A Shared Care Network:
Enhancing Mental Health Services
In Ontario

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1.0 Introduction

The Ontario College of Family Physicians and our partners (see 3.10) recognize the efforts the Ministry of Health and Long Term Care is making to improve access to quality, affordable mental health services throughout Ontario. As services move from a largely institutionally based system to one that facilitates effective care in the community, legislative changes were needed. The OCFP commends the Ministry for taking the lead role in changing the legislation. We recognize that for these changes to be implemented a well-organized, full-spectrum, integrated system must be in place. As the major providers of Mental Health Services and the first point of contact for patients, Family Physicians are in a unique position to play a key role in the mental health team’s provision of comprehensive services and continuity of care. The OCFP and our Shared-Care Partners, intends to develop a “Shared-Care” Network to support “Brian’s Law” and the establishment of a brief community-based Mental Health delivery system. Family Physicians are also ideally positioned to treat mentally ill individuals at all ages along the spectrum – from children and adolescents to elderly persons.

2.0 Program Description

2.1 Family Physicians – Major Providers of Mental Health Services

It is often assumed that Psychiatrists are the major providers of mental health services; however, over eighty per cent (80%) of the services provided in Ontario are delivered by Family Physicians. Typically, fifty per cent (50 %) of visits to a Family Physician are due to a mental health problem. Nine out of ten cases can be effectively managed by the Family Doctor and only one in ten requires a referral to a Psychiatrist. In most communities, reduced access to psychiatric consultation means that Primary Care Physicians are dealing with Major Mental Illness or patients suffering from concurrent disorders. In other communities, patients may be viewed as “difficult-to-serve” and referred inappropriately to Psychiatrists for primary mental health services. The reluctance to accept these patients back into practice places inappropriate burdens on a specialty experiencing shortages and increased workload.

The relative shortage of Psychiatrists in the province, and significant geographical and functional distribution problems, have reduced access to consultative services at the time when such services are most required. As we move toward increased care in the community and the establishment of Community Treatment Orders, the need for Psychiatrists will only increase unless system changes are made to more effectively utilize this increasingly scarce resource.

2.2 The Split-Care Model

Currently, referrals to Psychiatrists are difficult to obtain and much valuable time is spent by Family Physicians searching for consultative services. If a Psychiatrist referral is available, the relationship between the Psychiatrist and Family Doctor often leads to less than optimum care. The current collegial relationship has been referred to as “Split-Care”. Once the patient has been referred to the Psychiatrist, treatment delivery generally takes place between the patient and the Specialist in relative isolation from the Family Doctor. Family Medicine should be offering patients access to comprehensive services and continuity of care. The “Split-Care” model reduces the likelihood that the patient will receive co-ordinated holistic care.
After hours care is often compromised by the Family Physician’s lack of access to the psychiatric treatment plan. Likewise, other health problems that may have an impact upon the mental health regime are often not shared with Mental Health professionals providing psychiatric care and support. In addition to being an inefficient way to utilize scarce specialty resources, the Split-Care model decreases the Family Doctor’s ability to deliver effective care. This inability makes it more difficult to transfer even relatively stable patients back to their Family Physicians. As a result, Psychiatrists are often inundated with the primary care of patients who could be handled quite comfortably by Family Physicians. Psychiatrists are therefore, unable to accept referrals to patients in crisis. The “Split-Care” model does not reflect the trend towards integration of services and this problem needs to be addressed in conjunction with Mental Health and Primary Care Reform initiatives.

2.3 The Shared-Care Model

To provide effective care for patients, “Shared-Care” arrangements between Family Physicians, GP Psychotherapists and Psychiatrists need to replace the current “Split-Care” model. “Shared-Care” is being implemented provincially and nationally as a means of overcoming the difficulties inherent in the current mental health care delivery model. “Shared-Care” is essential as we move towards community-based service models that include the use of community-treatment orders.

The “Shared-Care” model provides Psychiatrists and Family Physicians with the opportunity to collaborate with patients and their families to develop a treatment plan and to appropriately define the respective roles of each healthcare professional. In the case of seriously compromised patients, the Psychiatrist may assume the “most responsible physician” role, but the contribution of Family Medicine will ensure that continuity of care is maintained. Stable patients who have diagnoses within the competency of the Family Physician will remain his or her primary responsibility while the Psychiatrist will provide services, as required.

