Developing partnerships to improve system capacity and create a seamless path for patients accessing housing supports in the Durham Region, Ontario

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Introductions

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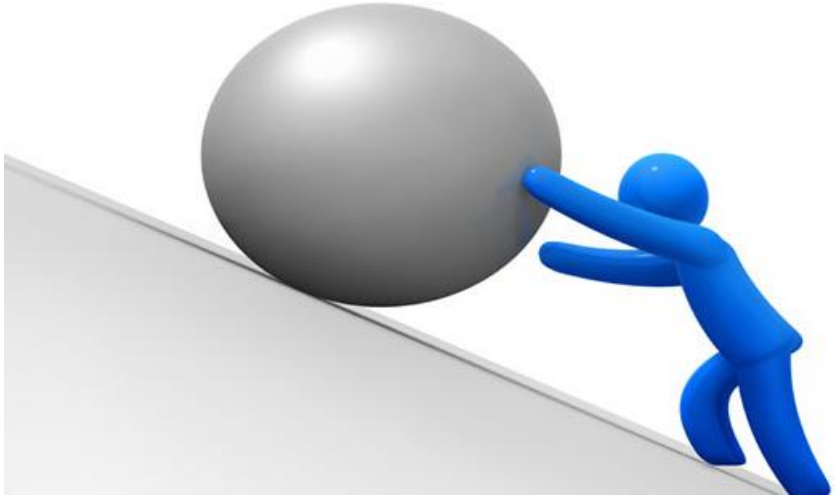
* Collaborative partner: Paul Secord, Director, Programs and Clinical Services, CMHA – Durham

- No conflicts of interest to declare

Learning Objectives

1. Participants will learn about the **partnership model** which enabled the system change.
2. Participants will learn the **processes** that were established and presenters will share the **results and outcomes**.
3. Participants will discuss the **tools** utilized to support the processes.

Patient Story



The Problem

- Identified system gaps in accessing housing support services
- "Siloed" approach to funding opportunities
- Many individuals have complex needs and experience difficult transitions within the system
- Lack of a common understanding regarding the level of support and environment each partner could provide
- Hospital based intervention and support can be difficult to translate to community based settings.
- Limited housing capacity and supports (demand and capacity mismatched)

Our Solution

- Developed collaborative partners table
- Identified all housing support resources in the Durham Region and developed a continuum for care
- Identified barriers and system gaps
- Established communication tools
- Increased awareness of settings and limitations prior to transitions

Our Solution (con't)

- Aligned processes to create one centralized process for three housing providers
- Developed a common wait list
- Utilized a common assessment tool (LOCUS)
- Dedicated point-of-contact at each partner organization
- Monthly meetings with all partners to review the wait list and develop customized strategies and plans of care

Housing Continuum

- Established a common understanding of the language and definitions
  - Level of support; level of need to inform appropriate matching
- Took the continuum characteristics to those with lived experience and evolved the continuum to support informed choice.
- Shared with all organizations involved and with other community partners

Snapshot of the Tool

Name of Homes/Services
Characteristics:
Type of Housing
location
Specific Criteria
Population served
24/7 over night staff
On call staff available 24/7
transitional
permanent
expected length of stay
Availability of staffing support
Provider type
Staff Mix
Staff with mental health training
requires finances in place

Referral source
number of individuals accepted and waiting (indicate snapshot date)
number of individuals in process (indicate snapshot date)
Prioritization Method
wait time
Client -Home Community considered
Support for life skills available
Independent with ADLs required
Meals
Housekeeping
Laundry
appointment support provided
personal care support provided
medication monitoring provided
day programming provided
shared rooms
private rooms
curfew - ability to come and go

total beds available
female/male occupancy
Cooperative Living Dynamics
financial skill support
transportation
Visitor Protocol
transit route
parking
phone
internet
cable
smoking
pets
furniture

