Shared Care Final Project Report

Project Title	Adult Mental Health and Substance Use Shared Care "Enhancing Collaborative Psychiatric Care" (SCC3480)
Physician leads	Dr. Stephanie Aung, Family Physician Lead Dr. Carllin Man, Family Physician Lead Dr. Angelo Wijeyesinghe, Psychiatrist, Specialist Lead Dr. Stephen Ogunremi, Psychiatrist, Specialist Lead
Project lead	Cindy Young
Date of Submission	August 28, 2023

EXECUTIVE SUMMARY

Background / overview

The Fraser Northwest (FNW) Adult Mental Health and Substance Use (AMHSU) Shared Care initiative started in 2019 in response to the growing number of challenges that made the delivery of optimal care for patients with mental health concerns difficult. Psychiatrists are facing increased demand and long wait times and family physicians are burdened with lengthy counselling visits for patients with mental health concerns, which in turn impacts the ability to provide care to their regular panel of patients. The goal of the project was to foster relationship building, learning, increased capacity and improved communication between family physicians, nurse practitioners, psychiatrists and mental health teams across the FNW region.

Project Outcomes

Increased communication flow among family physicians and psychiatrists	• Increased satisfaction in knowing who to connect with and when to connect • Increased understanding of physician scope of practice by other physicians • Increased understanding of available services depending on where patients are at in healthcare needs • Increased family physician confidence and capacity in supporting patients
Improved patient care	• Improved access to timely support and counselling services
Effect on system costs	• Increased access to mental health supports for patients as provider awareness increases

Conclusion

The FNW AMHSU Shared Care initiative involved collaboration between family physicians, psychiatrists, nurse practitioners and mental health FHA partners to understand and address the complexities involved in navigating the mental health system. This project implemented mental health improvements by fostering relationships, enhancing communication and providing education. Continued collaboration with stakeholders is crucial to improving patient care and sustaining the improvements implemented.

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 traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

The FNW Adult Mental Health and Substance Use (AMHSU) Shared Care initiative started in 2019 in response to the growing number of challenges that made the delivery of optimal care for patients with mental health concerns difficult. Primary care providers and patients identified the need for mental health education and training, increased understanding of where to refer patients in the community, improved communication with mental health services, free to low cost counselling services and timely access. Psychiatrists faced increased demand in 2019 as the average wait time was 3-6 months. Family physicians were burdened with lengthy counselling visits for patients with mental health concerns that impacted the ability to provide care to their regular panel of patients. As a consequence, primary care providers experience increased wait times, frustrations and burn out.

Problem Statement:	**Aim Statement:**
Long wait times for a psychiatric consultation and lack of communication between family physicians and psychiatrists leaving family physicians feeling unsupported while patients wait for care	The goal of this project is to foster relationship building, learning, increase capacity, and improve communication between family physicians, psychiatrists, and mental health teams across the FNW region.

PROJECT OBJECTIVES

The objectives of the FNW Adult MHSU Shared Care project were to:

1. Improve communication between family physicians, nurse practitioners, and psychiatrists through establishing best practices for communication, referral navigation and sharing of timely consult notes.
2. Relationship building between family physicians, nurse practitioners, and psychiatrists through shared common goals for patient care.
3. Develop learning activities to engage and upskill family physicians and nurse practitioners to support their mental health patients.

TARGET POPULATION

The target population for this project included primary care providers, psychiatrists and adult mental health patients in the FNW communities. According to data pulled from the Health System Matrix, there are approximately 17.8% of people aged 18 and over who experience episodic depression or episodic mood and anxiety disorders in the FNW region.

ENGAGEMENT STRATEGY

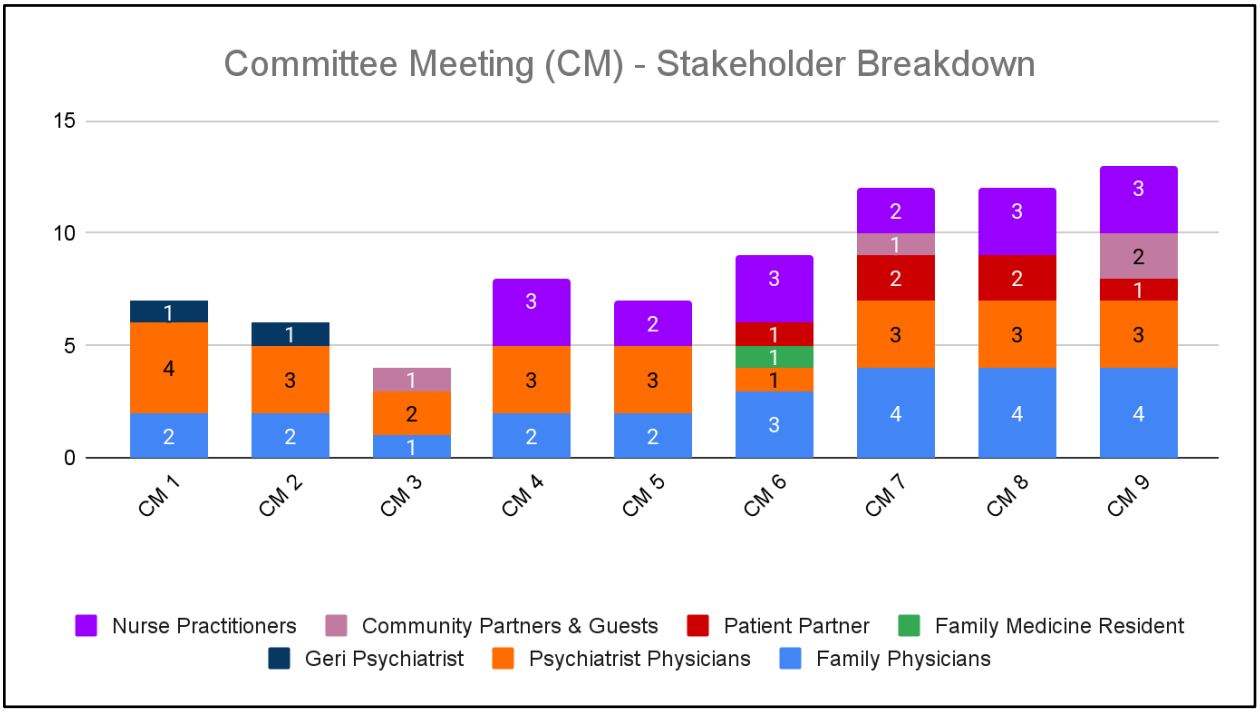
In the planning phase, the FNW Division engaged with family physicians, psychiatry physicians, nurse practitioners and community organization partners who identified challenges in the community that required collaboration to reach the intended goals. The following individuals and organizations were involved in the planning phase of the project and throughout the project's implementation:

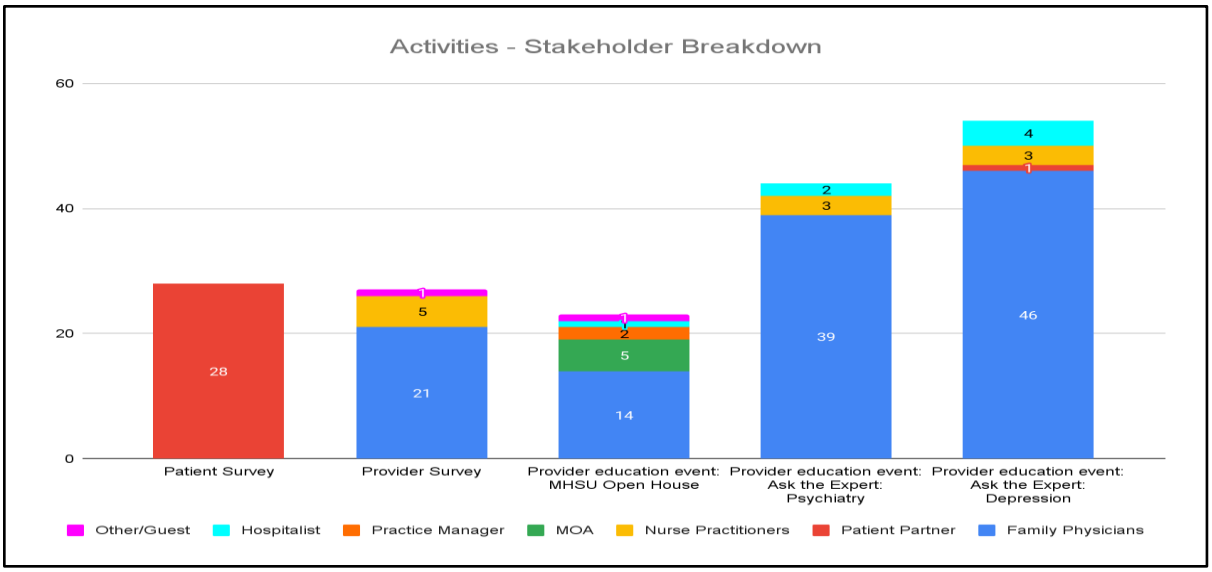
Name	**Role**	**Primary Practice Location**
Physician Engagements		
Dr. Stephanie Aung	Family Physician Lead	New Westminster
Dr. Carllin Man	Family Physician Lead	Burnaby & Coquitlam
Dr. Angelo Wijeyesinghe	Psychiatrist Lead	New Westminster
Dr. Stephen Ogunremi	Psychiatrist Lead	Tri-Cities
Dr. Nahla Fahmy	Family Physician	New Westminster
Dr. Tracy Monk	Family Physician	Burnaby

Dr. Gina Zheng	Family Physician	Coquitlam
Dr. Janel Casey	Psychiatrist	New Westminster
Dr Emiko Moniwa(Guest)	Psychiatrist	New Westminster & Tri-Cities
Dr. Simon Woo (Guest)	Geriatric Psychiatrist	New Westminster
Dr. Stephen Barron (Guest)	Family Physician (Retired)	Port Coquitlam
Dr. Gunpreet Singh(Guest)	Psychiatrist	Surrey
Dr. Asmaa Abdalla(Guest)	Family Physician Resident	Delta
Dr. Paula Flynn (Guest)	Family Physician	New Westminster & Richmond
Dr. Lisa Miller (Guest)	Family Physician (Lead for CBT Skills)	Vancouver
Dr. Erin Burrell (Guest)	Psychiatrist (Lead for CBT Skills)	Vancouver
Dr. Marilyn Thorpe (Guest)	Psychiatrist (Lead for PIT Model)	Victoria
Non-Physician Engagements		
Denyse Houde	Director, Clinical Operations	Fraser Health Authority (FHA)
Walid Chahine	Director, Mental Health and Substance Use	FHA
Allison Luke	Manager, Mental Health & Substance Use	FHA
Jeffrey Nikkel	Manager, Mental Health & Substance Use	FHA
Jean-Marc Lamarche	Coordinator, Mental Health & Substance Use Services	FHA

Sharon Singh	Project Planning Leader, Clinical Programs	FHA
Annie Liao	Nurse Practitioner	Coquitlam
Chelsea Bruce	Nurse Practitioner	Coquitlam
Ruphina Muir	Nurse Practitioner	Coquitlam
Veronica Freeman	Patient Partner	
Debbie Halyk	Patient Partner	
James Musgrave (Guest)	Director of Counselling Program	New Westminster, S.H.A.R.E
Chrissy Tomori (Guest)	Executive Director for CBT Skills	Victoria

A breakdown of stakeholder engagement and involvement in committee meetings and project activities are graphed below. Throughout the project's duration, a total of 9 committee meetings were held to review, plan and implement the project activities. As seen in the graph below, stakeholder engagement continued to grow throughout the project's duration which indicates increased attention and recognition of the importance of the work. Core committee members provided valuable feedback and direction on project activities, including the planning and execution of the educational workshops. Other stakeholders and guests were invited to share information about relevant mental health services and initiatives which helped to inform the committee of resources on a broader context.





DATA COLLECTION ACTIVITIES

The evaluation approach was conducted through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from FHA analytic data and program administrative records. 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 purpose of this evaluation was to align and support the overall Shared Care goal which is to provide coordinated, continuous and comprehensive patient care in a way that fits the local context and community needs specific to the FNW. The evaluation objectives and questions link directly back to the overall FNW project aim statement. Implementing evaluation measures throughout this initiative supports real-time data collection and clear identification of when progress markers have been attained or when adjustments need to be made to existing measures. The evaluation program's main purpose is to support the cyclical quality improvement processes focusing on the PDSA cycle which supports the implementation, identifies opportunities for improvement, and allows for ongoing feedback between and amongst PCN stakeholders.

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:

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

1. **To evaluate the effectiveness of the AMHSU Shared Care Initiative in the Fraser Northwest community**
    a. To what extent does the program contribute to increased communication flow among family physicians and psychiatrists?
    b. To what extent does the program contribute to improved patient care?
    c. 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

Exploration of the PIT model

Initially, the committee was interested in exploring collaborative approaches to mental health care. The Psychiatric Interdisciplinary Team (PIT) model, developed by the University of Victoria, was identified as a potential pilot solution. The PIT model involves the patient, the patient's family doctor and the consulting psychiatrist meeting together in the family doctors office to enable providers to share information seamlessly, develop rapport and provide timely care to patients. However, upon further discussion and research, it was found that the model is not sustainable due to the current fee-for-service billing structure. With fee-for-service billing, two practitioners cannot bill for a visit at the same time. Furthermore, the coordination of these meetings would have faced challenges due to the limited capacity and availability of providers.

Improving Communication

The new direction focused on developing communication channels to improve provider collaboration, accessibility and two-way communication. The group discussed the option of having a consulting psychiatrist call the family doctor after the initial psychiatric consultation with their patient. This proposed method was piloted by a psychiatrist with a few family doctors and they shared that this is helpful for complex cases and building relationships with the family physicians. The group additionally discussed best practices for reaching out and communicating with the FHA mental health team when a patient's referral status is unknown. Based on this trial, the group determined the best practice for family physicians to contact psychiatrists is to first contact the case manager or the intake clinician in charge of the patient's care and if needed, requesting to leave a message for the psychiatrist if the issue is non-urgent.

Provider Education

A series of psychiatrists and sub-speciality workshops were hosted for primary care providers to increase the family physician capacity, education and relationships. The topics selected were based on the challenges and needs voiced by primary care providers. At each workshop, relevant resources and mental health services were shared to increase provider's awareness. The workshops conducted

through Zoom were recorded and shared with participants who could not attend in real-time. Furthermore, these recordings were posted on the member portal on the division's website for those who wished to view the sessions at a later time. Please see the evaluation section below for the post-workshop analysis.

a. MHSU Open House - January 9, 2020 (In person)

i. Approximately 24 attended
ii. Participants had a better understanding of what community resources are available and gained clarity on referral processes for mental health services.
iii. Participants noted that this session helped to put faces to names and facilitated relationship building.

b. Ask the Expert (ATE): Psychiatry - September 15, 2020 (Zoom)

i. 44 attended
ii. This session focused on anxiety and depression, borderline personality disorder and mental health referral processes and options.
iii. The committee members chose to narrow down on one condition for the next workshop due to feedback about the high demand for a session focused on depression.

c. Ask the Expert (ATE): Depression - May 11, 2021 (Zoom)

i. 54 attended
ii. Participants gained a better understanding of the treatment and management of depression.

Additionally, we are continuing to strengthen relationships with stakeholders by working together with the FHA MHSU leadership team to understand the challenges and identify the needs for improvement of patient care and provider satisfaction. The team collaborated to clarify referral processes for mental health services and gained an understanding of the challenges voiced by primary care providers with referral navigation and rejected referrals.

Lastly, a clinician resource for depression was developed during these meetings and reviewed by the AMHSU committee members. The depression care pathway contains practical information and resources while utilizing the Pathwaybc.ca infrastructure. This resource is applicable for providers across the province and has been stewarded over to UBC Continuing Professional Development (CPD) as part of their learning modules related to depression for continued spread, sustainability and maintenance. This resource was shared with primary care providers through the weekly newsletter, Division's Dispatch newsletter and on Pathways. Click here to view the resource. Please see the evaluation section below for more details.

