AFHTO Member Mental Health and Addiction Initiatives

AFHTO members have developed, implemented and evaluated a variety of mental health & addiction programs and initiatives. Listed below, are some of these programs and initiatives that have been shared at previous AFHTO conferences. The presentations are categorized into three areas: access, quality of care, and transitions, integrations and partnerships.

Access

Improving Access Without Increasing Resources
Team: Women's College Hospital FHT

This initiative demonstrates the ability to significantly increase access and make improvements to patient care without allocating more resources. It highlights the importance of engaging an inter-professional team in order to truly understand the problem and using creative methods to achieve sustainable change. In particular, this initiative shows how teams can increase access to Social Worker services for those who need it most by maximizing use of EMR technology. Ultimately, the team leveraged existing resources for patients in order to prioritize patients with the highest needs, who have fewer options available to them. In doing so, we were able to successfully cut wait times by over 50%.

Click here to view the poster presentation.

Keep Your Friends Close and Your FHOs Even Closer: Expanding Mental Health Services to Three FHOs In Kitchener-Waterloo
Team: Centre for Family Medicine

As part of a province-wide trend to increase patient access to inter-professional teams in primary care, the Centre for Family Medicine FHT has launched an initiative to provide mental health services to patients of three FHOs in Kitchener-Waterloo. This program makes counselling services available to 52 additional family-physicians, serving approximately 65,000 patients. This presentation will briefly describe the origin and formation of the Partnership for Mental Health Services, and the progress on the implementation of this pilot to date, with a focus on the perspectives of the three clinical therapists supporting the FHOs.

Click here to view the presentation slides.

Optimizing capacity of the Mental Health team, triaging the patient: who is the right provider?
Team: McMaster FHT

Primary care is often the first place a patient with mental health concerns present. These presentations are varied in complexity and urgency and require expert care. How does one decide the best way to support this patient? Understanding the skills mix of the Mental Health Team is essential. At McMaster FHT, a Mental Health Summit was organized and all staff who was interested in mental health services was invited to attend. This meeting revisited the priority and focus of the FHT; the skill set required to

meet that focus and the direction of new programming, including a commitment to the interprofessional triage team comprised of the system navigators, occupational therapists, administrative support, leadership, psychology and psychiatry. Outcomes were predicted (and achieved) with regard to wait times, provider and service delivery times.

Click here to view the presentation slides.

A System Overhaul: How We Reduced Our Mental Health Wait Times From 12 Months To 2 Months
Team: Connexion FHT

Wait times reduced from 12 months to 2 months for individual therapy and from 12 months to 2 weeks for initial service provision (Single Session Tx and short-term follow-up). Urgent patients can now be contacted and often seen face-to-face within a few days. Wait list reduced from 140 patients to 20 patients. Number of patients seen in 1 year increased from 300 to 350 and continue to grow. Pre/post outcome measures by patients showing a reduction in MH symptoms.

Click here to view the presentation slides.

Welland McMaster FHT Reduces ED Visits with Mental Health and Addictions Response Team
Team: Welland McMaster FHT

The Niagara Region has been experiencing an increased demand for emergency health services, which places non-sustainable demand on available resources. Niagara Emergency Medical Services (NEMS) engaged in strategic program development to address low acuity mental health and addictions calls in the community. This resulted in Welland McMaster FHT's 2018 Bright Lights-nominated program - Mental Health and Addictions Response Team (MHART). Made up by an Advanced Care Paramedic, a Mental Health Nurse and a Mental Health Community Worker, since its inception in July 2018, MHART has responded to 101 emergency calls for low acuity mental health and addictions patients with only 9 of those callers needing transport to the ED.

Click here to view the poster presentation.

Evolution of a Primary Care Based Psychiatry Program
Team: Guelph FHT

Guelph FHT psychiatry service was created from an expressed need for more support for patients with mild to moderate mental health challenges. Issues Included: limited psychiatry resources in the community, extended wait times up to 18 months, and Primary Health Care Provider needed better collaboration with Mental Health Specialists to improve patient care. The service strives to provide timely, patient-centered care to individuals, families in collaboration with their Primary Health Care Providers who utilize the service. In addition to Psychiatrists, the service is supported with a full-time Administrative Assistant and a part-time Social Worker.

Click here to view the poster presentation.

From 'First Contact': Engaging Patients, Assessing Needs, and Reducing Wait Times for Mental Health Counselling
Team: Dufferin Area FHT

In September 2016, the Dufferin Area FHT implemented an internal centralized intake process and dedicated staff resources to this change through the introduction of a Mental Health Intake Therapist role. Results over the past two years have validated our FHT's decision to invest in an enhanced intake process for mental health referrals.

