



DOCKET NO: I-02	BOARD MEETING: April 21, 2015	PROJECT NO: 14-046	PROJECT COST: Original: \$1,597,618
FACILITY NAME: Decatur Memorial Hospital		CITY: Decatur	
TYPE OF PROJECT: Substantive			HSA: IV

PROJECT DESCRIPTION: The applicant (Decatur Memorial Hospital) is proposing to establish a 20-bed acute mental illness category of service (geriatric psychiatric unit) on the campus of Decatur Memorial Hospital (DMH), Decatur. The cost of the project is \$1,597,618. **The anticipated project completion date is March 31, 2016.**

This project received an intent to deny at the December 16, 2014 State Board Meeting. Additional information was provided by the applicant to address the intent to deny.

The applicant stated the following: *"The following information will reply to the issues raised in the State Staff Report, the opposition letters and the questions asked by the Board Members. First, in response to the letter from St. John's Medical Center located in Springfield, St. John's is located according to map quest at 43 minutes from the applicant facility. The State Board's rules refer to a 45 minute travel time under Criterion 1110.730.c.5) v) which impacts only that criterion if the applicant is claiming that there are restrictive admission policies which prevent the applicant's patients from receiving care at another facility. Distance is, however, a factor to be considered. Several studies (Persky 2014, Mojtabi 2009, Bruce, Citters, Bartels, 2005) show that access to transportation is a significant component contributing to older adults not receiving necessary psychiatric treatment- both inpatient and outpatient. For the older adult, driving significant distances has been demonstrated to be an impediment to either accessing or participating in the treatment process for a spouse. The applicant has not claimed that St. John's Hospital has restrictive admission policies, but rather has stated that the Decatur Memorial patients have declined to seek care that is more than 30 minutes from their homes and physicians. Criterion 1110.730.d.1) requires the applicant under the unnecessary duplication of services to consider all facilities within 30 minutes travel time rather than 45 minutes travel time, which leaves only St. Mary's Decatur as a facility to be considered for unnecessary duplication of services. Decatur Memorial Hospital has had continuing difficulties in trying to' admit patients to' St. Mary's Hospital with psychiatric diagnoses who also require continuing simultaneous medical care. St. Mary's psychiatrists decline these patients due to their medical conditions. This category of patient makes up the majority of the patients proposed to be served in the new unit. At Decatur Memorial Hospital the patients' normal medical physicians and hospitalists will be available to treat medical conditions while the psychiatrist and psychologists address the psychiatric illness. The proposed project is not an unnecessary duplication of services but rather the extension of the services now provided by Decatur Memorial Hospital. The patients proposed to' be treated in the new unit will be patients who are currently treated at DMH as Medical Surgical Patients, but need the extended care for a secondary psychiatric diagnosis. The patients are above the age of 50 and have dual diagnosis which if treated correctly can avoid the need for long-term care or repeated admission to the hospital to care for*

their underlying psychiatric diagnosis. The proposed calculation of bed need differs from the State Board's formula in that it is an incidence based calculation rather than the demand based calculation used by the Board. The applicant's formula tries to' be proactive in treating the patient rather than calculating the need solely on the basis of who actually seeks care. The applicant's model will make care more readily available to' the patient allowing for earlier treatment and better results. This methodology is supported by the research studies referenced in the original application. This methodology indicates that a substantial number off geriatric patients are not receiving the care that they need in the hospitals and are, as a result, placed in Long-Term Care Facilities rather than being treated and allowed to maintain their independent living status. The need for the proposed beds is supported by the applicant's historical utilization by patients with a dual diagnosis. If only 25.4% of the 2,774 patients treated at DMH with a dual diagnosis of a medical problem and a psychiatric diagnosis (705 patients) were to be treated in the proposed unit, based upon an average length of stay of 8.8 days, the proposed 20 bed unit would achieve the target occupancy rate of 85%. Based upon these figures, it is clear that the proposed project would not be a maldistribution of services and would not negatively impact any other hospital in the planning area. The Board discussion of this project also centered on two other issues: the size of the project, and the staffing of the facility. In regard to' the size of the project the applicant agrees that the space proposed will exceed the State Norms, however, this deviation from the State Norm is made necessary by the utilization of existing space rather than constructing new space or even completely gutting and remodeling existing space to' accommodate the proposed beds. It would be much more expensive to' pursue either of these two options. The hospital currently has underutilized bed space which can accommodate the proposed unit without adding space or beds to the hospitals bed count. The proposed unit will result in a net zero change in the hospital space and number of beds. In regard to staffing, the applicant will be working with Diamond Healthcare to recruit the necessary staffing including Psychiatrists and where needed psychologists. The existing psychologists who work with hospital patients currently will remain actively involved in the proposed unit. The hospital will also work closely with the existing community mental health programs and providers to insure that all of their services are available to our patients upon discharge and when appropriate during their hospital stay. A question was also raised regarding the applicant's commitment to providing care to Geriatric patients rather than other age groups once the application was approved. We do not have any plans to treat any age group other than the elderly in the proposed unit. This unit will be designed to care for the older adult patient and will not be used to treat other AMI patients."

At the conclusion of this report are the supplemental information provided by the applicant and the December 2014 State Board Meeting Transcripts.

EXECUTIVE SUMMARY

PROJECT DESCRIPTION:

- The applicant (Decatur Memorial Hospital) is proposing to establish a 20-bed acute mental illness category of service. The applicant states the unit will be used to provide service to the geriatric population. The cost of the project is \$1,597,618. **The anticipated project completion date is March 31, 2016.**
- Current State Board rules do not distinguish between geriatric and adolescent acute mental illness care.
- The 20-bed unit will be located on the sixth floor of the hospital, in existing space currently being used as a Medical/Surgical (Med/Surg) Unit. The project also involves the discontinuation of 20 Med/Surg beds to accommodate this unit.

WHY THE PROJECT IS BEFORE THE STATE BOARD:

- This project is before the State Board because the project proposes to establish a category of service as required by Illinois Health Facilities Planning Act.

PURPOSE:

- In 2013, the applicant reports having treated 2,774 geriatric patients at DMH who had secondary psychiatric diagnoses alongside their initial medical conditions. The applicant notes these patients may have benefited from additional treatment in a separate psychiatric unit, equipped to treat both the psychiatric condition with the condition that warranted admission to DMH. The applicant states these patients lacked specific bed space dedicated to treating these compounded conditions, and if only 25 of the 2,774 patients identified in this 2013 population were treated, would have had a dedicated 20-bed geriatric AMI unit operating at the State Board utilization standard of 85%.

PUBLIC COMMENT:

- A public hearing was offered but no hearing was requested. The State Board Staff has received opposition letters regarding the proposed project.

CEO of St John's Hospital Springfield stated: *"I am the CEO of St. John's Hospital and am writing to oppose the proposed AMI unit that Decatur Memorial wishes to establish. It is duplicative of St. John's unit. Also, the application incorrectly states that St. John's does not provide geriatric services, In fact, all of the AMI beds at St. John's operate to serve patients 65 and older. The utilization of the beds is 54.9% (based on 2013 data), We have ample capacity to serve patients in need of psychiatric services who are 65 years or older, I also want to point out that in Decatur, St. Mary's, which is part of the same health care system as St. John's (Hospital Sisters Health System) operates 56 AMI beds, including a geriatric psychiatry service, As a result, St. John's and St. Mary's can and do collaborate and work together to serve the patient population at issue in Health Service Area 4, where there is a stated excess of 78 AMI beds per your inventory. I find the proposal to be unnecessary, It will result in a duplication of services and negatively impact St. John's Hospital. I appreciate your consideration of our concerns, and urge you to deny the project."*

CEO St. Mary's Hospital Decatur "I am writing on behalf of St. Mary's Decatur to oppose the above referenced application filed by Decatur Memorial Hospital ("Decatur Memorial") to establish a 20 bed Acute Mental Illness ("AMI") unit. It will be duplicative of services we already offer at our hospital, also in Decatur, and will negatively impact us. Decatur Memorial's proposed 20 bed AMI unit is unnecessary and unsupported by any physician referrals letters, as required by Health Facilities and Services Review Board rules. St. Mary's operates a 56 bed AMI unit. In 2013 the utilization of the unit was 73.7%, which is not at State Board target utilization. The unit has capacity to treat additional patients. Also, the unit provides care to geriatric patients. The Decatur Memorial application states that of St. Mary's 56 AMI beds only 14 are dedicated to geriatric psychiatric services. While this is currently true, St. Mary's can re-allocate more beds to geriatric patients as needed. The HFSRB rules do not distinguish between services/beds as relates to adult, geriatric or pediatric psychiatric services. Certainly the Hospital will re-allocate some of its current psychiatric beds to accommodate patients age 65 or older, if the need is present. With this said, I would like to point out some concerns about the application itself.

They are as follows:

- The application requests approval for an AMI service per the Board's rules. While the applicant states its services will be limited to geriatric patients, there is nothing that would prevent the applicant, once approved, from treating all ages in the unit.
- The application states architects' drawings are "N/A". However, the majority of the costs for the project are construction costs (for modernization) and Attachment 7 refers to architect/engineering fees. Further, there are specific IDPH design standards for AMI units, so it is likely the applicant is working with an architect. Thus, the applicant should note what stage of drawings the design is in.
- In the text of the application there is a statement that there is a need for beds in the area, even with the addition of the proposed 20 beds. This is misleading. The purported need is based on the applicant's calculation. In fact, there is an excess of 78 AMI beds in Health Service Area 4, per HFSRB need calculation.
- The alternatives section of the application contains no cost information for the alternatives considered, as required by HFSRB rules.
- The application contains no certified referral letters, as required by HFSRB rules. In looking at past applications to establish AMI units, the applicants provided referral letter. Decatur Memorial simply states that because it does not have a psychiatric service, it cannot provide referral letters. This is inaccurate and unacceptable. First, Decatur Memorial has two psychiatrists on staff. Either they or internists or ED physicians who see patients that require psychiatric services could provide referral letters. The application is devoid of any evidence supporting utilization of the unit at State Board target, because it has no referral letters indicating any physician will refer patients to Decatur Memorial. It also begs the question of whether these physicians (particularly the psychiatrists on staff) are currently referring to St. Mary's in Decatur, which precludes an analysis of true impact on St. Mary's should the Decatur Memorial application be approved. In summary, the application is proposing a service in an area with a significant number of excess beds - there is no need. In addition, the application proposes services that are duplicative of services in the same town, just minutes away

from the applicant's hospital. Further, the service is duplicative of other area hospitals' services in the area. There is ample capacity to address the patient population Decatur Memorial references (albeit without any physician referral letters to support same). The application provides no referral letters as required and/or evidence that in fact the applicant will achieve target utilization within two years as required. If necessary, the HFSRB has St. Mary's commitment to re-allocate some of its 56 AMI beds to serve patients 65 and older, if there is a need in the future for same. As a result of all of the above, I urge you to deny Decatur Memorial's request to establish an additional AMI unit in Decatur."

NEED:

- There is a calculated excess of 78 Acute Mental Illness (AMI) beds in the Health Planning Area 04, per the March 2015 Revised Bed Need Determination. However there are few facilities offering this specialized psychiatric service in the immediate service area, with the closest facilities offering this service located at St. Mary's Hospital, Decatur (9 minutes away).

TABLE ONE Facilities Closest to Decatur Memorial Hospital (50 minutes) Offering AMI Services				
Hospital	City	Time (min)	AMI Beds	Utilization
St. Mary's Hospital	Decatur	9	56	73.7%
St. John's Hospital	Springfield	43	40	71.5%
Lincoln Prairie Behavioral Health Center	Springfield	44	88	69.4%
Memorial Medical Center	Springfield	46	44	54.9%

FINDINGS:

- The applicants addressed a total of 18 criterion and did not meet the following:

State Board Standards Not Met	
Criteria	Reasons for Non-Compliance
1110.234 (a) - Size of the Project	The applicant exceeds the State Board Standard by 56 GSF per bed. The applicant stated <i>"The utilization of existing space makes it impossible to meet State Board standards for this unit. The existing layout of the floors and bay space present problems when trying to develop the space in the most efficient manner, resulting in spaces being somewhat larger than required"</i> .
1110.730(b) – Planning Area Need	The applicant proposes to establish a 20-bed AMI unit specializing in geriatric psychiatric services. HPA-04 currently reports having an excess of 78 AMI beds, and there are

State Board Standards Not Met	
Criteria	Reasons for Non-Compliance
	underutilized AMI facilities in the service area. One of the underutilized hospitals (St. Mary's Hospital, Decatur), offers geriatric psychiatric services.
1110.730 (c) – Impact on Other Providers/Maldistribution	HPA-04 currently reports having an excess of 78 AMI beds, and there are underutilized AMI facilities in the service area. One of the underutilized hospitals (St. Mary's Hospital, Decatur), already offers geriatric psychiatric services.

STATE BOARD STAFF REPORT
Decatur Memorial Hospital
PROJECT #14-046

APPLICATION CHRONOLOGY	
Applicant	Decatur Memorial Hospital
Facility Name	Decatur Memorial Hospital
Location	Decatur, Illinois
Application Received	September 5, 2014
Application Deemed Complete	September 5, 2014
Can Applicants Request a Deferral?	Yes

I. The Proposed Project

The applicants are proposing to establish a 20-bed acute mental illness category of service on the campus of Decatur Memorial Hospital, Decatur. The estimated cost of the project is \$1,597,618. The anticipated project completion date is March 31, 2016.

II. Summary of Findings

- A. The State Board Staff finds the proposed project **DOES NOT** appear to be in conformance with the provisions of Part 1110.
- B. The State Board Staff finds the proposed project appears to be in conformance with the provisions of Part 1120.

III. General Information

The applicant is Decatur Memorial Hospital. Decatur Memorial Hospital is located at 2300 North Edwards Street, Decatur, Illinois in the HSA IV Service Area and Acute Mental Illness Planning Area 4. HSA IV and the acute mental illness planning area includes the Illinois counties of Livingston, Ford, Iroquois, McLean, Vermilion, Champaign, DeWitt, Piatt, Macon, Moultrie, Shelby, Coles, Douglas Edgar, Clark, and Cumberland.

The licensee operating entity and owner of the site is Decatur Memorial Hospital. There are five hospitals in the Acute Mental Illness Planning Area 4 that provide acute mental illness services.

Facilities within the HSA 04 AMI Planning Area				
Facility	City	Beds	Time	Utilization
Advocate BroMenn Regional Medical Center	Normal	19	54	52.40%
Presence Covenant Medical Center	Urbana	30	55	38.90%
Sara Bush Lincoln Health Center	Mattoon	20	70	41.10%
St. Mary's Hospital	Decatur	56	9	73.70%
The Pavilion Foundation	Champaign	69	48	69.50%

The March 2015 Revised Bed Determination indicates a calculated excess of 78 Acute Mental Illness beds in the Acute Mental Illness Planning Area 4.

The estimated start-up costs/operating deficit for this project is \$1,455,737. This is a substantive project subject to a Part 1110 and Part 1120 review. Project obligation will occur after permit issuance.

IV. Summary of Support and Opposition Letters

No public hearing was requested. Letters of opposition were received by the State Board Staff.

V. The Proposed Project - Details

The applicant is proposing to establish a 20-bed acute mental illness category of service, specializing in the care of geriatric AMI patients at Decatur Memorial Hospital, Decatur. The proposed service will be located on the sixth floor of the existing hospital, in 12,315 GSF of space. The proposed project will also involve the discontinuation of 20 Med/Surg beds to accommodate the new service. Upon project completion, the overall bed complement at Decatur Memorial Hospital will remain at 300 beds, with the Med/Surg bed complement being reduced from 224 to 204. The cost of project is \$1,597,618.

VI. Project Costs and Sources of Funds

The applicant is funding this project internally, with cash and securities of \$1,597,618. Debt is not being used to fund this project, and all identified costs are classified as clinical.

TABLE TWO	
Project Costs and Sources of Funds	
USE OF FUNDS	CLINICAL
Preplanning Costs	\$20,000
Modernization Contracts	\$1,278,748
Contingencies	\$143,420
Architectural/Engineering Fees	\$153,450
Consulting & Other Fees	\$2,000
TOTAL USES OF FUNDS	\$1,597,618
SOURCE OF FUNDS	CLINICAL
Cash and Securities	\$1,597,618
TOTAL SOURCES OF FUNDS	\$1,597,618

VII. Cost Space Chart

The applicant is proposing a total of 12,315 GSF of space for this service.

