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TIPP-TOE: TRANSFER TO PRIMARY PRACTICE

THE OTTAWA HOSPITAL EXPERIENCE

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DISCLOSURES

Tracy Meeker has nothing to disclose

Colleen MacPhee has nothing to disclose

Paddi O'Hara has nothing to disclose

LEARNING OBJECTIVES

1) Identify the impacts on a patients physical and mental health when they are transferred to a primary care physician in a Family Health Team
2) Review the possible implications of challenges in implementing and recruiting for TIPP-TOE
3) Discuss what the limitations of TIPP-TOE taught us about the needs of physicians taking on individuals living with more serious mental illness
4) Briefly introduce a new project that was influenced by the TIPP-TOE experience and which reflects the new look of mental health Care in the Champlain LHIN

TIPP-TOE – a review

- **Primary question**:
  Would the participants be happy with their mental health care after transferring from a mental health specific institution to primary care?

- **Other questions**:
  1. Would the mental health of the participants decline
  2. How would primary care providers experience the transfer of patients with serious but stable mental illness
  3. Would participants be satisfied with the transitional transfer method

TIPP-TOE – a review con't

Inclusion Criteria

- Chronic moderate to severe mental illness
- Duration of Mental Illness > 2 years
- If ever hospitalized, time of last admission greater than 1 year
- Patient is clinically stable. TAG score 8 or less.
- Insight/motivation and willingness to participate
- Pt. does not have a primary care physician

Exclusion Criteria

- Clozapine treatment
- Active substance use
- Outstanding psychosocial issues (homelessness)
- Frequency of out-patient psychiatry visits greater than one visit per month
- History of self harm or harm to others in the last 6 months
- Pt has a primary care physician

Closing the loop

Initial years was a demonstration project

- Aim was to provide support to family physicians in dealing with current patients living with mental illness. Research and evaluate impact of this type of a “in-house” specialty team.
- Secondary Gains:
  - Knowledge transfer to family physicians, residents, NP etc. to assist with “stepped care” approach to identify and initiate best practice treatment options for individuals presenting with mental health issues.
  - Transition patients being served in outpatient mental health clinic to primary care. At the time of our study only 35% of individuals being served in our Outpatient mental health clinic had a family physician.
  - “In order to facilitate access to primary care from the mental health system for patients with severe mental illness who lack a family physician, it is recommended that the SHARE Team serve as a link to the hospital-based mental health services.” (Recommendation from 2006 – Ottawa SHARE Demonstration Project final evaluation report)

Challenges

1. Significant delay between receipt of ethics approval and recruitment into study due in part to staff changes within the SMH team

2. Immediate challenge with recruitment
    - Very few patients who met inclusion criteria were without a family doctor
        - Actions: added a third recruitment site – resulted in 3 participants
        - Removed Clozapine as an exclusion criteria — resulted in 1 participant

<u>Discussion</u>

- Change in the landscape of mental health patients in the region from time of study design to time of recruitment – how did this influence recruitment challenges?

PARTICIPANTS

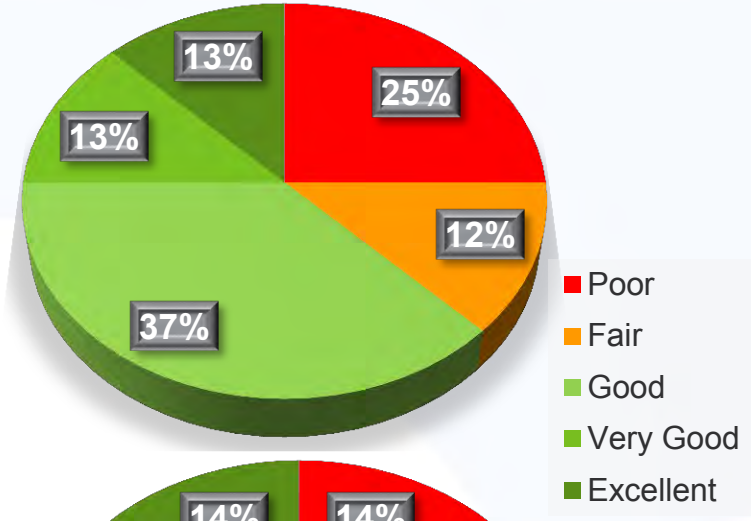
Goal: 10
Actual: 8

- 8 patients → 1 female, 7 males
- Average age: 34.50 years, range: 27 to 53 years
- 7 diagnosed with schizophrenia, 1 diagnosed with psychosis
- Followed over one year for 5 research assessments

