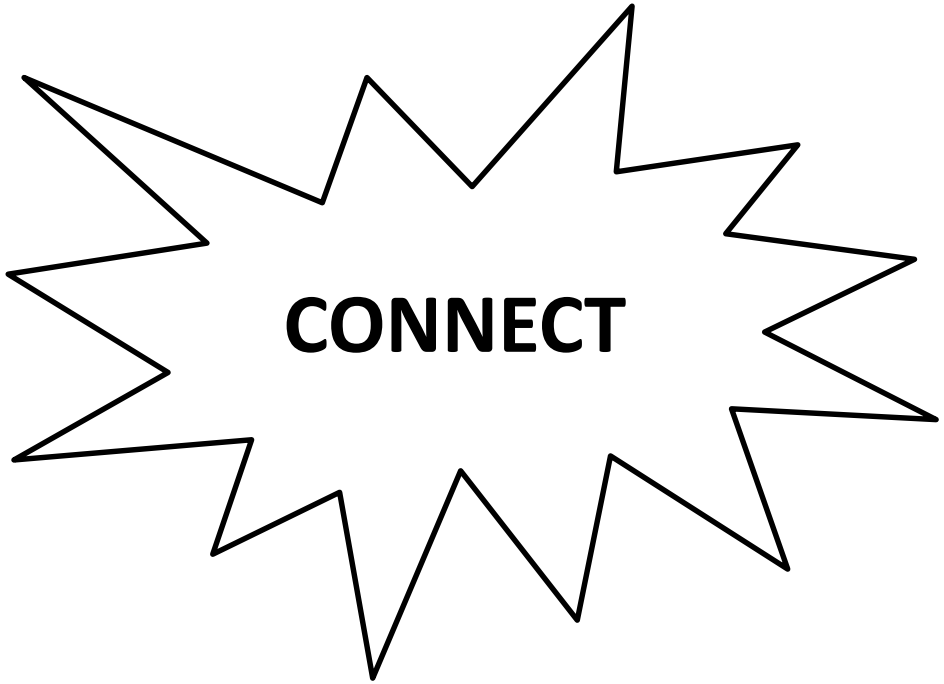
St. Joseph's Healthcare Hamilton | Connect Mental Health and Addiction Outpatient Programs

Connection. Collaboration. Care.

Ashley Hough, MSW, RSW

MADE WITH PATIENT & FAMILY INVOLVEMENT

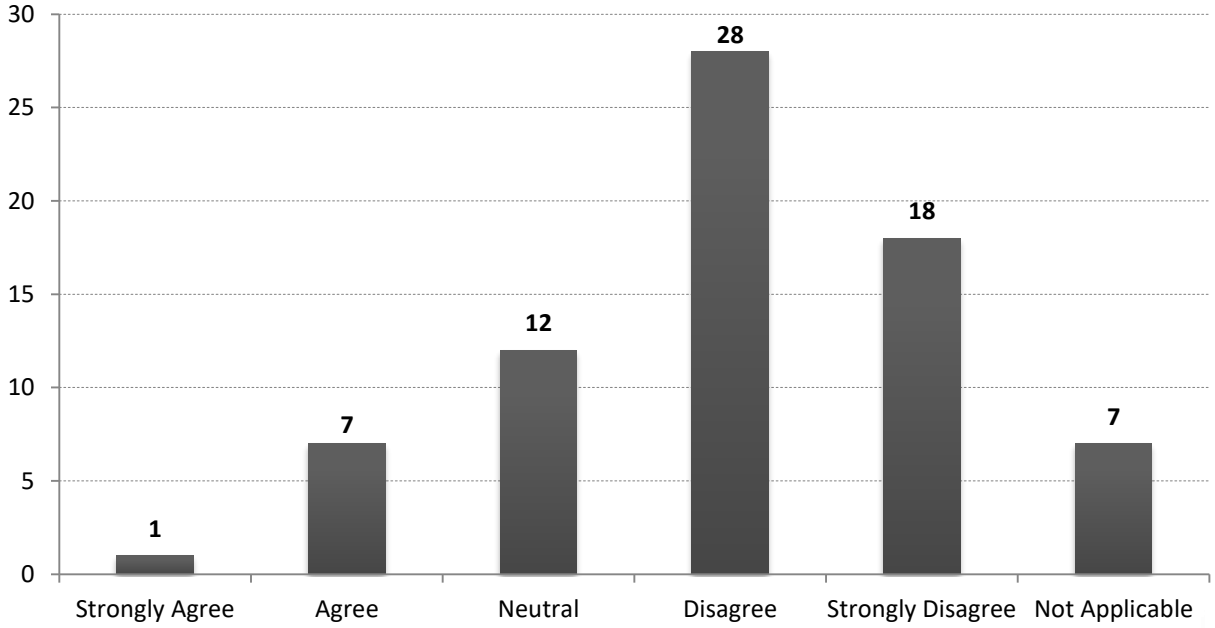
Why ?



