The Evolution of Mental Health Care Delivery: Implications for The Work Force

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Introduction and Overview

- Mental health and mental health care improved notably over the past 30 years
- Much still needs to be done
- The evolving system has altered how funding and economic rewards are distributed within mental health care
- Part of the evolution is driven by large social and economic forces; some is a result of mental health policy
- It may be time for some adjustments

Dimensions of Performance

- Access to care
- Quality of care
- Support for people with severe mental disorders
- Cost/spending

Access to Care

	1990-1992	2001-2003	%Δ
Any Tx All	12.2%	20.1%	64.7%
Any Tx SMI	24.3%	40.5%	66.7%
Any Tx Disorder	20.3%	32.9%	62.1%

Source: NCS and NCS-R

Quality of Care Indicators

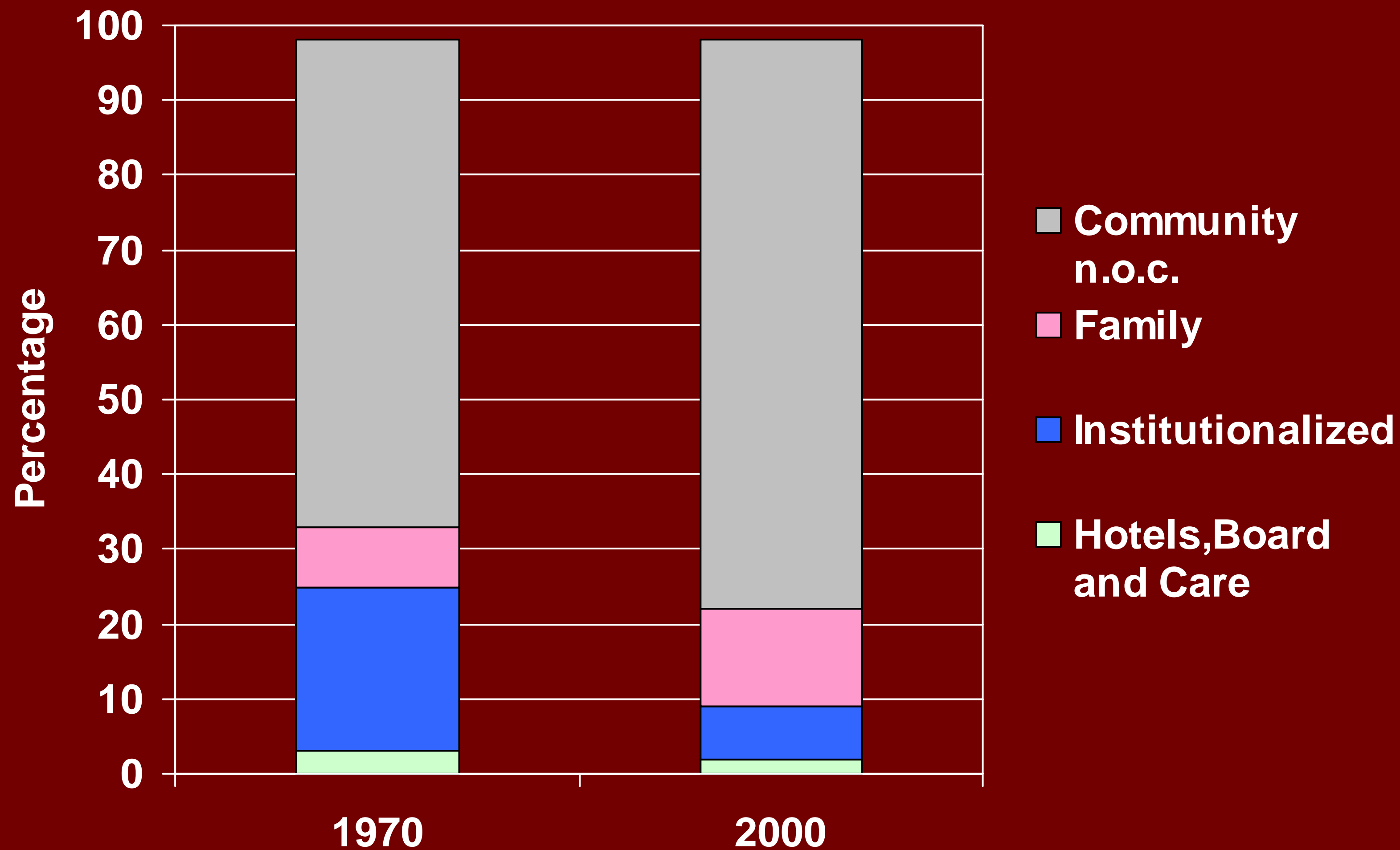
	1975	1997	2002
% of ADD care likely to be effective (acute phase)	17%	58%	60%
antipsychotics for schiz % appropriate dose and duration	25%	47%	59%
% appropriate bipolar prescribing (mood stabilizer)		45%	56%

