Shared Care Final Project Report

Project Title	Improving the Geriatric Psychiatry Referral Process (SCC4546)
Physician leads	Dr. Carllin Man, Family Physician Lead Dr. Simon Woo, Geriatric Psychiatrist Lead
Project lead	Cindy Young
Date of Submission	January 2024

EXECUTIVE SUMMARY

Background / overview

The *'Improving the Geriatric Psychiatry Referral Process'* Shared Care initiative started in response to challenges expressed by Family Physicians (FPs) who faced difficulties with navigating the mental health system. This project focuses on addressing the needs of older adults aged 65 and above, recognizing there are specific mental health services available for this patient population which differ from the general adult population. Patients of all age groups are triaged in the same system and Family Physicians are uncertain of where their patients get sent to and what services are available. Family Physicians and Geriatric Psychiatrists in the Fraser Northwest (FNW) region came together to collaborate on ways to streamline the referral and communication process for older adults with mental health concerns.

Project Objectives

The objectives of the project was to implement the following activities:

1. Establish a process for Primary Care Providers (PCPs), which include Family Physicians and Nurse Practitioners, to access a quick phone consult from a local Geriatric Psychiatrist
2. Create a Geriatric Psychiatry referral algorithm so PCPs better understand how to navigate geriatric MHSU services
3. Create and implement a referral acknowledgement letter into the communication process
4. Differentiate the referral criteria between geriatric psychiatry and geriatric medicine
5. Create a dementia condition specific care pathway for PCPs
6. Develop an educational series to share resources created from the project and increase PCPs knowledge of tools to support management of patients with dementia

Project Outcomes

This project achieved strong collaboration and engagement among PCPs and Geriatric Psychiatrists with a collective goal of streamlining the referral and communication process. Notably, communication was enhanced by incorporating an acknowledgment letter into the referral process to ensure that providers are informed about the outcomes of their referrals. The group also established a process for PCPs to access a quick phone consult from a local Geriatric Psychiatrist, resulting in decreased barriers in communication. To facilitate connection building and knowledge exchange, 3 workshops were successfully developed with high levels of engagement. The project resulted in the development of the Geriatric Psychiatry Referral Algorithm and the Dementia Care Pathway resources, which are accessible to PCPs at any time through the Pathways website. Overall, the project has been successful in achieving its intended outcomes

INTRODUCTION

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses Family Physicians in New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra representing the catchment area of the Royal Columbian and Eagle Ridge Hospitals. The FNW Division deeply respects and acknowledges the privilege of being able to work on the ancestral, traditional and unceded territory of the Coast Salish Nations, including the Kʷikʷəƛ̓əm (Kwikwetlem) and Qiqéyt (Key-Kayt) nations. The FNW Division remains mindful of the health inequities and are committed to better understand the needs of Indigenous peoples.

The Geriatric Psychiatry Shared Care initiative began in 2019 based on frustrations from Family Physicians around navigating the mental health system for their geriatric patients. Family Physicians shared challenges around providing caring for geriatric patients with psychiatric concerns due to lack of communication about the status of their referrals and unclear of the available resources to support their patients. In the FNW communities, a central intake process exists for mental health services which triages both adults and older adults through the same pathways. This approach can cause delays for patients due to the volume of referrals sent in and the confusion for Family Physicians in not knowing where their patients end up in the system.

This challenge presented Family Physicians and Geriatric Psychiatrists with an opportunity to increase awareness of older adult mental health services to enable providers to make referrals based on the specific needs of their patients. This initiative focused on streamlining the referral and communication process for geriatric psychiatry services, in order to 1) expedite patient access to specialist care and 2) improve communication channels between PCPs and Psychiatrists to enable better coordination of care.

PROJECT OBJECTIVES

Objectives may have changed over time, so include the most up-to-date and relevant information.

The objectives of the project was to implement the following activities:

1. Establish a process for PCPs to access a quick phone consult from a local Geriatric Psychiatrist
2. Develop a Geriatric Psychiatry referral algorithm so PCPs better understand how to navigate geriatric MHSU services
3. Create and implement a referral acknowledgement letter into the communication process
4. Differentiate the referral criteria between geriatric psychiatry and geriatric medicine
5. Develop a dementia condition specific care pathway for PCPs
6. Develop an educational series to share resources created from the project and increase PCPs knowledge of tools to support management of patients with dementia

TARGET POPULATION

The target population for this project included PCPs (Family Physicians and Nurse Practitioners), Geriatric Psychiatrists and older adult patients above the age of 65 with mental health concerns living in the Fraser Northwest communities of New Westminster, Port Moody, Coquitlam, Port Coquitlam, Anmore and Belcarra.

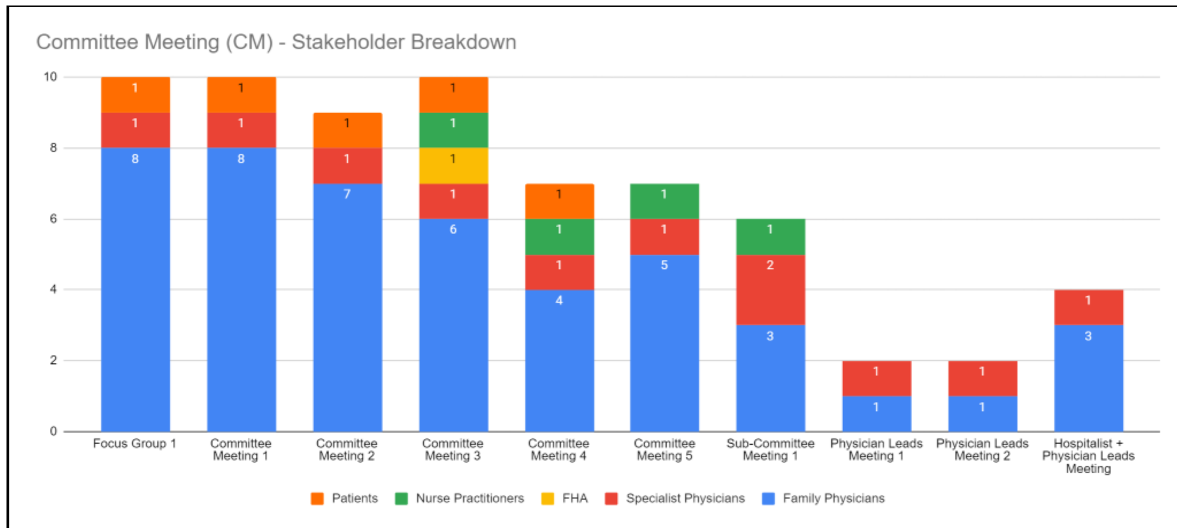
ENGAGEMENT STRATEGY

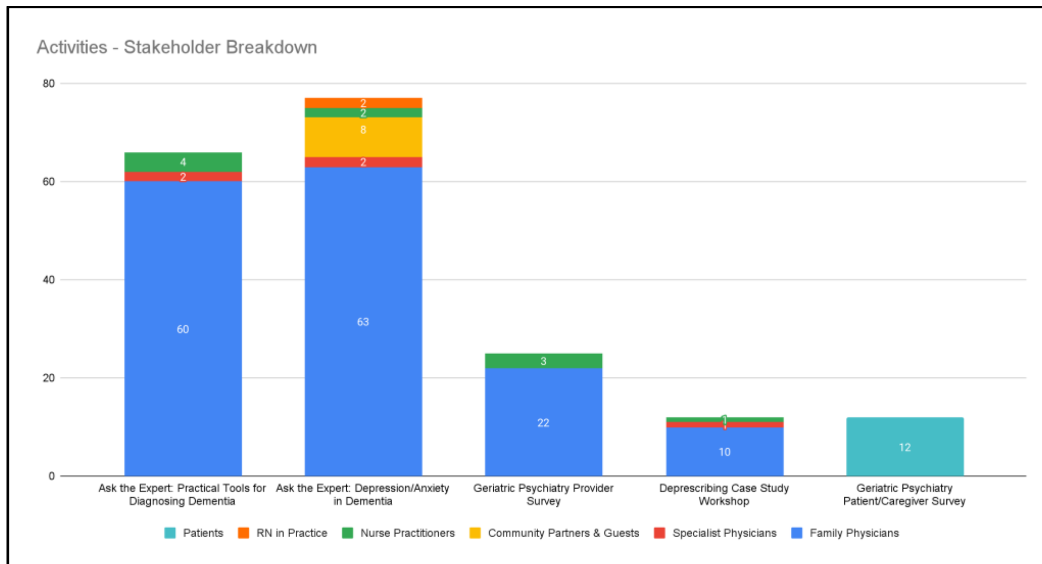
The FNW Division engaged with Family Physicians, Geriatric Psychiatrists and Nurse Practitioners who identified challenges in the community that required collaborative efforts to reach the intended goals. The following individuals and organizations contributed to the success of the project due to their continued collaboration and engagement throughout the project:

