Mental health care and nutrition

Integrating specialist services into primary care

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ABSTRACT

PROBLEM BEING ADDRESSED Primary care reform is an important component of health services restructuring. One of the goals of primary care reform is to integrate specialized services into primary care settings. To date, few programs have successfully achieved this.

OBJECTIVE OF PROGRAM To integrate specialized mental health services into the offices of family physicians through the Hamilton Health Services Organization (HSO) Mental Health and Nutrition Program.

MAIN COMPONENTS OF PROGRAM Since 1994, the Hamilton HSO Mental Health and Nutrition Program has integrated mental health counselors, psychiatrists, and dietitians into the offices of 87 family physicians. Activities of specialists are coordinated by a central administrative body.

CONCLUSION Lessons learned from this program can indicate how to succeed in integrating specialist services into primary care offices.

RÉSUMÉ

QUESTION À L'ÉTUDE La réforme des soins de première ligne est un élément important de la restructuration des soins de santé. Un des objectifs de cette réforme est d'intégrer des services spécialisés aux établissements dispensant des soins de première ligne. Jusqu'à présent, peu de programmes ont relevé ce défi de façon adéquate.

OBJECTIF DU PROGRAMME Intégrer des services de santé mentale spécialisés aux cabinets des médecins de famille grâce au Mental Health and Nutrition Program de la Health Services Organization (HSO) de Hamilton.

PRINCIPAUX ÉLÉMENTS DU PROGRAMME Depuis 1994, le Mental Health and Nutrition Program de la HSO de Hamilton a intégré des conseillers en santé mentale, des psychiatres et des diététistes aux cabinets de 87 médecins de famille. Les activités de ces spécialistes sont coordonnées par un organisme administratif central.

CONCLUSION L'expérience acquise grâce à ce programme peut nous indiquer comment intégrer efficacement des services spécialisés aux établissements de soins primaires.

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Primary care reform, stimulated by publication of the "Victoria Report" by the Federal/Provincial/Territorial Advisory Committee on Health Services in 1995,[1] has become an important part of provincial health system restructuring and federal health care policy. Provincial plans for primary care reform share several general goals.[2-11] They all envision a system that is better coordinated, patient-centred, more comprehensive, more accessible, and community focused, and that places emphasis on illness prevention and health promotion and on greater use of computer technologies.

To achieve this, most plans identify the importance of building networks of primary care providers. These networks can range from groups of existing family practices[3] to larger groups of primary care practices linked with other providers of health and community services[10] to ambitious linkages of primary care practices with local community agencies and social service providers in a single organization.[5,9] Most plans also recognize the need for alternative funding arrangements to support such networks.[3,6,8,11]

One important goal identified in provincial planning documents is greater integration of specialized services into primary care settings. There are, however, few details in these documents as to how this should be approached and few examples of services that have successfully achieved such integration. Integrating specialized services is important because it is consistent with the three main goals of hospital restructuring: shifting resources from hospitals to the community, strengthening the role of primary care as the cornerstone or entry point into the health care system, and building stronger links between generalists and specialists.[4,7,12]

For many communities, primary care reform is a journey into uncharted waters. Some programs, however, have managed to integrate general and specialized services successfully, although there are very few published evaluations of their effect. Examples of successful programs include the centres locales des services communautaires (CLSCs) in Quebec, community health centres in many parts of the country, and the Health Services Organization (HSO) Program in Ontario.

This paper reviews the experiences of 36 HSOs (with 87 family physicians) in integrating specialized mental health and nutrition services into primary care practices through the Hamilton HSO Mental Health and Nutrition Program (MHNP). In many respects, the MHNP represents an important bridge to current primary care reform in Ontario. Because Ontario is committed to having 80% of family physicians join in primary care reform within 4 years,[13] it could be instructive to review the lessons learned by the MHNP in integrating specialists into primary care offices during the last 8 years and to consider the implications of these lessons for primary care reform.

Goal of the program

The Hamilton HSO MHNP aims to increase accessibility to specialized care for primary care patients and strengthen links between primary care and secondary and tertiary mental health and nutrition services. It also aims to increase family physicians' skills and comfort in managing the mental health and nutrition problems of their patients and to increase primary care physicians' capacity to handle a broader range of mental health and nutrition problems.

