Addressing Challenges in Providing Rural Behavioral Health Services

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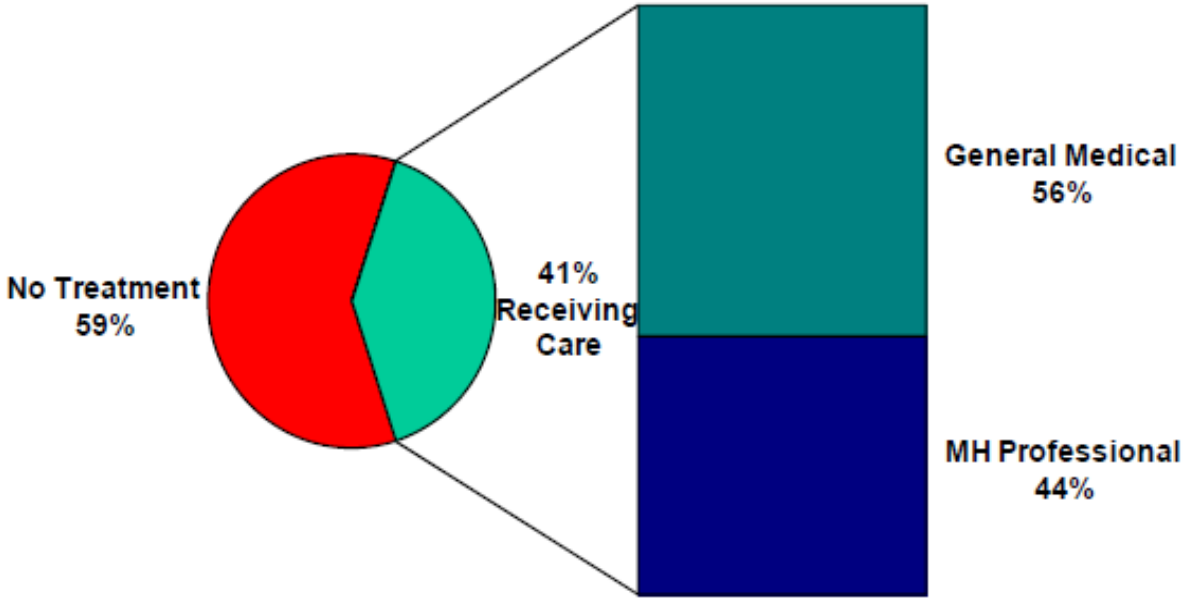
NATIONAL HEALTH CARE
YOU WANT TO SEE THE DOCTOR!? SURE... HERE HE IS!
Stayskal
Tampa Tribune

National Comorbidity Survey Replication

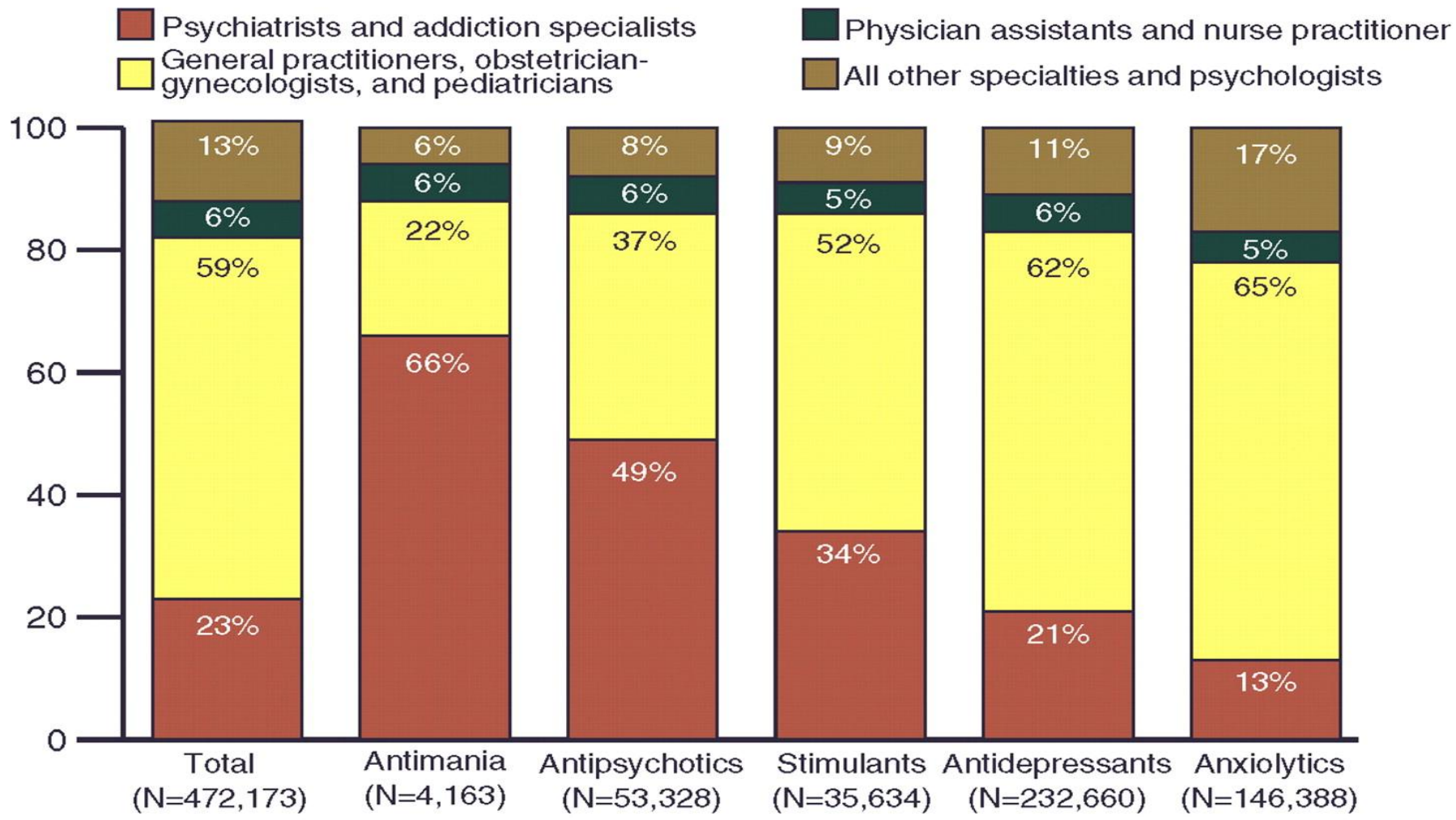
Provision of Behavioral Health Care: Setting of Service



