

Healthcare Reform

Healthcare inflation is driven by several major inflation drivers: Hospital Costs; Insurance and Managed Care Overhead and Profit related Costs; Pharmaceutical Company Profits and related Drug Costs; and a traditional focus on bioreductionistic conceptualizations leading to largely palliative or maintenance care approaches. Healthcare inflation cannot be brought under control unless these inflation drivers are managed, curtailed, limited, and the focus of approaches to healthcare reform plans. Remedies must include establishing reasonable limitation on profits taken on a national resource such as healthcare and monitoring of healthcare company operations to ensure that they are in the public interest. This would include such things as holding of non-profit corporations accountable to plow “excess fund balances” (in the private sector these are called profits) back into reduced cost and expanded services rather than excessive executive salaries, non-core business investments, and unrealistic and non-functional perquisites for executives and board members.

It would include that hospital management companies (largely for-profit) that manage public hospital and primary care assets prove that they are not creating costs or jointly beneficial investments and contracts in excess of what the public facility could accomplish by hiring and supervising their own management staff. It would include such things as repeal of the Dole Act allowing University Research Scientists to patent publically funded research derivative products (medicines) jointly with Pharmaceutical Companies and thus create highly costly (thus inefficient) drugs using public tax and grant sunk costs. It would include such things as establishing public option health coverage to provide market competition and efficiency to put downward salary and profit pressure regarding Insurance and Managed Care Company operations. It would include funding prevention and behavioral interventions for diseases of end stage organ damage or wear that result from negative attitudes, decisions, and habits (such as obesity, behavior related to Type II Diabetes, substance abuse, stress management, reckless lifestyles, domestic violence, child abuse, etc.).

Policy on Integrated Care

Congress should pass comprehensive health care reform legislation that ensures that mental health and psychologists' services are central to primary care, available in all medical surgical hospitals and emergency rooms, and in psychological and geriatric residential and skilled care centers that receive licensure and certification and reimbursement through federal programs. The psychological services should include, in addition to mental health and psychological aspects of physical disease, prevention initiatives and interventions since these interventions have the greatest opportunity to curtail long-term human and economic healthcare costs. The legislation should insure that mental health benefits are included in all plans offered in a national insurance pool at parity with physical illness.

Primary Care Facilities and Programs. Psychologists and their services should be required for certification, licensure, and federal reimbursement and fully integrated in primary care facilities. Psychologists should be allowed to admit and discharge patients, independently diagnose and treat, order appropriate laboratory tests and screening pertinent to their training and education,

prescribe or recommend medications when appropriately trained and their state licensure permits, refer for medical evaluation and specialty medical treatment when their screening indicates it is needed, to write treatment orders within the purvey of their licensure, training, and scope of practice, and to participate in integral components of the continuous quality improvement (CQI) and program management activities

- Multidisciplinary team treatment should be emphasized among physician and psychologist providers should be required and fostered in rule and regulation, reimbursement and incentive programs, and in program monitoring and evaluation. In these systems providers should be allowed to autonomously deliver services within the full scope of their licensure when established by law and rule as independent diagnosticians and providers. Monitoring and program evaluation should guard against costly, restrictive, and unnecessary physician supervision or exclusion of psychologists from Medical Staff Membership, policy and procedure development and monitoring, and peer supervision by a senior and board certified psychologist who sets on the Medical Staff Executive Committee of the Medical Staff. The psychologist member of the Medical Staff Executive Committee and the psychologists in the psychology department or service will assist the facility with the development of appropriate policies and procedures for the monitoring, supervision, and development of the psychology department/service.
- If a case management, medical home, or diagnostic related group or capitated allocation model of patient monitoring and leadership is utilized, a psychologist will be involved in the design, development of policies and procedures, monitoring and program evaluation, and supervision of the program.
- Primary care centers hospitalizing their patients during periods of clinical need must ensure that their doctors of psychology have hospital privileges and are allowed to follow the psychological aspects of the case during hospitalization to provide both quality and continuity of care and to facilitate the conservation of resources and rapid medical and psychological stabilization and return to outpatient care.
- Payment and other incentives to promote provider primary care collaboration and accountability should be available to psychologists as well as physicians, and psychologists should be allowed to be joint owners (in Medical Corporations) with physicians to bring their expertise on Behavioral and Systemic and Lifestyle components of healthcare in primary care centers.

