FRASER HEALTH MENTAL HEALTH & SUBSTANCE USE INTEGRATED PRIMARY & COMMUNITY CARE

SYMPOSIUM

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Better health. Best in health care.

June 16th, 2012

Agenda

- 10:00 – 10:05 ☐ Welcome and introductions
- 10:05 – 10:20 ☐ The BC Integrated Primary and Community Care Initiative
- 10:20 – 11:00 ☐ Fraser Health MHSU examples of integration
- 11:00 – 11:10 ☐ Success and challenges to date
- 11:10 – 11:25 ☐ Closing remarks and Q&A

Welcome and introductions

- Jenn Blatchford
  Initiatives & Collaborative Care Coordinator, FH Mental Health & Substance Use
- Dr. Linda Curtis
  Family Physician - New Westminster
- Dr. Terry Isomura
  Program Medical Director, FH Mental Health & Substance Use
- Polly Kainth
  Clinical Program Developer - IHNs, FH Mental Health & Substance Use
- Chrystal Mihelic
  Manager, FH Mental Health & Substance Use – White Rock/South Surrey and Peace Arch Hospital

THE BC INTEGRATED PRIMARY & COMMUNITY CARE INITIATIVE

Jenn Blatchford

Initiatives & Collaborative Care Coordinator, FH MHSU

Dr. Terry Isomura

Program Medical Director, FH MHSU

British Columbia Integrated Primary & Community Care (IPCC) initiative

- A provincial initiative in BC
- **Vision:** Reviving primary and community health care through new partnerships and collaboration
- **Objective:** To integrate family physicians, home and community care, and the mental health and substance use system
- Focus on populations with complex health and mental health/substance use needs
- Requires system realignment at the provincial, regional, community, and client levels

Primary and Community Care

Primary health care is…

- where 80% of health care happens
- where people's health is most influenced
- where sustainability of the entire system starts

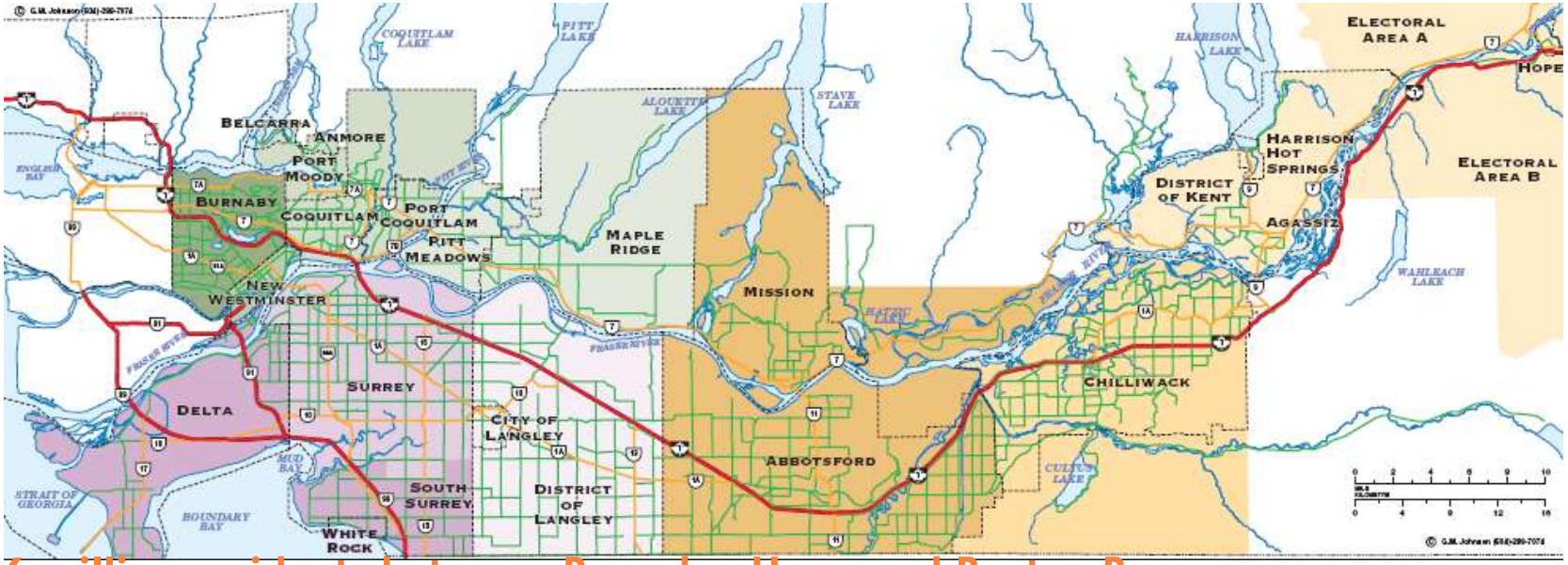
Good care in the community:

- prevents disease from starting or progressing
- prevents ER visits and hospital admissions
- keeps people living safely at home

Primary and Community Care in FH

Fraser Health's primary care system includes:

- 1400+ Family Physicians, PLUS specialists, nurse practitioners, public health workers, community nurses, midwives, pharmacists, clinical counselors, mental health professionals, physiotherapists, dieticians, community resources….



1.6 million residents between Burnaby, Hope and Boston Bar

- A rapidly growing and an ageing population, with complex health conditions and increasing chronic disease
- Patients experiencing fragmented care, people who cannot find an FP when they want one, and FPs and community health providers at capacity

Re-design in the community

- Changing what we do and how we do it

FH community-based health services

- Home Health, Mental Health and Substance Use, Public Health, Aboriginal Health, Older Adult, Residential Care, Primary Care, and community partners
- New thinking about how we deploy resources
- Working together instead of apart
- Deepen collaboration with community partners and agencies

4 strategies driving a new way of partnering

1. Divisions of Family Practice
   - Groups of community physicians voluntarily organized
   - Intent to collaborate with partners to address health care needs

2. Patient attachment – "A GP for Me"
   - Healthy people, happy people and care we can afford

3. Patients as partners
   - Supporting and engaging patients and families to participate in their own health care, decision making about that care, at the level they choose, and in quality improvement and health care redesign

4. Re-design of Community Health Service

A new partnership

Community services (re-designed)

- FH Home Health
- FH Mental Health & Substance Use
- FH Public Health
- FH Aboriginal Health
- FH Older Adult
- FH Residential Care
- FH Primary Care
- Community partners

+

Primary Care

- Family Physicians
- Divisions of Family Practice
- Nurse Practitioners
- Specialists
- Inter-professionals

