QI Power Hour with

Michael Seiferling

Crisis meets connection: How Saskatchewan reinvented mental health supports

Land Acknowledgement

Let's chat

Please share your questions, comments, and ideas in the chat during today's session.

Past sessions

Building a healthier future: How Saskatchewan is shaping the next generation of health research

Speaker: Megan Vanstone & Emiliana Bomfim

Using Community Paramedicine to advance out-of-hospital care in Saskatchewan

Speakers: Erika Stebbings, Jenna Mujer, and Sherri Julé

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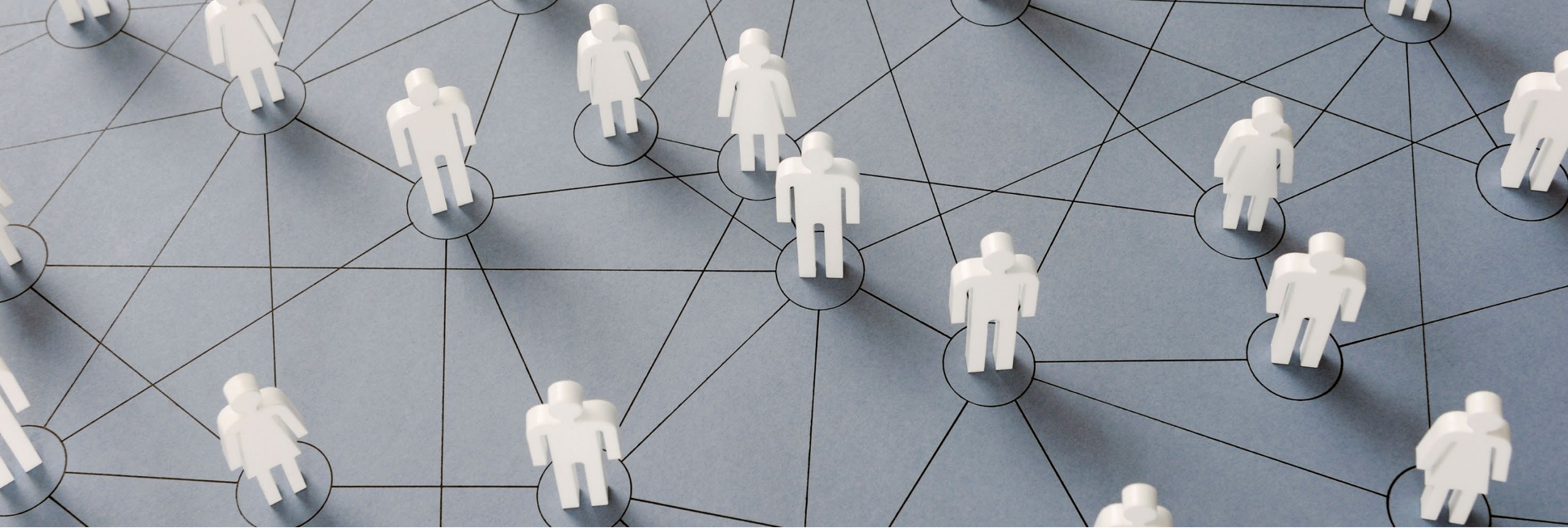
Introducing

Michael Seiferling

Director of Mental Health & Addictions Services Southwest

Saskatchewan Health Authority



Crisis Meets Connection

How Saskatchewan reinvented mental health supports

Saskatchewan Health Authority

saskhealthauthority.ca

Vision, Mission, Values and Philosophy of Care

VISION

Healthy People, Healthy Saskatchewan

MISSION

We Care.
We work together to improve health and well-being; every day, for everyone.

VALUES

- **COMPASSION:** ***We are caring.*** We practice empathy. We listen actively to understand each other's experiences.
- **ACCOUNTABILITY:** ***We are responsible.*** We own each action and decision. We are transparent and have the courage to speak up.
- **RESPECT:** ***We are collaborative.*** We treat everyone with kindness, dignity, and empathy. We honour diversity and value each person as an individual.
- **EQUITY:** ***We are committed to health equity.*** We recognize that factors such as geographic location, culture, and background are key determinants of health outcomes. We embrace the diversity of our teams, and work to remove barriers to ensure all Saskatchewan residents and communities can access high-quality care.
- **SAFETY:** ***We are aware***. We commit to physical, psychological, social, cultural and environmental safety. Every day. For everyone.

PHILOSOPHY OF CARE: Our commitment to a philosophy of Patient and Family Centred Care is at the heart of everything we do and provides the foundation of our values.

Objectives

Share the origin of a crisis and community outreach program

Outline the clinical models to inform the design

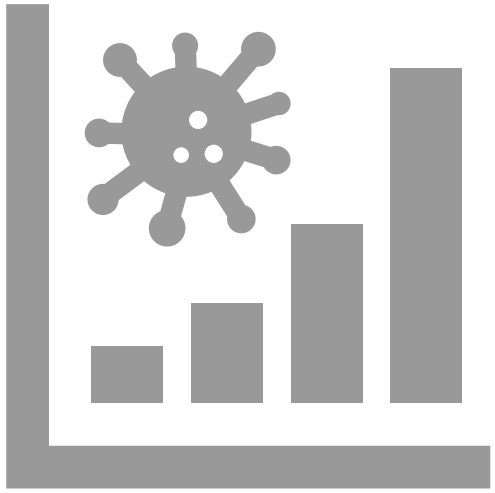
Report on the outcomes and impacts of the program

Consider the future of the design

Unexpected beginnings

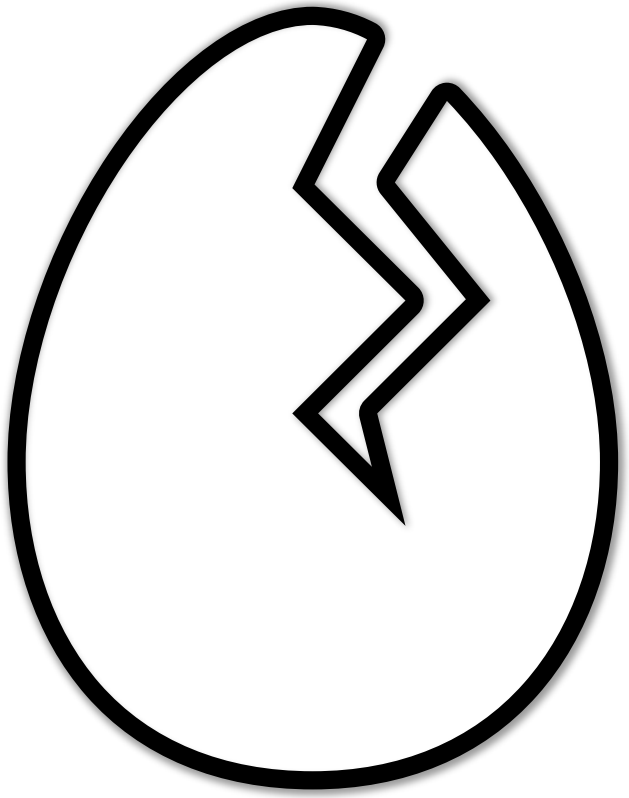
Where it all began

- Temporary pause in services
- Knowledge Exchange from Southeast
- *“exceptional barriers and elevated risks”*



Phase 1

Early efforts



Getting Started

2021-2022

Team	# of FTE	Population of SAG	Mental Health and Addictions ED visits in 2021-22	Ranked among all hospitals in Saskatchewan	Ranked Among Rural hospitals in Saskatchewan
Swift Current	4.5	21,311	965	10th highest	6th highest
Moose Jaw	2.2	38,887	1285	7th highest	3rd highest
Kindersley	1.2	9,801	315	23rd highest	18th highest

