



Winnipeg Regional  
Health Authority

Office régional de la  
santé de Winnipeg

*Caring for Health*

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# **Shared Mental Health Care Program**

## **Evaluation Report**

**WRHA**

**Mental Health Program and Family/Medicine Primary Care Program**

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# Executive Summary

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## Description of Shared Care Mental Health Care in the Winnipeg Health Region

The Shared Care Model in Winnipeg addresses the need for more expanded mental health care needs within primary care through a collaborative approach whereby mental health specialists (e.g., Psychiatrists, mental health Counsellors) are co-located with primary care providers. Within this model, the patient's primary care provider remains the primary decision maker and provider of mental health care and the mental health specialist offers assessment, consultation, and brief therapeutic intervention on-site. Collaboration between the mental health specialists and primary care providers is essential for this program to be successful.

The Program was established in 2003 and was implemented with the WRHA directly operated clinics (in an alternate funded, interprofessional environment). At the same time the program was introduced on a small scale into a small number of fee-for-service practices through the Federally sponsored Primary Health Care Transition Fund (the Northeast Project in Winnipeg).

In 2008-09 the Shared Care Mental Health Program significantly expanded into the fee-for-service environment, with around 100 Family Physicians (alternate funded and fee-for-service) and 10 nurse practitioners participating. The number of Counsellors and Psychiatrists doubled and there was a shift in the administrative staff of the program (central manager with clinical expertise role introduced). This expansion marked a dramatic change in the delivery of mental health within primary care, and in the region's role of providing interprofessional support and operational resources to fee-for-service practices. It is within this context that this evaluation was undertaken.

## Evaluation Description

The purpose of this evaluation was threefold 1) to inform program improvement and decision making 2) to document learnings on the implementation of Shared Care expansion into the fee-for-service Family Physician practices, and 3) to explore the clinical and operational elements of the Program that worked to support collaborative practice in primary care, and to inform decisions as efforts are underway to build the primary care system of the future. The evaluation approach involved the participation of all front-line providers and program leadership.

## Evaluation Findings

The evaluation demonstrated that Shared Care had an impact in all critical goal areas including:

1. Improved access to mental health services
2. Improved primary care capacity to manage mental health
3. Improved communication between primary care and mental health
4. Increased mental health providers understanding of primary care
5. Improved patient outcomes

### *Overall provider satisfaction and positive impact on patients' mental health outcomes:*

Shared Care has demonstrated an ability to adapt and successfully integrate into primary care. The evaluation findings reflect an overall provider satisfaction and positive impact on patients' mental health outcomes. Mental Health providers and primary care providers expressed a strong sense of engagement and commitment to the vision of the program, which included working collaboratively and integrating primary

care and mental health. Primary Care providers also indicated interest in exploring the model in other areas, such as specialty and chronic disease management support.

Provider groups described Shared Care as an entry point into the mental health system regardless of the severity of the patient's mental health condition. At times this included providing a brief therapeutic intervention, and included: "taking one step with a patient"; working in a sequential nature over several years; linking, bridging or preparing patients for more appropriate services; or providing service, referral and access information to patients/providers that otherwise would not have that knowledge. The service navigation function of Shared Care Providers was highlighted as important.

Overall, providers indicated that all patients on the Mental Health continuum were able to benefit from Shared Care. For example, those suffering with multiple stressors, relationship issues, and mild to moderate forms of depression and anxiety benefitted. In addition, those patients struggling with complex medical conditions and mental health challenges, who would rarely have the opportunity to receive a psychiatric opinion, were able to receive a psychiatric assessment and consultation through Shared Care. Patients with more complex mental health care needs also benefitted. Providers perceived that Shared Care prevented hospital admissions, facilitated more dignified and efficient hospital admissions, and prevented patients from deteriorating after hospital discharge.

Further, as collaborative relationship formed and deepened, Shared Care had a more significant impact on primary care practice. Through relationship and support the mental health professionals improved the PCPs capacity to treat patient's mental health condition even without direct contact with Shared Care. Some PCPs described an overall impact on their practice and their sense of comfort treating patients with mental health conditions.

### ***Elements of Shared Care considered essential for success.***

Evaluation findings highlighted two elements of the Shared Care Model that were key to the early success of the Program including Access and Collaboration. What is clear from the findings is that these two elements are facilitated through *co-location* and the *integration* of primary care and mental health.

#### **1. Access:**

PCP's indicated that access to mental health services improved their comfort with mental health and the ability to treat patients with Mental Health conditions. Ensuring that the program keeps wait times to a minimum and can adapt to urgent requests for assistance (direct and indirect assistance) is essential to the ongoing operations of the program.

The program positively impacted access to quality mental health services in four key ways

- Co-location of mental health in primary care increased access for patients – patients were more likely to use Mental Health services if linked to primary care.
- PCPs with Shared Care appreciated knowledge of how to access more specialized Mental Health services for their patients – Shared Care offers substantial expertise in navigation of the mental health system to the PCPs and given the nature of the PCPs role as “quarterback” and “gateway” to the larger system, this role can not be undervalued.

- Timely access (collaborative context facilitated access) – operationally, the program achieved this through mechanisms that prioritized seeing urgent referrals quickly, setting targets for when patients will be seen, and operating from a short-term counseling model.
- PCPs experienced the benefits of having “back up” and easy access to specialists (availability) to assist them with the ongoing treatment of care.

Despite positive impacts on access, PCP’s identified ongoing concerns about access for their patients to other mental health services -- especially those with severe and persistent mental illness and those with addictions, and pediatric/adolescent. They also had concerns about access to long-term psychiatry services.

## **2. Collaboration:**

Beyond access, collaboration was the second core component that lead to improved outcomes for patient care. The evaluation highlighted that when providers developed a deeper collaborative relationship, together they had a more profound impact on both quality and quantity of patients receiving care. The evaluation findings underlined the importance of the context within which collaboration between mental health and primary care was fostered. This context was explored to understand what was required from providers and within the environment to make the program successful operationally.

Elements that promoted the development of a collaborative partnership are:

- Co-location within the same office
- Provider factors that contributed to their collaborative behaviours (see PCP and Mental Health Provider Factors in Appendix 1)
- Welcoming behaviours within the primary care clinic. (See Appendix 1)
- Timely communication between PCPs and mental health specialists.
- Emphasize relationship building between providers (see relationship building process in Appendix 1). The evaluation findings pointed to the importance of relationship in enhancing the collaboration, and resulting in better outcomes. The more communication between providers, the deeper the relationship and the result was a more enhanced collaborative practice.
- The leadership role in negotiating formal structures and operational goals that will empower providers to reach for the vision of collaboration and inter-professional learning.
- The office clinic manager and clinic administrative staff role at each sites in facilitating the communication between patients, PCP’s, mental health specialists, and the Shared Care Program.
- Ongoing communication between program leadership and sites to establish communication and relationships, develop collaborative goals, and identify outcomes.
- Emphasis on collaboration at all levels of the program including leadership to coordinate, support, and facilitate this significant system change.

Counsellors, Psychiatrists, and leadership participants identified Shared Care as a significant system change and a “paradigm shift”, highlighting that the introduction of interprofessional practice into the fee-for-service environment was a “radical goal” and a facilitator of change on a number of levels. There was little precedent of regional staff working with independent primary care practices, and this experience is important for informing future collaborative care processes in primary care. Additional supports that were required to facilitate and support this change included:

- The role of the Shared Care Manager clinically to understand the complexity and intricacies of the work, to address the challenges, and to be responsive and accountable to sites.
- The Shared Care Manager role in assisting with the preparation and integration of new sites. This manager needs to ensure that timely access is clinically maintained (at times this may include reallocating resources). The manager also needs to pay attention to the matching between specialists and clinics that takes into consideration factors such as clinic culture, etc. to ensure continuity and to facilitate relationship building.
- A collaborative leadership team consisting of mental health, psychiatry, primary care, and psychology. The leadership team needs to have clarity of vision, goals, expectations, and roles within the collaborative partnerships, and be able to be flexible/adaptable to each clinic environment. This team needs to work cohesively to be responsive to issues within teams and to enhance the program in a manner that is respectful of all partners involved.
- Regular program communication with sites (e.g. Site Review Meetings) and the development of relationship between program leadership and PCPs and site administrative staff.
- A program that balances the tension of being a clearly defined program and adaptable to the clinic culture.
- Communication strategies that enhance opportunities to connect with PCPs. As the program developed an adjustment was made to place greater emphasis on the need for Psychiatrists and PCP's to have a post-patient consult debrief to improve communication and quality of patient care. (Removing the barriers to communication between providers in the Program should be a program priority – p. 37). Additionally, priority towards deliberate or intentional communication that facilitates capacity building.
- Intra-professional meetings (e.g., Psychiatrists, Counsellors etc.)
- Clinical excellence of service.

### *Summary/Conclusions*

When the expansion of Shared Care into the fee-for-service environment began (2008) there were several challenges in recruiting Family Physicians. In 2011 there was a wait list of Family Physicians wanting to participate in Shared Care. There was consensus among leadership that meaningful engagement with Family Physicians was the key to building successful partnerships and this required considerable outreach and individualization from the leadership to secure sites committed to participating in the Program, and ongoing support was necessary to maintain an excellent program.

As a next stage of development and in order to ensure all partnerships are primed for high levels of collaboration and opportunities to occur, the program will need to improve in a number of areas, based on evaluation feedback. These improvements will need to continue to align with Primary Care reform initiatives to ensure the integration of mental health as system development occurs.

### *Collaboration*

- Evaluation findings indicate that collaboration can be influenced by access/availability to services, communication between providers, and relationship development. Further research to enhance our understanding of collaboration would include the evaluation of:
  - a.) The impact and various aspects of relationship that enhance collaboration.
  - b.) The tension between creating timely access for patients and finding the time to collaborate with providers.
  - c.) PCP's screening and detection of mental health conditions within Shared Care.

- To maintain the principle of collaborative care within the fee-for-service environment and to inform future expansion and program development, ongoing attention to the context is imperative. For example, understanding that every clinic/practice has a distinct organizational culture, is an independent business, and has management and clinicians who are program partners, should continue to inform improvements to the model.
- Shared Care has been a successful model of collaborative practice in Primary Care. Therefore, it has the potential of serving as a model for effective collaborative service delivery in other disciplines in their development of collaborative partnerships with Primary Care.
- The Program needs to support the social identity of the professional groups within Shared Care. Evaluation findings indicate that the practice of creating opportunities for Psychiatrists and Counsellors, in particular, to interact, consult and plan worked well. Similar strategies should be explored to further engage the Family Physicians in the Program.

### ***Practice***

- Findings indicate that Shared Care has an important function in service navigation. Shared Care Counsellors should continue to be encouraged to build competency and skill in their ability to navigate the mental health system as a whole.
- Providers require more attention on program definitions of collaboration, goals, roles, and expectations.
- An ideal environment for collaboration ensures shared beliefs, expectations, and goals for Shared Care are explicit. Processes that promote capacity building and that are *intentional* encourage enhanced collaboration and lead to better outcomes for patients.

### ***Implementation/Sustainability***

- The value of centralized management and the importance of clinical expertise that the Shared Care Manager role emerged as an important theme. This centralization allowed the program to respond to system issues, ensure timely access to services (i.e. making adjustments to psychiatry resource allocation as required to accommodate patient need), and provided the clinical support/expertise to ensure standardization and practice excellence.
- To ensure success of the Program in a fee-for-service environment, ongoing attention needs to be paid to financial compensation for fee-for-service physicians and logistical issues (e.g. administrative support, electronic medical records, space).
- Mechanisms to ensure new providers support of the principles of Shared Care and collaboration is critical for the matching and choosing of sites.
- To enhance communication between the Shared Care Program and all Shared Care Providers is critical to avoid gaps/misinterpretations between providers. Further emphasis is required by the Program's leadership to ensure one-on-one relationships with clinic managers and each individual primary care provider (including alternative funded providers and fee-for-service providers) within each clinic is a priority of the Program.

- Given that meetings between Shared Care leaders and clinics were well received by providers as it allowed participation in program improvement and site improvements, the Program needs to continue to have regular meetings at each primary care clinic and include their on-site Counsellors at these meetings.
- The Leadership structure should continue to include members from all program partners including Mental Health, Psychiatry, Psychology, and Primary Care / Family Medicine in order to enhance the ongoing quality of the program.
- Upon reflection of the evaluative information, specific opportunities for respective groups to interact, consult and collaborate is required to ensure that appropriate services will be available in the future. This then may require the Program to provide educational opportunities in both Psychiatry and Family Medicine for residency within Shared Care environments.

**Section 1:**  
**Shared Care Mental Health Service**

## Section 1: The Shared Care Mental Health Service

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### *1.1 Description of Shared Care Mental Health Model*

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The Shared Mental Health Care service in Winnipeg is based on the principles of access, relationship, collaboration, and communication with professionals in mental health and primary care. This model developed in response to local population mental health needs, and evidence of effective Shared Care approaches within the Canadian context (Kates et al, 1996). The mental health specialists, including Psychiatrists, mental health Counsellors, are co-located with primary care providers and a Psychologist is available to the clinics upon request. Shared Care therapists, Psychiatrists, and Psychologist address and manage a variety of significant and serious mental conditions that would otherwise be seen in major mental health centres.

While the Shared Care model is adapted to the context (e.g., individual practice culture and business model) and with each individual primary care provider, several key requirements have been agreed upon as foundational:

1. The mental health specialists offer assessment, consultation, and brief therapeutic intervention on-site with the primary care providers. The primary care providers remain the primary decision maker and provider of mental health care.
2. Collaboration between the mental health specialists and primary care providers is essential and the program requires all primary care partners to meet with the mental health specialist for ½ hour of face-to-face discussion time per month, to share records and/or critical elements of patient health care, and to participate in program improvement discussions.

In 2011, fourteen mental health Counsellors consult with 120 primary care providers (alternate funded and fee-for-service Family Physicians and nurse practitioners) and eleven Psychiatrists, delivering x 1.6 EFT of service, and one Psychologist are available for assessment/consultation, on a less frequent basis. The roles and responsibilities of the providers are as follows:

#### ***Shared Care Psychiatrist***

The role of the Shared Care Psychiatrist addresses some of the diagnostic and treatment challenges seen by primary care providers. The co-location of the Psychiatrist within the primary care office affords the opportunity for the Psychiatrist to transfer mental health knowledge to colleagues and to discuss mental health issues both formally and informally.

#### ***Shared Care Counsellor***

The Counsellors provide therapeutic insights to staff and patients, and importantly the Counsellors provide a function in assisting staff and patients with mental health navigation. This navigation information is also critical to the ongoing care of patients that may extend beyond the brief (6-8 session) model of care that Shared Care espouses.

### ***Shared Care Psychologist***

The Psychologist was introduced to the Program in 2009 to address the demand for psychological testing, behavioural therapeutic interventions, and the ongoing need for quality improvements, evaluation, and research.

The Counsellor and Psychiatrist often meet when the Psychiatrist is on-site at the primary care clinic. Standard practice is that the Psychiatrist (typically with the Counsellor) make every effort to collaborate with the primary care provider after a psychiatric consultation to provide a brief update to the primary care provider about the assessment, advise them of recommendations, and offer any useful insights that they may have about the ongoing management of the patient. The Counsellors are available on-site to the primary care provider more frequently than the Psychiatrist or Psychologist, and as such often have hallway conversations and discussions about patient care and/or progress. In addition to on-site discussions, the Psychiatrists and Psychologist are also available by phone for brief consultations to primary care providers.

## ***1.2 The Evidence of Shared Care Mental Health***

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### *International/National Evidence*

Remarking on the importance of integrating mental health and primary care, Parikh noted,

When Family Physicians do treat mental health problems, they actually see greater numbers than those seen in the mental health sector (66%). Furthermore, by measures of severity or need, the mental health patients of Family Physicians are only modestly different from those of the specialty sector. Woven together, all these observations suggest that improving the care of individuals with mental health problems should involve strategies that strengthen the role of primary care physician and allow for improved collaboration between the primary care and specialty mental health sectors. Educational strategies for mental health specialists and health system design efforts should target the need to build better collaboration and enhance the treatment capability of the primary care sector." (Parikh, S.V., et al, 1997, p. 34)

Echoing these remarks Falloon noted, "The importance of the general practitioner's role in the treatment of mental disorders is well established. Over the last 30 years it has been shown repeatedly that 15-25% of general practice attendees have significant mental disorders, but only 5-10% of these patients are referred to specialist mental health services" (Falloon et. al., 1999, p. 34). Further, Hickie identified that "currently, 75% of that mental health care is provided in primary care sector, with limited access to specialist support." (Hickie, et al, 2005, p 401).

