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Contemplating on the end of integrated care-part II: Living the questions to foster adaptability

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In Part I of this article, I (D. George) traced the contours of integrated care in general and the development of the Collaborative Family Healthcare Association's (CFHA) growth using the ecocycle planning framework (George, 2023). Ecocycle planning is one of the thirty-three tools of a process called Liberating Structures (Liberating structures: Including and unleashing everyone, 1999) and is inspired by biological research that maps the stages and processes – development, conservation, destruction, and renewal – of ecological or natural systems. Organizational development experts (Hurst & Zimmerman, 1994) advocate using this framework to increase the adaptability and agility of systems to calibrate emerging challenges rather than becoming rigid in the face of change. From advances in technology to changing patterns of how people engage with information, healthcare, and help-seeking, disruptions in healthcare are accelerating at a dizzying pace. New players, such as private equity and retail giants, are entering the landscape, and profits are driving care delivery more powerfully than ever before. The promise and threat of technology has now fully immersed itself in our consciousness.

As CFHA enters the 30th year of its role as the intentional, professional network platform for all aspects of integrated care, we are in a mature position to reflect on our growth while simultaneously anticipating our future. Using the Phases of the ecocycle planning framework as a conceptual lens, I (D. George) tracked roughly 54 years of integrated care history, with 30 of those years tracing the birth and maturity of CFHA. The phases covered in Part I include *gestation* or *sowing*, *birth* or *tending*, and I make the argument that CFHA specifically, and the field, in general, is in a *maturity* or *harvesting* phase (Figure 1). CFHA and integrated care have overcome the *scarcity trap*, which in the Ecocycle planning framework occurs between gestation and birth. Between *maturity* or

harvesting and *creative destruction* or *plowing* is the **rigidity trap**. In part II of this article, Parinda Khatri – former President of CFHA and Chief Executive Officer of Cherokee Health Systems – and I outline challenges that CFHA and integrated care must wrestle with to be adaptable and avoid the rigidity trap. The challenges described below have emerged as prominent in our reading, reflection, and practice. They are to be considered a beginning list of contenders we are to reckon with rather than a conclusive list of challenges.

We face interwoven challenges of context, ecology, and morality. Early integrated care retrofitted our clinical contexts so that patients would be able to experience biopsychosocial care by design, however, the horizons ahead of us challenge us to reconstruct our resilience against the complexities that underwrite the state of affairs in healthcare in general. The case we are making is not that these ideas are foreign to integrated care, but that they should occupy a critical space in our viewfinder as we forge ahead to navigate the wild terrains of an inequitable healthcare system. Beyond creating access, the creative engines of CFHA and integrated care should be key informants in achieving a "whole-of-society effort" that supports the creation of healthy environments.

Clinic-driven innovations paved the way for our growth, but future ventures must prioritize spaces beyond clinic walls. Like Engel's call for a biopsychosocial model inspired the eras up to now, the Health and Human Service's critical mission in the "Roadmap for Behavioral Health Integration" (Bagalman et al., 2022) should serve as an inspiration moving ahead. Bagalman et al. (2022) write "The full spectrum of behavioral health care will be integrated into health care, social service, and early childhood systems to ensure all people have equitable access to evidence-based, culturally appropriate, person-centered care" (p. 3). Let us dive into the specifics to explore the challenges we need to right-size against to overcome the rigidity trap and sustain our growth.

Zip code, not genetic code: The 80/20 fact

The single best predictor of health and life expectancy in the United States is a person's ZIP code (Robert Wood Johnson Foundation, 2023). The 80/20 fact hinges on the idea that only 20% of healthcare outcomes are determined by access to clinical care, while 80% of the influence comes from social and economic factors. The Robert Wood Johnson Foundation identifies economic status, employment, education, housing, nutritious food, crime, pollution, and healthcare as elements that impact life expectancy. The element of the built environment therefore should be a sharp feature in the ongoing evolution of integrated care. In a recent Texas survey of patients, 65% of respondents said that they would be healthier if the state spent on non-medical factors – such as environment, nutrition, and employment – while 55% indicated that health insurance companies should cover non-medical drivers of health (Sim et al., 2023). The idea that health is determined beyond a doctor's visit is recognized by our population. Therefore, the same strengths that fortify our within-clinic practice – such as workflows, competencies, and communication training – should begin to address outside-the-clinic factors. Our familiarity with in-clinic behaviors such as screening and linkage to services are helpful yet do not address the root causes of external determinants. Expanding beyond our facilities and teams could involve shaping the environment through programs, policies, projects, or a combination (Carcedo et al., 2020). In a report titled *Healthy Places Toolkit: A Practical Guide to Improving Community Health*, the Episcopal Health Foundation, and Asakura Robinson map out how programs, policies, and projects are valuable strategies for healthcare facilities. As we move forward, the 80/20 principle should inform our key decisions around workforce development as well as community collaborations. We must recognize that the healthcare delivery infrastructure must expand to include non-traditional partners. CFHA and its members can serve as models, coaches, and advocates for this to advance and frame the contours of a more effective approach to integrated care and population health.

