

California Mental Health Policy Forum

Response to

PARADOXES & PROMISES: PLANNING FOR THE FUTURE OF THE BEHAVIORAL HEALTH WORKFORCE

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Overall Response

- Excellent presentation from two of the best and brightest in the field today
- Messages in simple, plain language
- Mixing substantive content with humor, a winning combination
- Plenty to reflect on and with clear messages to take action
- John and Mike are my friends and I want to keep it that way

However...

Projections forecast health spending increase for 2004-2014

TRENDS

U.S. Health Spending Projections For 2004-2014

Shifts in funding for prescription drugs and lower private health insurance premium growth are expected over the next ten years.

by Stephen Heffler, Sheila Smith, Sean Keehan, Christine Berger, M. Kent Clemens, and Christopher Truffer

ABSTRACT: National health spending growth is anticipated to remain stable at just over 7.0 percent through 2006, the result of diverging public- and private-sector spending trends. The faster public-sector spending growth is exemplified by the introduction of the new Medicare drug benefit in 2006. While this benefit is anticipated to have only a minor impact on overall health spending, it will result in a significant shift in funding from private payers and Medicaid to Medicare. By 2014, total health spending is projected to constitute 18.7 percent of gross domestic product, from 15.3 percent in 2003.

Source: Heffler, Smith, Keehan, et al (2005); Health Affairs, DOI 10.1377/hlthaff.W5.74

Projections forecast health spending increase for 2004-2014

“Over the 2003–14 period, national health spending is forecast to continue growing faster than gross domestic product (GDP). The consequence is a projected increase in health’s share of GDP from 15.3 percent in 2003 to 18.7 percent by 2014.”

(p. W 5 - 74)

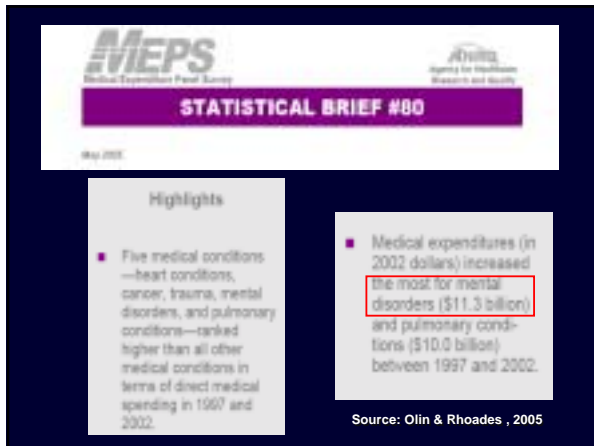
Source: Heffler, Smith, Keehan, et al (2005); Health Affairs, DOI 10.1377/hlthaff.W5.74

Spending for mental health and substance abuse (MHSA) treatment is on the Rise!

“Spending for mental health and substance abuse (MHSA) treatment in the United States totaled \$104 billion in 2001, representing 7.6 percent of all health care spending.”

(p. W5-133)

Source: Mark, Coffey, Vandivort-Warren, et al (2003); Health Affairs, DOI 10.1377/hlthaff.W5.133



MEPS
Medical Expenditure Panel Survey

STATISTICAL BRIEF #80

May 2007

Highlights

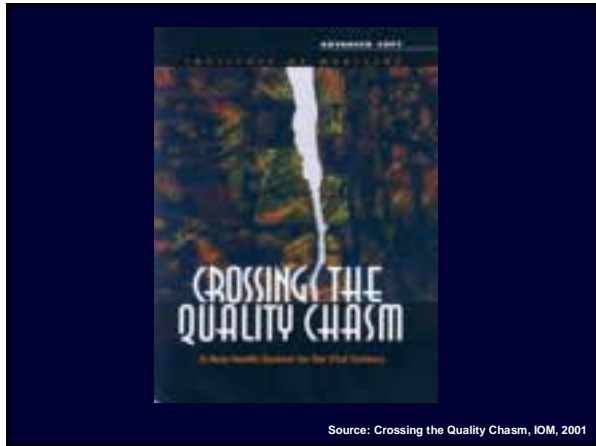
- Five medical conditions—heart conditions, cancer, trauma, mental disorders, and pulmonary conditions—ranked higher than all other medical conditions in terms of direct medical spending in 1997 and 2002.
- Medical expenditures (in 2002 dollars) increased the most for mental disorders (\$11.3 billion) and pulmonary conditions (\$10.0 billion) between 1997 and 2002.

