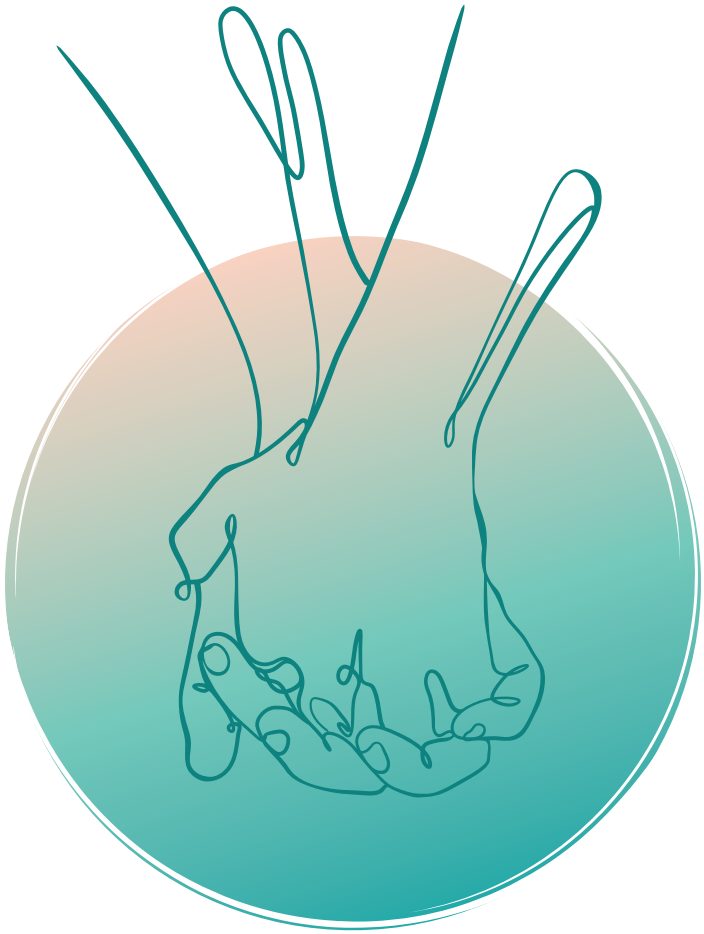
thumbsup foundation

# HARMONIZED HEALTH

## 2021 Executive Report



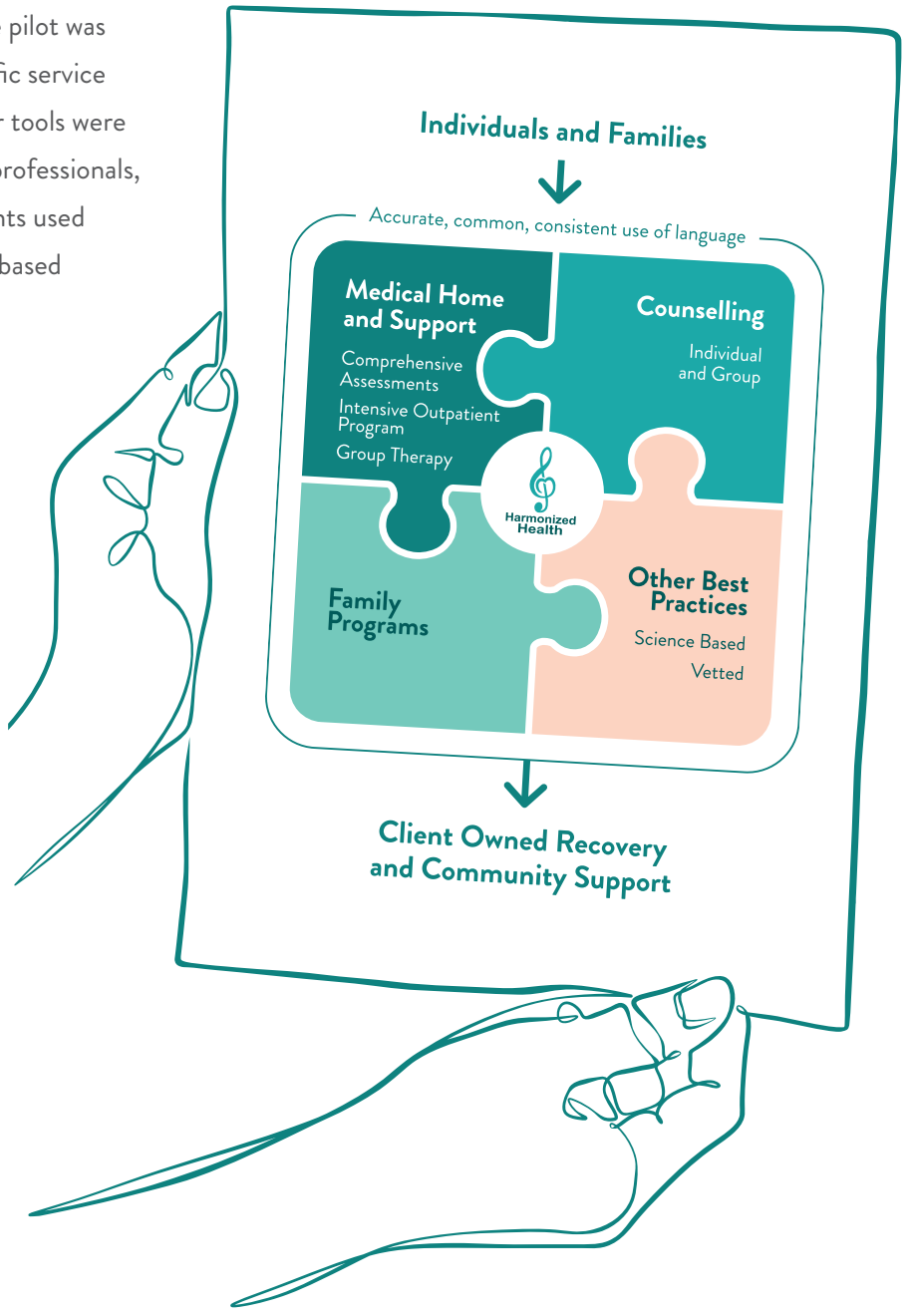
# Harmonized Health 2021 Executive Report

## Executive Summary

Thumbs Up Advocacy Foundation (TUF), established in 2016, advocates for positive change for mental health, with a focus on simplifying and rounding out access to services. TUF's purpose is to improve access to care while increasing knowledge, understanding, and awareness about mental health through the voice of lived and living experience. TUF advocates for systemic changes from the current short-term symptomatic standard of care to a preventative model of long-term sustainable health, happiness, and well-being with the goal of reducing the number of suicides. TUF is not a service provider itself but rather engages in state-of-the-art projects that improve client mental health outcomes.

The model for Harmonized Health (HH) began as a grassroots Airdrie community design, aligned to recent Alberta and Canada-wide research on mental health and addiction. The goal was to establish a new and different way of supporting individuals with mental health challenges—through a client-first caring and compassionate lens. The HH model incorporates lived experience and family and community working alongside medical professionals and other service providers.

The 12-month HH pilot set out to test the effectiveness of the HH model, one that was not constrained by system priorities, funding models, or processes. The pilot was not set up to test the performance of specific service providers; however, existing service provider tools were used where possible. Participating medical professionals, service providers, and community participants used a common language of addiction as a brain-based disease. Two physicians received some level of funded, specialized mental health and addiction training. The group of service providers each offered distinct services and were brought together in a unique and integrated way that did not previously exist.



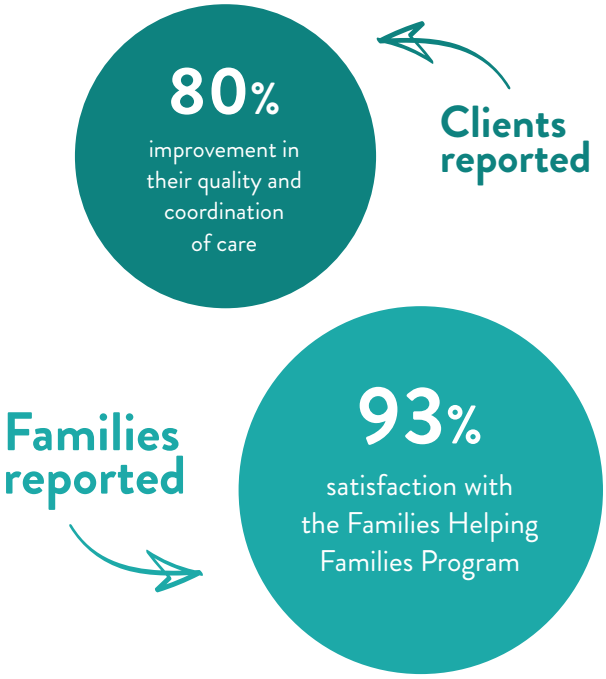

In the HH model, two groups of clients reached out to the HH Care Coordinator:

- Individual clients in pre-contemplative or contemplative stages
- Families with loved ones with mental health challenges, regardless of their loved one's state of readiness for change

The Coordinator took the time to really listen to their stories and explained some of the philosophies of HH, such as addiction as a brain disease.

When an individual client was ready to engage, they were directed to a medical clinic for intake, and their HH journey began. With upfront individual comprehensive assessments as the key to a solid treatment and recovery plan, and integrated data sharing among the providers, participating individuals received a proactive, holistic health approach through a variety of service providers. Depending on each client's recovery plan, the services included some combination of individual counselling, intensive outpatient therapy, and facilitated group psychotherapy. As required, these services were rounded out with specialized mental health physician support, a Community Peer Navigator network, and community-based peer group meetings.

When families were ready to engage, they signed up for the Families Helping Families program. This is a 10-week course offered to family members who have a loved one with mental health or addiction challenges. The family program was intrinsic to the HH model. Individuals' mental health challenges have consequences for others within their social networks, most notably their family, and these consequences are largely ignored. When we do not address the whole family's stress, collective mental health challenges grow exponentially. Family participants attended the Families Helping Families program independently from their loved one's journey. The program addresses how to have honest, healthy conversations about difficult situations and how to manage the associated conflict and stress, whether a loved one is ready to seek help or not.




The clients' results were outstanding. Individual clients reported a more than 80% improvement in their quality of care and coordination of care. Families reported a 93% satisfaction with the Families Helping Families Program, and in almost all cases, a family's developmental strengths improved. The Community Peer Navigator network in Airdrie grew from two peers to six peers over a few months, and regular community peer group meetings for individuals and families continue. Clients now have volunteer community supports with lived experience to reach out to between appointments.

The project did have some challenges with tools and processes, as should be expected with a pilot. The lack of an integrated electronic medical record (EMR) system proved challenging for some providers. Although every provider acknowledged the need for a Care Coordinator, there wasn't a clear agreement on where this role should live (clinic versus community). It was challenging to find like-minded physicians to participate in specialized mental health training and adopt a new way of thinking that may be contrary to what they learned throughout their medical education. Finally, ensuring the client comes first as opposed to the system requires everyone involved in the care model to be aligned on what 'client first' means, be guided by core values and principles, and committed to communication within the HH team as well as internally within their own organizations.

The project outcomes led to a clearer vision of how a HH model could work in a community. Based on the pilot period findings, the following steps are suggested to further develop the integrated client care model.


Determine and establish clearly defined roles for the Community Care Team (e.g., Care Coordinator, Community Peer Network Coordinator, and other administrative roles as required) and where this team should reside.

- During the pilot, Talent C performed a readiness assessment for these community roles. Talent C is a firm specializing in mentorship and works with organizations to foster leadership in communities. This work could be further developed and used as a platform for recommendations towards formal adoption and implementation of suitably integrated positions.

Establish a minimum of two community medical clinics to act as the medical home for individuals and provide integrated EMR systems that extend to participating service providers and the Community Care Team, with access on a need-to-know basis.



Proportionally reallocate existing Alberta Government health funding and resources to mental health services:

- Provide individuals with an annual mental health spending wellness account with the caveat that this is only spent with providers and clinics operating within an integrated model. This allows clients to take ownership, accountability, and responsibility for their care and make an informed choice about how and where they spend their health care dollars. This could also incent service providers to participate in an integrated model as they would receive client referrals they might not have otherwise. Further, clients being responsible for their health spending funds could help build accountability into the system based on their impression of service quality.

- Establish a Community Care Team base and, over time, build a Peer Navigator network of those with lived experience.



- Incent service providers and medical professionals to participate by funding their specialized mental health training and certification (e.g., Canadian Society of Addiction Medicine).
- Cover the cost of a Program Manager and formal evaluation for a limited time to track success over a defined period.