Artificial Intelligence: The agony and ecstasy

Artificial Intelligence (AI) has a pivotal role in almost all aspects of our daily lives – finance, transportation, commerce, and economic consumption – and has the potential to improve patient care and quality of life and to "revolutionize healthcare services" (Alowais et al., 2023). Alowais et al., (2023) predict that AI will eliminate or minimize the risk of human error, improve accuracy of results, reduce costs, and improve medical decision-making in diagnosing diseases. In addition to specialties like genomics, precision medicine, dose optimization, and therapeutic drug monitoring, AI will assist in population health management – a major context for integrated care. Predictive analytics and risk assessment are key promises of AI in population health management. AI's footprint also includes extending to virtual healthcare assistance, personalized mental health treatments such as cognitive-behavioral therapy (Graham et al., 2019), patient education, promoting health behavior changes (Aggarwal et al., 2023), and playing a role in preventing clinician burnout (Alowais et al., 2023). Lest the excitement of AI as a "magic bullet" to fix the ails of the healthcare system overcome us, let us look back to the similar promise of Electronic Health Records (EHR). As noted by Ashish Jha (2011) and frankly, reinforced by many of our own experiences, EHRs, while transformative, have not lived up to expectations of a safer, more effective, and more efficient system. The rollout of AI offers an opportunity to apply lessons learned from the implementation of EHR.

CFHA should be proactive in shaping AI's application to clinical practice to advance health equity as well as quality, value, and clinical safety. Specifically, CFHA should guide the role of emerging AI technology to optimize "efficiencies" in the frame of compassionate, empathic, human-centered care. The "right relationship" we aim to establish with AI must also account for race and sex-based biases that have been found to shape AI output (Buolamwini, 2019). For example, Buolamwini (2019) systematically demonstrated that AI systems had an error rate of 35%

in recognizing faces of dark-skinned women like Oprah Winfrey, Serena Williams, and Michelle Obama while only a 1% error rate for lighter-skinned men. AI systems generate their responses by combing through prior data and literature, which have often disfavored minority experiences, voices, and data. Therefore, as integrated care grows and AI becomes an unavoidable feature of healthcare, CFHA should work to embed key concepts of health equity into guiding frameworks for AI and its applications to clinical practice, program development, and workforce.

Technology, and populations: Accounting for the young and the old

The gap between digital natives – generations born into the current technology – and digital immigrants – generations accommodating their lives to emerging technology – continues to rise every day. Some studies have shown that older adults are at risk for "digital exclusion" and as technology becomes more central, older adults should be appropriately educated to make up for their lack of familiarity with emerging technologies (Heponiemi, et al., 2022). Because the social and educational experiences of younger generations are digitally bound more than previous generations, actively thinking about how younger generations prefer to access health should be a concern in integrated care. For example, what are the ways traditional approaches (e.g., an in-person visit with a provider) might prevent youth from seeking healthcare? Regardless of the age range, we should also be mindful of the deep inequities in digital access as determined by poverty. The digital inequity powered by poverty was most pronounced during the pandemic. While CFHA may not be able to sway the spread of digital solutions in healthcare, we can be a passionate voice that advocates for the young, the aged, and those experiencing digital exclusion because of poverty.

The prolonged presence of poverty

The uncomfortable truth in many societies across the world and especially in America is the continued, unabated presence of poverty. In one of my earlier columns (George, 2023), I (D. George) detailed how poverty remains an "unmitigated and out of focus" priority in the United States for economic and policy interventions. Furthermore, I (D. George) provide outlines of how the field of mental health in general relies on middle and upper-class samples in research studies to generate evidence. As reflected in that article, the integrated care workforce, especially in primary care, will continue to be the professionals who interface with patients living in poverty more frequently than those in other settings. It is a critical moral task that our future endeavors in integrated care should be decisively shaped by dynamics of poverty in health, healthcare access, and healthcare outcomes. Because there are no promising signs from our culture or governmental entities that a comprehensive solution to end poverty is near, CFHA should engage consistently with the intersection of poverty with physical and mental health, consider how to account for poverty in the clinical training of future providers as well as increase sensitivity in our workforce towards economic influences on health outcomes, and become proficient in adapting evidence for behavioral health interventions that account for poverty.

