



jurisdictional snapshot

**RURAL PSYCHIATRY PRACTICES AND MODELS:  
A CANADIAN JURISDICTIONAL SCAN**

April 2018 | Aimee Letto, Michelle Ryan, Stephen Bornstein

*A scan of health policies and practices implemented outside  
Newfoundland and Labrador*

Newfoundland & Labrador Centre for  
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HEALTH  
RESEARCH**  
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*To support our Health System Partners, CHRSP has produced this Snapshot Report of health care practices, processes, and protocols inside and outside of Canada. This report is designed to inform decision-makers about the healthcare landscape across jurisdictions, particularly with respect to practice variation and policy initiatives. It will also help guide topic selection for other CHRSP products, such as our Evidence in Context Reports and Rapid Evidence Reports.*

# 1. About *Snapshot* Reports

In 2016, the NL Centre for Applied Health Research (NLCAHR), under its Contextualized Health Research Synthesis Program (CHRSP), introduced *Snapshot Reports* to provide rapid decision support for stakeholders in the NL health system.

*Snapshot Reports* provide a brief scan of health policies, practices or models and a summary of established or emerging interventions that have been carried out on the issue in question in jurisdictions outside Newfoundland and Labrador. This new format was developed in response to demand from our health system stakeholder for timely information about policies/practices/models in other jurisdictions that might be suitable for adaptation within the NL context. *Snapshot Reports* are prepared in response to specific requests from CHRSP's health system stakeholders on topics identified by the health system as being of immediate interest. The results of a given *Snapshot Report* may provide all the information required or it may indicate that further study is needed, possibly in the form of a CHRSP *Evidence in Context Report* or of a *Rapid Evidence Report*

*Snapshot Reports* are not intended to be a comprehensive or exhaustive evaluation of the practice or policy under study; rather, they offer a brief overview that includes:

- an executive summary;
- the research objective that clearly states the policy or practice under consideration;
- the focus and scope of the report;
- a summary of key descriptive findings;
- a table listing the practices/policies/models identified in other jurisdictions, with web links to each where available; and
- an appendix containing more detailed information.

Given the limitations of this approach, *Snapshot Reports* should not be construed as a recommendation for or against the use of any particular healthcare intervention or policy.

## 2. Executive Summary

**Topic:** Upon request from senior health system decision makers in Newfoundland and Labrador, members of the CHRSP research team at NLCAHR have completed a jurisdictional scan of mental health and addictions service delivery models and best practices that, in other Canadian provinces and selected foreign jurisdictions, provide services in rural and remote communities and include psychiatry as a key component. This research is to assist the action plan laid out in *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador*.

**Study Approach:** For this study, we searched Canadian government and publicly available websites, including provincial and territorial governments and relevant mental health agencies, to identify approaches to delivering mental health and addictions services in rural and remote communities. We also explored publicly available information in several international jurisdictions. In addition, we contacted key informants in each of the provincial and territorial governments involved, requesting information on how their province or territory delivers mental health services to its rural and remote communities and for contact information regarding specific programs or policies highlighted in their response.

### Key Findings:

- Our jurisdictional scan uncovered nine rural mental health and addictions programs and services of interest. Six were found during our initial online search, while three were discovered during our key informant discussions.
- Highlights from the programs and services in the scan include:
  - *Use of technology:* nearly all of the programs identified used innovative digital information and communication technologies to reach rural and remote regions.
  - *Supporting primary care providers:* many jurisdictions are using models in which psychiatrists support primary care providers in rural and remote settings by means of consultations and education.
  - *Improving coordination of care:* a common goal of many programs is to improve coordination of care for rural and remote patients.
  - *Travelling clinics:* travelling clinics were commonly used to complement other community services.
  - *Increasing focus on northern areas:* strategies with a particular focus on the specific geographic, demographic and cultural challenges in northern regions are becoming more prominent.

### 3. Background & Research Objective

Newfoundland and Labrador has a geographically dispersed population that poses challenges to service delivery across the health care system. These challenges are particularly apparent in mental health and addictions services with their traditional focus on hospital-based care and face-to-face individual or group psychiatry. Currently, the province's only specialized psychiatric hospital and the majority of its psychiatrists are located in and around St. John's, resulting in inequitable access to services across the province.

Reforming mental health and addictions care is a priority for the NL health system. *Towards Recovery: A Vision for a Renewed Mental Health and Addictions System for Newfoundland and Labrador* lays out a clear action plan with short, medium, and long-term goals that are organized by five themes:

- the need for improved mental health promotion and mental illness and addiction prevention;
- better access to more services;
- better quality of care; the need for improved policy and programming; and,
- the need for strengthened community supports.

On March 29, 2018 the provincial government announced plans to build a new mental health and addictions facility in St. John's, along with a mental health unit in Happy Valley-Goose Bay, and to expand a series of community-based services, including assertive community treatment (ACT) and flexible ACT teams, community crisis beds, 24/7 supervised living arrangements, and mobile crisis response teams.

To support this ongoing system transformation, senior health system decision makers in NL asked NLCAHR to conduct a jurisdictional scan of mental health and addictions service delivery models and best practices in other Canadian provinces that provide services in rural and remote communities and that include psychiatry as a key component.

# 4. Focus and Scope of this report

The main focus of this report was to locate models and best practices for rural and remote mental health services that include psychiatry as a key component. The methodology used to complete this project was intended to generate a summary for decision makers that will outline programs and models being implemented in other jurisdictions rather than providing a comprehensive or exhaustive list of all rural mental health services and policies across Canada or from other jurisdictions. Below, we outline the search parameters, discuss the search strategy, and provide an overview of the findings.

### Search parameters

Table 1 outlines the parameters of our search. The search criteria for this report were refined in consultation with the health system partners who proposed the research question at Eastern Health, and with officials from the Department of Health and Community Services.

**Table 1: Search Parameters, Inclusion and Exclusion Criteria**

Parameter	Inclusion criteria	Exclusion criteria
Population	<ul style="list-style-type: none"> <li>all patients</li> <li>all age groups</li> <li>all conditions</li> </ul>	<ul style="list-style-type: none"> <li>in-patients</li> </ul>
Areas of program focus	<ul style="list-style-type: none"> <li>mental health and addictions services</li> <li>psychiatry services</li> <li>psychology services</li> </ul>	<ul style="list-style-type: none"> <li>no psychiatrist involvement</li> </ul>
Settings where program is implemented	<ul style="list-style-type: none"> <li>rural or remote communities</li> </ul>	<ul style="list-style-type: none"> <li>urban communities</li> </ul>
Who manages the program	<ul style="list-style-type: none"> <li>provincial departments of health</li> <li>regional health authorities</li> <li>universities</li> <li>other organizations (e.g., Canadian Mental Health Association)</li> </ul>	<ul style="list-style-type: none"> <li>none</li> </ul>
Jurisdictions	<ul style="list-style-type: none"> <li>Canadian provinces and territories</li> <li>selected international jurisdictions (i.e., United Kingdom, Australia, New Zealand)</li> </ul>	<ul style="list-style-type: none"> <li>none</li> </ul>

## Search Strategy

**Online search:** We began the search process by exploring Canadian government and publicly available websites, including the websites of provincial and territorial governments and relevant mental health agencies (e.g., the Mental Health Commission of Canada, Ontario's Centre for Addiction and Mental Health, the Canadian Mental Health Association, and the Canadian Psychiatric Association). Best practice databases (e.g., Canada Health Evidence and CADTH) were also searched. The goal of the search was to identify approaches to delivering mental health and addictions services in rural and remote communities that include psychiatry as a key component of mental healthcare delivery. Programs that did not have a psychiatric component were excluded. We used a data extraction table (Appendix A) to identify key features of the programs. Six programs were identified through the online search.

While the focus of our search was to identify Canadian approaches, we also explored publicly available information from several international jurisdictions. Unfortunately, this search did not yield any useful information on specific approaches to mental health and addiction services.

**Key informants:** The next step was to ask stakeholders in each of the provincial and territorial governments the following questions:

1. How does your province/territory deliver mental healthcare to its rural and remote communities? Here, please name any relevant programs that your province has developed (that include psychiatry services as a key component) and provide an overall policy statement (one or two sentences or refer to an online resource) that summarize your province/territory's approach to mental healthcare delivery within its rural jurisdictions.
2. Please provide contact name(s) and email(s) so we can follow-up with the appropriate leader(s)/ decision maker(s) responsible for the rural mental healthcare programs/policies mentioned above.

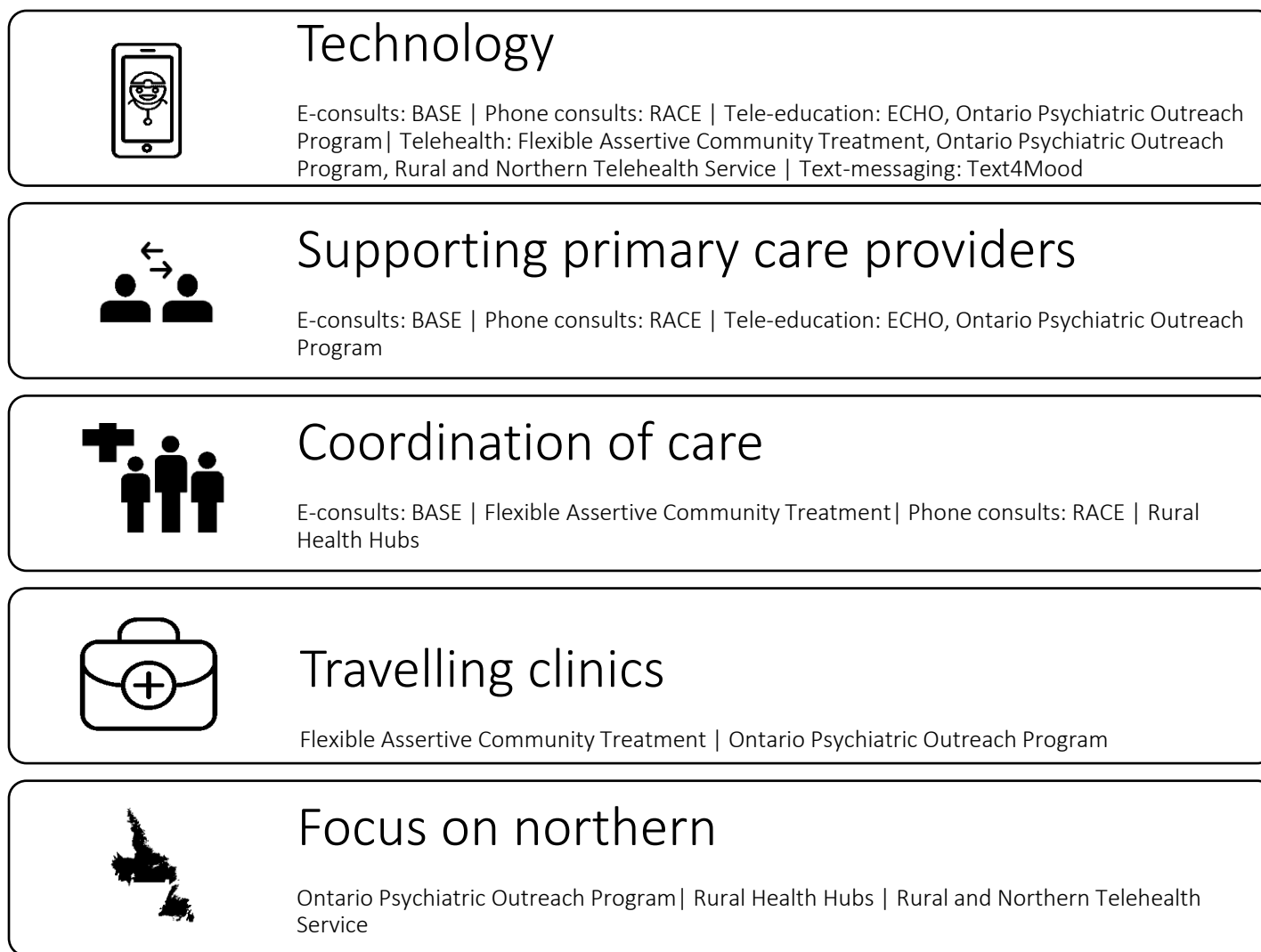
Nine of twelve inquiries yielded a response, either via telephone or via email. Additional informants identified in these consultations were then contacted. This process uncovered three additional programs that had not been found through our online search and provided other useful information about provincial and territorial mental health and addictions strategies (Appendix A).

