The Ottawa Hospital | L'Hôpital d'Ottawa

TOH Shared Care Team Next Steps: Patient Transfer from Acute Tertiary Outpatient to Family Health Teams

- Dr. Katharine Gillis
- Dr. Robert Swenson
- Dr. Doug Green
- Colleen MacPhee, RN, APN
- Claudia Hampel, RN

Objectives:

- Shared Care Program – 2004 – 2010
- Infrastructure Requirements
- Growth through Research
  - Outcome Indicators
  - Moving Forward

Evaluation Project to Clinical Program

Evaluation Project –

- Built in financial support for evaluation component.
- Monitored by research and ethics board of facility
- Finite start and end time
- Clinical workloads pre-determined

Clinical Program –

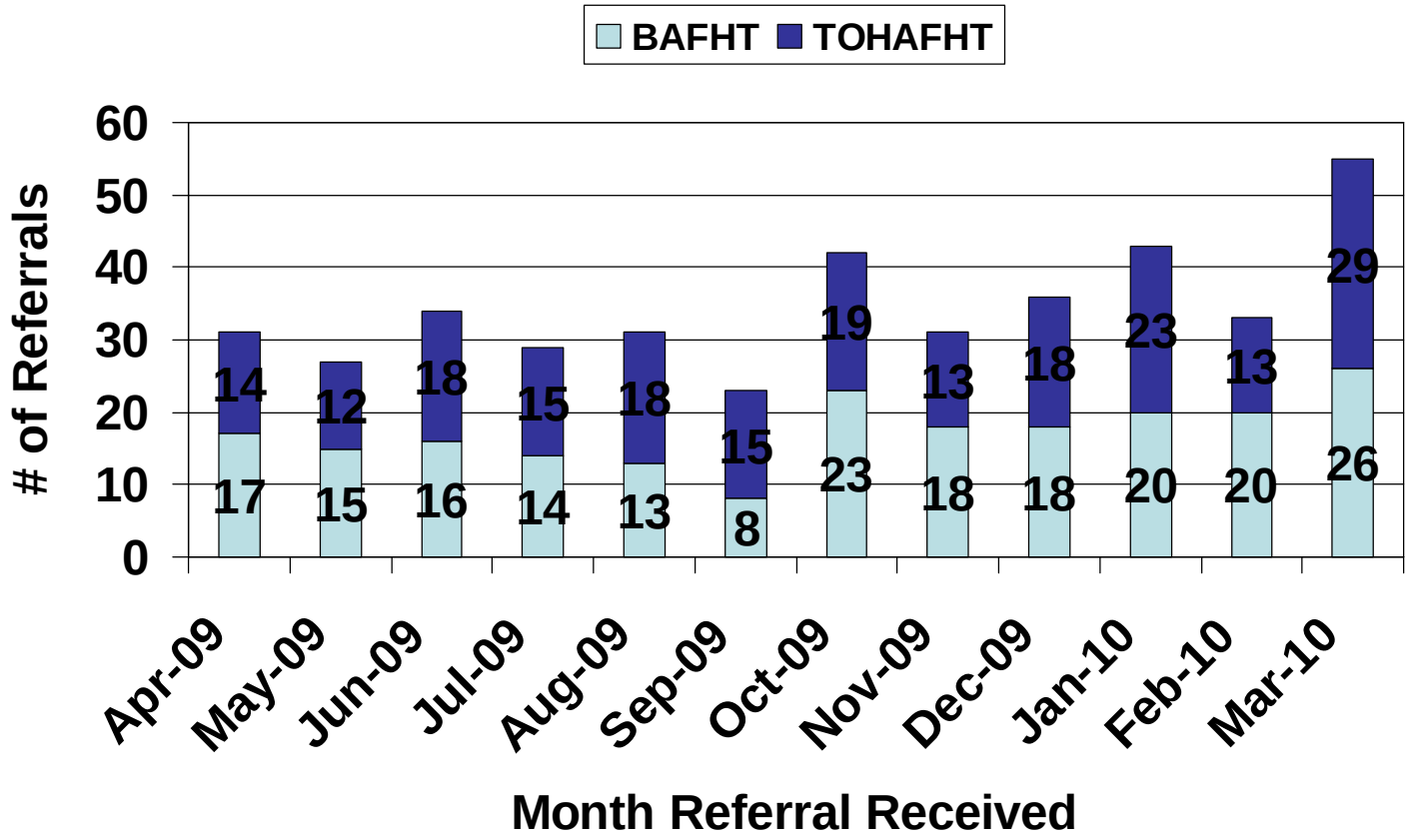
- None or minimal funding for evaluation component
- Priority is clinical / patient care – competing requirements for finite services.
- Continious needs for “new learners” e.g. residents