## Brain Story Training

Ensure that all participants, including professionals, service providers, and Community Care Team members, take the Brain Story training to ensure common language, knowledge, and awareness.

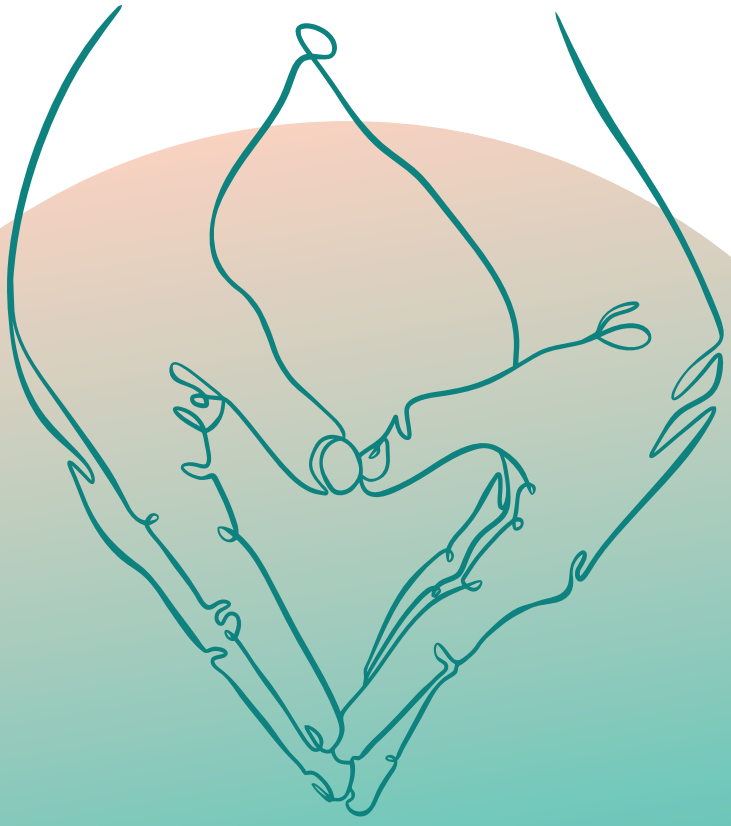
## Living in Recovery Culture

Create a culture that speaks to living in recovery rather than one of being 'treated' in addiction.

## Return on Investment with HH Model

To prove that there is financial and patient care return on investment when using a HH model:

- Add formal AHS tracking of participant costs across the whole health care system over a defined period of time.
- Measure client outcomes over a defined period using surveys and assessment tools.



Airdrie and Area is in a better place than at the start of the HH pilot.

## Airdrie and Area is in a better place than at the start of the HH pilot:

- Two physicians received some level of funded, specialized mental health and addiction training.
- Two clinical practices are invested in the further development of the HH model.
- The volunteer-based Community Peer Navigator team for individuals has grown exponentially since the start of the HH project. Several clients who participated in the HH pilot have become Community Peer Navigators, and community peer group sessions are still taking place.
- Several Families Helping Families programs have been held, a bi-weekly community support group is now operational, and this program has been established as a valuable service that was lacking in the community.
- Work continues on developing a comprehensive assessment tool that works for adults and youth, and community-based intensive outpatient and facilitated group therapy programs.


To move forward, we recommend the creation of a small team that includes HH representatives, the Alberta Government, and other strategic partners to fully understand the HH model for purposes of greater development both within the community model (Airdrie) and the broader spectrum (better definition of roles, etc.) for HH to be taken to other communities. This team could focus on how to move HH to a state of readiness so it can be replicated in other communities. For example, develop the proper training for everyone a client engages with throughout their journey as well as the right tools, e.g., comprehensive assessment and a transparent and mutually agreed-to client care plan.


Until there is a fundamental change in how mental health services are funded in the province, TUF continues to fundraise and pay for individuals' fee-based counselling and family programs on an as-needed basis. This funding model is not sustainable over the long term, but it is taking one step forward in ensuring that no client is left to their mental health or addiction battle because they cannot afford services.

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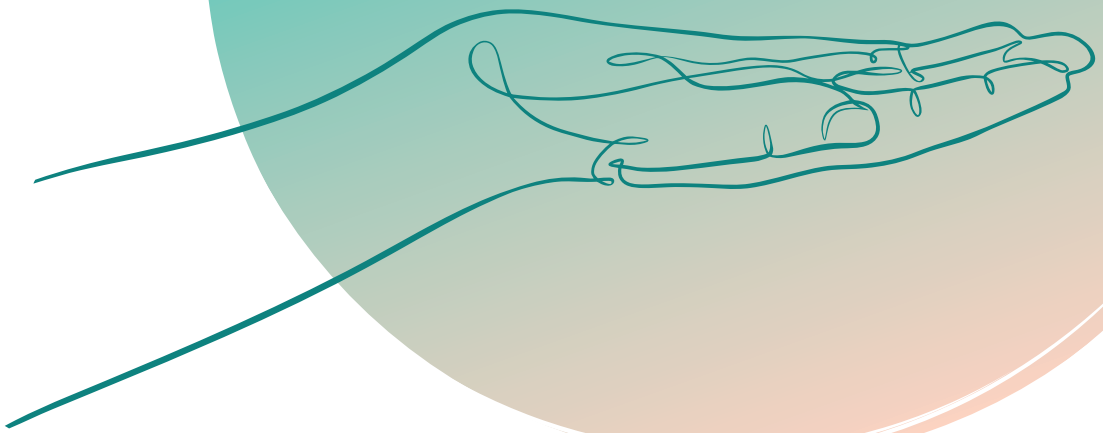


# The Roots of Harmonized Health

Since 2016, TUF has provided in excess of $170,000 to support local initiatives and pilot projects that encourage and promote mental health and awareness.


In 2017, TUF began to form connections with several service providers and another non-profit:

- Airdrie MLA Angela Pitt introduced TUF to Cool Family Solutions (CFS); a Families Helping Families peer support pilot project was subsequently held in Airdrie with very positive results.
- Through word of mouth, TUF was introduced to Anchor of Hope (AOH), an Airdrie-based counselling service for individuals.
- Jim Burns of BURNSWEST introduced Foundation for Addiction and Mental Health (FAMH) to TUF; the FAMH Board Chair introduced TUF to Health Upwardly Mobile (HUM) and the work of Dr. Raju Hajela. HUM is a private clinic in Calgary that offers fee-based comprehensive assessments, intensive outpatient therapy, individual counselling, and access to medical professionals.

In 2017, several meetings between AOH, CFS, TUF, and Al Hepworth (then a FAMH Board member) culminated in an Airdrie and Area community group forming under TUF's leadership to conceptualize a new and different individual-centric care model for mental health and addiction. Occasional update meetings with HUM were held. In the fall of 2018, TUF funded and hired 7 Principles Consulting of Calgary to help facilitate the framework of a Harmonized Health model of care. MLA Pitt also introduced TUF to Care First Medical (CFM) in Airdrie, who expressed an interest in becoming the medical 'home' for the developing model. The services providers were identified based on the value each could bring and how each aligned to what we understood clients' needs to be. Through TUF's efforts, Airdrie was already established as a community of choice for pilot projects and prototypes.

TUF founders had intimate experience with suicide, and TUF was known provincially through their work with CMHA-Alberta and their participation on the Valuing Mental Health Group steering committee through the University of Alberta. TUF established a strong community presence after recognizing the need for an Airdrie and Area Mental Health Task Force, then funding and participating in it. Individuals and their families were reaching out to TUF as a trusted resource. In turn, as an advocacy foundation and not a service provider, TUF was able to refer people to the service provider

organizations they had connected with. As individuals' finances often were a barrier to access services, between 2017 and 2020, TUF funded client services for comprehensive assessments, individual counselling, and the Families Helping Families program. FAMH provided TUF with some financial subsidies for comprehensive assessments performed at HUM. Based on individual and family feedback, TUF began to recognize a client-first care model had validity. As an example, the CFS Families Helping Families program received an approval rating of 93% from the program participants.

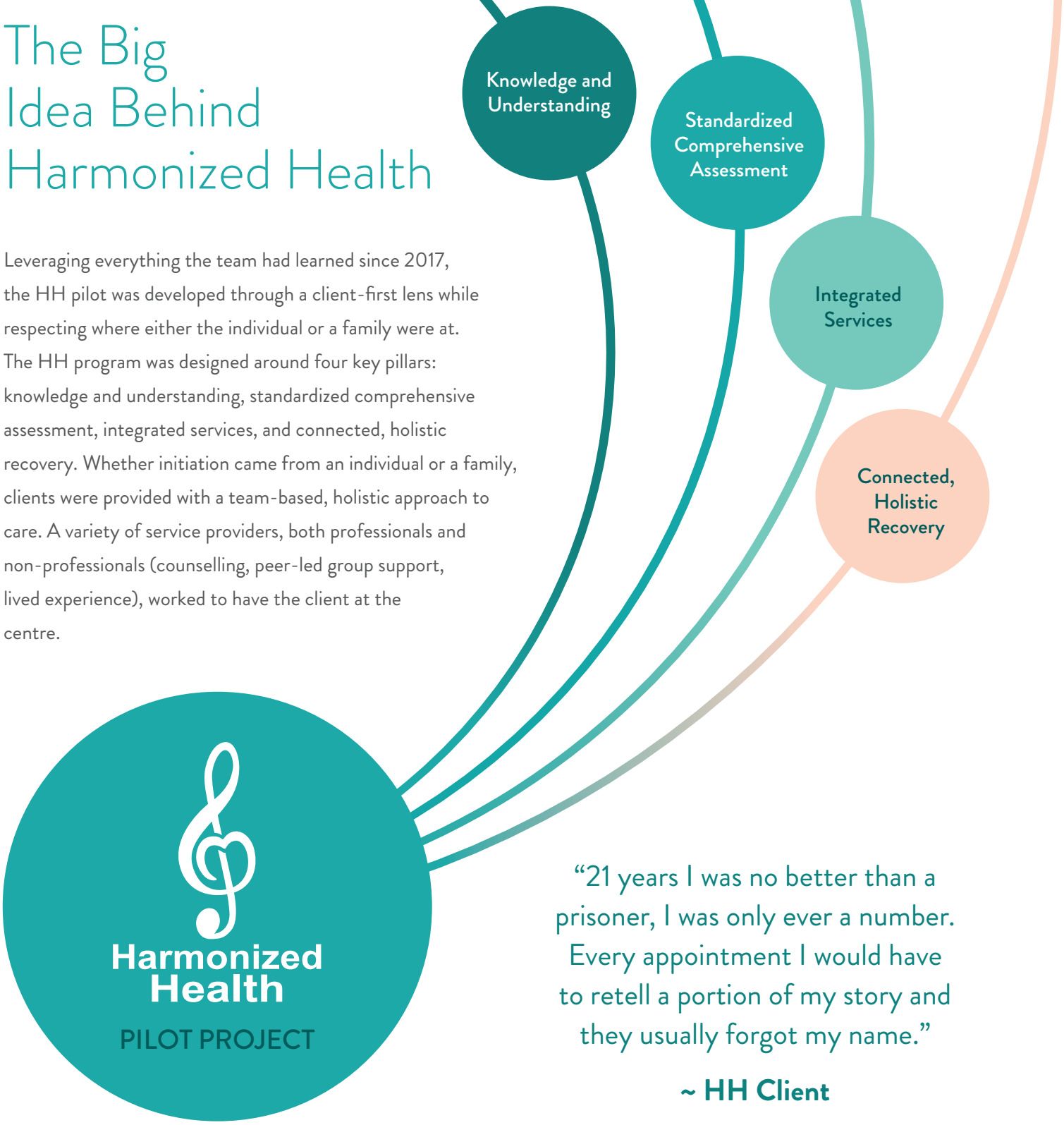
Harmonized Health (HH), as the model would later be named, was refined between 2018 and 2020. Members of the HH project core team (TUF, CFS, AOH, CFM, and HUM) and community volunteers met on a voluntary basis throughout 2018 to 2020, investing upwards of 8,000 hours to fine-tune the model.

"When dealing with mental health challenges, continuity of care is incredibly important, yet does not seem to be the standard that people receive. If I go to a hospital for a medical health care crisis, like a cancer diagnosis or a heart attack, I am likely to see many doctors and nurses and hopefully some of them will become my 'regular doctors' for as long as it takes to resolve my medical concern. That care team knows me and they know my history. Imagine if we took the same approach to continuity of care with mental health concerns as we did with physical health? I imagine broken hearts, broken spirits and troubled minds might be given a greater chance at healing."

