources, patient needs, and also internal resources when implementing integrated care. Often times clinics find themselves low on resources to implement a model to fidelity — for example, including each part of the treatment algorithm or team of the CoCM — and so they implement the pieces of the model that are feasible and often build as they go (Daniels, Dixon, & Campbell, 2014).

The literature over the years demonstrates this adaptability of integrated care to North Carolina practices. For example, CCNC reported on three practices in North Carolina following various models of integrated care such as CoCM, a primary care behavioral health type model in a pediatric practice, and a form of whole person care through a coordinated care effort by a pediatric practice (Howard, Laramée, & Byrne, 2018).

Similar models were highlighted in the western region of North Carolina in 2013, with a focus on co-location, primary care behavioral health and care management model, which appeared to be a variation of CoCM without the role of the consulting psychiatrist (Landis, Barrett, & Galvin, 2013). Of particular importance was the illustration that both a horizontal model (far-reaching across the general population) and a targeted or vertical model (e.g., disease/condition-specific) could be implemented simultaneously and demonstrate improved patient outcomes. While improvements in patient outcomes were noted, this study's results were not statistically significant, likely due to several limitations such as small sample size.

Integrating Care to Include Community Partners

The acknowledgement of the need for work to go beyond the office and clinic walls in integrated care has also been noted in North Carolina practices.

Goldsboro Pediatrics, a practice that grew quickly in size, grew to add mental health clinicians as they saw the need develop in their patients and then also worked beyond their clinic doors to partner within the school system to provide services on site at the school (Tayloe, 2016).

Cone Health Foundation supported the integrated care effort by not only investing in clinic processes internally, but also by fostering relationships and collaboratives among clinics and community sites labeled “connector sites” (Bailey, 2018). With a particular focus on serving the uninsured, the author stated that the clinics involved in the Cone integrated care effort reached 91% of their goal by delivering care to more than 4,500 people in the second year, and had stories of serving individuals who had not had services such as oral health in more than 20 years.

As a newly minted North Carolina PHP, AmeriHealth Caritas also voiced support for the inclusion of social drivers of health as part of the Medicaid transformation (Michael, 2019). From the east with Goldsboro Pediatrics, to the Triad with Cone Health, and also in the west, with practices like one of Blue Ridge Health’s locations in Columbus, NC, integrated care has been finding its way into practices across the state of North Carolina in a variety of programmatic formats. As it has been developing, the workforce also has needed to make some transitions.



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INTEGRATED CARE WORKFORCE

Workforce issues for integrated care are often a hot topic as the healthcare landscape reconfigures to include behavioral health.

A series of symposiums entitled, *"Two Worlds Unite,"* began in 2006 in the west and drew participation from across the state, necessitating a move toward the center of the state in Chapel Hill in 2009 (E. Christian and M. Morgan, personal communication, May 2020). Topics covered then were similar to ones covered today in various trainings, including motivational interviewing in primary care, chronic pain management, skills for behavioral health therapists in primary care, ADHD treatment, sustaining a mental health clinician in a primary care practice, and models of integrated care. These Two Worlds Unite symposiums ran until 2011.

During a similar timeframe, as stated earlier, the first of two national conferences with integrated care as their focus came to North Carolina. In 2007 and 2016, the Collaborative Family Healthcare Association held their national conference in Asheville and Charlotte respectively.

Picking back up in 2018, the state-wide symposium put on by the Center of Excellence for Integrated Care, in partnership with Wake AHEC, focused on the importance of building quality teams. A program of the Foundation for Health Leadership & Innovation, the Center of Excellence for Integrated Care began planning a symposium for 2020. However, due to the COVID-19 pandemic, this was put on hold until 2021.

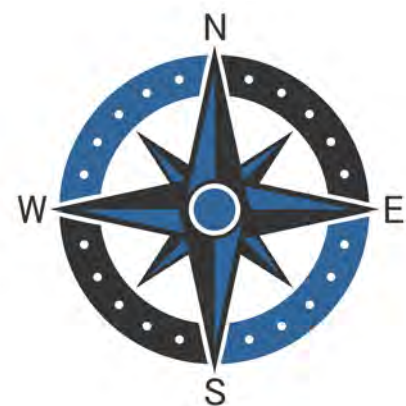
Innovating and Advancing NC Workforce Development

Despite the cancellation of the in-person gathering in Raleigh, the Center of Excellence still offered many virtual workshops during 2020 to support training needs related to the pandemic and behavioral health. The National Academy of Medicine also focused its 2019 symposium efforts on topics such as the integration of care as well as aligning payer models to support this care (Dzau, Cohen, & McGinnis, 2020). Other examples of workforce development include, but are not limited to, a training on whole person integrated care by Partners Behavioral Health (2017), and Charlotte AHEC's *"Integrated Care for Co-occurring Behavioral Health and Developmental Disabilities"* in fall 2019 (Charlotte AHEC, 2019).

