An Academic-Private Practice Hybrid Model for College Mental Health Services — A Pilot Study

Overview

College students represent a population that does not often seek out private mental health care, in part due to problems with accessibility and cost. Because many students have minimal or no coverage and many communities have limited options for low-cost care, colleges find themselves providing services for larger numbers of seriously ill students for longer periods of time (Schwartz, 2009). It has been shown that there is a large variation of psychiatric and counseling service use across campuses; at some campuses students seek twice the amount of care as others (Eisenberg, 2012). A variety of methods have tried to meet the growing demand, but it is worth considering more creative solutions to address the issue.

Little has been written in the literature about creating collaborative arrangements between academic institutions and private practices in order to help meet these demands on a larger scale. The following report describes an innovative program that seeks to address this critical imbalance and provide a testable solution. Novel delivery systems need to be created to assist and expand in providing these services, and the authors hope to provide the basis for further exploring a promising option. The suggested program utilizes fourth year psychiatry residents by bringing them into private practices under the supervision of a seasoned psychiatrist in order to rectify the imbalance and provide low cost care for nearby college student bodies. Not only will this design provide aid to students, but it will also allow the residents a unique opportunity to develop their skills in a private practice setting.

In the introductory section, a historical framework for the present study is provided and an innovative approach for medical training is summarized. Objectives, hypotheses, and justifications for the study are outlined. A detailed explanation of research methods is provided in the following section including the design and analysis, participants, procedure, and results. The article concludes with a discussion concerning implications for relevant populations, limitations of the present study, and recommendations for future research.

Introduction

Objectives

This report will demonstrate a testable model for providing college students with low-cost psychiatric care by using an academic-private practice model. The main objective of the study was to determine the efficacy of an academic-private practice model for providing mental health services to college students in a quantifiable manner. It was hypothesized that an academic-private practice collaboration would enable students to be provided with low cost psychiatric services and create an environment in which both clinicians and students would express satisfaction with the arrangement. The secondary objective was to examine the growing need for college mental health services with a review of current literature in the field, and provide a basis for further research to explore how the academic-private practice model can help students receive access to low cost psychiatric care.

Historical Context and Modern Approaches

Limitations of the Flexner model. The 1910 report by Abraham Flexner entitled "Medical Education in the United States and Canada" known today simply as the Flexner

Report, is considered to be the most influential development in Western physician training. It is widely thought to have heralded in a new age for the medical field, catapulting medical training out of the dark ages of the apprenticeship model and steering it towards the modern approach of placing medical education solely in the context of university culture.

Since the publication of the Flexner report in 1910, it has been used as the basis for creating standards of training at universities and as the reason for centralizing and consolidating training programs. It set the tone for using a centralized model as the paradigm for medical training at universities. In the Report, Flexner recommended that schools operating outside the standards for training he outlined in his report should either be closed or reformed. In the years immediately following his report, 12 out of the 138 schools he evaluated were closed, and another 26 schools were closed or merged in the next twenty years (Hiatt & Stockton, 2003).

It is important to note that Flexner's standards by which he graded schools were not solely based on the effectiveness and professionalism of training programs. Indeed, his criticism "…seems to have fallen most heavily on schools that professed philosophies diverging from the allopathic, were proprietary, or educated primarily women or blacks" (Hiatt & Stockton, 2003). He recommended that the "seven medical schools for negroes" be reduced to two, stating that African-American doctors should be continue to be trained but on a smaller scale, since they constituted "a potential source of infection and contagion"(Flexner, 1910). He also recommended closing every medical school specifically devoted to women (Hiatt & Stockton, 2003). It is worth considering that the standards on which our modern paradigm of training are based originate from a much more complex history than meets the eye.

It is possible that a "groupthink" has developed in the medical field regarding the Flexner Report and the supposed necessity of centralized training programs that can lead to stifling

innovation. The troublesome aspects of the Flexner report are widely overlooked in the abundance of academic and popular literature proclaiming the success of its impact. It is with this historical framework in mind, while considering the field's general consensus stemming from the impact of the Flexner Report is that models incorporating an apprenticeship aspect are archaic, that the present research was conducted. The authors wish to challenge the notion that the centralized model is the sole option for medical training by presenting a study in which a decentralized training model is used in combination with traditional university methods.

Decentralization of training as an alternative model today. The present study suggests that an academic-private practice hybrid model of training that combines a hands on apprenticeship-like approach in conjunction with the structure and standards that traditional university training provides is an option for modern training. In the context of providing psychiatric care for college aged students, this approach could prove exceptionally useful in bridging the gap between the high volume of students requiring care nowadays and the availability of clinicians who can provide low cost treatment.

