Integration of Behavioral Health into Primary Care: What's happening in Nebraska?

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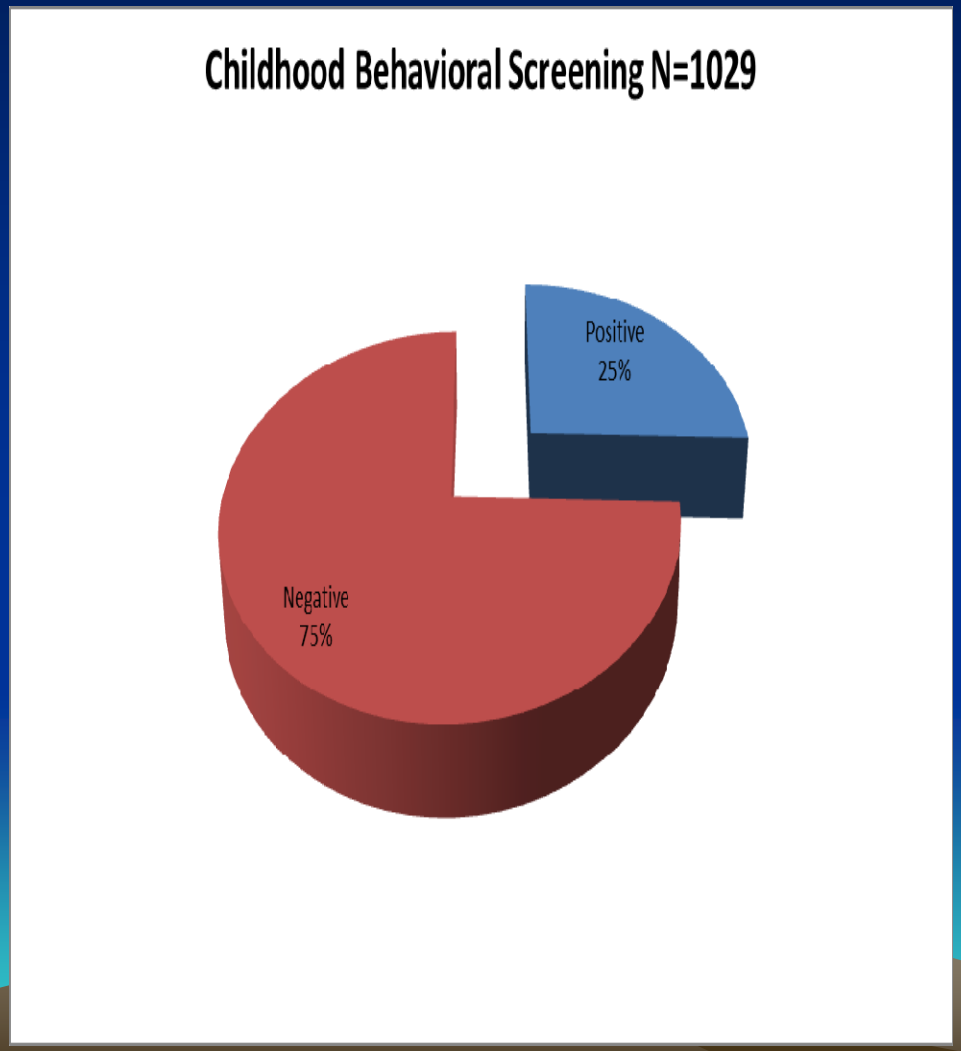
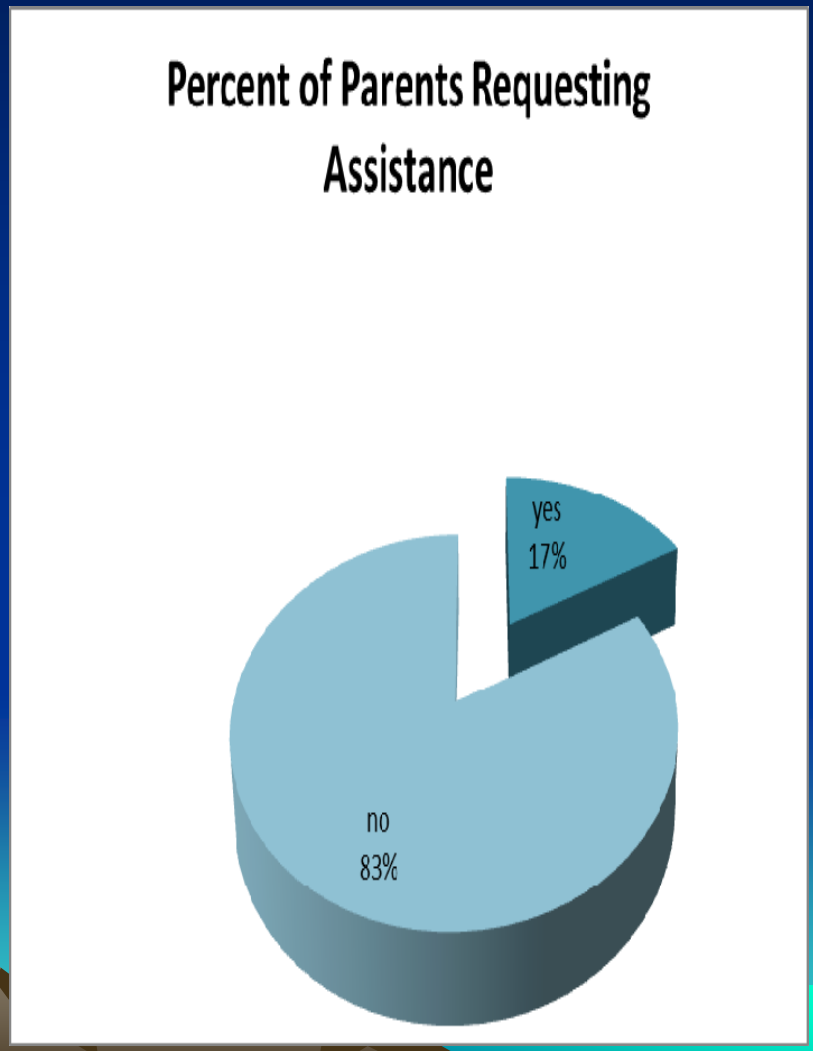
Health Resources and Services Administration (HRSA)

