National Council Medical Director Institute

The Psychiatric Shortage

Causes and Solutions

March 28, 2017

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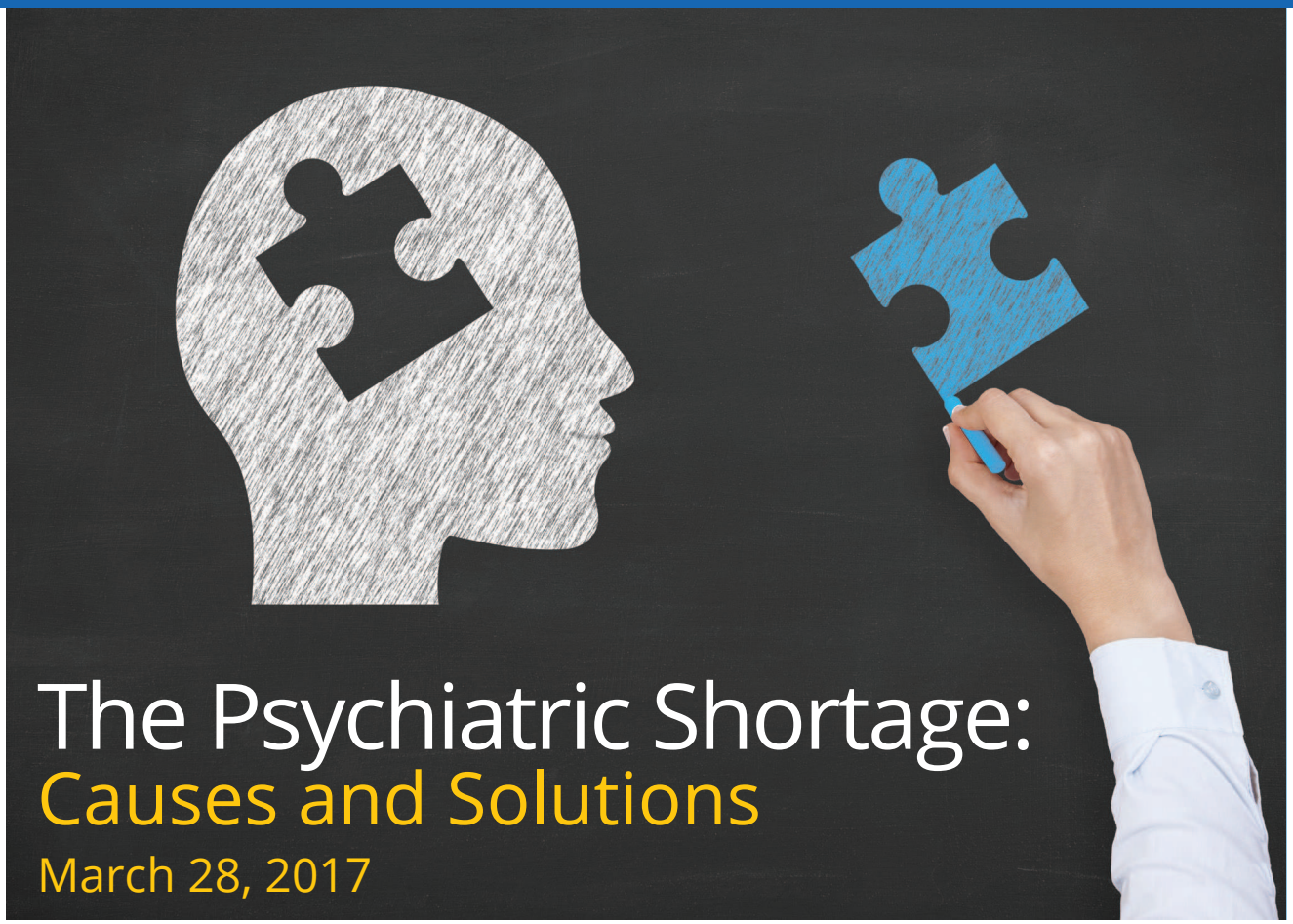

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Introduction

National Council Medical Director Institute

The National Council for Behavioral Health (National Council) is the unifying voice of America's mental health and addictions treatment organizations. Together with 2,900 member organizations, serving 10 million adults, children and families living with mental health and substance use disorders (SUDs), the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery.

Authorized by the National Council Board in 2015, the National Council Medical Director Institute (the Medical Director Institute) includes medical directors from mental health and substance use treatment organizations from across the country.

The Medical Director Institute advises National Council members, staff and Board of Directors on issues and topics that impact National Council members' clinical practices. The Medical Director Institute's members champion National Council policy and initiatives that affect clinical practice, clinicians employed by member organizations, national organizations representing clinicians and governmental agencies.

The Medical Director Institute identifies report topics to explore that the National Council Board and leadership then approve.

Initial Charge of the Medical Director Institute

The Medical Director Institute selected access to evidence-based psychiatric services as its first project. This report describes the problem, identifies solutions and proposes concrete solutions.

The Medical Director Institute chose this topic in response to the ongoing difficulties communities face providing adequate access to basic psychiatric services. These difficulties are particularly pronounced in public sector and Medicaid-funded programs, which frequently face the daunting task of caring for large populations with a limited number of providers. The fact that the majority of persons with mental health and substance use disorders frequently rely primarily on publicly-funded health care — due to the impact of these disorders on their ability to hold employment and their subsequent poverty — magnifies the problem to a such a degree that the Medical Director Institute felt that this issue was of utmost importance to address. Other factors that influenced this choice of topic included the increasing demand for psychiatric services because of expanded initiatives in early intervention and screening for mental health and SUDs in multiple settings, the aging of the psychiatric workforce and the substantial portion of psychiatrists choosing cash-only practices.

These trends led to a growing concern around reduced access to psychiatric services in a range of clinical settings that include outpatient clinics, primary care settings, hospital emergency departments (EDs) and care management programs. These settings are serving people with complex health conditions, which often include mental health and SUDs. The literature consistently shows that persons with co-morbid medical and psychiatric conditions have better outcomes, and cost the health system less in the long-run, when both are treated appropriately, compared to persons who do not receive adequate treatment of both. Inadequate access to psychiatric services ultimately drives up unnecessary costs of care in these settings and the total medical expenses, which include medical-surgical inpatient and specialty care.

To articulate the full scope of issues surrounding access to evidence-based psychiatric services, the Medical Director Institute convened a range of stakeholders for a two-day expert roundtable. The formal charge for the group was to:

> *"Improve access to evidence-based psychiatric services for children, adults and families served in National Council member organizations, others seeking psychiatric services under the expanded mental health and substance use disorder coverage of health care reform and persons newly screened for mental health and substance use disorder conditions in expanded settings such as primary care offices."*

The Medical Director Institute recognized the challenge's importance considering the increased attention and acceptance of mental health and substance use disorder services in other health care settings; the emerging consensus of the value of psychiatrists, other health professionals and behavioral health clinicians working with other medical professionals in team-based approaches to care and the need for more responsive interventions for patients who present with co-occurring behavioral health and medical conditions.

The detrimental effects of poor access to psychiatric services have come into sharper focus with the increasing pace of health care reform, the final enforcement guidelines for the Mental Health Parity and Addiction Equity Act (MHPAEA) and the national crisis surrounding opioid addiction.

Expert Panel

The Medical Director Institute brought together a diverse group of practitioners, administrators, policymakers, researchers, innovators, educators, advocates and payers to ensure depth of discussion from a variety of viewpoints for a two-day meeting. (See Appendix 1 for a full list of participants.) Expert panel members each provided literature and research from their area of expertise for review, as well as their unique perspectives to the vexing problem of lack of access to psychiatric services.

The agenda's structure allowed for content vetting through presentations and discussion and, upon the meeting's conclusion, a brainstorming session on practical solutions that meet the test of feasibility for implementation based on the expert panel's initial support.

This report's content includes an environmental scan, summary problem statement, solutions based on research and experience in the field and a set of actionable recommendations. Stakeholders with the capacity to implement these changes include the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA); professional trade organizations for psychiatrists, nurse practitioners, physician assistants and pharmacists; health care provider organizations; payers; advocacy organizations and consumer organizations.

Terminology for Persons Receiving Services, Providers Delivering Services and Problems Addressed

The Medical Director Institute is cognizant of the importance of the words chosen to describe persons receiving psychiatric care. Throughout this report, persons whose immediate situation is receiving care are referred to as "patients;" persons whose immediate situation is providing care are referred to as "peers;" persons with a psychiatric condition engaged in advocacy outside of a direct provision of care situation are referred to as "advocates."

When the report refers to "psychiatric service," it includes services such as medication management, consultation and supervision of other clinicians toward models of evidence-based practice. Along with psychiatrists, psychiatric services are delivered by other health professionals such as advanced practice registered nurses (APRN), physician assistants (PAs) and board certified psychiatric pharmacists (BCPP) . One of the major paths to improving access and outcomes is to shift the focus of each of these professional groups to practice up to the level of their professional licensure.

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The presenting problems that are addressed will be generically referred to as "mental health and SUDs" or "behavioral health conditions."

By identifying access to "evidence-based psychiatric services" as this paper's topic, the narrative refers to services that have been validated through published research, codified by SAMHSA or established as best practices by teaching institutions.

"Access" to services includes several criteria: service that is timely, service that is geographically proximate and service that is convenient, patient-centered and effective.

Summary

The report is a practical document designed to highlight key problem areas, identify the root causes and effects, evaluate risks with current trends, find specific innovative solutions already implemented in pockets around the country and list actionable recommendations for implementation. The Medical Director Institute believes that implementation of these recommendations can have the greatest impact on:

- Improving access to, and the quality of, evidence-based psychiatric services;
- Fostering better patient outcomes;
- Putting behavioral health provider organizations in a stronger position for the delivery of integrated care;
- Managing total health care costs through better integration;
- Reducing stigma towards individuals seeking treatment for mental health and SUDs; and
- Increasing recognition of the importance of treating co-morbid medical and psychiatric disorders for better patient outcomes and reducing the overall cost of care.

NOTE: At the time of publication for this report, there is great uncertainty regarding the future of federal support and parity requirements for access to psychiatric services. Both Congress and the President are discussing their intent to make substantial changes to Medicaid, which funds 27 percent of all behavioral health services in America. However, the details and outcome are far from settled.

The editors and expert panel members urge that President, Congress and the new administration assess any proposed changes to prevent any further limits to access to psychiatric services. Further they consider implementing the recommendations contained in this section and the solution outlined in the Section 6 to make psychiatric services more accessible and effective.

Executive Summary

The coverage of, and increasing demand for, psychiatric services is occurring at the same time as a growing shortage of outpatient and inpatient programs. The lack of access has created a crisis throughout the U.S. health care system that is harmful and frustrating for patients, their families and other health care providers, and is becoming increasingly expensive for payers and society at large.

Authorized by the National Council, the Medical Director Institute selected Access to Evidence-Based Psychiatric Services as their initial project. In order to inform this paper with depth and perspective to address this crisis comprehensively, the Medical Director Institute convened a diverse group of clinicians, policymakers, payers and advocates for a two-day expert panel. This report describes the problem, identifies solutions and proposes concrete next steps towards resolution as a foundation for the entire field of behavioral health. Improving access is an essential component of the changing landscape of health care delivery that is evolving toward outcomes-based reimbursement. The field of psychiatry is uniquely positioned to impact high-cost populations through improvements in workforce, reimbursement and duties of psychiatrists and other providers that encourage practice up to the level of their licensure.

Environmental Scan

Access to Psychiatric Services in Outpatient Psychiatric Programs, Hospital Emergency Departments and Inpatient Psychiatric Units

The lack of access to psychiatric services in health care service has been a constant challenge for decades, resulting in significant delays to treatment with concomitant consequences in reduced quality of care, low patient satisfaction, poor patient outcomes, reduction in the workforce and higher costs.

The providers of psychiatric services in outpatient psychiatric programs — mostly psychiatrists, but also psychiatric advance practice registered nurses, psychiatric physician's assistants, and board certified psychiatric pharmacists — face a cramped daily routine with increasingly briefer appointments scheduled back to back that limit in-depth clinical assessment, collaboration with other members of the treatment team and consultation to primary care providers outside of the program. Such a schedule leads to lower quality care.

In hospital EDs, lack of access to psychiatric services stands out among all other medical diagnoses, averaging up to 23 hours for some dispositions. The resulting extended waits have impacts on the full scope of care in the ED that, at times, can reduce access in the ED for more acute medical presentations and lead to poorer outcomes for psychiatric patients.

The shrinking number of inpatient psychiatric services has become a significant obstacle to improved access. Beds have been eliminated due to lower rates of reimbursement compared to other medical-surgical procedures and due to difficulty recruiting psychiatrists to staff the inpatient units.

Workforce

The pool of psychiatrists working with public sector and insured populations declined by 10 percent from 2003-2013. Aging of the current workforce, low rates of reimbursement, burnout, burdensome documentation requirements and restrictive regulations around sharing clinical information necessary to coordinate care are some of the reasons for the shrinkage.

Moreover, the workforce is unevenly distributed geographically across the country. Seventy-seven percent of counties are underserved and 55 percent of states have a "serious shortage" of child and adolescent psychiatry. Even in urban and suburban geographic areas with adequate ratios of psychiatrists, the supply of psychiatrists who work in inpatient and outpatient psychiatric facilities has been reduced by psychiatrists who practice exclusively in cash-only private practices. These practitioners now make up 40 percent of the workforce, the second highest among medical specialties after dermatologists.

Training

The training of adult psychiatry residents as well as psychiatric APRN's, psychiatric PA's and board certified psychiatric pharmacists (BCPPs) represents both a challenge and an opportunity. The Accreditation Council for Graduate Medical Education (ACGME) psychiatry milestones (a framework for measuring trainee outcomes) suggest the need for consultation and liaison work with primary care, but do not adequately reflect the specific skills needed for improved psychiatry access. To train the future psychiatry workforce in population health, greater emphasis is needed on critical skills such as telepsychiatry, collaborative care and other methods of efficient team collaboration with primary care.

Consequences of Lack of Access

There is an inadequate workforce to deliver safe and effective care in outpatient and inpatient psychiatric programs. The cramped schedule leaves less time to review clinical information, provide expert guidance to the treatment team and practice up to the level of their licensure. The reduced supply and limited opportunities to expand competencies in training programs also leave the workforce less prepared to participate in the innovative models of care that are central to health care reform. These models are key features of accountable care organizations and alternative payment mechanisms that reimburse providers on outcomes instead of volume.

There is a great irony in the implementation of health care reform. On one hand, there is increasing recognition of the value of psychiatry and of behavioral health services as key components to the reduction of the total cost of care and improvement of general health outcomes Yet, these developments contrast starkly with the historically low rates of reimbursement for psychiatrists, other providers and their associated outpatient and inpatient services.

Conclusions on Access and Environmental Scan

There is a shortage of psychiatrists that will only worsen with integration of primary care and behavioral health and the shift to Accountable Care Organizations (ACOs) as part of health care reform. Due to efficient screening for mental health and SUDs in primary care, there will be growing demand for access to psychiatric services.

Psychiatrists face a host of challenges in training and practice to learn about and participate in a host of innovative interventions in which psychiatric expertise would be invaluable to:

- Address co-occurring behavioral health and chronic medical conditions,
- Improve health outcomes of high-risk and high-cost populations where mental health and SUDs are prevalent and
- Address the social determinants of health that pose substantial barriers to primary care, specialty care and behavioral health care.

Solutions, Recommendations and a Call to Action

An expanded supply of psychiatrists and other providers trained in these emerging competencies will be a positive development for the behavioral health workforce and have a lasting impact on a multitude of troubling patterns of care such as:

- Over-reliance on EDs to provide urgent assessments and care,
- Poor health outcomes for persons with chronic mental health conditions,
- High rates of overdose from opioid use disorders and
- Rising costs of health care for complex, high-risk populations.

