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 – Part 2

## Support improved access, attachment, and/or transitions to primary care providers in the community.

*Released July 2017*

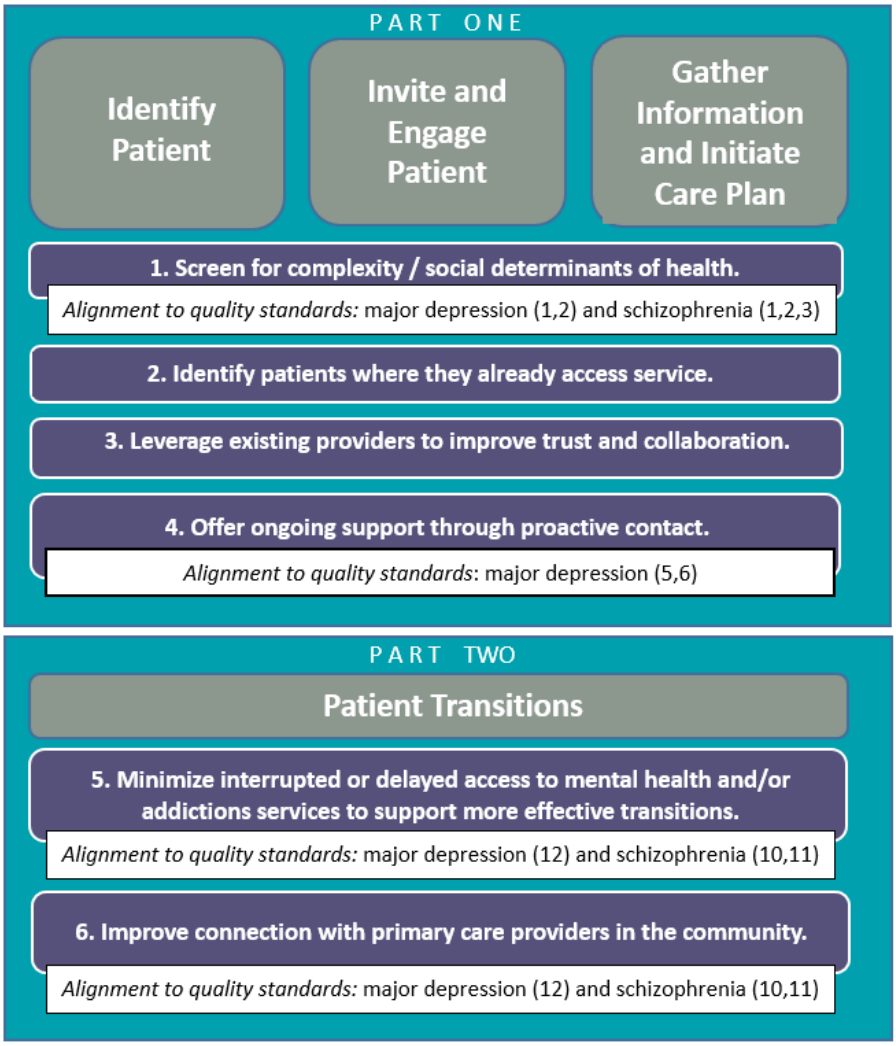
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based 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/or addictions conditions. The resultant innovative practices and accompanying implementation supports are presented in two parts. Part 1 focuses on innovative practices 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 highlights 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 unwarranted 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 the innovative practices that are designed to improve coordinated care management for patients with mental health and/or addictions conditions. Parts 1 and 2 are included, and associated quality statements are highlighted.

**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

After a visit to the emergency department or hospital admission, patients with mental health and/or addictions conditions are less likely to receive timely follow-up care from primary care providers in the community.[1] Timely follow-up care and ongoing attachment to primary care (and psychiatrists) can provide patients with ongoing health and wellness support and reduce the likelihood of requiring hospital admissions to manage their care.[1]

[1] Health Quality Ontario. Measuring up 2016: a yearly report on how Ontario's health system is performing [Internet]. Toronto: Queen's Printer for Ontario; 2016 [cited 2017 May 15]. Available from: http://www.hqontario.ca/portals/0/Documents/pr/measuring-up-2016-en.pdf.

