Pauline Pariser, I am the primary care lead for the Scope program.

Parisa Mehrfar, is our project director whose been newly hired to lead the expansion of the Scope program – seamless care, optimizing the patient experience. And, prior to joining us, Parisa worked at Markham Stouffville, where she led the development of the Eastern York region North Durham Ontario health team and she's also worked as an integration and planning manager.

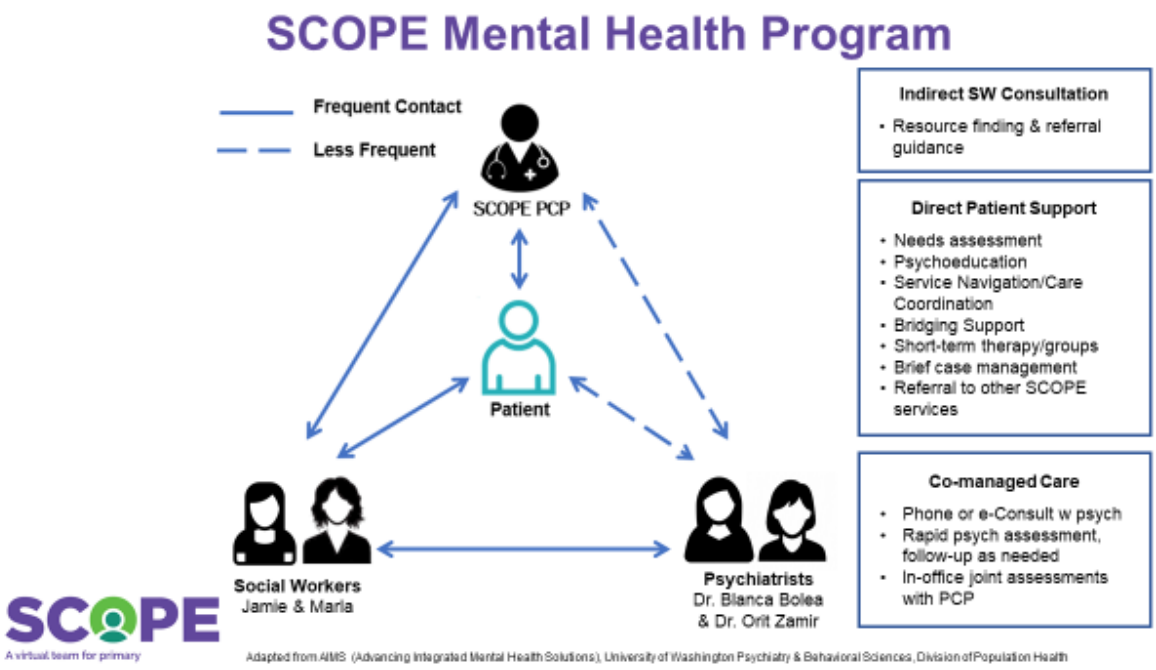
Jamie Smith, who has been with us since the beginning of the SCOPE program in November 2016. Jamie has a Master of Social Work from UofT, and many of you will have heard from Jamie in our operational meeting, she provides a range of services, care coordination, service navigation, case management, bring psychotherapy intervention and she has worked previously at camh and at LOFT community services.

Marla Russell also has a Masters of Social Work from UofT and she just joined us this January. She is in training, though she brings with her also a lot of skills and resources. The work she's done previously at UHN as a transplant resource specialist as well as many other positions with mental health and addictions programs at community agencies.

Dr. Blanca Bolea Alamanac who has a Masters of Science and a PhD in Epidemiology. She is the director and staff psychiatrist at the SCOPE mental health program. She's also an assistant professor at UofT and an innovation fellow at Women's College Hospital Institute for health systems solution and virtual care.

Dr. Orit Zamir - just joined this February.

The Structure of SCOPE Mental Health

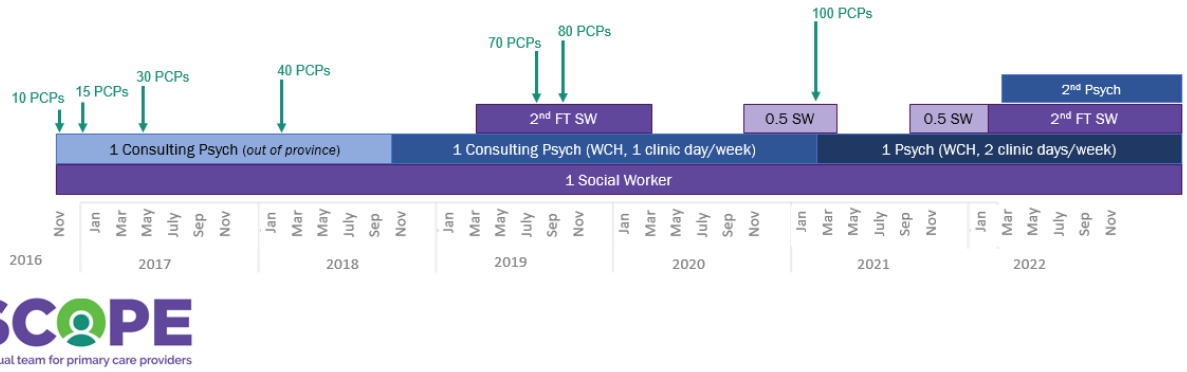


We support SCOPE PCPs and their patients with any mental health request.

