

Bridging the Gaps for Complex Pain Patients

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Presenter Disclosure

Presenter: June Bergman



- ▶ Relationships with commercial interests
 - Not Applicable

Presenter: Jean Leong

- ▶ Relationships with commercial interests
 - Not Applicable



Presenter: Debra McDougall

- ▶ Relationships with commercial interests
 - Not Applicable



Disclosure of Commercial support

- ▶ No commercial support



Mitigating Potential Bias

- ▶ N/A



Objectives

- ▶ To illustrate the effectiveness of an interdisciplinary team which includes the role of the Medical home along with speciality care as integral to the therapeutic process in treating complex pain patients.
- ▶ To understand the interplay between mental health and physical health through case example.
- ▶ To demonstrate the successes and challenges in integrated treatment of mental health and chronic pain and to review effectiveness of the model in comparison to more traditional speciality based models.

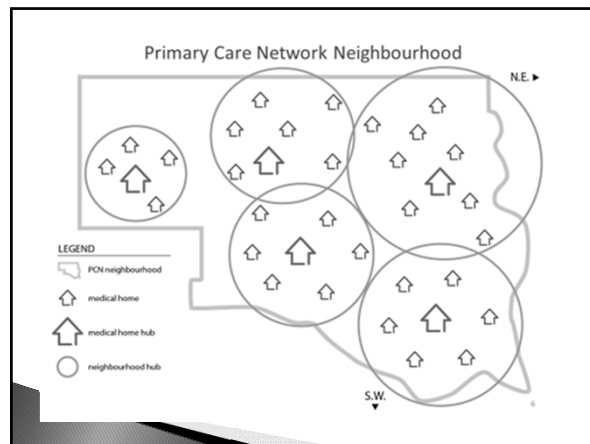
Primary Care Networks (PCN)

- ▶ Reforming Primary Care, Alberta's response.
 - Joint venture (FP groups & AHS)
 - Address gaps in service provision
 - Improve access to FP
 - 24/7 care provision
 - Health promotion, Chronic Disease Management
 - Integrate with secondary/tertiary/long-term care
 - Multidisciplinary teams in community
 - Supporting Medical Home

Where are we?

- ▶ Alberta – 44 Primary Care Networks, 3.6 million. One province wide health region
- ▶ Calgary is a city of over a million with 7 Primary Care Networks
- ▶ Calgary Foothills Primary Care Network has 401,000 patients and 401 physicians
 - Primary care with teams
 - Obstetrical care
 - Seniors care
 - Mental Health
 - Transitional support
 - Complex and chronic disease care
 - 24/7 care

Medical Home (Canadian)

- ▶ Patient Centric
- ▶ Family Physician (MRP)
- ▶ Broad comprehensive scope using team of professions
- ▶ Timely access
- ▶ Meets public health and population needs
- ▶ Continuity of care
- ▶ EMR
- ▶ Training (multiprofessional)
- ▶ Continuous Quality Improvement
- ▶ Governance (by all stakeholders)

Medical Home (Canadian)

- ▶ Comprehensive care
 - Patient needs
 - Public health needs
 - EMR
 - Supports Education of providers
- ▶ Evaluation
 - Effectiveness
 - Continuous improvement
 - Internal Governance
 - External Stakeholders

PCN Evolution

- ▶ To improve patient care delivery and align with provincial health care delivery
- ▶ Supporting (Health) Medical Home in each clinic
- ▶ Support from health team to improve access and increased services
- ▶ Collaborate with specialties to produce seamless care
- ▶ Moving expertise into the (Health) Medical Home

Primary Care based mental health services

Shared Mental Health Care Program–Calgary Model

- ▶ Family physician identifies patient and/or family
- ▶ Consultation process with family physician with or without patient
- ▶ BHC and Shared Care
- ▶ Enhanced mental health service at primary care
- ▶ Improving family physicians ability to identify, assess, treat and refer

