



**MEETING NOTICE**  
**COMMUNITY MENTAL HEALTH CENTER**  
**PLANNING COMMITTEE**  
**THURSDAY, JANUARY 18, 2012**  
**8:30 - 11:00 a.m.**  
**COUNTY – CITY BUILDING – 555 S 10<sup>TH</sup> ST**  
**ROOM 113**

**AGENDA**

1. Approval of Minutes for January 5, 2012
2. Review Draft: Report and Recommendations of the Community Mental Health Center Planning Committee
3. Update on Health Management Associates Report - Lori Seibel, Community Health Endowment
4. Health Care Innovation Grant Update - CJ Johnson Region V Administrator; Lori Seibel, Community Health Endowment

Due to public interest in attending this meeting the location has been changed to Room 113 (located on the first floor of the County-City Building). Also, the draft and recommendations will be emailed to Committee members on Tuesday, January 17, 2012.

**MINUTES**  
**COMMUNITY MENTAL HEALTH CENTER (CMHC) PLANNING COMMITTEE**  
**THURSDAY, JANUARY 18, 2012**  
**COUNTY-CITY BUILDING, 555 SOUTH 10TH STREET**  
**ROOM 113**  
**8:30 A.M.**

Present: Dean Settle, Community Mental Health Center (CMHC) Director; Pat Talbott, Mental Health Association of Nebraska (MHA-NE); C.J. Johnson, Administrator, Region V Systems; Deb Shoemaker, Executive Director, People's Health Center (PHC); Lori Seibel, President/Chief Executive Officer (CEO), Community Health Endowment (CHE); Kerry Eagan, County Chief Administrative Officer (ex-officio); and Kit Boesch, Human Services Administrator (ex-officio).

Also Present: Jane Raybould, Lancaster County Commissioner; Linda Wittmuss, Associate Regional Administrator, Region V Systems; Captain Joe Wright, Lincoln Police Department (LPD); Topher Hansen, Director, CenterPointe, Inc.; Jon Day, Executive Director, Blue Valley Behavioral Health; Yvonne Svec, Lincoln Lancaster Mental Health Foundation; Alan Green, Executive Director, MHA-NE; Bryon Belding, Deb Bodtke, Laurie Consbruck, Tom Dierks, Alan Fulton, Lisa Janssen, Monica Janssen, Marylyde Kornfeld, Daniel Leggiardo, Samuel Ridge, Rebecca Simerly, Joe Swoboda, Carol Volkman and RaDonna Westlund, CMHC; Gail Anderson, CMHC Advisory Committee; JRock Johnson, consumer advocate; Jackie Sordahl, Roger Svatos and Debra Trainor, concerned citizens; Nancy Hicks, Lincoln Journal Star Newspaper; and Ann Taylor, County Clerk's Office.

Eagan called the meeting to order at 8:32 a.m.

**AGENDA ITEM**

**1 APPROVAL OF MINUTES OF THE JANUARY 5, 2012 MEETING**

Item was held.

**2 REVIEW DRAFT: REPORT AND RECOMMENDATIONS OF THE COMMUNITY MENTAL HEALTH CENTER (CMHC) PLANNING COMMITTEE**

A list of CMHC's programs and services was disseminated (Exhibit A):

- Community Support
- Medical Services
- Outpatient Therapy
- Day Treatment/Partial Hospitalization Program
- Day Rehabilitation
- Homeless/Special Needs Outreach

- Psychiatric Residential Rehabilitation
- Crisis Center
- Peer, Volunteer & Student Placement
- Behavioral Health Jail Diversion Program
- Open Studio/Writers Workshop
- PIER (Partners in Empowerment and Recovery) Program
- Emergency Service Response
- 24-Hour Crisis Line/Mobile Crisis Service

The Committee reviewed the draft report and made the following suggestions (Exhibit B):

### **Report**

- Acknowledge Joan Anderson and Travis Parker, former Committee members, and Gail Anderson and JRock Johnson, individuals who have regularly attended and contributed to the proceedings.
- Include a summary of the main points from the community input process and number of citizens that participated.
- Change the term case management to service coordination, except in the community comments.
- Change Mental Health Jail Diversion Program to Behavioral Health Jail Diversion Program in the second paragraph on Page 3.
- Change Services to Systems in the last paragraph on Page 3 and indicate how much of the \$3,843,696 is related to the Crisis Center.
- Add language to indicate that CMHC's crisis response line has absorbed several other crisis lines within the community.
- Include peer-operated services as a model to consider in the first paragraph on Page 4.
- Indicate that integrated care could be bi-directional, i.e., primary health care could be provided in a behavioral health setting on Page 4.
- Add language to the second sentence in the second paragraph on Page 4 to clarify that as a federally qualified health center (FQHC), PHC only receives a higher federal reimbursement rate for Medicaid patients' medical visits. PHC does not receive an enhanced rate for behavioral health visits.
- Change the title the Center for Medicaid Services to the Center of Medicare and Medicaid Services in the last paragraph on Page 4.
- Delete the phrase to the medically indigent in the last paragraph on Page 4. Also include a statement to clarify the purpose of the grant that is referred to (better care, better health, and lower costs).
- Include staff expertise, specifically in the area of working with the severe and persistent mentally ill population, in the list of key points that were garnered from the community input process on

Page 5.

