Bountiful Opportunities: Understanding and Leveraging Behavioral Health Leadership

Josh Bradley, Psy.D., Tri-Area Community Health

Marcy Rosenbaum, L.C.S.W., SW Virginia Community Health Systems

James Werth, Jr., Ph.D., Tri-Area Community Health

Rationale for Topic

- Repeated themes in monthly Behavioral Health Director peer group meetings
  - Integration of Primary Care and Behavioral Health is misunderstood
  - Underutilized for patient and organization goals
  - Services undervalued
  - Lack of autonomy in decision making
- Peer group clearly recognized missed opportunities and significant discrepancies between Director experiences at different organizations
- Pandemic, impact of political tension and intersection of both resulting in stress on patients and families led to increased need for behavioral health services
- Behavioral health leadership often did not have space for their voice or use of their knowledge and skills

Outline

I. Primary Care Behavioral Health Integration: An Overview

- Why integrated behavioral health for FQHC's
- Brief overview of levels and models of integration
- Growth in need and funding
- Financial/UDS benefits of integrated behavioral health and case management
- Case example

II. Behavioral Health Leadership Opportunities

- Behavioral health leadership strengths
- Organization training and education opportunities
- Behavioral health leadership and initiatives
- Virginia FQHC Behavioral Health Director survey
- Qualitative data on impact of behavioral health in primary care

III. The Landscape for Behavioral Health Leadership in Virginia: A CEO's Perspective

- CEO perspective of opportunities
- CEO perspective of steps to leverage behavioral health leadership

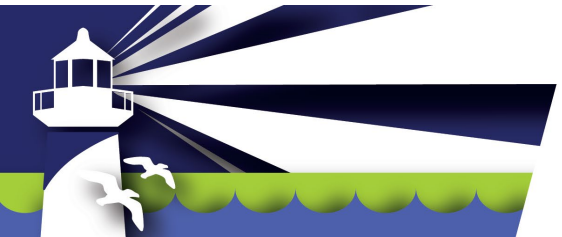
Learning Objectives

- Participants will be able to identify two different models of integrated primary care
- Participants will be able to identify at least two ways that Behavioral Health Director skillsets can be leveraged to strengthen the center's leadership team
- Participants will be able to identify at least three opportunities for Behavioral Health Directors/teams to enhance staff engagement and skills

What and Why of BH Services in an FQHC

What is Integrated Behavioral Health (BH) services?

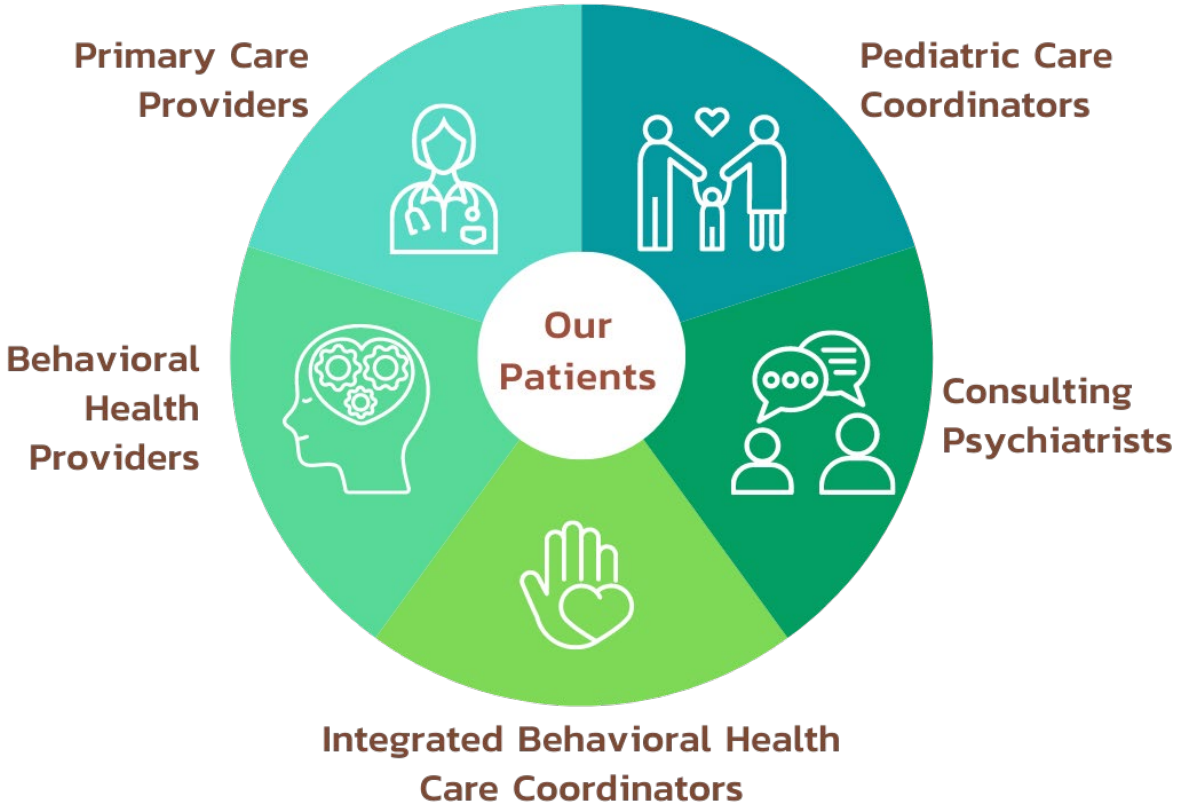
Why would you want to integrate BH services?



