Ontario's Community Health Centres
Les centres de santé communautaire en Ontario

Community Health and Wellbeing

Shift the conversation
JUNE 8 - 9 JUIN 2016
Sheraton Parkway Toronto North Richmond Hill

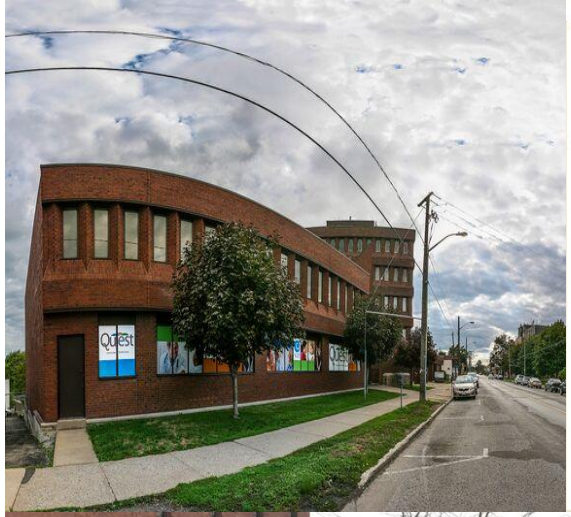
Changer la
Santé communautaire et bien-être

Presenter Disclosure

Presenters: Jenny Stranges, Programs Director
Despina Tzemis, Programs Manager
Ashley Edwardson, Outreach Social Worker

Relationships to commercial interests:

Grants/Research Support: None
Speakers Bureau/Honoraria: None
Consulting Fees: None
Other: None



Quest
Community Health Centre



Urgent Service Access Team (USAT):

From hospital to community: Working towards seamless transitional planning for complex clients with Mental Health and Addition in Niagara Region

Every One Matters

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Urgent Service Access Team (USAT)

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- Interdisciplinary Mobile Outreach Team
- Eligibility Criteria
  - Individuals who use the Emergency Department frequently for Mental Health and Addictions related issues
  - Individuals struggling with opioid dependency
- USAT supports clients on a short term basis, while connecting to ongoing long-term services
- Team act as a 'bridge' to link clients to primary health care, community resources/services, and opioid replacement treatments

Project Management Team

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- **Project Management Team (PMT) Partnership:**
  - Niagara Health System (NHS)
  - Canadian Mental Health Association of Niagara (CMHA)
  - Community Addiction Services of Niagara (CASON)
  - Quest Community Health Centre

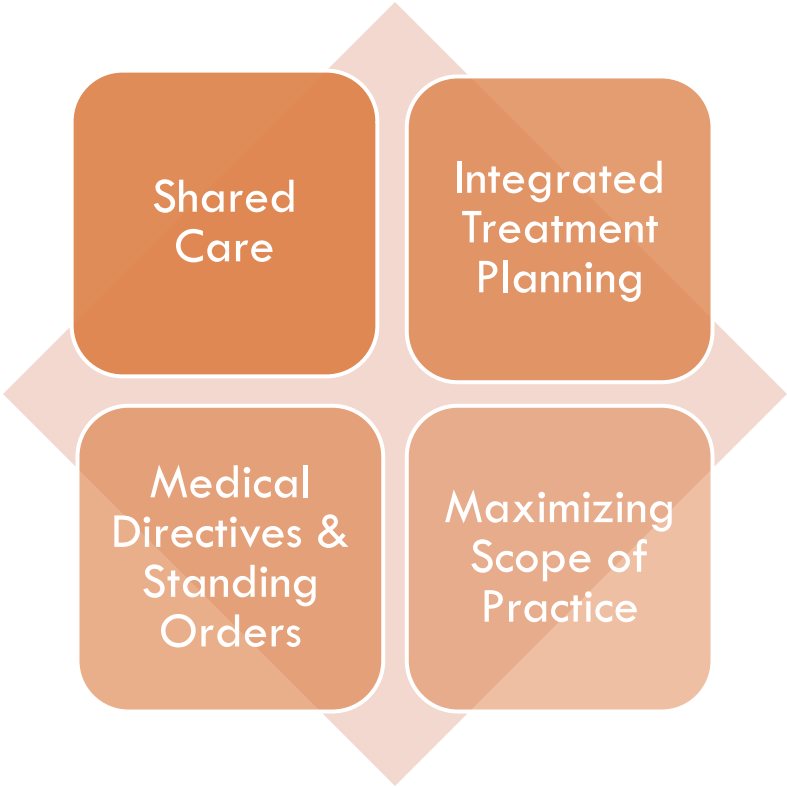
Purpose

- Identifies strengths and barriers in transitional planning in order to ensure secure linkages
- Support navigation of system challenges and facilitates successful transitions from hospital to community
- Provides agency navigators from each organization as the 'go to person' to help USAT clarify referral processes and answer questions when making referrals