**~ HH Client**

# The Big Idea Behind Harmonized Health

Leveraging everything the team had learned since 2017, the HH pilot was developed through a client-first lens while respecting where either the individual or a family were at. The HH program was designed around four key pillars: knowledge and understanding, standardized comprehensive assessment, integrated services, and connected, holistic recovery. Whether initiation came from an individual or a family, clients were provided with a team-based, holistic approach to care. A variety of service providers, both professionals and non-professionals (counselling, peer-led group support, lived experience), worked to have the client at the centre.




"21 years I was no better than a prisoner, I was only ever a number. Every appointment I would have to retell a portion of my story and they usually forgot my name."

**~ HH Client**

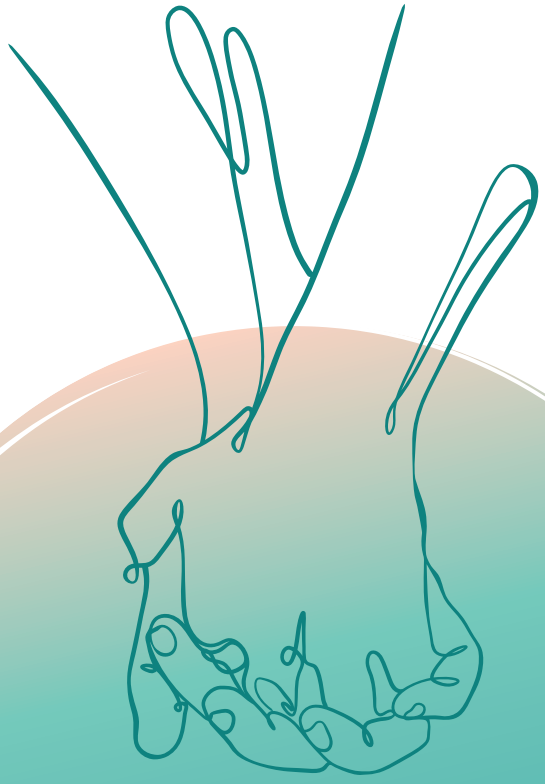
# Key Differentiators of a HH Model

| | Today's System | Harmonized Health Care Model Design Principles |
|---|---|---|
| Knowledge and Understanding | • Viewed, funded, and treated on a symptomatic and acute basis<br>• Access to information is poor<br>• Misconceptions and bad vocabulary = ignorance | • Acceptance that mental health should be akin to dental health (annual check-ups, maintenance plans)<br>• Understanding and acceptance that addiction is addiction, is a disease that is primary, chronic, and progressive, and it can be treated |
| Standardized Comprehensive Assessment | • Comprehensive assessments are not part of the standard of care<br>• Non-integrated approach to assessment and treatment plans<br>• 'Assessment' is done after the symptoms present and are typically life-harming<br>• Individuals can be wrongly diagnosed or labeled (e.g., ADHD), leading them to live up to the expectations of that diagnosis | • Affordable, readily available standardized comprehensive assessment (CA) as the first step<br>• Administered before symptoms become harmful<br>• Uses a health service, multi-disciplined approach<br>• Individuals understand they are 'unhealthy' and not 'bad' |
| Integrated Services | • Lack of specialized mental health resources in the health care system<br>• Lack of recognized, integrated, accredited training<br>• Lack of awareness of treatment options<br>• No coordination between services; patients retell their stories to different providers each time<br>• No access to a community support system between appointments | • A client-first view where each client is met where they are at in their journey and encouraged to be 'the captain of their own ship'<br>• A team-based approach of community members, service providers, and medical professionals help the individual to navigate the system<br>• Individual clients have access to Community Peer navigators with lived and living experience support |
| Connected Holistic Recovery | • Medical aspects are divorced from social and spiritual aspects<br>• Individuals and families have insufficient means (social, financial, knowledge) to obtain services<br>• Recovery plans are left to chance<br>• Family/relationships are often not included | • Individuals are treated holistically, incorporating biological, social, psychological, and spiritual aspects<br>• The client is encouraged to be 'the captain of their own ship' and own their resiliency and recovery<br>• Individual's financial barriers for fee-based services are removed<br>• The CA guides the individual client's recovery plan<br>• The HH team guides the individual through the system<br>• Family/relationships are an intrinsic part of resiliency |

# The Early Days of the Harmonized Health Pilot Project

In August 2020, TUF received a grant from the Alberta Government to test the efficacy of the HH model over a 12-month period. The project was established to test the concept of a community working alongside professionals and service providers to improve client outcomes and not to evaluate the effectiveness of each of the participating service providers. The pilot was designed to give clients the best chance of continuity of care within a community setting.

The pilot was not designed to have all service providers under one roof but rather to layer in a degree of community integration, processes, and technology that would ensure cohesion between the community and providers. A group of key service collaborators worked together with the Community Care Team.



"I think what's novel is we're trying to come at this where every discipline is represented. It is a one-stop shop. The patient is not expected to govern our broken system."

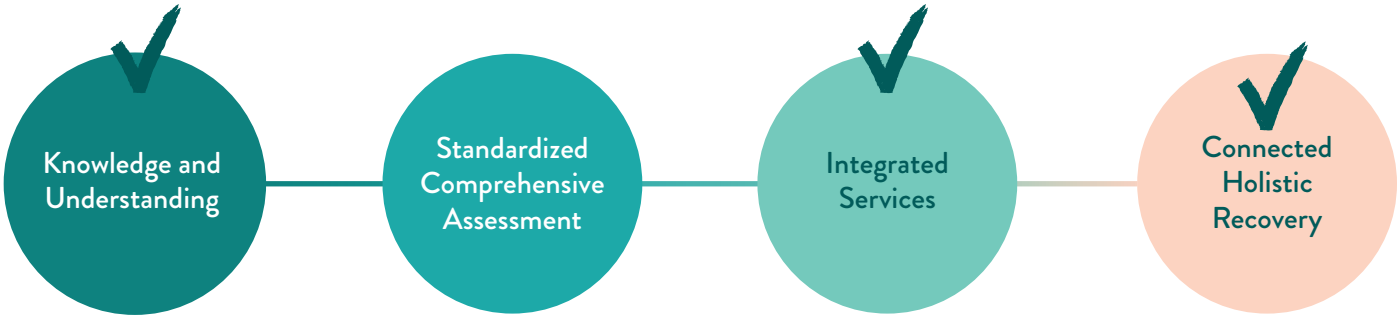
**~ HH Service Provider**

## The Key Service Collaborators

- Care First Medical (CFM), a family medical clinic in Airdrie, agreed to be the medical home for project participants. Over time, they will be set up to perform comprehensive assessments, intensive outpatient therapy, and facilitated group counselling in Airdrie.
- Anchor of Hope (AOH) is a private counselling clinic with training in addiction recovery that offers individual and family counselling.
- Cool Family Solutions (CFS) is an organization that provides a 10-week group program for families teaching them how to engage in difficult conversations. Participants in this program were typically family members who had a loved one dealing with mental health and/or addiction challenges, and their loved one was not typically participating in HH as an individual client. The program addresses the harsh reality that nothing changes if the collective family does not change.
- Health Upwardly Mobile (HUM) is a private clinic with a team of medical doctors, psychologists, social workers, and nurses who specialize in the assessment and treatment of addiction and chronic pain. HUM provides comprehensive assessments, individual counselling, and intensive outpatient therapy. Dr. Raju Hajela of HUM provided some level of specialized mental health and addiction training for medical staff, and HUM's comprehensive assessment tool, intensive outpatient program, and facilitated group therapy were used for purposes of the HH pilot.

## The Community Care Team

A unique aspect of the project was the introduction of a Community Care Team to provide a critical bridge between clients, service providers, and medical professionals. This team had multiple functions, from establishing systems and processes to providing a community touchpoint for clients and connecting clients to a peer community navigator when desired.




The Community Care Team was established at the onset of the HH project in August 2020. Almost all team members had some lived or living association with mental health and/or addiction. Project team members attended an information session with Dr. Hajela and learned about addiction and the common language necessary when interacting with clients and service providers. This team exhibited a great deal of flexibility in adapting to challenges presented throughout the pilot project. The Community Care Team operated virtually due to the pilot taking place during the COVID-19 pandemic.

## The Community Care Team members key responsibilities were:

| | | |
|---|---|---|
| Acting as the initial point of contact for clients interested in learning about the HH project | Connecting participating HH clients to Community Peer Navigator network | Connecting interested families with the CFS Families Helping Families program |
| Establishing HH project processes | Establishing an IT strategy for the HH pilot | Establishing HH project evaluation outcomes |
| Providing HH project management | Engaging the professional project evaluator | Organizing training and symposiums |

## This team consisted of:

| Role | Role Description |
|---|---|
| Program Manager | A HH contract position funded by the grant and established to:<br>• Provide project management and oversight, including developing the project charter and providing ongoing scope, timeline, and budget management.<br>• Monitor project readiness.<br>• Lead project risk management and contingent approach management.<br>• Lead the development of HH processes, procedures, data flow maps, and IT strategy, which required multiple iterations after input from participating providers.<br>• Coordinate the evaluation processes and data collection.<br>• Establish the community peer support system and associated operating guidelines.<br>• Facilitate ongoing meetings with TUF, service providers, and the Community Care Team.<br>• Participate in HH presentations. |

| Role | Role Description |
|---|---|
| Care Coordinator | A volunteer position established to:<br>• Be the first point of contact for clients by meeting them (individuals and families) where they were at.<br>• Listen actively to seek to understand whether they were at the pre-contemplative, contemplative, or action stage.<br>• Provide information on the HH project and the general expectations for them and the project.<br>• Provide high-level information on HH programs and philosophies, including addiction as a brain disease and the concept of 'unhealthy' versus 'bad.'<br>• Introduce the notion of the client being the captain of their own ship and the need for OARS (Ownership, Accountability, Responsibility for Self).<br>• Provide connection to the medical clinic for intake when and if the client was ready to participate.<br>• Establish participants for the Families Helping Families 10-week program and explain how this program fits into the overall HH model.<br>• Provide ongoing information and respond to inquiries from either individuals or family participants.<br>• Do occasional client check-ins throughout their journeys and periodic check-ins with those still in the contemplative stage.<br>• Provide advocacy support for the clients. |
| Operations Coordinator | A non-client facing HH contract position funded by the grant and established to:<br>• Facilitate communication between the service providers and the HH team.<br>• Ensure providers worked together to update client tracking systems so evaluation data was accurate and readily available.<br>• Host bi-weekly service provider meetings, taking minutes and disseminating notes.<br>• Provide IT support to the participating team. |
| Community Peer Network Coordinator | A HH contract position funded by the grant and established to:<br>• Act as a community peer support to provide individual clients with lived experience information on comprehensive assessments.<br>• Align community peer volunteers with participating client requests.<br>• Introduce clients to a suitable peer navigator upon request<br>• Host weekly group check-in sessions.<br>• Coordinate monthly no-cost community education and awareness sessions related to mental health and addiction (e.g., nature therapy speaker, intensive outpatient therapy video). |

| Role | Role Description |
|---|---|
| Community Peer Navigators | Volunteer community roles established to:<br>• Provide clients with a local community contact with similar lived experiences, available as a touchpoint between service provider appointments.<br>• Peer navigators and individuals continue to meet on a weekly basis to share experiences that promote learning and support for each other. |
| Community Peer Group Facilitators | A volunteer group of community members including:<br>• One facilitator of regular virtual weekly recovery meetings for individual clients of HH. (Peer group sessions are facilitated by community members and provide those in recovery with a space to share their journey and seek advice from others who have similar lived experiences.)<br>• One facilitator of bi-weekly learning and support meetings for participants of the Families Helping Families program. |
| Evaluation Administrator | A temporary community role established to:<br>• Distribute, collect, and provide oversight for both the client baseline and post surveys.<br>• Extract the survey data for the evaluation team. |

## Community Care Team Highlights

- Taking into consideration the 12-month duration of the pilot, the limitations on the number of overall participants in combination with certain budget and service provider constraints, Dr. Jacqueline Smith, Ph.D., RN and Assistant Professor of the Faculty of Nursing at the University of Calgary and Valge Research Group, helped determine the Care Coordinator role would be best filled by the founder of TUF, acting in a volunteer capacity. This determination was made as well because of an established pattern of individuals and families already regularly reaching out to TUF for assistance, as well as TUF's presence and reputation within the community.