- Change the phrase effective community mental health program to effective community mental health system in the last paragraph on Page 5.
- Add the word be in front of the word found in the last sentence of the first paragraph on Page 6.
- Revise the estimate of the cost of paying out sick leave and vacation balances to separated employees on Page 6 to reflect that it was \$994,224 at the end of 2011.
- Include peer-operated programs in the language regarding integration in the second paragraph on Page 7.
- Identify CMHC's core services.
- Attach an appendix listing all of the documents that were presented to the Committee. Also cite the table of indirect costs.

### **Recommendations**

- CMHC's core services should be maintained in its present location with as much continuity as possible during the transition period.
- Discussions should begin with Region V Systems for the purpose of providing interim administrative oversight of CMHC for a designated period of time while a new service model is developed.
- Use of advisors to craft a potential system redesign.
- A fully-detailed transition plan, timeline and communication plan should be developed.
- County should maintain its present level of funding for CMHC until alternative funding is in place.
- The County should participate in the establishment of a new system of care with integration of primary health and behavioral health services.

Settle felt the County should also remain the employer of record during transition period to ensure stability.

C.J. Johnson was asked to verify the amount of funding CMHC receives from Region V Systems (see Page 3).

There was consensus to post a copy of the draft report and recommendations on the County's website.

### **3 UPDATE ON HEALTH MANAGEMENT ASSOCIATES (HMA) REPORT** - Lori Seibel, President/Chief Executive Officer (CEO), Community Health Endowment (CHE)

Item was held.

**4 HEALTH CARE INNOVATION GRANT UPDATE** - C.J. Johnson, Administrator, Region V Systems; Lori Seibel, President/Chief Executive Officer (CEO), Community Health Endowment (CHE)

Item was held.

**5 OTHER BUSINESS**

Settle disseminated copies of the cover story in the January 16, 2012 edition of Modern Healthcare titled "Juggling the Lineup - Seeking better financial results, providers change services; experts worry about access" (Exhibit C).

**6 ADJOURNMENT**

There being no further business, the meeting was adjourned at 11:20 a.m.

**NOTE:** The next meeting will be held on February 3, 2012 at 8:30 a.m.

Submitted by Ann Taylor, County Clerk's Office.

CELEBRATING  
**35 years**  
OF SERVICE



## Annual Report 2010-2011

2201 S. 17<sup>th</sup> Street  
Lincoln, NE 68502

Tel: 402-441-7940

Fax: 402-441-8625

[www.lancaster.ne.gov/cnty/mental](http://www.lancaster.ne.gov/cnty/mental)

Lancaster County Board of Commissioners

Bernie Heier

Larry Hudkins

Jane Raybould

Deb Schorr

Brent Smoyer

## Strengths-Based

### Quality Care

### Recovery

### Hope

### Wellness

### Access

### Choice

## Evidence Based Programs

Services accredited by:



CMHC is funded by Region V Systems,  
State of Nebraska, Federal Grants,  
the City of Lincoln and Lancaster County

### EXHIBIT



## Mission Statement:

The Community Mental Health Center of Lancaster County is dedicated to providing quality mental health care and rehabilitation services for adults who experience acute psychological distress or serious mental illness.

## Programs & Services

- ◆ **Community Support** - Case management and services to adults and vulnerable elderly through the Harvest Project, and residential support services at The Heather, Independent Living Project, and Transitional Living for adults with severe and persistent mental illness.
- ◆ **Medical Services** - Outpatient psychiatric services for CMHC consumers including assessment, therapy, medication education and management, and inpatient psychiatric care.
- ◆ **Outpatient Therapy** - Individual and group therapy sessions focused on symptom alleviation, stabilization, and recovery. Community-based sex offender management.
- ◆ **Day Treatment / Partial Hospitalization Program** - Short term, intensive treatment provided through group formats, 6 ½ hours daily, Monday - Friday. May serve as an alternative to inpatient treatment or as a step down for individuals making the transition from a hospital setting to the community.
- ◆ **Day Rehabilitation** - The Midtown Center, open Monday - Saturday, is a clinical rehabilitation program engaging consumers in life skills, recovery and vocational activities. Employment and benefits counseling, job placement and training for consumers of CMHC services are also available through the AWARE program.
- ◆ **Homeless / Special Needs Outreach** - Outreach and case management for adults who have a mental illness and are homeless, near homeless or in contact with the criminal justice system.
- ◆ **Psychiatric Residential Rehabilitation** - The Heather is a structured residential facility operated by CMHC, and OUR Homes as a residential transition from the Lincoln Regional Center back into the community.
- ◆ **Crisis Center** - An assessment and crisis stabilization facility for adults placed on emergency protective custody by law enforcement in the 16 Counties of Region V.
- ◆ **Peer, Volunteer & Student Placement** - Students, volunteers, and peer recovery specialists augment the work of CMHC staff members in social and recreational activities, treatment and rehabilitation services.
- ◆ **Behavioral Health Jail Diversion Program** - This Program seeks to identify and divert individuals from jail with a mental illness or co-occurring substance use disorder who have committed a non-violent offense. The Program then links these persons to an array of community-based services with intensive case management.
- ◆ **Open Studio/Writers Workshop** - A collaborative effort by CMHC, Centerpointe, and Parks and Recreation for adult artists and writers we serve. Open-studio sessions, workshops, readings, and many exhibitions each year are provided to those using the arts as a means of expression and maintenance of wellness.
- ◆ **PIER** - A collaboration designed to serve individuals who have not responded well to traditional outpatient care. Services are provided to the client in their home and the community. Office is at 2000 P Street. Phone number - 435-4044.
- ◆ **24 hour Crisis Line/ Mobile Crisis Service** - Crisis assessment, intervention, and information available 24 hours by phone. Mobile services available to law enforcement or agencies requesting consultation / intervention, after regular business hours (441-7940).