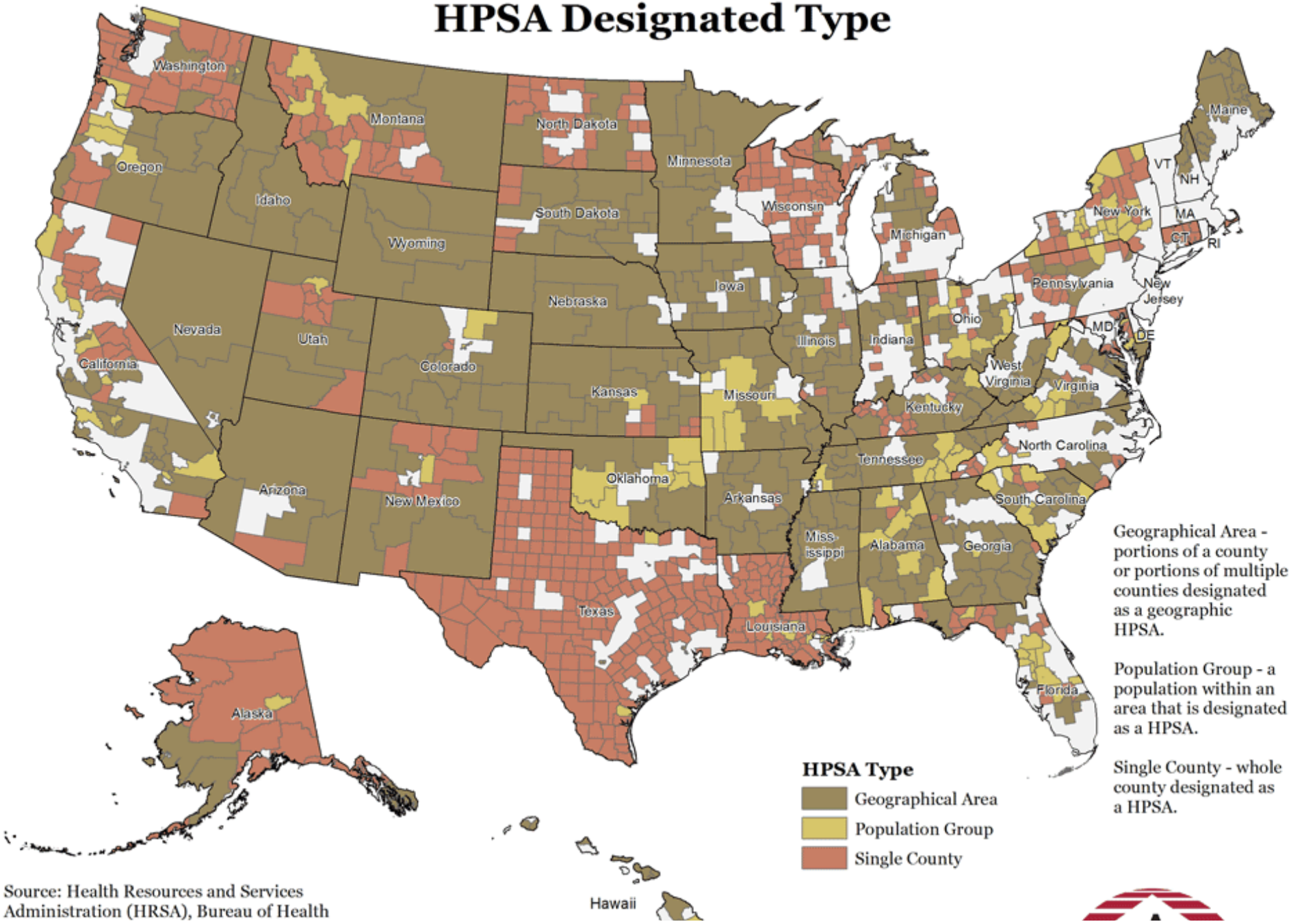
- Identified three “most vulnerable” populations (2010) in need of BH services:
  - Elderly
  - Children and Adolescents
  - Rural populations

LB 556 Screenings (11-2013 through 5-2014)





Health Professional Shortage Areas (HPSA) - Mental Health
HPSA Designated Type



Geographical Area - portions of a county or portions of multiple counties designated as a geographic HPSA.

Population Group - a population within an area that is designated as a HPSA.

Single County - whole county designated as a HPSA.

Source: Health Resources and Services Administration (HRSA), Bureau of Health

Nebraska Facts:

- Nationally, only 16% of the U.S. population lives in rural areas
- In Nebraska, 47% of the State population resides in rural counties, towns, and villages
- Nebraska population (2013) is 1,890,000, of which 53% (or 1,000,000 people) reside in urban (Omaha and Lincoln) Metropolitan Areas. approximately 7500 sq miles
- Rural Nebraska (remaining 70,000 sq. miles) is home to 47% (or 890,000 people) of the State population
- 80% of rural physicians are Primary Care Family Medicine Physicians

Nebraska Behavioral Health Workforce Facts:

- In NEBRASKA (2013 COPH data):
- 88 of 93 counties are Federal MH Health Professions Shortage Areas
- 74% of MH professionals practice in Metropolitan Omaha and Lincoln
- 37 counties have 0 MH professionals
- Of 156 licensed psychiatrists, only 27 (17%) practice in rural Nebraska and only 11 will see rural children
- Of 335 licensed psychologists, only 61 (18%) are rural
- #s of MH professionals are lower than the National average, per capita

Nebraska Behavioral Health Workforce Facts (continued):

- There is a “maldistribution” of BH providers in the State – only 511 BH practitioners (of 1,965) are in Outstate Areas
- Psychiatrists comprise 4% of the Rural BH workforce;
- Psychologists 12%;
- Psychiatric Nurse Practitioners 4%;
- LMHPs and LIMHPs are 80% (Social Workers, Marriage and Family Therapists, Clinical/Community Counselors) of the rural BH workforce
- Rural Nebraska is 70,000 square miles with a population of 890,000 (47%) BUT, only 26% of the BH workforce serves this population in our State.

Primary Care Physicians are Overwhelmed with:

- Screenings for:
  - Hearing
  - Vision
  - Development
  - Autism

One Solution:

Integrated Behavioral Health in Primary Care

Why Use Integrated Care?

Primary Care Physicians are “de facto” first line mental health providers!!!

