KANSAS HEALTH INSTITUTE

Behavioral Health in a Primary Care Setting

April 5, 2023

KAMMCO Spring Education Webinar

Who We Are

- Nonprofit, nonpartisan educational organization based in Topeka.
- Established in 1995 with a multi-year grant by the Kansas Health Foundation.
- Committed to convening meaningful conversations around tough topics related to health.

Who We Are

- Community Health Center of Southeast Kansas is a Federally Qualified Healthcare Center serving eleven counties in southeast Kansas and northeast Oklahoma.
- We provided care to 72,315 unique patients in 2022 accounting for 273,156 patient visits.
- We are a multidisciplinary integrated training center providing education. We provide practicum/residency experiences to nursing, dental, pharmacy, behavioral health, medicine, and legal disciplines.

Objectives

- Gain insight into the current state of the behavioral health system and workforce in Kansas.
- Build an understanding of models of integrating medical and behavioral health care in a primary care setting.
- Explore policy and practical options that can facilitate successful integrated care.

The behavioral health system refers to the system of care that includes the promotion of mental health, resilience and well-being; the prevention, referral, diagnosis, and treatment of mental and substance use disorders; and the support of persons with lived experience in recovery from these conditions, along with their families and communities.

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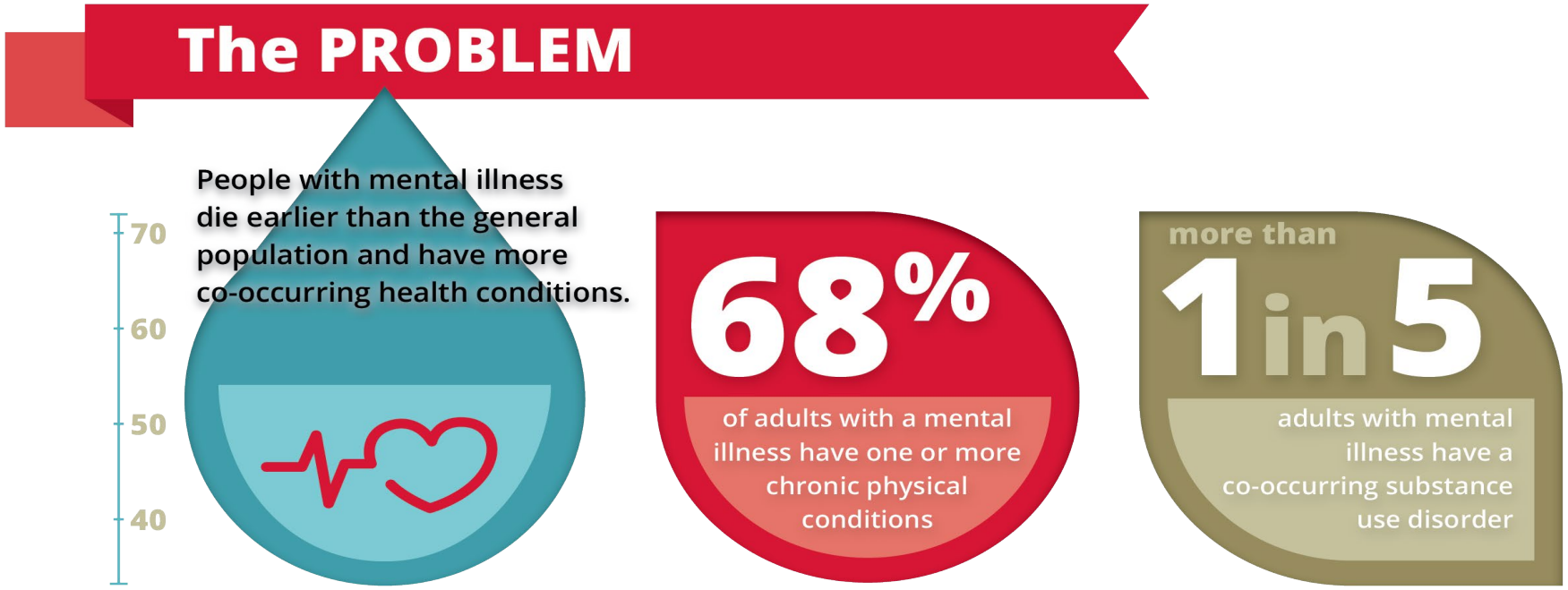
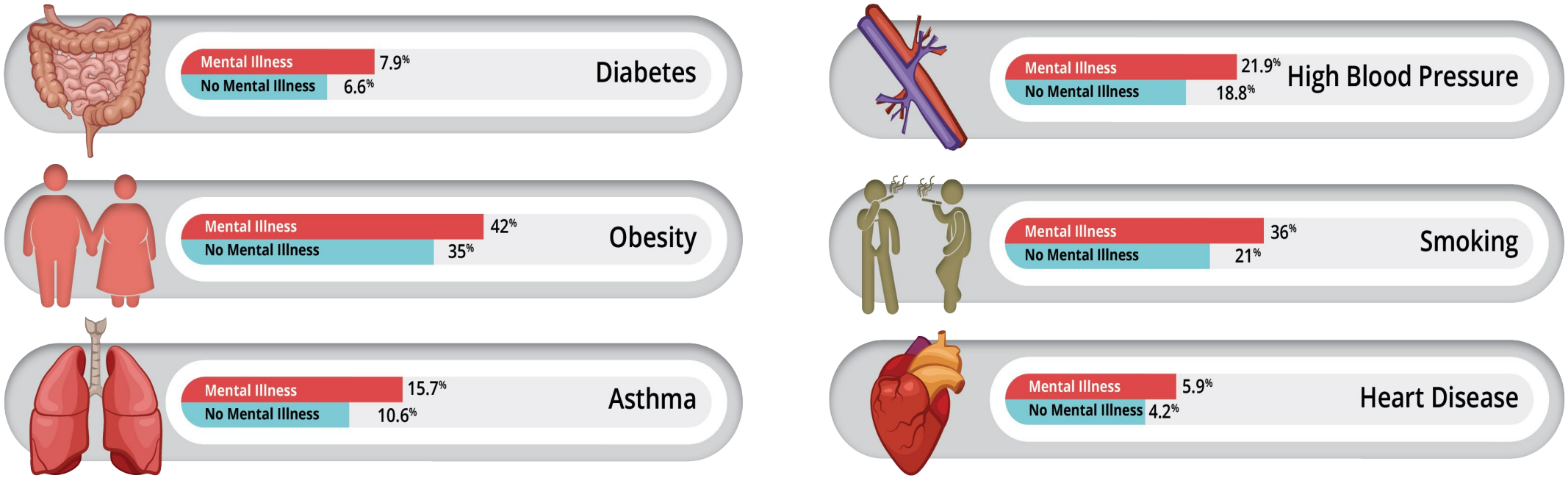
Behavioral Health and Health Outcomes



Source: SAMHSA-HRSA Center for Integrated Health Solutions.

Co-Occurring Conditions



Source: SAMHSA-HRSA Center for Integrated Health Solutions.

From the Field:
How do you see behavioral health conditions affecting the overall health and well-being of your patients?

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Community-Identified Needs

- KHI reviewed 78 community health assessments (CHA), community health needs assessments (CHNA) and community health improvement plans (CHIP) developed in Kansas between 2009-2015.
- Key findings:
  - All reviewed CHA, CHNA and CHIP discussed or mentioned behavioral health-related issues, but **half** did not prioritize behavioral health issues for further action.
  - Community capacity was referenced as top reason for not prioritizing these concerns for further action.