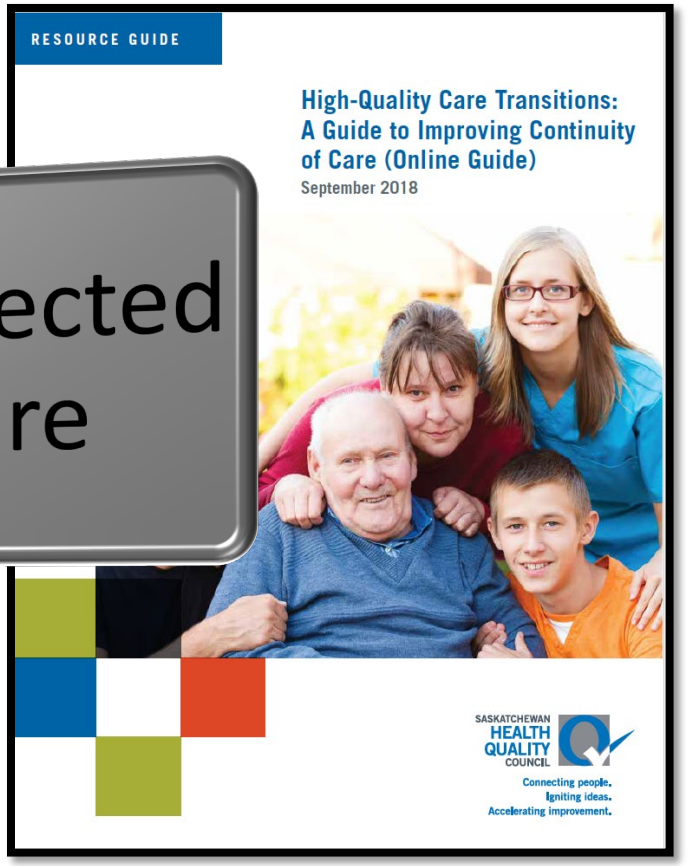
National Ambulatory Care Reporting System (NACRS); April 1, 2021 to March 31, 2024
Covered Population from SK Ministry of Health January 2024 version
Postal code table supplied from Population Health
Via: Health Network Profile Dashboard

Unexpected beginnings

Where it all began

Crisis Response Teams

Connected Care



Transition Team

Click icons to follow links

Crisis Resolution Team

Referrals and Access	How quick and easy it is to refer to the CRT
	Who can refer, early discharge
Content and Delivery	Assessment, provision of information to service users and carers
	Medication, physical health, psychological interventions, social and practical problems
Staff and Team	Staffing levels, multi-disciplinary teams,
	Risk assessment, communication,
Location and Timing	Alternatives to hospital admission,
	Frequency of visits and location of visits

core
Crisis Resolution Team Optimisation and Relapse Prevention

High Quality Care Transitions

Bridging the Gap between Community and Hospitals through Focused Process Improvement

Before Hospital

- High risk identification and case management
- Collaborative care planning (including advanced care planning)
- Intermediate care teams (rapid response/community paramedicine)

In Emergency Department

- Contact community case manager on presentation to ED
- Refer out to Intermediate Care at home if appropriate
- Medication reconciliation
- Refer to community care plan and advanced care plan
- Warm handover

During Hospital Stay

- Risk assessments
- Transition coach
- Collaborative care/advanced care planning
- Teachback
- Medication reconciliation
- Daily IDR at bedside
- Functional decline prevention
- ALC data collection

Close to Discharge

- Discharge summary available to MRP within 48 hours
- Warm handovers
- Follow-up appointments visit scheduled
- "After Hospital" care plans with red flags and contact information
- Medication reconciliation and update community pharmacist

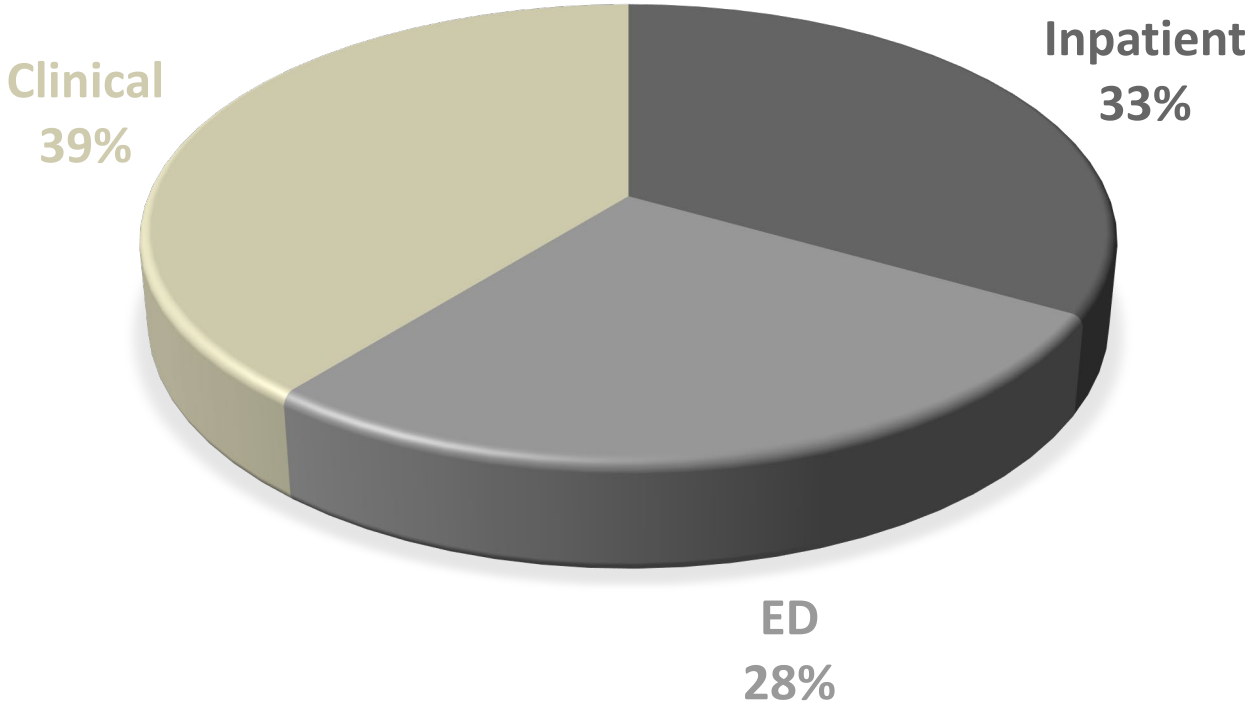
After Hospital

- Follow-up visit and/or phone call within 48 hours
- Activated/Resumed community case management and care planning
- Medication reconciliation
- Work with community-based organizations to leverage services and supports

SASKATCHEWAN HEALTH QUALITY COUNCIL

Before Hospital

Community and Clinical Referrals



"exceptional barriers and elevated risks"

Source: Mental Health and Addictions Information System (MHAIS)

Before Hospital

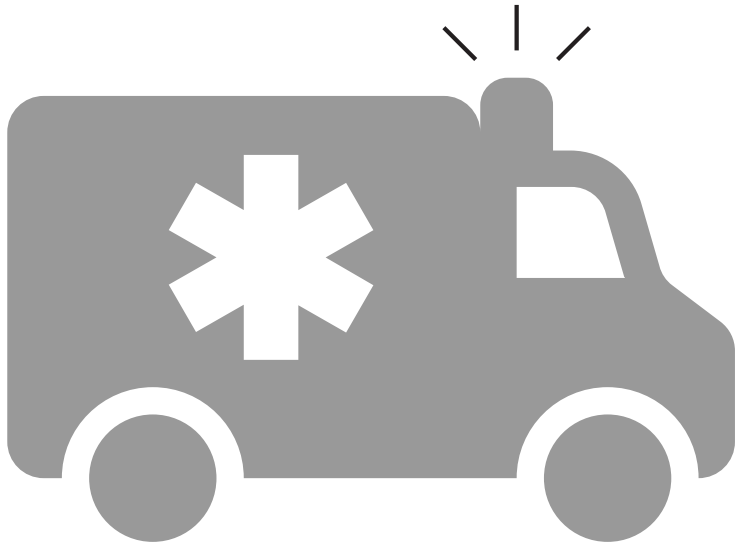
Community and Clinical Referrals

- All teams use a “FACT Board” to deliver services
- Ranges from 15 - 35 people at a time (1:10 per FTE)

Diagnosis/ Presenting Issue/ Addiction	Other Involvement	LOCUS Level	Risk Factors	Interventions	Notes TO DO:	Individual Social Network	Planner M	 T	 W	 T	 F	Primary Case Manager
Substance use and mood	Joanne	3		Risk management and Medication Management	ER		attempt to contact	attempt to contact	Dec.3/25 @ 10 PC	attempt to contact		
behavior, mood	Brooke	3	Youth	Risk management and Medication Management	MHIPU			Dec.9/25 @ 1:30 HV				

In the Emergency Department

Rapid Response



- Teams are deployed directly to ER or follow up with a patient within 24 hours of discharge
  - ***28% of referrals come from ER***

In the Emergency Department

Rapid Response

- No embedded mental health and addiction supports in the ED's at any of the sites we support
- When patient presents, nursing responds asap

