Practice Innovations

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Online First Publication, July 13, 2017. http://dx.doi.org/10.1037/pri0000047

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2377-889X/17/$12.00 http://dx.doi.org/10.1037/pri0000047

Disruptive Change and Health Service Psychology Transform a Clinical Psychology Doctoral Training Clinic

Cathy Moonshine, Irina Gelman, and Russell Sorenson
Pacific University

Health care reform and the triple aim of the Affordable Care Act have created disruptive change in health care. Heath care systems and practitioners have responded with integrated care and patient center home models. Similarly, psychology is in a state of disruptive change as the profession shifts to Health Service Psychology. Psychology, more than ever, is joining health care teams by engaging in interprofessional collaboration and providing team-based care. After more than 35 years as a low-fee self-pay community psychology clinic, the Pacific Psychology and Comprehensive Health (PCH) Clinics in Oregon became a State Certified Mental Health Center and a regional Medicaid provider. The PCH Clinics and the National University of Natural Medicine (NUNM) developed a partnership in 2014. Additionally, there are occupational, physical, and speech therapy services available to clients across the life span. All of these services are provided on a foundation of interprofessional collaboration. Utilizing the levels of integrated care published by SAMSHA and HRSA in 2013, the PCH Clinics have moved from a level 1 siloed program to beyond a level 4 colocated program, with the goal of exceeding level 5 in the near future. Clinician competencies are based on the *Core Competencies for Interprofessional Collaborative Practice* published by the Interprofessional Education Collaborative.

Public Significance Statement
The implementation of the Affordable Care Act caused drastic changes in mental health, which led to adaptations in how graduate school programs for psychologists train and work with their clinicians. The following article reviews how the doctoral psychology programs at Pacific University in Oregon used local resources to combine with other health professions and create a thriving clinic that continues to grow in both clientele and services offered.

Keywords: disruptive change, health service psychology, integrated care, interprofessional collaboration

As health care demands in the United States shift, emphasizing more comprehensive health care, and the American Psychological Association (APA) moves into an era of "health service psychology," our psychology training clinics implemented large-scale changes. This article outlines how Disruptive Change played an important role in integrating the clinics into a Behavioral Health Home, while continuing to deliver evidence-based, culturally responsive, and trauma-informed care across the life span. Additionally, clinics pursued becoming a Medicaid provider. The changes sought to increase caseloads, provide a unique training platform for students from various health professions, train health service psychologists, and respond quickly to health care demands as they were arising in response to the Affordable Care Act (ACA). Our responsiveness to community trends and health care demands aims

Cathy Moonshine, Irina Gelman, and Russell Sorenson, School of Graduate Psychology, Pacific University.

Correspondence concerning this article should be addressed to Cathy Moonshine, School of Graduate Psychology, Pacific University, 1411 Southwest Morrison Street, Suite 310, Portland, OR 97205. E-mail: drmoonshine@pacificu.edu

to increase access to care and increase clinical hours while offering cutting-edge training for students.

Where We Started

The psychology training clinics of the School of Graduate Psychology (SGP) at Pacific University in Oregon have served as the primary practicum site for clinical psychology doctoral students to provide outpatient psychological services to residents of the Portland metropolitan area since 1980. The SGP training clinics' doctoral internship program earned APA-accreditation in 2013. These training clinics have been known by several names over the years (reflecting their evolving purpose), including the Psychological Service Center, The Iris Clinic, and The Pacific Psychology Clinics. In 2014, the clinics were unified under the new name The Pacific Psychology and Comprehensive Health (PCH) Clinics. This new name captures the developmental trajectory of expanding health and wellness services with the goal of providing services as fully integrated care clinics.

Prior to integration, the psychology clinics functioned as an independent training site for the School of Graduate Psychology (formerly School of Professional Psychology), delivering only psychological services, such as psychotherapy and assessment. The integration created partnerships between PCH and National University of Natural Medicine (NUNM), as well as internal Pacific University programs: School of Occupational Therapy (OT), Speech Language Pathology program, School of Pharmacy, and School of Physical Therapy, to provide a wide range of health care services. Supervisors and students from all professions deliver care and engage in interprofessional training.

Integration brought additional professionals into the PCH Clinics. Prior to 2014, we were staffed by psychologists in training, licensed psychologist supervisors, and a psychiatric nurse practitioner who was on site 10% of the time. Our staffing now includes consulting behavioral pharmacists and student clinicians, naturopathic doctors and trainees, physical therapists and student clinicians, occupational therapists and trainees, along with speech pathologists and student clinicians. All of the licensed providers and supervisors are employed by Pacific University or the National University of Natural Medicine. Because of limited funding, no funds are provided to these departments for staffing that they have allocated to the PCH Clinics. Our hope is to one day be a robust clinic that can reimburse professionals or their departments and expand their services.

The PCH Clinics train future psychologists and other health care professionals to work interprofessionally and provide integrated care. In addition to psychological services, the not-for-profit PCH Clinics provide primary care, natural medicine, integrative care, pharmacological consultation, medication management, occupational therapy, physical therapy, and speech therapy services. Services are provided on a self-pay basis, through contracts with specific organizations such as Vocational Rehabilitation, or are covered by Medicaid.

