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POSITION PAPER

Elements of Care—Indirect Services in Psychiatry

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Context

The Canadian Psychiatric Association Economics Committee (CPA-EC) has developed numerous papers describing psychiatric service provision in different models of care (for example, fee-for-service and alternate payment plans). This approach examines clinical care provision in a vertical fashion, aligning with the practice model of the care provider. Another way of analyzing clinical care is to consider what patients need for appropriate psychiatric care regardless of practice model. This approach examines care in a horizontal fashion, by identifying common elements necessary for appropriate psychiatric care in any model or blend of models. This paper is the first of a planned series of Elements of Care papers identifying relevant services needed across all models of care to allow delivery of appropriate psychiatric services.

Definition

Traditional care approaches, especially in fee-for-service models, have heavily focussed on provision of direct patient care, meaning the physician is in the

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same room at the same time with the patient. Indirect services refer to services performed without the direct physical presence of the patient. These services may be for diagnostic assessment, treatment, or other patient management. These services have also been variably referred to as non–face-to-face services, third party communications, or other terms. Many of these other terms are excessively narrow or potentially confusing. For example, indirect services may include face-to-face interactions with a patient's family or other care providers, or they may involve interaction with the patient (rather than third parties) on the phone. For purposes of this paper, the term indirect services will be used in lieu of these other terms.

While indirect services is the preferred term for describing these forms of care, it is also open to potential misinterpretation. First, there may be a pejorative connotation that indirect services are somehow inferior to or less important than direct services. It is important to understand that indirect refers only to the method of service provision, not to its importance; indirect services are directly necessary for patient care, especially in psychiatric care (as outlined below).

Second, while indirect service and indirect care can often be used interchangeably, the term service is deliberately used in this paper rather than care, as it is important to realize that the psychiatrist is providing an actual service necessary for patient care, even if the patient is not in the same room.

Finally, the indirect services referred to in this paper refer to elements involved in providing patient health care; they are not meant to include communication with third parties for other purposes (for example, in this paper indirect services do not refer to insurance or legal reports written for third parties).

Unique Importance of Indirect Services in Psychiatry

Some degree of indirect service would be necessary for patients requiring many types of medical care. However, there are several factors unique to psychiatric care that lead to higher levels and increased importance of indirect services for people with mental illness.

The nature of psychiatric illness itself is one of these factors. Psychiatric illnesses can impair cognitive ability, including memory and recall, communication skills, insight and judgment, orientation and thought processes, and, in the context of delusions and hallucinations, even reality testing. Psychiatric illness can also impair interpersonal dynamics, leading to suspiciousness and paranoia, splitting and acting out behaviours, extreme defensiveness or other dysfunctional dynamics. All these issues may interfere with the clinician's ability to obtain accurate information from the patient for assessment and to engage the patient for treatment and management. Indirect services involving the patient's family, community partners or others become essential in these situations, or proper psychiatric care cannot be provided.

It is important to emphasize that the issues that lead to a high need for indirect services are linked to the very reason the patient is requiring care in the first place—their mental illness. Expecting proper psychiatric care to be delivered in such situations without the ability to provide indirect services would be akin to a patient seeing a cardiologist for evaluation and management of chest pain but the cardiologist being unable to obtain an electrocardiogram (EKG), pulse or blood pressure.

Another reason high levels of indirect services are necessary in psychiatric care relates to the goals or outcomes being sought. For example, in the case of a hospitalized patient with agitated delirium, an initial goal would be behavioural stabilization. Appropriately and safely managing all the clinical and environmental factors impacting the patient's delirium and behaviour might involve far more work in the nursing station with the medical team rather than being directly in the room with the patient. Similarly, a patient who is suicidal and wishes to kill themselves may not fully convey relevant information, and hearing from a spouse that the patient has been hoarding pills for weeks, for example, would be essential in properly assessing suicide risk.

Thus with psychiatric illnesses, the very illness for which the patient requires help can interfere with proper assessment and treatment, and the absence of indirect services would preclude proper and safe management. The above examples illustrate that indirect services are a direct and necessary part of psychiatric patient care, and, in fact, have a unique importance for people with mental illness.

Consequences of Lack of Indirect Service Availability

In addition to the general concerns described above regarding the negative impact on psychiatric patient care without the availability of indirect services, specific psychiatric patient populations would be particularly disadvantaged in models lacking indirect services.

Patients with more severe mental illness, for example, those with schizophrenia, psychosis or severe cognitive impairment, require higher levels of indirect care, thus

lack of indirect services has even greater negative impact on care of those most in need of care. Certain patient populations, such as children or the elderly with dementia, also require particularly high levels of indirect care, and their care also suffers when indirect services are not available.