Name	Role	Primary Practice Location
Dr. Carllin Man	Family Physician Lead	Burnaby
Dr. Simon Woo	Geriatric Psychiatrist, Specialist Lead	New Westminster
Dr. Sue Rajabali	Family Physician, now retired	New Westminster
Dr. Ian Woods	Family Physician, in memoriam	Port Coquitlam
Dr. Hortensia Shortt	Family Physician	Port Coquitlam
Dr. Tracy Monk	Family Physician	Burnaby
Dr. Kathy Kiani	Family Physician	Coquitlam
Dr. Sang Ko	Family Physician	Coquitlam
Dr. Mahsa Mackie	Family Physician	Coquitlam
Dr. Ramak Shadmani	Family Physician	Coquitlam
Dr. Ashvin Punnyamurthi	Family Physician	Port Coquitlam
Dr. Lalji Halai	Family Physician	Burnaby
Dr. Gene D’Archangelo	Family Physician, now retired	Tri-Cities and New Westminster
Dr. Fahreen Dossa	Family Physician	Burnaby
Annie Liao	Nurse Practitioner	Coquitlam
Dr. Iva Jokic	Geriatric Psychiatrist	New Westminster

Dr. Sharleen Gill	Geriatric Psychiatrist	New Westminster
Debbie Halyk	Patient Partner	-
Jean-Marc	Older Adult Mental Health Team Coordinator, Fraser Health Authority	Tri-Cities and New Westminster

A breakdown of the stakeholder engagement and involvement in committee meetings and project activities are graphed below. The committee meetings were integral in providing a collaborative space for PCPs and Geriatric Psychiatrists to gain a common understanding of the challenges and work towards achieving the project activities. Throughout the project's duration, a total of 6 committee meetings, 1 focus group and 3 physician lead meetings were held. PCPs were highly engaged in the project activities which demonstrates the demand for initiatives of this nature.





DATA COLLECTION ACTIVITIES

The evaluation approach was conducted through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Qualitative data was collected from surveys and interviews with physicians, specialists, stakeholders, patients, and program administrators. The data collected has a developmental lens that focuses on continuous quality improvement and links back to the overall Shared Care goals.

RESULTS / DATA MATRIX

The work of this project and its subsequent evaluation are to focus and improve the following key attributes:

- Shared Care Project Goals
- PMH Attributes
- PCN Attributes
- Quadruple Aim

The evaluation has two main objectives and their subsequent evaluation questions below:

1. **To evaluate the effectiveness of the Geriatric Psychiatry Shared Care Initiative in the Fraser Northwest community**
    a. To what extent does the program contribute to increased confidence, satisfaction and communication between Primary Care Providers and Psychiatrists?
    b. To what extent does the program contribute to improved patient access to specialist care?
    c. To what extent does the program contribute to improved health outcomes for patients seeking care?
    d. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?
2. **To identify areas for quality improvement and document lessons learned**
    a. What were the unanticipated outcomes of the proposed strategies?

PROJECT ACTIVITIES & DELIVERABLES

Addressing Communication Gaps:

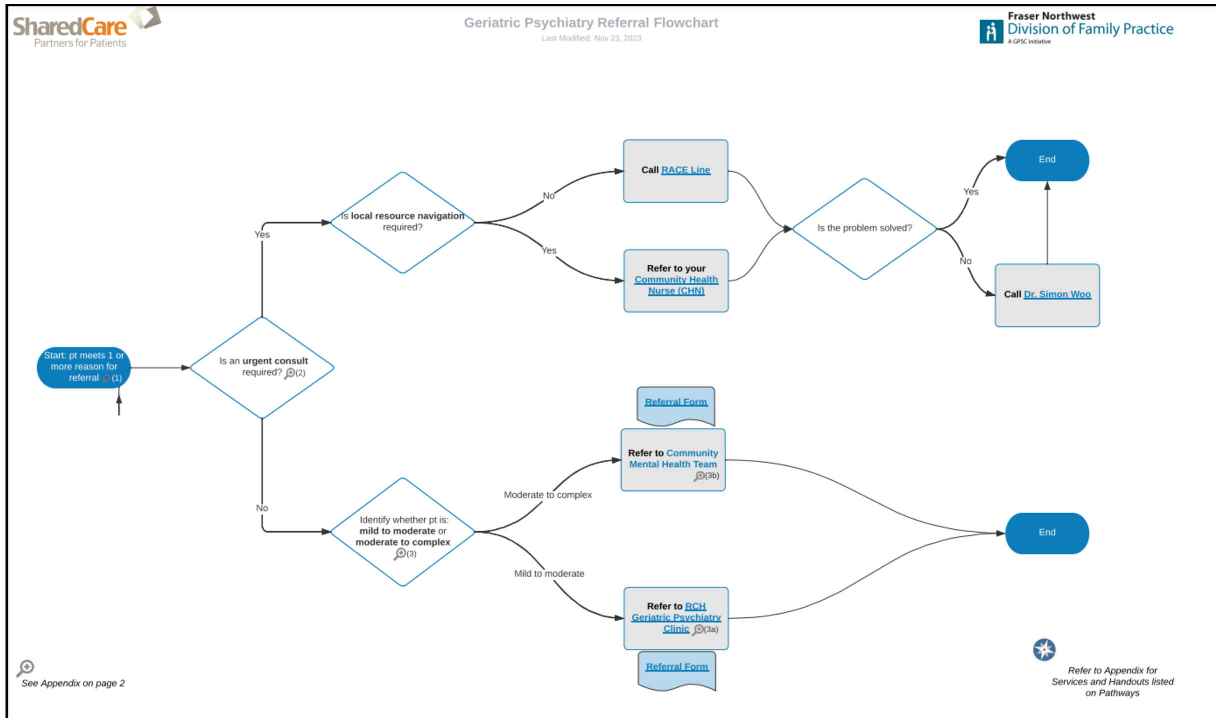
PCPs voiced the need for a quick consult from local Geriatric Psychiatrists as sometimes a full referral is not needed and wait times can be long. One of the first suggestions brought forward by the committee was to create an on-call consult line for PCPs to access. However, due to the limited number of Geriatric Psychiatrists in the region and a lack of capacity, this was not a feasible solution. The project's Geriatric Psychiatrist Lead, Dr. Simon Woo, thought it was important to reduce barriers in communication for PCPs to mitigate the need for a referral if not necessary. As many PCPs use Pathways, Dr. Simon Woo posted his personal phone number on his Pathways profile for a quick informal consult or advice. PCPs could call or text their questions to Dr. Woo and the average response time is the same day. In 2023, Dr. Woo has also activated the new messaging feature that is available on Pathways, whereby PCPs can send a message or question to him.

Additionally, another communication gap that was brought up was that PCPs are unsure of what happens to their referral to the Royal Columbian Hospital (RCH) Geriatric Psychiatry clinic. The physician leads took the initiative to develop a referral status letter, which was implemented in February 2021 and led the way to implement such letter in the rest of psychiatry services at the health authority. The unit clerks at the clinic have integrated this process into their workflows which resulted in improved communication to PCPs. Please see Appendix 1 for an example of the letter.