This model of care enhances the delivery of service by providing patients, their families and health care professionals with the means to a clear agreement regarding treatment and a well defined delineation of responsibilities. Continuity of care and optimal treatment are more likely and missed opportunities for treatment reduced as communication is improved. By utilizing the skills of Psychiatrists more effectively, access to specialty services is enhanced. By providing effective back up to Family Physicians, their ability to deliver appropriate mental health services is expanded.

Shared-Care provides opportunities to release patients from inpatient care earlier as it increases the confidence of Family Physicians to provide the necessary level of care. Effective patient monitoring results in reduced admissions and length of hospital stay.

Mrs. T. wouldn’t come to see me so that I could monitor her psychiatric drugs, but I got her to come in every week for a blood pressure check. It works. I kill two birds with one stone.

- Dr. W., Family Doctor
2.4 Mental Health Act/Community Treatment Orders

In many communities throughout Ontario access to Psychiatrists is severely limited. The shortage of Psychiatrists is further compromised by a significant distribution problem. The majority of Psychiatrists are clustered in the larger urban centres, especially those with academic health institutions. In addition to the geographic maldistribution, many Psychiatrists are functionally unavailable or unable to accept referrals due to the demands of private practice. The remaining Psychiatrists feel overwhelmed by their current workload and have concerns regarding the potential workload implications that may result from changes to the Mental Health Act. Many psychiatrists fear that the development, issuing and monitoring of adherence to Community Treatment Orders will overwhelm current psychiatric resources.

In rural and remote communities access to psychiatric services is compromised by the distance to care. “Shared-Care” provides an opportunity to stretch scarce psychiatric resources further. By developing Community Treatment Orders in consultation with a Psychiatrist, Family Physicians would be able to resolve access to care issues and would be in a better position to provide effective monitoring of adherence to the CTOs. The shared responsibility would decrease pressures for both disciplines.

2.5 Case Management

Case management is seen as a critical element of community care; however, there are a number of problems with this model. The case management role typically falls to community mental healthcare workers. Patients require the commitment of a case co-ordinator to serve over an extensive period. Co-ordination must take place irrespective of where care is required – in the hospital, at home, in hostels, community clinics or on the street, if necessary.

In the current system, fifty per cent (50%) of mental health workers move to another position within one year and are unavailable to establish a long-term relationship. Bureaucratic barriers between institutions and the community prevent case managers from following the individual throughout the system. Seventy per cent (70%) of persons with Severe Mental Disorders also have one or more significant physical illnesses. Often, these illnesses do not receive the attention they deserve for a number of reasons. This lack of attention may be due to patient fears or suspicions of health care workers. It may be due to the case managers heavy caseload, or to a lack of skill in meeting the physical, as well as the mental health needs of these patients, including alcohol, drug and tobacco addictions.

The model of healthcare delivery provided by Family Medicine has a distinct advantage over the current case-management model. Surveys repeatedly identify the Family Physician as the healthcare professional viewed most helpful by patients who have been diagnosed with serious mental illness. As the Family Doctor sees the patient and their family members from cradle to grave, a relationship of trust develops over time. As Family Physicians guide the patient and the family through significant life events, a bond develops that is key to effective case management. The artificial barriers that prevent community-based providers from providing care in institutional settings are not an issue for the patients' own doctors. Moreover, Family Physicians have the knowledge and skills to address the entire healthcare needs of the patient.
The Shared-Care model should be integrated with Assertive Community Treatment Programs and Psychogeriatric Outreach Programs in order to be effective and to build upon the trusting relationship established between the Family Doctor and the patient. Mental Health workers should be included in the Primary Care team to provide patients with the continuity of care not available within the current fragmented system. In addition to Psychiatric expertise, Family Physicians and their patients need to be directly linked to the Assertive Community Treatment Teams and the Psychogeriatric Outreach Teams, and Child and Adolescent Mental Health Programs.

By enhancing the role of Family Physicians in the delivery of Mental Health services and providing appropriate back up from Psychiatrists and community-based service providers, the positive impact of the Mental Health Reform initiatives can be realized.