TABLE THREE Cost Space Chart					
Department	Cost	Proposed GSF	New Construction	As Is	Vacated
AMI Unit	\$1,597,618	12,315	12,315	0	0
Total Clinical	\$1,597,618	12,315	12,315	0	0

VIII. Section 1110.230 - Project Purpose, Safety Net Impact and Alternatives

A) **Criterion 1110.230 (b) - Purpose of the Project**

The applicant shall document that the project will provide health services that improve the health care or well-being of the market area population to be served. The applicant shall define the planning area or market area, or other, per the applicant's definition.

The applicants stated the following regarding the purpose of the project.

In 2013, the applicants report having served 2,774 patients age 60 and older who presented with secondary psychiatric diagnoses, and would have benefitted from having treatment in a separate psychiatric unit, equipped and staffed to treat both medical and psychiatric conditions simultaneously. The applicant acknowledges the excess of AMI beds in HPA-04, but attributes this overage to the conglomeration of adolescent psych, adult psych, and geriatric psych data. The applicant isolated the utilization data for the geriatric patient base, and identified a need for 55 beds in the region. The applicant also notes the only other provider of specialized AMI services for the elderly is St. Mary's Hospital, Decatur. This facility currently has 56 AMI beds to serve all three age demographics. The applicant propose to establish a 20-bed AMI unit, dedicated to the geriatric psych population, in an effort to meet the needs of an underserved portion of the AMI population in the region.

B) **Criterion 1110.230(b) - Safety Net Impact Statement**

All health care facilities, with the exception of skilled and intermediate long-term care facilities licensed under the Nursing Home Act [210 ILCS 45], shall provide a safety net impact statement, which shall be filed with an application for a substantive project (see Section 1110.40). Safety net services are the services provided by health care providers or organizations that deliver health care services to persons with barriers to mainstream health care due to lack of insurance, inability to pay, special needs, ethnic or cultural characteristics, or geographic isolation. [20 ILCS 3960/5.4]

The applicant stated the following:

"The hospital currently serves as a safety net hospital for a n an area with historically high unemployment and a substantial minority population. The population projections utilized to develop this project shows that the area has experienced more than a 10% growth in the population age 65 and over, which

means an increasing number of Medicare patients will be served by this hospital. The proposed project will allow the hospital to provide additional services to the planning areas geriatric population without adversely impacting any other are facility's ability to also serve as a safety net for their patients. All of the projections used in this application show that a significant number of additional beds are needed to serve the geriatric psych population of the area"

The applicants supplied charity care information, which is illustrated in Table Four.

TABLE FOUR			
Safety Net Information per PA 96-0031			
	2011	2012	2013
Net Revenue	\$247,225,994	\$246,286,986	\$243,155,509
Amount of Charity Care (charges)	\$23,734,612	\$23,792,647	\$23,762,064
Cost of Charity Care	\$5,548,867	\$5,713,114	\$5,422,408
Ratio	\$2.24%	2.32%	2.23%
CHARITY CARE			
Charity (# of patients)	2011	2012	2013
Inpatient	977	1,020	935
Outpatient	13,979	15,210	13,019
Total	14,956	16,230	13,954
Charity (cost In dollars)			
Inpatient	\$2,020,583	\$1,713,562	\$1,897,179
Outpatient	\$3,528,284	\$3,999,552	\$3,525,229
Total	\$5,548,867	\$5,713,114	\$5,422,408
MEDICAID			
Medicaid (# of patients)	2011	2012	2013
Inpatient	2,360	2,400	2,324
Outpatient	42,415	41,964	40,592
Total	44,775	44,364	42,916
Medicaid (revenue)			
Inpatient	\$8,192,738	\$7,349,672	\$6,895,729
Outpatient	\$7,091,432	\$6,471,656	\$6,048,820
Total	\$15,284,170	\$13,821,328	\$12,944,549

C) Criterion 1110.230 (c) - Alternatives to the Proposed Project

The applicant shall document that the proposed project is the most effective or least costly alternative for meeting the health care needs of the population to be served by the project.

The applicant reviewed the following three alternatives:

1) Do Nothing

The applicant rejected this alternative, due to the inability to address the growing need for inpatient geriatric psych services at DMH. In the absence of the proposed service, DMH's geriatric psych patient population would have gone without care, or be placed in nursing homes. The applicant did not identify a cost with this alternative.

2) Construct an Addition to the Existing Hospital

The applicant rejected this option for two reasons. 1) it was determined that the cost of constructing a new addition would be triple the cost for upgrading/utilizing existing space. 2) The applicant reports having an excess of Med/Surg beds, which could easily be remodeled to meet the needs of a Geri-Psych program, without adversely impacting the applicant's ability to serve the inpatient needs of the area. The applicant did not identify a project cost with this option.

3) Alternative as Proposed

The applicant chose the alternative to convert existing Med/Surg bed space, based on its low cost, and availability of bed space for a 20-bed unit. The applicant found the option chosen was the least costly alternative to meet the needs of the planning area, in the most efficient manner possible.

IX. Section 1110.234 - Project Scope and Size, Utilization

A) Criterion 1110.234 - Size of Project

- 1) The applicant shall document that the physical space proposed for the project is necessary and appropriate.**

The following table shows the project's square footage versus the State Norms:

TABLE FIVE Size of the Project				
	Proposed GSF	State Standard		Difference
20 Bed AMI Unit	12,315 GSF	440-560 GSF//Bed	11,200 GSF	1,115 GSF over/ 56 GSF/Bed

The applicant is proposing a total of 12,315 GSF for a 20-bed AMI unit. This is factored down to 616 GSF/bed, which exceeds the State standard by 56 GSF per bed (See Table Five).

The applicant stated in regards to the GSF overage *“The utilization of existing space makes it impossible to meet State Board standards for this unit. The existing layout of the floors and bay space present problems when trying to*

develop the space in the most efficient manner, resulting in spaces being somewhat larger than required”.

A negative finding has been found for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE SIZE OF THE PROJECT CRITERION (77 IAC 1110.234 (a)).

B) Criterion 1110.234 (b) - Project Services Utilization

The applicant shall document that, by the end of the second year of operation, the annual utilization of the clinical service areas or equipment shall meet or exceed the utilization standards specified in Appendix B.

The applicant is proposing to establish a 20-bed AMI unit dedicated to the care of geriatric psych patients, and bases the need for this project on the prevalence rate of individuals in this specific age group requiring necessary intervention in order to allow the individual to perform normal activities of daily living. The applicant notes having treated 2,774 patients in 2013, with either primary or secondary diagnoses of mental illness. The applicant notes that the unit would achieve acceptable occupancy standards (85%), if only 705 patients were treated in the unit, after project completion. This is based on an average length of stay consisting of 8.8 days. Based on these projected utilization data, a positive finding results for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECT SERVICES UTILIZATION CRITERION (77 IAC 1110.234 (a)).

X. Section 1110.730 - Acute Mental Illness – Review Criteria

a) Introduction

- 1) This Section applies to projects involving Acute Mental Illness (AMI) and Chronic Mental Illness (CMI). Applicants proposing to establish, expand or modernize AMI and CMI categories of service shall comply with the applicable subsections of this Section, as follows:

PROJECT TYPE	REQUIRED REVIEW CRITERIA
Establishment of Services or Facility	(b)(1) & (3) – Background of the Applicant
	(c)(1) – Planning Area Need – 77 Ill. Adm. Code 1100 (formula calculation)
	(c)(2) – Planning Area Need – Service

PROJECT TYPE	REQUIRED REVIEW CRITERIA
	to Planning Area Residents
	(c)(3) – Planning Area Need – Service Demand – Establishment of AMI and/or CMI
	(c)(5) – Planning Area Need – Service Accessibility
	(d)(1) – Unnecessary Duplication of Services
	(d)(2) – Maldistribution
	(d)(3) – Impact of Project on Other Area Providers
	(f) – Staffing Availability
	(g) – Performance Requirements
	(h) – Assurances

B) Criterion 1110.730 (a) - Background of Applicant

1) **An applicant must demonstrate that it is fit, willing and able, and *has the qualifications, background and character to adequately provide a proper standard of health care service for the community.* [20 ILCS 3960/6**

The applicant supplied licensing and accreditation information on pages 32-35 of the application. The applicant also attested that the State Board may access any documentation that the State Board deems pertinent to the application for permit.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH BACKGROUND OF APPLICANT CRITERION (77 IAC 1110.730(a))

C) Criterion 1110.730 (b) - Planning Area Need

The applicant shall document that the number of beds to be established or added is necessary to serve the planning area's population.

1) 77 Ill. Adm. Code 1100 (Formula Calculation)

A) The number of beds to be established for each category of service is in conformance with the projected bed deficit specified in 77 Ill. Adm. Code 1100, as reflected in the latest updates to the Inventory.

2) Service to Planning Area Residents

A) Applicants proposing to establish or add beds shall document that the primary purpose of the project will be to provide

necessary health care to the residents of the area in which the proposed project will be physically located (i.e., the planning or geographical service area, as applicable), for each category of service included in the project.

3) Service Demand – Establishment of AMI and/or CMI

The number of beds proposed to establish a new AMI and/or CMI service is necessary to accommodate the service demand experienced by the existing applicant facility over the latest two-year period, as evidenced by historical and projected referrals, or, if the applicant proposes to establish a new hospital, the applicant shall submit projected referrals.

D) Patient Type

The applicant shall identify the type of patients that will be served by the project by providing the clinical conditions anticipated (e.g., eating disorder, borderline personality disorder, dementia) and age groups (e.g., childhood, adolescent, geriatric) targeted.

5) Service Accessibility

The number of beds being established or added for each category of service is necessary to improve access for planning area residents.

The applicant is proposing to establish a 20 bed acute mental illness service to care for geriatric patients in Acute Mental Illness Planning Area 4. There is a calculated excess of 78 acute mental illness beds in this planning area. Currently the State Board does not distinguish between geriatric or adolescent AMI beds. The primary service area for the proposed project also is the primary planning area for hospital as a whole with the majority of the applicant's patients being located within the boundaries of HSA 4. HSA 4 includes the Illinois counties of Livingston, Ford, Iroquois, McLean, Vermilion, Champaign, DeWitt, Piatt, Macon, Moultrie, Shelby, Coles, Douglas Edgar, Clark, and Cumberland. There is one other hospital within 30 miles of the applicant's facility that provides specialized geriatric psych services. St. Mary's Hospital, Decatur is reported as having a dedicated geriatric psych service with a complement of 14-beds, but shares its clinical care space with the adult and adolescent psych services.

The applicant did not provide referral letters to estimate the number of patients to be served by the AMI service. Instead the applicant projected the number of patients who will utilize the service based upon admission data from 2013, and estimated population growth of geriatric patients in the service area.

The applicant provided the following methodology to estimate the number of AMI beds being proposed.

“Need for the proposed acute mental illness beds are based on the prevalence rate of individuals with an acute mental illness requiring intervention in order to allow the individual to perform nominal activities of daily living. The annual prevalence rate is based on studies performed for the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH) published in 1999. (US Department of Health and Human Services, Mental Health: A report of the Surgeon General, National Institute of Mental Health, 199 and as updated, pages 46 through 48). These rates are applied to the hospital's primary and regional market populations to provide an estimate of the baseline population at-risk of needing treatment services. In general, approximately 13% of the child and adolescent population (persons under 18 years of age), and 14% of the general adult population (persons 18-54 years of age), and 14.7 % of the older adult population (persons 55 to 64 years of age) and 19.8% of the geriatric population (persons 65 years or older) have an acute mental illness appropriate for intervention. The child and adolescent population is not considered in developing the need for beds in this application because the unit proposed will be dedicated for service to patients 55 years and older. Using the prevalence rates discussed above and the population shown on Attachment #22b and an average length of stay of 8.8 days (the standard of practice for the facilities in the region) while adjusting for inpatient and outpatient utilization, the number of beds needed to support the population age 55 and over, totals 55 beds in 2012 and 58 beds in 2017. Only one facility within 30 minutes travel time of the proposed project offers any kind of dedicated service to the geriatric population of the planning area, St. Mary's Hospital, which is located in Decatur and has 56 beds to serve all age levels for AMI services. St. Mary's Hospital has designated 14 of the 56 beds to treat the geriatric population.

Again, utilizing the same data as discussed above for the total adult population, but not utilizing and children or adolescent population data and not calculating any need for those younger patients the need for adult patients 18 and over totals 116 beds in 2012 and 116 beds in 2017. Even if the applicant's proposed 20 beds are added to St. Mary's existing 56 beds, the proposed service area would still have an additional need for 40 beds. When the child and adolescent need is added to that figure even more additional beds would be needed. It is important to note here than St. Mary's hospital has specifically designated 14 of the hospitals 56 beds for older adult and geriatric patients. When the applicant's proposed 20 beds are added to St. Mary's unit the total number of beds designated for service to the 55 and older population in the service area would be only 34 beds which is substantially less than the 55-58 beds projected to be needed to serve this population group.

The figures below appear to be consistent with the hospital's experience regarding patients with either a primary or secondary psychiatric diagnosis treated at the hospital. During 2013, 2,774 patients were treated at Decatur Memorial Hospital, who were age 60 and older, and had secondary psychiatric diagnoses and may have benefited from additional treatment in a separate geriatric psychiatric unit equipped to treat both their psychiatric problems and

simultaneously continue treatment of their medical problems Based upon an average length of stay of 8.8 days and an 85% occupancy rate if only 705 of these patients were treated in the proposed unit (25.4% of the total) the unit would have fully met the State Board's utilization standards.”

TABLE SIX						
Estimate of Need for AMI Beds						
Age Group	2012 Population	Percent Needing Inpatient Services	Estimated Inpatients	ALOS	Estimated Patient Days	Estimated Bed Need *
18-54	75,510	2.83%	2,135	8.8	18,788	61
55-64	23,585	2.97%	700	8.8	6,160	20
65 and older	30,200	4.00%	1,210	8.8	10,648	35
Total	129,295		4,045	8.8	35,536	116
	2017 Population					
18-54	72,090	2.83%	2,035	8.8	17,908	58
55-64	23,180	2.97%	690	8.8	6,072	20
65 and older	33,295	4.00%	1,330	8.8	11,704	38
Total	128,565		4,055	8.8	35,684	116

The applicant identified four facilities within a 45-minute radius that offer AMI service, but only one with a dedicated geriatric psych program. Of the four facilities identified in Table One, none were operating at or above the State standard (85%).

There is a calculated excess of 78 acute mental illness beds in this planning area by CY 2015, and there appears to be underutilized acute mental illness service available within 30 minutes of the proposed site. A negative finding has been made for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE OF PLANNING AREA NEED CRITERION (77 IAC 1110.730 (b))

D) Criterion 1110.730(c) - Unnecessary Duplication/Maldistribution – Review Criterion

- 1) The applicant shall document that the project will not result in an unnecessary duplication.
- 2) The applicant shall document that the project will not result in maldistribution of services.
- 3) The applicant shall document that, within 24 months after project completion, the proposed project:
 - A) Will not lower the utilization of other area providers below the occupancy standards specified in 77 Ill. Adm. Code 1100; and

- B) Will not lower, to a further extent, the utilization of other area hospitals that are currently (during the latest 12-month period) operating below the occupancy standards.**

As can be seen by Table One on page 2, there are underutilized AMI beds within 45 minutes of the proposed site, and there is also an excess of 78 AMI beds in HSA 4. The closest hospital which provides specialized geriatric AMI services is 9 minutes from the proposed unit, but according to the applicant, would be unable to serve the projected increase in geriatric AMI patients in the coming years. It appears the establishment of 20 additional AMI beds in the planning area would contribute to unnecessary duplication/maldistribution. A negative finding results for this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT DOES NOT APPEAR TO BE IN CONFORMANCE WITH THE UNNECESSARY DUPLICATION OF SERVICE/MALDISTRIBUTION CRITERION (77 IAC 1110.730(c))

- E) Criterion 1110.730 (f) - Staffing Availability**

The applicant shall document that relevant clinical and professional staffing needs for the proposed project were considered and that licensure and Joint Commission staffing requirements can be met. In addition, the applicant shall document that necessary staffing is available by providing letters of interest from prospective staff members, completed applications for employment, or a narrative explanation of how the proposed staffing will be achieved.

