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Enhancing Collaboration through Shared Care in Peterborough




Family Health Teams and Mental Health Services

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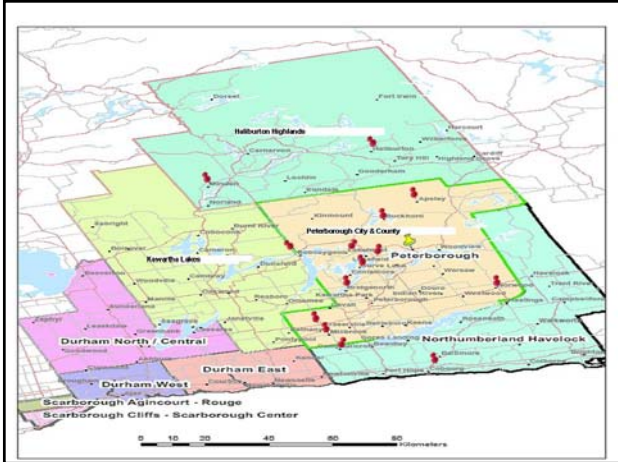





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Peterborough


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Peterborough 

- City population:
- County population:
- Schedule 1 Facility with 28 inpatient psychiatric beds, AOP, and 3 Separate Vote programs serving four counties
- Currently 5 family health teams developed in 2006 with 75 doctors

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Historical Perspective 

- Shared care between Psychiatry and Family Practice has been discussed in the literature since the 1990's with models evolving since then.
- Shared care models have been recommended to improve diagnosis and management of mental health (Can Fam Physician 2008;54:884-9)

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Historical Perspective



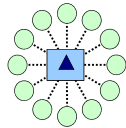
- In the mid 1990's a program was developed at PRHC in response to severe shortage of psychiatrists and difficulty providing adequate mental health care.

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Mid 1990s



- Gradual depletion of Psychiatric manpower through the early 1990's
- 10-12 Family Physicians recruited to support on call and care of inpatients
- Psychiatrist acted as mentor / consultant to group
- Education Program was provided

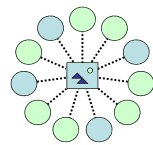


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Later 1990s



- Psychiatric manpower began to grow slowly
- 5 Family physicians remained as part of the Dept of Psychiatry
- 1 FP worked out of Adult Outpatient Program
- 3 FPs continued to provide on call coverage



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2000's

- Psychiatric manpower continued to grow at PRHC during the time the FHT model was developed and implemented
- 1 FP continues to provide on call support to this day
- 2 FP work out of the Adult Outpatient Program

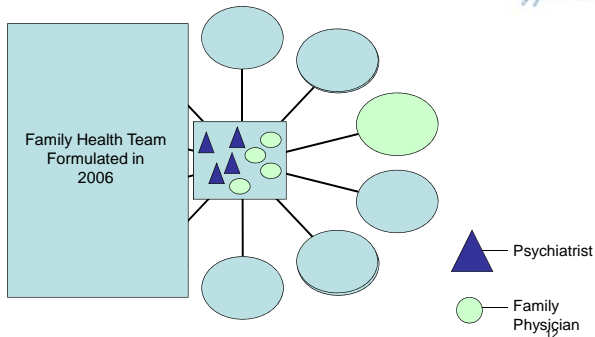
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Community Need

- 15-50% of all patients in family medicine have significant psychological dysfunction
- 21% receive care from mental health specialists
- 54% are seen by primary care (Regier et al.)
- Limited mental health resources in the community

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2006 and beyond



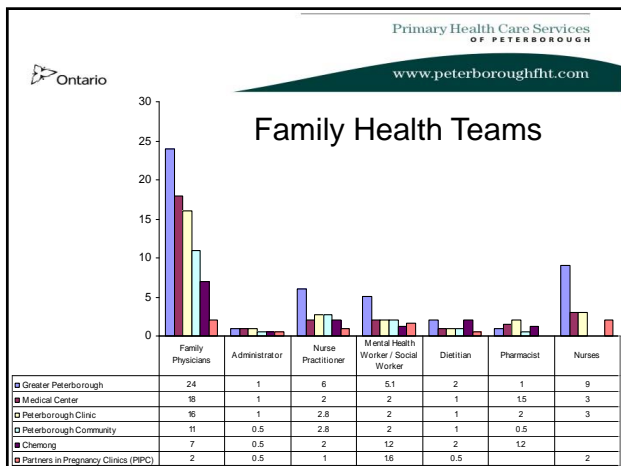
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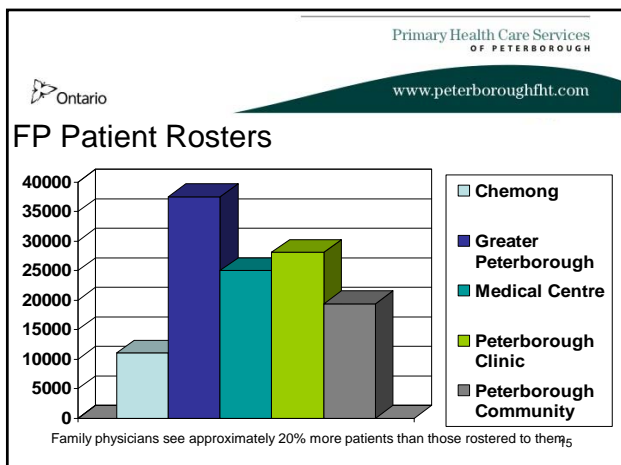
PRHC Peterborough Regional Health Centre
by your side