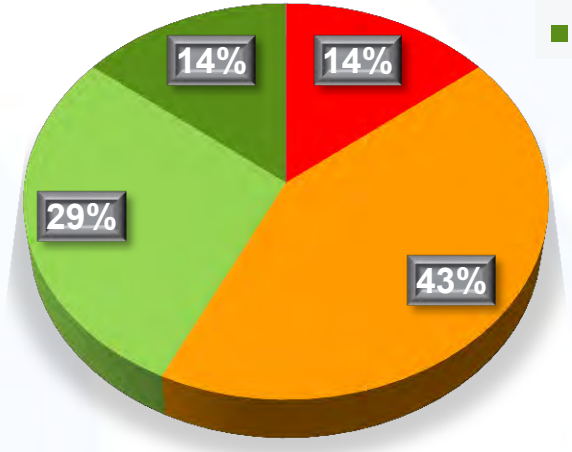
IMPACT ON PHYSICAL WELL-BEING

- Self-ratings of health

First Visit: 63% Rated Health Good to Excellent



Last Visit: 43% Rated Health Good to Very Good



IMPACT ON MENTAL WELL-BEING

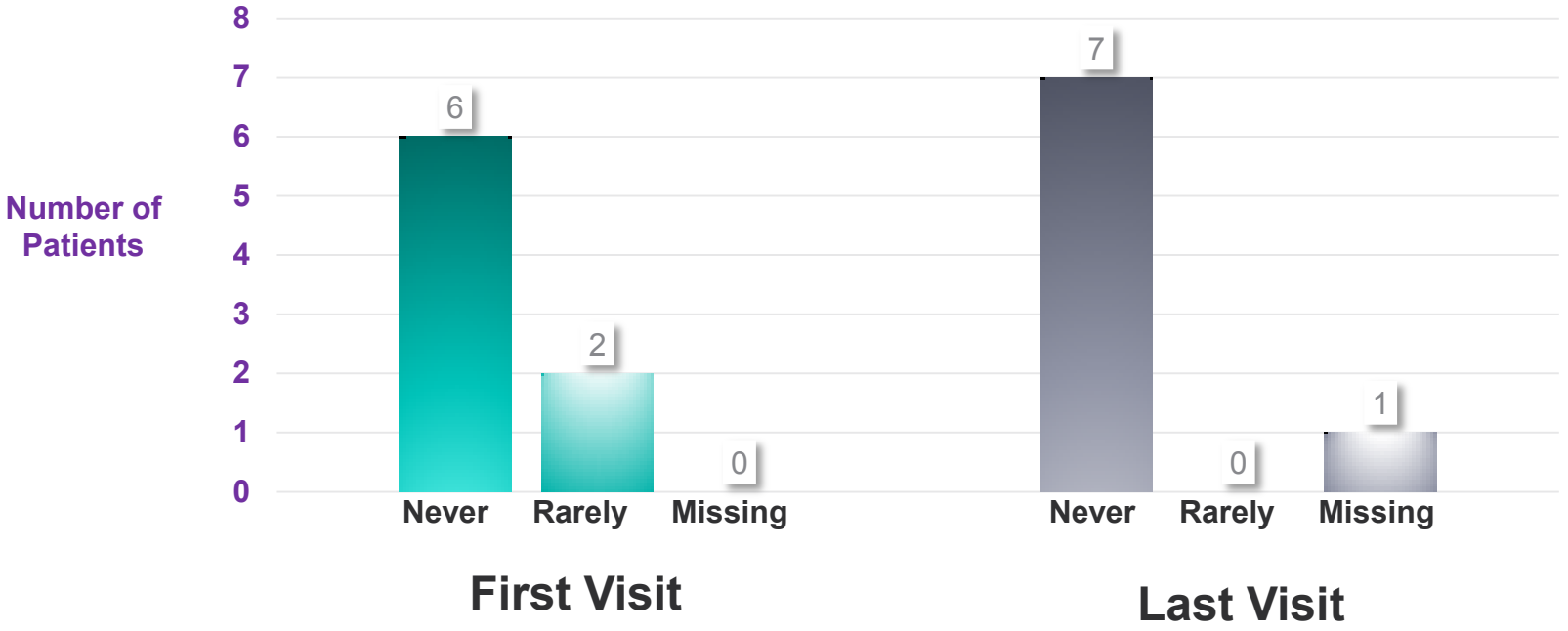
- Outcome Questionnaire: OQ-45→ designed to measure the severity of mental health symptoms

