Health Quality Ontario

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

Bring Coordinated Care Management to Patients Where They Are Already Accessing Health (or Other) Services

Released April 2017

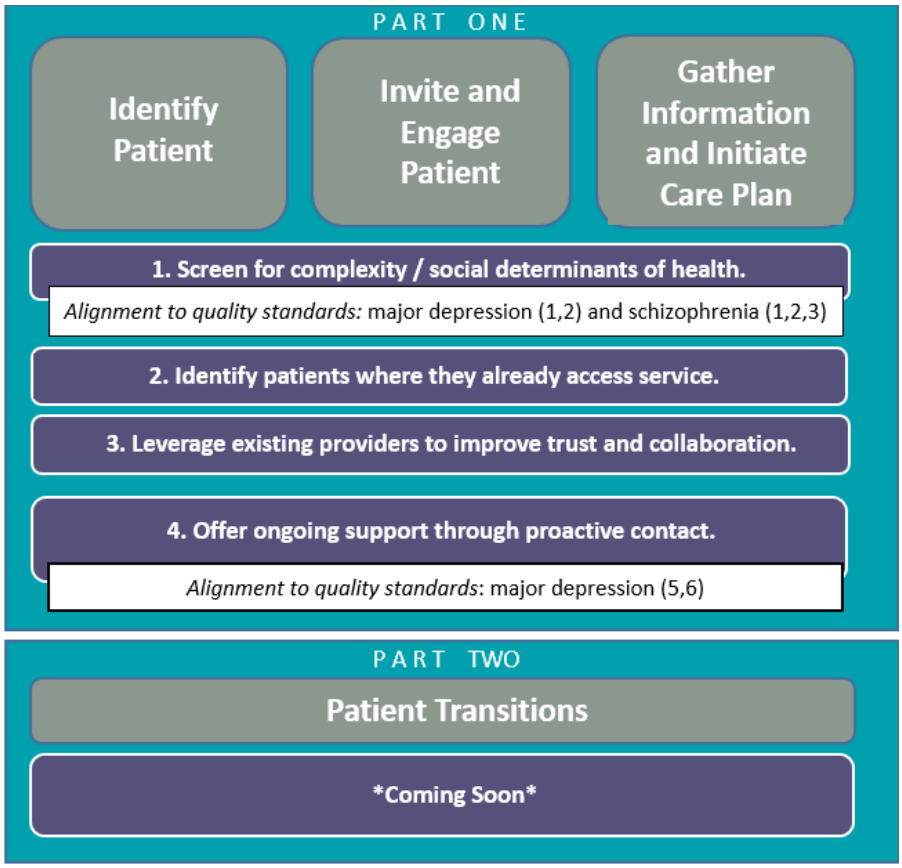
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based 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 1) health equity and social determinants of health, 2) unique partnerships with social and community services, and 3) 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. Based on the best evidence, 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 http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/View-all-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

Context

Accessing health care can be difficult for patients who have mental health and/or addictions conditions.[1] For example, patients with mental health and/or addictions conditions are less likely to have timely access to primary care and are more likely to visit the emergency department (ED) for care that could best be provided elsewhere.[1] Health Link providers have reported that some patients may also receive care in other systems, such as social services (e.g., emergency shelters) and justice systems (e.g., emergency services and penal systems). Connecting patients to appropriate health care when needed could potentially lead to improved health and better outcomes.

Description of this Innovative Practice

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*).[1,1]

Innovative Practice	Innovative Practice Assessment*	Clinical Reference Group Endorsement for Spread
Bring coordinated care management to patients where they are already accessing health (or other) services	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework* in 1 year (April 2018)

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
At the Health Link planning level: 1. Create partnerships with social and community service agencies that interact with complex patients with mental health and/or addictions conditions 2. Develop processes that facilitate improved care for patients or patient populations **At the clinical level:** 1. Clinical providers should participate in training and/or self-directed learning to understand the local Health Link and coordinated care management processes and practices in place 2. When in contact with a patient with complex health and wellness issues that include mental health and/or addictions conditions, follow Health Link processes to initiate coordinated care management	**Hamilton Niagara Haldimand Brant (HNHB) Coordinated Care Planning Toolkit**: http://www.hnhblhin.on.ca/forhsps/HealthLinkResources.aspx **Central East Health Links Toolkit—Coordinated Care Planning**: http://www.centraleastlhin.on.ca/goalsandachievements/healthlinks.aspx	**At the Health Link planning level:** Consider agencies that are not within the realm of the traditional health care system but that may have significant impact on long-term success for complex patients (e.g., housing, transportation, language services, and employment agencies) If distance is a challenge to receiving timely care, Ontario Telemedicine Network (OTN) may enable connection between clients and teams **At the clinical level:** Each partner organization and provider should be clear about their roles in coordinated care management. For example, some organizations are positioned to identify and engage patients, but are unable to support the full coordinated care management process. In these cases, it is beneficial to have processes in place to connect with organizations and providers that *can* complete the coordinated care management process moving forward.

