MIDD Briefing Paper

BP 2 Psychiatrists into Agencies

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept x (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This concept would allow substance abuse treatment and smaller mental health agencies to hire psychiatrists. Both staff and clients would benefit from this professional medical expertise. As systems integrates care across services, psychiatrists have the expertise and training to diagnose and treat co-occurring disorders, assess how physical conditions and behavioral health conditions may interact with each other, and provide general health screenings in behavioral health settings.

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	Role	Organization
Richard Ries, MD	Director of Addictions Services	University of Washington Department of Psychiatry
Craig Jaffe, MD	Staff psychiatrist	DESC

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

   Substance abuse treatment and smaller mental health agencies often do not have the financial resources to hire psychiatrists. Both staff and clients would benefit from this professional medical expertise, even if only one day a week (0.2 FTE). Psychiatrists can provide:

   - expert clinical consultation and supervision to staff
   - psychiatric services to clients (including, but not limited to, medication management, including medication assisted treatment, psychotherapy services, treatment planning for clients with complex needs)
   - liaison services with other medical providers (e.g., nurses and physicians in hospitals, emergency departments, jails, outpatient clinics)
   - program design and implementation assistance to agencies as related to the provision of care to people with more complex or medical needs

   As systems integrates care across services, psychiatrists have the expertise and training to diagnose and treat co-occurring disorders, assess how physical conditions and behavioral health conditions may interact with each other, and provide general health screenings in behavioral health settings.

Most of the substance use disorder treatment agencies in the system currently do not have any medical personnel. In these agencies psychiatrists can specifically expand treatment options for clients through medication assisted treatment, assess for and treat mental health conditions that may interact with substance use disorders, and facilitate communication across other treatment agencies and primary care.

This new concept has some relation to MIDD I strategy 1e, which sought to support the training of chemical dependency professionals so the workforce for substance use disorder treatment programs could grow and provide proficient treatment to clients.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

☒ **Recovery and Re-entry** ☒ **System Improvements**

Please describe the basis for the determination(s).

Crisis diversion: Psychiatrists can provide urgent interventions to individuals to reduce the likelihood of referral to emergency departments or jails. They can also provide consultation to other agency staff to facilitate de-escalation of crisis. They can also serve as liaisons across systems (e.g., by talking with police or hospital staff) to coordinate care to reduce referral to more restrictive settings.

Recovery and Re-entry: Psychiatrists can provide or continue interventions when a client returns to the community from institutions, such as jails and hospitals, to promote community retention. Because some programs, such as drug and mental health courts, would like clients to receive ongoing monitoring and treatment from a medical professional, agencies with psychiatrists can better accommodate these clients.

Prevention and Early Intervention: Psychiatrists in the community can provide education and promote healthy practices, such as tobacco cessation, primary care prevention related to common medical conditions, and harm reduction, to reduce the likelihood that people will engage in behaviors that will require a higher level of care. They may also identify early signs of mental illness and facilitate early intervention.

System improvements: The addition of psychiatrists to community agencies can enhance the level and type of available clinical expertise. As the health care system adopts integration, psychiatrists can serve as boundary spanners to help coordinate care across systems. There is evidence that the strategic addition of psychiatrists to primary care settings has resulted in improvement in depression and anxiety outcomes. Clients able to access psychiatric care in primary care settings have also reported improvement in mental health quality of life, medication use, and patient satisfaction.[1] Adding additional psychiatric capacity at smaller mental health agencies will also improve timeliness of critical service delivery. Internal data show that individuals sometimes have to wait as long as three months after treatment initiation to be seen by a psychiatrist.

[1] Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012;10:CD006525.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Psychiatrists have the expertise to facilitate integrated care within agencies and across systems, particularly as the health care system adopts full integration. As noted above, agencies that do not currently have psychiatrists cannot take advantage of a variety of psychiatric services, such as expert clinical consultation, psychiatric services that include medication management and treatment planning for clients with complex needs, medication assisted treatment prescribing for drug dependency, liaison services with other medical providers, and program implementation and design. This particularly applies in substance use disorder treatment programs, most of which do not have any medical personnel.

