Expanding Access to Psychopharmacologic Management

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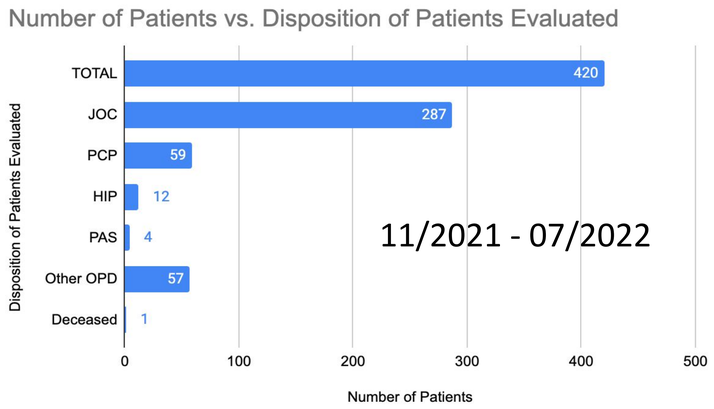
Problem

- In 2020, 12 psychiatrists departed CHA leaving 1000 patients without psychopharm care
- Notwithstanding these staff losses, the burden of care is often placed on PCPs and ED staff who are ill-equipped to address the mental health needs of complex patients
- Departmental silos and lack of mental health supports have only reinforced these challenges
- To reduce wait times for psychopharm treatment of CHA patients, we established the Joint Operating Clinic (JOC), a team of PCPs collaborating with a psychiatrist and pharmacist, to provide the behavioral health care for those patients and required evaluation to understand value of feasibility long term.

Interventions

- Trained 3 PCPs to provide psychopharm treatment
- Pharmacist shared patient care and helped lead team education.
- JOC provider template was congruent with those across CHA.
- Developed spiel for patients introducing concept of the JOC and what to expect.
- Preliminary risk stratification for initial patients managed in the JOC included complexity of mental illness, complexity of medication regimen, history of hospitalizations and suicide attempts.
- The team was able to determine which patients needed JOC care and which could return to the PCP. These discharges increased over time.
- Increased capacity of scheduling staff to meet patient and provider needs.

Results



July-Aug 2021
Chart Review (600 pts), Risk Stratification, referred back to PCP (~20%)

Jan-Jul 2022
Extended patient pool to include Service Adds

Aug-Dec 2022
Two providers stopped seeing patients, 0.33 FTE remained. Patients redistributed to the JOC, Primary Care and Outpatient Psychiatry

Aug-Dec 2021
Four providers (0.65FTE) managed patients whose psychiatrists left, including those covered by departing locums tenens

Jan-Present 2023
Continued to take on patients of newly departing psychiatrists, improve operations and provide recommendations to leadership

Patient Satisfaction

- "I like the service I am receiving and I am happy. I would not change anything"
- "Dr. Mathews helped with my problems"
- "It's been a year and I think things are better"

Counter Measure

- Number of patients scheduled into JOC templates are fewer than those in primary care
  - PCP 12pts/session
  - JOC 8pts/session

Impact

- **Quality of care was not compromised.**
- Complexity of patients who could be managed was greater than expected. Only those who were not engaged in care, required more case management, ECT or were treatment refractory needed to be referred to OPD provider.
- **Per unit FTE, JOC providers held a larger panel 572 patients/1FTE adjusted compared to a psychiatrist in the OPD ~360 patients/1FTE.**
- Utilization of clinical pharmacist greatly increased, expanding the number of new patients who were seen. This change is becoming standard of care.
- Psychiatrists' departures are ongoing and this poses an opportunity to increase FTE of JOC to counter the losses felt by patients without compromising quality of care.

Lessons Learned

- When patients are given the option to receive their psychopharm care from a team, we learned through qualitative feedback, that they find the care subjectively equivalent to the care they received from their prior psychiatrist.
- Psychiatry front desk can learn to work seamlessly with primary care staff to share best practices and thus improve patient and provider experience.
- Despite skepticism among psychiatrists early on, their doubts went away through collaboration, reassurance, and shared systemic improvements.
- We have identified perceived barriers between departments and are learning how to address those barriers through managing up.