Wang P, et al., Twelve-Month Use of Mental Health Services in the United States, *Arch Gen Psychiatry*, 62, June 2005

Figure 1

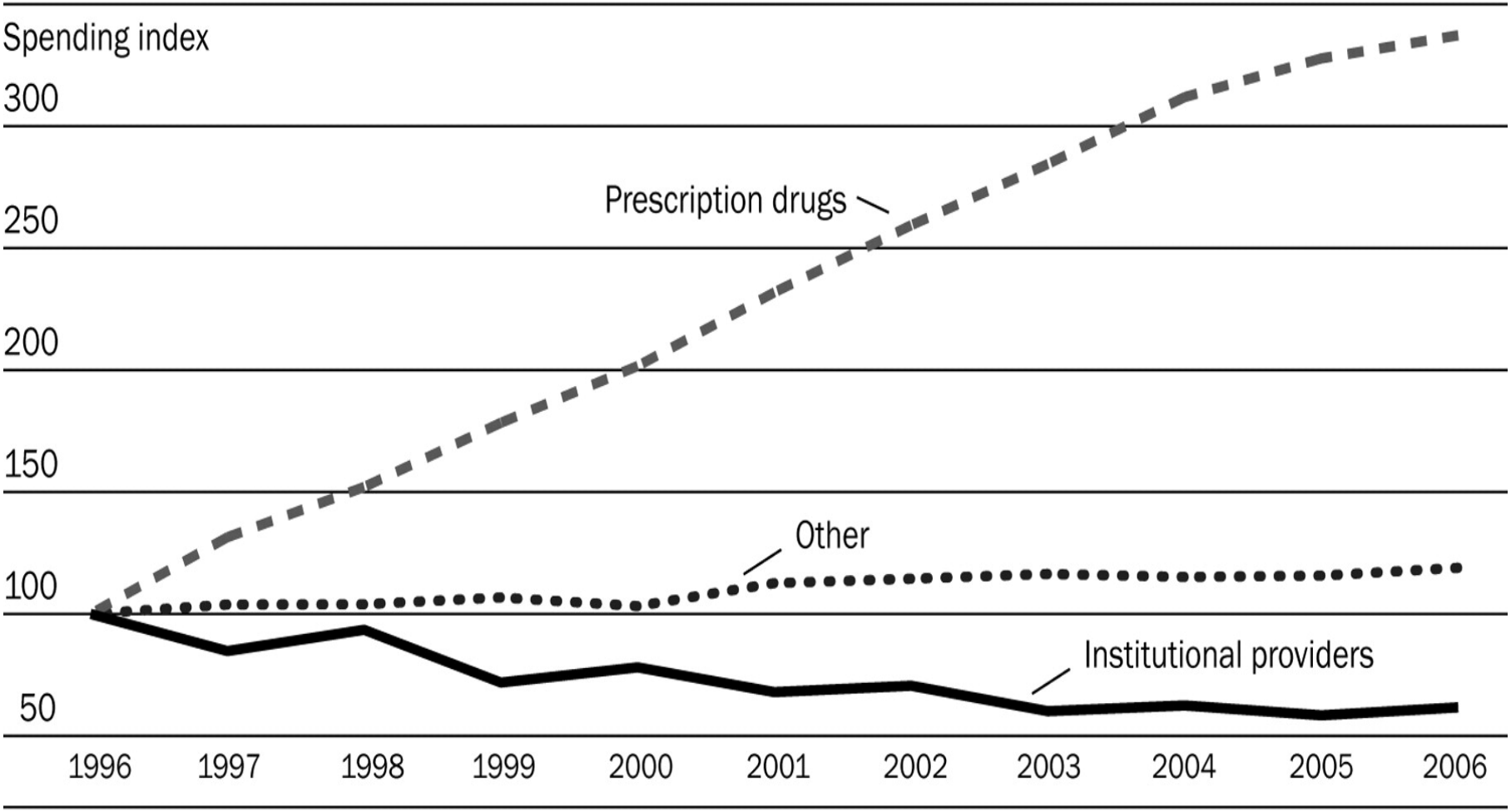
Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider[a]



