Health Quality Ontario

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Coordinated Care Management for Patients with Mental Health and/or Addictions Conditions

Summary of Innovative Practices

Released April 2017

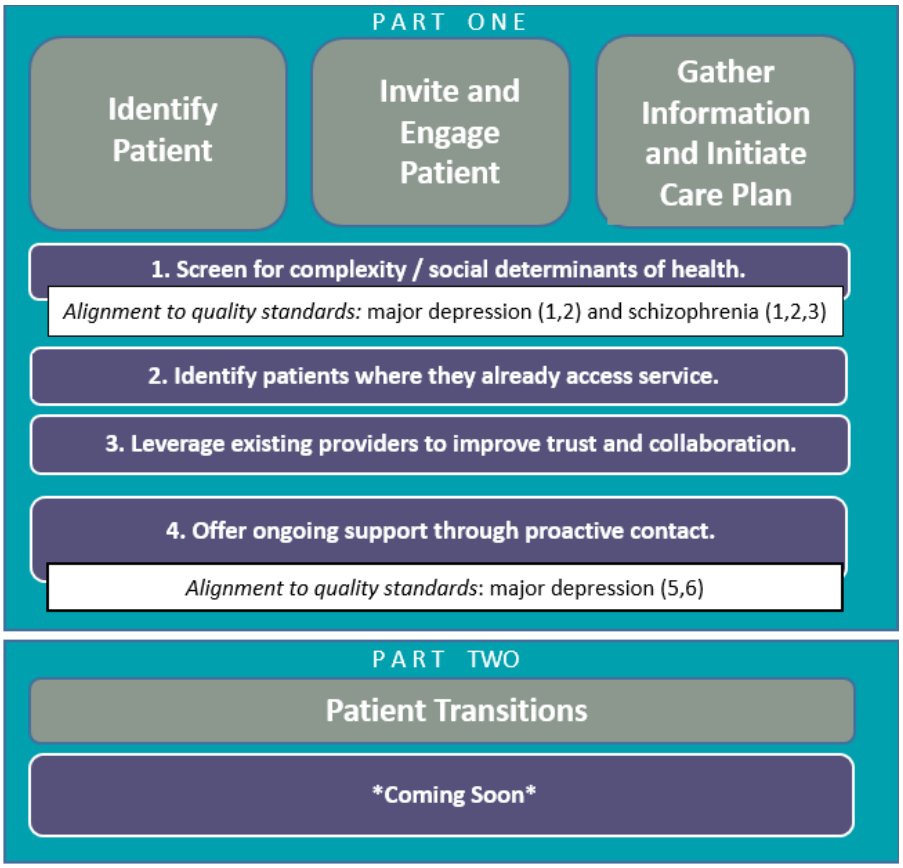
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based on best available evidence and quality improvement data to date) to improve the quality of coordinated care management for Ontarians with complex health and wellness issues. Patients, families, care providers, and system planners identified special considerations for coordinated care management that may be indicated for individuals with mental health and/or addictions conditions. These considerations specifically relate to themes of a) health equity and social determinants of health, b) unique partnerships with social and community services, and c) trust and relationships.

In collaboration with the Health Links, Health Quality Ontario completed an environmental scan of current innovative practices being trialed in the field, conducted a review of the best available evidence and quality improvement data, and identified a collection of innovative practices aimed to improve the quality of care relating to coordinated care management for patients with complex presentations that include mental health and addictions conditions. The resultant innovative practices and accompanying implementation supports will be released in two parts. Part 1 will focus on innovative practices that are associated with the *Identify Patient*, *Invite and Engage Patient*, and *Gather Information and Initiate Care Plan* steps of the coordinated care management process. Part 2 will focus on practices that are associated with the *Patient Transitions* step.