Contains four subscales:

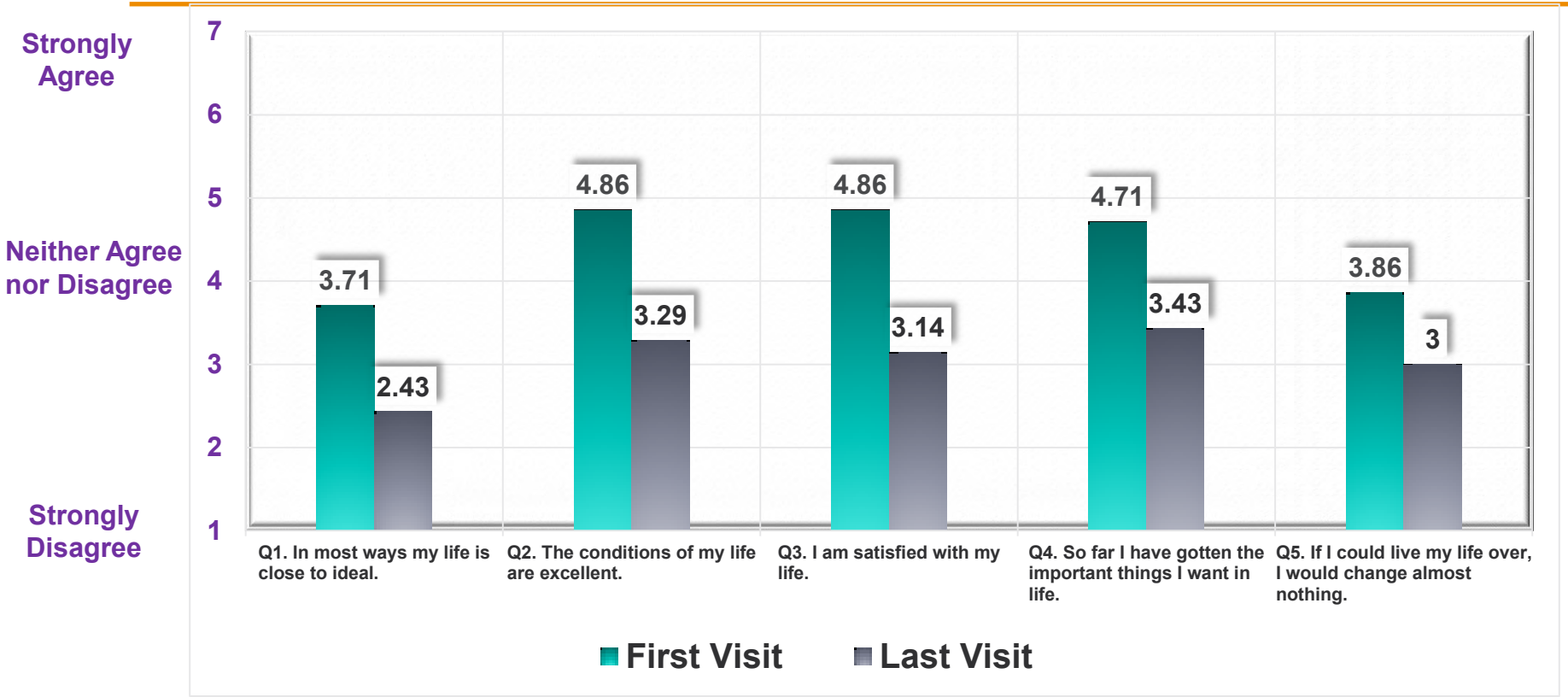
1. Symptom Distress (depression and anxiety)
2. Interpersonal Relationships (loneliness, conflict with others and marriage and family difficulties)
3. Social Role (difficulties in the workplace, school or home duties)
4. Risk

Total Scores for each OQ-45 Subscale	First Visit Score M (SD)	Last Visit Score M (SD)	Clinical Cut Off Score
Symptom Distress	32 (9)	31 (15)	36
Interpersonal Relations	16 (3)	15 (5)	15
Social Role	10 (5)	10 (4)	12
Risk	2 (2)	2 (1)	0
Total Score	59 (13)	55 (20)	63

I HAVE THOUGHTS OF ENDING MY LIFE….



