The Shortage of Psychiatrists and of Inpatient Psychiatry Bed Capacity
Minnesota Psychiatric Society Task Force Report
September 2002

Task Force Charge: To objectively assess the decrease in net availability of beds in inpatient/ intensive outpatient treatment programs in Minnesota over the last ten years, and determine the cause of the shortage. Issue a report detailing the hardships and harm resulting from the lack of availability of these treatment options, and recommend steps to alleviate this crisis.

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I. Summary

The shortages of psychiatrists and of inpatient psychiatric bed capacity in Minnesota represent a crisis in the care of Minnesotans with mental illnesses. According to a survey by the Minnesota Hospital and Healthcare Partnership (MHHP), the demand for emergency or inpatient psychiatric services has risen 16-39% between 1997 and 2001, and the demand for similar services for children and adolescents has risen 49-68%. In spite of increasing demand, the number of licensed mental health beds in Minnesota has decreased over 15% between 1996-2001, according to MHHP. Shortages of psychiatrists, of inpatient bed capacity, and of child or adolescent services are generally worse in most non-metro areas. There is also an overall shortage of psychiatrists in Minnesota, with about 33% fewer psychiatrists per capita than the national average.

Inadequate funding, due to lack of parity in mental health reimbursement, is at the heart of this crisis. Psychiatrists are paid 10-40% less than primary care physicians for equivalent outpatient work, in typical contracts with large Minnesota payers. This is compounded by corresponding limits in other providers' reimbursement. According to an estimate from Reden and Anders in 2002, the percentage of Minnesota health care insurance premiums that go to mental health reimbursement has dropped 16% between 1998 and 2002, down to 2.6% of premium (excluding prescription drug costs). This decrease is on top of the 54% decrease in employer-based mental health expenditures in the decade before that (Hay Group report, page 9). This is despite the fact that psychiatric disorders are at or near the top of most

measures of disability, death, and cost to society, and despite the cost-effectiveness of treatment (pages 8-9).

Another root cause is a lack of discharge placement options, outpatient psychiatry services, and case management services. Inpatient and outpatient services are not uniformly well coordinated, especially when care is divided between government and non-government organizations. Funding plays a role here as well. The task force estimates that 10-30% of bed capacity could be freed up if there were an adequate and well-coordinated network of outpatient services, to prevent hospitalizations and provide timely post-discharge placements.

Increasingly onerous inpatient working conditions have caused a number of psychiatrists to stop doing inpatient work. Examples include the interpretation of EMTALA laws that have made it difficult to control how many patients we see at a time, new seclusion/restraint regulations, case management requirements, difficulty finding discharge placements through county and state facilities, and the complicated environment of malpractice liability and commitment laws.

We intend to disseminate this information widely, seeking input and collaboration from partners such as advocacy groups and other organizations that provide for patients, represent clinicians, or oversee mental health programs. We hope to collaborate with payers, regulators, and the business community to the greatest extent possible to rectify the severe difficulties patients have in receiving appropriate and timely mental health care.

II. Recommendations

1. **Increase reimbursement to levels of parity with general medicine.** Psychiatric reimbursement for inpatient and outpatient care should be increased to parity with general medical and subspecialty reimbursement. Hospitals should be reimbursed at levels that allow them to cover costs and remain financially solvent. The reason for parity is to correct the fundamental problem- inadequate funding- that limits or prevents people with mental illnesses from receiving the care they need. Parity is also necessary, in our opinion, to comply with the parity legislation below.

   In some cases, a change in what payers pay for would improve access to outpatient care and would allow rapid response to crises to prevent hospitalization. Specific recommendations:

- Reimburse clinicians' crisis response activities including telephone calls and brief nurse visits.
- Reimburse providers for case management services, especially for children and adolescents, at 2 hours per month, if the patient meets criteria for seriously and persistently mentally ill (SPMI) or seriously emotionally disturbed (SED).
- Work with our national legislators to repeal the Medicare Mental Health Outpatient Treatment Payment Limitation, which limits psychiatric payment to 50% of the Medicare fee schedule instead of the 80% given to all other medical practitioners. In many situations, this raises costs to patients, in terms of higher co-payments.

