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Process Evaluation of the Hamilton HSO Mental Health & Nutrition Program

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List of Abbreviations

Abbreviation	Description
CMT	Central Management Team
FP	Family Physician
FTE	Full-time Equivalent
HSO	Health Service Organisation
ISP	Institutional Substitution Program
MHC	Mental Health Counsellor
MOHLTC	Ministry of Health and Long Term Care
PSY	Psychiatrist
RD	Registered Dietitian
RPP	Regional Psychiatry Program
WSIB	Workplace Safety and Insurance Board

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Executive Summary

Health Service Organisations (HSOs) were introduced in 1973 as an alternative payment program based on capitation and later on institutional substitution program (ISP) grants for primary care. In 1994, the HSO introduced the Mental Health Program in Hamilton which was expanded in 1996. In 2000, a local Nutrition Program, in operation since 1994, was integrated into the HSO and both programs were amalgamated under one administrative body: the central management team (CMT). The Hamilton Mental Health and Nutrition Program's general aims are to increase accessibility to high quality mental health and nutrition services in primary care and to enhance the role of the family physician (FP) as a provider of mental health and nutrition care. Thus, the FPs, mental health and nutrition staff work in interdisciplinary teams to collaboratively provide the best treatment available by the most appropriate health care provider.

The purpose of the current study was to complete a comprehensive process evaluation using mixed methods. Our team aimed to assess the HSO Mental Health and Nutrition Program pertaining to the Ministry of Health and Long Term Care's (MOHLTC) goal of advancing interdisciplinary health care, to assess the delivery of the program in relation to the program's objectives, to identify its strengths and challenges, to present general recommendations for viable costs of the program, and to put forward recommendations on improving the delivery and monitoring of the services it provides.

A process evaluation focuses on whether the program is meeting its program delivery objectives. This evaluation began with the development of a program logic model for the CMT and the HSO practices. The quantitative component included the review of documents provided by the central office and the qualitative component involved reviewing CMT satisfaction questionnaire results and conducting six focus groups to obtain the perspective of various HSO health care practitioners regarding the implementation and functioning of the program. The current report enumerates the program objectives and lists the processes utilised by the program to reach those objectives. Furthermore, the report discusses how the program contributes to the MOHLTC's goals pertaining to primary care, lists the strengths and challenges of the program, and makes recommendations with regards to enhancing delivery and monitoring of the services provided by the program.

The HSO was found to be an excellent example of a program in the primary care setting which contributes to both the provincial and federal objectives. It is a program dedicated to advancing interdisciplinary care by having providers with various expertise working in a common setting, collaborating to provide appropriate patient care, and helping each other learn about various aspects of health and wellness. The program provides the opportunity for increased access to care, decreased waiting times for early detection and intervention, simultaneous care from multiple providers for continuity of care, and patient education material and group sessions to encourage health promotion and disease / injury prevention as well as patient empowerment. Furthermore, the program is organised such that any person experiencing mental health or nutrition problems has the opportunity to be assessed by a qualified professional in a timely fashion. Other qualities of the program, which contribute to the MOHLTC objectives, are the provider and patient satisfaction questionnaires which are assessed on a regular basis and allow the CMT to maintain both provider and patient satisfaction.

Program strengths

1. A CMT that coordinates, monitors, evaluates, troubleshoots, reports and negotiates with the MOHLTC, serves as a voice in the community for the program, oversees the administrative component of the regional HSO practices, participates in numerous committees, and maintains a relatively problem-free implementation of the program.

2. Accessibility to mental health and nutrition services in primary care which allows for early detection and intervention.

3. Interdisciplinary teams in a common primary care setting allowing for shared care and collaboration in providing the best possible care and continuity of care.

4. Health care provider opportunities for formal and informal education via provider collaboration and educational activities organised by the CMT.

5. Patient education possibilities via group sessions and courses offered by the allied health care providers, as well as educational material provided by the CMT.

6. Flexibility to prioritise patients according to care needs and to choose the most appropriate treatment approach / protocol for patients.

7. Health care provider access to detailed patient information via patient charts and personal communication with team members.

8. Assessment and treatment of patients in a primary care setting for a reduced stigma and a decreased burden on the traditional system.

Program challenges

1. Time constraints due to increased caseloads resulting in less time for collaboration and communication, record keeping, and data collection.

2. Lack of physical space for the increase in personnel and patients making it difficult to have all team members working simultaneously and sharing care.

3. Standard forms are time consuming and lead to legibility issues because they are in a paper format. Also, there is a lack of clarity regarding data collection for chronically ill patients.

4. Lack of clear definition of the providers' roles and expectations with regards to shared care.

5. Difficulties associated with referrals to community clinics which appear to be caused by long waiting lists, strict intake criteria, and an overestimation by these clinics of HSO resources.

6. No-shows and cancellations.

Recommendations for viable costs

1. The HSO program appears to be providing increased access to mental health and nutrition care for more patients with a wider variety of mental health and nutrition problems, and at the same time reducing the burden on community clinics (traditional system).

2. Sharing of common patient medical charts suggest an increased efficiency and may contribute to a more holistic approach to patient care than the traditional system.

3. Valid recommendations would need to emanate from an economic analysis of the program.

4. An economic evaluation assesses the tradeoff between costs and outcomes; therefore, it cannot be conducted until an outcomes evaluation is completed.

5. Economic or even cost analyses require comparator programs or "control" no program.

6. It is recommended that the Ministry consider supporting a comprehensive outcomes and economic evaluation in the future.

Recommendations to improve service reporting and program enhancement

Since the CMT is diligent about adjusting and troubleshooting as issues arise, there are no major changes required to improve the program. However, some of the small issues identified under the challenges section could be considered.

1. The CMT should consider exploring a digitised format for all forms or introducing a computerised system in the individual practices to improve the efficiency of data collection, or at least have the option of electronic or paper versions for all forms. However, it is clear that IT resources would be needed for the program to develop a computerised system of data collection.

2. We recommend to consider an increase in the FTE of all the allied professionals or introducing changes to the flexibility allotted in how the current FTE is spent (clinical vs administrative vs education hours). It is apparent in the data that there is a need for these services and that having such services in primary care seems to reduce the burden on the traditional system. Changes to the way time is spent in practice may allow for more time to collaborate and coordinate with other community services. It appears that the RDs may need more time to become fully integrated into the program. An increase in FTE or a change in the way time is spent in practice could allow for more collaboration and continued education for all professionals regarding the advantages of nutrition services.

3. The program should continue to increase the awareness of community services regarding the limitations of the resources available in the HSO practices.

4. No-shows and cancellations are a serious challenge for the HSO and the program should continue to work on strategies to reduce this problem.

5. Lastly, it is important to consider clearer definitions, roles, and expectations. Although a certain degree of flexibility is necessary to mould the program according to the patient population and team dynamics, it may be that the provision of clearer definitions of or the development of group consensus on the components and reporting lines within the model could eliminate some of the inconsistencies leading to ambiguity and occasional provider frustration. If the program were to consider more stringent protocols and uniformity across the practices, one would hope a comprehensive evaluation of the current methods and patient outcomes would be completed first. Such an evaluation would help ensure that the most appropriate protocols would be chosen to provide a service that leads to better health outcomes for patients in combination with both patient and provider satisfaction.

Chapter 1:
INTRODUCTION

Health Service Organisations (HSOs) were introduced in 1973 as an alternative payment program based on capitation and in time institutional substitution program (ISP) grants for primary care. In 1994, the HSO introduced the Mental Health Program in Hamilton into 13 practices which was expanded in 1996 into 23 additional practices. In 2000, a local Nutrition Program, in operation since 1994, was integrated into the HSO and both programs were amalgamated into the Hamilton HSO Mental Health and Nutrition Program administered by the central management team (CMT).

The program's general aims are to increase accessibility to high quality mental health and nutrition health care services in the primary care setting and to enhance the role of the family physician (FP) as a provider of mental health and nutrition health care. For this to be possible, the program CMT is responsible for a number of administrative duties such as allocation of resources, provision and circulation of educational materials, evaluation of the program, and advocacy on behalf of the program. The CMT is currently comprised of one part-time director, one full-time program coordinator, and a research and administrative team of seven people (three full-time evaluation team members, two full-time receptionists, one full-time research assistant, and one project manager). During the 2002-2003 fiscal year, the program included a total of 146 HSO health care practitioners dispersed over 38 practices (one of the original 36 practices separated in two and one practice is part of the nutrition program only). Of these, 79 were FPs, 39 were mental health counsellors (MHCs) (equivalent to 23.0 full-time employment [FTE]), 17 were psychiatrists (PSYs)(2.0 FTE), and eight were registered dietitians (RDs) (7.0 FTE). The FPs, mental health staff, and nutrition staff work in interdisciplinary teams in 38 practices where they have the opportunity to collaborate in order to provide the best treatment available by the most appropriate provider.

The purpose of the current study was to complete a comprehensive process evaluation using mixed methods. Our team aimed to assess the HSO Mental Health and Nutrition Program pertaining to the Ministry of Health and Long Term Care's (MOHLTC) goal of advancing interdisciplinary health care, to assess the delivery of the program in relation to the program's objectives, to identify its strengths and challenges, to present general recommendations for viable costs of the program, and to put forward recommendations on improving the delivery and monitoring of the services it provides. As process evaluations focus on whether the program is meeting its program delivery objectives, the first component of the evaluation involved the development of a program logic model. The quantitative component included document reviews and the qualitative component involved reviewing questionnaire results and conducting focus groups. The study received ethics approval from the University of Western Ontario Review Board for Health Sciences Research Involving Human Subjects.

Throughout the document, we will refer to allied staff, allied providers, allied professionals or allied practitioners all of which include MHCs, PSYs, and RDs. Furthermore, allied mental health staff comprises both MHCs and PSYs and allied nutrition staff comprises RDs only.

Chapter 2:
DESIGN & PROCEDURES

Sections:

2.1 Program Logic Model

A logic model is a diagrammatic representation which reveals the relationship among program objectives, activities, and indicators so a program's purpose and causal linkages can be clearly understood and evaluated. The development of the program logic model for this project was accomplished in several stages. First, a literature search of MEDLINE and PsycINFO was conducted wherein any documents published by the CMT were collected and reviewed. These documents were combined with proposals and reports provided by the CMT and used to identify the major components, target groups, and activities of both the CMT and the HSO practices. Second, the initial program logic model was discussed with the HSO program director and program coordinator to identify any areas where the model was incomplete or inaccurate. At this time, potential indicators were discussed with the CMT for each of the activities identified. Following this review, the program logic models were amended and a copy was sent to the CMT for further review. After a period of approximately two months of ongoing collaboration with the program's CMT, program logic models were completed for both portions of the program; the CMT and the HSO practices. Both models include the following sections: components, activities, target groups, short-term outcomes, and short-term indicators.

2.2 Quantitative Component

Some of the indicators identified in the program logic models were examined quantitatively to determine whether the short-term outcomes of the program are being met. The data were gathered through informal meetings with the CMT, onsite or via email and by examining files kept onsite at the HSO central office. These files contained information regarding professional meetings, newsletters, workshops, and other administrative activities.

Furthermore, the CMT provided descriptive data from their central patient database including information from standard forms which are routinely completed by the HSO health care practitioners. The pertinent information such as the number of patients seen, the number of patients referred, the number of forms completed, etc, was then grouped and presented in summary tables.

2.3 Qualitative Component

Questionnaires

The results of a number of internal qualitative studies and satisfaction questionnaires were made available to our team. The contents were reviewed and summarised.

Focus Groups

The focus groups were organised to obtain the perspective of various HSO health care practitioners pertaining to the implementation and functioning of the program. The discussion was semi-structured in that guiding questions were used, but the participants were encouraged to bring up other topics they felt were relevant throughout the discussion. The general guiding questions were developed from information from CHEPA and an expert panel (N.B.: the questions were not necessarily presented in the order provided below during the focus groups):

1. What are the goals of the program?
2. Define shared care?
   a) Is your definition of shared care different from how it occurs in your practice(s)?
   b) What are the factors influencing the different applications of shared care across practices?
3. What do you like about working in your practice(s)?
4. What don't you like about working in your practice(s)?
5. What types of patients benefit from your practice(s)?
6. What types of patients do not benefit from your practice(s)?
7. Do you think shared care has changed the way patients are treated in your practice(s)?

All the members of the program were invited by the CMT to participate in the focus groups. The only criterion was that the participants be a member of the program as an FP, PSY, MHC, or RD. The FPs and the PSYs were invited via a personal letter and later contacted by one of two members of the current research team by telephone. The MHCs and the RDs were invited to participate at two consecutive professional meetings. All MHCs and RDs are sent meeting minutes following the meetings, and so those who were not present at the meetings were aware of the general invitation to participate. Therefore, all members of the program were invited to participate either in person, through a personal letter, telephone call, or email (meeting minutes). In addition, professionals were invited to participate as a group from individual practices. The aim was to obtain two volunteer groups: one located in the inner city of Hamilton and another from the outskirts. Since only one practice volunteered, the CMT contacted a second practice to participate.

A total of six groups of health care professionals were interviewed: i) 8 FPs , ii) 7 PSYs, iii) 13 MHCs, iv) 4 RDs , v) one HSO practice (Group 1: 11 various health care professionals), and vi) another HSO practice (Group 2: 10 various health care professionals). Each group was interviewed separately in their workplace or at the central office by two investigators from our team. Prior to beginning each focus group, one of our investigators introduced our team and listed the aims of the focus group. She reminded the participants that any comments made would

remain anonymous and that the session would be tape-recorded. All participants were given an information sheet and required to sign a consent form prior to starting the focus group.

Ethnographic and content analyses were conducted by multiple investigators. The first investigator, present during the focus groups, conducted an analysis using NVivo, a computer software program designed to analyse qualitative data. In this analysis, the investigator identified broad themes and representative quotations. A second investigator was responsible for

summarising the discussion as per the topics of the guiding questions and making note of any additional topics brought up in the discussions. Since this investigator was not present during the focus groups, her analysis was accomplished by using the summary of the first investigator, the audio tapes, and the transcripts of the interviews.

While summarising the discussions, this investigator formulated a complex list of themes pertaining to the topics. Once the list was complete, two additional investigators, one of whom was naive to the project, were provided the list of themes and the transcripts to ensure that the themes were appropriate. Any discrepancies were discussed until a consensus was reached.

After reviewing the list of themes, the second investigator conducted a content analysis to determine the number of participants and the number of times a theme was expressed. The results are listed in a table format. In addition, the results of the ethnographic analysis are reported as a combination of discussion summaries and direct quotations.

Central Management Team Program Logic Model

Components	Education	Evaluation	Program Development & Administration
Activities	♦ Develop, organise and run training programs/workshops for MHCs ♦ Distribute educational materials ♦ Case consultation/supervision ♦ Treatment groups (eg. stress management) ♦ Facilitate training of students ♦ Presentations at academic forums ♦ Organise and facilitate educational activities for non-HSO providers and health planners ♦ Write publications ♦ Organise, facilitate, and evaluate educational activities for PSYs ♦ Run small continuing medical education activities ♦ Provide informal case based information ♦ Work collaboratively with people in other mental health facilities	♦ Collect demographic data ♦ Collect treatment, outcome, and activity data ♦ Collect satisfaction data ♦ Maintain database ♦ Analyse data ♦ Report on data ♦ Develop forms ♦ Work with other programs to develop evaluations ♦ Collect utilisation data ♦ Collect data on individual practices ♦ Collect data on workshops ♦ Collect minutes of meeting groups ♦ Review evaluation literature ♦ Evaluate psychological assessment tools	♦ Linkage with psychiatric networks ♦ Allocate funds from MOHLTC ♦ Reallocate funds - move resources among practices ♦ Submitting audited financial statements/reports ♦ Advertise for staff ♦ Interview staff ♦ Recommend staff for each HSO practice ♦ Maintenance of physical facilities in central office ♦ Representing practices to MOHLTC ♦ Representing MOHLTC to practices ♦ Development of proposals for external funding/MOHLTC ♦ Manage budget ♦ Negotiate with members of practices ♦ Maintain contract with MOHLTC
Target Groups	♦ FPs ♦ MHCs ♦ PSYs ♦ RDs ♦ Patients ♦ Students ♦ Non-HSO health care practitioners ♦ Planners (health)	♦ MOHLTC ♦ HSO practices ♦ Patients ♦ FPs ♦ MHCs ♦ PSYs ♦ RDs	♦ MOHLTC ♦ HSO practices ♦ Patients ♦ FPs ♦ MHCs ♦ PSYs ♦ RDs

Short-term Outcomes	**Internal knowledge and skills** 1. Increase the skill level of FPs 2. Increase FPs' confidence to detect and manage mental health and nutrition problems 3. Increase the availability of education to FPs, mental health staff, RDs, patients, and students 4. Provide members of the HSO practices with updates about the program **External dissemination** 5. Inform non-HSO health care providers about the program 6. Assist non-HSO providers in setting up similar programs 7. Provide non-HSO health care providers with updates about the program	1. Collect patient data 2. Maintain the quality of data collected 3. Maintain standards of service delivery using evaluation data 4. Provide reports to the MOHLTC as required 5. Provide feedback regarding evaluations to HSO providers and practices 6. Use tests with good psychometric properties	1. Maintain the psychiatric and nutrition networks 2. Maintain equitable distribution of funds 3. Reduce FPs' recruitment workload 4. Distribute allied and specialised staff across the HSO practices 5. Obtain grants
Short-term Indicators	**Internal knowledge and skills** 1 Number of workshops/ publications/ 2 newsletters/ education material 3. relating to FPs, students, patients/ number of professional meetings (minutes of meetings)/ qualitative data 4. Number of people sent a newsletter **External dissemination** 5. List of data disseminated/ number of domestic and international visitors who requested information about the program 6. Number of requests for information/ case studies of assistance to others setting up a similar program 7. List of publications providing information about the program	1. Description of the type of data collected 2. Description of trouble shooting when data are missing and proportion of missing data 3. Document the protocol for improving service delivery following the evaluation and provide examples of problems with service delivery and how they went about improving them 4. Document MOHLTC's reporting expectations and how the HSO meets these expectations/number of reports sent to MOHLTC 5. Document how they provide feedback. Is it a formal system? (eg. newsletter, individual discussions) 6. Document the protocol for reviewing the psychological tests	1. Description of linkages with psychiatric and nutrition network 2. Description of formula for equitable distribution of funds 3. Description of the protocol for recruitment 4. Number of individuals with various qualifications 5. Number of grants obtained

Chapter 3:
RESULTS

Sections:	
3.1	Central Management Team
3.1	HSO Practices
3.1	Focus Groups

Section 1 of the results section provides the program logic model and the results of the process evaluation for the CMT. Section 2 provides the program logic model and the results of the process evaluation for the HSO practices. In Section 3, the summary of the ethnographic analysis of the focus groups is presented. The focus groups were conducted to complement the information identified via the program logic models by obtaining the perspectives of professionals of the program with regards to the program's implementation and functioning.

Section 3.1:
Central Management Team

Components:	
3.1.A	Education
3.1.B	Evaluation
3.1.C	Program Development & Administration

Part 3.1.A:
Education

Short-term Outcomes:	
3.1.A.1	Increase the skill level of FPs
3.1.A.2	Increase FPs' confidence to detect and manage mental health and nutrition problems
3.1.A.3	Increase the availability of education to FPs, patients, mental health staff, RDs, and students
3.1.A.4	Provide members of the HSO practices with updates about the program
3.1.A.5	Inform non-HSO health care providers about the program
3.1.A.6	Assist non-HSO providers in setting up similar programs
3.1.A.7	Provide non-HSO health care providers with updates about the program

The first three short-term outcomes of the CMT are associated with increasing the knowledge and skills of health care providers who are members of the HSO program.

3.1.A.1 Increase the skill level of FPs

3.1.A.2 Increase FPs' confidence to detect and manage mental health and nutrition problems

3.1.A.3 Increase the availability of education to FPs, patients, mental health staff, RDs, and students

To achieve these outcomes, the CMT has undertaken four activities: a resource centre, professional meetings, a newsletter, and workshops.

Resource Centre:

The resource centre provides a means of disseminating educational material. It is located in the cental office and contains reference texts, pamphlets, audio and video tapes, and journal articles organised by topic. The resources can be used free of charge and signed out by HSO professionals, students, and patients. Some of the resources are also available on the shared care website (http://www.shared-care.ca/hso.shtml). The effectiveness of the resource centre in increasing the education, skills, or confidence level of health care providers has not been formally evaluated.

The resource centre holds 123 and 124 free pamphlets on the following mental health issues and nutrition issues, respectively (the number in parentheses represents the number of pamphlets ordered by MHCs and RDs to be displayed in the HSO practices in the 2002-2003 fiscal year):

- Legal Issues (10)
- Childhood Issues (110)
- Teenage Issues (40)
- Aged Persons' Issues (140)
- Anxiety Disorders (70)
- Depression (110)
- Suicide (0)
- Diabetes (3330)
- Calcium and Iron (490)
- Vegetarian Eating (387)
- Cholesterol Health (4876)
- Renal Problems (289)
- Activity (364)
- Attention Deficit/Hyperactive Disorder (10)
- Womens' Issues (80)
- Alcohol and Drugs (80)
- Grief (80)
- Obsessive-Compulsive Disorder (10)
- Mental Illness (60)
- Schizophrenia (0)
- Pregnancy, Breastfeeding and Menopause (80)
- Childhood Nutrition/Activity (230)
- Eating Out (954)
- Healthy Eating/Weight (1097)
- Fibre and Gastrointestinal/Oncology (1879)

MHCs ordered a total of 790 pamphlets in the 2002-2003 fiscal year. The most popular topics were Aged Person's Issues, Childhood Issues, and Depression. As for RDs, 14 000 pamphlets were ordered with the most popular being the Shopper's Guide (1028) and the Fat Scoreboard (588) both related to cholesterol health, and The Diabetes Food Guide to Healthy Eating (604) related to diabetes.

A study aimed at examining the optimal location to display mental health educational material was recently conducted at a number of HSO practices. Preliminary results indicated that patients

are interested in mental health educational material and the optimal place to display such information in the FP's office is in the examining room. The group has submitted a manuscript which was accepted and is now in press.

Professional Meetings:

Professional meetings are ideal forums for HSO professionals to meet and discuss current issues in mental health or nutrition practice, as well as to share information about good community resources. Information regarding upcoming educational programs, groups, conferences, and workshops is distributed at the meetings, and guest speakers are often invited to provide information about contemporary mental health or nutrition issues.

Professional meetings were organised for FPs in the early stages of the program; however, due to scheduling conflicts and very low attendance, the meetings are no longer organised for this group on a regular basis. Meanwhile, some meetings are scheduled when there are critical issues or changes in the program to be discussed. Furthermore, the CMT has helped to facilitate continuing medical education activities as noted in section 3.2.A.3. Professional meetings are organised annually for PSYs to discuss any issues with the program. Also, they are invited throughout the year to participate in educational activities organised for other groups.

Since June of 2001, the CMT has organised nine meetings per year for both MHCs and RDs. Although participation at the meetings is not mandatory, an average of approximately 55% and 92% of HSO MHCs and RDs attended these meetings, respectively.

In 2001, provider satisfaction questionnaires were completed by 42 MHCs and provided insight into the value of these meetings. When addressing satisfaction with the support offered by the CMT, 23 MHCs were very satisfied, 15 were satisfied, three were neutral, and only one was dissatisfied. Only two comments pertaining specifically to the meetings were made: "*meetings are very informative*", and "*meetings are helpful for getting updates, info, etc*".

Newsletter:

The quarterly newsletter is sent out to all professionals of the program directly and provides educational information, updates on recently implemented mental health or nutrition programs, and notices of upcoming workshops, conferences, and educational groups for HSO staff and patients. Furthermore, the newsletter provides administrative updates, details about HSO awards, and staff announcements.

When evaluated by the CMT for educational efficacy in 2000, the newsletter was noted as good or excellent and said to be very informative. The study did not disclose any negative comments regarding the educational value of the newsletter, but one practitioner did comment on the lack of availability of the newsletter and believed many were not aware of its existence. This is likely an internal problem as the newsletter is sent out directly to each member or practice.

Workshops:

Since 1997, 36 workshops were conducted to increase the knowledge of the HSO professionals (Appendix A). The workshops are free of charge and usually conducted in an auditorium or similar venue. The date, time, location, and topics of the workshops are announced in the newsletter, flyers, mail outs, and emails to HSO professionals, and in some cases, affiliated organisations.

In general, qualitative evaluations revealed that participants believe the workshops increased their knowledge and skills. A qualitative study involving 72 health care practitioners provided detailed data regarding the perceptions of the educational workshops. For example, three individuals commented that the workshops were excellent and comprehensive, and nine noted that the meetings were successful, good, or of high quality. It was recommended by one provider that more psychiatry specific education was required, but there were no negative comments regarding the educational value of the existing workshops.

3.1.A.4 Provide members of the HSO practices with updates about the program

Up-to-date information about the program is distributed via the newsletter. It should be noted that HSO program policy changes are not included in the newsletter, but rather written up as memoranda and sent to all HSO professionals individually. Also, see section 3.1.B.5 regarding CMT evaluation feedback to the HSO health care providers.

3.1.A.5 Inform non-HSO health care providers about the program

The CMT has increased awareness of the program via publications as well as national and international meetings with non-HSO professionals. A total of 13 journal articles/reports about the program (Appendix B) were published between 1997 and 2002 in the following journals/reports:

- Canadian Family Physician
- Canadian Journal of Psychiatry
- Canadian Psychiatric Association Bulletin
- Families, Systems & Health
- General Hospital Psychiatry
- Israel Journal of Psychiatry & Related Sciences
- Mental Health Program Biannual Report
- Psychiatric Services
- Psychosomatics
- Santé au Québec

Approximately 74 presentations/posters and 15 courses were presented since 1995 at various conferences and academic institutions. The presentations/posters/courses presented in the 2002-2003 fiscal year are listed in Appendix B.

Meetings with non-HSO professionals have resulted in a number of contacts both nationally and internationally. Interest in the program was expressed by providers from the following geographical areas:

National

- British Columbia
- Halifax/Nova Scotia
- Ontario (Kitchener, London, Mississauga, North Bay, Ottawa, Parry Sound, Penetanguishene, Sault Ste. Marie, Thunder Bay, &Windsor)
- Winnipeg

International

- Australia
- Chile
- England
- Holland
- Israel
- USA (California, Michigan, Rochester/ New York, Salt Lake City, & Seattle)

3.1.A.6 Assist non-HSO providers in setting up similar programs

Several groups have demonstrated interest in setting up a shared care program similar to the Hamilton HSO Mental Health and Nutrition Program. A list of the contacts and programs, along with a brief summary of the assistance provided by the CMT is found in Table 1. In general, the CMT provided information regarding the set-up of their program via informational meetings in Hamilton including onsite visits and in some cases by visiting the other organisations' sites and/or programs.

3.1.A.7 Provide non-HSO health care providers with updates about the program

The CMT provides updated information regarding the Hamilton HSO Mental Health and Nutrition Program via publications, presentations, and an electronic website (http://www.shared-care.ca/hso.shtml). The publications specific to this aim are highlighted in Appendix B.

Table 1: International and national program assistance.

International
GGz Groningen Raad van Bestuur Clinic, Holland
Three Dutch visitors including a PSY, a FP, and a social nurse in mental health, met with the Hamilton HSO staff to learn about the Hamilton HSO shared care model and its operations.
Holland
Two additional groups of Dutch visitors came to review the program, following which they returned to Holland to establish the model at a national level. To date, approximately thirty clinics have been established across Holland using an adapted form of the Hamilton model and evaluation procedure.
Altaview Center for Counselling, Intermountain Healthcare, Salt Lake City
This centre set up a program similar to the Hamilton HSO Program following reciprocal visits between the two cities to discuss the existing set up of the Hamilton HSO.
Department of Psychiatry and Behavioral Health Rochester, New York
Members of the Department set up a program similar to the Hamilton HSO following meetings with Hamilton HSO health care providers.

Department of Psychiatry, Oxford University, United Kingdom
The CMT worked collaboratively with the department to provide information regarding the set up of the Hamilton HSO Program. The department has since set up a shared care program.
Mental Health Services Victoria, Australia
Dr. Graham Meadows met with the CMT to discuss the set up of the Hamilton HSO Program. Dr. Meadows has since developed a shared care program.
Kaiser Permanente, California
The HSO Mental Health Program Director visited Riverside, California to present a workshop and consult to staff from a Kaiser Permanente group who were setting up a collaborative model for their members.
Israel
Professor Binyamin Maoz from Ben Gurion University in Beersheba visited the program to learn about both the model and how it could be adapted to training psychiatry residents.
National
Department of Psychiatry, Fraser Health Authority, British Columbia
The Department of Psychiatry met with the CMT to develop a program based on the Hamilton HSO model. Dr. Nick Kates conducted two follow-up visits with the department to discuss their program.
Canadian Mental Health, Windsor
Members from Canadian Mental Health visited the Hamilton HSO for 2½ days to learn about the set-up of the HSO Program and to discuss the implementation of a similar model in Windsor.
Lakehead Psychiatric Hospital, Thunder Bay, Ontario
The Lakehead Psychiatric Hospital set up a similar shared care program following 3 visits to Hamilton. Dr. Nick Kates also visited this psychiatric hospital and has continued an ongoing working relationship with this group to discuss the evaluation of both programs.
Mental Health Centre, Penetanguishene, Ontario
The CMT visited members from the mental health centre and offered to conduct a workshop regarding the organisation of the Hamilton HSO Program.
Dr. Claude J. Ranger Mental Health Clinic, North Bay, Ontario
Members from the Mental Health Clinic visited Hamilton to discuss ways in which they could implement a shared care program into FPs' offices in their area.
Winnipeg, Manitoba
Three groups of visitors from the Winnipeg Regional Health Authority have visited Hamilton to look at lessons learnt as they establish a similar model in a variety of clinics across the city of Winnipeg.
London, Ontario
Dr. David Haslam visited Hamilton to discuss the program and look at ways in which it could be adapted, particularly the evaluation component, to a project he was starting in Winnipeg.
Parry Sound, Ontario
A Project Manager from Parry Sound interested in setting up a project visited Hamilton to learn about the program and its evaluation.
Halifax, Nova Scotia
Staff of the program consulted to a number of programs in the Halifax area, both around establishing collaborative projects and the use of evaluation materials, and also around the training of undergraduates in shared care.

Part 3.1.B:
Evaluation

Short-term Outcomes:
3.1.B.1 Collect patient data
3.1.B.2 Maintain the quality of data collected
3.1.B.3 Maintain standards of service delivery using evaluation data
3.1.B.4 Provide reports to the MOHLTC as required
3.1.B.5 Provide feedback regarding evaluations to HSO providers and practices
3.1.B.6 Use tests with good psychometric properties

3.1.B.1 Collect patient data

The CMT has developed several standardised forms that FPs, mental health staff, and RDs are required to complete. These forms are collected on a regular basis and the data are entered into a central database. The forms include the following:

Mental Health Program:

- Mental Health Referral Form
- MHC Assessment and Intervention Plan
- MHC Treatment Outcome Form
- MHC Activity Sheet
- Psychiatric Consultation Form
- Psychiatric Follow-Up Form
- Psychiatrist Sessional Fee Invoice

Nutrition Program:

- Nutrition Referral Form
- RD General Treatment Outcome Form
- RD Diabetes/Dyslipidemia Outcome Form
- RD Activity Form

In addition to collecting patient data, the following questionnaires have been handed out to each patient or provider to collect other pertinent information about the program:

- Client Satisfaction Questionnaire (Oct. 2000 - Mar. 2001)
- Visit Satisfaction Questionnaire (Jan.1998 - Oct.1999: Mental health program only)
- Visit Satisfaction Questionnaire (Feb. 2000: Nutrition program only)
- Centre for Epidemiological Studies Depression (CESD) scale (May 1998 - Jun. 2001)
- Short Form-36 (SF-36) (Oct. 1999 - Jun. 2001)
- General Health Questionnaire-12 (GHQ-12) (May 1998 - Oct. 1999)
- Provider Satisfaction Questionnaire (1996)
- Provider Satisfaction Questionnaire (1997)
- Provider Satisfaction Questionnaire (1999-2000)
- Provider Satisfaction Questionnaire (2001)

A more detailed description of these forms and questionnaires can be found in Appendix C.

3.1.B.2 Maintain the quality of data collected

The quality of the central patient database depends on the standard forms completed by the HSO providers and returned to the CMT. To ensure the quality of the data collected, each form received by the CMT is checked for completeness. Information from completed forms is entered into the database whereas incomplete forms require contacting the provider to obtain missing details or using existing information in the database to complete the missing fields.

Every four months, any outstanding forms are requested to be forwarded to the CMT. Outstanding forms may be due to non-completion of paperwork or ongoing treatment into the next fiscal year. Therefore, although the CMT ensures the data entered into the system are complete, outstanding forms may reduce the accuracy of the database and the information provided in this report.

3.1.B.3 Maintain standards of service delivery using evaluation data

Satisfaction questionnaires and evaluations help maintain standards of service delivery by providing data regarding patient waiting lists, no shows or cancellations, staff problems, and administrative issues. This information is assessed by the CMT on a monthly basis. Potential problems are identified and the practices and providers are notified (section 3.1.B.5.). Also, the CMT offers recommendations to rectify these problems. For example:

- Clinical caseload – When long wait lists develop, the CMT examines the number of referrals and the appropriateness of those referrals. To resolve caseload issues, human resources can be increased in the practice, or the appropriateness of the referrals can be discussed in a meeting with the FP, MHC, or RD.

- No shows and cancellations - To reduce the number of no shows and cancellations, the CMT recommends that FPs discuss the implication of a referral with the patient prior to making the referral. They can provide the patient referral information to take home and consider before making a decision. Another option is to not set an appointment for a patient until he/she has been contacted by the MHC/RD to ensure their willingness to meet with the allied professional. An alternative approach is to require a re-referral following 2-3 missed appointments with an MHC or an RD. Information regarding a cancellation policy can be included in a brochure for potential referral patients.

- Staff facilitation - Problems identified within individual practices most commonly involve the physical environment and resources provided to MHCs and RDs by the FPs. When a problem is identified from the satisfaction questionnaires, members of the CMT meet with allied health staff and/or FPs to discuss possible solutions.

- Administrative issues - Problems with the administrative activities of the program are determined from the satisfaction questionnaires. For example, data from the MHCs' satisfaction questionnaire revealed that even though the professional meetings are considered useful, the time was not suitable for some. This led to alternating the time of the meetings to better accommodate the schedules of the MHCs.

3.1.B.4 Provide reports to MOHLTC as required

The Ministry of Health and Long-Term Care provides a standard evaluation form which is to be completed every year. It involves evaluating the goals and objectives of the program, main activities, target population, community partnerships, current personnel, as well as direct and indirect clinical activities of health care providers. The CMT completes this form and also provides the Ministry with progress reports pertaining to any Ministry-funded projects conducted by the program.

3.1.B.5 Provide feedback regarding evaluations to HSO providers and practices

Positive and negative feedback from evaluations is provided to HSO professionals. The results of the provider satisfaction questionnaires are summarised, so every FP receives all of the FPs' comments as well as the practice specific comments made by the allied health care providers. Furthermore, the information from the client satisfaction questionnaires and other pertinent information, such as the number of patients seen, number of clinical hours, number of cancellation and no shows, etc., are provided to allied mental health staff and RDs 2-3 times a year. Any specific comments made by the clients, such as, "*I really enjoyed the opportunity to meet with [so and so], it was wonderful to attend to my problem in my family doctor's office*" or "*It took forever to get an appointment with [so and so]... "* are forwarded to the allied provider in question or the FP.