What people think BH in FQHC is

"Ever since I signed up for Twitter, I get the feeling that people are following me!"

What BH in an FQHC really is



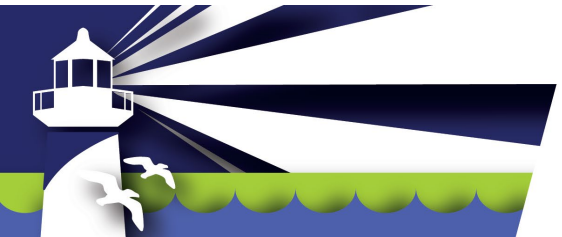
What is Integrated Behavioral Health (BH) services?

Behavioral Health is “an umbrella term for any behavioral problems bearing on health, including mental health, substance abuse, stress-linked physical symptoms, patient activation, and health behaviors” (Peek &National Integration Academy Council, 2013)

Integrated Behavioral Health blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being. Integrated behavioral health care, a part of “whole-person care,” is a rapidly emerging shift in the practice of high-quality health care. (Agency for Healthcare Research and Quality, 2023)

Not Your Traditional Behavioral Health Services

Traditional BH Services	Integrated BH
• At mental health clinic • Tx goals for BH issue • Refer to PCP • Individual focus • Approx. 50min. session • Minimal communication with PCP • Single service offered	• At PCP office • Tx goals for whole person • BH serves patients of the PCP office • Population focus • Approx. 20-50min. Sessions • Continuous communication between PCP and BH provider • Array of BH services: exam room consult, outpatient counseling, psychiatric med. management, care management, population management



Levels of Integration

Coordinated

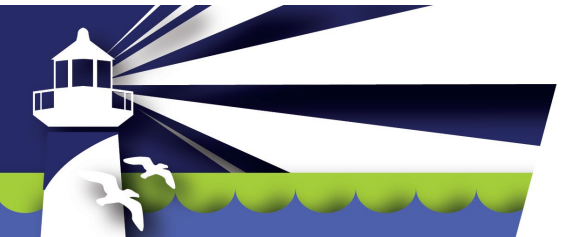
- Screen and refer to each other
- Basic collaboration at separate locations
- Separate systems

Co-located

- Meet occasionally to discuss pt
- Basic collaboration at same site
- Some system integration

Integrated

- In same space and facility
- Collaborate consistently as a team
- Shared goals & treatment plans
- Shared system (EHR, check-in, billing)

