

# UT MH Access and Workforce Availability

An Overview of Current Challenges and Opportunities

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# Overview

- Introduction
- Nature of the Problem
- Federal, Private, and State Efforts
- Opportunities and Best Practices
- Lessons learned from neighboring states

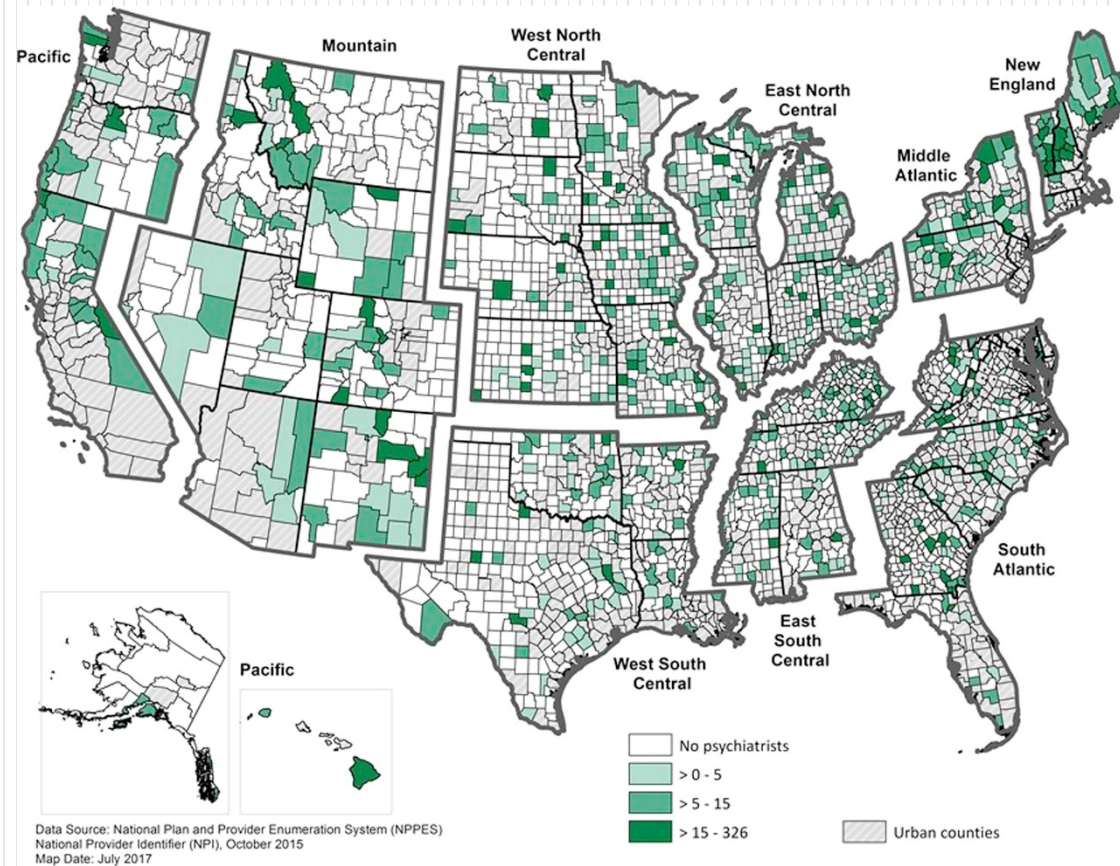
# Nature of the problem

- More than half of U.S. counties have zero psychiatrists<sup>1</sup>
- About 111 million people live in "mental health professional shortage" areas.<sup>2</sup>
- Two-thirds of primary care physicians report difficulty referring patients for mental health care.<sup>3</sup>
- The number of patients going to emergency departments for psychiatric services 42 percent.<sup>4</sup>
- Expected to grow to nationally to 250,000 providers by 2025<sup>2</sup>