### Persons Served

Duplicates included

Program	Number
Community Support	1,085
Medical Services	1,909
Inpatient Psychiatric Services	347
Outpatient Therapy	883
Day Treatment / Partial Hospitalization	227
24 Hour Crisis Services	4,897
Day Rehabilitation Services	195
Homeless / Special Needs	253
Psychiatric Residential Rehabilitation	28
Crisis Center	615
Vocational Support	44
Harvest Project *	153
Mental Health Jail Diversion	48
PIER **	79
Open Studio / Wordshop ***	342
<b>Total number served</b>	<b>11,105</b>

### Demographics

Unduplicated

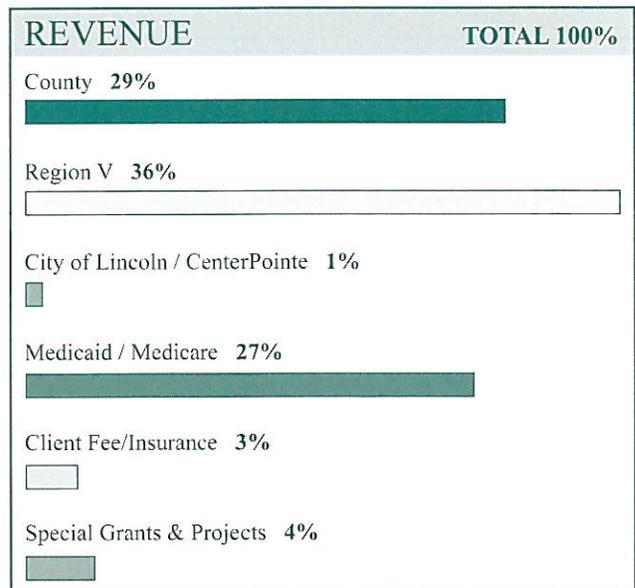
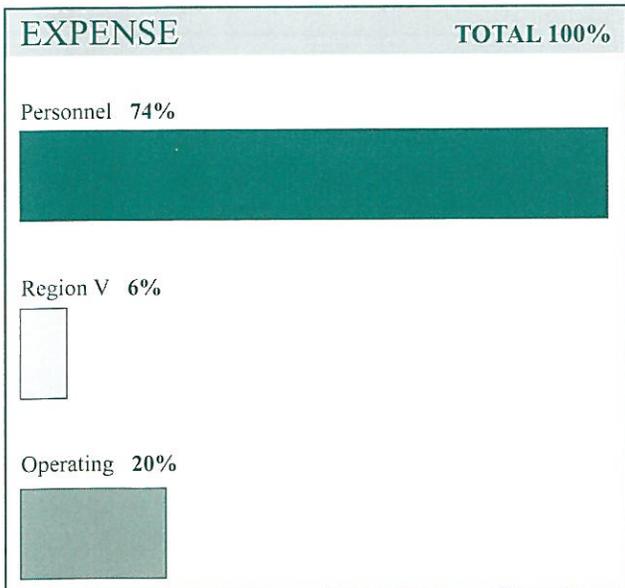
N = 4,911

48% Women      52% Men

Age	
18 - 34	31%
35 - 49	39%
50+	30%

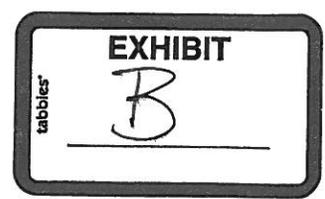
Caucasian 85%  
 Black 5%  
 Hispanic 5%  
 Other 2%  
 Native American 2%  
 Asian 1%

**\$10,149,301**



\*Collaborative Project with Aging Partners and CenterPointe, Inc.  
 \*\*A collaborative project with CenterPointe and Lutheran Family Service  
 \*\*\*A collaborative project with CenterPointe and Lincoln Parks and Recreation

DRAFT



REPORT AND RECOMMENDATIONS  
COMMUNITY MENTAL HEALTH CENTER PLANNING COMMITTEE  
JANUARY 18, 2012

INTRODUCTION

The Lancaster County Board of Commissioners established the Community Mental Health Center (CMHC) Planning Committee in June of 2011 for the purpose of reviewing how the County is providing mental health services at the CMHC, determining the best model for providing services in the future, and advising the Board as to the proper role of the County in funding and providing these services. The stated goal of the Committee is to provide the County Board with an effective, sustainable long-term plan regarding how community-based mental services should be provided in Lancaster County.

**Committee Membership**

In establishing the Committee the Board appointed a broad range of community providers, funders, and consumers who have an interest in the provision of mental health services in Lancaster County. Committee members include:

- Lori Seibel, Community Health Endowment
- Pat Talbot, Mental Health Association
- CJ Johnson, Region V Systems
- Dean Settle, Community Mental Health Center of Lancaster County
- Deb Shoemaker, People's Health Center

**Facilitators and Ex-officio Members:**

- Kerry P. Eagan, Chief Administrative Officer to the Lancaster County Board
- Kit Boesch, Lincoln-Lancaster County Human Services Director

**Support Staff**

- Ann Taylor, Lancaster County Clerk's Office

(Recognition of others who regularly attended meetings and contributed to the discussions?)