[a] Ns represent prescriptions in thousands

EXHIBIT 6

Growth In U.S. Mental Health Spending (Indexed To 1996), By Sector, 1996–2006

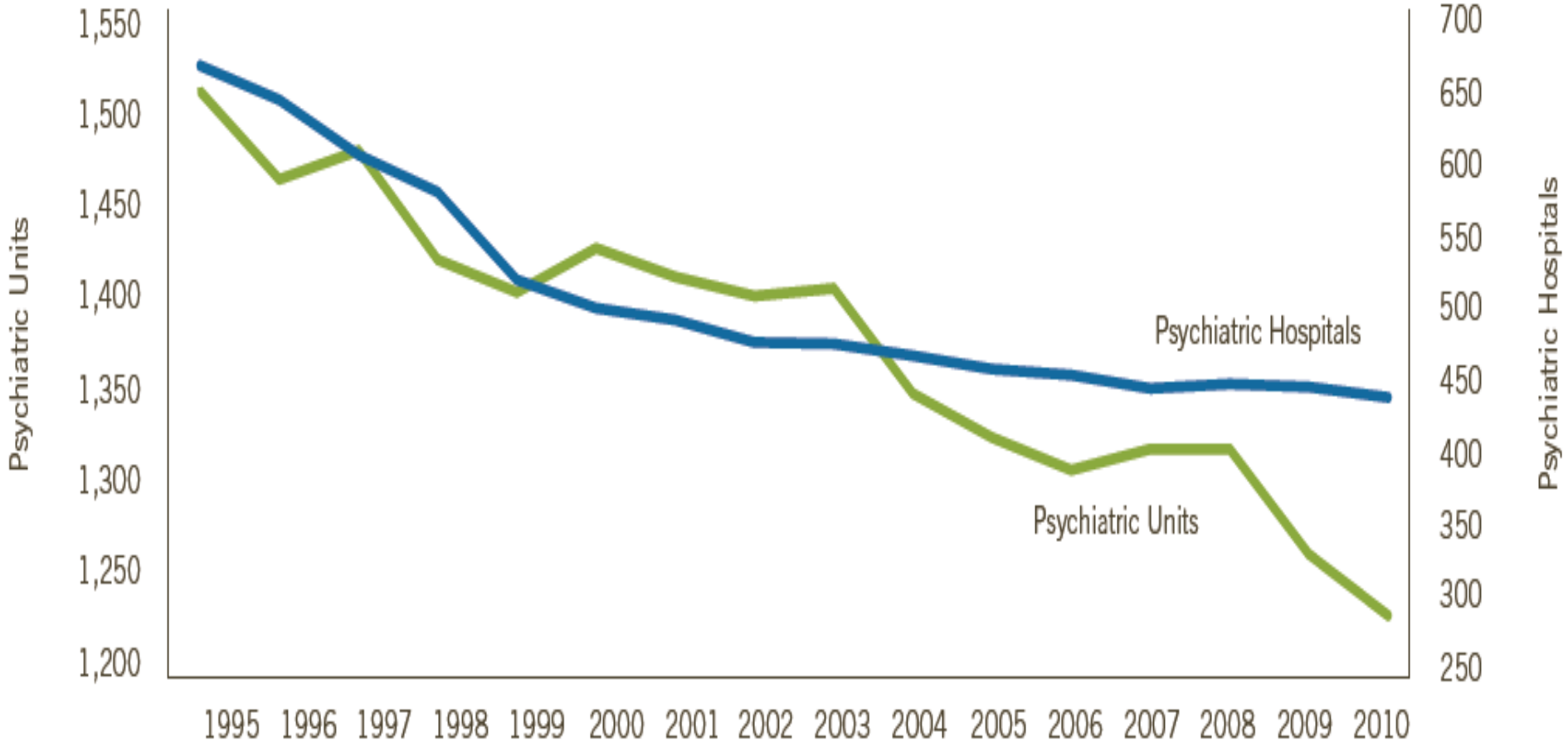


SOURCE: Medical Expenditure Panel Surveys, 1996–2006.

NOTES: Spending index constructed through regression analysis, available in the online appendix at http://content.healthaffairs.org/cgi/content/full/28/3/649/DC1. 100 represents mean spending in 1996 for each group. For regression details, see Exhibit 3 notes.

The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units[1] in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals[2] in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.

