Recommendations

Behavioral Health Challenges in the General Hospital
Practical Help for Hospital Leaders

American Hospital Association

Table of Contents

Unavoidable Realities

EVERY hospital treats patients with behavioral health disorders,[1] even when an acute care, community hospital has no organized behavioral health service or psychiatric clinical specialists.

- Patients with behavioral health disorders frequently access care through the hospital's emergency department.[2]

- As access to an appropriate continuum of behavioral health services within a community has diminished, hospital CEOs report a dramatic increase in the average length of stay for emergency department (ED) patients requiring psychiatric admission. Many hospitals report an increase in "ED boarding" of patients with behavioral health disorders. The boarding interrupts patient flow, prolongs care, delays disposition, and results in considerable inconvenience and distress for all ED patients and their families. In addition, ED problems may increase tension with community agencies, such as local police, whose resources are tied up by the delay.

- "Almost one-fourth of all stays in U.S. community hospitals for patients age 18 and older involved depressive, bipolar, schizophrenia and other mental health disorders or substance use related disorders in 2004"[3]

- Behavioral health disorders co-occur with a significant number of general medical illnesses, such as heart disease, diabetes, and cancer and can adversely impact the cost of care, the results of treatments, and the outcomes for these conditions.

- For example, one-fifth of patients hospitalized for heart attack suffer from major depression. Evidence from multiple studies documents that post-heart-attack depression triples the risk of dying from a future attack or other health condition.[4]

- During the 1990s, the proportion of mental health services delivered in the U.S. general health sector rose from 32 percent to 50 percent.[5]

- "In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from all causes and slightly more than the burden associated with all forms of cancer."[6]

- Employers, including hospitals, are more aware that behavioral health disorders are a major cause of lost employee productivity and absenteeism. Two hundred seventeen million days of work are lost annually due to productivity decline related to mental illness and substance abuse disorders, costing United States employers $17 billion each year.[7]

- Significant under-funding of public agencies historically responsible for behavioral health care is increasing general hospital utilization and shifting the costs and care for these patients to the general hospital.

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1. In this report behavioral health is used to include both mental health and substance abuse disorders. Persons with behavioral health needs may suffer from either or both.

2. Cunningham, Peter; McKenzie, Kelly and Taylor, Erin Fries. "The Struggle to Provide Community-Based Care to Low-Income People with Serious Mental Illnesses," Health Affairs 25:3 (May/June 2006), 697.

3. U.S. Agency of Healthcare Research and Quality. Care of Adults with Mental Health and Substance Abuse Disorder in U.S. Community Hospitals, 2004 at http://dev.ahrq.gov/data/hcup/factbk10/.

4. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance-Use Conditions November 2005, p. 6; Bush et al, 2005.

5. Druss, Benjamin G. "Rising Mental Health Costs: What are we getting for our Money?" Health Affairs 25:3 (May/June 2006), 616.

6. U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. 1999, p. 3.

7. National Business Group on Health, "An Employer's Guide to Behavioral Health Services," p. 3.

The Challenge

Despite these realities, behavioral health services have not been funded on a par with physical health services. As a result, some hospitals have reduced the scope of their services, and access to care has become more difficult. Other hospitals have found ways to provide their behavioral health services with a positive net margin. Their success depends upon many factors, including the payer mix, state funding for Medicaid, sufficient demand to permit efficiencies in program operation, new management practices, and a comprehensive assessment of the costs and benefits of behavioral health services.

The American Hospital Association (AHA) recognizes that:

- behavioral health disorders are a major public health issue;

- effective psychopharmacological treatments for mental health and substance abuse have advanced markedly the past three decades;

- new discoveries and research in neurobiology and genetics are transforming our understanding and treatment of behavioral health disorders;

- behavioral health treatment is increasingly successful;[8] and

- the movement from state-provided institutional care to community-based care has presented general hospitals with new challenges.

Several national reports have been written to address the many problems with behavioral health services,[9] but none focuses significantly on behavioral health services provided by general, community hospitals. Therefore, in 2005, the AHA formed a Task Force on Behavioral Health[10] to:

- develop realistic strategies to assist hospital leaders in establishing an appropriate behavioral health role for their general, acute care hospital, and

- provide real-world examples of hospitals that have successfully addressed the behavioral health care needs of their communities.

In this report, the task force provides recommendations to hospital leaders on behavioral health service strategies and examples of successful practices that can serve as models for implementing the recommendations.