HEDIS Antidepressant Management: Commercial

Year	Contacts	Acute Phase	Continuation
1998	22.7%	54.3%	38.0%
2000	20.6%*	57.8%*	41.0%
2002	19.2%	59.8%	42.8%
2004	20.0%	60.9%	44.3%
2005	20.6%	61.4%	45.0%

*interpolated
Source: NCQA

More People with SPMI are living Independently or with Family



Income Support, Homelessness And Incarceration Have All Increased For People With SPMI

	1970	1980	2000
SSI/DI for SPMI	-	17%	62%
Correctional Facilities	2%	3%	7%
Homeless SPMI	2%	2%	3%

Summing Up

- Far more people are getting care today than ever before
  - There remains much under treatment
- A higher proportion of people receiving care obtain more effective care than in past
  - A large portion of people in treatment do not receive evidence based care; Many treatments for major illnesses offer only modest improvements
- More people with SPMI are living independently in community settings
  - People with SPMI are most often condemned to a life of poverty: percent of people with SPMI who are homeless or in prison increased

Mental Health Spending by Payer Class 1971-2003

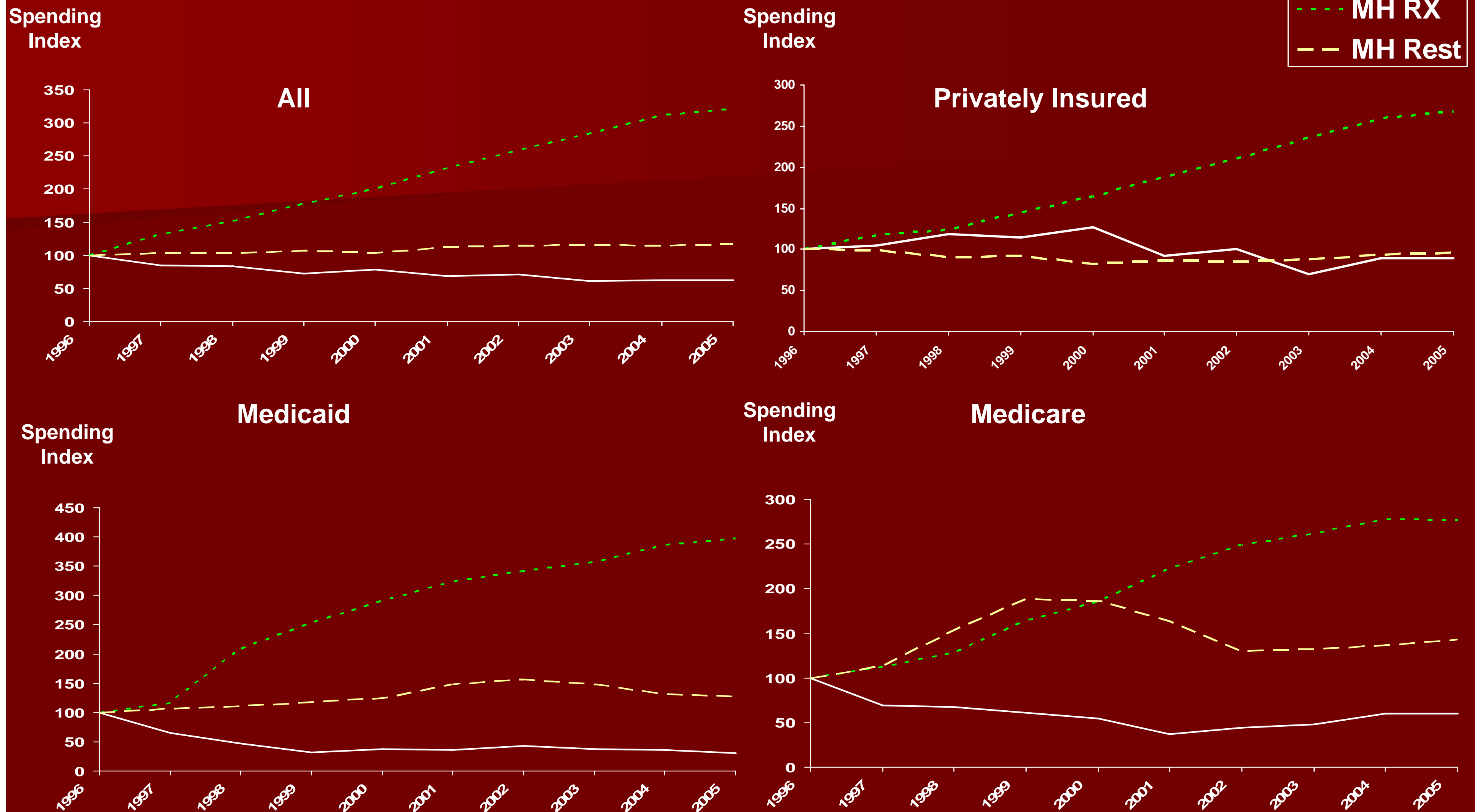
	1971	1991	2001	2003
Medicaid	$1.28b (14.2%)	$9.2b (18.8%)	$23.4b (27.4%)	$26.4b (26.3%)
Medicare	$0.23b (2.6%)	$3.3b (6.7%)	$6.3b (7.3%)	$7.3b (7.3%)
State (exclude Medicaid)	$2.720b (30.4%)	$13.1b (26.7%)	$20.0b (23.4%)	$21.1b (21.0%)
Private Insurance	$1.10b (12.3%)	$10.6b (21.7%)	$18.7b (21.9%)	$24.3b (24.2%)
Fees/OOPs	$3.19b (35.6%)	$7.5b (15.3%)	$10.9b (12.8%)	$14.3b (14.2%)
Total	$8.96b (100%)	$48.9b (100%)	$85.4b (100%)	$100.3b (100%)
Share of National Health Expenditures	11.1%	6.4%	5.9%	6.2%
Share of GDP	0.84%	0.82%	0.84%	0.91%

