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Mental Health Workforce

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Current Shortage Nationally

- Best data: Study by University of North Carolina commissioned by Health Resources and Services Administration (HRSA)
- Demonstrated shortages for all MH professionals, especially “prescribers”
 - 77% of U.S. Counties have “a severe shortage of prescribers, with over half their need unmet”
 - 96% of US counties have “some unmet need”

Current supply and demand for psychiatrists nationally

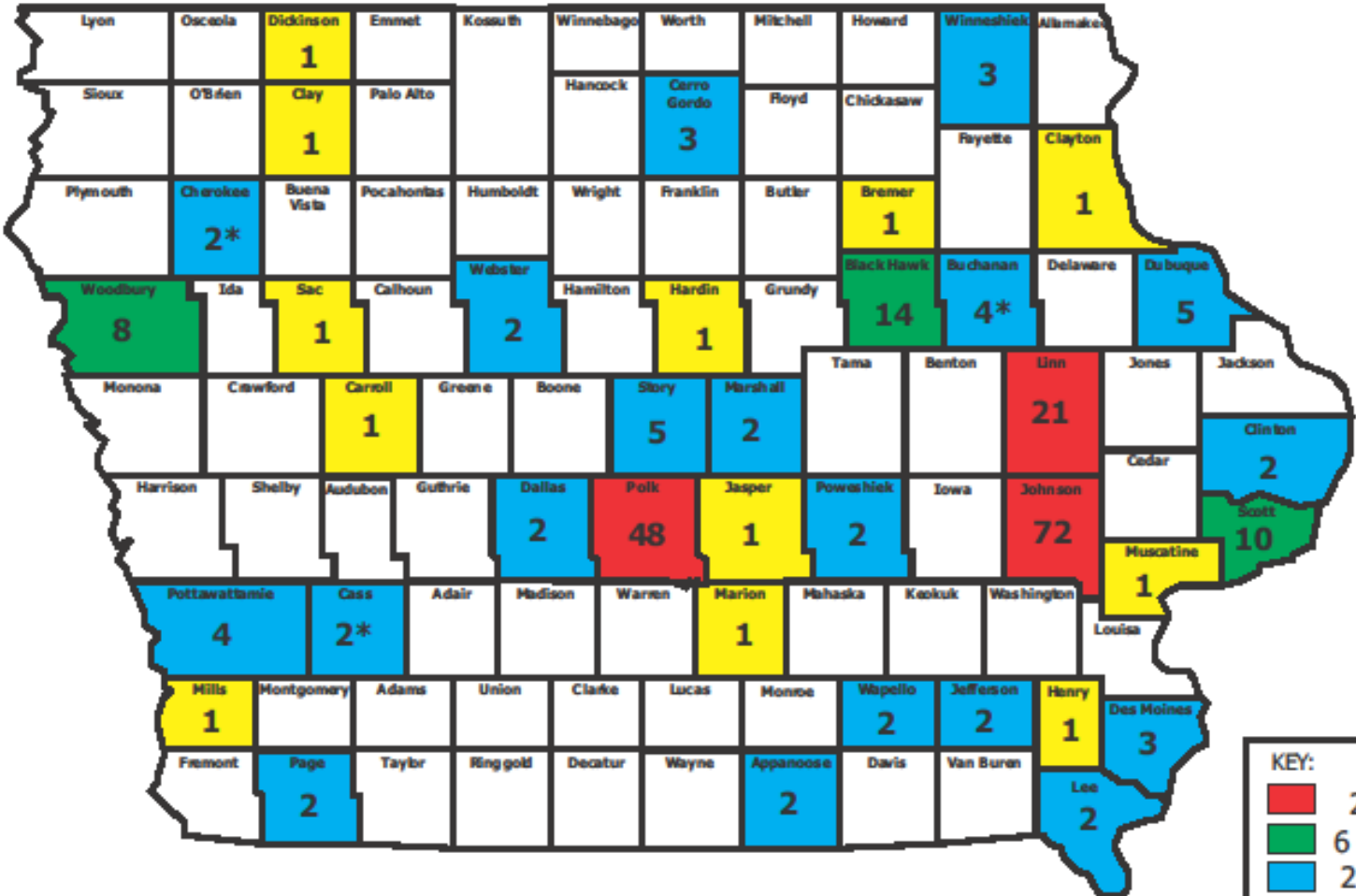
- Estimated need of 25.9 psychiatrists/100,000 population
 - With current population of 300,000,000, this is 78,000.
- Current supply is ~ 48,000 (~ 16/100,000)
- Current gap = at least 30,000
- Much greater supply vs. need gap for child and adolescent psychiatry (~ 7,500 total)

