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Coordinated Care Management for Patients with Mental Health and/or Addictions Conditions – Part 2

Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.

Released July 2017

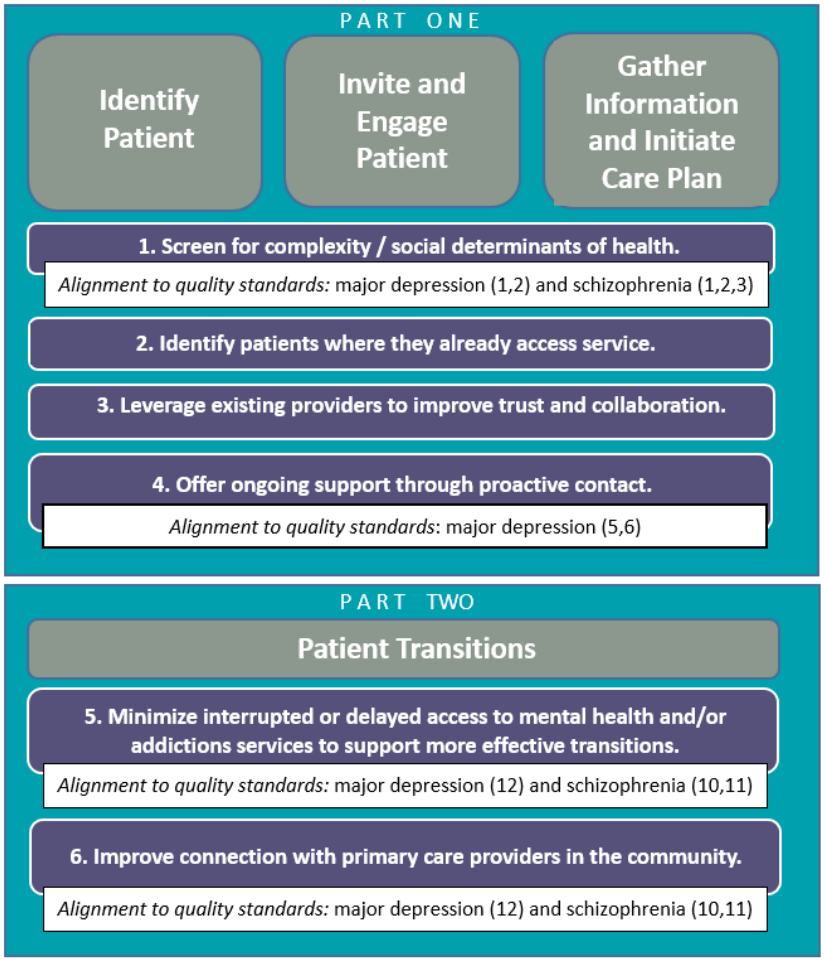
It has been established that coordinated care management is an effective approach to improving the quality of care for patients with complex health and wellness issues. In 2016, Health Quality Ontario collaborated with the provincial Health Links to produce a collection of innovative practices (based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

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

Hospital emergency departments can be a valuable resource for patients with mental health and/or addictions conditions who are experiencing a crisis or who need urgent access to health care and support. However, some visits may be more appropriately managed elsewhere. Ensuring the right care in the right place at the right time may provide better health outcomes and experiences for patients and may also reduce avoidable emergency department visits and subsequent admissions.[1]

[1]Brien S, Grenier L, Kapral ME, Kurdyak P, Vigod S. Taking stock: a report on the quality of mental health and addictions services in Ontario. An HQO/ICES report [Internet]. Toronto: Health Quality Ontario and Institute for Clinical Evaluative Sciences; 2015 [cited 2017 May 15]. Available from: http://www.hqontario.ca/Portals/0/Documents/pr/theme-report-taking-stock-en.pdf.

Description of this Innovative Practice

This practice is intended to encourage Health Links to enable partnerships and leverage or create practices or processes that support diversion to appropriate and timely community-based care at the onset or exacerbation of mental health conditions and that support effective transitions from hospital to home (ensuring that the necessary plans and services are in place to best support the patient's ongoing wellness in the community). This practice includes processes and services that may be offered to the patient upon entry to hospital, during admission or discharge planning, or upon discharge from hospital.

