STRATEGY: STRENGTHEN THE CAPACITY, EFFECTIVENESS, WELL-BEING, AND RETENTION OF THE HEALTH WORKFORCE.

Recommendation 3.3: Develop a psychiatric nurse practitioner program that recruits from and trains providers to serve in underserved rural and urban communities.

Main Takeaway

A psychiatric-mental health nurse practitioner (PMH-NP) program would prepare 300 advance practice RNs to practice as PMH-NPs. Over five years, these PMH-NPs would treat approximately 377,600 patients with mental health conditions. PMH-NPs would be able to address gaps in access because compared to physicians, NPs are more likely to serve rural and underserved populations. The total program cost is $24.6 million over five years or $82,000 per student, of which $36,000 is a stipend and $46,000 is education and marketing costs. Program costs and increased mental health treatment would be partially offset by decreased overall health care utilization for many of the 377,600 patients with mental health conditions treated by these providers. This is a nine-month program, and demand is dependent on the existing nurse workforce finding it attractive.

(Excerpt from impact assessment conducted by Health Management Associates.)

Context

Nearly 17% of Californians have mental health needs; 1 in 20 suffers from serious mental illness.[1] Over 50% of people with mental illness receive no care. In addition, the Healthforce Center at UCSF projected a 34% decrease in the number of psychiatrists in California between 2016 and 2028.[2] As the number of psychiatric medication prescribers declines, psychiatric-mental health nurse practitioners (PMH-NPs) are a potential solution to meet this need.[3]

Rationale

Advanced practice registered nurses (APRNs) specializing in psychiatric-mental health can help address the gap in mental health services. These registered nurses with advanced degrees train as nurse practitioners (NPs) who can diagnose and treat mental health and substance abuse problems and can provide counseling, crisis intervention, family and couples therapy, and prescription medications. In California, NPs are supervised by physicians through standardized agreements; however, PMH-NPs are not required to be supervised by psychiatrists.[4]

Prior efforts have demonstrated effective utilization of psychiatric NPs and how they fill a critical need. For example:

- In 2016, the Department of Health and Human Services Substance Abuse and Mental Health Services Administration launched a training program for nurse practitioners to prescribe buprenorphine in response to the opioid crisis.[5] Previously only physicians could prescribe this treatment for opioid addiction.
- Psychiatric nurse practitioners have been effectively utilized in meeting the needs of vulnerable patients in New Hampshire, where incremental legislative change resulted in full practice authority through significant change to the Nurse Practice Act in 2005.[6]

1. Wendy Holt and Neal Adams, *Mental Health Care in California: Painting a Picture*, California Health Care Foundation, July 16, 2013, www.chcf.org/publication/mental-health-care-in-california-painting-a-picture/.
2. Janet Coffman et al., *California's Current and Future Behavioral Health Workforce*, Healthforce Center at UCSF, February 12, 2018, https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce.
3. Ibid.
4. Joanne Spetz, *California's Nurse Practitioners: How Scope of Practice Laws Impact Care*, California Health Care Foundation, September 6, 2018, www.chcf.org/publication/californias-nurse-practitioners/.
5. "HHS to Launch Buprenorphine Training for Nurse Practitioners, Physician Assistants," press release, American Hospital Association, November 18, 2016, www.aha.org/news/headline/2016-11-18-hhs-launch-buprenorphine-training-nurse-practitioners-physician-assistants.
6. Alexander De Nesnera and Diane E. Allen, "Expanding the Role of Psychiatric Mental Health Nurse Practitioners in a State Psychiatric System: The New Hampshire Experience," *Psychiatric Services* 67, no. 5 (May 1, 2016): 482–84, doi:10.1176/appi.ps.201500486.

Experience with other programs suggests that incentives for participants, such as stipends to offset lost income during enrollment, can help sustain demand for the program. Clinical site placements and supervision may be achieved by partnering with large organizations (e.g., VA, prisons, large FQHCs) to secure adequate clinical training opportunities.

Proposed Action

UC schools of nursing propose to combine resources to prepare approximately 300 additional APRNs over the next five years. Three UC schools of nursing (UCSF, UCLA and UC Davis) would prepare NPs with the additional post-masters' training to practice also as PMH-NPs. UCSF is a nationally recognized leader in the preparation of PMH-NPs and currently has an in-person program with similar courses. A steering committee of psych-mental health faculty experts developed this collaborative program, which would employ online resources of the UCLA Extension Service. The nine-month (three quarters), 28-unit (part-time) program would include online and classroom instruction. Additionally, 500 hours of supervised clinical training would be required in facilities such as hospitals, Federally Qualified Health Centers (FQHCs), prisons/jails, schools and university student health centers, Veterans Administration facilities, or drug and alcohol treatment centers, in urban and rural communities. The program is intended to be self-supporting and would be incorporated into ongoing operational and financial plans of the schools of nursing within the proposed five-year project period. An assessment of program results and sustainability will inform future enrollment level and resource requirement decisions.

Estimated Cost

Building on existing resources, the plan requires additional investments. Costs include one-time planning and program development costs, followed by ongoing operational expenses and student stipend support.

- Estimated development costs (including course development, online platform, clinical site development) — $1.6 million.
- Ongoing annual operational costs (including instruction and marketing) — $2.9 million annually (including inflation at 3%), $12.2 million over five years.
- Recommended student aid: stipend of $36,000 per year to each student (64 students in year 1, assuming attrition in years 2–5) to incentivize student enrollment by offsetting lost income during enrollment —$10.8 million total over five years. Stipends are critical to achieving impact goals since target students are qualified, working NPs who would incur expenses and lost income during enrollment and may not earn additional compensation after program completion.

Program and Stipend Expenses	Year 1	Years 2–5 (annual)	Total
Planning and development	$1,200,000	$100,000	**$1,600,000**
Operations and marketing	$400,000	$2,950,000	**$12,200,000**
Stipends to incentivize enrollment	$2,300,000	$2,125,000	**$10,800,000**
Total	**$3,900,000**	**$5,175,000**	**$24,600,000**

Impact Summary

Over five years, establishing a psychiatric-mental health nurse practitioner (PMH-NP) program would cost $24.6 million and prepare 300 advance practice registered nurses (APRNs) to also practice as PMH-NPs. The program would cost $82,000 per student, of which $36,000 is a stipend and $46,000 is for education and marketing costs. A portion of the program cost and subsequent expenditures on new mental health treatment are anticipated to be offset by decreased overall health care utilization and increased economic productivity. This is a nine-month program, and demand is dependent on the existing nurse workforce finding it attractive.

Over five years, these PMH-NPs would treat approximately 377,600 patients with mental health conditions. PMH-NPs would be able to address gaps in access because compared to physicians, NPs are more likely to serve rural and underserved populations. PMH-NPs have demonstrated similar prescribing compared to psychiatrists and a whole-person approach to treatment; as a result this program would generate health and economic returns by providing quality behavioral health treatment access to underserved populations. People with mental health conditions tend to have higher overall health care costs and are more likely to have chronic health conditions. Behavioral health treatment is associated with medical cost savings of 20%–30%. Overall, treatment of depression is associated with gains in health returns and economic returns with a benefit-to-cost ratio of 5.3 to 1, and similar treatment of anxiety is associated with a benefit-to-cost ratio of 4.0 to 1. Medical savings accrue from decreases in inpatient length of stay and emergency department visits, along with the potential for a reduced cost-per-service compared to care by MDs. In addition, the overall economy benefits from decreased absenteeism and increased productive work time for those receiving appropriate behavioral health treatment.

(Excerpt from impact assessment conducted by Health Management Associates.)