



**Behavioral Health Panel:
Addressing the Needs of Texas Through Best
Practices & Innovative Delivery Models**

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Texas is Changing



- ❖ Texas' population reached 25 million in 2010, growing 20.6% since 2000. That's 4.3 million more people – a population gain greater than any other state.
- ❖ One out of 10 Texans is 65 or older; one out of four is under 18.
- ❖ Texas is now one of four majority minority states in the U.S., meaning that no single ethnic or racial group is greater than 50% of the total population.

Sources: Office of the State Demographer and the U.S. Census Bureau

State of Mental Health in Texas



- ❖ One in four U.S. adults experiences a diagnosable mental illness annually; six percent have a serious mental illness. One in five children in the U.S. has a diagnosable mental health disorder.*
- ❖ ½ of all lifetime cases begin by age 14 and ¼ have begun by age 24. #
- ❖ Only a third of 488,520 adults in Texas with serious and persistent mental illness received services through the community mental health system. **
- ❖ One in four of the 154,724 Texas children with severe emotional disturbance received treatment through the community mental health system. **
- ❖ Less than 33% of the state's 48,700 practicing doctors accept Medicaid patients. †
- ❖ Texas has now fallen to 50th place in per capita funding for mental health services (51st including Washington, D.C.) ††



* Substance Abuse and Mental Health Services Administration

** Texas Department of State Health Services

National Institute of Mental Health

† Texas Health and Human Services Commission

†† Kaiser Family Foundation, June 2011

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State of Mental Health in Texas



- ❖ Suicide is the second leading cause of death for 15 to 19 year olds.
- ❖ Almost as many teens die by suicide as those who die from all natural causes combined.
- ❖ From 1999 to 2004, a total of 13,257 suicide attempts made in the state of Texas resulted in death. 2,100 of these deaths were children and young adults from 10 to 24 years of age.
- ❖ For Texas high school students within a 12-month period:
 - 16% think seriously about suicide
 - 9% attempt suicide
 - 3% make a suicide attempt that requires medical attention

• Source: The Suicide and Crisis Center of North Texas



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The Reality of Care



- ❖ Most people seek help for behavioral health conditions in primary care
- ❖ About half of all care for common psychiatric conditions occurs in primary care
- ❖ Mild to moderate psychiatric conditions are common in primary care: anxiety, depression, substance use, ADHD, behavioral problems
- ❖ Populations of color are more likely to seek and receive services in primary care than behavioral health settings
- ❖ ACE Study showed us how childhood trauma causes disrupt neurodevelopment and social, emotional, and cognitive impairment – which results in behaviors that lead to the development of disease, disability, and social problems, which can cause early death.

- Fellitti, V.J., et al. (1998). Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *American Journal of Preventive Medicine*, 14, 245 – 258.



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The Reality of Care



- ❖ People with chronic medical conditions have high rates of behavioral health problems
- ❖ PCPs frequently miss psychiatric disorders and when detected, fail to provide adequate treatment. (R1) (R2)
- ❖ Less than 50% of referrals for specialty mental health care follow through
 - No health insurance:
 - 33% of Adults 17% of children Source: Texas Medical Association
 - Living in poverty:
 - 17% of elderly 21% of Adults 34% of Children Source: Texas Medical Association
 - Often insurance inadequately covers behavioral health services
 - State's restrictive eligibility criteria for public mental health services
 - Cultural beliefs and attitudes
 - Logistics, especially in rural and pioneer settings



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The Reality of Care



- ❖ In behavioral health settings, more than half of medical conditions go unrecognized. Most common disorders are cardiovascular disease, diabetes, hypertension, arthritis and digestive disorders. ^(R3)
 - PEs are done less often in outpatient settings.
 - BH providers often fail to ensure children and adolescents have had a recent physical exam or make referrals to a pediatrician. ^(R6)
- ❖ Individuals with diagnosed psychiatric illness are less likely to receive certain medical services than the general population.
 - Ex: heart attack victims with diagnosed psychiatric disorders are much less likely to receive necessary surgical procedures than other patients with the same severity of heart problems. ^(R5)
- ❖ Texans with severe mental illness who receive services in the state's public mental health system die 29 years earlier than the general population. Nearly two-thirds of these deaths are caused by treatable physical illnesses. ^(R4)

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Health Care Crisis in Texas



- ❖ Workforce shortages cut across most if not all health care professions in Texas today.
- ❖ The most severe shortages are in mental health services, but behavioral health workforce shortages are often overlooked.
- ❖ Texas ranks far below the national average in the number of mental health professionals per 100,000 residents.
- ❖ These shortages are even greater in rural, poor and Texas – Mexico border communities.