Clients range in age from preschool-aged children to older adults. Psychology practicum clinicians, doctoral psychology interns, and postdoctoral residents provide clinical services under the close supervision of licensed psychologists. Other members of the care team include licensed naturopathic doctors, a behavioral pharmacist, speech therapists, occupational therapists, and physical therapists along with clinical trainees in all of these disciplines. Table 1 lists the professional domains covered by our care team members and the services they provide at the PCH Clinics.

The PCH Clinics have provided psychological services to underserved, impoverished, and marginalized individuals, couples, and families for the last 35 years. For the majority of this time, we have been a self-pay, low-fee psychology clinic serving approximately 1,000 unduplicated clients per year including nearly 10,000 psychological sessions, which includes therapy and assessment. Most of our clients paid $20 per therapy session.

Before the ACA expansion, services at the PCH Clinics were not eligible for payment from public and commercial insurance as these are rendered by students who are unlicensed status and working under the supervision of licensed psychologists. This resulted in reduced clinical hours after implementation of ACA, as clients were seeking services through their new insurance coverage. During 2012–2015, the PCH Clinics experienced more than a 20% reduction in psychological services providing approxi-

Table 1
Services Provided at PCH Clinics

Professional domains	Services types
Psychotherapy	Individuals, couples, groups, and families, with treatment, approaches following a variety of theoretical foundations, including cognitive-behavioral, behavioral, psychodynamic, gestalt, and integrative orientations.
Psychological assessment	Neuropsychological, intellectual, personality, and psychoeducational batteries.
Community outreach	Psychoeducational workshops, seminars, participation in health fairs and community events that are strengthening relationships with community partners.
Pharmacological services	Medication evaluation, management, and patient education.
Primary care services	Comprehensive medical histories, exams, and lab testing.
Natural medicine and integrative care	Nutritional counseling, supplements and natural remedies, acupuncture, chiropractic, and massage therapy.
Occupational therapy	Functional, sensory, and other assessments, which vary depending on client needs/concerns. Primary areas include activities of daily living and instrumental activities of daily living.
Physical therapy	Restore quality of life and function and prevent and/or reduce physical disabilities due to neurological and/or musculoskeletal disorders.
Speech therapy	Eating/swallowing challenges as well as a variety of communication challenges, such as speech articulation, voice, language, and cognitive-communication challenges; cognitive rehabilitation services can help manage attention, memory, organizational, and everyday communication following brain injury.

Note. PCH = Pacific Psychology and Comprehensive Health.

mately 750 clients with nearly 8000 hours of psychological assessment and psychotherapy. In the years before 2012, we typically served approximately 1000 clients receiving 10,000 sessions of psychological service. This shift resulted in the PCH Clinics providing psychological services to fewer people for shorter periods, creating challenges to maintaining adequate caseloads for clinicians in training. In response to this downturn in productivity, the PCH Clinics engaged in intensive marketing efforts starting in 2013, equivalent to over 5,000 hours of marketing and community outreach. Additionally, we reduced session fees to $10 and increased the amount of probono services provided. These efforts created some improvement, but not proportionate to the time and energy invested. Some of the factors that we expected to account for the downward trend included an increase in the number of mental health clinicians in the community and more individuals utilizing their insurance coverage.

Between 2012 and 2015, we estimate the expansion of the Medicaid benefits within the Affordable Care Act (ACA) decreased our client base by more than 20%. This hypothesis is supported by data that show, 16.4 million uninsured people now have health care coverage nationally. Over 12.3 million additional individuals enrolled in State Medicaid programs between October 2013 and April 2015. Communities of color have shown a dramatic increase in the number of individuals with health insurance. All of this has led to small increases in health insurance costs over the last five decades since the implementation of the ACA (Assistant Secretary for Public Affairs, 2015a).

The rate of uninsured individuals dropped nearly 6% in Oregon during 2014. In November 2015, the U.S. Department of Health and Human Services reported that provisions in the ACA allowed Oregon to significantly increase the number of individuals with health insurance. More than 400,000 individuals were new enrollees in Medicaid plans since the implementation of the ACA. Medicaid coverage extends to 817,160 Oregonians, who now have coverage to pay for mental health and substance use disorder treatment (Assistant Secretary for Public Affairs, 2015b).

These data support our hypotheses that the decrease in clients served and clinicians' caseloads are largely related to more people having health insurance and coverage for mental health

and addictions treatment. Coverage has expanded provider options for clients that initially accessed low fee services at the PCH Clinics.

Leveraging Disruptive Innovation

Jack Welsh said, "If the rate of change on the outside exceeds the rate of change on the inside, the end is near (Terry, 2016, July 1). Jack Welch's quote may point toward some of the reasons for the PCH Clinics' downward trend of reduced demand for psychological services. When we recognized that the primary strategies of marketing the PCH Clinics did not result in the desired and reasonably expected outcomes, we decided disruptive change and innovation was needed. Disruptive change can be defined as large-scale changes in organizational structure, technology, and ways of doing business (Higgitt, 2014). The idea of disruptive change is not new as Bower and Christensen (1995) discussed this concept in the business world. Disruptive change may necessitate sufficient change on the inside in order to match the rate of change on the outside, thus allowing an organization to survive. Sometimes disruptive change is vehemently opposed, regarded as impossible or too revolutionary by insiders. Other times, disruptive change is ignored in hopes that it will fail and simply fade away. Health care and psychology are neither immune nor opposed to factors leading to disruptive change.