North Carolina Area Health Education Centers (NC AHEC) has also been developing leaders in integrated whole person care for quite some time. Divided into regional systems, each serves their communities and respective workforce in a variety of ways. In several systems — for example, the Mountain Area Health Education Center (MAHEC) and Southern Regional Area Health Education Center (SR-AHEC — there exists a healthcare campus where providers are practicing whole person care, as well as serving as presenters and instructors to external clinicians and practitioners. AHEC has been and remains a critical element of integrated care workforce development in North Carolina.

Expanding the Members Included in the Care Team

Disciplines such as social work, nursing, and medical family therapy have advocated for their role on the integrated care team. Miller (2013) called for social workers to play a regular role in practices — such as pediatrics and family practices — in an effort to normalize behavioral health as part of their general healthcare. Working to more specifically understand what tasks a cohort of masters-level social work interns completed in an integrated care setting in North Carolina, researchers discovered that social work interns were likely to be documenting in the EHR, addressing patient's social



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determinants of health, and participating in team-based care in the role of behavioral health specialists and care managers (Fraher, Richman, Zerden, & Lombardi, 2018). At this time in their training and development, and due to other factors — such as potential clinic role confusion — social workers were least likely to be engaging in intervention based tasks such as SBIRT, functional assessments of daily living, behavioral activation, and problem solving therapy.

The researchers noted that though the social work students felt they were in the role of behavioral health specialist, they were not performing at the top of their license due to their lack of providing intervention-based services. However, an additional part of the study was the experience of the social work supervisors who indicated a much higher likelihood to perform the interventive-level tasks. The results from this study indicate that the employers of behavioral health clinicians in an integrated clinic should keep in mind the importance of the clarity of roles, as well as supporting behavioral health specialists to work to the highest level of their licensure.

Psychiatric-mental health nurse practitioners and medical family therapists can also serve in the role often called behavioral health specialist or consultant or clinician in a primary care setting. Soltis-Jarrett (2016) advocated for a need to develop an increased psychiatric-mental health nurse practitioner workforce to provide clinically competent and culturally sensitive care, and integrate behavioral health not only into primary care, but into acute and extended care settings, with a particular focus on rural North Carolina.



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Soltis-Jarrett additionally articulated the role of nurse practitioners as leaders of whole health primary care teams in an effort to increase access to whole health integrated care for rural communities (2019). Williams and Williams (2018) advocated for the role of the medical family therapists on a healthcare team, as medical family therapists are trained, "...to work with patients and families as they navigate illnesses, traumas, and loss, and disease."

Several disciplines have been noted to serve in the behavioral health role in integrated care clinics across North Carolina, and educational institutions, such as East Carolina University, UNC-Greensboro and A&T, and UNC-Chapel Hill have been working to launch graduates with a degree of orientation to working in integrated care. However, this focus varies greatly by program.

It is beyond the scope of this literature review to capture all of the continuing education trainings that have been offered both at the professional level, as well as the increased classes and shift in perspective at the university level. However, it is clear from the work experience of those at the Center of Excellence for Integrated Care that there has been an increase in trainings in whole person care topics.

INTEGRATED BEHAVIORAL HEALTHCARE SUPPORT

Within the last several years, there has been a tremendous uptick in internet and website chatter about integrated care in North Carolina. Managed care entities — both for the PHPs for primary care and the standard plans, as well as the LME/MCO entities for the tailored plans — posted webpages and press releases highlighting integrated care and whole person care.

Titles such as, *“What is whole person integrated care?”* and *“Payers support integrated care services for NC Medicaid Patients”* made it clear that the support from the financial side of the house was on the rise.