## 5. Summary of Key Findings

Across Canada, various innovative models are being used to deliver psychiatric services to rural and remote communities. Emerging themes, identified across the programs described in this report, are highlighted below:

- **Use of technology:** Technology is a powerful tool to increase access to mental health and addiction services in our large, sparsely-populated country. Nearly all of the programs identified in this report use digital information and communication technologies to reach rural and remote regions. Many use audiovisual technologies to administer telehealth, telepsychiatry or videoconferencing services, while others use phone lines, apps, or email to deliver services, consultations or education for healthcare providers.
- **Supporting primary care providers to provide mental health and addictions services:** Many jurisdictions are using models in which psychiatrists support primary care providers to deliver mental health and addictions services in rural and remote communities. Most often, this support is achieved through timely consultations between psychiatrists and primary care providers working on the ground in rural areas, which helps to reduce wait times for non-urgent cases, improves the patient experience, and provides peer-to-peer education to enhance skills for primary care providers. Another strategy is providing tele-education for primary care providers on specific mental health and addiction topics.
- **Improving coordination of care:** A common goal is to improve coordination of care for rural and remote patients to simplify the patient's journey through the healthcare system. Programs typically depend upon a high level of collaboration between healthcare providers and community-based workers/resources to improve access and transitions, and to create improved, more timely responses to patient needs.
- **Travelling clinics:** Some programs use travelling psychiatry clinics, or intermittent community visits, to complement other services available within a rural or remote community. These models provide psychiatric services to patients as close to home as possible, with some care occurring in community clinics and some occurring in schools or in a patient's home. Bringing psychiatrists into rural and remote communities also improves coordination and collaboration between specialists and primary care providers.
- **Increasing focus on northern areas:** There is an increasing focus on mental health and addictions strategies for northern regions, with their specific geographic, demographic and cultural challenges. For example, technology is being harnessed to provide care where there are geographic barriers to service delivery in northern communities that are fly-in only or have limited road access. In areas with high rates of youth mental illness or addiction, early intervention programs targeted at youth have been implemented. Another innovation is rural health hubs, where a number of core healthcare services are available in one location.





**Figure 1: Emerging Themes in Rural and Remote Mental Health and Addictions Care**

## 6. Summary Tables

The following summary tables contain the key components of the nine Canadian rural mental health and addiction programs identified in this jurisdictional scan. For each program identified, the tables provide decision makers with the following key information:

- an overview of the program and the province in which it is administered;
- a brief description of the communities where services take place;
- information about service users;
- information about service providers;
- details about the way the program is delivered;
- the types of interventions performed;
- key outcomes of the program; and
- financial considerations.
- hyperlinks to program websites, where available

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Appendix A on page 20 provides decision makers with more detailed information about the programs within each Summary Tables.

Appendix B on page 37 includes information from other Canadian jurisdictions and points raised by key informants that were not included in the Summary Tables.



**TABLE 1: Telepsychiatry in Rural Nova Scotia**

<b>About the Program:</b>						
Nova Scotia’s Inverness/Cheticamp Telepsychiatry Program, initiated in 2002, uses electronic communication and information technologies to provide and support clinical psychiatric care at a distance. It was initially a pilot project developed to provide improved access to psychiatric care in underserved communities in rural Cape Breton. The program has now become a highly utilized service which allows clients to be supported locally in their own communities. The clinician at the remote site works in conjunction with the attending psychiatrists at a distance.						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>• Small, rural communities</li> <li>• Long commuting distances to urban centres</li> <li>• Small catchment area</li> </ul>	<ul style="list-style-type: none"> <li>• Individuals with psychiatric diagnoses</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrist</li> <li>• Nurse</li> <li>• Social worker</li> <li>• Family physician</li> </ul>	<ul style="list-style-type: none"> <li>• Telepsychiatry</li> <li>• Outpatient</li> <li>• In existing community health settings</li> <li>• Referral required</li> </ul>	<ul style="list-style-type: none"> <li>• Initial assessment</li> <li>• Diagnosis and follow-up</li> <li>• Clinical interviews</li> </ul>	<ul style="list-style-type: none"> <li>• Increased access to service</li> <li>• Improved partnerships and collaboration</li> <li>• Consistent care</li> </ul>	<ul style="list-style-type: none"> <li>• Funded by the Nova Scotia Government</li> </ul>

**TABLE 2: New Brunswick’s Flexible Assertive Community Treatment (FACT)**

<b>About the Program:</b>						
Flexible Assertive Community Treatment (FACT) is a comprehensive service delivery model based on the observation that people who are the most severely mentally ill have episodic rather than continuous needs for more intensive services. FACT enables clients to move back and forth between higher and lower intensity services, such that a higher number of clients with serious mental illness can be provided services. FACT offers treatment, rehabilitation, support, guidance and assistance in activities of daily living, services coordination and community outreach. FACT has been instituted based on the <i>Action Plan for Mental Health</i> in New Brunswick 2011-2018.						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>• FACT available in rural and urban NB</li> <li>• Demographics vary considerably from one region to another</li> <li>• For rural areas, there can often be long commute times to get to clients</li> </ul>	<ul style="list-style-type: none"> <li>• Adults 19 years and over with a serious mental illness</li> <li>• Clients with schizophrenia, other psychotic disorders, bipolar disorder and depression</li> <li>• Not those with personality disorder, substance abuse disorder, developmental disability or organic disorder</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrist</li> <li>• Nurses</li> <li>• Social workers</li> <li>• Human service counsellors</li> <li>• Occupational therapy</li> <li>• Psychologist</li> <li>• Peer support</li> <li>• FACT coordinator</li> </ul>	<ul style="list-style-type: none"> <li>• Services are offered where the clients are, as close to their natural environment as possible</li> <li>• Videoconferencing, skype or other technology may be used in smaller rural offices</li> </ul>	<ul style="list-style-type: none"> <li>• Pharmacotherapy and medication management education</li> <li>• Psycho-education on illness, illness management and recovery</li> <li>• Peer support</li> <li>• Dual diagnosis treatment</li> <li>• Early psychosis intervention</li> <li>• CBT</li> <li>• Motivational intervention and stages of change</li> <li>• Education and support for ADL</li> <li>• Rehabilitation and skills development</li> <li>• Integrated addiction and mental health treatment</li> <li>• Family intervention and support</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation outcomes are being measured in the following areas:                             <ul style="list-style-type: none"> <li>○ psychiatric hospitalization,</li> <li>○ incarceration,</li> <li>○ education,</li> <li>○ employment,</li> <li>○ stage of substance abuse treatment,</li> <li>○ housing,</li> <li>○ family/natural support involvement, and</li> <li>○ community inclusion</li> </ul> </li> <li>• Initial evaluation of this program is ongoing</li> </ul>	<ul style="list-style-type: none"> <li>• Department of Health for NB added additional human resources to all regions of the province</li> <li>• Mental health centers utilize current human resources as well to complete FACT teams</li> <li>• Psychiatrists are a mix of fee for service and salaried</li> </ul>

**TABLE 3: Ontario’s Champlain BASE eCONSULT Program**

**About the Program:**

[The Champlain BASE™ \(Building Access to Specialists through eConsultation\) eConsult service](#) is a secure online platform connecting primary care providers and specialists. The program was initiated in 2009, in the Champlain Local Health Integration Network (LHIN), to address the issue of long-wait times for patients with non-urgent health concerns to see certain specialties. Psychiatry is one of the specialties available through eConsult. As of December 31st, 2017, a total of 33,327 cases have been completed by 1,355 registered primary care providers (1,160 family physicians and 195 nurse practitioners) from 449 clinics in 105 towns/cities, who can access 105 specialty services.

The service is currently [being expanded across other parts of Canada](#), including a [demonstration project in Newfoundland and Labrador](#).

Community Profile	Service Users	Service Providers	Program Delivery	Interventions	Outcomes	Financial Considerations
<ul style="list-style-type: none"> <li>Champlain LHIN covers the Ottawa region of Eastern Ontario</li> <li>1.2 million patients</li> <li>Five sub-regions with complex differences in <a href="#">population health profiles</a> including: rurality, Aboriginal population, primary language, demographics</li> </ul>	<ul style="list-style-type: none"> <li>Patients who receive care from a primary care provider (family physician or nurse practitioner)</li> </ul>	<ul style="list-style-type: none"> <li>Primary care provider</li> <li>Specialist physician</li> </ul>	<ul style="list-style-type: none"> <li>Web-based portal</li> <li>Service builds on existing infrastructure</li> <li>Technical support: user support service for technical troubleshooting, information technology</li> <li>Human resources support: project coordination, clinician engagement and training</li> </ul>	<ul style="list-style-type: none"> <li>eConsult: a primary care provider electronically sends a question to a specialist, potentially avoiding the need to refer the patient to a specialist</li> </ul>	<ul style="list-style-type: none"> <li>Reduced wait times for accessing specialist care for non-urgent cases from months to days, with an average wait time of two days</li> <li>40% of cases resulted in avoidance of an unnecessary face-to-face referral</li> <li>Large impact on cost savings: weighted average cost of an eConsult case across specialty groups is \$47.35, compared to \$133.60/case for traditional referrals</li> <li>Service is highly rated by providers and patients</li> <li>Educational benefits for primary care providers</li> </ul>	<ul style="list-style-type: none"> <li>Ongoing service costs covered by the Champlain LHIN (staff, infrastructure, specialist payments), the Bruyère Research Institute, The Ottawa Hospital (infrastructure) and multiple research grants</li> <li>Majority of specialists receive compensation at a rate of \$200/hr</li> <li>Primary care providers are not compensated</li> </ul>

**TABLE 4: Ontario’s Rural Health Hubs**

About the Program:						
<p><a href="#">The Rural Health Hubs</a> pilot project, initiated in Ontario in 2012, allows local health and social service providers, through formal agreements and partnerships, and on-going community consultation, to improve the coordination and effectiveness of care for a defined population and/or geographic area. Each rural health hub is locally defined and tailored to the community. A rural health hub is flexible, not one size fits all, is innovative, based on local need and provides coordinated access to care. To be successful, health hubs need to have formal linkages and agreements with at least one regional referral center to ensure access to specialized care. Core service requirements to be provided by a local health hub: emergency and inpatient care, comprehensive primary care, home and community long term care, mental health and addiction.</p>						
Community Profile	Service Users	Service Providers	Program Delivery	Interventions	Outcomes	Financial Considerations
<ul style="list-style-type: none"> <li>• Small, rural and northern (SRN) communities</li> <li>• 5 Pilot sites in the province</li> <li>• Population less than 20,000 but there may be exceptions for remote northern communities</li> <li>• Initial rural health hub discussions should always stay focused on the needs of clients/caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• Services are provided to a variety of areas across the province, and as such there is no specific service user</li> </ul>	<ul style="list-style-type: none"> <li>• Core Services: Acute Care (inpatient &amp; outpatient), ER, Complex Continuing Care, Rehab, Long Term Care facilities and community support services, <b>Community Mental Health &amp; Addictions</b>, Homecare, Primary Care</li> <li>• Additional Partners: EMS, Public Health, Social Services</li> </ul>	<ul style="list-style-type: none"> <li>• No specific programs discussed but the vision is that care will be delivered collaboratively based on trusting relationships using interprofessional teams</li> </ul>	<ul style="list-style-type: none"> <li>• Targeted Prevention Services</li> <li>• Information, Assessment and Referral Services</li> <li>• Counselling and Therapy Services</li> <li>• Peer and Family Capacity Building Support</li> <li>• Specialized Consultation and Assessment</li> <li>• Intensive Treatment Services</li> <li>• Crisis Services</li> </ul>	<ul style="list-style-type: none"> <li>• Greater responsiveness to the needs of patients/clients/residents</li> <li>• Improved access and transitions of care to improve patient/client/resident experiences</li> <li>• Reduced travel costs based on care closer to home</li> <li>• Shared (common) client intake process so patients only have “To Tell Their Story” once</li> <li>• More robust patient and family engagement</li> <li>• Better system navigation and transitions of care</li> <li>• Comprehensive supports for seniors</li> <li>• Shared electronic patient records</li> </ul>	<ul style="list-style-type: none"> <li>• Single Governance Structure (achieved through voluntary or facilitated integration process)</li> <li>• An important enabler of the Local Health Hub model is the creation of a single funding envelope which is provided to a lead organization. The benefits of moving to a single fundholder model have been well documented by the Ontario Hospital Association and others</li> </ul>

