Groups Seek Parity for Emergency Psych Patients

BY JENNIFER SILVERMAN
Associate Editor, Practice Trends

WASHINGTON — Mental health organizations called for greater parity in treating emergency psychiatric conditions before a technical advisory group on the Emergency Medical Treatment and Labor Act.

So many things have not been thoroughly discussed or defined in the EMTALA regulations regarding psychiatric conditions, Kathleen McCann, R.N., director of clinical services with the National Association of Psychiatric Health Systems, said in an interview.

"Emergency psychiatric conditions weren't well thought out when the original regulations were promulgated." Medical conditions—such as a head injury, or child convulsing inexplicably—are easier to pinpoint, in terms of emergency treatment.

"What we need to develop are the psychiatric correlates" or equivalents of those medical conditions, she said.

EMTALA obligations end when an emergency medical condition has been stabilized, yet there is "significant anxiety" in the field about what constitutes stabilization of an emergency medical condition of psychiatric patients, Ms. McCann told the technical advisory group, which advises the Department of Health and Human Services and the administrator of the Centers for Medicare and Medicaid Services on issues related to EMTALA.

The terms "expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others," are not clinically precise, she testified. "Many psychiatric patients have suicidal thinking that does not necessarily constitute an emergency medical condition or require stabilization at the inpatient level," she said. "For some clinicians, this can be a difficult distinction."

These ambiguities often result in unnecessary transfers of patients, witnesses testified. "It is all too easy for an emergency department without its own mental health staff on site to casually make a determination of a psychiatric emergency medical condition as a way of forcing a transfer of a patient to a psychiatric emergency service," Jon Berlin, M.D., president of the American Association of Emergency Psychiatry, noted in his testimony.

Right now, insurance coverage is dictating how psychiatric patients are treated in the emergency department, observed Mark Pearlmutter, M.D., an emergency physician and member of the technical advisory group.

"If a patient with pneumonia has Blue Cross Blue Shield of Wisconsin, and his or her insurance company doesn't have a contract with that hospital, we don't start calling around the state to find a bed with that insurance," he said. The patient is treated immediately.

However, if a patient comes to the emergency department with depression and requires inpatient admission, "even though we might have a bed upstairs, we can't treat the patient if the hospital doesn't have a contract with the patient's insurance company. If we do admit, we won't get paid," Dr. Pearlmutter explained.

For these reasons, psychiatric patients sometimes get shipped unnecessarily across one, two, or more primary service zones, he told the technical advisory group.

Dr. Berlin spoke of a colleague at Bellevue Hospital in Manhattan who received a patient all the way from Baltimore "because he had the appropriate service, and they didn't."

In some cases, these patients aren't even transferred from Hospital A to Hospital B directly, but to an inpatient ward of a psychiatric hospital, Dr. Pearlmutter said in an interview. Depending on the patient's condition, they may or may not truly need an inpatient stay, "and it's expensive to transfer these patients to such a facility, and take care of them overnight."

Physicians are somehow given the opportunity to do things to psychiatric patients that they would never do to a patient with pneumonia or a heart attack, Dr. Pearlmutter continued. "Stabilization" or resolution of an emergency medical condition means that the patient no longer presents harm to himself/herself or others, he said.

However, "if I have to put agitated patients in restraints or give them medication in order to drive them for 3 hours to another hospital, is that stabilization? Is that rational or reasonable? I don't think so," said Dr. Pearlmutter.

Several issues are compounding these problems, such as declining bed supply for psychiatric patients and a steep rise in the number of individuals with psychiatric disorders who are visiting emergency departments, Ms. McCann said.

To achieve some consistency in the handling of these patients, Julie Mathis Nelson, a lawyer and member of the technical advisory group, suggested that hospitals should employ qualified medical professionals to evaluate each psychiatric patient who presents to the emergency department. These personnel would be able to determine whether the patient has an emergency psychiatric condition within the context of EMTALA.

"We have to treat psychiatric patients in the same way we do medical patients. Anything short of that will be a disservice to these patients," Dr. Pearlmutter said.