   With respect to funding, we recommend an investigation of how to improve the access of patients to outpatient care, social services including case management for persons with serious and persistent mental illnesses, and to discharge settings such as group homes, nursing homes,

outpatient mental health providers. This might involve not only increased funding but also streamlining of services and processes, including the civil commitment process. Success here would prevent 10-30% of admissions, as estimated by the Task Force.

Increased reimbursement is in keeping with Minnesota's parity legislation (http://www.revisor.leg.state.mn.us.stats/62Q/47.html) which states that "Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency services… must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services."

2. **Collaborate with primary care and with supervised midlevel practitioners.** The shortage of psychiatrists should be remedied by continuing to encourage psychiatrists to collaborate with primary care practitioners, including supervised mid-level practitioners in both primary care and mental health. Midlevel practitioners include physicians' assistants and nurse practitioners in primary care, and clinical nurse specialists in mental health. Specific options include:

- Increase funding for psychiatric residencies.
- Focus efforts at state medical schools to attract more medical students to psychiatry.
- Loan forgiveness programs for psychiatrists willing to practice in areas that are particularly underserved.
- Alternate models of psychiatric practice should be considered where this is feasible and acceptable to patients, such as the model in Bemidji where a psychiatrist saw a large number of primary care patients in a purely consultative role, with ongoing followup provided by primary care clinicians.

3. **Coordinated dialogue.** We recommend a coordinated dialogue with all involved parties for an organized approach to mental health care delivery that bridges inpatient and outpatient care, and that bridges gaps between the multiple private and public payers. These gaps currently are a major cause of the inpatient bed shortage, and of the lack of timely and appropriate mental health care delivery. Involved parties, at the least, should include provider organizations, government agencies that administrate social services, public mental health care, nursing home funding, court systems that conduct commitment and criminal proceedings, group home agencies, state mental health advisory groups, patient advocacy organizations, payers, and representatives of the business community. Current administrative structures, both public and private, have not succeeded in providing a community system of coordinated, effective mental health care. Populations involved include persons with mental illness, chemical dependence, developmental disability, or a combination of these.

   Specific suggestions to improve coordination include:

- In collaboration with payers, use criteria for identifying SPMI adult patients so that provider groups can track them and deliver coordinated services, whether with government-funded services or private payer services. State and County agencies already do some measurement of

numbers of SPMI patients. Reimburse for these services with criteria that payers and providers agree upon.

- Instead of utilization review and micromanagement, have payers design true rehabilitation-oriented case management services for SPMI patients, and have their workers work directly with patients to provide what is needed to keep patients as well as possible and out of hospital. The money saved by not micromanaging and by not hospitalizing people would pay for this. Successful examples of this include the Assertive Community Treatment and case management model of the University of Wisconsin, Madison, Dane County, and the Sheppard Pratt Health System (Mulligan K: Sharfstein gives survival tips for troubled hospitals. Psychiatric News Online 37, No. 15, August 2, 2002).
- Responsible parties from counties (Rule 25, case management, nursing home screeners) should see patients in hospital to facilitate the discharge process (George Dawson, M.D.).
- Unify the governmental funding streams for mental illness and chemical dependence treatment.

4. **Implement the recommendations of the Minnesota Children's Mental Health Task Force** (as communicated to the task force by George Realmuto, M.D., Minnesota Psychiatric Society; members of Children's Mental Health Task Force include legislators, state administrators, stakeholders and parents):

