NDMA Est.1887 NORTH DAKOTA MEDICAL ASSOCIATION

NORTH DAKOTA PSYCHIATRIC SOCIETY
A District Branch of the American Psychiatric Association

Interim Human Services Committee
November 7, 2019

Madam Chairwoman, esteemed members of the committee,

I am Gabriela Balf, MD, MPH and I am testifying on behalf of the North Dakota Medical Association and the North Dakota Psychiatric Society. I am the ND Psychiatric Society President and APA State Representative. I am a practicing psychiatrist and Associate Director – UND School of Medicine – Psychiatry Dept.

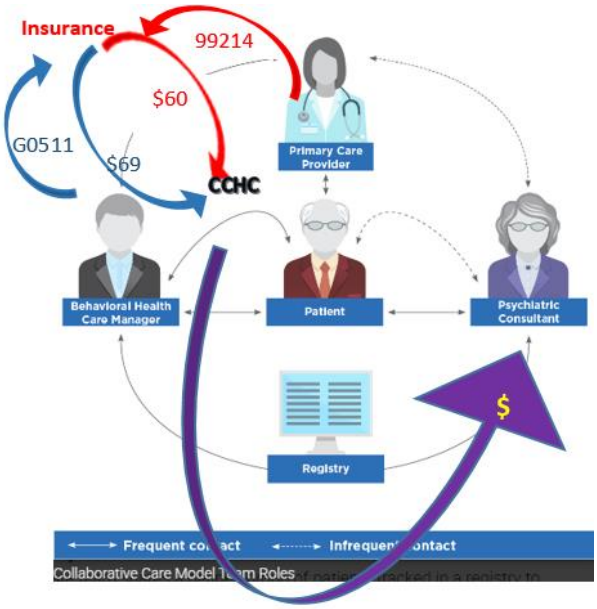
We are writing to **salute the DHS efforts** to review the state's behavioral health system, in both the state and in the private sector. The HSRI report follows a rigorous procedure where legislators are scientifically finding out what are the issues that clinicians face in their daily practice.

We discussed the report at our Annual NDPS Meeting last week, in the presence of our national APA President-Elect Dr. Jeffrey Geller. The following is the result of our collective experience with what we think are excellent strategies in the HSRI report and are worth highlighting as requiring some detail information, to further target the problem and its solution in the most effective way.

Recommendation 4 – Expand outpatient and community-based service array
4.1 Ensure access to needed coordination services and 4.4 support and coordinate efforts to enhance the availability of outpatient services in primary care.

Over three decades into testing[1]and years into monitoring its results, **The Collaborative Care Model** is one answer to this question that has the most substantial evidence [2]to date for its effectiveness and cost-savings[3]. What is this about?
If we perpetuate the current "working hard" model, where each patient is individually seen by a psychiatrist, regularly and forever, we need 500 full-time psychiatrists for ND instead of 80 (see Attachment A). Or each psychiatrist should see about 3,400 patients in Western ND, instead of the roughly 300.

Making the best use of all clinicians' time and expertise, "working smart" model, while monitoring the results, for a FQHC like Coal Country Health Center in Beulah, ND, that serves 14,694 Patients, you only need one psychiatrist. They currently have none.



Scenario: the doctor PCP sees the patients and talks with the Behavioral Health Manager BHM about their BH needs.
PCP bills the patient's insurance an evaluation and management code CPT 99214 (25 min visit).
During the weekly/biweekly, etc. meetings, PCP, BHM and Consultant Psychiatrist talk about patients and make plans for the PCP to recommend to patients. BHM bills the insurance of each patient discussed: code G0511. They can only bill for this type of consultation once a month. The insurance pays the institution: Coal Country Health Center CCHC.
CCHC pays the Consultant Psychiatrist a fixed fee. It also pays PCP and BHM.

There have been implementations of this model in 22 states so far. How many implementations of this model we have in ND as of today?

Zero.

Let me tell you the story of a short fall. After dozens of hours of discussions and visits, Coal Country and Dr. Balf reached a working agreement and were very excited to start working together. This was 8 months ago. We still have not figured out how to make this agreement viable, due to difficulties related to reimbursement: to this day, only Medicare reimburses the codes above. The sickest patients have Medicaid or Medicaid expansion and therefore do not qualify for this model. The working patients who are struggling but cannot take off work to come to Bismarck 2 hours one way to be seen have private insurance, usually, and, same, do not qualify for this program. BCBS will cover the program starting Jan 1 2020.

Another service sorely needed in the community is intensive outpatient behavioral health, or Partial Hospitalization Programs. This type of program serve the needs for

Recommendation 3. Ensure all North Dakotans have timely access to behavioral health services, especially 3.3 Ensure a continuum of timely and accessible crisis response services.

Dr. Huber, the NDPS President-Elect and psychiatrist at Sanford Behavioral Health noted that the biggest problem they see is safely managing the behavioral health patients in emergency departments. Across the nation, Dr. Geller said that the issue of “boarding” patients in EDs has already spurred various solutions.

On the other hand, in ND, it seems that we patch this issue by passing the headaches to another system. For instance, an intoxicated person from Dickinson ED who muttered last night that he is suicidal will be brought via police car and admitted on a Bismarck inpatient psychiatric unit; he will wake up in the morning sober and will wonder why he is admitted and how can he get back to Dickinson. He has occupied a bed, triggered a host of useless efforts from the admitting doctors and nurses. Meanwhile, the psychotic patient from Williston who has not taken his meds in months and is loud and disorganized and came at midnight will be shipped to Fargo where a bed is available. The beds in Bismarck are already filled by my intoxicated patient above and several patients from South Dakota. These beds stay full unnecessarily due to unavailability of lesser levels of care in the community.

