A Call to Action in the Wake of the Newtown Massacre

Jan 22, 2013

Editor's Note:

In the aftermath of the tragic death of 26 people (including 20 children) in Newtown, Connecticut, on December 14, 2012, much needed attention is being paid to mental health care in the United States. Additional stress on the system has resulted from major disasters like Hurricane Sandy and the recent wars, which have severely taxed civilian and service populations, further affecting already limited psychiatric resources. Many of those directly and indirectly affected by mass shootings, war, or disasters will need mental health treatment. And, of course, large portions of our population independently suffer from serious psychiatric disorders. Unfortunately, those in need of psychiatric care often have very poor access to appropriate management due to lack of resources; others don't seek out care due to real or perceived societal stigma. Together, these barriers represent a major inadequacy in US mental health care. Medscape recently spoke with psychiatrists Richard H. Weisler (UNC-Chapel Hill and Duke University Medical Center), Henry A. Nasrallah (University of Cincinnati College of Medicine and University Hospital), and Joe Parks (Missouri Institute of Mental Health) about the status quo of mental health care in the United States and what can be done to repair the system.

Introduction

Medscape: It seems like every week we hear about another psychiatric hospital or unit closing its doors, or another state cutting mental health care funding. Can each of you comment on the worsening lack of psychiatric resources in the United States and the impact that this worrisome trend might have?

Dr. Weisler: If you do an online search, you'll find article after article from small towns to big cities -- and also at the state level -- about the impact of all of the recent closures. Chicago's Tinley Park Mental Health Center closed this past summer while Cedars-Sinai in Los Angeles closed its psychiatry department. Also this past summer, in North Carolina, the final patients left the storied Dorothea Dix Hospital. This is happening around the country, leading to a shortage in psychiatric services.

There is also a severe shortage of mental health providers in the United States, and it's getting worse. This is in part because half of US psychiatrists are over age 55 years, and not as many new people are entering the field as are needed. There is also a shortage in researchers.

Dr. Nasrallah: In the '60s and '70s, the National Institute of Mental Health provided additional residency stipends prompting many medical students to enter the field of psychiatry. Now there is a bottleneck due to inadequately funded residency positions. There are also a lot of very good international medical graduates out there desperately trying to get into psychiatric residency programs. But for various reasons, many of them are being turned down. If there were more slots available, I think they would be filled. We can train 50% more psychiatrists a year than what we are currently producing, which is roughly 1200 psychiatrists a year, which barely keeps up with the attrition on the other end with retirement and mortality.

Dr. Parks: I don't think we do well at the local level because we tend to separate ourselves -- the "mental health group" -- and don't join and assist others, such as primary care providers or even the police, with their issues. All we do is ask for help with our needs and our problems -- it's not an effective approach to partner with somebody like that. If you want a partner, you go and find out what their needs and problems are, take care of them, and then you ask for something for yourself.
Dr. Weisler: That's an excellent thought, Joe. It should be easy for us to find partners. For example, and I've done this recently, one contact to make is with your local emergency department (ED) providers and administrators. The EDs are frequently filled with psychiatric patients waiting for beds. It's even worse than when we talked about it a couple of years ago here on Medscape. They'll wait for days and sometimes for weeks. There's usually a huge waiting list, and there are also what they call "no admit" lists. If a patient is aggressive, it often feels like nobody really wants and/or feels that they have the staff to care for them. If you have a demented patient with psychosis, it's also much harder to find a bed, especially if they are agitated. Remember, we have no US Food and Drug Administration (FDA)-approved treatments for psychosis or agitation in dementia, yet the numbers of patients who will require such treatment are rapidly increasing as our population ages.

Dr. Parks: To that point, I have a problem with EDs saying they're choking or they're backed up with mentally ill people or substance abusers. I ran some 10-year trend numbers on Missouri from 2000 to 2009, the last year we have complete data posted on our Website. During that time, the number of mental health ED visits went up about 43.9%, and the total ED visit rate went up 17.4%. If you look at the numbers, the increase in ED mental health visits was about 19,732 from 2000 to 2009, which is only 6.1% of the total ED visit increase of 324,585 visits from 2000 to 2009. Overall mental health ER visits went from being 2.40% of total ER visits in 2000 to 2.96% of total ER visits in 2009. How can they be choking on mental health patients when we represent 6.1% of the total ER volume increase and a net proportional increase of 0.56%?

