Grey Bruce Mental Health & Addiction Providers Integration Process

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Each of the partners agrees that a new single community health service provider, which builds on the staff expertise and program strengths of the existing organizations, will improve access and coordination for all patients.
Background

- The South West LHIN initiated a series of meetings in 2015 with the four providers of adult mental health and addiction services in Grey Bruce (Canadian Mental Health Association Grey Bruce, Grey Bruce Health Services, G & B House and HopeGreyBruce Mental Health and Addictions Service) to explore opportunities for closer alignment and collaboration among all organizations to better care for the people they serve.

- Memorandum of Understanding signed by the four organizations in February 2017 committing the partners to work towards creating a single new community agency.

- Newly formed Transition Council, consisting of three board members from each of the four boards, begin meeting in May 2017. The Transition Council acts as an advisory body recommending to the four boards the actions required to create a new community organization.

- Transition Agreement signed by the four organizations in May 2017, to create a transition plan resulting in the integration of MH&A organizations and services.

- SW LHIN provide $392,200 in one-time funding to support the amalgamation process for 2017/18 and 2018/19.
Early Milestones

- Due Diligence completed October, 2017.
- Name/Brand determined November, 2017.
- Realignment and transfer of services determined December, 2017.
Each of the organizations provide high quality services, but from a patient perspective, it can be challenging to understand which organization best meets patient needs, and to move between the four different providers.
One Client’s Story

• 34 year old male experiencing symptoms of psychosis, history of substance abuse, minimal social supports currently an inpatient. Best practice would be to start him on clozapine given his history, however adhering to medication regimen is difficult for this client. He would benefit from eyes on meds but it is not offered in his geographic region (Hanover), only in Owen Sound, where his only family support resides. Currently, lives in market rent apartment with $100 per month to cover all other living costs outside of rent.

• Inpts – makes referral to Hanover team; Hanover team – reviews referral deems appropriateness for services and completes intake (phone); assigns to aftercare worker (hospital) as well as outreach supports (HOPE), Referral for NP

• Hanover team sends information to hospital to be put in electronically to be assigned to hospital employee

• Hospital employee begins working with client; Outreach worker (HOPE) begins working with client

• Client attends all appointments and group programming with some assistance of Case manager and outreach worker; client becomes more stable

• Client referred to Concurrent Disorders Counselling (HOPE, separate intake from team); client completes intake for Concurrent Disorders

• Client referred to MH housing supports (HOPE); Client completes MH housing support intake

• First available housing support is in Port Elgin – client decides to accept this apartment

• Client leaves all supports in Hanover and is transferred to new outreach worker (HOPE). Client’s file closes in Hanover.

• New referral to Bruce Shoreline Team (CMHA). New Intake completed with Bruce Shoreline Team.

• Assigned a new case manager

• Programming offered in Hanover not the same as Port Elgin (as well majority of programming offered in Southampton)

• Transportation an inhibitor to engaging in service for this client

• Client disengages from service. Client decompensates and presents to non-local ER (Wiarton)

• Meets with URT worker (CMHA), URT worker asks if he has a case manager/worker.

• Client is confused and starts naming off all the workers he has had in the last year (does not mention any CMHA workers or Shoreline team workers). URT worker starts calling different agencies to determine client’s case worker and begin the process of reconnecting him to service.

• Client sees URT

• Client sees crisis via OTN

• Client hospitalized

• Client referred to ICM - CMHA

• Note – each organization’s files are separate – URT can only see CMHA. Different intake forms for each program within each organization. Hospital has one referral form. Each program assesses for suitability for service, client fearful of being declined service each step of the way.
Criteria for the transfer and realignment of services:

The transfer of a service/program will:

• Improve inflow and outflow of MH&A patients.
• Reduce fragmentation between MH&A services.
• Reduce duplication of MH&A services.
• Enhance patient/client experience (e.g., be ‘easier’ to access and navigate).
• Respond to populations not typically well-served (e.g., dual diagnosis or members of cultural groups) and improve health equity.
• Improve consistency and timely access to care.
Service Re-Alignment

- Mental Health Consultation Liaison Service
- Mental Health Crisis Line of Grey Bruce
- Sexual Assault & Partner Abuse Care Centre (SAPACC)
- Psychiatric Ambulatory Clinic
- Inpatient Mental Health Units
- Geriatric Behavioural Response Team (BSO)
- Mental Health Nurse Practitioner
- Crisis Assessment and Support Team (CAST)
- Community Mental Health Service Coordinator
- Community Addiction Treatment Services (CATS)
- Rapid Access Addiction Medicine Clinic (RAAM)
- Withdrawal Management Services (WMS)
- Urgent Response Team (URT)
- Primary Care Telemedicine Program
Service Re-Alignment

- Assertive Community Treatment Team (ACTT)
- Aftercare (Case Manager Program)
- Intensive Case Management (ICM)
- Prevention and Early Intervention Program for Psychosis (PEPP)
- Family Crisis Support Worker
- Dual Diagnosis Program
- Dialectical Behaviour Therapy (DBT) Program
- Community Mental Health Teams (Wiarton, Southampton, Owen Sound, Hanover, Markdale)
- Brief Counselling
- Drop-In Clinic
- Employment Services & Identification Clinic
- Friends and Neighbours (FAN) Club—elementary; Let’s Talk—secondary school
- Leisure Links
- Partner Assault (PAR) Program—The Men’s Program, My Dad’s Group, The Male Survivor Program

- Brunch Program
- Community Leisure Access
- Mental Health Court Support Services
- Applied Suicide Intervention Skills Training (ASIST)
- Mental Health First Aid Training (MHFA)
- Community Network Support Team
- Community Connections: Housing and Support
- Family Support Initiative
- Consumer/Survivor Development Program
- New Directions for Alcohol, Drug & Gambling Problems
- Choices Drug and Alcohol Counselling for Youth
- Task Force Coordinator
- G&B House
Organizations Join Forces to Enhance Access to Mental Health & Addiction Services

- Changeover date September 1, 2018.
What’s Next: Feb-Sept 1/18

- CEO Search and Recruitment (to be completed by June, 2018)
- Regulatory filings
- Navigate staffing changes
- Harmonize policies/procedures and internal processes
- Harmonization of wages
- Legacy celebrations
- Continue to engage and communicate with patients, clients, employee groups and system stakeholders
Reflections...

- Common Vision - Maintained focus on better services for clients/patients.
- Board members committed to the process and end state.
- Highly invested Senior Leaders willing to persist through setbacks or difficult conversations.
- Pertinent information was communicated regularly and discussed with staff.
- Met regularly allowing trusting relationship to be built.
- Set a clear process, agreed upon project plan and time lines.
- Hired an external resources (e.g. Co-ordinators, legal counsel) with an understanding of the context of the amalgamation.
- Establish working groups tasked with specific activities/deliverables.
- SW LHIN was interested and engaged, but did not cross operational or governance lines.
Questions?