If this concept is not implemented, the status quo and its attendant problems will continue:

- Agencies will have greater difficulties communicating and coordinating care across the gap between primary care and behavioral health care.
- The identification, diagnosis, and treatment of co-occurring disorders will be less likely to occur.
- Agencies will not feel as comfortable working with clients with more complex medical, behavioral health, and/or co-occurring conditions.
- Agencies will not be able to provide the full breadth of treatment options, such as medication assisted treatment and other evidence-based practices.
- Clients will not have the option to access the full range of treatment to achieve recovery and wellness.
- Clients at smaller mental health agencies will continue to experience long waits for psychiatric care.

This decentralized care contributes directly to current problems, such as:

- Clients going to emergency departments for psychiatric assessments and medication requests
- Agencies turning clients away due to discomfort with or inabilities to treat co-occurring disorders
- Lack of diagnostic clarity, that results in under-treatment or incorrect treatment (i.e., staff may not be able to differentiate between medical, substance-induced, psychiatric, or co-occurring conditions)
- Substance use treatment agencies are unable to provide medication assisted treatment concurrently with counseling as they have no prescribers. This contributes to the shortage of appropriate treatment availability for the increasing opiate epidemic.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

As described above, the addition of psychiatrists into treatment agencies will result in:

- expert clinical consultation and supervision to staff
- psychiatric services to clients (including, but not limited to, medication management, psychotherapy services, treatment planning for clients with complex needs)
- liaison services with other medical providers (e.g., nurses and physicians in hospitals, emergency departments, jails, outpatient clinics)
- program design and implementation assistance related to the provision of care to people with more complex or medical needs
- increased prescribing of medication assisted treatment for individuals with drug dependencies

Furthermore, the addition of psychiatrists may help agencies adopt more evidence-based practices, such as medication assisted treatment, integrated dual diagnosis treatment, and collaborative care. It also aligns with the goals of healthcare reform, which aims to improve integration of mental health, substance use disorder, and primary care treatment for clients.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

A paper from Saxon and Calsyn[2] demonstrated that clients with co-occurring disorders who received psychiatric services stayed in treatment longer compared to clients with only substance use disorder diagnoses, even though clients with co-occurring disorders were more likely to test positive for drugs in urine toxicology screens during the first six months of treatment. During the next six months, those clients with co-occurring disorders were less likely to test positive in urine drug screens. The authors concluded that "patients [with co-occurring disorders] may initially perform more poorly than substance only diagnosis patients in substance dependence treatment. However, in the presence of psychiatric care, they eventually exhibit comparable success."

The Substance Abuse and Mental Health Services Administration (SAMHSA) publishes Treatment Improvement Protocols (TIP), which provide guidelines related to behavioral health conditions and interventions. TIP 42 describes "Substance Abuse Treatment for Persons with Co-occurring Disorders".[3] It states that on "the list of essential components of treatment for [co-occurring

[2] Saxon AJ, Calsyn DA. Effects of psychiatric care for dual diagnosis patients treated in a drug dependence clinic. Am J Drug Alcohol Abuse. 1995;21(3):303-13.

[3] Substance Abuse Treatment for Persons With Co-Occurring Disorders Treatment Improvement Protocol (TIP) Series, No. 42. Center for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005.

disorders]" is "psychiatric consultation, or an onsite psychiatrist" who can provide services related to assessment, diagnosis, and medication. The document also suggests that, without psychiatrists on staff, agencies will have difficulties implementing evidence-based practices described in the TIP.

