Use of a Health Planning Conference in a Family Practice

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Many factors, including economics and training, have an impact on the process of addressing mental health and preventive health concerns of patients. Cassata et al[1] and Noran et al[2] have documented an apparent discrepancy between the diagnosis of and therapeutic initiative for psychosocial or mental health problems of family practice patients. Moreover, the prevalence of psychosocial and mental health problems is high.[3-5] Better integration of medical and counseling care has been called for[6,7]; one study has shown that patients are more likely to seek help from a mental health professional linked closely with a family physician.[8]

This study reports briefly on the use of an interview process for new, unestablished, nonurgent care patients entering a private family practice clinic. Along with physician and patient, a counselor and a nurse participate in an initial conference (20 minutes for a single patient, 30 minutes for a couple) to establish health care. The intent of the initial team interview is to use the counselor as a front-line participant in the diagnostic process with the physician and nurse educator, and the purpose of the study is to evaluate (1) the implementation of such an interview process into the operations of a private family practice medical and counseling clinic, (2) patient and staff acceptance of the tool, and (3) sensitivity of the conference to mental health and preventive health needs.

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Methods

The interview process was called a health planning conference.[9] A health inventory and bro-

chure (describing the intent and cost of the conference) were developed. Receptionists recommended participation in the conference to all new, nonestablished patients calling for an appointment. Receptionists relayed the informal nature of the conference, the cost, and the opportunity to get to know the staff and relate "all of your health concerns." The health inventory was sent by mail to be completed prior to appointment time. New patients being seen for immediate care needs were introduced to the conference following their initial appointment and were encouraged to schedule a conference. The conference was not introduced to those in crisis or to those unable to participate because of communication disability.

The conference was purposely not used as a replacement for a medical history or counseling intake and was directed by the concerns and input of the patient, whether the concerns were physical, psychosocial, preventive health, or a combination.

Evaluation included (1) poststudy review of the conference summary forms, and (2) review of a one-page, 12-point anonymous questionnaire sent to all participants within nine months of their conference.

Results

Sixty conferences took place over a nine-month period, with 57 percent of new patients aged over 18 years choosing the conference as a means of beginning their health care. Seven conferences involved married, engaged, or related couples. Three conferences were excluded from the study for protocol inconsistency. Thus, 57 conferences including 64 patients were evaluated. Forty-nine of the 64 questionnaires sent out were returned (76 percent response rate). Respondents did not differ from nonrespondents in economic status, sex, marital status, age, or religious preference.

Sixty-six percent of participants were female. The median age was 29 years with a range of 20 to 74 years. Three patients were aged over 60 years. Fourteen percent were on welfare; the remaining were fee-for-service patients.

Staff evaluation was favorable. The conference was easily integrated into the scheduling of the physician, counselor, and nurse and was enthusi-

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astically presented to patients by the receptionists once they understood clearly its intent. The staff felt that health concerns were often uniquely clarified through the team approach. Moreover, the team dynamic allowed suspension of the boundaries of the physician's medical focus to permit a more wholistic diagnostic process.

There was either unqualified satisfaction (98 percent) or high satisfaction with the care modality by those patient respondents requesting service at the clinic who chose the interview process. Ninety-seven percent were either very satisfied or satisfied with their level of personal involvement in the process, 92 percent were satisfied or very satisfied with their treatment plan, and 48 of 49 respondents would positively recommend the conference to others. Fifty-five percent of respondents felt the conference would be valuable as an annual event.

Analysis of the 57 health plans was used to determine sensitivity of the conference to counseling needs. Seventeen participants (27 percent) were referred to counseling directly, and an additional six (9 percent) were referred to a support group (eg, Alcoholics Anonymous, Weight Watchers).

Analysis of recorded health needs of the participants was used to determine sensitivity to preventive health concerns. Fifty-six (24 percent) expressed concerns having to do with health promotion needs. It was the staff's experience that the conference provided an opportunity in a busy practice to stop and affirm the singular value of a person wanting to achieve a higher level of wellness. The conference also provided a starting point for the nurse educator to schedule health education sessions in such areas as weight control, nutrition, stress management, and smoking cessation.

Comment

This study has limitations. The determination of whether three professionals are better than one in identifying and addressing counseling and preventive health needs has not been made. The percentage of counseling referrals made through the interview process appears high, however, when compared with the diagnosis of and therapeutic initiative for mental health problems of family practice patients elsewhere.[1,2] The high referral rate could be explained either, as Kiraly[8] suggests, by the accessibility and presence of the counselor in the family physician's office or by the use of a counselor as a front-line participant. Of 118 adult patients who were offered the conference over a nine-month period, 67 chose the conference. Those choosing the conference may be more interested in counseling and self-care, or they may simply be following the physician's recommendation in defining the nature of optimal care. No attempt was made to demographically or diagnostically compare those who chose the conference with those who did not.

Uses for the above-described interview process in family practice that should be explored include (1) identifying counseling and wellness needs, (2) validating a less expensive counseling and preventive health screening modality, eg, a health inventory, (3) clarifying complex psychosomatic problems using a biopsychosocial model, (4) clarifying which counseling needs naturally rest (by patient perception) with the counselor and which rest with the physician, and (5) making available an integrated medical and counseling modality of care for research and educational purposes either in or out of training programs.

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