3.0 Work Plan: Project Overview

The Ontario College of Family Physicians, in conjunction with St. Joseph’s Health Centre, Toronto, Hamilton and Wentworth HSO Mental Health and Nutrition Program, North York General Hospital in Toronto, Homewood Health Centre in Guelph, University of Toronto, Faculty of Medicine – Department of Community and Family Medicine and McMaster University, Faculty of Health Sciences, Department of Family Medicine would like to develop a “Shared-Care Network” that extends the reach of Psychiatry to smaller and remote communities to provide better care for patients with psychiatric disorders.

3.1 Steering Committee

The OCFP has established a Steering Committee to oversee all aspects of development of this project. The Steering Committee consists of representation from each of the partnering organizations and other physicians with specific interests and expertise in Shared-Care and the Mental Health System (see Appendix A).

3.2 Preparatory Phase

In preparation for this proposal, the Committee has conducted a Needs Assessment to identify the learning and service needs of Family Physicians in the area of Mental Health. This assessment confirmed previous indications that access to psychiatric services is difficult and identified educational needs specific to Family Physicians (see Appendix B). The partners (institutions outlined in 3.1) also actively participated in the first National “Shared-Care” Conference in June and worked to further define the direction of Shared Care through open discussions with colleagues and policy makers across Canada. Qualities required for effective mentoring and rights and responsibilities of mentors and mentees are being researched. This work will be used to evaluate the relative strengths of the applications for mentors and mentees. Consultation with the College of Physicians and Surgeons and the Canadian Medical Protection Association has occurred to address and reduce concerns regarding potential physician liability in Shared-Care practice.
3.3 Call for Shared-Care Network Members

The Steering Committee will issue a call for 10 Psychiatrists interested in participating in the “Shared-Care” project. To date, a number of Psychiatrists have come forward and are interested in participating. The call for participants is expected to attract more than the required numbers. The proposed mentees will be evaluated using the mentor criteria and the ten most appropriate mentors will be selected. A second call will be issued to ninety (90) Family Physicians, especially those working in remote, rural and smaller communities where access to psychiatric services is limited. A third call will be issued to the (10) GP Psychotherapists. Each Psychiatrist will be paired with nine (9) Family Physicians and 1 GP Psychotherapists.

3.4 Shared-Care Workshop

The Steering Committee will develop a facilitated workshop to introduce the participants to the Shared-Care model and to changes within the Mental Health Act that will affect practice. The workshop will provide each Psychiatrist with an opportunity to meet the ten Family Doctors/GP Psychotherapists assigned to him/her. Time will be set aside for each group to discuss effective communication strategies (telephone consults, e-mail, office consults, visiting specialists schedules, etc.) The participants will also be provided with guidance and advice on the establishment of collaborative relationships and methods to better align the “Shared-Care” relationships with local community Mental Health providers. This workshop is expected to reduce barriers to communication and enhance rapport between the mentors and mentees thus leading to a positive and effective mentoring relationship.

3.5 Program Requirements

It is anticipated that each Psychiatrist will devote an average of two hours per week to this project. Funding will be required to support this work on an ongoing basis. A variety of funding options are currently available and need to be investigated on an individual basis.

A follow-up workshop will be required to address system and educational needs of the involved physicians. To improve cost efficiency, the workshop will be held in conjunction with the OCFP's Annual Scientific Assembly. Fifteen Family Physicians will be specifically trained as Peer Presenters in Mental Health. These Peer Presenters will provide CME throughout the province to increase awareness amongst all Family Doctors of the changed Mental Health legislation, as well as clinical updates in Mental Health.

3.6 Network Support

The Steering Committee anticipates that each region of the province (Northern, Georgian, Southwestern, Eastern, Southern and Toronto) will be represented in the Network. The Steering committee will support each region by acting as “expert consultants” to address both system and practice issues as they arise. The committee will also investigate the availability of Information Technology, including telehealth, e-mail consultations, Electronic Medical Records and computerized CME programs, clinical guidelines and access to informational databases. The
“Shared-Care” program will proceed more effectively if technological connectiveness is in place, especially in connecting remote areas of the province with Specialty services. As Primary Care Enhancement (PCR) takes place, the technology and support for this program will be more readily available, but efforts will be made to speed up this process for program participants.