Iowa Is An Extreme Example

(absolute #s and distribution)

- Within the bottom 3-5 states in terms of psychiatrists per capita, e.g AMA data:
 - Iowa ranks 47th
 - MN 28th, MO 30th, NE 35th, IL 16th, WI 24th
- About half national average
 - ~ 8/100,000 vs. ~ 16/100,000 nationally
- 85/99 counties designated as HPSA shortage

GEOGRAPHIC DISTRIBUTION OF IOWA PHYSICIANS Psychiatrists (238)*



KEY:

Red	20+ (3)
Green	6 - 19 (3)
Blue	2 - 5 (19)
Yellow	1 (12)
White	0 (62)

*Includes psychiatrists based at state mental health institutions

Professional Activities of Iowa Psychiatrists (2011)

Activity	Adult / Gen Psychiatry	Child & Adol. Psychiatry	Grand Total
Private Practice	110	29	139
Teaching/Rsrch	42	9	51
Federal/Veterans Admin	16		16
Public/Community Health	12	2	14
State Institution/Agency	10		10
Administration	2		2
Student Health	2		2
Hospital Medicine	1		1
Grand Total	195	40	235

Full-time	 (1.0)	216	(216.0 FTE)
Part-time	 (.5)	<u>19</u>	<u>(9.5 FTE)</u>

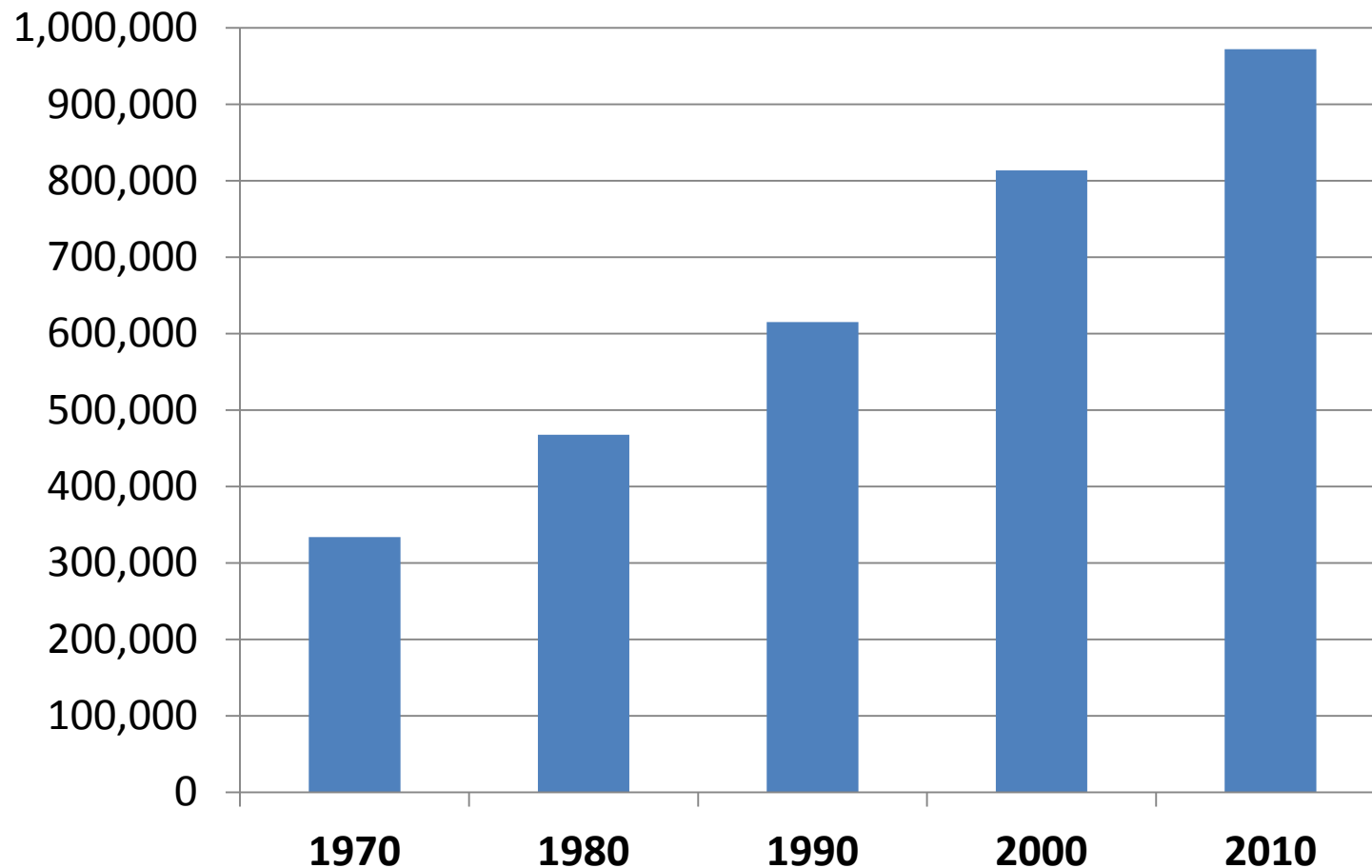
Total		235	(225.5 FTE)
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Looking at the Numbers...

