CHILLIWACK FRASER HEALTH RURAL PCN

Mental Health and Substance Use Service

Phase 1 Report

June 2021

REICHERT & ASSOCIATES
PROGRAM EVALUATION & RESEARCH

Chilliwack Division of Family Practice
A GPSC initiative

fraserhealth
Better health. Best in health care.

Executive Summary

About this Report

This report summarizes evaluation findings related to the development, implementation, early impacts and learnings from **Phase 1** of the Chilliwack and Fraser Health Rural Primary Care Network Initiative (PCN) Mental Health and Substance Use (MHSU) Service, spanning from **January 1 to April 30, 2021**.

Development, implementation and utilization of the MHSU service

Key Finding	Details / Examples
The service was developed in consultation key stakeholders with MHSU expertise	○ A working group was created, involving physicians, Chilliwack Division staff, Fraser Health staff, and consulted a psychiatrist and person with lived experience, to inform the design and implementation of the service
Phase 1 of the service was implemented as planned	○ 3 MHSU clinicians were integrated into 3 clinics ○ Regular check-in meetings helped to refine the service and troubleshoot and resolve issues as they arose
Providers activated the service for 89 patients	○ From January-April 30 2021, providers activated the service for 89 patients ○ The majority of service activations were from GPs, followed by NPs
202 patient visits/sessions were provided by clinicians	○ 202 visits and/or one-to-one counselling sessions were provided ○ 60% of these visits were in person, and 37% were by telephone ○ The highest proportion of visits were continuing sessions and 7 patients have completed the service as of April 30, 2021
MHSU system/service navigation support provided by clinicians	○ Clinicians connected patients to, or informed providers of, other services/resources (e.g. crime victims assistance, transition houses or adult mental health and substance use)

Early impacts from Phase 1

GP/NP Interviewees:

"It's an extension of what they (patients) are used to already, rather than an unknown entity."

"It takes a weight of your shoulders."

"There are patients that are getting counselling who wouldn't have gotten counselling."

Reduces barriers for patients and may lead to improved quality of care, patient satisfaction and health outcomes	○ Having providers refer to a clinician on their team helps to build trust and 'normalize' MHSU services for patients ○ Having both physical and mental health experts working together is expected to improve the quality and continuity of patient care ○ The timeliness of the service is expected to improve the patient experience of care, and potentially health outcomes
The service supports providers and increases their awareness of resources available	○ Having access to a clinician with the time and expertise to support their patients has made providers feel supported and less stressed or worried ○ Clinicians are identifying helpful services/resources that providers were previously unaware of
Addresses a gap in the MHSU system and enables preventative care	○ The service is serving those who cannot afford or who would not qualify for other MHSU services ○ Providing care for the mild-moderate population may help to prevent the need for hospitalization or more acute care

Facilitators and learnings from Phase 1

Key Finding	Details / Examples
Facilitators of Success	
The experience of the providers and clinicians involved	○ Providers at the participating clinics had experience with team-based care and were familiar with identifying and/or connecting patients to MHSU services

	○ The clinicians hired were experienced and had existing relationships and connections in the community
Co-location of the clinician and informal communication and relationship building	○ Clinicians were able to meet with clinic teams and serve patients in-person which enabled them to be seen by patients as 'an extension of the clinic' and have access to patient information ○ Co-location enabled clinicians to have brief 'hallway' conversations with GP/NPs to provide updates on patients and offer timely advice or support
Learnings	
High demand for MHSU services	○ All 3 clinicians have reached capacity and there is a waitlist ○ Caseload capacity fluctuates and depends more on the needs of the patients than the total number of patients being seen by the clinician
Difficulties defining what is mild to moderate	○ There is no standard definition of mild to moderate; it varies based on the experience/comfort level of the providers/clinicians involved
Difficulties understanding the role of the clinician	○ The role of the clinician in this service was seen as a move away from the typical understanding of the role, both providers and clinicians felt the role differed from their initial expectations or understanding
Limitations of the inclusion criteria and number of sessions	○ Providers need support for patients outside of the inclusion criteria: moderate to severe patients, complex MHSU patients, and youth ○ The maximum number of sessions may be a barrier for some patients and may not allow the clinician time to provide comprehensive care
Inefficiencies documenting patient information	○ While accessing patient information is easy, the wealth of information may be time consuming for clinicians to review as is sharing/receiving information through Exceleris.

Suggestions from Phase 1

Key Finding	Details / Examples
Importance of preparing clinics for onboarding and integration	○ Ensure both the clinicians and providers/clinics involved have a clear understanding of the service, the role of the clinician, and what to expect well in advance of the onboarding process ○ During onboarding, it is suggested that more time is allotted for providers and clinicians to discuss how to define mild to moderate and caseload capacity ○ Consider creating/circulating a cheat sheet for patients
Streamline administrative processes	○ Review with providers how to access the patient information provided by the clinician ○ Explore ways to streamline the documentation of patient visits across clinic and Fraser Health EMRs and/or increase utilization of alternative ways of sharing information (e.g. Basecamp)
Formalize a waitlist system and consider what supports can be provided to waitlist patients	○ Standardize a waitlist process, including a timeframe and person responsible for connecting with waitlist patients, how to support GP/NPs to "triage" service activations, and a process to rotate waitlist admissions from different GP/NPs ○ Consider offering supports to waitlist patients, potentially a MHSU service/resource one-pager and/or group counselling
Retain co-location and enhance relationship building	○ It is suggested to continue to co-locate clinicians at the clinic and to increase the amount of time clinicians have at the clinic ○ Explore opportunities for clinicians to meet with clinic teams in-person or to participate in team-building events/activities ○ Consider allotting time for clinicians/providers to work together to develop collaborative care plans for their patients

Introduction

This report summarizes evaluation findings related to the development, implementation, early impacts and learnings from **Phase 1** of the Chilliwack and Fraser Health Rural Primary Care Network Initiative (PCN) Mental Health and Substance Use (MHSU) Service, spanning from **January 1 to April 30, 2021**.