Our approach is patient-centered and a social worker often works as the primary point of contact between the patient, PCP, and psychiatrist. SCOPE doctors have the opportunity to consult directly with the team's social workers for resource finding questions, or guidance with referrals. They can also refer their patients directly to social work and/or psychiatry. This involves a needs assessment and typically some psychoeducation with the social worker as a first step, then depending on the needs of the patient, we can offer: Assistance with service navigation and connecting to appropriate resources, or some bridging counselling support and/or case management. We will also refer patients or PCPs to other SCOPE/TIP services when appropriate as well. In the past, we also offered in-office joint assessment/case management with family physicians.

And then of course, the social workers are in frequent contact with the psychiatrist for consultation. The psychiatrist also provides patient assessment with follow up when needed and is available for phone or e-consult with the family doctors.

Timeline



SCOPE
A virtual team for primary care providers

The SCOPE MH program has been running since November 2016. The team has always consisted of at least one social worker and one consulting psychiatrist; however, the composition of the team has varied over the years. Currently we have two consulting psychiatrists (Dr. Bolea, with 2 clinic days/ week and Dr. Zamir, with 1 clinic day/week) and two full-time social workers (Jamie Smith and Marla Russell).

We are currently supporting 101 PCPs. Initially, we started the program with a small group of PCPs and we have expanded over time as we increased our capacity. We worked to improve capacity both in terms of the team size, as well as by improving efficiencies with what we offer and improving PCPs' capacity to manage mental health.

As the program progressed, the number of referrals has increased steadily as well. I'll just note the peak in the Fall of 2019, that's when had two full time social workers for the first time. We doubled the number of doctors that we were serving and we offered group therapy at that time, so we were able to serve a significantly higher number of patients.

In terms of adding new PCPs to the program, we started with the physician advisory group (PAG), which is a group of physicians who have proven to be dedicated to SCOPE. We then expanded to PCPs within the same office as the PAG members. From there, most onboarding was done based on expressed interest. For example, we offered the opportunity to sign up for SCOPE MH after PCPs attended a SCOPE engagement event, or we have done an e-blast where we offered access to the first twenty PCPs to respond.

Funding

Allied Health professional: Included in the SCOPE budget, at each team's discretion to use towards a mental health resource

Psychiatry: OHIP-covered for consultations, in-kind coverage from hospital division, $15,000 stipend for 1-day psychiatry support that covers calls, supervision of mental health team, educational events, etc.

Evaluation - Through grants, private funding ($6000, WCH Funds $7000), may be subsumed under central coordinating hub

Ethos of Service

Since the beginning, we've tried to maintain a few factors that we feel are really integral to the service.

1. **Low barrier** access for patients and PCPs
    - **Simple** referral pathway
    - Interventions are **patient-led**, needs-based
2. **Flexible** – intervention can range from virtual to in-office collaboration with PCP & patient
3. Aim to promote **equitable care**, with a **stepped care approach**, serving populations that are **vulnerable** and have difficulty accessing services

We keep the service very **low barrier**, both for the patients and the PCPs. We accept referrals by phone, email, fax, and patients are always welcome to reconnect. All of our interventions are patient-led, trying to provide the right type of care at the right time, to really match where the patient is at.

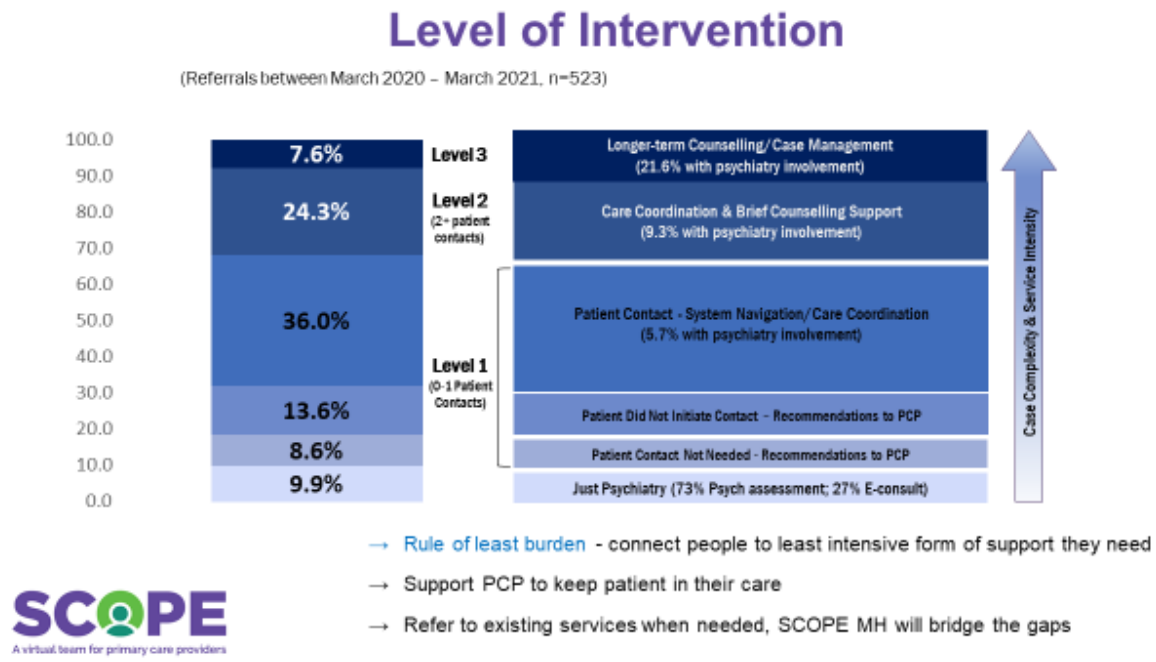
The intervention that we provide remains flexible. We've pivoted the service to entirely virtual over the past few years and have provided in-office, joint appointments as needed. We even facilitated in-home assessments when there is no other option available to the patient.

