

Futures Brief

Why Integrate Mental Health with General Health Care Services?

What is Clinical Integration?

Clinical integration occurs when patient care services are coordinated across people, functions, activities and sites over time. Because many psychiatric illnesses and their treatments complicate or are complicated by other medical conditions, the most effective integration is proactive.¹ Integration occurs when mental health and general medical personnel work together in a general or specialty medical setting to provide co-located, simultaneous, evidence-based treatment to patients who have interacting psychiatric and (other) medical disorders.

Patient Outcomes Improve When Clinical Care is Co-Located and Provided Concurrently

Co-location and clinical integration enhance clinical effectiveness of care. Research evidence suggests that lengths of stay for severely mentally ill patients are reduced and patient symptoms improve more in an integrated setting than in a stand-alone psychiatric service.²

Co-occurring Medical Disorders are Very Common in Psychiatric Patients

National studies have indicated that 15 % to 20% of psychiatric patients have other serious medical conditions.³ The rate of co-occurring conditions among VSH patients is very high. Approximately 49 – 59% of VSH patients during 1999 – 2002 were classified as serious, high risk patients with multiple medical conditions.⁴

¹ Shortell, S.M. et al. (2000). *Remaking Health Care in America: The Evolution of Organized Delivery Systems*, 2nd ed. San Francisco: Jossey-Bass. Horvitz-Lennon, M., Kilbourne, A., & Pincus, H. (May/June 2006). "From Silos to Bridges: Meeting the General Health Care Need of Adults with Severe Mental Illnesses," *Health Affairs*, 25, 3:659-669. Cartesian Solutions The Next Generation of General Medical and Behavioral Health Services: http://www.cartesiansolutions.com/hospitals_clinics.htm

² Kishi, Y., MD., & Kathol, R., MD. (August 1999). "Integrating Medical and Psychiatric Treatment in an Inpatient Medical Setting The Type IV Program," *Psychosomatics* 40:345-355. <http://www.psy.psychiatryonline.org/cgi/content/full/40/4/345>

³ Lyketsos, C, Dunn, G., Kaminsky, & Breakey, W. (February 2002). "Medical Co-morbidity in Psychiatric Inpatients" *Psychosomatics* 43:24-30. □ HYPERLINK "<http://psy.psychiatryonline.org/misc/terms.shtml>" □ [The Academy of Psychosomatic Medicine](#) □ Sokal, J., et al (2004). "Comorbidity of Medical Illnesses among Adults with Serious Mental Illness Who Are Receiving Community Psychiatric Services," *Journal of Nervous and Mental Disease* 192, no.6: 421-427, cited in Horvitz-Lennon, M., Kilbourne, A. M. and Pincus, H.A. (2006). "From Silos to Bridges: Meeting the General Health Care Needs of Adults with Severe Mental Illnesses," *Health Affairs* (May/June) 25, 3: 659-669. Felker, B., Yazel, J. & Short, D. (1996). "Mortality and Medical Comorbidity Among Psychiatric Patients: A Review," *Psychiatric Services* 47: 1356-1363. Carney, C., Jones, L., Woolson, R. (Nov 2006). "Medical Co-morbidity in Women and Men with Schizophrenia: A Population-Based Controlled Study," *Journal of General Internal Medicine* 21: 1133.

⁴ Vermont Department of Health, Division of Mental Health, Conceptual Certificate of Need Response to Questions and Answers, Question 113, October 16, 2006, p.62.

Contemporary Standards Require Integrated Structures of Service Delivery to Achieve Improved Clinical Care

Emerging neuroscience is changing contemporary standards of care. It is no longer accurate to split “mental” from “physical” health. “The brain is the recognized integrator of thought, emotion, behavior, and health.”⁵ Current models of best practice recommend that management of psychiatric and other medical conditions be organizationally integrated and physically co-located.⁶

The organizing principles of the Institute of Medicine (IOM) Standards for Access to Care (adopted by the Vermont Health Resource Allocation Plan) support co-located services.⁷ The current IOM Standard states that care must be timely and equitable, reducing waits and harmful delays and does not vary in quality because of geographic location and socioeconomic status.⁸

The Vermont Health Resources Allocation Plan (HRAP) itself endorses the Futures Plan, and supports clinical integration of care:⁹

“The HRAP endorses the Futures Plan and strongly emphasizes the importance of clinical integration. By...ensuring an adequate number of beds to provide essential core services, including ...Inpatient beds at an appropriate general hospital (preferably an academic medical center), (and) intensive care beds at another hospital.”