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
- January 2007 – Permanent Funding through two Academic Family Health Teams.
  - 4 family health team sites (two organizations)
  - Client base of 30,000
  - Funding – clinical component – no funding for ongoing research.
- Centralized Intake Referral Process for Shared Care
- Inter professional Shared Care Team (Psychiatrists, MSW, Psychology, RNs, Clerk) 4.4 FTE
- Number of referrals that have been referred to our program:
  - 2008/09 fiscal year - 477
  - 2009/10 fiscal year - 415

Referral Volume:

Number of Referrals Received by SHARE Team per month by Site 2009/10
BAFHT – 208 TOHAFHT - 209 (total = 415)



Logic Model

Need to review short term and long term objectives of our established shared care program.

The Ottawa Shared Mental Health Care Program Project Logic Model - A Collaborative Approach

Assumption: That a multi-disciplinary mental health team linking The Ottawa Hospital psychiatric emergency service and outpatient urgent mental health consultation clinics with two Academic Family Health Teams will result in improved access to, and quality of, both psychiatric and physical care for patients with mental health problems who are seen first within the primary health care system.

GOAL: To demonstrate that this model of shared mental health care will improve quality of mental and physical health care, particularly for patients with severe mental illness.

OBJECTIVES:

- To increase the support base and capacity of family physicians to provide primary care for patients with mental health issues
- To address service gaps and emphasize health promotion and prevention
- To improve efficiency of mental health care service provision
- To improve patients' mental health and quality of life

RESOURCES:

- Shared Care Clinical Team
- Bruyere Academic Family Health Team Physicians, Residents and allied staff
- TOH Academic Family Health Team Physicians, Residents and allied staff
- The Ottawa Hospital Mental Health Programs including: Psychiatric Emergency Service and Mobile Crisis Team, Outpatient Psychiatry, Acute Partial Hospitalization and the Regional First Episode and Eating Disorders Programs

ACTIVITIES:

Family Physicians/Residents:
- Refer patients to the Shared Care Clinical Team
- Participate in case consultation, case review and training

Shared Care Clinical Team:
Screens referrals for acuity and appropriate level of intervention and determines suitable services for each referral:
- **Psychiatrist**
  - Diagnosis and medication review
  - Individual consultation
  - Short term therapy
  - Resident training
- **Advanced Practice Nurse**
  - Management of patients with co-morbid mental health and physical problems
  - Diagnosis and monitoring of medication
  - Counselling and education
  - Overall management of the program
- **Social Work**
  - Individual/family therapy
  - Referral and resource information
  - Education
- **Psychology**
  - Psychometric assessment
  - Cognitive Behaviour Therapy
  - Referral and resource information
  - Education

Ottawa Hospital Psychiatric Emergency Service and Urgent Psychiatric Consultation Clinics:
- Emergency psychiatric services
- Intensive outpatient mental health care
- Refer patients to family practice settings
- Case consultation, review and training

OUTPUTS:

- # of patients referred from primary care physicians to the Shared Care Clinical Team
- # of patients with severe mental illness referred from Ottawa Hospital and accepted for care by primary care physicians
- # of assessments of patients by Shared Care Clinical Team
- # of patient case conferences with primary care physicians
- # of external referrals made by Shared Care Clinical Team
- # of patients seen in counselling or therapy by Shared Care Clinical Team
- # of sessions of counselling or therapy offered by Shared Care Clinical Team
- # of educational sessions offered to patients/family members
- # group patient services formed and participants
- # of psychiatry and family medicine residents trained

SHORT TERM OUTCOMES:

Family Physicians/ Residents
- Improved capacity for early intervention in mental illness in the family practice setting
- Enhanced training for residents and family physicians in mental health

Mental Health Practioners
- Enhanced training for psychiatrists and allied mental health professionals in family practice issues

Patients
- Increased patient access to mental health programs
- Increased access to primary care for patients with serious mental illness