Spending as Percentage of GDP

	1971	1991	2001	2003	%Δ
All Health	7.10%	12.20%	14.10%	15.30%	115.5%
Mental Health	0.84%	0.82%	0.84%	0.91%	8.3%

Observations

- Until recently (2002) spending on mental health grew slower than health spending
- Mental health spending grew at roughly the rate of national income (GDP), health care spending grew at GDP+2-3%
- Private insurance has grown especially fast recently



Source: MEPS; 1996 – 2005

Spending index constructed through regression analysis. 100 represents mean spending in 1996 for each group. Regression included sex, race/ethnicity, region of the country, MSA status, health and mental self-reported status and age as controls. Reported values are the regression analysis coefficients on each year with 1996 normalized at 100.

Observations

- Prescription drug spending is driving mental health spending growth across all payers in recent years
- Inpatient psychiatric spending continued to decline through 2005
- Outpatient mental health care spending is flat
- This helps to explain why mental health providers see the world as bleak even though meaningful spending growth continues

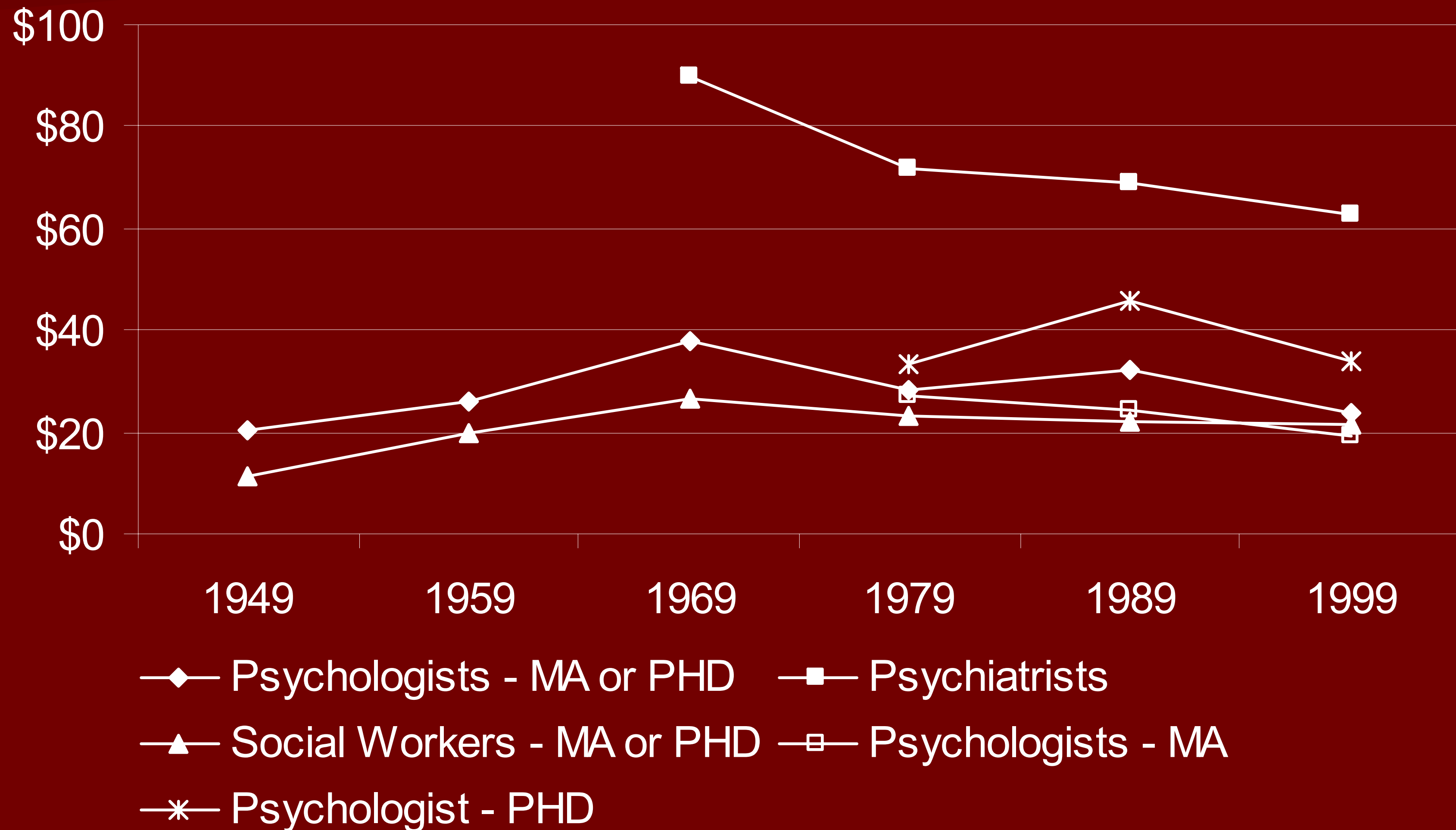
Explanations

- Clinical science in mental health has invested heavily in drug development
- Insurance coverage for prescription drugs has grown rapidly since the 1980s
- Managed behavioral health care (MBHC) carve-outs are paid to control spending on inpatient and outpatient mental health care BUT no use of psychotropic drugs
  - Price of drugs to carve-out is zero
- Result: MBHC encourages use of treatment that emphasizes prescription drugs

Index of Trainees

	1984	1989	1996	1998	2000	2002	2004
Psychiatry	100	114	115	114	108		105
Psychology	100	116	197	158	141	161	179