**Committee Process**

All meetings of the CMHC Planning Committee were conducted in compliance with the Nebraska Open Meetings Act. The Committee met \_\_\_\_\_ times, from July 2, 2011 through

January \_\_\_\_\_, 2012. Agendas and minutes for all Committee meetings are available on the Lancaster County Clerk's web site. The County Clerk is also maintaining a copy of all documents and exhibits presented to the Committee which can be reviewed by the public upon request. The Committee toured mental health facilities operated by Lancaster County and spoke directly with staff members about the programs and services offered at the CMHC. Tours were conducted of the main CMHC facility, the Crisis Center, the Mid-Town Center, and the Heather Program.

An important component of the Committee process was the solicitation of community input through listening tours, focus groups, a public comment line, a computer survey, and a town hall meeting. A series of core questions was developed to obtain information from consumers, providers, family members, advocacy groups, and other interested parties. Valuable information was received from the community for consideration by the Committee in formulating its recommendations to the Lancaster County Board.

### **COMMITTEE DISCUSSIONS**

The first order of business for the Committee was a review of the history and purpose of the CMHC, including a review of services provided, budget information, and funding sources. The CMHC was established in 1976 through a federal grant under the Comprehensive Community Mental Health Centers Act for the purpose of treating individuals with severe mental illness in the community rather than in state institutions. Moving mental health treatment to the community was driven in part by Lancaster County's desire to save money. State law requires counties to pay a portion of the cost for housing their residents with the Nebraska Department of Public Institutions, and the County believed that community-based mental health treatment is not only more effective but also less expensive than institutional care.

Original funding under the grant was 80% federal with a 20% match of state and local funds. The grant mandated a list of services including: inpatient care, outpatient care, medical services and administration, day treatment, partial hospitalization, consultation and education, children's services, and program evaluation.

The CMHC has added a number of additional programs including:

- case management
- the Heather, a transitional living program for patients moving from the Lincoln Regional Center (LRC) to the community
- the Sexual Trauma Offense Prevention Program (STOP)
- the Outsider Arts Program
- the Harvest Program, a collaboration with CenterPointe and Aging Partners providing services to mentally ill elderly persons with substance abuse issues

- Assertive Community Treatment (ACT), a collaboration with CenterPointe and Lutheran Family Services providing specialized services in the community and at home to clients who have not responded well to traditional outpatient care
- the Mid-Town Center, which provides vocational rehabilitation and other related services

Until recently the CMHC also operated the Mental Health Jail Diversion Program. However, this program was transferred to the Lancaster County Community Corrections Department at the beginning of the County's 2011-2012 budget year.

In 1988 the CMHC opened the Crisis Center. Originally consisting of ten (10) beds located at the Lincoln Regional Center, the Crisis Center was established pursuant to an interlocal agreement with Region V to meet the emergency protective custody (EPC) needs of the sixteen (16) counties served by Region V. The Crisis Center is now located on the second floor of the CMHC and consists of fifteen (15) beds. It is important to note the County is statutorily mandated to pay the cost of providing emergency protective custody for its residents. See Neb.Rev.Stat. §71-919 (Reissue 2009).

The CMHC's approved budget for fiscal year (FY) 2011-12 is \$9,490,537. The primary funding sources are Medicaid, state funding through Region V, and Lancaster County property tax. The property tax request for this fiscal year's budget is approximately \$2.2 million, down \$500,000 from the previous fiscal year due to program and staffing cuts. Not counting the Crisis Center, CMHC operations will require approximately \$800,000 of property tax this fiscal year.

The Committee also examined the role of Region V in providing behavioral health services in Lancaster County. Pursuant to the Behavioral Health Services Act, Neb. Rev. Stat. §§71-801 through 830 (Reissue 2009), the State of Nebraska is divided into six (6) behavioral health regions which are responsible for the development and coordination of behavioral health services. Lancaster County is included in Region V, which serves sixteen (16) counties in southeast Nebraska. Each county within a region is required to contribute funding for the operation of the regional authority and for the provision of services.

The Nebraska Department of Health and Human Services, Division of Behavioral Health Services contracts with Region V to ensure the availability of behavioral health services to residents in southeast Nebraska who do not have insurance or funds to pay for services. In turn, Region V contracts with a network of service providers within the sixteen (16) counties it serves to provide an array of behavioral health services to adults and children.

The CMHC is a member of the Region V Systems service provider network. For FY 2011-12 the CMHC is budgeted to receive \$3,843,696 from Region V Services for a wide array of services and programs.

Although the CMHC has effectively provided community-based mental health services since 1976, the Committee recognized the traditional way of providing services will need to evolve to meet future challenges. The number of Medicaid recipients needing services is expected to increase sharply in the next few years. Providers will need to become more efficient, and collaboration will become more important. New models are being developed for providing services to the medically indigent which integrate primary health care and behavioral health care. The Committee looked at several different integration models, including the formation of a partnership between the CMHC and a primary health care provider.

Pursuing this analysis, the Committee reviewed extensive information on the People's Health Center (PHC), a federally qualified health center (FQHC) providing primary health care to the medically underserved in Lincoln. As an FQHC, the People's Health Center receives a higher federal reimbursement rate for Medicaid patients. Recognizing the behavioral health needs of its patients, the PHC has established the Behavioral Health Integration Project (BHI Project). The BHI Project is funded by Region V and the Community Health Endowment, and is seeking to establish partnerships with a number of behavioral health providers in the community, including the CMHC.

