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
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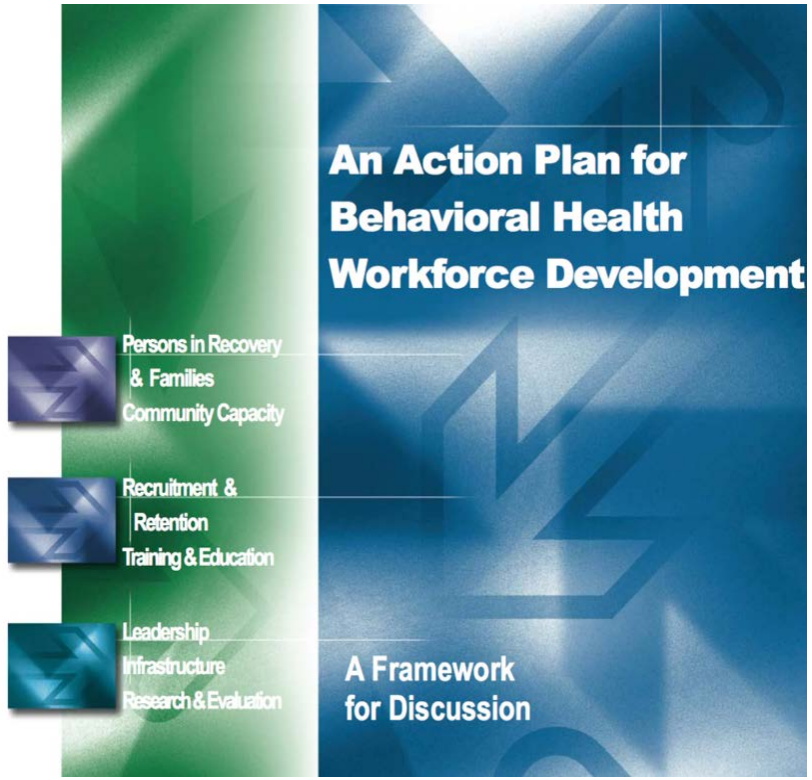
Overview

- Workforce challenges in behavioral health
- Behavioral health integrated care models
- Workforce factors impacting integrated care delivery
- Best practice example

Workforce Challenges in Behavioral Health

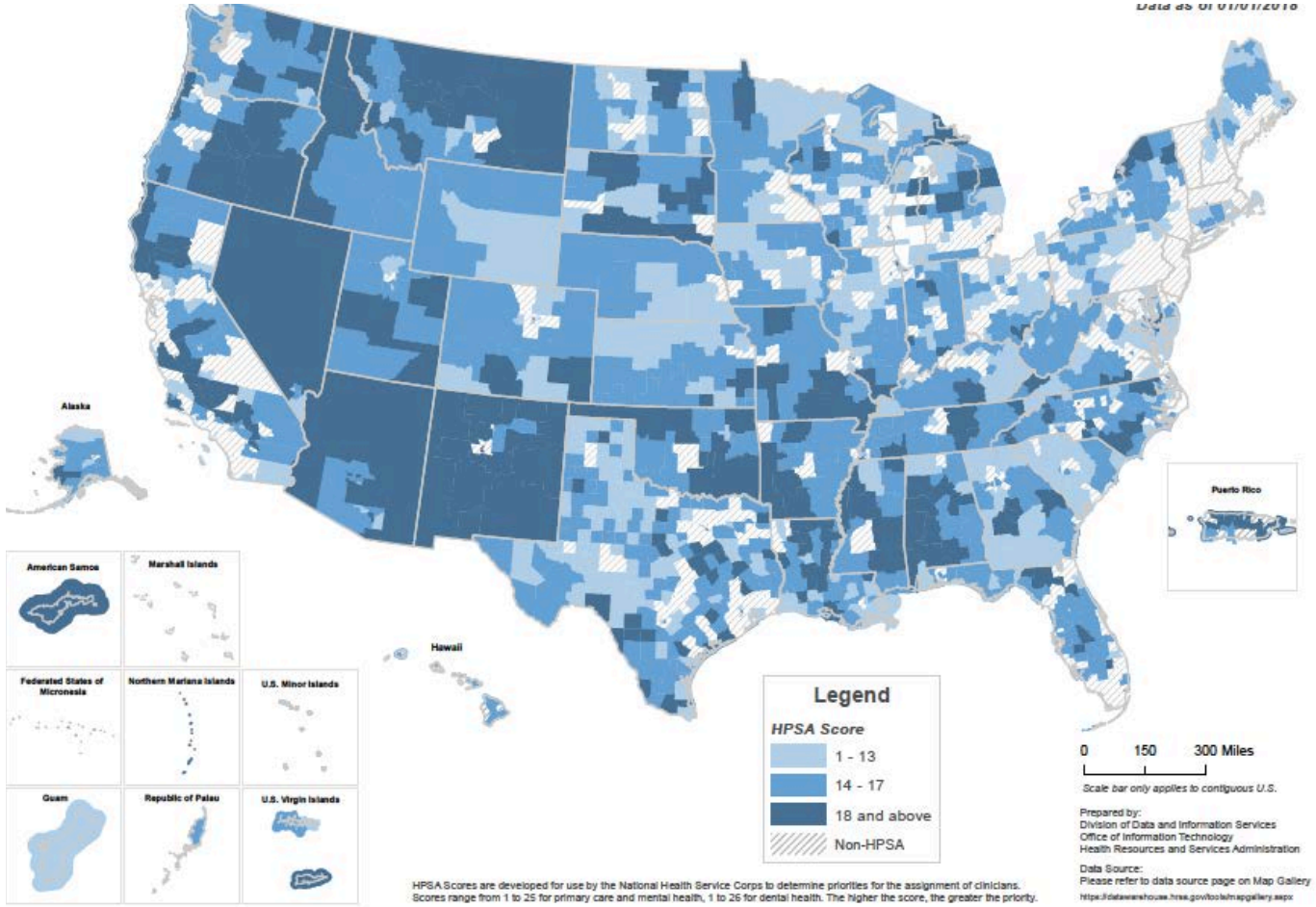
“A Workforce Crisis”

