Pilot Study: An Assessment of Primary Care Provider Equity in Nonprofit Behavioral Health Service Organizations

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RESEARCH

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ABSTRACT

It is commonly known that persons with behavioral health disorders die years earlier than the general population and further understood that the separation of behavioral health and primary care services, particularly in The United States, significantly contributes to this Inequity. Nonprofit providers are often the service delivery system that is on the frontline of this public health crisis. Although researchers and policymakers alike agree on the need for this improvement in the standard of care, change in the provision of services continues to be unequal within the community based, nonprofit behavioral health services sector.

The results of this pilot study sought to ascertain where US nonprofit, community-based practices have adopted primary care services and what impedes implementation. Using a convenience survey distributed through the National Council for Behavioral Health, (NCBH) a Washington, D.C. based, 501 (c) (3) trade association, we began to look at what service delivery barriers may still exist.

Unequal public funding and the competing high costs of employing primary care physicians should lessen state regulatory restrictions in order to allow for alternate medically trained professionals to serve as primary care service providers nationwide. This strategy may mitigate inequities within the service delivery system, and address public health policies allowing community-based organizations to adopt a more patient-centered, cost-effective, model of care coordination, intended on improving the health of the population they serve.

Keywords: behavioral health, delivery of health care equity, integrated, mental health, nurse practitioners, physician assistants, primary health care integration, workforce training; nonprofit, community-based care.

INTRODUCTION

Dating back almost 20 years, the Surgeon General Report declared that vastly poor health outcomes for persons suffering from mental health and substance abuse disorders were a public health crisis. The result is lives filled with long term disability and early mortality caused, in part, due to service fragmentation within the U.S. health care system [1]. At the same time, there were estimates that 10% or more of the U.S. adult population was using mental health services during the course of any given year, making access to comprehensive quality services of this type imperative for the general population [2]. Nowhere in the service system does this problem become more heightened than in the private, nonprofit community. All across the

United States, private, nonprofit organizations carry a significant portion of the population's behavioral health treatment needs. According to the National Mental Health Services Survey (N-MHSS): 2017 which reports Data on Mental Health Treatment Facilities by service setting and facility type estimates that almost 40% or 4,612 of outpatient mental treatment services are provided by this sector [3]. Likewise, providers have been adopting multiple models of integration attempting to meet the broad-based primary care needs while funds are diminishing to the nonprofit sector. Primary care provider shortages, coupled with continued state specific laws restricting the scope of practice for Nurse Practitioners (NP) and Physician Assistants (PA) is a way to increase primary care capacity. Because state laws vary widely in the level of physician oversight required for alternate providers with some states allowing practice independently, others limit authority to diagnose, treat and prescribe medications to patients without supervision [4]. As Kwan states when looking at the integrated behavioral health care processes the structural practice and organizational design of mental health care with a primary infrastructure may not matter as much as long as it enables the provision of certain services, now the intersection of this reality has changed the focus from defining the ideal care models to sustainability through the adoption of the efficient and cost-effective interdisciplinary teams [5].

The juxtaposition of this awareness and service need was well noted as far back as 2006 when the National Association of State Mental Health Program Directors (NASMHPD) technical report which urged state policy leaders to address this need and develop opportunities for providers to unite these highly utilized mental health services with access to quality primary care [6]. Among those in the behavioral health field, these reports have become widely referenced as they convey the changing core principles of care; mental health and primary care integration is a necessary and basic tenets for this population.

In the Bazelon Center for Mental Health Law, "Get It Together" report, rectifying poor health outcomes and restricted health care access, particularly for those living in low income and underserved areas of the country, further underscored that the lack of physical and mental health integration for people with serious mental disorders was a systemic problem. The problem is due to diminished financial incentives for health care providers to coordinate care in the best interests of patients that are in "recovery" from such disorders. They advocated that "in a recovery-oriented mental health system, physical health care is as central to an individual's service plan as housing, job training or education" [7]. Despite the convergence of this schism, we propose that the provision of integrative services continues to be unequal for community-based, nonprofit behavioral health services, in part due to shrinking public funding and the competing high costs of employing primary care physicians.

