Transitions in Care

Consultation Summary May 2019

EPION

EARLY PSYCHOSIS INTERVENTION ONTARIO NETWORK

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Contents

Background

Transitions in care, including clients leaving the program, transferring and re-entering, are consistently identified as challenges for Early Psychosis Intervention (EPI) programs. These issues emerged from the Ontario EPI Survey in 2012, the provincial consultation process in 2015 and most recently they were again flagged as issues during EPION's Fall 2017/Winter 2018 strategic planning process.

Transition challenges can affect the flow of clients through programs and therefore the ability of programs to accommodate new clients and their families. Given that a fundamental tenant of EPI is early access to services, supporting the effective flow of clients through the program is critical.

The Early Psychosis Intervention Program Standards, published in 2011 by the Ministry of Health and Long-Term Care, includes one standard related to transitions, Standard 6: Graduation from the Program. This Standard includes the premise that EPI is a time-limited program and the importance of linking clients to new services once they graduate.

It does not, however, provide any detailed guidance on when clients should be discharged or strategies for managing the limited availability of programs that will accept clients after discharge. The Standards additionally make no reference at all to issues related to disengagement and readmission. These gaps leave programs with little guidance, resulting in inconsistent practices across and even within programs.

Approach

Consultation Approach and Process

In response to the clear need identified by the network, EPION identified this issue as a priority in its 2018 Strategic Plan. EPION Committed to **"Facilitate a stakeholder dialogue around transitions of care, identifying implications for the EPI model, service delivery, care pathways, and systems level coordination to facilitate client flow to and from EPI services and easier access to EPI service."**

As a first step in this work, EPION held a brainstorming session during the May 11, 2018 EPION Network Meeting. The ideas raised during this discussion formed the basis for a Transitions of Care Consultation.

Transitions in Care Consultation

On June 15, 2018, twenty-four EPION members representing sixteen programs gathered to address the issue of what comes after Early Intervention and how to support our clients in the transition from EPI programs. The group represented programs located across the province, urban and rural, large and small. Participants included clinicians from a range of disciplines, an individual with lived experience and a family member. A reference list was provided to the group ahead of time as part of the process. See Appendix A.

The goal of this consultation day was to explore three domains related to transitions:

1 Discharge planning and transitions

COMMON CHALLENGES

- No clear criteria or structured way to assess when clients are ready to be discharged, which sometimes results in them staying in the program longer than needed.
- Often no appropriate services exist to discharge clients to.
  - Primary care may be insufficient for the client's level of need, and often they feel unprepared or uncomfortable taking on the client's care, even if it is within their scope.
  - At the same time, clients may not meet criteria for other available services (e.g., not 'severe enough' or on medications they cannot support) or even if they do, other programs can have long wait times and very different cultures (i.e., not youth friendly) which can be distressing for clients or deter engagement.
- If the individual is transferring to another EPI service, it may be difficult when there are inconsistent admission criteria and/or approach to care.

2 Disengagement

COMMON CHALLENGES

- Clinicians are often unclear on when a disengaged client should be removed from the program roster and the process for doing so.
- Unclear what the program's responsibility is towards disengaged clients.

3

Readmission

COMMON CHALLENGES

- No clear guidance on when clients should be readmitted vs when they are no longer eligible for an EPI program:
  - Is it based on number of times they have been admitted?
  - Is it based on their age?
  - Severity?
  - Length of time they were disengaged?
  - How long they were in the program before they disengaged?
  - Other service options available?
- Given the lack of other community services, clients who were stable in the community often come back to EPI whenever in crisis.

For each domain, the goal was to:

Start the process of developing and reaching consensus on 'Principles of Care'.

These principles of care would articulate the high-level approach to care to which all EPI programs, regardless of size, resources or service delivery model, should strive to achieve.

Share specific strategies that have been used successfully in EPI programs to address the challenges identified.

These strategies may not be universally applicable given the diversity of programs in Ontario but could be a resource to support programs towards achieving the identified principles of care.

Outcomes

Across all three domains a clear overarching theme is that, in EPI, one size does not fit all. It is not possible to create 'rules' that apply across the board, for example, related to when a client is ready for discharge or whether or not an individual should be readmitted to services. It is important to be flexible and consider the circumstances and unique needs of each client. However, at the same time, it is also important that we develop a consistent approach to ensure that all clients receive the same opportunities and to provide clinicians with guidance on how to make decisions. In addition, it is essential that decision-making involve the whole treatment team, including the psychiatrist and/or most responsible physician.

Related to transitions it is not appropriate to create strict rules. However, we can create clear guidance on the criteria to be considered in decision making and a systematic approach to assess those criteria routinely for all clients.

