Champlain Pathways to Better Care – Improvement through Collaboration

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Insights

Rural Capacity

There is a shortage of psychiatrists and psychiatric resources available to Champlain's rural regions.

KEYWORDS:

Physician, Shortage, Urban, Rural, Psychiatrist, Retirement, Canada, Ontario, Champlain, Technology, Telepsychiatry, CritiCall, Models, IMG, International Medical Graduate, Jurisdictional Scan

There is a known physician shortage across Canada. In 2017, Canada ranked 28th out of 39 developed countries based on physician-to-population ration (i.e. the number of physicians per 1000 people) (OECD, 2017). On average, there are 2.7 doctors per 1000 people across Canada (OECD, 2017). This is problematic as a physician shortage encourages access to care challenges for patients, and promotes physician burnout in the small group of physicians supporting the larger system. Additionally, work underway by Dr. Paul Kurdyak proposes further segregation of the already small group of physicians supporting our system. Kurdyak outlines three practice styles that separate psychiatrists by their caseloads.

1. **Urban, small volume** psychiatrists are typically found in the community settings within Toronto and Ottawa. They see 40-60 patients at a frequency of up to 18 times per year per person, who tend to be healthier, and require minimal intervention.
2. **Urban, large volume** psychiatrists are typically found in the community setting. They see 100 patients at a frequency of 5-9 times per year. These patients tend to be sicker than those seen by urban small volume psychiatrists.
3. **Rural psychiatrists** see many sick patients often in an ED setting, only 1-2 times per year. With many of Ottawa's community psychiatrists falling into the urban small volume practice style, one can see how it could be challenging for a primary care provider to refer a patient to a community psychiatrist as most are not taking on new or additional patients.

It is a known fact that psychiatrists in rural areas of Champlain are in undersupply, therefore, it is fair to assume that most patients requiring Mental Health and Addictions (MH&A) care must access care through the emergency departments (EDs). Further complicating this is the inability of rural physicians to refer their clients on to close by community psychiatrists who may practice in the Ottawa area, as most Ottawa psychiatrists are characterized as urban, small volume doctors who are not taking on new patients.

A high proportion of psychiatrists in Champlain are nearing retirement age (46% over age of 60) (OPTIMUS SBR, 2017b). This poses challenges for the rural setting due to low overall numbers of practicing psychiatrists, with one full-time psychiatrist plus another fractional time physician practicing across all of Renfrew County. In addition to the low numbers of psychiatrists in rural areas, low numbers of primary care providers encourages access to MH&A care through the ED. When a primary care provider retires, many individuals become unattached as no primary care providers are able to take over the roster of the retiring physician. Patients without a primary care provider are left to seek MH&A care through the ED, placing pressure on psychiatrists working EDs and ED

physicians who are often the first contact for those with MH&A challenges.

According to Canadian Medical Association (CMA), there are 4,864 psychiatrists across Canada, (CMA, 2018). This translates to 13.2 psychiatrists per 100,000 population across the country, with variances from 1.6 (Territories) to 15.5 (British Columbia) psychiatrists per 100,000 population (CMA, 2018). Looking specifically at the Champlain region, there is an estimated total of 287 psychiatrists (22/100,000 population) (Ontario Physician Human Resources Data Centre (OPHRDC), 2015). The 2017 Champlain LHIN Inpatient Mental Health & Addictions Capacity Plan revealed that there is an average of 0.07 FTE psychiatrists per funded bed across Champlain, with the majority of psychiatrists located in urban areas (OPTIMUS SBR, 2017a). It also revealed that psychiatry per bed is particularly low in Cornwall and Pembroke, despite the fact that both hospitals have been recruiting for several years with little success (OPTIMUS SBR, 2017a). This trend matches the greater trend found across Ontario: for every specialist physician working in a rural region, there are almost 90 specialists working in urban areas (CIHI, 2016). With the majority of psychiatrists located in urban areas of Champlain, this poses challenges for Champlain's rural regions, including, but not limited to:

- Reliance on urban hospitals for the provision of MH&A services
- General lack of community resources that patients can access
- Need for patients to travel great distances to receive care
- Over-burdened existing MH&A workforce
- Extensive wait times to access care within their home community

There are several reasons why physicians prefer to practice in urban settings over rural settings. There are more professional and personal opportunities in larger cities, especially if they have a family (i.e. where can the spouse work? What kinds of schools are there? What social networks are available to us? etc.). Additionally, rural practice limits a physician's opportunity to interact with colleagues, the number of opportunities to continue their medical education, and often requires frequent care of patients with high rates of illness, complex chronic conditions and more, which can be challenging when there is limited access to specialist services (Arora et al., 2013). These factors, and many more factors that are unique to each individual, combine to support a poor urban-rural mix of psychiatrists across Champlain.