- 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



Annapolis Coalition, 2007

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

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

National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025

November 2016

U.S. Department of Health and Human Services

Health Resources and Services Administration

Bureau of Health Workforce

National Center for Health Workforce Analysis

HRSA Health Workforce

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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

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Year 1

- National Council for Behavioral Health — State Associations of Addiction Services — Stronger Together.
- Community Partnership of Southern Arizona
- Southwest Michigan Behavioral Health
- NAADAC — NAADAC.org — The Association for Addiction Professionals
- astho™
- NACCHO — National Association of County & City Health Officials
- Center of Excellence in Public Health Workforce Studies — University of Michigan School of Public Health

Year 2

- American Psychological Association
- CSWE — Council on Social Work Education
- BHECN — Behavioral Health Education Center of Nebraska
- National Board for Certified Counselors — Promoting counseling through certification
- AAMFT — American Association for Marriage and Family Therapy

Year 3

Confirmed:

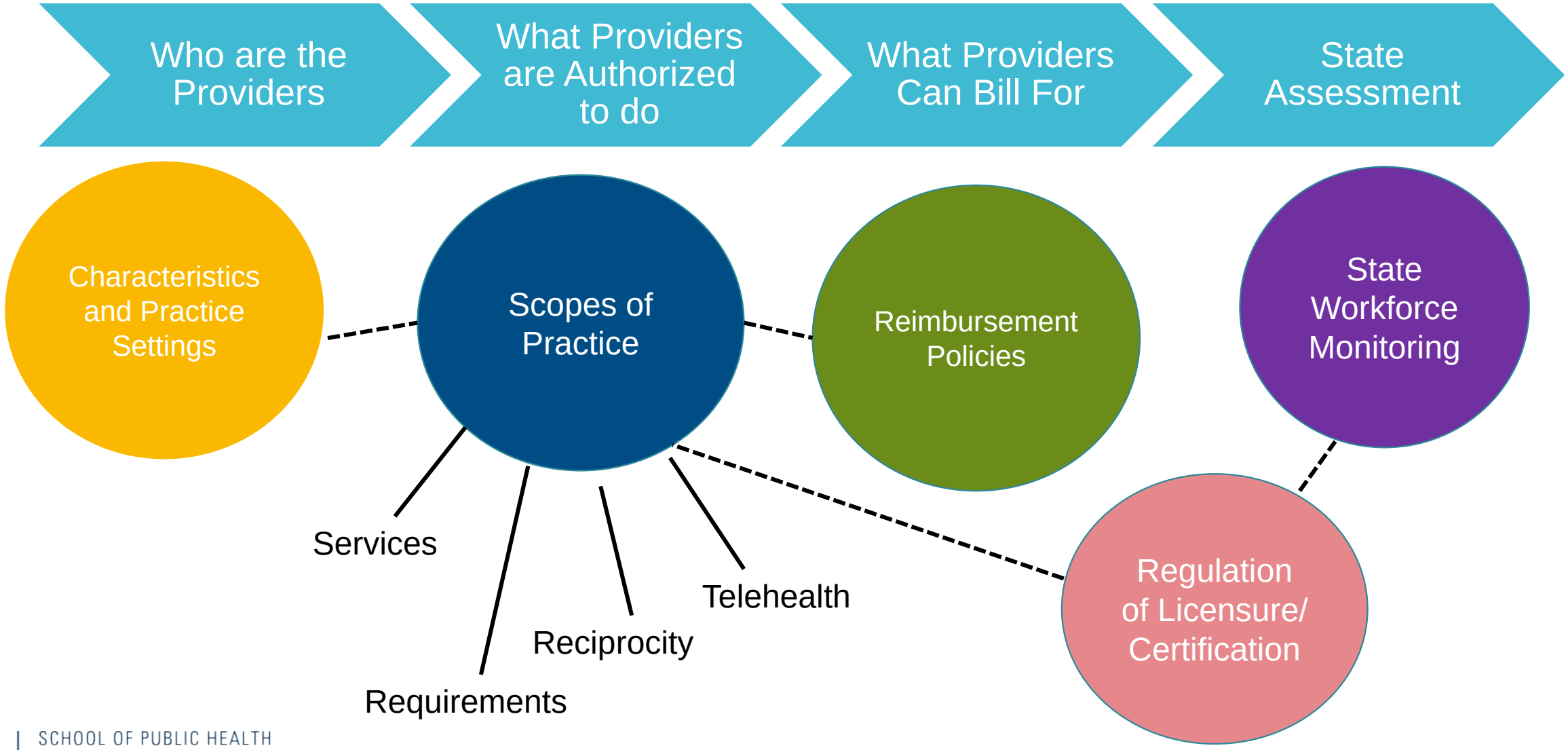
- American Psychiatric Association
- AAPA
- American Psychiatric Nurses Association

Outreach:

- College of Psychiatric & Neurologic Pharmacists — cpnp
- American Academy of Child & Adolescent Psychiatry
- American Hospital Association
- National Association of Psychiatric Health Systems

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



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

[1]O'Donnell et al, 2013.

www.integration.samhsa.gov

Integration Models

Integration

Reverse Integration

Collaboration Continuum

