Implementing a quality framework in collaborative mental health care

Advancing best practices in a community-hospital partnership

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Ann Marie MacDonald, CEO
Mood Disorders Association of Ontario

June 2, 2018

Mood Disorders Association of Ontario

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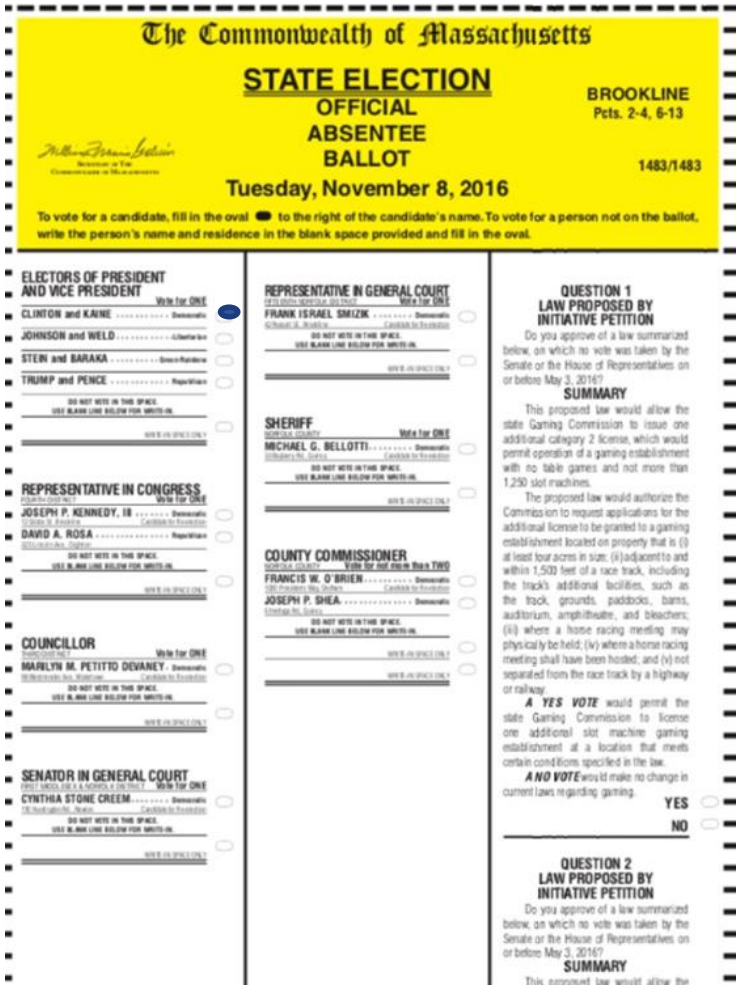
when it matters MOST

Disclosures

- Nothing financial, but..

And Yes, I Voted



The Commonwealth of Massachusetts

STATE ELECTION
OFFICIAL
ABSENTEE
BALLOT
Tuesday, November 8, 2016

BROOKLINE
Pcts. 2-4, 6-13

1483/1483

To vote for a candidate, fill in the oval ⬬ to the right of the candidate's name. To vote for a person not on the ballot, write the person's name and residence in the blank space provided and fill in the oval.

ELECTORS OF PRESIDENT AND VICE PRESIDENT — Vote for ONE
CLINTON and KAINE
JOHNSON and WELD
STEIN and BARAKA
TRUMP and PENCE
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

REPRESENTATIVE IN CONGRESS — Vote for ONE
JOSEPH P. KENNEDY, III
DAVID A. ROSA
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

COUNCILLOR — Vote for ONE
MARILYN M. PETITTO DEVANEY
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

SENATOR IN GENERAL COURT — Vote for ONE
CYNTHIA STONE CREEM
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

REPRESENTATIVE IN GENERAL COURT — Vote for ONE
FRANK ISRAEL SMIZIK
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

SHERIFF — Vote for ONE
MICHAEL G. BELLOTTI
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

COUNTY COMMISSIONER — Vote for not more than TWO
FRANCIS W. O'BRIEN
JOSEPH P. SHEA
DO NOT VOTE IN THIS SPACE. USE BLANK LINE BELOW FOR WRITE-IN.

QUESTION 1
LAW PROPOSED BY INITIATIVE PETITION

Do you approve of a law summarized below, on which no vote was taken by the Senate or the House of Representatives on or before May 3, 2016?

SUMMARY

This proposed law would allow the state Gaming Commission to issue one additional category 2 license, which would permit operation of a gaming establishment with no table games and not more than 1,250 slot machines.

The proposed law would authorize the Commission to request applications for the additional license to be granted to a gaming establishment located on property that is (i) at least four acres in size; (ii) adjacent to and within 1,500 feet of a race track, including the track's additional facilities, such as the track, grounds, paddocks, barns, auditorium, amphitheatre, and bleachers; (iii) where a horse racing meeting may physically be held; (iv) where a horse racing meeting shall have been hosted; and (v) not separated from the race track by a highway or railway.

