Community Networks of Specialized Care
Building Health Care Capacity to Serve Individuals with a Developmental Disability

Establishment of Networks

On May 18, 2005, as part of the transformation of developmental services, the Ministry of Community and Social Services announced that four networks of specialized care would be established across the province.

Networks’ Mandate

To better coordinate the specialized service system, increase the range and availability of specialized supports and build expertise and community capacity through joint research and training initiatives.
The Four Networks

Together, we are building our capacity by supporting and facilitating the development of the skills, knowledge and attitudes of professionals and caregivers in the provision of services and support to adults with a developmental disability and co-existing mental health issue and/or challenging behaviours (Dual Diagnosis).

Health Care Issues

- Individuals with developmental disabilities have on average 5.4 medical conditions (more than twice the usual)
- Many of these conditions (e.g., Epilepsy, mental disorders, sensory impairments, swallowing disorders, chronic constipation, reflux esophagitis and dental disease) are more common in patients with a developmental disability than the general population
- Many also have communication impairments which makes it difficult to communicate health-related issues
- Patients with DD are often recipients of too many, or sometimes inappropriate, medications and often experience serious side-effects which go unrecognized

(Source: The Consensus Guidelines for Primary Care of Adults with Dual Diagnosis)

Health Care Issues

- Patients with DD often do not receive health promotion or disease prevention maneuvers (e.g., Immunizations)
- Medical conditions often combined with lifestyle issues such as poor diet, obesity and inadequate physical activity
Background

- Historically, provincial facilities provided both primary health care expertise and training in the field of developmental disabilities
- Individuals developmental disabilities are now living in the community and professionals without specialized knowledge are being asked to care for them
- The Consensus Guidelines for the Primary Care of Adults with Developmental Disabilities were released in November, 2006 to assist primary care physicians

Why is Primary Care Difficult to Access?

- Primary care providers receive little (if any) formal training in developmental disabilities
- Lack of specialized experience makes providers uncomfortable in providing care
- Individuals with developmental disability often have complex medical issues requiring more attention from a physician
- General shortage of physicians in the community

Building Healthcare Capacity to Serve Individuals with a Developmental Disability

- May 2010, Minister of Community and Social Services announced funding to improve access to health care for individuals with a developmental disability
- Funding divided between four Community Networks of Specialized Care to implement their plans to improve access to primary care
- Funding intended to support recruitment of new Health Care Facilitators
**Purpose**

- To build capacity in the local health care community
- To compliment efforts by MOHLTC to improve overall health care experience of Ontarians
- Expand access to health care for individuals with a dual diagnosis
- **Not** intended to duplicate the role of health care providers

**Activities**

- Provide system support that gains access for individuals to the primary care system
- Develop access protocols and training with Family Health Teams, Community Care Access Centres, Community Health Centres, hospital emergency departments and other organizations which have involvement with either delivery or referral to primary health providers
- Create linkages so that supports are in place for individual clients to receive the best possible health care

**Activities**

- Identify gaps in accessing primary health care, long term care and mental health systems and developing strategies to navigate or fill these gaps
- Education and increasing the capacity of other systems (e.g. justice system) with respect to health care needs of persons with developmental disabilities
- Educating and increasing the capacity of developmental and mental health service providers with respect to the health care needs of persons with developmental disabilities; and
- Creating professional linkages between health care services (e.g. Community Health Centres, Family Health Teams, CCACs, primary care providers)
Role of the Health Care Facilitator

- Facilitate referrals and linkages to medical resources and social services
- Educate providers in the implementation of appropriate care and treatment plans
- Development knowledge of existing generic health services and identify deficits/gaps which will require augmentation
- Provide advice to agencies to support development of their own network of health care services
- Promote professional linkages between health care professionals