LESSONS LEARNED

What worked well?	Challenges and Gaps
The committee members shared a common goal of improving patient care through open discussion - the group was able to bring up concerns and challenges which led to including more stakeholders that have influence to improve processes at a systems level. This led to improved communication between family physicians and psychiatrists around referral acknowledgements and timely consult notes.	Continued collaboration among family physicians and psychiatrists to address gaps and maintain relationships. Additionally, more buy-in from HA partners is needed for larger system level change and consistent sharing of feedback and lessons learned.
Increased awareness in navigating the mental health system in ensuring providers know about the central intake service plus clarification on referral processes.	There continues to be long wait times to see a psychiatrist, lack of supports for moderate to complex mental health cases. More psychiatrists are needed. More education for primary care providers to be comfortable with complex mental health patients (prescribing medications, diagnosing complex ADHD/anxiety patients, administering long acting injections like clozapine, etc.)
Increased collegiality and relationships between family physicians and psychiatrists through committee meetings and provider education events.	Difficult to sustain the provider workshops that were held - information that's been shared and recorded may go out of date. Continuous knowledge and information sharing opportunities is needed (i.e. for new providers who join the community or to refresh existing provider's knowledge).
	Project activities were difficult to measure the direct impact to patient care. Ongoing feedback will be collected from patients to ensure alignment with future activities.
	As there were many gaps and challenges identified from the onset of the project, this project experienced scope creep and due to the pandemic, some project activities were delayed. Future projects related to mental health will be more targeted and specific in scope.

NEXT STEPS

The Adult MHSU Shared Care project highlights the importance of providing a space for information sharing and education to foster physician relationships. Further collaborative efforts with stakeholders are needed to continue addressing gaps and challenges related to mental health at the

systems level. Recognizing the significance of this work, both the division and FHA are committed to better understanding the complexities involved in navigating mental health services. The division has taken accountability by hiring a Patient Medical Home Support Coordinator and FHA will be providing a matching position who will be working in tandem together. These support staff from both sides will look at all referral challenges across the health care system to ensure a comprehensive analysis is done. Their findings will be shared with partners and stakeholders with the ultimate goal of improving efficiencies and improving patient care.

Additionally, to gain insight into the experiences of the patients that we intend to benefit, the division will be collecting ongoing patient feedback through a community wide survey. The survey, along with other patient surveys, will be accessible on the division's website and will be promoted through social media and patient newsletters. By collecting valuable patient input and feedback, the division can monitor trends and ensure efforts are aligned with what the patient's needs are in the community.

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EVALUATION FRAMEWORK & DATA MATRIX

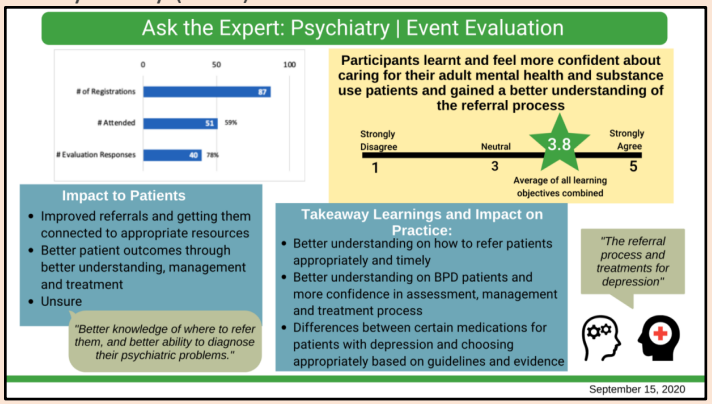
IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
Provider experience: To what extent does the program contribute to increased communication flow among family physicians and psychiatrists?	Increased satisfaction in knowing who to connect with when Increased understanding of physician scope of practice by other physicians Increased understanding of available services depending on where patients are at in healthcare needs Increased family physician confidence and capacity in supporting patients	Program documentation FNW bi-monthly member survey FNW member events Family physician satisfaction survey Specialist satisfaction survey MHSU program documentation SHARE referring provider survey	This project emerged due to the need to improve the communication, collaboration and coordination of care between family physicians and psychiatrists for patients accessing psychiatric care within the FNW. This was attributed to patients being met with long wait times, while family physicians were simultaneously feeling unsupported. In 2020, a survey was administered to family physicians and nurse practitioners who provided care to patients with mild to moderate mental health symptoms. It was identified that 74% of providers reported being confident in managing the care of patients with mental health symptoms, while 67% were confident in providing resources/referrals to patients with mental health symptoms. Similarly, when asked “What is needed to improve care for patients with mental health symptoms in your community?”, respondents noted the following 5 major themes: *1) Continuity of care* *2) Coordination of care across settings/outpatient services* *3) Increased access to counselling and community supports* *4) Treatment for complex mental health cases* *5) Access to geriatric psychiatry*

To upskill family physicians in providing care for patients, the project hosted a series of provider education events for the following topic areas:

1) MHSU Open House (2020)

The project hosted their first provider education event in person, where 88% of members gained a better understanding of what community resources were available as it pertained to MHSU, in addition to the referral processes for MHSU services and resources.

2) ATE: Psychiatry (2020)



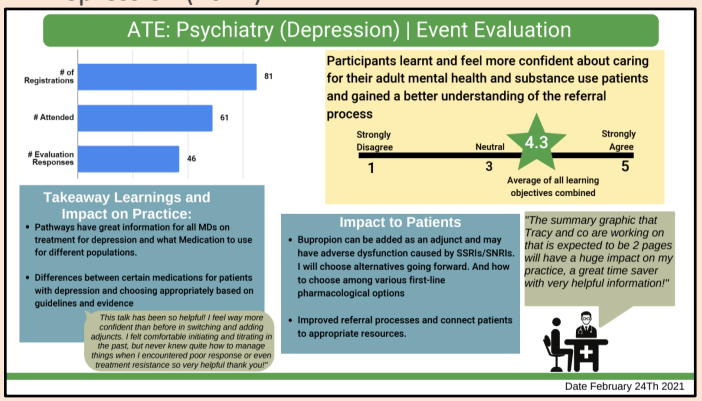
(See appendix 1)

After attending this event, family physicians expressed increased confidence when managing the care for their adult mental health and substance use patients. In addition, they gained a better understanding of the referral processes and the available services and treatment options for their MHSU patients.

When asked, *"What is one thing you took away from this workshop that will be applicable to your practice"* family physicians identified the following themes as their key takeaways:

1) Information about the referral process for mental health patients
2) Better understanding on the complexity of Borderline Personality Disorder (BPD) patients and the assessment, management and treatment process
3) Learning the differences between certain medications and choosing the most appropriate one based on guidelines and evidence for patients with depression

3) ATE: Depression (2021)

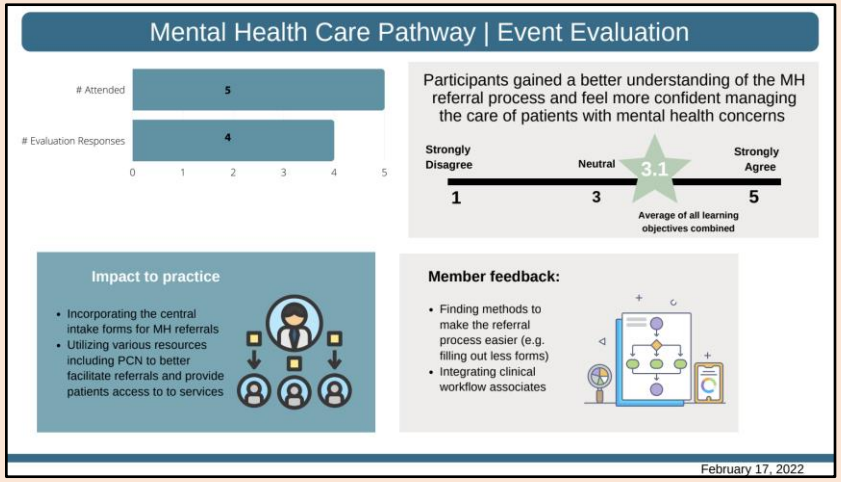


(See appendix 2)

Following this event, 86% of providers gained a better understanding of the referral processes and the available options for their MHSU patients. In addition, 88% of providers noted an increased confidence in treating and managing care of patients who suffer from Depression. Similarly, 84% of

providers expressed that they can easily communicate with specialists as it pertains to their patients.

