Integration in Ontario LHINs

Mental Health & Addictions

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Think Tank on Problem Gambling Treatment Systems Integration
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Highlights

- Patients First Act (Bill 41) - Impacts and Integrations
- LHIN Sub-Region Planning and Integration Opportunities
- Provincial Mental Health and Addictions Leadership Advisory Council: Integration Strategies and Priorities
- Integration Models and MH&A Examples:
  - The Health Links Model
  - Staged Screening and Assessment Project
  - Ontario Perception of Care
Champlain LHIN - Mandate

• To ensure health services are well-organized, appropriately funded, and meet the health needs of the 1.3 million residents in the Champlain region.

• We work with ~120 health service providers that offer about 240 health programs in hospitals, home and community care, mental health and addiction services, community health centres, and. long-term care homes.
What is Integration?

- Regional
- Provincial
- System
- Sector
- Structural
- Functional
Some changes from Bill 210 include:

- **Oversight of primary care providers, including physicians, to support collaboration between the LHINs and primary care providers**

- **Recognizing the importance of French Language Services provision as an important step towards more equitable access to health services**

- **Removing the LHIN directive over hospitals so that directive powers – for supervisors, operations and new policies – are only at the Minister’s discretion.**

- **Health Information Protection Act, 2016 - confidential health records remain secure.**
Community Care Access Centres

- Provide a range of specialized care at home and in the community, including: physiotherapy, nursing, speech therapy, palliative care
- Now under the direction and authority of the LHINs
- LHINs as health service providers delivering home care
- Integration into Health Links, LHIN Sub-Regions, Mental Health and Addictions Services
CCAC Services

- help seniors live independently at home
- arrange for delivery of government-funded home and community support services
- determine eligibility for government-funded services and settings
- determine the availability of financial subsidies for particular service options
- help apply for admission to day programs, supportive housing or assisted living programs, or certain chronic care or rehabilitation facilities
- provide information about health care and community services
LHIN Sub-Regions

- Geographic sub-regions within each LHIN (Champlain has 5)
- Allow LHINs to better identify, capture and respond to diverse population needs (including linguistic and cultural needs)
- Serve as the focal point for integrated health-service planning and delivery
- Focus on the health needs of people who live within sub-regions, and address equity issues (both within and between sub-regions)
- Support better leverage of local community resources and knowledge. Each community understands the health needs of the people who live there, and the services they need.
Ontario’s Comprehensive Mental Health and Addictions Strategy, **Open Minds, Healthy Minds**, has four guiding goals:

1. Improve mental health and well-being for all Ontarians
2. Create healthy, resilient, inclusive communities
3. Identify mental health and addictions problems early and intervene
4. Provide timely, high quality, integrated, person-directed health and other human services
## 2016-2021 MHA Strategy Areas of Focus

<table>
<thead>
<tr>
<th>OMHM Goals</th>
<th>OMHM Description</th>
<th>OMHM Expected Outcomes</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Improve mental health and well-being for all Ontarians</td>
<td>Ontarians are happier, more resilient and more likely to succeed in school, work and life when they are able to cope with stress and manage the ups and downs in life. Programs will be available for all ages to help Ontarians develop the skills they need early in life to improve their mental well-being and to lead healthier lives.</td>
<td>Less stigma and discrimination in public services and in the workplace • More community supports for people with lived experience and their families • More people with MHA issues employed and integrated in their communities • More people living in safe, stable homes</td>
<td>• Children and youth PPEI • Workplace mental health • Suicide prevention</td>
</tr>
<tr>
<td>Create healthy, resilient, inclusive communities</td>
<td>We will help build inclusive, supportive communities. All Ontarians deserve access to the basic elements of a safe and healthy life – education, employment, income and housing – as well as opportunities to participate in meaningful ways in their community. Healthy communities help create a sense of belonging, which leads to better mental health.</td>
<td>More Ontario youth will graduate from high school and move on to post-secondary education More Ontarians with MHA problems will be identified early and receive appropriate services and supports</td>
<td>• Supportive housing • Stigma • Support provincial initiatives such as income security reform, Poverty Reduction Strategy, Long-Term Affordable Housing Strategy, etc.</td>
</tr>
<tr>
<td>Identify mental health and addictions problems early and intervene</td>
<td>Acting early – at the first signs of mental illness or problematic substance use and gambling – can have a profound effect. It can help prevent addictions from taking over, and for those with a mental illness, it can shorten the journey to recovery. To intervene early, we must be able to identify and reach out to people with problems, wherever they are: in school, at work, in their doctor’s office or in the justice system.</td>
<td>More Ontarians with MHA problems will be identified early and receive appropriate services and supports</td>
<td>• Primary care • Early identification and intervention • Support provincial initiatives such as the Opioid Strategy, etc.</td>
</tr>
<tr>
<td>Provide timely, high quality, integrated person-directed health and other human services</td>
<td>Ontarians with a mental illness and/or addictions need timely access to health and social services that meet their needs. These services should be integrated so people have easy access to the right mix of supports. Better coordination across health and other human services – such as housing, income support, employment and the justice system – will lead to better mental health.</td>
<td>Shorter wait times for community and hospital based services Fewer repeat ED visits and unplanned hospital readmissions More appropriate service linkages and referrals from the justice system Better mental health outcomes Better quality of life for people with MHA and for their families Lower per person cost of MHA services</td>
<td>• System transformation related to core services, data, quality, and funding • Youth • Justice • Indigenous • French-language services</td>
</tr>
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</table>

