

BBNOHT Mental Health & Addiction Steering Committee Minutes

Date: March 11, 2025

Time: 1300-1500

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| **Item** | **Agenda** | **Lead** |
| 1.0 | Welcome and Introductions   * Land Acknowledgment * Agenda Review and Approval of Previous Meetings Minutes\* | Lynn Hinds (Land Acknowledgement) Jaleesa Bygrave |
| 2.0 | Local, Regional & Provincial Updates – Standing Item   * Local Program Updates or Changes * Nothing from group * Mental Health & Addictions Centre of Excellence (MH&A n CoE) * MH&A CoE is agreeable to attending a future MHA&A SC meeting to discuss the Provincial Data Set (PDA) * Questions to post to MH&A CoE: * What are the reporting capabilities for OHT geography? * Can local OHT data be extracted? * What data points are being collected? * Are there aggregate reporting capabilities? * How can PDS inform local service needs? * If we want to continue to use the MH&A dashboard, everyone must to use it and we need to define the purpose. * Plan to make a decision on this after we get information from the CoE.   ***Action: Jaleesa will connect with CoE and send them our questions.*** | Team |
| 3.0 | Digital Health & Navigation – Standing Item   * The provincial eReferral vendor has not yet been announced. Anticipate end of month. * Kim and Priya have been doing a lot of promotion and education around ConnectMyHealth. If anyone has a meeting where you want help registering, Kim and/or Priya are happy to attend. * We also have a large amount of promotional material. | Kim Meier |
| 4.0 | Collaborative Quality Improvement Plan (cQIP) Overview & Discussion     * Ontario Health has now shifted the MH&A cQIP indicator (rate of first contact to ED for MH&A) to “optional.” This can broaden the scope of some of the projects we are governed by and can be explored for the broadening of potential project opportunities in 2025-2026. * Last month we talked about what would be the ramifications if we decided not to continue with that metric. Ben stated that there aren’t any impacts but mentioned that it could be helpful to follow that metric to observe trends. He mentioned Ontario Health might incentive us if we follow this metric and see an improvement over time. * Group Feedback * Kim added that the Substance Use Disorders Working Group for Ontario Health West focused more on the 30-day revisit rate. This metric is more controllable compared to the initial visit rate. The group honed in on the revisit rate because it allows for better intervention when individuals present in the ED and transition to community-based services. Kim emphasized that discouraging people from going to the ED when they need help is inherently problematic. * Kristin mentioned that while the cQIP indicator met its target, it didn't provide a great deal of useful information. There is still plenty of opportunity, but broader projects should be considered. * The main point is to consider broader projects that have maximum impact on system users. This doesn't mean excluding projects related to the indicator, but we are not beholden to it. * It's more important to focus on projects that have meaningful impact. We can map these projects to any cQIP indicator we choose. * We need to decide whether to keep the indicator, choose a different one, or not use an indicator this year. * Suggest we land on projects that have meaning, then map to an indicator for the cQIP. | Jaleesa Bygrave |
| 5.0 | Project Review – Review all current BBNOHT MH&A Projects, including status and next steps   * Mental Health and Addictions Dashboard\* * Decision to be made after the CoE presentation * Cross-Sector Screening \* * The GAIN SS tool was selected for triaging individuals. The next step is piloting. * Kim emphasized the importance of early screening for better outcomes. The GAIN SS tool is already used extensively and maps to step care implementation work and is within the scope of coordinated access. * Kristin raised concerns about abandoning this project, noting the significant work already done. * GRCHC was a pilot site for GAIN SS for primary care in the past and found it to be very useful. * Jaleesa reported sharing the tool with some colleagues from different equity deserving groups (Indigenous, Black, gender diverse) who had some concerns about the tool coming across as deficit based and intrusive. Suggested considering additional or broader tools to include both MH and substance use. Raised concerns about whether the tool accounts for diverse experiences and whether it discourages treatment continuation. * Kristin shared that other tools were explored and it was decided that GAIN SS was the best option. * The selection of GAIN predates the OHT and it was selected because it is already broadly used. There has been more than 70,000 applications of the screener. No standardized tool will account for all social determinants of health and individual experiences. They are implemented in a context, as part of a therapeutic exchange, where patients gave autonomy of choice to answer questions and/or move forward with treatment. * There may be other tools to augment for certain populations. * Lynn suggested seeking out advice from other organizations with experience on these issues and finding out what Ontario Health recommends. * Jaleesa reached out to the manager of AMANI at CAMH, Thunderbird Foundation and Disability Justice Network and waiting to hear back on various identity-informed screening tools. Kim suggests reaching out to Chestnut Health Systems who developed the GAIN SS tool to see if they have information on utilization of this tool with diverse populations. Kim can share contact info.   ***Next Steps: Restart the working group, determine representation, and develop a blurb on the redevelopment of the table. Jaleesa will share a draft. Kim will inquire about the next meeting of the coordinated access CoP.***   * Substance Use Clinical Pathway \*      * A report was prepared and circulated for feedback that provided an overview of substance use treatment options in our community and included a journey map of a service user named Xander. * This resulted in recommendations about how to optimize substance use treatment. What do we do now with the information?   Discussion:   * The drug strategy/lighthouse strategy might be working on this already. Consider seeing what they are doing already and if we can support that work. * Need to determine if this is for BBN or just Branford. * The recommendation #6 around seamless transitions and warm handovers relates to ED visit and re-visit rates. Can we leverage existing work in this area? * The outcome of #3 consistent referral practices will be informed by the provincial eReferral vendor announcement. * These have different pieces and projects within each recommendations. What is the capacity of the group as a whole? Address them in increments based on our capacity as a group.   ***Action: Jaleesa check with drug strategy and lighthouse about work they are doing in these areas.*** | Team |
| 6.0 | Project Planning for 2025-2026   * Review Project Proposals from Alyssa Striker & Jaleesa Bygrave * Primary Care proposal from Alyssa:      * This project would explore barriers to primary care providers in Brantford, Brant and Norfolk integrating people with substance use disorders into their practices and identify opportunities to reduce barriers. * Noted that Alyssa’s purview is Brantford Brant, so leadership needed for Norfolk. * There is a relationship between this and discharge planning transition from integrated substance pathway work. * Jaleesa shared proposal for project “Community Voices: Equity in Mental Health and Addictions Services” * This would serve as an equity audit and would supplement the work led Ruby Latif with the EDI maturity grids   Comments/ questions   * This is important work and speaks to a lot of priorities and projects across the board. * What analysis across OHT to inform this project, is there collaboration with PWLE? * This is a service user perspective vs provider self report * The participants would be PWLE, can tap Nicki for participants and/or could use as an opportunity to recruit to the PLWE network. * Determine a process for selecting projects to continue for the 2025-2026 year * Team recalls there was a survey used for this previously. Kim will try to find this survey and bring to next meeting. | Team |
| 7.0 | Terms of Reference Review\*   * Group reviewed the TOR membership table. Change made to Lynn’s title and updated Southcoast Wellness organization’s name. * We need to get clarity on who is the agency representative from each of the organizations. Some of the representatives listed are not the ones who attend meetings.   ***Action: Jaleesa will connect with members listed to identify correct representatives.*** | Team |
| 8.0 | Next Steps/Additional Items   * Next meeting: April 8/25 1300 – 1500 hours | Team |

