Response to Moulin and Jones: "The Alameda Model: An Effort Worth Emulating"

Scott Zeller, MD Alameda Health System, Department of Psychiatric Emergency Services, Oakland, California

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We sincerely appreciate the thoughtful discussion of our study from Drs. Moulin and Jones. However, we would like to provide clarification on several of the points they raised.

As Moulin and Jones correctly indicate, there is no delineation of the relative acuity of the study patients to those seen in other emergency settings in California. However, we are unaware of any established metric to provide such a comparison for this patient population, and no such categorization was noted in any of the other boarding time studies cited in the article.

And while Alameda County does have an elevated number of involuntary psychiatric holds, the county also has a disproportionate share of California's chronic and persistently mentally ill residents – out of which arise a significant percentage of the psychiatric emergencies. This might be attributable to the agreeable local climate and the tolerance of Berkeley and Oakland for those with alternative and transient lifestyles. But also, the county has a great number of psychiatric boarding homes and nursing facilities into which other Bay Area counties place many of their most severely psychiatrically disabled. We postulate that it is these population factors, along with persisting inner-city dilemmas like crack cocaine and concentrated poverty (which are less an issue in most other parts of the state), that lead to the increased involuntary detentions.

Further, the greatest percentage of the patients brought to the study site are detained by police in Oakland, a city recently described as the second most-dangerous in the United States (U.S.), due to its high incidence of violent crimes.[1] Yet Oakland has a police officer to population ratio less than half of the nation's most dangerous city, Detroit.[1] The idea that the relatively overwhelmed Oakland police would be taking time away from intervening in violent crimes, to instead detain sub-acute psychiatric patients that other counties would not find in need of treatment, seems contrary to common sense.

The Federal Demonstration Project allowing more psychiatric hospitals to accept Medicaid has two major shortcomings which we propose may limit its impact on boarding. For one, it fails to recognize that many of these hospitals may already be at or near capacity with otherwise-insured patients, and would be unlikely to suddenly accept large numbers of low-reimbursement Medicaid instead. Secondly, this approach would still only be continuing the status quo of shunting patients directly from EDs to inpatient psychiatric beds, rather than attempting outpatient-level stabilization. A medical analogy to this would be skipping ED interventions in patients with asthma attacks, admitting to the inpatient floor instead, and only then beginning inhaler treatment – hardly the most efficient paradigm.

We suggest the most impactful way to reduce ED boarding of psychiatric patients would be to facilitate treatment alternatives which lower demand for scarce inpatient beds; one possible such design is described in our study. There is nothing magic or extraordinary about the methods used at the study site, nor are its percentages of patients discharged within 24 hours unusual for crisis stabilization programs across the U.S. The important factor is that with prompt treatment, the majority of psychiatric emergencies can be stabilized in less than a day, often in less time than patients currently spend boarding in EDs awaiting hospitalization. Just as surgeries which formerly required hospitalization are now done in ambulatory centers, and uncomplicated childbirth can have discharges the following morning rather than after several days, so too can acute psychiatric treatment be converted from the tradition of days to hours. This redefinition could lead to improved access to appropriate, timely care, while greatly reducing costs and unnecessary hospitalizations -- all consistent with the goals of healthcare reform.

Address for Correspondence: Scott Zeller, MD. Alameda Health System, 2060 Fairmont Dr., San Leandro, CA 94563. Email: szellermd@gmail.com.

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