ASSESSMENT OF JACKSON COUNTY COMMUNITY MENTAL HEALTH FUND GRANTEES' PSYCHIATRIC PRESCRIBING CAPACITY

Prepared for the
Jackson County Community Mental Health Fund
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—REPORT CONTENTS—

Executive Summary

The Jackson County Community Mental Health Fund (JCCMHF or the Levy) began receiving anecdotal reports of seriously ill residents needing psychiatric medications several years ago. These individuals have been seeking intermittent care through some of the County's special population or niche providers – providers not historically structured or funded to provide these services. Reflecting its concern to better rationalize its planning for these high cost resources ('…to assure strategies that improve and sustain access…'), the JCCMHF initiated a five month study of capacity and demand for psychiatric prescribing services. A central question for Integrus Health Group as we undertook the study --- was whether there were adequate capacity to share prescribing resources between its CMHCs, FQHCs and Children's Center and some of the niche providers.

Integrus identified a number of factors that seem to play a key role in the appearance of under resourcing through the use of quantitative and qualitative methods. We estimate that the current demand exceeds easily accessible capacity by 10%. This estimate is based on niche provider reports of 243 incidents of seriously ill individuals seeking help over a three-month period. While this is fairly modest and would not appear to overstretch current system-wide capacity, the distribution of prescribing professionals at the provider level may not consistently match the demand coming from one or more niche providers. To better understand this and to enable JCCMHF to manage public resources in a more predictable manner, Integrus developed a model for quantitatively assessing capacity. Capacity itself, the actual ***availability*** of prescriber resources, is dependent on a complex interplay of variables as demonstrated in the schematic on page 6 of this assessment. Among these are no show rates, direct vs indirect care hours for each prescribing professional, case mix i.e. severity, complexity of the case load, other supportive services, management of utilization and transition of patients from specialists to others, such as physician extenders or primary care providers.

The study points point to improved program operations as well as 'system efficiencies' as a key component in addressing capacity, with several recommendations that can be put into place in short order in tandem with several that are mid- or longer-term in nature. Integrus recommends the initiation of several projects that have been 'in waiting' with the caveat that the short and longer-term structural work be undertaken – as follows:

- simple steps such as a short but important gathering of additional information from niche providers to better quantify and define the population in need and from the Centers to tailor or calibrate the quantitative assessment;

- expanding and improving upon formal agreements between niche providers and the Centers;
- enhanced management practices across JCCMHF's provider community for these high-cost resources – by more consistent adoption of utilization review processes; and
- support for innovative delivery and reimbursement models, including the catalyzing of integration, the use of consultation to increase effective capacity, and training of future staff within such innovative settings.

JCCMHF can play a pivotal role in rationalizing the use of public funds, building on its critical fulcrum as not only a funder but as a planner and overseer to assure accountability. Building such infrastructure with an aim to balance resource allocation reduces the intensity of stressful competition needed to obtain scarce resources -- a preoccupation of most management teams due to more than a decade of retrenchment in public funding. It is, as well, an essential ingredient in the creation of community – a cornerstone for mental health.

Acknowledgements

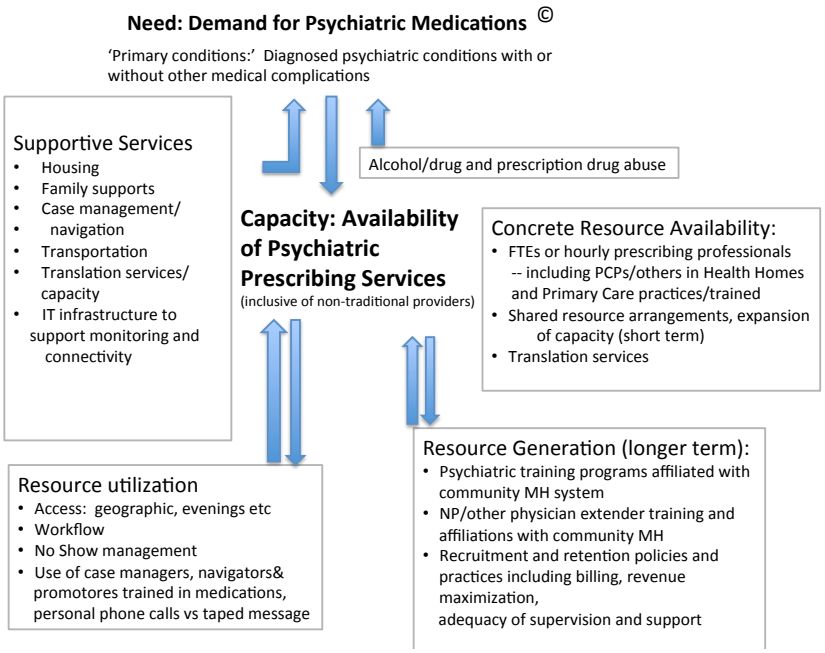
Integrus Health Group wishes to thank JCCMHF's Board, its very engaged Chair, Jackie Moore – and its leadership, Bruce Eddy, Ph.D. and his energetic staff, particularly Theresa Cummings, for their very substantive assistance in the development of this undertaking. It has been our privilege to work with an enlightened regulatory authority interested in the most objective allocation of public resources to address emerging and historic need in a community undergoing change. In the course of this work, we have developed the highest regard for the provider community, among which we have found several who not only embrace but also embody 'best practice' and in some cases, have become trend setters nationally. Due to the time constraints, we regret not having more on-site interface with peer and family advocates.