In this document, a brief paragraph describing the successful practices is presented; in the accompanying publication on *Case Examples*, there is a more complete description of the initiative and contact information for a person at the institution.

Additional case examples are available on the American Hospital Association Web site at *www.aha.org*.

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8. Recently, the National Institute of Mental Health found the rate of successful treatment for depressions of 70-80 percent compared favorably with the rate for other chronic illnesses.

9. U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. 1999. p. 3. President's New Freedom Commission Report on Mental Health. Achieving the Promise—Transforming Mental Health Care in America. U.S. Department of Health and Human Services, July 2003. President's Commission on Mental Health. "Subcommittee Report on Acute Care." U.S. Department of Health and Human Services, June 2004. "Transforming Mental Health Care in American: The Federal Action Agenda: First Steps." U.S. Department of Health and Human Services, July 2005. Institute of Medicine. Improving the Quality of Health Care for Mental and Substance-Use Conditions. November 2005.

10. Task Force members are listed on p. 12.

Background

The core problems in behavioral health care can be summarized in the following 11 points:

- The movement that began in the 1960s to remove mental health patients from state institutions and return them to their community was not accompanied by adequate financial support for creating and sustaining community agencies.

- The continuation of multiple, distinct funding streams for both mental health and substance abuse care fails to recognize that almost half of the patients with a current addictive disorder also have a mental health condition and somewhere between 15 and 40 percent of persons with a mental health disorder have an addictive disorder.

- The multitude of organizations involved in the care and support of behavioral health patients is fragmented, poorly coordinated, and encompasses: the specialty health sector; general medical sector; post-acute care sector, human services sector, including public education, vocational training, and housing; voluntary support services sector; law enforcement and the courts.

- The introduction of managed care "carve outs" for persons with mental health and/or substance abuse disorders has further fragmented care between physical health and behavioral health services.

- The importance of state laws and agencies in the financing and care of behavioral health patients limits the application of a single, national approach to reform of behavioral health care.

- Unlike patients with most physical disorders, mental health and substance abuse patients still are stigmatized in our society.

- There is not parity of coverage for behavioral health and general health care. Privately-insured patients often have policies providing limitations on the number and types of services that will be covered. Medicaid programs often have low payments for practitioners and institutional providers. Many patients with behavioral health disorders are uninsured.

- The 24/7 availability of the hospital emergency department makes hospitals the "safety net" or "provider of last resort" for behavioral health care.

- Many patients with severe behavioral health disorders seek care in general hospitals that are designed for short-stay medical-surgical patients.

- Only 1,349 of 4,919 (27 percent) community general hospitals have an organized, inpatient psychiatric unit.

- There is a shortage of psychiatrists in general, and of child and adolescent psychiatrists in particular. The shortage is compounded by a maldistribution of the present population of psychiatrists and by an aging of those in practice as the number of new entrants does not equal the number of those retiring.

Additional problems could be listed, but a more lengthy recitation of problems will not improve the situation faced by patients, families, communities or hospitals. Therefore, this report emphasizes recommendations for leaders of community hospitals accompanied by examples of their implementation.

Recommendations

Recommendations and Successful Practices

The task force's recommendations are presented around six themes that address strategies hospitals can undertake within their own organization, within their community, and in advocacy. Following most recommendations is a brief case example. More thorough case examples can be found in our companion piece, "Case Examples." All behavioral health resources are available at www.aha.org. The task force encourages hospital leaders – executives, board members, and medical staff leaders – to study the recommendations and examples and implement them whenever possible.

Community Needs Assessment

Many hospitals have given inadequate attention to behavioral health services. But behavioral health disorders are present as a common primary or secondary diagnosis in the hospital's patients. The absence of a plan for addressing the needs of these patients doesn't mean that they or the issues that accompany them are not present.

The statement "all health care is local" is especially accurate for behavioral health services. It is in their community that persons with mental health and/or substance abuse disorders live out their lives. However, because of their marginal economic situation and the social stigma of their disorder, many individuals with mental illness and addictive disorders are often invisible. Their prevalence is underappreciated. Moreover, the continuum of health and community services needed to support a patient's recovery is quite broad and includes a variety of social services agencies and state-supported services. The first step in improving services is to measure the need.

Recommendation 1

Hospital leaders should ensure that assessments of the health needs and resources in their community include specific attention to behavioral illness.

