

Welcome to Fireside Chat # 439
March 3, 2015 1:00 – 2:30 PM Eastern Time
(Teleconference open for participants at 12:50 ET)

Psychiatry Workforce :
Meeting the Needs :
More Psychiatrists or role clarification?

Advisor on Tap:
Paul Kurdyak MD PhD FRCPC

How to post comments/questions during the Fireside Chat

Joining in by
Telephone
+
Adobe Connect Internet Conference

Use the text box!



Joining by
Telephone +
Backup PowerPoint

Respond to the 'access instructions email
animateur@chnet-works.ca



Please introduce yourself!

- *Name*
- *Organization*
- *Location*

Group in Attendance?

Step #1: *Teleconference*

All Audio by telephone

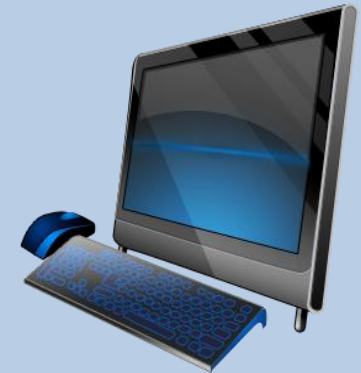
- If your line is 'bad' – hang up and call back in
- Participant lines muted
- Recording announcement



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No audio via internet 

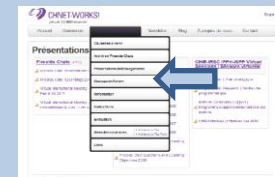
- SEE the PowerPoint being shown.
- Post your comments/questions.
- See postings from your colleagues.
- Join in the interactive polls.



Difficulties? *You can still participate! (use the back up PowerPoint - post your comments via email)*

Step #3: *Back up PowerPoint Presentation*

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Advisor on Tap



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Meeting the Needs : More Psychiatrists or role clarification?

Paul Kurdyak MD PhD

Director, Health Systems Research, CAMH

Lead, Mental Health and Addictions Research Program, ICES

Disclosure

- Operational grant - MOHLTC Health System Research Fund Capacity Award
- No conflicts of interest to disclose that could influence the content of this presentation

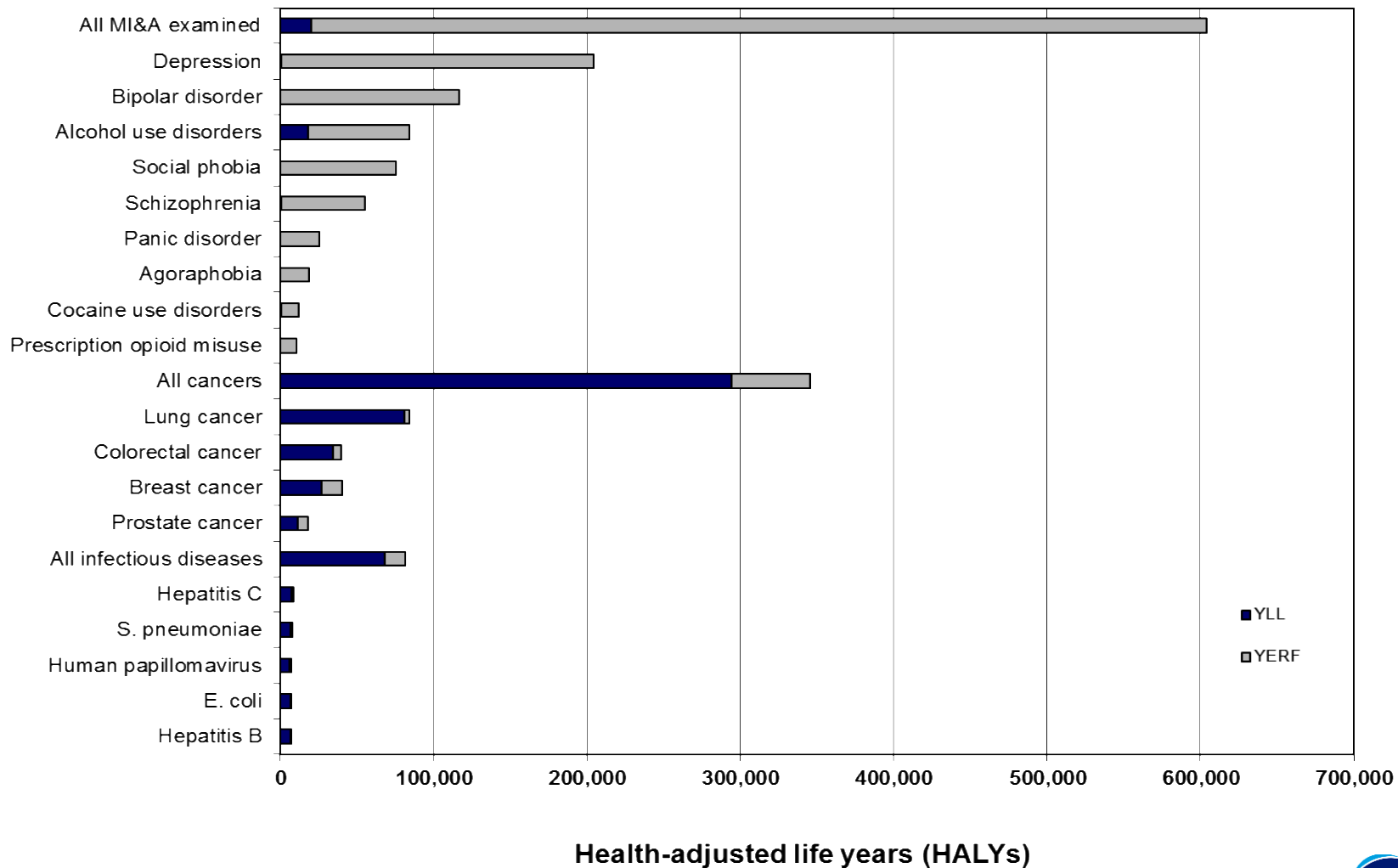
Objectives

1. To learn about the relationship between psychiatrist supply, practice patterns, and region on access to care.
2. To engage in a discussion about the role of a psychiatrist in a publicly funded health care system.

What I am going to show you . . .

1. Impact of an anti-stigma campaign on CAMH ED and gen psych clinic volumes (evidence of need)
2. Psychiatrist supply and access to care (outpatient practice patterns)
3. SCZ Post-Discharge Access to MDs (access)

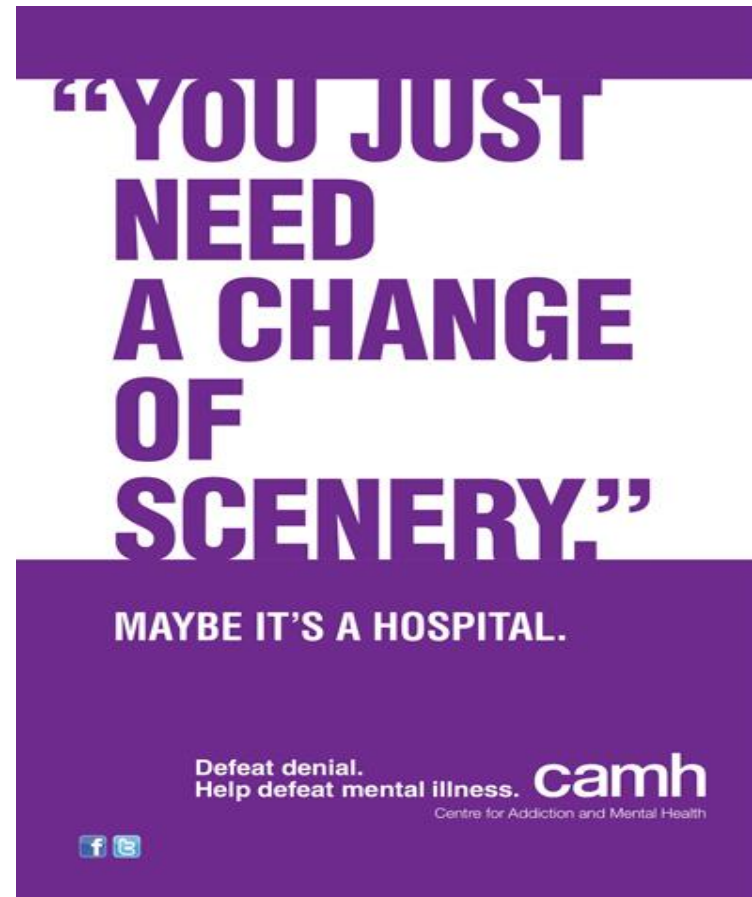
Ontario Burden of Mental Illness



Mental Illness and Addiction Treatment Rates

- Two thirds of people with depression do not seek help
- Up to 90% of people with addictions do not seek treatment
- Very little evidence on increasing treatment-seeking behaviours to address burden of mental illness and addiction



The CAMH Campaign

A graphic for the CAMH campaign. It features a purple background with white text. At the top, a thick purple horizontal bar is partially obscured by the text "YOU JUST NEED A CHANGE OF SCENERY." which is written in large, bold, white, sans-serif capital letters. Below this, the text "MAYBE IT'S A HOSPITAL." is written in smaller, white, sans-serif capital letters. At the bottom, the slogan "Defeat denial. Help defeat mental illness." is followed by the "camh" logo in a bold, lowercase font. Below the logo is the full name "Centre for Addiction and Mental Health" in a smaller font. To the left of the logo are small icons for Facebook and Twitter.