Discharge Planning and Transitions

PRINCIPLES OF CARE

1. Engagement and education of other service providers to support the development of transition options.

   » Ensure clients have a good primary care provider and build a relationship with them early in the clients' EPI treatment (e.g., attend a primary care appointment with client; send regular brief up-date notes).

   » Deliver public education to the larger service system to help them understand the specific needs and approach for EPI clients ("infect the rest of the system with EPI ethos") so that transition for EPI clients to other services will be less drastic.

2. Discharge is a process, not an event, and discharge planning should start from beginning of treatment.

   » Use of a care plan or structured approach to ensure that discharge planning begins early in treatment.

   » Consider language used throughout client care to ensure messaging that EPI is only the first phase of a continuum of care across a person's life span. Consider using language of "transition" vs "discharge" (discharge implies an end of service, which can raise concerns that they will be without resources vs framing it as a care transition).

   » Develop the relationship with client's GP at an early stage, to build that capacity. (This might involve actively assisting clients to connect with a new GP/Family Practice/Nurse Practitioner and developing facilitative relationships with primary care providers.)

3. Structured, flexible, client centered approach to identify when clients are ready to transition and to support the transition process.
   - » Flexible end point based on client, family, what is available in community
   - » Individualized transition plan that is client and family centered; clients and families should be included in discussions related to discharge planning
   - » Support families to prepare for discharge, it can also be a difficult transition for them
   - » Value of Involving peer support workers/peer navigation

4. EPI programs should make every reasonable effort to connect clients and families to the most appropriate service and support a warm handoff
   - » Develop formalized pathways of care in the community in order that it is clear where to refer clients at discharge
   - » Provide overlapping/shared care or consultation options for the receiving service
   - » Create step-down' or alumni programs
   - » Advocate for more service options for clients

5. EPION programs should utilize standard eligibility criteria to support transition between programs.

Discharge Planning and Transitions

STRATEGIES

The following are some locally developed initiatives that programs have attempted, to address successful transition:

Strategies for early and ongoing discharge planning:

1. Use of standardized tools to access readiness for discharge and level of care required:
   - LOCUS (Lynx-Peterborough);
   - ACT Transition Readiness Scale (North Bay).
2. Use a structured care path to track progress, guide discharge procedures and define intensity of care requirements.
   - STEPS for Youth, Toronto;
   - On-Track, Ottawa;
   - Cleghorn, Hamilton;
   - Slaight, Toronto;
   - PEPP, Elgin

Strategies to support warm handoff and educate other programs:

1. Use a peer support coach to help support the transition process.
   - 1st Step, Waterloo-Wellington
2. Offer groups that are broader than EPI clients only, that gives clients the opportunity to build relationships outside of EPI
   - PEPP, Elgin;
   - PEPP, Woodstock
3. Offer a support group for families to support transition, as the prospect of discharge can be very difficult.
   - PEPP, Elgin;
   - Phoenix, Halton

4. Conduct and get involved in regular education rounds with other community services to provide education on the EPI model and build the competency and comfort of programs which receive EPI clients
   - PEPP, Woodstock

Strategies using shared-care approaches

1. During the transition period, the case manager from the receiving program works together with EPI case manager for a period of overlapping care (up to 12 months). This allows knowledge to transfer from the EPI case manager to the new programs, and supports the client in building a relationship with the new case manager.
   - Lynx, Peterborough;
   - Cleghorn, Hamilton;
   - On Track, Ottawa
2. For the first year after discharge, the client's family physician can consult with the EPI program and its psychiatrist, e.g. by phone, e-consult or OTN.
   - On Track, Ottawa;
   - Cleghorn, Hamilton

Strategies offering continued support to the client after discharge ("alumni" or "booster sessions")

1. Structured support after discharge for a specified period of time. Process starts before discharge and continues after discharge. May include group sessions to talk about the process, reinforce safety plans and skills learned.
   - On Track, Ottawa
2. Discharged clients may come in for "booster sessions" for a specified period of time (e.g. up to one year). May include check-up with program psychiatrist for medication review or brief re-admission to optimize medications.
   - Cleghorn, Hamilton;
   - On Track, Ottawa

Disengagement

PRINCIPLES OF CARE

1. Treat disengagement as a natural part of services and plan for it from the beginning, like any other stage of care.

2. Actively promote client engagement in service (to reduce disengagement).
   - Youth friendly approach to services
     - Use of technology (e.g., OTN, texting, email) to give clients the option to participate remotely and to communicate in a manner they are comfortable with
     - Consider how to use youth friendly language (e.g., 'club' instead of 'group')
   - Early active outreach
     - Consider conducting a first appointment in the community or on the inpatient unit
     - Active outreach to people who don't attend their first appointment
   - Client centred services
     - Give clients choices in how or to what extent they want to participate in services, meet them where they are at
     - Get feedback from clients about activities provided and include clients in program planning to ensure services meet their needs
   - Engage family members
     - Family education and support is important to reduce stigma and support families to support their loved ones
     - Even if a client has disengaged, families still need support and, if possible, programs should continue to support them

