A Functional Conditions Care Network in Nova Scotia: Executive Summary

Nova Scotia Planning Group for Functional Conditions. September 30, 2018

Functional Conditions (FC): Functional Conditions is the term used for physical symptoms with no discernable structural causes such as cancer. These conditions include irritable bowel syndrome, headaches, unexplained pain, pseudoseizures and a range of other conditions. These conditions can co-exist with structural conditions, like cancer or MS, and produce a worse outcome.

Burden of Functional Conditions: In Nova Scotia the direct health system and insurance cost is over $600 million per year including 1/6 of all emergency visits, 1/2 of new medical consultations, 1/10th of admissions and up to 1/2 of family practice visits. These conditions result in excess investigations, medications, use of procedures, wait times and hospitalizations.

Current situation: The Centre for Emotions and Health is a Halifax service providing tertiary level psychotherapy for a limited number of patients with FC (total staff is 2.8 FTE) who are going to emergency departments, hospitals and specialists in the province. Patients from outside of Halifax are challenged in that they have to drive to Halifax for treatment. The treatment method used at the centre, called ISTDP, has been successfully applied to severely impaired people with FC, disabled workers, community services benefits recipients, frequent attenders to emergency department and in the Family Practice Units at Dalhousie University. The service to emergency departments in Halifax is a Canadian Leading Practice with Accreditation Canada. Summaries of cost data from these implementations is following:

Location (Number patients)	**Service Use % Reduction**	**Pre vs post Cost Difference**
Queen Elizabeth II Emergency Department (n=50)	69% drop in repeat emergency visits	$45,500 by 1 year later
Centre for Emotions and Health (n=890)	31% reduction Doctor costs 71% reduction in Hospital costs	$11,303,000 by 3 years later
Dalhousie Department of Family Medicine (n=87)	32.4% drop in Family Doctor use 37.5% drop in Emergency use	$37,930 by 2 years later
Psychiatry Residents Cases (n=140)	36% Reduced Total Doctor/ Hospital Costs	$528,000 by 3 years later
CDHA Occupational Health referred cases (n=18)	87% successfully maintained work	$240,000 by 2 years later
Community Service Clients (n=65)	No longer requiring DCS Support	$740,000 by 5 years later
Workers Compensation referred Cases (n=188)	56.4% return to work after nearly 2 years disabled (cases seen more than consult)	$5,285,800 by 2 years later

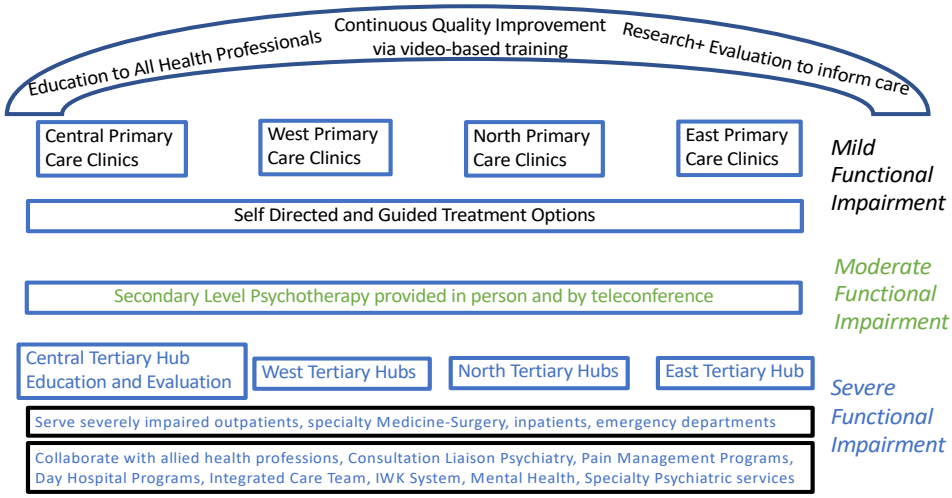
A three-year implementation of a collaborative care approach in the Dalhousie Department of Family Medicine found that doctors had improved confidence and less anxiety treating FC after training.

Working group: A 23 person working group was struck including medical specialists, a surgeon, primary care professionals, a nurse, a physiotherapist, psychologists, psychiatrists, administrators and 4 members of public. We reviewed the available evidence, communicated with others in the system and got feedback on developing proposals to craft a detailed *Guidance Document* which informs this recommended plan. CBC Radio and CIOE Radio interviews were aired and a website

www.nshealth.ca/mus was created for public input. Newspaper articles with the Globe and Mail and Herald are in process.