The Project for Psychiatric Outreach to the Homeless (PPOH) earned the Silver American Psychiatric Association Achievement Award in 2010.[4] PPOH is "dedicated to recruiting, employing, supporting, and training community psychiatrists to work with homeless and formerly homeless adults in community-based programs and other non-traditional settings". The PPOH psychiatrist often works with small agencies for a fraction of an FTE per week. In 2009, PPOH psychiatrists saw over 3,000 clients and 65 percent of clients who received ongoing treatment showed improvement in their psychiatric conditions. Furthermore, most clients find their engagement with psychiatrists to be respectful and productive.

There is empirical data from current agencies that employ psychiatrists to show that psychiatrists add value to both clients and agency staff. Formal data, as described above, support these observations.

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

   While no formal studies have been done to assess the addition of psychiatrists to publicly-funded behavioral health agencies, the data described above (Archer; Saxon; SAMHSA; Psychiatric Services) suggest that it is a promising practice. The presence of psychiatrists in these settings has been considered essential for at least 20 years, as evidenced by the SAMHSA TIP. The primary barrier to the addition of psychiatrists to agencies has been the funding of their positions.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

   The addition of psychiatrists, even if at only 0.2 FTE per agency, can result in:

   - reduction in wait times for clients across the system to have appointments with psychiatrists
   - more clients having access to psychiatrists
   - more clients choosing and using medication assisted treatment across the system
   - improved services and coordination of care for clients with complex needs (e.g., co-occurring disorders, comorbid medical and behavioral health conditions)
   - decreased referrals to emergency departments, due to greater breadth and depth of interventions available through the psychiatrist
   - decreased referrals to jails, due to greater breadth and depth of interventions available through the psychiatrist
   - substance use disorder treatment agencies accepting more complex clients (e.g., clients with co-occurring disorders)

[4] Silver and Bronze Achievement Awards. Psychiatr Serv. 2010;61(10):1045-6.

- decreased use of detox programs, as outpatient detox through the agency could become an option
- increased referral to lower acuity services other than hospitals and jails, as issues (such as medical problems) may be discovered sooner for intervention
- increased diagnosis and treatment of underlying mental health conditions that clients with substance use disorders may be self-medicating for

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☐ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☐ **Adults**	☐ **Immigrant/Refugee**
☐ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☒ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

Individuals with more complex conditions, such as co-occurring disorders or medical conditions, would likely derive the greatest benefit from the addition of a psychiatrist to an agency.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

The addition of psychiatrists will benefit the agency and the population served regardless of where the agency is located, as there is a national[5] and statewide[6] shortage of psychiatrists.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities,**

[5] Japsen, Bruce. "Psychiatrist Shortage Worsens Amid 'Mental Health Crisis'" Forbes. September 15, 2015. Accessed December 4, 2015. http://www.forbes.com/sites/brucejapsen/2015/09/15/psychiatrist-shortage-worsens-amid-mental-health-crisis/.

[6] Groover, Heidi. "Where Are All the Doctors?" Inlander. February 27, 2014. Accessed December 4, 2015. http://www.inlander.com/spokane/where-are-all-the-doctors/Content?oid=2271525.

law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.

Mental health and substance use disorder treatment agency leadership must be willing to work with a psychiatrist.

A partnership with the psychiatry residency training program at the University of Washington can help place psychiatrists into agencies. Senior residents, who can practice without constant and direct oversight, can spend one day a week at specific community agencies. Residents benefit from the unique training experience and agencies benefit from having a psychiatrist on site. The University of Washington psychiatry department could provide clinical supervision and oversight to these residents.

The Veterans Administration (VA) Puget Sound Health Care System currently funds two addiction psychiatry fellowship slots. Fellows have completed their residency training and are choosing to specialize in the treatment of substance use disorders. King County or Washington State could purchase one fellowship slot from the VA. The addiction psychiatry fellow could then work in various publicly-funded behavioral health agencies. The VA addiction psychiatrists could continue to provide clinical supervision and oversight.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?

Washington State Senate Bill 6312 mandates the integration of physical and behavioral health. As noted above, the addition of psychiatrists, who are trained as physicians, to agencies would help meet the mandate of this law.