Our Team, Our Program

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- Interdisciplinary mobile outreach team:
  - Client Coordinator
  - Nurse Practitioner
  - Registered Practical Nurses
  - Outreach Social Workers
  - Therapist
  - Program Manager



Niagara Wide Program

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- Points of Services:
  - Niagara Health System
    - PERT (Psychiatric Emergency Response Treatment)
    - St. Catharines Hospital Site - MH Inpatient Units
    - Withdrawal Management Services
    - New Port Residential Treatment Centre
  - Drug Dependency programs (e.g. Methadone clinics)
  - Home visits
  - Other agreed upon community locations
- Services across both Niagara's urban and rural areas



Integrated Community Lead & Health Links

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- The Integrated Community Lead (ICL) is a concept USAT adopted to create firm care pathways for clients

- The ICL takes the lead in organizing, facilitating and coordinating client care across the community to ensure that clients do not fall through the cracks, including ensuring the Community plan is created/updated/communicated

- USAT has been identified as a lead for Health Links in it's recent expansion phase for individuals who frequenting the ED seeking MH&A support.

Project Management Team & Electronic Databases

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Key Success Factors:

1) PMT ensuring ease in system navigation (agency navigators)

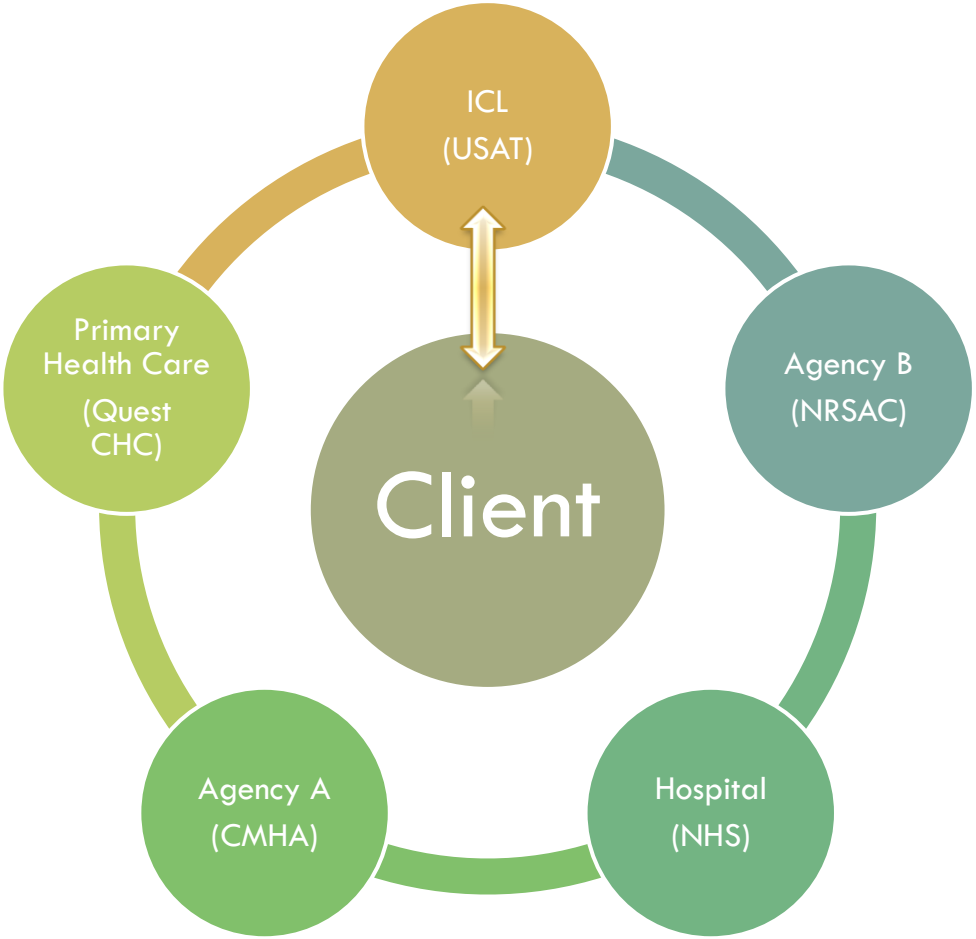
2) Embracing ICL concept and HL

3) Maximizing health data to reduce client frustration with the system by maximize information flow, reduce duplication of efforts and ensuring a broader picture of client journey
   - Quest CHC EMR
   - Clinical Connect
   - Integrated Decision Support (IDS)

- Maximize use of OTN services (Psychiatry, Endocrinology etc.)

