Health Links Leadership Community of Practice

Jan 25, 2017

Innovative Practices:
Mental Health & Addictions “Sneak Peek”

Today's Agenda & Objectives

- Listen to and reflect upon a patient story related to experiences with mental health and addictions
- Understand the purpose and approach to identifying these practices in the field
- Participate in a 'sneak peek' of our current work and what is coming with these important practices
- Upcoming Events

PARTICIPATING IN THE WEBINAR

- This webinar is being *recorded*.
- ALL participants will be muted (to reduce background noise). You can access your webinar options via the orange arrow button.
- Discussion period post presentation, please type your questions for the presenter after each presentation.
- If you would like to submit a question or comment at any time, please use Question box feature.

WEBINAR PANEL

Shannon Brett, *Manager, Quality Improvement & Spread, Health Quality Ontario*

Jennifer Wraight, *Quality Improvement Specialist, Health Quality Ontario*

Monique LeBrun *Quality Improvement Specialist, Health Quality Ontario (Moderating Discussion)*

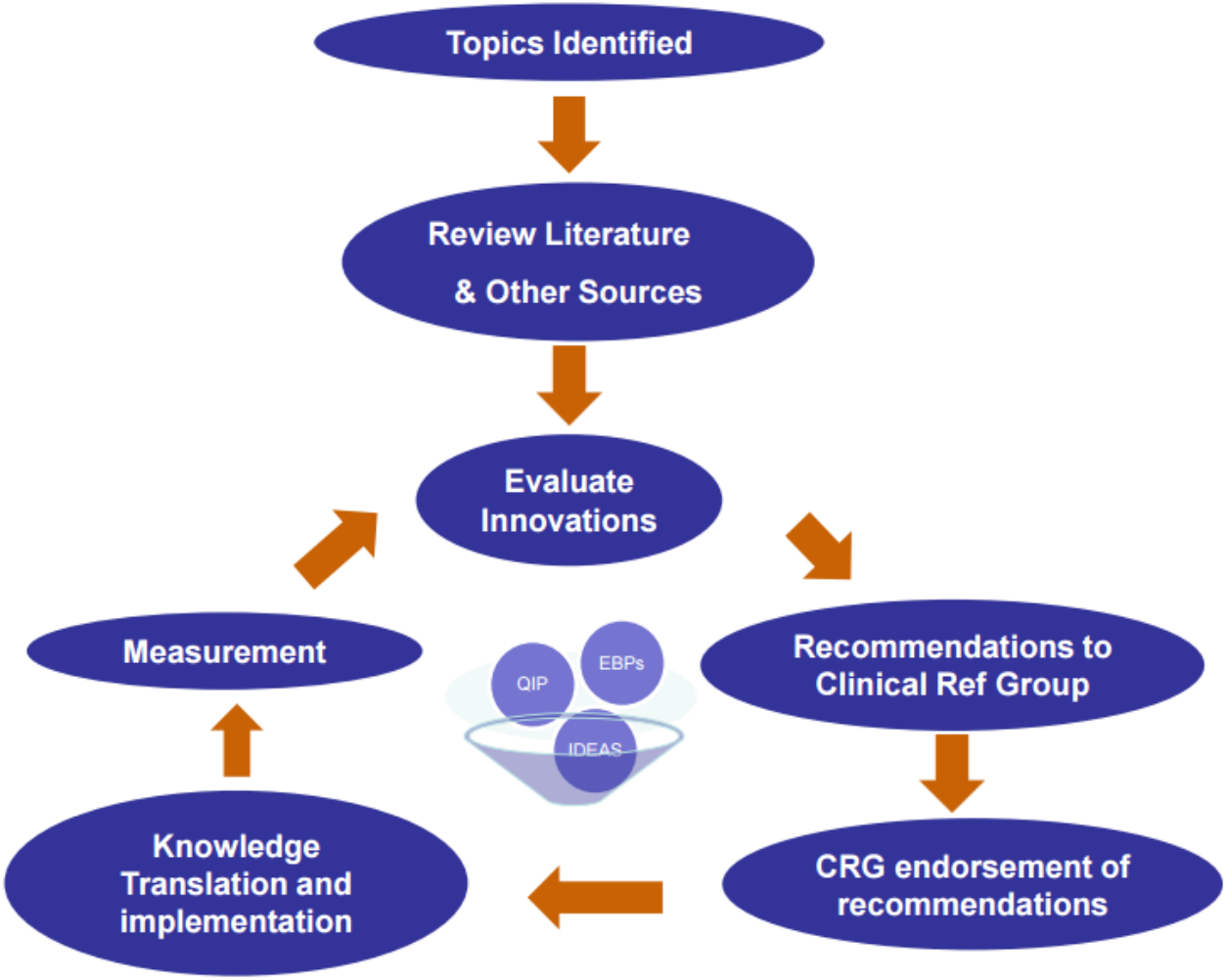
GUEST SPEAKERS

Tracy Koval, North Simcoe Community Health Link, NSM LHIN

HEALTH LINKS LEADERSHIP COMMUNITY OF PRACTICE

'Communities of practice can be defined as groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly'

INNOVATIVE PRACTICES



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SHEDDING LIGHT ON THE COORDINATION OF CARE FOR CLIENTS WITH MENTAL ILLNESS IN NORTH SIMCOE COMMUNITY

A CASE STUDY APPROACH

Meet Vanessa

- 54 year old female
- History of: paranoid schizophrenia, anxiety, depression, chronic pain, degenerative disc disease and osteoarthritis
- Common issues: medication compliance, homelessness, food insecurity, anger management, lack of trust amongst health service providers, revolving door to the mental health system
- Organizations involved in client care upon approval to health link: Chigamik CHC (primary care and community outreach worker), Wendat, Guesthouse Shelter, David Busby Centre, Salvation Army Street Outreach, Midland Police, ODSP, Pharmacy

