CHILDREN'S ACCESS TO PSYCHIATRIC CARE IN OHIO: FINAL REPORT

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EXECUTIVE SUMMARY

This study consisted of three data collection activities. First, we conducted a "mystery shopper" survey, in which researchers posed as parents and called a random sample of 561 psychiatry offices across 9 regions of Ohio under different scenarios (e.g., a 14-year-old female with depression, covered by Medicaid). We systematically recorded whether the office could take such a patient, and if so, the process and wait time to see a psychiatrist. This methodology enabled us to assess how appointment wait times for child psychiatry varied by insurance type, region, and other factors. Second, an online survey of 557 primary care providers (PCPs) assessed perceptions of access to psychiatric care as well as their familiarity with, and perceptions of the Pediatric Psychiatry Network (PPN). Third, we completed semi-structured interviews with 7 physicians who staff PPN to summarize their experiences with the service and recommendations for improvement.

We analyzed the data from these efforts in order to answer four central questions. Each of these questions with a summary of related results appears below.

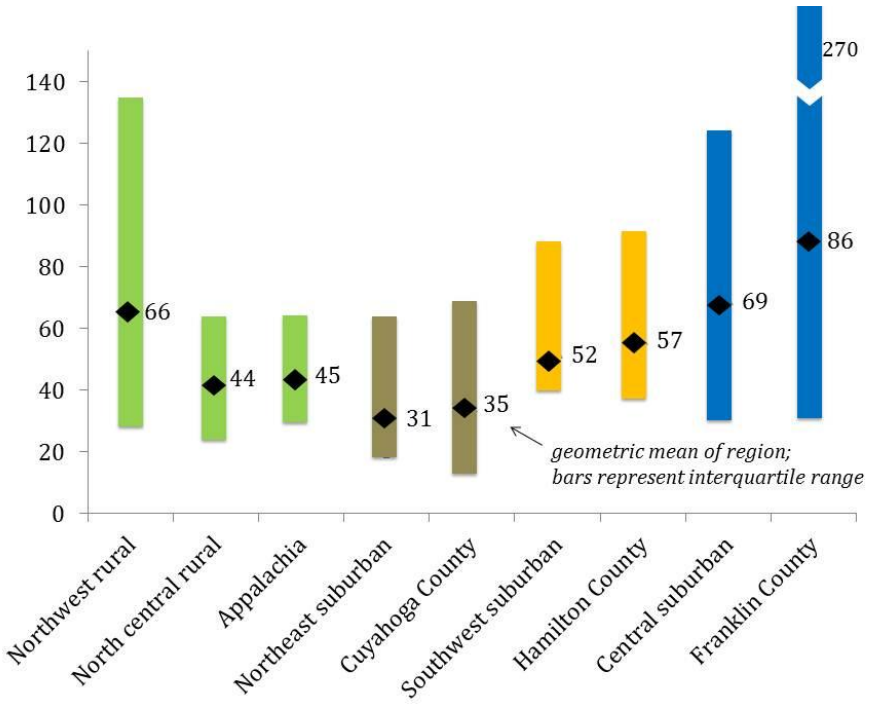
How long must Ohio children wait for psychiatry? An adolescent in Ohio typically waits 6 ½ weeks for a new patient appointment with a psychiatrist for routine medication management (geometric mean=46.2 days, s.d. =2.4). In the spring, **teens covered by Medicaid wait longer than those covered by a private insurance provider, Medical Mutual of Ohio** (MMO; 51 vs. 42 days). During the summer, however, we found no difference by insurance type. This discrepancy may result from heightened demand for psychiatry during the school year as well as greater availability of feasible appointment time during the summer when students are able to fill morning and mid-day slots without missing school.

For both Medicaid and MMO, **wait times in northwest rural Ohio, Franklin County and the central suburban counties were significantly longer compared to those in Cuyahoga County and northeast suburban counties**. Around each of the state's major metropolitan areas, adjacent counties report similar wait times (see figure below). The presenting problem (depression vs. anxiety) was not associated with wait times.

Using a benchmark figure of 30 days as the maximum reasonable wait time for this type of appointment, only 140 of 498 wait times (28.1%) were <30 days. For Medicaid, only 178 of 234 (24%) appointments met this threshold, although with considerable differences by region, and to a lesser extent, season. During the spring, for example, **54% of the Medicaid wait times in Cuyahoga County, were <30 days, compared to 0% in both Franklin and Hamilton counties**.

While long wait times were common, most regions had at least one office with shorter wait times. In the core metropolitan and suburban counties, minimum wait times were < 1week, whereas in the rural areas they were closer to 2 weeks (Table 4a). **Even with Medicaid only, it was possible to get an appointment within 2 weeks in 8 of the 9 regions.** Only Northwest rural Ohio was the exception, with a minimum wait time of 28 days.

Psychiatry appointment wait times (in days) for adolescents covered by Medicaid: Differences by Ohio region



How easy is it for Ohio parents to schedule an appointment with a psychiatrist? With a list of approved providers from an online directory of psychiatrists, it took a median of 3 calls and 9 minutes on the phone to find a psychiatrist who would see an adolescent for routine medication management. **Scheduling an appointment in Cuyahoga County was more difficult than in other regions**, necessitating a median of 9 calls and 23 minutes on the phone.

Overall, the provider directories were quite inaccurate. We were only able to make appointments at 18% of the 431 psychiatry offices listed in the Medicaid directories. Our experience in certain regions of Ohio was particularly troubling. **In Hamilton County, for example, only 5 of the 57 (9%) of the offices listed in the Medicaid directory could actually provide routine medication management for a 14-year-old covered through Medicaid.**

Physicians often agreed that parents often have a difficult time making appointments. In the words of one provider from a group practice in Hamilton County:

> *We need better access for patients to be seen. We have some very severe cases of mental illness and have to depend on parents to remember to call and call again, and make an appointment, and then keep an appointment when many times the parents have mental illness. This frequently leads to patients not being seen even when it is very important to function.*

How and why do Ohio primary care providers use the Pediatric Psychiatry Network?

On the survey, 7% of PCPs (n=35) reported they had already used PPN. Of this group, **68% agreed that overall, PPN was quite helpful,** and 41% reported that it helped them avoid referring the patient to a psychiatrist. Interviews with PPN psychiatrists yielded similar findings. Every interviewee noted that most calls go very well, from helping with complicated cases to reassuring PCPs that their initial treatment approach was appropriate. As one psychiatrist noted, "Most of the time I'm reassuring the PCP that their hunch is correct. They really appreciate it."

Yet the majority of respondents had never heard of, let alone used PPN. In short, **PCPs do not use PPN because they are simply unaware of it.** Among the PCPs responding to our survey, 77% were unfamiliar with the service. Even in Franklin County where PPN is most active, 64% of surveyed PCPs were not familiar with PPN. Of the 170 PCPs who had heard of PPN but had not used it, not having enough time for consultation (49% agreed), was a much greater barrier than the perception that they could handle cases on their own (27%) or the lack of reimbursement (20%).

Despite such barriers, **most PCPs liked the PPN concept** and reported they were "very likely" (20%) or "likely" (54%) to use the service in the future. Future likelihood of using PPN was more common among practices without a mental health provider on staff (77% vs. 63%, $\chi^2_{(1)}=7.43$, $p<.01$, $n=493$) and among providers who felt they could already handle most cases themselves (76% vs. 58%, $\chi^2_{(1)}=5.22$, $p=.02$, $n=162$).

What improvements to the Pediatric Psychiatry Network would be most effective and popular? On the survey, we asked PCPs: for each $1,000 state agencies might invest in improving PPN, how much should they spend among three realistic options. In descending order of popularity, their responses included: $497 to improve continuity of care, so you could access the same psychiatrist to discuss the same patient on multiple calls; $326 to improve the quality of written feedback from the PPN psychiatrist following each consultation; and $177 to provide quarterly updates of appointment wait times for child psychiatrists in your area.

PPN psychiatrists supported other, complementary approaches to improving the service. Many felt PPN would benefit from providing psychiatrists with time blocked off to respond to PPN calls. Doing so would enable them to gather more information and provide more detailed feedback – one of the more popular approaches favored by PCPs on the survey.

Some PPN psychiatrists also encouraged expanding and regularly updating the PPN web site. Practice guidelines, links to relevant grand rounds and local resources – especially for rural areas – were some of the suggested additions.

Conclusions and Recommendations

Based on our key findings, the following actions are realistic, compelling approaches for strengthening PPN and developing other efforts to improve Ohio children's access to psychiatric care.

PPN-specific recommendations

- Most PCPs are unfamiliar with PPN, yet support the concept – especially with a local connection. PPN should broadly and regularly advertise the service to PCPs in rural areas and in areas where it is already active (Cincinnati, Columbus, Akron).
- Update the PPN website to include resources such as psychotropic medication guidelines. Engage PCPs in the process of encouraging utilization.
- The PPN Steering Committee may want to consider training, developing a quality improvement component, and restructuring schedules to assist psychiatrists with the quality of written feedback provided to PCPs.

General recommendations

- Within Ohio, wait times vary markedly by region. Local Addiction, Drug Abuse and Mental Health (ADAMH) boards should work with insurance providers to monitor wait times and to develop region-specific strategies to recruit and retain child and adolescent psychiatrists.
- Wait times in northwest rural Ohio and central Ohio are especially long. Statewide efforts to improve children's access to psychiatry should be sure to focus on these regions. Working with universities around Toledo and Columbus may be particularly helpful in this regard.
- Around Ohio's three major metropolitan areas, wait times in adjacent counties resembled those in the core counties. This suggests that core and adjacent counties can be thought of as one market where families experience similar access to care. Metropolitan area ADAMH boards should work with their hospital catchment areas when considering actions that will affect access to care.
- ODMH may want to replicate the appointment availability assessment in other areas of Ohio that were not included in this study (e.g., Dayton, Toledo, Youngstown) to determine access issues.

ODMH should consider forming a working group of community stakeholders to create specific strategies to monitor and reduce wait times for child psychiatry and determine how to incorporate these strategies into other continuity of care initiatives.

We organized this project around four central goals:

Goal #1: To determine how long Ohio children must wait for an appointment with a psychiatrist for routine medication management.

Goal #2: To describe the ease with which an Ohio parent with Medicaid can schedule an appointment with a child psychiatrist for routine medication management (regardless of the wait).

Goal #3: To describe primary care providers' perceptions of their ability to access psychiatric care for routine medication management for their child patients.

Goal #4: To understand how and why Ohio primary care providers use the Pediatric Psychiatry Network (PPN).[1]

This report describes the methods we used to meet the goals, a summary of our findings, and related recommendations for improving children's access to psychiatric care in Ohio.

METHODS

This section provides details on how we collected and analyzed data for this study. All these activities were reviewed and approved by the Behavioral and Social Sciences Institutional Review Board of the Ohio State University. Please refer to the Appendix for additional related materials.

APPOINTMENT AVAILABILITY ASSESSMENT

At multiple sites within multiple regions of Ohio, we assessed wait times for an initial[2] appointment with a psychiatrist for routine medication management. We refer to this as the "Appointment Availability Assessment" or colloquially, "Mystery Shopper Survey." From March 15 through May 25, 2012, 3 members of the research team telephoned psychiatry offices across Ohio, each posing as a parent seeking a new patient appointment for routine medication management for his/her 14-year-old daughter[3] under four

[1] PPN is an initiative of the Ohio Department of Mental Health and several children's hospitals. It aims to build the capacity of primary care providers to manage their patients' mental health care. The centerpiece of this activity is a phone consultation service, by which a provider can request a psychiatric consultation and a trained child psychiatrist will respond to her/his request within 30 minutes. In addition the website (www.pedpsychiatry.org) can provide additional useful resources.

[2] The study focused on fictitious new patients because of the considerable logistical, legal and ethical concerns associated with using the names of real existing patients for assessing other types of appointments.

[3] In order to reduce the likelihood of bias, we maintained the gender and age of the fictitious patient as a constant (i.e., a 14-year-old daughter). After making 1,945 calls, we have no reason to suspect that patient gender influenced results and so feel that our results are generalizable to boys as well. In terms of age, however, these results are only representative of patients 14-17 years of age. On several occasions, an office noted that the psychiatrist would not see patients younger than 14 years old.

scenarios: (1) the child has depression and is covered by Medicaid; (2) the child has an anxiety disorder and is covered by Medicaid; (3) the child has depression and is covered through Medical Mutual of Ohio[4] (MMO; a large private insurance provider); and (4) the child has an anxiety disorder and is covered through MMO. We then repeated this procedure from June 21 to August 14, 2012.

Through this design, we assessed how our main outcome, appointment wait time, varied by region, insurance type (Medicaid vs. MMO), condition (depression vs. anxiety) and season (spring vs. summer). We also documented the ease of making an appointment, including the number of calls required, the total time on the phone and the frequency of inconsistent information from the same office.

SAMPLE OF PSYCHIATRY OFFICES

In February 2012, we selected offices that take Medicaid from the publically available Ohio Medicaid Managed Care Enrollment Center's online provider directory (http://www.ohiomcec.com/providerSearch/), using the following criteria: *provider type = physician; specialty = psychiatry; accepts patients as young as = 14.* The site included two types of results, "confirmed" providers who met all 3 criteria and "unconfirmed" providers who were missing information on minimum patient age, but who otherwise met the criteria. Because some psychiatrists who typically see adults will sometimes see a 14-year-old patient, we included both "confirmed" and "unconfirmed" providers in the sampling frame.

Concurrently, we used the publically available online provider directory of Ohio's second largest private insurance provider – Medical Mutual of Ohio (https://providersearch.medmutual.com/NetworkRealignment.aspx) to identify psychiatrists taking one type of private insurance. We searched for medical doctors in Ohio in their SuperMed PPO (Plus) Network, and then downloaded .pdf copies of directories by county. To parallel the "confirmed" versus "unconfirmed" criteria from Medicaid, we included providers listed as "child and adolescent psychiatrists" as well as "psychiatrists." We recognize that MMO is not representative of all private insurance providers in Ohio. Our including them is intended only to put the findings from Medicaid into context.

Because compiling data by cutting and pasting from online sources may result in data entry errors, two members of the research teams independently assigned unique officeids to each unique address and insured that all available phone numbers and providers at a given address were accurately recorded. Upon comparing the two draft versions, we detected 16 discrepancies out of 3,652 entries for a concordance rate of (99.6%). We investigated and corrected each discrepancy to produce of final spreadsheet of addresses and phone numbers for 578 unique office addresses.

[4] To limit bias, we chose a single private insurer provider to compare to Medicaid. Initially, we chose Aetna, which has the largest insurance provider (by market share) in the state, but they have relatively few child psychiatrists in network. Thus, we chose the next largest provider, MMO, which had considerably more child psychiatrists in network.

We stratified this sampling frame across 9 regions of Ohio, including 3 major metropolitan counties, 3 multi-county suburban regions and 3 multicounty non-metropolitan regions. Table 1 describes each region.

Table 1. Definitions of Ohio regions for the CAPCO appointment availability assessment

Region	Counties
1. Northwest rural	Defiance, Fulton, Hancock, Henry, Mercer, Paulding, Putnam, Van Wert, Williams
2. North central rural	Ashland, Crawford, Holmes, Huron, Marion, Richland, Sandusky, Seneca, Wayne, Wyandot
3. Appalachia	Adams, Athens, Belmont, Brown, Carroll, Coshocton, Columbiana, Gallia, Guernsey, Harrison, Hocking, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Perry, Scioto, Tuscarawas, Vinton, Washington
4. Southwest suburban	Butler, Clermont, Clinton, Warren
5. Central suburban	Clark, Greene, Madison, Fairfield
6. Northeast suburban	Geauga, Lorain, Medina, Lake
7. Hamilton County	Hamilton
8. Franklin County	Franklin
9. Cuyahoga County	Cuyahoga

We constructed these regions based on two criteria. First, we preserved multi-county groupings of local Addiction, Drug Abuse and Mental Health (ADAMH) Boards, since they are the most relevant government entities to act on this study's policy implications. We also employed a collapsed version of rural/urban continuum codes[5] to distinguish metropolitan and non-metropolitan counties. All three multi-county suburban areas consist of counties that are classified as either "central metropolitan" or "outlying metropolitan." The three rural areas consisted of "central micropolitan" or "non-metropolitan" counties, with a few exceptions necessary to preserve each region's geographic contiguity.[6]

From these sources, within each region we were able to generate one list of potentially eligible psychiatry offices that took Medicaid and another, overlapping list of psychiatry

[5] United States Department of Agriculture, Economic Research Service. *Measuring rurality: Urban influence codes.* Washington, DC: USDA; 2007. Available: http://www.ers.usda.gov/briefing/rurality/ruralurbcon/

[6] The North Central rural region includes Richland County which is classified as "central metropolitan" because of the presence of Mansfield (2010 population=47,821) . In the 24-county Appalachian region, four counties along the Ohio River are considered "central metropolitan" because of their proximity to small cities in other states, including Lawrence (Ashland, KY; Huntington, WV), Washington (Parkersburg, WV), Belmont and Jefferson (Wheeling, WV). Also, Brown and Carroll counties are now classified as "outlying metropolitan" because of the growing metropolitan sprawl of Cincinnati and Canton, respectively.

offices that took MMO. Table 2 summarizes the number of potentially eligible offices by insurance type in each region.