(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

Total Operating State Hospital Beds

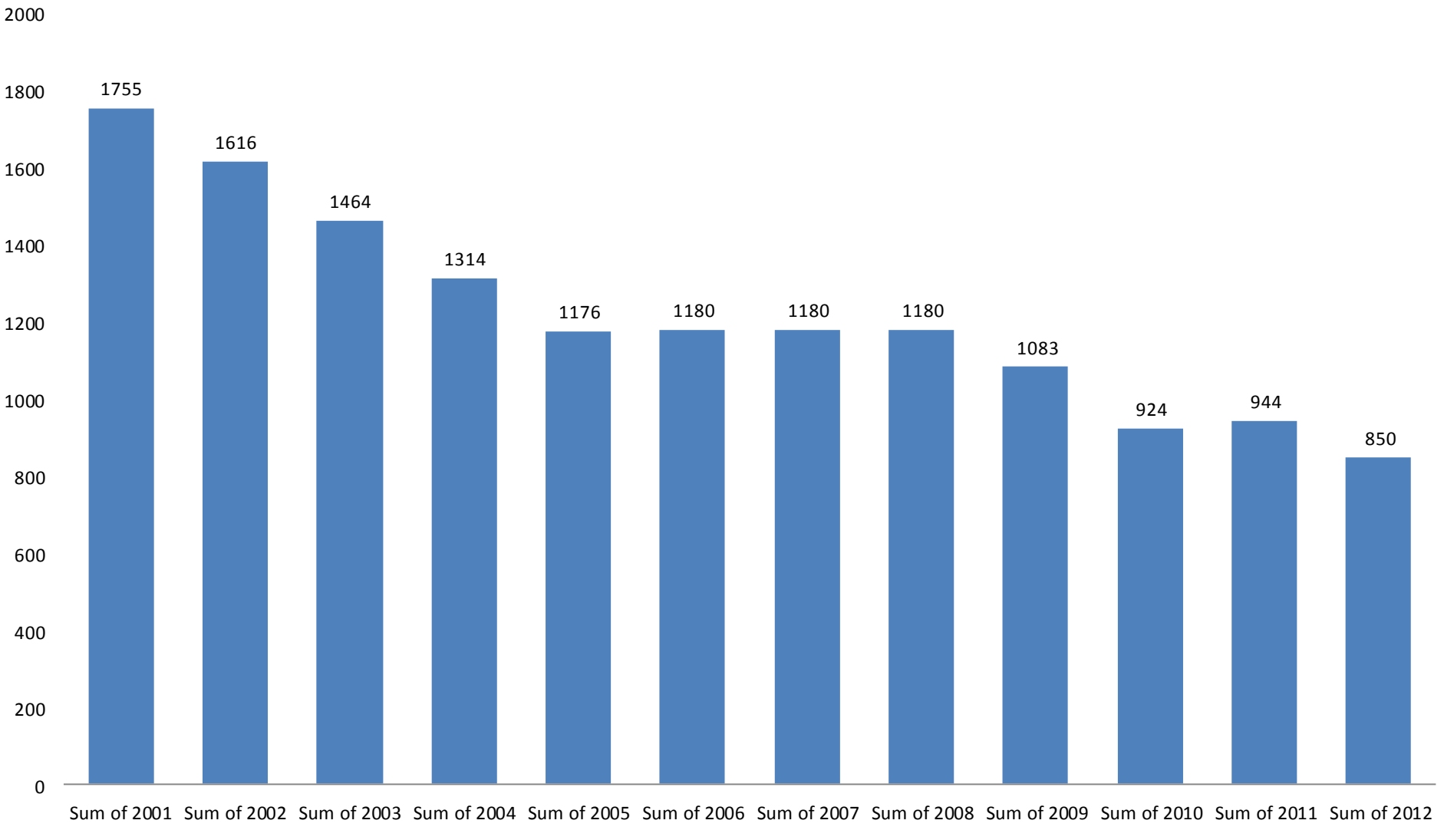
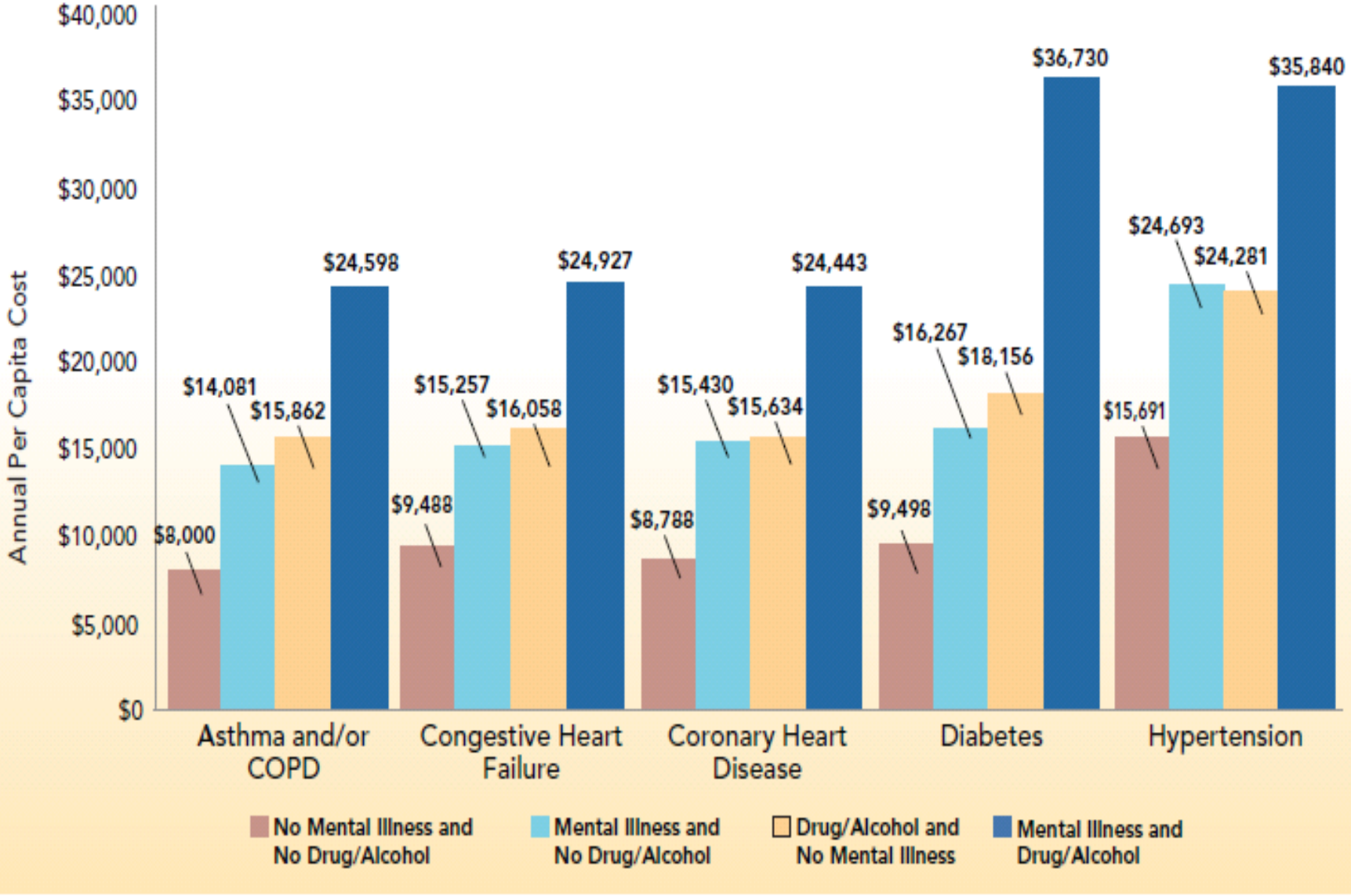


Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities



Are Mental Disorders More Prevalent in Rural Areas?

- Few community/epidemiologic studies have compared rural and urban rates of disorder.
- Extent of urbanicity and rurality varies greatly and is on a continuum.
- Ideal epidemiologic studies would contrast contiguous but distinct highly rural and urban areas.