Findings: Community Needs

Mental Health

- Access to health insurance coverage
- Provider shortages
- Access to comprehensive and integrated services
- Assessment of the need for mental health services in the community

Substance Use

- Use of tobacco products
- Access to comprehensive substance use treatment programs
- Use of smokeless tobacco
- Use of tobacco during pregnancy
- Use of alcohol products by adults and youth
- Alcohol-related traffic accidents
- Use of prescription drugs

From the Field:
Have these needs changed, and how did the COVID-19 pandemic affect needs?

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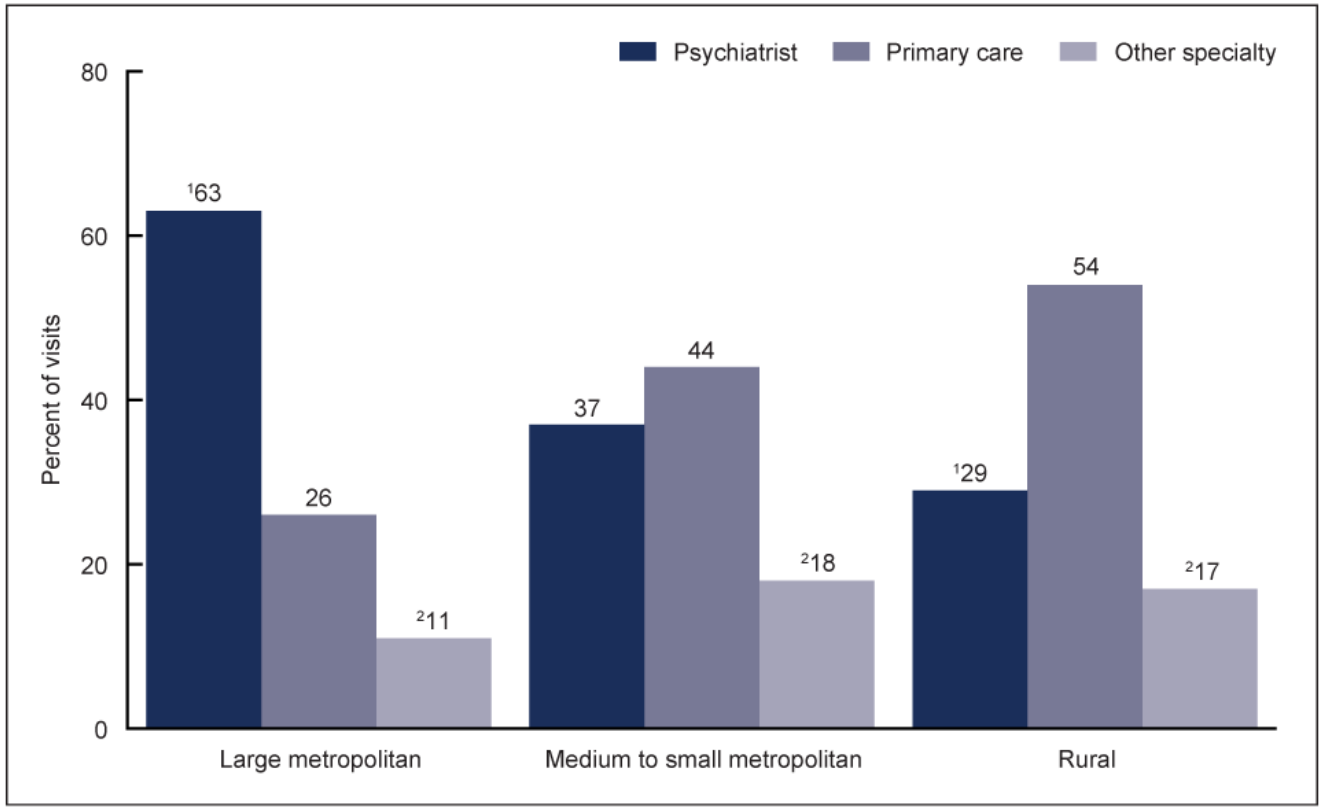
Behavioral Health and Primary Medical Care

Mental Health Visits

- Nationally, among adults age 18 and older, more than half of mental health office visits are with a psychiatrist, and one-third with a primary care physician.
- However: In rural areas, **more than half** of all mental-health related physician office visits are with primary care providers.