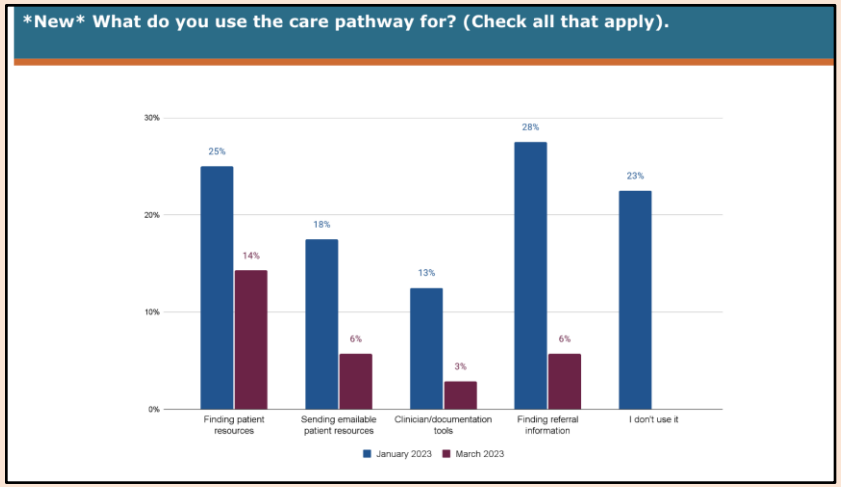
4) Mental Health Care Pathway (2022)



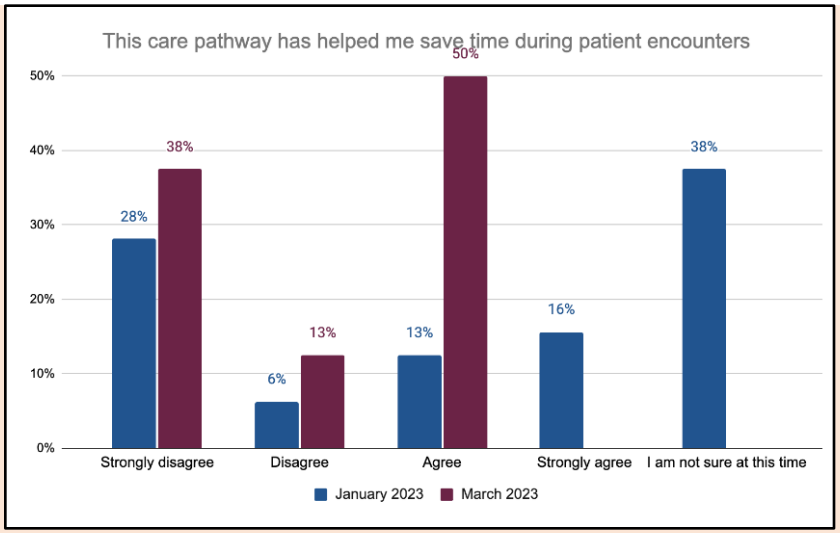
The division hosted 4 mental health care pathway meetings between 2021 to 2022 with the FHA MHSU leadership team. These meetings helped to strengthen relationships between stakeholders, while educating primary care providers on the referral processes of community programs such as the MHSU central intake and mental health teams.

Collectively, the aforementioned provider education events have equipped physicians with the necessary tools and knowledge within their scope of practice. As a result, physicians' confidence increased in treating and managing the care of their patients for various MHSU conditions.

The Depression Care Pathway was developed as a tool to equip providers with a resource that houses vast information related to Major Depressive Disorder (MDD) among patients. While there was variation among the number of providers who utilized this tool, providers who employed the Depression Care Pathway listed their main reasons for usage below:

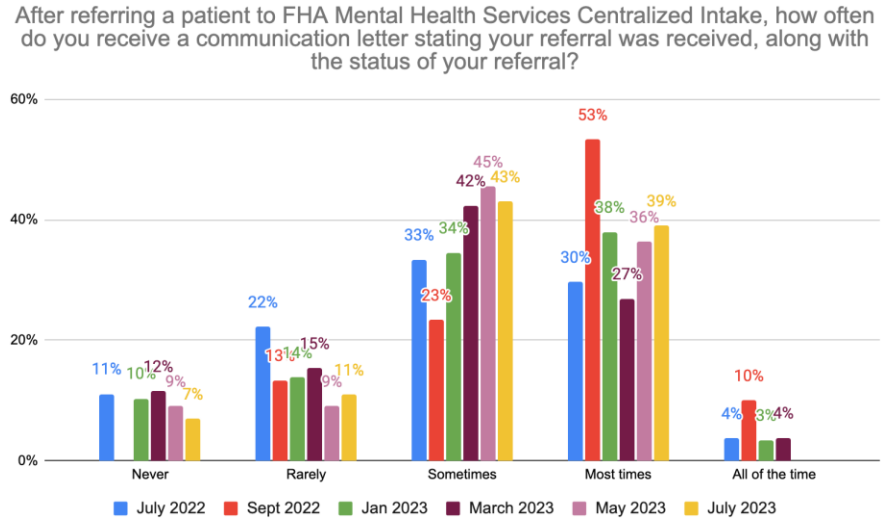


Similarly, when asked if “this care pathway has helped save time during patient encounters”, providers noted mixed responses, with 38% strongly disagreeing and 50% agreeing.



The care pathways resources receives an average of 12 page views per month on Pathways from local FNW users and an average of 98 page views per month province wide. While this tool was developed with the intention of aiding providers within their clinical interactions, the mixed feedback suggests this care pathway may not have addressed all ongoing challenges and clinical efficiencies as it related to treating patients.

Another component of provider feedback that was collected throughout the duration of the project on an ongoing basis, was from primary care providers. Primary care providers were surveyed through the division's FNW bi-monthly member survey between July 2022 to July 2023. Providers noted variations in communication from FHA for mental health services when referrals were being rejected, as seen in the graph highlighted below:

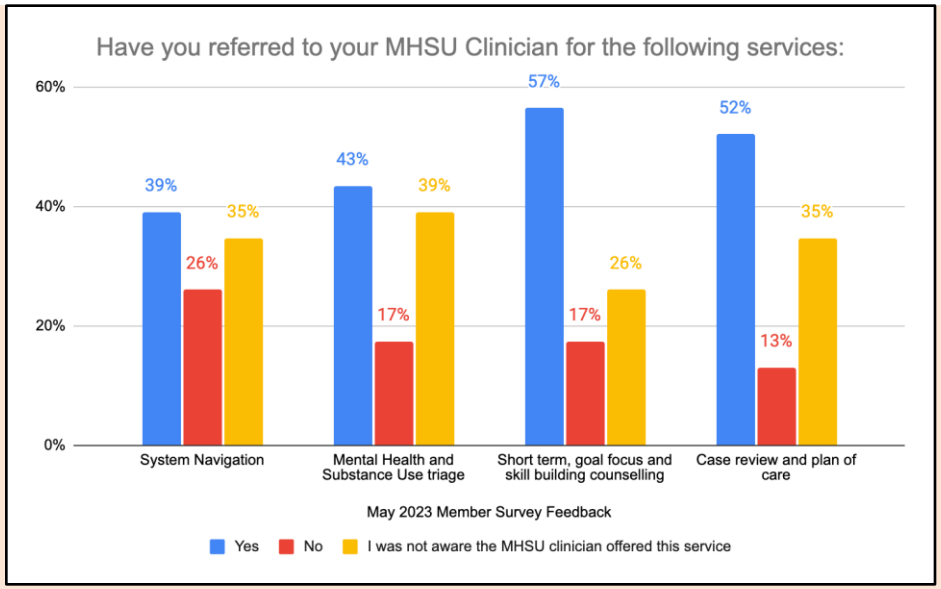


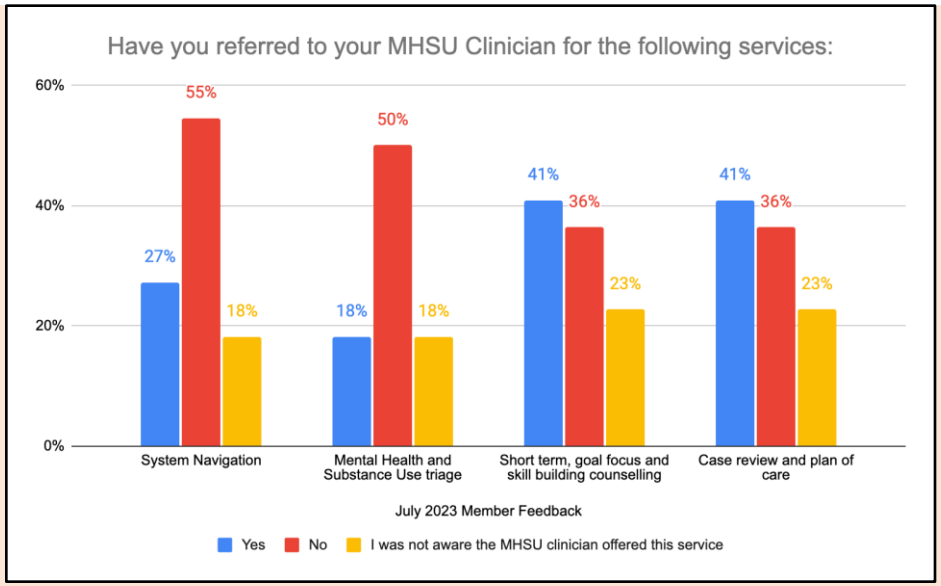
To assist primary care providers with mental health patients, the FHA MHSU Clinician was introduced as part of the PCN plan. However, survey data from May and July 2023 showed that 81% of providers noted being unfamiliar with who the MHSU Clinician assigned to their clinic.

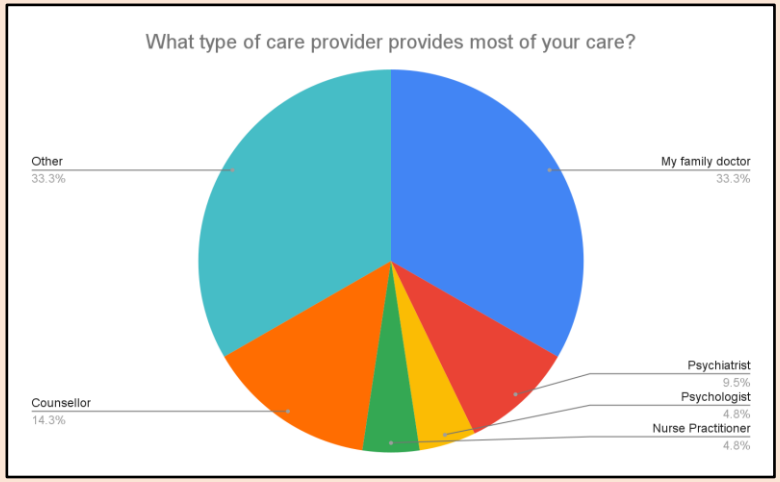
Similarly, when asked which of the following services they referred to their MHSU clinician for, primary care providers indicated the following in May and July 2023: 29% of providers were unaware that MHSU Clinicians provide mental health and substance use triaging and 27% were unaware of system navigation supports that are provided.

TEMPLATES AND FORMS

SharedCare
Partners for Patients



			 Through the collective feedback provided from primary care providers, it is evident that there continues to be gaps in the coordination and communication of care between healthcare providers. Additionally, there are gaps in provider knowledge about the services provided by their MHSU Clinician, which could present as an opportunity to help providers and patients navigate the complex mental health system.
Patient experience: To what extent does the program contribute to	Increased perception and understanding of available community resources	Patient satisfaction survey Provider survey	In 2020, the FNW administered a patient satisfaction survey to better understand the current climate of patient care, as it pertains to the accessibility of mental health supports and coordination of care between involved healthcare providers.

improved patient care?	Increased awareness and ability to access timely supports for patients	FNW Bi-monthly member Survey Program data	Through this survey, it was identified that 33% of patients indicated that they access mental health care support directly from their family doctor, with an average of 14.6 visits in the last year.  With regards to care coordination, an average of 64% of patients respondents noted they received enough support from their team of care providers, while 60% knew who to talk to if they had questions about their care. However, on average, respondents were less positive about knowing the next steps of their care plan (59%).

What is working well in your community?	
Theme 1: Emotional Support	
· I have strategies to deal with my anxiety. I have support · realizing I was not alone in experiencing my thoughts and feelings. There are care givers that CAN help.	· very positive affirmations and friendly people · empathic listening. Feeling supported. It's ok and will be ok · respect and kindness
Theme 2: Accessibility and Services	
· being able to make an appointment within usually a week or two · an importance of mental health and self-care focus when accessing counselling.	· had a whole team behind me; wait time to get to a specialist was short; check ins were easy; medication was not a focus, it was suggested but alternative routes were encouraged. · some exercise were guided and provided.
Theme 3: Other	
· someone noticed that I shouldn't be on 2 SSRIs · my own change, being lucky finding good practitioners, even though they are all private, So I had the opportunity to choose.	• self-sufficiency skill building, general care for others, always happy moments

Patients also noted *emotional support and accessibility to services* within their community as some themes that are working well. However, some ongoing barriers that impede patients ability to access care within their community include:

- Long wait times
- Access to mental health professionals
- Prohibitive costs associated with the services and types of care

Similarly, in the ongoing FNW bi-monthly member survey , members also recognize the barrier of the long-wait times that patients face when accessing mental health support within their communities. Family physicians indicated variations in wait times; ranging anywhere between few weeks to several months.

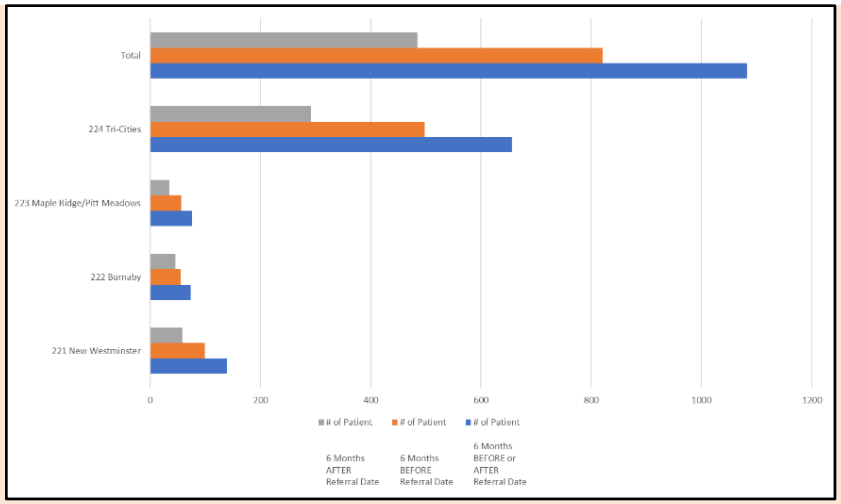
What are you noticing to be the current urgent Mental Health Wait times?