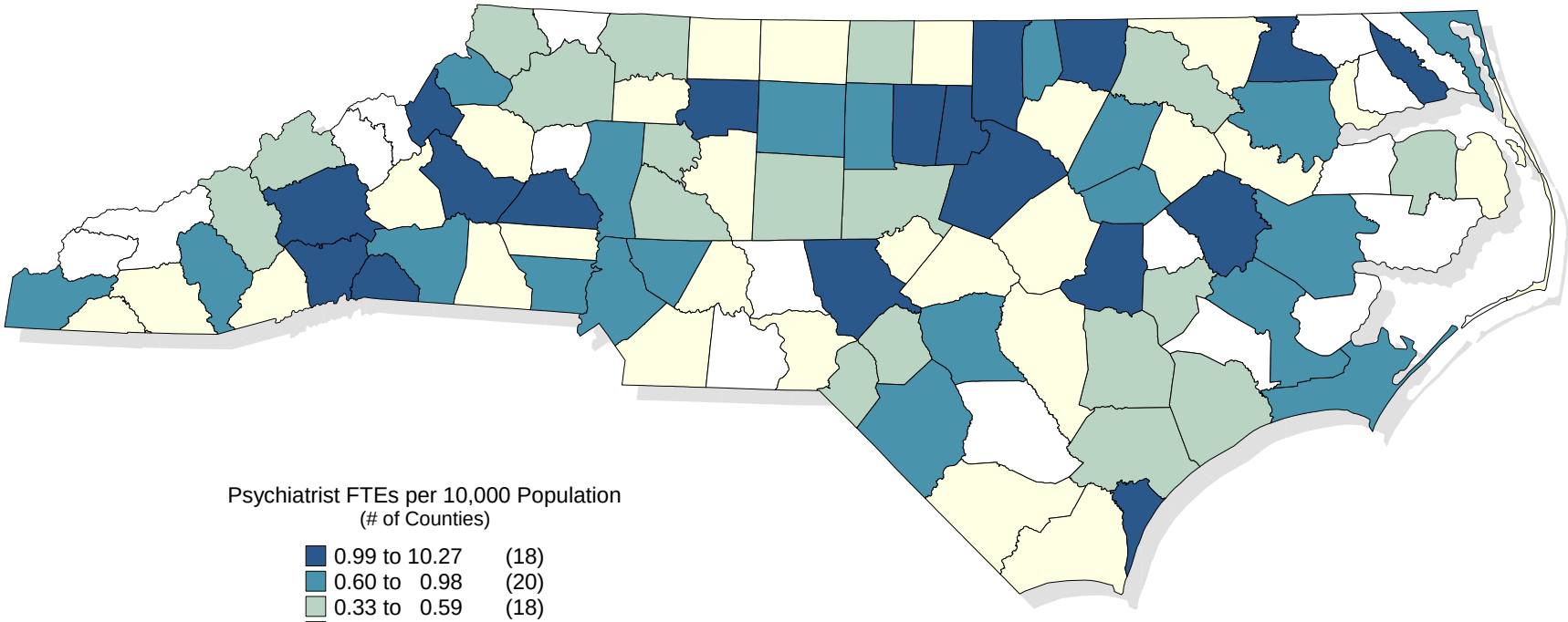
Summary of Epidemiologic Evidence

- No major rural/urban differences in lifetime prevalence of aggregate mental disorder.
- Prevalence differences not a major factor in urban/rural studies.
- Suicide higher in rural areas.
- Access to services bigger issue than prevalence.

Rural Mental Health Services

- **Originally believed that rural attitudes/acceptance of mental health services was lower.**
- **Differences in attitudes toward treatment not likely to be different in rural vs urban areas.**
- **Strains of rural life may be different but are unique to types of rural communities (eg. farming vs other economies, poverty, migration, etc.)**
- **Clear differences are evident in mental health services -- resources and services stretched thinner in rural areas.**