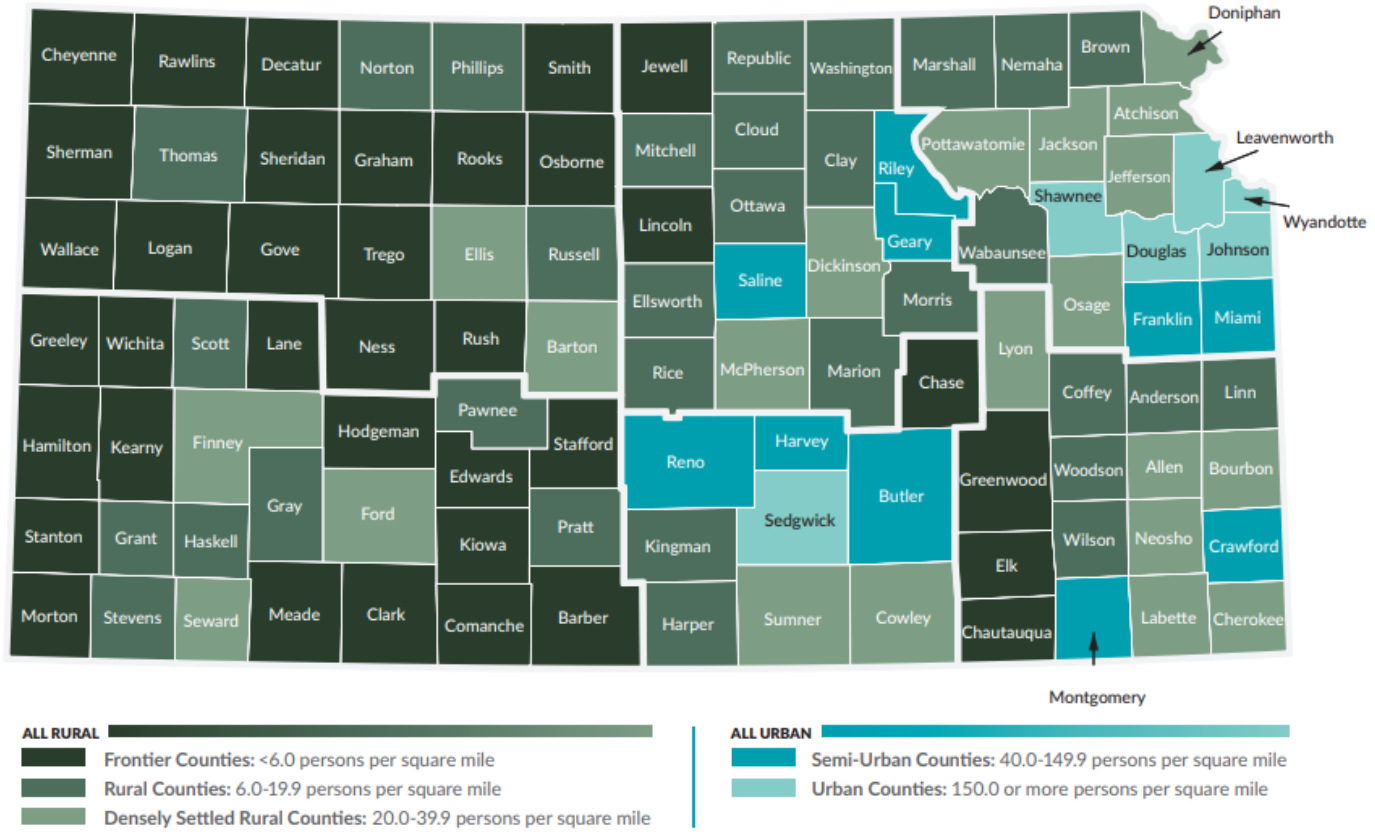
Mental Health Visits

Figure 3. Percentage of mental health-related physician office visits by physician specialty, according to urban–rural status for adults aged 18 and over: United States, 2012–2014



