Fraser Northwest
Division of Family Practice
A GPSC initiative

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Community Health Services Focus Group - Year in Review

(April 2021 - March 2022)

The purpose of this focus group is to create an open dialogue between home health, mental health and community physicians; discuss ways to provide optimal care in the community; and highlight areas to work on moving forward.

Summary of Topics Covered

Home Health

- Introduction to Community Resources *(April 2021 - March 2022)*
- Communication Processes *(April 2021 - March 2022)*
- Covid-19 Vaccines *(April 2021 - December 2021)*
- Relational Continuity *(July 2021 - August 2021)*
- Financial Barriers *(July 2021 - November 2021)*
- Emergency Access to Home Support *(October 2021)*
- Pronouncing Death *(February 2022)*
- Caregiver Support Clinician *(July 2021 - February 2022)*
- Advanced Care Planning *(February 2022 - March 2022)*
- Medical Assistance in Dying *(March 2022)*

Mental Health

- Wait Times *(April 2021 - March 2022)*
- Central Intake *(April 2021 - March 2022)*
- Referral Forms *(April 2021 - March 2022)*
- Communication Process *(April 2021 - March 2022)*
- Rejected Referrals *(April 2021 - March 2022)*
- Self Referrals *(February 2022 - March 2022)*
- Navigation of Services *(April 2021 - March 2022)*
- Access to Psychiatric Care *(June 2021 - March 2022)*

Acronym Dictionary:
CHN: Community Health Nurse
CHW: Community Health Worker
NP: Nurse Practitioner
RNiP: Registered Nurse in Practice
PCN Clinician: Primary Care Network Mental Health Clinician
MOA: Medical Office Assistant

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Home Health, Home Support & Community Outpatient Services

Introduction to Community Resources

Provider Challenges or Concerns:

- There is a need to provide education to ensure that primary care providers, especially those that are new to working in this community, are aware of the different community resources available.

Barriers:

- The virtual events organized by the Division to introduce these services received feedback that they were not personalized or interactive.

Actions Implemented:

- The teams have aimed for a more individualized, targeted approach with clinics by arranging meetings with each clinic's physicians, NP, MOA and RNiP to introduce themselves. Clinics that do not have not have a direct connection with their CHN were prioritized.
- Scheduled check-in meetings with the clinic's CHN and PCN clinician are being offered to continue this relationship building.

Ongoing or Future Work:

- Create videos that share the supports available to providers and instructions on how to access the different services.
- Hold an in-person event where providers are introduced to the community services available to support them.

Communication Processes

Provider Challenges or Concerns:

- There is a need to clarify when initial assessment notes from CHNs and rehab staff are faxed to the client's physician.

Barriers:

- Providers have different opinions and preferences on the best method of communication and what information is necessary to be shared.

Actions Implemented:

- The Division sent a survey to providers in the community to find out their preferences about communication with their CHN. It was determined that providers prefer receiving communication through fax, and would like to receive an initial report when a patient is referred and consult notes when there are changes to the patient's condition.

- The Home Health team reminded and followed up with CHNs and Rehab staff to fax initial assessment notes and any change in care plan to the client's physician.
- Feedback about the Primary Care Practitioner (PCP) Communication tool and process was discussed and a decision was made to discontinue use of PCP Communication tool. Fax communication implemented.

Covid-19 Vaccines

Provider Challenges or Concerns

- Providers were not aware of which of their patients had declined to receive the Covid-19 vaccine.
- It is unclear what the referral process is for vaccinating non-home health clients who are homebound.

Actions Implemented:

- Home Health compiled a list of patients followed by their teams that declined the vaccine and faxed this list to the provider for follow up.
- It was shared that any referrals sent through the service line for vaccines are administered if the client is homebound, regardless if they are a Home Health client.

Relational Continuity

Provider Challenges or Concerns

- When there is a consistent CHN attached to the clinic, the provider feels more comfortable taking on new homebound, frail patients.

Ongoing or Future Work:

- Plan ways to measure relational continuity among CHNs and patients in the community.

Emergency Access to Home Support

Provider Challenges or Concerns:

- There should be a process for a rapid response if a patient urgently needs access to home support.
- It is challenging to get urgent support if the patient is not known to Home Health.

