Physician Assistants in the Psychiatric Workforce: A Practical Guide to Training, Implementation and Innovation

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Crisis is a subspecialty

Crisis services go here!
Agenda

• Who we are and what we do
• The case for PAs in the crisis setting
• Training psychiatric PAs in crisis care
• PAs and integrated care
Who we are
We are a physician-owned organization specializing in facility-based crisis services

Urgent Psychiatric Center
in Phoenix, AZ

Crisis Response Center
on the Banner-University Med Ctr Campus in Tucson, AZ

“We address any behavioral health need at any time.”
What we do

- Facility-based health crisis programs that provide
  - 24/7 on-demand access
  - A safe and welcoming environment
  - Rapid triage and psychiatric assessment
  - Crisis Stabilization:
    - Via counseling, medications, peer groups, family engagement, etc.
  - Connection to community resources

Studies show this model reduces:
- ED boarding\(^1,2\)
- Inpatient hospitalization\(^1,2\)
- Arrest\(^3\)

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Low clinical barriers to access

• “No wrong door”
• We do our best to take everyone:
  – No such thing as “too agitated”
  – Can be highly intoxicated
  – Can be voluntary or involuntary
• Fewer medical exclusionary criteria than many inpatient psychiatric hospitals
• Police are never turned away
23-Hour Observation Unit

- Staffed 24/7 with MDs, NPs, PAs
- Medical necessity criteria similar to that of inpatient psych (danger to self/other, etc.)
- Diversion from inpatient:
  - 60-70% discharged to the community the following day
  - 70-80% conversion from involuntary to voluntary treatment
  - Early intervention
    - Median door to doc time is ~90 min
  - Interdisciplinary team
    - Including peers with lived experience
  - Aggressive discharge planning
  - Collaboration and coordination with community & family partners
  - Assumption that the crisis can be resolved
Why PAs for psychiatric care??

A good psychiatrist is hard to find!

We have long depended on multidisciplinary teams – including PAs and NPs – to make our model successful.
Why Physician Assistants?

- There were approximately 80,019 Certified PAs at the end of 2010; the profession grew 44.4% over the next 6 years reaching 115,547 Certified PAs at the end of 2016.

- On Dec. 31, 2016, there were 115,547 Certified PAs. The number of PAs has grown 6.3% between 2015 and 2016.

Why PAs for psychiatric care??

- Physician Assistants aren’t heavily marketed for psychiatry. Current data shows only 1.3% of all PAs are currently practicing in Psychiatry.

Why PAs? For primary care.

• We need to keep our patients out of the ED
  – Sending patients to the ED unnecessarily opposes our tx model
  – We have encouraged our psychiatric providers to “doctor up” and treat basic medical issues

• We need to do a better job with chronic medical illnesses
  – Our population is becoming more medically ill
  – More focus on whole health and wellness
  – Let’s do a better job engaging these hard-to-track patients in primary care while they are with us

• This is a challenge with psychiatrists
  – Who are already hard to find
  – And even harder to find for the crisis subspecialty
Perhaps with dual supervision PAs can help with both?
Training Psychiatric PAs for Crisis Care

• Analyze facility need:
  – Urgent Psychiatric Care Center:
    • In 2007, 12 million, or 12.5% of total ED visits, were related to mental health and substance abuse.
    • American College of Emergency Physicians (ACEP) conducted a survey in 2008 which found that 99 percent of emergency physician admit psychiatric patient daily
    • Ideal candidates and recruitment efforts may shift pending data analysis (PA’s with ER experience vs. Psych experience)

• Analyze facility resources:
  – Supervising Physicians
  – Multidisciplinary approach
  – Hours and resources available for new hire training

Hiring Process

• New graduate PAs
  • Qualities for successful integration
  • Clinical Rotation experience
  • Fellowship programs
  • *References*

• Experienced PAs
  • General Medical vs. Psychiatric
  • Years of experience
  • Certification of Added Qualifications (CAQ)
  • Multidisciplinary approach
  • *References*
First 30-45 Days
(New Grad or Experienced)

Day 1-15: “Deer in Headlights”
• Expect NOTHING
• Standardized New Employee Orientation
• General overview of facility infrastructure
• Creation/Integration of multidisciplinary resource team
  – Integrated Care Approach
• Supervising Physician relationship building
  – Need time/resources allocated to this process
First 30-45 Days (New Grad or Experienced)

Day 15-45: “Test the waters”

• Shadowing approach
  – Educational
  – Relationship Building
  – Identify Strengths/Weaknesses
  – Resource Allocation

• Direct Patient Interaction
  – Supervising Physician Involvement
  – Multidisciplinary Team Involvement
  – Case Reports
  – Disposition and Treatment Recommendations
First 30-45 Days
(New Grad or Experienced)

Day 30-45

• Performance Evaluation
  – Identify strengths
  – Discuss weaknesses
  – Initiate a performance improvement plan (PIP)
Establish a standardized workflow from the Performance Improvement Plan (PIP)

- What level of Shadowing/Direct Oversight/Auditing is required (State vs. Facility)
- Begin weekly case studies
- Continue developing relationship with Supervising Physician
  - *Allocate Time and Resources*
  - Weekly to Biweekly meetings
- Engagement with multidisciplinary team to assist in PDP
  - Weekly to every other week
  - Identify strengths/weaknesses
  - Challenge team to improve development efforts
Day 90: Performance Evaluation

Clinical Expectations:
New Graduate vs. Experienced PA

- PIP overview
- Treatment Plans and Medication Recommendations
- Multidisciplinary integration
- Career Path and Development
- Resources for success (PIP, case studies, auditing, etc.)
Challenges and Next Steps

• Pearls:
  – *Only take on 1 new grad at a time if possible*
  – Focus on the long term- “Loyalty is earned”
  – Prepare for regression along the way
    • Multidisciplinary team support

• Next Steps:
  – PA Emergency Psychiatry Fellowship
    • Integrated with emergency medicine fellowship
Integrated Care Model

• Dynamic Approach to Psych PAs
  – Integrated Care Model with two supervising physicians
    • Psychiatry & General Medicine
    • Scope of Practice
    • Delegation Agreements
    • Training Protocols
Integrated Care Model

• Patient and PA outcomes
  – Full integration of body and mind
  – Improve patient satisfaction/compliance
  – Ideal for both rural and urban settings
  – PA recertification and professional responsibilities
Integrated Care Pilot at the CRC

• PAs with two supervising physicians
  – Psychiatrist
  – Family medicine physician
    • Case reviews, on-call for phone consultation

• Alternating weeks to avoid “pigeonholing”
  – One week focused on psychiatric care
  – Next week focused on primary care
    • H&Ps on the inpatient unit and 23h obs unit
    • Followups and consults as needed
    • Work with social services on care coordination for primary care followup
    • Helps with psych care when H&Ps are done
Outcomes

We didn’t see a big change in the percent of patients requiring transfer to the ED

But anecdotally:
- Less transfers for minor issues
- More transfers for serious issues that may not have been picked up before
- Bad outcomes averted by more thorough medical care
- Staff and patients like it
Challenges and next steps

• Challenges
  – Finding the right people for this unique role
  – Constantly having to resist the urge to pull the primary care PA to do psych care when there are coverage issues and surges in volume

• Next Steps
  – Reimbursement for H&Ps
  – More preventative care for this difficult to track population while they are a “captive audience”
Questions?

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Now THIS guy could really use some crisis intervention.