- 60% of all care mental health visits occur in Primary Care settings (Magill & Garrett, 1988)
- 25% pediatric PC visits include behavioral health concerns (Cooper, Valleley, Polaha, Begeny, Evans, 2006)
- Pediatricians rank behavior as most common problem (over otitis) (Arndorfer, Allen, & Aljazireh, 1999)
- Estimates are that 50% to 70% of adult medical visits are somatic - no diagnosable diseases (Cummings, 1997).
- 80% of anti-depressants are prescribed by primary care physicians but 72% of patients had NO Dx in their files (Johns Hopkins 2013)
- BH training on Primary Care residency = ONE month plus continuity clinics with attendings

Adult Behavioral Issues in Primary Care

- Anxiety
- Depression
- Back Pain
- Headaches
- At least 50% - 70% of which have no identifiable physical cause (O'Donohue, 2003)

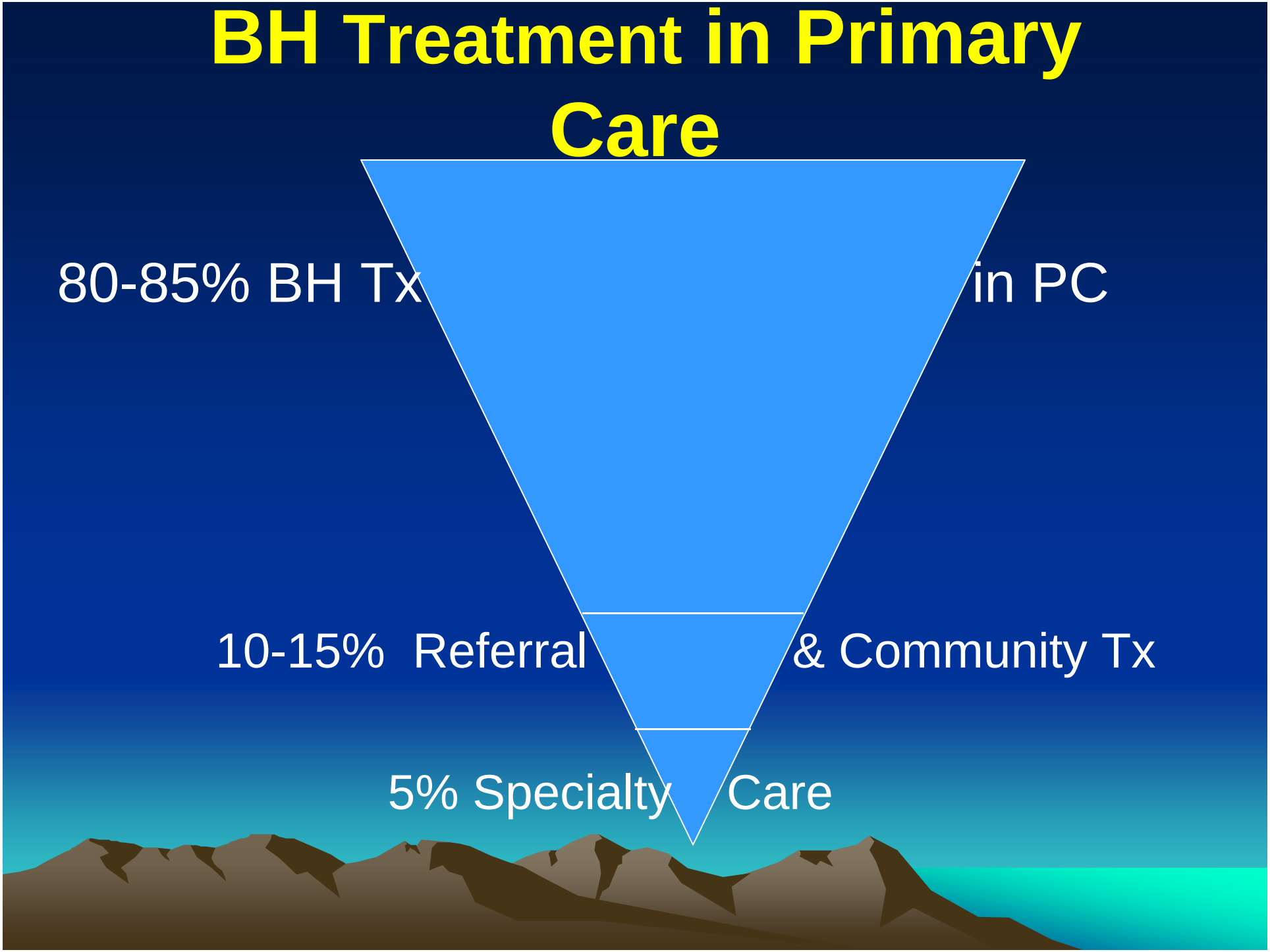
Child-Adolescent Behavioral Problems Presenting in Primary Care

- Non-compliance
- Excessive Tantrums
- Elimination Disorders
  - Enuresis
  - Encopresis
- ADHD
  - Inattentive
  - Hyperactive/Impulsive
  - Combined
- Sleep Disorders
- Learning Disabilities
- School Behavior Problems & Refusal
- Developmental Delays
- Depression
- Anxiety
- Relationship Problems

BH *OPTIONS* for Primary Care Physicians

- Behavioral Diagnosis and Treatment by:
  - Pediatrician/Family Physician
  - Referral outside to community BH specialist
  - Handoff from the practice to a "co-located psychologist/ BH provider"
  - Within practice collaborative care with an "Integrated psychologist/BH provider"
  - Back-up services from MH Specialty Care (Psychiatrist, Psychiatric Nurse, Hospital)

BH Treatment in Primary Care



WHY NOT??? Barriers to Integrated Primary Care

One Answer: BH WORKFORCE SHORTAGES!!!

- “Integration of behavioral health into primary care is a concept that is frequently discussed but rarely implemented” (Lambert, 2001)
- Traditional BH training programs do NOT prepare professionals to work in primary care settings- leading to failures
- BH training programs not located in university medical centers
- Few BH training programs have an interdisciplinary care focus

NOT!!!!!!!

