Health Quality Ontario

Let's make our health system healthier

Ontario
Health Quality Ontario

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

Proactively Contact Patients to Promote Engagement with Coordinated Care Management While Continuing to Support Self-Efficacy

Released April 2017

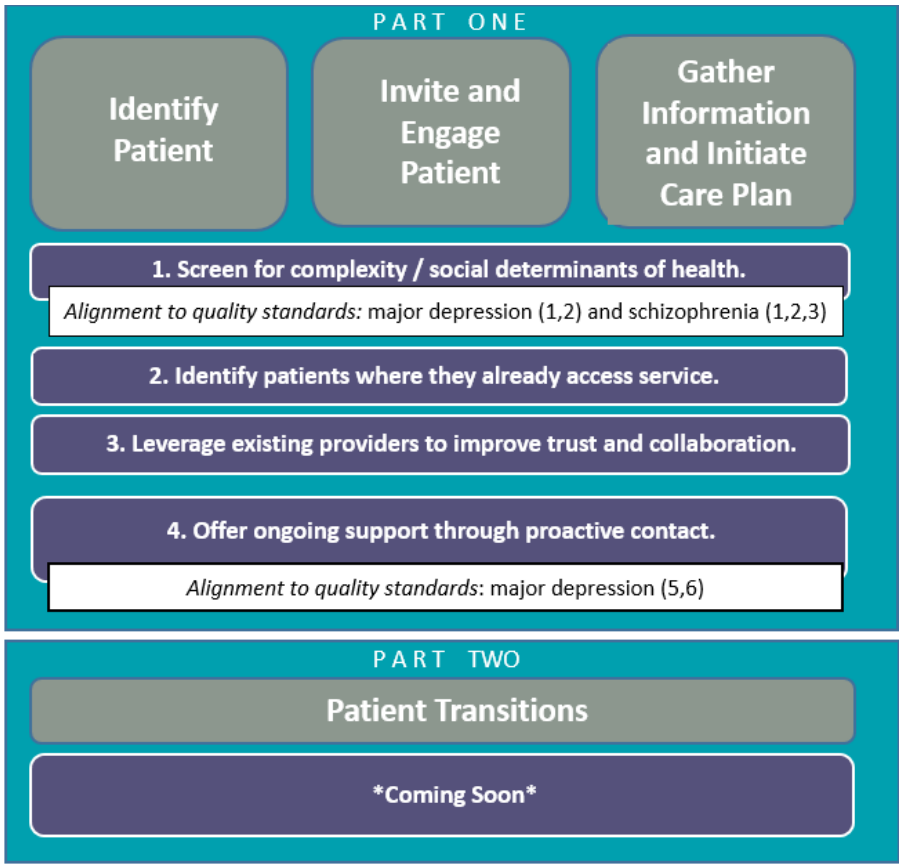
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based 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. 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 *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

Context

During an environmental scan, some Health Link providers reported that engaging patients who have mental health and/or addictions conditions in coordinated care management and maintaining this engagement over time can be challenging. This was attributed to a number of reasons, including issues related to stigma, mistrust of care providers and the health care system, and other factors. Some Health Link providers have indicated that patients with complex health and wellness issues that include mental health and/or addictions conditions are more likely to decline coordinated care management or else will provide consent then subsequently withdraw from the process.

Description of this Innovative Practice

The foundation of this practice builds on the principles of intensive case management, which is generally accepted as an effective approach that includes offering ongoing, supportive one-on-one care to patients with complex health and wellness issues.

A number of LHINs and Health Links reported that*, in particular*, proactively contacting patients at regular intervals (to maintain a connection and offer support) appears to contribute to improved patient engagement and participation in coordinated care management and to promote wellness and reduce the occurrence of crisis (e.g.,

medical issues leading to avoidable emergency department visits). Typically, proactive engagement involves ongoing appointments, phone calls, or other methods of regular follow-up.

