WORK FORCE CAPACITY IN INTEGRATED MODELS OF CARE: MISSING LINKS

Karen Linkins, PhD
Director
CalMHSA Integrated Behavioral Health Project
The Solution: Integrated, Collaborative, Patient-Centered Care

Primary Care

Sub-specialty Service
Social Work
Psychiatrist
Physician
NP, PA, RN, MA, etc.
Patient
ACA → Practice Transformation

- Integrated, Coordinated Care, e.g. Patient-Centered Medical Home
- ACA and CMS call for Core PCMH Provider Standards
  - Comprehensive Care Plan for each patient
  - Quality driven, cost-effective, evidence-based, patient-centered services
  - Services: prevention/health promotion, health, mental health, substance use, long-term care, linkages to community supports
  - Care management, care coordination, and transitional care from hospital to community
  - Use of HIT for measurement, population management, QI
New Models of Care: Expand Beyond Leading Edge and Early Adopters

- Significant progress in practice and system transformation in CA and nationally providing strong evidence base, **BUT** there are issues with sustainability and spread

- Workforce and Practice Culture Challenges in achieving:
  ✦ Improved **population management**
  ✦ Better implementation and use of HIT, e.g., QI tracking of treatment outcomes
  ✦ Integrated, **team based care** with all members working to the top of their license, delegating activities to different team members, as appropriate
Example 1: Primary Care Clinic

New Patient’s first Visit to PCP includes behavioral health screening

Possible BH Issues?

Behavioral Health Assessment by BH Professional working in primary care

Need BH Svcs?

Integrating Door #1

Clients with Low to Moderate BH need enrolled in **Level 1**; to be case managed and served in primary care by PCP and BH Care Coordinator with support from Consulting Psychiatrist and other clinic-based Mental Health Providers

Clients with Hi Moderate to High need referred to **Level 2** specialty care; PCP continues to provide medical services and BH Care Coordinator maintains linkage; this is a time-limited referral with expectation that care will be stepped back to primary care

Clients with Hi Moderate to High need transferred to **Level 3** BH specialty care; takes over ensuring that whole health needs of clients are met including primary care through integration or partnership model.

Referrals to other needed services and supports (e.g. Social Services, Vocational Rehabilitation)

No Wrong Door!
“Ideal” Fully Integrated PC Clinic

- Co-location of PC and BH staff and services
- All patients screened for BH issues
- Shared workspace for Interdisciplinary Team for daily “huddles”
- Integrated EHR that supports QI assessment
- Share care plans
- Warm handoffs from PCP to BH
- Care coordinator
Example 2: Collaborative System of Care

- Multiple service agencies touch high-risk patients (e.g., frequent users of ED)
  - Medical (primary care clinics; hospitals)
  - Mental Health
  - Substance Use
  - Social Service Agencies
  - Other: e.g., Housing, Education, Employment, Criminal Justice, Welfare
New Models of Care are Changing Faster than Work Force Supply & Preparedness

- Vast majority of providers across the sectors receive limited training on how to work in teams, and most gain this knowledge on the job.
- Mental health provider shortages across many rural communities in CA (OSHPD, 2011)
- Demand for MH/SU social workers, and SU and behavioral disorder counselors is projected to increase by 22.8 percent and 35.4 percent, respectively, from 2006 to 2016 (California Employment Development Department)
- Medical and Behavioral Health fields have distinctly different training programs, professional cultures, and treatment approaches.
  - Within BH, there are significant difference between MH and SU
- BH providers lag behind medical providers in their capacity to track treatment outcomes and use data for clinical decision making
Challenges: Capacity and Capabilities

Key workforce capacity barriers:

- Insufficient academic training and inadequate skills for integrated practice.
- Resistance to change practice patterns amidst a myriad of other health reform transformations (change fatigue & training overload)
- Attitudes and issues related to stigma within and across provider groups
- Negative attitudes about persons with mental health and substance use problems
Strategies to Improve WF Capacity and Address Parity

- Adoption of consistent standards/core components of integrated care (AHRQ/IBHP sponsored competencies project)
- Educate medical and MH providers about addiction as disease and re-frame SUD treatment in the chronic disease model
- Improve AOD provider training on MH/Medical conditions
- Reinforce clinical competencies and support efforts to advance cross system integration (including social services and other community supports), improve care pathways, development of shared accountability and improve cross-sector partnerships
Strategies to Improve WF Capacity and Address Parity

• Reinforce and support workforce competency standards to encourage BH professionals to work to top of license
• Eliminate barriers for using tele-psychiatry and related strategies to overcome rural shortage issues
• Develop clear scope of practice for AOD counselors to define parameters of counseling and therapy for co-occurring population
• Test models that include peers as part of the care team (e.g., outreach and engagement, health coaching, care coordination)
Promising WF Capacity Strategy: Peer Providers

• Five Peer Models supported by OptumHealth nationally:

1. **Peer coaching**: (SPMI) Delivered by a trained peer who is in recovery and completed an approved training program and is credentialed through a state process. Coach provides face to face support with strength-based activation and self-care tools.

2. **Peer Bridging**: (New York State). Connects a trained mental health peer with a peer in the hospital and helps them make a “soft landing” back into the community.


4. **Whole health coach**: (MH and chronic condition) Coach has additional training that allows them to serve a person with a mental health issue AND a physical health issue like diabetes, COPD and more.

5. **Parent Partner Coach**: (Children) Trained parent whose child has successfully moved into resiliency and who is trained to offer support, engagement, activation, and self-care tools and services as well as navigation support to the parents of a child who is frequently hospitalized.
Strategies to Improve WF Capacity and Address Parity

- Key strategy to reduce stigma and other barriers to engagement
- Barriers include: Lack of reimbursement, knowledge and understanding of the value and role peer providers can play in integrated care
- Advocate for CA to fund traditional peer support specialists in the Medicaid program (currently N=32 states cover peer services in through the Medicaid program)
Contact Information

- Karen Linkins, PhD
  karen@desertvistaconsulting.com