

Expanding Child Psychiatric Services During Behavioral Health Redesign: Lessons Learned from the Stark County Experience



Stephen Grcevich, MD and Elizabeth Hayford, MD
Child and Adolescent Behavioral Health, Canton OH
Presented at All Ohio Institute on Community Psychiatry
Worthington Ohio
March 15, 2019



Educational Objectives

- Identify strategies for increasing local access to child psychiatric services
- Explore challenges and opportunities in establishing primary care collaborations
- Discuss approaches used in Stark County to build a workforce for providing psychiatric services to children and adolescents.
- Consider strategies for providing the highest possible quality of child psychiatric care under BH redesign.



Disclosures

Potential Conflict	Dr. Grcevich	Dr. Hayford
Pharmaceutical Industry Consulting	Shire U.S. (2016) Ironshore (2015)	None
Grant/Research Support	Stark MHAR Board Sisters of Charity Foundation	None
Speakers' Bureaus	None	None
Other Financial Support	Book contract with Harper Collins/Zondervan	None
Major Shareholder	None	None



State of Stark County's child psychiatric delivery system in 2016

- Care provided by...
 - Part-time child psychiatrists
 - APNs contracted through local pediatric hospital
 - Registered nurses working under MD supervision
- Indefinite wait time for new referrals
- Medical department lost more money than any other in county's largest child serving agency
- Agency board actively considered disbanding Medical Services



BH redesign as the “perfect storm” for child psychiatric services?

- Primary agency couldn't afford to grow services.
- BH redesign cuts reimbursement for psychiatrists, APNs
- Half of all services provided by medical department (RNs) largely ineligible under BH redesign
- Shortage of qualified prescribers locally



A diagnostic formulation...

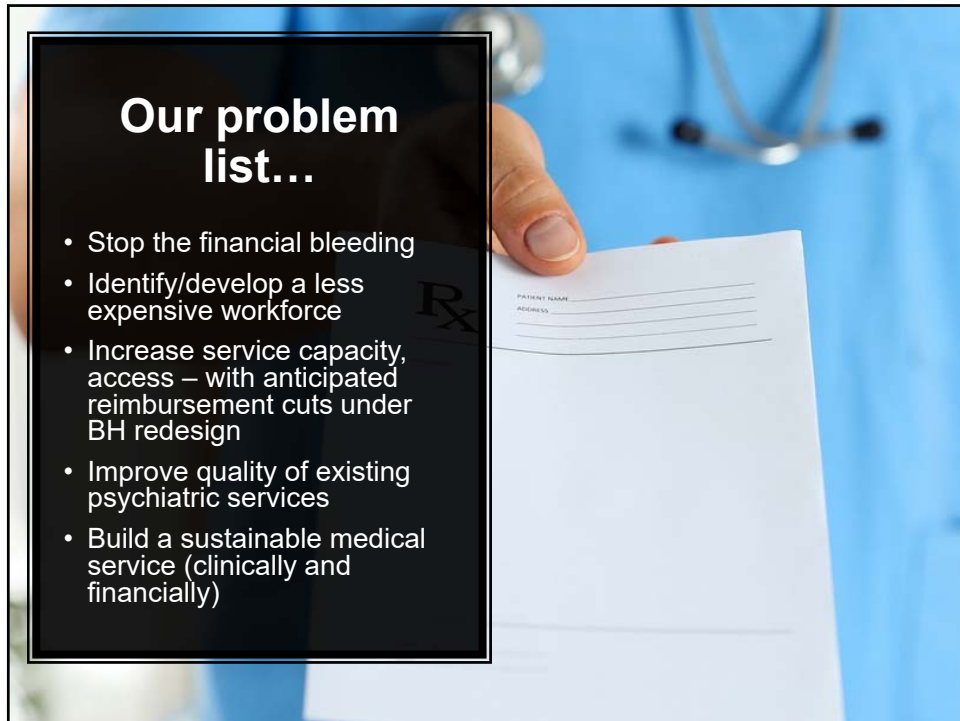
- Absence of medical input among senior leadership for many years led to atrophied service ill-prepared for BH redesign
 - Good child psychiatry in short supply
 - Psychiatrists too costly for management activities
 - RNs most cost-efficient in old system
- The need for action was precipitated by...
 - Reimbursement changes under BH redesign
 - Financial constraints limited service capacity