Raw Responses:

- *6 months for UCRC & 6 months for community referred psychiatrist*
- *few weeks*
- *getting worse x2*
- *Haven't had to refer anyone urgently recently, but when I did refer a few months ago, the patient had an intake interview relatively soon (within the week). Still need to wait to see a Psychiatrist, not sure how long.*
- *I do not routinely refer to psychiatry any more. This has greatly reduced my angst. The wait times are interminably long, and the lengths we go through to get psych involved are more and more convoluted - e.g. referring through web based portals to a psychiatrist in Vancouver.*
- *LOL maple ridge and surrey MH don't even respond to use.New West responds maybe a little quicker then before"*
- *Over a year for certain psych reviews!*
- *That they are long. That patients who can't afford to pay have to wait long times.*
- *Unsure/I don't know x7*
- *Very long...I find them very inefficient. Pts wait for months and see mental health team 1-2 times and sent back to GPs. Very frustrating*
- *4 weeks x3*
- *2 months x2*
- *1 month x5*
- *3 weeks*
- *long*
- *4-6 months*
- *I haven't needed to refer to MHT urgently in a long time. The last time it was just to update a Psychiatrist on an urgent issue for a patient who already had an appointment. The Psychiatrist saw the patient the following week and did comment on my concerns, so I was glad that they did read my letter.*
- *4 to 6 hours*
- *2-4 weeks x4*
- *MHT comes to our facilities so minimal*
- *months x2*
- *long... sometimes 6 months maybe longer - possibly falling through cracks*
- *6+ months from time of referral*
- *3-4 months often*
- *months for psych and almost impossible for therapy*
- *very long as usual since the pandemic*
- *1-2 weeks*
- *1-3 months*
- *2-10 days*
- *3-6 weeks*
- *As a locum I work in various communities; but across the board, very long. Feel like do not have anywhere to send patients other than ED when urgent*
- *Impossible - very hard to get into a psychiatrist quickly*
- *months*
- *No*
- *Quick to get into the MH clinician but long waits for psychiatry or actual therapy*
- *Times and no follow up after discharge*
- *tough to say as its so long it's hard to tell when I refer them and when they are seen*
- *Wait times have been reasonable lately*
- ***New** 3-6 months*
- ***New** Depends on service*
  Contacting patients are quick but rapid access or psychiatric 4-6 months"
- ***New** FEW WEEKS*
- ***New** I haven't done any urgent MH referrals lately.*
- ***New** Lack of availability to see them.*
- ***New** Long wait times to see a MHT*
- ***New** Many weeks, getting longer*

(See appendix 3)

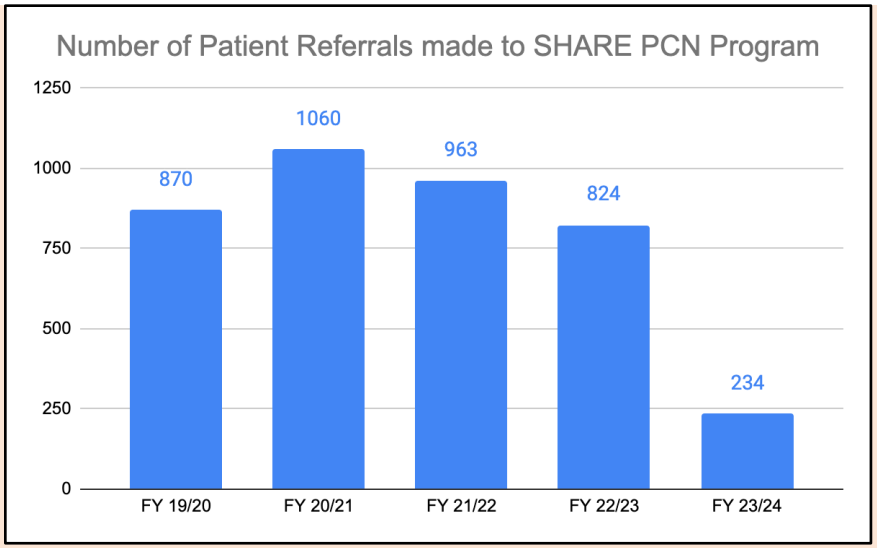
Throughout this project, it was identified that there were limitations with the data collected that addressed the impacts of accessibility to mental health services as it related to patient care. However, it is important to highlight the aggregate level data documented by the Ministry of Health (MoH). The visual below exemplifies how the introduction of community based counselling programs, such as SHARE and PCN MHSU, has resulted in decreased utilization of counselling services at the Patient's Medical Home.



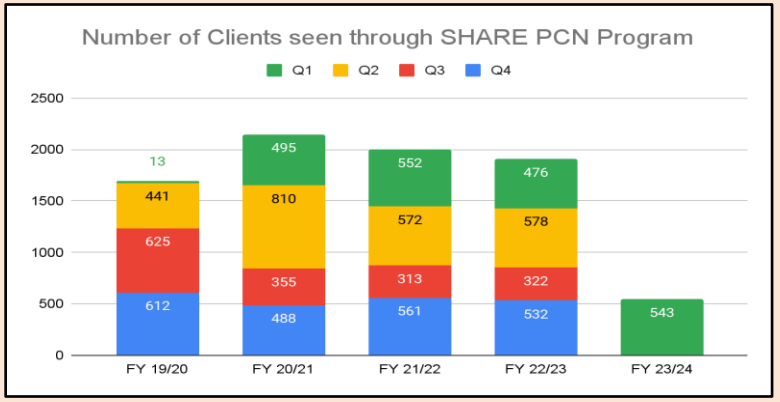
This data shows an aggregate percentage of healthcare usage among patients within the FNW (Tri-Cities and New Westminster) prior to referrals being issued by family physicians. As a result, there is a trending and consistent decrease in service utilization in the month prior to a referral being made to community counselling supports.

While this data may not address the patient perspective on the available community resources or timely access to services, it does show how many patients have increased access and utilization of community counselling services and its direct impact on provider capacity.

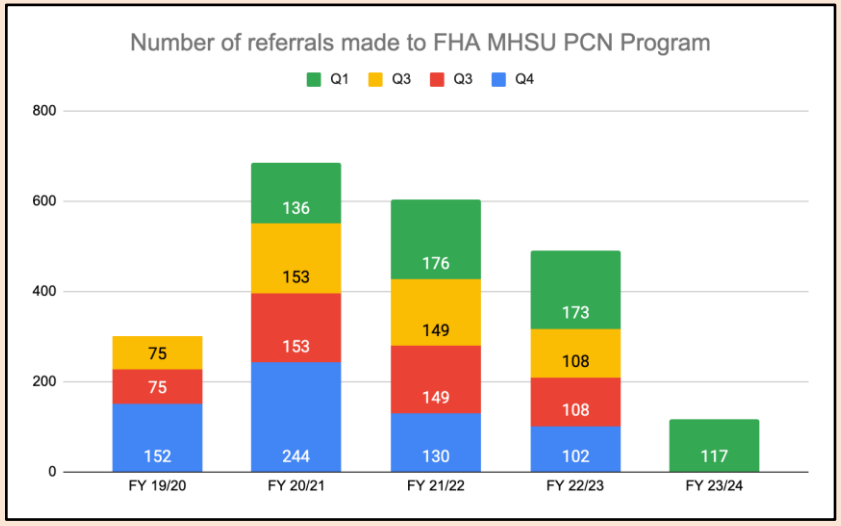
System costs: To what extent did the program contribute to a change in healthcare utilization and what effect did it have on system costs?	Decrease in wait times for certain specialities as understanding of care pathway by patients/providers increases Increase in visits to mental health community supports for patients as providers education increases	Program data FNW bi-monthly member survey Program documentation Pathways data FNW member Events SHARE Referring Provider Survey	It is also important to highlight the ongoing use of specialty clinics, such as the *Rapid Access Psychiatry Clinics* located in New Westminster and the Tri-Cities. In a recent report pulled from Pathways, the current average wait times from referral to appointment is approximately 2-4 months. The *Outpatient Psychiatry Department at RCH* is another program patients can be referred to. Currently, the average wait time from referral to appointment ranges between 4-6 months. Due to limited data collected on the average wait times throughout the course of the project, and restricted access to historical data, reporting on changes in average wait times cannot be reported at this time. While wait times to access psychiatry are often long, providers may refer patients to mild to moderate mental health supports in the interim. Throughout the duration of this project, the FNW obtained ongoing data speaking to the number of referrals directed to SHARE and MHSU PCN counselling services. A project activity that was identified as a focus was increasing visits to mental health community support for patients. The intention of these services was to provide rapid counselling support for patients, while reducing the burden placed on family physicians. The average wait time for both services is 1-2 weeks. Below are the number of referrals made to SHARE Clinical Counsellors:



The graph below provides an overview of the number of clients seen through the SHARE PCN program:



The graph below provides an overview of the number of referrals made to the FHA MHSU Program per fiscal year:



This data shows the ongoing utilization and need for community programs such as SHARE and MSHU PCN for patients within the FNW Communities. Through the collected data, it is evident that there continues to be an increase in the usage and demand of community mental health support for patients residing in the FNW region. Feedback from primary care providers noted that these programs are helpful for their patients and noticed improvements in their mental health. A gap identified by physicians is that the counselling services only provide short term counselling and that some patients may need longer term counselling services. Below shows the feedback that was collected:

Are there any gaps that remain for your patients with low-moderate mental health concerns? (please describe.)