Background

Until the advent of primary care reform, Ontario's HSO program was the largest capitated primary care program in the country. Health service organizations serve rostered populations and receive a fixed amount of funding per patient per year. This funding covers all costs of the practice, including physicians' and other staff's salaries. Additional funding is made available for specific programs. These programs were initially referred to as Ambulatory Care Incentive Programs (ACIP), but were replaced in 1993 by the Institutional Supplementary Program (ISP). Funding from the ISP has enabled HSOs to integrate a variety of additional services into their practices, predominantly in the areas of mental health, nutrition, and health promotion.

In Hamilton, where half the HSOs in Ontario were located in 1994, 13 HSOs applied for ISP funding for mental health services. These practices were integrated into a single program, the Hamilton HSO Mental Health Program. In 1996, the remaining 23 HSOs in the Hamilton-Wentworth area applied for

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and were granted funds to add mental health workers to their practices and were integrated into the HSO Mental Health Program.

In a similar way, practices that applied for nutrition services were integrated into a single program coordinated by the nutrition department of a local general hospital. In February 2000, administrative responsibility for this program was transferred to the Mental Health Program, which became the Hamilton HSO MHNP and which now coordinates both components. The program now includes 87 family physicians in 36 practices at 51 locations serving 180 000 people (40% of Hamilton's population).

How the Hamilton HSO MHNP works

Mental health component. Each practice has a counselor who is permanently attached to the practice. The amount of time the counselor spends in the practice depends on practice size (one full-time equivalent [FTE] counselor for approximately 8000 patients). A psychiatrist visits each practice for half a day every 1 to 4 weeks depending on practice size and need. Currently, 23 FTE counselors (41 people) and 2.2 FTE psychiatrists (14 physicians) work in the program.

Counselors and psychiatrists see patients referred by the family physicians and manage an array of adults' and children's mental health problems.[14,15] They also spend time discussing and reviewing cases or problems with the family physicians and provide information on local resources and programs and management of mental health problems. This sometimes occurs in formal, organized sessions, but is more often part of consultations or discussions of cases family physicians are managing. Between visits, psychiatrists are available by telephone to discuss cases with family physicians or counselors.

Nutrition component. Each practice also has a registered dietitian (RD) who visits the practice for 3 hours to 3 days a week, depending on practice size. An RD can work in six to eight practices over the course of a week, although attempts are made to assign RDs to practices in the same geographic area to reduce traveling time.

The RDs assess patients referred to them by the family physicians and initiate treatments or education programs according to need. They also serve as educational resources for the family physicians, discuss cases that might not require referral, and provide information on other aspects of nutrition or resources.

Central management team. Activities in individual practices are coordinated by a central management team that is responsible for (re)allocating resources to practices, assisting practices in resolving on-site problems, setting program standards, circulating educational materials, linking practices with local mental health and nutrition systems, screening and preparing staff who wish to work in the program, and advocating on behalf of the program. The team is also responsible for evaluating the program and providing feedback to the practices and reports to the funding body.

Program evaluation

In 2000, the MHNP received 4015 referrals. Care was provided to 4656 patients (including cases open at the end of 1999). Each FTE counselor receives an average of 150 new referrals each year, and each FTE psychiatrist provides 580 new consultations a year. Responses to the General Health Questionnaire,[16-18] the CES-D,[19] and the SF-36[20] have demonstrated substantial improvement in patients using these services.

The MHNP has greatly increased access to mental health services. Number of referrals for mental health assessment made by each family physician in the program has increased from five a year before the program started to an average of 51 a year during the last 7 years, a 10-fold increase since the program started.[15]

Since inception of the MHNP, referrals to outpatient clinics by participating family physicians have decreased by 66%. Referrals to inpatient services are down by 10%, and the average length of stay is 1 day shorter for patients of family physicians in the program compared with those of colleagues who are not (neither of these differences is statistically significant).[15]

Patients' ratings of their satisfaction with the program (using the Client Satisfaction Questionnaire[21] and the Visit Satisfaction Questionnaire[22]) have consistently been higher than 90% and even higher (92%) for receiving mental health care in their family physicians' offices. Family physicians, counselors, and psychiatrists have also rated their satisfaction with the program higher than 90% since it began.[23]

The 7.0 full-time RDs in the program see more than 5500 referrals a year. The most common reasons for referral are dyslipidemias (46%), type 2 diabetes (26%), and weight reduction related to medical problems (17%).

