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

Customize the Approach to Coordinated Care Management by Leveraging or Building Trusted Relationships to Improve Engagement

Released April 2017

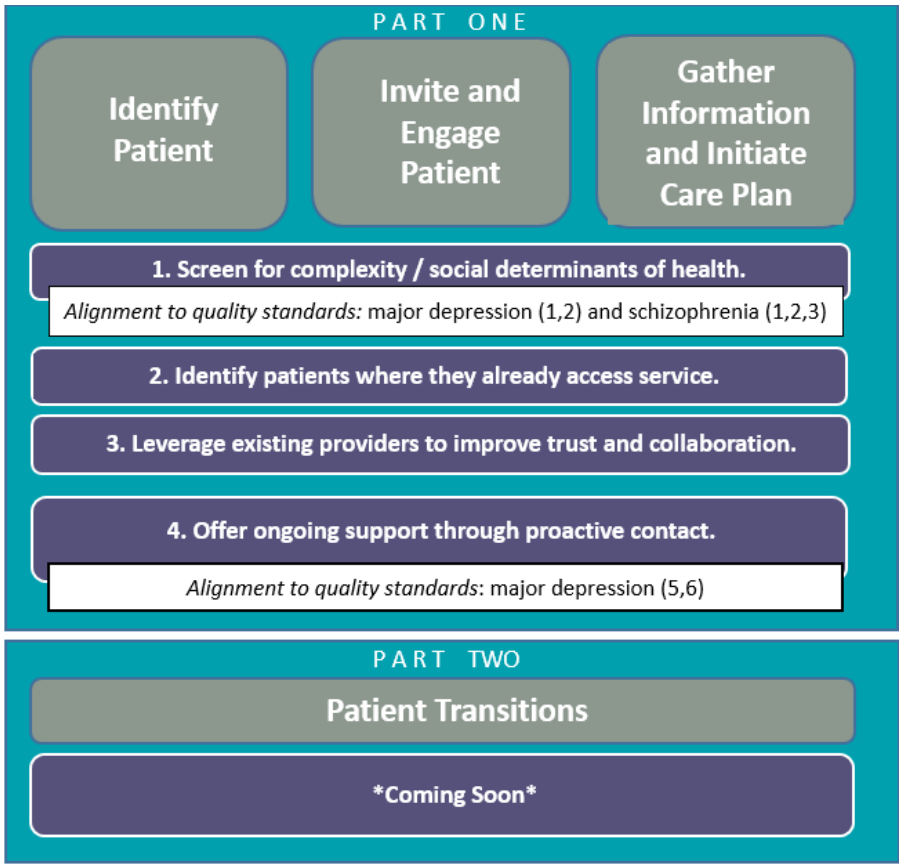
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based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

To establish and improve engagement of patients with mental health and/or addictions issues, leveraging or creating partnerships among members of the care team 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 who 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.

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

Innovative Practice	Innovative Practice Assessment*	Clinical Reference Group Endorsement for Spread
Customize the approach to coordinated care management by leveraging or building trusted relationships to improve engagement	EMERGING	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. Ensure that health care organizations and providers within the Health Link (those able to collect, manage, and store patient-level health information) who provide care to patients with mental health and/or addictions issues are able to support patients with the *full* coordinated care management process, where possible 2. Create partnerships with social and community service agencies that interact with complex patients with mental health and/or addictions conditions, enable these providers to identify and engage patients in coordinated care management, then effectively partner with health care providers to support the patient **At the patient level:** 1. Health care and social/community support 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	**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 **"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	Health Links partner organizations may wish to explore temporary secondments to support the development of cohesive, seamless teams. For example, a partner organization may explore having a mental health and/or addictions provider co-locate within a health care organization to increase opportunity for collaboration Health Links may also wish to explore how to enable and support other members of the care team (caregivers, volunteers, peers, etc.) to assume role of the

*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.

Implementation of the Innovative Practice		
Steps for Implementation	**Tools and Resources**	**Considerations**
2. On a patient-by- patient basis, select the most appropriate single point of contact for the patient, referencing coordinated care management innovative practices ("Invite and Engage Patient"). *If* the single point of contact does not have an established relationship with the patient, select an additional member of the care team with an existing relationship (preferred) OR a mental health and/or addictions provider (alternative) to support the patient by leveraging or building a trusted relationship. Ensure close collaboration between the single point of contact and the selected member of the care team to support the patient throughout the coordinated care management process.		supporting member of the care team, where possible. This may include education, consultation, and support. If exploring this option, Health Links will wish to ensure that all processes and practices meet legislative, legal, and regulatory requirements

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 Measure	**Process Measure**
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 for 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*

Appendix A: Examples of this Innovative Practice from the Field
Customize the Approach to Coordinated Care Management by Leveraging or Building Trusted Relationships to Improve Engagement

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.

