The Next Ten Years : More Than Just Collaboration

Nick Kates MB.BS, FRCP(C)
Professor
Dept. of Psychiatry,
McMaster University
Ontario, Canada

Program Director,
Hamilton Family Health Team

A lot has changed over 10 Years

National Picture

- Primary care reform gathering momentum
- Work of the CCMHI
- Increasing credibility
- Increasing interest on the part of providers
- Increasing interest on the part of funders
- Being seen as an accepted (if not yet integral) part of practice
- Collaboration increasingly expected by consumers
- Increasing consumer involvement
- Interest of the Mental Health Commission
- Being included in training programs

Provincial Picture

- Mental Health and Primary Care Branches / Divisions starting to work together
- Increasingly included in provincial planning
- More models of collaboration are being funded
  - Family Health Teams (Ontario)
  - Primary Care Networks (Alberta)
  - CSSSs (Quebec)
  - Depression module in PSP (BC)

Provincial Picture

- Increasing interest from RHAs
- Recent CCMHI provincial consultations
  - **Nova Scotia, Manitoba and Saskatchewan**
  - Common findings
    - **Interest**
    - **Seen as relevant to health system issues**
    - **Want assistance to proceed**

Examples of Canadian Collaborative Projects

- Broadening network of providers
- Strong evidence-base – more Canadian data
- Increasingly fertile and receptive environment
- Relevance to issues facing health care systems
  - Access
  - Waiting times
  - Communication
  - Co-ordination / continuity of care

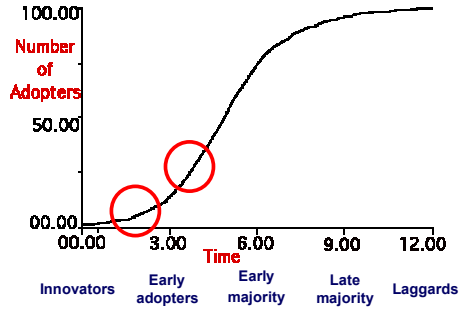
Increasing number and variety of successful projects

- Projects aimed at different populations
  - Children
  - Homeless
  - Seniors
  - First nations communities
  - Individuals with substance abuse problems
- Other settings
  - Canadian Forces
  - Student health
  - Workplace
  - Shelters
- Physical health care of the mentally ill

Two Broad Goals of all Programs

- Increasing the capacity of the system
- Improving access and reducing waiting times

Rogers Diffusion of Innovation Theory



Looking Ahead
The Next 10 Years

Challenges

- Meets the needs of underserved populations
- Physical health care of the mentally ill
- Developing common evaluation tools
- Training future practitioners
- Mental health problems of the medically ill and chronic disease management
- Advocate for inclusion in regional planning

Let's go back to why we wanted to improve collaboration in the first place.

We recognised

- The high prevalence of mental health problems in primary care
- These problems often presented with co-morbid medical problems
- The key role primary care plays in delivering mental heath care

Despite this

- Detection rates were low
- Treatment rates were low
- Individuals often didn't receive guideline based care
- Referral rates were low
- Family physicians felt unsupported by mental health services
- There was general dis-satisfaction with the relationship

We saw the need for better collaboration between the two sectors

What we also started to realise……
Collaboration Alone isn't Enough

- Collaboration can improve outcomes
- But many of the problems we were addressing were with systems that weren't working well in the first place
- Making a difference required more than just collaborative partnerships
- Collaboration works best when supported by system changes or redesign

System change

- An innovation is introduced
- Everyone in the system is affected and changes their behaviour to support it
- Moves the system towards achieving its vision

We know

- Screening without treatment doesn't change outcomes
- CE events without follow-up doesn't change behaviour
- Starting people on medication without ensuring follow-up leads to poorer compliance rates
- Improved outcomes with multi-faceted interventions

These program included

- Care manager
- Psychiatric consultation
- Consumer education
- Provider education
- Planned visits

We were often building bridges between systems without realising the systems themselves were broken and couldn't sustain the innovation

We were working within poorly functioning systems

- At both the clinic / practice and organisational level
  - Didn't support innovation
  - Impediments at the entry point
  - In-out models of care
  - Just seeing those people who reached us
  - Fragmentation of our services
  - Poor discharge planning
  - Collect data but don't use it to improve care
  - Not always thinking about improving the quality of care

