Clinical and Financial Impact of Integrated "Higher Management" Consult Liaison Psychiatric Service

Pratheek Mangini MD, Robert Simons MD, Jessica Kovach MD
Psychiatry Residency Program, Lewis Katz School of Medicine at Temple University

Introduction

Patients with severe medical and psychiatric comorbidities often receive fragmented care that is associated with higher lengths of stay, overall costs, readmission rates, and repeated transfers between facilities.[1] Proactive consult services, comanaged care, and medical-psychiatry units have been shown to improve care and decrease costs.[2] However, all institutions may not be ready to implement these levels of integration and may look for more targeted approaches to service innovation.

Population

Temple University Hospital treats patients with severe economic and social challenges, with high rates of co-morbid severe mental illness (SMI) and acute medical needs that cannot be effectively managed on an inpatient psychiatric unit.

Temple University Hospital:

- 722 bed, tertiary-care academic hospital
- 45% living below the federal poverty level
- 51% suffering from mental illness
- 25% with substance use disorders
- Countless with acute medical needs that cannot be effectively managed on an inpatient psychiatric unit

Temple University Hospital Episcopal Campus:

- Stand-alone psychiatric hospital with 118 inpatient beds
- Maximum capacity 154 days of the year
- On average operates at 98% capacity

Rationale

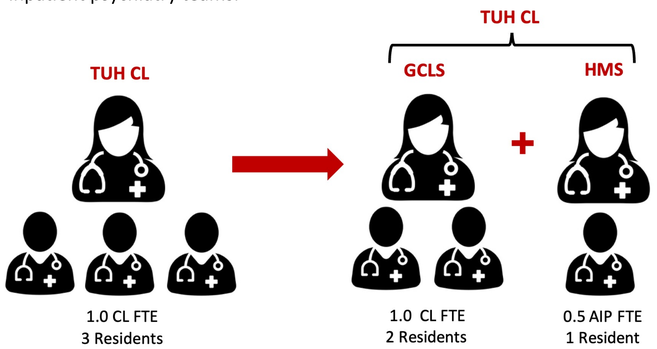
We sought to develop a novel Consult Liaison service structure that proactively identifies and manages patients receiving medical care with the most severe psychiatric comorbidity. The aim was to improve clinical care and reduce financial costs by maximizing the impact of an additional attending psychiatrist to optimize care for medical inpatients with the most severe psychiatric comorbidity. To achieve this, we utilized a faculty member with extensive inpatient experience, rather than consult liaison, who was given 0.5 FTE to round with one assigned resident daily.

Intervention

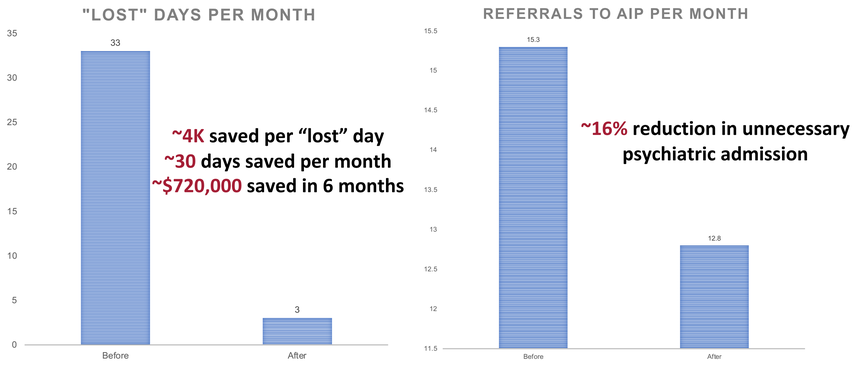
The General Consultation Liaison Service (GCLS) completed initial consultation and referred patients to the Higher Management Service (HMS) based on the following criteria:

(1) Likely or definite need of acute inpatient psychiatric level of care
(2) Transferred to medical unit from inpatient psychiatry
(3) Symptoms of Severe Mental Illness (SMI) disrupting medical care

HMS provided brief psychotherapeutic interventions, medication management, team education, and streamlined disposition planning of transfers between medical and inpatient psychiatry teams.