We aim to promote equitable care with a stepped care approach. Again, providing the right care at the right time to serve vulnerable populations who may have difficulty accessing services or who don't easily fit into the existing system. We adapt the level of intervention or support to match each individual need rather than providing a "one size fits all" sort of approach.

Patient Demographics

Similar to our population distribution to the geographical area that we serve, we also haven't seen much variation in our patient demographics over the last four/five years that the program has been running. Notably, the above sample is from peak pandemic year of March 2020 to March 2021. We have seen an increase in referrals for adjustment reaction. Referrals re: trauma and PTSD have increased a bit which, in discussion with Blanca, we feel is related to the reduced availability of existing trauma programs for the majority of the pandemic, as well as patients with severe concerns that were then exasperated by the long-term nature of this pandemic.

Level of Intervention



Another way to look at our work is through our level of intervention. The majority of our referrals end up with a light touch, often brief intervention. Cases with longer, more intensive involvement make up a smaller number of our referrals, but they tend to take up majority of our time. Again, looking at this stepped care approach, we try to connect patients with the least intensive level of support appropriate. We try to connect them to existing services when possible and we try to stay involved in cases where there aren't other services available, or where there remains a gap in their care. So again, equitable care is our main focus.

Resources recommended

For the majority of our referrals, we'll recommend resources either that are in addition to our services or as a next step to their care. Low-cost, OHIP-covered, or government-funded counselling is the highest

need. This year we've seen an increase in online mental health programs as more services are available and have been funded by the provincial government and also, as people feel more comfortable with the online modality. Referring to outpatient programs, typically this is in regards to specialized psychiatry programs such as: eating disorders or addictions or this may also be related to comorbid medical conditions. For the N/A, that is referring to patients who are not interested in any further services or who we were able to support within our SCOPE team itself and did not need to be referred elsewhere. In regards to the other psychosocial services, this refers to employment services, legal, housing, or more complex financial support.

PCP Orientation and Onboarding Process

When we introduce a new family doctor to the mental health program, the social workers will email them with a package that provides an overview of the service and how to access it. We always offer to discuss in more detail over the phone or with an in-office visit to help strengthen that personal connection from the beginning

The orientation package includes:

- PCP Orientation one pager - how to access the service
- Patient handout - We ask PCPs to give this handout to any referred patient. It explains how the patient can connect with us.
- Case examples to give a better idea of what we can do with different types of cases/referrals
- Copy of up-to-date SCOPE mental health patient resource guide (also on the SCOPE hub website)

Patient Handout

We ask patients to initiate contact with us in most cases. In the beginning of the program, the SW was actually reaching out to every patient that was referred, but we found that a number of patients weren't in need of our intervention. Some had already been referred to other services, some had found resources on their own, and of course, some weren't interested in support at that time. As a result, we've adjusted to having patients initiate contact with the social workers. Of course there are patients that may have trouble reaching out, so PCPs can always ask the social workers to initiate contact. PCPs can request this on their referral.

Since a large number of the referrals we get are for support in finding individual therapy resources, we've tried to outline some initial considerations for finding a therapist. This is in hopes of diverting some calls and saving some patients from having to speak with us as an added step in getting connected to care.

SCOPE MH Patient Resource Guide

There is a big need for low-cost and accessible counselling services, so we've created the patient mental health resource guide, which is available on the SCOPE hub website as well. It includes things like

frequently asked questions, information on how to find a private therapist, as well as different types of mental health therapy resources. PCPs can always share this with their patients as a first step.

We have a number of other resource lists available on the website, so PCPs can review these themselves or they can direct patients to the website when the patient is able to pursue services independently.

PCP Orientation one pager

This provides information on how to access the program and provides an overview of the services that we offer.

Of note - We outline the general goals of the service, adding that we are continually working to adapt our service to really best fit the needs of the PCPs.

We also emphasize the importance of not promising any specific aspects of the service to their patients when they refer in order to manage expectations of both the patients and the PCPs. It's partially to allow for some variation in what we offer, depending on capacity of the team at different points in time. Also, to keep the possibilities open for the patient. Sometimes, the patient will be referred specifically for a psych assessment, or for CBT let's say, but this doesn't match their concerns and maybe wouldn't best serve the patient in where they're at, at that time. But, if the patient sort of sees this on their referral, they might think that they need to proceed with what the PCP has specified. So we find that when it's more open ended, there's a higher chance that patients will engage and that together we can figure out the best point of care for them.

