Rethinking the Delivery of Care

December 6, 2011
Howard J. Gershon, FACHE
New Heights Group
Session Objectives

• Historical Context
• Adding Value
• Critical Success Factors
Historical Context
Historical Context

• Challenging financial performance
  – Lack of highly reimbursed procedures
  – Poor payer mix
  – Disposition and LOS problems

• Safety and security concerns

• Physician coverage issues

• Other?
A New Day?

In his second year in office, President Obama has won historic reform that some once saw as impossible.

Major Milestone: House passes Health Care Bill

In the House of Representatives, the health care reform bill passed with a 219 to 212 vote. The bill now moves to the Senate, where a similar fate is expected. 

Timeline: Change won't be overnight.
What Keeps CEOs Up at Night

• What does accountable care mean?
• How to prioritize cost & quality imperatives?
• How to engage community partners to improve the health of the population?
• How will I move to integrated care delivery?
• How will we move from volume-based payment to value-based payment?
Adding Value

- Inpatient Consultation
- Emergency Interventions
- Primary Care
Inpatient Consultation: An Idea Whose Time Has Come?

• 20 -30% of Med/Surg inpatients have some kind of MH/SA comorbidity
• How many actually get consults?
• How timely are the consults?
• What actions result?

Proactive Consultation Programs
Psychiatric illness increases claims expenditures.

For 6,500 Medicaid Patients.
Proactive Consultation Programs

- Proactive Case-Finding
- Multidisciplinary Staffing
- Disease Management Perspective
Proactive Consultation Programs

Proactive Case-Finding

- Admission screening with “red flags” for complexity
- Unit nursing staff use of complexity-assessment tools
Proactive Consultation Programs

- Multidisciplinary Staffing
  - Adequate consultation team staffing to meet clinical demands
  - Involvement in all (or most) admissions with high complexity through an automated referral process
  - Active communication with unit staff and physicians
  - Unit staff training when necessary
Proactive Consultation Programs

Disease Management Perspective

- Use of case- and disease-managers
- Regular follow-up throughout the hospital stay
- Continuous outcome measurement
- Coordination of discharge referrals into integrated outpatient services
A Brief Example

- Five-Hospital System
- Average of 245 consults per month
- 1.6 MD FTE & 4.2 CNP FTE
  - 60% of calls by CNP
- 90% of requests within 24 hrs.
  - 70% same day
- Documented reduction in LOS
Adding Value

- Inpatient Consultation
- Emergency Interventions
- Primary Care
Emergency Interventions: The Problem

- One out of 8 ED patients nationally has a behavioral health issue.
- Nearly 41 percent of BH-related ED visits resulted in hospitalization.
- Many of these patients are agitated and disruptive.
- Disposition is a challenge so they spend an inordinate amount of time in the ED.
- Some of these patients just need a quiet place to decompress.
Emergency Interventions: ACEP Study

- 79% of total respondents board psych patients in the ED.
- 90% board weekly.
- 62% did not provide psych services in ED.
- 85% said ED wait times would improve with better psychiatric services.
Emergency Interventions: Psychiatric Emergency System

Identification
- Police
- Families
- Clients
- Shelters
- Hospitals
- Social Services
- Child Protective Services
- Adult Protective Services
- Crisis Help Line

Assessment/Stabilization
- Psychiatric Emergency Services
  - Screen/Triage
  - Assessment
  - Diagnosis
  - Crisis Intervention
  - Emergency Treatment

Community Alternative
- Crisis Stabilization Unit
- Mobile Crisis Outreach Team
- Crisis Residential Unit
- Crisis Counseling Unit
- CMHC
- Respite
- Private Providers
- Homeless Services
- Dual Disorders
- ACT
- Other Agencies

Extended Observation
- 23-Hour Observation

Inpatient Unit
- Other Hospitals
Emergency Interventions: Pre-Acute Models

- Psychiatric Urgent Care Clinic
- Psychiatric Evaluation and Triage Service
- Psychiatric Emergency Department
- Comprehensive Psychiatric Emergency Service
Psychiatric Urgent Care Clinic

- Developed by hospital or in partnership with community-based provider
- Provides short-term intervention and triage for non-suicidal patients as an alternative to ED or inpatient care
- Focus is on stabilizing and linking patients to available outpatient programs for longer-term care
- Walk ins, referrals from ED and from “hotline/intake number”
- Services available 9-9 Monday through Friday, 12-12 on weekends
- Staffed by psychiatric nurse practitioners with psychiatrist backup
Example: The Community Crisis Center in Billings, MT

- Started in 2007 as a collaborative effort between Billings Clinic, St. Vincent's Healthcare, South Central Montana Mental Health Center and Yellowstone City-County Health Department
- Freestanding facility: located close to hospital and MHC
- Non-medical model: staffed by counselors, nurses
- Capacity to provide “respite” for up to 24 hours for 18 clients at a time
- Approximately 4,500 visits in 2010
- Estimates that it averts 1,100+ ED visits/year

Avg Visits/Month

2007 Late 2010

+77%
Psychiatric Evaluation and Triage Service

- Hospitals and community providers collaborate to develop an alternative to ED based crisis management
- Secure setting where police and families can transport and drop off agitated patients
- Location contiguous to accessible medical-surgical coverage for medical clearance/ emergencies
- Offers emergency and urgent care walk-in capacity 24/7, but at a minimum 3-11 and 11-7 shifts 7 days/week
- Staffed by psychiatric nurse practitioners, RNs, MSWs, mental health counselors, with physician oversight
- May include observation beds
Example: Cincinnati Children’s Medical Center

• Psychiatric Intake Response Center is the admission and evaluation center for all psychiatric services.