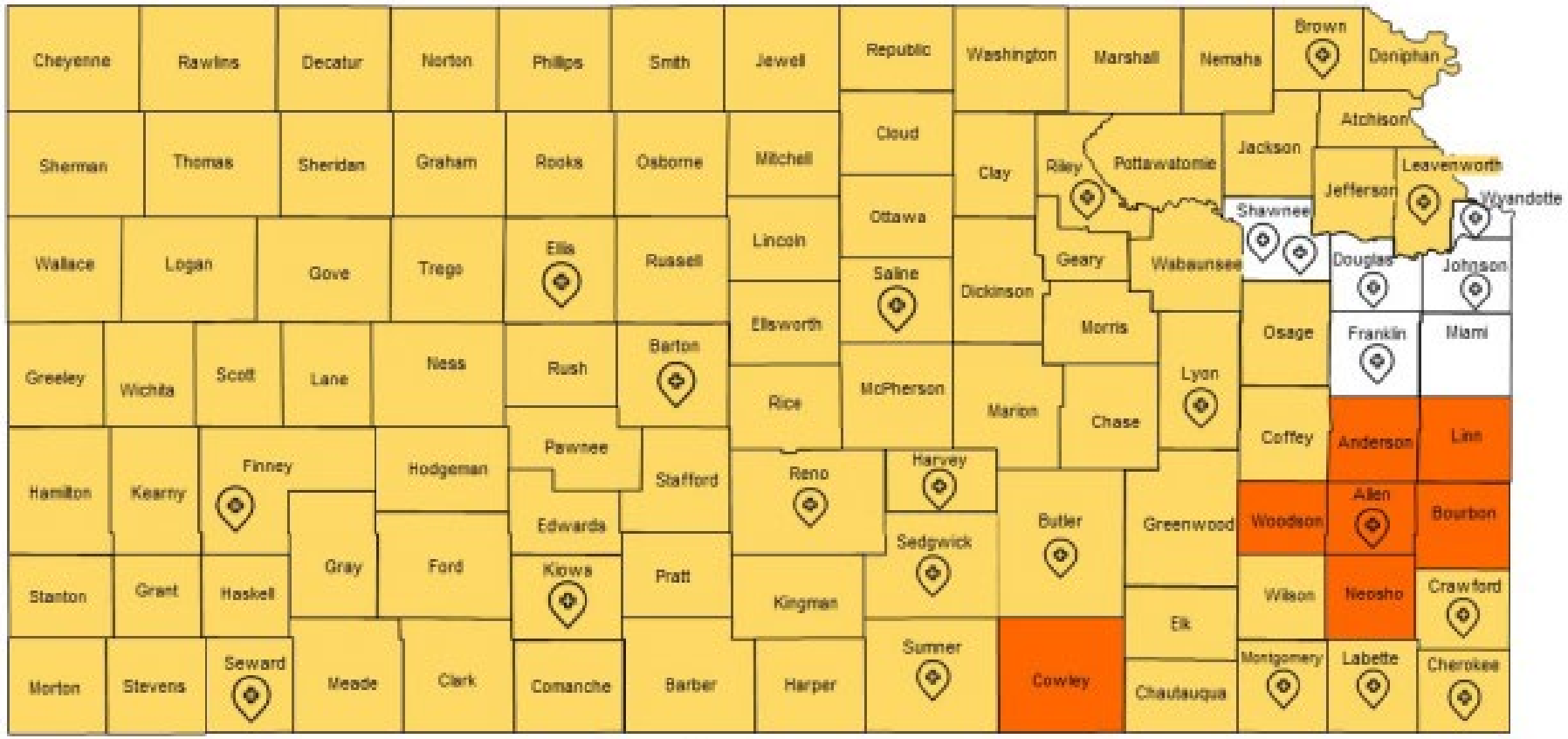
[1]Significantly different ($p < 0.05$) from percentage of primary care physician visits, based on a two-tailed t test.
[2]Significantly different ($p < 0.05$) from percentage of primary care physician and psychiatrist visits, based on a two-tailed t test.
NOTES: Data are based on 3-year averages. Visits with missing urban–rural status category were excluded from this analysis. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db311_table.pdf#3.
SOURCE: NCHS, National Ambulatory Medical Care Survey, 2012–2014.