Creating meaningful pathways for the workforce

The past decade has witnessed federal, state, and private investments in workforce development for advancing integrated care. The Health Resources and Service Administration (HRSA) and the Substance Abuse and Mental Health Service Administration (SAMHSA) have a portfolio of funding options to advance workforce development during Master's and Doctoral studies. However, there are several economic, career progression, and practical difficulties in helping an integrated behavioral health-trained professional to remain and prosper in an integrated care setting.

In this paragraph, I have built upon key insights from Laura Brassie, LPC's LinkedIn post (Brass, 2023). Laura posed thought-provoking questions that signal future challenges for the mental health workforce that CFHA and integrated care must also wrestle with. Most clinicians on the frontline tend to be master's level providers, which many systems tend to invest in due to lower costs as compared to a provider at the doctoral level. Often, they are likely to remain in that position, with no meaningful career advancement pathways within an organization. Very few health systems invest in leadership opportunities for clinicians on the front line; therefore, we will likely lose them in a few short years to non-integrated care jobs. While the demand for integrated behavioral health-trained providers is rising, compensation for behavioral health clinicians remains low. Despite the lower wages paid to behavioral health clinicians, the demand for mental health needs continues to rise and insurance companies typically maintain their profit margins.

Finally, while there is frequent, periodic national attention given to the shortage of mental health providers, policies to adequately reward and sustain an integrated behavioral health workforce have miles to go. For example, only this year in 2024 will Licensed Marriage and Family Therapists (LMFTs) and Licensed Professional Counselors (LPCs) become eligible for Medicare reimbursements. Because there tends to be a high Medicare population in typical primary care practices or health systems caring for underserved populations, LMFTs and LPCs – before this billing legislation took effect in 2024 – were less preferred as integrated care providers. We hope there will be more targeted recruitment of LPCs and LMFTs for integrated care in 2024.

The path to attaining full licensure poses several challenges for many graduates due to the stipulations of accruing hours and payment for supervision. A trainee is less likely to get a reasonably paying job, and those who complete their licensure often work multiple jobs to make ends meet. The services provided as a master's level provider while accruing hours toward licensure are not reimbursable. If the workforce is the bridge to help us address shortages in integrated care

professionals, CFHA and integrated care must advocate for more equitable pathways for passionate students to enter primary care and other integrated care settings. For example, could there be a system for master's level trainees where they can bill under their supervisor's license like Psychology Interns or medical interns in residency programs? Can there be special exceptions for primary care and rural locations where appropriate and eligible supervisors may not be available? Would such an experimental pathway increase interest and willingness among trainees to pursue integrated care as a career path? The challenge for us is to think equitably about the longevity of the workforce and ensure we do right by the thousands of passionate students who aspire to be part of the solution.

Rethinking empirically supported treatments for integrated care

All clinician-scientists engaged in integrated care need to rethink how evidence-based interventions are promulgated in the next ten years to advance the integrated care mission. Strosahl and Robinson (2018) advocate that for a larger impact on public health, empirically supported treatments in mental health should be "brief, cost-effective, patient-centered" and can be learned and applied by mental health and a variety of healthcare professionals. Strosahl and Robinson argue for a "good fit" frame and make the case that current empirically supported treatments fail this criterion as the evidence generated in mental health research is not grounded in population-based healthcare. In other words, they summarize that empirically supported approaches are "complex, labor-intensive treatments" that require therapists to undergo specialized training to deliver them. Such stringent requirements to deliver treatments are not a "good fit" for "practical realities of community care contexts generally, and primary care specifically" (P. 3) (Strosahl & Robinson, 2018). They advocate for a methodological approach that takes into account population health, primary care, the dose-effect relationship of interventions to outcome, increasing uptake of interventions, and framing the development of new evidence-supported treatments in the context of interdisciplinary work. They

surmise that while the old question focused on "Which treatment(s) are known to work best with which specific mental health or addiction-based conditions or both," the new population-based care question should be "Which treatment(s) works best, in the shortest possible time, with the least resources used, with the lowest refusal and attrition rates, when delivered by mental health and non-mental health providers (with different levels of training) in a variety of different community settings, and with patients suffering from medical and mental health conditions of varying levels of severity?" (P. 8) (Strosahl & Robinson, 2018). This question, along with the moral commitment to account for the role of poverty should also occupy an important space in the future of integrated care, especially the scientists who continue to advance our missions. For example, integrated care researchers can ensure patient samples in treatment trials reflect real-world care (e.g., multiple comorbidities, poverty levels), testing interventions that match real-world care patterns (e.g., a few 20–30-minute visits), and including clinicians of various training levels and licensures to deliver interventions in trials.