Determining a plan of care

- Based on client goals (initial visit)
  - Housing (November 1)
  - Bank account
    - For ODSP direct deposit
  - Birth Certificate
  - Photo I.D.

Determining a plan of care

- Expanding client goals
  - Assistance with transportation
    - Taxi account created for client with local taxi company
      - soup kitchen daily
      - pharmacy weekly
  - Regular visits with writer to purchase groceries etc

Mental Health Struggles

Admission Date	Discharge Date	Actions/Plan of Care
December 22 (Waypoint)	January 8	• Client restarted on medication • Day of discharge, message left for psychiatrist stating client called and does not sound well • Upon discharge, client talking to herself and urinated pants
April 29 (Waypoint)	May 10	• Psychiatrist attempting new medication regimen • CST not accepting new referrals • Client refuses ACTT • 7 organizations involved with client to send letters highlighting how client is incapable in hopes to have her deemed incapable for personal care and property • Letters to be sent by May 10- (sent May 9). Client discharged May 10

Admission Date	Discharge Date	Actions/Plan of Care
May 30 (Waypoint)	June 8	• Client restarted on medication • Waypoint to discharge client to homelessness • Waypoint encouraged to read letters from previous admission that were sent from organizations- to have client deemed incapable • Denied by psych-states capable
July 7 (RVH)	TBD	• Injectable initiated • Case conference with those involved • Client states injectable for arthritis, client is not corrected and advised its for schizophrenia • Capacity discussed- psychiatrist states client capable for personal care, not property. To have assessment completed • CTO discussed- to be overseen by PCP as client does not have psych in Midland (PCP refused) • Client transferred to Sans Souci at Waypoint as no CTO and housing • Sans Souci overseen by MD, not psych. MD states client unwell and should be incapable

Struggles Summarized

- Communication
- Plan of care discussed not followed
- Mental health support voluntary
- Capacity as defined by the Mental Health Act
- Differing views amongst practitioners

