HA work underway

s.13

s.13

HA Responses to Access and Utilization Request

VIHA

1. What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds in your region?

[Leadbetter, Sheila]

- Referrals to services are received at the local MHSU Intake Office. Referrals are accepted via self, acute care, primary care, Indigenous Health Centres, contracted service providers
- Connection with a support system whether IH MHSU or community partner is optimal for referral process, continuity of care both when individual receiving care and discharge. Linkage to support system is critical for success as treatment is a service delivery in time and individuals need to return to their home community following discharge
- Referral sources both IH and external partners knowledge and awareness of resources and trust in this service promotes referral and access
- Access to services is supported/facilitated by referral sources – consideration for travel requirements, storage of belongings, housing security, pet, family arrangements
- Timing of bed availability and communication to client to ensure appropriate time is provided for necessary arrangements to be made and psychological readiness to attend.

2. What barriers are you aware of that exist along the care pathway?
    a. What policies exist in your region that facilitate or create barriers to accessing treatment and recovery beds? Do these disproportionately impact priority populations?

[Leadbetter, Sheila]

- Access is through an Intake process and walk in is not an option
- Some people may not know how to navigate the system
- Factoring in transportation costs and logistics for travel for those accessing treatment at the regional sites
- Policies for recovery beds could include on site expectations that may be challenging for folks to adhere to. Eg., curfew, no pets, limits to use / harm reduction vs. abstinence based
- Culturally safe and informed sites specifically may not be available for people to receive the types of services / interventions that are meaningful.
    b. Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?

[Leadbetter, Sheila]

- Eligibility criteria and equally exclusion criteria. Violence and history of sane can be a barrier to someone accessing treatment and recovery services
- History of certain changes could be a barrier dependent on site/location. Eg., history of youth sexual offenses, violence, predatory history
- Age criteria – limited youth services available regionally and provincially for Tx and Recovery services.
    c. Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?

[Leadbetter, Sheila]

- Harm reduction philosophy which is absent in many substance use treatment and recovery sites is a big piece for many services that may impact access for people along with those listed above
- Lack of cultural and spiritual knowledge and awareness in sites to meet the needs of indigenous populations

d. How does recruitment/retention/staffing levels impact access and utilization?

[Leadbetter, Sheila]

- We have had to reduce medical detox capacity due to staffing shortages and we also struggle with same day admits due to staffing limitations
- Constant turnover of staff on the teams that make referrals and awareness of resources a challenge to ensure all practitioners are aware and up to date on the referral sources and processes to access services.

e. What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?

[Leadbetter, Sheila]

- As indicated in 2b. It isn't about the referral process, source, or criteria – more about the availability of resources based on the clients unique history.

3. What is the primary policy or process barrier you want to tackle in your region related to this issue?

[Leadbetter, Sheila]

- Open and transparent relationship with contracted treatment resources to ensure the services offered meet the needs of the client population access. An integral part of this will be ensuring client feedback is readily available and attended to ensure feedback mechanisms are effective and meaningful.

4. What work is your region already doing/or planning to undertake to address access and flow challenges?

[Leadbetter, Sheila]

- Attention to both access and egress to services which includes ensuring not only ar people able to access the services when they are ready, but also can move through the continuum of substance use services in a fluid and supportive manner
- Ensuring supports and transitions in care are effective and available when people are ready to move from one level of service to the next. Eg., once a person completed their time in a bed based tx program – if they require access to a supportive recovery site in their home community and / or robust stance use counselling and after care, this is available to them without issues of wait lists etc.

IHA

From: Dolman, Corinne <Corinne.Dolman@interiorhealth.ca>
Sent: March 14, 2023 8:37 AM
To: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>

Cc: Morris, Debi <Debi.Morris@interiorhealth.ca>; Mcadam, Tasha <Tasha.Mcadam@interiorhealth.ca>
Subject: RE: Action Required: Community Substance Use Beds - Access and Utilization Data Follow-up

One more thought Bethany. s.13 – so we are here right now - *the median wait time for treatment and recovery services across the province is 29.5 days with utilization rates ranging from 44%-73%* - s.13
s.13

5. What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds in your region?

For treatment beds

- We recommend s.13
  s.13

- Most treatment sites require a referral agent to support with preparation and aftercare;
  s.13
- People need to have access to a physician to write a prescription for medications needed during treatment and to complete the medical portion of the application; this can be a significant barrier but most treatment sites don't have physicians/ prescribers on site.

Supportive Recovery

- Has fewer admissions barriers and usually people can self-refer but often people have to give up housing in order to access this service

6. What barriers are you aware of that exist along the care pathway?
   a. What policies exist in your region that facilitate or create barriers to accessing treatment and recovery beds? Yes described above. Do these disproportionately impact priority populations? Yes, those living in rural areas may have more challenges accessing a referral source and/or a physician to complete the necessary paperwork. Some communities currently have wait times to be assigned to an MHSU clinician to support with referrals and service navigation.
   b. Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?

- Many BC Housing funded housing sites are not designed for people exiting treatment and recovery services. If people have to return to low barrier housing sites, maintaining recovery is difficult and so some choose not to attend treatment at all in order to stay housed.
- BC Corrections: MSDPR forms cannot be completed until applicant is released from incarceration; this can delay referrals to treatment; also continuity of OAT medication can be challenging.

c. Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?

- Yes, many of these restrictions exist and some are needed; for example most sites require the person to not need a medically supported WDM and lining up these services can be difficult especially in communities with wait times for WDM beds.
- Some sites do block intakes which significantly reduces utilization of beds as beds are not filled if people leave during the block.
- Travel is often a barrier for individuals coming from rural and remote areas of the region; although funding is available to support travel it is difficult to access and only certain items can be supported (e.g. a bus ticket) when what is usually required is gas money/ hotel for a driver.
- Most treatment centres cannot accommodate/ manage complex concurrent mental health issues; access to psychiatry would be required.

d. How does recruitment/retention/staffing levels impact access and utilization

- s.13; s.17

e. What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?

- We have worked with our providers and eliminated some of these barriers (e.g. medical referral for WDM beds) but a referral from a medical professional is still required for treatment as most sites have little or no onsite physician support.

7. What is the primary policy or process barrier you want to tackle in your region related to this issue?

s.13

8. What work is your region already doing/or planning to undertake to address access and flow challenges?

We are working to change the block intake model at one treatment centre; we have removed medical referral requirement at one WDM site. We are moving toward more regionally / HA supported screening and intake for beds.

VCH

1. **What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds in your region?**
    - Referrals to Vancouver Contracted community substance use beds and provincial treatment beds across all Communities of Care (CoC) go through CAIT (Central Addiction Intake Team).

    - Referrals for beds in other VCH Communities of Care (Richmond, Coastal) are sent directly to the service provider (e.g. Turning Point).
    - Clients who completed withdrawal-management and are waiting for a bed are referred to transition/stabilization beds (VCH funded and/or unfunded beds). If transition/stabilization beds are not available and clients can stay 1-2 days longer at WDM to bridge to their intake to community-based substance use beds or are discharged back to the community.
    - For individuals leaving detox who do not have housing, or a stabilization or treatment bed immediately available to them, and are not actively supported by a community team (e.g. ICMT, Assertive Outreach Team), a referral is made to a dedicated team on the Overdose Outreach Team, who provide short-term case management support to assist individuals in navigating next steps on their wellness journey

In development to address the above:

- Work across PHC and VCH region is underway to strengthen the pathway described above, as a major challenge for clients is that the transitions from bed/treatment request to a long-term recovery space is often mired by waiting lists, loss of communication with clients while waiting, and lack of timely access to treatment. Please see attached slide deck for description of the work underway to strengthen substance use stabilization pathways across the region.

2. **What barriers are you aware of that exist along the care pathway?**

2.1 What policies exist in your region that facilitate or create barriers to accessing treatment and recovery beds? Do these disproportionately impact priority populations?

Financial barriers:

- Per diem costs are a barrier for clients who qualify and are not on income assistance, cannot move to 'comfort allowance' as their only income, do not get the provincial income assistance or disability and cannot afford the per diem.

Regulatory complexity/lack of clarity:

- Community Care and Assisted Living Act (CCALA) and licensed care-facilities: the legislation and licensing regulation are not specific to the needs of the sector: leads to confusion, unique interpretations by the service providers and mistrust of the licensing officers – and further compounds the lack of clarity around standards of care in treatment and supportive recovery care.
- Updated Standards of care for treatment beds & supportive recovery are urgently needed to apply across sector are needed.
- Service providers who have treatment/supportive recovery beds that are funded differently (multiple contracts public/private and private) have mixed expectations or more autonomy to make decisions that are not evidence-based.

Challenges with timely access:

- Lack of capacity to match client need to appropriate bed/ service: Clients with no fixed address, or living in an SRO or shelter that is not conducive to their recovery goals, will often the first bed available, and may not be the best fit clinically and with the site's philosophy of care and are discharged without completing the program.
- Administrative barriers such as long wait times, clients not having a phone, admission requirements that are not evidence-based (e.g., abstinence, WDM, UDT).
- Priority populations (people living with poverty, homelessness, cognitive complexity) disproportionately affected by access issues.
- Frequency of those needing higher level care have led to individuals being transferred to hospital for escalation of care.

In development to address the above:

- Working in partnership with PHC (via the Road to Recovery initiative), VCH is working on strategies to strengthen clinical assessment and care plan prior to admissions (i.e. upon request for bed-based substance use stabilization support) to strengthen transitions along the continuum. Assessment will include access to pharmacological therapies, connections to primary care, mental health, and outreach support.
- Road to Recovery hospital-based beds will provide a needed level of clinical support to address client complexity the system is grappling with.

2.2 Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?

BC Housing:

- People with a history of challenging behaviours related to cognitive and mental health challenges in addition to their substance use (i.e. acquired brain injury, substance use-related psychosis) that pose safety issues within housing and/or shelters (e.g. chronic fire-starting, self harm, self neglect, challenges with activities of daily living). These individuals have fewer options on the housing spectrum, posing immense challenges for supporting transitions between detox/treatment/recovery and back to community housing. At present, there is insufficient housing designed to support the number of people requiring a higher level of support in their housing.

In development to address the above:

- New complex care housing investments are creating more spaces to address above need, but spaces remain limited.

BC Corrections:

- Services to support transitions from Provincial institutions are provided by PHSA; stronger integration with health authority services would support more seamless transitions.
- Indigenous people- First Nations, Inuit and Metis (FNIM) face extremely high rates of incarceration throughout Canada and are over-represented. In BC, indigenous people represent only 5.9% of the population yet nearly 35% of those incarcerated [i]. Although there are efforts to expand programing and address systemic structural violence contributing to this phenomenon, more preventive services and culturally appropriate programing is needed.

Municipal Cells:

- Some municipal cells and detachments are working towards expanding their programming and forms of treatment. For example, virtual care options (via VCH/PHC partnership program Lighthouse Virtual Clinic) have been implemented with West Vancouver and Sechelt municipal cells. Additionally, Vancouver has Rock-Doc for persons who require care while detained (including some OAT therapies for people with substance use disorders). Since decriminalization, local police have been providing the newly created resource card for all persons discharged from municipal cells. Timely access to substance use treatment options for persons that are detained remain limited remain a challenge for those detained in municipal cells. These issues can become compounded for persons who are pregnant, have concurrent disorders or other existing health needs. OAT therapies provided in the community (i.e. fentanyl patch, safe supply, injectable therapy) may be disrupted during detention leading to withdrawal.

In **development to address above:**

- Continued expansion of Lighthouse Virtual Clinic to all municipal cells across the region
- Implementation of some on the ground navigation services to work with local police (via funding for enhanced services to support decrim pathways)
- Continued strengthening of overdose outreach team (including perinatal substance use sub-team) as a referral source for law enforcement

Drug Treatment Court:

- Drug treatment court in VCH Region (DCTV) has been in operation for nearly twenty years.

s.13

s.13

In **development to address above:**

s.13

2.3 Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?

- Travel requirements are a definite challenge for individuals living outside the Vancouver urban centre.
- Central Coast (Bella Bella/ Bella Coola) face a particular challenge to access bed-based services
- For those non-contracted VCH services, admission requirements for abstinence or a particular period of being substance free, is a definite challenge for timely access to support that is safe, and evidence based.
- Medications are not supported: not applicable to VC contracted but still happen in other settings.
- Couples/families e.g., no couples or family members entering together.

In development to address above:

- Overdose Outreach Teams (OOT) in coastal communities have organized a coordinated effort with Vancouver OOT to provide seamless transportation support for individuals seeking to go to Vancouver withdrawal management services. This has increased access and successful completion of those accessing bed-based services from coastal communities.

- Powell River detox and stabilization beds (funded and in implementation phase), will provided vital service for those living in qathet region.

2.4 How does recruitment/retention/staffing levels impact access and utilization? Admission requirements eg. Absence

- Contracted Supportive Recovery and Treatment sites have limited access to nurses and prescribers, and this has made their work more challenging, as clients' needs are becoming more acute and complex (presence of benzodiazepines in the illicit supply, increased prevalence of acquired brain injury). Sites then redirect what they screen as a crisis to EDs.
- Contracted sites are reporting challenges with recruitment , retention and staffing levels –
- Some sites have had to reduce bed capacity to be able to more safely manage complexity (e.g. Harbour Light Detox reduced beds).
- Inadequate funding per bed, and decline in private pay revenues, has led to some sites having to reduce staffing levels, which results in less programming, and a concern that staff are further stretched thin to provide programming on site.

In development to address above:

- New contracts with contracted sites have enhanced/more robust reporting to ensure VCH is getting timely information on health and productivity of
- Additional clinical resources are being implemented at Harbour Light and Onsite to better manage client clinical complexity.

2.5 What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?

- Certain medications are not permitted at services not contracted by VCH (site eg. benzodiazepines, pharm alts), leaving fewer options for individuals, and unsafe situations for individuals referred to these types of sites by other services (e.g. drug treatment court)
- Limited access to clinical assessment and care planning prior to admission lead to services providers denying referrals that could have been served with the appropriate clinical support
- History of violence/sexual violence

3. What is the primary policy or process barrier you want to tackle in your region related to this issue?

- Updated Standards of care for contracted community-based substance use bed-based services
- Standardizing Admission and discharge Standard Operating Procedures (SOP)s at Vancouver contracted sites – to be expanded to sites across region.
- Increasing support through coordinated intake (Road to Recovery, Central Access Intake Team, START Team, OOT Teams, regional substance use teams) to support client throughout their recovery journey from referral to after discharge
- Increasing capacity and reducing wait times for the appropriate services

4. What work is your region already doing/or planning to undertake to address access and flow challenges?

In addition to the "in development" referenced throughout document above,

- Overdose Outreach Team (OOT):
  - Facilitates access to social workers or counsellors for clients who do not have them in the community.
  - Supports clients placed in stabilization beds alongside VCH WDM partners in care. These beds offer a stable environment for clients who are waiting for placement with a treatment or supportive recovery bed. OOT can connect with clients and work on personal care plan goals (e.g., primary care, substance use counseling) and support transitions to a treatment/supportive recovery bed when available.
- New VCH UDT Decision Support Tool (DST) implemented at Supportive Recovery and Treatment sites

- New VCH admission/discharge DST being implemented at Supportive Recovery and Treatment sites

- 1st & Clark shared project with BC Housing and CoV: New SU & Withdrawal Management **Centre**

scheduled to open in 2026
- Providence Health's new Road to Recovery plan being implemented in phases – planning for a coordinated system across the region – see attached slide deck on "substance use stabilization system"

PHSA

9. *What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds?*

- Client connects to a community level referring agent (community mental health and substance use support clinician)
- Referral agent makes appropriate referrals to regional health authority treatment services
- If a higher level of care is required than available at the regional HA services, then the referral agent refers the client to Provincial Level Services through a key contact

person (“Health Authority Liaison”) identified by each regional health authority

- The Health Authority Liaison reviews the referral for completeness and appropriateness and forwards to the appropriate Provincial Level Services
- Referral is screened by the Provincial Level Service Intake/Access Committee and referral either accepted or declined based on pre-determined inclusion and exclusion criteria
- If the referral is declined, the referral is discussed at a Provincial Level join leadership access committee with senior leadership from BCMHSUS for appropriate program matching (when possible); alternate recommendations are made for treatment
- If a person is declined, the referral agent is able to discuss with the client and appeal the declination by meeting virtually with the Program Intake/Access Committee for further discussion.

10. *What barriers are you aware of that exist along the care pathway?*
    a. *What policies exist that facilitate or create barriers to accessing treatment and recovery beds? Do these disproportionately impact priority populations?*
        i. Inclusion and exclusion criteria
            - facility/structural building limiting exclusions such as proximity to children’s care sites, inadequate fire mitigation features of the building
            - requirement of an established mental health disorder (RFHC program specific); difficult for rural and remote people to access a psychiatrist

for mental health diagnosis and/or care—disproportionally impacts priority population
    - exclusion of severe cognitive impairments and severe eating disorders (due to lack of medical care to support care needs)
    - requiring client to be independent with ADL's (excludes client who need care with hygiene or other physical limitations)

ii. Requirement for a referral partner (case manager, MHSU support clinician); clients are not able to self-refer, depends on availability of having a clinician in the client's home area, limitations in ability to access a clinician who would satisfy the criteria of a referral agent.
iii. Inclusion/exclusion of a severe mental health and substance use concern (program specific).
iv. Challenges with determining program match based on diagnosed mental health conditions (RFHC program specific) versus current mental health treatment needs.

b. *Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?*
    i. Medication funding limitations and seamless access to medications (for some sites/programs)
    ii. Challenges with MSDPR: funding to maintain housing, people are reduced to comfort allowance and unable to pay other bills
    iii. Housing/bed might be given up to another person while attending treatment
    iv. Not enough housing to meet clients complex needs upon completion of treatment
    v. Long waits for many supportive housing options

vi. Not enough housing or treatment programs for people who have children
vii. Challenges connecting people in corrections/forensics with long-term regional level MHSU supports

c. *Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?*
   i. Limited available intake spots at program sites due to physician availability to complete new intake assessments
   ii. Challenges with transportation and limitations of staff to intake clients outside of business hours (limited flight availability from remote communities)
   iii. Gender restrictions for some sites/programs
   iv. Withdrawal management services are sometimes required prior to admission to some programs (impacts timely access to services as some communities may be unable to provide withdrawal management)
   v. Shared rooms while in treatment (program specific), many people accessing services have histories of trauma, this is not desirable for clients
   vi. Infection prevention and control restrictions (no HVAC, old building) impacts ability to fill programs to capacity due to shared rooms

d. *How does recruitment/retention/staffing levels impact access and utilization?*
   i. In some cases, challenges with maintaining balanced staffing level and skills mix

ii. Challenges with recruitment and retention of physicians, NP, and other skilled professionals
iii. Challenges with recruitment and retention of health authority liaison and clinicians/referral agents (regional health authorities)- this significantly impacts capacity to facilitate timely referral processes, intake planning, and related occupancy

e. *What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?*
   i. People applying to the program are required to have community MHSU supports/case manager/referral partner
   ii. Lack of consistent follow-up in community (related to staffing shortages, challenges accessing clinical information required to complete referrals, client changing communities of care and/or being lost to follow-up)
   iii. Program/site dependent restrictions around history of aggression/violence or sexual activities involving a minor
   iv. Lack of services with skills set to manage people who experience additional disorders in conjuncture with their concurrent MH&SU (ie. Severe eating disorders or cognitive challenges in addition to mental health and substance use concerns)

11. *What is the primary policy or process barrier you want to tackle in your region related to this issue?*
   i. Lack of vacation coverage for positions or positions are being done off the side of one person's desk (ie. Health Authority Liaison)

ii. Special authority for medications
iii. Referral process: multiple documents required, people's presentations are dynamic and change throughout the referral process, delays in accessing information about referrals in order to screen referrals

12. *What work is your region already doing/or planning to undertake to address access and flow challenges?*
    i. Weekly meetings between BCMHSUS AMHSU programs to determine best fit and most timely access for people referred to Provincial Level MH&SU Services (moving clients easily between one program's waitlist to another based on clinical needs and program matching)
    ii. Quarterly meetings with health authority liaisons and with health authority stakeholders and Indigenous partners

FHA

13. What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds in your region?
    - Connection to an approved referral agent
    - Connection with clinician intended throughout recovery journey
    - Referral complete and submitted to FH Referral Coordination Service (includes confirmation of income)
    - Screened and decision to waitlist and level of care determined (may be referred to medical assessment at RAAC)
    - Matched to available bed in next 30 days
    - Service provider reviews and registers clients, contact client and referral agent
    - Arranges for admission
    - Admission complete

14. What barriers are you aware of that exist along the care pathway?
    a. What policies exist in your region that facilitate or create barriers to accessing treatment and recovery beds? Do these disproportionately impact priority

Creates Barriers:

- Need for TB test for licensed care; this slows down the process for accessing licensed care beds.

s.13

- Quality of referrals to the referral coordination service
- Inconsistency on response to UDS results, service providers and requirement for confirmation of income assistance and lack of adequate funding for Accommodation Fee Subsidy.

