the future is now are we ready?

The 8th Annual Behavioral Health Care Symposium

California Hospital Association
Center for Behavioral Health
Restoring the Promise — The Role of a Community Hospital in Behavioral Health Care

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California Hospital Association
Behavioral Health Care Symposium
December 2013
A Promise Made

- President John F. Kennedy on October 31, 1963—his final legislation was to sign the Community Mental Health Services Act

- His words: “The emphasis should be upon timely and intensive diagnosis, treatment, training, and rehabilitation so that the mentally afflicted can be cured or their functions restored to the extent possible. Services ... must be community based and provide a range of services to meet community needs.”
Funding outpatient mental health services in community clinics, inpatient services in general hospitals for a period not to exceed 90 days, and rehabilitation services in clinics, general hospitals or special centers.
A Promise Broken

“For too many Americans with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.”

– President’s New Freedom Commission on Mental Health 2003

“More than half of teens with psychiatric disorders go untreated.”

– Nov 2013 study released, National Institute of Mental Health
Relevant History Of Hospital Based Behavioral Health Care

- **1960s**: Community Mental Health Services Act shifts inpatient treatment from state to local hospitals.

- **1980s**: Stand-alone psychiatric hospitals sprout up: FFS and maximum lifetime cap structure. Birth of carve-out HMOs.

- **1990s**: Specialty hospitals drain profitable volume from full service hospitals, reducing cross-subsidization ability for unprofitable service lines (especially psych and substance abuse)\(^1\)

- **2010**: ACA and Mental Health/Substance Abuse Parity Laws improve BH service line outlook, especially for non-county facilities and outpatient services.

- **2013**: Episode-based payment rewards treatment of co-morbid BH conditions to reduce LOS and recidivism of chronic care conditions\(^2\)

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2. Trial, participating hospitals for Medicare. Geisinger/others for commercial accounts
Total Number of Psychiatric Units\(^{(1)}\) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals\(^{(2)}\) in U.S., 1995-2010

Note: Includes all registered and non-registered hospitals in the U.S.
(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.
(2) Freestanding psychiatric hospitals also include children’s psychiatric hospitals and alcoholism/chemical dependency hospitals.
De-institutionalization

Number of U.S. Psychiatric Beds per 100K, 1940-2010

No Room at the Inn: Trends and Consequences of closing Public Psychiatric Hospitals, Treatment and Advocacy Center Report 2012
California: Community Psychiatric Beds/Population

![Graph showing the number of psychiatric beds and population in California from 1995 to 2010. The graph indicates a decrease in the number of psychiatric beds and an increase in population over time.](Image)
Institution Change

Number of US Psychiatric Beds and Prisoners per 100K, 1940-2010

No Room at the Inn: Trends and Consequences of closing Public Psychiatric Hospitals, Treatment and Advocacy Center Report 2012
## Cost of care for BHS - 1973

A listing of the current fees for various services of the Department of Psychiatry is provided as follows:

1. Full day with 2 meals (Partial Hospitalization)  $22.00
2. One half day care with one meal  $15.00
3. Outpatient group therapy on unit  $8.50
4. Therapy outing  $15.00
5. Outpatient electro-shock therapy plus medication charge  $15.00
6. Couples group and "generation gap" group  $15.00
7. Psychodrama (Friday 4:00-5:30)  $8.50
8. Emergency Hospital Unit Visit  $10.00 per/hour
9. Relaxation therapy (1 night a week)  $10.00 per/month
10. Social Worker Consultation (Outpatient)  $25.00 per/hour
11. Inpatient care (District)  
    (Out of District)  
    $74.00  
    $79.00
## Cost of Care: 1973 and 2013 (Inflation and Actual)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>1973</th>
<th>2013 equiv</th>
<th>2013 contract rate (est)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full day PHP (with meals)</td>
<td>$22</td>
<td>$115.72</td>
<td>$500</td>
</tr>
<tr>
<td>1/2 day PHP (1 meal)</td>
<td>$15</td>
<td>$78.90</td>
<td>$325</td>
</tr>
<tr>
<td>Outpt Group Therapy</td>
<td>$8.50</td>
<td>$44.71</td>
<td>$76</td>
</tr>
<tr>
<td>Therapy outing</td>
<td>$15</td>
<td>$78.90</td>
<td></td>
</tr>
<tr>
<td>Outpt ECT (incl meds)</td>
<td>$15</td>
<td>$78.90</td>
<td>$900</td>
</tr>
<tr>
<td>Couples Group/Generation Gap Gp</td>
<td>$15</td>
<td>$78.90</td>
<td>$76</td>
</tr>
<tr>
<td>Psychodrama group</td>
<td>$8.5</td>
<td>$44.71</td>
<td>$76</td>
</tr>
<tr>
<td>Emergency Hospital visit (per hour)</td>
<td>$10</td>
<td>$52.60</td>
<td></td>
</tr>
<tr>
<td>Relaxation Therapy (4x month)</td>
<td>$10</td>
<td>$52.60</td>
<td></td>
</tr>
<tr>
<td>Social Worker Consult (per hour)</td>
<td>$25</td>
<td>$131.50</td>
<td>$100</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>$75</td>
<td>$394.50</td>
<td>$1,450</td>
</tr>
</tbody>
</table>
Figure D
Distribution of Mental Health Expenditures by Type of Service, 1986 & 2005