Dr. Weisler: You may be right about the numbers, but it's often true that there is no place to send these patients in many cases, especially if state mental health beds are full.

Dr. Parks: So why do these hospitals not have inpatient psychiatric units? If they had more women delivering babies than they could handle, they would open more obstetrics capacity. If they had more people with broken legs than they could handle, they would open more orthopedic capacity.

Dr. Nasrallah: You're absolutely right, Joe. There seems to be no feedback loop in mental health. It's just a one-way street, and there doesn't seem to be a correction for anything, which tells me that the entire field of mental health may go downhill very fast. And no one is trying to pull it back and approach care in a rational manner based on data such as patient and population needs. If 25% of the US population has a recognizable, diagnosable, and treatable mental disorder, why is this happening? A total of 80 million people in the United States are not being well represented, namely because, as Joe said and Rick insinuated, we're not partnering. We're not doing our job collectively in order to fight the current crises at the local level. But we need to scream loudly that for everything that happens around the country, and that communication pattern, we're failing to communicate and to have rapid response, and therefore those who are cutting mental health budgets are continuing to cut unabated because they don't face any tangible resistance.

Dr. Parks: I think the ED is an excellent feedback loop for identifying what's needed in a local healthcare delivery system. I think making the problem the lack of public beds is exactly the wrong message. It says that it's okay to push these people off to the side; the local hospital doesn't want to deal with them. And that is unacceptable. These hospitals, these people with mental illness in the EDs are members of their community, and these are community hospitals. If there's a medical need, they should be developing that capacity.

But Psych Units Lose Money

Dr. Weisler: Part of what Joe is saying is because psychiatric units often lose money, and at best administrators suggest that they break even. Often patients are on "no admit" lists. This may be because either ED doctors and hospital staff/administrators feel like they just don't have the staff resources to care for them, or perhaps it's too expensive and/or dangerous when somebody is either really aggressive, psychotic, or demented with psychosis. And perhaps, as a result, beds are limited or closed in many of the community hospitals.


1/30/2013
Dr. Parks: I think that's garbage. Most complicated cases lose money. Hospitals are paid on diagnosis-related groups. If you have a heart attack patient who goes to the intensive care unit (ICU) for more than a day, the hospital loses money. Does that mean that they refuse to admit people who need more than 5 days of ICU care? No, they don't scream about it.

Dr. Weisler: You're right, but that's the rationale they give us.

Dr. Parks: We need to call them on it instead of letting them off the hook. Just building public beds enables them to exclude patients with mental illness into a separate, second-class healthcare system. I have 15-20 years of data on bed counts in Missouri. The biggest drop in beds since we started tracking it in about 1990 has actually been on the private-sector side. Before the Tax Equity and Fiscal Responsibility Act (TEFRA) was passed in 1982, which was when diagnosis-related groups (DRGs) came into play, hospitals made more money by doing more things in all medical lines of business. So the big fountains of profit were ICUs, EDs, and surgery suites. Since switching to DRGs, we haven't had any growth in ICU beds. They have replaced old ones with new ones, but the total volume hasn't gone up because you've got a flat payment for everything.

Well, if you remember, psych beds were exempt from going to DRGs for about 15 years after that, and that caused the explosive growth of the private freestanding psych hospital industry. We had a hospital in Northern Missouri in a little town of 17,500 that had a helicopter that would fly people in from around the state. You know you have excess capacity when you have hospitals flying people in, scouting around with helicopters for people. The new private psychiatric hospitals were looking everywhere for patients to fill their beds and were happy to get Medicaid patients, so state hospitals experienced a drop in acute bed use and downsized.

But the inappropriate admissions and long lengths of stay at the private psych hospitals got shut down when behavioral health managed care companies came in. So there was egregious gouging by the private hospital companies, but then there was an overreaction by mental health managed care and that bed bubble burst. But the states had already downsized their psychiatric capacity because the private sector was sucking up every patient they could find during this temporary 10-year bed bubble. So then many of the private psych beds closed in the late '80s to early '90s. From 1990 to the bottom of the bed collapse in 2001, Missouri state beds dropped 23% (386 beds) and Missouri non-state beds dropped 43% (1388 beds).

Dr. Weisler: Another thing we should touch on is Medicaid. Is it true that Medicaid reimbursement is not provided for psychiatric patients in institutional beds?