The suggested arrangement entails bringing fourth year residents into private practices under the supervision of a physician to offer students an opportunity to obtain supervised care at a reduced fee. In order for this model to work on a larger scale, a marked adjustment is required in the culture of academic medicine and its relationship with both clinical and adjunct faculty. It calls for a paradigm shift with the emphasis on training moving away from academic centers and outsourcing it to private practices and volunteer adjunct faculty, often with small or no staff and little financial incentive to teach. This model would attract faculty who are more altruistically inclined due to the removal of financial incentives, versus other models that place greater emphasis on obtaining a high reimbursement.

The posited approach is reminiscent of apprenticeship programs that trained American physicians from the late 18th to the early 20th century (Corner, 1965). It encourages greater collaboration between academic centers and clinicians in the area, perhaps opening up more research opportunities and the chance to reach certain patient populations that, due to location or cost, may not obtain care otherwise. A fourth year elective rotation through a psychiatry residency program can mitigate the problem and expand available services. An elective rotation is a method whereby clinical care can be provided to a particular group in need, college students, which meets both the training requirements for a PGY-4 psychiatry resident elective and provides a treatment option for local college students at a reduced cost.

With 193 psychiatry residency programs in the United States (Graduate Medical Education Data Resource Book, 2015), the proposed model could be of great benefit to these programs in providing clinical rotations for the residents throughout the United States while simultaneously providing low cost care for college students. Initial start-up costs for such a program would include identifying adjunct faculty qualified and interested in training residents and designing an official program protocol. Once the initial protocol is established, training programs for adjunct faculty could be designed, standardized, and taught online at minimal cost. Informing patients in the area about the availability of these services may also incur some varying cost, depending on the region's demographics.

Decentralization of the teaching model would require greater scrutiny of the services provided to ensure success. The creation of metrics would be necessary to measure the performance of programs run by adjunct faculty, and comparative metrics would be helpful to ascertain whether the hybrid model is as effective for both patient care outcomes and teaching residents compared to the more traditional pathway.

Justification for the Present Study

The rise of mental illness among college students. The demand for college mental health services is growing rapidly. Several factors are cited as contributors to this trend, including reduction in stigma and students coming to college already on psychotropic medications (Grasgree, 2013). Other reasons include increased awareness of college mental health issues following the Virginia Tech tragedy, greater media coverage regarding campus suicides, and a growing Internet presence addressing campus mental health issues.

Lack of providers for college students. Most of the 4,500 degree-granting institutions in the United States provide mental health counseling support to their students, but only 63% of schools provide psychiatric services on campus (Schwartz, 2009). Given that 14% of students seen at college counseling centers are referred for psychiatric evaluation (Schwartz, 2009), many students annually require psychiatric care. Colleges and universities are struggling to meet the students' needs, and the present study posits a novel way for university counseling centers to meet the growing need for psychiatric services working in collaboration with local practices.

There is a gross imbalance between the number of college age students seeking mental health care and the physicians available to provide care. Efforts to address this imbalance include placing limits on the length of treatment permitted, using nurse practitioners for medication management, having medications prescribed by student health staff, or triage followed by referral to the community. If the university has a medical school, students may be seen by a member of the faculty or a resident in the department of psychiatry; although some counseling centers are staffed with a resident as a clinical rotation. Schools without this resource frequently

make arrangements with a specific private provider who will accept a reduced fee or a contracted HMO (Mistler, Reetz, & Krylowitz, 2012).

If unaddressed, problems with mental health can significantly affect academic outcomes in college. The search for solutions is elusive. There are no reports about utilizing private practitioners in partnership with an academic program to address this need. As a way of meeting the demand for services, this alternative private-practice hybrid model is proposed. The authors believe that the remarkable lack of research exploring an academic-private practice option combined with the growing need for college mental health services is sufficient justification for the present study. The results of the pilot study entail vast implications regarding the utility of conducting further research, and indicate that an academic-private practice model is a promising option worth exploring in further studies.

Method and Results

In March of 2013, a collaborative arrangement was launched with the Georgetown University Hospital Department of Psychiatry and Fairfax Mental Health, a private practice in Northern Virginia. The arrangement utilized a fourth-year psychiatry resident from the adult psychiatry program, Katharine Adams, D.O. Dr. Adams worked to complete her residency at Fairfax Mental Health under the supervision of Roy Stefanik, D.O., an adjunct faculty member at Georgetown University and private practice entrepreneur. Dr. Adams provided low-cost psychiatric services to students from a variety of universities including George Mason University, Northern Virginia Community College, and Duke University. If additional patient appointment times were open, members of the general public were also scheduled. Availability

of the services was made public by advertising on the practice website in addition to notifying students through the Counseling and Psychological Services Center at George Mason University.

