



**ARE YOU
READY?**

PRIORITY HEALTH INNOVATION CHALLENGE

ARE YOU READY TO IMPROVE ACCESS TO MENTAL HEALTH AND
ADDICTIONS SERVICES, OR HOME AND COMMUNITY CARE?

TEAMS



Canadian Foundation for **Healthcare Improvement**

Fondation canadienne pour **l'amélioration des services de santé**

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About the Canadian Foundation for Healthcare Improvement

The Canadian Foundation for Healthcare Improvement supports partners to accelerate the identification, spread and scale of proven healthcare innovations. We work shoulder-to-shoulder with you to improve health and care for everyone in Canada.

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HOME AND COMMUNITY CARE

CBI Home Health Group, Etobicoke, Ontario

Team Lead	Kathleen McQueen, Manager of Clinical Excellence, Therapy
Patient/Family Representative	Curtis Hiemstra
Senior Officer/Director	Omar Aboelala

Indicators:

- **Primary Outcome Indicator:** Caregiver distress
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Caregivers who are all ages

Care for the Caregiver Program

CBI Health Group, the largest provider of community healthcare services in Canada, has developed the Care for the Caregiver Program – a three-tiered program offering varying levels of support for caregivers. Tier 1 provides referral to the appropriate services or programming. Tier 2 provides caregiver support needs assessment (via the Caregiver Strain Index (CSI)). and Tier 3 provides a self-management approach to well-being, supporting and connecting caregivers to a comprehensive suite of resources and tools. The program has been initiated for caregivers involved in the enhanced palliative program and restorative care program in the South West Local Health Integration Network with plans to spread next to Erie St. Clair LHIN.

Learn more: https://www.youtube.com/watch?v=b_0tQy8ayuw&feature=youtu.be

Connect: [@CBIHealthGroup](#) [@KatMcQueenOT](#) [@OmarAboelelaPT](#)

Alberta Health Services: Edmonton Zone Home Living, Edmonton, Alberta

Team Lead	Jasneet Parmar, Physician Medical Lead, Home Living and Transitions, AHS EZ Continuing Care
Patient/Family Representative	Brenda Bell
Senior Officer/Director	Anita Murphy

Indicators:

- **Primary Outcome Indicator:** Home care services helped the recipient stay at home
- **Supplementary Outcome Indicators:** Caregiver distress
- **Patient/Population Reach Indicator:** All primary caregivers of long-term supportive and maintenance home-care clients

The Edmonton Zone Enhanced Home Living Supports Pilot Program

Alberta Health Services developed the Edmonton Zone Enhanced Home Living Supports Pilot Program to ensure caregivers and homecare clients with complex chronic conditions have a real choice to remain in their homes in the community and caregivers are supported to sustain care and maintain their own well-being. Homecare staff are educated to provide Caregiver Centered Care. Case managers use the Carer Support Needs Assessment Tool (CSNAT) to complete a person-centered assessment of family caregivers’ support needs and the Caregiver Risk Screen [CRS] is used to identify “at risk” caregivers. Homecare staff help caregivers access the support they need and navigate health and community systems. Enhanced respite care and supports for independent activities of daily living are available for caregivers at high-risk of burnout and/or being unable to sustain caregiving. This program is being piloted in multiple settings: urban, rural, suburban and inner city, and is being rolled out to the entire Edmonton Zone from late 2019.

Learn more: <https://www.youtube.com/watch?v=vybuT51KJck>

Connect: [@AHS_YEGZone](#) [@jatiprin](#)

Lanark Renfrew Health and Community Services, Lanark, Ontario

Team Lead	Christina Dolgowicz, Lung Health Coordinator
Patient/Family Representative	Christine Love
Senior Officer/Director	John Jordan

Indicators:

- **Primary Outcome Indicator:** Home care services helped the recipient stay at home
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Clients over the age of 40 with a diagnosis of chronic obstructive pulmonary disease (COPD)