### OMHM Expected Outcomes
- **Lower prevalence of MHA problems in Ontario**
- **Fewer attempted and completed suicides**
- **More Ontario youth will graduate from high school and move on to post-secondary education**
- **More Ontarians with MHA problems will be identified early and receive appropriate services and supports**
- **Shorter wait times for community and hospital based services**
- **Fewer repeat ED visits and unplanned hospital readmissions**
- **More appropriate service linkages and referrals from the justice system**
- **Better mental health outcomes**
- **Better quality of life for people with MHA and for their families**
- **Lower per person cost of MHA services**
Invest in additional supportive housing

Implement 10 standardized indicators and a comprehensive data and quality strategy

Address critical service gaps

TOWARDS A HIGH PERFORMING MH&A SYSTEM
Enhancing Person – Centered Care

Develop a new funding model for community services

Enhance promotion and prevention

Adopt a core set of services across the province

The Leadership Advisory Council will issue its second annual report with additional recommendations to help move Ontario towards a high performing mental health and addictions system that will enhance person-centered care
Proposed Areas of Focus for 2017

- Prevention, promotion and early intervention
- Primary care
- Justice: corrections, policing
- Youth: mental health and addictions; transitions; developmentally appropriate care
- Equity, Indigenous and French-language services
- Other?

- Advancing/implementing critical service gaps AND of elements of system transformation: data strategy, quality strategy, funding reform, core services
LHINs MH&A Systems Planning Table

3 Work Group Streams

• **Primary Care Work Group:** *Ensure accessible and appropriate primary care for those experiencing MH&A conditions*

• **Coordinated Access Work Group:** *Ensure better coordinated, centralized and integrated access points for MH&A services*

• **Supportive Housing Work Group:** *Ensure availability of flexible service support housing options for key MH&A populations*
A Health Link is a team of providers (primary care, hospital, home, community care, long-term care providers, community support agencies and other community partners) in a geographic area working together to provide coordinated health care to patients with multiple complex conditions – often seniors – with the patient.
Health Links: Excerpts from the 2016-17 Q2 Report
02-Dec-2016
Supporting the Advanced Health Links Model

**Health Links**

*Improving integrated care for patients with multiple conditions and complex needs*

<table>
<thead>
<tr>
<th>MOHLTC</th>
<th>LHIN</th>
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<tbody>
<tr>
<td>• Sets the <strong>strategic direction</strong> for Health Links</td>
<td>• Sets <strong>regional priorities</strong> for Health Links and ensures alignment with provincial priorities</td>
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<tr>
<td>• Provides overall funding to the LHINs</td>
<td>• <strong>Funds</strong> Health Links in accordance with priorities</td>
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<td>• Oversees the overall <strong>performance</strong> of the Health Links initiative to guide strategy</td>
<td>• Maintains <strong>overall accountability</strong> for Health Links performance</td>
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<td>• Facilitates <strong>operational success</strong> by implementing provincial level tools and supports</td>
<td>• Drives operations through implementation of plans and support for adoption of provincial tools</td>
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<td></td>
<td>• Identifies and <strong>implements</strong> regional supports and tools as required</td>
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**Health Quality Ontario**