Dr. Parks: Well, it depends on what kind of Medicaid reimbursement you mean. If you mean the Medicaid fee for service, it's not reimbursable in an institution using 50% of their beds or more for mental health, or substance abuse, and having over 16 beds. So you can build all the psych beds you want in a general hospital as long as it doesn't go over 50% of the capacity. But if you build a freestanding site, you cannot charge Medicaid for people between 22 and 64 directly to Medicaid or Medicare. However, if your state is one of the three quarters of the states that's part of the Disproportionate Share Hospital (DSH) program, you can get federal reimbursement for adults with mental illness. In that case, you don't get paid by Medicaid, you get paid from the Centers for Medicare & Medicaid Services DSH payment, which actually can pay you close to the total shortfall of costs for both underinsured (Medicaid) and uninsured persons. So if our state psychiatric hospitals could directly bill Medicaid a per diem, our state match would be 65%; we put 35 cents down and we get 65 cents back from the fed on the dollar. Instead, we get over 90 cents on the dollar out of the DSH program, so we actually make more off of our state psychiatric hospitals from DSH than we could if we billed Medicaid. And that's a major inaccuracy in the National Treatment Advocacy Center Report. They don't take into account DSH, which is billions of dollars, and the majority of the states are on that program.

"Obamacare": Good for Mental Health Care?
Dr. Weisler: Henry, are you finding it harder and harder to get people in the hospital or find beds for your patients in Ohio?

Dr. Nasrallah: Absolutely. And just a few months ago the state of Ohio abruptly cut the budget that we had been getting for the past 25 years to run a state-supported inpatient unit for the indigent patients in Ohio. Many of these patients are severely mentally ill and were being taken care of at our University Hospital in a ward dedicated to them. They literally cut the funding to zero overnight, even though we strongly protested and lobbied hard and had various meetings and called on our friends and discussed it with everybody possible.

So a lot of our patients are stranded, and we had to abruptly lay off many mental health professionals. Then we decided to go ahead and do everything we can to take it upon ourselves, at significant financial risk, to reopen the ward at our own expense. We rehired the staff and are hoping to serve this underserved and disabled population even though we expect to lose money. We just couldn’t see the ward closing, because those patients would have nowhere to go.

Dr. Parks: The key thing that will be a huge help for your unit and for mentally ill people in general is if healthcare reform goes forward on the Medicaid expansion side, because then when we get to 2014, there will be a huge reduction of the uninsured, and almost all of those patients you're seeing as uninsured will now be reimbursable.

Dr. Nasrallah: Yes. And I was going to ask you that question, Joe: Do you really think that what is referred to as Obamacare is going to be good for mental health? And if so, can you elaborate?

Dr. Parks: Healthcare reform has been a rolling issue long before the Obama proposal and healthcare reform. We had the Parity Act that finally passed after years, and we haven't focused enough on bringing the appeals to make that reality. Any time you get a law, you have to follow up with the administrative process to enforce the law, and that's an individual case-by-case action.

I think that the Parity Law, the Wellstone-Domenici Mental Health Parity Act, has already made a huge difference on quantitative limits. We have not yet gone as far as we can on the qualitative limits, but it's gotten much better. A lot of the people deemed mentally ill in EDs have a lot of substance abuse problems, and a lot of them are young men. And those are the uninsured that nobody wants to treat because there's no funding stream. All of those people end up categorically eligible by income and will have resources to treat them. I think our problem is going to be the lack of manpower. A number of these psych units are closing because they can't hire psychiatrists to staff them. Also the Affordable Care Act requires that the new Essential Benefit plan that will be offered on the health insurance exchanges must comply with the Wellstone-Domenici Parity Act and cover mental illnesses and substance abuse disorders at parity with other medical conditions. In addition, the Affordable Care Act has numerous demonstrations and incentives for integrating behavioral health with other medical care.

Dr. Weisler: Outpatient resources are also severely diminished, and I've also seen how these significant budget cuts affect the Assertive Community Treatment teams in a lot of states. A third or so of their budgets have been cut, and sometimes more, I am told. A lot of our counties in North Carolina lack these community resources. What is it like in Missouri, Joe?

Dr. Parks: Our state funding has been reduced, and many of these funding reports just look at the state funding. But we've been able to increase our federal funding. So we've held about even.