**TABLE 5: Ontario Psychiatric Outreach Program**

<b>About the Program:</b>						
<p><a href="#">The Ontario Psychiatric Outreach Program (OPOP)</a> was formed in 1999 at the request of the Ontario Ministry of Health and Long-Term Care (MOHLTC). OPOP is a unique collaborative network of dedicated academics and practitioners in the field of mental health, providing on-site and telepsychiatry clinical services, education and support to remote and rural communities throughout Ontario. OPOP is funded through the Underserved Area Program of the Ontario Ministry of Health and Long-Term Care.</p>						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>There are no specific community profiles for OPOP, as they provide services to individuals across the province</li> </ul>	<ul style="list-style-type: none"> <li>There is no one specific kind of service user, as the demographics and disorders treated are highly variable</li> </ul>	<ul style="list-style-type: none"> <li>Psychiatrists and resident psychiatrists who provide on-site and telepsychiatry clinical services, education and support to remote and rural communities</li> </ul>	<ul style="list-style-type: none"> <li>Telepsychiatry</li> <li>Fly-in</li> <li>Drive-in</li> <li>Consultation services</li> <li>Education services</li> <li>Visiting specialist clinics</li> </ul>	<ul style="list-style-type: none"> <li>There are no specific interventions provided to service users in this program, as the clients and communities vary</li> </ul>	<ul style="list-style-type: none"> <li>A multidisciplinary, contextually relevant, community-oriented psychiatric and mental health service</li> </ul>	<ul style="list-style-type: none"> <li>OPOP is funded through the Underserved Area Program of the Ontario Ministry of Health and Long-Term Care</li> </ul>

**TABLE 6: ECHO Ontario**

<b>About the Program:</b>						
<p>ECHO Ontario is a tele-education model that addresses urban-rural disparities in access to specialist care by building capacity at the community level. A Specialist ‘Hub’ supports primary care providers (‘Spokes’) across the province by building a virtual community of practice, and disseminating best practices. There are 9+ teleECHO clinics and more than 300 community sites in Ontario. Two of the teleECHO clinics are focused on mental health: <a href="#">Mental Health and Addictions</a> and <a href="#">Child and Youth Mental Health</a>. These programs leverage technology and the high concentration of psychiatrists and other specialized mental health experts in Ontario’s academic and urban centres to provide the best care for patients in rural parts of the province.</p> <p>Mental Health Link: <a href="https://www.porticonetwork.ca/web/echo-on-mh">https://www.porticonetwork.ca/web/echo-on-mh</a>                      Child and Youth Mental health Link: <a href="http://www.cheo.on.ca/en/project-ECHO-ontario-CYMH">http://www.cheo.on.ca/en/project-ECHO-ontario-CYMH</a></p>						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>Rural parts of the province</li> </ul>	<ul style="list-style-type: none"> <li>Rural patients with mental health and addictions needs and their primary care providers</li> </ul>	<ul style="list-style-type: none"> <li>Hub: specialized interprofessional mental health care team, including psychiatrists</li> <li>Spokes: healthcare providers in community, including physicians, nurse practitioners, nurses, social workers, counsellors and others</li> </ul>	<ul style="list-style-type: none"> <li>Weekly 2 hour virtual clinics</li> </ul>	<ul style="list-style-type: none"> <li>Tele-education model</li> <li>20-30 minutes: presentation on a clinical topic from the hub</li> <li>90 minutes: case-based learning, where spokes present de-identified cases and receive recommendations from both the hub and other spokes</li> </ul>	<ul style="list-style-type: none"> <li>There is a large evidence base for the Project ECHO model, but a 2017 Canadian study was the first to report on its use for mental health care</li> <li>The Canadian study provides evidence for knowledge translation effects and the potential for increasing primary care provider capacity in mental health and addictions in rural areas</li> </ul>	<ul style="list-style-type: none"> <li>Fully funded by Ministry of Health and Long-Term Care</li> <li>Free for primary care providers to participate</li> </ul>



**TABLE 7: Manitoba’s Rural and Northern Telehealth Service**

<b>About the Program:</b>						
<p><a href="#">The Rural and Northern Telehealth Service</a> provides mental health services via telehealth to select First Nations communities in northern Manitoba, and was developed in 2010 in response to recommendations outlined in ‘Reclaiming Hope: Manitoba’s Youth Suicide Prevention Strategy’. The program has expanded to provide services to 63 communities. It is managed by the Manitoba Adolescent Treatment Centre, and jointly financed by the Manitoba and Federal governments.</p>						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>• 63 First Nation communities in Manitoba</li> <li>• Many communities are isolated – fly in and no road access</li> <li>• Population varies from 400-10,000</li> <li>• Median age 14-15 years</li> </ul>	<ul style="list-style-type: none"> <li>• Children and adolescents between the ages of 5 and 18</li> <li>• Youth experiencing psychotic issues, trauma, suicidal ideation, ADHD, behavioural difficulties, autism, neuro-developmental problems, anxiety, depression etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health clinicians and, where appropriate, psychiatrists</li> <li>• Most service providers are located in Winnipeg, provide telehealth services daily, and visit communities as needed</li> <li>• High level of collaboration with local community services</li> </ul>	<ul style="list-style-type: none"> <li>• The majority of service delivery is via telehealth, complimented by community visits as needed</li> <li>• Referrals accepted via phone or fax from identified community professionals</li> <li>• Services accessed at local clinic or school</li> <li>• Services are outpatient</li> </ul>	<ul style="list-style-type: none"> <li>• Consultation, assessment and treatment services</li> <li>• Follow-up on individuals discharged from hospitals</li> <li>• Psychosocial rehabilitation, suicide prevention, individual therapies, mindfulness, family therapy, horticultural therapy etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluation has been challenging</li> <li>• Program has received positive feedback from the communities in which it works</li> </ul>	<ul style="list-style-type: none"> <li>• All mental health clinicians are salaried</li> <li>• Funding provided by the Manitoba Government, along with some Federal funding</li> </ul>

**TABLE 8: Alberta’s Text4Mood Program**

<b>About the Program:</b>						
<p>The Text4Mood program began in January 2016. The program provides daily supportive text messages to subscribers which have been composed by mental health therapists in collaboration with service users. Patients in Alberta can subscribe to the program by texting the word “mood” to a designated phone number. The program is based on a successful clinical trial in Alberta.</p>						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>• Patients in Northern Alberta who have inadequate access to services</li> <li>• Patients on waitlist for services</li> <li>• No specific community profile</li> </ul>	<ul style="list-style-type: none"> <li>• Children, adolescents, adults, older adults and minority populations suffering from depression, anxiety or stress-related disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Text messages created in collaboration by mental health therapists, including psychiatry, and service users</li> </ul>	<ul style="list-style-type: none"> <li>• Patients subscribe to program by texting ‘mood’ to designated number</li> <li>• Patients receive a daily supportive text message to their mobile phone</li> </ul>	<ul style="list-style-type: none"> <li>• Texts based on principles from Cognitive Behavioural Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Subscribers feel more hopeful, in charge of their mental illness, more connected to a support network</li> <li>• Improved overall mental well-being</li> <li>• Cost savings</li> </ul>	<ul style="list-style-type: none"> <li>• Technology is low cost, high impact and scalable</li> <li>• Free to users</li> <li>• Funded by Alberta Health Services</li> </ul>

**TABLE 9: British Columbia’s Rapid Access to Consultative Expertise (RACE) Program**

<b>About the Program:</b>						
<p><a href="#">Rapid Access to Consultative Expertise (RACE)</a> is an innovative model of shared care where primary care providers can call one phone number and choose from a selection of specialty services for real-time telephone advice. In 2008, the Division of Cardiology and Department of Family Medicine at St. Paul’s Hospital in British Columbia completed a pilot project where a pager was shared between three cardiologists, allowing family physicians to contact them directly to get a timely response to questions. Through a partnership with Providence Health Care, the Shared Care Committee, and Vancouver Coastal Health (VCH), this initiative was expanded beyond cardiologists to include other specialties, including psychiatry, and Rapid Access to Consultative Expertise (RACE™) was launched. RACE expanded to Manitoba in 2016.</p>						
<b>Community Profile</b>	<b>Service Users</b>	<b>Service Providers</b>	<b>Program Delivery</b>	<b>Interventions</b>	<b>Outcomes</b>	<b>Financial Considerations</b>
<ul style="list-style-type: none"> <li>• Service available across the Vancouver Coastal Health and Fraser Health Authority regions</li> <li>• Vancouver Coastal RACE</li> <li>• Fraser Valley RACE</li> <li>• South Island RACE</li> <li>• Kootenay Boundary RACE</li> <li>• Northern RACE</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care practitioners across the region (family practitioners, nurse practitioners, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatrists specializing in: eating disorders – psychiatry, geriatric psychiatry, psychiatry adult; (provincial services) addictions medicine, child and adolescent psychiatry, perinatal addictions, perinatal psychiatry</li> </ul>	<ul style="list-style-type: none"> <li>• RACE provides structure, through one phone line, to an organized specialist coverage rotation, timely call back and specialists who will provide an educational experience for the primary care provider to enhance the care of their patients</li> <li>• 80% of calls are returned within 10 minutes</li> </ul>	<ul style="list-style-type: none"> <li>• RACE provides an opportunity to speak with specialists, timely guidance and advice, assistance with plan of care, learning opportunities, enhanced ability to manage the patient in the caller’s office</li> <li>• The use of SBAR (Situation, Background, Assessment, Recommendation) is encouraged on phone calls</li> </ul>	<ul style="list-style-type: none"> <li>• Simplifies the patient journey</li> <li>• Improves patient outcomes</li> <li>• Reduces system costs</li> <li>• Connects primary care with specialists</li> </ul>	<ul style="list-style-type: none"> <li>• Family Physicians General Practice Urgent Telephone Conference with a Specialist Fee: \$40.00</li> <li>• Specialist Telephone Advice Fee - Response within 2 hours - \$60.00</li> <li>• Specialist Telephone Patient Management Fee -Initiated by a Nurse Practitioner – per 15 minutes or portion thereof - \$40.00</li> </ul>

# 8. Appendices

## Appendix A: Detailed Data

This section contains more detailed information on the programs listed in the nine Summary Tables. Associated web links are included, where available. Most of the information is taken directly from websites and reports associated with the programs; however, some details were ascertained through telephone interviews or additional materials provided by key informants.

