# Reducing Wait Times
# And
# Making Best Use of
# Mental Health Resources
# in a Small, Rural Clinic

# PRESENTER DISCLOSURE

- **Presenter:**

**Flora MacKay, MSW, RSW**

Shared Mental Health Clinician (SMHC)

Alberta Health Services (AHS)

- **Relationships with commercial interests:**

No conflicts to declare

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# LEARNING OBJECTIVES

1. **Understand some challenges of providing Shared Mental Health Services in a small, rural setting**

2. **Learn about three strategies this project used to help improve service and reduce wait times for patients**

3. **Identify the measures used to date in evaluating this project**

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# Overview of the Setting

## Campbell Clinic Coaldale

- Small primary care clinic (6 physicians)
- Rural community (population 8500)
- Nearest Community Mental Health Services located 20-25 minute drive away
- Shared Mental Health Clinician (SMHC) on site one day per week (funded by AHS)

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# Our Project Team

Flora
Shared Mental Health Clinician

Jean Iwaasa
Nurse Educator

Kim Daniels
Clinical Care Coordinator

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# Identified Need

- Patient wait time > 7 weeks for Shared Mental Health
  - Patients needing simple coping strategies for less severe symptoms may only need education
  - Patients in crisis not seen in a timely manner
  - Long wait time a possible factor in high no-show rates?

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# Goals

1. Improve access to SMH services by:
   a. Triaging appointments to determine need of SMHC vs. Clinic RN
   b. Decrease missed appointments
   c. Increase access to a professional for those in crisis at time of family physician visit
2. Utilize team appropriately and to full scope (screening, collecting history, and initial patient education can be provided by other staff)
3. Use time more efficiently (streamline referral, assessment, documentation)

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# Overview of Clinical Innovation/Program

1. Explored skills of other team members at the clinic (Education Nurse with background in psychology and child and youth work)
2. Obtained permission for education nurse to work with SMHC
3. Developed a clinical pathway
4. Developed a SMH Intake Form to be filled out by patients
5. Developed a chart note template specifically for mental health sessions

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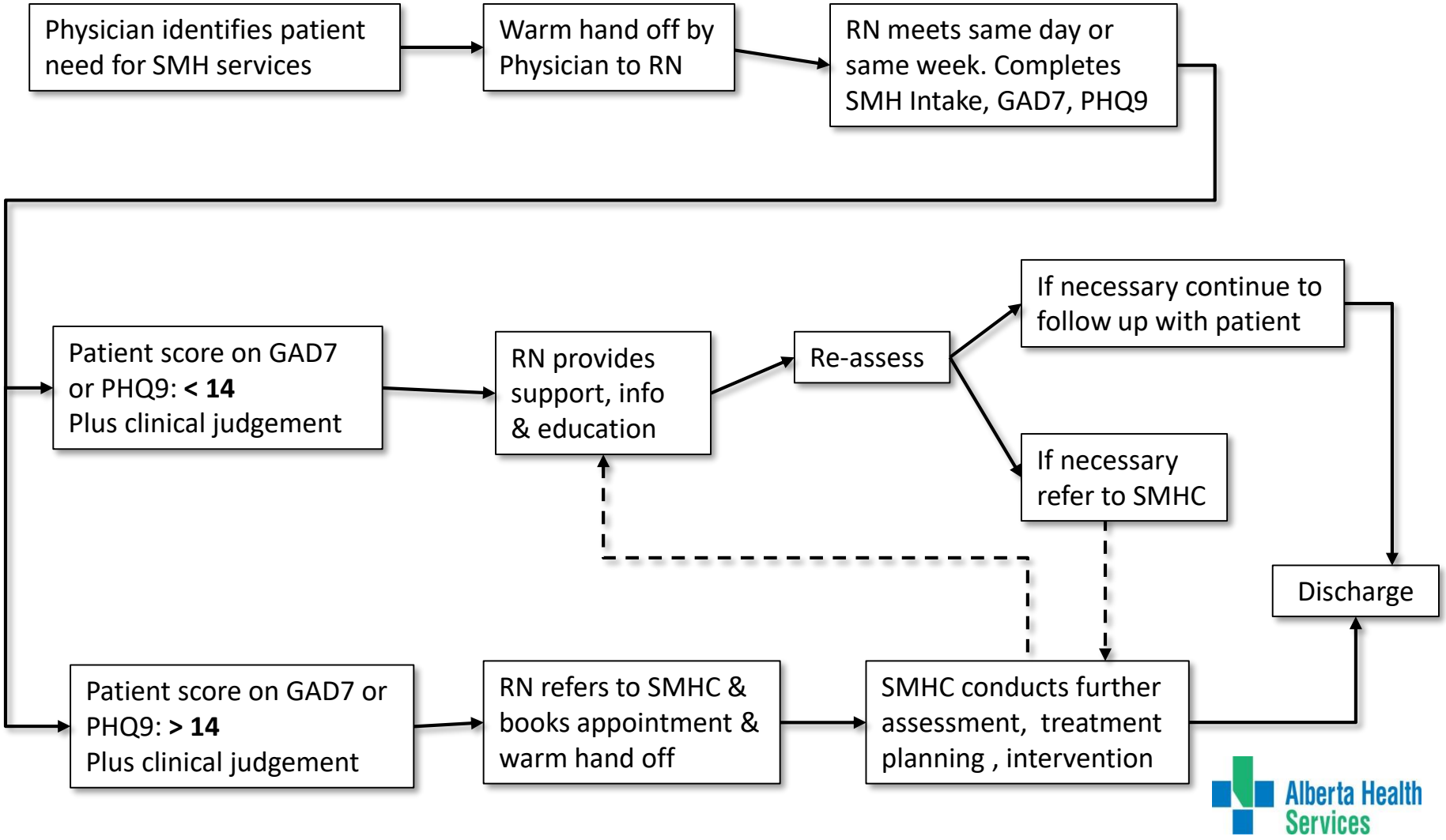
# Our Clinical Pathway