Jurisdictional Scan and Best Practices Review

Canadian Environmental Scan

The Newfoundland and Labrador Centre for Applied health Research conducted a jurisdictional snapshot in the Spring of 2018 of rural psychiatry practices and models found across Canada (Letto, Ryan, & Bornstein, 2018). This report found *nine models* used that support and deliver psychiatric services to rural and remote communities across the country, and one initiative highlighted comes from Champlain: the Champlain BASE eCONSULT model (Letto et al., 2018). This report found the following key findings (Letto et al., 2018):

1. Technology is a powerful tool that can increase access to MH&A services, especially in regions with geographic barriers.
2. Supporting primary care providers to provide MH&A services in rural and remote areas fosters less reliance on psychiatrists for the delivery of MH&A services.
3. Coordination of care is integral to ensure patients receive timely MH&A care through the simplest means possible.
4. Travelling clinics, or intermittent community visits can complement a community's permanent services.

Technology and Telepsychiatry

Telepsychiatry is the delivery of acute MH&A care, including diagnosis or treatment, by means of a secure, two-way real-time interactive audio and video by a health care provider in a remote location to an individual needing care at a referring site (Holton, Andrew Brantley, 2014). North Carolina (NC) has had great success with their NC Statewide Telepsychiatry Program (NC-STeP)—a hub and spoke model that is run out of East Carolina University. NC-STeP ensures that individuals experiencing an acute behavioural health crisis who present to an ED in NC receive timely, evidence-based psychiatric treatment through videoconferencing technology (Saeed, 2016). Since 2017, over 26,500 assessments have been provided, which has resulted in a cost savings of over $15 million from overturned involuntary commitments (N.C. Department of Health and Human Services, 2017).

In addition to the provision of care through technology, the use of technology can also support remote supervision of medical trainees. An Australian study looked at the effectiveness of remote supervision of medical trainees in a rural town found in North Queensland (Cameron, Ray, & Sabesan, 2015). The study found that remote supervision via videoconference provided "readily available guidance to trainees supporting their delivery of appropriate care to patients" (Cameron et al., 2015).

International Medical Graduates (IMGs)

As an area becomes more rural, the percentage of IMGs practicing within the area increases. Just over 25% of practicing rural or remote physicians obtained their Doctor of Medicine (MD) outside of Canada (CIHI, 2009). Of the new physician graduates practicing in rural and remote areas, IMGs make up almost 53% of this population (CIHI, 2009). The trend of IMG movement to rural practice settings holds across most of Canada, with the exception

of Ontario and Quebec (CIHI, 2009). Something is inherently different about the practice settings found in these two provinces that draws IMGs away from rural practice settings, to urban locations. The draw towards urban centers within Ontario is most likely due to the offerings of Toronto—outside of the practice setting, there is significantly more opportunity for IMGs and their families. IMGs represent an untapped resource, especially those who are living and working in Ontario in non-physician roles, to help support Champlain's rural psychiatrist shortage.

Models

There are several models which can be considered for Champlain such as the following examples.

CritiCall Facilitated Rotating On-Call Telepsychiatry Schedule

CritiCall supports access and delivery of urgent and emergent care within Ontario and is currently used to facilitate MH&A bed capacity and patient transfers within Champlain. CritiCall is integral to MH&A surge capacity across Champlain and is accessed daily by hospitals. Champlain small hospitals with limited ability to provide MH&A services are partnered with large, schedule one facilities located in Ottawa. For example, Deep River is partnered with The Ottawa Hospital Civic Campus. When a patient presents in the emergency department (ED) in Deep River, they should be sent to the Civic Campus for care if Deep River does not have the capacity to provide adequate services. Based on visits to the small hospitals, challenges with respect to the provision of MH&A care were brought to light (e.g. no transfers in the evening, challenges with staffing levels over night, little to no MH&A professionals available to patients, etc.). The creation of an on-call telepsychiatry schedule aims to tap into the already existing relationships between small rural hospitals and their partnered schedule one facility, the relationship Champlain has with CritiCall, and the schedule one psychiatry on-call schedules that are already in place to resolve challenges around the provision of MH&A care in Champlain rural small hospitals.

Schedule 1 hospitals in Ottawa and The Royal would provide on-call telepsychiatry services to providers in Champlain small rural hospitals on a weekly rotating schedule. A weekly rotating schedule spreads the addition of responsibility across the region; therefore no single schedule 1 facility is burdened with the sole responsibility of providing on-call telepsychiatry services to the small hospitals. No new on-call schedule would be created; rather the small rural hospitals would tag onto the on-call schedules of schedule 1 facilities that are already in place. CritiCall would act as the on-call telepsychiatry facilitator.

When small hospitals require a MH&A consultation, they would contact CritiCall. CritiCall would identify the on-call schedule 1 facility and would contact them to inform them of the need for consultation. The schedule 1 facility on-call would have a window of time (e.g. 60 minutes) to reach out to the small hospital to provide their telepsychiatry consultation.