Continued Challenges for Patients in Separate Settings

The need for integrated medicine continues in the primary care arena as well. Underreporting emotional issues to primary care physicians' estimates are as high as 30% [8]. This furthers the idea that general medical practices typically manage multiple patient symptoms and problems during a brief visit, which according to the AAFP averages 13 minutes [9]. Therefore, detecting and managing mental health problems must compete with other priorities such as treating acute physical illness. Meanwhile, prescriptions such as antidepressants or anti-anxiety medications are written to address psychological complaints as singular interventions, leaving follow-up visits and further treatment recommendations out of the treatment planning process. This method of practice leaves a person suffering from these symptoms that subsequently become undertreated, making for even a less effective intervention.

Moreover, many of the individuals suffering from debilitating mental health or addiction disorders never initiate a primary care referral for several reasons. If patients do elect to seek treatment for mental health or addiction problems through a general medical office, they typically present somatic complaints such as "stress" or "fatigue." Such a complaint sounds less urgent than other

types of physical matters, thus the patient leaves the doctor's office without an established psychiatric diagnosis. Masking problems with physical symptoms while leaving the underlying mental health problem unaddressed cause the problem to get worse. In addition to these limitations, we have come to know that traditional medicine is challenging for mental health patients because of the social stigmas associated with mental illness. In general, patients are reluctant to seek help this way, as the time needed to explain the nature of their emotional problems and the fear of being labeled "difficult" or "crazy," leads to the avoidance of regular annual check-ups. Subsequently, traditional medical practice is often not conducive to the treatment and management of these types of problems.

Similarly, the psychiatric profession's clinical lens within a traditional behavioral health treatment facility is primarily geared to identify mental health problems. These results in frequent concealments of underlining physical illnesses, leaving the care plan dually inadequate in addressing how these problems are connected. We know that psychiatric professionals are an essential part of the total health care continuum; however, mental health services have not historically been an integral component of general medicine for these and other reasons. Initially through residency training, and later on through continuing professional medical education, all physicians receive the necessary training to manage mental health problems in adults, adolescents, and children. However, they often approach treating these types of problems through referrals to behavioral health specialists. As noted by Dickinson, primary care practice models report considerable difficulties in finding behavioral health clinicians trained in brief, solution-focused interventions, who are adaptable to the pace of primary care, and who understand the broad-based needs to be met in a primary care practice. This furthers the cultural divide between service models [9].

Alternative Models of Care: Primary Care Physicians Shortage and Funding Limitations

Compounding these service delivery limitations is the growing shortage of primary care physicians. In a study conducted by the American Association of Medical Colleges (AAMC), it is projected that by 2030 there will be a shortfall of between 14,800 and 49,300 primary care physicians. This is largely due to three reasons: the growing U.S. population, which by 2030 is expected to grow 11%; the aging of the " Baby Boomers," with the over 65 population expected to grow by 50%; and the shortage of medical residents interested in pursuing a primary care practice over a lucrative career as a specialist. This year alone, the number of U.S. medical school graduates entering the workforce with interest in primary care and with residencies including family medicine, internal medicine primary care categories and pediatrics totaled 2,730 [10]. The shortfall does not even come close to addressing the predicted deficiencies in the primary care provider pool, which are projected to reach 23,640 by the year 2025 [11].

On the contrary, according to the Bureau of Labor Statistics Occupational Outlook Handbook, the projected change in employment for nurse practitioners from 2016 to 2026 is 31%, while the projected growth for physician's assistants is 37%, resulting in an increased supply for both occupations due to signifying higher than average growth rates [11] Combined with this labor force reality is the unequal distribution of funding available to the nonprofit sector for support of integrated service delivery models. We know that the largest portion of resources available to this sector came through the Substance Abuse and Mental Health Services Administration (SAMHSA) 2009-2016 Primary and Behavioral Care Integration (PBHCI) Program grant, which averaged $400,000 per year, per the organization, and was renewable for up to four years [12]. The grant was developed to address community-based service capacity issues, but what remains unclear are the sustainable effects for the service systems' abilities to continue cost-effective primary care models in an era of reduced funding. Consequently, with the limited supply of physicians and existing economic challenges for nonprofit behavioral health providers, we propose a departure from the traditional model of physician-based primary care. We also advocate for the adoption of an industry standard that allows for alternative primary care providers to been given