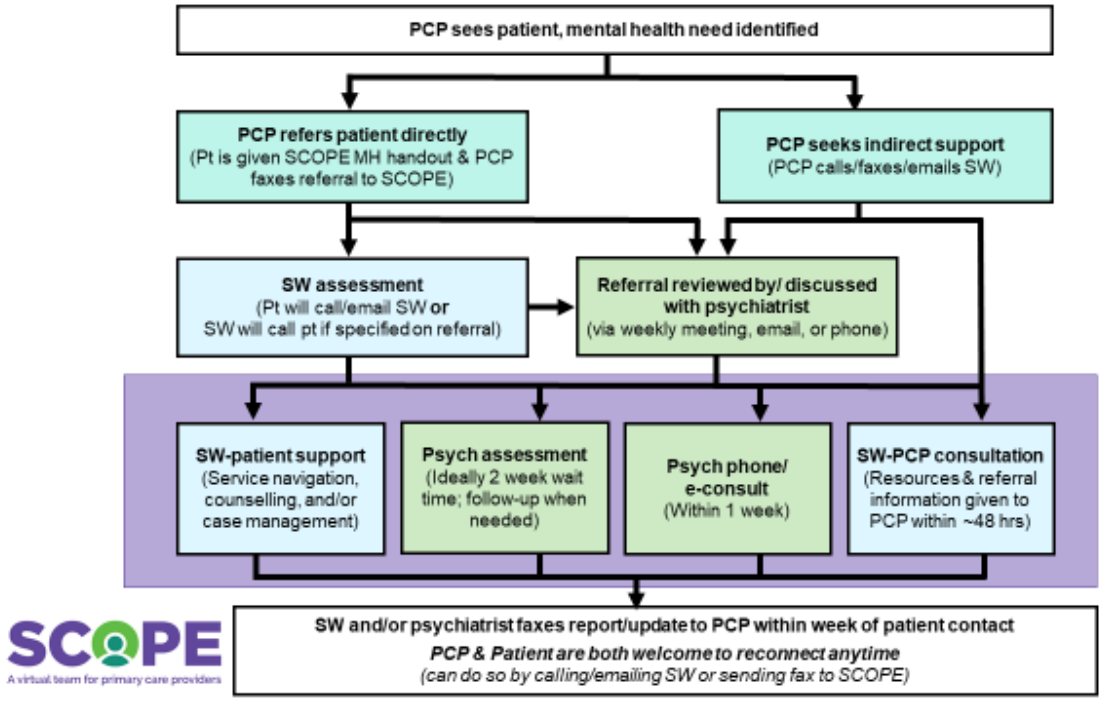
How to Access Services

PCP can reach us by phone, email or fax. The vast majority of referrals we get are received as fax, including patient information and reason for referral. We ask that the PCP provide their patient with our contact information via the patient handout. From there, the patient can call or email as a first step.

Note: The SCOPE MH program has always had a separate phone number and email address, even though the broader SCOPE team at each hospital has a central point of access. PCPs can always connect to SCOPE MH through the SCOPE nurse navigator or through the main SCOPE contact number. We find it's useful for frequent referrers to be able to contact us directly, but for PCPs who don't use the service very often, it's handy that they can connect through the main SCOPE contacts and don't need to remember another number or another email.

It's important for patients to have the SW's number and not the main SCOPE number, so the nurse navigator doesn't get inundated with patient calls.

Possible pathways with SCOPE MH



Above is a flow chart explaining the many different pathways or steps that can be involved in a patient's care

First - the patient is in contact with their PCP and the PCP identifies a need for mental health support that's outside of their own capacity.

From there, they can either refer a patient to receive direct support from the mental health team, or the PCP can consult with the social worker or psychiatrist without involving the patient (more similar to the nurse navigator role).

Direct Patient Contact:

The first step is always contact with one of the social workers. We will usually have a phone conversation with the patient to get a better idea of their needs. If the needs don't involve psychiatry, we typically won't discuss the referral with the psychiatrist, but will help with service navigation, possibly some short-term counselling or bridging, or light case management. We can stay involved with a patient for as little as one phone call, or the patient may stay engaged for many months if there are barriers to connecting them with appropriate supports and if the patient requires a bit of follow-up to ensure they don't get lost in the gaps of the system.

If the referral is particularly complex or if it has a clear need for psychiatry, it will be discussed with the psychiatrist. In urgent cases, the psychiatrist is usually available within hours by phone/email, and in less time-sensitive cases, we discuss during our weekly consultation meeting. The SWs and psychiatrists have a weekly 1hr meeting to discuss cases.

Following this discussion – the psychiatrist might provide a phone/e-consult based on the referral and any additional information gathered by the SW, or they will see the patient directly for assessment. The psychiatrist will provide follow-up as needed, and will send a report to the PCP within a week of seeing the patient.

The SWs also try to send an update to the PCP within one week of patient contact. For longer-term involvement, we'll send updates as needed.

From one referral – the patient might receive support from the social worker and/or the psychiatrist – they can flow between different components in the purple box as their needs change/develop.

PCPs can always reach out with updates or new questions. Patients are also always welcome to reconnect (they don't need a new referral, the only requirement is that they are still a patient of the SCOPE PCP).

> **Pauline: this came up in the chat – can you speak to how quickly referrals are dealt with by the social workers? What's the wait time?**
>
> Following a referral, we try to have contact with the patient within 48 hours. When the patient is given our contact information, they have 2 weeks to respond. In cases where the patient doesn't reach out, we'll send a note back to the family doctor within 2 weeks, just saying that the patient hasn't connected and we will provide them with some resources or recommendations based on the initial referral.
>
> In cases where we have contact with the patient, we try to send a note back to the PCP within 1 week of contact. That's the same for the psychiatrist as well, if she sees a patient, she sends a referral back within a week of assessment. And same with a phone or e-consult.

Indirect Referral:

If a PCP refers with a question that doesn't require direct contact with a patient, this can either result in the social workers responding with some resource recommendations or referral information. Alternatively, the psychiatrist will review the referral and they will provide some recommendations by phone or e-consult.

Occasionally following an indirect referral, we will have contact with a patient. This happens only in cases where we don't feel we can adequately answer or support the PCP's question without learning more from the patient. We would contact the PCP to explain that contact with the patient would be useful before we can provide any recommendations.

There remains a flexibility of developing or changing needs for all referrals.

Of course, a patient's journey is never going to be a straight line, or we can't expect it to be. Some common or expected issues that may come up include:

If the patient doesn't initiate contact, we send a no contact note back to the doctor to let them know that they haven't reached out and they can always like reconnect in the future.

