

Why World Class Commissioning Requires System Change and Co-operation : Lessons from a Canadian Experience

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

**Program Director,
Hamilton Family Health Team**

PLAN

- The Canadian Context
- The Hamilton Family Health Team Mental Health Program
- Key Lessons learnt
- Implications for World Class Commissioning

CANADA

- 10 Provinces and 3 territories
- 9,600,000 sq. kms.
- Federal Government
- Provinces responsible for Health Care (13 health care delivery systems)
- Canada Health Act defined principles to guide the entire system (1964)
 - Universality
 - Portability
 - Publicly Administered
 - Comprehensive
 - Accessible
- Almost all health services are publicly funded (9.2% of GDP)

CANADA

- Originally cost-shared now 80:20 split
- Provinces increasingly autonomous
- No national mental health plan
- Primary care planning ad hoc – provincial responsibility
- Regional health authorities (not Ontario)

REGIONAL HEALTH AUTHORITIES

- Cost containment
- Enhanced public participation in (local) decision making
- Improved system planning
- Service integration
- Greater emphasis on population planning
- Greater accountability
- Allow government to deflect criticism
- May not cover all health services

CANADA'S HEALTH CARE SYSTEMS

- Ontario spends \$3,500.00 per capita
- 50 / 50 split – specialists / primary care
- Strong base of primary care – 40% Solo practitioners
- 10% of the population have no family physician
- Shortages of specialists, especially psychiatrists / child

ONTARIO

- Most family physicians funded by fee for service - moving to capitation (33%)
- Average practice size 2,200 patients
- Capitation pays \$140 per pt. (covers expenses)
- Average salary = \$200,000
- Bonuses - For processes not outcomes : Can earn up to \$100,000 - Usually closer to \$25,000

REASONS FOR THE MENTAL HEALTH PROGRAM

REASONS FOR THE PROGRAM

- Family physicians already playing a key role
- Low detection and treatment rates in primary care
- Family physicians see this as a major area of unmet need
- Resource availability
- Co-morbidity
- Problems with access to traditional mental health services
- Problems in the relationship between mental health and primary care services

HAMILTON FHT (HSO) MENTAL HEALTH PROGRAM

- 1994 MH Program started – 45 physicians
- 1996 Expansion – 41 new physicians
- 2005 Became part of Hamilton Family Health Team
- 73 new physicians

FAMILY HEALTH TEAMS

- Next step in evolution of primary care in Ontario
- 150 FHTs funded in 3 waves + 50 more approved
- Involve over 20% of all comprehensive care family physicians in Ontario

FAMILY HEALTH TEAMS

- 2-25 family physicians
- Funded by capitation
- Rostered populations
- Funded by capitation
- Supported by IT
- Comprehensive care
- Population-based care

FAMILY HEALTH TEAMS

- Emphasize health promotion and illness prevention
- Based on chronic disease management
- Emphasize self-management
- Team based care
 - Nurse
 - Nurse practitioner
 - Social Worker
 - Dietitian
 - Pharmacist
 - Health Educator
- Linked with other community and health services

HSO MENTAL HEALTH PROGRAM - 2007

- 80 practices
- 105 sites
- 145 family physicians
- 340,000 patients (68%)

STAFF RATIOS IN THE HFHT MHP

	Ratio Clinicians	FTEs 1996	FTEs 2006
• Counsellors	1:7,200	22.9	50.5
• Psychiatrists	1:75,000	2.2	4.8

Co-ordinated by a central program team

INCLUDES OTHER PILOT PROGRAMS

- Children's mental health
- Addictions
- Depression chronic disease management
- Peer support for depression

HOW THE PROGRAM WORKS

- See any case / any age (3-98)
- Emphasis on short-term care
- Specialists integrated within primary care
- Indirect as well as direct service
- Emphasis on education
- Charting integrated
- Stepped model of care

CENTRAL PROGRAM TEAM

- Coordination / management
- Direction
- Guidelines
- Evaluation
- Trouble shooting
- Liaison with MoHLTC
- Recruitment
- (re)allocation of resources

DOES IT MAKE A DIFFERENCE?

Data from the programs evaluation.