UNMC Training in Integrated Behavioral Health in Primary Care

Goal: Attract, Recruit, Train, Place and Retain Integrated BH Providers in Primary Care Practices

- Provide “Learning Through Service” & Modeling Opportunities - Providing Behavioral Health to underserved areas and populations
- Training for Physicians in Community Settings
- BHAG: BH Providers in Every Nebraska Town >5,000
- Applied Research and Program Evaluation
- DISSEMINATION and Replication

Training Opportunities and Options for Integrated BH Care

- Preparation of Primary Care Physicians during Residency & Continuity Clinics
- Classroom Preparation & Courses
- Internships for BH Trainees (600 to 2000 hrs)
- Post-doctoral Training
- Certification for Currently Practicing Physicians and/or BH Professionals

MMI Integrated Behavioral Health Internship Training Program

- Training for BH providers in primary care practice includes:
- The "*Culture*" of Primary Care
  - Fast-paced
  - Short-term (average 4.8 to 5.6 sessions)
  - Solution focused
  - Directive
  - Evidence-based
  - Protocol driven
  - Clients become long-term, returning "Patients"

UNMC Integrated Behavioral Health Internship Training Program

Traditional Medical Psychology training focuses on "Bodily Systems" and Diseases:

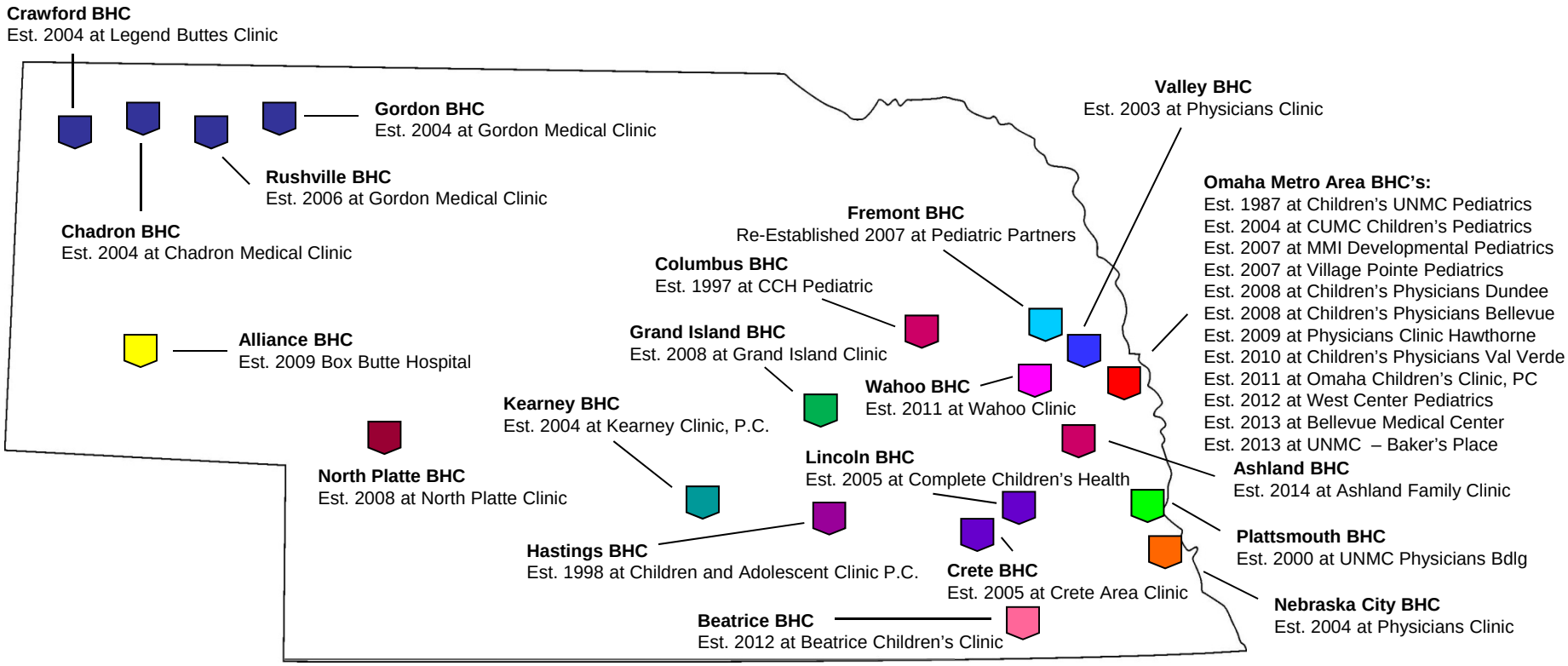
- Cardiology
- Pulmonology
- Endocrinology
- Oncology
- Gastroenterology
- Neurology
- Diabetes
- Epilepsy
- Psychiatry

Primary Care BH training focuses on Prevention & Wellness:

- Anticipatory guidance
- Screening
- Brief Treatment interventions
- Acute Care protocols
- Management of Common Behavioral Health issues
- Wellness Activities
- Knowing When & to Whom to Refer

Integrated BH Clinics in Primary Care N=17 (Towns over 5,000)

UNMC/MMI
Outreach Behavioral Health Clinics
2014



Behavioral Health Clinics in Underserved Areas

Columbus (20,000)Pediatrics

Kearney (27,000) Physicians Clinic

Crawford (900) Medical

WHY MMI Successes in Integrated Care?

RURAL Nebraska Clinics - 19 Integrated Sites with MMI Trained BH staff:

- 8 Owned
- 4 Contracted
- 7 Collaborating private practices

URBAN Clinics (Omaha and Lincoln):

- 21 of 24 Pediatric Practices in Omaha Metro area are integrated (13 with MMI trained Psychologists)
- 4 of 7 Peds practices are integrated in Lincoln

DISSEMINATION at additional training sites in Florida, Pennsylvania, and Michigan