Med LOS by Hours

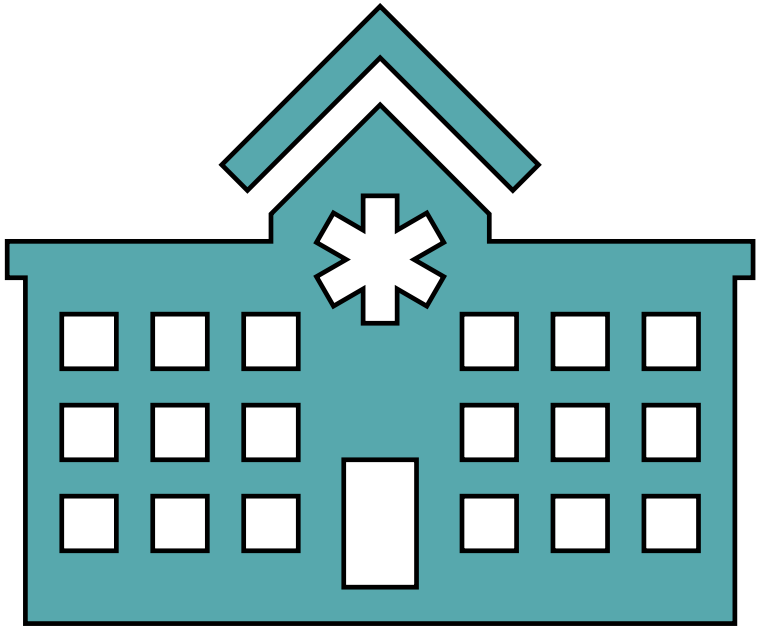
Site	2023-24	2024-25
Swift Current	2.82	2.62
Moose Jaw	4.90	4.55

Source: National Ambulatory Care Reporting System (NACRS); April 1, 2023 to March 31, 2025

During the Hospital Stay

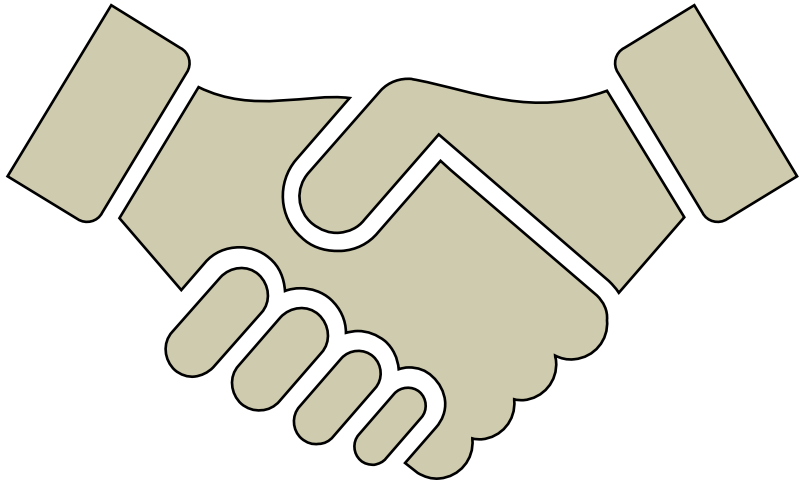
Bed side intervention

- ***33% of referrals come from inpatient units***
- ***Bed-side response*** and consultation have been critical to engage at risk patients



During the Hospital Stay

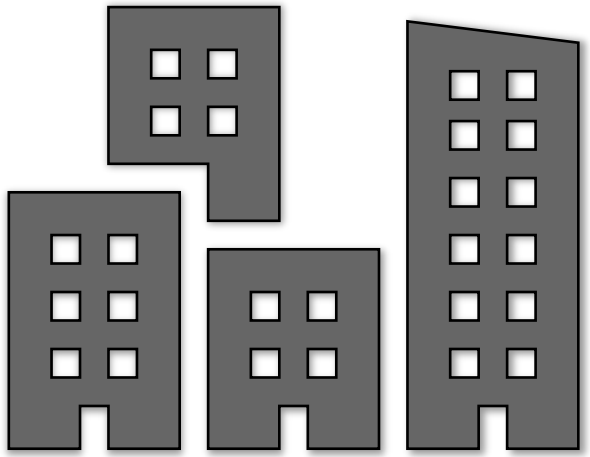
Bed side intervention



- Team provides assessment, brief treatment and connection to support services
  - In Swift Current, addictions programming is available on site

Close to Discharge

Getting Ready to come home

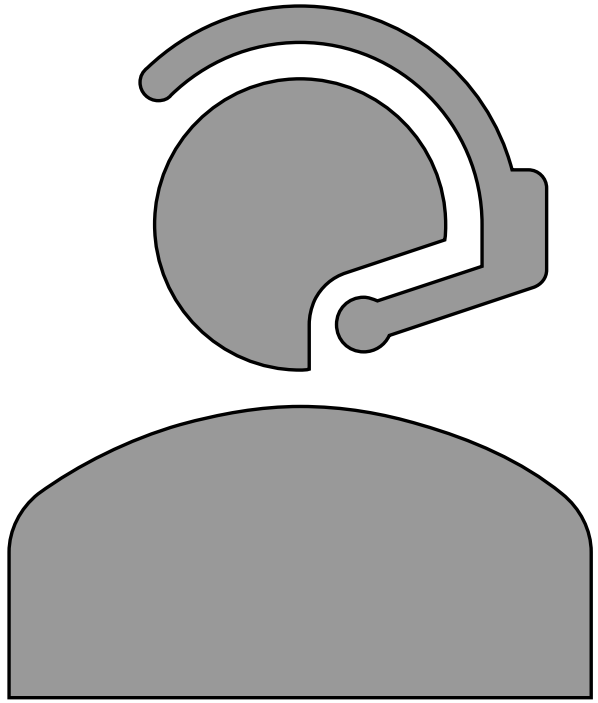


- Teams focus shifts to the ***8 domains of discharge support***
  - Medication Safety
  - Shared decision Making
  - Self-management and Health Promotion
  - Coordinated Transitional Planning
  - Timely Follow up for Post-Transition Monitoring
  - Social Community Support
  - Information Flow
  - Functional Decline Prevention

Close to Discharge

Getting Ready to come home

- In Swift Current, daily huddles occur between teams off site in rural areas to ensure proactive and comprehensive discharge support
- Inclusion in patient rounds, when possible, at various sites

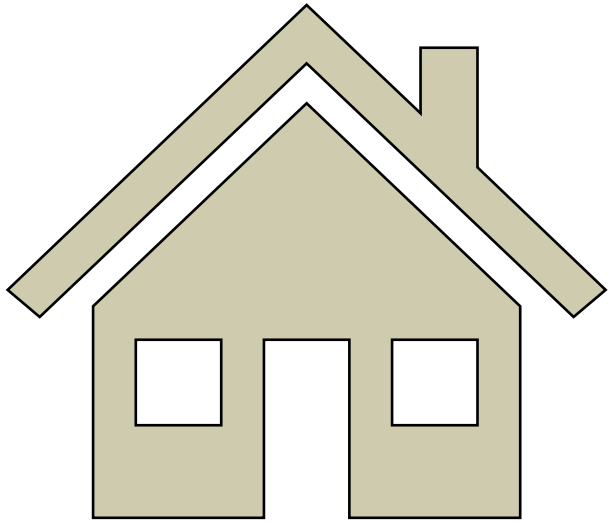


After Hospital

Follow up at home

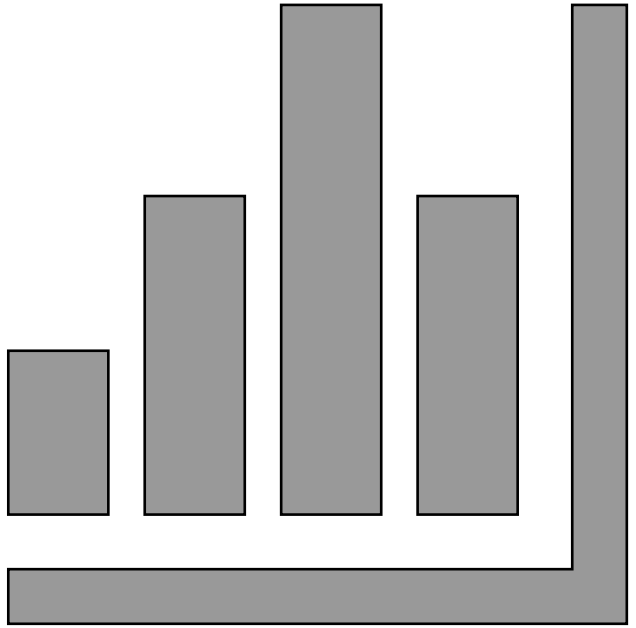
Year one measure

- ‘60 day follow up’ used to determine long term impact
    - 83% (N=315) of patients were in clinical services with MHAS
    - Of the 16% (n= 51) that were not in care at follow up:
        - ***36 were considered “Treatment Complete”***
        - 15 were ‘Treatment discontinued’ (i.e. failed to show and unable to contact)
    - Only 19 of 315 participants were readmitted to hospital for care after discharge (6%)



