The Alameda Model: An Effort Worth Emulating

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Supervising Section Editor: Mark I. Langdorf, MD, MHPE
Submission history: Submitted October 30, 2013; Accepted November 20, 2013
Electronically published January 27, 2014
Full text available through open access at http://escholarship.org/uc/uciem_westjem
DOI: 10.5811/westjem.2013.11.20610
[West J Emerg Med. 2014;15(1):7–8.]

Because the mental health care system in California is fragmented and chronically under-funded, the burden of psychiatric care has predictably fallen on emergency physicians. Community mental health resources and funding have decreased steadily over recent years, with the number of acute inpatient psychiatric beds per capita decreasing by over 30% since 1995.[1] In 1995, there were over 9,000 acute inpatient psychiatric beds, only to decrease each year to just 6,367 beds statewide in 2011.[1,2] In addition, 25 of California's 58 counties have no adult beds, and 45 have no pediatric beds, largely affecting rural counties and making post-discharge care nearly impossible – all while the number of acute psychiatric discharge diagnosis has been steadily increasing since 2007.[2] As a result, the struggle to find resources to care for this challenging patient population has become all too familiar to most emergency physicians.

The "Alameda Model" described by Zeller et al[3] is an example of a regional solution to the increasing problem of mental health patients boarding in emergency departments (ED). Zeller et al[3] provides an answer to the ubiquitous question in emergency medicine…Where is this patient going? Too often for our mental health patients the answer is nowhere fast. Alameda County has established a dedicated psychiatric hospital with an accompanying crisis stabilization unit. The regionalization of psychiatric care in Alameda allows expedited transfers from local EDs to the psychiatric hospital. The authors report an average time to transfer of 1 hour 48 minutes after completion of medical clearance. This is a considerable achievement, in comparison to the 6 to 16 hours noted in Stone et al.[4] In addition, Alameda's dedicated psychiatric hospital also accepts patients directly from EMS without an initial evaluation in an ED, which the authors note is a majority (60%) of their patient population. It would be interesting to know how many of the patients discharged in less than 23 hours were transferred from local EDs versus direct admissions from the field.

Furthermore, John George Hospital, Alameda's dedicated psychiatric hospital, meets its EMTALA obligation by accepting all transfers for emergency stabilization of the acute psychiatric emergency. It is time that all of our hospitals treat mental health patients with the same urgency as our trauma and medical patients. Regionalization of psychiatric care may prove to have outcome benefits as it has with regionalized trauma centers.

The Alameda model focuses on providing timely, specialized care to patients with mental health emergencies. Many times this care is given with the reality that no inpatient beds exist, and operate "with a goal of avoiding hospitalization when possible." Zeller et al[3] reports 75% of patients transferred to the dedicated regional psychiatric hospital were discharged – a high percentage. The authors attribute their high discharge rate to superior, timely care provided at the dedicated hospital, rather than on overall patient acuity. However, no data are provided to support these claims. For example, according to the Office of Statewide Health Planning and Development (OSHPD), Alameda County places more involuntary holds per population than any other county in California. In 2009 Alameda placed 11.0 involuntary holds per 1,000 population, while the next highest county in California only placed 6.4 per 1,000 population.[5] This may suggest instead that some of Alameda's mental health patients would not have been placed on an involuntary hold in other California counties in the first place, increasing the proportion of lower acuity psychiatric emergencies and thus accounting for the high discharge rate.

As a response, Zeller et al[3] propose two solutions: to increase the number and/or access to inpatient psychiatric beds, or to provide more access to crisis services "to help avoid inpatient care altogether." The authors highlight a specialized Medi-Cal billing code to encourage the establishment of more crisis stabilization centers. Certainly, a specialized stabilization center is preferable to a neglected corner of a busy ED where many mental health patients languish while awaiting transfer. But who will provide the funding and staffing to initially establish these centers? As the authors alluded to, this is an area that needs further exploration.

Reference is also made to the Medicaid Emergency Psychiatric Demonstration, which was established under Section 2707 of the Affordable Care Act as a means to

improve quality of care at a lower cost by reimbursing freestanding private psychiatric hospitals, referred to as "Institutions for Mental Disease" (IMD). California is one of 11 states participating. The federal definition of an IMD is "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." Historically, IMDs are ineligible for Medicaid/Medi-Cal reimbursement for acute psychiatric services for beneficiaries aged 22-64. Because of this federal exclusion, California counties currently pay for 100% of the associated costs for acute psychiatric care in IMDs. In California, IMDs together comprise 60 facilities and 6,200 additional acute psychiatric beds, which would provide a substantial boost to California's depleted psychiatric resources. The intent of this federal three-year project is to test whether this increased coverage improves access to care and reduces ED boarding times.[6,7] Only time will tell if this will provide relief to California's mental health care needs.

Although implementation of the Affordable Care Act presents many uncertainties, both new opportunities and challenges related to mental health care service are undoubtedly ahead, especially in California. The decentralization of the state's public mental health delivery structure, and subsequent financial responsibility shifted to individual counties, has led to a wide variation in program operations, quality, and availability. Certainly the Alameda model is a feasible alternative to the situation of other counties struggling with limited resources to provide care for mental health patients. Also, creating and expanding a national billing code for crisis stabilization is a worthwhile goal. Until more funding is achieved, it is also our hope that more of our counties and psychiatric hospitals would accept their responsibility to provide quality care to our patients with psychiatric emergencies. Regardless, emergency physicians will continue to care for these patients and fight for them to receive the most appropriate and timely care for their condition and state.

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Conflicts of Interest: By the *West*JEM article submission agreement, all authors are required to disclose all affiliations, funding sources and financial or management relationships that could be perceived as potential sources of bias. The authors disclosed none.

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