Another area where Lancaster County might gain from a partnership with the PHC is General Assistance. The County budgeted approximately \$1.6 million to cover the projected costs of medical care under General Assistance for FY 2011-12. Providing this medical care through the People's Health Center could save money for the County and provide needed funding and continuity of care for the PHC and its patients.

As the County considers future challenges in providing community-based mental health services, as well as the development of new service models to meet those challenges, the information and recommendations contained in the final report from Health Management Associates (HMA) should be carefully considered by the County Board. At the same time this Committee was formed by the County Board to examine community mental health services, the Community Health Endowment commissioned a study by HMA to provide recommendations on how to better provide for the medically underserved in our community. The Lancaster County Board contributed \$5,000 toward this study to include an analysis and recommendations regarding the CMHC. The guidance provided by HMA will be extremely helpful in crafting the best solution to address the primary care and behavioral health needs of the medically underserved.

In this regard, HMA has already identified a grant opportunity being offered by the Center for Medicaid Services could have a profound effect on how primary care and behavioral health services are provided to the medically indigent not only our community, but for the entire area of southeast Nebraska served by Region V. This grant opportunity is being pursued by a consortium of stakeholders, including Region V, the Community Health Endowment, the Lincoln Medical Education Partnership, the People's Health Center, and other key entities. From the County's perspective, an important part of the grant proposal will seek funding to

create a collaborative primary care/behavioral health system of care.

The final essential piece of the puzzle analyzed by the Committee is the extensive comments received from consumers, family members, advocates and providers. This invaluable information was gathered as part of the community input process conducted on behalf of the Committee by the Community Health Endowment and Leadership Lincoln. Funding to conduct the process was graciously provided by the Mental Health Association. Some of the key lessons which can be garnered from the comments include the following points:

- the present location of the CMHC is extremely important; patients have moved to the area because of the CMHC, and other services are readily available in the area; this location is also well-served by public transportation
- accessing a wide array of services at one location is helpful
- case management is a critical service which should be maintained and expanded
- others?

Consumer involvement is a priority in all aspects of behavioral health service planning and delivery, and the information received during the community input process was weighed heavily by the Committee in formulating its recommendation to the Lancaster County Board.

## ISSUES AND CONCERNS

Based on the information presented and the analysis summarized above, the following issues and concerns have been identified by the Committee:

### **Potential Cost to the County if Effective Community Mental Health Services Are Not Provided**

Although Lancaster County is not statutorily mandated to provide behavioral health services, maintaining a strong and effective community mental health program is in the best interests of the County. By providing an array of services to patients with severe and persistent mental illness, the CMHC is reducing the amount of admissions to the Crisis Center, law enforcement contacts, jail admissions, and involvement with the criminal justice system. Since all these functions are the responsibility of the County in whole or part, the question which must be addressed is whether the County is saving money in the long run by operating an adequately funded mental health center. The analysis of this question should include a review of which programs offered at the CMHC are most effective in reducing the number of EPC's and amount of involvement with the criminal justice system. Also, are the services being provided in the most efficient manner with the present ownership and business structure, or should the County pursue a new model for providing services? When making this decision it is critical for the County Board to have accurate information on the true cost to the County of owning and operating the CMHC.

### **General Assistance**

Lancaster County is statutorily responsible for providing medical care, including behavioral health care, to individuals who meet the income and resource standards set forth in the Lancaster County General Assistance Guidelines. The cost of providing mental health services to General Assistance clients at the CMHC is approximately \$420,600 per year, and is absorbed in the CMHC budget. If medication costs are included then the estimated cost exceeds \$600,000 per year. If the County discontinues operation of the CMHC other service providers will need to be found for General Assistance clients.

### **Indirect Costs**

For the budget year ending June 30, 2010, the cost of services provided to the CMHC by other County departments was \$394,000. The value of these services must be taken into account as the County Board considers other service models.

### **Community Treatment of Sex Offenders**

A disproportionate number of sex offenders live in Lancaster County. The CMHC is actively involved in treating this population. Concerns have been raised whether adequate funding is being provided by the State for this purpose, and whether treatment programs at the CMHC could be provided by non-governmental organizations.

### **Funding Concerns**

The committee raised a number of concerns regarding funding for the CMHC. During the 2011 legislative session the CMHC suffered a 2.5% reduction in Medicaid funding. For 2012 Governor Heineman is proposing to eliminate the inheritance tax, which could result in a loss of over \$6 million to Lancaster County. Loss of the inheritance tax would cripple the County's ability to adequately fund community mental health services. Other concerns include the fairness of existing funding formulas for the behavioral health regions. Since the Lincoln Regional Center and the State prison are located in Lancaster County, the County experiences an influx of patients from other counties. Also, residents from other counties relocate to Lincoln because of the availability of services. Do the funding formulas adequately account for this added burden on Lancaster County? Another concern is whether the CMHC is able to maximize funding from other sources which may be available for behavioral health treatment.

### **Cost of Divesting the CMHC**

Although the County is presently contributing \$2.2 million of property tax to the CMHC, \$1.4 million of this cost is for operation of the Crisis Center, leaving \$800,000 of funding for CMHC programs. After accounting for the cost of General Assistance, approximately \$600,000, the actual savings the county could be as low as \$200,000 per year. Moreover, at the time of divestiture the County will be required to pay sick leave and vacation balances to separated employees. This figure is estimated to be \$800,000. The County will realize some indirect cost savings.