By its nature, dramatic change brings rapid and remarkable transformation, often in the face of market demands and cultural influences. Examples of disruptive changes in American society include the Internet, cell phones, personal computers, and Google. These innovations changed things so quickly that we struggle to keep ourselves abreast of what it means to have them. Large changes and innovations have also been transpiring in health care over the last decade. Examples in health care include electronic health records (EHRs), chains of urgent care clinics that resemble retail businesses and telemedicine (McGuinness, 2014). Disruptive changes and innovations in health care include the ACA, which resulted in a dramatic increase in the number of individuals with health insurance. McMorrow and Holahan (2016) estimate a $2.6 trillion-dollar savings in health care costs between 2014 and 2019 based on health care reform and the ACA. Additional disruptive changes in health care and psychology are related to the push toward interprofessional collaboration, integrated care, and health service psychology aimed at treating the whole person (Rozensky, 2013).

Terry (2016, July, 1) stated:

> The rate of change external to each of our organizations is now so great that no organization can ensure it is changing faster than the external system. Global interconnectedness, the rapid speed of ideas in a digital economy and new means of working and collaborating means that change will only continue to accelerate.

We realized that for the administrators of the PCH Clinics to effectively interact with disruptive, external changes and innovations, we needed to restructure operations to resemble a responsive organization that was open to dramatic change on the inside. Responsive organizations structure themselves in ways that respond quickly, integrate new information, and adapt business strategies to be nimble and best serve its network of customers, staff, and stakeholders (Cambridge, 2008). The PCH Clinics have a small team of clinical directors and administrative staff that meet several times a week. These meetings center around topics such as responding to change, develop new business lines, expanding clinical services, updating and creating new policies and procedures, and training clinical staff. PCH stakeholders include not only those who pay for services but also the clinicians, supervisors, staff, community partners, funders, licensing boards, and accrediting bodies.

Being Flexible and Nimble

Responsive organizations value experimentation and tolerate ambiguity and imperfections. This description captures the PCH Clinics' recent management style. The clinical, administrative team does not wait to have an ideal plan in place before moving forward with change. Members of the team research potential organizational changes online, in consultation with similar clinics and with trusted colleagues. The team then discusses the information gathered and decides if changes appear to make sense and how to move forward. Organizational changes are monitored very closely in the beginning and modifications are made along with way as new information is acquired or roadblocks are encountered. The leadership team

maintains regular contact through e-mail and hallway consults that empowers the PCH Clinics to respond nimbly and flexibly growth opportunities and effectively modify business practices.

The PCH approach to change is aligned with the understanding that responsive organizations move away from a focus on efficiency, extrinsic rewards, and traditional work structures (Fisher & Dickinson, 2014). Traditional work structures in psychology include providing services during a 9 a.m. to 5 p.m. workday, office-based services, and weekly 50-min therapy sessions (Fisher & Dickinson, 2014). The PCH Clinics are open until 8 p.m. on weekdays and Saturdays. We provide treatment in the community and in clients' homes when clinically appropriate. We deliver traditional 50-min therapy sessions as well as abbreviated behavioral health consultations in collaboration with our health and wellness providers.

Responsive organizations are adaptive, empowering, intrinsically motivated, collaborative, flexible, innovative, and seek out community partners (Cambridge, 2008). Strategies utilized in a responsive organization include the following principles, all of which are fully embraced by the PCH Clinics.

- Participation of stakeholders is highly valued and sought out; however, consensus is not required before implementing changes.
- Transparency is valued; however, not all information is public.
- Acceptance of learning through experimentation and failure is of great importance.
- Adaptability and adjustment on the fly are crucial.

Rapid cycle change tends to be used by responsive organizations. The mantra of rapid cycle change is "plan, do, study, and act" (West, 2012). The management style and organizational structure of the PCH Clinics shifted to embrace this approach and facilitated the transformational processes now occurring within the PCH Clinics. The transformation began in 2010 with the implementation of an electronic health record. This transformation was not part of a deliberate shift to create internal change at a rate matching the external changes occurring. In hindsight, we realized that this shift kicked off a series of disruptive to dramatic change events that have helped us transform the PCH Clinics. The second major event was the introduction of interprofessional collaboration and evolution of the PCH Clinics into integrated care clinics. These two endeavors will take another four to six years to come to full fruition and complete integration into the organization's functioning.

We began integrating health and wellness services to the array of resources already available to our clients in 2014. We established a partnership with naturopathic physicians and several other health professions including pharmacy, occupational therapy, physical therapy, and speech therapy. The goals of these partnerships include fostering interprofessional collaboration and training while integrating care for all PCH Clinic patients. The PCH Clinics' mission statement evolved accordingly and now expresses the following commitment: "providing children, teenagers, and adults with quality mental health treatment and integrated care services that are culturally sensitive, trauma-informed and evidence-based. Training future clinical psychologists and healthcare professionals to work interprofessionally to improve patient outcomes and satisfaction."

A Changing Landscape for Psychology and Health Care

Given the downward trend of direct clinical hours and the implementation of the ACA, we wondered whether the PCH Clinics needed to undergo even more disruptive change. When assessing outcomes needed for the PCH Clinics to reach or exceed 80% capacity, we arrived at a minimum enrollment number of 520 unduplicated therapy clients at any point. This calculation was based on 32 full-time equivalents of clinical staff carrying a 50% caseload. Total capacity for the clinics is 650 unduplicated therapy clients at any point.