Slide 7

YM1 will confirm # physician members
Yolanda Martens-Vanhilst, 26/04/2014

Primary care based mental health services

Shared Care – Calgary model

- ▶ Implemented in 1998 in primary care
- ▶ Building capacity and providing training to family physicians to manage mental health and addictions in their practice
- ▶ Direct consultation/brief therapy to patients with mental health and addiction issues
- ▶ Family physician, mental health clinician or psychiatrist and patient in the same room, same time in the medical home

Primary care based mental health services

Behavioral Health Consultants

- ▶ Masters and doctoral level psychologists and social workers
- ▶ Integrated into the Primary Care setting
- ▶ Typically see 8–10 patients per day
 - 30 minute consultations
 - Touch base with physicians
 - Notes on the patient's medical chart
- ▶ Providing brief, targeted interventions
 - Approx. 4 sessions
 - Flexibility is essential

Primary care based mental health services

- ▶ Telepsychiatry – started around 2000
- ▶ Psychiatric consultations

Extended Team – Chronic Pain

- ▶ Patients identified by medical home
- ▶ Time and Team
- ▶ Strong Biopsychosocial Model
- ▶ Change management perspective
- ▶ Support patients from where they are to the next attainable step

Case Example: Anne

- 44 yr. old female – teaching assistant, special needs children, ++ work absences. Living with common-law, a labourer. Supportive relationship, no extended family, no social network
- Long history of 'all-over' pain, worse in lower back at 10/10 severity, diagnostic imaging shows degenerative disc disease, pain interferes with sleep
- Severe anxiety and depression including suicidal ideation
- Multiple trials of analgesic and psychotropic medications have had minimal, typically temporary effect
- Patient presents to her family physician at least 2X per month – desperate and overwhelmed by pain, fatigue, and depression
- Patient describes prior mental health interventions as 'intrusive and judgemental'

Questions

- ▶ What are the treatment needs of this patient?
- ▶ Where do you think this patient is best managed?
- ▶ What do you think are the challenges in providing care for this patient?

Principles of Primary Care

- › Whole person care
- › Care is provided throughout the patient's life span
- › No exclusionary criteria
- › Referral to specialty care for diagnoses and specialty treatment
- › Specialist recommendations are incorporated into ongoing care
- › Community-based



Common Assumptions in Mental Health Care

- › Physical health should be as stable as possible before engaging in mental health care.
- › Mental health and physical health issues have been dealt with in separate places.
- › Mental health issues are sensitive so both patients and mental health clinicians want to have boundaries around confidentiality



Gaps

- › System gaps
- › Paradigm gaps
- › How health care providers collaborate to break down the silos
- › Lack of understanding/knowledge in how to work with the connection between physical and mental health issues



Our approach to bridging

- › Primary care physician as an active participant
- › Interdisciplinary team
- › Extended team

“Challenging ourselves to think beyond the silos”



Our approach to bridging continued

- › Biopsychosocial perspective
- › Start where patient is at
- › Focus on self management
- › Blending of patient, medical and psychological expertise
- › Integrative conversations
- › Orientation to moving ahead/change
- › Intentional connection with the medical home

Our work with Anne

Anne's reflections:

- I went in looking for them to give me a fix for my pain
- 'I have a physical problem - pain - that is causing my psychological problem - depression.'
- › Key turning point:
 - I changed my thinking and actions. I let go of my desperate search for the external solution.
 - Emphasis on patience, pacing, mind/body integration, focus on function not fix
 - What moves me forward? Awareness, willingness to experiment.

Shared care reflections:

- Intermittent sessions with 'gently disruptive' questions.

Family physician reflections:

- I am involved but not solely responsible

Challenges with this approach

- ▶ Requires a paradigm shift
- ▶ There are system challenges - both internal and external
- ▶ Can be time consuming



Challenges moving forward/Next Steps

- ▶ Identify ways these concepts are used in the work you do now.
- ▶ What will you take from this presentation to incorporate in your practice?
- ▶ What one idea from the presentation are you going to use?



Questions?



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