3.7 Project Rationale

This project will improve continuity of care and service delivery for patients with Major Mental Illness especially in rural communities where there are scarce Specialist resources. The system changes will ultimately have a major impact on how services are coordinated in Ontario and Canada between Family Doctors and Specialists. This is vitally needed in light of the shift from institutional to community-based care for this patient population. The success of this project will establish “Shared-Care” as a model of delivery for Specialty services generally in this province. This program is the first of its kind to pair CME with a system change to better support the delivery of comprehensive care for patients with Mental Illnesses including other disorders such as Addictions and HIV/AIDS. As such, it is a model for changing the relationship between Family Medicine and all Specialists. The program supports Primary Care and Mental Health Reform initiatives by emphasizing the key role of Family Doctors in providing care in a “Specialist” supported framework. The proposal reflects the position paper recently developed by the College of Family Physicians of Canada and the Canadian Psychiatrists Association and will assist with the implementation of the Community Treatment Orders.

3.8 Project Benefits

This project is aimed at Family Doctors; however, the goal of the project is to provide comprehensive services and continuity of care for patients with Mental Illnesses including Addictions by:

1. Developing a Continuing Medical Education (CME) program to prepare Family Doctors to take a more active role in providing care for patients with severe Mental Disorders.
2. Developing a network of Specialists and Family Doctors providing services through a “Shared-Care” collaborative model.
3. Providing support, education and mentoring for Specialists and Family Physicians interested in developing a collaborative practice
4. Supporting system changes to facilitate a “Shared-Care” delivery system.

The program will develop the “Shared-Care” model and will leave a legacy that will continue to provide excellent care for these vulnerable patients.

3.9 Outreach Mechanisms

Effective Patient Care cannot be delivered without knowledgeable and skilled physicians. Access to care for Mental Illnesses is restricted in many communities throughout Ontario. By training physicians in these communities and linking them through a “Shared-Care” network to Specialists, people in remote, rural and smaller communities will have improved access to care.

This is a Peer Presenter Program that will ultimately train physicians from these communities who will then return to their own regions and provide educational programs for their peers.
The program will include ready access to Specialists. This component may include a face-to-face “visiting Specialist” program, a regularly scheduled teleconference and email communications and website to better link Family Doctors and Specialists.

3.10 Project Partners

The Ontario College of Family Physicians will be working with the following partners whose roles are as follows:

- **The Ontario College of Family Physicians** will take a lead role in overseeing all aspects, especially the Peer Presenter Program.

- **The Homewood Health Centre**
  
  Dr. Graeme Cunningham  
  Director  
  Homewood Addiction Division  
  150 Delhi Street, Guelph, Ontario N1E 6K9

  - The Homewood Health Centre will provide leadership in developing the curriculum related to Addiction Services, as well as identifying Specialists in Addiction Management to participate in the “Share-Care” program.

- **University of Toronto**
  
  Dr. Walter Rosser  
  Chair, Department of Family and Community Medicine  
  University of Toronto  
  620 University Ave., 8th Floor, Toronto, ON M5G 2C1

- **McMaster University**
  
  Dr. Cheryl A. Levitt  
  Chair, Department of Family Medicine  
  Faculty of Health Services  
  McMaster University Medical Centre  
  1200 Main Street West, Room 2V11  
  Hamilton, ON L8V 3Z5

  - These universities will assist the evaluation of the model and provide expert advice regarding the system changes needed to support the “Shared-Care” model. Both Departments of Family Medicine will assist with curriculum design for the Conferences and Workshops.

- **St. Joseph’s Health Centre Toronto**
  
  Dr. Ty Turner  
  Medical Director/Mental Health Program  
  Chief, Department of Psychiatry  
  St. Joseph’s Health Centre  
  30 The Queensway  
  Toronto, ON M6R 1B5
Hamilton Wentworth HSO Mental Health & Nutrition Program

Dr. Nick Kates
Director
40 Forest Avenue
Hamilton, ON L8N 1X1

- Physicians from these hospitals have expertise in working in a “Shared-Care” model between Psychiatrists and Family Doctors. They will provide the leadership in developing the “Shared-Care” network.