Contrastingly, at the end of the 2014–2015 academic year, the PCH Clinics were serving fewer than 150 active therapy clients leaving a gap of approximately 370 clients. Our recent marketing efforts clearly had not resulted in sufficient referrals. In reviewing our revenue, which was also negatively impacted, we noted that revenue had suffered disproportionately to patient numbers. We discovered that many of the patients we were serving, based on referrals from our marketing efforts, utilized the bottom of our sliding scale or were unable to afford the

clinics' minimum fees for service (i.e., $10 per session). We had arrived at an unsustainable business model. This realization prompted discussion of additional disruptive and innovative changes that could increase the number of clients served, as well as augment the number of training hours for clinicians and dramatically improve the PCH Clinics' financial forecast.

With this recognition, we began numerous dialogs among clinicians, clinical supervisors, administrative staff, and executive leadership focused on ideas for future opportunities and potential corrective action. We conducted meetings and conversations with referents, community partners, and other stakeholders. Many options emerged, all with its own set of challenges. It occurred to us that we wanted to choose an option that was within our scope of management skills and experience, yet radical enough to create sufficient change to induce success. We finally settled on a path that would draw on the past experience and skills of the current PCH Clinics' leadership. Specifically, the scope of management practice of the clinic directors has included running State-certified mental health centers that provided services to the Medicaid population, with more than 10 years of experience leading community mental health and addiction treatment centers and serving in the roles of clinicians, supervisors, managers, and directors at community mental health centers.

Through our discussions and research on how the PCH Clinics might dramatically increase the number of clients served, we began to consider becoming a State-certified mental health center and contracting with local counties to provide services to Medicaid recipients. In the State of Oregon, there are three levels of unlicensed mental health professionals that are qualified to treat clients with mental health and addiction diagnosis under the Medicaid reimbursement rules. State designated qualifications are listed in Table 2. The majority of clinicians at the PCH Clinics exceed the standards of the Qualified Mental Health Associates (QMHA) and qualify as Qualified Mental Health Interns (QMHI). Approximately 25% are considered Qualified Mental Health Professionals (QMHP). All clinical staff members are closely supervised by licensed psychologists or licensed medical professionals. Thus, serving Medicaid populations seemed like a realistic course of action to pursue.

One barrier to the PCH Clinics providing services to Medicaid recipients was the acuity, severity, and chronicity of mental health symptoms that have historically been outside the scope of practice of the PCH Clinics. However, because of the ACA, Medicaid now covers significantly more individuals, not just those with severe and persistent mental illness. Two new groups of individuals covered by the ACA would fall into the PCH Clinics' scope of practice because they are more functional and less complex than traditional Medicaid populations.

Given the changes in the diagnoses covered by Medicaid, new credentialing standards, and the scope of practice of the clinic directors, we chose to pursue certification from the State of Oregon and entered contract negotiations with two counties. In September 2015, the Oregon Health Authority awarded the PCH Clinics a Certificate of Approval to provide mental health services to Medicaid recipients. One of the PCH Clinics is located in Multnomah County, which includes Portland, Oregon's largest city. According to census data, Multnomah county's population is just under 800,000, including 45,000 veterans. Its population includes 20% ethnic minorities with 12% over age 65 and 20% under age 18; it has a median household income of $52,000, and 18% of residents live in poverty (United States Census Bureau, 2014a). Devarshi Bajpai, the Medicaid Manager at the Multnomah County Mental Health Department, reported nearly 800 adult clients and 50 youth clients were in need of services (personal communication, July 23, 2015) and had not been able to access care due to capacity limitations at the existing community mental health centers (CMHCs). The other PCH Clinic is located in Hillsboro, Oregon, which is part of Washington County. According to census data, Washington County has a population of just over 560,000, including nearly 33,000 veterans. Its population includes 18% ethnic minorities, 12% over age 65, and 24% under age 18; it has a median household income of $64,000, and 11% live below the poverty line (United States Census Bureau, 2014b). Nick Ocon, Behavioral Health Supervisor at Washington County Mental Health, estimated having approximately 200 adult clients and 25 youth clients who were unable to access care through state CMHCs

Table 2
State Designated Qualifications

Professional qualifications	Expected competencies	Required education
Qualified Mental Health Professionals (QMHPs) in compliance with 309–019–0125(8)	Conduct assessments; identify precipitating events; gather histories of mental and physical health, substance use, past mental health services, and criminal justice contacts; assessing family, cultural, and social and work relationships; conduct MSEs; complete DSM diagnoses; write and supervise the implementation of a Service Plan and provide individual, family, or group therapy within the scope of their training.	Bachelor's degree in nursing and licensed by the State or Oregon Bachelor's degree in occupational therapy and licensed by the State of Oregon Graduate degree in psychology, social work, recreational, art, or music therapy or a behavioral science field A qualified Mental Health Intern, as defined in 309–019–0105 (61).
Qualified Mental Health Interns (QMHIs) in compliance with 309–019–0105(61)	Conduct assessments; identify precipitating events; gather histories of mental and physical health, substance use, past mental health services, and criminal justice contacts; assessing family, cultural, social, and work relationships; conduct MSEs; complete DSM diagnoses; write and supervise the implementation of a Service Plan and provide individual, family, or group therapy within the scope of their training.	A person who meets qualifications for QMHA and is currently enrolled in a graduate program for a master's degree in psychology, social work or in a behavioral science field; Have a collaborative educational agreement with the QMHP or another provider, and the graduate program; Receive, at minimum, weekly supervision including two individual sessions per month, by a qualified clinical supervisor employed by the provider of services.
Qualified Mental Health Associate (QMHA) in compliance with OAR 309–016–0005(58)	Communicate effectively; understand mental health assessment, treatment, and service terminology and to apply the concepts; provide psychosocial skills development and to implement interventions prescribed on a Treatment Plan within the scope of their practice.	A bachelor's degree in a behavioral sciences field; or a combination of at least three year's relevant work, education, training or experience; Delivers services under the direct supervision of a QMHP.