*For more information about the Innovative Practices Evaluation Framework assessments, please go to the following link: http://www.hqontario.ca/Portals/0/documents/qi/health-links/innovative-practices-evaluation-framework-overview-en.pdf.

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** please visit* http://qualitycompass.hqontario.ca/portal/getting-started.

The following measures have been developed to help to evaluate whether the innovative practices 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.

Suggested Measurements ***(please see Appendix A for additional details)***	
Outcome Measures	**Process Measures**
Number of patients with complex health and wellness issues 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/non–health care organizations involved in identifying patients with complex health and wellness issues that include a mental health and/or addiction condition

References

Brien S, Grenier L, Kapral ME, Kurdyak P, Vigod S. Taking Stock: A Report on the Quality of Mental Health and Addictions Services in Ontario [Internet]. Toronto: Health Quality Ontario and Institute for Clinical Evaluative Sciences; 2015 [cited 2016 Oct 15]. Available from: http://www.hqontario.ca/Portals/0/Documents/pr/theme-report-taking-stock-en.pdf.

2. Health Quality Ontario. Measuring Up 2016: A Yearly Report on how Ontario's Health System is Performing [Internet]. Toronto: Health Quality Ontario; 2016 [cited 2016 OCT 15] Available from: http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf.

Appendix A: Examples of this Innovative Practice from the Field
Bring Coordinated Care Management to Patients Where They Are Already Accessing Health (or Other) Services

Released April 2017

This appendix contains examples of how Health Links, partner organizations, and providers have implemented this innovative practice to date. Please note that this resource is intended to support (not replace) operational and clinical decision-making within the Health Links. Each Health Link may choose to build on the examples or use them to inform the design of alternative implementation approaches as appropriate.

These examples were identified through broad consultation with LHINs, Health Links, and Quality Improvement Specialists supporting the LHIN regions. Additionally, innovative practices were captured through analysis of Quality Improvement Plans (QIPs), Improving and Driving Excellence Across Sectors (IDEAS) project work, the Excellence through Quality Improvement Project (E-QIP), and Health Quality Transformation abstract submissions.

How Have Others Implemented the Practice?

Please note that implementation of these innovative practices are presented in alphabetical order, by name of the first LHIN cited.

Hamilton Niagara Haldimand Brant (HNHB) LHIN
Hamilton East Health Link

The Hamilton East Health Link has built partnerships and worked in collaboration with community agencies, such as Street Outreach and the Wesley Urban Ministries, to actively seek out at-risk patients, support their coordinated care management, and connect them with appropriate services and resources. Anecdotal findings suggest that this approach has been very effective in keeping the Integrated Care Lead (ICL) in contact with individuals who are transient and do not have a phone.

Tools and Resources

- "Hear What Matters, Imagine What's Possible" (video): http://hchealthlink.ca/what-we-do/patient-engagement
- Hamilton Niagara Haldimand Brant LHIN's Coordinated Care Planning Toolkit: www.hnhblhin.on.ca/forhsps/HealthLinkResources/CoordinatedCarePlanningToolkit.aspx

The Hamilton East Health Link at St. Joseph's Healthcare Hamilton ran a pilot project to explore the impact of bringing a community addiction counsellor to the bedside of patients admitted for reasons associated with addictions to engage them in a discussion about their care. The objective was to "turn a crisis into an opportunity" by connecting patients with support in a timely manner. Through this pilot, it was learned that a key factor for ongoing success of the project would include transitional support and ongoing post-discharge support from a skilled addictions treatment provider. The Health Link is now aiming to create a sustainable funding model to support the continuation of this project.

North Simcoe Muskoka LHIN
South Georgian Bay, Barrie, Couchiching, and North Simcoe Health Links

Within the North Simcoe Muskoka LHIN, four Health Links have participated in a provincially funded pilot project exploring the effect of creating connections with paramedic services. Specifically, when a patient calls 911, the paramedic who responds to the call ascertains whether or not the patient may benefit from coordinated care management. Patients are identified as potential candidates for coordinated care management if a) they frequently access 911 services; b) the paramedic observes potential factors related to risk of health and well-being in the home; or c) they present with at least one chronic illness. Patients meeting one to two of these criteria are connected with a paramedic coordinator, who initiates a Health Link referral form (link to template, below). The patient is then connected with a geographically appropriate Health Link, and coordinated care management is initiated. An evaluation of the impact of the program is underway.

