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Senate Committee on Homeland Security and Government Affairs

"Improving Federal Health Care in Rural America: Developing the Work Force and Building Partnerships"

May 23, 2013

I. Introduction

Chairman Tester, Ranking Member Portman and distinguished members of the committee, on behalf of NAMI Montana (The National Alliance on Mental Illness) I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding *Improving Federal Health Care in Rural America: Developing the Workforce and Building Partnerships.* NAMI Montana and the entire NAMI community applauds the committee's dedication in addressing the critical issues surrounding rural health care and NAMI looks forward to working closely with the committee in addressing these and other issues throughout the 113th congressional session.

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

II. The General View From Montana

Montana is the nation's fourth largest state with over 147,000 square miles. Just over a million people reside in Big Sky Country. The very rural nature of the state, with an average of fewer than six persons per square mile, creates unique challenges for our healthcare providers. It is very hard for rural Montana communities to recruit and retain healthcare workers. Our rural healthcare professionals have to walk a tightrope between finding enough patients to make a

living and paying off their student loans while, not being overwhelmed by the workload. It is a difficult balance to strike due to variable patient rates and a shortage of relief for times of overflow.

These challenges are especially difficult for treating serious mental illness because of the complex nature of serious mental illnesses, the level of care required for mental health crises, and the ongoing treatment needs of persons living with these conditions. Our state consistently has one of the highest suicide rates in the country and we are in desperate need of more mental health professionals, particularly in our more rural communities. For instance, there is one psychiatrist between Billings, Montana and Bismarck, North Dakota. That is one psychiatrist to cover over four hundred miles of interstate highway. Providers are trying to find ways to fill the gaps will psychiatric nurses and telepsychiatry, but it is still a desperate situation. The need for psychologists, social workers, and counselors is also dire.

Montana's healthcare system is intrinsically tied to the federal government in a number of ways:

- We are honored to have one of nation's highest per capita rates of military service in the country. Montana is home to more than 108,000 veterans, representing 16.2% of the total state adult population; the second highest population density of veterans in the United States.[1]
- Montana is home to twelve tribal nations and seven reservations.[2] The reservations comprise nine percent of the state's land base. Montana is home to over 66,000 people of Native American heritage. The majority of Montana's native population lives on reservations. Montana residents that qualify for Indian Health Services are served by the Billings Area Indian Health Services which delivers care to over 70,000 people in the states of Montana and Wyoming.

[1] Taken from the State of Montana's recent grant application to HRSA.

[2] Indian Education for All, "Montana Indians: Their History and Location."(April 2009) http://opi.mt.gov/pdf/indianed/resources/MTIndiansHistoryLocation.pdf

- Montana had just under than 110,000 participants in Medicaid as of December 2012.[3] The Montana Medicaid program can generally be classified as hard to qualify for in comparison to other states, but more generous benefits for those that do qualify.
- Over 170,000 Montanans received Medicare benefits in 2011.[4]
- Montana has forty-seven critical access hospitals which qualify for relaxed staffing requirements and cost-based reimbursements Medicare and Montana Medicaid patients.

The federal, state, local and private healthcare programs across Montana rely on each other to succeed. For instance, a veteran who goes into a mental health crisis in Darby, Montana would likely drive or be transported to the emergency room of the private Marcus Daly Memorial Hospital sixteen miles away in Hamilton. The emergency room would refer them to the Western Montana Mental Health Center's crisis center where the veteran would be safe and receive the quality of care to begin to relieve the crisis. In the next day or two, the veteran maybe transported 166 miles by ambulance from Hamilton to the Veterans Administration's (VA) Inpatient Psychiatric Facility in Helena. After a few weeks of treatment, the veteran will likely return home to Darby where they will be able to receive services either through the VA via telehealth or through the VA's. contract with Western Montana Mental Health Center in Hamilton. The fiscal streams that fund each level of treatment overlap between federal, state, and private payers.