Fraser Health is actively facilitating the removal of barriers through:

- Policy is that referral agents facilitate referral pathway and system connection.
- Standard referral form and Fraser Health central referral process.
- Is in process of developing a change management process to dispel myths.

b. Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?

Creates Barriers:

- For provincial and federal corrections, community follow-up is required for support pre bed based treatment during and after care and this is not consistent. Current programs do not provide services tailored to support people who have corrections court dates or other penal system requirements.

c. Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?

Creates Barriers:

- Transitioning between multiple programs for different levels of care.
- Various abstinence requirements of facilities (i.e. even tobacco) and level of tolerance of relapses or consideration of what is considered an addiction (smoking etc.)

d. How does recruitment/retention/staffing levels impact access and utilization?

Staffing levels:

- Due to significantly increasing service demand fully recruited teams are unable to meet the need to provide longitudinal connection in order to support barrier reduction and seamless care.

s.13

Solutions:

s.13

e. What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?

Impact:

- People with offences such as sexual offences are excluded from bed based services
- Lack of specific facility that is Diversity safe for LGBTQ2S to ensure specialized service and support
- Lack of indigenous specific and culturally informed programs may limit desirable options

15. What is the primary policy or process barrier you want to tackle in your region related to this issue?

1) s.13

s.13

2) Enhancement of clinical supports for sustaining connections across the system of services to address gaps in transitions for wrap around care and for ensuring quality care and adherence to standards in bed

based programs (clinical space within all Fraser Health facilities to promote an evidence based culture at the sites).

3) s.13
s.13

16. What work is your region already doing/or planning to undertake to address access and flow challenges?

s.13

Creekside Withdrawal Management (Section A):

Barriers:

- Lack of withdrawal management continuum of care to prevent need for inpatient setting. Currently FHA has 24 adult beds for supervised inpatient withdrawal management for 1.9 million population. Increased beds, as well as a continuum of day program withdrawal management (through Rapid Access to Addiction Care clinics) would expedite and increase access. This is being called for by our clients and families, municipal partners, and community service providers.

Current Solutions:

- Onboarding a DASW to provide waitlist management in support of reducing barriers and identifying needing concurrent resources.

NHA

1. **What are the key steps along the care pathway for people to access health authority funded treatment and supportive recovery beds in your region?**

- *For Provincially funded treatment beds located in the lower mainland:*
  - *An application is completed with the client - typically over the course of multiple appointments*

- *Application/referral is sent to the Northern Health Regional Tertiary Utilization Committee (RTUC); some programs require supplement information (such as psychiatry consultation). This is also gathered and submitted*
- *The referral is reviewed by RTUC*
  - *Committee is comprised of regional representatives for each Health Service Delivery Area*
  - *Applications are reviewed with an emphasis on supporting people to access local resources as a first line, and with a view to ensure regional equity in access to funded treatment beds*
  - *During this time period, the person continues to receive support from the local care team*
- *RTUC provides feedback to referral agent and notice of whether or not the referral is approved*
- *If approved, the referral is submitted to the treatment center*
- *RTUC communicates intake date to referral agent once available*
- *Referring team supports arrangement for withdrawal management (typically through Prince George Adult Withdrawal Management Unit, which is the regional resource for withdrawal support)*
- *Individual travels to the treatment center*

- *For Supportive Recovery sites in Northern Health:*
  - *A person can apply directly to the agency providing Supportive Recovery or be supported in their referral by Northern Health staff to complete an application*
  - *Access is determined by the agency providing Supportive Recovery who keep a waitlist and will admit based on bed availability*

2. **<u>What barriers are you aware of that exist along the care pathway?</u>**

a. **What policies exist in your region that facilitate or create barriers to accessing treatment and recovery beds? Do these disproportionately impact priority populations?**

- *For Provincially funded treatment beds located in the lower mainland:*
  - *The Regional Tertiary Utilization Committee follows the above process to ensure equity in access for patients across all 3 Health Service Delivery Areas (by ensuring each HSDA has representatives on the committee) and recommends local interventions as the first line of support for patients prior to escalating to funded treatment beds*
  - *Northern Health has the following allotment of provincial treatment beds: 5 beds at Heartwood Treatment Centre for Women, 9 beds at Red Fish Healing Centre for Mental Health and Addictions, 6 beds at Provincial Substance Use (Phoenix Society and Elizabeth Fry's Sequoia at Firth Residence)*
    - *This can limit access when the bed(s) are full which is often the case resulting in people needing to wait for access to the treatment program*
  - *Withdrawal management access can be a barrier; travel to Prince George is lengthy with limited options for transportation, and local access is often contingent on hospital bed availability which are often over capacity*
- *For Supportive Recovery sites in Northern Health:*

- *Communication between agencies providing Supportive Recovery and Northern Health can be variable; reported instances where the beds are filled without full consultation with Northern Health*
- *Some contractors have an abstinence-based philosophy which can limit the accessibility of the service*
- *No additional comment on Supportive Recovery policies at this time as it would require more extensive local consultation to verify what policies are in place at each agency*

- b. **Where treatment and recovery services intersect with social services (e.g., BC Corrections, BC Housing, MCFD) what kind of barriers to access and utilization are created?**
- *For Provincially funded treatment beds located in the lower mainland:*
  - *Information sharing can be an issue between organizations, e.g.: arrangements for funding for travel or incidental expenses for people attending treatment, direct communication about renewal requirements for housing due to attending treatment resulting in application becoming inactive without care teams knowing*
    - *Confidentiality considerations can create barriers. When agreements aren't in place or able to be established, information cannot be shared with the Health Authority and this impacts continuity for people accessing services from multiple agencies*
- *For Supportive Recovery sites in Northern Health:*
  - *Information sharing can be an issue as well per above*

c. **Are there service-level restrictions that may impact access and utilization (e.g., travel requirements, if abstinence is required by a service or where a parent might be restricted from contacting family members while in a service)?**

- *For Provincially funded treatment beds located in the lower mainland:*
  - *Yes, all of these are factors, particularly in the North where large geographical distances exist between communities. When consulting with operations, this issue is raised as one of the most substantial barriers for access*
  - *Lack of government issued ID and the timeline for obtaining same*
  - *Application process for treatment is lengthy and involved which can be a barrier for people as they must have multiple appointments and a waiting period during this process*
- *For Supportive Recovery sites in Northern Health:*
  - *See response under 2a re: abstinence requirement*

d. **How does recruitment/retention/staffing levels impact access and utilization?**

- *For Northern Health staff who support access to both funded treatment beds and Supportive Recovery*
  - *Staffing shortages and turnover have an impact for patients attending treatment and Supportive Recovery in terms of continuity with the same care team member. The level of detail and supplemental information required for access to these programs can pose challenges when a new team member is supporting a person who doesn't have the same level of familiarity, or in some instances due to the transitory nature of the population*

being supported it can mean that staff from an entirely differently community are being asked for updates about a person requesting access to a service

- *No additional comment on behalf of Supportive Recovery contractors and their staffing considerations at this time as it would require more extensive local consultation*

e. **What impact do referral pathways and eligibility criteria have on access and utilization (e.g., a referral from a medical professional is required or clients with a criminal record are ineligible)?**

- *For Provincially funded treatment beds located in the lower mainland:*
  - *Ultimately, eligibility is determined by the treatment centres. Most have criteria around history or violence, risk around other people, and history of sexual offences with minors. These specific criteria have not been observed to be particularly prohibitive. However, some of the supplemental requirements (psychiatric assessment, TB testing) can be prohibitive due to waitlists and access to a primary care provider. Additionally, referrals are required to be submitted by a dedicated case manager which not all people seeking referral may have immediate access to.*
- *For Supportive Recovery sites in Northern Health:*
  - *Overall the process for access for Supportive Recovery is lower barrier and simpler - patients can self-refer or be supported by a Health Authority team member to access*

3. **What is the primary policy or process barrier you want to tackle in your region related to this issue?**

- *Northern Health has been working on improving existing processes, care planning and coordination regarding travel and transportation for people living in the North to access these supports.*

4. **What work is your region already doing/or planning to undertake to address access and flow challenges?**

- *Working with our stakeholders and partners to enhance access and support for patients who need to travel for their substance use care*
- *Looking at what additional programing and services can be implemented in the North, ensuring safe and appropriate care (e.g. day treatment programs)*
- *Enhancing outreach programs to maintain contact with this population pre and post treatment*

From: Levinson, Smadar [VCH] (Smadar.Levinson@vch.ca)
To: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
Cc: Cousineau, Danielle [VCH] (Danielle.Cousineau@vch.ca); Morgan, Jenn R MMHA:EX (Jenn.Morgan@gov.bc.ca); XT:Partridge, Stephane EHS:IN (Stephane.Partridge@vch.ca); Compton, Miranda [VCH] (Miranda.Compton@vch.ca); Lajeunesse, Julie [PH] (JLajeunesse@providencehealth.bc.ca); Holliday, Elizabeth [VCH] (Elizabeth.Holliday@vch.ca)
Subject: Request for information on WDM tools and processes
Sent: 06/02/2023 18:52:00
Attachments: image001.jpg, Waitlist prioritization - Interim workflow 2023-05-11.pdf, VDC.HBL exclusion criteria 2023-05-19.pdf, SUS SET Presentation - jan 31 2023 RAP.pdf
Message Body:

Hi Bethany,

We appreciate the opportunity to share background information about our Withdrawal-Management system of care. We are in the midst of multiple initiatives across our programs. The significant investment in the Road to Recovery Initiative provided us with the opportunity to revision and transform our system of care through collaboration between Providence Health Care and Vancouver Coastal Health (leadership operating the existing services and the Regional Addiction Program).

Background about the programs:

In Vancouver Community, VCH is currently operating 3 bed-based withdrawal-management (WDM) sites:

- Vancouver Detox: 24-hour medically supervised and monitored service
- Harbour-Light Detox and Onsite Detox: 24-hour medically supervised services

Vancouver Community also operates an outpatient and at-home WDM program (START)

Road to Recovery (PHC) will be adding this year new substance-use WDM stabilization beds (in SPH hospital). In addition to the new WDM Stabilization beds, the Road to Recovery Initiative will include recovery beds (combination of transitional and Support-Recovery or Treatment beds), as well as, strengthening community services by launching a new ICMT and a dedicated transportation service (VCH).

In our current state, intakes in Vancouver Detox, Harbour-Light Detox and START are coordinated by the Access Central team; people from the entire VCH region call Access to request withdrawal-management services. The call-centre is open 7 days a week from 0900-2000.

Onsite detox triages clients who present to Insite (supervised consumption site) requesting access

to services.

Coordination of care across the continuum of services is a central component of our shared work to support clients' journey in and out of WDM and SU recovery programs. The services in Vancouver Community include a continuum of SU bed-based programs, MHSU and PC clinics and outreach based programs. PHC Rapid Access Addiction Clinic provides outpatient addiction care to the community and recently launched a virtual clinic (Light-House). VCH Overdose Outreach team provides services across VCH region by engaging and connecting people to health care services.

Led by Regional Addiction Program, VC and PHC are working on a shared project of creating an integrated access to the current WDM beds and the future PHC Road to Recovery WDM Stabilization beds (see attached Regional Addiction SUS SET presentation).

We are moving from a model of 'first-come- first booked' process to robust model with the goals of:

o Same day access to clinical care

o Clinical Assessment Care Planning/delivering prior to admission

o Matching Clients to the appropriate level of care and prioritization/triaging (see attached current criteria and current prioritization)

o Centralized Waitlist

o Pro-active follow-up to prevent people lost to care

(see the background presentation RAP presented in VCH Senior Executive Team)

Two weeks ago VCH and PHC moved to an interim phase workflow with the goal of completing the Integrated Access project in the fall. PHC Light-House and VC START teams are working closely with Access Central Team. In our current interim workflow the clients who call the Access Central phone line are given the option of having their call transferred directly to a team of nurses, social work and prescribers (MD or NP) for same-day care initiation (provided by Light-House or START):

o The nurses and the prescribers all use a shared assessment to determine the level of care, priority and address immediate care needs including, but not limited to:

▪ Same day OAT initiations, bridges, or titrations

▪ Initiate low risk alcohol withdrawal management

o If needed, the clinical team will follow the clients until their admission, coordinate care with other community teams and initiate referrals.

o Clients are given an intake time to VDC or HBL, or removed from the waitlist if their needs can be met through out-patient care from one of our teams (see attached current exclusion VDC & HBL criteria)

o All efforts are made to accommodate urgent referrals by providing earlier dates due to our current system's capacity for same day or next day admissions (see attached waitlist prioritization

interim workflow)

o Clients who do not get to speak with a nurse and prescriber: the nurses review their electronic charts to identify care needs and attempt to connect with them

o Clients with booked intakes, can call Access to inquire about an earlier admission (when no-show or cancelations free up intakes)

o Access Central also call clients 48-hours prior to their scheduled intake to remind them and find out if they need any additional support

Last January, in collaboration with VCH Decision Support Team, we launched a workflow to improve communication with community teams. Decision Support sends a daily email to all MHSU, addiction and PC teams that let them know if any of their clients are on our waitlist. The community teams are then asked to provide support for their clients including:

o Coordinate a plan to ensure clients arrive to their WDM pre-booked intakes

o Begin working with their clients on post-WDM-discharge client-centered plans

In June we will move from the daily email report to a web based report that gets refreshed daily (Tableau platform).

In September we are looking to expand the scope of our Integrated Access project and move to scheduling all intakes based on prioritization/triaging. We are currently piloting a clinical assessment tool and would be happy to share it once it's finalized.

Our ongoing evaluation framework include:

o Waitlist KPI's including median wait times, average # of days wait for pre-booked intakes and average number of people on waitlist

o Number of daily intakes/admissions (broken by type; pre-booked admission, stand-by, hospital transfers and step-up/down between programs)

o Occupancy rates

o The number of call Access team receive

o No-show rates including comparing between clients who confirmed that they will make it to their intake and those who did not

o Clinical team interventions (nurses, social work, nurse practitioners and physicians)

(see attached weekly report; please note that we are planning to expand it to next week to capture the expansion of our interim phase)

Aftercare planning:

o Clients who are connected to community teams: the teams are notified when their clients are on waitlist and are asked to support their clients to create a post-discharge plan including making referrals to other bed-based services

o Clients who are not connected to community teams are provided ongoing care from our virtual clinical teams until they are successfully transitioned to the appropriate care provider in their community

o HBL, VDC and Onsite have social workers who connect with clients during their admission and support them in making plans for after their discharge

o Overdose Outreach Team provides in-reach service all sites to connect with clients who are not connected to care and are at risk of overdosed after their discharge

o If needed, clients who have future scheduled intakes at a treatment or support-recovery bed-based program can access a transitional bed directly from WDM

We will be happy to provide more information and context as needed!

Thank you,

Smadar

Smadar Levinson, MSW, RCSW

Vancouver Coastal Health MHSU Senior Manager

Vancouver Community Substance-Use Strategy and Special Projects

Cell: (604) 619-9150

I acknowledge that the land on which we live, work, and play is the unceded territory of the Coast Salish peoples, including the territories of the xʷməθkwəy̓əm (Musqueam), Skwxwu7mesh (Squamish), and Səlilwətaʔ/Selilwitulh (Tsleil-Waututh) Nations

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Tuesday, May 30, 2023 10:55 PM
To: Partridge, Stephane [VCH] <Stephane.Partridge@vch.ca>
Cc: Morgan, Jenn R MMHA:EX <Jenn.Morgan@gov.bc.ca>
Subject: Request for information on WDM tools and processes

Hi Stephane,

Thank you again for the meeting the other day. Interestingly, the Government of PEI reached out to us today asking for examples of intake/assessment tools and waitlist management practices for withdrawal management services. They are building a MHSU “campus” and significantly expanding services.

I was wondering if there are any examples you could provide regarding what is being used in Vancouver? Below are the specific questions, I already added in my notes from our call the other day (feel free to change the content if I interpreted it incorrectly) and I would be grateful for any additional information or examples you can share:

- What are the tools VCH uses for withdrawal management screening, assessment, and intake? PEI is particularly interested in tools that help assess fit for inpatient vs outpatient?
- Intake or admission criteria used for inpatient and outpatient withdrawal management services in Vancouver?
- What withdrawal waitlist management tools or approaches used for withdrawal management services? How do these tools support triage or prioritization of clients? What supports are offered if clients must wait for withdrawal management services?
    - Example of VDC and HL:
        - Clients are provided a booked intake date when they call for WDM services .
        - Client charts reviewed by nurses to identify care follow-up needs leading up to the booked intake.
        - Access staff have regularly/daily connect with clients while they are waiting.
        - Vancouver is working towards daily contact with nurses during the wait period (helps to assess emerging medical needs, complexities etc).
        - There is also a call within 48 hours of the booked intake date.
        - Preliminary data shows the regular contact leading up to intake make increase show rates.
- Do you provide any aftercare or post-completion supports for those who access withdrawal management services? If so, can you describe these?

I realize this may be a lot to ask but if you have any information or examples you can share, could you send them to me by end of day Monday? Even bullets and links to docs would be really help us out.

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

Bed prioritization

Once it has been identified which service is the most appropriate for the client, with consideration given to the client's goals and identified needs, priority will be determined considering the following examples and clinical judgement. The examples below are not exhaustive. Changing clinical presentation while receiving out-patient care may require client priority level to be escalated.

Emergent **(same day access to bed)**
• Client will likely require hospital admission if unable to access bed. • Presented to ED/clinic/called AC in active moderate to severe withdrawal, appropriate for transportation.
Urgent **(ideally access to bed within 3 days)**
• People with increased risk factors related to their substance use. • Recent unsuccessful attempt at out-patient stabilization. • Recent missed intake.
Routine **(next available regular booking)**
• Requires bed-based service, deemed not emergent or urgent.