A brief primer on the economics of outpatient behavioral health

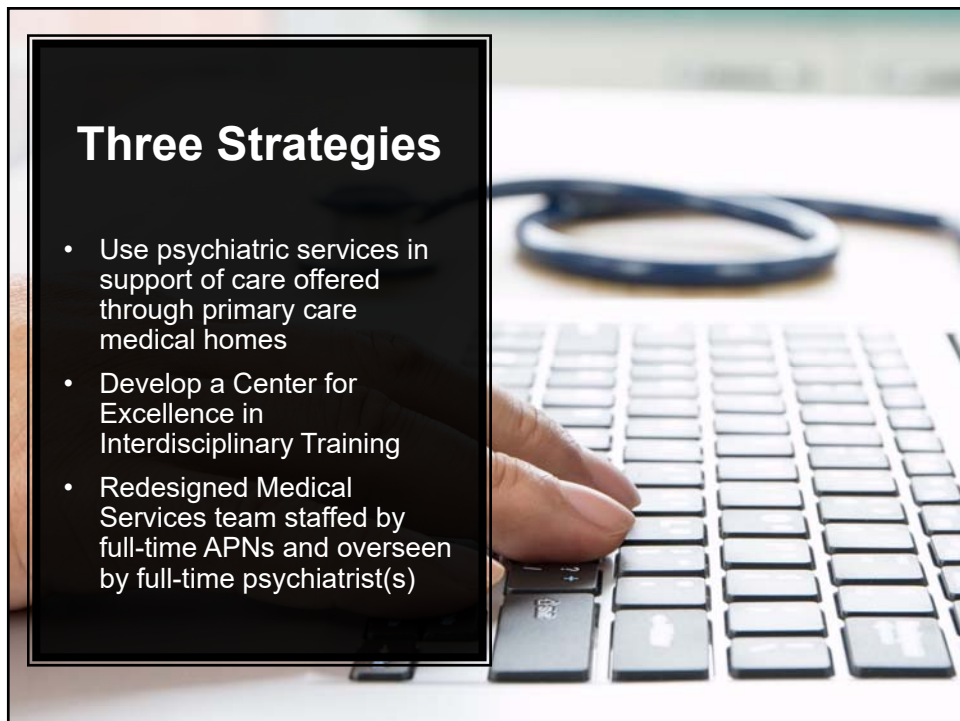
- Psychiatrists are “loss leaders”
 - E/M rewards brief assessment, “assembly-line” care
 - A reasonably productive child psychiatrist can bill enough to cover salary, benefits but NOT overhead
 - APNs typically paid 50-60% of what physicians make, reimbursed at 85% of physician rates
 - Greater documentation demands in public agencies cuts productivity
- Prescribers support needs > therapists
 - Scheduling
 - Volume of phone calls, record requests
 - Prior authorizations for medication
- Counseling, psychotherapy make money





Our problem list...

- Stop the financial bleeding
- Identify/develop a less expensive workforce
- Increase service capacity, access – with anticipated reimbursement cuts under BH redesign
- Improve quality of existing psychiatric services
- Build a sustainable medical service (clinically and financially)



Three Strategies

- Use psychiatric services in support of care offered through primary care medical homes
- Develop a Center for Excellence in Interdisciplinary Training
- Redesigned Medical Services team staffed by full-time APNs and overseen by full-time psychiatrist(s)

Why focus on primary care medical homes?

- Better outcomes for kids with mental health conditions
- PCPs positioned to identify kids at risk of mental illness
- Expands service capacity without increasing costs
- Maximize impact of limited child psychiatric resources
- PCPs caring for “stabilized” patients improves access
- Are kids better off with PCPs who have known them over time when Medicaid won’t pay for thorough evaluations?



What supports did we offer?

- “Curbside Consultation” service
- “Care Coordinator” to facilitate access to agency services
- Toolkit for common, serious mental health conditions
- Regularly scheduled “lunch and learn” meetings
- Interactive, online educational opportunities – Project ECHO
- Medical Director saw patients in two partner practices



What worked and what didn't?

What Worked?

- Curbside consults
- Lunch and Learns
- Identifying sites for “co-located” services

What Didn't

- Project ECHO
- Screening tools weren't widely accessed
- Sending mental health staff to PCP offices
- Many practices never participated
 - Institutional barriers
 - Long-standing frustration with system

What did we learn?

