Vancouver Division of Family Practice
An FPSC initiative

Vancouver CoastalHealth

IPT Program Evaluation Report | 2024

About the Evaluation

In January 2024, 36 allied health professionals (65% of AHPs) and 105 providers (23% of providers with access to AHPs) completed an online survey. The survey assessed the functioning of the IPT Program and its impact. The evaluation results also include feedback from 312 IPT patients (5% of 2023 IPT patients) which was collected via an online patient survey that is sent to all patients at the end of their AHP sessions. This is the second IPT evaluation; the first evaluation was conducted in the fall of 2022.

Main Findings

Program Communications

The program is very well understood amongst providers and onboarding supports are very highly rated and help providers build confidence and trust in the program. Providers report knowing who to contact about questions and are very satisfied with overall communications about the program.

Workflow

The majority of providers are satisfied with the IPT referral form. The referral criteria for Registered Dietitians, Clinical Counsellors, and Clinical Pharmacists is understood by the majority of providers, however confusion exists around the referrals criteria for Social Workers and Occupational Therapists. The majority of AHPs (61%) report that about half of the providers have a good understanding of the referral criteria.

IPT intake staff report that some information is lacking from the referrals. Intake staff would like patient service goals, existing assessments, medication lists, and other relevant collateral to be included in the referrals. Almost half the providers (49%) reporting having had a referral declined.

Receipt of notification of referrals is routine. Almost all providers (80%) report they receive a notification of receipt of referral "all" or "most of the time". Ninety percent of providers see the IPT referral process as comparable or easier than other referral processes.

The evaluation findings reveal that improvements in the referral process are needed in the following areas:

- Understanding of the referral criteria for social workers and occupational therapists
- Timeliness of acknowledging referrals
- Instructions on the collateral to include in the referral
- Referral decline rate
- Rationale for declined referrals, and
- Providing alternatives when referrals are declined.

Patient Experience

Patients rate the AHPs very highly as shown in the graph below. Almost all patients report that the AHPs treat them with dignity and respect, are sensitive to their values and identity, explain things well, and ask about their health care goals.

Team-Based Care (TBC)

Communications between the AHPs and providers beyond progress and discharge notes is limited but the AHPs and providers do not see a need to communicate more:

- Just under half the providers participate in care conferences with the AHPs (46%)
- About half of providers (52%) report routinely receiving progress reports, and
- 68% of providers report routinely receiving discharge reports.

Providers and the AHPs are almost equally divided on their perceptions of the success of the program in enabling team-based care (TBC). About half the providers and AHPs (52% of providers and 50% of AHPs) report the program supports some elements of TBC and slightly fewer report the program fully enables TBC (47% of AHPs and 43% of providers). The AHPs report good working relationships with providers.

Challenges and Program Improvements

Wait times were the most frequently reported challenge with the IPT program.

Additional challenges reported by providers and the AHPs include:

- Incomplete referrals (AHPs)
- Declined referrals (providers)
- Lack of access to consultation notes (AHPs)
- Age restrictions on referrals (e.g., no services for pediatric patients, youth or adolescents (providers)
- Language barriers for non-English speaking patients (providers)
- Service limits (service concludes after 10 sessions) (providers)
- Wait times for AHPs (providers)
- Low use of case consultations (AHPs)
- Inappropriate referrals (AHPs)
- Locations with accessibility challenges (AHPs)
- Knowledge of referral criteria for some AHPs (AHPs), and
- More timely communications (providers).

The AHPs also report challenges with isolation, space, workload management, complex referrals, spending too much time on administration, limited opportunities for collaborative learning (e.g., team building among AHPs and shared learning), and missed or cancelled appointments.

Physiotherapists are the most frequently reported additional AHP wanted. In total, 32 additional services were mentioned by providers. See Appendix A for full list of additional services desired.

The most frequently reported suggestions for improving the IPT program were:

- Support collaboration, communication, and relationship building between the AHPs and providers
- Implement a secure way for the AHPs and providers to communicate directly with each other, provide updates, and share case notes
- Patients most frequently asked for additional sessions, reduced wait times, in-person sessions, and AHPs who speak different languages.

The full list of suggestions for improvements can be found in Appendix B.