Case example summaries

- Edward Hospital & Health Services, Naperville, IL, collaborated with the Naperville local United Way and the county health department to conduct a comprehensive, multimodal needs assessment for their community. The results of the assessment assisted Edward Hospital in allocating resources to meet the behavioral health needs identified.

- Partnering with the local United Way and other health care providers in a community needs assessment, Stormont-Vail Regional Health Center, Topeka, KS, identified community needs related to behavioral health services in the area and developed goals to meet these needs as part of the system's strategic planning process.

Hospital Behavioral Health Plan

Patients with mental health and substance abuse disorders are commonly seen in general hospitals. The behavioral health disorder may be a patient's primary disorder. It also may be a co-morbid condition accompanying pregnancy or a physical health disorder such as diabetes, cancer or coronary artery disease.

Whether hospitals do or do not have organized behavioral health services, they must be prepared to address issues arising from patients with mental health and substance abuse disorders, including:
- Involuntary admission,
- Informed consent,
- Refusal of treatment,
- Patient competency,
- Confidentiality of records,
- Difficult to manage or aggressive patients,
- Violent or suicidal patients,
- Hospital "duty to inform" staff regarding violent patients, and
- Restraint and seclusion of patients.

These responses are resource intensive and likely to extend length of stay. They impact the cost of care, risk management, patient satisfaction, and employee morale.

Recommendation 2

Hospital leaders should review and evaluate the organization's behavioral health plan in light of identified community needs, the behavioral health needs of their patients, and available community resources.

Case example summaries

- California Hospital Medical Center (CHMC), Los Angeles, CA, collaborated with local hospitals to conduct a community assessment. Findings from the assessment suggested a need for increased capacity to provide more culturally sensitive and competent mental health services in a timelier manner. CHMC set strategic priorities that leverage hospital and community resources to meet these needs.

- By identifying a need for services targeted at children liv-

ing in homelessness, Memorial Hospital of South Bend, IN, was able to partner with a local community organization to create the Play, Exploration & Developmental Support program, a unique program that addresses a complex range of developmental, behavioral, and social needs for very young children in homeless families.

🔶 Tanner Medical Center, Carrollton, GA, became aware of the need for more effective treatment options for juveniles with sexual behavior problems through their behavioral health needs assessment services. At the urging of local juvenile judges, they developed the Tanner Intensive Program for Behavioral Change, a partial hospitalization program with an intensive outpatient treatment component for adolescent sex offenders.

The hospital's plan should include consideration of existing community resources, the opportunities to partner with others, and an assessment of the economic viability of behavioral health services. Failure to develop the hospital's plan in the context of the full array of community resources can create discontinuities in care and lead to duplication of programs and unnecessary costs. Failure to recognize and address existing community resources also results in the hospital becoming the default source of care in its community.

In developing a hospital plan, hospital resources must be balanced with community needs. Hospitals often have assessed the economic impact of behavioral health services using a narrow, pro-forma financial statement limited only to the revenue and expenses associated with patients whose principal diagnosis is a mental health or substance abuse disorder. Some acute care hospitals using a broader financial analysis have improved their operations in order to continue providing behavioral health services. In particular, successful initiatives have included triaging the mentally ill in the ED to improve patient flow, appropriate staffing, optimal program bed size, and adoption of technological improvements such as electronic medical records and telemedicine.

The task force believes a more comprehensive assessment is needed to guide the evaluation of the organization's internal behavioral health plan. Cost reductions and savings to general patients with a physical health diagnosis are an important benefit of behavioral health services. For example, behavioral health services may reduce length of stay for obstetrical and open-heart surgery patients and increase patient compliance for diabetic patients or HIV-positive patients.

Providing behavioral health services reduces costs or risks for medical and surgical patients who otherwise would require a longer length of stay, a patient sitter, specialized patient transport, or other specialized services.

The following table presents a conceptual example for a comprehensive assessment of the financial viability of behavioral health services:

	Cost	Revenue	Cost Avoidance	Risk Avoidance
Patients with a Principal Behavioral Health Diagnosis				
Emergency Department Mental Health				
Outpatient Mental Health				
Inpatient Mental Health				
Home Health Service				
Patient Sitters				
Suicide Watch				
Other				
Patients with a Principal General Physical Health Diagnosis				
Heart patients				
Cancer patients				
Patients with depression as a secondary condition				
Patients with substance abuse as a secondary condition				
Other				
Other				
Total				

Recommendation 2a

Hospital leaders should use a comprehensive financial and operational assessment to evaluate the benefits and value of behavioral health services to all operational components of the hospital.