## Description of this Innovative Practice

This practice involves supporting effective transitions from hospital to home, including effective communication and transition of care to primary care providers. It might also include the provision of interim primary care support in the period of transition back into the community to fill the gap in care for patients not currently attached to primary care.

| Innovative Practice | Innovative Practice Assessment[2] | Clinical Reference Group Endorsement for Spread |
|---|---|---|
| Support improved access, attachment, and/or transitions to primary care providers in the community. | EMERGING | Provincial spread with reassessment using the Innovative Practices Evaluation Framework[2] in 1 year (July 2018). |

| Implementation of the Innovative Practice | | |
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| **STEPS FOR IMPLEMENTATION** | **TOOLS AND RESOURCES** | **CONSIDERATIONS** |
| **At the Health Link planning level:**<br><br>1. Explore opportunities for patients to connect with primary care at the onset of need. Establish new partnerships, as necessary.<br><br>2. Create processes and practices that support connections to primary care (interim or ongoing connections, as available). When an effective process or practice is established, communicate those with providers and patients.<br><br>**At the clinical level:**<br><br>1. Help patients connect with (or understand how to connect with) primary care as early as possible in the patient journey to reduce potentially avoidable hospital visits, overall.<br><br>2. If the patient is seen in hospital, ensure communication with the primary care provider(s) at entry and upon discharge, and at other points in the patient admission process, as indicated. | **Hamilton Niagara Haldimand Brant (HNHB) Coordinated Care Planning Toolkit:** http://www.hnhblhin.on.ca/forhsps/HealthLinkResources/CoordinatedCarePlanningToolkit.aspx<br><br>Note: Template letters for physicians, billing codes, etc. can be found within this toolkit. | **At the clinical level:**<br><br>Providers may provide education, information, and support to patients as they make decisions about their care. However, the decision of whether or not to be formally connected to/rostered with a primary care provider or team ultimately lies **with the patient** or substitute decision maker. Patients should continue to feel empowered and supported when |

[2]For more information about the Innovative Practices Evaluation Framework assessments, please visit 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** |
| If the patient does not have a primary care provider, collaborate with the patient to explore options to establish connections.<br><br>3. Include primary care providers in the discharge planning process and support timely flow of information to reduce the potential for gaps in service upon return to the home and community.<br><br>4. Document arrangements in the coordinated care plan as appropriate and ensure that the primary care provider has a copy of the plan. | **Central East Health Links Toolkit—Coordinated Care Planning:** http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf<br><br>Additional tools and resources can be found in Appendix A. | making decisions about their health care. |

## 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 is available at http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards.

This innovative practice aligns with the following quality standards:

- **Quality Standard for Major Depression: Care for Adults and Adolescents,** which 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.
- **Quality Standard for Schizophrenia: Care for Adults in Hospitals,** which addresses care for people older than 18 years of age receiving care in an emergency department or admitted to a hospital. It also provides guidance on care that takes place when a person is between settings, such as when discharged from hospital.

**Quality Standard for Major Depression: Care for Adults and Adolescents**
http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/view-all-quality-standards/Major-Depression

- **Quality Statement 12—Transitions in Care:** Transitions between care providers can increase the risk of errors and miscommunication in a person's care. It is important for people with major depression who are moving from one care provider to another to have a care plan that is shared with them and between providers. Optimal communication and coordination of treatment with other health care professionals lessens the risk of relapse and can reduce side effects. If the person is being referred to a new provider, it is important to ensure that the new provider accepts the patient before transferring them. A follow-up appointment after hospitalization helps to support the transition to the community. It can allow for the identification of medication-related issues; it also helps to maintain clinical and functional stability and aims to prevent readmission to hospital. It is especially important for people with major depression who are admitted to hospital with a high risk for suicide to be followed up soon after discharge. If the person's consent is obtained, their family or caregivers should be notified of their potential risk for suicide.