Source: Center for Public Policy Priorities Hobby Conference, 2010

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Looking Ahead: Troubling Trends

- ❖ Behavioral health workforce trends in Texas paint a troubling picture.
- ❖ The per capita workforce ratio is falling in a number of categories, such as psychiatrists, social workers and marriage and family counselors.*

Year	Texas Population*	Psychiatrists**	# of Psychiatrists per 100,000 residents	Social Workers**	# of Social Workers per 100,000 residents	Marriage and Family Counselors**	# of Marriage & Family Counselors per 100,000 residents
2000	20,945,963	1,422	6.79	14,549	69.46	3,417	16.31
2009	24,782,302	1,634	6.59	16,574	66.88	2,789	11.26

* U.S. Census Data, November 2010, and

Texas Dept. of State Health Services, November 2010



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Troubling Trends (cont.)

- ❖ The current workforce is aging and beginning to retire* ...

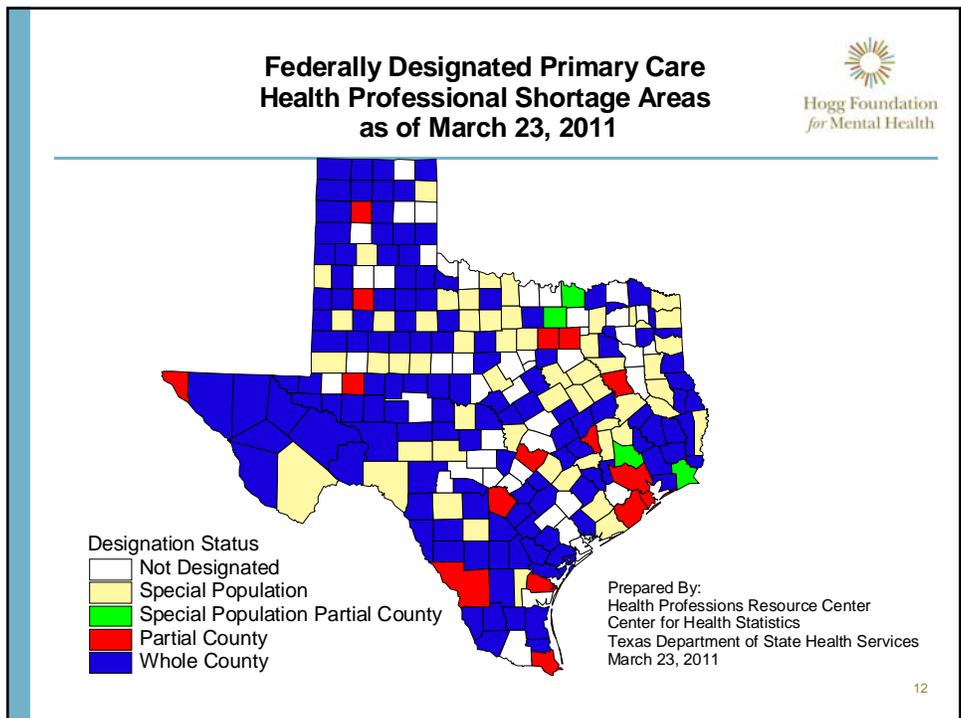
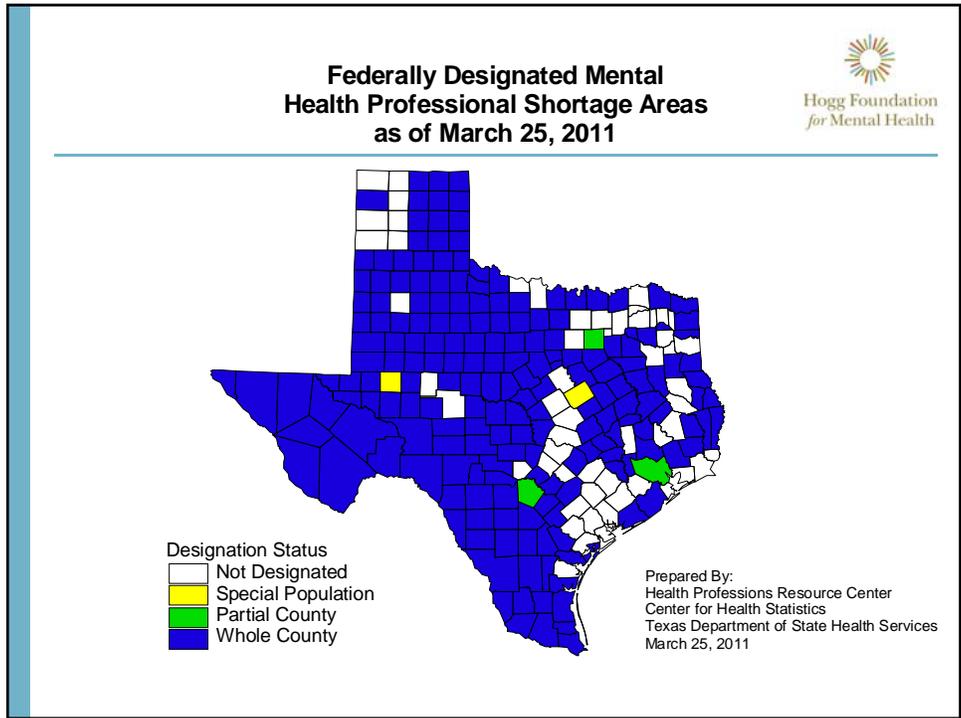
Mental Health Professional	Median Age Male	Median Age Female
Psychiatrists	57	50
Licensed Chemical Dependency Counselors	53	50
Social Workers	54	47

