Supporting Primary Care to Deliver Mental Health and Addiction Care: Contrasting Current Models in Ontario, Canada
Presenters:

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  Co-Chair, Collaborative Mentoring Networks – Medical Mentoring for Addictions and Pain (MMAPP)
  Ontario College of Family Physicians

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  Co-Chair Collaborative Mentoring Networks – Collaborative Mental Health Network (CMHN)
  Ontario College of Family Physicians

The presenters have no relationships with commercial interests to declare.
Upon completion of this presentation, participants will be able to:

- Identify 3 existing models designed to support primary care providers to deliver mental health and addiction care
- Compare and contrast the different approaches to supporting primary care providers to deliver mental health and addiction care
- Discuss how these different models are viable opportunities for adaptation into various primary care contexts.
Part 1:
Compare and Contrast Services
Components

1. Providers Served and How
2. What is the Content
3. Evaluation
OCFP Collaborative Mentoring Networks

Providers Served and How:

- Collaborative Mental Health Network (CMHN)
- Medical Mentoring for Addictions and Pain (MMAP)
Collaborative Mental Health Network

i. Providers Targeted: Family physicians including those with focused practice in mental health and addictions; Residents in family medicine

ii. Provider practice characteristics (e.g., FHTS, CHCs, Solo, etc.): All practice types

iii. Accessibility to service: Any time by telephone, fax, email, portal; both asynchronous and synchronous communication
Responsive Formats

Mentorship is being used in multiple formats and environments to suit the needs of the learner.

**Mentoring relationships**

- Mentor-Mentee
- Peer Mentoring
- Group Mentoring

**Mentoring Environments**

- Email and portal
- Face to face meetings
- Phone
- Web and video conferencing
Network Membership

Cumulative network membership by LHIN

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Cumulative</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Mentees</td>
<td>Mentors</td>
</tr>
<tr>
<td>CMHN</td>
<td>250</td>
<td>44</td>
</tr>
<tr>
<td>MMAP</td>
<td>150</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>437</td>
<td>887</td>
</tr>
</tbody>
</table>

Please note that some individuals are members in both networks
## Network Demographics

<table>
<thead>
<tr>
<th></th>
<th>CMHN</th>
<th>MMAP</th>
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</thead>
<tbody>
<tr>
<td><strong>Mean Age (range)</strong></td>
<td><strong>Mentees</strong></td>
<td><strong>Mentors</strong></td>
</tr>
<tr>
<td></td>
<td>53 (28-71)</td>
<td>60 (41-71)</td>
</tr>
<tr>
<td><strong>Gender (F%)</strong></td>
<td>64%</td>
<td>45%</td>
</tr>
<tr>
<td><strong>Duration in the network</strong></td>
<td>58% ≥ 5 years</td>
<td>78% ≥ 8 years</td>
</tr>
<tr>
<td><strong>Practice Type</strong></td>
<td>63% in community practices (solo &amp; group physicians)</td>
<td>72% in community practices (solo &amp; group physicians)</td>
</tr>
<tr>
<td><strong>Practice Location</strong></td>
<td>81% in urban/suburban areas</td>
<td>77% in urban/suburban areas</td>
</tr>
</tbody>
</table>

- Members are located across Ontario including rural and remote areas (9% MMAP, 5% CMHN)
- Members predominantly work in physician practices (solo and group)
## Network Activity

<table>
<thead>
<tr>
<th> </th>
<th>CMHN &amp; MMAP</th>
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</thead>
<tbody>
<tr>
<td><strong>Annual Survey (2015-16)</strong></td>
<td>&gt;80% have had 1 or more interactions /year</td>
</tr>
<tr>
<td><strong>Mentor Logs (2002-15)</strong></td>
<td>2-4 interactions /year/ member over 15 years</td>
</tr>
<tr>
<td><strong>Portal (2015-16)</strong></td>
<td>100 discussion threads</td>
</tr>
<tr>
<td></td>
<td>&gt;2700 views</td>
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</tbody>
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**Portal (2015-16):**

- 70% of posts receive a response within 1 hour
- MMAP: 88 thread, 2500 views
- CMHN: 24 thread, 446 views
## Network Impact

- >80% of members report participating in the networks to improve comfort, confidence, competency, access to experts and timely advice