MADE WITH
PATIENT & FAMILY
INVOLVEMENT

St. Joseph's
Healthcare Hamilton

The referral process was easy, hassle free and timely.



MADE WITH PATIENT & FAMILY INVOLVEMENT

St. Joseph's Healthcare Hamilton

"There are too many forms and confusion over which program to refer to and what forms are required. A centralized process would be most welcome with administrative triage to determine which clinic is most suitable."

MADE WITH PATIENT & FAMILY INVOLVEMENT

St. Joseph's Healthcare Hamilton

"It would be great to have a SHORT centralized referral form to use to make referrals instead of having a separate multi-page form for every sub-specialty mental health clinic…It is time consuming, inefficient, and leads to errors and delays in patient's being seen in a timely fashion."

"My impression and that of many of my colleagues, is that the main focus of your program seems to be in spending all of your efforts in devising ways and reasons to avoid actually seeing patients.

When patients are referred, there are a multitude of excuses why they cannot be seen. One program suggests sending them to another program and that program suggests sending them to the first program!"

What is Connect?

- A service that completes the intake functions for incoming ambulatory referrals (~ 1500 referrals/month)
  - registration
  - referral review/intake screen
  - collateral collection
  - triage/disposition
  - scheduling 1st appointment
- Process to respond to urgent referrals
- Process to respond to intake calls (Live Answer)
- Process to respond to family calls

LOCATION:
Level 1 near Seniors Inpatient Unit

MADE WITH PATIENT & FAMILY INVOLVEMENT

St. Joseph's Healthcare Hamilton

Clinics We Connect With

- Anxiety Treatment and Research Clinic
- Women's Health Concerns Clinic
- Senior's Mental Health Clinic (Hamilton & Brant)
- Eating Disorders Clinic
- Mood Disorders Clinic
- Youth Wellness Centre
- Concurrent Disorders Clinic
- General Psychiatry Clinic
- Rapid Consultation Clinic
- Borderline Personality Disorder Services
- Cleghorn Early Intervention Clinic
- Schizophrenia Outpatient Clinic
- East Region Mental Health Service
- TMS Clinic
- ECT Clinic
- Bridge to Recovery
- Dual Diagnosis Clinic

St. Joseph's Healthcare Hamilton

REFERRAL FLOW

Internal Referrals can be made to CONNECT by placing an order in Dovetale

- Ensure patient's primary care physician is aware of referral

DO NOT utilize CONNECT for:

- MHAP inpatient referral to outpatient clinic
- MHAP outpatient clinic to another outpatient clinic ("redirect")

St. Joseph's Healthcare Hamilton

Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy (2010):

> Develop and implement common assessment and intake, referral and resource matching tools (p.42).