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INNOVATIVE PRACTICES

Coordinated Care Management

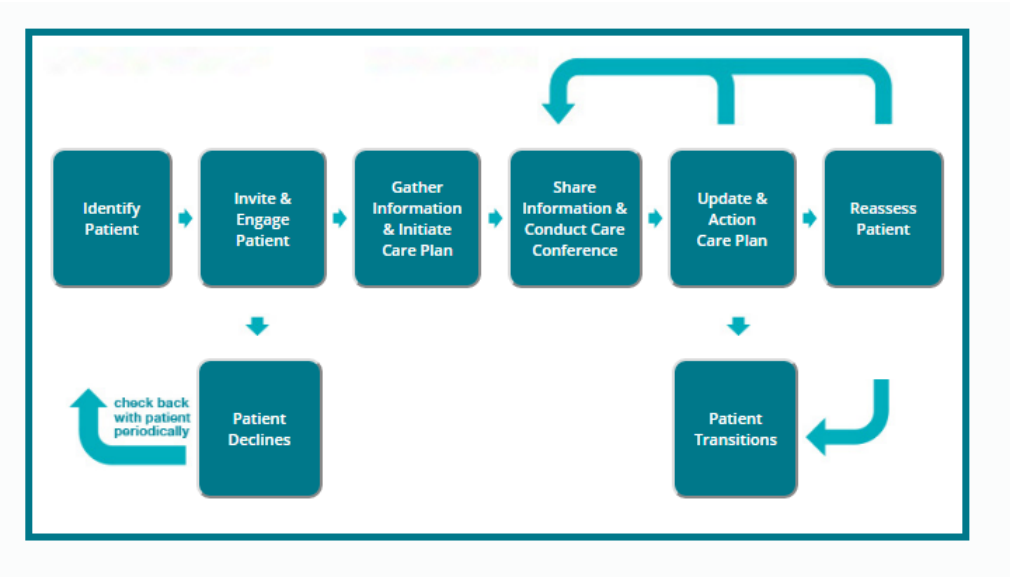
with patients who present with

Mental Health and/or Addictions

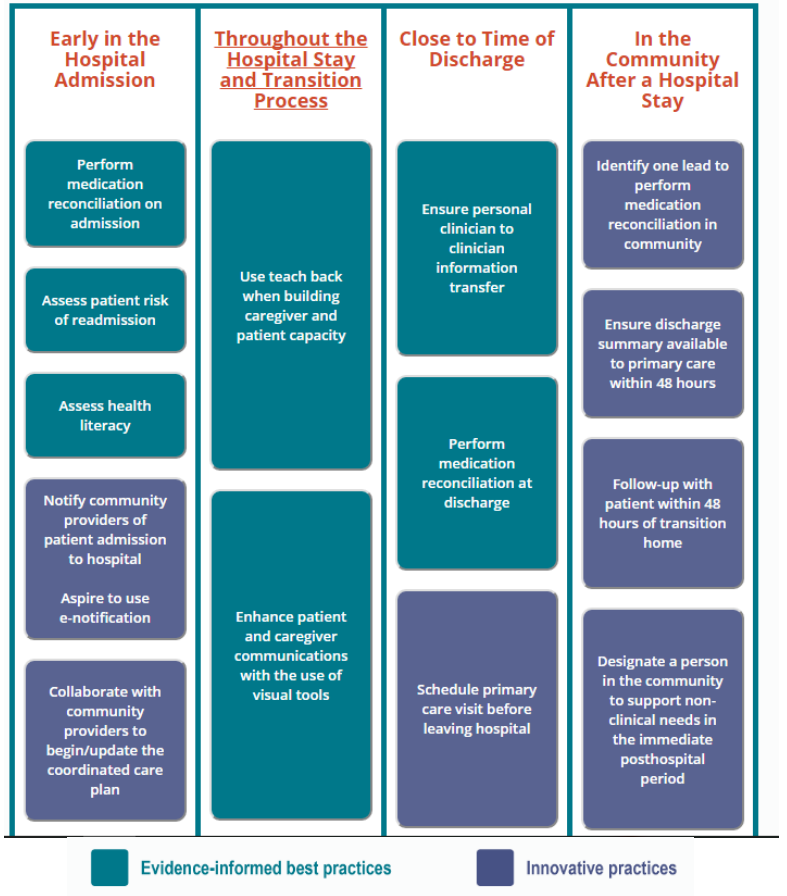
Conditions

