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

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- 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)

Childhood Behavioral Screening N=1029

- Positive: 25%
- Negative: 75%

Percent of Parents Requesting Assistance

- Yes: 17%
- No: 83%
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

80-85% BH Tx in PC

10-15% Referral & Community Tx

5% Specialty 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

Kearney (27,000) Physicians Clinic

Columbus (20,000) Pediatrics

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 provider(s)
- “Independent practice” BH provider(s)
- “Circuit Rider Model” - Provider across Sites
BH Referral Follow Through: Traditional Referral vs Integrated BH Resources

- BH Appointment Follow Through
  - Strosahl Adults
  - Briggs-Gowan-kids
  - Overall I BH Clinics

- Comparison of referral follow-through rates between traditional referral and integrated BH resources.
## Time Spent in Pediatric Primary Care Visits

<table>
<thead>
<tr>
<th>% Visit Type</th>
<th>Minutes when Behavioral Concern Raised $M$ (SD)</th>
<th>Minutes when NO Behavioral Concern Raised $M$ (SD)</th>
<th>Average Difference in Minutes</th>
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</thead>
<tbody>
<tr>
<td>Acute</td>
<td>16.18 (5.56)</td>
<td>6.97 (2.87)</td>
<td>9.21</td>
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<tr>
<td>Well-Child</td>
<td>20.25 (13.79)</td>
<td>9.32 (4.85)</td>
<td>10.93</td>
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<tr>
<td>Chronic</td>
<td>‡</td>
<td>10.00 (8.88)</td>
<td>NA</td>
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<tr>
<td>Psych Consult</td>
<td>19.13 (8.49)</td>
<td>‡</td>
<td>NA</td>
</tr>
<tr>
<td>Average</td>
<td>18.69 (8.31)</td>
<td>8.16 (4.23)</td>
<td>10.53</td>
</tr>
</tbody>
</table>

‡Not included due to no occurrences
# Reimbursements per Minute for Pediatric Primary Care Visits: MMI IBH Clinics

<table>
<thead>
<tr>
<th>% Visit Type</th>
<th>Reimbursement Rate when NO Behavioral Concern Raised M (SD)</th>
<th>Reimbursement Rate when Behavioral Concern Raised M (SD)</th>
<th>Average Difference in Reimbursements per Minute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>$16.68 (21.35)</td>
<td>$5.89 (2.53)</td>
<td>$10.79</td>
</tr>
<tr>
<td>Well-Child</td>
<td>$20.17 (15.42)</td>
<td>$9.34 (4.36)</td>
<td>$10.83</td>
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<tr>
<td>Chronic</td>
<td>$7.37 (4.55)</td>
<td>‡</td>
<td>NA</td>
</tr>
<tr>
<td>Psych Consult</td>
<td>‡</td>
<td>$5.02 (6.01)</td>
<td>NA</td>
</tr>
<tr>
<td>Average</td>
<td>$18.12 (18.56)</td>
<td>$5.53 (15.57)</td>
<td>$12.59</td>
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</tbody>
</table>

‡Not included due to no occurrences
Medication Cost Off-Set: Geisinger Clinics Pilot Project

Pilot Sites vs. Other Sites BH Medications

Pilot Sites vs. Other Sites Non-BH Medications
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
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 Pediatricians 2, $p = .08$; and for Pediatrician 3, $p = .04$. 

Figure 1: Number of 45 Minute Appointments Per Month in Howell Pediatric and Teen Clinic Before and After Integrated Behavioral Health
Figure 2: Number of RVUs Per Month in the Howell Pediatric and Teen Clinic Before and After Integrated Behavioral Health

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 specialist was placed in the Howell Pediatric and Teen Clinic. For Pediatrician 1, p = .10; for Pediatricians 2, p = .42; and for Pediatrician 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
Contact Information

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References


References