The applicant provided a narrative at page 46 of the application for permit that details the process the applicant will use to recruit staff for this 20 bed unit. The applicants' strategy includes recruiting an additional psychiatrist, and executing a contact with Diamond Healthcare Corporation to manage the unit, and assist with all other staffing needs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH THE STAFFING AVAILABILITY (77 IAC 1110.730(f))

- F) Criterion 1110.730 (g) - Performance Requirements – Bed Capacity Minimums**

- 1) The minimum unit size for a new AMI unit within an MSA is 20 beds.**
- 2) The minimum unit size for a new AMI unit outside an MSA is 10 beds.**

The applicant is not located within an MSA; therefore the unit size meets the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH THE PERFORMANCE REQUIREMENTS-BED CAPACITY CRITERION (77 IAC 1110.730(g))

G) Criterion 1110.730(h) -Assurances

The applicant representative who signs the CON application shall submit a signed and dated statement attesting to the applicant's understanding that, by the second year of operation after the project completion, the applicant will achieve and maintain the occupancy standards specified in 77 Ill. Adm. Code 1100 for each category of service involved in the proposal.

The applicant provided the necessary assurance at page 111 of the application for permit that the proposed AMI unit will be at target occupancy of 85% by the second year of operation.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT TO BE IN CONFORMANCE WITH THE PERFORMANCE REQUIREMENTS-BED CAPACITY CRITERION (77 IAC 1110.730(g))

XI. Section 1120.120 - Availability of Funds

The applicant shall document that financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources.

The applicant is funding this project internally, with cash and equivalents, including investment securities, and unrestricted funds. The applicant provided a consolidated financial statements from years 2012 and 2013 (application, p. 114), attesting to the financial to undertake the proposed project.

TABLE SEVEN Decatur Memorial Hospital Audited Financial Statements September 30, 2013	
	2013
Cash	\$23,633,334
Current Assets	\$73,365,928
Assets Limited to Use	\$51,274,408
PPE	\$110,268,550
Total Assets	\$391,590,668
Current Liabilities	\$42,280,888
Long Term Debt	\$11,475,000
Total Liabilities	\$80,148,738
Net Patient Revenue	\$243,156,509
Total Revenues	\$260,575,546
Expenses	\$258,140,872
Operating Income	\$2,434,674
Excess of Revenues over Expenses	\$18,036,102

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE AVAILABILITY OF FUNDS CRITERION (77 IAC 1120.120).

XII. Section 1120.130 - Financial Viability

The applicant provided a consolidated financial statements from years 2012 and 2013 (application, p. 114), attesting to the financial to undertake the proposed project. Because the applicant is funding the transaction internally (cash and securities) the applicant has qualified for the financial viability waiver.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE FINANCIAL VIABILITY CRITERION (77 IAC 1120.130).

XIII. Section 1120.140 - Economic Feasibility

A) Criterion 1120.140 (a) - Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements.

There is no debt associated with this project; the applicant has met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF FINANCING ARRANGEMENTS CRITERION (77 IAC 1120.140(a)).

B) Criterion 1120.140 (b) - Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable.

There is no debt associated with this project; the applicant has met the requirements of this criterion.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE CONDITIONS OF DEBT FINANCING CRITERION (77 IAC 1120.140(b)).

C) Criterion 1120.140 (c) - Reasonableness of Project and Related Costs

The applicant shall document that the estimated project costs are reasonable and shall document compliance with the State Board Standards.

Preplanning – These costs total \$20,000, which comprise 1.4% of the Modernization, Contingencies, and Equipment Costs. This appears reasonable when compared to the State Board Standard of 1.8%.

Modernization and Contingency Costs – These costs are \$1,422,168 or \$115.48 per GSF. This appears reasonable when compared to the State Board Standard of \$284.10.

Contingency Costs – These costs are \$143,420 or 11.2% of modernization costs. These costs appear reasonable when compared to the State Board Standard of 10-15%.

Architectural and Engineering Fees – These costs are \$153,450 or 10.7% of new modernization and contingency costs. This appears reasonable when compared to the State Board Standard of 7.63% – 11.45%.

Consulting & Other Fees – These costs are \$2,000. The State Board does not have a standard for these costs.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE REASONABLENESS OF PROJECT COSTS CRITERION (77 IAC 1120.140(c)).

D) Criterion 1120.140 (d) - Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct costs mean the fully allocated costs of salaries, benefits and supplies for the service.

The projected operating costs per equivalent patient day are \$1,746.80. The applicants have met this criterion.

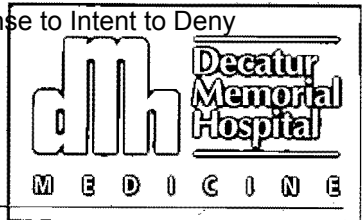
THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE PROJECTED OPERATING COSTS CRITERION (77 IAC 1120.140(d)).

E) Criterion 1120.140 (e) - Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

The total effect of the Project on Capital Costs is \$174.16 per equivalent patient day.

THE STATE BOARD STAFF FINDS THE PROPOSED PROJECT APPEARS TO BE IN CONFORMANCE WITH THE TOTAL EFFECT OF THE PROJECT ON CAPITAL COSTS CRITERION (77 IAC 1120.140(e)).



M A S T E R I N G M O D E R N

M E D I C I N E

RECEIVED

JAN 06 2015

HEALTH FACILITIES &
SERVICES REVIEW BOARD

January 6, 2015

Ms. Courtney Avery, Executive Secretary
Illinois Health Services Review Board
525 W Jefferson Street
Springfield, IL 62761

Re: Project #14-046 Decatur Memorial Hospital Geriatric Psychiatric Unit's "Intent to Deny"

Dear Ms. Avery:

Thank you for the opportunity to provide additional information regarding our proposed project in response to the HFSRB's initial decision on this application. The applicant believes that this is a project which is needed in Decatur to serve the residents who utilize Decatur Memorial Hospital and who are attended by the physicians whose practices serve Decatur Memorial Hospital.

The following information will reply to the issues raised in the State Staff Report, the opposition letters and the questions asked by the Board Members.

First, in response to the letter from St. John's Medical Center located in Springfield, St. John's is located according to map quest at 43 minutes from the applicant facility. The State Board's rules refer to a 45 minute travel time under Criterion 1110.730.c.5.A.v, which impacts only that criterion if the applicant is claiming that there are restrictive admission policies which prevent the applicant's patients from receiving care at another facility. Distance is, however, a factor to be considered. Several studies (Persky 2014, Mojtohi 2009, Bruce, Citters, Bartels, 2005) show that access to transportation is a significant component contributing to older adults not receiving necessary psychiatric treatment- both inpatient and outpatient. For the older adult, driving significant distances has been demonstrated to be an impediment to either accessing or participating in the treatment process for a spouse. The applicant has not claimed that St. John's Hospital has restrictive admission policies, but rather has stated that the Decatur Memorial patients have declined to seek care that is more than 30 minutes from their homes and physicians. Criterion 1110,730,d,1 requires the applicant under the unnecessary duplication of services to consider all facilities within 30 minutes travel time rather than 45 minutes travel time, which leaves only St. Mary's Decatur as a facility to be considered for

unnecessary duplication of services. Decatur Memorial Hospital has had continuing difficulties in trying to admit patients to St. Mary's Hospital with psychiatric diagnoses who also require continuing simultaneous medical care. St. Mary's psychiatrists decline these patients due to their medical conditions. This category of patient makes up the majority of the patients proposed to be served in the new unit. At Decatur Memorial Hospital the patients' normal medical physicians and hospitalists will be available to treat medical conditions while the psychiatrist and psychologists address the psychiatric illness.

The proposed project is not an unnecessary duplication of services but rather the extension of the services now provided by Decatur Memorial Hospital. The patients proposed to be treated in the new unit will be patients who are currently treated at DMH as Medical Surgical Patients, but need the extended care for a secondary psychiatric diagnosis. The patients are above the age of 50 and have dual diagnosis which if treated correctly can avoid the need for long-term care or repeated admission to the hospital to care for their underlying psychiatric diagnosis.

The proposed calculation of bed need differs from the State Board's formula in that it is an incidence based calculation rather than the demand based calculation used by the Board. The applicant's formula tries to be proactive in treating the patient rather than calculating the need solely on the basis of who actually seeks care. The applicant's model will make care more readily available to the patient allowing for earlier treatment and better results. This methodology is supported by the research studies referenced in the original application. This methodology indicates that a substantial number of geriatric patients are not receiving the care that they need in the hospitals and are, as a result, placed in Long-Term Care Facilities rather than being treated and allowed to maintain their independent living status.

The need for the proposed beds is supported by the applicant's historical utilization by patients with a dual diagnosis. If only 25.4% of the 2,774 patients treated at DMH with a dual diagnosis of a medical problem and a psychiatric diagnosis (705 patients) were to be treated in the proposed unit, based upon an average length of stay of 8.8 days, the proposed 20 bed unit would achieve the target occupancy rate of 85%. Based upon these figures, it is clear that the proposed project would not be a maldistribution of services and would not negatively impact any other hospital in the planning area.

The Board discussion of this project also centered on two other issues: the size of the project, and the staffing of the facility.

In regard to the size of the project the applicant agrees that the space proposed will exceed the State Norms, however, this deviation from the State Norm is made necessary by the utilization of existing space rather than constructing new space or even completely gutting and remodeling existing space to accommodate the proposed beds. It would be much more expensive to pursue either of these two options. The hospital currently has underutilized bed space which can accommodate the proposed unit without adding space

or beds to the hospitals bed count. The proposed unit will result in a net zero change in the hospital space and number of beds.

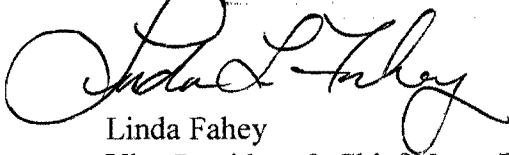
In regard to staffing, the applicant will be working with Diamond Healthcare to recruit the necessary staffing including Psychiatrists and where needed psychologists. The existing psychologists who work with hospital patients currently will remain actively involved in the proposed unit.

The hospital will also work closely with the existing community mental health programs and providers to insure that all of their services are available to our patients upon discharge and when appropriate during their hospital stay.

A question was also raised regarding the applicant's commitment to providing care to Geriatric patients rather than other age groups once the application was approved. We do not have any plans to treat any age group other than the elderly in the proposed unit. This unit will be designed to care for the older adult patient and will not be used to treat other AMI patients.

Thank you for this opportunity to address the Board and staff concerns regarding the proposed project.

Sincerely,

A handwritten signature in cursive script, appearing to read "Linda Fahey".

Linda Fahey
Vice President & Chief Nurse Executive



OVERLOOKED AND UNDERSERVED: ELDERS IN NEED OF MENTAL HEALTH CARE

by: *Trudy Persky, MSW, ACSW*

- **Managed Care**
- **Positive Perspective**

CURRENT CONCERNS

Over the last decade there has been a striking number of articles in professional journals and the public press attesting to the high prevalence of psychiatric disorders in the nation's elderly population. Although adults 60 years of age and older constitute 13 percent of the United States population, their use of inpatient and outpatient mental health services falls far below expectations.

Elders account for only 7 percent of all inpatient psychiatric services, 6 percent of community mental health services, and 9 percent of private psychiatric care. Less than 3 percent of all Medicare reimbursement is for the psychiatric treatment of older patients. It is estimated that 18 to 25 percent of elders are in need of mental health care for depression, anxiety, psychosomatic disorders, adjustment to aging, and schizophrenia. Yet, few seem to receive proper care and treatment for these mental illnesses. It is also a distressing reality that the suicide rate of the elderly stands at an alarming 21 percent, the highest of all age groups in the United States. Every day 17 older individuals kill themselves.

Given such statistics, why are millions of our nation's elderly deprived of adequate mental health care? There are numerous factors accounting for this apparent state of apathy and indifference towards the unmet mental health needs of the elderly.

Stigma

Many elders resist treatment for depression and other disorders, as their association with mental illness is based on images frequently propagated by the mass media and popular culture. Very often, television and movie portrayals of characters labeled mentally ill are frightening and powerful sources of mental illness misinformation. For the older generation, movies like "The Snakepit" and "Psycho" have left lasting negative perceptions of people experiencing psychological distress. The media rarely produces dramas depicting people coping with feelings of depression or anxiety who are not violent, nor do they have any regular programming that provides basic mental health information. It's therefore extremely important to have alternative TV programming that helps to re-educate people about what mental illness is and how it can be effectively treated.

Agism

Myths and misperceptions (ageism) about older people by the media, the public, and professional health and mental health providers have also affected mental health service delivery to elders. For administrators confronted with budgetary restraints, it has too often been the older population that has been cast aside, on the basis that they are too old to benefit from services. It would stand to reason that a society that places such great emphasis on youth and the importance of looking young does not lend enthusiastic support to better mental health care for the geriatric population.

Primary Care Physicians

Generally, the first person elders turn to for help with problems that require mental health treatment is their primary care physician. Many of these physicians have limited training in the care and management of geriatric patients. This makes the current lack of adequate mental health care particularly insidious because neither the elderly person nor the health care provider may recognize the symptoms. In no other age group is the combination and interrelationship of physical, social, and economic problems as significant as with the elderly. Elders tend to assume that complaints such as sleep disturbances, changes in appetite, and mood differences are related to physical problems. This tendency is reinforced by physicians, who often attribute symptoms to the aging process. Medical practice today does not usually allocate time for the detailed medical and social history that would encourage a more accurate diagnosis.

A 1990 study of elderly suicides in the Chicago area found that 20 percent of the suicide victims had seen their primary care physicians within 24 hours of their suicide, 41 percent within seven days, 84 percent within 30 days. This data greatly underscores the importance of early detection by health professionals and caregivers.

Service Delivery

Practices and policies pertaining to the organization of elderly service delivery have not been based on actual experiential data, but on the attitudes and assumed efficiency of planners and funders in the private and public sectors. An illustration of this approach is the assumption that older consumers will self-refer to community mental health centers (CMHCs) for help with psychiatric disorders. In most instances, older adults do not appear at a CMHC unless they are brought by a relative or there is an acute crisis that requires an emergency visit. Even on those visits, few CMHCs have staff members that are responsive or knowledgeable about the special needs of this population.

At the state and local level, there is a question as to which service organization - the county aging agency or the county mental health system - is responsible for the mental health care of the elderly. Conflicting priorities led each system to focus on what they regard as their primary functions rather than addressing collaborative programs and strategies. In recent years, the aging agencies have been more concerned with long-term care while the mental health systems in many states have focused on developing programs for the *seriously and persistently mentally ill*.

A conundrum for advocates requesting additional mental health funding is the response from state funders that there is no point in additional allocations since they believe the elderly

don't take advantage of the services already available. It is difficult to convince the people in control of the purse strings that the reason existing services aren't more frequently used is that the programs are not responsive to the needs of older consumers in the first place.

Service Integration: Is it An Impossible Dream?

The lack of coordinated, comprehensive health care has a negative impact on all age groups in the United States. For older adults who tend to have multiple needs, these health systems are highly fragmented and a bewildering source of patient confusion. Many elders withdraw from service feeling overwhelmed by the long waits and complex procedures.

Connections between primary care and social services are limited as are links with primary care and mental health services for older adults. Although there is unanimous agreement about the value of communication and of streamlined intake procedures, most agencies continue to function in isolation from one other. A big reason for this is the limited and parallel funding the agencies receive, which does not encourage the sharing of resources. As a result, many service organizations are deeply concerned about maintaining their autonomy and their funding - attitudes which do not foster inter-agency collaboration.

CMHCs in most areas of the country have devoted their resources to serving children and seriously mentally ill young populations. These centers have not been well integrated with social service agencies or with the network of primary care providers that are so important to older consumers.

Reimbursement

There is a large disparity in Medicare and Medicaid reimbursement between psychiatric care and medical care. This has deterred many prospective psychiatrists, social workers, and psychologists from considering careers in geriatric mental health. Since its enactment in 1985, Medicare has specifically limited reimbursement to all the disciplines engaged in treating older adults. Not only are professionals reimbursed at lower rates, but co-payments for consumers are higher than for standard medical care. This is another drawback for older persons considering mental health treatment. Despite pressure from national professional organizations, there has been no significant improvement in this area from the Health Care Finance Corporation (HCFA), the agency that administers the Medicare program.

Lack of Organized Support

In contrast to the activities of groups such as the Alliance for the Mentally Ill (AMI), the National Mental Health Association, Disabled Americans, and Developmentally Disabled Children, there has been very little national attention directed to the quality and quantity of mental health services available to the nation's elders. Attempts to organize older people struggling with psychiatric disorders combined with physical impairments have met with minimal success. Local attempts to engage adult sons and daughters have not generated positive results.