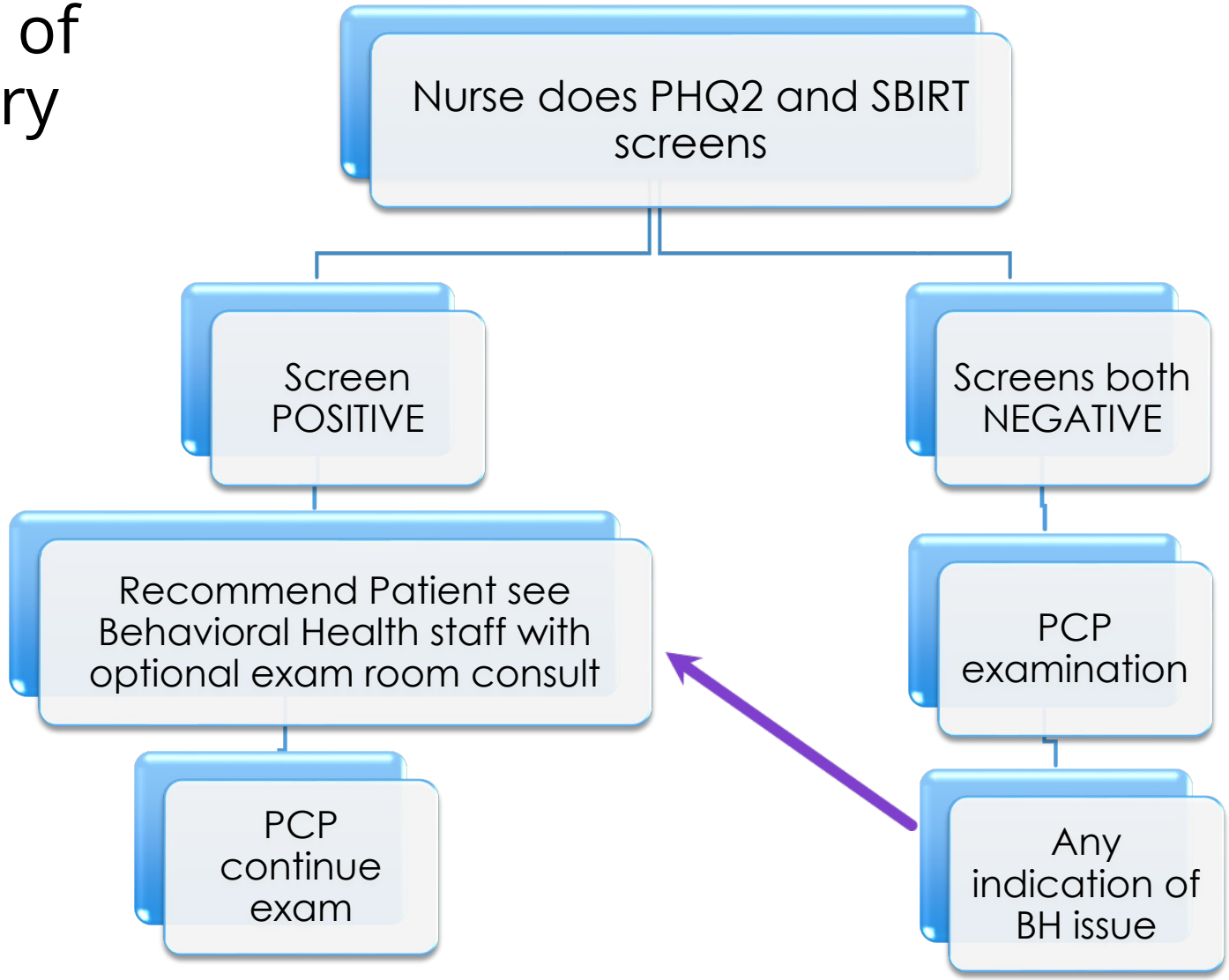


Models of Integrated Care

Primary Care Behavioral Health (PCBH)	Collaborative Care Model (CoCM)	Hybrid Model

• Co-located Behavioral Health Consultant (usually licensed)
• Warm handoff in exam room to BH specialist
• Brief interventions
• Tx duration 6 sessions or less
• Refer out for specialty, long term BH services
	• Co-located and integrated BH care manager
	• Team based chronic care delivery for improved outcomes
	• Decision support to PCP on complex BH needs
	• Psychiatric consult/medication services
	• Licensed BH provider for outpatient counseling
	• Tx duration 3-12 months
		• Includes parts of PCBH and CoCM
		• Rationale for use by most FQHCs:
		  • Exam room consults improve tx adherence and screens for BH need
		  • Limited community resources
		  • CSBs providing less individual outpatient counseling
		  • Access
		  • Better outcomes

Patient Flow Example of BH Services at Primary Care Sites



Why have fully integrated BH?

