

Discarding Community Psychiatrists

The Third Report Card by the North Carolina Psychiatric Association

April 18, 2006

EXECUTIVE SUMMARY

With nation-wide shortages of public sector mental health clinicians (especially psychiatrists), the architects of North Carolina's mental health reform directed public agencies to divest themselves of clinical staff. This Report Card presents the only known data on mental health reform's effect on the professional workforce, with estimates of the impact on mental health consumers. (While the North Carolina Psychiatric Association [NCPA] acknowledges with gratitude the work of the North Carolina Council of Community Programs in conducting this survey, NCPA alone is responsible for the content of this Report Card.)

In the two years from 2003 to 2005:

1. **The estimated number of Local Management Entity (LME) sector psychiatrists fell by 48 full-time equivalents.**
2. **Per capita LME-sector psychiatrists fell 16.1%. These losses affected rural LMEs (19.7%) more than urban LMEs (13.7%).**
3. **Small-population LMEs lost 44% of its psychiatrists, compared to 8-9% for larger-population LMEs. Small LMEs went from an average of 5.2 to an average of 2.9 psychiatrists/LME, imperiling clinical viability.**
4. Impact of losses on patients: **NCPA estimates that the patient/psychiatrist ratio has worsened by 24.2% and at least 31,000 LME-sector patients with mental illness are unable to access psychiatric care. These workforce losses result in more difficulty getting appointments and longer waits to be seen.**
5. Local Management Entity CEOs estimated that **70 more FTE psychiatrists, or 23% of the current workforce, are needed.**

Major Changes Needed to Reverse the Losses

In NCPA's view, substantial intervention is needed to reverse these losses. Incomplete measures will not suffice unless clinicians have both clinical viability and financial viability. Clinical viability refers to the ability to have a professionally meaningful career in a setting where patients can be well cared for. Financial viability means that psychiatrists can make a living without undue anxiety about organizational survival. **Under current conditions, assuring financial viability is probably impossible without substantial state subsidies, whether in the form of direct subsidy, state positions, or support of a state-wide organization.**

I. NATIONAL DATA AND NORTH CAROLINA SURVEY

According to 2004 data from the National Association of State Mental Health Program Directors (NASMHPD),¹ 45 states reported shortages of mental health professionals. Of these, 100% reported shortages of psychiatrists (87% of them in the community sector), 89% reported shortages of RNs, 76% reported shortages of masters' prepared nurses, 67% reported shortages of social workers, and 44% reported shortages of psychologists. North Carolina itself reported shortages in all these disciplines: shortages of psychiatrists, psychologists and RNs in the community; and of RNs, masters'-prepared RNs, social workers, and non-psychiatrist physicians in hospitals.

In the summer of 2005, the NC Council of Community Programs, through its Support Services Work Group (with NCPA participation), conducted a survey of LME CEOs to investigate what has happened to community psychiatrists in the state. Distributed to the 32 LME CEOs, the survey asked, for each LME (and its predecessor organizations):

1. For July 1999, July 2003, and July 2005: the number of full-time equivalent (FTE) psychiatrists, by employment relationship to the LME: (a) directly employed, (b) individually contracted, or (c) contracted through a provider agency or member of provider community.
2. How many additional FTEs do you estimate are needed for direct services in your catchment area?
3. What problems is the LME encountering around availability and utilization of psychiatrists?
4. Please give suggestions to improve the availability and utilization of psychiatrists in your area.

Twenty of thirty-two LMEs responded (1 provided incomplete information on psychiatrist workforce, so it was excluded from that part of the survey).² As Table 1 shows, from the responses we estimate that in 1999 335 FTE psychiatrists worked in the LME sector;

Table 1: FTE psychiatrists in LME sector 1999, 2003, 2005
(Extrapolated from data from 19 LMEs, representing 61.8% of NC population)

	<u>FTE</u> <u>Psychiatrists</u>	<u>Change in FTE</u> <u>Psychiatrists</u>	<u>Percent</u> <u>Change</u>
1999	334.8		
2003	348.6	+ 13.9	+ 4.1%
2005	300.8	- 47.8	- 13.7%

¹ <http://www.nri-inc.org/defprofiles.cfm> – search on Year: 2004 and Keyword: shortage. Accessed March 3, 2006.

² For details on responding LMEs, see Technical Notes, below.

between 1999 and 2003 this number increased 4.1% to 349; and between 2003 and 2005 the number of FTE psychiatrists fell by 47.8 to 300.8, representing a 13.7% loss.

LME CEOs estimated that an additional 69.7 FTE psychiatrists are needed for direct services, 23.2% of the current psychiatrist workforce.

Per capita FTE psychiatrists in the LME sector fell 16.1% between 2003 and 2005, from 0.414 LME psychiatrists per 10,000 population in 2003 to 0.347 in 2005.

As Table 2 shows, the per capita loss of LME psychiatrists between 2003 and 2005 affected rural LMEs (19.7%) more than urban LMEs (13.7%). Given that non-metropolitan NC has 0.58 psychiatrists/10,000,³ the 0.408 psychiatrists/10,000 provided by rural LMEs in 2003 were 70% of NC rural psychiatrists. This points to the particular impact that losing LME-sector psychiatrists has on rural North Carolina.