Collaborative Goals Set

- Managers & FP from Adult Outpatient Program, Family Health Team Lead Physician and Exec. Director met with Dr. Nick Kates and colleagues in Hamilton
- Proposal for a Mental Health Project forwarded along with overall FHT proposal to the Ministry

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Ontario

Mental Health Project in FHT's

- Mental Health Liaison role developed to lead the project
- 12 FTE Mental Health Clinicians of various disciplines
- Addressing the mental health needs for those with mild to moderate illness

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Ontario

Primary Care Focus with Mental Illness

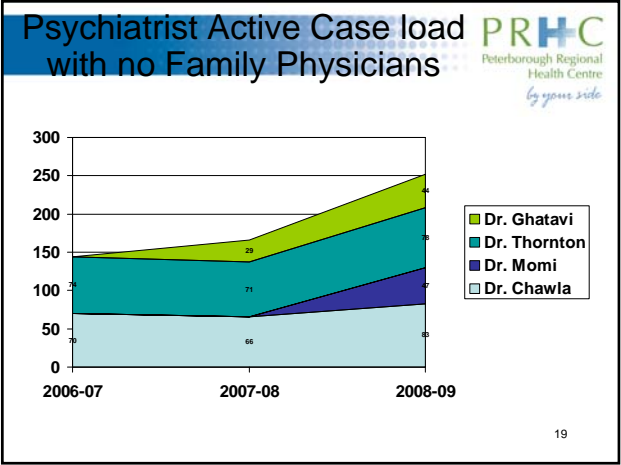
MOOD DISORDERS Early Identification Diagnosis Treatment Depression and Concurrent Medical Illnesses	PSYCHOTIC DISORDERS Early Identification Diagnosis Support Monitoring Antipsychotic Metabolic Side Effects	ANXIETY DISORDERS Early Identification Diagnosis Treatment Stress Management and Relaxation Training	ADDICTIONS Identification Motivational Interviewing Appropriate Referrals	PSYCHOSOCIAL CRISIS / ADJUSTMENT Crisis Management Supportive Therapy System Navigation
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Psychiatrist Active Case load **PRHC**
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Psychiatrist	Active Case Load
Dr. Chawla	~75
Dr. Momi	~375
Dr. Thornton	~220
Dr. Ghatavi	~175

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- ### Current Phase
- Assignment of psychiatrists to individual FHTs
 - Approx. 8 hours/per month of psychiatry to each FHT
 - Meetings between individual FHT and Mental Health Services to establish working relationships specific to needs of FHT

- ### Current Phase
- Identification of unassigned patients within MHS for assignment to FHT FP in a shared care relationship
 - Identification of outcome indicators and process for data collection
 - Development of processes to enhance access to range of MHS such as ED Crisis Services and AOP groups

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- ❖ Multidisciplinary care conferences
- ❖ Consultation onsite / Televideo
- ❖ Access to Mental Health Clinician
- ❖ Clinical Rounds (Medicine/Psychiatry)
- ❖ Clinical teleconferences

OTN Making the Connection to Health

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Lessons Learned

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- Family physicians spend considerable time diagnosing and treating psychiatric problems (Orden 2009).
- Shared Care can be brought about through removal of systemic barriers (Craven 2006)
 - Poor communication
 - Insufficient access to psychiatrists
 - Lack of continuity of care
 - Encouragement of collaborative practice

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Lessons Learned

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- Our Enhanced Collaborative Model
 - Interdisciplinary
 - Offers complimentary services and mutual support
 - Ensures timely appropriate services from providers in suitable location

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Future Opportunities



- Evaluation of the Shared Model
- Creation of Communities of Practice or 'Webs of Care" enabled by telemedicine
- Availability as a Regional / Provincial Resource
- Expansion of model within Long term care, Community Health Centres, other FHTs



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