Proposal for restructuring Sector Teams and Specialized Clinics in CPC Outpatient Clinics

Henry Olders, MD, FRCPC
Directeur clinique des soins continus, CPC

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Introduction

This report describes one possible approach to a restructuring of the CPC Outpatient Clinics. While preserving the desirable characteristics of sectorized teams including close linkages with specific communities, this approach rationalizes the number of teams and the clinician distribution to improve efficiency and to distribute workloads more evenly.

Although this proposal calls for the creation of three new specialized clinics and for conversion of clinic coordinator positions from half- to full-time, this is envisaged without any increase in the number of paid positions in the clinics.

Existing Situation

Figure 1, "Cliniques Externes - Etat actuel et statistiques", details the distribution of population served (population figures are derived from 1986 census figures, please see Appendix 1 for details) and of clinicians (from the report "Etude sur le fonctionnement des cliniques externes"[1]) for each of the existing 6 sectorized teams and the two specialized clinics.

As can be seen, there is a large variation in both population and staffing, with population per team ranging from a low of about 14,000 for each of the Verdun East and West teams, to a high of almost 27,000 for LaSalle Francophone, almost double the lowest value. Similarly, each of the two Verdun francophone teams has only 3 full-time equivalents in terms of clinical staff, compared to 4.8 for the LaSalle francophone team.

The bottom of the spreadsheet gives values for several statistics relating to workload:

- "population/clinicien" (population for a team, divided by the number of clinician full-time equivalents (FTE's));
- "dossiers ouverts"[2];
- "dossiers/1000 population" (dossiers ouverts divided by population in thousands).

1 Dufort F. Etude sur le fonctionnement des cliniques externes du Centre de Psychiatrie Communautaire. Comite d'Etude des Cliniques Externes, 1990 jan; Equipe d'Evaluation et de Recherche Appliquee du C.P.C.

2 ibid., tableau 4, p 10

- "dossiers/clinicien" (dossiers ouverts divided by clinician FTE's);
- "nombre de rencontres" is the number of patient visits based on statistics collected for government purposes[3];
- "rencontres/clinicien" (nombre de rencontres divided by clinician FTE's);
- "rencontres/dossier" (nombre de rencontres divided by dossiers ouverts).

Four of these statistics are graphed in Appendix 2. The visual presentation helps to underline the variability in these indices of workload from one team to another. It should be noted that the reliability of the data is decidedly poor, and these statistics may not represent the actual situation.

Proposed Changes

I propose to replace the existing six sectorized teams and two specialized clinics with a total of five teams: two Case Management Teams, and three Specialized Clinics (see Figure 2: spreadsheet "Cliniques Externes - Equipes Cliniques Proposés"). Even though the number of clinicians will increase, and there will be a full-time administrative position in each of the two outpatient clinic locations, the total number of paid positions will remain unchanged.

Each of the five multicisciplinary teams or clinics will have a coordinator as well as a clinical director.

Specialized clinics:

The specialized clinics will provide consultations and specialized, time-limited treatments, both biological and psychosocial.

Figure 2 shows the staffing for the proposed three Specialized Clinics, the "Contact" Evaluation & Brief Therapy Clinic, the Psychotic Disorders Clinic, and the Mood & Anxiety Disorders Clinic.

"Contact" Clinic

The "Contact" Evaluation & Brief Therapy Clinic would provide, in addition to intake evaluations for new patients referred to CPC from the community (ie the CLSC's or GP's) or from the Emergency, consultations to community GP's and other CLSC programs, and time-limited psychotherapy, whether insight-oriented, behavioral, cognitive, or interpersonal.

This clinic includes a part-time psychiatrist and occupational therapist, as well as psychologists, social work, and nursing staff. In addition to their own direct clinical workload, these staff would also be involved in providing supervision and teaching to the trainees, students, and residents who would be attached to this clinic and doing much of the clinical work. The spreadsheet shows a research assistant who would be funded by research grants.

