South East Local Health Integration Network

Transforming Addictions and Mental Health Services to Better Serve Our Residents

Addictions and Mental Health Redesign

South East LHIN Addictions and Mental Health Redesign

June, 2015

Objective for the Addictions and Mental Health Redesign

South East Local Health Integration Network

To design and implement a regional system of integrated addiction and mental health services along the continuum of care and across a person's life journey.

Why?

- Client and caregivers, clinicians, direct care providers and related stakeholders repeated communications that while direct service is good, there continue to be gaps in service transition, difficulties and confusion in accessing service when needed, insufficient service to meet demand on a timely basis, duplication in story-telling, assessments and treatment approaches, and ongoing issues with stigma
- Demand by the population is predicted to increase while funding remains static
- Presentations to ER and readmissions rates remain unwaveringly high

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Clients told us the system needed to change!

"I feel lost when I am in the system, I don't get told the information I need to know and the coordination between the hospital and community doesn't exist. I was left with no support."

"I would like more proactive care and there being more responsibility for people with Addiction and Mental Health. Stop "dumping" us."

"No matter where you live, I would like everyone to have equal access to support."

"There needs to be more access to services, to psychiatrists and to medication. We go to the ED as there is no other accessible service."

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Clinicians told us the system needed to change!

"Duplication and delay conditions for decreased quality of service exist NOW. The onus is on the client to have to do multiple consents, tell multiple stories, make sure all pieces are connected, navigate through the system themselves." - Psychiatrist

"It's not that the system is broken and we have to fix it, rather we do not have a system in the first place and need to create one." - Health Links Leads

"A circle of service encompassing all is critical to ensure we have conditions to be successful versus the parallel system we have today" - Psychiatrist

"By not having access to an integrated record of history, by having to wait for multiple consents to be signed, the patient is delayed in receiving treatment and/or of receiving treatments that have been tried before but have not previously worked". - Psychiatrist

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Objective for AMH Redesign

Why redesign the entire system?

- Increasing wait-times, high ER visits, rising readmission rates
- Lack of standardization, fragmentation - providers operating in silos throughout AMH services across the region
- Difficulty implementing standardized tools and protocols through Clinical Services Roadmap
- Lack of understanding by primary care physicians, clients and caregivers and other stakeholders as to what services and programs currently exist, how to access them, and where they are located
- The number of individuals requiring AMH services continues to increase. Given that we have to work within the resources we have available in the South East region, the impact of the increase in volume will put pressure on the existing capacity.

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AMH Redesign Phases

- Development of a Project Plan
  - January – March 2013
- SE LHIN Board confirms status quo is not an option, launches the AMH Redesign
  - April, 2013
- Launch of the AMH Redesign – Redesign Task Force
  - May – November, 2013
- Ideal Individual Experience, Service Elements and Governance Options presented to SE LHIN Board
  - Decision made to further explore implications of Governance Option 2
  - December – March, 2014
- Future State Planning Teams and Client and Caregiver Advisory Panel Formed
  - Implications presented to SE LHIN Board with approval given to proceed to implementation
  - April – August, 2014
- Integration Plan Development and Full Implementation Launch
  - September 2014 – April 1, 2015
- Implementation Phase
  - Part A, B, C

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Client and Caregiver Involvement

- Visioning Day, Validation Day, Stakeholder Engagement Sessions
- Redesign Task Force
- Future State Planning Teams
- Client and Caregiver Advisory Panel
- Transitional Alliance
- Governance Transition Teams

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Client Focused Process/Client Led Design

Client Led Design

- Throughout the AMH Redesign Process, it has been integral that all conversations, recommendations, feedback and insights maintain the client as the focus
- Throughout the AMH Redesign and Future State Planning process, multiple client and caregiver engagement sessions were held to ensure that their voices, experiences and recommendations were included and that the work being done by the RTF and the FSP teams resonated with what the clients felt they needed to be successful on their journey of recovery
- There was client representation on the Redesign Task Force and a Client and Caregiver Advisory Group that provided insights and feedback to the Future State Planning teams for reflection and incorporation into the final plans

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Client Focused Process/Client Led Design

Client Focused Process

- The AMH Redesign Task Force (RTF) and the Future State Planning (FSP) Teams committed to reviewing their recommendations and feedback at the end of each session to ensure that the conversations were client-focused and that the work being done to improve the system would deliver on the Ideal Individual Experience and related service elements
- The Governance Transition Teams and the Transitional Alliance maintained the client at the center of their conversations and ensured that the client perspective and focus was maintained throughout the Integration Plan documents
- Clients also participated as equitable partners on the Transitional Alliance, providing feedback and recommendations for the Governance Transition Teams and for the Future Strategic Alliance

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Engagement

Stakeholder Engagement

- Extensive stakeholder engagement began with the development of the project plan itself and continued, without pause, throughout the entire process.
- The engagement of stakeholders has been multitudinous, from the Visioning Day held in June with 160 participants, through seven RTF meetings, multiple engagements with AMH organizations at the Executive Director and Board level, provider network committees, psychiatry sessions, targeted engagements with primary care and Health Links, the francophone community, Children and Youth Mental Health and Addictions services, First Nations communities, housing, client and caregiver feedback meetings and a Validation Session with over 200 participants.
- Over the course of two years, the SE LHIN, KPMG, and other stakeholders have engaged 102 unique stakeholder groups and over 200 clients and caregivers experiencing Addictions and Mental Health challenges

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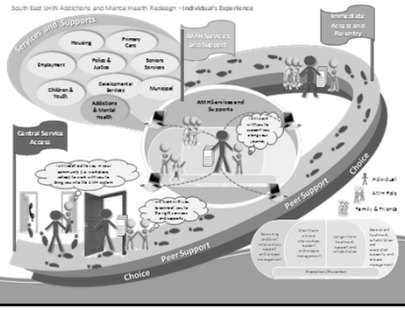
What is the end goal of the AMH Redesign?