About the MHSU Service

The MHSU service is a component of the PCN initiative. The stated goals of the service are to integrate MHSU clinicians and social workers into practices/health systems to provide team-based care and to support patients to receive timely access to comprehensive and continuous MHSU care. The service intends to build on existing foundations, use collaborative two-way communication and develop strong relationships with patients and other providers to provide timely and nimble, low-barrier access to MHSU care to patients that is culturally-safe and stigma free.

As stated in service documents, the service is being implemented in 3 phases (see Appendix A). In Phase 1 MHSU clinicians will be deployed in select practices to offer service navigation, in-person and virtual counselling, and to develop collaborative care plans for patients, primarily adults with mild to moderate MHSU challenges, who have not improved with primary care counselling/medication and who cannot afford private counselling services. **The stated goals of Phase 1 were to produce learnings to help develop a scalable model for the service and inform the integration of additional PCN resources into the health system**.

Areas of Learning for Phase 1

- The patient assessment criteria
- Facilitators of team-based care
- Impacts on providers, patients and broader health system

About the Evaluation

Reichert & Associates was engaged by the Chilliwack Division of Family Practice (CDoFP) to conduct an evaluation of the PCN initiative, with the MHSU service as a case study within the overall evaluation. To evaluate Phase 1 of the MHSU service, the evaluation team reviewed the following:

Document review: 32 MHSU service meeting minutes, from August 25, 2020 to May 5, 2021, were reviewed, including 8 MHSU working group meetings, 1 information session, 4 orientation sessions and 19 check-in meetings. Slide decks from MHSU working group meetings, the information session, the orientation sessions and check-in meetings were reviewed as was the MHSU Service Cheat Sheet.

Key Informant interviews: 11 providers involved in the service were interviewed (4 MHSU Clinicians and 7 GP/NPs).

Administrative data: Service activations and patient visits from January 1, 2021 to April 30, 2021.

Survey: A survey was administered to patients upon completion of the MHSU service. An estimated 7 patients had completed the service as of April 30, 2021 and 2 patients completed the survey. *Due to few patients having completed the service by the end of Phase 1, this data has not been included in this report but will be reported in Phase 2/3*.

Development of the MHSU Service

In August 2020, a working group comprised of physicians, staff of the CDoFP and Fraser Health, and consultation with a psychiatrist and person with lived experience, was created to support the development and phased implementation of the MHSU service. The working group has, and continues, to provide a variety of service design recommendations related to the **patient inclusion criteria**, including target populations, the **nature of the service**, including focus areas of practice, **the roles of the MHSU clinicians**, as well as the **service activation and utilization process**, including specific mechanisms, processes and protocols for service activation, service utilization, coordination and communication.

Inclusion criteria:

- Patients with mild to moderate MHSU challenges (i.e. are not incapacitated by their MHSU issues)
- Patients previously provided medication and/or counselling by their physician but are not improving
- Patients who cannot afford private counselling (according to their own self-report)
- Adults (18 plus)

Nature of the service:

- Short term 1-1 counselling (1-8 sessions mild; 10-20 sessions moderate)
- Support to access longer term services, if needed
- Assistance to navigate and access other MHSU supports
- Team-based care with primary care provider

Implementation of Phase 1

An initial information session about the MHSU service was held on December 1, 2020 and was open to all members of the CDoFP. A total of 31 individuals attended this session, including 25 Division members, 3 Division staff, 1 Fraser Health staff and 2 team members from Reichert & Associates. The session outlined the consultation process, the goals of the service, the nature of the service, the inclusion criteria, and the phased approach to implementation whereby the service would be piloted in a small number of clinics to 'work out challenges' and inform the development of a scalable model for the service and the integration of additional PCN resources into the health system.

Evaluation findings suggest that efforts were made to engage providers in the development of the service and an overview of how the service was developed was included in information and orientation sessions. Several GP/NP and MHSU clinician ('clinicians') interviewees, however, were unaware of, or did not recall, how the service was developed or how the inclusion criteria was decided upon.

Hiring process

Three clinics were involved in the initial pilot phase of the MHSU service and three MHSU clinicians were hired and integrated into these clinics in January 2021. A fourth clinic, and fourth clinician, was hired and integrated in May 2021[1]. The hiring process for the clinicians, as described by one interviewee, involved an interview panel, including staff from the CDoFP, Fraser Health and a physician. As noted by two clinician interviewees, the hiring process was long, having applied in October/November and assigned to a clinic in January.

Integration process

Once the clinicians were assigned to a clinic(s), they were provided with workspace at the clinic a few shifts a week in order to meet in-person with patients and clinic staff. In all cases, the CDoFP and Fraser Health

[1] *This clinician left the MHSU service after 2 weeks in the role.*

hosted a planning meeting and an orientation session to introduce the clinician to the clinic, and discuss the following topics:

- The role and scope of the MHSU clinician
- The nature of the service
- The patient selection criteria (inclusion criteria)
- Service activation process (referral process)
- Logistical considerations (e.g. space, policies, safety, patient consent, access to EMR, access to physicians)
- Billing, compensation and credits

Tasks of the MHSU Clinician*:

- Diagnostic client assessment, brief short term individual therapy
- Crisis intervention and outreach as required
- Coordinate cases and formulate treatment plans
- Linkages to community services
- Advocacy to assist patients accessing social determinants of health-housing, food security, income
- Education to families

