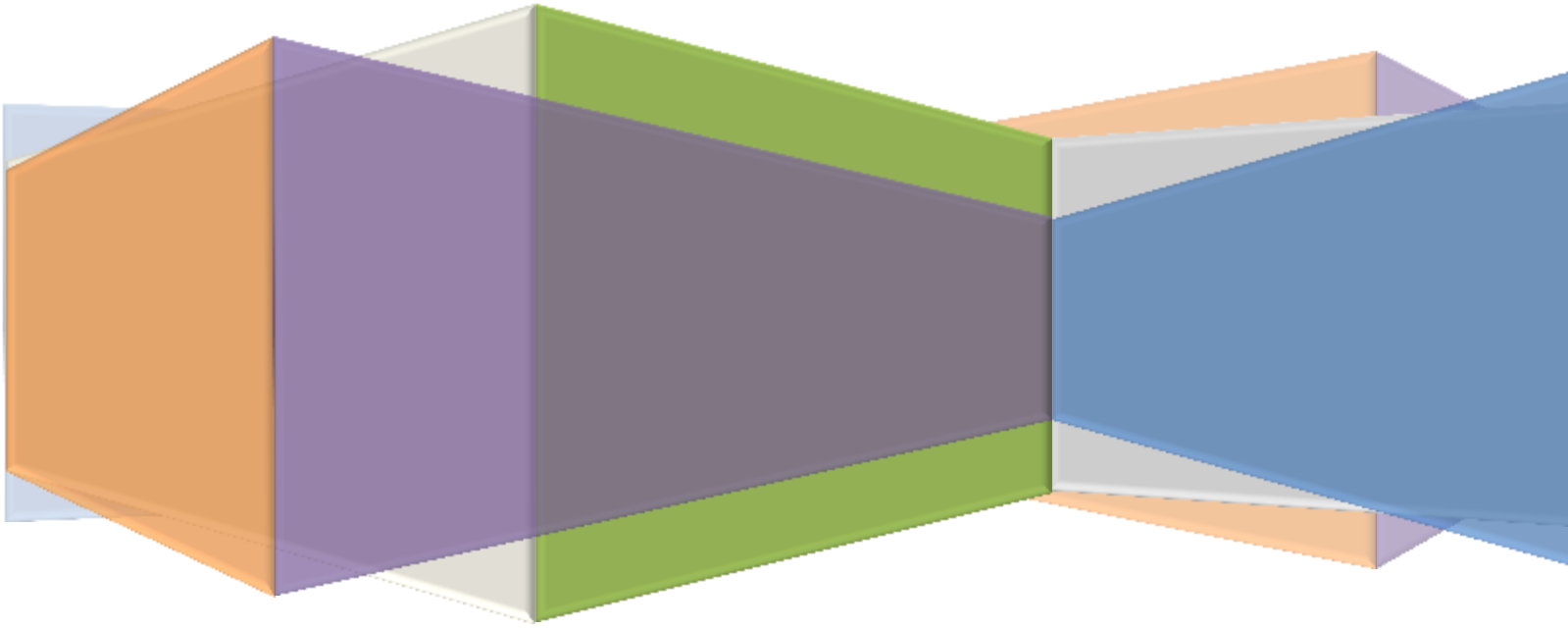
Thunder Bay and District Service Collaborative