Lessons learned

Part of a continuum. Specialized services in primary care need to be seen as part of a continuum of care. Ideally, specialized services in primary care should complement rather than replace traditional

hospital-based services and clinics. While complex cases or patients requiring very specialized treatments still need easy access to specialized services, many patients currently being treated in secondary or tertiary centres could be managed in primary care if appropriate support were available. The program allows many patients who would not otherwise have received specialized care to access these services. A question that requires further investigation is: Which problems can best be handled in primary care (with accessible specialist input and advice) and which do better in specialized settings?

Full integration. Advantages result from fully integrating specialized services into primary care. From the outset, the MHNP attempted to integrate its services and staff into primary care, rather than just establish separate clinics within these practices (although that model has been implemented elsewhere[24]). Integration included charting and clinical records. This led to improved communication between primary care and specialized services with opportunities to discuss patients who might not need to be seen or who had been seen at a previous visit. Such discussions have enhanced continuity of care and provided additional support to primary care staff.

Specialists' adjustments. Specialists need to make adjustments to work effectively in a "non-traditional" setting. Specialists have to understand the demands of primary care and adapt to the culture and space limitations of the practice in which they are working. They need to adapt to a different style of clinical consultation, taking advantage of the opportunity to discuss cases with referring health care providers before patients are seen. This often means that consultation questions are more focused and plans can be reviewed together.

Specialists have to be able to adjust to a model where care is shared and health care workers provide services according to their respective abilities and provide comfort in response to the specific needs of each patient. This often demands a change in attitude on the part of specialists as they move from working in relative isolation to working collaboratively.

Family physicians' adjustments. The main adjustment for family physicians is to free up time to discuss and review cases with specialists. In the MHNP, this usually takes only a few minutes a week for each family physician. Meeting times are booked around clinical activities to keep disruptions to a minimum. Family physicians also need to be willing to take a few minutes to discuss specific issues that arise during assessments.

The MHNP has also found that some family physicians need time to fully appreciate the benefits of having specialists in the office. As well as seeing cases, specialists can discuss management of patients who might not need to be seen, develop health education programs, run groups, set up preventive or screening projects, and assist with referrals to other secondary and tertiary programs.

New opportunities for continuing education. Much of the education that takes place in the program is informal and case-based, taking advantage of the regular contact between family physicians and specialists, particularly following consultations. These educational contacts are usually brief (2 to 3 minutes) and relevant because they are linked to clinical problems family physicians are currently managing. The program has also developed monthly in-office, small-group, problem-based learning sessions (accredited for MAINPRO-C credits by the College of Family Physicians of Canada) on topics chosen by family physicians.

This kind of clinical attachment also provides opportunities for learners in all disciplines to spend part of their training in primary care, seeing collaborative care modeled by their supervisors. These rotations have been evaluated extremely highly by those who have experienced them, especially residents.

New opportunities for early detection and prevention. Working in primary care, specialists can have direct access to populations, such as cultural minorities, who might otherwise underuse or not use their services, but who feel comfortable visiting their family physicians' offices. Specialists can work with primary care staff to identify patients at risk of developing specific problems and can screen or monitor these patients at regular intervals. They can also help family physicians increase their skills in detecting problems at an early stage and assist with development and distribution of educational materials.

Advantages of same location. Practices in the program range in size from one to six physicians. The more physicians in a practice, the less time is spent traveling between practices. Consequently, specialists have more time to discuss cases or problems when they are on-site.

For smaller practices, time has been saved by informally grouping practices according to location.

This allows counselors and dietitians to serve two or three practices that are in close proximity to each other. These groupings also provide a larger population base upon which to draw when setting up groups and bring family physicians from various practices together for in-office educational activities.

Each practice's own model. No single model fits every practice. Within guidelines laid down by the central management team, each of the 36 practices has developed its own model for linking specialists and family physicians in a way that meets the needs and culture of each particular practice. This principle should apply to other locations or programs looking at similar approaches.

Central body to coordinate activities. It was apparent from the outset that, with activities in many settings, a central body was needed to coordinate these activities, support individual practices and clinicians, and assist with activities that might be beyond the scope of individual practices, such as developing evaluations. The role and size of the central coordinating body will depend on the size of the program.