*In addition to the criteria outlined above, people may have 1 or more of the below social, structural, or medical vulnerabilities which would increase the urgency for access to services:

- Indigenous people
- Youth (under the age of 25)
- Perinatal people (and their partners)
- LGBT2SQ+
- Adults (55+)
- People who need travel coordination from outside Vancouver (in VCH region)
- People who are NFA or have unsafe housing
- People who are fleeing domestic violence
- Concurrent disorders

Consider planning intake dates to line up with scheduled:

- bed based treatment or support recovery

Substance use stabilization: site exclusion criteria

If a client has any of the following they are not appropriate for the listed service and should be offered a higher level of care.

<table>
<tr><th colspan="2">Community bed-based medical stabilization</th></tr>
<tr><td colspan="2">- Acute medical or mental health conditions requiring transfer to acute care medical facility
- Altered LOC
- Certified under Mental Health Act (people can be admitted on extended leave)
- Unable to independently mobilize and/or transfer
- History of violence and a care plan to address safety concerns for staff, client and co-clients is not possible due to the client's current health status and/or context in which the incident occurred</td></tr>
<tr><td>VDC
(24 hour nursing and prescriber coverage)</td><td>HBL
(8-12 hours daytime nursing and prescriber coverage)</td></tr>
<tr><td>s.13</td><td>- AUD and/or BUD and/or GHB use and at risk of withdrawal
- Requiring medical supervision for PRN pharmacotherapy administration more than 3 times per day
- History of needing overnight opioids during admission to VDC
- Requiring frequent vital signs or clinical monitoring for withdrawal, unstable medical and/or mental health conditions
- Pregnant people (stimulant only may be considered on a case by case basis)
- Not currently on OAT (Temporary)
- Are currently on a sub-therapeutic prescribed OAT dose defined by: Methadone less than 80mg OR Kadian less than 700 mg OR Suboxone micro induction AND they are using more than 2 points of Fentanyl per day (Temporary)
- People with mobility devices (wheelchairs/walkers) but are otherwise independent (Temporary)

Due to risk for benzodiazepine withdrawal related to the unregulated opioid supply:
- History of withdrawal related seizures (likely to experience another seizure)
- History of delirium tremens (likely to experience again)
- As per Medinet, has recently required greater than 30 mg diazepam/day to stabilize benzodiazepine withdrawal and health/hx is similar to previous presentations.
-CIWA of 10 or greater x 2 after treatment with benzodiazepines (consider step up to VDC or R2R/hospital bed)

Special consideration for clients who have OUD and are declining OAT start at time of assessment (potential for rapidly changing care plan)</td></tr>
</table>

Regional Substance Use Stabilization System

Presentation to Senior Executive Team

January 31st , 2023

Presented by:
Dr. Nadia Fairbairn, Medical Director, Regional Addiction Program
Miranda Compton, Director, Regional Addiction Program

Vancouver CoastalHealth | one VCH | Providence Health Care

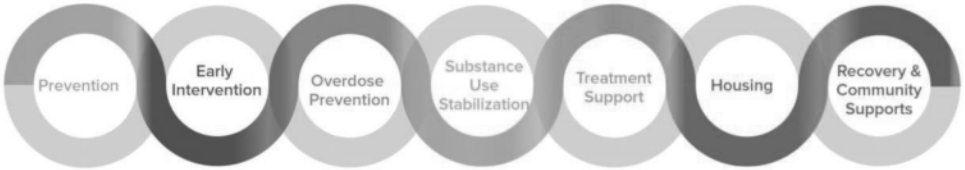
We wish to acknowledge that the land on which we gather is the traditional and unceded territory of the Coast Salish Peoples, including the Musqueam, Squamish, and Tsleil-Waututh Nations.

Vancouver Coastal Health is committed to delivering exceptional care to 1.2 million people, including the First Nations, Métis and Inuit in our region, within the traditional territories of the Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, shíshálh, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.

Agenda

1. Background & Context
2. Re-visioning Substance Use Stabilization System of Care
3. Current Investments
4. Data Driving Change
5. Substance Use Stabilization System and Components
6. Key Recommendations

Vancouver CoastalHealth



REGIONAL ADDICTION PROGRAM

We aim to address substance use disorders and reduce harms related to substance use by creating a continuum of accessible, connected, evidence-informed, culturally relevant, and inclusive substance use, and addiction services that identifies, links, engages and retains clients, clinicians, and support teams in care and support across Vancouver, Coastal and Richmond communities.

Early intervention, screening, assessment & pathways

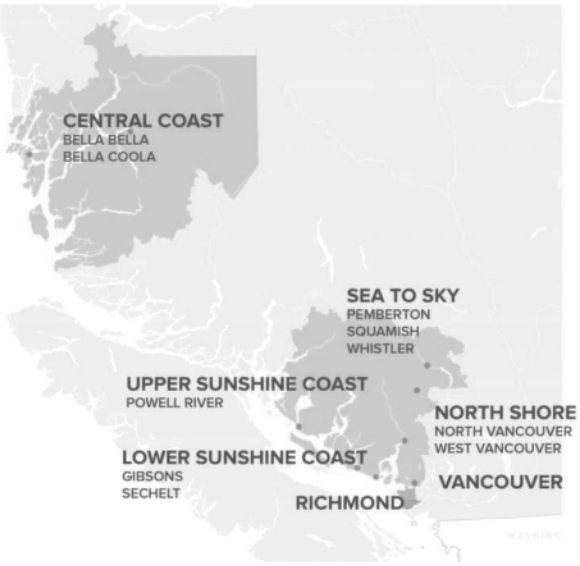
-Build up prevention initiatives.
-Transform the way we screen for substance use.
-Streamline diagnosis and linkage to care.

Building capacity across the system

-Expand education and access to treatment across the continuum of care.
-Address stigma and cultural safety.

Ensuring services evolve to meet emerging needs

-Ensure services are evidence-informed and that best practices are embedded into existing specialized services through continuous quality improvement and service transformation/revisioning.



The unceded and occupied homelands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh), Shíshálh, Tla'amin, Wuikinuxv, Heiltsuk, Nuxalk, Kitasoo-Xai'xais, Lil'wat, Samahquam, Xa'xtsa, Skatin, N'Quatqua Nations

Strategic Goals 2020-2025

Deliver an effective system of care

Strengthen the workforce

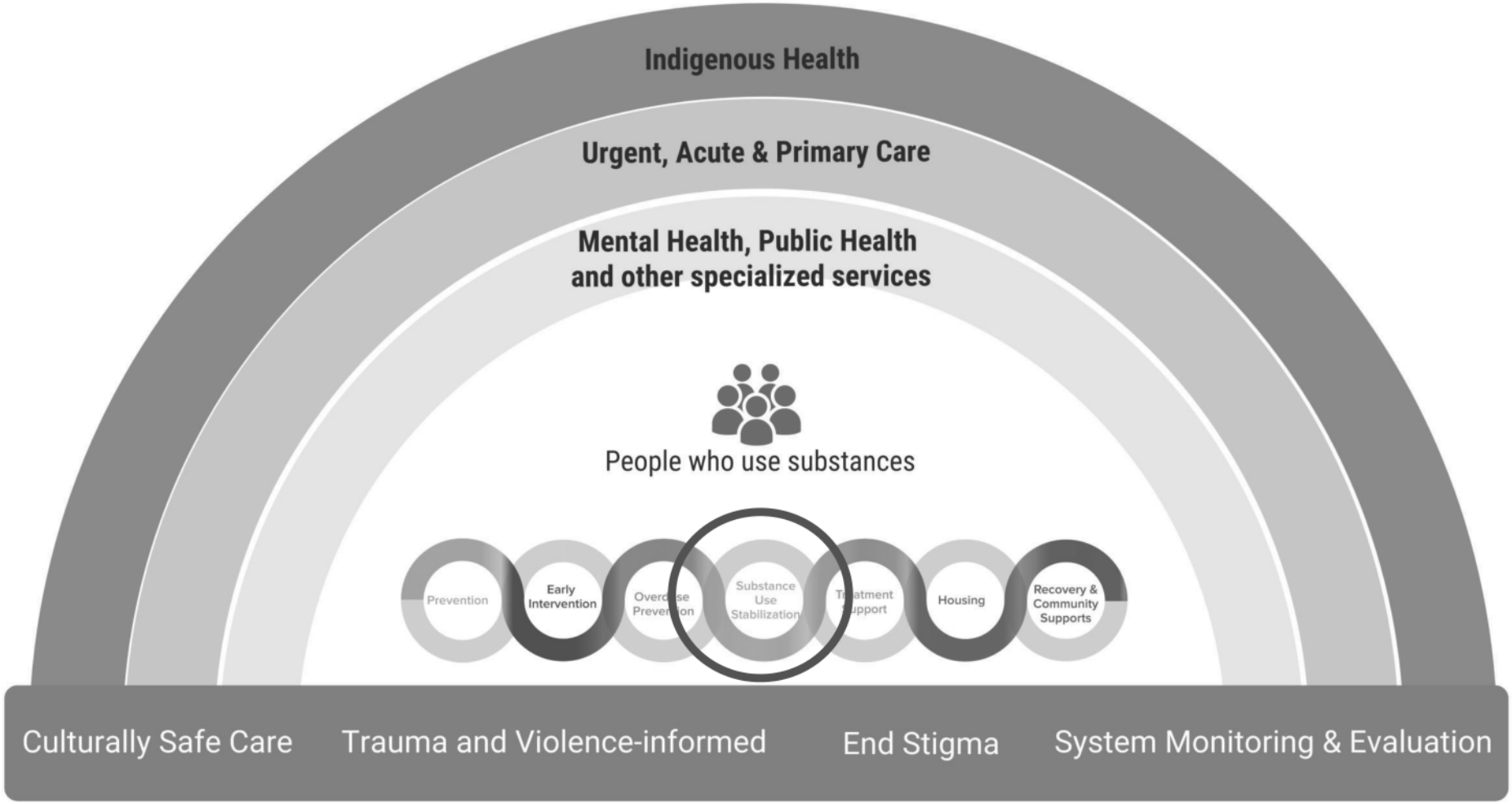
Continually Improve quality and accountability

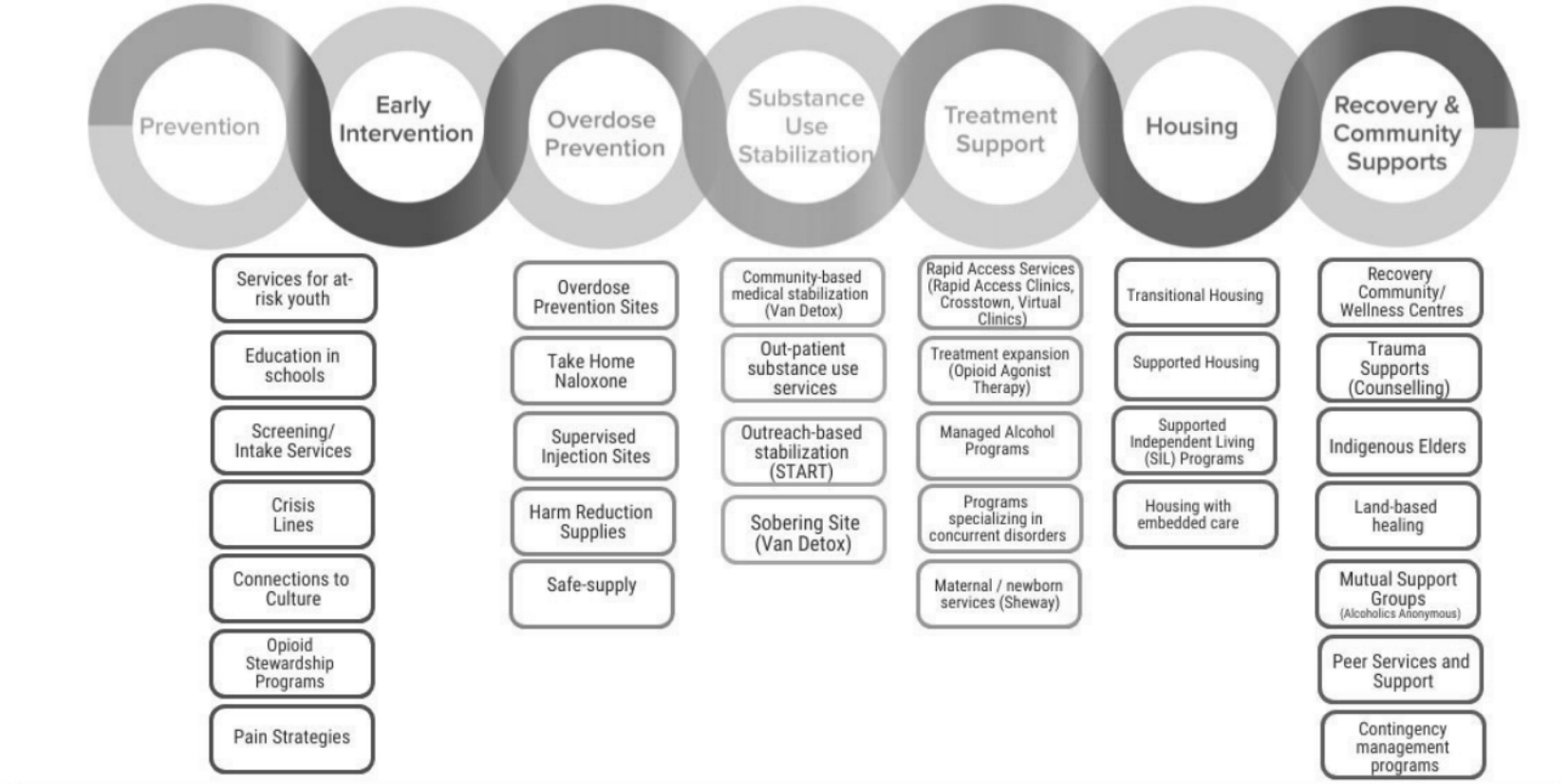
Advocate for people with substance use and addiction

Guiding Principles

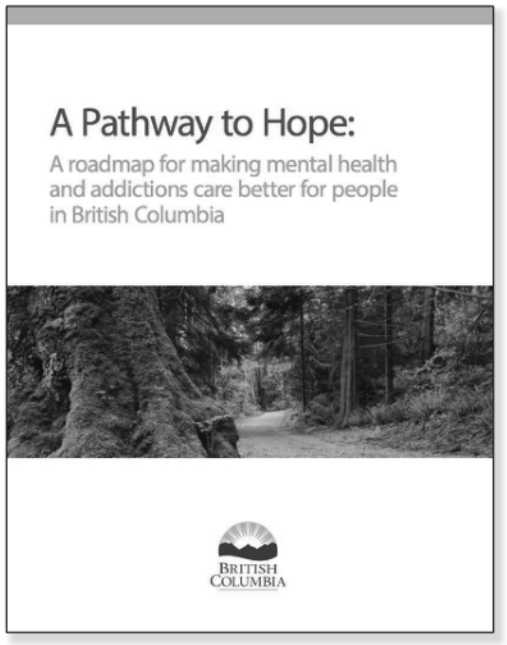
- Evidence-informed, best practice and clinical guidelines
- Technology and Infrastructure
- Peer and client involvement
- Advocacy, Education & Training
- Engagement with Indigenous people
- Evaluation & reporting

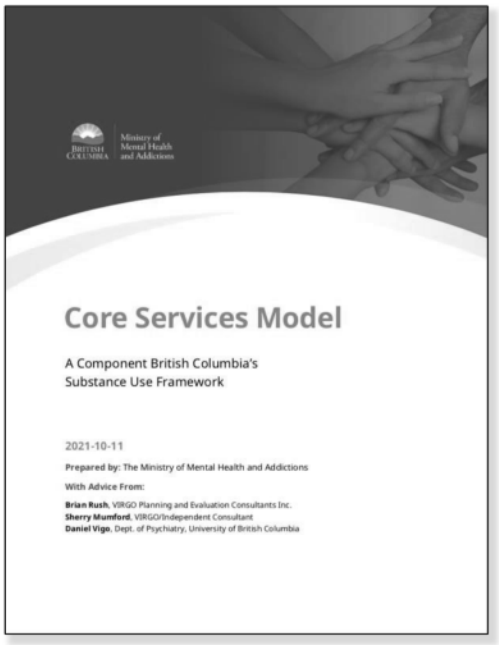
Integrated System of Care

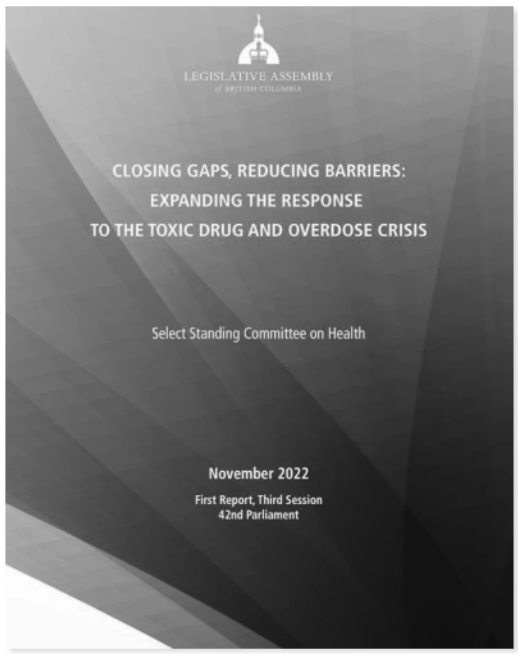



Prevention
Early Intervention
Overdose Prevention
Substance Use Stabilization
Treatment Support
Housing
Recovery & Community Supports
Services for at-risk youth
Education in schools
Screening/ Intake Services
Crisis Lines
Connections to Culture
Opioid Stewardship Programs
Pain Strategies
Overdose Prevention Sites
Take Home Naloxone
Supervised Injection Sites
Harm Reduction Supplies
Safe-supply
Community-based medical stabilization (Van Detox)
Out-patient substance use services
Outreach-based stabilization (START)
Sobering Site (Van Detox)
Rapid Access Services (Rapid Access Clinics, Crosstown, Virtual Clinics)
Treatment expansion (Opioid Agonist Therapy)
Managed Alcohol Programs
Programs specializing in concurrent disorders
Maternal / newborn services (Sheway)
Transitional Housing
Supported Housing
Supported Independent Living (SIL) Programs
Housing with embedded care
Recovery Community/ Wellness Centres
Trauma Supports (Counselling)
Indigenous Elders
Land-based healing
Mutual Support Groups
(Alcoholics Anonymous)
Peer Services and Support
Contingency management programs
Services Across the System
Outreach and Intensive Case Management Teams
Mental Health Services, Harm Reduction Services, Outreach Services, Cultural Supports
Emergency Departments, Acute Care, VCH Primary Care Clinics & Urgent Primary Care Centres, Community Health Centres
Decriminalization/ Policy Changes

Ministry and Government Direction







BC’s Decriminalization Exemption in Effect January 31, 2023

Applies to Adults 18+.

Cumulative (total) threshold floor.

Opioids, Crack/Powder Cocaine, MDMA and Methamphetamines.

Police provide resource cards with information on local supports and will make voluntary referrals.