One of the messages here is that when you look at funding, you have to look at all funding. We've been more successful also at getting funds through the Medicaid system, but that's again building our new programs in a manner that helps Medicaid achieve their goals. We don't open by saying, "Boy, we have all of these mentally ill people and they have all these needs." We go to them and say, "Hey, we noticed that you're really concerned about very expensive people that go to the ED all the time. Let's run an analysis and see who those people are." Then, lo and behold, they turn out to be mentally ill people often with a lot of medical problems. So we get our case
managers, instead of just getting them to the psychiatrist, to also get them to primary care and instead of just watching out for their antidepressant, to watch out for their antihypertensive too. Our Medicaid agency has agreed to put more of their budget money into mental health because we give them a better return on the dollar than their other methods. That's what I mean by going to somebody to help them with their problem, not just bringing your problem to them.

Dr. Weisler: And here's another thing that ties in with an interview that Len Paulozzi and Ashwin Patkar and I did looking at unintentional drug poisoning deaths in EDs. Poisoning deaths in many cases have passed suicides and motor vehicle accidents as a cause of death. EDs seem to be very eager to work with us on this problem, and we should really be developing more partnerships.

Dr. Parks: Absolutely.

Mitigating Mismanagement

Medscape: With biomarkers and imaging tests slated to play an increasing role in psychiatry, could such revenue sources make psychiatric services more desirable and profitable and less likely to be cut?

Dr. Nasrallah: I don't think that laboratory tests and biomarkers will be enough to satisfy hospitals in terms of breaking even or making money from psychiatric wards, as they can be in cardiology or cancer or other medical specialties. I think it's the per diem they get paid and the DRGs they get. And the reimbursement for the beds is their big focus. We provide hospitals with a lot of laboratory tests when we admit psychiatric patients, but that is not incentive enough for them to keep those beds open, let alone expand them. I really think we need not just parity for psychiatric care in general but we need parity in terms of profitability of psychiatric hospitals. There has to be an incentive for hospitals to keep those beds open, and there have to be incentives for psychiatrists to work there. If you want to have more providers, you have to provide them with incentives. And all of these are lacking.

Dr. Parks: Also, you need to look at hospitals' analyses of whether they're gaining or losing money on psychiatric beds with the same scrupulous eye with which we looked at the CATIE study. First of all, the staffing costs on psych units and the hardware costs are far below medical. We don't use as many nurses. We don't have oxygen lines. We don't have telemetry. Often in these assessments, they will load the psychiatric unit overhead at the same rate they load overhead across the whole hospital. Then they go the opposite way on attributing revenue, so if a person on inpatient psychiatry gets an MRI of their head, the revenue from the MRI is all attributed to radiology. Finally, if hospitals get DSH payments, they often count them as some kind of post net loss grant instead of revenue. So they claim to be losing money on psychiatry due to us having a higher uninsured and Medicaid case mix. Then they turn around and get DSH funds for having a higher uninsured and Medicaid case mix without booking them as revenue coming from psychiatry. The psychiatry profit/loss numbers they present to us are often incorrect, and when we sit down with administrators and try to go through them line by line, suddenly things get really quiet.

Dr. Nasrallah: Right; they charge us the same high rate they charge for a very heavily equipped ICU.

Medscape: Are you referring specifically to how hospitals operate in Missouri, Dr. Parks? Or does this reflect the situation nationally?

Dr. Parks: I've only looked closely at Missouri hospitals, but there's a lot of sloppy management going on in healthcare. Healthcare is not a well-managed industry.

Dr. Weisler: One thing that would really help is if we could find tests that would help us predict which medicine somebody might respond to or have trouble with, or what dose would be best. Much of the cost is due to people not taking their medications or doing poorly on the medication. When people follow appropriate treatment, typically we can prevent a lot of hospitalizations and improve outpatient care results as well. Many if not most psychiatric

patients can become functional and pay taxes, as opposed to using the system to get reimbursed with disability or other claims. And this gets at what Joe was saying -- that administrators will just see the cost of a patient visit or a medication cost, without considering that if you don't treat people, they're going to end up in the ED, they're going to end up in the jail, they're going to be on disability -- whatever it might be.