Case example summaries

🔶 Behavioral health leaders at Northeast Hospital Corporation, Beverly, MA, developed a "dashboard" of

key performance indicators in order to provide information to executive leadership and governing board members regarding trends in behavioral health service utilization and the value the service provides to the overall system of care.

🟧 St. Helena Hospital, St. Helena, CA, conducted a comprehensive review of their behavioral health services in order to achieve the clinical and operational levels required to become a center of excellence within the organization. Their goal was to build a firm financial base for behavioral health services while continuing to provide effective patient care.

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Community Collaboration

Many persons with behavioral health disorders need services from multiple and diverse practitioners, agencies, and organizations. In addition to health care services, these can include housing assistance, educational services, legal advice, transportation, and job placements among others. When these services are available in a coordinated and collaborative network of services, patients with behavioral health needs have alternatives to the hospital's emergency department. Where the services are a disorganized or fragmented patchwork, the hospital's emergency department often becomes the default point of access. It is in the hospital's own self-interest to help provide the leadership and initiative to develop a community-wide plan of services and for staff to be aware of behavioral resources in the community.

Recommendation 3

Hospital leaders should encourage and actively participate in (1) developing a community-wide and/or regional plan for persons with behavioral health disorders and (2) coordinating community agencies addressing behavioral health needs.

Case example summaries

🟧 To achieve its vision of a seamless system of behavioral health care for the residents of southeastern New Jersey, AtlantiCare, Egg Harbor Township, NJ, integrated the capabilities, facilities, information systems, and resources of two health care organizations. The merger has expanded outreach capability for psychiatric emergency services throughout the region.

🟧 Central Peninsula Hospital, Soldotna, AK, led the creation of a 10-agency coalition that provides prevention and early intervention services in communities in the Central Kenai Peninsula. Goals are to reduce the adverse effects of substance abuse, especially during the prenatal period; reduce suicide and parasuicidal

behaviors; and increase community protective factors among residents.

🟧 Trends in substance abuse-related hospitalizations and deaths in the Charlestown area of Boston prompted the Massachusetts General Hospital to create a coalition of community leaders who work together to reduce substance abuse in the community by utilizing existing community resources and organizing programs to meet identified needs.

In most communities, the general hospital should not become, by default, the provider of last resort for persons with behavioral health disorders. The strengths of the community hospital are to provide access to emergency interventions, outpatient care, inpatient services in a community-based sanctuary, and referral to the network of appropriate community practitioners, agencies, and organizations. The short-stay hospital is only one component of the care that many behavioral health patients need. The general hospital has an acute care or short-stay orientation and is not structured for long-stay admissions. Therefore, it is important to collaborate with all community components and agencies.

Moreover, the general hospital – by impression if not design – is associated in the minds of behavioral health patients and their advocates as a confining rather than enabling setting. For many patients, however, the services provided by the general hospital within the community are a beneficial alternative to treatment in a geographically-removed or isolated setting.

Recommendation 3a

Hospital leaders should work with community agencies and support services and with state and local governmental authorities to ensure that all patients are treated in the most appropriate setting so that the hospital's backstop role is appropriately limited.

Case example summaries

🟧 Carondelet Health Network at St. Mary's Hospital, Tucson, AZ, collaborated with the local regional behavioral health authority to create an extended care unit for high-risk patients. The interdisciplinary, inter-agency program helps to achieve the best possible clinical outcomes for the seriously mentally ill and reduce the downstream costs associated with emergency department visits, hospital stays, and crisis management.

🟧 By implementing a psychiatric emergency department, the University of New Mexico Hospitals, Albuquerque, NM, ensured that patients in urgent need of behavioral health services received them in the most appropriate setting. The psychiatric ED also eases the pressure of

overcrowding in the main ED and helps the whole system to function more responsively.

🟨 Through the Coalition for Crisis Intervention at the Utah Valley Regional Medical Center, Provo, UT, the hospital, local health and social service agencies, law enforcement, and other providers collaborated to ensure that behavioral health patients in the ED receive the appropriate level of care in the most appropriate setting.

The task force recognizes that a specific hospital's behavioral health role will vary with the size of institution, location, scope of hospital and physician services, and community and other state resources. Whatever services the hospital develops; they should be integrated with other resources in the community.