REFERRALS 2007

(141 FAMILY PHYSICIANS)

◆ Total	7064
◆ Counsellors 151 per Full Time Equivalent	6084 (87%)
◆ Psychiatrists 594 per Full Time Equivalent	1664 (23%)

REFERRALS 2004

Total Referrals	4014
<12	4%
<18	13%
>65	8%

MAJOR PRESENTING PROBLEMS

Problem	Primary (%)	Any (%)
Depression	35.7	68
Marital / family	16.0	37
Anxiety	12.1	45
Work problems	4.4	12
Child behaviour problem	2.4	20
Anger / temper control	2.9	8
Psychotic symptoms	2.8	4
Bereavement	2.0	10
Suicidal	1.4	7
Substance abuse	1.3	8

REASON FOR REFERRAL TO HSO PSYCHIATRIST

Reason for referral	(%)
Clarification of diagnosis	68
Advice regarding:	
Medications	84
Psychotherapy	32
Risk to self / others	6
Community resources	5
Family / Marital problem	8

DIAGNOSIS: CASES SEEN BY PSYCHIATRIST

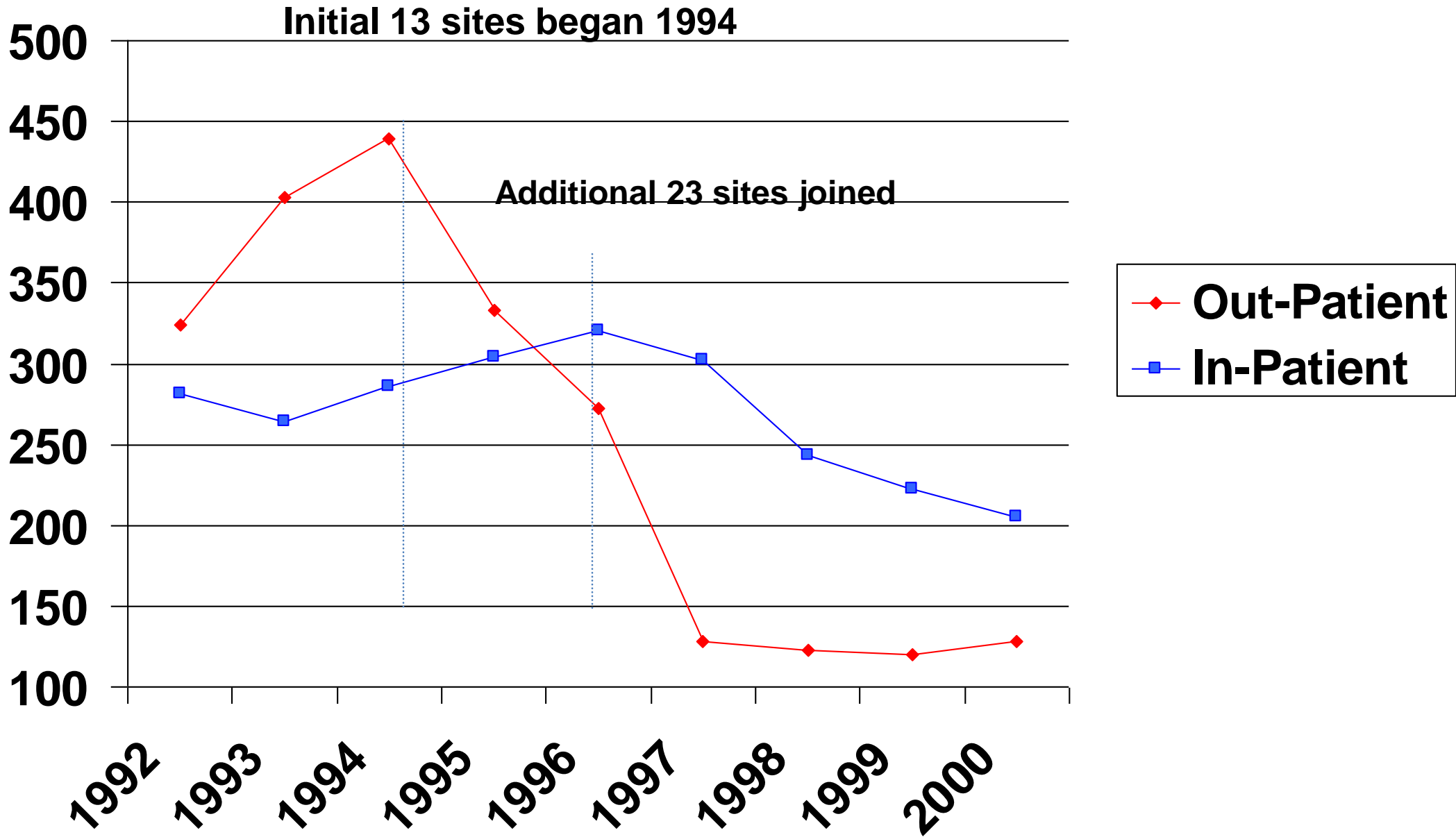
Diagnosis (DSM IV)	(%)
Depression	31
Anxiety disorder	16
Dysthymia	10
No psychiatric diagnosis	8
Adjustment disorder	7
Personality disorder	6
Schizophrenia	5
Substance-related disorder	5
Bipolar disorder	4
Disorder of childhood / adolescence	4
Somatoform disorder	2
Other	2

