



HIGHLIGHTS GOVERNING COUNCIL MEETING AHA Section for Psychiatric and Substance Abuse Services May 12-13, 2008, Chicago, IL

The Governing Councils members and guests of the AHA Psychiatric and Substance Abuse Services met for their second meeting at the Sofitel in Chicago's Northwestern suburb. Members received reports on Washington Environment, a continuance of the discussion on the AHAs *Health for Life* framework, and solutions to the growing problem of effectively triaging those seeking psychiatric care via the emergency department.



Washington Update:

Members were briefed the governing council on the current political environment in Washington, DC, current advocacy issues, and the politics of health reform. They reviewed the progress on the national elections and discussed implications for health care policy and advocacy, progress on the Medicaid moratoria and creation of a Medicare package. AHA staff identified several emerging issues including hospital billing and collections, payment for treatment of immigrants, nurse visas, and labor concerns and updated members on status of parity legislation.

The discussion then proceeded to update the council on federal regulatory and policy issues, the inpatient prospective payment system (IPPS) proposed rule, the proposed changes to payment and quality measurement and reporting, Medicare Recovery Audit Contractors (RACs) regulatory issues impacting psychiatric providers and, the recently proposed cuts to Medicare psychiatric partial hospitalization programs (PHP).

Members discussed AHA's position on the budget neutrality issues, a part of the Center for Medicare and Medicaid Services' (CMS) proposed changes to the Inpatient Prospective Payment System (PPS). They concurred that it was best to leave this at the federal level, not state. During this discussion, a member from New York shared that this state is moving to develop an Inpatient Psychiatric Facility PPS for Medicaid. The Greater New York State Hospital Association (GNYSHA) is involved in the effort to create the Medicaid PPS.

A council member shared that Recovery Audit Contractor (RAC) auditors had recently requested a tour of their hospital. Others expressed concern that CMS may use the RAC program to create a new trend in reimbursement. Council members asked what impact a change in administration would make on the RAC program. AHA staff informed them that even if the Democratic Party won the White House, there was very little hope that this program would be eliminated.



Coverage for All, Paid for by All:

Members were provided a framework for several options outlining ways to obtain coverage for all. The majority of the council expressed support for an *Individual Mandate and Employer Mandate*. They believed the combination would create a balance between keeping the individual involved in their own health while maintaining the momentum of the employer's impact and interest in cost-effective health care.

During the discussion, members offered some support for *Medicare for All*. It was perceived that this option would allow employers to focus on their business and thus increase America's employers' ability to compete in the international market. Finally some simply articulated their belief that health care is a social good and should be the responsibility of the government and that employers should not be in the business of health care.

The council believed the combination of an individual and employer mandate to be most politically viable. They felt its political viability would be increased if combined with heavy subsidies, and mandated inclusion of all employers, including small businesses and the self-employed. They thought this option would combine the role of the Equal Employment Opportunity Commission, protecting small businesses, and the Internal Revenue Service, ensuring individual accountability.



Health for Life: Hospitals' Future Business Model

Marilyn Bowcutt, AHA Board Liaison, discussed the transition from developing the framework for reform to determining what the framework means for hospitals and delivery system reform. Members were asked to discuss the implications of the framework on their current business model. Moreover, given the transformation called for in the *Health for Life* framework, members were asked to detail what hospitals' future business model look like. Ms. Bowcutt also called for the council to share recommendations on steps that hospital leadership should take now to prepare for this future change.

Members stated that the size, design, and location of the hospital will significantly impact the ability of a hospital to adapt to the *Health for Life*, framework. They discussed the reality that each of those elements had significant implications for business model changes. The council thought the answer to the coverage question (what is covered and how) would be a key driver of the business model chosen. Additionally, members informed staff that most psychiatric providers find it hard to imagine a business model that's not based on managing the involuntarily committed patients and forensic patients.

Council members were asked to share their insights on what hospitals' future business model might look like, given the transformation AHA calls for in *Health for Life*. Members responded that there would be a significant need to train people to change their behavior and perception of "health care." This change and training would need to reframe health care to focus on wellness and prevention, rather than sickness. Elements for a successful transformation would include being part of a system, and existing partnerships with physicians. Members believed that business models would be very different for hospitals that limit care to end stage disease treatment versus disease management.

Council discussion then turned toward what steps hospital leaders should take to prepare for change. In general members felt that hospital leaders should consider creative ways to begin/continue the incremental steps that are part of the five pillars of AHA's *Health for Life* initiative. For example, in Montana, one hospital has negotiated with Blue Cross/Blue Shield to reimburse physicians first and hospitals second, based on the quality measures. Other members shared the effectiveness of working with state/metro hospital associations to improve health, such as working together to ban smoking in a city.

Other preparatory actions suggested included working to fully integrate physicians and hospitals through information technology; working to stabilize a hospital's workforce, which allows the leaders to then focus on improving the health of the workforce; and, of course, the continued

work to educate the hospital's board members! The council certainly stressed the importance of continuing work to integrate behavioral health into physical health.

Some members also expressed interest in AHA's past and present work with the state/metro hospital associations on this framework, particularly for those states with existing health reform efforts such as Oregon's Health Plan. The council urged staff to have AHA play a key role in helping members more toward *Health for Life* by sharing best practices that have saved hospitals money. They felt such best practices would go a long way towards helping hospitals not "freeze" when confronted with what seems, at times, such an insurmountable task. Finally, members expressed their belief that AHA needs to continue to strengthen the relationships with various business groups across the United States, because they are important and can also balance the voice of the insurers.



Psychiatric Care in Emergency Rooms: Problems & Solutions

Dr. Anil Godbole, governing council chair-elect, and chairman, Department of Psychiatry, Advocate Illinois Masonic Medical Center (AIMMC); Carroll Cradock, Ph.D., director, Behavioral Health Services, AIMMC; and Deborah Taber, R.N., M.S., administrative director,

Department of Psychiatry, Evanston Northwestern Healthcare, led a discussion on the challenges and collaborative relationships members are using to provide quality psychiatric care in emergency departments (EDs). The speakers shared that a key success factor of this initiative was the involvement of the Illinois Department of Mental Health. ILDMH sent representatives, as well as the medical directors from each of the state psychiatric facilities to the meetings.

During the discussion, members shared that the American College of Emergency Room Physicians was soon to release a report on solutions to crowded EDs. Others commented that the American Medical Association has plans to take a position on this issue, in an effort to shape the outcome. Members stressed that the growth in demand for services via the emergency department should be viewed as a public health issue. They discussed the need to involve state and local health departments in any solution to emergency department overcrowding. Further comments noted that the Joint Commission has plans to put a regulatory twist on this issue. In fact, apparently two hospitals were recently cited because psychiatric patients were waiting "too long" in the emergency department. The plan of correction requires that psychiatrists now round in the ED.

Members shared some of their own innovative practices: (1) engaging peer support facilitators (consumers of mental health services in recovery), employed by the hospital to be in the ED and help work with the patients in need of services; (2) working with the local Community Mental Health Centers and the state to find an acceptable place for psych patients to wait while a bed is found; (3) working to be more consumer friendly with terms and behaviors; and (4) experimenting with tele-psychiatry to avoid the ED in the first place.

For more information about topics covered in these highlights, or about the Governing Councils, please contact Section Director, Rebecca Chickey, 312-422-3303, or rchickey@aha.org