How To Use A Quality Framework To Guide Implementation And Evaluation Of Collaborative Mental Health Care

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St. Michael's
Inspired Care. Inspiring Science.

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

Learning Objectives

At the conclusion of this session, the participant will be able to:

1. Apply a quality framework for collaborative mental health care to choose a specific dimension of quality as a target for improvement.
2. List several measures which would be useful to drive quality improvement in their setting.
3. Develop a plan for implementing Collaborative care measurement in their own setting.

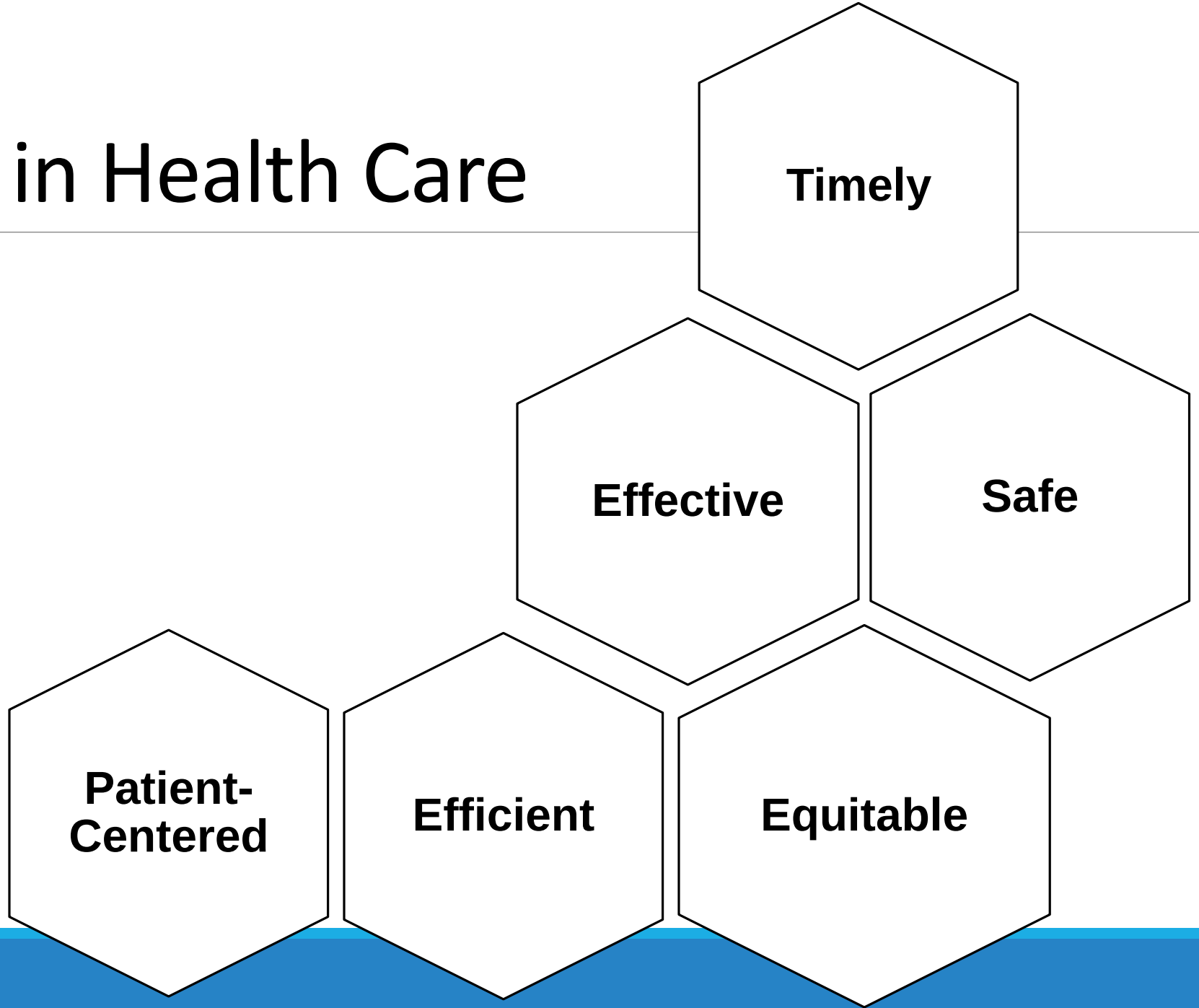
Outline

1. Evaluation and improvement in collaborative care
2. Introducing a framework for measuring and improving integrated care
3. Application to your settings
4. Wrap up & Questions

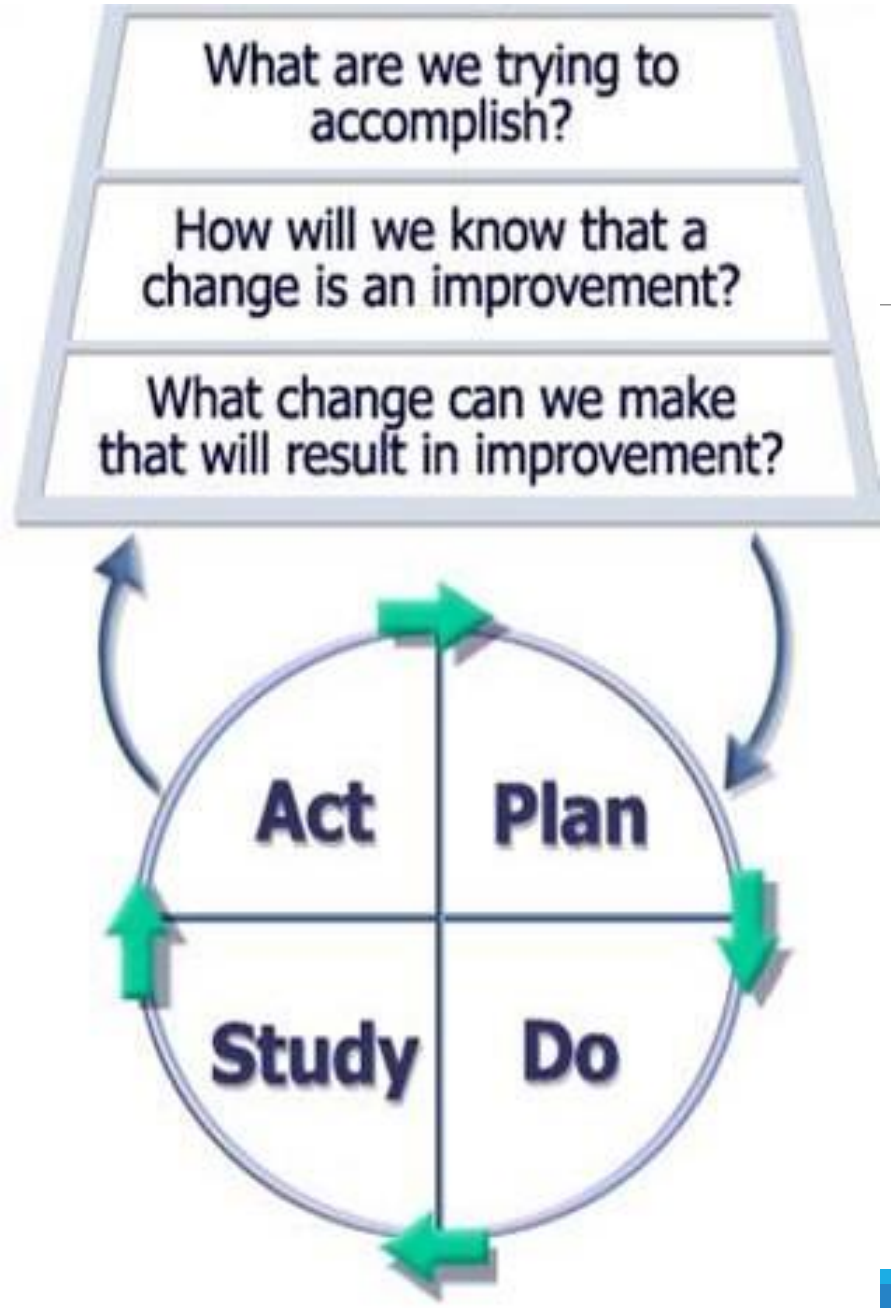
Quality and Evaluation in Collaborative Care