There are a wide range of opportunities that a general hospital may offer to compliment the community's network of coordinated, collaborative services. General hospitals may provide some or all of these behavioral health services, directly or under arrangement.

- Early intervention programs in schools
- Mobile crisis care/hotlines
- Peer support services (similar to Alcoholics Anonymous)
- Home mental health care
- Telepsychiatry
- Consultation and liaison
- Case management, assertive community treatment
- Outpatient care
- Adult day care
- Crisis stabilization centers
- Partial hospitalization
- Inpatient psychiatric or substance abuse unit
- Residential treatment programs (e.g., group homes, assisted living, licensed nursing homes)

Regardless of the means used to provide the services, the hospital should provide the training necessary for all staff to be comfortable meeting the needs of patients with behavioral health disorders. A special effort should be made to provide training programs that enable medical staff, nurses, other caregivers, and support staff to recognize and work effectively with patients having a behavioral health disorder secondary to another cause of admission.

Recommendation 3b

Hospital leaders should create a formal plan that clearly defines its role and its established relationships for behavioral health with other providers, practitioners, and governmental and community agencies.

Case example summaries

🟨 Prior to their affiliation, Baptist Hospital, Pensacola, FL, a general acute care hospital, and Lakeview Center, a community behavioral health center, had overlapping service areas and service lines. Realignment of services not only created more effective organizational relationships but also allowed public and private funding sources to be managed in a complementary manner.

🟨 Cincinnati Children's Hospital Medical Center, Cincinnati, OH, created the Attention Deficit Hyperactivity Disorder (ADHD) Collaborative to increase local physicians' involvement in diagnosing and treating straightforward presentations of ADHD. This arrangement improves patients' access to care and emphasizes the hospital's role as a referral point for more complex ADHD cases.

🟨 Behavioral health leaders at John Muir Health, Concord, CA, collaborated with acute care hospitals in the system to develop psychiatric assessment and liaison services. These services leverage behavioral health expertise in a collaborative effort to improve operating efficiencies and enhance patient care throughout the system.

In urban areas, but especially in rural regions, no single general hospital may be able to provide the short-stay inpatient services needed by behavioral health patients. General hospitals may need to collaborate to ensure that at least one hospital in the community or region has inpatient behavioral health capability. This level of collaboration may be hampered by anti-trust concerns.

Recommendation 3c

Where inpatient acute beds for behavioral health patients are not available in a region, hospital leaders should seek governmental assistance that would allow hospitals to collaborate across multiple institutions in order to develop needed regional inpatient behavioral health services.

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Adequate Financing

Behavioral health services have been the poor stepchild of contemporary American medical care.

• Historically, behavioral health services have been under-funded. Many public and private organizations providing care have been financially starved and had to limit their capabilities

• Many behavioral health patients have been uninsured, underinsured, and their care reimbursed less than cost.

• Others have had health insurance that excluded or restricted behavioral health benefits.

• Inadequate funding has contributed significantly to the shortage of professional staff with specialized training in the care and treatment of patients with behavioral health disorders.

• The ability of hospitals to cross-subsidize care is declining and opposed by increased numbers of private and public payers.

To maintain access, payment for behavioral health services is going to have to cover costs or the services will be less available.

When a community lacks adequate behavioral health services, the community bears other costs that it may not attribute to the shortage of these services. For example, truancy and crime may increase and add costs for law enforcement and the courts. Untreated behavioral health disorders may increase absenteeism, reduce labor productivity, and increase disability.[11]

Recommendation 4

Hospital leaders should clearly communicate to public and private payers the costs required to care for behavioral health patients, especially those with chronic and severe conditions, and the costs to society of not treating those patients.

Case example summaries

▪ The Child FIRST program at Bridgeport Hospital, Bridgeport, CT, provides early-intervention behavioral health services for vulnerable, underserved children. Program leaders have developed varied funding streams by emphasizing the fact that these services prevent conditions that require more costly and generally less effective services later on in these children's lives.

▪ To meet the addiction treatment needs of its region, Mercy Medical Center, Williston, ND, helped create a coalition to represent those needs to legislators and payers. The coalition spurred passage of legislation to cover residential services, which allowed Mercy to provide day treatment services to a population dispersed across a large service area.

▪ Hospital leaders at Ohio State University Medical Center, Columbus, OH, have actively communicated with both internal and external stakeholders the clinical and economic benefits of developing better-coordinated systems of care for behavioral health needs and the costs to the community of not developing effective systems of care.