### Data Extraction – Rural and Remote Mental Health and Addictions Service Delivery Models/Programs

Program name	1. Telepsychiatry in Rural Nova Scotia
Province	Nova Scotia
Description	Telepsychiatry can be an effective vehicle to provide mental health services to rural and remote communities. It can also offer support for professionals who live and work in these areas. In Nova Scotia, there was a recognized need to provide consistent care in areas with no access to psychiatry. A collaborative approach to providing care closer to home, despite barriers, was required. The <i>Inverness/Cheticamp Telepsychiatry Program</i> uses electronic communication and information technologies to provide and support clinical psychiatric care at a distance. It was initially a pilot project developed to provide improved access to psychiatric care in underserved communities in rural Cape Breton. The program has now become a highly utilized service which allows clients to be supported locally in their own communities. The clinician at the remote site works in conjunction with the attending psychiatrists at a distance.
Community profile	The communities involved in this telepsychiatry program are small, rural communities in Nova Scotia with a long commuting distance to either Sydney or Halifax. These areas have seen population decline, have fewer households in highest income category and have high medical co-morbidities. Clinics that offer telepsychiatry have small catchment areas of approximately 15, 000 people.
Service users	Individuals diagnosed with illnesses such as schizophrenia, major depressive disorder, dysthymia, anxiety disorders etc.
Service providers	Nurses, social workers, family physicians and visiting psychiatrists are all involved in the collaboration of this service.
Program delivery	The program is delivered through telepsychiatry using existing community health care infrastructure. Referral is required.
Interventions	<p>The <b>planned activities</b> commence with an initial assessment by a rural clinician who then refers clients for a face-to-face interview with the program psychiatrist at the consultation site. There is a pre-existing relationship between the client, the remote clinician(s), and the attending psychiatrist. Once diagnosis and the need for follow-up has been determined, telepsychiatry becomes an option. Clients can be followed in a comprehensive approach through this application.</p> <p>Orientation to the telepsychiatry program begins at the initial assessment phase. This is where the concept and purpose of the model is introduced to potential users. It is made clear that the intent is not to replace face-to-face contact but that telepsychiatry is an alternative to traveling long distances, or not receiving service locally at all.</p> <p>Once appointments are arranged, a number of activities are implemented to ensure compliance with attendance. This includes an appointment card mail out and prior to the</p>

	day of telepsychiatry, a reminder call to enhance consistent attendance to scheduled appointments. The clinical interview via telepsychiatry involves the client, the remote clinician, the psychiatrist, and at times others, such as the family physician or medical social worker.
<b>Outcomes</b>	<p>The <b>goals</b> of this rural telepsychiatry program are:</p> <ul style="list-style-type: none"> <li>• To increase access to Mental Health Services to residents in rural areas who are geographically isolated and underserved</li> <li>• To provide and support clinical psychiatric care at a distance</li> <li>• To increase partnerships and collaborative relationships with internal and external care/service providers, as well as clients and families, to improve the effectiveness and efficiency of rural mental health services</li> <li>• Recognized need to provide consistent care to an area with no resident psychiatrist</li> <li>• Collaborative approach to providing treatment closer to home despite barriers</li> </ul>
<b>Financial Considerations</b>	Program is funded by the Government of Nova Scotia

<b>Program name</b>	<b>2. Flexible Assertive Community Treatment</b>
<b>Province</b>	New Brunswick
<b>Description</b>	FACT is a comprehensive service delivery model that was developed over the last ten years in the Netherlands. The model is based on the observation that people who are the most severely mentally ill have episodic rather than continuous needs for more intensive services. FACT enables clients to move back and forth between higher and lower intensity services, such that a higher number of clients with serious mental illness can be provided services. FACT offers treatment, rehabilitation, support, guidance and assistance in activities of daily living, services coordination and community outreach. FACT has been instituted based on the <i>Action Plan for Mental Health in New Brunswick 2011-2018</i> .
<b>Community profile</b>	FACT services are available in both rural and urban New Brunswick. Demographics of clients vary considerably from one region to another. Challenges are often faced reaching rural and remote clients, as some require long commutes.
<b>Service users</b>	FACT services are intended for adults 19 years and over with a serious mental illness (psychiatric disorders that cause symptoms and impairments in basic mental and behavioural processes) and significant functional impairment. Clients are actively involved in the development of their treatment and recovery plan, along with family members and natural supporters, as necessary. The largest group serviced by FACT is composed of clients with schizophrenia, other psychotic disorders, bipolar disorder and depression. Individuals with a primary diagnosis such as personality disorder, substance abuse disorder, developmental disability or organic disorders are not the intended client group.
<b>Service providers</b>	<p>A full FACT team includes: psychiatrists, nurses, social workers, human service counsellors, occupational therapists, psychologists, peer support and FACT coordinators. Human resources needs are factored based on client volume, such that in larger centres there is a full FACT team, and in smaller rural centers there are half teams or smaller.</p> <ul style="list-style-type: none"> <li>• <b>Psychiatrists</b> function as team members, not just as consultants; they provide clinical services to all FACT clients, work closely with team members to monitor each client's clinical status and response to treatment, and direct psychopharmacologic, medical services and other clinical care.</li> <li>• <b>Nurses</b> provide a full range of assessment, treatment and rehabilitation services, offer education about serious mental illness and the role of medication in treatment, administer depot medication, coordinate medication regimes with the client and promote healthier living patterns.</li> <li>• <b>Social workers</b> are involved in developing and providing therapeutic interventions with the client and through group intervention, ensure family member engagement and partnership, are involved in building relationships with critical stakeholders, and provide a full scope of case management responsibilities.</li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Human service counsellors</b> participate in assessment of clients, play a key role in rehabilitation through mentoring and teaching life skills to enhance daily functioning of clients, connects clients to community resources, and play a key role when a client requires high intensity services.</li> <li>• <b>Occupational therapists</b> focus on enabling the client to participate meaningfully in activities of daily living, and may also provide vocational leadership within FACT services.</li> <li>• <b>Psychologists</b> are involved in assessing and diagnosing the client’s needs, abilities or behaviours using a variety of methods. They bring a distinctive perspective to the team, and promote evidence based practices, such as CBT, motivational interviewing, relapse prevention and approaches aimed at reduction of positive symptoms, adaptation to illness and improvement of psychosocial functioning.</li> <li>• <b>Peer support</b> is a person with lived experience with a mental health or concurrent substance abuse challenge or illness. They are a fully integrated team member who provides individualized services, advocates and empowers clients, educates and connects clients to community resources, and assists client in maintaining, developing or renewing interpersonal connections with natural support network. Peer support plays a key role during high intensity interventions.</li> <li>• <b>FACT coordinators</b> lead client-centered assessment and individualized treatment planning by working side-by-side with the client and the FACT service providers, as well as providing clinical consultation. They organize and participate in FACT meetings and treatment planning meetings.</li> </ul>
<b>Program delivery</b>	<p>FACT is a community based and outreach service, offering services where clients are, where clients need them, as close to their natural environment as possible. Most services are provided during home visits but may include other community settings. New referrals for adults with a serious mental illness proceed according to provincial guidelines. Service providers at a patient’s initial access to the healthcare system complete an assessment to determine if services are required, the priority in the provision of services and the type of services needed. When FACT is deemed the appropriate service, the internal process for each Centre shall be followed when transferring the client’s care for on-going services. Videoconferencing, Skype/Lync or other technology may be an option in smaller rural offices to link with larger FACT services to coordinate treatment planning.</p>
<b>Interventions</b>	<p>FACT uses recovery-oriented, strength-based and evidence-based practices, such as:</p> <ul style="list-style-type: none"> <li>• Pharmacotherapy and medication management education</li> <li>• Psycho-education on illness, illness management and recovery</li> <li>• Peer support</li> <li>• Dual diagnosis treatment</li> <li>• Early psychosis intervention</li> <li>• Cognitive behavioral therapy (CBT)</li> <li>• Motivational intervention and stages of change</li> <li>• Education and support for activities of daily living and adoption of a healthy lifestyle</li> <li>• Rehabilitation and skills development (e.g., social and interpersonal skills)</li> <li>• Integrated addiction and mental health treatment when required</li> <li>• Family intervention and support</li> </ul> <p>Clients have access to crisis/emergency services 24/7 from different agencies/programs; namely FACT, mobile crisis services, Telecare and other community agencies. The provision of family support and education specific to FACT families and natural supports is an essential component of FACT service delivery. FACT provides two levels of intervention, depending on the client’s changing needs:</p>

	<ul style="list-style-type: none"> <li>• <b>Individual caseload:</b> Treatment, rehabilitation, support, guidance and assistance in activities of daily living (ADL) are coordinated by the primary service provider, and may include other members of the interdisciplinary team as needed. Services are provided through community outreach (i.e.: in the client’s home or community visits) and take place approximately two to four times a month. The primary service provider may request services from other team members as needed, according to the client’s needs, goals and intervention plan.</li> <li>• <b>Shared caseload:</b> When the client’s needs and risk are increasing, FACT moves to another level of service and provides intensive treatment and care using a shared team approach and assertive community outreach is provided to these specific clients. For this group of clients, the high intensity and complexity of needs require more than one service provider to ensure that services are organized and provided effectively. These clients may also need coordinated services from multiple agencies, family involvement, major decisions to be undertaken, risk assessment, etc. The responsibility for treatment planning and services offered is shared among all service providers.</li> </ul>
<p><b>Outcomes</b></p>	<p>FACT evaluation shall occur every two years. A baseline evaluation using the FACT Fidelity Scale is to occur when starting FACT services to determine what core components are already in place and to develop an action plan on the areas that require improvement. The FACT fidelity evaluation is conducted internally by FACT Coordinators who evaluate sister centers, thus maintaining consistency in an objective evaluation process. The purpose of the FACT Fidelity Scale evaluation is to determine whether services are being delivered in a way that research has shown will result in clients achieving their recovery goals and identify areas of strengths and areas for improvement. Every mental health service intervention has both immediate and long-term client goals. In addition, clients have goals for themselves, which they hope to attain by receiving mental health services. These goals translate into outcomes and the outcomes translate into specific measures.</p> <p>Each FACT service will measure:</p> <ul style="list-style-type: none"> <li>• Psychiatric hospitalization</li> <li>• Incarceration</li> <li>• Education</li> <li>• Employment</li> <li>• Stage of substance abuse treatment</li> <li>• Housing</li> <li>• Family/natural support involvement</li> <li>• Community inclusion</li> </ul> <p>The instrument to capture this information is the <i>FACT Outcomes Report Form</i>, and this is completed quarterly for each FACT client.</p>
<p><b>Financial Considerations</b></p>	<p>A province-wide scan of resources and potential clients was performed, and based on these results the Department of Health provided additional human resources to all regions (mostly occupational therapists, human resource counsellors and peer helpers). Mental health centers may also have to utilize some of their existing human resource availability to complete the FACT teams. Psychiatrists on the teams are a mix of fee for service and salaried.</p>

3. Champlain eConsult	
<b>Program name</b>	3. Champlain eConsult
<b>Province</b>	Ontario, Champlain LHIN
<b>Description</b>	The <a href="#">Champlain BASE™</a> (Building Access to Specialists through eConsultation) eConsult service is a secure online platform connecting primary care providers and specialists. <a href="#">The program was initiated in 2009, in the Champlain Local Health Integration Network (LHIN), to address the issue of long-wait times for patients with non-urgent health concerns to see certain specialties.</a> Psychiatry is one of the specialties available through eConsult. The service is currently being expanded across Ontario and Canada, including <a href="#">a demonstration project in Newfoundland and Labrador.</a>
<b>Community Profile</b>	<ul style="list-style-type: none"> <li>Champlain LHIN covers the Ottawa region of Eastern Ontario, with a population of 1.2 million patients.</li> <li>Five sub-regions with complex differences in <a href="#">population health profiles</a> including: rurality, Aboriginal population, primary language, demographics.</li> </ul>
<b>Service Users</b>	<ul style="list-style-type: none"> <li>Patients who receive care from a primary care provider (family physician or nurse practitioner).</li> </ul>
<b>Service Providers</b>	<ul style="list-style-type: none"> <li>Primary care provider, specialist physician                             <ul style="list-style-type: none"> <li>Primary care provider (or their delegate, such as an assistant or office administrator) submits a question.</li> <li>Specialist physician provides an answer to the primary care provider.</li> </ul> </li> <li>Specialty groups offered can vary and should be chosen to benefit the population being served.</li> <li>Primary care provider holds the duty of care to proceed with the eConsult and move the interaction into the patient record.</li> <li>There are many restrictions on interprovincial consultations, virtual and in-person. Provincial regulations set by each College govern credentialing guidelines and rules for licensure, which may restrict clinicians from submitting or answering consultants from outside their home province. The rules around eConsults are not always clear. For example, many communities in the territories are linked to a larger centre in a neighbouring province for consultations, but these are exceptions, not the norm.</li> </ul>
<b>Program delivery</b>	<ul style="list-style-type: none"> <li>Web-based portal – a secure platform based on Microsoft SharePoint, a standard off-the-shelf platform – that meets standards set by patient privacy legislation.</li> <li>Service builds on existing infrastructure.</li> <li>Ongoing technical and human resources support, including: a small user support service available to respond promptly to questions, particularly during business hours, by email and/or telephone; project coordination; information technology (E.g. system updates); clinician engagement and training.</li> </ul>
<b>Interventions</b>	<ul style="list-style-type: none"> <li><u>How it works:</u> The PCP submits a question via a web-based portal, requiring minimal demographic information (specialist type, confirmation of patient consent, date of birth, and gender) and any additional information they may wish to attach (e.g., test results, images, EMR-generated letter). Next, the Champlain LHIN Regional eConsult Specialist assigns the case to a specialist physician based on availability. The specialist receives an email notification prompting them to access the case via a secure site. They are expected to provide an answer within one week, although the average response time is two days. They can reply to the question, request additional information or recommend a referral, as well as advise the PCP on other matters such as medication changes, additional tests or other critical actions to be completed before the referral visit. The PCP can then choose to ask for or submit additional information, and the dialogue can continue, or the PCP can close the case and upload the information into their EMR or patient chart.</li> <li>Less than 15 percent of eConsult requests involve “back and forth” communication.</li> <li>If a referral is recommended, the specialist who sees the patient may not necessarily be the one who answered the eConsult request.</li> <li>eConsults are a form of consultation and carry a duty of care. In 2017, the Canadian Medical Protective Association published a statement clarifying liability issues around eConsults: <a href="#">Is that eConsultation or eReferral service right for your medical practice?</a></li> <li>Patient consent is not explicitly needed, under Ontario legislation, to conduct an eConsult. Consent requirements may vary by jurisdiction.</li> <li>For a detailed description of the intervention see the eBook:</li> </ul>



