Timely Access to Psychiatric Medication Management Services Across the State

Stakeholder Workgroup Report

Required by: Resolve 2023, c. 157, *Resolve, Directing the Department of Health and Human Services to Establish a Stakeholder Group to Study Timely Access to Psychiatric Medication Management Services Across the State*

Submitted by: Department of Health and Human Services

REPORT TO THE LEGISLATURE

The Maine Department of Health and Human Services (Department) is submitting this report, pursuant to Resolve 2023, Ch. 157, *Resolve, Directing the Department of Health and Human Services to Establish a Stakeholder Group to Study Timely Access to Psychiatric Medication Management Services Across the State*. This resolve requires the Department to convene a stakeholder group to study access to psychiatric medication management services across the State.

Per the Resolve, the Department was required to invite the following parties to represent the assembled stakeholder group:

- Psychiatric nurse practitioners who currently deliver psychiatric medication management services;
- Physicians who currently deliver psychiatric medication management services;
- Consumers and family members of consumers of medication management services;
- Advocates for mental health services;
- Experts in increasing the mental health workforce;
- Representatives of the Department of Labor and the Finance Authority of Maine;
- Representatives of educational institutions that train psychiatric nurse practitioners; and
- Representatives of professional associations for psychiatric nurse practitioners.

The stakeholder workgroup participants are listed in Appendix A. MaineHealth, a participant organization and large provider of psychiatric medication management services, submitted a minority report found in Appendix B.

The resolve directed the stakeholder workgroup to examine three aspects of psychiatric medication management services:

1) The availability of psychiatric medication management services across the State, including review of geographic and other disparities in accessing psychiatric medication management services;
2) The availability of psychiatric nurse practitioners to provide psychiatric medication management services; and
3) Challenges to sustaining and expanding the psychiatric nurse practitioner workforce, including an examination of educational opportunities, financial support for the education of nurse practitioners and the availability of nurse educators to train nurse practitioners.

This report addresses the three points noted in LD 2083 and presents the findings garnered from the multidisciplinary stakeholder group.

Availability of Psychiatric Medication Management Services Across the State, Including Review of Geographic and Other Disparities in Accessing Psychiatric Medication Management Services

Perception about availability of access to psychiatric medication management and the reality around access is not always aligned. Participants noted that there is a perception that more urban areas such as Greater Portland have more readily available access to medication management services, however, access is limited even in the urban areas of Maine. Cumberland County, for example, has both urban and rural areas. Although Cumberland County is thought to be well resourced, the reality is that this cannot be said for the entirety of the County, especially the more rural areas that are closer to Oxford County, for example. Further, the population is denser, requiring more resources to maintain adequate access.

Waitlists for medication management services were discussed noting that the wait times for medication management services ranged from one month to over a year[1]. It was noted that some agencies no longer keep waitlists because they don't anticipate having any ability to admit new clients for medication management services. Individuals who are admitted tend to remain in service for prolonged periods of time, preventing greater turnover and access. The issue of wait times is compounded by recruitment and retention challenges. It was noted that some agencies no longer keep waitlists because they don't anticipate having any ability to admit new clients for medication management. One community-based agency noted that a waitlist for medication management services already existed when a provider resigned, necessitating the remaining providers to absorb a client panel of 350 existing service recipients, and directly impacted the ability to take in new clients from the waitlist. Another organization has had an open provider position for two years. One participant noted concern that agencies keep different waitlists for MaineCare and commercially insured clients and recommended that the Department take note and look into this. MaineCare and commercially insured clients and recommended that the Department take note and look into this.