<table>
<thead>
<tr>
<th>Provider Impact</th>
<th>Systems Impact</th>
<th>Patient Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 80% satisfied or very satisfied with the networks</td>
<td></td>
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<tr>
<td>• 76% improved competence in assessing and managing patients (75%(^1))</td>
<td></td>
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<tr>
<td>• 78% improved confidence even with more complex patients (88%(^1))</td>
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<tr>
<td>• 89% feel safer in managing clinical issues</td>
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<tr>
<td>• 70% report seeing a wider range of patients with mental illness, addiction and chronic pain</td>
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<tr>
<td>• 57% report managing more patients with these health issues</td>
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<tr>
<td>• 39% report a reduction in referrals to specialists</td>
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<tr>
<td>• 56% of members believe that participating in the networks has helped to improve their patient’s quality of life</td>
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</tbody>
</table>
iv. Acceptability/Uptake by targeted providers

v. Capacity of service

vi. Flexibility: mentors respond to participants challenges with actual cases regardless of geography and level of need. Responses include knowledge translation into community context and resource availability as well as practitioner skill and knowledge.
CMHN

vii. Responsiveness to targeted providers: case based interactions at moment of need allows for optimal response. Attempts are made to connect to geographically congruent mentors in order to optimize contextual understanding of local resources and challenges.

viii. Communication Modes: telephone, fax, email, portal

ix. Faculty: faculty include psychiatrists, focused practice FD and comprehensive practice FD with adjunct mentors including social work and pharmacy. Selection process requires letters of reference from 2 FD, CV, interview with co-chairs and review by steering committee.
x. Cost and funding sources: Supported through an evergreen grant from the Ontario Ministry of Health and Long Term Care Oversight: Ontario College of Family Physicians

xii. Credits for participants: CPD credits.
iii. Duration

1. Of program enrollment overall: No time limit; some participants have been enrolled for over 15 years

2. Of each educational intervention: the educational intervention is prospective case based and continuous over years. Comfort in discussing issues that related to provider’s vulnerabilities is leveraged by relationship with mentor built over years.

xiv. Frequency of offered components: mentoring is continuous over time; annual conference every 1-2 years; smaller geographical conferences 1-2/year; small group meetings 1-2/year
CMHN

• What is the Content
Information and skills

1. Perceived needs: these are the focus in mentor interactions by virtue that contact is triggered by a case though discussion of case may identify unperceived needs

2. Unperceived needs: addressed through large and small group meetings

3. Best practice: translated into individual practice and patient

4. Guidelines: translated into individual practice and patient

5. Assistance with application to individual patients: extensively
CMHN

ii. Support with challenging cases: this is the focus

iii. Accountability: yes, faculty discuss actual cases and liability is shared

iv. Professional support: yes, key component is to optimize sustainability of providing mental health and addiction care by PCP
CMHN

Evaluation:

i. What is measured: satisfaction with mentoring, small group and large group activities; regular needs surveys

ii. How is the service evaluated: questionnaires and currently broader system level outcomes being evaluated
Medical Mentoring for Addictions and Pain

• Providers Served and How
i. Providers Targeted

Family physicians across the province in all practice environments. Expanding focus to include FP residents, specialists looking to include pharmacists and NP prescribers.

ii. Provider practice characteristics

We have been able to consistently bring in physicians from all practice environments including solo and physician only group practices that have been historically difficult to reach.
MMAP

iii. Accessibility to service
The service is available on demand, in many cases it is virtually a point of care service. Access is available in a variety of formats to address issues of time, geography and cater to the individual learning styles of the provider.

iv. Acceptability/Uptake by targeted providers
About 500 mentees and 70 mentors in the programs. Proportion of uptake reflects the proportions seen in the NPS survey. There is a natural attrition over the life of the program but experience is mostly longitudinal with members in the programs for years. Majority of members report interacting about once every 2 months.
v. Capacity of service

We believe the networks can support up to 500/network or 1000 in total but this is a theoretical limit.
vi. Flexibility: Highly flexible and extremely tailored to the need, geography of the user and the patient. Best practices are interpreted to the stated need and where the best practice ends the gaps are filled with not a singular providers anecdote but with anecdotes from a broad cross section of providers from across the province; provides insight into the practice standards that are there in the community the dialogue around this provides insight into the nuances in the discussion from a variety of perspectives.