REFERRALS TO MENTAL HEALTH SERVICES

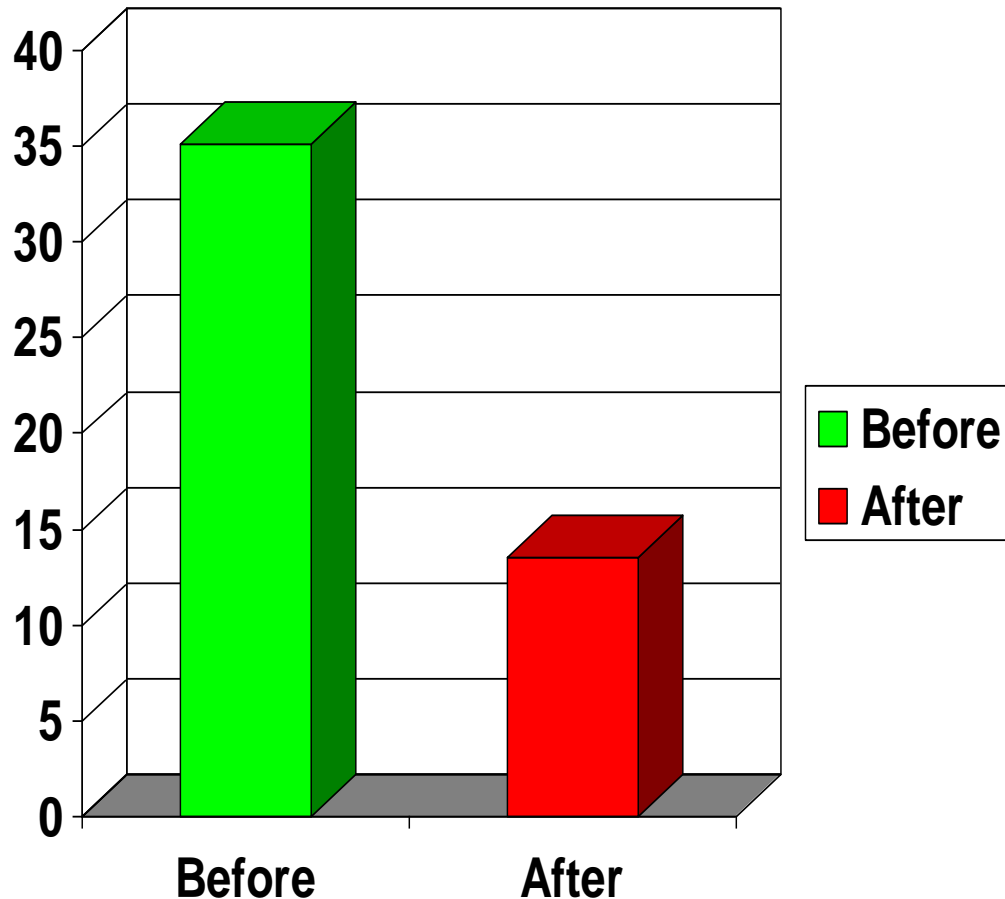
(FIRST 13 PRACTICES - 45 PHYSICIANS)