Dr. Adams was scheduled to see patients one afternoon per week for a total of four hours each week. Fairfax Mental Health provided office space and administrative services for a six-month period. The collected patient fees contributed to overhead such as office space, staffing, and covering the resident's salary portion. 10% of the resident's salary was paid by Fairfax Mental Health; the remainder by Georgetown University. The practice does not accept insurance and patients are required to pay at the time of the visit. Dr. Stefanik, the attending physician, did not accept any stipend or salary for the position of adjunct faculty, but operated as a volunteer supervisor spending two to three hours per week overseeing and meeting with Dr. Adams.

During the course of Dr. Adams' time at Fairfax Mental Health, twenty-six intakes were completed within the first five and a half months of training; no new patients were scheduled beyond that time due to excessive patient demand for follow-up. The reimbursement for services from the patients was found to adequately cover expenses due to overhead and 10% of Dr. Adams' salary. It is important to note that of the twenty-six patients under Dr. Adams' care 54% suffered from anxiety and 46% suffered from depression (some percentage overlap due to comorbidity). She also attended to patients diagnosed with ADHD, PTSD, OCD, and other mood disorders.

Anecdotally, patients expressed satisfaction with the quality of psychiatric care provided at the reduced cost and appreciated the availability of the resource. Although formal collective outcome measures were not obtained, the patients' return rate spoke to their satisfaction. Dr. Adams found it professionally gratifying to see patients in a private practice model prior to finishing residency. She stated, "Working at Fairfax Mental Health was such a great experience.

I was able to get a feel for having my own patients." As a supervisor, Dr. Stefanik was highly satisfied with the opportunity to provide low-cost services to this population.

Discussion

Conclusions and limitations. In pooled 2007 and 2009 Healthy Minds samples from over 13,000 survey respondents at 26 schools, only 36% of students with an identified mental health problem- defined as positive for depression, panic disorder, generalized anxiety disorder, suicidal ideation, or self- injury- received any form of treatment in the previous year. Of those obtaining treatment, 11% received psychiatric medication only; 11%, psychotherapy/counseling only; and 14% both (Hill-Burton Free and Reduced-Cost Health Care, n.d.).

Most of these students who receive help are primarily experiencing conditions such as mood disorders, anxiety disorders or substance abuse, rather than schizophrenia or other psychotic disorders (Hill-Burton Free and Reduced-Cost Health Care, n.d) Higher cost medical services (e.g., inpatient or partial hospitalization services, ECT, rTMS, etc.) may not be able to operate within such a cash-based fee for service model. For now, the primary focus of care using the hybrid model would be for less complicated outpatient services such as medication management and psychotherapy.

A potentially complicating issue with the proposed model would be the frequent changing and rotating of residents. Developing long-term relationships with providers can become problematic as some patients may have reservations about sharing personal or private information with a provider who may leave the rotation within a short time. A potential solution could be found if some of these same patients transition to the same resident if he or she decides

to go into private practice nearby. In joining the private practice after residency, the resident will enter with an established group of patients.

Geography could pose an obstacle if some of the adjunct programs are a considerable distance away from the university. Solutions for these areas and associated cost must be further analyzed and discussed. This model could be particularly beneficial in more rural areas where psychiatrists or primary care physicians are relatively scarce, but nearby academic centers may be able to distribute residents to the available sites. The increased revenue can then offset the cost associated with travel or relocation of the resident.

Various subspecialties in psychiatry may also benefit from the proposed model, such as child or adolescent, geriatric, or medical illness programs. Practitioners would also benefit from the marketing of a private practice affiliated with a university training program. Further study is needed to determine what level of improvement in patient satisfaction, if any, would be derived from such a model change. This alternative approach is applicable to college mental health but can be extrapolated to other medical fields as well. Primary care practices nationwide potentially face a massive influx of patients following the implementation of the Affordable Care Act.

Routine medical services could be provided in a similar fashion. Specialties that may be able to use this model include family practice, internal medicine, dermatology, or others that focus primarily on outpatient care. It is important to consider the long-term effect of this program on the medical market place. Since residents do not operate under the auspices of managed care, it is possible that a shift back to a more traditional cash-based system may eventually create a competitive marketplace that can make medical care more cost-sensitive as patients would have greater incentive to shop for medical services. This has become more of a factor recently as some medical laboratories and medical practices throughout the country are now offering significantly

reduced rates for services to patients not going through insurance (Grasgree, 2013). Because the sample size used is small, it is critical to establish metrics on a larger scale to further test the proposed theory.

