REVERSED SHARED CARE IN MENTAL HEALTH:
BRINGING PRIMARY PHYSICAL HEALTH CARE TO PSYCHIATRIC PATIENTS

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Disclosure

- We have no conflict of interest to disclose.

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Agenda

- Introduction to Collaborative & Shared Care
- Comorbidity between mental and physical health
- Lack of access to physical health care
- Reversed Shared Care: An Innovative Approach at North York General Hospital in Toronto, Ontario, Canada

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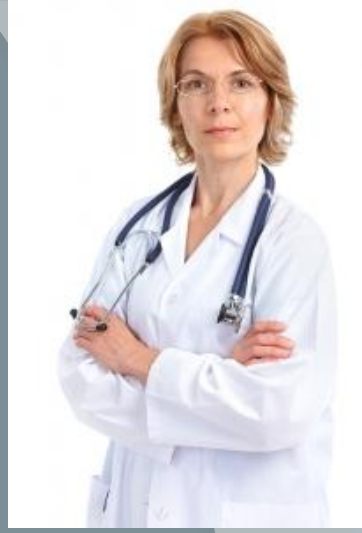
Shared Care



- Shared Care originally defined as:
  - “A process of collaboration between the family physician and the psychiatrist that enables the responsibilities of care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental illness and the respective skills of the family physician and psychiatrist” (Kates, et al., 1997)

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Collaborative & Shared Care

- Within Canada the movement towards Shared Care began in 1996 (Craven, & Bland, 2002; Kates, et al., 1997)
- Included the development of a number of initiatives:
  - Collaborative Working Group between the College of Family Physicians and the Canadian Psychiatric Association (Craven, & Kates, 2000)
  - Canadian Collaborative Mental Health Initiative (CCMHI, 2006)
- The term Shared Care evolved to Collaborative Mental Health Care to include all members of the health care team including the person with mental illness and their families

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- “Over the last 10 years [since the movement began in 1996], shared or collaborative mental health care has moved from being a “fringe” area of practice for a handful of providers across the country to one that is increasingly seen by provinces and health authorities as an integral part of their mental health care delivery systems”
  - Kates, Gagne, & Whyte, 2008

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Improvements to Shared/Collaborative Care

- Vital component of Shared and Collaborative Care:

  Improving equitable access to physical health care for those with mental illnesses

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Comorbidity Between Mental and Physical Health

It is vital those with mental health received adequate care for their physical health needs

- Mental health patients seen in psychiatric care have significant health conditions
- Many mental health problems associated with high rates of physical health concerns (Nuti, et al., 2004; Roy-Byrne et al., 2008)

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Comorbidity Between Mental and Physical Health

- Mental health problems have been found to be associated with higher rates:
  - Neurodegenerative disorders (e.g., Nuti, et al., 2004)
  - Cardiovascular diseases (e.g., Brown, Inskip, & Barraclough, 2000)
  - Endocrine disorders (e.g., Anderson, Freedland, Clouse, & Lustman, 2001)
  - Other chronic health conditions (e.g., Roy-Byrne et al., 2008)
- Depression: A factor in the development and course of many health conditions:
  - cancer, cardiovascular disease, diabetes, epilepsy and stroke (Evans, & Charney, 2003)

Mental and Physical Health

- Some mental health medications associated with increased risks of health complications or exacerbation of medical problems (Pacher, & Kecskemeti, 2004; Witchel, Hancox, & Nutt, 2003).

- Mental health concerns associated with decreased adherence to medical treatments & poorer health outcomes (Meyer, Peteet, & Joseph, 2009; Prince et al., 2007).

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Social Context

- Social context of some people living with a mental illness (poverty, inadequate housing, violence, substance use) has impact upon physical health (Fisher, & Baum, 2010; Oraka, King, & Callahan, 2010)
- Difficult to engage in a healthy diet & lifestyle ➔ increased health concerns (Beydoun, & Wang, 2010; Cerin, & Leslie, 2008)

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Lack of Primary Physical Care

- People with mental illness:
  - High frequency users of the health care system, such as emergency departments (Druss, 2007)
  - Underutilize primary care services
    - Use less primary health care than patients without mental health issues (Chwastiak, et al., 2008)
    - Fewer than ½ with a severe mental disorder consult their primary care physician (Fleury, et al., 2010).
  - Report having substantively unmet medical needs and poor access to primary care (Levinson, et al., 2003)