3.1.B.6 Use tests with good psychometric properties

Outcome measurement tools administered to patients and health providers, are chosen by the CMT based on two criteria: it must possess sound psychometric properties, and be a benchmarked outcome measure. They are chosen by firstly reviewing the literature and secondly by determining which tests are being used by other centres and community programs. The scales are reviewed yearly for appropriateness and analysed monthly with research staff and providers in terms of return rate. Tools which are easier to fill out and more appropriate for both practitioners and patients are identified and considered by the CMT on an ongoing basis.

Part 3.1.C:
Program Development & Administration

Short-term Outcomes:

3.1.C.1 Maintain the psychiatric and nutrition networks

3.1.C.2 Maintain equitable distribution of funds

3.1.C.3 Reduce FPs' recruitment workload

3.1.C.4 Distribute allied and specialised staff across the HSO practices

3.1.C.5 Obtain grants

3.1.C.1 Maintain the psychiatric and nutrition networks

Dr. Nick Kates, program director, is involved in the Regional Psychiatry Program (RPP), a consortium of services, programs, and organisations, which aims to provide mental health services in the City of Hamilton. The main goal of the RPP is to facilitate the planning, integration, coordination, and ongoing evaluation of child and adult mental health services in Hamilton. Furthermore, he is the vice-chair of the McMaster University's Department of Psychiatry and Behavioural Sciences with responsibilities for the coordination of clinical services in Hamilton. He chairs two national committees promoting shared mental health care: the CPA/CFPC Conjoint Working Group on Shared Mental Health Care and the Canadian Consortium on Collaborative Mental Health Care. In addition, he was a member of the Central South Mental Health Implementation Committee.

Anne Marie Crustolo, program coordinator, is involved in the Network Interface Committee which is responsible for the identification and resolution of problems related to entry of patients into the system, movement between services, and the identification of policies that may prevent the resolution of day-to-day problems among services. It provides a forum wherein information can be exchanged regarding intake criteria and activities taking place within services. Furthermore, it is involved in the development of collaborative programs and planning initiatives among services.

Furthermore, members of the CMT and Dr. Kates played an active role in the development of the National Conference on Shared Mental Health Care. This annual 2-day conference provides an opportunity for various disciplines, nationally and internationally, to learn about shared mental health care. The conference has been running for the past five years in the following cities: twice in Toronto, Ontario, and once in Edmonton, Alberta, once in Halifax, Nova Scotia, and once in Vancouver, British Columbia.

In addition, members of the CMT attend various community nutrition meetings and symposia. Some include the Hamilton Diabetes Network, Heart Health Hamilton-Wentworth, Obesity: Problems and Approaches for the Healthcare Provider Symposium, and Dairy Farmers of Ontario Seminars. Also, they participate in regional nutrition programs and have met with other community primary care nutrition planners. As members of the Canadian Diabetes Association, Diabetes Hamilton, and the Canadian Society of Clinical Nutrition, the team provides recent nutrition information to members of the program on a regular basis (ie. RDs and FPs).

3.1.C.2 Maintain equitable distribution of funds

To ensure funds are equitably distributed across the HSO practices, the CMT has developed a general formula for fund distribution. One full-time MHC is awarded for approximately every 8000 patients, one part-time RD (10-15 hours per month) per FP, and one PSY a ½ day per month per FP. This formula is adjusted slightly by the CMT if the allied health staff is under-worked or overworked.

An annual administrative stipend is provided to HSO FPs by the CMT. This stipend is to help cover the administrative cost associated with the presence of additional professionals in the practice. The formula set by the Ministry is 15% of the mental health staff's and RDs' salaries based on their FTE at individual practices.

3.1.C.3 Reduce FPs' recruitment workload

The CMT reduces the FPs' recruitment workload by conducting the majority of the recruitment process. The CMT advertises for staff, interviews applicants, and provides FPs with a list of the best qualified candidates. The FP may then choose the most suitable applicants for their practice, or advise the CMT to choose for them. Once a candidate is selected the CMT meets with the new member to provide an introduction package and other information about working within the organisation.

Protocol:

- An advertisement is placed either in the local newspaper (Spectator), the Globe and Mail, or on the internet. Advertising for RDs typically occurs via Dietitians of Canada.
- An interview is conducted with those applicants who meet the minimum requirements. This interview is approximately one hour long and includes both a structured and an unstructured component. The structured component includes questions regarding working in primary care and how it differs from inpatient or outpatient settings, questions about patient treatment, experience in dealing with treatment/educational groups, and several case studies.
- Interviewees are rated on a scale of 1 to 5 for each set of questions.
- The scores are combined and the references are checked.

Mental Health Counsellor Minimum Requirements:

- A degree in social work, nursing, or psychology, and experience dealing with mental health issues.

Thirty-nine MHCs were employed by the HSO practices at the end of the 2002-2003 fiscal year. There were 27 social workers (11 with a bachelor's degree and 16 with a master's degree), eight registered nurses, one social worker/registered nurse, two community workers, and one psychologist.

Dietitian Minimum Requirements:

- ♦ A master's or bachelor's degree in food and nutrition and a member of Dietitians of Canada.

3.1.C.4 Distribute allied and specialised staff across HSO practices

The size of the practice determines allocation of allied health staff as described in section 3.1.C.2. If one practice requires more allied staff, the CMT will examine evaluation data, determine the extent of the need for additional human resources, the number of hours worked by the allied health staff, and adjust accordingly. Any adjustments are based on patient needs in individual practices. It is important to note that allied PSYs with an expertise in a particular area such as child psychiatry, are made available to all practices based on patient needs.

3.1.C.5 Obtain grants

To date, the CMT has applied for two external research grants. The first is the Educating Future Family Physicians of Ontario grant. This grant was obtained and used to develop a learning package for FPs for Attention Deficit Disorder. Also, they applied for the Ontario envelope of the Primary Health Care Transition Fund grant. The outcome of this grant application has not been determined.

HSO Practices Program Logic Model

Components	Physicians	Mental Health Counsellors	Psychiatrists	Dietitians
Activities	♦ Assessment and treatment of patients ♦ Monitor patient progress ♦ Aftercare (follow up after case is referred back from mental health staff) ♦ Attend educational meetings ♦ Collaboration and case discussion with mental health staff and RDs ♦ Referrals to mental health staff and/or RDs and completion of referral forms ♦ Referrals to secondary or tertiary facilities based on patients' needs ♦ Complete requirements of CMT	♦ Triage referrals ♦ Assessment and treatment ♦ Facilitate/run counselling groups ♦ Telephone advice for patients ♦ Attend educational/administrative meetings ♦ Participate in research projects ♦ Participate in presentations about the program ♦ Advise FPs regarding mental health management techniques ♦ Collaboration with FPs and PSYs regarding management plan and follow-up care ♦ Referrals to community programs and mental health services ♦ Referrals to PSYs ♦ Completion of patient forms as required by the CMT ♦ Complete insurance, medical, and legal forms ♦ Supervise students ♦ Provide information about community resources ♦ Maintain professional accreditation ♦ Participate in evaluation meetings	♦ Patient consultations ♦ Assessment and treatment of patients ♦ Telephone advice ♦ Attend educational/ administrative meetings ♦ Participate in research projects ♦ Participate in presentations about the program ♦ Conduct educational sessions for MHCs and FPs ♦ Provide advice about mental health management techniques ♦ Collaborate with FPs and MHCs regarding management plan and patient monitoring ♦ Referrals to MHCs ♦ Referrals to community programs and mental health services ♦ Complete consultation, follow-up, and activity forms as required by the CMT ♦ Complete medical, legal, and insurance forms ♦ Supervise students	♦ Triage referrals ♦ Assessment and treatment ♦ Run nutrition groups ♦ Conduct educational sessions for FPs ♦ Provide advice to FPs about nutrition management techniques ♦ Attend educational/ administrative meetings ♦ Participate in research projects ♦ Participate in presentations about the program ♦ Collaborate with FPs regarding the management plan and follow-up care ♦ Complete treatment and outcome forms as required by the CMT ♦ Supervise students ♦ Provide information about community resources ♦ Maintain professional accreditation ♦ Represent the program on other nutrition committees ♦ Collaborate with other nutrition departments ♦ Participate in program planning/ direction
Target Groups	♦ Patients ♦ CMT ♦ Allied professionals ♦ Other FPs	♦ Patients ♦ FPs ♦ CMT ♦ PSYs ♦ Mental health community agencies	♦ Patients ♦ FPs ♦ MHCs ♦ CMT ♦ Mental health community agencies	♦ Patients ♦ FPs ♦ CMT ♦ Outpatient departments and community nutrition agencies

Short-term Outcomes

Primary Care

1. Assess and treat patients
2. Provide follow-up care for patients who have seen mental health or nutrition staff

Education

3. Attend educational meetings/ sessions

Collaboration

4. Maintain collaborative relationships with mental health staff and RDs

Access to Care

5. Refer patients to mental health staff and RDs within HSO practices
6. Refer patients to community clinics

Records

7. Provide accurate and consistent patient data

Other

8. Maintain accountability to the CMT

Mental Health Care

1. Maintain triage protocol
2. Assess and treat patients
3. Run mental health counselling groups
4. Provide required telephone advice

Education

5. Attend educational/ administrative activities
6. Assist in research and presentations about the program
7. Increase comfort, knowledge, and skills of FPs in managing mental health issues
8. Increase comfort, knowledge, and skills in handling mental health issues in primary care
9. Increase peer support among HSO MHCs

Collaboration

10. Maintain collaborative relationships with FPs and PSYs

Access

11. Refer patients to community clinics
12. Refer patients to PSYs

Records

13. Provide accurate and consistent patient data
14. Complete insurance, medical, and legal forms

Other

15. Supervise students
16. Collect and discover community resources
17. Maintain professional accreditation
18. Participate in evaluation meetings

Psychiatric Health Care

1. Assess and treat patients
2. Provide required telephone advice

Education

3. Attend educational/ administrative activities
4. Assist in research and presentations about the program
5. Increase comfort, knowledge, and skills of FPs and MHCs in managing mental health issues
6. Increase comfort, knowledge, and skills in handling mental health issues in primary care
7. Increase peer support among HSO PSYs

Collaboration

8. Maintain collaborative relationships with FPs and MHCs

Access

9. Refer patients to MHCs
10. Refer patients to community clinics

Records

11. Provide accurate and consistent patient data
12. Complete insurance, medical, and legal forms

Other

13. Supervise students

Nutrition Care

1. Maintain triage protocol
2. Assess and treat patients
3. Run nutrition counselling groups

Education

4. Increase comfort, knowledge, and skills of FPs in managing nutrition issues
5. Attend educational/ administrative activities
6. Assist in research and presentations about the program
7. Increase comfort, knowledge, and skill in handling nutrition issues in primary care
8. Increase peer support among HSO RDs

Collaboration

9. Maintain collaborative relationships with FPs

Records

10. Provide accurate and consistent patient data

Other

11. Supervise students
12. Collect and discover community resources
13. Maintain professional accreditation
14. Attend external committee meetings
15. Collaborate with other nutrition programs
16. Participate in program planning

Short-term Indicators	1. Number of patients assessed and treated 2. Number of patient follow-up visits 3. Attendance at educational meetings (qualitative comments about education component) 4. Qualitative comments regarding level of collaboration 5. Number of referrals to mental health and nutrition staff 6. Number of referrals to community clinics 7. Number of referral forms completed 8. Document protocol for maintaining accountability to CMT	1. Document triage protocol 2. Number of patients assessed and treated 3. Number of counselling groups 4. Number of telephone hours 5. Attendance at educational/ administrative meetings 6. Participation in publications and presentations 7. Qualitative comments pertaining to knowledge, skills, and comfort of FPs after the introduction of MHC in practice 8. Qualitative comments 9. Qualitative comments regarding peer support 10. Qualitative comments regarding the level of collaboration 11. Number of referrals to community clinics 12. Number of referrals to PSYs 13. Number of referral, treatment and outcome forms completed 14. Describe protocol for completing insurance, medical, and legal forms 15. Number of hours supervising students 16. Number of community resources discovered and collected 17. Describe protocol for maintaining professional accreditation 18. Attendance at evaluation meetings	1. Number of patients seen 2. Number of telephone hours 3. Attendance at educational/ administrative meetings 4. Participation in publications and presentations 5. Qualitative comments pertaining to knowledge, skills, and comfort of FPs and MHCs after the introduction of PSYs in practice 6. Qualitative comments 7. Qualitative comments regarding peer support 8. Qualitative comments regarding the level of collaboration 9. Number of referrals to MHCs 10. Number of referrals to community clinics 11. Number of consultation, follow-up, and activity forms completed 12. Describe protocol for completing medical, legal, and insurance forms 13. Number of learners present at sessions	1. Document the triage protocol 2. Number of patients assessed and treated/patient comments from visit satisfaction questionnaires 3. Number of nutrition groups run 4. Qualitative comments pertaining to knowledge, skills, and comfort of FPs after the introduction of RDs in practice 5. Attendance at educational/ administrative activities 6. Participation in publications and presentations 7. Qualitative comments 8. Qualitative comments regarding peer support 9. Qualitative comments regarding the level of collaboration 10. Number of treatment and outcome forms completed 11. Number of hours supervising students 12. Number of community resources discovered and collected 13. Describe protocol for maintaining professional accreditation 14. Describe participation in external committees 15. Describe collaboration with other programs 16. Participation in program planning

Section 3.2:
HSO Practices

Components:

3.2.A Family Physicians

3.2.B Mental Health Counsellors

3.2.C Psychiatrists

3.2.D Dietitians

Part 3.2.A:
Family Physicians

Short-term Outcomes:

(Primary Care, Education, Collaboration, Access to Care, Records, Other)

3.2.A.1 Assess and treat patients

3.2.A.2 Provide follow-up care with patients who have seen mental health or nutrition staff

3.2.A.3 Attend educational meetings/sessions*

3.2.A.4 Maintain collaborative relationships with mental health staff and RDs

3.2.A.5 Refer patients to mental health staff and RDs within the HSO practices*

3.2.A.6 Refer patients to community clinics*

3.2.A.7 Provide accurate and consistent patient data

3.2.A.8 Maintain accountability to the CMT

* = Outcomes which are not mandatory but rather completed voluntarily as needed.

3.2.A.1 Assess and treat patients

The number of patients assessed and treated each year by FPs is not available. However, FPs referred 3223 patients to the mental health staff and 3431 patients to the RDs (Tables 2 & 3; Figure 1). This is described in detail in the following sections.

3.2.A.2 Provide follow-up care for patients who have seen mental health or nutrition staff

Due to the nature of the program, FPs never fully transfer care of patients to the allied health professionals. They see patients throughout the course of treatment provided by the allied providers. Therefore, patients advised to follow up with FPs (Tables 2 & 3) represent those who have received additional care from an allied professional and no longer require such additional treatment for the particular problem referred. Furthermore, it is important to note that there are some difficulties in identifying cases which are open or closed by the allied providers due to the continuing nature of some problems. Some allied staff close cases after each episode of a chronic illness whereas others keep the case open for specified periods of time. This may account for some of the variability among practices and for what seems to be incomplete paperwork as described in a later section.

Table 2: Number of patients referred by FPs to, and seen by, mental health staff, outcome and consultation forms, and patients advised to follow up with the FP in the 2002-2003 fiscal year.

Practices	Patients referred to			Patients seen by		Outcome	Consultation	Follow up with FP	
	MHC	PSY	Both	MHC	PSY	MHC	PSY	MHC	PSY
HSO# 036	33	1	0	80	N/A	1	N/A	1	N/A
HSO# 034	53	14	1	93	29	96	25	55	11
HSO# 007	114	33	5	193	48	139	39	25	31
HSO# 045	36	10	0	60	25	N/A	23	N/A	9
HSO# 060	35	7	1	71	19	42	14	4	13
HSO# 009	121	6	1	197	26	152	N/A	50	N/A
HSO# 093	81	4	1	165	32	112	29	32	2
HSO# 041	26	2	1	64	14	22	13	4	2
HSO# 017	34	18	2	81	32	3	26	3	22
HSO# 010	61	14	4	165	59	36	56	17	26
HSO# 039	45	1	3	82	21	13	20	1	13
HSO# 094	30	0	0	56	10	41	7	18	0
HSO# 095	67	4	1	96	13	78	9	35	5
HSO# 061	59	17	2	135	49	85	37	42	20
HSO# 075	75	27	0	60	39	67	24	23	22
HSO# 083	23	8	0	62	19	13	19	2	18
HSO# 043	67	5	0	88	18	56	10	45	9
HSO# 035	57	21	1	88	25	94	25	23	23
HSO# 006	39	19	7	100	38	41	37	12	36
HSO# 076	160	49	14	286	121	225	105	73	47
HSO# 073	138	30	11	133	57	129	53	38	36
HSO# 052	52	18	1	90	47	1	38	0	20
HSO# 071	31	1	0	45	3	42	5	27	5
HSO# 038	35	20	2	45	94	36	30	12	19
HSO# 069	118	1	1	138	12	127	10	53	10
HSO# 080	28	2	0	38	5	32	5	11	1
HSO# 092	32	6	2	51	13	61	12	22	12
HSO# 044	27	8	0	40	23	N/A	24	N/A	11
HSO# 067	89	8	37	166	57	143	48	76	44
HSO# 047	312	37	11	534	86	450	80	181	52
HSO# 021	23	29	3	66	30	48	41	22	28
HSO# 065	60	24	1	92	28	88	29	58	20
HSO# 005	92	20	6	194	22	86	20	25	19
HSO# 059	107	19	2	221	47	147	41	76	15
HSO# 099	17	6	0	35	10	36	8	20	6
HSO# 004	117	19	2	168	30	118	25	54	23
HSO# 079	57	40	1	89	N/A	70	55	20	33
Sub Total	**2551**	**548**	**124**	**4367**	**1201**	**2930**	**1042**	**1160**	**663**
Total	**3223**			**5568**		**3972**		**1823**	

Table 3: Number of patients referred by FPs to, and seen by, RDs, outcome forms, and patients advised to follow up with the FP in the 2002-2003 fiscal year.

Practices	Patients		Outcome Forms	Follow up with FP	Follow up with FP for:	
	Referred	Seen			Monitoring	Care
HSO# 036	38	84	33	28	19	9
HSO# 034	128	161	32	27	21	6
HSO# 007	179	241	210	142	88	54
HSO# 045	23	31	24	23	11	12
HSO# 060	44	57	12	11	5	6
HSO# 009	108	144	33	26	20	6
HSO# 093	197	278	138	102	61	41
HSO# 041	126	123	40	32	18	14
HSO# 017	36	41	21	12	8	4
HSO# 010	120	133	53	42	33	9
HSO# 039	45	49	13	10	9	1
HSO# 094	37	62	12	10	6	4
HSO# 095	110	144	24	18	14	4
HSO# 061	33	38	28	23	12	11
HSO# 075	54	67	11	11	9	2
HSO# 083	21	56	9	9	7	2
HSO# 043	92	103	33	27	22	5
HSO# 035	127	188	109	83	55	28
HSO# 006	66	82	21	20	16	4
HSO# 076	154	210	60	51	40	11
HSO# 073	191	232	74	53	41	12
HSO# 052	57	73	37	34	24	10
HSO# 071	45	52	21	18	12	6
HSO# 038	67	75	13	11	8	3
HSO# 069	22	25	14	11	6	5
HSO# 080	67	67	26	19	12	7
HSO# 092	67	123	73	54	47	7
HSO# 044	17	30	14	14	9	5
HSO# 067	145	253	76	60	47	13
HSO# 047	304	343	340	146	56	90
HSO# 021	72	96	63	57	44	13
HSO# 065	80	72	39	33	20	13
HSO# 005	106	94	50	36	24	12
HSO# 059	187	289	66	51	42	9
HSO# 099	16	26	23	19	15	4
HSO# 004	106	104	17	15	15	0
HSO# 079	83	91	29	25	20	5
HSO# 023	61	92	4	4	3	1
Average or Sub Total	**90**	**117**	**50**	**36**	**919**	**448**
Total	**3431**	**4429**	**1895**	**1367**	**1367**	

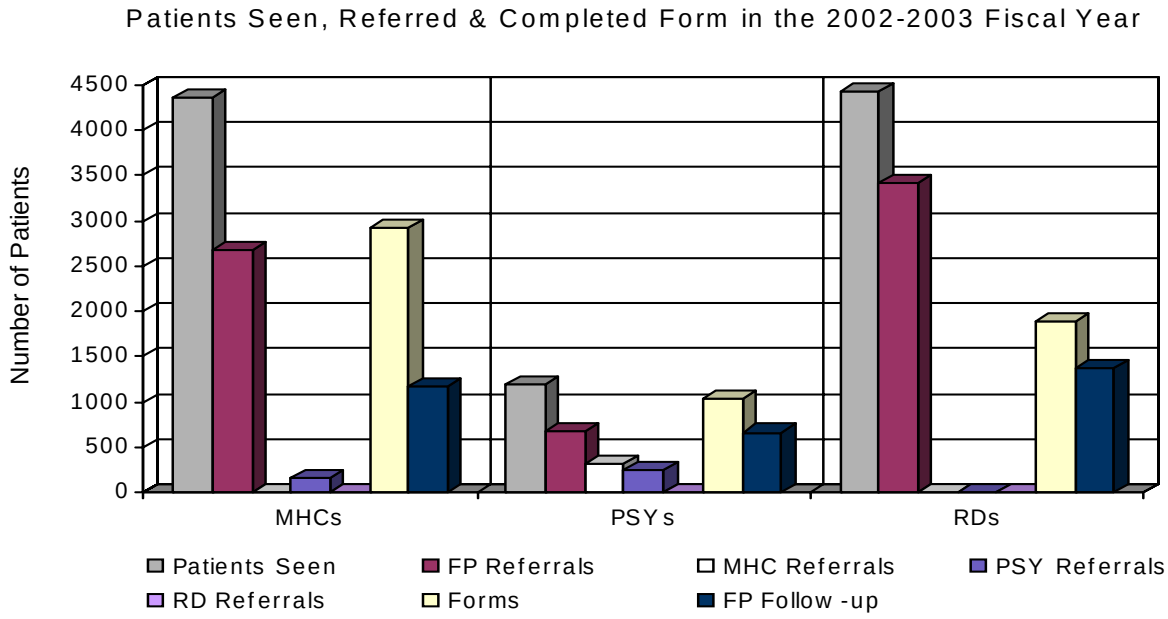

Figure 1- *Number of patients seen and referred, and the number of completed outcome and consultation forms in the 2002-2003 fiscal year.*

The number of patients who follow up with their FPs, after receiving mental health or nutrition care, is not specifically documented because it is a standard procedure. However, the outcome and consultation forms, filled out by the mental health or nutrition staff, indicate the number of patients advised to follow up with their FP. These data are a proxy measure in the present report.

Mental Health Counsellors:

The MHC treatment outcome forms showed that 1160 (39.59%) patients were advised to follow up with their FP. In the 2002-2003 fiscal year, outcome forms were returned for 2930 (67.09%) of the 4367 patients seen (Table 2; Figure 1). The variability in the number of outcome forms returned and the number of patients advised to follow up with their FP among the practices is noted in Table 2.

Psychiatrist:

In the 2002-2003 fiscal year, psychiatric consultation forms were returned for 1042 (86.76%) of the 1201 patients seen by PSYs (Table 2; Figure 1). Of these, 663 (63.63%) were directed to return to their FP for follow-up care. The percentage of patients who were advised to see an FP for follow-up care varies widely among practices (Table 2).

Registered Dietitians:

The nutrition treatment outcome form distinguishes among patients directed to follow up with their FP for routine monitoring versus continuing care. In the 2002-2003 fiscal year, 4429 patients were seen by RDs (Table 3; Figure 1) and 1895 (42.78%) of the nutrition treatment outcome forms were returned (Table 3; Figure 1). Of these patients, 1367 (72.14%) were

directed to return to their FP for follow-up care; 919 for routine monitoring and 448 for continuing care. Table 3 shows a breakdown in the number of patients per practice advised to return to their FP for follow-up care.

3.2.A.3 Attend educational meetings/sessions

The percentage of FPs who attend formal educational meetings and workshops is characteristically low. In the 2002-2003 fiscal year, 21(26.58%) of the 79 HSO FPs attended the workshop titled "The management of chronic pain in the primary care setting". In another workshop (Anxiety Disorders), 34 health professionals attended; however, there are no data available to distinguish the number of FPs, MHCs or PSYs who attended (Appendix A).

Due to the limited number of FPs attending formal workshops, the CMT facilitated the introduction of MAINPRO-C Educational Groups. MAINPRO-C groups comprise FPs who organise in-house education on a regular basis. For each of the meetings attended, FPs earn MAINPRO-C credits. At one point, 51 (64.56%) of the 79 FPs were involved in MAINPRO-C groups, but only one MAINPRO-C group with 12 members remains in the 2002-2003 fiscal year. Of these 12, eight FPs are associated with an HSO practice and the other four are part of a Primary Care Network.

Although limited numbers of FPs attended formal workshops or MAINPRO-C groups in the 2002-2003 fiscal year, they participated in informal educational activities such as meetings with various health professionals within the individual practices. There are no data on the number of informal meetings held by FPs or the number of FPs who attend such meetings.

3.2.A.4 Maintain collaborative relationships with mental health staff and RDs

In the provider satisfaction questionnaire of 2001, providers were asked to comment on their satisfaction with the willingness of FPs to discuss cases. Each professional completed one questionnaire for each practice they work in. PSYs completed 36 questionnaires: two were neutral, eight were satisfied, and 26 were very satisfied. Of the 40 questionnaires completed by RDs, one was neutral, 17 were satisfied, and 22 were very satisfied. Finally of the 57 questionnaires filled by MHCs, one was dissatisfied, seven were neutral, 15 were satisfied and 34 were very satisfied. Many of the PSYs, RDs and MHCs commented that although the willingness to collaborate is often there, there are time constraints in terms of availability. In addition, the allied professionals made reference to some variability in the degree of willingness to collaborate among FPs.

During the focus group of 2003 with FPs, a number of comments pertained to collaborative relationships with the mental health staff. For example, five comments were made by five different physicians. The first felt that in the program, *"you're sharing with your staff, yourself, the social worker, the psychiatrist, and the patient . . . It's a team approach."* Others proceeded to comment on how this sharing occurs with comments such as, *"we've tried to set up a meeting sort of once a month and that doesn't work. So it's more like can I talk with you a couple of minutes, and over lunch time we do that,"* and *"if there is a problem, the social worker can call you, or talk to you,... you can make real time adjustments... without paper work, just by a couple of sentences,"* or *"just having them onsite and the sharing of charts... They see the medical*

component, we see the social work and the psychiatry." These comments were somewhat reflective of a variability in the way collaboration occurs, one extreme being collaboration through direct conversation and the other via paperwork/charts. Another FP made reference to going beyond quick casual communication of a couple of minutes to intricate discussion about a case and intervention plan with multiple members of the team. His exact words were, *"one of the advantages is that you have people readily available to discuss what's going on. As a result of that discussion you may come to a conclusion and it's often the psychiatrist or the social worker or the mental health worker that does the actual planning with agreement."*

In terms of collaboration with RDs, only one comment was made.*"[We, FPs, are] dealing with a whole area we don't know [nutrition therapy], and the fact that it's onsite, again the chart can be shared, the blood work can be shared, it makes life very, very simple."* Hence, the only reference made by FPs regarding collaboration with the RDs pertained to paperwork as opposed to direct communication or discussions. For more information see section 3.3.B.1.

3.2.A.5 Refer patients to mental health staff and RDs within the HSO practices

Mental Health Referral Form:

FPs referred a total of 3223 patients to mental health staff during the 2002-2003 fiscal year (Tables 2 and *4-i*). Of these 3223 patients, 2551 patients were referred to an MHC, 548 patients were referred to a PSY, 124 patients were referred to both an MHC and PSY (Table 2), and six patients were referred to a mental health group (not in Table). Patient demographics pertaining to age and gender are provided in Table *4-i* and Figure 2. Individuals between the ages of 25 to 44 (42.20%) comprise the largest majority of patients referred by FPs to mental health staff. Of the total number of patients referred, 63.57% were female patients and 36.43% were male patients.

Nutrition Referral Form:

A total of 3431 patients were referred to nutrition staff during the 2002-2003 fiscal year (Tables 3 & 4-*ii*). Table 4-*ii* and Figure 2 provide a summary of the number of referrals to nutrition staff and the demographics of those patients including age and gender. FPs referred slightly more female patients (53.95% of all patients) than male patients (46.05% of all patients), and the patients between the ages of 45 to 64 accounted for 46.69% of all the patients referred to nutrition staff.

3.2.A.6 Refer patients to community clinics

HSO FPs referred a total of 204 patients to outpatient clinics in 2002, and a total of 241 to inpatient units (Table 4-*iii*). In 1993, prior to the creation of the Hamilton HSO Mental Health Program, the same FPs referred 422 and 264 patients to outpatient and inpatient clinics, respectively (Table 4-*iii*). Table 4-*iii* and Figure 3 clearly indicate a decreasing pattern of referrals to community clinics over the past 10 years. It is important to note that the program was not introduced until the fourth quarter of 1994 where 13 practices were involved. The program was then expanded mid-way through 1996 to include 23 additional practices. In Table 4-*iii*, ERMHS refers to the East Region Mental Health Services and CPS refers to the Community Psychiatric Services in St. Joseph's Hospital.

Table 4: Patient referrals, patient demographics, and community clinics.

i) *Demographic information of patients referred to mental health staff by FPs.*

Age Range	Patients Referred		Males		Females	
	number	percent	number	percent	number	percent
0 to 12	124	3.85%	68	2.11%	56	1.74%
13 to18	297	9.22%	106	3.29%	191	5.93%
19 to 24	359	11.14%	136	4.22%	223	6.92%
25 to 44	1360	42.20%	503	15.61%	857	26.59%
45 to 64	854	26.50%	292	9.06%	562	17.44%
65 and over	229	7.11%	69	2.14%	160	4.96%
Total	**3223**	**100.00%**	**1174**	**36.43%**	**2049**	**63.57%**

ii) *Demographic information of patients referred to RDs by FPs.*

Age Range	Patients Referred		Males		Females	
	number	percent	number	percent	number	percent
0 to 12	42	1.22%	19	0.55%	23	0.67%
13 to18	71	2.07%	14	0.41%	57	1.66%
19 to 24	103	3.00%	29	0.85%	74	2.16%
25 to 44	801	23.35%	374	10.90%	427	12.45%
45 to 64	1602	46.69%	776	22.62%	826	24.07%
65 and over	812	23.67%	368	10.73%	444	12.94%
Total	**3431**	**100.00%**	**1580**	**46.05%**	**1851**	**53.95%**

iii) *Patient referrals to community clinics by HSO practices.*

Referrals to Community Clinics									
	Outpatient Clinics				Inpatient Units				
Year	ERMHS	CPS	3G	Total	0.125	4X	4 Psych	Liaison	Total
1992*	146	95	111	352	73	42	83	83	281
1993*	150	146	126	422	69	46	81	68	264
Introduction of HSO Mental Health Program in the 4th Quarter of 1994 (13 practices)									
1994	incomplete data			293	incomplete data				271
1995	incomplete data			329	incomplete data				192
Expansion of the HSO Mental Health Program in the Mid-year of 1996 (36 practices)									
1996	incomplete data			288	incomplete data				237
1997	36	48	41	125	82	60	67	77	286
1998	47	49	47	143	66	52	28	79	225
1999	46	44	53	143	81	32	56	65	234
2000	54	102	60	216	75	32	61	61	229
2001	43	114	44	201	62	41	49	42	194
2002	37	114	53	204	81	57	53	50	241

* = pre-HSO Mental Health Program

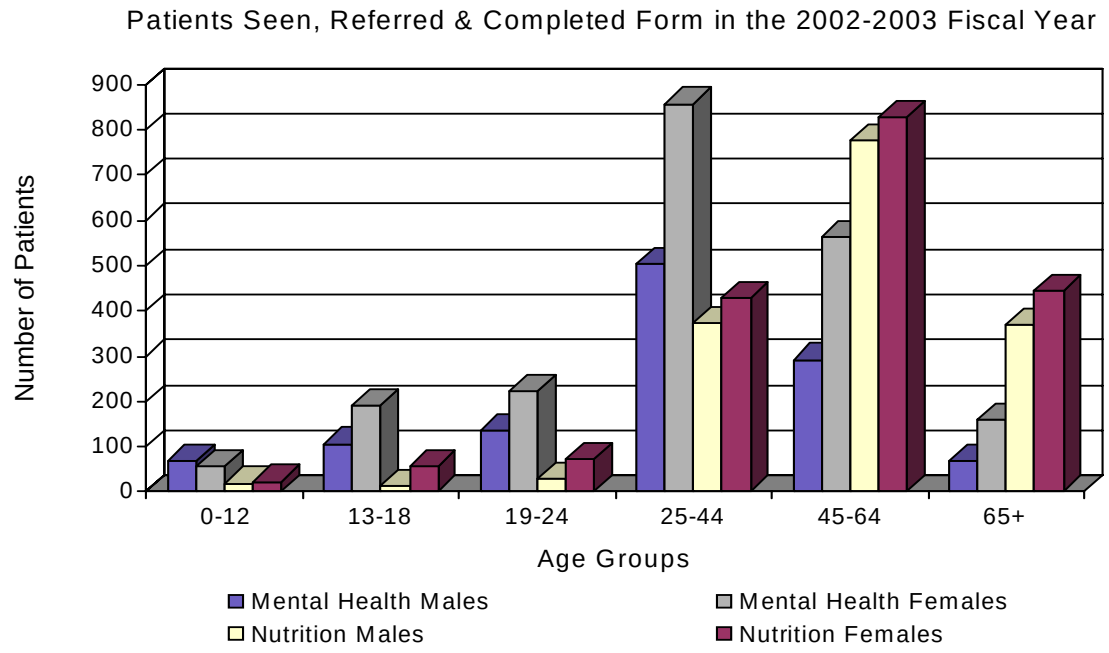

Figure 2- *Demographic information for patients referred by FPs to mental health and nutrition staff in the 2002-2003 fiscal year.*

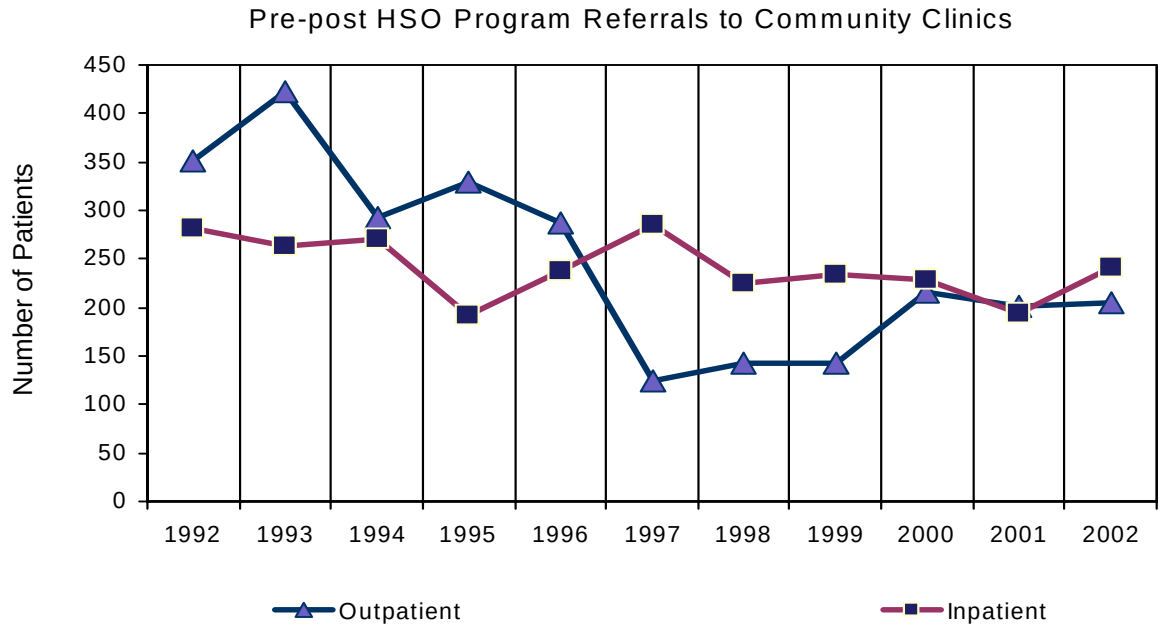

Figure 3- *Pre-post program data for referrals to inpatient and outpatients units by HSO practices.*

3.2.A.7 Provide accurate and consistent patient data

No data are available regarding the accuracy and consistency of the FPs' records. This is not the responsibility of the program but rather that of the Royal College of Physicians and Surgeons of Canada. As for patient data, FPs are required to complete a mental health or nutrition referral form in order for patients to be seen by the allied professionals. This form includes a description of the health problem, recommendations for treatment, and any other pertinent information. In the 2002-2003 fiscal year, FPs completed a total of 6654 referral forms.