Click here to view the poster presentation.

Quality of Care

The DAVINCI Project - Using Patient Tablets to Support a Data-Driven, Sustainable Shared Care Group Approach to Mental Health
Team: Hamilton FHT

The DAVINCI program is an integrated care pathway developed by CAMH to concurrently treat patients with a diagnosis of depression and alcohol use disorder. The Hamilton FHT adapted the program to optimize delivery for a large primary care organization through a series of clinical and technical innovations. This includes introducing a shared care group format model and using the Ocean Tablet platform to improve patient experience and easily collect and manage large amounts of data - with real-time feedback to clinicians. You'll get a detailed look at how the FHT developed and implemented an integrated care pathway for the 16-week program that can be easily repeated. You'll also learn how the team at Hamilton FHT leveraged the Ocean Platform to administer bi-weekly assessment scales before the group session, automatically completing a series of complex algorithms that were not possible in the EMR.

Click here to view the presentation slides.

Mind the Gap: Creating a Successful Mindfulness Program
Team: Peterborough FHT

The Peterborough Family Health Team (PFHT) is a large family health team, serving both rural and urban patients and supports 5 FHO's. PFHT began offering mindfulness programming 8 years ago. Since that time, the program has adapted and developed to meet the needs of the patient population. A patient centered approach of being able to increase access and accessibility to patients of all 5 FHO's was a goal embarked on in 2016-2017 and the lessons learned from this will be provided. The program is now in great demand across Peterborough and county and approximately 24 mindfulness programs and over 360 patients are served yearly. The implementation of this program has also informed other centralized group programming for PFHT such as CBT-Insomnia and Mindfulness Based Cognitive Therapy.

Click here to view the presentation slides.

HARMS program
Team: Marathon FHT

The HARMS program (High-yield Approach to Risk Mitigation and Safety) applies proven risk mitigation strategies from the addictions literature to chronic pain patients being prescribed opioids. It is designed for a primary care setting and is systems-based so can be implemented easily by any clinic, with minimal resources. It applies Urine Drug Testing (UDT) in a systematic way and START-IT is a key feature of HARMS, which uses Automated Urine Drug Testing to interpret and compile UDT results. This gives recommendations to prescriber on what to do with UDT results.

Click here to access the HARMS Program website.

Utilizing the Knowledge and Skills of a FHT Pharmacist and Social Worker for Opioid Weaning and Pain Management
Team: London FHT

In May 2017, new Canadian opioid guidelines called for a restriction in prescribing doses and the Ontario Drug Benefit Program notified prescribers that narcotics exceeding the 90-morphine equivalent threshold would be delisted as a benefit. Data from HQO showed that 1.3% of patients at the London FHT have been prescribed a high-dose opioid as of March 31, 2017. That percent equates to 264 patients. Of that, 191 patients had prescriptions from their own FHT physician, and 73 patients had prescriptions from other providers. When the guidelines were released, it was expected that up to 1/3 of patients would not be able to tolerate weaning of their doses.

Click here to view the poster presentation.

Responding to the Needs of Patients with Anxiety-Developing a Comprehensive Group Program at a FHT
Team: McMaster FHT

This presentation will provide an overview a three-year research project partnering with Ontario Family Health Teams (FHTs) evaluating an innovative integrated care model of telephone-based, computed aided care management to support the mental health care of primary care patients. The project will compare enhanced usual care (EUC) and a telephone-based intervention -- including psychoeducation, regular monitoring, and support from a Mental Health Technician (MHT) and team supervision from a psychiatrist. Within the context of primary care and an integrated care model, partnering FHTs will speak to their experiences identifying and referring patients, utility of recommendations, and communication and collaborating with MHT role.

Click here to view the presentation slides.

Mind Over Mood: A CBT Approach to Anxiety and Depression
Team: Thames Valley FHT

This program is based on the CBT workbook Mind Over Mood by Padesky & Greenberg and provides participants the opportunity to learn how thinking differently can affect feelings, and mood, and help them cope better with stress.

Click here to view the poster presentation

Transitions, Integrations and Partnerships

Taking Collaboration to the Next Level: Dealing with the Social Determinants of Health
Team: Superior FHT

During our Medically Complex Patient Pilot Program (MCPPP) some of the most complex patients identified by our partners did not come to appointments and were frequently unreachable. These were often folks with no phone, no fixed address or had mental health and addiction problems which made travelling to appointments and or making appointments near impossible for them. The Innovation Centre is an organization in Sault Ste Marie which uses data to drive innovation. They identified an area of the city where a significant number of residents are marginalized and economically and socially disadvantaged. The police had already initiated a Neighbourhood Resource Centre (NRC) located in the heart of the identified region where frontline Mental Health workers work side by side with police officers to serve the population in a better way. We identified a lack of primary care through a community engagement survey funded by NELHIN and with support from Police Services, the Resource Centre was equipped with an examination room and a weekly drop in clinic was started. Through our MCPPP and the NRC, we have forged collaborations with various agencies to identify and address a broad spectrum of concerns, including medical and social issues.

