GROWING THE PRIMARY CARE
BEHAVIORAL HEALTH WORKFORCE
OF TOMORROW

ALEXANDER BLOUNT, ED.D.
Disclosure:

I will mention the training programs of the Center for Integrated Primary Care at the University of Massachusetts Medical School. www.UMassMed.edu/CIPC

I founded the Center and created most of the content in the Primary Care Behavioral Health Course.

I currently work for them 1 hour per month doing live Q & A for people taking the course.

I do not get any other financial benefit from their success. Any income over expenses of the Center in a given year is held in an account to help the Center through hard times in other years. It is part of a non-profit institution.
## Mental Health Workforce Data is a Mess

Quality of MH Health Professions Shortage Area Workforce Data
Bureau of Health Workforce, HRSA, HHS

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Mental Health Care HPSA Designations</th>
<th>Population of Designated HPSAs</th>
<th>Percent of Need Met</th>
<th>Practitioners Needed to Remove HPSA Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Hampshire</td>
<td>20</td>
<td>32755</td>
<td>0.9492</td>
<td>0</td>
</tr>
<tr>
<td>New York</td>
<td>162</td>
<td>16</td>
<td>0.4097</td>
<td>147</td>
</tr>
<tr>
<td>Vermont</td>
<td>24 N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Current National Studies Add Little Analytic Insight


Conclusions:
Models are too variable to make predictions.

Weaknesses:
Use 4 Quadrant Model as a basis for analysis

Ignore one of the two most influential models if integration in analysis. Possibly related to Univ. of Washington institutional interest in the other model.
Some of the Factors That Determine Workforce Needs in PCBH

• Population of Patients
• Experience of PCPs
• Experience and training of BH clinicians
• Model of Care: Co-location, Targeted Population Approach (CCM), Behavioral Health as Infrastructure (BH Consultant Model)
• Few examples of implementations where payment model is not a limiting factor in ratio of PCP to BHC.
Examples:

Kaiser-Permanente of Northern California in late 1990s: 1BHC/5PCPs
- Largely employed population
- Co-located model
- PCP experience unknown

Cherokee Health Systems – close to 1BHC/2 PCPs
- Low income, underserved population, many homeless or recent immigrants
- Behavioral Health Consultant Model
- PCPs very experienced in BHI
- Complete system with Primary Care Behavioral Health and Specialty Mental Health
Scope NH PCBH Workforce Assessment Study

Focused only on primary care behavioral health workforce in New Hampshire

Assessing how behavioral health care is delivered to the most “stressed” populations

Studied the “safety net” clinics (FQHCs and look alikes plus RHCs)

Looked at how well the training infrastructure of the state is poised to produce the workforce needed to supply these sites and by extension, the state.
The practices perceived themselves as more integrated than we suspect they are.

**Observer versus Site Perceptions of Level of Integration**

<table>
<thead>
<tr>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 5</th>
<th>Level 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Collaboration</td>
<td>Basic Collaboration at a Distance</td>
<td>Basic Collaboration Onsite</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
</tr>
</tbody>
</table>

Observer Report 2.85 (n=13)  Provider Self-Report 5.15 (n=13)
We defined behavioral health broadly.

1. Prescribing and consulting about psychotropic medications
2. Consulting with PCPs and other team members about patient BH needs and treatment.
3. Providing behavioral interventions or therapies for mental health and substance abuse needs and health behavior change
4. Creating and maintaining patient engagement in care
5. Addressing health literacy, adherence, and healthy living
6. Keeping information about the patient’s health needs and health behavior flowing between the patient and the health team
7. Addressing social and economic barriers patients face in caring for their health (“social determinants of health”)
Role of “Care Enhancers”

Lots of roles being added:

- Care Manager
- Care Coordinator
- Navigator
- Health Coach
- Patient Advocate
- Community Health Worker
- Patient Educators
  (and on and on)

Some are new types of training and some are new roles for existing disciplines (RN, LPN, MA, MSW).

Whatever their training, these roles require behavioral skills.
We conceptualized the workforce by categories of function rather than discipline.

**Care Enhancer (CE)**

**Consulting Psychiatric Clinician (CPC)**
- Psychiatrist (MD, DO), Psych Nurse Practitioner, Psych Advanced Practice Nurse, Psych Physician’s Assistant

**Behavioral Health Clinician (BHC)**
- Psychologist (PsyD, Phd), Marriage & Family Therapist, Substance Abuse Counselor, Mental Health Counselor, MSW
BHCs, PCCs, & some forms of CE’s will be in great demand.

Substance Abuse Counselors, Care Managers, BHCs Needed

Number of Professionals: **Now**, Wanted **Now**, Wanted in **5 years**

**Care Enhancers, Consulting Psychiatric Clinicians, Behavioral Health Clinicians**

- Health Coach
- Navigator
- Patient Advocate
- Patient Educator
- Community Health Worker
- Care Coordinator
- Care Managers
- RN/BSN
- Medical Assistant
- Consulting Psychiatric Clinician
- Substance Abuse Counselor
- Behavioral Health Clinician

Number of Professionals Needed
The Fourth Core Role in BHI

**Primary Care Clinicians** – (MD/DOs, APRNs, PAs working in Family Medicine, General Internal Medicine, Pediatrics, and sometimes OB/GYN)

We did not study this workforce because a number of federal and state agencies already do so.

Yet PCCs play a core role in the success of BHI.