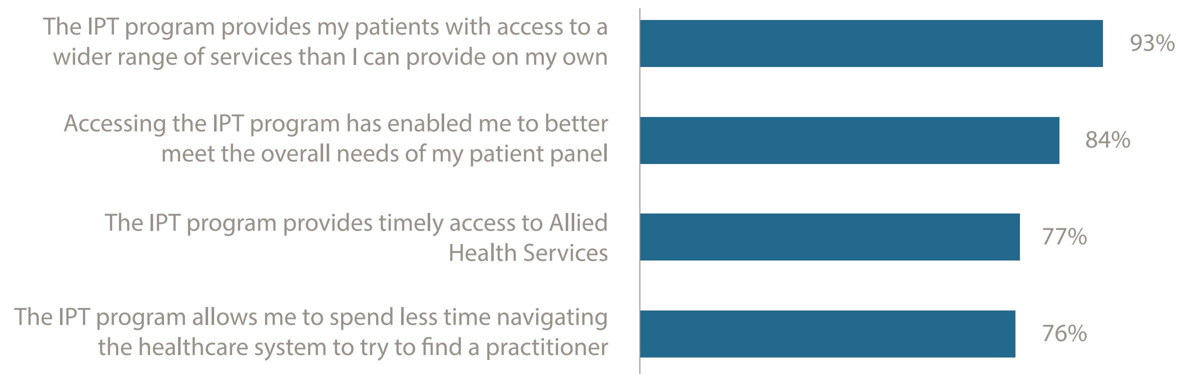
Impact of the Program

Providers report that the IPT program provides patients with increased and more timely access to services compared to typical referral wait times.

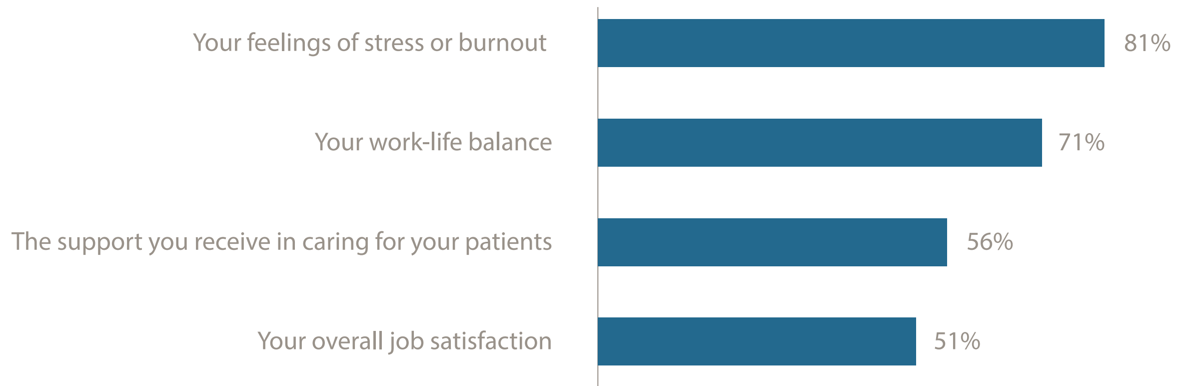
In addition, almost all patients (90%) report that the AHP has a positive impact on their health.

The IPT program enables providers to better meet the needs of their patients and allows providers to spend less time navigating the health care system to search for resources for their patients as shown in the graph below.

Percent of Providers Strongly Agreeing and Agreeing



As shown below, the IPT program positively affects providers in a variety of ways, most commonly by improving providers feelings of stress or burnout (reported by 81% of providers) and improving their work-life balance (reported by 71% of providers). About half the providers also report the program improved the support they receive in caring for their patients and their overall job satisfaction.



Recommendations

1. Increase efforts to promote understanding of referral criteria for social workers and occupational therapists.
2. Revise the referral form to highlight the type of collateral to include.
3. Review the list of suggestions for increasing collaboration and determine which are desirable and feasible (see Appendix B).
4. Explore options for reducing wait times.
5. Determine the feasibility of adding physiotherapists and other desirable services (see Appendix A for list of additional services wanted).
6. Explore the feasibility of enabling interoperability between IPT and provider systems.
7. Explore patient, AHP, and provider suggestions for improvements and determine which are desirable and feasible (See Appendix B).

Appendix A – List of Additional Services Desired

1. Audiology
2. Audiometry
3. Chronic Disease supports
4. Chronic pain
5. Counselling
    a. Longer term
    b. Eating disorder counselling
    c. Substance use counselling
6. Dentist
7. Diabetes nurse/educator
8. Dieticians
9. Foot care
10. Form Support
11. Geriatric focused supports
12. Kinesiologist
13. Lactation consultant
14. Nurse
15. Optometrist
16. OT (in-home appointments)
17. Pediatric counselling
18. Pediatric social workers
19. Personal Trainer
20. Pharmacist
21. Physiotherapy
22. Podiatry
23. Psychiatrist
24. Psychologists
25. Registered Massage Therapist
26. Screening Coordinator
27. Sleep/CPAP
28. Social Worker
29. Speech Language Pathologist
30. System navigator
31. Wound Care, and
32. Youth Mental Health