Robust monitoring and evaluation framework.

NO arrests or seizures under the threshold.

NO fines, tickets, or other administrative sanctions.

NON-coercive: No mandatory treatment or diversion.

Ministry of Mental Health and Addictions. Decriminalization: Next Steps for Health Systems Pathways, pg. 6 (Aug, 2022)

Vancouver CoastalHealth | one VCH | Providence Health Care

Substance Use Stabilization

Previously "detox" or "withdrawal management"

- Focus on "detoxing" or removing harmful substances from the body
- Often as a first step in addiction and recovery treatment
  - Relapse is common, and may need to be the first step many times before moving forward
- Services offered in a variety of settings (out-patient, home, community, or hospital).

Moving toward individualized care for each unique person

- Stabilizing people with rapid titrations of medications to treat substance use
  - Sudden elimination of the substance can be life-threatening and painful, requiring medical monitoring and support.
- Services to meet needs of changing substance use and increasingly toxic drug supply.
- Stabilization services to be followed or preceded by other addiction treatment and recovery supports

Key issues to be addressed through system revisioning

- Lengthy waitlists for people requiring bed-based services
- Lack of coordination between outpatient and bed-based services to support treatment initiation/bridging services across region
- Gaps and inequities in access to continuum of services across region
- Diversion away from criminal justice system and toward health care via new decriminalization legislation could lead to increased system pressures
- Road to Recovery – and other new substance use investments: Potential of new resources for PHC/VCH offer opportunity to strengthen/reorganize system of care

Re-visioning Substance Use Stabilization Service Continuum (PHC/VCH Partnership)

Potential new resources with Providence's Road to Recovery Initiative provide an opportunity to revision and transform our substance use stabilization system of care across the region, including:

- Formalize collaboration and coordination across VCH, PHC and contracted services
- Harmonize client access and flow across substance use stabilization services in the region
- Re-define the system to accurately align with current best practices for people receiving our services
- Address key gaps in our system
- Improve equity in access to services across the region

Key Goals

Same-day access to care

Clinical assessment & care planning *prior* to admission

Matching clients to the right service

Centralized waitlist

Pro-active follow-up to prevent lost-to-care

Vancouver CoastalHealth | one VCH | Providence Health Care

How clients access our system

VS

How our system functions

Vancouver CoastalHealth | one VCH | Providence Health Care

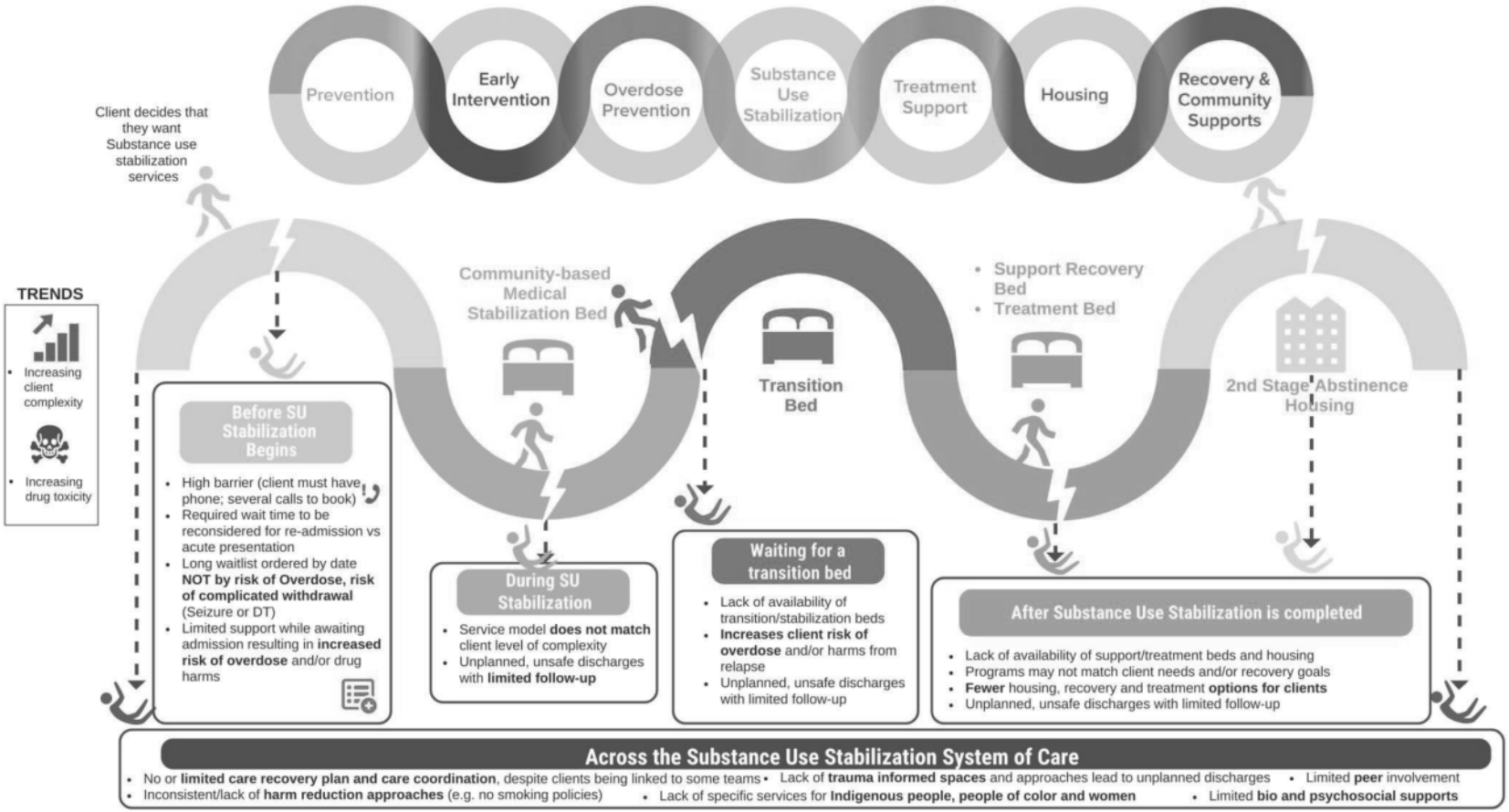
Client Journey Example

s.22

Client Journey Example

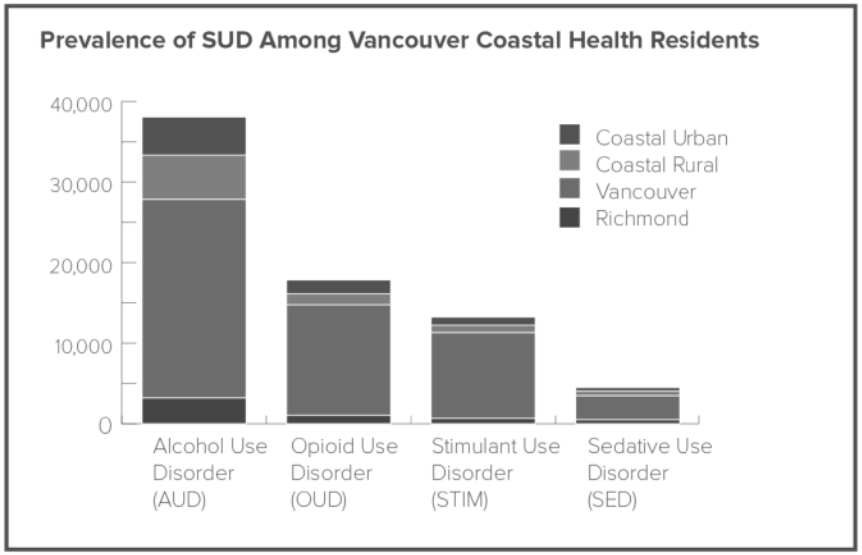
s.22

Current State- Substance Use Stabilization Journey Client Journey



Vancouver CoastalHealth | one VCH | Providence Health Care

Prevalence of Substance Use Disorder (SUD) Among VCH Residents

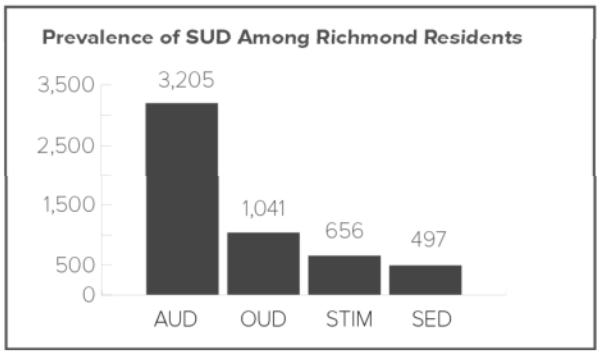


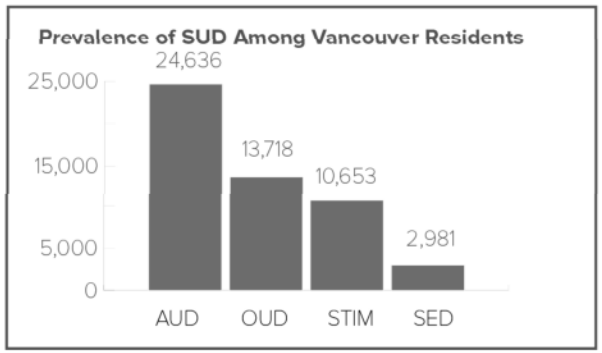
Community of Care	Alcohol Use Disorder (AUD)	Opioid Use Disorder (OUD)	Stimulants (STIM)	Sedatives (SED)
Richmond	3,205	1,041	656	497
Vancouver	24,636	13,718	10,653	2,981
Coastal Urban	5,502	1,380	923	553
Coastal Rural	4,723	1,701	1,012	464
Total	**38,066**	**17,840**	**13,244**	**4,495**

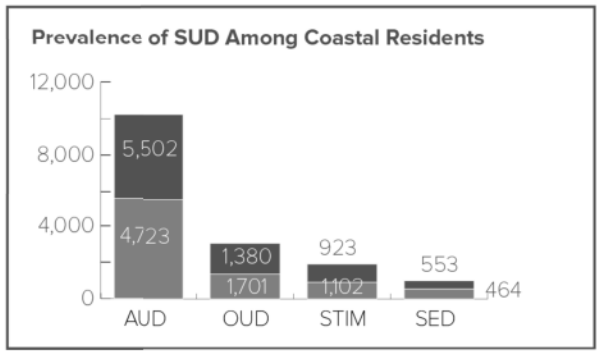
Stimulants: cocaine and other stimulants
Sedatives: sedatives, hypnotics including benzos

The prevalence is based on individuals who had ever accessed health services for SUD from 1996 among people who were alive and not administratively censored as of Sep 30, 2021.

Data Source: Nosyk et al

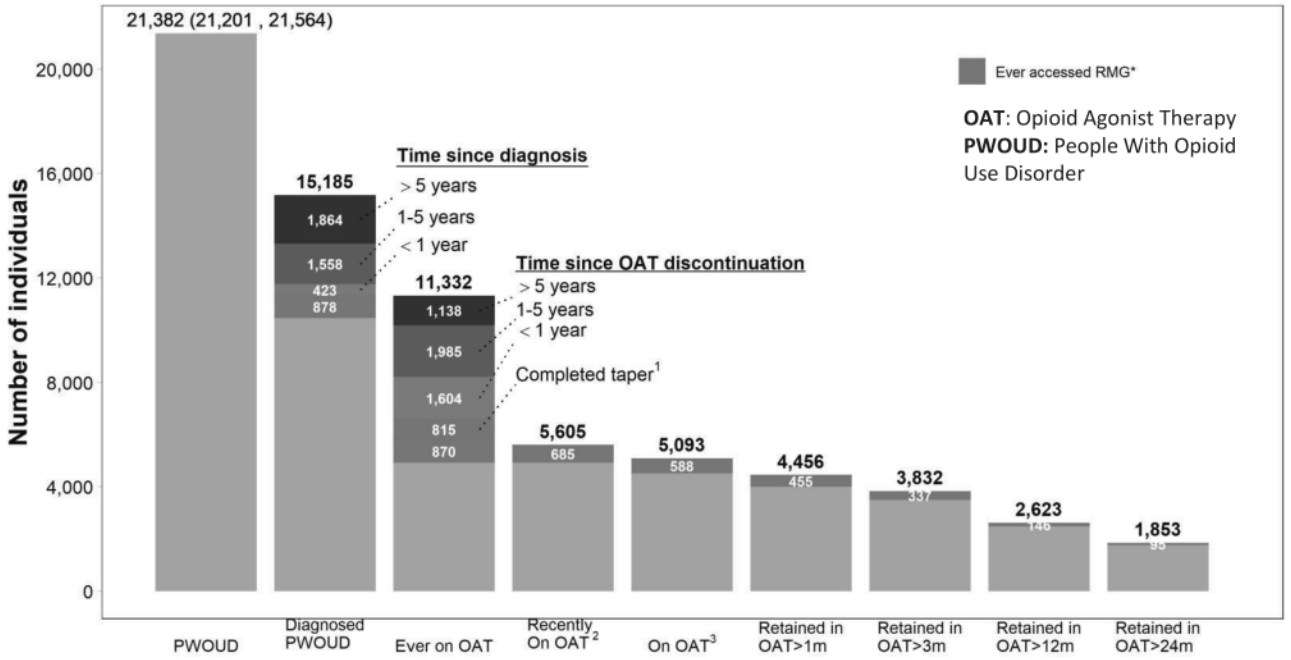






Opioid-Use Disorder (OUD) Cascade of Care in VCH

As of September 2020



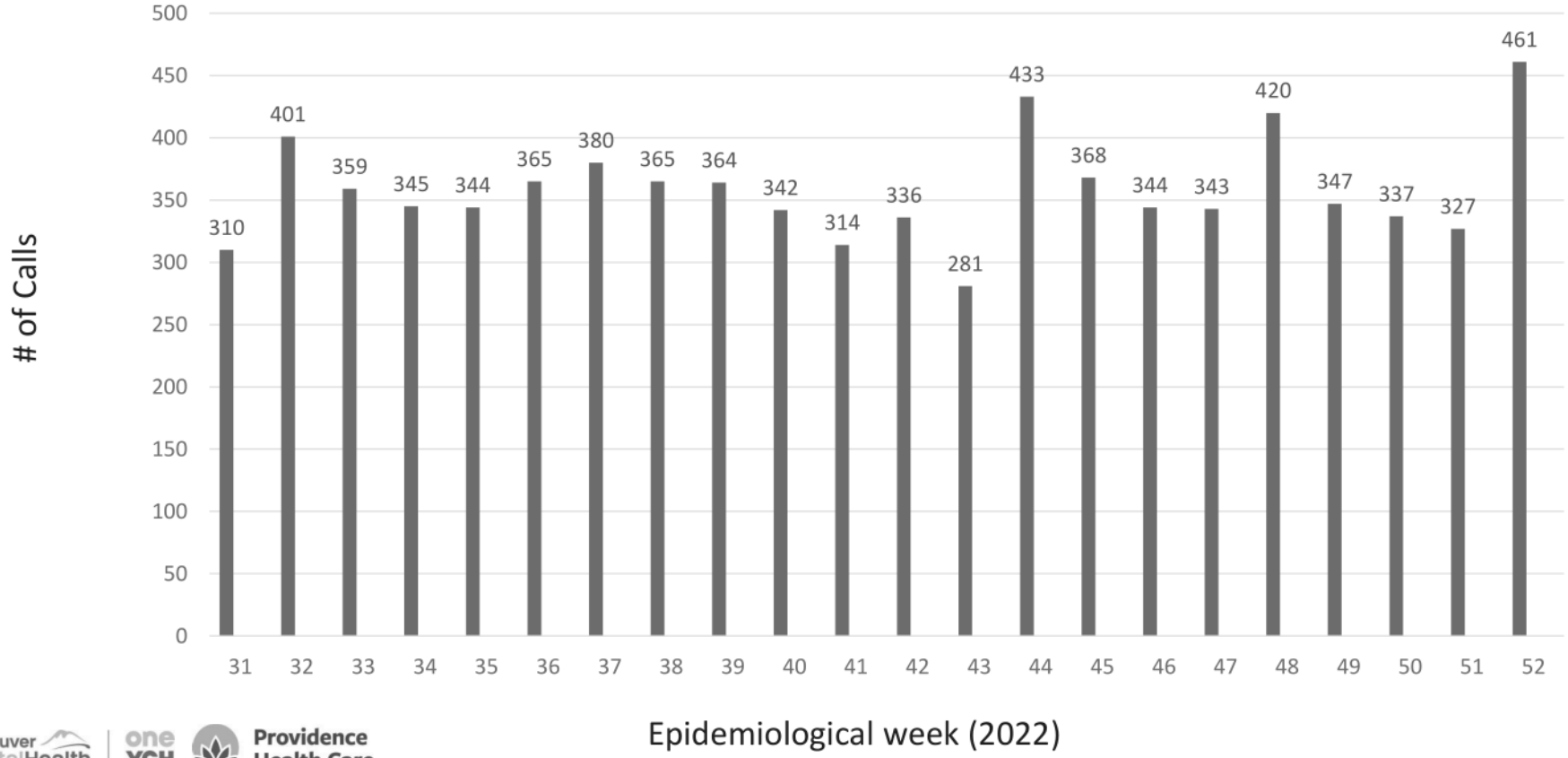
Percentage	1.9	71	74.6	49.5	44.9	87.5	86	68.4	70.6
Numerator	21,382	15,185	11,332	5,605	5,093	4,456	3,832	2,623	1,853
Denominator	1,124,364	21,382	15,185	11,332	11,332	5,093	4,456	3,832	2,623

