Improved Access to and Utilization of Mental Health Care Service by MCH Populations

Unmet mental health and behavioral health needs significantly impact the population. They have life-course and trans-generational impacts on health and well-being; decrease productivity and achievement in school and work settings; increase risks for adverse outcomes; and amplify disparities.

One in five Nebraskans are reported to experience mental illness; a significant number of others also experience behavioral health concerns.[1] The prevalence of mental health disorders among persons with Intellectual or Developmental Disorders range from 15% to 41% depending on the diagnosis.

- Among youth aged 12-17 in Nebraska during 2013-2017 with a major depressive episode in the past year, an average of 30.7% received depression care in the past year[2];
- 10% of children aged 3-11 years received mental health care in the past year;
- 10% Nebraska youth received mental health care in the past 12 months.[3]

From a cross-cutting/systems point of view, unmet mental and behavioral health needs are related to issues of access to and utilization of services. Lack of access and utilization contribute to costs associated with impaired learning and development, leading to increased costs of later, as opposed to earlier interventions. Critical learning periods of development are missed without the early intervention services. Disparities in access and utilization contribute to unequal outcomes in the population in the sectors not only of mental health, but physical health, education, work, social adjustment, and more.

Criterion 1: Disparities Exist Related to Health Outcomes

There is strong evidence of long-standing inequities resulting in documented disparities in outcomes.

Traditional (Physical) Access: Rural areas in Nebraska are *designated health professions shortage areas* for behavioral health. And yet, approximately 40% of Nebraska women of childbearing age reside in rural areas; 43.1% Nebraska children reside in rural areas; and 44% Nebraska youth reside in rural areas.[2] Due to behavioral health professions shortage areas in Nebraska, nearly half the population is without traditional access to care: the ability to see a provider in your town.

Health Literacy: Approximately 40% adults aged 18 and over in Nebraska have difficulties understanding information medical professionals tell them; and approximately 40% adults aged 18 and over in Nebraska have difficulties understanding written health information.[4]

Access and utilization of health care services are limited by English proficiency. According to the 2019 Behavioral Risk Factors for the Limited English Proficient Population in Nebraska[5] there are racial/ethnic disparities in mental health by English proficiency.

Income: Available services, like EPSDT screenings, are not utilized by all populations. Children in low-income households are disproportionately affected by lead poisoning, which is associated with impaired cognitive and

social development in young children. All Medicaid-enrolled children are required to have a lead test at ages 1 and 2.[6] Older children up to age 6 should receive a test if there is no record of a previous screening test. However, in 2018:

- 7% of Medicaid-eligible infants received no screening
- Only 0.7% of Medicaid-eligible infants received blood lead screening
- 48% of Medicaid-eligible children aged 1-9 years received no screening
- 67% of Medicaid-eligible youth aged 10-18 years received no screening.[2]

Criterion 2: Data Exists to Document the Problem

Quantitative, high quality and generalizable data document the problem.

Some data in this issue brief are from U.S. Census Bureau, specifically the Current Population Survey (CPS) and the American Community Survey (ACS). The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The survey has been conducted for more than 50 years and is the primary source of information on the labor force characteristics of the U.S. population. The sample is scientifically selected to represent the civilian non-institutional population.

Nebraska Medicaid data are derived from the annual EPSDT (Early Periodic Screening Diagnosis, and Treatment) Participation Report, Form CMS-416. EPSDT is the child health component of Medicaid. Required in every state, it is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. Participation in EPSDT is constricted by the availability of providers willing to accept Medicaid clients.

The Behavioral Health Barometer provides a snapshot of behavioral health in Nebraska. The report presents a set of substance use and mental health indicators as measured through the National Survey on Drug Use and Health (NSDUH) and the National Survey of Substance Abuse Treatment Services (N-SSATS), sponsored by SAMHSA. This array of indicators provides a unique overview of the nation's behavioral health at a point in time as well as a mechanism for tracking changes over time.

Criterion 3: Alignment, use the priority to maximum advantage

The issue has been identified as a priority by others and there are opportunities to align efforts.

Nebraska Medicaid estimates that 80,000-90,000 individuals will become eligible for Medicaid under voter-approved Medicaid Expansion, to be called Heritage Health Adults. This represents a significant new avenue to access behavioral health care for those individuals who need services, but also a strain on the current provider network of Nebraska requiring action to be taken on expanding the provider network.

According to the Nebraska Association of Local Public Health Directors (LPHD) Cross-walk of Community Health Improvement Plans (2019):

- 15 LPHDs identify Mental Health as a priority; and
- 8 LPHDs identify Access to Care as priority.

Improved access to and utilization of mental health care is the focus of Nebraska's federally-funded Pediatric Mental Health Care Access grant, for which Nebraska Title V serves as the lead entity.