COORDINATED KEY ELEMENT: COMMUNICATION		CO-LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	**LEVEL 2** Basic Collaboration at a Distance	**LEVEL 3** Basic Collaboration Onsite	**LEVEL 4** Close Collaboration Onsite with Some System Integration	**LEVEL 5** Close Collaboration Approaching an Integrated Practice	**LEVEL 6** Full Collaboration in a Transformed/ Merged Integrated Practice

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**

Organization	State	Description
Cherokee Health Systems	TN	Provides behavioral, physical, and dental health care for children and adults in their community.
Community Caring Collaborative	ME	Non-profit organization that provides integrated care to infants, children, families, individuals with SUD, and individuals and families living in crisis or poverty.
County of San Mateo Health System Behavioral Health and Recovery Services	CA	Serves children, youth, families, adults, and older adults for the prevention, intervention, and treatment of mental health, substance use, and physical health conditions.
Durham VA Medical Center	NC	Provides integrated care to veterans.
Intermountain Healthcare	UT	Uses a team-oriented approach to provide mental health treatment within primary care settings in over 90 clinics.
Morehouse School of Medicine National Center for Primary Care	GA	Training-based organization that provides resources for the primary care system. Conduct both research and training, with a focus on health information technology.
Northwell Health	NY	Regional health system that provides integrated health care to a highly diverse population in multiple healthcare delivery settings.
VA - Ann Arbor Healthcare System	MI	Provides integrated care to veterans.

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

[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…"*

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

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

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

"…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."

- **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**

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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Behavioral Health Workforce Research Center

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