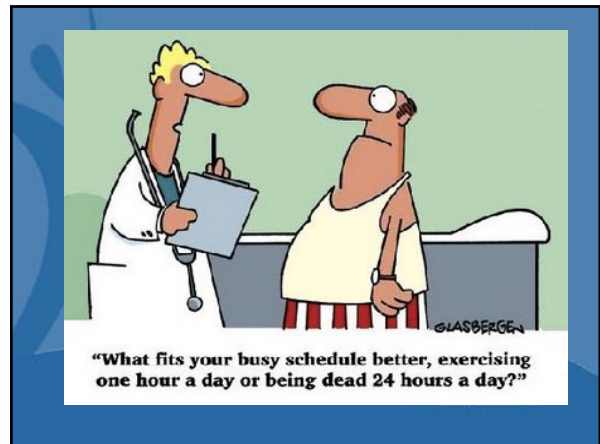


Introducing Primary Health Care Services into Community Mental Health Settings

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Discussion Points

- LHIN agenda and WOTCH Operational Plan
- Chronic Disease and Mental Health
- Cultural Change and Where to Start?
- Partnership Initiatives
- Diabetes Screening and Support Clinics
- WOTCH Medical Clinic
- Innovations and what Works Well
- Successes and Lessons Learned
- Adjunct Services



WOTCH Operational Plan

- The LHIN has 6 initiatives; “Primary Health Care and Chronic Disease Prevention and Management” is one of their priorities
- Discussion: Cultural Change in the organization
- “Strengthening and Improving Primary Care” and “Preventing and Managing Chronic Illness” became part of the WOTCH operational plan

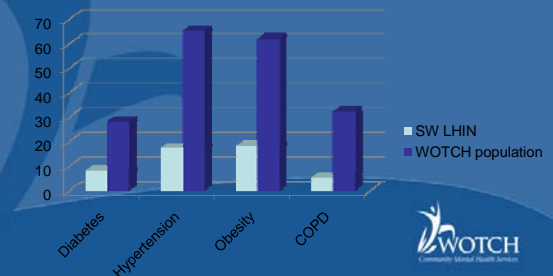


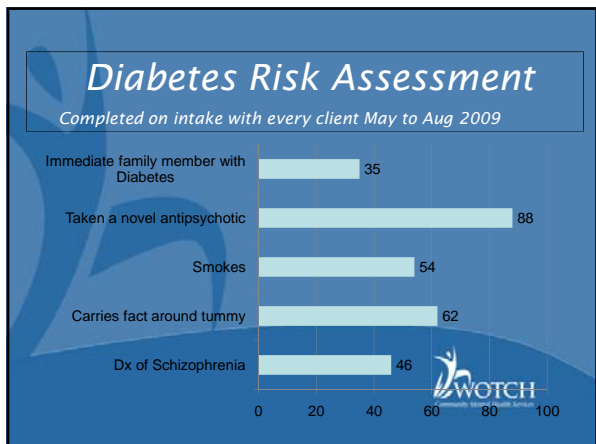
Chronic Disease and Mental Health



Co-Morbid Conditions

Completed on intake with every client



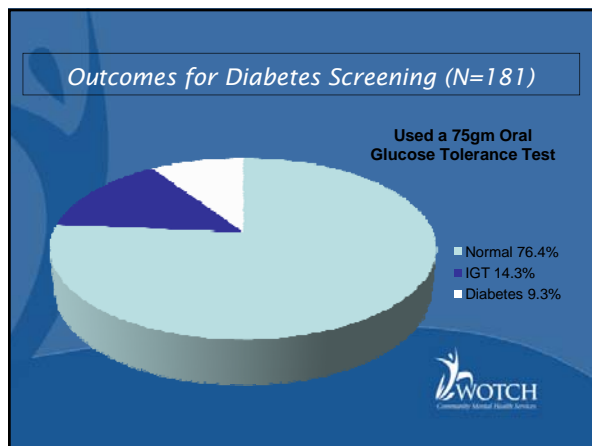


- ### Where to Start?
- Initial Nursing Assessment and Diabetes Risk Assessment on intake (identify needs)
 - Assessments: BP, WT, BMI, % body fat
 - Point of care access
 - Diabetes screening and support clinics
 - Flu Shot Clinics
 - Free Foot Care Clinics
 - Nutrition Clinics
 - Addition of Occupational Therapist to staff
 - Walking Program (pedometers)