full regulatory state approval to act as the patient's primary care professional. Historically, community-based nonprofit providers have been contractually obligated to engage a minimum amount of physician services. This has limited alternative solutions to meet patients' primary care needs, especially when other qualified medical providers are often better suited to meet the demands of this population and are much more cost-effective. NP's are licensed in all states and the District of Columbia and practice under the rules and laws of the state in which they are licensed. State boards of nursing regulate nurse practitioners, and each state has its own licensing and certification criteria.

NPs can provide to patients, according to a new qualitative study by the Center for Studying Health System Change (HSC). However, scope-of-practice laws do appear to have a substantial indirect impact because requirements for physician supervision affect practice opportunities for NPs and may influence payer policies for nurse practitioners [13].

National Survey on the Adoption of Integrative Practices

Data Collection Procedures

To ascertain where the nonprofit, community-based adoption of integrative practices currently exists, we requested survey distribution initially through the Alliance, a Connecticut Association for nonprofit organizations, in June 2018, and later that year through the National Council for Behavioral Health (NCBH) a Washington, D.C. based, not for profit 501 (c)(3) association who's mission it is to advance member's ability to deliver integrated health care as 501(c)(3) requirements allow.

This voluntary survey was created using Qualtrics software and sent out to all members of the NCBH consisting of 3,326 members via email in the form of a clickable link. The survey content appeared in a seven-page document consisted of 24 numbered questions. Data collection took place between October 2018 and August 2019. Facilities were contacted with several follow up reminder notices during this time period. The survey consisted of twenty-four questions focused on the demographics of the organization and their progression of primary care integration.

Topics include:

- Facility type, the operation, and primary treatment focus
- Location of services, State and Region within the United States
- Facility treatment services provided (e.g., settings of care; mental health, substance abuse only, co-occurring disorders, continuum of care practices, e.g. supportive housing, emergency services.
- Percentage of patient use of onsite primary care
- Facility operating characteristics (e.g., age groups accepted)
- Facility management characteristics (e.g. licensure, certification)
- Sources of payment and funding including PBHCI grants.

RESULTS

The survey we conducted on The Adoption of Integrative Care into Nonprofit Behavioral Health Organizations originally consisted of 3326 known facilities. Of the total 3326 facilities included in the survey frame, (0.81 percent) 27 responded with complete information. Ineligible facilities included those that did not provide mental health treatment, or substance abuse treatment or provided general health care only, provided treatment only for incarcerated persons in jail or prison, or where an individual or small group mental health practice not licensed or certified as a mental health clinic or center.

In total 27 Nonprofit Behavioral Health Organizations completed the requested surveys. Of the 27 responses, 13 organizations stated that they have progressed to integrate primary care.

There were multiple attempts to collect this data with the use of reminder emails. This survey sampling had several limitations due to the small sample of respondents and the absence of random sampling capabilities.

Considerations and limitations of specific data items are discussed where the data are presented here.

Chart A: presents data on facilities reporting of years as a service organization.

