

**South Eastern Ontario LHIN
Community Forum
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Background/Context

- Ministry “transformation” activities (future?)
- LHIN activities at the regional level
- FHT at the local level
 - We presently have 5 FHT’s in our immediate region with more than 100 family physicians and about 15 N.P.’s.
 - In S.E. Ontario 15 FHT’s and several CHC’s
 - 2 psychiatrists (in the Kingston area) so far, employed by FHT’s
 - Currently exploring new & enhanced programs & services, including M.H.
 - Networks and linkages are identified as key
 - “wider range of and improved delivery of services”
 - Excellent model of primary health care delivery



What will a FHT do?

Ministry expectations of FHTs:

1. Comprehensive care
2. Patient-centred care
3. Expanded access
4. System navigation & coordination
5. Emphasis on health promotion and
6. Chronic disease management
7. Linkage with other healthcare organizations at the community level, and be adapted to the needs of the specific community through some form of participation at the governance level
8. Use of IT to support system integration

What new or enhanced services are being explored?

- **More effective care and improved health outcomes** through a team approach that will network us with local and outside experts to provide care, starting with:
 1. Mental Health team care
 2. Diabetes team care
 3. Chronic Lung disease care (asthma, COPD)
 4. MSK team approach
 5. Children's Services including adolescent outreach



MOHLTC backgrounder on FHTs: Guiding Principles

- Flexibility :“...tailored to meet the needs of the local population...”
- Community and provider partnerships: “ community representatives, local health care delivery organizations and HCP will be encouraged to work together to develop FHTs that reflect the unique needs of the population served & develop collaborative local working relationships that will enhance access & continuity of care”.
- Interdisciplinary Team Care tailored to the size and the needs of the population served

Guiding Principles of FHT's

- Rostering and population-based health planning
- FHTs will progressively evolve- balancing evidence, continuous re-evaluation, flexibility for innovation & responsiveness to community
- Stakeholder & community input and consultation will maximize acceptance and commitment to common goals, respective responsibilities, and mutual accountability



Shared Mental Health Care

Why Primary Care?

- In North America the prevalence of mental illness in the community is about 25% (higher if we include disabling 'subthreshold' psychiatric illness)
- Of those with mental illness less than 40% get adequate mental health care
- In a given year 80% of the population will visit their family physician (schools are the other agency which has similar access to children and adolescents in the community)
- Family physicians and their staff have an ongoing therapeutic relationship with their patients
- Family physicians see and care for 80% of (adult) patients with psychiatric illness in the community
- There is wide variation in the ability of GP's to detect and treat psychiatric illness in their patients



Why Shared Care? Why Primary Care Setting?

- Mental Illness is already a major public health problem
- Psychiatry will not access the majority of patients with mental illness in psychiatry outpatient clinics or hospital based services
- There are not enough psychiatrists to assess and treat all those patients with mental illness
- Family physicians already see and (are involved in) care for the majority of mental illness in the community
- Family Physicians and their staff have the necessary community links to help us reach the patients and agencies with whom we need to work
- Primary care setting is a suitable environment for a “long term care” model
- Because of the nature of mental illness (majority is chronic and/or recurrent); long term care is the most suitable model of care



The Goals of Shared Mental Health Care

- Increase the accessibility of mental health care to patients and their families in primary care settings
- Improve communication between primary health care workers and mental health care workers
- Improve case detection and adequate treatment of people with mental illness in the community
- Improve understanding between primary care and mental health workers
- Integration of primary care reform and mental health reform



Present Activities of One Community Based Psychiatrist

- Works only in rural areas
- Works with 6 different groups of Family Physicians, in their offices, in their communities// 2 of the groups are FHT's// 3 of the groups form a primary care network
- Verona Medical Center// Sydenham Medical Center// Tamworth Medical Center// Sharbot Lake Medical Center// Northbrook Medical Center// Prince Edward Family Health Team
- Total of 38 different F.P.s// 5 N.P.'s /total patient population of about 40,000+ and growing
- Visits each practice weekly
- About 250 – 300 new consults per year



- Full time Family Practice Resident who helps with new referrals and follow – ups/ between us we see about 20 patients per day
- Provides collaborative/ concurrent care
- Consults one on one with family physicians and N.P.s
- Links with community agencies
- Links with specialty services ER/ in patient/ mood disorders/ child and adolescent psych/ geriatric psychiatry/ first episode and chronic care/ ACT teams/ DDCOT (developmentally disabled)
- All medical records are shared by psychiatrist and clinic staff



