

AACP Positions on Access to Psychiatric and Psychopharmacology Services in Underserved Areas

Overview:

The AACP, as a professional organization committed to public service, believes that quality psychiatric care should be available to all in need. We call on our profession and our allies in this mission to make this a reality and to work vigorously toward the elimination of the designation “underserved” for communities and populations. Toward that end, we offer the following paper to spark further actions.

AACP believes that the issue of access to psychiatric services in underserved areas, particularly rural areas, is an important priority for attention by psychiatry organizations. AACP supports the availability of competent psychiatric services through a combination of direct access to psychiatrists (in person and via telehealth linkages), to psychiatric practice extenders who have access to consultation and/or supervision, and to primary care providers in Federally Qualified Health Centers (FQHCs) and other settings with appropriate psychiatric consultation and support.

Creating service access within these areas, particularly in rural and impoverished urban and suburban communities most critically requires an organized PUBLIC HEALTH approach, which:

- defines the global needs of populations (including children and adolescents) in underserved communities for various categories of psychiatric services, and then develops a strategic plan for how to best meet those needs.
- clearly delineates the role of the psychiatrist as a *specialist* within an array of service providers, and establishes which functions can be most appropriately performed by other providers with psychiatric support (and with what types of support), and which functions require the special knowledge and skills of a psychiatrist (and through what mechanisms).
- includes strategies to attract adequate numbers of primary health and behavioral health workers of all types to underserved areas, as well as approaches to specifically attract and retain psychiatrists.

The following outline incorporates bullet point strategies for achieving this outcome.

OUTLINE

- I. **Define the Needs of the Population and Available Resources:**
 - a. Epidemiology/Prevalence of adult, youth, and child behavioral health service needs.
 - b. Penetration of service in underserved areas compared to average urban or suburban areas – measurement of gap.
 - c. Availability of behavioral healthcare human resources, primary healthcare

workforce resources, psychiatrists and psychiatrist extenders, physicians and physician extenders.

d. Direct psychiatric services – assessment, medication prescription, hospital management, emergency and crisis care, forensic evaluations, and medical psychotherapy for both adult and child/adolescent populations.

e. Indirect psychiatric services – consultation and liaison with primary care physicians and physician extenders, consultation to and supervision of psychiatric nurse clinical specialists or nurse practitioners and physician assistants with prescribing privileges (both adult and child/adolescent specialists), oversight and supervision of, as well as consultation to non-medical front line behavioral health providers and interdisciplinary teams; and specific medical direction to behavioral health programs, agencies, and systems.*

f. Identification of Federally designated Mental Health Manpower Shortage Areas and areas that might be eligible for such designation.

g. Identification of existing projects for creating or expanding psychiatric services in underserved areas: APA survey of district branches, National Association of State Mental Health Program Directors (NASMHPD) Medical Directors survey, managed care organization survey, Health Access Foundation Grants, National Rural Mental Health Association (NARMHA)

h. Continued monitoring of “access” data at the state and tribal level: e.g., by NASMHPD, the American Psychiatric Association (APA) and its District Branches, AACP, and using this data to organize continued improvement efforts.

i. Discuss how some but not all of these functions can be offered through other professionals under psychiatric supervision.

CORE POSITION

AACP supports the availability of competent psychiatric and psychopharmacology prescribing services through a combination of the following:

- *access directly to psychiatrists (both in person and via telehealth linkages)*
- *access to psychiatric practice extenders who have available consultation and/or supervision (both on site and via telehealth),*
- *access to primary care providers (both those in FQHCs and those in other settings) with adequate psychiatric consultation and support.*

Each of these areas will be discussed in the following recommendations.

II. Recommendations to improve access to psychiatric services and access to competent psychopharmacology prescribing providers in underserved areas.

