National Council Medical Director Institute Update
National Council Medical Director Institute

• Medical directors from mental health and substance use treatment organizations from across the country.

• Advises National Council members, staff and Board of Directors on issues that impact National Council members’ clinical practices.

• Champions National Council policy and initiatives that affect clinical practice, clinicians employed, by member organizations, national organizations representing clinicians and governmental agencies.
Membership

• Chief Medical Officers of behavioral health organizations
  – 22 Provider Representatives
  – Four Affiliate Representatives
  – Board Liaison

• Diverse Backgrounds
  – Psychiatrists and Primary Care
  – Child/adolescent, addiction, academic, emergency, geriatric
  – CMHCs, FQHC, Addiction Treatment, Hospital systems, MCOs, Foundation, Consulting
Current Vacancies

• Regions
  – Region 6 - AR, LA, NM, TX, OK
  – Region 9 - CA, Guam, HI, NV

• Desired Characteristics
  – Addiction expertise
  – Developmental disabilities expertise
  – Minority status
The Psychiatric Shortage: Causes and Solutions
Expert Panel

- Practitioners
- Administrators
- Policymakers
- Patients/Peers
- Researchers
- Innovators
- Educators
- Advocates
- Payers
Modular Tool You Can Customize

• Executive Summary
• Environmental Scan – Causes and Impacts
• Potential Solutions
• Recommendations – specific and actionable
  – Federal and State Government
  – Provider Organizations
  – Psychiatrists and Allied Psychiatric Professions
  – Payers
  – Training Programs
Presenters and Editors

• Joseph Parks, MD  
  – National Council for Behavioral Health
• Patrick Runnels, MD  
  – Center for Families and Children
• Howard Y Liu, MD  
  – University of Nebraska Medical Center
• Adam Biuckians, MD  
  – Community Services Group
Extended Outpatient Wait Times

• Common in all settings
• High risk in publicly-funded community behavioral health centers (Medicaid-covered)
  – Centers have high percentage of chronic mental health disorders
• Can lead to medication non-adherence with more ED visits and hospitalizations
Consequences

• For referring primary care physicians
  – 2 out of 3 reported difficulty accessing psychiatric services

• For Emergency Departments
  – 42% increase in individuals using EDs to obtain psychiatric services over the last 3 years.
  – Patients stuck waiting for evaluations and referrals
  – Frustrated ER staff, impacts care of other patients

• For inpatient psychiatric services
  – Closure of psychiatric inpatient units
  – Unable to recruit and retain psychiatrists
Consequences

• Inadequate diagnosis, prescribing and overuse of antipsychotics among vulnerable populations

• Lack of timely access to collateral clinical information and less time to talk with patient’s family or other caregivers

• Prescriptions refilled without monitoring for side-effects

• Rationing services to most severe illnesses, limiting access for patients milder conditions
Consumer Experience

• Low patient satisfaction in community mental health centers due to:
  – Quality of patient-clinician interaction
  – Time limit (often 15 minutes)

“Compressed time with patients may lead to cold environments and an over-focus on deficits or weaknesses that may disempower or frustrate individuals” – Depression and Bipolar Support Alliance (DBSA)
Geographic Access

• 55% of counties in continental U.S. do not have any psychiatrists
• 77% of U.S. counties had severe shortages of psychiatrists and other behavioral health providers

Declining Psychiatric Workforce

• Psychiatrists working with public sector declined 10% from 2003-2013 due to:
  – aging workforce
  – low reimbursement rates
  – burnout
Contributing Causes
Workforce Shortage Contributing Factors

- Psychiatrists burnout
- Rates and methods of reimbursement
- Documentation requirements
- Regulatory restrictions
Burnout by the Numbers

- Physicians experiencing burnout increased 8% from 2011 to 2014
  - 8% decrease in work satisfaction due to insufficient family and personal time
- U.S. Department of Veterans Affairs psychiatrists report alarmingly high burnout rate
  - 86% report high exhaustion
  - 90% report high cynicism

Psychiatrist Burnout Causes

• Regulatory restrictions on sharing information
• Limited time with patients
• Increased documentation requirements
• Minimal support resources to organize medical records, conduct routine assessments, etc.
• Schedules do not allow collegial sharing, supervision and consultation
Populations Served by Existing Workforce

Cash-only private practice is common.

