

Arkansas Health Workforce Workgroup



August 17, 2011

Strategic Plan Draft Outline

- **Basic overview of the approach to writing the strategic plan, not yet comprehensive**
- **Recommendations from workgroup (and other content experts) will be further explored by staff, then incorporated into recommendations sections**
 - **2-3 Year Recommendations**
 - **Primary**
 - **Secondary**
 - **Long-Term Recommendations**
- **Comprehensive list of recommendations to date will be sent to workgroup in the next week for your review and comments back to staff**



Demand Issues Lessons Learned

Dr. Joe Thompson

Assurance of Demand

- **Supreme Court will likely take up the issue of the individual mandate in October**
- **Courts have been unanimous in upholding Congress's power to expand Medicaid**
 - **250,000 Medicaid eligible in Arkansas**
- **Remainder of law, including employer mandate and tax credits for small businesses now and individuals later, are still intact**
 - **41,000 businesses currently eligible for credits**
 - **150,000 to 200,000 individuals eligible for tax credits in 2014**



Assurance of Demand - Continued

Massachusetts After 2006 Health Care Reform

General Internists

- **Wait times went from 33 to 52 days in the year after reform**
- **Percentage of offices accepting new patients dropped by 13% in the year after reform**

Family Medicine

- **Wait times went from 34 to 44 days in two years after reform**
- **Percentage of offices accepting new patients dropped by 23% over four years after reform**



Assurance of Demand – Continued

Oregon Medicaid Experiment:

Medicaid coverage increases the use of health care.

- **35% increase in probability of using outpatient care**
- **15% increase in use of prescription drugs**
- **30% increase in hospital admissions**
- **70% more likely to report having a regular place of care and 55% more likely to have a usual doctor**

Increased use of preventive care

- **60% increase in mammograms**
- **20% increase in cholesterol monitoring**

(“The Effects of Medicaid Coverage—Learning from the Oregon Experiment,” NEJM, July 20, 2011)

Integrating Behavioral Health into Primary Care

Drivers for BH integration into PCMH

- **Coverage for Preventive measures in ACA**
- **Getting population level interventions deployed in anticipation of enhanced payment (100% Medicaid federal payment for newly eligible thru end of 2016)**
- **New 2011 NCQA Standard : Charting the Course for Integration: Integrate behaviors affecting health, mental health and substance abuse**



Preventive Services from the USPSTF and the Affordable Care Act

- **A&B Behavioral Screenings: alcohol misuse screening & counseling, depression screening for adolescents & adults, healthy diet counseling, obesity screening & counseling for adults & children, tobacco cessation counseling and interventions for adults**
- **Insurance must cover with no out of pocket cost to enrollee**
 - Medicare began in 2011
 - Medicaid begins in 2013
 - New private plans, including self-funded plans, phased in beginning in 2010



Problems Addressed

- A large number of all primary care visits are driven by psychological factors.
- Patients with mental and behavioral health conditions are often seen in the primary care setting.
- Most primary care providers (PCPs) are ill-equipped to treat mental illness on their own.
- Patients referred to outside specialists often fail to keep their appointments due to the stigma associated with mental illness.
- Integrating behavioral health into the primary care setting can yield clinical and cost benefits, but PCP practices often have difficulty getting reimbursement for mental health services provided in their offices.



Benefits of Integrating BH into PC

Care Benefits

- Reduced hospitalizations, need for medical services and office visits, physical symptoms
- Increased treatment success, medication adherence, social activities, better perception of overall health

Economic Benefits

- 20-30% overall cost savings is the average of studies reviewed (Strosahl & Sobel, 1996)
- Integrating behavioral health service adds \$264 per case of depression treated in primary care but saves \$491 (Von Korff, et.al., 1998)
- Integrating behavioral health practitioners into PC setting to manage BH patients frees the PCP's time to see medical patients with higher RVU conditions (Strosahl, K, Robinson, P, 2009)