Program also provides an opportunity for the experts (mentors) to also engage in discussion with each other and mentees to learn and expand knowledge particularly in those gaps between best practice and clinical needs (practice standard).

Responsiveness to targeted providers

Very responsive, mentor respond within 48 hours, portal posts have 70% receive an answer within 1 hour. Pooled expertise allows providers to share best practices and experiences from different regions to address clinical challenges.
vii. Communication Modes

Mentoring formats: one to one, small group and network wide. Mentoring environment: face to face, email, telephone and web/video conferencing.

viii. Faculty

Includes members with an expertise in mental health, addictions and chronic pain. Selection process requires a number of factors including recommendations from the community, from a network member, CPSO good standing, interview process, feedback from regional mentors and Steering Committee review and vote. Ongoing CPSO good standing and no concerns raised from peer mentors or from mentees.
ix. Cost and funding sources

Full MOHLTC funding no cost to the participant.

x. Oversight

Provided by two OCFP administration individuals and the Network Steering Committee that is composed of two co-chairs and 10 members with expertise in clinical areas, FP practice, evaluation, education.

xi. Credits for participants (e.g., CPD credits, remuneration, etc.)

Members receive 15 credits/year (3 credits/hr – highest certification level) for participation (as either a mentor or mentee) and completion of annual survey. Can submit for more credits with further documentation at 3 credits/hour. Also receive 1 credit/hour for Annual Conference (8 Mainpro + and 5.75 through Canadian Psychiatric Association), Regional conference (5.25 Mainpro + credits/session). Regional conference certification for specialists is available.
MMAP

xii. Duration

1. Of program enrollment overall (e.g., time limits of provider enrollment)

No time limit for mentorship activities or attendance at conferences. Mentees: CMHN 58% > 5 years in the program, MMAP 49% 2-5 years. Mentors: CMHN: 78% > 8 years, MMAP 71 % > 5 years. Our mentees have the opportunity to develop into mentors and this process is actively supported.

2. Of each educational intervention - see above

xiii. Frequency of offered components

Mentorship is available on demand. Annual conference is once a year in person in Toronto in alignment with the ASA. Regional meetings are twice a year (at a minimum) and rotate throughout the province from urban to rural locations. Small group meetings are on demand but typically take place twice a year.
ECHO® Ontario Mental Health at CAMH and U of T

Eva Serhal, Manager Telepsychiatry & ECHO Ontario Mental Health
@eva_serhal
@ECHO_ONMH
What is Project ECHO?

**Project ECHO** is a novel “hub and spoke” educational model that has been replicated globally. All teach. All learn.

**Key goals of Project ECHO**

- Use telemedicine to leverage scarce healthcare resources
- Share best practices and reduce variation in care
- Develop specialty expertise in primary care providers to allow them to practice to full scope
- Improve and monitor outcomes

*Started in 2003*
i. Providers Targeted

- Primary Care (Interprofessional) Providers: Family physicians, nurse practitioners, and other primary and community care providers

ii. Provider practice characteristics

- Mix of providers
  - Solo practitioners; FHTs; CHCs; CMHAs etc.
iii. Accessibility to service

• Uses easily accessible videoconferencing software (Zoom)

• If providers not able to join by videoconference, can still able to connect through telephone audio
iv. Acceptability/Uptake

- Total registered: 336 providers
- Majority are social workers & counsellors (30%), nurse practitioners (28%), and physicians (14%)
- Average of ~33 participants representing 17 sites attending each session.
- Spoke retention rate in cycle 1 was 92.3%; cycle 2 is still ongoing so we are unable to report on this statistic at this point in time.
v. Capacity of service

- max 50 sites per weekly session call (although platform can handle 100)
vi. Flexibility

- Curriculum designed using triangulated needs assessment: 1) population data; 2) expert identified areas of need; 3) participant-identified areas of need
- Flex Sessions based on participant interest.
- Conscious of the resources available in each particular community/recommendations reflective of reality
- Content focuses on disseminating current best practice guidelines.

vii. Responsiveness to targeted providers

- Respond to questions in weekly sessions. If urgent questions arise, respond as necessary.
viii. Communication Modes