A YES VOTE would permit the state Gaming Commission to license one additional slot machine gaming establishment at a location that meets certain conditions specified in the law.

A NO VOTE would make no change in current laws regarding gaming.

YES
NO

QUESTION 2
LAW PROPOSED BY INITIATIVE PETITION

Do you approve of a law summarized below, on which no vote was taken by the Senate or the House of Representatives on or before May 3, 2016?

SUMMARY

Mood Disorders Association of Ontario

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Objectives

- Identify key components in delivery of effective collaborative care
- Demonstrate how application of a quality framework can improve outcomes and collaborative care practice in a community-based mental health setting
- Highlight emerging best practices in the implementation of a collaborative mental health care program

ABOUT MDAO

VISION:
People with mood disorders and their families receive the support they need in order to recover and lead healthy lives

MISSION:
To deliver quality peer support and clinical programs and services, developed through the lens of lived experience, offering hope to those living with mood disorders and their families, and empowering their recovery

31-year history of supporting adults, youth, families and caregivers, province-wide, who experience mood disorders, early psychosis, and multiple mental health or addictions issues.

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MDAO's Strategic Framework

Mood Disorders Association of Ontario

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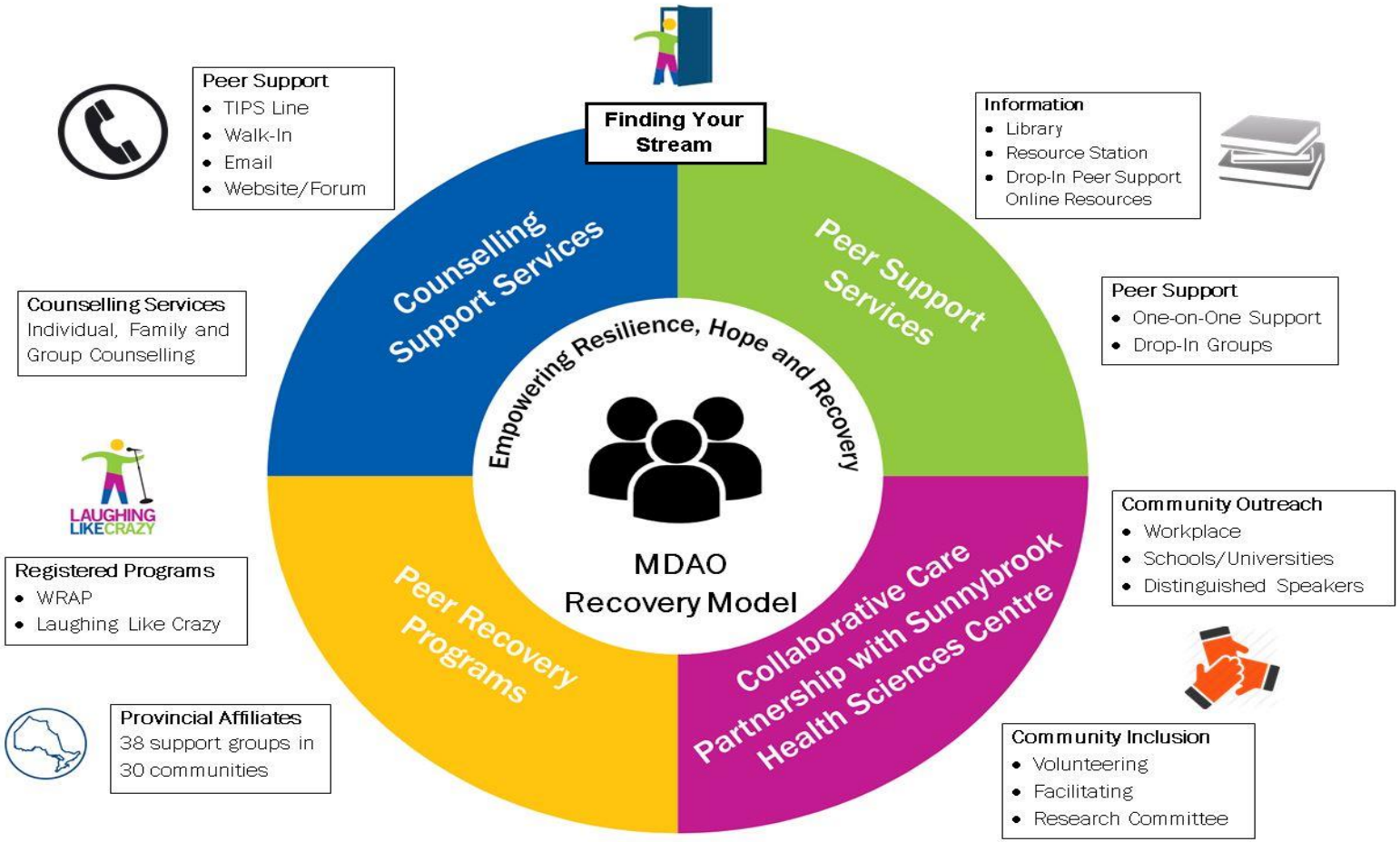
Streams of Recovery