Another possible issue is if the patient and the family doctor don't agree on next steps. Early on, we actually considered not having direct contact with the patients, but we found that their concerns differed often enough from their PCPs that it was beneficial to speak with them directly. Often having the time and space to talk with a safe third party allows for the patient to explore their concerns and their needs in more detail

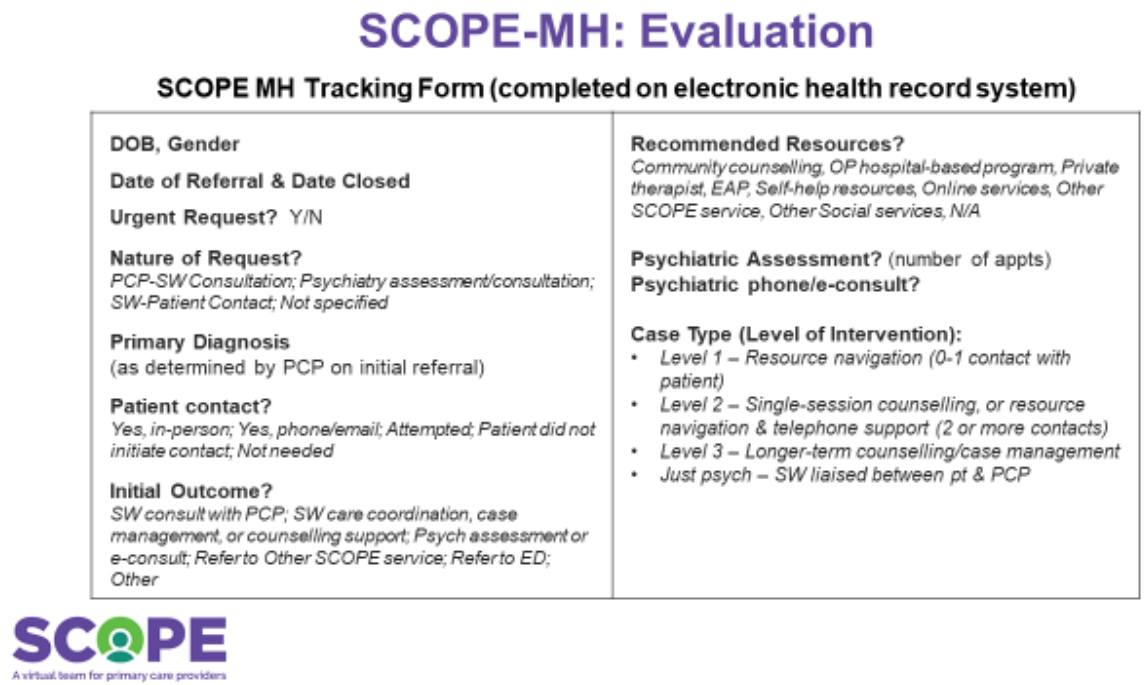
Another issue, patients may benefit from psych consultation or referrals to other services, but they're not ready yet. We'll provide some bridging support, or leave the door open for the patient to reconnect. Sometimes we'll offer a check-in a month later or even 6 months later to see if the patient would like to reconsider supports at that time

And then lastly, the patient initiates contact, but then disengages. We can provide recommendations back to the PCP, so that then they'll hopefully have the opportunity to discuss with the patient in the future, and they can always encourage them to follow up on the recommendations or reconnect with the team if their needs change.

SCOPE-MH: Evaluation

I strongly believe if you're going to start a service like a SCOPE mental health, you want to have an evaluation attached to it from day one. Having this in place before you start will facilitate first adjusting the service to new needs and also will give you important metrics and data for your terminals or your .Next one. (25 mins)

Tracking form within hospital EMR



One very important step is to make sure you gather some data to start with in a form that's EMR or the way you work. And, after a lot of thinking, Jamie and I, at the beginning of this service, we agreed that this was kind of the basic data that we wanted to collect. I just want to bring your attention to the level of intervention, which is a bit different from all SCOPE services. One of the challenges we have is that some patients will have the full thing. So, they will be followed by Jamie or Marla, they will be given social support, they will be given maybe some informal counselling, and then I will see them as a psychiatrist or maybe even follow them for a few months. So, we call these like the higher levels of intervention. But they are all the levels of intervention that we do and it's very important in an evaluation to capture all that. So we created this scale level 1, level 2, level 3, or psychiatry, in which we can capture how much or the intensity of that care to the patient, which again, will be tailored to a specific patient, depending on their specific needs.

RE-AIM Framework

We follow the RE-AIM framework, there's a beautiful paper about it by the University of Washington, we just reference them. So basically, the first data includes outreach, adoption, implementation and maintenance. And these, what you define as outreach, adoption, implementation, and maintenance may be different depending on how you set up the participants, but these were all definitions. I'm just going to mention that we think maintenance, particularly, is very important. So how many referrals can you accept and process. And tracking that effect overtime gives you a lot of information about the stability of the service and allows you to project for the future what you want to do. The other parameter that is very important, is implementation. How many patients can you assess and conclude or close, and what interventions are you doing with those patients. Again, we go back to the level of

intervention. Adoption and outreach are relatively easy to measure because you have that data from the start, but still, it's important to keep tracking overtime.

Patient and PCP Feedback

Okay, data is data, very good, but we want to also have experiential opinions and we serve really 2 different populations. We serve the family doctors and we also serve patients. So we want the opinion of family doctors and the opinion of patients. So we did that by a brief survey, by the way this was all asked through the RAB with a specific processes called atquick for quality improvement, which is a little bit faster and it was all reviewed by the RAB and I will definitely suggest for everybody doing that to contact their local atquick or singular process to get all the approvals. Next one.