The solutions cannot rely on a single change in the field such as recruiting more psychiatrists or raising payment and reimbursement rates. Rather, the solutions depend on a combination of interrelated that require support from a range of stakeholders.

Multiple solutions are needed in five areas:

- Workforce development,
- Improved efficiency of service delivery,
- Reducing burdensome regulations and confidentiality restrictions,
- Broader implementation of innovative models, and
- Adoption of novel reimbursement methods that provide adequate reimbursement for psychiatric services.

These changes can only occur if the multiple stakeholders (federal and state governments, payers, providers, provider trade associations and advocates) take action within their respective spheres of influence in the design, funding, regulation and delivery of behavioral health care. Each of the stakeholders have a role to play and must choose among these solutions to make an impact.

The national organizations that design and approve residency training programs should expand and improve the skills of the workforce by deploying three strategies:

1. Add specific milestones that address competencies required for new models of care, such as collaborative care, telepsychiatry and data-driven population health;

2. Secure expanded funding for graduate medical education (GME) programs in underserved areas from the Health Resources and Services Administration (HRSA) and

3. Invest in outstanding psychiatry clerkship rotations for third-year medical students that can be replicated in other training programs.

These solutions also apply to the training programs for other providers of psychiatric services who are a valuable resource in the behavioral health field: APRN's, PA's, and BCPPs. The champions for these solutions are the professional organizations to which psychiatrists, psychiatric APRNs, psychiatric PAs and BCPPs belong.

The biggest opportunity to expand the workforce is to reduce the portion of psychiatric providers who practice exclusively in cash-only practice. The APA and National Council need to work with their members to implement a wide range of incentives that promote the engagement of psychiatric providers with outpatient and inpatient psychiatric programs that accept commercial, Medicare, and Medicaid coverage that pays for the majority of Americans with psychiatric health care needs. The organizations can:

- Expand opportunities for psychiatric providers to practice in alternative clinical settings, such as peer-run services and family support services;

- Negotiate with payers to establish models of reimbursement that recognize the true cost of psychiatric providers (not simply what has historically been paid) and

- Provide more support in clinical settings that allow the provider to work up to his or her level of licensure.

Improving efficiency of the delivery of psychiatric services can be accomplished in a number of ways:

- Reducing no-shows in outpatient psychiatric programs by setting up Open Access models of scheduling,

- Expanding telepsychiatry by reducing regulatory barriers and reimbursing adequately,

- Adding adequate support for prescribers and

- Reducing the administrative burdens around information sharing and documentation requirements.

The Medical Directors Institute recognizes the challenge of amending 42 CFR, Part 2, but believes that attention to outcomes of care, integration, and timely intervention all necessitate a better way to share information to improve care.

These solutions must be generated through the provider trade organizations such as the National Council for Behavioral Health, the individual practitioner trade organizations such as the APA, The American Psychiatric Nurses Association (APNA), the American Association of Physician Assistants (AAPA), and the College of Psychiatric and Neurologic Pharmacists (CPNP).

Technical assistance to providers will be required to continue the transformation to broader implementation of innovative models of care, which is the most exciting and most challenging of the solutions and recommendations for calls to action. The technical assistance must come from multiple sectors:

- States that implement accountable care models with high-risk, high-cost Medicaid members whose behavioral health diagnoses significantly raise the total cost of care,
- The federal government that has an interest in ensuring best practices and
- Training and research organizations that can ensure validation and continued evidence base for these models.

The expanded implementation of these modes must include a pricing methodology that covers the cost of psychiatric services adequately.

Within these innovative models of care are opportunities to expand access using video technology and electronic communication:

- Telepsychiatry is the most developed model, but its expansion has been hampered by conflicting and burdensome regulations and limits on reimbursement. The national trade associations must press state and federal agencies for clarity on these regulations.
- Payers need to reimburse adequately for telepsychiatry and other models of remote communication (such as apps to monitor psychiatric symptoms and communicate remotely with providers to address more complex triggers).

Other recommendations include:

- Building competence in the workforce to address the impact of psychiatric providers on reducing the total cost of care for high-need, high-risk, high-cost populations that have mental health and SUDs co-occurring with chronic medical conditions.
- Emphasizing skills in team-based care, population health analysis and clinical problem-solving in psychiatry residency programs and training programs for psychiatric APRNs, psychiatric PAs, and BCPPs.
- Payers need to address several billing and reimbursement inequities and limits to help to level the playing field as these innovative models become established.
- Establishing payment rate and methodology parity with medical-surgical reimbursement in Federally Qualified Health Centers (FQHC) and other primary care settings that will provide incentives for psychiatric providers to participate in these programs and remove the business incentive to minimize psychiatric services in order to avoid financial losses.

The Medical Directors Institute recommends these solutions so that access to psychiatric services does not remain a barrier to the overall success of health care reform and service delivery improving the health of Americans.

NOTE: At the time of publication for this report, there is great uncertainty regarding the future of federal support and parity requirements for access to psychiatric services. Both Congress and President Trump are discussing their intent to make substantial changes to Medicaid, which funds 27 percent of all behavioral health services in America. However, the details and outcome are far from settled.

The editors and expert panel members urge that President Trump, Congress and the new administration assess any proposed changes to prevent any further limits to access to psychiatric services. Further they consider implementing the recommendations contained in this section and the solution outlined in Section 6 to make psychiatric services more accessible and effective.

Environmental Scan

Access to Psychiatric Services

The lack of access to psychiatric services across the health care service delivery field has been a cold, hard reality for decades and significantly delays treatment and reduces the quality of treatment received. This delay results in unacceptable patient experiences in care, poor outcomes and higher costs. The phenomena of "waiting lists" to see psychiatrists in outpatient clinic settings, the "boarder" waiting days in hospital EDs for an inpatient bed to open and the pockets of geographic isolation to any psychiatric services in many parts of the country all result in unacceptable patient experience, poor care and poor outcomes.

Extended Wait Times for Psychiatry in Outpatient Clinical Settings

Delays in accessing psychiatric services occur in all clinical settings. Private clinics, group practices and individual offices are not immune to lack of timely access. Not surprisingly, the most extended delays in outpatient care occur in publicly-funded community behavioral health centers (i.e., Medicaid-covered). A high percentage of the population they serve includes people with chronic mental health disorders, including schizophrenia, major depression and bipolar disorder. These individuals regularly take psychotropic medications with burdensome side effects and are at great risk for comorbid medical conditions such as diabetes, heart disease and chronic obstructive pulmonary disease, which together result in greatly reduced lifespans compared to individuals without mental health disorders. Extended times between appointments can lead to non-adherence to medications and incomplete symptom management, which often leads to more frequent visits to the ED and more hospitalizations. As demand increased and the supply of psychiatrists dropped or turned over, clinic administrators compressed the daily schedules of remaining staff to address some of extended wait times.

The daily routine of a psychiatrist working in a community mental health center often becomes a series of brief medication management appointments, some as short as 15 minutes, with patients who have severe, persistent and chronic mental health disorders. This cramped schedule leaves limited time for in-depth assessments and limits their ability to perform other critical activities, such as leading and participating in care teams, consulting with primary care clinicians, engaging in problem-solving with other health professionals on complex cases and providing clinical supervision.

A related consequence of the cramped schedule is the lack of timely access to collateral clinical information. Proper evaluation can identify the diagnosis and appropriate evidence-based care, allow for the review of records from other health care providers and facilitate meeting with family members. Higher quality care is achieved when a psychiatrist has time to talk to the patient's family, other caregivers and/or has more frequent interactions with the patient. Psychiatry is unique among medical disciplines because of the correlation between a strong relationship between clinician and patient and treatment compliance; there is no substitute for active listening and engagement with patients, especially those who have major mental health disorders.

As the psychiatric shortage has become more pronounced, clinic administrators and group practice managers have taken one or more steps to address the lack of timely access, including:

- Rationing psychiatric services to only individuals with the most severe illnesses who engage with case managers in the agency, leaving many other patients with more mild-to-moderate behavioral health conditions without access to psychiatric services.
- Setting up intake groups with nurses or case managers to bridge the weeks- or months-long wait for a scheduled appointment with a psychiatrist.
- Extending prescriptions from 30 days to 60 or 90 days, even for major antipsychotic medications such as Risperdal, Zyprexa and Seroquel without monitoring for response (or lack thereof) and side effects.
- Reducing appointment times from 30 minutes to 20, 15 or even 10 minutes.
- Inadequate diagnosis and prescribing and overuse of antipsychotics among vulnerable populations such as foster children and older adults.

The lack of access has not gone unnoticed by regulators, accrediting bodies, state contractors, insurance companies and managed care organizations. They have made efforts to strengthen provider and managed care contracts to meet access standards of 10 days for routine appointments, 48 hours for urgent appointments and two hours for emergency appointments. Insurers are measured on their ability to provide follow-up after hospitalization within seven days. However, there is little evidence that these efforts result in improved access to psychiatric services. In one study of a state's members in Massachusetts, more than 50 percent of respondents had wait times greater than one month to access a psychiatrist — even within the structure of the Open Access Model (to be discussed in the Solution section).

Lack of Access in Emergency Departments

The function of a hospital ED is *timely* triage, evaluation and treatment for acute symptoms, stabilization and discharge. The person "stuck" in the hospital ED awaiting follow-up psychiatric services presents a stark contrast to this model for ED clinicians to expedite dispositions. In some cases, these patients wait for days or even weeks before a disposition is completed. Unfortunately, such long delays are not artifacts of a few problematic dispositions isolated to rare instances[1], but is now a national phenomenon. This national crisis has been documented in several states — North Carolina and Massachusetts, to name two — that struggled with extended ED delays[2].

Published case studies and a host of published papers have documented longer wait times for patients presenting with psychiatric symptoms and diagnoses — most recently in a Health Affairs study that reviewed data sets made up of more than 8 million visits to 350-400 EDs across the U.S. from 2002 through 2011[3]. Among several important findings, the study noted longer delays for psychiatric patients who were admitted for observation, transferred or sent home. Among those patients with psychiatric diagnoses, the delays were eight hours for discharge, 12 hours for observation and 23 hours for transfer, compared to six, seven and nine hours, respectively, for patients without psychiatric diagnoses. As described in the study, the extended wait times for transfers contributed to wait times overall, consequent to a lack of access to inpatient beds throughout the system.

In addition, hospital ED staff frustration regarding the ineffectiveness of the behavioral health system to find a timely disposition and a concomitant lack of faith in treatment programs that sometimes refuse to take patients from the ED into more secure settings, has reduced the credibility of psychiatric service's effectiveness. The overcrowding of EDs also reduces access and timely treatment for other patients with risks of bad outcomes[4]. One reason for increased delays in dispositions from EDs is that individuals who

are unable to obtain assessments or timely access to psychiatric services increasingly use EDs, with one study reporting a 42 percent increase in utilization over a three-year period[5].

Access for Children and Families

As they have for adults, advocates have called attention to the diminished access to behavioral health services for children, including access to psychiatric services. The documented history of absence of children's behavioral health services has resulted in successful litigation in four states — California, Massachusetts, Arizona and Mississippi — leading to implementation of a range of children's behavioral health services under court orders or consent decrees.

Access for Referring Primary Care Clinicians

Despite the push toward improved evidence-based integration of primary and behavioral health care, extended wait times continue to be a barrier for referrals from primary care providers. According to a Health Affairs report, two-thirds of primary care clinicians reported difficulty accessing psychiatric services, more than double the percentage reporting difficulty referring to any other specialty[6].

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Lack of Access to Inpatient Psychiatric Beds

Reimbursement rates lower than the cost of care lead to closure of psychiatric inpatient units. There are a steady stream of media reports of psychiatric units closing due to being unable to recruit and retain psychiatrists to staff units.

Summary

The lack of access to psychiatric services across the health care service delivery field has been a reality for decades. This gap in mental health and substance use disorder services significantly delays treatment and reduces the quality of treatment, resulting in unacceptable patient experiences in care, poor outcomes and higher costs.

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The lack of access to psychiatric services has exacerbated the negative impact on the ability of providers to address the "social determinants of health" that have been greatly emphasized in the implementation of Medicaid Accountable Care Organizations. *Timely* treatment for mental health and SUDs, in combination with patient engagement to address housing, legal, school, family and employment issues, can lead to better health outcomes.

www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx

Workforce

Workforce Trends and Projections to Meet Demand

The most recent study of psychiatrists practicing in the U.S. was completed by Tara Bishop, et al. and published in Health Affairs in 2016[7]. The population of practicing psychiatrists declined by 10 percent between 2003–2013 when measured by the number of psychiatrists per 100,000 of population. The findings also showed that neurology, a related specialty, *increased* by 15.3 percent during the same period and primary care physicians increased by 1.3 percent.

In a study commissioned by the U.S. Department of Health and Human Services[8], the authors used a 2013 baseline for their projections. Working from this model, they identified that the current workforce of 45,580 psychiatrists would need to increase by 2,800 to meet current demand for mental health and substance use disorder conditions. In other words, there is currently a 6.4 percent shortage in the psychiatry workforce. Based on estimates of retirement and new entries into the workforce, they projected that in 2025, unmet need will increase to 6,090 psychiatrists or a deficit of 12 percent of the workforce. Under a different methodology based on survey data on the population identifying a treatment need, the demand for psychiatry will outstrip supply by 15,600 psychiatrists, or 25 percent, in 2025. The study considers the expanded access under health care reform as one of the factors driving demand for behavioral health care.

Geographic Populations with Inadequate Access to Psychiatry

In addition to the number of practitioners in the workforce, access is also commonly measured geographically to ensure that there are enough practitioners to serve the population in the state, county or other service area designated by a government or insurance entity. National estimates are usually tallied based on the availability of professionals by county. In the study by Bishop cited earlier, the number of adult psychiatrists per capita in a specific cross-section of the population were calculated versus the need[9]. Her study revealed that 55 percent of counties in the continental U.S. do not have any psychiatrists. Another study concluded that 77 percent of U.S. counties had “severe shortages” of psychiatrists and other behavioral health providers.

These findings on the preponderance of counties with little or no psychiatric care available in geographically isolated areas are most severe for child and adolescent psychiatry, a psychiatric sub-specialty. Another study concluded that 43 of 50 states report a “severe shortage[10].”

Populations Served by the Existing Workforce

The reduced supply of psychiatrists and the unbalanced concentration in different regions have resulted in a limited workforce in many geographic areas, as documented earlier. However, access to psychiatrists for some of the population, even in areas with sufficient professionals in the workforce, is further diminished by the type of reimbursement accepted by private practice psychiatrists. As stated earlier, it is not unusual for psychiatrists to practice in more than one setting, spending some time in a publicly-funded clinic, teaching at a medical school and having a small private practice. Yet, there is also a concentration of the workforce exclusively in private practice who accept only cash for reimbursement. Forty percent of all practicing psychiatrists are in this category[11] and it is the highest percentage of any medical specialty except dermatology.