Year	Number of Residents
2005	68
2006	59
2007	53
2008	49
2009	49

... at a time when fewer people are entering the workforce or completing their professional training in Texas.**

* Statewide Health Coordinating Council, January 2011

** Texas Medical Association, December 2010



Contributing Factors:



- ❖ Separation of physical and behavioral health care systems:
 - Evolution over time into two separate health care systems
 - Deadly results for people with mental illness and for people with physical conditions
- ❖ Lack of cultural and linguistic diversity in the workforce:
 - Growing diversity in Texas increases need for services that are culturally and linguistically sensitive to those being served
 - Need for a workforce that is cultural and linguistically competent and that represents the diversity of Texas
- ❖ Inadequate pay and reimbursement rates (especially as it relates to Medicaid)

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Contributing Factors:



- ❖ Lack of professional training opportunities in Texas:
 - Shortages in training programs cause graduates to go to other states
 - Lack of professional internships in a variety of behavioral health fields: psychiatry, psychology, nursing, counseling, etc.
 - Scarcity of graduate-level training programs and paid internships
- ❖ Recruitment and retention challenges in many behavioral health professions:
 - Stigma linked to mental illness
 - Students' perceptions of behavioral health as a career path
 - Professional burnout rates
- ❖ Tremendous population growth

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Integrated Health Care



❖ **Integrated Health Care (IHC):** the systematic coordination of physical and behavioral health care.

- Simply increasing the numbers of PCPs and MH/SU providers is not enough. Competencies, skills and geographic location are essential components.
- Social Determinants of Health: unemployment, poverty, inadequate insurance, transportation, health literacy, etc.
- People with chronic physical illness are more likely to have mental health conditions that interfere with self-care.
- Stigma of mental illnesses resulting in marginalization and discrimination can be addressed.
- Integrating physical and behavioral health care improves outcomes for people with behavioral and physical conditions.



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Levels of Integration Within Practice Models



- ❖ **Minimal Collaboration:** mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically.
- ❖ **Basic Collaboration at a Distance:** separate systems at separate sites; periodic communication about shared patients, typically by telephone or letter.
- ❖ **Basic Collaboration On-site:** separate systems, but shared facility; more communication, but each provider remains in his/her own professional culture.
- ❖ **Close Collaboration in a Partly Integrated System:** providers share the same facility and have some systems in common (scheduling appointments, medical records); regular face-to-face communication; sense of being part of a team.
- ❖ **Close Collaboration in a Fully Integrated System:** providers are part of the same team and system; the patient experiences mental health treatment as part of their regular primary care or vice versa.

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Example #1: Primary Care Behavioral Health Practice Model



- ❖ The behavioral health clinician is part of the primary care team, not part of specialty mental health.
- ❖ PCP is the principal “provider” with the behavioral health clinician temporarily co-managing when a referral is made. Key features include “warm handoffs” and “curbside” consultations.
- ❖ Hallmark of this model is its focus on an epidemiological, public health view of service delivery. Service delivery consists of multiple formats: patient education, case management, telephone monitoring, and skill coaching.
- ❖ Emphasis is on brief, focused interventions. Goal of the brief intervention is to educate patients about their condition and to discuss different types of self-management strategies.
- ❖ Knowledge and skills to implement validated screening tools, motivational interviewing, self-management, focused brief interventions/therapy, consultations, chronic disease models, clinical algorithms, disease management processes, medications, substance abuse screenings and interventions, recovery models and cultural competencies are needed.