I. Introduction

Over the past several years, The Jackson County Community Mental Health Fund, hereafter referred to as JCCMHF or the Levy, has heard from numerous sources that people with acute, serious behavioral health conditions requiring medication assistance have been seeking help from some of its providers not traditionally resourced to provide psychiatric prescribing. There has at least been the appearance of a gap in prescribing capacity, and in JCCMHF's attempt to respond to a critical need while carefully shepherding public resources, its leadership has wanted to clarify both demand and capacity in the system through addressing the immediate need as well as the root cause. An RFP was made public on September 15, 2015 that spoke to the following:

"This project should quantify the extent and nature of the need for prescribers among Levy grantees (Need)…and 'current service capacity for prescribers among Levy grantees, and gauge grantees' ability to accept additional referrals (Capacity), in order that future projects develop strategies to improve and sustain access. "

Integrus Health Group, a team of specialists drawn from medical/psychiatric, administrative, quality and informatics backgrounds, was selected from among several proposals. The schematic below best captures the approach taken by Integrus to understanding the factors or variables that impact on the actual availability of prescribing resources.



Schematic i: Integrus Health's Conceptual Framework for Capacity

At a broader policy and practice level, not only has there been a national shortage in psychiatry (both adult and child), but the use of psychiatrists as sole prescribers. Much as the use of specialists in any medical field leads to impacted caseloads and reduced access (with unmet need for specialty consultation when it can and should be sought), this becomes financially prohibitive. That nearly 80% of psychiatric prescribing is done in primary care settings reflects this 'unmet need' of decade's duration is general health settings – where often psychiatric prescribing has been carried out by professionals without training in psychiatric diagnosis and psychotropic medications. More recent 'best practice' calls for better integration between primary care and specialty behavioral health, yet requires a careful strategy for interfacing systems, transferring patients from one to another system (bi-directionally) and assuring the skill level and scope of practice for prescribing practitioners. Importantly, changes in reimbursement with movement toward performance-based payment will soon be impacting how resources are paid for – from the federal to state and local levels.

II. Methodology

To conduct this assessment, Integrus utilized a multifaceted process to gather both quantitative and qualitative information to inform our understanding and subsequent recommendations. This included the following approaches:

- Document reviews;
- Grantee Community Forum;
- Formation of a Task Group;
- On-line Grantee Survey;
- On-Site visits with selected grantees.

Document Review

The Integrus project team reviewed pertinent materials and documents provided by JCCMHF to familiarize itself with JCCMHF's structures and service provider network. This provided an initial understanding of the breath and scope of the system's design and capacities.

Grantee Community Forum

A grantee community forum (Town Hall format) was conducted to launch the process and to introduce the Integrus team to JCCMHF's grantees. All JCCMHF grantees were invited to participate. The purpose of the Forum was to give all grantees an opportunity to share their perspectives on the system strengths, challenges and discuss opportunities/areas for improvement. Approximately 32 individuals participated representing 25 grantee organizations (from among CMHCs, FQHCs, Children's Centers and Special Population Providers such as domestic violence shelters and homeless population services).

Formation of Task Group

A group of fourteen (14) grantees was selected from the entire set of grantees representing each of the categories of services to achieve the following:

- To review the On-line Survey and insure that the information requested was clear and could be actually collected.
- To review the Draft Report and assist in clarifying any conclusions that were not accurate based on information not available through the meetings and surveys.

On-Line Grantee Survey

Integrus developed an initial draft of an on-line survey as a mechanism for gathering information from all of JCCMHF grantee organizations. The Task Group, including review by JCCMHF staff, provided invaluable guidance and feedback that Integrus incorporated into the final surveys. The grantees requested and were given four (4) weeks to submit the on-line survey. The on-line surveys were electronically transmitted to JCCMHF's thirty-four (34) grantee organizations. At the end of the survey period, eight Center (CMHC and FQHC) and fourteen specialty provider surveys were submitted; resulting in a 67% survey submission rate, a rate of return that is well above the expected and which indicates the level of interest in and participation by the provider community.

On-Site Visits

On-site visits with a sample cross-section of selected grantee organizations were conducted. Over a three-day period 2-3 hour interviews were conducted with two (2) special population providers; two (2) CMHCs; two (2) FQHCs; and one (1) children' center. In addition, an hour-long telephone interview was conducted with NAMI's Executive Director. The purpose of the on-site interviews was three-fold, to:

1. gather individual provider perspectives and experiences relative to their own prescribing capacity and as well as their relationships with niche providers;
2. have a deeper more intimate discussion related to the capacity question than the Town Hall format or survey afforded; and
3. follow-up and clarify information submitted via the on-line survey.

The on-site interviews were conducted with either individual/s or a group of key informants that generally included the grantee organization Executive, Clinical and Finance Directors, Behavioral/Mental Health and/or other Program Managers, Quality Assurance and Billing Managers and/or Supervisors. During the course of the on-site time, Integrus met with a total of 35 individuals from the seven (7) grantee organizations visited. Additionally, Integrus was able to meet with one major training center.

Study Limitations

- Data from one of the larger centers is not reflected in this report, our calculations and findings due to a delay in completion of the survey until very late in the drafting of the report. While Integrus will provide feedback on the information provided, this resulted in it not being possible to incorporate their information in the report.