How Rural Is Rural?



Source: Kansas Health Institute presentation of KDHE county peer groups by population density.

Mental Health Geographic and Population County-Level HPSA Designations



County-level Mental Health HPSA Score of 18 or higher

County-level Mental Health HPSA Score of 17 or lower

Not eligible for County-level Mental Health HPSA score

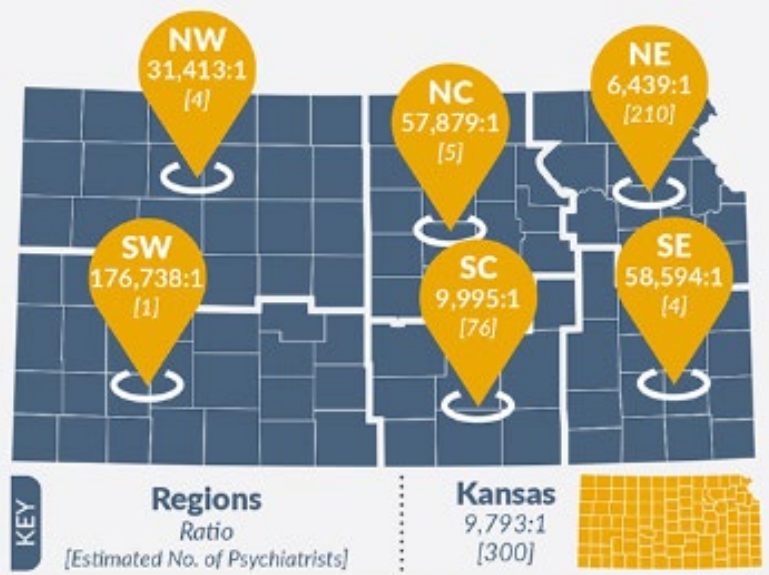
Community Mental Health Center Location

Data Sources: Health Resources & Services Administration Data Warehouse, December 2020
Association of Community Mental Health Centers of KS, Inc., 2018

Data Note: HPSA scores shown are listed in Data Warehouse as of December 2020. Updates to HPSAs made after this date are not reflected.