Creation of a Referral Algorithm:

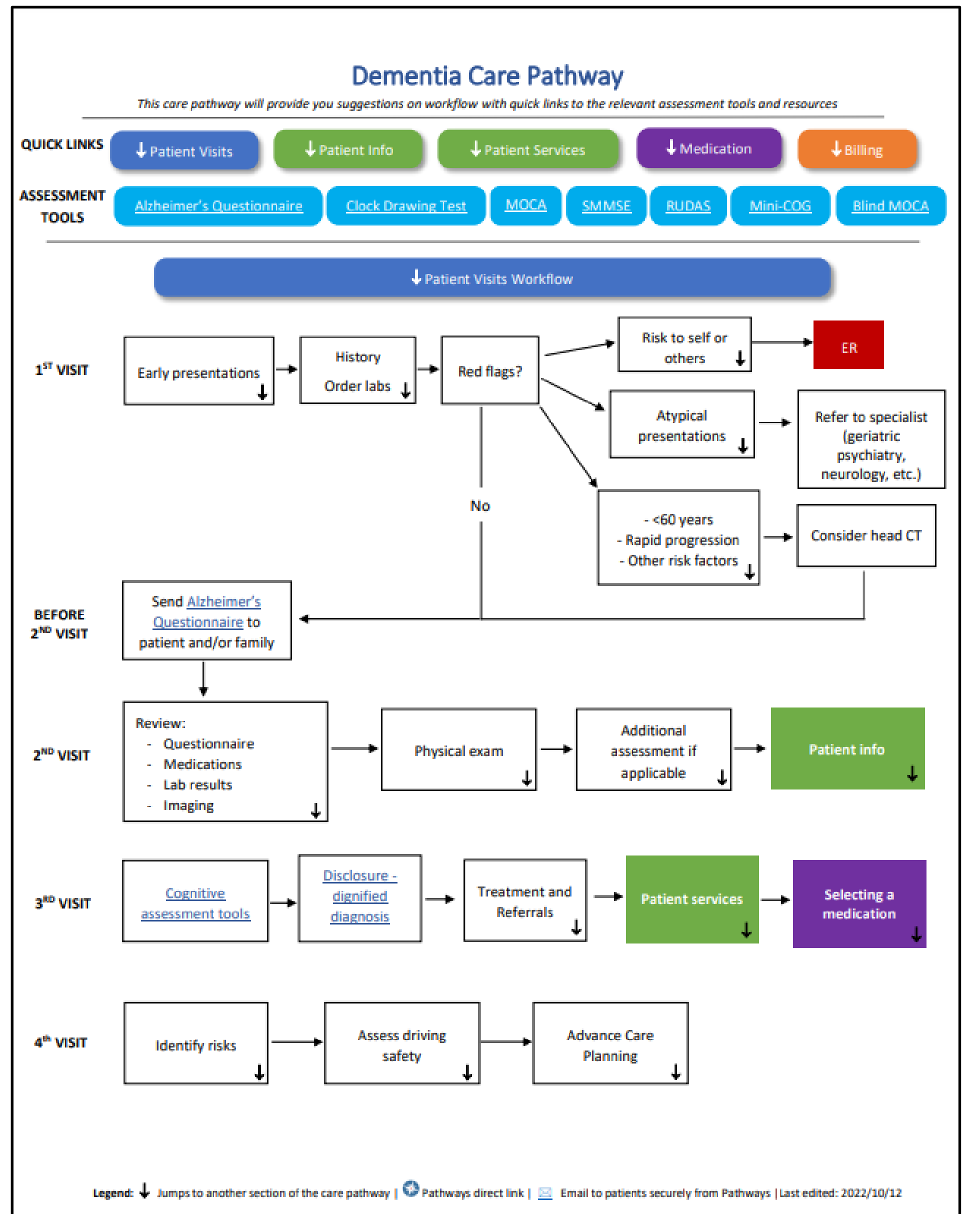
Given the diversity of mental health needs by this patient group, the committee developed a Geriatric Psychiatry Referral Algorithm in hopes of increasing PCPs understanding of how to navigate geriatric mental health services. The intent of this resource was to help clarify the differences between services and help determine which patients would be best suited for each service depending on their needs to avoid unnecessary time delays between trying to find the most appropriate place to refer. Additionally, PCPs mentioned confusions between not knowing when to refer to geriatric psychiatry versus geriatric medicine, which was incorporated into the appendix of the resource.

The referral algorithm was demonstrated to PCPs during the education workshop series, shared on Pathways and through newsletter communication. The resource received varied utilization, with 43% of PCPs stating that they do not use the resource and 48% of respondents saying they do after attending the educational workshops. Since April 2022, there’s been a total of 81 page views to this resource from PCPs in the FNW region on Pathways. Please see the evaluation plan section below for more information.



See [Appendix 2] for the full resource or [click here to view the resource on Pathways].

Creation of a Dementia Care Pathway:



After creating the Referral Algorithm, the committee thought there was still a gap since the resource did not include what happens prior to making a referral. Hence, creating a condition specific pathways for clinical use was recommended. Based on feedback and demand from Family Physicians, a care pathway specific to dementia was created. Members from the committee were recruited to form a sub-committee to create a draft. The sub-committee aggregated information from well known organizations, such as the Centre for Effective Practice, the Fraser Health Authority (FHA) and the Guidelines and Protocols Advisory Committee and distilled the information into a practical format based on a recommended number of patient visits in the PCPs office. The resource contains key messages, assessment tools, red flags and patient information and services. See Appendix 3 for the full resource or click here to view the resource on Pathways.

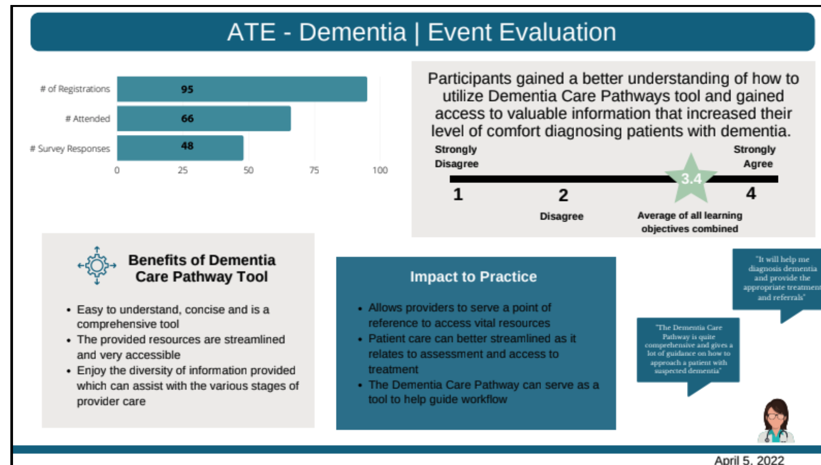
The resource has been demonstrated through case studies during the educational workshops. Additionally, the resource has been shared provincially on Pathways and in the Division's Dispatch to reach a wider audience. Similar to the Geriatric Psychiatry Referral Algorithm, this resource received varied utilization among PCPs. 40% of PCPs stated that they do not use the resource and 50% of respondents stated they used the resource in various frequencies after attending the educational

workshops. Since April 2022, there's been a total of 326 page views to this resource from PCPs in the FNW region on Pathways. Please see the evaluation plan section below for more information.

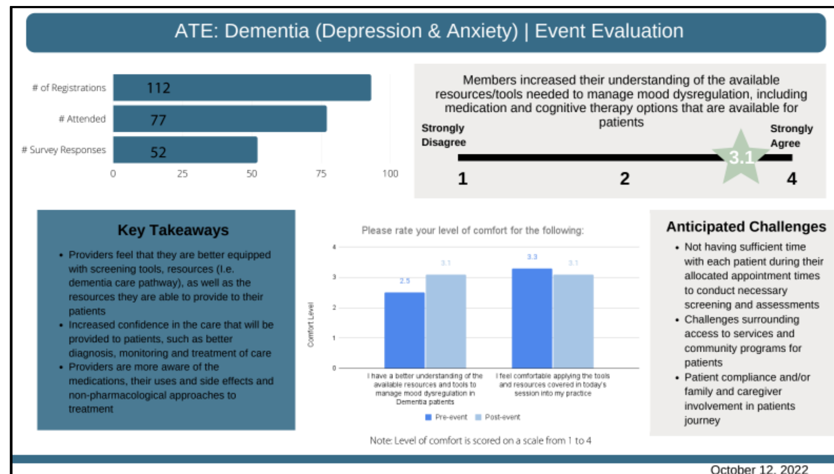
Development of Educational Workshops:

Feedback from PCPs showed confusion around managing patients with mild-cognitive impairments and dementia since these conditions can be seen by both geriatric medicine and geriatric psychiatry. A two part series on dementia was developed to provide clinical education and to clear up the referral criteria. Workshops were held virtually through Zoom to decrease barriers in attending.

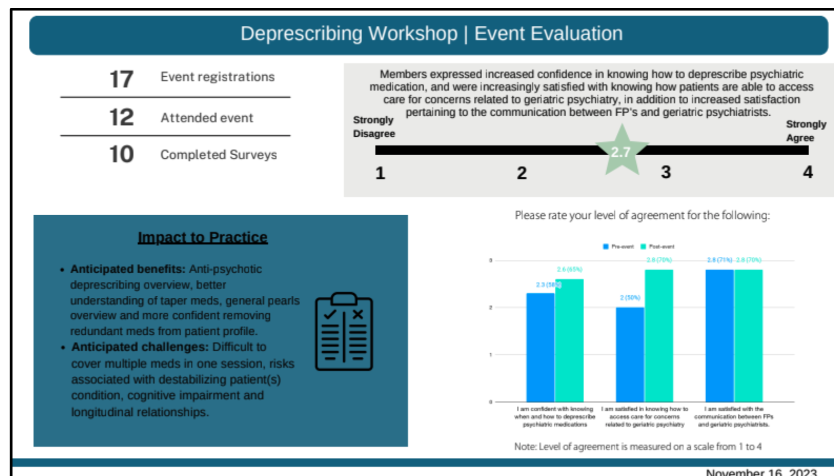
A total of 66 providers attended the first workshop, **"Practical Tools for Diagnosing Dementia"** on April 5, 2022. Participants reported an average of 85% in agreement that the workshop provided valuable information and resources related to Dementia to help providers diagnose patients with Dementia. The visual below provides an overview of the feedback from attendees.