…and now the numbers

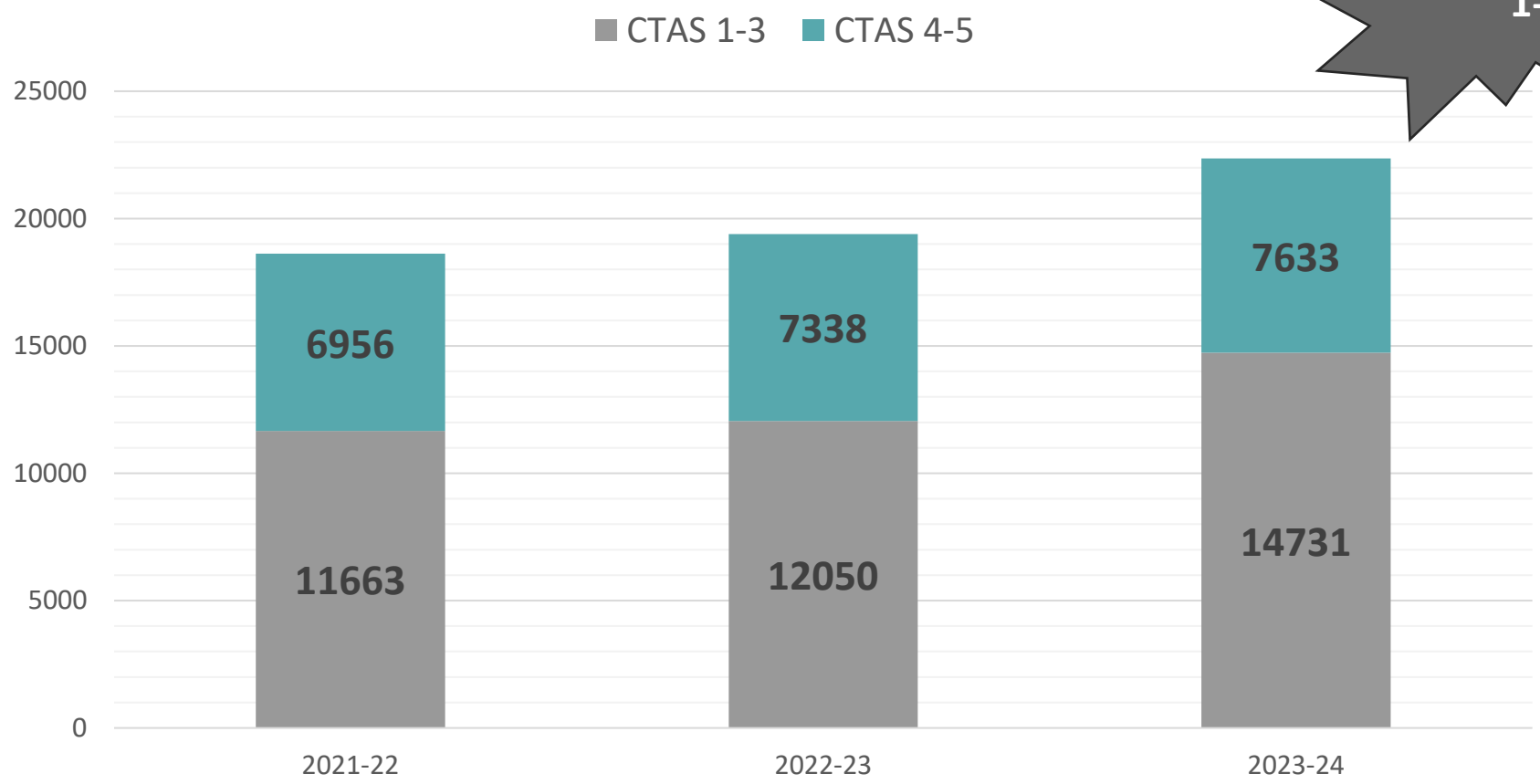
Demand data



Addictions ED visits by CTAS

SHA

25% increase in 1-3



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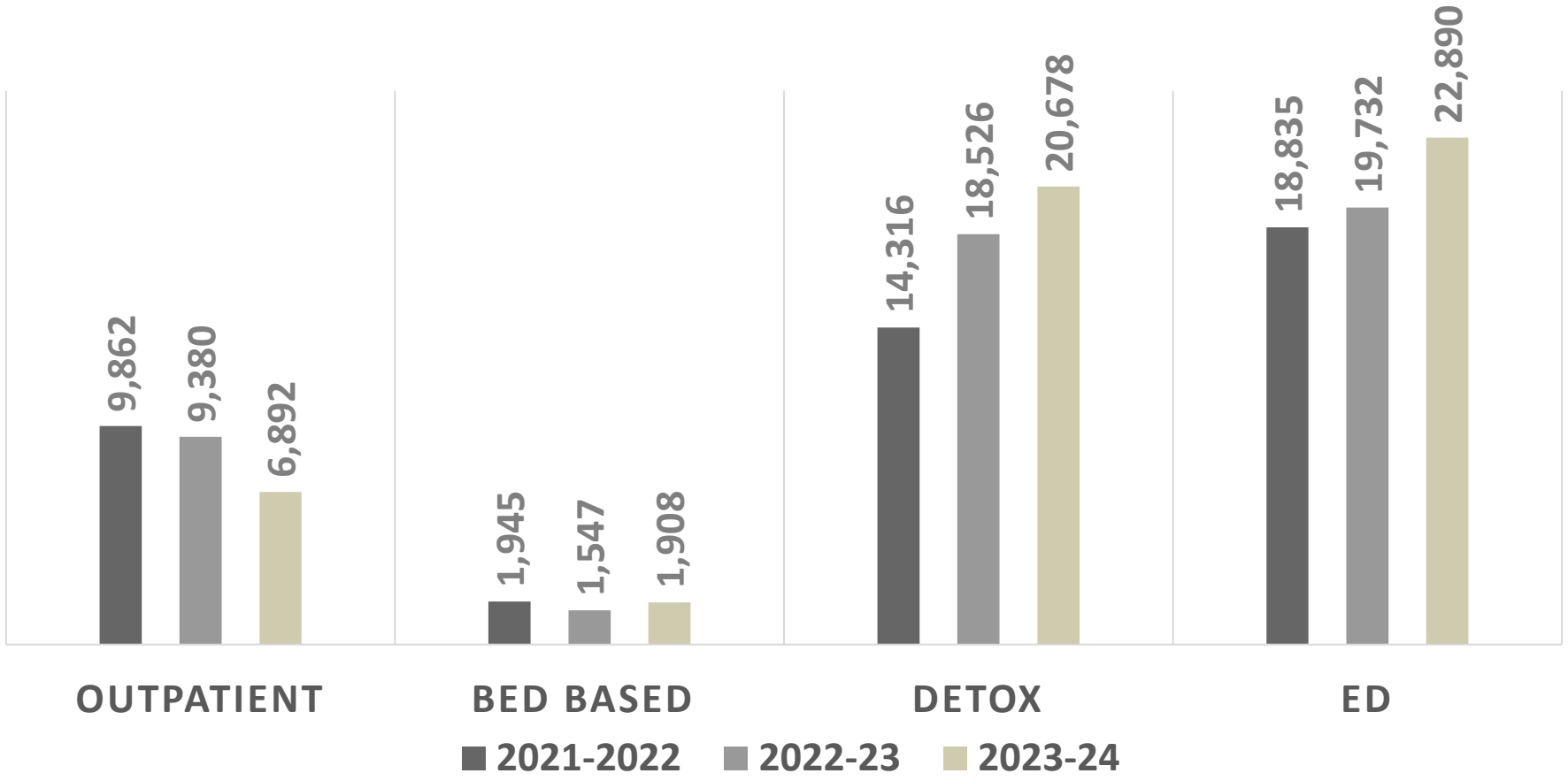
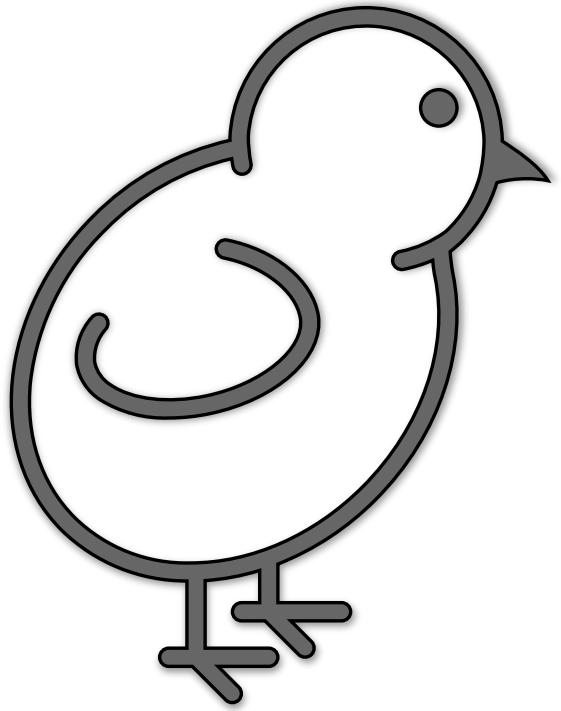
Addiction Services by Type with ED