- We'd need to double our current numbers of psychiatrists to reach the national average, and nearly triple the numbers to meet expected need
- This is not going to happen, either in Iowa or elsewhere
- Indeed, we may well be facing a decline

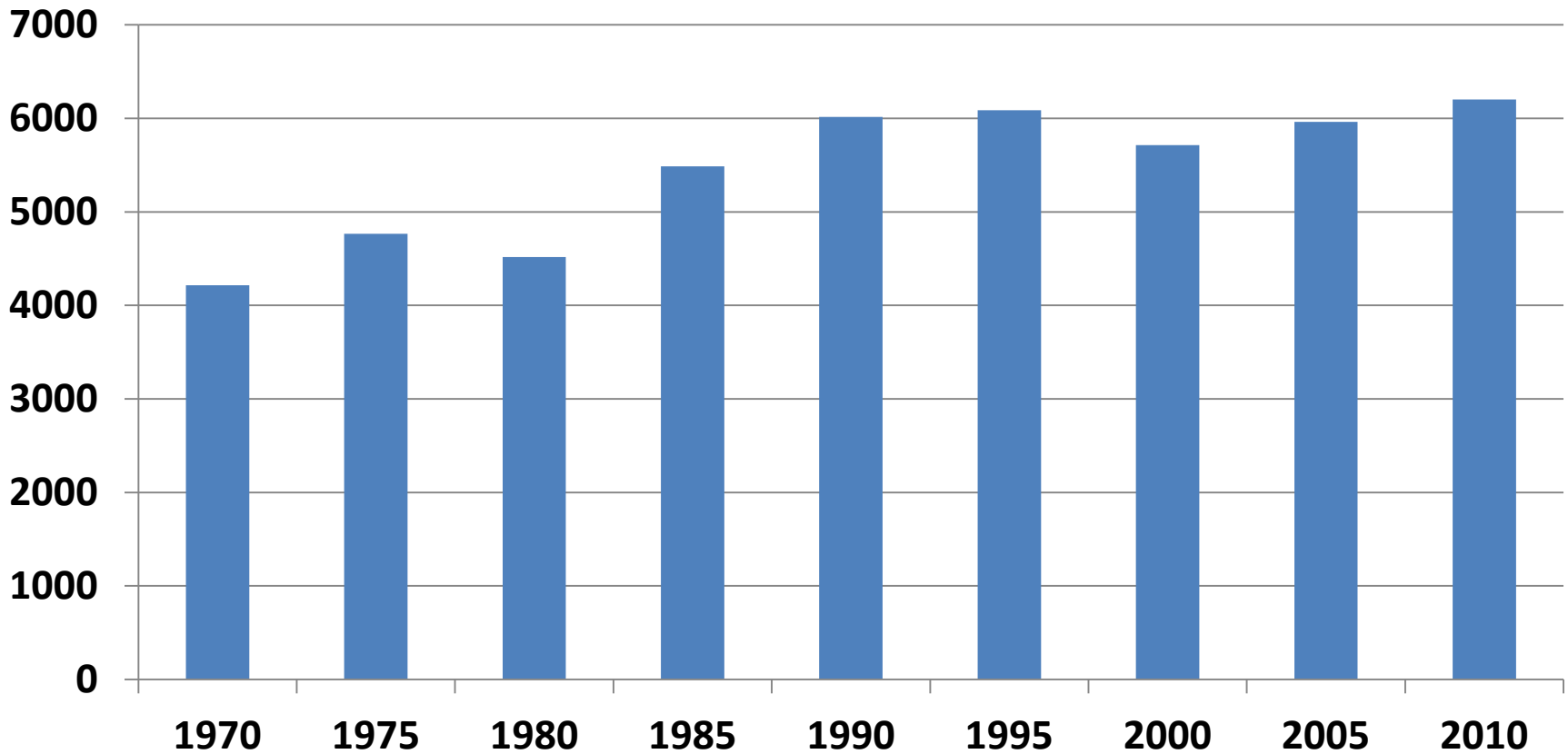
Total Number of Doctors in US – Steady Increase

