Shared Care

The Core Concept of Primary Care Renewal

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He that will not apply new remedies must expect new evils; for time is the greatest innovator.

—Francis Bacon Essays (1625)

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I would like to expand on some thoughts presented by Dr. Joseph Burley, guest editor of the Shared Care Special Feature section of the April 2004 Bulletin (1).

The strength of the shared care model resides largely in its applicability to a broader primary care renewal process. Such a process—variably questioned, maligned or anticipated—is nevertheless underway. This year’s federal election has further highlighted the issue of primary care renewal, as has the National Primary Health Care Conference held in Winnipeg in May. Mental health is, of course, an important and ongoing primary care concern.

The inextricably entwined relation between primary care renewal and shared mental health care was emphasized at the National Conference on Shared Mental Health Care held in Vancouver in early June. This fifth such conference had its highest registration ever and seems destined to continue to grow. It proved to be of interest both to a variety of clinicians and to policy-makers.

It is unlikely that primary care renewal can succeed without wide adoption of shared care principles. In fact, in the primary care renewal literature, some authors increasingly replace the term “collaborative care” with “shared care.” The term “shared care” may better reflect the fact that care is not only collaborative: it also occurs in the context of professionally distinct paradigms and scopes.

What do shared care and primary care renewal have in common?

In most respects, practising shared care is nothing more than common sense: that is, using appropriate providers, ensuring those providers are communicating and collaborating, delivering services as locally as possible and empowering and educating consumer—patients and fellow providers to enhance capacity. Perhaps the concept of shared mental health care is merely an expressed attempt to articulate and inculcate values that should in fact be system-wide. Perhaps mental health has been first targeted for shared care for no other reason than that many of the most pressing service delivery challenges exist in mental health care.

For the following reasons, shared care is the paradigm most likely to satisfy the goals of patients, policy-makers, funders, administrators and practitioners whenever primary care renewal is discussed:

• The right provider delivers the right service.
  Patients’ various needs require corresponding skill sets in appropriately trained providers with relevant professional affiliations offering specific services (for example, prescriptions, counselling, referrals and treatment). Several categories of practitioners may competently provide certain needed mental health services (assuming appropriate education, experience, credentialing and evaluation). In such situations, it is advantageous to select the most appropriate provider, with appropriateness determined by multiple factors, such as availability, interest, cost and training.

• Providers collaborate and cooperate.
  In a shared care model, providers must communicate with each other. This breaks down barriers, misconceptions and biases and creates synergies that make the outcomes of this team approach greater than the sums of their individual parts. When patients see that professionals are collaborating, they receive both implicit and explicit messages that are indeed powerful and perhaps therapeutic in themselves.

• Access is more local and more timely.
  Ideally, patients receive care in their family physician’s office, or at least within their own communities. Moreover, patient prioritization and triage is improved, since the specific practitioner requesting help is empowered to schedule it.

• Educational opportunities exist.
  Many think that interdisciplinary training opportunities will increasingly consitute the educational model of the future, so that health profession students will be better prepared to work in a system that will increasingly require collaboration. Thus shared care settings are the most likely future training sites, or alternatively,
existing training sites are more likely to become implementation sites for shared care.

- Professional development opportunities exist.
  Most of the relevant professional licensing bodies and associations acknowledge the importance of interdisciplinary collaboration. Where better to acquire and exercise such professional skills than in a shared care setting?
- All providers are validated or affirmed.
  This may be vitally important in educating the public to use a broader range of appropriate mental health service providers. Currently, the public can be indiscriminate or biased in its selection of providers, resulting in suboptimal outcomes. Yet, who can blame a public exposed to turf battles and access problems?
- Care is co-coordinated.
  In Canada, family physicians most often coordinate care, for varied and often complex reasons. Although some would debate the merit of this, there is no question that in the minds of most patients and policymakers there is great comfort and confidence in having such skilled generalists (who often are able to provide definitive treatment as well) fulfilling this role.

What are the benefits of shared care?
In general, the quality of health care and system sustainability tend to improve when providers work up to their potentials—when they provide care of a complexity consistent with their training—within a collaborative environment. Increasingly, outcome evaluative data confirm the benefits to patients, care providers and such system parameters as access. Because shared care models are more likely to “case find,” the impact on cost is less clear (although for patients already identified as being in the mental health system, cost savings due to shared care human resource efficiencies probably exist).

How to begin?
Fortunately, shared care can be implemented incrementally according to interest and opportunity. It does not usually require significant change in office flow or practice pattern. Ministries and (or) health regions are often willing to explore alternate payment schemes where requested. Ministries are also generally more likely to be sympathetic to funding requests designed to minimize practitioner isolation. A quick review of successful primary care transition submissions will illustrate the importance the government places on connectedness and networking.

What are the barriers to shared care?
Of course, there are barriers and even dangers in embarking on any new model. Ownership is a big one. Hopefully, we are moving beyond this. Other barriers include lack of, or poorly configured, supporting infrastructure such as appointment scheduling, travel time, reimbursement models, conferencing and patient education, to name but a few. Learning to work in a new system requires energy and commitment. Isolated practice styles (too often a reality for those physicians not in groups or not affiliated with hospitals) may be attractive to maintain for the “wrong” reasons—a fact probably true of psychiatrists and family physicians alike. Paradoxically, family physicians, who collectively have the greatest capacity in terms of sheer numbers and geographic dispersal, are often the most isolated.

What is currently happening?
It is fascinating to observe how certain communities have resisted moving toward shared care and how others have embraced it. We know that, where shared care has been attempted, it has persisted as the model of choice for mental health service delivery. More and more sites continue to define, develop and implement shared care models relevant to their settings. Increasingly, shared care learning environments are being developed and made available to trainees. This is happening to a variable extent in all provinces.

Communities not moving toward shared care may want to define whether the barriers rest with family doctors, psychiatrists, other providers or the system (which includes payment mechanisms, professional cultures, opportunities, policy-makers, supporting infrastructure and awareness). The good news is that shared care can begin with no more than an interested family physician and psychiatrist.

Making shared care opportunities available is a valued, meaningful and symbolic way of supporting the activities of those primary care physicians who continue to provide mental health and other comprehensive services. Supporting such physicians also advances the so-called primary care renewal agenda, as does locating more specialized mental health providers and expertise in the community setting. The catalytic impact on primary care renewal of co-locating mental health providers with family physicians cannot be overestimated. While this is often only one possible element of shared care, it can be a most important one.

Invariably and repeatedly, family physicians state that access to on-site mental health counselling services, along with improved access to psychiatric consultation (also ideally on-site), would significantly allow them to improve patient capacity, wait times and patient and practice satisfaction.

Moving Forward
Primary care reform and shared care implementation are inseparable. We cannot have one without the other. The “shared care train” has left the station, is picking up steam and isn’t likely to brake soon. Failure to board will almost certainly result in increasing professional and educational isolation. Recognizing this, some specialty programs other than psychiatry have already begun to explore shared care models with family physicians. The Romanow Report made this same point, using different words (2).
None of this is rocket science. We need to roll up our sleeves and make it happen.

In future issues of the Bulletin, Dr. Burley and I will collaborate to provide articles from both generalist and specialist perspectives. My hope is that future articles within this section will contribute to the ongoing maturation of the shared care concept through timely comment on the following topics, among others:

- methodology to facilitate more integrated and continuous care that can be applied to shared care
- evolution of the professional and educational boundaries of specialists and generalists within models of shared care
- relevant and interesting projects demonstrating shared care
- evaluative initiatives and critical appraisals of shared care
- funding opportunities for shared care
- Canadian health care system evolution and its interplay with shared care

References