3.2.A.8 Maintain accountability to the CMT

Each practice involved in the HSO Mental Health and Nutrition Program must sign a contract with the CMT which stipulates details about funding, recruitment, FTE allocation, termination protocol, etc. Furthermore, FPs provide accountability to the CMT via the standard evaluation forms and questionnaires.

Part 3.2.B:
Mental Health Counsellors

Short-term Outcomes:	
(Mental Health Care, Education, Collaboration, Access, Records, Other)	
3.2.B.1	Maintain triage protocol
3.2.B.2	Assess and treat patients
3.2.B.3	Run mental health counselling groups
3.2.B.4	Provide required telephone advice*
3.2.B.5	Attend educational/administrative activities*
3.2.B.6	Assist in research and presentations about the program*
3.2.B.7	Increase comfort, knowledge, and skills of FPs in managing mental health issues
3.2.B.8	Increase comfort, knowledge, and skills in handling mental health issues in primary care
3.2.B.9	Increase peer support among HSO MHCs
3.2.B.10	Maintain collaborative relationships with FPs and PSYs
3.2.B.11	Refer patients to community clinics*
3.2.B.12	Refer patients to PSYs*
3.2.B.13	Provide accurate and consistent patient data
3.2.B.14	Complete insurance, medical and legal forms*
3.2.B.15	Supervise students *
3.2.B.16	Collect and discover community resources*
3.2.B.17	Maintain professional accreditation
3.2.B.18	Participate in evaluation meetings

* = Outcomes which are not mandatory but rather completed voluntarily as needed.

3.2.B.1 Maintain triage protocol

A common standardised triage protocol is not employed by MHCs in the program. Rather, the MHC(s), in conjunction with the FP(s) within each practice, adopt their own triage procedure according to the needs of the practice. Data are not available on the triage protocols employed by individual practices.

3.2.B.2 Assess and treat patients

In the 2002-2003 fiscal year, activity forms revealed that MHCs assessed/treated 4367 patients (Tables 2 & 5; Figure 1). The outcome and assessment/treatment forms were completed and returned for 2930 (67.09%) and 2528 (57.89%) patients, respectively (Tables 2 & 5; Figure 1). The outcome forms showed that patients visit MHCs an average of 6.0 times before a case is closed (Table 5). A total of 68 main presented problems and 17 management strategies were

Table 5: Number of patients referred by FPs to, and seen by, MHCs, average number of visits, hours worked, and completed assessment and outcome forms by MHCs in the 2002-2003 fiscal year.

Practices	MHC	Patients referred	Patients seen	Average # visits	Hours		Forms	
					Practice	FTE	assessment	outcome
HSO# 036	1	33	80	2.0	776.5	0.50	8	1
HSO# 034	1	54	93	6.2	823.5	0.47	78	96
HSO# 007	3	119	193	6.5	2068.4	1.30	123	139
HSO# 045	1	36	60	N/A	371.3	0.30	33	N/A
HSO# 060	1	36	71	6.3	478.5	0.30	40	42
HSO# 009	2	122	197	5.5	1746.3	1.00	135	152
HSO# 093	2	82	165	6.1	1900.5	1.10	71	112
HSO# 041	1	27	64	7.6	497.2	0.30	31	22
HSO# 017	1	36	81	1.7	724.8	0.40	14	3
HSO# 010	1	65	165	7.4	1380.4	0.70	89	36
HSO# 039	1	48	82	5.1	698.6	0.40	41	13
HSO# 094	1	30	56	6.1	335.8	0.20	37	41
HSO# 095	1	68	96	6.4	613.5	0.50	69	78
HSO# 061	2	61	135	6.4	2111.2	1.26	60	85
HSO# 075	1	75	60	7.3	414.5	0.25	49	67
HSO# 083	1	23	62	5.9	867.0	0.50	30	13
HSO# 043	1	67	88	4.7	696.5	0.40	64	56
HSO# 035	1	58	88	8.7	1055.0	0.60	30	94
HSO# 006	1	46	100	4.7	707.1	0.40	47	41
HSO# 076	4	174	286	6.5	4628.5	2.80	168	225
HSO# 073	1	149	133	4.1	648.6	0.45	110	129
HSO# 052	1	53	90	N/A	1154.1	0.40	39	1
HSO# 071	1	31	45	4.2	251.6	0.20	33	42
HSO# 038	2	37	45	6.3	1011.1	0.60	28	36
HSO# 079	2	58	89	4.3			58	70
HSO# 069	1	119	138	5.1	806.9	0.50	106	127
HSO# 080	1	28	38	3.3	339.2	0.20	22	32
HSO# 092	1	34	51	10.2	639.8	0.40	16	61
HSO# 044	1	27	40	N/A	187.9	0.30	24	N/A
HSO# 067	1	126	166	4.4	1255.3	0.75	114	143
HSO# 047	2	323	534	7.3	3858.4	2.20	316	450
HSO# 021	1	26	66	6.8	480.3	0.32	50	48
HSO# 065	2	61	92	3.7	721.5	0.43	63	88
HSO# 005	3	98	194	8.2	1717.0	1.05	89	86
HSO# 059	2	109	221	11.6	2463.7	1.50	122	147
HSO# 099	1	17	35	8.5	269.9	0.23	18	36
HSO# 004	3	119	168	6.2	1336.9	0.80	103	118
Average	**1**	**72**	**118**	**6.0**	**1112.1**	**0.67**	**68**	**84**
Temporary staff							**241**	
Total	**39***	**2675**	**4367**		**40037.3**	**24.01**	**2528**	**2930**

* an MHC may work in more than one practice

** Some MHCs joined or left the program during the fiscal year; therefore, not necessarily 2 or 3 MHCs in practice simultaneously.

identified in the assessment/treatment forms, and in some cases, more than one strategy was utilised for the same problem (Appendix E). The most common problems encountered included depressed mood (32.99%), marital problems (13.13%), and anxiety symptoms (12.91%), and the most common strategies were individual counselling (19.88%), assessment and recommendations (18.11%), and supportive therapy (15.79%) (Appendix E). Of the 1840 cases of depressed mood, 400 (21.74%) were treated with individual counselling.

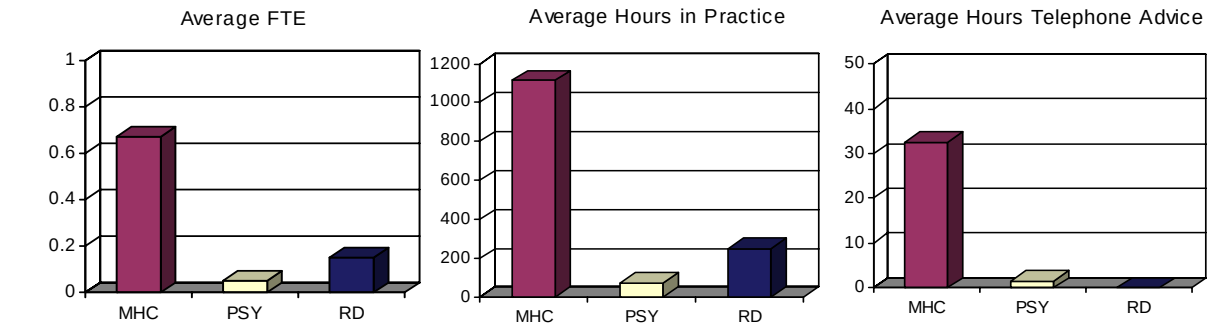

Figure 4- *Number of hours worked by the allied professionals.*

The variability in patients per MHC and the average number of visits per patients may be a result of the proportion of full-time hours worked (FTE) by MHCs and the presenting problems of their patients (Table 5; Figure 4; Appendix D).
Visit satisfaction questionnaires were completed by patients between April 1998 and March 1999. In this questionnaire, the patients were to indicate their satisfaction with the following indicators as excellent, very good, good, fair, or poor:

1. How long you waited to get an appointment
2. Convenience of the location of the office
3. Getting through to the office by phone
4. Length of time waiting at the office
5. Time spent with the person you saw
6. Explanation of what was done for you
7. Technical skills (thoroughness, carefulness, competence)
8. The personal manner (courtesy, respect, sensitivity, friendliness)
9. The visit overall
10. Being seen for counselling in your FP's office
11. Major concerns being addressed during the visit.

An average score was calculated and summarised in Table 6, where the average is equal to the total patient score divided by the total number of responses. For example, an average of 5.0 is representative of excellent (excellent = 5.0, very good = 4.0, good = 3.0, fair = 2.0, and poor = 1.0). When taking the average of the total responses for all practices, patients rated all of the indicators between very good and excellent.

Table 6: Results of the patient visit satisfaction questionnaire (1998-1999) for the Mental Health Program.

Practice	Responses	Indicator #										
		1	2	3	4	5	6	7	8	9	10	11
HSO# 036	16	3.4	3.6	2.2	3.7	3.9	3.9	3.8	4.1	4.1	4.0	3.9
HSO# 034 HSO# 065	104	4.2	4.4	4.3	4.4	4.6	4.5	4.7	4.9	4.5	4.6	4.4
HSO# 007	129	3.7	4.3	4.2	4.6	4.6	4.3	4.5	4.8	4.5	4.4	4.4
HSO# 045	37	4.6	4.8	4.8	4.6	4.8	4.7	4.7	4.9	4.6	4.8	4.6
HSO# 060	50	4.0	4.2	4.3	4.4	4.5	4.1	4.4	4.7	4.3	4.4	4.2
HSO# 009	65	4.4	4.7	4.4	4.7	4.7	4.6	4.7	4.8	4.6	4.6	4.6
HSO# 093	66	3.7	4.4	4.3	4.6	4.8	4.4	4.7	4.8	4.6	4.6	4.6
HSO# 041	25	4.2	4.0	4.0	4.0	4.3	3.9	4.0	4.4	4.0	4.0	4.0
HSO# 017	9	3.7	3.9	3.1	4.0	4.1	4.2	4.1	4.3	4.2	4.2	3.9
HSO# 010	44	4.1	4.1	4.2	4.0	4.5	4.3	4.6	4.7	4.3	4.3	4.3
HSO# 039	26	3.7	3.9	4.1	4.6	4.7	4.4	4.6	4.7	4.5	4.5	4.4
HSO# 094	27	4.6	4.1	4.7	4.6	4.5	4.2	4.3	4.6	4.4	4.4	4.3
HSO# 095	50	4.3	4.2	3.6	4.1	4.5	4.2	4.4	4.6	4.4	4.4	4.4
HSO# 061	52	4.4	4.3	4.4	4.5	4.7	4.5	4.7	4.8	4.6	4.5	4.5
HSO# 075	51	4.4	4.6	4.5	4.7	4.5	4.1	4.3	4.7	4.4	4.5	4.3
HSO# 083	23	4.4	4.3	4.7	4.7	4.7	4.5	4.6	4.7	4.5	4.5	4.6
HSO# 043	26	4.1	3.8	4.5	4.1	4.4	4.2	4.5	4.8	4.3	4.1	4.1
HSO# 035	5	3.0	4.2	3.8	4.2	4.6	3.8	4.2	4.4	4.2	4.3	4.6
HSO# 006	34	4.0	4.4	4.3	3.9	4.5	4.3	4.6	4.8	4.4	4.5	4.3
HSO# 076	73	3.5	4.3	4.3	4.4	4.7	4.5	4.6	4.9	4.7	4.6	4.5
HSO# 073 HSO# 021 HSO# 099	98	4.1	4.5	4.0	4.3	4.6	4.5	4.7	4.8	4.6	4.6	4.5
HSO# 052	43	4.2	4.7	4.6	4.7	4.7	4.5	4.7	4.9	4.7	4.8	4.7
HSO# 071	17	4.2	4.5	4.1	4.5	4.1	3.9	4.1	4.4	3.9	4.5	4.2
HSO# 038 HSO# 079	112	4.2	4.5	4.5	4.4	4.5	4.3	4.6	4.7	4.5	4.6	4.5
HSO# 069	82	4.4	4.0	4.1	4.6	4.6	4.4	4.6	4.8	4.5	4.5	4.5
HSO# 080	46	4.3	4.5	4.5	4.5	4.8	4.8	4.8	4.8	4.7	4.4	4.6
HSO# 092	7	4.6	5.0	4.8	4.6	5.0	4.9	5.0	5.0	4.9	4.4	5.0
HSO# 044	22	4.6	4.7	4.6	4.5	4.5	4.5	4.7	4.8	4.6	4.8	4.5
HSO# 067	23	3.8	4.0	3.1	3.7	4.3	3.9	4.3	4.3	4.0	4.0	4.0
HSO# 047	181	3.8	4.4	4.1	4.3	4.6	4.5	4.7	4.8	4.6	4.6	4.5
HSO# 005	56	3.8	4.2	4.1	4.3	4.6	4.3	4.7	4.8	4.6	4.5	4.4
HSO# 059	93	3.8	4.3	4.2	4.4	4.6	4.3	4.6	4.8	4.5	4.6	4.4
HSO# 004	77	3.4	4.5	4.1	4.2	4.6	4.5	4.7	4.8	4.6	4.5	4.4
Total	**1769**	**4.0**	**4.3**	**4.2**	**4.4**	**4.5**	**4.3**	**4.5**	**4.7**	**4.4**	**4.5**	**4.4**

* Average: excellent = 5.0 very good = 4.0 good = 3.0 fair = 2.0 poor = 1.0

3.2.B.3 Run mental health counselling groups

In the 2002-2003 fiscal year, 23 counselling groups were run by 14 MHCs who are associated with 22 practices. These groups were organised to address the most common problems encountered in the HSO practices. The groups include couple communication (4 sessions ran twice), depression education (1 session ran 10 times), self-esteem and stress management for both men and women (10 sessions ran 4 times for women and twice for men), adolescent group workshops (5 sessions ran once), general anxiety disorders (5 sessions ran once), relaxation group (4 sessions ran once), and pain management group (11 sessions ran twice). All groups follow a standard course outline and make use of specific course material which was prepared in combination by the CMT and MHCs.

3.2.B.4 Provide required telephone advice

The MHCs' activity sheet indicates that on average MHCs, by practice, provided 35.03 hours of telephone advice to patients in the 2002-2003 fiscal year. The number of hours varies among individual MHCs ranging from 1.3 to 198.1 hours with a total of 1296.1 hours for the fiscal year.

3.2.B.5 Attend educational/administrative activities

The two main educational/administrative activities held specifically for MHCs are workshops and professional meetings.

Workshops

In the 2002-2003 fiscal year, five workshops were attended by HSO MHCs. Four of these were attended by MHCs only: Utilising problem solving treatments in primary care, Functional and vocational issues, ADHD in adults, and Psychopharmacology update. On average, 62% of MHCs, ranging from 41 to 95%, attended these workshops (Appendix A).

Professional Meetings

The CMT organised nine professional meetings for MHCs in the 2002-2003 fiscal year. Of the 39 MHCs employed by the HSO Program, attendance ranged from 16 to 28 MHCs at each meeting with an average of 21. Therefore on average, more than half (53.8%) of the HSO MHCs attended the professional meetings.

3.2.B.6 Assist in research and presentations about the program

In the 2002-2003 fiscal year, MHCs did not present any papers or posters regarding the program. However, the following paper was presented in June of 2003:

- Sloan, A., & Geier, D. (2003). Development and use of group treatment within the Hamilton HSO Program from the perspective of the MHCs. Paper presented at 4th National Shared Care Conference at Halifax, Canada, 21-22 June.

3.2.B.7 Increase comfort, knowledge, and skills of FPs in managing mental health issues

Since the introduction of MHCs in the practice, self-reported data in the provider satisfaction questionnaires, suggest that the majority of FPs perceived a significant or extensive increase in their skills (79.16%) and comfort level (79.17%) when dealing with mental health problems (Table 7). These results support those found in the 1997 satisfaction questionnaire which was completed by 72 physicians (response rate 92%). It was indicated that 63% of physicians were "*satisfied*" or "*very satisfied*" with the "*helpfulness of the counsellor in increasing the physicians' understanding of counselling techniques*" and 80% were "*satisfied*" or "*very satisfied*" with the "*helpfulness of the counsellor as an educational resource.*"

Table 7: Increase in the level of comfort and skills of FPs after introducing the allied health professionals into the practice (satisfaction questionnaire 2001).

	Degree of increase					
Question	**very little**	**some**	**neutral**	**significant**	**extensive**	**total**
skills handling mental health problems since **counsellors** joined the practice	1 1.39%	5 6.94%	9 12.50%	32 44.44%	25 34.72%	72
comfort in handling mental health problems since **counsellors** joined the practice	1 1.39%	3 4.17%	11 15.28%	27 37.50%	30 41.67%	72
skills handling mental health problems since **psychiatrists** joined the practice	1 1.45%	6 8.70%	13 18.84%	27 39.13%	22 31.88%	69
comfort in handling mental health problems since **psychiatrists** joined the practice	1 1.47%	4 5.88%	11 16.18%	30 44.12%	22 32.35%	68
skills handling nutrition problems since **dietitians** joined the practice	3 4.11%	4 5.48%	34 46.58%	21 28.77%	11 15.07%	73
comfort in handling nutrition problems since **dietitians** joined the practice	3 3.95%	7 9.21%	34 44.74%	21 27.63%	11 14.47%	76
Average	2 2.33%	5 6.74%	19 26.05%	26 36.74%	20 28.14%	72

During a focus group conducted in 2003, one FP stated that his "*level of confidence and competence in managing mental health has dramatically improved with the sort of on-site exposure to the team all the time.*" Some felt that having the opportunity to access expert opinion readily, formally or informally, contributed to their increased comfort in dealing with mental health problems. One FP stated, "*mostly it's not really anything formal, it's just talking about patients when they're in and reviewing charts with them.*" One of the MHCs mentioned in a separate focus group that "*family physicians are identifying those problems earlier, they are putting patients on medication, they are asking questions . . . as part of their routine.*" When interpreted in context, the MHC was referring to the increased ability of FPs to assess patients, make diagnoses regarding mental health issues, and provide the patients with appropriate treatment. More details are available in section 3 of the results.

3.2.B.8 Increase comfort, knowledge, and skills in handling mental health issues in primary care

The theme of mental health issues in primary care was not addressed specifically during the focus groups of 2003. However, one PSY's comment was as follows:

> W*hat we don't know is how much it increases the capacity of primary care. I mean, how much [do] family physicians do that's different? I mean, this is one of the things that we know so little about, what family physicians actually do and does it, [the program], make a difference, but the sense would be that they're a bit more comfortable taking patients a little bit further before they use a resource than they would have been in the past. And, that may be with medications, that they are now comfortable going up to 50 mg rather than 20, which is the difference often between recovery and continued morbidity*.

Another PSY continued, "*I'm seeing a lot more comfort in that. Like over ten years... I would say they are doing things now that they never would have considered doing when I started... They are doing a lot of primary psychiatric care now that's substantially different than when I started.*"

The issue of comfort was evident in all the focus groups in terms of referral patterns, the ease of follow-up, easy and quick access to patient history, and treatment plans and outcomes. These topics are discussed in greater detail in section 3 of the results.

3.2.B.9 Increase peer support among HSO MHCs

Although peer support meetings for MHCs are known to occur, the program does not oversee or evaluate them. However, the CMT will in some instances help with logistics for the meetings.

3.2.B.10 Maintain collaborative relationships with FPs and PSYs

The focus groups of 2003 revealed that MHCs felt collaboration was ideal when there was daily contact with FPs, when treatment plans were established together, and when all the providers maintain an open door policy (see result section 3). Comments of two MHCs regarding the way in which collaboration occurs between themselves and the FPs are as follows: "*If I have a question, if I have a concern, if the patient has a question and it would be like four weeks wait... I'll step out and get him, [the FP], in the hallway,... I'll ask the question, he'll address it and sometimes comes into the session*" and "*we have an open door policy and essentially what that is is he'll, [the FP], knock on my door and interrupt me and say I'm really sorry, can I talk to you for a minute. And I'm free to do the same thing and there's never a problem.*" Unfortunately, it was said that this varies widely from one practice to the next and can be limited by the physical environment or the interest of the FP in shared care (see result section 3). One MHC noted that in one practice she "*interacts with him, [the FP], about the mental health stuff... [but only] gets a piece of the pie,... where with a couple of the other physicians, you actually work with the client and the physician very closely and you're in almost daily contact.*" Two other MHCs noted that the "[*physician] just sort of is kind of hands off. He's always available if I wanted to talk to him, but he wouldn't sort of seek me out,*"and that collaboration is "*quite difficult unless there's a team meeting... They, [FPs], are so so busy,... how much actually becomes shared in case planning and that in my practice... I think is very limited.*" Meanwhile, one MHC noted that "*even if you have a*

mute doctor, they are going to have a link with the communication with the records." In other words collaboration is possible via patient charts and records if not via direct communication.

3.2.B.11 Refer patients to community clinics

In the 2002-2003 fiscal year, the MHC treatment outcome forms indicated that 151 patients were referred to community mental health services (Table 8). Forty-seven (31.13%) of these patients were referred to community mental health programs, 28 (18.54%) to school counsellors, and 76 (50.33%) were referred to other community programs or services (Table 8).

3.2.B.12 Refer patients to PSYs

In the 2002-2003 fiscal year, psychiatric consultation forms showed that MHCs referred a total of 312 patients to PSYs within the program, ranging from 0 to 38 depending on the individual practices (Table 8). These patients represent 25.98% of the total number of patients seen by PSYs (1201 patients) (Table 9).

3.2.B.13 Provide accurate and consistent patient data

Patient data are provided via three standard forms: the activity sheet, the assessment and intervention plan form, and the treatment outcome form (Appendix C). The number of patients seen by an MHC is 4367, as per the activity sheet (Tables 2 & 5; Figure 1). This number reflects all patients carried over from the previous years as well as new referrals made in the reporting year. An assessment and intervention plan form was returned for 2528 new referrals (Table 5). A treatment outcome form was returned for 2930 patients reflecting long term and short-term cases coming to a close (Tables 2 & 5; Figure 1). Therefore, on average, more than half of these forms were returned to the CMT by MHCs. The outstanding forms may be a reflection of incomplete paperwork or an indication of patient carryover into the next fiscal year.

3.2.B.14 Complete insurance, medical and legal forms

There are a large number of insurance, medical and legal forms that an MHC may be required to complete. These fall into three broad categories: Routine Forms (completed when requested by an insurance company or Workplace Safety Insurance Board [WSIB]), Insurance letters/forms (completed by MHCs when advocating for an individual who has been denied benefits to which they are entitled), and Legal Letters (written at the request of lawyers and others, to advocate for a patient). MHCs are less likely than PSYs to be asked to complete legal letters. There are no data available on how many of these forms were completed by HSO MHCs. The CMT has the following guidelines in completing insurance, medical, and legal forms:

1. Completion of forms is usually fairly straightforward. If there is a payment for completing the forms, the provider can accept this remuneration to cover the time spent. If not, the provider could complete these forms during their scheduled time in the practice.

Table 8: Number of patients referred by MHCs to HSO providers and community clinics in the 2002-2003 fiscal year.

Practices	MHC	Patients seen	HSO referrals			Community referrals		
			FP	PSY	group	program	school	other
HSO# 036	1	80	1	N/A	0	0	0	0
HSO# 034	1	93	55	11	1	5	2	3
HSO# 007	3	193	25	6	0	0	0	6
HSO# 045	1	60	N/A	9	N/A	N/A	N/A	N/A
HSO# 060	1	71	4	5	0	5	0	7
HSO# 009	2	197	50	N/A	0	1	1	3
HSO# 093	2	165	32	24	0	1	0	3
HSO# 041	1	64	4	9	0	0	0	0
HSO# 017	1	81	3	3	0	0	0	0
HSO# 010	1	165	17	25	0	0	1	1
HSO# 039	1	82	1	13	0	1	0	2
HSO# 094	1	56	18	7	0	0	0	2
HSO# 095	1	96	35	8	0	4	0	0
HSO# 061	2	135	42	14	2	1	0	1
HSO# 075	1	60	23	1	1	2	0	2
HSO# 083	1	62	2	10	0	1	1	0
HSO# 043	1	88	45	1	0	0	4	2
HSO# 035	1	88	23	10	1	0	0	2
HSO# 006	1	100	12	8	1	1	0	1
HSO# 076	4	286	73	24	2	3	1	14
HSO# 073	1	133	38	6	1	0	0	0
HSO# 052	1	90	0	10	0	0	0	0
HSO# 071	1	45	27	2	0	1	1	1
HSO# 038	2	45	12	3	0	0	0	1
HSO# 069	1	138	53	5	0	0	0	0
HSO# 080	1	38	11	1	0	0	0	1
HSO# 092	1	51	22	6	0	0	1	0
HSO# 044	1	40	N/A	8	N/A	N/A	N/A	N/A
HSO# 067	1	166	76	12	1	1	4	2
HSO# 047	2	534	181	38	0	9	6	8
HSO# 021	1	66	22	3	0	0	0	0
HSO# 065	2	92	58	3	0	3	0	4
HSO# 005	3	194	25	0	0	2	0	3
HSO# 059	2	221	76	10	0	3	3	2
HSO# 099	1	35	20	0	0	0	0	1
HSO# 004	3	168	54	5	1	2	1	1
HSO# 079	2	89	20	12	0	1	2	3
Average	**1**	**118**	**33**	**9**	**0**	**1**	**1**	**2**
Subtotal			**1160**	**312**	**11**	**47**	**28**	**76**
Total	**39***	**4367**	**1483**			**151**		

* an MHC may work in more than one practice

Table 9: Number of patients referred by FPs to, and seen by, PSYs, hours worked, and completed consultation and follow-up forms by PSYs in the 2002-2003 fiscal year.

Practice	PSY	Patients referred	Patients seen	# Hours			# Forms	
				Practice	Telephone	FTE	Consultation	Follow-up
HSO# 036	1	1	N/A	51.8	N/A	0.034	N/A	N/A
HSO# 034	2**	15	29	71.6	0.2	0.047	25	21
HSO# 007	1	38	48	152.4	4.9	0.095	39	56
HSO# 045	1	10	25	40.8	0.2	0.034	23	21
HSO# 060	1	8	19	40.5	1.3	0.034	14	2
HSO# 009	1	7	26	37.8	0.9	0.047	N/A	N/A
HSO# 093	1	5	32	80.8	1.0	0.047	29	26
HSO# 041	1	3	14	17.6	0.2	0.034	13	18
HSO# 017	1	20	32	86.3	N/A	0.047	26	22
HSO# 010	1	18	59	62.8	0.8	0.047	56	64
HSO# 039	2**	4	21	40.4	N/A	0.047	20	18
HSO# 094	1	0	10	10.0	0.8	0.047	7	3
HSO# 095	1	5	13	66.2	N/A	0.047	9	2
HSO# 061	2	19	49	97.0	1.8	0.060	37	75
HSO# 075	1	27	39	76.5	N/A	0.047	24	47
HSO# 083	1	8	19	78.0	N/A	0.047	19	7
HSO# 043	1	5	18	86.9	3.0	0.047	10	11
HSO# 035	1	22	25	92.5	3.5	0.047	25	16
HSO# 006	1	26	38	138.0	1.0	0.047	37	9
HSO# 076	2	63	121	202.6	2.3	0.119	105	194
HSO# 073	1	41	57	56.7	1.6	0.047	53	49
HSO# 052	1	19	47	88.9	1.2	0.034	38	116
HSO# 071	1	1	3	17.5	N/A	0.024	5	2
HSO# 038	1	22	94	124.6	1.2	0.047	30	34
HSO# 079	1	41			1.6		55	65
HSO# 069	1	2	12	21.3	0.4	0.047	10	3
HSO# 080	1	2	5	13.9	0.4	0.024	5	10
HSO# 092	1	8	13	50.7	N/A	0.047	12	6
HSO# 044	1	8	23	44.2	0.7	0.034	24	62
HSO# 067	1	45	57	98.4	7.3	0.047	48	16
HSO# 047	3	48	86	226.0	2.0	0.143	80	21
HSO# 021	1	32	30	45.9	0.7	0.047	41	13
HSO# 065	1	25	28	87.7	N/A	0.047	29	34
HSO# 005	3**	26	22	95.6	0.9	0.071	20	11
HSO# 059	1	21	47	93.7	N/A	0.047	41	16
HSO# 099	1	6	10	21.2	1.0	0.024	8	1
HSO# 004	2**	21	30	11.8	0.3	0.047	25	11
Average	**1**	**18**	**34**	**73.0**	**1.5**	**0.050**	**30**	**31**
Total	**17***	**672**	**1201**	**2628.6**	**41.2**	**1.798**	**1042**	**1082**

* a PSY may work in more than one practice
** Some PSYs joined or left the program during the fiscal year; therefore, not necessarily 2 or 3 PSYs in practice simultaneously

2. If a written report is requested, an HSO provider should:
   a) inform the FP and clarify the contents/purpose of the letter (allowing for congruence of opinion stated by the FP and allied mental health staff).
   b) and is entitled to review the entire chart in preparing a report (should inform the FP and medical records person of the need for the chart as opposed to taking and returning the chart themselves).
   c) include a copy of the report/letter in the HSO records automatically.
   d) complete a form14 (Consent to the Disclosure, Transmittal, or Examination of a Clinical Record Under Subsection 35(3) of the Mental Health Act) for every note going out of the HSO.
   e) consider showing the FP the note before it gets sent to make sure there are no inaccuracies and there is nothing in the note that might affect the long-term care the other providers may be providing for that patient.
   f) consider providing the patient with a copy of the note.

3. Any questions should be directed to the program coordinator or director.

3.2.B.15 Supervise Students

In the 2002-2003 fiscal year, MHCs supervised two social work students: one for a 6-month placement required to complete a master's in social work and the other as a PhD candidate. In an evaluation report complete by the PhD candidate, regarding her placement at the HSO, she wrote:

> *The collaborative supervision of this internship rotation facilitated the application of psychology in a primary care setting, including the use of the latest empirically-supported treatment protocols for panic disorder. It also facilitated pursuit of an in-depth understanding of anxiety in primary care... My experience at the HSO internship site has been a rewarding one and I believe, mutually beneficial. It certainly fulfilled my expectations, and has unequivocally provided an important understanding of the prevalence and treatment of anxiety in the primary care setting. I am grateful to all concerned for the opportunities this internship provided, and for the facilitative attitudes in which they were cloaked.*

Also the PhD candidate mentioned that the following principles were outstanding within the program: "*respect for ideas, one another, and other disciplines; sharing of information with staff (regular meetings), counsellors (regular meetings, active professional development), patients (community workshops, seminars), research community (publications, conferences); structuring professional development to facilitate upgrading; and flexibility in operation, problem-solving attitudes, openness to new ideas.*" Overall she rated the quality of the placement as excellent.

3.2.B.16 Collect and discover community resources

Any community resources collected or discovered by the MHCs are brought to the professional meetings and recorded in the minutes. Approximately five community resources were discussed at each meeting for a total of about 45 for the year. Additional resources may have been discovered and handed out at meetings, but not discussed. The types of resources included

booklets on various types of community education sessions such as workshops, courses, and groups.

3.2.B.17 Maintain professional accreditation

Social Workers

Membership with the Ontario College of Social Work and Social Service is required for any person who wishes to use the title social worker or social service worker in Ontario. To be eligible for membership, one must hold a degree in social work or social service, and pay an application fee. Also, the members must provide evidence of their continuing competence to practice social work. Certificates of registration with the college are provided to the CMT by each of the social workers working as an MHC in the HSO Program.

Nurses

Membership with the College of Nurses of Ontario is required for any person who wishes to practice as a registered nurse in Ontario. To be eligible for membership one must have completed an approved nursing program and passed the registration/licensor examination. Once registered with the College, members are registered for life. Members maintain competence through participation in the College's Quality Assurance Program, which requires them to engage in three continuing education programs. Certificates of registration are provided to the CMT by each of the nurses employed as MHCs for the program.

Psychologists

Membership with the College of Psychologists of Ontario requires a doctoral degree in psychology. Also, they must undergo a period of postdoctoral supervised practice in Ontario under two members of the College and sit through several examinations to demonstrate knowledge of legislation and clinical practice. Furthermore, they must participate in continuing quality assurance programs. Clinical psychologists employed by the program must provide a certificate of registration with the College to the CMT.

In addition, the HSO Mental Health and Nutrition Program requires that each MHC is covered by liability insurance; thus, certificates of coverage must be provided to the CMT.

3.2.B.18 Participate in evaluation meetings

In the 2002-2003 fiscal year, a meeting was held to establish an evaluation committee. Its purpose would be the ongoing evaluation of the target population of the program, how long appointments should be, which patients should be seen for longer than two years, as well as developing appropriate evaluation forms based on their experience in the program. A total of six (15.38%) of the 39 MHCs employed by the HSO attended this meeting.

Part 3.2.C:
Psychiatrists

Short-term Outcomes:	
(Psychiatric Health Care, Education, Collaboration, Access, Records, Other)	
3.2.C.1	Assess and treat patients*
3.2.C.2	Provide required telephone advice*
3.2.C.3	Attend educational/administrative activities*
3.2.C.4	Assist in research and presentations about the program*
3.2.C.5	Increase comfort, knowledge, and skills of FPs and MHCs in managing mental health issues
3.2.C.6	Increase comfort, knowledge, and skills in handling mental health issues in primary care
3.2.C.7	Increase peer support among HSO PSYs*
3.2.C.8	Maintain collaborative relationships with FPs and MHCs
3.2.C.9	Refer patients to MHCs*
3.2.C.10	Refer patients to community clinics*
3.2.C.11	Provide accurate and consistent patient data*
3.2.C.12	Complete insurance, medical, and legal forms
3.2.C.13	Supervise students*

* = Outcomes which are not mandatory but rather completed voluntarily as needed.

3.2.C.1 Assess and treat patients

HSO PSYs assessed and treated 1201 patients in the 2002-2003 fiscal year. The number of patients treated by each PSY varies widely (Tables 2 & 9; Figure 1).

Psychiatric consultation forms were completed for 1042 (86.76%) of the 1201 patients seen in the 2002-2003 fiscal year (Tables 2 & 9; Figure 1). A total of 54 mental health issues were identified and managed using 11 different management strategies (Appendix F - It is important to note that one presenting problem may have been treated with more than one management strategy). The most common problems were depressed mood (48.21%) and anxiety symptoms (18.15%) (Appendix F). Supportive therapy (26.21%), cognitive-behavioural therapy (20.99%), and individual therapy (15.12%) were the most commonly adopted management strategies (Appendix F).