Innovative practices are designed to complement quality standards, which based on the best evidence, are concise sets of easy-to-understand statements that explain what quality care looks like. Quality standards focus on conditions and other health system issues where there are large unwanted variations in how care is delivered, or where there are gaps between the care provided and the care patients should receive (additional information available at www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards). Where there is alignment between an innovative practice and a specific quality statement from an associated quality standard, it is recommended that implementation of the quality statement precedes the implementation of innovative practices.

Figure 1 is an outline of innovative practices that are designed to improve coordinated care management for patients with mental health and addictions conditions. Associated quality statements are highlighted in this visual.

Figure 1: Practices to improve coordinated care management for patients with mental health and/or addictions conditions



Numbers in parentheses indicate the associated quality statements within the quality standard.

Although each practice, organization, region, or Health Link may have varying areas of foci, the following collection of innovative practices and implementation resources are designed to **help teams improve care for patients within the Health Link and support the ongoing alignment and advancement of consistent practices at a provincial level**.

Quality Improvement: Getting Started

Quality improvement (QI) is a proven methodology for improving care for patients, residents, and clients. Quality improvement is a formal approach to measuring performance and progress, wherein teams work **toward a defined aim**, gather and review data to inform their progress, and implement change strategies using rapid-cycle improvements. Quality improvement science provides **tools and processes** to assess and accelerate efforts for testing, implementation, and spread of QI practices (such as the coordinated care management practices).

*For additional information on quality improvement, please visit **qualitycompass.hqontario.ca/portal/getting-started** or contact **hlhelp@hqontario.ca** for access to e-learning modules.*

The materials for innovative practices are developed in collaboration with Health Links and the Clinical Reference Group.

Innovative Practices

Innovative practices are based on the highest quality evidence and information available and have been defined and assessed by a Clinical Reference Group.* It is suggested that Health Links draw upon this collection of innovative practices to create the foundation for supporting their coordinated care management processes and improving care for their patients with mental health and/or addictions conditions.

You will find the selected innovative practices relating to coordinated care management for patients with mental health and/or addictions conditions listed below. These practices were selected using a comprehensive environmental scan, evaluated using the **Innovative Practices Evaluation Tool**, and reviewed by the **Health Links Clinical Reference Group** in December 2016.

For additional information regarding this process and assessment criteria, please visit ***http://www.hqontario.ca/Portals/0/documents/bp/bp-inovative-practices-en.pdf****.*

Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
Use tools or approaches to screen for and/or assess complexity related to the social determinants of health, particularly income, housing, and food stability. *This practice is intended to build on the guidance provided by the Ministry of Health and Long-Term Care and the coordinated care management innovative practices previously endorsed by the Clinical Reference Group, which encourage Health Links to "identify patients" for coordinated care management using both "clinical and data-driven case-finding approaches." This practice places an emphasis on using standardized tools and/or clinical assessment methods to screen for/assess issues relating to social determinants of health in order to identify patients who may benefit from coordinated care management when indicated. It may also be used to complete further assessment and planning during the next step in the coordinated care management process: interview, gather information, and initiate care plan.*	EMERGING	Recommendation for provincial spread with reassessment using the Innovative Practices Evaluation Framework in 1 year (April 2018).
Bring coordinated care management to patients where they are already accessing health (or other) services. *This practice enables providers in a variety of settings where patients access services or care (health care or other) to identify complex patients and connect them to the coordinated care management process. This practice draws upon evidence that bringing care to marginalized populations supports improved access and engagement in care (compared to approaches that require patients to proactively seek out care).*	PROMISING	
Customize the approach to coordinated care management by leveraging or building trusted relationships to improve engagement.	EMERGING	

*The Clinical Reference Group is composed of subject matter experts in Health Links, researchers, academia, and stakeholders from across the province.

