

Collaboration in caring for psychiatric inpatients

Family physicians team up with psychiatrists and psychiatric nurses

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ABSTRACT

PROBLEM BEING ADDRESSED The standard organization of psychiatric inpatient care at our hospital involved consultations with various specialist physicians visiting the psychiatry wards to assess patients' medical needs and to provide appropriate interventions. We thought that this type of clinical care pathway might not be leading to the best integration and timeliness of patient care, the most efficient use of specialist resources, or the least cost to the health care system.

OBJECTIVE OF PROGRAM To initiate a protocol that would involve an FP visiting all the psychiatry wards daily (on weekdays) to conduct medical consultations. We hoped this program would improve the timeliness and integration of patient care, reduce patients' length of stay in hospital, and alter the pattern of specialist consultations.

PROGRAM DESCRIPTION The FP consulted on patients referred by psychiatrists and registered psychiatric nurses; carried out assessments; initiated treatment of common medical problems; referred to other specialists when necessary; and made arrangements for follow-up care as appropriate.

CONCLUSION The FP consultations improved patient care in several ways, was highly valued by staff, and modified the pattern of specialist consultations on participating psychiatry wards.

RÉSUMÉ

PROBLÈME À L'ÉTUDE L'organisation courante des soins aux patients psychiatriques hospitalisés à notre hôpital comprenait des consultations par divers spécialistes, qui visitaient le département de psychiatrie pour évaluer les besoins médicaux des patients et intervenir de façon appropriée. Nous pensions que ce type d'approche n'était pas nécessairement le meilleur modèle pour obtenir des soins cliniques opportuns et bien intégrés, pour utiliser les ressources spécialisées de façon optimale ou pour minimiser les coûts pour le système de santé.

OBJECTIF DU PROGRAMME Instaurer un protocole dans lequel un médecin de famille (MF) visiterait tous les départements de psychiatrie quotidiennement (les jours de semaine) pour effectuer des consultations médicales. Nous espérions que ce programme conduirait à des soins plus opportuns et mieux intégrés, raccourcirait le séjour à l'hôpital et modifierait le mode de recours aux spécialistes.

DESCRIPTION DU PROGRAMME Le MF a visité les patients référés par les psychiatres ou par les infirmières cliniciennes en psychiatrie, effectué les évaluations, amorcé le traitement des problèmes médicaux courants, dirigé les patients à d'autres spécialistes lorsque nécessaire et organisé un suivi approprié.

CONCLUSION Les visites du MF ont amélioré les soins de plusieurs façons, ont été fort appréciées par le personnel et ont modifié le mode de recours aux spécialistes dans les départements de psychiatrie participants.

*Full text is available in English at www.cfp.ca.

This article has been peer reviewed. Cet article a fait l'objet d'une révision par des pairs. Can Fam Physician 2008;57

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Tt is very common for psychiatric inpatients to have medical issues that require attention.1-3 The preva-Lence of comorbid medical conditions in psychiatric inpatients has been reported to be as high as 71%.3 Many of these conditions (eg, HIV and hepatitis C) are the result of high-risk behaviour.4 Other conditions, such as diabetes, could be the result of lifestyle or even medications used to treat mental illnesses.⁵ The standard organization of inpatient psychiatric care at our tertiaryquaternary care hospital involved consulting specialists visiting patients to assess their medical needs and to provide appropriate interventions. We thought this model might not be optimal in terms of timeliness of interventions, integration of patient care, efficient use of resources, and cost to the health care system. Informal feedback from psychiatrists and registered psychiatric nurses suggested that patients who were otherwise ready to leave hospital were unable to be discharged because they had not yet been seen by specialty consultants. There were also concerns about fragmentation of medical care when consulting specialists consulted additional specialists. Finally, there was an impression among psychiatric staff that most of the medical problems fell within the purview of family practice.