- New programs are continually being implemented to improve the quality of care.
- It is important to understand the impact of these programs within real-world settings and continue to improve them.
- Program Evaluation – are services meeting intended objectives?
- Quality Improvement (QI) – specific process to improve a program

Quality in Health Care



Model for Improvement

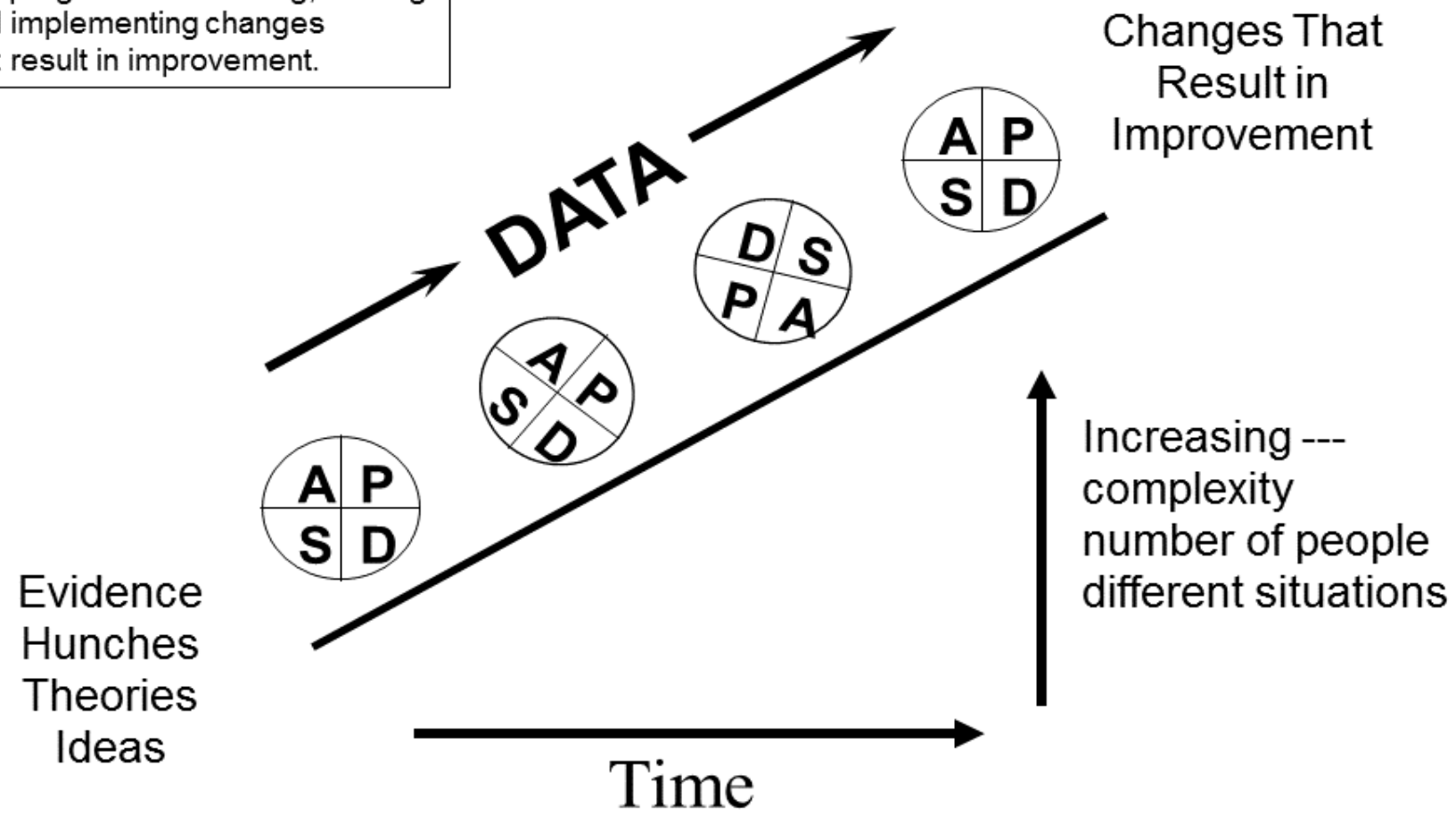


Institute for Healthcare Improvement (IHI)


A
Act
Step 8: Standardize the improvement or develop a new theory
Step 9: Establish future plans
P
Plan
Step 1: Getting started
Step 2: Assemble the team
Step 3: Examine current approach
Step 4: Identify potential solutions
Step 5: Develop an improvement theory
Do
Step 6: Test the theory for improvement
D
Study
Step 7: Use data to study the result
S

PDSA Ramp

"RAMP"
A series of PDSA cycles that follow in a progression of testing, refining and implementing changes that result in improvement.



Small data

NARRATIVE REVIEW

Value of small sample sizes in rapid-cycle quality improvement projects

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► Additional material is published online only. To view please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2015-005094).

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Quality improvement initiatives can become bogged down by excessive data collection. Sometimes the question arises —are we doing an adequate job with respect to a recommended practice? Are we complying with some guideline in at least X% of our patients? The perception that one must audit large numbers of charts may present a barrier to initiating local improvement activities. The model for improvement and its Plan–Do–Study–Act (PDSA) cycles typically require frequent data collection to test ideas and refine the planned change strategy. The perception that data collection must

