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

Use Tools or Approaches to Screen For and/or Assess Complexity Related to the Social Determinants of Health, Particularly Income, Housing, and Food Stability

Released April 2017

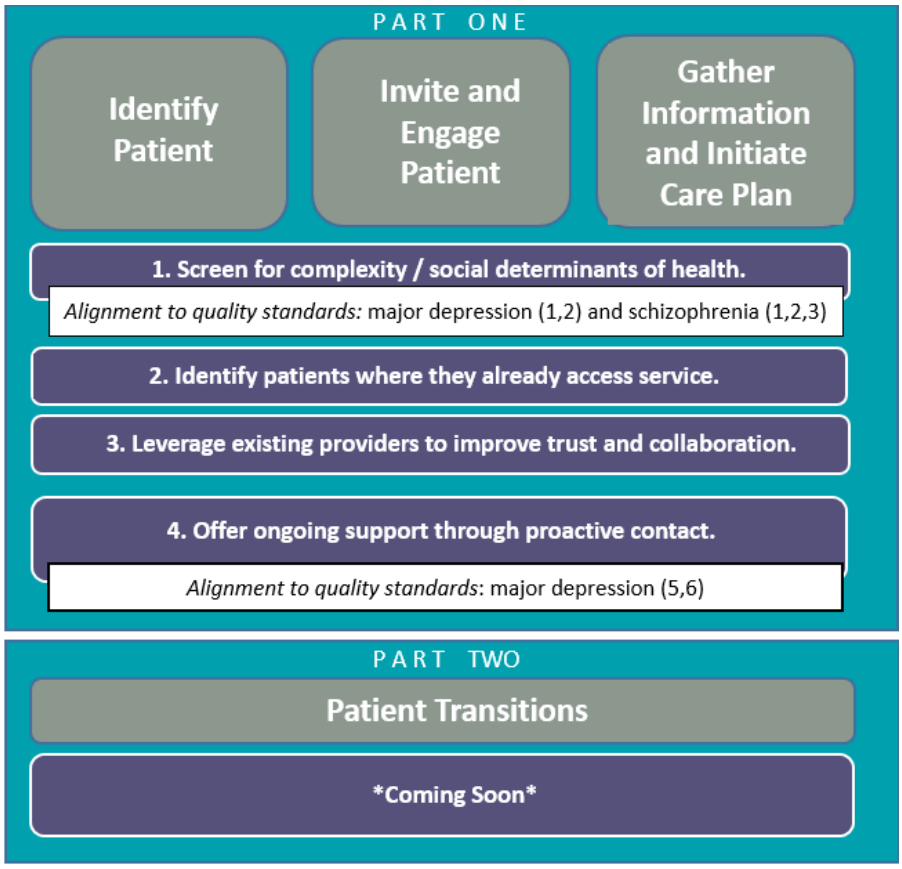
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based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

Individuals who have mental health and/or addictions conditions are more likely to present with issues relating to social determinants of health compared to other health care consumers.[1] Instability relating to income, housing, and/or food security appears to be associated with future high-cost health care consumption.[2] Additionally, many Health Links providers and patients report that issues relating to social determinants of health can be significant barriers to health and can impact discharge from hospital to home. However, there is *variation* in how Health Links screen for/assess issues relating to social determinants of health.

Description of this Innovative Practice

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. 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: gather information and initiate care plan.

Innovative Practice	Innovative Practice Assessment*	Clinical Reference Group Endorsement 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	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. Develop a shared language and common understanding across the Health Link, regarding social factors and their effect on health and well-being 2. Consider ways to share and leverage information that may already be collected (such as findings from the Ontario Common Assessment of Needs tool) with Health Link providers **At the clinical level:** 1. Select a formal/ informal assessment tool or build processes into clinical flow that support information finding regarding a patient's income, housing, and food stability (e.g., trigger questions,	**Ontario Common Assessment of Need (OCAN) tool:** https://www.ccim.on.ca/CMHA/default.aspx **Be Well Survey:** https://www.aohc.org/Canadian-Index-Wellbeing-Project **Ontario College of Family Physicians (OCFP) poverty screening tool:** http://ocfp.on.ca/cpd/povertytool **Patient-focused interactive map to determine possible supports**: http://www.nschl.ca/clients.html **Situation/Connectivity Table information:** http://taylornewberry.ca/addressing-risk-through-system-collaboration-evaluation-of-the-connectivity-situation-tables-in-waterloo-region/ http://www.usask.ca/cfbsjs/documents/FINAL%20Hub%20PIA%20May%202014.pdf http://www.vvcnetwork.ca/ipc/20161206/	**At the Health Link planning level:** Health Links are encouraged to collaborate to establish a consistent and streamlined approach to addressing and documenting social determinants of health to ensure efficiency (i.e., so that providers and patients are not required to ask and answer the same questions repeatedly) **At the clinical level:** Ensure that selected assessment tools and/or processes are aligned with legislative, legal, and regulatory criteria.