**12 month pilot project highlights**

- Upon intake at CFM, individuals signed a consent form acknowledging they were participating in a pilot project and giving permission for their information to be shared among service providers, the project leadership, and the evaluation team.
- A true integrated multi-clinic electronic medical record (EMR) system was not in scope of the HH pilot. Some service providers did express early concern about the strategy of using multiple, temporary EMR systems. Others expressed concerns that the overall requirements of a truly integrated, multi-clinic EMR were not understood well enough to incorporate into a 12-month pilot project.
    - Each clinic and service provider has its own EMR system, and they were asked to use two more systems to track patients in addition to maintaining their own clinic's system.
    - Some individuals started their HH journey before Care First Medical (CFM) was established as the medical home, so using the clinic's EMR was not possible at the outset of the project.
    - Because the number of individual and family pilot participants were very limited and grant funding allowed for $14,000 to cover IT applications, a temporary and low-cost solution was established and agreed to for the 12-month project. The understanding was that the HH project would use the pilot period to seek to understand the requirements of an integrated EMR. Airtable, an off-the-shelf application, was recommended for purposes of tracking client progress through the various stages of care and acting as a data depository at key points. This data was to be accessed by the appointed program evaluations team. To maintain data confidentiality, a bespoke designed product called Nula was developed by a consultant to provide service providers and medical professionals with an additional layer of client information that could be viewed between themselves on a confidential and need-to-know basis.
- The team invested significant time in defining an outcome-based logic model to determine what the project was trying to achieve and how the team would understand success. This work was facilitated by Valge Research Group and guided by the expertise of Dr. Jacqueline Smith.
- In mid-2020, Valge Research Group secured permission for the HH project to be able to use C-PROM at no cost. C-PROM was developed by Canadian Dr. Skye Barbic, Ph.D. and scholar in the area of mental health and outcome measurements. C-PROM is a patient-reported questionnaire that ranks their response to 30 questions individually on a scale of 0 (none of the time) to 4 (all of the time). The client's total score is divided by 4 to determine an adjusted score. The highest possible C-PROM adjusted score is 30.
- Due to COVID-19 restrictions, the team was not able to hold a community-wide symposium. A virtual symposium was held in October 2021.

**C-PROM**
is a patient-reported questionnaire that ranks their response to 30 questions individually on a scale of 0 to 4.

# Key Community Care Team Deliverables

## Project Processes

Multiple iterations of process drafts were developed and circulated among service providers and Community Care Team participants for input and signoff.

- A Client Consent Form was developed and vetted through participating service providers and TUF's legal team.
- The Client Journey Process Map ensured client continuity of care and established points at which data was to be collected.
- The Client Recovery Passport was a folder provided to clients containing a FAMH brochure on addiction, signed consent form, a schematic of their resiliency and recovery team (professional care team and community supports), their C-PROM results, their personalized recovery care plan, and copies of their pre- and post-experience surveys. The passports were designed to be a way for C-PROM interfaces to be tracked and encouraged by service providers.
- A Community Peer Navigator handbook was developed.

## Evaluation Strategy

To assess project success, the team agreed to use:

- C-PROM for individuals
- Family Resiliency Assessment Tool for family programs
- Client baseline surveys were completed, capturing their experiences prior to HH.
- Client surveys were also completed at the end of the project capturing their HH experience.

Three Hive Consulting produced a mid-term and a final evaluation report.

## IT Strategy

Highlights of the IT strategy included:

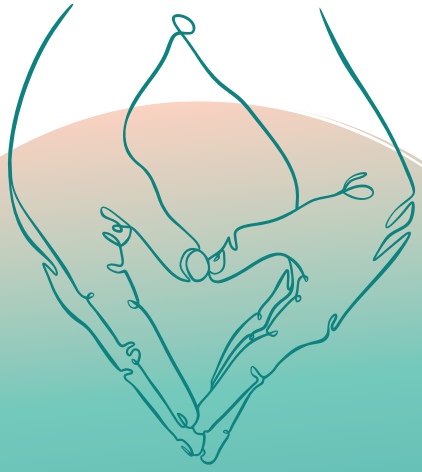
- Nula: an access-restricted database used by physicians and service providers to store confidential patient information on diagnosis, C-PROM scores, treatment plans, medications
- Airtable: database established to store client demographics, meeting appointment dates, Community Care Team notes
- Microsoft Teams: for regular messaging, sharing of non-confidential files between Community Care Team and participating service providers, and bi-weekly video meetings
- Microsoft Excel: As the pilot progressed, some providers requested an easier system of viewing individual client contact information and appointment dates, provider involvement, and community peer navigator involvement. The Operations Coordinator began to extract key data regularly from Airtable into an Excel spreadsheet and made the spreadsheet available in Teams. The Care Coordinator also used Excel tracking sheets to track client touchpoints and families participating in CFS programs.

## Project Management

- Scope, budget, risk tracking
- Project team meeting cadence to provide an avenue to discuss client status, process challenges, IT challenges, training requirements, and project successes. These meetings provided the ability to be agile and to respond and improve tools and processes in a timely manner.
    - bi-weekly service provider meetings
    - weekly Community Care Team meetings

# Key Community Care Team Findings

Core findings presented are a result of interviews with Community Care Team members, the Three Hive Consulting Final Evaluation Report, and the *Harmonized Health Healing Journeys* collection of client stories.



"We need the community to be involved in our recovery, without that connection we are all wandering in the dark and dying."

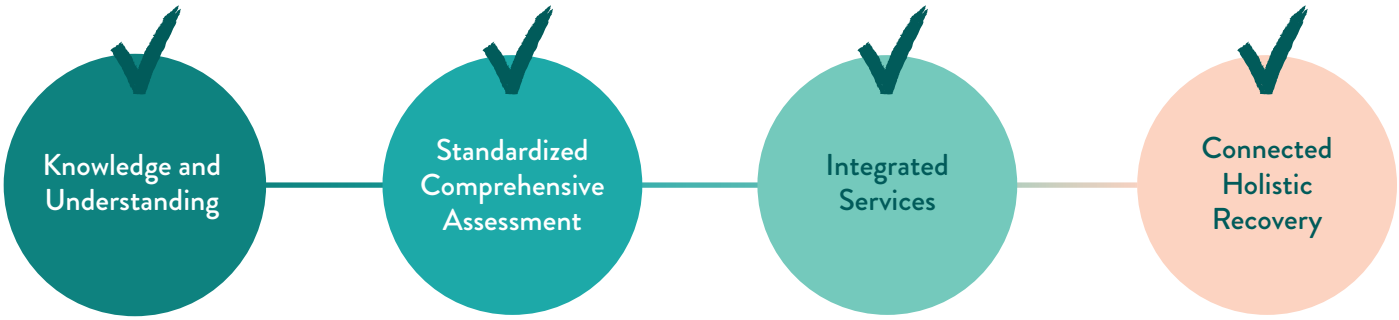
**~ HH Client**

- Clients valued having a Care Coordinator that was independent of service providers and medical professionals and could act as an advocate on their behalf. The Care Coordinator established initial relationships and advocated and aligned service providers. Further assessment is needed on where this role should reside, how it could be funded, and what functions the role should perform.
- Clients see the Community Peer Navigators as critical to their ongoing recovery. They wanted a place to share their stories with people with lived experience and to whom they could reach out to between appointments. Community Peer Navigators found that volunteering in this role also helped with their own recovery.
- Not all client interactions with the Care Coordinator resulted in clients signing up for the HH pilot. Client interactions were tracked, and it became clear the establishment of a trusting relationship sometimes took time, as did the client moving from pre-contemplative or contemplative to action.
- The Client Recovery Passport and Client Care Plan were designed as tools to aid integration and bring a collaborative client-first approach to care, which involved the client, service providers, and community peer-led support services. The intention of having individual clients 'own' their care plan was deemed necessary to ensure they took ownership, accountability, and responsibility for their recovery. An opportunity was identified to use IT to link the Client Care Plan and C-PROM (and with it any subsequent updates as the client engaged in their professional services and community support) directly to an EMR for consistency and efficiency. Due to funding restrictions, this idea was not implemented; however, it warrants further consideration.
- The IT strategy, as expected, was not without its challenges. However, the Community Care Team felt they did everything possible within budget and time constraints while servicing evaluation requirements to provide a means of capturing data within a pilot framework while maintaining a line of sight on what key features could be embedded in a future version to sit alongside a fully funded integrated model.

- Regular bi-weekly meetings were established with the Community Care Team and participating service providers. Although this cadence was set up to seek regular, ongoing project input, attendance was at times sporadic, communication problems persisted within some provider's own organizations, and some key issues and concerns were not raised until very late in the project.
- Service providers were encouraged to use the communication tools and processes that were available such as MS Teams Messaging, Airtable database, Nula database, one to one and mini 'offline' meetings between themselves, and the routinely scheduled meetings to deal with the fluid and evolving nature and challenges of individual client care.
- A process was put in place to deal with exceptions to the 'usual' client continuity of care procedure (e.g., clients getting counselling outside of AOH); however, this process was not always followed.
- Because this was a pilot project, and it took place in the middle of a pandemic, things continually evolved. The ability to adapt quickly to unforeseen changes and have these changes communicated appropriately was essential. On occasion, this was lacking or proved challenging, although the addition of Microsoft Teams as an internal communication tool helped.
- The Community Care Team was able to establish strong connections with participating individuals and clients even while operating virtually.

# Harmonized Health from the Client Lens

Clients who participated in the HH project generally had years of unsuccessful experiences within the current health care system when seeking treatment for their mental health and/or addiction challenges. The 2018 Airdrie Mental Health Task Force report surveyed 545 adults, and almost 50% reported their needs were either not met or inadequately met. This is a key reason that clients, their families, and their loved ones continue to reach out to TUF—they have not been able to receive meaningful support and resources. If their needs were being met, these clients would not still be seeking help.



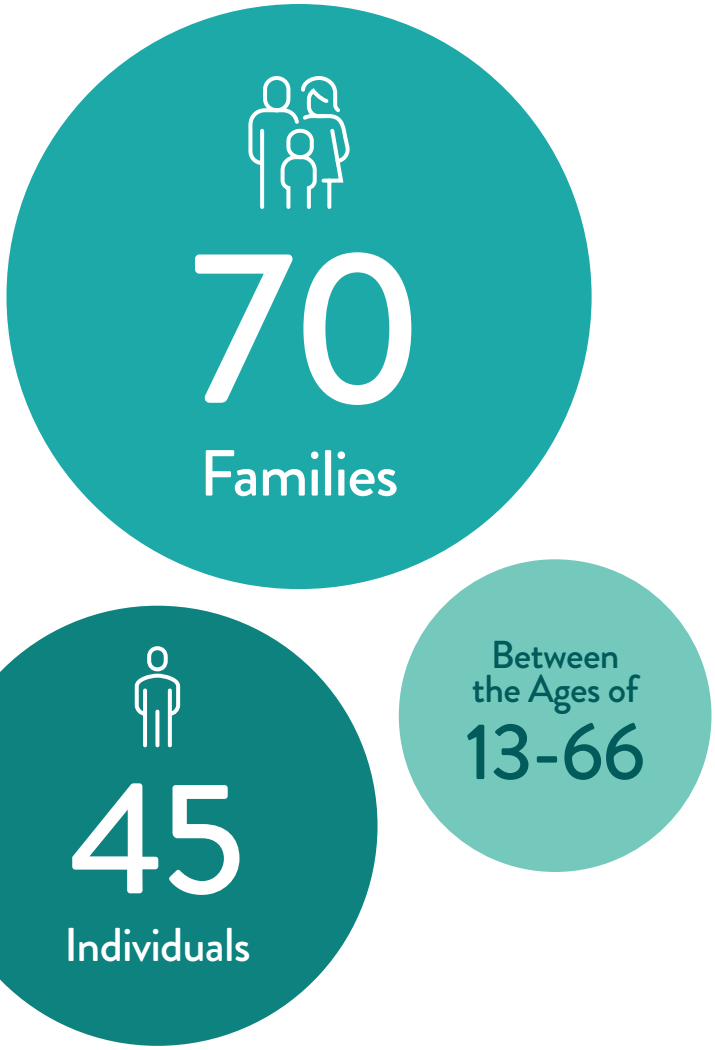
"Prior to meeting the
Titus family and Harmonized Health,
I had sought out every avenue this province
had to offer. I have been seeing professionals and on
medication since 1985. Through years of every different form
of abuse over 30 plus years, I was given the labels of Borderline
personality disorder, PTSD, Anxiety, Depression and ADHD. With
Harmonized Health, I felt like there was someone there to support
me at all times and I have never felt like just a number."