The baseline need for mental health workers in rural Montana has increased dramatically in the past few years in Eastern Montana due to drilling in the Bakken Formation. The rural communities in this region have experienced a major population boom and the mental health programs and facilities are struggling to keep up. The high wage jobs available in the oil industry make it very difficult to recruit and retain support staff in those communities. Untreated mental illnesses, alcohol, and substance abuses in these areas have the potential to lead to long-term institutionalization in Montana's mental illness and corrections facilities.

III. Highlights

[3] "Montana Department of Public Health and Human Services Report to the 2013 Legislature: The Montana Medicaid Program State Fiscals Years 2011 and 2012." http://www.dphhs.mt.gov/publications/2013medicaidreport.pdf

[4] Medicare Resource Center. "About Medicare in Montana." See, http://www.medicareresources.org/montana.

A. Veterans Administration Contracts with Private Mental Health Centers

The Veterans Administration of Montana has utilized contracts for several years with community partners across Montana as a tool to increase mental health care access for Montana's veterans who live with rural communities or who choose not to seek mental healthcare services at a VA facility. This contracting arrangement allows the VA to provide in-person counseling services in many of Montana's rural communities.

While the Montana VA and our Veterans Center have been extremely adept at using telehealth services, vans, and other mobile delivery services; the contracts with the mental health centers has provided a consistent level of care for veterans in some communities which would not otherwise be possible. The federal contracts also help improve the financial grounding of the local mental health centers which improves their workforce recruitment and retention.

B. Psychiatric Nursing Program at Montana State

Montana State University received a grant of $814,021 from the Division of Nursing (DN), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) to establish an advanced degree in psychiatric nursing. This program graduated six advance practice psychiatric nurses in 2012 and will likely graduate thirteen in 2013. Seven students will be beginning studies this fall for the program's Doctor of Nursing Program specializing in psychiatric care.

This program is making an incredible difference across Montana as it brings more and more psychiatric advanced practice nurses into the workforce. These nurses are working with psychiatrists to expand the reach of high level psychiatric care into more communities and are allowing key crisis facilities to open and stay open. It is hard to imagine a more powerful and enduring one-time investment in Montana's mental illness treatment system.

C. Telepsychiatry

Telepsychiatry and other telehealth services are essential to providing effective care throughout Montana. These services have been expanding throughout Montana over the last decade through federal, state, and private investments and they appear to be hitting critical mass. The Veterans

Administration, AWARE Inc., American Telepsychiatry, and other providers have all provided telepsychiatry services to Montanans suffering from serious mental illnesses. The Center for Medicaid and Medicare services recently awarded Healthlinknow, Inc. a $7.7 million grant to establish telepsychiatry resources to Montana and Wyoming's Medicaid populations. As of this week, over fifty one different facilities in Montana and Wyoming have expressed interest in partnering with Healthlinknow to offer telepsychiatry in their facilities.

The Montana Legislature recently passes a bill which requires all health insurers in the state to cover telemedicine services. State Senator Ed Buttrey brought this legislation and it easily passed both houses with bipartisan support. The federal government's investment in these services combined with a firm legal footing and ever-improving technology has given telepsychiatry momentum in the push to provide more rural Montanans with effective psychiatric coverage.

D. Inpatient Psychiatric Unit at Fort Harrison

In June of 2011, the Veterans Administration completed construction of a $7 million inpatient psychiatric facility in Helena, Montana. Unfortunately, it took a year and a half until the VA was able to find enough mental health professionals to open the Post Traumatic Stress Disorder wing to treat veterans in mental health crisis.

The VA originally planned on utilizing three psychiatrists to staff the facility, but they had to become more flexible after they could not recruit three inpatient psychiatrists to the facility. The unconventional staffing structure that they designed utilizes one inpatient psychiatrist, the hospital's outpatient psychiatrist; two psychiatric nurse practitioners; and on-call psychiatrists at the Salt Lake City VA Medical Center. In addition, a newly hired staff psychologist oversees all mental health programs in the VA's Montana Health Care System.