Objective of the program

In the interest of better integrated patient care and possibly reduced lengths of stay in hospital, the departments of psychiatry and family medicine collaborated to provide a new model of medical care that involved an FP visiting all psychiatry wards every weekday to consult on patients' medical problems.

There is little literature in this area. A search on MEDLINE, CINAHL, PsycINFO, and Google found no reports of similar programs. We used combinations of the following search terms: *inpatient psychiatry, medical problems* (and synonyms of "problems"), *comorbidity, family practice,* and the MeSH terms *organization/administration, inpatient consult(s), patient care team, shared care,* and *tertiary care.*

Program description

This program was carried out at a large urban tertiaryquaternary care hospital (445 beds plus 101 short-stay beds). Two inpatient wards (A and B) and a short-stay

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assessment area near the emergency department contained 41 psychiatric beds. Admissions to all 3 of these areas total approximately 900 yearly. We initiated a protocol in October 2004 that involved an FP visiting all 3 areas every weekday.

The FP performed the following functions:

- consulted on patients referred by psychiatrists and registered psychiatric nurses;
- assessed, diagnosed, and treated common medical problems;
- referred to other specialists for conditions that required special expertise; and
- facilitated arrangements for follow-up care.

Psychiatrists and psychiatric nurses identified patients with medical problems and wrote these patients' names on clipboards on each ward. The FP (occasionally accompanied by second-year family practice residents) attended the psychiatric wards each morning to review the lists, examine patients, initiate investigations, treat medical conditions, and arrange further consultations. Though the physician undertook the consultations in the morning, he was available for calls until 5:00 pm. After-hours and weekend coverage were neither funded nor formally provided, although the FP frequently made himself available by pager after hours and on weekends when this was compatible with his clinical work outside the hospital. The physician was remunerated through sessional funding (ie, non-fee-for-service) that allowed for approximately 3 hours of clinical service per weekday.

The consulting FP attempted to arrange follow-up care for patients who did not have FPs and required post-discharge care for medical issues. This benefited a substantial number of patients, given that many homeless and transient patients were admitted to this innercity hospital without identified primary care providers. Patients who did have primary care providers were triaged back to them for post-discharge medical care with written or verbal communications, as appropriate.

Evaluation

We evaluated 3 parameters of the program:

- length of stay on the 2 psychiatric wards;
- rate of specialist referrals before and after initiation of the consultation service: and
- satisfaction of the psychiatric staff.

The charts of a random sample of 40 psychiatric inpatients admitted to wards A or B in the months of June 2004 and June 2005 (20 patients for the pre- and post-protocol intervals, respectively) were reviewed. To control for seasonal differences possibly affecting the admissions profile of psychiatry inpatients, we chose to sample from matching months of the year.

Psychiatry ward staff's satisfaction with the FP consultation service was measured through an anonymous questionnaire. On a scale ranging from "Not at all satisfied" to "Extremely satisfied," respondents indicated

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their level of satisfaction with 4 aspects of the program: timeliness of response of FP consultations, appropriateness of FP consultations to patients' management plans, continuity of care for patients whose treatment included FP consultations, and quality of communication with staff involved in patients' management plans.

Program results

Length of stay. Mean length of stay for patients sampled on both wards decreased after initiation of the FP consultations protocol. Mean length of stay in the ward A sample was 36.30 days (standard deviation [SD] 20.47) before the protocol and 12.78 days (SD 6.74) after the protocol. Mean length of stay in the ward B sample was 28.40 days (SD 15.78) before the protocol and 24.70 days (SD 11.98) after the protocol. It is important to note that, while the mean length of stay of patients decreased after the consultations were initiated, mean length of stay had been on a downward trend before our protocol was initiated.

Rate of specialist referrals. Mean rate of referrals (ie, average number of referrals to specialists per admission) for patients on both wards decreased after initiation of the FP consultations. Mean rate of referrals for the ward A sample was 1.0 (SD 1.15) before the protocol and 0.70 (SD 0.82) after the protocol. Mean rate of referral for the ward B sample was 1.30 (SD 1.16) before the protocol and 0.90 (SD 1.29) after the protocol.