40 percent of practicing psychiatrists do not take any insurance.
Outpatient Reimbursement

• More than 75% of the National Council’s state association members lost $$ on psychiatry
  – 3 year losses increased from $481,000 in 2013 to more than $550,000
• Must earn surplus of 15% or more to balance budget
Inpatient Reimbursement

- Rates not sufficient to underwrite their cost of psychiatrists in general hospitals
- Reimbursement rates lower than cost of care lead to psychiatric inpatient unit closures
- Reluctance to admit potentially violent clients due to risk of property damage, funding security staff
- Salaries for psychiatrists are lowest among specialties
“GME curriculums lack sufficient emphasis on care coordination, team-based care, costs of care, health information technology, cultural competence and quality improvement — competencies that are essential to contemporary medical practice.”

– Institute of Medicine, 2014
Consequences

• Inadequate workforce has limited ability to deliver safe and effective care
• Low level of patient satisfaction
• Limited opportunities for innovation
• Less supervision and collaboration
• Limited opportunities to practice up to level of licensure
• Residency training does not provide adequate population health skills
• Psychiatry is a “loss leader,” despite emerging acceptance of its value
Impact on Services

• For referring primary care physicians:
  – 2 out of 3 reported difficulty accessing psychiatric services
• Closure of psychiatric inpatient units
• Unable to recruit and retain inpatient psychiatrists
Conclusions

• The shortage of psychiatrists will increase
• Traditional model of psychiatric care delivery is unsustainable
• Psychiatrists are not sufficiently groomed or practicing up to level of licensure
• Increasing number of psychiatrists will not be sufficient enough to improve access and quality of care
Solutions and Recommendations
“The solutions cannot rely on a single change in the field such as recruiting more psychiatrists or raising payment and reimbursement rates. Rather, the solutions depend on a combination of interrelated that require support from a range of stakeholders.”
Stakeholder Groups

• Government
• Payers
• Health care treatment organizations
• Advocacy organizations
• Psychiatrists
• Nurse practitioners, PAs and clinical pharmacists with specialty psychiatric certifications
• Psychiatric training programs

“If all stakeholders take even just one action that is immediately feasible for them, meaningful improvements in access to psychiatric services will occur.”
Overview of Recommendations

- Expand the psychiatric workforce
- Increase efficiency of delivery of services
  - Reforming and revising constraining regulations
- Implement innovative models of care to impact total cost of care for high-cost/high-risk populations
- Improve training for psychiatric residents
- Adopt effective payment structures
Update Psychiatry Residency Training

• Design new skills, including:
  – Team leadership
  – Health care data analysis
  – Population health
  – Impact of chronic medical conditions on mental illness

• Increase availability of training beyond inpatient/outpatient mental health programs

• Practice in settings that include expanded role for families supporting care
Fund Psychiatry Residency Training

• Increase funding for training in shortage areas such as rural hospitals, correctional settings, etc.

• Expand HRSA funding for GME programs in underserved areas

• Expand federal funding for GME resident positions through Medicare and Medicaid
Expand Workforce of Other Providers

• Develop Physician Assistants psychiatric subspecialty

• Expand APRNs
  – Valuable for patients with co-occurring medical conditions
    • Currently 13,815
    • Projected to reach 17,900 by 2025
Telepsychiatry

• Increased access for:
  – Rural areas
  – Areas with cultural/linguistic barriers
  – Settings requiring immediate access to psychiatrist, such as an emergency room

• Can provide more efficient consultation to other behavioral health providers

• Eliminates travel time, increasing productivity
Open Access Scheduling

- Likelihood of no-show increases the longer a patient must wait between requesting appointment and seeing psychiatrist

- Approaches include:
  - Unscheduled blocks of time
  - Open blocks of time on certain days
  - Specific number of appointments kept open in each clinic session
  - Can use more than one approach!
Adequate Staff Support