=

Integrated Primary and Community Care

(12 communities by 2015)

FH Divisions of Family Practice

Our engagement model

- Predetermined order of community engagement determined collaboratively with Divisions of Family Practice and initiative leads
- Invitation from local Divisions of Family Practice to engage and collaborate
- Discuss local issues with MHSU system from Family Practice perspective, and with Primary Care system from MHSU perspective
- Agree upon priority issue(s) to address
- Develop prototype initiatives, or adopt existing initiative, to address priority issue(s)

Fraser Health Mental Health and Addiction Continuum of Care

Mental Health Services

Health Promotion/ Prevention and Harm Reduction

- Health Promotion and Prevention activities
- Information on Mental Health & Addictions
- EPI
- Mind Check Website

Primary and Shared Care

- 16 Collaborative Mental Health Care programs
- 2 Primary Care Clinics

Urgent/ Emergent/ Withdrawal Management

- 2 Police & MH Partnerships (eg. Car 67)
- Adolescents Crisis Response Programs (ARCP)
- Psych Liaison Staff in all Emergency Departments
- 32 CRESST Beds (Community Residential Short Stay Treatment)
- Regional Crisis Line
- Centralized After Hours Services
- ASTAT - Brief Assessment & Treatment

Community/Counselling /Outpatient/ Outreach

- 17 Community Mental Health Teams: ACSS / ACM · Outpatients · Group Program · Geriatric · EPI · Eating Disorders · Adult Concurrent Disorders Therapists
- Rehab Recovery Services: Voc/Rehab · Club Houses · Peer Support · Life Skills Training · Therapeutic Volunteers · Supported Employment
- Developmental Disabilities Mental Health

Inpatient, Day Treatment, Short-Term Residential

- Acute Home Treatment Program (South Communities Only)
- Adolescent Day Treatment (MCFD, SMH, ARH)
- Adolescent Psych Unit (10 Beds)
- Adult Psychiatric Assessment (12 Beds)
- Adult IPU (182 Beds)

Tertiary Care, Long-Term Residential

- Memorial Cottage (25 beds)
- Cypress / Cottonwood / Connolly Lodges (64 Beds)
- Delta View Habilitation Center (71 Beds)
- *Tertiary Adult Rehab (20 Beds) - 2011*
- *Tertiary Older Adult (24 Beds) - 2011*
- *Tertiary Adult Acute (59 Beds) - 2012*

Addiction Services

Health Promotion/ Prevention and Harm Reduction

- Health Promotion and Prevention activities
- Information on Mental Health & Addictions
- 12 School-based prevention workers in primary and high schools
- Outpatient clinics deliver limited community based prevention/ promotion

Primary and Shared Care

- No dedicated resources

Urgent/ Emergent/ Withdrawal Management

- Drug and Alcohol Resource team (DART - Surrey)
- Creekside Withdrawal Management Unit 24 adult + 6 dedicated youth beds & Daytox program
- Fraser East Home/Mobile Daytox/Detox (May 2010)

Community/Counselling /Outpatient/ Outreach

- Direct services outpatient/outreach counselling programs (Surrey and Burnaby)
- Outpatient/outreach services contracted with 20 Health Service Providers
- Specialized Youth Outreach Program
- Youth Concurrent Disorder Therapists

Inpatient, Day Treatment, Short-Term Residential

- MRTC 60 beds (male)
- Kinghaven 32 beds (male)
- Peardonville 28 beds (women)
- Day Treatment for Young & Adults
- Elizabeth Fry Short Term Stabilization 4 beds (women)

Tertiary Care, Long-Term Residential

- 11 STLR (support recovery) adult facilities across Fraser Health (127 Beds)
- 15 youth beds in Kennewos

Mental Health & Addictions Housing

- Supported Housing Units
- Supported Living Program (SIL)
- Minimum Barrier Housing
- MH Licensed Residential
- Family Care Homes
- Youth Supported Living Program (YSLP)
- Second Stage Addictions Housing

Fraser Health IPCC initiative

- **Vision:** To work collaboratively with other service providers towards a more coordinated, holistic, and patient- and family-centered experience

- **Objective:** Enhance the continuum of Fraser Health MHSU services by expanding the range of services and supports available to primary care physicians/providers and their clients

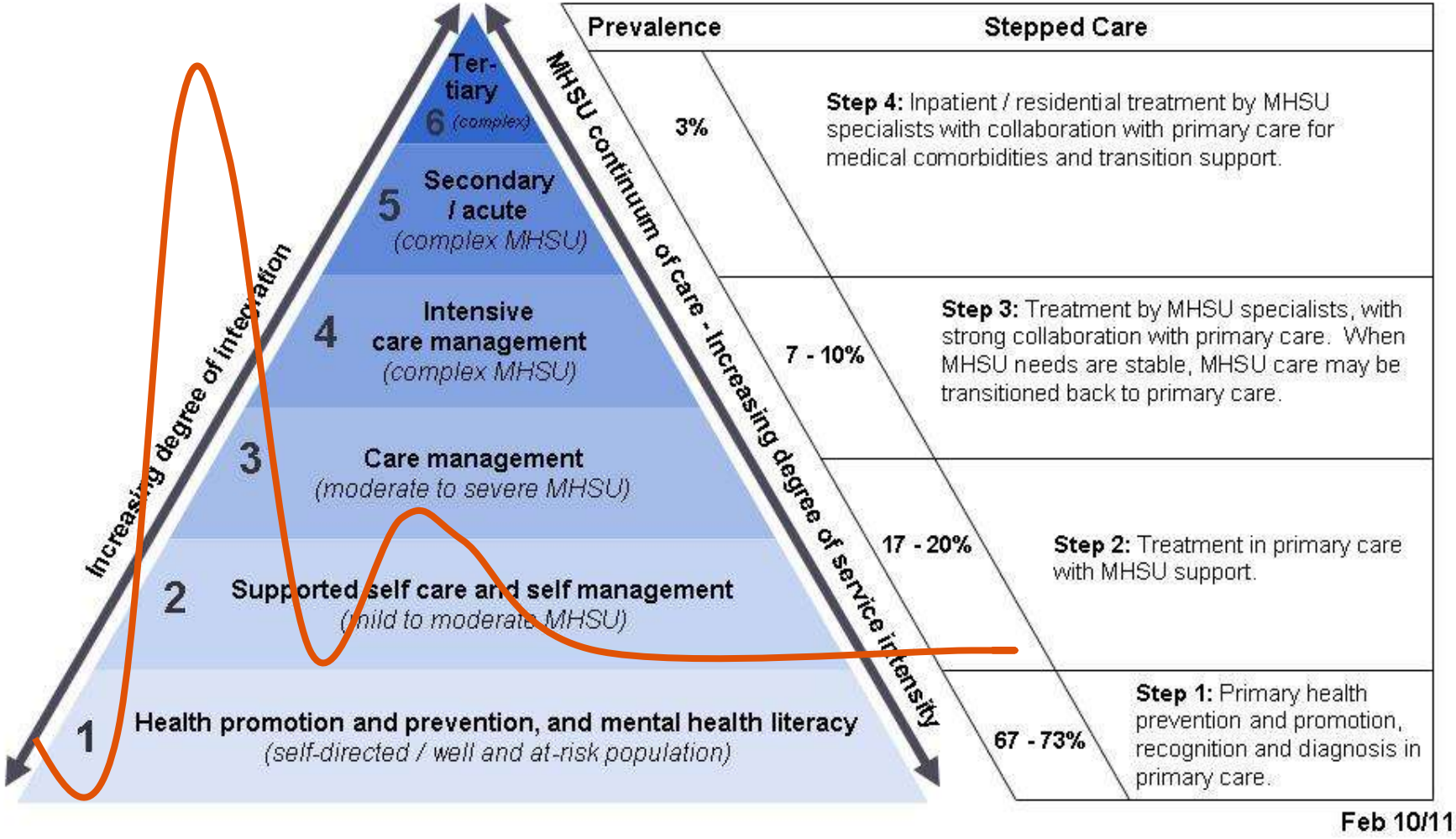
- **Outcome:** Improved integration of care services among GPs and other primary health care providers, clinicians and specialists serving MHSU clients