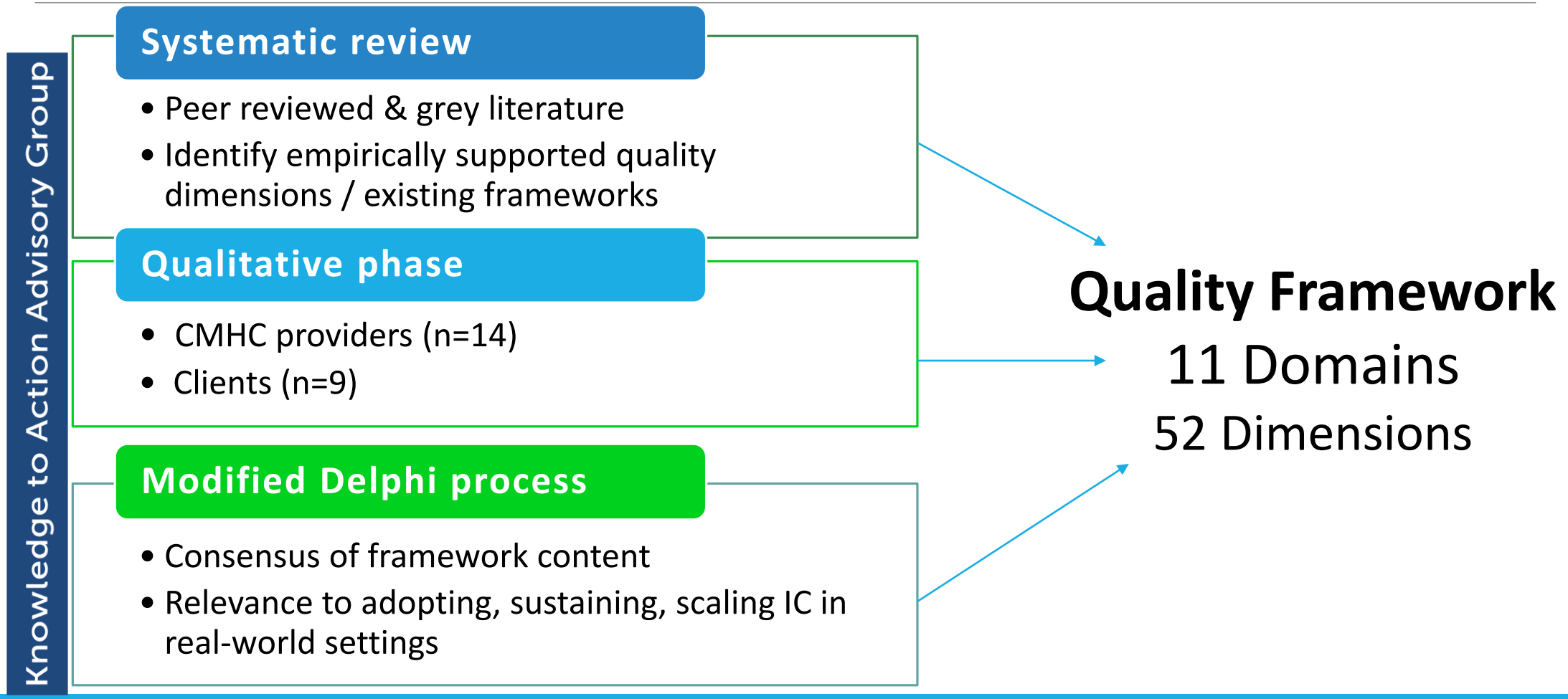
Surprisingly, your sample of 20 consecutive admissions actually provides strong evidence that local performance falls short of your performance target. If your service were actually performing medication reconciliation 80% of the time, a sample of 20 charts would produce an observed reconciliation rate of only 50% (or worse) about three times out of every 1000 similar audits.[3] This probability corresponds to a p value of 0.003, well below the conventional threshold of p=0.05 for statistical significance. In other words, you can confidently reject the null hypothesis that your

Observed system performance (%)	Desired system performance	
	80%	90%
95	26	140
90	70	Not applicable
85	260	180
80	Not applicable	50
75	280	28
70	80	20
66	45	15
60	25	10
50	12	6
40	10	5
20	5	5