- "The Minnesota Department of Human Services should work with the Minnesota Department of Health regarding recruitment services such as the J-1 visa waiver processing program, which, for example, allows internationally trained physicians to remain in the United States and practice in under-served areas. Develop state and foundation loan repayment programs for mental health professionals to address lack of providers and maldistribution of providers. Develop state grants for recruitment of providers, particularly culturally specific providers. Use medical education and research costs (MERC) trust fund to cover reimbursement for trainees/supervision.
- Increase Medical Assistance reimbursement rates to retain the work force we have.
- Allow reimbursement for consultation with family practitioners and other providers.
- To better manage our limited resources, invest in prevention by:
  - Increasing mental health services in the schools. To do this, extend the responsibility of the State Department of Human Services to facilitate services in schools for identification, early intervention, and prevention.
  - Fully implement Federally-mandated Early Periodic Screening, Diagnosis, and Treatment (EPSDT) programs (In Minnesota this Federal program is called Child and Teen Check-Up) to identify emerging mental health problems at easily treatable stages. Develop funding for prevention services for children at high risk for mental health problems.
- For children who meet the criteria for Seriously Emotionally Disturbed (SED), review the experience with the Children's Mental Health Collaboratives in each county. Where successful, publish the lessons learned. Where unsuccessful, based on number of children served and maintained in the community, disband the authority of the collaboratives and revise those programs, studying the examples of successful county collaboratives. Mandate representation at Children's Mental Health Collaborative Meetings by service providers from private payer organizations for each child served within their benefit contract.

5. Consider strategies implemented at the Minneapolis Veterans' Administration Hospital:
NOTE: Many of these ideas are typical of case management, or have to do with housing. Non-governmental clinicians are currently not reimbursed by health plans for these services.

"Over the last decade, we've been able to reduce our beds from 90 to 25 while increasing our annual number of patients from 3,000 to 9,000 through a variety of means, including the following:"

- A community based team that takes care of patients who have required many inpatient days (5 staff members who provide serves for our most needy 60 patients);
- A team orientation in which groups of clinicians are responsible for providing care for a panel of patients, which fosters crisis-avoidance, crisis intervention, crisis support, etc. through non-inpatient venues;
- A homeless program/team, so that homeless patients do not end up using the inpatient service for shelter and food;
- We have hotel/dormitory-type beds on campus that we can use while we are evaluating or treatment patients (especially useful for rural or recently homeless patients);
- Our Geropsychiatry team sends a CNS out to nursing homes once a week, to provide guidance, instruction, etc.; this has helped to avoid unnecessary admission of our elderly and/or demented patients and/or medically incapacitated patients;
- Our addiction and other services maintain relationships with community programs, so we can work collaboratively with other agencies/institutions who have programs that we do not have.

"Having a system of care, with sufficient staff and programs to treat a wide variety of chronic and acute cases, has been key in keeping inpatient care low. Parenthetically, we have one of the lowest VA inpatient admission rates in the country (about 6.6% of all patients in the last fiscal year, I believe) and one of the lowest readmission rates in the country (measured by counting the number of readmissions within 6 months of discharge)" (From Joseph Westermeyer, M.D., Ph.D.):

III. Background Data and Individual Input from Task Force

Data on the shortage of psychiatrists and psychiatric bed capacity in Minnesota

We were unable to gather our own data on the shortage of hospital bed capacity in Minnesota, nor did we find studies going back 10 years. What follows is the best information we could obtain, including the most comprehensive study, conducted by the Minnesota Hospital and Healthcare Partnership (MHHP).

Increasing Demand for Service:
According to a 2002 survey by MHHP, demand for emergency psychiatric and chemical services in Minnesota has risen:

Group	Percentage increase 1997-2001
Emergency psychiatric And chemical dependency Visits	39%
Inpatient psychiatric And chemical dependency Visits	16%
Youth ages 15-20 Emergency Mental health treatment	68%
Youth ages 14 and under Emergency mental health Treatment	49%

According to HealthPartners (Michael Trangle, M.D.), rate of HP patients receiving treatment is escalating, growing 6.9% between 2000 and 2001.

Decreasing Supply of inpatient beds and providers:

According to MHHP, the number of licensed mental health beds has decreased 15% in the years 1996-2000, from 2352 to 2001. This figure is probably an underestimate, because it omits the loss of beds from psychiatric facilities or units that no longer exist (David Feinwachs, MHHP, personal communication 2002).

In addition, there has been a reduction in the number of psychiatrists choosing to do inpatient psychiatry, especially child psychiatry. Minnesota also has a relative shortage of psychiatrists in all settings, with about 500 practicing psychiatrists listed by the Department of Health, many of them part time, and an average age of 51.

