

INTEGRATED HEALTH CARE DELIVERY: PAST, PRESENT AND FUTURE

SECTION VII. INTEGRATED HEALTH CARE DELIVERY: PAST, PRESENT AND FUTURE. *ASSESSMENT OF LOCAL MODELS OF INTEGRATING PHYSICAL AND MENTAL HEALTH CONCERNS*

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A. OVERVIEW

This session provided a historical perspective of the philosophy and practice of an integrated approach for the evaluation and management of disease during the golden era of Arabic civilization. Samir Yahia, MD, a rheumatologist by specialty and a student of the history of Arab medicine, highlighted the numerous contributions in medicine from a large number of physicians and scientists across several centuries and vast geographic terrain of the Arabic/Islamic empire. Yahia emphasized the need for the integration of various fields of knowledge in the education and training of future physicians in order to prepare them to adopt a comprehensive approach with consideration for the mental and social background of each patient.

Bringing the concept into contemporary frame, Michael Massanari, MD offered a general assessment for the ability of the medical delivery practice in the United States to account for relevant mental, behavioral and logistical considerations when doctors attempt to manage patients. His report illustrates real life examples of the failure of the current medical practice system to comprehensively address patients' needs. The environment of "reductionism" that focuses on studying, specializing and practicing within increasingly narrowing areas of sub-specialties, results in fragmented care, competition for resources and worse, passing the responsibility of ensuring the delivery of coordinated care

from the medical/health system where it belongs, to the patients and their families who are not equipped to fulfill this task.

Three presentations of this session outlined the approach adopted by two hospital-based systems, (Henry Ford and Oakwood) and one community-based system (ACCESS), for integrating the mental health component, depression in particular, into the assessment and management of patients seen within these facilities and their outpatients satellite and affiliated physicians offices in the Detroit, Michigan area. The first speaker, Edward Coffey, MD, concentrated on the effects of depression on cardiovascular and central nervous system morbidity by presenting mounting data confirming the negative impact, particularly of long-standing untreated depression, on these systems. He also outlined a Ford Health system plan that was implemented to facilitate screening for depression in the primary care setting. The essence of the plan is to identify an effective way for the clinician to diagnose depression for treatment to begin in a timely fashion.

Issam Khraizat, MD, from the Oakwood Health Care System, addressed the issue of depression and women's health. Women have a 25% lifetime risk of developing depression with a high likelihood of recurrence once diagnosed. In addition, pregnancy, delivery, post-delivery period and peri-menopause are events that can often trigger depression in some women. Khraizat also highlighted programs at the Oakwood Health Care Systems designed to in-

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INTEGRATED HEALTH CARE DELIVERY - *Sakr and Massanari*

corporate screening for depression at both the general practice and specialized levels. For Arab Americans, in particular, Khraizat acknowledged the bilingual capabilities of the healthcare professional, social workers and supportive services

within the system to address the needs of this population.

Finally, the presentation by Ibrahim Kira, PhD from ACCESS emphasized the importance of integrating research programs within a community network

with physical and mental health care. His data demonstrated the paradigm shift that resulted from the advances in this area including primarily data from ACCESS but also with reference to national research.