Raw responses

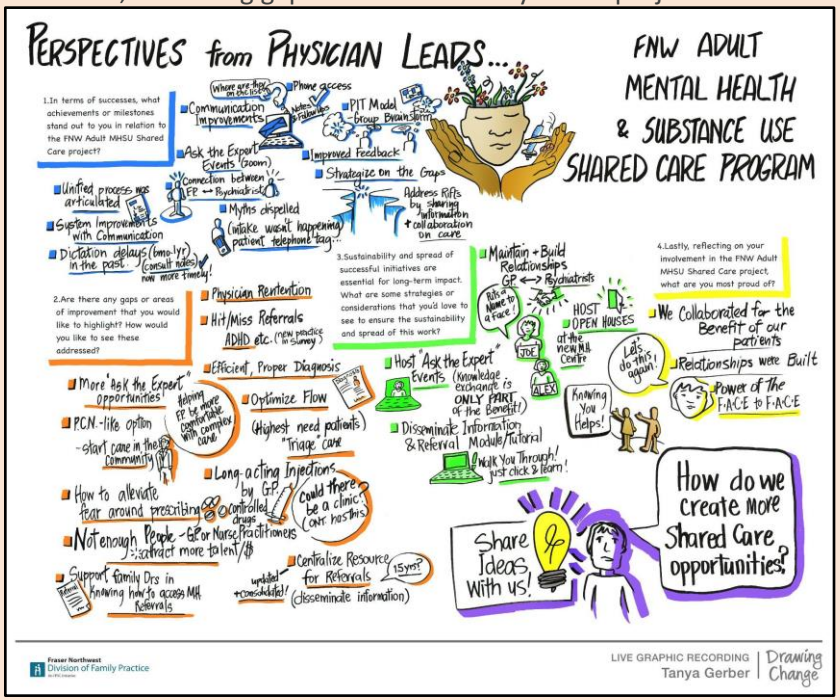
- Attendance and participation
- Face-to-face one-to-one therapy (not virtual) that is not financially prohibitive.
- free counselling
- Increased options for in-person services, particularly CBT, are needed. Updated guidelines indicate CBT is first line but options are limited to virtual and group CBT.
- Language barrier affects access to counseling services for some pts. Lack of social support and financial strain are some of triggering/exacerbating factors
- limitations in the number of sessions they are able to receive.
- Limited amount of sessions. Communication about what was worked on and what improved from the sessions and recommended follow-up.
- Long term 1 on 1 counseling options for those requiring CBT are non-existent. CBT through RCH /health authority only provides group therapy
- no
- not with this program
- One o one counseling with a consistent counsellor still challenging
- patients often struggle to follow up with organizing counselling on their end
- Possibly support groups, group counselling
- Pts would benefit from longer term counselling but I know there are finite resources. Would also be helpful to have passively suicidal patients seen earlier because mental health team waitlists are so long.
- "specialized counselling- trauma/ PTSD / ADHD
- more CBT focused therapy
- group therapy
- SUBSTANCE USE for adolescents - including marijuana use disorder"
- "Wait time
  Language barrier"
- Yes
- Yes. Sometimes need to get a psychiatrist opinion, many barriers with that

Note: The above data was obtained from the SHARE Counselling Referring Provider survey in June 2023

Similarly, the Cognitive Behavioural Therapy (CBT) skills program is another service that has been introduced across the province. The group engaged with our committee and the primary care providers in our region to increase awareness of this service.

Below highlights the number of referrals made between 2020 to 2023:

Year	# of referrals
2020	22
2021	108
2022	183
2023	153

			Note: The above referrals were made from a total of 234 referring providers. It is important to note, there is a steady annual increase in the number of referrals made to the CBT skills program. While there is limited data to suggest the impact this may have on patients and providers, it is evident that there is an increase in mental health visits to community support programs and services; in addition to a growing awareness of these resources by providers.
Sustainability & Spread: What were the unanticipated outcomes of the proposed strategies?	Sustainability of program	Physician lead interviews/Provider Journey Map	As part of the close out activities for this project, a graphic facilitator helped to document and visualize the physician leads feedback around the successes, remaining gaps and sustainability of the project.  (See appendix 4)

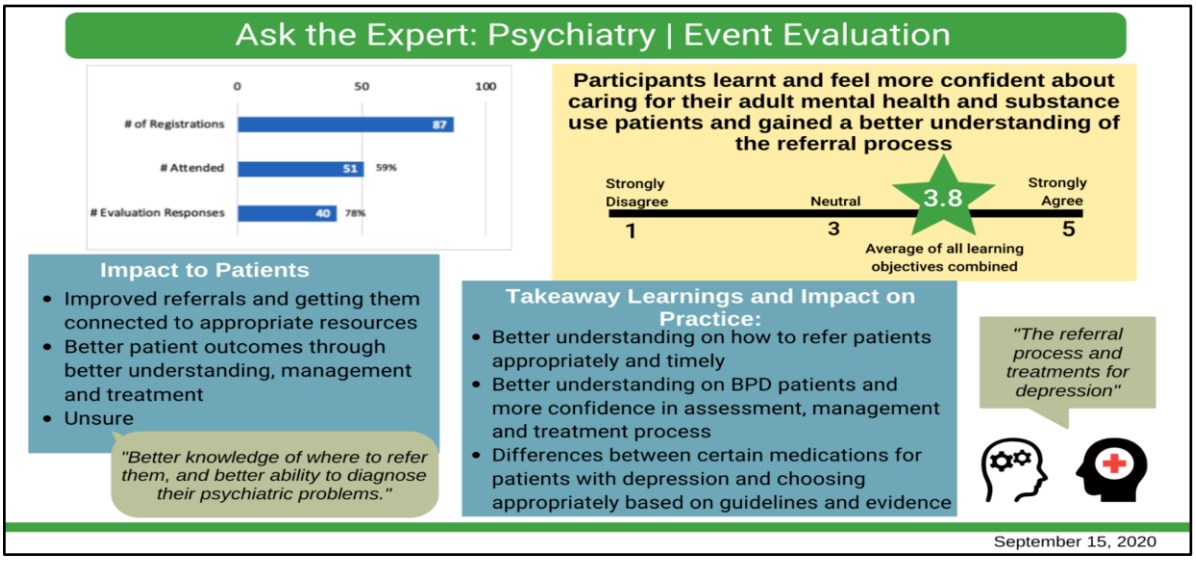
			Successes: ● Improved communication among providers - *"Biggest issue at the beginning was we didn't know what happened to the referral, but the fact that we could directly talk to each other and bring it back to the people who can help change is what helped to dispel the myth that intake wasn't happening"* ● Provider education events - *"Great way to connect family physicians to the psychiatrists to create familiarity"* **Remaining Gaps** ● Complex mental health patients - "*Biggest thing we are facing now - a lot of complex patients with a lot of ADHD/anxiety and differentiating between the two. Some psychiatrist don't diagnose but some psychiatrists are okay with doing this."* ● Lack of primary care providers to support mental health patients in their care **Sustainability** ● Continued expanding on relationship building through provider education events - *"A lot of what we did was knowledge exchange - can't sustain the knowledge for these new providers. The value came from interaction and ability to ask questions…however certain processes have been hard coated and will continue (such as the intake process and referral communication)"* Overall the key lessons learned from this project include the importance of ongoing education events and relationship building through collaborative efforts between family physicians and specialists. Through the aforementioned efforts, this may have the opportunity to better support providers in the delivery of patient care.

