Expanding Access to Mental Health Care, a Critical Strategy Toward Achieving Zero Suicides

Jon A. Lehrmann, MD
Charles E. Kubly Professor and Chair,
Department of Psychiatry and Behavioral Medicine,
Medical College of Wisconsin,
ACOS for Mental Health,
Milwaukee VAMC

MCW

"There is no Health without Mental Health."

Suicide Prevention Strategies

- Education and Awareness Strategies
- Means Reduction
- Gatekeeper Strategy
- Monitoring and Supporting Individuals at Elevated Risk
- Enhancing Screening
- Expanding Access to Treatment (VA example)

Goals for this session:

- Understand the access challenges to behavioral health care
- Learn population health approaches that can minimize effects of stigma
- Develop ideas for improving access to mental health care with limited resources
- Describe how MH care access is critical in suicide prevention

In the Midst of a Crisis?

- Merriam Webster **Definition of Crisis**: an unstable or crucial time or state of affairs in which a decisive change is impending; especially one with distinct possibility of a highly undesirable outcome.

We Are In the Midst of a National Mental Health Crisis

Evidence of highly undesirable outcomes in Wisconsin: Suicide Rates Up, Rise in Opiate Use related Deaths,

In the Midst of a Crisis

What Factors have led us to being here?

- Stigma- remains a major barrier
- No true Parity- poor reimbursement
- ACA has increased awareness and demand
- Shortages of Psychiatrists and other MH Care Providers
- Caps on GME funding: CMS has not significantly increased GME funding since the Balanced Budget Act of 1997
- Not enough Access

Let's take a closer look:

Provider shortages

- General psychiatrists (Merritt Hawkins)
- Competition resulting in salaries increasing
- Child psychiatrists and child psychologists
- Any specialized psychiatrists
- APP's trained in MH
- MH Nurses
- MH Social Workers

Psychiatry Shortage

- A Wisconsin Department of Health Services' Division of Public Health study revealed that 68 of 72 WI counties have inadequate numbers of psychiatrists to meet population needs.

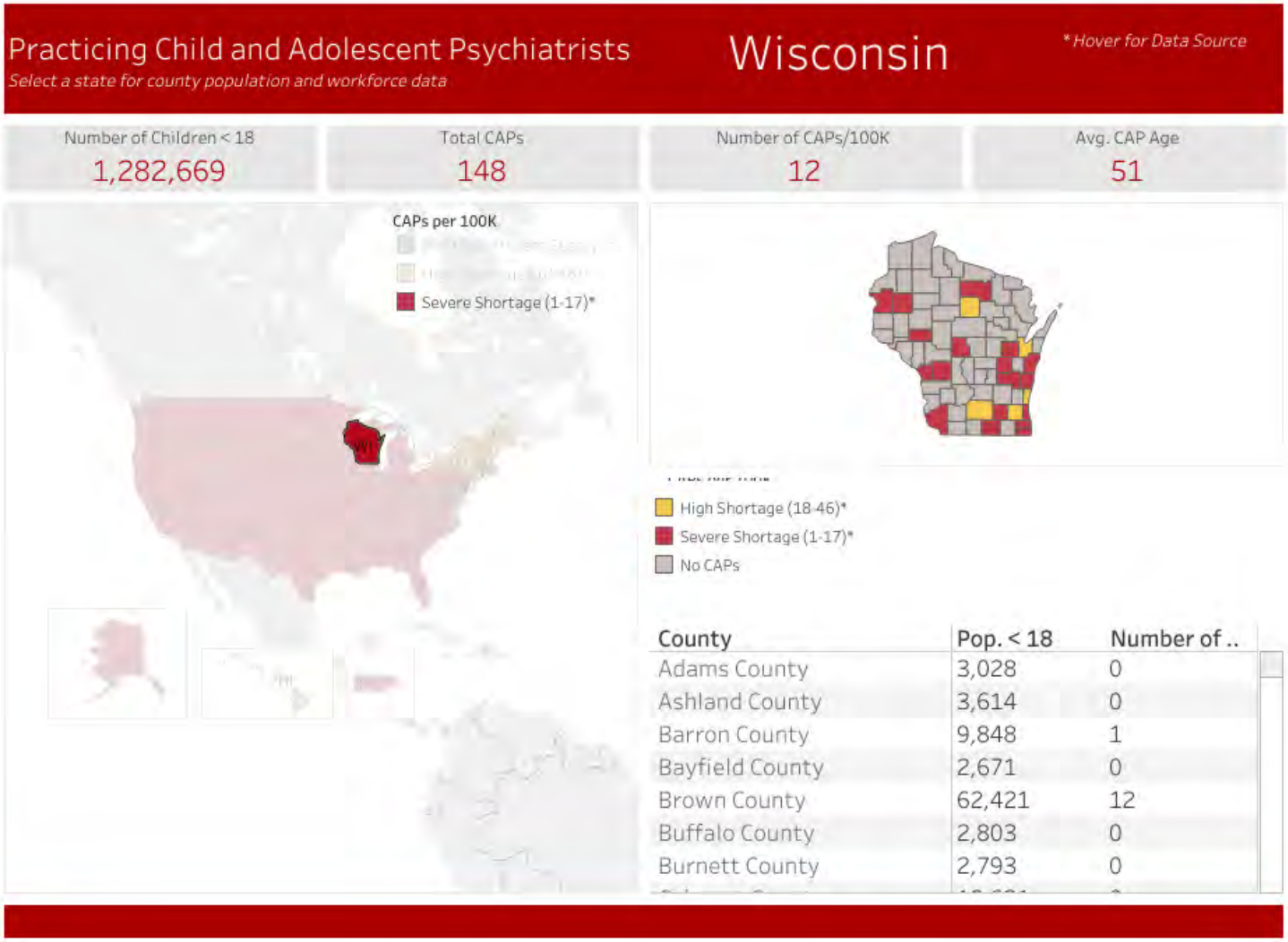
DHS (2012). Number of Psychiatrist FTE's Needed to Reduce Significant Shortages for the Resident Population. Retrieved from https://www.dhs.wisconsin.gov/publications/p0/p00376.pdf. Accessed 11 Apr 2018.

