Emergency Psychiatry: A Managed Care Perspective

Emergency psychiatry plays an extremely vital role in the continuum of psychiatric care. At a time when managed care and other pressures are causing a tremendous amount of change and restructuring in the behavioral health care field, this emerging area has become a lynchpin in the future organization and delivery of psychiatric services.\(^\text{1-4}\) For many years, emergency psychiatry has played the role of “poor stepchild” in the behavioral health care field. Meanwhile, the more mainstream divisions, such as outpatient therapy, acute hospitalization, child and adolescent, and consultation-liaison, have enjoyed a more accepted and prestigious role.\(^\text{5}\)

Spending time in the unfamiliar confines of the emergency department (ED) is often not the most coveted part of psychiatric training. Indeed, coverage of emergency services is sometimes relegated to the most junior of clinicians (eg, medical students, interns, and junior faculty), who look forward to completing their rotations so that they can advance to more traditional (and familiar) locales such as the inpatient ward or the outpatient clinic.

Despite the lack of attention that psychiatry has paid to the ED, it continues to serve as a key point of entry into the mental health care system for many patients.\(^\text{6}\) This fact makes the ED a critical junction for the triage and ultimate disposition of patients in crisis. In turn, this creates an important contact point between the ED and the managed care organization (MCO). If patients reach a crisis point before becoming engaged in the mental health care system, there is a decreased likelihood of coordinating a successful outpatient intervention.

For many lay persons, the ED serves as the de facto behavioral health care triage and referral system.\(^\text{6}\) Due to problems with access, lack of knowledge about obtaining help, or concerns regarding the stigma of mental illness, some patients delay obtaining professional assistance until a crisis has occurred, which may result in an unexpected visit to the ED. Some hospitals have 24-hour staffing with expert behavioral health care clinicians who can evaluate, diagnose, stabilize, and triage patients with a wide variety of behavioral health conditions.\(^\text{7}\) Other EDs rely on nonbehavioral health care staff to provide the initial assessment and disposition. This last scenario may result in varying patterns of diagnosis and referral.\(^\text{8}\)

**CURRENT PROBLEMS**

Our current health care system does not always provide a clearly defined entry point for individuals with behavioral health problems. In addition, there remains wide variability in the types and intensity of services that may be provided to an individual. That is, patients with similar illnesses may receive different treatments based more on the providers’ training and philosophical orientation than on the patients’ needs.\(^\text{9}\) This represents a significant challenge to an MCO, which is trying to allocate scarce resources on a need-based scientific basis as opposed to local practice patterns.

A number of studies have investigated the various reasons for patient referrals to specific levels of care.\(^\text{8,10-14}\) MCOs have attempted to bring about more consistent treatment patterns through the use of contracted networks of behavioral health care clinicians who will follow specific guidelines. In addition, MCOs have used pre-certification as another tool for gaining control of the port of entry for the patient. Although these techniques have been controversial in the provider community, MCOs believe that they have brought about a greater degree of conformity to standards of care.
Most third-party payers are interested in three main things for their members: improved health, improved customer satisfaction, and decreased costs. By the very nature of their design, most EDs are not configured to optimally meet these needs. Although EDs do offer access to care (usually 24-hour availability), the types of services available are not always optimal for behavioral health emergencies. On occasion, EDs have access to a wide variety of behavioral health care services and are skilled at matching individual patients up with the most appropriate service, whereas others use different methodologies (e.g., a bias toward inpatient treatment or little follow-up unless the problem is life-threatening).

In terms of outcomes and cost, the ED can be problematic for MCOs. The quality of the evaluation and the placement of patients may vary significantly from one ED to the next. In addition, the associated costs may be high. It is important to note that EDs are not usually set up to evaluate and triage patients with behavioral health problems. Many provide this as a service to their community because of patient needs. However, the use of high-cost emergency medical diagnostic treatment centers as one of the key entry points into the behavioral health care system is the opposite of what most MCOs are trying to accomplish. Due to these factors, the MCO goal of “the right patient, receiving the right service, at the right location, at the right time” is not always fulfilled in a busy ED in the middle of the night.