Ongoing or Future Work:

- Home Health will work on improving the presentation of the after hours contact information on Pathways

- Home Health will provide steps on how to get a temporary, urgent nursing response.
- Home Health will look at the capacity for an after hours call line and for the evening nurses to provide urgent home support.

Pronouncing Death at Home

Provider Challenges or Concerns

- There needs to be an improved process for pronouncing a death at home if a patient is not palliative; it is unclear who to call and this is not the best use of emergency services.

Ongoing or Future Work:

- Develop a care pathway for dying at home.

Caregiver Support Clinician

Provider Challenges or Concerns:

- There is a need for improved communication dissemination about the role of this social worker, their scope of practice and the referral process.
- It is important to expand these services to support those that are not attached to home health.
- It was discussed that the title “Caregiver Support Practitioner” was unclear.

Actions Implemented:

- A listing on Pathways was created for this service.
- Educational documents were sent out in a Division newsletter as well as shared with the RNiPs, CHNs and CHWs.
- The title of the service was updated to “Caregiver Support Clinician”.

Ongoing or Future Work:

- The Home Health team will include information about the program in the standard home health admission package that is currently being developed.
- Pilot a QI project to gather data on the drivers behind caregiver stress and develop a caregiver stress assessment algorithm in order to make systematic change.
- Look into expanding referral criteria so that a relationship to home health is not required for a referral.

Advanced Care Planning

Provider Challenges or Concerns:

- Some providers are not aware of the process for faxing advanced care planning records to FHA to be uploaded and recorded in their system. There may be a gap in how this is communicated from community to acute and vice versa.
- Doctors do not have access to Green Sleeves or My Voice booklets in their clinics.

Actions Implemented:

- Continue highlighting the Advanced Care Planning Pathway for Division members to refer to.
- It was incorporated in the patient screening process to identify patients who do not have their MOST filled out and ensure the CHN informs the provider if it is not completed.
- Home Health ordered Greensleeves and My Voice booklets for the Division to provide to clinics.

Medical Assistance in Dying

Provider Challenges or Concerns:

- It is difficult to find clear information for providers on their role when supporting a patient who is interested in MAiD.
- It is a lengthy process and there is a package of forms that the provider needs to fill out.

Actions Implemented:

- The Division has scheduled an educational session for members on this topic.
- The MAiD team worked with Pathways to confirm that information on this service is appropriately presented on Pathways.
- A care pathway for MAiD was developed.

Mental Health and Substance Use Services

Wait Times

Provider Challenges or Concerns

- Services have lengthy wait times which has a detrimental effect on providers and patients.

Barriers:

- There are differences in population size, capacity and funding for services in different communities.

Ongoing or Future Work:

- Provide a list of alternative resources for patients to access in the meantime if there are long wait times and a plan for steps the provider can take if the patient decompensates.
- Conduct a formal review of data that collects population metrics to advocate for increased funding.

Central Intake

Provider Challenges or Concerns

- There is confusion surrounding the Central Intake process.
- Some believe this is an extra step to take since the service is not standardized across the health authority.

Barriers:

- There are conflicting needs depending on physician autonomy, length of experience in the community, and experience with the patient panel; some providers want a single referral entry point while others want to understand the services so they can refer directly.

Actions Implemented:

- FHA explained that the purpose of this service is to reduce the burden of rejections as referrals sent to Central Intake should not be declined.

Ongoing or Future Work:

- Central Intake was previously not tracking referrals, but they are now working with FHA analytics to capture this data.
- Plan a PDSA cycle to evaluate the Central Intake service.
- Look into options to make the Central Intake service relational (similarly to the PCN Clinician) or standardized across the health authority.

Referral Forms

Provider Challenges or Concerns:

- Referral forms are lengthy to fill out and costly to update.

Actions Implemented:

- The PCN Clinician Pathways listing has been updated to state that generic referral forms are accepted, including a list of information that is required to be included in a generic referral letter.

Ongoing or Future Work:

- The Division is exploring different options with PSP or DoBC to provide clinical workflow support to clinics to assist with filling out forms.
- Programs need to ask for input from providers when developing referral forms, as sometimes information on the form is not used and/or the patient is asked the same questions at intake.

Communication Process

Provider Challenges or Concerns:

- The communication loop that indicates confirmation of referral receipt, approximate wait times and next steps is sometimes delayed or inconsistent.