Psychiatry Shortage

- A leading physician search and consulting firm's white paper on the psychiatric shortage revealed that the average age of practicing psychiatrists is third oldest, with 59% of the nation's 30,451 active psychiatrists aged 55 years or older." According to a Kaiser study cited in the white paper, Wisconsin is only meeting 20.8% of the state's mental health needs, ranking it 49th of 50 states.

Merrit Hawkins (2018). The Silent Shortage – A White Paper Examining Supply, Demand and Recruitment Trends in Psychiatry. Retrieved from https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/News_and_Insights/Thought_Leadership/mhawhitepaperpsychiatry2018.pdf. Accessed 11 Apr 2018.

Child Psychiatrists in Wisconsin 2017



Milliman Study

- 2017 published study
- National study looking at 42 million lives
- Shows BH gets reimbursed 20% less than Primary Care, even when using same codes.
- Still lack parity!

Suicide Rates Up

- Suicide rates up approximately 27% in Wisconsin since 1990's.
- Suicide was the 2nd leading cause of death for youth in Wisconsin and 3rd in the country.
- Wisconsin had the 14th highest rate of suicide in youth among all states (age 5-19).
- Wisconsin's youth suicide rate has been higher than the national rate for 29 of the last 32 years (1981-2013).
- Almost half of suicides occur in people who have a mental health challenge (yet this likely is a significant underestimate)

Opiate Crisis

- National crisis of opiate addiction and accidental overdoses across our country- hitting all demographic groups.
- Opiate overdose related deaths have surpassed deaths due to auto accidents!

Primary Care Providers Feeling the Pressure and Weight

- With the shortage of psychiatrists and long wait times to get someone in to see a psychiatrist (in some cases up to 2 years), PCP's are having to take on more MH care whether they want to or not!
- Most PCP's have *limited training* in MH care

Here is Some Good News:

- Psychiatry has become the most competitive field in all of medicine this past year

(However, we need to create more psychiatry residencies)

Opportunities to Focus on:

- Build workforce pipelines
- 1500 funded GME positions within the VA from VACAA available for funding MH, PC, and Critically needed specialty GME training (approximately 750 remain available)
- Collaboration
- Inter-professional teams including Clinical Pharmacists
- New Population Health Models
- Integration of BH Care into PC

Building New Residencies

- Challenges: No CMS increases in 22 years, Many hospitals already capped (5 years from start), no psychiatrists to provide supervision, require specialty rotations
- Opportunities: VA, Rural Hospitals, need to partner with multiple systems, State grants
- Our experience: Building Psychiatry Residencies in Green Bay and Wausau, WI, and Health Psychology Residency
- Child Psychiatry Fellowships

Population Health:

- Definition: “ the health outcomes of a group of individuals including the distribution of such outcomes within the group”
- Medical care, public health interventions, education, social support, employment, the environment, and culture all affect population health

New Pop Health Models Expand Reach of BH Specialists

- SCAN ECHO (VA)
- CPCP
- Periscope Project
- Collaborative Care

Collaborative Care Models-

- Multiple Collaborative Care Models have been developed integrating mental health care into the medical home.
- Here we briefly review the DIAMOND Model and then share our Froedtert-MCW experience.
- The VA has been a leader in developing PCMHI and is a great place where we can best look at caring for a population of individuals without the immediate concern for reimbursement

DIAMOND Model

- Developed based upon IMPACT- by Wayne Katon, MD University of Washington
- "Depression Improvement Across Minnesota Offering a New Direction"
- Criteria:
  1. Adults 18+
  2. Dx of MDD or Dysthymia
  3. PHQ9 score of 10 or more

DIAMOND Model's 6 Key Components:

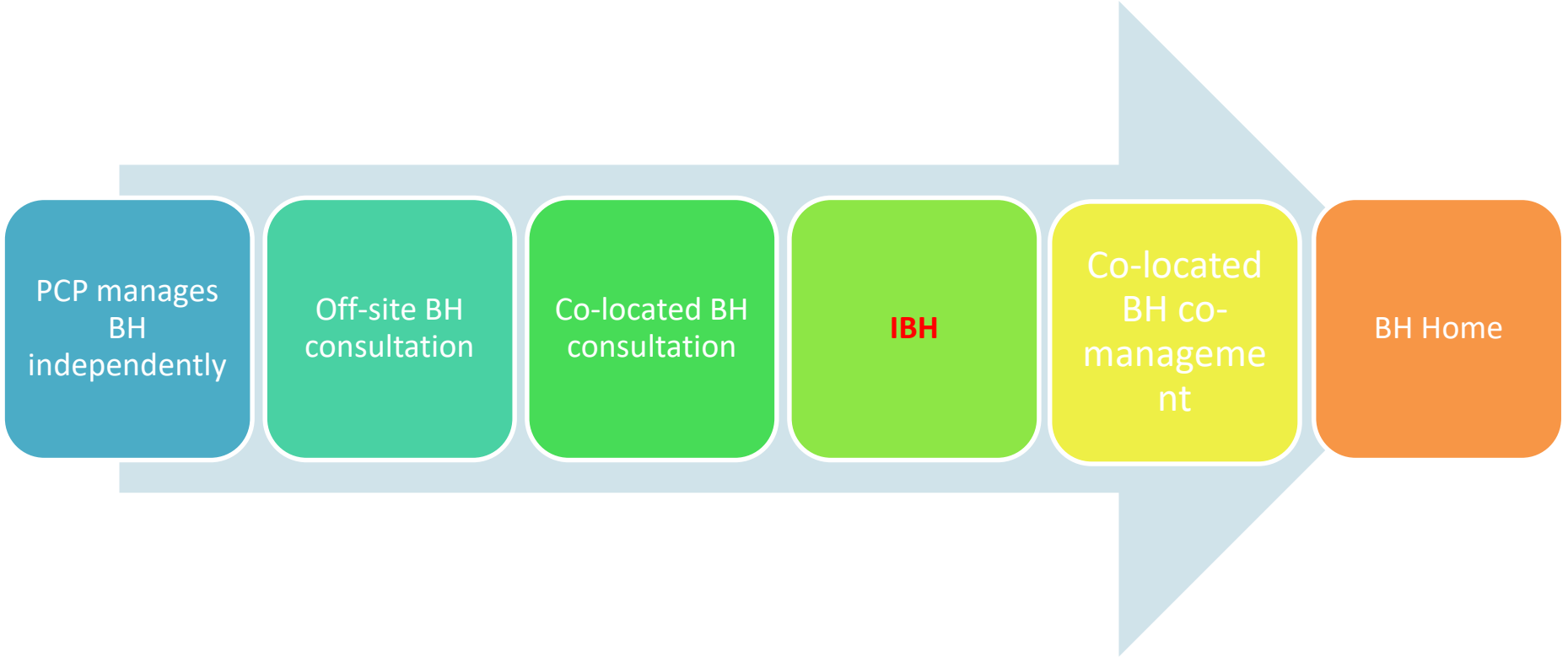
1. Standard and reliable Screening Tool: PHQ9
2. Systematic patient follow up tracking and monitoring
3. Evidence-Based Guidelines and a "Stepped Care Approach"
4. Relapse Prevention Plan for patients ready to move out of case mgmt
5. Addition of Care Manager to educate, coordinate and trouble shoot
6. Psychiatric Consultation and caseload review

Our Integrated Behavioral Health (IBH) Value Plan

Provide the clinician and patient access to high quality, evidence-based, behavioral health care within the primary care setting

- Magnify the reach of behavioral health through collaborative care
- Improve the treatment of behavioral health conditions under management
- Demonstrate health care cost control through a patient-centric population health approach to care

Where IBH Fits



The Core Principles of IBH

- Patient-Centered Care
- Population-Based Care
- Measurement-Based Treatment to Target
- Evidence-Based Care

Aims.UW.Edu

The IBH Team


Patient
Primar y Care Provid er
Resour ces
Therap ist
Psychiat rist
Care Manag er