	<ul style="list-style-type: none"> <li>○ Liddy C, Afkham A, Keely E. (2016). Faster access, better care: A guide to establishing an eConsult service. Available at: <a href="http://itunes.apple.com/us/book/id1108131512">http://itunes.apple.com/us/book/id1108131512</a></li> </ul>
<p><b>Outcomes</b></p>	<ul style="list-style-type: none"> <li>• <u>Does it work? (Yes!)</u> Champlain LHIN continues to evaluate and test the service in multiple ways, including ongoing research and quality improvement studies. They collect ongoing utilization data and query the PCP each time they close a case. All of this information is continually analyzed and used to improve the service (for instance, the menu of specialty groups has grown based on direct requests from PCPs) and is published in peer-reviewed journals to ensure the information is available to all stakeholders.</li> <li>• List of <a href="#">Peer-Reviewed Publications</a>, for example:             <ul style="list-style-type: none"> <li>○ Liddy C, Afkham A, Drosinis P, Joschko J, Keely E. Impact of and satisfaction with a new eConsult services: A mixed methods study of primary care providers. J Am Board Fam Med 2015;28:394-403. Available at: <a href="http://www.jabfm.org/content/28/3/394.full.pdf">http://www.jabfm.org/content/28/3/394.full.pdf</a></li> <li>○ Liddy C, Drosinis P, Deri Armstrong C, McKellips F, Afkham A, Keely E. What are the cost savings associated with providing access to specialist care through the Champlain BASE eConsult service? A costing evaluation. BMJ Open 2016;6:e010920. Available at: <a href="http://bmjopen.bmj.com/content/6/6/e010920.full.pdf">http://bmjopen.bmj.com/content/6/6/e010920.full.pdf</a></li> <li>○ Liddy C, Rowan SM, Afkham A, Maranger J, Keely E. Building Access to Specialist Care through E-Consultation. Open Medicine. 2013 Jan 8;7(1):e1-8. Available at: <a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3654501/">http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3654501/</a></li> </ul> </li> <li>• Quadruple aim outcomes:             <ul style="list-style-type: none"> <li>○ Improving the Health of Populations                 <ul style="list-style-type: none"> <li>▪ eConsult cuts response times from months to two days</li> <li>▪ Two-thirds of cases did not require a face-to-face specialist referral</li> <li>▪ Exploration of specific populations (e.g. chronic pain patients, pharmacists) reveals high value of the service</li> </ul> </li> <li>○ Enhancing the Patient Experience of Care                 <ul style="list-style-type: none"> <li>▪ eConsult responds to patients’ previously articulated dissatisfaction with wait times</li> <li>▪ Interviews with patients reveal high satisfaction with eConsult’s impact on access, care quality, and continuity of care</li> </ul> </li> <li>○ Reducing the Per Capita Cost of Health Care                 <ul style="list-style-type: none"> <li>▪ We demonstrate a cost effective payment model for specialists</li> <li>▪ Across specialty groups, the service costs a weighted average of \$47.35/case versus \$133.60/case for traditional referrals</li> <li>▪ Costs drop dramatically after the start-up period, reaching ~\$6.45/case by year 3</li> <li>▪ Further savings that account for societal costs are being explored</li> </ul> </li> <li>○ Improving the Work Life of Health Care Providers and Staff                 <ul style="list-style-type: none"> <li>▪ PCPs rank eConsult as high/very high value in over 90% of cases</li> <li>▪ 94% of specialists report that eConsult improves communication with PCPs</li> <li>▪ eConsult provides a powerful teaching tool for PCPs</li> </ul> </li> </ul> </li> <li>• Following an initial 2009 pilot, a broader pilot was launched in 2011 with more specialties. A 2012 evaluation showed very positive feedback and strong interest in expanding the service to even more specialties. The innovation is currently being spread across Canada through the <a href="#">Connected Medicine collaborative</a>, a partnership between the Canadian Foundation for Healthcare Improvement, the College of Family Physicians of Canada, Canada Health Infoway, and the Royal College of Physicians and Surgeons of Canada.</li> </ul>

<p><b>Financial Considerations</b></p>	<ul style="list-style-type: none"> <li>• Ongoing service costs are being covered by the Champlain LHIN (which provides staff and infrastructure, along with specialist payments), the Bruyère Research Institute, The Ottawa Hospital (which provide infrastructure) and multiple research grants from various government branches and federal funding agencies.</li> <li>• In an effort to ensure long-term sustainability, the eConsult team has been involved in discussions related to fee-codes. However, any changes in this area are incredibly complex.</li> <li>• Specialists receive compensation for completing eConsults at a rate of \$200 per hour prorated to the amount of self-reported time it takes them to complete an eConsult case. Exceptions include non-physician specialists, who are compensated at a different rate, and salaried specialists, who complete eConsult as part of their clinic duties.</li> <li>• Primary care providers are not compensated for completing eConsults, as they do not receive compensation when completing traditional referrals. <i>(Note: The traditional referral-consultant model does not compensate primary care providers for making referral to a specialist or other health care provider, but some non-traditional models do; similarly, eConsult models vary in whether they reimburse primary care providers. The Champlain model does not reimburse them.)</i></li> </ul>
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<p><b>Program name</b></p>	<p><b>4. Rural Health Hubs Pilot Project Ontario - <a href="https://www.oha.com/health-system-transformation/rural-health-hubs">https://www.oha.com/health-system-transformation/rural-health-hubs</a></b></p>
<p><b>Province</b></p>	<p>Ontario</p>
<p><b>Description</b></p>	<p>Rural Health Hubs allow local health and social service providers, through formal agreements and partnerships, and on-going community consultation, to improve the coordination and effectiveness of care for a defined population and/or geographic area. Each rural health hub will be locally defined and tailored to the community. A rural health hub is flexible, not one size fits all, is innovative, based on local need and provides coordinated access to care.</p> <p>Guiding Principles:</p> <ol style="list-style-type: none"> <li>1. Person-centred and high quality care</li> <li>2. Enhance collaboration and efficiencies</li> <li>3. Accountability</li> </ol> <p>A commitment to enhanced and more integrated mental health and addiction services figures prominently in all LHIN strategies. However, for many rural and northern communities, there continues to be considerable variation in the type and amount of services available for clients with mental health and/or substance abuse challenges. Key services include Assertive Community Treatment (ACT) teams, case management, crisis support, and supportive housing. But for many individuals with a moderate mental illness who are not connected with a case worker, there are often insufficient community supports, and in times of crisis, they overly rely on emergency department (ED) visits.</p>
<p><b>Community profile</b></p>	<p>Communities with populations less than 20,000, but there may be exceptions for remote northern communities.</p> <p>Characteristics of rural communities:</p> <ul style="list-style-type: none"> <li>• Geographically remote and isolated</li> <li>• Low population density</li> <li>• Long travel times for services not locally available</li> <li>• Weather extremes and inadequate public transportation impact access to care</li> <li>• High density of elderly, Aboriginal and other distinct populations (such as francophone, migrant workers, etc.)</li> <li>• High burden of chronic disease</li> </ul>

	<ul style="list-style-type: none"> <li>• High use of tobacco, alcohol and other substances</li> <li>• High prevalence of mental illness and social isolation factors</li> <li>• Limited health service options</li> <li>• Limited health care provider availability</li> <li>• Gaps in secondary/tertiary level clinical services and limited community and support services available</li> <li>• Limited mental health and addiction services</li> <li>• Requirement to maintain service capacity in spite of lower volumes</li> <li>• Pressure from service regionalization initiatives that may impact critical mass and stability of clinical service provision</li> <li>• Recruitment and retention issues</li> <li>• Low service volumes and small data sample sizes make meaningful statistical analysis difficult</li> </ul>
<b>Service users</b>	Services are provided to a variety of areas across the province, and as such there is no specific service user.
<b>Service providers</b>	Core Services of Rural Health Hubs: Acute Care (inpatient & outpatient), ER, Complex Continuing Care, Rehab, Long Term Care facilities and community support services, Community Mental Health & Addictions, Homecare, Primary Care Additional Partners: EMS, Public Health, Social Services
<b>Program Delivery</b>	As mentioned above, there are no specific programs discussed but the vision of the rural health hubs is that care will be delivered collaboratively based on trusting relationships using interprofessional teams.
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Targeted Prevention Services</li> <li>• Information, Assessment and Referral Services</li> <li>• Counselling and Therapy Services</li> <li>• Peer and Family Capacity Building Support</li> <li>• Specialized Consultation and Assessment</li> <li>• Intensive Treatment Services</li> <li>• Crisis Services</li> </ul>
<b>Outcomes</b>	<p>A survey of health hub hospitals revealed the following types of additional benefits that would result from fully integrating a rural health hub:</p> <ul style="list-style-type: none"> <li>• Benefits to patients/clients/residents</li> <li>• Benefits to hub partner organizations</li> <li>• Administrative efficiencies</li> <li>• Local system planning and governance</li> <li>• Additional community partnerships</li> </ul> <p>In terms of benefits for patients/clients/residents, the following were specifically identified:</p> <ul style="list-style-type: none"> <li>• Greater responsiveness to the needs of patients/clients/residents</li> <li>• Improved access and transitions of care to improve patient/client/resident experiences</li> <li>• Reduced travel costs based on care closer to home</li> </ul>

	<ul style="list-style-type: none"> <li>• Shared (common) client intake process so patients only have “To Tell Their Story” once</li> <li>• More robust patient and family engagement</li> <li>• Better system navigation and transitions of care</li> <li>• Comprehensive supports for seniors</li> <li>• Shared electronic patient records</li> </ul>
<b>Financial Considerations</b>	<p>An important enabler of the model is the creation of a single funding envelope which is provided to a lead organization (the Hub Sponsor). The benefits of moving to a single fund holder model have been well documented by the OHA and others:</p> <ul style="list-style-type: none"> <li>• Removes the longstanding problem of incompatible funding silos</li> <li>• Reduces the administrative costs of preparing multiple accountability agreements</li> <li>• Reduces overlap and duplication of governance oversight and administration</li> <li>• Aligns with the system trend to population-based funding</li> <li>• Facilitates timely allocation of funds for new service delivery models that could emerge from initiatives, such as Health Links</li> <li>• Creates much needed flexibility to better manage patient/client/resident care across the continuum</li> </ul>