1. Innovative Practices – Update

1. Coordinated Care Management

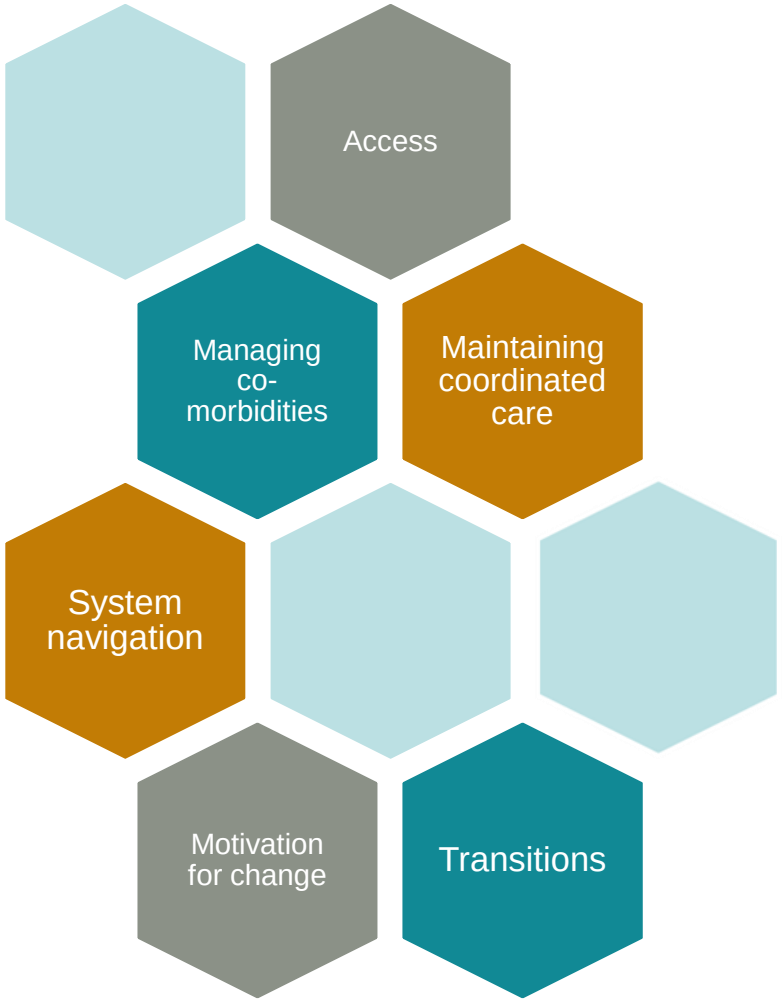


2. Transitions from Hospital to Home



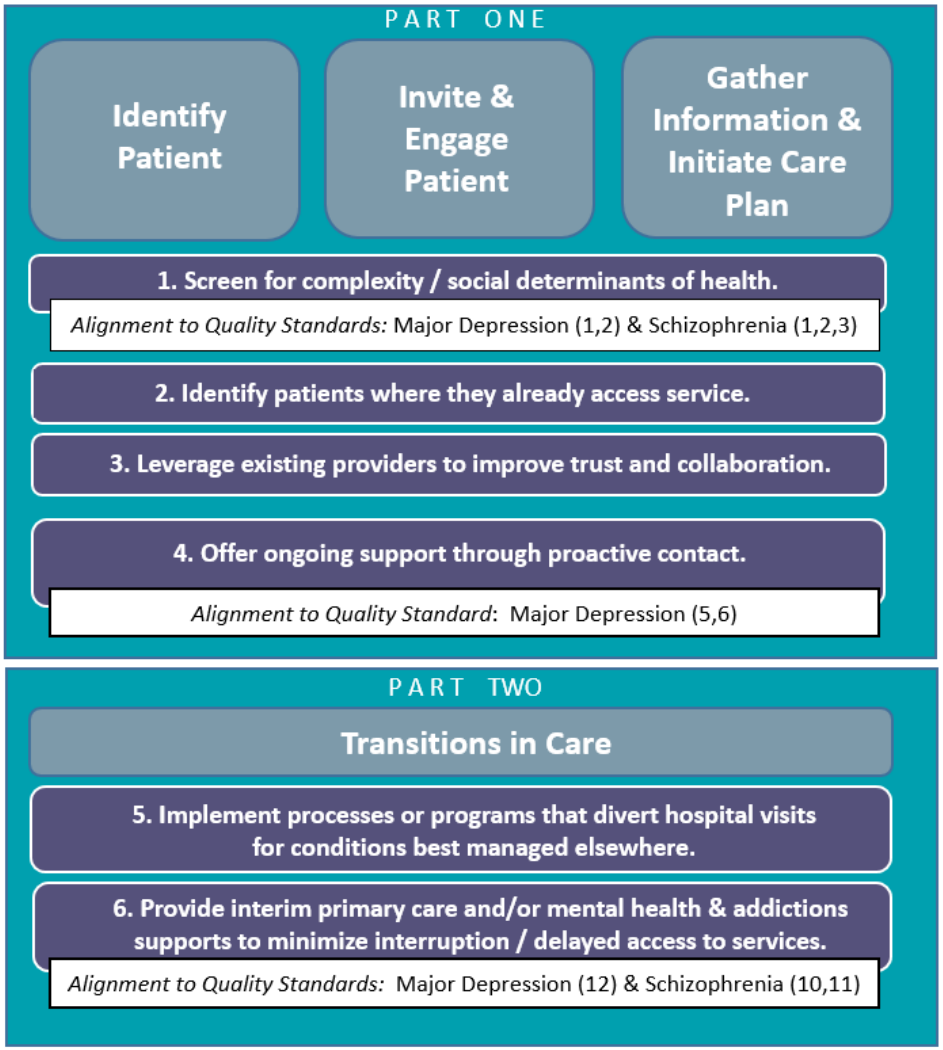
COORDINATED CARE MANAGEMENT with patients who present with MENTAL HEALTH and/or ADDICTIONS CONDITIONS

