Shared/Collaborative Care
Lessons Learned from the First 5 Years of the Ottawa Experience

Dr Katharine Gillis
Dr Doug Green
Dr Robert Swenson
Colleen MacPhee APN
Donna Klinck MSW
Dr Pam Cooper PhD
Claudia Hampel RN
Department of Psychiatry
University of Ottawa

The Ottawa Hospital | L'Hôpital d'Ottawa

uOttawa

Disclosure

- I have no involvement with Industry
- I have no identifiable or perceived conflicts of interest

Learning Objectives

- Know the key features of shared/collaborative mental health care in the primary care setting and what it is like to work in this type of model.
- Be aware of what has worked well and what has not in the Ottawa team's experience and be able to incorporate relevant information into development of a new shared care program or an existing program.
- Be able to use the practical tips and tools provided in your own practice.

Tools for Sharing

- Program brochure for patients and family health team
- Our Wellness Group for Anxiety and Depression content overview
- Guide/grid for assessing/completing Disability documentation
- PHQ 9 screening tool information
- Referral form to Shared Care Program
- Tips for Effective Consultation Writing (power point presentation)

TOH Shared Care Program

- 2004 - July, 2006 – Pilot Project – Primary Care Transition Fund (2 sites)
  - **Evaluation component built into funding grant**
  - **Program – clinical and evaluation components**
  - **Evaluation Report**
  - **Published Article**
  - **Inter professional Shared Care team**

TOH Shared Care Program

- January 2007 – Permanent Funding through two Academic Family Health Teams.
  - **4 family health team sites (two organizations) ~30,000 patients**
  - **Funding – clinical services**

- Centralized Intake Referral Process for Shared Care

- Inter professional Shared Care Team (Psychiatrists (sessional payment), MSW, Psychology, RN, Advance Practice RN, Clerk) 4.4 FTE

- Number of referrals that have been referred to our program:
  - **2008/09 fiscal year - 477**
  - **2009/10 fiscal year - 415**

Physician Sessional Allocation

- 277 sessionals are allocated to Psychiatry by FHT (0.8 FTE)
- Average breakdown of these sessionals (based on 2009/10 activity):
  - **83% direct patient care (assessment / f/u / patient advocacy with form completion return to work plans etc.**
  - **5% program development / team meetings / education sessions / research – quality improvement / conferences**
  - **8% consultation / patient rounds / inter professional review of cases**
  - **4% - indirect communication with staff / shared care team / clinic staff (informal or formal review of chart and recommendations)**

Shared Care Program Purpose

- Increase family MD and primary care team knowledge and comfort level with mental health diagnosis and treatment
- Leverage psychiatrists capacity to be involved in patient care through indirect work: chart reviews, in person case discussions
- Provide direct consultation (inter professional) and limited follow up
- See any patient the FHT feels they need us to see 16 years and up

Lessons learned

- Scheduling and rescheduling of appointments: assign one individual
- Patients and primary care team need to know limitations of the service so they are realistic in their expectations. Written paper and e-brochure recommended.
- Putting a cap on how many return visits can be helpful and needed to ensure patient flow (there are always some exceptions)
- Use a referral sheet and have one person who receives the referrals electronically or by fax

Lessons learned: in praise of EMR

- Electronic Medical Record allows a Shared Care Program to be more effective
- Can always locate the patient chart and read it!
- Most have medication start and stop dates that can be quickly reviewed
- EMR messaging functions allow for easy two way communication between mental health team and primary care team
- Messaging system makes it easy to do indirect chart reviews on request
- Voice Dictating, such as Dragon Dictate 10, allows for all documentation to be typed and signed off on the same day the patient was seen. It is efficient and less fatiguing.
- Family MD quickly gets your recommendations.

Lessons learned- Pyschoeducation Groups

- Wellness Group for Anxiety and Depression
- Social Anxiety Group
- Coping with Chronic Illness Group (including chronic pain)
- Run for 8 weeks once per week with post group once monthly sessions

- Very good feedback from patients
- Efficient use of mental health team clinicians time
- More patients can be given treatment sooner
- Any primary care team member can refer
- Addictions is not an exclusionary criteria

Education Provided by our team

- All of our Shared Care Team members are involved in providing education/teaching
- CME placed where possible in consult reports by psychiatrists
- ½ -1hr regular time assigned as “drop in” for case discussion or ad hoc topic discussion based on family MD or resident request
- Lunch and learn interdisciplinary rounds –FHT chooses topic.
- Shared Care Team has developed and tries to update list of mental health services in our region for the FHT (never seems complete)
- Family medicine residents, psychiatry residents and psychology interns (less frequent) spend time with our shared care team

Shared Care Team Cohesiveness

- Monthly team meetings are highly valued and needed
- Role of team clerk really important (essential) to our functioning
- Team members seek CME especially at National Collaborative Care Mental Health Conference
- We submit abstracts to national, provincial and regional conferences
- Research is challenging as we have no funding for this
- While age 16 and up is our mandate we recognize we need to provide indirect support to Family MDs for younger patients. Our team is arranging CME to improve our skills.
- Annual full day Shared Care Team Retreat started this year ,helped set goals for quality improvement/systems level care

Outcomes/measures of success

- Increasing complexity of referrals
- Focus of team goes beyond immediate service delivery to quality of service issues. Are consult recommendations followed up on? Are patients lost to follow up?
- Recognition of need to look at systems level issues such as screening of at risk populations for depression eg patients with diabetes
- Promoting the use of screening tools by interdisciplinary primary care team such as PHQ9
- Patient Satisfaction measures (we have not been able to do this consistently apart from our Groups)
- Family Health Team Satisfaction measures (we have not formally done this since initial research project but informally do it)

Patient Health Questionnaire (9) - depression

Patient Health Questionnaire – PHQ-9

Patient name: ______________________ Date: ______________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

TOTAL SCORE ____________

Score 0 – 27

5 – 14 – Mild MDE

15 – 19 – Moderate MDE

20 - Severe MDE

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Why get involved in Shared/Collaborative Care?

- It's fun to work in a primary care environment for part of work week
- Good camaraderie within the mental health team and family health team
- More opportunity for early detection
- 16-25 year olds often seen (about 23% of our volume)
- See patients who would not usually agree to a referral because of anxiety or stigma but ok with being seen in family MD setting
- Access to family MD chart gives valuable history that you would usually not have available
- Your skills can be leveraged in this model to provide care to more patients through direct and indirect work

Advocacy

- We need more shared/collaborative care opportunities in our province
- Current Royal College training requires psychiatry residents to have 8 weeks of shared /collaborative experiences
- We need job opportunities in collaborative care for residents post training
- OHIP model does not promote or enable shared/collaborative care as it does not fund indirect work
- Sessional funding fits the collaborative care model and can have accountability reporting. Advocacy is required for such sessionals.

- June 2011 Canadian Journal of Psychiatry updated Position Paper on Collaborative Mental Health Care –great advocacy tool