Treating the Whole Patient

July 01, 2001

In addition to improving patients' emotional well-being, aggressive treatment of psychiatric illnesses such as depression can substantially increase patients' cognitive functioning and even decrease mortality. A growing number of psychiatrists and other medical doctors are joining forces to create integrated care settings where the diagnosis and treatment of mental disorders occurs alongside that of physical illness.

(The following is the second in a two-part series examining the diagnosis and treatment of psychiatric illness among patients with comorbid physical illness-Ed.)

Back in the 17th century, French philosopher Ren Descartes theorized that mind and body were irrevocably distinct entities. Despite increasingly strong data linking diseases of the mind with diseases of the body, American medicine continues to be organized around a paradigm popular during the reign of Louis XVIII. Unhappy with this split, a growing number of psychiatrists and other medical doctors are joining forces to create integrated care settings, where the diagnosis and treatment of mental disorders occurs alongside that of physical illness.

Research and clinical experience indicate that psychiatric disorders frequently occur in conjunction with general medical illnesses such as stroke, cardiovascular disease and Parkinson's disease. In addition to improving patients' emotional well-being, aggressive treatment of psychiatric illnesses such as depression can substantially increase patients' cognitive functioning (Kimura et al., 2000) and even decrease mortality (Penninx et al., 2001).

Integrated treatment of patients with concurrent psychiatric and physical illness can shorten inpatient length of stay and significantly curtail treatment costs for both types of illnesses, according to Roger Kathol, M.D., who ran University of Iowa's integrated inpatient unit for 15 years. Kathol explained in an interview with Psychiatric Times that while most patients with psychiatric disorders do not have significant comorbid physical illness, the minority that do have such disorders generate disproportionate costs due to longer hospital stays and other factors (Kwentus et al., 1999). In addition, the lack of integrated care means patients' mental and general medical needs are treated consecutively, often delaying patients' functional recovery, said Kathol, who now heads Cartesian Solutions Inc., an integrated health care consulting firm in Iowa City, Iowa.

In outpatient settings, integrated care means common patient waiting rooms and close collaboration between psychiatrists and general medicine colleagues. For inpatient settings, it means having staff who can manage suicidal and psychotic patients who might also need to have their heparin pump dosing adjusted or their peritoneal dialysis fluid changed. In terms of infrastructure, setting up an integrated inpatient unit involves, among other things, equipment ranging from crash carts to barricade-proof doors (Kathol and Stoudemire, in press). Kathol said there are at least 34 integrated inpatient units nationwide, some of which have affiliated outpatient programs.

Despite growing evidence and support for integrated care, significant obstacles remain. Among them is mistrust between professionals in different specialties and the continued unwillingness of many insurers to reimburse for services seen as outside the designated sphere of treatment.

"I think the important prerequisite for collaboration is a sense of respect between psychiatrists and primary care doctors," Darrel Regier, M.D., M.P.H., director of the Division of Research at the American Psychiatric Association, told PT. "That type of respect and confidence comes from working together, and it doesn't happen overnight or with arm's-length relationships."

Regier believes the lack of goodwill that can exist between primary care doctors and psychiatrists reflects some legitimate concerns on both sides. "On the part of the primary care doctor, there has to be a sense that the psychiatrist is available for referrals when they need them. Primary care doctors are in a very fast-paced business." In addition, Regier believes some primary care physicians feel that psychiatrists are "generally unavailable for 'real' medicine and don't want to take any really sick patients."

Conversely, "the worry on the part of the psychiatrist is that this is a dump and the primary care physician doesn't want to take the time to deal with the problem," Regier said. "When you have a busy practice and you don't have a good working relationship with your colleagues, there often is that kind of reaction. If you have a good working relationship and know that the [primary care
physician] does a careful evaluation and generally is able to handle routine depression and anxiety with first-line treatment that is up-to-date and sound, you have confidence [in their referral] There's nothing like having an intelligent conversation that makes it clear that the primary care physician has thought about alternative explanations for anxiety or depressive symptoms to make you feel like you want to perform adequately for the patient and for your [referring] colleague." Advocates of integrated care agree that the best way to improve these relationships is to create working environments where psychiatrists and other physicians work in close physical proximity. Kathol believes the traditional mind-body split that continues to pervade American medicine poses a significant obstacle to integrated care, particularly when it manifests itself in reimbursement problems for doctors. Psychiatrists generally are unable to recoup costs insurers deem medical, while primary care doctors and other nonpsychiatric specialists have little if any financial incentive to do much in the way of psychiatric assessment and treatment (Kwentus et al., 1999). Added to this is the tendency to see patients' difficulties almost exclusively through the lens of one's specialty. Kathol explained, "The practitioners in each area are dedicated to solving problems in their own area. Patients are not assessed for the other illness when they see practitioners in other settings."