Lanark Renfrew Lung Health Program

North Lanark Community Health Centre is working to integrate and enhance three regional chronic obstructive pulmonary disease (COPD) related programs currently offered through the North Lanark Community Health Centre: lung health program, community-based pulmonary rehab program and primary care outreach for seniors. The integration of these programs will improve early screening of COPD, enhance appropriate referral and care and identify patients requiring palliative care supports. Four key areas for improvement are targeted to increase access with the goal to keep patients at home:

- Increasingly early screening and detection for people at risk of COPD.
- Implementation of a 1-833 phone number to connect patients with a respiratory therapist to manage care from home.
- Connecting patients to primary care outreach programs and providing education sessions to rehabilitation participants.
- Early identification of palliative care clients based on specific indicators of decline. .

Learn more:

https://www.nlhc.on.ca/PrimaryCare/Lung_Health.html

<https://www.youtube.com/watch?v=9OdYWI3qibc>

Connect: [@christinadolgow](https://twitter.com/christinadolgow)

University of Alberta, Calgary, Alberta

Team Lead	Tammy O'Rourke, Nurse Practitioner
Patient/Family Representative	Pearl Todd
Senior Officer/Director	Tammy O'Rourke

Indicators:

- **Primary Outcome Indicator:** Home care services helped the recipient stay at home
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Homebound seniors

Collaborative Community Care (C3) for Seniors: Health Services @ Sage

Collaborative Community Care (C3) for Seniors: Health Services @ Sage is a senior focused/senior friendly clinic providing all the services that a traditional health team provides, with additional services not typically offered by traditional community primary care teams (for example clients can access housing assistance or purchase a meal during their visit). Home visits are provided to seniors who are homebound as part of an integration into a social services program, helping recipients to stay at home. C3 Nurse Practitioners and other team members see seniors in their home for both ongoing primary care and urgent care requests. Both of these types of visits contribute to the seniors ability to stay at home, decreasing the number of non-urgent visits to emergency rooms, avoiding hospitalizations and potentially decreasing 911 calls for non-emergency concerns.

Learn more: <https://www.mysage.ca/at-sage/health-services>

Connect: [@SageYEG](#)

McGill University Health Centre (MUHC), Montreal, Québec

Team Lead	Carolyn Freeman, Chair of the MUHC Clinical Pertinence Coordinating Committee
Patient/Family Representative	Susan Szatmari
Senior Officer/Director	Martine Alfonso

Indicators:

- **Primary Outcome Indicator:** Death at home/not in the hospital
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** All stage IV lung cancer patients referred to palliative support within 60 days of initial visit to the MUHC for diagnosis or care

Integrating Palliative Support as Routine Care for Patients with Stage IV Lung Cancer

The McGill University Health Centre (MUHC) is rolling out a program to integrate early referral to palliative support as part of routine care for all patients with stage IV lung cancer treated at the MUHC. A feasibility study will be undertaken by conducting stakeholder interviews to assess readiness of clinicians and the institution/network and identify preferences of patients and caregivers. The program involves:

- All patients with stage IV lung cancer presenting at the MUHC will be referred to palliative care within 60 days of initial visit.
- In order to implement this policy, we plan to organize several focus groups with the various stakeholders including physicians, patients and caregivers, allied health care providers, as well as hospital managers and senior administrative staff.
- Qualitative data from these focus groups and interviews that will help evaluate feasibility and stakeholder preferences and identify current gaps and areas to target (for example, patient and physician education about end-of-life discussions and need for methodical and transparent recording of advance care directives).

Learn more: <https://muhc.ca>

Connect: [@cusm_muhc](#)

Children's Hospital of Eastern Ontario (CHEO), Ottawa, Ontario

Team Lead	Carlie Brown, Case Manager, Home Ventilation Program
Patient/Family Representative	Teresa Macmillan
Senior Officer/Director	Sherri Katz

Indicators:

- **Primary Outcome Indicator:** Home care services helped the recipient stay at home
- **Supplementary Outcome Indicators:**
 - i. Wait times for home care services, referral to services
 - ii. Caregiver distress
 - iii. Death at home/not in hospital
- **Patient/Population Reach Indicator:** Pediatric home ventilation patients (age newborn to 18), including tracheostomy dependent and invasive ventilation patients, patients on non-invasive ventilation for life support, complex patients on positive airway pressure devices and patients requiring lung airway clearance devices such as LVR and cough assist. Secondary reach includes caregivers (RN's, PSW, school staff and family members) via caregiver competency checklists and number of providers trained

Complex Respiratory Care for Pediatric Patients

The Children's Hospital of Eastern Ontario's (CHEO) intensive care unit plans to address the length of stays and admission rates by improving home care services for pediatric patients so they can remain at home. This program is funded by the Local Health Integration Network (LHIN) and modeling the Somerset West complex respiratory care program which has demonstrated success for moving adult patients with complex respiratory needs and technology from the acute care setting back to the community.

A community pediatric respiratory specialist will offer home visits as needed for complex respiratory patients – addressing home equipment issues and creating a more seamless transition between patients and hospital teams. It will also deliver training and education to home care agencies to decrease wait times to home care services and decrease length of stay for inpatients requiring home care services.

Learn more: <https://www.cheo.on.ca>

Connect: [@CHEOhospital](https://twitter.com/CHEOhospital)

Children’s Hospital of Eastern Ontario (CHEO), Ottawa, Ontario

Team Lead	Amelie DesLauriers, Social Worker-System Navigator
Patient/Family Representative	Lillian Kitchen & Teresa MacMillan
Senior Officer/Director	Michele Hynes, Director & Chantal Krantz, Manager

Indicators:

- **Primary Outcome Indicator:** Caregiver distress
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Parents in the Champlain region experiencing caregiver distress who have children and youth under the age of 18 with medical complexities and are receiving support from CHEO.

Navigator Program

Parents of children and youth with medical complexities (CMC) experience many challenges when caring for their child, directly impacting the social determinants of health. Among the highest concerns are the effects on the physical and mental health of the parent and increased social isolation. Providing early screening and intervention will ensure that families thrive and are supported to provide the best life for themselves and their children and youth.

The Navigator Program is in the final year of a 5-year federally funded program to help address critical gaps in supports and connections for parents of children and youth with medical complexities. The program promotes the social and emotional health of families by helping them access peer supports and navigate key services, and by providing counselling.

In order to support parents, the Navigator Program has two Parent Navigators and one System Navigator. The two Parent Navigators provide peer support to families who have children and youth with medical complexities, with the goal of providing the families with a means to socialize, share ideas, and connect with others who share their experiences in order to end their isolation and improve their wellbeing. The Parent Navigators do this by organizing workshops, wellness and social events, being present on social media, meeting parents individually or in groups, and supporting parents during admissions and clinic visits.

Families with needs beyond social isolation may also receive services from the System Navigator. The System Navigator provides help to families navigating the complex care system by finding resources and through one-on-one counselling, family counselling and workshops. With the re-initiation of the System Navigator, more families will be provided services and counselling to help alleviate caregiver distress. Parents decide what their goals are and will meet with Parent Navigators and/or System Navigators depending on their needs. The System Navigator will be using a pan theoretical evidence-based approach, specifically the Feedback Informed Treatment (FIT) approach during counselling. This approach allows clinicians to adjust their treatment approaches based on their clients’ feedback, and to monitor their clients’ progress.

Connect: [@CHEOhospital](#)

MENTAL HEALTH AND ADDICTIONS

Indigo Harm Reduction, Edmonton Alberta

Team Lead	Dakota Drouillard, Licensed Practical Nurse
Patient/Family Representative	April Bullchild
Senior Officer/Director	Shelby Young

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** The target population will be individuals using programs, treatments, or support services to overcome challenges and barriers they face due to mental health and addictions, and to assess if treatment is easily accessible

Introducing Electronic Medical Records (EMR) to preventative and primary care resources

Through environmental scanning and distribution of surveys, Indigo Harm Reduction will be comparing the population of Albertans who identify personal challenges with mental health and addictions to utilization of services, as reported by Statistics Canada. The aim is to unite programs in a way that referral of services is easier, that clients know the criteria for utilizing services and create a way in which appropriate services are found that match to an individuals needs almost fully.