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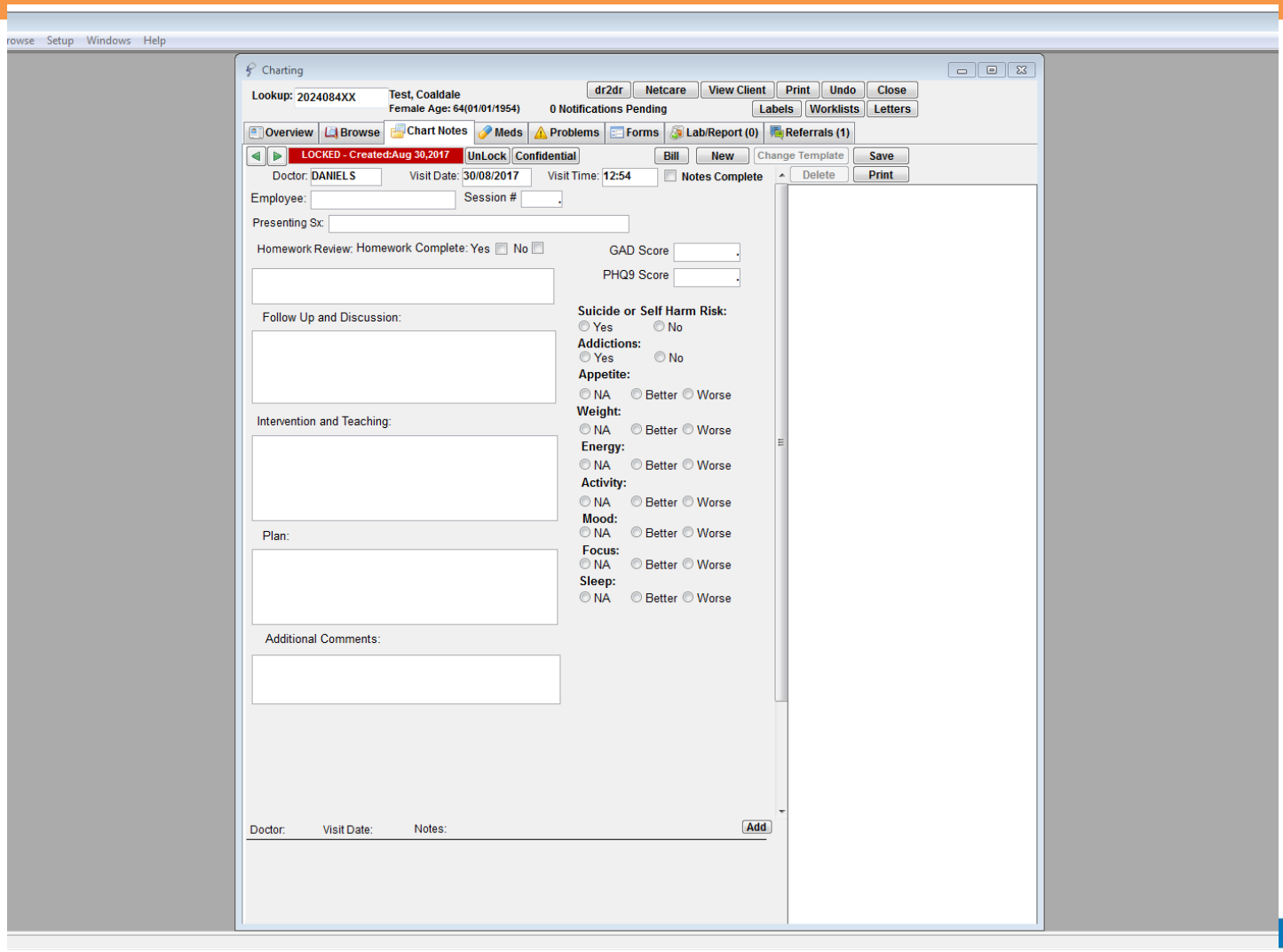
# New Mental Health Chart Note

