Academic Psychiatry and Health Care Reform: Strategic Initiatives for Sustaining the Clinical Mission

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Health care reform has posed special challenges for departments of psychiatry in academic medical centers. This report describes one department's strategic responses to a marketplace with high penetration by managed care and provides examples of the kinds of faculty concerns that can arise when major departmental reorganizations are attempted. The department's successful adaptation to a radically altered professional environment is attributed to the following five initiatives: vertical integration and diversification of clinical programs, service line management, outcomes measurement, regional network development, and institutional managed care partnerships Although the authors did not design their adaptive efforts as a research study, they offer objective data to support their conclusion that the viability of their overall clinical enterprise has been sustained despite an external environment inhospitable to academic psychiatry. (*Psychiatric Services* 54:236–239, 2003)

Numerous publications have documented the threat posed to academic medical centers by health care reform (1–3). The emergence of managed care posed special risks to funding of clinical services in academic psychiatry (4–6), particularly when carve-outs administered by managed behavioral health organizations (MBHOs) excluded such programs from their care delivery and reimbursement systems. Although some psychiatric programs in academic medical centers can negotiate facility fees with MBHOs, this option does not exist in Maryland, where a health services cost review commission regulates hospital reimbursement rates.

Both private- and public-sector managed care in Maryland has expanded dramatically during the past decade. In 1997, the state's medical assistance program for indigent persons was placed under managed care. Known as HealthChoice, this program reimburses specialty mental health care through a fee-for-service carve-out managed by a commercial MBHO. Other medical care, including substance abuse treatment, is funded through a capitation system in which each medical assistance enrollee is required to register in an HMO-like managed care organization (7).

Developing new institutional strategies

In the early 1990s, anticipating these reforms, Johns Hopkins Medical Institutions (JHMI) adopted a proactive program emphasizing several approaches: creating strategic partnerships and contracting agreements, maintaining a specialty-based orientation, organizing an integrated network of community-based physicians and hospitals, and generating new information about clinical outcomes and practice guidelines that could be applied to future care. The integrated network of physicians and hospitals was organized with particular attention to primary care but was safeguarded against financial risk or dilution of JHMI autonomy.

JHMI also established a new organization, Johns Hopkins HealthCare LLC. Its mission is to contract with existing insurance carriers and third-party payers, to administer the health plan benefits of self-insured employers, to build provider networks, and to partner with community programs to function as a managed care organization and provide medical care for the medical assistance population in the Health-

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Choice program (8). In establishing this partnership, JHMI was able to counter the threat posed to institution-patient relationships and to JHMI's tripartite mission: research, teaching, and clinical care.

Psychiatry strategies

Aligning with its parent institution's goals, the department of psychiatry and behavioral sciences (referred to in this article as "the department") determined that it also should pursue strategies for sustaining clinical volumes and ensuring the financial viability of its 103-bed inpatient service, which includes multiple specialty programs. The management contract with Johns Hopkins Hospital provided incentives for meeting key performance objectives, which included accelerating inpatient discharges, decreasing inpatient length of stay, and increasing day hospital visits. It was determined that accomplishing these three departmental objectives would secure higher reimbursement and at the same time reduce unit costs. The objectives were pursued by establishing innovative subacute and short-stay programs, decentralized clinical management, outcomes measurement, and expansion into managed care.

The department recognized that it did not possess the in-house organizational expertise needed for this substantial undertaking. Therefore, an office of behavioral health care was formed, and a director—a former research faculty member who also had a business background and hospital reorganization experience—was recruited from the private sector. The department's organizational structure was refined to improve efficiency and match faculty and staff expertise to departmental needs. An executive committee was formed that included the department chair and director, the clinical director, the administrator, the research director, and the director of the office of behavioral health care.

With faculty input and assistance from hospital and medical school administrators, five key initiatives were launched, which are described below.

Vertical integration and diversification of clinical programs

External demand for cost-effective alternatives to traditional inpatient services dictated that the department develop new partial hospital programs linked to specific inpatient units. One innovative partial hospital program is a dual-department collaboration: The First Step Day Hospital treats patients with substance abuse disorders and serious comorbid medical conditions. The program permits patients requiring intense medical care, such as antibiotics administered by an indwelling catheter, to be discharged from the general medical inpatient units and continue their medical and substance abuse treatment in a specifically structured setting. An arrangement with a community-based substance abuse domiciliary unit offers patients the availability of a safe, semistructured, cost-efficient environment at night.

As a result of this new program, patient outcomes have improved, with fewer readmissions to inpatient medical units and shorter stays for patients who are readmitted. The number of partial-hospital patients in the department of psychiatry has greatly increased, with concomitant increases in outpatient clinic visits.

