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Hospitals Test Putting Psychiatrists on Medical Wards

To identify problems early, trials embed mental-health workers on teams of doctors seeing patients

David Gitlin, chief of medical psychiatry service at Brigham and Women's Hospital, standing with Melissa Bui, a psychiatrist who is embedded in the hospital's medical intensive care unit. Dr. Bui is doing a clinical trial to test whether having a psychiatrist in the ICU helps patients recover more rapidly. *PHOTO: MAINFRAME PHOTOGRAPHICS INC.*

By **LUCETTE LAGNADO**

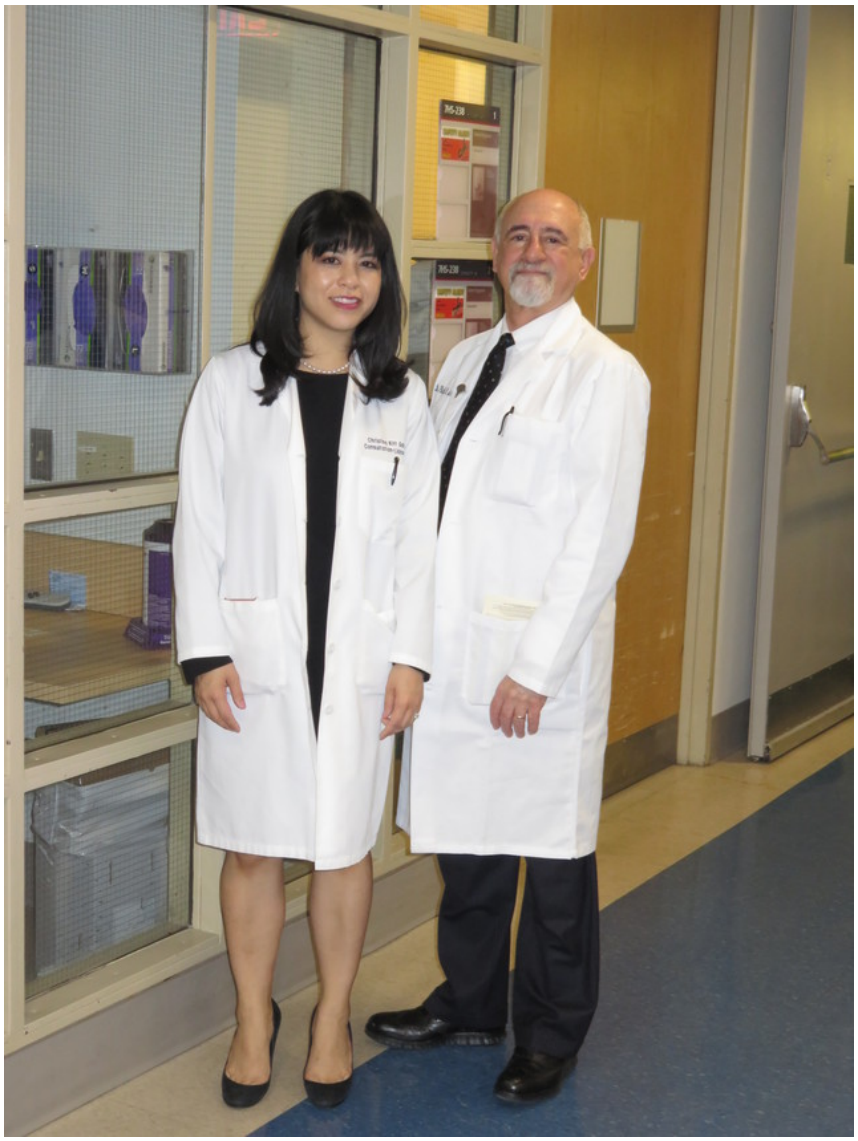
April 25, 2016 1:19 p.m. ET

Some leading hospitals have begun placing psychiatrists and other mental-health professionals into medical units to identify psychological problems early in a patient's stay.

Mental-health professionals working on the front lines with medical doctors improve care and help reduce the time patients need to stay in the hospital, studies suggest. Some practitioners also say the approach might cut the likelihood patients will need to be readmitted.

Hospitals traditionally call upon psychiatrists as consultants when needed—often during a crisis, such as when a patient becomes unmanageable.