Role of the Dual Diagnosis Health Care Facilitator

- Identify specialized training needs and recommendations of training resources
- Provide selective training to network partners and community agencies
- Integrate with other support systems within the community such as LHINs, Family Health Teams, Community Health Centres, etc.
- Act as a consultant by providing information to clients, caregivers, service providers and staff regarding community health care systems and the availability and suitability of community health care

Regional Activities
Southern Network of Specialized Care

Activities to Date
- Launch of the Primary Care Initiative at the Southern Network's Clinical Conference on November 19, 2010
- Introduced the Primary Care Initiative at the Southern Network's Community Networking Day on November 30, 2010

SNSC Activities cont’d
- Hired two Dual Diagnosis Health Care Facilitators – Began work on Feb 28, 2011
  - Deb Lawrence, R.N. for the South West region
  - Tom Archer, B.A. for Hamilton, Niagara, Haldimand Norfolk and Brant

  They will work in collaboration with the Research Facilitator and the 5 Local SNSC Facilitators supporting 11 local Dual Diagnosis Tables

Primary Care Website Project
- In partnership with CAMH, Surrey Place Centre and the Central Network/Toronto region, developing a web based resource for Primary Care Professionals which is based on Toronto’s “Pathway to Home” website
- Launch date is July 2011
- Remaining Networks will come on board with this project in 2011/2012
SNSC - Priorities for next 6 months

1. Development of a Primary Care strategic work plan
2. Development of an inventory of primary health care physicians
3. Collaboration with the Clinical Support Networks being led by Dr. Bill Sullivan

SNSC Priorities con’t

4. Create & deliver a presentation on the Consensus Guidelines for primary care of adults with disabilities to members of SNSC
5. Determine how many Primary Care Professionals from SNSC have participated in the Primary Health Care Guidelines to date & develop a connection with them
6. Evaluation of outcomes & effectiveness after one year

Central Network of Specialized Care

• Central Region: Central East, Toronto & Central West = the Tri Region Alliance (TRA)
Central Network of Specialized Care

- Three regions in Central: Central East, Toronto and Central West.
- Three Primary Care Facilitators have been hired to represent each region respectively.
- Provides immediate access to the uniqueness of each area's needs.

Primary Care Facilitator—Central East Network of Specialized Care

- Beverly Vaillancourt, DSW, BA Gerontology
- Primary Care Facilitator, Central East Network of Specialized Care, located #6 230 Aberdeen Blvd., Midland, Ontario
- Background: 30 years experience in the Developmental Sector

First steps will include the three facilitators developing common elements of a work plan for the Tri Region Alliance recognizing the uniqueness and primary care needs of each region.
- Visiting each of the quadrant tables to start to identify the needs in each quadrant; to start to build on work already underway locally.
- Develop linkages with Community Health Teams, Primary Care Providers, Mental Health Programs, Local Health Integration Networks, Community Care Access Centres, and Long Term Care through attending meetings/committees as opportunities arise.
Health Care Consultant – Toronto Region

- Angie Gonzales, RN MN CRNC
- Health Care Consultant for the Toronto Network of Specialized Care (TNSC)
- Located at Surrey Place Centre, lead agency for the Toronto region
- Background: Advanced Practice Nurse with a Master of Nursing degree in Community Health

First Steps include:
- Establishing consensus: 3 health care facilitators from each of 3 regions within the Central Region, to set up work plans
- Toronto region to transform focus from MCSS Facilities Initiative follow-up to facilitating education of primary care providers
- Support the Primary Care Guidelines project lead by Dr. Bill Sullivan at Surrey Place Centre

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Health Care Facilitator (HCF) - Central West

- Sabrina Vertolli RN, B.Sc.N, M.A. Ed.
- Health Care Facilitator for Central West Network of Specialized Care
- Located at Central West Specialized Developmental Services in Oakville
- Background: Registered Nurse with a Master of Arts specialized in Adult Education
Health Care Facilitator (HCF) - Central West

- **Central West Region** is comprised of Waterloo, Wellington, Dufferin, Halton and Peel counties.