Specific benefits have included the following:

- distribution of up-to-date information on local mental health and nutrition services through mailings, a quarterly newsletter, regularly scheduled meetings of program participants, and circulation of key references or articles;
- assistance in recruiting specialized personnel;
- assisting practices in resolving problems, such as finding adequate space, reducing scheduling conflicts, and gaining access to local programs and services;
- reallocating resources;
- organizing the program's evaluation;
- developing guidelines, protocols, and standards for clinical activities; and
- representing and advocating for the program with other local health service providers and the program's funding source.

Applicable to a variety of specialties. The MHNP model lends itself well to greater participation in primary care by other specialists, such as cardiologists, endocrinologists, and pediatricians, who could be involved in case consultation, on-site education, and case discussions that include follow up of patients previously seen by specialists in primary care or their own practices. For example, another Ontario program[25] has successfully brought pharmacists into family physicians' offices on a regular basis to review medication regimens and potential drug interactions for patients on multiple (more than five) medications.

Conclusion

While most provinces are beginning to reform their primary care systems, there are few examples of programs that have successfully integrated specialized services into primary care. One such program is the Hamilton HSO MHNP, which has demonstrated the benefits of integrating a variety of specialized services into the practices of 87 family physicians. Benefits include increased access to services, improved communication between specialists and primary care staff, more continuity of care, and increasing family physicians' skills and comfort in handling complex problems. The MHNP has created an informal but effective network of practices with a coordinating body serving an important monitoring and support role.

The program works most effectively when specialized services are well integrated as part of primary care teams, when there are larger groups of family physicians (three to nine) in a single location, and when primary and secondary or tertiary care are seen as part of a well-linked continuum of care. Primary care staff and specialists both need to adjust to what is, in some ways, a new style of practice. If they can adjust, this model opens up new opportunities for early detection and prevention of illness and for continuing education for family physicians.

Other factors important to the success of the Hamilton MHNP are having a central management team that coordinates activities in practices and can reallocate resources as needed and the ability of each practice to develop a model that best suits the skills and interests of participating family physicians and specialists. While the Hamilton program includes only mental health and nutrition components, the model is likely to be applicable to other specialties and to have broader implications for primary care reform.

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Editor's key points

- The Hamilton Health Services Organization Mental Health and Nutrition Program is an early model of integrating specialist services into primary care.
- Each of 36 practices, together serving 40% of Hamilton's population, has an assigned mental health counselor, psychiatrist, and dietitian. These specialists visit regularly according to the needs of the practice.
- These specialized staff provide direct patient care and discuss and review problems with family physicians. The psychiatrists are available by telephone between visits.
- A central management team coordinates assignment of staff, assists practices in setting up the system, provides ongoing support, and conducts evaluations.
- The program has greatly increased access to mental health services and reduced referrals to outpatient clinics and admissions to hospital. Patients, family physicians, and specialists rate the program highly.

Points de repère du rédacteur

- Le Mental Health and Nutrition Program de la Health Services Organization de Hamilton est un des premiers modèles d'intégration de services spécialisés aux soins de première ligne.
- Un conseiller en santé mentale, un psychiatre et un diététiste sont maintenant assignés à 36 établissements qui, à eux seuls, desservent 40% de la population de Hamilton. La fréquence des visites des spécialistes est fonction des besoins de chaque établissement.
- Ces spécialistes fournissent des soins directs aux patients et discutent de leurs problèmes avec leur médecin de famille. Entre les visites, les psychiatres peuvent être rejoints au téléphone.
- Un organisme administratif central coordonne l'affectation du personnel, aide les établissements à instaurer le système, assure un support continu et effectue les évaluations appropriées.
- Ce programme a eu pour effet d'augmenter considérablement l'accès aux services de santé mentale et de réduire le nombre de patients dirigés vers des cliniques de consultation externe ou hospitalisés. Patients, médecins et spécialistes jugent ce programme excellent.