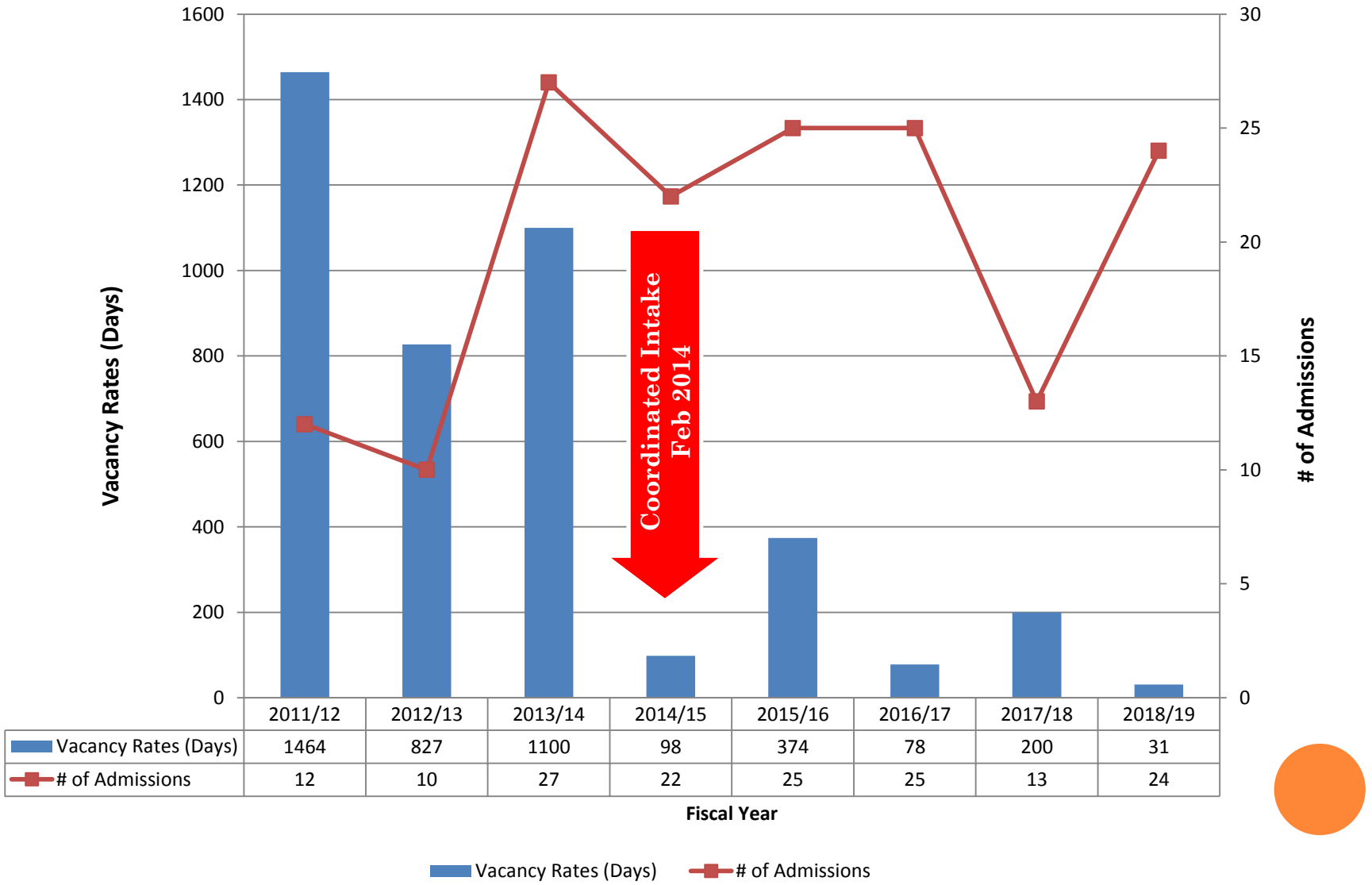
Results and Outcomes

- Process improvement and standardization across all three partner organizations
  - Shared referral process
  - Joint-intake, admission, transition and care planning process
- Eliminated duplication of referrals
- Ensured individuals were properly matched
- Improved system capacity and patient flow for complex patients accessing housing support services
- Improved transitions