Geographic Distribution: Psychiatrists

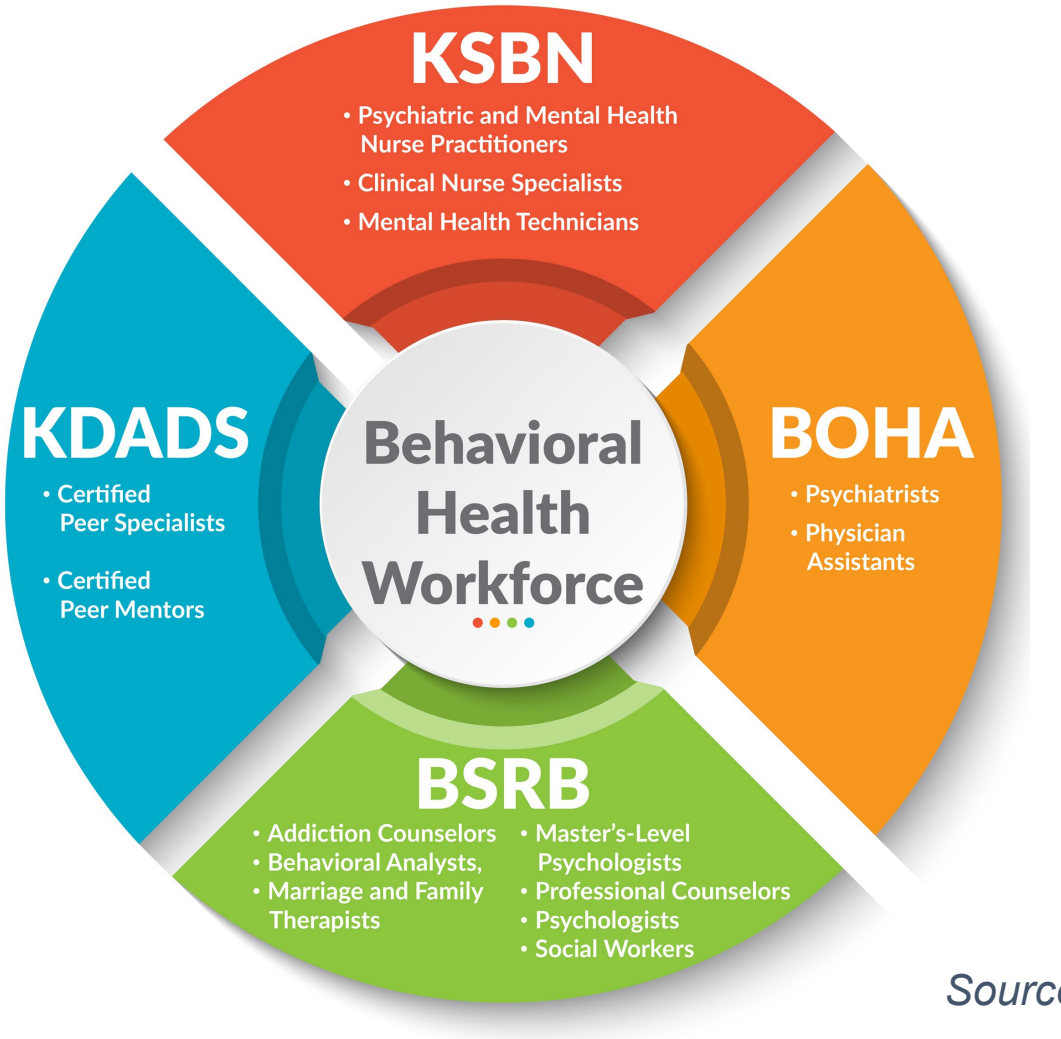
- Southwest Kansas has the fewest psychiatrists.
- Northeast Kansas has the most psychiatrists.



Region	Estimated Population	Estimated No. of Primary Psychiatrists	Ratio
Northwest	125,650	4	31,413:1
North Central	289,393	5	57,879:1
Northeast	1,352,138	210	6,439:1
Southwest	176,738	1	176,738:1
South Central	759,584	76	9,995:1
Southeast	234,377	4	58,594:1
Kansas	2,937,880	300	9,793:1

Source: Kansas Health Institute analysis of BOHA data obtained through KDHE in July 2021 and 2020 decennial census data from the U.S. Census Bureau.