3. Develop structured process for determining when clients who have disengaged from services should be removed from the client roster.
   - » Written policy/guidelines including the factors to consider when deciding a client should be removed from the client roster
     - › Ensure guidelines align with professional obligations
     - › Recognize that flexible approach is needed as each client situation is unique
     - › Inclusion of structured risk assessment and safety planning process
   - » Build risk for disengagement into care path; formal process to identify if it is a risk and strategies to mitigate based on stage of treatment

Disengagement

STRATEGIES

Strategies for early, active engagement:

1. First contact with new clients is a friendly 'meet and greet' in the community instead of a formal intake appointment. This approach supports engagement by making the initial contact more informal and away from the hospital environment. It also allows the first contact to happen more quickly, instead of waiting for the psychiatrist to be available
   › On Track, Ottawa
2. Conduct focus groups or establish peer advisory councils with clients to seek their input and ideas to ensure that programming is meeting client needs
   › Cleghorn, Hamilton
3. Hold regular drop in sessions (e.g. café) where clients come in, give feedback on services, and request topics for programming
   › On Track, Ottawa

4. Sign a contract with all clients at the beginning of treatment that states that if they miss too many appointments the clinician has permission to call an agreed upon secondary contact number
   - › CMHA, Timmins
5. Using the entire team to help with early engagement, including peer mentors/coaches, to help with early engagement
   - › CMHA York, Toronto
6. Use of secure personal video-conferencing to connect with clients where it is difficult or undesirable for them to meet in person. This allows clients to use their personal computer to access support and care.
   - › CMHA, Simcoe

Strategies for youth friendly communication

Using electronic communication such as text, email, apps, video, web-based tools, while respecting local agency and professional privacy regulations. Some examples of how agencies/ programs manage these restrictions include:

- » Using automated text reminders for appointments. It is a one-way communication only so reduces risk. (reference not available)
- » One central program cell phone is available that any clinician can use to text clients for the purpose of scheduling appointment
  - › Heads Up!, Kingston
- » All staff members have work cell phones that they can use to communicate with clients but the agreement is that it is for the purpose of scheduling appointments. The client also signs an explicit consent to receive text messages.
  - › Phoenix (ADAPT), Halton

Readmission

PRINCIPLES OF CARE

1. Every person who has been referred deserves the full breadth and scope of an early intervention service for the full 3 years

2. Need for clear process to guide decisions related to readmission, while allowing for flexibility to consider the unique factors related to individual cases

    a. Factors to consider in this process may include: reason for original disengagement, reason for readmission, timeline (length of time disengaged from service, length of time in service before disengaged), number of readmissions, current program capacity.

    b. In cases where full readmission is not possible or not appropriate, program should support the individual to connect with another more appropriate service, or could provide bridging care until another service is available.

STRATEGIES

1. Develop a written treatment agreement together with client when readmitted, that includes the goal in re-entering treatment, the expected time frame, and a method for evaluating
    - Cleghorn, Hamilton
2. Develop a policy for readmission after disengagement, e.g. timeframe for keeping files open, impact on length of treatment upon re-admission, etc.

Although agencies are attempting various strategies, there is no consensus on approaches. A consistent challenge remains with how best to provide follow-up care for individuals leaving early intervention services.

Summary

We recognize that this consultation process has served just to scratch the surface of this important issue and that developing appropriate and locally viable practices is a work in progress. We hope that this consultation will serve to stimulate discussion and action within and among all our EPION programs and that discussion will continue through our EPION forums. A major challenge is the difficulty of meeting the needs of our clients given gaps in service in the local system. In addition, programs face the challenges of the changing landscape of the work-place and multiple and ongoing intra-system changes, leading to difficulties in finding time to address inter–systems issues. We have included reference to various strategies that programs have attempted, in the hope that programs will connect with each other and try something that another program has found to be useful. We recently learned that following their participation in the June 2018 Consultation, PEPP Elgin created an 'Active Engagement and Retention Protocol' which addressed these issues for their own program, and which they are pleased to share with others (see reference list).

Recommendations

1. EPI Programs are encouraged to work towards adopting principles of care as outlined in this report.
2. EPI programs are encouraged to continue to connect with each other, solicit and share ideas and offer cross-program mentoring and support within and outside of EPION forums.
3. Administrators are encouraged to raise these issues at their organizations, integration inter-service tables and with funders and at any opportunities for consideration of improving service provision to clients.
4. EPION is encouraged to directly raise these concerns in their discussions with the MOHLTC.
5. EPION is encouraged to support the development of best practice processes and inform revisions of the provincial EPI standards regarding transitions in care.

Acknowledgments

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Appendix A

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