Given the geographic distribution of our target providers, we predominantly communicate with our Spokes via videoconference, telephone, and email. We also share information on a private members only community of practice website.
ix. Faculty

- Hub consists of specialized mental health care providers, including: physicians with expertise in child and youth, trauma and medical psychiatry, family medicine and addictions; social worker; other health care providers.
x. Cost and funding sources

• This program is funded by the Ministry of Health and Long Term Care. There is no cost to providers participating in the program.

xi. Oversight

• This project is coordinated by a project team, with oversight from a manager at the Centre for Addiction and Mental Health. The Manager reports up to an executive leadership team consisting of three Co-Chairs (two Psychiatrists and our program Vice President).

xii. Credits for participants

• Each session is fully accredited as Continuing Medical Education, so participants will receive CME credits at no cost on the condition that they attend the session and complete a satisfaction survey post-session.
xiii. Duration

1. Enrollment overall
   • Providers can enrol at any time throughout the intervention, although there is a preference for enrollment at the beginning of the curriculum. Providers that join later on in the intervention are further encouraged to join sessions that they have missed in the subsequent cycle.

2. Of each educational intervention
   • 40 week curriculum, with each weekly session being 2 hours in length.

xiv. Frequency of offered components

• 2 hours in length, weekly (except during holiday and break periods)
ECHO® Ontario Mental Health at CAMH and U of T

Content

**General Assessment and Safety**
- ECHO Basics: Aims, Principles and Practical Tips for Participating in ECHO
- Examination and Assessment of Psychiatric Patients
- Safety Assessment
- Introduction to DSM 5
- Clinical Care Pathways and Guidelines
- H.O.P.E. and its Role in Mental Health Care
- Sleep - A Psychiatric Vital Sign
- CBT Essentials

**Pharmacology**
- Psychopharmacology 101 and Novel Treatments of Psychiatric Conditions
- Collaborating Around Adherence to Medications
- Rational Polypharmacy

**Addiction Medicine**
- Addictions 101
- Motivational Interviewing
- Alcohol Use Disorders
- Benzodiazepine Use Disorders
- Opioid Use Disorders
- Gambling and Technology
- Medical Marijuana - Current Guidance

**Mood and Anxiety**
- Assessment and Diagnosis of Anxiety Disorders
- Management of Anxiety Disorders
- Assessment and Diagnosis of Major Depressive Disorder
- Management of Major Depressive Disorder
- Assessment of Bipolar Disorder
- Management of Bipolar Disorder

**Psychological Trauma**
- Assessment and Diagnosis of Trauma and PTSD
- Management of Trauma and PTSD

**Psychosis**
- Assessment of Psychosis
- Management of Psychosis

**Development**
- Attachment
- Assessment and Diagnosis of Personality Disorders - Focus on Cluster B
- Assessment and Management of ADHD

**Geriatric Psychiatry**
- Screening for Dementia
1. Perceived needs
   • Conducted a survey of perceived learning needs to develop a needs assessment that guided the development of curriculum topics.

2. Unperceived needs
   • Unperceived needs were identified through a population-level needs assessment that guided the development of curriculum topics.
   • Identified throughout weekly sessions and addressed with flex sessions.
ECHO® Ontario Mental Health at CAMH and U of T

3. Best practice

• All content – whether in session (e.g., during the didactic presentation or case recommendations) or out of session (e.g., library resources) – is rooted in best practice guidelines for mental health, e.g. CAMMAT Guidelines

4. Guidelines

• Intervention is rooted in best practice guidelines for mental health
5. Assistance with application to individual patients:

- Providers who present anonymized cases are provided a list of community-derived recommendations for patient management, along with opportunities to follow up with the expert hub for further support.
ii. Support with challenging cases

- Each session consists of anonymized case presentations from spoke sites, followed by discussion and recommendations for assessment and management from the community of practice.