(personal communication, April 27, 2015). In summary, we could quickly document a great need to in our communities for mental health services we were qualified to provide, along with funding available to support such efforts. Thus began our process of becoming a State-certified mental health center.

Becoming a State-certified mental health center, contracting with county mental health authorities, and serving clients with Medicaid turned out to have negative and positive facets. A negative facet pertains to the evolution required numerous organizational changes, including expanding the PCH Clinics' infrastructure and implementing extensive compliance protocols, along with dramatic policy changes. This process would prove to be a disruptive change and produced significant innovation at the PCH Clinics. Change is hard, stressful, and does not always work; however, we believe the risks were worth the benefits. The benefits included increasing the number of enrolled clients by at least 200, expanding the scope of practice for clinicians, and adding financial viability. Increased revenue allows us to allocate funds in beneficial and expansive ways. We could allo-

cate funds to increase pay for supervisors and administrative staff, increase the number of positions for doctoral interns in our APA-accredited internship, add another psychological resident, and expand continuing education opportunities for clinicians and supervisors. Furthermore, we expanded our community outreach efforts to include a focus on reaching underserved individuals and those who do not seek traditional office-based mental health services.

March 2016 marked the beginning of the Portland PCH Clinic accepting clients enrolled in Medicaid services. This change was preceded by many months of negotiation, significant training for staff and clinicians, implementation of compliance protocols, and an overhaul of clinical documentation protocols. The initial Medicaid contract was with Multnomah County Mental Health. The Coordinated Care Organization, Healthshare of Oregon, administers the mental health Medicaid benefit for the three metro counties of Clackamas, Multnomah, and Washington. Members often live in one county but work in another or sometimes change their county of residence. In an effort to better serve their members, Healthshare of Oregon changed its contracting structure. Instead of mental health Medicaid being contracted by county and restricting members to seek services in their county of their residence, Healthshare of Oregon established regional contracts at the start of July 2016 (Healthshare of Oregon, 2016). At this time, both PCH Clinics became regional providers, serving children, adolescents, and adults with Healthshare of Oregon. At the 1-year anniversary of serving Medicaid clients, we have enrolled more than 150 unduplicated clients. By June 30, 2017, the end of the fiscal year, we hope to have more than 200 unduplicated individuals engaged in services at the PCH Clinics.

The PCH Clinics serve a wide range of diagnoses across the life span. As providers, we believe we consider each client's best interests. For example, if clients are better served by a different agency, such as those specializing in domestic violence within couples, we refer to appropriate community partners or clinicians. The Portland metropolitan area has a number of community mental health centers that are funded and organized to provide comprehensive services to individuals diagnosed with severe and persistent mental illness, and we typically refer such clients to these programs. That said, because of the diverse expertise of our licensed supervisors, our clinicians have been able to work with clients with personality disorders, bipolar disorders, trauma, obsessive–compulsive disorders, hoarding, psychotic disorders (such as schizoaffective disorders), and depersonalization disorders. We also provide therapy to clients with mild to moderate substance use disorders, sometimes in conjunction with formal addictions treatment programs or community support groups.

The PCH Clinics strive to provide services to underserved, impoverished, and marginalized populations. Although psychology's image has improved over time, Chen et al. (2006) remind us that stigma is a present and active deterrent for many who are in need of psychological services. We offer a variety of discounts for those living at or near poverty and bundling discounts for individuals enrolled in multiple services or multiple family members enrolled in services. We have a strong outreach program that provides psychoeducation to the community and aims to fight the stigma of mental health difficulties. We offer integrated health services that serve to strengthen these efforts. We also provide services designed for veterans in partnership with Returning Veteran's Project and Veteran Services in Washington and Multnomah Counties. Typical issues presented by our adult clients include depression, anxiety, relationship conflicts, anger management problems, trauma, stress management, interpersonal difficulties, adjustment to illness, work or academic difficulties, financial hardships, and parent–child problems. Presenting problems of child and adolescent clients include academic or family difficulties, anxiety, and depressive disorders, sleep problems, enuresis, oppositional defiant behaviors, ADHD, and issues related to trauma. The number of services provided by the PHC Clinics over the past three academic years is shown in Table 3. Data from 2015/2016 show an increase in both client sessions and psychological evaluations. Of the 9,855 sessions, 8,860 were for mental health services. That means we delivered 1,500 additional mental health sessions in 2015/2016. Early analysis of data shows that the addition of the Medicaid contract increased clients served and sessions provided.