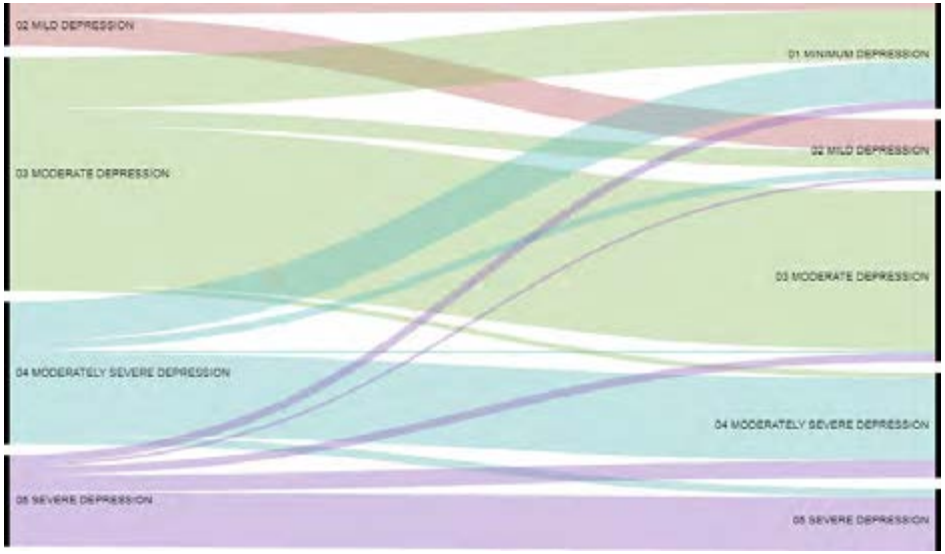
Integrated Behavioral Health

Impact on Depression

IBH's Impact on PHQ-9 Scores

Δ in PHQ-9 Score: 1/1/2017 – 10/12/2018

Patients without an IBH Episode



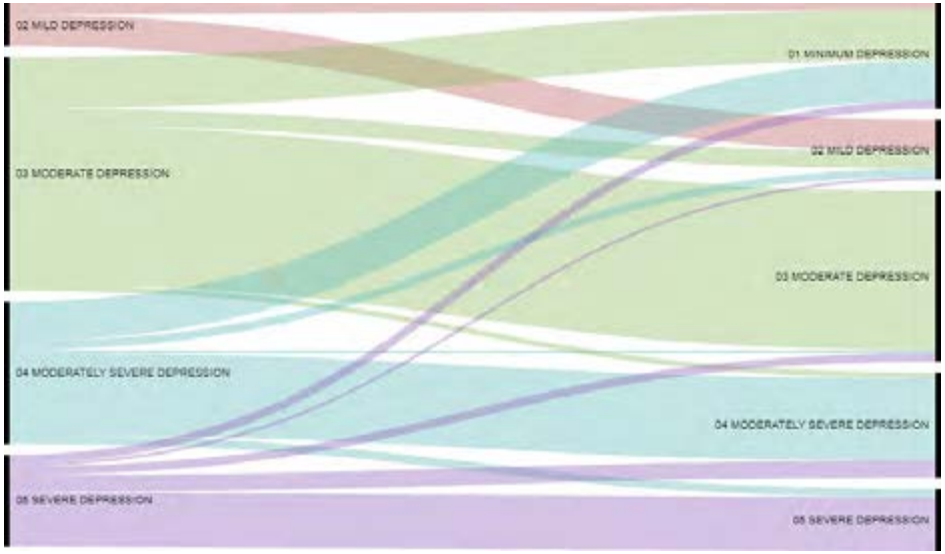
Graph Interpretation:

- From left to right: patient's initial score interpretation, patient's most recent score interpretation.
- Thickness of line corresponds to number of patients in grouping