5 Fiscal Models of Integrated BH

- Assigned BH provider services from “Mothership”
- “Contracted” BH provider(s) from “Mothership”
- “Practice-owned” BH providers(s)
- “Independent practice” BH provider(s)
- “Circuit Rider Model” - Provider across Sites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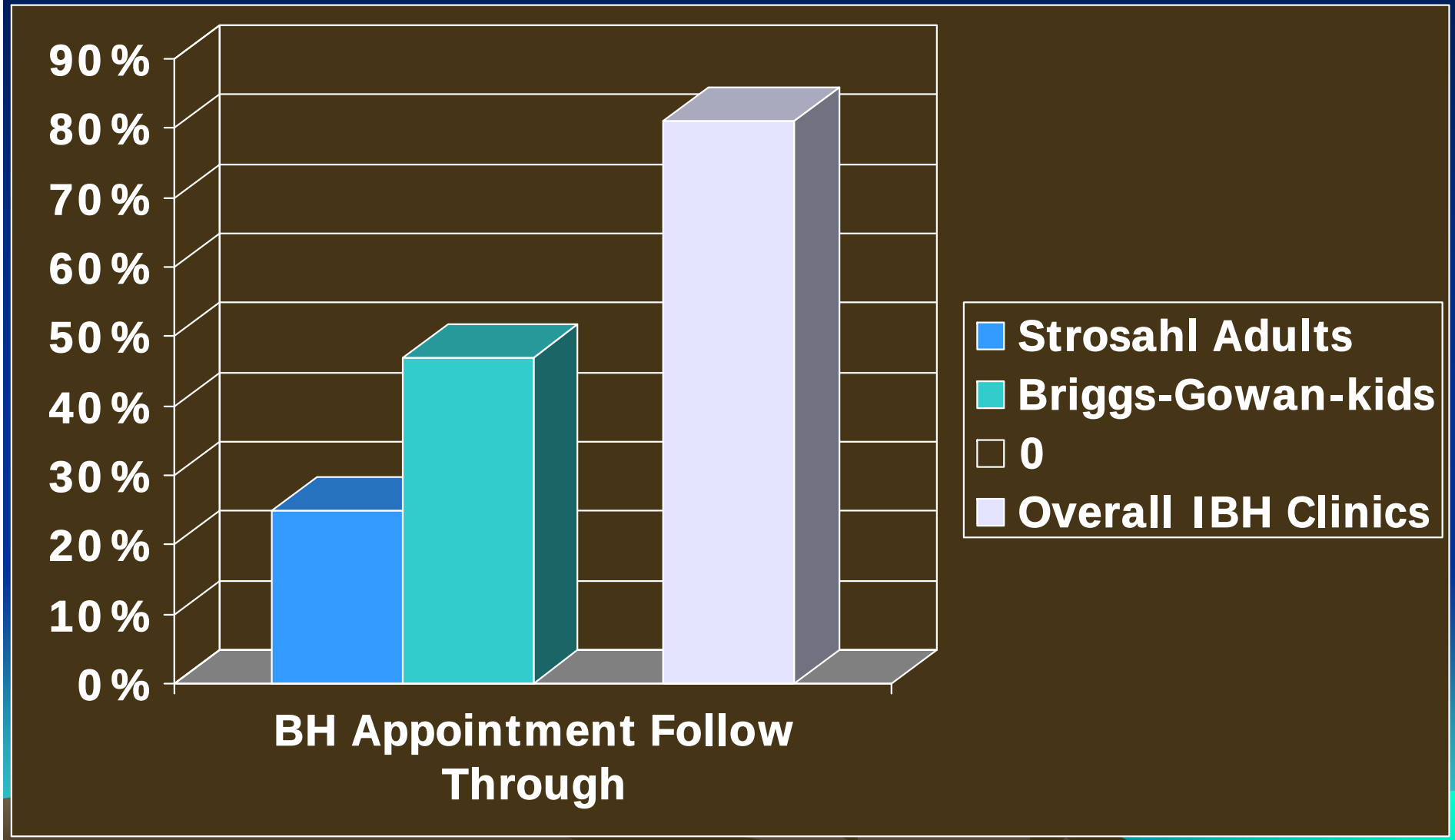
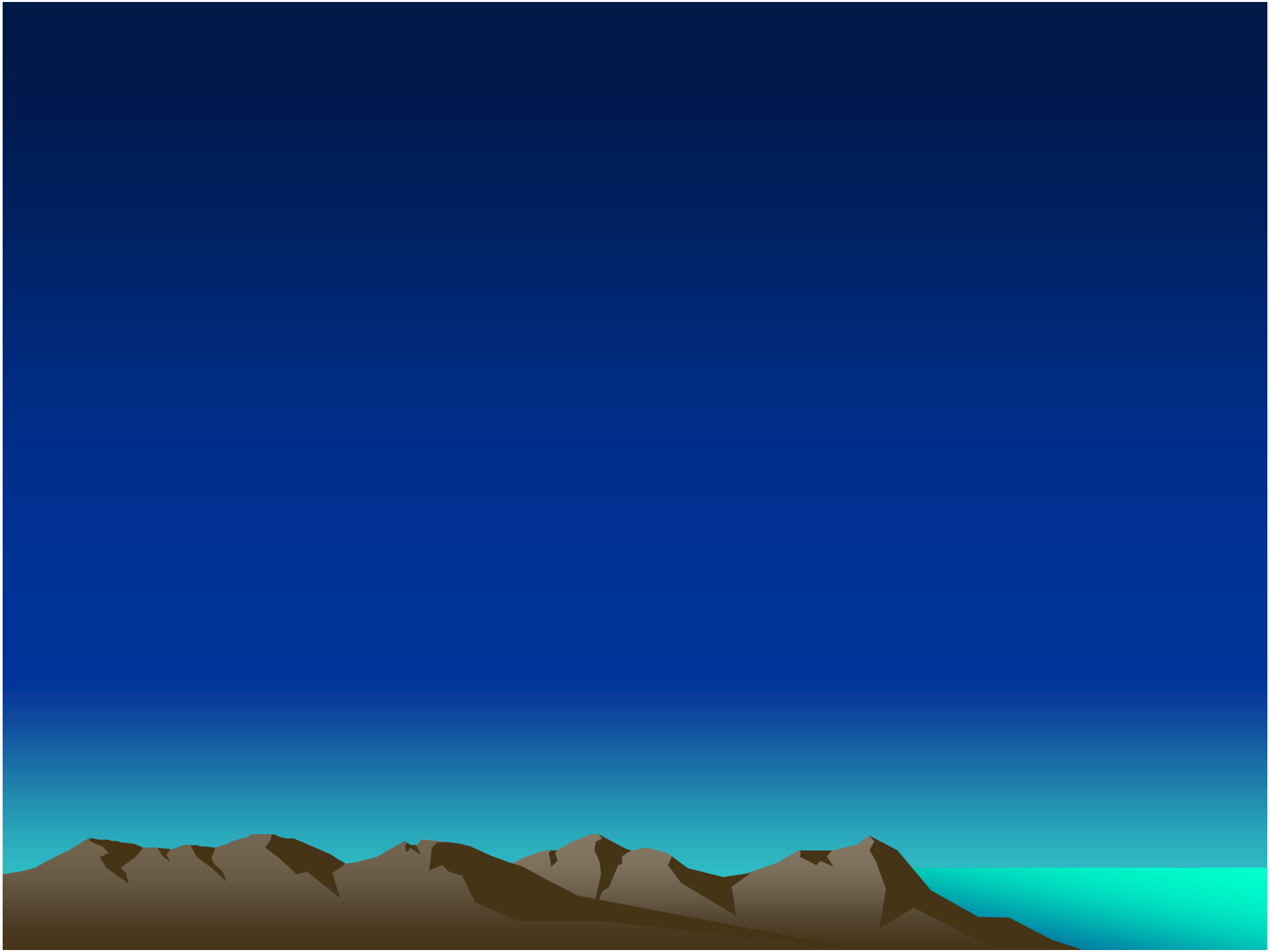
BH Referral Follow Through:Traditional Referral vs Integrated BH Resources