Psychiatrist Full-Time Equivalents per 10,000 Population
North Carolina, 2004



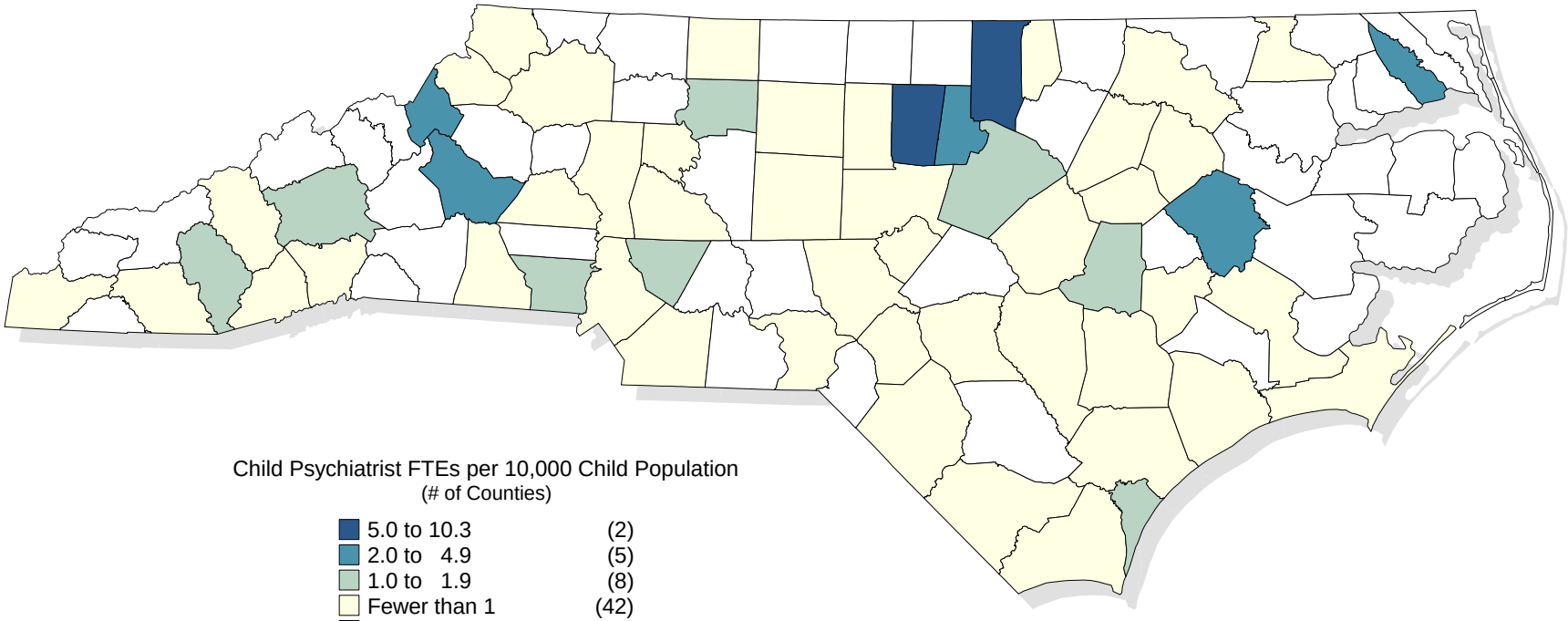
Total Psychiatrists = 1,061

Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2004; LINC, 2005.

Produced by: North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Psychiatrists include active (or unknown activity status), instate, nonfederal, non-resident-in-training physicians who indicate a primary specialty of psychiatry, child psychiatry, psychoanalysis, psychosomatic med, addiction/chemical dependency, forensic psychiatry, or geriatric psychiatry, and secondary specialties in psychiatry, child psychiatry and forensic psychiatry.

Child Psychiatrist Full-Time Equivalents per 10,000 Child Population
North Carolina, 2004



Child Psychiatrist FTEs per 10,000 Child Population
(# of Counties)

5.0 to 10.3	(2)
2.0 to 4.9	(5)
1.0 to 1.9	(8)
Fewer than 1	(42)
No Child Psychiatrists	(43)

Total Child Psychiatrists = 223

Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2004; LINC, 2005.

Produced by: North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Child psychiatrists include active (or have unknown activity status), instate, nonfederal, non-resident-in-training physicians who indicate a primary or secondary specialty of child psychiatry. Child population includes children 18 and under.

Implications for Rural Mental Centers

- New models of treatment needed.
- Challenges of cultural diversity emerging (especially Latino migration).
- Reliance and use of primary care and other human services and resources needed.

Can NC Grow it's Way Out of Psychiatry Shortages?

- Most of the counties with psychiatry shortages are also primary care shortages!
- Need different models of care
- Calls for task-shifting and collaborative care type models.

“Trying harder will not work, changing systems of care will.”

Don Berwick
Former Administrator CMS
CEO Institute for Healthcare Improvement

Potential Approaches

- Telepsychiatry
- Internet based counseling and follow-up
- Telephone based counseling and follow-up
- Education/Self-help/natural supports
- Collaborative Care/Integrated Care models

Need to Apply Unified Approach within a Public Health Model

- Unified approach that recognizes mental health workforce shortages
- Adopt a Public Health Model
- Develop shared treatment protocols for specific conditions,
- Screen, follow outcome measures, **treat to target**
- Use mental health counselors and Advance Practice Professionals
- Reserve 1:1 time with psychiatrists for complex cases