<b>Program name</b>	<b>5. Ontario Psychiatric Outreach Program - <a href="https://www.porticonetwork.ca/web/opop">https://www.porticonetwork.ca/web/opop</a></b>
<b>Province</b>	Ontario
<b>Description</b>	<p>The Ontario Psychiatric Outreach Program (OPOP) is a unique collaborative network of dedicated academics and practitioners in the field of mental health, providing on-site and telepsychiatry clinical services, education and support to remote and rural communities throughout Ontario. OPOP is funded through the Underserved Area Program of the Ontario Ministry of Health and Long-Term Care.</p> <p>OPOP was formed in 1999 at the request of the Ontario Ministry of Health and Long Term Care (MOHLTC). Several university programs had been providing clinical service and education in mental health to under-served areas across the province since the late 1980s. The Ministry asked those university programs to form a new organization that would allow for better coordination of their activities to avoid duplication of effort and increase the capacity of under-served areas to provide mental health services to their clients.</p> <p>The OPOP founding university programs were the Northern Psychiatric Outreach Program at CAMH (at the time the University of Toronto Psychiatric Outreach Program), the University of Ottawa Northern Ontario Francophone Psychiatric Program and the University of Western Ontario Extended Campus Program. OPOP has also worked collaboratively with the McMaster University Psychiatric Outreach Program, Queen's University, the Child and Youth Telepsychiatry Program, HealthForce Ontario Marketing and Recruitment agency, and the Northern Academic Health Sciences Network, which preceded the founding of the Northern Ontario School of Medicine (NOSM).</p> <p><b>Northern Psychiatric Outreach Program at CAMH</b></p> <p>The Northern Psychiatric Outreach Program at the Centre for Addiction and Mental Health (NPOP-C) is committed to providing clinical service, education and support of the highest quality to communities throughout Ontario, but in particular to communities that are rural or remote, or are considered under-served in terms of access to mental health care. We work collaboratively with communities to provide community-relevant service and education.</p>

**Northern Ontario Francophone Psychiatric Program at the University of Ottawa**

The Northern Ontario Francophone Psychiatric Program (NOFPP) strives to provide the highest quality francophone psychiatric services to clients and health care professionals in community mental health programs or other Ministry of Health and Long-Term Care agencies in northern Ontario that have identified the need for such a service. The program maintains a pool of francophone psychiatrists who are willing to travel to northern Ontario to work with community mental health programs and physicians by providing various clinical and educational services. The activities of the NOFPP are currently offered in ten communities by the various psychiatrists of the program. The psychiatrists offer the equivalent of 450 days of clinical activities to these service points in a given year.

**Extended Campus Program at Western University**

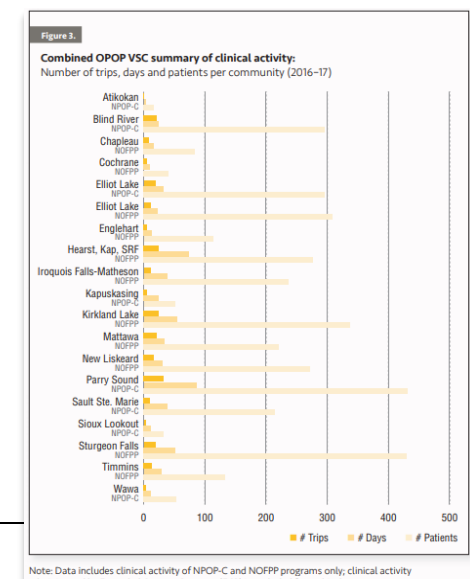
Primary objectives are to:

- Collaborate with the departments of psychiatry of the medical schools in Ontario for the provision of psychiatric health care to northern Ontario and to continue sharing expertise and information with OPOP on all the related issues
- Continue active clinical services for the remote and under-served areas of northern Ontario through face-to-face and tele-video consultations
- Continue educational and research activities related to provision of psychiatric care to northern Ontario
- Continue to deliver medical education events for physicians and other mental health care professionals in rural and distant areas of Ontario
- Support the development of academic and professional programs and their evaluation in northern Ontario

**Community profile**

There is no specific community profile for OPOP, as the communities, populations, demographics, level of remoteness and cultural considerations all vary from site to site. Below there is a map outlining where services were provided throughout the province, as well as a summary of clinical activity for the 2016-17 year.

Areas served by OPOP 2016-17



Note: Data includes clinical activity of NPOP-C and NOFPP programs only; clinical activity administered by Extended Campus Program (ECP) is excluded from this dataset.

<b>Service users</b>	There is no one specific service user for OPOP, as the demographics and disorders treated through the program are highly variable.
<b>Service providers</b>	Psychiatrists and Psychiatry residents, in collaboration with local health clinicians.
<b>Program Delivery</b>	<p>OPOP is delivered through the following means:</p> <ul style="list-style-type: none"> <li>•Telepsychiatry</li> <li>•Fly-in</li> <li>•Drive-in</li> <li>•Consultation services</li> <li>•Education services</li> <li>•Visiting specialist clinics</li> </ul> <p>All services are outpatient. To access OPOP services through one of the collaborating OPOP programs, a referral from northern, remote, rural site medical staff is required (e.g., general practitioner, psychiatrist, psychologist, social worker, clinical nurse specialist).</p>
<b>Interventions</b>	<p>Interventions vary from site to site and client to client, but in general the program provides high quality clinical and educational services in psychiatry, with the goal of building mental health services capacity in under-served areas of Ontario.</p> <p>To access OPOP services through one of the collaborating OPOP programs, a referral from northern, remote, rural site medical staff is required (e.g., general practitioner, psychiatrist, psychologist, social worker, clinical nurse specialist).</p>
<b>Outcomes</b>	The anticipated outcomes of the program are to provide multidisciplinary, contextually relevant, community-oriented psychiatric and mental health services and education.
<b>Financial Considerations</b>	OPOP is funded through the Northern Health Program of the Ontario Ministry of Health and Long-Term Care.

<b>Program name</b>	<b>6. ECHO Ontario</b>
<b>Province</b>	Ontario
<b>Description</b>	<ul style="list-style-type: none"> <li>• The model: Project ECHO uses a hub and spoke model of knowledge dissemination and capacity strengthening, aiming to build a community of practice and promote knowledge exchange between academic health centres (the hub) and frontline primary care providers (the spokes). Primary care providers (PCPs) become part of a learning and support community, where they receive mentoring and feedback from the team of experts. Working together, community providers get the help and the support they need to provide care to their patients as close to home as possible. The model is appropriate for both physicians and allied healthcare providers, and has been successfully replicated throughout the US, and globally.</li> <li>• Ontario has applied the model to nine different areas of practice, two of which focus on mental health: <ul style="list-style-type: none"> <li>○ <b>ECHO Ontario Mental Health:</b> The Centre for Addiction and Mental Health and the University of Toronto help PCPs build capacity in the treatment of mental health and addictions by empowering PCPs to use best practice to reduce the need for specialist visits. This is the first ECHO in Canada in the area of mental health and addictions.</li> <li>○ <b>ECHO Ontario Child Youth Mental Health (CYMH):</b> Hub Specialists at the Children’s Hospital of Eastern Ontario and PCPs share experiences, expertise and resources in 90 minute clinic sessions. Participating PCPs have access to expert support both during the clinic session and after-hours if they have a specific and/or emergency case.</li> </ul> </li> </ul>
<b>Community profile</b>	<ul style="list-style-type: none"> <li>• Rural patients with mental health and addictions needs</li> </ul>

<b>Service users</b>	<ul style="list-style-type: none"> <li>• PCPs providing care to patients with mental health and addictions needs</li> </ul>
<b>Service providers</b>	<ul style="list-style-type: none"> <li>• Hub: specialized interprofessional mental health care team, including psychiatrists</li> <li>• Spokes: primary care provider sites across Ontario, including physicians, nurse practitioners, nurses, social workers, counsellors and others.</li> </ul>
<b>Program delivery</b>	<ul style="list-style-type: none"> <li>• Weekly 2 hour virtual clinics</li> <li>• Technology is a free web-based videoconferencing system (Zoom Technology) that allows you to join sessions through your computer and a web cam, or a smartphone</li> <li>• Each clinic has:             <ul style="list-style-type: none"> <li>○ a 20-30 minute didactic lecture on a specific clinical topic (there is a set curriculum for the year to cover a variety of topics) from the hub</li> <li>○ 90 minutes of case-based learnings, where spokes present de-identified cases to the community of practice and receive recommendations from both the hub team and other community partner spokes</li> </ul> </li> </ul>
<b>Interventions</b>	<ul style="list-style-type: none"> <li>• Tele-education</li> </ul>
<b>Outcomes</b>	<ul style="list-style-type: none"> <li>• <a href="#">Sockalingam, et al. Building Provincial Mental Health Capacity in Primary Care: An Evaluation of a Project ECHO In Mental Health Program. Academic Psychiatry, 2017.</a> <ul style="list-style-type: none"> <li>○ First study to report objective mental health outcomes related to Project ECHO</li> <li>○ Captured improvements in primary care provider knowledge test scores and perceived competence related to managing mental health and substance use disorders, supporting use of Project ECHO as a knowledge translation vehicle to improve patient outcomes</li> <li>○ Evidence for Project ECHO as a model for maintaining high engagement, satisfaction, and retention rates while delivering continuing professional development to increase primary care mental health capacity</li> <li>○ Further research needed to clearly establish the impact of Project ECHO on primary care teams’ mental health and addictions practice behaviours and patient outcomes</li> </ul> </li> </ul>
<b>Financial Considerations</b>	<ul style="list-style-type: none"> <li>• Both Project ECHO Mental Health and CYMH are fully funded by the Ministry of Health and Long-Term Care</li> <li>• Clinic sessions are free for PCPs</li> <li>• The programs are fully accredited for CME, so participants receive CME credits at no cost</li> </ul>

<b>Program name</b>	<b>7. Rural and Northern Telehealth Service - <a href="http://www.matc.ca/services-rnts.html">http://www.matc.ca/services-rnts.html</a></b>
<b>Province</b>	Manitoba
<b>Description</b>	<p>The Manitoba Adolescent Treatment Centre (MATC) falls under the jurisdiction of the Winnipeg Regional Health Authority Mental Health Program - Child &amp; Adolescent Mental Services, and is governed by a Board of Directors appointed by the Minister of Health.</p> <p>The Rural and Northern Telehealth Service provides mental health services via telehealth to targeted First Nations communities in northern Manitoba and was developed in response to recommendations that were outlined in the Reclaiming Hope: Manitoba’s Youth Suicide Prevention Strategy. The program initially started with four indigenous communities and only two mental health clinicians. Over the first three years this expanded to seven communities, and an additional third clinician. In July 2017, under Jordan’s Principle, the program received funding to expand the service by five more clinicians to provide services to sixty-three communities, including more southern First Nations communities.</p> <p>The service works with partnerships formed with First Nations communities, stakeholders, as well as branches of government such as the Departments of Health, Family Services and the First Nations Inuit Health Branch.</p>

<b>Community profile</b>	Some communities serviced have a population between 400 to 600 people, while others are between 8000 to 10,000 people. All of the communities are rural, and a number are geographically isolated with no road access or fly-in only access.
<b>Service users</b>	The service addresses the needs of children & adolescents between the ages of 5 to 18 years who are experiencing emotional or mental health difficulties, such as psychotic issues, trauma, suicidal ideation, developmental problems, behavioural difficulties, autism, ADHD, etc.
<b>Service providers</b>	Mental health clinicians, master’s level trained therapists and psychiatrists
<b>Program delivery</b>	The program is delivered to clients via telehealth through local clinics or schools in the communities. Service providers are located in Winnipeg and telehealth services are provided daily. Trained therapists pay visits to the participating communities on a regular basis and if a client visits Winnipeg, they may access the services there as well. The service accepts direct referrals via phone or fax from identified community professionals. These may include: nursing station staff, guidance counsellors, child welfare workers, National Native Alcohol and Drug Abuse Program (NNADAP), building healthy community workers, suicide prevention coordinators etc. There is a high level of collaboration between the mental health clinicians in the telehealth service and the existing health and community workers.
<b>Interventions</b>	Mental health clinicians and, where appropriate, Psychiatrists, provide consultation, assessment and treatment services to clients within targeted First Nations communities. Services range from support and coordination to formulate plans for psychosocial rehabilitation; suicide prevention; individual therapies; cognitive behavioural therapy; dialectical behaviour therapy; mindfulness; relaxation strategies; horticultural therapy; and other interventions as needed.
<b>Outcomes</b>	The goal of the program is to enhance mental health service delivery in all northern and remote communities in Manitoba. Evaluating the program thus far has proved challenging, due to a general lack of response and issues related to remoteness, and access to internet or telephone services. However, the program has received a wealth of informal positive feedback from clients and service providers.
<b>Financial Considerations</b>	The program is mainly financed by the Manitoba government through the Changes for Children Fund, in response to the Manitoba Youth Suicide Prevention Strategy. Recently, the program has received additional federal funding through the Jordan’s Principle initiative. The psychiatrists and mental health clinicians of the program are all salaried.