References

1. Advisory Committee on Health Services. *A model for the reorganisation of primary care and the introduction of population-based funding; The Victoria Report*. Ottawa, Ont: Health Canada; 1995.
2. Provincial Coordinating Committee on Community and Academic Health Science Centres Relations (PCCCAR), Subcommittee on Primary Health Care. *New directions in primary health care*. Toronto, Ont: Ontario Ministry of Health; 1996.
3. Ontario Ministry of Health. *Primary care reform goals, objectives and targets*. Toronto, Ont: Ontario Ministry of Health; 1998.
4. Nova Scotia Department of Health. *From blueprint to building: renovating Nova Scotia's health system*. Halifax, NS: Nova Scotia Department of Health; 1995.
5. Saskatchewan Health. *Primary health services initiative*. Regina, Sask: Saskatchewan Health; 1997.
6. New Brunswick Health and Community Services. *Physician compensation in New Brunswick: report of a working group on alternate forms of physician remuneration*. Fredericton, NB: New Brunswick Health and Community Services; 1997.
7. Alberta Health. *Advancing primary health care: a discussion paper*. Edmonton, Alta: Alberta Health; 1998.
8. Newfoundland Department of Health and Community Services. *Achieving comprehensive primary care services: reorganizing and reimbursement of primary care physicians in the Clarenville and Bonavista area*. St John's, Nfld: Newfoundland Department of Health and Community Services; 1998.
9. Manitoba Health. *Neighbourhood resource networks: primary health care working document*. Winnipeg, Man: Manitoba Health; 1997.
10. Ministre de la santé et des services sociaux du Québec. *Examen des responsabilités respectives du Ministere de la santé et des services sociaux, des regies regionales et des establissements—reflexions et propositions*. Quebec city, Que: Ministre de la santé et des services sociaux du Québec; 1996.
11. British Columbia Ministry of Health and Ministry Responsible for Seniors. *Primary care demonstration project. Policy and information guide*. Victoria, BC: British Columbia Ministry of Health and Ministry Responsible for Seniors; 2000.
12. Ontario Ministry of Health and Long Term Care. *Report of the Health System Restructuring Commission*. Toronto, Ont: Ontario Ministry of Health and Long Term Care; 1999.
13. Government of Ontario. Ontario's innovative health care reforms improving patient care [press release, June 12th, 2000]. Toronto, Ont: Government of Ontario; 2000. Available from www.newswire.ca/government/ontario. Accessed 2002 June 17.
14. Kates N, Craven M, Crustolo A, Nikolaou L. Integrating mental health services into the family physician's office: a Canadian program. *Gen Hosp Psychiatry* 1997;19:324-32.
15. Kates N, Craven M, Crustolo A, Nikolaou L, Allen C, Farrar S. Sharing care: the psychiatrist in the family physician's office. *Can J Psychiatry* 1997;42(9):960-5.
16. Goldberg D. *The detection of psychiatric illness by questionnaire* [Maudsley monograph No. 21]. London, Engl: Oxford University Press; 1972.
17. Goldberg D. *Manual of the General Health Questionnaire*. Windsor, Engl: NFER Publishing; 1978.
18. Goldberg DP, Hillier VF. A scaled version of the General Health Questionnaire. *Psychol Med* 1979;9:139-45.
19. Radloff LS. The CES-D scale: a self-report depression scale for research in the general population. *Appl Psychol Measure* 1977;1:385-401.
20. Ware JE Jr, Sherbourne CD. The MOS (Medical Outcomes Study) 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Med Care* 1992;30:473-83.
21. Larsen DL, Attkisson CC, Hargreaves WA, Hguyen TD. Assessment of client/patient satisfaction: development of a general scale. *Eval Prog Plann* 1979;2:197-207.
22. Rubin HR, Gandek B, Rogers WH, Kosinski M, McHorney CA, Ware JE. Patients' ratings of outpatient visits in different practice settings: results from the MOS. *JAMA* 1993;270:835-40.
23. Farrar S, Kates N, Crustolo A, Nikolaou L. Integrated model for mental health care. Are health care providers satisfied with it? *Can Fam Physician* 2001;47:2483-8.
24. Sibbald B, Addington-Hall J, Brenneman D, Freeling P. Counsellors in English and Welsh general practices. *BMJ* 1993;306:29-33.
25. Sellors J, Sellors C, Woodward C, Dolovich L, Poston J, Trim K, et al. Expanded role of pharmacists consulting in family physicians' offices—a highly acceptable program model. *Can Pharmaceut J* 2001;134(7):27-31.