Where are the gaps?



COORDINATED CARE MANAGEMENT with patients who present with MENTAL HEALTH and/or ADDICTIONS CONDITIONS

****COMING SOON****



****IMPLEMENTATION SUPPORTS CURRENLTY UNDER DEVELOPMENT****

COORDINATED CARE MANAGEMENT with patients who present with MENTAL HEALTH and/or ADDICTIONS CONDITIONS

1) Use tools or approaches to screen for and/or assess complexity related to the social determinants of health, particularly income, housing, and food stability.	Emerging
2) Bring Coordinated Care Management *to* patients where they are already accessing health (or other) services.	Promising
3) Customize the approach to Coordinated Care Management by leveraging or building trusted relationships, to improve engagement.	Emerging
4) Offer proactive and supportive contact to patients to promote engagement with Coordinated Care Management, while continuing to support self efficacy.	Promising
5) Implement processes or programs that divert hospital visits for conditions best managed elsewhere.	Promising
6) Provide *interim* primary care and/or mental health and addictions supports for the patient to minimize interruption/ delayed access to services during transitions.	Emerging

1. Use tools or approaches to screen for and/or assess complexity related to the social determinants of health, particularly income, housing, and food stability.

EMERGING PRACTICE	
Context	• Many individuals with Mental Health and/or Addictions conditions present with issues relating to social determinants of health. • Instability relating to income, housing, and/or food security appear to be associated with future high cost health care consumption. • Health Links providers and patients report that issues relating to the social determinants of health can be significant barriers to health, and can impact discharge from hospital to home. • However, there is significant variation in how Health Links screen for/assess issues relating to the social determinants of health.
Description	• This practice is intended to build on the guidance provided in the Ministry of Health and Long-Term Care in previous webinars, and guidance documents, and also the previously released Coordinated Care Management Innovative Practices. • This practice places emphasis on using standardized tools and/or clinical assessment methods to screen for/assess issues relating to the social determinants of health in order to 1) identify patients and/or 2) complete further assessment to inform planning, *when indicated.* • May be implemented in a variety of ways; informal (trigger questions), and/or using formal assessment tools/ data (OCAN, Be Well Survey).

2. Bring Coordinated Care Management *to* patients where they are already accessing health (or other) services.

PROMISING PRACTICE	
Context	• Timely access to health care can be difficult for patients present with Mental Health and/or Addictions conditions and associated complexities. • Providers and patients report that patients who present with mental health and/or addictions conditions may not be well connected to the health system, and may receive services through other systems, such municipal or social services, and/or the justice system.
Description	• This practice is intended to draw upon evidence that bringing care to marginalized populations supports improved access and engagement in care (in comparison to compared to approaches that require patients to *proactively seek out care*). • This practice involves enabling providers in a variety of settings (where patients already access service/ care) to identify patients and start/connect the patient to the Coordinated Care Management Process.

3. Customize the approach to Coordinated Care Management by leveraging or building trusted relationships, to improve engagement.

EMERGING PRACTICE	
Context	• Engaging patients who have Mental Health and/or Addictions conditions in Coordinated Care Management, and/or maintaining this engagement can be challenging. • Providers report that patients within this population are more likely to decline Coordinated Care Management, or consent and then withdraw from the process. • Providers have attributed this to issues relating to stigma, trust of the health care system and providers, and other factors.
Description	• To establish and improve engagement of patients with mental health and/or addictions issues, leverage or create partnerships amongst members of the care team to ensure that the process of completing the Coordinated Care Management process can be customized to meet the patient's needs. • Specifically in addition to having a single point of contact (often the role of a health care provider that can collect, manage and store health care information), the team should ensure that a member of the care team is a *trusted* support person of the patient AND/OR a provider with mental health and addictions experience. • This role may be represented by a) one individual that can successfully assume all of these roles), or b) multiple individuals *working in close collaboratio*n. This cohesive team (that together, can manage the logistical aspects and support the patient) appears to support improved engagement of patients.