Innovative Practice	Innovative Practice Assessment*	Clinical Reference Group Endorsement for Spread
Proactively contact patients to promote engagement with coordinated care management while continuing to support self-efficacy	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. Develop a shared language and common understanding of patient engagement concepts and strategies 2. Develop a common protocol and process for selecting which patients may benefit from proactive and supportive contact **At the patient level:** 1. On a patient-by-patient basis, select patients who may benefit from proactive and supportive contact, as per common protocol or process (or clinical judgement) 2. Determine most responsible person(s) to conduct proactive follow-up and establish a schedule or interval for regular check-ins 3. Complete proactive check-ins as per schedule or interval 4. Ensure that revisions to the coordinated care plan are documented and shared with the care team	**Proactive Monitoring via the Guided Care Nursing Model**: www.healthlinkSSM.com http://www.hopkinsmedicine.org/institute_nursing/models_tools/guided_care_nursing.html **"Engaging the Patient in Care Coordination and Obtaining Consent to Share Information with the Health Links Care Team" (Health Quality Ontario Webinar; September 22, 2015)*:*** http://www.hqontario.ca/portals/0/documents/qi/health-links/ccp-webinar-step-2-en.pdf	**At the Health Link planning level:** Health Links are encouraged to provide education on the benefits of proactive check-ins and support the ongoing development of clinical skills, such as motivational interviewing or brief action planning, to ensure the success of these interactions **At the clinical level:** Providers and care teams are encouraged to embed the decision-making, planning, and scheduling of the proactive contact into the coordinated care management process to ensure efficiency (i.e., reduce the likelihood of omission or duplication of efforts)

*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.

Connecting the Dots: Aligning Innovative Practices and Quality Standards

Quality standards are concise sets of easy-to-understand statements based on the best evidence. They provide practices that can further assist partners with coordinated care management. *Additional information regarding Quality Standards available at: http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards*

Quality Standard for Major Depression: Care for Adults and Adolescents
This quality standard includes quality statements that apply to care for adults and adolescents who have suspected major depression, in all care settings, with the exception of women with postpartum depression and young children. *Additional information regarding this Quality Standards available at: http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/view-all-quality-standards/Major-Depression*

This innovative practice aligns with the following quality statements:

- **Quality Statement 5—Adjunct Therapies and Self-Management:** Therapies and self-management strategies such as light therapy, yoga, physical activity, behavioural activation, sleep hygiene, and good nutrition can be effective complements to antidepressant medication or psychotherapy for major depression, potentially resulting in faster improvement and fewer residual symptoms. Therapies that are more feasible and pleasurable for people improve their likelihood of being effective.
- **Quality Statement 6—Monitoring for Treatment Adherence and Response:** Assessing treatment response is critical to optimizing care. Nonadherence to treatment is common and a major reason for inadequate response to treatment and the recurrence of symptoms. As depression is increasingly conceptualized and treated as a recurrent or chronic condition, efforts to enhance treatment adherence should be encouraged. Additional emphasis should be put on closely monitoring adolescents and young adults (under 25 years of age).

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 ***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.

Suggested Measurements ***(please see Appendix A for additional details)***	
Outcome Measures	**Process Measure**
Percentage of patients with complex health and wellness issues 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 health and wellness issues that include a mental health and/or addiction condition who provide consent for coordinated care management *then subsequently withdraw their consent*	Number of patients who receive proactive monitoring from Health Link within a target number of days OR within a target interval

Appendix A: Examples of this Innovative Practice from the Field

Proactively Contact Patients to Promote Engagement with Coordinated Care Management While Continuing to Support Self-Efficacy

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
Brant Health Link

The Brant Health Link ensures patients know who their care coordinators are and what is in their care plans, and executes periodic check-ins to ensure the care plan is working to improve well-being and reduce return visits to the emergency department. When a patient refuses care, the Brant Health Link has an open door policy so patients can connect when they are ready.

Niagara South West Health Link

The Niagara South West Health Link has had success with a few patients simply by providing them with a community paramedic cell phone number and having a case manager check in on them regularly. Anecdotal findings suggest that having access to a specific provider increased the likelihood that a patient would seek support, particularly in the management of acute addiction episodes. Several patients with addiction conditions have reported long stretches of sobriety and attribute that to this proactive support.

North East LHIN
Sault Ste. Marie Health Link

Within the North East LHIN, the Sault St. Marie Health Link has implemented the Guided Care® Nursing model from Johns Hopkins Medicine to support coordinated care management. The Guided Care® model includes proactive monitoring for patients. Specially educated nurses monitor patients by telephone or home visits at a minimum of once a month; evaluate adherence to the action plan to detect and address emerging problems;

communicate back to patients' primary care providers when any health concerns emerge; facilitate and implement appropriate actions; and communicate with identified care team members on progress, changes, and updates.

