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Special Feature Article

Reforming the Clinical Field: The Necessity of "Micro" General Hospitals

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Abstract

The effects of declining birthrates and an aging population are affecting psychiatric hospitals. In recent years, nearly 90% of newly admitted patients have been discharged within one year. The vacancy rate of hospital beds in psychiatric hospitals continues to rise. However, long-term hospitalized patients have a high rate of physical complications, and many psychiatric hospitals struggle to accommodate them.

Aisei Century Hospital has an Orthopedics Department with an operating room, a Rehabilitation Department with a physiotherapy room, and an Internal Medicine Department and Dentistry Department that can handle dysphagia and oral hygiene. As a result, many inpatients who are currently referred to our hospital are patients with physical complications. Furthermore, in the autumn of 2021, an internal medicine doctor was selected as director of Aisei Century Hospital.

In recent years, there has been a lot of discussion about community-based integrated care systems. The length of hospitalization has become shorter; however, about one-third of patients are re-hospitalized within a year after being discharged. Physical complications and medical fees in psychiatric hospitals are specific problems.

In order for patients with mental disorders to live in the community, it is necessary to have a general hospital with a psychiatric department or a psychiatric hospital like ours that can treat physical complications.

Keywords: micro general hospital, physical complications, medical fees, community-based integrated care

Introduction

The effects of declining birthrates and aging populations have reached psychiatric hospitals. Over the past few years, the number of inpatients has gradually decreased, with nearly 90% of new admissions being discharged within one year. Currently, the vacancy rate in psychiatric hospitals nationwide is steadily increasing. Meanwhile, patients forced into long-term hospitalization often have physical complications, leading many psychiatric hospitals to struggle with managing these complications.

Discussions on “Community-Based Integrated Care that also Addresses Mental Disorders” have been ongoing for several years. According to the Ministry of Health, Labour and Welfare, this system comprehensively ensures access to medical care, disability welfare, nursing care, housing, social participation (employment), mutual community support, and education. Its goal is to enable individuals with mental disorders to live safely and realistically as members of their communities. Achieving this requires collaboration among multiple professions and organizations within

the community, including medical institutions, administrative bodies, and welfare/nursing care service providers. Discussions are underway at prefectural and municipal levels. However, even within the medical field, goal setting is not always successful.

Currently, the length of stay in psychiatric hospitals is clearly decreasing. However, approximately one-third of discharged patients are readmitted within one year. Explanations for this often point to an insufficient community support capacity. While this is generally true, it is necessary to identify specific local problems more concretely. The issue of physical complications is one such specific problem.

This paper introduces how Aisei Kinen Hospital (hereinafter, our hospital) addresses physical complications and explains issues related to medical fees when psychiatric hospitals address them.

I. Focus on Complications

Originally a long-established single-specialty psychiatric hospital, our hospital underwent significant transformation around the turn of the

21st century, anticipating the changing landscape of psychiatric care. We successively added departments, including an orthopedic surgery department with an operating room, a rehabilitation department with physical therapy facilities, an internal medicine department, a geriatrics department including dementia care, and a dental department capable of addressing oral hygiene and dysphagia.

The impetus for this focus on complications arose when elderly inpatients were transferred to other hospitals for surgery and, despite successful procedures, were frequently returned to our hospital without having received adequate rehabilitation. Seeing patients grimacing as they walked with difficulty, struggling to hold chopsticks, and even developing pseudoarthrosis or becoming nearly bedridden, we began to consider whether we could address these issues ourselves. Certainly, patients with psychiatric symptoms might be difficult to manage on general medical wards, and so it is understandable that directing them to rehabilitation could be challenging. Therefore, we considered whether the psychiatric hospital itself, well trained in the care of patients with mental disorders, could establish a system capable of providing everything from surgery to rehabilitation.

II. Establishing Orthopedics

At the time, many hospitals were pursuing ward standards focused on high-profit areas, such as emergency and acute care. Our hospital, however, shifted its focus to managing physical complications, an area that was not receiving much attention at the time. Fortunately, having an orthopedic surgeon in the author's family also supported this idea. This ultimately led to a focus on the needs of patients with mental disorders who would eventually live in the community.