Table 2: Psychiatrist FTEs per 10,000, rural vs urban: 1999, 2003, 2005

	<u>July 2003</u>	<u>July 2005</u>	<u>Percent Change</u>
Rural	0.408	0.327	-19.7%
Urban	0.418	0.361	-13.7%

The loss of psychiatrists was most severe in small-population LMEs (population under 165,000; see Table 3). These lost 44% of their psychiatrists between 2003 and 2005, a loss that brought the average small-population LME from 5.2 psychiatrists to 2.9 – a number that brings a medical staff almost to the point of being unable to provide medically necessary services. Losses experienced by larger-population LMEs were less severe (8-9% from 2003 to 2005).

Table 3: Psychiatrist FTEs per LME, by size of LME
1999, 2003, 2005

<u>% of state population in LME</u>	<u>July 1999</u>	<u>July 2003</u>	<u>July 2005</u>
< 2% (95,000-165,000)	5.8	5.2	2.9
2 – 4 % (176,000-310,000)	9.9	11.1	10.2
> 4 % (350,000-760,000)	20.6	21.1	19.2

³ Fraher E, Swartz M, Gaul K: The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform. A Collaboration of: North Carolina Area Health Education Centers (NC AHEC) Program; the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine; and the Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. http://www.shepscenter.unc.edu/hp/Psychiatrist_Brief.pdf Accessed March 16, 2006. For the 0.58 datum, see Table 2 on page 4.

Table 4 shows that between 2003 and 2005 the FTE number of LME-employed psychiatrists fell by 66 and the number of individual contractors fell by 26. The increase of 43 in provider community psychiatrists did not make up for these losses.

Table 4: Psychiatrist FTEs, by employment relation to LME,
(Extrapolated from data from 19 LMEs, representing 61.8% of NC population)

	<u>July 1999</u>	<u>July 2003</u>	<u>July 2005</u>
Employee	174.4	172.6	106.8
Individual Contractor	62.3	66.2	40.6
Provider Community	94.8	110.2	153.1

When asked the top three problems in recruitment/retention, the LME CEOs reported:

1. Insufficient reimbursement / funding,
2. Lack of availability, and
3. Non-competitive salaries.

The Council summarized the LME CEOs' suggestions for improvement:

1. Improve reimbursement rate for psychiatrists⁴
2. Increase salaries & fringe benefits to make public sector work more desirable and attractive
3. Increase staff support for medication management and treatment team activities of psychiatrists
4. Address state-wide workforce shortage itself: develop out-of-state recruitment programs, work with medical schools & training programs

⁴ This refers to third party reimbursement for psychiatric services.

II. IMPACT ON PATIENTS OF LOSING COMMUNITY PSYCHIATRISTS

Table 5 displays patients per psychiatrist FTE. In 1999 and 2003, this ratio was remarkably stable, with around 650 patients per psychiatrist FTE. With the loss of psychiatrists by 2005, this ratio has increased 24.2%, to 807 patients per psychiatrist FTE. (It is noteworthy that when the 69.7 additional psychiatrist FTEs that LME CEOs estimated were needed are added in, the result is a 2005 caseload in the 1999-2003 range of 650-655 patients per psychiatrist FTE.)

Table 5: Patients per Psychiatrist full-time equivalent (FTE)
1999, 2003, & 2005 (both actual 2005 and with 69.7 additional FTEs)

	<u>July 1999</u>	<u>July 2003</u>	<u>July 2005</u>	<u>July 2005</u> <small>(with 69.7 more FTEs)⁵</small>
Persons with mental illness served ⁶	219,253	226,453	242,654	242,654
Psychiatrist FTEs	334.8	348.6	300.4	370.1
Patients / Psychiatrist FTE	654.9	649.6	806.7	654.9

So what does the loss of community psychiatrists mean to public sector patients? As noted above, the average caseload of the remaining LME-sector psychiatrists was 24.2% higher in 2005 than in 2003. This translates into more difficulty accessing community psychiatrists, longer waiting times to appointments and less flexibility in scheduling.

By another measure, the loss of 47.8 psychiatrist FTEs, multiplied by 650 patients/FTE, suggests that at least 31,070 patients lost access to psychiatric services between 2003 and 2005.

⁵ This column assumes that the 69.7 FTEs that LME CEOs estimated were needed were available.

⁶ Data on "Persons with mental illness served" from <http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm> FY 98-99 used for July 1999, FY 02-03 used for July 2003. July 2005 is an estimate based on total number served in FY 04-05. Accessed April 9, 2006.

III. CONCLUSIONS and RECOMMENDATIONS:

UNDOING FAILED POLICY:

INCREASING THE COMMUNITY PSYCHIATRY WORKFORCE

The loss of community psychiatrists between 2003 and 2005 was self-inflicted by the state of North Carolina. State officials assumed that market forces would ensure an adequate supply of clinicians and developed policy intended to replace public sector psychiatrists with private sector psychiatrists serving community-based mental health programs. As the data presented in this Report Card demonstrate, this policy failed.