Most hospital revenues "follow the patient." The hospital bills the patient's public or private coverage and is paid primarily by that third party. Some mental health and substance abuse patients have coverage, and their care is paid in a similar manner for some services. However, many services are not covered by insurance and many behavioral health patients lack insurance. Funding for these services and patients, to the extent it is available, is primarily programmatic. It is not tied to individual patients but to offering a specific service or activity.

Recommendation 4a

To supplement public and private insurance for behavioral health services, hospital leaders should seek additional and specialized funding from foundations, employers, community philanthropies, grants, and governmental appropriations.

Patients with chronic, severe behavioral health disorders often need long-term services beyond the coverage available from public and private payers. For these persons, state agencies become the likely provider. Unfortunately, many state agencies have inadequate resources for their assigned missions and/or lack the financial flexibility to re-allocate resources. When this happens, patients remain in local communities and often seek services general hospitals are not prepared to provide.

Recommendation 4b

Hospital leaders and their associations should become advocates for the public mental health system and its adequate funding.

Case example summaries

▪ Children's Hospital Boston, MA, collaborated with four other organizations to launch a long-term campaign calling for major reform of the state's mental health care system for children. They are not only seeking legislative remedies, but also are working with state administrative offices and private payers to reach their goal of a more effective children's mental health system.

▪ Leaders and staff at Moses Cone Health System, Greensboro, NC, are strongly encouraged to become active in advocating for their areas of responsibility. Health system leadership have actively addressed the needs of behavioral health care at local and regional levels and have cultivated relationships with elected officials, opinion leaders, and policymakers, as well as local and national grassroots organizations.

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11. A recent California study found that on average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings. Health Services Research 41:1 (February 2006), p. 192.

Employer Practices

Hospitals are large employers in their communities. Their personnel practices can help set the standard for other employers. Within the past year, the National Business Group on Health has published a comprehensive set of recommendations for employers on behavioral health services, including recommendations to improve the design, delivery, and purchase of employer-sponsored behavioral health services.

Recommendation 5

Hospital leaders should incorporate, as feasible and appropriate, the employer practices recommended by the National Business Group on Health in "An Employer's Guide to Behavioral Health Services" and share the recommendations with other employers in their community.

Excepts from "An Employer's Guide to Behavioral Health Services:"

Recommendations to Improve Benefit Design for Behavioral Health Screening and Treatment Services
a. Equalizing Benefits Structures — Equalize medical and behavioral health benefit structures.
b. Reimbursement for Non-Psychiatrist Physicians — Reimburse primary care and other non-psychiatrist physicians for screening, assessing, and diagnosing mental illness and substance abuse disorders. [Rules and policies regarding the payment of non-psychiatrist physicians (e.g., primary care physicians) for the treatment of mental illness and substance abuse disorders should be well publicized to primary care physicians, other non-mental health providers, and their clinical/business administrators.]

Recommendations to Improve Behavioral Healthcare Services for Individuals with Serious Mental Illness
a. Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI) — Provide coverage for evidence-based treatment modalities for seriously mentally ill children and adults. Such evidence-based modalities include:
• Targeted clinical case management services;
• Assertive community treatment (ACT) programs;
• Therapeutic nursery services; and
• Therapeutic group home services.
b. Providers of Evidence-Based Treatment Modalities for the Seriously Mentally Ill (SMI) — Direct managed care organizations (MCOs) and managed behavioral healthcare organizations (MBHOs) to add providers that can deliver the evidence-based treatment modalities described in 5a to their networks.
c. Annual Review of Behavioral Health Treatment Modalities — Direct MCOs and/or MBHOs to annually review behavioral health treatment modalities and make recommendations about whether new treatment modalities should be added to employers' benefit structures.

Recommendations to Improve the Structure of Employee Assistance Programs (EAPs)
a. Reduce redundancies between EAPs and health plans by re-structuring EAPs. EAPs should not duplicate services offered through the health plan (MCOs and MBHOs), but should be re-structured, if necessary, to provide the following functions:
• Support management in addressing issues of productivity and absenteeism that may be caused by psychosocial problems.
• Assist in the design and development of a structured program to deliver health promotion and healthcare education tools that significantly affect employee and beneficiary health and productivity and lead the effort to deliver behavioral healthcare education programs.
• Functionally coordinate with other health services including health plan, disability management, and health promotion.
b. Based on an analysis of current EAP services, the NCESBHS found that an important function that EAPs provide is assessment and short-term counseling for individuals at risk of mental illness and substance abuse disorders and those with problems of daily living (e.g., divorce counseling, grief processes). In the restructuring of EAP, as recommended in 7a, it is essential that these services be retained and provided by an EAP or other entity.
c. Conduct periodic organizational assessments to evaluate the effects of work organization on employee health status, productivity, and job satisfaction.