Table 2. Psychiatry offices listed as taking Medicaid or Medical Mutual of Ohio (MMO)

Region*	# offices taking Medicaid	# offices taking MMO	# offices taking either
1. Northwest rural	18	18	26
2. North central rural	30	30	46
3. Appalachia	60	47	78
4. Southwest suburban	46	35	60
5. Central suburban	27	24	36
6. Northeast suburban	38	41	56
7. Hamilton County	52	34	66
8. Franklin County	42	54	73
9. Cuyahoga County	92	106	137
TOTAL	405	389	578

* See Table 1 for definitions

Source: Ohio Medicaid Managed Care Enrollment Center's online provider directory; Medical Mutual of Ohio Online Provider Directory

To generate a random sample of offices we randomly ordered the list in each region for each insurance/condition/season cell (e.g., Medicaid/Depression/Spring). In region 3, for example, in the spring under the Medicaid/Depression scenario, we began calling office 30012, then 30053, then 30009 and so on down the random list of Medicaid offices in that region, until we were able to record wait times at 8 offices. We then proceeded to a different scenario (e.g., MMO/anxiety), where we progressed through a randomly ordered list of the MMO offices in that region.

When an office was unable to schedule an appointment, we asked for a referral to another office nearby. We recorded these referrals but did not immediately follow them in order to preserve the randomization of the sample. If we exhausted our list before recording wait times at 8 different offices, we then examined our list of referred offices, and if any were not on our original list, then added them to the list and called them accordingly. These new offices became part of our list and were randomly ordered and appended to the bottom of our list for calling in future cells in that region.

CALLING PROCEDURE

Three research team members posed at parents, including a 44 year old man, and two women, ages 24 and 26 years, who completed 50%, 23% and 27% of the calls respectively. We purposefully assigned different scenarios to each team member, so that no one person was exclusively responsible for completing all calls in a given region or under a certain insurance/condition cell.

In calling an office, each research team member posed as a parent and tried to find an appointment time under the given scenario *at the listed address*. For those offices that had more than one phone number, we randomly chose one number to begin calling. A call list decision tree chart appears in Appendix A1.

Three members of the research team completed the phone calls during regular business hours (i.e., Monday - Friday, 9am - 5pm). The scenario is summarized below. Whereas it is impossible to predict real world speech, a phone script describing how each conversation should proceed appears in Appendix A1.

The Scenario

Each caller is posing as a parent of a 14-year-old girl who has been on medication for a mental health condition. The family doctor has been prescribing the medication, but thought that she should see a psychiatrist because things have not been going well and she may need to adjust her medication.

Within this scenario, we alter two variables: insurance type (Medicaid or Medical Mutual of Ohio) and mental health condition (anxiety or depression). In one combination, for example, a caller will pose as a parent of a 14-year-old girl who is covered by Medicaid and who has been on medication for depression.

We never actually made an appointment, we only asked whether that office had a psychiatrist who would see a 14 year old for routine medication management and who would take the appropriate insurance type. If so, then we asked when next available appointment was with any psychiatrist in that office who met those criteria.

To minimize confusion, each team member was assigned a specific cell in a specific region. In the spring, for example, one member completed calls in region 3 (Appalachia) in the Medicaid/depression scenario, before another team member began calling offices in that region under a different scenario. To avoid overburdening any one office, no one address was phoned more than 4 times during a season.

Often, offices required patients to see a counselor or social worker for an intake assessment before patients could schedule an appointment with a psychiatrist. In such cases, we recorded the wait time as the sum of the days until the intake assessment plus the days until the next available psychiatrist appointment. When an office required multiple appointments with a counselor prior to seeing a psychiatrist, the appointment wait time

consisted of the cumulative wait until the psychiatry appointment. A few offices had a psychiatrist on staff as part of a larger multi-specialty practice and would only accept new patient appointments from one of their own in-house primary care providers. In such a case we assessed the wait time for a new patient appointment with a primary care provider and added that to the subsequent wait time for a referral to the psychiatrist at that address.

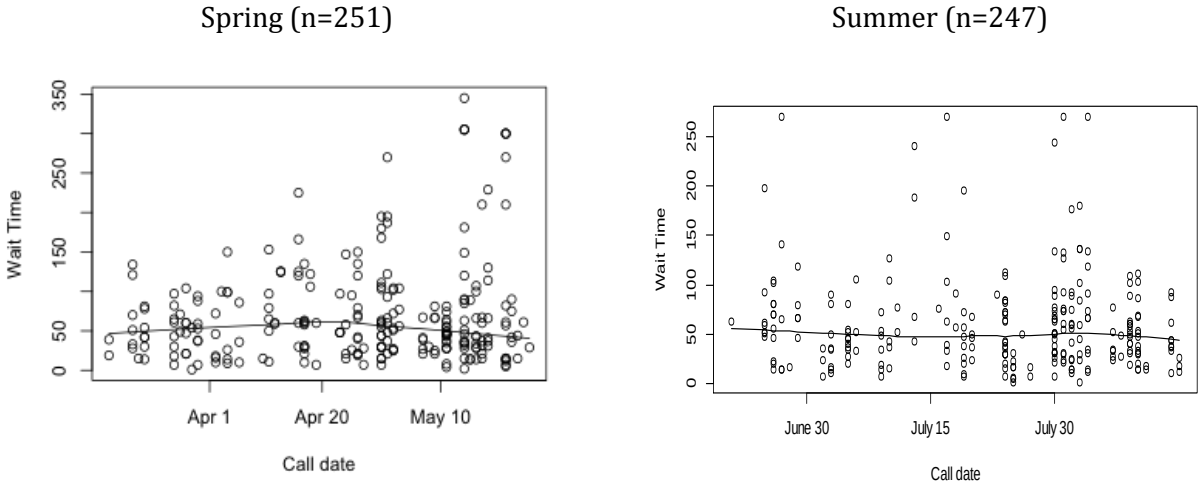
In addition to appointment wait time, we recorded the number of different offices, the number of phone calls and the total number of minutes on the phone required to make an appointment. For offices that were unable to schedule an appointment, we recorded the reason that we were unable to do so.

POSSIBLE SOURCES OF BIAS

In any study, certain aspects of the methodology can bias findings. For the mystery shopper survey, we identified three possible sources of bias, assessed the extent of their influence on our findings and, when possible, explored remedies.

One source of bias involved the point in time during the season (spring or summer) that we completed calls within a given insurance X condition X region cell. If wait times were longer in May than in March for example, then cells we called later in the spring might differ from those called earlier that season. We considered this effect before beginning the survey and so arranged our cells so that we called each region, insurance type, and condition throughout the period. Figure 1 presents the date of each call against the wait time. In the spring, there appear to be a few more extremely long waits in May, but overall the mean wait time (solid plotted line) is similar throughout the period. There was no apparent trend during the summer.

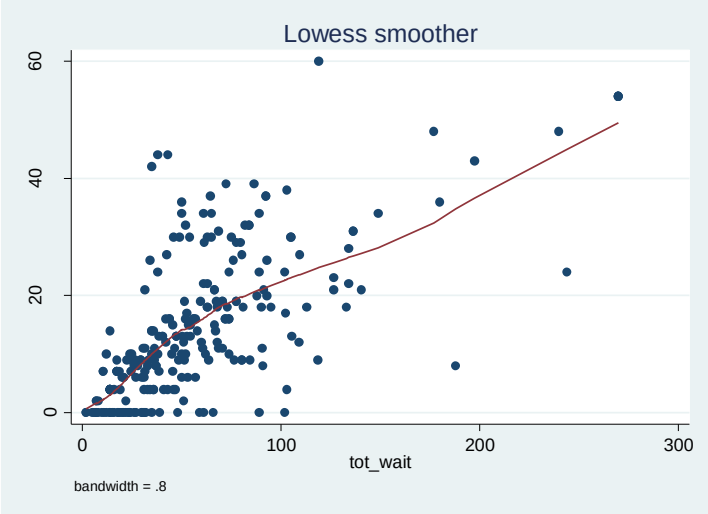
Figure 1. CAPCO Mystery Shopper survey: Appointment wait time by date of call



Another potential source of bias related to the need to estimate wait times. Most offices were not able to give us an exact date of the next available appointment. Instead, they often reported that the urgency would depend upon the intake assessment. In such situations, we asked approximately how far out they were scheduling and we got answers like "2-3 months" or "late August." We systematically recoded such ranges (see Appendix

A2), and took the median value as the wait time. A response of "4-6 weeks" for instance, would be entered as 35 days (i.e., 5 weeks). In the spring we only recoded the median value. In the summer, however, we recorded both the maximum and minimum values so we could examine the precision of each estimated wait time. As Figure 2 suggests, the longer the wait time, the less precise the estimate.

Figure 2. CAPCO Mystery Shopper survey: Appointment wait time by range of wait time



One approach to assessing the extent of this concern is to perform analyses on a subsample of offices with wait times with relatively precise estimated wait times (≤ 21 days). This approach, however, presents its own problems since it excludes all wait times from the spring and nearly all wait times during the summer that exceed 4 months. As such we discuss the possible effects of such bias in the conclusion section.

STATISTICAL ANALYSIS

Descriptive statistics for estimated wait times by region, provider, condition, and season were calculated. Three different summary measures for "typical" wait times are provided: the mean, median, and geometric mean. All summary measures have various strengths and weaknesses. The arithmetic mean and standard deviation are easily interpretable, but are very sensitive to large outlying values, which are likely to exist in a study of wait times. The median and interquartile range (75^{th}-25^{th} percentiles) are both very insensitive to outlying values, which makes them a useful description of "typical" wait times for the middle of the distribution. However, the insensitivity of these measures to outliers limits their utility in comparing across regions, conditions, and insurance types. Using only the median could mask important differences outside of the middle of the distribution. For these reasons, we prefer the geometric mean (and geometric mean standard deviation) to summarize the wait times. The geometric mean is the arithmetic mean of the log-transformed data, exponentiated back to the original scale. Equivalently, the geometric mean is the n^{th} root of the product of all values in the set (where n is the total number of observations). Because it is based on a logarithmic scale, the geometric mean is less influenced by large outlying values, however, these values still have some impact on the result. Therefore the geometric

mean is a compromise between the arithmetic mean and the median in terms of the influence of large outlying values on the result.

Due to imbalance in the final sampling scheme, adjusted linear regression models were run to account for possible confounding by region, condition, season, and insurance. If the original planned design (with perfect balance by these four factors) had been achieved, these linear models would have been unnecessary. Results from the regression models are presented as estimated geometric means assuming this complete balance. For example, the estimated geometric wait time for Medicaid in the spring is calculated from the model using an equal weight for each region (1/9) and condition (1/2). Similarly, the estimated geometric wait time for the Appalachian region in the spring would be calculated from the model using an equal weight for each condition (1/2) and each insurance type (1/2). All analyses were conducted using Stata 12.0 and R 2.14. Statistical significance was $p<0.05$ and results are unadjusted for multiple comparisons.

ONLINE SURVEY OF PRIMARY CARE PROVIDERS

The primary goal of the online survey was to learn why more primary care providers are not using PPN and which possible improvements they might find most helpful. This section describes our sampling frame, survey administration procedures, survey instrument and plans for data analysis.

SURVEY INSTRUMENT

The survey included 18 to 23 closed-ended items (depending on skip pattern), had four optional open-ended items, and typically took <6 minutes for the respondent to complete. We randomly split the sample into three groups and randomly administered a different version of the survey to each. The versions varied in a few questions about different common mental health conditions, specifically ADHD, depression and anxiety disorder. Six members of the research team and their colleagues pilot tested drafts of the survey to assess the instrument's clarity as well as the accuracy of its online administration.

The survey assessed several characteristics of the practice including size, type (e.g., private solo primary care practice; multi-specialty group practice), location, % of patients paying through Medicaid and whether a mental health provider was on site. Also we distinguished whether respondents were medical doctors (MDs) or osteopaths (DOs).

In addition to this background information, the survey questions focused on five topics: (1) experiences handling patients with common mental health problems; (2) familiarity with PPN; (3) barriers to providers using PPN; (4) experiences using PPN; and (5) preferred approaches to improving PPN. Appendix B1 includes the final draft of the depression version of the survey.

SURVEY ADMINISTRATION

We used the Ohio State University College of Public Health's account with Zoomerang (www.zoomerang.com) to administer the survey online. All communications were sent via an email address and respondents completed the survey on a secure (HTTPS/SSL) link to the

College of Public Health's password-protected account. The Zoomerang account also enabled us to track individual respondents and subsequently send reminder messages to only those providers who had not yet responded.

Our communication with participants included an initial invitation on July 9, 2012 with a deadline of July 16, 2012. We also sent 3 reminder emails spaced 3 days apart to individuals who had not yet visited the survey website. We closed the survey on July 24, 2012.

SAMPLE

The unit of analysis for the survey was each individual primary care provider.

We recruited PCPs from lists of MDs and DOs provided by the State Medical Board of Ohio. Information on each list included provider name, mailing address, email address, specialty codes and the first issue date of their license to practice. To identify providers who were most likely to be current primary care providers we only included providers with at least one of the following specialty codes:

> MDs[7]: FM (Family Medicine); FP (Family Practice); PD (Pediatrics); ADL (Adolescent Medicine, Pediatrics); MPD (IM/Pediatrics); AMI (Adolescent Medicine, Internal Medicine); FSM (Sports Medicine – Family Practice); PSM (Sports Medicine – Pediatric)
>
> DOs[8]: FM (Family Medicine); FP (Family Practice); PD (Pediatrics)

To be eligible, a respondent must have a valid email address and currently provide primary care to child and/or adolescent patients in Ohio. Thus, we also excluded individuals with a current mailing address outside Ohio as well as those with no listed email address.

From these lists we identified 6,282 MDs and 1,296 DOs with a current Ohio address, a valid email, and at least one specialty code associated with primary care. Despite meeting all these criteria, we suspected that a large but unknown proportion of the individuals on this list were NOT eligible in that they did not currently serve as PCPs. For this reason, our response rates are only approximations.

Table 3 presents the responses rates associated with three different versions of the survey. Overall, we estimate that 10.6% of eligible respondents completed the survey. Response rates did not vary significantly by version. This figure is a bit lower than other published online surveys of health providers, but may be an underestimate. A large but unknown proportion invited participants were probably ineligible, yet we assumed that they were no less likely to visit the website (and then be screened out) than individuals who were actually were eligible.

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[7] American Medical Association *AMA Physician Specialty Groups and Codes*. http://www.mmslists.com/definitionspdf/AMA%20Specialty%20Codes.pdf

[8] Illinois Osteopathic Medical Society. *Specialty Codes*. http://www.ioms.org/publicaccess/specialitycodes.htm

Table 3 Response rate and disposition of online provider survey by survey version

	depression	ADHD	anxiety	Total
(1) invited	2,484	2,685	2,409	7,578
(2) hard bounce	71	91	87	249
(3) soft bounced	74	71	54	199
(4) opted out	42	45	46	133
(5) screened out	84	72	81	237
(6) not responded	2,196	2,416	2,136	6,748
(7) completed survey	177	162	163	502
(8) usable partial completion	15	15	12	55
(9) unusable partial completions	14	22	19	42
(10) estimated eligible non-respondents*	1,489	1,673	1,427	4,589
response rate	11.1%	9.3%	10.6%	10.6%
numerator**	192	177	175	557
denominator***	1,723	1,895	1,648	5,279

*estimated eligible non-respondents=(7/[5+7])*6 **numerator=7+8 ***denominator=4+7+8+10

DATA MANAGEMENT & ANALYSIS

Because the data were from a convenience sample, we did not weight data to be representative of all PCPs in the state.

