
Topic: State Hospitals Fill the Void of Community-based Crisis Services: Does Privatization Work?

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I have been asked to provide an update on the hospital system in the state and whether privatization will work, given our particular system. The answer is, “It depends.” We should never doubt, as Margaret Meade wrote once, that a small group of dedicated people can change the world. Indeed, nothing else ever has. So I do believe that advocacy is an essential piece to improving our system, whatever improvement we decide upon. We have a tremendously dedicated staff of individuals in our hospitals. We have seven hospitals across the state, serving consumers every day in large numbers. Last month, our utilization on adult mental health was at 108 percent, and it reached 130 percent for some hospitals for some days.

We have an acute-care mission in our hospitals. We do not, as in many other hospitals, only serve chronic-care patients. That probably explains a large part of the higher utilization rate of beds in our hospitals than in other states. For example, a person in Florida cannot apply for admission to the state hospital until he/she has been hospitalized for 30 days. Our state hospitals are on the front line, along with our crisis stabilization units. It is important to identify that there is a need for both inpatient care and crisis stabilization and that the missions are different. Crisis stabilization has a focus on stabilizing systems so individuals can receive their care on an outpatient basis. Inpatient psychiatric care focuses on stabilizing illnesses that cannot be stabilized on an outpatient basis.

We have a challenge in providing care where people are. We have a challenge in providing appropriate care. We need more crisis stabilization, and crisis stabilization is appropriate for many of the people we serve in our state hospitals. Our crisis stabilization units need to increase. However, under an agreement with the Georgia Hospital Association, our crisis stabilization units can be operated only by the state or by a community service board. So privatizing crisis stabilization would require certificates of need for inpatient psychiatric beds. It is not possible in our state under our current rules to just privatize crisis stabilization.

Our state facilities do operate some community services where we have had difficulty identifying private providers who were willing to provide those services. We do have a crisis stabilization program for children and adolescents in the Savannah area in addition to our two child and adolescent units in the Atlanta and Central State hospitals. We also have an assistive community treatment team in the southwest area of the state out of the Thomasville hospitals. And we have a crisis stabilization unit there as well that is state-operated because we have been unable to find willing community providers to provide those services.

We are working diligently to improve our hospitals. We recently implemented a contract with APS Healthcare as an external review organization to collect data and look at inappropriate hospitalizations and what community services are needed to

be able to prevent those inappropriate hospitalizations. We are implementing an electronic medical record, which will give us access to data about the care we provide and how well we are doing and will enable us to improve our care. We are using the treatment model approach at many, if not all, of our hospitals to ensure we can individualize care and that we have many

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different groups and classes offered at the same time and people can go to the treatment that they need. We are among the lowest in the nation in the use of seclusion and restraint at our hospitals, and we are proud of the efforts that we have made and the response we have gotten to those initiatives to decrease seclusion and restraint. We are implementing evidence-based practices. We are implementing algorithms, and we are working on replacing treatment plans with an individual recovery plan that will belong to the consumer and will go with the consumer into the outpatient setting. That planning process has to be person-centered.

We have seven hospitals in five administrative regions. These regions are aligned to match the regions for the departments of Juvenile Justice and Family and Children's Services so that we can improve collaboration with our sister organizations.

It is important for people to understand and recognize, as we begin to consider privatization, what the Georgia Code has to say about the difference between public and private facilities. Public facilities must take all comers at all times. A private facility that agrees to become an emergency receiving facility under Georgia law may decline to accept any patient who is unable to pay it for hospitalization or for whom it has no available space.

When we have someone sent on a 1013 [involuntarily committed] to one of our state hospitals, these are the three things we do: We are an emergency receiving facility, and we do assessments. We are an evaluating facility, and we evaluate the health of people. And we are a treatment facility treating people with mental illnesses.

We also have a responsibility to accept those individuals who have substance abuse problems; however, we currently do not provide active substance abuse treatment. We are working to provide education, and we are working to integrate with substance abuse facilities external to our hospitals so we can hook people in. That is another challenge that we have.

Again, according to code, we have to accept those who are brought to our facilities, and we have to take custody of any patient that a private facility requests to transfer to our facilities. We have been studying privatization, trying to do some cost-benefit analyses and looking at options in terms of privatizing. The first option we came up with was to privatize a state facility or facilities. As we have worked to develop our seven hospitals into a hospital system rather than seven hospitals, we would lose some of our flexibility to move beds, to collaborate, and coordinate care. Some of the proposals we have seen include increasing salaries for our hospital staff as part of privatization. Increasing salaries is a needed action. However, if we privatize one facility, or one or two facilities, and increase salaries at those facilities, that is going to increase pressure on the state salary scale for professionals at our other hospitals.

Contracting may need to include an option to bid on the provision of essential community services. The integration of the hospital and community services and the

flow across the continuum of care are extremely important issues. One of the things we struggle with is how to build community services that are needed in order to keep people out of the hospital and to get people out of the hospital. Can we require a privatized facility to accept all comers and not say “no,” just like our state facilities? We can certainly write that into a contract, but such a privatized facility could decide to challenge that portion of a contract because of the state law. A private contractor, however, may bring ideas and innovations to our hospital system that are needed and may bring some flexibility in terms of

financing and in terms of quick responses to immediate needs that are more difficult in a bureaucracy such as the state.

The second option we looked at is to privatize a service or a system of care. We have variable types of management and different service lines at our different hospitals. Might it be a better option to privatize child and adolescent care, to privatize forensics, to privatize any number of different service lines across the state rather than privatizing a single facility with all of the service lines? There are these systems of care that need to be developed where the monies are in different departments and divisions across the state. Is this an opportunity to save and improve consistency of care? Aside from the systems of care, we also have looked very actively at – and, in fact, have a request for proposal out – for privatizing services such as pharmacy within our hospitals. We also are investigating whether or not privatizing food service across all the hospitals might be an option. So privatization does not necessarily have to focus on a single facility or facilities but may make more sense if you are privatizing particular services across facilities.

The third option we have looked at is doing both. Why not privatize one or more facilities and a service or system of care? Services do not exist at all facilities. There are some services that have a particular hub where it might make sense to privatize that hospital and the service of care where they serve as a primary. The division is interested in receiving input from the community as we move forward.

