A Resident-Designed Rotation in Shared Care: What Residents Need in Order to Practice Community Collaboration

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Learning Objectives

1. Describe an experience of shared care in a Canadian residency program.
2. Discuss the process of creating a shared care community rotation.
3. Outline aspects of a shared care rotation that may enhance or interfere with developing specific collaborative skills.

Premise

- Shared/Collaborative Care is:
  - an important health care paradigm for many reasons

  AND
  - worthwhile learning during residency

Specialty Training Requirements RCPSC - 2003

- Collaborator, General Requirements
- Consult effectively with other physicians and health care professionals.
- Provide treatment cooperatively with primary care physicians in a "shared care" relationship.
- Contribute effectively to interdisciplinary team activities.
- No prescribed specific rotation.

Specialty Training Requirements RCPSC - 2007

- Core Senior Resident Rotation
- 2 months of collaborative/shared care
- Much higher priority

Problem

- Some residency programs have not yet developed a shared care curriculum
- Several exceptions (See Compendium by Kates and Ackerman)

Our Experience in Kingston

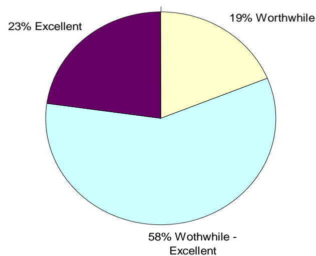
- **July 2005 - two psychiatrists collaborating at Queen's University family medicine center.**
  - **(psychiatry residents rarely involved)**
- **One community shared care team with family medicine resident involvement but rarely psychiatry resident.**

Shared Care Rounds

- **March 2006 – both GP and psych. residents expressed interest in joint rounds**
- **Monthly rounds - Two 20min case presentations – one by a Psych resident, one by a GP resident.**
- **Topics included somatic complaints, psychiatric presentations of medical problems, dementia and delirium, ADHD, and post-partum blues/depression**

Evaluation

- **All attendees rated the rounds as worthwhile to excellent.**



Mid-residency

- Teaching off-service residents
- Experiences in core rotations emphasized importance of collaborative care (Kates, 2000)
- C&A - Chronic care – Geriatrics - Emerg

Experience in Shared Care

- One psychiatrist working exclusively with a Family Health Team of 25 GPs.
- Resident rotation – 3-month duration
- ½-1 day per week in 6 different clinics
- Average – 10 new consults weekly
- Direct supervision

Evaluation

- Importance of co-location
  - Hallway consults
- Communication with GPs in person and on EMR (electronic medical record)
- Lacked formal meetings with GPs
- Lacked the development of relationship with GPs

Longitudinal Rotation

- 9 month duration
- Priority
  - Exposure lacking from our residency experiences
  - Experience a variety of practice paradigms
  - Applying a shared care perspective
- 1 day biweekly in 7 different settings

7 Settings

1. Prince Edward Family Health Team
2. Community Mental Health Agency – ACTT
3. Community Mental Health Agency – Transitional Case Management
4. Street Health – Addictions
5. Correctional Psychiatry – Kingston Penitentiary
6. Dual Diagnosis - Adolescent
7. Dual Diagnosis - Adult

Family Health Team

- Referrals from GPs and RN practitioners
- Some shared-care case presentations
- Developed communication on EMR and hallway discussions

Community Mental Health – Transitional Case Management

- Mandate – 6-8 week psychiatric care before transitioning back to primary care
- Referrals from Case Managers
- Worked on increasing communication b/w inpatient ward and follow-up service
- Consultation/Collaboration with the case managers

Street Health Addictions

- Primary care for patients with substance use problems.
- Referrals for psychiatric consultation from all other staff.
- Co-located with nurse practitioners, social workers, addictions counselors, methadone GPs, RNs.
- Unified and diversified management of challenging patients.

Correctional Psychiatry

- Psychiatric consultation for corrections population
- Referrals from GP, RN, or self-referred

- Knowledgeable and experienced psychiatric nurse
- Lacked collaborative relationship with guards

Dual Diagnosis Clinics

- Referrals from GPs
- Team consultation – psychiatry, psychology, social work, RN
- Good exposure to roles of other disciplines
- Inefficient consultation meetings – lack of “hands on” learning

Post hoc Evaluation

Advantages

- Expanded range of patient exposure
- Broad range of practice paradigms and a unique opportunity to compare/contrast
- Longer duration allows for developing working relationships with supervisors and support staff

Post hoc Evaluation

Disadvantages

- “spread too thinly” over several sites
- Lacked regularity needed to become familiar with/known to primary care staff
- Co-location vs. Conventional outpt clinic

Strengths Promoted and Developed

- Awareness of the team involved
- Acceptance of roles of other disciplines
- Communication skills
  - Quick note vs. assessment database
  - Efficient, affirming and respectful
- Co-managing patients with other providers
- Educating GPs re. meds, community resources, and countertransference

Realistic Suggestions for Improvement

- Brief formal introduction of resident to team
- Attend each clinic weekly
- Poster-board with names and photos
- Include shared-care rounds
- Joint consultation time with primary care provider enhances care

Evaluation

Outcomes

- Changes in primary care provider's personal practice / broadening of skills
- Accessibility of psychiatry / clarifying of psychiatrist's role
- Communication considered most useful to GPs (diagnosis/formulation, treatment recommendations, assessment database)

References

- Kates, N. Sharing Mental Health Care – Training Psychiatry Residents to Work with Primary Care Phyisicians. Psychosomatics 2000; 41:53-57.
- Specialty Training Requirements in Psychiatry. Royal College of Physicians and Surgeons of Canada. 2003.
- Specialty Training Requirements in Psychiatry. Royal College of Physicians and Surgeons of Canada. 2008.

Discussion