- This case-based, iterative learning allows for the case presenter as well as the rest of the community of practice to receive support with assessing and managing challenging cases in their own practice.

iii. Accountability

- The Hub team provides an informal consultation for each case presentation, but it is up to each provider to make decisions about their client; the Hub is not a direct consult.
iv. Professional support

• Across our evaluation framework we aim to capture providers’ feelings of competency and satisfaction
  
  • Competency: measured pre- and post- program using MCQ vignettes
  • Satisfaction: Measured weekly using online surveys

• Community of practice
  
  • Spokes are offered professional support that extends beyond their weekly participation
  • Should Spokes require psychiatric consultations and have limited access to psychiatry services in their area, we can provide consultations through our Telepsychiatry program.
  • We also ask questions about if the project helps reduce feelings of isolation.
ECHO® Ontario Mental Health at CAMH and U of T

v. What is measured?

• Use Moore’s CME evaluation framework
  – Spans participation through to community health outcomes

• Cycle 1 and 2: main focus has been on provider participation, satisfaction, learning, and competency

• Recent CIHR grant to increase capacity to research ECHO outcomes
# ECHO Ontario Mental Health Outcomes: Cycle 1

<table>
<thead>
<tr>
<th>EVALUATION FRAMEWORK</th>
<th>OUTCOMES</th>
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<tbody>
<tr>
<td>Level 1 PARTICIPATION</td>
<td>Spoke retention rate was 92.3%, with an average of 34 providers representing 26 sites participated weekly</td>
</tr>
<tr>
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<td>68 hours of accredited CME provided</td>
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<tr>
<td>Level 2 SATISFACTION</td>
<td>Satisfaction ratings consistently &gt;4 on a 5-point Likert scale</td>
</tr>
<tr>
<td>Level 3 LEARNING (KNOWLEDGE)</td>
<td>Performance on MCQ-based knowledge test improved post-ECHO program (p&lt;.001)</td>
</tr>
<tr>
<td></td>
<td><strong>12% increase in knowledge</strong></td>
</tr>
<tr>
<td>Level 4 COMPETENCE</td>
<td>Perceived self-efficacy increased post-ECHO, approached significance (p=.053)</td>
</tr>
<tr>
<td>Level 5 PERFORMANCE</td>
<td>Primary Care Physicians implemented 76% of ECHO recommendations</td>
</tr>
<tr>
<td>Level 6 PATIENT HEALTH</td>
<td>In progress</td>
</tr>
<tr>
<td>Level 7 COMMUNITY HEALTH</td>
<td>TBD</td>
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vi. How is the service evaluated?

• Evaluated using:
  – Weekly surveys (for outcomes of participation and satisfaction)
  – Pre-post knowledge and self-efficacy surveys (used to measure changes in knowledge and perceive competency)

• Future studies will focus on provider performance, and patient and community health outcomes.
Other Primary Care Mental health Support Models at CAMH

• Telepsychiatry:
  – FHTs throughout Ontario matched with psychiatrist for bi-weekly 3-hour sessions
  – Developing Indigenous Telemental Health Pilot
  – Telemedicine embedded within many of our programs

• E-consult:
  – Piloting with several FHTs

• NPOP/OPOP
  – Fly into rural primary care sites to provide consultations.
Project ECHO® Ontario
Child and Youth Mental Health

We all teach and we all learn - every week.
ECHO® - Extension for Community Healthcare

Outcomes

One standard of care for everyone, no matter where they live.

Deliver specialty level mental health care to kids in every corner of Ontario by moving knowledge, not people.
Key Principles of ECHO®

Concept of "force multiplication"
Via Hub/Spoke design
Our primary care provider partners...
How does Project ECHO® CYMH work?
Project ECHO® CYMH Innovation: System Navigation

- Unique perspective on needs of entire family
- Provides resources per case/LHIN
- Searches for strengths
- We provide contacts, wait times, etc.
So how much does this cost?

1. Funded by MoHLTC; no cost to PCPs.

2. CPD credits (all disciplines).


5. Urgent consultations with Hub.

6. Community of Practice.

5. Permanent membership in ECHO.
Challenges to participating:

1. Weekly 1.5 hour ECHOClinic.
2. Currently 12:00-1:30 PM.
3. 24-week commitment.
4. Presentation of cases.
5. Open discussion of cases.

And I'm supposed to do what?

And how much time will it take?