SLMC: a current snapshot of providers & services

- 2 Family Physicians; and
- 1 Nurse Practitioner
- providing comprehensive care
- Electronic Health Records for past 5 years
- already using a team approach (e.g. mental health)
- existing strong linkages with North Frontenac Community Services & other community agencies
- serving as a teaching site for Queen's FMC residents & NP students
- already participating in various primary care research projects



A snapshot of the population served & the broader community

- Providing care to over 2600 formally rostered patients & other residents in this community:
 - to a significantly disadvantaged population, where social factors correlate with health status
 - a population with a heavy burden of illness
- STATS from the 2001 Census



North Frontenac	27.2	32.65	\$14,655	30.2%	\$36,057	\$418
Central Frontenac	19.09	31.60	\$23,599	23.1%	\$40,345	\$751
South Frontenac	10.66	19.18	\$30,993	10.4%	\$60,382	\$627
City Of Kingston	14.78	15.76	\$30,600	12.2%	\$58,321	\$677
Province of Ontario	12.9	19.92	\$35,185	9.8%	\$61,024	\$753
Source: STATS CANADA Census 2001: Community Profiles	% of pop'n >65 yr	% with less than Grade 12 education (ages 20-64)	Average earnings for an individual	% of income from gov't transfers	Median family income	Average monthly rent

NFCS: Children

- Early Years Centre
- Daycare
- Outreach play groups
- After school programs
- Pathways counsellor
- Infant Dev /link to CDC
- Early Expressions/P.H.
- Nutritional program
“Good Food Box”

NFCS: Adults

- Home support for Seniors & Disabled
- Family counsellor
- APSW
- PCCC rural outreach SW
- FCMHS-1 CMHW
- Ongwanada B.Mngt
- Rural Women’s counsellor
- CAS
- ODSP/OW
- HIV/AIDS outreach
- KAIROS

Queen’s U.

- FMC resident
- NP students

Sharbot Lake Medical Centre

- PHC team
- MHS team

Seniors home

- Alzheimer’s day program
- Psychogeriatric outreach

PATIENT

Rural Legal Services

OPP

Probation officer

Hinchinbrooke P.S..

Land O’ Lake P.S.

Sharbot Lake P.S..

Clarendon Central P.S.

COMMUNITY

FAMILY

Sharbot Lake High School

- Adolescent counsellor
- KAIROS & Pathways outreach

- All schools have access to
Special Student Resource Team
Clinical psychologist,

N. Connections Adult Learning Centre

- Literacy programs
- Workforce development for 64%
- Goal of Independent living
for maximum 36%
- Self-management skills
- Outreach from many NFCS services
- Family C./Abuse C/ KAIROS /HIV

Community Living N. Frontenac

- Provides support &
facilitates community integration
of the developmentally disabled
- Many clients with dual diagnosis
- Strong link to APSW / case manager:
 - advocacy, support
 - education & linkages

Sharbot Lake Mental Health Team

Mental Health Specialty Links

- Emergency Psychiatry
- Inpatient Psychiatry (Johnson III – Hotel Dieu Hospital)
- Adult Psychiatry/ Rehab and Chronic Care
- Geriatric Psychiatry
- Child and Adolescent Psychiatry
- Mood Disorders Unit
- Frontenac Community Mental Health Association
- Lennox and Addington Mental Health Association



Role of the Nurse Practitioner

- Legislated role in Ontario since 1998
- Regulatory framework – collaborative model with MDs- function both independently & interdependently
- Broad PHC
 - Emphasis on prevention, screening, early dx and tx & managing stable chronic diseases
 - Assessing and diagnosing
 - Treating
 - Incl.counseling and Rx for 1st line meds
 - does not include authority to Rx psychiatric meds
 - Community assessment planning & development

Providence Continuing Care Centre: Specialized Mobile Outreach

- Provide direct specialty services
 - Intake & triage
 - Assessment
 - Time limited treatment/intervention
 - Shared-care
 - Linkage and access to specialty programs
- Community Development and education
- Collaborative Program development



Frontenac Community Mental Health Services (FCMHS)