Does the absence of organized concern suggest indifference to the mental health needs of elders? There is no one reason why older people with mental health problems have been overlooked and underserved. If funds were available, a public health education campaign to

sensitize legislators and the general public might be a positive initial step.

MANAGED CARE

At this stage in the development of managed care, it is difficult to determine whether Medicare HMOs will be a friend or foe to older members. With strong encouragement from Health Care Finance Corporation (HCFA), Medicare beneficiaries are joining HMOs at the rate of 80,000 members a month. The most common arrangement for all managed mental health care is for HMOs to contract with other behavioral health companies to provide the missing mental health component.

Despite the rapid increase in subscribers, mental health advocates are concerned that with the so-called *carve out* for mental health care, there may be even greater coordination problems for elderly consumers who have complicated physical and mental disorders. To date, HMOs have not demonstrated much interest in developing long term care services - essential for the well being of elders - as such services are more costly than short-term programs. Although preventive health is used as a marketing strategy, reports indicate that few of the 600 plans have made more than token efforts in this direction. Information about the exact number of physicians and other staff with geriatric training that are employed at HMOs is not available at this time.

Despite their glaring weaknesses in this regard, the HMOs remain an attractive option to the elderly because of the elimination of the costs for supplementary Medicare insurance and the various additional benefits - the reimbursement for glasses and prescriptions, for example - that many HMOs offer.

A POSITIVE PERSPECTIVE

While many of these barriers continue to restrict improvement and expansion of elderly mental health services, there are innovative programs that are either currently operational or under consideration in several states. There is still a good deal to be learned about interventions to better ease the psychic distress of older Americans, but there are programs that have used innovative ideas to achieve a level of success. Some of these successful programs have initiated or implemented one or more of the following:

- Outreach efforts to locate and identify older persons who are depressed and provide care relevant to their needs.
- Mobile programs with staffs that treat consumers in their own homes. Treatment in familiar surroundings reduces the fear of stigma.
- Effective treatment for elderly depression. Treating elders has been found to be just as effective as treating young adults and middle-aged people; supportive therapy and drug treatment can be safely administered with beneficial results.
- Coalitions of staff members, statewide and local, associated with mental health and aging networks.
- Meetings with state mental health departments to ask that older people be officially designated as a special population with unique needs.
- Meetings with state legislators or their aides to brief them about the unmet mental health needs of their constituencies.

- Training sessions conducted by staffs of aging and mental health agencies so each can have a better understanding of the services and limitations of organizations serving elders.

Trudy Persky, M.S.W., A.C.S.W., has had a four-decade career in human services, including 12 years as Project Director for Mental Health and Aging in the Philadelphia Office of Mental Health. She is now a consultant on mental health and aging issues.



ABOUT US

The Mental Health and Aging Advocacy Project is a program of the **Mental Health Association of Southeastern Pennsylvania (MHASP)**. MHASP's executive director, **Joseph A. Rogers**, recognizes the need for MHASP to support local, state and national advocacy efforts by older adult mental health consumers. For this reason the project's director, **Tom Volkert**, in addition to organizing on a local level is also assisting the **Bazelon Center's** efforts at developing a national senior consumer constituency.

The Project brings several already successful programs to MHASP:

- The **Delaware Valley Mental Health Aging Advocacy Committee**, focused on increasing awareness of mental health and aging issues and providing a forum for discussion and exchange of information.
- The **Mental Health and Long-term Care Task Force**, targeted to expanding and improving services in residential facilities - including training nursing home staff members.

And the Project is expanding to include greater **advocacy** and information and **referral** efforts. Also, read more about our **Purpose** and **Background**.

Mental Health/Aging Advocacy Project | a project of the **Mental Health Association of SE PA** | 1211 Chestnut Street | Philadelphia, PA 19107 | 215-751-1800, ext. 266 | mhaging.org

Unmet Need for Treatment of Major Depression in the United States

Ramin Mojtabai, M.D., Ph.D.

Objective: This study examined the extent and correlates of perceived unmet need for treatment among individuals with depression in the U.S. general population. **Methods:** Analyses were based on a representative sample of 6,510 adult participants in the 2005 and 2006 National Surveys on Drug Use and Health who reported a major depressive episode in the past 12 months. **Results:** A total of 3,568 (62.4%) participants had sought mental health treatment in the past 12 months, and 2,942 (37.6%) had not; 34.9% and 26.8% of these groups, respectively, reported unmet need for treatment. In both groups, older age was associated with a lower likelihood of reporting unmet need for treatment, whereas greater distress and impairment and higher education were associated with a greater likelihood of reporting unmet need. Among treatment seekers, treatment from general medical providers was associated with greater likelihood of unmet need, and more outpatient visits and insurance coverage for the full year were associated with a lower likelihood of unmet need. The most common reason for not seeking needed treatment was a concern about costs (cited as a reason by 46.0% of the total sample). **Conclusions:** Even though rates of treatment seeking have increased, many persons with major depression continue to experience unmet need for treatment, which in this study was mainly attributable to concerns about treatment costs. (*Psychiatric Services* 60: 297–305, 2009)

Studies throughout the 1980s and 1990s showed that a large proportion of individuals with major depression do not seek treatment (1–6). Although some studies found that low levels of perceived need for treatment and negative attitudes toward mental health treatments were more significant barriers to treatment seeking than system-level barriers (7–9), others found that characteristics of the health care system in general, and financial barriers in particular, were more prominent in this patient population (10).

More recent data suggest that the rate of treatment of depression in the community has increased (11,12). However, there are indica-

tions that the increased demand for treatment has coincided with a greater perception of financial barriers (13)—a trend that is likely associated with the increased out-of-pocket cost of mental health care in recent years (14–16).

A better understanding of the extent of perceived unmet need for care among individuals with major depression, as well as its predictors and the reasons for unmet need, would have important implications for understanding the barriers to mental health treatment seeking and for designing programs to improve access to mental health care.

The study reported here used data from a large and nationally represen-

tative sample of U.S. adults to examine the extent and correlates of perceived unmet need for treatment among persons with major depression. More specifically, the study used regression models to examine sociodemographic, access, and clinical correlates of perceived unmet need for treatment among depressed adults whether or not they had had any mental health treatment contacts in the past year. The study also explored the reasons for not seeking needed treatment among those who perceived an unmet need for treatment.

Methods

Sample

The sample for the study was drawn from participants in the 2005 and 2006 National Survey on Drug Use and Health (NSDUH) (17,18). Overall, 74,192 adults were interviewed in these two surveys. (The response rates for the 2005 and 2006 survey were 76% and 74%, respectively.) Of the 73,583 participants who completed the questionnaire about major depressive episodes in 2005 or 2006, a total of 6,531 (7.1% weighted) met criteria for a major depressive episode in the past 12 months; 6,510 of these participants also responded to questions about treatment seeking and perceived unmet need and constituted the sample for this study.

Assessment

The presence of a major depressive episode in the past 12 months was assessed by using a structured interview based on *DSM-IV* criteria (19). Questions were adapted from the depression section of the National Comorbidity Survey Replication (20) and administered by using computer-assisted interviewing methods.

Perceived unmet need for mental

Dr. Mojtabai is affiliated with the Department of Mental Health, Bloomberg School of Public Health, and the Department of Psychiatry, Johns Hopkins University, 624 North Broadway, Room 797, Baltimore, MD 21205 (e-mail: rmojtoba@jhsph.edu).

health treatment was assessed with one question: "During the past 12 months, was there any time when you needed mental health treatment or counseling for yourself but didn't get it?" A positive response to this question was rated as perceived unmet need for treatment. This question was asked of all participants whether or not they had sought treatment in the past year. (Respondents were not asked specifically about unmet need for treatment of depression.)

Reasons for not seeking treatment were assessed for those who reported an unmet need. Participants were presented with a series of statements about why they did not get needed mental health treatment or counseling. The reasons included inability to afford the cost, concern about opinions of neighbors or the community, concern about the effect of treatment seeking on the person's job, lack of health insurance coverage, inadequate health insurance coverage, lack of knowledge about where to go for services, concern about confidentiality, fear of being committed to a psychiatric hospital or having to take medicine, the person's belief that he or she could handle the problem without treatment, a belief that treatment would not help, lack of time, a desire not to have others find out, lack of transportation, too great a distance to treatment or inconvenient hours, and other reasons. For these analyses, lack of insurance and inadequate insurance coverage were combined, as were concerns about opinions of neighbors and community and not wanting others to find out.

Treatment seeking was assessed by a series of questions. Participants were asked whether at any time in the past 12 months they had seen or talked to a medical doctor or other professional about their depressive symptoms. Participants who responded positively to this question were presented with a list of professionals and asked to identify the professional or professionals whom they had seen or talked to about their depressive symptoms. The list included nonpsychiatrist physicians, psychiatrists, psychologists, social workers, counselors,

and other health professionals (for example, nurses and occupational therapists). Religious helpers and nontraditional helpers (for example, herbalists, chiropractors, and acupuncturists) were also included.

The extent of outpatient service use was ascertained by asking participants about the number of visits over the past year. Consistent with past research (21,22), the variable was dichotomized into fewer than four visits and four or more visits in the past 12 months.

Participants were asked whether in the past 12 months they had taken any medication that was prescribed for their mood symptoms. Participants were also asked about inpatient hospitalizations for mental health reasons in the past 12 months.

Impairment in role functioning associated with depression was assessed by four questions from the Sheehan Disability Scale (SDS) (20,23), a measure of the impact of depression on a person's daily activities in four domains of life. Participants were asked to think about the time in the past 12 months when problems with mood were the worst and to rate the degree of impairment in "chores at home," "ability to do well at school or work," "ability to get along with family," and "social life" on a scale from 0 to 10 (0, no impairment; 1 to 3, mild impairment; 4 to 6, moderate impairment; 7 to 9, severe impairment; and 10, very severe impairment). An overall role impairment score is defined as the highest level of severity of impairment reported in any of the four domains. In addition, the total number of lifetime depressive episodes was ascertained, and on the basis of the median split, the variable was dichotomized as fewer than five episodes and five or more episodes.

Severity and level of distress were also measured by using K6 (24,25), a six-item screening instrument for nonspecific psychological distress during the worst month in the past 12 months. Possible scores on K6 range from 0 to 24. A score of 13 or higher has been found to correspond to clinician-rated measures of serious mental illness as ascertained by a semistructured interview instrument (25).

In addition, participants' age, gender, family income, insurance type, and the extent of insurance coverage in the past year were ascertained. Coverage was dichotomized as coverage throughout the year and any period without coverage in the past year.

Statistical analyses

Analyses were conducted in two stages. First examined was the association between perceived unmet need for treatment and specific sociodemographic, access, service use, and clinical characteristics among adults who reported a major depressive episode. These analyses used bivariate and multivariate logistic regression models. The analyses were conducted separately for participants who did or did not seek treatment in the past 12 months.

Second, the percentage of participants who reported different reasons for not seeking treatment when they needed it was examined. These analyses were limited to those who reported unmet need for treatment. The analyses were conducted for the entire group of adults with a major depressive episode and then separately for individuals who did or did not seek treatment in the past 12 months.

Analyses were conducted using Stata 10, which adjusts for the complex sampling design of the NSDUH. All percentages were weighted by sampling weights, and only weighted percentages are reported here. A significance level of $< .05$ was used.

Results

Of the 6,510 participants who reported a 12-month major depressive episode in the 2005 and 2006 NSDUH surveys, 3,568 (62.4%) reported seeking mental health treatment in the past 12 months and 2,942 (37.6%) reported that they did not seek treatment. Furthermore, 2,354 (31.9%) reported an unmet need for treatment, and 4,156 (68.1%) did not report an unmet need. Overall, 72.5% of this sample of adults with a major depressive episode either sought treatment, perceived an unmet need for treatment, or both (Figure 1).

Correlates of perceived unmet need

Among the 3,568 adults with a 12-month major depressive episode who sought treatment, 1,432 (34.9%) reported an unmet need for treatment. Among the 2,942 who did not seek treatment, 922 (26.8%) reported an unmet need.

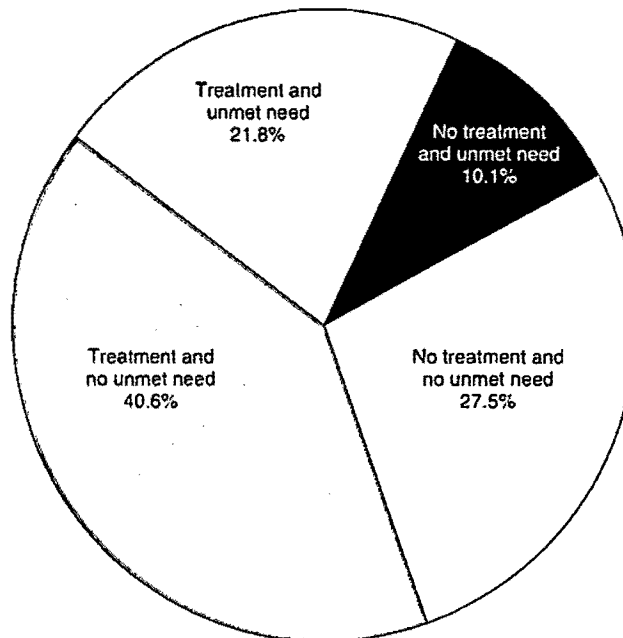
Sociodemographic, access, and clinical variables that were correlated with perceived unmet need among participants who sought treatment are presented in Table 1. Table 2 presents these correlates among participants who did not seek treatment.

The bivariate analyses indicated that among participants who sought treatment in the past 12 months, age, racial-ethnic group, type of insurance, extent of insurance coverage, psychological distress, impairment in role functioning, number of depressive episodes, and type of provider were associated with perceived unmet need (Table 1). Variables that remained significant in the multivariate model were age, racial-ethnic group, the extent of insurance coverage, psychological distress, impairment, number of depressive episodes, and type of provider (Table 1). In addition, education and number of outpatient sessions in the past year became significant in the multivariate model. Participants who were older than 25 years, those with full-year insurance coverage, and those who had had more than four outpatient mental health visits were significantly less likely to report an unmet need, whereas participants from the "other" racial-ethnic group, college graduates, those with more distress or impairment, those with a greater number of depressive episodes, and those who had seen a primary care physician for their mental health problems were more likely than other participants to report an unmet need (Table 1).^a

Among participants who did not seek treatment, gender, age, type of health insurance, psychological distress, impairment in role functioning, and number of depressive episodes were associated with perceived unmet need in bivariate analyses (Table 2). Variables that remained significant in the multivariate

Figure 1

Treatment seeking and perceived unmet need for mental health treatment among 6,510 adults who reported a major depressive episode in the past 12 months^a



^a Data were from participants in the 2005 and 2006 National Survey on Drug Use and Health.

ate model were age, distress, impairment, and number of depressive episodes. Participants in the 50- to 64-year age group were less likely than those in the 18- to 25-year group to perceive an unmet need, whereas participants with a greater level of distress or impairment in role functioning and those with a greater number of depressive episodes were more likely to perceive an unmet need. In addition, having a college education was significantly associated in the multivariate model with perceiving an unmet need (Table 2).

Reasons for not seeking treatment

Across both groups of participants with a major depressive episode who did and did not seek treatment, concerns about cost were the major reason for perceived unmet need; this reason was reported by 46.0% of the total group (Figure 2). The percentage of participants who reported cost concerns was larger among those who did not seek treatment than among those who did (53.9% compared with

42.4%; design-based $F=12.23$, $df=1$ and 60, $p<.001$).

Participants who did not seek treatment were also more likely than those who did to report concerns about confidentiality (12.2% compared with 8.0%; design-based $F=5.40$, $df=1$ and 60, $p=.024$) and concerns about neighbors or other people finding out (18.7% compared with 13.2%; design-based $F=5.70$, $df=1$ and 60, $p=.020$). Participants who sought treatment were more likely than those who did not to report concerns about transportation or inconvenience (5.8% compared with 2.9%; design-based $F=4.16$, $df=1$ and 60, $p=.046$). The percentages of participants who reported that they believed they could handle the problem on their own were similar in the groups with and without a history of treatment seeking (25.6% and 26.5%, respectively); the percentages reporting that treatment would not help were the same in both groups (9.6%), as were the percentages of participants who reported other reasons for not seeking treatment.

