Preparing the Workforce for Behavioral Health Integration

SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Montana State University Healthcare Policy Conference
April 6, 2018
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Overview

• Workforce challenges in behavioral health
• Behavioral health integrated care models
• Workforce factors impacting integrated care delivery
• Best practice example
Workforce Challenges in Behavioral Health
“A Workforce Crisis”

- Increased demand for behavioral health services
- Too few workers
- Poorly distributed workforce
- Need for additional training
- Increased emphasis on integrated care and treatment of co-occurring disorders
Maldistribution of Workforce Limits Access

- As of 2018, 5,042 mental health Health Professional Shortage Areas (HPSAs); approximately 5,906 psychiatrists needed to remove the designation
- Increase from 2012: 3,669 mental health HPSAs, 1,846 psychiatrists needed
- 55% of U.S. counties (rural) have no practicing psychiatrists, psychologists, or social workers

Sources: HRSA Data Warehouse, 2018; KFF, 2016; SAMHSA, 2013
# Behavioral Health Workforce Projections: 2025

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Supply</th>
<th>Demand</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Counselors</td>
<td>243,450</td>
<td>321,500</td>
<td>-78,050</td>
</tr>
<tr>
<td>Clinical, Counseling, School Psych</td>
<td>188,930</td>
<td>246,420</td>
<td>-57,490</td>
</tr>
<tr>
<td>MH/SA Social Workers</td>
<td>109,220</td>
<td>157,760</td>
<td>-48,540</td>
</tr>
<tr>
<td>MH Counselors</td>
<td>145,700</td>
<td>172,630</td>
<td>-26,930</td>
</tr>
<tr>
<td>SA/BD Counselors</td>
<td>105,970</td>
<td>122,510</td>
<td>-16,540</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>45,210</td>
<td>60,610</td>
<td>-15,400</td>
</tr>
<tr>
<td>MFTs</td>
<td>29,780</td>
<td>40,250</td>
<td>-10,470</td>
</tr>
<tr>
<td>BH NPs</td>
<td>12,960</td>
<td>10,160</td>
<td>2,800</td>
</tr>
<tr>
<td>BH PAs</td>
<td>1,800</td>
<td>1,690</td>
<td>110</td>
</tr>
<tr>
<td>TOTAL</td>
<td>883,020</td>
<td>1,133,530</td>
<td>-250,510</td>
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Behavioral Health Workforce Research Center

- Established September 2015 at the University of Michigan School of Public Health
- Part of HRSA’s Health Workforce Research Center Network
- Jointly supported by HRSA and SAMHSA
- Work through a Consortium model
- Guided by two key advisors: Ron Manderscheid, PhD and Peter Buerhaus, PhD
BHWRC Partnership Network

Year 1
- National Council for Behavioral Health
- Community Partnership of Southern Arizona
- SouthWest Michigan Behavioral Health
- NACCHO
- Center of Excellence in Public Health Workforce Studies

Year 2
- American Psychological Association
- CSWE
- BHECN
- National Board for Certified Counselors
- AAMFT

Year 3
- American Psychiatric Association
- American Academy of Child and Adolescent Psychiatry
- National Association of Psychiatric Health Systems

Confirmed:
- American Hospital Association

Outreach:
- BHECN

School of Public Health
Behavioral Health Workforce Research Center
University of Michigan
How do we build workforce capacity to ensure continuous access to quality behavioral health care?
Factors Impacting Behavioral Health Workforce Capacity to Engage in Integrated Care

Who are the Providers
What Providers are Authorized to do
What Providers Can Bill For
State Assessment

Characteristics and Practice Settings
Scopes of Practice
Reimbursement Policies
State Workforce Monitoring

Services
Reciprocity
Telehealth
Requirements
Regulation of Licensure/Certification

State Assessment Services
Characteristics and Practice Settings
Scopes of Practice
Reimbursement Policies
State Workforce Monitoring

Requirements
Reciprocity
Telehealth
Services

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Behavioral Health
Integrated Care Models
Integrated Care and Collaborative Care

Systematic coordination of general and behavioral healthcare
→ integrating mental health, substance misuse, and primary care services

Collaborative care: behavioral health works with primary care

Integrated care: behavioral health works within and as a part of primary care

Benefits of integrated care¹
- Access to care
- Patient outcomes
- Employee productivity/satisfaction
- Readmission rates

SAMHSA-HRSA Center for Integrated Health Solutions

ABOUT CIHS
SAMHSA-HRSA Center for Integrated Health Solutions

CIHS promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings.