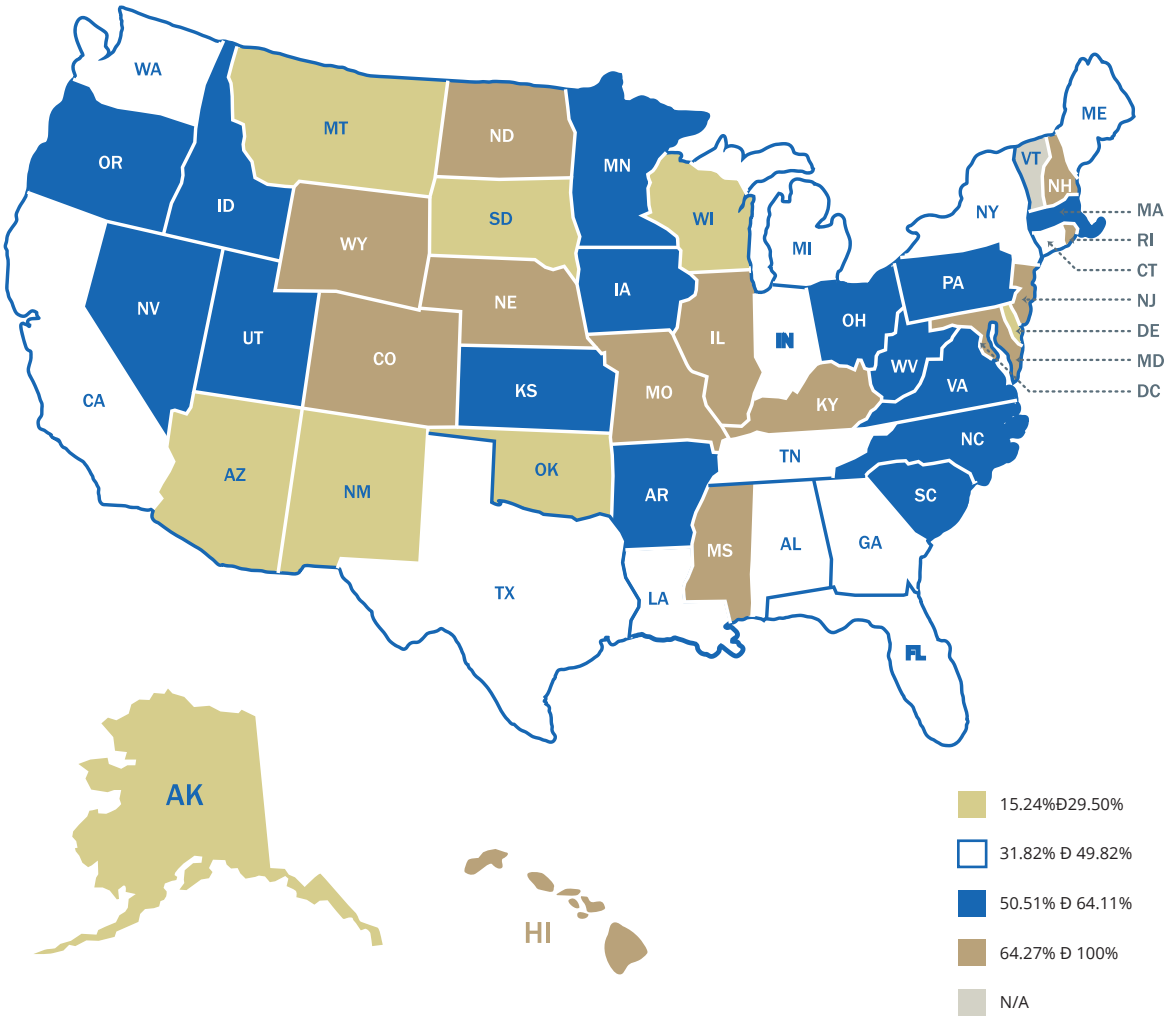
Physicians per 100,000 Residents Within Hospital Referral Regions

EXHIBIT 1

		Total	Mean per 100,000 residents	Median per 100,000 residents	Interquartile rage	Interquartile ratio	Gini Coefficient
Psychiatrists	2003	37,968	10.5	8.2	5.5-12.9	2.37	0.354
	2013	37,889	9.6	7.4	4.9-11.9	2.42	0.358
	Change	-0.2%	-9.0	-10.2	_[a]	2.3	1.3
Neurologists	2003	12,720	3.64	3.11	2.30-4.36	1.89	0.293
	2013	17,268	4.39	3.61	2.38-5.51	2.31	0.339
	Change	35.7%	20.4	15.8	_[a]	22.4	15.7
Adult Primary Care	2003	192,801	63.3	59.9	52-71	1.36	0.142
	2013	211,121	64.4	60.7	53-73	1.38	0.149
	Change	9.5%	1.7	1.3	_[a]	1.2	4.6
All Physicians	2003	755,270	227.7	206.1	168-255	1.52	0.196
	2013	862,444	236.9	208	167-272	1.62	0.214
	Change	14.2%	4.0	0.1	_[a]	6.7	9.6

Source: Authors analysis of data for 2003 and 2013 from the Area Health Resources Files (see note 20 in text).
Note: Primary care is general practice, family medicine, and general internal medicine. The interquartile range and ratio and the Gini coefficient are explained in the text. [a] Not applicable.

Mental Health Care Professional Shortage



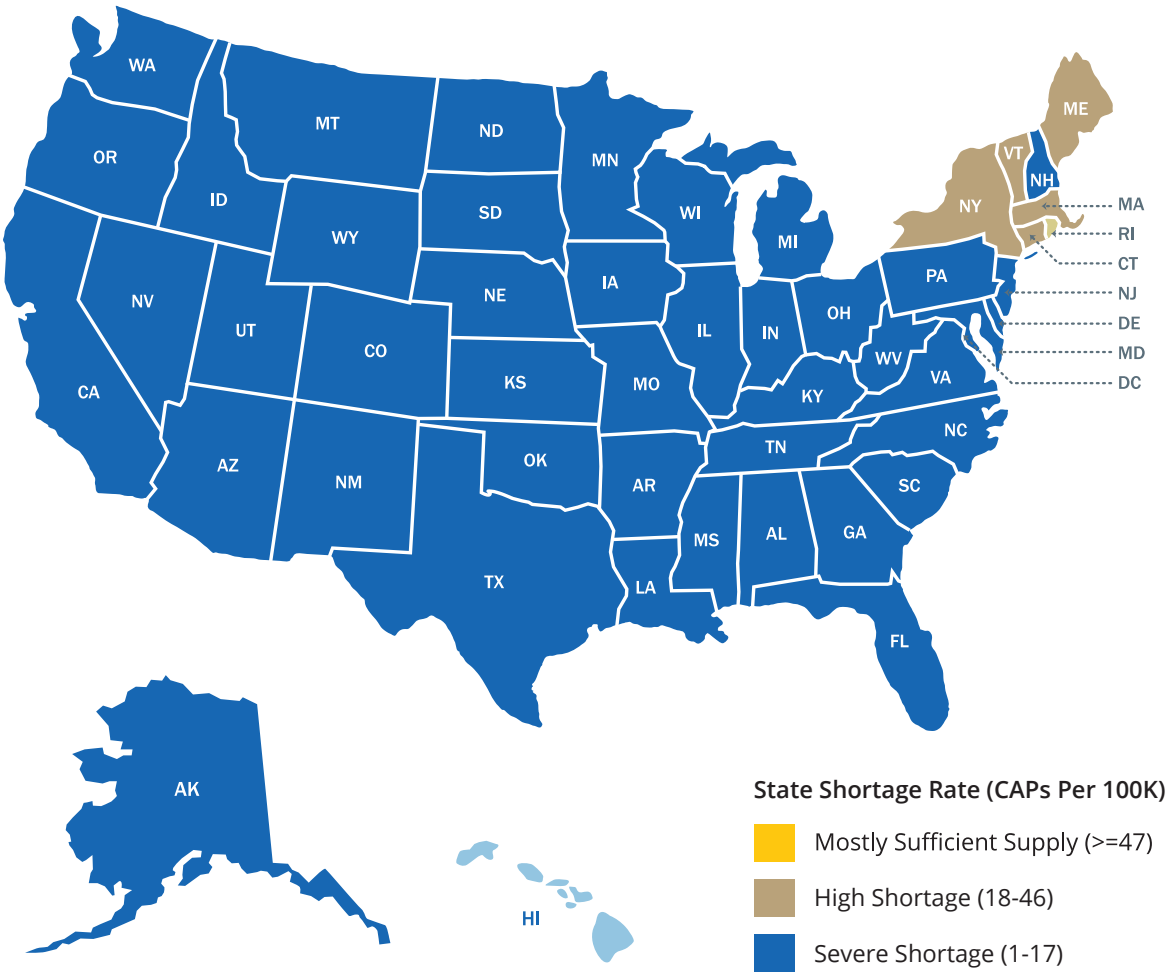
The drift of psychiatrists to private practices that accept cash exclusively is a significant barrier to increasing access for patients in community mental health centers and other publicly funded programs, as well as for expanding models of collaborative care in primary care settings. Psychiatrists in exclusively cash-only practices are not available to supervise other behavioral health professionals, collaborate with primary care and specialty care providers on complicated cases or participate in high-risk, high-profile complex cases across the treatment continuum.

Influences on the Psychiatric Workforce

Burnout of Psychiatrists

There are a host of administrative burdens on psychiatrists working in public community behavioral health centers that contribute to low job satisfaction and high rates of burnout. They are included throughout this paper, but, in summary, include:

Practicing Child and Adolescent Psychiatrists By State 2015



- Regulatory restrictions on sharing information that can better coordinate care.
- Limited time with patients to explain their conditions, assess the impacts of psychiatric medications and support the patient and family.
- Increased requirements for documentation and data entry into the electronic medical record (EMR).
- Minimal support resources to organize medical records, conduct routine medical assessments, arrange for scheduling and complete required documentation.
- Schedules that do not allow for collegial sharing, supervision of staff and consultation with colleagues.

A report on a study of physicians experiencing burnout in 2011 and 2014 showed an increase from 40 percent in 2011 to 48 percent in 2014, with a corresponding reduction in work satisfaction due to insufficient time for family and personal time — from 58 percent to 50 percent[12].

A study of psychiatrists with the U.S. Department of Veterans Affairs[13] found an alarmingly high percentage of occupational burnout, with 86 percent reporting high exhaustion and 90 percent reporting high cynicism.

Rates and Methods of Reimbursement for Psychiatric Services

Outpatient Psychiatry. The Access to Care section of this report refers to some of the factors in the psychiatric field and delivery of behavioral health care that contributed to the reduced workforce. It is not surprising that lack of access is most critical in public programs serving people with chronic mental health disorders that are either contracted by the state mental health authorities or reimbursed by Medicaid. Simply stated, psychiatry is necessary in these programs, but operates at a loss with increasingly fewer options for agencies to make up the shortfall. Common causes include:

- Low reimbursement rates for inpatient and outpatient behavioral health services, including psychiatry, from state Medicaid programs and Medicaid-contracted managed care payers.
- Federal and state cuts to grants and contracts for public sector programs serving individuals with severe and persistent mental illnesses. These funding streams often include mechanisms for providers to buffer their budgets to offset the direct care losses from low Medicaid reimbursement rates.
- A cycle of rate-setting for psychiatric services based on payments that are already inadequate. The principle of "actuarial soundness" for insurers contributes to this cycle, where, even if a payer wants to raise rates to increase access, they are constrained by rates based on past payments.

The evidence of how low rates of reimbursement impacts community behavioral health organizations was demonstrated in a National Council State Association member survey. The survey that found more than 75 percent of members lost money on psychiatry, with three-year losses increasing from an average of $481,000 in 2013 to more than $550,000. To balance their budgets, these organizations must earn surpluses of 15 percent or more from other programs or services to make up the shortfall in providing psychiatric services.

Inpatient Psychiatry. Historically, rates of reimbursement for inpatient psychiatric programs have not been sufficient to underwrite their cost in general hospitals, and for-profit private psychiatric hospitals were able to offer lower rates due to lower administrative costs. However, these low rates of reimbursement for inpatient services can also impede access[14].

Reimbursement rates lower than the cost of care lead to psychiatric inpatient unit closures, as noted in the Access to Care section. There is a steady stream of media reports of psychiatric units closing due to being unable to recruit and retain psychiatrists.

With low margins, inpatient units are reluctant to admit potentially violent clients who pose a risk of property damage, injuring staff or other patients or requiring additional staff for security. Patients who present with complex bio-psychosocial problems such as homelessness, dementia, lack of family support or a criminal history that don't lead to a clear discharge plan may also have difficulty accessing inpatient and follow-up care.

Because of these patterns of reimbursement, it is not surprising that salaries for psychiatrists as a specialty profession are the lowest among other specialties, including neurology. This is exacerbated by the increasing level of educational debt incurred by physicians during training.

Participation of Psychiatric Providers in Alternative Payment Mechanisms. Behavioral health has long been reimbursed as a fee-for-service for specific types of services. Even as the health care field has moved toward "value-based" or "bundled" payments, services for mental health and SUDs have not been part of the formula determining the total cost of care or a target for intervention. This historical exclusion of behavioral health conditions in the formula for innovative reimbursement methods has left the field with less expertise than primary care providers and hospital-based practitioners to develop innovative models. In 2016, states finally began working with the CMS to include behavioral health services in the bundled payment methodologies in Accountable Care Organizations models for Medicaid populations. Through exclusion from these bundled payment programs in earlier models, psychiatrists have neither gained the experience of participation nor benefited from shared savings from the total cost of care that many programs achieved. In 2017 eight states will begin paying their Certified Community Behavioral Health Centers a cost-based perspective payment as part of a two-year demonstration through the Excellence in Mental Health Act which will remove financial incentives to limit and minimize the availability of psychiatric services.

Documentation Requirements and Regulatory Restrictions

At the same time as these new programs roll out, psychiatrists in high-volume outpatient settings experience increased demands for documentation and collateral activities around medication prescribing, which impedes the efficient use of their time and their practicing to the top level of their professional training.

Because psychiatrists are the highest level of licensure for the prescription of psychotropic medications, some state regulation and licensing authorities require them to serve as the supervising authority for other professionals who are licensed in their state to prescribe psychotropic medications. These professionals include APRNs and PAs.

Psychiatrists and other behavioral health practitioners are also required to take many steps to comply with enhanced requirements of 42 CFR, Part 2 — above and beyond the Health Insurance Portability and Accountability Act (HIPAA).

Gaps in Residency Training

Recruitment of the psychiatric workforce is a product of several contributing factors:

- Medical students completing clinical rotations in mental health and substance use disorder treatment settings that engage and encourage them.
- The pool of medical students who choose to specialize in psychiatry and proceed to residency training programs across the U.S.
- The nature of psychiatric residency and subspecialty psychiatric fellowship training as it evolves to meet the emerging trends in delivering behavioral health services.
- Training the current psychiatric workforce in new approaches to health care delivery that expand psychiatry access such as collaborative care and telepsychiatry.
- The choice of settings for residents who completed residency and have begun their professional practice.

Milestone: Integrated Behavioral Health

SBP4. Consultation to non-psychiatric medical providers and non-medical systems (e.g., military, schools, businesses, forensic)

A: Distinguishes care provider roles related to consultation

B: Provides care as a consultant and collaborator

C: Specific consultative activities

Has not Achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	1.1/A Describes the difference between consultant and primary treatment provider	**2.1/A** Describes differences in providing consultation for the system or team versus the individual patient **2.2/B** Provides consultation to other medical services **2.3/C** Clarifies the consultation question **2.4/C** Conducts and reports a basic decisional capacity evaluation	**3.1/C** Assists primary treatment care team in identifying unrecognized clinical care issues **3.2/ C** Identifies system issues in clinical care and provides recommendations **3.3/ C** Conducts and reports a basic decisional capacity evaluation	**4.1/B** Provides integrated care for psychiatric patients through collaboration with other physicians[1] **4.2/C** Manages complicated and challenging consultation requests	**5.1/B** Provides psychiatric consultation to larger systems **5.2/B** Leads a consultation team

- The growing contributions of other health professionals in concert with psychiatrists, including APRNs, PAs and board certified psychiatric pharmacists (BCPPs). Prescribing psychologists are a small but emerging profession practicing in four states: New Mexico, Illinois, Louisiana and Iowa.

Once training is complete, the psychiatric workforce lands in one or more of the expanding field of psychiatric practice settings that include:

- Inpatient direct care;
- Inpatient consultation and liaison;
- Outpatient direct care in community mental health centers, public behavioral health agency settings, academic health centers or a variety of other settings such as corrections and schools;
- Private group practices with other psychiatrists, psychologists, nurses, social workers and other licensed mental health professionals;
- Individual practices;
- Primary care settings as part of the collaborative care team for patients in care management and consulting on complex cases involving chronic medical conditions such as diabetes or asthma that co-occur with mental health diagnoses;
- Private, public and governmental sectors, as well as insurers and managed care organizations serving as managers and directors of behavioral health programs and
- Academic health centers to teach and conduct research.