Learn more: <https://www.indigoharmreduction.com/>

Connect: [@indigoHRS](#) [@dakotaleee](#)

Joseph Brant Hospital, Burlington, Ontario

Team Lead	Bila Sabra, PHAST Charge Nurse
Patient/Family Representative	Lynn Gallagher
Senior Officer/Director	Cheryl Gustafson

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:**
 - i. Wait Times for Community Mental Health Services, Referral/Self-Referral to Services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
 - ii. Rates of Repeat Emergency Department and/or Urgent Care Centre Visits for a Mental Health or Addiction Issue
- **Patient/Population Reach Indicator:** The target population for PHAST is transitional age youth, adults and seniors (aged 16-99) who experiencing acute instability of a mental health and addiction concern

Prioritizing Health through Acute Stabilization and Transition

Joseph Brant Hospital has led the development of a multiagency Mental Health and Addictions (MH&A) model in Burlington called PHAST (Prioritizing Health through Acute Stabilization and Transition). PHAST is an innovative, system-wide integrative “hub and spoke” service delivery model; the goal is to provide the most appropriate urgent MH&A care through timely access, assessment and intervention while preventing unnecessary emergency room visits and hospital admissions. The stabilizing interventions will help to reduce recidivism to the Emergency Department while the warm transfers, i.e. those transfers occurring from service to service, are designed to improve the initiation into community treatment, particularly for more complex situations.

Learn more: <https://www.youtube.com/watch?v=nt-D-Ha-RXo>

Connect: [@Jo_Brant](#)

Vancouver Coastal Health, Vancouver, British Columbia

Team Lead	Andrew Reyes, Project Coordinator
Patient/Family Representative	Community Engagement Advisory Network (CEAN)
Senior Officer/Director	Monica McAlduff

Indicators:

- **Primary Outcome Indicator:** Wait Times for Community Mental Health Services, Referral/Self-Referral to Services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Number of patients (with depression and anxiety) successfully referred to Kelty's Key – VCH Online Therapy

Kelty's Key

Kelty's Key is a free online psychotherapy platform that enables therapists to incorporate Therapist Assisted Internet-Cognitive Behavioural Therapy (TAI-CBT) into their practice. TAI-CBT is as effective as face-to-face therapy and gives clients added flexibility. Kelty's Key can help therapists treat more clients and reach individuals who may otherwise be unable to access treatment. The program is based on email therapy and online courses. Our modules are evidence based and developed by clinical CBT experts at Vancouver Coastal Health and Providence Health Care. Courses offered include: Anxiety, Chronic Pain, Complicated Grief, Depression, Insomnia, Panic and Substance Use.

Learn more: http://www.vch.ca/Pages/Kelty%E2%80%99s-Key--Online-Therapy.aspx?res_id=474

Connect: [@VCHhealthcare](https://twitter.com/VCHhealthcare)

Calgary Foothills Primary Care Network, Calgary, Alberta

Team Lead	Jackie Aufricht, Program Manager
Patient/Family Representative	Farah Anastas
Senior Officer/Director	Allison Fielding

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Two interprofessional groups of health and community professionals in the Calgary area
 - i. Children and youth aged 5-20 with complex addiction, mental health and related psycho-social needs and their families in the Cochrane area
 - ii. Older adults with complex addiction, mental health and related psycho-social needs in the Bowness area

Case Collaborative Models

A joint initiative between the Calgary Foothills Primary Care Network (PCN) and Alberta Health Services (AHS), the Case Collaborative Model has been tested as a method for better coordinating care for individuals challenged by mental health and addictions issues – bringing together providers from multiple organizations to problem solve complex patient situations. The Case Collaboratives promotes the successful navigation of mental health and addiction services by immediately connecting the patient to the most appropriate services in their community based on their needs, while the model brings together providers from multiple organizations to problem-solve complex patient situations and improve continuity of care.