3.2.C.2 Provide required telephone advice

On average, PSYs provided 1.5 hours of telephone advice by practice in the 2002-2003 fiscal year ranging from 0 to 7.3 hours. The variability in the amount of telephone advice may be related to the FTE of PSYs in each practice and the presenting problem of their patients (Table 9; Figure 4).

3.2.C.3 Attend educational/administrative activities

Limited data are available on the number of educational activities attended by PSYs. The PSY's sessional fee invoice form did not include a category for PSYs to state how many hours they spent in continuing education until February 2003. Since PSYs only account for 2.0 FTE hours in the program, the CMT does not organise educational activities for this group. However, PSYs have the opportunity to participate in a number of educational activities organised externally by academic and pharmaceutical organisations. Furthermore, the PSYs are invited to participate in the educational activities organised by the CMT for other professionals in the program.

3.2.C.4 Assist in research and presentations about the program

PSYs' publications in the 2002-2003 fiscal year (publications, posters, and presentations are noted in Appendix B):

- Kates, N. (2002). New Approach. Collaboration between primary care and mental health practitioners [FRENCH]. Santé mental au Québec, XXVII(2): 93-108.

- Kates, N., Crustolo, A. M., Farrar, S., & Nikolaou, L. (2002). Counsellors in primary care: benefits and lessons learned. Canadian Journal of Psychiatry: 47(9) 857-862.

- Kates, N., Crustolo, A. M., Farrar, S., Nikolaou, L., Ackerman, S., & Brown, S. (2002). Mental health care and nutrition: Integrating specialist services into primary care. Canadian Family Physician, 48: 1898-1903.

3.2.C.5 Increase comfort, knowledge, and skills of FPs and MHCs in managing mental health issues

A questionnaire, conducted in 2001 revealed that the majority of FPs felt having a PSY in their office had significantly or extensively increased their skills (71.01%) and comfort (76.47%) in dealing with mental health problems (Table 7). These results support the finding of the 1997 satisfaction questionnaire where the majority of FPs stated that they were "*satisfied*" or "*very satisfied*" with the "*helpfulness of the psychiatrist in increasing their detection/diagnostic skills*" (79%), and their "*knowledge of psychiatric disorders*" (85%). Furthermore, 86% stated that they were "*satisfied*" or "*very satisfied*" with the helpfulness of the PSY in increasing their understanding of treatment approaches and 89% stated that they were "*satisfied*" or "*very satisfied*" with the "*helpfulness of the psychiatrist as an educational resource.*"

During a focus group conducted in 2003, FPs noted that their diagnostic skills, familiarity with medications and dosages, and various mental health management strategies had improved since the introduction of MHCs and PSYs in their practice. This was clearly stated by one FP, "*We use drugs much more frequently and I hope very much more appropriately both in terms of our choice and in terms of our experience with which ones to use and what dosage*" and "*my level of confidence and competence in managing mental health has dramatically improved with the sort of on-site exposure to the team all the time.*" Furthermore, some felt having the opportunity to access expert opinion readily, formally or informally, increased their comfort in prescribing high doses of medication for people with mental health problems. One stated, "*I feel much more*

comfortable with mega doses than I ever used to... [I've] become a more powerful tool because I've been better educated by the psychiatrist."

PSYs perceived that FPs' repertoire of treatment strategies and their knowledge of various medication/appropriate dosages had improved as a result of the program. They felt FPs were more familiar with resources available in the community and referred patients with more ease both internally and externally when necessary.

3.2.C.6 Increase comfort, knowledge, and skills in handling mental health issues in primary care

See comments in section 3.2.B.7, 3.2.B.8, and 3.2.C.5.

3.2.C.7 Increase peer support among HSO PSYs

The issue of peer support among PSYs was not addressed specifically during the focus groups of 2003; however, the topic did emerge in conversation. The PSYs enjoyed the opportunity to get together to talk about the program and discuss various issues. The following suggestion was made, "*one of the things that the HSO Program could do better would be to have more regular meetings like this because I find it always stimulating when we get together... [group agreement]... I think we could be of better support to each other in managing... issues.*"

3.2.C.8 Maintain collaborative relationships with FPs and MHCs

During the focus group of 2003 the overall consensus was that collaboration with FPs and MHCs varies dramatically across the practices. Collaboration with FPs occurs in different ways such as "*here's my chart - have a look at it; to here's my assessment; to let's see the person together; to give me a call if you don't know what's going on.*" For example, one PSY's experience at one practice is that "*the family doctors don't have an interest in dealing with patients who have psychiatric problems so I guess they recognise the problem and then they refer,*" whereas in another practice the same PSY described his experience as "*family doctors are very much involved... we're always talking about the patients. So there really is a back and forth and the family docs are very involved, and I'm very involved, and the counsellors are very involved.*" Yet another PSY felt collaboration with the MHCs also varies."*There are some counsellors who clearly are proxies for the primary care and some who, as you said, are really operating a private psychotherapy practice on the premises.*" Another PSY explained that there exists two approaches "*one where the counsellor is much more involved with the psychiatrist and one where the psychiatrist is more directly involved with the family physician... [in some practices] it's actually physically very difficult to get the family physician and the psychiatrist and the counsellor all working in the same office at the same time.*" Thus, the general consensus seems to be that collaboration occurs in different ways, among different allied health professionals, and in different practices.

3.2.C.9 Refer patients to MHCs

In the 2002-2003 fiscal year, the psychiatric consultation forms indicated that 156 (14.97%) patients were referred to an HSO MHC by PSYs (Table 10). These data do not include patients referred to an MHC subsequent to the initial visit with the PSY.

3.2.C.10 Refer patients to community clinics

The psychiatric consultation form revealed that 359 patients were referred to community programs and services (Table 10). Seventy-five of these patients were referred to a community program, 14 to a school counsellor or program, and 270 to other community services such as counsellors (161), outpatient services (66), medical specialists (15), or other groups and programs (28). This does not include patients referred after follow-up visits with the PSY.

3.2.C.11 Provide accurate and consistent patient data

Patient data are recorded by PSYs in the psychiatric consultation form, psychiatric professional sessional fee invoice, and psychiatric follow-up form (Appendix C). The psychiatric consultation forms were completed for 86.76% of the patients seen in the 2002-2003 fiscal year (Tables 2 & 9; Figure 1). Since the PSYs can engage in more than one follow-up visit with each patient, it is difficult to ascertain the number of outstanding follow-up forms. Table 9 provides details of the number of consultation and psychiatric follow-up forms returned by PSYs for each practice. The professional fee invoice is provided to the central management team on a monthly basis.

3.2.C.12 Complete insurance, medical, and legal forms

PSYs may be requested to complete insurance, medical, or legal forms. The forms fall into three broad categories:

Routine Forms:

These forms are completed when requested by an insurance company or WSIB.

- ♦ Workplace related medical forms
- ♦ Insurance company work related medical forms
- ♦ WSIB forms
- ♦ Ontario Disability Support Program forms
- ♦ Canadian Pension Plan forms
- ♦ Life insurance or related forms
- ♦ Forms related to eligibility to drive
- ♦ Forms to be completed to enter into a treatment or vocational program.

Advocacy forms/appeals:

These forms are completed when a PSY is advocating for patients who have been denied benefits to which they are entitled.

Table 10: Number of patients referred by PSYs to HSO providers and community clinics in the 2002-2003 fiscal year.

Practices	PSY	Patients seen	HSO referrals				Community referrals		
			PSY	FP	MHC	group	program	school	other
HSO# 036	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HSO# 034	2**	29	7	11	2	0	2	0	2
HSO# 007	1	48	24	31	2	0	3	4	7
HSO# 045	1	25	4	9	3	0	3	1	4
HSO# 060	1	19	3	13	2	0	0	0	2
HSO# 009	1	26	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HSO# 093	1	32	4	2	3	1	0	0	10
HSO# 041	1	14	0	2	2	0	0	0	2
HSO# 017	1	32	9	22	1	1	0	0	9
HSO# 010	1	59	8	26	11	0	4	0	11
HSO# 039	2**	21	0	13	2	0	1	0	2
HSO# 094	1	10	0	0	2	0	0	0	2
HSO# 095	1	13	3	5	2	1	0	0	3
HSO# 061	2	49	12	20	9	0	1	0	5
HSO# 075	1	39	18	22	0	0	4	3	15
HSO# 083	1	19	4	18	2	0	1	0	7
HSO# 043	1	18	2	9	2	0	0	0	1
HSO# 035	1	25	2	23	1	0	0	0	3
HSO# 006	1	38	1	36	6	0	0	1	8
HSO# 076	2	121	37	47	22	1	10	0	26
HSO# 073	1	57	13	36	14	4	6	1	25
HSO# 052	1	47	8	20	6	0	1	0	6
HSO# 071	1	3	2	5	1	0	1	0	1
HSO# 038	1	94	7	19	4	0	4	1	10
HSO# 079	1		17	33	8	0	6	0	15
HSO# 069	1	12	0	10	2	0	1	0	2
HSO# 080	1	5	1	1	3	0	1	0	1
HSO# 092	1	13	4	12	1	0	0	0	1
HSO# 044	1	23	5	11	3	0	4	0	4
HSO# 067	1	57	4	44	11	0	2	0	6
HSO# 047	3	86	10	52	13	0	10	2	16
HSO# 021	1	30	9	28	8	1	5	0	8
HSO# 065	1	28	19	20	0	0	1	0	13
HSO# 005	3**	22	1	19	3	0	2	0	10
HSO# 059	1	47	7	15	0	0	1	1	15
HSO# 099	1	10	4	6	2	0	1	0	6
HSO# 004	2**	30	1	23	3	0	0	0	12
Average	**1**	**34**	**7**	**19**	**4**	**0**	**2**	**0**	**8**
Subtotal			**250**	**663**	**156**	**9**	**75**	**14**	**270**
Total	**17***	**1201**	**1078**				**359**		

* a PSY may work in more than one practice

** Some PSYs joined or left the program during the fiscal year; therefore, not necessarily 2 or 3 PSYs in practice simultaneously

Legal Letters:

These letters are written at the request of lawyers, and/or others, to advocate for a patient.

- ♦ Psychiatric opinion for someone facing charges
- ♦ Letter of support for someone facing charges
- ♦ Psychiatric opinion regarding family disputes (marital or custody issues).

There are no data available regarding the number of insurance, medical, and legal forms completed by PSYs in the program. See section 3.2.B.14 for the CMT guidelines in completing such forms.

3.2.C.13 Supervise students

Five HSO PSYs were involved in the supervision of a total of 35 students: 27 medical students, six psychiatric residents, and two family practice residents. "*I think it's an excellent place for teaching... You're taking them, [the students], to the real world of medicine... They are learning that in general practice [there are] other people with other health wellness and illness, [they learn] how to do psychiatric assessments*."

Part 3.2.D:
Dietitians

Short-term Outcomes:	
(Nutrition Care, Education, Collaboration, Records, Other)	
3.2.D.1	Maintain triage protocol
3.2.D.2	Assess and treat patients
3.2.D.3	Run nutrition counselling groups*
3.2.D.4	Increase comfort, knowledge, skills of FPs in managing nutrition issues
3.2.D.5	Attend educational/administrative activities*
3.2.D.6	Assist in research and presentations about the program*
3.2.D.7	Increase comfort, knowledge, and skills in handling nutrition issues in primary care
3.2.D.8	Increase peer support among HSO RDs
3.2.D.9	Maintain collaborative relationships with FPs
3.2.D.10	Provide accurate and consistent patient data
3.2.D.11	Supervise students*
3.2.D.12	Collect and discover community resources*
3.2.D.13	Maintain professional accreditation
3.2.D.14	Attend external committee meetings*
3.2.D.15	Collaborate with other nutrition programs*
3.2.D.16	Participate in program planning

* = Outcomes which are not mandatory but rather completed voluntarily as needed.

3.2.D.1 Maintain triage protocol

The RDs in the HSO Program do not follow a formal triage protocol. Instead, each RD, in conjunction with the FP, develops his or her own protocol. Data are not available on the triage protocol employed by each of the RDs or its efficiency.

3.2.D.2 Assess and treat patients

Activity forms revealed that RDs assessed/treated 4429 patients in the 2002-2003 fiscal year (Tables 3 & 11; Figure 1). The nutrition outcome form provides details on the types of problems encountered and the management strategy employed by RDs (Appendix G). The most common problems were dyslipidemia (43.63% of patients) and type II diabetes (21.59% of patients), and the most common management strategy employed was individual treatment (84.19%).

Visit satisfaction questionnaires were completed by patients starting in 2000. The questionnaires were no longer distributed once the individual practices achieved a return rate of 70%. This occurred for all practices in 2002 or 2003. The questionnaire was the same as described in section 3.2.B.2.

Table 11: Number of patients referred by FPs to, and seen by, RDs, hours worked, and completed outcome forms by RDs in the 2002-2003 fiscal year.

Practice	RD	Patients referred	Patients seen	Hours		Outcome forms
				Practice	FTE	
HSO# 036	1	38	84	194.5	0.129	33
HSO# 034	1	128	161	261.1	0.143	32
HSO# 007	2**	179	241	521.1	0.314	210
HSO# 045	2**	23	31	107.2	0.057	24
HSO# 060	1	44	57	142.9	0.086	12
HSO# 009	1	108	144	347.0	0.200	33
HSO# 093	1	197	278	560.5	0.457	138
HSO# 041	2**	126	123	235.1	0.114	40
HSO# 017	3**	36	41	89.6	0.057	21
HSO# 010	2**	120	133	316.1	0.200	53
HSO# 039	1	45	49	100.6	0.057	13
HSO# 094	2**	37	62	134.5	0.086	12
HSO# 095	1	110	144	317.8	0.200	24
HSO# 061	2**	33	38	94.4	0.057	28
HSO# 075	1	54	67	116.7	0.057	11
HSO# 083	1	21	56	91.6	0.057	9
HSO# 043	2**	92	103	188.6	0.086	33
HSO# 035	1	127	188	412.9	0.200	109
HSO# 006	1	66	82	159.1	0.086	21
HSO# 076	1	154	210	645.0	0.400	60
HSO# 073	1	191	232	398.6	0.243	74
HSO# 052	2**	57	73	182.2	0.086	37
HSO# 071	2**	45	52	150.8	0.057	21
HSO# 038	1	67	75	110.6	0.057	13
HSO# 069	2**	22	25	64.0	0.029	14
HSO# 080	2**	67	67	150.5	0.086	26
HSO# 092	1	67	123	305.0	0.143	73
HSO# 044	2**	17	30	136.2	0.086	14
HSO# 067	2**	145	253	531.7	0.329	76
HSO# 047	1	304	343	762.7	0.457	340
HSO# 021	2**	72	96	206.7	0.142	63
HSO# 065	2**	80	72	171.1	0.114	39
HSO# 005	2**	106	94	194.9	0.114	50
HSO# 059	1	187	289	504.1	0.314	66
HSO# 099	1	16	26	70.0	0.057	23
HSO# 004	1	106	104	188.6	0.114	17
HSO# 079	1	83	91	168.6	0.114	29
HSO# 023	1	61	92	185.5	0.100	4
Average	**1**	**91**	**117**	**252.2**	**0.151**	**51**
Total	**11***	**3431**	**4429**	**9518.1**	**5.685**	**1895**

* an RD may work in more than one practice
** Some RDs joined or left the program during the fiscal year; therefore, not necessarily 2 or 3 RDs in practice simultaneously

An average score was calculated and summarised in Table 12, where the average is equal to the total patient score divided by the total number of responses. For example, an average of 5.0 is representative of excellent (excellent = 5.0, very good = 4.0, good = 3.0, fair = 2.0, and poor = 1.0). When taking the average of the total responses for all practices, patients rated all of the indicators between very good to excellent.

3.2.D.3 Run nutrition counselling groups

HSO RDs are required to run various nutrition groups: Lipids Groups and Healthy You Weight Management Groups. Standard course outlines and materials were developed for both nutrition groups by the RDs and the CMT. The Lipid Group was developed to free up the RDs' time by allowing them to meet with several individuals with similar problems at one time. In the 2002-2003 fiscal year, RDs booked 61 classes of which 38 classes were evaluated. The other 23 were either not evaluated or cancelled due to low enrolment. The Healthy You Weight Management Group is offered to all HSO patients. This group provides general nutrition education along with practical tips on the best way to engage in healthy eating, as well as a self-esteem component. The Healthy You Weight Management Group is 11 classes and runs 4 times per year. The RDs rotate the running of this group such that each RD runs approximately 1 group every 2 years.

3.2.D.4 Increase comfort, knowledge, and skills of FPs in managing nutrition issues

In 2001, the results of a provider satisfaction questionnaire revealed some disagreement among FPs as to the contribution of RDs to their skills in managing nutrition problems. Specifically, 43.84% of FPs reported that having an RD in their office had significantly or extensively increased their skills, while 46.58% stated that they were neutral. The other 9.59% saw very little to some increase in their skills. Similarly, there was disagreement on whether having an RD in the office increased their comfort level in dealing with nutrition problems where 42.10% of FPs felt their skills had significantly or extensively increased, 44.74% were neutral, and 13.16% saw very little to some increase (Table 7). Since the nutrition program was introduced in February 2000, an assessment of the increase in comfort, knowledge, and skills of FPs with nutrition issues may require further examination after a longer period of time.

The same may apply to the lack of information provided regarding the contribution of RDs to the program during the focus groups of 2003. When prompted to comment, FPs suggested that RDs contributed a lot to patient education regarding nutrition problems, but the benefits of education in alleviating problems were not always clear. One of the FPs stated, "*I don't know how people really managed without it these days. You have to have somebody talk to the people about that [cholesterol]. I'm not even sure how effective it is, I mean ultimately, but... it does delay the situation.*"

3.2.D.5 Attend educational/administrative activities

Professional meetings are organised by the CMT specifically for RDs. In general, all RDs attended the 9 meetings held in the 2002-2003 fiscal year. During the focus group of 2003, RDs noted the positive educational value of the meetings. They felt the meetings were "*very, very useful because [the RDs] are decentralised,*" and so the meetings provide them the opportunity

Table 12: Results of patient visit satisfaction questionnaire (2000-2003) for the Nutrition Program.

Practice	Responses	Category #										
		1	2	3	4	5	6	7	8	9	10	11
HSO# 036	29	4.2	4.5	4.3	4.6	4.7	4.7	4.7	4.8	4.7	4.8	4.7
HSO# 034	102	4.5	4.5	4.1	4.5	4.8	4.7	4.8	4.9	4.7	4.8	4.6
HSO# 007	149	3.7	4.3	4.0	4.4	4.5	4.6	4.7	4.7	4.5	4.6	4.6
HSO# 045	21	3.8	4.5	4.7	4.6	4.6	4.6	4.7	4.8	4.7	4.7	4.9
HSO# 060	15	4.1	4.4	4.3	4.3	4.7	4.7	4.6	4.8	4.7	4.6	4.5
HSO# 009	73	3.9	4.6	4.4	4.4	4.8	4.8	4.8	4.9	4.7	4.7	4.7
HSO# 093	34	4.3	4.1	4.3	4.8	4.7	4.7	4.8	4.7	4.6	4.5	4.6
HSO# 041	28	4.7	4.1	4.6	4.7	4.6	4.6	4.5	4.7	4.5	4.7	4.6
HSO# 017	46	4.7	4.7	4.7	4.7	4.8	4.9	4.9	4.9	4.8	4.8	4.8
HSO# 010	36	4.4	4.2	4.2	4.7	4.6	4.7	4.7	4.8	4.7	4.8	4.8
HSO# 039	20	4.7	4.7	4.4	5.0	4.9	4.9	4.9	5.0	4.9	5.0	5.0
HSO# 094	30	4.5	4.4	4.7	4.6	4.8	4.8	4.7	4.8	4.8	4.7	4.7
HSO# 095	133	4.4	4.5	3.9	4.5	4.6	4.6	4.7	4.7	4.5	4.6	4.6
HSO# 061	13	4.2	3.9	4.5	4.7	4.4	4.5	4.5	4.5	4.5	4.5	4.4
HSO# 075	7	3.9	4.4	4.4	4.6	4.6	4.4	4.5	4.6	4.6	4.6	4.4
HSO# 083	18	3.8	4.6	4.8	4.6	4.7	4.8	4.7	4.8	4.7	4.9	4.6
HSO# 043	16	4.9	4.4	4.7	4.9	4.6	4.8	4.8	4.8	4.8	4.9	4.8
HSO# 035	30	4.1	3.8	4.1	4.6	4.6	4.5	4.7	4.7	4.5	4.6	4.5
HSO# 006	20	4.6	4.8	4.4	4.8	4.8	4.8	4.8	4.9	4.8	4.8	4.8
HSO# 076	75	4.4	4.6	4.3	4.7	4.8	4.8	4.8	4.9	4.8	4.8	4.8
HSO# 073	45	3.8	4.0	3.0	4.2	4.5	4.7	4.7	4.8	4.5	4.7	4.6
HSO# 052	24	3.7	4.5	4.3	4.3	4.6	4.5	4.5	4.7	4.5	4.7	4.5
HSO# 071	8	4.4	4.0	3.9	4.8	4.5	4.4	4.5	4.6	4.5	4.7	4.6
HSO# 038	12	4.1	3.8	3.8	4.5	4.4	4.4	4.4	4.5	4.5	4.5	4.5
HSO# 069	6	3.3	4.0	3.3	4.5	4.5	4.5	4.5	4.3	4.5	4.6	4.7
HSO# 080	9	4.6	4.4	4.4	4.7	4.4	4.7	4.7	4.6	4.4	4.6	4.6
HSO# 092	10	4.2	4.7	4.6	4.6	4.6	4.7	4.6	4.6	4.7	4.6	4.6
HSO# 044	14	4.4	4.7	4.5	4.4	4.5	4.5	4.6	4.7	4.6	4.5	4.5
HSO# 067	65	4.3	4.4	3.8	4.4	4.6	4.7	4.8	4.9	4.7	4.7	4.7
HSO# 047	225	4.3	4.5	4.2	4.6	4.7	4.8	4.8	4.8	4.8	4.8	4.8
HSO# 021	42	4.5	4.2	4.4	4.5	4.8	4.8	4.9	4.9	4.8	4.8	4.7
HSO# 065	25	4.4	4.5	4.3	4.7	4.8	4.8	4.6	4.8	4.8	4.7	4.8
HSO# 005	37	3.6	4.0	3.8	4.5	4.6	4.6	4.7	4.8	4.7	4.8	4.7
HSO# 059	71	4.2	4.5	4.3	4.4	4.7	4.7	4.8	4.9	4.8	4.7	4.7
HSO# 099	6	3.5	4.7	3.3	4.7	4.8	5.0	4.8	4.8	4.5	4.8	4.7
HSO# 004	12	4.8	4.8	4.7	4.9	4.8	4.8	4.8	4.9	4.8	4.9	4.8
HSO# 079	23	3.9	4.4	4.4	4.7	4.7	4.8	4.9	4.9	4.7	4.8	4.7
HSO# 023	49	4.3	4.5	4.1	4.3	4.7	4.7	4.8	4.9	4.7	4.8	4.6
Total	**1578**	**4.2**	**4.4**	**4.2**	**4.6**	**4.7**	**4.7**	**4.7**	**4.8**	**4.7**	**4.7**	**4.7**

* Average: excellent = 5.0 very good = 4.0 good = 3.0 fair = 2.0 poor = 1.0

to gather and share information. They recognised that the program has, "*RDs who tend to specialise in different areas*"; therefore, the meetings offer them a chance to "*tap into [each others'] resources and... variety of skills and experiences.*"

Five workshops pertaining to a nutrition topic were organised since the introduction of the Nutrition Program in 2000 (Appendix A). The workshops were evaluated and all HSO RDs attended these workshops (Appendix A). Furthermore, continuing education courses run by Dietitians of Canada are extremely well attended by HSO RDs. In 2002-2003, two continuing education courses, Pharmacology for the RD and Recovery Package, were completed by 100% and 85% of the HSO RDs, respectively.

3.2.D.6 Assist in research and presentations about the program

HSO RDs did not present any research in the 2002-2003 fiscal year. However, the following posters were presented during the late spring of 2003:

- MacDonald Werstuck, M., Kates, N., Crustolo, A.M. & Mach, M. (2003). The delivery of diabetes services in primary care: Outcomes and opportunities. Poster presented at the American Diabetes Association, at New Orleans, 13 June.

- Hussey, T., & Crustolo, A. M. (2003). Healthy You: outcomes of a group weight loss intervention. Poster presented at the Dietitians of Canada 6th Annual Conference at Calgary, May.

- Gamblen, W., Crustolo, A.M., Kates, N., & McGregor, J. (2003). The role of the registered dietitian in primary care settings: The Hamilton HSO Nutrition Program experience. Poster presented at the Dietitians of Canada 6th Annual Conference at Calgary, May.

During the focus group of 2003, the opportunity for doing research in the program and the role of the CMT were noted by the RDs. "*The central program here is very supportive and they're really in agreement with us continuing our education and doing research and going to conferences.*" "*Having someone actually manage the data that we collect all the time anyway gives us a chance to actually publish the data... It's wonderful as a dietitian to have that service.*"

3.2.D. 7 Increase comfort, knowledge, and skills in handling nutrition issues in primary care

FPs did not contribute much information with regards to the contribution of RDs in primary care during the focus group 2003. Meanwhile, the MHCs suggested that they were starting to notice the great advantages and benefits for patients of combining both nutrition and mental health counselling therapy. "*With having nutrition now, as they've sort of come on board and are developing some of the program, I've noticed there are opportunities for mental health and nutrition to interact,... eating disorder problems for instance, which is a mental health issue, and talking with the family physician about that and the psychiatrist...*" was the comment of one of the MHCs.

RDs noted that there is "*a lot of variability between practices and... GP's and how they view [the dietitians'] services.*" RDs noted that the variability may be related to the FPs previous training and experience, or even their "*confidence in diet therapy.*" "*Some doctors like your input, but they don't... include you in the patient care.*" However, the RDs noted that "*some offices are definitely using shared care philosophy and others are sort of still striving towards it.*" In any case, they feel that "*doctors learn more about nutrition and [RDs] learn more about mental health...[they] learn from each other*" despite the level of shared care. Other comments such as being "*able to interact with GP's daily; you learn a lot*" emphasises that the program can be conducive to education among the different professionals.

3.2.D.8 Increase peer support among HSO RDs

During the focus group of 2003, peer support was noted as a major advantage of the program. RDs felt that the professional meetings were of great benefit providing them the opportunity to discuss both clinical and administrative issues. It was noted that being able to access each others' knowledge of special topics in areas such as infant nutrition and sports nutrition was very helpful. (See quotations in section 3.2.D.5)

3.2.D.9 Maintain collaborative relationships with FPs

Like other groups, RDs noted during the focus group of 2003 that the collaboration with FPs varies greatly from one practice to the next. They felt that some of the main contributing factors were the amount of time spent in the practice and the FPs view of the need and benefits of nutrition counselling (see comments in section 3.2.D.7). Since RDs are in practices for a limited amount of time (Table 11; Figure 4), and often at different times than other staff, they can find it difficult to have any sort of direct collaboration. Comments such as, "*I think all of the doctors want more communication between the dietitians and family physicians and time is only the limiting factor*" and "*I might never see the mental health counsellor or the doctor might never be there the day I am there*" were numerous during the focus group. This issue of time spent in practice may be very critical when listening to comments like "*I'd have to say that the offices I'm at where the family physicians are there at the same time, I feel that the shared care model is working much more efficiently... I see a distinction in the referral rate..., no-show rate, cancellations."*

3.2.D.10 Provide accurate and consistent patient data

As depicted in Table 11, a large number of outcome forms remain outstanding for the 2002-2003 fiscal year. Only 1895 forms were completed for the 4429 patients seen (Tables 3 & 11; Figure 1). However, the outcome form is completed upon cessation of treatment; thus patients still being treated, into the next fiscal year, may account for some of the outstanding forms. Unfortunately, at this time there are no data available to determine how many patients continue treatment into the next fiscal year. This is an issue particularly for RDs due to the large number of patients with chronic problems such as diabetes.

3.2.D.11 Supervise students

In the 2002-2003 fiscal year, six RDs were responsible for the supervision of six dietetic interns.

3.2.D.12 Collect and discover community resources

Community resources collected or discovered are presented at the professional meetings and recorded in the minutes. An average of two pieces of community resources were presented at each meeting such as nutrition pamphlets and educational services, community workshops, courses, and groups. Additional resources are often provided, but not necessarily discussed at the meeting.

3.2.D.13 Maintain professional accreditation

RDs are required to be members of the College of Dietitians of Ontario. To maintain membership, an individual must hold an accredited degree in food and nutrition, have achieved competency in an approved internship program, have passed the dietetics registration examination, and engage in the continuing quality improvement program. The quality improvement program requires RDs to undergo professional development, and on a random basis, undergo a peer-reviewed assessment of practice. All RDs in the HSO Program have provided copies of their certificates of registration to the CMT as well as certificates of professional indemnity insurance.

As part of their professional development the RDs have selected the Nutrition Dimension courses. The courses are completed on an ongoing basis by the RDs as a group and then each RD is tested individually online. The courses covered in the 2002-2003 fiscal year included Pharmacology for the Dietitian, Weight Control & Eating Disorders jointly with Diet, Addiction, and Recovery, and lastly Childhood and Adolescent Nutrition. They are currently studying Alternative Care: Alternative & Complementary Nutrition Therapy and Herbal Supplements.

3.2.D.14 Attend external committee meetings

Several of the RDs in the program are involved in committees external to the HSO Program. There are limited data on attendance by HSO RDs; however, information pertaining to the various committees where at least one HSO RD is a member, is provided below:

- The Hamilton-Wentworth Nutrition Committee. This committee meets once per month to discuss nutrition issues in the Hamilton area. It involves RDs from local hospitals, community clinics, the public health unit, and the HSO Program.

- Joint Dietetics Patient Education Committee. This committee meets monthly to review and develop educational resources.

- Dietitians of Canada Primary Health Care Action Group. This committee meets three to four times per year and has several aims. First, to develop an advocacy process for RD services in primary health care. Second, to promote participation by members in initiatives that impact on the improvement of RDs services in primary health care. Third, to disseminate information on primary health care related activities among members.

Furthermore, RDs are involved in various committees within the HSO Program. These include:

- The HSO Nutrition Resources Committee. The HSO Nutrition resources committee meets four times per year to ensure the resources used by the HSO RDs are up to date.

3.2.D.15 Collaborate with other nutrition programs

In addition to participating in external committee meetings (3.2.D.14), one RD sits on a committee for researching and developing new resources for Niagara Region and thereby shares information between the programs. Committee membership is reviewed every eight months to offer the RDs diverse experiences and to relay a fresh perspective to the HSO Program.

3.2.D.16 Participate in program planning

Before incorporating the Nutrition Program into the HSO in 2000, the RDs were involved in the planning and development of the program structure and implementation. The following meetings and day-long retreats were critical in facilitating the introduction of the program and its continued development:

Meetings:

- Orientation session (Dec 1999)
- Nutrition Orientation Meeting (Dec 1999)
- RD's Meeting (Dec 1999)
- Nutrition Evaluation Meeting (Jan 2000)
- Nutrition Meeting (Jan 2000)
- Introduction of Nutrition Program in Practices (Feb 2000)
- First RD Professional Meeting (Feb 2000)

Retreats:

- September 2000
- June 2002
- June 2003

Retreat Topics:

- Disease Standards of Care
- Treatment Outcome Forms and Guidelines
- Workshop Suggested Topics
- Writing Papers for Publication and Presentations at conferences
- Role of the RD in Primary Care
- Patient Education Methods

All the retreat topics have led to projects which are either complete or in progress in collaboration with the CMT.

Section 3.3:
Focus Groups

Components:

3.3.A Program Goals

3.3.B Shared Care Model

3.3.C Positive Outcomes of the Program

3.3.D Program Challenges

3.3.E Target Population of the Program

The focus groups were conducted to complement the results presented in sections 1 and 2. In order to determine how the program actually functions, the team felt it was critical to obtain the perspectives of the practitioners involved in the program. A description of the focus groups and the participants is presented in section 2.1 of chapter 2. In Appendix H, a list of themes is provided with a description of the source (which groups referred to the theme) and a content summary for individual groups (theme mentioned by how many participants and how many times). A summary of the total number of participants, groups, and times mentioned is provided in a totals column. Following is a brief overview of the findings as well as an ethnographic summary (summary of the discussion intertwined with direct quotations).

Part 3.3.A:
Program Goals

Guiding Question: "What are the goals of the program?"
Focus Groups:

3.3.A.1 Program goals as perceived by FPs

3.3.A.2 Program goals as perceived by MHCs

3.3.A.3 Program goals as perceived by PSYs

3.3.A.4 Program goals as perceived by RDs

3.3.A.5 Program goals as perceived by Group 1

3.3.A.6 Program goals as perceived by Group 2

The most common themes pertaining to the program goals included accessibility for a variety of patients, patient empowerment, collaboration/interdisciplinary care, health promotion/disease prevention as well as early detection and intervention, and lastly more efficient mental health care. All of the above themes were noted by all six groups. Furthermore, education of the team members for increased skills and knowledge was noted by four groups, more efficient nutrition care was described by the FPs, and the RDs made reference to the evaluation component of the program as an important measure of program success.

3.3.A.1 Program goals as perceived by FPs

As a whole, the participating FPs seemed to perceive the program's goals as increasing the education of the HSO health care providers by working in interdisciplinary teams. Furthermore, they felt the program aims to provide early detection and intervention for more efficient mental health care.

For example, one of the participating FPs described the goal of the program as providing an integrated approach to patient care in a community office setting. He felt this set-up results in improved accessibility of mental health care. A second FP added, "*[the program aims] to improve the health of our patients...[and to] provide education to the family physicians and the social workers and those who work in the program.*" In addition, a third FP complemented the above by noting the "*easier access for patients to mental health delivery. The mental health program allows us to intervene in a user-friendly manner at a lower level of intensity where we may be able to actually modify the patient's behaviour before it becomes fixed in that function.*"

3.3.A.2 Program goals as perceived by MHCs

When listing the goals of the program, MHCs mentioned the following: "*provide short-term mental health counselling to a wide variety of clients...with a minimal amount of waiting lists*," "*early intervention*," "*more accessibility*," working "*as an adjunct*" to the FP, education regarding external services, and "*provide shared care, ...[for] more efficient mental health counselling.*"

In summary, MHCs felt the goals of the program are to assist FPs in providing patients with accessible, quick, and efficient mental health counselling and to support the FP in making appropriate referrals to external services when necessary.

3.3.A.3 Program goals as perceived by PSYs

The goals of the program as perceived by the PSYs were centred mainly around education. For example, 3 PSYs expressed the goals of the program as follows: "*raise the level of consciousness and knowledge amongst the group*," "*improve the knowledge and capability of family physicians and allied health professionals in managing people with [mental health] problems*," and facilitate "*referrals to tertiary care services or knowledge of services.*" To accomplish these goals, a PSY noted, "*[one must] address the fact firstly that in family practices there's a large amount of unrecognised and untreated mental illness,...[then, one can] increase the capacity of those doctors to recognise patients,...[and] give them, [FPs], the wherewithal to deal with [patients] by themselves, both diagnose and treatment.*"

The education component of the program was perceived to be critical in meeting the following goals: "*treat people and keep them out of the acute crisis emergency room at the hospital...*" and "*increase access of some patients who may not otherwise agree to see a psychiatrist.*" Therefore, it appears that PSYs felt the aim of the program is to educate the team to make early detection and intervention possible, thereby preventing exacerbation of mental health problems, and attend to those who associate a stigma with mental health care and would not otherwise seek treatment.