**Tasks highlighted in orientation slide deck*

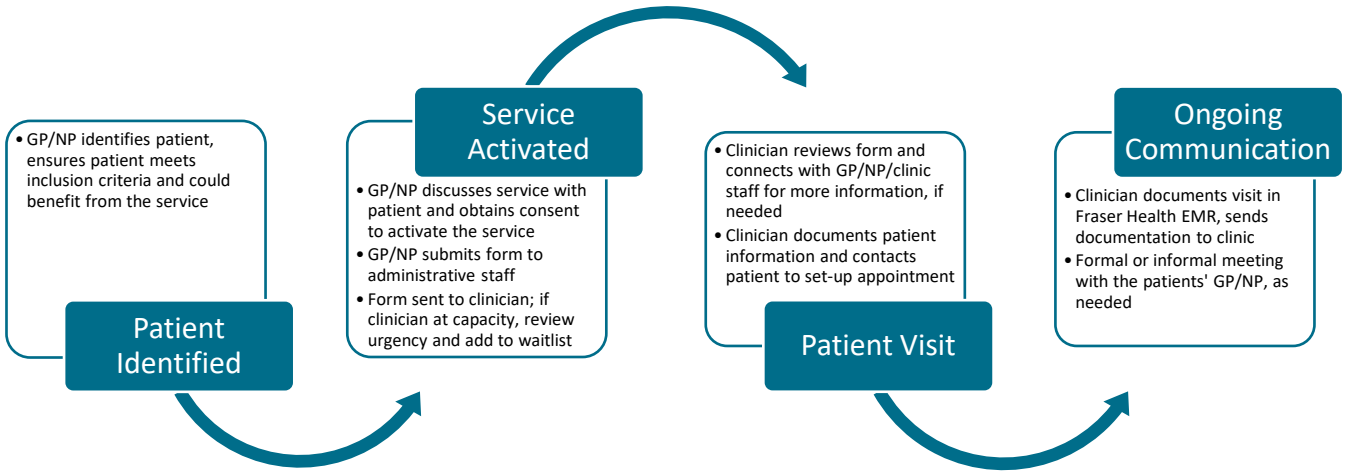
Training on cultural safety and humility, how to document/retrieve patient information and billing was delivered to the providers and clinicians involved during onboarding and one clinician interviewee also shared that training was provided through Fraser Health prior to their integration to the service, stating that *"I think we were **offered quite a bit of training which I was thankful for**".*

After this in initial orientation, the participating clinics decided to institute regular check-in meetings (bi-weekly, monthly, as needed, as decided by the clinic) with CDoFP and Fraser Health to monitor how the service was operating, identify needs or troubleshoot any issues. In addition to these meetings, a 'cheat sheet' was developed and circulated by the CDoFP and Fraser Health to participating clinics in early February 2021, which provided an overview of the inclusion criteria, the nature of the service, how to refer patients to the service, how to bill activities related to the service as well as provided key support contacts (see Appendix B).

When asked about their onboarding experience, clinician interviewees described the process as slightly disjointed, sharing that *"It was kind of **figure it out as you go along** for the clinic I was at"*, however this was largely attributed to having limited opportunities to connect and build relationships with the clinic teams due to COVID-19.

Service activation process

Fig. 1: Overview of the service activation process



Patient Identification and Consent

Once a provider has identified a patient that could benefit from the service, and aligns with the inclusion criteria, the provider discusses the service with the patient, ensures they are receptive, and proceeds with the activation of the service. While patient consent is implied, as the MHSU clinician is part of the patient's care team, and providers are bound by confidentiality, findings from the check-in meetings indicate that some clinics have implemented additional consent processes, such as using a Doctor's of BC consent form or obtaining verbal consent from the patient and making a note in the patient's file.

Service activation

According the MHSU Service cheat sheet, the provider fills out a Wolf/Oscar service activation form which is submitted electronically to their administrative staff who submits to the clinician by e-fax.

Once the information has been received by the clinician, the clinician may connect with the administrative staff or provider for more information and connects with the patient to schedule an appointment. If the provider has indicated "urgent" on the service activation form, the patient is to be contacted within one week, and if "semi-urgent" they are to be contacted within 2-4 weeks. According to check-in minutes, the MHSU clinicians make two attempts by phone (ideally using the clinic phone, but only to schedule the first appointment), leave a phone message and also follow up by text. If no response, the clinician connects with the provider for more context and the provider will follow-up with the patient. In all cases, the MHSU clinician confirms with the provider prior to closing the service activation. If the patient follows-up in future, the provider can re-activate the service.

Patient Visits and Ongoing Communication

Once the patient has had an appointment with the MHSU clinician, the clinicians have different options to communicate the status of the patient to their provider. In all cases the MHSU clinicians discuss confidentiality with the patient to confirm whether there is any information from their sessions they do not want shared with their provider. The MHSU clinician has access to the clinic's EMR and use the following communication strategies to update the provider:

- Patient charting in Fraser Health EMR and using Exceleris to report back to providers or adding a note in the clinic EMR
    - Providers can view notes, open as PDF and re-name to their EMR
- Informal in-person "hallway" meetings while the MHSU clinician is at the clinic
- Virtual or in-person meetings scheduled as needed or on a regular basis (i.e. weekly, monthly)

Waitlist Process

A waitlist system was implemented in 3 clinics whereby the MHSU clinician communicates with the MOA/Office Manager when they are at capacity and when they are able to take on new patients.

The MOA/Office Manager maintains the waitlist, makes note of urgent service activations to facilitate triage by the clinicians and rotates new service activations between physicians to ensure equity.

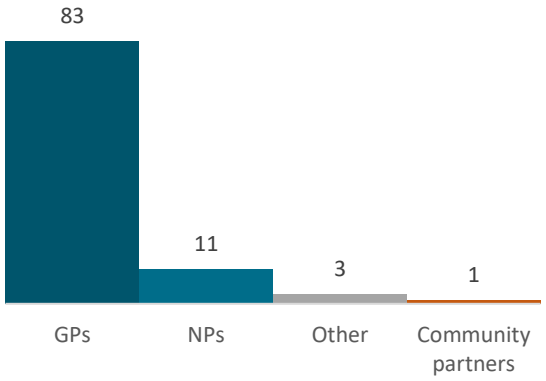
Utilization of the MHSU Service

The evaluation team created an Excel database to be used by the MHSU clinicians to facilitate tracking of service activations and patient sessions. The database was implemented in February 2021, with service activations/sessions entered retroactively for January 2021.