*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**
intake forms, referral prompts) as indicated 2. If the patient is in agreement, coordinate plans to support appropriate connections to services and resources in order to address any needs identified. Document plans in the coordinated care plan		Additional training and resources may be required

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 are 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 standard is 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 1-Comprehensive Assessment:** A comprehensive assessment allows for an accurate diagnosis of major depression and the collection of baseline measurements. It also allows for the identification of potential underlying conditions or issues (e.g., physical, cognitive, psychiatric, functional, or psychosocial factors) that may cause symptoms, and it informs their subsequent treatment. In addition, the assessment enables early identification of suicide risk.

- **Quality Statement 2-Suicide Risk Assessment and Intervention:** People with major depression have an increased lifetime risk of suicide and should be assessed for suicide risk on initial contact and throughout treatment. Health care providers, family members, and caregivers should be alert for suicide risk in people with a sad or depressed mood, suicidal ideation, and one or more risk factors, including previous suicide attempts, a family history of suicide, physical or sexual abuse, family violence, and chronic pain.

Quality Standard for Schizophrenia: Care for Adults in Hospitals

This quality standard includes quality statements that apply to care for people older than 18 years within an emergency department or hospital admission setting. It also provides guidance on care that takes place when a person is between settings, such as when discharged from hospital. *Additional information regarding this Quality Standard is available at* http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/view-all-quality-standards/Schizophrenia

This innovative practice aligns with the following quality statements:
• **Quality Statement 1-Comprehensive Interprofessional Assessment**: An assessment undertaken by an interprofessional health care team—and, ideally, informed by family, caregivers, and/or personal supports—provides an opportunity to thoroughly examine biological, psychological, and social factors that may have contributed to the onset, course, and outcome of the illness. An assessment can establish a diagnosis and determine a baseline level of functioning to track potential changes in the person's status. It should identify targets for intervention and treatment, as well as the person's own goals.
• **Quality Statement 2-Screening for Substance Use**: Substance use is common among people with schizophrenia and is associated with poor functional recovery. Substance use may exacerbate the symptoms and worsen the course of schizophrenia and may interfere with the therapeutic effects of both pharmacologic and nonpharmacologic treatments. Validated screening tools such as the Dartmouth Assessment of Lifestyle Inventory and the Leeds Dependence Questionnaire can assist with screening for substance use.
• **Quality Statement 3-Physical Health Assessment:** Adults with schizophrenia have poorer physical health and a shorter life expectancy than the general population: males with schizophrenia die 20 years earlier and females 15 years earlier. The most common cause of death is cardiovascular disease, which is partly owing to modifiable risk factors such as obesity, smoking, diabetes, hypertension, and dyslipidemia. Antipsychotic medications can be associated with weight gain and can aggravate other metabolic or cardiovascular risk factors. There is a need to comprehensively assess physical health, with a particular emphasis on cardiovascular risk factors and diabetes, to enable treatment if necessary.

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* 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 Measure**
Percentage of patients with complex conditions that include a mental health and/or addiction issue who are offered coordinated care management	Percentage of Health Links reporting that, in at least one care setting (e.g., Hospitals, Community Care Access Centre, Primary Care, etc.), patients are identified using information regarding social determinants of health, where indicated

References

1. Brien S, Grenier L, Kapral ME, Kurdyak P, Vigod S. Taking Stock: A Report on the Quality of Mental Health and/or 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. Fitzpatrick T, Rosella L, Calzavara A, Petch J, Pinto A, Manson H, et al. Looking Beyond Income and Education. Socioeconomic Status Gradients Among Future High Cost Users of Health Care. Am J Prev Med. 2015;49(2):161-171.

Appendix A: Examples of this Innovative Practice from the Field
Use Tools or Approaches to Screen For and/or Assess Complexity Related to the Social Determinants of Health, Particularly Income, Housing, and Food Stability

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.