Time is money, you know.
## ECHO vs. Other Technology Based Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>What is it?</th>
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<tbody>
<tr>
<td><strong>ECHO®</strong></td>
<td>Provincial free educational program funded by MOHLTC for PCPs; innovative, technology-enabled collaborative learning program to share knowledge about CYMH amongst PCPs and with tertiary care specialists; offering CME/CPD for PCPs.</td>
</tr>
<tr>
<td><strong>Telepsychiatry</strong></td>
<td>Telehealth for psychiatry, direct CYMH clinical care (assessment and treatment) provided by CHEO and The Royal Youth Program using OTN.</td>
</tr>
<tr>
<td><strong>TeleMental Health Service</strong></td>
<td>Provincial program funded by MCYS; referral source is MCYS agency; service provides a one-time CYMH assessment to patients via OTN; also used for agency consultations and education; no direct connection to PCPs.</td>
</tr>
<tr>
<td><strong>eConsult</strong></td>
<td>A web-based consultation platform that enables PCPs to access specialist advice for their patients; any time by sending an e-mail consult to specialists.</td>
</tr>
<tr>
<td><strong>Phone consult</strong></td>
<td>PCP to Psychiatrist phone consultation scheduled from CHEO Centralized Intake.</td>
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</tbody>
</table>
There are lots of educational opportunities for PCPs; ECHO is not for everyone.

Join if you:

1. Have a high rate of CYMH problems in your practice.
3. Want to learn how to access local non-medical CYMH resources.
4. Enjoy being part of a virtual community of practice.
5. Can take advantage of urgent consultation or long-standing opportunity for case-based learning.

So, should I join or what?
How are we doing so far?
In our first cohort, we have **16 Spoke Sites** and **33 participants** from two LHINS: Champlain and North Simcoe Muskoka.
Research

Using pre-post cohort and pre-post ECHOClinic surveys plus real-time polling to measure factors such as:

1. Knowledge acquisition.
2. Self-reported competence.
3. Signs of force multiplication.
4. Effects on management of patients.
5. Growth of Community of Practice.
OTN, eConsult and Mental Health

Dr. Rob Williams, CMO
June 3, 2017
The views expressed here do not necessarily reflect those of the Government of Ontario.
AGENDA

About OTN

eConsult

Virtual Mental Health
OTN is a not-for-profit organization funded by the government of Ontario

Far reaching membership
26,125 Hub users including 8,759 physicians

We partner with many provincial organizations
LHINs, Health Quality Ontario, eHealth Ontario, KO eHealth, OntarioMD, Champlain BASE, WIHV and Canada Health Infoway

Key capabilities include technology, program development and clinical change management
VIRTUAL HEALTH BRINGS CARE RIGHT TO THE HOME

Enables new models of health care delivery that

1. Improve access to care
2. Support people living with chronic disease or mental health challenges
3. Improve care for patients and their caregivers living with complex health problems in the community
CLINICAL VIDEOCONFERENCING

786,986 patient events

284.2M km of travel avoided

67.1M kg of carbon pollution avoided

$70.1M in Northern Health Travel Grants avoided
TOP 10 SPECIALTIES

- Mental Health
- Primary Care
- Oncology
- Emergency Telemedicine & Trauma
- Cardiology
- Respirology
- Endocrinology (includes diabetes)
- General Surgery
- Physical Medicine and Rehabilitation (Physiatry)
- Nephrology (includes Dialysis)
- Hematology
OTN Invite
21,000 direct to home clinical video visits in 2016/17

eConsult
“Ask a Specialist” for advice

Access to Primary Care
eVisits with your primary care provider or their community of practice

ACCESS TO PRIMARY CARE INITIATIVES

NEW ACCESS TO PRIMARY CARE INITIATIVES
NEW MODELS OF CARE
IN DEVELOPMENT

<table>
<thead>
<tr>
<th>Improved Access</th>
<th>Disease Self-Management</th>
<th>Mental Health</th>
<th>Complex Care in the Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care eVisit</td>
<td>CHF</td>
<td>Anxiety &amp; Depression*</td>
<td>Wound Management</td>
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<tr>
<td>Retinal Screening</td>
<td>COPD</td>
<td>Addiction Management</td>
<td>Home Palliative Care</td>
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<td></td>
<td>Diabetes Coaching*</td>
<td>eCognitive-Based Therapy</td>
<td>Surgical Transitions to Home</td>
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<tr>
<td></td>
<td>Home Dialysis*</td>
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<td>Dementia and Caregiver Support in the Home</td>
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* Clinical Trial
A Partnership Between