Additionally, those entities that provide both support for providers as well as for patients, indicated a focus on whole person care — for example, Community Care Partners of Greater Mecklenberg, Community Health Partners, Community Care of North Carolina, AccessEast, i2i, and Emtiro Health to name a few — had websites indicating their shift in helping practices provide whole person care. Of course, provider websites began to highlight whole person care and the importance of behavioral and mental health, as well.

The spread of integrated care across the state of North Carolina was one of the original goals of the work of the Center of Excellence for Integrated Care (COE) more than 20 years ago. The COE continues to be a voice for integrated behavioral healthcare today practicing much in the way it was originally intended with the mission as follows:

“The mission of the Center of Excellence for Integrated Care is to aid in the clinical, operational and financial transformation of healthcare systems to provide whole person care for all.”

COE works with healthcare centers and health systems to better integrate behavioral health into medical healthcare settings and serves as a source of education, consultation, and thought leadership regarding whole person care. As agencies and entities across the state continue to move forward on this path of integrated whole person care, COE will continue to serve North Carolina healthcare clinics and systems in a way that helps them shine their brightest light and sees that light reflected in their patients.



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SUMMARY

During the past 20 years, the practice of whole person care through integrated care has had a wide range of advocates in North Carolina.

While the handling of whole person care comes in degrees of integration — some with behavioral health co-located in practices for increased access to behavioral health services, to others fully integrated with behavioral health acting in full partnered capacity with physical health providers — it is clear through the literature that North Carolina has been gradually acknowledging the mind-body connection and its importance when treating patients.

Until recently, providers were limited to providing pieces of whole person care and subsequently often getting limited results unless funded by grants. It seems that North Carolina is truly at a crossroads for a paradigm shift in how patients’ needs are seen and, as a result, how providers work together with patients in their healthcare journey.



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It seems North Carolina is truly at a crossroads for a paradigm shift in how patients’ needs are seen and, as a result, how providers work together with patients in their healthcare journey.

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REFERENCES

- Bailey, M. (2018). The Cone Health Foundation: Expanding integrated care for the uninsured. *North Carolina Medical Journal*, 79(4), 261-262.
- Botts, M. (n.d.). North Carolina general assembly permits greater information sharing between health and mental health providers. Retrieved August, 19, 2020 from <https://www.ncpsychiatry.org/assets/docs/IntegratedCare/communication%203%20-%20nc%20general%20statutes%20article.pdf>
- Bray, P., Cummings, D. M., & Thompson, D. K. (2012). Use of integrated care delivery to improve the quality of diabetes management among African Americans. *North Carolina Medical Journal*, 72(5), 390-392.
- Charlotte Area Health Education Center (2019). Integrated care for co-occurring behavioral health and developmental disabilities. Retrieved from <https://www.charlotteahec.org/continuing-professional-development/event.cfm?eventid=58855> on July 20, 2020.
- Christian, E., Krall, V., Hulkower, S., & Stigleman, S. (2018). Primary care behavioral health integration: Promoting the quadruple aim. *North Carolina Medical Journal*, 79(4), 250-255.
- Cohen, M., & Richard, D. (2018, November 27). Connecting physical and behavioral healthcare is a big step for NC. *The News & Observer*, retrieved from <https://www.newsobserver.com/opinion/article222244635.html>
- Collins, C. (2009). Integrating behavioral and mental health services into the primary care setting. *North Carolina Medical Journal*, 70(3), 248-252.
- Collins, C., Fernandez, G., & Ruppenkamp, J. (2011). Reverse co-location report. Office of Rural Health and Community Care. <https://www.communitycarenc.org/media/files/reverse-co-location-report.pdf>
- Collins, C., Hewson, D. L., Munger, R., & Wade, T. (2010). Evolving models of behavioral health integration in primary care. Millbank Memorial Fund. Retrieved on July 17, 2019 at <https://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-in-primary-care/>
- Cummings, D. M., Lutes, L. D., Littlewood, K., Solar, C., Carraway, M., Kirian, K., ...et al. (2019). Randomized trial of a tailored cognitive behavioral intervention in type-2 diabetes with comorbid depressive and/or regimen-related distress symptoms: 12 month outcomes from COMRADE. *Diabetes Care*, 42, 1-8.
- Daniels, L. M., Dixon, K. E., & Campbell, L. C. (2014). Building capacity for behavioral health services and clinical research in a rural primary care clinic: A case study. *AIMS Public Health*, 1(2), 60-75. doi: [10.3934/publichealth.2014.2.60](https://doi.org/10.3934/publichealth.2014.2.60)
- Del Boca F., McRee B., Vendetti J., & Damon D. (2017). The SBIRT program matrix: a conceptual framework for program implementation and evaluation. *Addiction*, 112 (Suppl. 2), 12-22.