**~ HH Client**

## The Clients

The project funded some mix of mental health services for 45 individuals and 70 family members. The majority of clients were between the ages of 40 and 59.

TUF was aware that they could not advertise for HH participants within the community as demand may substantially outweigh the available project funds for clients' fee-based services. If demand was too high, the service providers would not have the ability to provide timely services within a 12-month period. TUF was well-known due to their founders' intimate experience with suicide, for their advocacy role, and because of their prior investment in services funding for comprehensive assessments, individual counselling, and the Families Helping Families pilot program in the community.



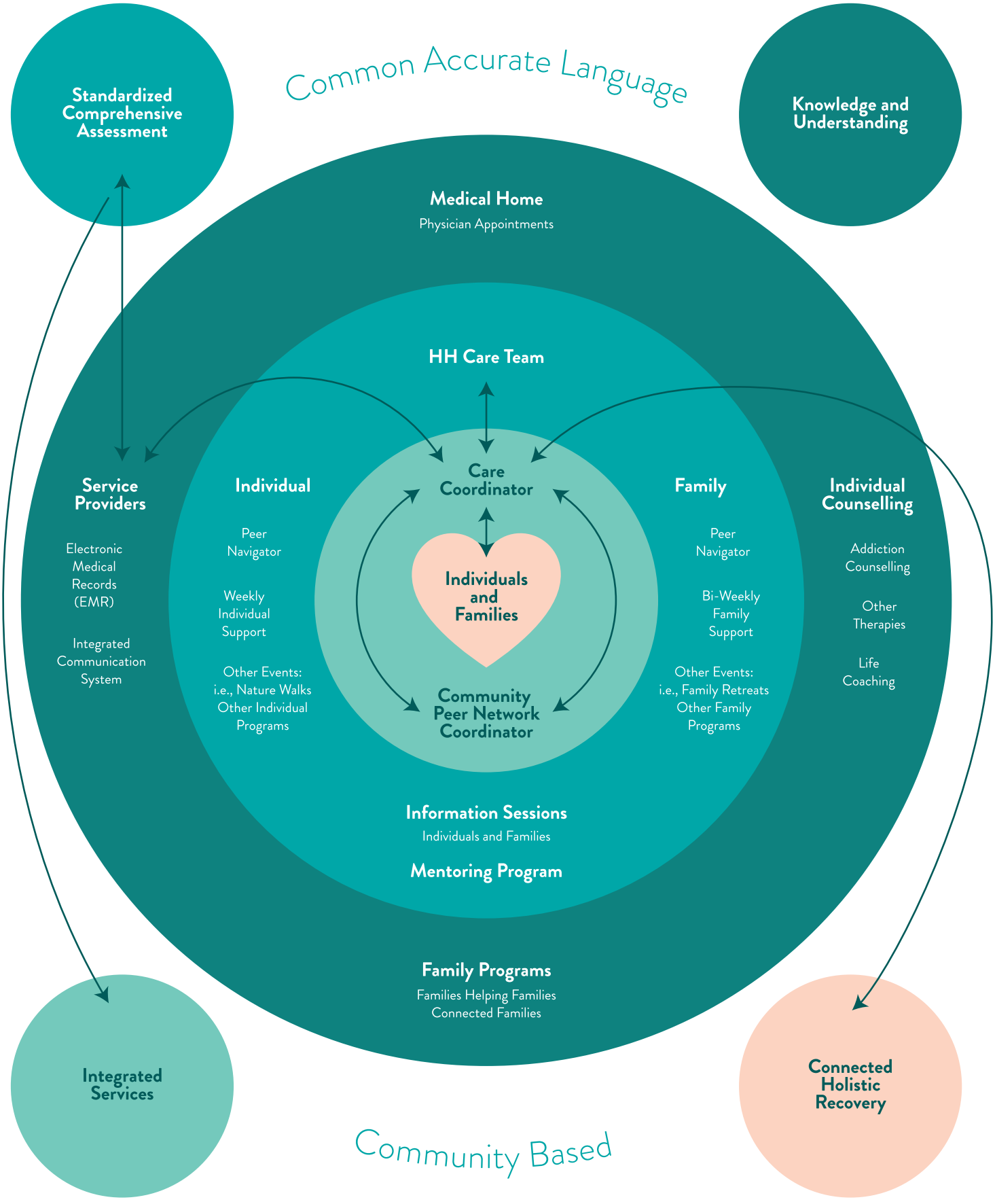

### HH clients were referred to the HH project's Care Coordinator through:

Service providers whom TUF had a past relationship with (e.g., CFS, AOH, CFM)

Direct awareness of and connection to TUF (via fundraising events, community presentations, word-of-mouth, etc.) through information disseminated in the community

HH clients who were experiencing positive outcomes because of their successful participation with HH

# The Client Process



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STEP 1

## Connecting with Care Coordinator

Clients initially connected with the HH project through the Care Coordinator. The Care Coordinator listened to the client's story, advised them on the HH pilot project, and met clients where they were at. Clients themselves determined whether the information provided to them resonated and whether they wanted to proceed.

- Of the 54 individual clients who expressed interest in HH, 17% of them did not engage. The remaining 83% of individual clients participated in some combination of HH services.
- Seventy family members participated in the Families Helping Families program.

Once the individual clients or family members determined their level of participation, the Care Coordinator referred the individual clients to CFM or family members to CFS for intake.

Family members who participated in the CFS Families Helping Families program did not move on to steps 2 through 5 (below). The family member participants had an initial discussion with the Care Coordinator. Past results from previous sessions were shared, and an explanation of the HH model overview was provided. When they were ready to proceed with the family program, they were connected with CFS for intake. Intake included interviews, questionnaires, and information on the next program's availability. If the family were not quite ready to begin, the Care Coordinator would reconnect with them to advise when program space became available.

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2

STEP 2

## Medical Home Established

The HH project team agreed that participating fully funded clients needed to be attached to a medical home at CFM for purposes of their mental health and/or addiction concerns; however, this did require some ramp-up time. For the first two months of the pilot, CFM searched for like-minded physicians willing to participate in mental health and addiction training. In the interest of moving the project forward and as an interim measure, a HUM physician worked part-time out of CFM, allowing CFM time to find a physician willing to participate.

Once the client agreed to participate in the HH project, at the client's first CFM appointment, the client was seen by the Clinic Manager and then a physician. The client signed the HH consent forms, received a Client Care Passport, and completed their initial C-PROM. If the client already had a family physician, this physician was advised (by letter) that their patient was accessing additional mental health services through CFM. If a client did not have a family physician, they were advised that they could receive ongoing physical and mental health care at CFM. Of the clients seen at CFM, 42% were not already attached to a family physician.

The clinic would then connect the individual with the Community Peer Network Coordinator.

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3

STEP 3

## Connected the Client with the Community Peer Network Coordinator

The Community Peer Network Coordinator emailed the basic information about the HH program to clients and was also available to answer any general questions through their lived experience lens. Typically, questions were related to the comprehensive assessment. At times, the Community Peer Network Coordinator helped the client set up their comprehensive assessment appointments with HUM and set up Community Peer Navigators if the client wished.

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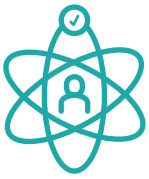
STEP 4

## Comprehensive Assessment Was Completed



A comprehensive assessment takes a deep dive into a client's history to investigate root causes, make an accurate diagnosis, provide a medications review, and determine an appropriate, individualized treatment and recovery plan. It takes a deeper dive into family history and current relationships, the past and present social situation, values, and psychological and biological factors.

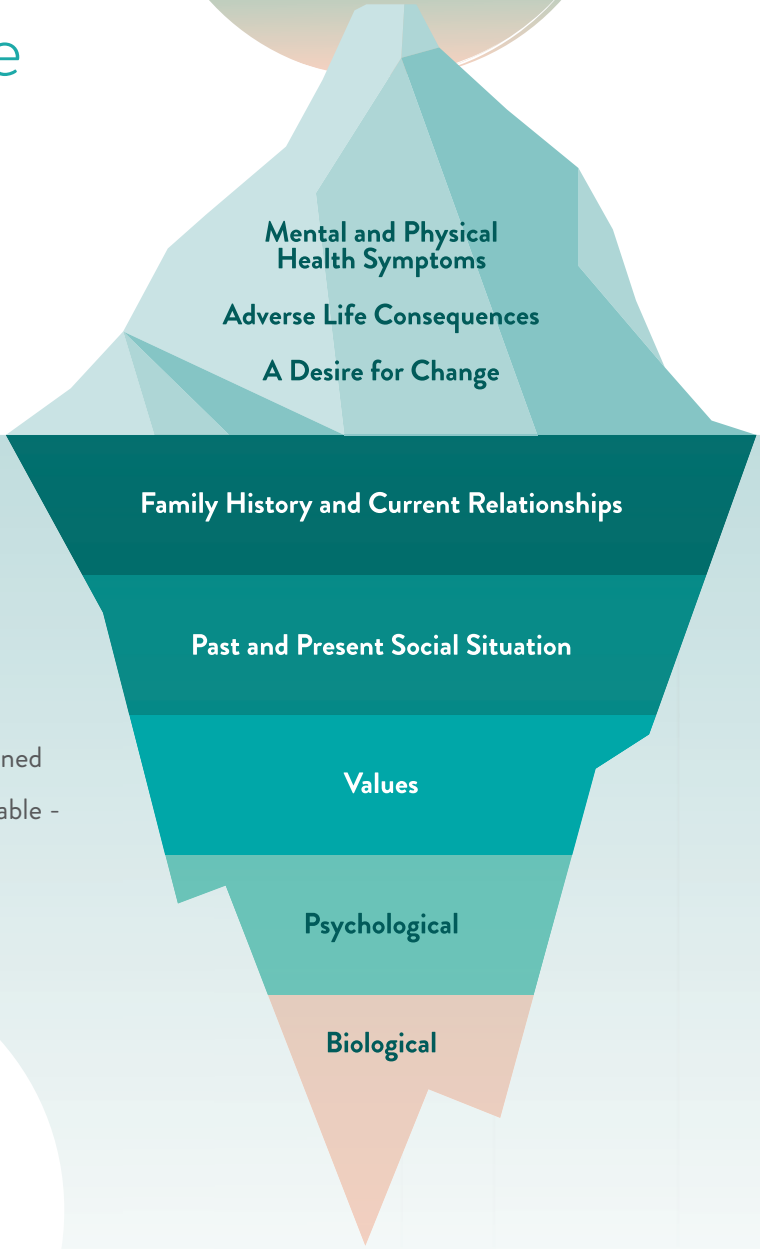
The assessment provided the individual with accurate knowledge and understanding and a true perspective on where they were at in the starting point for their mental health wellness journey.

# Why a Comprehensive Assessment?

It provides the means to address progressively worsening situations negatively impacting quality of life.

"Resiliency is the psychological and biological strengths required to successfully master change."

**~ Fredric Flach**




## Full Assessment of Root Causes

- Accurate diagnosis
- Treatment and recovery plan determined
- Ongoing encompassing services available - professional and non-professional

Conventional approaches to building resiliency usually do not take into account the biology and chemistry of our being.

| | HH Project Funded Cost Per Participant | Participants | What the Program Covers |
|---|---|---|---|
| Standardized Comprehensive Assessments | $400 total for 3 sessions and $200 deposit | 30 individuals x 3 sessions per individual | • **Part 1:** An RN met with a client to gather background information regarding the client's biological, psychological, social, and spiritual history.<br>• **Part 2:** A Registered Psychologist or Social Worker met with the client to expand on the data collected during the first session.<br>• **Part 3:** A physician met with the client to review information collected, analyze medications, and provide recommendations for an individualized treatment plan depending on the individual's needs and interests. These recommendations could include intensive outpatient therapy, individual counselling, and/or facilitated group therapy in combination with recommendations for yoga, journaling, and 12-step programs. The client determined which services they would participate in. |

STEP 5

## 5 Client Engaged in Agreed-To Recommendations from the Comprehensive Assessment

The key mental health care program components differed for each client depending on the results of their comprehensive assessment. The results were documented in the Client Care Plan and agreed to by the client. As individual counselling was a key component in the recommendations, prior to a client engaging in the counselling, they were advised to do an initial 'meet and greet' to ensure the right relationship fit.