MoH and SHA



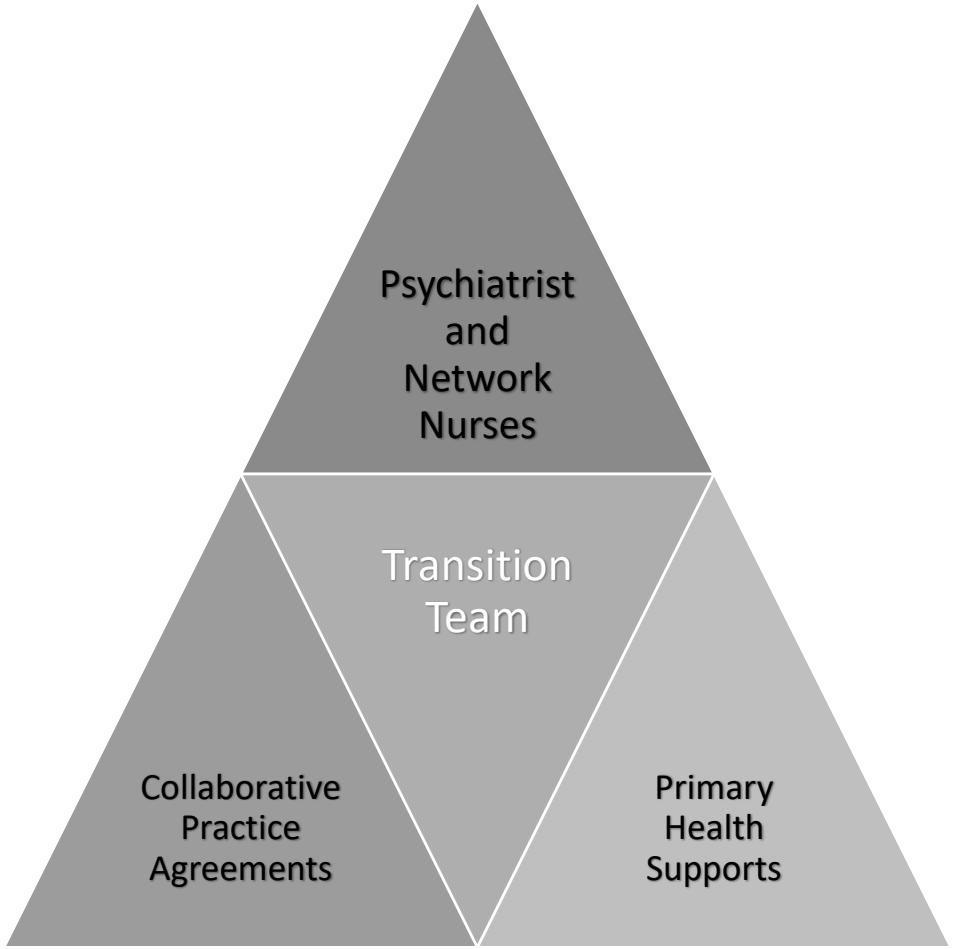
Phase 2

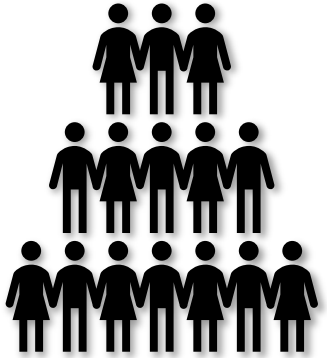
Growing up…



Building a team, around a team

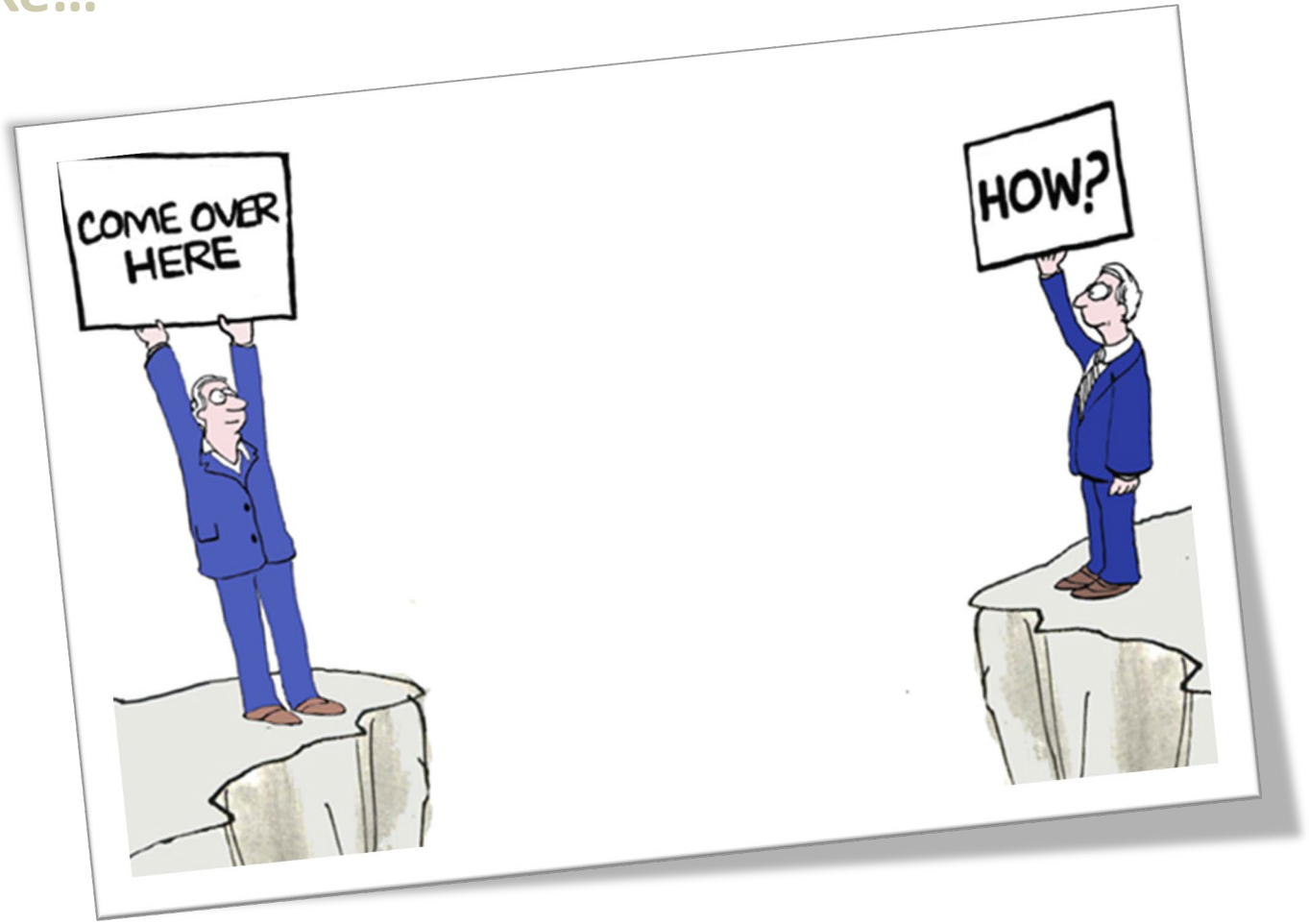
Expanding the Supports





Primary Health Care

What it can be like…



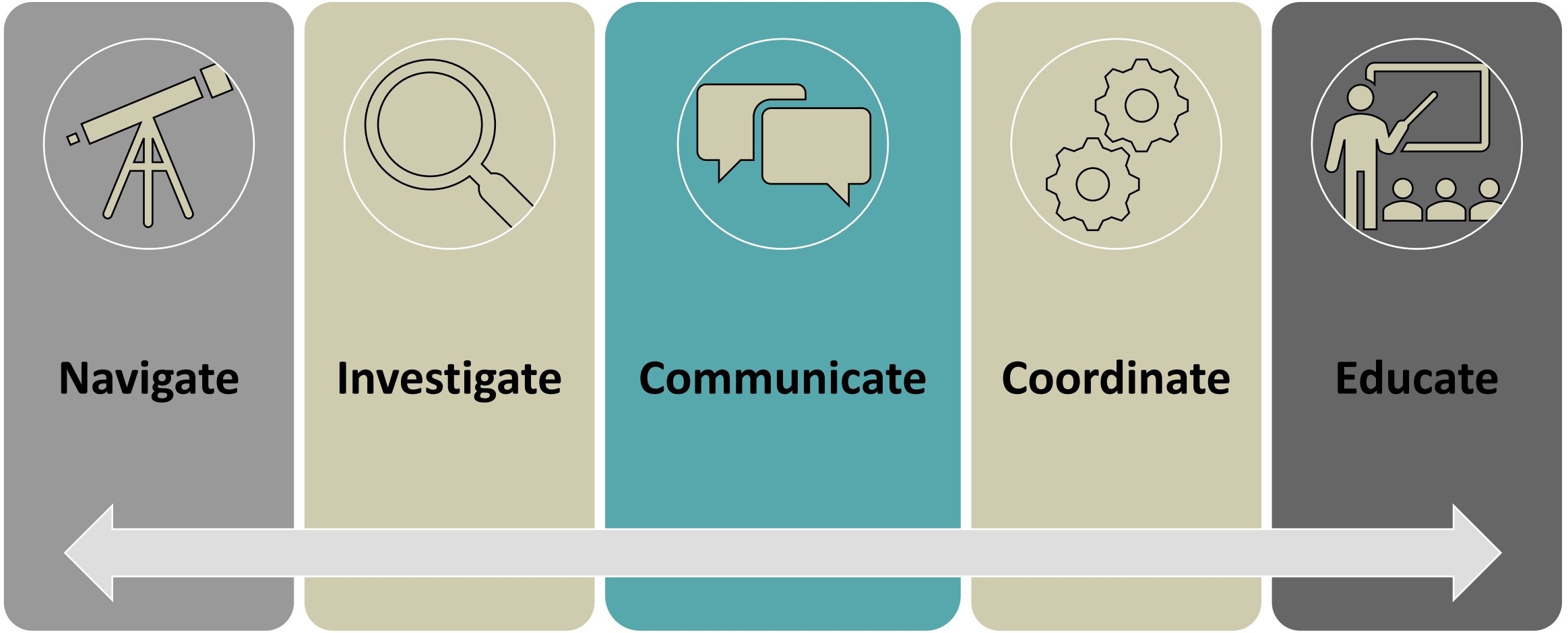
The Behavioral Health Consultant

At the Base of Response

- Embedded staff, in clinic
- Trained in brief and focused treatments
- Applied to wide range of issues
- Aligned to ‘health home’ model