- The construction of a few of the survey questions may have resulted in less uniformity in the data collection.
- As a first 'study' on this issue, it was advisable NOT to have the surveys become too lengthy, and consequently, Integrus was able to gather and assess only this first round of information gathering.
- Additional 'demand' may exist as reflected in people who are placed on wait lists but drop off and are not currently captured by the Center's information systems (which are driven by claims data and such individuals, because they have never made it to an evaluation are therefore not captured). This can be a significant and important number from the larger standpoint of 'access' but was not the focus of this more limited study.

III. Capacity Findings

In order to address the core question that prompted this five-month study ---**asking whether the JCCMHF's grantees with prescribing capacity were able to accept additional referrals from niche providers** -- Integrus included capacity questions within the center and specialty provider surveys. The surveys provided the following results:

- The Centers employ or contract with 18.5 full time equivalent (FTE) adult psychiatrists and advanced practice nurses (APN) in psychiatry;
- The Centers employ 12 FTEs in child psychiatry and child and adolescent APNs in child psychiatry;
- 9,601 adults and 5,634 children and adolescents required prescriber services;
- Specialty providers reported 243 persons quarterly, extrapolating to 972 annually, requiring unmet prescriber services.[1] This number may be smaller if there are duplicated individuals among those reported.
- Four (4) of the Centers reported a total of 15 FTE non-psychiatry prescribing professionals (including Family Practice and Nurse Practitioners) willing to prescribe psychiatric medications.

A. Assessment of current capacity

Before addressing whether the system could accept additional referrals, Integrus needed to examine whether the existing capacity was sufficient to serve the current population of adults, children and families. Integrus developed a methodology to address this question.

To conduct this analysis required an understanding of ***both*** capacity and demand:

- **For capacity (the prescriber side of the analysis**), a gathering of the number of prescribers in the system was necessary, ***and*** the time available to them for direct patient care, which were seen as time for psychiatric evaluation and medication management. Several assumptions were made pertaining to non-direct patient care activities, i.e. meetings, supervision, treatment planning, documentation as well as employer leave (holidays, sick, vacation, etc.).

[1] For the current purpose of determining the sufficiency of the system to accept additional referrals from the specialty providers for the

- **An *initial* proxy for demand** was based on need for psychiatric evaluations and ongoing medication management as well as the frequency of these activities per participant using the estimated 972 additional' intakes' that would be generated from the niche providers' unmet 'need.' It is recognized that additional 'unmet demand' exists, but was outside the scope of this study.

Integrus' methodology incorporated the variables highlighted above using the "best estimates" reported through the survey for both adults as well as children and adolescents requiring prescriber services. These figures served as the starting point to assess the sufficiency of prescribing capacity and demand to serve the existing population and to determine if the system could accept additional referrals from special population providers.

B. Using variable rates of direct vs indirect time

In the analysis below, Integrus has used three slightly different assumptions on the amount of time available for prescribing activities: the first, 50% of a full-time equivalent would translate to 20 hours weekly; the second, 60% would translate to 24 hours weekly; and the third, 70% would translate to 28 hours weekly. While it has not been within the scope of this study to delve more deeply into the actual allocations used on a per facility basis, Integrus has been able to make some preliminary projections based on information gleaned from the Surveys and on-site interviews.

C. Using variable service utilization patterns

The methodology utilized three different service utilization patterns. Integrus established High, Moderate or Low service utilization categories to assign service participants who required prescriber services. *High users* of services are those who would require more direct prescriber contact/time than the *low utilizers* of services. For instance, an individual recently placed on a medication regimen requiring regular visits might well be seen every month even more initially, especially if there were complicating factors, while someone long stabilized on medication might be seen on a quarterly or less frequent basis. Particularly when there are other supportive services or outlets – such as trained outreach staff whether nurses or care managers, school-based consultation etc. – the demand for more frequent prescriber contact can be reduced. Based on these variables, Integrus has calculated and projected the number of prescribers required to meet the needs of the current population as well as approximated the adequacy of capacity to meet the needs of the special population providers.

D. Quantitative Findings using Capacity Modeling

Using the variables outlined above, Integrus has used the assumption that most Centers are operating at roughly 60% direct time. This is reflected in Tables 1 and 2 below. (Appendix G contains a more detailed set of tables used to analyze capacity, including varying assumptions of provider "direct care time" and of patient "services utilization patterns.")

In Table 1 below, 60 % direct care time is being used. What is shown is that with appropriate management, there is likely prescriber time available inside the Centers themselves.

With only 1.4 and .9FTEs as seen in scenarios 1 and 1A respectively, the system is nearly in equilibrium. However, adding 10% demand or the estimated 972 individuals coming from the niche providers would create significant pressure on the system .The number of FTE's required at this higher level would jump to 3.4-4 FTEs. With improved management, it can be anticipated that 30% additional capacity can be freed up, but this will require time and consistent focus.