Service	92-93	94-95	2000	2003
Out-patient clinics	203	75	72	82
HSO Mental health team	-	2532	2180	2255
Total Referrals	203	2607	2252	2337
Referrals / Phys / year	5	54	53	55

Impact on in-patient admissions



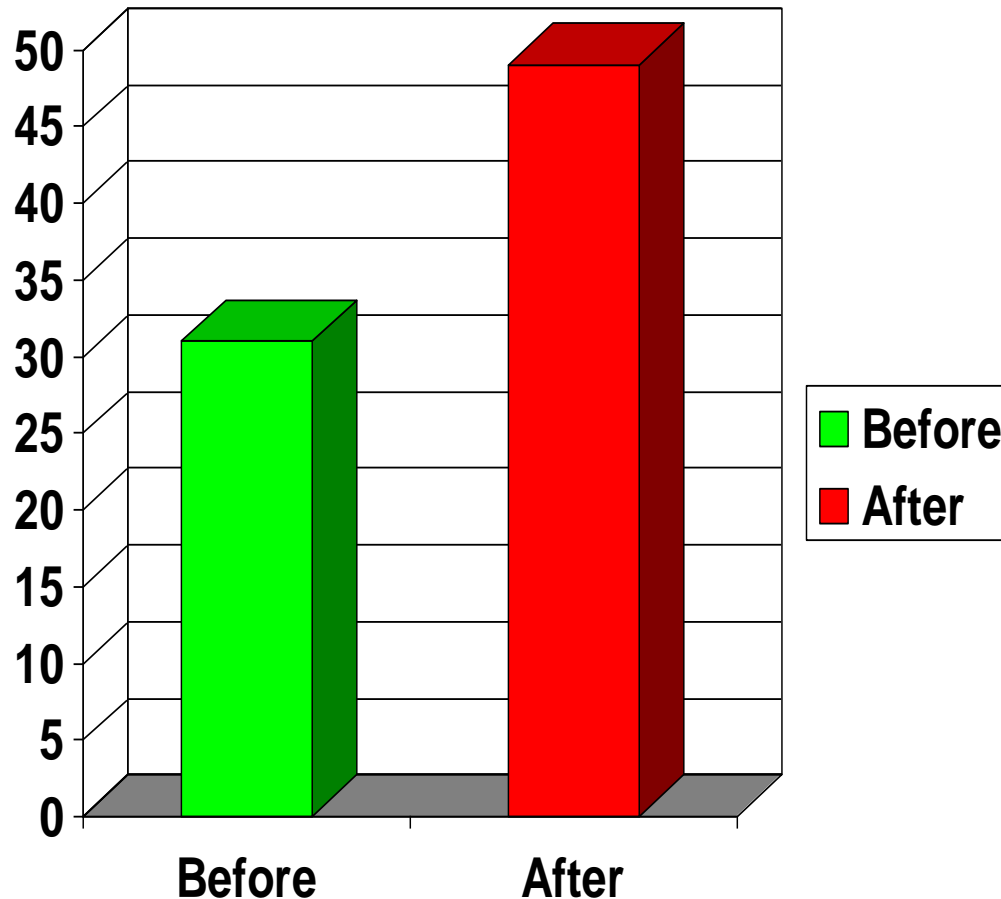
OUTCOME MEASURES CES-D



- Mean change **21.2**
- Improved > 1 SD **68%**
- Score reduced
 > 50% **79%**

All changes significant $p < .05$

OUTCOME MEASURES SF-8



- Mean change **17.8**
- Improved > 1 SD **62%**
- Score reduced
 > 50% **68%**

All changes significant $p < .05$

SATISFACTION WITH SERVICES

CONSUMER SATISFACTION

- CSQ - 91% satisfaction
- Ave score on V.S.Q. 4.5 out of 5
- Each item meets or exceeds AAGH Benchmarks

PROVIDER SATISFACTION

- Family Physicians
 - With Counsellors 92%
 - With Psychiatrists 92%
- Counsellors 90%
- Psychiatrists 90%

HAMILTON FAMILY PHYSICIANS SATISFACTION WITH MENTAL HEALTH SERVICES

- Those with HSO Program 86%
- Those without HSO Program 56%

“ I think that knowing we have great back-up makes us less resistant to explore social issues during a busy clinic.”