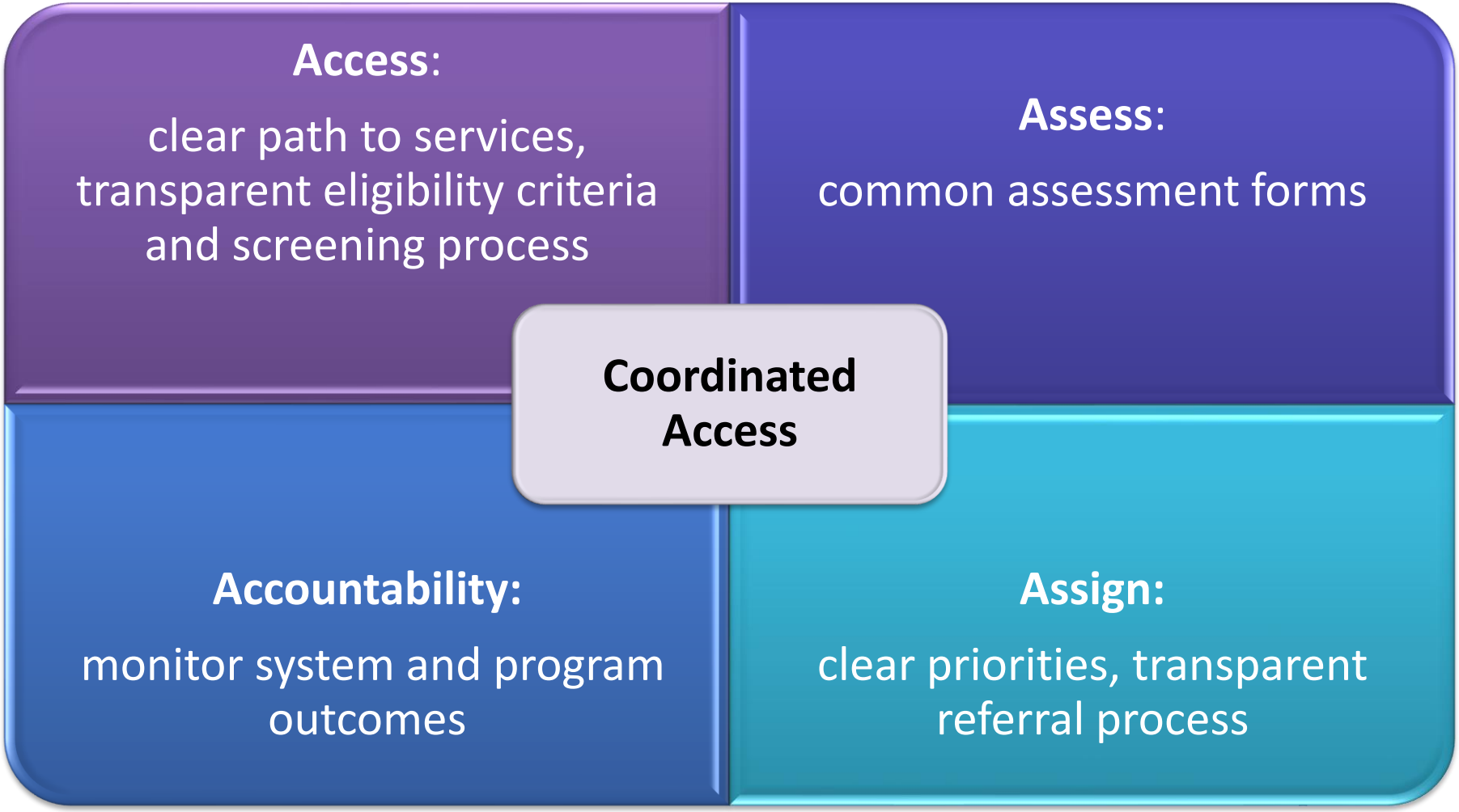
St. Joseph's Healthcare Hamilton

Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians (2010):

> "Clients and their families should have access to system navigators who will connect them with the appropriate treatment and community support services (e.g., housing, income support, employment, peer support, and recreational opportunities)" (p.7).