Table 1

Analyses of correlates of perceived unmet need among 3,568 adults who reported a major depressive episode and who also reported seeking treatment in the past 12 months^a

Variable	Weighted %	Bivariate logistic regression			Multivariate logistic regression		
		OR	95% CI	p	Adjusted OR	95% CI	p
Gender							
Female (reference)	70.2						
Male	29.9	.99	.77–1.27	.930	.96	.74–1.28	.760
Age							
18–25	13.8						
26–34	17.7	.82	.66–1.02	.071	.77	.60–.98	.038
35–49	35.4	.61	.49–.75	<.001	.59	.46–.77	<.001
50–64	27.3	.44	.34–.58	<.001	.43	.30–.63	<.001
≥65	5.8	.13	.06–.28	<.001	.12	.05–.31	<.001
Race or ethnicity							
White (reference)	78.9						
Black	9.0	1.23	.80–1.90	.339	1.36	.92–2.01	.121
Hispanic	8.2	1.14	.79–1.65	.479	.97	.66–1.41	.855
Other	4.0	2.46	1.32–4.58	.005	2.32	1.17–4.60	.016
Education							
Less than high school (reference)	14.8						
High school	29.3	.92	.66–1.29	.606	.84	.58–1.22	.363
Some college	32.3	1.18	.86–1.64	.301	1.14	.78–1.66	.501
College graduate	23.7	1.34	.94–1.89	.106	1.79	1.15–2.78	.011
Family income							
<\$20,000 (reference)	27.5						
\$20,000–\$49,999	35.4	1.06	.79–1.42	.704	1.18	.87–1.61	.282
\$50,000–\$74,999	16.5	.72	.51–1.03	.071	.84	.57–1.22	.350
≥\$75,000	20.6	.85	.63–1.14	.263	1.04	.73–1.50	.815
Type of insurance ^b							
Private	58.9	.72	.57–.90	.005	1.09	.72–1.65	.671
Medicaid	17.8	1.00	.75–1.32	.984	1.01	.70–1.46	.950
Medicare	16.9	.69	.47–1.02	.060	1.43	.88–2.31	.147
CHAMPUS ^c	6.3	.75	.43–1.32	.317	1.18	.64–2.17	.584
Insurance coverage							
None or only part of the year (reference)	22.9						
Full year	77.2	.43	.34–.55	<.001	.48	.35–.67	<.001

Continues on next page

Discussion

The results of this study should be viewed in the context of its limitations and the limitations of the NSDUH data. First, this study did not examine correlates of treatment seeking for depression per se. Such a study would likely have revealed significant differences in gender, racial-ethnic group, and other sociodemographic characteristics between persons with depression who did and did not seek treatment. These differences have been explored extensively in past research (12,20,26). Instead the study sought to examine the correlates of perceived unmet need for treatment within groups of participants with major depression who had or had not sought mental

health treatment. Second, the study focused on major depression, which is among the most disabling and severe mental health conditions. Barriers to seeking mental health treatment might vary according to severity of mental health conditions. Third, treatment seeking is not equivalent to having received adequate treatment (27). Unfortunately, NSDUH does not provide data beyond number of visits to assess the quality or intensity of mental health treatments received. Fourth, the NSDUH data are cross-sectional and do not cover timing of events. Therefore, causal relationships cannot be established in these data. Thus, for example, the association of number of outpatient visits with perceived

unmet need may be a result of early drop-out from treatment among participants who believed that treatment did not meet their needs, or fewer visits may be a cause of perceived unmet need. Fifth, perceived unmet need is not equivalent to objectively assessed unmet need. However, among persons who seek treatment, perceived unmet need constitutes an important dimension of their views of adequacy and quality of treatments, and among those who have not yet sought treatment, it provides important information about demand for services. Furthermore, perceived unmet need for treatment was strongly correlated with level of distress and impairment in role functioning in this

Table 1*continued from previous page*

Variable	Weighted %	Bivariate logistic regression			Multivariate logistic regression		
		OR	95% CI	p	Adjusted OR	95% CI	p
Psychological distress ^d							
<13 (reference)	27.0						
≥13	73.0	3.08	2.31–4.09	<.001	2.67	1.97–3.61	<.001
Impairment							
None or mild (reference)	5.3						
Moderate	24.0	2.91	1.30–6.51	.010	3.01	1.31–6.92	.011
Severe	47.1	5.29	2.41–11.59	<.001	4.04	1.81–9.03	.001
Very severe	23.6	6.97	3.19–15.23	<.001	5.02	2.26–11.12	<.001
Number of depressive episodes							
<5 (reference)	39.9						
≥5	60.1	1.45	1.17–1.80	.001	1.38	1.09–1.74	.007
Type of provider ^e							
Psychologist	25.3	1.30	1.03–1.66	.031	1.23	.93–1.61	.138
Psychiatrist	29.0	1.02	.77–1.36	.870	.82	.61–1.12	.218
Social worker	10.0	1.53	1.04–2.25	.032	1.33	.85–2.07	.210
Primary care physician	61.7	1.15	.93–1.42	.194	1.43	1.13–1.80	.003
Other physician	11.0	.86	.59–1.26	.435	.94	.61–1.46	.790
Counselor	20.7	1.12	.88–1.44	.350	.90	.68–1.19	.456
Number of sessions							
<4 (reference)	69.0						
≥4	31.0	1.01	.79–1.28	.942	.72	.54–.94	.019
Psychotropic medication							
Not prescribed (reference)	25.8						
Prescribed	74.2	1.07	.83–1.36	.607	.91	.65–1.26	.554
Psychiatric hospitalization							
None (reference)	92.5						
≥1	7.5	1.41	.94–2.10	.096	1.28	.80–2.05	.296

^a Data were from participants in the 2005 and 2006 National Survey on Drug Use and Health.^b Percentages total more than the percentage of individuals with any insurance coverage because some individuals were covered by more than one type of insurance. In bivariate analyses individuals with each type of insurance were compared with all other individuals.^c Civilian Health and Medical Program of the Uniformed Services^d As measured with the K6 (24,25). A score of 13 or higher has been found to correspond to a clinician-diagnosed serious mental illness using a semi-structured interview instrument (25).^e Percentages total more than 100% because some individuals saw more than one type of provider. In bivariate analyses individuals who saw each type of provider were compared with all other individuals.

study, and similar correlations have been found in past research (28).

In the context of these limitations, the data presented provide useful information on correlates of perceived unmet need and barriers to treatment in a sample of persons with a major depressive episode from one of the largest mental health surveys of the U.S. general population. This study had three main findings. First, almost three-fourths of adults who reported a major depressive episode in the past year either sought mental health treatment or perceived an unmet need for such treatment. This rate is higher than those in previous community studies (29,30) and indicates an increase in the perceived need for care and in treatment seeking in

the U.S. population, at least among individuals with depression. This trend is consistent with other time-trend studies of mental health treatment seeking for depression (11) and other common mental health problems (13,31). The trend may be attributable to increased knowledge about mental disorders (32), reduced stigma associated with mental health treatment seeking (33), or increased demand for and supply of psychiatric medications (34). It is notable that among participants with major depressive episodes who reported any mental health treatment seeking, 74.2% reported receipt of a prescription for a psychotropic medication (Table 1).

Although increased rates of mental health treatment seeking are encour-

aging, it is notable that a large majority of persons who sought any treatment made fewer than four outpatient visits in the past year—which is generally considered the minimum number of visits required for adequate management of depression in outpatient settings (21,22). In addition, most sought treatment from primary care physicians. In the analyses, both these factors were associated with higher perceived unmet need for treatment (Table 1).

Past research has generally found that compared with psychiatrists, general medical providers are less accurate in diagnosing mental disorders and tend to provide treatments with lower intensity than required by evidence-based standards (35–37). However, provision of mental health

Table 2

Analyses of correlates of perceived unmet need among 2,942 adults who reported a major depressive episode and who had not sought treatment in the past 12 months^a

Variable	Weighted %	Bivariate logistic regression			Multivariate logistic regression		
		OR	95% CI	p	Adjusted OR	95% CI	p
Gender							
Female (reference)	56.4						
Male	43.7	.75	.57–.99	.043	.76	.56–1.03	.072
Age							
18–25 (reference)	29.4						
26–34	21.8	.94	.71–1.24	.654	.91	.68–1.20	.490
35–49	31.5	.79	.57–1.09	.145	.85	.59–1.21	.357
50–64	13.0	.23	.11–.50	<.001	.23	.10–.49	<.001
≥65	4.3	.22	.07–.69	.010	.46	.09–2.43	.354
Race or ethnicity							
White (reference)	66.3						
Black	11.5	.75	.45–1.27	.281	.65	.39–1.08	.092
Hispanic	16.5	.69	.43–1.10	.118	.68	.44–1.04	.075
Other	5.8	.86	.53–1.40	.542	.70	.40–1.21	.193
Education							
Less than high school (reference)	19.3						
High school	32.7	1.01	.66–1.54	.952	1.03	.70–1.51	.873
Some college	28.8	1.20	.77–1.89	.413	1.40	.87–2.24	.164
College graduate	19.3	1.28	.81–2.02	.285	1.91	1.25–2.92	.003
Family income							
<\$20,000 (reference)	28.8						
\$20,000–\$49,999	37.3	.84	.62–1.13	.236	.96	.70–1.32	.814
\$50,000–\$74,999	13.4	1.06	.74–1.52	.750	1.28	.83–1.97	.255
≥\$75,000	20.4	.74	.49–1.11	.144	.88	.56–1.38	.573
Type of insurance ^b							
Private	54.9	.77	.57–1.03	.074	.84	.58–1.19	.317
Medicaid	10.5	2.03	1.22–3.37	.007	1.51	.85–2.69	.160
Medicare	6.5	.43	.21–.88	.022	.83	.27–2.53	.742
CHAMPUS ^c	3.3	.33	.13–.83	.019	.41	.15–1.14	.086
Insurance coverage							
None or only part of the year (reference)	38.8						
Full year	61.2	.84	.64–1.09	.174	1.08	.73–1.60	.701
Psychological distress ^d							
<13 (reference)	38.6						
≥13	61.4	3.30	2.50–4.36	<.001	2.37	1.71–3.28	<.001
Impairment							
None or mild (reference)	9.8						
Moderate	36.3	2.08	1.17–3.72	.014	1.88	1.07–3.30	.029
Severe	40.9	4.50	2.60–7.78	<.001	3.35	1.93–5.79	<.001
Very severe	13.0	6.23	3.36–11.58	<.001	4.14	2.13–8.04	<.001
Number of depressive episodes							
<5 (reference)	48.1						
≥5	51.9	2.08	1.69–2.55	<.001	1.83	1.42–2.37	<.001

^a Data were from participants in the 2005 and 2006 National Survey on Drug Use and Health.

^b Percentages total more than the percentage of individuals with any insurance coverage because some individuals were covered by more than one type of insurance. In bivariate analyses individuals with each type of insurance were compared with all other individuals.

^c Civilian Health and Medical Program of the Uniformed Services

^d As measured with the K6 (24,25). A score of 13 or higher has been found to correspond to a clinician-diagnosed serious mental illness using a semi-structured interview instrument (23).

treatment by general medical providers expands available services in the community and increases the number of individuals who receive treatment. Future research should examine the impact of the expansion

of mental health treatments in the general medical sector on outcomes of common psychiatric disorders in the community.

The second finding of the study was that a large percentage of partic-

ipants with a major depressive episode reported an unmet need for mental health treatment, whether they received treatment or not.

More than one-fourth of participants who did not seek any treatment and

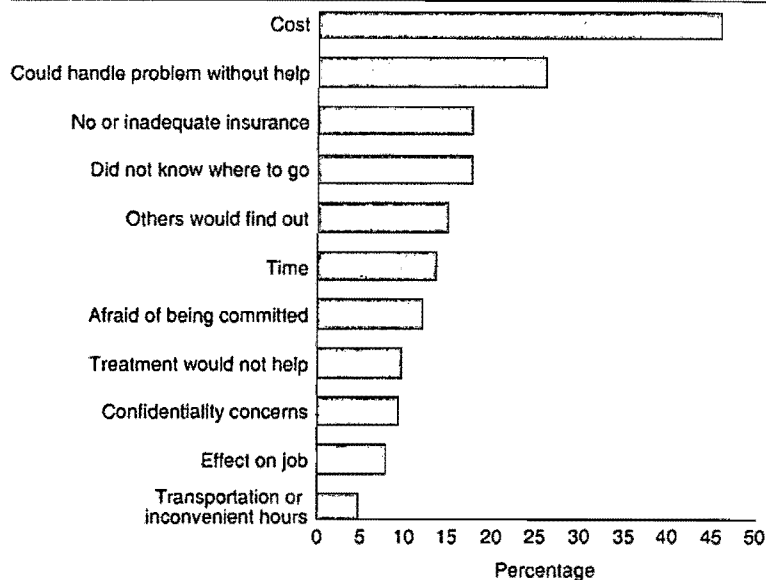
one-third of those who sought treatment reported an unmet need for treatment. In both groups, participants with a college education, more distress and impairment, and a greater number of past depressive episodes were more likely to perceive an unmet need. Although the association with distress, impairment, and number of depressive episodes likely reflects severity of depressive illness, the association with higher education may reflect more favorable attitudes toward receiving treatment and, among participants who sought treatment, a demand for more or better treatments.

There were also differences between the groups who did and did not seek treatment with regard to correlates of perceived unmet need. Among participants who sought treatment, those from the "other" racial-ethnic group were more likely to perceive an unmet need, whereas those with health insurance coverage for the full year were less likely to perceive an unmet need. Most past studies of racial-ethnic differences in receipt of mental health treatment have found differences between blacks and Hispanics compared with the white majority group (38–43). The study reported here found no such differences in the extent of perceived unmet need for treatment. Some studies have also found disparities in quality of and satisfaction with treatment between racial-ethnic groups categorized as "other" and the white majority group (44,45). The heterogeneous composition of the "other" racial-ethnic group in the study reported here further complicates interpretation of the findings. Future studies with even larger samples of persons with depression from "other" minority groups are needed to further explore their treatment experiences.

The association of perceived unmet need with the extent of insurance coverage among participants who sought treatment highlights the impact of financial barriers on the receipt of mental health care. An association between insurance coverage and treatment seeking has been consistently noted over the years (46,47). Health insurance coverage is likely a

Figure 2

Reasons for not seeking treatment cited by 2,354 adults who reported a major depressive episode and perceived unmet need for treatment in the past 12 months^a



^a Data were from participants in the 2005 and 2006 National Survey on Drug Use and Health.

more critical factor in access to appropriate health care among persons with disabilities and persons who are poor because both groups have fewer available resources (48). Furthermore, with the growing cost of mental health care, lack of adequate health insurance coverage will likely feature even more prominently in coming years as a barrier to accessing mental health treatment.

The bivariate analyses also indicated variations across different types of insurance. Among participants who sought any treatment in the past year, those with private insurance were less likely to report an unmet need. Also, among individuals with a major depressive episode who did not seek care, those with Medicaid were more likely to report an unmet need than participants with other types of coverage, and those with Medicare or CHAMPUS were less likely to report an unmet need than others.

Differences in quality of treatments have been noted among individuals with different insurance types. For example, in some studies, persons with depression who had public insurance were less likely than those with private insurance to receive psychotherapy or

continuous medication treatment (49). It is notable, however, that differences in insurance type did not persist in the multivariate analyses in the study reported here. Thus many of the differences between these groups may be attributable to differences in the sociodemographic or clinical characteristics of persons with different insurance types.

The third finding of the study was the prominent place of cost concerns as barriers to seeking mental health treatment among participants who reported an unmet need for such treatment. Cost concerns were reported by about half of all participants and were more prominent among participants who had not sought any mental health treatment. A far greater number of participants cited cost as a barrier than any other barrier. This finding is in contrast with results of some research from the 1990s in which attitudinal barriers to mental health treatment seeking were judged to be more prominent than cost barriers or to be on par (7–9). However, an increase in cost barriers in tandem with increased demand for mental treatments in recent years has been noted

(13). This finding is also consistent with other data on trends in out-of-pocket costs of mental health care in recent years (14). Furthermore, perceived barriers to treatment seeking may vary according to severity of mental health conditions, and attitudinal factors may play a more prominent role among less severely distressed individuals.

If the trends of the recent past continue in the near future, both the demand for mental health treatments and the cost of such treatments will continue to grow. Barring dramatic expansion of mental health insurance coverage and reduction in out-of-pocket costs, the number of individuals with depression who will experience cost as a barrier to receiving needed treatment will likely continue to grow as well. Reducing the impact of cost barriers and improving the quality of mental health treatments in general medical settings remain important challenges for future efforts to reduce the burden of depression in the community.