• Support data collection, timely reports and analysis
• Lead systematic identification of emerging innovations and best practices
• Increase rate of progress through standardization of best practices across all Health Links
• Support inter-Health Link sharing of lessons learned on regional and/or provincial basis
• Connect LHIN Health Link Leads with other relevant provincial quality initiatives

Source: “Guide to the Advanced Health Links Model Guide” Ministry of Health Long-Term Care, November 12, 2015
Getting Started—Q2 Update

Health Links progressing from planning to recruiting patients

100 Health Links are planned in order to expand coverage to include all geographic areas.

79 of 100 Health Links were actively recruiting patients by the end of Q2;

The remaining 21 Health Links are still in the planning stages.

Data Source: Health Quality Ontario’s Quality Improvement Reporting and Analysis Platform (QI RAP) – self-reported by Health Links
# Health Links at a Glance – Q2 Update

<table>
<thead>
<tr>
<th></th>
<th>Number of Hls Actively Recruiting Patients</th>
<th>Number of Coordinated Care Plans (CCPs) Completed</th>
<th>Number of Patients Connected to a Primary Care Provider (PCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2016-17 Q1</strong></td>
<td>79</td>
<td>3,782</td>
<td>3,668</td>
</tr>
<tr>
<td><strong>2016-17 Q2</strong></td>
<td>79*</td>
<td>3,670</td>
<td>3,787</td>
</tr>
<tr>
<td><strong>Cumulative Total to Date</strong></td>
<td>79</td>
<td><strong>26,391</strong></td>
<td><strong>37,436</strong></td>
</tr>
</tbody>
</table>

*Note: No new Health Links started recruiting patients in this quarter*
Margaret’s Story

About Margaret:

• Margaret was a 60 year old woman with a complex health history that included diabetes, mental health issues (bipolar, major depression with suicidal ideation, and borderline personality disorder), vision impairment, chronic back pain from arthritis, an unresolved pressure ulcer, and hypertension
  – Some of her medications resulted in unpleasant side effects, and was therefore not compliant with her medication regime
  – Margaret was also divorced and estranged from her daughter

• In the summer of 2015, Margaret’s right leg was amputated due to diabetic complications
  – Margaret was evicted from her apartment during her lengthy hospital stay post-amputation for non-payment of rent
  – Her motorized wheelchair was disposed of during the eviction process, limiting her mobility, and forcing her to rely on a walker and a broken wheelchair

• Following Margaret’s amputation, she was homeless and socially isolated

• Without a family physician or mental health supports, she received no treatment for the trauma and loss related to the amputation
Margaret’s Story

Health Links Supports:

• After at least 7 hospital admissions within the year, Margaret was identified as a Health Links patient in July 2016, and was quickly provided with services from the Central Community Care Access Centre (CCAC)

• All partners (LOFT, CCAC, Canadian Mental Health Association, Salvation Army, and the patient) met immediately for an initial case conference and care goals were identified with a Coordinated Care Plan
  – Margaret’s goals included stable housing, medical care, follow-up regarding a prosthetic leg, mental health supports, socialization, and intensive case management

• Margaret was referred to LOFT Behavioural Support Services by shelter staff
  – LOFT worked with Margaret and the CCAC to ensure the appropriate personal care supports were in place in the shelter
  – LOFT coordinated housing for Margaret, first in a LOFT respite unit, and then to more stable and permanent housing in Toronto

• Margaret’s situation was reviewed at Health Links Rounds with support and recommendations from other community agencies. A York Region Outreach Worker was able to successfully advocate to have York Region cover costs for a new manual wheelchair so Margaret could be independently mobile
Margaret’s Story

Margaret Today:

- Margaret’s complex needs were effectively addressed through coordinated, efficient, and effective care
- Margaret is now receiving an appropriate level of support in her home and community. She has medical and mental health supports in place, is engaged in her own health care, and is becoming a part of her community once again
- Margaret is now also financially supported by the Ontario Disability Support Program
- She has been able to begin to repair the relationship with her daughter, and has been reunited with her pet dog in her apartment
- Now with secure housing and the proper supports, she says she feels that her life has purpose
- While Margaret continues to struggle with the numerous losses she has experienced over the past year, she has not had any emergency department visits and has not been readmitted to any hospital since she became a Health Links patient
Quarterly and Cumulative Data

