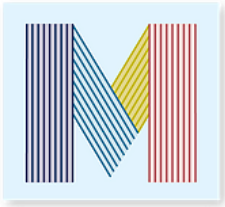
OVERVIEW:
WORKFORCE NEEDS TO SUPPORT THE WELL-BEING OF OLDER ADULTS WITH MENTAL HEALTH CONDITIONS

Stephen J. Bartels MD, MS
James J. and Jean H. Mongan Professor of Health Policy
and Community Health
Professor of Medicine
Director, The Mongan Institute



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Disclosures

- Scientific Co-Director SAMSHA E4 Center of Excellence for Behavioral Health Disparities in Aging at Rush University
- Grant Funding
  - NIH
  - Patient Centered Outcome Research Institute

2012 IOM/NAM Report Findings and Recommendations

- **Finding:** A substantial proportion of older adults warrant a provider skilled in geriatric MH/SU problems. Yet, only a **minority receive specialty care**. Specialty training of geriatric providers (psychiatrists/psychologists/geriatricians) will never be able to meet the need.
- **Finding:** Primary **care for MH/SU conditions is inadequate** despite many evidence-based practices: Shortages of primary care providers, ever-expanding responsibilities, lack of coordination, fragmentation of care, high costs, and conflicting health information systems.
- **Finding:** Conspicuous lack of national attention to the health care workforce to care for older adults with MH/SU conditions. HHS and its many agencies, have authority to strengthen the geriatric MH/SU workforce - But it is in "**no one's hands**"

- **Recommendation 1**: Congress direct Secretary of **HHS to designate a responsible entity** to coordinate federal efforts to develop and strengthen the nation's (MH/SU) workforce.
- **Recommendation 2**: The Secretary of HHS should ensure that its agencies—including **AoA, AHRQ, CMS, HRSA, NIMH, NIDA, and SAMHSA—assume responsibility for building the capacity** and facilitating the deployment of the MH/SU workforce for older Americans.
- **Recommendation 3**: Organizations responsible for **accreditation, certification, and state licensing boa**rds, should modify standards, requirements, and credentialing procedures to **require professional competence in geriatric MH/SA screening and treatment**.
- **Recommendation 4:** Congress should appropriate funds for the Affordable Care Act (ACA) workforce provisions to **authorize training, scholarship, and loan forgiveness** for individuals who work with or are preparing to work with older adults who have MH/SU conditions.
- **Recommendation 5:** HHS should direct a responsible entity to develop and coordinate implementation of a **data collection and reporting for geriatric MH/SU workforce planning**.

A Decade Later?
Minimal Adoption of 2012 IOM/NAM Workforce Recommendations

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"Supply Side" *Worsening Shortfall*: Older Adult MH/SA Specialty and Primary Care Workforce

- 4,700-5700 geriatric psychiatrists needed
- 2018: 2.6 Geriatric Psychiatrists/100,000 65+ pop
- Geriatric psychiatry fellows in training *decreasing*: 106 (2002-2003) -> 48 (2020-2021)
- Psychiatrist Medicare participation rates *decreasing* between 2013 and 2019
- Rural America (2019): majority of rural HSAs have no Medicare psychiatrists (59.6%)
- Only 1% (n=660) of PhD licensed Psychologists are in field of geriatric psychology
- Projected need: 30,000 Geriatricians by 2030 7,300 in 2020 and half of fellowships unfilled
- Primary Care Crisis: 40% of workforce will be over age 65 in coming decade- high rates of burnout

"Supply Side" *Promising Trends?*

- 2013-2019 Medicare Psych MH Nurse Practitioners doubled; 80% rural HSAs have Medicare PMHNPs
- Effectiveness of non-licensed Mental Healthcare Providers (mental health counselors, community health workers
- Growing evidence: Certified Peer Support Specialists
- Effectiveness of task sharing: effective and scalable in low-resource settings
- Improved access, and effectiveness of tele-mental health delivery and digital health interventions

Consolidated Appropriations Act of 2023- Medicare

-Licensed professional counselors, marriage & family therapists under supervision 2023; Direct bill 2024

