The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

Psychiatric Care in a Primary Care Clinic

The optimal place to deliver outpatient psychiatric services is in the patient's primary care clinic, where both psychiatric and medical needs can be easily met. Here is a report on a program that succeeded and failed.

An urban clinic of a small East Coast city recognized the lack of psychiatric services for its largely Hispanic patient base and contracted to receive the services of an adult psychiatrist. In 2005–2006, a psychiatric clinic was established in the treatment rooms of the medical clinic, with the psychiatrist available once per week for three-fourths of a day. The population base was 70% Hispanic, with approximately 50% speaking no English, and 80% were covered by medical assistance. A medical clinic staff member saw new patients first and was available to translate for the psychiatrist (myself), who spoke no Spanish. A nurse practitioner saw each new patient for a general medical evaluation. Initial psychiatric evaluations were scheduled for 30 minutes, and follow-up clinic appointments were scheduled for 15 minutes each. A bilingual social worker was available to provide psychotherapy services.

Psychiatric clinic appointments were immediately full, and a waiting list quickly developed for new evaluations. Patients were comfortable being seen in their own neighborhood and receiving psychiatric services in their routine medical treatment rooms. The examination table's footrest served as the desk for the visit. Patients generally felt comfortable, benefiting from the trust the clinic had established in the community and having the support of the staff member who was present for translation. Affective disorders were the most common psychiatric problem seen, although substance abuse was a common co-occurring disorder. Several patients with schizophrenia who had never been seen by a mental health professional not only came for treatment but also continued receiving care in the clinic. Even though the psychiatrist had no experience working in the Hispanic community, the show rate for clinic appointments was 85%.

Working in the medical clinic enabled medical follow-up for patients to be done easily, and checks of weight and blood pressure were routine. Clinicians in the medical clinic, including physicians, a physician assistant, and nurse practitioners, routinely obtained psychiatric "curbside consultation" about patients who may have been present in the next room for their medical appointments. Likewise, care for pain, obesity, and chronic health problems was easily obtained for chronic psychiatric patients.

The consultation process was efficient. The average number of psychiatric clinic visits per patient was four in the first nine months of the clinic. Seeing patients in their "home" clinic reduced stigma and encouraged access to psychiatric care.

Yet the psychiatric clinic failed.

Our current structure of psychiatric payment was partly to blame. Psychiatric care, even through publicly funded programs in medical assistance, is "carved out" to separate psychiatric insurance systems. These insurance programs, often with for-profit status, have already received prospective payments and use separate forms, separate copayments, separate payment regulations, and different criteria for certifying psychiatric clinics before they will release payments for any services. To obtain this payment, then, a medical clinic must establish a separate administrative structure, separate billing processes and collection systems, and separate forms and procedures in the clinic. If a payment is denied, there are separate appeals processes as well.

Although we in psychiatry are now familiar with the complex rules of the carve-outs, having had experience with them over the past 15 years, our colleagues in medicine are overwhelmed by these regulations. At my clinic, the medical director was wonderfully supportive of providing psychiatric services. The director knew that the clinic would lose money and allowed willing staff to drop their duties and translate at a moment's notice. Despite this support, the program still failed.

At the end of nine months, the clinic still had not been able to traverse the series of steps required to receive payment for psychiatric services. At one year, some payments for psychiatric services were just beginning to be received. Negotiations for a contract renewal were obviously affected, and the psychiatric clinic closed after 14 months, still with a waiting list for services.

Psychiatric professionals have accepted separate and unequal insurance systems. However, having payment systems separate from those of medical systems also separates us from medical clinics for delivering services and separates us from our patients' primary care providers. Patients' optimal place for community psychiatry should be in their primary care clinic, where psychiatric and medical health needs can both be addressed.

Paul Kettl, M.D., M.H.A.

Dr. Kettl is professor of psychiatry at Pennsylvania State College of Medicine, 500 University Drive, Hershey, PA 17033 (e-mail: pkettl@psu.edu). Dr. Kettl is also on staff at Lancaster General Hospital.

Assertive Community Treatment for Older Adults

Adults age 60 and older are the fastest-growing segment of the U.S. population. An estimated 20% experience specific psychiatric disorders, but of those only half receive treatment from any health care provider. Few older adults receive specialty mental health services.