Adult System Table 1:
FTE Projections for Adult Prescribers at 60% Direct Care Contact [2]

	Adults Served	High Users	Moderate Users	Low Users	60% direct care contact	Adult Prescribers (FTEs) in System	Difference
Scenario 1	9,601	25%	35%	40%	19.9FTEs	18.5	**-1.4FTE**
Scenario 1A	9,601	25%	25%	50%	19.4FTEs	18.5	**-.9FTE**
Scenario 2	10,561	25%	35%	40%	22.5FTEs	18.5	**-4FTEs**
Scenario 2a	10,561	25%	25%	50%	21.9FTEs	18.5	**-3.4FTEs**

Table 2 on Children and Youth also reflects a system that is near equilibrium. At 60%, an excess of .4FTE prescribers would be available to serve a population of 5,634 for Scenario 1. When the frequency with which youth are scheduled varies from high to low, (utilization case mix is adjusted) as in scenario 1A (more youth being seen on a quarterly basis), .7FTEs of additional prescriber capacity is needed for the same population of 5,634 youth. A 10% increase of youth into the system as seen in Scenario 2 and 2A would suggest that there is some flexibility system-wide.

[2] Please see Appendix G for the additional tables utilizing 50% and 70% direct care time projections.

Children and Adolescent Table 2:
FTE Projections for Children and Adolescents Prescribers at 60% Direct Care Contact

	C&A Served	High Users	Moderate Users	Low Users	60% direct care contact	C&A Prescriber (FTEs) in System	Difference
Scenario 1	5,634	25%	35%	40%	11.6FTEs	12	.4FTE
Scenario 1A	5,634	25%	25%	50%	11.3FTEs	12	**.7FTE**
Scenario 2	6,197	25%	35%	40%	13.3FTEs	12	**-1.3FTEs**
Scenario 2A	6,197	25%	25%	50%	12.8 FTEs	12	**-.8FTE**

E. Conclusion on Quantitative Findings for Capacity

Based on the information available, Integrus finds that the current prescriber capacity is not overly stretched to handle the ***current*** demand, but may become stressed by an increase of 10%. This conclusion is based on the following:

- assumption of a moderate direct care contact rate of 60% per prescriber per service participants;
- the severity and utilization patterns assigned to the population in the scenarios constructed above (which likely require further 'calibration'); and
- on-site interviews with Centers with prescribing capacity.

While Integrus' model reflects a modest need for additional prescribing capacity ranging from .9FTE - 3.4FTEs and .8 FTE and 1.3 FTE for adults and youth respectively, **there are other critical factors that have a direct impact on the effective management of prescriber resources that Integrus took into consideration in arriving at its conclusion concerning capacity.** Those factors are discussed in Section IV of this report.

IV. Other Factors Affecting Capacity

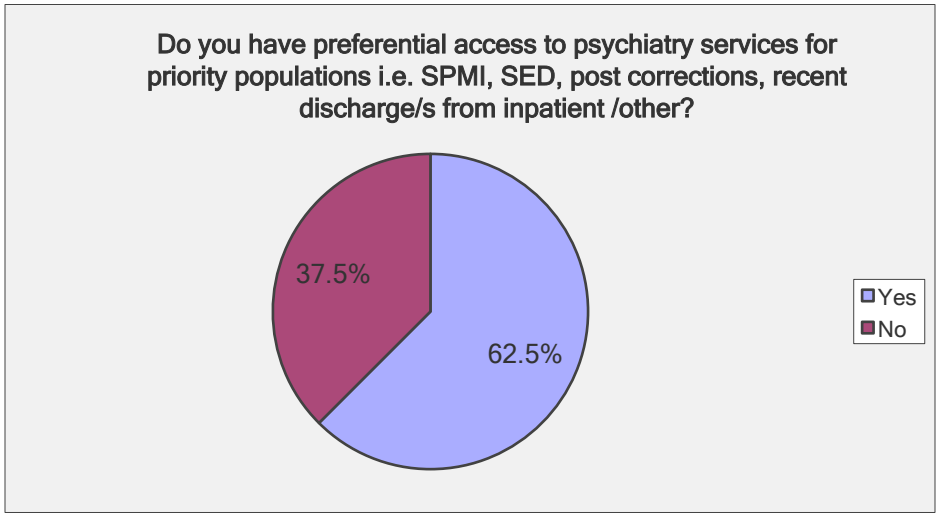
Formulating a point of view on the adequacy of the system's prescriber capacity requires an examination of supply (prescribers), demand (clients/consumers/participants) and case-mix (in other words, complexity and acuteness of illness generating patterns of utilization high initially to low when more stable – or remaining intense for a subset of the population) as illustrated utilizing Integrus' methodology above. Assessing capacity also requires an examination of other variables that can affect how well prescriber time is or can be maximized, not only in terms of scheduling and management of participant no shows, prescriber-participant caseload ratios, case-mix, but in supporting their time through the creative use of supportive services.

A. No-show rates and wait times for first appointments

These two factors are widely felt to be related. Integrus discovered significant variability in no-show rates between the Centers in the management of prescriber resources. The no-show rates cited during the on-site interviews ranged from as low as 20% to as high as 50%. The ability to establish and work toward system wide targets or goals for no-shows can, on the one hand, unleash additional prescriber capacity within existing resourcing and speaks to the general proviso that many systems of care reflect some 30% or more inefficiency. High no-show rates increase cost and prescriber downtime. However, unless overbooking is done carefully it can create significant overload and burnout.