- Whatever we do needs to make the primary care physician's life easier.
- Access and responsiveness necessary for partnership
- Inefficiencies outweigh the benefit of providing services in primary care offices
- Family practitioners as likely to be willing partners as pediatricians



Future directions with primary care

- Consider collaborative care model with specially-trained care managers in PCP offices.
- Seek to engage reluctant primary care offices when our access is best (May-July)
- Identify funding for child psychiatry involvement with family practice residents in training
- Identify APN students with interest in children's mental health and place them in primary care practices after graduation with support
 - Maintain some level of collaboration with child psychiatry/continuing education from C&A



A Center for Excellence in Interdisciplinary Training

- Train APNs to meet mental health service needs of agency, local primary care practices
- Build upon existing APA- approved psychology internship
- Students need preceptorship sites
- MHAS Board-supported activities open to staff from all funded agencies



You need a productive farm system!

- Success under BH redesign depends upon workforce development.
- Need to develop, counselors as well as prescribers
- Where to find the least expensive prescriber?
- How to make up for vast differences in APN, MD training?



Photo by Erik Drost - Flickr, CC BY 2.0, <https://commons.wikimedia.org/w/index.php?curid=59434521>

Where do we find APN students?

- Very intentional in building relationships with area nursing schools
 - Agreements with CWRU, Akron, Kent
 - Involvement with psychopharm course at Akron
- Word of mouth
- Local students pursuing APN degrees online
- Medical Director serving as preceptor until home-grown staff gain enough experience



What we've learned about training APNs

- We've needed to create a de facto internship for our APNs
- Elimination of preceptorship requirement in 2017
- Training in evaluation, clinical formulation, child psychopharm, managing complex cases is essential
 - 2 hours of supervision/week for 6-12 months
 - Year-long didactic seminar on key topics
 - Journal Club studies seminal articles relevant to clinical duties



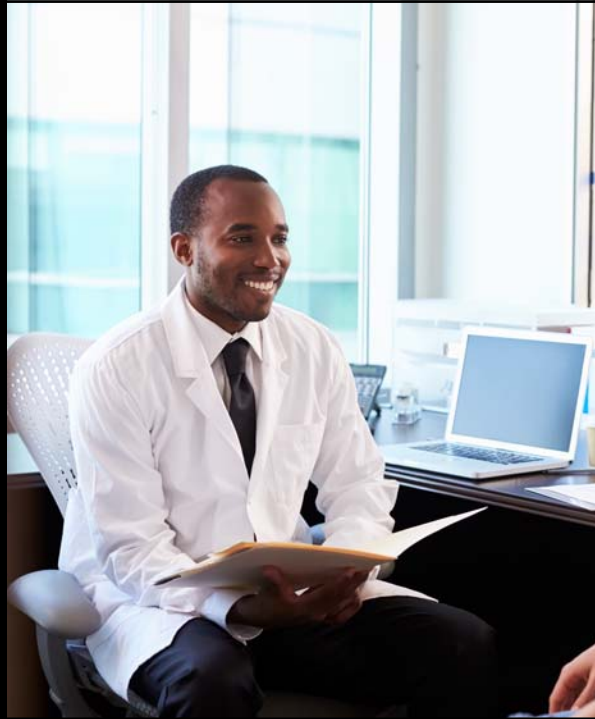
Future directions in training

- Developing a resource bank for future staff
 - Library of key articles
 - Video library of didactic presentations
- Expanding training opportunities for other mental health disciplines
- Opportunities for electives for family practice residents from Aultman Hospital
- Medical student rotations



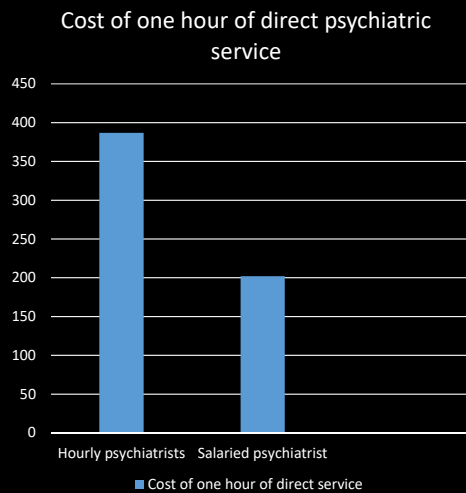
Features of a redesigned medical team

- APNs provide 80% or more of direct service (most cost-efficient prescriber)
- Replace part-time contractors with full time employees
- Led by child psych with long-term commitment to the community



Our greatest cost savings came from switching to full-time employees

Cost to the agency of providing one hour of psychiatric service is \$184.77 less when the psychiatrist is a full-time employee



A new, different role for child psychiatry

- Support PCPs (consultation, lunch and learn)
- Supervises agency's team of prescribers
- Provides ongoing care for kids and families with most complex needs
- Offers consultation, support to agency's leadership team