Bridging - Mental Health Discharge

Centre for Addiction and Mental Health



Contents

Background

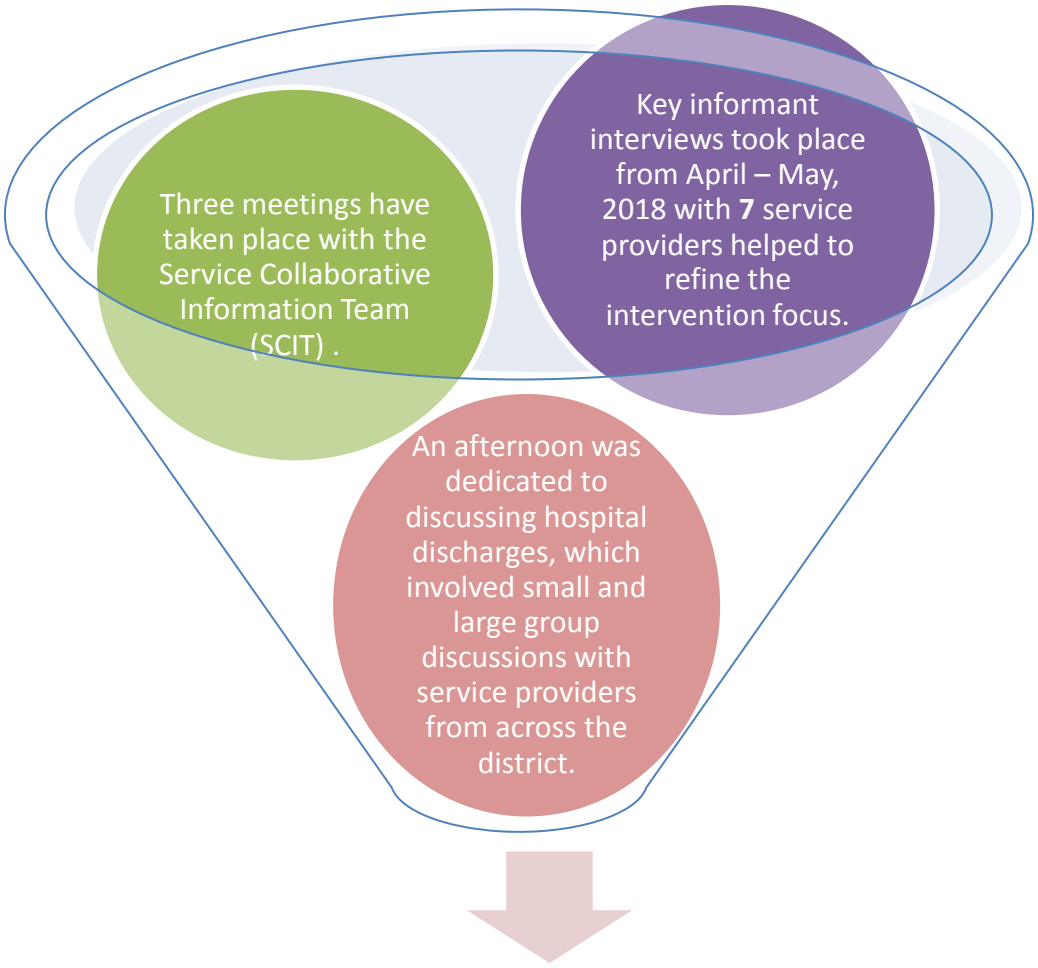
Supported by the Centre for Addiction and Mental Health (CAMH) Provincial System Support Program (PSSP), the Thunder Bay and District Service Collaborative began in 2016 as a part of the System Improvement through Service Collaborative (SISC) Initiative. This project falls under the Ontario 10-year mental health and addictions strategy dedicated to the transformation of mental health and addictions services.

The Service Collaborative stakeholders identified an important service gap as the transition for people moving from in-patient mental health services at the Thunder Bay Regional Health Sciences Centre to community. PSSP has been engaging with stakeholders across the district to better understand the experiences of people that have been released from the in-patient adult mental health unit at the Thunder Bay Regional Health Sciences Centre (TBRHSC).

The intention of this report is to provide a project update to inform Service Collaborative members of recommended next steps for the duration of the initiative (project end date March 2019). This report contains information on Thunder Bay Service Collaborative activities and data for the period January 2018 to August 2018.

Note: This report briefly touches on the selection of the Critical Time Intervention (CTI) and the subsequent refinement of the gap to focus on the activities that occur in the 'pre-CTI phase'. Themes and key messages from the discussions of a discharge planning protocol are summarized.

Who we've heard from



To date, we have heard from **34** stakeholders at **7** district agencies, who collectively service more than **19** communities across the district, and work in social work, nursing, case management, counselling, and program management fields.

Note: Key informant interviews with persons with lived experience of hospitalization in the in-patient adult mental health unit have started and are planned to continue throughout the summer.