Wait time is often used as an indicator in assessing prescriber capacity. Integrus again found wide variation in reported wait times for first appointments for individuals needing prescriber services. Some centers report virtually no wait times, while others reported wait times of 3-4 weeks. Because 'no show' rates for first evaluations increase in direct proportion to wait time, it is an accepted 'best practice' to reduce wait times to a minimum, for improved utilization of resources AND for the vital improvement in 'patient/client experience of care and improved engagement. However, even the Centers with the longer wait times shared that they can fast track access for urgent cases, if necessary. Generally, the centers appear to operate with creativity and flexibility to maximize access to services. Some centers report utilizing 'Just-in-Time' scheduling, establishing walk-in clinics for no-shows or missed appointments, meds only clinic and holding slots for new appointments, etc. The Graphic below shows that 62.5% of the centers responding to the survey indicated that they have preferential access to psychiatry services for priority populations i.e. SMI, SED, hospital discharges etc. However, the perception of access by the special population providers was not consistent with this and may require further exploration.

Preferential Access for Priority Populations



B. Participant Management of clinical complexity and Acuity (Case Mix)

There were also differences in the internal management of the participants enrolled by the centers. One site stated that they did not have a utilization management system in place to address the quality and intensity (frequency) in which participants are seen by prescribers. Providing clients in need of psychiatric services with the right service at the right time is critical. However, providing the right amount of services is equally important.

The absence of a utilization management process can create a drain on prescriber time. For example, a young adult with serious depression comes in seeking psychiatric help. Their situation is fairly complicated with underlying medical issues and pending loss of housing, requiring not only medical and psychiatric attention, but also a range of case management activities. In one scenario, following evaluation and treatment planning, a multi-disciplinary team is brought together to address each aspect of the problem list. Consequently, after three months of intensive work, weekly or bi-weekly visits are no longer needed; and after additional time for further psychiatric stabilization, even monthly visits may no longer be necessary. In scenario two, this same individual is retained on monthly visits with the prescriber even though they have become stabilized. If we apply this same type of thinking across caseloads of several thousands, it that becomes apparent that such inattention to ***managing the caseload has far reaching repercussions on capacity.***

C. Prescriber Caseloads

Integrus noted that the actual caseloads of individual prescribers varied as well, ranging from 400 – 800 – not out of keeping with industry average for outpatient clinic/CMHCs. However, the caseloads ***should depend*** on supportive services, caseload mix (acute, stabilizing, long-term/complex, etc.) and it was not in the scope of this study to assess this more accurately.

D. Participant Transfer

Movement between specialty behavioral health and primary care caseloads is an important consideration in freeing up capacity within the Centers; however, a number of questions must be answered to manage this responsibly, such as:

- Which individuals are best suited to such transfer?
- Which cases can and should remain in primary care?
- What is the scope of practice of prescribers in primary care who see less seriously ill individuals – and who can take on more complicated cases with specialty back up?
- What is the 'best practice' in terms of using non-specialty trained prescribers for more complex cases?

E. Use of supportive services

Integrus found variable practices in how supportive services are deployed within the centers. Nursing services and supports can be utilized as "extenders" to maximize the direct patient hours of the prescribing professionals. Some centers have been very intentional in their efforts to free up prescribers to address client concerns by reorganizing and shifting specific tasks to nursing services. Some centers cited that their nursing services are checking client blood pressure, receiving lab work, responding to pre- and reauthorizations calls from pharmacy, providing client and family medication education etc. to free up prescriber time. When these strategies are implemented consistently throughout the system, this will have a positive impact on the provider capacity of the current prescriber pool. Dependent on Missouri regulations, RNs may also provide interim medical care between doctor visits, as could Physician Assistants, effectively becoming physician extenders. Such use of supportive staff anecdotally improves retention of prescribing professionals.

F. Demand

According to the survey, 31,057 individuals were served by the centers, approximately 15,235 or 49% required prescriber services. While not a focus of this study, Integrus learned that individuals who were uninsured who are placed on wait list are not counted in the figures provided through the survey – implying that the demand ***for the system overall*** is higher than it appears. Any definitive statement would requirement further study.

Within specific age grouping, the demand for prescribing for persons 6-12 and 13-17 years of age was 72% and 84% respectively. While these number appears higher than anticipated, further assessment would be needed of the interplay between shortened lengths of stay, reduced residential capacity, shrinking community resources and prevalent cultural 'mind-set' around taking medication vs other approaches -- how individual and collectively these factors can impact on demand. A good example can be the 'demand' of school staff especially in overpopulated classrooms or other institutional settings (from corrections to nursing homes) to provide medications for children or adults due to lack of adequate staff and training in managing behavioral disruption. It is also unclear how some providers determined the need for prescriber services.

Even when evaluations are paid for through JCCMHF funding, that medications are often not covered creates an acute demand in the lack of access to likely prescriber recommendation.

V. Themes

A. System Strengths

Several aspects of the Jackson County mental health system present as strengths vital to addressing this and other challenges facing the County.

- The Mental Health Levy itself represents palpable evidence of an enlightened community based on legislation and funding for mental health dating back three decades. Jackson County is among a handful of localities and/or states providing such taxpayer commitment, including Butler County, Ohio and California. Jackson County represents one of the oldest and best-established levies in the country.

- The resulting funds have made possible a range of services to children, adults and families including the uninsured population, those with serious mental illness, and those outside of mainstream state Medicaid or block-grant funding, such as domestic violence shelters and services to homeless individuals. This has meant the difference between closing doors or retaining community-based often diversionary services to the most vulnerable people in the County.

- JCCMHF has itself provided significant support for neighborhood and culturally based services reflecting the proviso that 'all healthcare is local'.