Number of All U.S. Physicians
1970-2010



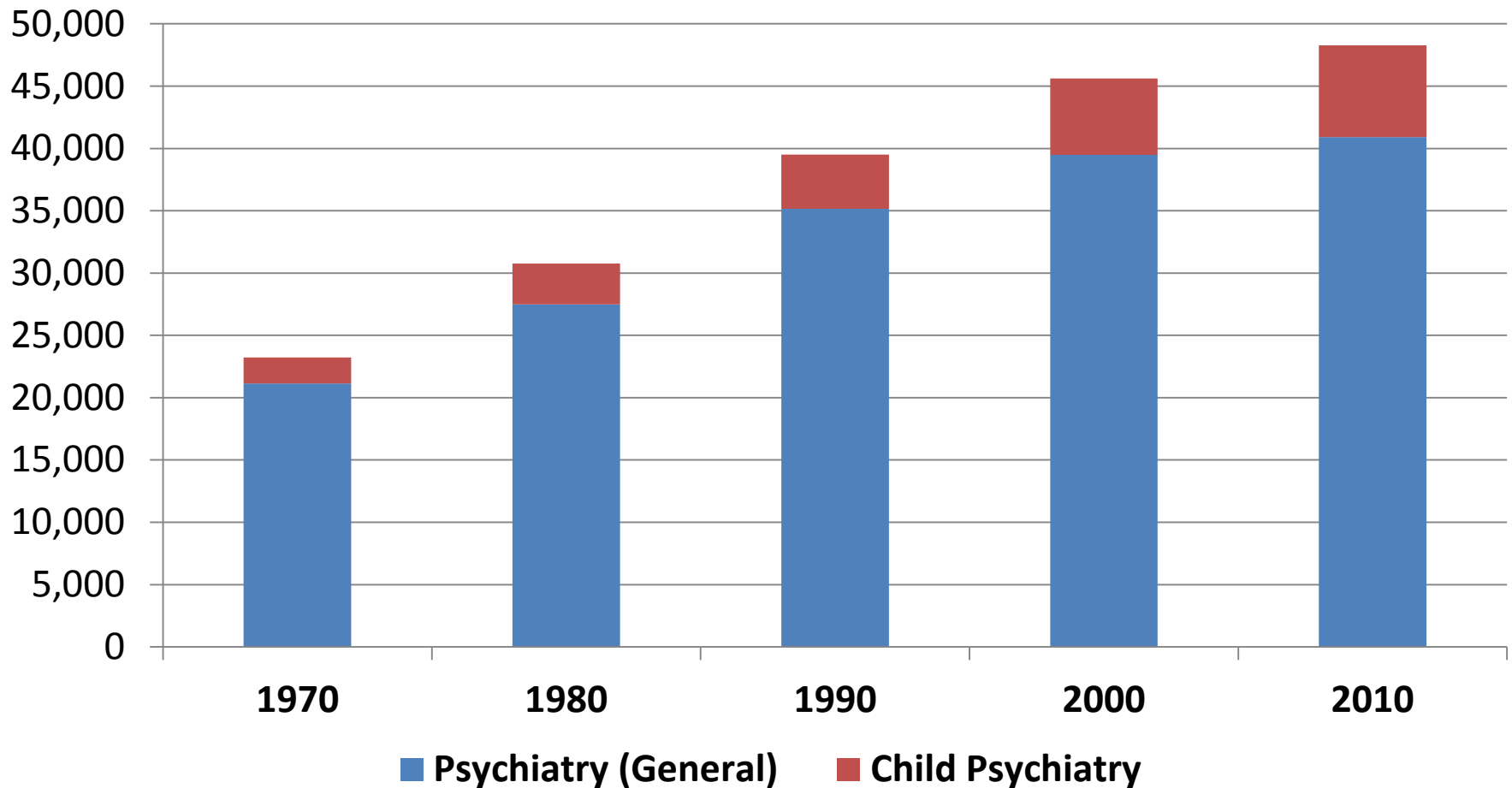
Number of Psychiatry Residents In US Programs Has Been Flat