**HCF Role:**
- Navigate across sectors
- Facilitate training
  (Support the Primary Care Guidelines project led by Dr. Bill Sullivan at Surrey Place Centre)
- Consultation & responsiveness
- Identify gaps/ trends/ opportunities

**Next steps ...**
- Role definition
- Building capacity / professional development
- Networking & building community partnerships
- Promoting HCF role
- Facilitating training to meet community needs
Activities to Date:
- Two Health Care Facilitators recruited
  - Carole Levellé, South East Region – Registered Social Service Worker with 25 years developmental and mental health experience primarily in community outreach/case management
  - Liz Kacew, East Region – Registered Nurse Practitioner with developmental service background and experience on clinical team providing support to primary care providers on developmental disabilities
**Eastern CNSC**
- VC Launch event held March 3, 2011
- Stakeholder consultations (service provider tables, DS/MH committees, Primary Care Forum) are ongoing
- Communication materials developed
- Distribution of revised 2011 Primary Care Guidelines and Tool-kit to all health care providers
- Development of health care provider database

**Eastern CNSC**
A Health/DS/CNSC Collaboration:
- Partnership between North Hastings Family Health Team, Eastern Region CNSC and North Hastings Community Integration Association – South East Health Care Facilitator represents CNSC
- Project deliverables:
  - to clarify identified gaps and service needs
  - Explore successful practices and service options that may exist in other regions
  - Identify partners who would like to collaborate in creating service solutions for people with dual diagnosis
  - Develop a work plan and proposal to address this service gap
  - Conduct focus group of local mental health providers to identify training needs to enhance capacity of existing counseling services
  - Explore options for funding of on-going initiatives
  - Provide knowledge transfer to other regions experiencing similar gaps

**Eastern CNSC – Next Steps**
- Meeting with health care providers to familiarize them with the Primary Care Guidelines and accompanying tool-kit
- Build upon existing health sector linkages (ie. CCACs, LHINs, Integrated Mental Health Networks, etc.)
- Developing a data base of health care providers willing to expand their practice to include more individuals with developmental disabilities
Eastern CNSC – Next Steps
- Providing information to CNSC Coordinator and Committees on system gaps and barriers to accessing health care
- Identify training & education needs of health care providers
- Development of training and education calendar
- Establishment of regional Clinical Support Networks in collaboration with Dr. Bill Sullivan

Eastern CNSC - Next Steps
- Link with Coordinator for French Language Resource Network to establish training and resource materials in French for primary care providers
- In the East Region, the Health Care Facilitator (Nurse Practitioner) will clinically supervise and be faculty advisor for Nurse Practitioner Master’s Program at the University of Ottawa
- Establishment of outcome measures
North Network Dual Diagnosis Health Care Facilitators

Geographical Considerations
- Three LHINS, Ministry of Health
- Six Service Planning Areas, Ministry of Community Social Services
- Vast Geographical Area

Year One Activities
- Recruit Dual Diagnosis Health Care Facilitators – Three 0.6 FTE.
- Locate Facilitators in the Northwest, North Central and Northeast.
- Establish Co-Location Partnership with Primary Health Care Agency
Year One Activities Continued

- Inventory of Primary Health Care Professionals, Services & Agencies, as well as, Developmental Services

- Establish Database

- Develop Service Navigation Maps for each Northern Community

Year One Activities Continued

- Establish Clinical Support Network Linkages

- Link to Health Care & Education

- Determine Training Needs in the North

Provincial Activities

- Provincial working group to be established to collaborate with Dr. Bill Sullivan in relation to the Training Course on Primary Health Care and Primary Care Guidelines

- Joint Training & Educational Events (ie. Adults with a Dual Diagnosis in the Emergency Department)

- Sharing of resources across Networks

- Linking with the regional LHINs

- Health Care Facilitators to meet regularly by videoconference for information sharing
Questions ??

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