# Underlying issues related to shortage

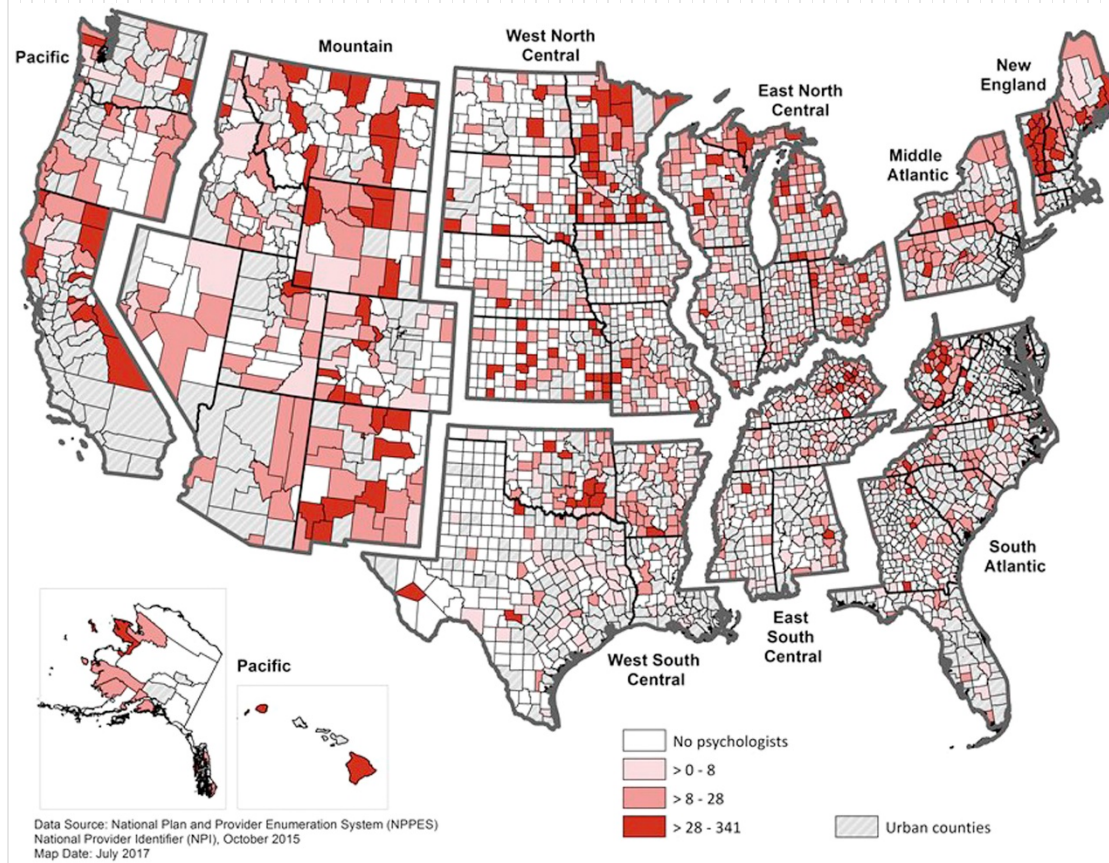
- Nationally a lack of:
  - Workforce Development
    - Targeted recruitment, training and retention<sup>6</sup>
  - Efficiency of regulations and service delivery
  - Implementation of innovative technologies and models
  - Systems responsive and culturally appropriate services
  - Health Insurance and Provider Network Capacity
    - 10% of in-network availability
    - Adequate reimbursement for MH services<sup>5</sup>

