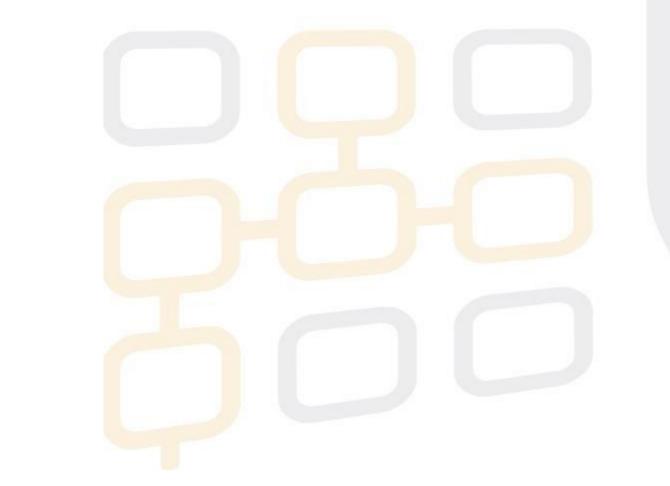


Primary care provider perceptions of the challenges of managing patients with mental-physical multimorbidity: A qualitative study

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Introduction

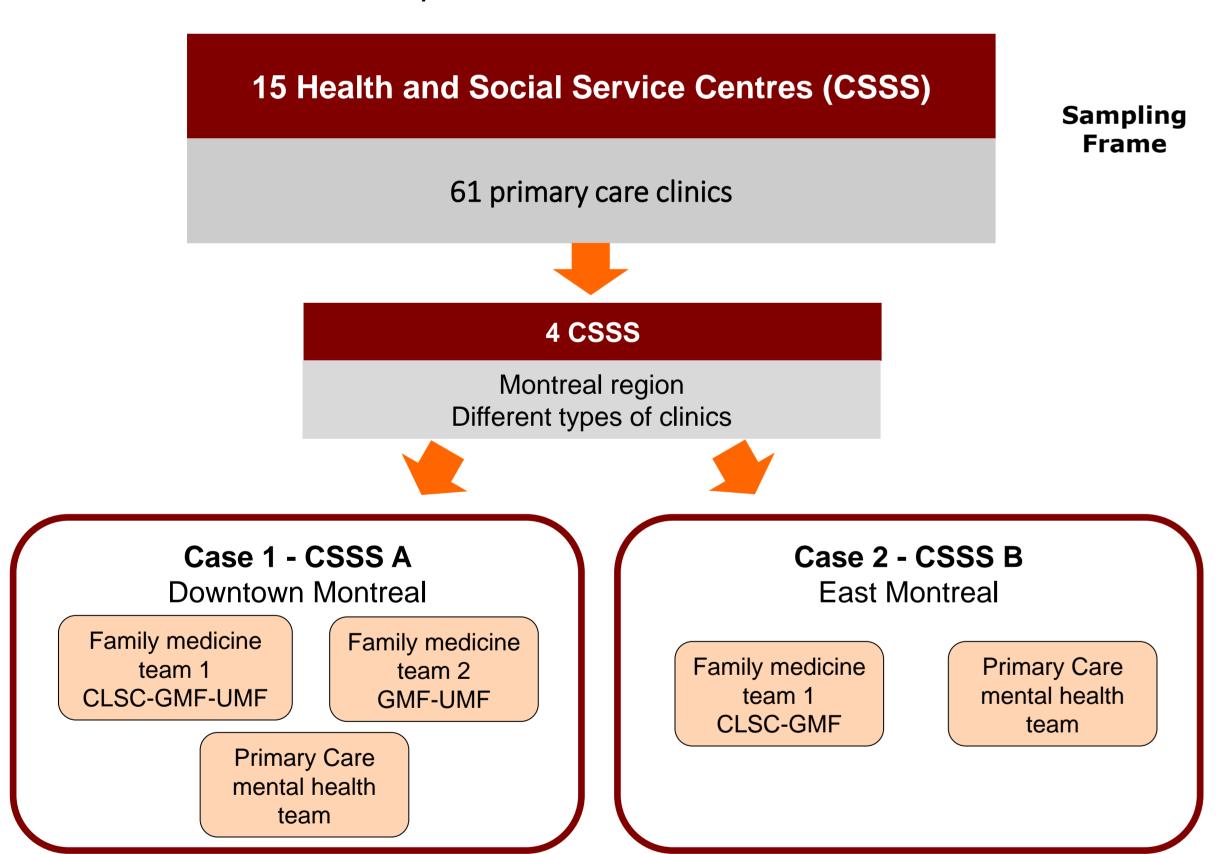
- Every year, more than 1 out of 10 Canadians are directly affected by mental illness and more than half of these individuals also suffer from one or more comorbid chronic diseases^{1,2}
- Mental-physical multimorbidity is a commonly encountered phenomenon in primary care settings³
- There have been few studies exploring primary care providers' experiences managing patients with mental-physical multimorbidity and the unique challenges they face in trying to deliver high-quality care to these patients