The Affordable Care Act aims to expand access to health insurance so more people can receive health care services, which includes psychiatric services. People should be able to access behavioral health services regardless of their station and circumstances in life.

The President of the United States also issued a memorandum to Federal Departments and Agencies in October 2015 to combat prescription opiate drug abuse and the heroin epidemic.[7] The memorandum included increased education to nurse practitioners and physicians about the prescribing of opiate medications. It also urged improving access to treatment. The addition of psychiatrists to agencies would meet the second item in the memorandum.

2. What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?

[7] "FACT SHEET: Obama Administration Announces Public and Private Sector Efforts to Address Prescription Drug Abuse and Heroin Use." The White House. October 21, 2015. Accessed December 4, 2015. https://www.whitehouse.gov/the-press-office/2015/10/21/fact-sheet-obama-administration-announces-public-and-private-sector.

The Mental Health and Chemical Abuse and Dependency Services Division administered a survey to its contracted agencies. 29 agencies responded, 18 of which provide both mental health and substance use disorder services. The survey was administered between 9/28/2015 and 11/2/2015. During this time, 23 of the 29 agencies had at least one open job position. Some jobs were open for one week; others were open for 15 or more weeks. Most jobs (31%) had been open for one to three weeks, but had been posted for between four and seven weeks (44%). Most of the open positions were for psychiatrists or nurse practitioners, licensed mental health professionals, and chemical dependency professionals. Over 80 percent of the agencies reported that they lost employees to programs that offered better pay or benefits. A majority of the agencies reported specific difficulties in recruiting nurse practitioners and psychiatrists.
As described above, there is both a nationwide and statewide shortage of psychiatrists. This is the primary barrier to implementing this proposal. Community psychiatrists, even locally, have lower salaries compared to psychiatrists working in hospital centers, private clinics, and other organizations. This is often a direct consequence of the suboptimal reimbursement from Medicaid and Medicare. Thus, even if there were a sufficient number of psychiatrists, some would choose to work elsewhere where they have greater salaries and benefits.

Strategies to recruit psychiatrists into the public sector include increasing training opportunities both in residency and fellowship and the provision of mentorship while in training. Loan repayment programs can also assist with recruiting and retaining psychiatrists in the public sector. Providing time and resources for education and professional development to psychiatrists will also help overcome the barriers associated with salary and benefits.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Some agencies that are not familiar with the medical model of care may feel discomfort with physician culture, though psychiatrists who choose to work in community behavioral health settings often differ in attitude and approach compared to their colleagues. Clients may initially be referred more frequently to urgent and routine medical care due to psychiatrist-identified concerns about medical conditions; this may initially increase costs for the health care system and distress for clients and agency staff alike, although improved health outcomes should follow over time. More clients may take medications indicated for their conditions.

If agencies become reliant upon MIDD funding to add psychiatrists to their staff, and if the funding should disappear, agency staff and clients may experience deleterious effects due to the absence of psychiatric services.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

If this proposal is not adopted, the status quo and its attendant problems will continue. Clients will continue to experience split care (e.g., mental health treatment in one agency, substance use disorder treatment in a second agency, and primary care in a third). Clients with co-occurring disorders may not receive appropriate assessment and treatment. Clients who may want or benefit from medication assisted treatment will have no access to this option.

Coordination of care across systems, particularly in medical systems, such as hospitals and clinics, will suffer due to the ongoing difficulties with communication. Agencies may not be able or willing to serve clients with more complex needs due to their medical or co-occurring conditions. Thus, some of the most vulnerable people in our communities may not receive services, and others will continue to receive sub-optimal fragmented services.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

Due to the current lack of psychiatrists, the system now uses alternative approaches that are suboptimal: Agencies refer clients with mental health and/or substance use disorder conditions to primary care providers for evaluation and medication interventions. However, primary care providers may lack the expertise to provide accurate diagnosis or treatment. Some clients receive mental health and substance use disorder services in parallel (e.g., mental health services at Agency 1 and substance use disorder services at Agency 2); some clients may not be eligible for services simultaneously and must receive "serial" treatment (e.g.., mental health services at Agency 1 first, until symptoms have resolved, then substance use disorder treatment at Agency 2).