As the CLSC's develop their capacity to do initial screening of patients, it would make sense for the "Contact" team to do its intake evaluations at the CLSC's, using office space and resources provided by the CLSC's.

Psychotic Disorders Clinic

The Psychotic Disorders Clinic is staffed to provide, for patients with schizophrenia and delusional disorders, assessments and consultations on medication and psychosocial treatments such as occupational rehabilitation, activities of daily living training, and social skills training. It will also do time-limited individual and group therapies for selected individuals.

It is proposed that the Clinic be physically situated at the Verdun Clinic on Bannantyne; however, clinic staff will have a schedule for seeing patients at LaSalle Clinic.

[3] ibid., tableau 6, p 13

Mood & Anxiety Disorders Clinic

The third specialized clinic represents an amalgamation of the two existing clinics ie the Affective Disorders Clinic and the Anxiety Disorders Clinic It will provide consultations, group and individual psychotherapy, and somatic treatments as well as teaching and research It is proposed that this clinic be physically situated at the LaSalle Clinic with clinical services provided on a regular weekly schedule at the Verdun Clinic

Case Management Teams

Instead of the existing sectorized teams, I propose the creation of two Case Management Teams one serving LaSalle and associated with the LaSalle CLSC, the other serving Verdun and Ville Emard and associated with the Verdun CLSC, including its "point de service" in Ville Emard

Each Case Management team will have a complement of Nurse-Clinicians, a full-time social worker, a part-time occupational therapist, and part-time psychiatrists and GP's with privileges in psychiatry, working as consultants to the teams

Reducing the number of teams serving specific geographic areas will improve efficiency by reducing the amount of co-ordination work between teams and other services in CPC However, fewer teams means larger geographic sectors which reduces the intimacy of a team's connection with its community Other factors to consider are the maximum number of team members for cohesive functioning, and the minimum size of a team's workload required to efficiently utilize secretarial staff, social workers, etc

Although the case management function of the Case Management Teams will continue while a patient is receiving specialized treatments from a specialized clinic, it is expected that Case Managers will need to provide fewer services such as medication followup or supportive therapy while patients are receiving specialized treatments

An alternate approach to the separate Case Management Teams that I am proposing, would be to have each specialized clinic responsible for the long-term followup and case management of its own patients The following points support keeping case management separate

- patients with diagnoses such as personality disorder, drug or alcohol abuse, somatoform disorders, etc, who do not fit well into the specialized clinics will not "fall between the cracks" ie they can be followed by the Case Management teams in conjunction with the CLSC's community GP's, or the teams' own medical consultants
- specialized clinics will be more attractive to researchers and teachers if they do not need to treat patients whose problems are complicated by personality disorder, drug or alcohol abuse etc
- Given that the CLSC's will, in the future, have the responsibility for the long-term followup of psychiatric patients, including those with severe mental illness, it makes sense to concentrate the case management function, instead of having each specialized clinic need to cut back on its services as the CLSC s come up to speed
- The development of Assertive Outreach Teams in the future will be much simpler as an outgrowth of Case Management Teams instead of taking staff away from specialized clinics
- When Case Management Teams are responsible for developing and maintaining links with the CLSC's alternative resources, police, welfare offices, and community GP s, specialized clinics will need to devote less time to such relationships and thus have more time for research and teaching Furthermore, the duplication of effort required for each specialized clinic to be involved in these multiple community relationships will be avoided by having the Case Management

Teams "specialize" in community involvement
- Links with the Emergency, the inpatient units, day hospitals, day programs, and the module d'hébergement as well as with other hospital programs (eg Rehabilitation) will also be less duplicated and less time-consuming, just as for links with the community
- Case Management Teams will be better able to provide continuity of care
- Long-term supportive psychotherapy is a high-level clinical skill which deserves its own specialized clinic - the Case Management Teams
- Feedback from clinicians in the existing sectorized teams indicates a strong bias towards maintaining a sector responsibility with continuity of care - seen as essential components of "community psychiatry"
- Since the Case Management Teams will not be providing insight-oriented therapy, either brief or long-term, there will be no competition within teams for "good" psychotherapy cases