It is not unusual for a psychiatrist's career track to include a weekly practice that is divided among more than one of these different settings as their careers advance and skill sets expand.

Matching Residency Training to Innovative Health Care Delivery Models. The practice of psychiatry has extended beyond the traditional outpatient and inpatient settings at the same time access to services has been highlighted in health care reform. There is greater recognition of the positive impact of timely behavioral health intervention in primary care settings on reducing primary care, medical-surgical admissions and unnecessary visits to EDs[15]. Models such as collaborative care have also demonstrated improved health outcomes for participants with co-occurring behavioral health and chronic medical conditions. However, several reviews of the milestones for psychiatry residents have identified gaps in skills sets for practicing in these settings with training provided to residents. These gaps in psychiatrists' residency training include omission of specific milestones in key population health skills such as team-based collaborative care, telepsychiatry, supervision of other health professionals and medication-assisted treatment (MAT) for opioid use disorders. Without such training, there is less incentive for residents to practice population health, resulting in psychiatrists who practice "treatment as usual" in live clinical encounters. This only perpetuates the status quo of geographic maldistribution of psychiatric services, lack of substance use providers and poor integration with other health professionals on clinical teams.

The Milestone: Integrated Behavioral Health table shows the reported ACGME Advance Beneficiary Notice (ABN) 2013 milestones for adult psychiatry residency training. There is a lack of specificity in Levels 3, 4 and 5 in the areas of integrated care and team-based skills and the exclusion of collaborative care,

population health analytics and telepsychiatry demonstrate the gap between the training skills currently required and the emerging models of care for the next generations of psychiatrists. Findings of the Institute of Medicine (IOM) concur with this conclusion[16].

> *"GME curriculums lack sufficient emphasis on care coordination, team-based care, costs of care, health information technology, cultural competence and quality improvement — competencies that are essential to contemporary medical practice."*
>
> *– Institute of Medicine, 2014*

Workforce of Other Providers

Psychiatrists are not now, and never will be, the clinicians doing the majority of diagnosis and treatment of mental health and SUDs. Primary care providers have historically been the frontline for diagnosis and initial treatment of behavioral health conditions. With projected gaps in the psychiatrist workforce needed to meet demand expected to widen, other professionals will play an increasingly critical role in ensuring greater access to psychiatric prescribing. There are currently 13,815 psychiatric mental health APRNs, 1,033 psychiatric PAs and 955 BCPPs practicing in the U.S. By 2025, it is estimated that there will be 17,900 psychiatric mental health APRNs, a "significant increase in the number of PAs practicing in psychiatry" and more than 2,400 BCPPs. Although scope of practice varies by state, these providers are a welcomed addition[17] to the psychiatric prescribing workforce. (See Appendix 2 for an overview of the non-physician professional workforce involved in psychiatric prescribing.)

Consumer Experience

One indicator of high-quality psychiatric care is the patient's experience with the clinician. Patient satisfaction is low in community mental health centers' psychiatric services. Patients and family members are increasingly vocal about reduced quality of those interactions as access to care has become more difficult. The major complaint is that the psychiatrist does not spend adequate time with the patient, with 15-minute sessions the norm. This time limit is clearly a result of the inadequate workforce in settings that tend to be community mental health centers serving a primarily Medicaid population. According to the Depression and Bipolar Support Alliance (DBSA), the 15-minute session ranked second of six barriers to access on impacting trust and expectations[18]. Their report says that "compressed time with patients may lead to cold or overly clinical environments" and "over-focus on deficits or weaknesses [that] may disempower or frustrate individuals." Barriers related to "expectations" include lack of psychoeducation and limited or no options for involvement of loved ones or community supports, if not clearly offered.

Consequences of Problems Identified in the Environmental Scan

1. An inadequate workforce has a limited ability to deliver safe and effective care. Psychiatrists and other health professionals lack time to review all relevant clinical information and provide expert guidance to other members of the patient's treatment team up to the level of their licensure.

2. There is a low level of patient satisfaction among those receiving psychiatric services in community mental health centers and other publicly funded programs.

3. There are limited opportunities for a reduced workforce to participate in innovative models of integrated delivery of care. In programs that implement a primary and behavioral health care integration model, the team can include a primary care physician, primary care nurse, specialist for chronic conditions, care manager and care management representative from the patient's managed care organization. Without a psychiatrist's guidance, these teams are less likely to note early onset of psychiatric symptoms, misdiagnose physical symptoms that mask psychiatric symptoms and correctly assess the interactions of medications.

4. Psychiatrists face a severe limit on their capacity to supervise other behavioral health professionals, collaborate with primary care and specialty care providers on complex cases or participate in high-risk, high-profile complex cases across the treatment continuum.

5. Residency training does not have adequate milestones to provide participants with enhanced skills to participate in population health programs that manage the total cost of care within integrated care settings and build models that recognize the true cost of psychiatry and reimburse behavioral health providers for shared savings in these evolving models.

6. Psychiatry is a "loss leader" in many outpatient and inpatient settings, despite emerging acceptance of its value in integrated care settings.

It is ironic that the challenges of a limited psychiatric workforce are exacerbated at the same time the value of psychiatry and behavioral health in general is recognized more broadly. Providers of psychiatric services can be a valuable resource helping their colleagues in primary care settings intervene with emerging behavioral health problems, preventing costly use of ED and inpatient care. Furthermore, psychiatrists and other providers can incorporate peers, family members and community support workers into primary care settings to set the tone for a strength-based, recovery-oriented approach to the population being served as part of the collaborative care team model.

Psychiatrists are among the leaders addressing the opioid crisis in many settings by helping improve prescribing patterns, train prescribers to screen for SUDs, engage patients in denial of addictions to pursue proper treatment and obtain valuable support care and align the patient's treatment more closely to best practice models.

Conclusions on Access and Environmental Scan

The Shortage of Psychiatrists Will Only Increase

Increased availability of behavioral health coverage for the expanded population insured under health care reform continues to raise demand for behavioral health services in general and for psychiatrists specifically. Referrals come from an expanded pool of primary care providers expected to facilitate timely referrals for behavioral health services, including psychiatry. Evidence-based and data-driven practices continue to evolve and are progressively becoming the standard of care, especially with deepening understanding that people with co-occurring chronic medical and behavioral health diagnoses have exponentially rising costs of care.

Psychiatrists' contributions to the assessment and formulation of a treatment plan for these populations should ultimately lower costs, as skilled specialists can recommend and provide treatments most likely to address problematic symptoms quickly and effectively. Doing so will reduce the overall illness burden on the health system, especially by reducing the need for expensive ED visits and hospitalizations. In addition,

healthier populations generally comprise a more effective and productive workforce. As such, psychiatrists are invaluable as treatment team leaders and demand for their participation as care providers will increase.

As accountable care organizations and managed care organizations seek solutions that meet the Triple Aim of improving care, improving health outcomes and reducing cost, they will increasingly turn to psychiatrists for their help and guidance. The lack of an adequately trained workforce, however, poses a serious challenge in meeting this demand.

The National Council for Behavioral Health Medical Director Institute concluded that the traditional model of psychiatric care delivery is unsustainable.

Given this information, the Medical Director Institute concluded that the traditional model of psychiatric care delivery and training is seriously detrimental to patients. Psychiatrists who spend their first year in inpatient psychiatric hospital units are trained in skill sets that, while helpful for serious acute psychiatric issues, are less useful for the more common issues facing an outpatient population that can benefit from a broader range of behavioral health services. Trainees can benefit from more exposure to outpatient evidence-based practices that include team-based collaborative care, early screening and intervention for SUDs with an emphasis on MAT for opioid use disorders, trauma-informed care, cognitive behavioral therapy and recovery-oriented practices. Expanded training can address current shortfalls and limited development of the skill sets needed to collaborate with other health professionals such as PAs and APRNs, analyze claims data to identify patterns of care and effectively use advances in technology to provide clinical interventions such as telepsychiatry.

In short, psychiatrists face expanded challenges in training and practice to participate in a host of innovative interventions in which psychiatric training can be most valuable to:

- Address co-occurring behavioral health and chronic medical conditions;
- Develop and lead behavioral health early intervention and screening programs;
- Facilitate a team-based approach to develop individualized plans for patients with complex symptoms and challenges, especially those whose social conditions constitute a significant barrier to receiving high quality health care;
- Improve health outcomes of high-risk and high-cost populations where mental health and SUDs are prevalent;
- Address the social determinants of health that pose substantial barriers to primary care, specialty care and behavioral health care and
- Promote the value of peers and family members with lived experience as full members of the treatment team towards recovery and resiliency.

Psychiatrists are neither sufficiently groomed for nor are they practicing up to the level of their licensure in most outpatient community clinical settings.

An expanded supply of psychiatrists trained in these emerging competencies can set a positive example for the behavioral health workforce and champion the implementation of effective interventions for a multitude of troubling patterns of care such as:

- Over-reliance on the ED to provide urgent assessments and care,
- Low client satisfaction with psychiatric services,
- Poor health outcomes for persons with chronic mental health conditions and
- High rates of overdose from opioid abuse.

To conclude, there is a shortage of psychiatrists. However, it takes time to train new psychiatrists and increasing the number of psychiatrists — ***by itself*** — will not be sufficient to improve access and the quality of care

There is a shortage of psychiatrists. However … increasing the number of psychiatrist — by itself — *will not be sufficient to improve access and the quality of care.*

The psychiatric workforce is aging and will need to be replaced. Demand for psychiatric services will continue to increase as health care reform becomes more established. So, *yes*, the health care field continually needs more psychiatrists, APRNs, PAs and BCPPs.

Most rural and some urban communities have a severe shortage of psychiatrists. So, *yes*, those communities need more psychiatrists.

There is a limited number of psychiatrists serving the population with severe and persistent mental illness that receive services in public community mental health centers and those who are primarily on Medicaid. So, *yes*, that population needs more psychiatrists and other health professionals participating in these settings.

There is a limited supply of psychiatrists who have been adequately trained in team-based, integrative care that involves a range of team members, including peer counselors, therapists, psychologists, other health professionals as prescribers, primary care clinicians and other support staff. So, *yes*, there is need for more psychiatrists with this training to guide the team to individualized solutions that can — on an outpatient basis — address social determinants, screen for SUDs, engage patients, improve health outcomes for chronic medical and behavioral health issues and increase a person's quality of life.

However, there is *no* need for more psychiatrists who:

- Work solely in cash-only practices;
- Refuse to take clients covered by Medicaid;
- Do not include people with severe and persistent mental illness in their caseload;
- Do not work with other behavioral health, primary care, peer counselors and family members in integrated treatment teams or

- Are unwilling to consider alternative payment mechanisms and population health approaches to the most complex patients in their caseload or in the population of the local community served by their organization.

In the Solutions and Recommendations sections that follow, we seek to develop incentives, training programs, shared jobs or other creative measures for career paths inclusive of the full range of patients needing access to psychiatric services by:

- Requiring/encouraging all psychiatrists and other health professionals to enroll as a Medicaid provider and to participate in Medicaid managed care networks;
- Including in their private or public practice, patients with severe and persistent mental illness in their caseload;
- Developing ongoing collaborations with other behavioral health, primary care, peer counselors and family members in integrated treatment teams and
- Building skills and willingness to consider alternative payment mechanisms and population health approaches to the most complex patients in their caseload or in the population of the local community served by their organization.

Summary

Policy initiatives related to the Affordable Care Act (ACA), MHPAEA, the Comprehensive Addiction and Recovery Act (CARA) and the opioid crisis have resulted in not only more demand for psychiatry, but more demand from a broader range of stakeholders that include community health centers, FQHCs, primary care practices, hospital EDs, courts and schools. While inclusion is a welcome step in improving understanding of behavioral health problems and demonstrating behavioral health's value in a broader context, the demand for onsite presence, timely intervention and team-based collaboration — compared to the historical outside referral processes that usually involved a telephone call for follow-up — further stretch already limited resources.

The solutions cannot rely on a single change in the field such as recruiting more psychiatrists or raising payment and reimbursement rates. Rather, the solutions depend on a combination of interrelated fields that require support from a range of stakeholders.

There is need for multiple strategies and solutions to address the lack of access to psychiatric services. The design and implementation of those solutions will need to carry across multiple professional groups outside of psychiatry. The blend of needed change in policy, training, advocacy, program development and funding will require ongoing efforts to promote and facilitate that change — from trade associations, state and federal policymakers, advocates, consumers and family members, legislators, researchers, medical school educators and individual professionals within psychiatry. The solutions cannot rely on a single change in the field such as recruiting more psychiatrists or raising payment and reimbursement rates. Rather, the solutions depend on a combination of interrelated fields that require support from a range of stakeholders. Certainly, success is possible with coordinated efforts, sound data and thoughtful interventions.

Solutions

Overview of Solutions

As outlined in the previous sections, the scale of the problems related to lack of access to evidence-based psychiatric services is significant, and the range of factors contributing to the problems is broad. Relying on one or two solutions in isolation from other systemic improvements in health care delivery to narrow the gaps, remove the barriers and meet the challenges in an altered health care delivery environment will not adequately address the current situation. The Medical Director Institute, with input from their expert panel, asserts that multiple solutions addressing a host of practice settings, stakeholders and methods of delivery are needed. This section addresses the topics identified in the Environmental Scan section: access, quality of care, workforce, including other prescribers, residency training, reimbursement, consumer experience and regulatory requirements. The panel identified six broad areas requiring change:

- Expanding the workforce providing psychiatric services;
- Increasing efficiency of delivery of psychiatric services, including,
    - Reforming and revising existing regulations that constrain well-coordinated care and access to valuable clinical information;
- Implementing innovative models of integrated delivery of primary care and psychiatric care in more settings that have the potential to impact the total cost of care for high-cost/high-risk patient populations with co-occurring medical and behavioral health conditions;
- Training psychiatric residents and the existing psychiatric workforce in delivering new models of care;
- Adopting effective payment structures in conjunction with matching models that adequately reimburse psychiatric providers for improved outcomes of care and
- Reducing the portion of psychiatric providers who engage in exclusive, private, cash-only practices.

Expanding the Psychiatric Workforce

The strategy for expanding the psychiatric workforce must have two parts: increasing the number, distribution and population served by psychiatrists and expanding use of nurse practitioners, clinical pharmacists and physician assistants with specialty training in psychiatry.

Recruitment

First, academic health centers should continue to prioritize recruitment of medical students into psychiatry and improve support of psychiatry residency positions, particularly in rural and urban underserved communities. According to a survey of psychiatry faculty at 36 American medical schools, the two critical factors consistent across “high recruiting” schools were a strong reputation of the psychiatry department and its residents and longer clerkships (i.e., the period in the third year of medical school in which students receive clinical exposure to psychiatry[19]). The key strategy to improve recruitment into residency programs is to encourage academic health centers with lower rates of recruitment to replicate the educational quality and student engagement of psychiatry clerkships in higher recruiting medical schools.

Second, there is a need to expand the limited federal funding for GME resident positions through Medicare. The Association of American Medical Colleges (AAMC) asserts that "lifting the cap on Medicare GME funding will help alleviate the doctor shortage[20]." Strategically, these additional GME-funded positions should be prioritized in underserved rural and urban communities that are federally designated mental health professions shortage areas.

Updating Psychiatry Residency Training

Current psychiatric training should include specific milestones related to population health, developing models of integrated behavioral health care, data-based decision-making, telepsychiatry and other skills that will allow them to increase impact on patients with improved health outcomes and total cost of care. Proponents of integrated behavioral health believe that if psychiatrists designate a significant portion of their practice as consultants to primary care rather than direct care providers, they will significantly increase access without a requirement for more psychiatrists[21]. However, this would require a substantial shift in residency training and psychiatrist identity.