Finally, from a systems perspective, clinicians may be inappropriately blamed for gaps in care if necessary care is not provided; yet, in reality, a model of care that does not explicitly acknowledge and allow for indirect service provision fails to provide clinicians the tools needed to provide proper psychiatric care (for example, not being able to communicate or engage in necessary collaboration to ensure safe transfer of care for high-risk patients being discharged from hospital or the emergency department).

Types of Indirect Service Provision

Indirect services can be provided in many ways, including, but not limited to, those listed below:

Directly to the patient without being in the same room —directly indirect

This would include communicating with the patient over the phone, videoconference or other electronic communication. While not all phone interactions should be considered indirect care (for example, setting up appointments), and some can reasonably be considered similar to indirect care provided for any medical illness (for example, discussing medication side effects that emerge between appointments), some directly indirect interactions are unique and necessary to psychiatric care (for example, speaking with a suicidal patient on the phone may involve active patient management and safety issues).

Benefits of directly indirect services may include improved access (including in instances of geographic isolation), rapid response, clinical support between appointments, improved adherence, and cost savings (for example, by increasing preventative care and effective triaging, or through reduction of emergency department visits or hospitalizations).

With family, community partners or others

This can be either indirectly direct (for example, meeting with the patient's family members) or indirectly indirect (for example, speaking with police officers over the phone to ensure patient safety). These interactions can be important for getting information to obtain an accurate history and formulate an assessment, and are essential as active parts of management, especially for patients with cognitive impairment, impaired reality testing or behavioural risk such as suicide. Additional benefits of these services include improved monitoring and safety, as the family, community partners or others can inform the clinician of deterioration that may occur between appointments.

With other care providers involved in patient care

Again, these can be indirectly direct (for example, meeting with the clinical team) or indirectly indirect (for example, discussing a patient's management over the phone in a collaborative care model). These interactions can be particularly important in chronic illness management or where the target of management is behavioural.

Further benefits of these services include improved collaborative care, safety (for example, necessary pharmacist contact with the clinician), improved patient management (especially with multiple morbidities or medical diagnoses), leveraging skills of involved health care providers and optimizing providers' roles in the patient's health care management.

Reviewing other relevant information necessary for patient care

This could include reviewing results of personality testing, psychometrics or other evaluation tools. Results and interpretations from such measures can be lengthy and require significant time and expertise to assess, and should be considered as important and necessary as evaluative tools that are used in other areas of medicine (for example, computed tomography–magnetic resonance imaging or other scans, EKGs and diabetic glucose monitoring).

Incorporation Into Models of Care

The various types of indirect services cited above should be part of every model of care, to allow for proper assessment and management of psychiatric patients. Indirect service provisions can be introduced into any model of care, regardless of type of funding.

Historically, medical funding models, especially in fee-for-service systems, have had little, if any, acknowledgement of the value of indirect services. This may be partly due to the fear of funding bodies that, for example, clinicians would sit around talking on the phone all day. This misperception is particularly ironic, as psychiatric services have traditionally been far more time-based than other medical speciality services (with the exception of Quebec), and the clinician essentially bills for time spent providing a service. The potential for

double-billing or inappropriately increasing billings by manipulating billing codes is inherently limited in such a time-based system, and necessary psychiatric services should be remunerated, whether provided directly or indirectly. Proper implementation of indirect provisions, with an appropriate balance between identifying specific care being provided and not being overly restrictive in definition, further minimizes the risk of inappropriate use of such provisions.

Adequate acknowledgement of indirect codes in service models also helps minimize systemic gaps that may otherwise develop in those models. For example, strict adherence to remunerating only for direct care undermines collaborative care models that are increasingly important, especially in chronic disease management. Fee-for-service models have sometimes been regarded as being unsuitable for collaborative care, but this reflects a lack of available indirect codes that would otherwise allow for communication between health care providers, rather than reflecting inherent structural deficiencies in the model. Collaborative care is not the exclusive purview of any single care model; it can be part of any model, so long as the model has suitable indirect service provisions.

As psychiatrists in different jurisdictions increasingly work in multiple funding models, it is important that indirect service provisions are part of each model of care to ensure that patients with mental illness receive appropriate and necessary care.

Note: *An appendix of specific examples of indirect care provisions in various jurisdictions is being maintained by the CPA Economics Committee separately from this document, as the purpose of this document is to outline principles relevant to indirect service provision.*