Workload Balancing

Current statistics gathered from inpatient clinics do not accurately reflect workloads of clinicians or teams. For example, telephone calls, patients failing to show for appointments, interventions with family members, foster home proprietors or other professionals (eg supervision of trainees) are not counted, nor is the length of time of interventions taken into account. Moreover, social worker statistics are compiled separately, and it is unclear how clinical activities of trainees should be accounted for.

Accordingly, the statistics as currently gathered are not helpful in calculating clinician or team workloads, or in reallocating clinical or secretarial resources.

The project currently under way to computerize the clinics, promises to improve the validity and reliability of the statistics. For example, it should be possible to provide breakdowns of the caseload of each clinician by such patient demographic variables as age, sex, diagnosis, frequency of clinic visit, type of intervention, level of functioning (eg weeks worked in past year), length of treatment, or number of hospitalizations.

We may thus be in a position to refine our understanding of clinician workload beyond simple statistics such as number of interventions, of what type, per period, to consider severity of illness in the case mix.

The above proposal for reallocation of clinicians is based on only the crudest workload index, that of population served. With the availability of better statistics in the near future, we will be able to fine-tune the allocations of clinicians to teams to equalize workloads.

Process of Restructuring

The following process is suggested for the restructuring of the clinics.

1 Define precisely the various positions in each team. I suggest each team or clinic have one full-time nurse-clinician or other professional who functions as team coordinator in addition to clinical responsibilities. In addition, each team or specialized clinic should have a clinical director (usually an MD) who is responsible for the clinical functioning of the team. Other positions on each team could be half-time, thus giving staff an opportunity to work in another activity centre, either in the outpatient service or in the hospital. Besides making the work more interesting for clinicians, this would also provide good communications between activity centres. In general, individuals should be allowed to compete for the half-time job postings separately. No individual would work

in more than two teams or activity centres at the same time.

2. Once positions have been posted, a date can be set for closing the clinics.
3. We would plan for a couple of days of orientation for all clinic employees (eg in policies and procedures for evaluation, record-keeping, statistics, etc.), followed by a couple of days of orientation for each individual team or clinic.
4. Following orientation sessions, the new teams and clinics would "open for business".

Job Responsibilities

Given the decreasing availability of psychiatric manpower, it is becoming more and more important to find ways of using these physicians more efficiently. In Case Management teams, psychiatrists or GP's with psychiatric privileges should be functioning as consultants only, and not following patients themselves (ie all patients should have a "case manager" who is not an MD). Other suggestions include:

- In general, a patient's case manager can determine when the patient needs to be assessed re medication, and can request an appointment with the physician.
- Team secretaries can book such assessments.
- The case manager should participate in the interview with the MD.
- Progress notes for such interviews can be written and signed by the case manager, and countersigned by the physician.
- Initial evaluations, annual reviews, and discharge summaries can also be written and signed by the case manager, and the treating physician can add a brief note referring to the case manager's note.

In the interests of efficiency, it may also be worthwhile to assign patients requiring medication primarily to nurse clinicians for case management.

Alternative Proposals

This proposal suggests two Case Management Teams and three Specialized Clinics. Other possibilities suggest themselves, and could be examined in greater depth, for example:

- Maintain the Mood Disorders Clinic and the Anxiety Disorders Clinic as independent entities, as at present.
- Create a Brief Therapy Clinic separate from the "Contact" Evaluation team.
- Combine case management with the Evaluation teams.

Conclusions

This proposal shows one way in which the CPC outpatient clinics can be restructured. By reducing the number of teams, workloads can be more evenly distributed between teams, and less infrastructure (secretaries, word processors, etc.) is required. Team size will increase, thus making for greater efficiency in team operations such as team meetings and communications with other activity centres.