Conclusions

This study found that despite the increased prevalence of treatment seeking for major depression in recent years, many individuals with this disabling condition continue to experience an unmet need for treatment. Even among individuals who seek treatment, a large percentage report an unmet need for mental health treatment. Concern about treatment costs is the largest single barrier to seeking needed treatment among these individuals.

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***Psychiatric Services* Invites Submissions by Residents and Fellows**

Psychiatric Services has introduced a continuing series of articles by trainees in order to highlight the academic work of psychiatric residents and fellows and to encourage research by trainees in psychiatry.

Submissions should address issues in the planning and delivery of psychiatric services in any setting, including those of special interest or concern to trainees. Submission of original research is encouraged. Literature reviews will be considered only if they are mentored or coauthored by a senior scholar in the field.

Joshua L. Roffman, M.D., is the editor of this series. Prospective authors—current residents and fellows—should contact Dr. Roffman to discuss possible submissions. He can be reached at Massachusetts General Hospital, 149 13th St., Room 2656, Charlestown, MA 02129 (e-mail: jroffman@partners.org).

All submissions will be peer reviewed, and accepted papers will be highlighted in the issue in which they appear.



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Evidence-Based Mental Health Services for Home and Community

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The articles elsewhere in this issue describe the large evidence base of effective treatments for the mental health problems commonly experienced by older adults. However, despite the availability of pharmacologic and psychotherapeutic interventions with demonstrated efficacy in geriatric patients, mental illness remains undertreated in older adults [1]. As many as one half of older adults with a recognized mental disorder fail to receive any mental health services, and even fewer receive evidence-based treatments [2]. Bridging this gap between the scientific findings and community-based practice is an explicit goal for the National Institute of Mental Health and the Institute of Medicine [3,4]. In some cases, the lack of mental health treatment reflects decisions made by older adults or their clinicians about the need and preferences for mental health treatment. But in many cases, older adults are unable to access mental health treatment because of barriers posed by the health care system, at both the policy and organizational levels.

Timely access to evidence-based mental health treatment for older adults is a key goal of recent reports by the Older Adult Subcommittee of the

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President's New Freedom Commission on Mental Health [5], the Administration on Aging [6], and the Surgeon General [7]. The research literature documents widespread costs of not providing timely access. For older adults with a mental illness and for their families, the lack of access prolongs their suffering. Untreated mental illness in older adults also has a significant impact on health, functioning, and health services use and costs. For instance, late-life mental illness contributes to the risk of decline in cognition and medical status [1], increased disability [8], self-neglect [9], and compromised quality of life [7,8]. Mental illness among older adults is also associated with excess use of health care, increased placement in nursing homes, greater burden to medical care providers, and higher annual health care costs [9–13]. Depression specifically worsens the outcomes of many medical disorders and increases the risk for falls [14], suicide [15], and nonsuicide mortality [16–19].

Access to appropriate mental health care can be especially difficult for homebound and other frail, community-dwelling older adults, who are often isolated from mainstream medical settings such as primary care, where most depression screening now takes place. Common barriers to access, such as lack of transportation, difficulties in identifying mental health symptoms in the context of medical burden, and the disconnect between multiple service providers, are magnified for older adults, whose mobility is compromised and whose ability to navigate complex services is impaired. The need is especially great among homebound seniors. Community-based studies, including population-based surveys and studies of home health care patients, home-delivered meal clients, and other homebound populations, confirm the high rates of many types of mental illness in these groups [20–23]. Depression and other mental health problems are especially insidious among frail or homebound [20,21] community-dwelling older adults, who are made vulnerable by encroaching disability, medical illness, and social isolation, factors associated with both the risk for and outcomes of depressive illness in late life [8,24,25]. The risks associated with the lack of care are also magnified because a quintessential feature of frailty is the inability to withstand acute illness, emotional upheaval, or physical dislocation (Activities of Daily Living (ADL) decline, falls, hospitalizations, institutionalization, and death) [25–28].

Evidence that frail and homebound, community-dwelling older adults have special difficulty accessing adequate mental health care has prompted researchers to test novel strategies for providing mental health services to older adults. The common theme to this growing evidence base is the development of interventions that reach out from traditional health care practice to provide care in the settings where older adults reside or spend a significant amount of time. Elements of home-based and community services may include case finding, assessment, referral, treatment, and care management. These services commonly are multidisciplinary and sometimes integrate social and medical services into mental health care. For instance, outreach

programs may offer early intervention, facilitate access to preventive health care services, refer individuals to supportive services, and provide services designed to help keep older adults living longer in the community.

In this article, the growing evidence base surrounding the provision of home and community-based mental health services for homebound and frail older adults is evaluated. Specifically, the focus is whether home-based geriatric mental health services are effective in improving mental health symptoms or outcomes.

Method

To identify relevant articles for this review, the MEDLINE, PsychINFO, CINAHL, and Web-of-Science databases were searched within three topic areas for English language articles indexed through July 2005: community outreach services (keywords outreach, gatekeeper, and consultation and referral), mental illness (keywords mental or “depress” or “psych”), and older adults (keywords geriatric or late-life or elderly). Additional articles were identified through bibliographic review, MEDLINE, and Web-of-Science “related records” searches.

Studies were included that evaluated face-to-face psychiatric outreach and treatment services for older adults (target population age ≥ 65) that provided care in community-based noninstitutional settings such as senior centers, senior housing, and home-based settings. Eligible studies consisted of randomized, controlled trials, quasi-experimental studies, longitudinal outcome studies, and a comparison of two or more interventions.

Studies that evaluated services provided in institutional settings (ie, nursing homes or hospitals) were excluded. Because the goal of this review was to determine the effectiveness of outreach services for primary psychiatric disorders, interventions focused explicitly on persons with dementia or on caregivers of persons with dementia were excluded. Finally, duplicate publications with at least one author in common and only minor differences with respect to study samples and efficacy results were excluded.

This article provides an update to a systematic review evaluating the literature published through May 2004 [29]. Although the updated search strategy identified an additional 21 articles, none of these articles met the eligibility criteria for inclusion in this systematic review of home and community-based mental health services for older adults.

Selection of trials

Approximately 164 articles were identified through the literature search. Ninety-six articles were rejected because of sample selection (ie, nongeriatric population), provision of services in an institutional setting, or the lack of face-to-face contact. The remaining 68 articles were reviewed by examining the abstract or content of the article. Bibliographic and related records

searches identified 17 additional articles that were subjected to all review criteria. After these articles were reviewed, an additional 29 were excluded because of sample selection, provision of services in an institutional setting, or a lack of face-to-face contact. Forty articles were excluded based on the quality of data presented; of these, 36 articles contained only model descriptions or descriptive data, and four articles described small case studies. Of the 16 remaining reports, 12 fulfilled all inclusion criteria, but four were published in duplicate. Five studies described results of randomized, controlled trials [30–36]; one reported on a quasi-experimental study [37], four reported on a noncontrolled prospective cohort [38–41], and two reported on a noncontrolled retrospective cohort [42,43].

Data extraction and analysis

Descriptive characteristics and outcome data were abstracted from all of the studies included using a standard data collection form. Data included study type, model description, inclusion and exclusion criteria, sample characteristics, duration, and completeness of follow-up, blinding to intervention and outcome assessment, study measures and outcomes, and strengths and weaknesses. Primary outcomes of interest included the use of mental health services and improvement in psychiatric symptoms. A statistical aggregation of data was not feasible because of the lack of similarity among studies with respect to study design, inclusion criteria, sampling, and outcome measures.

Results

All twelve studies that met full criteria for this review examined the impact of home-based mental health services on improving psychiatric symptoms and community tenure (or reducing the risk of nursing home placement or other institutionalizations). Study designs included five randomized, controlled trials, one quasi-experimental study, and six uncontrolled cohort studies (Table 1). Older adults participating in these studies were predominantly female and between 75 and 85 years old. Three studies focused exclusively on older persons with depression, whereas the other nine studies included individuals with a range of diagnoses. The intervention models generally used a multidisciplinary team of providers to develop a care management protocol, which was implemented in the patient's home. Treatment recommendations varied significantly across individuals and were implemented through a variety of sources.

Four of the five randomized, controlled trials examined the effectiveness of the implementation of a care management protocol developed by a multidisciplinary team, although providers differed across studies. Rabins and colleagues [31] and Waterreus and colleagues [34] used nurses, Banerjee and colleagues [33] used a care manager, and Llewellyn-Jones and

colleagues [32] used physicians and residential staff to implement the intervention. The fifth randomized, controlled trial evaluated the effectiveness of problem-solving therapy provided by social workers under the supervision of a psychiatrist in public senior housing [30]. Relative to usual care, all interventions were associated with a significant improvement in depressive symptoms (Table 2). Of note, Rabins and colleagues [31] also found that outreach services were associated with a decrease in overall symptom severity, as measured by the total Brief Psychiatric Rating Scale score, for individuals with a variety of psychiatric disorders.

A recent quasi-experimental study evaluated a multifaceted education and support program administered in a residential care setting, and compared it with usual care. The target population included older persons who were incapable of living independently because of physical, psychiatric, or psychosocial constraints but did not require extensive nursing home care. The intervention included training for caregivers and other employees of the residential home, informational meetings for residents and their relatives, support groups, and discussion and feedback sessions for care providers. Results indicate that an intervention providing education, support, and feedback to residential care providers can reduce depressive symptoms and maintain health related quality of life for older persons [37].

Findings from the small group of longitudinal cohort studies suggest positive effects of multidisciplinary outreach teams in reducing psychiatric symptoms, relative to baseline levels (Table 3). These studies provided in-home assessment followed by interventions ranging from referral and linkage to outpatient treatment to in-home psychiatric care. However, the specific interventions and outcomes differed, limiting cross-study comparisons or pooling of results. These multidisciplinary geriatric mental health outreach interventions were associated with improved global functioning [38], reduced psychiatric symptoms [40,43], and fewer behavioral disturbances [39], relative to baseline measurements of symptoms and functioning. In addition, these interventions were associated with maintained independence [41,42] and were perceived as helpful to caregivers and referring agents [39]. No difference was found in the degree of being homebound [38].

Discussion

This systematic review of the relatively small but growing literature of randomized, controlled trials, quasi-experimental outcome studies, and cohort studies provides qualified support for the effectiveness of home-based mental health services in improving psychiatric outcomes and, in some cases, for extending the ability of older adults to remain in the community. Any general conclusions drawn from these data are necessarily tempered by the varying quality of the different studies and the methodological limitations of specific studies.

Table 1

Studies that evaluated home- and community-based treatment for older adults in noninstitutional settings who are aged 65 and older and have mental illness

Study	Model	N	Setting	Diagnoses	Age (mean $\pm$ SD y)	Female (%)	Demographic characteristics
Randomized controlled trials ^a							
Ciechanowski et al [30] 2004	Problem-solving therapy delivered by social workers under a psychiatrist's supervision; intervention delivered in coordination with primary care providers (examines the Program to Encourage Active, Rewarding Lives for Seniors [PEARLS])	138	Senior public housing	Dysthymia, 49%; minor depression, 51%	73 $\pm$ 8.5	79	11% were married or lived with partner; 72% lived alone; 58% were white; 36% were African American
Rabins et al [31] 2000	Multidisciplinary development of care protocol; nurse-based outreach (examines the Psychogeriatric Assessment and Treatment in City Housing [PATCH])	298	Senior public housing	Variable	75.4 $\pm$ 8.5	85 (intervention group; 70 control group)	8% were married; 50% were widowed; 93% lived alone

Llewellyn-Jones et al [32] 1999	Shared care treatment was delivered primarily by the general practitioner	220	Residential facility	Depression	84.3 ± 5.8	85	10% were married; 71% were widowed; 66% lived in a hostel
Banerjee et al [33] 1996	Psychogeriatric team treatment for elderly who receive home care	66	Home	Depression	80.7 ± 6.8	83	16% were married; 64% were widowed; 78% lived alone
Waterreus et al [34] 1994; Blanchard et al [35] 1995	Nurse-based case management; implementation of a care plan that was created by a hospital-based psychogeriatric team	96	Home	Minor depression, 58%; major depression, 23%; dementia, 6%	76 ± 6.8	85	22% were married; 63% were widowed
Quasi-experimental study ^a							
Cuijpers et al [37] 2001	Training for caregivers and other employees of residential home; information meeting for residents and relatives; group interventions offered	424	Residential facility	All residents; targeted on depressive symptoms	23.7% were 71–80 y, 57.8% were 81–90 y, and 16.4% were ≥90 y	79	10.6% were married; 74.3% were widowed; 33.5% lived in a residential home for 1–3 y; 37.7% lived in a residential home for ≥3 y

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Table 1 (continued)

Study	Model	N	Setting	Diagnoses	Age (mean $\pm$ SD y)	Female (%)	Demographic characteristics
Uncontrolled cohort, pre-post study Prospective Kohn et al [38] 2002	Multidisciplinary outreach team; treatment plan implemented by a social worker	93	Home: study focused on homebound older adults	Affective disorder, 33%; dementia plus depression, 18%; other dementia, 33%	79.7 $\pm$ 7 y	76	19% were married; 56% were widowed; 58% lived alone; 66% were white; 18% were African American; 14% were Hispanic
Seidel et al [39] 1992	Multidisciplinary outreach team; management plan implemented by a case manager	100	Residence: 27% lived in their own home, 40% lived in a nursing home, and 33% lived in a hostel or rest home	Major depression, 14%; Alzheimer's disease, 29%; other dementia, 14%; schizophrenia or delusional disorder, 19%	79.2 $\pm$ 7.6	63	31% were married; 49% were widowed

Wasson et al [40] 1984	Multidisciplinary geropsychiatric outreach team; home evaluation and linkage to medical, mental health, and social services	83	Home	Variable	Mean age 77 y; range, 60–94 y	71	63% were white; 35% were African American; 80% were single
Reifler et al [41] 1982	Multidisciplinary outreach team; home evaluation and treatment	100	Home	Depression, 13%; dementia, 21%; alcohol abuse, 9%; schizophrenia, 4%	Mean age 75 y; 25% were 60–69 y, 36% were 70–79 y, and 28% were 80–89 y	69	82% were white; 5% were black; 18% were married; 40% were widowed
Retrospective Brown et al [42] 1996	Multidisciplinary outreach team; case finding followed by home assessment and community support	95	Home	Affective disorder, 42%; organic mental disorder, 40%; schizophrenia, 12%; another diagnosis, 7%	36% were 65–74 y, and 48% were 75–84 y	71	34% lived with their spouse; 44% lived alone
Buckwalter et al [43] 1991	Multidisciplinary rural elderly outreach program; case finding followed by assessment, referral, treatment, follow-up, and coordination	30	Home and community	Depression, 15%; depression was the most common diagnosis	35% were 65–74 y, and 36% were 75–84 y	71	35% were married; 49% were widowed; 43% lived alone

^a The comparison group consisted of persons who received usual care.