Service activations

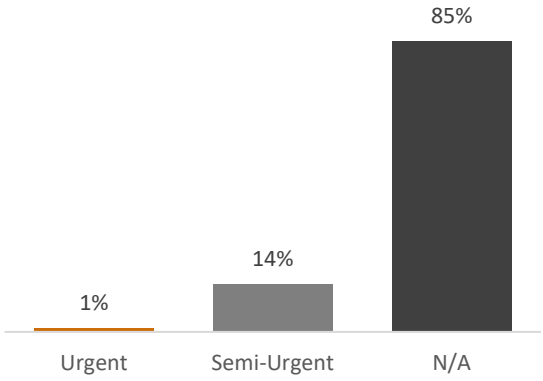
From January to April 2021 a total of 89 service activations were recorded in the database. 88% (83 of 94) of service activations were from GPs and 12% (11 of 94) were from NPs, with most GP/NP interviewees estimating they had each activated the service for about 10-15 patients during Phase 1 of the service. The database also enabled the identification of multiple service activation sources, of which there were four. Of these four activations from multiple sources, 3 were activated by a midwife and 1 by a community partner.

Fig. 2: 88% (83 of 94) of service activations were from GPs



No acuity, or level of urgency, was specified for the majority (85%) of the service activations received by the MHSU clinicians. 15% of the service activations were specified to be semi-urgent (14%) or urgent (1%). The database did not include patient identifiers therefore time between the service activation and the first session was not tracked, however one GP/NP interviewee described the service as "***timely***" and another as "***Very quick compared to any other service I have used***. *Even patients who are using private counselling or over the phone employee assistance programs it has been even quicker than that.*" One GP/NP interviewee noted, however, that uptake for the service may be low amongst her patients, estimating that "maybe 50% to 75%" of referred patients have used the service.

Fig. 3: The majority (85%) of service activations did not specify a level of urgency to see the patient

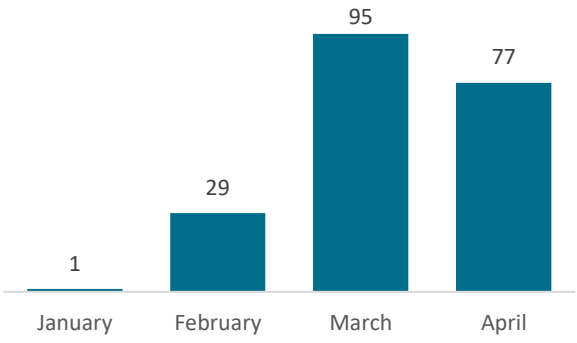


Patient Visits

A total of 202[2] visits were recorded in the database, from January 3rd to April 30, 2021, with the highest number of visits in the month of March.

As for the modality, the highest proportion (60%) of visits were delivered by the MHSU clinician in-person, whereas 37% of visits were by telephone and 2% were virtual.

Fig. 4: 202 patients visits were recorded, with the highest number of visits in March



[2] *Numbers in graphs do not add up to total visits (n=202) as no visit type or modality was specified for one of the visits*

One MHSU clinician noted in the check-in meetings that they had received more requests for telephone counselling than in person, while other clinicians noted that many clients prefer their first visit to be in person but are open to virtual sessions as it can reduce the stigma of "being seen" as well as transportation costs.

Fig. 5: The highest proportion of patient visits are continuing visits, and 7 patients have completed the service to date

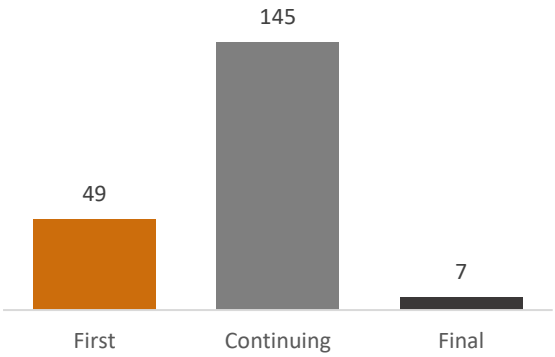
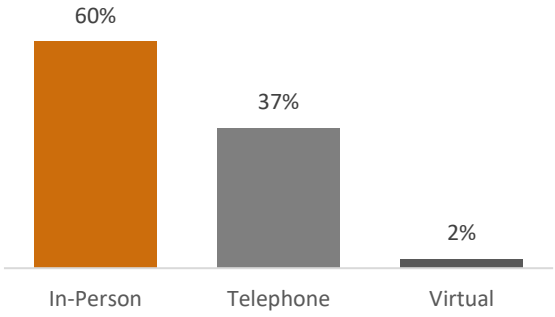


Fig. 6: In-person visits, followed by telephone appointments, are the most commonly used modalities by patients



Service Navigation

In addition to providing one-to-one counselling for patients, interview findings indicate that the clinicians have also offered mental health service/system navigation support. As described by one GP/NP interviewee, *"She (the clinician) doesn't only do counselling, **she is also happy to see people to figure out what services will work with often just a one-off appointment**"* while another GP/NP interviewee noted that several of their patients have been connected to other services they needed, such as crime victims assistance, a transition house or adult mental health. Service navigation has also been provided by clinicians in cases where the provider has a patient in need, but that does not meet the inclusion criteria or is outside the scope/experience of the clinician (e.g. patients below the age of 18).

Early Impacts of the MHSU Service

IMPACT ON PATIENTS

"Having the person in your office is a really positive thing partly because patients know the office and are comfortable coming there…**it's an extension of what they are used to already, rather than an unknown entity**."
- GP/NP interviewee

"We have that this collaborative care-plan with the doctor and counsellor, **it is this synergistic care plan where one plus one equals three**"
- GP/NP interviewee

"It's very quick and efficient to loop that we're all providing care as team and communicating…Patients have responded very favourably to that…**they're confident I know what's going on, they don't have to tell me their story again**."
- GP/NP interviewee

While this summary does not include direct patient feedback from the patient survey, several impacts for patients were identified in the interviews with clinicians and GP/NPs.

