Windsor Essex
Community Health Centre
Centre de santé communautaire
de Windsor Essex
Supporting the Vulnerable

PARTNERSHIP ADVISORY COMMITTEE (PAC)
Transition Points Workgroup
Diabetes Wellness ~ 2885 Lauzon Parkway, Windsor
Monday November 25, 2013
2:00 – 4:00 pm

Chair: Karen Plunkett, Director Community Programs
Recorder: Lynn Thomson, Administrative Assistant

Attendance: Judy Ellis (WECHC), Joel Furlotte (Windsor Essex County Community Drug Strategy), Mark Horrocks (Ministry of Community & Social Services, Ministry of Child & Youth Services), Ivan Nicolleti (CCAC), Joseph Perry (Hospice of Windsor), Karen Plunkett (WECHC), Sharon Pyke (Greater Essex County District School Board), Pat Samson (CCAC), Doris Stillman (House of Sophrosyne), Rita Taillefer (WECHC), Mia Tannous (BANA), Wendy Tavares (John McGiveny Centre)

1. Introductions and Welcome **K. Plunkett**

2. Summary / Outcome of PAC meeting in September 2013 **K. Plunkett**

2.2 Common theme on concerns with transitioning clients

A recurrent theme of concerns over transitioning clients effectively from one agency to another was raised at the meeting in September. The Transition Points Workgroup was formed to provide a forum to share what is working well and where there are deficiencies that can be improved upon to provide better cohesive care to our clients.

3. What is Working in Terms of Transition Points

Greater Essex County District School Board

- Adopted a Diabetes Resource package, in conjunction with the Health Unit, to educate staff, students and parents in the school system. Specific planning is also done on an individual basis to provide consistency from the school to home. This is for non insulin dependent diabetics.
- A crisis response partnership has been formed with Maryvale and CCAC. A gap in care is identified in 16-18 year olds. There are two social workers assigned to schools. Anxiety is the main issue identified followed by substance abuse issues and eating disorders.
- CCAC has piloted Mental Health and Addiction nurses in 2 schools.
- An growing concern over students with concussions and the right to play and right to learn was identified. Concussions are becoming more and more common. This has become a province wide issue in the school system and addressing this issue.
- Concern over the appropriateness of physicians' notes and students' activities was raised. There is no forum to address this issue with primary care providers to identify boundaries and the ability to fulfill the requests of some notes.
- Working towards getting children to walk to school in as part of a healthy lifestyle and obesity prevention.

CCAC

- School Nurses to provide care through a school health program utilizing a different protocol for students with diabetes requiring insulin.
- A referral process is in place to link with WECHC Diabetes Wellness. Diabetes Educators attend the schools to provide education.
- Developing discharge bundles with WRH for CHF and COPD clients (informed of diagnostics, lab work, education taught). This information will go to community partners.

House of Sophrosyne

- Utilizes Dr. B. Mundle, Ob/Gyn at WRH to provide maternal-fetal care and Dr. P. Fargo to provide addiction counseling/treatment.
- A Psychiatrist screens the intake of clients and determines treatment needs.
- Discharge plans are completed to release clients back to the community and research is done on aftercare available in the area the patient is returning. If there is no aftercare program in their area, a social worker will be assigned.
- OTN is being underutilized and would be beneficial while patients are residents in addition to providing continuing psychiatric care on discharge.

John McGivney

- Utilize NPs to provide system navigation for parents of children with pediatric special needs.
- A gap in transitioning adults with physical disabilities was identified. Finding primary care providers to take on the care of these clients challenging. As a result patients attend ER for treatment.
- Transition Clinics are held but there is a shortage of adult Orthopods willing to take on clients. A partnership with WECHC (SCH) has enable NPs to provide primary care on site of some of these clients. The NPs also participate in the Transition Clinic.

BANA

- Partnership with WECHC (Teen Health) has secured funding to develop protocols for a public campaign to bring awareness of treatment places for clients with eating disorders. Clients up to 20 years will be treated at Teen Health and then transition to BANA. Services will be mirrored to provide a smoother transition. There will be a centralized intake department for all eating disorder clients.
- Clients requiring in patient treatment are sent outside of province due to bed shortage for eating disorders in Ontario.

Learning Disabilities Association

- Partnership with the City of Windsor to assist clients obtaining ODSP. There are 300-400 referrals per year and 125-150 completed forms per year. Many of these clients are currently on Ontario Works.
- WECHC provides assistance at Street Health in form completion.
- Concerns around the volume of requests from Leamington due to the recent factory closure were discussed.
- Barriers in obtaining physicians to fill out forms and sourcing appropriate medical records are challenging. The City has engaged in a contract to assist with psychiatric assessments.

WECHC (Street Health)

- Working with the Director of Admitting and ER at WRH to develop a process for access to client information for those attending ER and having recent admissions to enable appropriate support on discharge.

Hospice

- Identified inappropriate referrals (not palliative care or end of life care) for patients who require narcotics. Some physicians are not willing to prescribe narcotics and provide after hours coverage.
- The Privacy Act has hindered the ability to receive information which results in fragmented care.
- Insufficient information sharing, especially from clients attending hospital. The responsibility is put on the recipient agency rather than the care provider.

4. Leading Practices in Windsor Essex

- GECDSB has developed a crisis response partnership with Maryvale and CCAC
- CCAC has piloted Mental Health and Addiction Nurses in 2 schools

- BANA and WECHC have centralized their intake process for clients with eating disorders and are streamlining treatment services to enable a smooth transition of care.
- John McGivney holds Transition Planning Clinics and has partnered with WECHC to provide primary care for clients.
- Learning Disability Association is working with the City of Windsor to assist clients with ODSP packages. A partnership at with WECHC provides assistance from the Street Health providers.
- Diabetes Wellness and the Metabolic Clinic at Metropolitan Campus have developed a transition night to transfer clients reaching the age of 18 to Diabetes Wellness.
- CCAC and Diabetes Wellness have streamlined the referral process for school age children to provide education in schools.
- CCAC is developing discharge bundles for patients with CHF and COPD following hospitalization.

5. Gaps in Transition Points that Need to be Addressed

- Discharge from hospital – lack of information available to assist clients on discharge
- Information sharing is lacking from patients attending ER and admitted to hospital or the information is not provided in a timely manner. Some efforts need to go into a local solution.
- GECDSB would like the opportunity to discuss doctor's notes with physicians
- System navigation being done by primary care providers instead of a system navigator
- Knowledge of services each community partner provides

6. Key next steps?

- ✓ Discussions required with hospitals to develop a process to ensure client information is shared
- ✓ Provide an opportunity for the GECDSB to meet with primary care providers to clarify the ability to address student needs arising from medical certificates
- ✓ Provide opportunities at meetings for organizations to highlight their organizations to provide education
- ✓ Clients requiring system navigation can be referred to CCAC for short team assistance to provide linkages to community resources

7. Report back to PAC in January 2013

The minutes will be circulated prior to the meeting in January for further discussion on how to address the gaps in successful transitioning of clients.

8. Closing Remarks / Thank You

A request was brought forward to clarify the Committee name to represent Windsor Essex and avoid confusion due to other committees having similar names.

9. Adjournment

The meeting was adjourned at 3:20 pm.

10. Next Meeting

The next scheduled meeting will be held for the Partnership Advisory Committee on Wednesday January 15, 2014 from 9:00-11:00 am at Wisers Reception Centre.

Respectfully Submitted by: Lynn Thomson