*__Shared Measures__ were not implemented at the time of this project creation/implementation

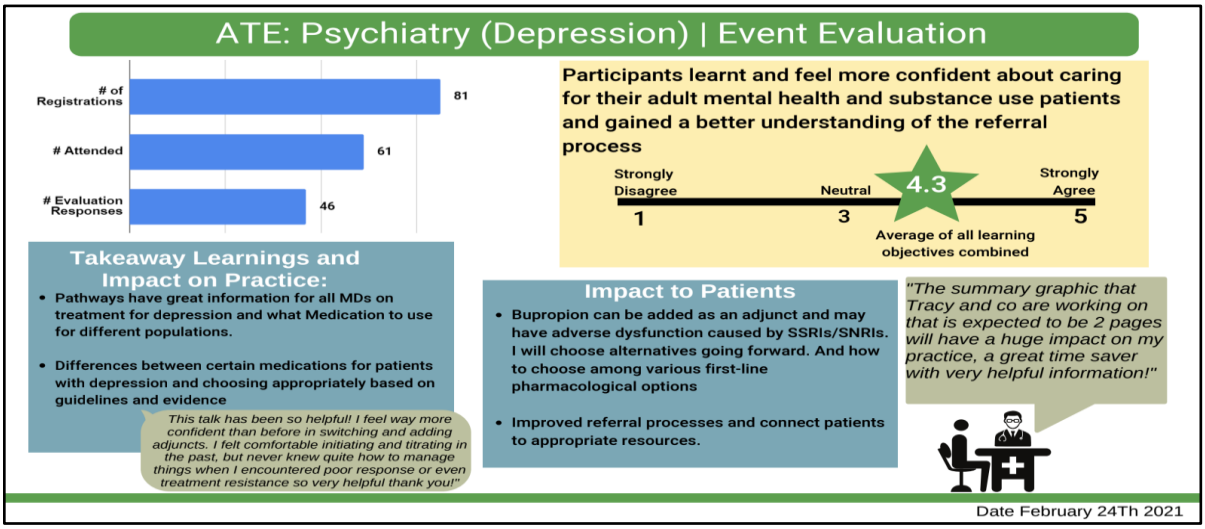
APPENDICES

- Appendices of relevant documents that would be helpful for the audience.
- Provider testimonials, patient impact stories, and quotations including the Physician Lead End of Project Survey
- Include PDF copies and links to all resources created during the project.

Appendix 1: Ask the Expert(ATE) Psychiatry (2020) Event Evaluation



Appendix 2: ATE Depression (2021) Event Evaluation



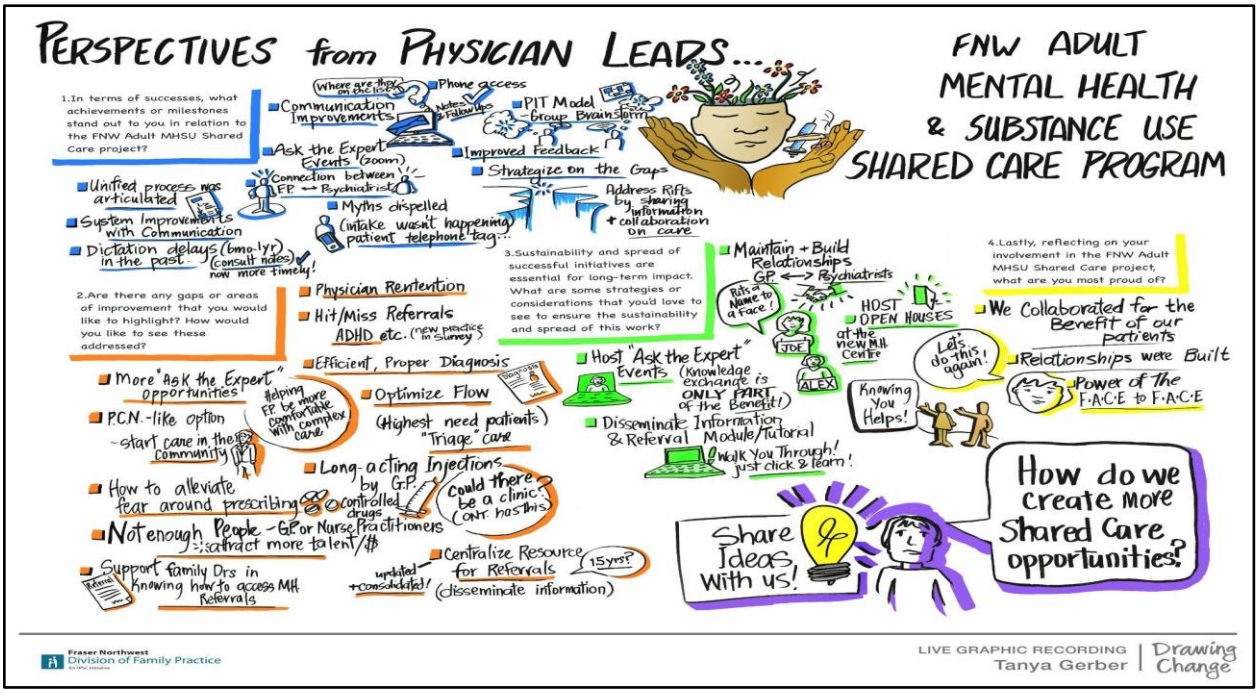
Appendix 3: Bi-Monthly Survey

What are you noticing to be the current urgent Mental Health Wait times?

Raw Responses:

- *6 months for UCRC & 6 months for community referred psychiatrist*
- *few weeks*
- *getting worse x2*
- *Haven't had to refer anyone urgently recently, but when I did refer a few months ago, the patient had an intake interview relatively soon (within the week). Still need to wait to see a Psychiatrist, not sure how long.*
- *I do not routinely refer to psychiatry any more. This has greatly reduced my angst. The wait times are interminably long, and the lengths we go through to get psych involved are more and more convoluted - e.g. referring through web based portals to a psychiatrist in Vancouver.*
- *LOL maple ridge and surrey MH don't even respond to use.New West responds maybe a little quicker then before"*
- *Over a year for certain psych reviews!*
- *That they are long. That patients who can't afford to pay have to wait long times.*
- *Unsure/I don't know x7*
- *Very long...I find them very inefficient. Pts wait for months and see mental health team 1-2 times and sent back to GPs. Very frustrating*
- *4 weeks x3*
- *2 months x2*
- *1 month x5*
- *3 weeks*
- *long*
- *4-6 months*
- *I haven't needed to refer to MHT urgently in a long time. The last time it was just to update a Psychiatrist on an urgent issue for a patient who already had an appointment. The Psychiatrist saw the patient the following week and did comment on my concerns, so I was glad that they did read my letter.*
- *4 to 6 hours*
- *2-4 weeks x4*
- *MHT comes to our facilities so minimal*
- *months x2*
- *long… sometimes 6 months maybe longer - possibly falling through cracks*
- *6+ months from time of referral*
- *3-4 months often*
- *months for psych and almost impossible for therapy*
- *very long as usual since the pandemic*
- *1-2 weeks*
- *1-3 months*
- *2-10 days*
- *3-6 weeks*
- *As a locum I work in various communities; but across the board, very long. Feel like do not have anywhere to send patients other than ED when urgent*
- *Impossible - very hard to get into a psychiatrist quickly*
- *months*
- *No*
- *Quick to get into the MH clinician but long waits for psychiatry or actual therapy*
- *Times and no follow up after discharge*
- *tough to say as its so long it's hard to tell when I refer them and when they are seen*
- *Wait times have been reasonable lately*
- ***New** 3-6 months*
- ***New** Depends on service*
  Contacting patients are quick but rapid access or psychiatric 4-6 months"
- ***New** FEW WEEKS*
- ***New** I haven't done any urgent MH referrals lately.*
- ***New** Lack of availability to see them.*
- ***New** Long wait times to see a MHT*
- ***New** Many weeks, getting longer*

Appendix 4: Graphic Illustration of Physician Leads Feedback



Appendix 5: Physician Lead End of Project Survey