Number of Psychiatry Residents and Fellows in U.S. Programs, 1970-2010



Total Number of Psychiatrists (including FMG's) - Slight Increase

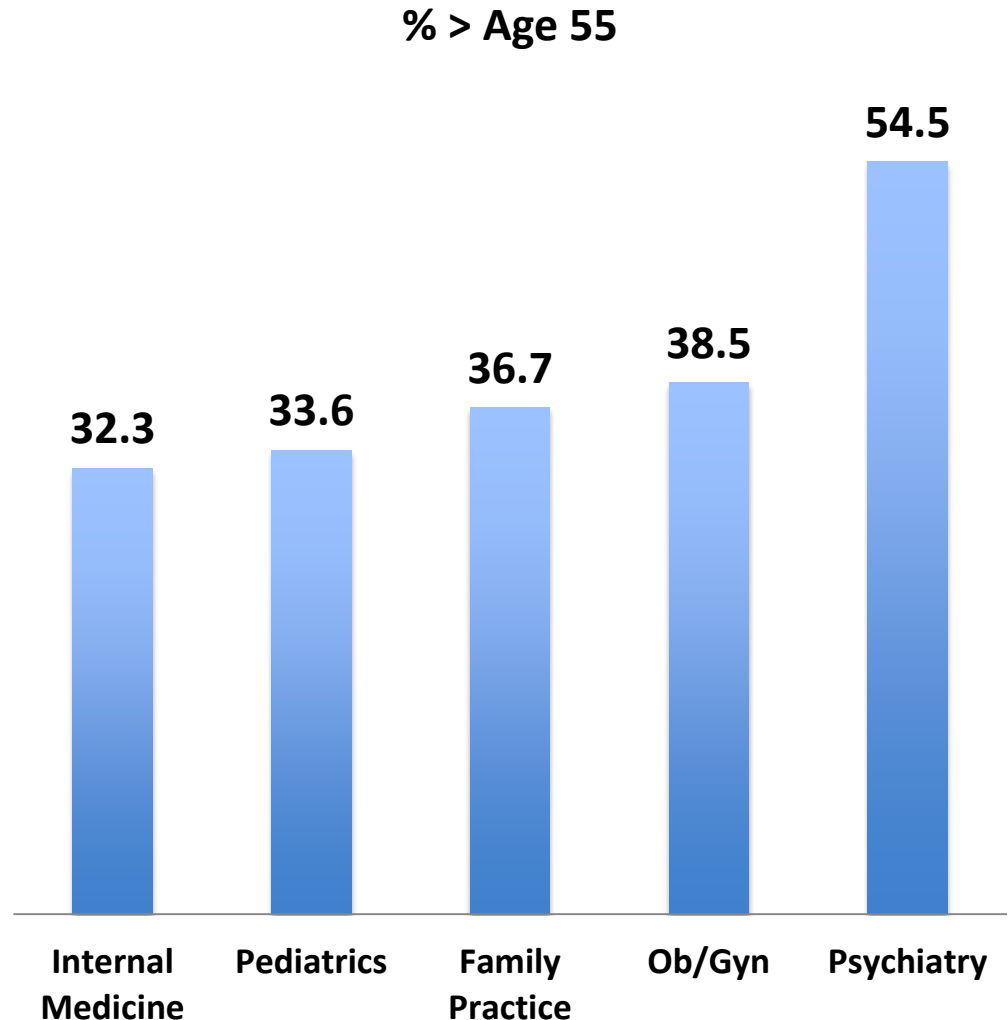
Number of Psychiatrists and Child Psychiatrists in the US 1970 - 2010