Champlain LHIN and North Simcoe Muskoka LHIN
Upper Canada, Central Ottawa, and North Simcoe Health Links

A selection of Health Links are using the Be Well Survey to screen for or assess factors relating to a patient's health and well-being. The Be Well Survey includes 64 indicators for measurement, which are grouped across eight domains: community vitality, democratic engagement, education, environment, healthy populations, leisure and culture, living standards, and time use.

Both the Upper Canada Health Link and Central Ottawa Health Link administer the Be Well Survey with patients as a way of assessing social determinants of health. The information collected is used to inform the coordinated care plan.

The North Simcoe Health Link provides the Be Well survey for the patient to complete, then reviews and discusses the survey questions at the second appointment. The North Simcoe Health Link has also created a web-based tool—an online map—for patients to identify areas of improvement and inform the coordinated care plan. The map lists local services that might help patients with those specific areas, which can then be accessed by the patient directly or arranged via the Health Link.

Tools and Resources

- Be Well Survey*:* https://www.aohc.org/Canadian-Index-Wellbeing-Project
- Additional information from North Simcoe Health Link: http://www.nschl.ca/clients.html

Erie St. Clair LHIN
Chatham Kent Health Link

Within the Erie St. Clair LHIN, the Chatham-Kent Health Link leverages connections between the Canadian Mental Health Association (CMHA) and the Inn of Good Shepherd shelter and housing organization. Two providers from CMHA support individuals accessing the services of the Inn of Good Shepherd with accessing food, clothing, and finances (for example, with obtaining services to complete taxes). Also, these two providers attend the shelter three times per week to complete housing assessments, and support the transition to independent living.

North West LHIN and Toronto Central LHIN
City of Thunder Bay Integrated District Network and Mid East Health Links

The City of Thunder Bay Integrated District Network Health Link embedded questions related to the social determinants of health into the coordinated care plan, which prompt for related information. Social determinants of health receive the equitable attention, along with the patient's physical and mental health.

The Mid East Health Link includes questions related to the Social Determinants of Health on their referral form, to support screening.

South West LHIN
South Grey Bruce and North Grey Bruce Health Links

The Ontario College of Family Physicians (OCFP) Community of Practice has developed a poverty screening tool (available at https://thewellhealth.ca/poverty) consisting of just one question: “Do you have difficulty making ends meet at the end of the month?" The OCFP provides training on how clinicians can respond to the answers the question may solicit. They also tailor their training to the local resources that are available to physicians as well as to the provincial and federal programs that are available to all areas. North Grey Bruce and South Grey Bruce Health Links each hosted workshops centred on this tool. In each case, a half-day session was provided for all health care providers and a separate half-day/evening session was provided on the same day for primary care providers specifically.

Tools and Resources

- Additional information regarding the OCFP Community of Practice: http://ocfp.on.ca/cpd/povertytool

South East LHIN and Waterloo Wellington LHIN
Rideau Tay, Thousand Islands, Salmon River Health, Wellington, Guelph, Cambridge, and Kitchener-Waterloo (KW4) Health Links

These Health Links bring health and social service agencies together to address situations of acute elevated risk and help individuals access the services they need. These gatherings are often referred to as Situation Tables or Connectivity Tables. Cambridge Health Link was the first in the province to implement a Connectivity Table, which brings organizations together to identify patients requiring coordinated care management. The most appropriate organization to support coordinated care management is selected at that time. The Connectivity Table uses a 4-

filter approach to protect privacy of individuals involved. A 4-filter approach is a framework that supports decision-making about who may access/ handle personal health information, under what circumstances, and for what purposes, and outlines measures that must be in place to best protect a patient's personal health information.

Tools and Resources

- Nilson C. A Risk-Driven Collaborative Intervention [Internet]. Saskatoon: Centre for Forensic Behavioural Science and Justice Studies, University of Saskatchewan; 2014 [cited 2017 Feb 27]. Available from: http://www.usask.ca/cfbsjs/documents/FINAL%20Hub%20PIA%20May%202014.pdf
  - Evaluation report and background information: http://taylornewberry.ca/wp-content/uploads/2015/11/Connectivity-WR-Evaluation-Report-TNC-Nov-2015.pdf
- Additional Information regarding the 4-filter approach: https://www.ipc.on.ca/wp-content/uploads/2016/10/situation-table-deck-final-10-17-2016.pdf

Toronto Central LHIN and Mississauga Halton LHIN
In collaboration with the Oakville Health Link

Within the Toronto Central LHIN, mental health service providers utilize the Ontario Common Assessment of Need (OCAN) tool as an assessment tool within their local service delivery. Most Ontario CMHA health service providers (HSPs) have implemented the OCAN as part of a province-wide initiative. The OCAN is an evidenced-based tool that supports a consumer-driven approach, focusing on needs, strengths, and the development of a recovery plan based on the patient's daily life. Factors relating to the social determinants of health are included in the assessment. The information is collected by providers engaged in the provincial OCAN project, and shared among the care team.