North York General Hospital

Dr. Thomas Ungar (consultant)
Psychiatrist
North York General Hospital
4001 Leslie Street
North York M2K 1E1

Canadian HIV/AIDS Mentorship Program (CHAMP)

Mr. Rob Throop
Sunnybrook Health Sciences Centre
2075 Bayview Avenue
Toronto, ON M4N 3M5

- This federally supported organization is already working with the Ontario College of Family Physicians to address the educational needs of Family Doctors in regards to HIV / AIDS expertise and in mentoring Family Doctors caring for HIV / AIDS patients.

3.11 Project Timelines and Key Milestones

Preparatory Phase (June, 2000 to September, 2000)

- Establish Steering Committee
- Needs Assessment
- Establish criteria for mentors and mentees in program

Organize Network (October, 2000 – February, 2001)

- Call for Mentors and mentees
- Review CVs and choice participants
- Develop curriculum for facilitated workshop
- Host workshop

Support Developing Networks (March, 2001- June 2001)

- Identify communication system and technological support
- Organize meetings, teleconferences, e-mail communication system and website

- Identify Education needs
- Develop and Provide Peer Presenter Program
- Troubleshoot and provide system and clinical guidance


Physician and Patient/Family satisfaction
- Outcome Measures: Study Group versus Central
  - Increased complexity of care by FP
  - Decreased number of stable patients care by Specialists
  - Decreased number of re-admissions and shortened lengths of stay

Revise Program (November, 2003)
- Using evaluation results, implement quality improvement.

Funding will support the work of a conference coordinator and a research assistant. The conference coordinator will assist with the educational activities and the research assistant will assist with evaluation of the project.

The Executive Director of the Ontario College of Family Physicians will manage the work by overseeing the staff and supporting the work of the steering committee. This work is in keeping with other Peer Presenter programs developed by the Ontario College of Family Physicians.

3.12 Projected Results

The major success of this project will be seen in an increased number of Family Doctors willing to care for these “hard-to-service” patients, as well as patient and physician satisfaction with the model of care delivery. The project will demonstrate that patients are provided with comprehensive service and continuity of care in a manner that decreases reliance on Specialists for direct care while maintaining adherence to “best practice” treatment regimes. The University of Toronto and McMaster University will help to formally evaluate the project results by providing a tool for objectively measuring comprehensive services and continuity of care such as number and type of visits to the Family Doctors versus Psychiatrists, number of Emergency Department visits, and hospital admissions pre and post intervention and a change in length of hospital stay. Patient outcomes will be monitored with respect to GAF scores, compliance with treatment regimes, patient satisfaction, decreased time to treatment and reduced treatment costs.

This project will lay the groundwork for a new model of delivery in Ontario. The model has had an effective trial in Hamilton and Toronto, and many Family Doctors are already managing patients in keeping with the model. However, the model needs to be developed to better serve remote, rural and small communities. Once, the network is in place, it will be self-sustaining as evidenced by the commitment to the model by physicians currently engaged in “Shared-Care” practices. Once the model is established with the original on hundred Family Physicians, a further hundred will be enrolled. This method of rolling out in teams of 10 / 100 will continue until all physicians in the province are part of the “Shared-Care” model. Decreased MOH LTC costs may accrue in light of this cost-effective model of care that is expected to reduce visits to the ED, readmission to hospital and decreased length of stay.
3.13  Province-Wide Impact

The intent is to engage a select group of Family Physicians from all parts of the province who will then train their peers to allow province-wide access to the program. By so doing, patients with Mental Illnesses including Addictions will have better access to quality care as close to their communities as possible.

3.14.  Research & Educational Potential

This project builds upon the recommendation in “2000 and Beyond: Strengthening Ontario’s Mental Health System” Ontario Ministry of Health Position Paper of June 1998 by providing the education and system support so that “Shared-Care” can be more widely practised throughout the province. This project will provide the province with the information needed to support on-going changes in service delivery and medical education to support a “Shared-Care” model of delivery. Currently, Family Physician Residents and Psychiatrists tend to be trained in isolation. If the model is successful, it will have a major impact on medical school education, the continuing medical education of doctors throughout the province in the country and the delivery model used by Family Doctors and Specialists throughout the province.