- ### Where to Start?
- Training for staff: certification in foot care, diabetes mentorship program, education on life coaching, adding physical health goals to the IRP (Individualized Rehab Plan)
 - Healthier choices in the Bistro (menu)
 - Offered health and wellness strategies for staff (Nia, Staff Day Away, massages)
 - Collective Kitchen


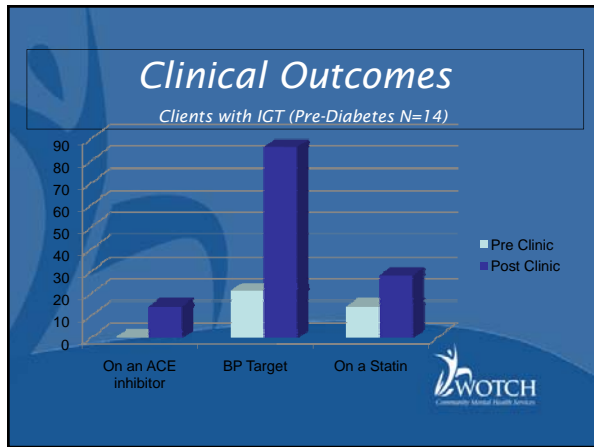
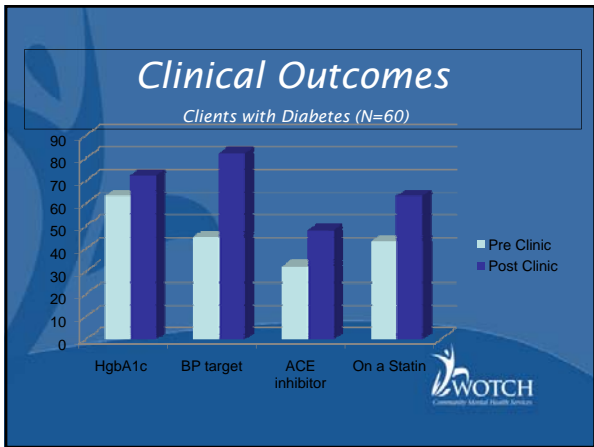
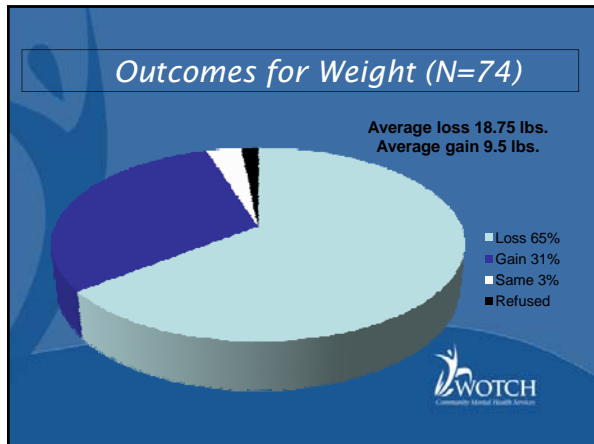
- ### Partnership Initiatives
- Formal partnership with a CHC- LIHC for a diabetes screening and support program
 - Connection to the University of Western Ontario for funding initiatives
 - Primary Health Care Transition Fund
 - Dietician from LIHC
 - Nurse Practitioner and Diabetes Educator through St. Joseph's Health Care