We downloaded the data from each of the survey versions into a combined Excel file, where we cleaned and formatted the data. One member of the research team (KJS) then completed a series of analyses of the numerical data in Stata 12. Open-ended responses were grouped thematically in Excel and analyzed with data from the structured qualitative feedback (see below). The de-identified raw data were provided to project sponsored in October 2012.

STRUCTURED QUALITATIVE FEEDBACK

We conducted key informant interviews via telephone with psychiatrists who have consulted with PPN at Akron's Children's Hospital, Nationwide Children's Hospital and Cincinnati Children's Hospital. Based on information from our state agency partners, we identified 12 PPN psychiatrists, including 3 from Akron, 4 from Columbus (Nationwide) and 5 from Cincinnati. We contacted these psychiatrists by email and phone to invite them to participate. Of those contacted, 7 completed interviews, 0 refused and 5 declined to return our repeated calls and emails within our study schedule. Six of the participants had been involved in PPN since the beginning, including 4 who were involved in its original conceptualization. Two

participants had only personally fielded 4-6 calls, whereas the others had handled 30-40 calls, or simply too many to count.

DATA COLLECTION & ANALYSIS

During the interview the research team recorded written notes. If the participant said something the interviewer considered noteworthy, the interviewer asked the participant to stop or repeat the phrase so it can be recorded verbatim.[9] Immediately following each call, the interviewer will type up the notes and include additions and comments based on her/his recollections. The only identifying information that the written notes included were the date of the interview and the participant's location (Akron, Columbus or Cincinnati). The typewritten notes omitted names and identifying information other than the participant's location. Following completion of the typewritten notes, the interviewer destroyed the original handwritten notes on which they were based.

Prior to the interviews, the members of the research team developed a codebook that included the range of responses we anticipate participants will give to each question. At two meetings, members of the research team participated in team-based coding and analysis,[10] in which they compared notes from each interview and identified common themes across the interviews and assessed how these compare to the codebook developed a priori. We also considered how they relate to the open-ended comments provided by respondents to the online provider survey and how participants' responses vary across different sites. These common themes along with unidentified verbatim quotes appear in a written summary of our findings (see Appendix C2).

RESULTS

We organized the results section of this around the project's four central questions: (1) How long must Ohio children wait for psychiatry? (2) How easy is it for Ohio parents to schedule an appointment with a psychiatrist? (3) Why and how do primary care providers use PPN? and (4) What improvements to PPN would be most effective and popular?

HOW LONG MUST OHIO CHILDREN WAIT FOR PSYCHIATRY?

An adolescent in Ohio typically waits 6 ½ weeks for a new patient appointment with a psychiatrist for routine medication management (geometric mean 46.2 days, s.d.= 2.4).[11] Wait times ranged widely, however, from as little as 1 day, to up to 345 days, with

[9] Verbatim quotes from the interviews appear in quotation marks "". Otherwise, notes reflect the interviewers written notes from the interview.

[10] Guest G, Macqueen KM. *Handbook for Team-Based Qualitative Research*. Lanham, MD: Altamira Press; 2008.

[11] There are several figures we could use to summarize the experience of the "typical" wait time. These "measures of central tendency" (e.g., mean, median) have different strengths and weaknesses. In general, we report the geometric mean because it uses all data points, but is less sensitive to the influence of

the interquartile range[12] being 29 to 81 days. Table 4a presents the detailed results by region, insurance and condition, and Table 4b presents results for the Medicaid sample.

In the spring, **teens covered by Medicaid wait longer than those covered by MMO** (51 vs. 42 days). During the summer, however, we found no difference by insurance type. This discrepancy may result from heightened demand for psychiatry during the school year as well as greater availability of feasible appointment time during the summer when students are able to fill morning and mid-day slots without missing school.

For both Medicaid and MMO, **wait times in Northwest rural Ohio, Franklin County and the Central suburban counties were significantly longer** compared to those in Cuyahoga County and Northeast suburban counties. Around each of the state's major metropolitan areas, adjacent counties report similar wait times (see Figure 3). Presenting problem (depression vs. anxiety) was not associated with wait times.

Despite these trends, there was still considerable variation within each region. In the core metropolitan and suburban counties, minimum wait times were about < 1week, whereas in the rural areas they were closer to 2 weeks (Table 4a). **Even with Medicaid only, it was possible to get an appointment within 2 weeks in nearly every region** (Table 4b). Only the Northwest rural counties lacked an attractive alternative. There, the minimum Medicaid wait time was 28 days. While this may be due to the small number of offices that accept Medicaid in this region, it still highlights the reality of unusually limited access to care in this region.

extreme values (i.e., outliers). The geometric mean is similar to the arithmetic mean, except that the numbers are multiplied and then the *n*th root (where n is the number of items in the set) of the resulting product is taken.

[12] The interquartile range (IQR) refers to the range of values that fall between the 25th and 75th percentiles in an ordered set. In Table 4a, for example, the IQR of appointment wait times overall was (29,81). This means that of all the different wait times we collected, 25% were less than 29 days and another 25% were more than 81 days. Or in other words, 50% of the wait times were between 29 and 81 days.

Table 4a. Psychiatry appointment wait times (in days) for adolescents by condition, insurance, region and season

	n	Mean (sd)	Median (IQR)	Range (min, max)	Geometric Mean (sd)
Overall	498	64.7 (56.6)	50.0 (29,81)	(1,345)	46.2 (2.4)
Anxiety	246	65.1 (55.6)	52.0 (30,81)	(2,345)	47.8 (2.3)
Depression	252	64.3 (57.8)	47.0 (28,78)	(1,305)	44.7 (2.5)
Medicaid	234	70.1 (61.9)	55.5 (31,84)	(2,305)	50.3 (2.4)
Medic. Mutual of Ohio	264	59.8 (51.1)	47.3 (26,78)	(1,345)	42.8 (2.4)
Northwest rural	32	75.8 (40.0)	73.3 (37,105)	(11,149)	64.2 (1.9)
North central rural	60	51.8 (27.7)	48.0 (30,64)	(12,166)	45.1 (1.7)
Appalachia	64	54.6 (34.5)	46.5 (33,70)	(14,177)	46.2 (1.8)
Southwest suburban	64	65.6 (46.6)	55.3 (33,91)	(4,229)	50.1 (2.2)
Central suburban	62	82.8 (71.0)	60.5 (37,93)	(7,345)	60.9 (2.2)
Northeast suburban	61	41.5 (28.4)	37.0 (15,61)	(2,113)	30.3 (2.5)
Hamilton County	43	60.4 (32.7)	66.5 (39,81)	(1,137)	47.4 (2.4)
Franklin County	56	113.8 (99.5)	84.5 (26,150)	(2,305)	69.6 (3.1)
Cuyahoga County	56	41.8 (43.2)	28.0 (14,55)	(2,210)	27.1 (2.6)
Spring	251	69.2 (63.4)	51.0 (28,89)	(1,345)	47.8 (2.5)
Summer	247	60.0 (48.5)	50.0 (30,76)	(2,270)	44.6 (2.3)

Note: Figures do not adjust for clustering by office or imbalance in calls made. IQR=Interquartile Range

Table 4b. Psychiatry appointment wait times (in days) for adolescents covered by Medicaid, by condition, region & season

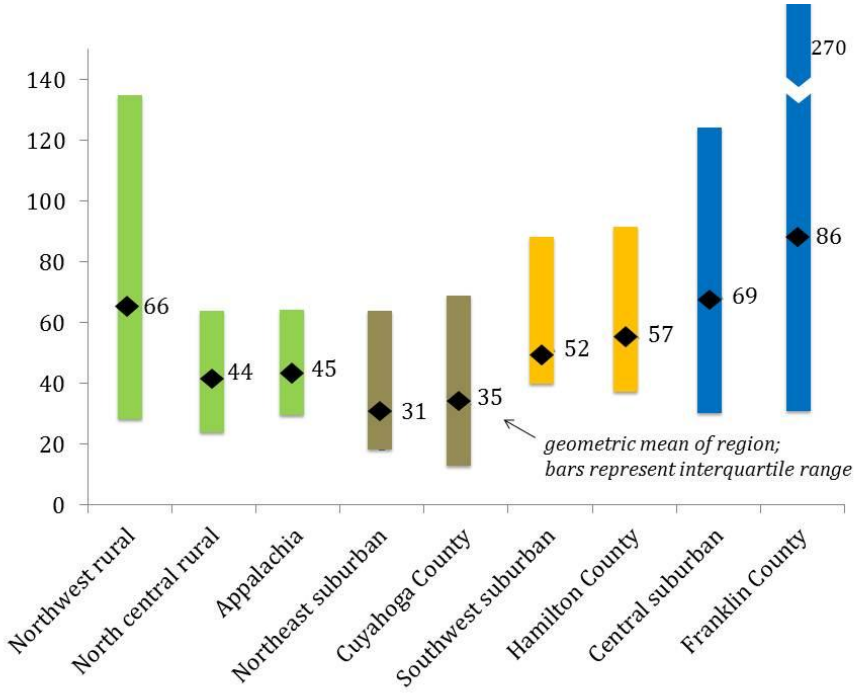
	n	Mean (sd)	Median (IQR)	Range (min, max)	Geometric Mean (sd)
Overall	234	70.1 (61.9)	55.5 (31,84)	(2,305)	50.3 (2.4)
Anxiety	119	70.4 (58.4)	60.0 (31,89)	(2,300)	51.6 (2.3)
Depression	115	69.8 (65.6)	49.0 (32,78)	(2,305)	49.1 (2.4)
Northwest rural	14	78.9 (46.9)	66.5 (35,134)	(28,149)	65.8 (1.9)
North central rural	28	52.4 (31.9)	51.0 (28,64)	(12,166)	44.1 (1.8)
Appalachia	32	52.1 (31.4)	44.5 (33,64)	(14,177)	45.1 (1.7)
Southwest suburban	32	62.3 (30.4)	57.5 (46,88)	(4,120)	52.0 (2.1)
Central suburban	31	90.5 (68.9)	62.0 (37,122)	(16,270)	69.3 (2.1)
Northeast suburban	30	41.2 (24.5)	43.0 (18,63)	(2,84)	30.9 (2.5)
Hamilton County	15	65.8 (30.1)	67.0 (41,89)	(14,107)	56.5 (1.9)
Franklin County	27	145.3 (115.7)	93.0 (36,270)	(2,305)	86.2 (3.6)
Cuyahoga County	25	48.8 (37.1)	42.5 (15,67)	(7,135)	34.9 (2.5)
Spring	121	78.2 (71.8)	60.0 (34,93)	(2,305)	54.0 (2.5)
Summer	113	61.4 (48.0)	52.5 (31,75)	(2,270)	46.7 (2.2)

Note: Figures do not adjust for clustering by office or imbalance in calls made. IQR=Interquartile Range

Using a benchmark figure of 30 days as the maximum reasonable wait time for this type of appointment,[13] **only 140 of 498 wait times (28.1%) were <30 days** (data not shown). For Medicaid, only 56 of 234 (24%) appointments met this threshold, compared to 84 of 264 (32%) for MMO. This metric, however differed markedly by region, and to a lesser extent, season. During the spring, for example, **54% of the Medicaid wait times in Cuyahoga County, were <30 days, compared to 0% in both Franklin and Hamilton counties**.

Compared to the spring, MMO wait times were about the same in the summer, yet **Medicaid appointment wait times decreased significantly during the summer** from 51 to 42 days (Table 5a). This trend was limited, however, to Franklin, Hamilton and the Central suburban counties (Table 5b). Medicaid wait times in Franklin County, for example, declined from 120 days in the spring to 48 days in the summer.

Figure 3. Psychiatry appointment wait times (in days) for adolescents covered by Medicaid: Differences by Ohio region



Note: Please refer to Table 4b for complete data, and to p. 15 for a description of geometric means and interquartile range

[13] There is no standard benchmark for an acceptable waiting time for a routine child psychiatry. We chose the 30-day figure following consultation with two experts in children's access to psychiatric care (Kelly Kelleher and Cynthia Fontanella). Also, the Canadian Psychiatric Association recommended "4 weeks" for "access to a psychiatrist after referral by a family physician" for "scheduled diagnostic and medication management." Canadian Psychiatric Association. *Wait Time Benchmarks for Patients with Serious Psychiatric Illness*. Ottawa, ON: Canadian Psychiatric Association; 2006. Available: http://www.waittimealliance.ca/waittimes/CPA.pdf .

Table 5a. Seasonal differences in psychiatry appointment wait times (in days) for adolescents: Estimated[1] Geometric Means (95% CI)

	Spring	Summer
Insurance		
Medicaid	50.9 (42.3, 61.2)	41.9 (35.2, 50.0)
MMO	41.9 (35.8, 48.9)	43.8 (37.9, 50.5)
Region		
Northwest rural	75.6 (48.1, 118.9)	74.6 (53.0, 105.0)
North central rural	47.7 (35.8, 63.5)	41.9 (31.0, 56.6)
Appalachia	47.9 (37.4, 61.2)	51.6 (40.7, 65.5)
Southwest suburbar	47.9 (31.2, 73.4)	47.0 (34.0, 65.1)
Central suburban	59.2 (40.3, 86.8)	43.9 (28.2, 68.4)
Northeast suburban	26.2 (17.0, 40.4)	36.9 (25.0, 54.5)
Hamilton County	42.5 (24.3, 74.5)	43.3 (26.6, 70.5)
Franklin County	72.6 (43.8, 120.5)	44.0 (24.2, 79.9)
Cuyahoga County	24.1 (15.9, 36.6)	20.7 (13.0, 33.0)

[1] Values are estimated assuming complete balance by condition, region, insurance. MMO=Medical Mutual of Ohio

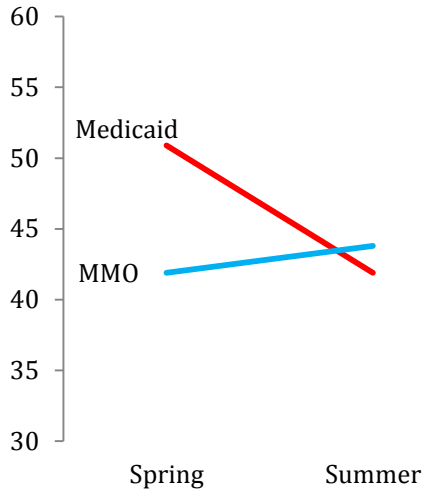
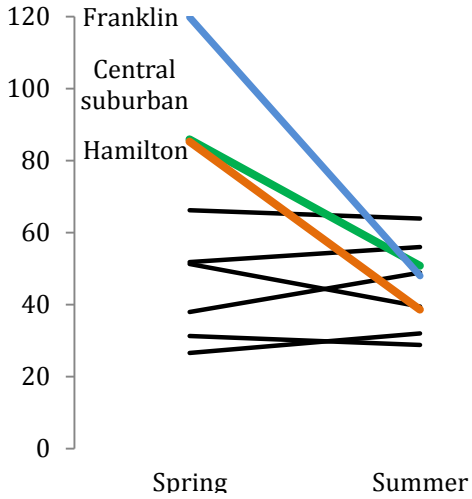


Table 5b. Seasonal differences in psychiatry appointment wait times (in days) for adolescents covered by Medicaid: Estimated[1] Geometric Means (95% CI)

	Spring	Summer
Region		
Northwest rural	66.2 (37.5, 116.7)	63.9 (37.3, 109.6)
North central rural	51.3 (36.5, 72.0)	39.5 (26.3, 59.5)
Appalachia	38.0 (28.5, 50.7)	48.9 (36.8, 65.0)
Southwest suburba	51.8 (28.7, 93.2)	56.0 (44.3, 70.8)
Central suburban	85.9 (55.5, 132.9)	50.8 (33.3, 77.6)
Northeast suburbar	26.6 (14.2, 49.8)	32.0 (18.4, 55.6)
Hamilton County	85.3 (63.4, 115.0)	38.6 (21.4, 69.6)
Franklin County	119.8 (55.0, 261.1)	48.0 (19.9, 115.8)
Cuyahoga County	31.3 (18.6, 52.6)	28.8 (15.0, 55.4)

[1]Values are estimated assuming complete balance by condition.