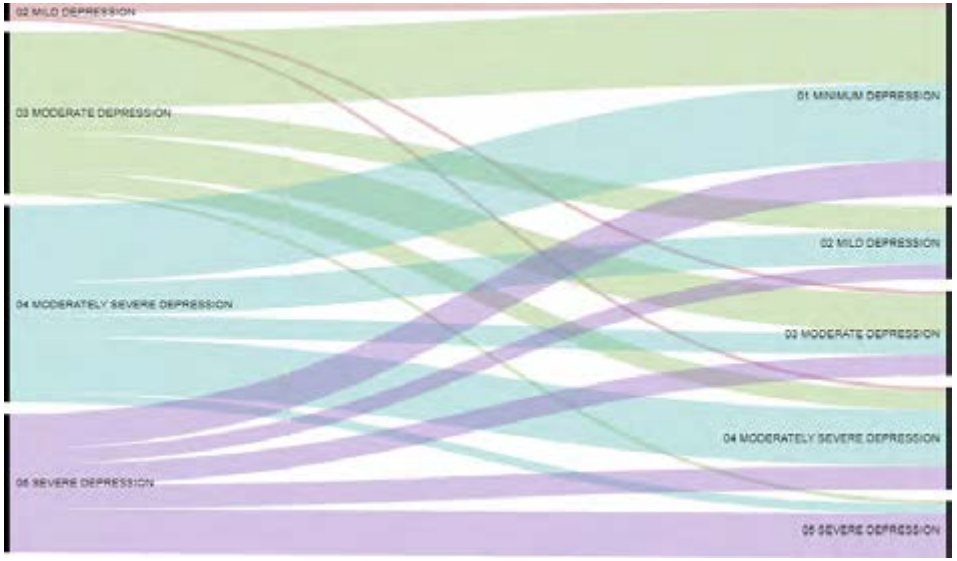
IBH's Impact on PHQ-9 Scores

Δ in PHQ-9 Score: 1/1/2017 – 10/12/2018

Patients without an IBH Episode



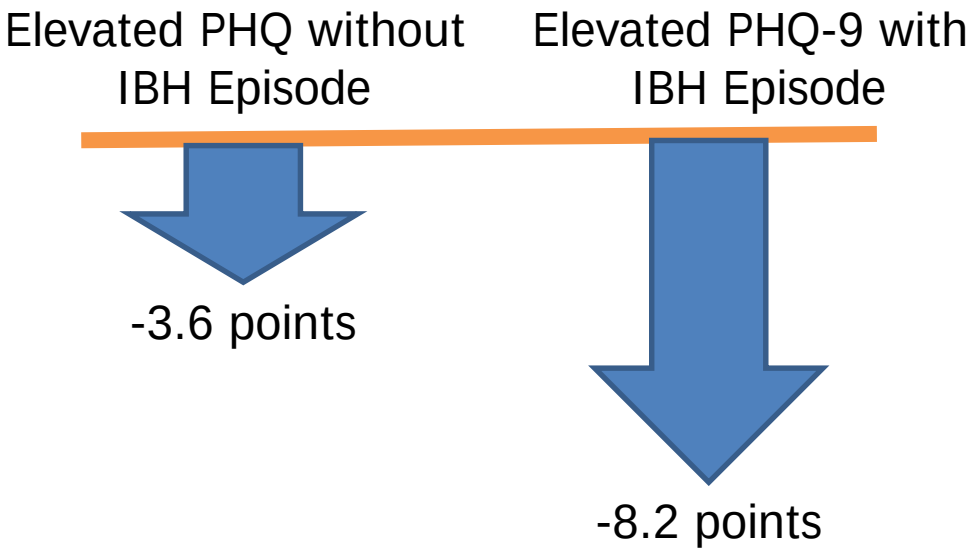
Patients with IBH Episode



Trend suggests greater movement in IBH group, especially at more severe cases of depression

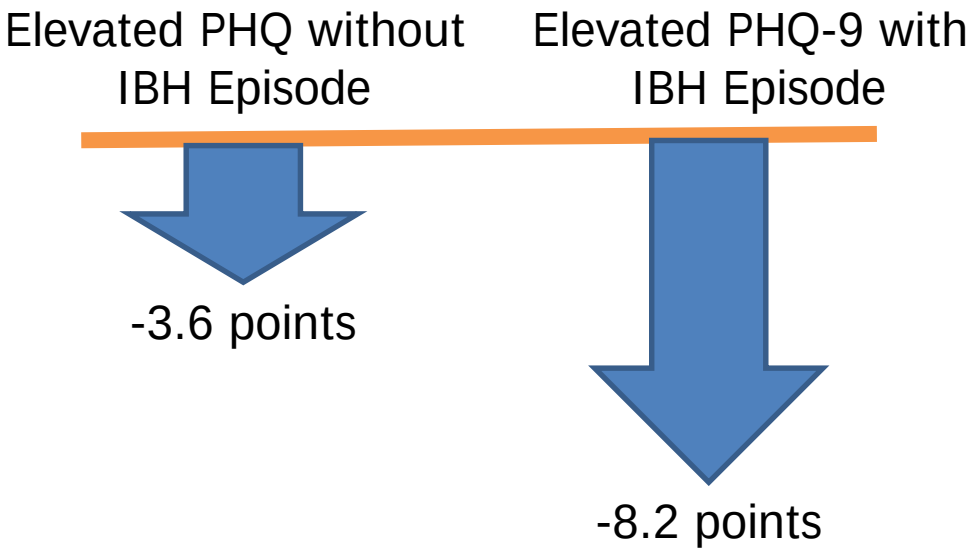
IBH's Impact on PHQ-9 Scores

Δ in PHQ-9 Score: 1/1/2017 – 10/12/2018



IBH's Impact on PHQ-9 Scores

Δ in PHQ-9 Score: 1/1/2017 – 10/12/2018



Depression

- Response (PHQ ≥10→PHQ <10)
  - IBH program → X2 rate of response compared to patients not enrolled in IBH
- Remission (PHQ ≥10→PHQ <5)
  - IBH program → x2 rate of remission compared to non-IBH patients

Integrated Behavioral Health

Impact on Cost

Assumptions

Patient	•Patient had PCP at either Sargeant or Lincoln Health Centers •Patient had elevated PHQ9 •IBH Patient: Had an IBH related encounter/episode •Non IBH patient: Did not have an IBH related encounter/episode
Costs	•Inpatient and outpatient activity for CMH, FMLH and SJH hospitals •Cost avoidance analysis does not include physician activity
Time	•Pre period: Six months prior to initial depression screening •Post period: Six months post initial depression screening

Cost Avoidance Savings

Inpatient Cases

Inpatient Cases		Total		Average per Unique Patient						
Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	Inpt Cases Avoided	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	21	22	0.11	0.12	0.01	4.8%	10.5	$6,190	$64,714
Non-IBH Patients	103	22	34	0.21	0.33	0.12	54.5%			

Outpt Visits		Total		Average per Unique Patient						
Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	Additional Outpt Cases	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	574	737	3.14	4.03	0.89	28.4%	-55.6	$99	-$5,522
Non-IBH Patients	103	679	806	6.59	7.82	1.23	18.7%			

[1] Analysis only includes Froedtert Health activity. Does not included activity billed by physicians.