Separate from education, the program was said to aim at "*facilitating the psychiatric assessment because ... you have [access to] a family doctor who may have known this person for years or decades.*" When taken in context, this statement seems to indicate the importance of interdisciplinary care in providing more efficient care.

3.3.A.4 Program goals as perceived by RDs

RDs who participated in the focus group enumerated the following goals: "*good patient care in a shared-care model*," "*health promotion*," "*identify those individuals at risk ... [for] early intervention*," "*patient having an input and contributing to their own health care plan*," and "*evaluation... seeing if what we did was effective and made a difference. That's really important to... look at how successful we are.*" Thus, interdisciplinary care, health promotion, early intervention, patient empowerment, and measuring success rate are perceived by the RDs to be the main goals of the program.

3.3.A.5 Program goals as perceived by Group 1

Group 1 described the goals of the mental health program as follows: "*offer relatively short-term care, early access [for a] variety ... of clients*," "*offer increased availability of mental health care to a wider variety of people, support the role of the family doctor in the delivery of mental health care ... , [and] increase communication between different arms of mental health caregivers.*" "*From a nutrition service point of view, ... [provide] access to nutrition care...[otherwise, patients] don't have access to that service unless they pay for it themselves.*" Therefore, the goals of the program as perceived by this group are interdisciplinary collaboration to provide early access to mental health and nutrition care for a wide spectrum of patients.

3.3.A.6 Program goals as perceived by Group 2

This group of professionals identified one of the goals of the program as "*people of different disciplines [working] together and [sharing] their expertise and sort of [collaborating] ... for the benefit of patients.*" An FP noted that "*working in concert with mental health counsellors and dietitians further facilitates the opportunity to deliver the best quality of care*," and so "*the patients benefit, [and] the physician benefits on an ongoing basis knowledge-wise.*" This was said to be possible via a joint approach to patient care and the communication that occurs among the different providers.

The group felt the program is critical in helping "*patients feel more comfortable coming to a place like this [rather] than to an institution for nutrition and mental health services.*" Since "*people will come to their family physician and confide in them about certain issues that are going on in their life where they may feel uncomfortable doing that in an institutional setting,... [the program allows for] access to care quickly*." Another provider agreed, "*patients are not only looked after better but they're seen that much quicker, I mean there's a prioritisation of who should be seen and they seem to get slotted a lot quicker.*" Furthermore, providers "*see anyone who walks through the door and provide them with a consultation...[whereas with] outpatients, so many cases would be rerouted to different services.*"

In other words, the goals of the program were described as working in interdisciplinary teams to provide better care to all patients quickly and effectively in a comfortable setting. In addition, the program aims to increase the capacity of the team members via their collaboration in providing more efficient patient care.

Part 3.3.B:
Shared Care Model

Guiding Questions: "Define shared care.
Is your definition of shared care different from how it occurs in your practice(s)?
What are the factors influencing the different applications of shared care across practices?"

Focus Groups:

3.3.B.1 Shared care as perceived by FPs
3.3.B.2 Shared care as perceived by MHCs
3.3.B.3 Shared care as perceived by PSYs
3.3.B.4 Shared care as perceived by RDs
3.3.B.5 Shared care as perceived by Group 1
3.3.B.6 Shared care as perceived by Group 2

The shared care model is included as a program strength in Appendix H under the following categories: flexible model and key features of shared care. For flexible model, all six groups felt that the model definition is different from how it is applied; and so, this leads to a lot of variability among the practices. This was presented as a strength because it allows the providers to mould the model to fit the needs of the practice and its patients. Three to four groups reported that this is done via the flexibility in the treatment protocol and scheduling. This flexibility allows providers to tend to patients in order of priority and provide treatment that is appropriate for the patient whether in the clinic, in the home, or at the bus stop as described by one of the MHCs. Another program strength was described as improving and changing over time. Providers noted that as time goes by, relationships among team members, organisation of the setting, individual skills, etc, evolve making the program more efficient.

The key features of shared care are themes which were noted to have a great influence over how shared care actually occurs within individual practices. All six groups agreed that the following themes contribute to shared care: level of communication (either in person or on the telephone, or in writing via notes and patient charts), availability of team members (to collaborate and support/back up other providers with regards to appropriate patient care), setting (all providers working in the same facility using common resources), individual skills and comfort of the providers, and the relationship among the team members. Furthermore, five groups noted the perspective, comfort, and interest of the FP in shared care as a critical element in shaping the model.

3.3.B.1 Shared care as perceived by FPs

The definition of shared care varied greatly among the FPs. Moreover, they perceived this variability as one of the advantages of the shared care model. One FP explains:

> *[The model has] some flexibility in it and the way it's done in my office may not exactly be the way it's done in the other office. You've got a basic framework and within that there's a lot of flexibility and a lot depends on ... your counsellor... her strengths ... the*

> *psychiatrist ... it depends on the relationship with the person ... What works in my office may not work in the other offices and that's good because I think the end points will all be the same. There's more care being given ... more quickly.*

Another FP followed up on this comment by introducing the element of the patient population in terms of ethnicity, age, etc, as an additional factor which can influence the way shared care works in individual practices.

Two FPs referred to shared care as a "*team approach,*" and a "*multi-disciplinary approach.*" The primary care setting of the HSO Program was said to be a critical feature in making it a better program than other shared care programs: "*common resources in the common setting,*" "*everyone is sort of physically together.*" Shared care in a common setting was said to lead to the "*integration of information with regards to the patient. You can make real time adjustments... It's much more flexible and efficient because a lot of things get done without paperwork, just by a couple of sentences.*" Another FP agreed stating, "*the chart is there, you talk in the hallways, the conversation is going on, there is communication going on regularly.*" Communication and collaboration were noted by FPs as a critical elements of shared care (see section 3.2.A.4.).

Only one of the physicians was less involved in this discussion making only one comment, "*It's not truly shared care... family doctors are still the primary professional caregiver where the others are only assisting... If you left the office they may not be able to continue, but you would be able to continue with the care if they left.*" The opportunity did not arise for this FP to expand on his comment; however, it was noted in the content analysis as a program challenge (Appendix H). It is important to note that although the overall opinion of the participating FPs appears to be that the program is a true model of shared care with a lot of flexibility, some HSO providers may not perceive the program as a true model of shared care (see section 3.3.D).

3.3.B.2 Shared care as perceived by MHCs

Before defining shared care, one of the MHCs noted:

> *There's a bit of difference in how you define shared care and the reality of how it does work ... I work with four family physicians and they all see shared care as being something very different... Sometimes I get a piece of the pie, I do all the mental health stuff, ... [whereas] with a couple physicians, you actually work with the client and the physician very closely and you're in almost daily contact.*

Another MHC agreed, "*[It] depends upon the doctor.*" A third MHC pointed out that shared care varies because MHCs "*have different relationships with the physicians.*" Lastly, a fourth MHC described the influence of the FP on shared care as follows:

> *How the physical environment unfolds is really a reflection of a physician's own perception of how mental health work should interface with physical health work... It's really reflected in the type of service and the sense they have of working as a team and really kind of shaping, in the true sense of the word, the mental health care,... [FPs] drive the ship when it comes to how the process unfolds.*

Four MHCs made reference to the availability of FPs and how it influences shared care: "*If I have finished a session and I have issues that the doctor should be aware of, he has no problem coming in after the session and we will discuss the issues... They, [FPs], are both very accessible that way.*" An MHC who works in a clinic with seven or eight FPs noted, *"[It's] my responsibility to make sure I communicate whatever I do with them.*" Whereas the MHC who works with one FP feels, "*[the FP is] just sort of is kind of, hands off. He's always available if I wanted to talk to him, but he wouldn't sort of seek me out."* Finally, "*unless there's a team meeting time or something, sort of nabbing them in the hallway which I find a bit limiting because they are so, so busy... That's where I see that while the intent is there, how much actually becomes shared in case planning... I think is very limited.*"

Despite all the difficulties surrounding the opportunity for shared care such as time, availability, and relationships, it was noted that "*even if you have a mute doctor, they are going to have a link with the communication in the records,... [but] when they, [patients], move out of the system of primary care into other agencies, you automatically lose that.*" In other words, despite the variability and the difficulties associated with sharing care, the program does provide the opportunity, whether it is via patients' charts or via in-depth discussions among the providers, to share care.

3.3.B.3 Shared care as perceived by PSYs

Most of the PSYs associated shared care with the transfer of patient care among the various health care providers and the level of communication/collaboration among the providers. Three PSYs made reference to the transfer of patient care, the following is one representative quotation:

> *[One can] sort of trade the person back without difficulties, with relative ease, which is very different than what might take place in an outpatient setting where, yes the same transfer takes place, but doesn't take place with a phone call or a face-to-face contact... I think the ease with which the transfer back and forth takes place is dramatically different. That's kind of how I see the shared care model take place.*

As for the level of communication and collaboration among providers, PSYs made note of the large variability within the program (see section 3.2.C.8.).

> *[Care] can go backwards and forwards at any time... [and] unique in the health care system [is] where the consultant and the consultee actually see each other on a regular basis... Shared care can be whatever you want it to [be] because I think all it means is that you have an opportunity for mental health and primary care to be actively involved at the same time and that can be everything from here's my chart - have a look at it; to here's my assessment; to let's see the person together; to give me a call if you don't know what's going on.*

A second PSY described his/her experience with the variability of shared care as follows:

> *I think the model is so different in each practice ... In one [practice], the family doctors don't have an interest in dealing with patients who have psychiatric problems... They recognise the problems and then they refer to a counsellor who often then refers to me for*

psychiatric consultation and then the person is often followed by me with medical recommendations going back to the family doctor. But, it's not as much of a shared care as I would ideally like to see. In the other practice, the family doctors are very much involved... There really is a back and forth... it really depends on the practice I'm in... I sometimes feel like I'm running a little mini-outpatient clinic within the HSO in the other practice but I think it's different than an outpatient clinic because of the location.

A third and fourth PSY noted that shared care does not necessarily involve all the providers:

[One could say there are] two models, one where the counsellor is much more involved with the psychiatrist and one where the psychiatrist is more directly involved with the family physician ... In some of the smaller practices,... it's actually physically very difficult to get the family physician and the psychiatrist and the counsellor all working in the same office at the same time.

The actual working part of it is shared differently depending on the practice, depending how much the counsellor is involved too... Sometimes [it's] not that much different from being in my own office and just getting a phone call. But, most of the time there's a lot more communication and it does seem more shared.

Lastly, a fifth PSY made known his view of shared care by saying:

[There is] tremendous variety in the interest and engagement and expectations and willingness and availability, etc., etc., of the family doctors... I think that in some way the term shared care, like all sorts of other terms, means really whatever one wants it to mean. Not exactly, but there are some who because you're in their office and reading their chart and know their private line if you need to speak to them, I mean at a minimum that could be called shared care because you don't have it in the clinic necessarily. But on the other hand, there are plenty of examples I think where the care truly is shared, where the doctor engages you in the discussion about the patient beforehand, tells you exactly what it is she wants help with, then sits in on the consultation with you and participates in some way either as a listener or jointly or even does much [of the talking] while you listen. Then afterwards you talk about the case and agree on a plan and the counsellor who has been party to it all, you know, implements the psychotherapy in conjunction with the meds which the doctor prescribed in consultation with you... That seems to me to be what shared care really is except that it doesn't happen a lot of the time. It doesn't happen a lot of the time, but I don't suppose the ideal should necessarily be the enemy of just a workaday kind of compromise somewhere else down the line.

In the end, all PSYs who participated in the focus group seemed to agree that the shared care model is beneficial in terms of providing patients with mental health care, despite the large amount of variability encountered in the different practices.

3.3.B.4 Shared care as perceived by RDs

The shared care model was described by one of the RDs as a model that provides "*the opportunity to talk to the other health care professionals more closely that are involved in the patients' care*

than other models." The other 3 RDs agreed, "*[there is] more efficient delivery of care because you have quicker collaboration between health professionals and quicker communication... improving the patients' outcome measures through both physician and dietitian collaboration," "different areas of expertise can be relied upon,*" and "*it's a combination of knowledge, different areas of knowledge... different knowledge bases all coming in and being utilised for the patient.*"

When asked to describe how shared care actually functions within the practices, the RDs, like the other professionals, noted the variability among the practices. One RD felt that "*some offices are definitely using the shared care philosophy and others are sort of still striving towards it... I think most of them are very open to trying to improve that. I think all of the doctors want more communication between the dietitians and physicians and time is only the limiting factor.*" Two RDs then described their experience in different practices as follows:

> *[In some practices], it's more of a traditional nutrition role where you would make recommendations to the doctor about say a medication change and he would think about it, either yes or no type of thing, and he may actually want to see the patient before actually implementing those recommendations, versus more of a shared care model. If you recommend the medication then the doctors say based on your judgment this is what we recommend and by all means order it. It's more of a almost a delegated act.*
>
> *Within my practices, I have a lot of doctors that will just pass the care off to me. So this person has been referred to me and from there on, I'm going to be dealing with that issue,... That issue with that patient, you know, documenting and discussing... with the physician, but basically the physician has said this is your baby, you deal with that and I'm here if you need my help kind of thing. Whereas other physicians are the exact opposite, where that's their baby and they'll ask you questions and they'll refer to you just for nutrition advice only and it's not as broad. So you get a variety.*

The RDs provided some theories as to the reasons for some of the variety of FP approaches such as personality issues, previous FP training, FP confidence in diet therapy, FP previous experience with RDs, and time spent in practice (see sections 3.2.D.7. and 3.2.D.9.).

3.3.B.5 Shared care as perceived by Group 1

The key feature of shared care described by this group include increased communication and collaboration among various providers, and the opportunity to see more patients for increased accessibility. For example, "*health professionals are seeing the patient and then reviewing [the case], having interaction together,*" and "*the interaction could be [with] anybody. It could be with counsellors or the psychiatrist or the nutritionist, you can then chat about the case, and take turns seeing [patients]*". A third provider noted that this leads to "*accessibility at a much more increased rate... We really do have again people coming into the system that I think would not be seen elsewhere because of accessibility."*

The group agreed that "*there's lots of communication back and forth between the different team members whether it be the dietitians or the social workers or psychiatrists around a specific patient issue.*" For this to occur, "*it's a lot better when you're all here, [when allied providers are] not here when I'm here,... it's more like a traditional outpatient service.*" However,

communication can still occur "*by note or by phone. So it happens [even if] it's not as good... Optimally it works best when everyone has a chance to be onsite. We just find that communication is so much better when you're right onsite.*"

3.3.B.6 Shared care as perceived by Group 2

One of the major features of shared care described by group 2 pertained to group decision-making with regards to treatment plans. "*Treatment and management decisions aren't made by one individual. Generally the medication or when the person is back to work or whatever management decision could be made by two or three people; dietitian, mental health counsellor, [etc].*" "*There's input again from a larger group of people... There's also a bit of a safety check or a fail-safe mechanism in place that everybody is looking out for ultimately the interests of the patient. That is a big help to all of those that are involved.*" Communication regarding patient care was said to occur in multiple ways. For example, "*there's a lot of ad hoc meetings in the hallway*", or "*I'll knock on her door and say have you got a second, this and this is happening, do you have any ideas. So it's wonderful to be able to do that for the patient's benefit.*" Therefore, "*communication is easy because you are in the same place every week or two or we are accessible by phone.*"

The availability of the various health care providers was depicted as a key feature of shared care. "*There isn't really a very long lapse of time at all before the person has a network around them.*" Another provider felt that "*part of the point of this, [shared care], is to support the family doctors who deliver mental health services in the community with timely, accessible back-up... and also, I think again for counsellors also, I think there's a timely and accessible back-up for any questions that may arise... Timely accessibility to a psychiatrist for back-up as needed.*"

In addition to easy access to expert opinion, the group noted the possibility for education as an important feature in delivering fast and efficient care to patients. "*We actually meet as a group when the psychiatrists come to actually present a case and then the case is sort of commented on by the psychiatrist and everyone present,... that's quite a learning process.*" Another provider described the process as, "*the first hour I'm here we sit around and cases are presented,... [There are] particular issues that we can make a learning point,... So a lot of indirect care can happen efficiently*."

Part 3.3.C:
Positive Outcomes of the Program

Guiding Questions: "What do you like about working in your practice(s)?"
"Do you think shared care has changed the way patients are treated in your practice(s)?"

Focus Groups:

3.3.C.1 Positive outcomes as perceived by FPs
3.3.C.2 Positive outcomes as perceived by MHCs
3.3.C.3 Positive outcomes as perceived by PSYs
3.3.C.4 Positive outcomes as perceived by RDs
3.3.C.5 Positive outcomes as perceived by Group 1
3.3.C.6 Positive outcomes as perceived by Group 2

Providers appear to be satisfied with many aspects of the program. The interdisciplinary team approach and collaboration among the providers was said to give the opportunity for formal and informal education. Also, it was described as providing access to all pertinent patient information whether in person or in writing. The above were some of the most popular themes noted by all six groups. Furthermore, all the groups made reference to an overall general satisfaction with the program, satisfaction with the independence and flexibility they have within the model, and satisfaction with the assistance provided by co-workers with things such as external referrals. Three of the groups noted the opportunity to focus on their personal expertise because of the easy access for patients to providers with other expertise. Four groups felt the program offers easy transfer of patient care among providers within the team and for some, this comes with an increased comfort in transferring authority over patient care. Less common themes included the opportunity for student education within the program, co-worker assistance in dealing with insurance companies on behalf of patients, and the opportunity to work in multiple settings with multiple co-workers.

Multiple features of the program were described as contributing to better patient care. Among those factors, the most popular was associated with increased accessibility. Increased accessibility was said to result from things such as a comfortable and familiar setting for patients and an opportunity for allied providers to be seen as part of the system. This allows for more patient acceptance and buy-in as well as patient empowerment. A second theme emerged noting the main elements of primary care including early detection and intervention, health promotion and preventive care, as well as patient education. The last theme in this category mentioned by all six groups was the opportunity for continuity of care. Five groups made specific reference to a reduced stigma associated with mental health care and a decreased burden on the traditional system by avoiding exacerbation of symptoms which would require external referrals or hospitalisation. Finally, two groups felt the model provides practitioners the chance to outline clear treatment plans for patients and give more feedback to patients regarding their care and progress.

Four groups made some mention of the role of the CMT as a strength of the program. They focused mainly on its role as a facilitator of the program and shared care. Also, two groups made reference to the education and research opportunities offered by the CMT for the providers to increase their skills and knowledge and get published.

3.3.C.1 Positive outcomes as perceived by FPs

One of the major themes revealed by FPs as a positive outcome of the program is the availability of the allied professionals for advice and referrals. One "*can walk down the hall and leave a note or whatever, and talk to a person within a matter of minutes*" (see section 3.2.A.4 and 3.3.B.1). "*We're still doing the things we do, but when it becomes very obvious that this might be an ongoing, much more cognitive approach,...we've got somebody there who can do it.*" This led to comments such as "*it gives us more time to spend on what we're trained to do*." Another positive outcome noted by the group was the opportunity for informal as well as formal education (see section 3.2.B.7., 3.2.C.5., and 3.2.D.4).

The availability of PSYs and MHCs was revealed as beneficial in dealing with administrative issues in addition to clinical issues. The example provided for administrative issues was battling insurance companies for "*patients [that are] off [work] for obvious psychiatric disorders.*" "*I am finding now with the psychiatrists and with the counsellor that we can really give credible reports*" when dealing with insurance companies. "*So that is very useful because that takes the pressure off the patient, they're getting money so now let's deal with the problem.*"

The program is "*a lot more accessible to the patient and you will get more buy-in from patients... They feel more comfortable coming to a familiar setting.*" A second FP noted that "*the outcomes are better as well. That may be in part compliance, comfort, [or] expertise.*" In staying with the theme of comfort, the same FP commented that "*the feedback mechanisms are much better for patients.*" To further this point, a third FP felt that "*if you offer the patient a plan, that takes a lot of the pressure off... That in itself is a stress reliever and reduces the crisis to some extent.*" Taken in context, this FP was referring to the opportunity of telling the patient exactly who they will see, when they will see them, and in some instances may even have the opportunity to be introduced to the MHC prior to the initial assessment (see section 3.3.C.2.). A fourth FP agreed, "*[patients] feel comfortable ... [There is a] comfort level of coming into the office, in a setting that they know.*" In addition, he noted a reduced stigma for the patients receiving mental health care.

3.3.C.2 Positive outcomes as perceived by MHCs

Prevention was noted as a positive outcome of the program by most MHCs who participated in the focus group. It was associated with: early detection; "*catching problems, or psychosocial problems or psychiatric problems, sooner,*" early intervention; "*family physicians are identifying those problems earlier... putting patients on medication... asking questions... as part of their routine,*" and patient empowerment; "*patients referring themselves [and their family and friends].*"

Patient empowerment was seen to be the result of the increased comfort and trust patients feel in the program. The program "*[decreases stigma by] making it, [mental health services], part of*

kind of your, average day... I'm right there... There's a connection. It doesn't jump agencies... You're just part of the system." A second MHC agreed,"*[the patients] see me as an extension of him, [the FP], and there's that automatic 'Oh well, I don't think I want to go out, but yes I'll see anybody in your office.' It's like going to see the nurse or the nutritionist. It's an element of trust, really.*" A third MHC noted that "*because we're in the doctor's office and because they, [patients], know us over a period of time, even if we don't know them, they've seen us around. It's like a small town. I think it makes life so much more personal and approachable.*" Likewise, a fourth MHC's experience with building trust and comfort is as follows:

> *This one particular doctor will come in [my office] and say 'Do you have a couple of minutes, I'd like to introduce you to someone that I would like you to possibly see'. So I'll go in his office and he'll tell me what's going on. So we already have direct contact and then he leaves and I just stay a few minutes to set up an appointment. So the uncomfortability has already been taken away there.*

Furthermore, a fifth MHC felt that their presence in primary care contributes to the **"***elimination of all that craziness that happens between the client needing help to getting it in our service, it's like it's just there... It takes away a lot of the pressure, a lot of the stress that normally people go through.*" A sixth MHC believes the increased comfort and trust has led patients to "*take more responsibility for their wellness... [They are] taking a responsibility and coming to see somebody quicker and I think that's where the easy access plays a part just in terms of responsibility for their own care (some group agreement).*"

As indicated in chapter 3 section 3.2.B.10, MHCs' perceive communication and collaboration as a positive outcome of the program. For example, one MHC said: "*I like the continuity of care... where I'm right there and if I have a question, if I have a concern, if the patient has a question... I'll step out and get him, [the FP], in the hallway... I'll ask the question, he'll address it and sometimes come into the session if that's needed...The same thing in terms of the psychiatrist."* Another MHC added, "*having nutrition now,... there are opportunities for mental health and nutrition to interact. So getting referrals from nutritionists because they have eating disorder problems, for instance, which is a mental health issue, and talking with the family physician about that and the psychiatrist.*" A third and fourth MHC described their experience as follows:

> *We have an open door policy and essentially what that is is he'll knock on my door and interrupt me and say: 'I'm really sorry can I talk to you for a minute'. And I'm free to do the same thing and there's never a problem ... The communication is really good... Over lunch we talk about the other members of the family and how maybe they would contribute to how this person is presenting at this point. So I really like that. I like having all the information; it makes me feel like I'm ready to go.*
>
> *I love everything about it. I love the independence. I love the fact that we're seeing families with continuity... It doesn't feel like you're getting a piece of this person... there's a backdrop to the relationship with the family physician.*

MHCs felt "*there's also a lot more accessibility*" and that "*follow-up is easier*". The following are comments from three MHCs: "*There's a high degree of flexibility,... there's the flexibility to do what is really necessary... One of the things that I think is a real strength of the program is*

that type of work is not just permitted, but it's valued. " "I do think that one of the pluses for me here is there is the flexibility to do what you need to do... [such as] home visit." "That's right. Things get done."

Two MHCs expressed their general satisfaction with the program as follows:

> *I don't know how to put it, the service that you can provide in a doctor's office that you can't in a kind of clinic setting also gives a lot more satisfaction and there's a lot more especially after being there so many years. Like now I'm starting to meet the kids of, or I'm meeting the adults that I saw as children. So it just becomes a whole different way of relating to the service.*
>
> *I would say it's very rewarding.*

Furthermore, the group made reference to the benefit of the administrative body. "*The central program, I think they're wonderful in other ways, in supporting the development of clinical practice. They're really supportive of writing papers and doing research... They have a library that we can borrow books and just all kinds of things."* In response, two MHCs made additional positive comments regarding the support of the CMT in the education of the health care providers.

3.3.C.3 Positive outcomes as perceived by PSYs

PSYs felt the program has led to "*an improved pick-up rate, a much quicker pick-up rate to seeing patients*" and people are being assessed "*within a month instead of six months and it seems to be very beneficial.*" In addition, PSYs have noticed that FPs have enlarged "*their repertoire of prescriptioning skills because they are developing more comfort.*" FPs "*can rely on you, [the PSY], if something happens, quickly and easily,*" and "*through just informal conversations they seem to be a lot more comfortable with what can be done for people.*"

One PSY described his experience in working with FPs and how it contributes to decreasing the burden on the traditional psychiatric system:

> *You do form relationships with family doctors in a way that is quite distinct and different from my experience in an outpatient practice... [This] provides an opportunity for really significant learning... Family doctors feel more comfortable, I would say, than the average about contacting me in person at the times they have questions around medical issues that probably goes a long way to providing a lot of treatment that doesn't require formal assessment or emergency psychiatric service, admission to hospital, [or] referral to an outpatient services.*

Another positive outcome of the program for patients is that there is *"flexibility in scheduling... when I come in, my morning is booked, but they, [allied health professionals], know that if there's a crisis or an emergency they'll put it in or they'll call and say look, we've got someone who needs to be seen, can we put them in at the beginning or the end or can we juggle around. And that seems to work very well.*" Therefore, patients can be prioritised and those who need immediate care are seen as early as possible. "*If the family physician identifies someone that they*

think is in crisis or urgently requires assessment, and almost invariably they are correct, that person I see earlier or I make special arrangements." Furthermore, "*unlike in the outpatient clinic, where you don't have access necessarily to anyone who knows the patient and you don't have access to the patients' old records, you're sitting in the family doctor's office and you have their whole chart and their medical records and you have a family doctor who may have known this person for years or decades.*" The group believes the opportunity to access patient information readily results in more efficient assessments leading to more appropriate intervention plans for the patient. Thus, patients with moderate to severe mental health issues are more likely to remain in primary care as opposed to being transferred to external community services.

The group expressed an interest in the future of the program. For example, "*I think the HSO does in this city what probably needs to be done elsewhere in Ontario. I think because it's a sessional payment model for psychiatrists, it attracts psychiatrists to be willing to see people with real mental health problems, i.e., undiagnosed mental health problems.*"

In summary:

> *It's a remarkably pleasant experience and our colleagues in general in the family practices are very benevolent and the administration of the program is benevolent. So any of the hassles that we might run into from time to time, and there are, are more or less offset by the remarkable degree to which head office makes it easy and trouble free. You know, as trouble free as they reasonably can. It's not like working in the hospital, that's for sure.*

3.3.C.4 Positive outcomes as perceived by RDs

With regards to the positive outcomes of the program, RDs focused mainly on the following: education, team approach, patient care/empowerment, and provider satisfaction. In terms of education, one RD believes "*the doctor learns more about nutrition and we, [RDs], learn more about mental health than we would have otherwise.*" This was said to be possible because, "*physicians are always really approachable"* and "*you get a variety of disease states*". One RD described her experience as follows:

> *You get a variety of everything... My knowledge of medicine has increased greatly just since I've been in this program, just having the ability to be able to interact with GPs daily; you learn a lot... [In addition, the program includes] a lot of dietitians who tend to specialise in different areas so this way for each of us it's a benefit to tap into their resources... Coming together and sharing of that information and they help us to stay on top of things too... [In the practices, education is] very informal and it's ongoing all throughout the day. [Furthermore],we meet weekly. We have a Lunch & Learn session.*

Another RD made reference to the benefit of the professional meetings. "*Those team meetings [with the RDs] once a month...[are] very, very useful because we're fairly decentralised... [We work in different practices and] encounter different types of clientele...[We] benefit from resources for instance and/or approach taken with a particular client [by other RDs]*."
One RD felt the program allows for an

> *holistic approach [to patient care]... I think the quality of care is better too because you're collaborating with the physician and you're trying to come up with the best recommendations very quickly, so the patient can start making changes and you following up with them. I think you follow up on a much more frequent schedule than most of the clinics do as well, but your chance for actual behavioural changes are much higher.*

A second RD agreed and added that the care is holistic in the sense that a patient may be referred for one problem, but since RDs have access to the patient's chart, they may see additional problems. Furthermore, there is a *"snowballing effect... give them, [patients], all these recommendations and then it snowballs because they take it home and then their kids start eating better and things like that. So it's not just maybe that specific person that's benefiting, but it branches out to other people too.*" A third RD noted having access to the chart is beneficial because *"[patients] can always be re-referred,... A few years later, if their cholesterol is high again, you are just re-referring them. We have all the notes from prior"* visits in the chart. In addition, RDs being onsite, "*makes people more accountable because they're going to have to come see us."* It gives patients the chance to become more "*involved in their own care.*"

Finally, two RDs pointed out a few personal benefits to working in the HSO Program: "*I really like the independence of actually working at different sites and working with so many different health professionals*" and "*I like... that I do all my own scheduling. So I'm fairly flexible in that I can come in late or come in early and stay late.*" Lastly, RDs made reference to the support of the CMT with regards to education and research (see section 3.2.D.6.).

3.3.C.5 Positive outcomes as perceived by Group 1

Access, availability, communication, collaboration, continuity of care, flexibility, education, provider comfort, and patient comfort were some of the major strengths of the program mentioned by group 1.

When describing the positive aspects of the program one provider noted:

> *We can book our own appointments with XXX. But if you're trying to book with 3G, [an outpatient clinic], you often don't find out for months... Six months later and you still haven't heard, whereas here... you know that in February or March on such and such a day he is going to be able to see the patient. So from my perspective at least I know there's a timeline and I can tell the patient well look I know it's not for two or three months but there is an appointment.*

Another provider was quick to point out that when "*there is a bit of a waiting time to get somebody in... [the PSY] can be very helpful if you need to give him a call and say what can we do in the meantime.*" The PSY then described the advantage of this interaction. *"[We] can blend the indirect and the direct care,... we really get to know each other here,... I know what people can do... [We] can do a lot of indirect stuff [because]... the family doctors and counsellors know they have access to me... [and] if someone is urgent,... you could bump someone off on a regular day... There's flexibility in the system.*" However, providing indirect care

> *depends on the mental health counsellor because I think sometimes,... the family doctor, some mental health counsellors might not have had that much training in say medications, so this system pushes you, pushes all of us to be somewhat more broad... [and] I think there are some counsellors who are quite okay with doing a little more as long as there is appropriate back-up... Ultimately, [it] results in hopefully better patient care and quicker response*.

Meanwhile, another provider felt that although the program pushes the providers to expand their knowledge and to improve their skills, it has "*the flexibility of working at whatever comfort level works for us. I think that's not always available [in other settings]*."

In addition, the treatment protocols are flexible. "*We are able to do home interviews for some of those folks that can't get here or don't have the money, or single parents or the elderly."* Another provider agreed, "*I do school interviews, with the school social workers and teachers and so on. I've been going once every week in the last little while to one little guy, just trying to get him back into the classroom.*" Whether the providers go to the patients or the patients go to their FP's office, the group agreed that there are benefits for the patient. "*Coming to their family doctor's office is hugely reassuring... They have a little bit more anonymity... A lot of people are very reticent and extremely hesitant and it would be 'No', if it was somewhere else."* Another provider added, "*they're driving to a place they know... They don't have to go to the city.*" In some cases, "*it takes about five sessions,... to get them to accept that there may be some depression... Then sometimes they get on board... They would have dropped out [if they were somewhere else], but... [here] they are willing to almost humour the counsellor I think for awhile.*"

As for the advantages in terms of providing appropriate patient care, two providers noted the "*access to the clients' medical charts [is very advantageous]. They've got all the background information that you need in terms of doing assessment. And again, it's the communication. Oftentimes, I find I'm not communicating directly with the physicians just because of timing,... but I usually do it more through notes.*" "*Having the notes right in the chart... there it is, right away. Done. And just having access, period.*" Similarly, an FP described his experience:

> *[It is] very helpful reading the nutritionist's notes because they've been able to spend more time than I could ever spend on that topic. They get more information and I can use that information and see what the recommendations are... Two or three months later you can provide some follow-up,... Having the notes right in the chart I find really, really helpful. Sometimes it's also very eye-opening for what you thought someone's diet was like, from the quick sort of thumb-nail sketch they give you, then from the detailed assessment, to what it actually is like. It really helps to fill out the picture of understanding the patient*.

In summary:

> *[The program] just works so well. And I have worked in different systems so I know what it's like when patients don't have access to the services that are provided here and literally they fall off the edge and it ends up that the society in that area is generally not as healthy as the society in the areas that have a good integrated system of services. It makes a huge difference, it really does*.

"*Just being able to offer somebody these services and they're in-house. That's incredible!*"

3.3.C.6 Positive outcomes as perceived by Group 2

This group made reference to patient comfort, reduced stigma, the clinical setting, access, collaboration, communication, flexibility, and education when speaking to the strengths of the program.

Two providers noted the intake criteria of external services make it difficult for patients to obtain care. In addition, getting patients to go to such specialised services is hard. Whereas in the shared care model:

> *There's a certain degree of comfort in that you're not looking for the door in the hospital that says 'Memory Clinic', or 'Eating Disorders Clinic', you know -- or if you're a 'wacko' you go in this door. I mean here, you just come to the office, you sit in the waiting room and you're called in to see the counsellor and there's no stigma associated with doing that. I think that's a help for the patients as well.*

Another provider agreed and added *"being here onsite all at the same time,... [we can] go in and meet the person before a referral is actually in progress... to ease that transition.*" Likewise, a third provider believes patients "*feel more comfortable.*" Unlike external services, *"[we] see whatever comes in the door and do your best.*" Another problem with referring to external services is "*quite often, people just get lost in the system when they're discharged. Here, they are still retained in the practice and the specialist comes to them and there isn't that 'us and them' situation.*" Seeing as there is such a broad spectrum of patients that get referred, "*[we, the MHCs], bounce off of each other... every Monday we have an intake meeting at 12:00 noon where all the referrals from the family doctors are brought to XXX and I, and we go through them and sort of prioritise them.*" Therefore, patients who need more immediate care are seen first.

Communication among the providers does not occur simply for prioritising patients. "*We can talk about [any concerns or questions] before [seeing the patient]..., at lunch time meetings and I can certainly knock on anyone's door when I come out of a room or just meet them after I've seen the cases. That's both with family doctors and counsellors who are very accessible.*" Providers were said to be accessible partly because in this office, "*we have the luxury of having that space for them, [allied professionals], and not being jammed into a clothes closet to see some people,*" which some acknowledged is not the case in all HSO practices. Since this is a large office "*there are more physicians so the dietitian is here more... I can actually meet with the mental health counsellors where I'm not sharing the same room... There is then the opportunity to talk to people a little bit more, at least two days a week versus being somewhere for two hours.*" Similarly, another provider felt that access to other professionals onsite is a key feature of this program. "*It's a big clinic [here] and the two counsellors are here full-time. I think the system works better because other places where... the counsellor is not there onsite when I'm there, it doesn't work as well.*" Another provider agreed, "*it's just not the same to leave a note for somebody.*" However, *"sharing of medical records [is certainly beneficial]. Counsellors and family physicians know immediately what medication they're, [patients are] on. [Meanwhile], other issues that we might not put into the medical record, we can transmit verbally to them quickly.*" In the end, "*we do a better job, first of all identifying the problem and secondly treating the problem both with*

pharmacotherapy and with counselling. Also, my sense is that we are getting these patients integrated back into their communities, the work community, the home community, the school environment, whatever the case might be". Furthermore, if "*people are not able to work, they are unemployed, and the insurance company is responsible to its shareholders, it's not responsible to the poor unemployed worker who is depressed... [We] will all write letters on the patient's behalf to the insurance company... dealing with those outside agencies is horrendous for patients.*"

Another positive aspect identified by the group is the opportunity to learn.