# National Shortages: Psychiatrists



Source: American Journal of Preventative Medicine, 2018

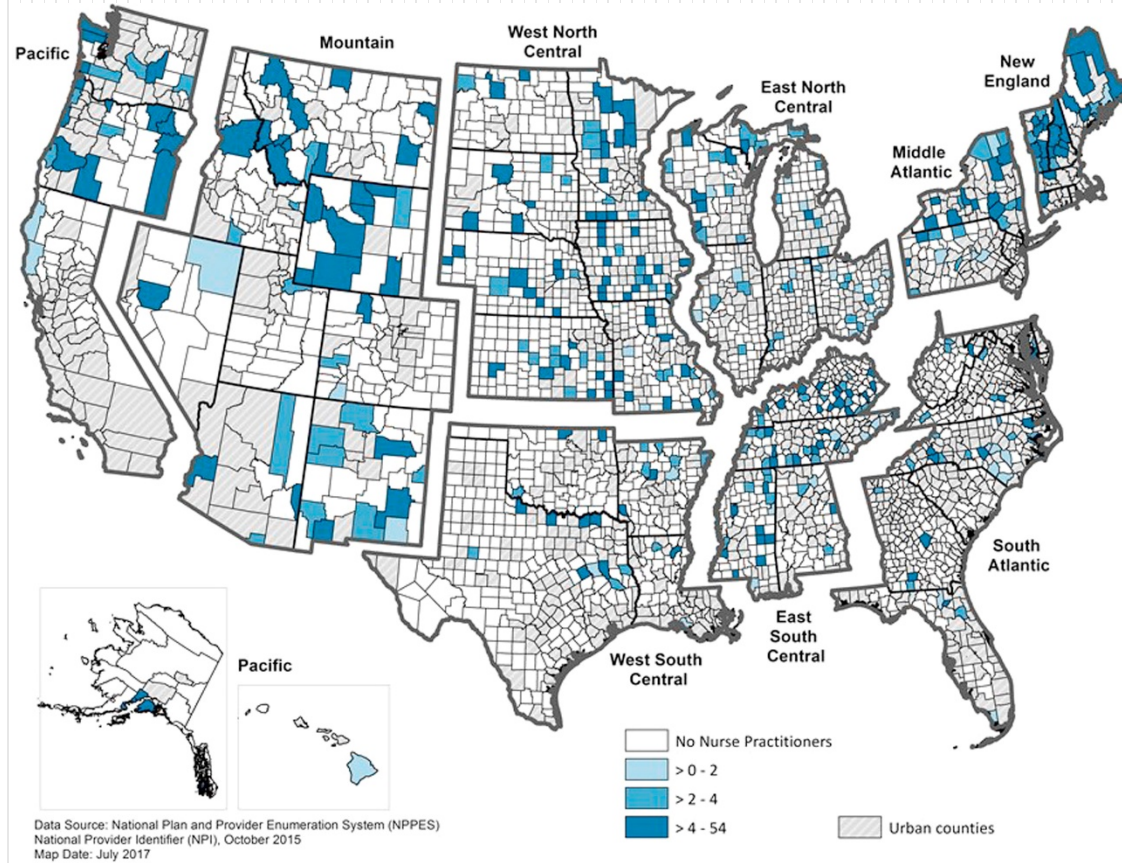
# Psychologists



Source: American Journal of Preventative Medicine, 2018



# Nurse Practitioners

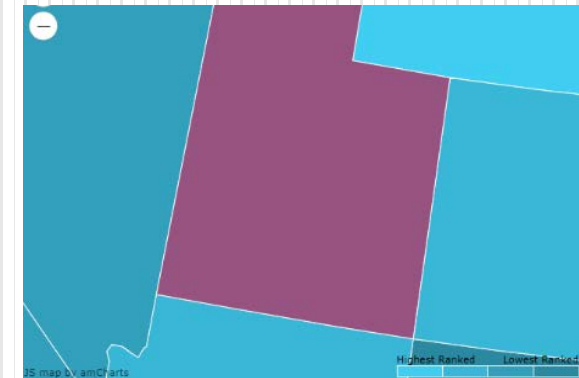


Source: American Journal of Preventative Medicine, 2018

# Access Within Utah

Location	Total Mental Health Care HPSA Designations	Population of Designated HPSAs	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Utah	39	2,012,634	47.62%	57

- 34<sup>th</sup> nationally<sup>8,9</sup>
- Higher (and lower) incidence rates
- Delays of 3-6 months at major medical centers