Subsequently, an orthopedic surgeon expressed interest in transferring to our hospital. In 2001, we established a fully equipped Orthopedic Surgery and Rehabilitation Department complete with an operating room. We also abandoned the initial plan for a psychiatric day care center at that location, instead establishing a dedicated physical therapy room there. This led to us being the first psychiatric hospital in the Tokai region capable of providing postoperative management. Gradually, more patients admitted to our hospital presented with physical complications, fundamentally changing the nature of ward nursing within the hospital.

From that time until now, despite strenuous efforts, profitability has remained low. Compounded by various contradictions in medical fees, we have

been forced to navigate difficult hospital management. Nevertheless, we pressed forward, believing that this hospital's direction could become a viable model for psychiatric hospitals to survive in urban areas in the future.

III. The Wave of Population Aging and Subsequent Developments

After operating for over a decade as a psychiatric hospital with an orthopedic department, we made a significant strategic shift around 2019. Coincidentally, a physician who had been the head of internal medicine at a public hospital in the prefecture transferred to our hospital. Given that the aging inpatient population was leading to various internal medicine-related complications, the reassurance provided by having both an orthopedic surgeon and internist permanently on staff became significant. The figure shows the age distribution of our hospital's inpatients as of June 30, 2022. As can be seen, the overall aging rate at our hospital stands at 57%. The ward with the youngest average age is the 15:1 fee-for-service ward, which also handles the highest number of admissions for complications.

Furthermore, since the onset of the COVID-19 pandemic several years ago, we have actively promoted vaccination among local residents through our newly established internal medicine

outpatient clinic, aiming to become a community-rooted psychiatric hospital. At the time of writing, vaccination rates stood at 94.8% for our hospital staff and 93.8% for inpatients. We have administered vaccines to over 3,000 local residents.

The course of the COVID-19 pandemic revealed that psychiatric hospitals are vulnerable to infectious diseases. Consequently, a guidance system was established to ensure functioning through implementation of standard precautions from an internal medicine perspective, and plans were made to establish an in-house testing system.

Then, in the fall of 2021, an internal medicine physician was appointed as the director of our psychiatric hospital.

IV. Issues Regarding Medical Fees

The most critical question when managing complications in a psychiatric hospital, where all hospital beds are psychiatric beds, is whether the medical fees allow the hospital to remain financially viable. However, discussions on medical fees likely do not consider facilities like ours, resulting in an inappropriate situation, as described below.

For example, introducing some of the items billed by our orthopedic department: the average monthly number of inpatients receiving physical

rehabilitation is 22; the average monthly number receiving pressure ulcer prevention measures is 7.5; the average monthly number billed for orthopedic physical complication additions is 4.5; and the average monthly number of surgeries (such as for fractures) is 2.3.

However, while physical rehabilitation is permitted on psychiatric wards, it is not permitted on acute care wards. Consequently, even if an inpatient requiring rehabilitation due to complications is appropriately admitted to an acute care ward because of their psychiatric symptoms, medical-fee points for rehabilitation cannot be claimed when they are admitted to such a ward.

Furthermore, while general hospitals receive medical-fee points for osteoporosis prevention plans, our hospital, despite implementing osteoporosis prevention measures, cannot bill for these medical-fee points because it is a psychiatric hospital.

Regarding postoperative physical rehabilitation as well, medical-fee points cannot be claimed for patients who undergo surgery at our hospital, whereas only patients transferred postoperatively from other hospitals can be billed for those points, creating a contradiction.

Furthermore, in the internal medicine field, there are numerous

issues, particularly in outpatient care. For example, the Outpatient Specific Disease Management Fee cannot be billed at hospitals with 200 or more licensed beds. Consequently, even when treating physical diseases such as tuberculosis, malignant neoplasms, thyroid disorders, diabetes, dyslipidemia, hypertension, ischemic heart disease, arrhythmia, heart failure, cerebrovascular disease, chronic obstructive pulmonary disease (COPD), emphysema, bronchial asthma, gastric and duodenal ulcers, gastritis, duodenitis, and chronic liver disease as the primary illness in outpatient care, fees cannot be billed.

