Family Physician – Based Care of Patients with Serious Mental Illness Using a case-managed approach

Abstract

Access to mental health care, particularly for individuals with more severe mental illness, is often problematic both in Ontario and generally in Canada. Psychiatrists prefer to provide consultative care rather than ongoing care, necessitating patients to receive their care from their primary care provider (PCP). While a variety of programs exist, they are not integrated or coordinated with PCPs. Patient care may suffer as a result. To deal with this problem of access and ongoing care for patients with more severe mental illness, our team integrated this program into the FHT. This model of care facilitated the management of the patient's complex psychiatric, medical and social needs, whilst providing access to established programs and health care providers within the FHT. The case manager additionally coordinates care with outside agencies and consulting psychiatrists as needed. PCPs and a part-time psychiatrist are consulted and available for advice as needed. The case manager maintains a patient population of approximately 175 patients.

Objectives

To offer accessible care for the patient population with more severe mental illness by utilizing a collaborative case management model of care to ensure a holistic approach to meeting their psychiatric, medical and social needs

Integration of our program through the FHT with cross referrals to established programs and health care providers.

The collaboration of primary care providers and part-time consulting psychiatrist with the Nurse Practitioner Case Manager to ensure patient care does not suffer.

Coordination of care with outside agencies and consulting psychiatrists.

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Family Practice-Based, Case Managed Care

•Family practice based care for the more common and less serious and disabling mental health problems is now a common feature of group practices.

•The effectiveness of this approach has been well studied (2-4) and is described as a collaborative model.

•The advantages for patients, if successfully implemented, are improving accessibility, providing a location that is non-institutional and comfortable, allowing for a more comprehensive and integrated approach.

•This model improves collaboration between psychiatrists and primary care providers, and integration of mental health and primary care can also lead to better and more efficient deployment of resources.

•The Canadian Mental Health Association published a paper highlighting that severe mental illness could be managed in a chronic disease management framework using a comprehensive holistic approach (What is the fit between mental illness and Ontario's approach to chronic disease management and prevention) (5).

•Patients are referred to our full time case manager (Nurse Practitioner) by their family physician, based on the serious nature and disabling degree of their mental illness. All the patients will have been diagnosed previously.

•Approximately 80% of our patients are disabled from work and most are supported financially by some form of disability pension. Ages range from 18-80 and the average age is 45.

•The case manager works with our FHT psychiatrist, community psychiatrists, involved community agencies, family physicians, nurse practitioners and psychotherapists in our FHT.

•The expanded role of the Family Nurse Practitioner is ideally suited to the collaborative management of these complex patients, as they are able to manage patients independently, reassessing and modifying treatment regimens and consulting with appropriate providers as needed. Managing the patients' physical issues, social issues (e.g. housing), mental health care, facilitating linkages with community agencies, and advocating for access to provincial and federal programs.

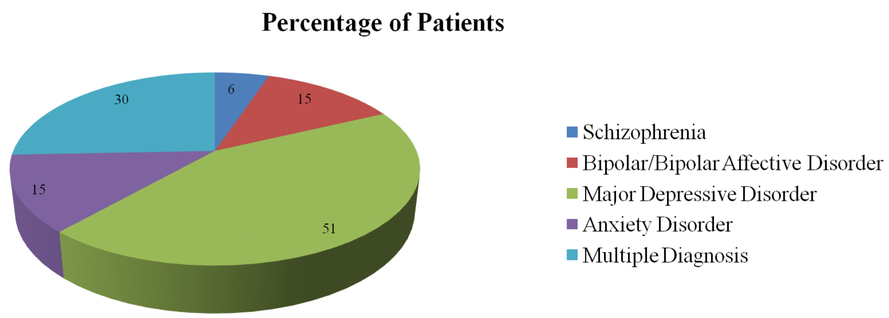
•This program has been in place now for more than 10 years and manages at least 175 patients at any given time. Patients that have shown a marked improvement may be referred back to their family physicians for care, so that new patients may be referred into the program.

•Patients that are very ill and unstable will usually be stabilized through referral to institutional psychiatrists or teams before admission into the program. Where behavioral approaches (e.g. cognitive behaviour therapy) might be helpful, patients may be referred to our psychotherapists, and if treatment or diagnosis complications occur, we would refer either to our visiting psychiatrist internally or if appropriate, to an outside psychiatrist. If health issues occur best managed by a medical specialist, the case manager may refer to a specialist outside the practice (e.g. internist, surgeon, diabetic specialist etc). Home assessments are common, as some patients are house-bound or require investigation of the home environment.

•The patient's family physician is kept informed through our EMR system, or by corridor consultations.

•One physician is designated as responsible to liaise with the case manager and staff.

•The acceptance of this program by our patients and FHT team staff were viewed as quite favourable, after completion of patient satisfaction surveys and informal discussion with staff.



Results

It is our contention that this approach is very effective in providing excellent mental health and holistic care for our patients with a serious mental health illness. This is endorsed by those patients treated within the program, as they have been provided continuity of care within the FHT and become more confidant as active participants in co-managing their chronic illness. In the initial phase of the program and while still a pilot project, we found that fewer patients within the program needed emergency department care, or were admitted to the local department of psychiatry in the first year of the program, as compared to the year prior to the program. In addition, this arrangement of care does allow for the better implementation of recommendations from institutional psychiatrists and coordination with the FHT family physicians. This is critically required, since the care for the seriously mentally is becoming, unfortunately, more fragmented than ever before.

The co-location of staff and mental health programs under one roof is very powerful and efficient, but other arrangements utilizing a primary care, case managed model are possible, and even a system where the case manager travels to the family physician office to see patients is conceivable. Now, more than ever, it is important for individuals with mental illness to have patient-based care that is comprehensive and accessible.

Conclusion

Since the inception of the program there has been an identified increase in the ability of the patients to co-manage their care with the nurse practitioner case manager. Also within the first year of the program there was an identified decrease in emergency department visits with the participating patient population. A randomized population of 89 participating patients identified attending 59 ED visits, after 1 year of participation 14 ED visits were identified within this same population.

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