Source: Olin & Rhoades, 2005

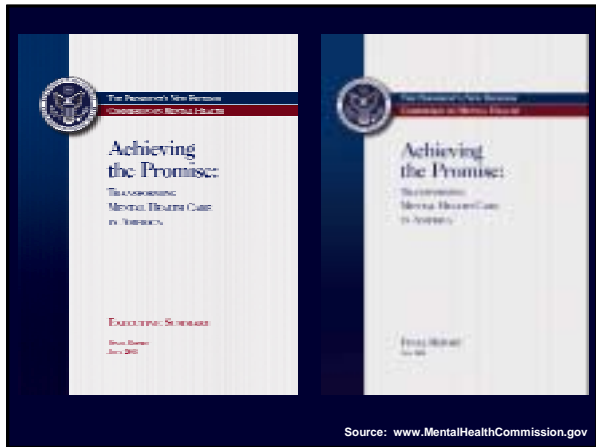
“The United States has the know-how and technology to deliver world-class health care to the public, but often fails to translate such expertise into everyday clinical practice. For many Americans, this situation results in suffering that could be prevented.”

Source: National Academies: <http://www4.nationalacademies.org/news.nsf/isbn/03090854387?OpenDocument>

After all that spending what do we have to show for?



Source: Crossing the Quality Chasm, IOM, 2001



Source: www.MentalHealthCommission.gov

Improving the Quality of Health Care for Mental and Substance-Use Conditions

“The M/SU workforce is not uniformly and sufficiently equipped in terms of its knowledge and skills, cultural diversity and understanding, geographic distribution, and supply to provide the access to and quality of M/SU services that consumers need.” (p. 264)

Source: Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, 2006

Improving the Quality of Health Care for Mental and Substance-Use Conditions

“This has long been the case and persistently resistant to change despite recurring acknowledgements of the nature and magnitude of the problems, the recognition that major improvements should be made, and repetitive recommendations to do so.” (p. 264)

Source: Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, 2006

So, indeed, Stop!

- Hiring people, but not supporting & developing them.
- Having untrained staff deliver care
- Delivering unsupervised care
- Spending money on ineffective training
- Discouraging use of newly learned skills
- Assigning leadership responsibility without leadership training
- Ignoring the culturally and linguistically needs of consumers and their families

Source: Hoge & Morris, 2006

The 11 paradoxes presented are a sobering reminder of the practices we repeatedly continue to engage in without truly evaluating the impact of those practices/efforts

Are we going to allow “**more of the same**” with the fresh influx of resources from the MHSA?

John and Mike presented us with a sound

National Strategic Plan on Workforce Development

with a core set of strategic directions that is promising

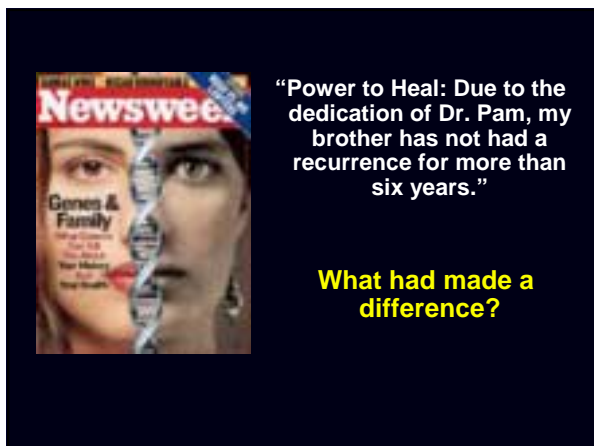
What kind of adaptations should be made to the plan to tailor it to the realities of the great State of California?

- **Diversity is the name of the game in California.**
- The MHSA with its unique promise of transforming the mental health system to make it more responsive to the unmet mental health needs of its diverse population.

Some big, cross cutting themes emerge

- The role of people in recovery (and families as appropriate) as both members of the workforce and as educators of the rest of the workforce.
- The critical need to reduce disparities in **access**, whether caused by “race or place”—cultural competence and special needs of rural, remote and other special needs groups of people.
- I would add disparities in **quality of care**







"Robert telephoned. "Alan's leaving-Alan's leaving!" he kept screaming. Alan was my brother's social worker-a man to whom he was very attached and whom he had known for many years, from his long-term stay at another hospital."

After interviewing hundreds of former mental patients for a book, what made the difference was:

"...they all-every last one said that a **key element was a relationship with a human being**. Most of the time, this human being was a professional-a social worker, a nurse, a doctor. Sometimes it was a clergyman or family member. In every instance, though, **it was the presence in their lives of an individual who said, in effect, "I believe in your ability to recover, and I am going to stay with you until you do" that brought them back.**"

Jay Neugeboren

Source: <http://www.msnbc.msn.com/id/11077662/site/newsweek/page/>

So whatever you do with the workforce, make sure to encourage:

Consumer-Centered Care that

- Promotes patient dignity and personal responsibility;
- Improves communication;
- Focuses on cultural [and linguistic] context;
- Improves quality;
- Increases access to high-quality care;
- Emphasizes workforce training.

Source: Frist, W.H. (2005); Health Affairs, 24(2), 445-451.