Current residency programs. Psychiatry specialty training has grown in popularity for medical school graduates. The National Resident Matching Program (NRMP) offered a total of 1371 residency programs with a fill rate of 98.4% in 2013 (National Resident Matching Program, 2013). Although there is some variability in design, all psychiatry residency programs offer a core curriculum as part of the training. For example, the first year at the University of Pennsylvania program combines rotations in internal medicine and neurology with inpatient and emergency psychiatry (Program Structure, n.d.). At the University of California, San Francisco (UCSF) the residents have a total of six months combined experience in the UCSF Departments of Medicine, Emergency Medicine and Neurology, as well as six months of psychiatry training at San Francisco General Hospital (Clinical Rotations, 2015-2016).

Despite efforts to standardize requirements, many psychiatry programs do not offer college mental health as part of the training. The Dartmouth College Student Mental Health Rotation is a notable exception. It is a popular fourth-year elective in which the residents have the chance to individualize their own training with guidance and approval of faculty (Dartmouth-Hitchcock, n.d.) Another example is the Northwestern University psychiatry residency curriculum, which allows residents the option to work in college mental health at either Northwestern University or the University of Chicago (Department of Psychiatry and Behavioral Sciences, n.d.). Residency training in college mental health plays a vital role in training programs at some of the top psychiatric facilities in the nation.

Structuring a general model for future research. In order to provide non-medical university students with low-cost psychiatric care, medical universities can work alongside adjunct faculty associated with a private practice. Physicians will make it known to medical universities that they are willing to supervise fourth-year residents. The university will then send the fourth-year psychiatry residents into the private practices. It will be necessary for adjunct faculty to support the teaching of established curriculums and confirm that residents meet minimum requirements for completion of training consistent with the Accreditation Council for Graduate Medical Education (ACGME). Residents require experience in treating patients of varying backgrounds and diverse problems.

Adjunct faculty will be responsible for reviewing university guidelines to deal with any problematic behavior by residents or staff such as HIPAA violations or disciplinary issues. Universities would have less direct monitoring of programs and would have to rely more on providers not located on the university campus. If the program expands, these providers would essentially become an army of volunteer faculty.

An attending physician providing supervision pays for ten percent of a resident's salary, amounting to approximately $8,000/year for a resident to work four hours per week. In a densely populated area with 300 private providers who are adjunct faculty and half choose to participate in this program, it would generate $8,000 x 150 = $1,200,000 per year in additional revenue for the university. This revenue can be used to expand the number of available residents and support the program's expansion, thus meeting two primary goals: providing low-cost care to college students and giving the fourth-year residents invaluable training.

Patients seen by the resident pay a reduced fee. Many residency programs currently operate under the premise that residents cannot contract with insurance companies, Medicare or

Medicaid, and function primarily on a cash-based reduced fee for service model. In eliminating insurance usage, the resident can focus on caring for patients as opposed to tending to administrative tasks associated with managed care.

The supervising physician will spend 2-3 hours a week working alongside the resident and ensuring proper care is provided. Adjunct faculties are currently vetted as part of the process of being affiliated with a university making them accessible to universities and residents. This allows for a starting point in determining which private practices to contact. The arrangement is predicated on the assumption that adjunct faculty would be willing to volunteer time to provide a significant portion of the education and training of each resident. The physician does not need to receive a stipend from the university. Competent office staff is necessary to ensure efficient scheduling practices, assist in maintaining adequate patient volume to cover essential overhead costs, and collect fees at the time of the visit.

Implications for clinicians and student populations. The prospect of an academic-private practice hybrid model to provide mental health services for college students offers promise in providing good care at a low cost. Patients, residents, and faculty may all find the simplified model appealing. It can also be applied in a variety of different subspecialties of psychiatry as well as other medical specialties. In addition, it may generate a new source of revenue for universities to expand training.

This model not only provides a novel method of providing psychiatric care in a cost-effective way, but it also fundamentally alters how residency programs approach the training and teaching of residents in a number of different disciplines. It creates a promising opportunity for adjunct faculty to “pay it forward” by striving to enhance the educational experience of the resident in a practical setting while providing quality low-cost health care. Since this program

can be introduced slowly, future evidence-based studies can assess its effectiveness, validity and value. It may be a winning situation for patients, residents, universities and providers alike.

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