While nurse practitioners have prescriptive authority, psychiatrists have more training and expertise, particularly for clients with more complex needs. Psychiatric nurse practitioners have minimal physical assessment skills, cannot prescribe certain classes of medications (e.g., buprenorphine and medications for medical conditions such as high blood pressure, diabetes, etc.), and often do not receive training in school on how to manage clients with co-occurring disorders.

Nurse practitioners can and should work with these populations. However, psychiatrists have greater breadth and depth of knowledge and clinical expertise to establish a clinical service in an agency that currently lacks medical personnel. The psychiatrists can also work with agency leadership to craft and implement clinical services that complement the agency's vision and goals, which may include the addition of nurse practitioners. These psychiatrists can then provide supervision to nurse practitioners and any other medical personnel.

Telepsychiatry is an alternative approach. For agencies that have never worked with psychiatrists, however, having a psychiatrist on site and available will initially add more value to the agency. Agency vision, goals, and culture are more difficult to translate through telehealth and psychiatrists can better demonstrate their skills and value in person. Furthermore, given that King County is not considered a health care provider shortage area, telepsychiatry should perhaps be reserved for instances where there is truly a lack of psychiatrists.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and**

Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

The addition of psychiatrists to agencies fully aligns with Behavioral Health Integration, as the health care system aims to integrate behavioral and physical health services. Psychiatrists, as physicians, can facilitate this integration.

This proposal also aligns with Best Starts for Kids, as psychiatrists are vital in evidence-based models used to detect and treat early psychosis in youth. Psychiatrists can aid in prevention and early intervention in children and youth; they can provide education to families about non-medication interventions and assess whether medications are even indicated in the treatment of children and youth.

Psychiatrists can also aid in the efforts of All Home. Individuals who experience chronic homelessness are more likely to have mental health and substance use disorders.[8] Psychiatrists working in agencies who focus on individuals who are homeless can assist in treating underlying mental health and substance use disorders in individuals who may not choose to seek care on their own.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Many individuals want and benefit from the care of a psychiatrist in their recovery journey. The addition of psychiatrists to agencies aids in the integration of care so that people have more options to pursue and achieve recovery and develop resiliency. Psychiatrists are trained in and deliver trauma-informed care. Many individuals with substance use disorders are surprised to discover they have undiagnosed underlying mental health conditions, such as depression or PTSD that contribute to their desire to use substances. Treatment of underlying conditions can be critical to facilitating recovery.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

People from all walks of life who want or may benefit from consultation with a psychiatrist should be able to access this service, regardless of their current circumstances or who they are. Placing psychiatrists in community based organizations will increase access to individuals who traditionally have not had this access. If their psychiatric issues are appropriately addressed, it could reduce their odds of becoming homeless or engaged with the criminal justice system.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

[8] Caton, Carol L.M., Carol Wilkins, and Jacquelyn Anderson. "People Who Experience Long-Term Homelessness: Characteristics and Interventions." 2007 National Symposium on Homelessness Research (2007): 4-1--44. Web. 5 Dec. 2015. http://aspe.hhs.gov/sites/default/files/pdf/125246/report_20.pdf.

The primary resource required is money to fund the position.

Other resources that would help the psychiatrist provide better care to clients include access to a private meeting space, a lab and pharmacy. If the agency offers services through telepsychiatry, the provision of the equipment and technology is necessary.