The facility is an incredible tool to help improve the lives of Montana veterans with severe post traumatic stress injuries. It is also an excellent example illustrating the federal government's need to have enough flexibility in its system to adjust to the staffing challenges presented by a rural environment.

IV. Recommendations

A. Residency and Other Training Programs

Graduate residency programs are one of the most effective methods of bringing doctors into a community. Medical school graduates form ties with the hospitals they perform their residency at and with the communities they reside in and it makes them much more likely to stay in the area. Unfortunately, these residency programs, especially for hard-to-fill positions such as psychiatry, are very rare in rural states. This shortage of rural residency programs only exacerbates the physician shortages in rural areas. For instance, Montana does not have a psychiatry residence program. That makes it extremely difficult for the federal government to fill its psychiatry needs in the VA and Indian Health Services.

The nation is currently experiencing a shortage of residency slots and several federal lawmakers have introduced legislation to add between 3,000 and 4,000 federally funded residency positions over a five-year period. The House version is the "Training Tomorrow's Doctors Today Act" (H.R. 1201) and Senate version is "The Resident Physician Shortage Reduction Act of 2013" (S. 577).

Federally funded residency programs funded through legislation like this must ensure that some of the residency slots are designated for rural communities. The residency programs may require some design modifications to meet the staffing challenges of rural America, but that flexibility will pay off by reducing long-term costs incurred by the federal government in continuously having to recruit physicians into these areas.

B. Loan Repayment

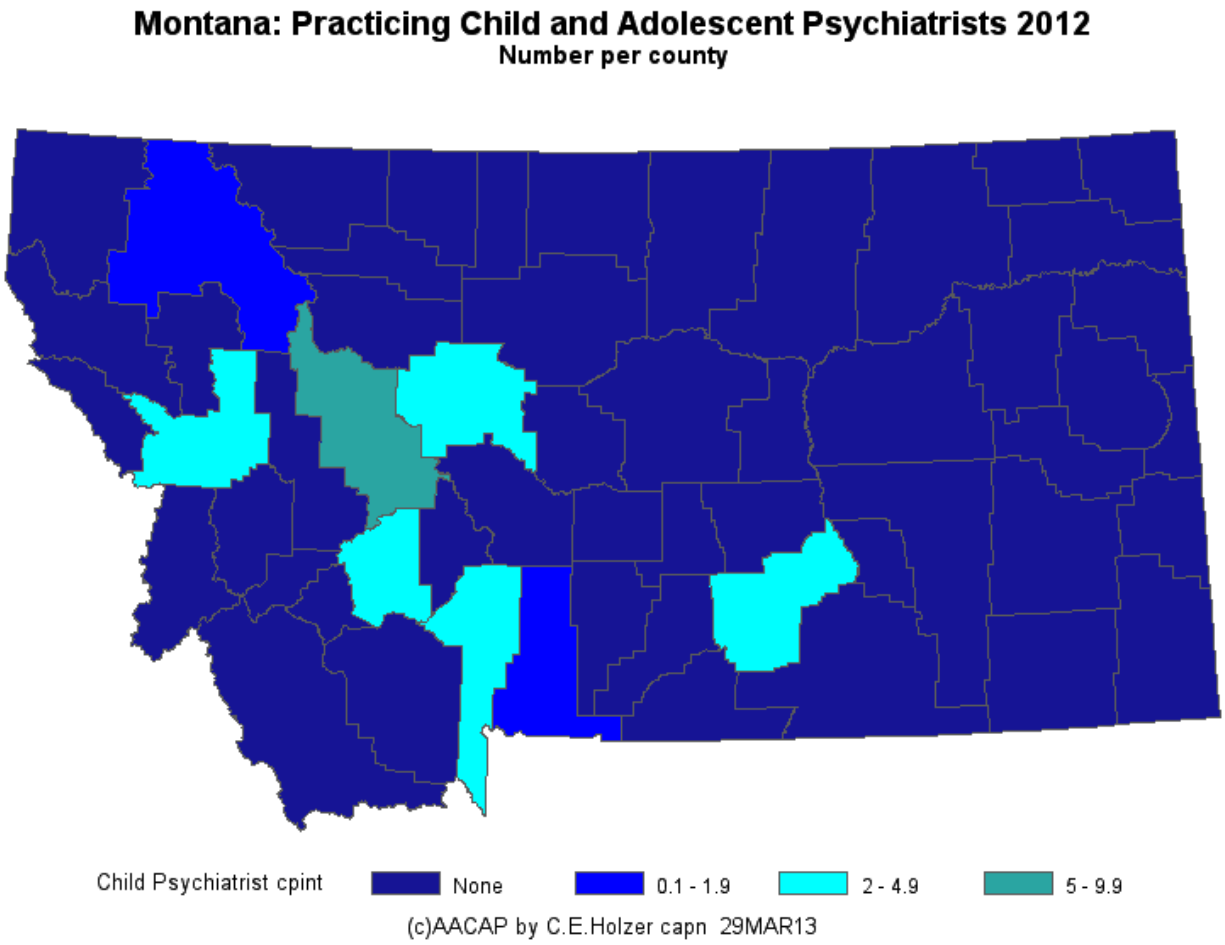
The federal government's loan repayment programs are an essential tool to recruiting mental health providers to Montana's rural communities. However, these programs should be reviewed to ensure that they are broad enough to incentivize healthcare workers to dedicate a portion of their practice to serving individuals in rural areas either through a satellite office or via telemedicine.