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Example #2: Collaborative System of Care Practice Model



- ❖ This model is geared to serve those patients with high mental health needs and those who require more specialized mental health services than primary care can realistically offer.
- ❖ This model seeks to develop individualized plans of care for high-risk patients across multiple service agencies such as housing, education, employment, justice, and welfare organizations.
- ❖ This model may be partly or fully integrated depending on degree of collaboration.

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Case Example: The IMPACT Study



- ❖ 1998 – 2003
- ❖ 1,801 depressed adults in primary care
- ❖ 18 primary care clinics
- ❖ 8 health care organizations in 5 states
 - Diverse health care systems (FFS, HMO, VA)
 - 450 primary care providers
 - Urban and semi-rural settings



❖ Funding

- John A. Hartford Foundation, California HealthCare Foundation, Robert Wood Johnson Foundation, Hogg Foundation for Mental Health

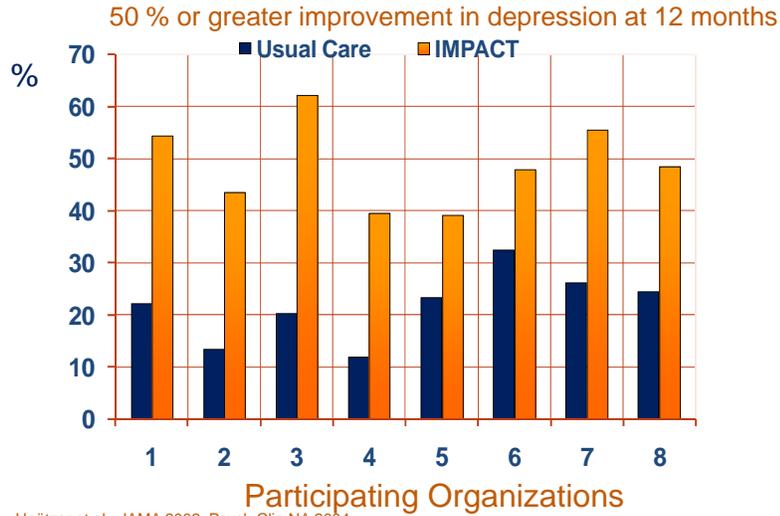
IMPACT Study Methods



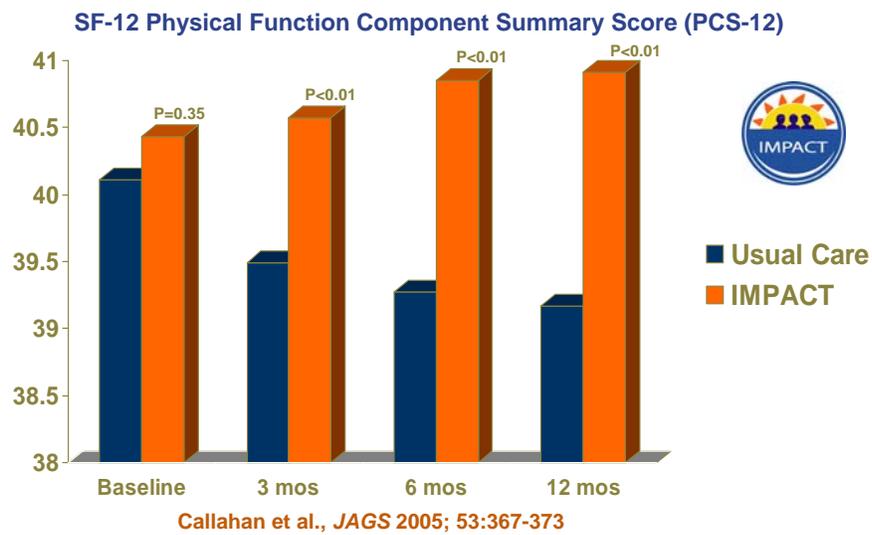
- ❖ Design: Randomized control trial
- ❖ 1,801 older adults with major depression and / or dysthymia randomly assigned to IMPACT or Care as Usual
- ❖ Usual Care: Primary care or referral to specialty mental health as available (70% Rx, 20 % MH referral)
- ❖ IMPACT Care: Collaborative care program for depression in primary care offered for up to 12 months
- ❖ Analyses: Independent blind assessments of health outcomes and costs for 24 months.