Results and Outcomes

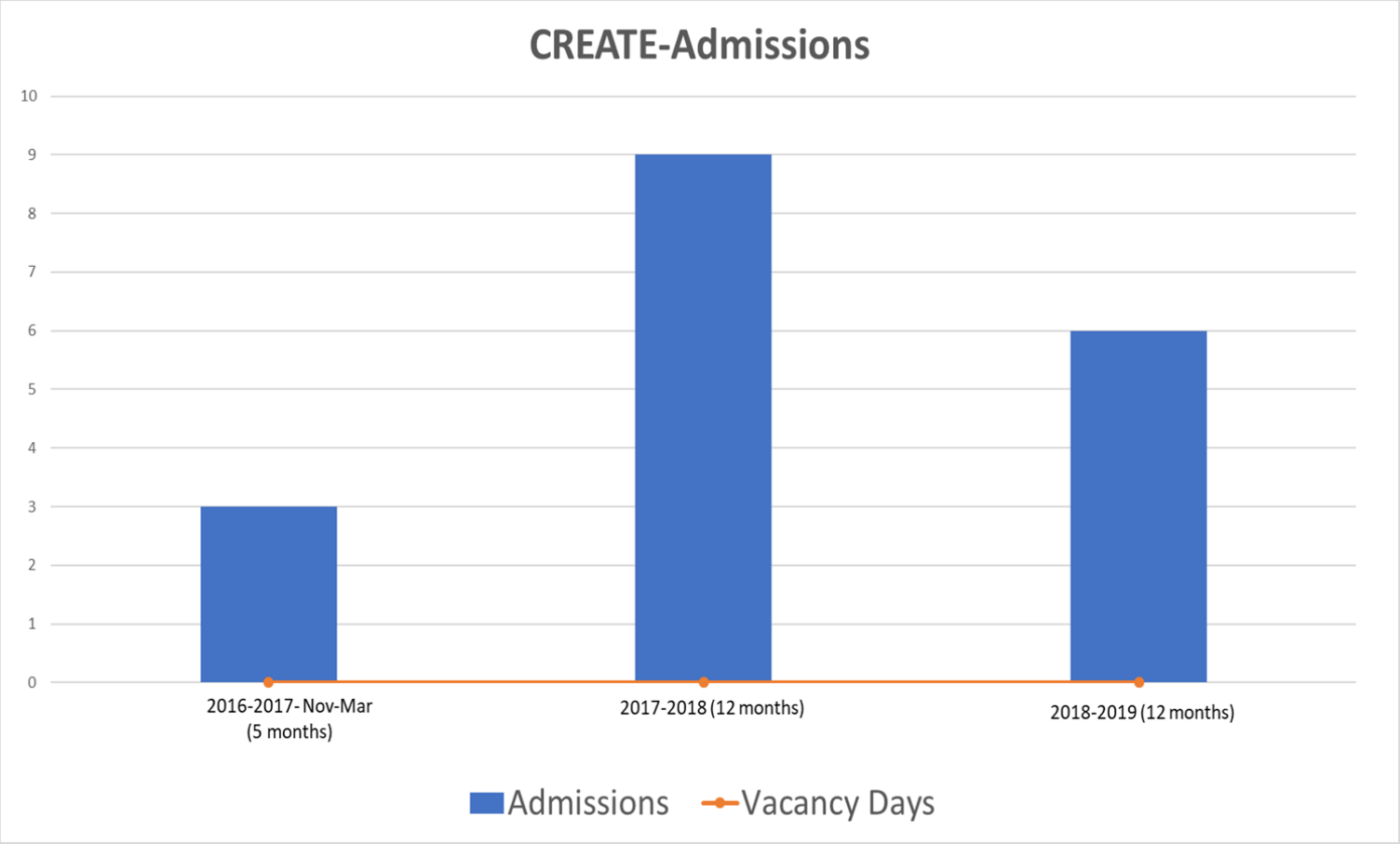
- 2018/19 – Joint Referral meeting outcomes
  - 78 patients were reviewed
  - Outcome of Referral Meeting
    - Total number of admissions to:
    - HSC = 18
    - DMHS = 38
    - CMHA – Durham (CREATE) = 12
    - Not placed = 10
- Since 2014, 5 patients experienced unplanned readmissions to Ontario Shores within 30 days of discharge

DMHS – Results



CMHA – Durham

- 100% of referrals from Ontario Shores
- 0 vacancies



Patient Story

- Mary – patient at Ontario Shores
- Required high support housing in the community due to her complex mental health concerns.
- Reviewed at the Joint Referral meeting
  - Collaborative and coordinated approach
- Referred to CMHA – Durham CREATE Program
- Transitional supports and transition plan established
- Now actively engaged in her recovery; participating in her community.

Top 5 Lessons Learned

1. Shared vision between all organizations was foundational that was focussed on the person.
2. By having a better understanding of each organizations' mandate and role, we were able to work better together and built capacity within each organization.
3. Taking a regional approach to a system issue to remove barriers and provide person-centred care.
4. "A day in the life tool" – to ensure needs, preferences and supports are articulated with the view of the person.
5. Holistic hospital approach vs. siloed approach

Q & A