Actions Implemented:

- A referral letter is being sent to the referring provider to ensure they receive accurate information about the status of their referral.
- A discharge letter is being sent to the referring provider after a patient has been released from care.

Ongoing or Future Work:

- Advocate for the implementation of the Pathways Referral Tracker in this region.
- Map out the care pathway to find out all of the steps in the process when a referral is made to each service.

Rejected Referrals

Provider Challenges or Concerns:

- There are common themes that have been identified for rejected referrals (i.e. concurrent disorders, addictions, patients refusing to take medication, and history of ICBC or WBSC claims).
- Referrals to the Child & Youth eating disorders program are rejected if specific information is not included. Some patients are unable to get these diagnostic tests done due to their disorder (i.e. patient weight) and it becomes a barrier for them to access these services.
- Referrals for patients living in different communities are rejected and sent back to the referring provider, when it would be more helpful if the program referred directly to the service in the appropriate community on the provider's behalf.
- A point of contact needs to be identified who is accountable for explaining why a referral is rejected so that we can work to reduce rejections in the future.
- A patient's file is closed if the program cannot contact patients after trying several times.

Barriers:

- There is no cookie cutter algorithm to explain why a referral is rejected.

Actions Implemented:

- It was shared that services are not meant to refuse a referral due to a Worksafe claim as this is against college guidelines to provide access to medical care without discrimination.
- Providers can contact the Fraser Northwest Division, their PCN Clinician or ask to speak to an intake worker at the Mental Health Centre to find out why a referral was rejected.

Ongoing or Future Work:

- Implement a regional process for referrals to be sent to the appropriate location rather than rejected.
- FHA will take a closer look at how the decision to reject a referral is made and see if the process can be improved (i.e. have the intake worker call the clinic if there is missing information, send the referral to the PCN clinician to triage and navigate the referral through the system).

Self Referrals

Provider Challenges or Concerns:

• Unattached patients without a referral from a walk-in clinic were being refused by intake clinicians until they could get a referral from a provider.
Barriers: • The psychiatrists have limited sessional funding, and require a GP referral for FFS billing.
Actions Implemented: • FHA is no longer requiring unattached patients to seek a doctor referral; they have educated the intake clinicians to ensure patients are not being refused for this reason.
Ongoing or Future Work: • Advocate for an increase in sessional funding and/or a patient self referral fee for psychiatrists so that they do not require a GP referral.

Navigation of Services

Provider Challenges or Concerns: • The services listed on Pathways are challenging to navigate through. • Rejected referrals tells us that the referral criteria is not clear and it is not well understood what the programs offer.
Barriers: • It is difficult to know where to refer based on severity/clinical diagnosis and which referral form to use. • The differences between the counselling services are not clear. • Pathways has a hard time of listing and organizing services because there is no specific contact person.
Actions Implemented: • The Division mapped out a navigational tool to better understand FHA MHSU services. • The Division and FHA have met to review the information in the Pathways listings for accuracy.
Ongoing or Future Work: • Find a “go to person” for each service on Pathways to clarify the content and information listed. • Organize the Pathways service list so there is one page that is clearly differentiated into categories where you would be able to click to quickly find the referral form. • Organize an event that provides an overview of all mental health services, processes for referrals and Pathways navigation tips for MOAs and providers.

Access to Psychiatric Care

Provider Challenges or Concerns:

- After a psychiatrist provides a diagnosis, the onus to initiate therapy for the patient has been pushed back on the provider without any consultation and the provider is expected to prescribe medication they are not familiar with.
- Providers are expected to provide continuity of care for patients' psychiatric care as there are limited options for longitudinal psychiatric care.
- Lack of access to rapid access mental health resources means that patients in a mental health crisis often end up in the Emergency Department.

Barriers:

- It is more efficient for psychiatrists to send patients back with a treatment plan and allow the provider to follow them, as a method to address the significant wait times.
- There are capacity issues with a patient being cared for long-term by a psychiatrist that is meant to only provide rapid access care.
- All sites across the province are having difficulties staffing as there is a lack of psychiatrists.

Ongoing or Future Work:

- Work on using the available resources to ensure there are services available for a patient in a mental health crisis.
- Continue to explore options for a longitudinal psychiatric clinic and a walk-in rapid access psychiatry clinic.
- Advocate for the implementation of text based support services.