From HealthPartners presentation (Michael Trangle, Paul Goering, M.D.): Minnesota has 10 psychiatrists per 100,000 population, vs. 16 psychiatrists per 100,000 people in USA. (Data referenced by United Behavioral Health). Child psychiatrists per 100,000 are 4.6 in MN and 6.73 in USA (Thomas

and Hozer: National distribution of child and adolescent psychiatrists. J American Academy of Child and Adolescent Psychiatry, 38.1 January 1999).

From George Realmuto, M.D., Associate Professor of Child Psychiatry at the University of Minnesota, the bed shortage is even more severe for child and adolescent beds. Closures of beds have largely occurred because of difficulties in retaining or recruiting child and adolescent psychiatrists. He lists closures in recent years of:
Kindred Hospital: closed 30-40 beds 10 years ago
Mercy Hospital: closed 12-bed unit some years ago
University of Minnesota: closed 2 units of 12 each some years ago
Wilson Hospital in Faribault: closed 20-30 beds
Eitel Hospital: up to 60 beds closed

From Gabrielle Melin, M.D., Mayo Rochester: In 2001, Mayo converted a 23-hour observation unit of 10 beds to an acute care unit because most people admitted there required longer hospitalization than 23 hours (suggesting that proposals to build step-down observational units might need careful analysis to see if they would offer any advantage over the use of 23-hour observational admissions to general units, given the liability risks involved- ewl).

Detailed Consequences to patients from this shortage:

- Delays in receiving care, with more suffering, disability and death. Tens of patients turned away or sent far away for inpatient care every week.
- Frequent diversion of patients from metro area emergency rooms to inpatient beds as far away as St. Cloud, Rochester, Duluth, Fargo, even Milwaukee and Winnipeg. Patients waiting in emergency rooms as long as 72 hours, patients transported by gurney, in ambulances, to far-away inpatient units because of the lack of hospital beds in the metro area.
- One teen-age girl who hinted at suicide to a friend, was eventually put on a 72-hold and transported a number of hours away, where evaluation showed that she simply needed a thorough assessment and access to outpatient care, not hospitalization.
- Others understandably not getting the care they need in hospitals a long way from home because of the difficulty arranging adequate followup. Local patients in non-twin cities area not having access to care because local beds filled with twin cities patients. Payers refusing to pay for ambulance trips. Hold orders placed only in order to transport.

Societal Costs of Mental Illnesses

- Of the 10 leading causes of disability worldwide, measured in years lived with a disability, 5 were psychiatric disorders or addictive disorders: unipolar depression, alcohol use disorders, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Mental disorders collectively account for more than 15% of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer (Murray CJ, Lopez AD,Eds,1996. The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. Cambridge, MA: Harvard University Press, for the World Health Organization, World Bank and Harvard University).
- Depression and high stress have the greatest impact on worker healthcare costs, according to a study over 3 years of more than 46,000 workers in 6 national organizations (Journal of Occupational and Environmental Medicine, October 1998, vol. 40:10 p. 843-854).