**“YOU JUST
NEED
A CHANGE
OF
SCENERY.”**

MAYBE IT'S A HOSPITAL.

Defeat denial.
Help defeat mental illness. **camh**
Centre for Addiction and Mental Health

A Natural Experiment

- The campaign is the only intervention that occurred in March 2010 (nothing else changed that could explain changes in visit volumes)
- Permits an evaluation of the campaign using quasi-experimental methods
- ED volumes AND Gen Psych. Assessment Clinic volumes – direct-to-consumer marketing vs. service provider marketing

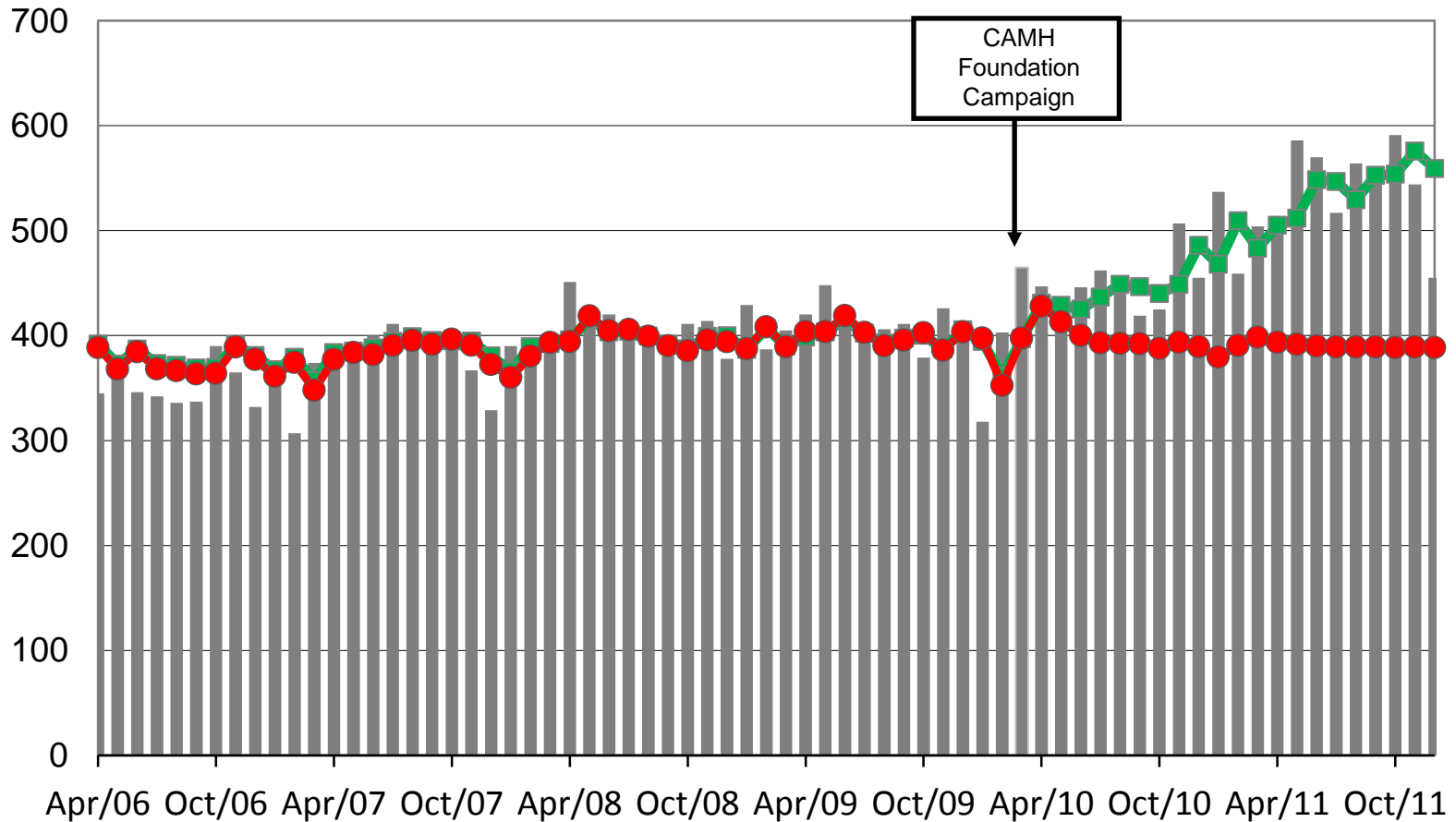
Methods

- All patients who presented to the ED (N=29,069) and the Gen Psych. Assessment Clinic (N=8326) from April 1, 2006 to December 31, 2011.
- Grouped monthly
- Pre-campaign – April 1, 2006 to March 31, 2010
- Post-campaign – April 1, 2010 to December 31, 2011
- Also used regional-level data for system-level analyses

Statistical Analysis

- Time series analysis methods used to model the data series and test for an effect of the campaign.
- Geographic Information Systems (GIS) using patient postal code for mapping patient distance from ED.