Table 3
Services Provided By the PCH Clinics

Service type	2012/2013	2013/2014	2014/2015	2015/2016
Mental health therapy sessions	9059	8194	7286	8870
Psychological evaluations	121	117	129	143
Primary care visits			371	620
Speech therapy visits			109	249
Physical therapy visits				83
Occupational therapy visits				43

Note. PCH = Pacific Psychology and Comprehensive Health.

We anticipate that the increase in therapy clients will result in growth in the number of individuals who utilize our integrated care services. With more therapy clients served, we expect that other service lines will experience growth as students are expected to engage in warm hand-offs and discuss overall health care as part of each client's treatment.

Providing more integrated care services will increase collaborative treatment. Increasing interprofessional collaboration is consistent with the mission statement for the PCH Clinics of providing children, teenagers, and adults with quality mental health treatment and integrated care services that are culturally sensitive, trauma-informed and evidence-based. Increasing interprofessional collaboration is also consistent with national trends toward training future clinical psychologists and health care professionals to work interprofessionally to achieve improved patient outcomes and satisfaction. We hope to more than double the number of visits to our health and wellness providers.

Providing Services in a Diverse World

Another component of the disruptive change process for the PCH Clinics is to feature inclusive forms of diversity in our clients and staff. In an effort to be culturally competent and responsive, we developed a new mission statement and a number of new policies and procedures.

The PCH Clinics' diversity mission statement embraces the diversity embodied within each individual and acknowledges group differences. We strive to provide culturally responsive and evidenced-based services in a safe and affirming space. Our therapeutic, assessment, outreach, and educational programs are delivered in a caring and compassionate manner that values the unique characteristics and experiences of the individual. Our clinicians, supervisors, and staff are committed to the promotion and affirmation of diversity in its broadest sense. We recognize that prejudice and discrimination based on sex, gender identity and expression, ethnicity, race, sexual or affectional orientation, age, physical and mental abilities, size, religious beliefs, and socioeconomic status have historically affected mental health practices, both in terms of defining mental health issues as well as in the provision of care that is informed by cultural awareness and identity-affirmation (Bingham & Banner, 2014). Prejudice and discrimination run counter to the PCH Clinics' commitment to social justice and psychology's professional ethics. Furthermore, prejudice and discrimination are detrimental to the practice of psychotherapy, assessment, outreach, integrated care, and interprofessional collaborations (Ponterotto, Potere, & Johansen, 2002).

The PCH Clinics' policy and procedure manual contains a Civil Rights and Nondiscrimination Policy. It states that discrimination is prohibited at the PCH Clinics with respect to clients, family members, support systems, potential clients, community partners, clinicians, clinical supervisors, administrative staff, and clinic directors. Services are offered to clients and potential clients, who fall within the PCH Clinics' scope of practice. All clients and potential clients are valued regardless of their age, class, ethnicity, gender, ability, race, sexual orientation, spiritual practice, and socioeconomic status. Thus, all clients are treated without discrimination. Clinicians, supervisors, administrative staff and clinic directors are valued regardless of their age, class, ethnicity, gender, ability,

race, sexual orientation, spiritual practice, or socioeconomic status. Thus, all staff are treated without discrimination.

In a separate policy, Accessibility and Lowering Barriers, it is stated all PCH facilities are accessible to persons with mobility impairment. Both clinic locations have elevators and accessible restrooms. Both locations are easily accessed by public transportation and have parking available. Within this policy, clinicians, supervisors, and clinic directors are required to demonstrate cultural competency.

Provision of culturally and linguistically appropriate services is another policy in the PCH Clinics' policy and procedure manual. This policy outlines how the PCH Clinics strive to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This ensures that governance, leadership, and workforce are culturally responsive. The PCH Clinics provide communication and language assistance and engage in continuous improvement and accountability. Diversity is woven into supervision of clinicians, interprofessional (IP) team meetings, administrative meetings, and leadership meetings. We increase our competency to practice within a diverse cultural community by acquiring knowledge of the histories, cultures, norms, and values of diverse groups. We also increase our competency by adjusting our clinical practice to provide respectful and effective services to this diverse cultural community. Clinical staff, supervisors, administrative staff, and clinic directors are expected to demonstrate certain competencies outlined by the APA (2015), which include the following:

- discuss personal worldview and biases;
- reflect attention to each client's cultural values within the context of psychological services as well as health and wellness visits;
- articulate at least one model of multicultural competency;
- incorporate ethical guidelines regarding diversity into clinical work; and
- sensitively discuss issues of diversity in supervision and other professional interactions.

Developing Integrated Care Services in Behavioral Health Home

An enormous disruptive change at the PCH Clinics was moving from paper charts to an electronic health record in 2011. This created challenges and opportunities for both clinical and administrative staff. Without this technology, the communication and coordination needed to create an integrative health care system would not be possible. A student under our supervision worked for a clinic that had two locations in the same city. This clinic required that charts be driven back and forth between the two locations. This practice slowed progress and was a hassle not only for the clinic but for the patients as well. According to the student, patients often called looking for information but called the office that did not have the chart. Sometimes, neither office could determine where information was located. Electronic health records (EHRs) eliminate not only stress but also the potential of losing a chart in transport. Additionally, overhead costs for storage space and additional charting staff. EHRs expand the ability to communicate between providers and expedite the healing process. As patients and clients seek to improve their quality of life, they can reduce paperwork and look up information while with their providers.