St. Joseph's Healthcare Hamilton

The four guiding principles of coordinated access (4 A's):



(Wagner, 2013):

Intended Outcomes:

- Right patient, right place, right time
- Improve referral quality
- Facilitate more effective screening
- Triage referrals
- Reduce wait times
- Facilitate continuity of care

(CMA, 2011; Mohr & Bourne, 2004)

St. Joseph's Healthcare Hamilton

Gustafson (2011):

Crucial Elements	Connect
Immediate/timely help	• Triaged first contact • Self-initiation of referral with support to connect with GP
Minimal variation in the quality of assessment, treatment, and continuing care	• Standardized screening tool completed by trained regulated healthcare professionals
Emerging and existing technologies	• Shared electronic clinical chart • Flexible use of technology to contact patients (ex. Text, email)
Connect, support and engage patients, families, peers, and providers **before**, during, and after treatment	• Identify individual barriers and develop a plan to facilitate access to service • Engage in MI to increase personal motivation

Success of centralized intake:

Depends On	Connect
Ongoing collaboration	• Patient/family advisory group • Weekly triage table • Quarterly review
Flexibility	• Change in response to feedback
Adequate resources	• 7 intake assistants • 5 intake clinicians

(Rush & Saini, 2016)

St. Joseph's Healthcare Hamilton

EXCELLENT CARE, EVERY TIME.

Provide a patient-centered, personalized experience

Assist patients in navigating the system with limited barriers

Collaborate with patients/families and community partners

Leave no one without support and/or information

MADE WITH PATIENT & FAMILY INVOLVEMENT

St. Joseph's Healthcare Hamilton

Next Steps:

1. Reporting dashboard
2. Community education
3. Patient flow (cross clinic triage table)
4. Unannounced arrivals
5. Family doctor partnerships

St. Joseph's Healthcare Hamilton

QUESTIONS ??

St. Joseph's Healthcare Hamilton

REFERENCES

- Pattinson, J. (2003). Primary care. Central reservations. The Health service journal, 113(5838), 30-31.
- Barron, N., McFarland, B. H., & McCamant, L. (2002). Varieties of centralized intake: the Portland Target Cities Project experience. Journal of psychoactive drugs, 34(1), 75-86.
- Hamm, T. S., & Callahan, H. E. (1999). Functional model for centralized intake and care management within a home health integrated delivery system: a case study. Home Health Care Management & Practice, 11(3), 58-68.
- Cloutier, P., Cappelli, M., Glennie, J. E., Charron, G., & Thatte, S. (2010). Child and Youth Mental Health Service Referrals: Physicians' Knowledge of Mental Health Services and Perceptions of a Centralized Intake Model. Healthcare Policy, 5(3), e144.
- Rush, B. and Saini, B. (June, 2016). *Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications.* Report submitted to the Ontario Ministry of Health and Long-Term Care.
- Cunningham, C.E., Boyle, M.H., Hong, S., Pettingill, P., Bohaychuk, D. (2009). The Brief Child and Family Phone Interview (BCFPI): 1. Rational, development, and description of a computerized children's mental health intake and outcome assessment tool. Journal of Child Psychology and Psychiatry, 50:4, 416-423

re·new
the
promise

- 96 Wagner, S. (July, 2013). Coordinated Access Overview. Presentation at the National Alliance to end homelessness conference. Retrieved on October 6, 2015 from http://www.endhomelessness.org/library/entry/2.7-introduction-to-coordinated-assessment
- 97 Mohr, G., & Bourne, D. (2004, July). Implementation of a New Central Intake System in Community Care. In Healthcare Management Forum (Vol. 17, No. 2, pp. 38-40). SAGE Publications.
- 98 Canadian Medical Association. (2011). A Collection of Referral and Consultation Process Improvement Projects. Retrieved on September 25, 2015 from https://www.cma.ca/Assets/assetslibrary/document/en/advocacy/Physician-directories.pdf
- 99 Guydish, J., Stephens, R. C., & Muck, R. D. (2003). Lessons learned from the National Target Cities Initiative to Improve Publicly Funded Substance Abuse Treatm
- Rohrer, J. E., Vaughan, M. S., Cadoret, R. J., Carswell, C., Patterson, A., & Zwick, J. (1996). Effect of centralized intake on outcomes of substance abuse treatment. Psychiatric services (Washington, DC), 47(11), 1233-1238

re·new the promise