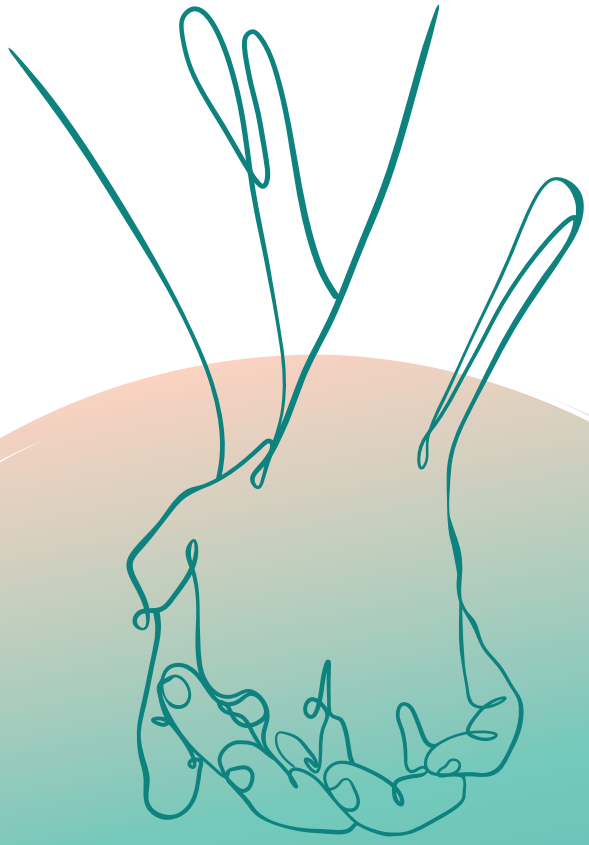
## Services provided by the HH project included:

| | HH Project Funded Cost Per Participant | Participants | What the Program Covers |
|---|---|---|---|
| Ongoing Physician Appointments at CFM | N/A (Covered by AHS) | 44 ongoing appointments | • Physician/client discussions about mental health, physical health, and medications. Clients determined when they felt it necessary to visit their physician. |
| Intensive Outpatient Program | $5,000 per participant | 5 individuals<br>2 physicians | • For the purposes of the pilot, HUM's Intensive Outpatient Program was utilized. This is an 18-day program (144 hours) over 3 months and includes 3 phases.<br>• The program was designed for people who have already completed the comprehensive assessment at HUM and where intensive treatment for addiction in an outpatient format was recommended in their recovery plan.<br>• Participants learned what addiction is and how it impacts different aspects of their lives. |
| Individual Counselling | $1,500 for 10 sessions | 89 sessions at AOH<br>9 sessions at HUM | • Provided generally by AOH with approaches uniquely tailored to the individual.<br>• Therapies can include addiction treatment, as well as cognitive behavioural therapy and dialectic behaviour therapy, as examples.<br>• Sessions incorporate body, mind, and spirit.<br>• Opportunities for alternative counselling provisions were accommodated outside the agreed-to process on a case-by-case basis (i.e., chronic pain management). |
| Facilitated Group Psychotherapy | $70 per session per attendee | 5 clients participated over 12 weeks | • Weekly group therapy sessions were facilitated by medical professionals over 12 weeks and were hosted in person. |

| | HH Project Funded Cost Per Participant | Participants | What the Program Covers |
|---|---|---|---|
| Community Peer Navigators | $0 | 81 community peer check-ins | • Community volunteers with lived experience and who are in recovery themselves were paired up with clients to walk them through what to expect, from the comprehensive assessment through ongoing recovery.<br>• Peer meetings were done by text, by phone, or at times in person. |
| Peer Group Facilitation | $0 | 16 clients participated over 16 weeks | • Virtual group sessions by facilitators with enough recovery experience were facilitated by community members.<br>• Their experience included the ability to organize and facilitate a group of HH clients for regular recovery meetings. |

## The family training program was provided by CFS throughout the HH pilot:

| | HH Project Funded Cost Per Participant | Participants | What the Program Covers |
|---|---|---|---|
| Families Helping Families Training Program | $300 per 10-week course, per participant + GST<br><br>This was a discounted rate established for the HH pilot. | 7 overall sessions with 70 family participants | • Family program participants were family members with a loved one facing mental health and/or addiction challenges regardless of loved one's state of readiness for change.<br>• The sessions did not typically include participation from the HH individuals themselves.<br>• Participation from HH individual clients were determined on a case-by-case basis.<br>• The Care Coordinator guided the family to CFS, and CFS provided their intake. |



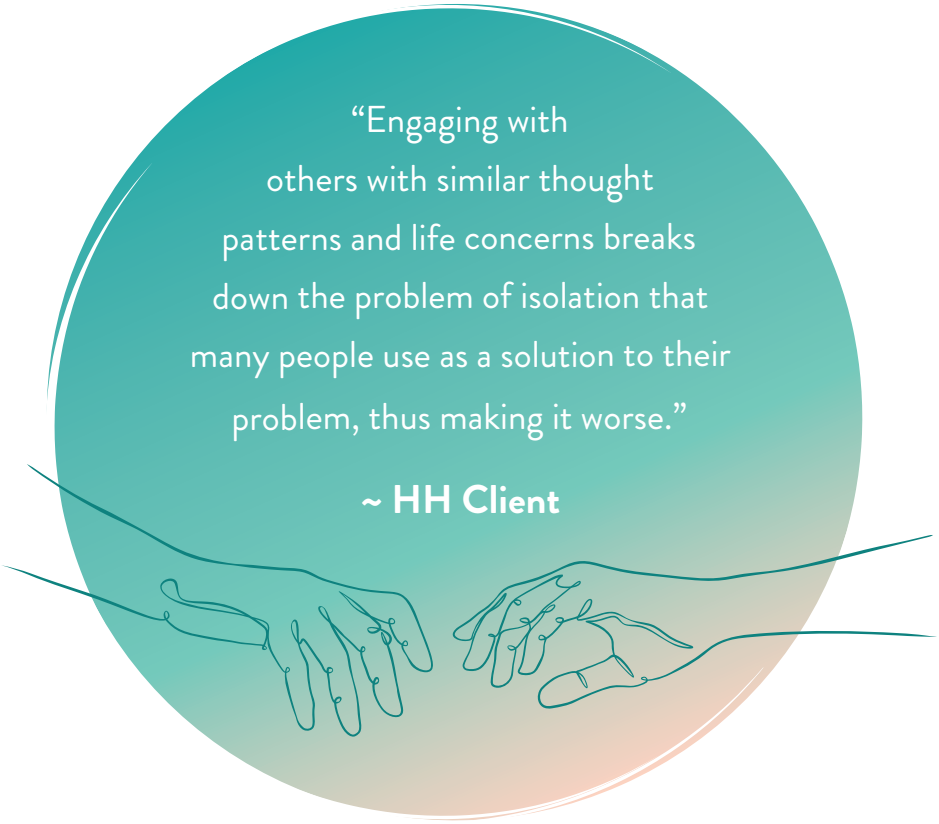
"I can't say that any one part of it has been better or more valuable than the others. Each piece, whether individual counselling or group therapy, functions like a spoke on a bicycle wheel. Each spoke contributes greatly to the wheel's ability to provide a safe, smooth ride for the rider. Take out one spoke and you might be able to still ride the bike, but you might not have the best ride either."

**~ HH Client**

# Key Client Findings

The client findings are extracted from the Three Hive Consulting Final Evaluation Report and the *Harmonized Health Healing Journeys* collection of client stories.

- Clients appreciated the person-centred approach of the HH model—that they were no longer 'just another number.' They wanted someone to treat them as a unique individual, taking the time to listen to their story, and guide them on their recovery path. They wanted a safe space to put up their hand and reach out for help.
- Clients reported that removing fee-based costs as barriers was a significant determining factor in seeking and accessing quality care.
- Families who participated in CFS Families Helping Families noted this was the first time the focus was put on them as the caregiver. If even one person in the family made a positive change, it had a ripple effect on those around them.
- The Community Peer Navigator system was used extensively. Participating individuals checked in with their Community Peer Navigators 6.75 times on average during the pilot, and 50% participated in community support groups. On average, these same clients had 7.4 individual counselling sessions with AOH, 3 visits with HUM, and 3.6 CFM medical appointments.



# Measurable Client Outcomes

## Individuals

70% of the clients reported that the comprehensive assessment definitely encouraged them to seek care for their mental health concerns.

Clients reported an **81% improvement** in their satisfaction with their quality of care.

Prior to participating in HH, no clients were completely satisfied, and only 14% were very satisfied with their quality of care.

After participating in HH, 73% of clients were completely satisfied or very satisfied with their quality of care.

Clients reported an **83% improvement** in the coordination of their care.

Prior to participating in HH, no clients were completely satisfied with the coordination of their care, and 17% were moderately satisfied.

After participating in HH, 50% of clients were completely satisfied with the coordination of their care, and 50% were moderately satisfied.

# Measurable Client Outcomes

## Individuals

There was a **35% improvement** in client comfort levels with sharing their personal experiences honestly and fully with their care providers.

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Prior to participating in HH, 50% of clients were always or almost always comfortable sharing their personal experiences honestly and fully with their care providers.

After participating in HH, 77% of clients were always or almost always comfortable.

On average, client C-PROM scores increased from 15 to 18.3 on a 30-point scale.

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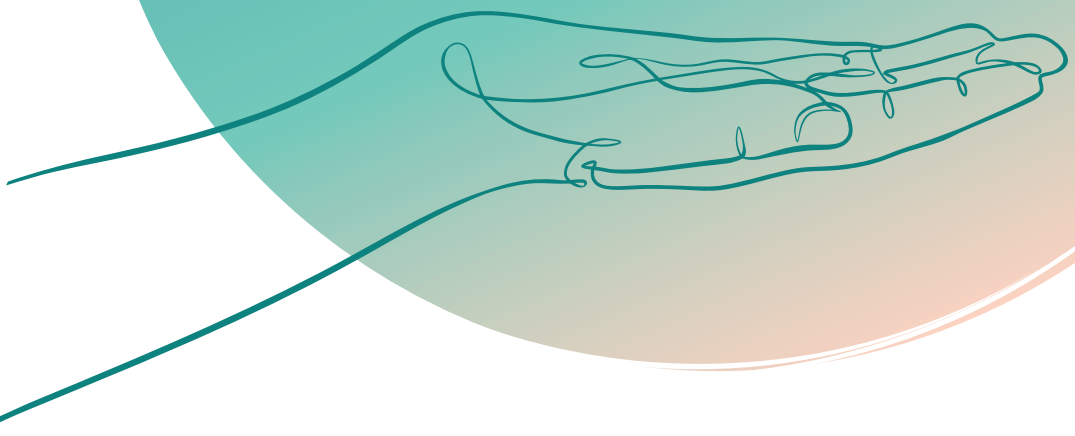
An average of 5.9 C-PROMS per client were completed during their HH journey.

"I wish we attended
this group 4 years ago when our hell
started. I think this should be widely available
and advertised for all struggling families who could
easily use the help to better themselves and their families.
It's a sin to have to beg for money to help those who
suffer from mental health."

**~ HH Families Helping Families Participant**



# Measurable Client Outcomes

## Families

**57**
Families Participated

**7**
Total Sessions

**70**
Total Participants

**70%**
Women

**30%**
Men

**13**
Couples

**44**
Singles

Families expressed an overall 93% satisfaction with the CFS Families Helping Families program.

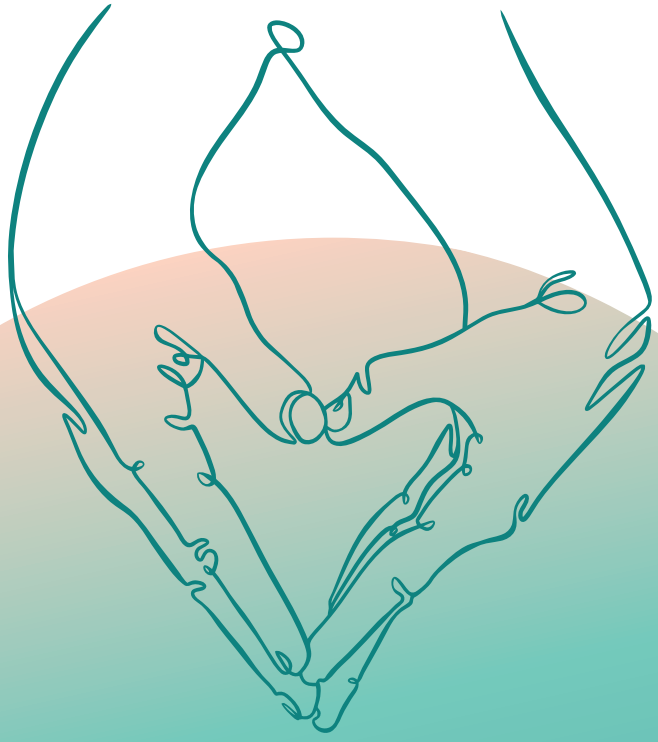
**93%**
Overall Satisfaction

On average, the developmental strengths of most families improved. Families experienced:

**13%**
Improvement in Persistence

**15%**
Improvement in Community Cohesiveness

**12%**
Improvement in Self-Sufficiency



"We were dealing with some difficult issues and each week we felt better equipped to handle our own emotions so that we could better help our struggling family member. My husband was quite reluctant at first, and I could see him learning a lot and taking it into practice more and more each week. It also helped us as a couple to better communicate. We were lucky to be in a fantastic group where everyone made each other feel comfortable and heard."