Dr. Nasrallah: Most states, and the country as a whole, are going through a serious financial crisis and are looking everywhere to cut funds. And guess who is the first on the chopping block? It's us. It's psychiatry. And mental health rarely puts up a decent fight, unlike surgeons, who would aggressively resist. I mean they wouldn't dare cut a surgical program because they are a powerful force. They unite and they fight back. We psychiatrists tend to be soft and meek and conflict-avoidant. We are almost cowardly in our position or attitude to fight back. We complain about it, but we don't unite. We don't organize. We do not have a plan. Nobody has even thought about creating a plan including the major psychiatric organizations that supposedly represent us in this country. I don't see them rallying the troops, raising the volume, on everybody involved in these cuts at the state level and at the federal level. We just have to find better solutions than what we have right now, which is no solutions whatsoever.

Dr. Parks: I think that kind of planning is usually highly specific to each state budget situation, and the plan that works for Ohio would be different from the plan that works for Missouri. I think one error we do make is whenever anybody talks about cutting, we always say don't cut anything. It's more successful to say, here are some ways I can help you out with budget. You can take this, but for these other items I want to redesign some services and redirect some of the historic funds to the new services. If you let us redesign and redirect them, you get some funds to patch your budget hole in return.

Dr. Nasrallah: But how can we give up anything when this process has been going on so long we are down to the bone marrow? There is no room for compromise. We cannot tell them to cut this bone but not that bone. They shouldn't be cutting any bone. We need flesh and we need to have decent funding and resources for our programs for our patients to survive. What you're saying is right, but we should have done it long ago when there was some fat in the system.

Dr. Parks: I think there are still things we do that are ineffective and can be cut. A budget cut is an opportunity not to give it all up but to give part of it up and then change the rest in a way that you end up with more than what you had to start with, certainly in efficacy and often with funding if you get into the details with some of your financial planners.

A PCP, Just Down the Hall

Dr. Weisler: Another area affected by these budget cuts is the medical and primary care management of patients with mental illness. What kinds of trends are you seeing here, Joe?

Dr. Parks: We will not be able to have psychiatrists doing the majority of the prescribing in specialty settings, even in the specialty mental health settings, or doing the majority of the inpatient care. We'll be increasingly supervisory and consultative on the most difficult cases or just the initial assessments -- or just when things are going poorly. There are just not enough of us to treat everybody ourselves.

I think this actually might be helpful in terms of mortality. I worked for 10 years in community mental health centers and now for the last 10 years as a psychiatrist in a primary care clinic. And I'm actually able to do better care in a primary care setting than I could do in the mental health centers. The patients get their vital signs taken and I can get the labs drawn right away; ECGs get done and read right away if, for example, I'm concerned about QT prolongation due to some medications. I can talk to their treating primary care physician by walking up the hall and knocking on the door and have an immediate consultation rather than sending a letter or an email that you wait for a week to get back if you ever do get one back.
I think the issue of people with serious mental illness dying in their mid-50s primarily of medical illnesses, heart disease, hypertension, would be greatly helped by psychiatrists practicing in primary care clinics, where we can be near our medical colleagues.

Henry wrote the excellent CATIE substudy\(^3\) about two thirds of the patients who had hypertension or dyslipidemia or cholesterol problems, and about two thirds of those were not being treated. About 20% had diabetes, and 30% of those were not being treated. These are academic clinics that can do multicenter national research yet can't detect and treat hypertension and diabetes. It's pitiful.

**Dr. Nasrallah:** Yes, I was appalled by what we found. As you said, 30% of schizophrenia outpatients with diabetes had never received treatment in their life, 60% of the hypertensive patients had never ever received medication for it, and 90% of those with high cholesterol/high triglyceride never received a statin. I cannot agree with you more. I've been advocating that in our residency training program we must train our residents by putting them in a primary care clinic -- in a back-and-forth collaborative model so they could follow up with their patients after they finish. Our primary care colleagues are desperate for our expertise as well, so it's a win-win for everybody, especially the patient. But very few programs in the country are doing this.

**Dr. Weisler:** Primary care providers write close to 80% of the antidepressant prescriptions in the country. And, as you say, more and more we're going to be seeing the sickest patients. The situation is similar with endocrinology -- I think there are roughly 3800 practicing US endocrinologists in a country with a huge diabetes epidemic. So primary care has to fill the void, and working with them will be increasingly important in order to deal with the care shortage.

**Dr. Nasrallah:** I would liken your endocrinologist analogy to the severe shortage of geriatric psychiatrists as opposed to psychiatrists as a whole. In a country that has a skyrocketing geriatric population, we barely have 2500 board-certified geriatric psychiatrists. This means generalists must be doing all of the work and only referring difficult patients to the specialists.