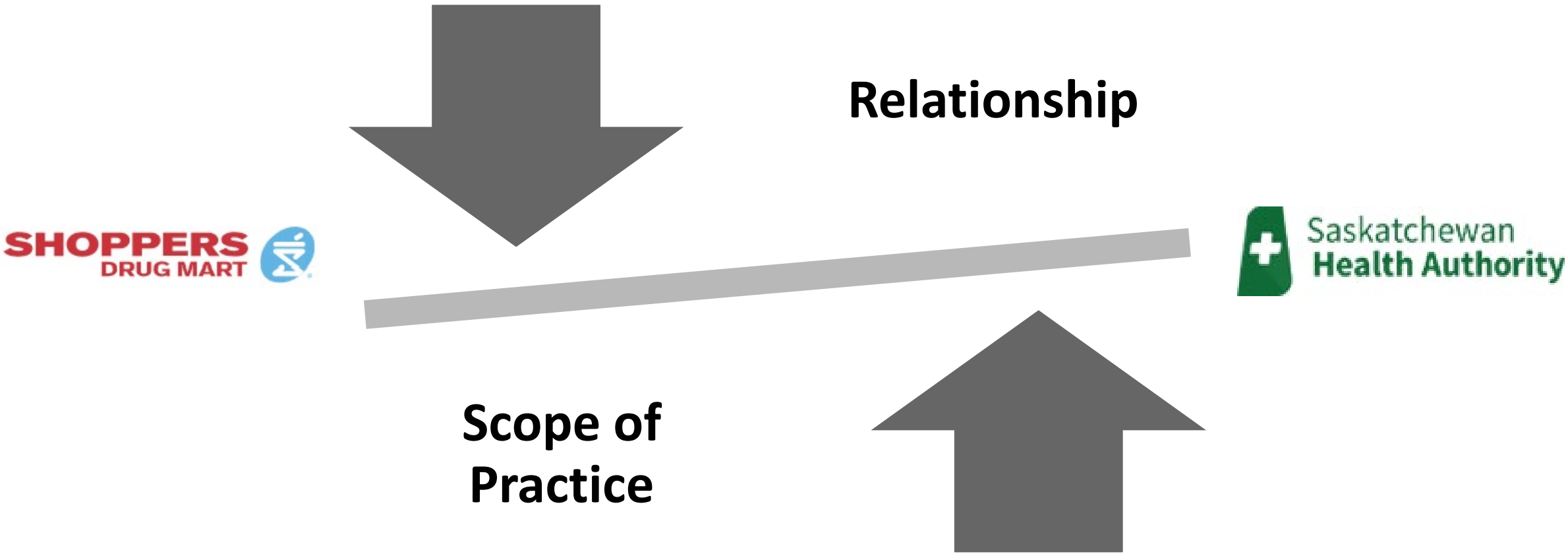
NICCE Framework

Psychiatric Nursing Team



Collaborative Practice Agreements

New opportunities, same partners



Collaborative Practice Agreements

Main Functions

Communication

- Documentation in Shared Record
- Triage Guidelines

Monitoring

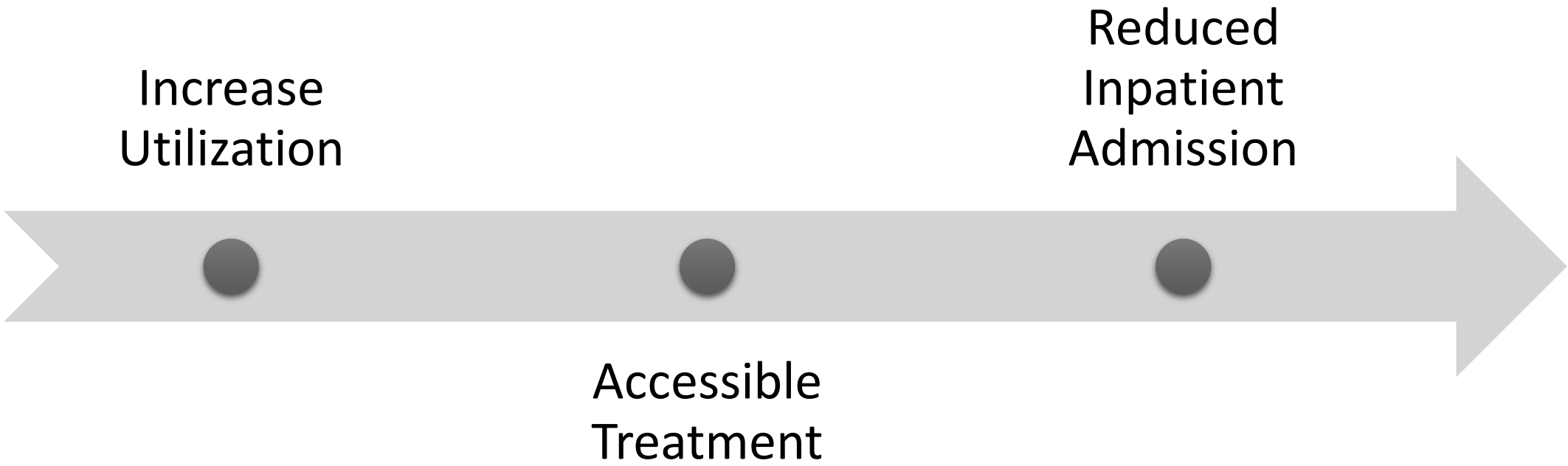
- Lab and Point of Care
- Psychiatrists Consultation

Prescribing

- Adjustments and Medication Changes

The Impact

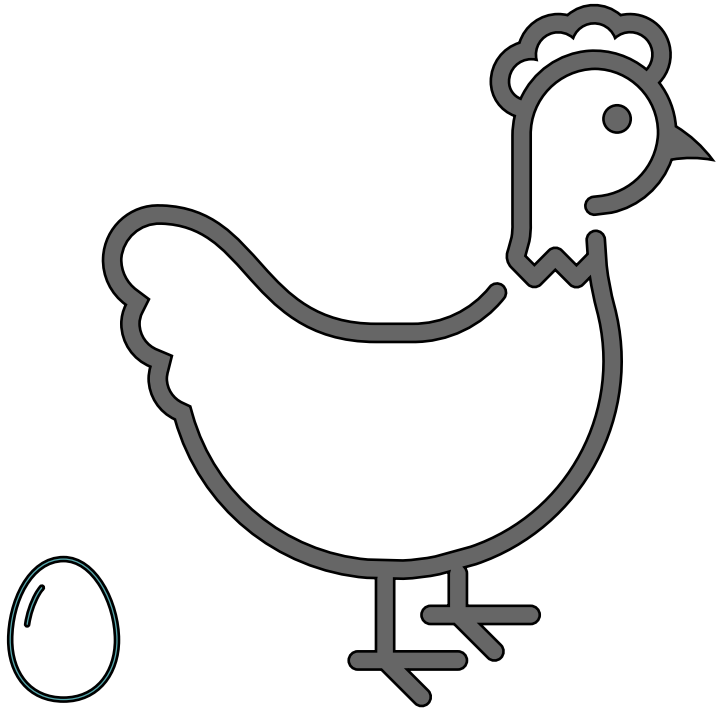
What does this mean for patients?