Johns Hopkins Hospital in Baltimore in April launched a program to screen patients for psychological problems shortly after they are admitted. About 20% of the nearly 50,000 patients the hospital discharges a year have mental-health disorders in addition to their physical ailments, the hospital says.



Christina Garza, a psychiatrist who is embedded in one of the medical wards at NewYork-Presbyterian/Columbia uptown, with Philip R. Muskin, a professor of psychiatry at NewYork-Presbyterian/Columbia. Dr. Muskin was the lead author of a recent study on a group of patients that found that only 34% of patients assessed by a psychiatrist stayed in the hospital for more than five days compared to another group a year earlier that didn't have the benefit of a psychiatrist. *PHOTO: PHILIP MUSKIN, M.D.*

At NewYork-Presbyterian/Columbia University Medical Center, in New York City, psychiatrists join the morning rounds with interns and residents to stop by patients' bedsides in some medical units. And Brigham and Women's Hospital in Boston last fall

assigned a psychiatrist to a medical intensive-care unit.

“It is a different environment than most psychiatrists are used to,” says psychiatrist Melissa Bui, who works half-time in the Brigham and Women’s ICU.

Most patients in the unit are sedated and hooked up to ventilators. They are prone to “delirium,” a state of extreme confusion, paranoia and hallucinations that can impede recovery. “When the body breaks down, the mind is also affected,” Dr. Bui says.

By diagnosing delirium early and tinkering with the medications, Dr. Bui says a psychiatrist can help stabilize patients and make it easier for ICU doctors to get them breathing on their own again. She is currently leading a clinical trial to test whether embedding psychiatrists in the ICU can help shorten a patient’s length of stay in the unit.

“We believe that we are changing the curve, and that people are getting better faster,” says David Gitlin, Brigham’s chief of medical psychiatry service.

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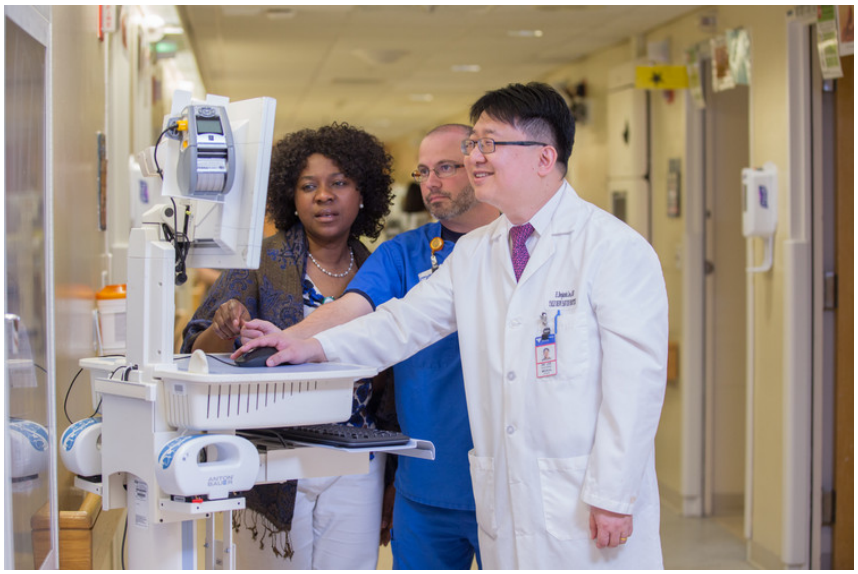
Doctors say emotional disorders can significantly affect the course of a patient’s physical condition. Someone with depression, for instance, may neglect themselves and not take medicines intended for their physical maladies. Outpatient clinics run by hospitals have increasingly integrated mental-health specialists into their practices. But the approach is still being tested for hospitalized patients.

Proponents say the model can help pay for itself. “Reduced length of stay allows the hospital to admit more patients,” which, in turn, generates more revenue to pay for hiring additional mental-health professionals, says Hochang Lee, chief of psychological medicine at Yale-New Haven Hospital, who has studied the economics of introducing

psychiatric care into medical wards.

Dr. Lee says length of stay was reduced by “a little more than half a day” on average when the hospital used a mental-health team to deal proactively with behavioral issues in patients. This means that if a patient can be discharged a few hours earlier in the morning, the bed can be prepared and a new patient admitted that afternoon, others say.