Vancouver CoastalHealth | one VCH | Providence Health Care

Nosyk et al

Number of Weekly Calls to Access

August 1 2022 – Dec 31 2022

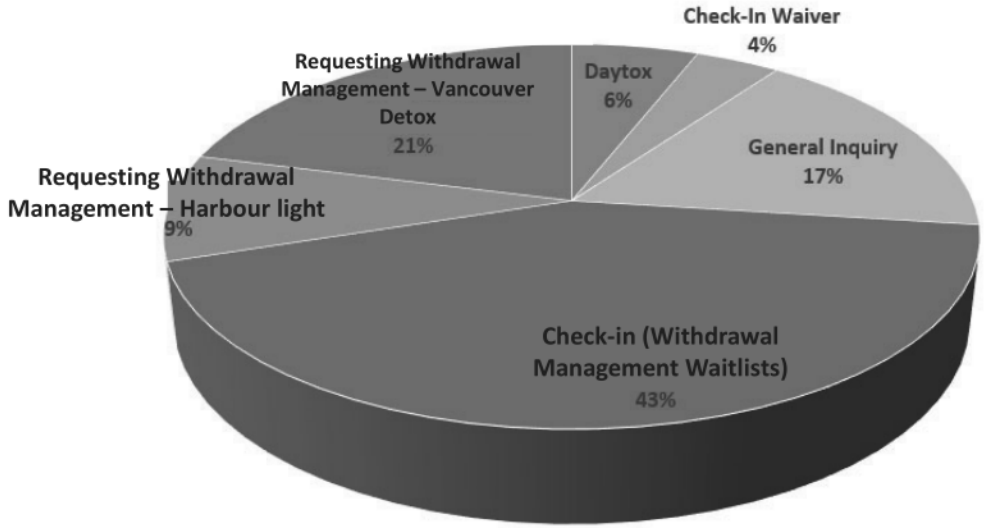


Vancouver Coastal Health | one VCH | Providence Health Care

Access Central Phone Tracking Survey

Reason for Call

August 22 - September 3
Total Calls: 302

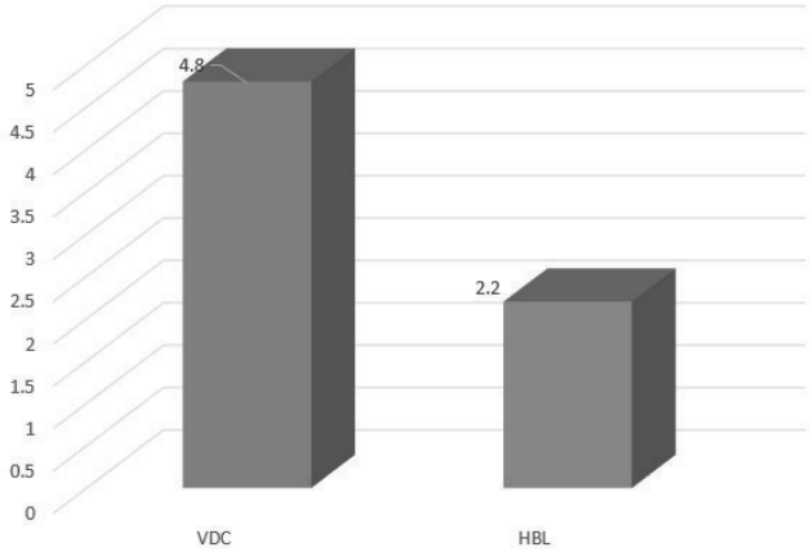


Vancouver CoastalHealth | one VCH | Providence Health Care

Access Central Phone Tracking

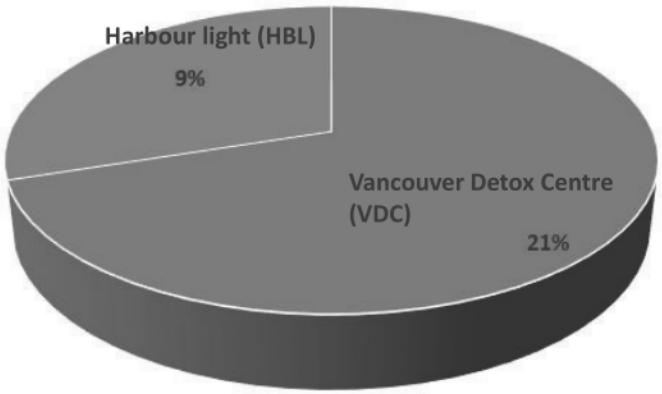
Reason for Call

New Daily Average – Requesting Withdrawal Management



Overall New – Requesting Bed-based Withdrawal Management

Out of 302 Calls
30% were "Requesting Withdrawal Management"

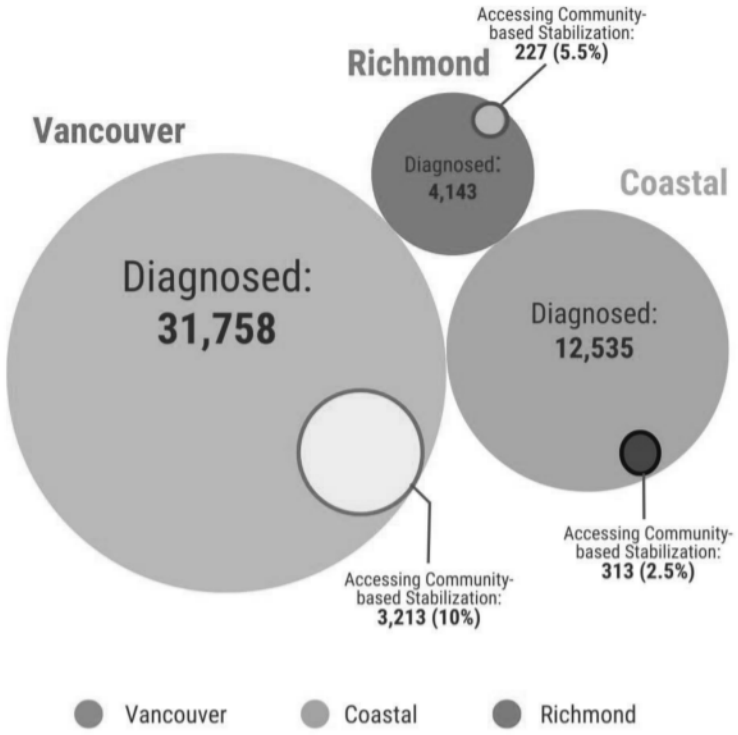


Vancouver CoastalHealth | one VCH | Providence Health Care

Clients Accessing Community-Based Medical Stabilization

Vancouver Detox, Harbour Light, and Onsite from April 1, 2021- March 31, 2022

Local Health Area	Population 19+ (2021)	# of Clients diagnosed with 1 or more Substance Use Disorder	# Clients accessing Community-based Stabilization (2021/22)	% Clients diagnosed who are accessing Community-based Stabilization
1. **Vancouver**	**619,105**	**31,758**	**3,213**	**10.1%**
2. **Coastal**	**253,461**	**12,535**	**313**	**2.5%**
3. **Richmond**	**180,653**	**4,143**	**227**	**5.5%**



Data Sources:

1. Population 19+: BC Stats Population 2021: https://bcstats.shinyapps.io/popApp/
2. # Clients diagnosed with 1 or more Substance Use Disorder: Noysk et al.
3. Clients Access SU Stabilization Services in 2021/22: VCH Decision Support

Vancouver CoastalHealth | one VCH | Providence Health Care

Vancouver Detox Centre
Average Percentage of Pre-booked Intakes Who Were a No-Show (2022)

Vancouver CoastalHealth | one VCH | Providence Health Care

Vancouver Substance Use Stabilization Bed Data

April 1 2022 – August 31 2022

Occupancy rate defined as total days occupied / total bed days available for use

Community-based Medical Stabilization

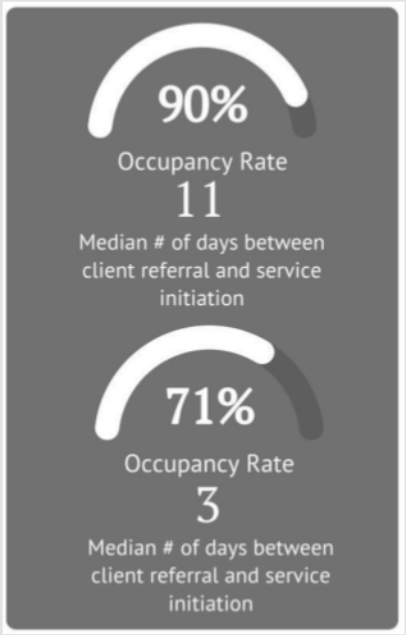
Vancouver Detox

Currently approximately 100 people on the waitlist

Harbour Light

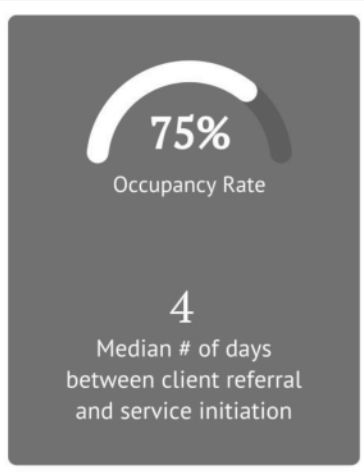
Currently approximately 30 people on the waitlist

Onsite – 2nd Floor



Transition Beds

Rice Block
Pacifica
Turning Point
Onsite-3rd floor *
*not included in median # of days



Key Considerations:

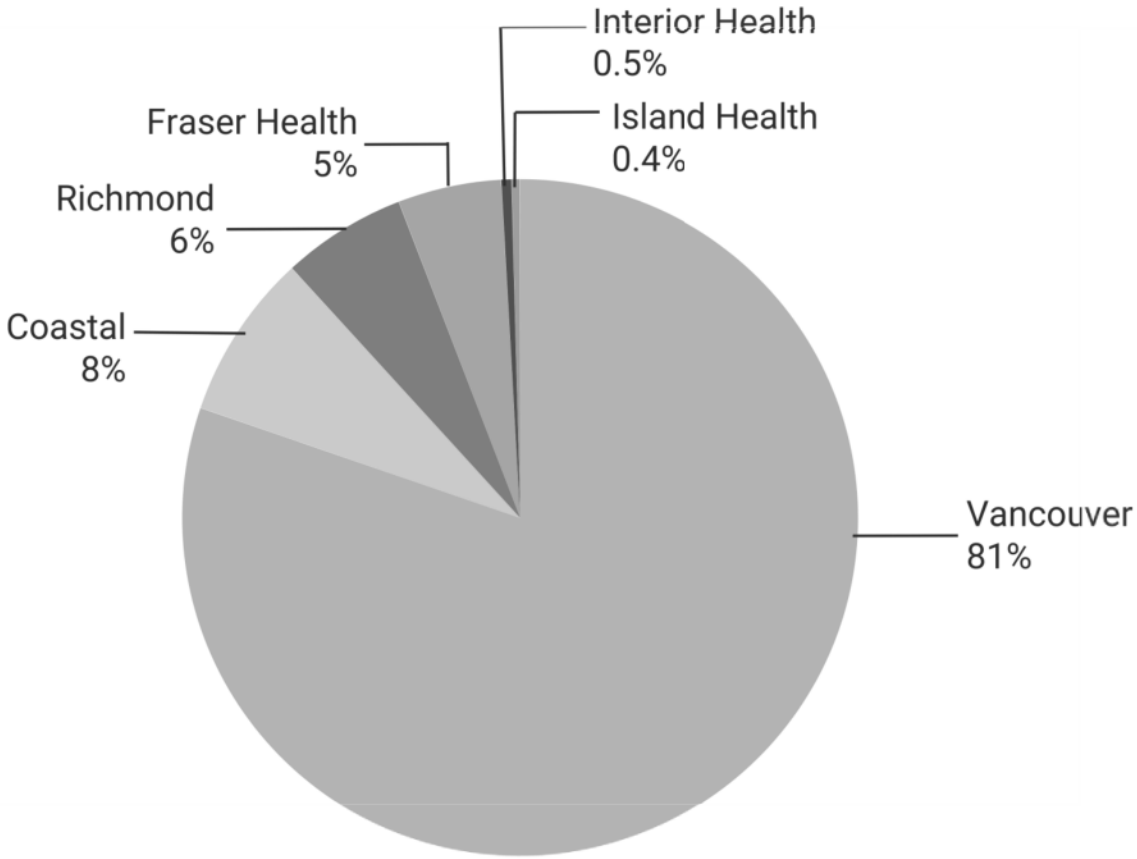
- Limited number of new intakes can be completed per day
- Client no shows for admissions remains an issue to be addressed with new plan
- Human resources challenges
- Lack of clinical assessment means clients are accessing the wrong service

Vancouver CoastalHealth | one VCH | Providence Health Care

Client Location - Overall

Vancouver Detox, Harbour Light, and Onsite from April 1, 2021- March 31, 2022

LHA	n	%
1. Vancouver	3,213	81%
2. Coastal	313	8%
3. Richmond	227	6%
4. Fraser Health	182	5%
5. Interior Health	20	0.5%
5. Island Health	17	0.4%



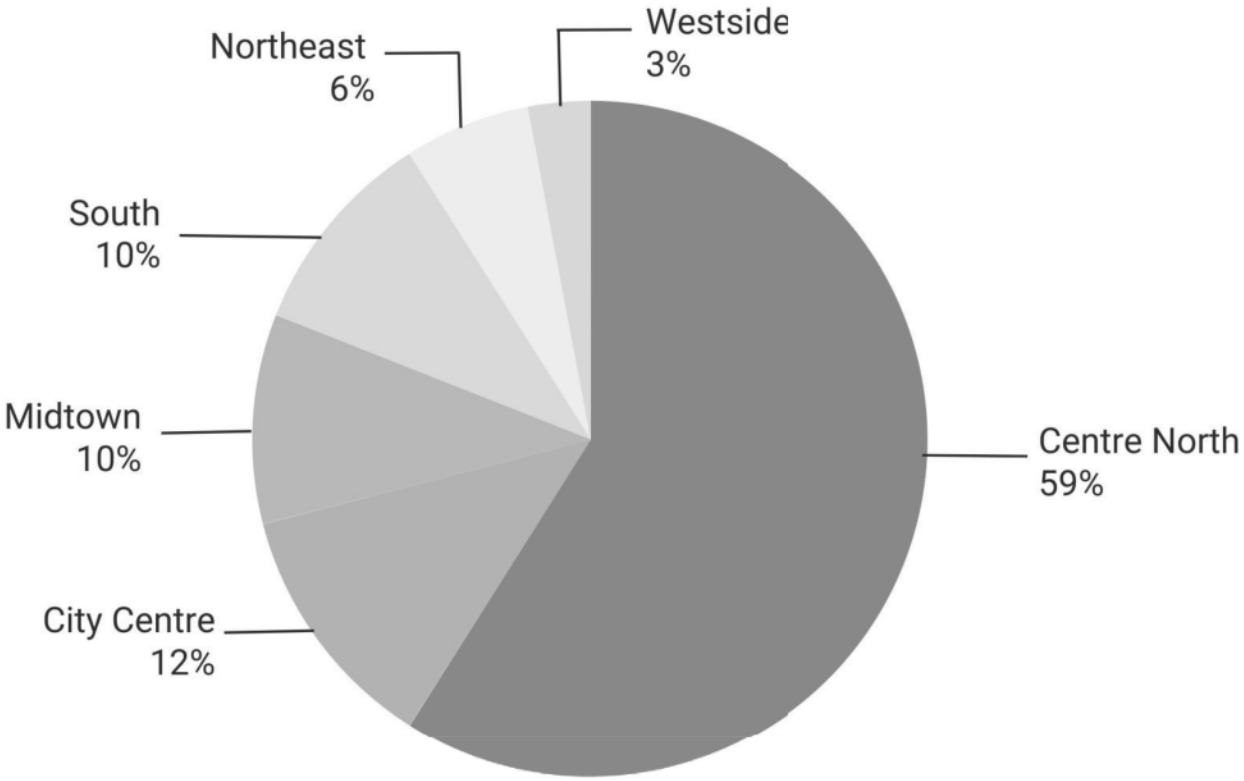
Vancouver CoastalHealth | one VCH | Providence Health Care

Source: PARIS

Client Location – Vancouver by LHA

Vancouver Detox, Harbour Light, and Onsite from April 1, 2021- March 31, 2022

LHA	n	%
1. **Centre North**	**1,910**	**59%**
2. **City Centre**	**394**	**12%**
3. **Midtown**	**328**	**10%**
4. **South**	**308**	**10%**
5. **North east**	**183**	**6%**
6. **Westside**	**90**	**3%**



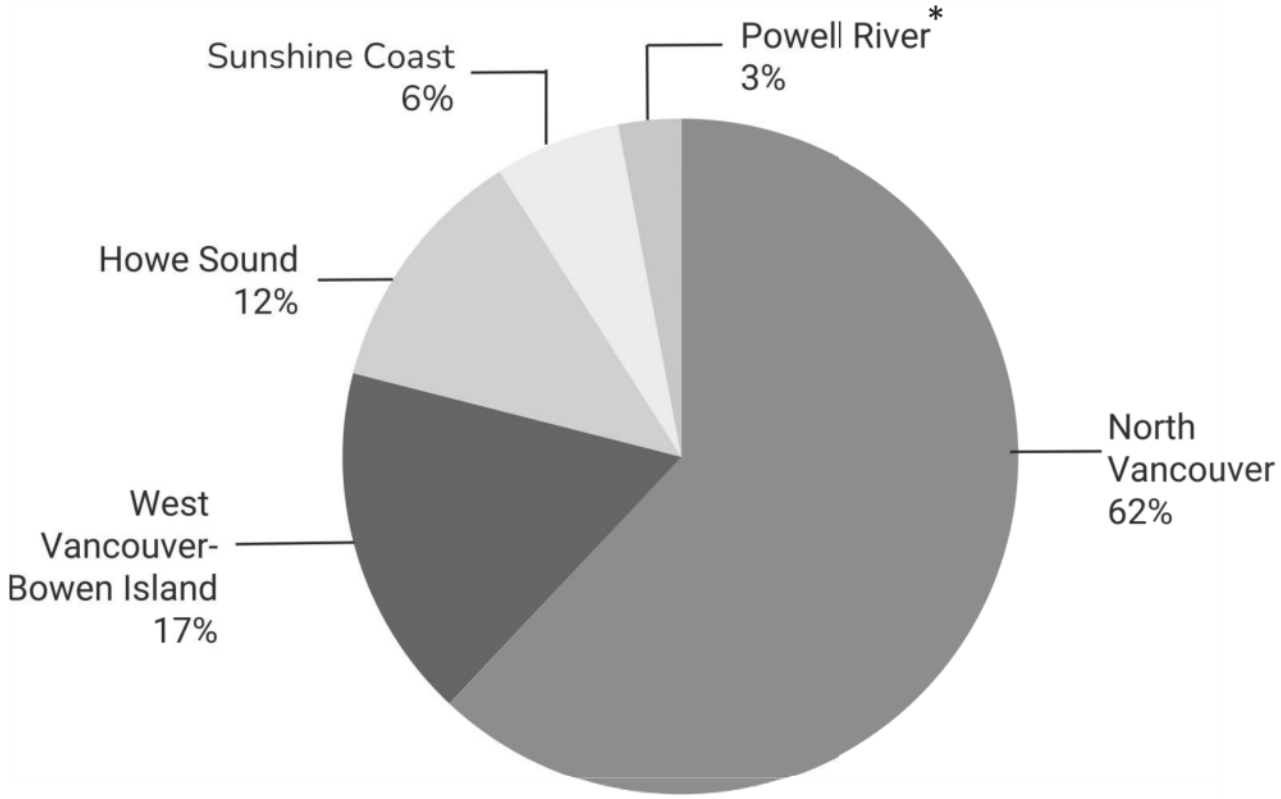
Vancouver Coastal Health | one VCH | Providence Health Care