Results



Discussion

By utilizing a proactive, co-managed care model, we were able to demonstrate significant financial and clinical benefits, consistent with the literature, in the medical and psychiatric care of patients with SMI.[3]

Clinical Factors → We believe the HMS provided direct benefits in patient care through facilitated communication between primary teams and patients with SMI, targeted management of psychiatric behaviors that impede medical care, reduction of further medical risk through limited use of restraints, and improved patient and primary team satisfaction with efficient and concurrent medical and psychiatric care.[4]

Systems Factors → At a systems level, patients with SMI often have acute medical needs that prevent their transfer to inpatient psychiatry due to safety risks (e.g. ligature risk with various medical lines or fire risk with electrical devices) as well as lack of certification of mental health nursing staff with certain treatments such as burn care, chemotherapy, dialysis, etc.[5,6] By providing co-managed psychiatric care on the appropriate medical unit, these patients do not have delays in psychiatric care due to system barriers placed on their unique medical needs.

Financial Impact → To develop a medical-psychiatric unit requires a significant financial and administrative investment from an institution[2]; however, our co-managed care model has provided similarly impressive results by maximizing the impact of a part-time attending psychiatrist to reduce lost days by 90%, prevent unnecessary transfers, and optimize bed utilization, which are key factors in financial viability of CL services.[7]

References

1. Chan AC, Burke CA, Coffey EM, Hilden DR, Coira DL, Warner-Cohen J, Grady M, Muskin PR, Shinozaki G. Integrated Inpatient Medical and Psychiatric Care: Experiences of 5 Institutions. Ann Intern Med. 2018 Jun 5;168(11):815-817. doi: 10.7326/M17-3186. Epub 2018 Apr 24. PMID: 29710091.
2. van Schijndel MA, van Wijngaarden JDH, van de Klundert JJ. Organization and Outcomes of Integrated Inpatient Medical and Psychiatric Care Units: A Systematic Review. Psychiatr Serv. 2022 Jan 1;73(1):64-76. doi: 10.1176/appi.ps.202000416. Epub 2021 Aug 19. PMID: 34407632.
3. Muskin PR, Skomorowsky A, Shah RN. Co-managed Care for Medical Inpatients, C-L vs C/L Psychiatry. Psychosomatics. 2016 May-Jun;57(3):258-63. doi: 10.1016/j.psym.2016.02.001. Epub 2016 Feb 2. PMID: 27039157
4. Noblett J, Caffrey A, Deb T, Khan A, Lagunes-Cordoba E, Gale-Grant O, Henderson C. Liaison psychiatry professionals' views of general hospital care for patients with mental illness: The care of patients with mental illness in the general hospital setting. J Psychosom Res. 2017 Apr;95:26-32. doi: 10.1016/j.jpsychores.2017.02.004. Epub 2017 Feb 7. PMID: 28314546.
5. Canavera K, Johnson LM. Integrating Mental Health Care for Medically Complex Children. Pediatrics. 2020 Aug;146(2):e20190898. doi: 10.1542/peds.2019-0898. PMID: 32699070.
6. FGI Guidelines Institute (FGI). *2022 Guidelines for Design and Construction*.
7. Bronson BD, Alam A, Calabrese T, Knapp F, Schwartz JE. An Economic Evaluation of a Proactive Consultation-Liaison Psychiatry Pilot as Compared to Usual Psychiatric Consultation on Demand for Hospital Medicine. J Acad Consult Liaison Psychiatry. 2022 Jul-Aug;63(4):363-371. doi: 10.1016/j.jaclp.2021.12.008. Epub 2022 Jan 11. PMID: 35026472.