Coordinated Medical and Psychiatric Care in Schizophrenia

Viron et al,\(^1\) in this issue of the *Journal*, review for the primary care provider how to recognize and manage patients with schizophrenia. Coordinated care offers the best hope to address the 2-decade-shorter life expectancy of this population attributed, importantly, to cardiovascular disease. Other major comorbidities include prediabetes and diabetes mellitus, leaving such patients at high risk for the metabolic syndrome with or without antipsychotic drug treatment.\(^2\) When antipsychotic drugs are prescribed, the risk of sudden cardiac death increases 2-fold.\(^3\) There are 3 core challenges in managing medical comorbidity: the patient, the provider, and the system.

**THE PATIENT AND THE PROVIDER**

Impaired cognition, emotion, and insight make it especially difficult for psychotic patients to make lifestyle changes,\(^4\) leaving a substantive burden for providers and family to help reduce risk factors for cardiovascular disease and the metabolic syndrome. Antipsychotic drugs may improve the positive features of psychosis (hallucinations, delusions, thought disorder, and bizarre behavior) but leave cognition unchanged and likely impaired. Training both primary care providers and psychiatrists to deal with the medical comorbidities of psychiatric disorders is currently inadequate. Many primary care providers feel ill equipped to effectively communicate with the paranoid or apathetic patient about such things as importance of healthy lifestyle, cardiometabolic risks of antipsychotic drugs, reduced lifespan, and specific cardiometabolic measures.

**THE SYSTEM**

The system of care for this population remains fragmented and poorly reimbursed. The psychiatrist in most community mental health centers simply provide medication management in 10- to 15-minute sessions quarterly and struggles with large caseloads to provide even minimum psychiatric care, let alone integrated care for comorbid conditions. Mid-level providers and nurses (except to give injections) are not part of the system, and preventive care is nonexistent. Apathy and poor insight contribute to noncompliance. There are no substantive community interventions for comorbid conditions in either system, and interspecialty communication is minimal. Third-party payers encourage split rather than integrated care through poor reimbursement policies for the simultaneous care of physical and mental conditions.

**LOOKING AHEAD**

The Synthesis Project Report from the Robert Wood Johnson Foundation\(^5\) details the scope and complexity of the comorbidity problem and available models of care: concluding that a model of a single care manager offers a cost-efficient and practical approach. The medical home model\(^6\) offers another holistic concept in coordinated care particularly useful for patients with schizophrenia. This model would involve physician-directed medical practice in which care is coordinated across specialists (including psychiatrists), hospitals, home health agencies, and nursing homes.

Viron et al\(^1\) provide a thoughtful approach for the primary care providers treating the patient with schizophrenia in the medical home model. Within psychiatry, there is currently a debate as to whether the psychiatrist will be an integral team member (favored by us) or a consulting specialist. Different models must be tested—the cost and suffering of doing nothing are unacceptable.

W. Victor R. Vieweg, MD\(^{a,b}\)
Mehrul Hasnain, MD\(^c\)
Ananda K. Pandurangi, MD\(^d\)
\(^a\)Department of Psychiatry
\(^b\)Department of Internal Medicine
Virginia Commonwealth University
Richmond
\(^c\)Department of Psychiatry
Memorial University of Newfoundland
Waterford Hospital
St John’s, NL, Canada

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References