- Dickens, R. S., Lancaster, M. S., & Crosbie, K. (2012). Primary care/behavioral health integration efforts in North Carolina. *North Carolina Medical Journal*, 73(3), 204-208.
- Duke Integrated Pediatric Mental Health (2019). Child psychiatric telephone consultation programs address child mental health needs. Retrieved from <https://ipmh.duke.edu/news/child-psychiatric-telephone-consultation-programs-address-child-mental-health-needs> on July 22, 2020.
- Dzau, V. J., Cohen, M., & McGinnis, J. M. (2020). Vital directions for health and health care. *North Carolina Medical Journal*, 81(3), 167-172. doi.org/10.18043/ncm.81.3.167
- Earls, M. F. (2018). Trauma-informed primary care: Prevention, recognition, and promoting resilience. *North Carolina Medical Journal*, 79(2), 108-112.
- Eugene S. Farley, Jr. Health Policy Center. (2017). Scaling integration through health policy: North Carolina policy summit. <https://foundationhli.org/wp-content/uploads/2017/01/Integrating-Care-in-North-Carolina-A-CFHA-Policy-Summit-Report.pdf>
- Fraher, E. P., Richman, E. L., de Saxe Zerden, L., & Lombardi, B. (2018). Social work student and practitioner roles in integrated care settings. *American Journal of Preventive Medicine*, 54(6Sd), S281-S289. doi: 10.1016/j.amepre.2018.01.046
- Freeman, J. S. (2015) Providing whole-person care: integrating behavioral health into primary care. *North Carolina Medical Journal*, 76(1), 24-28.
- Gabryel, C. (2019). Federal award funds collaborative child health effort from UNC, Duke, NC DHHS. Retrieved from <http://news.unhealthcare.org/news/2019/december/federal-award-funds-collaborative-child-health-effort-from-unc-duke-nc-dhhs> on July 22, 2020.
- Hollowell, L. (2020). Increasing access to mental health services. The Duke Endowment, Retrieved from <https://www.dukeendowment.org/story/increasing-access-to-mental-health-services> on July 20, 2020.
- House Bill 916 (HB 916). An act to establish requirements for the department of health and human services and local management entities with respect to statewide expansion of the 1915(B)/(C) Medicaid waiver. General Assembly of North Carolina Session 2011. Session Law 2011-264.
- Howard, D., Laramée, N., & Byrne, J. (2019). The Collaborative Care Model (CoCM) and pediatric practices in North Carolina: Three case studies and discussion. Retrieved from <https://www.communitycarenc.org/what-we-do/clinical-programs/behavioral-health-integration/clinical-resources/collaborative-care>
- i2i Center for Integrative Health. (n.d.). Policy exchange series on integrated care – Part 1: How do we define healthcare integration? Retrieved from <https://i2icenter.org/pxintegrated/> on July 21, 2020.
- i2i Center for Integrative Health (2019). Healthy opportunities pilots to further whole person care. Retrieved from <https://i2icenter.org/healthy-opportunities-pilots-to-further-whole-person-care/> on July 22, 2020.