**~ HH Families Helping Families Participant**

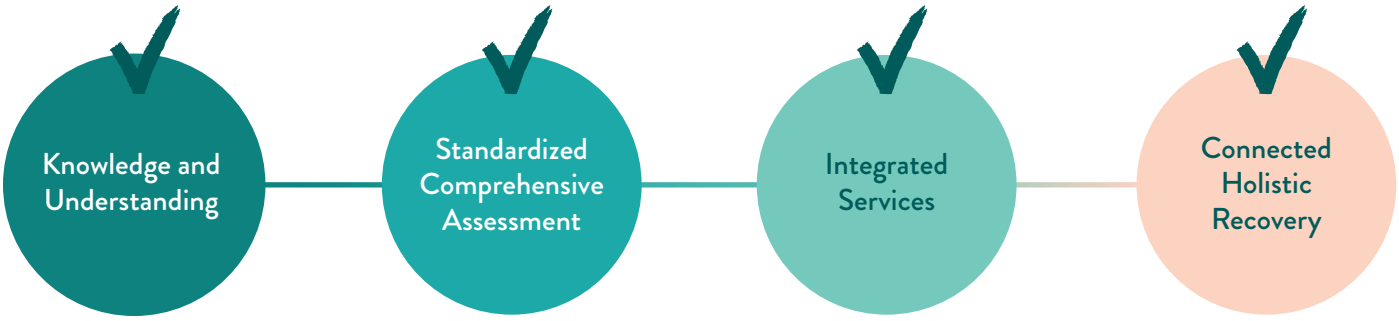
## Client Transition Process from HH to Ongoing Community Care

As the HH pilot phase wrapped up in August 2021, a formal client transition included the following steps:

- Each participating client's files (Nula and Airtable) were transitioned to the CFM clinic.
- HH clients met with a social worker at the clinic to ensure consistency of an ongoing medical home for these participants.
- HH clients were provided with contact information for each service provider.
- For those HH clients who wanted it, the HH team ensured that a Community Peer Navigator was assigned.
- Clients also were asked for permission to remain on a distribution list to receive advisories relating to future Airdrie and Area-based services, such as facilitated group support and ongoing TUF and HH developments.
- Clients were reassured that they could continue to seek services from the participating service providers; however, the client may have to self-fund the services as HH project funding stopped.

# Harmonized Health Through the Service Provider Lens

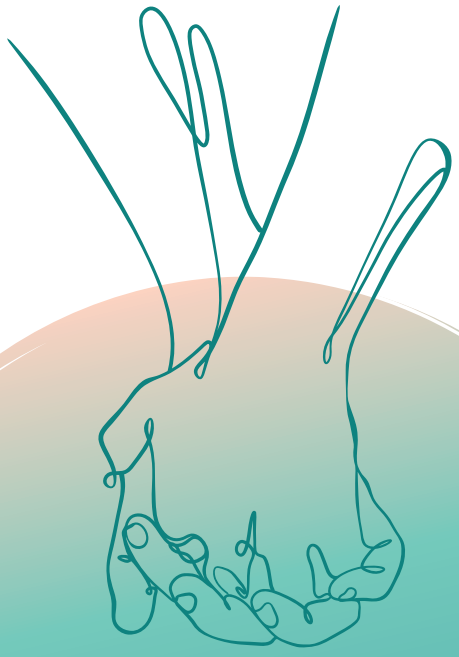
Service providers participated in the pilot based on their expertise and desire to test a new way of offering integrated mental health and addiction services. The pilot was not intended to evaluate each provider but rather to evaluate the success of an integrated, seamless community-based delivery model.




Participating service providers were aligned on treating mental health and addiction as a disease-based model rather than the traditional psychiatric language of behavioural disorders and their treatments. Clients were treated as 'unhealthy' and not 'bad.'

## Highlights:

- Service providers provided their established fee-based services to clients. Two of the service providers provided a discounted price for their services for purposes of the HH project.
- In addition, service providers volunteered their time to participate in project planning activities, input project data, and attend bi-weekly project team meetings.
- While all service providers had the opportunity to review clinical notes within the established IT tools and processes, the degree of participation varied between service providers.
- The pilot project highlighted the need for professional training on the C-PROM tool to teach service providers the value of the tool when properly understood and implemented.
- Some of the evaluation feedback described the HH system of data collection as cumbersome. The need to collect data for purposes of a professional evaluation contributed to this issue.
- Community Care Team notes in the system were important to service providers. The information helped inform their client conversations.



"I think the vision is building a better mental health care service and a healthier community, which, you know, I think we're all on board with that."

**~ HH Service Provider**

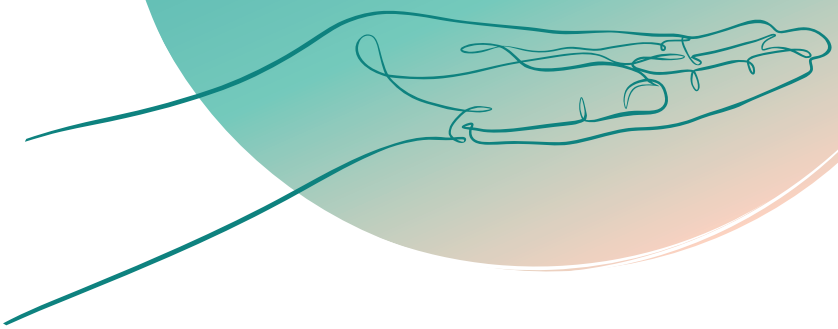
# Key Service Provider Findings

The core findings presented were extracted from the Three Hive Consulting Final Evaluation Report.

- Service provider participation highlighted the need for a multi-clinic, integrated EMR system:
  - The EMR needs to provide a record of client recovery steps available across the spectrum of recovery team participants, including clinicians, other professionals, and community, with access on a need-to-know basis.
  - The EMR should allow for the Client Care Plan and C-PROM to be regularly updated and printed for inclusion in the Client Recovery Passport.
- Service providers acknowledged the importance of the Care Coordinator role; however, there was insufficient time within the pilot phase to work with the team to identify where this role best fits (e.g., in a clinic or in the community external to a medical clinic) on a move forward basis.
- Attracting like-minded physicians that were keen to shift thinking towards addressing addiction within a disease-centred model framework (away from what was traditionally schooled or otherwise believed) proved more challenging than was envisioned. CFM worked hard to attempt to attract like-minded physicians who were open to taking the specialized training provided by the project.

"An EMR alone will never impact a client's success or change people's lives. It takes collaboration with like-minded people, a client-first focus, wrapped by integrated tools and processes."

**~ TUF Founder**



# Overall Harmonized Health Project Findings

Client results indicate that a Harmonized Health approach works. Understanding and addressing the lessons learned from the pilot could improve outcomes, and system economies are possible. In just 12 months, clients reported over 80% improvement in the continuity and quality of their care.

## Client

- Clients do not follow the same path to care. The comprehensive assessment takes a deeper look into a client's overall biological, psychological, social, and spiritual health, and the results guide their recovery plan.
- Clients appreciate choice in the services and service providers that best fit their needs. Clients may have underlying reasons for not wanting to deal with a particular service provider (e.g., inability to travel, past poor experience, personality differences, differing values).
- Some clients are unable to sustain their recovery journey, regardless of what supports they were provided.
- The least healthy member of the family impacts the whole family unit. Engaging with and teaching families the skills needed to manage mental health challenges can have a large impact on improving the circumstances of the family.
- Broadly speaking, clients appreciated having a centralized Care Coordinator they could rely on to provide information about the care process as well as a lay person's perspective as an alternative way of looking at their journeys.
- Clients value having a community advocate external to the service provider and medical systems.

## Community Care Team

- All participating clients, Community Care Team, service providers, and physicians saw the value in the Care Coordinator role; however, they do not all agree on where that role belongs (e.g., in a clinic or in the community external to a medical clinic).

- There is the need to incorporate ongoing client feedback and evaluation into the system to answer the question, Is the system working for you or not?
- One hour of recovery-based professional service leaves 23 hours of recovery to live; community involvement helps substantially fill that gap. Clients truly value the lived experience of Community Peer Navigators. Most HH clients had more touchpoints with their peer navigator than they did with service providers over the course of 12 months. The concept of Community Peer Navigators has broad community potential use beyond mental health and wellness (parenting, financial management, etc.).
- It takes clients time to move from pre-contemplative to contemplative to action; not all clients are ready to start immediately. This needs to be considered when determining where the role of a Care Coordinator should exist. Some individuals may need time to consider their options and may take no action until much later.
- It is possible to have a HH model without everyone being under one roof. With some form of a Community Care Team and an integrated EMR, providers, clients, and a Community Peer Navigator network can work together virtually or in person.

## Service Providers

- A clinic/medical home is necessary to make the system work; physicians with mental health speciality training provide comprehensive patient care.
- Some providers tended to default to how the system works today. At times, it was easy to fall into the 'you can't because' mentality instead of the 'you could if' mentality.

The HH pilot was unable to prove whether there is a reduction in cost to the overall existing health care system as the team was not able to track an individual's access to other mental health care prior to, throughout, or since the pilot.

Based on the collective HH team's knowledge of where the participating clients are at today, the team can only speculate that a small investment in fee-based services will pay off in the long run. For example, one participating HH client had previously been to treatment three times and had attempted suicide twice. Since participating in HH, this same client stated they had not accessed any mental health services outside of HH, and they are doing well. While the HH team cannot validate this data or any additional system costs incurred, the Alberta Government would be able to.

The key to Harmonized Health is that participating community members, service providers, and medical professionals keep the client at the core of everything they do, receive specialized mental health training, and speak a common language. When this is wrapped with a medical clinic as a home, an agreed and transparent care plan (Client Care Passport) and a community network, the client benefits are more likely to be improved upon.

# How Is Airdrie Better Off Since the HH Pilot?

The HH pilot project provided the following advantages:

- A total of 45 clients and 70 family members received help with their mental health challenges.
    - Forty-two percent of the clients seen at CFM were not already attached to a family physician.
- Two physicians received some level of funded, specialized mental health and addiction training.
- Two clinical practices are invested in the further development of the HH model.
- The volunteer-based Community Peer Navigator team has grown exponentially since the start of the HH project. Several clients who participated in HH have become Community Peer Navigators, and community peer group sessions are still held weekly.
- The Families Helping Families program was established as a valuable community service. Families continue to sign up, and TUF continues to fund this service where possible.
- Previous family program participants still meet bi-weekly in a facilitated support group format.
- While the value of comprehensive assessments, intensive outpatient therapy, and facilitated group therapy has been proven, the community still has work to do on adopting a comprehensive assessment tool and in developing community-based programs for intensive outpatient therapy and facilitated group psychotherapy.
- Community referrals are now happening between medical clinics, TUF, service providers, and the Community Peer Navigators. HH clients themselves are referring people in their circles to TUF.



