INPATIENT PRACTICE

Psych Beds in General Hospitals Needed

Almost half of all psychiatric admissions to a 24-hour facility in the United States are made to a psychiatric unit in a general hospital. The number of psychiatric beds in general hospitals probably peaked in 1998, at 54,434 beds.

Since then, however, the decline of psychiatric beds has been steady. A 2006 survey of state mental health authorities, for example, reported that 80% of states have a shortage of psychiatric beds.

At the same time, one survey of emergency departments showed that mental health–related visits rose 75% from 1992 to 2003. Furthermore, it is thought that nurses in emergency departments spend twice as much time finding beds for psychiatric patients as they do for medical patients.

What explains these trends? Most experts point to an evolution in venues where inpatient services are provided. In 1970, about 80% of psychiatric beds were in state- and county-run mental hospitals.

But those closed throughout the 1970s. Until the late 1990s, private hospitals compensated for the loss of the government hospitals by opening psychiatric units because the reimbursement situation was favorable. However, that no longer appears to be the case, according to Dr. Benjamin Liptzin, who serves as chair of the department of psychiatry at Baystate Medical Center, Springfield, Mass., and is a professor of psychiatry at Tufts University, Boston.

From the peak in 1998, the number of psychiatric beds in general hospitals dropped to 40,000 in the year 2000, while admissions were increasing. It has been estimated that the number has dropped an additional 3% since 2003.

Reimbursement no longer favors psychiatric beds, Dr. Liptzin says.

In 1983, Medicare enacted the prospective payment system for hospitals, but psychiatric services were exempt because the costs and needs of psychiatric patients were deemed too unpredictable. Later, managed care cost-cutting hit the market, and in 2005 the Medicare exemption was rescinded. As a consequence, the number of beds in private and general hospitals is falling.

Dr. Liptzin believes that if nothing is done to reverse this trend, the future of psychiatric services in general hospitals will be in peril. CLINICAL PSYCHIATRY NEWS spoke with Dr. Liptzin about the situation.

CLINICAL PSYCHIATRY NEWS: What kinds of trends have you observed in the area of inpatient psychiatric services?
Dr. Liptzin: The beds in private and general hospitals increased dramatically with the availability of health insurance coverage and the decline of the public mental health system. The number had been going up during the 1990s and only more recently declined.

CPN: What factors explain this decline?
Dr. Liptzin: There are a couple of explanations. One is that length of stay has come down, so not as many beds are needed. But also, the reimbursement has become inadequate. In Massachusetts, for example, general hospitals are now being reimbursed for psychiatric services by Medicaid at 39% less than their costs.

CPN: Admissions and emergency department visits are going up. If length of stay is going down, how would you assess the need for beds?
Dr. Liptzin: I think the demand has gone down some, but the reason beds are being closed is largely economic.

CPN: You recently wrote a commentary titled, "The Future of Psychiatric Services in General Hospitals" (Am. J. Psychiatry 2007;164:1468-72). What led you to write that commentary?
Dr. Liptzin: I talk to colleagues all around the country, and all feel the same economic pressure: that is, that psychiatry in the general hospital is a money loser, and there is always pressure from senior hospital administrators to either close beds or at least improve the financial performance. That's hard to do in states where there is a lot of managed care. So somebody needed to stand up and say that this isn't working.

CPN: What is it about psychiatric units that have made them so vulnerable to downsizing?
Dr. Liptzin: Reimbursements are set differently for psychiatry. And general hospitals have not gone to the mat for their psychiatric services as long they are making money on their other services.

Then, when there is a choice between how to allocate beds, the hospitals say, 'Well, we can add more cardiology and surgical beds, or we can keep our psychiatric beds. We make money on the first, and we lose money on the second.' Even though you are a nonprofit, it is hard to resist that pressure.

CPN: And do they lose money on psychiatric beds?
Dr. Liptzin: By and large, they do. There are people who will argue that the overhead costs in general hospitals are too high, that we pick up costs for the emergency department, and a full radiology suite and all of that, even though we don't use all those services. But private psychiatric hospitals are not as profitable as they used to be, either. This raises a public policy decision. Do we want to force patients out of the mainstream of medical care into freestanding psychiatric hospitals? I think we do not. Some patients with combined medical and psychiatric needs need to be in general hospitals. How are we going to have those available if we are closing psych units?