### **CMHC Location**

Based on numerous comments received during the public comment process, the availability of an array of services at one location is critical to the population served by the CMHC. Moreover, the present location of the CMHC is also extremely important to consumers and family members. As the County goes forward with the planning process, careful consideration must be given to the actual location of facilities and services.

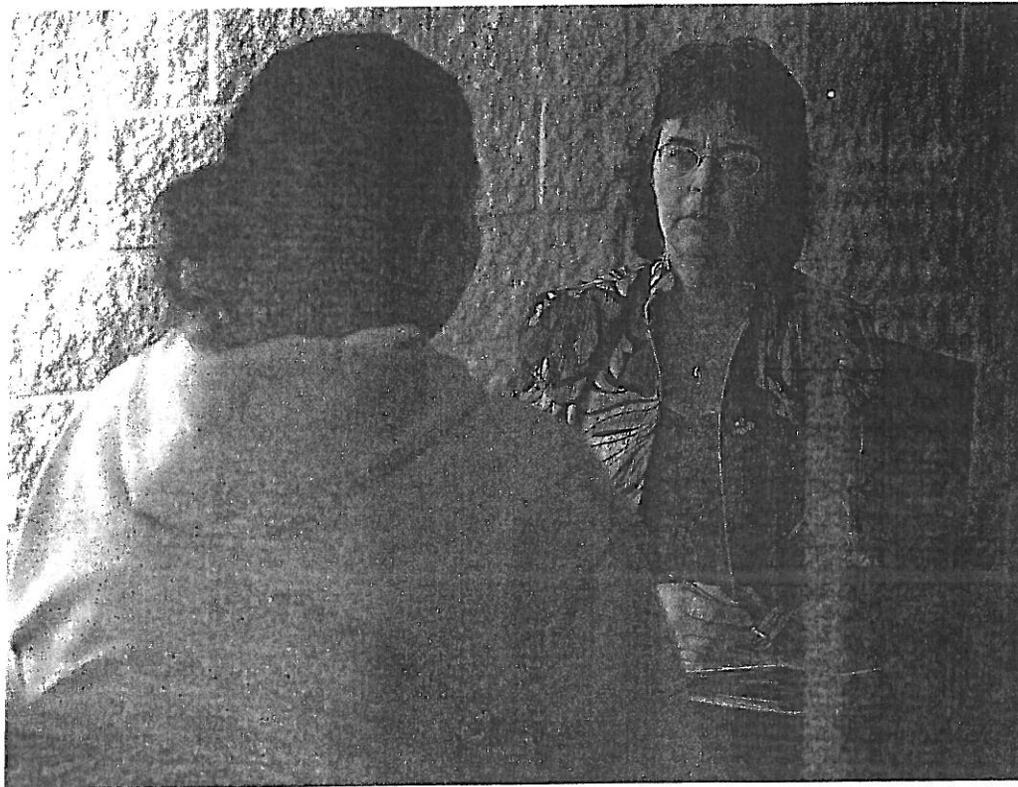
## **RECOMMENDATIONS**

The Committee strongly believes the CMHC is an indispensable component of the provider network and service array established to meet the behavioral health needs of the residents of Lancaster County. However, financial challenges are making it increasingly difficult for the County to adequately fund the critical programs and services offered by the CMHC. At the same time, opportunities exist to establish a new service model based on the integration of primary health care and behavioral services. Therefore, the following recommendations are tendered to the Lancaster County Board of Commissioners:

- 1. Negotiations should begin with Region V for the purpose of transferring the operation of the CMHC to Region V;**
- 2. The CMHC should be maintained in the current location for a reasonable period of time to allow for an orderly transition for consumers and family members;**
- 3. Lancaster County should maintain its present level of financial support for the CMHC for a period of time to be determined until alternative funding can be put in place; and**
- 4. The County should participate in the establishment of a new system of care for the medically underserved based on the integration of primary health care and behavioral health services, including the use of General Assistance funding for medical services to support the new system.**

Respectfully submitted this \_\_\_\_ day of January, 2012.

Members of the Committee



ANNIE M. O'NEILL

**Excelsa Health eliminated Pam Kowalczyk's job when the Pennsylvania health system scaled back its behavioral health services. She joined a mental health clinic that was given financial aid to absorb new patients.**

# Juggling the lineup

*Seeking better financial results, providers change services; experts worry about access*

**E**xcela Health entered the Great Recession as the largest mental health provider for the Pennsylvania county that's home to its three hospitals.

A year and a half later, as the recession drew to a close, Excelsa began to refer and transfer outpatient mental health patients to primary-care doctors and community clinics to stem losses.

"When you're in good economic times you can oftentimes carry programs you know should be revised," said Sam Raneri, senior vice president and chief strategy officer for Excelsa Health, based in Greensburg, Pa. "The recession and the drop in admissions and elective cases put more pressure on us to look at behavioral health in a brand new way."

Excelsa and other not-for-profit hospitals across the U.S. have reduced or shed unprof-

itable services and expanded or opened more lucrative business lines as the severe recession and weak recovery stripped health insurance from many households, while others who were still insured did not seek care to avoid the cost.

Those strategies have come as part of hospitals' broader—and quite successful—efforts to cut expenses or find new sources of revenue to protect margins through the economic downturn.

