Funding Education, Health Care Reform and Opportunities for Psychiatry

Sarah K. Rivelli, MD FACP
FIGURE S-1 Current flow of GME funds.

NOTE: DGME = direct graduate medical education; DoD = Department of Defense; HRSA = Health Resources and Services Administration; IME = indirect medical education.
Impact of Medicare funding of GME

• Linked to volume of Hospital Medicare pts
  – Inpatient days, resident/bed ratio

• No analysis of
  • Quality of programs
  • Workforce needs

• No requirement to treat Medicare or Medicaid pts in the future

• Children’s hospitals, preventive medicine, public health systematically disadvantaged
Revenue

Direct Revenue ($29M)
- Medicare direct reimbursement (DGME) ($13M)
- External rotations (VA, DRH and Children’s) ($9M)
- Training grants and contracts ($5M)
- Gifts and endowments ($2M)

Indirect Revenue ($53M)
- Medicare indirect reimbursement (IME) ($53M)

Cost

Total Cost ($86M)
- Trainee stipends and fringe ($50M)
- Faculty and staff salaries ($20M)
  - Teaching effort ($13M)
  - Program coordination ($7M)
- Malpractice insurance ($4M)
- GME administrative office ($3M)
- Facilities ($1M)
- Internal moonlighting ($1M)
- SoM operating expense ($5M)
- G&A expenses ($3M)
How do departments fund education?

- Medicare funding -> DUH -> GME
- Clinical overhead, grants, clinical coverage contracts, philanthropy
- GME infrastructure support from DUHS to Dept
- Academic transfer (G4) to Dept
- GME innovation grants
### Figure 2
Prevalence of Behavioral Health Comorbidities among Medicaid-Only Beneficiaries with Disabilities

<table>
<thead>
<tr>
<th>Condition</th>
<th>No Mental Illness and No Drug/Alcohol</th>
<th>Mental Illness and No Drug/Alcohol</th>
<th>Drug/Alcohol and No Mental Illness</th>
<th>Mental Illness and Drug/Drug and Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>51.7%</td>
<td>31.4%</td>
<td>13.2%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>54.2%</td>
<td>32.1%</td>
<td>11.1%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>52.5%</td>
<td>26.3%</td>
<td>16.8%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>48.0%</td>
<td>30.1%</td>
<td>16.2%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Asthma and/or COPD</td>
<td>50.6%</td>
<td>23.8%</td>
<td>21.1%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Prevalence of Mental Illness and/or Drug/Alcohol Disorders Associated with Index Condition
High proportion of health care costs are used by complex patients

80% have MH/SUDs

Psychiatrists in outpatient practice are less likely to accept Insurance.

Bishop et al JAMA Psychiatry Online December 2013
Healthcare Reform
The Triple Aim

1. Improved Patient Experience
2. Reduced Cost
3. Improved Population Health
Medical Home

- Patient-centered
- Whole person approach
- Team approach
- Expand chronic condition management
  - mental health and SUD included in health care coverage initiatives
- Increase preventive care
- Coordinated, integrated care
- Quality, safety
Primary Care-Mental Health Medical Home

Care Team

- Social Work
- PCP
- APP
- Care Manager
- Med-Psych Attending

Mental Health Advisory Board

Higher Intensity

- Structured care coordination with ED/IP
- Clinic same day access for "Familiar Faces" (FF)
- Care Plans for FF patients
- In-house psychiatric consultation & med mgmt
- Co-management with community providers
- CBT/Life Skills Training
- Algorithmic Depression and Anxiety Treatment

Lower Intensity
Re-Imagining DOC Implementation Timeline

Timeline:
- **Begin Implementation**: 1/28/13
- **Implementation Team Kickoff**: 2/7/13
- **Executive Review**: 3/7/13
- **Final Recommendations Due**: 6/3/13

Events:
- **Attg Model**: 12/12/12 - 2/7/13
- **Care Mgmt**: 12/12/12 - 2/28/13
- **Post-discharge Clinic f/u**: 1/7/13 - 4/7/13
- **Resident Experience Recs**: 1/7/13 - 4/7/13
- **MH CC Model Finalized**: 4/7/13 - 5/7/13
- **Final Metrics/KPIs**: 5/7/13 - 6/7/13
## Improving Duke Psychiatry Emergency Services