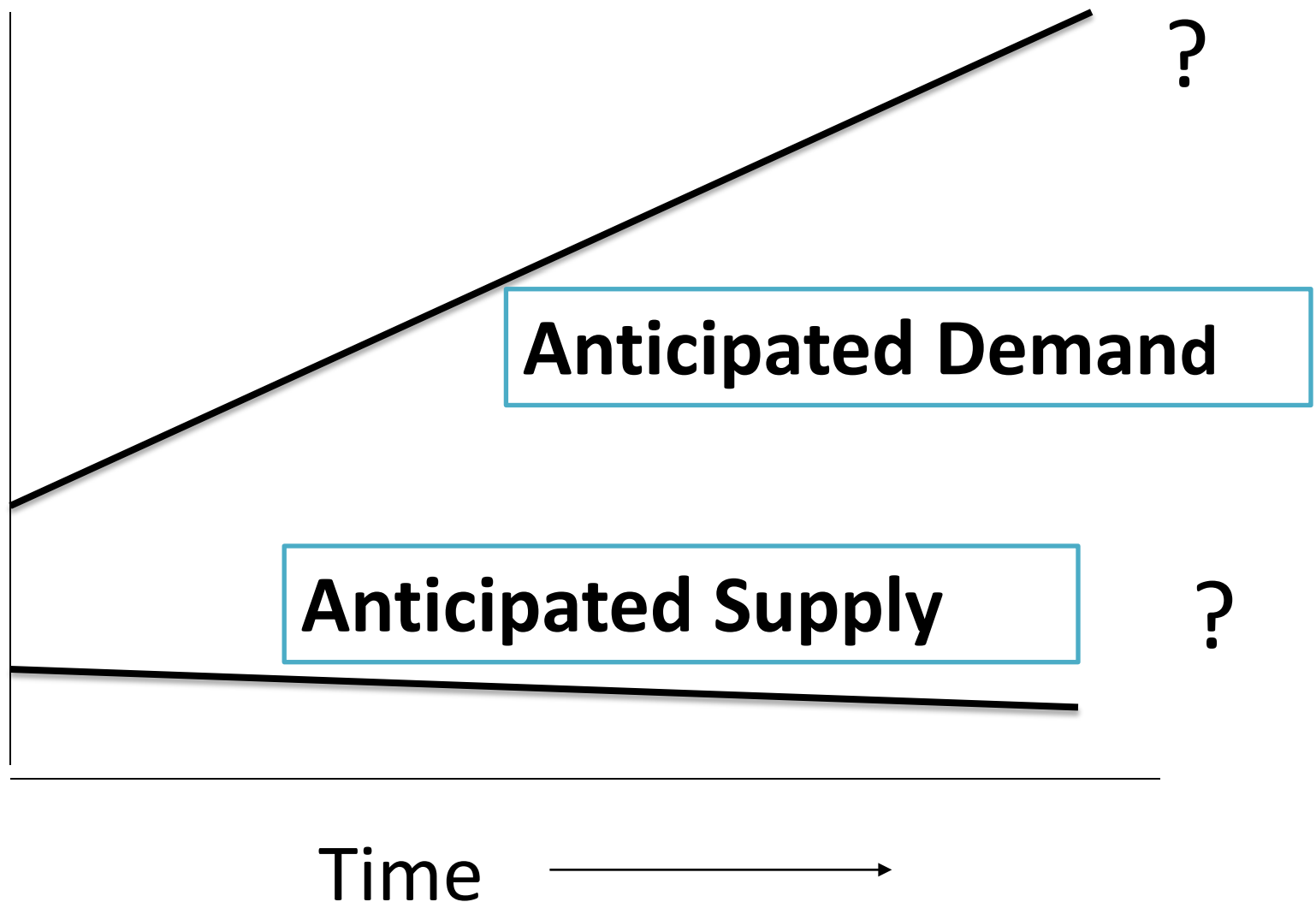
Aging Out!

% of MD's by Specialty > age 55

- Off all sub-specialties (35), Psychiatry is second oldest (Second only to Preventive Medicine)
- 55% of current psychiatrist are > age 55



Meanwhile, Demand for Psychiatric Services Continues to Increase



Increased Demand: Possible Factors

- Increase in number of patients utilizing services
 - Growing and aging population
 - Mental health parity, Affordable health care act
 - Some progress in anti-stigma efforts
- Psychiatric problems related to:
 - Economic downturn
 - Psychological toll of two wars
- Direct marketing to the public for psychoactive meds
 - “...Ask your doctor if the addition of Abilify to your antidepressant is right for you?”
- Black box warnings (e.g., kids, elderly)

The Challenge

Current

- Too few providers
- Clustered in a few locations
- Long waiting lists and bottlenecks for services
- Over-reliance on emergency, hospital services

Future

- Demand likely to increase
- Supply likely to decrease
- WE NEED TO DO BUSINESS DIFFERENTLY

So, what to do...

- There is NO one magic bullet
- More and larger “help wanted” signs simply won’t do
- Warm bodies with prescription pads simply won’t do
- It is critical that we have a multi-faceted approach and that we focus future training, recruitment and retention strategies on the development of a creative, adaptable and collaborative workforce

Pieces of the Solution

- “Mid-level” providers
- Tele-health
- Recruitment and retention strategies
- Collaborative models with primary care
 - Medical homes, mental health homes
- Expanding concept of workforce
 - Consumers, families, care coordinators
- Maximize utilization of psychiatrists