As noted in two key publications (Official Action: "Training Psychiatrists for Integrated Behavioral Health Care[22]" and "A Proposal for Next Generation Psychiatric Residency: Responding to the Challenges of the Future[23]"), the call from the Medical Director Institute's researchers and medical educators echoed these important arguments. There is a growing need to "modernize psychiatry education" to provide residents with the skills and competencies necessary to actively participate in the redesign of health care delivery. This will afford them the best chance of contributing psychiatry's important perspective to the solution for complex clinical presentations that involve chronic health conditions, behavioral health diagnoses and biopsychosocial factors that make up the "social determinants of health." Among the specific areas in which training can be updated effectively include:

- Designing competencies and skills to be developed during residency that include:
    - Team leadership skills, including incorporation and facilitation of different perspectives, appropriate delegation of tasks to team members and active inclusion of individuals with lived experience with mental illness and SUDs, including parents of children with severe emotional disturbances.
    - Health care data analysis and expanded perspectives on population health.
    - Expanding knowledge of the impact of chronic medical conditions such as diabetes on various mental illnesses.
- Increasing the availability of training in alternative treatment settings where psychiatrists complete their residencies beyond inpatient and outpatient mental health programs. The settings should match the emerging models of integrated primary and behavioral health care and include community health centers; large primary care practices, especially those that are certified as patient-centered medical homes and/or those reimbursed with alternative payment mechanisms (APMs); team-based behavioral health settings that practice the wraparound model of care, include persons with lived experience in their team; assertive community treatment (ACT) teams; health homes established under Section 2703 of the ACA; and clinically-supported MAT programs.
- Exposure and training in telepsychiatry for direct care, consultation, training and staff supervision in underserved areas.

- Increase funding for psychiatric residency training in health professions shortage areas such as rural critical access hospitals, correctional settings, FQHCs, etc.
- Practicing in settings that include an expanded role for families as support for — not a barrier to — good care. Part of the skill of team building is engaging peers, families and paraprofessionals who can impact outcomes related to overcoming barriers related to social determinants of health.
- Greater collaboration on training at the national, regional and local level among psychiatric residency, psychiatric APRN, psychiatric PA and BCPP training programs on population health, total medical expense (TME), financing and payment models.

Select residency training programs have implemented or have begun to implement some of these solutions across the country. Implementing a systemic change in residency requirements necessitates involvement of many different parties involved in medical education within the field of psychiatry and across medical education. This includes ongoing recruitment of medical students interested in psychiatry, increased graduate medical education funding for psychiatry residents to train in underserved areas, updated general psychiatry milestones to require population health skills, expanded rotations in settings such as patient-centered medical homes to practice population health and establishment of measures of best practice in these alternative clinical settings.

Expanding Workforce of Other Providers

Expanded use of other providers who prescribe psychiatric medications is a necessary strategy in the face of the declining number of psychiatrists per 100,000 population at the national level. The efficient use of these providers allows psychiatrists to devote their time to more complicated cases, whether by assigning those cases to psychiatrists or providing space for psychiatrists to consult closely with other professionals to help them manage more difficult cases. APRNs, PAs and BCPPs (see page 4) all bring unique skills to these behavioral health settings and can complement the team-based approach to many patients with complex comorbid medical and behavioral health problems.

There are currently 13,815 APRNs and by 2025 the number is projected to reach 17,900. Nurses can be especially valuable for patients with co-occurring medical conditions and can effectively liaise with primary care and specialty care providers around care coordination involving more complex medication interventions. However, scope of practice varies by state creating both confusion for how the professions can best collaborate and potentially also limiting the extent to which they can contribute to the team.

PAs with specialty psychiatric training are a relatively new development that has tremendous potential for expansion. Since their duration of training is the shortest of the psychiatric prescribers, they represent one of the most cost-effective solutions to the shortage of psychiatric workforce. Although the 1,033 psychiatric PAs only represent 1.3 percent of total PAs, this demographic is expected to grow and AAPA estimates that there will be 125,847 total PAs by 2026[24]. There are only eight PA postgraduate programs established in psychiatry. These program typically last 12 months and expose trainees to a comprehensive blend of inpatient and outpatient psychiatry[25]. PAs have a well-established collaborative practice model with physicians, lending themselves well to team-based and integrated behavioral health models. Scope of practice also varies by state laws, presenting the same problems faced by APRNs.

BCPPs are another emerging workforce that has special expertise in patients with complex medications regimens, such as those in community mental health. Currently, 955 BCPPs practice in the U.S., and estimates suggest that by 2025, there will be more than 2,400[26]. They are typically not allowed to make an initial diagnosis or change a diagnosis, but the Department of Veterans Affairs (VA), the Department

of Defense (DoD) and several states, such as Oregon and Ohio, allow BCPPs to prescribe and manage medications through a collaborative practice agreement with a physician[27]. For complex patients and in team-based care, they represent a key resource for managing multiple medications. Clinical pharmacists within DoD and the VA are credentialed to the same level as nurse practitioners.

Increasing the Efficiency of the Delivery of Psychiatric Services

Telepsychiatry

Telepsychiatry has the potential to dramatically increase geographic access to psychiatric services for children and adults in rural areas. These include areas with minimal access due to geography, areas where cultural and/or linguistic barriers exist and settings outside of mental health clinics that may require more immediate access to a psychiatrist for evaluation, such as an emergency room. The example of how telepsychiatry was deployed in a rural county in Pennsylvania to produce dramatic increases in access, coupled with high rates of patient improvement and satisfaction[28] provides evidence of the tool's potential.

Telepsychiatry can also be used as a tool to provide more efficient and timely consultation to other behavioral health and health care professionals who work in schools, health centers, EDs, homeless shelters, day care centers and jails. Telepsychiatry can be a faster and just as effective, intervention to assist ED staff in timely clinical assessment of the client, both for consultation with the ED staff and direct patient assessment from a remote location. Telepsychiatry can also be made available to primary care practices where there is no behavioral health presence on site. This model is currently most commonly applied for pediatricians seeking consultation from a child psychiatrist. The original model from Massachusetts has now expanded to a handful of other states. Sources of funding include insurers: Massachusetts recently adapted a formula to supplement an annual state appropriation and Rhode Island just implemented a model funded by their State Innovation Model grant.

To the extent that telepsychiatry eliminates travel time, there is a corresponding increase in psychiatrist productivity when they are able provide psychiatric services during time that they would have previously spent traveling to a clinic location.

Open Access Scheduling

The longer a patient must wait between requesting an appointment to see a psychiatrist and actually getting to see the psychiatrist, the more likely the patient will not show up for the appointment. This both limits the patient's access to psychiatric services and decreases the psychiatrist's productivity and ability to generate income to cover costs. Open access covers a variety of scheduling approaches, including time that is completely unscheduled (a model that is similar to deployment of resources in an EDs or an urgent care centers), open blocks of time on certain days and a specific number of appointments kept open in each clinic session. A practice could utilize more than one of these options in conjunction with traditionally scheduled appointments. The imperative is to do what makes the most sense for the patients in their course of recovery and improved health. For instance, it might make sense for a psychiatrist to block out Tuesday mornings for routine follow-up appointments and let patients come in at their convenience for these typically quick appointments. The methodology could also support scheduled group meetings at the beginning or end of the open access period to disseminate general information and answer typical questions. The National Council provides training and technical assistance to its members to implement this model.

Adequate Staff Support to Increase Psychiatrist Efficiency

Primary care and other specialist medical practices uniformly dedicate staff to assist the physician with all aspects of care, which increases overall efficiency of the provider. Support staff includes nurses, medical assistants or other non-licensed personnel with some specialty training. Common areas include: initial handling of incoming phone calls, collecting routine screening information and vital signs, assuring that all the required forms for the visit are immediately available, arranging for referrals and return visits, tracking down laboratory and pharmacy information and making photocopies. Psychiatrists working in community clinic settings are much less likely to receive the same level of clinical administrative support, which represents an unnecessary waste of a valuable resource.

Improving Capacity to Share Information

The potential for sharing information has been greatly enhanced by the growing use of EMR and technological improvements in sharing information among providers, which will be referenced in the discussion of other solutions. However, regulatory barriers to sharing such information persist and will be addressed in the narrative on solutions relating to regulatory changes. An EMR that is interoperable with other health care delivery systems, including pharmacies, emergency rooms and primary care providers is an essential tool. Timely exchange of information is critical for effective interventions and collaboration with other providers. It is understood that ED interventions, for example, deploy a standard of care that is more conservative for patients about whom little or nothing is known. Shared patient registries can offer more targeted interventions and team members can be deployed to help ED staff develop an appropriate and effective intervention.

Another resource that can aid assessment is identification and contact with the patient's behavioral health providers, primary care providers and other prescribers and access to the patient's treatment history and current treatment regimen, including medications. With timely exchange of information via shared patient registries, ED staff can contact the providers who are most familiar with the patient. The providers, as well as family members, can provide context for the presenting symptoms to validate or moderate the seriousness of the symptoms and ED staff identify the best match of services to the patient's needs for disposition, including returning to the provider for follow-up. A best practice model is activation of the patient's Wellness Recovery Action Plan (WRAP), or other client-generated crisis plan that draws upon the patient's strengths, supports and resources to address the triggers of the current psychiatric crisis. The Medical Director Institute recognizes HIPAA and confidentiality issues in expanding access to a patient's medical history; however, these data are critical to identifying the problem, targeting the intervention and measuring the outcome. In no case does such data need to include any progress notes or confidential information shared in any medical setting between a patient and his/her medical provider. With this protection, the patterns of care do not violate the spirit of patient confidentiality.

Reducing Excessive Documentation Requirements

Psychiatric evaluations and treatment plans are almost always substantially longer and more elaborate than those of primary care or other medical specialties. The level of detail is driven by both tradition and training, as well as regulatory and payment requirements. Much of the required information is not relevant or useful in addressing the reason the person sought treatment or their immediate clinical situation. Much of the mandated information in planning areas is mandated due to concerns that for a small fraction of patients, the psychiatrist performing the evaluation will miss a pertinent factor if a particular question is not mandated. This also results in the added patient burden of having to answer multiple questions unrelated to the immediate problem that led them to seek care prior to that problem

being addressed. Since psychiatric time is limited, providing an unnecessarily comprehensive assessment and treatment plan to some patients results in other patients not receiving any assessment or treatment planning. Also, primary care and other medical specialists are less likely to review long and elaborate assessments and treatment plans due to their limited time.

Expanding Innovative Models of Delivery of Psychiatric Care

Collaborative Care Model for Integrating Primary Care and Behavioral Health

The collaborative care model (CoCM) is gaining support as evidence for improved outcomes through continued research and new funding processes. With a psychiatrist as the team leader in a primary care setting, the CoCM has demonstrated that persons with chronic medical conditions and accompanying mental illnesses such as depression and anxiety, are matched with the most appropriate and individualized complement of team members who can best intervene to improve specific health outcomes related to these conditions. There is emerging evidence for success of the CoCM with bipolar disorder, SUDs and attention deficit hyperactivity disorder (ADHD). This model specifically targets one of the cohorts of diagnostic groupings that account for the 5 percent of the population that consume 50 percent of the health care costs: persons with co-occurring chronic medical conditions and behavioral health conditions.

By using a "stepped care approach[29]," the model ensures cost-effective allocation of the different providers on the team. With enhanced training and competency in team facilitation and delegation of tasks, the psychiatrist is in the best position to implement this approach and identify the skill sets among team members, assign the right mix to each patient's care team and assist in addressing gaps in care and barriers to engagement. The team, led by the primary care clinician, will then be in a better position to align care with established clinical practice guidelines for the chronic conditions.

Expanded implementation of this model will require payers, primary care providers and individual team members to support an intervention model that includes a case manager with ongoing use of outcome measures and data interpretation skills to measure progress, identify gaps in care and brainstorm interventions to address gaps and emergencies that may occur in a Medicaid population and with persons with chronic and severe mental illnesses, such as bipolar disorder.

Reducing Stigma in the Primary Care Setting

The psychiatrist must work with primary care colleagues, including peers, people with lived experience, family members and recovery coaches assigning responsibility based on their effectiveness at client engagement. A psychiatrist can share unique skills engaging the patient, providing support and acting as an advocate when multiple providers are involved, customizing crisis plans to address triggers for harm to self or others and insuring that people from diverse cultures are fully engaged in planning to address cultural barriers. All these skills and interventions will lead to greater compliance and trust in the medical team. To reduce stigma, primary care should begin enhancing medical education in psychiatry for primary care providers in both medical school and residencies. Reduced discrimination in primary care will increase the likelihood of effective screening and early intervention of behavioral health conditions.

Early Intervention and Prevention

Primary care settings can enhance the value of early identification of behavioral health conditions. Greater access to psychiatric services will address the complaint, "What good is it to identify a substance

use or mental health problem when there is no one to refer to?" as will the growing practice of rapid access in community mental health centers. The psychiatry profession would also be advised to develop consensus on standardized screening tools and rating scales that serve as a cornerstone of the CoCM. The two most widely accepted measures are the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder 7-item Scale (GAD-7). Training, demonstration of inter-rater reliability and acceptance by primary care providers will be much more efficient with a smaller set of tools and wider distribution.

Colocation of Primary Care and Psychiatry

While colocation alone does not assure functional integration between primary care and psychiatry, it does make functional integration easier to achieve. Colocation decreases discrimination, increases access to primary care providers for informal consultations, reduces the administrative burden of sharing information through a common medical record, increases the likelihood of patient follow-through with referrals and is preferred by most patients. Colocation increases a primary care practitioner's knowledge of standard psychiatric treatment and increases a psychiatrist's knowledge of primary care's current standards and treatments.

Shift in Culture from the Mental Health Clinic to the Primary Care Setting

Psychiatrists and other behavioral health clinicians must adapt to the primary care culture where visits are shorter, schedules more often disrupted and quick summaries are the norm, often in the proverbial "hallway conversation[30]." This model can help with early intervention when a primary care clinician engages the patient and a behavioral issue is first disclosed. At that moment, timely intervention from a team member can be the first step to engagement. Without prompt intervention, the opportunity may be lost and the patient may become at higher risk for more acute episodes.

This shift in culture for the behavioral health professional can be achieved through expanded contact with primary care providers, enhanced training in primary and behavioral health care integration models, participation in CoCMs and joint problem-solving in case reviews and crisis interventions. Improved training of psychiatrists in team leadership, delegation of duties to other team member and structuring case reviews to match identified needs can also achieve this culture shift (more on this in the Residency Training section.) A key component of culture shift is on-demand consultation and engagement by psychiatrists and behavioral health clinicians in primary care settings. As Call to Action — Training Psychiatrists for Integrated Care noted[31], the availability for "curbside" consultations can achieve a great deal, including: building rapport with the primary care provider, addressing a potential crisis in its early stages, engaging a patient who may be ambivalent about acknowledging a behavioral health problem and improving acceptance of behavioral health problems as part of the primary care providers' work.

In addition to training psychiatrists and other behavioral health providers to work outside the comfort zone of fixed appointment times, this model can be more easily implemented by establishing bundled payments for the populations served in primary care settings with accommodations for enhanced resources for persons with co-occurring chronic medical and behavioral health diagnoses through a "risk adjustment" methodology that is common in actuarial practice (though not simple to calculate and apply).

Measurement-based Care

Similar to the implementation of the CoCM in a primary care practice of psychiatry and behavioral health, organizations must identify key problems, gaps in care and potential for recovery and improved health

to formulate the problem and identify solutions for both the individual and the population they serve. For the individual, the team must have a method of reviewing the patient's treatment history beyond the medical record, which only includes services within the direct care organization. The EMR must include patterns of utilization of other services, especially ED, inpatient admissions and pharmacy. These patterns of care can help identify gaps, redundant and duplicative care, overuse of more restrictive care and, at times, care that is contraindicated to the specific problem, such as a patient with a substance use disorder receiving an opiate prescription from another prescriber.