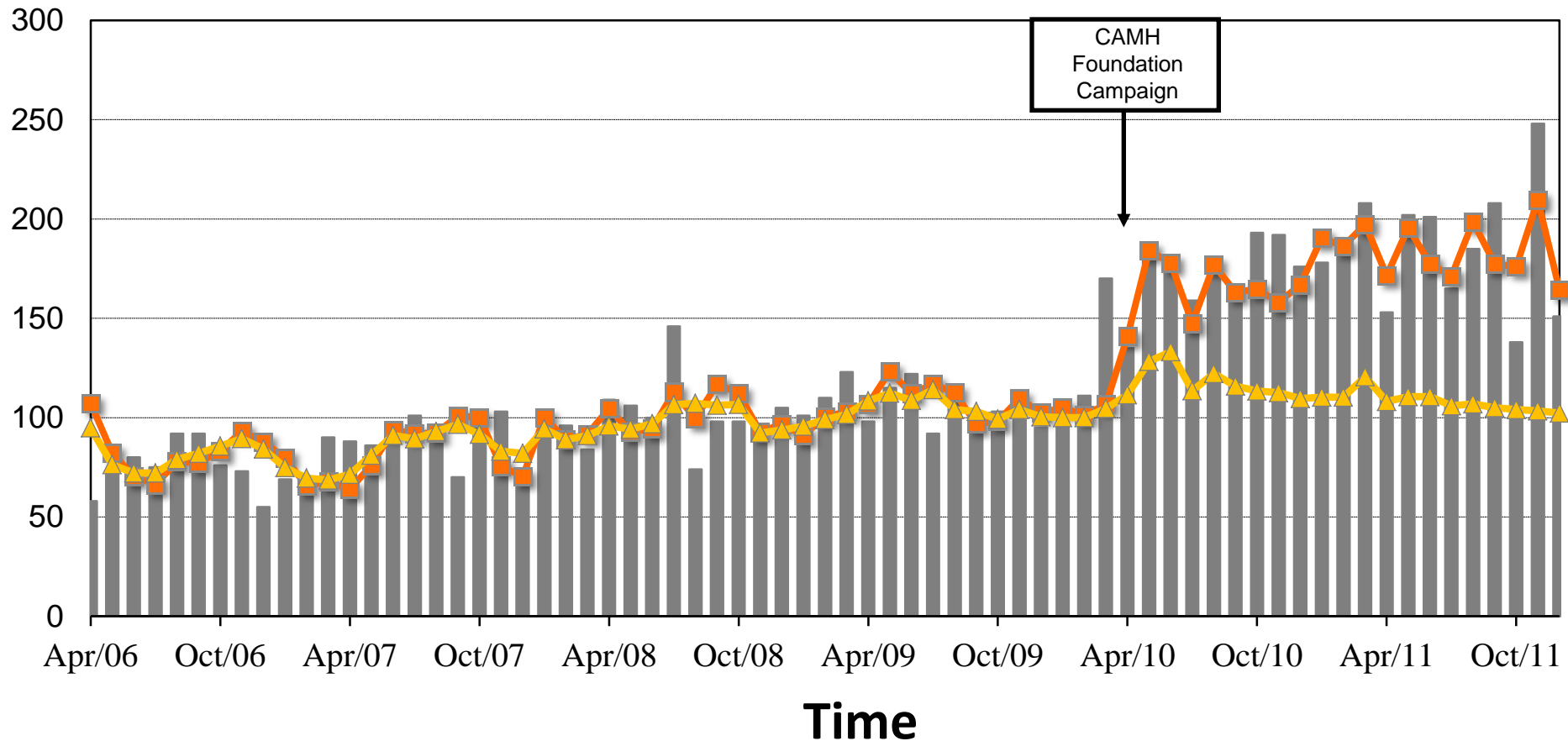
ED Volumes



Time

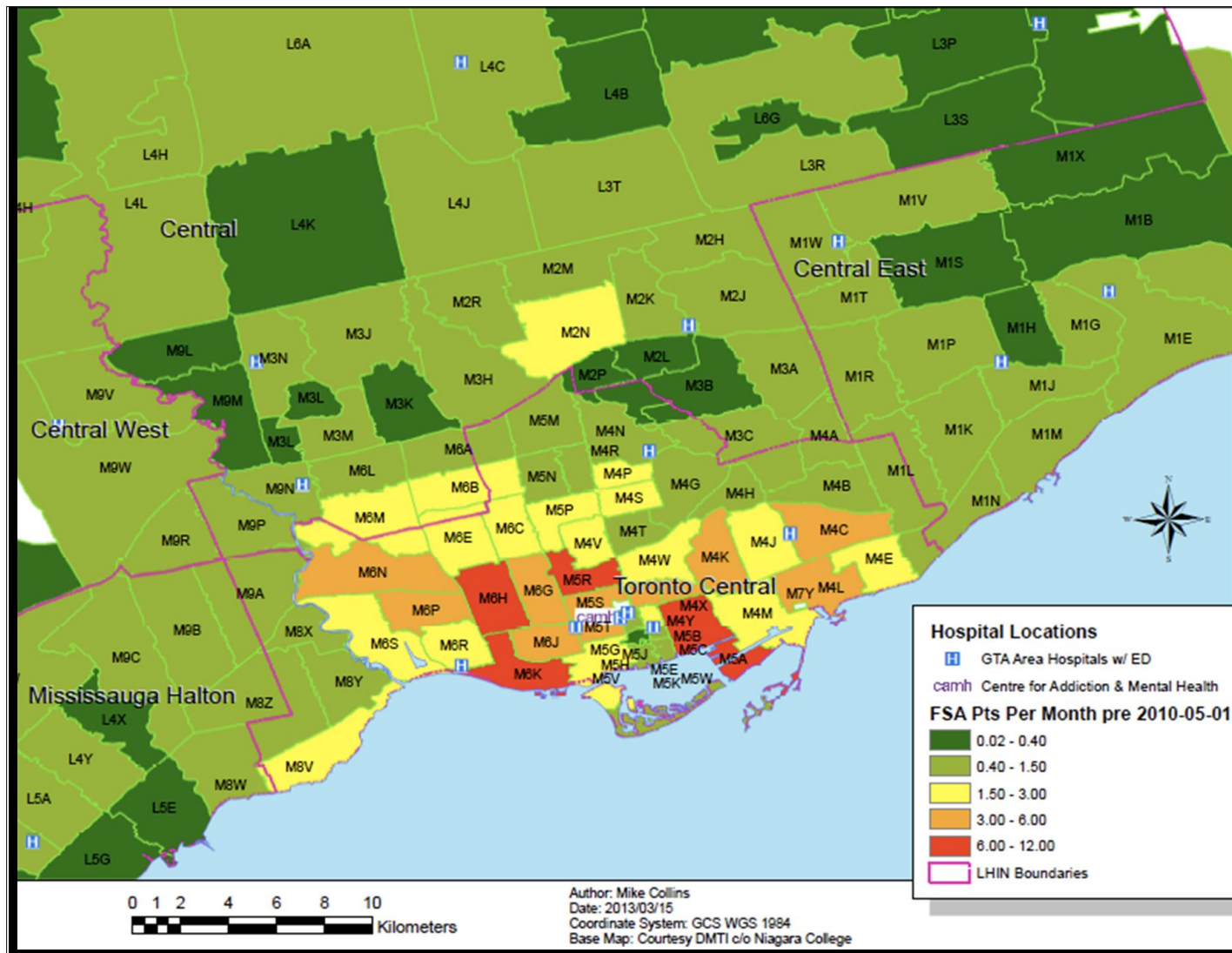
Actual # visits

General Psychiatry Assessment Clinic Volumes

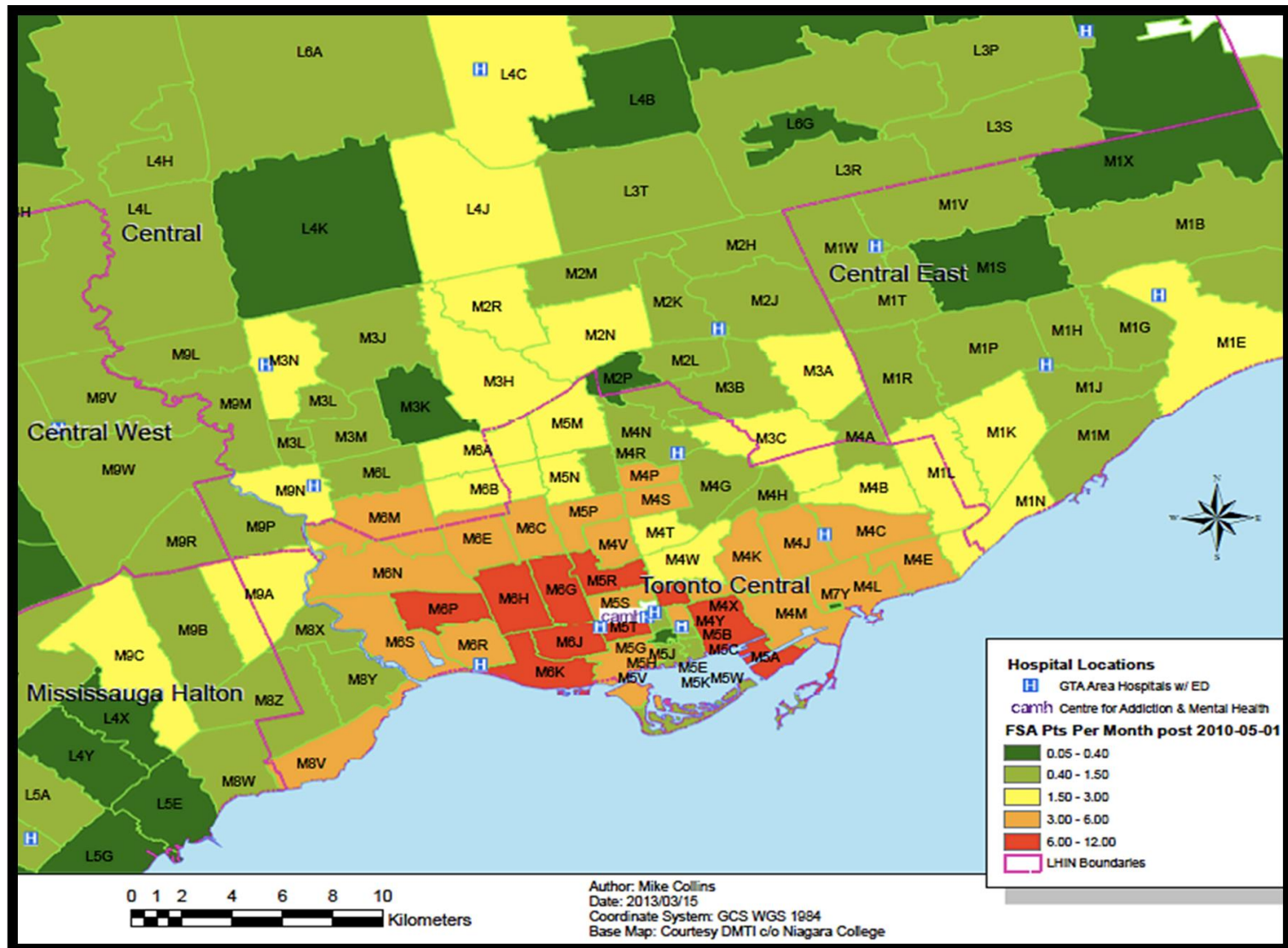


■ Number of referrals

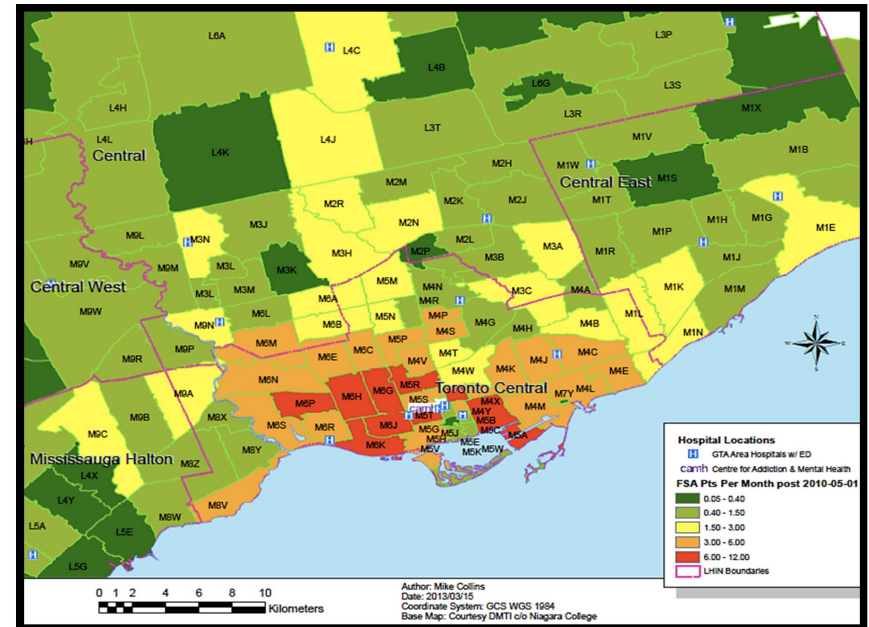
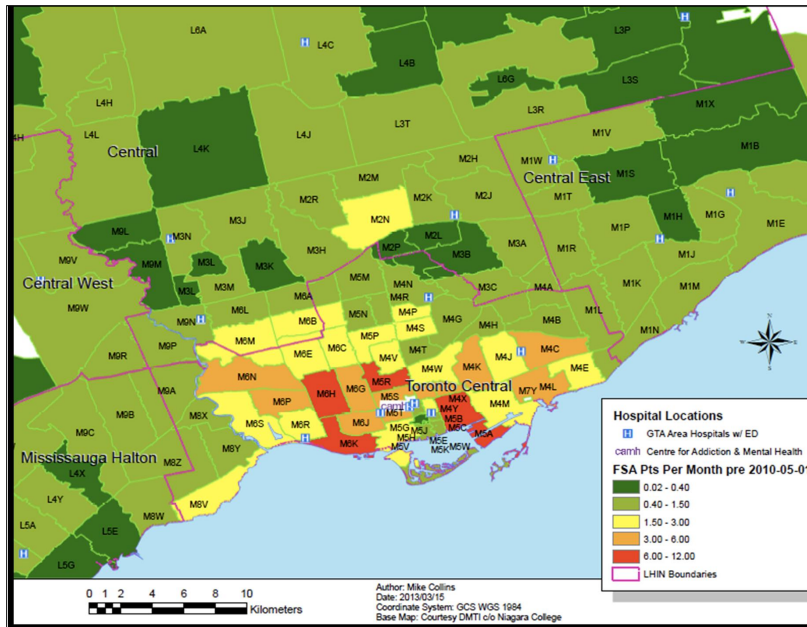
Pre-Campaign Map



Post-Campaign Map



Maps Side by Side



Main Findings

- Addressing stigma increases help-seeking and referral behaviour
- Can have a significant impact on volumes
- Low treatment rates can be addressed using marketing strategies addressing stigma AND highlighting service availability

What About Access to Psychiatrists?