Central LHIN
North York West Health Link
Within the Central LHIN, the North York West Health Link in partnership with Across Boundaries, the Canadian Mental Health Association, Cota, and LOFT Community Services, offers a rapid-response service to provide support to patients with mental health and/or addictions conditions. The goal of rapid response is to develop a rapport and relationships with clients who may not yet be ready for intensive case management, providing tailored, supportive, coordinated care. Specifically, the rapid-response service employs a patient-centred approach by engaging the client where they are most comfortable in their health care journey.

North East LHIN
Greater Sudbury Health Link

The Greater Sudbury Health Link has adopted a “liaison model,” in which providers from eight Greater Sudbury Health Link (GSHL) partner agencies have assumed the role of GSHL Liaison. These trained staff comprise diverse service, linguistic, and cultural mandates. The GSHL Liaisons are selected based on which liaison agency is best suited to support the patient, based on individual preferences, needs, goals, and existing relationships.

North West LHIN
City of Thunder Bay Health Link

Within the North West LHIN, the City of Thunder Bay Health Link has introduced the role of Health Coach. Health Coaches develop strong therapeutic relationships with patients based on unconditional positive regard, empathy, and genuineness. One of the functions of the Health Coach is to build relationships and improve patient

engagement. In addition to providing personal assistance Health Link patients, they support, empower, navigate, and advocate in partnership with patients for their health and well-being.

South West LHIN
Huron Perth Health Link

Within the South West LHIN, the Huron Perth Health Link has been exploring peer support models which have been identified as a local improvement initiative. Augmenting the circle of care with peer support is considered to be an effective intervention for people experiencing mental health and addiction challenges. In Huron Perth, the focus of their program included improving existing models, promoting standards, establishing linkages and better integration between CSIs (community survivor initiatives) and the mental health care system, as well as enhancing governance and infrastructure. Further details of this work can be found in the report below which provides recommendations and considerations that may assist other Health Links exploring the implementation of peer support models.

Tools and Resources

- Peer Support Strategy Report and Logic Model: http://connectformh.ca/wp-content/uploads/2014/12/1_SWLHIN-Peer-Support-Strategy-Final-April-6_15-2.pdf.

Waterloo-Wellington LHIN

Guelph Health Link has established processes that, with patient consent, provide strong connection and channels of communication between Primary Care/Psychiatry, and the patient's preferred main care team.

Guelph Health Link
Integration of Canadian Mental Health Association (CMHA) Support Coordinator. Support Coordinator (SOS Services) connects patients without primary care to the Community Health Clinic (CHC). The CHC has a "Health guide" role that provides lower intensity services and can ramp up and down between SOS support coordinator.

Cambridge Health Link has embedded a mental health and addictions peer worker into the care team. This provider is able to provide assistance to the patient for basic daily needs such as teaching the patient to navigate the public transit system to access appointments. Early anecdotal information suggests that this role may be contribute to enhanced patient engagement.

Appendix B: Measurement Specifications

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Released April 2017

1. Percentage of patients with complex health and wellness issues that include a mental health and/or addiction condition who a) decline coordinated care management OR b) provide consent for coordinated care management *then subsequently withdraw their consent.*

Innovative Practice	Customize the approach to coordinated care management by leveraging or building trusted relationships to improve engagement
Type of Measure	Outcome measure
Definition/Description	Support patient engagement (indicated by the reduction in the percentage of patients who withhold or withdraw consent for coordinated care management) by leveraging patients' existing trusted relationships Dimensions: Safe, effective, patient-centred 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 decline coordinated care management OR 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 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	Selected outcome measures will help to evaluate how the innovative practice impacts patient care relating to coordinated care management

2. Percentage of patients with one or more mental health and/or addictions conditions who report they feel supported with coordinated care management *by someone that they trust.*

Innovative Practice	Customize the approach to coordinated care management by leveraging or building trusted relationships to improve engagement
Type of Measure	Process measure
Definition/Description	Ongoing engagement of patients in coordinated care management can be accelerated building trusting, supportive relationships with patients Dimensions: Safe, effective, patient-centred Direction of improvement: ↑
Additional Specifications	Numerator: Number of patients with mental health and/or addictions issues who consent to coordinated care management and who subsequently report that their care coordination is supported *by someone they trust* Denominator: Number of patients with mental health and/or addictions issues who consent to initiate coordinated care management with the Health Link Exclusion criteria: Patients who are identified as good candidates for coordinated care management but who either do not consent or do not begin the process; those who have moved beyond Health Link catchment area; or those who 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	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