The second data tool that teams need is a population-based summary for patients with similar presentations, often referred to as a disease registry. By having access to total cost of care, targets for improvement based on data from a larger sample and standardized health care outcomes scores for one or more presenting chronic health conditions, the team can set reasonable targets for improvement and differentiate interventions more effectively. Many private insurers already use large data sets for predictive modeling to identify opportunities to improve care and operate disease registries. Many managed care organizations organize their care management programs around this predictive modeling and triage their nursing and care management staff to work with enrollees with chronic condition such as diabetes, asthma and chronic obstructive pulmonary disease (COPD). These data sets form a foundation for team-based collaborative care. However, these models neither account for many behavioral health conditions, especially chronic and severe mental illnesses, nor social barriers, such as cultural diversity, poverty, inadequate housing and environmental constraints. The collaborative care teams in primary care settings and multi-disciplinary clinical teams in mental health centers can enrich these data sets by evaluating and accounting for these barriers and addressing them with targeted interventions.

Underscored by the wide popularity of "Hot Spots[32]," there is now widespread acceptance of utilizing population health as a field of inquiry to help identify actionable care gaps in high-risk populations, then targeting best practice interventions to achieve improved health care outcomes.

The population health data will serve another critical purpose: matching services to needs within the context of total cost of care and aligning interventions to health outcomes and reductions in unnecessary and more restrictive care. Psychiatrists must build skills in analyzing these data and assigning the resources on their team to address the key problems that put the patient at risk.

We recognize that such data sets exist for much larger populations and that they do not consider psychiatric diagnoses or social determinants that often accompany patients in community mental health centers. There is no better time to take a leadership role in incorporating these key factors into assessing population health, designing outcomes and developing innovations to address key barriers.

Team-based settings must have data on groups of patients and individual patients that identify gaps in care, which may be evidenced by such things as overutilization of the ED, contraindicated prescriptions, lack of follow-up and abnormal scores of proxies for chronic illnesses such as the hemoglobin A1C scores for diabetes. The data must also contain metrics for total medical expense and how individual patients and their cohorts are tracking to be above, at or below the estimated target cost. Psychiatrists need data in a format that accommodates and acknowledges social determinants of health, like hot spotting does, so that team-based interventions can address housing, food insecurity, child welfare and criminal justice to harmonize the sounds in the symphony of a well-coordinated integrated solution. This team-based approach incorporated from clinical problem-solving has had promising results[33] in primary care settings and can be expanded to cover more populations. The key contribution of the psychiatrist lies in delegating tasks to the team member who can best solve the patient's problem. By matching the best staff person, the psychiatrist and other professionals can work up to the level of their licensure and

also benefit from the contributions of peers, family partners and recovery coaches who are uniquely positioned to engage the patient — often more successfully. The differential use of the team is a key component to managing limited resources and working to identify key problems and target specific interventions that often include addressing social barriers, such as housing, domestic violence, criminal justice issues and educating children. Peer specialists, recovery coaches and family partners have a proven track record of addressing "social determinants" and providing the individual patient with support to focus more on mental health, substance abuse and primary care health issues.

Use of Emerging Technologies

The field of behavioral health offers many opportunities for consumers, family members and providers to communicate more actively and effectively with each other to address mental health and SUDs. People, especially younger people, increasingly want treatment interventions on-demand without scheduling an appointment, and often not face-to-face in an office. Innovators are offering as an extension of the "Fitbits," smartphone apps, text message services and websites that can allow patients to query their provider, take self-administered tests on mental health conditions, search for peer support, check in with their provider on their status, even be reminded if they are traveling to an area that is at high risk for finding and using substances that are addictive. These technologies can increase access to information, quickly identify the risk and need for more timely follow-up, allow the psychiatric provider to respond to questions, provide reassurance or intervene in a crisis and provide the patient with direct feedback that can strengthen recovery.

Reducing Psychiatrist Burnout and Optimizing Retention

Retaining both current and future psychiatrists in community clinic practice will require significant expansion of the variety of clinical duties they are asked to perform and an increase in the amount of connection with and support they receive from other clinic staff.

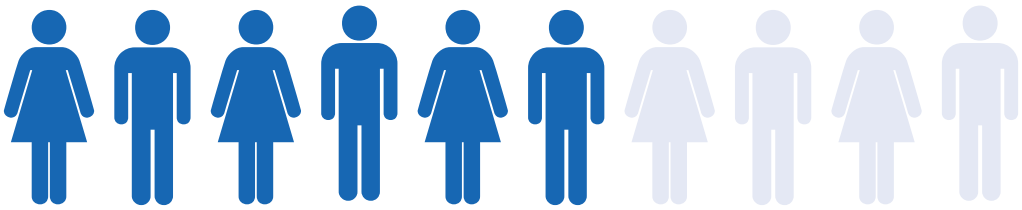
Strategies for retention include improving the variety of clinical duties they are asked to perform, as well as their connection with and support from other clinic staff. Solutions include training in team-based and collaborative care, expanded use of alternative prescribers, reduced demands for documentation and greater facility in delegating tasks for other staff in the clinic setting.

Another solution to reduce burnout and the portion of cash-only private practice is to expand the options for loan forgiveness for psychiatrists and other providers who work in underserved areas.

Finance and Reimbursement

Delivery of psychiatric services in both inpatient and outpatient settings results in a financial loss to the agency or hospital with a decreasing number of sources available to underwrite the loss. At the same time, the value of psychiatric services is becoming better understood in the innovative models of care.

Stakeholders need to address the growing financial gap between rates of reimbursement and the cost of delivering the services, particularly in community mental health centers, and adopt alternative payment mechanisms and implement the other recommendations. The statistic that 40 percent of psychiatrists have chosen cash-only practice, and regular complaints from patients with commercial, Medicare and/or Medicaid coverage that they cannot find a psychiatrist on their network panel who is willing to accept new patients is strong evidence that current rates offered by payers are significantly below the actual market and insufficient to offer reasonable access to services.



40 percent of practicing psychiatrists do not take any insurance

Providers must continue to negotiate for fair market rates that approach the real cost as part of their due diligence with payers and to Boards of Directors. The Medical Director Institute recognizes, however, that rate relief and adding more psychiatrists will not solve the problem of lack of access to psychiatry. This effort must be combined with other recommendations within this paper to be effective.

Since Medicaid is the major payer of behavioral health nationwide, behavioral health providers do not have the same opportunity as other specialists to make up for payment rates that are below cost in Medicaid with the commercial coverage portion of their business. Setting psychiatric payment rates below costs strongly incentivizes clinics providing behavioral health to provide no psychiatric services, or as little as possible, as opposed to staffing their clinics consistent with their clinical population's needs. While appropriate to offer both upside and downside incentives for good and bad performance, the base rates for psychiatry must be approximately equal to the cost of providing service if access is to be maintained. There are several recent payment methodology innovations that show promise in properly incentivizing adequate access to psychiatric services.

Prospective payment systems (PPS) for behavioral health services in FQHCs and soon-to-be-initiated Certified Community Behavioral Health Clinics (CCBHCs) utilize a rate setting methodology that is primarily cost-based, assuring adequate payment of psychiatric services. Adopting PPS methodologies would remove the current pervasive business incentive to inappropriately minimize access to psychiatric services to avoid operating at a net loss.

Bundled payments, such as episode of care-based payments, bundle the psychiatric component with multiple other services that allow more flexibility to utilize psychiatrists. The new collaborative care and chronic care management billable service codes just implemented by Medicare are excellent examples of this approach. Collaborative care codes bundle psychiatric consultation with a behavioral health care manager and a data registry in a single payment. Chronic care management bundles non-face-to-face care interventions and a data registry in a single payment.

Simultaneous to the transition from fee-for-service to alternative payment mechanisms, the delivery of psychiatric services must be evaluated on the outcomes of client care that are aligned with the Triple Aim to provide objective measures for all stakeholders. The challenge to document outcomes includes establishing cost-effectiveness of collaborative care teams and developing a baseline for the total medical expense that must include the true cost of care.

Regulatory Barriers and Opportunities

Mental Health Parity and Access

Integrating MHPAEA parity requirements with the new Medicaid managed care access requirements presents a real opportunity to enforce rates of payment for psychiatric services that are adequate to assure appropriate access to care. MHPAEA requires parity between behavioral health and medical care,

both quantitatively and qualitatively. MHPAEA parity requirements have applied to commercial plans for several years and will apply to all Medicaid managed care plans beginning in October 2017. MHPAEA requires that psychiatric services be quantitatively and qualitatively as accessible as medical services for plans that offer treatment for any behavioral health condition and cover physician services. CMS guidance states that rate inequities in some circumstances can be construed to be a non-quantitative limitation on treatment. The new Medicaid managed care access rule requires all state Medicaid programs to have a monitoring plan that measures access to care in their fee-for-service programs. The monitoring plan must include comparisons between behavioral health providers and primary care providers in terms of provider to patient ratios, distance to treatment and time to first appointment, payment rates and conclude with a judgment as to whether patient needs are adequately met. In short, it requires a formal assessment of access to psychiatric services compared to access to primary care services. Access that is found to be substantially different and concludes the patient needs are not adequately met could be determined to be a non-quantitative parity violation under MHPAEA.

Confidentiality Regulations

Confidentiality regulations that treat psychiatric information (related to both mental health and SUDs) differently than general medical information creates substantial barriers to access to psychiatric services. Although HIPAA does not treat psychiatric information substantially differently than general medical information, many states have confidentiality statutes that put more restrictions and requirements around the use of psychiatric information than for general medical information. Federal regulations regarding substance use disorder treatment, and the recently-revised 42 CFR Part 2, contains multiple, substantial additional restrictions on the use of psychiatric information related to substance use disorder treatment compared to general medical information. Confidentiality regulations that are more restrictive for psychiatric information than general medical information have harmful consequences that include:

- Making it less likely that general medical providers will have access to psychiatric assessments and recommendations regarding a patient. Those providers are often unable to benefit from psychiatric assessments and recommendations that have already been made.
- Not having knowledge of, or access to, prior psychiatric evaluations results in referrals for additional, potentially unnecessary and redundant psychiatric assessments.
- A substantial disincentive for health care providers to add psychiatric services to their health care organization's services.

Revising confidentiality regulations so that requirements for psychiatric services align equally with general medical services can increase access to psychiatry.

Telepsychiatry Regulations

The growing acceptance of telepsychiatry has enabled timely access to psychiatric care in areas of the country where there are significant provider shortages. Although telepsychiatry has become a clinically accepted modality of care, federal and state laws and regulations have been inconsistent in keeping pace with telepsychiatry's growth. A major challenge for telepsychiatry is the Ryan Haight Online Pharmacy Consumer Protection Act (Ryan Haight Act), which was enacted in 2008 and amended the Controlled Substances Act (CSA) by adding various provisions "to prevent illegal distribution and dispensing of controlled substances by means of the Internet[34]." Revising and updating The Ryan Haight Act would increase the application of telepsychiatry.

The increased use of telepsychiatry as a fundamental solution to help meet the need for timely access to psychiatric care has been well-documented in this paper. The increased acceptance from Medicare, Medicaid and private payers; state regulatory agencies and community behavioral health clinics clearly supports telepsychiatry as a clinically acceptable modality of care. Despite the increased use and growing acceptance of telepsychiatry, impediments still exist. A significant barrier to psychiatrists' availability to provide care in multiple states continues to be individual state licensing requirements. Although the need to move toward a national licensing standard has received some recognition, significant delays in obtaining individual medical licenses continue; however, the VA and the DoD have documented notable advances. For example, a practitioner working for the VA may be licensed in any state and can provide care in the VA system, or can provide care to active duty military through the DoD.

The Interstate Medical Licensure Compact is a new medical licensing option to remove one of the significant impediments to telepsychiatry. Physicians who seek a medical license to practice medicine in multiple states will be eligible for an expedited medical license in all participating states. The interstate compact has several main principles:

- State medical boards and physician's participation in the interstate compact will be strictly voluntary.
- A state's participation in the interstate compact will create another pathway for medical licensure, but does not change the state's existing Medical Practice Act.
- The practice of medicine will occur where the patient is located and the physician will be required to be under the jurisdiction of the state medical board where the patient is located.
- The physician will be required to cover the cost of the medical license issued under the interstate compact.
- The participating state medical board will retain regulatory authority.
- Physicians who choose to participate in the interstate compact will be required to comply with the statutes, regulations and rules of each participating state in which they are licensed.
- State medical boards that participate in the Interstate Compact will be required to share disciplinary information about physicians who participate in the contract.

As of June 2016, 17 states have enacted legislation for the Interstate Medical Licensure Compact.

Loan Forgiveness

A driving force in determining primary versus specialty practice and location is student debt, and the percentage of debt has risen over the years. According to the Association of American Medical Colleges (AAMC), in 2013, the median cost of a private four-year medical education was more than $275,000 and $200,000 at a public institution. Medical students anticipate that upon graduation, they need to immediately address their debt, and this impacts what and where they practice. Those with higher debt are choosing higher-paying specialties.

There needs to be a change in how and where resources are focused to more efficiently incentivize behavioral health practitioners toward practices that provide for the underserved.

Federal scholarships and loan forgiveness programs are funded through Title VII, reauthorized by Congress every five years. These funds are targeted to increase primary care provision of underserved

care, which is defined to include work in community health centers, rural health centers, National Health Service Corps (NHSC), rural or urban Health Professional Shortage Areas (HPSA), or Medically Underserved Area/Population (MUA/P). The administration of these programs comes through HRSA.

Behavioral health care is changing in many ways, including expansion of other professional providers and provision of care to patients via new technologies, such as telepsychiatry and practices like integrated care. There needs to be review and revision of current programs and creative thinking toward creating new ones linked to loan forgiveness for psychiatrists participating in primary care settings in areas of "Underserved Care."

Areas of review include:

- Funding and administration of Title VII programs to increase the areas/populations where providers qualify for scholarships and loan programs. HPSA and MUA/P site rankings need to be revised to attract greater numbers of behavioral health practitioners and there need to be incentives for those willing to practice integrated care.
- In both state and federal scholarship and loan forgiveness programs, increase the percentage of hours allowed for provision of telepsychiatry/telehealth to underserved populations. (Currently there are strict limitations on credit hours for telepsychiatry as opposed to "in-person.")

Conclusion

These wide-ranging solutions and recommendations have practical steps that can be taken by stakeholders within their professional ranks, in individual agencies and through their trade organizations. At the same time, a coordinated call to action for external parties, including state mental health and Medicaid authorities, CMS, SAMHSA and academic authorities, will also be needed to build support for these recommendations. The next section lays out steps for the Medical Director Institute's expert panel to take within their influential organizations.

The Medical Director Institute proposes these solutions as critical steps toward realizing the vision of psychiatrists practicing up to their level of licensure in a range of clinical settings. Psychiatrists trained and experienced with an expanded range of competencies in team leadership, collaborative care and interpretation of health care utilization data should lead teams of health care professionals and paraprofessionals. At the height of their profession, they can map out the presenting problem across a set of dimensions relating to primary care, behavioral health and social determinants. As facilitators, psychiatrists help orchestrate an equally full range of robust, dynamic and creative solutions that draw out patients' strengths, resources, natural community supports and complementary use of limited health care resources all designed to achieve the Triple Aim of improving health outcomes for the patient, achieving high levels of positive patient and family member experience and better managing limited health care resources.

The best practice tools in modern health care include interoperable health records, telepsychiatry links, apps and monitors to provide the patient and practitioner with emergent notifications, allowing for the mobilization of the team members to intervene. Increasingly, performance will also be measured via universal metrics such as reduced ED use and restrictive inpatient care, compliance with established best practice for chronic medical and behavioral health conditions, patient satisfaction and reduction in the total cost of care as measured for similar cohorts in other settings.