Rank	State	%	#
1*	Connecticut	48.6	12,000
2	Maine	50.1	5,000
3	Vermont	50.6	2,000
4	Minnesota	51.9	21,000
5	Alaska	53.1	3,000
6	Oregon	54.9	26,000
7	Massachusetts	55.5	26,000
8	Maryland	55.6	24,000
9	Wyoming	55.7	3,000
10	Iowa	56.4	13,000
11	Ohio	58.0	56,000
12	New Hampshire	58.0	7,000
13	South Dakota	58.1	3,000
14	Delaware	58.8	4,000
15	West Virginia	59.9	8,000
16	Idaho	59.9	9,000
17	New York	60.3	91,000
18	Rhode Island	61.6	7,000
19	Illinois	61.8	66,000
20	Michigan	62.0	55,000
21	Colorado	62.1	36,000
22	Nebraska	62.1	8,000
23	Arizona	62.1	47,000
24	North Carolina	62.3	58,000
25	Washington	62.5	36,000
26	North Dakota	62.5	2,000
27	Indiana	62.7	50,000
28	Oklahoma	63.1	18,000
29	Kansas	63.3	14,000
30	New Jersey	63.5	34,000
31	Nevada	64.0	20,000
32	District of Columbia	64.1	1,000
33	Montana	64.6	4,000
34	Utah	64.7	19,000
35	Kentucky	64.9	20,000
36	California	65.0	233,000
37	Louisiana	65.0	19,000
38	Georgia	65.5	46,000
39	Missouri	66.3	30,000
40	Pennsylvania	66.4	65,000
41	Arkansas	66.6	17,000
42	Hawaii	66.7	6,000
43	Florida	66.8	105,000
44	Alabama	67.1	24,000
45	New Mexico	68.2	12,000
46	Texas	69.5	183,000
47	Mississippi	70.0	15,000
48	South Carolina	70.6	23,000
49	Virginia	70.8	55,000
50	Wisconsin	71.8	51,000
51	Tennessee	72.2	31,000
	National	63.0	1,548,000

\* Due to data limitations, figures were taken from two sets of data: annual averages from 2013-2015 and 2010-2015. Data set denoted for each state in the Appendix





# Costs of our access issue

- Delayed diagnosis and intervention => Increased chronicity and severity
- Overwhelmed PCPs are frontline for MH care
- Systemic barriers and poor quality of care inoculate against seeking treatment
- Exponential increase in expense and suffering



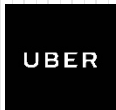
# Current Federal Efforts

- **H.R. 6597, *the Mental Health Professionals Workforce Shortage Loan Repayment Act of 2018***
  - loan repayment program for MH professionals working in shortage area
- **H.R.5102 Substance Use Disorder Workforce Loan Repayment Act of 2018**
- **SAMHSA**
  - **Workforce Development Strategic Initiative**
    - Provider access to integration and screening resources, scholarships, specialty fellowships and peer training programming.
  - **Behavioral Health Workforce**
    - Serious Mental Illness Coordinating Committee, Funding of the Behavioral Health Workforce Education and Training Program, Certified Community Behavioral Health Clinics, Assertive Community Treatment programs and Community Mental Health Services Block Grant

# Selected Utah State Legislative Efforts

- 2016: H.B. 265 Mental Health Practitioner Amendments -Tax credit
- 2017: S.B. 106 Psychology Interjurisdictional Compact
- 2018: H.B. 199 Evidence Based Treatments (held)
- 2018: SB 19: Competency to Stand Trial Amendments
- 2018: HB 173: Occupational Licensing Requirement Amendments

# Private Sector Efforts to address the gap

- “Bishop Pay”
- Expansion of Employee Mental Health Benefits
  - E.g.   
- Insurance Capitated Payments
- Movement to tie incentives to clinical outcomes (or customer service ratings)

# Opportunities and Best Practices

- Expansion of collaborative care models
  - Integration and EHR is critical
  - Telepsychiatry/psychology services
- Provider network adequacy
  - Policies that encourage provider participation
- Education Recruitment and Loan repayment
  - Pipeline initiatives, dedicated “rural tracks”
- Investment in research and training for better care models
  - Comorbidities, EBTs, burnout prevention



# Lessons Learned

- Need for:
  - Improved stakeholder input and collaboration
  - Locally-relevant data direct from the source
  - Public education campaigns to reduce stigma
  - Nuance by discipline in licensure reciprocity
  - Caution with scope of practice expansion<sup>6,7</sup>



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