BH Primary Goals of Integration

- **Address tremendous unmet demand among PC patients at the time of presentation.**
- **Assure that treatments have a high population impact because additional staffing and resources are likely to be scarce.**
- **Make Primary Behavioral Health services available to large percentage of eligible population**
- **Focus on health and behavioral health issues simultaneously**
- **Emphasize early identification and prevention**
- **Effectively triage patients in need of specialty behavioral health**
- **Maximize initial response, reduce acuity and prevent relapse**



Role of BH Provider

- **Functions as a consultant and treatment member of health care team**
- **Helps to inform PCP decision making**
- **Builds on PCP interventions**
- **Reinforces “core” behavioral health skills for the entire care team**
- **Educates patients in self-management skills through training**
- **Monitors, with care team, “at risk” patients**
- **Assists in team building**



Unique Core Behavioral Health Skills for BH Provider in Integrated Care

- **Consultation liaison skills with medical problems as well as behavioral health problems**
- **BH Population screening administration and interpretation**
- **BH Population management strategies**
- **Chronic disease management**
- **Behavioral medicine skills such as treatment adherence**
- **Case management skills**
- **Stepped care approaches to problems (e.g., self management, e-health)**
- **Short and long term evidenced based interventions**
- **Group interventions**



Continuum of Integration

source: Strosahl, et al. Mountainview Consulting Group, Inc. 2009

Model	Desirability	Attributes
Separate space and mission	--	Traditional BH specialty model
1:1 Referral relationship	+	Preferred provider/some info exchange
Co-location	++	On-site BH unit/separate team
Collaborative care	+++	On site/shared cases with /BH specialist
Integrated Care	+++++	BHC as PC Team member



Educational Opportunities on the Horizon

- **Primary care clinics will need training for assessment and interventions for “access to care” new mandates such as depression, obesity, smoking, substance abuse, health care management**
- **Access needs to be in the clinic, on-site and available**
- **Primary care physicians will continue to need training to help them make the referrals to their trained interventionist**
- **The person who would then do the assessment and interventions needs training, a certification process**

Source: Betty L. Everett, Ph.D., UAMS



Clinical Applications on the Horizon

John Fortney, PhD

Division of Health Services Research

Department of Psychiatry

University of Arkansas for Medical Sciences



Practice-Based Collaborative Care

- **20/28 randomized trials of collaborative care for depression significantly improved outcomes¹:**
 - **Median effect for response rates: +18%**

1) Williams J et. al. Systematic review of multifaceted interventions to improve depression care. *General Hospital Psychiatry*, 29, 91-116, 2007

