

Integrated Psychiatry

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Guest Editor



This issue of *Psychiatric Annals* focuses on the notable work of numerous integrated and collaborative psychiatry programs. The authors review implementation of inpatient and outpatient models of care, discuss integration and education, and demonstrate how collaborative care models embody the fundamentals of quality and safety. These groundbreaking projects include integrating psychiatric treatment during transitions from inpatient to outpatient medical care as well as during transitions in patient life cycles; in other words, treating the whole patient where they are in life and the health care system itself.

The value-added practice of integrated and liaison psychiatric care makes sense for patients, providers, and for health systems. However, despite rising support, including recent promotion of the new Medicare payments for integrated behavioral health in the *New England Journal of Medicine*, implementation of col-

laborative models remains challenging.¹ The challenges are not unexpected; integrated care models ask for fundamental shifts in the nature of both medical and psychiatric practice, present difficulties in fee-for-service payment models, and require adjustment of electronic medical records and patient flow designs, along with myriad other factors such as the relatively new role of the care manager. At the same time, however, these programs are also increasingly popular, and requested more by patients, physicians, and insurers. The articles in this issue attempt to address some of the questions about opportunities for and implementation of integrated psychiatry.

Medical comorbidities adversely affect the quality of life for the majority of patients with mental illness, including recovery from underlying psychiatric disorders and overall morbidity and mortality.^{2,3} There are embedded factors making it difficult for people with psychiatric illness to

obtain medical care, including the segregation of clinical, administrative, and financial aspects of psychiatric and other care in our medical system.^{4,5} It is also clear that psychiatric syndromes have significant impact on the morbidity and mortality of many medical conditions.^{6,7} Despite this, we are still struggling to justify widespread implementation of collaborative care. There also appears to be a shortage of psychiatrists practicing integrated care, and there will be an ongoing need to improve and expand training of future physicians.

In the first article, “New Models of Psychiatric Consultation in the General Medical Hospital: Liaison Psychiatry Is Back,” Drs. Paul H. Desan, Hochang B. Lee, Paula Zimbrea, and William Sledge write about their experiences changing the traditional reactive consultation liaison model. Their group was one of the first to study the effects of proactive psychiatric consultation in an inpatient setting. They review the

literature supporting this practice and suggest that expanding this model to cover transitions of care might be another opportunity for psychiatrists to address disparate effects of psychosocial situations on patient outcomes.⁸

In the next article, “The Physical Health of Patients with Psychiatric Disorders: What Is the Role of the Psychiatrist?,” Drs. Geetha Reddy and Jeffrey T. Rado review the experience of a psychiatry trainee working with medically complex outpatients, and share their methods and challenges of making sure patients receive holistic care. Dr. Rado is a dual-boarded internist and psychiatrist who co-wrote the American Psychiatric Association Position Statement on the “Role of Psy-

chiatrists in Reducing Physical Health Disparities in Patients with Mental Illness,” empowering psychiatrists to embrace some roles within primary care.⁹ Their experience is among the first reports about the practice of this ideal.

In the third article, “Integrated Perinatal Mental Health Care,” Drs. Abbey Kruper and Christina Wichman review their implementation of integrated psychiatric care in a women’s health practice, providing an experienced voice of challenges and success. Their model affirms the idea that providing opportunities for psychiatric treatment holistically, where patients are and during windows of transition in lifecycles, may be a critical way to address the needs of more patients.

In the final article, “Integrated and Collaborative Care: Quality Improvement in Action,” Dr. Mark W. Newman writes an eloquent and unique article about the intersection of collaborative care and quality improvement. Quality and safety have become increasingly recognized indicators of effective and patient-centered medical care and are more frequently demanded by insurers. He demonstrates how the goals of collaborative care models embody the tenants of quality and safety.

Hopefully, the tide is turning and innovations of funding and collaboration will allow new opportunities for psychiatrists to contribute to the care of our patients as they progress through life and through medical and sur-

about the guest editor



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gical conditions. Capturing these moments of psychosocial vulnerability might be an effective method for expanding models of integrated care. There is an opportunity for all of us to work in these evolving settings and continue to address morbidity and mortality of the whole patient.

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Disclosure: The author has no relevant financial relationships to disclose. doi: 10.3928/00485713-20170601-02