HOW EASY IS IT FOR OHIO PARENTS TO SCHEDULE AN APPOINTMENT WITH A PSYCHIATRIST?

With a list of approved providers from an online directory, it took a median of 3 calls and 9 minutes on the phone to find a psychiatrist who would see an adolescent for routine medication management. **Scheduling an appointment in Cuyahoga County required considerably more phone calls than in other regions**, necessitating a median of 9 calls and 23 minutes on the phone. These figures do not include the amount of time required to wait between calls. A common experience, for example, was for a "parent" to call an office and leave a message. She would receive a return phone call two days later only to learn that the office no longer sees children. She then phones another office where she is able to make an appointment.

One source of frustration for parents is that many offices listed on provider directories are not actually able to serve 14-year-olds seeking routine medication management. We quantified this by calculating the proportion of offices listed in the Medicaid and MMO provider directories where confirmed that they could indeed provide this service and would accept the type of insurance.

At 79 of the 431 offices (18%) listed in the Medicaid directories, we were able to schedule appointments (Table 6). In comparison, we were able to do so at 25% of the 406 offices listed in the MMO directories. Differences in the respective accuracy of the Medicaid and MMO directories varied by region. In many regions, differences were modest. Yet in Hamilton County and the Southwest suburban counties, the Medicaid listings for child psychiatry were much less accurate than those of MMO (Table 6; Figure 4). **In Hamilton County, for example, only 5 of the 57 (9%) of the offices listed in the Medicaid directories could actually provide routine medication management for a 14-year-old covered through Medicaid.**

PCPs often agreed that parents often have a difficult time making appointments. In the words of one provider from a group practice in Hamilton County:

> *We need better access for patients to be seen. We have some very severe cases of mental illness and have to depend on parents to remember to call and call again, and make an appointment, and then keep an appointment when many times the parents have mental illness. This frequently leads to patients not being seen even when it is very important to function.*

In calling the offices, we encountered similar difficulties in trying to make an appointment using the Medicaid or MMO listings. Combining data from both lists (Figure 5), the most common explanations were that the office did not see children (26%), did not offer psychiatry (24%),[14] or that we were simply unable to contact them (23%).[15] Among the offices that we could contact, that offered psychiatry and would see children, many were not taking new patients (9% of total) or no longer took the listed insurance type (6%).

[14] This category includes offices that had closed or had no MD willing to prescribe medication.

[15] This category included wrong numbers and unsuccessful repeated attempts to call.

Table 6. Regional differences in the number and proportion of offices listed in Medicaid and Medical Mutual of Ohio provider directories where it was possible to schedule a child psychiatry appointment.

	Medicaid			Medical Mutual of Ohio		
	# of listed offices called	# of offices able to schedule	% of offices able to schedule	# of listed offices called	# of offices able to schedule	% of offices able to schedule
Northwest rural	19	4	21%	19	5	26%
North central rural	38	9	24%	34	10	29%
Appalachia	55	16	29%	43	18	42%
Southwest suburban	52	8	15%	35	14	40%
Central suburban	29	9	31%	26	11	42%
Northeast suburban	43	9	21%	45	13	29%
Hamilton County	57	5	9%	39	8	21%
Franklin County	45	8	18%	58	9	16%
Cuyahoga County	93	11	12%	107	15	14%
TOTAL	431	79	18%	406	103	25%

Note: See p. 6 for a description of the sources of the provider directories.

Figure 4. Regional differences in the percentage of offices listed in Medicaid and Medical Mutual of Ohio provider directories where it was possible to schedule a child psychiatry appointment.

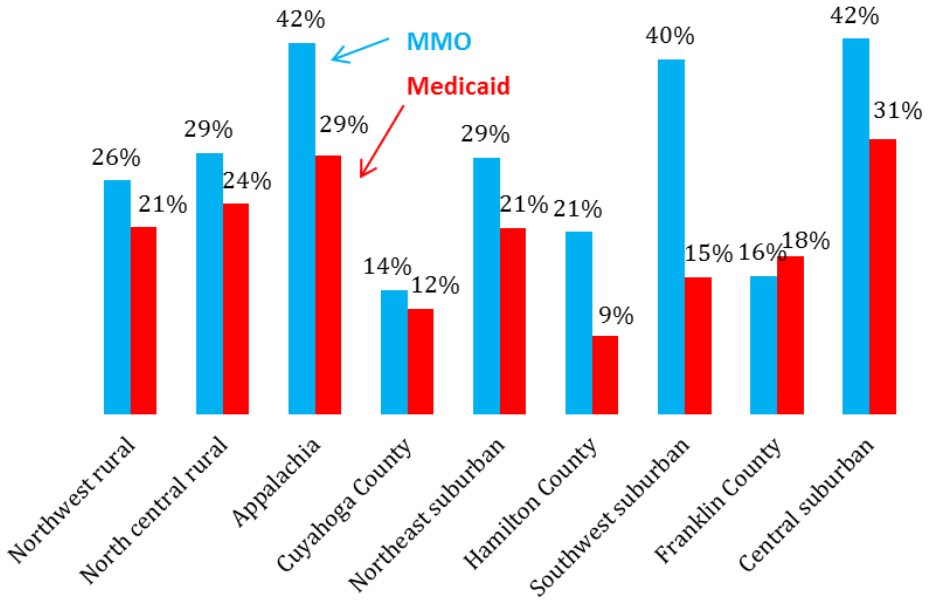
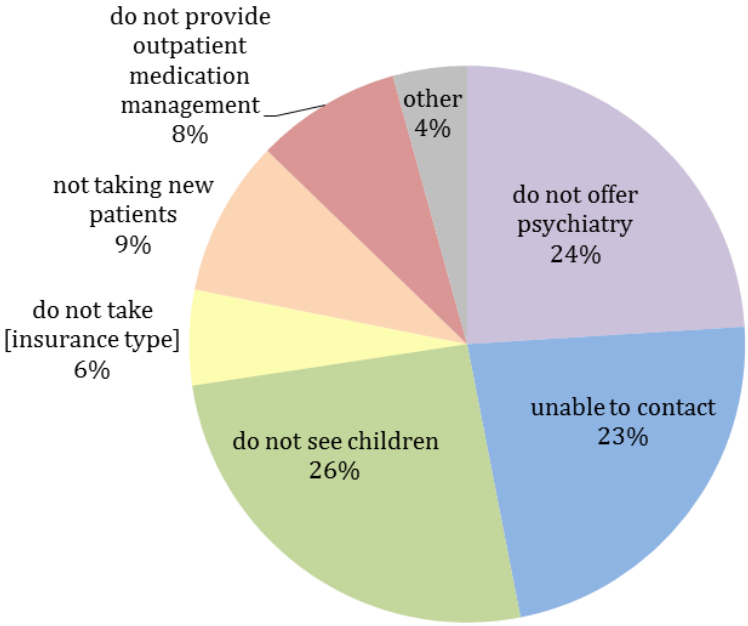


Figure 5. Primary explanations for caller's inability to make a child psychiatry appointment at 650 listed psychiatry offices



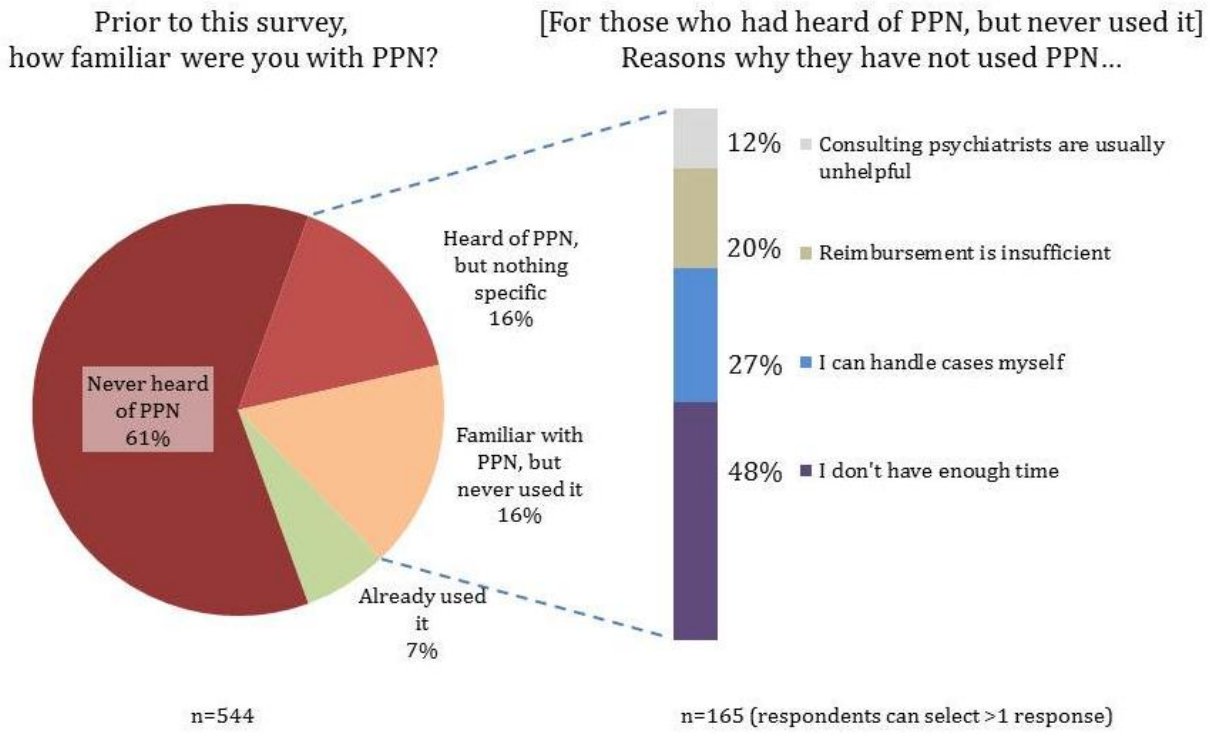
Note: Figures presented combine data from psychiatry offices listed by Medicaid and/or Medical Mutual of Ohio. See text for details.

Another barrier to parents getting their child to see a psychiatrist is that the child often must complete intake assessments and/or participate in multiple sessions with a counselor before they are able to see a child/adolescent psychiatrist. Across the state, 67% of the offices that could schedule appointments required an intake assessment before a patient could see a psychiatrist. Also, 15% of offices provided inconsistent information regarding the process for obtaining an appointment with a psychiatrist.

HOW AND WHY DO OHIO PRIMARY CARE PROVIDERS USE THE PEDIATRIC PSYCHIATRY NETWORK?

More than anything else, **PCPs do not use PPN because they are simply unaware of it.** Among the PCPs responding to our survey, 77% were unfamiliar with the service, including 61% who had "never heard of it" and 16% who "had heard of it, but nothing specific." Even in the Columbus area where PPN is most active, 64% of surveyed PCPs were not familiar with PPN. Among PCPs who had heard of PPN but had not used it, not having enough time for the consultation (48% agreed), was a much greater barrier than the perception that they could handle cases on their own (27%) or the lack of reimbursement (20%), or the perception that consulting psychiatrists are usually unhelpful (Figure 4).

Figure 4. Primary care providers' familiarity with PPN and reasons why they do not use it



WHAT IS WORKING WELL?

Despite such barriers, **most PCPs liked the PPN concept** and reported they were "very likely" (20%) or "likely" (54%) to use the service in the future. In the words of a provider who had heard about PPN, but nothing specific:

> *I love my patients and certainly want to be able to provide the best for them. Because it is so difficult to get help for some of them, I feel that sometimes I'm the best they've got. Having some guidelines and guidance would be GREAT. (Wayne County)*

Or the pediatrician who had never heard of PPN:

> *I think getting the word out about this service is key! I would use this service A LOT including the website access to guidelines to treat on my own frequently if available. (Hamilton County)*

Likelihood of using PPN was similar across regions and generally not associated with provider and practice characteristics. However, respondents were somewhat less likely to use PPN if they had a mental health provider on staff (63% vs. 77%, $\chi^2_{(1)}=7.43$, $p<.01$, $n=493$) or if they felt they could already handle most cases themselves (58% vs. 76%, $\chi^2_{(1)}=5.22$, $p=.02$, $n=162$). Also, future likelihood of using PPN was greater among providers whose practices had a smaller proportion of children covered by Medicaid, although this was only true for providers with less than 20 years' experience, and those who already

were familiar with PPN. Among providers already familiar with PPN, for example, 95% of those serving fewer (<25%) Medicaid patients were likely to use the service, compared to only 60% with a larger (>50%) Medicaid population $\chi^2_{(3)}=14.76$, $p<.01$, $n=115$).On the survey, 35 PCPs (7% of total) reported they had already used PPN. Of this group, **68% agreed that overall, PPN was quite helpful**, and 41% reported that it helped them avoid referring the patient to a psychiatrist. One PCP summed up the experience this way:

> *I had a very positive experience. I was contacted very quickly and was happy with the advice I received. (Summit County)*

Interviews with PPN psychiatrists yielded similar findings. Every interviewee noted that most calls go very well.

Through interviews with PPN psychiatrists, we identified several ways in which they felt the service was working. First, **PPN helps PCPs handle complicated cases.** One PPN psychiatrist gave the following example:

> *I treated a patient with a case of bipolar disorder. I was able to get them into a study, and get them some help. I was able to consult on medication and management for this patient. It was a complicated situation and a patient that really needed help.*

Yet on the survey, many PCPs expressed skepticism about PPN's ability to help them manage complicated cases. Consider the following:

> *When I have a child I am very worried about, I don't feel comfortable with just a phone consultation. (Athens County)*

> *I don't mind doing ADHD or a teen with straightforward depression and I don't need help doing either. I don't want to do anything else, nor do I think pushing primary care pediatricians into doing things that are 1) not their specialty 2) takes way more time than we are allotted 3) is not our interest is a goal you should be pushing. Since psychiatrists spend 50 minutes with one patient, is the expectation we do the same in 10 to 15 or is it you will now get insurers to pay us the same? (Franklin County)*

> *really more helpful to get kids into psychiatrist and have them manage cases/dx/tx instead of being an intermediary in the process; not too comfortable with managing more complicated/challenging pediatric cases (Greene County)*

> *Consultant had little time, and seemingly little interest, in helping me unravel a complicated diagnosis. This case may not have been appropriate for the PPN, which seems geared to providing quick answers to straight-forward questions, but I don't need help with simple cases. (Franklin County).*

PPN also helps **reassure PCPs that their treatment approach is appropriate.** A PCP from Franklin County, for example, noted that calling PPN "Helped to confirm my initial impressions." PPN psychiatrists reported that many of their calls involve reassuring PCPs:

"Most of the time I'm reassuring the PCP that their hunch is correct. They really appreciate it. About 50% of my calls are like that."

"About 1/3 of the calls are already headed in the right direction. They totally value that I can reassure them."

WHAT PROBLEMS IS PPN EXPERIENCING?

Although both PCPs and PPN psychiatrists were generally pleased with the service, our review of interview notes and comments from the survey identified a few common problems. One concerned **dropped calls and delayed responses.** PPN psychiatrists acknowledged occasional delays in receiving messages as well as the challenge of returning calls promptly amid their busy schedules. While it is difficult to quantify how often such problems occur, from the PCP's perspective these delays were frustrating:

I had to call 3 times before I received a call back over a 4 day time period, then I was transferred to the tertiary med center nearest to me that didn't have an insurance contract to see this patient so a suggestion on therapy was made but only after an inordinate amount of time on my part---not 30 minutes (Butler County)

I did not receive a call back (Van Wert County)

Response time was > what is promised (Franklin County)

Another potential problem is whether PCPs are **using PPN only to expedite referrals** to child psychiatrists. Some saw this as a concern.

Instance in which they asked some things I can't provide – such as trying to get a child sent quickly. I don't have answers to those questions. "I'll redirect back to our intake center and tell them it's an access problem."

Someone calls up and wants to know if I can get their kid in quicker or if I can make an appointment. About 25% of my calls are like that. It's not an appropriate use of PPN

Others, however, reported that the problem had largely disappeared or that they empathized with the caller and tried to help with referrals.

We were getting some calls just looking for a referral. Once we discovered we were doing it, we reworded the answering machine message and those types of calls dropped to near zero.