- Prescription Drugs: 7% in 1986, 27% in 2005
- Residential: 22% in 1986, 14% in 2005
- Outpatient: 24% in 1986, 33% in 2005
- Inpatient: 42% in 1986, 19% in 2005

Total in 1986: $32 billion
Total in 2005: $113 billion

Note: Excludes spending on insurance administration. Data not adjusted for inflation.
Figure C

Behavioral Health and All Health Expenditures by Payer, 2005

Behavioral Health

- Private Insurance: 24%
- Medicaid: 26%
- Medicare: 7%
- Other Private: 3%
- Other Federal: 7%
- Other State & Local: 21%
- Out-of-Pocket: 11%

Total = $135 Billion

All Health Services

- Private Insurance: 37%
- Medicaid: 18%
- Medicare: 17%
- Other State & Local: 6%
- Other Federal: 5%
- Other Private: 4%
- Out-of-Pocket: 13%

Total = $1.9 Trillion

Homeless and Mentally Ill

- 744,000 homeless in America
- 250,000 have untreated psychiatric illness

Study of 81 US cities shows direct correlations of decreasing availability of psychiatric beds, and increases in homeless, crime, and arrest records

Fred E. Markowitz, “Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates,” Criminology, 2006:44:1
Receipt of Mental Health Services among Adults Aged 18 or Older, by Level of Mental Illness: 2011

Any Mental Illness: 38.2%
Serious Mental Illness: 59.6%
Moderate Mental Illness: 39.0%
Mild Mental Illness: 28.0%
No Mental Illness: 7.7%
Why Would Anyone Get Help.....?
Stigma and Stereotypes
Reasons for Not Receiving Mental Health Services
Among Adults Reporting Unmet Need, 2011

- Could Not Afford: 50.1%
- Can Handle Without Treatment at Time: 28.8%
- Did Not Know Where to Go for Services: 16.2%
- Treatment Would Not Help: 10.4%
- Did Not Have Time: 15.1%
- Did Not Want Others to Find Out: 7.1%
- Worry about Neighbors/Community Opinion: 8.0%
- Health Insurance Not Covering Enough: 8.3%
- Might Have Negative Effect on Job: 7.0%
- Fear of Commitment/Forced Medications: 7.0%
- Health Insurance Doesn’t Cover Treatment: 6.7%
- Concerned about Confidentiality: 5.9%
12-month and Lifetime Prevalence of Mental Health Conditions (2007 Data)

- Anxiety Disorder: 19% within past 12 months, 31% ever in lifetime
- Mood Disorder: 10% within past 12 months, 21% ever in lifetime
- Impulse Control: 11% within past 12 months, 25% ever in lifetime
- Substance Abuse: 13% within past 12 months, 35% ever in lifetime
- Any Disorder: 32% within past 12 months, 57% ever in lifetime

Argument for Hospital Engagement in Behavioral Health Care

- Emergency Department — higher numbers of psychiatric diagnosis patients seeking services
- Can be done (!) without losing large $
- Doesn’t have to include inpatient (but need must be evaluated)
- Drives new patients to profitable services (ACA)
- Consultation availability
- Good will to hospital from community
- Lack of quality treatment elsewhere
- RIGHT THING TO DO
Value Benefits of Behavioral Health Care

- Early treatment of mental health and substance abuse conditions reduces costs over the long term
- Bundled payments for disease management rewards mental health treatment

Myths in Mental Health Care Delivery

1. Mental illness is different than physical illness and should be cared for separately
   - Both conditions are inextricably linked
   - Care should be organized around the patent’s needs, with integration of physical and mental health providers

2. Outcomes for mental health care are too variable and subjective to measure performance
   - Outcome measurement is even more important in mental health, to learn more about effectiveness treatment models
   - Outcomes measurement is essential in shifting from paying for volume to paying for value

3. Mental health care should be reimbursed separately to control costs
   - Bundling payments will encourage integration of physical and mental health providers and hasten the adoption of outcomes reporting

Why an Integrated (Hospital BH/Primary Care) Model?