<b>Program name</b>	<b>8. Text4Mood</b>
<b>Province</b>	Alberta
<b>Description</b>	<p>The Text4Mood program began in January 2016. The program provides daily supportive text messages to subscribers which have been composed by mental health therapists in collaboration with service users. Patients in Alberta can subscribe to the program by texting the word “mood” to a designated phone number. The innovation addresses problems related to lack of access to psychological therapies for patients with depression and anxiety, including long wait times to access services and geographical barriers for patients in under-serviced remote areas.</p> <p>The goal of the intervention is to address the lack of access to psychological therapies for patients with self-reported depression and anxiety symptoms in the following ways:</p> <ol style="list-style-type: none"> <li>a) Wait times for service – daily supportive texts are sent to those on a waitlist for services if they subscribe to the Text4Mood service. Although not a substitute for face-to-face service for those who require it, the Text4Mood program provides an immediate service for patients on a waitlist who would otherwise receive no assistance as per routine procedure, thereby effectively decreasing wait time for an intervention to zero.</li> <li>b) Geographic/distance barriers – for those who may not be able to access services immediately when offered due to distance, they can subscribe to the Text4Mood program to receive daily supportive texts until a service closer to their home is available. The technology is unaffected by geography.</li> </ol>



	Prior to the launch of the Text4Mood program, a clinical trial was conducted in Alberta which provided local evidence of clinical effectiveness of the intervention for patients with depressive symptoms. The results of this trial, as well as evidence from other research, provided a compelling rationale to administrative leadership for sustaining this program as a clinically useful and low-cost intervention for depressive symptoms, particularly in under-served rural Alberta.
<b>Community profile</b>	The program was designed to provide a daily supportive text message service for patients in Northern Alberta, an area which has a widely dispersed population and patients in remote locations with inadequate access to psychological or counselling services. Additionally, the program provides support to patients on waitlists for mental health and addiction services in Alberta.
<b>Service users</b>	The service is intended for children, adolescents, adults, older adults and minority populations suffering from mild to moderate depression, anxiety or stress related disorders.
<b>Service providers</b>	The lead investigator in the program is a Psychiatrist, and the text messages sent to subscribers have been created in collaboration between mental health therapists, including psychiatrists, and service users.
<b>Program delivery</b>	Program provides a novel means to address common health problems, specifically wait time for mental health interventions, and geographic barriers to service. Through the use of text messaging technology, Text4Mood provides an immediate service to persons who are on a waitlist or may have difficulty accessing services due to geographic barriers (e.g., underserved communities in Northern Alberta). The program can also be used to offer complimentary psychological support for patients who are attending individual or group counselling. Patients subscribe to the program by texting ‘mood’ to a designated number, and, once subscribed, receive a daily supportive text message.
<b>Interventions</b>	The intervention, a daily supportive text message, is administered to subscribers via their mobile phone daily, and the content of the text messages are based on the principles of Cognitive Behavioural Therapy.
<b>Outcomes</b>	In the first year of its launch, over 10,000 people subscribed to the Text4Mood program. Following an evaluation, 82% of subscribers reported the text messages made them feel more hopeful about managing issues, 77% felt in charge of managing depression and anxiety, 75% felt connected to a support system, and 83% felt the messages improved their overall mental well-being.
<b>Financial considerations</b>	The technology is a relatively low cost, high impact, and easily scalable program that uses existing technology, overcomes geographic barriers to care, and is free and accessible to end users. Although the program is not a replacement for psychotherapy and counselling for those who require it, an economic comparison with conventional forms of therapy can be made. It costs \$5.40 to deliver daily text messages to a patient for 6 months, compared to an average of \$1800 for 12 sessions of face-to-face therapy in Alberta. The program is funded by Alberta Health Services.

<b>Program name</b>	<b>9. Rapid Access to Consultative Expertise - <a href="http://www.raceconnect.ca/">http://www.raceconnect.ca/</a></b>
<b>Province</b>	BC – (expanded to MB)
<b>Description</b>	RACE is an innovative model of shared care where primary care providers can call one phone number and choose from a selection of specialty services for real-time telephone advice. RACE is based on a pilot study that was conducted in 2008 by the St. Paul’s Hospital Division of Cardiology and the Providence Health Care Department of Family Medicine where family practitioners (FPs) could page a cardiologist. As a result of the encouraging results from this pilot project, the Specialists Services Committee put a billing code in place in April 2010 to allow specialists to bill for the telephone call. Shortly after, the General Practice Services Committee put a billing code in place to allow family physicians to bill for the telephone discussion. Through a partnership with Providence Health Care, the Shared Care Committee (a joint committee of the BC Medical Association and the Ministry of Health), and Vancouver Coastal Health (VCH), the expanded RACE model of shared care began in June 2010 with 5 services. Since June 2010, it has steadily grown with feedback from family physicians on what services would be useful and, 7 years later, 33 specialty services provide telephone advice through RACE. The RACE team is grateful to the Canadian Foundation for Healthcare Improvement (CFHI) and Health Canada for the support it received through its EXTRA program.

	<p>In 2016, the RACE team was approached by the CFHI to participate as faculty in a national collaborative focused on spreading the RACE model, as well as the Champlain BASE eConsultation model. The Connected Medicine collaborative is now in its second iteration focused on service implementation.</p> <p>Since its launch in 2010, the RACE program has facilitated about 7000 calls. The majority of these calls (78%) were answered within 10 minutes while patients were still in their doctors’ offices. A third of patients avoided hospital visits, and 60% of patients who were candidates for referral avoided a visit to a specialist altogether. The system was enhanced in 2015 with eRACE™, a mobile application that enables primary care practitioners (PCPs) to initiate contact via email, text or Short Message Service (SMS), depending on the preference of the specialist. Awareness and use of eRACE™ is expanding rapidly.</p> <p>In 2016, a partnership between the Manitoba College of Family Physicians and the WRHA Mental Health Program, along with the Primary Care Program, launched RACE in Manitoba on June 1, 2016. In Manitoba, this service provides access to a psychiatry consultant for advice.</p>
<p><b>Community profile</b></p>	<p>RACE is available across the Vancouver Coastal health and Fraser Health Authority Regions:</p> <ul style="list-style-type: none"> <li>• Vancouver Coastal RACE</li> <li>• Fraser Valley RACE</li> <li>• South Island RACE</li> <li>• Kootenay Boundary RACE</li> <li>• Northern RACE</li> </ul>
<p><b>Population served</b></p>	<p>In BC, the service is available for all FPs across the region, Monday to Friday from 0800-1700. The service is set up to provide support for family physicians within VCH. Some specialty areas provide support provincially.</p>
	<p>MANITOBA: The service is available to FPs, as well as nurse practitioners and pediatricians, 0900-1600 Monday to Friday.</p>
<p><b>Service providers</b></p>	<p>In the spirit of “capacity building”, specialists are recruited for their interest in teaching and communication, as well as their recognition as key opinion leaders. Compensation for physicians is via fee for service billing. Service providers are as follows: In VCH, psychiatrists specializing in eating disorders, geriatric psychiatry, adult psychiatry; Provincial Services are available for addictions medicine, child and adolescent psychiatry, perinatal addictions, perinatal psychiatry and substance use disorders. An educational interaction is encouraged when the specialist answers the call. The service provides an opportunity for in-time learning, often when the patient is still in the FP office.</p>
<p><b>Program delivery</b></p>	<p>While any FP could call any specialist, prior to RACE, it was on a “catch me if you can” basis and there was no guarantee that a specialist could be contacted or would call back in a timely manner. The RACE line provides structure to promote easy accessibility while allowing for sustainability through an organized rotation. Patients may have their healthcare issue dealt with in their FP office instead of needing to see a specialist. This will often render face-to-face consultation or referral to an emergency department unnecessary. RACE provides structure, through one phone line, an organized specialist coverage rotation, timely call back and specialists who will provide an educational experience for FP to enhance the care of their patients. 80% of calls are returned within 10 minutes. To be added to the RACE™ service, specialists must be able and willing to respond to a RACE™ call in a timely manner (calls must be answered within two hours to be billable). A three-month trial is suggested for specialties that want to discover how RACE™ would affect their work flow.</p> <p>How RACE™ works:</p> <ul style="list-style-type: none"> <li>• PCP provides information on the patient’s condition, background and possible causes for the condition.</li> <li>• Participating specialists provide coverage via an organized rotation schedule and are expected call back within two hours.</li> </ul>

	<ul style="list-style-type: none"> <li>• The RACE™ service is available from 0800 - 1700, Monday to Friday.</li> <li>• Quite often, the patients are still in the PCP’s office and a meaningful consultation can take place before they leave.</li> </ul>
<p><b>Interventions</b></p>	<p>It is encouraged that physicians use a standard, structured communication approach such as SBAR:</p> <ul style="list-style-type: none"> <li>• <b>Situation</b> – A statement of the problem: What is going on</li> <li>• <b>Background</b> – Brief information related to the problem: What has happened</li> <li>• <b>Assessment</b> – Analysis/consideration of options: What you found/think it is</li> <li>• <b>Recommendation</b> – Request/recommend action: What you need</li> </ul> <p>Consider Calling RACE when you need:</p> <ul style="list-style-type: none"> <li>• Advice on diagnostic testing</li> <li>• Advice on general management</li> <li>• Advice on therapeutics</li> <li>• Other clinical questions</li> <li>• When you are fairly certain what to do but just need some reassurance</li> </ul> <p>A RACE app for Android and IOS allows a PCP to request advice from the specialty of their choice in one easy step. Patient demographics is entered as part of the request, allowing the phone conversation between the PCP and specialist to be focused solely on the patient.</p> <p>RACE provides:</p> <ul style="list-style-type: none"> <li>• Enhanced ability to manage the patient in your office</li> <li>• An opportunity to speak directly with a Psychiatrist</li> <li>• Timely guidance and advice</li> <li>• Assistance with plan of care</li> <li>• A learning opportunity</li> </ul>
<p><b>Outcomes</b></p>	<p>For the majority of patients, care planning decisions can be made in the FP office. In some cases, all that is needed is minor input from a specialist, which can be obtained through a telephone interaction.</p> <p>RACE is guided by the IHI “Triple Aim” principles:</p> <ol style="list-style-type: none"> <li>1. Enhances the <b>care experience</b> by providing in-time educational advice for the FP. Patient experience is enhanced as they receive information while at their appointment instead of having to wait to see a specialist and consults may be avoided thus avoiding redundant travel and time off.</li> <li>2. <b>Population health</b> may be improved as patients are receiving timely care in their GP office instead of waiting to see a specialist. Access to specialists is also enhanced as the specialists are seeing the patients who they really need to see.</li> <li>3. <b>Per capita cost</b> of health care is at least controlled, as utilization of the RACE line avoids unnecessary consults and emergency visits.</li> </ol>

	<p>MANITOBA: The goal of RACE is to improve care for patients with psychiatric conditions through:</p> <ul style="list-style-type: none"> <li>• Access to early psychiatric advice for mental health patients in a Primary Care practice</li> <li>• Advice on treatment adjustments</li> <li>• Reduction in low-priority office referrals</li> <li>• Ongoing information transfer and continuing education</li> <li>• Promotion of ambulatory health and reduction in hospital admissions</li> <li>• Support on choice and timing of investigations</li> </ul>
<b>Financial Considerations</b>	<p>A billing code was created in 2010 to allow specialists and family physicians to bill for the telephone call.</p> <p><b>Billing Information for a RACE call in BC</b></p> <ul style="list-style-type: none"> <li>• Billing code <b>G10001</b> Urgent Specialist Advice – \$60.00 – for calls returned within <b>2 hours</b></li> <li>• Billing code <b>G10002</b> Specialist Advice for Patient Management – \$40.00/15 minute interval – for non-urgent calls and advice provided to a nurse practitioner</li> </ul>
	<p>MANITOBA: Family Physicians can bill for a RACE call using MB Health Tariff <b>#8006</b>.</p>

# Appendix B:

## Additional Information & Other Jurisdictions

This section contains a discussion of general information on provincial/territorial mental health and addictions strategies received from key informants. The information outlined below did not contain the level of detail required for inclusion in the data tables above with regards to specific programs or models; however, we felt it was important to include this information, as it creates a more complete picture of activities across the country and may assist health system leaders.