Unützer et al, *Med Care* 2001; 39(8):785-99

IMPACT doubles effectiveness of care for depression



IMPACT improves physical function



■ Usual Care
■ IMPACT

IMPACT reduces health care costs

ROI: \$ 6.5 saved / \$ 1 invested



Cost Category	4-year costs in \$	Intervention group cost in \$	Usual care group cost in \$	Difference in \$
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	31,082	29,422	32,785	-\$3363

Savings



Unützer et al., *Am J Managed Care* 2008.



Replication studies show the model is 'robust'



Patient Population (Study Name)	Target Clinical Conditions	Reference
Adult primary care patients (Pathways)	Diabetes and depression	Katon et al., 2004
Adult patients in safety net clinics (Project Dulce; Latinos)	Diabetes and depression	Gilmer et al., 2008
Adult patients in safety net clinics (Latino patients)	Diabetes and depression	Ell et al., 2010
Public sector oncology clinic (Latino patients)	Cancer and depression	Dwight-Johnson et al., 2005 Ell et al., 2008
Health Maintenance Organization	Depression in primary care	Grypma et al., 2006
Adolescents in primary care	Adolescent depression	Richardson et al., 2009
Older adults	Arthritis and depression	Unützer et al., 2008
Acute coronary syndrome patients (COPEs)	Coronary events and depression	Davidson et al., 2010

Key Components of Effective IHC Models



- ❖ Team Approach
 - Real team collaboration: not co-location
 - Team building and implementation support
 - Provider training and ongoing support
- ❖ Population-focused
 - Registry to make sure patients don't fall through the cracks
- ❖ Stepped Care
 - Individual and caseload summaries facilitate measurement-based practice/ treatment to target
- ❖ Care management functions
 - Structured templates facilitate efficient / effective clinical encounters
- ❖ Outcomes-based Feedback and Quality Improvement
 - Example: Pay-for-performance program where 25 % of payment depends on meeting quality indicators

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Cultural and Linguistic Competency in IHC



- ❖ The increasing racial, ethnic and linguistic diversity of Texas makes cultural and linguistic competency an ethical imperative
- ❖ Professional biases and stereotypes: “cultural” differences between primary care and behavioral health: time, training, interest
- ❖ CLC skills are as important as diagnostic skills



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Clinical Implications of Culture



- ❖ Provides a proper understanding of human beings.
- ❖ Provides guidelines for judgment of normative behavior.
 - The act of diagnosis is an interpretation of the meaning of a cluster of behaviors according to a cultural norm.
- ❖ Enhances diagnosis and treatment.
 - Guides the clinician to choose the right questions to ask, to interpret the responses, and to lay out a therapeutic plan.
- ❖ Understanding of the **context** of the illness experience is essential in making clinical judgments.
 - Culture provides the essential **context** for such critical analysis.
- ❖ Enriches medical knowledge.

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<http://hogg.utexas.edu/uploads/documents/FinalReport%20-ConsensusStatementsRecommendations.pdf>



Enhancing the Delivery of Health Care:
Eliminating Health Disparities through
a Culturally & Linguistically Centered
Integrated Health Care Approach

Consensus Statements and Recommendations

June 2012

U.S. Department of Health and Human Services
Office of Minority Health and
Hogg Foundation for Mental Health



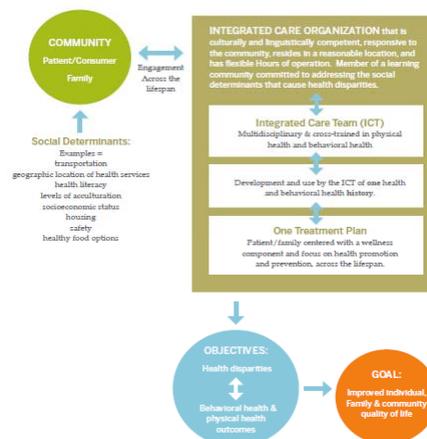
Enhancing the Delivery of Health Care: Eliminating Health Disparities through a Culturally & Linguistically Centered Integrated Health Care Approach



1. Integrated care organizations and teams will be culturally and linguistically competent and responsive to the needs of the communities they serve, including being located in reasonably accessible areas and providing flexible hours of service.
2. Integrated care teams will actively engage with patients/consumers, their family members, and their community across the lifespan. The team must be multidisciplinary and cross-trained in health and behavioral health, thereby leveraging the strengths of the team.
3. Integrated care teams will recognize and incorporate the strengths of patients/consumers, their family members and their cultures, permeating all levels of assessment, diagnosis and intervention.
4. Integrated care organizations will ensure one health and behavioral health history and treatment plan for each patient/consumer, under one roof, with a wellness component and a focus on health promotion, prevention and person-centeredness across the life-span.
5. Integrated care organizations will participate as a member of a learning community in which health and behavioral health professionals gain knowledge, develop data collection plans, and foster the growth of an ethical workforce that represents the diversity of the community with language and cultural competency.