What we've learned

Hospitalizations, transition planning, and discharge

- Existing processes that support select hospital discharges to the district include:
  - PODS (Patient Oriented Discharge Summary) – used in some cases at TBRHSC and at some other district hospitals.
  - Provision of forms from the hospital that include a summary of services provided.
    - According to a representative from the TBRHSC, existing processes that support transition planning for hospital discharge are practiced in the city but have not yet expanded into the district
- Contact between a district service provider and a client is often *not* maintained once a client becomes hospitalized.
  - Some variation exists with this finding but this was a strong sentiment among different agencies.
- District service providers are often *not* notified when their clients are discharged from the hospital.
- Communication to hospitalized individuals is lacking around details of their discharge and available community supports. This may result in the perception that one's discharge is unexpected.

Care in the community

- A client-centered approach to care is practiced across the district. Service providers 'meet clients where they are at' and base care plans around what a client wants.
- Most participating organizations have multiple services and disciplines on hand, allowing for clients to receive *some* additional supports without having to leave the organization. External referrals are still required.
- Some community collaboration/referrals occur as part of client care in the community. However, silos remain, and there is a desire to change this and work more collaboratively.
- There is a shortage of services/ supports in the district communities.

Service Provider Information Gaps

- When individuals and clients from the district are hospitalized, service providers aren't always informed.
- The patterns and protocols relating to how service referrals are determined by the hospital, particularly in cases where a client was not previously connected to services.
- How to communicate/ follow-up with clients that have been discharged without phone/ email/ family support/ peer support.

Refining the CTI Intervention Focus

Through exploration of potential evidence-based interventions, the Service Collaborative was particularly interested in the Critical Time Intervention (CTI) to address the identified gap of transitioning from hospital to community. However, further discussions with stakeholders highlighted the need to focus on activities that occur in the 'pre-CTI' phases of the intervention, with a focus on discharge planning and connecting individuals to community service providers.

In May 2018, twenty-five service providers from seven agencies in the District of Thunder Bay came together for an education/ discussion session. In the morning, a CTI expert provided an educational training session in which participants learned about the intervention and its implementation. In the afternoon, participants had small and large group discussions facilitated by the CAMH PSSP focused on prioritizing components of effective hospital discharge to district communities. Following these discussions, the tri-chairs of the SCIT further reiterated the need to narrow the focus of the intervention to the 'pre-CTI' activities that pertain to discharge planning from client admission in the hospital to client discharge. These activities include consideration of the discharge planning protocol, client connection with community service providers, and others.

Note: More information about the CTI can be found at https://www.criticaltime.org/).

Image Source:
https://www.google.ca/url?sa=i&source=images&cd=&cad=rja&uact=8&ved=2ahUKEwihjOCt6PTcAhWoxVkKHdJ0DyEQjRx6BAgBEAU&url=http%3A%2F%2Fhowsnashville.org%2Ftag%2Fcritical-time-intervention%2F&psig=AOvVaw2iBGBfISrxLQca2bqV4s7l&ust=1534620298849234