### TAKING STOCK: Progress in the Duke ED Since Psychiatry Trainees Got Involved in QI Activities

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>November</td>
<td>January</td>
<td>March</td>
</tr>
<tr>
<td>Regular meetings of PTD and ED leadership</td>
<td>Ongoing discussions about optimal staffing in the ED</td>
<td>Ongoing discussions about physical space, renovations, location</td>
<td></td>
</tr>
<tr>
<td>Discussions about physical environment (cleanliness, beds, office, etc.)</td>
<td>Discussions about roles of staff in ED</td>
<td>Team-building activities, MAESTRO optimization</td>
<td></td>
</tr>
</tbody>
</table>

### Psychiatry Attending in the ED: Conceptualization through Approval through Implementation – 18 months
- Paint Colors in the PEU: Conceptualization through Approval through Planning through Planned Renovations – 18 months
- Nurses Violence Checklist: Proposal through Pilot through Nursing Uptake – 12 months
- Location of Psych Providers: From Discussion to Implementation – 9 months

### Social Work Staffing: Proposal through Approval through Pilot – 11 months

### (perpetual ongoing complaints about staffing model)

- 3/9/2015: Attending psychiatrist started in the ED during the day
- 4/20/2015: Pilot SW started in the ED to help with psych disp 6pm-midnight
- 5/11/2015: Planned renovations will start to improve environment and safety in the PEU
Key elements

• Speaking up
• Sharing ideas
• Assessment
  – Data
  – Benchmarking
  – Outcomes
• Common ground across stakeholders
• Celebrating success
Will ACA help us do the right thing?

Nora Dennis MD, MSPH
April 30, 2015
Residents are experiencing burnout due to difficulty finding patient disposition, exhaustion, and feeling that they are providing low-quality patient care. Some residents have plans not to accept public insurance. They have been assaulted in the ER and are discouraged by patient LOS.
The health care system’s capacity to deliver mental health services has been shrinking.

Chart 5: 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.

Original Investigation

Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care

Tara F. Bishop, MD, MPH; Matthew J. Press, MD, MSc; Salomeh Keyhani, MD, MPH; Harold Alan Pincus, MD

**IMPORTANCE** There have been recent calls for increased access to mental health services, but access may be limited owing to psychiatrist refusal to accept insurance.

**OBJECTIVE** To describe recent trends in acceptance of insurance by psychiatrists compared with physicians in other specialties.

**DESIGN, SETTING, AND PARTICIPANTS** We used data from a national survey of office-based physicians in the United States to calculate rates of acceptance of private noncapitated insurance, Medicare, and Medicaid by psychiatrists vs physicians in other specialties and to compare characteristics of psychiatrists who accepted insurance and those who did not.
Map C. Number of Psychiatrists per 10,000 Population

Note. The state as a whole had 1,164 psychiatrists (1.20 per 10,000 population). Psychiatrists included physicians who listed their primary area of practice as psychiatry, child psychiatry, psychosomatic medicine, addiction/chemical dependency, medicine/psychiatry, forensic psychiatry, addiction psychiatry, alcohol/drug abuse, psychiatry/geriatric, or hypnosis. Stars denote the state’s 54 nonmetropolitan counties.
ACA matters because...

1. Mental Health and Substance abuse services = Essential Health Benefit in accredited plans
2. Millions of new patients from insurance exchanges (12.3m) + Medicaid Expansion (13m)
3. Mental Health Parity and Addiction Equity Act (2008) applies to accredited plans
4. No pre-existing condition exclusions, no higher rates for pre-existing conditions
What does it mean for education?

Mental health beds make sense again
What does it mean for education?

Qualitative treatment limit parity = fewer peer-to-peer treatment reviews?
What does it mean for education?

Value-based care = new role for mental health in the larger system
What does it mean for education?

Dependent coverage up to age 26 = more opportunity for early intervention