Hospitals have scaled back care for the mentally ill since the recession, and one survey of more than 1,000 hospital executives by the American Hospital Association found one-fifth reported in March 2009 that they reduced services that lost money, including behavioral health, post-acute care and patient education services. Meanwhile, hospitals have invested in services that deliver profits, including neurosurgery and interventional cardiology.

Many hospitals came through the recession with profit margins intact—even improved—despite more uninsured patients, slack demand for profitable elective procedures, and public and private insurers that have squeezed payment rates.

Analysts and executives credit the industry's strong performance to aggressive efforts to slash costs, including stark options such as mass layoffs and service cuts.

But if the strategies have protected hospital margins, they raise thorny questions for health policymakers about access to care for vulnerable patients and growth of unneeded and costly high-margin services.

And the nation's fledgling economic recovery probably won't ease the pressure on hospital revenue. Private insurers are expected to wring hospital payments to curb health spending, and federal and state lawmakers will continue to look to healthcare for budget savings.

As hospital executives continue to search for ways to shelter margins, the recession suggests hospitals will continue to pare unprofitable services and expand lucrative ones.

In Los Angeles, Cedars-Sinai Medical Center announced plans last November to close psychiatry for patients inside and outside the 931-bed hospital, with a few exceptions such as consultations and mental healthcare for transplant and cancer patients. Cedars-Sinai also said it would stop training new psychiatrists.

Executives with the hospital declined to be interviewed. But Thomas Priselac, Cedars-Sinai president and CEO, seemed to suggest in a statement released as the hospital unveiled its plans that psychiatry was a drain on hospital resources.

"At a time when the healthcare delivery system in our country is undergoing a massive transformation, every medical center has a responsibility to examine what it should focus on to ensure that it is strong over the long term to serve the community," he said.

Cedars-Sinai emerged from the recession with a solid operating margin of 6%, though lower than the 8% operating margin going into the downturn.

### Unsurprising

"It is not surprising that hospitals respond to financial pressure by changing their service mix by adopting profitable services and discontinuing unprofitable services," Jill Horwitz, a law and health policy and management professor at the University of Michigan who has studied the relationship between hospital finances and healthcare delivery, said in an e-mail.

Bundled payments under the healthcare reform law that give hospitals a lump sum to cover patients' medical costs, called capitation, could lessen financial incentives that make some services more profitable than others, she said.

But the Patient Protection and Affordable Care Act will more likely prompt more scrutiny of profitable and money-losing services as the law squeezes hospital payments.

## FIXING THE MIX

Hospitals driven to cut costs in tough times have reduced unprofitable services while investing in profitable ones

OUT

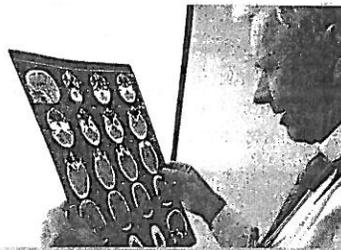


Behavioral health

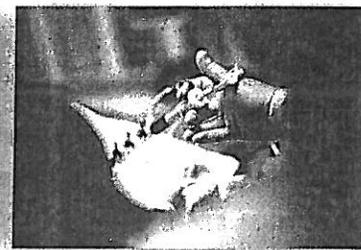


Skilled nursing

IN



Neurosurgery



Interventional cardiology

Source: Modern Healthcare reporting

MODERN HEALTHCARE GRAPHIC

"This will put more pressure on hospitals," Horwitz said, "leading to more efforts to find profits. Changes to service mix are one of the more obvious methods for increasing revenues and profits."

Economic research published last year suggests hospitals respond to less demand, or the threat of less demand, for more profitable services by investing less in unprofitable ones.

The study, published last August by the not-for-profit and nonpartisan National Bureau of Economic Research, found psychiatry and substance abuse services declined at Arizona acute-care hospitals where specialty heart hospitals had entered the market to threaten acute-care hospitals' profitable cardiac margins. Notably, profitable neurology services also increased among acute-care hospitals, the research suggests.

In Savannah, Ga., 543-bed Memorial University Medical Center moved to combat sluggish operations in 2009 and 2010 by expanding cancer and neurosurgery services, two profitable business lines, and expanding into markets where insurers pay more favorable rates, according to a credit report from ratings agency Moody's Investors Service.

In Riverdale, Ga., 317-bed Southern Regional Medical Center reported fewer patients, more Medicaid and uninsured

patients, and weak operations during the same period. In a turnaround effort, Southern Regional sought to boost volume for profitable services such as neuroscience, interventional cardiology and surgical oncology, Moody's said.

The trend has implications for healthcare access, quality and spending, Horwitz said. Patients who need unprofitable services, such as mental healthcare, are typically lower income and will find care harder to get, Horwitz said. An expansion of profitable services, which can be expensive as well, could increase health spending and creates incentives for hospitals to treat more patients—including those who may not need it, she said.

### Poor, difficult, complicated

"I think that programs that deal with poor, difficult, complicated people and illness are at risk," said Richard Frank, an economics professor at Harvard Medical School's healthcare policy department who studies mental healthcare. "It's not just behavioral health, but behavioral health inpatient is one that is especially focused on poor people."

Mentally ill patients who require hospital care—those grappling with severe illness such

See COVER STORY on p. 16

# The Week in Healthcare

## COVER STORY from p. 7

as schizophrenia—also often are low-income and covered by safety net insurance, Frank said. States responded to the recession by squeezing Medicaid hospital payments just as unemployment pushed more people onto Medicaid rolls, he said.