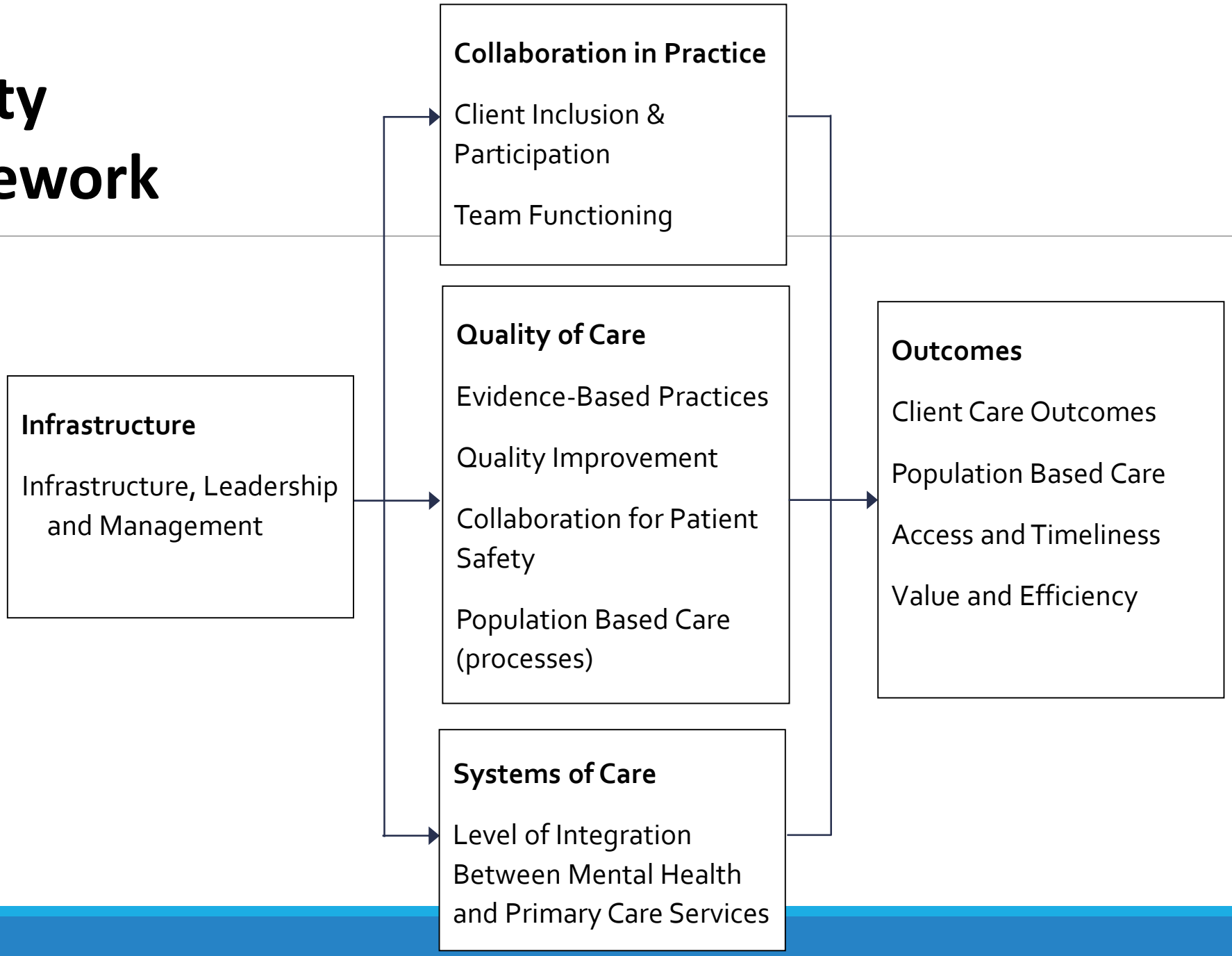
The table shows the approximate sample size required to reject the null hypothesis that observed performance (from an audited sample) is consistent with the desired system performance, shown here as being either 80% or 90%. If you wish to calculate an exact p value for your

Quality Framework For Collaborative Mental Health Care

Methods


Knowledge to Action Advisory Group
Systematic review
• Peer reviewed & grey literature
• Identify empirically supported quality dimensions / existing frameworks
Qualitative phase
• CMHC providers (n=14)
• Clients (n=9)
Modified Delphi process
• Consensus of framework content
• Relevance to adopting, sustaining, scaling IC in real-world settings
Quality Framework
11 Domains
52 Dimensions

Quality Framework



Domains of Quality

Client Care Outcomes
Care achieves good results for clients (e.g. improves symptoms of mental illness, improves quality of life).

Population-Based Care
Appropriate care is delivered to the whole population of clients who are (or who should be) served by the primary care team (e.g. services are allocated equitably to those in need).

Evidence-Based Practices
Programs and treatments are designed and implemented with consideration of the best available research and the local context.

Client Inclusion & Participation
The extent to which care is geared toward providing the best possible experience for clients, and achieving outcomes that are important to clients (e.g. care is appropriate to their culture, literacy level, and socioeconomic status).

Domains of Quality

Access and Timeliness of Care
Clients can easily receive care within a reasonable timeframe considering their illness severity, level of risk, and level of function (e.g. wait time for psychotherapy after recommendation is made).