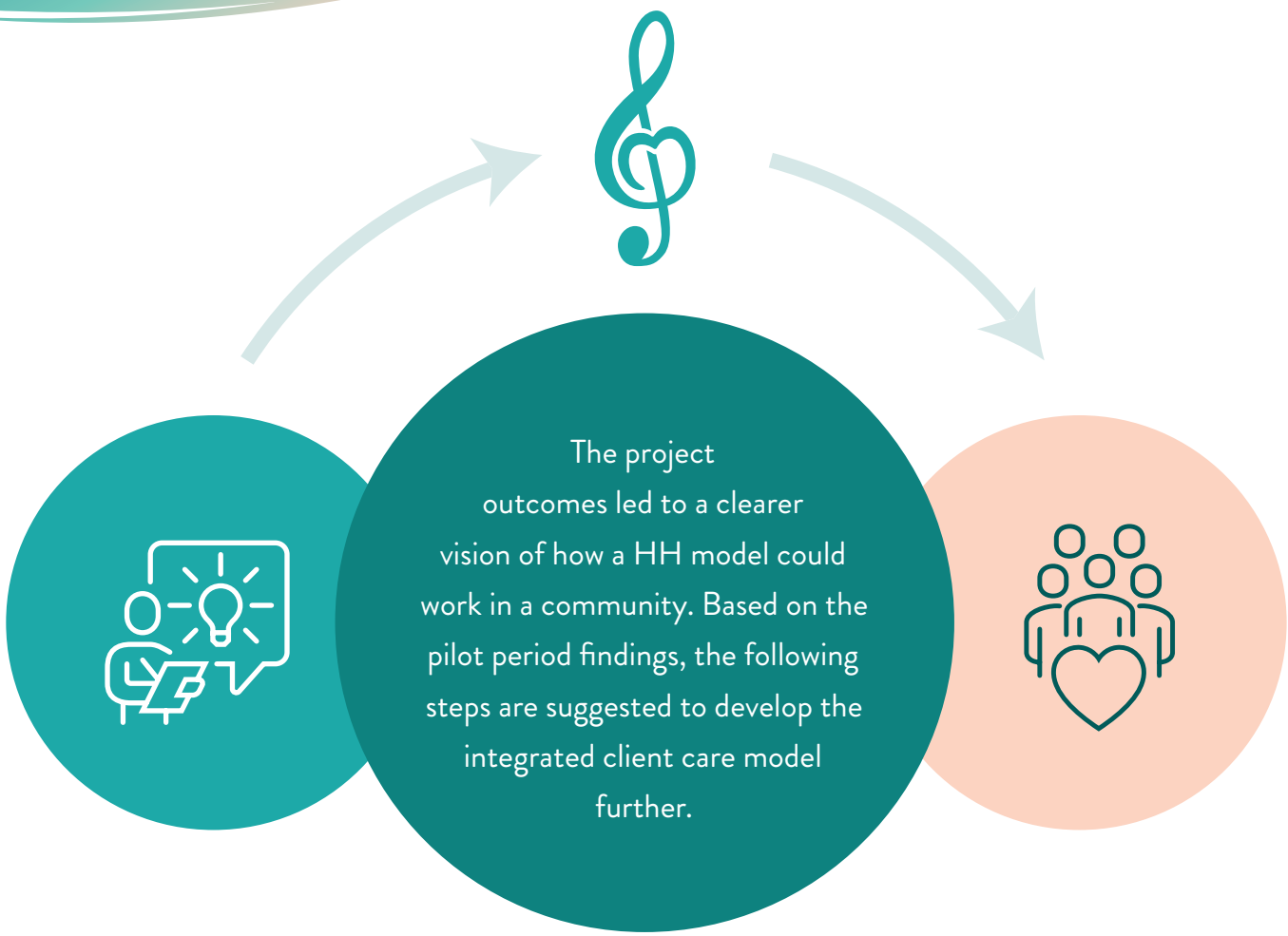
# HH Project Challenges

The pilot identified a few key challenges:

- It was difficult to attract physicians interested in specialized mental health training and it was difficult to source accredited, approved training resources.
- Some members of the HH team had different perspectives on what a client-first lens meant. At times, clients wanted a choice in who they wanted to provide their services which may have gone against the service provider's recommendation.
- Some providers struggled with the 'volunteer overhead' expectations. The providers were asked to donate time to the project by attending operational meetings (which are necessary when collectively developing new approaches to old methodologies) and collecting data in a manner that evaluators could effectively use.
- Guiding principles, overarching processes, and role definitions were not well understood and adopted by all project participants, and therefore, ongoing adherence to these principles did not always occur.
- At times, there was information dissemination breakdown within provider organizations, external to the HH core team. The bi-weekly service providers were typically only attended by one representative from each organization, and attendance was sporadic at times.
- Some clients reported being rushed at their initial meeting with a physician. In the future, to prevent this, the first client appointment with a medical home/clinical practice could be initiated by a non-physician role. Initial appointments within a mental health physician specialist need to be longer than a typical medical appointment in a clinic.

# How Can the Harmonized Health Model Be Replicated in Communities?

TUF can now envision a clearer path to having Harmonized Health a reality in communities, leading to better continuity of care at no incremental cost to the government. These recommendations address the key challenges presented during the pilot and consider all the HH project learnings.




- Establish guiding principles and core values for the collective team and ensure a system is in place to evaluate adherence to these principles.
- Ensure all providers share the philosophy of addiction as a brain disease and are certified through the Canadian Society of Addiction Medicine (CSAM). CSAM offers a certification program for physicians who treat addiction in Canadian communities.
- Create a culture that speaks to living in recovery rather than one of being 'treated' in addiction.
- Determine and establish clearly defined roles for the Community Care Team (e.g., Care Coordinator, Community Peer Network Coordinator, and other administrative roles as required) and where this team should reside.
    - During the pilot, Talent C performed a readiness assessment for these community roles. Talent C is a firm specializing in mentorship and works with organizations to foster leadership in communities. This work could be further developed and used as a platform for recommendations towards formal adoption and implementation of suitably integrated positions.
- Establish a minimum of two community medical clinics to act as the medical home for individuals.
- Individuals already attached to a family physician for regular health care remain with that physician for non-mental-health appointments.

    - Initial intake appointments at a clinic need to be at least one hour long. This initial intake visit can be done by a social worker/physician combination to make the most effective use of people's time and knowledge.

- Incorporate an integrated technology solution that allows access across multiple service providers, clients, and community team participants (on a need-to-know basis).
- Provide service provider bench strength to protect against service interruption.
- Ensure common language, knowledge and awareness between all participants, including professionals, service providers, and Community Care Team members, i.e., Brain Story or other science-based, cutting-edge mental health training.
- Proportionally reallocate existing Alberta Government health funding and resources to:
    - Provide individuals with an annual mental health spending wellness account with the caveat that this is only spent with providers and clinics operating within an integrated model. This allows clients to take ownership, accountability, and responsibility for their care and make an informed choice about how and where they spend their health care dollars. This could also incent service providers to participate in an integrated model as they would receive client referrals they might not have otherwise. Further, clients being responsible for their health spending funds could help build accountability into the system based on their impression of service quality.
    - Establish a Community Care Team base and, over time, build a trained Peer Navigator network of those with lived experience.
    - Incent service providers and medical professionals to participate by funding their specialized mental health training and certification (e.g., Canadian Society of Addiction Medicine, C-PROM).
    - Cover the cost of a Program Manager and formal evaluation for a limited time to track success over a defined period.
- To prove there is financial and patient care return on investment when using a HH model:
    - Add formal AHS tracking of participant costs across the whole health care system over a defined period of time.
    - Measure client outcomes over a defined period using surveys and assessment tools.

As a result of the Alberta Government's financial support, this pilot project has created the ideal opportunity for further collaboration. There are opportunities for significant and meaningful change in the way mental health services are provided to ensure better outcomes for affected members of the community and the potential for improved efficiencies in how health care dollars are spent.

We would welcome the opportunity to work with the Alberta Government and/or other interested parties to explain the model in further detail. Using a think tank approach, together we can explore opportunities for the next phase of development to progress the thinking on options for meaningful, incentivized change within the professional and peer communities. We believe the lessons learned in working the concerns, issues, and process improvements with care providers operating within the HH model would be useful in answering questions around how to incentivize and create an inclusive, integrated model that would build on the successes shown by the pilot phase.

The Government may also wish to establish a 'change agent' role that would be available to work alongside us, under a mandate to deliver recommendations for improvements to efficiency, outcomes, and social improvements to all affected by adverse mental health and addiction.

Upon further development, as previously described, there is the potential for the model to be incorporated into correctional institutions and Indigenous communities. The HH core components (comprehensive assessments, intensive outpatient therapy, facilitated group, counselling, family programs, peer support) can be combined with other community-specific potential adaptations, such as conflict management, sweat lodges, and drumming circles.

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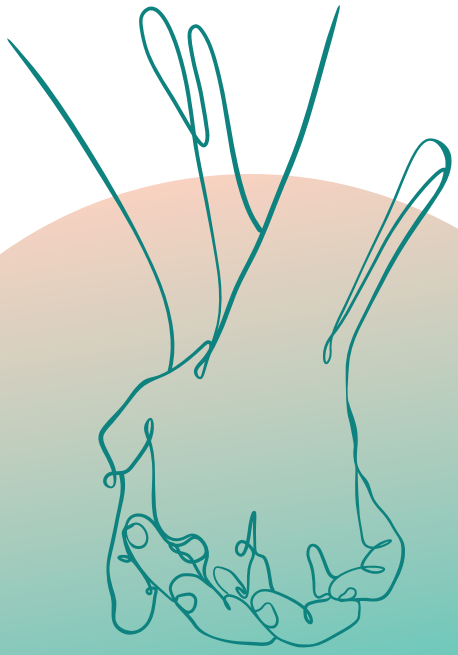
# Taking It One Step Further



We believe our innovative idea can offer bold and transformational change to how a community currently supports mental health.

TUF has been exploring whether the concept of a Healthy Brain Community Hub (HBCH) is feasible. We believe our innovative idea can offer bold and transformational change to how a community currently supports residents' mental health. Using everything we have learned since 2016, TUF's high-level concept is to take the Harmonized Health (HH) model into a wellness hub that will provide ongoing easy access to knowledge and information from experts and professionals. The HBCH we envision incorporates private practice, government, and community, all using the efficacy of a patient-first model while leveraging best practices. We will shift the culture to a better understanding of the mind and emotions and how to respond to difficult situations using science-based, vetted, and researched best practices.

The HBCH would complement existing medical care systems, not replace them. Individuals will be referred to medical services as needed.

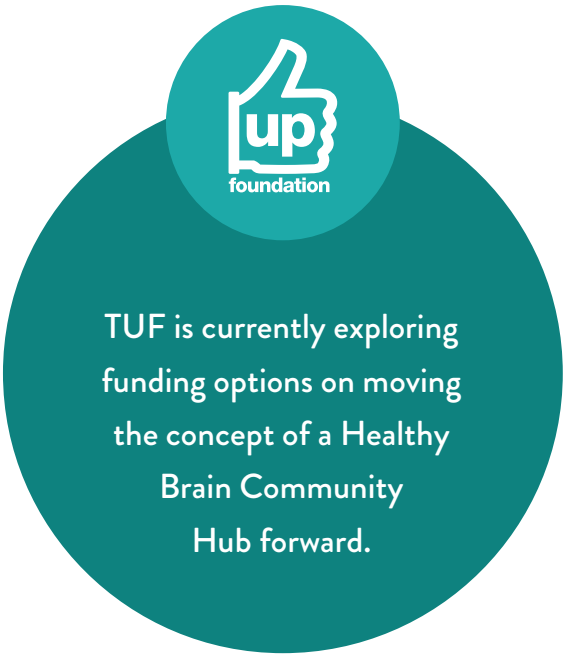
- Medical professionals can make patient referrals to the centre for cutting-edge mental health care and diagnoses.
- With individuals and their families at the core, they will be supported by a wide network of services and providers, some of which are on-site while others may remain in their existing locations or provide services virtually.

The HBCH would complement the existing medical care systems, not replace them. Individuals will be referred to medical services as needed.

- With a keen focus on advancements in innovative approaches to mental health care through leveraging research done by others, the HBCH will integrate these learnings as appropriate.
- Other municipalities, organizations, and agencies would be able to leverage the HBCH learnings and best practices through education sessions and site visits.
- The HBCH can also offer virtual capabilities to expand our reach to rural and remote areas. The HBCH could also accept referrals from outside the immediate area.
- The medical research would be done by places like the Hotchkiss Institute at the U of C; however, those research facilities could use the HBCH to test practical applications of their research at the community level.

The HBCH we envision would:

- House the HH community roles of Care Coordinator and Community Peer Network Coordinator.
- Incorporate a drop-in facility (a physical implementation of 'hotline' type services) for those who wish to obtain information proactively.
- Meet each person where they are at and connect them to the community services that are the best immediate fit, whether the hospital, counselling, or even e-mental health service referrals.
- Offer an integrated training hub for physicians, service providers, and the community.
  - CSAM certification, Brain Story, and C-PROM training are examples.
- Advance comprehensive assessments through the addition of brain neuroimaging.
- Potentially include some type of emergency short-term 30-day bed service for those awaiting treatment.



# The Journey Needs to Continue

Please connect with us to get involved or to learn more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