Recommendations and Call to Action

To implement the expansion of other health care professionals, the Medical Director Institute will continue to work with trade associations representing other health professionals through more accommodating regulations at the state and national level, expanded coverage by insurers and payers for the services they provide and uniform standards for supervision and licensure. (More specifics are contained in Section 6, Recommendations and Calls to Action.)

Recommendations and Call to Action

NOTE: At the time of this report's publication, there is great uncertainty regarding the future of federal support and parity requirements for access to psychiatric services. Both Congress and President Donald Trump are discussing their intent to make substantial changes to Medicaid, which funds 27 percent of all behavioral health services in America. However, the details and outcome are far from settled. The editors and expert panel members urge that President Trump, Congress and the new administration do not implement any changes that further limit access to psychiatric services. Rather, we urge that any changes undertaken by the new administration expressly enhance access to effective psychiatric services as contained in the recommendations of this report.

In this section, the Medical Director Institute lists specific, concrete and actionable recommendations to increase access to psychiatric services. The recommendations are specific to seven distinct stakeholder groups:

- Government;
- Payers;
- Health care treatment organizations and their state and national trade organizations;
- Advocacy organizations, such as the National Alliance on Mental Illness (NAMI) and national Clubhouse Coalitions;
- Psychiatrists and their professional organizations;
- Nurse practitioners, physician assistants and clinical pharmacists with specialty psychiatric certifications and their professional organizations and
- Psychiatric training programs.

"If all stakeholders take even just one action that is immediately feasible for them, meaningful improvements in access to psychiatric services will occur."

The recommendations are designed to present a wide selection of options so that any individual stakeholder can choose what is most immediately feasible within their individual scope of influence and practice. The Medical Director Institute does not assert that all these recommendations must be implemented. Instead, it asserts that there are at least three specific concrete actionable recommendations that any individual stakeholder can begin to implement immediately. If all stakeholders take even just one action that is immediately feasible for them, meaningful improvements in access to psychiatric services will occur.

Recommendations for All Stakeholders

1. Fund technical assistance to behavioral health systems to develop reimbursement mechanisms that supplement and eventually replace fee-for-service with measurement-based care. The goal is to remove the barrier between behavioral health and medical care to build models of intervention that link specific care management and best clinical practice tasks that lead to improved health outcomes, better patient experience and reduced total cost of care. There is

clear evidence of behavioral health's exponential impact on increased cost of care for chronic medical conditions and this recommendation will strengthen the health care delivery system that struggles with high-cost and high-risk populations. *This project is especially critical for models that incorporate social determinants of health into bundled payments, incentive models of reimbursement and total cost of care models.*

2. Provide training, technical assistance and capacity building to increase awareness in behavioral health settings of the link between behavioral health services and total medical expenditure, and develop strategies for intervention to establish foundations of reimbursement for clinical practice to shift the field (outside of small and solo providers) from fee-for-service reimbursements toward bundled payments that directly tie to improved patient outcomes *and reductions in the total cost of care.*

3. Remove barriers in state and federal law that restrict PAs and APRNs from providing psychiatric care consistent with their education and experience (i.e., laws limiting providing psychiatric services, signing documents to psychiatrists only). These types of barriers are also found in laws that exclude PAs and APRNs from the definition of mental health providers.

4. Implement new strategies to reduce the burden of documentation so information exchange can be timely and appropriate to the patient's clinical needs and so that psychiatrists and other health professionals spend less time on documentation. One possible strategy is a set of pilot programs sponsored by the National Council for Behavioral Health on clinical workflows that address these issues but remain in compliance with governmental and payer requirements.

5. While the recently released revised 42 CFR Part 2 regulation made some improvements, it remains a barrier to access to psychiatric services. SAMHSA and states should revise or eliminate all parts of 42 CFR part 2 and individual state statute and regulation that restrict use of SUD treatment information and any other behavioral health treatment information beyond what HIPAA requires for all other personal health information. The prohibition on use of SUD treatment information for investigations or prosecution and requirement for written consent should be retained. The current harmful restrictions include: consent to a specific organization unless listed disclosures are available; consent must be time limited; consent is limited to the minimum necessary for the specific purpose and, especially, the prohibition on re-disclosure.

   Across all clinical settings, confidentiality training can be updated to improve access to psychiatric expertise already in patient records.

   a. Do not overemphasize prohibitions and penalties on sharing information in organizational policies and training on HIPAA and 42 CFR Part 2.

   b. Confidentiality training should primarily emphasize the extent to and ways in which treatment information can be shared between clinicians, as well as with family members; training should encourage patients to involve families and not keep them at arm's length because it is more convenient for clinicians.

   c. Do not make reduction of a future hypothetical legal liability a higher priority than immediate health, safety and clinical liabilities.

6. Behavioral health care delivery — whether provided in specialty community organizations, hospital settings or primary care locations — should focus not only on what is "best" for the

patient, as determined by the appropriate clinicians, but on what the patient needs *and* wants from a whole person perspective (i.e., physical health, mental health, social services, community supports).

Disclaimer: While the majority of Expert Panel members strongly supported the recommendations on 42 CFR Part 2, two members representing SAMHSA advised that SAMHSA cannot support this recommendation.

Recommendations for State and Federal Governments

1. Federal and state governments can target funding for psychiatric residencies programs in the following areas:

    a. Increase federal and state funding of psychiatric residency programs that require residents to graduate with population health skills such as telepsychiatry, integrated behavioral health and team-based care with other health professionals.

    b. Increase funding for programs in which residents spend a substantial period of time — no less than one year — practicing in underserved communities (i.e., health profession shortage areas) including rural communities, FQHCs, correctional facilities, behavioral health treatment organizations and state hospitals — among other practice settings.

    c. Increase funding to incentivize residents to pursue psychiatric fellowship programs that have a pressing need for additional providers, such as child and adolescent psychiatry, addiction psychiatry, community psychiatry, consult-liaison specialists gifted at communication and leading teams and geriatric psychiatrists.

2. Develop regional and state collaborations on the psychiatric and behavioral health workforce that engage state agencies and federal agencies (e.g., SAMHSA, HRSA) in developing solutions to expand access to psychiatric services.

    a. Review with HRSA, the geographical distribution of professional mental health nurse practitioners (NPs) and PA psychiatric specialty programs in relation to documented regional/state public need for behavioral health services and to consider incentivizing professional mental health NP program development in these high need states.

    b. Collaborate with HRSA, APNA, AAPA and others to map development of specialty training programs for professional mental health NP fellowships and specialty training programs to certify PAs in psychiatry.

3. All states should pay for mental health services at FQHCs and pay for mental health services on the same day as primary care services at FQHCs. HRSA should encourage states to do so.

4. Expand the number of States Allowed to Participate in Excellence in Mental Health Act Certified Community Behavioral Health Center perspective payment methodology in order to remove financial incentives to minimize and limit access to psychiatric services.

5. Revise the Conrad 30 Waiver program so states can waive the return to home country requirement for J-1 visa physicians who are board certified or board eligible in psychiatry without psychiatrist J-1 visa waivers counting towards their states of 30 total slots. The revision should also include a waiver for psychiatrists who seek to practice in underserved areas.

6. Enforce network adequacy requirements for insurers and managed care organizations by deploying "secret shopper surveys" to ensure that wait time standards for counseling or psychiatry and geographic access within five miles of the member's home are maintained.

7. Closely examine psychiatric rate and access disparities and fully enforce MHPAEA and the new Medicaid access rule to assure that inadequate rates for psychiatric services — compared to rates and access for primary care — are not a cause of inadequate access and a non-quantitative limitation on psychiatric services.

8. Remove regulatory barriers to broader use of telepsychiatry.

    a. Include telepsychiatry as a distinct category that makes available sufficient psychiatric and medical information to allow for the prescribing of controlled substances. A telepsychiatry practitioner who prescribe controlled substances in line with the standard of care should receive one Drug Enforcement Agency (DEA) registration number with a telepsychiatry modifier (TP/state abbreviation). The certificate of registration, registration renewals, change of business address and termination of registration would remain the same. Changing the requirement to one DEA number for a prescribing clinician would enhance the ability to track prescribing patterns and identify the majority of clinicians that practice within the established guidelines, while enhancing the DEA's ability to review those who prescribe outside the guidelines.

    b. Unites States residency trained and state licensed practitioners providing telepsychiatry services living internationally who prescribe controlled substances must have a DEA registration in the state where the patient receives the telepsychiatry services. However, there should be an exemption for DEA registration at the international practice location and for the administrative inspections.

    c. Expand federal and state loan forgiveness to include telepsychiatry. Increase allowable NHSC encounter hours above the current 25 percent and lower the distance site HPSA score (i.e., do not require that the originating and distance site scores be the same). States should also allow increased telemedicine hours to count for direct time in state loan forgiveness programs.

    d. Eliminate the requirement that telepsychiatry is allowed ONLY in rural areas. Urban areas may have higher concentrations of psychiatrists per 100,000 citizens, but the number of psychiatrists serving public payers is often reduced because of urban psychiatrists who practice exclusively in cash-only practice.

    e. Eliminate requirements that require patients and clinicians to be located onsite at the clinic.

    f. Explore options for unsupervised telepsychiatry treatment.

    g. Pay for telepsychiatry at the same rate as in-person psychiatric services.

9. Put psychiatry Medicare GME at parity with primary care GME by:

    a. Revising the direct GME calculation for psychiatry residents to use the same or a higher per resident amount as for obstetrics and gynecology (OB/GYN) and primary care, since there is a greater shortage of psychiatrists than of primary care physicians (PCPs) or OB/GYNs.

b. Revising the redistribution requirements for unused Medicaid direct graduate medical education (DGME) training slots to be such that psychiatry residency training slots cannot be reduced and psychiatry along with primary care and surgery should account for at least 80 percent of all Medicare GME resident funding slots.

10. Increase support for training and payment of psychiatric mental health nurses, APRNs and PAs working in psychiatry as psychiatric prescribers and BCPPs supporting prescribers through mechanisms, such as graduate education funds and Medicare pass-through dollars by:

    a. Allocating state and federal funds to support psychiatric prescriber training programs that require population health skills: telehealth, integrated behavioral health and team-based care.

    b. Apportioning state and federal funds for psychiatric prescriber training programs in which trainees spend substantial time (at least one year) practicing in underserved communities (i.e., HPSAs), including rural communities, FQHCs, correctional settings, mental health centers, state hospitals and other settings.

    c. Allotting state and federal funds for addiction and MAT for opioid use disorders (applies to APRNs and PAs).

    d. Support preceptor costs of psychiatric prescriber clinical training, including GME funding from Medicare pass-through funding.

    e. Collaborate with HRSA, APNA, AAPA and CPNP in the regular review of the geographical distribution of psychiatric prescriber training programs and the impact of their graduates on HPSAs.

11. CMS and the American Medical Association (AMA) should develop new Current Procedural Terminology (CPT) codes for billing population health models of care/team-based care that incorporate psychiatric services in behavioral health settings, like the new Medicare code for chronic care management targeted to behavioral health conditions, to increase access to non-face-to-face psychiatric consultation services and measurement-based care.

Recommendations for Payers

The current reimbursement system and rates for psychiatrists leads to medical students not choosing psychiatry as a profession and psychiatrists choosing to not accept insurance and run cash-only practices, which limits their impact. Earlier medical intervention models in which there was less understanding of how the mind works, less attention to the complexities of treatment that go beyond psychotherapy and implicit, if not explicit, stigmatizing response that psychiatrists are not “real doctors” ended several decades ago. It is time for all stakeholders to re-examine the value of psychiatric treatment and support fair compensation. Without these changes, there is little incentive beyond passion for the practice to engage additional medical students in this line of work.

Payers recognize that increasing the overall funding for mental health would enable providers to increase capacity and, therefore, access for people with mental health needs. However, too often there is no latitude available to increase the amount spend on mental health. The following recommendations

present strategies that payers could adopt to increase access to evidence-based mental health care in the absence of — or limited — overall increases in funding and provide fairer compensation for providers of psychiatric services:

1. Work with providers, clinical subject matter experts and researchers to promote care models in behavioral health treatment organizations with reimbursement to match the practices and to provide incentives for improved outcomes and reduced total cost of care. Through joint design among clinicians, funders and rate-setters, a clinical problem that is trying to be solved will be financed as a driver to promote a solution and improved clinical outcomes. Specific suggestions include:

    a. Contract for services with bundled payment models in behavioral health programs similar to the CoCM developed for primary care practices. This will increase access to psychiatric services.

    b. Develop and test models for data-driven triage, treatment, decision-making and outcomes tracking for improved effectiveness.

    c. Ensure adoption of billing codes that support models of integration of behavioral health into primary care settings. (See prior recommendation on CMS and AMA developing new codes.)

2. Increasing the effectiveness of each individual psychiatric service with standardized measures of outcomes and partnership among payers, policymakers, providers and consumers can increase access to psychiatric services. To that end:

    a. Payers should engage in value-based purchasing based on measurable outcomes that will, in turn, increase access.

    b. For those patients with serious mental illness and other high-risk, high-cost populations, explore opportunities to take risk for total medical expenditure. This will increase the financial envelope available for wraparound services and improve outcomes.

    c. Payers can work with CMS to develop MACRA performance measures pertinent to psychiatric services. The field widely accepts measures such as the PHQ-9, GAD-7 and Physician Quality Reporting System (PQRS).

"While upside and downside pay for performance incentives are essential to improve care, the models for bundled payments, total cost of care and incentives for savings based on outcomes must be based on the actual cost to the provider of delivering the service as opposed to the claims paid for delivering the services."

3. Payers should have an in-house psychiatric medical director directly participating in financing, rate-setting and payment model planning and decisions.

4. Where possible, incentivize providers to operate "open access" or walk-in clinics where no advance scheduling is required.

5. As initial engagement can be a barrier to access, pay higher amounts for first appointments to incentivize providers to target harder-to-reach populations.

6. Include telepsychiatry as a covered service and encourage use by:
    a. Reimbursing telepsychiatry on par with face-to-face care.
    b. Allowing telepsychiatry to be conducted directly to patients at home and not require that the patient and provider be in a clinical setting.
7. To improve access to psychiatric care in EDs, payers can:
    a. Pay for mental health assessments in the ED to ensure people get the right care and the lowest level of care. Payers can also help coordinate care and move people out faster.
    b. Build and promote alternatives to the ED, such as the Illinois' living room concept.
8. Set the rate paid for psychiatric services high enough to cover the actual cost of providing the psychiatric services so that providers do not have a business incentive to minimize and limit access to psychiatric services and psychiatrists do not have a financial incentive to limit their practice to cash only.
9. Cover payment for collaborative care in primary care at no less than the Medicare rate.
10. Reimburse for psychiatric services that leverage evolving technologies for increased access to psychiatric expertise. The incentives will allow patients to track, monitor and communicate with their providers and establish a standard of care around effectiveness. Recommendations include:
    a. Developing a model to incorporate evolving technologies (e.g., smartphone apps, texting, web apps) into reimbursement methodologies.
    b. Encouraging telementoring approaches (i.e., consultation and training provided from one practitioner to another), like Project ECHO, to reduce the burden on specialty behavioral health by improving the care of mild-to-moderate mental illness in primary care.
    c. Promoting use of eConsult in both the primary care and psychiatric consultant domains to allow effective treatment in the primary care setting for as long as possible.
11. As newer models of care, such as telehealth become more widely available, ensure that administrative policies do not make the process overly burdensome for providers and members. When efforts are taken to reduce administrative burden upon implementation of these innovations, they will be much more effective and broadly adopted. Increased technologies increase psychiatrist efficiencies and patient access.
12. Design payments with population-based health components in mind with the actual cost of delivering direct psychiatric services in the bundled payment calculation. The formula should also include indirect psychiatric services and psychiatric administration and leadership time factored in, including:
    a. Psychiatric liaison services.
    b. eConsult.
    c. Registry review.
    d. Provider-to-provider consultation.
    e. Case-based learning with PCPs.

f. Asynchronous communication (e.g., secure messaging, text).

g. Collaboration, consultation and/or supervision with other psychiatric prescribers, which varies by state.

h. Team-building, management and leadership.

i. Extended Care Health Option (ECHO) programs and other integrated teaching modalities.