Perhaps the most impactful disruptive change at the PCH Clinics was responding to Health Care reform. This included exploring the possibility of providing integrated behavioral health and medical services in 2014. Prior to 2014, the PCH Clinics were a traditional mental health clinic without any medical services. Various health and wellness services were added during 2014–2016. These additional services have transformed the PCH Clinics to a Behavioral Health Home.

After several months of planning, which included psychology, physician assistants, pharmacy, and naturopathic doctors (NDs), we launched a pilot project. The pilot project established a primary care shift of NDs and residents in the Portland PCH Clinic. In the State of Oregon, Naturopathic Doctors (NDs) are recognized as physicians and have the comparable scope of practice as Medical Doctors. NDs can provide Western primary care services along with complementary and alternative medicine. NDs are able to prescribe medical and psychi-

atric medications. In 2015, the Naturopathic primary care services were expanded to two shifts in the Portland PCH Clinic and one shift in the Hillsboro PCH Clinic. Also in 2015, Occupational, Physical and Speech Therapy joined the integrated care teams. In 2016, all health and wellness services were expanded.

Interprofessional Collaboration

The Center for Integrated Care supported The Substance Abuse and Mental Health Services Administration (SAMSHA) and Health Resources and Services Administration (HRSA), who published a standard framework for levels of integrated care services in 2013. Level I is characterized by little collaboration between mental health and medical providers. Level 2 includes mental health and health care providers being in separate locations with a small amount of collaboration and few ongoing conversations. Level 3 is when mental health and health care providers are onsite together and have occasional communication and case coordination. Level 4 can be described as close collaboration in a system that has achieved some integrated characteristics. Level 5 is a fully integrated care office with close collaboration and case coordination between all team members including mental health. Level 6 integration is a fully integrated system that has transformed the practices of all team members and is focused on collaborative care for patients. (Heath, Wise-Romero, & Reynolds, 2013).

Prior to expanding services to health and wellness providers, the PCH Clinics were a Level I program. After expanding services, the PCH Clinics were considered a Level 4 program. Evidence of Level 4 integration includes a shared electronic health records, regular face-to-face meetings with the interprofessional team, face-to-face and electronic conversations for care coordination and active consultation between providers. We provided shared educational opportunities for all members of the interprofessional team. We are striving to reach Level 5 integration in 2017. This is evidenced by medical and psychology clinicians sharing responsibility for nearly all patients. Interprofessional collaboration and teams work systematically to meet the needs of patients. Clinical, operational, and financial variables must all be taken into account when maintaining and expanding integrated services.

The PCH Clinics foster a number of integrated care competencies published by SAMSHA and HRSA (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). Clinicians the PCH Clinics engage in interprofessional communication by establishing rapport and maintaining relationships with team members. They also effectively communicate with patients, support systems, and community stakeholders. Clinicians foster collaboration and teamwork by functioning as an effective interprofessional team, making joint decisions and integrated care plans. PCH Clinic clinicians understand and respect the roles of all professionals on the interprofessional team. Members of the interprofessional team conduct brief screening for medical and mental health needs, recognize the importance of in-depth and follow-up assessment, and refer to specialists when indicated. Care planning and coordination happen with all appropriate members of the interprofessional team. Team members work closely and diligently to implement treatment plans and to lower barriers for providers and patients' participation in the integrated care plans. Patients and support systems are encouraged to participate in the treatment process and receive support to manage complex medical systems. The interprofessional team provides prevention, wellness, health education and outreach services when appropriate. Services are evidenced-based and culturally responsive. Team members demonstrate cultural sensitivity and humility. Services are adapted to the meet the cultural and spiritual needs of the patients.

The American Psychological Association (APA), as well as associations representing other health professions, is responding to the evolving nature of health care. As part of this disruptive change, APA has begun to focus on health service psychology (Rozensky, 2013). The emphasis of health service psychology takes a broad and holistic approach to mental health and includes the acknowledgment and use of biological and social aspects of a client's life along with the psychological components (Rozensky, 2013). This vision aligns with the PCH Clinics' mission and developmental trajectory. As the field moves toward Health Service Psychology, the Interprofessional Education Collaborative published the Core Competencies for Interprofessional Col-

laborative Practice (Interprofessional Education Collaborative Expert Panel, 2011). Based on these guidelines, below are the competencies fostered among the IP professionals at the PCH Clinics.

Ethics and Values

Work with other professions with the climate of mutual respect and shared values.

Roles and Responsibilities

Use the knowledge of own roles and those of other professions to assess appropriately and address health care needs of patients.

Interprofessional Communication

Communicate with patients, families, communities and other health professionals in a responsive and responsible manner that supports a team approach.

Teams and Teamwork

Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient and population-centered care that is safe, timely, efficient, effective, and equitable.