**Dr. Weisler:** And the same thing is happening in child and adolescent psychiatry, where we have a severe national shortage. In 2004 in North Carolina, 43 counties had no child psychiatrists and another 42 counties had fewer than 1 child psychiatrist full-time equivalent per 10,000 population aged 18 years and under.\(^4\) What is it like in Missouri, Joe?

**Dr. Parks:** Child psychiatry has a more severe shortage than general adult psychiatry. Most of us adult psychiatrists are not terribly comfortable below age 12 years and certainly when you get down to age 6 or 7 years. And actually it is one of the areas in which it's a little easier to get additional funding because child fellowships are much smaller and easier to start, and to many it's more desirable than adding slots for general psychiatrists.

**Dr. Nasrallah:** There are over 120 child psychiatry training programs in the United States; however, there are only 60 or so geriatric psychiatry programs. Child psychiatry takes care of the first 18 years of life; geriatric psychiatrists take care of the last 35 or 40 years of life, and there are far, far fewer geriatric psychiatrists than child psychiatrists. I know that both are short, and I have been advocating for years for child psychiatry. But they have grown in numbers, and I would love for them to increase more. But while there are over 10,000 child psychiatrists now, we have far fewer geriatric psychiatrists despite the much larger population that they must serve.

### More Meds, ASAP

**Dr. Nasrallah:** In addition to the shortage of practitioners, we should also address our need for more and better treatments. One of my mentees and I published a study showing that 82% of psychiatric disorders in the DSM-IV have no approved medications whatsoever.\(^6\) So we have a tremendous pharmacologic treatment shortage, and in the meantime we're destroying the pharmaceutical companies; we're alienating them; we're demonizing them. But

they are the only ones who develop drugs for us, so we have little but to partner with them for the sake of our patients.

**Dr. Weisler:** Right. Just look at psych units and nursing homes around the country -- roughly 30% of the patients will have behavior-related problems related to mental psychosis, and we have no approved treatments, zero.

**Dr. Nasrallah:** Yes, nursing homes are full of elderly dementia patients with psychiatric symptoms -- severe agitation, violence, paranoia, delusions, depression, aggression, suicide, you name it -- and yet we are not developing any specific treatments for this population.

The risks of no treatment are sometimes worse than the risks of treatment. The FDA put a boxed warning on all first- and second-generation antipsychotics because the mortality was 4.5% in the antipsychotic group compared with 2.5% in the placebo group, a ratio of 1.6. And so they didn't approve any of the 4 atypical agents (risperidone, olanzapine, quetiapine, and aripiprazole) that were compared with placebo in controlled trials. No drug company has conducted controlled clinical trials of any antipsychotic for the psychosis of dementia since 2005.

**Dr. Weisler:** If we don't provide funding to find new approaches and treatments, the costs will likely end up being greater.

### Finding the Funding

**Medscape:** How can psychiatrists and mental health providers best advocate for more mental health care funding?

**Dr. Weisler:** I know that North Carolina recently reported a $275 million Medicaid shortfall. Something similar was seen in Louisiana, and the LSU Health Science Center ended up cutting its healthcare budget by close to 39%. There's no getting around the fact that budget cuts of this size will have a big impact. We have to keep trying to demonstrate to legislators that cuts like these -- in my opinion -- just shift cost to the jails, unemployment, and disability.

In addition, I am aware in North Carolina of reports of up to 9000 or more disabled individuals being on waiting lists, in some cases for many years, for behavioral care and occupational assistance. While they are entitled to Medicaid assistance, their needs were not deemed to be essential enough to be funded. In Wake County, for example, many people have been on the waiting list since 2009. The program began nationally in 1980 as a way to decrease the need for and expense of keeping them in an institution.

**Dr. Parks:** We really need people involved in healthcare management who can think creatively with financing. For example, the way we financed our Health Home Initiative gives a 90/10 state match; 10 cents generates 90 cents federal as opposed to our usual match where 35 cents generates 65 cents. We needed about $8 million to start this program. We took some funding for the uninsured that we expected to lose permanently. We instead went to the budget office and said, "Why don't you let us use this for Health Homes, but give us enough to make the 35% match and the budget office could keep 25% for 2 years -- 2 years temporary savings." At the end of the 2 years, they then give us back the other 25%, so we can sustain the program at our normal federal match rate after the first 8 quarters of enhanced funding ends. So after the federal match of state funds for every $1 of money for treating uninsured persons we took from the community mental health system, we were able to give $3 back for care coordination and disease management for persons with serious mental illness to reduce their excess mortality that Henry documented.