Social Work (masters)	100	125	150	151			
Nursing	100	96	87			80	
Counseling			100		68	163	
Source: Mental Health US, 2004							

Average Hourly Earnings (2002 Dollars)



I.iv: Percentage of Psychiatrists with 100% Self-Pay Patients (NAMCS)
12.00
10.00
8.00
6.00
4.00
2.00
0.00
4.17
5.71
5.26
9.59
7.04
3.66
3.95
7.07
2.33
1997
1998
1999
2000
2001
2002
2003
2004
2005
100% Self-Pay

Observations

- Spending on ambulatory mental health care is flat
- Care remains primarily “in network”
- Treatment is shifting toward pharmacotherapy
- More people are being treated
- More clinical professionals are being trained
- Simple economics predicts salaries will fall

New Developments

- Pressures for quality reporting, electronic records, use of IT to support evidence based treatment
- Increased public reporting, more accountability, pay for performance
- Medical home concept and expanded integration of mental health and health
- Implication: The solo-small group mental health practice will be threatened economically

Mental Health Practices 2004-2005		
	Psychiatry	All MDs
Use IT to:		
Obtain Guidelines	52%	65%
Write Rx	20%	22%
MD Exchange	34%	50%
Hospital	34%	66%
% in solo-2MD Practices	42.3%	32.5%
% in 6+ groups	4.4%	21.8%
Payers require less quality reporting of mental health outcomes		
Source: Center for Health Systems Change: Physician Tracking Study		

Policy Issues

- It may be time to redesign the carve-out model
  - To make for more balanced management of psychotropic drugs and psycho-social care
  - Payers: private employers and Medicaid can do this
- New economic models of ambulatory mental health care are called for
  - Role in medical practice
  - Multidisciplinary specialty practice
    - Making IT and care management affordable