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Evaluation of a Model of Integrated Care for Patients With Chronic Medical and Psychiatric Illness

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Background: *Chronic illnesses are prevalent in general medical and psychiatric practices, causing significant disease burden to care givers and providers. Systems of care that treat individuals with mental illness are often separate from general medical systems of care.* **Objective:** *This study sought to compare the quality of life, satisfaction with care, and utilization of care in patients with comorbid chronic medical and mental illnesses.* **Methods:** *A total of 64 participants from an integrated medicine and psychiatry clinic (medl psych), were compared with 52 patients from separate internal medicine and psychiatry clinics (within the same institution) for quality of life, satisfaction with care, and utilization of care.* **Result:** *Patients receiving integrated care reported being more satisfied with care compared with patients treated separately. There were no differences in quality of life between the groups. A nonsignificant trend toward fewer emergency room visits and fewer hospital stays for the integrated care group compared with the separate care group was observed.* **Conclusion:** *This study demonstrated that integrated care for psychiatric and medical disorders improved the patients' experience of care and therefore may have positively affected the outcome of care. Further work is needed to compare medical and psychiatric comorbidities and costs of care and quality measures in these 2 groups.*

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INTRODUCTION

Chronic illnesses have become prevalent in both general medical and psychiatric practices and constitute a major source of worldwide disease burden and mortality. Even more concerning is the well-established fact that a great number of these patients have both medical and psychiatric diagnoses that requires dual treatment.[1] Extensive investigations more than over the last 3 decades clearly demonstrate that mental disorders are present in approximately 25–30% of primary care patients and about 50–70% of psychiatric patients having significant medical illnesses.[1,2] These populations of patients are largely under-diagnosed and under-treated.[3] Kamara et al.,[4]

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found a mean of 8 medical disorders among 179 state psychiatric hospital inpatients who died of natural causes in a retrospective study. Despite these facts, systems of care that treat individuals with serious mental illness are often separate from general medical systems of care.

The integration of behavioral health and primary care has become increasingly important, with a new emphasis on providing care that meets the spirit of the "Triple Aim": improving the experience of care, improving the health of populations, and reducing per capita costs of health care.[1,5] The objective of this study was to evaluate a model of integrated care provided by dually-trained internist/psychiatrists. The dually-trained internist/psychiatrists refer to graduates of combined internal medicine-psychiatry residency program or both internal medicine and psychiatry following a sequential training and are boarded in both disciplines.[1] We compared the quality of life, satisfaction with care and utilization of care in patients with medical and psychiatric comorbidities, who were treated by dually-trained internist/psychiatrists at the same location with those who receive care from separate internists and psychiatrists at different locations. To improve their efficiency, physicians in the separate clinic shared electronic health record and maintained good communication through phone calls and electronic health record communications.

METHODS

The study was conducted in academic outpatient clinics for Psychiatry and Internal medicine. The integrated med/psych and internal medicine clinics were located in the same building but in separate clinic space, whereas the psychiatric clinic was located at another site. It was comprised of 64 participants from an integrated medicine and psychiatry clinic (med/psych participants from an integrated medicine and psychiatry clinic [med/psych] and 52 patients from separate internal medicine and psychiatry clinics. The study was approved by the Institutional Review Board of the medical school before data collection.

Overall, 2 dually-trained internist/psychiatrists, 2 psychiatrists, and 4 med/psych residents staff the med/psych clinic. Patients in the combined group received both medical and psychiatric care from the same dually-trained internist/psychiatrist, sometimes with med/psych residents. Patients in the separate group may have been separately treated at the internal medicine and psychiatry clinics, or they may have received either medical or psychiatric care in the med/psych clinic from dually-trained internists/psychiatrists, but also received either medical or psychiatric care at the other clinic. One of the dually-trained internist/psychiatrists provides most of the primary care for patients in the school's Assertive Community Treatment program and receives psychiatric care there. Some of these patients participated in the study in the separate group. Similarly, given the shortage of psychiatrists, many patients seen by dually-trained internist/psychiatrists are psychiatry consults from internists; these patients are also in the separate group. Thus, the study tested the effect of being cared for in one clinic, with the ability to address both issues at the same visit, not the effect of being cared for by a dually-trained internist/psychiatrist vs separately-trained providers.

To qualify for the study, participants had to be 18 years of age or more, have comorbid chronic medical and psychiatric illness, have been a patient of the clinics for a least 1 year and be willing to complete the study survey during a clinic visit. In addition, the participants were required to be experiencing chronic medical and psychiatric medical illnesses, such as diabetes, cancer, respiratory diseases and heart diseases, schizophrenia, schizoaffective disorders, major depressive disorder, and bipolar disorder, among others. This study was survey-based, with the nature of the study explained to the participants in a short introductory paragraph attached to the survey. Patients were enlisted by review of medical records for upcoming patient appointments. The study materials were given to the participants at the waiting room of the clinic to complete while waiting to be seen.

The survey had 2 parts; a brief questionnaire of demographic information, including number of prescription medications, number of emergency room visits in last year, number of hospitalizations in the last year, SF12 Quality of Life Questionnaire,[2] and Satisfaction with Health Care Questionnaire. A Likert scale was used to measure the level of satisfaction as it is very efficient in measuring qualitative data.[6] The researchers used a scale of 1–5, where 1 represented very dissatisfied and 5 very satisfied. The medical and psychiatric diagnoses were recorded from the electronic health record problems list. Data were analyzed using *t*-test, Fischer exact test, and chi square test for