- The annual societal cost of depression in the United States is at least $44 billion per year, and for anxiety disorders is $42 billion year (Greenberg PE, et al: the economic burden of depression in 1990. J Clin Psychiatry 54:405-418, 1993; and Greenberg PE et al: the economic burden of anxiety disorder in the 1990s. J Clin Psychiatry 60: 427-435, 1999). For depression, over half the costs are due to decreased productive capacity and absenteeism, and for anxiety, over half the costs are due to direct nonpsychiatric medical treatment costs. These costs occur in people who often do not meet the criteria for “seriously and persistently mentally ill”.
- The annual cost of schizophrenia in the United States is an estimated $40 billion per year, including lost productivity (Bunney WE, MeltzerHY: Schizophrenia: overview. Clin Neurosci 3: 55-56, 1995).
- In the United States, alcohol abuse and alcoholism cost $100 billion annually, 70% of which is attributed to losses in productivity, excess illness and early death (American Psychiatric Association, Division of Government Relations, May 2002).
- The total annual social cost of alcohol and drug abuse in 1997 was estimated at $297 billion, but only $11.9 billion was spent on substance abuse treatment. In addition to direct treatment costs, social costs include costs of treatment of other medical disorders caused by substance abuse, plus other costs related to premature deaths, lost wages, impaired productivity, crime-related losses, property destruction, and social welfare costs. The total social cost of mental illness, in 1997 dollars, was estimated to be $197 billion, while $73 billion was spent on treatment. Total health-related treatment costs in 1997 were estimated to be $1,057.5 billion (Substance Abuse and Mental Health Services Administration http://www.samhsa.gov/centers/csat/content/idbse/sa01ch2.asp)
- In Minnesota, suicide is the second leading cause of death among 15-24-year-olds, 3rd leading cause in ages 25-34, and 4th leading cause of death in ages 10-14 and 35-54, similar to national data (1999-2000 data, Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control, National Vital Statistics Report, Vol. 50, No. 16, September 16, 2002).
- “In any given week (in the United States), about 40 children and teenagers kill themselves, and another 52 children and teenagers are killed by others… When 19 children were killed in the Oklahoma City bombing, it was rightfully considered a national tragedy. Unbelievably, 4 times that number die every week of either suicide or murder, yet these figures go largely unnoticed.” Mrazek D: A crisis in child psychiatric service delivery: why hasn’t the piper been paid? Mayo Clin Proc 76: 1078-1080, 2001.

Value to Society of Mental Health Treatment

- Treatment success rates for depression and anxiety range from 50-90% (multiple studies, Coalition for Fairness in Mental Illness Coverage Fact Sheet, National Association of Private Psychiatric Health Systems, 2000; also Governors’ Blue Ribbon Commission on Mental Health 2000. Report of the Commission). These treatment response rates are higher than for angioplasty, a common procedure for cardiovascular disease (American Psychiatric Association, Division of Government Relations, May 2002).
- Antidepressant treatment reduces overall health costs not only for depression, but also for persons with depression and comorbid medical conditions such as cancer and heart disease. In one study of 1661 patients who took antidepressants for at least 6 months, patients who took antidepressants were 74% more likely to experience a large reduction in medical care costs (Thompsen et al: Predictors of a medical offset among patients receiving antidepressant therapy. American Journal of Psychiatry 155:6, June 1998.
- Primary care physicians who diagnosed more mental health disorders in their patients lowered health care costs by 9%, and avoided unnecessary hospitalizations 20% more often. This was a study over 5

years with 243,000 patients and 457 primary care physicians (Campbell T: Journal of Family Practice April 2000).
- In a study of major occupational groups in the United States, depression was associated with larger numbers of work absences (more than 9 missed work days in 3 months) than any other conditions except cancer and cardiovascular problems (Kouzis AC, Eaton WW. Emotional disability days: prevalence and predictors. Am J Public Health 84: 1304-1307, 1994).
- A Yale University study of the impact of cost-containment measures on health service use and costs at a large corporation found that cost-containment strategies typical of managed care (increased deductibles and co-payments, prior authorization and utilization review procedures) resulted in a "highly significant and substantial 34% reduction" in outpatient service use per patient per year over three years, and a significant decline of 37.7% in total mental health costs per user. However, this decline in mental health service use was *fully offset* by their concurrent 36.6% increase in non-mental health service costs. The mental health users had a 21.9% increase in sick days as well (Rosenheck RA, Druss B, Stolar M, Leslie D, and Sledge W: Effect of declining health service use on employees of a large corporation. Health Affairs September/October, 192-203, 1999).
- However, primary care providers might detect only 50% of depression and 40% of anxiety disorders (Guidelines for Depression and Panic Disorder, Institute for Clinical Systems Integration, sponsored by the Business Health Care Action Group (BHCAG), Minneapolis, 1995.
- In a landmark report to Congress in 1993, the National Mental Health Advisory Council concluded that parity coverage for severe mental illness would result in net savings of $2.2 billion per year (American Psychiatric Association, Division of Government relations, May 2002).
- A state of California study in 1994 demonstrated that for every $1 spent to treat alcohol and drug disorders, there were $6 saved in future costs, largely due to reductions in health care costs and crime (American Psychiatric Association, Division of Government Relations, May 2002)