> *We also have the luxury sometimes of sitting in with either the counsellor or the psychiatrist when the patient is in for a session and I can't imagine, for practical purposes, that that could happen anywhere else... So when you ask about the shared care model, that's the ultimate... [It may not] happen often, but the opportunities are there.*

Thus, the organisation of the program "*pushes the family docs to do a little more with back-up, but it also pushes the counsellors to do more in terms of diagnosing,... not overstepping what they know obviously, but... everyone is becoming more of a psychiatrist in this system, the family docs and the counsellors with back-up as needed from the psychiatrists.*" Another provider agreed, "*you ask questions that you dared not ask before... because you couldn't do anything about it, and now you have resources, you have experience, you have back-up*." Also, the CMT provides "*all kinds of patient information and literature that as they are sitting here they can pick up and read about.*" Therefore, there is the opportunity for everyone associated with the program to learn.

Part 3.3.D:
Program Challenges

Guiding Questions: "What don't you like about working in your practice(s)?"
"Do you think shared care has changed the way patients are treated in your practice(s)?"

Focus Groups:

3.3.D.1 Program challenges as perceived by FPs
3.3.D.2 Program challenges as perceived by MHCs
3.3.D.3 Program challenges as perceived by PSYs
3.3.D.4 Program challenges as perceived by RDs
3.3.D.5 Program challenges as perceived by Group 1
3.3.D.6 Program challenges as perceived by Group 2

The most common complaint noted by all six groups is the time constraints associated with caseload/waitlists, collaboration/communication with team members, paperwork, and accessing resources in multiple workplaces. Time was depicted as a major limiting factor of shared care as opposed to a weakness of the program. It was consistent across the groups, but varied as the FTE of allied professionals is dependent on the size of the practice. Ultimately, what was noted as a critical element of the program is the opportunity to have all the providers onsite at the same time. Most groups attributed the time constraint challenge to lack of adequate funding for the program.

Themes expressed by three to four groups were associated with difficulties related to external referrals and physical space for allied professionals within the family practices. External referrals were said to be difficult for various reasons such as long waiting lists, very specific intake criteria, and lack of willingness of patients to go to external community services. The other major difficulty faced by HSO providers is the overestimation of HSO resources by community organisations. This was said to be the result of unclear boundaries among the services. As for physical space, the issues were related to visibility, accessing resources, and availability of allied professionals. In smaller practices, some of the providers do not have a personal workstation. Some share one workstation with other allied professionals and others must utilise examination rooms, and so cannot be onsite simultaneously.

The following themes were mentioned by fewer participants and in fewer groups, but have value in terms of providing suggestions in making small changes for major improvement and increased provider satisfaction. For example, some participants perceived a lack of space on the standard forms to describe patient individuality and one group of participants felt the forms should be made available in an electronic format. This would allow computerised practices to incorporate the forms into their existing system and forward information to the CMT automatically and promptly electronically. Also, some providers felt this would increase the ease of access to patient information. Likewise, another group noted that a standard protocol for record keeping such as typed notes and electronic referral sheets would facilitate sharing of information. The main reason for this challenge was associated with the legibility of some providers' handwriting.

Lastly, two groups felt roles and expectations of the CMT and HSO providers should be more clearly defined. Some participants believed it is unclear where the authority lies in terms of dealing with attitudinal problems of team members and that the model may be too flexible in terms of provider expectations. Four groups agreed by suggesting that in some cases the program is not a true model of shared care as individual practitioners work very independently, very much like private practitioners in the traditional system. Other challenges included no-shows, access to the program for patients outside the HSO, access to specialised staff such as a child psychiatrist, access to other HSO providers in case of compatibility issues, and the degree of collaboration of RDs with community services to avoid duplication. Finally, two groups had concerns about the level of understanding other providers have of allied services and their effectiveness.

3.3.D.1 Program challenges as perceived by FPs

FPs associated the main challenges of the program with paperwork, physical space, and external referrals. The paperwork issues were mainly surrounding record keeping and providing data to the CMT. One FP felt he would benefit from "*a little more consultant approach to the psychiatrists in terms of dictating notes.*" He felt typewritten notes would certainly make it easier to decipher the PSY's notes. Others were quick to point out that PSYs as well as MHCs were required to type their notes in their offices. Some even type their prescriptions. This led to an expressed frustration with the standard forms. "*I'm totally electronic as well and it's frustrating to have these referral pads.*" Others agreed, " *We've got files that are basically empty, but they're filled with mental health notes which we cannot scan because they are handwritten,... and every nutrition referral requires about six sheets of paper,... otherwise, I don't have any paper.*" As the discussion continued briefly some FPs offered their assistance to other FPs in setting up a computerised chart system. Also, they brain-stormed on how electronic standard forms could be possible and efficient. Here were some of the comments: "*We just actually type in the referrals so perhaps we could just type in the referral format and print it off to the HSO Program,*" or "*just e-mail them.*" "*All of it should be computer friendly*."

As for the issue of physical space, the group noted that this was site specific and those that have gone from small offices to larger ones had this to say: "*It makes a big difference if they, [MHCs and RDs], have their own dedicated space. It makes a big difference.*" "O*ur social worker is able to have stress management classes in our facility... [and for] the dietitian aspect, [they sometimes see five to six patients in a row with cholesterol problems],... You do a group, it makes it much more time sensitive and that requires space.*"

The FPs made reference to some barriers in doing external referrals. For example, comments such as, "*When you refer out, they say well you've got your own psychiatrists, use your own psychiatrist*" and "*we've had to have them, [patients], seen by our psychiatrist before they'll accept a referral*." Many FPs agreed; however, one FP in particular did not agree with the majority. "*I haven't had too much difficulty with that... it's no problem. Well, maybe it's the way I deal with it... I haven't found any difficulties.*" Meanwhile, FPs were not the only group to comment on problems with external referrals (see section 3.3.D.3., 3.3.D.6., & 3.3.E.5.).

3.3.D.2 Program challenges as perceived by MHCs

MHCs identified the lack of clear roles and expectations in terms of shared care as the main reasons for challenges within the program. The variability among the practices may be the reason for some of the problems encountered by MHCs. They felt that it is unclear

> *how much the HSO, the program itself, can influence a physician to actually do what they're supposed to do within the constraints of the program... [Not] much of that is really clearly defined, or... there's just not enough structure put in place to define here's our expectations of what needs to be provided in terms of physical space, but also in terms of how definitive the roles [are]*.

A second MHC agreed:

> *The degree to which the central program actually is unable to regulate what goes on with certain, more problematic practices... the physicians are actually the owners of the practice, literally and figuratively. They're the case coordinators. And it is a tricky role when things are problematic... The clinical work actually I think is gratifying and one gets respect and feels at least for myself it's a good way to work. There are just sort of administrative glitches that I think are really exacerbated in certain areas where the physician is on board economically but not clinically*.

Physical space is another challenge identified by the MHCs in terms of having enough space to schedule all providers in the office simultaneously (limiting factor for collaboration/direct communication), keeping up with the increasing number of patients with limited FTEs, and accessing resources when working in multiple offices. For example, there are "*a lot of barriers in terms of just accessibility to office space. And when I'm in, there's no physician in at all, so I'm in pretty much on my own. So grabbing a physician is a real challenge*," and

> *it would be really nice if there were sort of clear guidelines on what you do... I don't think the physicians are clear. I mean I think they are very clear that my role is a consultative role and I think they're very respectful of the work that I do, which makes it very survivable. And I'm quite valued, I feel like I'm certainly an equal member of the team, but it's dicey when there's a difficulty, even with our office space*.

In addition,

> W*e can't see every patient once a week if you're there a day and a half... [in] more than one practice, it becomes quite a challenge... just in terms of the time it takes to pull charts in two different offices and run back and forth, so although the intent is there for good communication, when you're sort of stuck in the back corner in a kitchen or something, it's a bit limited... I think that's just the nature of the allotted hours per practices,... but I think it can be a barrier if you're in one office and need files or something from another office. It just gets a bit cumbersome*.

3.3.D.3 Program challenges as perceived by PSYs

The PSYs identified challenges with the lack of definitive roles and expectations, scheduling, lack of interest and participation in shared care from certain allied professionals, and lack of clear boundaries regarding the resources of the program.

Because there is a lack of clearly defined roles and expectations in the program, "*there are some counsellors who clearly are proxies for the primary care [sic] and some who, as you said, are really operating a private psychotherapy practice on the premises.*" This was said to be the result of the "*wide variety of counsellors and family doctors and us, [PSYs], who all come with different interests and expectations and experiences. I think the program would be immeasurably stronger if there could be greater synchronisation, practice by practice.*" Furthermore,

> *there isn't a centralised booking system in all that and for receptionists at practices and counsellors... [who] tried to juggle everybody's schedules and to try to prioritise patients because there isn't really a proper intake system. This sometimes means that the patients who need to be seen get seen later than they might have been seen if they had been tracked through the ordinary triage processes*.

Another issue with scheduling is having all the allied health professionals in the practice simultaneously. "*I have no contact with that person whatsoever because our schedules are opposite to one another... But that varies as well between practices.*" Having opposite schedules was indicated to hinder the opportunity for shared care.

Another issue noted as inhibiting collaboration among the various providers is the degree of interest expressed by individual providers. "*When the referring doctor and I are really equally interested in the care of the patient... that's an ideal that one sort of hopes for all the time and gets sometimes*" and "*if the goal of the HSO Program is to let's say improve the knowledge or capability of treating physicians, we might do better to target those that are less interested then I don't know how to go about doing that.*" One PSY's experience is as follows:

> *We have heightened their awareness to pick up psychiatric care... the volume... is increasing to the point where I have felt a lack of shared care even with the counsellors in the last while because they're busy seeing new patients while I'm seeing new patients. That has been a recent phenomenon which has become less satisfying to me... it's become like everybody having mini-practices... I think maybe we need maybe more counsellors or something... maybe we need to re-examine, if we wish to share care, you know, currently do all of our partners wish to be sharing and if they don't then maybe our services could be better used elsewhere.*

In addition, the PSY expressed some frustration with lack of understanding by external services regarding the resources of the HSO Program. For example, "*I think the rest of the psychiatric system sometimes overestimates what we can do within the HSO... [An] ill patient is somehow discharged back to my care at [the] HSO for follow-up... They don't realise that I'm there one-half day a month... They do overestimate what resources are actually there.*" The "*boundaries between hospital and outpatients, between outpatients and primary care [need to be*

clearly outlined so]...that the transitions take place in a relatively seamless way without there being a lot of territoriality or this is your patient or my patient kind of thing."

Furthermore, one PSY commented on peer support which seemed to yield group agreement.

> *[What the] HSO Program could do better would be to have more regular meetings like this because I find it always stimulating when we get together (group agreement)... I think we could be of better support to each other in managing... issues... [Furthermore], we want to know if it, [the program], makes a difference in looking at outcomes, outcomes for patients and outcomes for family doctors,... [but with the CMT], we end up shouldering the bulk of that responsibility and it might be possible that we as a group might be able to help out with some of those things... identifying any sub-group or population for specific focus and then target a bunch of interventions that would hopefully raise the level of skill, knowledge, expertise or awareness. And if we did that collectively, we probably would have greater impact than we do sort of individually*.

Lastly, "*this particular way of practising psychiatric [sic] in the community only covers a very small percentage of the family doctors and I wonder where it goes from here. I mean if we're saying it works so well, what about all the other people who don't have any access to this."* The group agreed with this comment. "I *think it is unfair... Some people have the advantage of being seen in primary care with all the support that entails and other people don't.*" The group observed that "*if there is sessional fees to support then I think more psychiatrists would be interested in promulgating the model outside of the confines of the HSO,*" but "*the rate should be at least what OHIP pays.*"

3.3.D.4 Program challenges as perceived by RDs

RD's felt scheduling was a challenge with regards to collaboration and efficient record keeping. "*If you're only there a couple of hours a week then it's really hard to have that kind of sharing going on between health professionals... I might never see the mental health counsellor or the doctor might never be there the day I'm there.*" Another two RDs described their difficulties with collaboration and record keeping as follows:

> *There are not physical spaces for us... We can't have all the health professionals there at the same time or the rooms would all be full... Where the physicians are there at the same time, I feel that the shared care model is working much more effectively than the offices where the physicians are not there while I'm there. And you do see a distinction. I see a distinction in the referral rate. I see a distinction in my no-show rate, cancellations, just everything. The whole efficiency of the system is different when the family doctor is not there at the same time*.
>
> *I find it's hard... to get everything done in the one scheduled time slot because you won't be back until the following week... You're sort of always racing to get the documentation done and get the charting completed on time... We have a lot of charting period, in terms of our College recommendations, but also in terms of data management collection there's a lot of charting... A few offices that have computer systems where the template charts are*

actually on the computer and they just pull up and I just fill everything in, which is much, much faster than the actual writing of it.

In addition to scheduling and charting issues, one RD noted that " *we move around offices too... Have[ing] your resources there is sometimes tricky,... 'that's at home and that's at the other office'... not only is there not another dietitian to ask, but I don't have my trusty book to look it up.*"

Furthermore, the group made reference to the fact that,

> *There is a lot of variability between practices and also between the different G.P.'s and how they view our services and how comfortable they are with us dealing with the patients... Some doctors like your input, but they don't I guess include you in the patient care... Some doctors are very open to it... Other doctors will be like 'whatever', they are not as interested in your services... Sometimes it just doesn't feel like it's a team approach.*

The lack of interest or understanding of nutrition counselling was said to sometimes result in the FPs prescribing medication too quickly and "*somehow they, [patients] get the message that it didn't matter, their diet. So that is a little bit upsetting sometimes because... they always cancel their follow-ups and go, 'I'm on medication now. I don't need to follow up'."* Also, the FPs' view of nutrition services can lead to lack of variability in problems referred to RDs: "*We're always trying to get the doctors to refer things other than high cholesterol, weight loss, and diabetes. I mean we want to see the other issues too.*"

Lastly, *"I know physicians who don't have access, some physicians are on the same site and are not allowed to refer for our services because they joined [the practice] later... So increasing nutrition services in general just to keep up with the demand because I think the demand is huge."*

3.3.D.5 Program challenges as perceived by Group 1

The two main challenges expressed by this group are time constraints and issues related to the standard forms. "*Because of my hours, I sometimes have difficulty accessing the other members of the team... I don't always like to grab people in hallways. I would find it helpful to have something a little more structured even if that was a quarterly check-in with physicians just to run through their cases.*" Time and access to allied professionals influences the program:

> *If you are not here at the same time, it becomes more of a traditional model. Although we still can, it's still better, I'd say because you've gotten to know each other, but it does kind of get in the way I think just by how it works. The other thing... [is] the amount of time a patient can be seen onsite. The counsellors are usually very busy and I'd say the psychiatrist is usually very busy. So we'll still have a waiting list here and I see it now as a few months, and that's not right. So part of it would be, would there be funding for me to come more often.*

> *[MHCs] are able to see someone every two, three or four weeks. Sometimes that isn't optimal, some should be seen weekly. Like a lot of people probably should be seen weekly, but it's not funded for. So I do believe in the system, as getting stuff to more people, you're getting very good care to more people in an hugely beneficial way... So I think funding has to be increased. Because I believe in the system, I think that still is the way to go*.

As for the standard forms,

> *I frankly prefer the consult mode as opposed to the tick-off. I know the tick-off sheet is here to stay, but I'm not a fan of the tick-off sheets. It doesn't really allow any individuality. Everybody has depression, everybody has [this and that]... It is much easier to write in a paragraph what I identified and what I thought what people should focus on. So usually in the box where it says 'Comments', I just put 'see chart entry of such and such a date'*.

Another provider agreed, "*The individual nuances of each case cannot really be [described on the forms], and there used to be a little tiny box which now I think is even smaller for comments... Well I often end up scribbling a note which probably leads to a discussion because you can't read it anyway*."

3.3.D.6 Program challenges as perceived by Group 2

This group noted the main challenges as time constraints in the HSO and with regards to external services. They believe more funding would allow allied professionals to spend more time in the practice and provide them the opportunity to increase the quality of care even more than the program already has done. For example, "*The only thing [that] might be [a challenge] is they, [MHCs and RDs] get very overwhelmed at times with referrals*". A second provider agreed:

> *The system is a victim of its own success. What I understand is that the rate of case discovery has gone up something like 1100 percent... and because of that, things kind of back-up a lot... If funding was not an issue, this place could use more funding for counsellors and for me in fact,... [MHCs see patients] every three or four [weeks] and I think it's the best care that we delivered in the funding arrangement to the greater number of people, but I think that more funding would help to make it possible to see [patients] every week or two... If there was more funding for me I could do follow-ups the way that I'd like and probably not have the same waiting list... [The program] is good it seems to me, bringing mental health care to a greater number of people,... [but] I think from what I've seen they are mainly legitimate cases that would benefit from [more time for] intervention*.

A third provider agreed:

> *I look after some special groups,... young offenders, two houses, so there's quite a turnover there. I also look after some Children's Aid homes and literally with the amount of pathology there, you need another two counsellors for that perhaps, to do justice. So those people go through the normal service [because they would overwhelm the HSO, but*

> *the external services are] not particularly efficient and they are groups of people who are very needy... If we could give these people some service and we can't at present, we would be able to help them tremendously. So there's potential to expand what we have here because the present system that cares for these people is overwhelmed so the end result is they get very little treatment*.

At the same time, the "*boundary between the outpatient clinics and the HSO that is still somewhat kind of ill-defined*." This can lead to problems with deciding who gets referred out and who is responsible for the care of certain patients. "*If you try to make referrals to outpatient clinics either the patient doesn't want to go... or you try to refer and you run into the situation of the criteria again ... [And when an outpatient clinic] finds out that they're a patient from here, we get them... I haven't found that system sort of working very well*." However, some of the problems are a result of "*the whole system that is backed up. So again, I think in an optimum world we would be referring more than we are to outpatient clinics and I think we'd have a little more time for the cases that we do see."*

Part 3.3.E:
Target Population of the Program

Guiding Questions: "What types of patients benefit from your practice(s)?"
"What types of patients do not benefit from your practice(s)?"

Focus Groups:

3.3.E.1 Target population as perceived by FPs
3.3.E.2 Target population as perceived by MHCs
3.3.E.3 Target population as perceived by PSYs
3.3.E.4 Target population as perceived by RDs
3.3.E.5 Target population as perceived by Group 1
3.3.E.6 Target population as perceived by Group 2

When asked to describe which patients benefit the most and the least from the program, all six groups were in agreement that at some level, all patients benefit. Specifically, patients with institutional barriers, family problems, general psychiatric ailments, some physical problems such as diabetes, lipidemia, gastrointestinal issues, etc, and patients with particular demographic characteristics like low socioeconomic status, the elderly, ethnic groups, etc, are some of the patient groups who benefit the most from the program. Some groups felt patients with fairly complex psychiatric problems such as schizophrenia and bipolar disease could also benefit. No matter the diagnosis, a number of participants believed that patient motivation was a critical feature of treatment success.

Patients who need ongoing treatment, frequent counselling, or emergency psychiatric care were identified as those who benefit the least from the program. Mainly, the participants believe those patients exceed the resources of the program. For example, patients who need vocational or addiction rehabilitation, patients with unstable schizophrenia/bipolar disease/etc, large families especially when associated with grief, and children because child psychiatric issues can become very complex involving a number of people (parents, siblings, etc). Finally RDs made reference to patients with weight management issues as being the least likely to benefit, although, RDs felt it was because in general they lack the required personal motivation as opposed to inadequate program services.

3.3.E.1 Target population as perceived by FPs

FPs felt the patients who benefit the most from the program are those "*that were never dealt with before,*" those with "*general psychiatric disorders*," "*people with depressions and panic disorder and family inter-problems*" to name a few. In addition, some FPs believe patients with stable schizophrenia or bipolar disease are also part of the target population for the program. Others strongly disagreed and some felt "*people who need long-term counselling, such as people with personality disorders or schizophrenia, things that require ongoing treatment to weekly counselling"* do not benefit because it is not the type of service they can provide. They "*exceed the capacity of whatever team [in the HSO]."* The lack of FTE allowed for a PSY or even the MHCs was noted as the main reason those patients benefit the least from the program. Other

patients said to benefit less from the program are acute suicidal patients who require emergency psychiatric service.

3.3.E.2 Target population as perceived by MHCs

The MHCs noted the patients who benefit the least are "*people that are really prone to become destabilised psychiatrically with diagnoses [such as]... schizophrenia or really unstable bipolar disorders.*" One MHC explains, "*although I have experience in working with people like that, I don't have the psychiatric back-up.*" However, a second MHC felt labelling patients as those who benefit the least from the program may not be the most appropriate wording "*because there is still a role to case manage and I think that could be very valuable and liaise with the other service [and] supporting the family, doing some education, [etc]...[but, the program is], too limited. I mean I'm there two days a week, that's not enough. Some of these folks need crisis [care]*". Lastly, a third MHC agreed, "*there are specialised services for that in the city that do a good job.*"

Some MHCs insisted that the program is beneficial for all patients. "*We are so generalised, I don't just see depression or psychoses. You know, you see whatever and you help out. I mean if nothing else, you can problem solve*." However, they did make special note of patients who "*get access to psychotherapy that nowadays is not accessible through traditional routes*" and "*people that would have barriers... because of cost and I think as well, stigma*" are patients likely to benefit the most from the program. Furthermore, one MHC noted that it may "*also depend upon the counsellors as well, what sort of strengths that they bring in, what knowledge base they have... If you have some experience [you treat them], otherwise you make a referral.*" Meanwhile, if patients are not accepted into an external service promptly, "*we just kind of keep at it and keep at it until something happens, either they do get admitted or they get treated, one or the other.*"

3.3.E.3 Target population as perceived by PSYs

The characteristics of patients who benefit the least from the program were listed by the PSYs as patients who need long term case management such as drug rehabilitation, vocational rehabilitation, management of schizophrenia, management of obsessive-compulsive disorder, and any patient requiring high intensity and frequent counselling. One PSY suggested that it may be in part due to the skills of the team, but mainly the group agreed that this population "*can't be well managed in an HSO model... [because] the volume is so great that I don't think it has the flexibility to kind of incorporate people whose demands are persistently high for a long period of time.*"

PSYs listed the following as the most likely to benefit the most from the program: families, ethnic groups, patients with institutional barriers (physical disabilities/isolated homes/refuse mental health care), chronic pain, addiction, sexual problems, attention deficit disorder, anxiety disorders, depression, and general psychiatric issues excluded from outpatient clinics. The following is a representative quote of what seemed to be the overall view of PSYs in terms of the target population of the program:

> G*iven the fact that the psychiatric system is overburdened,... there's been a shift in terms of who gets into the system... It's the sickest of the sick almost who get treated. You almost have to be acutely suicidal to get into an outpatient clinic anymore. So that leaves a whole draft [sic] of people who kind of don't really get service or easily get service. So I think that's one group of people that really benefit. [Meanwhile], I think that all levels of patients and patient pathology benefit because you can help the family physician sort out who... could actually be managed in the system..., and also help weed out who can't really be carried in that kind of system... Then try to appropriately refer them to the outpatient services where they would be better managed*.

In other words, it appears the group felt all patients with psychiatric problems can benefit from the program whether it is via implementation of treatment within the HSO or referral to an appropriate external community service organisation.

3.3.E.4 Target population as perceived by RDs

People with weight management issues were perceived to be the group who are the least motivated, and as a result benefit the least. This was deduced from the fact that they are the group with the highest no-show and cancellation rates. However, the group noted that regardless of the nutrition problem, patient motivation is critical. Motivation can be influenced by a number of factors such as fee for services or lack there of, and the FP. "*The perception that they get from the doctor... I mean if the doctor says you need to go see the dietitian, then they say, 'Oh, I've got to go see the dietitian.' But if the doctor says you might want to talk to the dietitian, then they go, 'Oh, whatever.' So I think a lot of it is dependent on how the physician states it or stresses the importance of it.*" In other words, the lack of confidence of some FPs in nutrition counselling may influence patients' motivation whether the intent is there or not.

In general, the group that benefits the most are motivated patients, whether they are pre-diabetics, have an impaired glucose tolerance, have diabetes, are obese, have lipidemia issues (high cholesterol), have hypertension, have gastrointestinal problems such as irritable bowel syndrome, need pre-natal nutrition advice, or are vegetarian. Meanwhile, it was said that it is difficult to judge who is motivated and who is not. "*We are not very good at judging who is motivated or not and I've stopped making comments about that either way because I just go well it will be a surprise when they come back, because people surprise you all the time*." Another RD agreed:

> *It's hard for us to judge who benefited the most. Sometimes that person might never come back, but then occasionally you meet up with them again and they'll say I've been following that sheet ever since I was here ten years ago. So you might never know that. Or people that seem like they don't care at all, and they make some good changes and they are actually telling other people about things that you said to them. It's surprising*.

3.3.E.5 Target population as perceived by Group 1

Group 1, as a whole, noted that in general all patients benefit from the program to some degree. Patients who benefit the most are "*people that would not be seen, even couples and families and children,*" people with "*general mood disorders and their families,*" "*the poor, people that are unemployed and are poor and don't have EAP and don't have money for $70 or $100 an hour for*

private counselling," "*folks that can't get here or don't have the money, or single parents or the elderly*," people with cholesterol, diabetes, etc.

A critical element in successfully treating patients is their level of personal motivation. "*If the doctor has already assessed that the person is willing in terms of wanting to make some lifestyle changes in terms of their diet, it really helps our success in terms of helping them.*" Some "*people who aren't interested, who you wouldn't end up referring say 'no I think I know enough about it', [the illness, or problem]. Then you just say 'okay', and then you just sort of work away at them, maybe point out the areas that might benefit. You probably wouldn't refer them at that stage because they're not interested*." However,

> *it's very few people that say 'thanks but no thanks' to the referral... We've had some tremendous success with diabetics... We've had some people where it's just turned their life around and between diet and exercise their sugars just plummet and they lose like 50 pounds. They just walk in the room and a few months later you can't believe it's the same patient... Cholesterol is a tougher issue because those people for the most part except [those who have had a] heart attack or a stroke usually feel well.*

Meanwhile, as health care providers, "*you can help them become more motivated through certain discussions about complications... Some people don't have a lot of insight into their diagnosis so you need to help bring them along.*"

In terms of mental health, patients who benefit the least are patients who require "*drug and alcohol treatment... [because] there's better services out there, people that have the expertise*." The same is true for children, "*I think children need to be referred out... their development is moving along quickly. Things should be dealt with sooner, not later. Six months to eight months in a school year is a huge difference... We don't have child psychiatrists and we don't have counsellors that see children comfortably*." However,

> *The resources are just very, very limited. There's long waiting lists. Sometimes there's medication issues that I try to get back to the physicians because I think the depression is pretty entrenched and I'm really concerned. So I think we volley that as much as we can and I end up having them for months and months when you'd like to see them referred out but that just isn't happening. So by default I will continue to at least support the family and the kids.*

Another group of patients who benefit the least from the program are "*the serious psychiatrically ill, but I think we kind of deal with them here too... If something comes up we can deal with it,... [but] I just didn't have the time... I feel actually with shared care it's not meant to be dealing with the serious mentally ill... That's probably where other systems might have a little more to offer*." However, an FP noted that those patients often "*end up back in our office [or on] our phone."* The PSY agreed, "*Yes, I do think that in general it does service everyone well because the other system isn't perfect either.*"

3.3.E.6 Target population as perceived by Group 2

Group 2 felt patients who benefit the most from the program are, "*single moms, and [the] elderly, and ethnic people," "depressed patients, ... those with panic disorder or various phobias," "the needy,... [patients with] personality disorders,... schizophrenics*," etc. One provider felt that,

> *all patients in this practice benefit, even if it's from the initial consultation and access to other community resources that we may know about. Being able to tap that person in and for them to have us as back-up. In my experience anyways I can say there is not one person that I can say that it's a terrible thing that they got referred to us... I see everything. We've had newly diagnosed schizophrenics, newly diagnosed psychoses, bipolar... There's all kinds of things and right from all age groups too, from kids all the way up to adults... [Therefore,] it's important ... [for the MHC] and myself to have a very strong psychiatric background. So if somebody comes in the door and they're hallucinating or they're suicidal... we can manage that, we can deal with that, and we have all the supports here that we need*.

As for the nutrition program, it helps "*people that would not normally be seen and I think the biggest group is people with diabetes, over and over there's so much anxiety when they first get diagnosed... We know that our people with diabetes, especially the impaired glucose tolerance patients, would never have been seen [in an outpatient clinic] for sure*." This is true for many patients with mental health problems as well, and "*the socio-economic status absolutely plays a significant role in this city*." The HSO helps all patients especially those who cannot access community services and those who cannot afford private counselling.

Chapter 4:
DISCUSSION

Sections:

When carrying out any comprehensive evaluation, the first task is to conduct a process evaluation. The process evaluation outlines how the program operates and whether or not the program is meeting its identified program objectives. This process evaluation provides a comprehensive and detailed appraisal of whether the Hamilton HSO Mental Health and Nutrition Program is delivering its intended services. In addition, this evaluation addresses the objectives outlined in the Agreement between the Population and Community Health Unit and the MOHLTC. The scope of the current evaluation as outlined in the Agreement included the development of program logic models, the gathering of administrative quantitative and qualitative data, and conducting focus groups with HSO health care professionals, to provide a complete and accurate description of the program. In describing the program, particular attention was to be focused on staff satisfaction, promotion of integrated services, appropriateness of the program in relation to the MOHLTC's goal of advancing interdisciplinary care, strengths and challenges of the program, viable costs of the program, and recommendations on how to improve service reporting so delivery of services can be monitored and tracked.

This evaluation began with the development of program logic models for both the CMT and the HSO practices. Program logic models are diagrammatic representations of program objectives, activities, outcomes, and indicators. Thus, they are useful for conceptualising the causal pathways by which a program can meet its objectives and for determining whether the program is delivering services as intended. The program objectives are defined by the expected indicators which identify measurable outcomes. This discussion will first answer the question of whether the program is meeting its program objectives and delivering its intended services. Then the discussion will address the specific issues regarding program delivery, staff satisfaction, appropriateness within MOHLTC's interdisciplinary care goals, strengths, challenges, costs and recommendations for improvements to service reporting.

The results of this evaluation indicate that the Hamilton HSO Mental Health and Nutrition Program plays an important role in the community as it provides access to comprehensive health care in a primary care setting. Overall, the program objectives of the CMT and HSO practices for education, evaluation, program development/administration, comprehensive health care delivery, collaboration, and health care accessibility are being met. The CMT and HSO practices were found to work together to improve access and delivery of primary care, mental health care, and nutrition services. Summaries of the findings for each of the program logic models' objectives are provided below.

Section 4.1:
Program Logic Model Indicators & Outcomes

Parts:

4.1.A The Central Management Team

4.1.B The HSO Practices

The program logic models of both the CMT and the HSO practices reflect a well organised and causally linked program. The components, activities, outcomes, and indicators clearly outline the complexity of the program and the extensive, evidence-based planning involved in the program's development. Furthermore, the CMT should be commended as the evaluation revealed that the implementation of the program is in accordance with the program logic models. This is evident in the results sections and critical features will be reviewed below.

PART 4.1.A:
The Central Management Team

Components:

4.1.A.1 Education

4.1.A.2 Evaluation

4.1.A.3 Program development and administration

The CMT is a critical part of the program. It plays a relevant and important function in education, evaluation, and program development and administration. Furthermore, it is crucial in managing the HSO practices as well as a complex central patient database which is vital in contributing to program quality control and improvement, research opportunities, and program advocacy. The current evaluation revealed that all of the objectives outlined in the CMT program logic model are being met.

4.1.A.1 Education

The CMT puts much emphasis on both patient and practitioner education. They have made it their responsibility to identify important resources and distribute them both in the central office and in individual HSO practices for public use. For the HSO health care providers, the CMT organises formal education opportunities such as professional meetings, workshops, and a resource centre. The evaluation revealed that all of these services are utilised and described to be satisfactory. For example, one of the MHCs said, "*The central program, I think they're wonderful in other ways, in supporting the development of clinical practice. They're really supportive of writing papers and doing research... They have a library that we can borrow books and just all kinds of things*." Furthermore, RDs noted that "*the central program here is very supportive and they're really in agreement with us continuing our education and doing research and going to conferences*," and the professional meetings are "*very, very useful because [we] are decentralised*." In the program the "*RDs tend to specialise in different areas, [and the meetings allow us] to tap into resources*."

Even though FPs were shown to be the least likely group of providers to use these resources, focus group data revealed that they participate in informal educational activities. These activities occur in individual practices and include case discussion, lunch and learn sessions, face to face communication, letters, and notes in patient charts. In fact, the results suggest that all providers in the program participate in informal educational activities based in the individual practices.

Therefore, there are both formal and informal opportunities for the different professionals in the HSO to learn from each other and improve their skills and knowledge. These educational opportunities may impact positively on patient care.

4.1.A.2 Evaluation

To maintain an extensive patient database and to monitor service delivery, the CMT has developed a vigilant and comprehensive evaluation component for the program. Some of the activities they have undertaken include the development, distribution, and collection of standard forms and questionnaires. These forms and questionnaires provide important information regarding demographics, treatment activity, effectiveness of resource distribution, and patient and provider satisfaction. Furthermore, the large quantity of data collected and managed, provides detailed information about the HSO services such as the number of patients seen, the number of patients referred, the types of main presenting problems encountered, the type of treatments or management strategies utilised, etc.

In addition, the sizable database allows the CMT to monitor, troubleshoot, and make appropriate and timely adjustments to the program to maintain delivery of quality services. The disadvantage to having such an extensive evaluation component is that the HSO providers are sometimes overwhelmed with the data collection required. It then becomes crucial to find the least time-consuming data collection format. In this case, as suggested in the focus groups by providers in paperless offices, the CMT may want to consider exploring a more computerised data collection system (see section 4.2.B.1).

4.1.A.3 Program development and administration

The CMT is focused on continuous quality improvement and program dissemination. Therefore, the members of the CMT are proactive in various centres and committees to improve the program locally, and to improve primary care nationally and internationally. They accomplish the latter by advocating on behalf of the program and by helping organisations in other regions develop and implement similar shared care model programs.

Since the CMT is active in many committees which are part of the psychiatric and nutrition networks, the team can play an important role in the management, monitoring, and quality improvement of the HSO practices. Moreover, they have the wherewithal to take a leading role in research and training with regards to both mental health and nutrition care.

Lastly, the CMT has an important function as the intermediary between the MOHLTC and the HSO practices. They are central in coordinating procedures and answering to the MOHLTC with respect to program objectives, activities, target population, current personnel, and community involvement.