Infrastructure, Leadership and Management
The conditions under which care is provided (e.g. appropriate physical space, having skilled healthcare providers from different disciplines).

Level of Integration between Mental Health and Primary Care Services
How well coordinated services are within the collaborative mental health program in primary care, and also how well coordinated care is between the primary care team and outside mental health specialists (e.g. hospital-based psychiatric care).

Team Functioning
How well the clinical team of primary care and mental health providers work together.

Domains of Quality

Collaboration for Patient Safety

Collaborative care program is organized to provide the safest possible care (e.g. promotes safe medication prescribing practices, engages all team members in improving patient safety).

Quality Improvement

Collaborative care program / team is continuously working to improve quality (e.g. program is routinely evaluated from multiple perspectives and the results inform program development and provider training).

Value and Efficiency

From a system perspective care delivers good value considering the costs. Multiple perspectives and systems are considered when measuring cost effectiveness (e.g. health care, social support, justice, child protection, client incurred costs).

Access and Timeliness of Care –Dimensions

Clients can easily receive care within a reasonable timeframe considering their illness severity, level of risk, and level of function (e.g. timely identification of mental illness, wait time for psychotherapy after recommendation is made).

1. Team monitors attendance and seeks to understand and minimize no show rates.
2. Written and oral communications between team members are timely and facilitate client care.
3. Mental health services are available in a range of intensities according to client needs (e.g. severity of illness) and provider needs (e.g. for assistance making a specific diagnosis).
4. Wait times from referral to mental health assessment, and from assessment to service (e.g. psychotherapy) are minimized and clients are offered relevant supports while awaiting specialized services.

Client Outcomes - Dimensions

Care achieves good results for clients (e.g. improves symptoms of mental illness, improves quality of life).

1. Care reduces mental illness symptom severity and increases remission rates (illness specific).
2. Care improves physical health status.
3. Care improves quality of life.
4. Care improves social and role functioning.
5. Clients achieve the outcome they hoped for.

Now Your Turn – On Your Own

Review the quality framework domains and reflect on how they apply in your practice setting

Application In Practice

Developing and piloting specific measures in 4-5 primary care settings across Ontario

Providing basis for QI projects and programmatic decisions

Examples:

Rates of benzodiazepine prescribing for elderly patients

- Rationale: Choosing Wisely, low resource intensity interventions
- Measurement via EHRs
- PDSA cycles of deprescribing

Application In Practice (2)

Wait times from mental health referral to receiving service, and from assessment to service (e.g. psychotherapy)

- Rationale: important to clients, emphasizes evidence-based treatment (versus role of one-off psych consult)
- Examining flow and re-examining prior decisions re: order in which services are provided

Application in Practice (3)

Optimal preventive care, reducing mental health-related disparities in care

- Measurement of cancer screening rates via EHRs
- Existing QI effort to increase cancer screening rates in low SES → potential to extend to mentally ill population

Meaningful engagement of clients and families in program development & evaluation, and QI

- Structural indicator
- Hiring FHT staff to provide leadership in this area

Mental health service availability in a range of intensities according to need

- Cataloguing group psychotherapy offerings and assessing appropriateness for population served, duplication, gaps, etc

Now Your Turn: Groups of 3

- Introduce yourself
- Very briefly describe your collaborative care setting
- Describe an area that you're interested in improving – why?

Strategically Plan Your Evaluation – Group Work

Groups of 3, 10 min

- What are you specifically evaluating?
  - Entire program or specific component?
- What are your objectives or key questions?
- Who is your audience for the evaluation? What do you hope the evaluation will do?

Q & A

Questions regarding the Quality Framework?

Questions / Learnings pertaining to applying the QF in your practice setting?

Questions / Learnings regarding about Quality Improvement in your practice setting?

Thank you!

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Some of our material is here: QI4CC.com

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