SELF-RATED SATISFACTION WITH LIFE



SELF-RATED CAPACITY TO WORK/STUDY

Item	Visit	Never	Rarely	Sometimes	Frequently	Almost Always
I am not working/ studying as well as I used to.	First	3	1	1	0	0
	Last	1	1	4	2	0
I feel that I am not doing well at work/school.	First	4	1	1	0	0
	Last	1	2	4	1	0
I feel something is wrong with my mind.	First	4	2	0	0	1
	Last	4	1	1	1	1
I feel angry enough at work/school to do something I might regret.	First	5	1	1	0	0
	Last	6	2	0	0	0

FEEDBACK FROM FAMILY HEALTH TEAM PHYSICIANS

- Feedback obtained from 7 of 8 physicians

Close-ended Questions

- 6 physicians felt they had established a therapeutic relationship with the patients accepted through the TIPP-TOE project.
- 6 physicians felt the process of transferring patients to their care was well organized
- 4 patients had been seen by the SMH team for other than study reasons in the last year.
  - 2 were stable but wanted to discuss medication changes
  - 2 had periods of instability with one seen for “legal issues” and one seen frequently for significant decompensation after going off his medication.

Discussion: Did the transfer increase risk of becoming non-compliant with medication?

FEEDBACK FROM FAMILY HEALTH TEAM PHYSICIANS

- Comments

"Has been effective. Have really appreciated SMH help with this difficult case."

"Yes it is effective Yes I would take another patient. Great collaboration with the SMH team."

"Its a good shared care model- and a good experience for me. My practice is full so I will not be able to accept more pts at this time but would certainly recommend it to my colleagues."

One physician expressed disappointment that SMH did not provide more *"real-time access to advice on management."*

"We have requests to take complex patients each week so there has to be a balance."

"Recent work with the shared mental health care team are addressing the need for support when we feel this is needed within the week. It is especially important with this group of patients because maintaining their trust and comfort with us as a team is crucial. When their symptoms flare up in a way that makes it harder to care for them or makes them more fearful of getting care from us, the longer this goes on the worse it is for the long term."

FEEDBACK FROM PATIENTS

- Two patients indicated some stress with the transition process:
  - *"Unnerving to meet new people but it has been good for me."*
  - *"Confusing, met too many people first day."*
- However, when asked if they were happy with care from the shared mental health care team, 63% said "Yes, definitely" and 37% said "Yes, I think so."
- When asked if they were happy with care from their FHT physician, 57% said "Yes, definitely," 29% said "Yes, I think so" and 14% said "No, I do not think so."
- Patients also rated their overall satisfaction with the transition into primary care/shared mental health care program: 37% were "Very satisfied," 50% were "Mostly satisfied" and 13% were "Mildly dissatisfied."

What's happening now?
And what's next?

- Patient's with mental illness being unable to find a family doctor is **less** of an issue in our region

- A widely acknowledged strain on the mental health care system in our region is the number of stable patients on Clozapine who are followed by mental health institutions

- A new pilot project is working towards addressing each of the obstacles in getting patients on Clozapine managed by family doctors

Transfer of patients on Clozapine from On Track to Primary Care

What was needed

- A systems approach to supporting individuals with schizophrenia and psychosis?
- A change in legislation? (prescribing requirements and blood monitoring requirements)
- Enhanced or accessible secondary level or community psychiatry?

What we could do

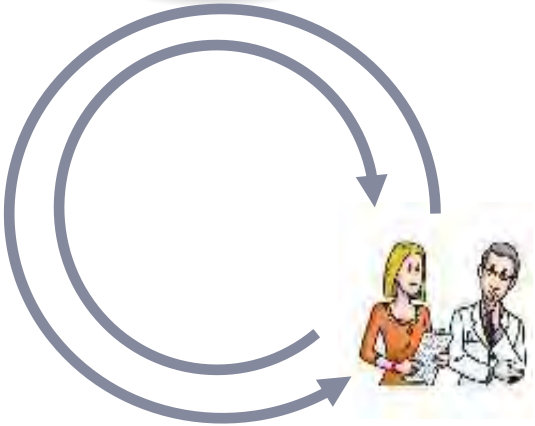
- Identify On Track individuals who were stable and prescribed clozapine (ready for a lower level of care)
- Identify family practitioners willing to take on care of individuals
- Test and pilot a transfer of care.

The Vision…

Not Just Patient Flow but also Information Flow

From this:

To this:



Questions?

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Thank You

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