<table>
<thead>
<tr>
<th>LHIN</th>
<th>Number of Health Links</th>
<th>Target Population for Health Links</th>
<th># Coordinated Care Plans Completed</th>
<th># Patients with Regular and Timely Access to a Primary Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Data Source: MOHLTC Health Analytics Branch, 2016)*</td>
<td>(Data Source: self-reported in QIRAP)</td>
<td>(Data Source: self-reported in QIRAP)</td>
</tr>
<tr>
<td></td>
<td># Actively Recruiting Patients</td>
<td>Total # HL Planned</td>
<td>Total Patients</td>
<td># Target Population (4+ conditions)</td>
</tr>
<tr>
<td>ESC</td>
<td>2</td>
<td>5</td>
<td>399,580</td>
<td>30,555</td>
</tr>
<tr>
<td>SW</td>
<td>4</td>
<td>6</td>
<td>772,248</td>
<td>43,795</td>
</tr>
<tr>
<td>WW</td>
<td>4</td>
<td>4</td>
<td>612,255</td>
<td>27,260</td>
</tr>
<tr>
<td>HNHB</td>
<td>11</td>
<td>11</td>
<td>1,192,442</td>
<td>80,155</td>
</tr>
<tr>
<td>CW</td>
<td>5</td>
<td>5</td>
<td>786,174</td>
<td>38,760</td>
</tr>
<tr>
<td>MH</td>
<td>7</td>
<td>7</td>
<td>1,018,435</td>
<td>47,385</td>
</tr>
<tr>
<td>TC</td>
<td>9</td>
<td>9</td>
<td>1,004,644</td>
<td>59,980</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
<td>5</td>
<td>1,565,436</td>
<td>79,485</td>
</tr>
<tr>
<td>CE</td>
<td>6</td>
<td>7</td>
<td>1,340,417</td>
<td>78,395</td>
</tr>
<tr>
<td>SE</td>
<td>7</td>
<td>7</td>
<td>413,366</td>
<td>26,895</td>
</tr>
<tr>
<td>Champlain</td>
<td>8</td>
<td>10</td>
<td>1,074,031</td>
<td>56,980</td>
</tr>
<tr>
<td>NSM</td>
<td>5</td>
<td>5</td>
<td>385,057</td>
<td>23,320</td>
</tr>
<tr>
<td>NE</td>
<td>6</td>
<td>14</td>
<td>472,283</td>
<td>33,430</td>
</tr>
<tr>
<td>NW</td>
<td>2</td>
<td>5</td>
<td>189,746</td>
<td>11,540</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>100</td>
<td>11,226,114</td>
<td>637,935</td>
</tr>
</tbody>
</table>

[1] The “Total Patients” refers to all patients who used these services in the 2013/14 fiscal year. Note that “Total Patients” and the population in an area are NOT the same. The analysis identified the presence of 55 conditions/interventions within any diagnosis field in any clinical record during the fiscal year. The conditions selected were those that can be identified within administrative datasets and that: affect a large number of patients, are risk factors for other chronic conditions, or contribute to significant length of hospital stay and/or cost in one or more health care sector.

[2] The TC LHIN is in the process of aligning 9 Health Links to 5 LHIN sub-regions. Business processes are transitioning and Q2 data was reported in the revised structure of 5 Health Links.
Integration Models and Examples
Staged Screening and Assessment Project, Ontario Perception of Care (OPOC)

• Provincial roll-out and implementation of standardized, evidence based screening and assessment, and perception of care, tools

• SSA: all LHIN funded addictions organizations

• OPOC: all LHIN funded MH&A organizations

• Provincial Data Bases
DTFP Staged Screening & Assessment

Objective:
• Improve the screening and assessment process for clients accessing Ontario’s substance use services through the implementation of a staged screening and assessment protocol

Projected Outcomes:
• Improve individual treatment plans developed for clients
• Increase treatment system efficiency and effectiveness
• Improve match between client needs and strengths and the services they receive
Stage 1 Screening: GAIN-SS