Innovative Practice	Innovative Practice Assessment[2]	Clinical Reference Group Endorsement for Spread
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[2] in 1 year (July 2018).

Implementation of the Innovative Practice		
STEPS FOR IMPLEMENTATION	**TOOLS AND RESOURCES**	**CONSIDERATIONS**
At the Health Link planning level: 1. Explore opportunities for patients to connect with existing organizations and providers at the onset of need. Establish new partnerships, as necessary. 2. Create processes and practices in collaboration with patients, providers, and community partners that support connections. When an effective process or practice is established, communicate these with providers and patients. **At the clinical level:** 1. Help patients connect with (or understand how to connect with) existing services for future conditions as early as possible in the patient journey to reduce potentially avoidable hospital visits, overall.	**Hamilton Niagara Haldimand Brant (HNHB) Coordinated Care Planning Toolkit:** http://www.hnhblhin.on.ca/forhsps/HealthLinkResources/CoordinatedCarePlanningToolkit.aspx Note: Template letters for physicians, billing codes, etc. can be found within this toolkit.	**At the clinical level:** Providers may provide education, information, and support to patients as they make decisions about their care. However, the decision of whether or not to access emergency services and/or the emergency department ultimately lies **with the patient** or substitute decision maker. Patients should continue to feel empowered and

[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**
2. If the patient is seen in hospital, connect with transition support systems early in the discharge planning process to reduce the potential for gaps in service upon return to the home and community. 3. Document arrangements in the coordinated care plan as appropriate.	**Central East Health Links Toolkit—Coordinated Care Planning:** http://healthcareathome.ca/centraleast/en/who/Documents/Health_Links/toolkit/CEHealthLinks-Toolkit-V2.pdf Additional tools and resources can be found in Appendix A.	supported when 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.

Quality Standard for Schizophrenia: Care for Adults in Hospitals 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 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, which will benefit all of the Health Links.

Suggested Measurements ***(please see Appendix B for additional details)***	
OUTCOME MEASURE	**PROCESS MEASURE**
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).

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

Appendix A: Examples of this Innovative Practice from the Field

Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.

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 local health integration networks (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.

Central LHIN

South Simcoe and Northern York Region Health Link

The South Simcoe North York Region Health Link has leveraged a partnership that has enabled a worker from the Canadian Mental Health Association (CMHA) to be present on an inpatient unit at Southlake Regional Health Centre. This worker supports patients' transitions from hospital to home. Patients with frequent visits to the emergency department or the mental health inpatient unit are supported with wraparound care, making connections to long-term services in the community, in an effort ensure a successful discharge and reduce the likelihood of hospital readmissions. This Health Link reported that these services lead to a decrease in subsequent hospital visits and admissions.

Tools and Resources

- Additional information regarding the South Simcoe and Northern York Region Health Link's participation in the Institute for Health Care Improvement (IHI)'s Better Health and Lower Costs for Patients with Complex Needs Collaborative: http://www.southlakeregional.org/Default.aspx?cid=1606&lang=1

Central East LHIN

Durham North East Health Link, Peterborough Health Link, Northumberland County Health Link, and Haliburton County and City of Kawartha Lakes Health Link

Within the Central East LHIN, providers and patients within the Durham North East and the Health Links associated with the North East Cluster (Peterborough Health Link, Northumberland County Health Link, and Haliburton County and City of Kawartha Lakes Health Link) have participated in the Hospital to Home (H2H) program. Within this initiative, staff members from community mental health and addiction treatment agencies are co-located in local hospital teams to support patients entering the Emergency Department, or being admitted to inpatient services with successful transitions back to the community, and reduce the likelihood of hospital readmissions. Among the partners are: Durham Mental Health Services, Canadian Mental Health Association, FourCAST Addiction Services and Pinewood Centre. Services vary locally, but include assessment, short term case management, Community Treatment Order Case Management, community crisis intervention, and housing supports. 30 day readmissions for mental health and substance issues were shown to be significantly lower for patients engaged with the service. The pilot has evolved, and is now in the process of being implemented in the remaining Health Links within the Central East LHIN.