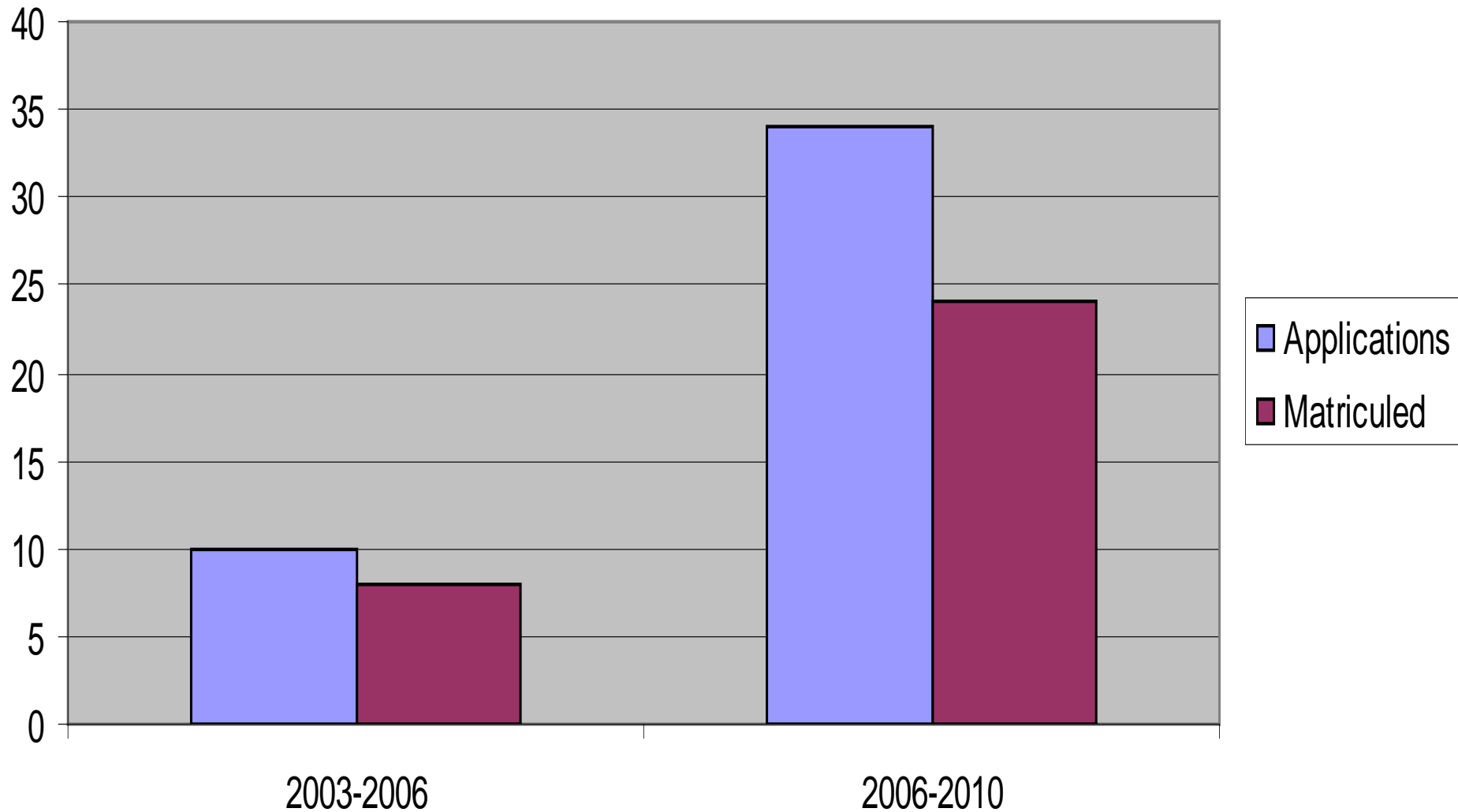
Mid-levels: Examples of “Low Hanging Fruit”

- Small line item grant from legislature starting in FY2006
 - <\$160K total / year
 - Continued each year since (although with less \$)
- Goal was to increase #'s and quality of “mid-level” providers for psych services
- 2 components – ARNP’s and PA’s

Incentives for Nurse Practitioners

- Funded tuition stipends (~ \$3,500/yr) for ARNP students choosing a psychiatry certification track
- Public Relations
- Job placement services
- On-line materials for NP's
 - Advanced competencies for non-psychiatric ARNP's

ARNP students choosing to focus in psychiatry at U of I during the 4 years prior to and since grant funding



Physician Assistant Post Graduate Fellowship in Psychiatry

- Developed 1 year “mini-residency” for PA’s
- Didactics with PG 1-2 residents
- Varied inpatient and outpatient clinical rotations
- Individual supervision in evidence-based psychotherapies
- One of 3 programs approved by AAPPA

What about Tele-psychiatry?