ED Visits		Total		Average per Unique Patient						
Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	ED Cases Avoided	Median Direct Cost per Enc	6 months - Direct Cost Saved

Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	Inpt Cases Avoided	Direct Cost per Enc	Direct Cost Saved
IBH Patients	183	21	22	0.11	0.12	0.01	4.8%	10.5	$6,190	$64,714
Non-IBH Patients	103	22	34	0.21	0.33	0.12	54.5%			

Cost Avoidance Savings

ED Visits

Outpatient Visits

		Total		Average per Unique Patient						
Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	Additional Outpt Cases	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	574	737	3.14	4.03	0.89	28.4%	-55.6	$99	-$5,522
Non-IBH Patients	103	679	806	6.59	7.83	1.23	18.7%			

ED Visits

		Total		Average per Unique Patient						
Patient Group	Unique Patients	Period Prior to Screening[1]	Period Following Screening[1]	Period Prior to Screening	Period Following Screening	Difference	Percent Change	ED Cases Avoided	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	72	62	0.39	0.34	-0.05	-13.9%	33.6	428	$14,359
Non-IBH Patients	103	58	77	0.56	0.75	0.18	32.8%			

1 - Notes:
- Period prior to initial depression screening was 6 months
- Period following initial depression screening was 6 months
- Analysis only looks at patients where PCP location was either Sargeant or Lincoln

Analysis only includes Froedtert Health activity. Does not included activity billed by physicians.

Total Direct Cost Avoided (6 Months) = $73,551

Total Direct Cost Avoided (Annualized) = $147,102

Total Direct Cost Avoided per Patient = $804

Cost Avoidance Savings

Outpatient Visits

Inpatient Cases

Patient Group	Unique Patients	Total: Period Prior to Screening[1]	Total: Period Following Screening[1]	Average per Unique Patient: Period Prior to Screening	Average per Unique Patient: Period Following Screening	Difference	Percent Change	Inpt Cases Avoided	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	21	22	0.11	0.12	0.01	4.8%	10.5	$6,190	$64,714
Non-IBH Patients	103	22	34	0.21	0.33	0.12	54.5%			

Outpt Visits

Patient Group	Unique Patients	Total: Period Prior to Screening[1]	Total: Period Following Screening[1]	Average per Unique Patient: Period Prior to Screening	Average per Unique Patient: Period Following Screening	Difference	Percent Change	Additional Outpt Cases	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	574	737	3.14	4.03	0.89	28.4%	-55.6	$99	-$5,522
Non-IBH Patients	103	679	806	6.59	7.83	1.23	18.7%			

ED Visits

Patient Group	Unique Patients	Total: Period Prior to Screening[1]	Total: Period Following Screening[1]	Average per Unique Patient: Period Prior to Screening	Average per Unique Patient: Period Following Screening	Difference	Percent Change	ED Cases Avoided	Median Direct Cost per Enc	6 months - Direct Cost Saved
IBH Patients	183	72	62	0.39	0.34	-0.05	-13.9%	33.6	428	$14,359
Non-IBH Patients	103	58	77	0.56	0.75	0.18	32.8%			

Analysis only includes Froedtert Health activity. Does not included activity billed by physicians.

1 - Notes:
- Period prior to initial depression screening was 6 months
- Period following initial depression screening was 6 months
- Analysis only looks at patients where PCP location was either Sargeant or Lincoln

Total Direct Cost Avoided (6 Months) = $73,551

Total Direct Cost Avoided (Annualized) = $147,102

IBH Cost Avoidance Savings

Breakout by Patient Type

	6-month	Annualized
Inpatient cases	64,714	129,428
ED Visits	14,359	28,718
Outpatient visits	(5,522)	(11,044)
Total	73,551	147,102
Per IBH patient	402	804

Backfill Inpatient Value

Reduced inpatient utilization (21 lost admissions)

- Negative impact on inpatient direct margin of $88K

Backfill revenue

- Assuming each backfill admission has about $8k direct margin/admission
- Backfill revenue for this created capacity would be $168K

Net gain → About $80K in inpatient backfill

Charles E. Kubly CPCP

How it is funded:

- Kubly family,
- CHW and the State of Wisconsin have been valuable and critical partners

How it works: Education, Consultation, and Resource Coordination

Expansion: New 5 year $2M HRSA grant

MCW

Where CPCP currently serves

CPCP Results

# of providers enrolled:

- 319 pediatricians
- 323 Family Medicine

# of consultations:

- **>2500**

# of education episodes provided:

- **>1200**

CPCP Results

Response Time:

- 95% of time within 15 minutes- in other words, while child is still in provider's office

Average age of child:

- 10.75 y/o

Most Common Issues for Consultation:

1. Anxiety
2. ADHD
3. Disruptive behavior
4. Depression

CPCP Results

Kids Covered so far:

- Estimated number of Wisconsin children covered: 277,369*
- *This is a huge underestimate since ~200 of our 674 enrolled PCPs do not have data available within the WHIO database

Provider Satisfaction:

Last quarter data for provider satisfaction with consultation was 100% satisfied

Periscope Project

How it is funded:

- United Health Foundation
- State of Wisconsin

How it works:

Periscope Program Results:

- Response time- average is within 8 minutes

MCW

THE PERISCOPE PROJECT

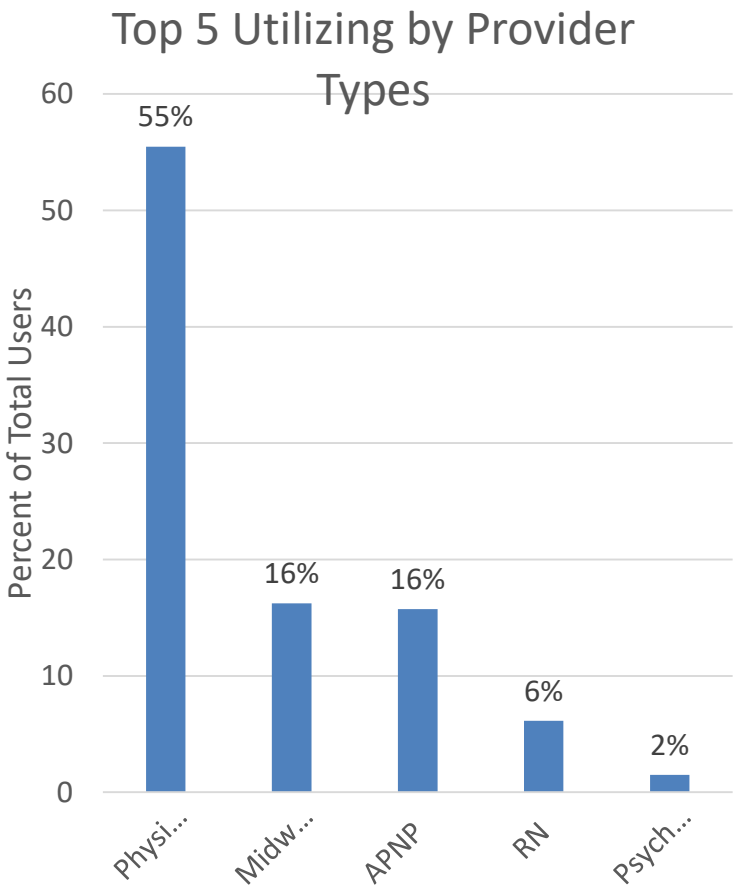
PERINATAL SPECIALTY CONSULT PSYCHIATRY EXTENSION

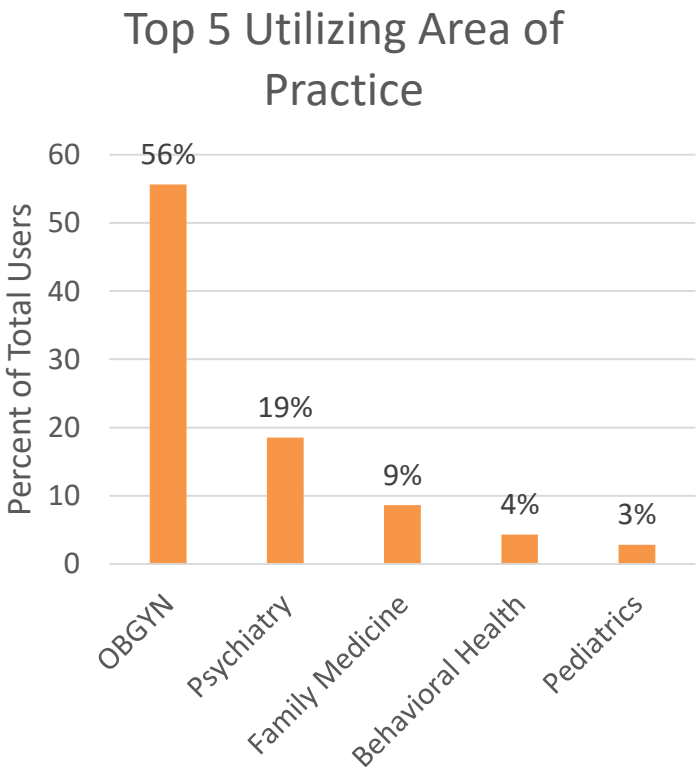
July 2017 – June 2019

879 Total Service Inquiries

Tele Consultations	737	Provider consultations with a subspecialty perinatal psychiatrist
Educational Presentations	153	**95 online modules** viewed, **22 in person didactic** presentations to **837 providers**
Resource Information	295	Requested information on resources to support the mental health of their perinatal patient