Integration Consultation
Interested in a free one-hour consultation with one of our integration experts? Contact us at integration@thenationalcouncil.org or 202-684-7457.

www.integration.samhsa.gov
Integration Models

**Integration**

- Primary Care Services
- Behavioral Health Services

**Reverse Integration**

- Behavioral Health Services
- Primary Care Services
# Collaboration Continuum

<table>
<thead>
<tr>
<th>COORDINATED KEY ELEMENT: COMMUNICATION</th>
<th>CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY</th>
<th>INTEGRATED KEY ELEMENT: PRACTICE CHANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEVEL 1 Minimal Collaboration</td>
<td>LEVEL 2 Basic Collaboration at a Distance</td>
<td>LEVEL 5 Close Collaboration Approaching an Integrated Practice</td>
</tr>
<tr>
<td>LEVEL 3 Basic Collaboration Onsite</td>
<td>LEVEL 4 Close Collaboration Onsite with Some System Integration</td>
<td>LEVEL 6 Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>
Workforce Factors Impacting Integrated Care Delivery
Integrated Care Team Members

Primary care: physicians, physician assistants, and nurse practitioners

Behavioral health: social workers, psychiatric mental health nurses, psychologists, psychiatrists, mental health counselors, addiction counselors, marriage and family therapists

Allied health: care coordinators, health educators, community health workers, promotores de salud, peer support specialists, patient navigators
Integration of Behavioral Health and Primary Care: Opportunities and Barriers

• **Purpose:** identify cases of primary and behavioral health care service integration and the effects of implementation on the workforce.

• **Methods:** Completed eight key informant interviews in spring 2016 with integrated care sites. Interviewees included clinical professionals and organizational leadership.

• Interview themes included:
  • Composition of workforce engaged in integrated care
  • Worker satisfaction with team-based care model
  • Workforce development and training initiatives
  • Barriers and best practices
<table>
<thead>
<tr>
<th>Organization</th>
<th>State</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cherokee Health Systems</td>
<td>TN</td>
<td>Provides behavioral, physical, and dental health care for children and adults in their community.</td>
</tr>
<tr>
<td>Community Caring Collaborative</td>
<td>ME</td>
<td>Non-profit organization that provides integrated care to infants, children, families, individuals with SUD, and individuals and families living in crisis or poverty.</td>
</tr>
<tr>
<td>County of San Mateo Health System Behavioral Health and Recovery Services</td>
<td>CA</td>
<td>Serves children, youth, families, adults, and older adults for the prevention, intervention, and treatment of mental health, substance use, and physical health conditions.</td>
</tr>
<tr>
<td>Durham VA Medical Center</td>
<td>NC</td>
<td>Provides integrated care to veterans.</td>
</tr>
<tr>
<td>Intermountain Healthcare</td>
<td>UT</td>
<td>Uses a team-oriented approach to provide mental health treatment within primary care settings in over 90 clinics.</td>
</tr>
<tr>
<td>Morehouse School of Medicine National Center for Primary Care</td>
<td>GA</td>
<td>Training-based organization that provides resources for the primary care system. Conduct both research and training, with a focus on health information technology.</td>
</tr>
<tr>
<td>Northwell Health</td>
<td>NY</td>
<td>Regional health system that provides integrated health care to a highly diverse population in multiple healthcare delivery settings.</td>
</tr>
<tr>
<td>VA - Ann Arbor Healthcare System</td>
<td>MI</td>
<td>Provides integrated care to veterans.</td>
</tr>
</tbody>
</table>
Case Study Findings: Top 5 Barriers to Implementation

#1: Clinicians may initially be resistant to this transition; often lack knowledge about integrated care and workflow

#2: 

**Insufficient number** of providers: workforce challenges across all roles; clinician shortages

#3: Difficulties in record sharing, particularly for patients with substance use disorders

[Site] is “constantly recruiting, trying to get the right person that will work in [the integrated care setting], and constantly dealing with primary care [providers] that just don’t get it…”
Case Study Findings: Top 5 Barriers to Implementation

#4: Administrative/workflow concerns: unsure how to implement effectively; physical space constraints make co-location difficult

#5: Lack of financial support for integration: billing and reimbursement obstacles
- Reimbursement structure was not built to really value team-based care
- Policy gaps in insurance reimbursement
- Cannot bill for physical and mental health services on the same day

“…you don’t have as many available providers in [behavioral health] as you do in other fields, so access is really not there. We have to increase that access and then, of course, reimbursement for it.”
Case Study Findings: Best Practices

- Important to get buy-in from leadership and providers at the beginning—work together on developing the model
- Help providers to understand their collaborative roles and importance of developing an ongoing relationship with the team
- Be clear about the benefits: when collaboration occurs, caseloads often feel easier to handle; patients have access to the services they need, and respond better to treatment
- In-house training is key; most providers are not learning skills for implementing team-based care in their degree programs

“...bringing all relevant parties to the table, to the same table, at the same time.”

“The communication is constant between all the team players. Team players have complex treatment cache that they follow based on the level of complexity of the patient and each of the team members are called in and perform their activities, that goes into the medical record and gets communicated throughout.”
Best Practice Example
Cherokee Health System

- Cherokee Mental Health → Cherokee Health System
- 70000+ served in 45 clinics across Tennessee
- 732 employees- primary care providers, behavioral health specialists, dentists, pharmacists

Co-located, Fully Integrated Care

- A behaviorist is nested within the primary care team- mimics a schedule of PCP.
- Providers in the room together- present treatment plan together; provide consistency in messaging
- PCP perspective: feels more efficient to treat patients with complicated mental health issues
- Needs creativity and funding stream to support it

“So much of primary care is really behavioral...about half of what a primary care provider does is related to the mental health of their patients”- Dennis Freeman, PhD, CEO
Summary

- Effective service delivery models may help address the workforce crisis
- Integration is complex - many models to consider
- Workforce training is important
- Policies can facilitate or inhibit this process
Thank You

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