- Non-Integration failures:
  - Shortage of quality in-network providers due to HMO rates
  - Two-thirds of PCPs report not being able to access outpatient mental health services for patients
  - Missed appointments, lack of treatment
  - Misaligned incentives

- Mental health services that integrate with primary care, ED services and inpatient care will decrease overall HC costs and will improve patient care outcomes

1. Cunningham, Health Affairs 2009;3:w490-w0501
2. Hoge et al, JAMA 2006;95:1023-1032
## The Question of “Carve-Out” or “Carve-In” Behavioral Health Care in an Integrated Payor/Provider System

<table>
<thead>
<tr>
<th>Carve-Out Model</th>
<th>Carve-In Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-sourced management</td>
<td>In-House management</td>
</tr>
<tr>
<td>Decreased risk through capitated agreement</td>
<td>Increased risk / ACO shared savings</td>
</tr>
<tr>
<td>Focus: short-term savings/episode management</td>
<td>Focus: long-term savings/life management</td>
</tr>
<tr>
<td>Dis-incentive to integrate services/records</td>
<td>Incentive to integrate services/records</td>
</tr>
<tr>
<td>Focus: Cost</td>
<td>Focus: Value</td>
</tr>
<tr>
<td>Business model benefits from fragmentation</td>
<td>Business model benefits from integration</td>
</tr>
</tbody>
</table>
Current State: Primary Care and Behavioral Health Care Services

Primary Care Physicians often are missing the MH condition patients

- 68% of Americans with Mental Health conditions also have medical conditions
- 29% of Americans with medical conditions also have BH conditions
- In a study tracking 500 patients over 5 years, only 1/3rd of Mental Health conditions are identified by the PCP
- When positive screening for depression — roughly 50% do not receive follow-up assessments at six weeks

Barriers to treatment in the primary care setting

- Lack of time to treat by PCP
- Lack of available expertise to treat in PCP setting
- Lack of reimbursement for BH treatment in PCP setting
- Mental Health “carve-outs” discourage integrated services
- Perverse incentives for fragmented care in FFS or capitated systems

3- Oslin,DW et al, Screening, assessment and management of depression at VA primary care clinics J Gen Intern Med 2004;21(1):46-50
4-Integration of primary care and behavioral health, Bazelon Center for Mental Health Law, 2008
Community Hospital Behavioral Health: Improved Climate

Two “game-changers” in past few years:

- **Mental Health Parity** requires that plans that provide psychiatric/substance abuse coverage must do so in the same manner as provided medical services

- 2013 “final rule” goes a step further: “non-qualitative treatment limitations” are forbidden (i.e. different UR processes, etc. *(despite objections from carve-out mental health payors)*)

- **ACA additional coverage** to:
  - Youth up to age 26 on parent’s plan
  - Pre-existing conditions
Overview of Behavioral Health Services at El Camino Hospital

Current Program

- 25 inpatient psychiatric beds (9 ICU, 16 acute care)
- Partial Hospitalization co-located building with inpatient services
- Addiction Services on-site
- Total Sq. Ft.: 25,680
- ECT Services in the Hospital PACU (surgical area)
- Post-Partum Mood Program
- Adolescent Program
- Older Adult Program
- Primary BH Care clinic opens Fall 2013

Future Program

- 36 inpatient psychiatric beds (12 ICU, 15 acute care, 9 specialty care)
- Expanded Brain Stimulation Services
- Partial Hospitalization expanded, remains co-located with inpatient
- Planned Total Sq. Ft.: 42,000
- Additional adult outpatient growth to the communities served
- Expanded outpatient services in community
- Outpatient clinics potential co-location
- Outreach Programs with schools and employers
Community Mental Health — Overview of BHS Outpatient Services
Financial Performance Contribution to Indirect (2011-13)
Mountain View Campus– El Camino Hospital

[Bar chart showing financial performance contribution to indirect for FY2011, FY2012, and FY2013 for outpatient, inpatient, and totals.]