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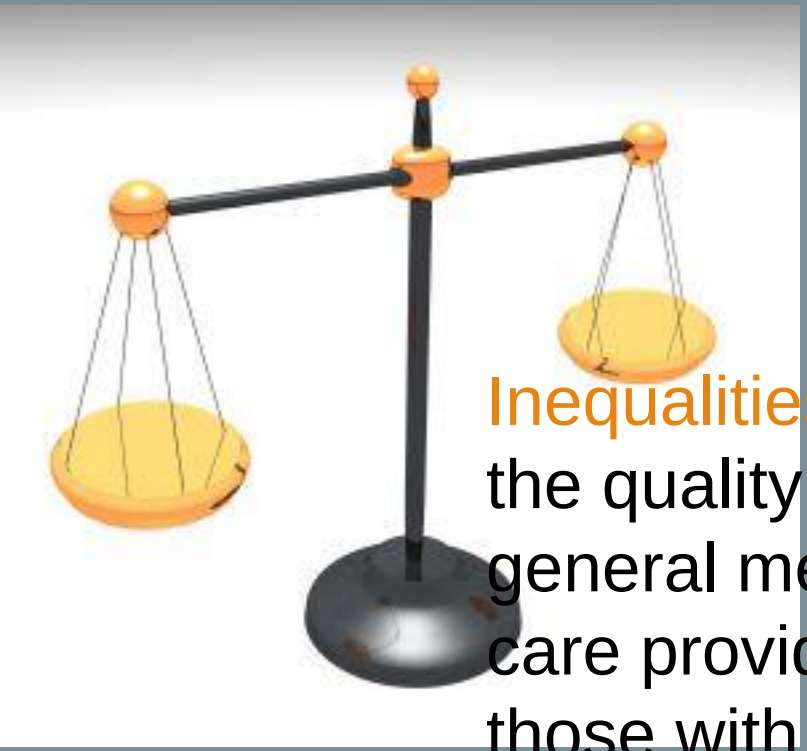

Inequalities exist in the quality of general medical care provided to those with mental illness

- Preventative & screening health services received by mental health patients are often of poorer quality than received by those without a presenting mental health issue
  - Lord, Malone, & Mitchell (2010)

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Increased Mortality

- This lack of access, inequality in care & high rates of comorbidity ➔ increased mortality
  (Cole, 2007; Felker, Yazel, & Short, 1996; Mitchell, & Lord, 2010)
- Deficits in the quality of cardiac care contributed to higher than expected mortality rates for individuals with schizophrenia (Systematic review: Mitchell & Lord, 2010)

Barriers to Primary Physical Care

- Potential barriers to physical health care include:
  - Socio-demographic factors (e.g., sex)
  - Personal barriers (e.g., attitudes of patients, more severe mental health symptoms)
  - Care provider issues (e.g., attitude of providers)
  - Systemic barriers (e.g., service fragmentation, availability of services)
    - (Byrne, 2008; Kim et al., 2007, Miller et al., 2003; Swartz et al., 2003)

Recommendations to Improve Access to Primary Physical Care

- One principle of the CCMHI Charter (2006): "All Canadian residents have the right to health services that promote a healthy mind, body and spirit"
- Therefore it is a necessity that those with mental health issues have adequate access to primary physical medical care within a continuum of care and co-location of services

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“Reversed Shared Care”

- Many mental health patients in the Mental Health Department of North York General Hospital (NYGH) did not have access to a primary care physician, despite having significant medical concerns

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- Community hospital in an urban area
- Large and active community based family medicine department
  - Over 365 affiliated family physicians/general practitioners
  - A community Family Health Team

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"Reversed Shared Care"

- Proposed to implement a form of Collaborative Care the author's of this paper have conceptualized as "Reversed Shared Care"

- Captures the less often thought of need for primary physical health care practitioners to provide service in psychiatric and mental health care practice settings

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NYGH's Reversed Shared Care Program

- Provides assessment and treatment for all patients of the NYGH Mental Health Department who do not have a Primary Care physician

- Provides co-location of both primary medical care and psychiatric care within one clinic