Family Physician in the Program

“Over the 3 years of the program, I am convinced that my own knowledge and comfort with mental illness has increased to a highly significant degree. It is no longer an area of uncertainty and doubt, but a discipline which has begun to fall into place and gives great satisfaction and reward.”

Family Physician in the Program

LESSONS LEARNED

BENEFITS

- Increases capacity of primary care
- Increases capacity of mental health system
- Improves access
- Improves access for underserved communities

BENEFITS

- Improves communication
- Increases continuity of care
- Creates a continuum of care
- Increases co-ordination of care
- Potential cost savings

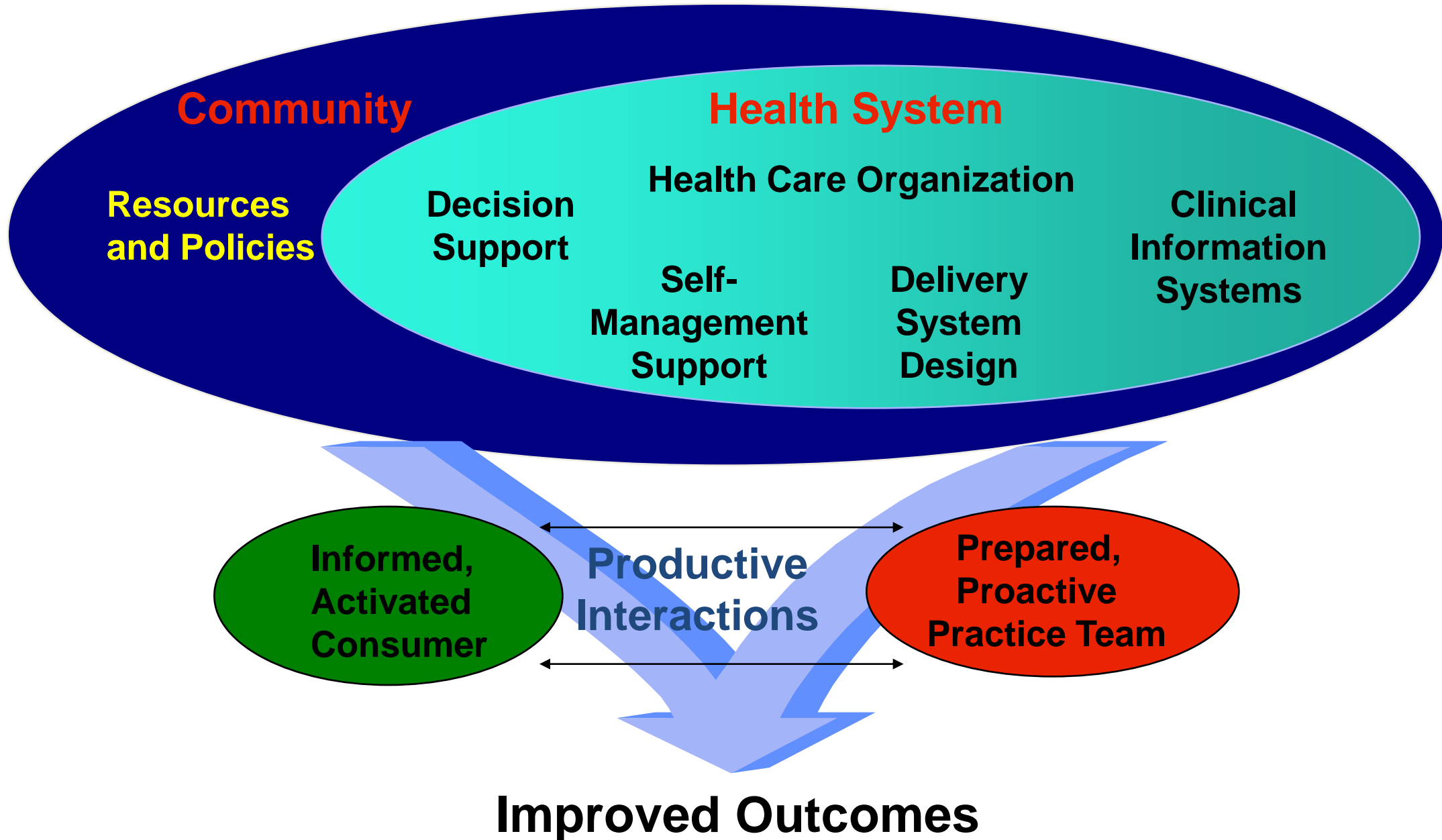
COLLABORATION HAS IMPROVED

- Access
- Waiting times
- Communication
- Relationships

CO-LOCATION IS NOT ENOUGH

**ALSO NEED CHANGES IN SYSTEMS
OF CARE TO SUPPORT THESE
INTERVENTIONS / ROLES**

Chronic Care Model



SOME COMPONENTS ALREADY IN PLACE

- Integrating counsellors in primary care
- Access to psychiatric consultation
- Organisational commitment / support
- Opportunities for case discussions
- Team-based care

COMPONENTS OF THE NEW PROGRAM

- Population health focus
- Registry
- Screening
- Treatment algorithm
- Pro-active follow-up
- Self-management support

CRITIQUING THE MODEL

- Not a standardised approach
- Can still be traditional
- Not as well community linked
- Not as much family work (depends on clinician)
- Solo offices – not comprehensive teams / options
- Not consumer driven

KEY COMPONENTS OF SUCCESS

- Space
- Well trained staff
- Family physician remains involved
- Stepped approach
- Responsive to individual practice needs
- Central co-ordinating team
- Partnership from the outset
- Flexible model within guidelines
- Assists practices with governance / management

TRANSLATING THE MODEL TO THE UK CONTEXT

WHO DRIVES THE AGENDA

- Government
 - Targeted investments
 - Development of provincial strategies