13. Closely examine psychiatric disparities in comparable reimbursement rates and access standards to assure compliance with MHPAEA and the recently promulgated Medicaid access rule by assuring that inadequate rates for psychiatric services (compared to rates and access for primary care) are not a cause of inadequate access and a non-quantitative limitation on psychiatric services.

14. Remove restrictions in certain states of management of common medical conditions by psychiatrists.

15. Work with providers and regulatory bodies such as The Joint Commission, CMS and state mental health authorities to reduce the burden of documentation and to standardize requirements. Eliminate documentation requirements that do not have a clear immediate added value to care and help assess the length of time needed for a psychiatric appointment.

16. Where states allow, incentivize the involvement and roles of other professionals and other non-medical prescribers in care delivery.

Recommendations for National Organizations and Treatment Organizations

Along with the APA, APNA and AAPA, the National Council and its members are poised to be effective champions of the following recommendations for states and the federal government:

1. To attract and retain psychiatrists in public settings, community-based behavioral health programs can implement several solutions:

   a. Cease limits on psychiatrists' work to diagnosis and medication visits.

   b. Reduce unnecessary and burdensome documentation requirements.

   c. Ensure the presence of a board-certified psychiatrist medical director who can adequately supervise, mentor and support staff psychiatrists and other providers.

   d. Conduct an appropriate budget analysis of not only personnel costs and collections, which currently demonstrate psychiatrists and other providers whose revenues do not cover costs, but also the total value to more effective care and the saving and cost containment of the time the psychiatric provider spends on teams, in consultation to primary care, etc. The analysis should calculate a relevant value unit credit for work outside of direct patient care.

   e. Provide adequate nursing and administrative supports to allow efficiency of psychiatric assessments and follow-up appointments. Such enhancements could reduce appointment times in some current systems and make appointment times more manageable in others.

   f. Ensure executive-level leadership and attention to psychiatric provider burnout, retention and appreciation.

2. Behavioral health treatment organizations and other clinical practices should shift their allocation of psychiatrists' time toward liaison services and capacity-building for other providers, especially primary care, pediatrics and obstetrics. The goal is for these providers to treat mild to moderate mental illnesses outside of the specialty behavioral health setting; other providers will refer only patients with the most severe problems for psychiatric services. Psychiatrists and other providers can support primary care to maintain patients who return from inpatient episodes of care and continue taking psychotropic medications.

"This transformation must take place concomitantly with the full integration of a community-based system of care that recognizes psychiatric access' effect across health care systems and goes beyond support through simple fee-for-service payment."

Community-based behavioral health programs can adapt a range of existing solutions, including:

a. Establishing and working on teams as psychiatric consultants utilizing the CoCM to effectively treat mild to moderate mental illnesses in the primary care — and potential specialty care — settings. This approach can limit the flow of patients to those who truly need more direct evaluations in specialty settings and to extend existing psychiatric expertise by an order of magnitude.

b. Making psychiatric eConsultation available in primary care settings.

c. Implementing provider-to-provider consultation such as the Massachusetts Child Psychiatry Access Project (MCPAP).

d. Adopting asynchronous communication (e.g., secure messaging, text).

e. Enduring collaboration, consultation and/or supervision with other prescribers, which varies by state.

f. Employing Project ECHO programs and other approaches to case-based learning for primary care and other providers.

3. Include a psychiatric medical director with a meaningful amount of time, at least 50 percent (except in very small organizations), for administrative and leadership duties and a meaningful amount of authority within the organization to manage and lead, including participating on the executive team in strategic planning, daily operations and management, and with final responsibility for clinical policy. The model from American Academy of Child and Adolescent Psychiatry (AACAP) is a standard for best practice to be adopted for provider organizations.

The Medical Director Institute will develop model job descriptions for the positons of staff psychiatrist and Medical Director that allow the diverse range of duties and qualifications for each position.

4. Hire and use psychiatric mental health APRNs and PAs with specialized psychiatric training in a stepped care team practice that allows utilization of the psychiatrist and other professional to practice at the top levels of their skills and credentials. How these stepped decisions are implemented will vary with the experience level of the other professionals, but general guidelines include:

    a. Initial assessments and routine follow-up visits should be done primarily by other psychiatric professionals.

    b. Psychiatry should be consulted by the other psychiatric professionals following initial assessment and if/when the patient's condition does not improve.

    c. Use standard symptom measures to track improvement over time and identify patients who are not improving.

5. Primary care providers should be encouraged to enhance their competencies in psychological interventions, interviewing skills, mental health diagnosis and management of common milder mental health problems.

6. Psychologists, psychiatric social workers and licensed professional counselors should be used for psychological interventions, interviewing skills, mental health diagnosis (if within their training and scope of practice) and management not involving medications.

7. A psychiatric pharmacist could be included as an integral member of collaborative care teams in behavioral health to improve patient outcomes through more comprehensive medication management. This could include management of Clozaril or long-acting injectable (LAI) clinics, for example. In addition to routine medication services, psychiatric pharmacist could be included.

8. In the primary care setting, the CoCM of psychiatric consultation should be employed to best use the limited psychiatric expertise for consultation, including registry reviews, education and care manager support in a stepped care fashion that does not utilize psychiatry for the typical routine initial assessments and routine follow-up visits.

9. Behavioral health treatment organizations need to build skills, competencies and infrastructure to develop financial models matched to patient outcomes to operate with bundled payment methodologies that include costs of care that are incurred outside of the organization.

10. Telepsychiatry, including "tele-teaming," should be widely adopted to address the geographical maldistribution of psychiatrists and used in multiple settings, including medication clinics, collaborative care in primary care offices, EDs, correctional setting and schools to address shortages

11. Leverage evolving technologies (e.g., smartphone apps, texting, web apps) to allow patients to track, monitor and communicate with their providers to track patient history, current prescribers and prescriptions and acute episodes of care in inpatient setting and EDs

12. Organizations providing community behavioral health should develop, implement and utilize measurement-based outcomes with standardized assessment tools such as the PHQ-9, GAD-7, PQRS and Merit-based Incentive Payment System (MIPS) measures, along with patient registries, and build models to demonstrate their interventions' effectiveness, monitor total cost of care and match agency effort to the bundled payments they receive.

13. Participate in advocacy. State and federal entities cannot enact these recommendations without the support of their communities. Along with the APA, the National Council and its members can be an effective champion to enact these recommendations for states and the federal government. Let your state and federal entities know what you need, invite representatives to visit your organizations and get to know your elected officials. Show them the impact of good (and inadequate) care.

14. Support local consumer and family advocacy organizations. They can help articulate the message on the value of access to effective services to elected officials and regulatory agencies.

Generate a white paper to enhance interprofessional training collaboration of behavioral health treatment professions and engage with members of other health professions in the effort. Leaders would represent psychiatrists, directors of psychiatric residency training, PNs, PAs and pharmacists (e.g., APA, APNA, American Association of Directors of Psychiatric Residency Training (AADPRT), AAPA, Association of Physician Assistants in Psychiatry (APAP) and CPNP).

Recommendations for Psychiatrists, Advanced Practice Registered Nurses, Physicians Assistants, Board Certified Psychiatric Pharmacists and Their Professional Organizations

1. Along with the National Council, APA, APNA, AAPA, APAP and CPNP will serve as key champions of the calls to action for recommendations listed for state and federal government.

2. The APA should continue to strengthen policy position, standards for practice and training curricula for psychiatrists and other providers to encourage expanded skill sets such as data-based decision-making, population health management and assessing the impact of behavioral health on chronic medical conditions. These additional skill sets will allow them to consult with, and practice in, primary care practices, FQHCs and specialty practices for chronic diseases.

3. APA, APNA and AAPA can strengthen collaboration with other behavioral health professionals and their trade associations to encourage team-based care, delegation of responsibilities and coaching to improve engagement with the patient panel in their practice settings.

4. Broaden psychiatric practice beyond diagnosis, medication management and psychotherapy. Psychiatrists should also routinely provide team-based care, psychiatric consultation to primary care and other psychiatric clinicians and collaborative care.

5. APA can promote adoption of evolving technologies (e.g., web apps, texting, smartphone apps) to allow patients to track, monitor and communicate with their providers allowing more patients to receive care more promptly in less time.

6. APA, APNA, AAPA, APAP and CPNP can encourage their members in whatever setting to organize their practices and work routines to increase their interactions with, and responsiveness to, other medical professionals (other M.D.s) in the interest of collaborative care, problem-solving complex clinical presentations and support and consultation in their areas of clinical expertise.

7. Develop platforms to develop skills among professional mental health RNs and PAs with specialty psychiatric certifications to be effective in integrated care teams (i.e., care management, telephone triage, comprehensive screening, collecting patient history components, delivering low intensity mental health interventions (in stepped models), engagement strategies).

8. Psychiatrists should not limit their entire practice to cash only patients. Psychiatric conditions especially serious mental illness cause cognitive impairments that make it difficult for patients to understand and manage their own insurance claims. Patients covered by Medicaid and Medicare are not allowed to submit their own claims. All patients deserve access to psychiatric care.

Recommendations for Training Programs

1. Integrate the following population health skills into general psychiatry milestones for psychiatry residents (or the equivalent competencies for psychiatric APRNs, psychiatric PAs, PAs working in psychiatry and BCPPs) and evaluate during training and at recertification:

    a. Telepsychiatry.

    b. Integrated behavioral health, specifically collaborative care.

    c. Team-based care.

    d. d. Population health management.

    e. Collaboration with other psychiatric prescribers, which varies by state.

    f. Leadership, team building and management.

    g. Teaching behavioral health topics to primary care and other health providers (i.e., ECHO programs).

2. American Association of Directors of Psychiatric Residency Training (AADPRT) and the APA maintain and endorse national model curricula to apply these recommendations in a population health approach and align training in unique ways to address the psychiatrist shortage, integrate these tools into the orientation of general psychiatry training directors and regularly survey U.S. training programs to measure dissemination. Similarly, the equivalent organizations for PAs and APRNs should do the same for their faculty and trainees.

3. Primary care training programs should expand and enhance psychosocial and behavioral health components of their training to include:

    a. Increased behavioral health training in outpatient settings.

    b. Education of the biopsychosocial model to build on the biomedical model.

    c. Improved interviewing skills and personal awareness.

    d. Basic psychological intervention skills.

    e. Exposure to integrated care models.

4. Professional organizations representing psychiatric prescribers (e.g., APA, APNA, AADPRT, AAPA, APAP, CPNP) can collaborate with the National Council to generate a white paper to enhance inter-professional training collaboration.

5. The National Council, in partnership with AADPRT, APNA, AAPA, APAP and CPNP, can develop and maintain a population health endorsement for psychiatry residency or psychiatric prescriber

training programs that require skills in population health, data-based decision-making and review of claims data for graduates.

6. Increase rural or underserved tracks and rotations that allow psychiatry residents, APRN students, PA students, PA postgraduate psychiatry and BCPP residents to provide clinical care and population health services to HPSAs and public psychiatry settings (e.g., correctional facilities, state hospitals).

7. Admissions committees for psychiatry residency and psychiatric prescriber training programs should consider the high need for culturally and linguistically appropriate services (CLAS) and workforce needs in underserved areas when recruiting trainees.

8. Encourage health professions training programs to offer students and residents exposure to the full range of alternative community-based settings with emphasis on:

    a. Peer-run and patient-run programs such as clubhouses, peer-run respite programs and peer support programs.

    b. Programs that provide wraparound model of care with family partners trained in the model.

    c. Assertive Community Treatment (ACT) programs.

    d. Medication-assisted programs.

    e. Emergency services programs that operate diversionary programs such as crisis stabilization, respite and mobile outreach that are effective in diverting inpatient admissions and reducing ED use.

    f. Admissions and reducing ED use.

Recommendations for Patient and Family Advocates and Organizations

1. Personal stories are invaluable in improving the health care delivery system. Individuals should talk about their experiences and get active. Encourage them to get to know their legislative officials and participate when action alerts are released to protect the behavioral health care system.

2. Challenge local, state and national advocacy organizations to speak up, to take a stand and get involved.

3. Ask questions. Push for information about why something is being done, or not done, until full understanding is attained.

4. Individuals should challenge their health care providers and/or family member to understand what they need and want. The system will not change if people's voices are unheard. Offer solutions to create places to participate as part of patient/family panels within treatment organizations, hospitals, FQHCs and other settings.

Appendix 1

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Appendix 2

Other Health Professionals Involved in Behavioral Health Diagnosis and Medication Treatment

Other professionals are a welcome addition to the workforce that serves people with behavioral health conditions. Their presence strengthens the team approach, adds another voice to the multidisciplinary team and allows more delegation by the psychiatrist to encourage clinicians to practice up to their level of licensure, freeing up the psychiatrist for professional endeavors on the clinical team. These professionals work collaboratively at the state and national level, coming together to advocate for mental health parity, reduction of stigma and more creative methods of integrating primary and behavioral health care. At the same time, each of these professionals ensures high quality licensing and credentialing standards to safeguard the public trust.

Primary care physicians remain the largest prescribers of psychotropic medications; however, over the past 20 years, many other health professions gained additional capacity to participate in the mental health and substance use disorder field as prescribers and clinicians. As evidenced by SAMHSA's November 2016 announcement expanding the right to prescribe buprenorphine to nurse practitioners and PAs to combat the opioid use disorder epidemic, these professionals now play a critical role in filling the shortage of psychiatric prescribers in the U.S.

"Primary care physicians remain the largest prescribers of psychotropic medications."

Psychiatric Clinical Nurse Practitioners/Advanced Psychiatric Registered Nurses

Psychiatric clinical nurse practitioners, sometimes referred to as Advanced Psychiatric Registered Nurses (APRNs), deliver many psychiatrist services and are members of the workforce as licensed practitioners in every state. Their scope of practice is largely directed by state scope of practice laws; currently 21 states and the District of Columbia have full practice authority allowing APRNs to diagnose, treat, order diagnostic tests and prescribe to patients without physician oversight under the licensure authority of the state board of nursing (state by state summary available at www.medscape.com/viewarticle/440315). Approximately 140,000 APRNs practiced in 2014, and 13,815 psychiatric mental health APRNs currently specialize in psychiatry, according to the American Psychiatric Nurse Association (APNA). By 2025, there will be 17,900 psychiatric mental health APRNs[35].

Physician Assistants

Physician Assistants (PAs) also function as psychiatric medication prescribers, as permitted in many states. According to the American Academy of Physician Assistants (AAPA), there are approximately 1,000 PAs prescribing psychiatric medications in the U.S. The general data on the PA workforce suggests that they are relatively young compared to other professions — only 17 percent are 55 or older, according to a recent survey. There were an estimated 93,000[36] PAs practicing in 2014.

Board Certified Psychiatric Pharmacists

A Board Certified Psychiatric Pharmacist (BCPP) is a pharmacist who enters a collaborative practice agreement with a physician to assist with medication management. They are usually not allowed to make an initial diagnosis, change a diagnosis or admit or discharge patients from acute settings. However, they may order referrals and labs or consults, assuming the collaborative practice allows for these types

of services and monitoring. Currently, the College of Psychiatric and Neurologic Pharmacists (CPNP) estimates that there are currently 955 BCPPs in the U.S., and by 2025, there will be more than 2,400.

Psychologists

Currently, psychologists may prescribe in four states — Iowa, Illinois, New Mexico and Louisiana — as well as in Guam, the Public Health Service and the U.S. military. The concept of psychologists as prescribers is not without controversy because it bypasses traditional medical training and there have been no outcome studies to assess impact on increasing access or quality of care.

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