4. Offer proactive and supportive contact to patients to promote engagement with Coordinated Care Management, while continuing to support self efficacy.

PROMISING PRACTICE	
Context	• Providers and caregivers reported that it can be challenging to engage patients who have Mental Health and/or Addictions conditions in Coordinated Care Management, and to maintain this engagement over time.
Description	• This practice was brought forth by a number of Health Links during the Environmental Scan with the LHINs and Health Links. • This practice involves proactively contacting the patient at regular intervals to support ongoing patient engagement and to promote wellness and reduce the occurrence of crisis (e.g., medical issues leading to avoidable emergency department visits). • This also builds on some of the principles of Intensive Case Management, which is generally accepted as an effective approach for supporting care of patients with complex health and wellness issues. .

5. Implement processes or programs that divert/ hospital visits for conditions best managed elsewhere.

PROMISING PRACTICE	
Context	• The emergency department is a necessary resource for patients who have Mental Health and/or Addictions conditions experiencing crisis. However, *some* visits to the emergency department may be better managed elsewhere. • Ensuring the right care, in the right place, at the right time, may provide better health outcomes and experience for patients, and may also reduce avoidable emergency department visits and subsequent admissions.
Description	• This practice is intended to encourage Health Links to leverage or create processes that support diversion to appropriate and timely community-based care, just prior to an emergency department admission OR upon entry to the hospital. • For example, there may be process in place to divert events just prior to crises, or diversion processes or programs that are offered to the patient upon entry to hospital.

6. Provide *interim* primary care and/or mental health and addictions supports for the patient to minimize interruption/ delayed access to services during transitions.

EMERGING PRACTICE	
Context	• After a visit to the emergency department, or a hospital admission, patients with Mental Health and/or Addictions conditions are less likely to receive *timely* follow up care with primary care providers and/or appropriate outpatient/ community based mental health services. • Providers report that the high rate of readmissions for patients with Mental Health and/or Addictions conditions, in comparison to other populations, may be associated with these interruptions/ delays in service.

Description	• This practice involves providing interim primary care and/or mental health and addiction supports to patients in the period of transition back to community to fill the gap in care for patients:
	  • 1) not currently attached to primary care; and/or
	  • 2) to those who need support during the transition; and/or
	  • 3) those awaiting community mental health and/or addictions services.

COORDINATED CARE MANAGEMENT with patients who present with MENTAL HEALTH and/or ADDICTIONS CONDITIONS

Hmmmm….wouldn't these practices be helpful for ***most*** patients receiving Coordinated Care Management?

Perhaps…

However, since these practices are presented within a Quality Improvement perspective, Health Links are encouraged to continue to *firs*t test these practices within the original population for which they were developed.

COORDINATED CARE MANAGEMENT with patients who present with MENTAL HEALTH and/or ADDICTIONS CONDITIONS

NEXT STEPS

1. Conclude ‘Check Ins with the Field’ and synthesize information

2. Develop Implementation Supports

3. Consult with Clinical Reference Group

4. Share Innovative Practices and Implementation Supports with Community of Practice, including:

    - Webinar- *Part One*: **April 26, 2017**
    - Webinar- *Part Two*: **May 24, 2017**

Discussion:

Please submit questions to us via the "Question" box.

HEALTH LINK LEADERSHIP COMMUNITY OF PRACTICE;

Resources and Events

- Quality Rounds Ontario – **February 8th (7:00am – 8:00am).** More information available on HQO's events website.

- Series of Webinars continuing monthly for the Health Link Community of Practice, invites to follow to members in near future.
  Mark your calendars: February 22nd, March 22nd, April 26th

- In the process of developing an online web presence for the Health Link Community of Practice. More information will follow as this evolves

Learn more about upcoming program dates and deadlines to apply:

ideasontario.ca/programs/advanced-learning-program/

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WE WANT TO HEAR FROM YOU!

Your input is important and we'd like to hear from you!

Please send suggestions for

topics you would like to see or hear about in future webinars to

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