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This practice builds on the innovative practice previously endorsed by the Clinical Reference Group to use patient-centred communication strategies (i.e., "Invite and Engage Patient") and provide a single point of contact for coordinated care management, determining which provider is the most appropriate candidate to take on this role. To establish and improve engagement of patients with mental health and/or addictions issues, leveraging or creating partnerships among members of the care team to ensures that the coordinated care management process can be customized to meet the patient's needs. Specifically, in addition to having a single point of contact (often the health care provider that can collect, manage, and store health care information), the team should ensure that a member of the care team is either a trusted support person of the patient OR a provider with mental health and addictions experience. These roles may be represented by one individual who can successfully assume all of these roles or multiple individuals working in close collaboration. This cohesive team (which together can manage the logistical aspects while supporting the patient) leads to improved patient engagement.		
Proactively contact patients to promote engagement with coordinated care management while continuing to support self-efficacy. *This practice was highlighted by a number of Health Links during the environmental scan with the local health integration networks (LHINs) and Health Links. It involves proactively contacting the patient at regular intervals to support ongoing patient engagement, promote wellness, and reduce the occurrence of crisis (e.g., medical issues leading to avoidable emergency department visits). It also builds on some of the principles of intensive case management, which is generally accepted as an effective approach to supporting care of patients with complex health and wellness issues.*	PROMISING	

*For additional information, please visit the Tools and Resources Tab in the Health Links section of the Health Quality Ontario at **http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links**.*

Measurement

Quality improvement measures are used to help with monitoring progress in implementation of a change and determining whether that change is leading to improvement. Just as a health care provider may monitor heart rate or blood pressure to determine a patient's response to treatment, collecting information relating to processes for the improved provision of care allows the team to know whether they are consistently moving towards a high-reliability care environment.

*For more information on quality improvement and measurement visit **qualitycompass.hqontario.ca/portal/getting-started**.*

The following measures have been developed to help to determine whether the innovative practices relating to coordinated care management are being **implemented**; the impact of these practices on Health Links **processes**; and the **outcomes** of care at the patient, population, or systems level.

Health Links, organizations, and providers that elect to implement one or more of the coordinated care management innovative practices are **strongly encouraged to collect data on the associated measures and report them to Health Quality Ontario**. This will enhance analysis at the next review (April 2018), which will benefit all of the Health Links.

Innovative Practice	Outcome Measures *Are the changes having the intended impact?*	Process Measures *Are the practices being implemented as planned?*
1. Use tools or approaches to screen for and/or assess complexity related to the social determinants of health, particularly income, housing, and food stability.	Percentage of patients with complex conditions that include a mental health and/or addiction condition who are offered coordinated care management.	Percentage of Health Links reporting that patients are identified using information regarding social determinants of health, where indicated, in at least one care setting (e.g., hospitals, Community Care Access Centres, primary care).
2. Bring coordinated care management to patients where they are already accessing health (or other) services.	Number of patients with complex conditions that include a mental health and/or addiction condition who are offered coordinated care management at a site where they are already accessing a service.	Number of health care organizations involved in identifying patients with complex health and wellness issues that include a mental health and/or addiction condition and subsequently initiating coordinated care management. Number of other/nonï health care organizations involved in identifying patients with complex health and wellness issues that include a mental health and/or addiction condition) and subsequently initiating coordinated care management.
3. Customize the approach to coordinated care management by leveraging or building trusted relationships to improve engagement.	Percentage of patients with complex conditions that include a mental health and/or addiction condition who a) decline coordinated care management OR b) provide consent to coordinated care management *then subsequently withdraw their consent.*	Percentage of patients with complex health and wellness issues that include a mental health and/or addiction condition who report that they feel supported with coordinated care management *by someone that they trust*.
4. Proactively contact patients to promote engagement with coordinated care management while continuing to support self-efficacy.	Percentage of patients with complex conditions that include a mental health and/or addiction condition who report that they strongly agree or agree with the following statement: "I have personalized support to enhance my wellness through the coordinated care management process." Percentage of patients with complex conditions that include a mental health and/or addiction condition who provide consent to coordinated care management *then subsequently withdraw their consent.*	Number of patients who receive proactive monitoring from their Health Links within a target number days OR within a target interval.

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