Improving Care in Mental Health and Addictions (MHA) and Dementia in Eastern York Region North Durham
From Design to Action –Creating Our OHT Action Teams

Summary of Joint Working Group Meeting

Members of the dementia and MHA working groups came together to get an update on the core insights and big ideas that emerged from the six co-design sessions. The attendees were asked to identify key priorities from the emerging, big ideas to begin working on over the next few months and to map out initial actions for those priority areas.

Emerging big ideas from co-design:

On November 22, the joint working groups explored where to start to bring these ideas to life in six somewhat overlapping zones of focus:

1. Develop / Link OHT Access and Navigation Service – one number, promoted, live support, online tools, education resources
2. Enable primary care to assess and make connections – clear what next and immediate connectivity to community primary MHA and dementia services
3. OHT asset mapping and full awareness of services and supports in our region (services, eligibility, waitlists, how to access)
4. Culture of caregiver support (asking "how are you doing" and providing support)
5. Day programming and short-term respite (rec programs / segmenting day programs based upon need)
6. Continue creating digital connectivity and mimic the future state today

Big ideas that were pushed forward to a next phase of work were:

- Social prescribing
- Satellite services and virtual care

Launching Initial Action Teams

Through the discussion it became clear that there was some foundational work to be done across these topics to get initial work off the ground towards the visions and directions set in the co-design sessions. We are now creating four *ACTION TEAMS* to advance the key areas identified.

Action Team #1: Access and Navigation

Overall Goals:

- *Every patient and caregiver has access to navigation and care coordination that works for them – with one person as a guide, or if preferred, through technology. Clients are connected to supports that match their needs.*
- *Create a system that ensures that people in need have timely access to the right care and get what they need when they need it in a way that gives them confidence that someone is there to help them figure out how to access services.*
- *All health and social resources in the OHT are known and coordinated so medical, counselling and community support resources that meet a range of need and quality of life are maximized.*
- *Ensure a variety of counselling and community supports are available that match the "age and stage" of the patient to support quality of life and slow progression of the conditions*
- *People with needs and their caregivers feel valued, supported and acknowledged.*

Stage 1 (December to February 2020)

Mandate #1: Map system assets: One of the critical needs identified by all groups was an accurate and robust mapping of system assets for supporting people living with these conditions and their caregivers in our regions. The asset map should include all health and social services available both in the public system and through private payment, to provide a full scope of what is available. The map should also clearly highlight information on eligibility criteria, types of clients targeted (age and stage as appropriate), capacity, waitlist status etc.

Mandate #2: Recommend a coordinated access and navigation model: In parallel with the asset mapping, the primary focus of this working group will be to design a user-friendly process through which people can access health and social services in a coordinated way in our region (and beyond). Despite the potential for this being a bigger provincial question, there was much energy for bringing together existing navigators and care coordinators to design what might happen when someone (client, caregiver, provider or community member) calls into a 24/7, single access line or reaches out digitally. This group will build on existing models in the region (Streamlined access / 310-COPE / First Link) to determine the best way for people to connect to OHT services and what might be needed in terms of people, skills, tools and resources to provide meaningful care and service. This group will also

create clear definitions for navigation and care coordination and will generate recommendations for how people in need are offered the most appropriate level of support. The intention is for this group to come up with clear recommendations for short- and longer-term access and navigation solutions.

Stage 2 (February to June 2020)

Mandate #3: Match system resources to needs: With the asset map complete, this action team will begin exploring existing capacity and deficiency in the region and begin recommending a rebalancing of services to better match needs at various ages and stages of MHA and dementia conditions (day programs, treatment centres, PSW support etc.). As part of this work there may be recommendations for programs that meet streamed needs and are supported by PSWs, RNs, etc.