- Elliot Goldner's study had a RC in Vancouver contact every psychiatrist in Vancouver who sees patients

Primary Care Physicians and Access to Psychiatrists*

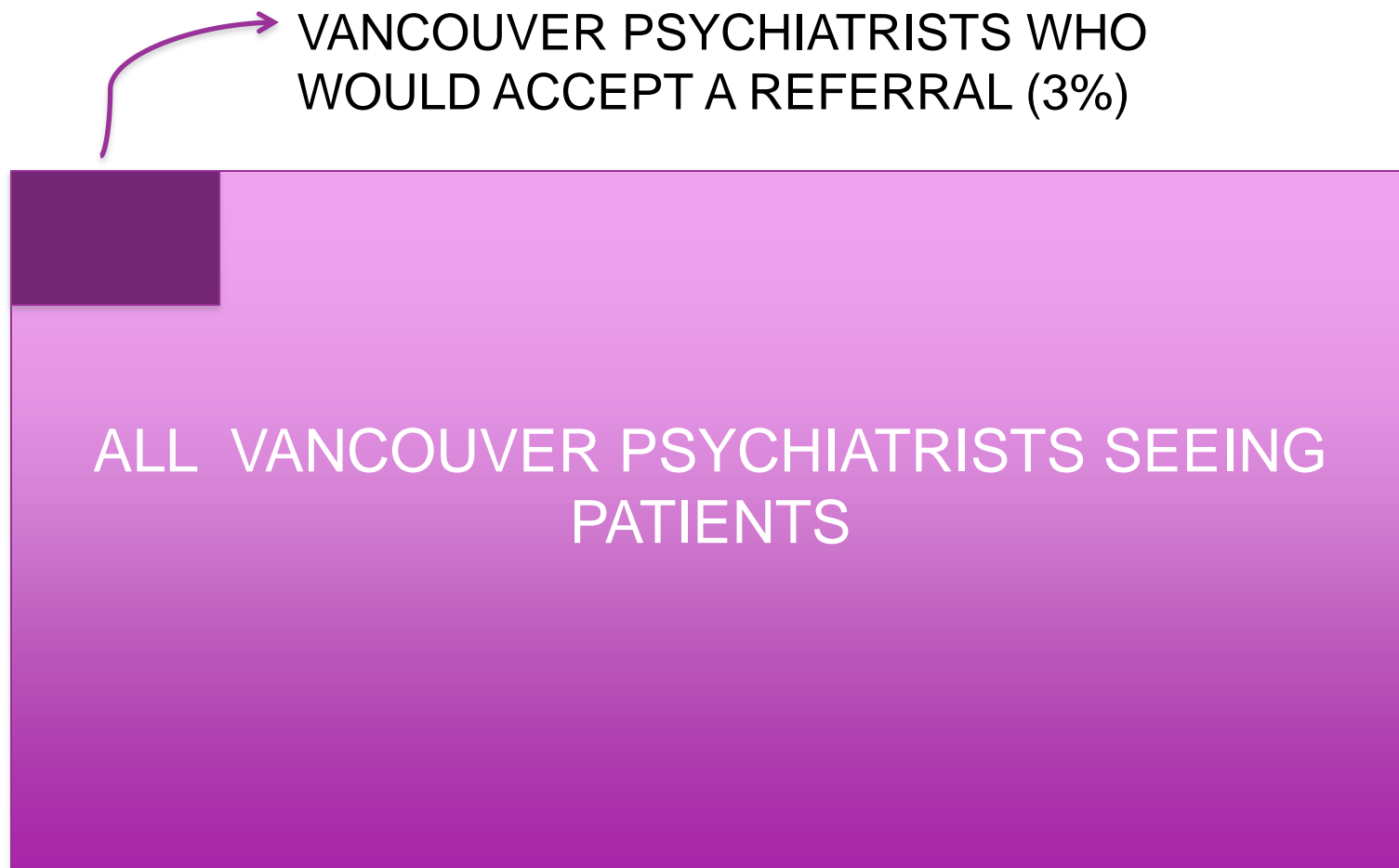
ALL VANCOUVER PSYCHIATRISTS SEEING
PATIENTS

*Goldner et al., 2012; Can J Psychiatry, 56:474-80.

INTERACTIVE SLIDE

- Of the 230 Vancouver psychiatrists who see patients, what percentage said they could see the patient in a timely manner for a consultation?
 - a) 50%
 - b) 27%
 - c) 11%
 - d) 3%

Primary Care Physicians and Access to Psychiatrists*



*Goldner et al., 2012; Can J Psychiatry, 56:474-80.

Universal Coverage Without Universal Access

Open Medicine

A peer-reviewed, independent, open-access journal.