Source: PARIS

Client Location – Coastal by LHA

Vancouver Detox, Harbour Light, and Onsite from April 1, 2021- March 31, 2022

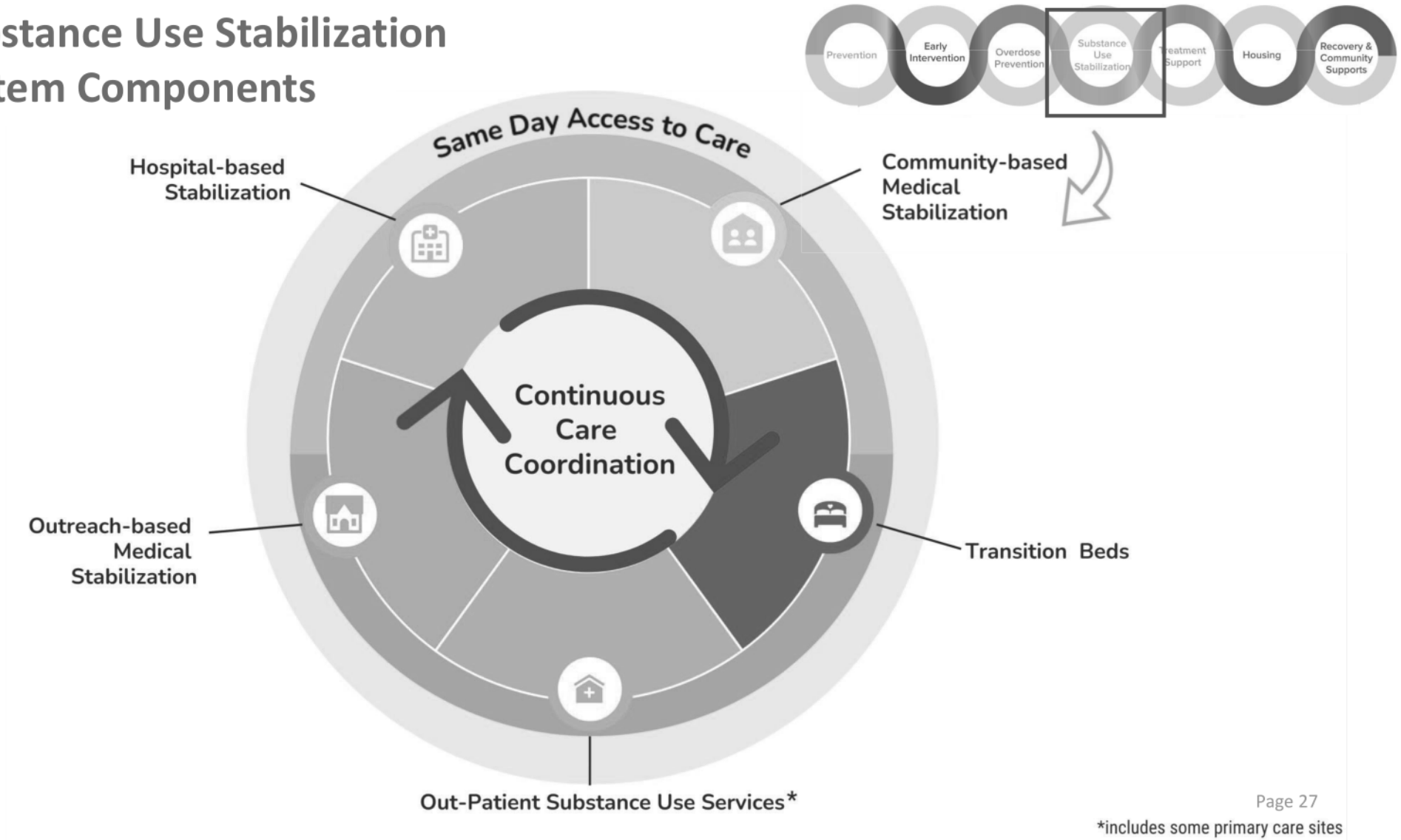
LHA	n	%
1. North Vancouver	191	62%
2. West Vancouver -Bowen Island	53	17%
3. Howe Sound	38	12%
4. Sunshine Coast	19	6%
5. Powell River	8	3%



*Powell River has sent 27 clients to VIHA for SU Stabilization Services since Aug 2021

Source: PARIS

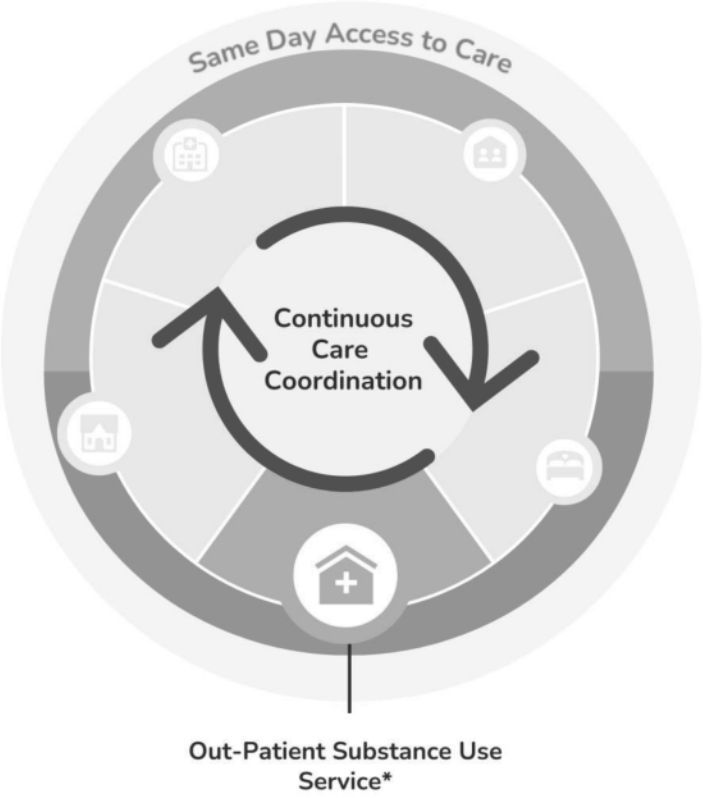
Substance Use Stabilization System Components



Page 27

*includes some primary care sites

Substance Use Stabilization System Components: Outpatient



*Includes some primary care sites

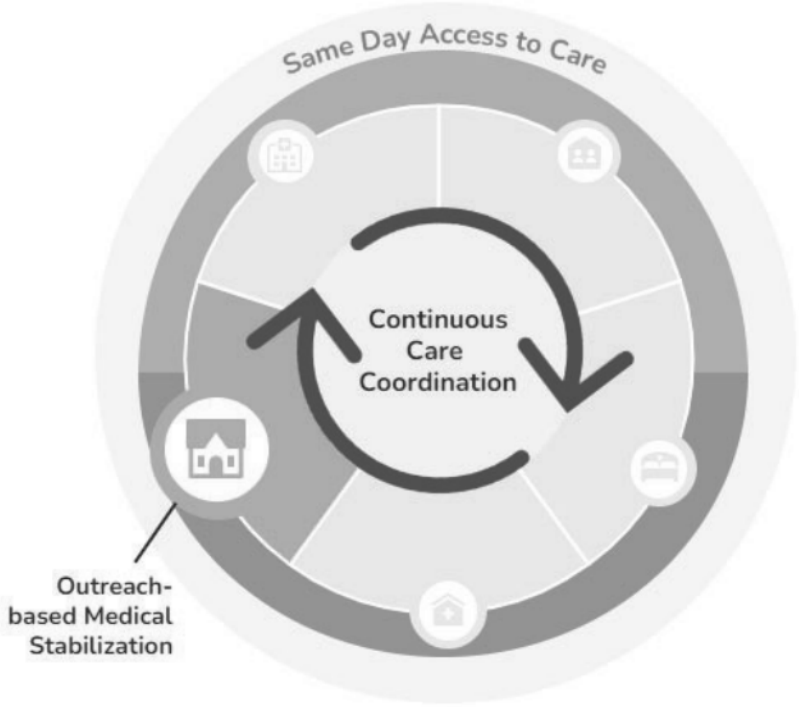
Definition

A virtual or in-person substance use service based in communities.

Services Provided

- Provides same day assessment and pharmacotherapy initiations, titrations and/or transitions for Opioid use disorder (OUD), Alcohol use disorder (AUD), Stimulant use disorder (SUD), Benzodiazepine use disorder (BUD) etc.
- Same day assessments will also be used to inform referrals to and level of priority for outreach, community, or hospital based stabilization to support people's goals' to reduce or eliminate substance use.
- Psychosocial and cultural supports

Substance Use Stabilization System Components: Outreach-based Medical Stabilization



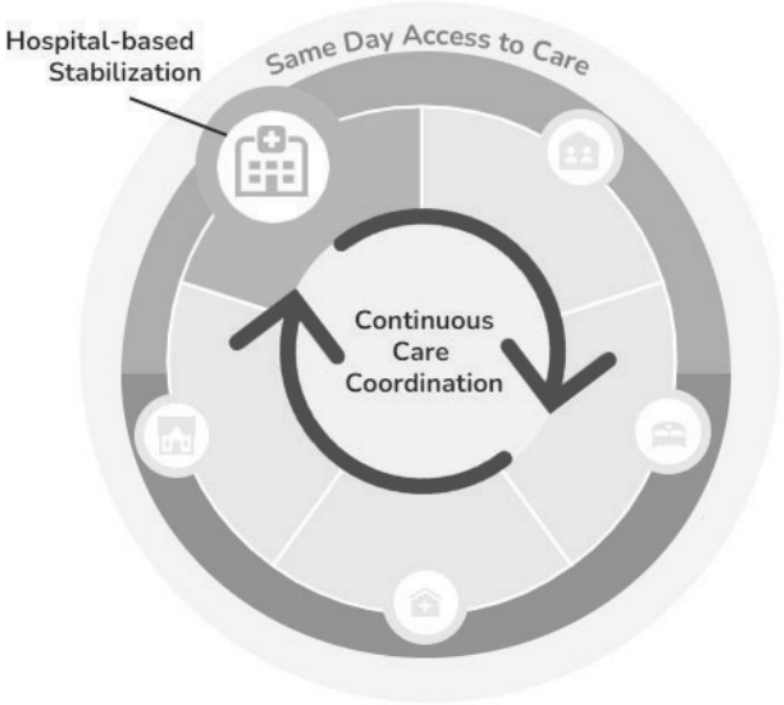
Definition

Outreach medical and psychosocial supports are provided to support people as they decrease/eliminate substance use and initiate and/or adjust medications to treat substance use.

Services Provided

- Pharmacotherapy initiations, titrations and/or transitions for Opioid use disorder (OUD), Alcohol use disorder (AUD), Stimulant use disorder (SUD), Benzodiazepine use disorder (BUD) etc.
- Daily in-person or virtual check-ins
- Limited medical monitoring available depending on team resources
- Psychosocial and cultural supports

Substance Use Stabilization System Components: Hospital-based Stabilization



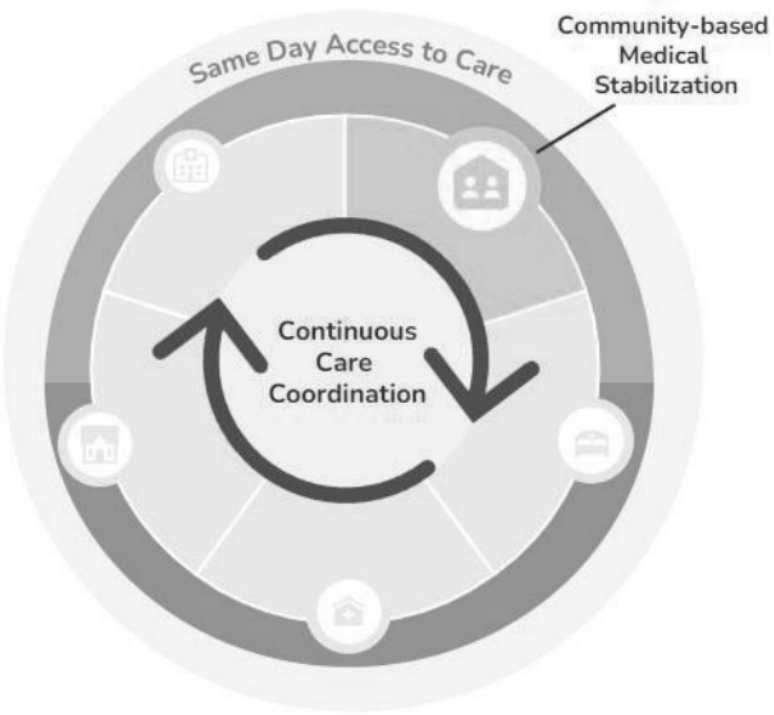
Definition

- Provides medical supports 24 hours per day on a unit or emergency department within a hospital to support people as they eliminate substance use and initiate and/or adjust medications to treat substance use.
- May also be used when outreach-based and/or community medical stabilization is not available in a person's home community.

Services Provided

- Rapid pharmacotherapy initiations, titrations and/or transitions for Opioid use disorder (OUD), Alcohol use disorder (AUD), Stimulant use disorder (SUD), Benzodiazepine use disorder (BUD) etc.
- Close medical monitoring for people who are at high risk of medical complications due to withdrawing from a substance or underlying medical condition(s).
- Psychosocial and cultural supports

Substance Use Stabilization System Components: Community-based Medical Stabilization



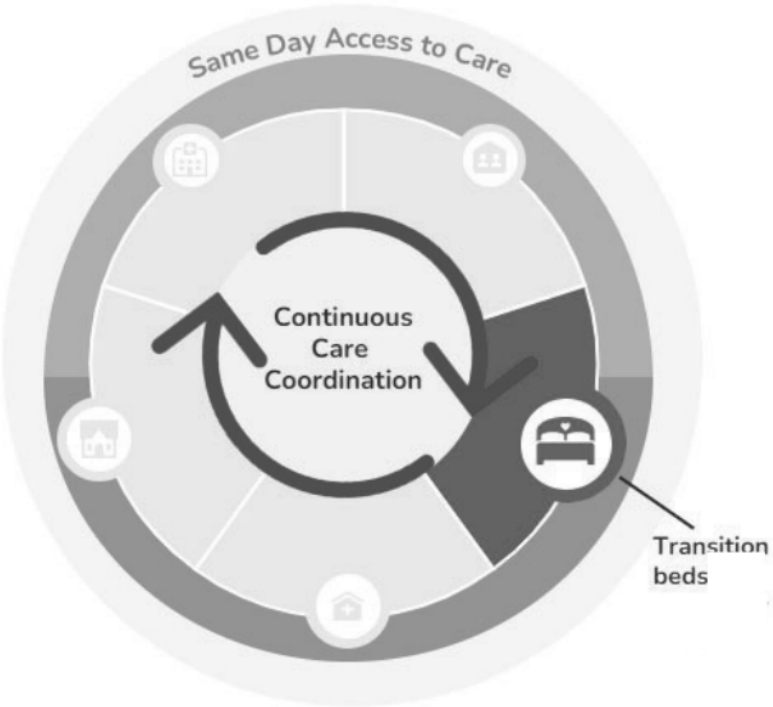
Definition

Provides medical supports 12 to 24 hours per day in a live-in centre to support people as they eliminate substance use and initiate and/or adjust medications to treat substance use.

Services Provided

- Rapid pharmacotherapy initiations, titrations and/or transitions for Opioid use disorder (OUD), Alcohol use disorder (AUD), Stimulant use disorder (SUD), Benzodiazepine use disorder (BUD) etc.
- Medical monitoring for people who are at risk of medical complications due to withdrawing from a substance or underlying medical condition(s).
- Psychosocial and cultural supports

Substance Use Stabilization System Components: Transition Beds



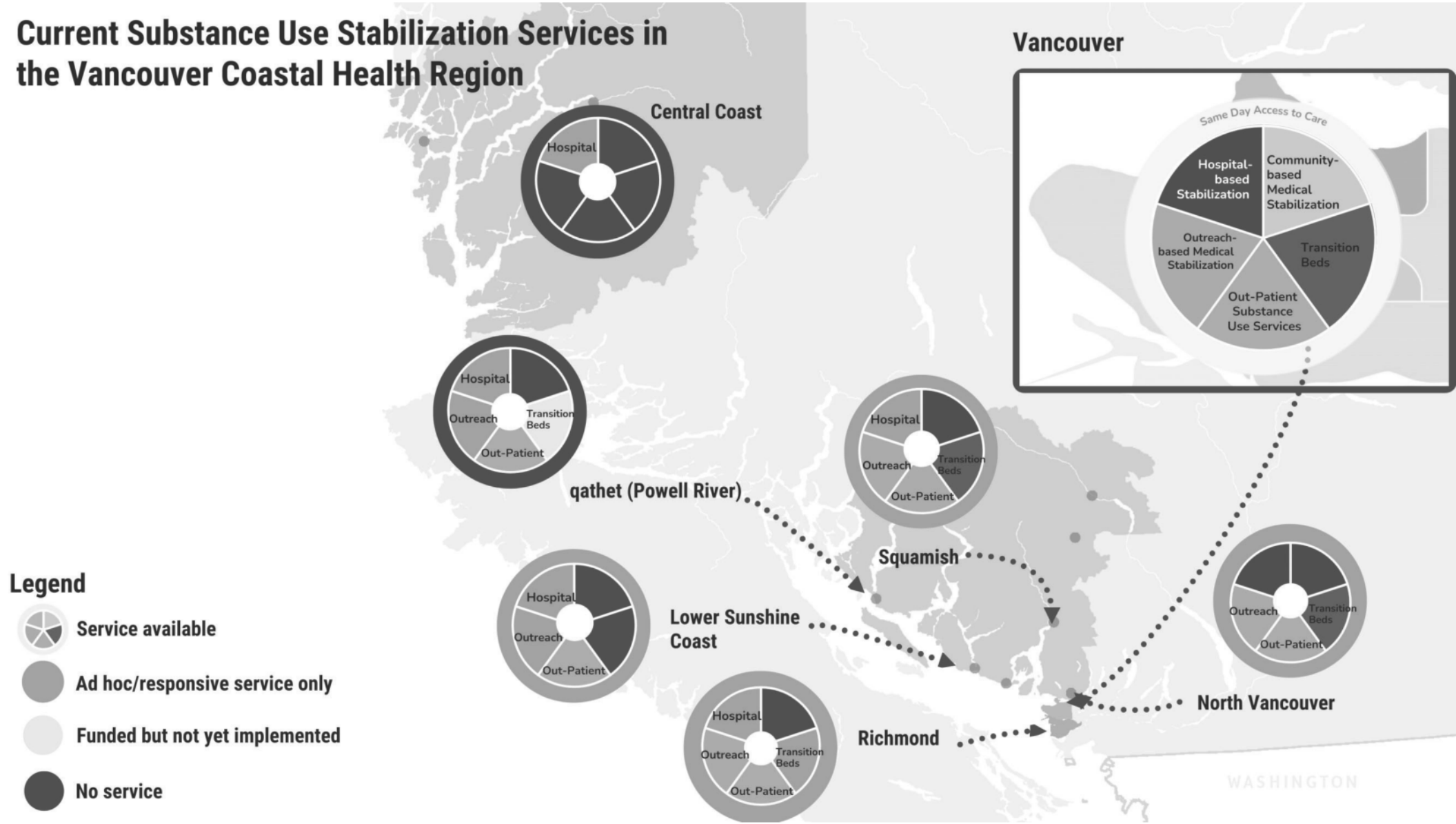
Definition

- Provides accommodation for people who are medically stable and require one of the following:
  - a safe space to receive outreach or out-patient medical stabilization for their substance use;
  - awaiting admission to a residential treatment/recovery program; or
  - awaiting housing to prevent having individuals return to their home setting (or the streets.