Also See: Gullacher, C. A., & Goernert, P. N. (2025). The use of community treatment orders in people with substance induced psychosis. *International journal of law and psychiatry*, *98*, 102043. https://doi.org/10.1016/j.ijlp.2024.102043

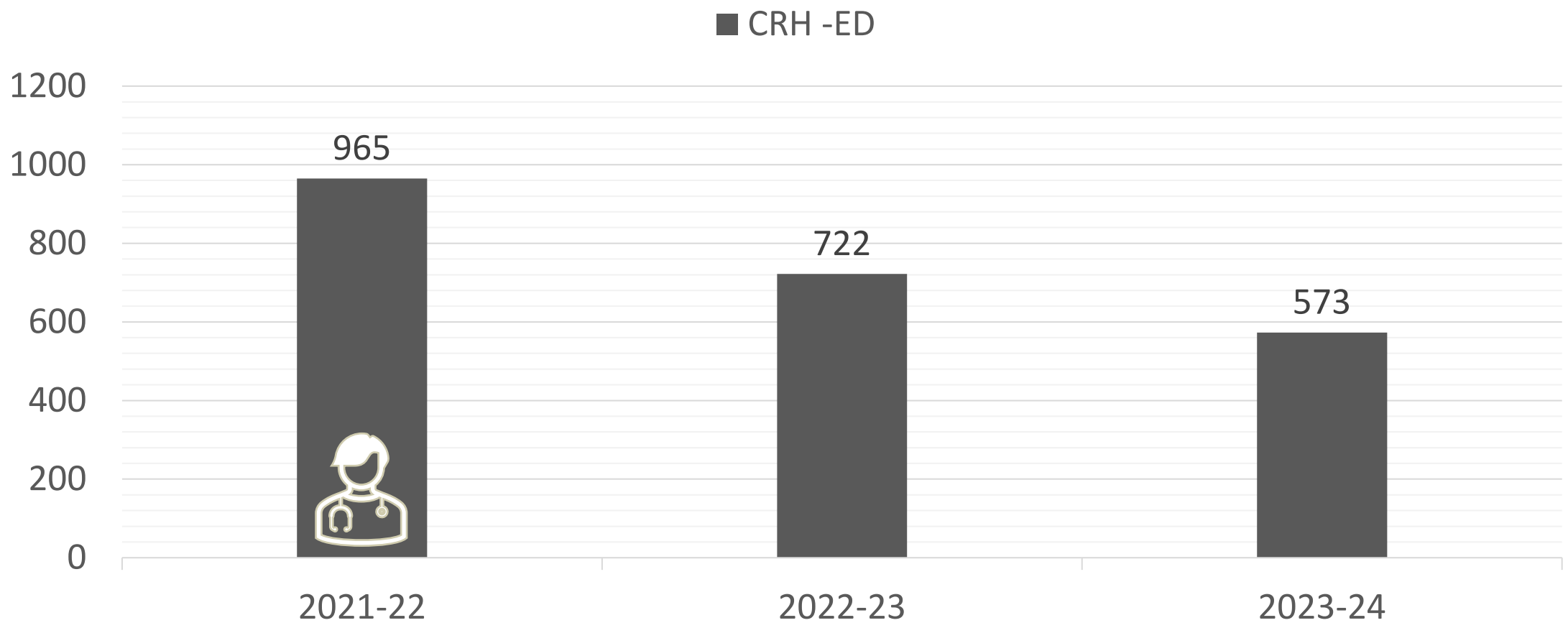
The Outcomes

What we know so far…



ED Visits

Swift Current 4.5 FTE + PHC



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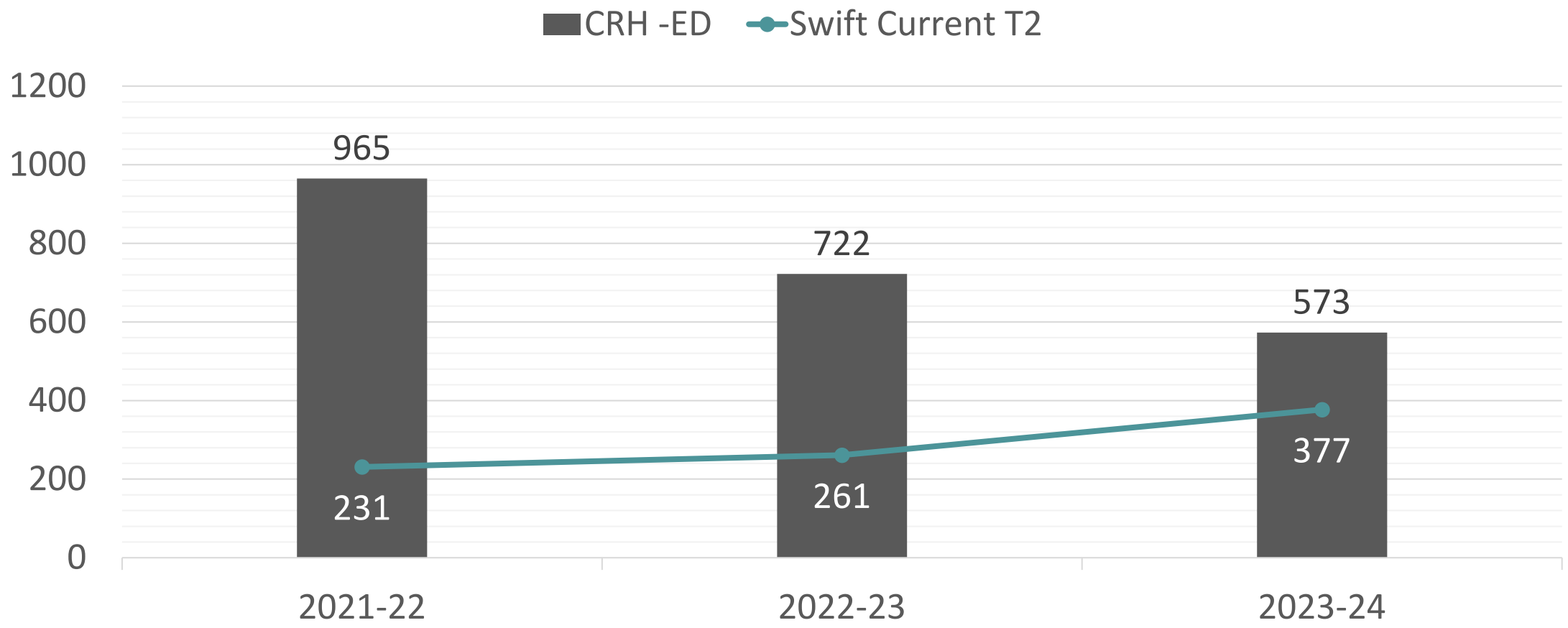
ED Visits and T2 Referrals