• Services provided include:
  – Admission and evaluation center for children and adolescents in acute crisis
  – Telephone triage and response
  – Mental Health Link to community services including outpatient referrals
  – Consultation services for medical patients
  – Insurance pre-certification and authorization

• All services are available 24/7
Psychiatric Emergency Department

- Typically developed by hospital or health system
- Provides 24/7 psychiatric assessment, crisis intervention, and linkage with appropriate resources
- May be “free standing” or contiguous to a general hospital ED
- Staffed by full-time psychiatrists, nurse practitioners, registered nurses, master's-level clinicians and psychiatric technicians.
Example: Banner Psychiatric Center

- 24/7 psychiatric emergency service
- Located on the campus of Banner Behavioral Health Hospital
- 7,000 square ft facility with 24 23-hour observation chairs
- Expected to divert patients from area general hospitals
  - Many patients are transferred from other EDs
  - Banner has 8 hospitals; 4 have psych beds
  - Banner Hospitals had 150,000 psych hold hrs in EDs last year
- Half of patients are admitted to BBHH and half are discharged home
- Staffed by Psychiatrists and PNPs
  - PNPs do evaluations 11-7
- Not making money but viewed as cost offset
Comprehensive Psych Emergency Service

- Developed by hospital in partnership with community providers
- Typically includes four components:
  - Psychiatric Emergency Room
  - Extended Observation Beds
  - Mobile Crisis Outreach Team
  - Crisis Residence Program
Example: St. Joseph’s Hospital and Healthcare

• Psychiatric Emergency Room
  – Fully staffed 24 hours a day, 7 days per week.; a locked, secured facility.
  – Patients receive a complete Psychiatric Examination, which includes triage by a Registered Nurse, a Psychosocial assessment by a Clinician and a psychiatric evaluation by a psychiatrist.
  – This process is generally completed within six (6) hours after being received into the Emergency Room.

• 4 Certified Emergency Observation Beds.
  – Individuals can be admitted to the EOB for a period not to exceed seventy-two (72) hours.
  – In-Patient Hospitalizations may at times be avoided after a brief period of stabilization.
(Cont’d): St. Joseph’s Hospital and Healthcare

- **Mobile Crisis Outreach**
  - Provides off-site initial screening for individuals in emotional crisis.
  - Individuals who require a full psychiatric assessment by the physician will be transported to CPEP by 911 services.
  - The Mobile Crisis Outreach Team also performs home visits with patients who have been recently discharged from CPEP.
  - The goal is to assist the patient in maintaining stability, until the connection with an outpatient provider has been completed.

- **Crisis Residence**
  - Provided through a linkage agreement with Hutchings Psychiatric Center.
  - Patients discharged from CPEP who are experiencing a crisis with their current housing can be referred to this service.
  - These beds have a maximum stay of five days.
Adding Value

- Inpatient Consultation
- Emergency Interventions
- Primary Care
Primary Care

- 70% of all PC patients present with psychosocial issues.
- 50% of all behavioral health care is provided by PCPs.
- 67% of all psychoactive drugs are prescribed by PCPs.
  - Individuals with severe mental illness have a much higher premature death rate.
  - The majority of causes of early death are preventable medical conditions.
Common Chronic Diseases and Depression

Diabetes 11-15%
Heart Disease 15-20%
Multi-Condition Seniors 23%
Stroke 30-50%

Major Depression

Source: NC Center of Excellence for Integrated Care, 2010
Barriers to Effective Primary Care

- Difficulty of getting needed consultations
- Time constraints of a busy practice
- Complicated nature of recognizing MH/SA disorders
- Reimbursement and compensation constraints
- Associated medical and social comorbidities
Patient-Centered Care Includes ON-SITE Integrated Care Team

NPs  PAs

Physician

Behavioral Health Therapists

Psychiatrists

Receptionists

Nurses and Medical Assistants

Medical Records

All Supported by:

- Common Chart
- Documentation Standards
- Billing Procedures
- Clinic Management System

Source: NC Center of Excellence for Integrated Care, 2010
Integrated Care Program

Behavioral Health Services Integrated with Primary Care:

- Screening
- Assessment
- Brief supporting counseling
- Therapy
- Case management
- Medication monitoring
- Coordinated team care

Nurse screens patients at established visits and annual appointments.

Physician sees patient and validates screening.

Physician introduces patient and therapist.

Physician and therapist provide team approach for coordinated care.

Source: NC Center of Excellence for Integrated Care, 2010
Intermountain’s MHI Program

- Implemented in 69 of 130 primary care clinics and in 4 uninsured school-based clinics.
- Team includes PCPs, their staff, MH professionals, community resources, care management, and the patient and his or her family.
- The integration model goes far beyond co-location in its team-based approach.
- Patients show improved satisfaction, lower costs, and better quality outcomes.
- Patients who received care for depression were 54 percent less likely to use higher-order ED services.
Critical Success Factors for Behavioral Healthcare in 2012

- Move care into venues that emphasize convenience.
- Use care teams and allied health personnel like case managers to help prevent the costliest episodes of care.
- Build connections across the continuum of care.
- Allow caregivers to focus more effort on sicker patients.
- Cultivate a shared belief in evidence-based medicine.
- Leverage information and decision tools.
- Shift from fee-for-service to value-based thinking.
- Engage and incentivize patients to take healthcare out of the exam room.
Contact

Howard J. Gershon, Principal
New Heights Group, LLC
41 Sundance Drive
Santa Fe, NM 87506
Phone: 505 986 1570

howard@reach-newheights.com
www.reach-newheights.com
Questions