Within the Winnipeg Shared Care model, mental health specialists support primary care providers by direct and indirect service delivery. The goal is to support the primary care provider with their skills and comfort in detecting and managing patients with mental health conditions in effort to provide a more efficient and effective system that provides more accessible quality based service to patients. The reason for this initiative is based on research evidence, which has been summarized well by Falloon.

As psychiatry has moved from hospital-based to community-based service provision, the role of the general practitioner has become even more important. A World Health Organization working party has emphasized that 'the primary care team is the cornerstone of community psychiatry'. A recent discussion paper by the New Zealand Ministry of Health outlined that logistics, consumer preference, accessibility, cost-effectiveness and the ability of the general practitioner to coordinate psychosocial and medical care were all factors favoring mental health care in the primary care setting. (Falloon et al, 1999, p. 34).

Movement of psychiatric patients out of the hospital into the community is a priority within Winnipeg, and as such it is critical that Mental Health supports Primary Care in their role as the ‘cornerstone’ by providing them with the resources, supports, and tools to provide quality care to their patients.

*Local evidence:*

In the initial development of Shared Care in Winnipeg, an evaluation study was conducted. This study evaluated patient outcomes in the Shared Care program. The outcome demonstrated “the involvement of Shared Care therapists within primary care practice settings appears to have resulted in improved mental health symptoms and functioning in the short term” (Goossen et al, 2008, p 43). A multitude of research has also been conducted on therapy effectiveness. This is highlighted by both Duncan & Miller (2006) and Graybeal (2007). Duncan and Miller stated “treatment is on average four times more effective than no treatment and twice as effective as a placebo” (p. 1). Graybeal stated “clients that receive psychotherapy or other related social work interventions are generally better off than 75-80% of those in similar situations who do not receive services... [and the] Benefits from interventions have generally been found to be statistically significant, clinically meaningful, and long-lasting” (p. 517). Due to the past outcome evaluation research and vast amount of current literature on effectiveness of therapy, the focus of this evaluation did not focus on patient/clinical outcomes.

### ***1.3 Shared Care Mental Health Objectives in Winnipeg***

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The Shared Mental Health Care Program aims to assist and support primary care providers (PCPs) within the community to meet the increasing demand for access and service by building capacity with PCPs providing consultation and direct treatment for patients, and assisting in navigation of clients to specialized mental health services. The model is collaborative practice and affords the opportunity for two-way interaction between primary care and mental health.

Consistent with the rationale for the implementation of Shared Mental Health Care, the program’s five objectives support the primary care providers’ role in the management of people suffering from mental health conditions. The primary care providers are recognized and valued for their significant contribution and role in providing mental health care to the public (Parikh, 1997; Falloon, 1999).

The five objectives for the Winnipeg Shared Care Program include:

***1. Improve Access to Mental Health Services and Information to the public***

- Patients within Primary Care will have access to mental health service and information.
- Physicians will screen patients for mental health conditions where evidence exists and along with the primary care team will create a welcoming environment for patients to discuss their mental health concerns.
- Patients will identify reduced barriers associated with access to mental health services. Patients will report reduced stigma and there will be an improvement in attendance rates to mental health appointments.
- Effective evidence-informed interventions will be offered to patient’s based on their personal characteristics and level of need. This includes psychoeducation, self-management tools, web-based resources, counselling, assessment, etc.

## **2. *Improve Primary Care's Capacity to Manage Mental Health Conditions***

- To enhance the capabilities of primary care teams to recognize and treat patient's with mental health problems within their practices (e.g. earlier and more accurate recognition, more appropriate treatment or options, more appropriate referrals, etc.).
- To enhance the primary care provider's comfort/confidence in treating the mental health aspects of their patients.
- Primary care providers will have the education, tools and resources available to promote good mental health and prevent illness/languishing.
- To provide support to primary care providers in a helpful way that enables them to feel confident in accepting new patients or continuing to treat existing patients who have complex health conditions with a mental health component.

## **3. *Improve Communication between Providers***

- Improve coordination and communication among mental health care providers across sectors and within primary care practices. Examples of this include improved communication between Family Physicians and mental health professionals, assessments that adequately answer the physicians' mental health referral request and offer the next level of care to the patient.
- Improve collaboration between mental health care and primary care.
- Patients experience coordinated physical and mental health care treatment in their primary care provider's clinic.

## **4. *Improve Mental Health Outcomes***

- Patients' will flourish even when living with a mental health condition.
- Patients will have improved quality of life.
- Patients' will benefit from strategies that promote, prevent, and detect mental health conditions early.

## **5. *Increase Mental Health Providers understanding of Primary Care***

- Mental Health Providers will understand the context of primary care including the Primary Care Providers role in the detection, diagnosis, and treatment of people with mental health conditions; as well as networks and primary care homes.
- Mental Health Providers will obtain an understanding of physical health conditions, their respective treatments and how these interact with the patient's mental health and overall health.
- Mental Health Providers will be able to communicate effectively with Primary Care Providers, so that the consultations and treatment plans are provided in a way that Primary Care Providers experience their usefulness.
- Mental Health Providers will understand the principles of Family Medicine and Primary Care, while Primary Care Providers will increase their understanding of counselling, psychiatry, and psychology.

## ***1.4 The Winnipeg Context***

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The model of the Shared Mental Health Care program implemented within the Winnipeg Health Region in 2003 was informed by best practice research combined with consumer and service provider need within the local context. Primary care providers and consumers identified access issues and service shortages in the area of psychiatric and therapeutic care within Winnipeg. As well, Psychiatrists and consumers identified challenges with obtaining a primary care provider for ongoing and follow-up care. A collaborative

partnership was developed between Primary Care, the Department of Psychiatry, and Community Mental Health to address these service delivery gaps and create a more seamless and accessible service model for consumers.

The original program started in WRHA directly-operated primary care clinics, where services are delivered by teams of providers and physicians are alternately funded. This model is closer to a community health centre, than a private fee-for-service practice. In 2003 Shared Care worked initially with one private clinic and expanded into three additional clinics as part of a federally funded primary health care transition fund project within the North East sector of the city until 2006. The evaluation and Family Physician feedback indicated that Shared Care was successful in those clinics and consequently the funding for those positions became permanent. In 2009 the program expanded again and formally partnered with the Department of Primary Care /Family Medicine and Department of Psychology. This expansion was facilitated by the demonstrated success of the program, the WRHA strategic focus on building relationships with fee-for-service physicians, and the Family Physicians’ requests for more service. The focus of the expansion was to integrate mental health services further into Winnipeg’s primary care sector with a focus on the fee-for-service sector, where more than 90% of citizens currently receive their primary care services.

In August 2009, 100 Family Physicians and ten Nurse Practitioners in at least twenty clinical sites throughout the city of Winnipeg had a Shared Care therapist and Psychiatrist working in their office. The mental health providers were available for consultation to the primary care provider and available to their primary care cliental. The model is based on the principles of collaboration and consultation and aims to support the primary care provider’s role in the ongoing management of mental health care.

Primary Care Providers made substantial referrals to the program between April 2010 and March 2011. Most referrals were made to the Counsellor and to a lesser extent to psychiatry. Due to the low amount of clinical time that the Psychologist has in the program, very few referrals were made to psychology. Typically people referred to the Counsellor have a lower score on the Threshold Assessment Grid (TAG) than those who are referred to the Psychiatrist/Psychologist. The TAG score enables the provider to prioritize referrals in the program and denotes a level of distress that the individual is experiencing at the time of referral. A score of 5 or more on a scale of 0-12 is consistent with a rating of individuals seen in psychiatric out-patient clinics (Slade et al, 2003). Table 1 outlines the number of referrals made to each provider including the average wait times in the program and the percentage of missed appointments, both of which are better than comparable general statistics in similar out-patient programs that are not located within primary care.

**Table 1: Number of referrals made to the Shared Care Program between April 2010 and March 2011.**

Provider	Number of Referrals	Number of direct sessions	Average wait times (days)	% of missed appointments	Average TAG* score
Counsellors	2400	7988	25	26%	5.4
Psychiatry	980	797	57	8%	6.0
Psychology	48	19	59	17%	6.6

\* *Threshold Assessment Grid* – [www.iop.kcl.ac.uk/prism/tag](http://www.iop.kcl.ac.uk/prism/tag)

Table 2 outlines the resource allocation and distribution at each site. Typically a formula of 7 PCPs to 1 EFT Counsellor and 0.1 EFT Psychiatry was used. Adjustments were made according to the other factors including number of PCPs within a clinic, number of patients on a PCPs roster, PCPs practice style, and

referral usage. To a lesser extent other factors included issues associated with space and resources available. Psychological services were offered as needed at each site.

**Table 2: Referrals Made by Site**

Clinic	Number of PCPs in the Clinic	Funding Model	Resource allocation	Number of Referrals made to Counsellors	Ratio one day of Counsellor time : number of referrals received per day (workload)	Number of patient visits with Psychiatry (direct sessions)	Number of Referrals made to Psychology
1	11	Alternative funded	1.0	142	1 : 0.5	62	1
2 *	12	Fee-for-service	1.0	91	1 : 0.7	26	0
3	7	Alternative funded	1.0	124	1 : 0.5	45	4
4	7	Fee-for-service	1.0	133	1 : 0.5	69	1
5	11	Fee-for-service	1.0	152	1 : 0.6	75	0
6	9	Alternative funded	0.8	76	1 : 0.4	82	9
7	6	Fee-for-service	0.8	113	1 : 0.6	34	2
8	7	Fee-for-service	0.6	150	1 : 1	52	2
9	8	Alternative funded	0.6	132	1 : 0.8	42	16
10	4	Fee-for-service	0.6	101	1 : 0.6	51	2
11	6	Fee-for-service	0.5	80	1 : 0.6	30	0
12	6	Fee-for-service	0.4	56	1 : 0.5	43	0
13	5	Fee-for-service	0.4	88	1 : 0.9	41	2
14	3	Fee-for-service	0.4	45	1 : 0.5	39	2
15	5	Alternative funded	0.4	123	1 : 1.2	18	6
16	1	Fee-for-service	0.2	34	1 : 0.7	6	0
17	1	Fee-for-service	0.2	21	1 : 0.4	13	0
18	1	Fee-for-service	0.2	37	1 : 0.7	13	0
19	4	Fee-for-service	0.2	89	1 : 1.7	13	0
20	1	Fee-for-service	0.2	42	1 : 0.8	13	0
21 *	1	Fee-for-service	0.2	37	1 : 1.4	4	0
22	1	Fee-for-service	0.2	35	1 : 0.7	2	1

\* Sites were operating for six months or less during this evaluation period.

**Section 2:**  
**The Evaluation Process and**  
**Methodology**

# Section 1: The Evaluation Process and Methodology

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## *2.1 Evaluation Purpose and Objectives*

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### **The Purpose of the Evaluation**

The purpose of this evaluation was to inform program improvement and decision making in real time, as well as documenting learnings on the implementation of Shared Care expansion into the fee-for-service Family Physician practices. This approach was collaborative and input was required from all stakeholders including front-line clinicians, and program leadership. There was a strong emphasis on gaining a better understanding of the provider perspective on the program including their level of satisfaction with it and the impact it has had on their practice and on patient care. The results were expected to inform improvements in the Program, support quality and access, and inform other initiatives related to primary care system development, and collaborative care within a fee-for-service environment. The decision was made to focus on implementation issues and provider perspectives, as there is a strong pre-existing literature demonstrating success of Shared Care models on patient outcomes, and there had been research conducted within this Program on patient outcomes (Goossen, 2008). Program leadership also considered the evaluation processes as facilitating provider feedback.

There was also a research component embedded into the evaluation, which aimed to better understand the inter-professional learning process that is occurring within the Shared Mental Health Care program. The research was conducted from December 2009 to May 2010. Please see Inter-professional Learning Process within Shared Mental Health Care for more information.

**The evaluation questions were developed collaboratively with the Program stakeholders and designed to ensure that the evaluation was aligned with the objectives of the program.** A theme explored in depth here, includes the barriers and facilitators of recruitment and implementation into Fee-for-service physician offices. The Program team also considered it important to understand how the current program is operating and what is working, what needs improvement, and to identify if and how the program goals are being operationalized. In an effort to understand the crucial components of the program, this evaluation aimed to identify what were the most important elements operationally that lead to collaborative practice and the overall program goals. Has Shared Care had any impact, including the intended impact on physician practice such as, increased comfort with the treatment and management of mental health conditions within primary care?

**There were four main questions. The following report is divided into sections around those questions.**

- 1) **What are the implementation challenges and successes of the Shared Care model from multiple perspectives, including primary care provider, Counsellor, Psychiatrist and program leadership?**
- 2) **Is there consistency between the Program goals and operations?**
- 3) **What are the important elements to increasing the collaborative practice in Shared Care (i.e. co-location, case review discussions)?**
- 4) **What has been the impact of Shared Care on physician practice?**

## ***2.2 Methodology***

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In order to conduct an appropriate evaluation that would adequately answer the questions, while at the same time appreciating the value of time and effort that all of the providers were giving to the program already, a mixed methodology was chosen. A literature review was conducted exploring other models and evaluations of Shared Care including current practices, models, and research findings. Further information was gathered related to the primary care experience and practice with mental health care, other collaborative models of practice, relationship building processes, and interprofessional learning.

### *Qualitative Methods*

#### ***1. Document reviews of site review meeting and implementation records***

As regular practice site review meetings were conducted by program leadership with all sites. This face-to-face contact was considered essential to relationship building with the sites and to ensuring that issues emerging at the front line were being addressed. These meetings provided sites with an opportunity to address any questions or concerns, receive feedback from sites about the program including what was working and not working, and discuss site specific program planning and improvement strategies. Due to the importance of these meetings occurring between leadership, and out of respect for the time that each site was giving to this process (meetings were conducted quarterly for all new sites and yearly thereafter) a decision was made to have an independent researcher review the notes taken from these meeting rather than conduct independent meetings with the sites as part of the evaluation process.

A review of the program documents was conducted in order to understand the program, implementation process, and discussions occurring within each site related to the program.

#### ***2. Interview Guide***

For the qualitative components a semi-structured interview guide was prepared for each respondent group. This guide was prepared by one member of the research team and was reviewed and revised by team members. The interview guide was tested by a small sample of respondents, and minor changes were made based on feedback.

The semi-structured focus group lasted approximately two hours and the individual interviews lasted approximately one hour. All interviews were digitally recorded, notes were taken, and the interviews were transcribed verbatim.

#### ***3. Counsellor and Psychiatry focus groups***

Focus groups were conducted with two Counsellor groups and one psychiatry group. All Psychiatrists were involved with the implementation of new sites. The psychiatry focus group consisted of all the Psychiatrists interested in participating in the evaluation and they were asked questions about their experience with the implementation and their evaluation of the program

Two Counsellor focus groups were conducted; one that consisted of Counsellors from existing sites and the other consisted of Counsellors working in newly implemented sites. Both groups were asked the same questions related to the evaluation of the program. The latter group, working with newly implemented sites, was also asked questions related to their experience with the implementation into fee-for-service clinics.

#### **4. Leadership interviews**

Leadership interviews were independently conducted with members from Primary Care, Psychiatry, and Community Mental Health to obtain perspective on the implementation and evaluation of the Shared Care program.

#### **5. Individual interviews with primary care providers**

Primary Care Providers that offered to be contacted (as self-identified on the surveys) were contacted by the research assistant. They were asked questions specific to the inter-professional learning process within the program, but within this gave substantial information related to their perspective on the program including overall satisfaction and feedback on the program.

#### **6. Analysis**

The transcripts were read by an independent research assistant using independent content analysis for common words, phrases, statements, or units of text for key themes. The research assistant brought forward the themes and sub-themes to the evaluation Steering group (with clinical representation) to develop a more comprehensive understanding of the qualitative findings. Participants were then asked to review the sub-themes, elaborate further, and ensure that the report represented their experience, as a form of member checking.

### *Quantitative Methods*

#### **1. Analysis of service delivery data**

Program statistical information was collected during the evaluation period related to the Counsellors, Psychiatrists, and Psychologist service delivery. A summary of the service delivery was captured to illustrate the work and volume being conducted within the program.

*Surveys* were chosen as part of the design to be able to assess primary care provider satisfaction with the program pillars as identified by the CPA/CFPC Position Paper on Shared Mental Health Care in Canada (Kates et al, 1996). Access, communication and relationship with each provider type (e.g. Counsellor, Psychiatrist) were clearly identified in the research as essential to the development of an effective partnership with primary care providers. Access was broken down into two categories including access for patients to services and availability of the mental health specialist to the primary care provider. The 17 item survey was sent out to all primary care providers within the Shared Care program. 54% of the providers responded. Respondents were asked to rate their satisfaction with the Shared Care program on a five-point Likert Scale ranging from one = “strongly disagree” to five = “strongly agree”. Respondents were also asked about their length of involvement with the program (including more or less than two years) and if they worked for a WRHA alternative funded clinic or a fee-for-service private clinic. Data was analyzed using the SPSS (Version 14.0).