In addition, there is no evidence that the state monitored the effects of this policy decision, reflecting insufficient monitoring of the overall effects of mental health reform on consumers and workforce.

And there is little reason to suppose these losses have stopped. Since it is now almost a year since the survey was conducted, it is likely that the losses have continued to the 20+% range.

To address this crisis, NCPA believes that policymakers must understand that psychiatrists and other clinical professionals need two things for successful recruitment and retention: clinical viability and financial viability.

Clinical Viability refers to the ability to have a professionally meaningful career. This requires a clinical environment in which professional work can be done – a setting of reasonable workload, a setting in which patients can get good care.

Clinical viability requires that:

1. psychiatrists have necessary interdisciplinary team and staff support (this includes funding for drug levels and other medically necessary tests and procedures);
2. psychiatrists have a manageable workload, including reasonable time for appropriate clinical evaluations and for communicating with other professionals;
3. psychiatrists have reasonable input into clinical governance and report to a psychiatrist, not to a non-clinician; and,
4. psychiatrists must feel valued and supported and have some sense of a meaningful professional career to remain in the system.

Financial viability means that psychiatrists can make a living, without undue anxiety about organizational survival. State policy has backfired particularly in its attempt to transfer the financial risk inherent in Medicaid billing directly to psychiatrists. This has destabilized community psychiatrists, who are either leaving the public sector or leaving the state. NCPA believes that at this point micro-policy adjustments, like adjusting Medicaid reimbursement rates, will not fundamentally assure financial viability and therefore will not correct current shortages. Substantial state subsidies will be necessary

to ensure financial stability sufficient to reverse the losses in community psychiatrists.

Where current arrangements are satisfactory, no change may be needed. However, elsewhere, the following must be considered:

1. The state may need to provide direct subsidies of half or more of psychiatrists' salary and benefit costs to organizations to ensure psychiatrist supply.
2. The state may need to commit state civil service positions to localities to ensure an adequate number of psychiatrists.
3. A "state-wide organization" (SWO) may need to be established to provide a financial superstructure for psychiatrists' employment in some localities. The SWO could contract with LMEs or other clinical providers. The SWO could be a part of an existing organization (such as a medical school department of psychiatry) or established for this purpose.

LME CEO suggestions.

NCPA supports the suggestions provided by the LME CEOs (see page 4). The first suggestion calls for improving the reimbursement rate for psychiatrists, which should be done as part of ensuring financial viability. The second suggestion, to increase salaries & fringe benefits, is part of ensuring financial viability; and the third, to increase staff support for psychiatrist's clinical activities, is a component of clinical viability.

In their fourth suggestion, to address the state-wide workforce shortage itself, the LME CEOs draw attention to the workforce shortage itself. As the March 2006 Fraher-Swartz-Gaul report on the Supply and Distribution of Psychiatrists in North Carolina shows, the overall supply of psychiatrists – private and public sector – is limited, with shortages, especially in child psychiatry, and especially outside the Raleigh-Durham-Chapel Hill area. That report presents an extensive discussion of policy options proposing many synergistic approaches to relieving psychiatrist shortages, which NCPA endorses. It recommends "conven[ing] a task force of key stakeholders to review existing data on the supply and distribution of psychiatrists and child psychiatrists in the state and develop a set of recommendations to address key areas of concern." NCPA has endorsed this recommendation and we urge stakeholders to join this effort. Recognizing workforce issues as a major state-wide priority is important, and developing programs involving key stakeholders is critical to assuring the long-term supply of needed mental health professionals.

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NCPA Responsibility

While the North Carolina Council of Community Programs has permitted NCPA to report on the Council's 2005 Survey, NCPA alone is responsible for the content of this Report Card.

TECHNICAL NOTES:

The 20 LMEs responding represent 62.5% of the 32 LMEs with 66.0% of the state's population. As can be seen in the table below, small-population LMEs were under-represented in the sample. (Medium-sized LMEs were over-represented and large LMEs were evenly represented.) Because small-population LMEs, which experienced greater losses of psychiatrists than larger LMEs, were under-represented, our data may understate the overall loss of LME psychiatrists.

<u>% of state population in LME</u>	<u>Responding LMEs</u>	<u>All LMEs</u>
< 2% (95,000-165,000)	6 (30%)	13 (40.6%)
2 – 4 % (176,000-310,000)	9 (45%)	11 (34.4%)
> 4 % (350,000-760,000)	5 (25%)	8 (25%)

Note that the unit of measure of psychiatrist workforce used in this Report is the full-time equivalent (FTE).

Abbreviations: LME = Local Management Entity. CEO = chief executive officer. FTE = full-time equivalent. MH = mental health. DMHDDSAS = NC Division of MH, Developmental Disabilities & Substance Abuse Services. NASMHPD = National Association of State MH Program Directors. NCPA = NC Psychiatric Association. SWO = state-wide organization (page 7).