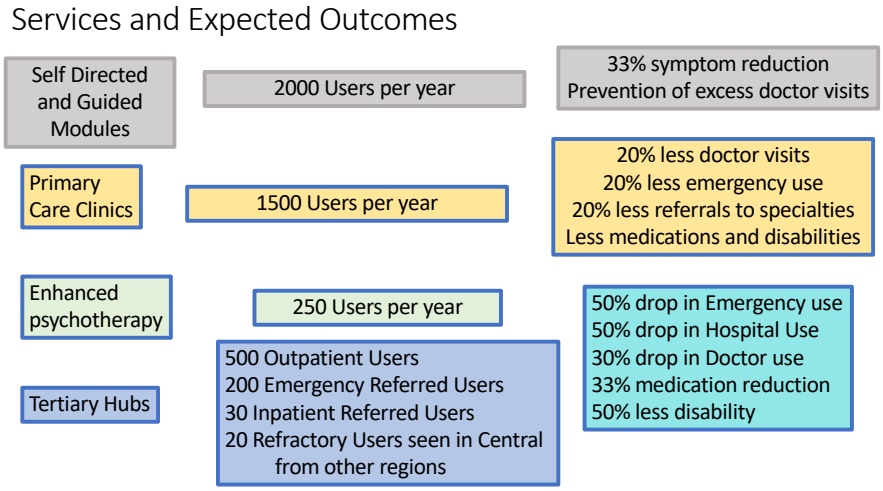
Main Partners: The main partners in this proposal are Greg Archibald, the Head, Department of Family Medicine, Sam Campbell, Chief of QEII Emergency Department, Kevork Peltikian (Gastroenterology), Roger McKelvey (Neurology), Volodko Bakowsky (Rheumatology) and the Centre for Emotions and Health. Even while there may be philosophical or priority differences in some cases, collaborative working relationships will be enhanced with Pain Management, Integrated Chronic Care, C-L Psychiatry and Mental Health Services. *Letters of support* are attached from the Chief of Emergency Services for Nova Scotia, the Executive Director of Community Services, Choosing Wisely, the Canadian Mental Health Association, the Doctors Nova Scotia Section of Primary Care, the Central Division Chief of Medicine, and the Dalhousie Dean of Medicine. See *Guidance Document* Page 2 for listing of working group members and those consulted.

Recommended Network Model: We propose a tiered model beginning with education support to health professionals, training of primary care workers to assess and counsel patients, self-directed and guided treatment modules. For those with more severe impairment, we recommend evidence-based and advanced psychotherapy methods based on evidence derived from research in Nova Scotia. The objective is a model program with thorough evaluation and a high degree of training and quality assurance throughout. It will enhance skills in Primary Care Practitioners, enabling collaborative care for patients with lower levels of impairment. See Page 10 in *Guidance Document* for Detailed Proposal.



Staff Recommendations: We recommend 5 tertiary level therapists be deployed in five regions of the province to reduce travel times or severely impaired patients. These therapists will provide inpatient, specialty-linked and emergency-based clinics in these five regions. It is recommended that the tertiary services in Halifax be extended (adding a psychiatrist and 1.6 psychologists) to provide an adequate level of local care since the bulk of people with functional conditions live in Halifax: this will allow service in specialty medical-surgical clinics and inpatient services who are the highest service requiring populations in the province. A second tier of therapists will provide mid-level evidence-based therapy to those with moderate impairment: some of these therapists would provide telehealth-based services for those unable to attend an office. As the more severely impaired patients are on multiple medications

and have multiple co morbid illnesses, 1.0 FTE trained family physician will be hired to team up with tertiary therapists in these five hubs. Finally, an increase in administrative support enabling a single-entry point would replace the existing 0.5 position, 1 fulltime technician to oversee evaluation would be hired to replace an existing 0.4 post and a 0.5 online media person to develop and maintain online resources would be hired. Once fully staffed, expected service loads and estimated service use reductions are following:



Evaluation Methods: Evaluation methods will include patient self-reports, satisfaction measures, utilization measures, counts of cases, wait times, work status, feedback from students in education events and medication status. Treatments will be supervised by video review. Periodic evaluation of health care utilization pre and post will be performed. An online evaluation method will be sought to make data collection and analysis easier. Details of the evaluation plan indicators are on page XXXX.

Benefits to Patients and the Health System: Patients treated in the service should function better and feel better both physically and mentally. The service should help reduce emergency, doctors and hospital usage, disability payments, medication use and investigations. It should thereby reduce harm from unneeded medications and procedures. It should help to reduce wait times for these services and parts of the health system. It should more fairly distribute care in the province for those in the most need thereby reducing travel costs. Through education, skill building and reduction of unnecessary visits, it should improve the quality of primary care practice. It should exemplify collaborative care in medical practice. Finally, it should showcase the health care innovations being developed in Nova Scotia to lead the country.

Costs vs benefits: Once phased in, this plan will cost $1,815,000 annually. The hiring will take place over the first 2 years. The expected minimum health service, medication and insurance cost reductions are expected to be $5,000,000 per year accruing year on year: these are conservative estimates based on 21 studies of the cost effectiveness of the core treatment we will provide. While some of these are indirect or virtual savings, medication and disability cost reduction for government/NSHA employees and those on community services or workers compensation are actual dollar savings. We will be able to adjust these figures when we see the cost effectiveness of primary care counseling, self-directed modules and guided self-help as estimates on the cost benefits of these modules is lacking in the current literature. These figures, with phasing in counted, suggest a payback period of 2 years with a 5 year Return on Investment of 400%. Please see *Business Case* for details.