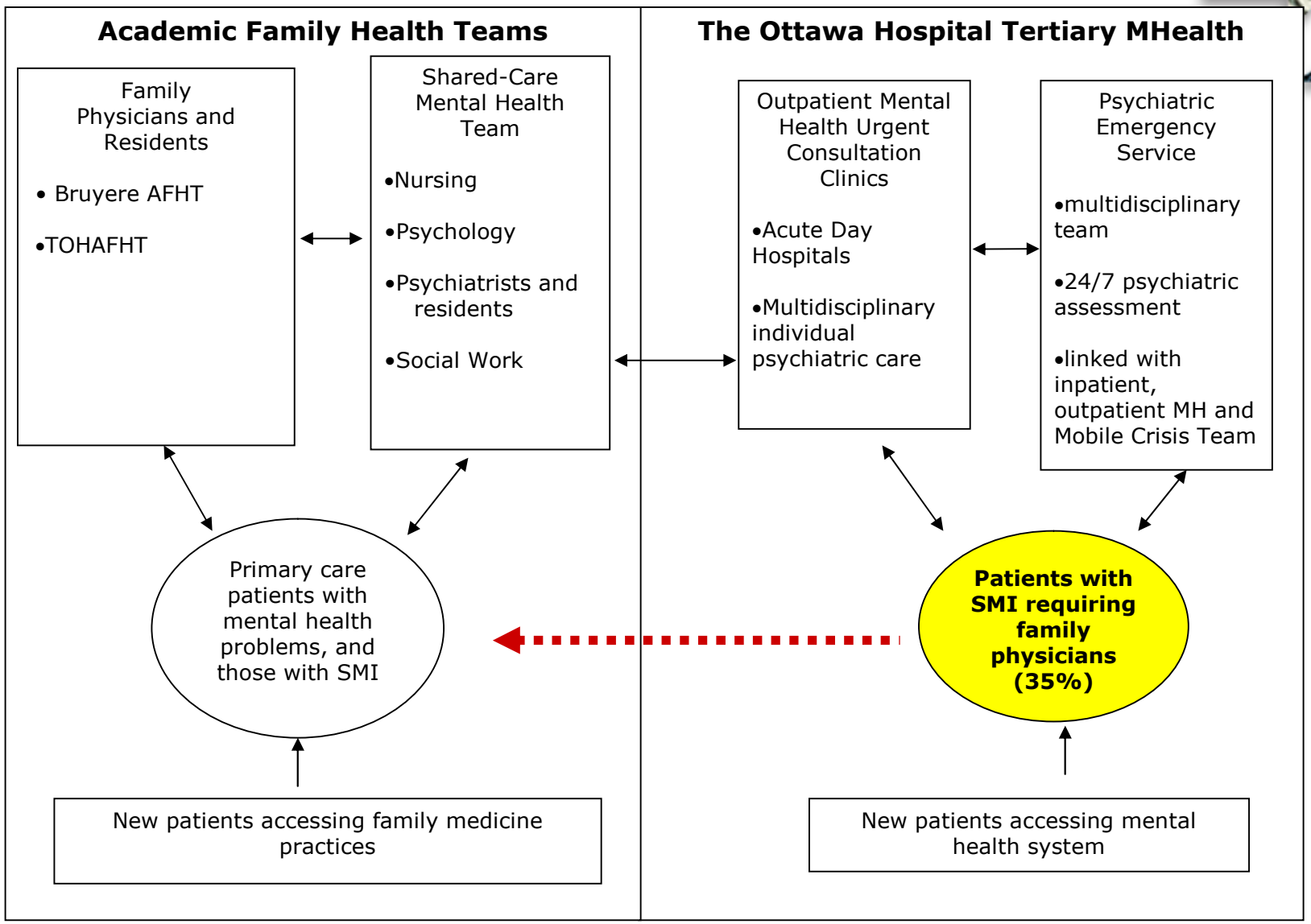
LONG TERM OUTCOMES:

Family Physicians/ Residents
- Increased competencies in addressing mental health issues of patients
- Increased receptivity to accepting persons with severe mental illness as patients
- Improved quality and depth of treatment in mental health at the primary care level

Mental Health Practioners
- Improved collaboration and knowledge transfer between the mental health system and family health practices

Patients
- Improved continuity of care
- Decreased mental health symptoms
- Decreased hospitalizations
- Improved functioning
- Improved quality of life

Improved Access to Mental Health Care and Primary Health Care Through a Shared Care Model



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Mental Health Practioners

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Patients

- Improved continuity of care

Responsibilities in Academic Teaching Setting:

- Skill development and enhancement for physician residents:
  - Family Practice
  - Psychiatry
  - Psychology
  - Nursing (not yet established)
- Shared Care to be a core rotation experience for senior psychiatry residents as per the Royal College new training objectives.

Future Directions / Expectations:

- Formalize relationships with primary care and mental health in academic setting.
- These relationships puts us in a position to take a lead role in creating or facilitating the development of:
  - More shared care arrangements
  - Mechanisms to assist the “orphaned” psychiatry outpatients to find family physicians (35% do not have a family physician or nurse practionner).

⇨ **Transfer Project – Mental Health Patients from Outpatient Mental Health Program to Family Practice**

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- Challenges:
  - Refocusing the emphasis of the outcome research to patient satisfaction and the patient experience – more qualitative collection requiring specific expertise.
  - Increasing demand of the Research Ethics Boards on primary investigators and clinical research.
  - No additional funding for research at this level (doing it within clinical roles).
  - Original timelines become unrealistic – need to rethink priorities in this setting / how we are organized to take on such important tasks.