\*Indicates attachment

**Present/Regrets:**

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| **Name** | **Organization** | **12/10/24** |
| Jaleesa Bygrave | BBNOHT | P |
| Kim Baker | St. Leonard’s | P |
| Alyssa Stryker | Brantford Brant Drug Strategy Coordinator | R |
| Bill Helmeczi | Southcoast Wellness | P |
| Brook Gardner | Woodview | R |
| Beverly Jones | Primary Care | P |
| Cheryl Collins | BCHS | P |
| Irene Perro | Haldimand-Norfolk REACH | R |
| Jo Ann Mattina | De dwa da dehs nye>s Aboriginal Health Centre | R |
| Joanne Cleland | Hope Brant | R |
| Leslie Josling | Executive Director Willowbridge | R |
| Kristin Toushan | BCHS | P |
| Lynda Kohler | Executive Director GRCHC | P |
| Roxanne Pierrsens-Silva | Norfolk FHT- Executive Director | R |
| Todd Gould | Director of Primary Care and Community Health GRCHC | R |
| Jeanette Bulgin | BCHS – Acute Care | R |
| Lynn Hinds | CMHA – Director | P |
| Kim Meier | BBNOHT Digital Health | R |
| Nicole Schween | Woodview | R |
| Melonie Mawhiney | Nurse at Indwell Simcoe | R |
| Paula Duarte | Director of 4B and Holmes House - NGH | P |
| Stephanie Rochon | Holmes House – NGH | R |