To create a regional system across the continuum of care that delivers on the Ideal Individual Experience for Additions and Mental Health clients.



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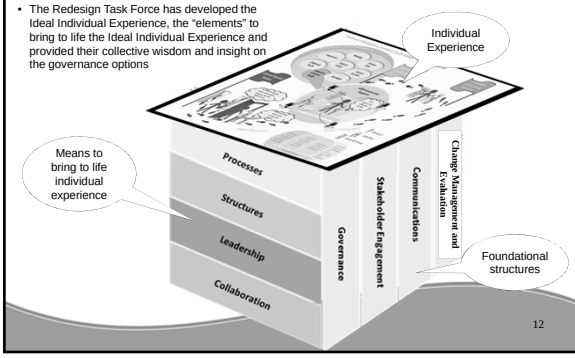
Foundation of the Ideal Individual Experience

- The Redesign Task Force has developed the Ideal Individual Experience, the "elements" to bring to life the Ideal Individual Experience and provided their collective wisdom and insight on the governance options



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Elements to Support the Ideal Individual Experience

Processes	Structures	Leadership	Collaboration
• Clear knowledge of available services and how to access them • Common service access processes • Coordinated service access • Clear roles and responsibilities • Formal processes for referrals/transfer and/or communicating changes in plan • Formal processes for co-management of individuals • Evidence-based care, services and supports • Standardized tools, protocols and pathways • Formal processes for peer support engagement • Formalized knowledge transfer and exchange • Centralized workload management • Waitlist management • Social inclusion processes • Transportation support • Employment support • Immediate re-entry access • Re-entry plan, safety plan, fast-track re-entry for clients • Regional decision making framework on transitions • Consistent pre-screening tools • Common training	• Centralized/streamlined service access model • Comprehensive range of services and supports across the continuum • Best practice models (i.e. wrap around, collaborative care, case management) – services that go to where the client is • Inclusion of community-based programs • System advisors and navigators • Formalized agreements • Resource and referral system to match capacity and resources to needs across the LHIN • Workforce optimization with collaborative care approaches • Competency based workforce • Mobile resources at local level • Integrated structures (with housing, employment, etc.) • Joint funding mechanisms • Communication structures • One team, one plan • Support experience of receiving hospital care in the home • Policy development in collaboration with clients • Therapeutic transitional housing	• System leadership that drives accountability such as a regional agency focused on quality and continuous improvement, integration and coordination, maximization of resources, and data quality • Build upon transformational leaders across front-line, management and governance levels • Leadership supports access to specialist(s) or specialized team(s) • Leadership supports system transformation – manages risk and resolves conflict • Service overlap with partners • 'System' ownership of the client, not 'organization' ownership • Transparency and support for people who provide services	• Formalized collaboration across the AMH continuum and transitions as well as across sectors (i.e. Cancer Care Ontario model) • Formalized collaboration across the AMH continuum and transitions as well as across sectors (i.e. strong linkages with primary care, social services, supportive housing, community health, municipalities) • Collaboration as foundational to supporting client, family and community • Interagency collaboration • Shared responsibility • Communication, trust, respect and accountability

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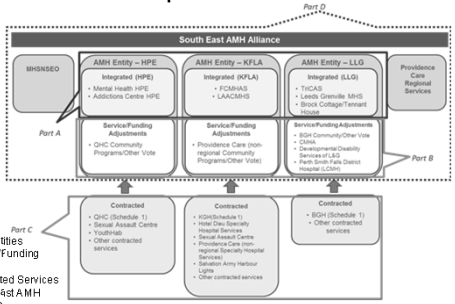
Option 2: Refined Governance Model



Part A – AMH Entities
Part B – Service/Funding Adjustments
Part C – Contracted Services
Part D – South East AMH Alliance Structure

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Implementation Process: April Achievements

- As of April, 2015, all agencies involved in Part A, amalgamated into three formalized geographic Agencies:
  - **Addictions and Mental Health Services – Hastings Prince Edward**
  - **Addictions and Mental Health Services – Kingston, Frontenac Lennox and Addington**
  - **Lanark Leeds and Grenville - Addictions and Mental Health Services**
- These amalgamations mark a tremendous milestone on the path to achieving the Ideal Individual Experience for clients and caregivers across the region
- The achievement of this milestone can be attributed to the continuous dedication of the Governance Transition Team members, the Transitional Alliance, senior leadership, front-line staff, clients and caregivers
- ***Change momentum is building!!***

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Addictions and Mental Health Redesign: Video

- In early 2015, it was decided that as part of the launch of the new system of Addictions and Mental Health Care for the South East LHIN, a video would be created to highlight the client perspective of the process of the Redesign and their thoughts on the new system of care to be implemented.
- Over the course of two months, Fifth Town Films has worked with clients, caregivers and Peer Support South East Ontario to better understand client's thoughts, feelings and perspectives on the Redesign process and how they felt their experiences would be different in the redesigned system of Addictions and Mental Health.
- The video also highlights the extensive geography where services are provided across the South East Region.

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Video

https://www.youtube.com/watch?v=WsCGljZ6xGY&feature=youtu.be

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