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Reversed Shared Care Pilot Program

- Staffed by a public insurance (OHIP) funded family physician and an Assertive Community Treatment (ACT) Nurse
- Available for appointments one morning a week
- A primary care office provided for use and co-located within the NYGH's Mental Health Community Day Treatment, Outpatient and Outreach Services

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Reversed Shared Care Pilot Project

- Conducted over a three-month period from January to March 2010

- Goals:
  1. Provide accessible primary physical medical care for one of our communities most underserved groups and improve the health of our patients
  2. To support the hospital's patient flow initiatives by diverting patients from presenting in the emergency department thereby also reducing wait times
  3. Provide teaching and learning opportunities for medical, nursing and other health professionals

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Reversed Shared Care Pilot Project

January – March 2010

Office Visits	50 office visits (25 first visits & 25 repeat visits) (6 no shows)		
N	25		
Gender	13 males and 12 females		
Age	Average age = 41.56 (SD=14.57)		
Diagnosis Used by Primary Care Physician Note: More than one diagnosis possible per patient	Attention Deficit Disorder Angular Cheilitis Anxiety Asthma (2) Bipolar Affective Disorder Chronic Pain Colitis Crohn's Disease Diabetes Duodenitis Eczema Epilepsy Fatty liver Gastritis	Gastroesophageal Reflux Disease (2) Gluten intolerance Headaches Hemorrhoids Hip Pain Hydrocele Hyperlipidemia Hypertension (2) Inguinal Hernia Insomnia Major Depressive Disorder (2) Neuralgia	Obesity (3) Obsessive Compulsive Disorder Patellar Femoral Vertigo Syndrome Pelvic Pain Peptic ulcer Rhinophyma Schizophrenia Sleep Apnea Substance Abuse/Dependence (4)

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- As patients used the Reversed Shared Care Pilot Project, (were assessed, treated and referred), this service was extended and in the subsequent 7 months (April - October 2010)

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Reversed Shared Care Program

April – October 2010

Office Visits	110 office visits (24 first visits & 84 repeat visits) (4 no shows)		
N	26		
Gender	11 males and 15 females		
Age	Average age = 36.08 (SD=13.24		
Diagnosis Used by Primary Care Physician Note: More than one diagnosis possible per patient	Acid Reflux Anxiety (3) Aspergers Syndrome Bipolar Disorder (4) Birth Control Bronchitis Cardiomyopathy Cholecystitis Chronic pain Colonic Polyps Constipation Depression (4) Diabetes Drug Induced Hepatitis Dysphonia Dysmenorrhea	Dysuria Ear, Nose and Throat Facial Cranial Neuralgia Facial Neurotic Dermatitis Fetal Alcohol Syndrome Fibromyalgia (2) Frontotemporal Dementia Hematoma Hepatitis C Hypertension (4) Irritable Bowel Syndrome Impulse Control Disorder Metabolic Syndrome (2)	Mixed Personality Nocturnal Palpitations Obesity (2) Polycystic Ovary Syndrome Post-concussion Headache Schizophrenia Septal Perforation Spastic Paraparesis Stress Substance Abuse/Dependence (5) Thalassemia Trigeminal Nerve Damage Xerosis