A. Improving availability of psychiatrists in underserved areas

* Also see AACP Position Papers: “Interface and Integration with Primary Care Providers” and, “AACP Guidelines for Psychiatric Leadership in Organized Delivery Systems for Treatment of Psychiatric and Substance Disorders.” Available at <http://www.comm.psych.pitt.edu/finds/leadership.html>

- a. Proposed Remedies to improve numbers of psychiatrists in rural and other underserved areas:
 - i. Economic incentives:
 1. Reimbursement rates on parity with other medical specialists enhanced in rural areas and other federally designated underserved areas.
 2. An organized effort to identify and create designations for mental health underserved areas in order to create prioritization for J-1 status and other federal initiatives.
 3. In addition to the above, initiate extensive review to expand the current criteria for designation of underserved rural areas. Many geographical areas fail federal “underserved” criteria despite pockets of very poor access, especially access to adult and child psychiatrists. The existence of homeless shelters within otherwise non-designated areas is such an example and such facilities should be designated as “underserved areas” for recruitment purposes.
 4. Expansion of the definition of “primary care specialty” to psychiatry
 5. Access to appropriate formularies – physicians are not attracted to work in environments where they cannot provide acceptable treatments.
 6. Tax and other incentives to attract psychiatrists to underserved regions
 7. Reimbursements for telehealth and for non face-to-face consultations with PCPs, Physician Assistants (PAs), Nurse Practitioners (NPs) (see below).
 8. Mechanisms for broadening the ability of FQHCs to oversee a broad array of community based mental health services under the auspice of their enhanced reimbursement framework.
 9. Similar mechanisms for health clinics in Native American tribal settings with 100% federal match for Medicaid.
 - ii. Other Job Enhancements:
 1. Involvement in a supportive multidisciplinary team as an essential feature of job satisfaction and attraction.
 2. Standardized job descriptions that are fair and meaningful and incorporate supports that compensate for professional isolation – e.g. involvement in clinical supervision, teamwork, and program development, as well as community consultation, *not* just direct service.
 3. Organized professional support networks for psychiatrists and psychiatry extenders in underserved and isolated areas.
 4. Appropriate compensation and fringe benefits.
 5. Relocation expenses, compensatory time off.
 6. Increased student loan forgiveness benefits.
 7. Paid educational opportunities to ensure professional growth.
 8. Appropriate availability of support staff.
 9. Access to good quality telehealth linkages, with adequate telecom and IT infrastructure.
 10. Access to university faculty appointments and telehealth-linkage to department supports.
 11. Membership in AACP.

iii. Developing enforceable regulatory standards

1. Federal and/or state guidelines defining a role for psychiatrists in rural and other underserved areas as a necessary component of a local system within the public health framework, and creating expectations that local systems invest in the recruitment process. This may involve setting minimum thresholds of psychiatrists (or sample ratios for rural and other underserved areas) needed to be part of a comprehensive delivery team that involves front line behavioral health providers, psychiatry extenders and PCPs.
2. AACP/APA/American Public Health Association/American Consortium of Mental Health Administration (ACMHA) playing a central role in determining these standards, collaborating with other organizations such as NASMHPD and the National Council of Community Behavioral Health and professional associations for Psychiatric PAs and NPs.

iv. Education re: benefits/need for psychiatry:

1. Clinics and hospitals, human services providers, government, and the public at large do not adequately appreciate the value of good quality psychiatric care.
2. Join with other educational advocacy initiatives to support increased awareness of value of psychiatric involvement.

v. Improved coordination of recruitment efforts through organized collaborations and information exchange mechanisms (e.g. available positions, work/pay conditions, resources for hiring) regionally and nationally.

1. Local psychiatric societies and university departments of psychiatry could be offered incentives to develop or expand current efforts to promote access to underserved areas, and to maintain regional job banks.
2. Partnering with Area Health Education Collaboratives and FQHCs in recruiting mental health expertise, including psychiatry, as part of core primary care responsiveness in rural and other underserved areas.
3. Organize local projects to facilitate recruitment and retention of individuals with J-1 Visa status.
4. Development of rural community psychiatry fellowships to attract residents and early career psychiatrists into underserved areas.
5. Block grants and fellowships from other sources – including pharmaceutical companies - to connect psychiatrists with jobs in underserved areas.
6. APA could coordinate and underwrite a recruitment service for underserved areas, given that *APA - Psychiatry News* classified advertisements and the APA Job Bank listings are costly.
7. Many publicly-funded agencies do not have adequate human resources departments for negotiating physician jobs. Their efforts could be standardized and supported by APA.
8. Partnerships with universities to promote community engaged scholarship and other community-academic partnerships with a focus on creating mechanisms for leadership training in public service psychiatry in underserved areas.
9. Create economic incentives for academic departments of psychiatry to extend training to these areas through federal funding enhancements and expansion of the J-1/H-1 visa programs.

