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).

Decreasing Unnecessary Care in a Psychiatric Emergency Service

Reducing the use of medically unnecessary emergency services is a way to reduce health care expenditures and provide better care for persons with true urgent and emergent needs. It has been estimated that 20 to 40 percent of emergency psychiatry visits are unnecessary. Despite efforts to redirect nonemergent psychiatric patients to more appropriate settings, many patients continue to rely on emergency services.

At the primary psychiatric emergency service in urban Detroit, staff developed an alternative, less costly, and more efficient service at the site of demand. Before this initiative, all presenting patients were provided with comprehensive services (assessment by a nurse, evaluation for substance abuse, psychosocial assessment, full assessment by a psychiatrist, laboratory work, and medication management). In our previous research, "needing medication" was one of four independent risk factors for high use of the psychiatric emergency service. The staff of the psychiatric emergency service developed a focused medication management level of care (brief assessment by a nurse and medication management by a psychiatrist) as an alternative to the more costly comprehensive care provided in the psychiatric emergency service.

The introduction of this alternative lower level of care raised concerns by community outpatient providers and the local community mental health payer. Community providers expressed fears that the psychiatric emergency service would "steal" their patients and substitute psychiatric emergency service care for more optimal outpatient care. The community mental health board was concerned that the psychiatric emergency service would not accurately identify patients who were in need of more comprehensive services. As a result, patients could deteriorate, they argued, resulting in increased inpatient admissions, more visits to the psychiatric emergency service, and "shopping" of other local psychiatric emergency departments for additional services. Although it has the potential to reduce costs in the targeted psychiatric emergency service, the new level of care was seen as having the potential to produce a net increase in costs to the system. The new level of care was formally implemented in late 2001 through mid-2002.

To evaluate the new level of care, we interviewed patients, surveyed psychiatric emergency service and community providers, and analyzed claims data from the local community mental health payer before and after introducing the focused medication reviews. Patients who received this level of care were overwhelmingly satisfied. Their mean score on a patient satisfaction questionnaire was 3.56 (with 4 representing "perfectly satisfied"). Ten percent of 84 patients reported that they had wanted hospitalization or shelter, but none were hospitalized in the following 30 days. There was no increased "shopping" for inpatient admission through emergency services at other facilities.

Psychiatric emergency service clinicians were also satisfied with the new level of care, reporting lighter workloads and perceived improvements in the quality of care. In contrast, community providers were less satisfied, perceiving their workload as increasing. The patients in this sample increased their rate of seeking care at outpatient clinics (from a median of .96 per year to 5.40 per year), with no significant increase in the rate of visits to the psychiatric emergency service. Thus the new level of care did not result in patients' being "stolen" from the outpatient clinics but, rather, encouraged more frequent outpatient care.

Furthermore, the number of patients who required hospitalization decreased from 22 to four among those who received the lower level of care. Thus it appears that the psychiatric emergency service can successfully identify patients in advance who do not need comprehensive psychiatric emergency service care. On the basis of claims data, we calculated a net median savings to the payer of at least $340 per patient per month for patients who were seen in the lower level of care.

In conclusion, we found that adding the option of a lower level of care in an urban psychiatric emergency service has potential to have a positive impact in multiple areas despite the less positive view held by some of the community providers. However, the program evaluation was limited to service use based on claims data and did not include direct assessment of symptoms and functioning at follow-up and did not control for temporal trends in health care use.

Despite the support for the focused medication review, it was discontinued in favor of less efficient comprehensive psychiatric emergency services to all patients, regardless of clinical justification. The fact that the medication review was discontinued underscores another issue in changing to a more efficient level of service—that of sustainability. Efforts by clinicians in the psychiatric emergency service to create new billing codes reflecting the lower levels of care were unsuccessful. Furthermore, other local third-party payers rejected claims for the new level of care on the basis that medication reviews can be provided in an outpatient setting even though pa-

tients present at the psychiatric emergency service instead.

Our experience highlights the fact that improved efficiency, improved patient and provider satisfaction, and higher perceived quality of care are not enough to result in sustainability of new initiatives. Multiple system factors need to be accounted for when attempting to alter long-standing protocols, involving multiple stakeholders with sometimes competing agendas.

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Psychiatric Nurse Practitioners in Rural Pediatric Telepsychiatry

In 2001 the U.S. Surgeon General's action plan agenda identified a critical need for mental health care for American youths. The report delineated the perpetual shortage of psychiatric specialists, especially in rural areas, that showed no signs of improving.

Children with psychiatric disorders in rural upstate New York, as in other regions of the country, have been chronically underserved, and rural mental health clinics are rarely able to recruit child psychiatrists. Nurse practitioners who pursue advanced specialty training and experience can acquire state specialty certification in psychiatry and in pediatric psychiatry. However, regulations require a collaborative agreement between the nurse practitioner and a child psychiatrist that ensures regular clinical collaboration between the parties.

The concept of a program for youths in rural, underserved areas of New York State through a regular, collaborative teleconference between nurse practitioners and a child psychiatrist based at the Upstate Medical University Syracuse was developed three years ago as a response to the growing need for child mental health services in rural regions. The primary barriers to developing the program were determining the appropriate level of technology (televideo or telephone), acquiring funding, and fine-tuning the contract between the county clinic, the university hospital, and the child psychiatrist.

These issues were relatively easily overcome. Telephone conferencing was readily and immediately available and inexpensive; funding, from the county clinic perspective, was easily justified because a weekly hour with the child psychiatrist and nurse practitioner was substantially less expensive than recruiting a full- or part-time child psychiatrist (even if it was possible), and the contract was crafted by the attorneys for the parties within three months.

Weekly (biweekly for the part-time nurse practitioner) collaborative clinically focused discussions between the child psychiatrist and the nurse practitioner have been ongoing. A total of 200 individual cases have been presented and discussed in the three years since the program began, almost half of which have involved follow-up collaboration. Three nurse practitioners are involved in the program, in two different rural counties. The nurse practitioners have learned to present a succinct case history of individual patients, followed by problem-focused discussions. Recommendations for improved assessment, diagnosis, record-keeping, collaboration with therapists and schools, and pharmacologic management have been implemented. A semistructured interview format and the use of specific rating instruments, including the Child Behavior Checklist, the Conner's Behavior Rating Scale, the Children's Depression Inventory, and the Multidimensional Anxiety Scale for Children, are now used routinely.

The nurse practitioners have gradually modified their style and approach to evaluation and treatment in response to regular mentoring. The patient profiles of the children and adolescents whom the nurse practitioners treat are often very complex and challenging, even to the child psychiatrist collaborator. These children are in desperate need of many services, including psychiatric care, and are often at extreme risk of deteriorating on a daily basis. Many patients come from dysfunctional families in which parents may be separated, divorced, incarcerated, or abusing drugs. Many have experienced violence, poverty, mental illness, multiple moves, foster placements, school failure, psychiatric hospitalization, residential placement, and numerous medication trials. Difficult and demanding consumers, frequent no-shows, abrupt out-of-county moves, acute decompensation, noncompliance with medications, noncompliance with laboratory testing and general medical care, and unrealistic expectations of medications are just some of the challenges facing the clinicians who work with this client population.

The clinic director has periodically interviewed the nurse practitioners to ascertain their level of satisfaction with the program. They have consistently responded positively, stating that the regular and systematic telephone contact has been an excellent source of useful clinical information and an indispensable component of care. Although the director has stated that the program will continue unchanged, a proposed outcome-based assessment in comparable rural clinics with and without child telepsychiatry could assist in budget and program development.

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