## 2.3 Provider Participation in Evaluation Activities

### Shared Care Counsellors

The fourteen Shared Care Counsellors were asked to collect anonymous data on the number of patients they supported during the evaluation period. They were also invited to participate in one of two focus groups. The responses to the request for participation are provided below.

**Table 3: Shared Care Counsellor Response Rates**

Evaluation Method	Response Status
Patient Care Statistical Data	14 of 14 (100%) complete
Focus group participants	14 of 14 (100%) complete

### Shared Care Psychiatrists

All Shared Care Psychiatrists were invited to participate in a focus group. Where there was a concern about dual roles between psychiatry and leadership, the Psychiatrist was invited to participate in an interview instead of the focus group. The responses to the request for data are provided below.

**Table 4: Shared Care Psychiatrists Response Rates**

Evaluation Method	Response Status
Focus group participants	7 of 9 (78%) complete
Psychiatry Interviews	2 of 2 (100%) complete

### Primary Care Providers

Several methods were used to get input from primary care providers, which included alternate funded Family Physicians, nurse practitioners, and fee-for-service Family Physicians. During the evaluation period Shared Care Leadership met with all newly implemented sites on a bi-yearly basis. This information was collected and reviewed using a document review methodology. All primary care providers within the program regardless of the length of involvement they had with the program were sent a satisfaction survey. Participants were asked if they had been in the program more or less than two years. All primary care providers were all also offered the opportunity to participate in an interview. The responses to the request for data are provided below.

**Table 5: Primary Care Providers Response Rates**

Evaluation Method	Response Status
Satisfaction Survey	54% complete *
Site Review Meetings	31 complete
Primary Care Provider Interviews	11 (9 Family Physicians, 2 Nurse Practitioners)

\* the number of completed surveys was considered significant and therefore representative of the respondents

## Shared Care Leadership

Leadership members of the program were invited to participate in individual interviews. The responses to the request are provided below.

**Table 6: Shared Care Leadership Response Rates**

Evaluation Method	Response Status
Leadership Interviews	5 of 5 (100%) complete

## ***2.4 Potential Evaluation Challenges and Limitations***

### **1. Implementation time frames and project deadlines**

- ✓ Some of the outcomes related to patient health outcomes and interprofessional learning is long-term outcomes and may require a longer implementation period than what was available during this evaluation period.
- ✓ There was considerable variability in provider experience with Shared Care during evaluation period. Some of the participants within the program were involved with Shared Care for over five years, while others had six months of involvement.
- ✓ Systemic changes with psychiatry also occurred during this implementation period, specifically, the creation of a centralized intake process for parts of the psychiatric system. Various primary care clinics within the program perceived that this negatively impacted them, that Shared Care obstructed them from receiving access to long-term psychiatric supports. Results gathered during this period were impacted by this dissatisfaction.
- ✓ This evaluation was set up with an action-oriented framework, and consequently continuous improvements and changes were occurring throughout the evaluation period. To address this, it was proposed that the surveys be repeated after two years to identify changes in respondent scores, and that evaluation be an on-going priority within the program.

### **2. Evaluation Breadth**

The evaluation was set up to provide a broad overview of the program including the aspects that are working and areas in need of improvement. It was also designed to be program focused, rather than evaluation focused, and respectful of provider time. The site review meetings were conducted by program leadership and it was only brief notes collected during those meeting from the leadership that were reviewed as part of the document review. These notes identified what issues were being addressed by sites or leadership and general overall satisfaction, but were not written or collected specifically for evaluation purposes. To balance this bias, information was collected regarding satisfaction during the primary care provider interviews and all primary care providers were offered the opportunity to complete the surveys.

### **3. Research Team Bias**

The interviews and analysis were completed by independent research assistance. To further understand the information gathered the assistance used an iterative process of analysis and discussion with the research team which included members of leadership as well as independent members. Attempts were made to minimize the leadership bias and member checking was utilized as a strategy to ensure that the evaluation was reflective of experience. Members of the leadership wrote the final version of the report in order to document the meaning of the results within the context of experience. Member checking was used as a process to balance the bias and ensure that the report represented the experience of the participants.

**Section 3:**  
**Evaluation Results**

## Section 3: Evaluation Results

### 3.1 Impact of Shared Care on Primary Care Provider's Practice

#### *Evaluation Question 1: How has the Shared Care Program been received overall and what general impact has it had?*

Overall the Shared Care program has been well received by all provider groups. Mental Health Specialists described feeling engaged in meaningful work and described the work as part of an important vision towards system change. They believed in the value of primary care and mental health working together for the better health of the community, and they were invested in contributing at all levels of program development to continue to assist in this vision. Counsellors enjoyed the opportunity to work with such an interesting and diverse cliental. Both mental health specialist groups expressed great value in being able to work collaboratively with primary care. Psychiatrists identified that through this work they are able to change the image of psychiatry amongst PCPs. Counsellors believed the program breaks down barriers between the two systems and focuses on positively impacting patient's lives by offering holistic Primary Health Care.

The evaluation results also demonstrated that the program has impacted all of its program objective areas including:

1. Improved access to mental health services
2. Improved primary care capacity to manage mental health
3. Improved communication between primary care and mental health
4. Improved patient outcomes
5. Increased mental health providers understanding of primary care.

#### *Primary Care Provider Satisfaction with Shared Care*

Overall the Primary Care Providers were very satisfied with the program and found the program to be an efficient use of limited mental health resources. This high level of satisfaction is consistent across Primary Care Providers, indicated by low variability in the responses. This satisfaction was further supported in the qualitative data collected in the evaluation (see Table 7).

**Table 7: Primary Care Provider Satisfaction Scores**

Question	Mean (SD)
Overall I am satisfied with the Shared Care Program	4.57 (91%)
Shared Care is an efficient use of limited Mental Health resources	4.68 (94%)

According to Burley (2002), Primary Care Providers are interested in *Access, Communication, and Relationship* with Mental Health Providers (CPA Bulletin, p 29). The satisfaction survey was designed to identify if the Primary Care Providers were satisfied with these core components of the program both with the Counsellor and the Psychiatrist. These core components were believed to be the foundation of the program that would foster collaboration.

**Table 8: Primary Care Providers Satisfaction Scores regarding the Counsellors**

<b>Question</b>	<b>Mean (SD)</b>
My relationship with my Shared Care Counsellor is satisfactory	4.91 (98%)
The Shared Care Counsellor is accessible to me	4.89 (98%)
The wait times for patients to access the Shared Care Counsellor are acceptable	4.41 (88%)
My communication with the Shared Care Counsellor is satisfactory	4.86 (97%)

**Table 9: Primary Care Providers Satisfaction Scores regarding the Psychiatrists**

<b>Question</b>	<b>Mean (SD)</b>
My relationship with my Shared Care Psychiatrist is satisfactory	4.29 (86%)
The Shared Care Psychiatrist is accessible to me	4.13 (83%)
The wait times for patients to access the Shared Care Psychiatrist are acceptable	4.14 (83%)
My communication with the Shared Care Psychiatrist is satisfactory	4.23 (85%)

Analysis of the findings displayed in Table 8 and 9 suggest that the Primary Care Providers are very satisfied overall with all foundational aspects of the program with both the Counsellors and Psychiatrists. Mental Health Provider's access was evaluated on two scales including the patient access to the provider and the provider's availability to the Primary Care Provider. In further analysis of the survey, it was found that most of these foundational questions (including respectful relationship and wait times to the Counsellor and Psychiatrist, communication with the Counsellor, and accessibility of the Psychiatrist) correlated highly with the PCPs belief that the time they invest in the program is worth the benefits that the PCP receives. Further it was found that those PCPs that found the wait times for the Counsellor to be reasonable, were equally satisfied with all aspects of psychiatry including access, availability, communication and relationship. This raised some interesting questions about the Counsellors' role in facilitating the PCPs relationship with the Psychiatrist.

## ***The Shared Care Program Improved Access to Mental Health Services and Information to the Public***

Primary Care Providers described the Shared Care program as being a “significant improvement to the mental health system”. They believed the program reduced access barriers for patients with a broad range of mental health issues (across the continuum from prevention needs to complex mental health issues) including barriers associated with stigma, finances, and geographic/familiarity barriers. They identified that some patients have a strong preference to receive services within the familiarity of their primary care office setting. Psychiatrists agreed that the program reduced barriers and increased the likelihood that patients would attend their psychiatric appointment as compared to the patient attendance rates within alternative psychiatric services.

Primary care providers further elaborated on the improvements they have identified. The service offers timely access to short-term counselling, psychiatric assessment, and community referral information. Patients considered to be on the preventative end of the mental health service continuum have been able to benefit from the high quality service that the mental health team offered including those that are suffering with multiple stressors, relationship issues, and mild to moderate forms of depression and anxiety. Those that are struggling with complex medical conditions and mental health challenges that may not have received a psychiatric opinion otherwise, were able to receive a psychiatric assessment and consultation. In addition to those on the prevention end of the mental health continuum, many others with more complex needs were also seen. Examples of care on this end included the prevention of hospital admissions, facilitation of hospital admissions, and team support that prevented patients from deteriorating post-hospital admission.

Provider groups described the Shared Care service as an entry point into the mental health system regardless of the severity of the patient’s mental health condition. At times this included providing a brief therapeutic intervention and at other times this included: “taking one step with a patient”; working in a sequential nature over several years; linking, bridging or preparing patients for more appropriate services; or providing service, referral and access information to patients/providers that otherwise would not have that knowledge.

Service providers believed that this enhancement in access lead to improved mental health outcomes for patients because they had access that was *timely*. The timely access was relevant because the service was available before the patient’s condition deteriorated and it was available when the patient was motivated. Some PCP described intentionally building patient motivation

***“This program has knocked down a lot of those barriers for those people who don’t have the private access to counselling. We have access now. And it is quick. They are seeing the Counsellor within a couple of weeks. And that is tremendous. And they are coming right back to the place that they are already comfortable. I am not sending them downtown somewhere and they appreciate that. Same with psychiatry.”*** (Family Physician)

over many visits to get them into the service. These providers described satisfaction with being able to coordinate access to the service at the same time as the patient was ready to receive assistance. Another example identified was when the PCPs introduced patients to the mental health provider at the point of referral, to facilitate a soft-hand-off to mental health. This approach was believed to improve the likelihood that the patient would attend the appointment.

Counsellors reported that they also provided services to individuals with severe and persistent mental illness. They noted that the difference in severity was present in all clinics, but there were some clinics where the concentration of individuals with severe and persistent mental illness was higher. Consequently, in some locations the patients referred to the Counsellor were further along the mental health continuum.

Program data shown in Table 4 showing the reason for referral and the mental health conditions that patients suffer from at the point of referral to the Counsellor, Psychiatrist, and Psychologist is instructive. Regardless of clinic, primary referral reasons to the Counsellor included depression, anxiety and relationship problems. Of those referred, 24% of the people also identified as having concerns with substance use. Similarly, psychiatry saw individuals suffering with mood and anxiety problems as the top two referral reasons. PCPs also regularly consulted with Psychiatrists on patients identified as having personality traits (32%) for ongoing treatment and management recommendations. Program members requested assistance from the Psychologist to assess cognitive functioning, attention deficit disorder, and the ongoing management of chronic pain.

**Table 10: Top Referral Reasons by each Provider Type**

Counsellor	Therapeutic Prevalence	Psychiatry	Diagnostic Prevalence	Psychology	Prevalence of Referral Question
Mood (either primary or secondary diagnosis)	1458 (72%)	Mood (either primary or secondary diagnosis)	416 (52%)	Cognitive and Intellectual Functioning	20 (42%)
Anxiety (primary diagnosis only)	738 (36%)	Anxiety (primary diagnosis only)	295 (37%)	Attention Deficit Disorder	11 (23%)
Relationship Issues	514 (25%)	Personality Traits	251 (32%)	Pain	10 (21%)
Substance Use	254 (24%)	Substance Use	123 (15%)	Mood	5 (10%)
Work	71 (4%)	Adjustment Disorder	38 (5%)	Work Competency	1 (2%)
		Severe Mental Health	22 (3%)		
		Average GAF	56		

***Shared Care Improved the Primary Care Provider’s Capacity to Manage Mental Health Conditions***

***“My level of anxiety is much better knowing that the patient will be seen. That I have a support system.”*** (Family Physician)

Primary Care Providers identified access as contributing to their sense of relief. It further contributed to their sense of comfort in dealing with mental health concerns/conditions. Prior to having improved access, some primary care providers experienced moments when they felt “stuck”, “at loose ends”, and “isolated” when treating patients with mental health conditions. With access, primary care providers identified experiencing a sense of team and support. Counsellors described times when they shared patient care with the PCPs by assisting in the monitoring of high risk patients. Counsellors and PCPs alternated weekly appointments with the patient to help stabilize the patient. A PCP also shared a story of developing a treatment plan for a high risk patient with the Counsellor. The Counsellors provide the PCP with someone to debrief with, consult with, and obtain the service information necessary to provide the patient with quality of care. It is this type of access and support that is identified as a theme throughout the evaluation.

The support that the PCPs experienced was created once they had a relationship with and access to the mental health provider (availability). It was through relationship and availability that descriptors of themes suggestive of ‘*Shared Care goes beyond service delivery*’ began to illuminate. These descriptors included; validation and debriefing following difficult patient encounters, new perspectives or alternative ways of viewing situations, information or suggestions regarding ongoing management, and information on community supports and referral options. Mental health specialists witnessed some primary care providers enhanced comfort in dealing with the patients’ difficult emotions, feeling less of a need to “fix the problem” for the patient, and integrating motivational interviewing philosophy into practice. Additionally, Counsellors and Psychiatrists believed some PCPs have made a notable change in their interest and willingness to try treatment themselves before referring to the Counsellor or Psychiatrist. They were more tolerant and less anxious when working with patients that had extreme behaviours and/or chronic suicidality. Some PCPs were using medications that they had not previously used to treat mental health conditions. Over time mental health specialists also noticed that some PCPs were more willing to manage complex patients.

***“I am no longer afraid to see patients who are psychiatric, who have psychiatric conditions. Before I would refer these patients and it was very frustrating. Psychiatrists would not see the patients for months or even years. They had to wait and then I was not getting reports after they see them. Now I get immediate report and feedback, a clear plan that I can understand. I have felt like practicing medicine again.”***

(Family Physician)

Quality of patient care was evidently the primary practice concern and focus of the decision making process for most/all PCPs within the program. Consistent with that, most wanted meaningful, specific, and timely information that would allow them to continue to care for their patients. They also wanted accessible quality based services that would meet the needs of their patients (i.e. high quality change oriented therapy). When Psychiatrists were able to tailor their information and consultation report to the specific PCP style, comfort level with the management of the presenting mental health condition, and specific referral question the PCP was more satisfied with the consultation. The importance of relationship building and understanding of the PCP practice was critical in creating a highly satisfactory service.

***“The service has not only helped my patients, but it has helped me to feel more confident about my approaches to mental health care. It has helped me to feel like I am part of a team and there is a bit of a burden that has been lifted off my shoulders. Where I used to feel, oh boy, this all on me, I have to help this person and I don’t have the time and I don’t have the techniques and I don’t have the knowledge. Now I feel like I am a team member that if I have come to the end of what I know I can defer to my colleagues who have an even broader knowledge base.”*** (Family Physician)

### ***Improved Communication between Mental Health and Primary Care***

Communication significantly improved between mental health providers and PCPs in multiple ways as relationships developed. In some circumstances the improvement in communication was relatively basic including access to PCP health records and documentation of the mental health treatment plan or encounter. In these instances mental health providers stated that they typically provided more detailed documentation to the PCP by offering more information and direction in their clinical notes. On the other far end of the spectrum, the providers described having significant and ongoing communication and collaboration as a team. This included consulting after every patient encounter. There were many partnerships in the middle of the spectrum. The partnerships varied based on providers and often came together around patients. The primary difference seemed to be based on the priority and value that providers gave to collaborative conversations.

### ***Access to documentation***

The impact of having access to the documents was considered valuable in the ability to offer coordinated care. It offered Psychiatrists a history of the patient's health, the patient's past diagnosis, and past treatment. This collateral information was useful to the consultation.