Diabetes Screening and Support Program

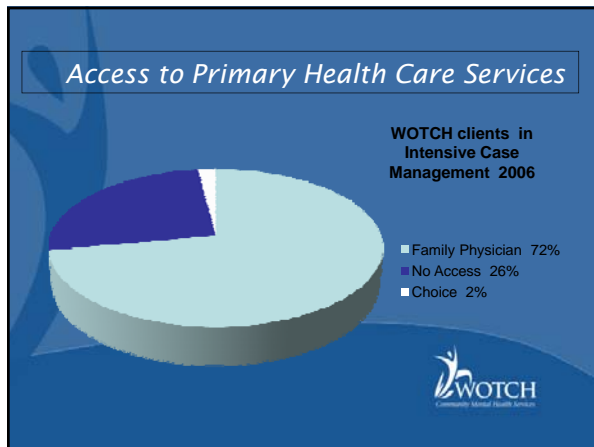


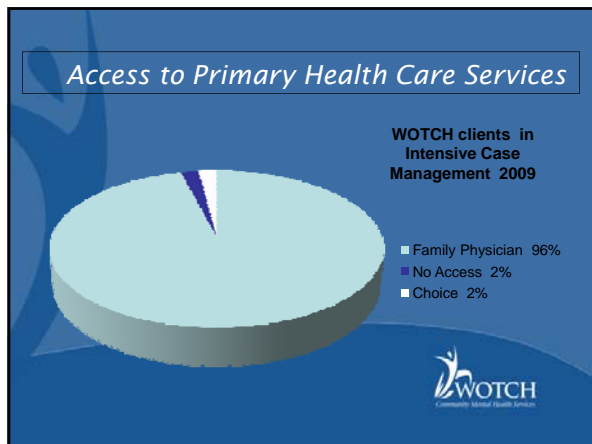
Diabetes Support Clinic

- Monthly visits
- Point of Care Access
- Assessments: A1c, review blood sugar readings, BP, WT, BMI, % body fat, diet review, eye exam, etc.
- Free foot care at each appointment
- Setting small goals
- Follow-up letter and flow-sheet faxed to the client's family physician

Medical Clinic



Medical Clinic

Initial Assessment

- Medical Hx
- Physical exam, dental health assessed
- Baseline blood work (liver enzymes, kidney function, chest x-ray, CBC, HIV, Hepatitis)
- Sexual health and communicable diseases
- Immunizations (Hep A&B, TdP, TB skin test, pneumovax, MMR)
- Age appropriate diagnostics (mammograms, stool for occult blood)

WOTCH
Community Mental Health Services

Medical Clinic

Initial Assessment Con't

- Smoking Hx and cessation readiness
- Diabetes risk assessment, screening and treatment
- Birth Control
- Injections
- Referrals to specialists (cardiologist, psychiatry, pain specialist, endocrinologist, etc)

WOTCH
Community Mental Health Services

Medical Clinic

Follow-up

- Histofreeze wart treatment
- Ear syringing
- Diabetes Care -- A1c, review of blood sugars, urine screen
- Hep C treatment
- STD treatment
- Drug testing and counselling
- Referrals to Specialists
- Diagnostics

WOTCH
Community Mental Health Services

Case Study

- 42 Year old male with diagnosis of Depression and Anxiety Disorder
- Suspected that client was infected with Hep C around 1994 while in jail (General Population - 0.18 % Hep C + Ontario Correctional Facilities - 15.9% Hep C +)
- Genotype is 1B high viral load of approx. 3,000,000 IU/ml

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Case Study

- Liver biopsy- Stage 2 fibrosis, recommendation of Interferon Tx by a Hepatologist
- Difficult to treat and referred to WOTCH Medical Clinic
- Weekly supervision for blood work and side effects

WOTCH
Community Mental Health Services

Case Study

- Ability to assess any mental or physical deterioration on a weekly basis
- Client cleared of Hep C with an undetectable viral load at week 12
- CM checks in with client on second day after injection-compliance / support
- Success! Noticeable change in client



Adjunct WOTCH Clinical Services

- Psychiatric Consultation Clinic
- Diabetes Clinic
- Dietician Consultation
- Nutrition Clinic
- Foot Care Clinic
- Collective Kitchen
- Family Support
- Occupational Therapy



Innovations

- Hep C Treatment on-site
- Light Therapy
- TENS Machine
- Occupational Therapists on staff
- Life Coaching and Strength Training
- Foot Care and Diabetes Support
- Nutrition Clinic



What Works Well

- Contact! Contact! Contact!
- Appointment reminders by phone, e-mail or via Case Managers
- Therapeutic relationship- meet often at WOTCH, client is comfortable to call and make contact
- Continual encouragement to be accountable for self-care and overall health and wellness



Successes

- Complex individuals have access to primary health care
- Over 85 clients receive Free Foot Care every month
- More client-centred holistic approach.
- Clients are more willing to make lifestyle changes to improve overall health and wellness



Lessons Learned

- Can't be everything to everyone
- Contact! Contact! Contact! Initially had high no show rates (47%)
- Double doctoring, really must do initial investigating
- Set boundaries at onset (no narcotics, benzodiazepines)
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