Table 2

Outcomes of randomized, controlled trials examining home- and community-based treatment of late-life mental illness

Study	Intervention sample size (n)	Control sample size (n)	Follow-up		Outcomes and results	Limitations
			Duration (mo)	Completion rate (%)		
Randomized controlled trials ^a Ciechanowski et al [30] 2004	72	66	12	93 (intervention group); 91 (control group)	Intervention group had more improvement in depressive symptoms (HSC). Possible scores of the checklist range from 0–4, with lower scores indicating better functioning. The intervention group had a mean $\pm$ SD score of 1.3 ± 0.5 before the intervention and a mean score of 0.8 ± 0.6 after the intervention. The control group had a mean score of 1.2 ± 0.5 before the intervention and a mean score of 1 ± 0.5 after the intervention; 43% of the intervention group showed a reduction in depression symptoms of (at least 50%) compared with 15% of the control group; 36% of the intervention group had remission of depressive symptoms compared with 12% of the control group. The intervention group had more improvement in functional and emotional well-being (FACTS). Possible scores of the scale range from 0–4, with lower scores indicating better functioning. Mean functional change scores were .52 (CI, .29–.74) for the intervention group and .09 (CI, –.14–.33) for the control group. Mean emotional change scores were .33 (CI, .14–.52) for the intervention group and .11 (CI, –.09–.31) for the control group. No difference was found between the groups in service use or social and physical well-being.	Intervention group had a greater proportion of dysthymia than control group

Rabins et al [31] 2000	131; 393 for weighted sample size	167; 488 for weighted sample size	26	50 (intervention group); 58 (control group)	The intervention group had more improvement in psychiatric symptoms (BPRS). Possible scores of the scale range from 1-140, with lower scores indicating better functioning. The intervention group had a mean score of 29.7 ± 8.4 before the intervention and a mean score of 27.4 ± 7.2 after the intervention. The control group had a mean score of 30.1 ± 11.2 before the intervention and a mean score of 33.9 ± 13.6 after the intervention. The intervention group also had more improvement in depressive symptoms (MADRS). Possible scores of the scale range from 1-60, with lower scores indicating better functioning. The intervention group had a mean score of 13.7 ± 9.5 before the intervention and a mean score of 9.1 ± 6.2 after the intervention. The control group had a mean score of 11.7 ± 5.8 before the intervention and a mean score of 15.2 ± 9.5 after the intervention. No difference was found between the two groups in undesirable moves, including evictions or moves to a nursing home or to a board and care home. (Analyses were based on weighted numbers of psychiatric cases: 62 cases in the intervention group and 69 cases in the control group.)	No single standardized treatment was given. Individuals were randomized into groups after identification of mental illness; 33% dropped out of the study because of death or a move; an additional 13% refused to complete the study.
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Table 2 (continued)

Study	Intervention sample size (n)	Control sample size (n)	Follow-up		Outcomes and results	Limitations
			Duration (mo)	Completion rate (%)		
Llewellyn-Jones et al [32] 1999	109	111	9.5	79 (intervention group); 75 (control group)	The intervention group showed greater improvement in depression symptoms than the control group at follow-up. Depression was measured by the GDS; possible scores range from 1–30, with lower scores indicating better functioning. Before the intervention, 44.2% of the intervention group had scores of 14 or higher, 55.8% had scores ranging from 10–13, and none had scores of 9 or lower. After the intervention, 33.7% of the intervention group had scores of 14 or higher, 32.6% had scores ranging from 10–13, and 33.7% had scores of 9 or lower. Before the intervention, 32.5% of the control group had scores of 14 or higher, 67.5% had scores ranging from 10 to 13, and none had scores of 9 or lower. After the intervention, 44.6% of the control group had scores of 14 or higher, 31.3% had scores ranging from 10–13, and 24.1% had scores of 9 or lower. Factors associated with lower GDS scores included low baseline GDS scores, high baseline basic functioning, low neuroticism, younger age, and intervention participation.	Control and intervention periods were not concurrent. The study was conducted in only 1 large residential facility. At follow-up, 75% of participants completed the GDS, but only 58% completed all measures.
Banerjee et al [33] 1996	33	36	6	88 (intervention group); 89 (control group)	The intervention group tended to recover from depression (58% compared with 25% in the control group). The intervention group also had a greater change in the level of depression, as measured by the mean change in score from baseline to the follow-up on the MADRS. Possible scores range from 1–60, with lower scores indicating better functioning. The intervention group showed a mean 18.3 ± 6.5 point reduction; the control group showed a mean 11.6 ± 6.4 point reduction.	There was a possible nonresponse bias. Results may not generalize to non-home care populations. It was difficult to tell which component of the intervention caused the effect.

Waterreus et al [34] ^b 1994; Blanchard et al [35] 1995	47	49	3	92 (intervention group); 80 (control group)	The intervention group showed greater improvement in depression symptoms than the control group (SCARE). Possible scores range from 1–18, with lower scores indicating better functioning. The intervention group had mean scores of 8.5 ± 2.5 before the intervention and mean scores of 5.9 ± 2.6 after the intervention. The control group had mean scores of 8.4 ± 2.3 before the intervention and mean scores of 7.2 ± 3.3 after the intervention. No difference was found between the intervention and control group in the number of persons meeting criteria for probable pervasive depression.	There was a lag time between initial assessment and start of intervention. Analyses did not control for baseline factors.
Blanchard et al [36] 1999 ^b	47	49	6–14.5	75 (intervention group); 59 (control group)	In an extension of the previous study [34,35], the control and intervention groups received care management protocols provided by the general physician. Individuals with long-term depression did better in the intervention group than the control group (SCARE). Possible scores range from 1–18, with lower scores indicating better functioning. The intervention group had mean scores of 9.3 ± 2.7 before the intervention and mean scores of 6.3 ± 3.5 after the intervention. The control group had mean scores of 9.1 ± 2.7 before the intervention and mean scores of 9.2 ± 3.4 after the intervention. This finding was the only difference that was found between the control and intervention groups.	The study had a small sample, low power, variable follow-up length, and limited implementation of social and antidepressant treatment. In addition, most analyses showed no difference between the two groups.

Abbreviations: BPRS, Brief Psychiatric Rating Scale; FACTS, Functional Assessment of Cancer Therapy Scale; GDS, Geriatric Depression Scale; HSC, Hopkins Symptoms Checklist; MADRS, Montgomery-Asberg Depression Rating Scale; SCARE, Short Comprehensive Assessment and Referral Evaluation.

^a Comparison group consisted of persons who received usual care.

^b Study provides longer-term follow-up of the participants in the study by Waterreus and colleagues [34]. In the study by Blanchard and colleagues [36] the investigators provided general practice physicians with care management protocols for all participants, and the nurse case management intervention was discontinued.

Table 3

Outcomes of quasi-experimental and uncontrolled cohort studies examining home- and community-based treatment of late-life mental illness

Study	Intervention sample size (n)	Control sample size (n)	Follow-up		Outcomes and results	Limitations
			Duration	Completion rate (%)		
Quasi-experimental study ^a						
Cuijpers et al [37] 2001	213	211	1 y	59	The intervention group had greater improvement in depression (GDS). Possible scores range from 1–30, with lower scores indicating better functioning. The intervention group had mean scores of 8.1 ± 5.1 before the intervention and mean scores of 7.6 ± 5.2 after the intervention. The control group had mean scores of 9 ± 5.4 before the intervention and mean scores of 9.3 ± 4.2 after the intervention. The intervention group also had greater improvement in health-related quality of life (20-SFHS). Possible scores range from 1–100, with higher scores indicating better functioning. The intervention group had mean scores of 30.4 ± 38.8 before the intervention and mean scores of 29.5 ± 34.9 after the intervention. The control group had mean scores of 37.9 ± 36 before the intervention and mean scores of 21.9 ± 31.5 after the intervention.	The study was not randomized, there was a high dropout rate, and it was unknown which participants received the group therapy component. Also, the change in the GDS score was not clinically significant.

Uncontrolled cohort, pre-post study

Prospective

Kohn et al
[38] 2002

93

NA

Variable

100

Participants had improvement in global functioning (GAFS). Possible scores range from 1–100, with higher scores indicating better functioning. Participants had mean scores of 40.5 ± 18.6 before the intervention and mean scores of 48.2 ± 22.3 after the intervention. Participants received more hours per week of homecare services after the intervention (34.6 h compared with 51.6 h), but they did not differ in their degree of being homebound.

The study did not have a control group and had a limited analysis of potential outcomes. The analyses were confounded by unmeasured variables, and there were potential systematic differences between participants who remained in the program.

Seidel et al
[39] 1992

100

NA

3 mo

86

Participants had improvement in behavioral disturbances (as measured on a 1 to 4 scale, with higher scores indicating better functioning). Participants had mean scores of 2 ± 0.8 before the intervention and mean scores of 3 ± 0.9 after the intervention; 87% of referring agents and 80% of caregivers perceived the service as helpful or very helpful.

The study did not have a control group and did not evaluate behavioral disturbances among individuals residing in their own home because behavioral disturbances were not a significant problem for that group. The analyses did not adjust for severity of psychiatric symptoms. Cell sizes were too small to be able to accurately detect changes within diagnostic groups.

Wasson et al
[40] 1984

83

NA

3 mo

80

Direct psychiatric services were recommended for 77% of the participants; 51% improved at follow-up (decreased symptoms, increased well-being, and reduced tension between participant and significant other).

The study had selection biases; for example, it excluded hospitalized participants from follow-up. Also, the study did not have independent raters, did not have standardized measures, examined few outcome measures, and did not have a control group.

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Table 3 (continued)

Study	Intervention sample size (n)	Control sample size (n)	Follow-up		Outcomes and results	Limitations
			Duration	Completion rate (%)		
Reifler et al [41] 1982	100	NA	3–4 y	74	Limited data were reported. Most participants maintained independence: 69% of participants owned their own home before the intervention, and 62% owned their own home after the intervention. Only 21% of participants used community services.	The study did not have a control group and did not have statistical evaluation or standardized measures. The study reported outcome data that were obtained by the clinicians who provided the interventions. Investigators attempted to contact 400 persons to identify the 100 persons who were included in the study.
Retrospective Brown et al [42] 1996.	95	NA	6, 12, and 18 mo	100	At 12 and 18 mo, respectively, 13% and 19% had died, 75% and 65% remained in the community, and 13% and 14% lived in long-term care facilities.	The study did not have a control group. Participants who were included in the caseload were more likely than those who were referred but not admitted to the caseload to have affective disorders or schizophrenia. The study was unable to link outcomes to intervention. Discharge locations were unknown. No functional or psychiatric outcomes were given.

Buckwalter et al [43] 1991	30	NA	4 mo	100	Improved psychiatric symptoms (GDS, SPMSQ, and SPES).	No data or statistics were provided. The study had a small sample size and no control group. The study was potentially biased because no description was given of the selection process for the 30 clients in the study. Also, sensitivity of the measures was questionable.
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Abbreviations: 20-SFHS, 20-item Short-Form Health Survey; GAFS, Global Assessment of Functioning Scale; GDS, Geriatric Depression Scale; NA, not applicable; SPES, Short Psychiatric Evaluation Schedule; SPMSQ, Short Portable Mental Status Questionnaire.

^a Comparison group consisted of persons who received usual care.

The considerable variation across studies in types of interventions, designs, and outcome measures precludes conducting meta-analyses of pooled data, prohibits the calculation of an overall effect size, and complicates interpretation of data. There were few randomized, controlled trials, and only one of the nine nonrandomized trials adjusted for symptom severity [37]. Follow-up periods ranged from 3 months to 4 years. Participant characteristics also differed across studies. Although most studies had high proportions of female participants aged 70 to 80, ethnicity and diagnoses differed. Several studies targeted individuals with depression, whereas others included a range of diagnoses, depression and dementia being the most common. Moreover, variability in participant characteristics may limit generalizability to younger male populations or to individuals with psychotic, anxious, or other symptom constellations.

The interventions themselves varied across studies, including the case identification method, type, and intensity of treatment provided and the composition of the treatment team. Two of the twelve outcome studies used gatekeepers to make patient referrals [31,43], two used traditional referral mechanisms [38,41], and most studies screened participants from home and residential care settings or senior service agencies [30,32,34,35, 37,40,44]. The studies also lacked a common taxonomy for characterizing types of mental health service models and associated outcomes.

The strengths of this review include the use of a broad search strategy and standardized inclusion and evaluation criteria to identify candidate studies. One limitation is that the search strategy was limited to published English language articles. In addition, studies that resulted in negative findings might not have been published, so that this review may overly reflect studies with positive outcomes. Home-based mental health care conducted by video was also excluded. Although geriatric telepsychiatry shows promise for improving access to mental health care in underserved areas, literature on the application of this technology remains limited to a small number of feasibility studies [45].

As a group and despite their limitations, these studies represent a significant step toward surmounting the barriers to providing evidence-based mental health care to frail or homebound community-dwelling older adults. The difficulties in meeting the mental health needs of this population mirror those faced by most geriatric mental health services and include concurrent mental health, cognitive, and medical problems, social losses, disability, cultural and ethnic diversity, variations in family resources and involvement, and competency in decision making. These problems can be particularly challenging in homebound older adults because this group tends to have a greater constellation of these concerns than average community-dwelling elders do. Homebound older adults also often do not have the kinds of clinical and professional support available to residents of nursing homes or other institutions. Moreover the health and social needs of frail and homebound older adults change rapidly over time, necessitating greater coordination of care over time and across providers.

An important methodological consideration in further developing this evidence base is the choice of outcome measures, especially in the context of multiple patient needs. Studies need to ensure that their outcomes and specific measures are relevant to age and culture. A similar consideration is the method used to assess outcomes. In the studies reviewed here, outcome measures varied substantially, and many studies failed to use standardized assessment measures [39–42]. Some of the studies reported only outcome data obtained by the same clinicians who provided the interventions, which might have led to biased outcome measures. Among the fourteen studies, nine used independent outcome raters [30–34,37–39,43], two documented inter-rater reliability [32,39], and seven used an intent-to-treat analysis [30–34,37,42]. Generally, uncontrolled cohort studies failed to qualify their conclusions by discussing the possibility that symptom improvement could represent regression to the mean.

Conducting intervention research in the home environment holds its own set of challenges. Difficult aspects include gaining access to potential research subjects, obtaining support from family members, involving appropriate personal clinicians, monitoring intervention fidelity, and ensuring subject safety while respecting individual autonomy, especially when research and services are provided in a person's home. The complexity and time demands of conducting randomized trials in this setting may help to explain the large number of studies in this review that reported qualitative and observational outcome data (as evidenced by 36 descriptive and four case study reports). Although experimental designs offer more support for the association of a causal relationship, there is an inherent difficulty in executing and evaluating randomized, controlled trials in the field of mental health services. As such, the contribution from lower tiers of evidence should not be ignored, especially in an area with potential for improving access and quality of mental health care.

Finally, despite promising evidence in support of interventions that integrate or coordinate care, a potential weakness of many of these models is their lack of sustainability. Only two of the studies reviewed in this analysis included information on the cost of the intervention [30,43], limiting the capacity of policy makers or providers to assess practical considerations associated with implementing and sustaining these treatment models in routine clinical settings. Particularly problematic are models that integrate home-based care by providers from multiple organizations. One hurdle to integrated models is that, to be most effective and sustainable, the intervention must be embraced at the levels of the organization and the frontline practitioner [46].

In summary, the current evidence provides promising support for home-based mental health services for older adults whose access to traditional practice-based models of care is limited. Observational, uncontrolled studies report that mental health outreach services may be associated with greater access for mentally ill older people. More rigorous studies report that

home- and community-based treatment is associated with a reduction in psychiatric symptoms. However, additional studies are needed using rigorous, standardized approaches to measure mental health outcomes and to characterize the intervention. Well-designed, controlled studies may help to identify effective and sustainable approaches to providing evidence-based mental health treatment to frail or homebound older adults.

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1 S100187A

2 ILLINOIS DEPARTMENT OF PUBLIC HEALTH
3 HEALTH FACILITIES AND SERVICES REVIEW BOARD
4 OPEN SESSION

5
6
7 REPORT OF PROCEEDINGS
8 Bolingbrook Golf Club
9 2001 Rodeo Drive
10 Bolingbrook, Illinois 60490
11 December 16, 2014
12 9:08 a.m. to 3:23 p.m.

13 BOARD MEMBERS PRESENT:

14 MS. KATHY OLSON, Chairperson;
15 MR. JOHN HAYES, Vice Chairman;
16 DR. JAMES J. BURDEN;
17 MR. DALE GALASSI; and
18 MR. RICHARD SEWELL.

19
20
21
22
23 Reported by: Melanie L. Humphrey-Sonntag,
24 CSR, RDR, CRR, CCP, FAPR
Notary Public, Kane County, Illinois

1 EX OFFICIO MEMBERS PRESENT:

2 MR. MATT HAMMOUDEH, IDHS; and

3 MR. MIKE JONES, IDHFS.

4
5 ALSO PRESENT:

6 MR. FRANK URSO, General Counsel;

7 MS. JEANNIE MITCHELL, Assistant General Counsel;

8 MS. COURTNEY AVERY, Administrator;

9 MS. CATHERINE CLARKE, Board Staff;

10 MR. MICHAEL CONSTANTINO, IDPH Staff;

11 MR. BILL DART, IDPH Staff; and

12 MR. GEORGE ROATE, IDPH Staff.

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**SUBSEQUENT TO INITIAL REVIEW -- 12/16/14
DECATUR MEMORIAL HOSPITAL**

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1 CHAIRPERSON OLSON: Okay. Next we have
2 Decatur Memorial Hospital.

3 May I have a motion to approve
4 Project 14-046, Decatur Memorial Hospital, to
5 establish a 20-bed AMI unit on the campus of its
6 hospital in Decatur?

7 MEMBER SEWELL: So moved.

8 VICE CHAIRMAN HAYES: Second.

9 CHAIRPERSON OLSON: If the Applicant
10 will be sworn in, the people at the table, please.

11 THE COURT REPORTER: Raise your right
12 hands.

13 (Four witnesses duly sworn.)