Schools and educational systems are very motivated to improve pediatric mental health care access, recognizing increasing incidence and

severity of mental health issues leading to school violence and bullying. Decreasing "missed opportunities to screen" is an opportunity to improve the quality of screening used by school districts. Use of standardized and normed instruments varies by school district. This contributes to lack of access and connection to services.

Criterion 4: Strategies Exist to Address the Problem/An Effective Intervention is Available

Evidence-based and evidence-informed cross-cutting and systems-building strategies are available. The following strategies are effective in improving population health through health systems and health providers:

Workforce Development: Focus on Primary Care Providers (PCP) as a critical point of access for children and families with mental and behavioral health issues. ***These can improve:***

- Health literacy practices;
- Family-centered medical home and integrated care practices;
- Screening for mental and behavioral health issues;
- Adoption of telehealth for provider-expert consultations; and
- Primary Care Provider (PCP) confidence in the usefulness of making behavioral health referrals.

The **Community Health Worker (CHW) workforce** has been identified as increasing the effectiveness of interdisciplinary teams in addressing communities' health and social needs. Nebraska's CHWs readily identified key societal, environmental and institutional barriers in their communities:

- Lack of or insufficient health insurance
- Need for health education
- Lack of health literacy
- Lack of prenatal care
- Provider shortages
- Lack of affordable child care
- Language barriers
- Transportation needs
- Need for medical interpreters
- Access to and knowledge of contraception.
- Mental health issues.[7]

Strategies to address these areas require sufficient resources and political will. Implementing of comprehensive interventions for these barriers will likely have long-term, measurable impacts on more difficult issues identified by the CHWs:

- Mental health: depression and anxiety
- Poverty and lack of financial support
- Child neglect
- Insufficient cultural understanding
- Lack of health insurance
- Unhealthy relationships
- Domestic violence

The CHW workforce has the capacity to help Nebraska address access and utilization of mental health services. Strategies include:

- Providing Mental Health First Aid and Suicide Prevention Training.
- Expanding system information and referral knowledge for CHWs;
- Using the CHW role as a "warm hand off referral" for primary care providers to assist patients and families with social needs and navigating access to care;
- Having CHWs educate their populations about Medicaid Expansion/Heritage Health Adult as a pathway to accessing mental and behavioral health systems of care;

- Reducing stigma about seeking care for mental health issues.

Criterion 5: Severity of Consequences

The problem has a high likelihood of death or disability.

Individuals with mental illness live on average 10 fewer years than their peers without mental health issues.[8] Mental health is one of our most prevalent health care concerns.

Suicide is a matter of life and death. The impact of mental illness and behavioral health issues transcends generations, when infants and children are in the care of individuals with unmet mental and behavioral health needs.

If this issue is selected as one of the Title V MCH priority needs in 2020, what do you expect this issue to look like five years from now? What kind of progress can you expect for the next five years?

If Title V MCH block grant addresses the issues of mental health care access and utilization, and disparities, among MCH populations in Nebraska, in five years we would expect to see:

- Better awareness of the mental health issues in the population, supported by data;
- Less stigma about accessing mental health and behavioral health care;
- Fewer disparities as measured by geography, income, race/ethnicity;
- The capacity of primary care providers in NE to screen, refer, and treat mild-to-moderate mental health conditions in the population increase;
- CHWs trained in Mental Health First Aid, Suicide Prevention, and statewide information/referral resources who are then positioned to receive warm hand off referrals from PCPs for care navigation and assistance with social needs;
- More integrated primary care-behavioral health practices using telehealth are available in rural areas.

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[1] University of Nebraska Medical Center. Nebraska Behavioral Health Needs Assessment. 2016. http://dhhs.ne.gov/Behavioral%20Health%20Documents/Needs%20Assessment%20-%202016.pdf

[2] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer, Nebraska Vol. 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-NE. Rockville, MD: Substance Abuse and Mental Health Services Administration. 2017. http://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Nebraska-BH-BarometerVolume5.pdf

[3] Nebraska Department of Health and Human Services. Nebraska 2020 Title V Needs Assessment – Data Fact Sheets.

[4] Nebraska Department of Health and Human Services. 2016-2018 BRFSS Nebraska report. 2019.

[5] Nebraska Department of Health and Human Services. Behavioral Risk Factors for the Limited English Proficient Population in Nebraska. 2019. http://dhhs.ne.gov/Reports/Behavioral%20Risk%20Factors%20for%20the%20Limited%20English%20Proficient%20Population%20-%202019.pdf

[6] Centers for Medicare and Medicaid Services. Early and Periodic Screening, Diagnostic and Treatment – Lead Screening. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/lead-screening/index.html

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[8] Walker, E. R., Mcgee, R. E., & Druss, B. G. (2015). Mortality in Mental Disorders and Global Disease Burden Implications. *JAMA Psychiatry*, *72*(4), 334. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4461039/