The second workshop, **"Depression and Anxiety in Dementia"** on October 12, 2022 saw an increase in engagement with 77 providers in attendance. Before attending the workshop, participants reported an average score of 56% in agreement that they had a good understanding of the available resources and tools to manage mood dysregulation in Dementia patients. After attending the workshop, there was an increased score of 80% of participants agreeing. The visual below provides an overview of the feedback from attendees. A total of 30 providers attended both dementia workshops. These workshops provided knowledge sharing and allowed local Family Physicians and Geriatric Psychiatrists to be familiar with each other.



A third workshop, **“Deprescribing in Older Adults”** was held virtually on November 16, 2023. The intent was to go through case studies in a small group to encourage participation. A total of 12 providers attended the workshop and we saw high levels of engagement which was our intended outcome with having a smaller group. In the pre and post survey responses by attendees, there was a slight increase in participants' understanding of knowing how to deprescribe psychiatric medications and how patients are able to access care for their geriatric psychiatry concerns. The visual below provides an overview of the feedback from attendees.



LESSONS LEARNED

What Went Well:

With strong physician leadership and collaborative efforts within the committee open to change, this project was quick to respond to feedback and implement necessary changes. Collegiality among providers in the committee were built through being open to hearing and sharing challenges with each other in committee meetings. After hearing the challenges experienced, improvements in communication were made quickly. A referral status letter was implemented in the referral process and a low barrier method of contacting the Geriatric Psychiatrist lead was developed. The referral status letter was eventually implemented in other psychiatry services across the health authority as well. The committee also made steady progress in developing resources tailored to the needs expressed in committee meetings and feedback from PCPs. Through developing these resources, the committee members also benefited from an increased awareness of how to navigate the mental health system and what resources are available to support their patients, which was also shared to those who attended the educational workshop series.

Challenges and Gaps:

Although the educational workshops were a success, it will be difficult to sustain the information that has been shared and recorded as information may go out of date. Ongoing opportunities for knowledge and information sharing are needed, whether for new providers who join the community or to update existing provider’s knowledge.

The project also experienced challenges with data collection due to limited access and authority. For future projects, it is important to engage with stakeholders who are aware of what data the project needs and a commitment to share data. We would strongly recommend initiating data collection early on in the project lifecycle and identifying and building relationships with stakeholders such as health authorities who can provide access to shared data.

Additionally, although there were high levels of engagement among physicians, more consideration and efforts to engage various stakeholders who are a part of the bigger health care system such as FHA may have provided more opportunities to ensure sustainability of the work done. The sharing of personal contact information among providers highlights the need for low barrier communication methods in the healthcare system for providers to be able to talk to each other. Having FHA partners involved could have presented more awareness of the system level barriers in referral navigation and communication among providers.

While gathering the patient perspective, there were gaps in the beginning of the project due to the complexities of the patient population group and the survey received minimal responses. However, a patient partner was recruited where they joined committee meetings to provide their valuable perspectives. Towards the end of the project, the language in the patient survey was adjusted to include caregivers, as we know that many older adult patients receive support from their loved ones and may be unable to fill out a survey independently.

NEXT STEPS

Various aspects of the project beyond the end of the Shared Care project will be sustained. The referral status letter is now an integral part of the existing workflow at FHA and an additional letter to acknowledge the referral will also be explored to ensure timely communication. Additionally, the established process of connecting with a local Geriatric Psychiatrist for a quick phone consult will continue to be available for Family Physicians on Pathways. The internal hyperlinks in the Referral Algorithm and Dementia Care Pathway will be maintained by Pathways, and the review of content for relevance will be maintained yearly by the FNW Division. The educational workshops were recorded and have been shared with Family Physicians through the Division's weekly newsletter and posted on the division's website for future reference. Furthermore, patient feedback is being collected on an on-going basis as a commitment to identify further gaps and challenges and ways to respond to the needs in the community.

Recognizing that challenges still exist with referral navigation, this project initiated the need for continued discussions between PCPs, FHA and FNW Division leadership teams. Continued collaborative efforts are scheduled to take place in 2024 to discuss enhancing access to the Specialized Seniors Clinic, a clinic that provides integral resources and supports for older adults in the community. It's important to ensure continued commitment and quality improvement to address the needs of patients and providers in the community.

Additionally, in 2023, the South Okanagan Similkameen Division reached out in interest of the educational workshops and resources created as their community lacked geriatric psychiatry services. Our group adopted and presented on the "Practical Tools for Diagnosing Dementia" workshop for the physicians at their division. These processes and resources can be successfully adopted across the region for those who are looking to improve communication, streamline referral processes and provide knowledge exchange opportunities. Project findings will be shared in various mechanisms with Shared Care, the FNW Shared Care Steering committee, the FNW Division Board, the members of the FNW Division, FHA Mental Health stakeholders, and posted on the Division's website for public viewing.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Provider experience: To what extent does the program contribute to increased confidence, satisfaction and communication between Family Physicians and Psychiatrists?	Increased referrals to geriatric psychiatry programs Decreased wait times for patients to seek care Increased satisfaction around communication between FP's, specialists and allied health providers Increased referrals from FP's not previously using these programs	Provider Experience Survey Program Data Engagement Data	During the project's timeframe, a total of 2 Ask the Expert (ATE) events and 1 workshop were conducted between 2022 to 2023. These included: 1. ATE: Practical Tools for Diagnosing Dementia (2022) 2. ATE: Depression and Anxiety in Dementia (2022) 3. Deprescribing Workshop (2023) In April 2022, an event was held on the topic of Practical Tools for Diagnosing Dementia. The feedback showed 85% of PCPs gained a better understanding of how to utilize the Dementia Care Pathways tool, which in turn served as a reference point to access vital resources in the delivery of patient care. ATE - Dementia | Event Evaluation # of Registrations 95 # Attended 66 # Survey Responses 48 Participants gained a better understanding of how to utilize Dementia Care Pathways tool and gained access to valuable information that increased their level of comfort diagnosing patients with dementia. Strongly Disagree 1 — 2 Disagree — 3.4 Average of all learning objectives combined — 4 Strongly Agree Benefits of Dementia Care Pathway Tool • Easy to understand, concise and is a comprehensive tool • The provided resources are streamlined and very accessible • Enjoy the diversity of information provided which can assist with the various stages of provider care Impact to Practice • Allows providers to serve a point of reference to access vital resources • Patient care can better streamlined as it relates to assessment and access to treatment • The Dementia Care Pathway can serve as a tool to help guide workflow "It will help me diagnosis dementia and provide the appropriate treatment and referrals" "The Dementia Care Pathway is quite comprehensive and gives a lot of guidance on how to approach a patient with suspected dementia" April 5, 2022 Specifically, PCPs noted the following:

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results

- 83% noted increased comfortability with diagnosing patients with Dementia
- 85% noted increased awareness of the geriatric psychiatry referral options and services
- 88% experienced a better understanding of how to use the Dementia Care Pathways tool on Pathways

In October 2022, an ATE event oriented on Depression and Mood Anxiety in Dementia showed 78% of PCPs experienced an increased understanding of how to manage the mood and dysregulation among Dementia patients.