Tools and Resources

- Resource Manual (which includes a process map): http://www.healthlinkssm.com/resources-tools.
- "It's About You, The Patient" [Health Link Video]: http://www.healthlinkssm.com/human-connection.

North Simcoe Muskoka LHIN

Barrie Health Link

Within the North Simcoe Muskoka LHIN, the Barrie Health Link has created connection with the Barrie Situation Table. Multiple agencies participate in the Situation Table, with the objective of identifying individuals in the community at "high risk." These individuals are then connected to services to reduce risk. With their consent, some "high-risk" individuals may receive a wellness visit from uniformed police officer and a Canadian Mental Health Association (CMHA) outreach worker for additional support, including connection to the Health Link and coordinated care management.

In the fall of 2015, the Barrie COAST (Crisis Outreach and Support Team) Pilot Program provided wellness visits by a CMHA outreach worker and a plain-clothes police officer in an unmarked car to patients identified as frequent 911 users. During the 90-day pilot period, approximately 75 individuals received these visits. An analysis of pre- and post-data revealed reductions in emergency department visits and police apprehensions and increased connection to support services, including Health Links.

Couchiching Health Link

As part of their coordinated care management process, the Couchiching Health Link includes close follow-up (daily, weekly, then every other week) with patients until all services are in place, to prevent admissions to hospital. Visits are done in conjunction with a mental health worker who is also a social worker. The relationship of trust created between the patient navigator and the patient is crucial to this process as it helps uncover who needs closer follow-up. Evaluation results suggest that this practice contributes to a reduction in emergency department visits at the local hospital.

Appendix B: Measurement Specifications

Proactively Contact Patients to Promote Engagement with Coordinated Care Management While Continuing to Support Self-Efficacy

Released April 2017

1. Percentage of patients with complex health and wellness issues 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."

Innovative Practice	Offer proactive support to patients to promote engagement with coordinated care management, while continuing to support self-efficacy
Type of Measure	Outcome measure
Definition/Description	Proactively contacting the patient at regular intervals can present additional opportunities to provide supports to enhance wellness and reduce the occurrence of crisis (e.g., medical issues leading to avoidable emergency department visits) Dimensions: Patient-centred, timely, equitable Direction of improvement: ↑
Additional Specifications	Numerator: Number of patients who report that they “agree” or “strongly agree” with the statement, “I have personalized support to enhance my wellness through the coordinated care management process" Denominator: Number of patients interviewed Exclusion criteria: Patients who meet the criteria but who are not offered access to the Health Link 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	Patient survey; manual data collection by participating primary care, hospital, and community care providers within the Health Link
Comments	Selected outcome measures will help to evaluate efforts to introduce innovative practices into coordinated care management

2. Percentage of patients who provide consent for coordinated care management then subsequently withdraw their consent.

Innovative Practice	Offer proactive support to patients to promote engagement with coordinated care management, while continuing to support self-efficacy
Type of Measure	Outcome measure
Definition/Description	In addition to providing additional support to promote wellness and reduce the occurrence of crisis (e.g., medical issues leading to avoidable emergency department visits), ongoing proactive contact may also help to retain patients and minimize attrition Dimensions: Patient-centred, timely, equitable Direction of improvement: ↓
Additional Specifications	Numerator: Number of patients with complex health and wellness issues that include a mental health and/or addiction condition who provide consent for coordinated care management then withdraw their consent Denominator: Number of patients with complex health and wellness issues that include a mental health and/or addiction condition who provide consent for coordinated care management Exclusion criteria: Patients who 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	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 patients who receive proactive monitoring from their Health Links within a target number of days or within a target interval.

Innovative Practice	Offer proactive support to patients to promote engagement with coordinated care management, while continuing to support self-efficacy
Type of Measure	Process measure
Definition/Description	Proactively contacting the patient at regular intervals 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. Providers are encouraged to set targets for the time frame during which patients will receive proactive follow-up and strive to achieve and maintain targets Dimensions: Patient-centred, timely, equitable Direction of improvement: ↑
Additional Specifications	Numerator: Number of patients with complex health and wellness issues that include a mental health and/or addiction condition who are eligible for proactive monitoring from a Health Link and who receive it within a target number of days or at target intervals Denominator: Number of patients with complex health and wellness issues that include a mental health and/or addiction condition who are eligible for proactive monitoring Exclusion criteria: Patients who 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	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