3.15.  Demonstrated Project Management

The Ontario College of Family Physicians (OCFP) is a chapter of the College of Family Physicians of Canada. The Ontario College was established in 1954 to oversee the establishment of standards of practice in Family Medicine Residency Programs across Canada. For almost fifty years, the OCFP has maintained high standards of practice and education in Family Medicine. The OCFP is the voice of over 6,000 Family Doctors in Ontario. The OCFP has seven years experience developing Peer Presenter Programs. Our experiences are positive. Each Peer Presenter Program has dealt with a sensitive patient population (HIV / AIDS, Sexual Assault / Spousal Abuse, Complementary & Alternative Medicine, Environment & Health, Healthy Child Development, and Pain & Symptom Management in Palliative Care). Each program has been received enthusiastically by our members and evaluations reveal that practice patterns change as a result of the programs. Our clinical partners have experience in “Shared-Care” and have successfully improved patient care as a result of collaborative care practices (see Bibliography). The Research Components will be effectively managed by the combined efforts of U of T and McMaster.

The monitoring and evaluation of results will be undertaken jointly by McMaster University and University of Toronto. The following results will be included in the review process:

1. Evaluation using the College of Family Physicians of Canada (CFPC) MAINPRO®–C process to determine the practice impacts of the Peer Presenters
2. Evaluation of quality of the Peer Presenter Workshop by physician attendees in keeping with the CFPC MAINPRO®–M1 process
3. Patient and Physician satisfaction surveys pre and post to determine the level of satisfaction with the “Shared-Care” approach vs. current referral system
4. Increase in the number of patients seen by Family Physicians in consultation with Specialists and decrease in the number seen by Specialists only.
The results of this project will be shared federally and provincially amongst the Ministries of Health. The results will be published in the *Canadian Family Physician*, *Hospital Quarterly* and other partner publications. The project lends itself to media interest. Papers based on our findings should be released approximately three months following the evaluation phase.

Appendix A
STEERING COMMITTEE

Dr. Patricia Rockman  Ontario College of Family Physicians (Chair)
Ms. Jan Kasperski  Ontario College of Family Physicians
Dr. Graeme M. Cunningham  Homewood Health Centre
Dr. Walter Rosser  University of Toronto, Faculty of Medicine, Department of Community & Family Medicine
Dr. Cheryl Levitt  McMaster University, Faculty of Medicine, Department of Family Medicine
Dr. Ty Turner  St. Joseph’s Health Centre, Toronto
Dr. Nick Kates  Hamilton & Wentworth HSO Mental Health & Nutrition
Mr. Rob Throop  Canadian HIV / AIDS Mentorship Program (CHAMP)

OCFP Shared-Care Sub-Committees

HIV / AIDS
Dr. Brendan Dempsey  Chair, CME Committee
Dr. Jeff Bloom
Dr. Mark Dube
Dr. Annette Richard
Mr. Rob Throop

Mental Health Mentorship
Dr. Patricia Rockman*  Chair
Dr. Doug Bates
Dr. Greg Dubord
Dr. Pamela J. Johnson
Dr. Bryan Moran
Appendix B
The Ontario College of Family Physicians (OCFP) is a voluntary, not-for-profit association which promotes the Principles of Family Medicine in the province of Ontario. OCFP represents about 6,000 Family Physicians providing care for remote, rural, suburban, urban and inner-city populations in Ontario. We are a provincial chapter of a national organization, the College of Family Physicians of Canada (CFPC) whose broad mandate includes undergraduate, post-graduate and continuing medical education of Family Doctors and the maintenance of a high standard of practice. The College was founded in 1954 to develop standards of practice in Family Medicine and to oversee the establishment of Family Medicine Residency Programs in each of the 16 university medical schools across Canada. We have remained close to our original roots over the years (leadership, advocacy, education and research). The Ontario College of Family Physicians is fully prepared to work with partners in developing, implementing and evaluating a Shared Care Network for Ontario.

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Enhancing Mental Health Services in Ontario

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Bibliography