Hospitals: All of the components and principles noted under Primary Care above should be applied to hospital settings. Fully one in four admissions to emergency rooms and hospital wards are mentally ill, and over half have diseases directly or indirectly caused, or severely exacerbated by lifestyle, attitudes, habits, and chronic negative choices. The research has consistently indicated the physicians are not equipped to diagnose, treat, or link these patients with appropriate and effective treatment. Hospitals should be required to have a chief psychologist who sets on the executive committee of the Medical Staff, doctors who are psychologists on the medical staff in sufficient numbers to service the psychological needs of the

expected volume of patients and programs offered by the facility, and they should be integrated into the CQI and program management systems of the hospital.

Nursing Homes: The nation's nursing homes are in a mess! Physician and psychologist reimbursement systems prohibit meaningful involvement, timely assessments and assessment updates, doctor (of medicine and psychology) involvement in active daily decision making and treatment planning, and make a mockery of the concept of quality of care. Nursing homes will dramatically expand their beds and stabilization units will take over many of the acute care functions of the hospital by 2025. We are not ready! Barriers to reimbursement must be removed so that nursing homes with more than 100 beds have physicians and psychologists available on a daily basis, they are active on the wards and in updating assessments and directing evolving treatment plans and they are active on a weekly basis in the facility CQI and clinical management programs. The PASSR system has been relegated to a paper compliance program. Mental health screenings, treatment planning using MDSs, PASSRs, and consultation must be revamped and states and facilities held accountable for the quality of mental health care. A psychiatrist dropping in at a 120 bed facility for an hour a month and dropping off 15 scripts for antidepressants and minor tranquilizers is not adequate geriatric intervention for depression and anxiety disorders, much less the psychological aspects of physical disease. We are perpetuating a myth and are disingenuous in our plan for nursing homes and any healthcare reform should include major reform in this component of the healthcare system.

Psychological Residential Care Centers: Many of the nation's most severely and persistently mentally ill children and adolescents that ultimately consume high quantities of mental health and corrections resources in their life-time start in the nation's psychological long-term residential care centers. They are there because they are repeatedly dangerous to self or others, have massive distortions of reality and inability to think rationally on a consistent basis, have such poor self-regulatory abilities that they require twenty-four hour and highly structured and secure supervision and settings, and they learn very slowly and with thousands of interventions and training episodes required to get concepts that are easily mastered by others. They have been abused, damaged, and neglected by adults whom they now distrust, resent, and avoid.

Yet in these centers we require the lowest levels of staffing and resources, the lowest credentials of professionals, very little in the way of qualified psychotherapists and family therapists (often exempting them from licensure laws for professional qualifications), and have such loose standards that the psychiatrist can breeze through several hours a month in more than 100 bed facilities and the psychologist can be there for less than a day a month (rendering them both signers and blessers of treatment plans rather than active in the treatment of these children and in the supervision of their staff). We can do better and no healthcare reform is real reform without increased enforcement of enhanced standards that require psychologist time in ratio to beds (like we do for nurses in Medical/Surgical Hospitals), high quality programs for growth and change rather than intensive medication and strong arm guards, and intensive family, placement, and occupational and educational programs. Many states (Louisiana and Hawaii, to name just a couple) have been so poor configured and performing in these programs that the federal government has had to step in and run their facilities for years and require dramatic improvement.

Healthcare Funding: The uninsured should be provided with a low cost and affordable public option with comprehensive mental health and substance use services and treatment for the psychological aspects of physical illness at parity with physical health services. Cherry picking, impedance of portability, herding of patients into sublicensed and unqualified programs and providers, and unnecessary application of gatekeepers and case management for permanently disabled and chronically ill patients who by definition require life-long and extensive services and interventions must be prohibited. The practices in these regards must be closely monitored with severe penalties. Unless improved monitoring and regulation of payers occurs healthcare reform will not work.

Healthcare Documentation: Healthcare has the most obsessional and unrealistic documentation requirements that exist. The costs related to documentation and documentation monitoring and regulation cripples and eviscerates the resources of the industry. Because programs are not regularly monitored by actual field officials who are trained healthcare professionals and we monitor facilities by analog (paperwork) we build in layers of unnecessary management, costs, and regulatory resource wasting. The paperwork should be cut by half using electronic records, checklists, canned scientifically validated protocols, etc., and monitoring for quality should be done by regional monitoring teams and by electronic data mining and trend analysis rather than by paper and management hierarchies at the facility and Government level. Psychologists are well equipped to help design, monitor, and field survey in such systems. They have research, statistical, management information, healthcare assessment and treatment planning, intervention evaluation, teamwork evaluation, and management skills. They have used these skills to manage research grants, facilities, and to do program evaluations for years.