- Innovation reflecting a commitment to 'best practices' is in evidence at a significant number of grantees, where the depth of thinking and work appears consistently reflected from governance to management to the front end of services. Such innovation is an active element in a cross-section of grantees -- from the larger behavioral health centers to the special population providers.

- Missouri itself has taken a leadership role in developing behavioral health homes to coordinate the primary/physical health care of individuals served through specialty mental health settings and several of JCCMHF's grantees are well along into this work.

- The state infrastructure allows for information gathering and regularized reporting on Medicaid eligible individuals – so that data is available for those on Medicaid.

B. Communities in Change

Gentrification, the diffusion of neighborhoods and erosion in low-income housing stock
Kansas City, as many if not most of the urban core is undergoing a process of rapid gentrification. That this is taking place across the Country in neighborhoods historically belonging to segregated minorities makes such dislocation no less poignant and disruptive to those living in Kansas City. A drive through Jackson County itself reveals streets blocked by cranes, neighborhoods undergoing construction, renovation of old housing and the appearance of new business. Mid and low income housing is becoming scarce, and whole swaths of communities with long-standing roots have been diffused or entirely displaced to the further reaches. We saw this in particular evidence around the Downtown area, which has had a direct impact on the Latino community now shifted into the Northeast Corridor or into Wyandotte County in Kansas.

This places an increasing burden on low-income individuals and families – among whom the seriously mentally ill and immigrants have significant representation – and on every acute and intermediate residential or emergency service requiring rapid discharge into a stable setting. Integrus believes it likely that the experiences of the County's domestic violence shelters in serving as stable residential placements reflect this reality.

A number of providers have met these changing needs by reallocating their service centers and staffing over the past several year period with extensive reach into newer neighborhoods often reflective of their attempts to maintain services. Integrus has become aware of several innovative housing initiatives to address the shortage of residential options.

Language and documentation barriers
The reality of these geographic shifts has been joined by the influx of immigrants from many more cultures and languages: while the dominant second language for decades (primarily from Mexico), several dialects of Spanish are now heard alongside Vietnamese, Thai and other languages.

C. Policy Issues

Several policy level decisions are impacting the need for and availability of prescribing clinicians; they include the following:

1. **From primary and secondary education to child welfare systems, many of our child serving systems reinforce or recreate the continuing, repetitive trauma** experienced in often disrupted family settings creating a pipeline of hopelessness and despair. Within the past five years, Adverse Childhood Experiences (ACE) has been shown to lie at the base of much later psychological and physical illness, forming the basis for trauma informed care that has become a hallmark of JCCMHF services.

2. **Abbreviated lengths of stay on inpatient units for psychiatrically ill children and adults.** While this has been going on for some time, the complexity of conditions and the misuse of medications is often compounded by the short length of stay, with heightened demand then placed on residential treatment and community providers as well as families themselves as non-stable family members are prematurely discharged.

3. **The lack of access to adequate low-income housing options** in rapidly gentrifying urban centers for people coming from emergency rooms and inpatient psychiatric services is creating a 'demand' for beds in some of the residential providers, undue hardship on families (who remain the repository of residential care in many localities), domestic violence shelters and likely nursing homes (a phenomenon that has been seen in many states).

4. **Movement toward performance or outcomes based reimbursement** with its emphasis on a 360-degree view of the individual, more integrated and preventive care and improved coordination between behavioral and physical health.

5. **The decision within both Missouri and Kansas to not extend Medicaid coverage** places a continuing burden on providers, including safety net and hospitals, that must manage with 20% of the population being uninsured. Issues of coordination and efficiency are paramount. This lack of coverage places a clear burden on JCCMHF to cover services for the uninsured, which since 2008 have grown nationally. While the impact on niche providers is unclear in Kansas City, where the Levy has for thirty years addressed some of the systemic gaps for the uninsured, this area requires additional monitoring.

6. **CCBHC with its enhanced reimbursement rates**, while not appropriate for all providers, will significantly enhance revenues and offset losses currently incurred for medical services (if not explicitly stated). It should be noted; however, that the CCBHC model is clearly not adapted to all providers, particularly the specialty population providers that lack necessary infrastructure to handle the CCBHC demands.

D. Grantee Operations

Access

As reflected above, Integrus was impressed by several examples of outreach and even relocation of services to improve access to communities or populations that had moved away or required specific engagement (such as the homeless). This said, Integrus noted several factors that may indicate opportunities for improved access:

1. **Funding.** JCCMHF funding that is unspent by large providers by the end of year.

2. **Geography.** Jackson County covers 607 square miles, from the urban core of Downtown KC to semi-rural low-density communities. The distances combined with gaps in public transport – as well as the need for multiple bus routes requiring hours of travel – make getting to an appointment an ordeal for those without a car. Some face additional challenges – whether due to parenting without child care, depression or immobilization due to real or imagined fears for safety (in some communities – with high rates of drug dealing and violent crime, this is particularly true.)

3. **Hours of operation.** While most of the providers seem to have flexible hours of operation, outside of the traditional 9-5 Mondays to Fridays – there remains a question as to the capacity of these services for handling the real demand. In the safety net, it is not uncommon for one or both parents in a family or members of a household to be carrying two or more jobs to make ends meet, the availability of and access to quality services during non-traditional hours is critical. Thus, the actual ***availability of services reflected in wait times, difficulty in reaching services and so on is tremendously important.***

4. **The *experience* of being welcomed.** Creating a welcoming environment is often an overlooked factor that affects access. The 'perception' of being welcomed may account for the reason that people familiar with some of the smaller neighborhood- based, culturally and linguistically aligned specialty population providers approach them directly rather than going to one of the larger but unfamiliar centers. They may have friends or neighbors who have used services there and it may be seen as more welcoming.