Many of the identified disparities below are not unique to this service; rather, because access can already be limited, there may often be increased pressure on or demand for specific services such as medication management:

- Access to telehealth: Some individuals either do not have access to technology needed for telehealth appointments, they aren't able to navigate the technology easily or at all, they have a limited number of minutes available to them on their devices and telehealth appointments would leave them without minutes or they don't have enough minutes for telehealth appointments.
- Access to in-person appointments: Some individuals prefer to have in-person appointments and are only able to access telehealth appointments due to provider capacity and availability rather than because of client choice.
- Gender: Some individuals prefer a certain gender of provider but feel compelled to accept whoever is available which can be trauma triggering, impact client retention, or impact the therapeutic relationship.
- Psychiatrist vs Nurse Practitioner (NP): Some individuals prefer to see a psychiatrist but only have the option of seeing an NP due to lack of availability of practicing psychiatrists.
- Transportation: The availability of transportation is variable across the state, making accessing services challenging.
- Childcare: Some individuals lack adequate childcare and either have to bring their children to their medication appointments or simply can't attend scheduled appointments.
- Financial: Many clients who access or seek access to community-based psychiatric medication management struggle with getting time off from work or have to go unpaid for the time away. For those with existing financial challenges, this becomes an added barrier to accessing care.

The workgroup noted that it is understood that both psychiatrists and psychiatric nurse practitioners enter the field to help people and often want to provide both therapy and medication management services. To accomplish this, many leave community-based settings and enter private practice because it is impossible to engage in full psychiatric service in 15-minute increments. It puts a lot of pressure on medication management providers which leads to burnout and turnover, and was noted that many medication management providers have dropped from full time status to part time status to balance burnout and

[1] The variance in wait times is predominantly driven by geography, size of the organization, and number of providers.

work/life balance. Our agency reported that of 19 medication management providers, only six are full-time, which impacts access to service. Additionally, provider agencies that accept MaineCare tend to serve those with higher clinical acuity. As providers leave community-based organization due to burnout and enter private practice, that increases the concentration of acuity being served at the community-based organization level.

The Availability of Psychiatric Nurse Practitioners to Provide Psychiatric Medication Management Services

Many participants expressed that realistically, NPs tend to be almost the only option for psychiatric medication management as there are very few practicing psychiatrists in the State of Maine and of those who are, many are in private practice and not in community-based settings or are only working part-time. It was noted that this lack of choice can impact a person's willingness to seek treatment.

There was some discussion regarding the differing expectations, as well as training, for the two primary types of providers - NPs and physicians – critical to medication management. While the expectations, at a practitioner level, are similar, NPs are expected to transition directly from school to practice with full or nearly full caseloads and productivity expectations before they may be professionally equipped to appropriately handle such. Medical school, on the flip side, is more graduated.

The workgroup noted that physicians are the highest trained psychiatric providers with more comprehensive training and highlighted the importance of looking more critically at all provider types that support medication management. The group also noted that recruiting and retaining psychiatric medication management providers is not just about filling gaps but about finding providers who believe in community-based behavioral health and are driven by its mission. It was noted in the workgroup psychiatrist numbers across the country are actually increasing, despite the significant decline in Maine, which points to the potential for attracting more psychiatrists to Maine[2]. There was consensus that a psychiatric system of care can't exist without psychiatrists and so attention must be paid to the full complement of psychiatric medication management providers and not just one level. The team-based approach to care is ideal and having physician collaborators is important.

It was noted that the lack of psychiatric medication management providers has led to primary care physicians and Family Nurse Practitioners providing more and more psychiatric care, which is not something within their comfort or expertise. Additionally, this trend compounds the overall systemic access challenges as there are also challenges to accessing primary care and those seeking primary care are often required to wait several months to a year before being admitted to a practice. This further emphasizes the need for psychiatrists in addition to NPs to successfully achieve sustainable expansion of medication management services. Another important aspect of psychiatric care being provided in primary care is that nurse practitioner educators are doing their best to prepare students in both family and psychiatric programs to be well rounded in their knowledge as they enter the field, however, this is becoming more difficult and the overall realities of practice expectations-both clinical and administrative-have the potential to be a disincentive for pursuing education and licensing as an NP.