- B. Improving access to psychiatric extenders in underserved areas** - Other non-MD health professionals are qualified to fill many psychiatric functions (NPs, and physician assistants [PAs]):
- i. Define which categories of medically trained non-MDs are already involved in meeting some functions defined above.
 - a. Define their current level of skill and training
 - b. Describe the scope and limitations of their practice (this varies from state to state, but APA could provide useful general guidelines for local societies to advocate).
 - c. Provide model(s) of successful collaboration between NPs/PAs and MDs.
 - d. Define mechanisms for psychiatry supervision, training, support (including organized mechanisms for telehealth consultation support by university departments of psychiatry) that enhance the capacity and functioning of physician extenders. This should include access to subspecialty consultation (child & adolescent, addictions, geriatrics).
 - e. Expand access to training opportunities for NPs and PAs in underserved areas.
 - f. Consider each incentive item above (see Section II Aa) for psychiatrist recruitment and retention, and apply the same items to the training, recruitment, and retention of psychiatrist extenders (including those with pediatric sub-specialization).
 - g. Identify APA as committing a substantial investment to the development of this workforce in order to be perceived as sincerely concerned about quality and not merely guild issues.
 1. Helpful will be data analysis comparing the development and training of non-medical mental health professionals concerning to the cost of developing a larger contingent of adult and child psychiatrically trained physician extenders.
 2. Take a position re: APA/AACP support *for* maximizing the availability of medically trained psychiatric extenders , versus being *against* using non-medical mental health professionals to solve the problem (e.g. psychology prescribing issue).
 3. A “Call to Arms” to other stakeholders to join with us to improve access to psychiatrists and psychiatric services.
 - a. APA
 - b. Consumer and other groups, for example: National Alliance on Mental Illness, National Mental Health Association NMHA, National Rural Mental Health Association, NASMHPD, NCCBH, and Association of Clinicians for the Underserved.

- C. Improving access to competent and well-supported primary care physicians and nurse practitioners, physician assistants, and Pharm.Ds** in underserved areas who can provide psychopharmacologic services.
1. Major investment in PCP training and organizing availability of consultation by psychiatric societies or university psychiatry departments of psychiatry in each state (the New Mexico Rural Health Initiative coordinated by AACP member Chris Pedersen is an example of a systematic approach by a university Department of Psychiatry to build behavioral health competency in rural primary care settings).

2. Teleconsultation methods.
3. Review of reimbursement for consultation.
4. Build on the Health Resources Services Administration's encouragement of behavioral health services development in FQHCs.
5. Delineation by APA of recommended scope of psychiatric practice for PCPs, PAs, and NPs in both routine settings and in underserved settings. It is important that APA take a position recognizing the value of PCPs in providing integrated behavioral health services in all practice settings.
6. Behavioral health integration into primary care in rural areas, with non-medical professionals to do assessments, PCPs to prescribe, and telepsychiatric consultations.
7. Definition of non-prescribing PCP interventions, such as brief interventions for alcohol misuse.

D. Improving methods for organizing teams of direct care adult and child behavioral health caregivers with primary health care providers and psychiatrist extenders, and with psychiatrists providing support to the whole team.

1. APA can take a position on the fact that good team development both attracts psychiatrist into underserved areas and enhances the ability of psychiatrists to provide competent access to care.
2. Further, APA can invest in supporting and encouraging the development of such efforts by local psychiatric societies and by local departments of psychiatry.
3. APA can partner with other professional organizations who would value more organized availability of interdisciplinary teamwork and consultation to create an advocacy base for this effort in both adult and child systems of care.