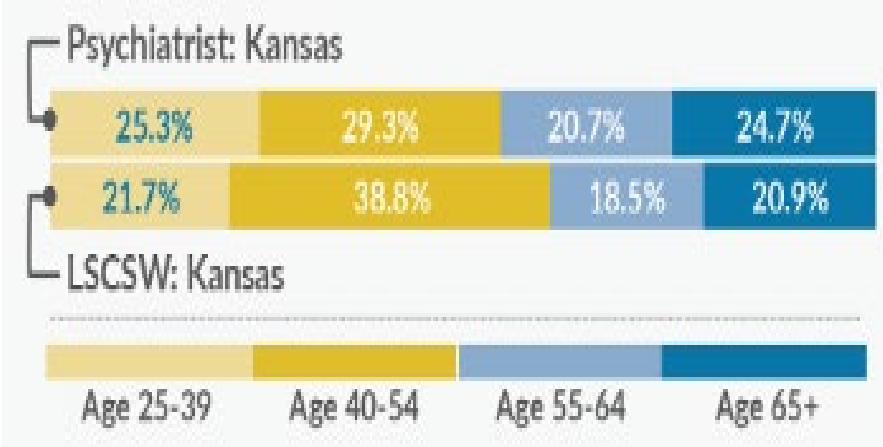
Defining the Behavioral Health Workforce



Source: Kansas Health Institute

Age Distribution of Psychiatrists and LSCSW

- 45.5 percent of psychiatrists in Kansas are over age 55, compared to 61.3 percent of psychiatrists nationwide.
- Average age of psychiatrists in Kansas is 53.
- Average age of licensed specialist clinical social workers in Kansas is 51.



Source: Kansas Health Institute analysis of BOHA data obtained through KDHE in July 2021.

From the Field:
How do workforce challenges affect people seeking behavioral health care?

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What Tools are Available?

Grow-Your-Own Approach

Telehealth

Integrated Care

Workforce Diversity

In any physical health or behavioral health setting, "integrated services" means the provision and coordination by the treatment team of appropriately matched interventions for both PH and BH conditions, along with attention to social determinants of health, in the setting in which the person is most naturally engaged.

Source: Comprehensive Healthcare Integration Framework, National Council for Mental Wellbeing.

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Constructs of Integration

Source: National Council for Mental Wellbeing, 2022

Example Progression

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
1. Integrated Screening, referral to care and follow-up (f/u).	**1.1** Screening and follow-up for co-occurring behavioral health (MH, SUD, nicotine), PH conditions and preventive risk factors. **1.2** Facilitation of referrals and f/u.	Response to patient self-report of co-occurring behavioral health and/or PH complaints and/or chronic illness with f/u only when prompted. Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	Systematic screening for high prevalence BH and/or PH conditions and risk factors and proactive health/BH. Identify PCP and BH providers (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.	Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services. Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow-up and coordination re positive screens, with access to well-coordinated referrals to internal or external PH and/or BH service providers.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity and/or utilization and measuring the level of intensity of integrated care coordination. In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.

Source: National Council for Mental Wellbeing, 2022

Care Coordination/Management Progression

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DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
3. Ongoing Care Coordination and Care Management.	**3.1** Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.	None or minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.	Provider team has a basic mechanism for tracking f/u to appointments with PH or BH referrals, navigating or assisting with appointments and encouraging/ prompting adherence to medications and other co-occurring treatment recommendations.	Team members who can provide data analysis to guide care and plan. Assigned team member(s) who can provide routine care coordination and monitor routine proactive follow-up and tracking of patient engagement, adherence and progress in co-occurring PH and/or BH services, whether provided by the team or by referral. Availability of coaching by assigned care coordinator or others to ensure engagement and early response.	In addition to Integration Construct 2: Availability of a continuum of care coordination, involvement of consulting specialists like a BHC or RN care manager based on stratification of need across the full range of populations served. Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.

Source: National Council for Mental Wellbeing, 2022

From the Field:
Can you share an example of how integration works in practice?

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Supportive Factors

- Leadership commitment
- Adequate staffing
- Customized communication and workflow systems
- Collaborative practice culture
- Healthy working relationships among providers

Impediments

- Workforce issues
- Billing/payment models
- Practice culture
- Siloed licensure/regulatory bodies

From the Field:
How have you addressed challenges to integrating care?

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THANK YOU!

Any Questions?

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