OntarioMD

OTN

eConsult

Champlain eConsult BASE™

OTN Telederm

OTN & BASE
South East eConsult Pilot

4 eConsult models active in Ontario
BENEFITS

The program enables healthcare professionals to:

- Find and select a specialist or program from a directory of providers
- Ask and respond to requests for consultation
- Securely and efficiently exchange patient health information
- Better coordinate the care of their patients
HOW IT WORKS

1. **Referrer sees patient, collects PHI such as:**
   - Exam results
   - Lab results
   - Digital photos

2. **eConsult**
   Create and send eConsult to Specialist along with PHI and clinical question

3. **Specialist reviews patient data**

4. **eConsult**
   Specialist:
   - answers clinical question or;
   - provides a consult report or;
   - requests that patient be referred

**Fast Response**
eCONSULT PILOT
REFERRALS BY SPECIALTY - DIRECT TO SPECIALIST MODEL

- Dermatology: 17%
- Hematology: 17%
- Endocrinology and Metabolism: 11%
- Neurology: 10%
- Cardiology: 9%
- Obstetrics and Gynecology: 7%
- Pediatrics: 6%
- Psychiatry: 6%
- Infectious Diseases: 6%
- Urology: 6%
- Orthopedic Surgery: 5%
- Infectious Diseases: 6%
- Endocrinology and Metabolism: 11%
- Neurology: 10%
- Cardiology: 9%
- Obstetrics and Gynecology: 7%
- Pediatrics: 6%
- Psychiatry: 6%
- Infectious Diseases: 6%
- Urology: 6%
- Orthopedic Surgery: 5%
Average response time for eConsults was between 2 and 2.5 days (FY16/17)

Some specialties have achieved even shorter response times:

- Nephrology eConsults are answered in an average 1.4 days
- Pediatrics in an average 1.5 days
- Vascular surgery specialists answered a total of 17 eConsults in an average 0.2 days
“Did eConsult help you avoid referring the patient to be seen directly by a specialist, either virtually or in-person?”

In 70% of eConsults, an in-person referral was avoided

- 85% of Hematology eConsults
- 89% of Infectious Diseases eConsults
“Without radical changes to the way psychiatrists practice, access to psychiatrists will remain a challenge in Ontario” (Kurdyak et al. 2017)

Questions:
1. How many patients truly need to see a psychiatrist beyond diagnostic and medication review?
2. Should psychiatry focus more on acute care management and can psychotherapy needs be met by allied health professionals?
3. Can GPs continue to manage their patients with supportive advice from the psychiatrist through eConsult or clinical videoconferencing?
Approaches to Virtual Collaborative MH Care

1. eConsult
2. ECHO
3. OCFP Collaborative Network
4. Methadone and addictions with VC
5. Shared MH Care with VC (CAMH, HSC to NE and NW Ontario, Parry Sound)
6. MH crisis support (Oshawa paediatric program)
7. Direct to consumer
   1. Social media (Big White Wall, patient support groups)
   2. Self help (CBT apps, Breaking Free)
8. Provider education (extensive library of MH content on OTNHub)
The Journey to a Healthy Ontario Has Begun
Part 2: Complementarity of Services
Small Group Activity

• This section is worked on by audience at small groups facilitated by distributed presenters
Factors to Consider

• Longitudinal fit
• Flexibility
• Developmental stages of provider’s expertise
• Type of practice (e.g., solo vs group vs multidisciplinary)
• Acceptability
• Timely Responsiveness to need
• Responsiveness to type of support sought
Part 3: Operationalize Coordination of Complementarity
Leveraging Complementarity

• Large Group Together (size of group permitting)
Examples

i. Econsult may provide the referring physician with a treatment plan. The provider however requires longitudinal support in implementing the treatment plan as barriers and challenges are encountered with the client.

ii. A provider “graduates” from one of the Project ECHO programs and then continues to receive mentoring and coaching in applying what was learned to individual patients.

iii. Enrollment in one service facilitates enrollment in the other services.

iv. Faculty in each service refers their users to the other services.