Learn more: <https://cfpcn.ca/>

Connect: [@foothillspcn](https://twitter.com/foothillspcn)

Kidthink Children's Mental Health Centre Inc., Winnipeg, Manitoba

Team Lead	Rossana Astracio-Morice
Patient/Family Representative	Rebecca McDermott
Senior Officer/Director	Analyn Einarson

Indicators:

- **Primary Outcome Indicator:** Wait Times for Community Mental Health Services, Referral/Self-Referral to Services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
- **Supplementary Outcome Indicators:** Awareness and/or Successful Navigation of Mental Health and Addictions Services
- **Patient/Population Reach Indicator:** Children in Manitoba aged 12 and under, along with their families and support systems (guardians, extended family, teachers, aides, pediatricians, nurses, coaches, faith leaders, community leaders, instructors, neighbors, and a variety of other grownups who support children)

KIDTHINK: Providing Evidence-Based Mental Health Treatment Services

KIDTHINK offers clinical and outreach services focused on improving mental health services with a focus on early intervention and prevention for children aged 12 and under. KIDTHINK leverages technology to remove geographical barriers to access timely services by offering services through a rapid screening process without requiring a diagnosis. Additional supports are offered to remove barriers that delay access and receipt of treatment, including financial aid , home visits to meet families or communities and partnerships with public schools to facilitate school psychologists and guidance counselors referrals. Using InterRAI's Child and Youth Mental Health Screener (ChYMH-S) and Child and Youth Mental Health Community Based Assessment Form (ChYMH), clients will be directed to the appropriate treatment stream within a corresponding timeframe according to the urgency of their presenting concerns.

Learn more: <https://www.kidthink.ca/>

Alberta Health Services : Calgary Zone, Calgary, Alberta

Team Lead	Jennifer Kuntz, Project Facilitator
Patient/Family Representative	Kerri Conner
Senior Officer/Director	Avril Deegan Andrea Perri

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Caregivers, clients and service providers

Connection in the Community - Empowering Families Affected by Trauma

The Child and Adolescent Addiction, Mental Health and Psychiatry Program (CAAMHPP) aims to improve the transition from psychiatric emergency department/urgent care to community care for children and youth who have experienced trauma. The proposed new service pathway will connect Calgary families with mental health and psychiatry outreach support and help create a crisis plan. The service will also coordinate a case conference for the child, youth and family's informal and formal supports (including primary care teams, education, government agencies and other health professionals). An important component of this new pathway will include regular reviews of the intervention/support plan as well as follow-up with the client, family and services providers.

Learn more: <https://www.albertafamilywellness.org/assets/Resources/CAAMHPP-ACE-TIC-Resource-Guide-Nov-2016.pdf>

Connect: [@AHS_YYCZone](https://twitter.com/AHS_YYCZone)

Bereaved Families of Ontario, Southwest Region, Ontario

Team Lead	Bronagh Morgan, Executive Director
Patient/Family Representative	Denise Ludrigan
Senior Officer/Director	Bronagh Morgan

Indicators:

- **Primary Outcome Indicator:** Early identification for early intervention in youth aged 10 to 25
- **Supplementary Outcome Indicators:**
 - i. Wait times for community mental health services, referral/self-referral to services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
 - ii. Awareness and/or successful navigation of mental health and addictions services
- **Patient/Population Reach Indicator:** Children and youth aged 5 to 17 in the London, Ontario region (including Middlesex, Elgin and potentially Oxford counties) who self-identify as needing support after the death of someone close to them, parents/caregivers of such youth, and other adults seeking supports for the children they serve (including teachers, social workers, psychologists, youth case workers)

Designing Support Programs to Support Bereaved Children and Youth

The Bereaved Families of Ontario - Southwest Region serves children, youth and young adults who have experienced the death of a close family member by offering services and programs with safe spaces and peer support. Current programs are designed to target children aged 5 to 9 and youth aged 10 to 17, while work is also being done to scope additional support to better address the needs of First Nations and LGBTQ+ communities facing societal barriers to provide support when and where they need it. Both previous and current programs and services will be evaluated to determine opportunities for improvement, ensuring programs are engaging, inclusive and effective in supporting their targeted groups.