Adding specialized clinics permits more efficient teaching and research, and reduces the duplication of skills required to provide specialized services in several sectorized teams. Specialized clinics may also help to attract new clinicians to CPC. By encouraging clinicians to work half-time in two different settings, the likelihood of professional "burnout" will be reduced.

The proposed structure will free up enough paid employee hours to permit hiring a full-time coordinator or manager for each clinic.

By defining more clearly the mandates of the Case Management Teams and

the specialized clinics, greater standardization will become possible in areas such as evaluation of new cases. This will permit more useful statistics to be accumulated and eventually to be applied to help balance workloads of individual clinicians more evenly.

Figur

CLINIQUES EXTERNES - Etat actuel et statistiques --- 09 mai 1990

EQUIPE	LaSalle franco		LaSalle bilingue		Verdun ouest		Verdun est		Ville-Emard		Verdun anglo		Tr. affectifs		Tr. d'anxiété	
	3		**4**		**5**		**6**		**7**		**2**		**8**		**9**	
population 18-65	26992		25777		14122		14122		16971		17977					
HEURES/SEMAINE																
psychiatres	28	0.7	15	0.4	7.5	0.2	7.5	0.2	9	0.2	18	0.5	3.5	0.1	15	0.4
	18	0.5	9	0.2		0.0		0.0		0.0		0.0	15	0.4		0.0
omnipraticien		0.0		0.0	10.5	0.3	21	0.5		0.0		0.0		0.0	3.5	0.1
psychologue	35	1.0	24.5	0.7	35	1.0	28	0.8	26.25	0.8	17.5	0.5		0.0	7	0.2
travailleur(se) social(e)	21	0.6	21	0.6	17.5	0.5	17.5	0.5	17.5	0.5	17.5	0.5		0.0		0.0
inf.-clinicien(ne)s	36.25	1.0	36.25	1.0	36.25	1.0	36.25	1.0	36.25	1.0	36.25	1.0		0.0		0.0
	36.25	1.0	14.5	0.4		0.0		0.0	21.75	0.6	18.12	0.5		0.0		0.0
		0.0	21.75	0.6		0.0		0.0		0.0	36.25	1.0		0.0		0.0
		0.0		0.0		0.0		0.0		0.0		0.0		0.0		0.0
assistant de recherche		0.0		0.0		0.0		0.0		0.0		0.0		0.0	35	1.0
TOTALE cliniciens	**174.5**	**4.8**	**142**	**3.9**	**106.75**	**3.0**	**110.3**	**3.0**	**110.75**	**3.1**	**143.6**	**3.9**	**18.5**	**0.5**	**60.5**	**1.7**
Population/clinicien	5682		6610		4787		4688		5519		4551		0		0	
Dossiers ouverts	300		323		113		133		138		205		56		110	
Dossiers/1000 populatic	11.1		12.5		8.0		9.4		8.1		11.4					
Dossiers/clinicien	63.2		82.8		38.3		44.1		44.9		51.9		121.1		66.2	
Nombre de rencontres	219		265.2		128.3		145		186.3		347.5		69.3		76.5	
Rencontres/clinicien	46.1		68.0		43.5		48.1		60.6		88.0		149.8		46.0	
Rencontres/dossier	0.73		0.82		1.14		1.09		1.35		1.70		1.24		0.70	