Call for Action Team Members:

Please suggest potential team members that represent the following groupings:

- √ Professionals with formal navigation roles in our region (within agencies / hospital or as part of existing entities like 310-cope)
- √ Staff with informal navigation roles in agencies, community organizations, faith-based groups
- √ LHIN care coordinator and team assistants
- √ Clients / consumers / caregivers / people impacted by MHA and dementia
- √ Culturally specific representation
- √ EMS

Action Team #2: Strengthen Primary MHA and Dementia Care

Overall Goal:

- *Primary care providers are educated to notice early signs and symptoms and have access to specialized MHA and dementia resources to support their patients.*
- *Bring easy to use resources and education to physicians to ensure they know what the MHA and dementia resources are and how to use them to best serve clients. E.g. 1-800 number*
- *Provide easy connections for solo practitioners and their patients (including caregivers) to primary dementia and MHA support resources including community, agencies, navigators, LHIN home and community care, caregivers and allied health teams.*

Mandate #1: Expand access to existing primary MHA and dementia resources to non-FHT primary care providers

A number of the Family Health Teams in our region have specialized support services for clients and caregivers that need mental health, addiction and dementia supports. In recent years there has been additional funding to support other providers outside of FHTs to access these resources. This action team will be charged with exploring ways to provide access to specialized services to a wider range of primary care providers in the region enabling their patients (and caregivers) to have immediate access to primary supports for MHA and dementia and services including more robust assessments and primary care and treatment. There is also opportunity to leverage the existing hospital to home program at Markham Stouffville as a model to expand and learn from.

Mandate #2: Engage the broader community of primary care providers in the region

There are over 600 primary care providers in Eastern York Region and North Durham. Many are already engaged in our OHT but, for our work to be successful, we need to strive for full participation across the region. Primary care providers are a critical link in our work of improving care and services.

Call for Action Team Members:

Please suggest potential team members from the following groupings:

√ Primary care physicians (FHT and non-FHT)
√ Allied health team members from FHTs
√ Executive directors from the FHTs
√ MSH Hospital to Home Service

Action Team #3: Digital Connectivity

The Digital Health working group will continue with efforts to create connections across our OHT in collaboration with other OHTs and the Ministry with the following refined mandates.

Mandate #1: Explore short term solutions to create connectivity across primary care and with hospital to home

Mandate #2: Recommend interim solutions that mimic future desired connectivity

Mandate #3: Provide guidance and support to expand virtual care offerings

Continue with Existing Team Members

Action Team #4: Community Education and Mobilization

Overall Goals:

- *The public understands the early signs and symptoms of mental distress and cognitive decline and feel comfortable talking about it. Self-assessment and navigation tools are available to help people notice possible signs and links to care that they need.*
- *Caregiver needs are acknowledged on par with those of "patients" and "clients"*
- *People in our community are aware of our OHT as a credible source for information about MHA and dementia, and a vehicle to access self-management tools and pathways to care*
- *The OHT will have a useful and easily navigable web and social media presence to enable easy access to information and tools to support better health*
- *People with needs and community service providers (city, library, faith-based groups, pharmacists etc.) are aware of how to support their clients to access OHT services*

Mandate #1: Gather and curate education, self-assessment and self-management tools – Throughout the co-design process, people with lived experience and care providers spoke about the value of having access to curated meaningful education and self-management tools to support people in their initial explorations around care and support. This action team will be charged with gathering a set of initial tools and links that will be made available on the OHT website. The focus here will be on finding and connecting people in our region to resources that make a difference, rather creating any new material. This work will connect directly with the work of the Access and Navigation Action Team.

Mandate #2: Create meaningful OHT education and awareness campaign for MHA and dementia: Launch a robust public awareness campaign and create engaging materials and messages that spread the word about the OHT and how to access care and information. Materials will launch in concert with the launch of OHT access and navigation services. Create an engagement strategy to mobilize key staff across existing municipal and community services as advocates for the OHT and for MHA and dementia care.

Mandate #3: Amplify care and support for the caregiver: Distinguish our OHT as a place where at every step of the care journey the caregiver is asked "How are YOU doing?" and caregivers are given a care plan of their own along with an inventory of support programs, workshops, peer support, coaching, etc.

Eastern York Region and North Durham Ontario Health Team (EYRND OHT)

Call for Action Team Members:

Please suggest potential team members from the following groupings:

√ Communication working group members
√ Community service providers from across city and social services (library, city services, housing, shelters etc.
√ Faith based leaders
√ Community health providers pharmacists, physiotherapists, psychotherapists, psychologists
√ Home and community care providers
√ Clients and caregivers
√ Caregiver association / change foundation