CPN: How does the notion of mainstreaming psychiatric patients fit in this discussion?
Dr. Liptzin: That's another piece, as opposed to 100 years ago when people were sent off to distant asylums and their care was not seen as part of general medical care. That was harmful. Plus, a lot of psychiatric patients wind up in general hospitals. They have surgical procedures, or they have medical problems, or they show up in the emergency departments. So if you separate out their inpatient psychiatric care, it becomes much harder to coordinate the care and deliver it efficiently.

CPN: Do we need to enhance the quality of care in general hospitals?
Dr. Liptzin: We need to make a decision about inpatient beds in general hospitals, and whether we need them. I would argue that we do, partly for patients who have comorbid medical and psychiatric problems, but also because general hospitals tend to be the academic medical centers where medical students and residents need to learn something about psychiatry.

Also, academic medical centers are doing all the research to develop new treatments and new ways to diagnose people. Destroying that system would have wide repercussions for the whole field of psychiatry. ■

By Timothy F. Kirn, Sacramento Bureau. Send your thoughts and suggestions to cpnews@elsevier.com.

Evidence Base Lacking for Medicare Coverage Decisions

BY LEANNE SULLIVAN
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Data reviewed by the Centers for Medicaid and Medicare Services to inform Medicare treatment coverage decisions reflect populations that are significantly different from the Medicare beneficiary population, a recent analysis has shown.

In 1998, the CMS established a panel of physicians and other professionals to review the evidence base before the agency makes national Medicare coverage decisions. The independent panel, now called the Medicare Evidence Development and Coverage Advisory Committee (MedCAC), reviews the literature described in a technology assessment and votes on the evidence to determine the health benefit of the medical procedure or device, wrote Sanket S. Dhruva and Dr. Rita F. Redberg, both of the University of California, San Francisco, which, along with the Robert Wood Johnson Foundation, provided support for the study. Dr. Redberg is a member of MedCAC, but had no financial conflicts of interest to disclose.

To examine whether the data used by MedCAC was generalizable to the Medicare population, Mr. Dhruva and Dr. Redberg looked at all six MedCAC decisions involving a cardiovascular product or service and analyzed the sample size, participant demographics, inclusion criteria, study location, and outcome stratification of the relevant technology assessments. The data in the technology assessments used for these six decisions included 141 peer-reviewed reports and 40,009 patients (Arch. Intern. Med. 2008;168:136-40).

Of 135 studies that reported clinical trial location, most (51.1%) were done in Europe.

DR. REDBERG

Significant differences were found between the study populations and the Medicare population. Participants in the trials described in the technology assessments were significantly younger (mean age, 60.1 years) than were most Medicare beneficiaries (mean age 70.8 years). Several trials excluded older patients, but "the mean age in studies with explicit age exclusions (59.0 years) and those without such exclusions (60.9 years) did not differ," the authors wrote.

"Studies for each cardiovascular [technology assessment] also differed significantly from the Medicare population in terms of sex," they continued. Of the study participants, 75.4% were men, compared with 43.7% of Medicare beneficiaries. Several of the studies had excluded women, but none excluded men.

Clinical trial location also was not representative of the Medicare population. Of 135 studies that reported location, 37% took place at least partly in the United States. However, most (51.1%) were done in Europe, 8.9% in Asia, and 6.7% in other locations. Overall, 40% of the technology assessment study participants were U.S. residents, compared with 100% of the Medicare population.

In addition, many of the trials excluded patients with conditions such renal insufficiency and diabetes that are common in the Medicare population.

To improve the relevance of the data used for coverage decisions, the authors suggested that future studies include demographic information. They also suggested that the CMS adopt a policy requiring data on women and the elderly, which would encourage trial investigators to include such data.

An alternative approach would be for the CMS to issue coverage decisions dependent on the addition of subgroup data within a specified period of time. ■