Comparison of Models

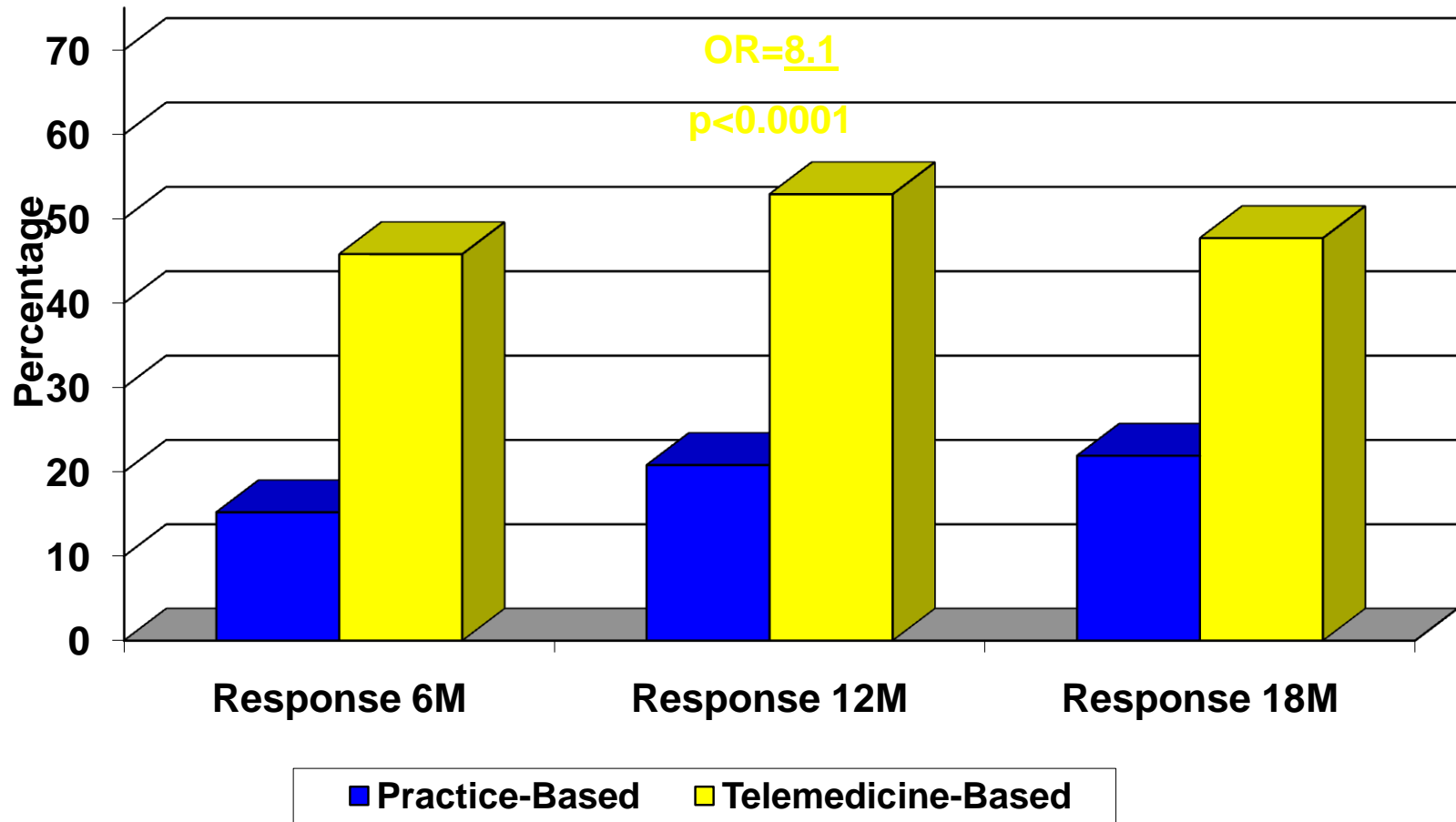
Component	Practice-Based	Telemedicine-Based
Provider Education	Yes	Yes
Screening	Yes	Yes
Patient Education	Yes	Yes
Self-Management	Yes	Yes
Medication Assistance	Yes	Yes
Monitoring	Yes	Yes
PharmD Management	No	Yes
Psychotherapy	No	Yes
Psychiatric Consult	No	Yes

Telemedicine-Based Collaborative Care

- **Offsite depression care team at UAMS Dept. of Psychiatry**
 - **Nurse care manager**
 - **Pharmacist**
 - **Psychologist**
 - **Psychiatrist**
- **Telephones**
 - **Care manager encounters with patients at home**
 - **Pharmacist encounters with patients at home**
- **Interactive Video**
 - **Evidence-Based Psychotherapy with patients at CHC**
 - **Psychiatric evaluations with patients at CHC**
- **Web-based Decision Support System for Care Manager**
 - **NetDSS**



Follow-up Response Rates



Strategy Development Session

Behavioral Health Scenarios

Strategy Development Session

- **QUESTION:** How will the existing workforce screen and diagnose this patient, and ensure that the patient receives treatment?
- **Your solutions should:**
 - Consider the framework of the PCMH
 - Be achievable in 2-3 years (meaning creation of a new capacity, either a new body or a new competency)
 - Initially consider the staff solution