5. **Access to trauma informed, condition specific primary and specialty care – and/or coordination with this aspect of care**. This can and does have a direct impact on prescribing of psychiatric medications – both in terms of need and capacity. For example:

    - An individual with uncontrolled diabetes for instance, may experience an exacerbation of existing psychiatric illness or a change in behavioral warranting access to primary care, screening and treatment.

    - A child (or adult) suffering from trauma may come to our attention – through a school clinic, through a pediatrician, a Head Start classroom or through a domestic violence shelter. In other instances, children may be identified and referred to specialty behavioral health care through such identification.

E. Human Resource Issues – Prescriber Pipeline

A national shortage of psychiatrists in training has been identified for the past decade. Both medicine and psychiatric residents are the subject of intense recruiting activity. Forty-seven percent of residents surveyed in 2011 said they have been contacted by recruiters 100 or more times during the course of their training.[3] Integrus sought to understand the relationship between JCCMHF grantees with prescribing capacity and the local training centers as a potential source of prescribers; however, this remained outside the scope of the current undertaking.

The data submitted in the survey revealed that 86% of the seven center providers responding to this question were not training sites for psychiatry or APN trainees in psychiatry. During its on-site conversations with the Centers, Integrus wanted to learn more about this data point. Concerning the lack of formal affiliations with the residency programs, Integrus learned that the cost, both direct and indirect i.e. loss billing capacity, to host residents was prohibitive. We learned that the cost of supporting residents and being part of a residency program could cost $75,000 -$100,000 annually. Most of the centers do not have the financial resources to bear these costs. This is an important factor in recruiting prescribers in the community post-residency if there is no affiliation with a training school to serve as potential pipeline to the frontline of the service delivery system. Training programs also serve to maintain rigor in further practice while providing teaching opportunities and thus assist in retention, particularly if compensation is relatively commensurate with other settings.

Centers also shared that due to the limited availability of prescribers entering the system, they are often in competition with each other to secure psychiatry services. Centers report that they often adjust (increase) the salaries to remain competitive. These adjustments are made knowing that reimbursements generated by these professionals are often insufficient to cover their costs. Significant losses on a per physician basis were cited, making the case for carefully managing prescriber resources.

[3] Merritt Hawkins 2011 Survey of Final-Year Medical Residents

VI. Recommendations

As Integrus considered all of the information gathered and its analysis, the following considerations were paramount in formulating the suggested recommendations below:

- immediate relief be provided for a situation that drains special population provider time from their service mission/s (e.g. accompanying very ill individuals to emergency rooms for psychiatric care);
- public funds support maximum efficiency within the service delivery system before adding significant new prescriber resources; this might include specific focus on meeting performance goals in exchange for funding or part of the funding, such as reduced no shows and wait times, use of supportive services to assist prescribers, and
- steps be considered that have the greatest likelihood of achieving and sustaining improved access to much needed services by the special population providers.

A. Short Term Recommendations

1. Targeted Data Collection

According to the on-line survey, ten of the fourteen specialty population providers gave their "best estimate" of the number of individuals presenting with behaviors that they believed warranted medication. Presenting behaviors[4] requiring medications were the ***most common*** (243 instances[5]) and the ***most concerning*** circumstance that the specialty providers encountered in the past three months for which access to prescriber services were required. However, MOST of this is highly anecdotal information.

Integrus recommends that to better measure the magnitude, frequency and nature of the demand for prescriber services, by individuals presenting to the niche providers, **that a short-term (up-to-three month), "low-demand" collection of data specific to this issue be undertaken.** This will move this issue from the anecdotal to better assess and understand what the actual experiences and demands are.

[4] Presenting behaviors were defined as: injurious to self that indicate that an assessment for medication is needed, aggressive toward others, extreme mood swings, out of control behaviors, behaviors that interfere with one's ability to function, etc.

[5] Our survey did not specify unduplicated individuals. Therefore, there may be individuals included in this count who repeatedly presented for services with a specialty provider. For the purpose of our analysis we counted each instance as an unduplicated individual. A more detailed data collection effort will help to tease out how many unduplicated individuals accounted for these presentations.

2. Development of formal access agreements with the CMHCs and FQHCs

Based on the data collected, JCCMHF should consider purchasing, through the development of priority access agreements, services through the CMHC's and/or FQHC's to serve the specialty population provider participants. This would be done on a highly individualized basis, between specific special population providers and Centers, but fostered through and overseen by JCCMHF. This access priority access agreement would describe the target population, timeframes for access, etc. Additionally, five of eight or 62.5% of the Centers indicated that they have preferred access for special population. JCCMHF should get a better understanding of what is contained in these agreements.

3. Assist individual providers in maximizing their existing prescriber resources

As discussed in Capacity Findings section of this report, we believe that there could be greater prescriber capacity unleashed in the system through enhanced management techniques. Every no-show is unused capacity. Small changes in some of the variables (such as moving to 60% direct time or more; or reducing no shows) can significantly impact prescriber availability. When you take something like this with movement within the caseloads – a fairly significant upward shift in capacity is generally the result.

