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Perspective

Co-managed Care for Medical Inpatients, C-L vs C/L Psychiatry

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Objective: *We report on a quality improvement program to co-manage patients with co-morbid medical and psychiatric disorders in the general hospital. A philanthropic donation allowed a high volume, high-acuity urban hospital to hire a co-managing inpatient psychiatrist. The expectation was that facilitating psychiatric evaluation/treatment of medical patients would result in fewer patients staying beyond the expected length of stay (LOS).* **Method:** *The psychiatrist became a member of a general medical team working with a group of internists and actively co-managing medical patients. After one year, we compared time-to-consultation request and LOS for patients seen through the traditional Consultation-Liaison model and patients seen through the co-managed care model. A second co-managing psychiatrist was hired. A new QI project investigated reduction in lost days.* **Results:** *There was a decrease in LOS for patients seen in the co-managed care model when compared with those seen via the traditional Consultation-Liaison model. Co-managed patients were seen earlier in the hospitalization. Excluding very-long-stay outliers, there was a reduction in LOS of 1.19 days ($p < 0.003$). There was an estimated annualized saving to the hospital of 2889 patient days.* **Conclusions:** *A program of co-managed care reduced both LOS and lost days to the hospital. This resulted in an increase in hospital support to hire 2.5 full-time equivalent psychiatrists and 1.0 full-time equivalent social worker for the Consultation-Liaison service. Such programs may permit the return of modernized psychiatric liaison programs to medical and surgical services.*

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MEDICAL/PSYCHIATRIC PATIENTS, LENGTH OF STAY, AND PSYCHOSOMATIC MEDICINE

The formation of general hospital psychiatric units was a turning point for the practitioner of what is now referred to as "Psychosomatic Medicine" and was previously called Consultation-Liaison (C-L) Psychiatry.[1] Psychiatrists moved from the isolation of psychiatric institutions to work along with other physicians in the clinical and social sphere of the general hospital. The presence of psychiatrists in the general hospital permitted psychiatric consultation that became essential for well-run medical services. The term liaison psychiatry was coined to

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describe another way psychiatrists could function in the hospital. As the field evolved, consultation and liaison came to take on different meanings. Consultation increasingly referred to a response to a request from a patient's primary physician to evaluate and make recommendations about psychiatric or behavioral issues affecting the patient's management and entailed the psychiatrist's face-to-face meeting with the patient. The psychiatric consultant was not a part of the team caring for the patient until his or her assistance was requested. In contrast, psychiatric liaison increasingly came to mean joining a care team in an ongoing fashion, with less emphasis on the psychiatrist's face-to-face encounter with the patient and more emphasis on education and on group process within the medical or surgical team.

A long-standing problem for C-L psychiatry has been its financial viability. Research indicated that fee-for-service reimbursement for C-L Psychiatry services is not adequate to fully fund faculty salaries.[2] In Lipsitt's review of the history of Psychosomatic Medicine, he highlights the problem of funding the psychiatric consultant: "Psychiatry paid little attention to the necessary economics of maintaining its own viability."[3] Academic C-L services have produced some research demonstrating decreased length of stay (LOS) associated with psychiatric consultation.[4,5] One of the first C-L services was the psychiatric service started by Billings at the Colorado Hospital in the 1930s. It was a "psychiatric liaison department" and had no separate psychiatric beds. The psychiatrists provided consultation, teaching, and research to all of the hospital wards. *Liaison psychiatry* was a term first used by Billings.[6] He wrote that this integration would, among other things, shorten LOS and save money.

A detailed review of studies investigating the correlation between mental illness and increased LOS found that impaired cognition associated with delirium, dementia, and depressed mood, as well as personality variables, contributed to prolonged LOS.[7] There is a high prevalence of psychiatric illness among hospitalized patients.[8] Agency for Health Care Research and Quality data indicate that 24% of patients admitted from the emergency department to general hospitals have co-morbid psychiatric conditions.[9] Bourgeois et al.[10] reviewed over 31,000 medical/surgical admissions to the UC Davis Hospital from 1999–2001 and found that 33%–35% had psychiatric disorders. Substance abuse, mood, and cognitive disorders were the most frequently encountered, and adjustment disorders were associated with the longest LOS. Desan et al.[11] demonstrated decreased LOS with a model of "Proactive Psychiatric Consultation," in which patients admitted to a specific medical service were "reviewed" by a psychiatrist who helped identify psychiatric co-morbidities and either provided a formal consultation or advised the primary team on management. There have been several attempts to address the issue of "cost offset," in which the focus of study was the cost savings for the hospital by the intervention of a psychiatrist. Problems associated with cost-offset studies have been described by Pincus.[12] Borus et al.[13] described their experience of 5 years with the C-L Psychiatry Cost Offset Study Group, enumerating the obstacles they encountered in trying to demonstrate cost offsets in so complex a field as C-L psychiatry within the even more complicated world of the general hospital. They concluded that new outcomes research should be based on markers of quality of care rather than cost offsets, including readmission rates, emotional dysfunction, adherence, and disability. They questioned why C-L psychiatrists should need to prove their benefit to medical patients at all, as it is obvious that psychiatric co-morbidities are worthy of treatment. They suggested turning away from the concept of cost offset to that of value added by psychiatrists for medical inpatients. Alter et al.[14] described 4 possible benefits of C-L psychiatry to hospitals as follows: decreased LOS, reduction of liability, establishment of new treatment programs, and improved patient satisfaction. Our experience with the inpatient collaborative care program has allowed us to enumerate the following 2 additional benefits: identification of patients in need of care and education of medical staff.

The extensive review by Huffman et al.[15] provides data on outpatient programs but little data on inpatient collaborative care programs. Although the effect of collaborative care has been beneficial to patient wellness, and to some extent costs, the data are almost exclusively in the outpatient setting or for targeted populations or both. There is a paucity of data on co-managed psychiatric/medical patients in the general hospital setting.

THE ROLE OF THE INPATIENT CO-MANAGING PSYCHIATRIST

Several factors have been posited to weaken the patient-physician relationship during hospitalization, e.g., health care delivery, including the emphasis on