In 2001 Telecare Corporation (a multistate mental health care organization) was asked by the Los Angeles County Department of Mental Health to provide a full-fidelity program of assertive community treatment for this underserved population. Three key adaptations were made: increasing knowledge about the complex interplay between physical and mental health, learning about community resources available specifically for older adults, and taking care not to let ageism affect services.

To be eligible for enrollment, individuals must meet six criteria: be age 50 or above, have a severe mental illness, have significant functional impairments, have continuous high-service needs, be willing and able to reside in a community setting within the geographic area served by the program, and be willing to accept services.

Telecare's ACT 7 program has a multidisciplinary team that serves as the primary provider of services. The team is led by a licensed clinical social worker and includes three nurses, three master's-level social workers, two half-time psychiatrists, a personal service coordinator (who is in recovery from mental illness), a substance abuse specialist, and an employment specialist. The staff-to-member ratio is 1:10 at full enrollment of 100 individuals.

The program is staffed Monday through Friday from 8:30 a.m. to 8:30 p.m. Weekend and holiday hours are 8:30 a.m. to 5:00 p.m. After hours, a team member is available by phone and will go out into the community to see a client when necessary.

The team meets every morning to discuss the individuals seen the day before and any crises that have occurred and to plan for the coming day. There are no assigned caseloads; the entire team is available to work with each individual on the basis of his or her needs.

Services are directed by a personal service plan that the team writes together with the client. All plans contain growth rather than maintenance goals. Services are founded on a psychosocial rehabilitation philosophy, which focuses on recovery and strengths rather than on illness and disability. Services are highly individualized; the content, amount, timing, and types of service vary across individuals and time. The contractual commitment is to have an average of three contacts per week by the team, although multiple contacts per day can be provided. Over 95% of face-to-face services are provided in the community, including visits by the psychiatrists.

Fifty-three individuals were admitted during the first year of the program, with 42 completing a full year's worth of service. The average age at admission was 59.95 years (range= 50.25–75.83). A majority (57%) were female. Sixty-seven percent were Caucasian, 19% were African American, and 14% were Latino or Hispanic. A majority had a diagnosis of schizophrenia (57%) or schizoaffective disorder (36%). Seven percent had a diagnosis of bipolar disorder.

Nearly three-quarters (74%) of the individuals were admitted directly from institutional care. In the year before enrollment, the 42 individuals spent a total of 10,771 days in a geropsychiatric skilled nursing facility, 483 days in acute psychiatric inpatient care, 631 days in subacute psychiatric care, 365 days in a state hospital, and 16 days in a jail inpatient psychiatric unit. This is a total of 12,266 days (mean±SD=292.05± 58.12) of institutional care. None of the 42 individuals received outpatient mental health services.

On average, in their first year in the program, individuals received 201.10 contacts (184.70 hours). This represents a mean of 3.9 contacts (3.5 hours) per person per week. Most contacts were for rehabilitation services, followed by medication support, case management, and crisis intervention.

Seventeen percent of individuals were hospitalized in acute care psychiatric facilities. Six people were hospitalized once, and one person was hospitalized three times. The total number of days of hospitalization was 86 (mean length of stay of 9.55 days per episode; range=2–20 days). These numbers are skewed by one person who was hospitalized for 39 days.

The combined cost of community and inpatient services was $1,319,115 ($31,408±$13,194 per person). The total cost for mental health services received the year before enrollment was $3,285,663 ($78,229±$33,773 per person).

As the population ages, the need for effective and appropriate mental health services for older adults will only continue to grow. The experiences of the Telecare ACT 7 program suggest that assertive community treatment is a promising model to meet the needs of older adults with severe mental illnesses.

Shelley Levin, Ph.D.
Kenneth Miya, Ph.D.

Dr. Levin is regional director of staff development, Telecare Corporation, 1080 Marina Village Parkway, Suite 100, Alameda, CA 94501 (e-mail: slevin@telecarecorp.com). When this report was written, Dr. Levin was the administrator of the Telecare ACT 7 program. Dr. Miya, now retired, was Los Angeles regional director of operations and development at Telecare Corporation when this report was written.