Learn more: <http://bfolondon.ca/>

Connect: [@SwBfo](https://twitter.com/SwBfo)

Sunnybrook Health Sciences Centre, Toronto, Ontario

Team Lead	Roula Markoulakis, Research and Evaluation Lead
Patient/Family Representative	Julie Cowan
Senior Officer/Director	Sugy Kodeeswaran

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:**
 - i. Wait times for community mental health services, referral/self-referral to services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
 - ii. Early identification for early intervention in youth age 10 to 25
- **Patient/Population Reach Indicator:** Youth aged 13 to 26 with Mental Health and Addictions (MHA) concerns and their families living in the City of Toronto, Peel Region, York Region, Durham Region, and Halton Region (i.e., Greater Toronto Area (GTA)). Family is broadly defined to include biological family members and those of significant importance to the youth

Family Navigation Project

Sunnybrook's Family Navigation Project (FNP) is a non-profit, free-of-charge service for youth aged 13 to 26 with Mental Health and Addictions (MHA) concerns and is designed to guide patients through care plans and reduce barriers to timely access and transition of services. Services are designed to be responsive and accessible. Upon initial intake through a screening assessment, cases are assigned to Navigators (graduate-level clinicians in mental health and/or addictions care, social work, psychology, child development, Parent Advocates with Lived Experience (PAL) and psychiatrists) who work one-on-one by phone or email with patients and/or their families to assist untangling the web of the MHA system and design care plans around the youth's medical, social and family goals. The model is designed to reduce barriers to access by creating meaningful relationships with families to engage them throughout the care process, and in some cases, working with families where youth are not motivated to access care or unwilling to engage in care.

Learn more: <https://sunnybrook.ca/content/?page=family-navigation-project>

Connect: [@Sunnybrook](https://twitter.com/Sunnybrook)

Canadian Mental Health Association: BounceBack, York Region, Ontario

Team Lead	Karen Leung
Patient/Family Representative	Shane Hooshmand
Senior Officer/Director	Ashley Hogue

Indicators:

- **Primary Outcome Indicator:** Wait Times for Community Mental Health Services, Referral/Self-Referral to Services (services provided outside of emergency departments, hospital inpatient programs and psychiatric hospitals)
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** New BounceBack referrals, that are screened eligible for the program (adults and youth aged 15+)

Improving Access to Bounceback

The program being delivered is BounceBack: Reclaim Your Life, which is a skill-building program designed to help adults and youth 15+ manage low mood, depression and anxiety, stress, or worry. The focus of the team is creating improvements, using quality improvement methodologies, that will improve wait-times to service, from date of screening through to the date of the participants first coaching session. The team is currently doing exploratory work to understand the problem and develop change ideas. Additionally, the team will focus on reducing the number of participants that become unreachable before an assessment to impact the wait-time.

Learn more: <https://cmha-yr.on.ca/>

Connect: [@CMHAYork](https://twitter.com/CMHAYork)

AIDS Network Kootenay Outreach and Support Society, Nelson, British Columbia

Team Lead	Brad Pollman
Patient/Family Representative	Nora Lilligreen
Senior Officer/Director	Cheryl Dowden, Executive Director

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Those living with and at the greatest risk of acquiring HIV/AIDS and or HCV, who have difficulty obtaining services elsewhere, especially due to substance use, mental illness, sexual orientation, gender identify race and ethnicity, and/or other social barriers
 - i. # of individuals who access the SMART 1 Pod who click on the “find support” functionality

Mobilizing Technology to Reduce Harm

ANKORS, a local harm reduction agency serving Nelson, British Columbia has partnered with technology firm SMRT1 to increase accessibility to harm reduction supplies, support and resources. The SMRT 1 Pod provides interactive touchscreen vending technologies that increase point of care access for substance use and harm reduction services. By adding a 24/7 access “SMRT1 POD (Personalized On-Demand)” at ANKORS, the organization will be able to increase access to the services existing content, resources and related services by providing on-demand, self-service locations in the community. Measurement and reporting can be generated in real-time through anonymous data collection accessed by both clients and providers which will increase population reach and program effectiveness. Interaction points are at the large format touchscreen to be located at ANKORS and through personal devices such as cell phones, tablets or computers which can provide continuity of care simultaneously.

