

Preface

It is not unexpected that the two of us responded positively when approached 2 years ago by Springer to edit a book on the integration of medical and psychiatric care for psychiatrists. Both of us developed an interest in the orphan population composed of patients with comorbid medical and psychiatric conditions during medical school. Both of us completed internal medicine and psychiatric residencies. Both of us, thereafter, have dedicated our professional lives to fostering better care for patients with concurrent mental health/substance use disorders, hereafter called behavioral health (BH) disorders, and medical conditions.

Our careers have crossed paths on many occasions, whether it was sharing thoughts on treatment of complex patients on the complexity intervention units (medical psychiatry units) we ran at our respective academic medical centers, complaining about challenges and strategies that would support payment for the care of comorbid patients in a segregated reimbursement system, or discussing our career “next steps” in a system that did not know how to deal with doctors who really wanted to provide care across specialty boundaries. Little did we know that our career paths would become even more connected because the patients that happened to strike our fancy as young trainees would represent an important population that would likely transform the practice of psychiatry in the era of health reform and beyond.

Why do we say this? More medical patients with concurrent psychiatric illness seen in the medical setting have serious mental illness (SMI) than those seen in the BH sector. Further, they have largely been made invisible by a BH sector that is focused on supporting the discrete care of SMI patients seen exclusively in the BH setting, often to the exclusion of their general medical care needs. An entire BH system, including clinical care and payment, has been built around maintaining what we would describe as segregated psychiatric care, i.e., care administered and delivered in stand-alone inpatient and outpatient psychiatric settings with little thought that 80 % of BH patients are seen entirely or, at least, primarily in the medical setting.

Initially, this distinct psychiatric care was considered important since it was thought that it would better support evidence-based psychiatric care of those in greatest need, i.e., SMI patients, and protect limited budgets for other essential services such as housing, case management, and transitions to work. Little did they know when independent managed BH was initially set up that several key factors would demonstrate that stand-alone psychiatric care was not always in the interest of psychiatric patients:

- The majority of those with both SMI and non-SMI psychiatric disorders refuse to be seen in a stand-alone BH sector. The general medical sector provides the majority of ambulatory care for all BH patients.
- Traditionally treated SMI patients, most of whom have concurrent medical illness, have difficulty in accessing even basic medical care due to segregated treatment settings, payment complexity, and non-communicating records. The tragic impact on disability and early mortality has been well known for many years.
- BH comorbidity in patients seen in the medical setting is associated with poor medical and psychiatric illness outcomes, higher medical complication rates, functional impairment, protracted illness, and doubling or more of total health care costs.
- Finally, segregated medical and BH payment business practices prevent the coordination of medical and BH services, leading to managing budgets and patients as if their care needs are not integrated in the same person with the health and cost outcomes described above.

It is these challenges for patients and physicians alike that have led to what we consider an upcoming sea change in the way that psychiatric care will be delivered. The central tenant of health reform is that the care experience, the care, and the cost outcomes should improve as the system changes from fee for service to population-based health. This is known as the Triple Aim and has to be focused on the needs of patients and organized around those needs—what is known as patient-centered care. Psychiatrists have a phenomenal opportunity to contribute to the Triple Aim. Current segregated payment practices have marginalized psychiatrists, i.e., they are prevented from participating in delivery of evidenced-based care in the medical setting. This should change as a part of health care reform. Let us explain.

We do not mean that the assessments and treatments currently being delivered are subpar, nor that excellent care cannot or should not occur in the offices of psychiatrists and others. Rather, we contend that the way that they are delivered and to whom lead to less than optimal results. For instance, a number of studies now demonstrate that medical patients with untreated psychiatric illness have higher hospital admission and readmission rates, that once admitted they have on average one or more days longer lengths of stay, that they use more health care services, and that they cost the medical health system several times more in unnecessary/excess medical and pharmacy service use than the total amount used to support actual psychiatric treatment. A generation of artificially trying to control the cost of psychiatric

care as if it represented a risk or a moral hazard has instead paradoxically cost more and not delivered the quality of total health care that any of us would want for our loved ones.

We now live in a segregated medical and psychiatric world and have done so for some time. In truth, the separation has led to the development of competing medical and BH subcultures that have learned not to talk with each other, and often view the competing culture with suspicion, if not disdain. They have built their own treatment infrastructures and have focused on discipline-specific work processes when care coordination and integration are the only way that negative clinical, functional, and economic outcomes are going to improve. Interestingly, colleagues in our respective specialties have even asked us where our allegiances lie, with medicine or psychiatry. They are uncertain what our answers mean when we say that they lie with our patients and the desire to improve poorly treated comorbid medical *and* psychiatric disorders.

Much progress has been made in defining models of integrated care that bring value, i.e., improved health while conserving health care resources, to patients both in the medical and mental health settings. We call these services “nontraditional” integrated or collaborative psychiatric services, i.e., those that are delivered in collaboration with medical and surgical colleagues in the general medical setting. This book is an attempt by the two of us to provide a roadmap for you to transition from segregated to integrated services and to be major contributors to the next generation of health care.

We wish to thank our families for helping us to put this book together. Roger’s wife, Mary, when told of this third adventure into book editing, said, “Again!” but has been gracious in helping him keep up with other responsibilities while working with the book’s authors, reviewing manuscripts, and finalizing what is hoped to be a contribution to colleagues in psychiatry wishing to be a valuable part of health in America. Paul’s wife, Randy, has not only been a patient supporter of yet another quixotic psychiatric adventure but as an internist–psychiatrist herself has spent decades caring for patients with complex medical and psychiatric illness as a consultation-liaison psychiatrist in Boston.

We also wish to thank our professional colleagues who have taken the time to share their expertise related to selected areas of integrated practice. You will see in the chapters of this book the effort and wisdom they have shared in an area of psychiatric practice that to many is like a foreign country. Not only have they described the rationale for and models of integration but they have also provided guidance about needed future training programs and research.

Finally, we wish to thank the publication staff at Springer for their support in making the mechanics of producing even an edited book as simple as possible for two very busy souls. They have been delightful to work with and timely and supportive to all our efforts to produce a guide to a rapidly changing medical-psychiatric landscape.

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