Had these patients been managed in EDs with less pressure from various agencies to "get a disposition" in 4 hours, a local solution could be accessed, and we would avoid overburdening the system. In Bismarck, we have the most efficient system ever: 4 hours max of ED "boarding," whereas throughout the nation the boarding can last for days and even weeks.

One frequently used solution is **Partial Hospitalization Program (PHP), aka Day Program**, a step below inpatient stay in terms of acuity. It is a mental health treatment at a level of care that is comprehensive, intensive, short-term, and less expensive than inpatient[4]. This type of program dates back to the 1970s when we noticed that inpatient psychiatric care is expensive, whereas partial programs remove both the residential component and the staffing associated with a continuous care model. Our patients are generally experiencing acute psychiatric symptoms that are difficult to manage but that do not require 24-hour care. They are attending structured programming throughout the day, five days a week and return home in the evenings. Benefits for the healthcare system aside, there are many advantages for patients to participating in a partial hospitalization program, including group therapy which allows them to interact with others who are experiencing

similar problems. They also interact with our psychiatrist, social worker, nurse, and occupational therapist. The goal of partial hospitalization is to closely monitor for safety, stabilize using the same swift medication management that would occur in a hospital, and develop skills that assist them to better manage their symptoms and all other areas of their life. Of note, the programs used in the inpatient hospital setting are notoriously less helpful, due to the ultra-short length of stay, and the very nature of the inpatient stay goal to "just keep people safe" i.e. warehouse patients. In contrast, data up to 12 month follow up shows that PHPs significantly improve social functioning (work, family life, etc.)[4]

Our experience with the Chambers and Blohm Bismarck PHP illustrates how the laws, as they are now, **perpetuate the centralization of behavioral health care** instead of delegating it to the community. Patients in crisis are admitted inpatient or have to wait 4 weeks to be admitted in the only other available PHP, while C&B PHP is dying because of low numbers of "covered" patients. C&B cannot serve the average of 4 patients/week who are referred because they have Medicare or Medicaid insurance, which do not allow PHP reimbursement if there is no affiliation to a hospital.

> Let me tell you about AM, an 18-year-old whom I monitored every day for a week until he got a spot into the CHI PHP. He has ND Medicaid and was not suicidal all the time to qualify for an inpatient level of care, yet was ill enough to concern his parents and his clinicians gravely. I currently check every day on MB, a 24-year-old with postpartum psychosis. She has ND Medicaid and has been waiting for a slot in CHI PHP for the last 2 weeks. All the while, our C&B PHP program is dying out.

Regarding the CMS requirement that only hospitals can have PHPs, how much suffering and unnecessary efforts have to happen to change a rule that does not fit our state? **An arbitrary rule that does not exist anywhere in the literature**?![5]

The answer our PHP received:

"We had some internal discussion regarding your request and we are supportive of your program however, have come to the conclusion that because of the Federal involvement it would require an amendment to the state plan and a fiscal analysis to assess the financial impact on our expenditures…therefore we are looking at the next legislature session that starts in January 2021."

The two lessons we learned:

1. Currently, we discourage local entrepreneurs from creating a needed service for their community. On the other hand, large institutions headquartered in other states can come and implement services that may or may not fit our community.
2. Currently, it is a long wait to find out the needed information to create a needed service, from the very insurances which cover the needing patients. It took more than 12 months to learn that this service will not be covered anyway. And one has to wait even longer for changes in the laws since they can only take place during the legislative session.

In sum, the final HSRI report brings excellent and timely points to the table, and we the **clinicians are eager to assist** with implementing the recommended changes today.

Thank you for the opportunity to testify today. I would be happy to answer any questions.

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Assoc Clin Prof UND School of Medicine

References:

1. Katon, W., et al., *Collaborative management to achieve treatment guidelines. Impact on depression in primary care.* Jama, 1995. **273**(13): p. 1026-31.
2. Hoeft, T.J., et al., *Costs of implementing and sustaining enhanced collaborative care programs involving community partners.* Implement Sci, 2019. **14**(1): p. 37.
3. Raney, L.E. and b. American Psychiatric Association issuing, *Integrated care : working at the interface of primary care and behavioral health*. 2015, Arlington, VA : American Psychiatric Publishing.
4. Marshall, M., et al., *Day hospital versus admission for acute psychiatric disorders.* Cochrane Database Syst Rev, 2011(12): p. Cd004026.
5. Lloyd-Evans, B. and S. Johnson, *Community alternatives to inpatient admissions in psychiatry.* World Psychiatry, 2019. **18**(1): p. 31-32.

Attachment A:

One in five Americans will experience a psychiatric illness each year. https://www.nyaprs.org/e-news-bulletins/2015/samhsa-releases-5-point-plan-to-improve-the-nation-s-mental-health

ND has 750,000 people – therefore 150,000 will experience an illness/yr –

There are 80 psychiatrists in ND – therefore, should all these patients be seen just once, we would have each a practice of 1,875 patients –

ratio psychiatrist: patients = 1:1,875

Reality:

- Only 22 psychiatrists in Western ND – therefore ratio 1:3,400
- Actually not everyone is working full time

If no new patients,

200 working days x 16 patients = 3,200 visits

If seen monthly – 300 patients , therefore to properly see 150,000 we need 500 psychiatrists.