Diverse Utilizing Providers





Early Identification and Treatment

Patient Status of Consulting Provider

7% Preconception or inter-conception

60% Pregnant

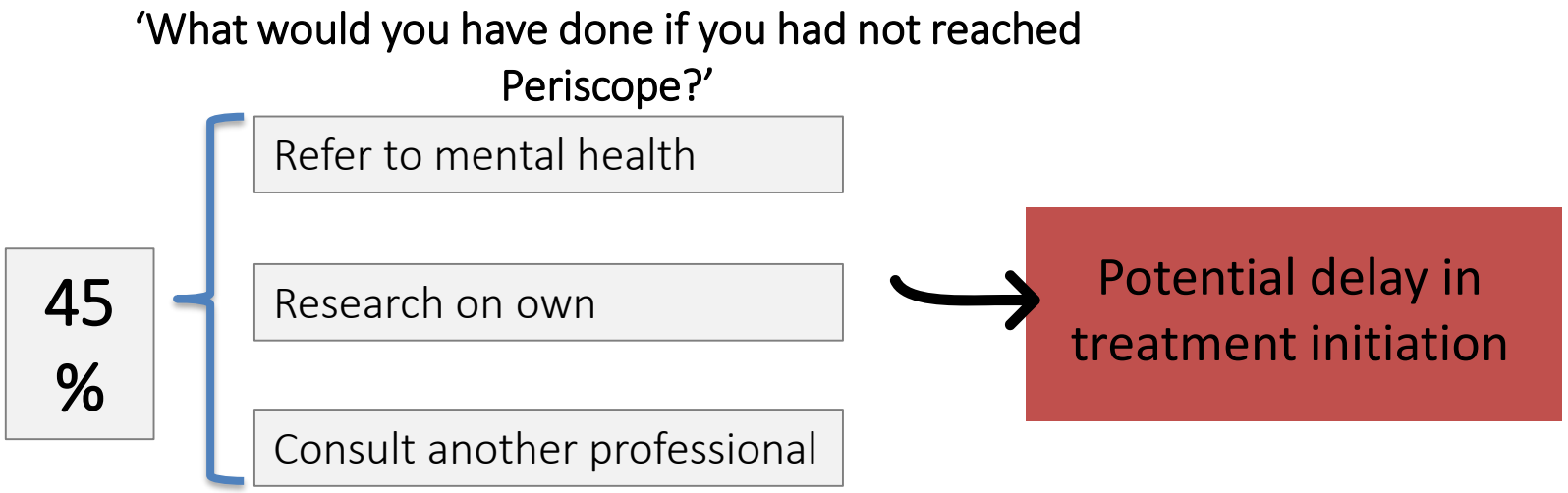
28% Postpartum

3% Perinatal Loss

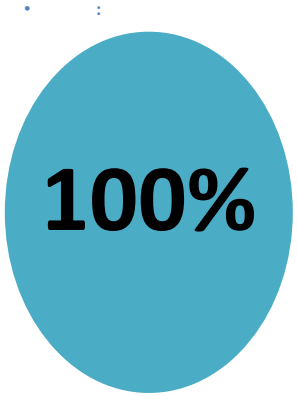
Top 5 Concerns of Utilizing Providers

- Mood Disorder (53%)
- Anxiety Disorder (28%)
- Substance Use (5%)
- ADHD (5%)
- Psychosis (4%)

Periscope is a Bridge to Treatment



Utilizing Providers are Satisfied



- Agreed or strongly agreed they were **satisfied** with the service they received
- Indicate their most recent encounter **helped them to more effectively manage their patient's care**
- Indicate they will **incorporate the information they learned in the future care of patients**
- Based on a three question post-encounter survey with a **69%** (346/502) **response rate**

"Such a quick turn around. I learn something every time I ask for help. My patients love this service, as do I! **It assures me I'm providing the best care possible for them**!"

"This service was so incredibly helpful. The psychiatrist was calm and explained things so clearly. I really feel like I can **more effectively treat my patient and manage her care appropriately because of the guidance I received**."

Success Story

- Certified Nurse Midwife (CNM) calls Periscope at 3:29 pm
  - **Case:** Patient is 3 months postpartum struggling with depression, complaining of 'lack of motivation to get out of bed' and 'very tired'
    - Positive PHQ9 on two sperate occasions, treatment initiated not effective, looking for advice on next steps
  - Triage ends at 3:34 pm
- Perinatal Psychiatrist returns call at 3:37 pm
  - Providers discuss the case and education is provided on treatment recommendations during a 7 minute conversation
- 15 days later, CNM reports:
  - "One of the patients I saw a few weeks ago who I called for consult on is **doing so much better! Her PHQ-9 score went from a 22 to a 6. I actually saw her smile for the first time in months.** It was a wonderful visit. I cannot thank you enough for providing this service to us! I greatly appreciate all the work you do in helping the women of our community."

Our Vision for a Comprehensive Consultation Program

Use CPCP Infrastructure/Vehicle and add components:

- Perinatal Psychiatry
- General Psychiatry
- Addiction Psychiatry
- Geriatric Psychiatry
- Veteran Psychiatry
- Pain Medicine

*One major barrier for growing this model of care remains a lack of reimbursement

Clinical Pharmacists

- VA is leading in utilizing this model with mental health clinical pharmacists
- The VA is uniquely situated where reimbursement is not as critical of a factor and in this system, the system can be created with the Veteran population in mind- what is best for the Veteran's care?
- If clinical pharmacists can help provide med check sessions between appointments, or during appointments as part of the MH care team, the psychiatrist can spend more time with patients and may be able to have a larger patient panel.
- MCW's new Pharmacy School

Optimizing Inter-professional Teams

- APP's
- Clinical pharmacists
- Psychologists
- Social Workers
- LPC's
- Nurses
- Peer Counselors

Each member of healthcare team must work at the "top of their license".

This is a cost-effective and patient centered approach to improving access by maximizing team work and collaboration. The BH field has often been a leader in inter-professional team care delivery.

Moving Forward:

- I hope you better understand the access challenges to behavioral health care
- You have learned some population health approaches toward expanding BH care access that can minimize the effects of stigma
- I hope you have gained some ideas for how to improve access to mental health care with limited resources
- We must take a multi-faceted approach toward improving MH care access and toward suicide prevention

If We Can Remove All Barriers for Access to MH Care….

- If we have open access for all people to MH care, I believe we can get much closer to zero suicides.

- Thanks for listening

- Questions?