***“they actually ask for your assistance in the situation as it's happening, as it's unfolding, and you can assist the doctor and then you can debrief with the doctor afterwards and that's beautiful. It's really, really cool.”*** (Counsellor)

PCPs appreciated having immediate access to diagnosis and treatment recommendations post-consultation. They also appreciated knowing if a patient attended an appointment with mental health or not, what the counselling treatment focus was, and some of the patient history that they may not have received (e.g. history of abuse). PCPs indicated that this information was useful for them in their own understanding of and treatment with the patient. Psychiatrists also identified their appreciation in working with PCPs, as they were able to suggest or review medical tests before determining the patient's diagnosis and treatment recommendations.

### ***Patient Care - Based Discussions***

Provider groups also identified collaborative conversation as impactful on patient care. For some patients, the providers developed collaborative treatment plans, consistent treatment goals, they supported and reinforced the work of their colleague, and they developed joint discharge plans. A Counsellor retold a patient situation, where the patient's addiction was identified as a treatment concern, but the patient had no interest in making a change. The physician, who had a long-term relationship with the patient, followed up the concern with the patient. The Counsellor stated that at the next session the patient wanted to change her treatment goals to focus on her addiction. The Counsellor believed that this change occurred quickly for the patient because of her collaborative relationship with the physician, the physician's long-term relationship with the patient, and the physician/Counsellors commitment to supporting and reinforcing each others work.

### ***Post-Consult Debriefs and Indirect Consultations***

Descriptions of effective collaborative relationships between PCPs and Psychiatrists were also identified. PCPs expressed value in the post-patient consult discussion with psychiatry, but also the indirect consults with psychiatry. They appreciated consults that were tailored to their style and the patient treatment history. Psychiatrists identified that knowing the PCP style and comfort level with the diagnosis or treatment recommendations allowed them to tailor their report and recommendation more specifically to the PCP so that the consult report would be useful to the PCP. Further, Psychiatrists identified that they felt more confident working within a consultation service model when they had trusting relationship with the PCP. The Psychiatrist wants to know that the PCP is willing to provide the ongoing management of the patient's care.

During the member checking process, Counsellors identified that they have been increasingly engaging with some PCPs in pre and post consultation debriefs and Psychiatrists/ PCPs have also started engaging in pre-consult meetings. They stated that this process has also been extremely valuable to their work as it expedites the work that the mental health specialist and patient are able to do together and it carries forward the work beyond the Counsellor/patient relationship. They further stated that indirect consultations have been extremely valuable to their practice as in some cases it postponed or eliminated the need for a psychiatry consultation, it directed a patient to the most appropriate community-based support efficiently, and it offered indirect support to patients/PCPs when the patient chose not to access the mental health service.

## *Shared Care Improved Mental Health Outcomes for Patients*

Even though the theme of patient outcomes was not the focus of this evaluation, many comments about the success of the Program in addressing patient mental health issues emerged. This is supported by local and national evidence that “short-term therapy... contributes to reducing symptoms associated with major depression and increasing certain areas of functioning.(Goossen et al, 2008, p 43)” The results were positive and independent of age and gender and indicated that there was even a positive impact on physical well-being.

Themes emerging in the present evaluation related to the provider’s beliefs that the program has had a positive impact on patient care. Consistently, providers indicated that the timely access to mental health services improved patient outcomes. PCPs described the Counsellors as providing high quality, change-oriented counselling and acknowledged receiving positive feedback from patients about the mental health providers. They also described the service as “patient-centered”, “practical”, and “relevant to help people to get on with life”.

*Counsellor retold a story of a situation where a Family Physician told the Counsellor that he was feeling overwhelmed and frustrated with a patient, but relaxed when he remembered that he had help. The physician reportedly stated to the Counsellor, “you made me a better doctor today”. (Counsellor)*

PCPs identified that for some patients the number of somatic visits actually decreased as a result of seeing the Counsellor. They also stated that in some circumstances, PCPs felt that they were able to focus their time with the patient on other health issues knowing that the patient’s mental health was temporality being addressed by the mental health specialist.

At another level, the providers also believed that the improvement in communication between mental health and primary care positively impacted patient care. This included even basic levels of communication and collaboration, because having access to integrated files improved communication. Integrated files enabled the PCP to be aware of the outcome of their referral and provided mental health specialists with information about the patient’s health history relevant to the patient’s current situation.

Higher levels of communication and collaboration between providers resulted in even further improvement in patient outcomes. This seemed to be most prevalent when the team was working with a particularly complex patient. As described above, collaboration lead to providers working together towards consistent goals, reinforcing each others work, and alternating provider appointments to reduce a crisis period for a patient. A Psychiatrist recounted a collaborative experience with a physician that led to investigation and diagnosis of a physical health condition. The physical condition was affecting the patient’s mental health and ability to benefit from psychiatric medications, this Psychiatrist concluded “*The physical and mental health working together in that way is really amazing.*”

At yet another level, some providers also identified that the program impacted quality of patient care as part of a second order change. This was represented by quotes including:

***“I think they [patients] are receiving better care. If I feel more comfortable, then I’ll be interacting with them better...if I feel comfortable, then I think I provide better care to patients. If I provide better care the patients are going to be healthier mentally, psychologically. If they are better psychologically and mentally, then their other health issues will be better, human beings are physical and mental. If you do not feel psychologically well, then you are not going to be 100% physically well. They go hand in hand, you can’t separate them.”*** (Family Physician)

Although further evaluation needs to be conducted to better understand the connection between physical and mental health, it appears as though the program has the potential to benefit the patient at multiple levels including better access to mental health services, a higher quality of mental health services because of communication/shared information, team based care, and better overall primary care.

### ***Increased Mental Health Providers Understanding of Primary Care, the PCP Role, Physical Health Conditions and their Respective Treatments***

All provider groups agreed that Shared Care has provided mental health with the opportunity to understand and appreciate all aspects of primary care including the role of the PCP, the effect of physical health on a patient’s mental health, and the benefit medications offer some patients. Providers identified that this partnership has afforded mental health specialists an appreciation of the challenges that PCPs face in their practice including the complexity of patients, the barriers to service, and the system pressures they experience. Mental Health Specialists identified appreciation of the history and relationship that PCPs had with their patients. This not only allowed the mental health specialist the ability to gain a better understanding of the patient; to provide service to the patient sequentially over the long-term; but also to have the confidence to work within a short-term / consultative model knowing that the PCP would continue to support, monitor and treat the patient.

Mental health Counsellors identified that by working in collaboration with primary care they have been afforded an opportunity to learn about physical health conditions, including the treatment and the effect these have on mental health. Some also identified learning from psychiatry, including assessment, medications, diagnosis, and treatment recommendations. PCPs believed that Shared Care has facilitated a process where mental health specialists are able to understand what they want out of a consultation and interaction. A Psychiatrist stated “I am always learning within Shared Care”, this comment referred to all aspects of learning that primary care offers from the patient level to the provider level to the system level.

### ***3.2 Operations: Is there Consistency between the Program Goals and Operations?***

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The analysis of the findings suggested that many of the impacts in the program were consistent with the program goals. This section will explore more deeply what operations were the facilitators of the program goals. It will also examine the areas of the program that needs improvement so that the goals can be optimized within all partnerships.

#### ***Overall, what is Working and what Needs Improvement in the Program?***

Overall, providers expressed a strong sense of engagement and commitment to the vision of the program, which included working collaboratively and integrating primary care and mental health. Counsellors, Psychiatrists, and leadership participants identified Shared Care as a significant system change and a “paradigm shift”. They were enthused to be a part of something so radical. Due to the high level of engagement in provider groups, providers valued ways to contribute to program development.

The partnership between mental health and primary care (and especially the partnership with fee-for-service physicians) was described as a venture into the “unchartered territory”. Consequent to this providers’ identified a high level of need for support. This included support from the Shared Care Manager and leadership to understand the complexity, the clinical work, and to address challenges. They also identified the need for formalized structures to communicate and provide support to one another. That is, Counsellors valued the opportunity to meet with the other Counsellors to discuss how they operationalize the program, so that they are able to enhance their learning and develop opportunities within their site. The Psychiatrists identified a similar need to start meeting with each other and with the program, to increase their communication with and about the program. While leadership identified that the operational working group was working well together (i.e. collaboratively), they suggested developing official structures and supports so that the leadership would occur regardless of personal relationships and interests.

As identified within the above section on impact, *collaboration* was not clearly defined. Providers identified that the goals, roles, and expectations within the program were not shared between all providers. The evaluation results indicated that there was significant variability in the understanding of collaboration within the program and consequently there was significant variability including the amount, type, and intensity of interaction within each site / provider group (i.e. PCP, Counsellor, Psychiatrist, and Psychologist). Another area that providers asked for clarification was related to referrals. Psychiatrists identified receiving referrals for the purpose of disability versus consultative treatment focused. Some Psychiatrists felt strongly that the Shared Care Psychiatrist role should not be utilized for disability, yet they also felt that PCPs expected them to conduct these assessments at times. Clarity about the program stance on assessments for purpose of disability was recommended.

Communication was also identified as an area of development between the program and some sites (particularly existing sites), and the program and psychiatry. Counsellors identified site review meetings as an important process that facilitated communication between sites and program. These meetings were held on a bi-yearly/quarterly basis for new sites and a yearly basis for established sites. These meetings reviewed what worked, what needed improvement, issues of specific concern, and updates that may impact either the program or site. The Counsellors recommended that the site review meetings be prioritized as an ongoing process within the program in all sites including alternatively funded sites.

Counsellors further identified that communication between the PCPs and program has been a challenge at times. They suggested that letters and memos from the program have been misunderstood by PCPs in the past, and great sensitivity needs to be paid when sending out written documents to the PCPs. Letters being sent to PCPs regarding changes in program, or system changes that impact service delivery (i.e. redirection of patients from Centralized Psychiatry Intake to Shared Care) need to be reviewed from a primary care perspective. They also suggested that when the message is important, communication between the program and all providers needs to be in multiple formats and repeated in many ways. This includes, written, formal and informal conversations and perhaps on multiple occasions. This need further highlighted the necessity of a collaborative leadership group consisting of mental health and primary care leaders.

### ***What operations are in place to facilitate Access?***

As described within objective 1 above, the program significantly impacted access in two ways:

1. ***Improved Access*** to patients within specific primary care clinics because mental health services are co-located within primary care. The mental health specialists believed that the patients were more likely to attend their mental health appointment because the location was familiar and less stigmatizing. Through co-location, PCPs were also able to gently facilitate a transition to the mental health provider when necessary by introducing the patient to the mental health specialist.
- “...what makes this program work is that people are coming to a place that is comfortable and familiar to them rather than the scary hospital, and first of all, trying to figure out how to get there and where to go. There are huge barriers to people having to go elsewhere. So I think having services on site is very helpful.”*** (Family Physician)
2. ***Timely Access***, identified by wait times, was significantly important in the evaluation. The operations that facilitated access included prioritizing timely access and keeping it a part of the program vision and goals. Consistently, wait times for services were a constant consideration within the program. The program set targets for when patients would be offered an appointment. This included; six weeks targets from time of referral to first counselling appointment and two months from time of referral to psychiatric consultation. The mental health specialists also accommodated and responded to urgent referral requests from patients and the PCPs by scheduling urgent time slots, adding extra appointments, not booking too far in advance, and offering indirect consultation. This ensured that the team was able to support the PCP when he/she was concerned about a patient’s level of risk or acute mental health condition. When the program was unable to meet these targets, wait times were communicated with PCPs and patients, including alternative treatment options and recommendations that may be useful while waiting for service.

A short-term therapy model (6-8 sessions), using a primarily psychiatric consultative model and working in collaboration with PCPs facilitated timely access within the program. There was a tension between this model and the need at times for further assistance and stabilization with certain patients. To manage this tension, Counsellors indicated that they utilize “booster sessions” to aid in the patient’s maintenance of health; they assess, recommend, and bridge to long-term services; they work within a sequential framework (i.e., take one step with the patient, encourage a therapy break, and then take the next step with the patient in therapy); and at other times they have been able to provide two sets of short-term therapy to help stabilize a patient. Counsellors also identified that when they work within a highly collaborative relationship with primary care they experienced a stronger sense of confidence working within the short-term model, because they know the PCP will continue to support the patient, reinforce the treatment plan, and alert the mental health provider when/if the patient starts to deteriorate.

Similar tension between service and access was identified for psychiatry. Some Psychiatrists reported offering follow-up support to some patients, but acknowledged that this had an impact on their ability to see new consults and consequently on wait times. Other Psychiatrists indicated that they did not provide follow up because of the need to provide timely access, but identified it as an area of concern because they felt that some patients were too unstable for the PCP to manage. Suggestions made by PCPs and Psychiatrists were offered to resolve this including the development of an out-patient psychiatric follow-up clinic and/or a model of “reversed Shared Care” (i.e., Psychiatrists would be the primary provider of care and the PCP would continue to provide the physical care to the patient) for certain complex patients.

Patient access to psychological services within the program was as an area of ongoing concern. One PCP expressed frustration with the Psychologist position referencing that the position was not “true Shared Care”, because the Psychologist was not accessible or co-located.

Mental health appointment no show rates came up as an area of concern for some PCPs. Although, the program attendance rates were on par or better than other mental health programs, PCPs identified a need to prioritize their attention to and ongoing problem solving regarding this issue. PCPs wanted patients to attend in order to receive assistance from the mental health specialist regarding a specific patient. They requested that teams continue to work creatively to increase attendance rates. Operationally, sites have implemented certain strategies to increase attendance rates including reminder calls for psychiatric appointments, scheduling appointments within four weeks, and utilizing friends/ family/ system supports to remove barriers of attending such as child care, transportation, reminders, and anxiety. PCPs have intentionally attempted to introduce their patients to the specialist after a primary care appointment to ease the transition. At times, mental health specialists have also availed themselves to the PCP to conduct a chart review and indirect consult when the patient has not attended.

There was no conclusive evidence within this evaluation that suggested that PCPs are screening for mental health conditions and/or offering evidence-informed interventions specific to the patient’s level of need, including self-management. The evaluation demonstrated outcomes related to service delivery, but it was less conclusive that the program was facilitating information to patients about self-management and mental health promoting activities. Operationally, there was less emphasis on these objectives as compared to timely access. The program believed that by being co-located and providing access to mental health services, PCPs would be more willing to screen mental health and offer a variety of options for treatment. Further evaluation would need to be conducted to see if the program has made an impact in this way.

Although PCPs were satisfied with services Shared Care offered, PCPs identified ongoing concerns about access to other mental health services. They identified service gaps for patients suffering with acute/crisis mental illness, severe and persistent mental illness, and those that require ongoing psychiatric care. Additionally they identified two groups including those with addictions and the pediatric/adolescent population as needing better access to mental health services. PCPs expressed concern that Shared Care created an obstacle to long-term psychiatric services. The desire for long-term psychiatric services is still desired by many, and due to their improved access to a consultation service, some worried that they would have less access to longer-term services.

## ***What facilitates Primary Care's Capacity to Manage Mental Health Conditions?***

Primary Care Providers clearly associated access to mental health services as improving their comfort to work with and treat patients with mental health conditions. Consequently, by virtue of the program emphasizing timely access within the service delivery model, Primary Care Providers felt more supported in their role with patients who have mental health conditions. As identified in the impact portion of the report, the program has made a significant impact in this area for certain PCPs. Facilitators included access, availability, communication, and relationship, most of which would not have occurred without co-location.

***“feel like you have back up”, “knowing that you are not alone”, “someone to say you are on the right track” (Family Physician)***

Providers identified that providing mental health services and having an opportunity to discuss and debrief shared experiences regarding a patient as helpful to capacity building. The data suggested beyond access, there was another level of comfort and confidence that emerged through a collaborative relationship. Mental Health Specialists identified providing PCPs with support, knowledge, suggestions, and new perspectives on patient situations. They described five minute hallway interactions as a facilitator to offering mental health information to the PCP. Mental Health Specialists made themselves available to support the PCP, they were willing to engage in joint service planning, willing to seek out unknown information (i.e., referral criteria for community resources), and would validate the PCPs treatment decisions and emotional experiences when working with difficult patients.

There was mixed reports between Counsellors and Psychiatrists about the impact of the program on referrals made to Shared Care and other mental health services. With some PCPs, communication via the referral form to the mental health specialist improved. Some providers felt that with exposure to Shared Care some PCPs referred more people for service because they recognize who benefited from the service, while others reduced the referrals that they made to the program as they were willing to try more treatment on their own. Psychiatrists projected that they may not see a change in the number of referrals made to them; however they

***“because the Family Physician know that we’re there, they might feel a little bit more resilient, a little bit more capable, a little bit less stressed by what comes in their office, knowing that we are available.” (Psychiatrist)***

suspected that they may find a change in the referral question asked over time. Overall however, Shared Care did seem to help guide PCPs in knowing who was appropriate for the Shared Care service and what other mental health service options there was for people who needed something different than Shared Care. This occurred through discussion and

written feedback to the PCP about the patient, the patient’s level of motivation for change, and the patient’s overall mental health condition or behaviours.