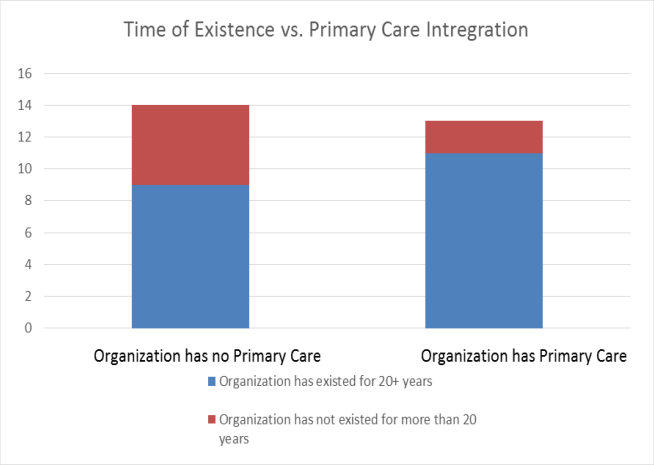
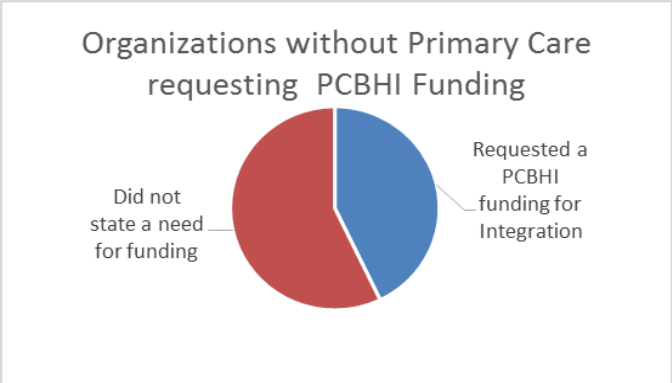


Chart B: Presents data on facilities reporting Organization Request for Future Funding.



Despite a small sample size, our results showed that nearly half (48%) of the organizations that have progressed to integrate primary care and of these 85% have been in existence for 20+ years, making the length of service the most significant finding and major contributing factors towards integration. The figure above shows the relationship between years of service and integration of primary care. Of the organizations that have not integrated primary care, only 64% have existed for more than twenty years. Organizational stability is often a byproduct of longevity particularly in the nonprofit sector. Increasing we know, that larger organizations that depend on state and federal funding over longer periods of time fair better when in need of service improvements because of the longstanding infrastructure that allows for cost-shifting and of centralized savings. This idea that adopting new practices and procedures becomes more likely due to systemic stability with years of service to the community often reinforcing revenue stability and operational efficiencies through the use of larger centralized systems [14].

Of the organizations who reported they have not progressed towards Primary Care Integration, 43% reported that they would need a PCBHI grant to begin this integration. Other reasons for not offering primary care included were lack of space, not in their field of expertise, or the need for someone to lead this project. As previously mentioned, many organizations that integrate primary care services into behavioral health treatment services are challenged with the need to balance costly labor practices with that of overburden, already stretched budgets. Many of these specialized programs struggle with financial deficits which then require those expenses to be offset by other more profitable programs within the organization, making national-level funding initiatives such as the PCBHI grants a necessity to address further expansion for advancing and sustaining integration [15]. Without such an infusion of funding, these long-standing barriers to integration, financial pressures, and lack of federal funding will make every provider wary of further decreases in the pool of patient care revenue. Primary care providers will be cautious about losing potential reimbursements to increased mental health services unless they feel they can benefit from cost savings through the utilization of primary health care. Comparably, the groups that control mental health revenue tend to protect their shrinking pool of dollars rather than face the unknown of collaboration with primary care. These struggles contain the opportunity for a renewed recognition of the interaction between the physical and mental lives of patients, as well as the need for the reintegration of care. This impulse to address the mind-body connection more effectively is probably part of the incentive behind the recent explosion of interest in alternative medicine.

Primary Care Provider (by credential)

When looking at the primary care providers credentials within the organizations that choose to adopt integration models of care, it was noted that 89% of the respondents employed some combination of MD, PA/APRN, and/or RN. This outcome suggests that of those who had already been established in providing these services, broadening the scope of credentialed providers was the mechanism being used to achieve this outcome within the nonprofit community. This supports the utility and implementation recommendations to further broaden the scope of practice requirements within each state's adoption as a viable alternate model of care. Furthering not only a more cost-effective practice but incentivizing the expansion necessary to allow for more advanced diagnostic tools and medical testing to assuage some of the medical needs of this underserved population. Such policy changes will broaden alternate practitioners' scope of practice and improve revenue streams for such systems of care without the burden of expensive contractual physician fees.

LIMITATIONS

The limitations of this study are those associated with a low convenience survey response rate. The results of this pilot study were limited as nonprofit contact names of organizations were ascertained where using public information was available, through websites, the Alliance, GuideStar and The National Council for Behavioral Health listserv distribution.