Role of the CMHW

- Assessment and goal planning
- Individual & family support
- Symptom management
- Case management
- Education on mental health issues
- Referrals to service providers



PCCC Geriatric/Mood Disorders Case Manager-Outreach

- Accepts referrals for geriatric patients with suspected mood disorder
- Provides assessment/case formulation
- Provides time limited interpersonal psychotherapy and support /caregiver therapy
- Links with GP/NP/CMW
- Consults shared care psychiatrist for diagnostic/treatment help
- Links with PCCC geriatric outreach for investigation/treatment of dementia cases



Shared Care Psychiatrist

- Visits SLMC 1 day / week
- Accepts new referrals from primary care workers and community mental health workers
- Provides follow up care for chronic/complicated patients
- Joint consultations with GP's/NP CMHW/ GMDCM/residents
- Supervises CMHW/ Mood Disorders-Geriatric CM/ Nurse Pract./ GP's / Fam Med Residents/ psych res.
- Leads / participates in monthly education sessions
- Refers /links to specialty services: consults to C&A psychiatry and geriatric (place for telepsychiatry?)
- Psychiatrist funding is combined fee for service and sessional



Shared Mental Health Care

Friday Morning Meetings

- **Team Members Present: Family physicians (2)**
 - Family medicine residents (2) / 1 for FM/ 1 for psych
 - Nurse practitioner
 - PCCC; mobile outreach CMHW
 - FCMHA: community mental health worker
 - PCCC mood disorders/psychogeriatric case manager
 - shared care psychiatrist
 - main receptionist
-
- **Friday morning meetings: review new referrals**
 - review ongoing cases/arrange follow up
 - discuss referrals to specialty services/ ER
 - “make time” for urgent referrals
 - arrange for “mini-consults”
 - verbal (hallway) consults

Monthly 'CME' Meetings

- Interactive learning sessions; primarily case based to learn about:
 - counselling / psychotherapy
 - diagnosis and treatment of mental and physical illness
 - methods of collaboration
 - case detection
 - increase awareness of MH services
- Disciplines present:
 - community mental health workers (3 agencies)
 - nurse practitioner / GP
 - rural women's counsellors
 - child and adolescent counsellor
 - community services counsellor/therapist
 - addictions counselor
 - family medicine (psychiatry) residents



Collaborative Care in Rural Family Health Team Lessons Learned

- Access to mental health care and communication between primary health care workers and mental health workers has improved since Shared Care Initiative / patients who were not being seen are now getting multidisciplinary mental health care
- Access to mental health care and communication between community mental health workers has improved since Shared Care Initiative
- Integration of primary care and mental health care has improved since Shared Care Initiative
- Mental health consultations have increased since Shared Care Initiative
- Research into collaborative models of care has shown much improved access and improved outcomes which are maintained in patients with mental illness



Shared Care in a Rural Family Health Team Lessons Learned

- G.P. and N.P. detection of mental illness and knowledge about mental health care has increased since Shared Care Initiative
- Other mental health care workers in the community have increased their knowledge about mental illness in the community since Shared Care Initiative
- A case can be made for including mental health care workers in Family Health Teams
- Funding for Psychiatrist will hopefully be resolved by FHT status
- Psychiatrists might be linked to rostered FHT populations as a method of payment for mental health care



Shared Care in Rural Settings

Lessons Learned

- Model of care changes from one practice group to another
- Collaboration and interdisciplinary care do not just happen but require time and planning/ it is an evolving process
- The only way to learn the skills is to be involved in a collaborative process
- Communication and time devoted to the collaborative process are keys to success
- Geography and numbers can be a limiting factor in the efficiency and effectiveness of collaboration
- Collaborative models should be learned (by experience and exposure) during the training process for physicians, nurses, social workers, occupational therapists, nutritionists etc etc)



Shared Primary Mental Health Care

- This model has been built from the ground up by community clinicians working with insufficient support from various academic health care agencies.
- What could we do if this were an organized mechanism of primary mental health care delivery in our area?



Rural Collaborative Mental Health Care

Goals of Shared Care

- Improve access and communication
- Improve case detection and G.P. / N.P. knowledge of mental illness in their practice
- Improve understanding between mental health professionals and primary care physicians/ nurse practitioners
- Improve integration of primary care reform and mental health reform