- ICARE (2009). Achieving integrated care in North Carolina: An ICARE policy brief in support of Governor Perdue's behavioral health agenda. Retrieved from http://www.ncmedsoc.org/non_members/mental_health_task_force/ICARE%20Document.pdf on July 10, 2019
- Landis, S. E., Barrett, M.L., & Galvin, S. L. (2013). Effects of different models of integrated collaborative care in a family medicine residency program. *Families, Systems, & Health*, 31(3), 264-273. <https://pubmed.ncbi.nlm.nih.gov/24059274/>
- Kelley, A. (2019). Bringing behavioral health services to primary care: new models. North Carolina Medical Group Management Association. Retrieved from <https://ncmgm.wordpress.com/tag/collaborative-care-model/> on July 20, 2020.
- Mauer, B. J. (2006). Behavioral health/primary care integration: Finance, policy, and integration of services. National Council for Behavioral Healthcare. Rockville: MD. Retrieved from <https://ncpsych.memberclicks.net/assets/docs/IntegratedCare/nccbhfinancepolicyintegration.pdf>
- McClellan, M. B., Alexander, M., Japinga, M., & Saunders, R. S. (2019). North Carolina: The new frontier for health care transformation. *Health Affairs Blog*, retrieved from <https://www.healthaffairs.org/do/10.1377/hblog20190206.576299/full/> on July 20, 2020.
- Michael, K. E. (2019). More than health care services: North Carolina's focus on improving whole-person health and patient experience. *North Carolina Medical Journal*, 80(5), 285-297. doi.org/10.18043/ncm.80.5.285
- Miller, E. J. (2013) Surveillance for behavioral health problems and developmental disabilities in pediatric primary care. *North Carolina Medical Journal*, 74(1), 63-64.
- Morrissey J.P., Domino M., Wicher C., Kilany, M., Gaynes B. (2009). Integrating primary care and mental health services: Final evaluation of the ICARE integration pilot sites. Report to the North Carolina Foundation for Advanced Health Programs, Inc. and the North Carolina Division of Medical Assistance, Department of Health and Human Services.
- Mount, D. L. Hairston, K. G., & Charles, S. M. (2012). Diabetes and adverse mental health among African Americans. *North Carolina Medical Journal*, 72(5), 400-401.
- North Carolina Community Care Networks, Inc. (2017). G-codes for integrated care models. Retrieved from <http://www.ncmedsoc.org/wp-content/uploads/2018/12/2017-G-Codes-for-Integrated-Models-DMA-CCNC-White-Paper-FINAL.pdf>
- North Carolina Institute of Medicine (2012). Growing up well: Supporting young children's social emotional development and mental health in North Carolina. Retrieved from <http://nciom.org/growing-up-well-supporting-young-childrens-social-emotional-development-and-mental-health-in-north-carolina/>
- North Carolina Institute of Medicine (2016). Transforming North Carolina's mental health and substance use systems: A report from the NICOM Task Force on Mental Health and Substance Use. Retrieved from : <http://nciom.org/wp-content/uploads/2017/07/MHSU-Issue-Brief.pdf>
- North Carolina Institute of Medicine (2014). North Carolina Rural Health Action Plan: A report of the NCIOM task force on rural health. Retrieved October 26, 2020 from https://nciom.org/wp-content/uploads/2017/07/RuralHealthActionPlan_report_FINAL.pdf

- North Carolina Division of Health Benefits (2018). Coverage for psychiatric collaborative care management. Retrieved on July 20, 2020 from <https://medicaid.ncdhhs.gov/blog/2018/09/03/coverage-psychiatric-collaborative-care-management>
- North Carolina Tracks – North Carolina Department of Health and Human Services. (2019). Coverage for psychiatric collaborative care management reminder. Retrieved from <https://www.nctracks.nc.gov/content/public/providers/provider-communications/2019-announcements/Coverage-for-Psychiatric-Collaborative-Care-Management-Reminder.html> on July 22, 2020.
- North Carolina Department of Health and Human Services. (2019). DHHS receives \$10 million grant to promote integration of primary and behavioral health care. Press release, February 11, 2019. Retrieved from <https://www.ncdhhs.gov/news/press-releases/dhhs-receives-10-million-grant-promote-integration-primary-and-behavioral-health> on July 22, 2020.
- North Carolina Department of Health and Human Services (2019). Healthy opportunities pilots: Lead pilot entities request for proposals fact sheet. Retrieved from https://files.nc.gov/ncdhhs/Healthy-Opportunities-LPE-RFP_FACT-SHEET_20191106.pdf on July 22, 2020.
- Partners Behavioral Health Management (2017). Partners health summit: Whole person integrated care. Retrieved from <https://www.partnersbhm.org/events/partners-health-summit-whole-person-integrated-care/> on July 20, 2020.
- Perrin, J., Reimann, B., Capobianco, J., Wahrenberger, J. T., Sheitman, B. B., & Steiner, B. D. (2018). A model of enhanced primary care for patients with severe mental illness. *North Carolina Medical Journal*, 79(4), 240-241.
- Phelps, K. W., Howell, C. D., Hill, S. G., Seeman, T. S., Lamson, A. L., Hodgson, J. L., & Smith, D. A. (2009). A collaborative care model for patients with Type-2 diabetes. *Families, Systems, & Health*, 27(2), 131-140. doi: 10.1037/a0015027
- Post, E. P., & Van Stone, W. W. (2008). Veterans health administration primary care-mental health integration initiative. *North Carolina Medical Journal*, 69(1), 49-52.
- Raths, D. (2020). Seven states begin work on integrated care for kids payment model. *Healthcare Innovation Newsletter*. Retrieved from <https://www.hcinnovationgroup.com/policy-value-based-care/alternative-payment-models/article/21124105/seven-states-begin-work-on-integrated-care-for-kids-payment-model> on July 20, 2020.
- Richard, D. (2017). What is next for behavioral health in managed care? *North Carolina Medical Journal*, 78(1), 30-32.
- Robinson, P, & Strosahl, K. (2009). Behavioral health consultation and primary care: Lessons learned. *Journal of Clinical Psychology in Medical Settings*, 16, 58-71. doi: 10.1007/s10880-009-9145-z