Capacity building, was a program goal area that needed further clarification. There were mixed views related to the program goal and the link between collaboration, interprofessional learning, and capacity building. Although, providers were able to identify the operational links, they did not consistently hold the vision or have shared goals in this area. This raised questions about what impact the program would have on Primary Care and Mental Health if PCPs and Counsellors intentionally attempted to contribute to the interprofessional learning process for each other.

## ***How did the Program Improve Communication?***

As stated in the section on impact, there was significant variability in the program related to communication between providers. There were operational structures designed to facilitate communication between the provider groups. These structures included co-location of mental health providers within primary care, integrated records, and an expectation that all primary care providers would spend half an hour conversing with the mental health providers per month (either as a structure meeting or informal hallway consultation). Co-location was reported consistently across provider groups to be *the* significant enabler to communication. Quotes such as:

“physically being in the same building is good for continuity of care and communication” (Family Physician) and

“having them physically in the office is better. We wouldn’t connect if they weren’t here.” (Family Physician)

were used to describe the significance of co-location within the Shared Care program. Close proximity and regular interactions were identified as enabling provider groups to discuss patients and creating an opportunity for them to problem solve issues as they arose.

Counsellors identified that they capitalized on being co-located by proactively seeking out opportunities to speak to PCPs, including spending time in the lunch room when the PCPs were around, keeping their door open, learning when and how to connect with each PCP within their clinic(s). Communication and collaboration with the PCPs were identified as a priority in the program and as such, Counsellors were encouraged to have time to communicate with the PCP within their day. The Counsellors identified that their proactive efforts to communicate, adapt to the PCP workflow, avail themselves to communicate, being open to communicate, and having brief conversations and/or small talk as facilitators in developing high levels of communication with PCPs. They described strategies such as catching PCPs between patients, connecting with PCPs in their charting room, leaving messages for the PCP indicating that they need to meet, and notifying the PCP when they are available. Additionally, Counsellors stated that sometimes they also scheduled meeting time with PCPs.

***“Physically being in the same building is good for continuity of care and communication.”*** (Family Physician)

Psychiatrists also identified that communication occurred more frequently when they took a proactive role in initiating and seeking out opportunities to connect with the PCP. Some Psychiatrists acknowledged that with some PCPs communication may not occur if they do not seek out the PCP. Psychiatrists reported efforts such as being assertive, seeking out a PCP, leaving their door open, and walking by the PCP office. Some facilitated group based consultations and responded to or followed up with phone call. Psychiatrists espoused a philosophy of collaboration and communication, including describing the Shared Care program as intending to facilitate interaction otherwise it would not be co-located. This attitude and the intentional behaviour are believed to be facilitators in the improvement of communication between providers.

The personal factors related to the PCP seemed to be another significant contributor to whether communication occurred and the amount of communication that occurred between providers. Factors such as if the PCP had an interest in working with mental health patients, if the PCP had prior experience with collaboration personally or professionally, and/or the priority they placed on the value of collaboration within their practice. Mental Health Providers identified that some PCPs were very receptive to communicating early on, while others have been slower to adopt a collaborative approach into their practice.

***“Having them physically in the office is better. We wouldn’t connect if they weren’t here.”*** (Family Physician)

There were also, a few PCPs identified by leadership, Counsellors and Psychiatrists that did not seem to want to work from a collaborative framework, but rather were

satisfied having access and integrated records with mental health (written communication only).

With regard to integrated records, the program structure ensured that PCPs received documentation on all encounters between the mental health specialists and the patients. This included documentation when a patient declined a referral, treatment plans, progress, and discharge plans. Suggestions and recommendations about how the PCP could help reinforce or support the treatment plan were also offered. Counsellors and Psychiatrists reported tailoring their documentation style in effort to communicate more effectively with each PCP. Counsellors stated that when they saw a patient with a complex situation, but were unable to communicate face-to-face with the PCP, they were more likely to be more detailed in their documentation including a clear treatment plan. Psychiatrists also reported attempting to adjust their style based on the PCPs receptivity and knowledge in the area of each specific patient's presenting concern. This level of tailoring required the Psychiatrists to have an understanding of the PCP and their practice.

During the evaluation period and in response to a service delivery gap, the program placed a greater emphasis on the need for Psychiatrists and PCPs to have a post-patient consult debrief. The intent of these discussions was to improve coordination of care. The PCPs wanted timely communication about what occurred during the consult to discuss the recommendations, and address any questions that the PCP had before the patient attended their next primary care appointment. This operational change not only improved patient service it also addressed the communication gap identified by both Psychiatrists and PCPs. Most Psychiatrists wanted more communication with PCPs. The same theme also emerged within the PCP interviews and site review meetings. Barriers that were identified related to communication included the Psychiatrist and PCP not being at the site on the same day; workload/ time issues; logistical barriers (i.e., not knowing when the Psychiatrist is on-site); and disruptions in relationships (i.e. Psychiatrist changes). Suggestions that were offered to improve this included facilitating a brainstorming process between providers regarding how to make themselves more available within the time they had. Other PCPs suggested that with time and relationship, they would continue to find ways more to increase communication between each other.

Factors needing improvement and identified barriers to communication included a lack of clarity between providers and within the program regarding expectations related to communication, the definition of collaboration, and the program goals. Additionally, barriers to communication included PCPs inexperience with or priority given to collaborative practice, issues associated with time within all provider groups, providers having to juggle multiple demands, and mental health specialists that did not prioritize the proactive role in communication. Psychiatrists opined that the consultation model was not as useful when communication with the PCP did not occur. They identified that there is an element of trust required to work from a collaborative consultation model, and for certain patients (if not all) Psychiatrists felt more confident working as a consultant when they could liaise with the PCP about the patient. Further, Psychiatrists stated that most wanted to be a part of the program because they believed in a collaborative framework and consequently the work was not as rewarding when communication did not occur. As such, removing the barriers associated with communication between providers in the program should be a program priority.

Four final suggestions were offered related to ways that Shared Care could improve communication:

2. Enhance tools to facilitate clarity regarding the reason for referral
3. Ensure that providers have access to relevant patient information
4. Facilitate intraprofessional meetings where providers can brainstorm and share ideas about how they communicate with other providers within their sites.
5. Facilitate Site Meetings where interprofessional providers can brainstorm and problem solve ways that they can improve their communication within the site.

## ***What are the Facilitators to the Improvement in Mental Health Outcomes?***

### ***Timely Access to High Quality Mental Health Service***

The facilitators for improving mental health outcomes are the similar operations that contribute to the other program goals. As a program foundation it is critical to provide high quality mental health service delivery in order to improve mental health outcomes. The high quality of service also facilitated trust and respectful working relationships with primary care providers. Within a short-term model of care, the Counsellors need to have a strong skill set in short-term change-oriented therapy. The providers indicated that timely access also improved patient outcomes.

### ***Flexibility in the Service Model***

Counsellors and PCPs appreciated flexibility in the short-term model of care including providing up to two booster sessions to help keep the patient from slipping back and offering sequential care to some patients. Despite the impact of Shared Care on patient outcomes and the flexibility within the model, PCPs still identified numerous gaps that exist within the mental health system. PCPs acknowledged that the Shared Care program can not be for everyone. They recommended a need to improve the pediatric and adolescent mental health system, the addiction system, and services that support the severe and persistently mental ill. Suggestions such as attaching a dedicated community mental health worker to primary care and services that make psychiatric follow-up services more available were specifically offered as desirable mental health supports.

### ***High levels of Collaborative Relationships***

Beyond access, the relationship dynamic (collaboration) that evolved between the PCP and mental health specialists lead to improved outcomes. Operational factors that facilitated communication (i.e. co-location, integrated files) and interprofessional learning (required interest/receptivity to learning about the topic), were important facilitators to improved outcomes / collaboration. However, it was those that described a high level of collaboration that expressed a more substantial impact on the quality of their practice overall with multiple (or all) patients.

### ***Early Detection and Treatment of Mental Health Conditions***

Early detection and treatment is identified as being associated with more positive mental health outcomes. It was not evident in the evaluation if PCPs screened patients more often for mental health conditions however, there was some evidence to suggest that patients were being detected and treated earlier for their mental health conditions. The program was found to offer services to those across the mental health continuum including the prevention end. It is logical then to assume that some individuals were treated earlier than if the PCP did not have access to Shared Care. Some comments by providers also suggested co-location increased the likelihood that PCPs would remember the service and identify more patients they could refer. Additionally, Shared Care enhanced the PCPs' and patients' knowledge of community services. Further evaluation needs to be conducted regarding the PCPs screening and detection process within Shared Care.

One final suggestion made by the Counsellors was the need for a patient feedback mechanism and satisfaction survey to capture and evaluate the ongoing impact the program has on patient mental health outcomes.

### ***How did Shared Care Facilitate Mental Health Providers Understanding of Primary Care?***

Consistent with all other operations that facilitate the program goal areas, co-location and opportunities to interact were the key operations that facilitated the mental health providers understanding of primary care. By being on-site, mental health specialists had an opportunity to understand the role of the PCP, the system and structural issues PCPs experience, and the PCP's work preferences. This facilitated a strong sense of empathy, appreciation, and respect for the PCP, which is considered by the literature (Kates et al 1996) to be important facilitators in relationship development and in the program's ability to meet the needs of primary care. Beyond co-location, interaction with the PCP including small talk and case based discussions helped to facilitate the mental health specialists' knowledge about the PCP role, experience, and physical health conditions/treatment. Additionally, the opportunity to provide service to the vast range of patients seen in primary care also afforded the mental health specialists the opportunity to understand the population health seen within primary care and the barriers that people experience in accessing mental health services.

### 3.3 *Operational Components that Led to Overall Program Goals and Collaborative Practice*

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Collaboration was identified as the overarching framework and core to the Shared Care model. To that extent it was important to understand the components that lead to collaborative practice. In the analysis of the data, there was an obvious challenge. The definition of collaboration was not clearly defined or consistently held by the various providers within the program. Despite this flaw there were obvious facilitators of communication (identified under the operational facilitators of communication) and there were provider groups clearly operating from a highly functional collaborative practice. Deeper analysis of the data was conducted reviewing the factors that facilitated the practices identified as functioning at a high level of collaboration. The results demonstrated that there are factors at multiple levels that influence collaboration. These factors have been broken down into then foundational factors, process factors, and system factors.

#### **Foundational Factors**

Foundational factors are the elements that are core components to the program and provide a base for a high level collaborative partnership to form. These foundational factors were broken down into environment, providers, and continuity of working relationships.

##### ***Environment***

Operationally factors that supported communication were fundamental to the development of collaboration. Environmentally this included:

- 1) Co-location, because it facilitated face-to-face interactions, and
- 2) the role of the office clinic manager and clinic administrative staff, because they were found to be significant facilitators of communication between PCPs, mental health specialists, and the program.

##### ***The Providers***

The providers themselves, including their beliefs, experience, and expectations that they held of Shared Care, were also fundamental in the development of collaborative partnerships. There was a large variation in providers' expectations and beliefs about collaboration within the program particularly within the PCP group. This is not surprising however, given that the program partnered with clinics versus individual PCPs. Key factors that need to be in place to have an effective collaboration between primary care and mental health are:

*PCP factors: (The PCPs considered to be highly collaborative were on the positive end of the factor spectrum)*

- ✓ openness to relationship,
- ✓ past experience with collaboration,
- ✓ time constraints,
- ✓ comfort level with mental health issues, and
- ✓ the priority they gave to collaboration.

*Mental Health Professional factors:*

- ✓ the skill level of the provider,
- ✓ proactive or assertive relationship building skills,
- ✓ flexibility or ability to adjust style to PCP,
- ✓ the priority they gave to collaboration, and
- ✓ the amount of intentionality they had in communicating.

Mental health providers had to be willing to assert themselves and communicate with PCPs, PCPs had to be receptive to the communication. PCPs who were exemplars of collaboration, also took a proactive role in consulting and communicating with the mental health specialists by seeking them out.

***Continuity of Working Relationship***

Stability of team members, including PCPs, Psychiatrists and Counsellors, was also important because of the significance of relationship in collaboration. Collaboration occurred more frequently and at a higher level when there was no disruptions to the continuity of provider assignment at each site and when the providers were on-site on the same day.

**Process Factors**

Process factors referred to the development of a trusting relationship between providers. Operationally these factors contributed to the development of a trusting relationship. Patient Care-based discussions were identified as the primary initial facilitator of relationship development. It brought providers together towards a common purpose and interest, and ultimately built trust between them. Timely communication was also identified by mental health providers as instrumental in the development of relationship. This included “sound-byte” communication, “informal spontaneous” communication, and “small talk”. This communication occurred face-to-face and included both in-depth and brief discussion about patients they shared, patients PCPs were considering to refer and patients that PCPs wanted to debrief about. The more communication between providers, the deeper the relationship and the result was a more enhanced collaborative practice. Clearly face-to-face interaction was an integral part to the development of high level collaborative partnerships, however written documentation and integrated files were also considered critical forms of communication.

To build a true collaborative practice, the effort to establish a trusting relationship is critical. The development of relationship is an interactive process between the PCP and mental health specialists that required continuity in the relationship. A listing of the operational factors identified by providers as instrumental in the development of a trusting relationship include:

- ✓ face-to-face interaction
- ✓ time to communicate,
- ✓ patient care-based discussions,
- ✓ timely communication / documentation
- ✓ familiarity with the other provider’s knowledge, experience, and practice style, and
- ✓ tailored relationship building techniques to each individual.
- ✓ Integrated files

As providers became more familiar with the team members practice style, collaboration improved.

## System Factors

System factors that clearly facilitated collaborative partnerships included 1) the program communication with sites, and 2) the program manager role, and 3) provider specific meetings.

*“I have appreciated this opportunity to hear where everybody is at and to think about it on a continuum. I think there is still room for me to grow in terms of how I could be providing other kinds of support with the doctors” (Counsellor)*

### 1. Program Communication with Sites

- A. Formally, site review meetings were facilitated between the program (Shared Care Manager and Medical Director from Primary Care / Family Medicine or Community Mental Health) and site members to discuss issues specific to Shared Care and the enhancement of collaborative care. These meetings invited providers to reflect on how satisfied they were with their relationships, the processes that are working, and other processes that they wanted to develop. Site review meetings demonstrated that the program was interested in all provider input regarding the development and adjustment of the program within that site. Issues and concerns that providers had were identified, addressed, or problem solved.
- B. Further to the issues identified, when concerns arose, *timely resolution* of those issues and the ability to respond to site concerns were critical to ensuring that collaboration was not disrupted or negatively impacted.

### 2. Program Manager Role

Based on the significance of communication and responsiveness, the providers highlighted the importance of the program manager role. This role was critical in responding to PCPs or site administrative concerns. The manager needed to be both responsive and accountable to address the concerns of PCPs and site members in a timely manner and able to speak to the clinical issues associated with mental health patients (particularly patients suffering with difficult symptoms often associated with personality disorders). The importance of the development of a relationship between the manager and PCPs was found to be important so that issues would be brought forward, communicated, and responded to in a timely manner. The program manager role was also critical in providing support to the Counsellors. The manager understood the clinical issues that the Counsellors faced and was able to assist them in their work. The manager was able to address issues as they arose at the site either by coaching the Counsellor or dealing with the concern directly from either the administrative staff or PCP. Issues included concerns about the management of a patient; interpretation of messages from the program/mental health, issues with the mental health system; facilitation of information or timely responses to question/issues; adjustment of resources to address access issues; and navigation or support with other community mental health services/ systems.

### 3. Intraprofessional Meetings

Further to site based meetings, Psychiatrists and Counsellors also identified the need for discussions within provider groups. Counsellors stated that having opportunities to support each other and to hear how others work is important. Psychiatrists also identified that it would be important for them to have opportunities to meet as an intraprofessional group on a regular basis to discuss operations specific to Shared Care. These meetings would provide opportunities to influence program development, support each other, and hear how others operationalize the program. Increased communication between the program and Psychiatrists was also identified as an area for program improvement that would assist with collaboration. Through better communication, Psychiatrists would be more informed and engaged with the program and receive support with the facilitation of collaboration within sites by addressing issues, clarifying roles, and facilitating collaborative pathways.

Other system factors considered important for the facilitation of collaboration, but still requiring development included a clear definition of collaboration within the program. Program leadership may also consider collaborative goal setting within sites as a useful system strategies that would help to further facilitated and emphasize collaborative practice within the program.

