

# Meeting Child & Adolescent Psychiatry Service Demand in Connecticut

## Challenges and Possible Strategies



## C & A Psychiatry primary functions (cut across all levels of care):

- Direct evaluation and med. mgmt (incl. ECC access standards)
- Rounds / case review teams / consults
  - Best practices
  - Evidence-based model adherence
- Medicaid documentation compliance

# Current C & A Psychiatry staffing in CT

- C & A Psychiatrists
  - How to expand availability
- Psychiatric Nurse Practitioners

(direct care only; not recognized for Medicaid compliance Dx or summary documentation oversight sign-offs)

  - How to broaden scope/utility

# The C & A Psychiatrist labor force shortage

- Connecticut's not alone, and regions of our state particularly struggle due to where the teaching hospitals are (and aren't).
- Recruitment and retention will only get tougher: over 80% of the nation's psychiatrists are age 55 or older.

*(source: National Council for Behavioral Health)*

- Supply vs demand = rising costs for CT's private non-profits (incl. recruiter fees)
  - Job satisfaction/retention vs. productivity/reducing red ink.

## Connecticut's Self-Imposed Barriers

- 48 states provide Medicaid reimb. for telehealth (incl. CT). Initial research indicates that at least 12 of those states (and CT's not one of them) include tele-behavioral health/psychiatry (direct patient care) in this scope.
- CT Senate Bill 298 (effective 7/1/16) leaves defining this scope to the DSS Commissioner, based on 3 criteria: (a) appropriateness of care, (b) cost-effectiveness and (c) likely expansion of access.
- In addition . . .

## Connecticut's Self-Imposed Barriers

- In addition, it's our understanding that approval of telepsychiatry (direct patient care) for Medicaid reimbursement would require, in this sequence,
  - Approval by the Office of Policy and Mgmt (OPM)
  - Successful submission of a new State Plan Amendment to CMS (Centers for Medicare and Medicaid Services) (SB 298 requires the DSS Commissioner to submit a SPA "as necessary".)

# Connecticut's Self-Imposed Barriers

- Note: For purposes of this discussion, we're focusing on the billable, direct patient care/"screen-to-screen" aspect of telepsychiatry.
- (ACCESS Mental Health CT and CT's FQHCs currently do Psychiatrist-to-PCP e-consults.)

Since the Psychiatry shortage is nationwide, what makes us think telepsychiatry would help?

- It's a tool being used in many states
- A number of for-profit businesses are marketing and contracting for it
- Anecdotally we know that some CT psychiatrists who are edging toward retirement have interest
  - a particularly graceful option with an agency's own retiring or otherwise departed psychiatrists

## What about cost and security?

- Cost “all in” is currently about the same and has been coming down.
- Available technology is HIPAA compliant

## What about quality of care?

- Client engagement, satisfaction and outcomes are reported to be equal to in-person care.
  - Evolving implementation approaches
- APA has endorsed

## Psychiatric Nurse Practitioners

- Another arrow in the quiver
- An increasing number of OPCCs and other providers/LOCs are including Psych APRNs in their prescriber staffing mix
  - Expanded labor pool and cost advantages
- Approval of Medicaid “sign-off” authority would enable CT’s C&A Psychiatrists to spend an increased % of their time seeing patients vs. these administrative/supervisory functions, but . . .

## Psychiatric Nurse Practitioners

- Achieving expansion of sign-off authority to include Psych APRNs would be a heavy lift.
- Would require a change in State regs. and in how Connecticut's OPCCs are categorized at the federal level.

## Back to Telepsychiatry . . .

- Questions and discussion
- Broad enough common interest?
- Next action steps?

## Contact information



Rick Calvert

Child & Family Agency of Southeastern CT

255 Hempstead St., New London 06320

(860) 443-2896, ext. 1404

[calvertr@childandfamilyagency.org](mailto:calvertr@childandfamilyagency.org)