Even when the call for a referral I try to be as helpful as possible; so I direct them to our response center…"I'm not a purist."

PPN psychiatrists expressed frustration with **not having enough dedicated time or staff to provide quality consultation**.

My clinic is very busy, and I don't have much time available to field these calls. "My time is limited." "It would be good if we could have done this by videoconference." It would

be nice if they could fax over some of their notes. If I had time blocked out, I'd be able to review the notes and give feedback.

"It all depends on how much time you have." I do not have time blocked out on my clinic schedule for PPN. "It's unpredictable when you're going to have time."

It's just unrealistic to schedule such phone calls when pediatricians are only able to spend 3 minutes with each patient. How do you time it so you can fit a phone call in that time slot?

WHAT IMPROVEMENTS TO THE PEDIATRIC PSYCHIATRY NETWORK WOULD BE MOST EFFECTIVE AND POPULAR?

On the survey, we asked PCPs, for each $1,000 state agencies might invest in improving PPN, how much should they spend among three realistic options. **Improving continuity of care was the most popular approach for improving PPN**. In descending order of popularity, their responses included:

- $497 to improve continuity of care, so you could access the same psychiatrist to discuss the same patient on multiple calls;
- $326 to improve the quality of written feedback from the PPN psychiatrist following each consultation; and
- $177 to provide quarterly updates of appointment wait times for child psychiatrists in your area.

PPN psychiatrists also recognized the value of continuity of care. For example:

"I get these frequent callers. I'll be talking with them over time and their questions become more advanced. We see them actively learning…"

There was a child in Nationwide Children's here. A nurse in one of the outlying offices [affiliated with NCH] was worried about this kid who had been discharged and was on multiple medications. I have spoken with her several times about suggestions for managing the meds.

As PPN is currently configured, however, it is difficult to provide continuity of care. In order to avoid overburdening any one psychiatrist with too many PPN calls (for which they receive no reimbursement), the system spreads calls across multiple physicians. Unless the PPN psychiatrist makes informal arrangements (e.g., giving the PCP their personal phone number), a PCP calling PPN will be routed to whichever psychiatrist is currently on call.

As for improving the quality of written feedback, some PPN psychiatrist support the idea but feel it is unrealistic with additional funding for dedicated staff time towards this end (see above, "not having a enough dedicated time or staff to provide quality consultation")

Providing quarterly updates of local appointment wait times elicited some interest from PPN psychiatrists.

> *"To publish wait times for various offices. That would be useful". It would help bring wait times down.*

> *"Awesome! That would be great data for the PCPs and the psychiatrists. When a PCP isn't sure of the wait time [for an appointment], he thinks it's going to be 14 years."*

Yet they also expressed concern with how this would work in practice, especially since shorter wait times may reflect lower quality care.

> *"Part of the problem is are we endorsing something?" Is there something to say Dr. X is a good practitioner? "Sometimes it may be that the people who don't have waiting times don't do the best jobs."*

> *But some docs take on lots of patients just to keep things flowing. They don't provide quality care. Referring people to just anyone based on short wait times – I would be hesitant.*

We also identified other realistic approaches for improving PPN. In particular, both PPN users and psychiatrists noted that **PPN may be most attractive when PCPs are able to consult with someone local.** Consider the following quotes from PCPs:

> *[PPN] sounds like a very useful service though. Wish I could call someone in my area (local mental health agency) instead. (Huron County)*

> *[I'd like] local resources for parents and teens such as support groups (esp in the areas of eating disorders, depression, LGBT), educational services (esp. for ADHD,), drug and alcohol services for children and teens, lists of community-based resources for families (i.e., home health care organizations with behav health components). (Greene County)*

> *Ensure local CAPs [child/adolescent psychiatrists] participate in the program. If there are no CAPs in Cuyahoga County participating, why would I use PPN? If the child might need a face to face follow-up with a CAP, I'm better off trying to work with a CAP who is local. (Cuyahoga County)*

PPN psychiatrists also noted the value of being able to connecting with someone in their area. In the words of one interviewee:

> *The local angle is important. Otherwise it feels like a 1-800 call… I can't tell them about resources in Ashtabula, but I know about the Cincinnati area; I try my best with what I can do.*

Because PPN already endeavors to connect callers with a psychiatrist in their area, that is often not possible because it is only staff from children's hospitals in Akron, Cincinnati and Columbus who regularly field calls. Nonetheless, planners should consider the importance of location in future efforts to expand or improve PPN.

Our findings confirm that wait times for child psychiatry in Ohio are often excessive. As agencies try to address this problem, the data from our appointment availability assessment can serve as a useful baseline to assess the effectiveness of their efforts. Future assessments using a similar methodology may be useful for measuring trends in access to care. One national study, for example, found that from 2004 to 2009, the increase in appointment wait times in Boston far exceeded changes in 14 other major metropolitan areas. [16] The authors conjectured that the change may be driven by the major healthcare reform that Massachusetts enacted in 2006. With similar reforms being considered for Ohio, such an assessment may be useful for assessing children's access to psychiatric care.

Overall, both PPN users and psychiatrists believe that the network is a worthwhile endeavor. While access to child psychiatry remains a serious concern, we hope that PPN will remain an important part of the solution. The following actions are realistic, compelling approaches for strengthening PPN and developing other efforts to improve children's access to psychiatric care.

PPN-specific recommendations

- Most PCPs are unfamiliar with PPN, yet support the concept – especially with a local connection. PPN should broadly and regularly advertise the service to PCPs in rural areas and in areas where it is already active (Cincinnati, Columbus, Akron).
- Update the PPN website to include resources such as psychotropic medication guidelines. Engage PCPs in the process of encouraging utilization.
- The PPN Steering Committee may want to consider training, developing a quality improvement component, and restructuring schedules to assist psychiatrists with the quality of written feedback provided to PCPs.

General recommendations

- Within Ohio, wait times vary markedly by region. **It is recommended that local ADAMH boards work with insurance providers to monitor wait times and to develop region-specific strategies to recruit and retain child and adolescent psychiatrists.** Because they plan for services and monitor quality service delivery, local boards would be in a better position than ODMH to develop these strategies. Likewise, they may be more apt to recognize shorter wait times that stem from quality concerns.

- Wait times in northwest rural Ohio and central Ohio are especially long. It is recommended that statewide efforts to improve children's access to psychiatry focus on these regions. Working with universities around Toledo and Columbus may be particularly helpful in this regard. Such efforts may fit with "hot spot"

[16] Merritt Hawkins & Associates. *2009 Survey of Physician Appointment Wait Times*. Irving, TX: Merritt Hawkins & Associates.

projects, funded through the 505 subsidy distributed by ODMH to local ADAMH boards.[17]

- Around Ohio's three major metropolitan areas, wait times in adjacent counties resembled those in the core counties. This finding suggests that core and adjacent counties can be thought of as one market where families experience similar access to care. **It is recommended that metropolitan area ADAMH boards work with their hospital catchment areas when considering actions that will affect access to care.**

- ODMH and its partners may want to **replicate the appointment availability assessment in other areas of Ohio** that were not included in this study (e.g., Dayton, Toledo, Youngstown) to determine access issues. The methodology from the present study would be relatively easy to replicate at relatively low cost.

- ODMH should consider **forming a working group of community stakeholders to create specific strategies to monitor and reduce wait times for child psychiatry** and determine how to incorporate these strategies into other continuity of care initiatives.

[17] Ohio Department of Mental Health, Office of Fiscal Services. *505 Line Item Subsidy Documentation*, *FY 2012*.

ACKNOWLEDGEMENTS

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APPENDIX

Our appendix includes the following materials

A1. Appointment Availability Assessment: Call list decision tree and phone script

A2. Appointment Availability Assessment: Quantifying appointment wait times

B1. Online provider survey instrument

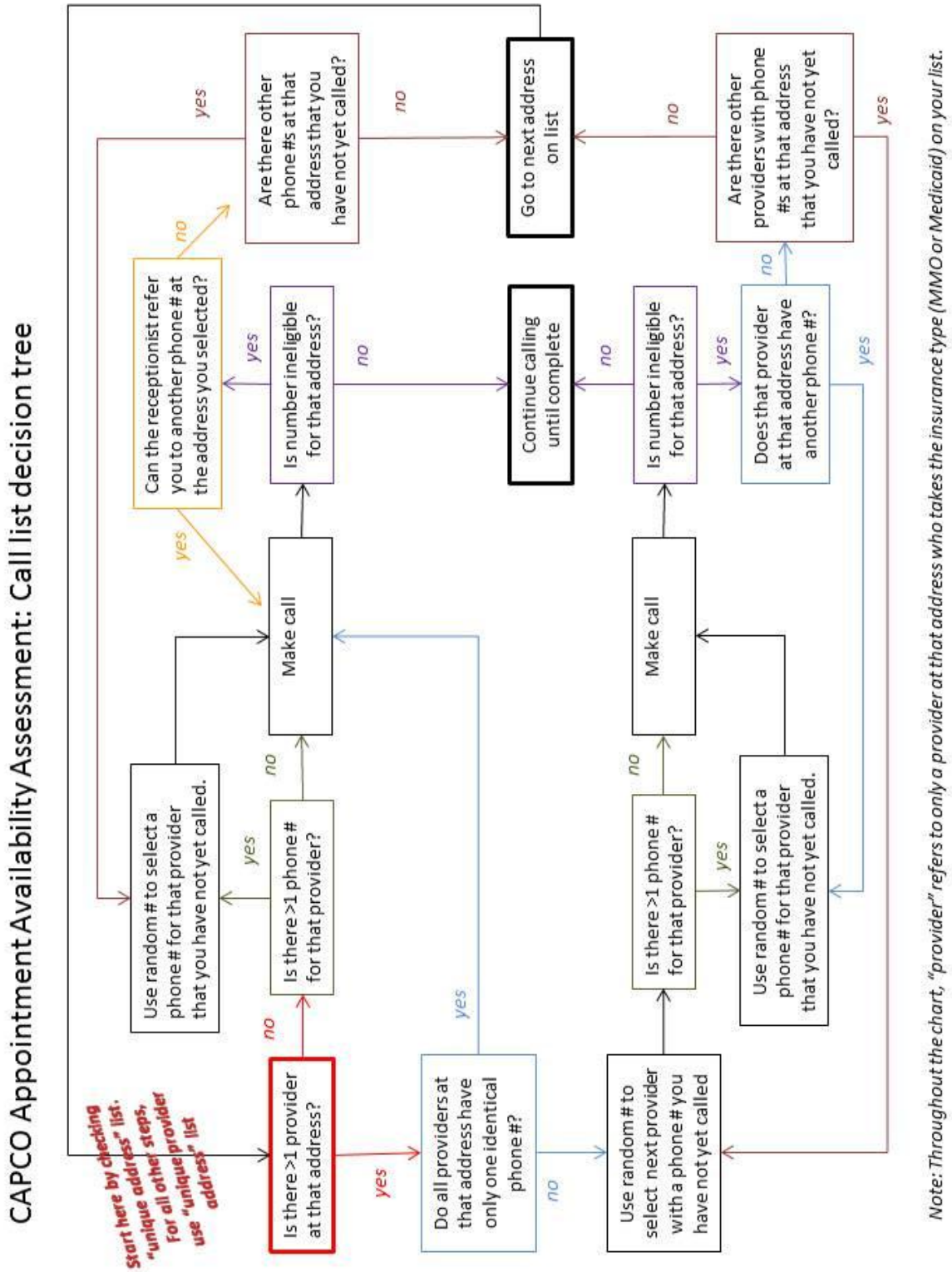
B2. Online provider survey: Open-ended comments

B3. Online provider survey: Email communication

C1. Structured qualitative feedback: Interview procedure

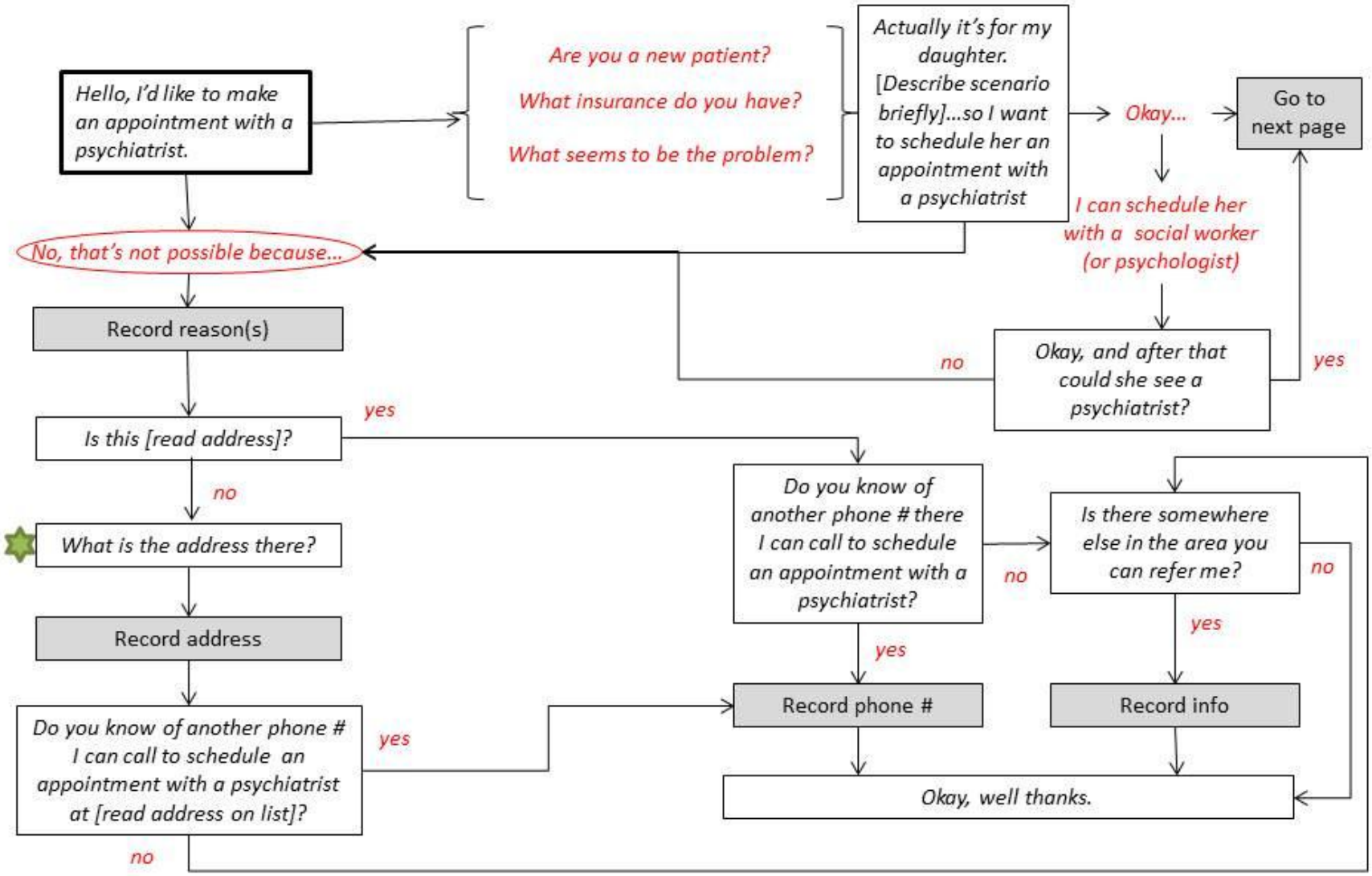
C2. Structured qualitative feedback: Thematic summary

APPENDIX A1


CAPCO Appointment Availability Assessment: Call list decision tree
Start here by checking "unique addres" list. For all other steps, use "unique provider address" list
Is there >1 provider at that address?
yes
no
Do all providers at that address have only one identical phone #?
yes
no
Use random # to select next provider with a phone # you have not yet called
Is there >1 phone # for that provider?
yes
no
Use random # to select a phone # for that provider that you have not yet called.
Make call
Is number ineligible for that address?
yes
no
Does that provider at that address have another phone #?
yes
no
Use random # to select a phone # for that provider that you have not yet called.
Make call
Is number ineligible for that address?
yes
no
Continue calling until complete
Are there other providers with phone #s at that address that you have not yet called?
yes
no
Go to next address on list
Are there other phone #s at that address that you have not yet called?
yes
no
Can the receptionist refer you to another phone # at the address you selected?
yes
no
Use random # to select a phone # for that provider that you have not yet called.
Make call
Is number ineligible for that address?
yes
no
Continue calling until complete
Are there other phone #s at that address that you have not yet called?
yes
no
Go to next address on list
Note: Throughout the chart, "provider" refers to only a provider at that address who takes the insurance type (MMO or Medicaid) on your list.