Client Experience

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Quest CHC

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Thank you for your time!

Urgent Service Access Team

Quest Community Health Centre

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Windsor-Essex County
Empowering Transitions to Wellness

Creating an Integrated Care Continuum Starts Within



AOHC Conference
June 9, 2016



Presenter Disclosure

Presenter: Claudia den Boer Grima

Relationships to commercial interests:

Grants/Research Support:	None
Speakers Bureau/Honoraria:	None
Consulting Fees:	None
Other:	None

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CMHA/CHC History

- A Primary Care working group reporting to the Board of CMHA-WECB was established in the fall of 1999

- Purpose was to explore the concept of a CHC serving the specific needs of the general public, as well as those with severe mental health issues living within a defined geographic area

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CMHA/CHC History

- In 2000, the Agency was approved for 1 NP and .5 Psychiatrist who addressed the primary health care and mental health needs of the clients receiving service at CMHA

- In 2001, CMHA-WECB submitted a Primary Care proposal to the MOHLTC after the completion of a needs assessment

- In 2006, the Agency hired a Health Promoter, Dietitian and 2 Therapists

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CMHA/CHC History

- In April 2008, City Centre Health Care became a fully operational satellite program of the Teen Health Centre working collaboratively with CMHA to promote integration of primary care and mental health services

- The Centre opened with a full time Manager, 2 Physicians, 2 NP's, 1 Dietitian, 1 Health Promoter, 1 RPN, 2 Medical Secretaries, 2 Social Work Therapists, .5 CMHA Psychiatrist, and .5 Chiropodist

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CMHA/CHC History

- In September 2012, City Centre Health Care divested from the then Teen Health Centre (now Windsor Essex Community Health Centre)

Current Staffing:

- 2 FTE Physicians
- 1 FTE Health Promoter
- 4 FTE NP's
- 1 FTE Dietitian
- 2 FTE Therapists
- .5 Foot Care Nurse
- 3 FTE Medical Secretaries
- 1 FTE RPN + 2 Temporary (Injection Program)

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Community Collaboration

- **WE CHC**: Diabetes education, Asthma Clinic, Tai Chi
- **Windsor FHT**: Nutrition group facilitation
- **Essex County Health Unit**: Healthy Kids Initiative, Healthy Weight Loss, Fluoride Varnish, Community Needs Assessment
- **Essex County NP Led Clinic**: Low Back Pain Pilot Project, (Physiotherapy, chiropractic, Massage therapy), Yoga
- **SEBGA Physiotherapy clinic**: Hydro pool therapy
- **Harrow FFT** (.5 CHC Therapist)

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Today in theory…

- CCHC staff working in partnership with CMHA Case Managers to address the mental health and addiction needs of clients who are at risk and presenting with primary care issues

- Clients are able to become connected to the various CCHC & CMHA supports and programs offered

- Recognized by Accreditation Canada as a "Leading Practice" in the delivery of primary and mental health care

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Look in the mirror…..



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The reality…

- Staff are not completely familiar with the full scope of services available
- Some duplication of services (e.g. therapy)
- Neither party knows which clients are receiving what services
- Referral & intake process into CCHC takes too long
- Two different consent and referral forms
- Two different documentation systems (NOD & CRMS)

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What problem are we trying to solve?