Results: RE-AIM Framework

So what we found is we correlated all our numbers from January 2021 to October 2021, this is because we were very interested in seeing the effects of the pandemic, just to say that we have the number from before and we are collecting data now, so it's a continuous process. The one that we are going to present today, is this months. So that time, we received 691 referrals, including 88 that were completely self-referrals by the patient. We calculated our adoption by seeing how many family practitioners would send patients to us from a pool of 101 and that was 54%. So we consider this adoption moderate. Next slide.

So on implementation, we consider that cases closed, so just to note that some people that we couldn't reach to start with, people move, people change phones, etc. And we have some cases that are still open. I think that we're going to close a lot of these cases in the next few months. This is because with the pandemic, people didn't have a lot of support access, so we carried more than we should. We will close around 556, which is a lot. So in that frame, I think people got what they wanted and they got on with their lives. In terms of maintenance, the average number of referrals received per month was 69. This is the referral for the whole service. This is not I'm seeing 60 patients, 69 patients a month, this is the whole team, we are seeing 69 patients a month. And some of them, we only will only get like, maybe we will discuss them on our weekly meetings, some of them don't even need that. Next please.

Results: PCP Survey

So I want to present some of the results of the survey. We're very happy, our intake of the survey was very good, so we have lots of responses coming back. If you do this, I will strongly suggest you send it by fax to family doctors, they respond really well that way. So, 89% of doctor referrals said that the program had to take some time. And this was one of our key metrics because family doctors are already very very busy, so the last thing they want is finding that this is time consuming. 97% of the program have put their patients on the right path. 86% said that we have introduced them to new mental health resources. Now this is important because we want to create capacity. We want to make family doctors more independent in dealing with mental health issues, so it's important that they learn things. I just want to say, that this goes both ways. So we give them the resources, they learn how to use the resources, and they will not use us because they already know that. But I also learn a lot about what I should give to the family care physicians and what they find useful, and what they don't. 82% felt they were better equipped to help patients. 53% consider that mental health, so SCOPE mental health is the default pathway. So will send all the mental health patients to us, and then you say well it's only 53%. So, basically, we were part of almost 79/80% of our family doctors will consider us as a primary

resource. And 58% of physicians felt that with the pandemic, that this was even more relevant. Next slide.

Results: Patient Survey

So we also obviously surveyed the patients. So 95% felt that their needs were understood, 95% felt that we answered their questions, 89% agreed that we had provided some helpful suggestions to improve their mental health and 86% said that the program had put them on the right path to find and improve their mental health.

Evaluation: Discussion/Conclusion

So, where do we go from this. So, first. I think the conclusion is that the program was well-received, both by patients and by family doctors, which is important. Our adoption rates were moderate, with over 50% of the primary care practitioners inducted using it. Those physicians that used the service were very very very satisfied and they expressed improvement in patient care. So physicians report having learned of new resources to support their patients and I think this is important, we're creating capacity, we're helping these physicians to deal with ever more complex situations. But also, patients felt this was a positive recovery or a positive experience. And I think this is crucial because one of the problems of mental health is that most of illnesses are chronic. So if you have a bad connection with mental health resources, you're not going to come back. Or, you're gonna back through on a mission, which is what totally we want to prevent.

What we've learned so far…

PCP Referral Behaviour

The Superman/woman

So, we learn a little bit about how doctors behave and just to say, this is an oversimplification, and everybody's different. We found some doctors addressed, like, you know, they address really good at mental health, they have a lot of insight, but when they refer to us, they're very very booked with patients. So, I think this is where we have to do collaborative mental health care, and help them to find the right resources, and continue supporting them longer.

The Miracle Woman (or Man)

So, we also found this other type of physician, that is very very busy. They usually deal with populations that are maybe landed immigrants, a specific ethnic groups that are under crisis, etc. And these people are just a mess, they try to do their best. But they're always overwhelming. So, I think that's where SCOPE can step in and help and give more support to these physicians, so we can increase equitable access. It's very difficult for people for example, that don't speak English, to access mental health resources. It's difficult for people of certain ethnographic groups to access services because of a stigma,

because of biases that we all have. So I think here, we have a great opportunity to help these very very dedicated practitioners to improve the mental health of the patients.

The Royal

So we also have physicians that are the other way around. We have physicians that deal with people who are maybe middle or upper class and that they have lots of resources. And we found that they might have felt there were an amount of patients, where the patients need was just a connection to a particular counsellor or to understand how things are. So, this is where we use the resource guide, and the patient to patient resources because these physicians usually have patients that are very independent and that can find resources just with very little help.

The non-user

And finally, and this is where we need to do more research on, why people don't use us. So, why? Why people don't use us? So, I think this is where our research has to focus – where are we not getting to people. In my view, the primary practitioner has a relationship with a particular psychiatrist, or a particular service, and sends everybody there. Which is perfectly fine. In my view, it may be that this physician is not keen on seeing patients that have mental health issues and refers to other physicians. We don't know. And this is where there is an opportunity for further evaluation.