Within the Mississauga Halton LHIN, the Oakville Health Link has engaged organizations that serve clients living with mental health and/or addiction conditions. These organizations are trained/coached to be able to identify clients who would most benefit from coordinated care management. Once the coordinated care plan is complete, the OCAN assessment results can be shared with the care team.

Tools and Resources

- OCAN: https://www.ccim.on.ca/CMHA/default.aspx

Waterloo Wellington LHIN
Guelph Health Link

Within the Waterloo Wellington LHIN, the Guelph Health Link is testing a tool originally developed by Public Health Wellington-Dufferin-Guelph called The Life Assessment Tool: Bridges Out of Poverty. This tool assesses many aspects of the social determinants of health, including housing, food security, violence, and safety. The tool is currently being tested in a Health Links context via an Improving and Driving Excellence Across Sectors (IDEAS) program, to be completed in the winter of 2017.

Appendix B: Measurement Specifications

Use Tools or Approaches to Screen For and/or Assess Complexity Related to the Social Determinants of Health, Particularly Income, Housing, and Food Stability

Released April 2017

1. **Percentage of patients with complex conditions that include a mental health and/or addiction issue who are offered coordinated care management.**

Innovative Practice	Use additional screening tools or approaches to screen for and/or assess complexity related to the social determinants of health
Type of Measure	Outcome measure
Definition/Description	Identify patients as potential candidates for coordinated care management by assessing and/or leveraging patient level information regarding social determinants of health, particularly income, housing, and food security. Dimensions: effective, patient-centred, equitable Direction of Improvement: ↑
Additional Specifications	Numerator: Total number of patients offered access to the Health Link Denominator: Total number of patients identified 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	Manual data collection by participating primary care, hospital, and community care providers within the Health Link
Sample Population	All patients who are receiving care through the Health Link are included in the sample
Comments	It is recognized that patients who meet these criteria may not need Health Links and patients who need Health Links may not be flagged through these criteria. However, using social determinants of health may help optimize the Health Link's ability to identify as many patients as possible who may benefit from coordinated care management

2. **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).**

Innovative Practice	Use additional screening tools or approaches to screen for and/or assess complexity related to the social determinants of health
Type of Measure	Process measure
Definition/Description	Assess the number of Health Links that report that patients are identified using information on social determinants of health Dimensions: effective, patient-centred, equitable Direction of Improvement: ↑
Additional Specifications	Numerator: Number of active Health Links within a LHIN reporting that they DO use social determinants of health to identify patients Denominator: Total number of active Health Links within the LHIN 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	The LHINs collect information by asking those working in the Health Link to implement coordinated care management and provide the information during the last Health Links quarterly data discussion of the 1-year innovative practice implementation cycle
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

Appendix C: Assessments that Elicit Information Regarding Social Determinants of Health

Use Tools or Approaches to Screen For and/or Assess Complexity Related to the Social Determinants of Health, Particularly Income, Housing, and Food Stability

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Which Clinical Assessment Should be Used?

A *single*, gold-standard assessment tool/method with adequate sensitivity and specificity to capture every patient who would benefit from a Health Links or coordinated care management approach was *not* identified. However, the following tools were highlighted by Health Links during the environmental scan, and are presented here for consideration. The decision to implement or administer one of these tools must be considered alongside other contextually relevant information.

Name of Tool	Overview	Source
Ontario Common Assessment of Need (Community Care Information Management)	Many Ontario Community Mental Health service providers have implemented the Ontario Common Assessment of Need (OCAN). The OCAN is an evidence-based tool that supports a consumer-driven approach, focusing conversations on needs, strengths, and the development of a recovery plan	https://www.ccim.on.ca/CMHA/default.aspx
Be Well Survey (Canadian Assessment of Wellbeing Project)	The Be Well survey was developed to provide members of the Associated Ontario Health Centres with information about the health and well-being of the people and communities they serve	https://www.aohc.org/Canadian-Index-Wellbeing-Project
OCFP Poverty Screening Tool (Ontario College of Family Physicians)	The Ontario College of Family Physicians (OCFP) developed a poverty screening tool that consists of just one question: “Are you having difficulty making ends meet at the end of the month?”	http://ocfp.on.ca/cpd/povertytool