Challenges to Sustaining and Expanding the psychiatric nurse practitioner workforce, including an examination of educational opportunities, financial support for the education of nurse practitioners and the availability of nurse educators to train nurse practitioners

[2] An article reflecting data on increasing numbers of graduates from psychiatric residency programs can be found here for additional reference: https://psychiatryonline.org/doi/10.1176/appi.pn.2023.05.5.043

One very significant factor in expanding the psychiatric nurse practitioner workforce is directly related to having enough providers/preceptors in the community that are willing and able to supervise both students and new graduates. One agency's medical director supervises six NPs while also carrying a caseload of clients. The agency provides two hours of 1:1 supervision per week for 24 weeks in addition to group supervision and supervision that is necessary outside of the formal structure. The agency is deeply committed to supporting NPs, however, there is a significant time investment which has both financial consequences and client access consequences. It was noted that this organization is fortunate to have the ability to provide this oversight and structure and that many organizations are not financially about to offer the same. Additionally, supervision doesn't stop at the requisite 24 weeks; ongoing supervision in psychiatry is imperative no matter the level or duration of experience.

It was noted that many agencies and providers within agencies are mission-driven and want to welcome students but are unable to. It is impossible to educate NPs when there is a lack of clinical placements and opportunity for clinical experience. It was noted that in the past, it was a bit easier to host students, but workloads have increased and productivity expectations for those supervising students are often not lowered, making it nearly impossible to provide the time and attention students need. Some agencies that used to host students are no longer able to do so.

There was discussion about the variability of clinical preparation students receive in NP programs and even more so between in-person and online programs. It has been observed and experienced that those coming from online programs need more hands-on, supervised clinical skills development which is another barrier to taking students that require more time. Additionally, it was observed that psychiatric nurse practitioners need more foundational training in general medicine which is requisite for psychiatrists but not psychiatric nurse practitioners. Medical background is necessary and the silos in which we provide treatment is part of what is driving increased care costs, particularly when there isn't time to collaborate across medical disciplines.

For those NPs who do either graduate from educational programs in Maine or are recruited from out of state, it was noted that there has to be a reason for them to remain in community-based settings - particularly in the central, western, and northern parts of the state where recruitment is more challenging. Individuals who live and work in the more rural parts of the state tend to be either mission driven or have family or other personal reasons for staying. Additionally, it is becoming progressively more challenging to retain medication management providers at any level due to the competition with out-of-state recruiters who are offering higher salaries.

The workgroup noted that psychiatrists have to complete four years of residency which helps to prepare them for ongoing practice. It is more than just learning diagnoses and how to prescribe medication; it is about building trust and rapport and truly understanding those being served. Nurse practitioners don't traditionally have residencies. One participant noted that a behavioral health system in northern Maine has started an NP residency for nine NPs which is fantastic but given the overall challenges with access to psychiatric medication management, this is not going to be enough, and that Maine is going to be challenged as retirements outpace new NPs entering the field.

Discussion occurred about financing NP education differently through loan repayment, stipends for NP residencies when they are available, as well as housing stipends for students as affordable housing becomes scarcer. One individual mentioned the Conrad State 30 Program, also known as the J-1 Visa Waiver Program that allows foreign medical graduates to practice medicine in underserved areas in Maine for two years and suggested that perhaps something akin to this program could be considered for NPs and Physician Assistants. It was noted that the Financial Authority of Maine (FAME) will be opening another

round of student loan repayment programs and are actively working on ongoing funding to support NP education. Another promising model that is receiving positive national attention hails from the Washington State Health Care Authority. The model endorses an enhanced teaching clinic rate which provides an avenue for agencies who host and train students to receive financial compensation.

Finally, discussion occurred around the various rules and regulations that community-based psychiatric medication management providers must adhere to. One provider acknowledged certain challenges in understanding and ensuring compliance with policies covering psychiatric medication management due to the different requirements. Similarly, there was also mention of the contrast in administrative expectations for the various practitioners – primary care, psychiatrists, and psychiatric nurse practitioners – with greater regulations and rules specifically for psychiatry. These challenges, coupled with the variations in acuity among individuals with SPMI, can have unintended consequences for the parity of accessibility and availability of providers depending on insurance type and individual needs.