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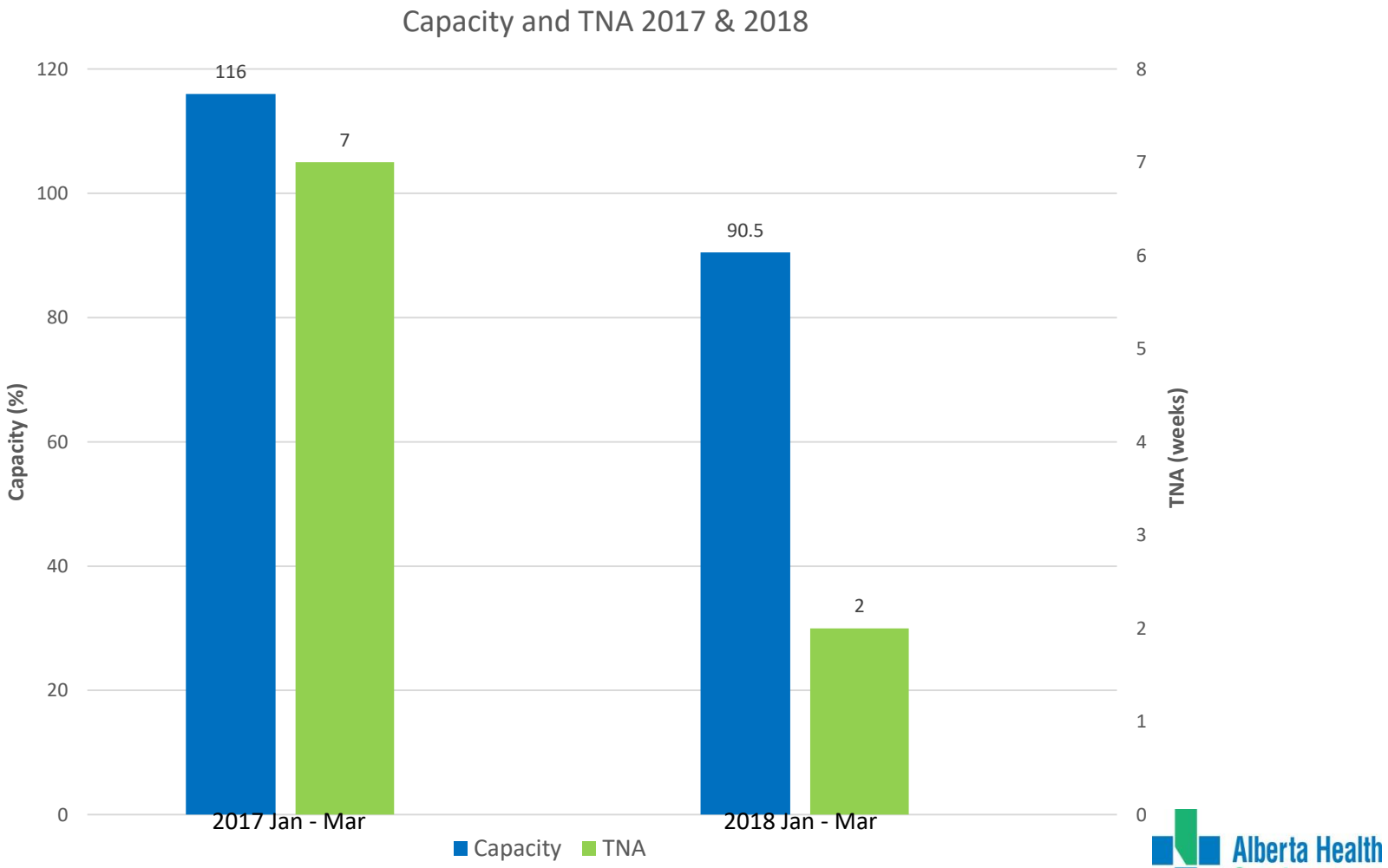
# Outcomes