H. Olders, MD

Figure 2: CLINIQUES EXTERNES - Equipes Cliniques Proposés --- 02 août 1990

EQUIPE	Case Management Teams				"Contact" Evaluation & Brief Therapy		Psychotic Disorders Clinic		Mood & Anxiety Disorders Clinic				
	LaSalle		Verdun & V. Emard									actuel	proposé
psychiatres	16	0.4	24	0.6	24	0.6	16	0.4	16	0.4	psychiatres	2.6	2.4
		0.0		0.0		0.0	16	0.4	16	0.4		1.1	0.8
omnipraticiens	20	0.5	20	0.5		0.0	20	0.5	8	0.2	omnipraticiens	0.9	1.7
psychologues		0.0		0.0	52.5	1.5	17.5	0.5	70	2.0	psychologues	5.0	4.0
travailleur(se)s social(e)s	35	1.0	35	1.0	17.5	0.5	17.5	0.5		0.0	travailleur(se)s soci	3.2	3.0
inf.-clinicien(ne)s	36.25	1.0	54.38	1.5	36.25	1.0	36.25	1.0	18.125	0.5	inf.-clinicien(ne)s	6.0	5.0
	36.25	1.0	54.38	1.5		0.0	7.25	0.2	18.125	0.5		2.5	3.2
	36.25	1.0	36.25	1.0		0.0		0.0		0.0		1.6	2.0
ergothérapeutes	14	0.4	21	0.6	7	0.2	28	0.8		0.0	ergothérapeutes	0.0	2.0
ass'tes de recherche		0.0		0.0	35	1.0	35	1.0	70	2.0	ass'tes de recherche	1.0	4.0
TOTALE clinicien hres	193.8	5.3	245.0	6.7	172.3	4.8	193.5	5.3	216.3	6.0	Totale cliniciens	23.8	28.1
											secrétaires	7.0	5.0
population 18-65	52769		63192								coordonnateurs	1.0	2.0
Population/clinicien	9956		9432								Totale postes payés	26.2	26.2
Dossiers ouverts	623		589										
Dossiers/1000 population	11.8		9.3										
Dossiers/clinicien	117.5		87.9										

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APPEL .X 1

CLINIQUES EXTERNES - Population-cible des équipes --- 08 mai 1990

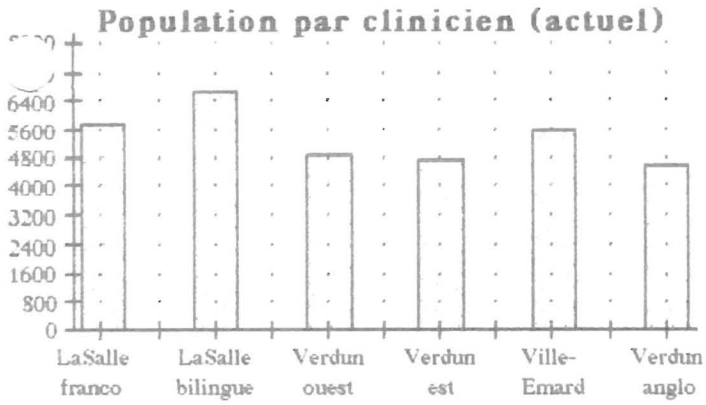
AGE	hommes	femmes	totale	Ville-Emard		Verdun		LaSalle	
15-19	6287	6207	12494	2100		3750		5605	
20-24	8456	9192	17648	3110		5635		7510	
25-34	16518	17293	33811	6005		11320		14010	
35-44	11466	12735	24201	3950		7825		10975	
45-54	10046	11181	21227	3760		6875		9250	
55-64	9801	11511	21312	4235		7310		8305	
65-74	5612	8401	14013	2920		5345		4770	
chaque an, 15-19	1257.4	1241.4	2498.8	420		750		1121	
chaque an, 65-74	561.2	840.1	1401.3	292		534.5		477	
TOTALES, 18-65	**59363**	**65235**	**124598**	**22192**		**41000**		**52769**	
Unilingue-français (1)				24060	74.1%	39955	66.3%	36410	48.2%
Unilingue-Anglais (2)				2740	8.4%	14460	24.0%	21375	28.3%
Unilingue-Autre (3				3625	11.2%	2415	4.0%	11155	14.8%
Mulitilingue-Fr.-Ang. (4)				1225	3.8%	2820	4.7%	3695	4.9%
Multilingue-Fr.-Aut. (5)				155	0.5%	150	0.2%	410	0.5%
Multilingue-ang.-Aut. (6)				260	0.8%	280	0.5%	1460	1.9%
Multilingue-Fr.-Ang.-Aut. (7)				385	1.2%	170	0.3%	1075	1.4%
Multilingue-Autre (8)				15	0.0%	15	0.0%	15	0.0%
Totale				32465		60265		75595	
Totale Bilingue (=2+3+4/2+6+7+8)				7638	23.5%	18750	31.1%	36928	48.8%
Totale Francophone (=1+4/2+5)				24828	76.5%	41515	68.9%	38668	51.2%
				Ville-Emard		**Verdun**		**LaSalle**	
18-65 Bilingue				**5221**		**12756**		**25777**	
18-65 Francophone				**16971**		**28243**		**26992**	

