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

Summary of Innovative Practices

Released July 2017

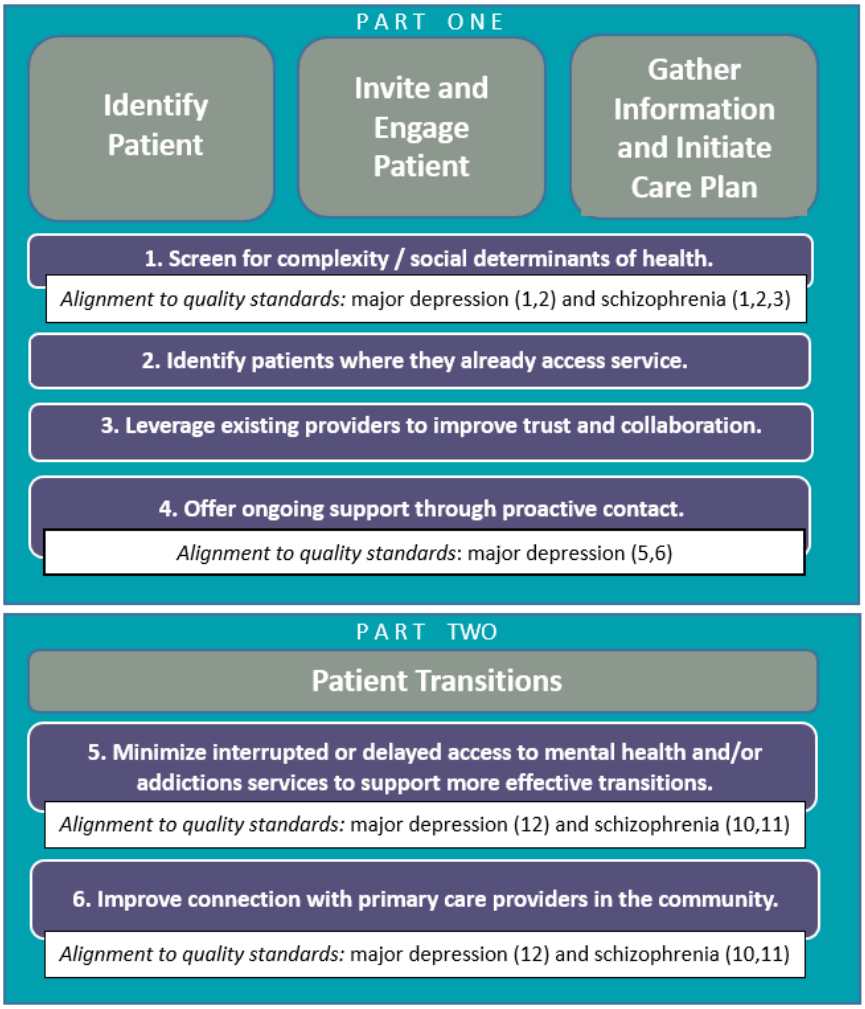
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based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

Although each practice, organization, region, or Health Link may have varying areas of foci, the following collection of innovative practices and implementation resources are designed to help teams improve care for patients within the Health Link and support the ongoing alignment and advancement of consistent practices at a provincial level.

Quality Improvement: Getting Started

Quality improvement (QI) is a proven methodology for improving care for patients, residents, and clients. Quality improvement is a formal approach to measuring performance and progress, wherein teams work toward a defined aim, gather and review data to inform their progress, and implement change strategies using rapid-cycle improvements. Quality improvement science provides tools and processes to assess and accelerate efforts for testing, implementation, and spread of QI practices (such as the coordinated care management practices).

For additional information on quality improvement, please visit **qualitycompass.hqontario.ca/portal/getting-started** or contact **hlhelp@hqontario.ca** for access to e-learning modules.

Innovative Practices

Innovative practices are based on the highest quality evidence and information available and have been defined and assessed by a Clinical Reference Group.[1,2] It is suggested that Health Links draw upon this collection of innovative practices to create the foundation for supporting their coordinated care management processes and improving care for their patients with mental health and/or addictions conditions.

Innovative practices relating to coordinated care management for patients with mental health and/or addictions conditions are listed below. These practices were selected using a comprehensive environmental scan, evaluated using the Innovative Practices Evaluation Tool, and reviewed by the Health Links Clinical Reference Group in June 2017.

For additional information regarding this process and assessment criteria, please visit **http://www.hqontario.ca/Portals/0/documents/bp/bp-inovative-practices-en.pdf**.

Innovative Practice	Innovative Practice Assessment	Clinical Reference Group Recommendation for Spread
5. Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.	PROMISING	Provincial spread with reassessment using the Innovative Practices Evaluation Framework[1] in 1 year (July 2018).
6. Support improved access, attachment, and/or transitions to primary care providers in the community.	EMERGING	

*For additional information, please visit the Tools and Resources Tab in the Health Links section of the Health Quality Ontario at **http://www.hqontario.ca/Quality-Improvement/Our-Programs/Health-Links**.*

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 **qualitycompass.hqontario.ca/portal/getting-started**.*

[1]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

[2]The Clinical Reference Group is composed of subject matter experts in Health Links, researchers, academia, and stakeholders from across the province.

The materials for innovative practices are developed in collaboration with Health Links and the Clinical Reference Group.

The following measures have been developed to help to determine whether the innovative practices above 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 these 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 (July 2018), which will benefit all of the Health Links.

Innovative Practice	Outcome Measures *Are the changes having the intended impact?*	Process Measures *Are the practices being implemented as planned?*
5. Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.	Percentage of patients or clients who visited the emergency department (ED) for conditions “best managed elsewhere."*	Percentage of patients with complex conditions that include a mental health and/or addictions issue eligible for diversion services who are provided with information about a suitable diversion program (including when and how to access the service).
6. Support improved access, attachment, and/or transitions to primary care providers in the community.	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.** 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.** Percentage of patients who saw a family doctor or psychiatrist within seven days of discharge after hospitalization for mental illness or addiction.

**This suggested measure is closely aligned to an indicator from Quality Improvement Plans (QIPs).*

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