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Advocacy

Hospitals have encouraged their associations to (1) fight the stigma attached to behavioral illnesses; (2) seek parity for behavioral health insurance coverage, and (3) support adequate payment for behavioral health services. These advocacy roles are essential, but inadequate, given the growing problems member hospitals face in planning, organizing, financing, and evaluating behavioral health services. Member hospitals are concerned that the behavioral health system is slowly collapsing but without the dramatic, widespread crash necessary to attract appropriate attention.

Recommendations

Recommendation 6

Hospital leaders should encourage and be actively involved with their regional, state, and national associations to broaden their engagement and advocacy for behavioral health, including:

• Promoting recognition that behavioral health is an essential component of positive health status;

• Continuing to advocate for parity in behavioral health coverage;

• Broadening the behavioral health advocacy agenda beyond payment;

• Supporting initiatives to increase the supply of behavioral health clinicians, including psychiatrists, psychologists, advanced practice nurses, and social workers;

• Encouraging primary care practitioners to identify and treat the behavioral health needs of their patients;

• Obtaining adequate payment rates for Medicaid and Medicare patients with behavioral health disorders;

• Assuring behavioral health is included in chronic care demonstration projects supported by Medicare and other payers;

• Supporting the financial needs of the public mental health system and increased public accountability for its performance;

• Monitoring major behavioral health initiatives (e.g., New Mexico's pooling of public funds) and sharing lessons learned with the membership, and

• Forming behavioral health partnerships and joint initiatives at the state and national level that mirror those needed in local communities.

Conclusion

Numerous studies have catalogued the substantial problems facing behavioral health patients and the practitioners, health providers, and agencies that care for them. As the 24/7 access point for health services in their communities, the general hospital is both the front door to services and too often the backstop to other agencies and organizations.

Trustees, executives, and medical staff leaders in general hospitals increasingly perceive a decline in the capabilities of the behavioral health "system." Behavioral health care is collapsing albeit slowly and demands immediate and sustained action to improve services and financing.

The AHA Task Force on Behavioral Health of believes there have been credible reports on the many challenges facing persons who need access to a continuum of behavioral health services, but an absence of broad recommendations to reverse the decline of behavioral health services in general community hospitals.

Therefore, the task force offers a series of practical recommendations with examples of their implementation that leaders in general hospitals can use to improve care for persons with behavioral health disorders – both mental illness and substance abuse. The recommendations address strategies for:

- Community needs assessment,

- The hospital's behavioral health plan,

- Community collaboration,

- Adequate financing,

- Employer practices, and

- Advocacy.

Together they identify actions hospital leaders can take in their own organization and in their communities to improve services for persons with behavioral health disorders.

Behavioral Health Task Force

Chair

Thomas Kennedy III
Southington, CT

Members

James Ahrens
President
MHA…An Association of Montana
Health Care Providers
Helena, MT

Gary Bembry
President, Lakeview Center
Senior Vice President
Baptist Health Care
Pensacola, FL

Carlos Carreon, LICSM
Regional Director, Behavior Health
PeaceHealth, Lower Columbia Region
Longview, WA

Michael Ebert, MD
Chief of Staff, VA Connecticut
Healthcare System and
Associate Dean for VA Affairs and
Professor of Psychiatry, Yale University
School of Medicine
West Haven, CT

Jack (John) Evans
President and CEO
Central Washington Hospital
Wenatchee, WA

Kester Freeman
Chief Executive Officer
Palmetto Health
Easley, SC

Phillip Gilmore
President and CEO
HSC Medical Center
Malvern, AR

Anil Godbole, MD
Chairman, Department of Psychiatry
Advocate Illinois Masonic Medical Center
Chicago, IL

Joel Hart
Chief Executive Officer
INTEGRIS Baptist Regional Health
System
Miami, OK

Thomasine Kennedy
Trustee
Duplin General Hospital
Kenansville, NC

Bruce Schwartz, MD
Executive Vice Chairman for Clinical
Affairs
Department of Psychiatry and Behavioral
Science
Montefiore Medical Center
Bronx, NY