### ***3.4 Implementation in Fee-for-service Practice: Challenges and Successes***

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Throughout 2008 and 2009 the Shared Mental Health Care program went through a significant expansion. The program doubled the number of full-time Counsellor and Psychiatrist positions, added an administrative assistant, Psychologist, and shifted the clinical specialist role to a Shared Care manager role. The program went from working primarily with alternative funded primary care providers, to primarily working with fee-for-service physicians. The number of PCPs within the program nearly tripled, from 35 to 110. The data collected during the evaluation suggested that this expansion was more than an addition, it had a significant impact on the operations and direction of the program.

Leadership and Counsellors clearly articulated that the expansion of services into fee-for-service physician offices as venturing into “unchartered territory” of collaboration. They described the program as being a “paradigm shift” for providers. They highlighted that the introduction of interprofessional practice into fee-for-service physician offices is a radical goal and a facilitator of significant change on multiple levels. Not only did the program integrate physical and mental health care, it also operated within the context of private primary care practice cultures. There had been little precedent of this type of partnership between private practice Family Physicians and WRHA operated services to organize the expertise to build this type of collaborative partnership previously.

Counsellors described the work and the role of Counsellor as complex. The work goes beyond offering therapy to patients. One Counsellor stated that the role is like being a “Counsellor multiplied by 10”, as they have to balance the needs of multiple systems within the clinic and between systems (WRHA and fee-for-service). They described that the cultures between the two systems as very different in ways that require extra attention and careful navigation. Counsellors identified the role of the Shared Care Manager as important in assisting them in the process of working within the fee-for-service environment, while maintaining the shared vision of the Shared Care Program. The manager understood the complexity of the Counsellor role, the complexity of the environment, and the clinical work. One of the challenges they experienced was “pressure” or responsibility to make the program work, while also attending to the needs of patients. Rather than the integration and implementation being experienced as an equal venture into “unchartered territories”, the Counsellors felt the responsibility to operationalize the integration rested on them.

The evaluation data clearly identified a process on how to develop collaborative relationships (identified in section 3.3). Leadership and Counsellors also had several recommendations about processes.

#### ***Engagement and Recruitment***

The engagement and recruitment process of finding fee-for-service PCPs and clinics to join Shared Care was described as “difficult”. The Inter-program steering committee agreed on the process, which included sending out an invitation to all fee-for-service clinics in Winnipeg to apply to have the Shared Care program associated with their clinic. PCPs were also invited to attend an information session if they wanted more information initially. The response from the community physicians was low both in attendance at the informational session and in applications received. All physicians who attended the information session or submitted an application were followed up with by a member of the steering committee. Additionally, physicians identified in the community as champions, potentially interested in partnerships, or interested in the treatment of mental health conditions were identified. Members from the steering committee followed

up with these physicians or physician groups to explore their interest in partnering with Shared Care. The leadership participants identified that the engagement and recruitment process required “a lot of selling” in part because PCPs did not know what Shared Care was about.

Specific challenges to the engagement process seemed to be related to the dissemination of information to physicians. PCPs could not speculate how the opportunity would benefit them. Most PCPs within the program did not recall receiving the letter that was originally sent out; rather it was through personal engagement that they became aware of Shared Care. Leadership hypothesized that the reason for the difficulties was related to the newness of the WRHA relationship with fee-for-service practices, and lack of clarity related to what was being offered. Leadership all agreed that the engagement process that eventually led to successful partnerships required considerable outreach and individualization from the program leadership to secure the sites who committed to the program.

Clear facilitators in the process of engagement were from the active efforts and guidance that Primary Care / Family Medicine offered. Champions within Primary Care / Family Medicine took a lead in promoting Shared Care as an opportunity and encouraged their partners and champions to consider Shared Care. The leads in Primary Care / Family Medicine were also vital in guiding mental health on how to engage with fee-for-service physicians and communicating the cultural landscape. Leadership recommended a multi-pronged strategy that includes utilizing community champions when planning to engage fee-for-service physicians. Additionally, emphasizing how the program impacts access and quality of care for patients is most relevant to fee-for-service physicians.

Further challenges identified within the recruitment phase were related to concerns of space, money, and time to be involved in the program. The program believed that co-location was important and negotiated ways to have the mental health service integrated into the primary care office. Strategies used to minimize the barriers included offering a nominal stipend to cover the costs for basic support (i.e. administrative support, use of office equipment), and space. Some physicians in the recruitment phase identified space and money as barriers to receiving the service. However, because this evaluation only collected data on those that were part of the program, all sites were willing to accommodate. The Shared Care program demonstrated significant flexibility in accommodation to site space issues including being on-site on certain days only or at certain times only. Careful coordination between mental health providers and sites, as well as a program commitment to finding ways to remove barriers, while remaining consistent with core principles, is critical in the implementation.

The data collected from physicians about fair compensation to participate in the program was positive and it is believed that the practice support (stipend) was an important facilitator. The stipend was used to off-set the financial barriers of implementing and operationalizing the Shared Care Program. Analysis of the responses from PCPs suggest that the majority of providers within the program found the compensation to be reasonable, regardless of whether the provider was alternatively funded or fee-for service. Additionally, 91% of the providers believed that the time they invest into the program was worth the benefits they received (see Table 11). During the member checking process PCPs highlighted the importance of fair compensation in this model. Issues associated with space, time, and logistics are a realistic barrier and all initiatives with fee-for-service physicians need to consider this challenge. Although the PCPs identified that they were satisfied with the compensation in the program, this is an important component to the success of the program and requires constant attention. Additionally, efforts to work with Doctors Manitoba and the Manitoba Health regarding the Fee Structure would be beneficial to minimize the issues associated with financial compensation for collaboration.

**Table 11: Primary Care Provider Satisfaction Scores (Logistics)**

<b>Question</b>	<b>Mean (SD)</b>	<b>Mean (SD) for Alternative Funded</b>	<b>Mean (SD) for fee-for-service</b>
The financial compensation available through WRHA for participation in the program is satisfactory	3.53 (71%)	3.6 (72%)	3.5 (70%)
I feel it is economically viable to partner with Shared Care	3.91 (78%)	3.88 (78%)	4.08 (82%)
The time I invest in the program is worth the benefits I receive	4.55 (91%)	4.5 (90%)	4.71 (94%)

### ***Screening***

Screening was conducted within the recruitment/engagement phase. Discussions occurred between program leadership and PCPs relating to the PCPs ideas about collaboration, mental health, and the Shared Care philosophy. Basic expectations were reviewed including what the program would offer and what was expected from the PCPs. In group practices, these meetings typically included the office clinic manager and physician partners. In smaller or solo practices, these meetings typically included all the physicians that the program would be working with, but did not necessarily include the administrative staff.

Although, not used as part of this implementation, the providers and leadership had recommendations about ways to improve the screening process. Recommendations were made to screen all PCPs being offered access to the Shared Care program for critical areas that would impact their readiness for Shared Care. These areas included the PCPs attitude towards mental health, past experiences with and understanding of mental health services, expectations of mental health supports, past experiences working in collaborative partnerships, and their perspectives on the partnership with WRHA. Recommendations were made by leadership and Counsellors to suggest that a site readiness scale with these identified criteria would help to screen new PCPs or clinics wanting to partner with Shared Care. If sites were found to be not ready at this point, feedback would be offered to them related to what they could do to better prepare themselves for integration and services in the future.

### ***Preparation***

Considerable coordination efforts on the part of leadership occurred to line up sites and mental health specialists. Efforts were made to balance the multifaceted factors related to sites, mental health specialists, matching between sites and specialists, and site readiness.

Site factors included the clinic organizational culture, PCP expectations, availability of space, patient roster size, and specific interest areas of PCPs. Mental Health Specialists included the amount of time they wanted to work in the program, the days they were available, the location they wanted to work, when they were able to start. Matching between sites and specialists included attempting to find a match between clinic culture and mental health specialist, matching between service demand within the site and amount of time Counsellor worked within the week. Efforts were made to have only one Counsellor at per site, to have a Counsellor attend no more than three sites, and to minimize disruptions in changes once relationships formed between the Counsellors and PCPs.

Counsellor and psychiatry recruitment was conducted as sites were being screened and prepared. As leadership understood site needs, allocation of mental health resources became clearer. The recruitment of specialists took a substantial amount of time. Leadership and providers identified that hiring the right person for the Counsellor position was important to the success of the program. In anticipation of this, leadership chose to recruit multiple times to ensure they had team members who encapsulated a high quality skill set, with the ability to proactively build relationships, adapt their style to individual PCPs, and remain flexible in all aspects of their work.

During this same time, leadership also worked with sites to prepare them for the implementation phase of the program. This included identifying and ensuring that there was a space available for the mental health specialists, as well as an orientation to the program. In the orientation, leadership covered the Shared Care philosophy, roles and responsibility of all providers within the program, orientation to the forms, a referral algorithm, identification of who is appropriate for the service, and contact information. Site processes were discussed and negotiations occurred related to how Shared Care would be integrated within their workflow and site processes. In most cases, Shared Care used the same patient scheduling system, had access to the patient's medical record, and provided the PCP with a copy of the documentation of the patient encounter. Financial support was offered to eliminate the licensing fees barrier to allow Shared Care to utilize the fee-for-service electronic medical record (EMR).

The significance of fully preparing a site to welcome the mental health specialists was a finding in this evaluation. Within some sites, PCPs put substantial consideration into creating a welcoming environment for the mental health specialists. Two provider groups were exemplars in this area, as they spent time preparing before the Counsellor joined their team by painting an office space, putting down new flooring, and ensuring that there was appropriate furniture to ensure the Counsellor would have the tools to conduct the work. Welcoming was considered to be a significant facilitator to successful integration of the counselor into the practice. It was characterized by a multitude of behaviours and most importantly included:

- ✓ warm friendly, respectful communication,
- ✓ preparation/designation of a space that is in a location that promotes access and facilitates interaction with PCPs,
- ✓ an orientation to clinic processes and procedures,
- ✓ inclusion in clinic procedures, activities, and meetings, and
- ✓ administrative staff that readily facilitate communication processes.

Leadership and Counsellors suggested that a checklist be developed to ensure that a clinic is prepared before the service is implemented.

Recommendations were also made by some providers and leadership regarding the importance of having a collaborative process in the development of site/program goals, deliverables, and indicators that could be monitored to help the teams achieve and develop the program. Providers were interested in being engaged in that process and Counsellors wanted to be involved in preparing sites. Recommendations were also given that it would be useful to review goals, roles, and expectations at multiple times in many ways.

### ***Integration***

Integration into primary care occurred soon after the mental health Counsellor was hired. The Shared Care Manager hosted a meeting with the PCPs and the Counsellor to introduce the Counsellor and facilitate communication. Conversations helped to facilitate provider's knowledge of each others roles, skill sets, and

interest areas. Operational issues were addressed including enquiry about the space, procedures, and offices processes. At the initial stages of integration, discussions related to how the program would operate within that clinic were held including who would do scheduling, how communication would occur, what the clinic culture and workflow processes were, how to effectively communicate within the site, and plans for reviewing/ monitoring the implementation.

Meetings were set up between the Shared Care manager and all Counsellors integrating into new sites on a regular basis to review the integration process, brainstorm/discuss effective strategies to streamline processes, track themes related to site and patients, and alert the manager to issues that needed to be addressed within the site. Themes discussed included challenges with communicating and building relationships with the PCPs and administrative staff; workload and access issues for counselling and psychiatry; ongoing clarification of vision, goals, and expectations; clinical discussions; and resource sharing. Counsellors identified the role of the manager as important in supporting the integration process through the recognition of the complexity of the Counsellor role, the high level of skill required, and the ways to facilitate collaboration within primary care.

Psychiatrists identified the importance of the Counsellor role in assisting them with integration. They described the Counsellor as orienting them to the clinic culture, facilitating communication between the site staff/PCPs and the Psychiatrist, and assisting them with building relationships with PCPs. In some sites the Counsellor was also identified as instrumental in coordinating processes including triaging patients, assisting with scheduling, and facilitating documentation/communication processes. Despite recognizing the value of the Counsellor role in the integration process, they identified a lack of clarity related to the Counsellors' role and what could be expected from them including how they are to work collaboratively together.

A barrier in the integration process that came out within the Counsellor and Psychiatrist evaluation discussions included a lack of clarity related to how collaboration is defined and how this definition is operationalized within each site. Mental health specialists acknowledged that each site culture is unique and although there needs to be clarity, there also needs to be flexibility with how each site operationalizes the program.

A facilitator identified in the integration process was the effective and positive relationships held between the leadership group. The leadership participants identified that this group should be made an official part of program leadership, rather than dependant on the relationships formed within the current leadership. This group oversees the operations of the program and offers consultation to the strategic planning process and issue resolution within the program.

### ***Monitoring***

The process of monitoring was identified as an important process for all sites, beyond implementation. Monitoring was set up to review all new sites on a quarterly basis and all existing fee-for-service sites on a yearly basis. Recommendations were made that these processes extend to the WRHA sites as well. Within the site review meeting the Shared Care Manager and Medical Director (either psychiatry or family medicine) met with the primary care providers at each site to discuss issues specific to Shared Care and ways to enhance the program experience within each site. Depending on site and team functioning these meetings also often included the Counsellor, and occasionally included the Psychiatrist and office clinic manager. Discussions were facilitated about what was working, what needed improvement, overall satisfaction with program and providers, and any operational/informational updates relevant. Counsellors identified wanting

to be involved in site review meetings, and some PCPs identified wanting to have the Counsellor there during site review meetings, while others wondered how they could provide feedback to the program in that

type of group setting. Based on the value of both aspects it is recommended that both processes be developed/continued including meetings between sites with the Counsellor and enhanced relationship between the program leadership/manager and PCPs/ site administrative staff so that feedback can be given between the site review meetings as well.

Once the program was operating within the site for a period of time, issues and critical program elements began to illuminate. Many of these have been described above under program operations. Key factors included continuity in relationships within the site. Challenges included balancing access, wait times, and demand for service. The mental health specialists experienced a high number of referrals at first implementation within a site. For practices that are typically closed, the referral numbers seemed to balance off after a period of time and adjustments needed to be made in the allocation of the resources. Monitoring of referral numbers and allocation of resources (particularly psychiatry) required ongoing attention in all sites to ensure timely access to services. Leadership held conversations with site teams regarding access, referrals, and service wait times, encouraging them to engage in decision making and program prioritization so that the program could best meet their site and population needs.

Site meetings also served the purpose of addressing perceptions, issues, and barriers either within the program or within the system. An example of this is the major system change outside of Shared Care that occurred approximately six months after the implementation phase of the program. The system shifted to a centralized psychiatry intake system for the two hospitals (Health Sciences and St. Boniface) and community psychiatry. Through this process of change, it was recommended that each Shared Care site utilize their own Psychiatrist before referring onto other parts of the system (quasi-centralized psychiatry in each site). As PCPs reacted to the communication from centralized intake, the leadership group developed multiple communication methods to help PCPs to understand the system change and mitigate the damage the change had on the program. PCPs expressed concerns about their lack of choice in the use of Psychiatrist, issues associated with continuity of care for patients who had a prior relationships/consult with a Psychiatrists, and barriers to access for long-term psychiatric resources. Communication related to this was important and was done in consultation with leadership operation committee. Many of the monitoring meetings were used to discuss the concerns PCPs had with the perceived barriers and aimed to minimize the barriers that PCPs experienced. The information received from PCPs was used to better understand their experience and to help the system to communicate more effectively within the partnership between WRHA and fee-for-service physician practices. During the member checking process it was highlighted that despite the efforts of the program to communicate, some PCPs did not believe that this information was communicated with them. This speaks further to the importance of having and the need for further development in a multipronged communication strategy. This strategy needs to be reviewed regularly in order to effectively communicate with all providers within the program.

Overall, evaluation data indicated very few sites experienced significant site challenges (less than 10% of the sites). Within these sites concerted effort was made to address the challenges. The leadership committee worked closely with all members of the sites to clearly identify the issues and deficit areas that needed to be corrected by both the program and site. In extreme situations, termination of the partnership did occur, after program leadership demonstrated that every effort was made to correct the issues on behalf of the program and when they felt no further action could be taken to resolve the situation. In these situations, the site and/or PCPs were offered information about what they could do to better prepare themselves for network or collaborative services in the future. Because of the nature of the partnerships, conflicts and/or site issues are

possible. It is recommended that there be clear timely processes to address conflicts, resolve issues, and/or terminate sites/partnerships that are not working.

Strategies necessary to facilitate timely resolution of issues/termination included regular communication between the Counsellors and Shared Care Manager and clear communication pathways between the manager and the leadership operations group. The leadership operations group developed a process for correcting the situation and for terminating the relationship. The strong collaboration, working relationships, and willingness on the part of all committee members to assist allowed the team to address the issues.