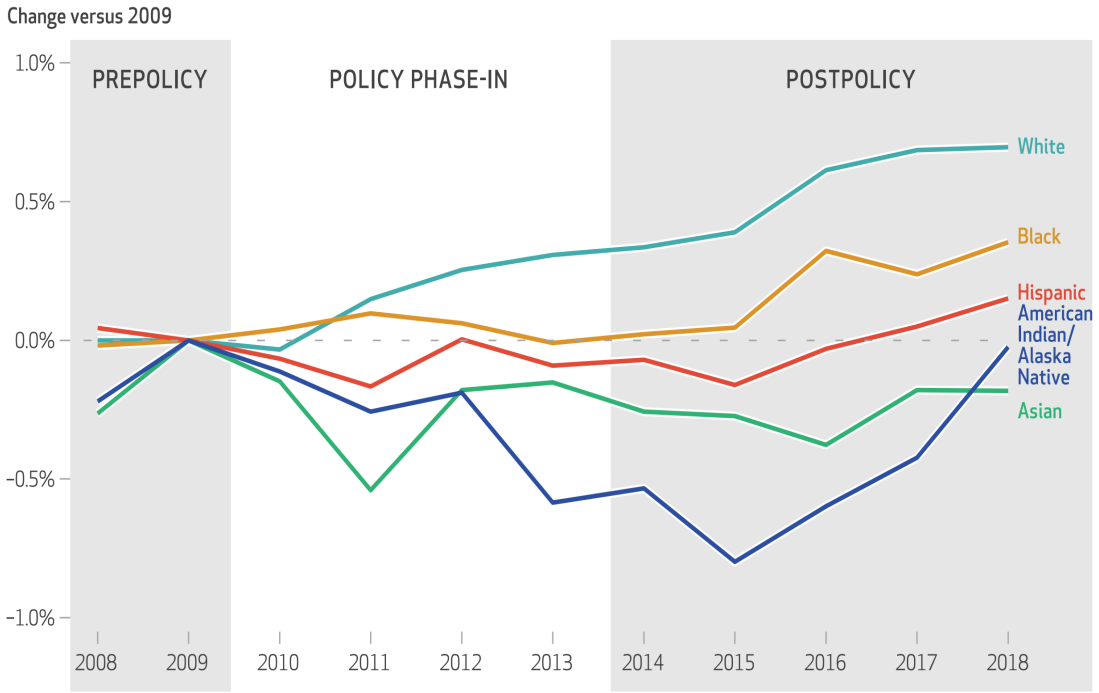
-Medicare Telehealth waivers extended to 12/2024. In-person MD visit prior to telehealth/annually 1/2025

AGS, APA, AMA; Arean et al., 2012;Ciechanowski et al., 2004; den Boer, Wiersma, Russo, & van den Bosch, 2005; ; Fung 2022'2023; Montgomery, Kunik, Wilson, Shea 2013, Stanley, & Weiss, 2010; Patel et al., 2011; Quijano et al., 2007; Waitzkin et al., 2011, Kunlk 2017, Commonwealth Fund 2022; HRSA 2022; Kaiser Family Foundation 2023).

"Demand Side" and Medicare Policy
Has Medicare Mental Health Parity Helped?

Use increased less among minority beneficiaries in the 5 years after full parity implementation, exacerbating existing disparities

Difference-in-differences results in percent of beneficiaries with specialty mental health and substance use disorder (MHSUD) visits with cost-sharing reduction versus free care compared with prepolicy year 2009, by race and ethnicity, 2008–18



Coverage Parity And Racial And Ethnic Disparities In Mental Health And Substance Use Care Among Medicare Beneficiaries. Fung V, Price M, McDowell A, Nierenberg AA, Hsu J, Newhouse JP, Cook BL. Health Aff (Millwood). 2023 Jan;42(1):83-93.