South East LHIN
Thousand Islands Health Link

As the lead organization for the Thousand Islands Health Link, with a long history of multiple partnerships in their communities, the Upper Canada Family Health Team is supporting the role of a 0.2 full-time equivalent (FTE) nurse practitioner (NP) in their methadone clinic. The methadone clinic is a stand-alone clinic that serves clients with an opioid dependency, typically with a dual diagnosis, who have three or more other medical conditions, many being chronic in nature. The role of the NP is to support the patient with coordinated care management; advocate for the client in the areas of housing, system navigation, facilitating transportation to appointments, and reducing stigma around mental illness; manage urgent medical conditions; and make referrals as necessary.

The success of this practice is due to strong community partnerships, high degree of trust and respect between clients and clinic professionals (NPs, physicians, nurses), and the high level of responsiveness to patient care needs. Many patients within the Health Link are unattached to primary care (by choice) and are comfortable receiving care at the clinic when the need arises. Anecdotal evidence suggests that this practice has been associated with a reduction in ED visits and hospitalizations. Evaluation is ongoing.

Appendix B: Measurement Specifications

Bring Coordinated Care Management to Patients Where They Are Already Accessing Health (or Other) Services

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1. Number of patients with mental health and/or addictions issues who are offered coordinated care management at a site where they are already accessing services.

Innovative Practice	Bring coordinated care management to patients where they are already accessing health (or other) services
Type of Measure	Outcome measure
Definition/Description	Identify patients with mental health and/or addictions issues where they are already accessing health (or other) services Dimensions: effective, patient-centred, timely, equitable Direction of Improvement: ↑
Additional Specifications	Calculation method: Simple count of patients Inclusion criteria: Patients with complex health and wellness issues, including a mental health and/or addictions condition, who are offered coordinated care management Exclusion criteria: Patients who meet the criteria but who are not offered coordinated care management because they have moved beyond Health Link catchment area or have died
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months
Data Source	Manual data collection by participating primary care, hospital, and community care providers within the Health Link
Comments	Selected outcome measures will help to evaluate the impact of innovative practices on coordinated care management outcomes It is recognized that some patients who meet these criteria may not need Health Links, and patients who need Health Links may not be flagged through these criteria. However, reaching out to patients where they are already accessing health or other services can optimize the Health Links' ability to identify as many patients as possible who may benefit from coordinated care management

2. 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.

Innovative Practice	Bring coordinated care management to patients where they are already accessing health (or other) services
Type of Measure	Process measure
Definition/Description	Engage health care providers outside of the Health Link to identify patients who may be eligible for coordinated care management in locations where they are currently receiving other services Dimensions: effective, patient-centred, timely, equitable Direction of improvement: ↑
Additional Specifications	Calculation method: Simple count of health care providers Inclusion criteria: Health care organizations that have identified a patient with complex health and wellness issues that include a mental health and/or addictions condition for coordinated care management in the past 3 months Exclusion criteria: Other/non–health care organizations that have not identified a patient with mental health and/or addictions condition for coordinated care management in the previous 3 months
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months
Data Source	Manual data collection by participating primary care, hospital, and community care providers within the Health Link
Comments	Process measures are used to assess: • Progress in implementation components such as reach (how often the practice is being used) • Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate • Sustainability of the process as designed so that it will continue once the initial attention has waned

3. Number of other/non–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.

Innovative Practice	Bring coordinated care management to patients where they are already accessing health (or other) services
Type of Measure	Process measure
Definition/Description	Engage other/non–health care providers to identify patients who may be eligible for coordinated care management in locations where they are currently receiving other services Dimensions: effective, patient-centred, timely, equitable Direction of Improvement: ↑
Additional Specifications	Calculation method: Simple count of other/non–health care providers Inclusion criteria: Number of other/non-health care organizations that have identified a patient with complex health and wellness issues, including a mental health and/or addictions condition, for coordinated care management in the previous 3 months Exclusion criteria: Other/non–health care organizations that have not identified a patient in the previous 3 months
Reporting Period	Recommend that Health Links collect and report data for a minimum of 3 months
Data Source	Manual data collection by participating primary care, hospital, and community care providers within the Health Link
Comments	Process measures are used to assess: • Progress in implementation components such as reach (how often the practice is being used) • Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate • Sustainability of the process as designed so that it will continue once the initial attention has waned