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| **Quality Standard for Schizophrenia: Care for Adults in Hospitals**<br>http://www.hqontario.ca/Evidence-to-Improve-Care/Quality-Standards/view-all-quality-standards/Schizophrenia |
| • **Quality Statement 10—Follow-Up Appointment After Discharge:** A follow-up appointment after hospitalization helps to support a person's transition to the community. It can allow for the identification of medication-related issues; it also helps to maintain clinical and functional stability and aims to prevent readmission to hospital. |
| • **Quality Statement 11—Transitions in Care:** Transitions from hospital are important events that can introduce the risk of breakdowns in a person's care and of crucial information being lost or miscommunicated. It is important for people with schizophrenia who are leaving hospital to have a care plan that is shared between their providers in hospital and those in the community. |

## 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 for patients with complex presentations that include mental health and/or addictions conditions 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, which will benefit all of the Health Links.

| **Suggested Measurements** *(please see Appendix B for additional details)* | |
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| **OUTCOME MEASURE** | **PROCESS MEASURES** |
| Hospital readmission rates for a mental illness or an addiction. | Number of Health Link patients with a coordinated care plan developed through the Health Link during the past quarter.*<br><br>Number of Health Link patients who either have a primary care provider on record with hospitals or community care access centres (CCACs); have access to primary care in the form of appointments, evening clinics, home visits, etc.; or have regular and timely access to a primary care provider.*<br><br>Percentage of patients who saw a family doctor or psychiatrist within 7 days of discharge after hospitalization for mental illness or addiction. |

**This suggested measure is the same as the current required measures reported quarterly in QI RAP by Health Links.*

# Appendix A: Examples of this Innovative Practice from the Field

## Support improved access, attachment, and/or transitions to primary care providers in the community.

*Released July 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?

*Implementation of these innovative practices are presented in alphabetical order, by name of the first LHIN cited.*

**North West LHIN**
*City of Thunder Bay Health Link*

The City of Thunder Bay Health Link has created linkages with the Enhanced Care Team Clinic (ECTC), a primary care clinic that helps to support improved access to primary care. This clinic supports patients with multiple chronic conditions, underlying mental health and addictions issues, and/or issues relating to social determinants of health, who frequently access the Thunder Bay Regional Health Sciences Centre hospital for care. Patients are eligible to access this clinic even if they have a primary care provider elsewhere. Patients are medically stabilized, helping to decrease unnecessary hospital visits, then transitioned to an appropriate primary care provider.

**South East LHIN**
*Rural Hastings Health Link*

Within the South East LHIN, the Rural Hastings Health Link has created process maps that illustrate processes to connect complex, unattached patients accessing Addiction and Mental Health Services (AMHS) to primary care and to refer patients with primary care attachment to AMHS.

**Toronto Central LHIN**
*Mid-West Toronto Health Link*

The Mid West Toronto Health Link has implemented the RED (Referrals from the Emergency Department) Project. This project represents a partnership between Toronto Western Hospital, Toronto General Hospital, Access Alliance Community Health Centre, Queen West Community Health Centre, EdgeWest Youth Clinic, and Taddle Creek Family Health Team. This project aims to establish a pathway to connect and schedule a patient's

first primary care appointment with an appropriate community health centre or family health team to foster stronger long-term care and reduce subsequent visits to the emergency department.

**Waterloo Wellington LHIN**

The Waterloo Wellington LHIN is actively collaborating with key stakeholders to achieve primary care and mental health substance abuse (MHSA) integration. The Health Links coordinated care management approach to patient care for those with mental health and/or addictions issues is included in the planning and implementation considerations for these integration efforts.

*Guelph Health Link*

Within the Waterloo Wellington LHIN, the Guelph Health Link has collaborated to enable a support coordinator from the Canadian Mental Health Association (CMHA) to support patients with moderate to severe mental health and/or addictions conditions with coordinated care management. Additionally, processes that allow the support coordinator to connect patients without access to primary care to the community health centre have been put in place as a mechanism for improving ongoing access to primary care for unattached patients.

## Appendix B: Measurement Specifications

# Support improved access, attachment, and/or transitions to primary care providers in the community.

*Released July 2017*

1. Hospital readmission rates for a mental illness or an addiction.

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| **Innovative Practice** | Support improved access, attachment, and/or transitions to primary care providers in the community. |
| **Type of Measure** | Outcome measure<br><br>Dimension: Effective<br><br>Direction of improvement: Reduce (lower) |
| **Definition/Description** | Rate of psychiatric (mental health and addiction) discharges that are followed by another mental health and addiction admission within 30 days. |
| **Additional Specifications** | Readmission rate is calculated as the number of patients readmitted within 30 days of discharge divided by the number of patients discharged during the study period.<br><br>**Numerator:** Number of individuals with any mental health and or/addictions hospital readmissions within (≤) 30 days following the incident* hospital discharge in the reporting period.<br><br>**Denominator:** Total number of incident* mental health and/or addictions hospital discharges in the reporting period. |
| **Reporting Period** | Recommend that Health Links collect and report on 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 efforts to introduce innovative practices into coordinated care management. |