Consultation-liaison psychiatrists traditionally have been the mental health professionals that hospital staff call on to assess patients in crisis. However, the short-term, crisis intervention orientation does not create the opportunity for ongoing interdisciplinary communication or patient follow-up, which is particularly important in treating patients with chronic illness. If organized properly, integrated settings yield considerable clinical benefits for patients, who are far more likely to show up in a primary care clinic than in a mental health care office. "There are lots of patients at the family practice office where I work who would never come to see me in my psychiatry office but will willingly see me in the family practice center," said Lawson Wulsin, M.D., who divides his time between both settings. "And that's a matter of logistics, stigma and payment," he told PT. "Just putting a psychiatrist into a large clinic gives the patients in that clinic a major increase in access to mental health care."

In addition to improving clinical outcomes by virtue of increased access to psychiatric services, integrated care settings are also more cost effective, Kathol said. He added that in his experience, due to greater billing flexibility, units that are licensed either as medical facilities or as dual psychiatric-medical facilities are far more likely to remain financially solvent than those with an exclusive psychiatric designation. Kathol said that there will always be a need for stand-alone mental health clinics, as more intensive interventions are not time- and cost-effective in primary care settings. As for fears among some that integrated care will mean an increase in the number of nonmedical psychiatric clinicians at the expense of psychiatrists, "there are more than enough people with complex psychiatric illness to keep psychiatrists busy," said Wulsin. "The problem is how to get the psychiatrically ill person to see the psychiatrist. The answer is 'setting.' I think our system will serve the mentally ill better if it brings psychiatric care to the patient in primary care clinics. Every primary care clinic should have a part-time to full-time psychiatrist working on the site and reimbursed at the same rates as primary care."

Despite growing evidence pointing to the effectiveness of integrated care for the treatment of concurrent psychiatric and general medical illness, questions remain about the willingness of insurers to pick up the tab. "There is really no incentive for prevention or long-term health improvement if you don't have to pay for the consequences down the line," Regier said. "That's been one of the real weaknesses of the 'contract to the lowest bidder' mentality that's been driving a lot of the managed care competition in the last decade There really has to be a quality of care incentive for it to occur."

Wayne Katon, M.D., professor of psychiatry and of family medicine at University of Washington's School of Medicine, told PT that a double standard exists for mental health care providers. "There's a bias that's still present in our systems," Katon said. "Somehow, if you provide good treatment for depression or for mental health in general, you have to have a cost offset. If you increase the [mental health] costs, then you have to show you've saved in medical care. I don't know of any other condition where you're held to that standard I think it's unfair."

Larger managed care companies with less subscriber turnover can afford to be more forward-thinking, according to Wulsin. So can organizations such as the U.S. Department of Veterans Affairs, which are obligated to their subscribers for life. The growth of integrated residency training programs is another encouraging sign, said Wulsin, who is training director of the family medicine/psychiatry residency program at University of Cincinnati's
School of Medicine. "The family medicine/psychiatry programs have only been around for about five years. It's a little soon to say what their net impact is going to be, but it's catching on," he said, adding that match rates for the combined specialty are very high. "The idea that justifies these combined programs is sort of the 'carve-in' approach to mental health, as opposed to the carveout approach. Most mental health care gets carved out, yet patients carry their mental illnesses right alongside their physical illnesses."

Currently, there are a dozen family medicine/psychiatry programs nationwide and 28 residency training programs that combine internal medicine and psychiatry (Yates, 1999). Other medical specialties that are teaming up with psychiatry include pediatrics and neurology. "What I'm interested in is training a small number of people who are the walking examples of integrated, carve-in care," Wulsin said. "When you have people who can do both, it's likely to drive systems that can do both."

Cincinnati joint program alum Lisa Cantor, M.D., is the kind of example that Wulsin is talking about. Cantor splits her time between Western Family Physicians, a family medicine practice, and the Drake Center, a regional rehabilitation center in Cincinnati. While it is not hard to find a psychiatrist who can effectively treat postpartum depression, Cantor is among the few who also routinely delivers her patients' babies. "Initially, I got a lot of negative feedback," Cantor told PT, referring to comments made by some doctors, medical students and residents. Some said, "I was wasting my talent and career There's some ivory tower stuff going on--you're not a real doctor unless you're an internist." Cantor said others thought a joint program made no sense since they believed she would inevitably end up doing either psychiatry or family medicine exclusively. "That's the biggest load of baloney," Cantor said. "You can't separate psychiatry and medicine, they're the same."

References: References

Source URL: http://www.psychiatrictimes.com/articles/treating-whole-patient