Improved clinical outcomes

- Proved by so many research studies that it has become a fact instead of a theory

Increased funding from HRSA, SAMHSA, and others for BH services

- 2021 HRSA award nearly $66 million to bolster BH workforce
- 2022 HRSA to award $13 million to increase rural BH care access
- 2023 HRSA announced nearly $9 Million to increase SUD Clinicians
- 2024 SAMHSA forecasts almost 2 million for PCBH integration training

Why have fully integrated BH? cont.

Increased need for BH services

- Since COVID pandemic hit, there is increased anxiety and depression in all ages, deaths due to drug or alcohol overdose, and suicide rates according to the Kaiser Family Foundation (KFF)
- KFF also reports the BH negative outcomes are disproportionately higher in communities of color and youth
- CDC shows adults receiving BH services was 19.2% in 2019, 20.3% in 2020 and then 21.6% in 2021
- RAND Corporation shows private insurance spending $2.3 million per 10,000 beneficiaries per month pre-pandemic and $3.5 million post pandemic

Why have fully integrated BH? cont.

Financial/UDS benefits of integrated BH and Care Management

- Improve medical providers' job satisfaction which improves job performance and retention
- UDS measures help continue HRSA funding
- BH helps improve clinical outcomes of the UDS measures for both depression screening and remission as well as the chronic care conditions
- Having BH services is an important component of many potential grant applications
- BH Care management can
  - decrease no-show rate by engaging patients
  - Review BH quality improvement care gaps and follow-up with patients such as positive phq9 scores
  - Care managers can assist with BH screenings in the exam room and referral to internal or external resources that improve UDS measures
  - Screen and follow-up with required social determinants of health assessments leaving nursing more time to address physical concerns

Patient Examples of Integrated BH

- Patient with panic attacks during dialysis
- Anxious and manic patient results in Hyperthyroidism dx
- Patient with K2 paranoid delusions: Tx antipsychotic and BH monitoring
- ER with heart attack symptoms vs panic attack
- Family fight in the exam room
- Psych hospital discharge to FQHC PCP

Behavioral Health Leadership Strengths

- Strong sense of meaning in work
  - Passion and drive if understood, valued and given autonomy
- Interpersonal skills
  - Observational skills
  - Listening skills
  - Communication skills
  - Emotional stability
  - Compassion
- Awareness of morale/pulse of the clinic
  - Message framing
- Problem-solving
- Education/research
  - Often more comfortable with public speaking/presentations

Training Opportunities

- Formal and Informal
- Provided and facilitated
- Diversity trainings

Clinical

- Treatment of variety of presenting concerns (behavioral health provider)
- Psychopharmacology for variety of presenting concerns (psychiatric provider)
  - Often pair BH and Pharm treatments in same presentation
- Assessment and treatment of Medically Unexplained Symptoms
- Process/Procedures

All Staff

- Self-Disclosure Considerations in Community Health
- Adverse Childhood Experiences in Primary Care
- Self-Compassion for Healthcare Staff
- Working with Difficult Patients
- Medically Unexplained Symptoms (basic)
- Behavioral Change
- Workplace Violence
- Stress Management

Leading Initiatives

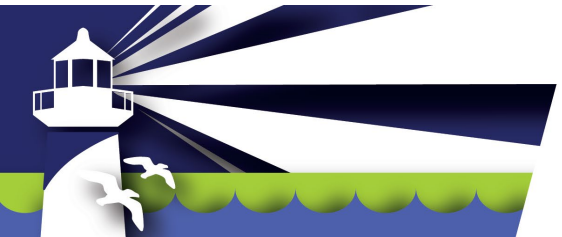
- Programs
  - Medication Assisted Treatment
  - Action Teams
    - Accountability
- Community and staff impact
  - Suicide Prevention Month
  - Technology and Health Month
  - Mental Health Month
  - Recovery Month

Survey and Implications

- Twelve participants who are in Behavioral health or psychiatric leadership positions at FQHC's in Virginia
  - Two organizations have split BH leadership positions so ten FQHC's represented
- License type-
  - Licensed Clinical Social Workers - 6
  - Licensed Professional Counselors - 3
  - Licensed Clinical Psychologist - 1
  - Psychiatric Mental Health Nurse Practitioner - 1
  - Medical Doctor – Psychiatrist - 1