FH IPCC initiative & MHSU

- Development of an MHSU Integrated Care model
- Identification and prototyping of new community services, and/or the re-design of existing community services to facilitate GPs and MHSU clinicians to work collaboratively to deliver care to MHSU clients
- MHSU support to initiatives developed by the Divisions of Family Practice in the Fraser Health region

Fraser Health Mental Health and Substance Use (MHSU)

Integrated Care Model



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Indicators

- Decreased use of emergency department
- Decreased admission to, or length of stay in acute care
- Increased patient satisfaction with their care
- Greater work satisfaction of the physicians and clinicians
- Lower cost

FH MHSU Integrated Care

MHSU led programs / initiatives:

- Assertive Community Treatment (ACT) Team – Surrey
- Collaborative / shared mental health care - 10 sites across FH
- Community MHSU Services referral form
- MHSU Primary Care Clinics - Burnaby, Surrey
- MHSU toolkit and process map
- Nurse Practitioner service - Hope, Boston Bar, Agassiz
- Outreach Substance Use Methadone Maintenance Program – Abbotsford, Maple Ridge
- Psychosis Treatment Optimization Program (PTOP) – Regional
- Rapid Access / Psychiatric Urgent Response Clinics - 5 sites

FH MHSU Integrated Care

MHSU supported programs:

- White Rock/South Surrey Primary Care Access Clinic
- Jim Pattison Outpatient Care and Surgery Centre (Surrey) Primary Care Clinics
  - Primary Care, Heart Health, Diabetes, Positive Health, Specialized Seniors, Pain Clinic
- GPSC Practice Support Program – Mental Health module

INTEGRATED CARE EXAMPLES

Jenn Blatchford

Initiatives & Collaborative Care Coordinator, FH MHSU

Dr. Linda Curtis

Family Physician - New Westminster

Polly Kainth

Clinical Program Developer - IHNs, FH MHSU

Chrystal Mihelic

Manager – White Rock/South Surrey and Peach Arch Hospital, FH MHSU

FH MHSU Integrated Care examples

1. Collaborative mental health care
2. Rapid Access / Psychiatric Urgent Response Clinics
3. Supporting the GPSC Practice Support Program – Mental Health module
4. MHSU toolkit and process map

Collaborative Mental Health Care

Gap/need identified:

- Enhance the capacity of and Primary Care and MHSU services through their realignment to be more closely integrated with each other

Target population:

- Patients with mild to moderate MHSU needs to support primary care providers in managing them in the primary care setting

Staffing:

- 0.05 – 0.1 FTE Psychiatry time per clinic per week
- 0.1 to 0.6 FTE MHSU Clinician per clinic per week
- Admin support through community MHSU centre

Collaborative Mental Health Care

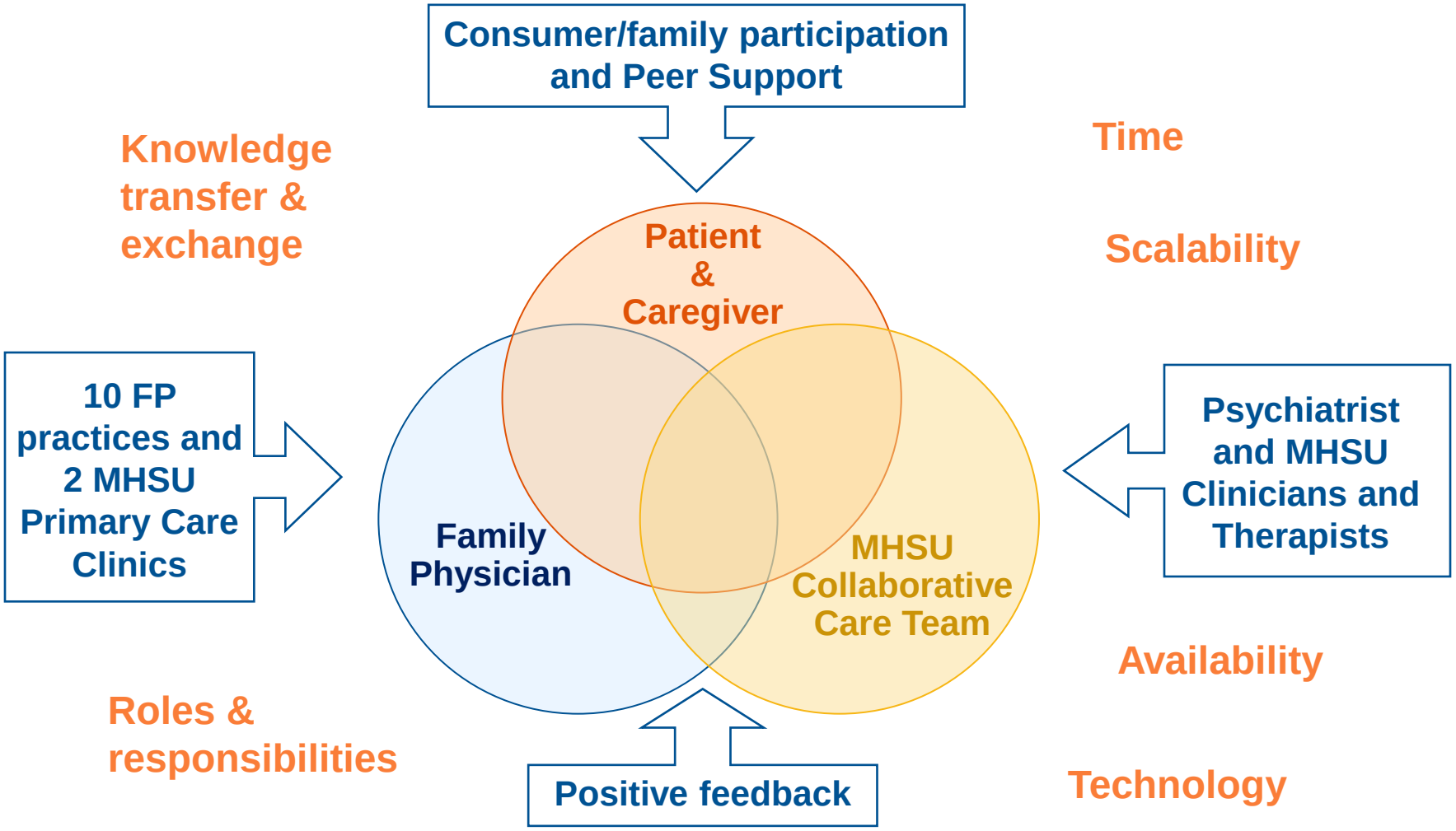
Key principles:

- Collaborative care planning
- Knowledge transfer and exchange

Service model:

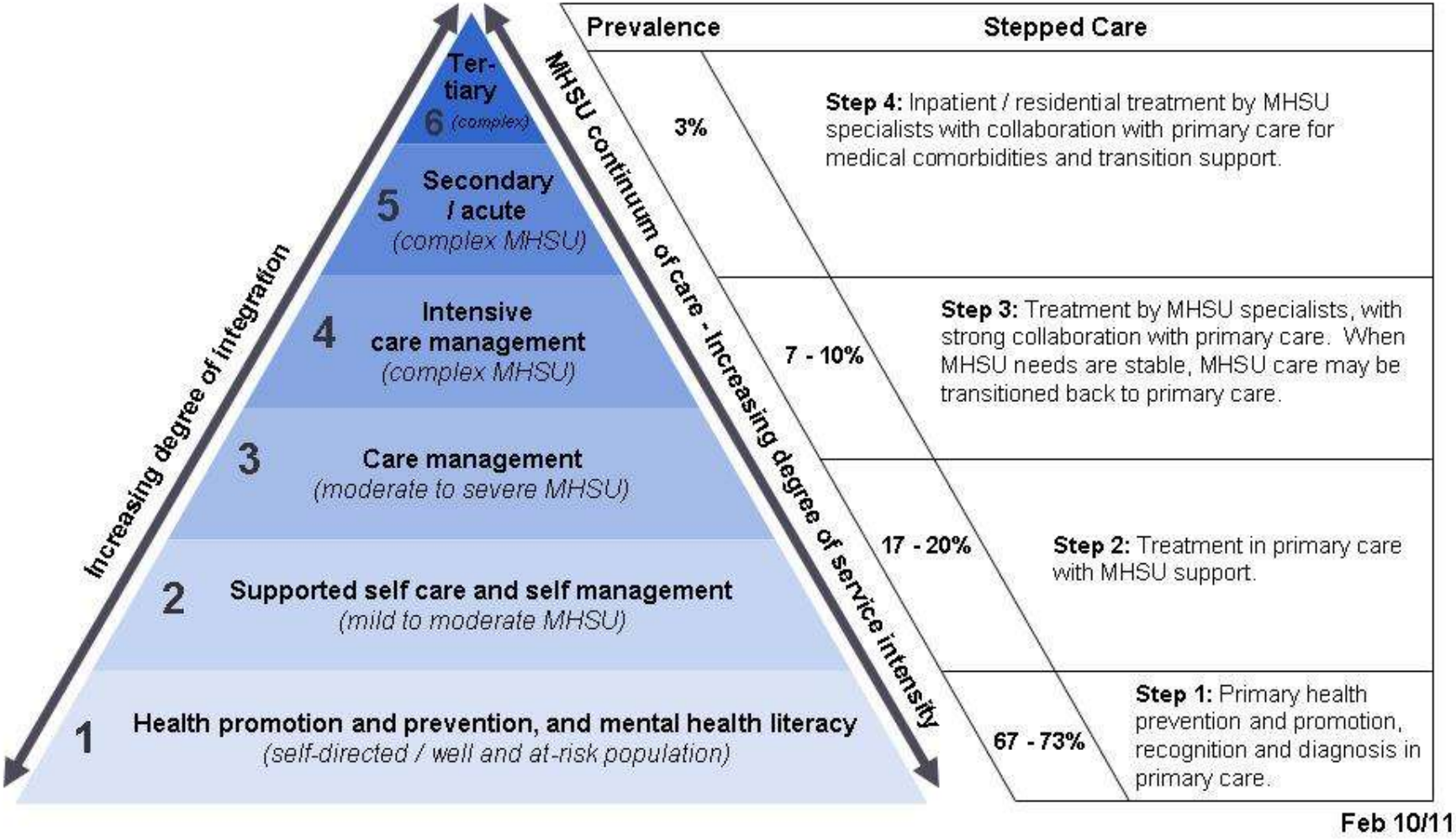
- Primary MHSU care provided in the primary care setting
- Where indicated, clients with more severe and complex MHSU issues may be referred to the appropriate community, acute or tertiary MHSU service(s) and/or to other community agency resources

FH MHSU Collaborative Care



Fraser Health Mental Health and Substance Use (MHSU)

Integrated Care Model



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Collaborative Mental Health Care

Expected outcomes:

- Increased capability of primary care providers to manage clients
- Increased communication between MHSU and primary care during MHSU service
- Improved health outcomes
- Improved health-related quality of life
- Improved patient experience
- Improved provider experience

Rapid Access Clinics

Gap/need identified:

- Improve access to timely psychiatry consultation for adults referred by their primary care provider
- Decrease utilization of ER for psychiatry consultation

Target population:

- Patients with mild to moderate MHSU needs to support primary care providers in managing them in the primary care setting
- Patients discharged from the ER requiring urgent psychiatric follow up/assessment, to prevent ER visits and/or hospital admission

Rapid Access Clinics

Staffing:

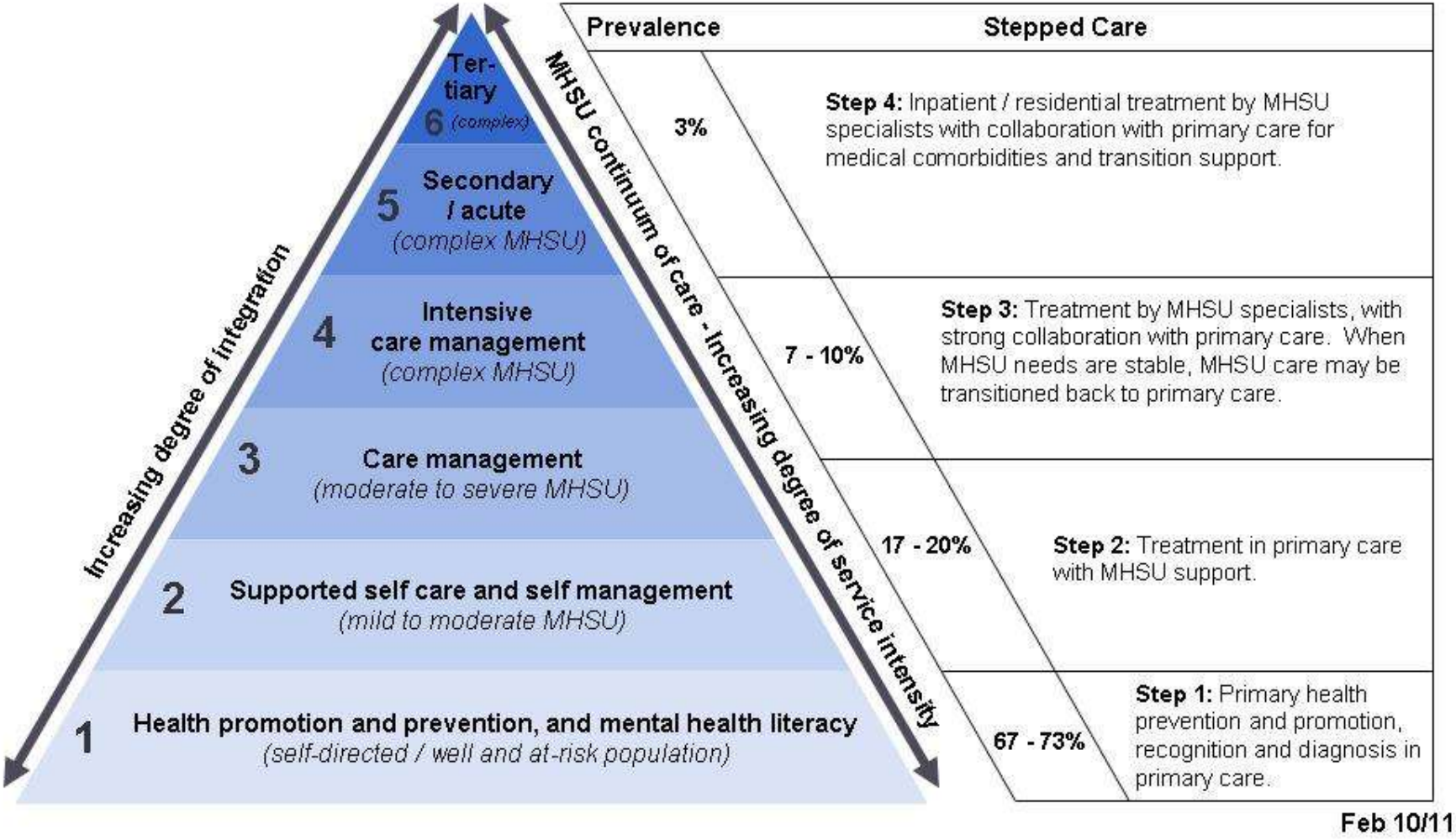
- 0.1 FTE Psychiatry time per week
- 0.2 to 0.5 FTE MHSU Clinician
- Admin support

Service model:

- Assessment-diagnosis: Brief intake screening by intake clinician, and comprehensive psychiatric assessment
- Treatment: A treatment plan is developed in collaboration with the client, family/caregivers, and other involved key service partners
- Access and flow: Where indicated, clients with more severe and complex MHSU issues may be referred to the appropriate community, acute or tertiary MHSU service(s) and/or to other community agency resource

Fraser Health Mental Health and Substance Use (MHSU)

Integrated Care Model



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Rapid Access Clinics

Key principle:

- All persons with mental disorders should have access to specialist expertise allowing for timely identification, diagnosis, and treatment

Expected outcomes:

- Improved access to *timely* psychiatry consultation → Improved client care
- Reduced psychiatric symptoms → Reduced/mitigated level of risk
- Optimal level of functioning and independence
- Improved quality of life and well-being
- Enhanced ability of primary care providers to manage clients with mental illness and/or substance use issues
- Improved service coordination and integration
- Enhanced continuity of care, service transition and follow-up
- Enhanced health care experience of clients and providers
- Decreased preventable ER visits and hospital admissions

Supporting the Practice Support Program

Gap/need identified:

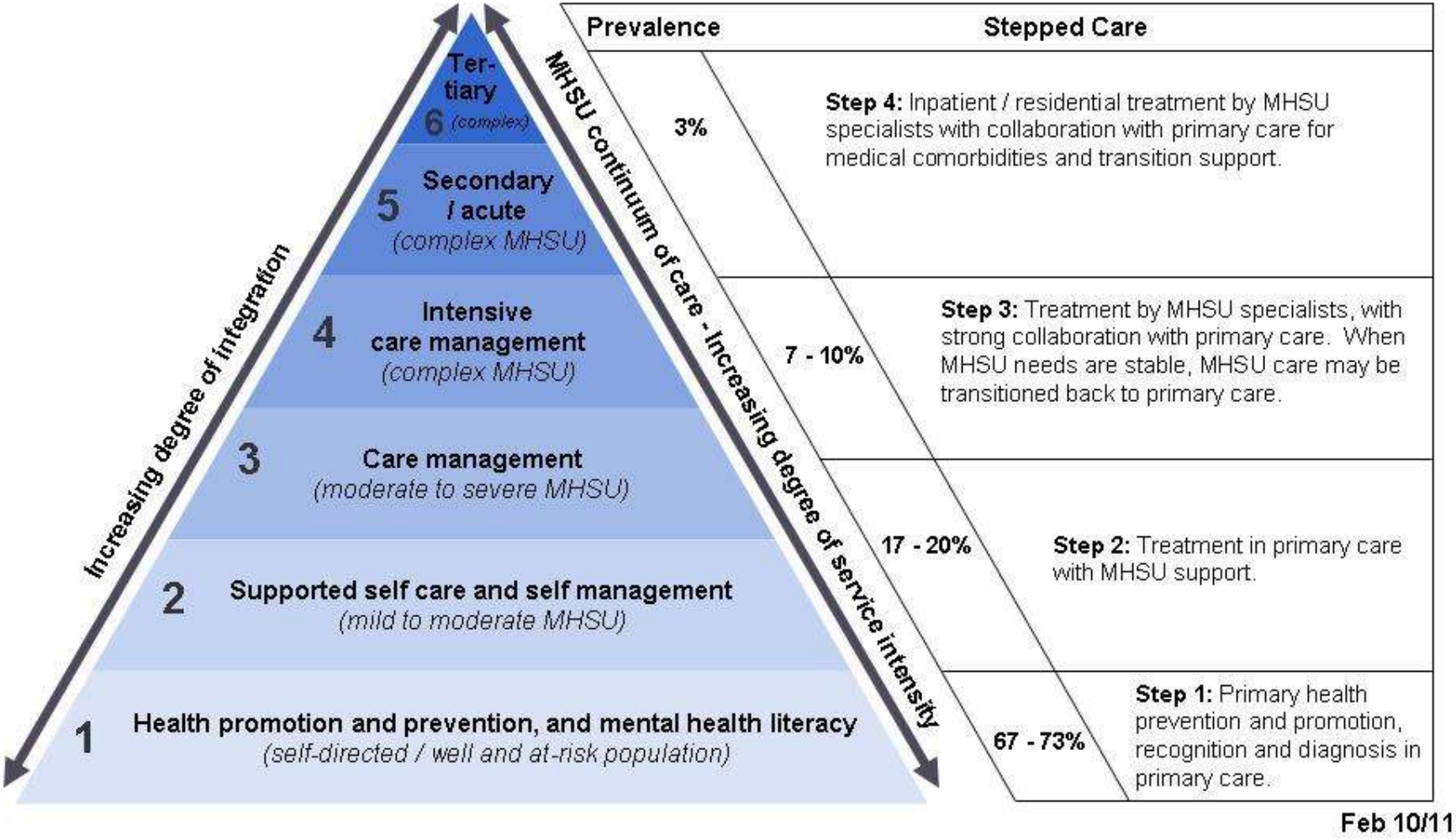
- Supporting the learning and its application in practice
- Connection and relationship building between Primary Care and front line MHSU Clinicians and Psychiatrists
- Speaking the same 'language'

How MHSU provides support:

- MHSU Clinician and Psychiatrist presenters at learning sessions
- Spreading awareness of and promoting the Mental Health module with our primary care colleagues
- Utilizing PSP tools and resources in MHSU services

Fraser Health Mental Health and Substance Use (MHSU)

Integrated Care Model



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MHSU toolkit and process map

Gap/need identified:

- Improve communication and collaboration between MHSU, Primary Care and other providers
- Enhance the capacity of primary care providers to support MHSU clients in the primary care setting

Description:

- Develop process map to improve communication and collaboration between MHSU and PHC providers
- Include process map in electronic toolkit, housed on Physicians website

Key principles:

- Simplicity
- Leverage resources primary care providers are already using
  - Practice Support Program Mental Health algorithm and the new FH Physicians website

http://physicians.fraserhealth.ca/resources/mental_health_and_substance_use/

RESOURCES
Clinical Guidelines & Protocols
Departments
Forms
Library Services
Mental Health & Substance Use
- Family Support Services
- Metabolic Monitoring
- Projects

Mental Health and Substance Use Services

Fraser Health provides a range of mental health and substance use services that stretch across the life span and care continuums starting from prevention and health promotion to specialized, intensive in-patient care.

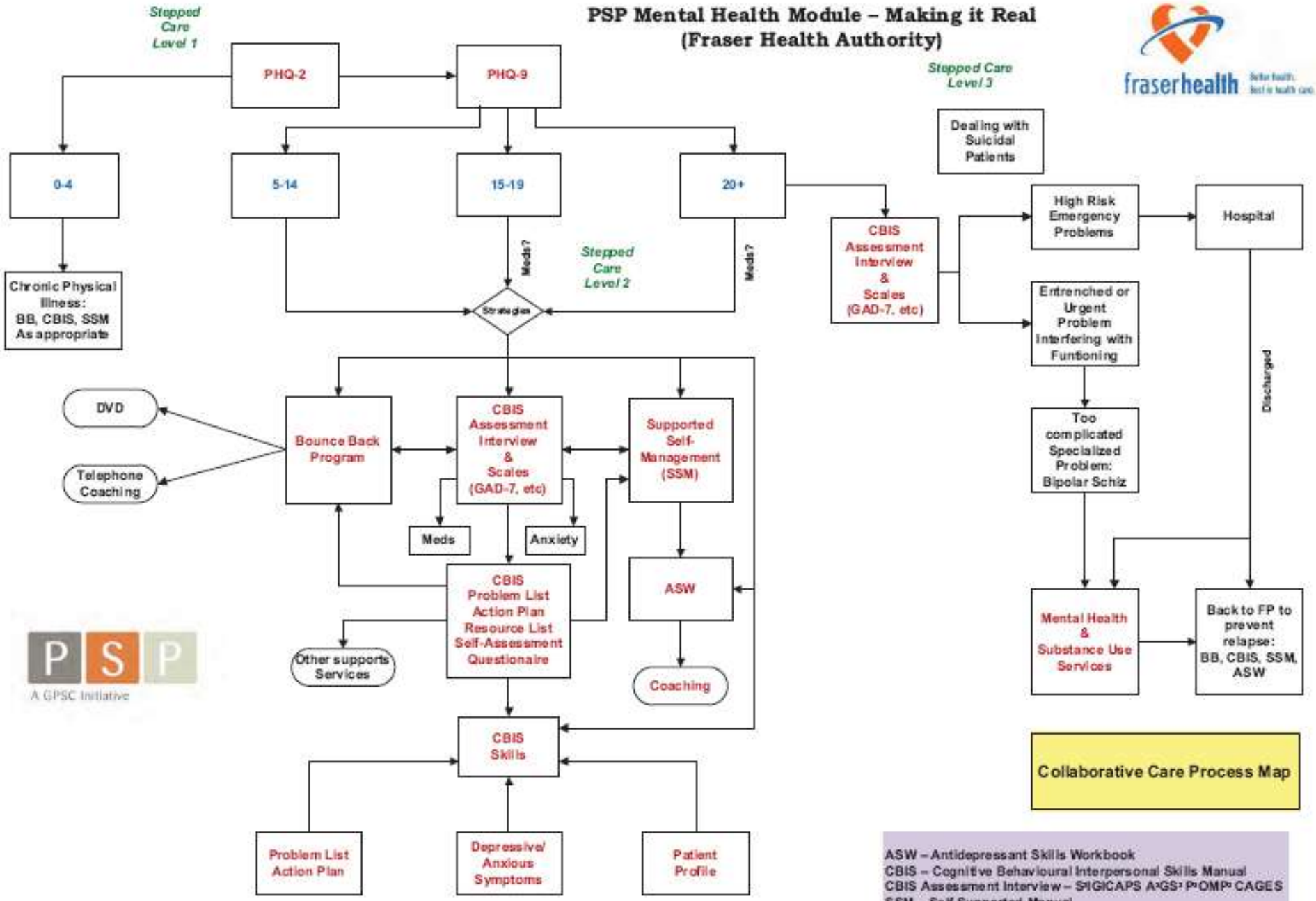
The services include in-patient and outpatient, community and residential services and are organized in 7 client service streams:

Resources

- PSP Mental Health Module-Making it Real (Fraser Health Authority) Updated Toolkit
- Collaborative Care Process Map
- GPSC Mental Health Initiative Billing Guide

SEE ALSO
- Mental Health and Substance Use Services
- Mental Health Services
- Substance Use Services
- Emergency Services
- Community Mental Health Centres
- Substance Use Centres

PSP Mental Health Module – Making it Real
(Fraser Health Authority)



PSP
A GPSC Initiative

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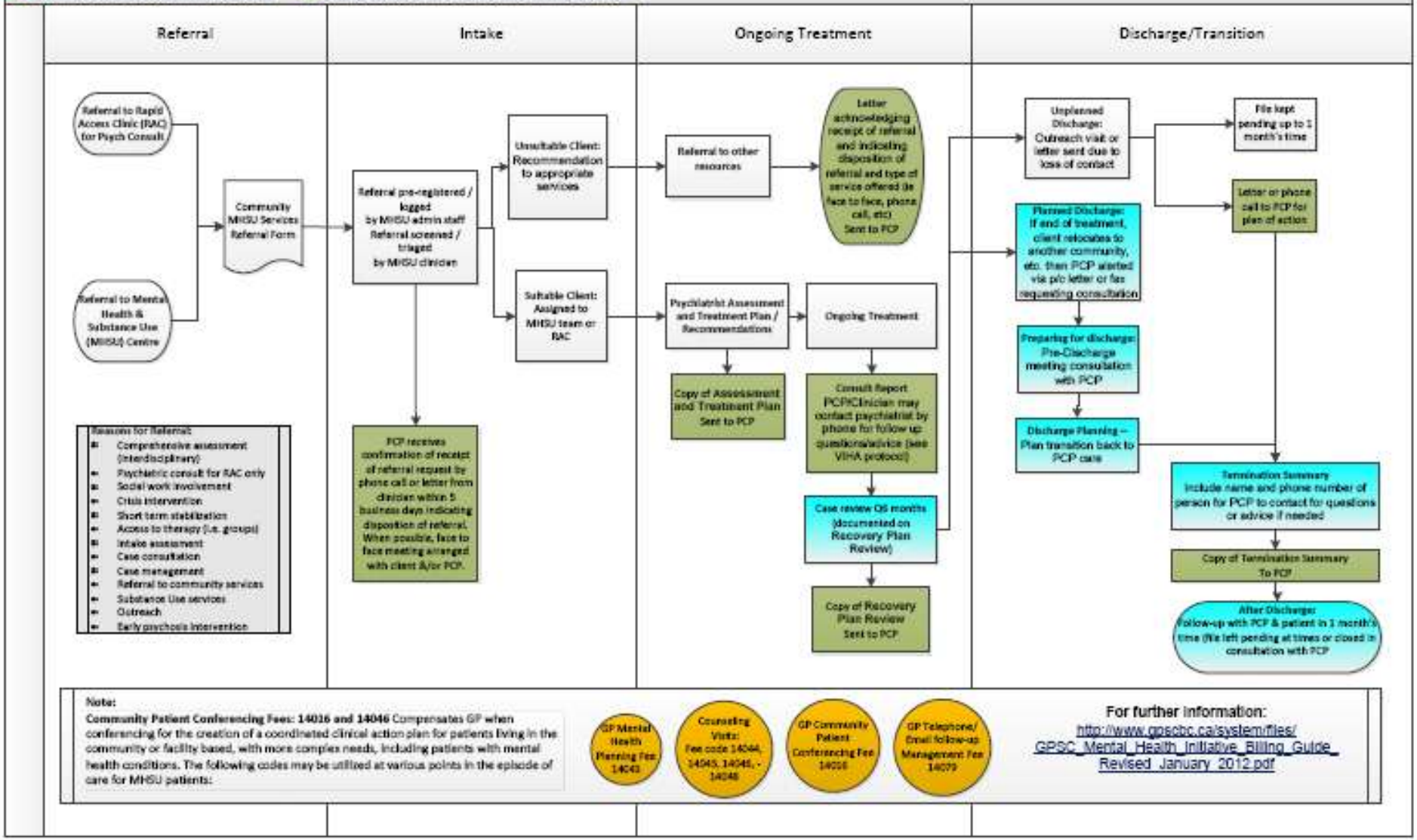
Collaborative Care Process Map

ASW – Antidepressant Skills Workbook
CBIS – Cognitive Behavioural Interpersonal Skills Manual
CBIS Assessment Interview – SIGICAPS A[3]GS[2] P[1]OMP[1] CAGES
SSM – Self Supported Manual

Collaborative Care Process Map-Episode of Care for MHSU Clients Referred by PCPs (Primary Care Providers) [DRAFT VERSION 12] April 25, 2012