As part of the member checking process, Counsellors identified that although this process was specific to the integration into fee-for-service clinics, the same process should be used as a framework within WRHA sites. Some recommended that it would be useful to consider all new professionals entering a collaborative partnership within primary care (including administrative staff) through this integration/implementation lens.

**Section 4:**  
**Summary and Recommendations**

## Section 4: Evaluation Summary and Recommendations

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### 4.1 Evaluation Summary

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The multiple impacts that Shared Mental Health Care has had provides a strong foundation to both enhance and expand the service. Shared Care has demonstrated an ability to adapt and successfully integrate into primary care. Providers recommended that the program model be used as a successful framework to build other Chronic Disease teams into fee-for-service practices. The evaluation findings reflect an overall provider satisfaction and positive impact on patients' mental health outcomes. Mental Health providers and primary care providers expressed a strong sense of engagement and commitment to the vision of the program, which included working collaboratively and integrating primary care and mental health.

The evaluation demonstrated that Shared Care had an impact in all critical goal areas including:

1. Improved access to mental health services
2. Improved primary care capacity to manage mental health
3. Improved communication between primary care and mental health
4. Increased mental health providers understanding of primary care
5. Improved patient outcomes

Provider groups described Shared Care as an entry point into the mental health system regardless of the severity of the patient's mental health condition. At times this included providing a brief therapeutic intervention, and included: "taking one step with a patient"; working in a sequential nature over several years; linking, bridging or preparing patients for more appropriate services; or providing service, referral and access information to patients/providers that otherwise would not have that knowledge. The service navigation function of Shared Care Providers was highlighted as important.

Overall, providers indicated that all patients on the Mental Health continuum were able to benefit from Shared Care. For example, those suffering with multiple stressors, relationship issues, and mild to moderate forms of depression and anxiety benefitted. In addition, those patients struggling with complex medical conditions and mental health challenges, who would rarely have the opportunity to receive a psychiatric opinion, were able to receive a psychiatric assessment and consultation through Shared Care. Patients with more complex mental health care needs also benefitted. Providers perceived that Shared Care prevented hospital admissions, facilitated more dignified and efficient hospital admissions, and prevented patients from deteriorating after hospital discharge.

Further, as collaborative relationship formed and deepened, Shared Care had a more significant impact on primary care practice. Through relationship and support the mental health professionals improved the PCPs capacity to treat patient's mental health condition even without direct contact with Shared Care. Some PCPs described an overall impact on their practice and their sense of comfort treating patients with mental health conditions.

***Operational Elements of Shared Care considered essential for success.***

Evaluation findings highlighted two elements of the Shared Care Model that were key to the early success of the Program including Access and Collaboration. What is clear from the findings is that these two elements are facilitated through *co-location* and the *integration* of primary care and mental health.

**1. Access:**

PCP's indicated that access to mental health services improved their comfort with mental health and the ability to treat patients with Mental Health conditions. Ensuring that the program keeps wait times to a minimum and can adapt to urgent requests for assistance (direct and indirect assistance) is essential to the ongoing operations of the program.

The program positively impacted access to quality mental health services in four key ways

- Co-location of mental health in primary care increased access for patients – patients were more likely to use Mental Health services if linked to primary care.
- PCPs with Shared Care appreciated knowledge of how to access more specialized Mental Health services for their patients – Shared Care offers substantial expertise in navigation of the mental health system to the PCPs and given the nature of the PCPs role as “quarterback” and “gateway” to the larger system, this role can not be undervalued.
- Timely access (collaborative context facilitated access) – operationally, the program achieved this through mechanisms that prioritized seeing urgent referrals quickly, setting targets for when patients will be seen, and operating from a short-term counseling model.
- PCPs experienced the benefits of having “back up” and easy access to specialists (availability) to assist them with the ongoing treatment of care.

Despite positive impacts on access, PCP's identified ongoing concerns about access for their patients to other mental health services -- especially those with severe and persistent mental illness and those with addictions, and pediatric/adolescent. They also had concerns about access to long-term psychiatry services.

**2. Collaboration:**

Beyond access, collaboration was the second core component that leads to improved outcomes for patient care. The evaluation highlighted that when providers developed a deeper collaborative relationship, together they had a more profound impact on both quality and quantity of patients receiving care. The evaluation findings underlined the importance of the context within which collaboration between mental health and primary care was fostered. This context was explored to understand what was required from providers and within the environment to make the program successful operationally.

Elements that promoted the development of a collaborative partnership are:

- Co-location within the same office
- Collaboration with positive provider factors including the providers' beliefs, experiences, and expectations about interprofessional collaboration. – Some PCP's were very receptive to collaborating and others were slower to integrate a collaborative approach into their practice. (See PCP and MH provider factors in Appendix 1)
- Welcoming behaviours within the primary care clinic. (See Welcoming Behaviours in Appendix 1)
- Timely access to a service with clear entry point and referral criteria.
- Timely communication including: documentation, informal spontaneous opportunities for communication, sound-byte communication, brief hallway communication, scheduled meetings, meetings post-consult, being available to communicate, and using case-based discussion to develop relationships.
- Special emphasis needs to be given to relationship building and development between providers (see relationship building process in Appendix 1). Intentionality and time should be given to the development of relationships. Further the importance of relationship development can not be overstated and as such efforts should be made to minimize disruptions in relationships between providers. The evaluation findings pointed to the importance of relationship in enhancing the collaboration, and resulting in better outcomes. The more communication between providers, the deeper the relationship and the result was a more enhanced collaborative practice.
- The leadership role in negotiating formal structures and operational goals that will empower providers to reach for the vision of collaboration and inter-professional learning.
- The office clinic manager and clinic administrative staff role at each sites in facilitating the communication between patients, PCP's, mental health specialists, and the Shared Care Program.
- Ongoing communication between program leadership and sites to establish communication and relationships, develop collaborative goals, and identify outcomes.
- Emphasis on collaboration at all levels of the program including leadership to coordinate, support, and facilitate this change.

Counsellors, Psychiatrists, and leadership participants identified Shared Care as a significant system change and a “paradigm shift”, highlighting that the introduction of interprofessional practice into the fee-for-service environment was a “radical goal” and a facilitator of change on a number of levels. There was little precedent of regional staff working with independent primary care practices, and this experience is important for informing future collaborative care processes in primary care.

***“The Shared Mental Health Program is consistent with [Doctors Manitoba] mission by allowing not only the physicians but allied health care providers to meet, engage and learn together to improve quality of life for Manitobans. The evaluation is consistent with my experience and I want to express my gratitude to all in making this happen.” (Family Physician)***

Additional supports that were required to facilitate and support this change included:

- The role of the Shared Care Manager clinically to understand the complexity and intricacies of the work, to address the challenges, and to be responsive and accountable to sites.

- The Shared Care Manager role in assisting with the preparation and integration of new sites. This manager needs to ensure that timely access is clinically maintained (at times this may include reallocating resources). The manager also needs to pay attention to the matching between specialists and clinics that takes into consideration factors such as clinic culture, etc. to ensure continuity and to facilitate relationship building.
- A collaborative leadership team consisting of mental health, psychiatry, primary care, and psychology. The leadership team needs to have clarity of vision, goals, expectations, and roles within the collaborative partnerships, and be able to be flexible/adaptable to each clinic environment. This team needs to work cohesively to be responsive to issues within teams and to enhance the program in a manner that is respectful of all partners involved.
- Regular program communication with sites (e.g. Site Review Meetings) and the development of relationship between program leadership and PCPs and site administrative staff.
- A program that balances the tension of being a clearly defined program and adaptable to the clinic culture.
- Communication strategies that enhance opportunities to connect with PCPs. As the program developed an adjustment was made to place greater emphasis on the need for Psychiatrists and PCP's to have a post-patient consult debrief to improve communication and quality of patient care. (Removing the barriers to communication between providers in the Program should be a program priority – p. 37). Additionally, priority towards deliberate or intentional communication that facilitates capacity building.
- Intra-professional meetings (e.g., Psychiatrists, Counsellors etc.)
- Clinical excellence of service.

### ***Highlights on the implementation***

When the expansion of Shared Care into the fee-for-service environment began (2008) there were several challenges in recruiting Family Physicians. In 2011 there was a wait list of Family Physicians wanting to participate in Shared Care. There was consensus among leadership that meaningful engagement with Family Physicians was the key to building successful partnerships and this required considerable outreach and individualization from the leadership to secure sites committed to participating in the Program, and ongoing support was necessary to maintain an excellent program. Space, money and time were key factors.

Counsellors played an instrumental role in the development of collaborative relationships within the team. Recommendations were made that more be done to prepare and assist in the integration of the mental health specialists into primary care. Sites where integration was most successful was when the clinic made efforts to welcome the mental health specialists and prioritized development of relationships with the mental health providers. Psychiatrists identified that the Counsellors were instrumental in helping them navigate primary care and develop relationships with the clinic members. They acknowledged that they were not on site as often as the Counsellor and appreciated the role of the Counsellor in facilitating their integration process.

Evaluation findings highlighted the importance of partnering with physicians on an individual basis (rather than group basis) that were interested in collaboration and mental health. Screening and preparation of sites were important processes to successfully integrate into a site and the leadership committee or manager needs to take a strong leadership role in ensuring that a site is “ready” before the integration occurs (see Appendix 1 regarding Site Readiness). Monitoring and ongoing relationship between the program leadership and sites was also felt to be an important priority for all sites even after the implementation was successful.

## 4.2 Summary/Conclusions

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As a next stage of development and in order to ensure all partnerships are primed for high levels of collaboration and opportunities to occur, the program will need to improve in a number of areas, based on evaluation feedback. These improvements will need to continue to align with Primary Care reform initiatives to ensure the integration of mental health as system development occurs.

### *Collaboration*

- Evaluation findings indicate that collaboration can be influenced by access/availability to services, communication between providers, and relationship development. Further research to enhance our understanding of collaboration would include the evaluation of:
  - a.) The impact and various aspects of relationship that enhance collaboration.
  - b.) The tension between creating timely access for patients and finding the time to collaborate with providers.
  - c.) PCP's screening and detection of mental health conditions within Shared Care.
- To maintain the principle of collaborative care within the fee-for-service environment and to inform future expansion and program development, ongoing attention to the context is imperative. For example, understanding that every clinic/practice has a distinct organizational culture, is an independent business, and has management and clinicians who are program partners, should continue to inform improvements to the model.
- Shared Care has been a successful model of collaborative practice in Primary Care. Therefore, it has the potential of serving as a model for effective collaborative service delivery in other disciplines in their development of collaborative partnerships with Primary Care.
- The Program needs to support the social identity of the professional groups within Shared Care. Evaluation findings indicate that the practice of creating opportunities for Psychiatrists and Counsellors, in particular, to interact, consult and plan worked well. Similar strategies should be explored to further engage the Family Physicians in the Program.

### *Practice*

- Findings indicate that Shared Care has an important function in service navigation. Shared Care Counsellors should continue to be encouraged to build competency and skill in their ability to navigate the mental health system as a whole.
- Providers require more attention on program definitions of collaboration, goals, roles, and expectations.
- An ideal environment for collaboration ensures shared beliefs, expectations, and goals for Shared Care are explicit. Processes that promote capacity building and that are *intentional* encourage enhanced collaboration and lead to better outcomes for patients.

***Implementation/Sustainability***

- The value of centralized management and the importance of clinical expertise that the Shared Care Manager role emerged as an important theme. This centralization allowed the program to respond to system issues, ensure timely access to services (i.e. making adjustments to psychiatry resource allocation as required to accommodate patient need), and provided the clinical support/expertise to ensure standardization and practice excellence.
- To ensure success of the Program in a fee-for-service environment, ongoing attention needs to be paid to financial compensation for fee-for-service physicians and logistical issues (e.g. administrative support, electronic medical records, space).
- Mechanisms to ensure new providers support of the principles of Shared Care and collaboration is critical for the matching and choosing of sites.
- To enhance communication between the Shared Care Program and all Shared Care Providers is critical to avoid gaps/misinterpretations between providers. Further emphasis is required by the Program's leadership to ensure one-on-one relationships with clinic managers and each individual primary care provider (including alternative funded providers and fee-for-service providers) within each clinic is a priority of the Program.
- Given that meetings between Shared Care leaders and clinics were well received by providers as it allowed participation in program improvement and site improvements, the Program needs to continue to have regular meetings at each primary care clinic and include their on-site Counsellors at these meetings.
- The Leadership structure should continue to include members from all program partners including Mental Health, Psychiatry, Psychology, and Primary Care / Family Medicine in order to enhance the ongoing quality of the program.
- Upon reflection of the evaluative information, specific opportunities for respective groups to interact, consult and collaborate is required to ensure that appropriate services will be available in the future. This then may require the Program to provide educational opportunities in both Psychiatry and Family Medicine for residency within Shared Care environments.

**Section 5:**  
**Discussion**

## Section 5: Discussion

What Family Physicians want from psychiatry “can be summed up in three words: access, communication and (respectful) relationship” (Burley, H.J., 2002, p 29). The development of the Shared Mental Health Program by Kates in the 1990s has expanded across Canada and although there are varying models, the three concepts of access, communication and relationship remain key to the collaborative movement in Winnipeg. The Shared Mental Health Care Program creates the possibility of system change in managing patients with mental health challenges within Primary Health Care. Given that Family Physicians manage over 50% of their client’s mental health problems, having an understanding of the important role of PCPs in effecting change and managing mental health concerns is essential to understanding Shared Care’s impact. What is clear from our findings is that access, communication, and relationship are indeed significant factors to the success of our program and that they are facilitated through the co-location of two systems that benefit in working together for their patients’ wellbeing. Co-location becomes the foundation for this ‘dance’ to occur.

The three factors of *access, communication and relationship* have become themes that together create the working milieu of collaboration. Key factors in facilitating collaboration for PCP’s appear to be a feeling of increased *comfort* which fosters a sense of renewed confidence. Our evaluation findings indicate that not only is *access* to mental health services essential it also serves a dual function. It specifically offers services to manage the mental health concerns of patients through their Primary Care Provider and as well, promotes the *availability* of mental health specialists for primary care providers to consult with. This availability then helps PCPs feel less of a burden of care as they feel supported by the team. With feeling supported in their mental health role, PCPs interact with their patients at a new level of comfort. This then, enhances the PCP’s ability to manage the mental health challenges their patients are facing and allows them to communicate with their patients effectively and continue to encourage them to pursue helpful mental health therapeutic interventions such as self-management. The comfort level experienced by PCPs appears to be an important facilitator for providing service. Evaluation findings indicate that PCP’s who feel comfortable in dealing with mental health issues are more likely to screen, detect, diagnose and manage mental health challenges in their patients. Given that many patients see only their PCP for their mental health concerns, the importance of ‘comfort’ cannot be overstated.

One can look at comfort building as a three-pronged approach which at each level may provide increasing depth:

- 1.) timely access to service increases PCP comfort by setting aside the challenge of managing mental health issues, ‘holding the bag’ so to speak waiting for assistance from a mental health professionals
- 2.) building a consistent trusting relationship with a mental health provider who acts as a sounding board to discuss concerns and is available to discuss concerns.
- 3.) interprofessional learning through case discussion, formal teaching, and spontaneous ‘sound byte’ communication ‘in the moment’ during hallway conversations.

As mentioned, these factors become possible within the co-location of professionals in the PCP’s office.

In regards to *communication*, the experience of front-line clinicians, and perceptions of leadership, indicates that an *intentional* effort is needed to promote sharing of information which is facilitated by co-location. Some examples include setting aside time to discuss patient issues by booking appointments in a busy physician practice is one such example. Another may be a Psychiatrist seeking out the PCP after a consultative assessment has been completed in order to discuss important findings and strategies for collaborative treatment options. Although there appears to be an increase in time and cost in having this

communication occur within PCPs' offices, the benefits may outweigh the cost by reducing the number visits related to somatic complaints and by increasing focus on specific issues/symptoms that create health barriers. By handing off some of the responsibility to the mental health team briefly, e.g. Cognitive Behavioural Therapy with the Shared Care Counsellor, PCPs open up their schedules to see other patients in need. The opportunity then to work together as a team allows for sharing of responsibility and increased comfort in dealing with complex situations. The PCPs are relieved to have support in managing and treating patients and the Mental Health Providers recognize that after a therapeutic intervention has been completed, the patient remains under the care of the PCP. Through this 'sharing of care' the PCP then develops more comfort with managing mental health concerns and will feel more confident in 'stepping out' to treat other patients in their practice. For mental health providers, a short term approach works well knowing that the patient 'isn't going anywhere'. That is, if further issues arise or are not ameliorated, the patient will be back to see their PCP. This frees the mental health provider's schedule to take on more patients and allows for the continuity of care (of mental health issues/treatment) to be managed by the PCP. Once communication patterns and a relationship is created between providers, the patient and their situation becomes familiar and further discussion in the future is facilitated. This collaborative relationship combined with the continuity of care using this team approach is then inclined to improve patient outcomes.