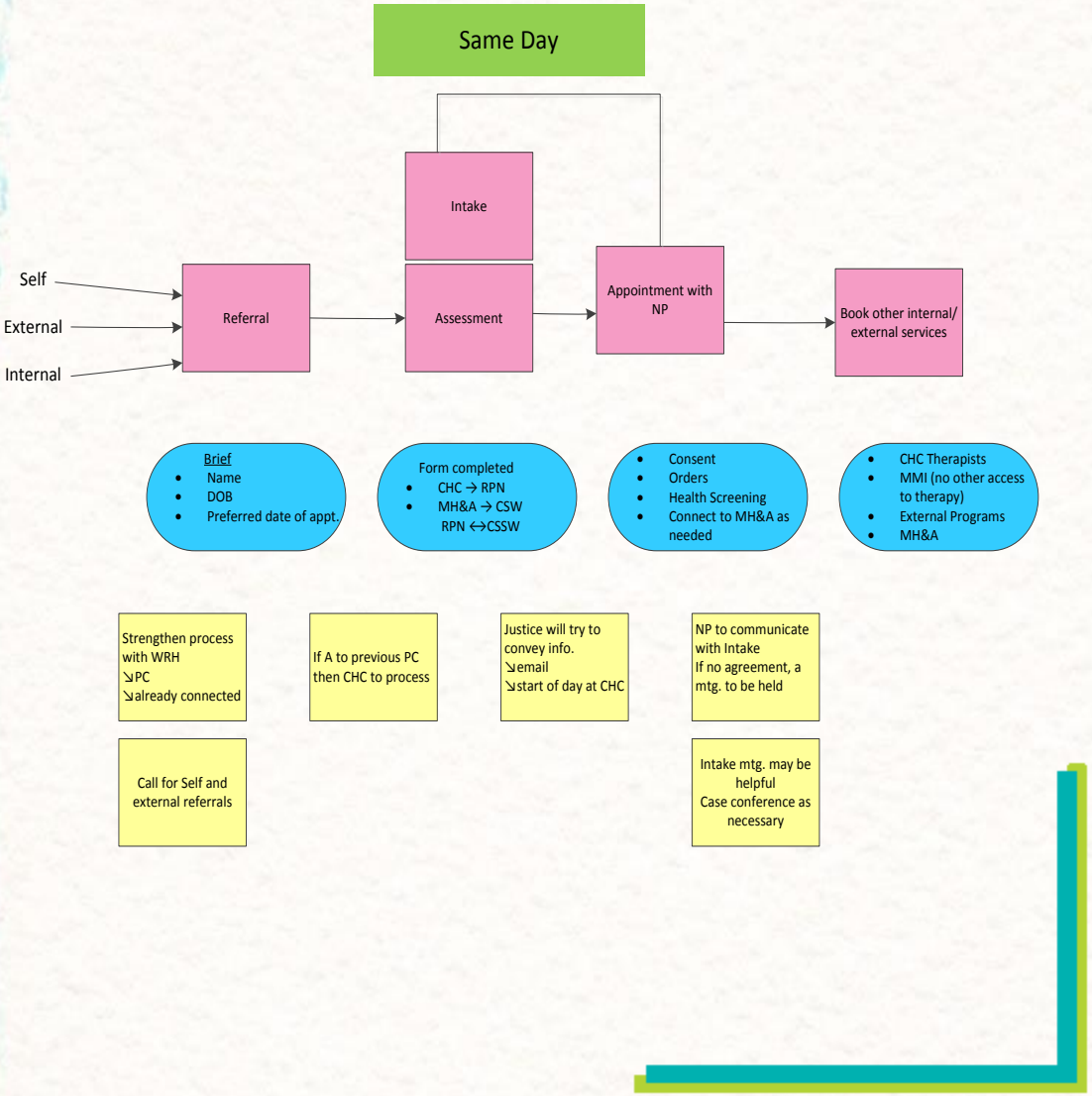
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Key Outcomes

- Improve communication between primary care & mental health & addiction services
- Improve access to both services
- Improve access to full suite of interdisciplinary services
- Clarity re: services offered
- Improve flow for the client
- Improve continuity of care - no lapses in services

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Map the Future State



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Challenges / Questions

- What is the mandate of the CHC?
- What about clients who have a physician but he/she has been “fired” by the client?
- Need a way to track current patients (patient list)
- Identify an internal referral process for clients from CCHC to MH & A and feedback loop
- Review intake and consent forms - simplify
- Technology needs to speak to each other (e.g. NOD & CRMS)
- Team and community education

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The Future…

Building a Continuum of Care:

- Timely access to psychiatry consultation
  - HDGHC General Psychiatry Clinic
- Central Access Initiative with HDGHC
- Acute Care Hospital (e.g. ED diversion)
- Housing First (Primary Care/MH&A)
- Expand services beyond current catchment area (Mobile clinic - NP + Social Worker?)
- Facilitator of Primary Care Reform - Community Primary Care Hub?

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Questions