Further Economic Background

The percentage of health care dollars devoted to psychiatric care has dropped significantly in the past 13 years, since the advent of the managed care era, widely considered to have started in 1988. According to the Hay Group Report in April 1999, prepared for the National Association of Psychiatric Health Systems and the Association of Behavioral Group Practices, the value of employer behavioral health care benefits decreased by 54.7% between 1988 and 1998. As a proportion of total health costs, behavioral health care benefits decreased from 6.1% in 1988 to 3.2% in 1998 (*HayGroup*, Arlington, Virginia, phone 703-841-3100). This contrasts with a rise in general health expenses during the same time of 7.4%. A broader report from the US Substance Abuse and Mental Health Services Administration (SAMHSA, 2000), which included the cost of private payments and of substance abuse treatment, showed a drop from 8.8% of total mental health care expenses in 1987 to 7.8% in 1997. These declines in funding for mental health services occurred despite the fact that this was an era of significant growth in the American economy, and despite a growing awareness and demand for mental health services.

In a study of claims from private insurance plans of large U.S. employers between 1992 and 1999, total health expenses grew 23%, or 3% annually. However, mental health and substance abuse expenditures fell by 20%, or 3.1% annually. This decrease occurred despite the cost of psychotropic drugs increasing by 9.9% annually during those years. Inpatient costs dropped by 19.1% annually, and outpatient visits per user declined by 10.6% (Mark T: What is driving the trends in private health insurance expenditures

on mental health and substance abuse treatment? Academy for Health Services Research and Health Policy http://www.academyhealth.org/2002/abstracts/behavioral/mark.htm)

According to an estimate for Park Nicollet Health Services in 2002 by Reden and Anders, Ltd., the percentage of Minnesota health care insurance premiums that have gone to mental health reimbursement has dropped an additional 16% from 1998-2002, down to 2.6% of premium (excluding prescription costs).

In Minnesota, most payers pay psychiatrists at least 10-40% less per unit of service than primary care practitioners, and this excludes contracts that were rejected because of low reimbursement (Personal communications, Park Nicollet Department of Finance). This discriminatory payment runs counter to the original intent of the Federal Resource Based Relative Value System (RBRVS), instituted over a decade ago to raise the payment value of cognitive services over procedures, and to even the playing field for primary care physicians. It also runs counter to the principle of parity of funding for mental health services, an elusive goal that is yet to be achieved despite Federal and state legislation.

Complete Listing of Reasons for the shortage

- **Inadequate Funding.** According to MHHP statistics reported in a Star Tribune article August 12, 2002, the average cost of a psychiatric hospitalization in 2000 was $1388, but health plans paid an average of only $678. Psychiatrists are paid 10-40% less than primary care physicians for equivalent outpatient work (William Telleen, Park Nicollet Vice President of payer relations). There is no extra reimbursement for the extra time needed for case management services, especially for hospital units and for child and adolescent services.
- **Increasing public awareness and demand.** Patients, celebrities, and legislators are speaking out on the toll mental illness has taken on their lives. Cover stories in *Time* and *Newsweek* in the past few years have covered depression, pain and addiction, anxiety disorders, schizophrenia, anxiety disorders, bipolar disorder, autism, and sleep disorders. Numerous other stories from individuals, patient advocacy groups and the media.
- **Lack of discharge placement options.** It takes an average of 3 weeks for a bed to open up for transfer of committed inpatients to regional treatment centers (MHHP). Similar difficulties exist in finding discharge placements from regional treatment centers, as well as in arranging discharge to nursing homes, group homes, and residential treatment units. Access is limited with respect to social service case management services or outpatient followup.
- **Onerous working conditions.** In recent years, the interpretation of EMTALA laws has led to psychiatrists feeling forced to accept more inpatient admissions than they thought safe or appropriate for patient. Burdensome case management requirements increased in recent years with the fading out of capitation, though some of the policies have been improved. Increasing workloads and less control over volume of practice, leading to psychiatrists and nurses leaving inpatient practice. Burdensome new regulations, such as having to see a child inpatient within 1 hour, day or night, if they are placed in seclusion or restrained.
- **Closing of State facilities, less availability of case management services** (Ramsey County, per George Dawson, M.D.). Fifty percent of discharge delays at Regions Hospital caused by lack of beds at regional treatment facilities for committed patients (Michael Trangle, M.D.).