How our staffing plan evolved

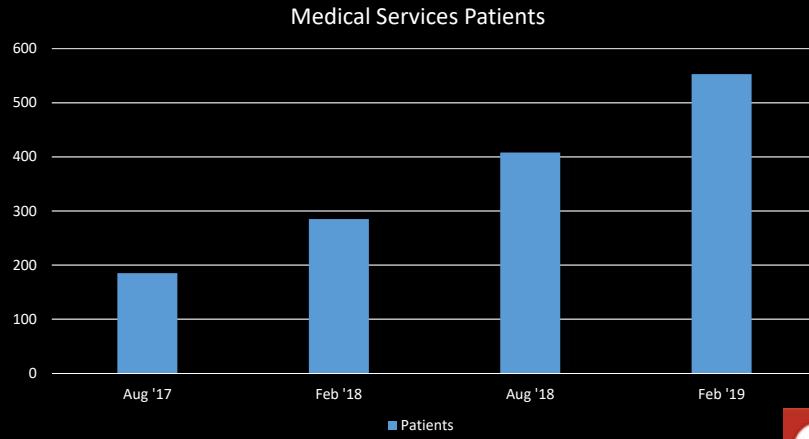
Our original plan

- Hire first APN in 2017
- Stay small for launch of BH redesign
- Find medical director for Summer '18
- Hire second APN in Fall '18, then one APN per year through 2021

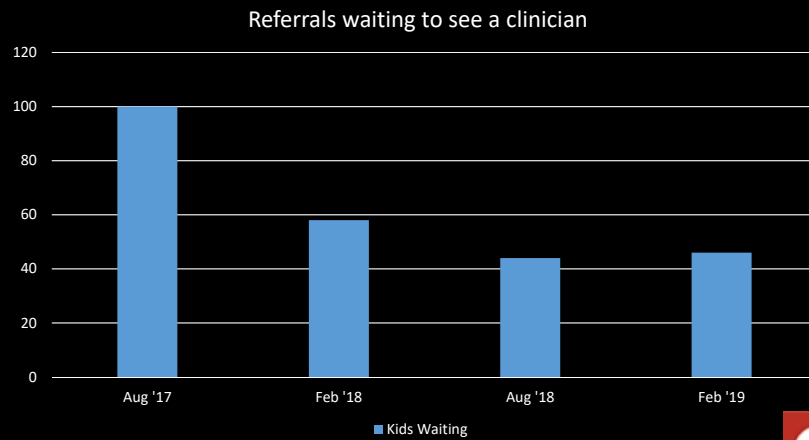
What happened...