The last two years of operationalizing Shared Care across the city has underscored that key components of access, communication and *relationship* play out uniquely in each 'culture' within the various clinics. Each primary care clinic creates a microcosm that reflects its own collaborative culture. Within this setting, the important role of the Counsellor to facilitate the working relationship both with the PCP and the patient is something to be negotiated. The Counsellor in essence often feel they have two foci – the patient of the PCP seeking assistance for the mental challenge and the PCP looking for support through the 'sounding board' access that the Counsellor provides. Again, being located in the same setting promotes both and in fact increases the comfort level for the latter and decreases the potential of feeling stigmatized by the former. Co-location again becomes the key for promoting a culture of support and acceptance.

The Winnipeg model demonstrates that access and availability work towards improved outcomes as perceived by all provider groups. As relationships form, mental health providers are able to offer a more comprehensive level of support to the PCP. As this support and relationship interact, further opportunities develop and relationships deepen (see figure 1). The program espouses the need to make collaboration 'intentional' so that it will take Shared Care beyond simple service delivery by discovering new ways to impact patient care. The concept of *intentional collaboration* then offers more to the Shared Care approach that goes beyond simple access. It inspires the participants to interact in creative ways that facilitates sharing of knowledge, communicates information, and develops treatment options. As per figure 1, simple co-location provides an opportunity to work together however (similar to the Maslow's hierarchy) when moving towards 'true collaboration,' much more can be achieved by *intentionally* creating opportunities to collaborate. By doing so, it creates a 'pebble in the pond' effect that has a greater impact beyond the patients that receive direct service from mental health providers. The significance of this concept is that literature speaks to the fact that 75% of the population seek support for their mental health needs from their PCP. What is important to note, however, is that PCPs may be for 33% of the population (Falloon et al (1999)), will be the only professional that they seek to manage their mental health concerns. Through *intentional collaboration*, PCPs that feel supported and gain comfort in managing mental health patients will reach those who may never come in contact with the regular mental health system.

A more in depth analysis of the system change allows for the development of a working model to create an understanding of what elements are required to afford change, particularly in Primary Health Care. If Shared Care rests on the foundation of 'co-location,' and the facilitators of improving patient outcome include

access, availability, communication and relationship (see figure 1) there is much more that can be explored in regards the dynamics of the process of collaboration. This dynamic facilitates change which may in fact

be multifactorial (see figure 2), including the milieu and culture of the clinic, the sense of welcoming experienced by the mental health providers, and the willingness of the PCPs to adjust to the change of practice.

The Shared Care program introduces a significant practice change and the implementation of the program creates a unique working relationship. The access that the service provides to both psychiatric consultation and affordable/timely counseling is considered by primary care providers as a significant improvement to the mental health system. The level of improvement is in fact considered to be so significant that once a PCP has access to the program, it is unlikely that a physician would choose to end the partnership with the program. The program however believes that collaboration is much more than ‘access’ and needs to be *intentional* in moving the relationship beyond this first step. This then speaks to the importance of recruitment and finding PCPs who are interested in going beyond the basic step of co-location. The challenge for the program has been finding PCPs who are able to make an ‘educated’ decision about joining Shared Care. Many PCPs who are in the program presently were approached (cold call) to determine their interest in joining. Having to ‘sell the product’ while looking for PCPs that ‘get’ collaboration creates its own tension.

The program expansion into fee-for-service practice was a venture into “unchartered territory”. The Shared Care philosophy is not well understood within the Primary Care community and partnering with Fee-for-service Physicians has extra barriers including time, space, and relatively new relationships with the WRHA. Further the program faces challenges when partnering with large clinic groups. One or two champion physicians within the group may understand the program philosophy and what it has to offer. They may influence others within their clinic who may be less interested in the philosophy but willing to support their colleague or receive access to the program. This issue alone may account for much of the variability in the program, as it is expected that not all physicians within a single clinic have the same interest in mental health or past experience with collaboration. Discussions with each potential partner will be beneficial to ensure that the program is developing relationships with physicians that value the program philosophy and are jointly interested in achieving the program outcomes. Additionally, utilizing PCP champions to “spread the word” about Shared Care will be valuable when recruiting and engaging clinics. Understanding what is important to foster relationships within the Fee-for-service culture may help to facilitate ideal partners with primary care.

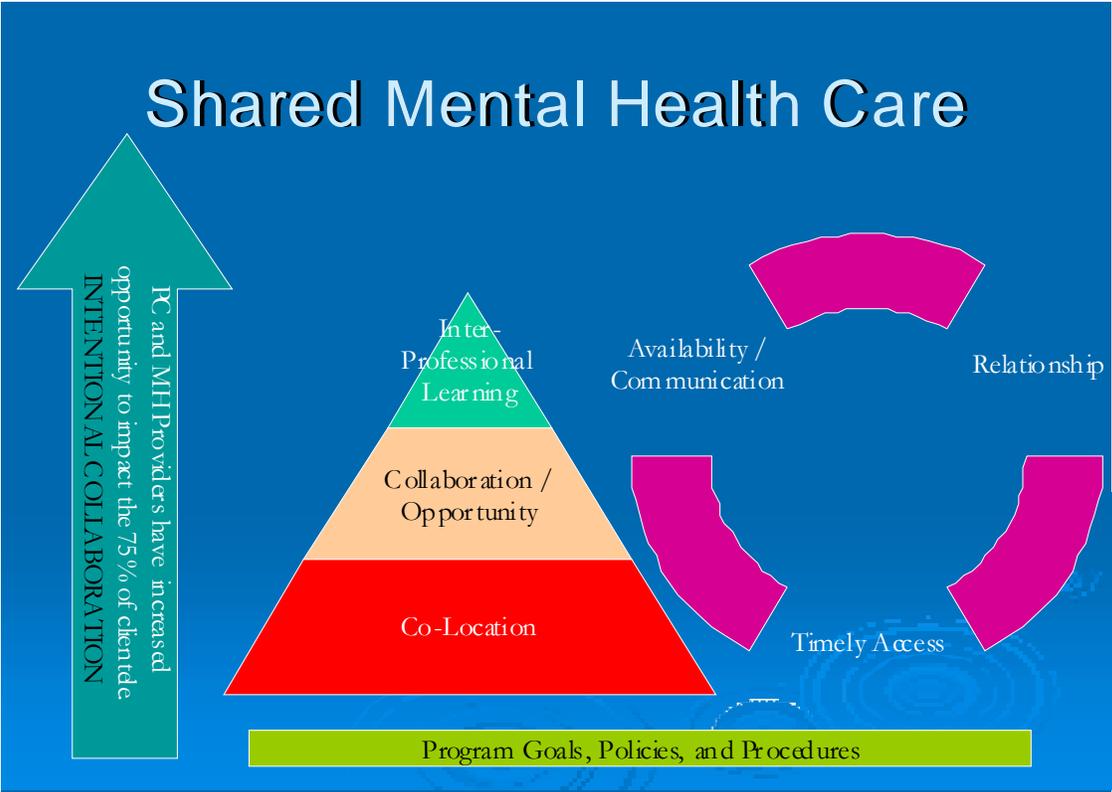
In looking forward to the next stage of development in Shared Care, specifically looking at promoting *intentional collaboration*, the program will need to create further clarity related to program definitions of collaboration, goals, roles, and expectations. Processes will need to be developed that intentionally lead to these goals which then will promote or facilitate support mechanisms within provider groups.

The opportunity for further evaluation on the impact of the promoting relationships should be conducted to see what changes in collaboration occur. Understanding the tension between the balance of providing access while taking time for collaboration could be further explored. The importance of knowledge sharing and the ability to impact PCP practice change needs to be addressed. The system as a whole affords the possibility to work with other initiatives Primary Health Care within Manitoba including the Physician Integrated Network. In its collaborative role in the community, Shared Care becomes the ‘on the ground’ facilitator towards the promotion of quality of health care both within the fee-for-service Sector and the WRHA primary health care clinics. Because of the unique collaborative relationship that mental health providers have with primary care providers, the opportunity to ‘translate’ principles of change and quality including

new concepts of chronic disease management within primary health would be within the reach of the Shared Care program. Strong leadership, a supportive environment, and an emphasis on the core components of the program will be fundamental in ensuring that this program can reach the elevated levels of collaboration within this very complex and unique practice environment.

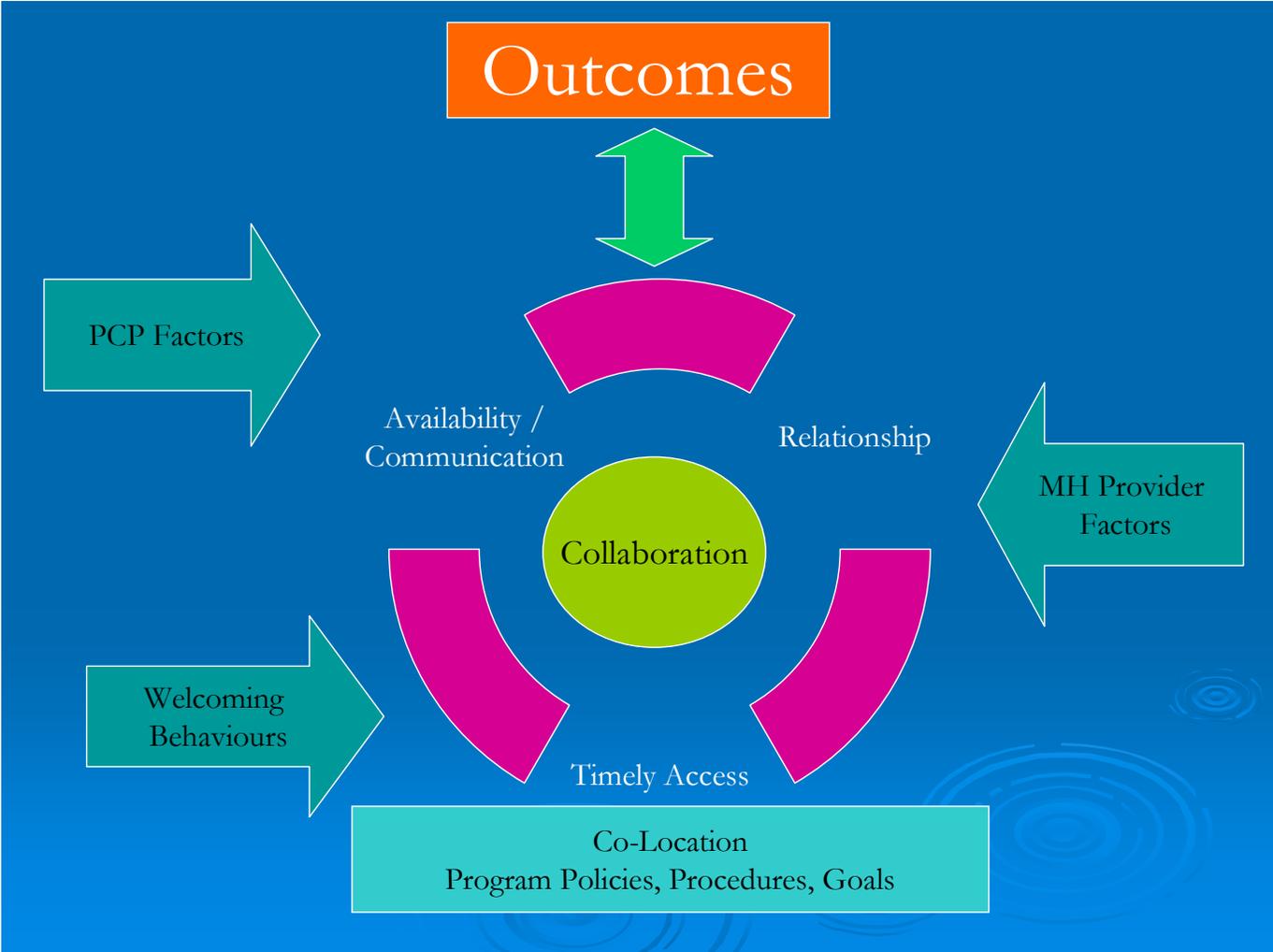
# Appendices

# Figure 1: Shared Care Mental Health - Intentional Collaboration



\*\*Currently, 75% of the mental health care is provided in the primary care sector, with limited access to specialist support.” (Hickie, 2005, p 401)

# Figure 2: Inputs / Outcomes to Shared Care Mental Health



# Appendix 1:

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## Model for Collaboration

Elements that promoted the development of a collaborative partnership are:

- Co-location within the same office
- Collaboration with positive provider factors including the providers' beliefs, experiences, and expectations about interprofessional collaboration. – Some PCP's were very receptive to collaborating and others were slower to integrate a collaborative approach into their practice. (See PCP and MH provider factors in Appendix 1)
- Welcoming behaviours within the primary care clinic. (See Welcoming Behaviours in Appendix 1)
- Timely access to a service with clear entry point and referral criteria.
- Timely communication including: documentation, informal spontaneous opportunities for communication, sound-byte communication, brief hallway communication, scheduled meetings, meetings post-consult, being available to communicate, and using case-based discussion to develop relationships.
- Special emphasis needs to be given to relationship building and development between providers (see relationship building process in Appendix 1). Intentionality and time should be given to the development of relationships. Further the importance of relationship development can not be overstated and as such efforts should be made to minimize disruptions in relationships between providers. The evaluation findings pointed to the importance of relationship in enhancing the collaboration, and resulting in better outcomes. The more communication between providers, the deeper the relationship and the result was a more enhanced collaborative practice.
- The leadership role in negotiating formal structures and operational goals that will empower providers to reach for the vision of collaboration and inter-professional learning.
- The office clinic manager and clinic administrative staff role at each sites in facilitating the communication between patients, PCP's, mental health specialists, and the Shared Care Program.
- Ongoing communication between program leadership and sites to establish communication and relationships, develop collaborative goals, and identify outcomes.
- Emphasis on collaboration at all levels of the program including leadership to coordinate, support, and facilitate this change.

## **Development of new partnerships with private physicians (Recruitment)**

### **Challenges:**

- Newness of the partnership between WRHA and private fee-for-service physicians
- Business and funding model
- PCPs lack of knowledge related to Shared Care program

### **Recommendations:**

- 1.) Primary care guidance and support in the development of the partnerships and promotion of the program
- 2.) Clarity about program goals and mandate, yet flexible enough to adapt to the culture within the clinic

## **Primary Care Provider Factors**

PCP professional factors included:

1. Attitude towards the partnership between WRHA and private fee-for-service physicians
2. Past experience with collaboration – professionally or personally. Including the openness to relationship, priority/value they give to collaboration, receptivity to relationship
3. Attitude or past experiences with mental health – comfort level with mental health, general attitude, past experiences and understanding of mental health service, expectations of mental health services
4. Willingness to overcome barriers physicians face inherent in the business / funding model including time and financial barriers.
5. Initiation and proactive collaboration with mental health providers (not required, however this factor represented those that were exemplar examples of collaborators)

## **Mental Health Provider Factors**

For Mental Health professionals factors included

- 1) High quality of professional skills and quality of care
- 2) Proactive or assertive relationship building skills,
- 3) Flexibility or ability to adjust style of PCP and the clinic
- 4) The priority they gave to collaboration,
- 5) The amount of intentionality they had in communicating.

## **Site factors**

- 1.) Included the clinic culture,
- 2.) Days space was available,
- 3.) Patient roster size,
- 4.) PCP expectations,
- 5.) Specific interest areas of PCPs

## **Welcoming behaviours**

It was characterized by a multitude of behaviours and most importantly included

- 1) warm friendly, respectful communication,
- 2) preparation of a space that promotes access and facilitates interaction with PCPs,
- 3) orientation to clinic processes and procedures,
- 4) inclusion in clinic procedures, activities, and meetings, and
- 5) administrative staff that readily facilitate communication processes.

## **Site preparation checklist**

- Welcoming behaviours acknowledged as important
- Space identified and prepared
- Administrative staff aware and engaged in the process
- All providers and staff aware of and believe in Shared Care philosophy and goals
- Documentation processes established
- PCP factors considered and PCPs engaged on all aspects

## **Relationship Building Process**

- 1.) face-to-face interaction
- 2.) time to communicate,
- 3.) patient care-based discussions,
- 4.) timely communication / documentation
- 5.) familiarity with the other provider's knowledge, experience, and practice style, and
- 6.) tailored relationship building techniques to each individual.
- 7.) Integrated files

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