- **Uncoordinated responses between inpatient/outpatient care and between private and state or county payers and providers of care, leading to delays in outpatient preventive services and in hospital discharges both from private and state hospitals.**
- **Inadequate supply of outpatient psychiatry.** Widespread shortages, with waiting times for appointments as long as 6 months, especially for child psychiatry. This does not include the psychiatrists whose practices are completely closed to new patients. One large provider organization closed 6 of 9 outpatient psychiatric clinics in the past 3 years, because of cost concerns. People get sicker before they seek or receive care, and need hospitalization more often.
- **Inadequate supply of services, and lack of coordination between inpatient and outpatient services, for people with mental illness and chemical dependence or developmental disabilities.** These populations have even more problems with this than general psychiatric patients, who also have these problems.
- **Uncertainty of state or Federal funding for training new psychiatrists (MHHP).**
- **Easing of requirements of commitment thought to potentially make problem worse** (despite the value of making it easier to provide treatment for people with mental illnesses)**.**

Prevalence Estimates of Mental Disorders in Minnesota in 2005

Sources: 1.Census projections from Minnesota State Demographic Center
2. Narrow WE, Rae DS, Robins LN, Regier DA: Revised prevalence estimates of mental disorders in the united states. Arch Gen Psychiatry 59: 115-123, 2002.

Projected Population of Minnesota in 2005: 4,948,730

Revised One-Year Estimate:		**Number of Minnesotans**
Factoring in clinical significance		
One-year prevalence of any disorder:	20.6-22.5%	1,019,438-1,113,464

Number of Psychiatrists in Minnesota- Current and Projected Need

Current Number of Psychiatrists in Minnesota in 2002:
500 psychiatrists (and of these many are part-time or have closed practices)
(Data from Michael Grover, Office of Rural Health and Primary Care, Minnesota Department of Health)

Estimate of Number of Psychiatrists Needed for Minnesota in 2005:

742 psychiatrists
(With projected Minnesota population of 4,948,730 people, and 15 psychiatrists/100,000 people-according to United Behavioral Health statistics)

NOTE: Not everyone who meets criteria for a mental disorder will present himself or herself for care. In addition, primary care physicians and supervised mid-level practitioners appropriately provide mental health care for some outpatients. However, no group but psychiatrists have the medical and psychiatric expertise to care for patients with severe mental illnesses in outpatient or inpatient settings.