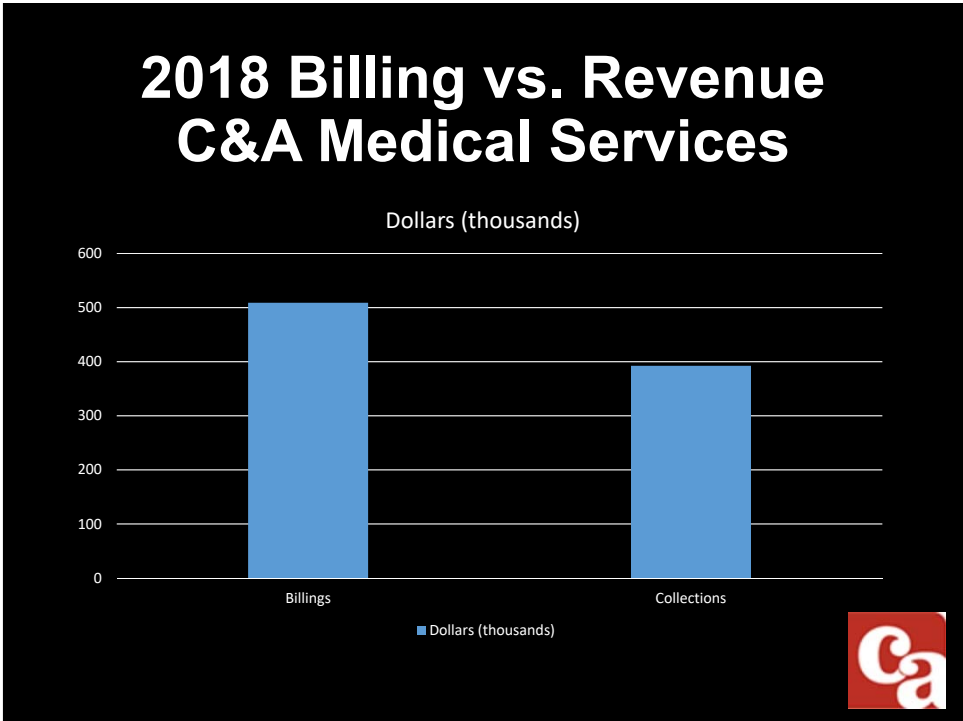
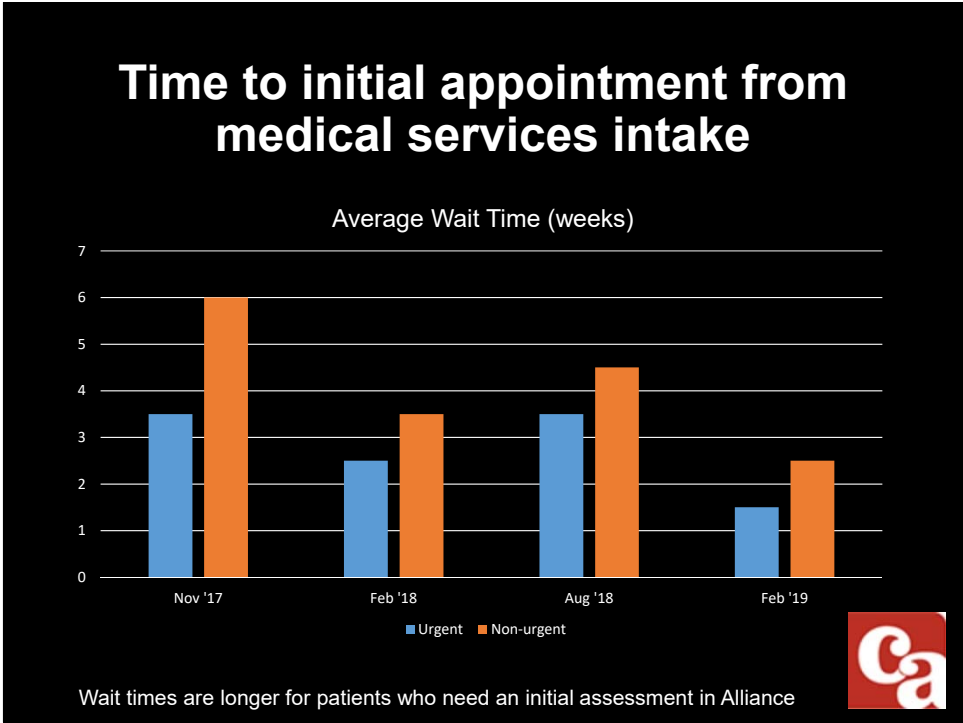
- Ideal medical director identified in Spring '17 – replaced three PT APNs, one PT psychiatrist
- First FT APN started in December '17
- Our first student became our second APN hire – started 5/18
- Two other local candidates approached us – started in August, September '18

Medical Services Active Patients



Medical Services Waiting List





Our “secret sauce”

- We hadn't intended to exclusively hire new graduates.
- We've seen clear advantages to APNs who come to us without bad habits.
- Quality standards to promote conservative, evidence-based care



What have we learned that will modify our plans?

- We underestimated the supervision and support APNs need to practice with excellence.
 - We needed to create a de facto internship for at least their first year of employment
- Economics of BH redesign mandate ongoing role for primary care collaboration
- Our primary care partners are just as likely to be family physicians as pediatricians



What can smaller counties, agencies do?

- Form consortium with other agencies to share cost of full-time practitioners
- Regional partnerships to address workforce issues across all mental health disciplines
- Consider funding for collaborations between child psychiatrists and primary care practices.



Advice for agency executive directors

- Resist temptation to push your medical staff to see more kids in less time
- Consider medical services expenses in context of your clinical services budget
- Pay for your medical department by growing profitable services under BH redesign
 - Counseling
 - Case management



Advice for local mental health boards

- Consider role of local boards in workforce development
- Creating incentives for service provision in primary care settings
- Partnering with foundations in developing local solutions



Conclusions

- BH redesign will rapidly accelerate trend for non-physician prescribers to provide most psychiatric care
- Unprecedented opportunity to create new capacity in underserved areas if training, supervision needs are addressed
- Opportunity to reconsider primary care practices in efforts to expand service capacity



Questions?



Contact us!

ehayford@childandadolescent.org



sgrcevich@neomed.edu