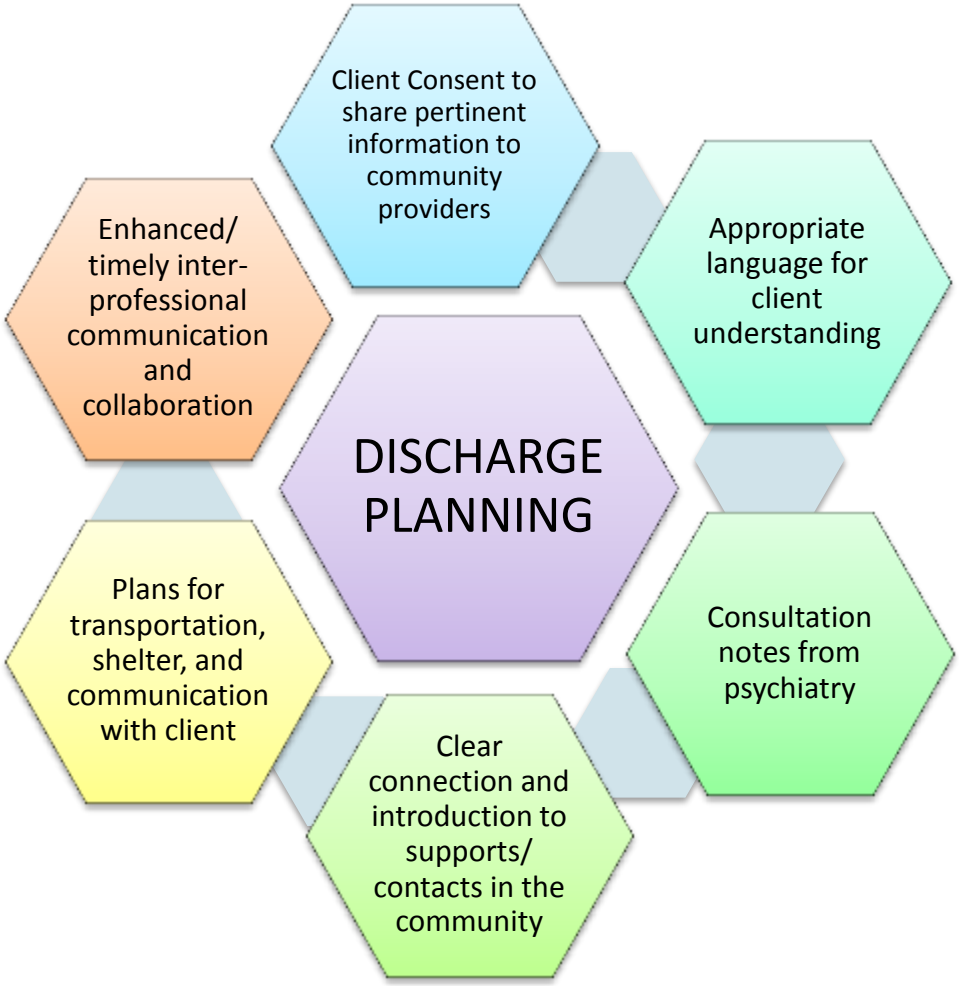
Bridging Process

Based on what has been shared throughout district engagement sessions so far, the bridging process from hospital to community ideally includes…

- ✓ Improved connection and collaboration between hospitalized individuals, hospital staff, and community service providers. Ideas include:
  - Connecting hospitalized individuals and hospital staff to community service providers through teleconference and OTN;
  - Identifying primary points of contact for discharges at each community service provider, and creating a contact list for hospital staff (including after hours and weekends)
- ✓ Improved information flow between TBRHSC and community service providers. Ideas include:
  - For receiving agencies to be informed that their clients are being discharged;
  - Receiving consent from clients to share information between service providers;
  - Providing a discharge report to community service providers;
  - Providing psychiatry consultation notes to community service providers;
  - Providing medication information to community service providers.
  - Expanding on PODS or a combination of EMR and form faxing between the hospital and providers (with patient consent)
- ✓ Further ideas for exploration include:
  - Having a community resource guide;
  - Providing transportation options
  - Referrals to support individuals with housing

Developing a Discharge Protocol

Discussions with stakeholders have informed this graphic of what a Discharge Planning Protocol would include:



Developing a discharge planning protocol requires…

- Consultation with service providers and people that have lived experience
- A Memorandum of Understanding between the hospital and community partners
- Implementation plans for assisting organizations with change management
  - Includes training/education materials
- Point people at community agencies who will act as the first point of contact for individuals that are discharged to the community
- Community of Practice to support consistency, ongoing improvement, and sustainability

Potential Barriers

- Support and commitment from hospital management and staff for protocol development
- Consistent engagement from district service providers for protocol development
- Weekend/ after-hours discharge
- Individuals not providing consent to share information
- Communication/ follow-up with clients that do not have phone/ email/ secure housing/ family & peer supports
- Community partner waiting lists
- Different databases used by community service providers could result in barriers for data sharing, data entry, and data collection

Recommendations

- Co-chairs of the SCIT and hospital service providers work with CAMH to develop and begin implementing a discharge planning protocol
- Develop a discharge contact list of point people at community service providers and at the hospital (including after-hours contacts)
- Memorandum of Understanding between community service providers and the hospital