Appendix B – Improvements Suggested

Ways to Improve IPT	Illustrative Excerpts
Relationship Building	
Assign AHPs to clinics	Teams that are specifically accessible to a certain number of clinics. Therefore creating a smaller team that our clinic can depend on for our patients. Especially for larger clinics with many practitioners (Provider).
Co-locate the AHPs	It could be valuable to have co-located AHPs for the numerous day to day care given. I believe this would enable primary care provider to take more patients and increase timely access to care for their patients with the care of patients shared amongst IPT clinicians. This likely would have a dramatic impact on improving health outcomes for patients (Provider).
Enable the AHPs to case find	Panel reviews to case find for more referrals. Maybe annually with a clinic. Visit each clinic or high value targets 1 x / year to case find, reinforce referrals, find clients, etc. in person or remotely. Helps refine and reinforce good referrals AHP).
Support collaboration	Increase collaborative opportunities (AHP). More case consultations, perhaps with an easier process for providers to book them (AHP).
Support relationship building among the AHPs and between the AHPs and providers	I want to suggest having some kind of face time (this could be on zoom) so that we get to know each other- could be a case conference with several cases to review - however, I would be concerned that it could be turned into a negative experience by certain providers. But hopefully those would be the exception (AHP). Having more opportunities for in-person interactions - maybe site visits or the opportunity to sit in on rounds/patient panel to advise of areas where OT can support their patients to improve their knowledge and awareness of this (AHP). More opportunities for working in an in-person format and getting to know your colleagues (AHP). More on-site meetings to address isolation; more education sessions between team; more opportunities for specific teams to educate others on the work they do (AHP).
Communications	
Implement a communication system	A more efficient way of communicating - maybe some kind of secure emailing or messaging service. A shared system for clinical documentation - this would eliminate the need for a lot of

	administrative tasks and keep all provider and clinicians informed and up-to-date with client progress, information, changes in health status or circumstances (AHP). Up-to-date access to primary care provider encounter with client and vice versa (AHP). If participating provider/clinics had an 'IPT hotline' that made connecting with the provider easier, that would of course improve communication and connection (AHP).
Support more timely communication	It would be great if I could just send a quick question to a doctor/NP and get a timely answer or have a bloodwork plan in place that doesn't require the client to initiate making an appointment because this can cause big delays (AHP). Consult note after each encounter (Provider).
Do not use fax	Send us back info via Excelleris not fax (Provider).
Send information on wait list and appointment to provider	Communicate waitlist and appt info directly to the referring physician as well as the patient (Provider).
Receive feedback from providers	Receiving feedback from providers if services provided meet their expectations (AHP).
Increase Division involvement with clinic	For the Division to have regular meetings with the clinic. The one clinic MD lead had asked us a few times who was their contact person (AHP).
Provide updates on program changes	Easier to read newsletter to update physicians on any changes of the IPT program (Provider).
Develop guidelines for TBC	Better guidelines about how to integrate these services to provide more meaningful team-based care (Provider).
Provide AHP scope of practice documents	A brief overview of the scope of practice for pharmacists that is made available for provider would be useful (AHP). Provide info re scope of duties (Provider).
Enable referral forms on multiple platforms	Please have referral forms available on multiple platforms or allow generic referral letter (Provider). Improvement in the referral form to have more space to fit in information for some of the complex patients (Provider). Referral that can be completed in the EMR similar to a referral to a specialist (without need for a specific form) (Provider). Simple referral process (Provider). Perhaps give a list to us of common reasons people refer to SW and OT (Provider).
AHP Experience	
Education for the AHPs	We will also benefit from having an educator that focuses on new learning opportunities for the ITP team (AHP).

Provide more administration support for the AHPs	It would be great if there could be more CAs taking on the administrative work being done by clinicians--setting up Zoom links, sending out Zoom links and email reminders for appointments, etc.) (AHP). More admin staff to re-schedule bookings, send reminder emails to clients, etc. (AHP). Less administrative work being done by clinicians so that we can spend more time with clients (AHP).
Provide information on referral sources	Maybe sharing more about what an appropriate referral is and other community/VCH/other resources that might be helpful (AHP).
Provide office space	Permanent office space/clinic where more staff can work together and build rapport with one another (AHP).
Expand Program	
Include attachment support	I would love if this program helped connect clients to MRPs when they lose a provider, or even to find a better match based on the client's needs and the provider's expertise (AHP).
Allow follow-up appointments	Probably if resource permit more F/U assessment after initial assessment (Provider).
Provide more funding/ more AHPs	I think the IPT program has had a big impact in a short period of time. Wait times are lengthening to see AHPs so increasing AHPs should increase timely access to care and therefore improve health outcomes and the patient and provider experience (Provider).
Patient Experience	
Offer in-person appointments	Option for in-person appointments (Provider).
Provide more accessible offices	We need more of them deployed everywhere (Provider).
Allow self referrals	Patient self-referrals (Provider).
Send text message reminders to patients	Text message reminders for patients if you don't do that already. (Provider).
Program Management	
Explore alternate models of oversite and management	I wish the IPT/VCH had more autonomy to make decisions about its criteria and rules (AHP). I would prefer that VCH not hire their own allied health professionals, but rather team up with existing successful services in the community that we value by offering funding to them, e.g., let us choose the counsellors in community. I can't use the dieticians for my anorexic nervosa pts as they need to have specialized training. Can I use the OT for mental health or ADHD? (Provider)
Streamline internal referrals	Streamline the internal referral process so that it doesn't feel like we have to ask another clinician for a "favour" (although everyone has been great about accepting internal referrals). (AHP).
Collect qualitative outcomes	Focus more on qualitative outcome rather than quantitative (AHP).