Objectives

 To explore primary care providers' perspectives on patient, provider and organizational factors that challenge the delivery of high-quality care to patients with mental-physical multimorbidity

Methods

Design: Study was conducted as part of a multiple case study with embedded units of analysis



- **Data collection**: Semi-structured interviews, observations, documents
 - 1) Interviews: 16 interviews (9 CSSSA, 7 CSSS B) with family physicians, psychologists, nurses, social workers, a psychiatrist
 - 2) Observations: On interview days clinic location, office layout, meeting rooms, information technologies, etc.
 - 3) Documents: Written descriptions of services, annual reports, etc.
- Analysis: Thematic analysis (deductive & inductive) guided by conceptual framework drawn from the organizational sciences literature on Knowledge Management

References

- . Pearson et al. (2013). Mental and substance use disorders in Canada. Health at a glance. Statistics Canada. 2. Wang et al. (2010). The incidence of major depression in Canada: The National Population Health Survey. The Journal of Affective
- Disorders, 123, 158-163.
- 3. Barnett et al. (2012). Epidemiology of multimorbidity and its implications on health care, research, and medical education: A crosssectional study. Lancet, 380, 37-43.

Results

Structural characteristics

Work structures, roles and responsibilities, resources, training programs, physical workspaces, etc.

Time constraints

"The biggest challenge is time. How do you manage all those things in the context of a single medical consultation? (...) the patient is very depressed, so I provide a follow-up for their depression, which presents with symptoms of diabetes or which presents with symptoms of another disease, I have to decide how I attend to each of these problems (...) And sometimes it's pretty difficult. I sometimes get the impression that I'm neglecting either the mental health part or the chronic disease part because of time. " (GP1C)

Role of primary care mental health teams

"And they'll say, oh we don't offer that kind of service. We provide short, intense follow-ups or whatever. Okay, but that doesn't work in primary care. (...) But for me it's the biggest challenge of primary care and presently all that we have in terms of supports for family doctors in mental health it doesn't address that issue which is how can I maintain a long-term relationship with someone who has both physical and mental health problems. It's (the system) is not built as a function of that, it's built as a function of diseases and when they're not too sick we stop following them..." (GP2C)

Epistemic characteristics

Clinic attributes or practices that allow people to be exposed to new ideas and build common knowledge

Lack of interprofessional care

"Often, people who have multiple diseases, several different diseases, they have several clinicians. So if there's an occupational therapist in the case, a social worker or a nurse, well then there's division between the clinicians and between them and the doctor. If the person has a cancer then there's people from oncology that are involved, and so there's this whole division that happens and people don't know what to do." (NU1A)

Lack of interprofessional communications

"I wish the GP would contribute more in terms of the information he provides. You know we nourish them a lot, we do a complete case history, we make conclusions, we direct them, we have indicated the current disease and current medication... (...) I allow myself to send progress notes to the GP (...) I think it's important that he knows what I'm trying to do and what have I seen in the patient's evolution. I would like the GP to nourish me in the same way " (PSY1A)