Don Sipes
Chief Executive Officer
Saint Luke's Northland Hospital
Smithville, MO

Marc Smith
President
Missouri Hospital Association
Jefferson City, MO

Elizabeth Stallings, RN
Chief Operating Officer
John Muir/Mt Diablo Health System
Concord, CA

S.R. Thorward, MD
Psychiatrist
Twin Valley Psychiatric Systems
Columbus Campus
Trustee
Ohio State University Harding Hospital
Columbus, OH

Kenneth Tuttle, PhD
Psychology Department
Utah Valley Regional Medical Center
Provo, UT

Federal Liaison

Charlotte Yeh, MD
Regional Administrator
Centers for Medicare & Medicaid
Services
Boston, MA

Staff

James Bentley
Senior Vice President, Strategic Policy
Planning

Eileen O'Keefe
Vice President, Constituency Sections
and Member Involvement

Rebecca Chickey
Director for Psychiatric and Substance
Abuse Services

David Allen
Associate Director, Media Relations

Jeanette Harlow
Director, AHA Resource Center

Brian Simmons
Graphic Designer

Judy Weinsheimer
Senior Associate Director, Advocacy
and Member Communications

Delores Wade
Project Manager

Recommendations Summary

Community Needs Assessment

Recommendation 1

Hospital leaders should ensure that assessments of the health needs and resources in their community include specific attention to behavioral illness.

Hospital Behavioral Health Plan

Recommendation 2

Hospital leaders should review and evaluate the organization's behavioral health plan in light of identified community needs, the behavioral health needs of their patients, and available community resources.

Recommendation 2a

Hospital leaders should use a comprehensive financial and operational assessment to evaluate the benefits and economic value of behavioral health services to all operational components of the hospital.

Community Collaboration

Recommendation 3

Hospital leaders should encourage and actively participate in (1) developing a community-wide and/or regional plan for persons with behavioral health disorders and (2) coordinating community agencies addressing behavioral health needs.

Recommendation 3a

Hospital leaders should work with community agencies and support services and with state and local governmental authorities to ensure that all patients are treated in the most appropriate setting so that the hospital's backstop role is appropriately limited.

Recommendation 3b

Hospital leaders should create a formal plan that clearly defines its role and its established relationships for behavioral health with other providers, practitioners, and governmental and community agencies.

Recommendation 3c

Where inpatient acute beds for behavioral health patients are not available in a region, hospital leaders should seek governmental assistance that would allow hospitals to collaborate across multiple institutions in order to develop needed regional inpatient behavioral health services.

Adequate Financing

Recommendation 4

Hospital leaders should clearly communicate to public and private payers the costs required to care for behavioral health patients, especially those with chronic and severe conditions, and the costs to society of not treating those patients.

Recommendation 4a

To supplement public and private insurance for behavioral health services, hospital leaders should seek additional and specialized funding from foundations, employers, community philanthropies, grants, and governmental appropriations.

Recommendation 4b

Hospital leaders and their associations should become advocates for the public mental health system and its adequate funding.

Employer Practices

Recommendation 5

Hospital leaders should incorporate, as feasible and appropriate, the employer practices recommended by the National Business Group on Health in "An Employer's Guide to Behavioral Health Services" and share the recommendations with other employers in their community.

Advocacy

Recommendation 6

Hospital leaders should encourage and be actively involved with their regional, state, and national associations to broaden their engagement and advocacy for behavioral health, including:

- Promoting recognition that behavioral health is an essential component of positive health status;
- Continuing to advocate for parity in behavioral health coverage;
- Broadening the behavioral health advocacy agenda beyond payment;
- Supporting initiatives to increase the supply of behavioral health clinicians, including psychiatrists, psychologists, advanced practice nurses, and social workers;
- Encouraging primary care practitioners to identify and treat the behavioral health needs of their patients;
- Obtaining adequate payment rates for Medicaid and Medicare patients with behavioral health disorders;
- Assuring behavioral health is included in chronic care demonstration projects supported by Medicare and other payers;
- Supporting the financial needs of the public mental health system and increased public accountability for its performance;
- Monitoring major behavioral health initiatives (e.g., New Mexico's pooling of public funds) and sharing lessons learned with the membership, and
- Forming behavioral health partnerships and joint initiatives at the state and national level that mirror those needed in local communities.