Providers also noted the following anticipated benefits of applying the knowledge covered during the event:

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			• More equipped with screening tools and resources, such as the Dementia Care Pathway; in addition to connecting their patients with community resources/services • Anticipated better care for patients as a result of increased confidence in diagnosing, monitoring and providing care to patients with mood and anxiety disorders • Increasingly more aware of the appropriate medications to use, their side effects and non-pharmacological approaches to treatment; in some cases reducing medication use Alternatively, PCPs noted the following challenges they anticipated as a result of applying the knowledge gained during this educational event: • Insufficient time for each appointment to conduct the necessary screening tools, administering a thorough assessment and/or tailoring a treatment for patients could be an anticipated challenge • While some PCPs reported no challenges, some suggest that accessing services and community programs can often be difficult for patients • Issues with patient compliance and/or family and caregiver involvement with patients journey with health condition In November 2023, a Deprescribing Workshop was held and an average of 65% of PCPs expressed confidence in knowing when and how to deprescribe psychiatric medications after attending the workshop.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Deprescribing Workshop | Event Evaluation 17 Event registrations 12 Attended event 10 Completed Surveys Members expressed increased confidence in knowing how to deprescribe psychiatric medication, and were increasingly satisfied with knowing how patients are able to access care for concerns related to geriatric psychiatry, in addition to increased satisfaction pertaining to the communication between FP's and geriatric psychiatrists. Strongly Disagree – Strongly Agree: 1 2 3 4 (2.7) **Impact to Practice** • **Anticipated benefits:** Anti-psychotic deprescribing overview, better understanding of taper meds, general pearls overview and more confident removing redundant meds from patient profile. • **Anticipated challenges:** Difficult to cover multiple meds in one session, risks associated with destabilizing patient(s) condition, cognitive impairment and longitudinal relationships. Please rate your level of agreement for the following: Note: Level of agreement is measured on a scale from 1 to 4 November 16, 2023 Specifically, providers noted the following: • *"Better understanding of what order to taper meds"* • *"Lots of pearls today, I wrote them on a notes doc and will be sharing them with my colleagues"* • *"More confident removing meds that may be redundant/not required from patient profile"* • *"Anti psychotic deprescribing was very helpful"*

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Patient experience: To what extent does the program contribute to improved patient access to specialist care?	Decreased wait times for patients to seek care Increased patient and family/caregiver confidence in knowing what available resource exist Increased number of referrals and follow-up for patients is more readily available	Program Data Patient Experience Survey Provider Experience Survey	**Patient Experience Survey** It is important to note a patient survey was disseminated in 2019, however, the results yielded a low response rate due to a lack of dissemination mechanisms. In September 2023, a survey targeting the patient and caregiver experience was launched to understand the current state of patient care. Feedback was collected from a total of 12 participants, comprising 10 patients and 2 caregivers. Among the 75% of patients who accessed psychiatric services, the survey results indicated varying wait times for accessing psychiatrists. The reported wait times ranged between a few weeks to a couple of months. Patients primarily sought care for the following psychiatry health conditions: 100% 75% 50% 25% 0% Anxiety 67% Bipolar 33% Depression 83% Financial capability 17% Medication advice 33% Other 17%

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Patients noted general improvements when accessing timely care as it related to medication prescriptions and its direct impact on patients quality of life, however, patients noted various levels of satisfaction with the care received, as shown below: Access to Mental Health Services, Average Patient Satisfaction Scores 100% 75% 50% 25% 0% 36% – The length of time you, or the patient waited for care (i.e. appointments, treatments or tests) 41% – The coordination of care by your team of providers 43% – The care received from your team of care providers 50% – How involved you, or the patient is with their provider in the decision making of their health care 45% – Knowing what services are available in the community to access 60% – The communication between the family physician and the psychiatry team (or other Mental Health services) that is involved in you or the patients care Therefore, the collected patient feedback highlights persisting gaps in patient care, specifically concerning accessibility, care coordination and the quality of services received. Consequently, these gaps continue to affect the overall impact on patient care.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Provider Experience Survey In January 2023, a survey was disseminated to PCPs who attended the dementia workshop series to better understand the impact of the workshop post 3 months after and their experiences providing care for geriatric patients with cognitive impairments. PCPs were 73% in agreement that the Geriatric Psychiatry Referral Algorithm helped them find relevant referral information and 65% in agreement that the Dementia Care Pathway helped them find relevant referral information. We can deduce that the education and resources which helped providers navigate resources and referral information will directly benefit their patients. It is imperative to emphasize that although the Dementia Care Pathway and the Geriatric Referral Algorithm resources were introduced to aid in improving patient care delivery, PCPs reported a divergence from their expected utilization of these tools. While providers expressed limited challenges utilizing the Dementia Care Pathway, some providers noted needing guidance on medication selection for the various dementia-related conditions and more strategies to integrate the care pathway into educational events. According to the data below, 40% of PCPs who responded to the survey did not make use of the Dementia Care Pathway, while 10% were unaware of the resources' existence. 43% of respondents did not make use of the Geriatric Psychiatry Referral Algorithm after attending the educational workshops as well.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Dementia Care Pathway and Geriatric Psychiatry Referral Algorithm Dementia Care Pathway / Geriatric Psychiatry Referral Algorithm I do not know what that is: 10% / – I do not use it: 40% / 43% I will start using it more: 0% / 5% I will start using this: 0% / 5% I refer to it when I have a pt with suspected dementia: 5% / – Once a month: 20% / 24% Once a week: 5% / 5% Once every few weeks: 20% / 14% Other: 0% / 5% Alternatively, 50% of PCPs utilized the Dementia Care Pathway, and highlighted the following reasons for usage:

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Finding patient resources: 23% Sending emailable patient resources: 16% Clinician/documentation tools: 9% Finding referral information: 19% Clinic visits and workflow: 14% Billing information: 2% I don't use it: 12% Other: 5% (axis: 0% 5% 10% 15% 20% 25%) Although there is limited data to suggest improved patient access as a result of incorporating the aforementioned clinician tools, some providers have highlighted improvements such as an average of 63% of providers indicating the Dementia Care Pathway saved them time during their patient encounters and an average of 68% of providers noted the Geriatric Psychiatry Referral Algorithm saved them time during patient encounters. We can infer that these resources may have the potential benefit in improving efficiency for PCPs who attended the educational workshops and were able to incorporate components of the resources into their workflows.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Health Outcomes: To what extent does the program contribute to improved health outcomes for patients seeking care?	Decreased wait times for patients to seek care Increased patient satisfaction in being able to access care Increased provider satisfaction in knowing how patients are able to access care	Program Data Patient Experience Survey Provider Experience Survey	***Provider Experience Survey*** The results of the geriatric psychiatry provider survey conducted in 2023 showed a significant increase in PCP's learnings after attending one or more of the dementia workshop series. A combined average of 83% of PCP's expressed increased comfort in diagnosing and managing patients with dementia in the past year. 85% of PCP's expressed an increase in their ability to find and provide their patients with the available geriatric psychiatry resources in the past year, similarly 83% expressed an increased ability to find dementia specific resources. Similarly, providers experienced increased comfort in utilizing the Geriatric Psychiatry Referral Algorithm and the Dementia Care Pathway into their clinical workflow, 83% and 85% of the time, respectively. The graph below details the responses.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Care Pathways Data The Dementia Care Pathway resource yielded the highest page views during the months of the two ATE events held in April 2022 (110 pageviews) and October 2022 (58 pageviews).

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Dementia Care Pathway Page Views, FNW vs. Provincial Data Similarly, the use of the Geriatric Psychiatry Referral Algorithm shows similar trends in page views following the ATE: Dementia workshops in April 2022 and October 2022.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Geriatric Psychiatry Referral Algorithm Page views, FNW Data Overall, the Geriatric Psychiatry Referral Algorithm and the Dementia Care Pathway received positive feedback from PCPs and initially garnered interest following each event. However, there is a significant decrease in page views in the subsequent months. It is also important to highlight that the consistent use of these clinician tools differs among providers. This can be attributed to varying patient requirements and the PCPs' level of familiarity and expertise with the tools and this patient population.
			Continuous feedback was gathered from members through the FNW bi-monthly member survey. Between the months of March 2023 to November 2023, members reported accessing various geriatric psychiatry services for their patients. As of November 2023, members reported utilizing the following: the

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Specialized Seniors Clinic (72%), the Mental Health Intake (32%), Community Mental Health Teams (28%) and Direct referrals to RCH Geriatric Psychiatry Clinics (28%). How do you access geriatric psychiatry services for your patients? (select all that apply)
System costs: To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?	Decreased ED visits and admissions as patient are referred to appropriate resource at the mild-moderate stage Decreased wait times as referral pathway streamlines access	Program Data FHA ED Data HDC data	It is also important to highlight the wait times of the specialized clinics and services mentioned above. The Older Adult Community Mental Health Services is a service offered by FHA, with clinics located in New Westminster and Tri-Cities. A recent report pulled from Pathways shows that the average wait time for both clinics ranges between 2-4 weeks at both locations for an initial intake assessment by a caseworker. Alternatively, the wait times at the Specialized Seniors Clinic in New Westminster range between 6-9 months.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			Similarly, the Outpatient Geriatric Psychiatry Clinic at Royal Columbia Hospital currently has a reported wait time of 4-6 months. In 2021, wait times for this clinic were estimated around 1 month. Therefore, there has been a steady increase in wait times over the last 2 years which allude to the increase in demand of this service. Limited data was collected on average wait times throughout the duration of the project due to data restrictions, and as a result, reporting on changes in average wait times cannot be accurately reported at this time. More information about these services can be found in the Geriatric Psychiatry Referral Algorithm in Appendix 2. Although referral data was requested for geriatric psychiatry services, the data request was not fulfilled at the time of completing this report, highlighting the need to advocate for greater access to shared data and gain more buy-in from our partners.
			To date, aggregate community level patient data derived from Health Data Coalition (HDC) indicates a consistent prevalence rate of individuals with Dementia-Cognitive Impairment with conditions such as Alzheimer's Disease over the past 5 years, as visualized below:

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			(see chart, legend and text below)

Legend	Data Source	Ratio	Data as of
Blue	Fraser Health Authority	2701 / 1002366 (0.27%)	2023 Q3
Pink	Fraser Northwest	469 / 211423 (0.22%)	2023 Q3
Green	New Westminster (CHSA 2210)	94 / 48364 (0.19%)	2023 Q3
Orange	New Westminster (LHA 221)	94 / 48364 (0.19%)	2023 Q3
Purple	Tri-Cities (LHA 224)	317 / 144276 (0.22%)	2023 Q3
Red	All Clinics	9786 / 2552951 (0.38%)	2023 Q3

There is a steady rate of 0.27% of Dementia-Cognitive impairment cases among older adults in the FHA region. Comparably, the Fraser Northwest Region has a steady rate of 0.22% active cases.

Due to challenges with collecting data, we are unable to report on how geriatric patients have accessed services in the ED.

EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Sustainability and spread: What were the unanticipated outcomes of the proposed strategies?	Sustainability of the program	Program documentation Survey/interview feedback (FP lead interview and close out survey)	As part of the close out activities for this project, the team conducted an interview with the physician leads to capture the key learnings, successes, remaining gaps and sustainability of the project. Below are the reported findings: **Successes:** The physician leads thought a big milestone achieved in the project was the implementation of the referral acknowledgement letter at the RCH Geriatric Psychiatry clinic, which led other psychiatry services at the health authority to follow suit in implementing a similar letter as well. This project highlighted an easy solution to incorporate into the workflow to improve communication. Physician leads were also proud of the dementia care pathway which received positive feedback among those aware of the resource, however, it's important to acknowledge continued sharing mechanisms and educational opportunities are needed for new providers who join the community and for those who did not get exposed to the resource. **Gaps:** Although there is now a letter being sent back to referring providers, the initial intent was to ensure these letters were sent within 1-2 weeks of receiving the referral. However, the process shifted slightly and the letter is only being sent out once a patient books an appointment or if there are troubles connecting with the patient. This process can take up to 1-2 months. A proposed solution is to include a separate referral acknowledgement letter to ensure timely communication is received.

EVALUATION FRAMEWORK & DATA MATRIX

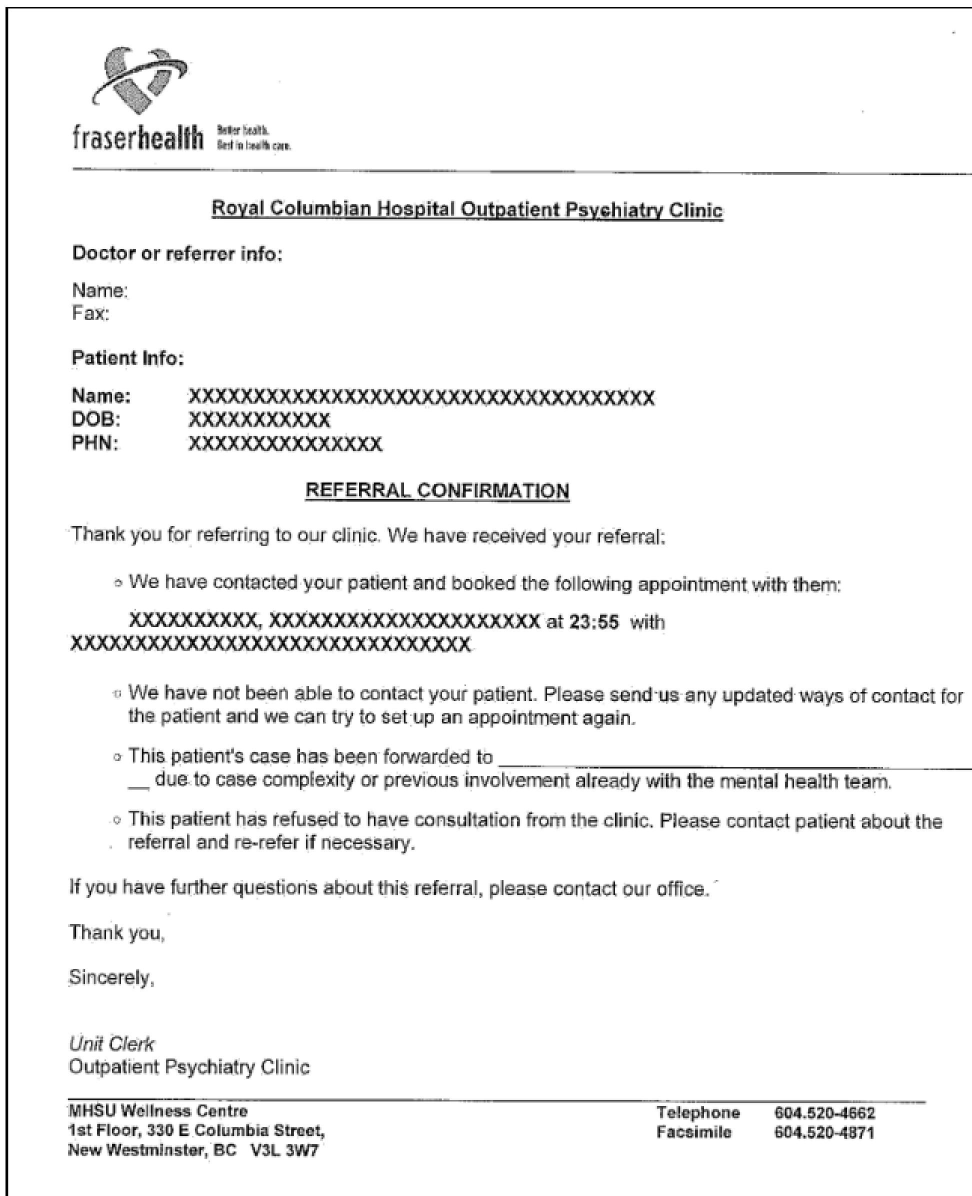
IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
			A bigger systemic challenge mentioned is the health authority's central intake process for mental health services. Challenges with the central intake process include bottle necks and delays in receiving referrals due to high volumes. Continued conversation is needed to deconstruct the workflow and investigate the delays. **Sustainability:** Targeted education for new providers through repeating topics on dementia and geriatric psychiatry will also allow the project to showcase the resources developed from this project. Another idea was to explore the sustainability funding available through Shared Care from all past Shared Care projects to sustain the work done across all specialties all at once. The physician leads agreed that on average, this project addressed the quadruple aim objectives. Please see Appendix 4 for the Physician Lead End of Project Survey.

Shared Measures were not implemented at the time of this project creation/implementation

APPENDICES

- Appendix 1: Referral status letter
- Appendix 2: Geriatric Psychiatry Referral Algorithm
- Appendix 3: Dementia Care Pathway
- Appendix 4: Physician Lead End of Project Survey

Appendix 1: Referral status letter



fraserhealth Better health. Best in health care.

Royal Columbian Hospital Outpatient Psychiatry Clinic

Doctor or referrer info:

Name:
Fax:

Patient Info:

Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
DOB: XXXXXXXXXXX
PHN: XXXXXXXXXXXXXXX

REFERRAL CONFIRMATION

Thank you for referring to our clinic. We have received your referral:

- We have contacted your patient and booked the following appointment with them:

  XXXXXXXXXX, XXXXXXXXXXXXXXXXXXXXX at 23:55 with **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX**

- We have not been able to contact your patient. Please send us any updated ways of contact for the patient and we can try to set up an appointment again.
- This patient's case has been forwarded to ________________________________ due to case complexity or previous involvement already with the mental health team.
- This patient has refused to have consultation from the clinic. Please contact patient about the referral and re-refer if necessary.