“The problem is that one of the things that we’re doing now is we’re splitting the haves and have-nots a bit,” Frank said. “By putting extreme pressure on public programs, you sort of give people who run those programs a choice: shrink the size of the program or push down on rates or reorganize. What you see is an attempt to do the last two. I think that, therefore, illnesses that disproportionately rely on public programs are generally going to have more economic pressure and that’s part of what’s going on with inpatient psychiatry.”

### Psychiatric ward closed

Chilton Hospital in northern New Jersey halted behavioral healthcare as the recession ended and the hesitant recovery began. More patients had arrived at 260-bed Chilton uninsured or covered by safety net plans, the hospital told Moody’s. Revenue dropped by \$2 million as the number of uninsured and Medicaid patients grew. Chilton’s operations slid from a narrow profit to a slim loss.

The Pompton Plains-based hospital, located in a competitive market, planned to borrow roughly \$40 million in October 2009 to finance investment in oncology and orthopedics, two service lines considered more profitable. Credit analysts warned that if Chilton’s finances did not improve, its rating could drop. Psychiatric care did not lose money, but did not earn enough to offset other hospital costs either, the hospital told potential investors.

In August 2009, the hospital closed its psychiatric ward—which saw 438 admissions in 2008 compared with 525 two years before—and applied to convert the beds into ones for medical and surgery patients, according to financial statements.

The hospital also saved money by cutting 78 jobs, a squeeze on supply costs and other moves, the credit analysts said. The next year, Chilton reported a \$2.3 million profit. Chilton did not respond to requests for an interview.

At Excela Health in Pennsylvania, inpatient psychiatric services were profitable, Raneri said. Outpatient mental healthcare was not.

The system was the sole significant provider of outpatient mental healthcare in Westmoreland County, but “suffered large and escalating losses” as costs grew but payment remained low, he said. “We were taking the burden of not only inpatient, but shouldering the burden of all the outpatient in the county as well.”

Excela lost \$1.6 million in 2008 on outpatient behavioral health.

During the year that ended in June 2009—the month the Great Recession ended—the system struggled with fewer patients than



**“We were taking the burden of not only inpatient, but shouldering the burden of all the outpatient in the county as well.”**

—Sam Raneri, Excela Health

expected, more unpaid medical bills and volatile markets that drained cash from Excela’s balance sheet, according to a Moody’s credit report. Excela Health lost \$2.3 million on operations that year.

By the following June, Excela reported a profit of \$7.5 million on operations after significantly curbing its outpatient mental healthcare and closing skilled nursing services at its hospitals.

Raneri said the weak economy and financial losses prompted Excela to make the changes, but only after officials were satisfied that access to services and quality of care would not suffer.

### Outpatient treatment

Now Excela offers outpatient mental health treatment for patients with an “acute need” or those who are leaving the hospital. All other patients are referred to mental health or primary-care doctors in the community.

Independent mental health providers entered the market to meet demand, Raneri said. The hospital also opened a crisis intervention center. Meanwhile, Excela Health cut losses on outpatient mental health in half.

Jane Jerzak, a partner with the consulting and accounting firm Wipfli, said hospitals saw demand for profitable services—including elective orthopedic surgery and imaging—decline as the economy worsened.

The trend left hospitals without profits to subsidize unprofitable services, which prompted executives to scrutinize subsidized operations between 2008 and 2010, said Jerzak, an accountant and registered nurse.

Figures released last week highlight house-

holds’ pullback from medical spending.

Health spending grew slowly again in 2010, increasing 3.9%, as households put off trips to the hospital or doctor’s office, CMS estimates show (See story, p. 8). The slowdown was pronounced among hospitals and medical groups, the agency said.

Jerzak said hospitals winnowed unprofitable services or sought to boost market share for more profitable businesses lines, but few shut programs entirely or launched entirely new services in response to financial pressures. “That is not a short-term strategy,” she said. “That is an intermediate strategy at best.”

### An upheaval

When hospitals revamp services, communities must find ways to meet local needs.

In Westmoreland County, where Excela scaled back its outpatient behavioral healthcare, local mental health officials pledged financial aid for a clinic that would agree to open to absorb former Excela patients, at first expected to be 3,700 patients, said Michael Quinn, CEO of Chestnut Ridge Counseling Services, based in Uniontown, Pa. The number later proved to be smaller, he said.

Chestnut Ridge, a not-for-profit, opened its third Pennsylvania clinic after being selected by the county to treat former Excela patients. Since the clinic opened 2½ years ago, demand has grown. “The good news is it’s getting busier,” Quinn said. “Unfortunately, that speaks to the fact there is a lot of unmet need out there,” he said.

Losses have narrowed and Chestnut Ridge has expanded into school-based services, which break even, and telepsychiatry, which earns a profit. Quinn blamed the shortfall on inadequate payment and burdensome regulations.

Pam Kowalczyk, a clinical social worker, joined Chestnut Ridge from Excela after the hospital cut back its services.

About one-third of Kowalczyk’s hospital patients followed her to the clinic. Kowalczyk said she turned down one job offer and held out for an offer from Chestnut Ridge because the clinic was among a few to accept Medicare patients, which would allow her Medicare patients to follow her, if they chose.

Patients found the transition stressful Kowalczyk said, but new clinic patients receive the same help with transportation and other support that hospital patients received. Some patients struggled with fear as the move approached, and she found her self repeatedly seeking to calm their anxieties.

“In their life, it’s like an upheaval,” she said. “It’s almost like an earthquake.” <<