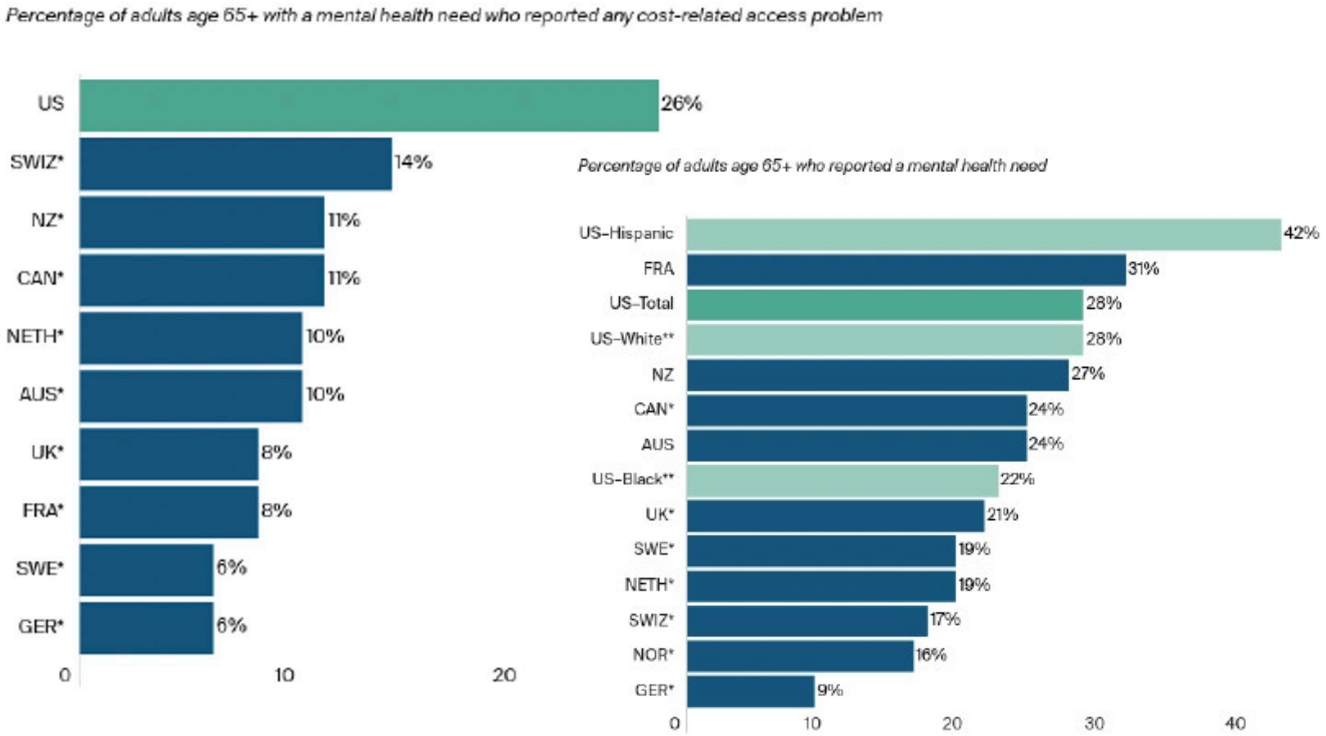
"Demand Side": Does Cost Sharing (Medicare Co-payment) Matter?

Medicare Part B deductible + 20% co-pay and Part D medication copay

Older adults with chronic conditions greatest obstacle for mental health: cost of therapy (32%), cost of health care provider (20%), cost of meds (17%)

Medicare Advantage plans- only 23% of regional psychiatrists are in network 30% beneficiaries seek out of network MH services

Compared to other higher income countries- US older adults most likely to cite costs as reducing access– -highest need 2/5 Hispanic older adults



Comparing Older Adults' Mental Health Needs and Access to Treatment in the U.S. and Other Countries. Gunja, MZ, Shah, A, Williams RD. Commonwealth Fund Issue Brief, 2022.

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Supply-side **Older Adult MH/SUD Workforce Strategies**

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- **Mandate HHS Accountability** → ***Charge lead HHS agencies- "In everyone's hands"***
  - Execute 2012 IOM/NAM recommendations at federal *and* state HHS, Aging, and MH/SUD agencies
- **Cross-Train** → ***Cross-train in geriatric MH/SUDs***
  - Cross-train aging service providers, MH/SUD providers in older adult screening and delivery competencies. Geriatric specialists as leaders and consultants for complex conditions
- **Integrate**
  - Integrate/finance geriatric MH/SUD support specialists in primary care and aging social services
- **Task-shifting/Task-sharing** → ***Capacity build for low-resource settings/services***
  - Train/reimburse community health workers, lay providers, peers: older adult MH/SUD screening & delivery
- **Expand, Finance & Sustain telehealth** → ***Tele-mental health equity for all ages***
  - Expand, finance, and sustain tele-mental health capacity and mandate digital health equity
- **Mandate Mental Health Equity** → ***Lifespan mental health equity is health equity***
  - Mandate and measure mental health equity spanning age,-race/ethnicity; disability; SES, LGBTQ
- **Prioritize Implementation Research** → ***We know what to do- we need to get it done.***
  - Designate implementation research as an NIH/PCORI priority on delivery of evidence-based older adult interventions for depression, anxiety, SUD, serious mental illness, and behavioral symptoms of dementia

Demand-side **Older Adult MH/SUD Workforce Strategies**

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- **Reform Medicare MH/SUD Policy** → ***Eliminate Policy and Payment Barriers***
- Enact Biden Administration proposal to eliminate deductibles and co-payment for first three MH/SUD Medicare visits
- Eliminate subsequent deductible & co-payment for low-income older adults (i.e., older poor not qualifying for Medicaid dual eligibility)
- Eliminate prior authorization mental health/SUD in Medicare Advantage Plans
- Eliminate 190-day Medicare lifetime limit for psychiatric hospitalization
- Ensure permanent Medicare coverage for MH/SUD telehealth visits
  -waive in-person physician pre- and annual visit requirement

- **Reduce Stigma- Older Adults and MH/SA Disorder Treatment** : National Anti-Stigma Initiative - Patients, Thought Leaders, Celebrities; Social Marketing