Services Provided

- No on-site clinical service
- Specialized out-patient substance use services or outreach-based medical stabilization services may be accessed
- Psychosocial and cultural supports

Current Substance Use Stabilization Services in the Vancouver Coastal Health Region



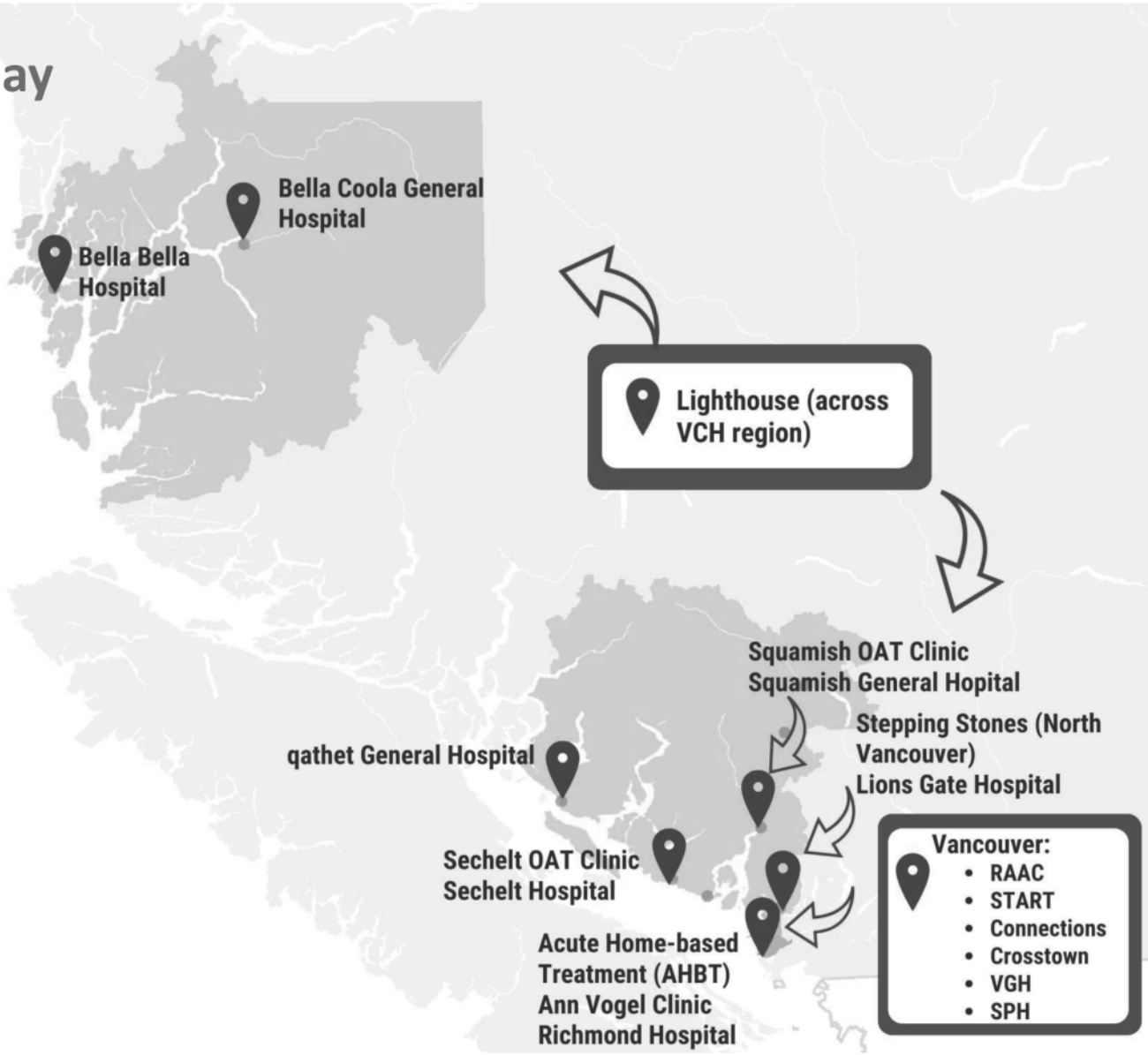
Potential Capacity for Same Day Access to Care

Current State:

- Rapid Access Addiction Clinic (St. Paul's Hospital) and Lighthouse offer same day access to treatment

Future State:

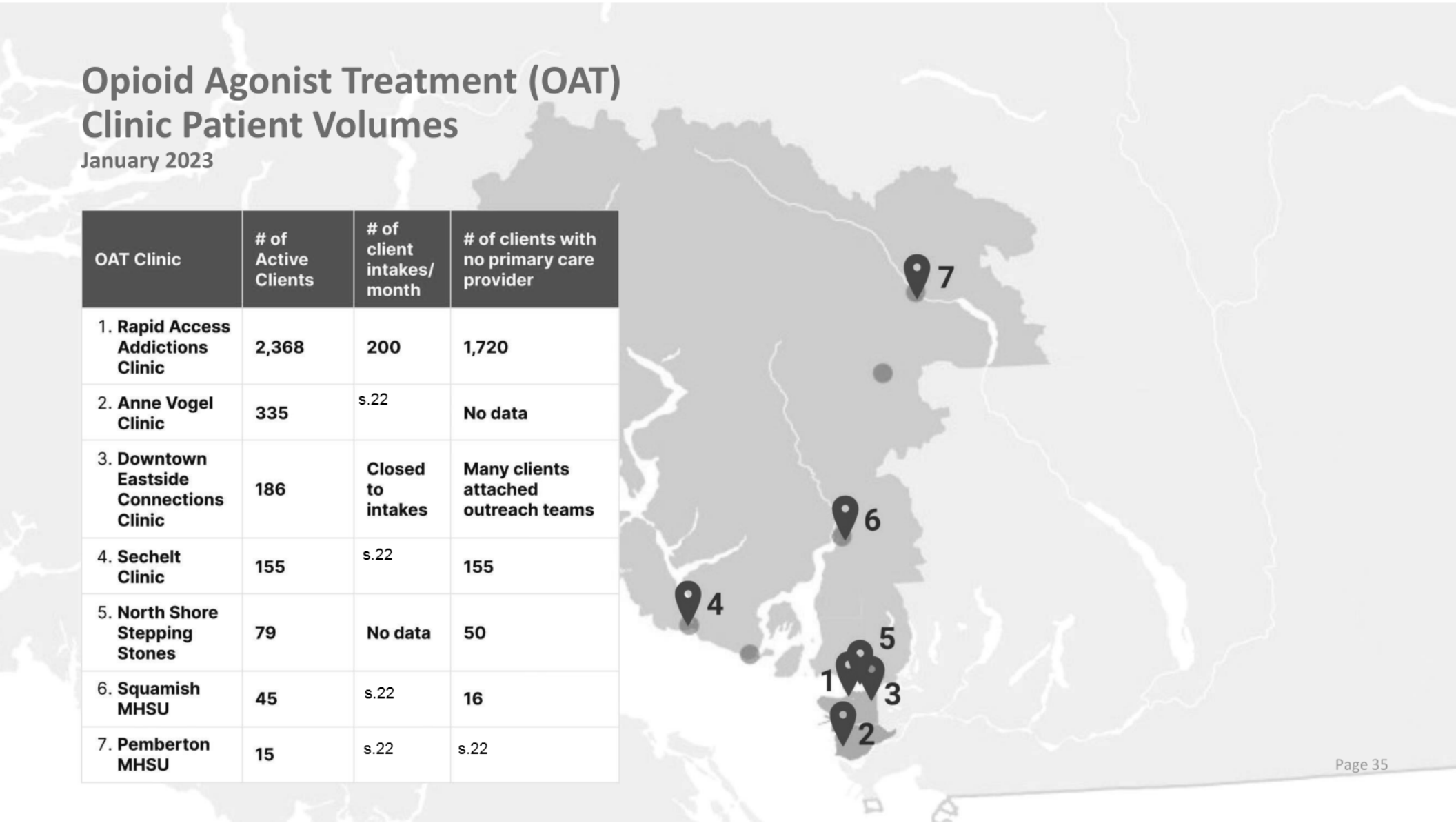
s.13; s.17

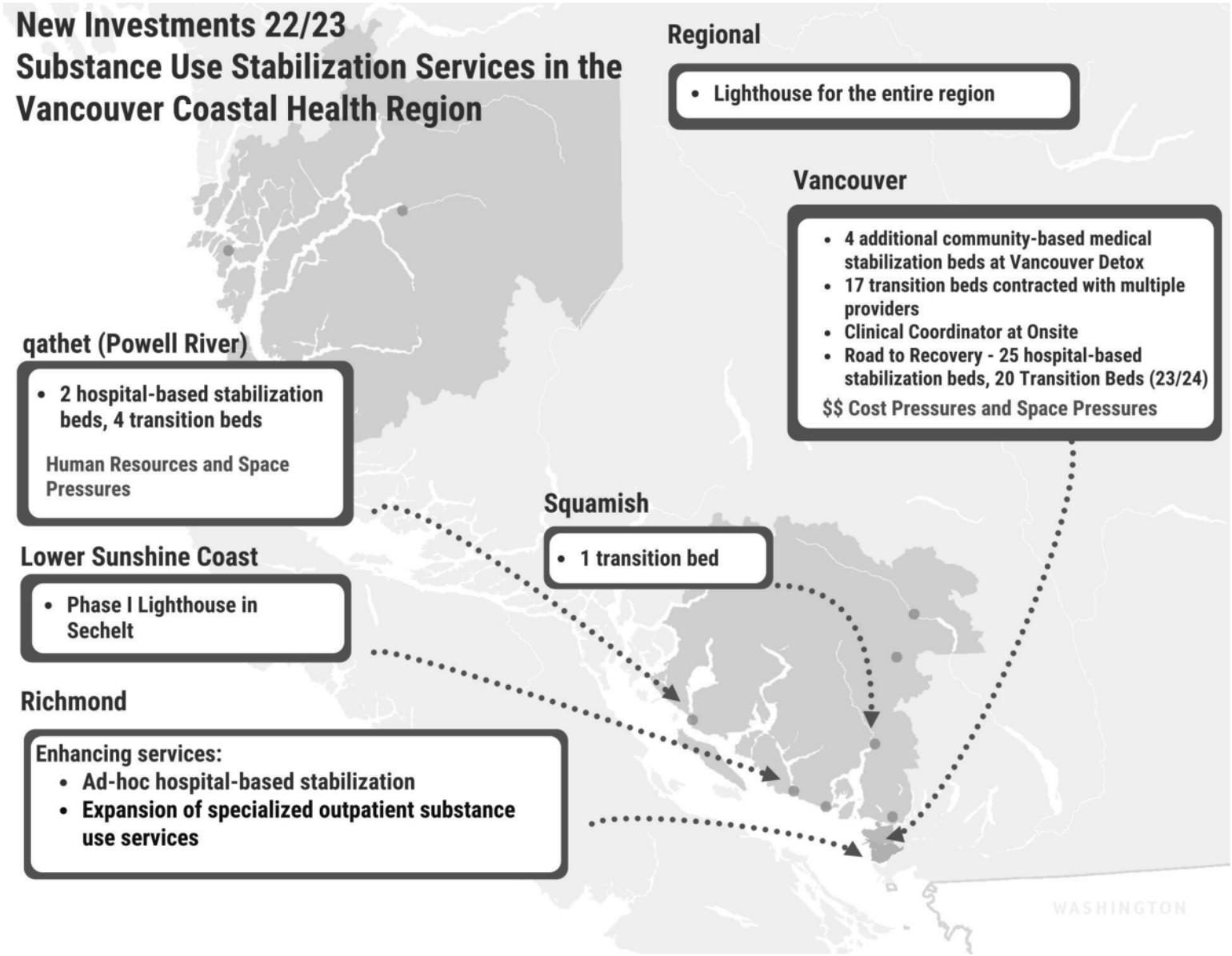


Opioid Agonist Treatment (OAT) Clinic Patient Volumes

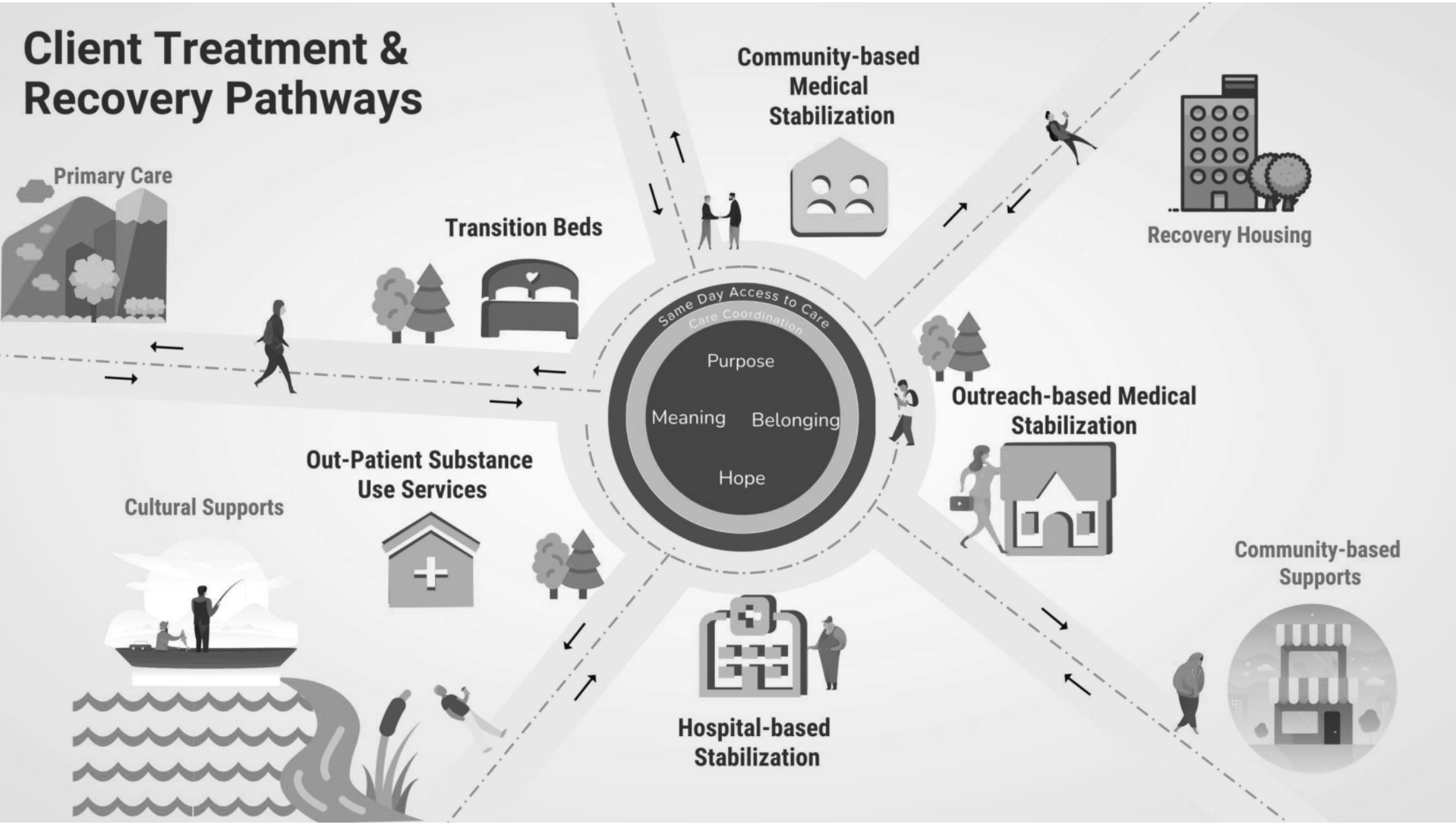
January 2023

OAT Clinic	# of Active Clients	# of client intakes/ month	# of clients with no primary care provider
1. Rapid Access Addictions Clinic	2,368	200	1,720
2. Anne Vogel Clinic	335	s.22	No data
3. Downtown Eastside Connections Clinic	186	Closed to intakes	Many clients attached outreach teams
4. Sechelt Clinic	155	s.22	155
5. North Shore Stepping Stones	79	No data	50
6. Squamish MHSU	45	s.22	16
7. Pemberton MHSU	15	s.22	s.22





Vancouver CoastalHealth


Client Treatment & Recovery Pathways
Primary Care
Transition Beds
Community-based Medical Stabilization
Recovery Housing
Same Day Access to Care
Care Coordination
Purpose
Meaning
Belonging
Hope
Outreach-based Medical Stabilization
Out-Patient Substance Use Services
Cultural Supports
Community-based Supports
Hospital-based Stabilization

Our Recommendation to SET

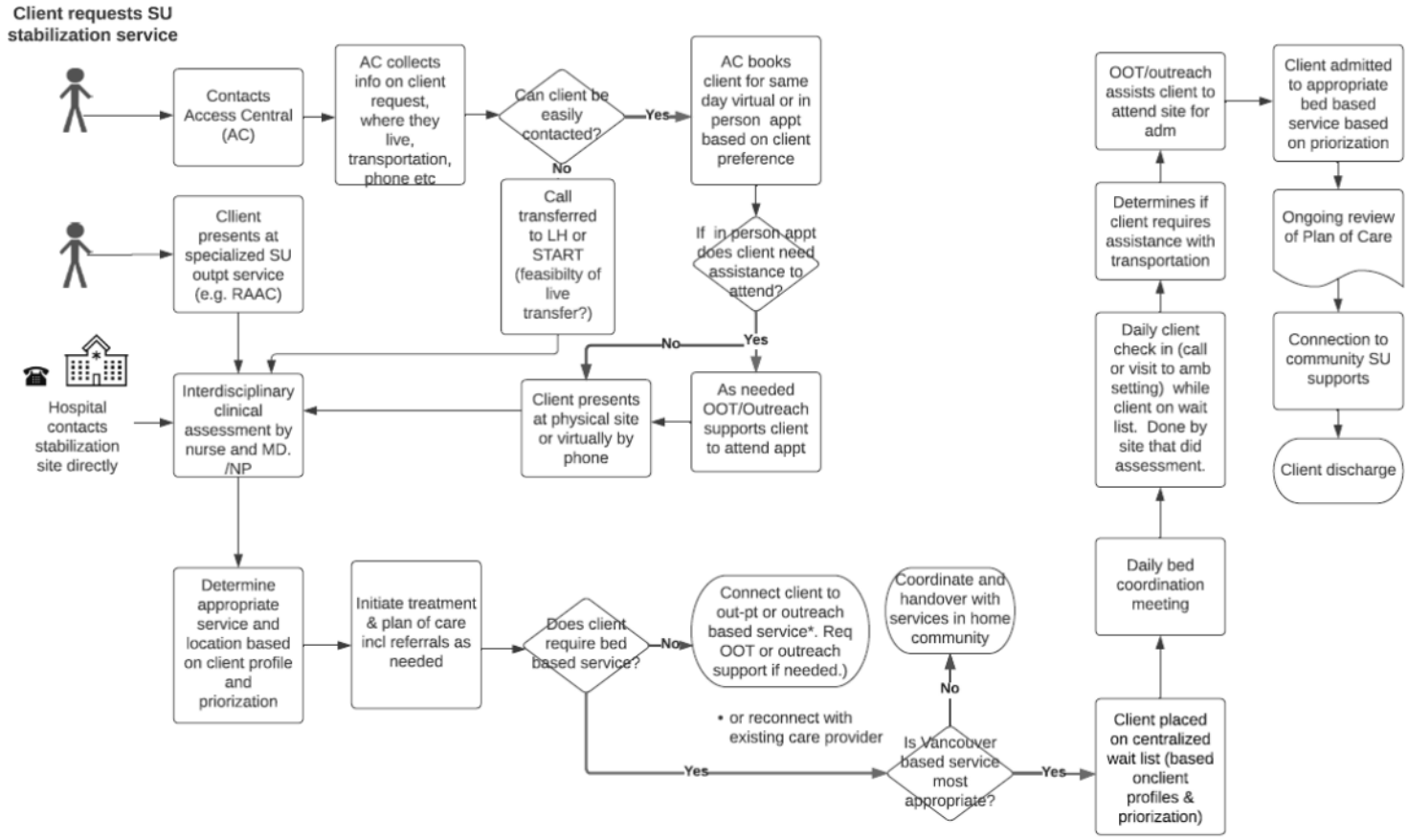
s.13

Our Recommendation to SET

s.13

Appendix

Regional Approach to Substance Use Stabilization – Assessment, Access and Treatment



Vancouver CoastalHealth

Guiding Principles

Same day assessment and initiation of pharmacotherapy
- Clinical assessment used to determine most appropriate service and priority for waitlist
- A single, centralized waitlist for all SU stabilization services (R2R, VDC, HBL, Onsite, START)
- Priority based waitlist

Client outcomes
- ·Seen and assessed at time they express interest in SU treatment
- Treatment initiation and support while waiting for bed based service
- ·Better equity in access to services across the VCH region

.