""
Financial Strategies for Community Hospital BHC

**Risks**

- **Rates:** Downward pressure from payors on rates to compensate for increased access of services under ACA/Mental Health Parity
- **Competition:** Growth potential of lower-cost, lower quality inpatient services from for-profit providers
- **Access:** Payors tightening access to covered services for cost containment
- **Patient Mix:** Potential further shifting of county responsible patients under Medi-Cal to hospital-based services
- **Costs:** Labor cost increases outpace revenue growth

**Mitigations**

- **Diversification:** Growth in outpatient and procedural services
- **Contract Stewardship:** Payor conversations to include the higher quality and higher costs of hospital-based inpatient care
- **Primary Care Partnering:** ACA will drive a continuum model for BH conditions including bundled payments
- **Cost Containment:** Labor and overhead expenses require creative fiscal fidelity and consideration of license alternatives to better align costs/reimbursements
- **Sizing of Inpatient:** focus on quality with recognition of limited quantity to maintain balance
Hospital/Primary Care Integration: Birth of a Specialty Program: “MOMS”

1. Perceived need based on experiences, media reports, studies
2. Medical Staff Departments requested hospital/community TF
3. TF surveyed community providers as part of needs assessment
4. Evidence that a program could support outpt. program ADC of 3
5. Program opened 2008
6. ADC average = 6 in 2013 (with babies can be a big group)
7. Foundation support for aftercare, partner’s group, home visit, “warm” line, etc.
8. High satisfaction from referring providers and patients
9. Expansion plans for another location
Meeting a Community Need: ASPIRE Program

1. Cluster of adolescent suicides in local community (via train)
2. Hospital led TF engaged schools, local programs, providers
3. Resulted in a hospital-based Intensive Outpatient Program
4. “Skills Training” for stress (anxiety/depression) incorporated as best evidence for reducing suicide risk in teens
5. Eight-week program, after-school to support education and provide better support for risky hours
6. Strong outcomes as reported by parents, teens and schools
7. Frequent wait lists: expands to other campus (Los Gatos) in 2012
8. Eight Schools now providing academic credit for completion
9. Exploring expansion to middle schools/community colleges
Key Partnerships for Success

- Partner with schools to provide resiliency training for a vulnerable population
- Partner with employers so that education and screening are available and early intervention is easily accessible
- Partner with primary care physician groups so that screenings, referrals and interventions are timely and effective

Here, more than in any other area, "an ounce of prevention is worth more than a pound of cure." For prevention is far more desirable for all concerned. It is far more economical and it is far more likely to be successful."

–JFK, Special message to congress, 2/5/63
Primary Care Referral to hospital-based clinic: “AIMS” approach to matching patient need with clinic

<table>
<thead>
<tr>
<th>“AIMS” Approach</th>
<th>Emergency Care Clinic</th>
<th>Immediate Care Clinic</th>
<th>Wellness Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong>ccess</td>
<td>ED visit = 24/7</td>
<td>Appointment within 48-72 hours</td>
<td>Appointment Within 10 days</td>
</tr>
<tr>
<td><strong>I</strong>ntensity</td>
<td>Single visit</td>
<td>Visits 1-2 weekly</td>
<td>Visits 1-4 Monthly</td>
</tr>
<tr>
<td><strong>M</strong>odel of care</td>
<td>Safety focused</td>
<td>Brief Solution Focused/Crisis</td>
<td>CBT / life transition focused</td>
</tr>
<tr>
<td><strong>S</strong>taffing</td>
<td>ED staff + BH counselors + MD on call</td>
<td>Licensed staff, daily team consultation</td>
<td>Licensed, Post-Docs, Interns</td>
</tr>
</tbody>
</table>

Outcome Measures: QIDS, GDS, GAD-7, EPDS
Pitfalls and Lessons Learned

- **Entrenched attitudes create barriers**
  - Stigma: alive/well

- **Not all players are partners**
  - Profitable enterprises benefit from status-quo
  - Other nonprofits may feel threatened for funding
    - **Partnering essential**

- **There is hunger for change**
  - By consumers, families and those dedicated to serve them

- **Beware the unintended consequence**
▪ What is the cost of treatment?

▪ What is the cost of not treating?
QUESTIONS?
Thank you

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