CAPCO Appointment Availability Assessment: Phone script

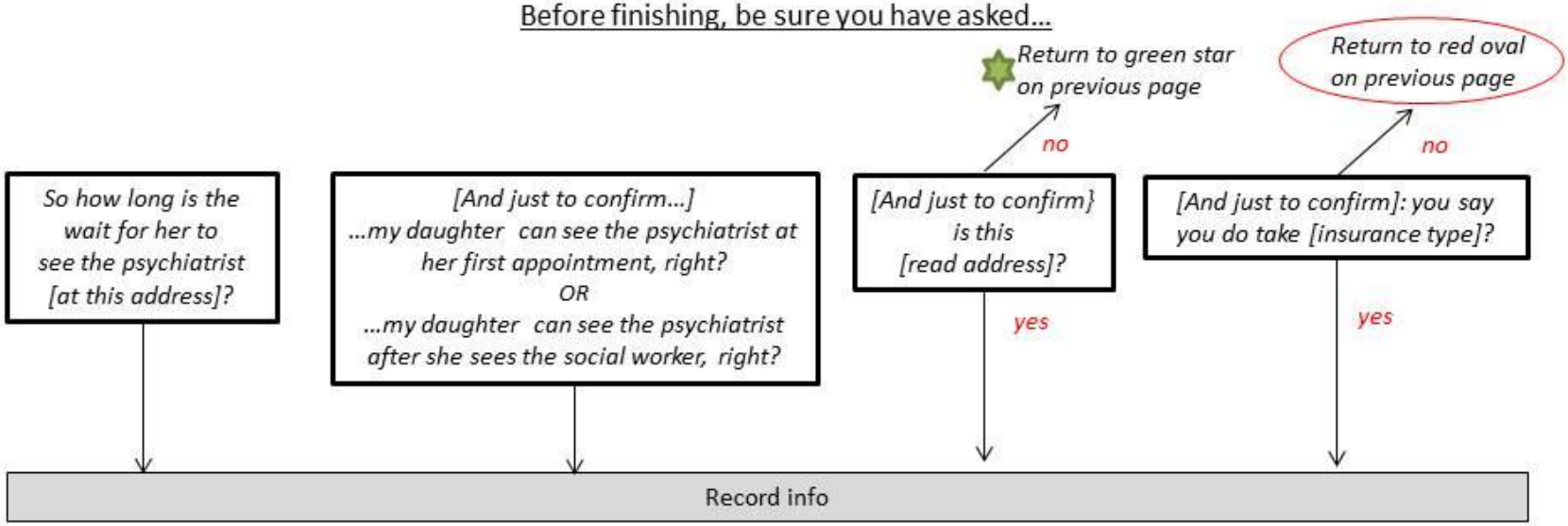
Red italics: what receptionist might say. *Black italics: what you might say.*



If it looks like they can schedule an appointment…

What the receptionist might say	How you could respond
Do you have a referral from a doctor?	*No, but I should be able to get one.*
What's your doctor's name? / *What is the patient's name?* / *What is your insurance number?*	*Actually, I'm not ready to make an appointment right now. I just want to see how long the wait is and what info I need to have to get an appointment.*
I can schedule you sooner at another office	*Actually, I'd prefer this office. How long is the wait at this office?*

Before finishing, be sure you have asked…



APPENDIX A2

Quantifying appointment wait times

Ideally the receptionist will provide a specific date for the next available appointment with a psychiatrist for a new patient. If this is the case, count the number of days until that date as both a minimum and a maximum. If the receptionist cannot give you an exact date for the next appointment, use the following rubric to convert their answer into a minimum and maximum number of days:

If they say…	**Then enter…**	
	Minimum	*Maximum*
Today	1	1
Tomorrow	1	1
This week	2	4
Next week	6	8
About 1 week	6	8
About 2 weeks	12	16
About 3 weeks	18	24
About 4 weeks	24	32
About “x” weeks	6x	8x
A couple of weeks	14	21
A few weeks	14	21
About 1 to 2 weeks	7	14
About 2 to 3 weeks	14	21
About 3 to 4 weeks	21	28
About 4 to 6 weeks	28	42
About “x” to “y” weeks	7x	7y
About 1 month	27	33
About 2 months	54	66
About 3 months	81	99
About 4 months	108	132
About “x” months	27x	33x
About 1 to 2 months	30	60
About 2 to 3 months	60	90
About 3 to 4 months	90	120
About 4 to 6 months	120	180
About “x” to “y” months	30x	30y

If they say…	Then enter…	
	Minimum	*Maximum*
	(count days until…)	(count days until…)
Beginning of July	July 1	July 10
Middle of July	July 11	July 20
End of July	July 21	July 31
Beginning of August	August 1	August 10
Middle of August	August 11	August 20
End of August	August 21	August 31
Beginning of “month x”	x/1	x/10
Middle of “month x”	x/11	x/20
End of “month x”	x/21	x/30
First week of July	July 2	July 6
Second week of July	July 9	July 13
Third week of July	July 16	July 20
Last week of July	July 23	July 27
First week of August	August 1	August 3
Second week of August	August 6	August 10
Third week of August	August 13	August 17
Fourth week of August	August 20	August 24
Last week of August	August 27	August 31
First week of September	September 3	September 7
Second week of September	September 10	September 14
Third week of September	September 17	September 21
Last week of September	September 24	September 28
First week of “month x”	x/1	x/5
Second week of “month x”	x/8	x/12
Third week of “month x”	x/15	x/19
Last week of “month x”	x/22	x/26

APPENDIX B1

Children's Access to Psychiatric Care in Ohio (d)

Created: June 05 2012, 12:40 PM
Last Modified: July 29 2012, 10:14 AM
Design Theme: Clean
Language: English
Button Options: Custom: Start Survey: "Start Survey!" Submit: "Next"
Disable Browser “Back” Button: False

Children's Access to Psychiatric Care in Ohio

Page 1 - Question 1 - Choice - One Answer (Bullets)

Are you currently a primary care provider for child/adolescent patients in Ohio?

- ○ Yes [Skip to 2]
- ○ No [Screen Out]

Page 2 - Heading

Please tell us a little about your practice.

If you practice in multiple locations, please choose the one where you spend the most time.

Page 2 - Question 2 - Open Ended - Comments Box

About how many child/adolescent patients are in this practice?

Page 2 - Question 3 - Choice - One Answer (Bullets)

About what % of these child/adolescent patients pay through Medicaid, at least partly?

- ○ <10%
- ○ 10-25%
- ○ 25-50%
- ○ >50%

Page 2 - Question 4 - Choice - One Answer (Bullets)

Is there a mental health practitioner in this practice?

- ○ Yes
- ○ No

Page 2 - Question 5 - Open Ended - Comments Box

In which county is this practice located? (e.g., Cuyahoga)

Page 2 - Question 6 - Choice - One Answer (Bullets)

Which of the following best describes this practice?

- ❍ private solo primary care practice
- ❍ private group primary care practice
- ❍ group multispecialty practice
- ❍ community health center

Page 3 - Heading

Think about your child and adolescent patients with depression.

Description

Page 3 - Question 7 - Rating Scale - Matrix

In the past year, about how many of these patients have you been able to adequately...

	Nearly all	Most	About half	A few	Almost none
...diagnose without having to consult with psychiatrists or other mental health professionals?	☐	☐	☐	☐	☐
...manage without having to consult with psychiatrists or other mental health professionals?	☐	☐	☐	☐	☐

Page 4 - Heading

The Pediatric Psychiatry Network (PPN) offers a new, free service that provides primary care providers with free telephone consultation 24/7. Providers can call 1-877-PSY-OHIO or visit www.pedpsychiatry.org and a child psychiatrist like Dr. Sorter will phone back within 30 minutes.

Michael Sorter, MD Cincinnati Children's Hospital

Page 4 - Question 8 - Choice - One Answer (Bullets)

Prior to this survey, which of the following statements best describes your familiarity with PPN?

- ❍ I had never heard of PPN [Skip to 7]
- ❍ I had heard about PPN, but nothing specific [Skip to 5]
- ❍ I was familiar with PPN, but had never used it [Skip to 5]
- ❍ I had already used PPN [Skip to 6]

Page 5 - Question 9 - Rating Scale - Matrix [Randomize]

Here are some reasons why primary care providers might not use PPN.Please indicate whether you agree each reason is true for you.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I can handle cases within my practice.	❍	❍	❍	❍	❍
I don't have enough time.	❍	❍	❍	❍	❍
Reimbursement is insufficient	❍	❍	❍	❍	❍
Consulting psychiatrists are usually unhelpful.	❍	❍	❍	❍	❍

[Skip Unconditionally to 7]

Page 6 - Question 10 - Rating Scale - Matrix

Please describe your experience using PPN. If you have used PPN more than once, reply based on your most recent experience.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Overall, PPN was quite helpful.	☐	☐	☐	☐	☐
Using PPN raised my comfort level with handling cases of this nature.	☐	☐	☐	☐	☐
Using PPN helped me avoid referring the patient to a child psychiatrist.	☐	☐	☐	☐	☐

Page 6 - Question 11 - Open Ended - Comments Box

Please include any comments about your experience with PPN.

Page 7 - Heading

The state of Ohio is investing in the Pediatric Psychiatry Network (PPN) to improve primary care providers' ability to manage child and adolescent patients with depression. For each $1,000 available to improve PPN, how much should we invest in each of the following approaches?

(Please enter $ amount below each option. Total of all options should = $1,000)

Page 7 - Question 12 - Open Ended - Comments Box

Improve continuity of care, so you could access the same psychiatrist to discuss the same patient on multiple calls.

Page 7 - Question 13 - Open Ended - Comments Box

Provide quarterly updates of appointment wait times for child psychiatrists in your area

Page 7 - Question 14 - Open Ended - Comments Box

Improve the quality of written feedback from the PPN psychiatrist following each consultation.

Page 7 - Heading

Enter a question

(Total of all options should equal $1,000)

Page 8 - Question 15 - Rating Scale - Matrix [Randomize]

PPN also offers free online tools for primary care providers. Please indicate how helpful it would be to have updated guidelines for…

	Very helpful	Somewhat helpful	Not very helpful
...diagnosing common mental health problems	❍ 1	❍ 2	❍ 3
...implementing practice-based, psychosocial interventions	❍ 1	❍ 2	❍ 3
...psychopharmacologic treatment of common mental health problems.	❍ 1	❍ 2	❍ 3

Page 8 - Question 16 - Open Ended - Comments Box

Please add any comments for guidelines that you would find useful.

Page 9 - Question 17 - Rating Scale - Matrix

In the future, how likely are you to use PPN?

Very likely	Likely	Not very likely	Unlikely
❍	❍	❍	❍

Page 10 - Question 18 - Choice - One Answer (Bullets)

Which of the following best describes you?

- ❍ Physician
- ❍ Nurse practitioner
- ❍ Other health care professional (e.g., RN, PA, social worker)

- ❍ Office manager/administrator
- ❍ Resident
- ❍ Other, please specify

Page 10 - Question 19 - Open Ended - Comments Box

For how many years have you been practicing in this role?

Page 11 - Question 20 - Open Ended - Comments Box

Please add any other comments about how Ohio can best help primary care providers manage child/adolescent patients with common mental health conditions.

Page 11 - Question 21 - Name and Address (U.S)

If you would like a copy of the survey results, please include your contact information below

- ✍ Name
- ✍ Email Address

Page 11 - Heading

Enter a question

Your name will not be linked to your responses.

Page 11 - Question 22 - Open Ended - One Line [Hidden]

county number

Page 11 - Question 23 - Open Ended - One Line [Hidden]

MD or DO

Thank You Page

For more information about this study and its findings, please contact Dr. Kenneth Steinman (ksteinman@cph.osu.edu)

Screen Out Page

If you would like more information about the survey and its findings, please contact Dr. Kenneth Steinman (ksteinman@cph.osu.edu).

Over Quota Page

Standard

Survey Closed Page

Standard

APPENDIX B2

Online Provider Survey: Open-Ended Comments

In addition to quantitative findings, we also received comments from respondents on two items. These appear on the following pages. In addition, 119 respondents requested a copy of the final report.

Question 11: Please include any comments about your experience with PPN.
Although PPN is helpful, most of my cases still need psychiatric evaluation and follow-up
Consultant had little time, and seemingly little interest, in helping me unravel a complicated diagnosis. This case may not have been appropriate for the PPN, which seems geared to providing quick answers to straight-forward questions, but I don't need help with simple cases. The PPN needs to provide a different kind of consultative venue to help physicians who are comfortable with garden-variety ADHD with more complicated issues such as diagnosing bipolar illness or schizophrenia, and assisting them in at least stabilizing the patient until he can get to see a psychiatrist.
Helped handle acute situations but did not increase availability of provider appts for further evils or mgmt
Helped to confirm my initial impressions
I did not receive a call back.
I had a very positive experience. I was contacted very quickly and was happy with the advice I received
i had to call 3 times before I received a call back over a 4 day time period, then I was transferred to the tertiary med center nearest to me that didn't have an insurance contract to see this patient so a suggestion on therapy was made but only after an inordinate amount of time on my part---not 30 minutes
I have only used it once - when I called the person seemed much more familiar with adult psychiatry, but it was a long time ago that I used it, so I can't remember the specific details.
I have primarily used PPN to help with medication decision-making and it has been quite helpful. I wish there were some way to improve my confidence in my assessment skills--PPN has not been useful for this thus far.
I have used once with a boy who was sexually abused in another state before moving to Ohio. The initial consultation was very helpful.
I think the information could be more robust and informative. It might be useful to have some clinical guidelines available here and ways to expedite referrals.
I was trying to find a local practitioner to deal with PTSD in a young child. The information I received was not different than I knew already.
I work at a children's hospital and had a complicated child needing a psychiatrist. Absurdly, the psychiatry group associated with the hospital felt it was appropriate to have me call PPN rather than being available to answer my question at that time. Since I expressed my concerns, I have been able to ask questions directly of my colleagues.
Immediate response. Recommended medication and dose has worked very well. I have used this recommendation for other patients as well based on good results with the initial patient.
Interaction was with a nurse practitioner who recommended increasing medication, rather than offer other modes of assistance for patient.
Response time was > what is promised
Some of the intake workers need to be aware of ALL the resources available to children/teens in the area, such as parenting classes, group classes for depression, etc.
This system does little to alleviate the medical-legal concerns I have when treating children that I am not trained to treat, or to alleviate the immense amount of un- or under-reimbursed time primary care doctors spend trying to help mentally ill children. Just being honest.
Very helpful doctor helped me start a child on medicine pending psychiatry evaluation.
Wasn't very helpful when I have used It in the past. We stopped using it in our office