Time Spent in Pediatric Primary Care Visits

	% Visit Type	Minutes when Behavioral Concern Raised *M* (SD)	Minutes when NO Behavioral Concern Raised *M* (SD)	Average Difference in Minutes
Acute	35%	16.18 (5.56)	6.97 (2.87)	9.21
Well-Child	28%	20.25 (13.79)	9.32 (4.85)	10.93
Chronic	1%	‡	10.00 (8.88)	NA
Psych Consult	36%	19.13 (8.49)	‡	NA
Average		18.69 (8.31)	8.16 (4.23)	10.53

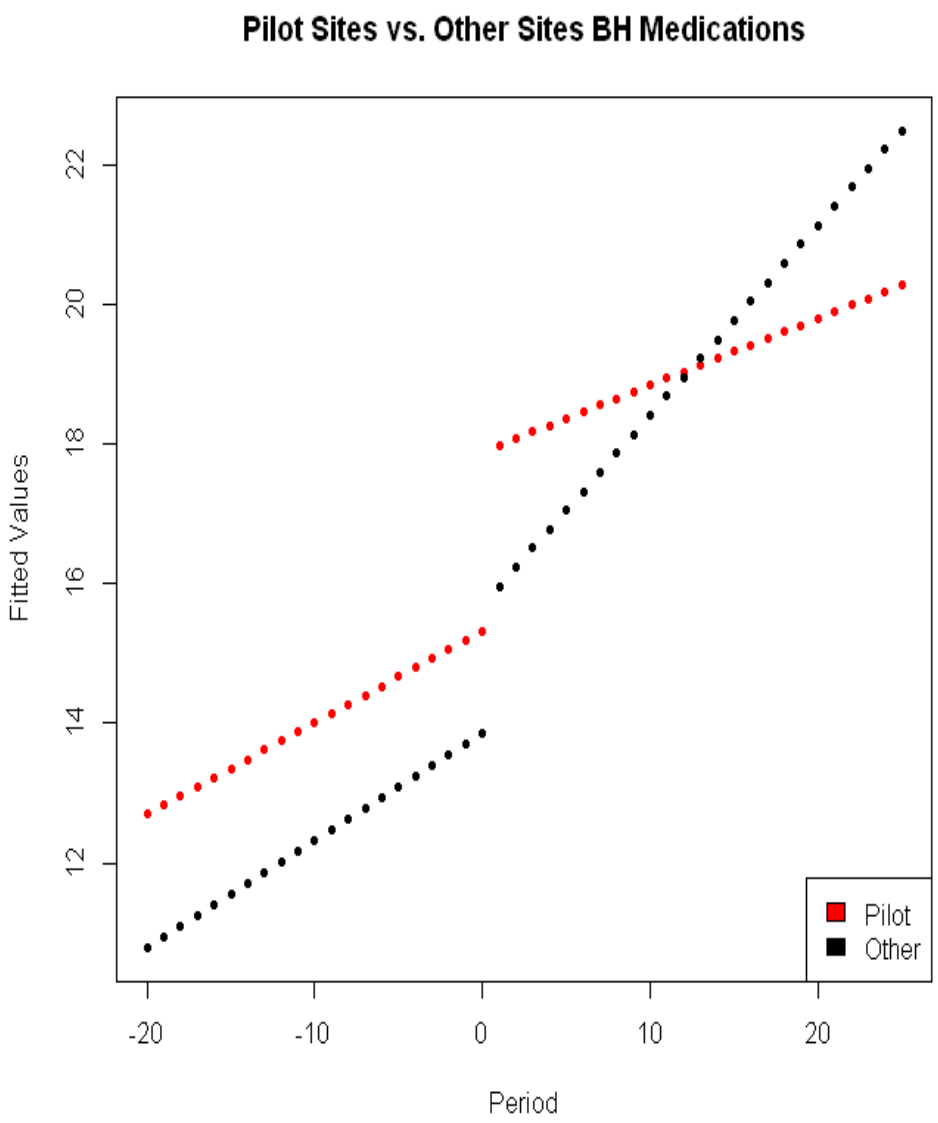
‡Not included due to no occurrences

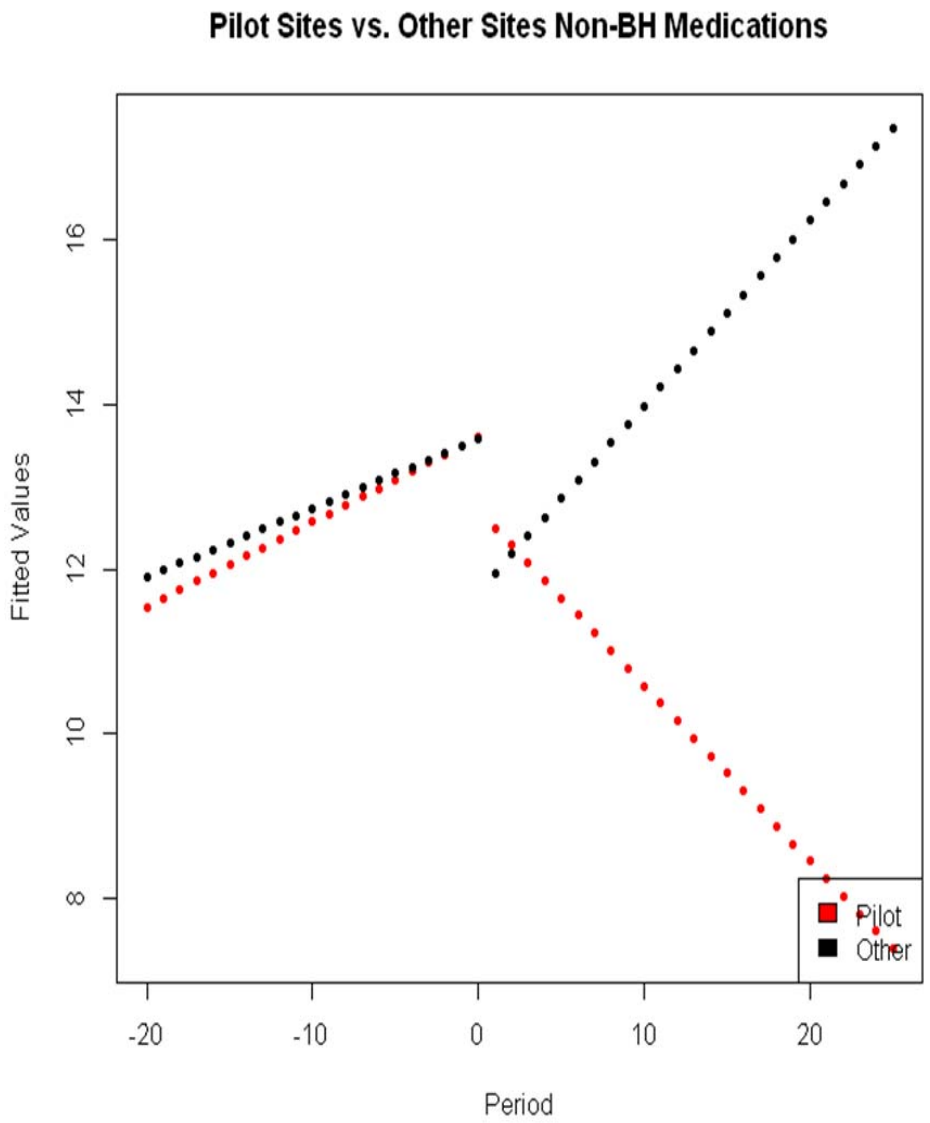
Reimbursements per Minute for Pediatric Primary Care Visits: MMI IBH Clinics

	% Visit Type	Reimbursement Rate when NO Behavioral Concern Raised M (SD)	Reimbursement Rate when Behavioral Concern Raised M (SD)	Average Difference in Reimbursements per Minute
Acute	35%	$16.68 (21.35)	$5.89 (2.53)	$10.79
Well-Child	28%	$20.17(15.42)	$9.34 (4.36)	$10.83
Chronic	1%	$7.37 (4.55)	‡	NA
Psych Consult	36%	‡	$5.02 (6.01)	NA
Average		$18.12 (18.56)	$5.53 (15.57)	$12.59

‡Not included due to no occurrences

Medication Cost Off-Set: Geisinger Clinics Pilot Project





Medication Cost Off-Set Data: Geisinger Clinics Pilot Project

Capitated Care Findings:

- The total reduction in cost is $.61 PMPM (per member/per month). This is equivalent **to $7.32 PMPY**(per member/per year).
- The entire GHP pediatric population (< age 19) =107,789 (regular GHP + GHP Medicaid and Chip program)
- IF behavioral health care integration project is implemented in the entire GHP population, there would be a **system-wide savings of $789,015**

Clinician Time Usage: University of Michigan Integrated BH Project

Figure 1: Number of 45 Minute Appointments Per Month in Howell Pediatric and Teen Clinic Before and After Integrated Behaviroal Health