This model shifted money out of the uninsured and into Medicaid. We gave up on serving uninsured, but in giving up on serving uninsured we were able to give our budget office some temporary funding cuts and put more money back into the community than we took out. It's hard to figure out a specific national plan because every state is so different.
in how it structures its finances. But because we were willing to give, we got more than we would have gotten if we had just said, "Don't take anything, don't touch it."

**Dr. Weisler:** How can you implement something like that on a national level? How can we go about creating this sort of give-and-take partnership in an organized fashion?

**Dr. Nasrallah:** I saw a positive story online recently that made my day. Massachusetts reversed a decision to close the psychiatric beds in all of their hospitals. I would like to know what happened to make them reverse their decision. What worked? Somebody must have done something right over there. Maybe we can learn from this and apply the lessons elsewhere.

**Dr. Weisler:** By the same token, I was teaching in Alabama at Bryce Hospital, which is in Tuscaloosa and was built around 1853. It was slated for closure this September, but they ended up negotiating something where the university took it over and will now have short- and long-term beds; the university is also building them a new facility. It may not be a good trade-off, but it's certainly much better than just totally shutting it.

**Dr. Nasrallah:** I'm glad to hear that! There seems to be a strong aversion to building psychiatric hospitals because of some old notions that they're restrictive asylums. But why is there no problem with prisons and jails and correction facilities? For some reason, those are acceptable as a place to send psychiatric patients even though prisons are more restrictive than the old state hospitals. This is one of the worst things that has happened to our patients. They have become criminalized and transformed into felons and put in prisons and jails when they belong in a hospital instead. I believe that around 50% of all those with schizophrenia in this country are in correctional facilities, according to a recent report by E. Fuller Torrey.[1] It shouldn't be a crime to behave erratically if it is due to a brain disease!

**Dr. Parks:** And a lot this problem is linked with drug laws. A large portion of these convictions are simple possession, and roughly 60% of our patients have comorbid drug abuse.

**Dr. Nasrallah:** Right. And don't forget that drug usage in a psychiatric patient can worsen their symptoms and make them more erratic, delusional, aggressive, and so on. So it's like a set-up for them to become criminalized. If we had them in hospitals where we could actually treat them, protect them from drug abuse and the dealers who sell them the drugs, and control their symptoms, they'd be far better off and we'd save a lot of money.

**Dr. Weisler:** Joe, are you aware of any other programs around the country that are working to coordinate care and reduce financial strain?

**Dr. Parks:** I think working with advanced practice nurses, developing prescribing nurses, is a great way to leverage resources. They're actually more thorough than us. They do have a tendency to prescribe more polypharmacy and go outside of guidelines than us, so it does take close supervision and not just a paper relationship.

Working with secondary prescribers, whether primary care providers or nurses, can be effective. I also think going to a consult model is effective. In this case, we can send a stable patient back to primary care to do the refills and maintenance, with the agreement that we are available, even after hours, for a consult, and that we're willing to take the patient back within a couple of days if they need a follow-up adjustment.

One nice thing about working in a primary care setting is that most of my refills are handled by the clinic nurses. I'm not calling all of those in. If they're routine, the nurses just take care of it, and they do a very good job of deciding what they can fill on their own discretion and what they need to pass back to me.

**Dr. Weisler:** And what about psychotherapy? I know with posttraumatic stress disorder, for example, that psychotherapy is certainly as good and in many cases superior to pharmacotherapy. Yet the number of people

---

getting psychotherapy in the country is also declining. Incorporating exercise in treatment also appears to benefit both emotional and physical health.

**Dr. Parks:** Excellent point -- we really rely way too much on pills and should be referring more patients to therapy. We have too high a unit cost to be doing much therapy ourselves, and we're too short on time, so I think it does need to fall to the professional counselors and the psychologists.

**Dr. Weisler:** And one benefit of having good partnerships with psychotherapists is that therapy dramatically improves treatment adherence and decreases relapse risk. Moreover, the combination of psychotherapy and pharmacotherapy, in my experience, is often superior to either alone.