Improving trust and reducing barriers to MHSU care

Several interviewees, 3 clinicians and 2 GP/NPs, highlighted that having the GP/NP facilitate access to mental health services available within the clinic has helped to build trust, normalize the use of mental health services and has made services more accessible for patients in need. As described by one clinician, *"Often people present first with their general practitioner – **if they have long-term relationship with their GP/NP, they are more comfortable talking about it there**."* The check-in minutes also noted how it is "***easy to build therapeutic rapport through a warm hand off***."

Improved quality and continuity of care

Several interviews, 1 clinician and 2 GP/NPs, also highlighted that having two disciplines, physical health and mental health, working together results in better care for patients. Not only do patients benefit from access to more expertise, and to more services if needed, the team-based care approach improves continuity of care for the patient. With the clinician and GP/NP communicating regularly and working as a team, they can identify issues the other can assist with during their appointment with the patient and communicate that issue to the other directly, reducing the need for patients to "re-tell their story". One clinician highlighted that having the whole team on the same page can also help to improve the patient's relationship with their doctor.

Timely service

Several interviewees (n=4) noted the immediacy of the service, with the clinicians able to connect with patients within a matter of days. While seen as a positive impact on the patient experience of care, and potentially on health outcomes, interviewees also cautioned that the timeliness of the service may change depending on the waitlist, with one interviewee stating, *"I don't know if that will change when she (the clinician) gets a longer waitlist or something."*

"I think a lot of people come in with such distress they aren't thinking systems level and just feel **'I am talking to someone, thank god!'"**

- Clinician interviewee

Improved health outcomes

Interview findings from both the clinicians and GP/NPs suggest that the service has achieved positive outcomes for patients, with one clinician noting that several patients have graduated from their care because they are "doing well" and one GP/NP interviewee stating that ***"90% (of referred patients) say that the service is beneficial"***. One clinician also noted that good attendance is a sign that the patient feels they are getting help while another noted that for some patients, just the fact that they have someone to talk to is beneficial.

IMPACT ON GPs / NPs

"**It takes a weight of your shoulders.** Previously, you would take some of that on yourself in terms of trying to talk through issues. Obviously we still do that, but it is nice to share that with someone who is first, better trained to do it, and, second, who has more time to do it"

- GP/NP interviewee

Improved supports

Five GP/NP interviewees shared how having ready access to a clinician, with the time and skills to care for their patients' MHSU issues, has made them feel better supported and more at ease. One GP/NP shared how the service has improved their mental capacity as knowing the patient is being taking care of by a skilled clinician has reduced the amount of time spent worrying about the patient.

One GP/NP interviewee highlighted how having access to the MHSU service has made her appointments with complex patients more enjoyable and also less time consuming. While the MHSU service has not yet resulted in time-savings for most GP/NP interviewees, one interviewee noted that they felt the MHSU service could help to reduce patient flow in the long run if patients with MHSU issues become easier to manage.

Increased awareness of resources available

Three GP/NP interviewees also noted how the service navigation offered by the clinician has been particularly helpful for their patients, and has expanded their own awareness of the services or resources available. As stated by one interviewee, "*(The clinician) on first service identified access to very supportive services through crime victim* ***services that I wouldn't even have considered***" and another interviewee, "*I have one patient she (the clinician) saw who has active substance use issues where there is a lot of stuff in the community already arranged for that and she can help them figure out how to access it. I found that quite helpful.* ***A lot of times we don't know or can't keep track of what is out there***".

IMPACT ON MHSU CLINICIANS

"I feel very supported and **the doctors are trying to protect my time**. This is the first time I have worked in a Health Authority and the idea of **being at capacity has been acknowledged**."

- Clinician interviewee

Satisfaction with their role

Interview findings suggest that the clinicians feel satisfied with their role, with one clinician noting their ability able to work to scope and ***"use a lot of skills"*** while another highlighting their appreciation for the opportunity to be able to ***"actually do integrated care"***. Similarly, being able to provide preventative care to patients increases the clinician's satisfaction with the work, with one clinician sharing how "***Being proactive is wonderful***!".

Supportive work environment

In addition to a sense of satisfaction with their work, interview findings, from both clinicians and GP/NPs, also indicate that the clinicians feel supported and feel comfortable providing feedback about their workload or how the service is operating. As described by one clinician, having their time and work valued, even *"when I say I don't have time to do more even when there is more demand than space"* is important in terms of mitigating clinician burnout and distress.

IMPACT ON THE HEALTH CARE SYSTEM

"Health care tends to be reactive and this is model can be more about **building resources and helping clients create substantial change so that hospitalization or higher levels of care can be avoided.**"

- Clinician interviewee

"I know in this short amount of time **there are patients that are getting counselling who wouldn't have gotten counselling**. They wouldn't have anywhere to go."

- GP/NP interviewee

Addressing a gap in care

Several interviewees (n=4) noted how, if not for the MHSU service, these patients would likely not have sought or received care elsewhere. This is particularly true for mild to moderate patients who do not have money for private counselling, do not qualify for government programs, who do not have extended health coverage or are not acute enough to qualify for other services, such as Adult Mental Health. As shared by one GP/NP interviewee, "It is a great option to be able to offer patients that access because **previously nothing like that existed**".

Reducing the need for acute care

Several interviewees (n=4) also highlighted how being able to provide preventative care to those with mild to moderate mental health or substance use issues helps to avoid hospitalization or the need for more acute care.

Building relationships across the mental health system

One clinician also noted that through the MHSU service, the clinicians are able to have discussions and build relationships with other services in the mental health system, such as Adult Mental Health. This clinician noted that there are conversations ***"that hadn't been happening before"***, particularly around the opportunity to work together and "pool" their scarce resources to be able to better meet the mental health needs in their communities.

Facilitators of success

Evaluation findings suggest the key facilitators of Phase 1 was the **experience** of the clinicians and providers involved and **co-location** of the clinicians in the clinic, which has facilitated **access to patients and patient information** and **opportunities for informal communication and relationship building**.