From: Mundel, Erika [PH] (emundel@providencehealth.bc.ca)
To: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
Cc: Morgan, Jenn R MMHA:EX (Jenn.Morgan@gov.bc.ca)
Subject: RE: Request for information on WDM tools and processes
Sent: 06/01/2023 19:46:06
Attachments: image001.jpg
Message Body:

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Hi Bethany, for lighthouse the service model is:

7 days a week, 8:30-4:30

LPN x2

SW X 1

Clerk x1

Plus physician sessions (same hours, but only 5 days a week right now, but that will be going up to 7 days very soon).

As it happen Lynn Mackinnon with as consulting PM for RAP and was heavily involved in setting up Lighthouse is going to be in PEI this summer, so if it's useful for her to meet with anyone while she's there she's happy to be connected.

Thanks, Erika

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Tuesday, May 30, 2023 10:58 PM
To: Mundel, Erika [PH] <emundel@providencehealth.bc.ca>
Cc: Morgan, Jenn R MMHA:EX <Jenn.Morgan@gov.bc.ca>
Subject: Request for information on WDM tools and processes

EXTERNAL SENDER. If you suspect this message is malicious, please forward to spam@phsa.ca and **do not** open attachments or click on links.

Hi Erika,

We received a request from the Government of PEI today asking for examples of intake/assessment tools and waitlist management practices for withdrawal management services. They are building a MHSU “campus” and significantly expanding services.

One of their questions related to the staffing models for virtual WDM services and I was wondering if you have this information for the Lighthouse virtual withdrawal management service?

Is that something you could share with us to help them develop their provincial services? Our timeline for this is end of day Monday, I know that is really tight and may not be possible.

I have copied Jenn here on my team who is pulling the information together.

Bethany

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

From: Morgan, Jenn R MMHA:EX (Jenn.Morgan@gov.bc.ca)
To: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
Subject: Request for information- email for VCH
Sent: 05/30/2023 20:53:33
Message Body:

Hi Bethany,

To complete the request for jurisdictional scan from PEI can you ask the following questions of Stefan and Miranda from VCH:

- What screening, assessment, and intake tools do you use when conducting intake for withdrawal management services in Vancouver? If there are any tools that support direction to inpatient or outpatient programs, can you describe these?
- What are your intake or admission criteria for inpatient and outpatient withdrawal management services in Vancouver?
- What waitlist management tools or approaches do you use for withdrawal management services? How do these tools support triage or prioritization of clients? What supports are offered if clients must wait for withdrawal management services?
- Do you provide any aftercare or post-completion supports for those who access withdrawal management services? If so, can you describe these?
- Can you provide information on staffing (including any physician or nurse practitioner positions) for The Lighthouse virtual withdrawal management service? Bethany- R2R proposal and business case mention expanding The Lighthouse but don't have the details PEI is looking for.

I've kept the questions close to what PEI has asked for but maybe this is too much for such a short timeframe?

Jenn

Jenn Morgan

Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

Office: 778-698-5966

Cell: 250-920-9287

From: Embacher, Kathryn [PHSA] (kathryn.embacher@phsa.ca)
To: Heinrichs, Kristelle [FH] (Kristelle.Heinrichs@fraserhealth.ca); MacFarlane, Andrew [VC] (andrew.macfarlane@vch.ca); Leadbetter, Sheila (Sheila.Leadbetter@islandhealth.ca); XT:Glynn, Keva HLTH:IN (Keva.Glynn@islandhealth.ca); jason.giesbrecht@interiohealth.ca; michelle.lawrence@nothernhealth.ca
Cc: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca); Curtis, Jennifer MMHA:EX (Jennifer.Curtis@gov.bc.ca); Colleen Salter (Colleen.Salter@fnha.ca)
Subject: Focus Group Session(s) on Indigenous Client Access to Provincial MHSU Programs
Sent: 05/15/2023 19:39:06
Attachments: image001.png, image002.png, image005.png, image006.png, image007.png
Message Body:

Hi everyone,

For those of you in attendance at the last Provincial MHSU Meeting, we discussed some of the challenges faced by our shared Indigenous clients during the access process to Provincial Substance Use or Concurrent Disorders Programs. We also discussed that after some discussions and planning, MMHA, PHSA, and FNHA would like to invite reps from each Region to 1 or 2 focus group sessions to help inform future processes for Indigenous Client Access.

Please reply to myself and Colleen Salter (FNHA – CCd) with the folks from your health authority, that have involvement in access to Provincial Substance Use and Concurrent Disorders Programs, who would be the right people to invite to these focus groups. If you could reply by Next Monday that would be very helpful.

Much appreciated,

Kathryn Embacher RN, CPHR, MSc

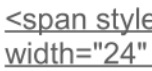
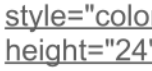
Provincial Executive Director, Adult Mental Health and Substance Use

BC Mental Health and Substance Use Services, PHSA

2745 Lougheed Hwy, Coquitlam, BC, V3C 4J2

604-524-7105 604-312-7876

Follow us @ www.bcmhsus.ca

I respectfully acknowledge that I work within the unceded territory of the kʷikʷəƛ̓əm, xʷməθkwəyəm (Musqueam), Səlílwətaʔ/Selilwitulh (Tsleil-Waututh), and Skwxwú7mesh (Squamish) Nations.

From: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
To: Dolman, Corinne (Corinne.Dolman@interiorhealth.ca)
Cc: Morris, Debi (Debi.Morris@interiorhealth.ca); Mcadam, Tasha (Tasha.Mcadam@interiorhealth.ca)
Subject: RE: Action Required: Community Substance Use Beds - Access and Utilization Data Follow-up
Sent: 03/14/2023 22:04:19
Attachments: image001.png, image002.jpg
Message Body:

Hi Corrine,

This is definitely on my mind as well. We are going to put forward a few areas for discussion on the potential Provincial role during the PSAC meeting this Thursday, this is on the list.

Bethany

From: Dolman, Corinne <Corinne.Dolman@interiorhealth.ca>
Sent: March 14, 2023 8:37 AM
To: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Cc: Morris, Debi <Debi.Morris@interiorhealth.ca>; Mcadam, Tasha <Tasha.Mcadam@interiorhealth.ca>
Subject: RE: Action Required: Community Substance Use Beds - Access and Utilization Data Follow-up

One more thought Bethany.s.13 – so we are here right now - *the median wait time for treatment and recovery services across the province is 29.5 days with utilization rates ranging from 44%-73%* -s.13
s.13

Corinne Dolman, MSW

Manager | Substance Use Services | MHSU Network

(she/her/hers)

Interior Health

p: 250-469-7070 | **ext.** 12926

c: 250-718-3282

e: Corinne.Dolman@interiorhealth.ca

www.interiorhealth.ca

I respectfully acknowledge my workplace is situated within the ancestral, traditional and unceded territory of the Syilx Nation.

I respectfully acknowledge all of the lives lost and the families affected by the ongoing overdose pandemic and toxic drug crisis.

The aim of our team is to ensure all people who use substances receive safe, effective, and compassionate person-centred care and treatment, when and where they need it.

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Monday, March 13, 2023 5:14 PM
To: Dolman, Corinne <Corinne.Dolman@interiorhealth.ca>
Cc: Morris, Debi <Debi.Morris@interiorhealth.ca>; Mcadam, Tasha <Tasha.Mcadam@interiorhealth.ca>
Subject: RE: Action Required: Community Substance Use Beds - Access and Utilization Data Follow-up

Hi Corrine,

This is very helpful. Thank you so much for taking the time to send this.

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

From: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
To: Butler, Ally MMHA:EX (Ally.Butler@gov.bc.ca)
Subject: Draft 1-1 Agenda
Sent: 03/30/2023 22:39:26
Attachments: image001.jpg, BUDGET 2023 MEETING ATTENDEES.docx
Message Body:

Draft Agenda:

Ally's Agenda Items

Division Priorities

- Prioritization for April

Budget 23

- Update from Capital Planning meeting
- Confirm dates for April meetings (options likely April 13 or 25? In the am), s.13
  s.13

- Confirm attached invitee list
- Given the upcoming AL, is it easier for me to work with Erica and Miranda to set up the information sessions on the models of care or do you want that request to come from you?
- Discussion on readiness criteria

Budget 21

. s.13

Standards Training:

- DM briefing – do you want the info up in eapps (deck and comms plan to share) so you can share it and offer a briefing?

Quality Care and Oversight:

- Health ADMs have decided the data base can move forward without the PPH readiness, Ross is just waiting for a final confirmation email
- We need to get a Joint DM and Minister meeting on the books, did you hear back from Ross regarding timing?
- ED meeting tomorrow with Sue

Access and Flow

- We are working on an IBN that proposes we pursue three next steps:

s.13

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

Page 83 of 98 to/à Page 85 of 98

Withheld pursuant to/removed as

s.13

From: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
To: Morrison, Mary J (Mary.Morrison2@islandhealth.ca); Leadbetter, Sheila (Sheila.Leadbetter@islandhealth.ca)
Cc: XT:Reid, Kelly HLTH:IN (kelly.reid@islandhealth.ca); Preston, Kelly A (Kelly.Preston@islandhealth.ca); Szafron, Melanee (Melanee.Szafron@islandhealth.ca); Germain, Suzanne - Strategic Advisor, RJH (Suzanne.Germain@islandhealth.ca)
Subject: RE: Our Place - Funding Update - notes from Apr 5th mtg
Sent: 04/07/2023 03:47:29
Attachments: image001.jpg
Message Body:

Hi Mary,

Thank you for joining me in the meeting with Our Place and for your excellent overview notes. I don't have anything to add.

Here is the BCARA website: https://bcaddictionrecovery.ca/ I don't think it will meet exactly what Our Place is asking to be part of but it certainly would be a good avenue for them to share their experiences and learn from others. OP was involved in some community advisory tables early on before Don Evans left.

Bethany

From: Morrison, Mary J <Mary.Morrison2@islandhealth.ca>
Sent: Thursday, April 6, 2023 5:23 PM
To: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>; Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Cc: XT:Reid, Kelly HLTH:IN <kelly.reid@islandhealth.ca>; Preston, Kelly A <Kelly.Preston@islandhealth.ca>; Szafron, Melanee <Melanee.Szafron@islandhealth.ca>; Germain, Suzanne - Strategic Advisor, RJH <Suzanne.Germain@islandhealth.ca>
Subject: RE: Our Place - Funding Update - notes from Apr 5th mtg

Hello everyone. It was great seeing you yesterday Bethany and thanks for walking through the future plans and Ministry expectations related to the 3 year grant funding for New Roads. Here is a brief summary of my notes and wanting to confirm next steps to ensure we are all on same page:

. s.13; s.17

.

ACTIONS:

- Mary to book Q4 mtg in May – done
- All parties to consider how the local recovery table could be brought to reality and discuss at May Q4 mtg – Bethany sharing some info about CAI and Be Care tables underway with VCA

Anything I misrepresented or missed Bethany?

I have been away, so may have missed it, but can someone send me the document that outlines the specific language provided to OP re the grant expectations and outcomes?

Contract Mmgt – this was going to move over to Mel with her SU focused portfolio, s.22 s.22 will this go to Jacqueline or stay with me? I am fine either way ☺

Have a great long weekend everyone!

Mary

From: Morrison, Mary J
Sent: Sunday, April 02, 2023 12:42 PM
To: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>; 'Estiverne, Bethany MMHA:EX' <Bethany.Estiverne@gov.bc.ca>
Cc: Reid, Kelly <Kelly.Reid@islandhealth.ca>
Subject: RE: Our Place - Funding Update

HI Bethany and Sheila. I have accepted the invite from Julian for Apr 5th 3-330. See you then Bethany ☺

Mary

From: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>
Sent: Tuesday, March 28, 2023 12:33 PM
To: 'Estiverne, Bethany MMHA:EX' <Bethany.Estiverne@gov.bc.ca>; Morrison, Mary J <Mary.Morrison2@islandhealth.ca>
Subject: RE: Our Place - Funding Update

Hi Bethany,

Kelly will be back that day so I think it should be Mary and Kelly. I am involved in the Island Health Board meeting in Nanaimo at that time so I can't attend.

Sheila Leadbetter (she/her) RN BsN MAL CHE

Executive Director Mental Health Substance Use South/Centre/North Island & Tertiary Adults and Seniors Services

Cell 250-415-8039 | Sheila.leadbetter@islandhealth.ca

www.viha.ca | Facebook | Twitter

C•A•R•E | Courage • Aspire • Respect • Empathy

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Tuesday, March 28, 2023 11:28 AM
To: Morrison, Mary J <Mary.Morrison2@islandhealth.ca>
Cc: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>
Subject: Our Place - Funding Update

Hi Mary,

As you know, the province is flowing additional end of year funding to Our Place to sustain the service at New Roads. This funding is intended to address the deficit over the next three years. I am planning to meet with Julian and Cheryl just to go over the funding agreement briefly on April 5 from 3-3:30pm. I am wondering if you might be available to join? If not I can look for another time in our calendars.

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

From: Leadbetter, Sheila (Sheila.Leadbetter@islandhealth.ca)
To: Estiverne, Bethany MMHA:EX (Bethany.Estiverne@gov.bc.ca)
Subject: RE: OP Tx Centre
Sent: 03/14/2023 23:30:16
Attachments: image001.jpg
Message Body:

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Bethany s.13; s.17
s.13; s.17

Sheila Leadbetter (she/her) RN BsN MAL CHE

Executive Director Mental Health Substance Use South/Centre/North Island & Tertiary Adults and Seniors Services

Cell 250-415-8039 |
Sheila.leadbetter@islandhealth.ca

www.viha.ca | Facebook | Twitter

C•A•R•E | Courage • Aspire • Respect • Empathy

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Tuesday, March 14, 2023 2:41 PM
To: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>
Subject: RE: OP Tx Centre

Hi Sheila,

This is where I landed on the final wording. I think this will address your concerns but please let me know if you still have any concerns.

•□□□□□□ Review and make necessary updates to the model of care, eligibility criteria and referral pathways to maximize/optimize service utilization and address service gaps in the Island Health regional as appropriate.

•□□□□□□ Revise the annual operational budget to ensure program feasibility over the course of the grant period to help inform service sustainability discussions.

•□□□□□□ Work with Island Health and other health system partners to identify opportunities to

support regional capacity building, leverage existing relationships and build new relationships with other contracted service providers.

•□□□□□□ Review and refine existing operator reporting requirements to align with data collection best practice, and provincial reporting requirements.

•□□□□□□ Provide a report back to the ministry on the above strategic planning activities within 6 months.

Bethany

From: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>
Sent: March 13, 2023 4:45 PM
To: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Subject: RE: OP Tx Centre

Hi Bethany,

s.13; s.17

Sheila Leadbetter (she/her) RN BsN MAL CHE

Executive Director Mental Health Substance Use South/Centre/North Island & Tertiary Adults and Seniors Services

Cell 250-415-8039 |
Sheila.leadbetter@islandhealth.ca

www.viha.ca | Facebook | Twitter

C•A•R•E | Courage • Aspire • Respect • Empathy

From: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Sent: Monday, March 13, 2023 3:31 PM
To: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>

Subject: RE: OP Tx Centre

Hi Sheila,

I don't think the grant process will require a contact changes.

Below are the new grant conditions I am considering, other conditions such as annual reports etc. will continue.

Can Island Health review and suggest any needed changes from your perspective? I know the timing is tight but hoping your team can take a look and let me know by end of day tomorrow if you have any concerns or suggestions regarding the wording of the bullets below.

Suggested additional grant requirements:

Specific strategic planning activities to be undertaken by New Roads in close collaboration with Island Health include the following:

•□□□□□□□ Review and make necessary updates to the model of care, eligibility criteria and referral pathways to maximize/optimize service utilization and address service gaps in the Island Health regional as appropriate.

•□□□□□□□ Revise the annual operational budget to ensure program feasibility over the course of the grant program. This includes working with Island Health to determine an appropriate annual per bed cost of the service, approved by Island Health, to help inform future funding discussions.

•□□□□□□□ Work with Island Health and other health system partners to identify opportunities to support regional capacity building, leverage existing relationships and build new relationships with other contracted service providers.

•□□□□□□ Review and refine, if needed, existing operator reporting requirements to align with data collection best practice, and provincial reporting requirements.

•□□□□□□ Provide a report back to the ministry on the above strategic planning activities within 6 months.

Bethany Estiverne

A/Senior Director, Substance Use Treatment and Recovery

Substance Use and Strategic Initiatives,

Ministry of Mental Health and Addictions

604 250-9564

From: Leadbetter, Sheila <Sheila.Leadbetter@islandhealth.ca>
Sent: March 13, 2023 9:46 AM
To: Estiverne, Bethany MMHA:EX <Bethany.Estiverne@gov.bc.ca>
Subject: OP Tx Centre

[EXTERNAL] This email came from an external source. Only open attachments or links that you are expecting from a known sender.

Hi Bethany,

We need to renew our contract with OP and I am thinking s.13
s.13

Sheila Leadbetter (she/her) RN BsN MAL CHE

Executive Director Mental Health Substance Use South/Centre/North Island & Tertiary Adults and Seniors Services

Cell 250-415-8039 |
Sheila.leadbetter@islandhealth.ca

www.viha.ca | Facebook | Twitter

C•A•R•E | Courage • Aspire • Respect • Empathy

From: Curtis, Jennifer MMHA:EX (Jennifer.Curtis@gov.bc.ca)
To: Samantha MMHA:EX Dodd (Samantha.Dodd@gov.bc.ca) (Samantha MMHA:EX Dodd (Samantha.Dodd@gov.bc.ca))
Subject: Executive Update- Draft Slides
Sent: 02/22/2023 22:27:45
Attachments: Leadership Update_ draft .pptx
Message Body:

Hi Sam,

Could you please look at the attached draft and recommend any changes or additions to the slides. It should be high level and capture the work we have done to date, and the conversations we have been having with our partners. This includes the conversation from yesterday where it was implied that further direction would be needed from leadership.

Your thoughts and comments are appreciated. If you could get this back to me before noon on Monday that would be great.

Jennifer

CEO-DM Meeting- Action Item

ACTION ITEM: s.13

s.13

s.13

System Access and Navigation: Improved Overall Client Outcomes

s.13

s.13

First Nations Prioritization: Potential Next Steps

s.13

For Discussion

Work to-date has focused on improvements to reduce barriers in the current system and increase clarity:

s.13