**THE MANAGED CARE PERSPECTIVE**

Most MCOs are under significant pressure to deliver increased quality for decreased costs. As such, they are looking for innovative ways to organize, manage, and ensure the delivery of high-quality behavioral health care to patients. Often, this is an extremely difficult task given the potential crisis nature of patients’ needs.

One of the most interesting examples of integrating new approaches is a county hospital ED that uses the concept of mobile outreach effectively. They have developed a multi-system approach to assessment and treatment of patients in crisis (along with their families) that has been successful in stabilizing acute behavioral health problems. They operate as an extension of the emergency psychiatric service and report being able to resolve 70% of their referrals on an outpatient basis. These, along with other mobile outreach programs, are the types of patient-oriented organizational changes that can be integral to the successful evolution of emergency psychiatry.

Another innovative solution involves the use of a “psychiatric holding area” for evaluation and stabilization of acutely ill psychiatric patients. In this extended evaluation unit, patients can be observed and treated for up to 24 hours. This structure provides a significant advantage in determining which patients are severely ill and in need of an extended acute hospitalization and which patients are in a short-term crisis and require briefer intervention-type services. The opportunity to further evaluate patients in an emergency setting can often provide a much clearer picture of which services are most appropriate for an individual. In one published report comparing a hospital with an extended evaluation unit to a hospital with traditional ED services, the acute psychiatric admission rate was noted to be 16% lower in the hospital with the psychiatric holding area. The authors of the study attribute most of that difference to the availability of the extended evaluation unit.

A similar program, called the Psychiatric Short Procedure Unit, is in place at another hospital. This program borrows from the surgical concept of moving less-intensive procedures away from high-cost, high-intensity settings when they are not required. Surgeons discovered a number of years ago that many procedures did not require overnight hospitalization or all of the intensive and expensive services of a hospital operating unit. The concept of a short procedure unit or an outpatient surgery center was readily accepted by the surgical community and has become a standard part of the practice of surgery. Similarly, there are many treatments, procedures, or circumstances in psychiatry that do not require the intensive services available in an acute hospital setting. In these situations, the short procedure unit could provide an
effective and efficient alternative to hospitalization. Other reports have similarly validated the effectiveness of matching the intensity of the service to the patient’s need. 19

INNOVATIVE SOLUTIONS: MODEL SYSTEMS OF CARE

The first step in describing a model system is to define the underlying organizational structure and then expand the framework to include additional elements of this ideal system. First and foremost, the leadership structure should be (1) patient centered, (2) clinically driven, and (3) stable. To provide world-class services in any area of health care, it is imperative to have stable, cohesive leadership providing the necessary tools and resources for the clinicians in the field to operate. In addition, stable leadership is important to the development and maintenance of strong relationships with other clinical and community agencies that are essential to the functioning of this world-class model system.

Second, an adequate trial period is necessary to work through the preliminary problems that are inherent in bringing a new and complex plan to “market.” It should be readily apparent that innovative systems of care that call into question old organizational paradigms will be met with some resistance. In addition, the new plan will almost certainly require some degree of field testing and appropriate adjustments based on the successes (and failures) of the various new components. Providing clear and open support for a significant (but not indefinite) trial period is important. This will give the staff the security to innovate and experiment with new structures and services without the feeling that any misstep will result in serious harm to the future of the program.

Next, there should be a clearly stated philosophy or mission statement for the organization. All members of the team should be intimately familiar with these principles and should be in full agreement with them (indeed, the initial members of the emergency team should be instrumental in the writing of these principles). Without clear agreement and acceptance from all team members, it will be extremely difficult (if not impossible) to fully and successfully implement the model system.

A critical success factor to bear in mind is that the type of services provided should depend entirely on the needs of the patients. This concept is at the heart of patient-centered medicine. This can be initiated by conducting an environmental assessment and then working “backward.” That is, the clients’ needs (and preferences) must first be understood and then the services developed.