Involving the "right" people

Interview findings suggest that the clinicians hired were a great fit for the MHSU service. The clinicians were experienced, some with experience in community health, and already had existing relationships in the community and with other services/resources. The clinicians also have skills that could be beneficial to the service down the road, such as experience offering Cognitive Behavioural Therapy groups, experience working with youth and families, as well as the ability to consult with physicians in regard to mental health medication and the development of care plans. Interview findings also suggest that the clinicians are flexible and responsive to the needs of both providers and their patients.

> "There is a real willingness to hear from GPs, among mental health clinicians, about what the needs are and to **try to meet those needs even if a patient doesn't fall within the strict criteria.**"
>
> *- GP/NP Interviewee*

Similarly, the three initial clinics piloting the MHSU service, and their GP/NPs, were a great fit as all clinics had experience with team-based care and some had even previously had a MHSU clinician as part of their team or had previous experience helping to develop or facilitate access to MHSU services for their patients. Furthermore, the three initial clinics and their GP/NPs already had a list of patients in mind, or were able to quickly identify a list of patients who could benefit from the service and meet the inclusion criteria.

Co-location with access to patient information

Another key facilitator was the co-location of the clinicians at the clinics, providing access to an in-person workspace, and enabling the clinicians access to patient information from the clinics' EMR (either in-person, remotely, or both).

By having a secure workspace with safety considerations in place, the clinicians were able to see patients in the clinic, rather than at a separate location, which may be a barrier for some patients. Interviewees also shared that the mixed model of working from home and at the clinic has been working well.

Informal communication and relationship-building

The co-location of the clinician was also particularly helpful in terms of building relationships across the clinic teams and enabling informal, "hallway" conversations to organically occur. While due to COVID-19, and GP/NPs limited time for in-person meetings has at times been challenging, 4 GP/NPs and 2 clinicians highlighted that these informal, brief, in-person interactions have been invaluable to build relationships across the team and discuss the needs and progress of their patients. As stated by one GP/NP interviewee, *"The more valuable feedback piece is when she (the clinician) says 'Oh hey, do you have a second to talk about so and so,' and she gives me an update."* This informal, in-person interaction is also how some of the service navigation opportunities have taken place. As described by one GP/NP interviewee, *"We take 5 mins in corridor, that's importance of being co -located and give me thoughts on this person and you can give me some ideas. **A five minute conversation is very helpful** because (the clinician) doesn't need to actually see them."*

Learnings from Phase 1

Evaluation findings suggest the key learnings from Phase 1 were related to the **high demand** for MHSU services, difficulties **defining 'mild to moderate'** mental health and **understanding the role of the clinician**, **gaps in the service** and **administrative and logistical difficulties**.

High demand for services

Six interviewees noted there is a high demand and scarce resources for this type of MHSU service in the region, which has resulted in three of the clinicians reaching capacity during the first 4 months of the service and developing a waitlist. Having a waitlist was described as potentially limiting the immediacy and timeliness of the service. Furthermore, the high demand has resulted in the GP/NPs having to triage patients, or as shared by one GP/NP interviewee, *"Keep my challenging borderline patients because I know there is nothing more the clinician can provide"*. Evaluation findings also suggest that due to the scarcity of resources for this type of service, some providers may be hesitant to participate in the service if they perceive there to be an expectation to attach more MHSU patients as a result of their access to a clinician.

In addition to high demand, understanding the capacity of clinicians has been challenging as capacity is variable and context-specific. As described by one clinician, capacity is not standardized, there is not a maximum caseload; it is more so related to the needs and state of the patient, with some patients requiring more frequent sessions, while others, who may be close to discharge requiring fewer.

> "Early on she (the clinician) said I'm at capacity. Wow that's not very many people. She comes in for the morning, she can see 3 people because she does an hour for each one. **If the service was allowed to be unlimited, she can easily be full time here**."
>
> *- GP/NP Interviewee*

> "It's working but **there's just so many people and one of me**; There's such a demand. I wish there can be one clinician per clinic even that you'd be overloaded too."
>
> *- Clinician Interviewee*

One GP/NP interviewee highlighted the importance of finding an effective way to communicate changes in capacity back to the clinic and a process to efficiently and fairly allocate such scarce resources.

Defining "mild to moderate"

Similar to difficulties understanding and defining the capacity of clinicians, five interviewees reported challenges related to defining 'mild to moderate' MHSU issues. Several interviewees explained that they do not have a standard definition for what is considered mild to moderate. As explained by one GP/NP interviewee, *"When we tried to use the mild to moderate definition **we struggle because each of us is at different comfort levels** of what we do"*.

Both clinician and GP/NP interviewees, agreed that coming to a definition for "mild to moderate" requires on-going collaboration and requires all those involved, clinicians and providers, to take into account their respective experiences, skills and comfort levels to develop a shared understanding.

Understanding the role of the clinician

The role of the clinician in this service was also identified as an area of learning as it was a move away from the typical understanding of a clinicians' role. Indeed, evaluation findings suggest both providers and clinicians felt the role differed from their initial expectations or understanding. One GP/NP shared how they initially expected the clinician to provide counselling to patients and was unaware the clinician could also provide case management or service navigation, *"I thought of the clinician as counsellor, I think I had limited* ***short sighted view on what skillset was and how we can use her****"*. One clinician interviewee shared that the majority of their time was dedicated to counselling rather than case management, which differed from their expectations based on the job description. Findings from the check-in meeting minutes indicate that discussions between the providers and clinicians were helpful in better understanding the role and how to work to scope.

Documenting patient information

Another common challenge across clinicians and providers was related to documenting patient information. While the clinicians' access to the clinic's EMR has been beneficial, resulting in a smooth service activation process for providers and easy access to patient information for clinicians, several issues were highlighted.