At the outset of CFHA's 30th year of existence and as the intentional professional network that continues to fan the flames of spreading integrated care, these themes should occupy our consciousness for the years ahead. These questions are layered with contextual, moral, and ecological dynamics that do not yield neat, predictable answers – much like the challenges that faced the generation that spawned the energy of integrated care and the creation of CFHA. We take comfort in the idea that the answers to these challenges are as unclear and complex as the human lives we care for as professionals, which beautifully reflect the complexity and dignity of our lives. After all, we are the descendants of pioneers who took no comfort in easy answers. May the generations leading us into our 60th year be inspired to "live these questions and tensions", especially when the answers remain unclear or elusive.

Figure 1 - The Ecocycle Planning Framework
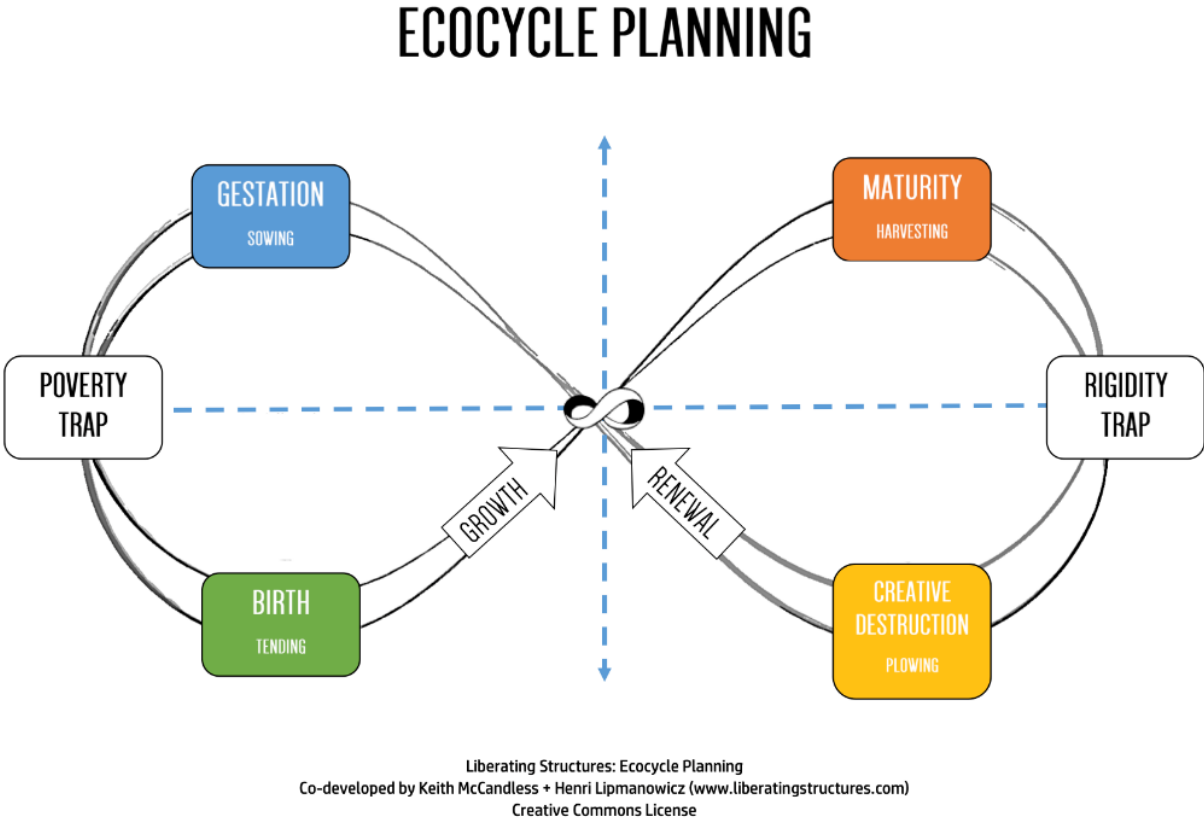
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