Clinical Integration Improves Access of Psychiatric Patients to Appropriate Care

Medical diagnosis may require brain imaging, electro-cardiograms, neurophysiologic testing, or other medical procedures. Treatment for a variety of psychiatric and other medical conditions is often more effective when delivered simultaneously (for example, diabetes and depression). Physical co-location of psychiatric and general medical services improves patient access to appropriate care by reducing wait time and permitting concurrent diagnosis and treatment.

Parity of Access is Enhanced When Psychiatric and Other Medical Services are Clinically Integrated

Access to clinically integrated, co-located inpatient care reduces stigma and promotes parity with all other forms of inpatient and outpatient care.

⁵ U.S. Department of Health & Human Services, National Institute of Mental Health (1999). *Mental Health A Report of the Surgeon General*. Preface.

⁶ See, for example: Shortell, S.M., et al. (2000). *Remaking Health Care in America: The Evolution of Organized Delivery Systems*, 2nd ed. San Francisco: Jossey-Bass. Bartels, S., MD (Dec 2004). “Caring for the Whole Person: Integrated Health Care for Older Adults with Severe Mental Illness and Medical Co-morbidity,” *JAGS*, 52, 12: S249-S257. Price, B., MD, Adams, R., MD, & Coyle, J., MD (Jan 2000). “Neurology and Psychiatry Closing the Great Divide,” *Neurology*, 54: 8-14. Martin, J., MD, Ph.D. (May 2002). “The Integration of Neurology, Psychiatry, and Neuroscience in the 21st Century,” *American Journal of Psychiatry*, 159: 695-704. Horvitz-Lennon, M., Kilbourne, A., & Pincus, H. (May/Jun 2006). “From Silos to Bridges: Meeting the General Health Care Need of Adults with Severe Mental Illnesses,” *Health Affairs*, 25, 3:659-669

⁷ Health Resource Allocation Plan for the State of Vermont, August 2, 2005, Section Three, Chapter 1: Hospital-Based Mental Health & Substance Abuse Services, p.44; Section Four, Certificate of Need Standards, p.332.

⁸ HRAP pp. xxxi – xxxiv.

⁹ HRAP Recommendations, Mental Health / Substance Abuse Services, Recommendation 1, p xii.

Parity of access for treating co-occurring conditions of psychiatric patients requires access times to diagnostic procedures and specialty care comparable to those provided inpatients hospitalized for other medical conditions. Similarly, hospitalized psychiatric patients should have parity of access to rapid medical response in the event of emergencies. Co-location of psychiatric and other medical inpatient care permits the desired rapidity of access. It also minimizes the difficulties of transport of patients between hospitals and improves the quality of emergency response.

Clinical Integration Improves Quality of Care

Co-location in an academic medical center enhances interaction among clinical professionals and promotes a culture that focuses on service improvement. For example, Dr. Alan Rubin evaluated his protocol for Internist involvement in the care of psychiatric inpatients at Fletcher Allen Health Care. His published results showed that twelve of seventeen processes of care improved significantly under the protocol, without increasing overall cost or patient length of stay.¹⁰

The research focus as well as the accreditation requirements of academic medical centers promote and sustain the quality of patient care.

Co-location of Psychiatric Services in a Tertiary Care Hospital is Organizationally Cost Efficient

All hospitals, regardless of size, have ongoing operating costs. Among these costs are infrastructure (IT systems, medical records, business and administrative functions), operations (other clinical services, lab, pharmacy, food service, laundry, security, engineering, and purchase of materials and supplies), and core systems (quality improvement/quality assurance, staff recruitment, human resources, and education and training). Efficiencies and economies of scale can be derived from partnering with a large host hospital that are difficult to obtain in a small, independent hospital.

Co-location of Psychiatric Services within a Hospital Setting Will Enhance Funding

Co-locating services in a sizeable inpatient facility (one that is not an Institution for Mental Diseases) permits federal fiscal participation for psychiatric inpatient operating costs. It is estimated that Medicaid could thus reimburse a significant portion of the costs of providing new inpatient services as described in the Futures Plan.

10 Rubin, .A. (April 2005). "Effects on Processes and Costs of Care associated with the Addition of an Internist to an Inpatient Psychiatry Team," *Psychiatric Services* 56:463-467 Available online: <http://www.psychservices.psychiatryonline.org/cgi/content/full/56/4/463>