Question 20: Please add any other comments about how Ohio can best help primary care providers manage child/adolescent patients with common mental health conditions.
very needed
consultation availability
1. More access to psychiatrists and psychologists. 2. Much better feedback from the mental health professional, it is very very poor currently
1. Enforce coverage by health insurance companies to cover mental health diagnoses 2. We need more psychologists, licensed social workers and psychiatrists interested in treating adolescents
1. Get access to help (with less than six months wait for appointment). 2. Easy online non-biased CME, in say, 15-30 minute bites. 3. Email cases that would take a few minutes to scan through about a patient with a particular problem(S) and then the approach psych used to solve.
1. When a mental health Pt (ADHD, anxiety, depression, etc.) gets beyond my comfort level in treating/managing (complexity, not responding to treatment), the Pt usually has to wait months before they can be seen by a Psychiatrist/Specialist. 2. When younger Pts (10 and under) have mental health issues (anxiety, depression, etc.) though *[name redacted for privacy]* is very good, trying to get a Pt seen there is long and difficult process. Six month plus waits is not surprising.
a state wide network would be very helpful to the primary care physician in any of the 88 County's of Ohio
Accept patients through age 21
Acceptance of private practitioners of state Medicaid and managed Medicaid services--reimbursements may need to be competitive with commercial insurance in order to attract psychiatric providers.
Access is my primary concern followed by cost of care which significantly limits follow up
Access to more child mental health providers in our area.
access to ongoing psychological therapy for anxiety, depression, drug use, etc.
access to psychiatry appointments and psychologist appointments
Access to psychiatry services even for patients with private insurance is limited and slow and feedback minimal. NCH behavioral health recently started sending reports of visits but wait times are still long. More practitioners would help...
Additional reimbursement to allow adequate time for assessment and management, linked to criteria for quality.
Advocate for adequate pay for mental health providers so that more of them will be willing to accept insurance payment for their services. Make it easier to figure out who's out there to see kids.
Aid in diagnosing and choosing appropriate treatment for our patients. With many new medications, black box warnings and the associated risks/liabilities, there is significant concern/ reluctance to treat these patients without a specialists' involvement.
also would be great to have help identifying resources in community especially those for Medicaid patients- counselors, behavioral health programs,
Anything more complex than ADD or requiring multipharmacology should be assessed by a trained mental health professional. Any other strategy would mean than mental health expertise is superfluous, which it is not
As I stayed above.
As mentioned above by offering primary care some type of training as a short fellowship for a year or so ,just giving example for may 1-2 days a week so that primary care can continue with their current practice responsibilities as well as get comfortable/trained in common peds psychiatric problems
as mentioned before - we don't need a lot of help with ADHD, we need more with depression, anxiety, eating disorders, we need more counselors for kids and families
Attract or subsidize more pediatric psychiatrists to increase numbers.
Better educate us if we are not going to be able to access more mental health providers in a timely manner
Better reimbursement to those who actually care for these patients.
big problem is trying to help patients who have depression or anxiety problems but have ignored symptoms and refused care until crisis situation
Biggest issue is access to Psychiatric care for Medicaid patients. Next major issue is reimbursement. I cannot spend the appropriate amount of time managing these patients on my own if I am losing money in the process. Pediatric practices (especially those with high Medicaid) are already stretched thin.
by training more specialists in this area. there should be eye to eye contact esp in this kind of field

Continue educating the public on the conditions and what to expect.
Continue to increase access to mental health professionals in an expedient fashion.
Cover the services with Medicaid.
Develop lists of community resources.
Develop support groups for teens - free
Do you have any speakers who would be willing to talk to resident physicians about child psychiatric issues?
elect Democrats
Employ more psychiatrists, increase their pay
Encourage some of them to have satellite office in rural areas outside of major cities. Many patients who need these services don't have means or finances to travel far. We need more counselors too!
Ensure local CAPs participate in the program. If there are no CAPs in Cuyahoga County participating, why would I use PPN? If the child might need a face to face follow-up with a CAP, I'm better off trying to work with a CAP who is local.
Ensure psychiatry follow-up for ALL children admitted for suicide attempt - I see these children referred to me, the PCP, for follow up of emergency services.
Financially support an integrative system rather than cutting corners with our future citizens.
Frankly, I need better access to in-person consultations. When I have a child I am very worried about, I don't feel comfortable with just a phone consultation, and a 6-12 month wait for an in-person consultation is not adequate
FYI, I work in a university setting with a counseling center in the same building as our clinic.
Get insurers to recognize our work and not refuse or limit payment because we are primary care providers instead of psychiatrists and counselors.
Get more child psych providers. In addition, encourage current psychologists to communicate with the patients PCP
Get more psychiatrists that can see children, especially those without insurance
have an easy access to Child Psychiatrist to consult
Have more child psychiatrists that we can refer patients to.
Have more mental health professional in southern ohio. There is a large population of children and adolescent with mental illness in this area.
help with interfacing with public school support systems -- if available
i believe we need more satellite access points so families do not have to travel far
I don't know. I don't have the training or malpractice to prescribe to children.
I don't mind doing ADHD or a teen with straightforward depression and I don't need help doing either. I don't want to do anything else, nor do I think pushing primary care pediatricians into doing things that are 1) not their specialty 2) takes way more time than we are allotted 3) is not our interest is a goal you should be pushing. Since psychiatrists spend 50 minutes with one patient, is the expectation we do the same in 10 to 15 or is it you will now get insurers to pay us the same ?
I find it impossible to do effective counseling in 15 minutes. In order to be efficient that is the rate at which I must schedule. The mental health system must accept responsibility for most ongoing counseling
I have some real concerns about the recent management at *[name redacted for privacy]* in that much of the diagnostic and subsequent treatment plans are being done by NPs rather than physicians. I have had at least 2 pts that have been followed and treated ineffectively without even question of misdiagnosis.
I love my patients and certainly want to be able to provide the best for them. Because it is so difficult to get help for some of them, I feel that sometimes I'm the best they've got. Having some guidelines and guidance would be GREAT
I practice in a hospital based primary care center with reasonable access to child psychiatrists and local mental health resources.
I practice in an academic environment with reasonable access to consultation. My in clinic assistance is a MSW. Your demographic and practice questions didn't really ask about these but they highly influence my likely need for and use of these services. So I am not at all typical of practicing docs.
i tell my patients to self refer to psych on their plan
I tend to treat my uncomplicated patients with mental health issues. Am very frustrated in getting my complex patients help-within even 2-3 months.
I think getting the word out about this service is key! I would use this service ALOT including the website access to guidlines to treat on my own frequently if available.

I think that a survey by itself will increase awareness of PPN...but to utilize its services requires face-to-face contact to learn more about the services and gain familiarity with PPN and its providers (as well as with credentials, etc)
I work in the *[name redacted for privacy]* as an adolescent medicine specialist. I have a social worker and a psychiatrist in my clinic. This is why I don't need the psychiatric consults. I'm probably not the most representative respondant in your survey!
I would have trouble remembering who to call, making that first call. Sounds like a very useful service though. Wish I could call someone in my area (local mental health agency) instead.
I would like to know that we can quickly reach a psychiatrist or psychiatric nurse practitioner that can make immediate recommendations.
If we are going to have to take responsibility for medical management of these patients, then we need counselors to whom we can refer for therapy, especially some that take medicaid/managed medicaid. Have an accurate list of providers would be very helpful.
Improve access to counselors/family behavioral therapists.
Improve access to psychiatrists for complicated depression and bipolar patients.
Improve access without restrictions. Get patients in quicker. Consistency of care ... with same provider. If same provider is not available, a partner should cross-cover and see patient or fill their prescriptions, instead of forcing the primary care doc to manage or prescribe something they're not comfortable with.
Improve and expand access to centers such at Child Focus.org Educate schools and provide consultation to them for their difficult cases
Improve compensation for diagnostic tools and extra consult time spent.
Improve coverage and reimbursement so practitioners would be willing to see these patients
Improve coverage for counseling of children and families
improve school-based programs for school-aged children.
Improved access to psychologists, social workers and psychiatric NPs.
improving access, ongoing education of providers
increase access to child specialists, change liability climate so you are not penalized/sued for practicing good medical care, which even if you do can have bad outcomes
Increase available inpatient beds.
Increase availability of comprehensive pediatric behavioral health evaluation and treatment programs.
Increase Medicaid reimbursement for Primary care. Most of the time managing ADHD patients is just not worth the hassle
Increase the availability of child psychiatrist.
increased number of locations for patient access
Inform physicians of updates with system. If you don't know something exists it is hard to use it no matter how much money you have for improvements.
Initial consultation, opinion on best treatment, advise on side effect mgmt and advise on when referral to psychology and psychiatry is necessary
Initial diagnosis and treatment of patients with psychiatric disorders is very time consuming and complicated. In a busy practice, there is not time to do a thorough job. Patients who do not have life threatening issues are referred to outpatient therapy, but this takes weeks to months. Having shorter wait times to be seen by a psychiatrist would be most helpful.
Insurance companies need to reimburse for mental health treatment the same as other illnesses. Specialist physicians (psychiatrists) should be available to help these children when a primary care doctor does not feel comfortable treating them, just like any other specialty.
It wasn't clear to me whether there was a cost to the consultations. This should be made clear in future contacts.
It would be good to have one particular consultant psychiatrist for a primary practice. Getting to know each other would streamline consultation time and be helpful. Also did not notice a scale on the survey questions. Question on how many ADHD patients I diagnose and manage only gave me to 5. We have many more and I didn't understand how to answer
It would be helpful to have an active list of Child Psychologist that do Cognitive behavior therapy in the Cleveland area, Also, it would be helpful to have beginning courses on this subject. I do a lot nw but from the bits and pieces I have self learned. I refer to Tamar Chansky's book as a parent child self help book but if there are other resources I would like to know especially I find parent/child books work great.
It would be helpful to have standardized diagnostic tools / surveys available for help with diagnosis AND monitoring, as well as tools to help with med management.

It would be very beneficial to have additional residency training sites and funding for board certified pediatricians to pursue the Pediatric Portal option to become certified in Child and Adolescent Psychiatry. I would be interested in doing so as would others.
Items mentioned previously are good--telephone consultation, updates on scheduling wait times, written consultation notes. CME in Perrysburg, Oh area would be great! (I'm 30 min out from there, but is good common location.)
keep it community based; CME and updates help, This is a step in the right direction;
Make access easier. Living in Athens cty I have send all kids to our local community mental health ctr (TCMHC)or to NCH in Columbus. The wait for intake at TCMHC is months sometimes and that is just for a counseling appt it could take 6 months to see a CNP or psychiatrist
Make available , local access to Psychiatrists, Psychologists, Counselors and Behavioral Therapists, regardless of insurance source.
Make insurance cover mental health. Require pediatric hospitals to have a psychiatrist to have trauma or level 3 facilities.
Many counselors in our area do not seem to be trained in cognitive behavioral therapy and counseling is often less effective than it could be. Prevention of mental illness is needed. From a public health standpoint children need education in learning self-soothing techniques perhaps within the public education system. Parents also need information about the early attachment needs of children and the consequences of these not being met. A public health education campaign could address the way parents can positively affect their children's happiness by having good relationships with their partners, etc.
Mental health problems are all too common in the pediatric population and we need all of the help that we can get.
More access to care!
more access to child psychiatrists so they can assume care. More crisis intervention resources
More access to psychological services in a timely manner. Waits are too long.
MORE ACCESS!!!!!!!!!
more available Psychiatric providers,
more child psych teach family physician
More child psychiatrists, faster access to appointments, preferably without 3 months or more of seeing a lesser-trained counselor as a gatekeeper before a psychiatrist can be seen.
More mental health professionals.
more providers
More Psychiatrists, very much need to shorten wait times.
Most pediatricians can identify and treat adhd. I need assistance in finding therapists that take medicaid.
My answer is skewed because I practice at *[name redacted for privacy]* and we have pretty good in-house coverage, which is the only coverage most of my patients have
My comments were previously expressed
my patients need integrated care - home and school
[name redacted for privacy] many times has a 6 month wait for behavioral and psych evaluations, especially with Depression/Autism/Asperger's ADD/ODD issues. This is unacceptable! Many pediatricians start antidepressant and antianxiety meds in their patients because we cannot get them in to see a psychiatrist in Central Ohio.
Need more local psychiatrists for referrals who take insurance not out of pocket up front
none
Over the 20 years that I have practiced in Ohio, both inpatient and outpatient care for children and adolescents have remained woefully inadequate.
phone triage of patients in crisis is adequately addressed with PPN phone triage. What is inadequate is the ability to get patients who are not in crisis seen by a psychiatrist in a timely manner
Please make written and online materials concise! Consider an outline format rather than prose - see FPNotebook.com. Please use doctors. NP's are great but I can do as well myself. If I need a consultation for dx and drug selection, I need a doctor.
Please send me more information about resources available for this.
Poorly designed survey, Please see previous comments
Primary care is a misnomer for patients w/o insurance. They are often seen in the ER and use an ER as their primary care. I

need some additional resources to manage the chronic depression, substance abuse, anxiety disorders and secondary somatic complaints.
produce incentives and expose medical students to role models that practice child psychiatry so that more would consider this badly needed specialty
produce more psychiatrists and reimburse them for their work.
Proved threshold guidelines for when a patient's sx's warrant psychiatry referral and provide quicker access/less wait time for the patient to see a psychiatrist.
Provide a Review Course
provide actual psychiatry specialists who might see psychiatry patients and treat and follow these problems--I do not want to call/treat and f/u these problems in addition to all my other work or I would have gone into psych only
Provide avenues and mechanism for evaluation without long distance and waiting times. This is desperately needed!
Provide competent diagnosis. We can monitor and manage meds. Absolutely needs psychiatrist, counselors and social workers available to Medicaid patients
provide database of counselors, any specific expertise they may have, and list of accepted insurances, sorted by county.
Provide detailed trainings for primary care providers regularly. How to use assessment tools, tips on medications, pros and cons of selected medications, monitoring for side effects
provide more psychiatrist and psychologist
PROVIDE TIMELY UPDATES AS TO WHICH PROVIDERS ARE ACTIVELY SEEKING NEW PATIENTS
quit trying to turn doctors into counselor/psychiatrists - invest the money in training the people who want these jobs. Start by decreasing teen pregnancy - we have a saying in our office - the more mental health problems you have, the younger you will be when you have that first baby that will save your life (save you from having to go to school, work etc.)Then add mental health providers - really good ones, into the schools, and get rid of violence and sex in the media as presented to children from the age of 1 day. Quit sending constant messages to children that sex is best when done with as many people as possible, in as short a time as possible so that you can't even be sure who the baby daddy is. (And he is sure to be a narcissist, or a sociopath who will never have anything to do with you or the baby ever - unless you are willing to love him unconditionally, turn all your earning over to him and let him abuse you and the children)
really more helpful to get kids into psychiatrist and have them manage cases/dx/tx instead of being an intermediary in the process; not too comfortable with managing more complicated/challenging pediatric cases
Really need help knowing where to refer pts in my area (an up to date listing), at least for therapy. very hard to find therapists/counselors.
Recruit and retain more mental health providers by requiring true parity from third party payers
recruit more child psychiatrists
recruit more child psychiatrists, as the current wait times are extremely long.
recruit more child/adolescent psychiatrists to our children's hospitals
recruit more mental health providers
Recruit pediatric psychiatrists to rural areas.
School failure, oppositional defiant, ADHD problems are most difficult to find consultants
Send me by email the phone number of the network and the email. I didn't have the ability to write it down when it was imbedded in the survey
Short of putting child psychiatrists and psychologists in every county, this is a great idea. It needs to be publicized more widely to PCPs. I would also suggest easily accessed CME. Thanks.
subsidize more pediatric mental health services and individuals to come to Ohio
The best thing for our staff would be to get follow up reports on a patient. Psychiatrists seldom send us reports, so we have to rely on what the parent tells us (which is very problematic). No one feels comfortable prescribing meds that the parent says they are on but there is no written documentation of.
The primary issue is TIME. In general most of us do not have the time to evaluate and follow these children on our own. When we attempt this, then patients cannot get in for checkups (which generate much more income for the practice)and perhaps they cannot get in for other acute or chronic ill issues because the schedule is full of ADHD follow up visits and mental health related visits. If there was a system in which we could use trained physician extenders to see these patients (both evaluation and treatment), I think this would go a LONG way in facilitating the care of mental health conditions into the realm of the primary care office.
the question asking how often I dx and manage mental health problems... doesn't ask whether it is by choice or by default.