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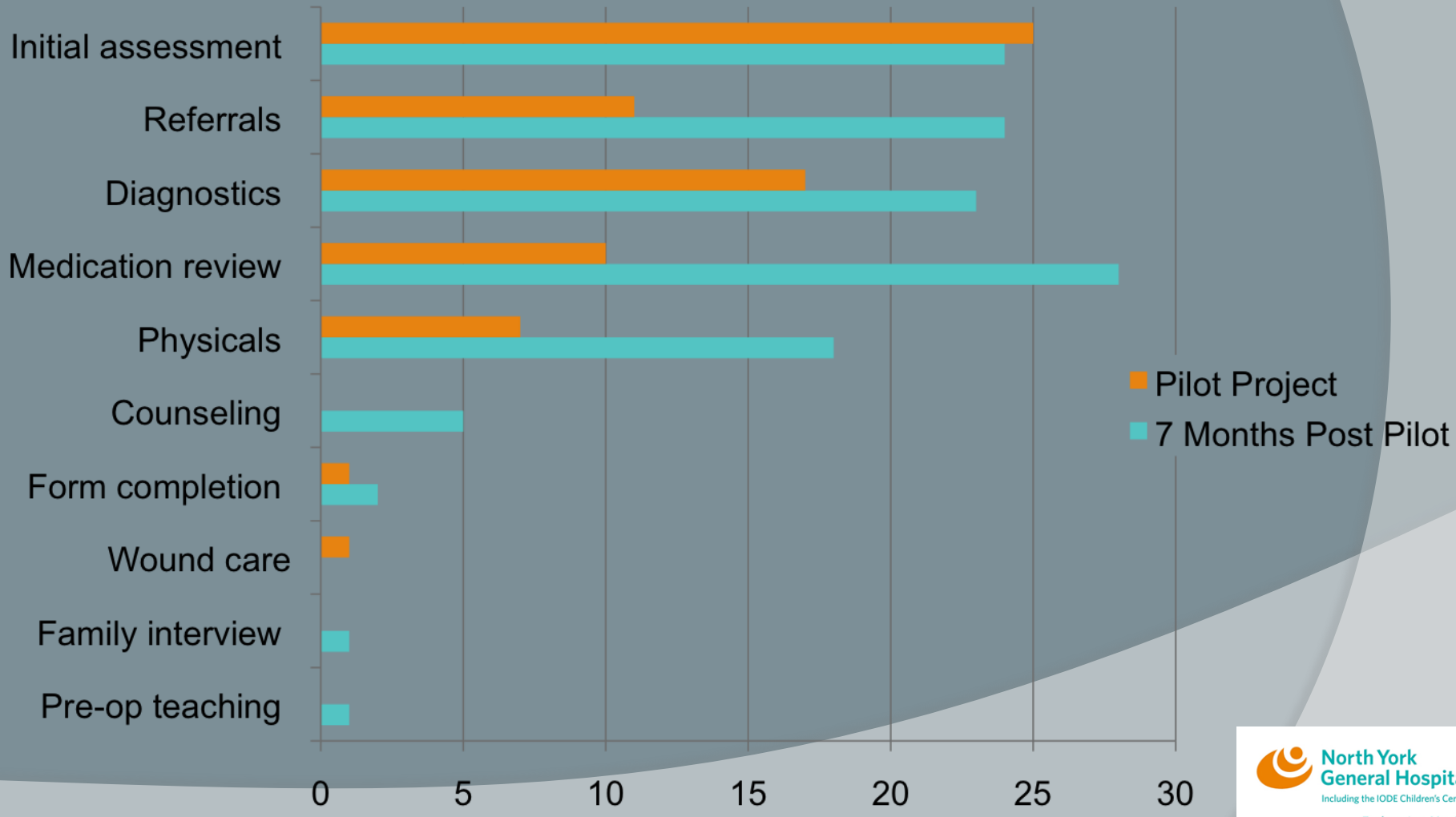
Primary Care Services Provided