Guiding Principles:

- As we become more attuned to the patient experience it will guide our reorganization
  - Type of Patient Encounters (phone / e-mail)
  - Incorporating wellness promotion and mental illness prevention
  - Building on the experience of other providers (TIPP and CLIPP) for measures and protocols.

CLIPP (Consultation Liaison in Primary Care Psychiatry) Australia

- CLIPP Shared Care Model has successfully implemented, and sustained, psychiatric liaison attachments to 12 general practices in Melbourne Aus.

- It has transferred over 160 patients from the local area mental health services (AMHS) into shared care with GPs using the channels of communication and collaboration developed within the liaison

- It attempts to synthesise the three models of shifted outpatient care (psychiatrist sees pt. in GP office), shared care (joint services of GP and psychiatric sector) and consultation liaison (indirect).

CLIPP-Focus

The development of psychiatric liaison attachments to general practices involving collaboration and consultation from psychiatrists.

The transfer of a selected group of psychiatric services clients into shared care, with general practitioners using the channels of communication and collaboration developed in the liaison attachments.

Source http://www.health.vic.gov.au/mentalhealth/publications/clipp

CLIPP project Overview

- The overall aim of this project was to assess whether care delivered to patients with severe mental illness in the context of shared care arrangements yields acceptable outcomes
  - Satisfaction
  - Physical Health Outcomes
  - Financial Impact on Clients
  - Carer Burden

TIPP (Transition into primary care Psychiatry) London and ThunderBay, Ont.

- Service for patients with stable but chronic mental illness transitioned from tertiary care to family physician.
- On-site communication between primary care, psychiatry, the client and client's family.

- Patients have improved access to good quality healthcare

- Family physician can receive case-by-case education on one-to-one basis

Haslam,Haggerety,McAuley, Lehto & Takha,2006.

TIPP-model

- Direct consultation: providing transfer summary, relapse signature, face-to-face transition meeting, mental health nurse and psychiatrist visits
- Indirect consultation: telephone consultation with nurse and psychiatrist, facilitation of access to community services and review of client documentation

Transition into primary care-the Ottawa experience TIPP-TOE

A safe, transitional discharge protocol for psychiatric out-pts to primary care

- Evaluation measures to look at patient satisfaction and patient functioning

TIPP-TOE-Rationale

- access to a family physician and a family health team (prevention & health promotion & treatment)
- access to allied health professionals and possible improved coordination of medical and psychiatric care
- improved health outcomes for patients at greater risk for co-morbid physical health problems.

TIPP-TOE Inclusion Criteria

Inclusion Criteria

- **Adult age 18-64**
- **Chronis moderate to severe mental illness**
- **Duration of Mental Illness > 2 years**
- **If ever hospitalized, time of last admission greater than 1 year**
- **Patient is clinically stable. TAG score 8 or less.**
- **Ontario resident with OHIP**
- **Insight/motivation and willingness to participate**
- **Pt is competent to consent to treatment**
- **Pt does not have a primary care physician**

TIPP-TOE Exclusion Criteria

Exclusion Criteria

- **Pt has a primary care physician**
- **Age 65 or over**
- **Clozapine (Clozaril) treatment**
- **Prominent Axis II diagnosis**
- **Active substance use**
- **Outstanding psychosocial issues (homelessness)**
- **Extensive legal issues/history**
- **Frequency of out-patient psychiatry visits greater than one visit per month**
- **History of self harm or harm to others in the last 6 months**

Methods/tools

We want to keep the data collected minimal:

- Patient Demographics (obtained in referral form)
- Appointment follow-up record (monitoring use of other components of the health system / outcome of referrals)
- Patient satisfaction questionnaire -CSI- (need to work on this)
- TAG (threshold assessment grid)
- GAF (general assessment of function)
- OQ45 (outcome questionnaire)
- PHQ (patient health questionnaire – still up for discussion)
- Physician satisfaction questionnaire
- Implementation of Patient Relapse Signature Plan / Specific Management Plan

Proposed TIPP-TOE Timeline

Pre-study	Baseline	1 month	3 month	6 month	9 month	12 month	24 month
Consent	Face-face with GP, mental health RN	GP visit physical exam	RN + psychiatrist	**RN**	**RN**	**RN**	**RN**
TAG	OQ45 GAF PHQ (?)	OQ45	OQ45	OQ45	OQ45	OQ45 GAF PHQ (?)	OQ45 GAF PHQ (?)
Referral form						CSI	CSI
		F/U visit form	F/U visit form	F/U visit form	F/U visit form	F/U visit form	F/U visit form
						FPSQ	

Questions:

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Contact Information

cmacphee@ottawahosptial.on.ca

kgillis@ottawahospital.on.ca