- Lots of experience with this
- National Laboratory for Rural Telemedicine 1994-2000
- Used throughout Iowa's Prison system since late 90's
- Good clinical outcomes
- Good patient satisfaction
- Magellan support (hardware and reimbursement)

Problem

- The technology is the easy part
- Reimbursement strategies can be worked out
- **You still need the horses**
- Tele-psychiatry suites are not being utilized, because all the psychiatrists are already overloaded doing what they do
- Telepsychiatry itself is not the answer – it is figuring out how to exploit that technology and build it into more efficient practice models

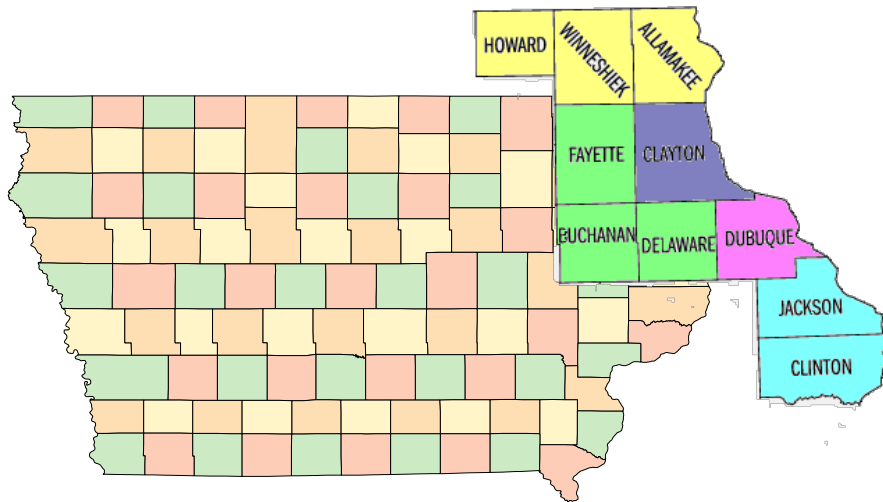
Example 1: Physician Assistant Post Graduate Fellowship in Psychiatry

- Developed 1 year “mini-residency” in psychiatry for PA’s
- PA’s expected to practice in Iowa
- Program up and running for 5 years
- Hope to attract some currently working in MH settings to go to PA school
- Small step – but can make a big difference for an area, e.g., most recent graduate

PA Program (cont.)

- Case example – Last year's graduate:
 - Ideal outcome – returned to his home, underserved area with intention to practice in psychiatry
- But...No one to supervise him
- Solution
- Distance supervision via tele-health
 - Approved by PA licensing board
 - Contract in place

Example 2: Integration with Primary Care: The CYC-I Project



CYC-I
CHILD & YOUTH PSYCHIATRIC
CONSULT PROJECT OF IOWA

**TOGETHER WE CAN
MAKE A DIFFERENCE**

Four Components

- Consultation for Pediatricians
 - By phone if psych to pediatrician
 - By telemedicine for patient or family interview
- Care coordination for families
- Seminars on mental health topics for PCPs
- Online resources for PCPs and families

Now we are getting somewhere!

- Lots to be worked out
- How to incentivize primary providers and consultants
 - ? How to fund this kind of activity in a sustainable manner
- Thinking through medical homes, mental health homes, who goes where...

Nebraska Behavioral Health Statewide Workforce Initiative



Developed out of the same issues we are facing now

- 2004

LB1083 is the restructure of behavioral health system of care from institution to community-based.

- 2009

LB603 passed, creating the Nebraska Behavioral Health Education Center (NBHEC).

NBHEC Mission:

Support the recruitment, retention and competency of the Nebraska behavioral health workforce by providing education and training in evidence-based practice, interprofessional collaboration and use of behavioral telehealth services to expand outreach and serve the people of Nebraska.

NBHEC Strategic Plan

- **Mission driven strategies**

1. Behavioral health education and training sites in each region
2. Behavioral telehealth training
3. Interprofessional behavioral health training, curriculum development and outcomes research
4. Fund psychiatric residencies and other behavioral health trainees
5. Behavioral health workforce analysis

- **Supporting strategies**

6. Networks
7. Resources: financial and operational

NBHEC Funding

- FY 2009-2010 → \$1,385,160
- FY 2010-2011 → \$1,563,993
- FY 2011-2012 → \$1,801,265

Take Home Message

- A focus on the development of an adaptable, efficient, effective and sustainable behavioral health workforce is needed.
- This will be a complex process.
- Expecting that this will happen through the creation of unfunded work groups is unrealistic.
- It will take resources.