4.5 FTE



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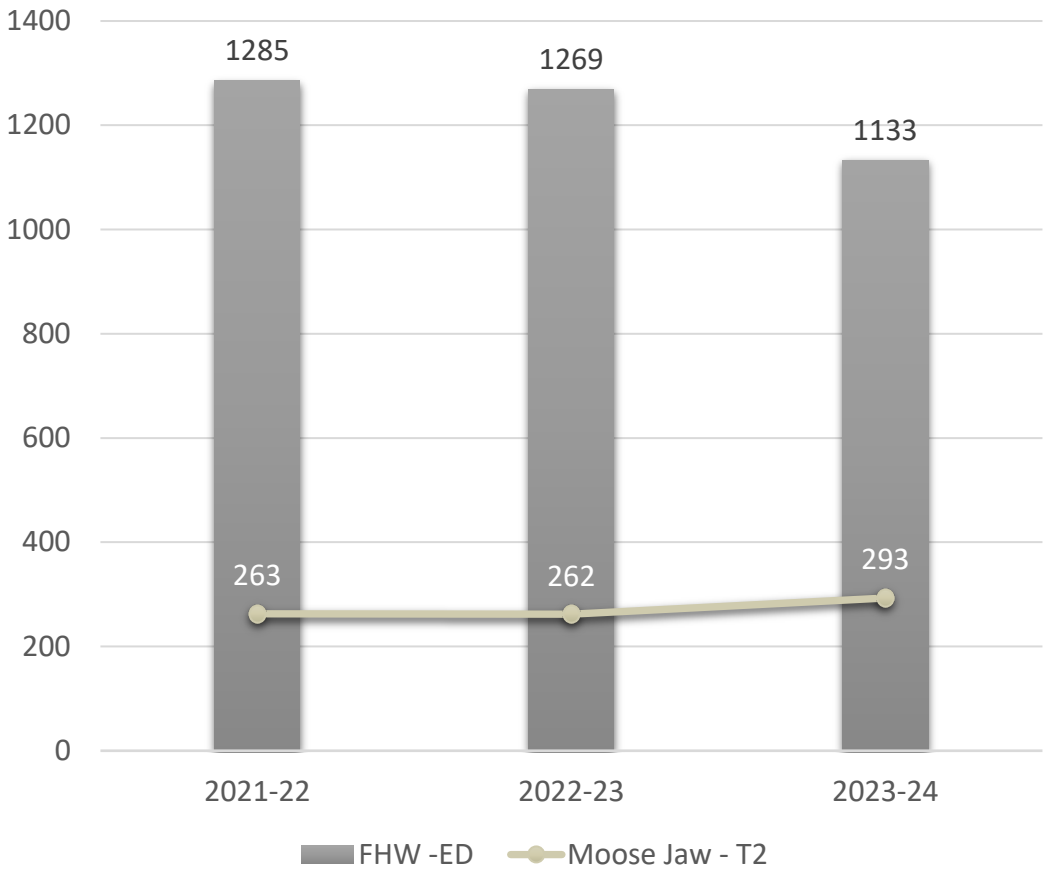
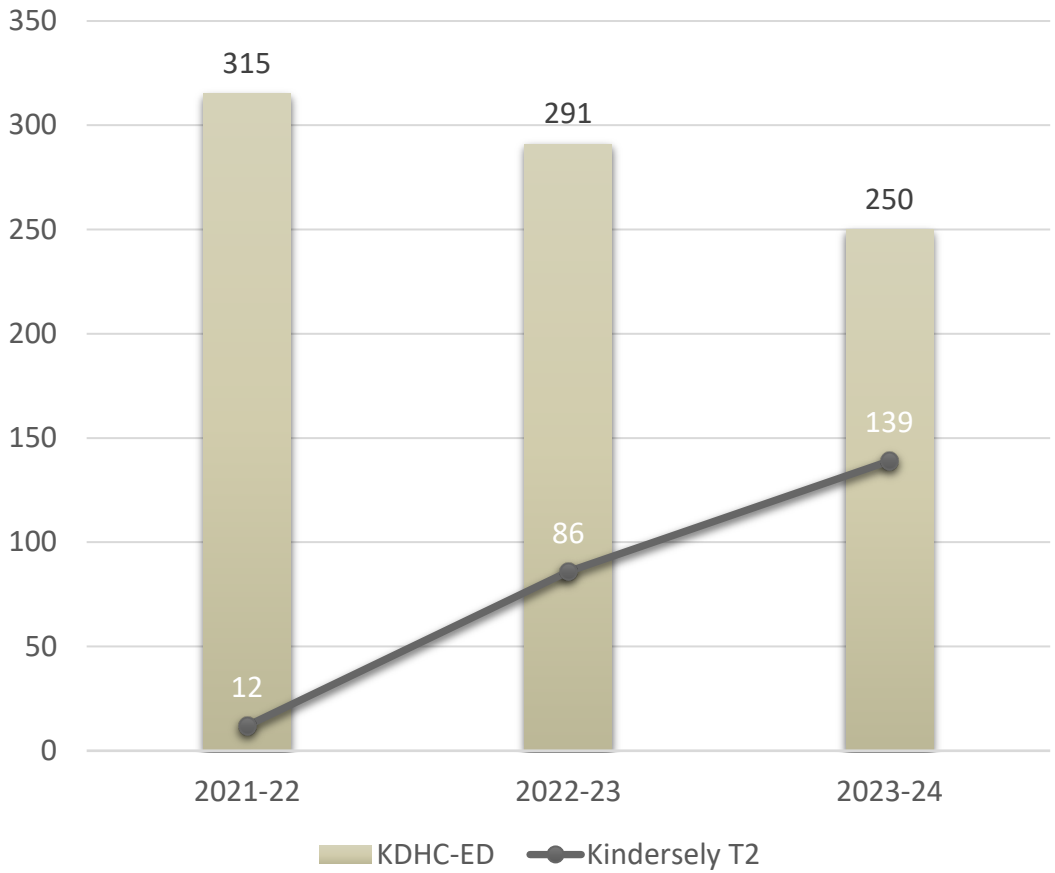
ED Visits and T2 Referrals

Moose Jaw: 2FTE



Kindersley: 1.2 FTE



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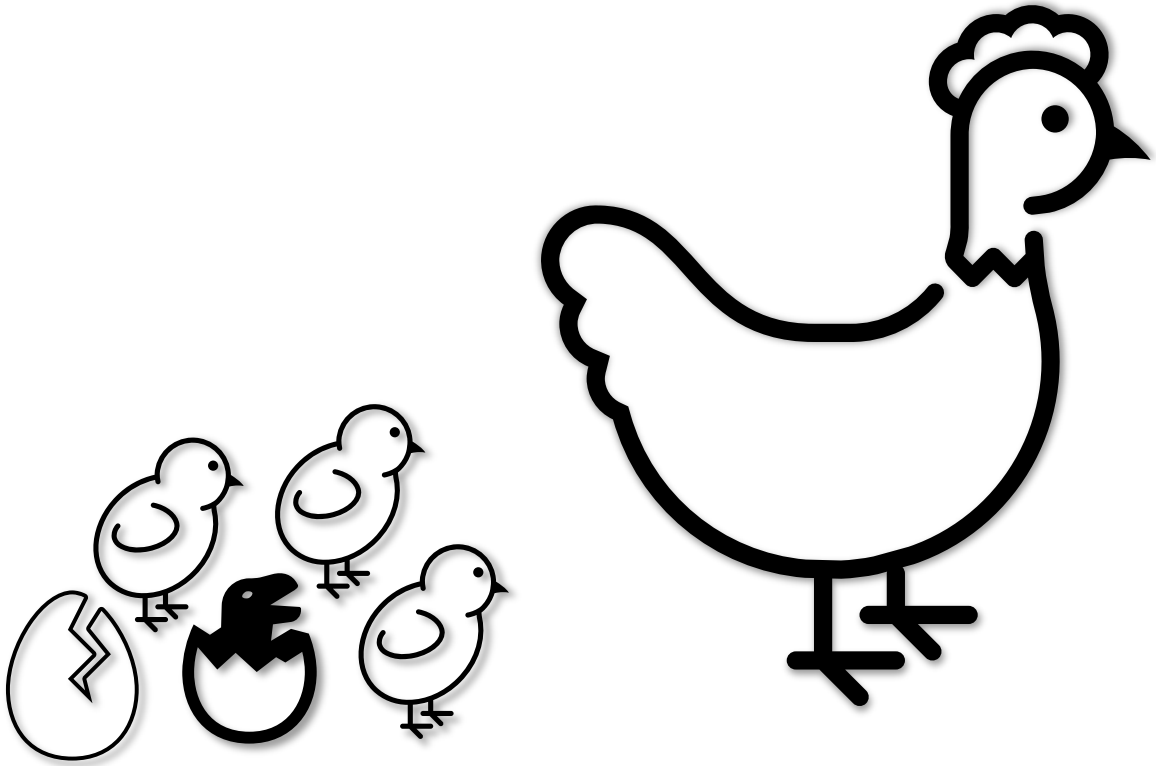
Future work

What's next…



Recovery Guide Pathway

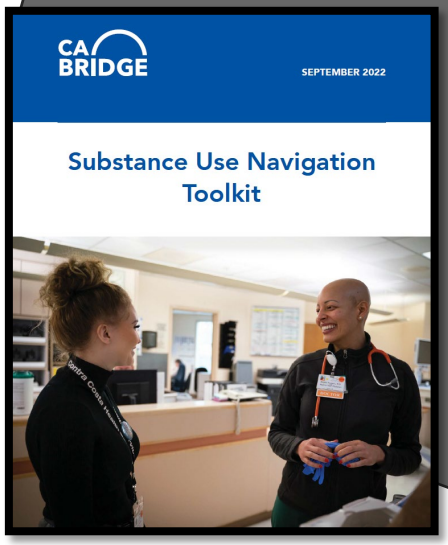
Risk/Relapse Management

Withdrawal Management

Case Management

Contingency Management

Outreach



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Mental Health ED Visits

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Present

Speak at Power Hour!

Get your socks

Receive I♥QI socks!

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