Central West LHIN
All associated Health Links

All Health Links in the Central West LHIN are currently in the process of implementing the In-STED program, which was created out of a partnership between three acute care sites (Brampton Civic Hospital, Etobicoke General Hospital, and Headwaters Health Care Centre), the Canadian Mental Health Association/Peel Branch (CMHA Peel), SHIP (Supportive Housing in Peel), and Punjabi Community Health Services (PCHS). The In-STED program aims to identify complex mental health and addictions needs early, and intervene through timely, high-quality, integrated, and culturally appropriate short-term case management services. Focusing on the most vulnerable repeat emergency department users, the In-STED team addresses individuals' most critical needs and links them to services. In-STED also helps to reconnect clients with services or resources that are already in place, often in different geographical locations. The hope is that In-STED will reduce repeat visits to hospital emergency departments, effectively support recovery, and provide stability for individuals while they wait for long-term services. Overall, this program has contributed to a significant decrease in 30-day readmissions to the hospital for mental health and substance abuse issues.

Tools and Resources

- Additional information regarding the In-STED program: http://cmhapeeldufferin.ca/programs-services/in-sted/

South East LHIN
Quinte Health Link

The Quinte Health Link has partnered with Addictions and Mental Health Services Hastings Prince Edward (AMHS-HPE) to implement an emergency department diversion program. This program offers 6 weeks of intensive and intentional case management support to patients in the community and reduces the likelihood of hospital admissions. The project has successfully connected patients to housing, food security, financial support, and other community resources. This project is currently in the pilot testing phase and is anticipated to be spread to other Health Links within the LHIN.

Toronto Central LHIN
Midwest Toronto Health Link

The St. Stephen's Community House (SSCH) Toronto Community Addiction Team (TCAT) is a Toronto Central LHIN–funded program that offers city-wide mobile case management to individuals experiencing complex substance issues with frequent readmissions to withdrawal management services and/or hospital emergency departments (EDs). The program services up to 153 clients at a time with approximately 13 case managers.

The SSCH–TCAT, the University Health Network, and the Midwest Toronto Health Link collaborated to establish an email notification system to improve coordination and continuity of care for TCAT clients to further reduce avoidable ED visits. When a TCAT client is seen within the ED, a notification email is sent to the assigned TCAT case manager and the social worker in the ED, who then work in partnership to coordinate care. This email notification system and coordinated care approach has been associated with improved client outcomes and a further reduction in ED readmissions.

Tools and Resources

- Additional information regarding the TCAT Program: http://www.addictionsandmentalhealthontario.ca/uploads/1/8/6/3/18638346/tb1_toronto_community_addiction_team_-_innovative_care_coordination.ppsx

Appendix B: Measurement Specifications

Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.

Released July 2017

1. Percentage of patients or clients who visited the emergency department (ED) for conditions “best managed elsewhere"*

Innovative Practice	Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.
Type of Measure	Outcome measure
Definition/Description	Percentage of patients or clients who visited the emergency department (ED) for conditions “best managed elsewhere" Dimensions: Efficient Direction of improvement: Reduce (lower)
Additional Specifications	**Numerator**: Total number of rostered patients with an ED visit for a condition best managed elsewhere in a given time period x 100. **Denominator**: Total number of rostered patients between 1 and 74 years of age in a given time period. **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.
Comments	Selected outcome measures will help evaluate efforts to introduce innovative practices into coordinated care management.

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

2. Percentage of patients with complex conditions that include a mental health and/or addictions issue eligible for diversion services that are provided with information about the diversion program (including when and how to access the service).

Innovative Practice	Implement processes and programs to minimize interrupted or delayed access to services, improving transitions and diverting avoidable hospital visits.
Type of Measure	Process measure
Definition/Description	Percentage of patients with complex conditions that include a mental health and/or addictions condition who are eligible for diversion services and provided with information about the diversion program (including when and how to access the service) Dimensions: Effective, timely Direction of improvement: Increase (higher)
Additional Specifications	**Numerator**: Number of patients who are eligible for diversion services and are provided with information about the diversion program (including when and how to access the service). **Denominator**: Number of patients eligible for diversion services. **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.
Comments	Process measures are used to assess: 1. Progress in implementation components, such as reach (how often the practice is being used). 2. Adherence (fidelity) to the specifications of the steps that must be in place for a program or practice to operate. 3. Sustainability of the process as designed so that it will continue once initial attention has waned.