At first, resistance by psychiatry faculty and staff surfaced. They had concerns about the risks of being primary practitioners for patients with severe medical conditions, about an increase in the number of chronic patients with poor prognosis and high costs, and about the shifting of limited resources from other important areas of the department. These concerns were resolved by having First Step become a formal joint venture with the department of internal medicine. It involved the following commitments. An internist would attend with the psychiatrist on all patients, patients would be readmitted to inpatient medical services with minimal difficulty, and the hospital would support program implementation until volumes and revenues could meet the budget requirements.

Another innovation is the department's short-stay inpatient intensive treatment unit (ITU) for patients with substance use problems and suicidal ideation. These patients, who have acute symptoms, receive brief, intensive psychiatric stabilization in a structured cognitive-behavioral program. The ITU program ensures that patient care is begun in a secure, highly controlled environment with enhanced linkages to First Step or an appropriate outpatient clinic. The typically brief lengths of stay (less than three days) help offset the longer stays of other units.

Service line management

Acknowledging the need for clearer management accountability and authority in clinical programs, the department's executive committee implemented a modified form of service line management by reconfiguring clinical services and operating them as independent profit centers (9,10). Under this decentralized model, faculty members who volunteer to be accountable for the clinical and financial success of a continuum of services are appointed service line directors and given the opportunity to demonstrate their entrepreneurial skills.

The faculty was initially concerned that another bureaucratic level was being added, with a resultant loss of professional freedom. However, the only increase in administration has been a monthly meeting of the service line steering committee held by the executive committee for each service line director. The ultimately recognized benefit of this approach for the service line leader was more clinical and financial autonomy—the latter within approved budget parameters. The initial success of the service line approach with the departments of community psychiatry, child and adolescent psychiatry, and substance abuse services resulted in other programs' being placed in this system, including the eating disorders and managed care programs.

The department's executive leadership is convinced that the service line approach facilitated the accomplishment of numerous goals perhaps not otherwise achievable during a time of extraordinary environmental change; however, the best model for allowing faculty members to balance traditional academic obligations with contemporary program management de-

mands remains a point of ongoing strategic discussions.

Outcomes measurement

Increasingly, purchasers of care are demanding value for their health care expenditures. Value, in this context, tends to be defined as quality divided by cost. In the absence of definitive treatment outcome information, cost has become the basis for many payers' investment decisions. Unless information is available that permits the payer to draw some conclusions about quality, value is considered to be inversely related to cost. Therefore, the department chose to commit resources to the development of indicators of treatment outcome that were relevant, quantifiable, and cost-effective. Data are being collected with the following instruments: a symptom checklist, a functional impairment rating, the Global Assessment of Functioning scale, and a general health status measure (11)—the first three measures being components of the Maryland State Uniform Treatment Plan Form. To enhance the reliability and validity of these instruments, the department has operationally defined, and provided concrete behavioral examples of, the scale ratings. The attending psychiatrist performs all assessments at the time of admission and discharge. The total time required for each assessment is less than five minutes. In addition, patients respond to a patient treatment satisfaction questionnaire administered by nursing personnel at the time of discharge.

The main obstacle to using these indicators was concern about excessive administrative burden on the faculty and the nursing staff, who felt that they did not have the time to add another reporting task to their already busy schedules and paperwork obligations. A clinical faculty meeting held once a month became an important venue for discussing the rationale for and faculty reservations about the outcomes measurement program. Subsequently, this meeting became a forum for program outcomes presentations and discussions about how to realize the original intent of the outcomes initiative.

The goals of the outcomes measurement program were to provide the department and payers with demonstrable evidence of improved symptom status, to generate data aimed at improving care, and to create additional opportunities for health services research. Specific descriptions and applications of the program have been presented at national conferences (12) and published in peer-reviewed journals (13). The successful evolution of the outcomes program is seen as relying heavily on faculty needs, input, and participation.

Regional network development

The department accepted responsibility for helping Johns Hopkins HealthCare develop a behavioral health network and incorporate quality standards commensurate with the Johns Hopkins reputation for excellence in medical services. Recognizing the variation in community-based practice approaches, the department thoroughly screened network applicants. Whenever possible, practitioners were interviewed by two faculty members to ensure that they were among the best in their field and were aware of the department's expectations for providing high-quality care. Another result of these interviews, many of which were conducted with psychologists and clinical social workers, was that these practitioners learned of the department's clinical programs as a new referral resource for consultations, hospitalizations, and other psychiatric services.