Open Medicine, Vol 8, No 3 (2014)

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RESEARCH

Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario

PAUL KURDYAK, THÉRÈSE A STUKEL, DAVID GOLDBLOOM, ALEXANDER KOPP, BRANDON M ZAGORSKI, BENOIT H MULSANT

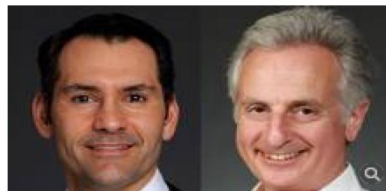


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KURDYAK AND GOLDBLOOM

Can't find a psychiatrist? Here's why

PAUL KURDYAK AND DAVID GOLDBLOOM

Contributed to The Globe and Mail

Published Thursday, Jul. 17 2014, 7:29 AM EDT

Last updated Thursday, Jul. 17 2014, 7:33 AM EDT

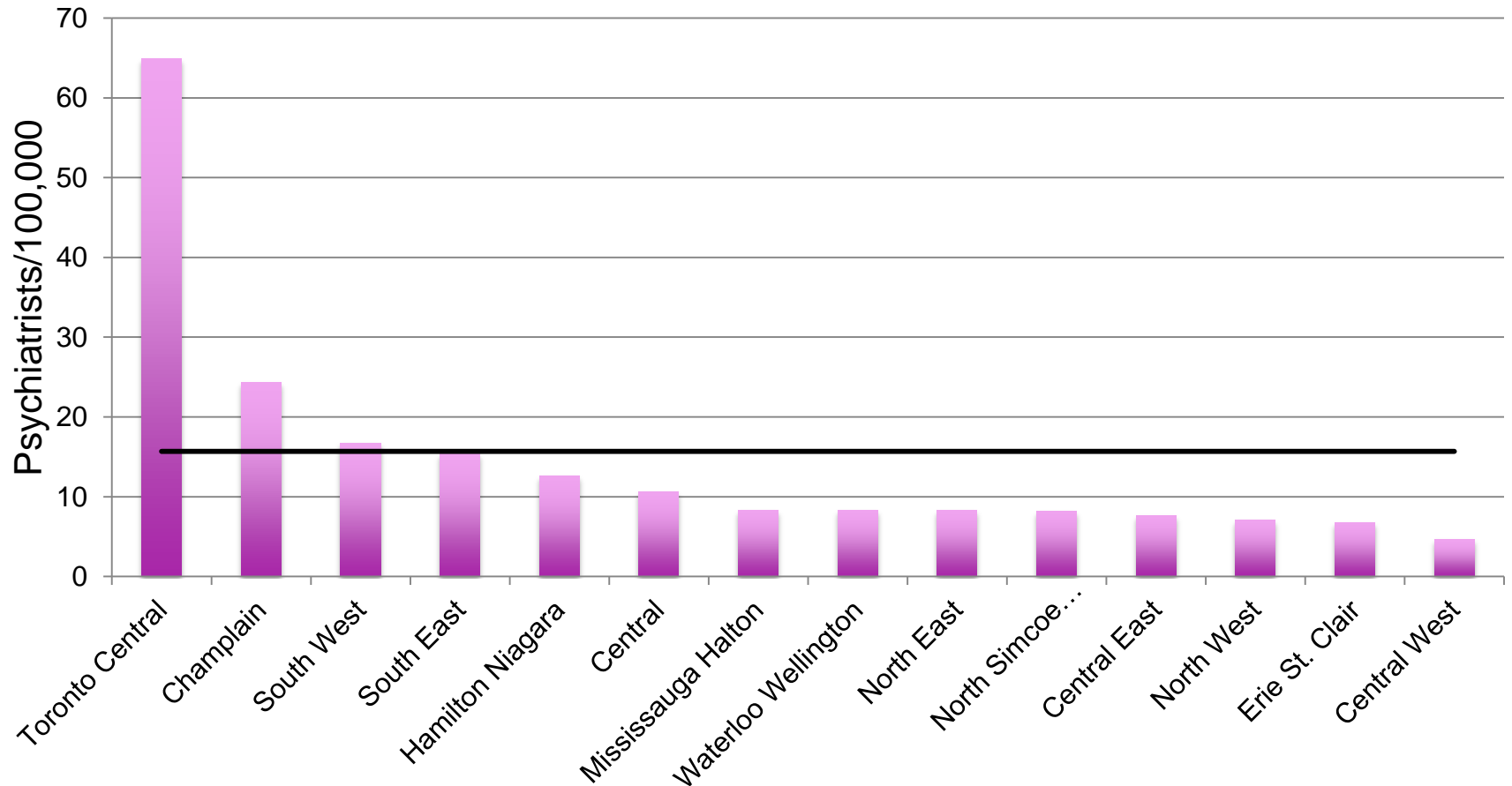
Why Do The Study?

- Started with a simple question:
 - Why is access to psychiatrists so poor when there are quite a few psychiatrists, particularly in the larger Ontario cities?
- Difficult to change current policy and practice in the absence of empirical data
- It is challenging to evaluate one's practice from a system perspective on a day-to-day basis
 - Very difficult to know who you are not seeing.
 - Need access to high quality, system-level data.
- Opportunity to evaluate practice patterns regionally (by LHIN) as a natural experiment to test the relationship between psychiatrist supply and practice patterns.