For example, if substance abuse were a problem for the patient, the evaluation service could provide expert advice and support on accessing the most appropriate level of care. In addition, they would be able to directly schedule the patient for that service while he or she was still in the evaluation setting. The evaluation service would pass their assessment information on to the next level of care so that the patient would not have to undergo the same evaluation again.

A PROPOSED MODEL SYSTEM OF EMERGENCY PSYCHIATRIC CARE

There are a number of elements that should be considered when designing a model system of emergency psychiatric care.

1. "Multichannel access" to skilled clinicians 24 hours a day, 7 days a week. This statement refers to the capacity to respond to patients when and where they need help. For some individuals this will mean a brief phone call during the day to answer a question about medication side effects. Other patients may require a crisis team in their home in the middle of the night or a weekend visit to an emergency diagnostic evaluation center.

2. A standardized and validated assessment and triage process that all members of the team adhere to and review at regularly scheduled team meetings. The ability to reliably and predictably place a patient in the right level of care depends heavily on the diagnostic process or tools that are used by the clinicians. If an emergency assessment team takes on the task of evaluating and triaging patients, they should use an agreed on instrument that guides them in making a high-quality reproducible decision regarding the placement of patients.

3. Rapid access to a continuum of care for all behavioral health and
CONCLUSION

Substance use disorders. Being able to quickly place patients in the right level of service is a key attribute of a truly successful model system. Notice that this does not require the model system to either own or operate these services. However, it does require access to them. The emergency assessment and triage arm of the team should have complete access to all parts of the behavioral health care continuum.

4. A "continuity process" whereby individual clients are observed and treated by the same clinician or team of clinicians throughout their contact with the model system. Another barrier to offering the highest quality of care is the lack of continuity for some patients. If a patient enters the system from different "portals," either geographically or programmatically, he or she is often assigned to a new clinician. This disrupts the ongoing therapeutic relationship he or she had with the previous clinician (or treatment team) and often results in lost time and information as the new clinician tries to understand the history and problems of the patient.

5. A comprehensive database of and relationship with all significant community resources. Often, the nature of the crisis that brings a person into contact with the behavioral health care system requires the ability to understand the social consequences and needs of the individual's immediate crisis. By maintaining an exhaustive database, as well as strong relationships with community resources, the model system can more rapidly and effective-ly address the needs of its clients.

6. Access to the local medical health care system (and, if possible, strong cooperation and even integration with it). Having strong ties to the local medical community can speed the access of patients to the medical system when they need it, but can also facilitate the flow of patients in the opposite direction. That is, a medical system that trusts and understands the functioning of a high-quality, user-friendly behavioral health care system is more likely to facilitate the early referral of patients for suspected or known behavioral health care issues.

7. A strong and readily accessible medical record or patient information system for tracking the treatment and progress of all patients. The ability to obtain timely access to relevant information on all of the system's patients will become an increasingly vital resource. There must be a system in place that allows for the rapid (but secure) access of relevant information on all clients.

8. As much as possible, a strong patient-centered and evidence-based approach to providing care. Psychiatric care is evolving on a daily basis. Although there remain many issues about which there is not a strong consensus, it is critical that we strive for consistent and evidence-based treatment of our patients as much as possible.

CONCLUSION

Emergency psychiatry services are a critical part of the health care continuum. By building on existing research and clinical experience, emergency psychiatry can serve as the center of a richly textured and extraordinarily effective behavioral health care system. I have suggested a number of important elements required to build a "best-in-class" model system. Some of these elements are essential to all systems. These include, but are not limited to, having strong, consistent leadership, being focused on the organization's mission, and having an adequate trial period to work out the "wrinkles." In addition, eight other attributes were suggested for implementation, but these may vary a bit depending on patients' needs, the organization's mission, and available resources.

I believe that the first step in developing the right organizational structure and services for your community is clearly understanding the needs of your patients. There is no substitute for a thorough and accurate environmental assessment. This will allow your organization to determine which steps to take first and define where you need to be in order to maximally serve your patients.

REFERENCES


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