- Support staff includes nurses, medical assistants, non-licensed personnel with specialty training
- Duties:
  - Handling phone calls
  - Collecting screening info and vital signs
  - Assuring all required forms are available
  - Arranging referrals, return visits
  - Tracking lab/pharmacy information
  - Making photocopies
Reduce Excessive Documentation Requirements

• Psychiatric evaluations and treatment plans are almost always more elaborate than other medical specialties
• Elaborate assessment for some patients results in no assessment for others
• Other medical professionals are less likely to review elaborate psychiatric assessments
Integrated Care

• Makes functional integration easier
• Decreases discrimination
• Increases access to primary care consultations
• Creates common medical record
• Increases patient follow-through with referrals
• Preferred by most patients
• Increases primary care practitioners’ knowledge of psychiatric treatment and vice versa
Collaborative Care Model

- Good evidence for the success of the collaborative care model (CoCM) resulted in new CPT code
- Stepped care approach includes case manager to measure outcomes
- Allows each psychiatrist to impact 5 times as many patients
Finance and Reimbursement

• Medicaid is major payer of behavioral health, so providers can’t make up for payment rates
  – Disincentive to provide psychiatric services

• New payment ideas:
  – Cost-based rate
    • Used by prospective payment systems (PPS) and certified community behavioral health clinics (CCBHCs)
  – Bundled payments
Recommendations for National and Treatment Organizations

• Attract and retain psychiatrists in public settings:
  – Provide Adequate nursing and administrative supports
  – Do not limit psychiatrists solely to diagnosis and medication visits
  – Reduce documentation requirements
  – Have a Medical Director
  – Attention to provider burnout, retention and appreciation
Recommendations for Payers

• Work with providers, experts and researchers to match reimbursement with practices and provide incentives for improved outcomes, reduced total cost of care
• Standardize outcome measures and partnership among payers, policymakers, providers and consumers
• Payers should have in-house medical director
Recommendations for Payers

- Incentivize open access or walk-in clinics
- Pay higher amounts for first appointments to incentivize providers to target harder-to-reach populations
- Include telepsychiatry as covered service
- Improve access to psychiatric care in EDs
- Cover payment for CoCM at no less than Medicare rate
- Reimburse for psychiatric services using evolving technologies for increased access
Recommendations for Payers

• Ensure that administrative and documentation policies are not overly burdensome
• Design payments with population-based health in mind with actual cost of direct psychiatric services in bundled payment calculation
• Ensure compliance with MHPAEA and new Medicaid rule
Medication Adherence
Adherence to Medications

“No medication works inside a bottle. Period.”
— C. Everett Koop, MD

“Drugs don't work in patients who don't take them.”
— C. Everett Koop, MD
### Rates of Medication Nonadherence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Nonadherence Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary Heart Disease</td>
<td>40-50%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>16-22%</td>
</tr>
<tr>
<td>Diabetes: oral meds</td>
<td>7-64%</td>
</tr>
<tr>
<td>Diabetes: insulin</td>
<td>37%</td>
</tr>
<tr>
<td>Asthma</td>
<td>25-75%</td>
</tr>
<tr>
<td>HIV</td>
<td>13%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>30-60%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>51-69%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>21-50%</td>
</tr>
<tr>
<td>Anxiety Disorders</td>
<td>57%</td>
</tr>
<tr>
<td>ADHD</td>
<td>26-48%</td>
</tr>
<tr>
<td>Alcohol Abuse / Dependence</td>
<td>35%</td>
</tr>
</tbody>
</table>

Lack of Adherence to Psychotropic Medications

- Lack of adherence to prescribed antipsychotic medication is recognized as a leading reason for poor outcome and symptomatic relapse among patients with schizophrenia.
- 30-60% of patients with schizophrenia are non-adherent.\(^1\)
- CATIE: ~40% of patients discontinued their antipsychotic medications on their own.\(^2\)
- Nonadherence is known to be an important contributor to rehospitalization among patients with schizophrenia.\(^3\)

Consequences of Nonadherence?

Failure to take medication as prescribed:

- Causes 10% of total hospital admissions
- Causes 22% of nursing home admissions
- Has been associated with 125,000 deaths
- Results in $100 billion/year in unnecessary hospital costs
- Costs the U.S. economy $300 billion/year

Questions?

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