- Soltis-Jarrett, V. (2016). Patient-centered homes and integrated behavioral health care: Reclaiming the role of “Consultant” for psychiatric-mental health nurse practitioner. *Issues in Mental Health Nursing*, 37(6), 387-391. doi: 10.3109/01612840.2016.1172686
- Soltis-Jarret, V. (2019). The TANDEM3-PC: The foundation for an innovative, integrated behavioral health NP-led model of practice in rural primary care. *Archives of Psychiatric Nursing*, 33, 2-10. doi.org/10.1016/j.apnu.2018.08.007.
- Stein, F., Lancaster, M., Yaggy, S., & Schaaf Dickens, R. (2011). Co-location of behavioral health and primary care services: Community Care of North Carolina and the Center of Excellence for Integrated Care. *North Carolina Medical Journal*, 72(1), 50-53.
- Tayloe, D. T. (2016). Patient-centered medical homes in 2016. *North Carolina Medical Journal*, 77(4), 279-282.
- Tilson, E. C., Muse, A., Colville, K., Cole, A., & Koller, C. F. (2020). Investing in whole person health. *North Carolina Medical Journal*, 81(3), 177-180. doi.org/10.18043/ncm.81.3.177
- Unutzer, J., Katon, W., Callahan, C.M., Williams, J. W., Hunkeler, E., Harpole, L....Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *Journal of the American Medical Association*, 288(22), 2836-45. doi: 10.1001/jama.288.22.2836
- Williams, J. (2012). Integrative care: What the research shows. *North Carolina Medical Journal*, 73(3), 205-206.
- Williams, J., Shore, S. E., Foy, J. M. (2006). Co-location of mental health professionals in primary care settings: Three North Carolina models. *Clinical Pediatrics*, 45(6), 537-543. doi.org/10.1177/0009922806290608
- Williams, R. & Williams, J. (2018). The patient and family as part of the health care team. *North Carolina Medical Journal*, 79(4), 252-253. doi.org/10.18043/ncm.79.4.252
- Yaggy, S. D. (2011). From fragmentation to integration: The North Carolina Center of Excellence for Integrated Care, presented at the Rowland-Hite Health Planning Seminar Retrieved on July 8, 2019 from https://dukeendowment.org/sites/default/files/media/images/stories/downloads/event/DAlbertoYaggyVeer_Presentation.pdf .
- Zolotor, A. J., & Yorkery, B. (2018). The Rural Health Action Plan: An update from the NCIOM. *North Carolina Medical Journal*, 79(6), 404 – 406.

APPENDIX A

Literature Review Specifics

Databases & Search Locations:

- North Carolina specific journals, especially North Carolina Medical Journal, or articles in the general literature with samples or case studies etc. rooted in North Carolina.
- North Carolina conference proceedings (behavioral health – all disciplines, medical professionals – all disciplines, conferences that would be marketed to mixed audiences and continuing education offerings in the AHEC system.
- Technical reports, policy reviews, government and stakeholder (LME/MCO, CCNC, etc.) documents related to Medicaid transformation, and potential state health plans or other documents looking for references to whole person care.

Search Terms/Phrases:

- Integrated care
- Whole person care
- Primary Care Behavioral Health
- Collaborative Care
- Integrated primary care
- Integrated Care Behavioral Health
- Value based care (not sure about this one)
- Practice transformation



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