Example: Collaborative Care/Integrated Care

- We are beyond the 'tipping point' of needing more data to prove that these new models have promise
- Examples:
  - 25 years of NIMH research on collaborative care www.nimh.nih.gov
  - California Endowment: Integrated Beh. Health Proj. www.ibhp.org
  - MacArthur Initiative on Depression and Primary Care www.depression-primarycare.org
  - Patient Centered Primary Care Collaborative: www.pcpcc.net
  - John A Hartford Foundation: IMPACT Program: http://impact-uw.org

Depression is the most studied

- 37 trials of collaborative care for depression in primary care (US and Europe)
  - Meta-analysis by Gilbody et al, *Archives of Internal Medicine*; 2006
- **Consistently more effective than usual care**
  - Unutzer et al, Report to President's Commission on Mental Health; *Psychiatric Services;* 2006.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:		2	+ 10	+ 3
(Healthcare professional. For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:			15	

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all: ____
- Somewhat difficult: ✓
- Very difficult: ____
- Extremely difficult: ____

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring—add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Effectiveness Studies of Depression in Primary Care

	Tx Guidelines	Case ID/ Screening	Patient Ed.	Physician Ed.	Tracking Systems	Tx Coord.	MH Spec.	Effective
Schulberg	+	+	+	+	+	+	++++	Yes
Mynors-Wallis	+	+	+	+	+	+	+++	Yes
Katon	+	+	+	+	+	+	++	Yes
Wells	+	+	+	+	+	+	++	Yes
Katzelnick	+	+	+	+	+	+	++	Yes
Rost	+	+	+	+	+	+	+/-	Yes
Hunkeler	+	+	+	+	+	+	+/-	Yes
Dietrich	+	+	+	+	+	+	+	Yes
Unutzer	+	+	+	+	+	+	+	Yes
Simon	+	+	+	+	+	+	-	Yes
Simon	+	+	+	+	+	-	-	No
Callahan	+	+	+	+	-	-	-	No
Goldberg	+	+	+	-	-	-	-	No

What happens to utilization costs?

Lower long-term (4 year) healthcare costs

ICSI Institute for Clinical Systems Improvement

Cost Category	Overall cost in $ (mean)	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT Intervention cost	NA	522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7284	6,942	7,636	-694
Other outpatient costs	14306	14,160	14,456	-296
Total outpatient cost	22516	22,182	22,859	-677
Inpatient medical costs	8452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost over 4 years	31082	29,422	32,785	-3363

Unutzer et al, Am J Managed Care 2008

The DIAMOND Model

Consistent with evidence on collaborative care:

Four Processes:

1. Consistent method for assessment/monitoring (PHQ-9)
2. Presence of tracking system (registry)
3. Stepped care approach to intensify/modify treatment
4. Relapse prevention

Two Roles:

1. Care manager for follow up, support, coordination
2. Consulting psychiatrist for caseload review and recommendations

Patient/Provider perspective

- Any patient meeting criteria
  - Age ≥ 18
  - PCP diagnosed dysthymia or major depression
  - Score on PHQ-9 of 10 or more
- Introduced to DIAMOND care manager
  - Screened for alcoholism, anxiety, bipolar disorder
  - Clinical scenario gathered along with past history
  - Presented weekly to psychiatrist for recommendations.
- PCP writes all prescriptions, patient management

New role for psychiatry

- Traditional consultation/liaison role is seeing patients identified by primary care providers.
  - **One patient at a time**
  - **Patients can wait 2-3 months to be seen**
  - **Many "no shows"**
  - **Frustrating to patients, PCPs and psychiatrists**
- New model
  - Review patients with care manager
    - **Many more patients addressed in same time frame**
    - **Patient problems are addressed within days of intake**
    - **Can focus on those needing attention**

Care Manager Coordination with Psychiatrist

- Weekly review with psychiatrist:
  - All newly enrolled patients
  - Patients the Care Manager or PCP has concerns about
  - Patients who are not improving
  - Any PCP requests for treatment recommendations
- Consult with covering Psychiatrist at any time to discuss acute concerns, patients needing hospitalization, or PCP requests

How many care managers do I need?

- I FTE care manager to about 12-14 FTE of PCP's.
- Based on several assumptions:
  - PCP panel size for full time provider of 1200-1400 (excluding those < 18 yrs old)
  - Assuming a adult depression prevalence in primary care of roughly 10%
  - Assuming roughly half of those eligible patients will be eligible and willing to enroll in care management
  - Averages out to be about a 120-140 case load for each care manager (full time FTE with both active and graduated patients to monitor)
- Also included in the model is 2 hours of Psychiatry supervision per week per full time care manager

Other Disorders

- Practice can address other disorders
  - Alcohol & Substance use
  - PTSD
  - Anxiety Disorders
- Use same protocol and principles and **treat to target**

Questions??
THANK YOU!

- Contact information

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