- Studied and used in a number of different settings including Canada
- Valid and reliable down to 10 years of age – Canadian validation with adults – recommend for age 12 and up
- CAMH Cost: $100 agency licensing fee for 5 years unlimited use
- Self- or clinician-administered (via GAIN ABS or paper and pencil)
- Reported to take 5 - 10 minutes to complete
- Pilot used the CAMH-modified version – 7 additional questions
Stage 2 Screening (Adults): Modified Mini Screen (MMS)

- Validated in public sector settings in the U.S.
- No cost
- 22 items divided into 3 sections to capture the three major categories of mental illness (mood, anxiety and psychotic disorders)
- Paper and pen: self-/clinician- administered
- Estimated 15 minutes to complete
Stage 2 Screening (Youth): Problem Oriented Screening Instrument for Teenagers (POSIT)

- Valid and reliable
- Designed to identify problems and potential treatment/service needs in 10 areas including substance abuse, mental and physical health and social relations
- Estimated 20-30 minutes to administer, 2-5 minutes to score
- Administered by self/clinician and with paper/computer
- For use with clients aged 12 - 17
Stage 1 Assessment: GAIN-Q3 MI (Ontario Version)

- Developed by Chestnut Health Systems in Illinois
- Good psychometric properties
- One of main instruments in the GAIN family of assessments
- Ontario version was developed to increase the tool’s relevance to the provincial context
  - Incorporated items around trauma and barriers
  - Cross-walk with ADAT; mapped to strengths and needs criteria
Stage 1 Assessment: GAIN-Q3 MI (Ontario Version)

• Multi-purpose tool that identifies a wide range of life problems
• For use among adolescents and adults in both clinical and general populations
• For use in diverse settings
• Established with strong focus on subsequent outcome monitoring
Content of GAIN-Q3 MI (Ontario Version)

Basic Domains Covered:

- School Problems
- Work Problems
- Physical Health
- Sources of Stress
- Mental Health
- Risk Behaviours for Infectious Diseases
- Substance Use
- Crime and Violence
- Life Satisfaction
Ontario Perception of Care Tool for Mental Health, Addictions and Concurrent Disorder Programs
Objective:
• Systematically implement OPOC-MHA across all MoHLTC funded substance use, concurrent disorder and mental health services

Projected Outcomes:
• Standardized information regarding client satisfaction/perception of care
• Enhanced quality improvement and accountability processes at both service and system levels across Ontario
Ontario Perception of Care Project

Background:

• Measures of client experience are widely used by customer-oriented businesses and healthcare services and settings

• Recognized as an important indicator of the quality of care as it is a direct measure of whether a client received services that met expectations and needs
## Domains of the OPOC-MHA

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sample Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access/Entry</td>
<td>“The location of services was convenient for me”.</td>
</tr>
<tr>
<td>Services Provided</td>
<td>“I had a good understanding of my treatment and support plan”.</td>
</tr>
<tr>
<td>Participation/Rights</td>
<td>“I felt comfortable asking questions about my treatment and support, including medication”.</td>
</tr>
<tr>
<td>Therapists/Support Workers/Staff</td>
<td>“I found staff knowledgeable and competent”.</td>
</tr>
<tr>
<td>Environment</td>
<td>“I felt safe in the facility at all times”.</td>
</tr>
<tr>
<td>Discharge/Leaving the Program</td>
<td>“I have a plan that will meet my needs after I leave the program”.</td>
</tr>
<tr>
<td>Overall Experience</td>
<td>“The services I have received have helped me deal more effectively with my life’s challenges”.</td>
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OPOC-MHA Versions

CLIENT Version (38 items)

- Registered clients of the program
  - Those receiving services for their own treatment/support
  - Family members/significant others/supporters who are receiving services in their own right)

Note: 6 items specific to inpatient/residential treatment services only

FAMILY/SUPPORTERS (17 items)

- Family members/significant others/supporters who are not registered clients but who are also receiving services from the program (such as parent who has a child in the program)
OPOC-MHA and Quality Improvement

- OPOC-MHA designed to capture information on quality improvement indicators such as:
  - safety, accessibility, client-centredness, equity, integration, effectiveness, and appropriate use of resources
- OPOC-MHA identified by Accreditation Canada as an instrument approved for use for assessing client satisfaction/perception of care for accreditation purposes