14 THE COURT REPORTER: Thank you. Please
15 print your name on the sheet.

16 CHAIRPERSON OLSON: Mike, State Board
17 staff report, please.

18 MR. CONSTANTINO: Thank you, Madam
19 Chairwoman.

20 The Applicants are proposing to establish a
21 20-bed AMI category of service at a cost of
22 approximately \$1.6 million.

23 No letters of support were received and
24 two letters of opposition were received. No public

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DECATUR MEMORIAL HOSPITAL**

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1 hearing was requested.

2 Thank you, Madam Chairwoman.

3 CHAIRPERSON OLSON: Thank you, Mike.

4 Questions from the Board?

5 MEMBER GALASSI: I would just like to
6 comment.

7 The -- I commend anyone -- and in this case,
8 Decatur Memorial -- for getting into the AMI business
9 today. It's certainly unique and there's a great need
10 out there that exists. And I'm pleased to hear it and
11 will support your project.

12 CHAIRPERSON OLSON: Oh, I'm sorry.

13 MEMBER SEWELL: I didn't hear what
14 he said.

15 CHAIRPERSON OLSON: Mr. Galassi,
16 Mr. Sewell did not hear your comment but I think --
17 I'm going to tell you -- go ahead.

18 MEMBER GALASSI: Just simply stated,
19 I was commenting support for the project for any
20 organization getting into AMI right now; in this case,
21 specifically Decatur. We're aware of the need and
22 fewer and fewer providers of AMI.

23 MEMBER SEWELL: I'm sorry.

24 CHAIRPERSON OLSON: I'm sorry. The

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1 Applicants will please give us your comments, please.

2 MS. FAHEY: Certainly. Thank you for
3 the opportunity to address the Board.

4 I'm Linda Fahey, the chief nursing officer
5 for Decatur Memorial Hospital. We're a 300-bed
6 independent community hospital, and I -- in central
7 Illinois, as you know.

8 And as we look at the population that we
9 serve, we are proposing to change 20 of our med/surg
10 beds to mental health-licensed beds so that we can
11 provide care for our patients that we currently serve
12 in our hospital who have secondary diagnoses that are
13 actually psychiatric diagnoses.

14 We believe that we need to provide this
15 additional service for our senior population because
16 they're coming to our hospital with chronic mental
17 illness along with chronic medical problems. And
18 while we're quite capable now of treating the medical
19 problems, we believe that we don't have adequate
20 services to adequately address those mental health
21 needs that they're coming to our facility with.

22 Most of these patients have dual diagnoses,
23 so they need their medical doctors, they need to be
24 managed both medically and psychiatrically, and right

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1 now Decatur Memorial Hospital does not provide
2 psychiatric services.

3 So we're looking at our capacity as far as
4 20 med/surg beds that we are not using right now and
5 changing that license category to 20 mental health
6 beds to treat our senior population that have these
7 disorders and who have both medical and psychiatric
8 illnesses.

9 We believe that, in doing so, we'll be able
10 to provide better care for our patients, that we will,
11 in some cases, be able to keep them independent for a
12 longer period of time, and then, in the long run, save
13 the State and the Federal government as far as
14 payments on health care because we believe that that
15 secondary benefit -- diagnosis or sometimes the
16 primary diagnosis needs to be adequately treated.

17 Our patients are very secure with their
18 medical doctors and so seek care at Decatur Memorial
19 Hospital where their doctors practice. They're not
20 really willing to go to another facility to seek that
21 kind of care and often certainly will choose going
22 home without that care and may come back with further
23 problems if we don't address it.

24 Our cost is minimal. You saw that staff

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1 findings were that the space was in excess of the
2 recommendations. That's because it's existing space.
3 And some of those rooms in existing space were
4 semiprivate rooms in some previous life, so the rooms
5 are large. This population, many of them need a
6 private room, and so a portion of this unit will be
7 private rooms to accommodate the population that we'll
8 be serving.

9 You also saw that we -- that there is not a
10 bed indication for our health services area. And we
11 believe, in this particular subsection of the
12 population, there is. It's demonstrated by our own
13 patient population that we treated in our hospital
14 last year.

15 Of those, about 2,700 and something ended up
16 with a secondary psychiatric diagnosis along with
17 their medical diagnosis. And even if we treated
18 25 percent of that 2,775 patients with additional
19 psychiatric care, that would fill that 20 beds up to
20 85 percent.

21 So we really believe that our own patient
22 population is signifying this need for those
23 particular beds and, really, won't have impact on the
24 bed counts in our health service area. There's also

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1 an excess of med/surg beads, so we'll be moving from
2 one category to another as far as that goes.

3 I have with me colleagues, my senior vice
4 president for our network, who is with me to answer
5 any questions, along with two colleagues, Mr. Copelin
6 and Mr. Berson, who helped me with development of
7 the CON. So we're here to answer any questions that
8 you might have. We believe this is a valuable service
9 that our patients need.

10 CHAIRPERSON OLSON: Thank you.

11 Questions?

12 Go ahead, Mr. Sewell.

13 MEMBER SEWELL: What's the system like
14 in your area for community-based mental health
15 services? Ambulatory.

16 MS. FAHEY: We work very closely with --
17 we do have a large facility in downtown Decatur that
18 provides some community-based care. We do have, as
19 you saw in the staff report, another psychiatric unit
20 at the other hospital in town.

21 We have limited access to psychiatrists and
22 some aging psychiatrists, so we will be recruiting a
23 psychiatrist to our community for this particular
24 service, and I believe, overall, that increases

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DECATUR MEMORIAL HOSPITAL**

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1 availability of community-based services, as well, for
2 this population. To get another psychiatrist in town
3 would also serve them.

4 MEMBER SEWELL: What about posthospital
5 services? Does this provider you speak of participate
6 in that?

7 MS. FAHEY: Yes. This provider will be
8 working with a psychology group who functions in
9 central Illinois who already -- the psychologists
10 already provide services at our hospital, and they
11 will be the one who will bring in a psychiatrist to
12 help on this particular unit.

13 MEMBER SEWELL: And does their patient
14 profile include many older patients?

15 MS. FAHEY: Yes. They specialize in
16 medical-psychology situations, and so they do visit
17 many of our skilled nursing facilities in town.

18 And in our certificate of need process,
19 you'll see that we also had letters of support from
20 many of our skilled nursing facilities who surround
21 the hospital themselves because we work very closely
22 with them.

23 CHAIRPERSON OLSON: Other questions or
24 comments?

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1 Doctor.

2 MEMBER BURDEN: Excuse me.

3 You mentioned recruiting another
4 psychiatrist. In my family we have two mental
5 therapists, one of whom is a psychologist at a major
6 university not in this area.

7 He assumes -- he assumes you are willing to
8 take mental health providers other than
9 psychiatrists -- he would since he is a
10 psychologist -- and the only difference between he --
11 in California there's none -- he writes prescriptions.
12 I think that's dangerous but that's California.

13 Psychologists would not help you there?
14 I mean, I think it's easier to recruit one of those
15 than a shrink.

16 MS. FAHEY: We will be using a number of
17 psychologists in this program as therapists, and, in
18 fact, our psychologists who work at our facility now
19 are wonderful in support of the care at our hospital.

20 It -- many of these patients have complex
21 medication management issues that require a physician
22 working in conjunction with those other wonderful
23 professions.

24 MEMBER BURDEN: That's what the shrinks

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1 tell you. I know that.

2 MS. FAHEY: That's true.

3 MEMBER BURDEN: I practiced for 40 years
4 in this area, and I had a fair number of those
5 patients along the line. You know what I mean. Okay.
6 That's fine to say it. I'll . . . be careful making
7 that statement --

8 MS. FAHEY: Right.

9 MEMBER BURDEN: -- but I knows otherwise.

10 MS. FAHEY: I strongly support the role
11 of our psychologists, as well.

12 MEMBER BURDEN: Good for you.

13 Thank you.

14 CHAIRPERSON OLSON: I actually have a
15 question.

16 The one opposition letter from St. Mary's
17 stated that they had some concern because it -- it
18 sounds like you're talking about general psych,
19 basically.

20 MS. FAHEY: That's correct.

21 CHAIRPERSON OLSON: But their concern
22 was that you would say you want 20 AMI beds for
23 general psych and then switch them into something
24 different.

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1 Can you respond to that concern?

2 MS. FAHEY: Well, at this point I -- our
3 patient population does not indicate that we would
4 need to do that.

5 And I can't tell you in the future, if the
6 population suddenly became younger in Decatur and the
7 demand was to serve our community focused in that
8 direction, we would have to consider that.

9 Right now we're participating as the only
10 hospital in Decatur in the State's managed Medicaid
11 program. And, you know, we'll -- along with the State
12 of Illinois, we would want to provide the most
13 cost-effective way to care for any of those patients,
14 whether seniors or otherwise.

15 But we have no plans at this point to do
16 that.

17 CHAIRPERSON OLSON: So did I just hear
18 you say you're the only hospital in Decatur
19 participating in the Medicaid managed care program?

20 MS. FAHEY: That is correct.

21 CHAIRPERSON OLSON: Thank you.

22 Any other questions or comments?

23 VICE CHAIRMAN HAYES: Madam Chairman.

24 CHAIRPERSON OLSON: Yes.

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1 VICE CHAIRMAN HAYES: I was -- wanted to
2 ask the Applicant specifically -- how far are you from
3 Champaign-Urbana?

4 MS. FAHEY: It -- in good weather, it
5 takes about 45 to 50 minutes to reach there. And
6 via -- and that's just the outskirts. If you're
7 trying to reach one of the hospitals, it's a little
8 bit longer than that.

9 VICE CHAIRMAN HAYES: Now, do you have,
10 you know, referral relationships where many of your
11 patients, for more complex cases, are referred to one
12 of those hospitals there?

13 MS. FAHEY: Yes. We have a very strong
14 working relationship with Carle, and so we do -- and
15 they are our designated trauma center -- so we do
16 refer patients to Carle.

17 Our patients -- and from time to time we'll
18 select -- going either direction, it is -- whether you
19 go to Springfield or whether you go to Champaign-
20 Urbana, it is a good 45-minute trek either way.

21 VICE CHAIRMAN HAYES: And do you have --
22 does Carle have an AMI unit?

23 MS. FAHEY: I don't believe Carle does.

24 VICE CHAIRMAN HAYES: But they were --

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1 they work closely with the hospital on the other side
2 of town?

3 St. Elizabeth? Is that it?

4 MS. FAHEY: I believe The Pavilion is
5 the psychiatric unit in Champaign, but I'm not sure of
6 their association.

7 VICE CHAIRMAN HAYES: Thank you.

8 CHAIRPERSON OLSON: Mr. Sewell.

9 MEMBER SEWELL: Who had -- who were the
10 other providers that have the AMI beds? Other than
11 St. Mary's.

12 MS. FAHEY: The -- St. John's does have
13 some AMI beds. That's in Springfield, about a
14 45-minute drive from us.

15 And then south of us, I believe Sarah Bush,
16 which is about the same direction south. Mileswise, a
17 little bit longer on true country roads. But, yeah,
18 they do have a small number of beds, as well.

19 MR. COPELIN: There's also The Pavilion
20 health care or health facility in Champaign, and it's
21 amazingly set up with psychiatric beds.

22 CHAIRPERSON OLSON: But you're the only
23 one -- I mean, you and St. Mary's are the only ones in
24 Decatur?

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1 MS. FAHEY: That is correct.

2 MEMBER GALASSI: Doesn't your community
3 health center have some outpatient community health --

4 MS. FAHEY: The community -- they're --
5 a health center called Heritage has some outpatient
6 services, yes.

7 MEMBER GALASSI: And limited but --

8 MS. FAHEY: Yes. And then our -- we
9 work very closely with our Federally qualified health
10 center, CHIC Clinic, and they have quite a bit of
11 outpatient support in the mental health arena.

12 CHAIRPERSON OLSON: Other questions or
13 comments?

14 (No response.)

15 CHAIRPERSON OLSON: Seeing none, I'll --

16 MEMBER BURDEN: I have something.

17 CHAIRPERSON OLSON: Oh, I'm sorry,
18 Doctor.

19 MEMBER BURDEN: Just one.

20 You -- I -- the CEO of St. Mary's obviously
21 is not anxious to see you do what you came to do
22 today.

23 Is that realistic? Or how do you rebut that
24 comment of St. Mary's regarding their AMI bed

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1 situation -- AMI beds?

2 MS. FAHEY: First of all, before we
3 applied for a certificate of need here, we did have a
4 conversation with the CEO at St. Mary's then -- who
5 was the current CEO at that time -- and he said that
6 they would not oppose the CON and, in fact, said he
7 was interested in recruiting a psychiatrist with us.

8 They have since changed leadership, and
9 apparently the new leadership had a different opinion.
10 However, we did try to reach out to them and work with
11 them before we tried to apply for the certificate of
12 need.

13 We believe that our unit will be slightly
14 different from theirs. They are fairly limited in the
15 patients that they'll take who are not medically
16 stable, and we believe it's very hard on our geriatric
17 population to achieve medical stability and
18 psychiatric stability independently. And we'll be
19 treating -- both our hospitalists, who are in-house
20 24/7 -- if their primary care physician is not
21 covering, they'll be covering these patients, and so
22 we'll be able to provide the medical support along
23 with the wonderful psychiatric support we plan.

24 MEMBER BURDEN: All right.

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1 CHAIRPERSON OLSON: Okay. May I have a
2 vote, please, roll call?

3 MR. ROATE: Motion made by Mr. Sewell;
4 seconded by Mr. Hayes.

5 Dr. Burden.

6 MEMBER BURDEN: This is a difficult call
7 because I think you're quite on board, notwithstanding
8 the comment made by one of our form -- one of our
9 Board members who feels very enthusiastic about your
10 attempts to create more AMI beds.

11 I don't necessarily disagree with him, but
12 I am faced with a problem here. According to this
13 staff report, there's 78 excess beds in the community.
14 That's what I see here, so I have trouble okaying
15 this.

16 I think I have to vote no.

17 MR. ROATE: Mr. Galassi.

18 MEMBER GALASSI: Yes, based upon their
19 own population needs.

20 MR. ROATE: Mr. Hayes.

21 VICE CHAIRMAN HAYES: I'm going to vote
22 no because of the State agency report and -- you know,
23 which mentions planning area need and impact on other
24 providers, maldistribution.

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1 MR. ROATE: Mr. Sewell.

2 MEMBER SEWELL: I'm going to vote yes.
3 And the reason is it's this specialized area involving
4 geriatric patients where there appears to be somewhat
5 of a deficit on that.

6 And I think the Applicant did a good job of
7 explaining away the problem with the size of the
8 project based on limitations of the facility. And it
9 looks like these beds, existing AMI beds, they're a
10 little bit of a distance away.

11 So I vote yes.

12 MR. ROATE: Madam Chair.

13 CHAIRPERSON OLSON: I also vote yes
14 based on the reasons that Mr. Sewell just outlined
15 but, also, on the fact that I believe that the managed
16 Medicaid population in Decatur needs some access. And
17 without these AMI beds at Decatur Memorial, they have
18 to go 45 to 50 minutes away for any access to Medicaid
19 managed care divisions.

20 MR. ROATE: That's 3 votes in the
21 affirmative, 2 votes in the negative.

22 CHAIRPERSON OLSON: Motion fails.

23 MR. URSO: You're going to be receiving
24 an intent to deny. You'll have another opportunity to

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1 come before the Board as well as submit additional
2 information.

3 Thank you.

4 CHAIRPERSON OLSON: Thank you.

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CENTRAL DUPAGE HOSPITAL**

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1 CHAIRPERSON OLSON: Next is 14-051,
2 Central DuPage Hospital, Winfield.

3 May I have a motion to approve
4 Project 14-051, Central DuPage Hospital, to modernize
5 and expand the pediatric service at its hospital in
6 Winfield?

7 MEMBER BURDEN: So moved.

8 VICE CHAIRMAN HAYES: Second.

9 CHAIRPERSON OLSON: Mike, State Board --
10 oh, let's swear in the Applicants, please.

11 THE COURT REPORTER: Raise your right
12 hands, please.

13 (Seven witnesses duly sworn.)

14 THE COURT REPORTER: Thank you. And
15 I have your names so you're good.

16 CHAIRPERSON OLSON: Mike, State Board
17 staff report.

18 MR. CONSTANTINO: Thank you, Madam
19 Chairwoman.

20 The Applicants are proposing the
21 modernization of their pediatric unit and asking you
22 to add 12 pediatric beds for a total of 22 pediatric
23 beds.

24 The cost of the project is \$14.2 million.