Collaboration between MHSU & PCP Examples of communication from MHSU to PCP



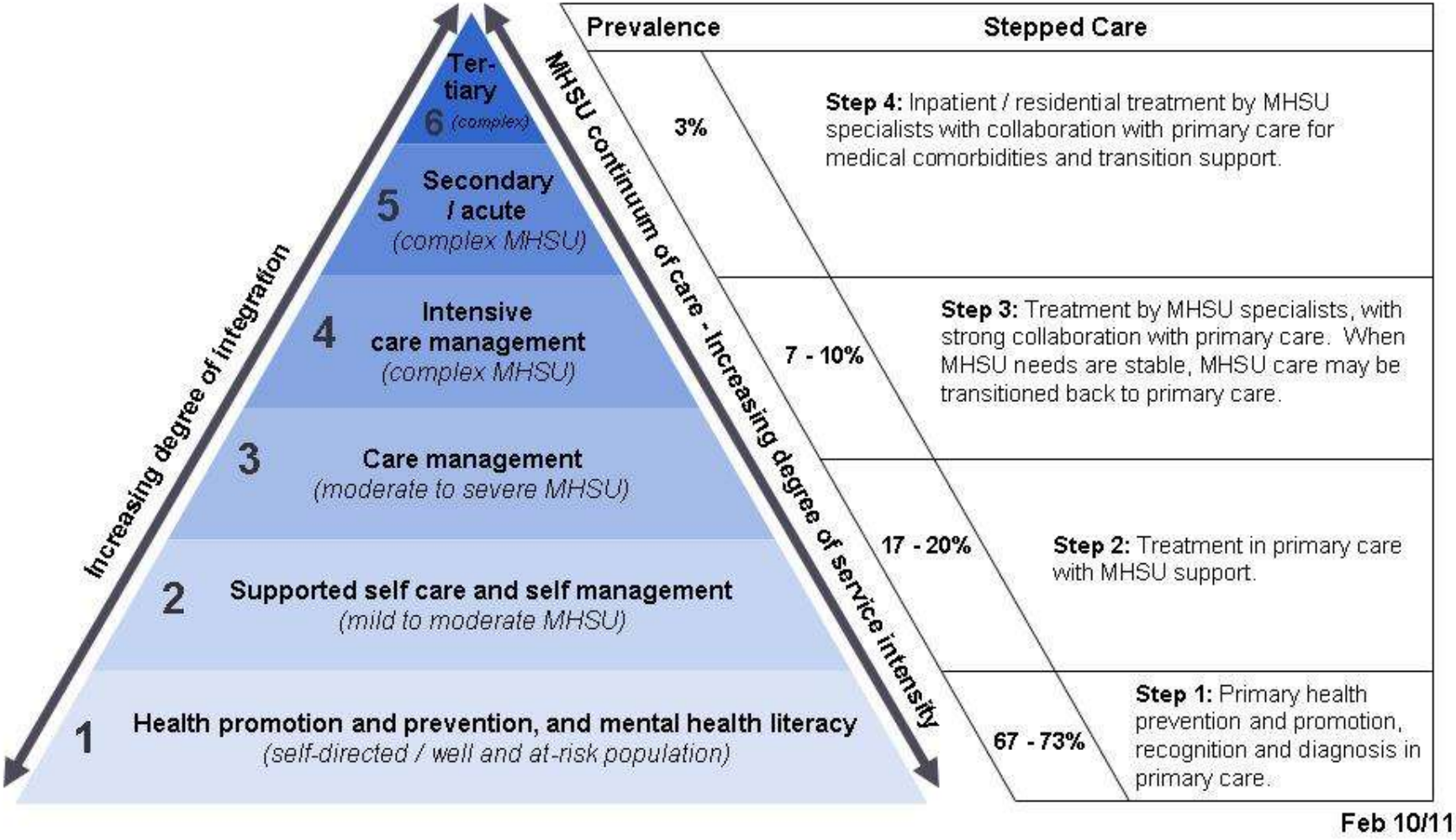
Note:
Community Patient Conferencing Fees: 14016 and 14046 Compensates GP when conferencing for the creation of a coordinated clinical action plan for patients living in the community or facility based, with more complex needs, including patients with mental health conditions. The following codes may be utilized at various points in the episode of care for MHSU patients:

GP Mental Health Planning Fee 14043 | Counselling Visits: Fee code 14044, 14045, 14046, -14048 | GP Community Patient Conferencing Fee 14016 | GP Telephone/ Email follow-up Management Fee 14079

For further information:
http://www.gpscbc.ca/system/files/GPSC_Mental_Health_Initiative_Billing_Guide_Revised_January_2012.pdf

Fraser Health Mental Health and Substance Use (MHSU)

Integrated Care Model



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MHSU toolkit and process map

Expected outcomes:

- Increased primary care provider awareness of MHSU services
- Increased primary care provider awareness and use of primary MHSU resources available
- Increased self-management skills of MHSU clinicians and primary care providers
- Increased MHSU screening/assessment and treatment skills in primary care providers
- Increased communication and collaborative care planning between MHSU and primary care during MHSU service
- Increased and improved transfer to primary care provider care (efficiency of MHSU discharge process)

SUCCESSES & CHALLENGES

Dr. Linda Curtis

Family Physician - New Westminster

Successes

- Created opportunities to dialogue as the Divisions of Family Practice provide a forum to engage and collaborate
- Learning directly about each others' systems and challenges
- Created opportunities for local specification (i.e., identifying and addressing the specific priorities of each community)
- Respectful communication, collaboration and problem-solving

Challenges

- When the priorities of the Division of Family Practice do not match with those of the Health Authority or are those that the Health Authority cannot meet
- Divisions of Family Practice are overwhelmed with Integrated Primary and Community Care initiatives
- Time – PSP module practices and IHN initiatives are time-consuming
- Mutual benefits not always an outcome (i.e., MHSU priorities)

CLOSING REMARKS

Dr. Linda Curtis

Family Physician - New Westminster

Summary

- BC Integrated Primary and Community Care initiative
  - To integrate family physicians and primary care with health authority community care programs
  - A new strategy for partnership via the Divisions of Family Practice
  - Triple Aim outcomes: Decreased acute care use, increased patient and provider satisfaction, and lower cost

- Some examples of FH MHSU integrated care initiatives
  - Collaborative mental health care
  - Rapid Access Clinics
  - GPSC Practice Support Program – Mental Health module
  - MHSU toolkit and process map

Questions?

For more information, please contact:

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