As Fraser Health employees, clinicians are required to document patient information in the Fraser Health EMR, which is not linked to the clinic EMR. This requires the clinician to use Exceleris to share patient information with the providers, which one clinician highlighting *"there's a lot of initial paperwork"* and one GP/NP interviewee sharing that *"the paperwork they have to do could be a sustainability challenge".* Furthermore, while beneficial to have access to detailed patient information from the clinic EMR, it takes time for the clinician to review the patient history, and as noted by one GP/NP interviewee, could in future become "too cumbersome".

While several GP/NP interviewees shared that the service activation process, and its integration with their IT system, is "very streamlined" and "very effective", some GP/NP interviewees noted that when patient notes are added through Exceleris *"You have to be pretty motivated to get to the [note] because it is a bunch of steps".*

For clinics who do not use their IT system for the service activation process, the manual paper process has been sufficient, but it relies on support from clinic staff and the clinician may require additional supports (e.g. access to a printer).

Gaps in the service

GP/NP interviewees shared that while support for mild to moderate patients has been helpful, they would also benefit from supports for patients outside of the current inclusion criteria, in particular patients with **moderate to severe MHSU issues**, **complex MHSU patients with significant co-morbidities** and **youth**. Two GP/NP interviewees expressed that the inclusion criteria did not meet their initial understanding of the service, with one provider stated it was *"not quite what GPs need"* while another that *"I was thinking it would be a little higher acuity"*. According to these interviewees, GP/NPs are generally comfortable with and able to provide care to patients with mild MHSU issues.

Interview findings suggest however, that the support provided has been beneficial, particularly for moderate patients and that regardless of the criteria, clinicians are trying to provide some form of support

for these patients, with one GP/NP noting there is a is "*a real willingness to hear from GPs, among mental health clinicians, about what the needs are and to* ***try to meet those needs even if a patient doesn't fall within the strict criteria***". While clinicians are finding ways to support these patients, one clinician noted that some of the patients referred have been ***"too severe to be able to use the service effectively".***

While these gaps were brough to light, the majority of GP/NPs recognize the already high demand for the service and did not specifically suggest changing or expanding the current criteria.

Time limitations of the service

While the co-location of the MHSU clinicians in the clinics has been beneficial, several clinician interviewees noted concern about the amount of time they have in the clinic. This was described to be a potential barrier to providing patient-centered care to patients, particularly in terms of scheduling in-person appointments. One clinician, that works in two clinics, also noted that logistical considerations need to be accounted for in terms of transporting confidential documents while travelling between clinics.

Interviewees noted that while the impact of the service on patients has largely been positive, some patients are concerned that they have a maximum of 15 to 20 sessions, and similarly one clinician interviewee noted that *"because it (the service) is short term I have to be really targeted, which is sometimes difficult".*

Identifying patients to refer

While most GP/NP interviewees described being able to quickly develop a list of patients to refer to the MHSU service, evaluation findings suggest that for some clinics it may take time to identify patients that meet the inclusion criteria and could benefit from the service. If a clinic does not have a list of patients identified, or a plan for how to identify patients, in advance of onboarding the clinician this may result in few service activations and under-utilization of the clinician.

Suggestions for Future Phases of the MHSU Service

Based on the learnings which emerged during Phase 1 of the MHSU service, the following suggestions were made to improve the onboarding process and enhance the utility and sustainability of the service moving forward. *Several of the suggestions below emerged and were acted on during Phase 1 of the service and are presented below to document the suggested best practice.*

SUGGESTION 1: Ensure clinics are prepared for clinician onboarding and integration

Participating clinics and clinicians highlighted the importance of having a clear understanding of the service, time to prepare for onboarding, and time for collaborative discussions.

- During the hiring process, ensure potential clinician candidates have a strong understanding of what their role will entail and how the service is intended to operate
- Prior to matching a clinician to a clinic, ensure the clinic has a clear understanding of the service, the role of the clinician, and what is expected of the clinics/providers involved including:
    - A list of patients to refer to the service (or a clear plan for how to identify patients)
    - A workspace for the clinician, including appropriate safety and confidentiality measures
- During onboarding, allot time for a collaborative discussion between the clinicians and providers involved regarding:

  - The inclusion criteria, particularly the definition of what 'mild to moderate' means within the context of the clinic and the clinicians and providers involved
  - The factors which impact a clinicians' capacity to take on patients and how changes in capacity will be communicated across the team
- It is also suggested that in addition to the service 'Cheat Sheet', **a patient cheat sheet** be developed, or more widely circulated, to help providers introduce patients to the service.

SUGGESTION 2: Streamline administrative processes

One interviewee suggested the service activation process could be streamlined by **implementing a check-box service activation form**, which would reduce the need to clinicians to review patient history (e.g. whether patient has already been connected to AMHSU). It is possible that clinic staff, or potentially social workers once hired, can help complete the service activation form so as not to transfer the burden from clinicians to GP/NPs.

To simplify the documentation of patient information, it is suggested to explore ways to more easily share clinician visit information with the clinic.[3] In the meantime, the following suggestions have been made:

- Review with participating providers how to access clinician notes from Exceleris
- Review with participating providers and clinicians how to use Basecamp to share patient information and reduce email volume

The evaluation team also suggests to determine whether service activation and visit information can be now be obtained using the Fraser Health EMR, rather than the Excel database.

SUGGESTION 3: Formalize a waitlist process

Evaluation findings suggest that with the high demand for the service and the scarcity of resources, clinics need to be prepared to manage a waitlist. In addition to discussing how waitlists will be handled during onboarding, evaluation findings indicate it may be beneficial to standardize this process in terms of:

- How to support GP/NPs to "triage" service activation
- Timeframe within which waitlist patients will be contacted
- Person responsible for contacting waitlist patients
- A defined, fair process to rotate waitlist admissions from different GP/NPs

It is also suggested that a **MHSU service/resource one-pager** be developed, in collaboration with the clinicians, which can be provided to waitlist patients. It may also be helpful to discuss whether a service can be provided to waitlist patients (e.g. a Mindfulness group).