PART 4.1.B:
The HSO Practices

Components:

4.1.B.1 Comprehensive health care

4.1.B.2 Education

4.1.B.3 Collaboration

4.1.B.4 Accessibility

4.1.B.5 Other

In the HSO practices program logic model, the components reflect the four types of professionals involved in the program: FPs, PSYs, MHCs, and RDs. The major objectives/short-term outcomes identified for these components include comprehensive health care (assessment, treatment, and follow-up), education (personal, co-workers, FPs, research), collaboration (professional relationships, patient care), accessibility (internal and external referrals), and other (data collection, accreditation, student training, program development). As described in the result sections, many of the program objectives are not mandatory requirements for the health care providers. However, the results indicate that despite the lack of requirement, these objectives are being met.

4.1.B.1 Comprehensive health care

The indicators for comprehensive health care clearly demonstrate that patients are being assessed and treated. For example, Table 2, 3, and Figure 1 show that MHCs assessed and treated 4367 patients and the PSYs and RDs assessed and treated 1201 and 4429 patients, respectively. Furthermore, evaluation data show that MHCs and PSYs encountered 68 and 54 main presenting problems for which they utilised 17 and 11 different management strategies, respectively. RDs encountered 51 main presenting problems and made use of four different treatment strategies. To complement individual treatment and management strategies, both the MHCs and the RDs offer group treatment sessions. This allows for more efficient use of their time by addressing common problems with a number of patients at once. However, it is important to note that FPs never fully transfer patient care to allied professionals. In other words, they continue to care for patients even when those patients are receiving additional care from one or more of the allied providers. This results in continuity of care by easing the transfer of patient care among the providers.

4.1.B.2 Education

As indicated in section 4.1.A.1, HSO providers have the opportunity to participate in both formal and informal educational activities. Participation in formal educational activities is not mandatory; however, 55 to 92% of the providers participated in professional meetings and 27 to 100% participated in workshops in the 2002-2003 fiscal year. It is evident that the education objective is being met with some enthusiasm by the HSO professionals.

Although informal educational activities are not evaluated by the program, qualitative data from the focus groups suggest that the majority of the providers' education occurs informally.

Furthermore, the focus groups revealed that all the providers learn from each other despite the fact that the program logic model is focused on FP education. For example one PSY said, "*one of the things I really appreciate is I've learned so much about general psychiatry, stuff that I just never would have [in a traditional setting]... things like pain and addictions, and sexual problems, and attention deficit.*" Another PSY noted, "*the exciting thing when you can make the shared care model work is the patients benefit and I think we learn from our colleagues in medicine. It reminds us we are doctors and sharpens us up on relearning our drug interactions and keeping on top of them and they remind us that the mind and the body interact*." In the words of one of the RDs, "*[we] learn from each other*."

4.1.B.3 Collaboration

The qualitative data revealed that HSO providers see collaboration as a critical feature of shared care. Shared care was defined by the providers as the opportunity for multiple disciplines to be involved in the care of patients and collaborating to provide the most appropriate care by the most appropriate professional. Within the mental health and nutrition program, collaboration was said to occur in many ways such as sitting in during assessments, face to face conversations, letters, notes in the patient charts, etc. The focus group data indicated that the type and the extent of the collaboration is dependent on a number of factors such as the clinical setting, availability of allied professionals for communication, individual skills of the providers, the relationship among the providers, and the personal view and comfort of individual members regarding shared care. All of these factors contribute to the large variability described by the providers from one practice to the next.

Moreover, the variability was described as a positive aspect of the program by a number of the providers. It was said that the flexibility offered by the shared care model allows individual practices to mould protocols and procedures to suit the individual skills of the team and its target population. Furthermore, in moulding the program, the providers can take into account the team dynamics and logistical issues so that whatever the process of collaboration, the program objectives can be met.

Some providers indicated a higher degree of personal satisfaction and perceived better outcomes for patients when making use of face-to-face collaboration as opposed to collaboration via patient charts. However, this process evaluation cannot assess whether one type of collaboration yields stronger or weaker outcomes for patients. A more complex research methodology with specific outcome data is needed to assess differential outcomes. Therefore, an extensive outcomes evaluation is necessary to do so. That said, it is important to note that regardless of the type of collaboration, the providers felt the model provides the allied professionals access to an extensive patient history and medical information which contributes to a more holistic approach to patient care than in the traditional system. As noted by one PSY, *"unlike in the outpatient clinic, where you don't have access necessarily to anyone who knows the patient and you don't have access to the patients' old records, [in this program] you're sitting in the family doctor's office and you have their whole chart and their medical records and you have a family doctor who may have known this person for years or decades.*"
All the allied professionals, including FPs, made reference to access to patient information multiple times during the focus groups. For example,

[It is] very helpful reading the nutritionist's notes because they've been able to spend more time than I could ever spend on that topic. They get more information and I can use that information and see what the recommendations are... Two or three months later you can provide some follow-up,... Having the notes right in the chart I find really, really helpful. Sometimes it's also very eye-opening for what you thought someone's diet was like from the quick sort of thumb-nail sketch they give you, then from the detailed assessment, to what it actually is like. It really helps to fill out the picture of understanding the patient.

At this time, the only quantitative measure of collaboration available is the number of hours of telephone advice provided by the allied professionals. It is difficult to measure other indicators because most of the collaboration occurs in an informal format. On average, PSYs spent 1.5 hours per practice and MHCs spent 35.0 hours per practice providing telephone advice in the 2002-2003 fiscal year.

Collaboration between the nutrition staff and other health care professionals seems less evolved, as noted in the focus group results. Since the nutrition program was amalgamated in 2000, the state of collaboration as described above is not surprising because there has been less time for RDs to build relationships and become integrated into the shared care model.

Another factor that may contribute to a lower degree of collaboration between RDs and FPs is the insufficient amount of knowledge and skills FPs are perceived to have about nutrition. This was perceived by a few RDs to be mostly related to the lack of emphasis placed on nutrition and diet counselling in their medical training. Therefore, it seems that the education component of the program is critical, especially for the nutrition program. Expanded formal educational workshops on nutrition information could possibly help encourage and advance the integration of RDs into the program and facilitate shared care.

4.1.B.4 Accessibility

Both the quantitative and qualitative data indicate that patient access to mental health and nutrition services is enhanced by the program. For example the quantitative data demonstrate a large number of referrals among the HSO providers. The FPs referred 2675, 672, and 3431 patients to MHCs, PSYs, and RDs, respectively. In turn, MHCs referred 312 patients to PSYs and advised 1160 patients to follow up with their FPs. PSYs referred 156 patients to MHCs, and 663 patients to FPs for follow-up. Moreover, RDs referred 919 patients to FPs for monitoring care and 448 patients for continued care. If the Hamilton HSO Mental Health and Nutrition Program did not exist, these patients may well be referred to inpatient or outpatient clinics, or may not have received any specialised care to complement that of the FPs.

When one examines the referrals to community clinics (Table 4-*iii* and Figure 3), there is a substantial decrease in external referrals to outpatient clinics from HSO practices following the implementation of the HSO Mental Health Program. This seems to indicate that fewer patients are referred to community clinics because they are receiving treatment within the HSO. However, the decrease does not account for all the patients treated in the HSO. Thus, as described by the providers in the focus groups, the program provides access to care for patients with institutional barriers who would not otherwise receive treatment. For example, FPs noted that some patients

"*were never dealt with before... [such as those with] general psychiatric disorders*." One of the MHCs said, "*we are so generalised... you see whatever and you help out*." A PSY felt the program helps care for a "*whole draft [sic] of people who kind of don't really get service or easily get service*." As a whole, the providers seemed to attribute the higher caseload to the increased pick-up rate, lack of stringent intake criteria, and the reduced stigma associated with mental health care in the primary care setting. In the words of one of the PSYs, the program, "*in general, does service everyone well*."

It is important to note that PSYs are available for consultation and short follow-up and the MHCs and RDs run group sessions in addition to performing assessments and providing individual treatment. Meanwhile, patients have access to specialised care via the FPs because FPs can readily access the allied professional for advice, support, and back up. "*[When] there is a bit of a waiting time to get somebody in... [the PSY] can be very helpful if you need to give him a call and say what can we do in the meantime*." Thus, early detection and early intervention are possible while patients wait for a complete psychiatric or nutrition assessment. In addition to indirect specialised care via the FPs, the general consensus during the focus groups is that the waiting lists in this program are much shorter than those in the traditional system.

Therefore, as per the information collected for this evaluation, it would appear that accessibility to mental health and nutrition services is greatly increased. However, a comprehensive outcomes evaluation is necessary to determine the extent of the impact of increased accessibility on the health outcomes for patients over and above the smaller scale, symptom specific outcome studies conducted by the program. If such a comprehensive evaluation were to be completed, some of the outcome data currently collected by the CMT would be an asset.

4.1.B.5 Other

The HSO professionals are required to maintain their professional accreditation. This is to ensure that services are provided by accredited professionals. In addition, the HSO providers are required to participate in data collection by filling out the appropriate standard forms regarding patient demographics, treatment activity, etc., and forwarding a copy to the CMT. As indicated in section 4.1.A.2, these forms help maintain the completeness and accuracy of the central patient database and allow for monitoring of service delivery.

Another objective of the program is for HSO professionals to provide opportunities for student training. However, this objective is not a requirement. In 2002-2003 fiscal year, MHCs supervised two social work students, five PSYs supervised 35 students (27 medical students, six psychiatric residents, and two family practice residents), and six RDs supervised six dietetic interns. The focus groups' data revealed that the HSO is an ideal setting for student education. One PSY noted, "*I think it's an excellent place for teaching... They, [students], love the HSO because you're not taking them to a psychiatric facility... You're taking them to the real world of medicine and they are being trained in medicine, but they are learning that in a general practice [there are] other people with other health wellness and illness, [and they learn] how to do psychiatric assessments.*" In other words, it is a great place to learn how to apply psychiatric training in the primary care setting.

Section 4.2:
Additional Evaluation Objectives

Parts:	
4.2.A	MOHLTC Evaluation Objectives
4.2.B	Research Team Evaluation Objectives

Part 4.2.A:
MOHLTC Evaluation Objectives

Components:	
4.2.A.1	Program contribution to the goals of the MOHLTC
4.2.A.2	Program strengths
4.2.A.3	Program challenges
4.2.A.4	Recommendations for viable costs
4.2.A.5	Recommendations to improve service reporting

4.2.A.1 Program contribution to the goals of the MOHLTC

Health Canada clearly states on their website (http://www.hc.gc.ca/phctf-fassp/english/), that the broad, national objectives for primary health care are to:

- *increase the proportion of the population having access to primary health care organisations accountable for the planned provision of a defined set of comprehensive services to a defined population;*
- *increase emphasis on health promotion, disease and injury prevention, and management of chronic diseases;*
- *expand 24/7 access to essential services;*
- *establish interdisciplinary primary health care teams of providers, so that the most appropriate care is provided by the most appropriate provider, and;*
- *facilitate coordination and integration with other health services, i.e. in institutions and in communities.*

The MOHLTC chose to focus on ensuring that there is flexibility in payment and delivery models for primary health care all the while making sure that the federal objectives are met. Thus, as indicated on their website (http://www.health.gov.on.ca/english/providers/project/phctf/phctf_app_051203.pdf), the provincial goals for primary care are:

- *improved access to primary health care;*
- *improved quality and continuity of primary health care;*
- *increased patient and provider satisfaction, and;*
- *increased cost-effectiveness of primary health care services.*

The HSO was found to be an excellent example of a program in the primary care setting which contributes to both the provincial and federal objectives. It is a program dedicated to advancing interdisciplinary care by having providers with various expertise working in a common setting, collaborating to provide appropriate patient care by the most appropriate provider, and helping each other learn about various aspects of health and wellness. As previously mentioned, the program provides the opportunity for increased access to care, decreased waiting times for early detection and intervention, simultaneous care from multiple providers for continuity of care, and patient education material and group sessions to encourage health promotion and disease/injury prevention. Furthermore, the program is organised such that any person experiencing mental health or nutrition problems has the opportunity to be assessed by a qualified professional in a timely fashion. Other qualities of the program, which contribute to the MOHLTC objectives, are the provider and patient satisfaction questionnaires. These questionnaires are assessed on a regular basis and allow the CMT to make appropriate adjustments to the program to maintain both provider and patient satisfaction.

4.2.A.2 Program strengths

One of the major strengths of the program is the CMT. It coordinates, monitors, evaluates, and makes adjustments to ensure the program is accomplishing its goals. Furthermore, the CMT is responsible for reporting and negotiating with the MOHLTC and serves as a voice in the community for the program and individual practices. It is important to have a team overseeing the administrative component of the regional HSOs, so that the program can grow and improve. Since the CMT participates in numerous committees collecting up-to-date information regarding mental health and nutrition care, they can elaborate on the program. As a result of the activities of the CMT, the program maintains a relatively problem-free implementation and appears to be meeting its objectives as intended.

The program enhances accessibility in terms of both availability of services and short waiting lists to obtain mental health and nutrition care. The organisation of the providers into interdisciplinary teams, working in the same setting, allows the various types of practitioners to share care and collaborate in order to provide the most appropriate care for their patients. The interdisciplinary relationships and the exposure to the expertise of other professionals provide a great opportunity for informal education. The focus group data and satisfaction surveys indicate that this informal education results in increased skills and knowledge of the different team members and develops a sense of understanding and respect of the expertise provided by other professionals. When interviewed by the current research team, the providers felt that patients benefit greatly from this set-up and the collaboration among the HSO providers. However, as there is some controversy in the literature on the extent of influence continuity of care has on improving mental health

outcomes for patients (Bickman, 1996[1], 1997[2], 2000[3]), a comprehensive outcomes evaluation of the program is recommended.

Other strengths of the program include flexibility, the opportunity to prioritise patients according to care needs, the access to detailed patient information, increased knowledge of resources available in the community, and the chance to offer better care (prevention, continuity of care, early intervention, etc.) while reducing the stigma often attached to receiving mental health or nutrition care. Finally, the program allows patients to be assessed and treated in a primary care setting which seems to reduce the burden on the traditional system.

4.2.A.3 Program challenges

As expressed during the focus groups the most common challenge in the program is time constraints. For example, smaller practices have smaller FTE for the allied providers and so there is less opportunity for face-to-face collaboration among the team members. Furthermore, it would appear that the program has increased the pick-up rate of mental health and nutrition problems leading to an increase in the caseload of allied professionals. This provides for less time to collaborate and communicate with co-workers. In addition, the facilities cannot always accommodate the increase in personnel and patients making it difficult to have all team members working simultaneously. Thus, time and space are limiting factors for collaboration.

In keeping with time constraints there is the issue of record keeping and data collection. The standard forms provided by the CMT are primarily in paper format. A number of practices are now paperless offices and feel they would benefit from having a computerised data collection system. This would allow for faster input of data and increased ease in sharing patient information among different providers. Another expressed challenge is the lack of clarity regarding data collection for patients with chronic illnesses. The outcome forms are to be filled out at treatment cessation. Unfortunately with the management of chronic illnesses, treatment is likely to be ongoing. The issue then becomes when does one complete the forms. The expectation for form completion is after a prescribed amount of time such as two or three months or at the end of an episode. But, how does one define an episode? It would be helpful for the data collection process if agreement could be reached regarding episode time-frames and a protocol could be put in place to ensure accurate and consistent data reporting.

Other issues that could be more clearly defined in the program include shared care and the roles and expectations of individual team members. The flexibility offered by the program can be an advantage as described in section 4.2.A.3, but as the focus groups data suggest, it can be a disadvantage by producing some misunderstanding surrounding protocols and procedures,

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[1] Bickman, L. (1996). A Continuum of Care: More Is Not Always Better. *American Psychologist*, 51(7): 689-701.

[2] Bickman, L. (1997). Resolving Issues Raised by the Fort Bragg Evaluation. *American Psychologist*, 52(5): 562-565.

[3] Bickman, L., et al. (2000). The Fort Bragg Continuum of Care for Children and Adolescents: Mental Health Outcomes Over 5 Years. *J of Consulting & Clinical Psychology*, 68(4): 710-716.

resource allocation, responsibility, authority, etc. When difficulties arise in individual practices it may be difficult for HSO practitioners to determine who is in charge and has the authority - the CMT or the FPs who own the practice.

Other challenges which are not restricted to the HSO, but rather common in the health care system are the long waiting lists and strict intake criteria of community services. In the case of the HSO Program, it may be increasingly difficult to access community services as the program is perceived to have the necessary resources to attend to all mental health and nutrition issues in-house. In fact, the program does not have the resources to care for all patients who require ongoing frequent counselling to maintain their health. Another problem that is prominent in health care in general is that of no-shows and cancellations. However, the CMT is aware of this issue and has attempted to remedy the situation in various ways such as patient empowerment (patients make their own appointment), patients meeting allied professional prior to a referral, requiring re-referrals after missing two or three appointments, take home information, etc. A clinical trial to examine no-show rates of the different problem solving strategies employed by the program may reveal some interesting results.

Lastly, inadequate funding to expand the program outside of the current HSO was seen as an issue during the focus groups. The providers felt that some patients were unfairly advantaged by having the opportunity to benefit from the HSO and the services it entails, when other patients with similar needs in the city, as well as throughout Ontario, do not have access to these services. One of the PSYs noted, *"I think the HSO does in this city what probably needs to be done elsewhere in Ontario."*

4.2.A.4 Recommendations for viable costs

Any valid recommendations regarding viable costs would need to emanate from an economic analysis of the program. Moreover, any economic evaluation is an assessment of the tradeoff between costs and outcomes. For that reason, economic evaluations cannot be conducted until an outcome evaluation has been performed. Economic or even cost analyses are complex and require the costing of variable, incremental, recurring, hidden, direct, indirect and opportunity costs, a challenge indeed for such an intricate program. Economic evaluations, be they cost-effectiveness analyses (CEA), cost-utility analyses (CUA), cost-benefit analyses (CBA) or cost minimization analyses (CMA) not only require outcomes data, but they also require comparator programs or "control" no program situations. This is necessary because economic evaluations compare the costs relative to the outcomes of two or more programs or of a program compared to no program. Thus, it is recommended that the Ministry consider supporting a comprehensive outcomes and economic evaluation in the future.

Meanwhile, it would appear that there is a substantial decrease in external referrals from HSO practices to community clinics following the implementation of the HSO Mental Health Program because patients are receiving treatment in primary care. The program enhances accessibility in terms of both availability of services and short waiting lists to obtain mental health and nutrition care and access to care for patients with institutional barriers who would not otherwise receive treatment. This suggests that the program is providing access to more patients with a wider variety of mental health and nutrition problems, and at the same time reducing the burden on community clinics. Additionally, since assessment and treatment information on patients referred to health practitioners outside of the FP clinic may or may not be sent back to the referring FP,

one can assume that the sharing of common patient medical charts by the HSO health care practitioners increases efficiency and contribute to a more holistic approach to patient care than the traditional system.

4.2.A.5 Recommendations to improve service reporting

As previously described in sections 4.1.A.2 and 4.2.A.3, identifying a format of data collection which yields comprehensive data through brief forms is a challenge. Over the years, the CMT has refined the forms, but continue to struggle with some providers in terms of getting the forms completed. The CMT should consider exploring a digitised format for all forms or introducing a computerised system in the individual practice to improve the efficiency of data collection, or at least have the option of electronic or paper versions for all forms. This could allow all data to be sent automatically to the CMT as the forms are completed, and reduce the burden on support staff. The electronic forms could be attached directly to patients' computerised charts and illegible handwriting would no longer be an issue. Furthermore, it could give all team members the chance to view patient information quickly and easily as needed. Additionally, current development and piloting of standardised patient chart forms and computerised data linkage systems in different jurisdictions for FPs, hospitals, and other health service providers to enhance continuity of care, may provide useful information downstream. However, it is clear that IT resources would be needed for the HSOs to develop further computerised systems of data collection.

Part 4.2.B:
Research Team Evaluation Objectives

Components:

4.2.B.1 Recommendations for program enhancement

4.2.B.2 Comparison of qualitative data to data collected by CHEPA

4.2.B.1 Recommendations for program enhancement

Since the CMT is diligent about adjusting and troubleshooting as issues arise to maximise efficiency and to respond to program needs, there are no major changes required to improve the program. However, some of the small issues identified under the challenges section could be considered.

An expanded computerised system for data collection appears to be one change that would impact upon multiple facets of the program. For one, for the practitioners who currently use computers in their practice, it has the potential to decrease the time required to fill out the forms giving practitioners more time to focus on clinical activities. Furthermore, it could prevent legibility issues as notes could be typed as opposed to hand written. Computerised data would make it easier to share information among the different providers and increase the ease of transfer of patient care. Finally, a digitised data collection system could be formatted so that copies of standard forms are automatically forwarded to the CMT to be incorporated into the central patient database. This may in turn reduce the number of outstanding forms, the burden on support staff, and although minimal, decrease some of the cost of supplies and postage. The disadvantages to implementing this type of system are the initial time and monetary costs, especially in practices that do not currently have a computerised charting system. However, some practices have already formatted the standard forms and included them in their computerised chart system. Some even made reference to sharing such information with the other practices during the focus groups. Also, many jurisdictions are conducting pilot programs for electronic data collection and management. For example the London Health Sciences Centre and the Thames Valley Family Practice Unit have developed a model and are currently implementing it. These may serve as excellent resources to explore the development and incorporation of such a system in the HSO.

A second recommendation was alluded to by many of the professionals during the focus groups. The program might consider increasing the FTE of all the allied professionals or introducing changes in the flexibility allotted in how the current FTE in spent (clinical vs administrative vs education hours). It is apparent in the data that there is a need for mental health and nutrition services and that having such services in primary care appears to reduce the burden on the traditional system. These services are accessible and provide patients an opportunity to address their mental health and nutrition problems at one location. Furthermore, there appears to be a reduced stigma attached to obtaining services in the primary care setting as well as possible patient empowerment. Changes to the way time is spent in practice may allow for more time to collaborate and coordinate with other community services. Additionally, it appears that the RDs may need more time to become fully integrated into the program. An increase in FTE or a change in the way time is spent in practice, could allow for more collaboration, in addition to continued

education for all professionals regarding the advantages of nutrition services. Once RDs are fully integrated into the program, there is a good possibility that more collaboration could occur with external services to avoid duplication.

Furthermore, the program must set clear boundaries and ensure that external services are aware of the resources available to the HSO practices to prevent overloading HSO providers with patients who cannot be treated efficiently or maintained in primary care. Also, no-shows and cancellations are serious challenges for the HSO and the program should continue to work on strategies to reduce these problems as they reduces the efficiency of the services.

Lastly, it is important to consider other issues pointed out in the focus groups such as clearer definitions, roles, and expectations. As described above, the flexibility of the program is an important and positive component of the program. Yet occasionally it can lead to frustration, especially for those who work in multiple offices. Although a certain degree of flexibility is necessary to mould the program according to the patient population and team dynamics, it may be that the provision of clearer definitions of or the development of group consensus on the components and reporting lines within the model could eliminate some of the inconsistencies leading to ambiguity and occasional provider frustration. If the program were to consider more stringent protocols and uniformity across the practices, one would hope a comprehensive evaluation of the current methods and patient outcomes would be completed first. Such an evaluation would help ensure that the most appropriate protocols would be chosen to provide a service that leads to better health outcomes for patients in combination with both patient and provider satisfaction.

4.2.B.2 Comparison of qualitative data to data collected by CHEPA

In comparing the qualitative data we collected to the summary of data collected by CHEPA, we found many similarities. For example, interviewed providers noted the following populations as those benefiting the most from HSO programs: patients with low socio-economic status, elderly patients, young mothers/single mothers, patients with diabetes, depression /anxiety patients, and ethnic groups/patients with language barriers. Furthermore, providers working in various HSO programs expressed an increased job satisfaction as a result of formal/informal collaboration among team members for a more holistic approach to patient care. They felt they had more time to spend with patients and focus on personal expertise; therefore offering patients the best care by the most appropriate professional. Moreover, providers felt they have more independence within the program and that their skills are valued and respected by their co-workers. Having access to patient charts/medical history and easy access to allied providers, was said to contribute to better patient care. Finally, the providers perceived a decreased burden on the traditional system for increased cost-efficiency.

In terms of patient care, the providers noted an increased access to specialised care for patients as well as continuity of care. Furthermore, they felt the programs allow for preventive care and patient education, as well as early detection/intervention which often helps to avoid crisis and exacerbation of symptoms that would require utilisation of emergency services. The providers reported that patients appear to be more comfortable in primary care leading to more buy-in, compliance to treatment, and decreased stigma. Lastly, there seems to be a decrease in waiting

times to receive specialised care and patients have the opportunity to receive care while waiting for external care when necessary.

Themes pertaining to challenges for the providers within HSO programs included a variability in training/skills/treatment approaches of allied providers, patient motivation issues, multiple site difficulties in terms of time for collaboration, not enough funding, lack of access to ISP funding/extended primary care services for non-HSO practices, and a time consuming evaluation component for providers. However, overall it appears that despite minor challenges, all HSO programs contribute to the MOHLTC's goals for primary care and deliver services greatly needed for a wide variety of patients.

Appendix A: Workshop description, attendance, and evaluation

Date (DD/MM/YY)	Workshop: Title & Description	Evaluation					Attendance HSO Members	
		Clinical Relevance	Theoretical & Didactic Info	Clinical Info & Case Discussion	Increased Understanding	Increased Skills in Area		
13/02/97	ETOH Project *Parkdale Part 1*: An overview of alcohol-related problems in the primary care setting (topic identified by FPs as one they wanted to learn about).	below average	useful	useful	-	-	9	▲
23/02/97	ETOH Project *Parkdale Part II:* Alcohol-related problems in the primary care setting part II.	above average	-	-	-	yes	5	▲
10/04/97	ETOH Project *Parkdale Part III:* Alcohol-related problems in the primary care setting part III (stimulated interest in topic).	above average	-	-	yes	yes	6	▲
19/11/97	Trauma Stress: (5 non-HSO members attended this workshop): Theoretical underpinnings and the treatment of trauma.	good	useful	useful	yes	yes	30	●
25/03/98	Assessing Alcohol Risk and Use of Brief Intervention *WWL area, Southwest area, & East Hamilton Area:* Identification and assessment of alcohol abuse and addiction in primary care setting.	good	-	-	yes	yes	8	▲●
24/06/98							14	▲●
23/09/98							14	▲●
4/03/98	*Anxiety Disorder Workshop: (Part I-IV):* General anxiety disorder, panic attacks, social phobia, obsessive-compulsive disorder and posttraumatic stress disorder.	good	-	-	yes	yes	21	●
6/05/98							20	●
3/06/98							21	●
30/09/98							15	●
27/05/98	*An Approach to the Treatment of Children (Part I-II):* Assessment of normal and disturbed child development in the primary care setting.	good	useful	useful	yes	yes (after 2nd session)	31	●
17/06/98							29	●
4/11/98	*Management of Pain in the Primary Care Setting:* General strategies in chronic pain management with an overview of a psychobiological model of treatment of pain in the primary care setting.	good	useful	useful	yes	yes	21	●
18/11/98	*Management of ETOH issues in Primary:* An overview of alcohol-related problems in the primary care setting and skill development (assist and advise clients) with regards to stages of change.	good	useful	useful	yes	yes	16	●
13/01/99	*CBT – Principles and Guidelines for Use in the Primary Care Setting:* The use of cognitive behaviour therapy (CBT) in the treatment of depression. Qualitative comments revealed that participants may have benefited from more case-based information.	good	useful	useful	yes	yes	16	●

Date (DD/MM/YY)	Workshop: Title & Description	Evaluation					Attendance HSO Members	
		Clinical Relevance	Theoretical & Didactic Info	Clinical Info & Case Discussion	Increased Understanding	Increased Skills in Area		
10/02/99	*Working with Divorce (Coping with Separation and Divorce)*: An overview of management and treatment of children presenting with issues pertaining to divorce.	good	useful	useful	yes	yes	18	●
27/01/99	*Detection and Management of ADD/ADHD in Children in Primary Care: Part I:* Assessment of ADHD. *Part II*: Various models of ADHD assessment and diagnosis. *Part III:* Treatment and management strategies for primary care.	good	-	useful	yes	-	10	▲
30/09/99							525	▲ ●
28/04/99	*Couple Therapy Seminars*: Overview of couple and individual therapy. Examination of various aspects of couple therapy including raising young children, gender issues, violence, and issues of power and control.	good	useful	useful	disagreed	disagreed	16	●
19/05/99							22	●
24/11/99	*Couple Communication Workshop:* Four communication processes to teach couples: talking, listening, resolving, and communication skills.	good	useful	useful	yes	yes	18	●
16/02/00	*Depression Education Workshop:* An empirical review of the literature embodying depression in primary care (5 of the 19 participants found their theoretical understanding of depression did not increase).	good	useful	useful	disagreed	yes	22	▲●
26/04/00							9	●
4/10/00	*Child Protection Workshop CFSA Amendments*: Overview of the revisions made to the Child and Family Services Act for child protection. Highlight of key revised requirements of the risk assessment model for child protection in Ontario and standards for child protection that were relevant to their work.	good	useful	useful	yes	disagreed	39	▲●
15/11/00	*Eating Disorders Workshop*: Practical approaches to the assessment and treatment of eating disorders, early warning signs, and current prevention techniques.	No evaluation was conducted for this workshop.					58	▲●
25/01/01	*Object Relations: Practical Tips for Use in the Initial Interview:* Theory of object relations and its application to client interviews to uncover serious personality pathology and determine the number of required treatment sessions.	good	useful	-	disagreed	disagreed	29	▲●

Date (DD/MM/YY)	Workshop: Title & Description	Evaluation					Attendance HSO Members	
		Clinical Relevance	Theoretical & Didactic Info	Clinical Info & Case Discussion	Increased Understanding	Increased Skills in Area		
25/01/01	*The Art of Making an Axis II Diagnosis:* Possibilities and limitations of personality assessment in an initial 60-minute interview and an examination of techniques for limiting the field of diagnostic possibilities on Axis II during the initial interview.	good	useful	useful	yes	yes	32	●
25/01/01	*Transforming Anger and Resistance in the Initial Interview*: Transforming angry encounters into meaningful interactions.	good	useful	useful	disagreed	disagreed	23	▲●
26/01/01	*Uncovering Depression and Comorbid Disorders that Complicate its Treatment:* The difficulties of rapid diagnosis of depression in a primary care setting, particularly when comorbid psychiatric disorders are involved. Overview of several screening measures for depression, panic disorder and OCD.	good	useful	useful	yes	yes	32	▲●
26/01/01	*Transforming Clinical Gremlins: Shut-Down, Wandering, and Rehearsed Interviews*: Three problematic interview styles; wandering interviews, shut-down interviews, and rehearsed interviews. Clinician and client contributions to strategies for improvement.	good	useful	useful	yes	yes	32	▲●
11/10/01	*Depression and Other Mental Health Disorders*: Depression and the role of RDs in the primary care setting.	good	useful	useful	yes	-	5	■
25/10/01	*Sleep Disorders Workshop*: Recognition, assessment, and treatment of sleep disorders commonly encountered in family practice.	good	useful	useful	yes	yes	23	▲● ■
1/11/01	*Pharmacology Workshop*: Pharmacological treatments for the most commonly presented problems in primary care.	good	useful	useful	yes	-	21	●
5/12/01	*Update on the Mental Health Act:* MHCs and FPs' rights and responsibilities under the new Mental Health Act.	good	useful	useful	yes	-	36	▲● ❑
4/04/02	*Management of Chronic Pain in the Primary Care Setting*: Developing a clear and organised approach to the assessment and treatment of patients with chronic pain with an overview of pharmacological and non-pharmacological pain control methods. Introduction of CBT as an approach to treatment of chronic pain as well as a variety of relaxation methods.	good	useful	useful	yes	yes	21	▲
24/04/02	*Poverty and Nutrition* (attended by 7 additional external RDs) (need more in-depth information)	good	useful	useful	disagreed	disagreed	7	❑

Date (DD/MM/YY)	Workshop: Title & Description	Evaluation					Attendance HSO Members	
		Clinical Relevance	Theoretical & Didactic Info	Clinical Info & Case Discussion	Increased Understanding	Increased Skills in Area		
15/05/02	*Utilising Problem-Solving Treatment in Primary Care*: The symptoms of psychological disorders commonly encountered in primary care and the therapeutic options.	good	useful	useful	yes	yes	37	●
10/09/02	*Pediatric Nutrition/Failure to Thrive* (need more time for case discussion)	good	useful	useful	yes	yes	7	❑
16/10/02	*Functional and Vocational Issues*: An overview of functional and vocational issues of patients with mood disorders and other mental health issues. Enhancing daily living skills and assisting patients with the process of employment searches.	good	useful	useful	yes	yes	18	●
5/11/02	*Anxiety Disorders*: The phenomenology of anxiety disorders, detection and assessment of different types of anxiety disorders, pharmacology knowledge, and treatment of anxiety disorders.	good	-	-	yes	yes	34	▲● ❑
13/12/02	*Eating Disorders* (excellent workshop)	good	useful	useful	yes	yes	7	❑
5/06/03	*Sports Nutrition* (also attended by 2 students) (excellent workshop)	good	useful	useful	yes	yes	7	❑
6/02/03	*ADHD in Adults: Detection and Management in Primary Care*: The prevalence of ADHD in adulthood, difficulties with diagnosis, theoretical models of ADHD, the symptoms of ADHD, and the treatment options for ADHD.	good	-	-	yes	yes	27	●
9/04/03	*Psychopharmacology Update*: Psychopharmacological treatment for the most commonly presented problems in primary care and the interaction among various psychotropic medications. There was disagreement over how comfortable participants felt with their knowledge of psychiatric medications.	good	-	-	yes	-	16	●

▲ = FPs (total of 79 in program)
● = MHCs (total of 39 in program)
■ = PSYs (total of 17 in program)
❑ = RDs (total of 7 in program)

Appendix B: Publications, posters, and presentations

Journal Articles

- Kates, N. (2002). New Approach. Collaboration between primary care and mental health practitioners [FRENCH]. Santé mental au Québec, XXVII(2): 93-108.
- ✶ Kates, N., Crustolo, A. M., Farrar, S., & Nikolaou, L. (2002). Counsellors in primary care: benefits and lessons learned. *Canadian Journal of Psychiatry*, *47*(9): 857-862.
- Kates, N., Crustolo, A. M., Farrar, S., Nikolaou, L., Ackerman, S., & Brown, S. (2002). Mental health care and nutrition: Integrating specialist services into primary care. *Canadian Family Physician*, 48: 1898-1903.
- ✶ Kates, N., Crustolo, A. M., Farrar, S., & Nikolaou, L. (2001). Integrating mental health services into primary care: Lessons learnt. *Families, Systems & Health*, 19(1): 5-12.
- Kates N. (2000). Sharing mental health care. Training psychiatry residents to work with primary care physicians. *Psychosomatics*, 41(1):53-57.
- Kates, N., & Crustolo, A. M. (2000). *Hamilton HSO Mental Health & Nutrition Program. Mental Health Program Biannual Report January 1998-December 2000*. Hamilton, Ontario: Hamilton HSO Mental Health & Nutrition Program.
- Kates, N., & Crustolo, A. M. (2000) *Hamilton HSO Mental Health and Nutrition Program. Mental Health Program Biannual Report January 1998 to December 2000*. Hamilton: St Joseph's Health Care.
- Kates N. (1999). Psychiatrists and family physicians sharing care. *Canadian Psychiatric Association Bulletin*, Aug: 107-108.
- Kates N. (1999). Significant Achievement Award - Bringing mental health services into the office of primary care physicians. *Psychiatric Services*, 50(11):1484-1485.
- Kates, N., Craven, M. , Crustolo, A. M., & Nikolaou, L. (1998). Mental health services in the family physician's office: a Canadian experiment. *Israel Journal of Psychiatry & Related Sciences, 35(2)*: 104-113.
- ✶ Kates, N., Craven, M., Crustolo, A. M., Nikolaou, L., & Allen, C. (1997). Integrating mental health services within primary care: A Canadian program. *General Hospital Psychiatry, 19(5):* 324-332.
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✷ = specific to providing updated information regarding the HSO Program

