sessions are most efficacious, and integration of these elements in an employee assistance plan during and after a disaster should be considered. It can be difficult to perform rigorous studies at the time of an emergency, but, to the extent possible, agencies should document interventions and conduct assessments of what works so that we can build on experience.

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Measuring Patient Satisfaction

It is very difficult to measure patient satisfaction on acute inpatient psychiatric units. The traditional method of using written surveys has a number of weaknesses. Cognitive impairment associated with acute exacerbations of schizophrenia, schizoaffective disorder, and severe depression can substantially influence patients' ability to complete these surveys, leading to inaccurate results. Unless surveys are conducted daily, a problem that can diminish patient satisfaction may persist for days before coming to the attention of staff. In many general hospitals, inpatient psychiatry is excluded from written patient satisfaction surveys, and thus the issue is ignored altogether. Yet the need to measure patient satisfaction in an accurate and timely manner persists.

After examining a number of instruments to address the measurement of patient satisfaction, Bridgeport Hospital adopted an innovative method of tracking patient satisfaction in the department of psychiatry. Our goals were to measure satisfaction on a daily basis, to use a simple and understandable method so that even impaired psychiatric patients could participate in the process, and to use an existing forum—the community meeting, which is a staple of many inpatient psychiatric units.

A meter was developed consisting of a "satisfaction board," which includes an arrow that can be used to point to any of five levels of patient satisfaction: outstanding, almost perfect, okay, could be better, and "the pits." The board is permanently mounted in the room where the community meeting takes place. As a regular part of the meeting, patients are asked to reflect on the factors that have influenced their satisfaction for the previous 24 hours. Patients are provided with some examples of such factors, such as the friendliness of staff, the quality of the group sessions they have attended, their feeling of safety while on the unit, the quality of meals and snacks, and patients' involvement in their own treatment plans. To ensure comparability from one day to the next, care is taken to repeat the instructions in the same manner each time. All patients are asked to indicate their level of satisfaction by raising their hands as each of the five levels of satisfaction is identified. A consensus level of satisfaction is then determined, and the arrow is moved to point to that level.

Patients are then asked to identify specific areas that have had a positive or a negative impact on their satisfaction. Care is taken to assure patients that their opinions and feedback are important. Examples of the changes made as a result of this process are cited to reinforce for patients that this is an open and nonpunitive process. Such changes include more consistent implementation of individual sessions with assigned staff, greater choice in meal selections, the development of a more efficient method of storing patients' personal belongings, and improved timeliness of staff response to patients' needs throughout the day.

Negative ratings are reviewed by the treatment team after the community meeting. Corrective action taken in response to these ratings is reported to the patients at the next day's meeting. Positive ratings are also reviewed by the treatment team and serve as reinforcement for staff, which enhances staff morale.

Patients have told us that the process of being asked for their opinions is as important to them as is the eventual resolution of their concerns. In many ways, measuring and responding to patient satisfaction has become a therapeutic process in itself.

The hospital's leadership has recognized that this process allows for accurate and immediate feedback on a daily basis, provides a method for correcting problems quickly, offers feedback to patients about corrective actions taken, and assures patients that their satisfaction is genuinely important, a concept that is too often overlooked in inpatient psychiatry.

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The Bridge Program: A Model for Reaching Asian Americans

Although Asian Americans represent one of the fastest growing populations in the United States, they have the lowest use of mental health services. Asian Americans with mental illness are often severely ill or in crisis by the time they receive a psychiatric diagnosis. As a result, this patient population is more costly to treat, frequently requiring lengthy inpatient hospitalization.

In an attempt to address these salient mental health issues, the Charles B. Wang Community Health Center in New York City developed the Primary Care and Mental Health Services Bridge Program in 1997. Asian Americans generally have very little awareness of mental health issues, and having a mental illness and seeking psychiatric services are profoundly stigmatized. The stigma is typically heightened by Asian culture, which puts tremendous emphasis on familial identity and honor, often preventing persons with mental illness from referring themselves or family

members to mental health services. Furthermore, there is a dearth of accessible, qualified bilingual Asian-American mental health professionals. And primary care providers, who address most of the medical needs in this population, are not equipped to provide mental health care for Asian-American patients.

The Bridge Program is designed to improve access by integrating mental health services in a primary care setting, by enhancing the skills of primary care providers in the identification and treatment of mental disorders commonly seen in primary care, and by providing community health education about mental health issues.

The program started by establishing contracts with two community health centers to share bilingual certified psychiatric social workers who were co-located part-time in the primary care centers. This arrangement enabled integrated staffing of mental health services in primary care and helped to smooth the interagency referral process. A board-certified bilingual psychiatrist was hired to manage psychotropic medication and oversee various clinical affairs and educational activities.

Typically, patients with psychiatric conditions are identified by primary care providers or through mandatory screening, which is usually performed by a case manager or nurse. After review by the primary care provider for medical clearance, patients who screen positive for a mental illness are referred to the on-site mental health clinician for further evaluation. Sometimes, interested primary care providers manage patients who have mental health problems on their own, with consultation from mental health clinicians about issues such as medication management and psychiatric treatment planning. Most of the time, identified patients are referred to the mental health clinicians for such services as management of psychotropic medications, individual psychotherapy, stress management, supportive therapy, and family therapy. The bilingual clinicians also explore patients' attitudes and beliefs about some culturally relevant alternative treatments, such as acupuncture, relaxation therapy, exercise, and behavior modification, and attempt to incorporate these beliefs into the treatment plan. Patients with chronic psychiatric illness, those with suicidal or homicidal ideation, and those who require long-term or intensive psychiatric treatment and monitoring are referred to an off-site specialty mental health facility.

The integrated service activity is supported by two other program components: training for primary care providers to detect, treat, and manage patients with mental disorders; and community education to increase awareness of mental health problems, reduce stigma, and promote mental health services that are available in the community. During the training provided by the Bridge Program's staff, primary care providers and nurses especially enjoyed learning how to use culturally acceptable and familiar words to describe psychiatric disorders, discuss treatment plans, and explain how mental health problems are linked to the brain and multiple organ systems. Radio programs and community forums that include testimony from consumers and their family members are among the most effective mechanisms for community education.

A few indicators of the Bridge Program's success include a continuing increase in the number of mental health patients identified through the program (from 77 in 1997 to 555 in 2002), overall patient ratings of the mental health treatment received as "excellent" or "good," an increasing number of mental health encounters involving primary care providers, dramatic improvement in the rate of successful referrals to off-site specialty treatment, and the accrual of revenue toward sustainable clinical services. During the past several years, the Bridge Program has been replicated in a number of Asian community-based organizations.

The program received the Bureau of Primary Health Care "Models That Work" award in 2000 and has been cited in the Surgeon General's report *Special Supplement on Mental Health: Culture, Race, and Ethnicity* as an example of bringing mental health care to the primary health care system to "strengthen the capacity of these providers to meet the demand for mental health services and to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve."

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