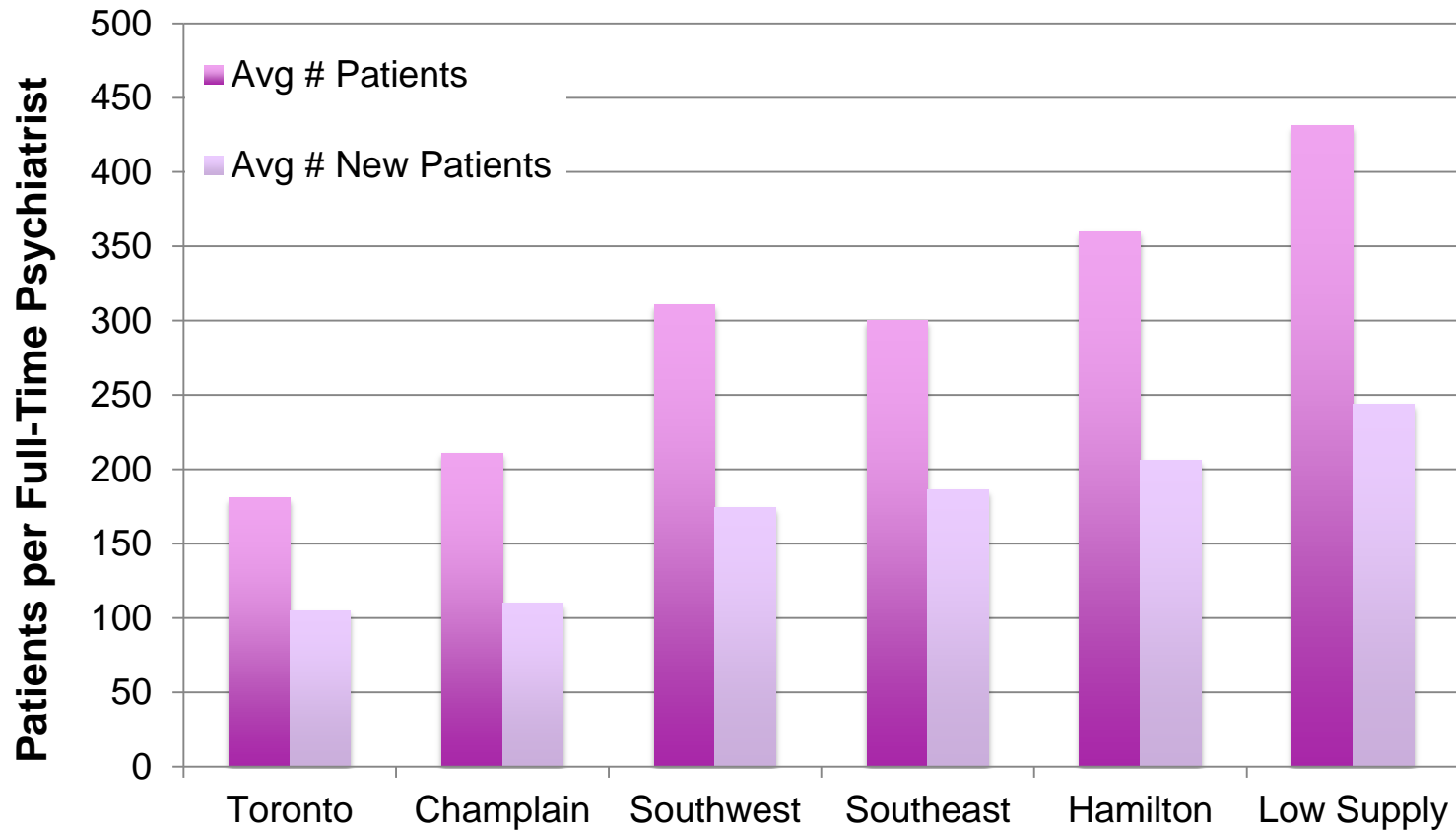
What this study is not about

1. Suggesting solutions to the issues raised.
2. Opposition to the practice of psychotherapy.
3. Quality of care.

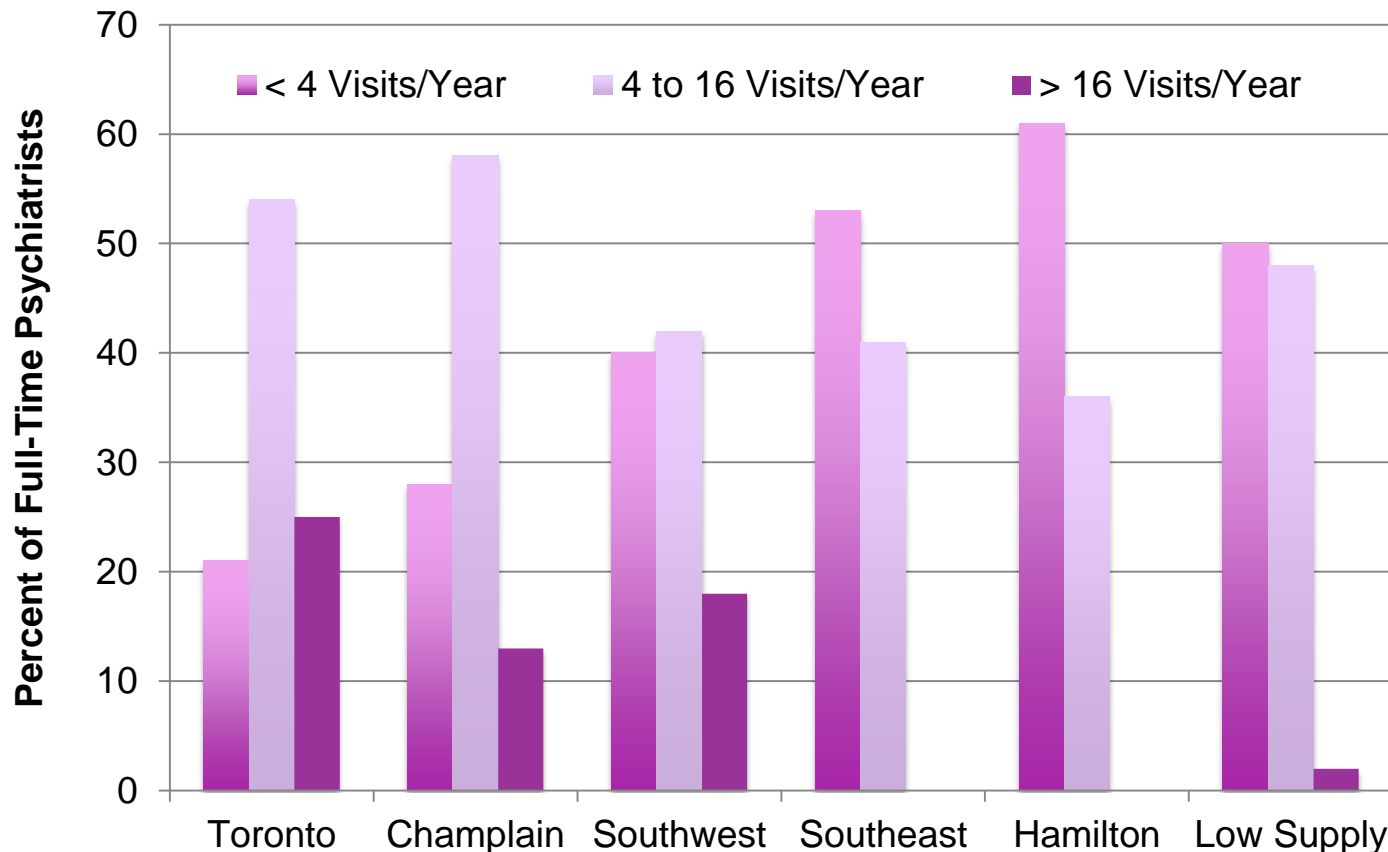
FTE Psychiatrists per Capita in Ontario



Total and New Patients Per Full-time Psychiatrist



Understanding the Distribution by Visit Frequency



- Patients in >16 visits/year more likely in highest neighbourhood income quintile and almost never had a prior psychiatric hospitalization

More Numbers

- 25% of Toronto psychiatrists who see patients >16 times per year account for 8% of total Toronto outpatient population.
- 10% of Toronto full-time psychiatrists have an average total annual outpatient practice of fewer than 40 patients per year (7% in Champlain; 8% in Southwest LHIN; 4% in Low Supply Regions)

Key Points

- Psychiatrists in high supply regions saw fewer patients, and saw their patients more frequently
- Fee schedule may be a factor (no limit on frequency of visits or duration of treatment)
 - BUT – same fee schedule applies to psychiatrists in high AND low supply regions
 - If fee schedule is a factor, it is only a factor regionally

INTERACTIVE SLIDE

- What factors explain the extreme regional differences in the way psychiatrists practice?
 - (I don't have the answer to this . . . yet)

The Impact of Type of Physician Involvement in Readmission Following Psychiatric Hospitalization for Schizophrenia

Why Do The Study?

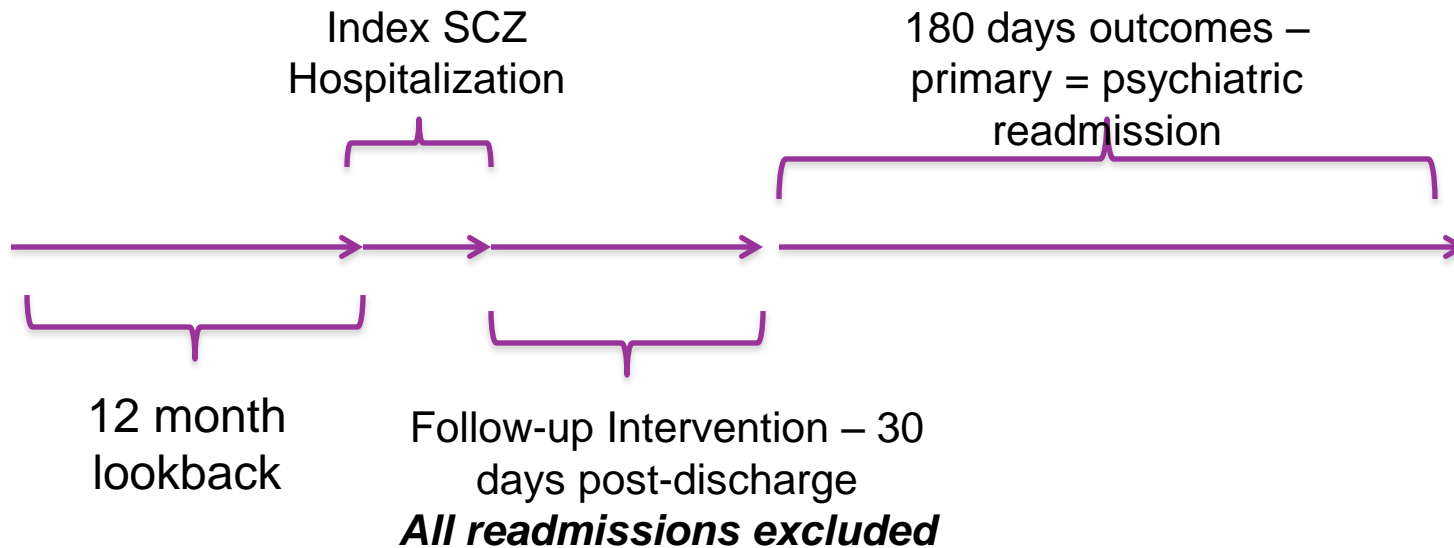
- SCZ readmission rates VERY high (12-14% within 30 days)
- Readmission rates are reported as a quality indicator
- Post-discharge physician follow-up is reported as a quality indicator
- Only 1 study, using US VA data, explored the relationship between access to follow-up and readmission (and focussed on concurrent disorders)*
- **Despite widespread use of readmission *and* follow-up as quality indicators, no evidence that physician follow-up reduces readmission rates!**

*Ilgen et al., 2008, *Continuing care after inpatient psychiatric treatment for patients with psychiatric and substance use disorders*. *Psychiatric Services*;59:982-8.

Objective

- To measure the impact of different types of physician visit (no MD, primary care only, psychiatrist only, or both primary care and psychiatrist) within 30 days of discharge on readmission rates 31+ days following schizophrenia hospitalization discharge.