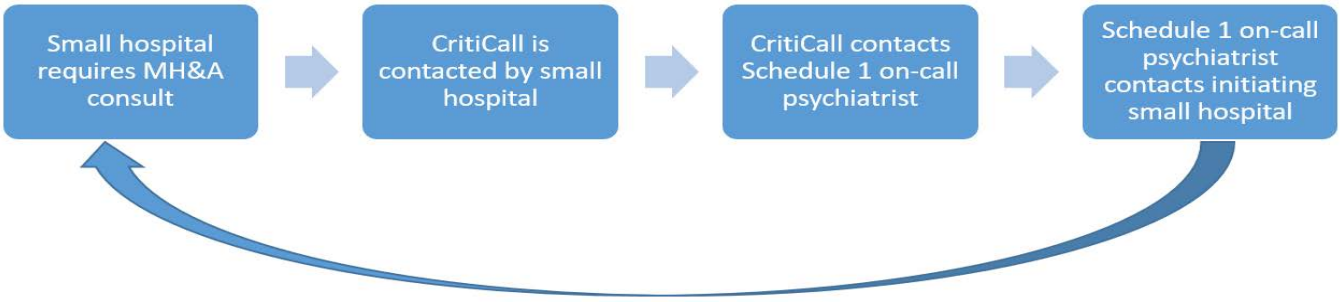
CritiCall Partner Hospitals On-Call Telepsychiatry Schedule

This model follows a similar process as the model outlined above. Instead of the Ottawa area urban hospitals supporting the rural small hospitals on a rotating basis, CritiCall partner organizations would create their own on-call telepsychiatry schedule that involves support from the Ottawa partner hospital to their associated partner small hospital(s). This model supports relationship building with already established partners, which could further strengthen ties to support timely access to MH&A across the Champlain region.

On-Duty Contract Service

This model involves the creation of a contract service that psychiatrists could opt to participate in, in addition to their duties at their respective organizations. Psychiatrists would be compensated for their time, and would be tasked with providing urgent, timely consultations to ED physicians in rural hospitals. This model ensures that those who do not want to participate in additional on-call duties are not required to, allowing those who truly want to provide this care to do so. Additionally, it does not place any added burden on the schedule 1 hospitals, and helps support capacity building in the rural setting.

Implementing an on-call/on-duty telepsychiatry model to support Champlain rural small hospitals will support small hospitals' ability to provide basic, well-supported psychiatric care to patients presenting in the ED. This is important because it allows patients to receive adequate health care in their hospital/location of choice (often keeping them closer to home) and helps build capacity in



our rural small hospital practitioners (psychiatrists, general practitioners, hospitalists, nurses, etc.). If adopted, this approach exemplifies a truly regional approach to the delivery of MH&A care in Champlain.

It is important to note that an on-call telepsychiatry model does not replace standard of care, and does not replace actions related to Form 1 status. The development of a care pathway outlining appropriate use of the on-call telepsychiatry resource will be developed.

IMG Recruitment

Utilizing IMGs to fill notable gaps in psychiatry care in rural Champlain can help our system as IMGs represent an untapped resource, therefore supporting potential IMG candidates, whether they are emigrating from another country, or are already here in Champlain, with their licensure and administrative needs will serve to benefit Champlain as a whole.

Health System Improvement

Understanding the current challenges and potential models can help in the development of solutions to the need for rural capacity. Supporting Champlain's rural areas provides not only benefits for the rural areas but also the urban centres. Strengthening rural health services means rural areas have greater capacity to meet their local needs, which reduces the necessity of rural clients/patients and family to flow across our region into urban centres. Strengthening rural capacity involves greater partnerships and a system approach which results in better coordination of services across all geographical areas. *To see how Pathways and Champlain stakeholders are collaborating to address this need, go to the Pathways website.*

CHAMPLAIN PATHWAYS TO BETTER CARE

Background

Champlain Pathways to Better Care is a regional initiative that emerged from the Connecting the Circle of Care Mental Health and Addictions Action Plan 2013-16. This plan actively applies the lens of lived experience to help build and sustain a quality improvement agenda around local priorities. The primary purpose of Champlain Pathways to Better Care is to prioritize and support the implementation of collaborative, cross-organizational, and quality improvement initiatives identified within the 3 year plan.

Mission

Champlain Pathways to Better Care will work with others to implement coordinated changes to the Champlain mental health and addictions system – leading to improvements for those with lived experience and their families. Our focus is on enabling and sustaining change through action, collaboration, knowledge, education, and expertise.

Principles

- The voice of those with lived experience and their families (as defined by them) must determine our focus and approach.
- We will continually work with a client perspective that promotes a strength based Recovery Model.
- We believe that having front line perspectives, those with lived experience, and family members at all tables will enable and support active collaboration.
- We believe in supporting diversity and equity. Through this approach this we will provide work to provide appropriate care and services that are responsive to clients and their families.
- We believe that a strong mental health and addictions system requires collective action and coordination.
- We will model and foster personal, professional and organizational cultures, attitudes and actions that support teamwork.
- We are committed to innovating to improve our system in a measurable way.
- We will work to build capacity through continuous quality improvement within our sectors and organizations
- We will solicit input to identify system bottlenecks and create as well as support the implementation of solutions.

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