They are already treating depression, anxiety, SA, ADHD, chronic pain, Medically Unexplained Symptoms, and non-adherence, usually presenting in multiples along with chronic illnesses.

Members of other roles who are skilled in behavioral health, at working on a team, and at supporting team members make a crucial difference for PCCs.

When co-location and integration are done well, PCCs’ job satisfaction goes up and (anecdotally) so does provider retention. The is an important workforce intervention.
We believe “substance abuse counselors” should be identified and trained as “behavioral health clinicians.”

Primary care patients usually present substance use problems as part of larger arrays of concerns. Treating the “whole person” doesn’t mean treatment for only a particular BH problem any more than treating only physical problems.

The BHC who engages them in working on their behavioral health issues has to be defined as a generalist who can competently address unhealthy habits or depression or substance use, depending on where the patient is ready to work.

The 42 CFR permits generalist behavioral health and medical professionals in general medical settings to communicate about substance abuse diagnoses and treatment without additional permission from the patient.
Academic Programs

Overall response rate of 40%

Master’s programs training therapists were largely unaware of their graduates as BHCs. Response rate much better – 86%

In general, the academic programs are well behind the primary care sites in knowledge of behavioral health integration.

The majority of respondents, whether they know about IBH or not expressed interest in learning more and in being involved if there was a role they could discern.
Training needs:

The literature and general experience says that BH clinicians need targeted training in addition to their curricula in graduate school to be able to succeed in primary care. Many programs have failed when this training was not required. (Hall, Cohen, Davis, et al., 2105).

It may make more sense to develop or contract for a post-degree training program rather than trying to insert the necessary training into the packed curricula in Master’s graduate programs.

Successful and extensively evaluated training programs are currently available online.

Additional training for Care Enhancers, Primary Care Clinicians and Consulting Psychiatric Clinicians is also available. Examples at: http://umassmed.edu/CIPC
As BHI matures, workforce needs evolve

More uses for BHCs, and new ways of using CEs and PCCs in the BH endeavor.

The first job is retraining the members of the current workforce who want to be a part of BHI.

Then we want to identify academic programs that want to make this training a priority.

As an example, Antioch has established a Major Area of Study in Behavioral Integration and Population Health.

The same could happen for Care Enhancer roles, i.e., post graduation modular training in new competencies with a few programs deciding to make this a priority for the future.
Doorways and Pathways
A Rationalized System Draws Workforce

- BHC $2.5x/hr
- Care Manager $2x/hr
- C.H.W. $x/hr
- Med Asst $1.5x/hr
- Pt Advocate $x/hr
- Health Coach $1.8x/hr
- Med. Interpreter $x/hr

Designated training
New Hampshire Primary Care Behavioral Health Workforce Development Plan

By Alexander Blount

With the guidance and support of: Laura J Bilodeau, Annamarie Cioffari, James Fauth, Nancy Frank, Suzanne Gaetiens-Oleson, Hwasun Garin, Joni Haley, Fred Kelsey, Will Lusenhop, JoAnne Malloy, Patrick Miller, Stephanie Pagliuca
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Stephanie Pagliuca, Recruitment Director, Bi-State Primary Care Association
Elements of the New Hampshire PCBH Workforce Plan

http://integratedprimarycare.com/NHPCBHWF

1. Identify available & effective PCBH training programs

2. Seek funding for training from Integrated Delivery Networks (newly organized health systems in NH)

3. Negotiate discounted NH rates

4. Offer live Q & A and coaching to current BHCs
Plan for Developing the Future PCBH Workforce.

1. Elicit input from academic programs for PCBH modules that orient students to primary care as a possible venue for future employment.
2. Develop these modules for undergrad, masters and doctoral programs.
3. Create and maintain a PCBH Workforce web portal for current and future workforce members, employers, trainers and other stakeholders.
4. Create a list of Care Enhancer roles, training pathways and salaries.
5. Identify training programs for primary care workers that can lead to PCBH licensure (masters clinician) without leaving employment.
6. Create a consensus list of Care Enhancer behavioral competencies and career ladder.
7. Created manual and tool/kit to help primary care sites initiate training positions.
8. Develop training modules in PCBH for psychiatric APRNs, trainees and staff.
Plan to Develop Integrated Leadership and Workflows

1. Develop a PCMH/NCQA/PCBH “cross walk” of requirements
2. Identify PCBH approaches that create sustainability outside F-F-S
3. Create pediatric-specific workflows and practice webinars
4. Create/deliver PCBH training for C.H.I. primary care practice facilitators
5. Create a webinar on PCBH levels and opportunities for practice and health system leaders
6. Identify and disseminate a list of IDN and other statewide PCBH workforce efforts
Carrying Out the Plan

• We are funded for two years by the Endowment for Health

• I am the P.I. (“University speak” for project leader)

• We have student and professional staff support within the Center for Behavioral Health Innovation from the Department of Clinical Psychology at Antioch University New England.

• For almost every sub-project we have identified, one or more partners from around the state will join us. (See “Responsible Organization/Other Participants” column in Plan).

• The role of partner is not closed. Where we can work in partnership we would like to. Where someone else is undertaking specifically what we have committed to do, we are happy to defer and consult.
References


Questions and Discussion

New Hampshire Primary Care Behavioral Health Workforce Portal

www.integratedprimarycare.com/NHPCBHWF

New Hampshire Primary Care Behavioral Health Development

integprimarycare@gmail.com