Study Design

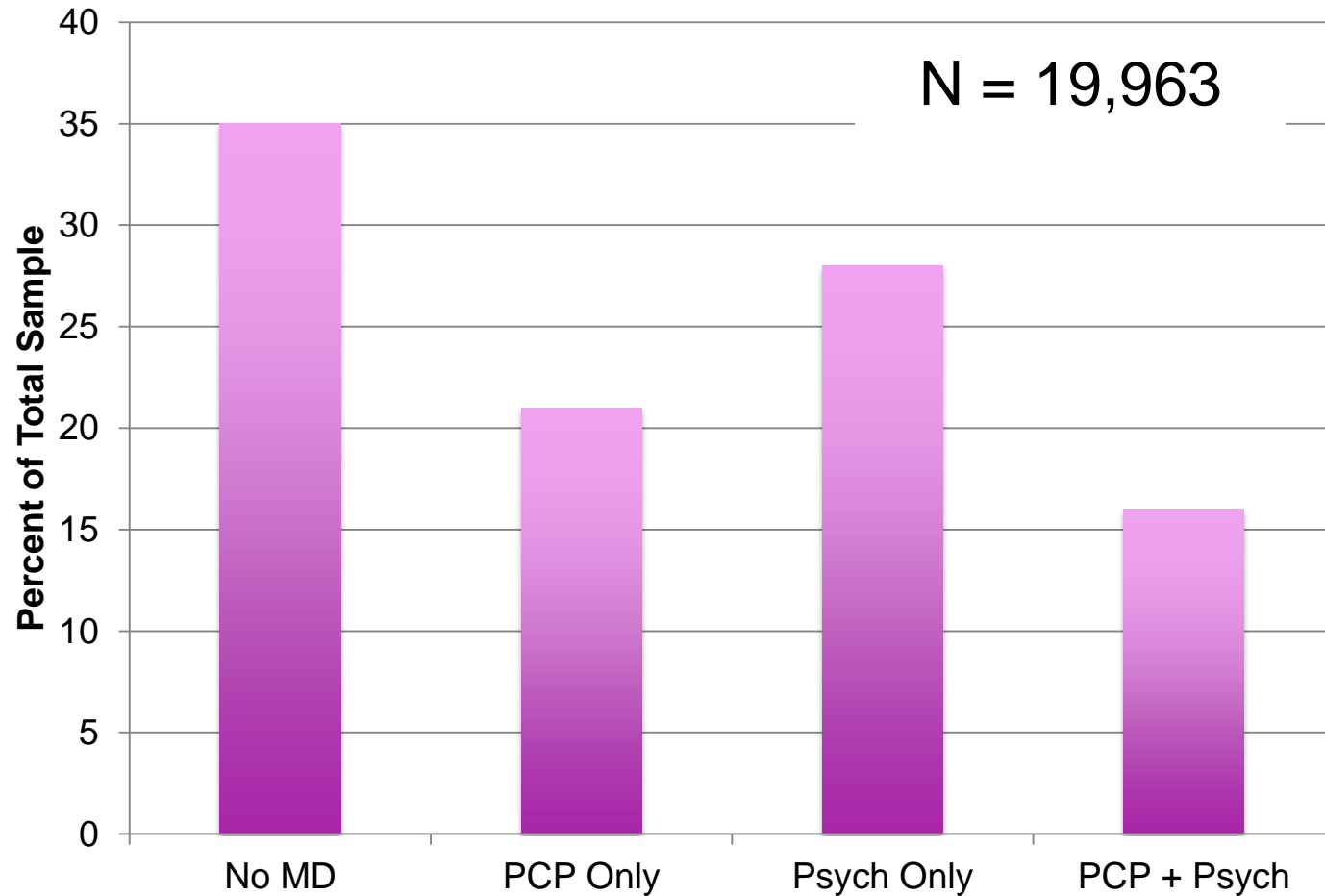


- All index hospitalizations within OMHRS
- April 1, 2007 to March 31, 2012 accrual
- Follow-up type = No MD visit, PCP only, Psych only, Both PCP + Psych

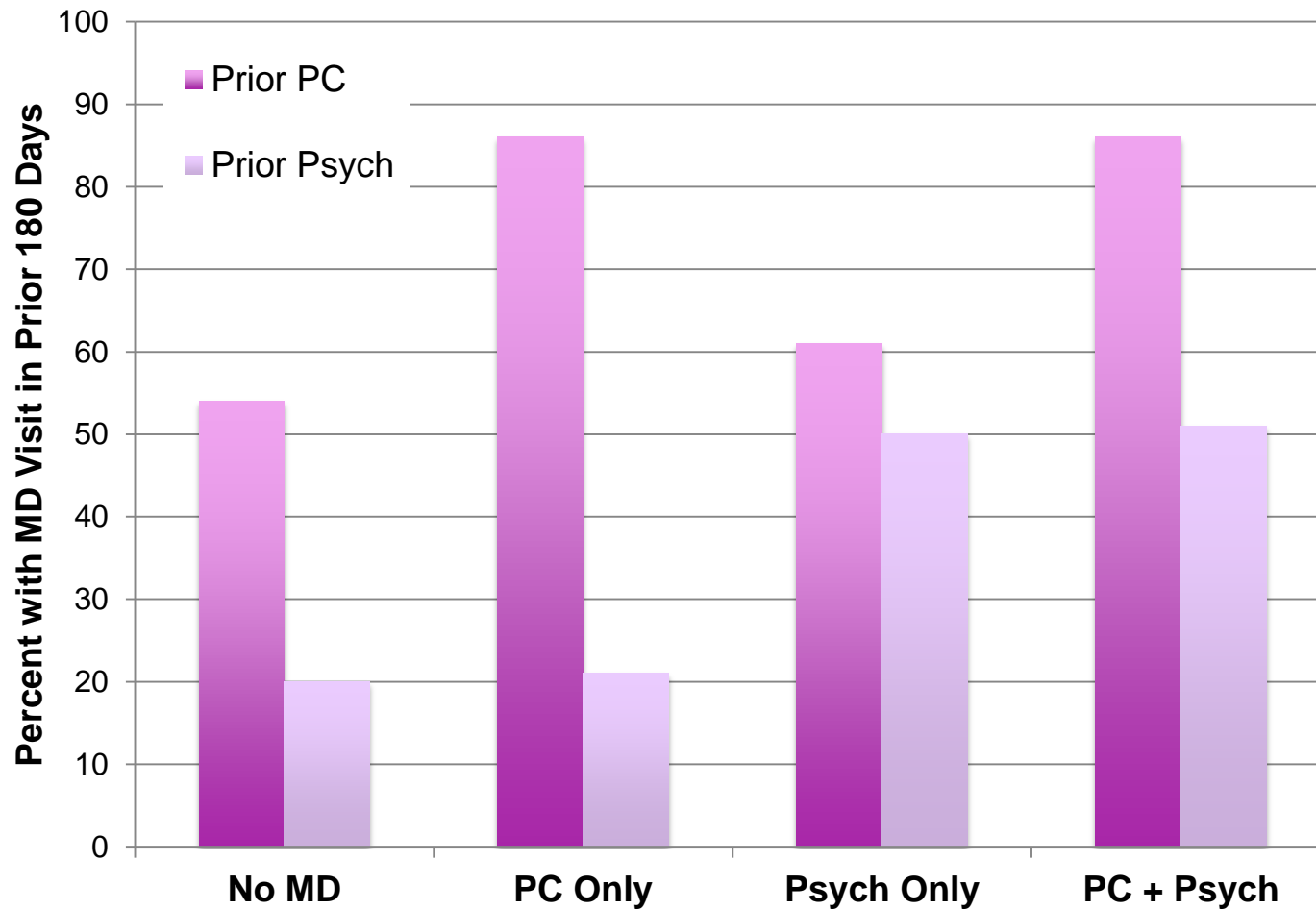
Covariates

- Demographics
 - Age (categories)
 - Sex
 - Income
 - Rural
- Health Service Utilization (prior year)
 - PCP visits – categorized as mental health and non-MH
 - Psychiatrist visits
 - ED visits
 - All OMHRS hospitalizations
- Comorbidities
 - ADGs
- Psychiatric Illness Severity (benefit of OMHRS RAI data)
 - Aggressive Behaviour, ADLs, Cognitive Performance, Depression Rating Scale, Psychotic Symptom Rating Scale, CAGE questionnaire, Suicidal Behaviours, GAF