Appendix C: Data collection

i) Standard forms

Standard Form	Description
Mental Health Referral Form	Completed by FPs when referring a patient to MHC, PSY, or group. This form includes a series of checklists for psychiatric, psychosocial, and physical issues, a section for recommendation of treatment, and an area for qualitative comments and other pertinent medical information.
MHC Assessment and Intervention Plan	Completed by MHCs after the initial consultation. This form includes a series of checklists for psychiatric, psychosocial, and physical issues, a section for a potential treatment plan, and an area for any further information or qualitative comments.
MHC Treatment Outcomes Form	Completed by MHCs at treatment cessation. This form includes a series of checklists for patient treatment and future patient care, information regarding missed appointments, and an area for any further information or qualitative comments.
Psychiatric Consultation Form	Completed by PSYs after the initial consultation. This form includes a series of checklists regarding patient's psychiatric symptoms, psychosocial issues, and physical problems, an area for qualitative comments on possible diagnosis, and a section for recommendations for medication, management, follow-up, and referral.
Psychiatric Follow-Up Form	Completed by PSYs after follow-up consultations. This form includes information regarding the reason for follow-up and the patient's clinical status, and a section for recommendations for medication, management, follow-up, and referral.
Nutrition Referral Form	Completed by FPs when referring a patient to an RD. This form has a detailed description of the referring problem and any ongoing treatment.
RD General Treatment Outcome Form	Completed by RDs after the initial consultation and subsequent consultations. This form includes detailed baseline data and the patient's goals, a list of functional improvements and behavioural changes, and qualitative comments about patient compliance and future patient care. A detailed medication profile prior and subsequent to the episode of care is also included.
RD Diabetes/Dyslipidemia Treatment Outcome Form (only applies to patients with diabetes or dyslipidemia)	Completed by RDs after the initial consultation and subsequent consultations. This form includes detailed baseline data and the patient's goals, a list of functional improvements and behavioural changes, and qualitative comments about patient compliance and future patient care. A detailed medication profile prior and subsequent to the episode of care is also included.
MHC Activity Sheet	Completed by MHCs on a weekly basis, This form includes a list of the activities undertaken each week, a note about the number of minutes spent on each activity, and the date on which the activities were completed.
RD Activity Form	Completed by RDs on a monthly basis. This form includes a list of activities undertaken each week, the number of minutes spent on each activity, and the date on which the activities were completed.
Psychiatrist Sessional Fee Invoice	Completed by PSYs on a monthly basis. This form includes a list of the number of patient consultations, follow-ups conducted, number of patient cancellations, and time spent in administrative or other clinical and educational activities.

ii) Questionnaires

Standard Form	Description
Client Satisfaction Questionnaire (Oct 2000 to Mar 2001)	Obtains information regarding the patient's perspective on the value of the services received. It focuses on access to care, time spent with the provider, communication, technical quality, interpersonal quality of staff, and overall rating of care and service.
Visit Satisfaction Questionnaire (for patients) (Jan 1998 to Oct 1999 for Mental Health Program and Feb 2000 to 2003 for Nutrition Program)	Obtains information regarding patient satisfaction with access to care, time spent with mental health staff, level of communication, technical quality, and interpersonal quality of staff. Furthermore, assess the level of satisfaction pertaining to the provider's attention to major patient concerns and the availability of mental health counselling in the FP's office.
Centre for Epidemiological Studies Depression (CESD) rating scale (for patients) (May 1998 to Jun 2001)	Patients rate their depressive symptoms to measure depression in the general population.
General Health Questionnaire-12 (GHQ-12) (May 1998 to Oct 1999)	Screening instrument to detect current, diagnosable psychiatric disorders in the general population. The scale measures the changes in a condition, not the absolute level of the problem.
Short Form-36 (SF-36) (Oct 1999 to Jun 2001)	Participants rate their general functioning to measure physical functioning, mental functioning, social/role functioning, and general health perceptions.
Provider Satisfaction Questionnaire (1996)	Providers were required to rate their satisfaction with the program. The FPs' scale assessed perceptions regarding the degree to which mental health staff fit with the culture of the family practice, quality of clinical service provided by mental health staff, and mental health staff's performance as an educational resource. The MHCs' and PSYs' scales assessed their satisfaction with the family practice setting and professional relationships with other providers.
Provider Satisfaction Questionnaire (1997)	Providers were required to indicate their satisfaction with their clinical and educational roles, team interactions and communication, volume of referrals, case mix, the role of the central program, and mental health counselling in primary care. Space was included for written comments.
Provider Satisfaction Questionnaire (1999-2000)	A qualitative questionnaire where FPs, PSYs, and MHCs discussed the successes and problems of the program, made recommendations pertaining to the environment of the HSO, the clinical issues and team functioning, the provided education, and the role of the central program.
Provider Satisfaction Questionnaire (2001)	Providers were required to indicate level of satisfaction with the program using both qualitative and quantitative methods. The FPs' survey assessed satisfaction regarding the role of the RDs, MHCs, and PSYs in their practice. The MHCs', RDs', and PSYs' survey assessed satisfaction with support received from the practice and the central team, time spent on paperwork, and whether they would recommend this practice to colleagues. A section listing satisfaction with various aspects of the practice including the level of support and the volume of referrals was included in the surveys of all providers.

Appendix D: MHCs' patients' main presenting problems, average number of visits and assessment forms

Presenting Problem	Patient Seen	Assessment Form	Average # Visits	Presenting Problem	Patients Seen	Assessment Form	Average # Visits
Abnormal eating	14	13	6.2	Motor vehicle accident issues	3	2	4.3
Abuse during childhood	24	17	6.0	Needs instrumental assistance	25	21	4.5
Accommodation	4	8	1.0	Obsessive thoughts	23	10	4.5
Alcohol abuse in family	7	8	5.3	Other anxiety symptoms	228	181	4.2
Alcohol abuse in self	38	24	4.7	Other current abuse	18	15	9.0
Anger/temper control	66	51	4.7	Other current psychiatric symptoms	17	7	7.9
Attention deficit disorder	18	17	3.9	Other family problems	102	88	4.2
Bereavement	123	107	4.7	Other medical/physical issues	4	2	9.3
Burden of caring for another	-	7	-	Other psychosocial issues	33	21	5.0
Child behaviour problem	75	66	4.0	Other relationship issues	110	81	4.6
Chronic pain	12	14	3.7	Other stressful events	22	16	4.1
Compulsive behaviour	8	6	5.9	Other substance abuse	16	15	3.0
Current abuse partner	11	6	9.0	Other symptoms other than chronic pain	5	-	6.6
Delusions	11	3	6.3	Other symptoms	-	3	-
Depressed mood	1435	876	5.6	Panic symptoms or attacks	148	98	5.6
Difficulty coping with illness	11	10	7.4	Paranoia	-	2	-
Disorganised thoughts	4	4	1.5	Parenting issues	77	66	4.8
Elevated mood	2	1	6.0	Past abuse victim	20	16	6.1
Emotional/verbal abuse	-	11	-	Past alcohol abuse in self	5	6	2.8
Excessive somatic symptoms	7	5	3.7	Past substance abuse in self	1	-	1.0
Financial issues	12	11	3.9	Personality problem	29	21	3.8
Flashbacks/other PTSD symptoms	-	11	-	Phobias	52	39	4.6
Fluctuating mood	33	29	7.4	Pregnancy-related issues	9	7	3.7
Gambling	-	2	-	School problems	22	20	4.6
Hallucinations	4	2	6.8	Self-esteem	77	58	4.4
Illness in family member	54	35	5.9	Separation/divorce	135	99	4.3
Insurance form	1	1	2.0	Sexual problem	5	5	6.8
Learning disability	2	2	3.5	Significant illness	11	-	6.0
Legal issues	17	14	3.4	Sleep disturbance	6	5	2.5
Legal letter/report to prepare	2	2	2.0	Social anxiety	-	14	-
Marital problems	375	287	5.2	Social isolation	14	10	5.4
Medication side effects	1	-	1.0	Suicidal thoughts	25	17	7.4
Medical/physical illness	-	6	-	Unemployment	3	3	5.0
Memory impairment	22	17	5.8	Unusual behaviour	7	4	3.1
Menopause/related issues	-	1	-	WSIB Issues	6	4	3.3
Mental retardation	3	2	9.0	Work problems	107	72	4.8
Total or Average					**3761**	**2704**	**4.9**

Appendix E: MHCs' management strategies according to the main presenting problem

Main Presenting Problem	Management Strategies																	
		IPT/problem solving	assess & recommendation	psychodynamic therapy	bereavement counselling	education	parenting skills	referral to community	CBT	other individual counselling	marital/couple counselling	family counselling	HSO PSY	HSO group	community program	OP PSY	other	**Total**
Abnormal eating behaviour	2	0	8	0	0	3	0	0	4	7	3	1	0	1	4	0	1	**34**
Abuse during childhood	5	1	3	0	0	1	1	0	4	9	2	1	0	0	2	0	1	**30**
Accommodation	1	0	4	0	0	0	0	0	0	2	0	1	0	0	3	0	1	**12**
Alcohol abuse in family members	0	0	3	0	0	0	0	0	1	5	4	1	0	0	1	0	1	**16**
Alcohol abuse in self	6	0	11	0	0	1	0	1	2	11	5	1	0	2	9	0	5	**54**
Anger/temper control	9	10	14	1	0	3	1	0	10	31	20	2	0	3	8	1	1	**114**
Attention deficit disorder	3	0	7	0	0	1	0	1	3	5	2	4	0	1	4	0	1	**32**
Anxiety symptoms	105	35	147	3	1	34	0	2	108	156	40	14	0	16	32	21	6	**720**
- Compulsive behaviour	*3*	*0*	*2*	*0*	*0*	*1*	*0*	*0*	*3*	*4*	*0*	*2*	*0*	*0*	*2*	*1*	*0*	***18***
*- Flashbacks/ PTSD symptoms**	*2*	*1*	*10*	*0*	*0*	*2*	*0*	*0*	*1*	*5*	*3*	*0*	*0*	*0*	*2*	*0*	*0*	***26***
- Obsessive thought	*3*	*0*	*4*	*1*	*0*	*0*	*0*	*0*	*4*	*4*	*1*	*0*	*0*	*1*	*1*	*1*	*0*	***20***
- Other anxiety symptoms	*50*	*23*	*76*	*1*	*1*	*12*	*0*	*1*	*51*	*66*	*25*	*8*	*0*	*12*	*11*	*4*	*2*	***343***
- Panic symptoms or attacks	*33*	*9*	*33*	*0*	*0*	*11*	*0*	*0*	*35*	*50*	*9*	*1*	*0*	*3*	*5*	*5*	*2*	***196***
- Phobia	*9*	*1*	*16*	*0*	*0*	*3*	*0*	*0*	*10*	*19*	*0*	*2*	*0*	*0*	*5*	*7*	*2*	***74***
*- Social anxiety**	*5*	*1*	*6*	*1*	*0*	*5*	*0*	*1*	*4*	*8*	*2*	*1*	*0*	*0*	*6*	*3*	*0*	***43***
Bereavement	42	11	36	0	30	2	0	0	12	40	12	1	0	2	9	0	2	**199**
Burden of caring for another*	2	1	6	0	0	2	0	0	0	1	1	2	0	0	2	0	0	**17**
Child behaviour problems	17	7	30	0	1	2	9	0	5	27	5	22	0	1	12	2	3	**143**
Chronic pain	3	2	6	0	1	3	0	0	3	5	4	0	0	2	1	1	1	**32**
Current abuse partner	3	1	1	0	0	0	0	0	1	4	3	0	0	0	4	0	0	**17**
Delusions	0	0	2	0	0	0	0	0	0	3	0	0	0	0	0	0	0	**5**
Depressed mood	320	149	307	5	16	63	9	1	196	400	208	21	0	46	70	8	21	**1840**
Difficulty coping with illness	3	0	5	0	1	2	0	0	0	5	1	0	0	1	0	0	0	**18**

Main Presenting Problem	Management Strategies																	
		IPT/problem solving	assess & recommendation	psychodynamic therapy	bereavement counselling	education	parenting skills	referral to community	CBT	other individual counselling	marital/couple counselling	family counselling	HSO PSY	HSO group	community program	OP PSY	other	**Total**
Disorganised thought process	1	3	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	**7**
Elevated mood	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	**2**
Emotional/verbal abuse	3	1	3	0	0	5	0	0	2	8	9	0	0	1	2	0	0	**34**
Excessive somatic symptoms	0	1	1	0	0	0	0	0	1	3	0	0	0	0	0	0	0	**6**
Financial issues	5	1	5	0	0	1	0	0	0	4	4	0	0	0	3	0	0	**23**
Fluctuating mood	13	4	7	0	0	1	0	0	4	12	5	3	0	1	2	1	2	**55**
Gambling*	2	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	**5**
Hallucinations	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**2**
Illness in family member	20	3	10	0	1	1	0	0	5	12	4	3	0	1	2	0	2	**64**
Insurance form	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Learning disability	1	0	0	0	0	0	0	0	1	1	0	1	0	1	0	0	1	**6**
Legal issues	3	2	7	0	0	0	0	0	1	6	4	1	0	1	2	0	0	**27**
Legal letter/report to prepare	0	0	1	0	0	0	0	0	0	1	1	0	0	0	0	0	1	**4**
Marital problems	93	49	102	2	3	24	7	3	39	85	284	5	0	11	13	2	10	**732**
Medical/physical illness	2	0	3	0	0	0	0	0	0	2	0	0	0	2	1	0	0	**10**
Memory impairment	4	0	8	0	0	1	0	0	1	1	3	7	0	0	5	1	8	**39**
Menopause/related issues*	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**1**
Mental retardation	1	1	1	0	0	0	0	0	0	1	0	0	0	0	2	0	0	**6**
Motor vehicle accident issues	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**2**
Needs instrumental assistance	3	0	9	0	1	0	0	0	0	2	0	10	0	2	12	0	8	**47**
Other current abuse	4	3	3	0	0	0	0	0	7	7	5	1	0	0	3	0	0	**33**
Other current psychiatric symptoms	2	0	4	0	0	0	0	0	0	2	0	0	0	0	1	0	0	**9**
Other family problems	28	14	41	2	0	4	2	0	4	30	9	17	0	2	7	1	3	**164**
Other medical/physical issues	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	1	**4**
Other psychological issues	4	1	9	0	0	0	0	0	1	10	1	3	0	1	4	0	4	**38**

Main Presenting Problem	Management Strategies																	
		IPT/problem solving	assess & recommendation	psychodynamic therapy	bereavement counselling	education	parenting skills	referral to community	CBT	other individual counselling	marital/couple counselling	family counselling	HSO PSY	HSO group	community program	OP PSY	other	**Total**
Other relationship issues	19	19	21	2	1	0	2	0	7	34	9	5	0	3	2	0	1	**125**
Other stressful events	6	1	7	0	0	3	1	0	3	9	1	0	0	0	3	1	2	**37**
Other substance abuse in self	4	2	6	0	0	2	0	0	1	4	4	2	0	0	9	0	2	**36**
Other symptoms	1	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	**3**
Paranoia*	0	0	2	0	0	0	0	0	0	0	1	0	0	0	2	0	0	**5**
Parenting issues	19	6	21	0	0	3	8	0	2	24	13	15	0	3	9	0	1	**124**
Past abuse victim	5	2	4	0	0	1	0	0	1	11	3	0	0	1	3	0	0	**31**
Past alcohol abuse in self	1	0	6	0	0	0	0	0	0	1	0	0	0	0	4	0	0	**12**
Personality problems	6	3	14	0	0	3	0	0	3	8	5	0	0	1	4	0	3	**50**
Pregnancy-related issues	5	0	1	0	0	0	0	0	1	1	1	0	0	0	1	0	1	**11**
School problem	8	2	11	0	0	1	0	0	2	6	1	5	0	0	2	0	0	**38**
Self-esteem	14	5	17	2	0	3	1	0	13	29	5	2	0	8	4	0	2	**105**
Separation/divorce	36	11	34	0	0	8	6	1	9	40	16	6	0	3	9	0	1	**180**
Sexual problem	2	0	1	0	0	0	0	0	0	3	1	0	0	0	0	0	1	**8**
Sleep disturbance	3	0	1	0	0	0	0	0	1	2	0	0	0	0	0	0	1	**8**
Social isolation	5	1	1	0	0	1	0	0	1	1	1	0	0	0	4	0	0	**15**
Suicidal thoughts	7	1	9	0	1	0	1	0	2	5	3	4	0	0	2	0	2	**37**
Unemployment	2	0	1	0	0	1	0	0	0	2	0	0	0	0	0	0	0	**6**
Unusual behaviour	1	0	3	0	0	0	1	0	0	0	0	2	0	0	1	0	0	**8**
WSIB issues	3	0	2	0	0	0	0	0	1	2	0	0	0	0	0	0	0	**8**
Work problems	23	15	34	0	2	3	0	2	10	25	5	0	0	0	3	1	3	**126**
Total	**881**	**369**	**1010**	**17**	**59**	**183**	**49**	**11**	**472**	**1109**	**708**	**163**	**0**	**117**	**285**	**40**	**104**	5577

* Introduced during the 2002-2003 fiscal year

Appendix F: PSYs' management strategies according to the main presenting problem

Main Presenting Problem		Management Strategies											
		Supportive therapy	Individual therapy	Marital therapy	Interpersonal Psychotherapy	Bereavement	Family therapy	Parenting skills	Education	Cognitive-Behavioural Therapy	Psychodynamic Therapy	Other	**Total**
Abnormal eating behaviour	4	1	1	0	1	0	0	0	0	2	0	1	**6**
Abuse during childhood	1	0	1	0	0	0	0	0	0	0	0	0	**1**
Alcohol abuse in self	9	2	3	2	0	0	0	0	0	1	0	3	**11**
Anger/temper control issues	13	4	2	0	0	0	1	0	0	2	0	3	**12**
Attention deficit disorder	39	3	6	4	4	0	7	1	0	2	0	18	**45**
Anxiety Symptoms	182	35	31	6	10	0	9	0	1	85	3	18	**198**
Compulsive behaviour	*17*	*1*	*3*	*0*	*0*	*0*	*2*	*0*	*0*	*9*	*0*	*2*	***17***
*Flashbacks/PTSD symptoms**	*3*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*2*	*1*	*1*	***6***
Obsessive thoughts	*17*	*4*	*4*	*3*	*0*	*0*	*2*	*0*	*0*	*9*	*0*	*1*	***23***
Other anxiety symptoms	*71*	*15*	*13*	*2*	*5*	*0*	*3*	*0*	*0*	*26*	*1*	*7*	***72***
Panic symptoms or attacks	*49*	*11*	*7*	*1*	*3*	*0*	*1*	*0*	*0*	*24*	*0*	*5*	***52***
Phobias	*18*	*2*	*1*	*0*	*2*	*0*	*0*	*0*	*0*	*11*	*0*	*1*	***17***
*Social anxiety**	*7*	*1*	*3*	*0*	*0*	*0*	*1*	*0*	*0*	*4*	*1*	*1*	***11***
Bereavement	9	2	0	0	2	0	0	0	0	2	0	0	**6**
Burden of caring for another*	1	0	0	0	0	0	1	0	0	0	0	1	**2**
Child behaviour problems	4	0	1	0	0	0	2	0	0	0	0	2	**5**
Chronic pain	14	5	1	0	0	0	0	0	0	2	0	3	**11**
Confusion	3	0	1	0	0	0	0	0	0	0	0	0	**1**
Delusions	33	15	4	0	1	0	2	0	1	0	0	9	**32**
Depressed mood	476	161	76	17	100	2	11	2	5	105	5	42	**526**
Difficulty dealing with illness	5	3	2	0	1	0	1	0	1	1	0	1	**10**
Disorganised thoughts	12	3	2	1	0	0	0	0	0	0	0	3	**9**
Elevated mood	3	0	0	0	0	0	0	0	0	0	0	1	**1**

Main Presenting Problem		Management Strategies											
		Supportive therapy	Individual therapy	Marital therapy	Interpersonal Psychotherapy	Bereavement	Family therapy	Parenting skills	Education	Cognitive-Behavioural Therapy	Psychodynamic Therapy	Other	**Total**
Excessive somatic symptoms	12	1	1	0	0	0	0	0	0	7	0	3	**12**
Fluctuating mood	39	12	4	1	4	0	0	0	0	5	0	6	**32**
Gambling*	2	0	0	0	0	0	0	0	1	1	1	0	**3**
Hallucinations	11	1	1	1	2	0	2	0	1	0	1	3	**12**
Illness in family member	2	2	0	0	1	0	0	0	0	0	0	0	**3**
Insurance form	2	0	1	0	0	0	0	0	0	0	0	0	**1**
Learning disability	2	1	0	0	0	0	0	1	0	0	0	1	**3**
Legal issues	2	0	1	0	0	0	0	0	0	0	0	1	**2**
Legal letter/report	4	1	0	0	0	0	0	0	0	0	0	0	**1**
Marital problems	20	3	5	11	1	0	1	0	0	1	0	2	**24**
Medication side effects	15	1	1	1	0	0	0	0	0	0	0	1	**4**
Memory impairment	15	2	1	1	0	0	1	0	0	0	0	9	**14**
Mental retardation	1	1	0	0	0	0	0	0	0	0	0	0	**1**
Other current psychiatric issues	5	1	2	0	0	0	0	0	0	0	0	1	**4**
Other family problems	10	2	3	0	3	0	1	0	0	0	1	1	**11**
Other relationship issues	6	2	0	0	1	0	0	0	0	2	0	0	**5**
Other stressful events	1	0	0	0	0	0	0	0	0	0	0	0	**0**
Other substance abuse	7	3	0	0	1	0	0	0	0	2	0	3	**9**
Paranoia*	5	2	0	0	0	0	0	0	0	0	0	1	**3**
Parenting issues	3	1	1	0	0	0	1	0	0	0	0	0	**3**
Past abuse victim	2	0	1	0	0	0	1	0	0	0	0	1	**3**
Past alcohol abuse in self	1	0	0	0	0	0	0	0	0	0	0	0	**0**
Personality problem	7	4	1	0	0	0	0	0	0	2	0	1	**8**
School problem	7	1	2	0	0	0	0	0	0	0	0	2	**5**
Self-esteem	2	0	1	0	0	0	0	0	0	1	0	0	**2**
Separation/divorce	5	0	1	0	0	0	1	0	0	0	0	1	**3**
Sexual problem	6	0	0	2	0	0	0	0	0	1	0	0	**3**

Main Presenting Problem		Management Strategies											
		Supportive therapy	Individual therapy	Marital therapy	Interpersonal Psychotherapy	Bereavement	Family therapy	Parenting skills	Education	Cognitive-Behavioural Therapy	Psychodynamic Therapy	Other	**Total**
Social isolation	5	3	2	0	0	0	0	0	0	1	0	2	**8**
Suicidal thoughts	10	4	1	4	4	0	1	0	0	3	0	0	**17**
WBC issues	1	1	0	0	0	0	0	0	0	0	0	1	**2**
Work problems	12	2	3	0	0	0	0	0	0	1	0	5	**11**
Unusual behaviour	4	1	1	0	0	0	2	0	1	0	0	1	**6**
Total	**1216**	**286**	**165**	**51**	**136**	**2**	**45**	**4**	**11**	**229**	**11**	**151**	**1091**

* Introduced during the 2002-2003 fiscal year

Appendix G: RDs' management strategies according to the main presenting problem

Main Problem	Subtype	Outcome Forms	Assessment Only	Individual Treatment	Group Treatment	Individual & Group Treatment	Other	Total
Billiary/Hepatic/ Renal	Intestinal cystitis	1	0	1	0	0	0	1
	Kidney stones	2	0	2	0	0	0	2
	Liver disease/high LFT's	4	0	2	0	0	2	4
	Cholecystectomy	1	0	1	0	0	0	1
	Other disease	3	0	3	0	0	0	3
Cardiovascular	Disease	12	3	8	0	0	1	12
	Dyslipidemia	864	111	664	14	11	64	864
	Hypertension	11	1	7	0	1	2	11
Diabetes	Gestational	3	0	2	0	0	1	3
	Hypoglycaemia	7	2	5	0	0	0	7
	Impaired glucose tolerance	75	16	56	0	0	3	75
	Type I	9	1	6	0	0	2	9
	Type II	419	46	349	0	1	23	419
Disease Prevention & Health Promotion	Adult nutrition	8	1	6	0	0	1	8
	Behavioural/ Social Issues	3	0	2	0	0	1	3
	Food security (affordability)	1	0	1	0	0	0	1
	Healthy eating	43	9	30	0	0	4	43
	Adult obesity	141	15	102	0	1	23	141
	Pediatric obesity (0-18)	9	1	6	0	0	2	9
	Pediatric nutrition (0-18)	3	1	2	0	0	0	3
	Perinatal nutrition	22	5	13	0	0	4	22
	Sports nutrition	4	0	3	0	0	1	4
	Underweight adult	13	4	9	0	0	0	13
	Vegetarianism	18	1	13	0	0	4	18
	Other weight issues	24	6	15	0	0	3	24
	Weight decrease	80	9	62	1	0	8	80
	Weight management	73	4	62	0	0	7	73

Main Problem	Subtype	Outcome Forms	Assessment Only	Individual Treatment	Group Treatment	Individual & Group Treatment	Other	Total
Gastrointestinal	Celiac disease	8	2	6	0	0	0	8
	Constipation/haemorrhoids	14	3	10	0	0	1	14
	Crohn's disease	3	0	2	0	0	1	3
	Diverticular disease	7	0	7	0	0	0	7
	Dumping syndrome	1	0	1	0	0	0	1
	Dysphagia	1	0	0	0	0	1	1
	Gas/bloating	3	1	1	0	0	1	3
	Irritable bowel syndrome	21	4	15	0	0	2	21
	Lactose malabsorption	4	0	4	0	0	0	4
	Ulcer/reflux	8	1	7	0	0	0	8
	Ulcerative colitis	3	1	2	0	0	0	3
Musculo-Skeletal	Arthritis	2	0	2	0	0	0	2
	Gout	6	2	4	0	0	0	6
	Osteoporosis	20	4	16	0	0	0	20
Family History of DM		1	0	1	0	0	0	1
Systemic	Iron Overload	2	0	2	0	0	0	2
	Anaemia (B12 and folate deficiency)	1	1	0	0	0	0	1
	Anaemia (Iron deficiency)	24	3	19	0	0	2	24
	Cancer	4	1	2	0	0	1	4
	Eating disorders	7	1	5	0	0	1	7
	Failure to thrive	7	1	4	0	0	2	7
	Food allergies	2	0	2	0	0	0	2
Sub Total			**261**	**1544**	**15**	**14**	**168**	
Percentage			**13.04%**	**77.12%**	**0.75%**	**0.70%**	**8.39%**	**2002**
Total		**1895***	**2002**					

* : one patient may have more than one main presenting problem and may receive more than one treatment
Note: Other represents no-shows and cancellations

Appendix H: Focus group themes and content analysis results

Focus Group Themes	FPs		MHCs		PSYs		RDs		Group 1		Group 2		TOTAL		
P = participants / T = times mentioned / G = groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
PROGRAM GOALS															
Increased accessibility for variety of patients/ patient empowerment	1	2	3	3	3	3	1	1	3	4	4	4	15	17	6
Interdisciplinary care (collaboration)	1	1	3	3	2	3	3	3	1	1	3	3	13	14	6
Health promotion / disease prevention/ early detection/ early intervention (short waiting lists)	1	1	2	2	4	4	3	4	1	1	2	2	13	14	6
More efficient mental health care	2	2	1	1	3	3	2	2	1	1	2	2	11	11	6
Education (increase team's knowledge/skills)	1	1	1	1	3	4					1	1	6	7	4
More efficient nutrition health care	2	2											2	2	1
Evaluation (measure success rate)							1	1					1	1	1
PROGRAM STRENGTHS															
Flexible model															
Model definition differs from its application leading to variability among practices (mould to practice needs)	3	6	3	6	7	21	3	5	1	1	2	3	19	42	6
Flexibility in treatment protocol	2	2	4	7					2	2			8	11	3
Program improves and/or changes with time			4	6	2	5	1	1	1	1			8	13	4
Flexibility in scheduling / prioritising according to patient needs			1	1	2	2			1	1	3	3	7	7	4
Provider satisfaction															
Interdisciplinary team approach / Collaboration among different providers	6	9	7	14	5	17	3	8	4	8	7	14	32	70	6
Opportunity for formal and informal education with team members (increase skills/knowledge)	3	12	4	4	6	14	4	10	3	6	2	4	22	50	6
Access to detailed patient information, patient history (Integration of patient information) for more holistic approach	5	9	4	7	4	12			3	4	4	4	20	36	5

Focus Group Themes	FPs		MHCs		PSYs		RDs		Group 1		Group 2		TOTAL		
P = participants / T = times mentioned / G = groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
General expression of satisfaction	3	4	9	13	2	6	1	1	1	1	3	3	19	28	6
Co-worker assistance with external referrals	5	5	1	1	2	2	2	2	2	2	2	6	14	18	6
Independence and flexibility	3	4	1	1	2	2	2	4	2	2	3	3	13	16	6
Opportunity to focus on personal expertise which is valued and respected	3	5	4	7							1	1	8	13	3
Transfer patient care with ease / Increase comfort in transferring authority of patient care	1	1			5	8	1	1			1	1	8	11	4
Student education/teaching					2	2					1	1	3	3	2
Co-worker assistance re: insurance companies	1	1									1	1	2	2	2
Multiple co-workers / workplaces							2	2					2	2	1
Key features of shared care:															
Direct communication /Indirect communication (charts, notes...)	7	11	8	13	6	16	2	2	7	12	6	10	36	64	6
Availability of allied professionals (for consultation, advice, collaboration) and support/ back up of allied providers	7	13	8	10	5	16	3	3	5	10	7	15	35	67	6
Setting (common resources, all providers in same settings)/ Decreased stress for patients	4	12	3	3	4	4	2	2	3	7	6	15	22	43	6
Individual skills and comfort of team members	6	6	3	3	2	2	2	2	2	4	2	2	17	19	6
Relationships among team members	3	4	1	1	5	7	1	1	2	5	3	3	15	21	6
FPs perspective, comfort, and interest in shared care	2	3	5	7	5	9	1	1			1	1	14	21	5
More efficient patient care due to shared care															
Accessibility / Comfortable setting / Opportunity to build trust with patients (part of a familiar system of care- extension of FP)/ Patient acceptance and buy-in / Patient empowerment	7	22	9	30	2	2	4	6	6	15	8	23	36	98	6
Better patient care in general	7	13	8	5	4	4	3	7	2	4	3	4	27	37	6
Early detection and intervention /Preventative care / Health Promotion /Patient education and education materials	5	11	8	12	4	6	4	7	2	6	4	8	27	50	6

Focus Group Themes	FPs		MHCs		PSYs		RDs		Group 1		Group 2		TOTAL		
P = participants / T = times mentioned / G = groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
Continuity of Care	2	2	5	8	4	4	3	3	3	5	2	4	19	26	6
Avoidance of hospitalisation or external referrals for decreased burden on traditional system	4	7	1	1	3	5			2	2	1	1	11	16	5
Reduced stigma	1	2	2	2	1	1			1	1	2	3	7	9	5
Clear treatment plan and feedback re: care	2	2							2	2			4	4	2
CMT															
Support providers and facilitate shared care			3	3	1	1	2	2			1	1	7	7	4
Provide formal education and research opportunities for providers			3	4			2	2					5	6	2
PROGRAM CHALLENGES															
Administrative issues															
Time constraints re: caseload/ waitlists / multiple workplace re: access to resources/ collaboration/ communication /paperwork	2	3	4	14	3	4	3	18	6	16	4	5	22	60	6
External Referrals: difficulties in making external referrals due to intake criteria, long waiting lists, and lack of patient comfort or willingness to go to external services	3	5	2	2					3	6	2	3	10	16	4
Physical Space re: visibility and workstation	2	2	3	6	1	1	1	1					7	10	4
Standard Forms/ Non-electronic evaluation format / Quick easy access to patient information (electronically in treatment room)	4	10							2	2			6	12	2
External Services: unclear boundaries leading to external services overestimating HSO resources	3	5			2	3					1	1	6	9	3
Unclear authority/action of CMT, re: attitudinal barriers or other practice specific issues			5	11	1	1							6	12	2
Unclear roles and expectations of provider within shared care model			5	11	1	1							6	12	2
Record keeping system (handwritten notes and referral pads)	3	5											3	5	1
Lack central booking system					1	1							1	1	1

Focus Group Themes	FPs		MHCs		PSYs		RDs		Group 1		Group 2		TOTAL		
P = participants / T = times mentioned / G = groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
Other issues															
Lack of interest in shared care or increasing knowledge and skills causing variability among practices and in some cases there's a feeling that it is not shared care, that team members work independently (delegated act, more traditional approach)	1	1	4	17	7	15	2	7					14	40	4
No-shows / Lack penalty system for no-shows	5	8			1	1	1	1					7	10	3
Lack of accessibility for patients outside HSO/ need to expand the program	1	1	1	1	4	5					1	2	7	9	4
Lack understanding of services provided by other professionals or their effectiveness	2	2					4	6					6	8	2
Lack access to specialised staff such as child psychiatrist	3	4			1	1			1	1			5	6	3
Lack access to other allied professionals when there is compatibility issue among provider and patient (personality and skills)	3	3											3	3	1
Lack of collaboration of RD's with external services/ duplication	2	3											2	3	1
Lack of regular meeting for peer support and program development/evaluation					1	1							1	1	1
TARGET POPULATION															
Patients who benefit the most															
Patient with institutional barriers	2	2	6	9	4	6	3	5	4	5	3	3	22	30	6
Patient with general psychiatric disorders such as depression, panic disorders / phobia, chronic pain, anxiety disorder	3	11	5	6	4	6			4	6	4	6	20	35	5
Patient with family problems/ or family groups	2	2	6	6	1	1	1	1	4	6	1	1	15	17	6
Patient demographic groups such as low socio-economic status groups, elderly patients, single mothers, ethnic groups, vegetarians			4	6	1	2	2	3	2	2	4	4	13	17	5

Focus Group Themes	FPs		MHCs		PSYs		RDs		Group 1		Group 2		TOTAL		
P = participants / T = times mentioned / G = groups	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#P	#T	#G
Patient with physical illness such as impaired glucose tolerance, pre-diabetic/diabetic, lipidemia/ cholesterol, hypertension, obesity, gastrointestinal problems, etc	4	9					3	21	3	6	2	3	12	39	4
All patients			3	5	3	4	2	4	1	2	1	2	10	17	5
Motivated patients	2	3					1	2	3	4			6	9	3
Patient with stable schizophrenia, stable bipolar disease, personality /behavioural disorders, suicidal patients, etc	2	4	2	3							2	3	6	10	3
Patients who benefit the least															
Patients who need ongoing treatment , high intensity/frequent counselling, emergency psychiatric care (acute crisis),	3	4	2	4	3	3			2	4			10	15	4
Patients with bipolar disease, schizophrenia, personality disorders, acute suicidal patients	3	4	2	4	1	1							6	9	3
Children	1	1							2	2			3	3	2
Patients experiencing grief											2	2	2	2	1
Patients who require drug rehabilitation					1	1			1	1			2	2	2
Patients who require vocational rehabilitation					1	1							1	1	1
Large families											1	1	1	1	1
Patients with weight management issues							1	1					1	1	1