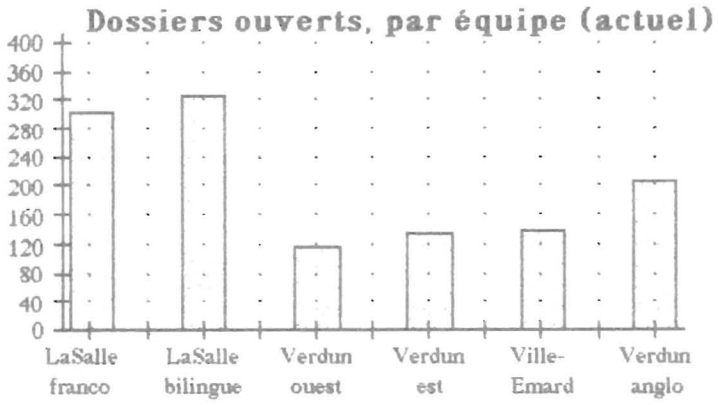
H. Olders, MD

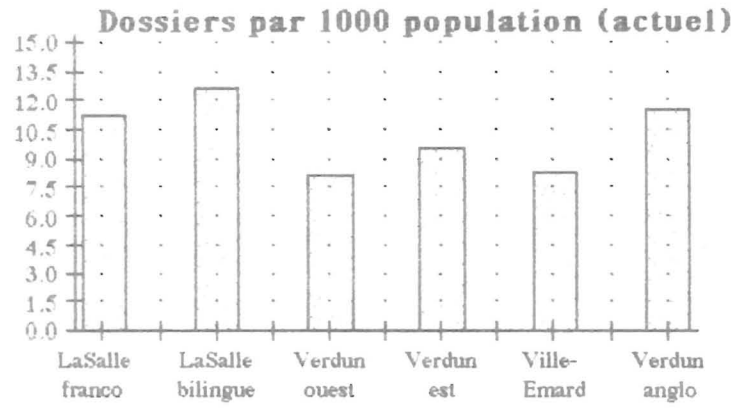
Appendix 2

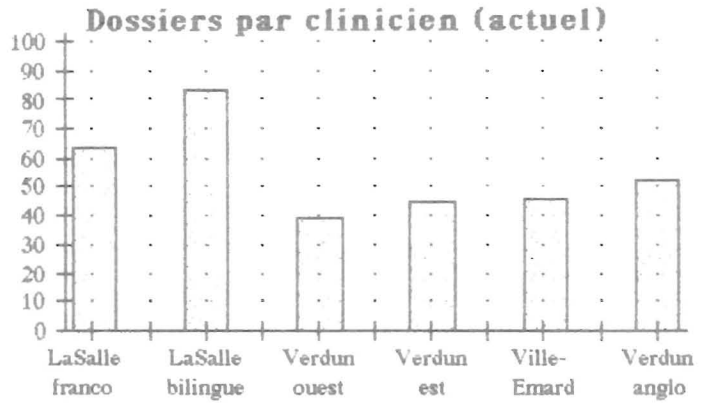
Statistiques Actuels - Cliniques Externes

Henry Olders
6 mai 1990









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