Despite multiple attempts to collect this data with the use of reminder emails, perhaps improved incentives should be adopted to further this work towards better engagement of nonprofit leaders. Furthermore, with a larger national distribution sample, community response rates could illuminate in what similarities are in inherent to organizations, namely costs savings associated with employing alternative primary care providers by credentials, (Nurse Practitioners, Physicians Assistants).

These and other strategies need to be examined to determine what factors successfully integrated behavioral health and primary care services and should be shared through governance and policy to assist those nonprofits needing primary care services in their communities. Despite this pilot study's lack of generalizability namely though a small sample of provider response rate, relevance of a future national survey could contribute to the literature regarding barriers, and continued disparities between those of integrated health models, and implementation barriers that still exist.

DISCUSSION

As we examine the findings of our convenience survey, we urge that future research be conducted specifically to examine in greater detail how physician shortages combined with reduced funding and unequal regulatory requirements have impacted integrative practices. In doing so, we believe this data may bring to light the current use of alternatives for other medical professionals and further support the idea that augmentation in service delivery models, industry-related expenditures, and gaps in primary care delivery are not evenly distributed across the populations. As advocacy leaders and champions of our mission, we have realized the benefits of primary care integration within our industry, and advocate for the adoption of federal regulatory changes and alternative strategies for medical providers within community-based nonprofit settings [16]. In light of the diminishing physician supply, alternative models of care are not just a good idea but have become more necessary as research shows that primary care access is the key for a healthier, longer life, we know the value and necessity of primary care have grown [17]. Therefore, better health outcomes, fewer disparities and lower costs for all individuals is the route to reducing unnecessary disabilities and premature deaths.

In order to justify wide-scale system changes towards integrated behavioral health care, conclusive and consistent evidence is needed to convince policy and decision-makers of the value of collaborative care compared to the status quo. Such evidence includes a deeper understanding of these alternative models of care for nonprofit providers, and the steps necessary to create

national service system improvement. While the evidence base is fairly well established in some other sectors, in others, it is quite limited [18].

Finally, although research into the results of cost-benefit analyses is likely to provide a strong driving force, it is also important to consider the integration of psychiatry and medicine because this association addresses patients' problems more comprehensively and sensibly. To achieve general wellness, we must address the structure and funding of the health care delivery system, and the lack of capacity for primary care physicians, coupled with the lack of adequate health care coverage [19]. Creating alternative strategies for medical professionals in community-based, nonprofit behavioral health service organizations is a must. Ensuring access to preventive health care and the ongoing integration of medical care is a primary responsibility and mission of mental health authorities. Such a mission suggests the need for establishing a system where people served by the public mental health system have access to appropriate health care and where all care is coordinated.

CONCLUSIONS

Nonprofit, private, community-based behavioral health treatment organizations continue to serve as the backbone of the social safety net for many underserved people. The funding available for the delivery, and provision of primary care services in the era of physician shortages sector needs sustainable business models that ensure cost-effective and efficient service delivery.

Drawing on evidence of the literature so clearly explains while gathering of further evidence, the primary goal is to improve patient health outcomes (e.g., quality care); additional goals may include reducing costs and increasing efficiency (e.g., high-value care) and enhancing patient and provider satisfaction (e.g., the Triple Aim; Berwick, Nolan, & Whittington, 2008) [20].

The status quo in the US healthcare delivery system is that mental and behavioral health concerns are largely addressed by separate and distinct specialty mental health and private care settings (or not addressed at all). Such a system is often described as “fragmented” and difficult for both patients and providers to navigate. Access to comprehensive, quality health care services are important for promoting and maintaining health, preventing and managing diseases, reducing unnecessary disabilities and premature deaths, and achieving health equity for all Americans [21]. Policymakers must focus on particular subgroups who are most at-risk for high costs and poor quality, such as the one proposed in this study, in order to improve the quality of health care and reduce costs. If rectified, community-based organizations could implement more patient-centered, cost-effective care coordination models that both broaden organizational visions and missions to include holistic care. Decades of economic strain for an already inadequately the funded safety net of providers has hastened the need for public policy leaders and researches to support alternative models for quality primary care services for all.

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