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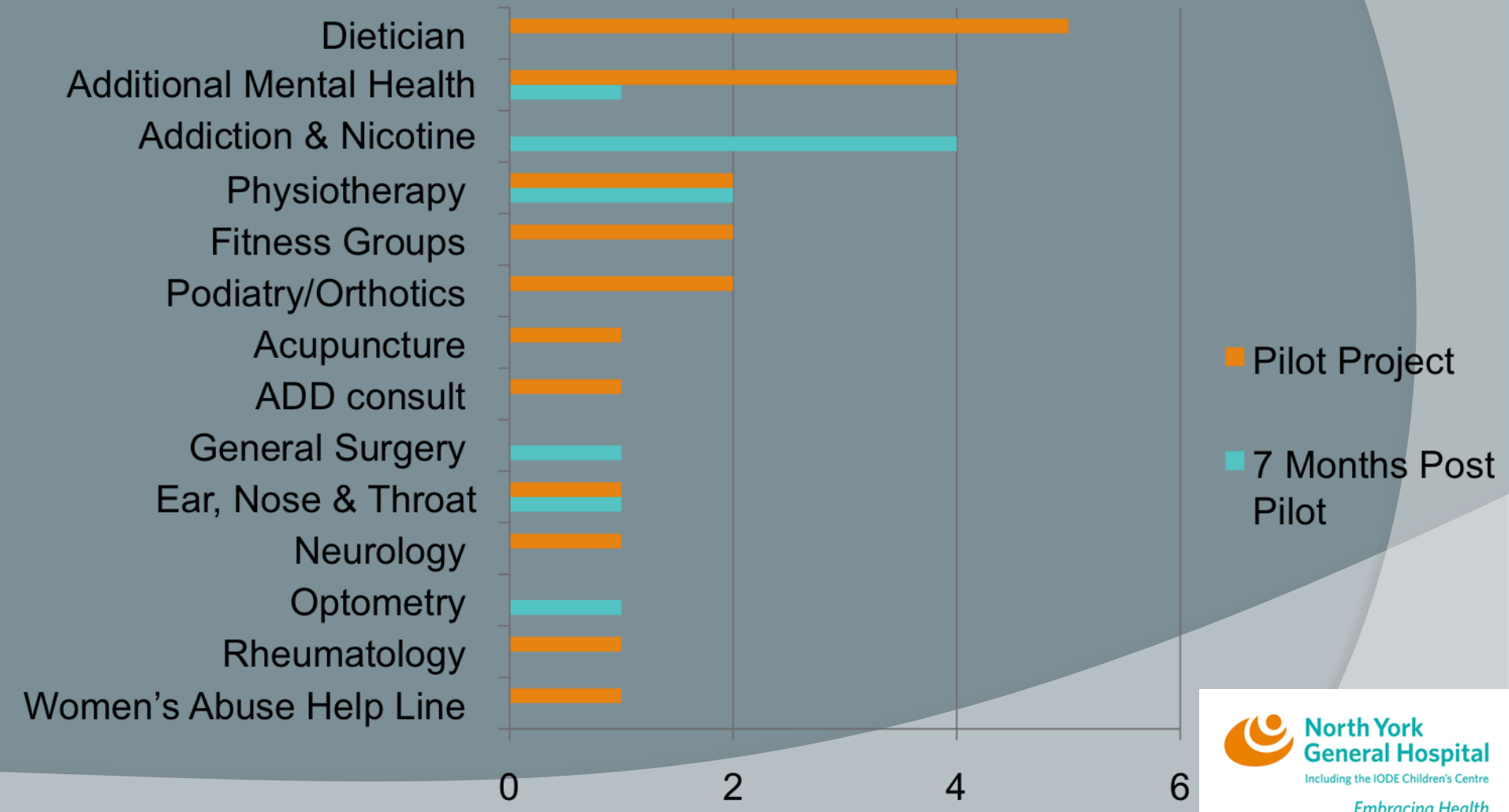
Referrals Made



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Goals of Reversed Shared Care Pilot Project

- Descriptive findings show utility of Reversed Shared Care:
  - Patients used the service (often repeatedly)
  - Patients received physical health medical care
  - Patients received referrals to the appropriate services

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Goals of Reversed Shared Care Pilot Project

- First objective of Pilot Project achieved:
  - NYGH's mental health patients provided with accessible high quality primary physical care
  - Increasing access to primary care services does improve health outcomes (Starfield, Shi, & Macinko, 2005).

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Goals of Reversed Shared Care Pilot Project

- Expect future monitoring will demonstrate decreased visits to the emergency department and improved patient flow
  - A community health clinic within mental health care services ↓:
    - # of hospital visits and admissions
    - length of stay in hospital
      - (Doey et al., 2008)

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Goals of Reversed Shared Care Pilot Project

- Provided opportunities for hallway interaction and relationship development between health care providers
- Multi-disciplinary team (mental health staff) ➔ Interdisciplinary team (mental health & primary care clinicians)

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Goals of Reversed Shared Care Pilot Project

- Interdisciplinary team: Physicians more available to each other and patients
- May lead to improved service delivery and improved patient outcomes
- Best practices in Interprofessional Care suggest co-location of services as an indicator and facilitator of increased collaboration (Appleby, Dunt, Southern, & Young, 1999; Koyanagi, 2004; Craven & Brand, 2002)

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Challenges: Reversed Shared Care Program

- Initial challenges in securing administrative and institutional support
- Developing adequate financial, time, and resource remuneration
- Need for a system-wide and integrated vision of service delivery and resource allocation from decision makers