--

### Tips for Practice

**Medscape:** What can mental health practitioners do immediately to better collaborate with their primary care colleagues and provide comprehensive psychiatric care in the setting of dwindling funding?

**Dr. Parks:** If they don't have a primary care practice that is ready for them to move in right away, they should approach one about spending, say, a half day a week to consult on a small group of patients. I would think in a large number of cases within 2-3 years they would be spending their whole day there and would have moved their practice over.

**Dr. Nasrallah:** I think that can be done at the individual level, but it will be more efficient if it's done at the institutional level -- if there are better collaborative models for residency training. And though it might not be easy to initiate at first, I think a lot of primary care groups would welcome psychiatrists and will probably accommodate them.

**Dr. Parks:** I agree that this would be far easier to do with administrative support, though I think it can be achieved by simply contacting your local primary care provider.

**Dr. Weisler:** Another thing we should touch on is the potential Medicare cuts on the horizon. As a reaction to these cuts, we are seeing many specialists being bought up by large hospital systems who don't get the same degree of budgetary cutback.

**Dr. Parks:** There is yet another Medicaid funding mechanism, called the clinic option, that's widely used by outpatient university hospitals and other large hospitals that does allow them to load some of their institutional overhead on top of their professional fees. I think we're going to see nothing but consolidation. There are going to be fewer and fewer small offices, solo practitioners, and even small agencies. We're going to see more and more large regional conglomerates. Over time, I think that getting consolidated into large hospital outpatient practices and multispecialty primary care groups will benefit psychiatrists and their patients. Separate is never equal.

**Dr. Weisler:** I think you're right. And yet at the same time, unless you have really skilled management who are both astute and caring, this could be a disaster for the mentally ill.

**Dr. Nasrallah:** As we consolidate, we need to proactively lobby to make sure that the final picture is better for our patients than it is now. But I'm very worried about what happens with consolidation. It can actually become worse.

**Dr. Parks:** We need to make it clear to administrators that we can help them as opposed to just being demanding. If we just make demands on them from our perspective, they will work hard to section us off and ignore us and act in spite of us. If we come to them and say we know you have these 3 problems but we have ways that we can use our techniques and resources to really help you, we'll end up with more influence and authority.
**Dr. Nasrallah:** Your philosophy is absolutely rational and effective. You have to work with others and make it a win-win for them and us. My main concern about that approach is that we have been cut so badly, and our need is so great that our bargaining position is very poor because we need more than we can offer them. But yes, we may have to do what you're saying to start.

**Dr. Parks:** It's hard to work off of a thin margin. It is thin going for the first 2 or 3 years building that relationship. Once they perceive you as a solution to their problems, they start letting you control and influence resources.

**Dr. Weisler:** And you have to be invited to sit at the table to be involved in the process.

**Dr. Parks:** Not necessarily. In Missouri on the public side, we started out going to public Medicaid meetings. They did not invite us. These were public meetings, and we showed up like John Q. Public and sat in the back and listened and tried to make a helpful supportive comment once in a while. After about 9 months to a year of that, they started inviting us. Now in the private sector in a closed hospital, you're right, it's harder to get in the room on the management meeting. I would recommend using motivational interviewing techniques when having discussions with your organization's managers and executives. These techniques are quite effective in most any relationship.

**Dr. Weisler:** So it seems to me that the major areas we have to work on here are: (1) adapting to provide effective mental health care given decreasing professional and financial resources; (2) better collaboration with our primary care colleagues to ultimately improve patient outcomes while decreasing costs; (3) taking a proactive role in working with administrators to devise a better collaborative model that involves psychiatry and related mental health disciplines; (4) reaching out to medical students, interns, and residents in primary care to encourage them to consider residencies and fellowships in psychiatry; and (5) encouraging nurses or physician assistants to specialize in mental health. Finally, as a field we should strongly advocate to our politicians, government, hospital administrators, and the public the clear need and societal benefits of having more mental health care and resources to first train and then provide first rate care for our citizens and troops.

**Dr. Nasrallah:** Yes. In closing, what bothers me the most since we last discussed this topic is that not much progress has taken place. In short, we need to rally the troops in order to stop the hemorrhage of resources and money and to change policies that are so adverse to our patients, and we need to come together and effectively lobby legislators. Let's all write angry letters about what's happening to the mentally ill in our country and demand nothing less than just and fair solutions!

**References**


