SPEAKER NOTES

Triple Treat: A Discussion with Guy Qvistgaard

Summarized by Thomas T. Thomas

GUY QVISTGAARD

Guy Qvistgaard was the speaker at our March 22 meeting. He essentially wears multiple hats, and he was asked to share his insights into three of his roles that are relevant to us. He has been on the Board of Directors of our state organization, NAMI California, and is currently serving as its President. For seven years, he was Chief Administrative Officer of John George Psychiatric Hospital in San Leandro, and since last November Qvistgaard has been Chief Operating Officer of the Kaiser Permanente Antioch Medical Center. With his 15 years of experience in hospital operations and 32 years in the behavioral health arena, he is considered an expert in the field of acute psychiatric care administration. Plus, he is just an awfully nice person who has always been accessible to families.

Qvistgaard originally intended to become a minister, but after he took a class in pastoral counseling he knew he wanted to help people that way and so became a marriage and family therapist. During the late 1970s he worked with school districts and homeless shelters, specializing in people with mental illness, dual diagnosis, and teenagers. For all of these people the common denominator is impulse control and establishing boundaries.

He loved working one-on-one with people, but in the '80s he joined the Kaiser organization as an administrator. "I could make bigger changes and help more people in that role. I had a wider reach by working with policies and programs." He specialized in hospitalization and psychiatric outpatients. It was there he came to focus on support systems and the concept of trauma-informed care.

"Trauma occurs with any acute loss," he said, "as when a patient loses a limb and the entire system goes into decline. People with a mental illness have also suffered a loss—of a job, a spouse, freedom, or family. We need to recognize this in our treatments."

He later worked as a contractor in mental health—"because there was no parity, and health plans could choose to treat mental illness or not"—at hospitals in Vallejo and St. Helena before he went to John George. This was a choice for him, because the hospital had gone through four administrators in rapid succession and lost its good reputation. "I wanted to bring compassion back to the facility."

Now at the Kaiser Medical Center in Antioch, he has been a voice for mental health in the hospital, bringing psychiatrists and social workers into the primary care

clinics and integrating physical and behavioral medicine. He noted that both mental illnesses and their treatment providers have become stigmatized in our society. In many cases, that stigma is deserved because, while some providers want to do the right thing and follow best practices, some of them simply do not belong in the field.

At Antioch, Kaiser has no inpatient psychiatric services, only outpatient. Right before our speaker meeting, Qvistgaard had attended a conference attended by representatives of Kaiser's 21 medical centers in Northern California. They recognized that behavioral health is a weakness in the system and identified it as one of eight challenges to be addressed this year, next year, and onward. Also, NAMI California is speaking with Kaiser officials about bringing NAMI-signature programs into the system and using them effectively in every area.

Finally, Qvistgaard became involved with NAMI because he comes from a family with a long history of alcoholism and abuse. "We are all walking stories of joy, love, pain and fear," he said. "This makes each of us unique." He now also has a daughter who suffered depression five years after a kidney transplant, and a son who has elected gender reassignment. Qvistgaard noted that before his son—who is one of the most well-adjusted people he knows—could get endocrine treatment for the change, he had to accept a diagnosis of "gender dysphoria," which certainly does not apply in his case. Situations like this have confirmed for Qvistgaard the need for treatment providers to hear the voice of the family.

As President of the NAMI California Board of Directors, he tries to set the agenda for the staff in supporting state legislation. He also wants to define the roles of the state NAMI and the local affiliates like NAMI East Bay, and between the state and national levels. Role definition and infrastructure support are his two main areas of focus for the NAMI organization.

Q. What are conditions like at John George?

Qvistgaard noted that he hasn't been there in four months. Like most county hospitals, it's underfunded, leading to low aesthetics and staff burnout. The facility has three inpatient units with 69 licensed beds and one crisis stabilization unit with 11 beds.

The inpatient units operate at almost 100% capacity. Each one has two psychiatrists, two social workers, an occupational therapist, and a utilization nurse, as required under the licensing ratios of staff to patients.

Because psychiatric emergency services (PES) are the default go-to place for law enforcement, the crisis stabilization unit is overcrowded with people in short stays of 24 to 72 hours. The unit will serve 30 to 40 patients at any one time, often spiking to 50 or 60—with people waiting for services in the lobby and in ambulances outside. The unit has one psychiatrist on duty 24 hours a day, three to five psychiatrists during the normal business hours, and now a triage physician—who was assigned to address the bottlenecks that can occur in the admitting process.

Qvistgaard advised family members to fill out Form 1424 when their loved one is admitted. It requires clinicians to consider family input in making treatment decisions.

Q. Why don't we have more transitional facilities in mental health?

You have them in physical medicine: subacute and rehab facilities, skilled nursing facilities, and home care assistance. It's a continuum of care. A brilliant woman in

the hospital association once said, "Follow the dollar." Mental health in California is at the county level, and the counties get block grants from the state to spend as they see fit. Inpatient treatment costs more than outpatient, so counties build more outpatient facilities. Mental health patients could move out of acute care beds if more subacute care were available.

Qvistgaard suggested that local NAMI affiliates address correction of this situation through the county boards of supervisors while NAMI California addresses it with the state. He also suggested watching the progress of implementing Proposition 63 funds through the Mental Health Services Oversight and Accountability Commission (www.mhsoac.ca.gov).

Q. How do you get more integration of primary care with mental health?

One way is to demonstrate the mortality rate of people with mental illness. Studies have shown that such people tend to die 25 years earlier than average in the population. People in the health system are looking more toward managed care allotted on a per-capita basis—that is we get money to take care of a certain number of people. In this situation, it pays to keep people alive and healthy. And it pays to "go upstream," diagnosing and treating people sooner and saving money by avoiding acute illnesses and hospitalizations.

As an aside, Qvistgaard noted that the University of California at San Diego now offers a joint residency in physical and behavioral care.

Q. What is the best way to get your voice heard in a treatment situation?

When Qvistgaard's son had a bad experience with a certain doctor, he went to the supervisor and said calmly, "This is what I saw. Is this your standard of care?" The supervisor said it was not and referred the son to someone else.

Every patient in the Kaiser system is supposed to have a treatment plan from the doctor. While patient privacy is ensured by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with his son's permission Qvistgaard got a copy of the plan and asked the doctor, "How can I support you in your efforts to treat my son—so I won't be exacerbating his condition or contradicting his treatment?"

Q. What will be the impact of the new American Health Care Act being discussed in Congress?

It's still preliminary—just a House bill, and then the Senate will pass a bill, and then the two bills will undergo reconciliation. But in its current form, giving Medicaid dollars back to the states with a cap, so they can pick and choose, it will be devastating to care for mental health and substance abuse.

Q. How can we get primary care physicians to recognize mental health issues?

The best approach is fighting stigma, as NAMI is trying to do. In physical care, cancer and HIV used to be stigmatized, but now we can talk about them. The ray of hope is that millennials are more open about their mental states like depression, schizophrenia, and bipolar and are more willing to talk about them. Language is powerful when we are open to using certain words. We need to normalize the conversation about mental health issues.