

Proactive consultation: A new model of care in consultation-liaison psychiatry

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During my residency training, I was trained in the standard “reactive” psychiatric consultation model. In this system, I would see consults placed by the primary team after they identified a behavioral issue in a patient. As a trainee, I experienced frequent frustrations working in this model: Consults that are discharge-dependent (“Can you see the patient before he is discharged this morning?”), consults for acute behavioral dysregulation (“The patient is near the elevator, can you come see him ASAP?”), or consults for consequences of poor management of alcohol/benzodiazepine withdrawal (“The patient is confused and trying to leave”).

As a fellow in consultation-liaison (C-L) psychiatry, I was introduced to the “proactive” consultation model, which avoids some of these issues. In this article, which is intended for residents who have not been exposed to this new approach, I explain how the proactive model changes our experience as C-L clinicians.

The Behavioral Intervention Team

At Yale New Haven Hospital, the Behavioral Intervention Team (BIT) is a proactive, multidisciplinary psychiatric consultation service that serves the internal medicine units at the hospital. The team consists of nurse practitioners, nurse liaison specialists, social workers, and psychiatrists. The team identifies and removes behavioral barriers in the care of hospitalized mentally ill patients.

The BIT collaborates closely with the medical team through formal and informal consultation; co-management of behavioral issues; education of medical, nursing, and social work staff; and direct care of complex patients with behavioral disorders. The BIT assists the medical team with transitions to appropriate outpatient and inpatient psychiatric care. The team also manages the relationship with the insurer when a patient requires a stay in a psychiatric unit.

This model has a critical financial benefit in reducing the length of stay, but it also has many other benefits. It focuses on early recognition and treatment, and helps mitigate the effects of mental or substance use disorders on patients' recovery. BIT members educate their peers regarding management of a multitude of behavioral issues. This fosters extensive informal collaboration (“curbside consultation”), which helps patients who did not receive a formal consult. The model distributes work more rationally among different professional specialists. It yields a relationship with medical teams that is not only more effective, but also more enjoyable. In the BIT model, psychiatrists pick the cases where they feel they can have the most impact, and avoid the cases they feel they cannot have any.¹⁻³

continued



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Disclosure

The author reports no financial relationships with any company whose products are mentioned in this article, or with manufacturers of competing products.



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The proactive model yields a more effective, more enjoyable relationship with medical teams



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Table

Consultation-liaison psychiatry: Traditional vs proactive models

Trait	Traditional 'reactive' C-L model	Proactive C-L model
Delivery of service	Reactive	Proactive
Personnel	Single discipline: MD	Multidisciplinary: MD, advance practice registered nurse, social worker
Case identification	Request by the primary team	Screening based on records and nursing staff report
Mode of intervention	Advice to the primary team MD	Collaboration with nurses, social workers, and clinicians with close follow-up
Service goals	Treatment recommendation, risk reduction, and crisis management	Prevention of behavioral barriers to care, avoidance of crises, provider synergy
Location	Team spread over hospital	Team embedded in assigned medicine units with co-located personnel

Source: Reference 4
 C-L: consultation-liaison

CASE

A better approach to alcohol withdrawal

Mr. X, age 56, has a history of alcohol use disorder, hypertension, and coronary artery disease. He's had multiple past admissions for complicated alcohol withdrawal. He is transferred from a local community hospital, where he had presented with chest pain. His last drink was 2 days prior to admission, and his blood alcohol level is <10 mg/dL.

During Mr. X's previous hospitalizations, psychiatric consults were performed in the standard reactive model. The primary team initially prescribed an ineffective dosage of benzodiazepines for his alcohol withdrawal. This escalated his withdrawal into delirium tremens, after which psychiatry was involved. Due to this early ineffective management, the patient had a prolonged medical ICU stay and overall stay, experienced increased medical complications, and required increased staff resources because he was extremely agitated.

During this hospitalization, Mr. X arrives with similar medical complaints. The nurse practitioner on the BIT service, who screened all admissions each day, examines the prior notes (she finds the team sign-outs to be particularly useful). She suggests a psychiatric consult on Day 1 of the admission, which the primary medical team orders. The BIT nurse

practitioner gives apt recommendations of evidence-based management, including a benzodiazepine taper, high-dose thiamine, and psychopharmacologic approaches to severe agitation. The nurse liaison specialist on the service makes behavioral plans for managing agitation, which she communicates to the nurses caring for Mr. X.

Because his withdrawal is managed more promptly, Mr. X's length of stay is shorter and he does not experience any medical complications. The BIT social worker helps find appropriate aftercare options, including residential treatment and Alcoholics Anonymous meetings, to which the patient agrees.

Participating in this case was highly educational for me as a trainee. This case is but one example among many where proactive consultation provided prompt care, lowered the rate of complications, reduced length of stay, and resulted in greater provider satisfaction. The *Table*⁴ contrasts the proactive and reactive consultation models. The following 5 factors are critical in the proactive consultation model^{4,5}:

1. Standardized and reliable procedure screening of all admissions, involving a mental health professional, through record review and staff contact. This screening should identify patients with issues who

will benefit specifically from in-hospital services, rather than just patients with any psychiatric issue. An electronic medical record is essential to efficient screening, team communication, and progress monitoring. Truly integrated consultation would be impossible with a paper chart.

2. Rapid intervention that anticipates impending problems before a cascade of complications starts.

3. Collaborative engagement with the primary medical team, sharing the burden of caring for the complex inpatient, and transmitting critical behavioral management skills to all caregivers, including the skill of recognizing patients who can benefit from a psychiatric consultation.

4. Daily and close contact between behavioral and medical teams, ensuring that treatment recommendations are understood, enacted, and reinforced, ineffective treatments are discontinued, and new problems are addressed before complicating consequences arise. Dedicating specific personnel to specific hospital units and placing them in rounds simplifies communication and speeds intervention implementation.

5. A multidisciplinary consultation team, offering a range of responses, including informal curbside consultation, consultation with an advanced practice registered nurse, social work interventions, advice to

discharge planning teams, psychological services, and access to specialized providers, such as addiction teams, as well as traditional consultation with an experienced psychiatrist.

Research has shown the effectiveness of proactive, embedded, multidisciplinary approaches.^{1-3,5} It was a gratifying experience to work in this model. I worked intimately with medical clinicians, and shared the burden of responsibilities leading to optimal patient outcomes. The proactive consultation model truly re-emphasizes the "liaison" component of C-L psychiatry, as it was originally envisioned.

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Proactive consultation can provide prompt care, lower the rate of complications, and reduce length of stay