Staff satisfaction. Response rate to the satisfaction survey was 58.3% (28 of 48 questionnaires returned). With "Timeliness of response and appropriateness of FP consultations," 93% of respondents reported that they were very to extremely satisfied. With "Continuity of care," 89% of respondents reported that they were very to extremely satisfied. On the amount of "Communication and involvement of staff in patient management plans," 68% of respondents reported they were very to extremely satisfied.

Discussion

This model is a formalized interdepartmental arrangement that strives to make the best use of both psychiatrists' and FPs' time and expertise. It also attempts to modify the consultation patterns of hospital-based specialists by interposing generalist assessment first, to facilitate initiatives to reduce length of stay through better coordination of care for co-existing psychiatric and medical problems, to support discharge planning and follow-up of medical concerns through FP-to-FP communication, and to encourage discussion of broader shared-care initiatives between departments.

While our literature search failed to find any reports of comparable programs, they likely do exist. One of the authors worked in a similar model at a community hospital in another province in the 1980s. That program, however, had neither formalized relationships between the departments of family practice and psychiatry nor formalized processes, such as systematic identification of patients with ongoing medical needs, defined processes, evaluation, and so on.

Our evaluation showed a very high rate of staff satisfaction and a drop in the number of specialist consultations per patient. We speculate that specialty consultations initiated during the project (initiated by the FP rather than a psychiatric nurse or psychiatrist as was the case before the project) might have been more appropriate for patients' needs. Although we did not look at the reasons for consultations or mix of consultants, we suspect that the FP frequently chose not to consult specialists in cases where a psychiatric nurse or psychiatrist might have done so, but also that the FP consulted specialists in situations where a psychiatric nurse or psychiatrist might not have thought to do so. Both argue for better use of specialty services.

Psychiatric inpatients often do not have access to stable primary care. About 45% of patients in our study sample did not have FPs. Most of the problems encountered by the consulting FP, however, were within the scope of a generalist. These included newly diagnosed diabetes, HIV, hepatitis C, dermatologic disorders, gastrointestinal disorders, and respiratory illnesses.

The length of stay statistic is clearly a complex one. While it is naïve to attribute improvements to our model alone (length of stay on these wards was trending downward at the time the model was implemented), it is apparent that our program had no detrimental effects, and that there might have been a positive effect. Although a more detailed analysis of length of stay was beyond the scope of this project, psychiatric staff's impressions were that this model had indeed decreased patients' mean length of stay in hospital.

Limitations

Our current model has some limitations and potential shortcomings. Although the FP who provides most of this service often makes himself available by pager outside his scheduled time on the psychiatric wards, funding is insufficient to support round-the-clock service. Many medical concerns are not urgent, however, and can be "stacked" until the following day, so it is possible that the current hours of service are adequate for most of the medical needs. Interestingly, the hospital in which this program is located has a family practice ward with supported after-hours physician coverage. We might explore cross-coverage opportunities that could be realized with only modest additional resources. Also, although the FP consultation service has been very well received, its continuation depends on ongoing funding. Provincial fee-for-service funding does not adequately finance the program, so the alternative funding model needs to be extended.

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Some members of our department expressed concern that such in-hospital models were robbing a community already starved of FP services. Over the past 2 years, however, there appears to have been a substantial shift in such perceptions. Our members increasingly appear to view such initiatives as part of the revitalization of family practice and as one effective way to highlight the value of skilled generalists in hospital settings. Our departmental profile has benefited not only at the hospital level, but also at the regional level. It is becoming clearer to us that the involvement of department members in various kinds of hospital care makes our department richer in experience, opportunities, and value to others. This ultimately benefits not only patients but also our members.