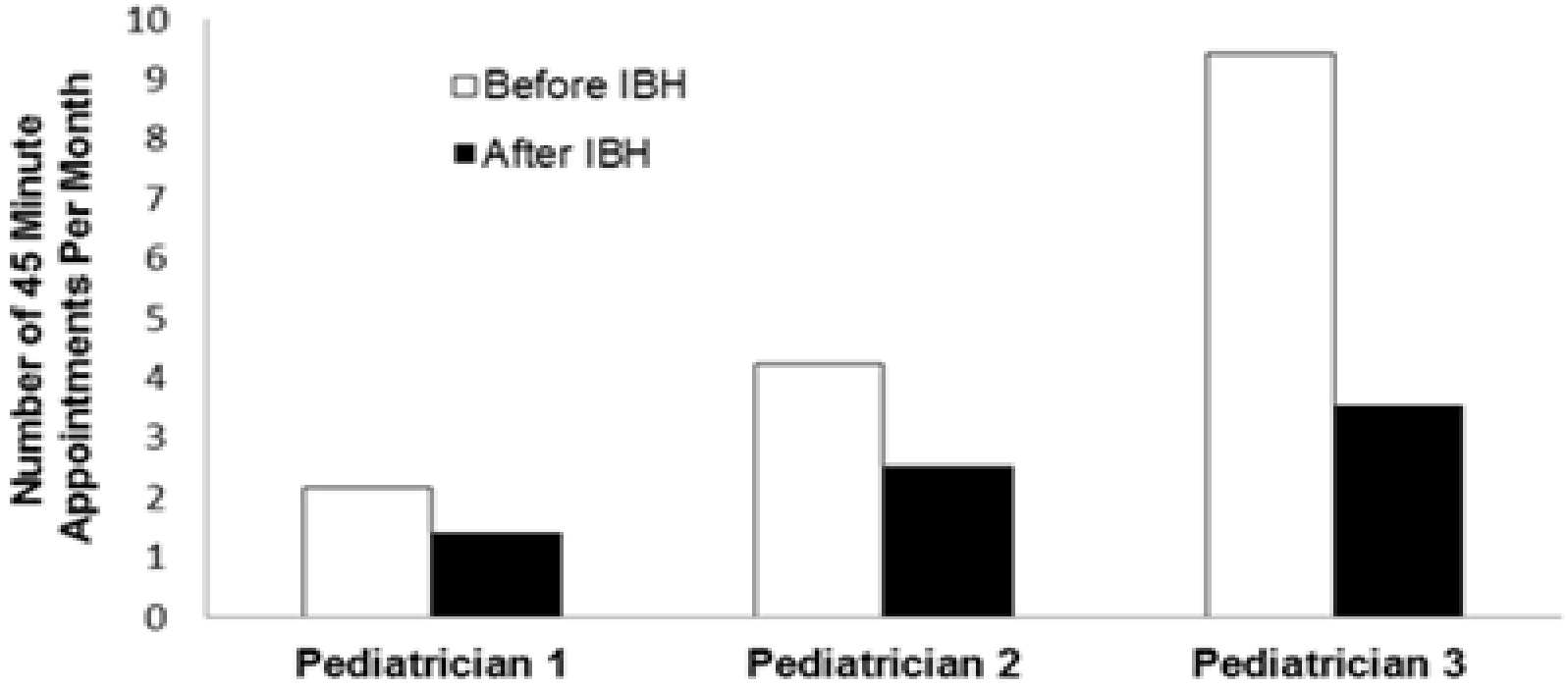


Figure 1: Most primary care pediatric visits are 15 minutes and billed at a Level 3 ($105.00) or 4 ($161.00). When pediatricians see a patient for 45 minutes they typically continue to bill at the Level 3 or 4, representing a roughly $210.00 to $322.00 loss for each 45 minute visit. For Pediatrician 1, p = .93; for Pediatricans 2, p = .08; and for Pediatrican 3, p = .04.

Clinician Time Usage: University of Michigan Integrated BH Project

Figure 2: Number of RVUs Per Month in the Howell Pediatric and Teen Clinic Before and After Integrated Behavioral Helath

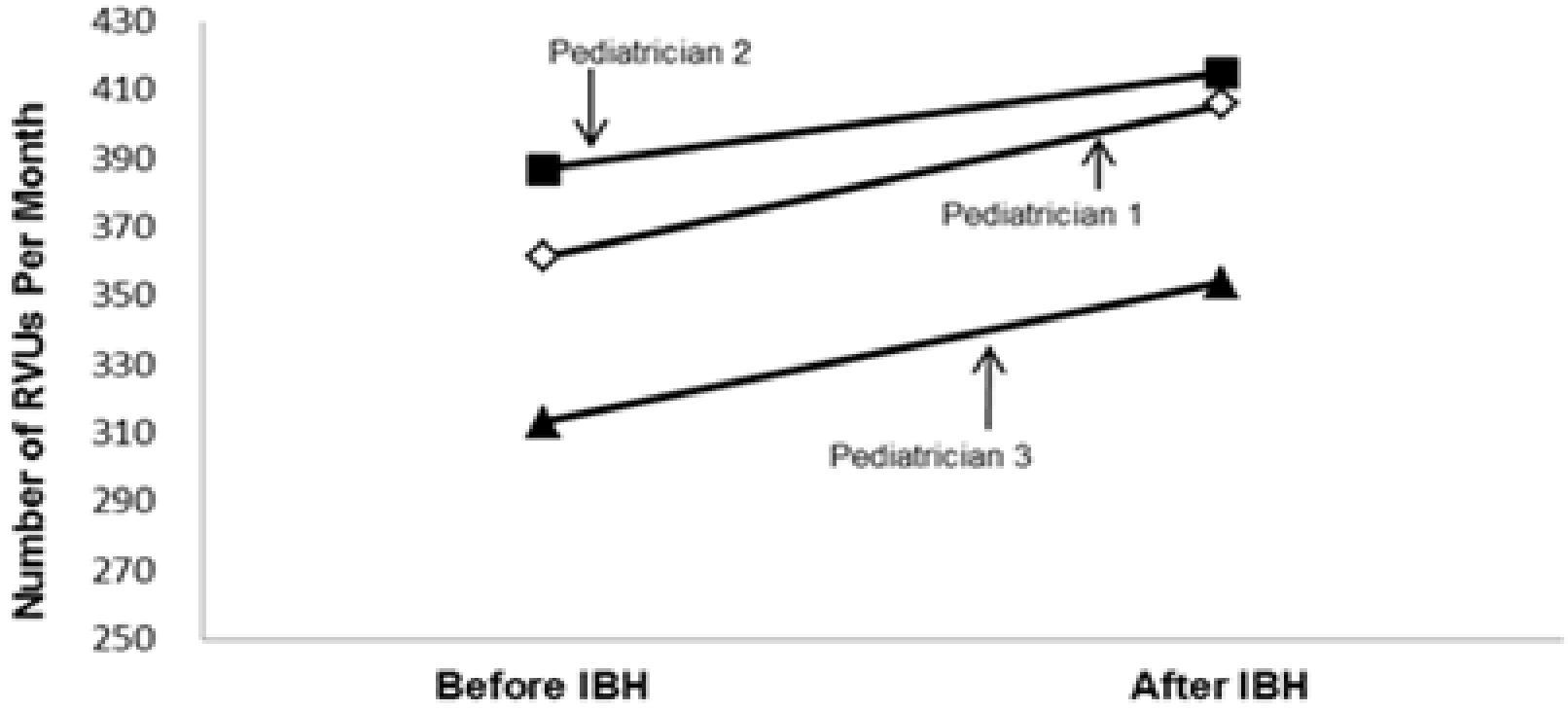


Figure 2: This figure represents the number of RVUs generated per month by three pediatricians for the 9 months prior and the 14 months after an integrated behavioral health specilist was placed in the Howell Pediatric and Teen Clinic. For Pediatrician 1, $p = .10$; for Pediatricans 2, $p = .42$; and for Pediatrican 3, $p = .05$

Kids prefer Tx in Primary Care

- Kolko, D., et al. (2014) *Pediatrics* findings:
  - 5 year study of Integrated MH in Pediatricians' offices vs kids referred to Outside MH Specialists
  - In Peds offices, patients were 7x more likely to complete Tx
  - Outcomes were better for children treated in Peds offices
  - 160 kids treated in Pediatric offices vs 161 in regular MH Tx
  - 99% of kids in Peds offices initiated Tx and 77% completed
  - 58% of regular MH Tx group initiated and 12% completed
  - Parents in Peds Tx group reported less stress
  - Results suggest the relationships in the Pediatricians' offices were convenient, trusted, and discreet

UNMC/MMI Integrated BH Faculty, Interns, & Post-Docs-2014

Contact Information

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