Hochang Lee, chief of psychological medicine at Yale-New Haven Hospital who has studied the economics of introducing psychiatric care into medical wards, with two colleagues. *PHOTO: YALE NEW HAVEN HEALTH SYSTEM*

A recent study posted online in the journal Psychosomatics examined the program at NewYork-Presbyterian/Columbia for one year and found that 34% of 324 patients assessed stayed in the hospital for more than five days. By comparison, 59% of a control group of similar kinds of patients stayed longer than five days a year earlier, before the mental-health program was put in place.

“We have proven to ourselves that this is worth an investment,” says Philip R. Muskin, the study’s lead author and a professor of psychiatry at NewYork-Presbyterian/Columbia.

Still, it is difficult to prove hospitals save money by adding psychiatrists, says James Levenson, a professor of psychiatry at Virginia Commonwealth University, in Richmond, Va. What’s more, he says, “serious mental disorders don’t get better” after one or two psychiatric visits in the hospital. “What we should be showing is that we are improving mental-health outcomes,” he says.

Christina Garza, a psychiatrist at NewYork Presbyterian/Columbia, each morning puts on a white coat and goes on rounds with a team of residents, interns, medical students

and a senior physician. They encounter patients suffering with a range of ailments, from gastrointestinal bleeding to pneumonia.

"I do bedside psychotherapy," says Dr. Garza, who aims to identify and treat patients in emotional distress. If she notices a psychiatric issue, she might recommend medication or seek to meet with the patient separately, she says.

> *'It is tough to have surgery. You want to chat about it. A lot of psychiatry is chatty.'*
>
> —Philip R. Muskin, NewYork-Presbyterian/Columbia

Dr. Garza says she tries to avoid being "shrink-y." Hospitalized patients already have it rough, and she tries to be reassuring and friendly. "They are not in their comfort zone. Therapy may feel strange and alien, and sometimes, they want a normal human interaction," she says.

Too often, medical doctors don't see beyond the physical ailments they are treating, says Dr. Muskin. "It is tough to have cancer. It is tough to have surgery. You want to chat about it. A lot of psychiatry is chatty," he says.

Yale-New Haven Hospital developed what it calls a behavioral intervention team, or BIT, comprising a social worker, nurse practitioner or other mental-health professional, and led by a psychiatrist. Dr. Lee says the model is a cost-effective system to screen and treat medical patients with psychiatric disorders.

"Sometimes behavior becomes a barrier—psychotic patients refusing blood draws, depressed patients not going through rehabilitation. These are the obvious barriers that need assistance," Dr. Lee says.

Johns Hopkins Hospital adopted the BIT model in launching its program this month. The team is currently circulating among just 90 beds, but expects to expand in coming months.

It is "clearly unaffordable" to have every patient with a mental-health condition seen by a psychiatrist, says Constantine Lyketsos, chairman of psychiatry at Johns Hopkins Bayview Medical Center, a sister facility where BIT has been in place for more than two

The team at Johns Hopkins Hospital. From left to right, Patrick Triplett, the psychiatrist overseeing the new program, Sunny Mendelson, the social worker on the team, Maureen Lewis, the nurse practitioner working with them, and Constantine Lyketsos, chairman of psychiatry at Johns Hopkins Bayview Medical Center and an advocate of the team approach. *PHOTO: JOHNS HOPKINS HOSPITAL*

years. Other mental-health professionals can do a great job in this realm, he says.

Social worker Katie O'Neil, a member of the BIT team at Bayview, works closely with medical doctors. She tries to offer a human touch. She cites the case of a skittish female patient with intractable nausea who kept getting readmitted to the hospital—and then checking herself out each time doctors wanted to do certain tests.

When Ms. O'Neil met with the patient and a physician, she realized what was wrong. The doctor wanted to perform a test that required the patient to eat cooked eggs containing radioactive material. The woman appeared "spooked. She looked at him like he had two heads," says Ms. O'Neil, who was able later to reassure the patient about the test.

"Doctors are so harried," says Ms. O'Neil. "It is bing, bam, boom, let us get it done. But with lots of people that is an impossibility."

Write to Lucette Lagnado at lucette.lagnado@wsj.com

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