Click here to view the presentation slides.

Scaling-Up the Eating Disorders Bridge Program: The FHT Model at Its Best
Team: Markham FHT

The Markham FHT ED Bridge Program, supported by a Nurse Practitioner, Registered Dietitian, and Social Worker, uses a multidisciplinary approach to care in order to keep patients medically stable and out of hospital. The team helps to "bridge" the waiting time often associated with formal eating disorders programs, by initiating clinical and psychosocial interventions in a timely fashion. As FHT's are similarly resourced, attendees of this presentation could use this model to implement their own ED Bridge Program simply by following the steps covered by the IHP's as outlined. Metrics, and most importantly how to set up your EMR to efficiently extract data, will be highlighted, as well as a "How to Build This Program" breakdown for the audience.

Click here to view the presentation slides.

Act as One Service: Integrating Addictions and Mental Health into Primary Care in Guelph
Team: Guelph FHT in collaboration with the Guelph CHC, CMHA Waterloo-Wellington, Stonehenge Therapeutic Community, Student Health – University of Guelph.

Act as One Service strategy: despite years of tweaking systems, there is a significant gap between primary care and A/MH providers in Guelph. In addition, access to psychiatry and other specialized A/MH remains difficult, unclear and has long wait times. The Sub-Region focus under Patients First presents an opportunity to fully integrate services around the population of Guelph and area. The Process: With strong clinical leadership, partner organizations committed to comprehensive service integration based on the "Patient Medical Home" model. A shared psychiatry lead was hired and four

"prototype practices" volunteered to iteratively test changes, so that a new comprehensive model can be expanded to the whole community.

Click here to view the presentation slides.

Building Strong Collaboration Between Primary Care and Children's Mental Health Services, Families First Model

Team: Caroline FHT in collaboration with Reach Out Centre for Kids

In 2014, the Caroline Families First Wraparound Program (CFF) was introduced in Halton, Ontario. Wraparound programs are evidence-based approaches that have been shown to have a positive impact in complex mental health care. However, the Caroline Families First program is unique in its funding, location, and inclusion of a paid peer support role – which address many of the recommendations within the Mental Health Strategy for Canada. This program is jointly funded by the Ministries of Health and Long-term Care and Child and Youth Services and co-led by a children's mental health organization and a family health team. The program is designed to improve the coordination between primary and community-based mental health care for children and youth with suspected or diagnosed mental health problems and illnesses that require multidisciplinary intervention.

Click here to view the presentation slides.

Improving On "Best Practices": Lessons from a FHT-Based Client-Centered E-Mental Health Project

Team: Huron Community FHT

Huron Community Family Health Team led an e-health project inspired by an Ontario Health Technologies Fund grant application. In collaboration with a private health internet technology company we have been introducing a client-centered mental health web application into a rural community in a stepwise process that began in January 2017. Participants include mental health providers with a variety of agencies including CMHA, addiction services, crisis services, community psychiatric services, private practice and family health teams along with consumers in the area of Huron and Perth counties in Southwestern Ontario. Use of a prototype client-centered e-mental health system will be reviewed with respect to potential barriers and ethical concerns as well as implications concerning mental health referral patterns, treatment planning and implementation, allocation of resources, and treatment outcomes.

Click here to view the presentation slides.

Reducing Harm from opioids in primary care

Team: St. Michael's Hospital Academic FHT

This inter-professional team following interviews with staff physicians, patients and analysis of data has created a multifaceted strategy with a sustained reduction in opioid prescribing, a steeper reduction than in the province. Strategies for success included an activated, interprofessional team, time spent understanding the problem locally, a multipronged initiative.

Click here to view the presentation slides.

Opioid Stewardship: Implementing Pharmacist Led Assessments for Patients Co-Prescribed Opioids and Benzodiazepines at an Academic Family Health Team

Team: St. Michael's Hospital Academic FHT

This project examined how a pharmacist can help teams reduce patients' mean daily opioid and benzodiazepine doses. As pharmacist involvement increased, opioid taper acceptance improved. The proactive identification of patients by a pharmacist differed from the historical referral-based approach but was accepted by prescribers. Pharmacist involvement increased alignment with Health Quality Ontario's opioid prescribing standards.

Click here to view the presentation slides.