Responsibilities

- Oversight
  - Outpatient psychotherapy/counseling - 10
  - Integrated behavioral healthcare services - 10
  - Behavioral health case management - 8
  - Psychiatry - 6
  - Substance use disorder treatment services - 6
  - Other response
    - Non-behavioral health case management - 1

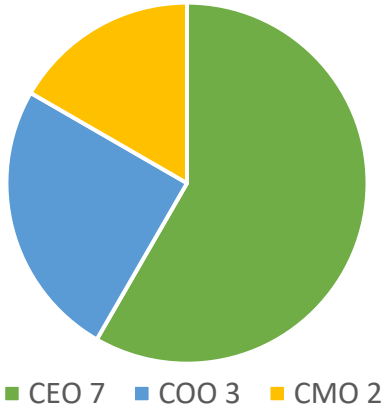


Leadership Involvement

- All participants indicated that their organization had a leadership team that was well defined
- Six participants indicated they were part of the leadership team
- One participant indicated he/she was not part of the leadership team
- Five other responses
  - Yes, but not necessarily at the highest level
  - Part of executive operations team but not highest level of leadership
  - Sometimes
  - I am considered “extended” management team
  - Varies depending on organization needs being addressed

Oversight of Behavioral Health Director

- Seven participants indicated reporting to the CEO
- Three participants report to the COO
- Two participants report to the CMO/Medical Director



Leadership Team Engagement

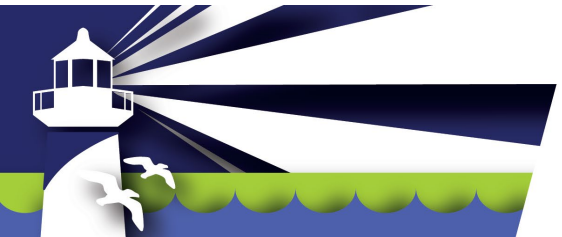
- Frequency of contact/meetings
  - Eight participants (67%) indicated that their leadership team met 1-2 times a month
  - Two participants (17%) indicated they were not sure how often the leadership team met
  - One participant (8%) indicated they did not meet monthly
  - One participant (8%) indicated they met more than 5 times per month
- Perceived level of leadership team understanding of services the BH team provides
  - Very clear - 33%
  - Somewhat - 50%
  - Not so clear - 17%
  - Extremely clear and not at all- none
- Perceived level of understanding ethical differences between BH and medical providers
  - Very clear - 8%
  - Somewhat - 50%
  - Not so clear - 42%
  - Extremely clear and not at all - none

Administrative Time

- Average percentage of time dedicated to administrative/program management versus what Behavioral Health Directors believed was needed
  - 33% (actual) versus 60% (need)

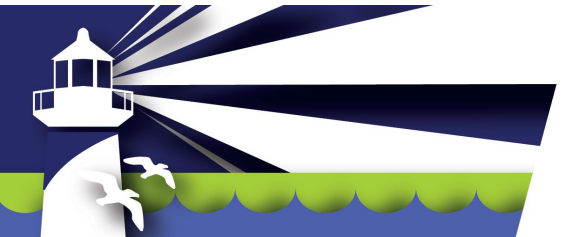
Value of Behavioral Health Leadership Skills

- Perception of CEO valuing of skillset
  - Extremely valuable - 17%
  - Very valuable - 25%
  - Somewhat valuable - 58%
- Perception of leadership team valuing of skillset
  - Extremely valuable - 8%
  - Very valuable - 25%
  - Somewhat - 67%
  - Not so valuable and not at all - none



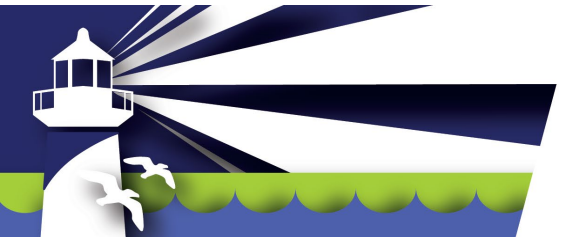
Use of Behavioral Health Leadership Skills