We start with the north, and then we move east to west.

### Yukon

In 2016, the Yukon introduced a [10-year mental wellness and substance use strategy](#). One of the strategy's objectives is to increase access to specialized psychiatric supports, by:

- Working with Yukon Hospital Corporation to review psychiatric services and other provider needs and supports to acute, primary and community care
- Increase use of technology to link specialist and acute care providers with other system providers for consultation and case support, prevention, assessment, intervention, service delivery and enhanced system capacity
- Increase use of tele-psychiatry, tele-mental health and addictions counselling, and explore and pilot use of other technology to support/monitor youth with clinical diagnosis
- Explore options with BC and Alberta Ministries of Health and medical groups to establish psychiatric and other support to Whitehorse General Hospital Emergency Department physicians, access to psychiatric services out of territory, training and other capacity-building partnerships
- Explore partnerships to provide forensic supports for Yukon Review Board individuals, individuals involved with the justice system, and aftercare for individuals leaving forensic treatment facilities out of territory

Mental wellness and substance use care is provided to rural and remote communities through four HUB communities that serve and support smaller communities around them. Referrals to the HUB can be made by community stakeholders, or through self-referral. HUB services are supplemented by in-patient treatment for psychiatric services and/or Intensive Treatment Services (for substance use), through referral by the HUB to Whitehorse. Patients have the option of traveling to Whitehorse for psychiatry appointments, or having psychiatry assessments and follow-ups at the HUB via telehealth.

Each HUB team include:

- 1 Supervisor, who reports up to a Community Manager
- 2 MWSU Counsellors
- 1 Clinical Counsellor
- 1 Child and Youth Counsellor
- 1 Mental Health Nurse
- AOC Support Workers, who visit homes and families

HUB communities also have Supportive Recovery Groups, and a local NGO who provides counselling services for mild/moderate depression, anxiety, trauma work, and family, child and youth and marital matters. Each of the smaller communities has 1 MWSU Counsellor and 1 Child and Youth Counsellor.

### **Nunavut**

Nunavut is in the early stages of developing an approach to mental health and addictions, and is undergoing their own review of models; as such, the territory did not have any meaningful documents to share.

### **Nova Scotia**

To ensure equitable access to mental health and addiction services in Nova Scotia, there are multidisciplinary health clinics scattered throughout the province, along with travelling clinics where members of the team will visit a remote or rural community a few times per week. These teams include psychiatry as needed. In other cases, a psychiatrist will see a rural patient face to face with a local health clinician, and then perform subsequent visits via telehealth. The Faculty of Medicine at Dalhousie is assisting the province by using psychiatry residents to offer telehealth to communities and areas without access to a psychiatrist.

Nova Scotia has initiated some unique methods of providing mental health care to its population. For example, there are health promotion and prevention teams spread out across the province who perform outreach, screening and referral as needed; in schools across the province, and

some First Nation communities, there are embedded mental health clinicians who seek to improve access for adolescents and children with mental health disorders. Access to psychiatry, however, is not a direct part of either of these initiatives.

Additionally, Nova Scotia is exploring other options to improve access to mental health services. The province recently trialed an app called Medeo, which can be used on a cell phone or tablet and allows for secure transmission of information between practitioners. The province is exploring more e-health options, such as therapy assisted online (TAO), is planning an expansion of Caperbase, a youth outreach program via the internet, and is seeking to maintain Strongest Families, a telephone treatment service for a range of specific disorders in children. None of these interventions involve a psychiatrist.

### **New Brunswick**

Operational guidelines for Addiction and Mental Health encourage mental health clinicians to go to a client's community or home to offer individual therapy and/or support. The province's new Flexible Assertive Community Team (FACT) will go in the client's home, residential facility or other location to offer services. This specialized service is for the population suffering from serious mental illness.

The province also encourages the use of video conference equipment to provide consultation with a psychiatrist – this is a work in progress however, as it is a service that is not being used as extensively as the health system leaders would like. Video conferencing would mean that the client wouldn't have to travel to a regional hospital to be seen by a specialist. The province is also beginning to look at eHealth to offer online therapy support.

### **Ontario**

Ontario has produced a number of policy documents and structures relevant to mental health and addictions services for rural and remote populations:

- The [Rural and Northern Health Care Framework](#) states that it's important that residents of rural and northern communities to have timely and appropriate access to high quality health care – including care for mental health and addictions issues. The unique challenges of these areas require support from across the Ministry of Health and Long-Term Care (MOHLTC) to help improve their specific local health care needs. Mental health and addictions related services and supports in rural and northern Ontario communities have similar limitations to those found elsewhere across the health system, as well as issues that are more likely to occur in rural and remote settings (E.g., only one provider in town; no specialized services close to home; challenges with privacy and confidentiality in smaller, close-knit communities, etc.).
- The [Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy](#) (2011) is a comprehensive mental health and addictions strategy. It was developed in part to help ensure equitable access to services and supports for people with mental illness and/or addictions, including people living in rural and northern communities in Ontario. In the implementation of Open Minds, Healthy Minds, the MOHLTC committed to a Parallel Indigenous Engagement Process, a francophone engagement approach, and an equity strategy to respond to health inequities, understood as avoidable differences in health outcomes between sub-populations, often related to the social

determinants of health. As such, there is a commitment to equity planning which acknowledges that health services must be provided and organized in ways that contribute to reducing overall health disparities and ensure that the province is responding to the needs of diverse and marginalized populations – including rural and remote communities.

- In 2007, **Local Health Integration Networks (LHINs)** were created across Ontario and were mandated with planning, integrating, and distributing provincial funding for all public healthcare services at a regional level. The northern LHINs, as well as the LHINs with large rural populations, are responsible for ensuring that the unique needs of those populations are considered in the administration of health services and supports across their respective regions. As a result, access to primary care is relatively consistent across Ontario. Some service models are adapted to meet needs in rural communities, including Assertive Community Treatment (ACT) Teams, which provide intensive treatment, rehabilitation and support services for individuals with serious mental illness and complex needs who find it difficult to engage in other mental health services. The distinguishing factor is often that in a rural area there may be fewer individuals with serious mental illness who can benefit from the program. For more information see the Institute for Clinical Evaluative Sciences (ICES) recent report, [Geographic Access to Primary Care and Hospital Services for Rural and Northern Communities](#).

Ontario leverages technology through various partners in delivery of health services and information. For example:

- ConnexOntario provides free and confidential health services information for people experiencing problems with alcohol and drugs, mental illness or gambling. This means that people can receive support in accessing services from home.
- The Ontario Telemedicine Network (OTN) enables access to care for more than 100,000 mental health and addiction patients annually through telepsychiatry services. Telemedicine provides timely access to care without the need for extensive travel, especially in rural and remote areas.
- CritiCall Ontario provides a variety of information services to physicians, hospitals and other healthcare stakeholders with the goal of helping to ensure Ontario patients can access the urgent and emergent care they need as close to home as possible.

## Manitoba

The Mental Health and Addictions Strategy in Manitoba is currently undergoing some changes. Since June 2017, there have been numerous consultations across the province with health authorities, private and grant-funded mental health and addiction service providers, indigenous populations, other government sectors, persons/families with lived experience and newcomer/refugee services. The province is looking to extract key messages from this process and this information, along with previous reports and additional consultation methods will be used to help form recommendations to improve mental health and addiction services in the province.



## Saskatchewan

The Ministry of Health in Saskatchewan fund a continuum of **mental health services** either directly or through the Saskatchewan Health Authority to support individuals with mental health issues.

- Eight communities in Saskatchewan have specialized mental health services in outpatient, inpatient and psychiatry services. Two of these communities could be classified as larger urban and the other six communities could be classified as smaller urban. All of these communities provide specialized services to outlying rural and northern areas who also have mental health and addictions staff.
- There are 100 full-time and part-time mental health clinics distributed throughout the province who provide more generic adult, child and youth services.

The Ministry of Health also funds a continuum of **alcohol and drug misuse services** either directly or through the Saskatchewan Health Authority to support individuals in their homes and in their communities. These programs include outreach and outpatient services, as well as inpatient treatment centres and detoxification centres.

- Outpatient services are located throughout the province and are often the starting point for individuals and families concerned about their own or others use of alcohol, drugs, or gambling.
- As a person's needs may vary over time, specialized services, such as detoxification inpatient treatment centres, can be accessed by all Saskatchewan residents regardless of their home community or contact with these services in the past.
- The Ministry of Health funds over 350 alcohol and drug treatment beds throughout Saskatchewan.

## Alberta

Alberta Health Services (AHS) is divided into 5 operational Zones, each with an Addiction and Mental Health (AMH) leadership group and frontline multidisciplinary staff and physicians who provide patient care. Provincial AMH provides oversight for province-wide initiatives, such as planning, accreditation, policy development, knowledge exchange, and provincial operations of some specialized services. All Zones have some degree of rural and remote communities within their boundaries for which they must deliver addiction and mental health services. The Zone that has the highest degree of rural and remote communities is the North Zone.

The North Zone plans its service delivery using a tiered continuum of care (see below), as well as what they refer to as a hub and spoke model. Services in tiers one, two and three are offered directly in larger communities, which function as spokes. Tiers four and five are generally offered in larger urban centres, which function as hubs. To facilitate accessibility of all services, transportation for patients, outreach from service providers and/or technological solutions are implemented. This tiered model is adapted from the five-tier model developed by the Canadian Centre on Substance Abuse.

<b>Fundamental Services:</b>				
➤ An addiction and mental health service that is available and accessible to all Albertans.				
<b>TIER 1</b>	<b>TIER 2</b>	<b>TIER 3</b>	<b>TIER 4</b>	<b>TIER 5</b>
<ul style="list-style-type: none"> <li>Health Promotion</li> <li>Addiction and Mental Illness Prevention</li> </ul>	<ul style="list-style-type: none"> <li>Brief Screening and Initial Assessment</li> <li>Early Identification and Initial Intervention</li> </ul>	<ul style="list-style-type: none"> <li>Community Services</li> <li>Outreach Services</li> <li>Crisis and Emergency Services</li> <li>Social and Community Support Services</li> </ul>	<ul style="list-style-type: none"> <li>Assertive Outreach Services</li> <li>Intensive Community Services</li> <li>Acute and Short-term Services</li> </ul>	<ul style="list-style-type: none"> <li>Residential or Long-term Services</li> <li>Specialized Services</li> <li>Justice-related Services</li> </ul>

With regard to outreach services, frontline clinicians are hired within several communities to make up a team. These clinicians travel to patients within the closest proximity of their home communities. The team comes together virtually to conference and plan for patient care. Where there is more remoteness, AMH community services function as travelling teams, choosing specific days to travel-out to smaller communities for scheduled and unscheduled appointments with local residents. AHS AMH also works with Primary Health Care providers through close association with Primary Care Network that promote the concept of ‘health home’, with addiction and mental health services transitioning to and from or wrapping around this home.

For children and youth, AMH community services are provided by AHS AMH Zone operations and are contracted through Regional Collaborative Service Delivery (RCSD) groups. A provincial service worthy of highlighting is the Mental Health Capacity Building (MHCB) Program. MHCB works in schools and communities to promote positive mental health in children, youth and families and supports community members who work with children and youth. There are currently 37 programs in 85 communities and 182 schools with an outreach to 74 additional schools, throughout Alberta. Of the 37 Programs, 28 are located in rural and remote geographic areas in Alberta with a formalized connection for 14 of those rural programs to Indigenous communities. The focus of the program is mental health promotion, prevention, early and brief intervention for children, youth and families by raising awareness, reducing stigma, building personal and interpersonal skills, supporting positive community

norms, and intervening early to help children, youth and families who are at risk for addiction and mental health issues. A primary role for MHCBC is to assist in connecting children, youth and families to treatment services when they need them.

AHS' Mission is: *to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans*. Therefore, accessibility is a primary focus of their efforts in delivering quality addiction and mental health care.