Furthermore, the Outpatient Lifestyle-Related Disease Management Fee cannot be billed at hospitals with 200 or more approved beds. Consequently, even when dyslipidemia, hypertension, and diabetes (excluding inpatients) are the primary conditions affecting patients, fees cannot be billed, even if a treatment plan is formulated with a patient's consent and comprehensive lifestyle-related treatment management is provided based on that plan.

I recall that these were measures intended to redirect patients, who had a tendency to consult large hospitals, toward clinics such as their regular family doctor. However, I believe that this policy does not apply to psychiatric

hospitals like ours. Unless some countermeasures are taken, such as creating a management fee like the Psychiatric Outpatient Physical Comorbidity Management Fee (tentative name), this may lead to a community-based integrated care system that is extremely disadvantageous for patients living with disabilities in the community.

Furthermore, as our orthopedic and internal medicine physicians manage physical illnesses, we recognize that the items and content of the Complication Add-on Fee are insufficient. For example, the scope for infectious diseases is narrow, and complications such as pyelonephritis, cholecystitis, and cholangitis, which are increasingly common, are not included.

Conclusion

I believe that in the near future, general hospitals with psychiatric departments or psychiatric hospitals like ours that can manage complications will become essential for the community integration of patients with mental disorders. If so-called “community-based integrated care that also addresses mental disorders” progresses, more patients will live in the community. Naturally, physical illnesses (complications) will increase as they age.

However, deep-rooted community prejudice against mental illness

persists even today, and regrettably, this extends to general practitioners in the community as well. Failing to recognize physical problems until it is too late, or being unable to receive adequate examination and treatment, is becoming one of the barriers for patients living with disabilities in the current community setting.

Finally, we conclude this article by listing the key issues:

- (i) Few physicians involved in physical medicine have a thorough understanding of psychiatric care
- (ii) Psychiatrists lack adequate education regarding physical illnesses (including infectious diseases)
- (iii) Nursing care for physical complications in psychiatric hospitals is burdensome
- (iv) Current medical reimbursement systems fail to adequately compensate for treating complications during psychiatric hospitalization
- (v) Current medical reimbursement systems fail to adequately compensate for treating complications in outpatient settings after community transition

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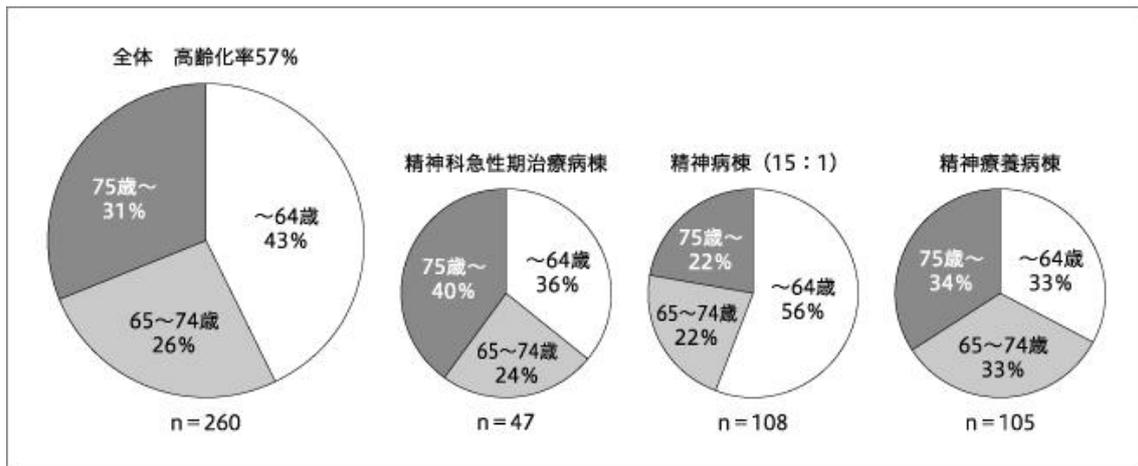


図 当院入院患者の年齢分布

Figure: Age distribution of inpatients at our hospital