The National Association of Psychiatric Health Systems and other psychiatric groups in their testimony urged the technical advisory group to convene a national work group, with a goal of developing better definitions of "stabilization" and "emergency medical condition" as they relate to individuals with psychiatric disorders.

The work group could also provide more specific interpretive guidelines to the field related to psychiatric care, and offer more specific provider education, Ms. McCann said.

Although no formal recommendations were made, the technical advisory group did vote for its action subcommittee to further study the definition of emergency psychiatric medical conditions and the definition of stabilization, and to seek more public testimony and outside expertise on the issue.

EMTALA was enacted in 1986 to ensure public access to emergency services regardless of ability to pay. The Medicare Modernization Act of 2003 required that HHS establish a technical advisory group to review EMTALA regulations. It is required by law to meet at least twice a year. ■

Psychiatric, Primary Care Colocation Can Cut Errors

BY MARY ELLEN SCHNEIDER
Senior Writer

NASHVILLE, TENN. — Integrating mental health and primary care has the potential to reduce medication mistakes and improve communication among providers, experts said at the annual conference of the National Academy for State Health Policy.

"This is a medical error reduction opportunity as well as a quality and cost opportunity," said Joseph J. Parks Jr., M.D., a psychiatrist and medical director for the Missouri Department of Mental Health.

Models that unify primary care and mental health care at one location are harder to set up initially, but are easier to operate on a day-to-day basis.

The status quo is not working, he said. Individuals with mental illness have increased or early mortality, have high rates of medical comorbidity, and receive inadequate and poorly coordinated health care.

Mental illness also predicts underutilization of medical services. A study of older patients with psychiatric disorders found that individuals with diabetes were less likely to receive more than one medical visit if they also had schizophrenia, bipolar disorder, or posttraumatic stress disorder. Patients with hypertension and any psychiatric disorder were also less likely to have more than one medical visit (Psychiatr. Serv. 2002;53:874-8).

There are several models for integrated mental health and physical care, including embedding primary care in a mental health program, creating a unified primary care/mental health program with common administration and financing, and improving collaboration between mental health and medical providers.

Evidence seems to show that trying to create linkage is difficult, Dr. Parks said. "Collaboration is basically an unnatural act between separate organizations," he said. Although this model is easier to set up initially, it is harder to make successful over the long run.

Models where primary care is embedded in mental health clinics or primary care and mental health programs are unified are harder to set up initially but easier to operate on a day-to-day basis, he said.

In general, the colocation of services is popular with both patients and providers. On the provider side, it allows physicians and other providers to have a more accurate understanding of one another's incentives, methods, and constraints, Dr. Parks said. Colocation also allows physicians to maintain a single clinical record, which requires less time and creates less potential for errors.

For patients, it breaks down some of the barriers to care, said Susan C. Braun, a nurse practitioner and project director of the Center for Integrated Health Care at the University of Illinois at Chicago.

She runs a program that brings primary care services into an established psychiatric rehabilitation program. That setup allows mentally ill patients to access medical services without going to a large medical center. Instead, they are cared for in a familiar setting, she said.

Providers at Cherokee Health Systems Inc. in Talbott, Tenn., have taken the opposite approach. There, a behavioral health consultant is embedded with the primary care team.

For example, a behaviorist is involved in all well-child visits, said Dennis Freeman, Ph.D., chief executive officer of Cherokee Health Systems. Behaviorists also manage the psychosocial aspects of chronic and acute diseases, address lifestyle and health risk issues, and comanage treatment of mental disorders.

Dr. Freeman said that state regulators and policy makers should reject carved-out payments for mental health services because the majority of these services will continue to be delivered by primary care physicians.

And he encouraged more payers to implement the Health and Behavior Assessment/Intervention CPT codes 96150 through 96155. The codes, issued in 2002, are for use by nonphysicians for services involving the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.

Contractual requirements and financial incentives through state Medicaid programs will also help encourage integration of services, Dr. Parks said.

"People will start doing things because it's the right thing to do, but people don't always keep doing things once the excitement dies down," he said.