Specific information from surveys and individuals

- Julie Gerndt, M.D., Mankato: Number of beds at Immanuel St. Joseph Hospital decreased 37% between 1990 (29 beds) and 2002 (18 beds). Maximal bed capacity was in 1995 at 32 beds. The relative shortage of psychiatrists and of inpatient beds is even more acute outside the metro area, especially for child psychiatry. The difficulty with coordination of care among private and public health care organizations exists outside of the metro area as well.
- Star Tribune article August 12, 2002: St. Cloud Hospital built a new adolescent psychiatric unit in 1998, and expects to lose $6 million in 2002 in mental health services.
- Abbott Northwestern child/adolescent unit turns away 2-10 patients per week during winter season. Physician availability is the limiting factor. Only 3 child psychiatrists taking busy overnight call every 3rd weeknight, then working all day and on call 1 weekend per month. One weekend they do not take admissions. Unable to recruit more child psychiatrists in recent years. At least one of the three child psychiatrists has said she is leaving the hospital practice in 2003. Outpatient child psychiatric care reimbursement is better than inpatient (Tim Gibbs, M.D., lead psychiatrist, President of Minnesota Society for Child and Adolescent Psychiatry).
- Lack of detox facilities a problem (George Dawson, M.D., at Regions, Julie Gerndt, M.D., at Mankato, Tracy Tomac, M.D., at Duluth), as are the separate funding streams for mental illness care and chemical dependence care (Michael Trangle, M.D.).
- Probate court delays (Commitment proceedings) also tie up hospital beds (George Dawson, M.D.)
- Julie Gerndt, M.D., Mankato: Transfer out 15 patients/month and decline to accept 30 patients/month because of the psychiatrist shortage. Primary care MDs admit 2-4 psychiatric patients/day to general medical units because of the psychiatrist shortage. Discharges are delayed because of lack of county resources or responsiveness.
- 10-30% of admissions could be prevented if we had better access to outpatient care (Tracy Tomac, M.D., Duluth; Michael Trangle, M.D., at Regions/ HealthPartners)
- Winona, Annette Smick, M.D.: All emergency management done inpatient as it is the fastest way to see a psychiatrist- outpatient waits are 3-6 months. Transfer patients from elsewhere sometimes cause bed shortages.
- George Dawson, M.D.: Counties used to come to hospitals to initiate case management services. Now patients might face a delay of 30-60 days after discharge before even an intake for case management services. Current system is a roadblock. Responsible parties from counties (Rule 25, case management, nursing home screeners) should see patients in hospital to facilitate the discharge process.
- Michael Farnsworth, M.D., Minnesota Security Hospital, St. Peter: 20% of patients at state-operated facilities would not need to be there if there were appropriate discharge facilities.
- Gabrielle Melin, M.D. (Rochester): When our units are full, it can take hours in the emergency room to arrange for transfer, as far away as Duluth. Emergency room visits have increased greatly in recent years because of the lack of outpatient psychiatric care. Patients often return to the emergency room because they cannot find followup months after we assess them in the emergency room. Patients come to the ER asking for chemical dependence treatment, but when they are told they need to call the County to schedule a Rule 25 assessment which might take several weeks, they leave demoralized and frustrated, usually losing their motivation to become sober. This roadblock to treatment would not happen for general medical illnesses. The increased

use of ambulances for transport of psychiatric patients has overloaded their systems and decreases their availability for medical emergencies.

Population and Healthcare Workforce Demographics

According to an analysis in 2000 by Cap Gemini, Ernst and Young (CGE&Y) for Park Nicollet Health Services, the 55-64 age bracket will grow by 82% by the year 2020, and the 25-34 age bracket will shrink by 26%. The demand for health care services will balloon as we experience this aging of the baby boom population. For example, general medical inpatient rates begin to rise dramatically in the 55+ population. Inpatient use rates in the next ten years are predicted to rise 41% for the 55-64 age group over the previous ten years. In the ten years after that, their inpatient use will rise another 78%. The decline in the 25-34 age cohort will decrease the supply of people to provide the care.

These general hospital statistics do not perfectly correlate with future predictions of psychiatric hospital needs, but offer general evidence that a growing and aging population will further challenge our limited psychiatric bed capacity.

In addition to a shrinking age cohort to perform health care services, there will likely be significant shortages of workers in specific health care fields. According to *The Nurse Shortage, An Opinion Poll,* conducted by The Federation of Nurses and Health Professionals, April 2001, 21% of nurses expect to leave the profession within 5 years unless working conditions change. The U.S. Department of Labor was already predicting a shortfall of nurses of 450,000 by 2008, prior to release of these findings. The poll asserted that the nursing profession was recognized as the most qualified to respond to current changes in the health system focusing on behavioral and preventive aspects of health care.

The shortage of psychiatrists is mirrored by shortages of physicians in some other specialties nationwide. This trend is expected to increase as 250,000 physicians are expected to leave the profession in the next decade. In 2001, 38% of physicians were over age 50. Medical school applications have dropped 20% in the past 5 years (data all from CGE&Y analysis, *Futurescan 2001- A Millenium Forecast of Healthcare Trends 2001-2005).*