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Costs: Reversed Shared Care Program

- Costs minimal:
  - Physician funded by public insurance (OHIP)
  - Re-tasking of an existing Assertive Community Treatment (ACT) team nurse
  - Use of existing physical clinic space for the half day per week service

Limitations

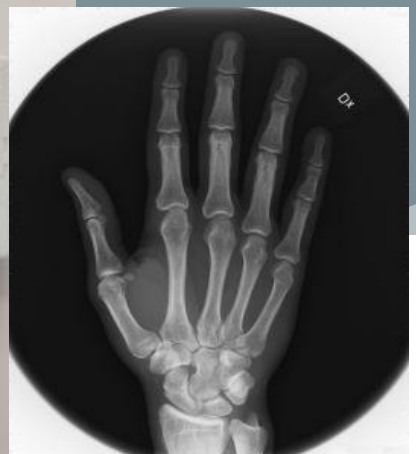
- Directionality implied in the terms ‘Shared’ and ‘Reversed Shared’ care
  - The new term ‘Reversed Shared Care’ is being used to draw attention to bringing needed primary physical health care services to a mental health clinic
  - Ultimately the directionality of service should be to the patient or person with mental illness in keeping with patient-centered care

Future Studies

- Creating programs that are targeting towards gaps in care for specific populations of patients (e.g., certain racialized communities)
- Future monitoring and evaluation of the utility and effectiveness of Reversed Shared Care
  - Improved hospital patient flow?
  - Improve health outcomes?
  - Patients' experience of the Reversed Shared Care program

Conclusions

- Benefits of Reversed Shared Care to this group of vulnerable patients are expected to be considerable, as they will have suitable access to primary physical medical care



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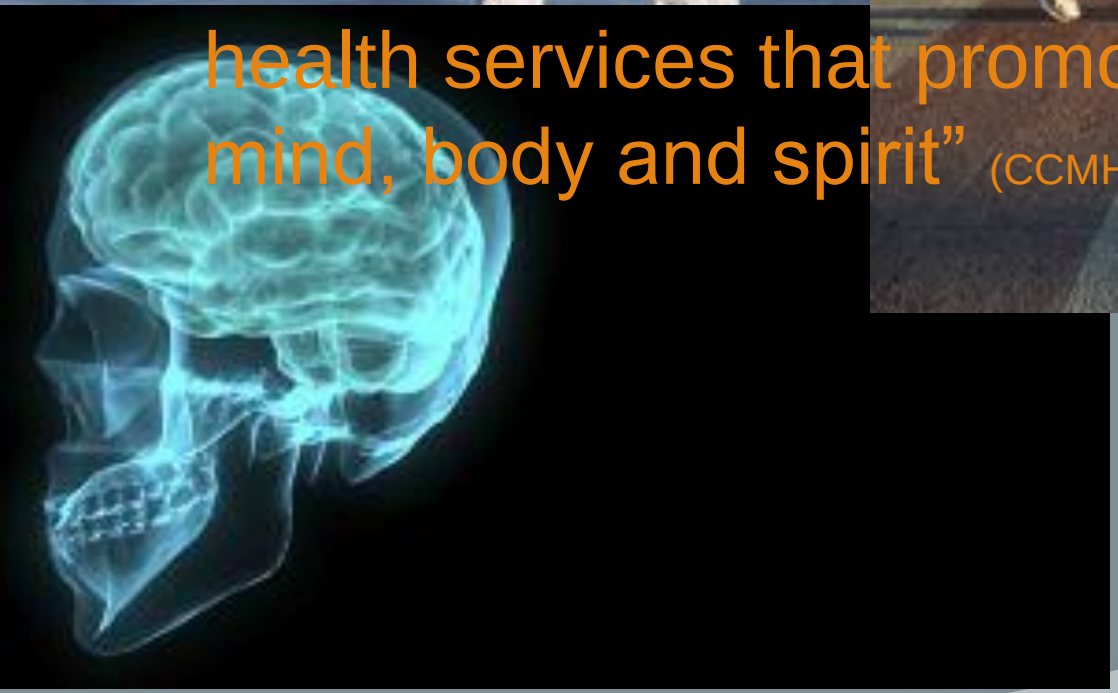

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Comments or Questions?

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