There is such a shortage that it is often by default, not by choice.
There are extremely limited psychiatry services for mentally ill children who have Medicaid
There is currently terrible access and minimal communication unless @ nationwide for care. We have mental health providers @ our office but none for adolescents.
This sounds like a good start
timeliness is key
Train more child psychiatrist and advocate for better reimbursement so more residents would go into the field.
Train more psychiatrists. Organize access of care.
Train more psychiatrists
Training seminars
waiting time for an appointment for high risk kids i.e., suicidal, is atrocious I am an MD and have my masters in social work, but I still need immediate help on these potentially fatal cases
We desperately need psychologists and well trained social workers and other mental health counselors. Routine ADHD and depression should not be the purview of the psychiatrists, but this network helps us with the slightly more complex patients. Having a mental health provider, at least part time would allow most primary care providers to do a better job with mental health issues. The state should be working on requiring insurance companies to provide appropriate reimbursement to physicians and mental health providers to provide appropriate care. Currently, it is a negative financial proposition. Accordingly, many primary care docs dump these patients onto the psychiatrist. This makes them less available for the patients that truly need them. Unfortunately, despite many people's well intended efforts, this is a financial issue that has great implications far beyond the acute care of mental health problems. (Sorry for the sermon, but you gave me a pulpit!)
We have very limited access to child psych treatment in our area- anything will be helpful.
We MOST need help with child psychologists and family psychologists for counseling as the essential addition to medication management!!!!!!
We need better access for patients to be seen. We have some very severe cases of mental illness and have to depend on parents to remember to call and call again, and make an appointment, and then keep an appointment when many times the parents have mental illness. This frequently leads to patients not being seen even when it is very important to function. I am hoping that at some point, the process can be made less cumbersome. I feel like we weed out the people who need the most help this way.
We need better community, insurance and professional support. Hell...any support would be appreciated. There is NO support at all and the children are paying a heavy price.
We need more competent mental health providers that see kids and take MEDICAID!!!!
We need more mental health professionals who have some availability. The only available help is for the patients who can pay out of pocket, but the rest of the patients have to wait forever.
We need more pediatric mental health providers and decreased wait times for evaluation and treatment
We need more psychiatrists in order for our patients to be seen quicker. In addition, more psychiatrists that see Medicaid or Molina patients are needed.
We need more resources and providers!!!
we need psychiatrists and mental health practitioners who can see pts within a few days to a few weeks. having to wait months for an appt, if we can even get one, is ridiculous and makes me take care of pts that i should not be taking care of. please help us!!!
We really need more LSW practitioners and APN in Psychiatry in the state who are able to see patients like this in a timely way
Web-based and community based CME opportunities re: common issues pediatric psychiatrists recognize at issue with the manner PCPs treat patients with mental health disorders prior to their involvement; updates in the mental health field that influence the care PCPs deliver for mental health conditions; "red flags" that should not be missed for specific diagnoses or therapeutic measures.
webinars on treating common mental conditions
When I have tried to refer to your Organization the people who answer the phone are rude and not helpful...there is no follow up or contact from some of the specialists...it makes it difficult to refer and to treat the patient esp when some of the children are not sent back for my care...
While a thirty minute return call is exceptionally expedient, it is too long to wait and tie up a room with a patient when the day is busy. That is the primary reason I do not use the phone in service. If we could talk to someone right away and discuss the case, it would be more helpful. I realize that this is the most realistic expectation. Appreciate your efforts.

With the paucity pediatric mental health providers of educate pediatricians with medications used to treat common conditions.
Work to recruit actual psychiatrist to our area. It is too much to expect family physicians to handle this burden.
years of practice--18 in Cincinnati
You really need to put the money into improved access to psychiatrists. Phone consultation doctor to doctor only without an assessment by the psychiatrist of the patient is not going to work. Also when I as an md decide I need the psychiatrist to consult it is useless to have them seen by a midlevel or intake worker and not see the psychiatrist and not have help with med management (which is why we want to refer, medication management). As well the limitations placed on pcp formulary access that do not apply to psychiatrist will need to be addressed. Otherwise the pcp cannot prescribe the needed medication that the psychiatrist can. Get rid of prior authorization requirements.

APPENDIX B3

[INITIAL EMAIL COMMUNICATION]

The Ohio Department of Mental Health and Ohio Department of Job and Family Services are developing policy initiatives aimed at improving child psychiatry access for Ohio's primary care practices and their patients. This survey is research that will help identify which aspects of these planned policy initiatives will be most attractive and useful to primary care providers throughout the state. We also aim to identify potential barriers to implementing these initiatives.

How did we choose you?

We selected you from lists of health professionals licensed by the state of Ohio. To insure our findings are representative, it is very important that you participate!

Exactly what are we asking you to do?

Complete a brief online survey. This will take no more than 6 minutes to complete.

Are there any risks in participating?

No. The survey will ask general questions regarding your experience with, and opinions about accessing psychiatric consultation and referrals for your patients. Your answers will remain strictly confidential and will only be used in summary form with other respondents' answers. Participation is completely voluntary and there is no penalty for declining to participate. Moreover, you can stop at any time without penalty or loss of benefits to which you are otherwise entitled.

Who is conducting this survey?

This survey is sponsored by the Ohio Department of Mental Health and is being conducted by a team from Nationwide Children's Hospital and The Ohio State University's College of Public Health. If you have any questions about the research or if you feel you have been harmed by taking part in the research, please contact Dr. Kenneth Steinman at ksteinman@cph.osu.edu . For questions about your rights as a research participant, or to talk to someone who is not a member of the research team, please contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

[REMINDER EMAIL]

PLEASE REMEMBER TO COMPLETE THE SURVEY FOR IMPROVING ACCESS TO PSYCHIATRIC CARE FOR CHILDREN. OHIO'S FAMILIES ARE COUNTING ON YOU!

TO BEGIN THE SURVEY, PLEASE CLICK HERE. IT TAKES LESS THAN 6 MINUTES.

APPENDIX C1

Structured Qualitative Feedback: Interview procedure

Members of the research team will phone the participant to conduct the interview. As a semi-structured interview, we will ask the following general questions and related probes:

1. Warm up question: tell me a little about your involvement with PPN.
    i. About how long have you been involved?
    ii. About how many calls have you fielded?
2. Without using names, please give me an example of a phone consultation that went especially well.
    i. Why do you think it went well?
    ii. How might have it gone ever better?
3. Again, without using names, can you give me an example of a phone consultation that did not go well?
    i. Why do you think it did not go well?
    ii. In the future, how might you handle a similar call differently?
4. In general, what aspects of PPN do you think are working well?
5. In general, what have you found frustrating?
6. There are different approaches for improving PPN. I'd like to get your thoughts on some ideas that have been suggested, for example:
    i. Developing a triage procedure, where a social worker or other trained staff person first screens the call before transferring it to a PPN psychiatrist?
        1. How useful would this be?
        2. What concerns do you have with this approach?
    ii. Another idea is piloting telepsychiatry – live interactive video patient consults – through PPN.
        1. How useful would this be?
        2. What concerns do you have with this approach?
    iii. We just completed a systematic survey of appointment wait times for adolescent patients seeking a first time appointment for routine medication management. Wait times are often long, but each region of Ohio nearly always has at least one office that had a much shorter than average waiting time (and that takes insurance). One approach to improve PPN is to regularly conduct such an assessment and provide online updates for wait times for different psychiatrists in their area. How useful would this be?
        1. How useful would this be?
        2. What concerns do you have with this approach?
7. Do you have any other ideas how PPN be more useful and efficient?
8. Is there anything else you'd like to add?

APPENDIX C2

Structured qualitative feedback: Thematic summary

This document presents interview notes from our interviews with 7 PPN psychiatrists conducted during August and September, 2011. The notes are organized thematically around key questions. Verbatim quotes appear in "quotation marks" and explanatory comments appear in [brackets].

What about PPN is working well?

PPN helps PCPs handle complicated cases.	"I think [the calls] they've all gone well." Typically, it's a colleague or pediatrician or community provider – they have a very difficult case – e.g., a very aggressive child, or a depressed or suicidal child. The pediatrician doesn't know how to proceed. They're been very receptive. Usually it's a pharmaceutical intervention, also a psychosocial intervention. I guide them to the closest access. (AD2)
	I treated a patient with a case of bipolar disorder. I was able to get them into a study, and get them some help. I was able to consult on medication and management for this patient. It was a complicated situation and a patient that really needed help. (AD3)
	I can help with a level of complication they can't always handle on their own. There was child in Nationwide Children's here. A nurse in one of the outlying offices affiliated with NCH was worried about this kid who had been discharged and was on multiple medications. I have spoken with her several times about suggestions for managing his meds. (KS4)
PPN helps PCPs handle common mental health problems.	Typically it's for a primary care MD in a rural area, that has a patient with ADHD, and had not responded to intervention. Sometimes depression or bipolar disorder. Mostly questions about management of the patient and side effects. "I was able to answer the MDs question." (AD1)
	"Most calls go well. We've been doing this a long time." A pediatrician will call up and say 'we have this kid who's depressed' and I can walk them through different treatment options, dosages. "Pediatricians are very receptive. They really appreciate it." Even when the call for a referral I try to be as helpful as possible; so I direct them to our response center (KS3)
PPN helps reassure PCPs that their treatment approach is appropriate	When a PCP calls up with a clear set up symptoms and wants to know if it really is OCD. He wants confirmation and most of the time their hunches are right. Then we might move on a medication question: how to start a kid on an SSRI. (KS1)
	It's clear cut; the PCP tells a great story. "Most of the time I'm reassuring the PCP that their hunch is correct. They really appreciate it. About 50% of my calls are like that." (KS1)
	"About 1/3 of the calls are already headed in the right direction. They totally value that I can reassure them." (KS4)

What problems do PPN psychiatrists encounter?

Calls are sometimes not routed quickly or accurately	I had one situation in which a message wasn't transferred to me promptly. The email message wasn't sent to me until after 5:00 PM. (AD3)
	We received two calls trying to connect to outpatient services and were rerouted in the wrong way. There was a mix-up on location of patient and provider. Could have been rerouted to different region. (AD1)
PCPs call PPN trying to get their patient quickly referred	Instance in which they [PCPs] asked some things I can't provide – such as trying to get a child sent quickly [to a psychiatrist]. I don't have answers to those questions. "I'll redirect back to our intake center and tell them it's an access problem." (AD1)
	It [a recent PPN call] went as well as it could go. I guess if I said, "Yeah, and I can see the kid in one week" that would be even better, but it's not realistic." (KS1)
	Someone calls up and wants to know if I can get their kid in quicker (to an appointment) or if I can make an appointment. About 25% of my calls are like that. It's not an appropriate use of PPN (KS1)
	"About one third of the calls I get are 'hey, this is a hot potato' can you take him off my hands. They don't feel confident handling it themselves." So I try to suggest where they can refer. "I'm not a purist." (KS3)
	We were getting some calls just looking for a referral. Once we discovered we were doing it, we reworded the answering machine message and those types of calls dropped to near zero. (KS4)
There is not enough time to provide quality care	If we could provide more services for them. "They really are alone out there [in the rural area]." Wanted to give so many details so was a bit inefficient. (AD2)
	"If there was state or federal funding so we could block off some time, that would be nice." (AD2)
	My clinic is very busy, and I don't have much time available to field these calls. "My time is limited." "It would be good if we could have done this by videoconference." It would be nice if they could fax over some of their notes. If I had time blocked out, I'd be able to review the notes and give feedback. (AD3)
	"It all depends on how much time you have." I do not have time blocked out on my clinic schedule for PPN. "It's unpredictable when you're going to have time" (AD3)
	If there was a way to block out time for participating physicians, especially If telemedicine was part of the model. Now it's more about being paged. Back-to-back patients creates a disruption. I had one situation in which a message wasn't transferred to me promptly. The email message wasn't sent to me until after 5:00 PM. (AD3)
	it's just unrealistic to schedule such phone calls when pediatricians are only able to spend 3 minutes with each patient. How do you time it so you can fit a phone call in that time slot? (KS3)
Need for local contacts	"The local angle is important. Otherwise it feels like a 1-800 call." The lack of participating hospitals in Cleveland, Toledo and Dayton means we could do a better job in those areas. (KS3)
	If we could provide more services for them. "They really are alone out there [in

	the rural area]." Wanted to give so many details so was a bit inefficient. (AD2) I can't tell them about resources in Ashtabula, but I know about the Cincinnati area; I try my best with what I can do. (KS3)
Other	"It's getting too spread out across the docs here. We have 16 docs who are answering calls. The bigger the group, the less dedicated any one person is." (KS3)

What do you think about improving PPN by…

… improving the triage process, so a trained staff person screens calls first?

"My hope is that our team will ask what their (the PCPs) need is before it gets directed to me." I assume they have a psychiatric problem, but they may not. Sometimes there is a misunderstanding about the nature of the need. (AD1)

"I think that's essential. It's what we do here [in Cincinnati]. " (AD1)

"We like the idea and that's what we do here." It's routinely triaged by a psych social worker. They are the gatekeepers and inform me of the caller's need. (AD2)

"Sounds like an improvement if they're not doing it already." (AD3)

it would be more appropriate to have a psych nurse triage the case first. To be most effective, it should be a psychiatric social worker or Advanced Practice Nurse, especially when the call is about medication. (AD3)

Not too useful. It would save me for those 25% of calls (that are requests for referrals) (KS1)

it might be annoying for the PCP, since they'd have to spend longer on the phone. We used to have something like that with another referral line I was involved with at Nationwide Children's – PCPC. The social worker felt is was a waste of time. (KS1)

Through LinkLine "Any pediatrician could call any specialist [at CCHMC] and we would, or we would try to answer their call within 5 minutes." PPN differs in that there is a screener who collects data – what's your name, what's the situation, how old is the kid – questions like that. The data are helpful, but she is not trained an follows a script. So I know some pediatricians find the process more onerous. With Linkline you can reach the physician with no questions asked. I know Nationwide started something similar. (KS3)

"The cost. How can we afford this?" (KS3)

There already is triage through Cincinnati, but the operator is not trained. She just directs the calls based on region. "But it's not an issue of too many calls." (KS4)

What do you think about improving PPN by…
… improving the website?

"Make our web site more functional. It's stagnant; there is no updated information that is posted. If there are new resources or information that has just come out we should be posting it there." (KS4)

The website could be more of a resource. They could coordinate with local ADAMH boards so if you want something in Hocking County you would have an easy way to look it up. (KS3)

What do you think about improving PPN by…
… integrating it with telepsychiatry?

Regular telepsychiatry can be good but we have to think about how we would integrate it through PPN. Usually you have to schedule it ahead of time so you can be virtually in the room with them, maybe along with other specialists who can all conference on the treatment of a complex case. (KS4)

it's just unrealistic to schedule such phone calls when pediatricians are only able to spend 3 minutes with each patient. How do you time it so you can fit a phone call in that time slot? (KS4)

"I don't know. It would be a different model completely to what we're doing." More complicated. Now we do curbside consultations. (AD1)

Not a true clinical consultation. I'd be concerned with billing and setting up time to do the whole consultation which might take a full hour. (rather than 10-15 as at present.) (AD1)

I don't think it's feasible, at least the way our department treats it. We wouldn't have access to the equipment. We take the calls on the fly. (AD2)

"It would be good if we could have done this [PPN call] by videoconference." It would be nice if they could fax over some of their notes. If I had time blocked out, I'd be able to review the notes and give feedback. (AD3)

That would be <u>extremely</u> useful. As long as its legally compliant. (AD3)

If there was a way to block out time for participating physicians, especially If telemedicine was part of the model. Now it's more about being paged. Back-to-back patients creates a disruption. (AD3)

It would be definitely useful. I like it; it would be a nice complement to PPN since you (the patient) could see someone right away. I don't know if it's practical to have someone always on standby, ready to go on TV. (KS1)

We need to sort out some fundamental questions, like "How do I exchange information? What level of responsibility do I have?" If I consult through telepsychiatry does this take it out of the hands of the pediatrician? I may be too overcautious here. I think it can work if it's clear that the responsibility stays with the pediatrician. (KS3)

What do you think about improving PPN by…
… regularly assessing wait times for child psychiatry at different offices in each region and publishing them on the PPN website?

"To publish wait times for various offices. That would be useful". It would help bring wait times down. (AD1)

What's published in different areas is not really available now. Some people may not want their wait times published. " It's a moving target. It can change pretty quickly" (e.g., when a psychiatrist is added). There are a lot of demands on the system. "Some psychiatrists wouldn't want the negative press." I personally don't have any concerns with that. (AD1)

"I think that's reasonable." Some PPN psychiatrists might be affected. The comparisons might affect some of the doctors calling us. (AD2)

Yes, helpful to know. At a lot of clinics, it often occurs that people drop out or don't show up. (AD3)

Awesome! That would be great data for the PCPs and the psychiatrists. "When a PCP isn't sure of the wait time [for an appointment], he thinks it's going to be 14 years." (KS1)

"Part of the problem is are we endorsing something?" Is there something to say Dr. X is a good practitioner? "Sometimes it may be that the people who don't have waiting times don't do the best jobs." (KS3)

"It would be helpful to families." (KS3)

Could be nice, "but we have to think about the context of quality care. In CAP (child and adolescent psychiatry), I don't have great worries because there are so few of us, frankly." The plus to it is that it might add a competitive edge. (KS4)

But some docs take on lots of patients just to keep things flowing. They don't provide quality care . Referring people to just anyone based on short wait times – I would be hesitant. (KS4)