Finally, it has been frustrating for the FP providing this service to attend to patients who do not have specific primary care providers to see in follow-up. Although he has attempted to connect such patients with follow-up primary care, it has not always been possible. Interestingly, our department has become engaged in a collaboration with the emergency department to connect patients without FPs with those of our members who are willing to accept them (with the judicious application of appropriate volume filters). It is conceivable that, in the future, we might be able to marry these 2 initiatives and provide, as a department, at least some primary care follow-up to patients discharged from the psychiatry service. In this respect, the perceived success of the psychiatry initiative has encouraged us to explore other opportunities, such as this new one with emergency.

Conclusion

We believe this program is consistent with primary care renewal principles: assignment of appropriate providers, timeliness, cost-effectiveness, comprehensiveness, and continuity of care. In fact, this program might be considered as an interesting hybrid of facility-based shared mental health care. We plan to explore the possibility of having our department provide a more formalized consultation service to other departments that require the involvement of generalists, or that require assistance with discharge and post-discharge follow-up.

One of the more intriguing developments of this interdepartmental collaboration has been the increasing willingness of both FPs and psychiatrists to explore shared-care models in the community. One such initiative is already in process. It is unlikely that this initiative would have been as practitioner-driven (as opposed to externally imposed) if there had not been adequate organization and infrastructure in the department of family practice to support such discussions and relationship building with the department of psychiatry.

The success of this program has raised the profile of the family practice department at the hospital, and we

EDITOR'S KEY POINTS

- Psychiatric units in hospitals frequently rely on various consultants to provide medical care, as the rate of comorbid conditions in psychiatric inpatients can be as high as 71%. This model of care can result in delays in discharge, fragmentation of care, and less efficient use of resources.
- In this program, family physicians provided consultations and coordinated medical care for a psychiatric inpatient unit, in addition to facilitating arrangements for follow-up care for discharged patients. On evaluation after 1 year, the authors found that the number of referrals had dropped, as had patients' length of stay in hospital. The staff were satisfied with the quality of care patients received.
- This program provides another example of the important role family physicians can play in hospitals, in this case a large tertiary-quarternary urban teaching hospital.

POINTS DE REPÈRE DU RÉDACTEUR

- Chez les patients des unités psychiatriques hospitalières, le taux de comorbidité peut atteindre 71%, si bien que ces unités doivent fréquemment recourir à divers consultants pour fournir les soins. Ce type de soins peut retarder le congé des patients et entraîner une fragmentation des soins et une utilisation moins efficace des ressources.
- Dans ce programme, des médecins de famille ont effectué des consultations et coordonné les soins dans une unité de patients psychiatriques hospitalisés, en plus de faciliter l'organisation du suivi clinique des patients sortants. Lors de l'évaluation du programme, un an après le début, on a constaté que le nombre de demande de consultations et la durée du séjour à l'hôpital avaient baissé. Le personnel était satisfait de la qualité des soins aux patients.
- Ce programme constitue un autre exemple du rôle primordial que le médecin de famille peut jouer à l'hôpital, un grand hôpital urbain de soins tertiairesquaternaires et d'enseignement dans ce cas.

are increasingly invited to participate in medical management of patients on other services (eg, in the post-fracture rehabilitation unit). In each instance, we have strived to ensure that models of hospital service permit our FPs to maintain their community practices. Finally, we believe that by entering into such service arrangements as a department, rather than as individual practitioners, we will be better able to promote both family medicine values and the value of family medicine.

Our department of family practice has successfully implemented a service that provides generalist medical care to patients in a psychiatric inpatient service. Staff satisfaction is high, patients' lengths of stay in hospital

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appear to have decreased (although this is multifactorial), and referral rates to medical specialists appear to have decreased.

Acknowledgment

The authors are sincerely grateful to Dr Gabor Maté, the family physician who provided the medical consultation service and who was the face of family practice on the psychiatry wards.

Competing interests

None declared

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