The office of behavioral health care also developed standards for availability and access to care; guidelines for network composition and practice; fee schedules; audit methods for treatment facilities; professional development opportunities with department-sponsored, reduced-fee CME programs; and a professional advisory board to oversee quality assurance and risk management. The behavioral health network is currently composed of the department's full-time clinical faculty members and several hundred independent practitioners and facilities within a 100-mile radius. The network serves the enrollees in various private- and public-sector contracts maintained through its institutional managed care partnerships.

Institutional managed care partnerships

Several departments of psychiatry that have formed their own MBHOs have documented the benefits of assuming the managed care role (14,15). The department's first experience in managing care began in 1994 with a partial-risk contract for mental health and substance abuse care for 8,500 enrollees of the TRICARE Prime managed care plan for retirees, dependents, and the families of active-duty members of the seven uniformed services. By 1998, the number of enrollees covered by this contract had increased to 21,000 (16). In the same year, the department secured its first full-risk contract for substance abuse services for 21,000 medical assistance recipients.

Since June 2000, the department has had a nonrisk contract to oversee care management of mental health and substance abuse services for 35,000 enrollees with commercial insurance through our internal third-party administrative organization and of the substance abuse treatment for an additional 100,000 medical assistance enrollees. The managed care enterprise, which now covers more than 150,000 lives, bases authorization decisions on clinical appropriateness rather than on medical necessity.

Operationally, this distinction represents the difference between covering only the minimum care needed to safely treat the patient and covering what is in the patient's best interest with regard to clinical effectiveness, speed of recovery, and functional improvement. In the medical necessity approach, patients typically must be considered a danger to themselves or others before inpatient treatment can be approved. The concept of clinical appropriateness acknowledges that there are other situations in which inpatient treatment is preferred, such as occasions when electroconvulsive therapy should be considered instead of beginning what would probably be a series of failed trials of outpatient pharmacotherapy.

All the department's managed care work has been performed through contractual arrangements within the institutional family; and the majority

of enrolled members in the private insurance plan are Hopkins' faculty, staff, students, and other associated individuals. Although some regional expansion is likely, because some employers seek the value-added features provided by health plan based in an academic medical center, there is no immediate intention of competing with commercial vendors on a national scale.

At one point, several department leaders challenged the department's involvement in managed care. In an effort to prevent any possible thought that no one was listening to these leaders, the department's director wrote down each criticism—even amplifying the objections—then offered an alternative viewpoint for consideration. The specific charges ranged from managed care being professionally unbefitting of Hopkins physicians to its being immoral. Admittedly, by consistently concluding that a treatment is not necessary when it is, some profit-driven MBHOs have caused severe injustice to many prospective patients. However, the point should not be lost that, by determining that a treatment is unnecessary when it is in fact unnecessary, managed care has eliminated inefficiencies and excesses—thus helping to reduce the unsustainable annual increases in behavioral health costs incurred by payers.

Primarily, our response to the faculty on this particular issue has been that, as part of a nonprofit institution, we obtain gratification from demonstrating model services to our profession and that any money saved by efficiencies or earned by management contracts is reinvested in enhancing departmental capabilities. Additionally, patients previously treated in MBHO-administered networks in which patients' access to services has been problematic can now receive services from our own health system. Given the seemingly ever-increasing costs of health care and the undeniable fact that our access to patients is necessary if our culture is to survive, we believe that it is not only a rational but a laudable endeavor to demonstrate that we can deliver and manage care in a clinically effective and cost-effective manner.

Supporting information

As we have stated here, key performance indicators for the department over the past decade support the conclusion that the viability of our clinical enterprise has been sustained in an environment inhospitable to academic psychiatry. The average length of stay in Johns Hopkins Hospital's inpatient psychiatric units has decreased from more than 21 days to about 12 days, and the volume of annual discharges has increased by about 40 percent. The number of visits to partial hospital programs has doubled, and outpatient visits have increased by 44 percent.

Hospital psychiatry has increased market share for all subspecialty services, brought in more revenue to offset budgeted expenses, increased faculty base salaries from the 20th to the 50th percentile, paid annual salary supplements, and invested in growth initiatives. Through the previously mentioned hospital and care management contracts, the department has generated a 47 percent increase in revenue (more than $10 million). Physician fee revenue increased from an unfavorable variance of .4 percent (fiscal year 1996 to fiscal year 1997) to a positive 25 percent (fiscal year 2001). Research grant awards increased from $22 million in fiscal year 1996 to more than $30 million in fiscal year 2001, residency positions were filled, and expansion is planned.

Clearly, the department not only has maintained its clinical mission but also has grown, and, more importantly, is controlling its own destiny. Overall, the faculty have expressed confidence that quality has improved, and they remain optimistic about the future of academic psychiatry at Johns Hopkins. ♦

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