- Perceptions of CEO utilization of skillset
  - Usually utilized - 33%
  - Sometimes - 58%
  - Rarely - 8%
  - Always and Never - none
- Perceptions of leadership team utilization of skillset
  - Usually utilized - 42%
  - Sometimes - 58%
  - Always, never, and rarely - none
- Participation in organization-wide strategic planning process
  - Yes - 75%
  - No - 25%



Opportunities for Leadership Team use of BH Leadership Skillset

- Qualitative responses provided by 8 of 12 participants
- Themes
  - Education/training of staff - 6 of 8
    - Included presentation skill training, coaching staff and interpersonal management/emotional regulation skill teaching
  - Representation on upper leadership team - 4 of 8
  - Involvement in strategic planning - 4 of 8
  - Involvement in policy development - 3 of 8
  - Involvement in grant funding/budgeting - 2 of 8
  - Other themes with one endorsement included hiring/salaries and increased independence to do job hired for

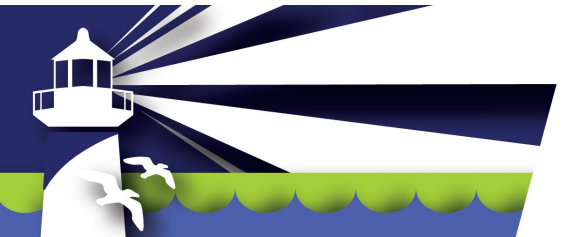


Qualitative Patient Data on Integrated Behavioral Health

- Benefits of receiving BH and medical at same place
  - *The feeling of having a team of professionals helping/treating the "whole" me*
  - *I can get counseling, flu shot, or minor illness or injury taken care of at the same visit*
  - *The doctors communicate with each other about concerns they have and work with each other on my behalf to make improvements when needed*
- What would you tell someone who is feeling hesitant to meet with a behavioral health provider
  - *Try it, after an initial visit you will likely see how life changing it can be. If you don't you have only lost a small bit of time*
  - *Give it a chance. You have nothing to lose and a lot to gain*

Summary

- Directors and BH Teams have been through a lot
  - Pandemic in medical settings
    - Navigating differences of opinion about safety measures, remote working, and increased turnover
    - Managing post-pandemic BH increase
      - Behavioral health workforce shortage
  - Political tension and being an advocate for those who are vulnerable
- Many are not thriving
  - Check in and support your BH Directors and staff



CEO Perspective of Opportunities

- My Experience
  - Licensed Clinical Psychologist for almost 30 years
  - Therapist in general practice and with people with chronic and terminal illnesses for abut 20 years
  - University Professor and Doctoral Program Training Director at Radford University for about 6 years
  - Behavioral Health and Wellness Services Director at Stone Mountain Health Services for about 6 years
  - CEO at Tri-Area Community Health for just over 4 years
- My Perspective
  - A CEO and a Leadership Team is missing out on opportunities if they are not fully utilizing their Behavioral Health Director and team
  - Would you not include your Medical Director on your Leadership Team?

CEO Perspective of Steps to Leverage Behavioral Health Leadership

- Do not make assumptions about what your BH Director brings to you and your team in terms of experience, perspectives, connections,…
- Assess your own gaps in knowledge / needs for perspective or information
- Assess your Leadership Team's functioning and whether someone skilled at interpersonal communication, group dynamics, reframing, opportunity-seeing, and team-building could be helpful
- Review what you are missing if you don't have an entire service line represented in your meetings and decision-making
- Determine if you want someone who is growth-focused at your side

QUESTIONS?

References

- Agency for Healthcare Research and Quality (n.d.). *What is Integrated Behavioral Health?* The Academy: Integrating Behavioral Health & Primary Care. Retrieved September 19, 2023, from https://integrationacademy.ahrq.gov/about/integrated-behavioral-health
- Peek, C. J., & the National Integration Academy Council. (2013). Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. Rockville, MD: Agency for Healthcare Research and Quality.
- Selby-Nelson, E. M., Bradley, J.M., Schiefer, R. A., & Hoover-Thompson, A. (2018). Primary care integration in rural areas: A community focused approach. *Family, Systems, and Health, 36 (4),* 528-534.