2. **Estimated ANNUAL COST. $100,000 or less Provide unit or other specific costs if known.**

FTE	Yearly total	Yearly salary ($100/hr)	Yearly benefits (30%)	Yearly overhead (15%)	Yearly malpractice insurance*
0.2	**$63,320**	$41,600	$12,480	$6,240	$3000
1 (0.2x5)	**$304,600**	$208,000	$62,400	$31,200	$3000

*Malpractice insurance costs vary, depending on group size, carrier, etc. The American Psychiatric Association provides individual malpractice insurance in Washington[9] that starts around $1500 per year for the first year, then increases to around $5000 by the fourth year.

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

Agencies can bill Medicaid for services provided by a psychiatrist to Medicaid-eligible individuals, although Medicaid payments for psychiatrists currently result in a net loss. Smaller agencies may not have the funds to recruit and initially support a psychiatrist.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**

The time-limiting step is the recruitment and hiring of psychiatrists. It will also take time for psychiatrists to go through "onboarding" at the specific agency; it also can take weeks for psychiatrists to complete the credentialing process with the managed care organizations.

Agencies may also have difficulties funding the remainder of the position that MIDD does not cover.

    b. **What are the steps needed for implementation?**

Agencies must be willing to work with and see value in hiring a psychiatrist. The agency will need to recruit for a psychiatrist. The hired psychiatrist must understand that s/he will essentially be crafting a new program within the agency and must be willing to work with the agency to define the role and scope of practice. If MIDD funds will cover only part of the psychiatrist's position,

[9] "American Psychiatric Association Endorsed Psychiatrist Professional Liability Program - Washington." American Professional Agency, Inc. N.p., n.d. Web. 5 Dec. 2015. http://www.americanprofessional.com/wp-content/uploads/APA_WA.pdf.

the agency must have the financial ability to fund the remainder of the position, or determine how to best use someone with a small piece of effort.

c. Does this need an RFP?

No.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

The lack of psychiatrists in publicly-funded behavioral health agencies is not limited to King County alone. This is an opportunity for King County to demonstrate leadership to the state by using funds creatively to provide integrated care in the health care system.

The most urgent need is within the substance abuse treatment agencies.

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

#2
Working Title of Concept: Getting More Psychiatrists Into Agencies
Name of Person Submitting Concept: Maria Yang
Organization(s), if any: King County MHCADS
Phone: 206-263-1103
Email: maria.yang@kingcounty.gov
Mailing Address: 401 5th Avenue, 4th floor, Seattle, WA 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Smaller agencies often do not have the resources to hire psychiatrists. Both staff and clients would benefit from the professional expertise, even if only one day a week (0.2 FTE). On average, psychiatrists are paid $100/hour. Smaller agencies can pay some portion of this salary (50%?) and MIDD funds can cover the remainder.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Psychiatrists have the skills to provide integrated care and direct care coordination. Psychiatrists can introduce medication assisted treatment to agencies that may have no other means of learning about or offering these services. Psychiatrists can provide education to staff and clients about both mental health and substance use disorders; they can also serve as liaisons with primary care providers to promote integrated care. Psychiatrists may also help reduce clients' use of emergency departments and jails, as they have the expertise to both identify and manage medical and behavioral concerns. Psychiatrists can also elevate the quality of care that an agency can provide.

3. How would your concept address the need?
Please be specific.

See above.

4. Who would benefit? Please describe potential program participants.

Clients would directly benefit from the care they receive from psychiatrists. Agency staff would benefit from more support and accessible expertise.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

Increased use of medication assisted treatment as indicated. More psychiatrists working in publicly funded agencies for longer periods of time. More coordination of care across medical programs and facilities. Hopefully less burnout and more clinical excellence within agencies.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Increasing psychiatric expertise within our publicly funded agencies should help achieve all the MIDD goals.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Agencies must be willing to work with psychiatrists and allow them to help direct services and programming, which may include medication assisted treatment. Agencies should also exercise flexibility to see how best to use the psychiatrists, as psychiatrists can do more than prescribe medications.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 21,000 ($50/hr for 0.2FTE) per year, serving (one small agency's clients) people per year**
Partial Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation:	**$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.