SUGGESTION 4: Retain co-location and enhance communication/relationship-building

Evaluation findings suggest that it would be best to continue to co-locate clinicians at the clinics, and if possible, increase the amount of time the clinician has at the clinic. It is also suggested to explore opportunities for **more in-person meetings** and for clinicians to be included in **team-building opportunities**, as they arise. It is also suggested that communication and relationship-building between

[3] According to check-in minutes, a Fraser Health staff member is already investigating this request.

clinicians and GP/NPs could be improved by taking the time to **develop collaborative care plans** for their patients.

Conclusion and Next Steps

Overall Phase 1 of the MHSU service was successful in addressing gaps in care and effectively supporting GP/NPs and serving patients, particularly those who may not have otherwise sought out MHSU services. Several learnings arose during the implementation and initial operation of the MHSU service and the clinicians and GP/NPs involved demonstrated their willingness to reflect on their experience and provide meaningful suggestions as to how to improve the service and its sustainability moving forward.

This report will be provided to the Chilliwack and Fraser Health PCN and will be used to inform Phase 2 & 3 of the MHSU service. A follow-up report, spanning all phases of the service, and including direct feedback from patients, will be prepared by the evaluation team at the end of Phase 3.

Appendix A: Phases of the MHSU Service

Prototype – Phase 1 Teams

3 Hub Teams – Home Health Teams

For 3-4 months, teams will participate in development of prototype which will include:

- Minimum monthly patient rounds to further define patient assessment criteria
- Team-based care training/support from PSP
- Team charting discussions
- Discussion on best referral pathways, i.e. phone, fax, text

(The above will be team-specific)

Phase 2

- Additional hub teams
- Connections to traditional wellness mentors, elders, healers

Phase 3

- Clients discharged from Psychiatry, Transition Outreach Team (TOT) who are stable
- Drop-in modality, co-location with primary care
- Acute care connections – Psych urgent response clinic- PERC

Appendix B: MHSU Service 'Cheat Sheet'

Chilliwack Division of Family Practice
A GPSC initiative
fraserhealth
Better health. Best in health care.

Physician Cheat Sheet: PCN MHSU Counsellor service

Inclusion Criteria:

- Patient with mild-moderate MHSU challenges. Many practices are focusing on moderate.
- Physician has previously tried to support with meds and/or counselling but patient is not improving – in most cases.
- Patient does not have severe MHSU issues – they are able not incapacitated by their MHSU challenges. If they have a diagnosed MH condition, they are stable.
- Patient cannot afford private counselling according to their own self-report.

Nature of service:

- Short term 1-1 Counselling; 1-8 sessions mild; 10-20 sessions moderate
- Short term treatment with support to access longer term services, if needed
- In person or virtual
- Free
- Assistance to navigate and access other mental health and community/social service supports
- Currently available M-F 8:30am - 4:30pm
- Team-based care with primary care provider – Clinician will share progress updates electronically, discuss case and provider brief on patient progress as relevant, according to privacy legislation and as per patient informed consent

How to refer:

- Primary care provider discusses service with patient and patient is aware of, and receptive, of referral
- Primary care provider may use a triaging system:
  - 1 "urgent": will contact patient within 1 week
  - 2 "semi-urgent": will contact patient within 2-4 weeks
- E-fax not in place: Primary care provider fills out Wolf or Oscar referral form and prints it. Primary care provider may add collateral info as they deem necessary. Physician places referral in binder at Reception with your MOA or Office Manager. Clinician reviews referrals in binder.
- E-fax in place: Primary care provider fills out Wolf or Oscar referral form. MOA sends via efax.
- Clinician phones/connects with MOA/primary care provider to gain more information on patient, including level of urgency
- Clinician contacts patient to set up appointment

How to bill:

- **PG 14043: FP Mental Health Planning Fee $100.00**
  This includes review of your EMR for patient identification, discussion of PCN MHSU service with patient, and preparation and submission of referral. *(Payable to MRP however clinician can*

Version 1, February 5 2021

Chilliwack Division of Family Practice
A GPSC initiative
fraserhealth
Better health. Best in health care.

Physician Cheat Sheet: PCN MHSU Counsellor service

support the care plan development and the face to face can be (16 min FP and 14 min Clinician – not necessarily on the same date).

- **PG 14044 – 48: FP Mental Health Management Fee $ 56.41 - 84.60** *(Can be same day as above if all criteria met)*
- **PG 14077: FP Allied Provider Conferencing Fee $40**
  FP participation in two-way collaborative conferencing by phone, video or in-person with 1 or more Allied Health Care Provider. Conference may be initiated by FP (who is the MRP) or Allied Care Provider.
- **PCN MHSU Clinician Bi-weekly Check-in meetings: time preparing for & participating in**
  Track: Date | Number of hours
  Submit monthly to Division PCN Manager unless you are participating in a PSP QI Project in which case, please connect with Ron Plowright on your hours
- **Division PCN Manager and Lead Physician check-ins: Time spent connecting**
  Track: Date | Number of hours
  Submit monthly to Division PCN Manager unless you are participating in a PSP QI Project in which case, please connect with Ron Plowright on your hours
- **Zero fee Attachment code billing - all new attachments at the practice:**

  Chilliwack South **97636**
  Chilliwack North **97637**
  Fraser Health Rural **97638**

Who to contact if you have questions or issues:

PCN MHSU Counsellor **(Direct email and phone for physician/MOA use only)**:

- Collaborative team-based care conversations
- Crossroads - Katrina Molenaar (604) 614 0284
- Newcombe House: Brenda Listoen (604) 614 0256
- Hope: Lydia Anderson (604) 614 0239

Division PCN Manager: Lara McLachlan lmclachlan@divisionsbc.ca

Indigenous Relations Manager: Gracie Kelly gkelly@divisionsbc.ca

Practice Support and Technology Coordinator: Patti Scott pscott@divisionsbc.ca

Fraser Health PCN Clinician Operations Manager: Andrea Mainer

Andrea.mainer@fraserhealth.ca (236) 522 1940

Version 1, February 5 2021