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# Outcomes

- Access to mental health support increased from 1 day/week to 5 days/week (RN in clinic 5 days/week)
- Patients in crisis are seen immediately.
- Wait time for SMHC dropped from >7wks to 2 weeks (still only in clinic 1 day/week).
- RN watches SMHC schedule and if an appointment becomes available, will call patients to fill.
- SMHC availability increased from max 5 patients/day to 5-7 patients per day as some have dropped from 60min to 30min follow up appointments

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# Outcomes

- Increased Warm Hand-offs

  (from physicians to RN, and from RN to SMHC)
- SMHC's initial appointment more focused on treatment and intervention (less time needed for history, screening tools)
- SMHC's stress level reduced, satisfaction increased

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# Goals of the Program Evaluation/Quality Improvement

**Why do we want/need to do an evaluation?**

- Curiosity and genuine desire to make measurable improvements
- Alberta Health Services (AHS) requirements
- Primary Care Network (PCN) requirements
- Program expansion resulting in scrutiny of what is working well/not working well

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# Goals of Program Evaluation

**What are we hoping will occur as a result of evaluating?**

- Provide proof of QI and program evaluation to AHS and PCN
- Provide clear evidence for possible replication of this project at other clinics
- Use evidence based decision-making as SMH program expands

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# Current Measures

Mainly:

- Wait time for patient to receive some form of mental health service
- Wait time to see the SMHC
- Anecdotal patient, physician, and staff comments

Because:

- Primary identified problem/need
- Easy to obtain from databases (data already being tracked)
- Familiar measure to for all stakeholders

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# Process of Collecting the Information

- Used data available in the EMR and in AHS stats

*Complicating factors*:

- Multiple systems, data sets (AHS, PCN, specific primary care clinic)
- AHS requires use of standardized satisfaction surveys (not necessarily what we would choose to ask/measure)

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# Questions

- What can we measure other than wait times?
- Some outcomes are based on anecdotal feedback. How could we evaluate this feedback more formally
- We are “dual citizens” of multiple large bureaucracies…any suggestions for navigating multiple systems/databases/bosses?

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# Questions

- If we replicate this project at another clinic, how can we set up better evaluation from the start?
- How do we evaluate the SMH Intake Form? (It has had multiple revisions, people keep suggesting changes)

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# Thank You

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*Thank you to Chinook Primary Care Network and Alberta Health Services for supporting this project.*

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