One other issue that NAMI Montana is seeing with repayment programs is that they seem to favor outpatient psychiatrists over inpatient psychiatrists. While both positions are important, the

inpatient positions are extremely hard to fill due to on-call requirements and the stress inherent in inpatient duties. The Veterans Administration's inability to open its inpatient unit in Helena, Montana more than a year after its construction due to a lack of psychiatrists willing to work in an inpatient setting is clear evidence of how challenging it is to fill inpatient psychiatry positions in rural states.

The repayment programs also do not seem to reflect the fact that inpatient treatment facilities in the cities of rural states are an essential tool to caring for mental illness in rural communities. For instance, Shodair Children's Hospital in Helena admitted 800 children in need of psychiatric treatment in 2012 – only 23% of them were from the Helena area. The psychiatrists that work in this facility are an essential tool to treating rural Montana children with emotional disturbances who go into crisis; unfortunately the federal loan repayment programs do not hold them in the same regard as their peers who work with these children in outpatient settings.

There is an effort underway, being led by Rep. Jim McDermott in the U.S. House of Representatives, to get funding restored for the Pediatric Subspecialty Loan Repayment Program. This program targets loan repayments specifically for child and adolescent psychiatrists of up to $35,000 per year for those who work in medically underserved areas. Our nation currently has about 7,500 child and adolescent psychiatrists with a need for 20,000 so there are families that are routinely told that they must wait an average of 3 to 6 months for their child to see a child psychiatrist. This places a tremendous burden on families. The shortage of child psychiatrists can also lead to a heavy burden on the federal government when some of these children and adolescents go into crisis due to lack of medical care and land in residential treatment facilities that cost hundreds of dollars per day.



C. Establish a National Mental Illness Diagnostic Research Center

One of the biggest challenges to the effectiveness of the federal workforce engaged in treating serious mental illness and other brain conditions is the primitive process of diagnosing these conditions. Instead of using concrete scientific tools to determine the illness affecting the inner workings of the brain, psychiatrists and psychologists work off of behavioral questionnaires. It is the equivalent of a doctor trying to determine whether a bone was broken before the invention of X-Rays.

This lack of a biological screening tool for these brain conditions leads to misdiagnoses, improper prescribing, and a general mistrust of the mental illness treatment system.[5] The

[5] *See example*, Alan Schwartz and Sara Cohen, "More Diagnoses of A.D.H.D. Causing Concern," *New York Times* (March 31, 2013) http://www.nytimes.com/2013/04/01/health/more-diagnoses-of-hyperactivity-causing-concern.html?ref=opinion.

wobbly status of the mental illness treatment system's diagnostic foundation is staggering when one considers that the total direct and indirect costs of severe mental illnesses exceeds $300 billion annually.[6] Many of those costs are absorbed by the federal government through both spending on medical care and for disability payments.