JCCMHF should support providers with prescriber resources who could benefit from technical assistance and consultation to help them implement strategies and systems that will increase their operational efficiencies. These providers have limited "bandwidth" or time to take on designing and executing these necessary management systems. JCCMHF's support in aiding these providers in implementing such strategies will give them the tools they need to manage and monitor what is happening in real time in their systems.

4. In considering short-term relief, purchase of services funding

While such contractual dollars may be useful on a short-term basis to alleviate the current 'demand,' combining this with a methodology, improvements in interface and management will ultimately, we believe, reduce these outlays.

B. Mid-term Recommendations

1. Development of consultative model to expand pool of highly skilled prescribers

Maximize use of adjacent systems and potential prescribers through the development of consultative model/s integrating behavioral health and primary care. This is reflective of national and state trends – with however, a number of important areas remaining to be addressed. Several such initiatives have already been started in a number of JCCMHF grantee settings, which can be 'two-way' – between specialty behavioral health and primary care, or infuse behavioral health within a primary care setting, such as an FQHC – or other.

Many questions remain to be answered re: the level of behavioral complexity that can/should be handled in a non-specialty practice, where the model used – from formal referral to co-location or embedded/side-by-side practice -- can have significant impact. Similarly, it is increasingly felt that many mild to moderate behavioral health issues can and should be dealt with in a primary care setting. This is not unlike the best thinking about any specialty practice. However, handling such care requires that primary care practitioners have far more formal training, clinical exposure, initial supervision and support.

It should be noted that use of alternate prescribers alone not only does not guarantee quality of outcomes, and that unless done carefully can further compound a problem already seen nationally. With 80% of prescribing being done, de facto, in our primary care systems by and large by professionals who lack adequate training in behavioral health diagnosis and medication management, we are seeing an increase in poorly managed complex cases.

JCCMHF can play an especially important role in creating an environment for such innovation, assistance with infrastructure and engagement around training, skills enhancement, reimbursement based on performance and oversight. (See below under 'Strategic movement)

2. Creation of telemedicine hubs

Tele-psychiatry offers the opportunity to provide psychiatric services within and from outside the immediate community without the need for providers to lose time to travel between sites. It also allows for use of prescribers from outside of the immediate Kansas City area, including other areas of the state and nationally. Since payment for tele-psychiatry is variable and dependent on state and, in the case of Medicare, federal regulations (Medicare, Commercial insurers and Medicaid vary in if and when they will pay for this) insurer may restrict use of tele-psychiatry however if used in a focused manner can assist in meeting demand.

Where existing technology infrastructure can be tapped into, this can maximize public dollars. While used on a limited basis, (37% of JCCMHF grantees indicated through the survey that they used telemedicine), there seems ample opportunity to expand on this with support from JCCMHF.

It should be noted that those providers familiar with the undocumented community, expressed extreme caution re: this type of technology for people already wary of disclosure and for whom engagement and the development of trust might be compromised. It may be that conducting a special pilot with input from the community itself could assist in overcoming some or all of these barriers.

3. Development of academic affiliations

Affiliations between departments of psychiatry, nursing and primary care can and should be underwritten by JCCMHF – with careful attention to the structure, supervision and learning opportunities within integrated settings.

Such training opportunities create a work force skilled in managing the dual realities of physical and behavioral health. With a focus on the outcomes in quality and cost, identifying behavioral conditions much earlier in their evolution is a transformative step toward a much fuller health and toward true value-based reimbursement. It should also be noted that attention to scope of practice is paramount in skill development and matching of complexity and acuity between patient population/s, provider/s and settings within which care is delivered.

JCCMHF can become a major catalyst in this transformation.

4. Strategic movement toward more integrated services and funding

With rapid and ongoing change in the reimbursement environment moving toward performance-based payment, there is far greater emphasis on quality measures, outcomes and accountability to funders, regulators and the public itself. All of these factors create demand for change in the regulatory environment and clarity from JCCMHF itself as to the desired result of its investments.

A strategic planning process is recommended to unify JCCMHF's Board and its leadership in what would be a series of manageable steps to promote and sustain these newer approaches. Several outcomes of such a process might include:

- **Pilot Development**
  Create one or more pilots using newer models of care delivery,[6] with the use of performance metrics and funding while testing out different reporting structures while preparing JCCMHF itself to enter this new landscape.
- **Allowing for greater flexibility to best utilize public funds**
  Develop greater flexibility while maintaining or improving accountability for public resource to **selectively** open restriction/s on grant funding for medications (establishing criteria and a mechanism to allow for this vs a completely open process, which Integrus does NOT recommend)

C. Long Term Recommendations

1. Make use of system wide triage unit

Leverage of the resources of the soon to be operational Kansas City Assessment and Triage Center (KC-ATC) initiative for people with substance use and mental illness to include referrals from selected homeless and domestic violence shelters.

[6] Delivery and reimbursement models such as CCBHCs may assist in expanding the breadth of services available in the community and also in providing a more robust payment for providers with the administrative, clinical and contractual capacity to meet all of the federal criteria that are part of this model. For CMHCs in particular moving to a CCBHC provides cost based reimbursement opportunities that can be leveraged to expand services to the populations of focus in the CCBHC model – adults with serious mental illness, children and adolescents with severe emotional disturbance and individuals with chronic addiction. It should be noted that CCBHC requires considerable existing infrastructure. Other models might include integrated behavioral health-primary care within FQHC or other contexts/outside of a CCBHC.