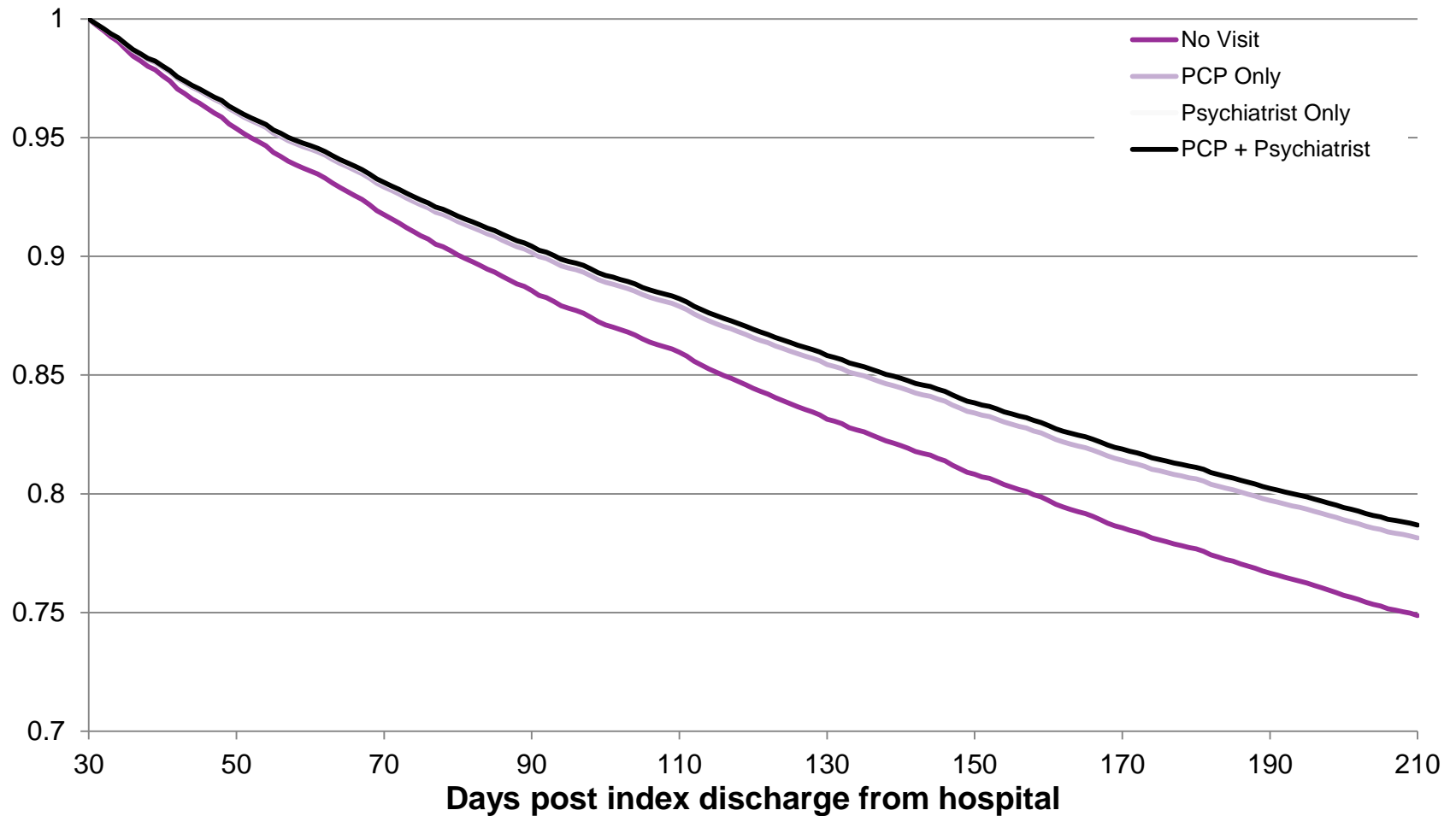
Sample of Discharged SCZ Patients (2007-12)



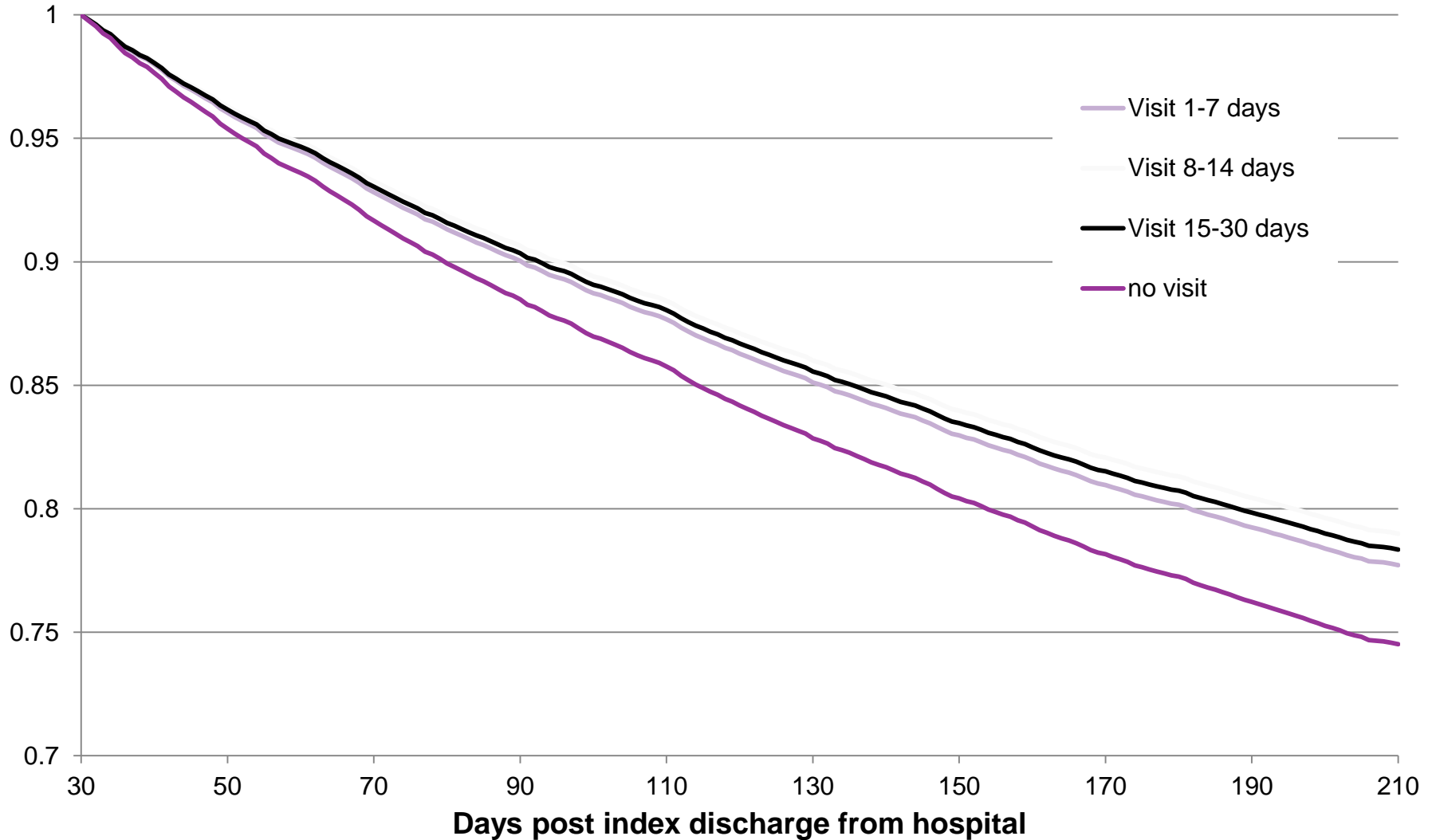
Missed Opportunities



Cumulative readmission-free survival by Physician Type



Cumulative readmission-free survival by time of Follow-up Visit



Discussion

- A large proportion (>40%) of individuals with a diagnosis of SCZ see no MD 1-month post-D/C
- Large proportion of prior MD visits represent “missed opportunity” for continuity of care
- Seeing a MD within 1-month post-D/C significantly (but modestly) reduces risk of readmission
- Need to better understand processes that improve transition from inpatient to outpatient

Wait Times for Mental Health and Addictions

- Most wait-times initiatives focus on procedures or Emergency Department
- Defining wait-times for MHA is not as straightforward
 - Multiple referral sources (self, community-based agencies, schools, MD offices)
 - Multiple potential issues/diagnoses (e.g., mental illness comorbid with addiction)
 - At point of entry, need to be able to discriminate based on broad diagnostic categories AND illness severity
 - Diagnostic category to align with evidence-based treatments
 - Illness severity to align with need/intensity of resources

Summary

- Burden of mental health and addictions is substantial
- There is a substantial “market” of unmet need (advertising increases “demand” by 80%)
- Access to psychiatrists does not follow normal supply/demand with increasing numbers of psychiatrists resulting in more psychiatrists choosing small volume practices
- Access to care at times of high need (post-D/C) for SCZ is quite low, but access to physicians reduces readmission rates (modestly)

INTERACTIVE SLIDE

- With high demand concurrent with poor access to care, what is the role of a psychiatrist in a publicly funded health care system?
- What are the most important aspects of the mental health system to address to improve access to treatment for mental health and addictions?

Your comments/questions please!

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*If you are referring to a
particular slide ...*

- **Thank you for joining in!**