**The first event in a calendar year, without any look-back for past events.*

2. Number of Health Link patients with a coordinated care plan developed through the Health Link during the past quarter.**

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| **Innovative Practice** | Support improved access, attachment, and/or transitions to primary care providers in the community. |
| **Type of Measure** | Process measure<br><br>Dimension: Effective<br><br>Direction of improvement: Increase (higher) |
| **Definition/Description** | Number of Health Link patients with a coordinated plan of care developed through the Health Link during the past quarter with the patient/caregiver and two or more health care professionals containing a plan for one or more health issues. |
| **Additional Specifications** | Enter the number of patients for whom coordinated care plans were developed (i.e., completed) in the 3-month reporting period (net new actual value). The plan must address a minimum of one health issue (health issues can be physical, mental, social, or spiritual). In the annotations section, include any information that may influence the number of patients with a coordinated care plan. |
| **Reporting Period** | Recommend that Health Links collect and report on data in QI RAP every quarter. |
| **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:<br>1. Progress in implementation components, such as reach (how often the practice is being used).<br>2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate.<br>3. Sustainability of the process as designed so that it will continue once initial attention has waned. |

***This suggested measure is the same as the current required measures reported quarterly in QI RAP by Health Links.*

3. Number of Health Link patients who either have a primary care provider on record with hospitals or community care access centres (CCACs); have access to primary care in the form of appointments, evening clinics, home visits, etc.; or have regular and timely access to a primary care provider.**

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| **Innovative Practice** | Support improved access, attachment, and/or transitions to primary care providers in the community. |
| **Type of Measure** | Process measure<br><br>Dimension: Effective<br><br>Direction of improvement: Increase (higher) |
| **Definition/Description** | Number of Health Link patients who either have a primary care provider on record with hospitals or community care access centres (CCACs); have access to primary |

| | |
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| | care in the form of appointments, evening clinics, home visits, etc.; or have regular and timely access to a primary care provider. |
| **Additional Specifications** | Enter the number of Health Links patients who have a primary care provider on record or who have access to a primary care provider for the quarter being reported in the field that best fits the patient's experience (see below).<br><br>**Fields**<br>A: For the quarter being reported, how many patients with the Health Link have a primary care provider on record with hospitals or the CCAC?<br>B: For the quarter being reported, how many patients with the Health Link have access to a primary care provider in the form of appointments, evening clinic, home visits?<br>C: For the quarter being reported, how many patients with the Health Link have regular and timely access to a primary care provider (ACTUAL)? |
| **Reporting Period** | Recommend that Health Links collect and report data in QI RAP on a quarterly basis. |
| **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:<br>1. Progress in implementation components, such as reach (how often the practice is being used).<br>2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate.<br>3. Sustainability of the process as designed so that it will continue once initial attention has waned. |

***This suggested measure is the same as the current required measures reported quarterly in QI RAP by Health Links.*

4. Percentage of patients who saw a family doctor or psychiatrist within seven days of discharge after hospitalization for mental illness or addiction.

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| **Innovative Practice** | Support improved access, attachment, and/or transitions to primary care providers in the community. |
| **Type of Measure** | Process measure<br><br>Dimension: Effective, timely<br><br>Direction of improvement: Increase (higher) |
| **Definition/Description** | This indicator measures the percentage of psychiatric discharges that had a follow-up visit to either a primary care physician or psychiatrist, within 7 days of discharge. |
| **Additional Specifications** | **Numerator:** The number of patients who within 7 days of discharge following index hospitalization had at least one psychiatrist or primary care physician visit.<br><br>**Denominator:** Number of acute care discharges from episode of care in which a Mental Health and Addiction condition is diagnosed and is coded as most responsible diagnosis in the first hospitalization of the episode within each fiscal year. |

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|---|---|
| | This indicator is calculated as: the numerator divided by the denominator, multiplied by 100. |
| **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:<br>1. Progress in implementation components, such as reach (how often the practice is being used).<br>2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate.<br>3. Sustainability of the process as designed so that it will continue once the initial attention has waned. |