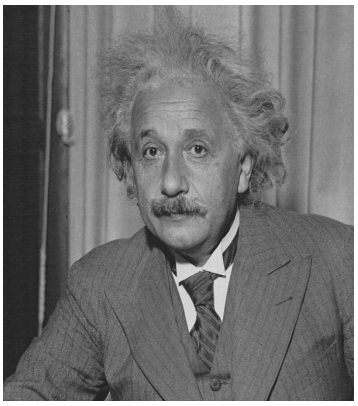
	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking (2007)	**3.5**	**5**	**2**	**3.5**	**1**	**6**
Quality Care	4	6	2.5	2.5	1	5
Right Care	5	6	3	4	2	1
Safe Care	4	5	1	3	2	6
Coordinated Care	3	6	4	2	1	5
Patient-Centred Care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Long, Healthy, and Productive Lives	1	3	2	4.5	4.5	6
Health Expenditure per Capita, 2004	$2,876*	$3,165	$3,005*	$2,083	$2,546	$6,102

* 2003 data.
Source: Calculated by the Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005, International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard, Commonwealth Fund (2007).

Why does this happen

- Focus on acute problems
- Emphasis on triage and patient flow
- Care isn't collaborative
- Not using the full potential of all team members
- Consumer education is formulaic and not interactive
- Follow-up is usually consumer initiated
- Treat only those people who reach us – can only react
- Problems with flow between services
- Our cultures of care
- Inefficiencies and waste

Thought for the Day



"Insanity is doing things the way we've always done them, and expecting different results."

Redesigning systems of care

Providing better care and improving outcomes require changes in the ways systems of care are organised

Successful collaborative partnerships must be supported by a re-design of the way systems of care are organized

To redesign our systems we need a new paradigm of care

We need to think about improving the quality of care

Changing the paradigm – what we want to achieve

- Population focus
- Proactive care
- System takes responsibility
- Informed, empowered, engaged consumers and families, supported in managing their own care
- Use data to drive improvement

Changing the paradigm – what we want to achieve

- New ways to improve access
- Collaboration in all aspects of care
- A culture of improvement and innovation
- Thinking about quality as well as quantity of care

Changing the paradigm – How are we going to make it happen

- Framework for identifying changes (Care Model)
- Introduce small rapid improvements (Improvement Model)
- Increase our efficiency and reduce waste
- Use IT creatively
- Think about spread and sustainability
- Leadership
- Thinking differently

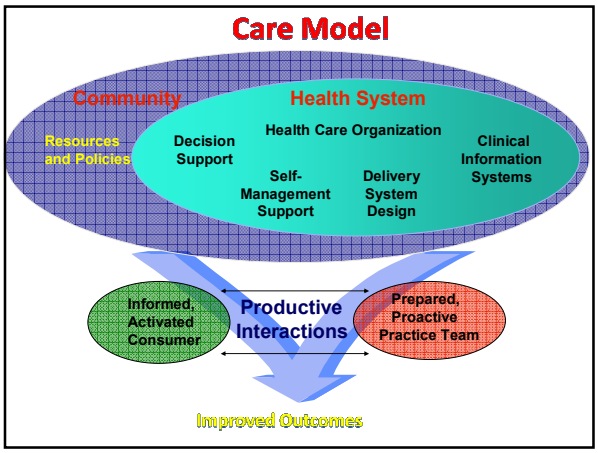
Thinking differently

“We have no money, therefore we must think.”

Sign at Maudsley Institute in London, England

“The stone age didn’t end because we ran out of stones”

The Framework



Change Ideas: What Can We Do Better

Change Ideas

Clinical Information Systems

- Registry

Decision Support

- Algorithm / flow sheet

Self-Management Support

- Individual care plans / goals

Change Concepts

Delivery System Design

- Screen for depression / anxiety with everyone who has a chronic medical condition
- Follow-up with individuals once they recover
- Morning huddle
- Medication reconciliation / health passport

Implementing these Changes

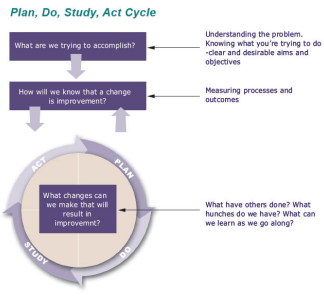
"It is not because things are difficult that we do not dare, it is because we do not dare that they are difficult."