Appendix A: Framework for the Integration of Behavioral Health and Primary Care Services for Racial and Ethnic Minority Populations and Those with Limited English Proficiency

Cultural & Linguistic Scope of Influence



Synergistic Adaptations



- ❖ **Certified Peer Specialists:** individuals in recovery who have received specialized training to use their experience to help others experiencing mental illness work toward their own recovery.
 - Peer Specialists in Texas are trained and certified through Via Hope. A project jointly funded by the DSHS and the Hogg Foundation for Mental Health.
 - The peer specialist certification process includes intensive training, a certification exam, and continuing education requirements.

Synergistic Adaptations



- ❖ **Telemental Health (TMH):** the provision of mental health care from a distance.
 - Includes mental health assessments, treatment, education, monitoring, and collaboration.
 - Locations can include hospitals, clinics, schools, nursing facilities, prisons, and homes.
 - TMH providers and staff can include psychiatrists, nurse practitioners, physician assistants, social workers, pharmacists, psychologists, counselors, PCPs, and nurses.

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Synergistic Adaptations



- ❖ **Consumer Directed Services:** part of a philosophy and an orientation to a service delivery option where individuals direct their own care, identify the services they need, select who will provide their services, and individualize their service plans.
 - Through this service delivery model, consumers are able to identify beneficial services outside of the standard mental health workforce.
 - It has been a successful service delivery option in the Department of Aging and Disability Services for a number of years.

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Mortality and Access to Care among Adults after State Medicaid Expansions



❖ Methods

- We compared three states that substantially expanded adult Medicaid eligibility since 2000 (**New York, Maine, and Arizona**) with neighboring states without expansions. The sample consisted of adults between the ages of 20 and 64 years who were observed 5 years before and after the expansions, from 1997 through 2007. The primary outcome was all-cause county-level mortality among 68,012 year- and county-specific observations in the Compressed Mortality File of the Centers for Disease Control and Prevention. Secondary outcomes were rates of insurance coverage, delayed care because of costs, and self-reported health among 169,124 persons in the Current Population Survey and 192,148 persons in the Behavioral Risk Factor Surveillance System.

❖ Results

- **Medicaid expansions were associated with a significant reduction in adjusted all-cause mortality** (by 19.6 deaths per 100,000 adults, for a relative reduction of 6.1%; $P = 0.001$). **Mortality reductions were greatest among older adults, nonwhites, and residents of poorer counties.** Expansions increased Medicaid coverage (by 2.2 percentage points, for a relative increase of 24.7%; $P = 0.01$), decreased rates of uninsurance (by 3.2 percentage points, for a relative reduction of 14.7%; $P < 0.001$), decreased rates of delayed care because of costs (by 2.9 percentage points, for a relative reduction of 21.3%; $P = 0.002$), and increased rates of self-reported health status of "excellent" or "very good" (by 2.2 percentage points, for a relative increase of 3.4%; $P = 0.04$).

❖ Conclusions

- **State Medicaid expansions to cover low-income adults were significantly associated with reduced mortality as well as improved coverage, access to care, and self-reported health.**

Sommers et al. NEJM, July 2012

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Recommendations



1. Promote integrated health care by addressing barriers and providing Medicaid reimbursement for a variety of service delivery models.
2. Expand the use and certification of peer support specialists.
3. Develop opportunities for Telemental Health and Telemedicine.
4. Expand the types of mental health services that are reimbursable and the types of professionals who can provide them.
5. Provide adequate reimbursement rates to increase acceptance of Medicaid patients.
6. Expand graduate education programs.
7. Require professional licensing boards to collect data to help identify cultural and linguistic workforce shortages.
8. Develop a learning community within each RHP.

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Recovery and Wellness for All of Texas: The Intended Outcome



- ❖ Recovery is a process of regaining physical, spiritual, mental and emotional balance.
- ❖ It is a process of healing and restoring health.
- ❖ With the appropriate infrastructure, physical health services, behavioral health services, and philosophy, the mental health of Texas can recover.



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