Technological characteristics

Information technologies that support the flow of knowledge in the clinic

Poor electronic medical records systems

"It's been ages that we've wanted an electronic medical record except that what they've offered us it's laborious, it's an old technology, we need to keep five tabs open and move from one to another, it's slow, passwords every two seconds... We're frustrated and we don't feel that anyone is listening. (...) we realized that we had to adapt to their system rather than their system adapt to us. (...) There's no text software, no way to add pictures on our pages... it's very basic. (...) And we find it annoying to put so much energy into doing something that's so outdated." (GP3B)

Practice Ecosystem Domain

Epistemic Structural characteristics characteristics

Social Technological characteristics characteristics

Quality of care

Social characteristics

Social relationships, inter-organizational linkages, values and norms of trust and mutual support

Lack of trust in some teams

"...there are case discussions offered on Wednesday afternoons and until now this element of climate of trust and group cohesion, I don't perceive it at the moment. It's not a place where I'll confess things. It will be more a place for more practical aspects, I need this type of resource for a client living with this and that, does anyone have any ideas?" (SW1A)

Central access point problems

"... the problem with the GASM (central access point) is that we don't know what's going on. (...) We send a patient there and then we don't hear anything. It's like a black box. (...) we see the patient once a month and they say yes a social worker called and said that I would see a nurse... But we don't know what they're doing and it's a problem for us because it's difficult in terms of continuity of care.' (GP2C)

Patient domain

École de santé publique

Université m

de Montréal

Social morbidity

..one of the major challenges is poverty. (...) poverty is a precipitating, perpetual aggravating factor for all medical conditions. 80% of my patients are very, very poor. So they cannot have access to care that is not covered by the government (e.g. psychotherapy)." (GP3B)

Feelings of powerlessness

"What's really complicated about people who have mental-physical multimorbidity is that it's something that lasts and people often feel powerless. (...) they have already gone to the pain clinic, they have gone to groups to manage pain and they've already received treatment for their pain (...) They are treated for depression, for their chronic pain and a number of things have been tried. And so people often arrive and they've already tried a lot of things and so there's a low fewer things left to try." (SW1A)

Patient Domain

Sociodemographic info. Conditions and comorbidities Attitudes and beliefs Knowledge and experience

Attitudes and beliefs Knowledge and experience Discipline of practice Training

Clinician Domain

Clinician domain

Medical training versus reality

(on comorbidities) "... he might have depression but I'm not sure so the challenge is being able to separate all that, which we are rarely able to do. (...) So that's the challenge. Those things are often together and it's not like we were taught in medicine." (GP2C)

Scope of practice

"If they have something like diabetes or hypertension or... things like that, we have a GMF nurse that can take care of certain diseases like that. (...) like before I had to call the patient every three days to increase their insulin, they'll do it, they will call or see the patient. So that means there's less for us... (...) So arthritis, there's not many people who can care for it, so it's us, the nurses are not good at that. Different things, different problems that people have it's us that takes care of it..." (GP1B)

Quality of care

Family medicine teams

(on psychotherapy) "...there are a lot of needs that are not met. As soon as the patient cannot go into the private sector, generally speaking it gets more complicated. A patient who has an exacerbation of their anxiety at a time in their life or has a depression at a certain time in their life, we make a request for service from the (primary care mental health team) and then after that has a few meetings there, six, seven, eight meetings over there, it's all they can offer people there. (...) But as soon as we talk about chronic problems and the person can not receive care in the private sector, it's very rare that things go well." (GP1C)

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Primary care mental health teams – access vs quality

(dealing with waiting lists) "...the last instructions since the end of the summer, the instruction is for all files that have lasted a year or more, look and see how you can close them. For sure there may be an opening from case to case but we can't have many of them. So that is tightening up and it's making it complicated, it's limiting how we can follow those people over the long-term. And I asked the question, from an organizational perspective, how and where are we going to direct these people?"

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Conclusions

- Factors at patient, provider, organizational and system levels make it challenging to manage primary care patients with mental-physical multimorbidity
- There are challenges related to providing comprehensive, patient-centred treatment and longer term care
- Major breakdowns in interprofessional and integrated care for these patients

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