AM Breakout Room Conversation Notes

Where do you see paitents getting lost to follow up?

Referrals from hospital to public health take time – sometimes there is a month or more delay in getting referrals from hospital to community

In small communities we often rely more on word of mouth

In the city there are lots of groups resources – but they depend on people to attend.

There is some discontinuity in care – nursing shortage contributes to loss of follow up

What kinds of collaboration have you tried for PP depression?

- Central referral is being used in Winniepg
- Often times the referral means a transfer of care rather than a collaboration of care
- Refer to mental health
- PCPs can work with public health, mental health, "Families First" programing
- White Raven Healing center
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How could we improve the transition from maternity to primary care?

- There is lots of delay in getting reports from hospital to PCP and public health

How can we reach the clients with depression who don't report for care?

- Very difficult
- Normalizing PP depression occurrence to clients and their support people. Sometimes it is partners or parents, or friends who encourage clients to reach out for care. Important to have the conversation about PP depression with the client's "village" as well if possible

Integrating mental health & addictions - essential to “meet people where they are at”

Barriers to collaboration:

1. Provider hesitancy - don’t know what the community programs are
2. Referrals go only one way - PCP to specialist. It can’t reciprocate.
    - 3-4 weeks in delay with a mental health referral can be a huge gap - that enough time for moderate symptoms to be come severe, or severe to become suicidal
3. Program disruption in the pandemic still hasn’t fully recovered.
4. Patient hesitancy since the pandemic - lack of trust in medicine at large. Vaccine reluctance can be a barrier.

5. Parental overwhelm - followup appointments are just “one more thing to do” even with mobile visits (feeling pressure to clean first)

Major gap is lack of PCP - postpartum there is lack of follow through, lost momentum with that failure in transfer

Success experiences:
Saturday walk-in clinic for postpartum access to family medicine - more flexibility
Co-located primary and maternity care - Mount Carmel
Co-located psychiatric and maternity care - HSC ACC

WISH LIST:

- More walk-in clinics, extended hours in evenings/weekends
- Co-locate public health RN, dietician, NP, maternity care provider
- Single file EMR so they can all communicate - collectively we can be one team in separate sites; avoids the trauma of retelling
- Move away from colonized model, normalize Indigenous grandmothers/aunties in care team

1. Where do you see patients getting lost to follow up postpartum?

- Not enough education in the medical field re: FASD as a disability and the challenges faced by individuals diagnosed with FASD (e.g. limitations to memory/organization → leading to challenges with showing up for appointments, difficulty accessing/using cellphones or calendar reminders)
    - Medical professionals accessing FASD training - how do we offer this training in an accessible and practical way?
        - CanFASD conference offered (next one = October)
    - Understanding the applications of certain medications to individuals with FASD specifically
    - How to utilize the strengths of the individuals to overcome barriers encountered

2. What kinds of collaborations have you tried in the past for pp Depression?

- Referral to Perinatal Psychiatry (Dr Ashdown)

3. How could we improve the transition of care from maternity care provider to primary care providers? Discharge summaries: discuss.

- The building of personal connections with other HCP also involved in perinatal care → use of Cortex to connect, more informal connections via conferences like this (= starting to recognize each other's names across specialities)

4. Patients with depression often don't present for care - how could we reach those folks better?

- Very flexible times for appointments (acknowledging that individuals with a lot of barriers to care / chaotic lives)
- Outreach Teams as part of primary care clinics to connect with people at their house, arrange transportation

5. Are there teams or specialists that you think are under utilized?

- Midwifery!! Excellent for low risk pregnancy. Follow for 6 weeks pp (a bit longer in special cases).
    - People typically self-refer, and then Midwives will reach out to primary care to try and collaborate on care plans.
    - Midwives would be very excited to have more communication/collaboration with primary care providers ... how do we facilitate this?

6. If funding was no object, how could we change care to improve recognition and treatment of postpartum depression?

1. Routine home visits post-partum - multiple home visits by all HCP on the team ("Coming to people instead of always having them come to us.")
2. Creation of user-friendly resources (posters, online resources) → current resources have so much professional jargon, not fun or simple to use
3. Shared Decision-Making Tool for HCP + clients (for post-partum depression, but also for other perinatal health concerns)