If you have further questions about this referral, please contact our office.

Thank you,

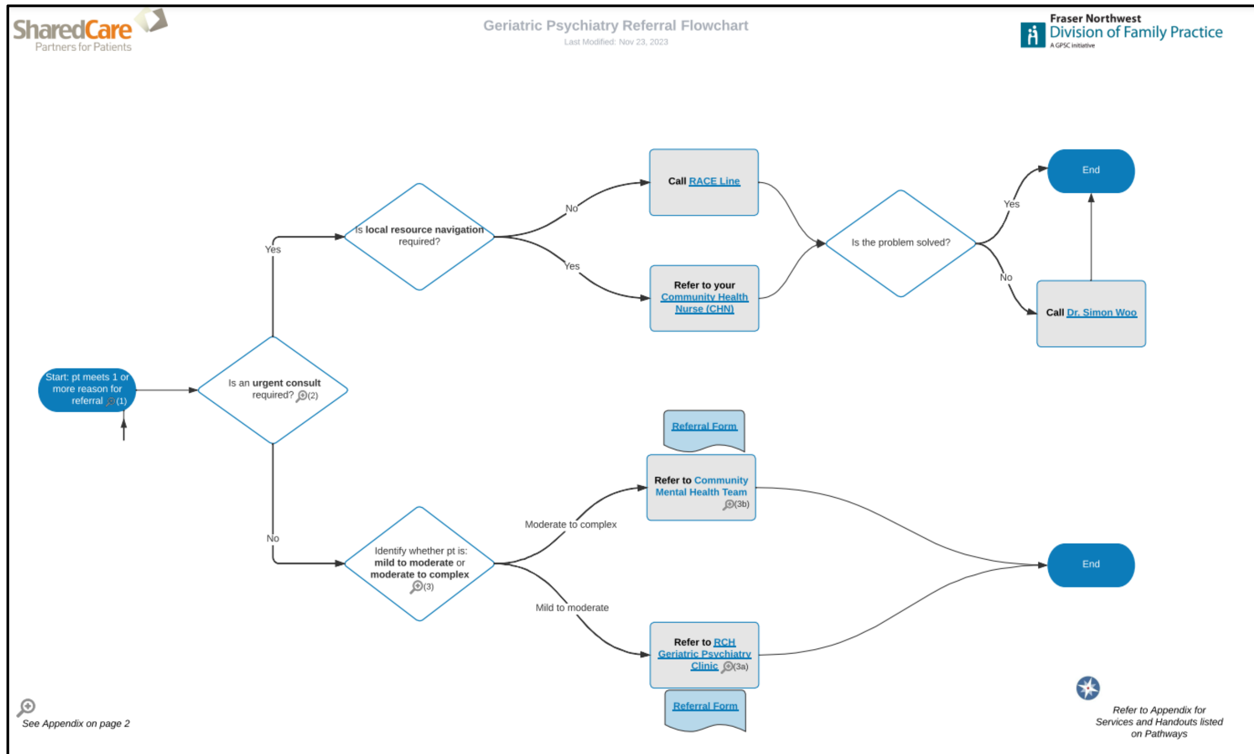
Sincerely,

Unit Clerk
Outpatient Psychiatry Clinic

MHSU Wellness Centre
1st Floor, 330 E Columbia Street,
New Westminster, BC V3L 3W7

Telephone 604.520-4662
Facsimile 604.520-4871

Appendix 2: Geriatric Psychiatry Referral Algorithm



SharedCare
Partners for Patients

Appendix: Geriatric Psychiatry Referral Flowchart

Last Modified: Nov 23, 2023

Fraser Northwest
Division of Family Practice

(1)

Reasons for Referral:

1. Mental health conditions in pts >65 and select cases <65 involving cognitive or neurological concerns
2. Geriatric depression/anxiety/psychosis
3. Cognitive assessment to clarify diagnosis of dementia
4. Parkinson's psychosis
5. Geriatric personality disorders
6. Dementia behavioral issues

Geriatric Medicine Vs. Geriatric Psychiatry:

Geriatric Medicine (Specialized Seniors Clinic):
- Poly-pharmacy
- Multi-morbidity
- Falls
- Osteoporosis
- Frailty
- Continence

Both:
- Dementia
- Delirium

Geriatric Psychiatry:
- Depression
- Anxiety
- Psychosis
- Neuropsychiatric symptoms (agitation and aggression)

(2)

Urgent Consult:

- *Send to ER* if risk to self or others (physical violence or severe self neglect).
- **Urgent cases**: If not improving and deteriorating but not to the point of needing hospitalization immediately and if change in management could prevent a hospital visit
- **Non-urgent cases**: Medication advice, cognitive assessment, likely not needing hospitalization

(3)

Mild to Moderate Cases:

- Short term follow up (6-12 months)
- Infrequent visits needed
- Never needed frequent & recurrent hospitalizations
- Reliable patient (shows up to appointment and compliant with treatment)
- Not on extended leave
- Home visits not needed
- Medication advice only
- Cognitive assessment for mild/moderate cognitive impairment
- Mild/moderate depression/anxiety

Moderate to Complex Cases:

- Long term follow up (> 1 year)
- Frequent visits needed
- Hospitalized for psychiatric reasons
- Dementia/Parkinson's requiring long term follow up
- Pt is in Long Term Care (LTC)
- Requires home visits
- Needs case management

(3b)

Community Mental Health Team:

- Multiple geriatric psychiatrists
- Intake with case manager
- Access to allied health (social work, OT) - In between follow ups will have **case manager** follow up
- Typically long term follow up (>1 year until client is stable, placement in LTC, or decease)

Case Manager:

- Case Manager (social worker, nurse, or counsellor) is assigned to the patient that will coordinate care.
- Support is available from the Case Manager during office hours to liaise with patients about issues or communicate with families.
- Case Manager will:
  - Set up and coordinate appointments
  - Help link and advocate for resources like home health
  - Liaise with team OT as needed
  - Monitor the patient in between appointments

(3a)

RCH Geriatric Psychiatry Clinic

- Run by Geriatric Psychiatrists
- Faster access to consult
- No case manager or allied health access
- Short term follow up (6-12 months)

Seniors Mental Health Pathways Resources

- **Top Anxiety Patient Services**
  - Anxiety Canada
  - Mindshift
  - BounceBack
- **Top Depression Patient Services/Resources**
  - Depression Toolkit Compass
  - Depression - Getting Active Toolkit
  - MoodFx - An Online Tool for Depression
- **Top Alzheimer's/Dementia Patient Services**
  - Support Personalized Dementia Solutions Inc.
  - First Link - Alzheimer's Society
- **Handouts**
  - Anxiety/Depression Patient Handouts
  - Alzheimer's/Dementia Patient Handouts

Appendix 3: Dementia Care Pathway (shown as 2 pages per sheet)

Dementia Care Pathway

This care pathway will provide you suggestions on workflow with quick links to the relevant assessment tools and resources

QUICK LINKS: ↓ Patient Visits | ↓ Patient Info | ↓ Patient Services | ↓ Medication | ↓ Billing

ASSESSMENT TOOLS: Alzheimer's Questionnaire | Clock Drawing Test | MOCA | SMMSE | RUDAS | Mini-COG | Blind MOCA

↓ Patient Visits Workflow

1ST VISIT
Early presentations ↓
History
Order labs ↓
Red flags?
Risk to self or others ↓
ER
Atypical presentations ↓
Refer to specialist (geriatric psychiatry, neurology, etc.)
- <60 years
- Rapid progression
- Other risk factors ↓
Consider head CT
No

BEFORE 2ND VISIT
Send Alzheimer's Questionnaire to patient and/or family

2ND VISIT
Review:
- Questionnaire
- Medications
- Lab results
- Imaging ↓
Physical exam ↓
Additional assessment if applicable ↓
Patient info ↓

3RD VISIT
Cognitive assessment tools
Disclosure - dignified diagnosis
Treatment and Referrals ↓
Patient services ↓
Selecting a medication ↓

4th VISIT
Identify risks ↓
Assess driving safety ↓
Advance Care Planning ↓

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | Email to patients securely from Pathways | Last edited: 2022/10/12

APPENDIX:

1st Visit
Virtual or in person

Early Presentations Basic Screening Questionnaire (Alzheimer Society)	1. Symptoms of cognitive impairment such as: a. Missed appointments b. Frequent or inappropriate calls to office c. Medication issues d. Repetitive in conversation e. Repeatedly misplacing items f. Unable to recall treatment instructions g. Defers to family members in answering questions h. Presents with signs of declined self-care i. Frequent visits to the emergency room j. Late life depression or anxiety k. Motor vehicle accidents 2. **Areas of difficulty in ADLs/IADLs** a. Obtain collateral history from family and caregivers b. Identify imminent safety concerns: car accidents, fire, flood, medication neglect
Medical History	• Comorbidities • Medication list (assess for polypharmacy) • Substance use/smoking • Education and employment history • Family history • Pain • Psychiatry review • Brain trauma
Lab Investigations	Rule out secondary causes: a. CBC, B12, UA, FBG, A1C, TSH, electrolytes, Albumin, Calcium, Creatinine/eGFR, ECG b. Other risk factors: liver enzymes, syphilis, HIV, drug toxicity levels (digoxin, phenytoin)
Red flags requiring the ER	Risk to self or others
Red flags consider head CT	• <60 years • Rapid progression or abrupt onset • Recent head injury • History of cancer (especially breast and lung) • Suggestion of stroke • Patient is on anticoagulation or has a bleeding disorder • Urinary incontinence and gait disorder
Red flags to consider referral to specialist (geriatric psychiatry, neurology, etc.)	1. Urinary incontinence, gait dysfunction a. Consider normal pressure hydrocephalus (NPH) 2. Rigidity bradykinesia, postural instability, tremor a. Consider Parkinson's Disease Dementia (PDD) 3. Early Falls, eye movement abnormalities a. Consider progressive Supranuclear Palsy (PSP) 4. Early psychosis and REM sleep disorders b. Consider Dementia with Lewy Bodies (DLB)

Back to Top

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | Email to patients securely from Pathways | Last edited: 2022/10/12

Appendix 3: Dementia Care Pathway - continued

Before 2nd Visit	
Prepare for 2nd Visit	• Send the Alzheimer's Questionnaire to the family – click ✉ to email to patients • Ask patient to bring family member to next appointment

2nd Visit *In person*	
Review the Alzheimer's Questionnaire and get insight from family member	
Review labs, imaging and medication review *Rule out medication side effects like benzodiazepines or anticholinergic medications that can cause confusion*	
Physical Exam	• Rule out visual or hearing defects • Any neurological signs, consider referral to neurologist (i.e. neuro defects, gait issues, Parkinson's) • Cardiovascular or cerebrovascular disease
Additional Assessments if Applicable	• Geriatric Depression Scale | Depression care pathway tool • Cornell Depression Scale for Dementia • Delirium assessment tools • Alcohol dependence • Adverse drug effects and polypharmacy (narcotics, benzodiazepine's, HS sedation) ⇒ Consider referral to a PCN Pharmacist | Click here for a list in your region • Co-morbid disease (including sleep apnea) • Anticholinergic burden calculator
Patient Information	• Mild Cognitive Impairment Handout – Alzheimer Society | Click ✉ to email • Lifestyle Factors to Reduce Risk (Short) | Click ✉ to email

3rd Visit *In Person*	
Cognitive Assessment Tools	Click here for the full list of assessment tools on Pathways • Clock Drawing Test • MOCA - Use the Alternative Versions of the MOCA if administered repetitively • SMMSE • Mini-COG • RUDAS – For language, cultural or education barriers • Blind MOCA – Verbal only, for virtual assessments
Dignified Diagnosis	Tips on disclosing to patients – Alzheimer Society
Treatment & Referrals	• Refer to GPAC Diagnosis and Management Guidelines • Refer to the available Patient Services ↓

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | ✉ Email to patients securely from Pathways | Last edited: 2022/10/12

	• Selecting a Medication Table ↓

Back to Top

4th Visit *Virtual or in person*	
Identify Risks	Patient Information: • Dementia Risk Factors and How to Reduce Risk (Long) | Click ✉ to email • Understanding Wandering - Video | Click ✉ to email
Assess Driving Safety	• Reporting Unfit Drivers Algorithm - RoadSafetyBC • Make a report to RoadSafetyBC for assessment/cancellation using this form here • You may be requested for further information including filling out a DMER (Driver's Medical Examination Report) • Patient Handout: Dementia and Driving | Click ✉ to email
Advance Care Planning	• Advance Care Planning | Care pathway tool • Serious Illness Conversation Guide

Patient Info — Click for List of ALL Pathways Emailable Dementia Patient Info

Initial Diagnosis Info	Email	Risk Management Info	Email
Dementia - Getting a Diagnosis	✉	Dementia and Driving	✉
Dementia – Patient and Caregiver Guide	✉	General Overview – Locating Devices for Wandering	✉
Video – Understanding Alzheimer's	✉	Understanding Wandering - Video	✉
Video – 5 Things to Avoid When Caring for Persons with Dementia	✉	Lifestyle Factors to Reduce Risk (Short)	✉
		Email all of the above together	|✉|
		Dementia Risk Factors and How to Reduce Risk (Long)	✉
		GPS Locater Devices – Cost and Review	✉

Patient Services — Click for a list of ALL Pathways Emailable Dementia Services

	Email	Referral Forms
Caregivers Support Network - Personalized Dementia Solutions Inc. *1:1 support for family caregivers*	✉	
Alzheimer's Society of BC – list of all services available here ⇒ First Link Helpline – Provides access to services and supports for dementia ⇒ Minds in Motion – Exercise Program	✉ ✉	PDF

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | ✉ Email to patients securely from Pathways | Last edited: 2022/10/12

Back to Top

Appendix 3: Dementia Care Pathway - continued

Medication — *Click here for more details from BC Guidelines*

Class	Selected Agents	Coverage	Contraindications
AcetylCholinesterase Inhibitors	Donepezil 10 mg/day Start 5mg or 2.5mg	Special Authority Request Form – Donepezil, Galantamine, Rivastigmine	- Avoid use in patients with cardiac conduction abnormalities (except RBBB), such as sick sinus syndrome, bradycardia, AV block, or unexplained syncope. - Use cautiously in patients with obstructive urinary disease, asthma, seizures disorder or those at risk of upper GI bleeds
	Galantamine ER 16-24mg/day Start 8mg		
	Rivastigmine 10mg bid Start 2.5 BID		
	Rivastigmine Patch 5mg or 10mg or 15mg	No coverage	
Memantine		No coverage	

$ Billing

KEY POINT
Ensure you have read all the fee details of any fee before billing it.
Click on the blue links below to read the full fee descriptions on the BC Family Doctors website. (Membership required for log in)

Code	Description	Value
14043	**Mental Health Planning Fee** This fee is payable upon the completion and documentation of a Care Plan (as defined in the GPSC Preamble) in the patient's chart for patients with a confirmed eligible mental health diagnosis when the effect on the patient is significant enough to warrant the development of a Care Plan. Neurocognitive disorders such as dementia are eligible. *Read the details on the BC Family Doctors website here (log in required)*	≈$100.00
14077	**FP Conference with Allied Care Provider and/or Physician** Per 15 minutes or greater portion thereof, documentation of time and care plan required *Read the details here*	≈$40.00
14067	**FP Brief Clinical Conference with Allied Care Provider and/or Physician** Less than 8 minutes, no time documentation required *Read the details here*	≈$18.00
14075	**Annual Complex Care Planning & Management Fee - Frailty** 14075 is payment for developing a care plan and managing the conditions of patients of any age who require assistance with instrumental (IADL) and non-instrumental (NIADL) activities of daily living. *Read the details here*	≈$315.00

Age	00120 Counselling (in office) 13*38 Telehealth Counselling *Max 4x/yr/patient any combo of above*	1404* MH Management *Use once 4 x00120 series and/or telehealth counselling is used up*	Value
2-49	00120 or for telehealth T13438	14044	$56.41
50-59	15320 or for telehealth T13538	14045	$62.05
60-69	16120 or for telehealth T13638	14046	$64.86
70-79	17120 or for telehealth T13738	14047	$73.32
80+	18120 or for telehealth T13838	14048	$84.60

Sources:

- Fraser Health Pathway for Recognition, Diagnosis, and Management of Early Dementia in Primary Care, 2018
- Centre for Effective Practice resource - Use of Antipsychotics in BPSD Discussion Guide, 2016
- Cognitive Impairment GPAC Guidelines, 2016

Draft of the Dementia Care Pathway created by the Geriatric Psychiatry Committee at the Fraser Northwest Division of Family Practice

Fraser Northwest Division of Family Practice   SharedCare Partners for Patients

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | Email to patients securely from Pathways | Last edited: 2022/10/12

Legend: ↓ Jumps to another section of the care pathway | Pathways direct link | Email to patients securely from Pathways | Last edited: 2022/10/12

Appendix 4: Physician Lead End of Project Survey