This report will close with a direct quote from a workgroup member:

> *"Psychiatric care is much more than the medication management which condenses the role to offering prescriptions. It's so much more than that. There is pharmacologic and non-pharmacologic care, referrals, connection to communities, connection to clubhouses for skills-building and making friends, so much more than just medications. Psychiatry is the field that builds bridges between islands."*

Appendix A
Workgroup Participants

- Angelina Klouthis Jean, Director of Innovation and Strategy, Department of Labor
- Arlene Almazan, MD, Medical Director, Kennebec Behavioral Health
- Beth Dube, APRN-BC, Director of Psychiatric Services for MaineHealth Behavioral Health Portland and Norway
- Debra Poulin, LCSW, CCS, Office of Behavioral Health, Director of Clinical Services
- Emily Mott, Staff Attorney, Disability Rights Maine
- Henry Eckerson, Children's and Behavioral Health Policy Manager, Office of MaineCare Services
- Joy Gould, Director of Healthcare Workforce Development, Department of Health and Human Services Commissioner's Office
- Leah Bauer, MD, Medical Director, Behavioral Health Services, MaineHealth Behavioral Health at Mid Coast Hospital
- Maine Nurse Practitioner Association (Did not respond to invitation)
- Rebecca Schroeder, MPH, PMHNP, Associate Professor, University of Southern Maine
- Sarah Calder, Senior Government Affairs Director, MaineHealth
- Simonne Maline, Executive Director, Consumer Council System of Maine
- Steven Fritzsche, Comprehensive Health Planner II, Office of MaineCare Services
- William Norbert, Governmental Affairs and Communications Manager, Financial Authority of Maine

Appendix B
Minority Report Submitted by MaineHealth

On behalf of MaineHealth, we appreciate the opportunity to provide additional information and context about the challenges related to increasing and sustaining access to Medication Management services.

MaineHealth is an integrated non-profit health care system that provides the full continuum of health care services to the residents of eleven counties in Maine and one in New Hampshire. As part of our vision of "Working Together So Maine's Communities are the Healthiest in America," MaineHealth, which includes MaineHealth Behavioral Health (MHBH), is committed to creating a seamless system of behavioral healthcare across Maine, coordinating hospital psychiatric care with community-based treatment services, and better access to behavioral healthcare through integration with primary care.

As the state's largest – and one of the last remaining – providers of Medication Management services, last year we denied nearly 31% of the referrals we received for outpatient psychiatry simply because we don't have capacity. To meet the growing demand for services, we must be able to offer competitive pay to recruit and retain both psychiatrists and psychiatric nurse practitioners. The majority of our patients seeking outpatient psychiatry are covered by MaineCare and we estimate that the current MaineCare rates cover only 50% of the cost of providing this care. MaineHealth lost over $5.5 million dollars last year alone providing Medication Management services, an increase of $1.1 million from the year prior.

Without sustainable rates, we are not able to compete with the salaries of private practice or recruit from out of state. MaineCare's decision last year to pause the rate review for Medication Management means that we will continue to sustain these losses – which are likely to continue to grow – for the next three years until the rate is scheduled to be reviewed again. This is not sustainable, and we will continue to lose access if the rates are not addressed.

With that said, MaineHealth requests that the investment approved by the Legislature last Session and then continued (albeit at a reduced amount) in the Governor's proposed biennial budget for Medication Management recruitment and retention be moved to the MaineCare budget so that we can maximize the State's investment and receive the federal match, and temporarily increase rates pending a rate review.

Medication Management is the very foundation of the services necessary to support individuals with behavioral health needs in their communities and keep them out of hospital Emergency Departments, and we look forward to working with the Department and the Legislature to ensure that this foundational service is available during a time of increased demand.