Interprofessional Team Meetings (IPTM) are weekly case conference meetings attended for all PCH professionals in which students and supervisors discuss cases they are treating to ensure effective coordination of care. In addition to care coordination, the meetings are a platform for educational opportunities where each provider addresses questions related to their field, supporting a mission of learning and collaboration. An example may be a discussion about clients with comorbid chronic pain and depression, where psychology, primary care, speech therapy, and occupational therapy provide information to enhance understanding of these issues while maintaining a patient-centered and compassionate stance. Through discussions of shared clients in the IPTMs, collaborative relationships between providers develop. As clinicians from one profession learn about the services of the other professions, they are more likely to make referrals to other service lines. This exchange of ideas and clients increases interprofessional collaboration, supports warm handoffs from one service to another, and deepens the integration of care. Ultimately, collaboration and integration improve the experience of patients by treating concerns holistically. Patients are less likely to fall through the cracks and to follow up on all aspects of their health care as it is convenient for them to be able to come to a single location for all their treatment needs. PCH psychology clinicians engage in interprofessional collaboration skills by

- asking the patient whether he or she has a PCP and whether he or she does not, providing support to help them find one;
- educating patients about the medical services offered through the PCH Clinics;
- coordinating care with the patient's medical providers, both within the PCH Clinics and in the community, where collaboration should be more than just the initial conversation;
- requesting medical and mental health records;
- attending appointments with the patient when they are seeing other PCH IP professionals, when appropriate, when client consents, and when schedules allow for it;
- following up with PCH IP professionals;
- attending weekly interprofessional team meetings when patients on their caseload are being discussed;
- attending at least one IP team meeting per month, even if no patients on their mental health caseload are being seen by the PCH IP professionals; and
- actively seeking out consultation with PCH IP professionals and other medical professionals to enhance their clinical knowledge and increasing their ability to provide integrated care.

PCH health and wellness clinicians engage in interprofessional collaboration skills by

- considering psychological factors that impact physical health and illness;
- including mental health and addictions issues of the patient and first-degree family members when conducting medical histories;
- utilizing motivational interviewing techniques to encourage behavior change and increase health seeking behaviors;

- evaluating the potential risk of harm to self, others and abuse of others. Involve PCH psychology clinician if concerns arise;
- engaging patient's family members in treatment if appropriate and feasible;
- regularly attending IPTMs to discuss patients and increase awareness of psychological factors;
- consulting with clinic directors for deeper understanding patient's mental health issues and consulting on complicated cases; and
- attending clinic-wide trainings on a variety of topics, including case conceptualization, risk assessment and abuse reporting, working with multicultural clients, and others.

Overcoming Barriers

We faced many barriers in this process of disruptive change. One significant barrier was understanding the state laws and regulations and then creating all new policies and procedures to ensure compliance with the laws and regulations. Developing relationships with county mental health departments and clinical care organizations was long and stressful process. Fortunately, it resulted in contracts to provide service to individuals that were not accessing services without the contract. Even with contracts that funded services, it took quite a while before we were receiving adequate referrals to match our capacity. It was very frustrating to have clinicians available to see clients, but only receiving few requests for therapy. It has taken quite a while for referral sources and word of mouth to circulate in the community that the PCH Clinics accept Medicaid. Overcoming these barriers took patience, persistence, and consultation.

There were often breaks in forward momentum and personnel changes that required regrouping and restarting the process. There was considerable resistance to change from within the PCH Clinics and at our academic institutions. Some of the medical providers that considered joining our integrated team had extreme concerns about the risk and complexity of mental health clients. Some of these concerns appeared to be ignorance and stigma. Additionally, there was a lot of misunderstanding and apprehension about working with Naturopathic Doctors. Ultimately, we found it essential to find licensed professionals who were interested in working in a clinic like ours with our unique set of team members and services offered. We are not a traditional primary care office or mental health center. Unique, creative, and collaborative professionals make the best fit for our team at the PCH Clinics. Working collaboratively as a team and not giving up on our vision has helped us overcome these barriers.

Conclusions

The ACA, health service psychology, and integrated care have brought disruptive change to mental health care as delivered across the nation and to our own PCH Clinics. After implementing an EHR, collaborating with numerous health and wellness providers and expanding the PCH Clinics' missions, the PCH Clinics have traveled a considerable distance on the developmental trajectory of becoming an integrated care clinic integrates primary care and other medical services to more holistically and comprehensively treats patients. We look forward to the challenges ahead while completing our evolution into a fully integrated care organization while being responsive to market forces by being nimble and adaptive.

We have learned in the last five years that the organizational health and viability of the PCH Clinics is well served by disruptive change and responsive organizational theory, which leads to rapid cycle change and innovation. These organizational processes have transformed the PCH Clinics into dynamic and evolving community organizations that seek to meet the needs of clients, clinical staff and community stakeholders. Disruptive change, responsive organizational theory, and rapid cycle change are the antidotes of organizational stagnation and atrophy. We are aware that the market forces, government regulation, and community demands are ever evolving.

The Disruptive Change model may be replicated in other settings where resistance to change is a barrier. Willingness to pilot programs and move forward with implementation despite initial opposition, remaining flexible throughout the process, and soliciting feedback to improve outcomes while involving stakeholders strategically has been essential to our

growth and when used by other clinics it has the potential of helping them adjust and grow.

Even as PCH Clinics have reached capacity serving the Medicaid population and institutionalize our business practices in relationship to the ACA, we are reminded that significant changes or an entire replacement of the ACA, may be on the horizon and with it, more disruptive changes and opportunity for innovation. We will face the near and distant future with curiosity, creativity, and faith in the wisdom of our leadership team, clinical staff, and partners.

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Received February 22, 2017
Revision received May 25, 2017
Accepted June 5, 2017 ■