Learn more: <https://ankors.bc.ca/> <http://www.smrt1.health/>

Connect: [@ANKORSWest](#) #SMRT1TECH #SMRT1HEALTH

Department of National Defense, Edmonton, Alberta

Team Lead	Captain Anna Harpe
Patient/Family Representative	Colonel Heather Morrison
Senior Officer/Director	Major Health Robson

(Note: participating team only, not eligible for awards)

Indicators:

- **Primary Outcome Indicator:** Awareness and/or successful navigation of mental health and addictions services
- **Supplementary Outcome Indicators:** N/A
- **Patient/Population Reach Indicator:** Members of the Canadian Armed Force (CAF) in Edmonton, Alberta (Experimental Group) and Petawawa, Ontario (Control Group) who have attended a residential addiction treatment program for a substance use disorder and subsequently enrolled in the 12-month Aftercare Program

Attitudes & Perceptions with the Addictions Aftercare Program

The purpose of this work is to investigate the impact of social support networks and system wide education and awareness initiatives on Canadian Armed Forces (CAF) members initiating and maintaining recovery from addiction. This study investigates perceptions and attitudes toward mental health and addictions aftercare services and the related effects on recovery capital, engagement and overall well-being of individuals who participated in aftercare services in two settings: CFB Edmonton (the experimental group), and CFB Petawawa (the control group). Inclusionary criteria for the study consists of members who have attended residential addiction treatment programs for substance use disorder and subsequently enrolled in the 12-month Aftercare programs at both bases (Edmonton = experimental, Petawawa = control). A proprietary interview questionnaire has been developed to discover the differences between pre and post-project attitudes and perceptions about addiction and the Aftercare program. Based on initial data collection results planning is underway to spread the project (Phase II) to Vancouver Island, where the CAF has both Navy and Air Force bases.

Learn more: www.dnd.ca

Connect: [@NationalDefense](https://twitter.com/NationalDefense)

Peter Lougheed Hospital, Alberta Health Services

Team Lead	Tacie McNeil, Clinical Nurse Educator
Patient/Family Representative	Jesse Dobson
Senior Officer/Director	Lois Ward, Senior Operating Officer

Indicators:

- **Primary Outcome Indicator:** Hospitalization rates for problematic substance use
- **Supplementary Outcome Indicators:** Rates of repeat Emergency Department and/or Urgent Care Centre visits for a mental health or addictions issue
- **Patient/Population Reach Indicator:** People who use substances (primary stimulants such as crystal methamphetamine) and are admitted to the Peter Lougheed Hospital

Contingency Management Programs for Inpatients with a Stimulant Use Disorder

Currently, there is no strong evidence-based medical treatment to support individuals with reducing or stopping stimulant use at the Peter Lougheed Hospital. Contingency Management (CM) has been shown to be an effective approach and will be implemented at our site to support individuals experiencing a stimulant use disorder. Stimulants can have profound effects on mental and physical health thereby contributing to increased visits to emergency departments and admissions to hospital. Stimulant use also makes it difficult for some patients to remain in hospital for the full course of their medical treatment, which contributes to multiple presentations for the same and worsening health problems.

By offering a CM group we will create opportunities for people who use stimulants to make positive changes including reducing or stopping their use of the substance, participating in addiction treatment and attending to their health and social needs. This will reduce repeat visits and readmissions for substance use and related medical issues.

While CM has been evaluated in the outpatient setting, it has not been implemented and formally studied in Alberta in an inpatient setting in the context of wrap-around supports from an Addiction Medicine Consult Service. The use of patient-centered objectives moves beyond abstinence-focused outcomes and allows the evaluation of additional important and meaningful outcomes.

Connect: [@ahs_yyczone](#)