Some tips with PCPs

So, every primary care physician is different. And it's very important to understand that. So, some people need a lot of support but they're very engaged. Every time something happens, they're going to call us, and they're going to tell us this patient is not doing well, what do I do? And the aim long term is to help this physician to feel more comfortable with mental health. And for that, I am available to discuss things, or with Jamie and Marla, cause that gives a sense of security to these physicians and they learn, and they act better the next time. And I think again, the capacities they have is very important. But there's also physicians who maybe are less insightful into mental health and I think it's important to educate, and physicians are always very eager to learn. So, the aim long term will be to make it more independent by giving resources, by slowly giving them the education to feel more comfortable and be less avoidant of these patients. And occasionally, we do have physicians that do not engage in collaborative care. They're not interested in collaborating with a specialist. And, you know, that's the way the fact is, and we have to understand. So, basically, in those cases, sometimes Pauline has had to intervene, but I must say it only happened once and we have one hundred family doctors. So this is not very common.

Challenges:

Trade-offs/competing priorities that come with growth/expansion

An ongoing challenge that we faced is the tradeoff between providing a lower intensity, lighter touch service to reach more patients, versus providing a higher intensity service for fewer patients. A challenge that goes along with that is whether to keep the service very low barrier and undefined in terms of what we offer or to create more eligibility criteria and enforcing a stricter referral process.

We've stuck with keeping things low barrier because we've received feedback from doctors that often when there are kind of specific eligibility criteria. It's difficult to remember the specifics of every different program out there, so they will avoid using the service because they don't want to risk the

patient not being accepted. Often, the doctors that work with SCOPE have high demanding practices and so, it's important to keep access simple so that these doctors can access.

Added points cut from webinar presentation due to time:

Making it so easy to refer can come with some challenges, where PCPs may not be available for collaborative care, which is essential to our service. It can also be difficult to divert inappropriate/low-need referrals if the PCPs aren't as receptive to our feedback and to learning what types of referrals we can be particularly effective with.

If we were to create a more regimented service – it may allow for a smoother process on our end (e.g. if a patient is only allowed 3 contacts with the SW, once 3 contacts are done, they can no longer access the service and their referral is closed). However , creating this type of definition defeats our goal of providing equitable care to patients who may not fit within existing boxes. Further, the doctors with demanding practices and complex patients are likely to refer less – arguably these are the doctors who need the service the most

There remains a lack of continuity of care/ long-term follow up in <u>existing</u> psychiatric, psychotherapy, and social services

Another challenge we come across often is that there remains a lack of continuity of care or long-term follow up in existing psychiatry, psychotherapy, or social services. But, as a small team, we can't just solve this problem by simply providing long-term therapy, long-term psych follow up or by facilitating prioritized access to existing services.

What we can do, is try to work within the existing system to promote continuity of care, and to try to help reduce the demand on highly used services.

- We try to promote continuity by co-managing patient care, so the patient really stays within the care of the family doctor and we only escalate to other services, including the social worker or psychiatrist, only when needed.
- We also, as we've said, never close the door on the patient. Just knowing that they can reconnect is often very valuable and this is the case for family doctors as well. As they're learning to manage more complex patients on their own, just knowing that they can consult with a psychiatrist, or that they can call the social workers, has proven to be valuable.
- A simple but effective element of our service is expectation management for patients and PCPs. For example, we've seen an impact just being able to explain to a patient that they don't need to see a psychiatrist if they are only interested in some general psychotherapy, or to explain that life-long, weekly therapy isn't necessarily going to be more effective than short-term CBT.

We can also try to reduce demand on existing services & keep patients within care of PCP

- *Using a stepped care approach we try to connect patients to the least intensive level of intervention needed. So again, not everyone needs to be referred to a hospital psychiatry program as the first step. And hopefully by intervening early and connecting or providing*

patients with timely & appropriate care, we can avoid having to escalate to more intensive services down the road. (e.g. someone who's really struggling with the death of a loved one – providing them with a few supportive counselling appointments right away rather than having them wait for 1:1 counselling in 6 months, we can hopefully prevent their grief from turning into depression)

- Rather than referring everyone to a small handful of sliding scale community agencies, by informing patients and PCPs of a broader range of options and also working to tailor our recommendations to individual patients, we can help to reduce the bottle neck for some services and disperse patients across under-utilized resources as much as possible
- We try to have these resources available on our website as well so that the SCOPE MH team isn't a necessary added step for those clients who can navigate services on their own, so this reduces the demand on our own program as well.

What we've learned: Positives

Just some of our key takeaways of what's been effective for us.

The importance of personal connections: with the PCPs, with patients, also with collaborating with hospital community services as well as our growing SCOPE team and SCOPE community.

It's also essential to keep things flexible. To adapt your level of support to unique needs that come with each referral and to be responsive to feedback from PCPs for the overall service. And also being able to adapt to changes within your small team structure because we noted our teams have changed in numbers and size over the years, but, by staying flexible, we've been able to maintain the same number of PCPs or actually, an increasing number without creating wait times because being responsive is extremely important for our efficacy overall.

The importance of keeping things simple. Simple interventions can have a high impact. Sometimes just having an initial conversation with someone who is on a waitlist for ongoing therapy can make them feel much more secure in their place within the mental health system. And again, for the patient and the PCP, just knowing that support is there can often make a big difference.

Q & A Section

1. **How are you able to distinguish and triage patients between the direct urgent referrals to the mental health services versus using the SCOPE mental health services?**

Dr. Bolea: We are absolutely not a crisis service. There are other crisis services in the city that work very well. We are not a crisis service. However, things happen. So sometimes, patients we already know enter a crisis. Sometimes doctors need to know something about a patient that we've never seen. So the whole team is very keen to talk with family doctors because I think if a family doctor is under stress because of a patient that has impacting the care of future patients with the same illness, so we often provide a bias about forming patients and what situation should work.