Seneca

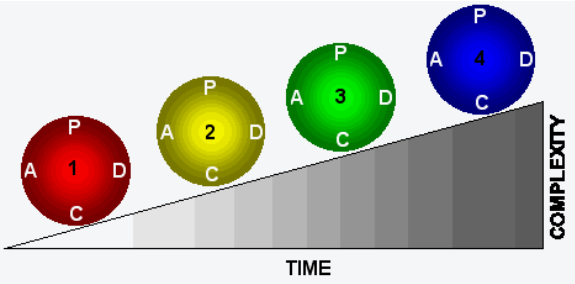
How Do We Introduce and Measure Improvements

Small rapid improvements that can be tested and inform further improvement

The improvement model



PDSA Cycles – Plan Do Study Act



PDSA Cycle - Example

Objective

To obtain consumer feedback on a service being provided

- **Plan**
  - **Introduce a consumer satisfaction survey**
- **Do**
  - **Decide on 9 key questions to ask**
  - **Test it on 3 visits tomorrow**
- **Study**
  - **Ask the consumer how it could be more helpful**
  - **How should it be completed**
- **Act**
  - **Adjust the form**
  - **Test it with 5 more people**

Testing Small Improvements

- Different from the traditional model
- Not designing a multi-faceted intervention then not changing it for a year because of the fidelity of the design
- Small rapid changes
- Learning as we go
- Relevant to that setting

Consumer (and family) engagement : The consumer as partner

The consumer as partner

- Support self management
- Prepared for each visit
- Consider health literacy
- Involvement in service planning / evaluation
- Understanding the consumer experience / journey - listening to their story
- Does everything we do add value for the consumer

Population Focus

- Think of populations as well as individuals
- Who aren't we seeing as well as who we are seeing
- Only way of moving towards early identification or health promotion
- Paves the way for proactive care and planned visits
- Needs a registry

Registry

- List of everyone in a specific population
  - everyone over the age of 75
- Can add risk factors
  - Living alone
  - History of depression
  - Problems with physical mobility
- Can add care required
  - When medications were reviewed
- Follow-up with a call / visit

Pro-active (planned) care

Pro-active care

- **Continuing care over the entire duration of an illness - Closing the loop**
- **System takes responsibility**
- **Need a registry / list**
- **Planned visits**
- **Preventive visits**
- **Callbacks**
- **Can be delivered in different ways**

Different types of visits

- Phone
- Skype
- Email visits
- Email
- Use of the Internet – Facebook, twitter

Improving Access

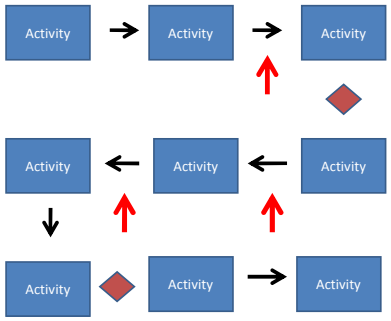
- Supply needs to match demand
- Supply is measured by available appointment slots, not number of providers
- Find ways to change the demand (i.e. self management, prepared visits)
- Find ways to increase the capacity (supply)
  - Time per case / visit
  - Phone
  - Other team members
  - Peer support
  - Shared medical appointments
  - Self management
- Improve efficiency

Increasing efficiency and reducing waste

Increase efficiency and reduce waste

- 40 - 60% of our activity is waste
- Keep doing things that don't work
- Waste comes in many forms ie
  - Not using everyone's role to their full potential
  - Duplication
  - Waiting
- Is everything we're doing adding value for the customer (consumer or system)
- We can map our processes to see where inefficiencies occur

Process Mapping



Creating a culture of improvement and innovation

A Culture of Improvement and Innovation

- Willingness to think differently
- Everybody feels empowered to suggest improvements
- New ideas are being introduced and tested regularly and rapidly
- Improvements are small scale
- Team able to support each others ideas and learn from each other
- Openness and transparency
- Actively encouraged by organization leaders
- Takes time to achieve

A Culture of Improvement

- Not what we can't do
- What can we do by Friday
- Think about how we can sustain these improvements from the outset

Start where you are.
Use what you've got.
Do what you can

Summary

- Collaborative care has demonstrated it can improve outcomes
- To optimize collaboration we need to redesign systems of care
- We need a new paradigm of care
- We need to always look at how to improve what we do
- We need to think differently
- We need cultures of care that promote improvement and innovation

"Some look at things that are, and ask why. I dream of things that never were and ask why not?"

George Bernard Shaw