Thanks to public and private funding, researchers are beginning to develop biological indicators for serious mental illnesses and other brain conditions. The promise of these techniques has moved from research journals to broad national media like *Time Magazine*.[7] It is in the best interest of the country for effective next-generation diagnostic tools to be brought to market as soon as possible. It is also in the best interest of the country to prevent ineffective biological diagnostic techniques from being utilized in our healthcare system.

A National Mental Illness Diagnostic Research Center (NMIDRC) would verify innovative biological techniques for diagnosing serious mental illnesses and other brain conditions. A large percentage of the costs of verification tests are in test design and participant recruitment/ management. The MIDRC will be able to reduce these costs through economy of scale by administering multiple tests at the same facility utilizing the same administrative staff. The NMIDRC should be funded with the goal of conducting five to ten verification trials per year. The first several years of testing will most likely focus on disproving new technologies and conducting proof-of-concept tests to refine potentially viable diagnostic techniques for further study.

D. Mental Health Awareness and Improvement Act of 2013 (S. 689)

The Mental Health Awareness and Improvement Act would would help address early intervention in mental illness and strengthening suicide prevention programs through:

- Reauthorization of the Garrett Lee Smith Memorial Act, which provides key youth suicide prevention programs targeted to states, tribes, and college campuses;
- Mental health awareness training for school and emergency services personnel so they can recognize the signs and symptoms of mental illness, become familiar with resources

[6] National Institute of Mental Health, "Annual Total Direct and Indirect Costs of Serious Mental Illness." http://www.nimh.nih.gov/statistics/4COST_TOTAN.shtml

[7] Alice Park, "Red Alert. New Blood Tests Promise Better Cheaper Diagnoses," *Time Magazine* (February 11, 2013)

in the community for individuals with mental illnesses, and learn how to safely de-escalate crisis situations involving individuals at risk for self-harm; and

- Expansion of the National Violent Death Reporting System (NVDRS) to all 50 states, which would ensure the availability of complete, accurate, and timely information used to design effective suicide prevention strategies.

NAMI-Montana and NAMI strongly support enactment of S. 689 as a step towards addressing the mental health crisis in rural America.

1.

E. Excellence in Mental Health Act (S. 2257)

This legislation will create a new, voluntary pathway for community mental health and addictions organizations to become Federally Qualified Community Behavioral Health Centers (FQCBHCs). Organizations would have to deliver specified services and meet requirements with respect to reporting, standards of care, and oversight. In return, FQCBHC status would offer a foundation for a whole-person approach to health that recognizes community behavioral healthcare organizations' experience and potential in treating complex patients with difficult healthcare needs. Specifically, the Excellence in Mental Health Act would:

- Expand access to mental health and addictions care by supporting FQCBHCs in treating all individuals regardless of their ability to pay, with a comprehensive array of evidence-based specialty behavioral health services that are not available in other settings.
- Reduce the use of emergency rooms for routine care by requiring FBCBHCs to provide specified primary care screening for key diseases like hypertension and diabetes.
- Improve the management of chronic health conditions by requiring FQCBHCs to partner with primary care providers such as Federally Qualified Health Centers to ensure that people with mental health and addictions disorders have access to all needed medical treatments and are appropriately monitored for disease risk.
- Cultivate a robust community mental health and addictions treatment system by requiring FQCBHCs to meet administrative requirements, reporting standards, and treatment objectives.

- Provide a stable foundation for this work by paying FQCBHCs a bundled per-visit rate that shares risk with the federal government.
- Save $400 million over 10 years by making FQCBHCs eligible for 340(B) drug pricing.

Thank you again for the opportunity to testify in from of this honorable Committee. Your attention to this issue means a lot to me and all of the rural American families affected by serious mental illness. We look forward in helping you come up with solutions to these workforce challenges.