Jamie: A PCP can always contact us with questions about urgent issues. The social workers are always available same-day to at least speak with the PCP and to provide information about what services would be more appropriate if there is a crisis or acute patient concern.

Pauline: Can I add just to that? Just to remind people that not all the SCOPE doctors have the mental health program. We intentionally did this incrementally. So it's the hundred and one. Our planning to expand now that we've added more resources. So, they would be availing themselves to the nurse navigator and community resources. And of course, some of the resources that are all on the website, like the inventory app that Jamie put together.

2. **Can primary care providers reach out directly to the SCOPE psychiatrist with fax, phone or email? Or do all initial contacts come through the social worker?**

Jamie: Yes, simple answer, everything comes through the social worker as the first point. We will typically receive a fax and then liaise between the psychiatrist and PCP.

3. **How are you able to investigate if the patient already has other services with other organizations?**

Dr. Bolea: That's exactly what we want. This is collaborative care. The more services with more people, the better. So it's not like us or camh, that's not what we do. We do ask, and we do have patients that have found counselling somewhere, but they need something, another piece, like social support by Jamie or Marla, or they want a second opinion. So, we're flexible like that and it's part of an exclusive situation.

Jamie: Just to add to that, when we talk to patients during that first needs assessment conversation, we ask questions to get an idea of what they're already connected to and how to best optimize those supports.

4. **__ is wondering if there has been adequate capacity in your local community resources or are there signs that more community services are needed?**

Jamie: I think that's a simple answer - There's always more need for mental health services and psychosocial services. I don't know if anyone has anything to add, but that's definitely my opinion.

Blanca: We ask that in the evaluation, and they wanted more services in all areas, but particularly counselling was something that people felt there wasn't enough of.

5. **Question for Marla and Jamie**. **How do you keep your inventory of resources up to date?**

Jamie: It's really an ongoing working process because of our role. Because we're always giving patients information about a range of resources, we're just constantly working on updating these things. We try to update the website as often as possible as well.

6. **You raise the point about requests for long-term counselling or psychiatric support that is desired by PCPs. So the question is how do you manage those requests? And any suggestions that you can share?**

Dr. Bolea: I do have outpatients, but this is not a community mental health team, we don't have that ability. However, I think the way to manage this is to say patient is stable now, we'll discharge the

patient, but they can come back at any time. Yes, call the social workers, sort it out. This approach gives some security to the primary care physicians that they have a point of care for the patient. But also, sometimes patients are tired of being seen and they're tired of being in the system. They feel more empowered even if you allow them to connect when they need.

?Pauline: I just want to add something to that. Just recall that when the team did their breakdown, the majority of requests are not for long-term counselling. I think that's what we assume that's what everyone wants, but when you actually get down to it, it isn't. It's actually a smaller percentage then you would think.

?Jamie: *As long as you provide ongoing support*, that seems to be enough or at least something to provide reassurance to the physician. I think as well a lot of people who are new to accessing any service or mental health supports, they may have an image of seeing a therapist once a week for the rest of their lives or something, so a lot of it is just explaining that short-term intervention can be more effective. Just sort of letting them know this can be empowering to the patient. The goal is to give you coping skills. So it's really just explaining why long-term isn't necessarily the best option.

7. **Do social workers provide counselling and therapy in addition to service navigation?**

Jamie: That's varied over time, just depending on our capacity. When we had two full-time social workers the first time around, we offered more structured or more formal therapy. Now it's being done on a case by case basis. If somebody needs that extra support, I'll provide some short-term support or meeting once a month. And it's something we're looking at more now that we have Marla on the team and looking at group therapy and things like that as well.

8. **Pauline, next question is for you. If you can elaborate on the stipend piece and the funding piece?**

Pauline: Honestly, that stipend was through donor funds. I applied for support for the mental health program and that's how we got the stipend. However, as we write our proposals for ongoing sustainability, I think that our intention is to include that as part of the maintenance of a viable SCOPE program because we know that this a critical need for primary care.

9. **So the question is if other sites in the future start a mental health pathway, will SCOPE help and provide resources for evaluation of the program?**

Blanca: The answer is yes. We are very much interested to do evaluation of all the SCOPE sites. We have recently applied for *SUHR* fellowship with the focus on looking at the spread and scale and looking to see how each sites have adopted locally and what that means. But as a hub, we are very interested to demonstrate the value of the program, so we will take on that.

Soon enough, we also will be starting an evaluation committee and we'll be asking about interests researcher from each of the SCOPE sites to come and join so that we can really frame the evaluation questions and look to see how we can share the results of the great work that everyone's doing. I'm very interested I can offer my expertise.

Signing off messaging:

I do not see any other questions. And definitely, we will send out an invitation for the evaluation committee. I know that we had a smaller group but we are looking to formalize a lot of our work at the coordination hub. So thank you for your showing interest.

So I hope that this webinar has been useful. We really offered it to sites that are at the point of embarking on, including a mental health component. But, we are available beyond the webinar. I think all of us want this to succeed, so you can reach out to Parissa, myself, we'll connect with Blanca or our social workers, if necessary. We're really here to share what we've learned and to support you. So thanks so much for joining us, we will be sending out the slides. A number of you have asked for them and Blanca and her team as well are going to be working on a tool kit. How to set up this kind of program for your site. I also wanted to say to any of the physicians who have joined, that you will be eligible to a CMA credit for participating today. Before you sign off, Katie, our amazing calms person has a feedback poll, which really helps us appreciate what we did well and what we could do better, so if you don't mind filling out the poll before we conclude for today, we would be very appreciative. Thanks so much to everyone and the panel.