 - Cost containment
- RHAs
 - Local efficiencies
 - Targeted investment
 - Co-ordination of local services
- Providers
 - Innovative initiatives (sometimes)
 - Pick up priorities
- Not patient choice / not market forces

WE HAVE CREATED A SINGLE ORGANISATION THAT IS RESPONSIBLE FOR

- **COMMISSIONING**
 - (re-)allocating resources
 - needs assessment

- **ACCOUNTABILITY**
 - defining standards of care
 - evaluation
 - reporting to funding source

WE HAVE CREATED A SINGLE ORGANISATION THAT IS RESPONSIBLE FOR

- OVERSEEING / SUPPORTING IMPLEMENTATION
 - training
 - space
 - governance mechanisms in the practices
- ADVOCACY
 - links with community partners
 - With funding source
 - Promotes mental health in primary care and primary care in mental health
- RESPONDING TO / PROMOTING PROVIDER DRIVEN CHANGES
- 10 of the 11 roles of commissioners – not stimulating the market

CENTRAL STAFF

(for program serving 340,000 people)

- Manager
- 2 Secretaries
- Program assistant
- 2 data entry clerk
- 0.2 Evaluation
- 0.5 Medical Director
- Leads for depression (0.5), addiction (0.2), child (0.2), peer support (0.1)

OTHER BENEFITS OF LINKING ROLES

- Opportunities for innovation
 - From the central team
 - From the practices
- Ability to introduce new changes uniformly / consistently
- Assists practices with governance / supporting the program
- Advocates for mental health in the wider organisation, practices, community

KEY COMPONENTS OF SUCCESS

- Regular contacts with the practices
- Commissioning staff know the practices and their needs
- Provider as well as commissioner driven
- Providers involved in program planning and needs assessment

AN OPPORTUNITY FOR IAPT PROGRAMS

- Based in primary care
- Integrated teams
- Majority of problems include depression and / or anxiety
- Multiple evidence-based treatments (not just CBT)
- Linked with community partners
- Better co-ordinated care
- Opportunities to support primary care as first point of contact