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Community and Peer Based Mental Health

"Talk to Someone who has been there"

Our moto and Our purpose

- MDAO is serving over 280,000 people province–wide, and anchoring 38 peer support affiliates across Ontario.
- MDAO peer supporters have the lived experience, are knowledgeable, empathetic, trained, and supportive people who 'get it' and convey hope.
- MDAO works to honour others' experiences and strives to understand their needs.
- Ontario-wide evidence -based programming is pivotal in fostering resiliency, promoting self-care, instilling empowerment and building hope.
- MDAO's work, and the cost efficiency of its programs, would not be possible without the contribution of over 375 volunteers.

Mood Disorders Association of Ontario

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Evolution of Collaborative Care Partnership at MDAO

- Partnership between a community MH agency and an Academic Department of Psychiatry
- Change in psychiatry “shared care” training requirement at U of T
- Initially piloted as an educational initiative July 2016
- Funding model in place (structure)
- Committed leadership (structure)
- Incorporated quality framework at the outset (process)

COLLABORATIVE CARE ROTATION AT THE MOOD DISORDERS ASSOCIATION OF ONTARIO

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OVERVIEW

Collaborative Care (previously called Shared Care), has become a new Royal College of Physicians and Surgeons training requirement for all Senior (or 5th year residency) psychiatry residents across Canada.

Two months of training in Collaborative Care is mandatory. At the University of Toronto, starting July 2016, all 5th year psychiatry residents must spend 1 day per week in Collaborative Care.

We partnered with Sunnybrook Health Sciences Centre and we were delighted to welcome Dr. Rosalie Steinberg to MDAO in July. Rosalie was a fifth year psychiatry resident with Sunnybrook Hospital, who spent every Monday at MDAO, as part of her Collaborative Care rotation at the University of Toronto.

A BIT ABOUT DR. STEINBERG

Dr. Steinberg is a graduate of McMaster Medical School, and received her Masters in Health Policy and Management from the Harvard School of Public Health. She has worked as a hospital administrator at the Cambridge Hospital in Boston, and later as the Administrative Director of Psychiatry and Community Development at Mount Sinai Hospital in Toronto. Prior to becoming a psychiatric resident, she developed several primary care and community-based mental health programs including the Northern Psychiatric Outreach Program, the Mount Sinai Assertive Community Treatment Team and the Sinai Family Health Team.

OUTCOMES OF COLLABORATIVE CARE ROTATION AT MDAO

1. Exposed senior psychiatry resident to community organization that provides a pivotal role in education, advocacy and peer support for people with mood disorders
2. Provided clinical support (direct and indirect) for MDAO clinicians in assessing and treating the psychiatric problems of MDAO clients who have limited access to a psychiatrist
3. Enhanced the quality of psychoeducation provided to clients at MDAO
4. Improved experience of MDAO clients through access to direct psychiatric expertise
5. Educated MDAO staff and built capacity to manage psychiatric difficulties experienced by clients

SUNNYBROOK’S COLLABORATIVE ON RESEARCH AND EDUCATION IN YOUTH BIPOLAR DISORDER (SCORE-YBD). DR. BEN GOLDSTEIN

Andrew Kcomt presented on Perspectives on Exercise from those with Lived Experience of Mood Disorders at the 5th annual event hosted by Sunnybrook’s Collaborative on Research and Education in Youth Bipolar Disorder (SCORE-YBD). The Collaborative is a joint effort between Sunnybrook’s Centre for Youth Bipolar Disorder (CYBD), parents of youth with bipolar disorder, and the Mood Disorders Association of Ontario. The 2017 theme was Exercise and the Future of Prevention, Treatment, and Research in Youth Bipolar Disorder.

MDAO Mood Disorders Association of Ontario

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Why do we need a Quality Framework?

- Collaborative care in mental health practice is increasingly more widespread (in primary care settings) but highly variable and not evidence based
- Limited evidence and lack of guidance re: effective implementation of the model
- Even less so in *community-based, non primary care* mental health settings
- Quality frameworks have been adapted to guide such implementation

Mulvale G, Danner U, Pasic D: Advancing community-based collaborative, mental health care through interdisciplinary Family Health Teams in Ontario. Canadian Journal of Community Mental Health 27:55–73, 2008

McDonald KM, Sundaram V, Bravata DM, et al: Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Vol. 7: Care Coordination. Agency for Healthcare Research and Quality, 2007 Jun. Report No: 04(07)-0051-7.

Nadiya Sunderji, M.D., M.P.H. F.R.C.P.C., Allyson Ion, M.Sc., Abbas Ghavam-Rassoul, M.D., M.H.Sc., Amanda Abate, M.D. Evaluating the Implementation of Integrated Mental Health Care: A Systematic Review to Guide the Development of Quality Measures, Psychiatric Services in Advance

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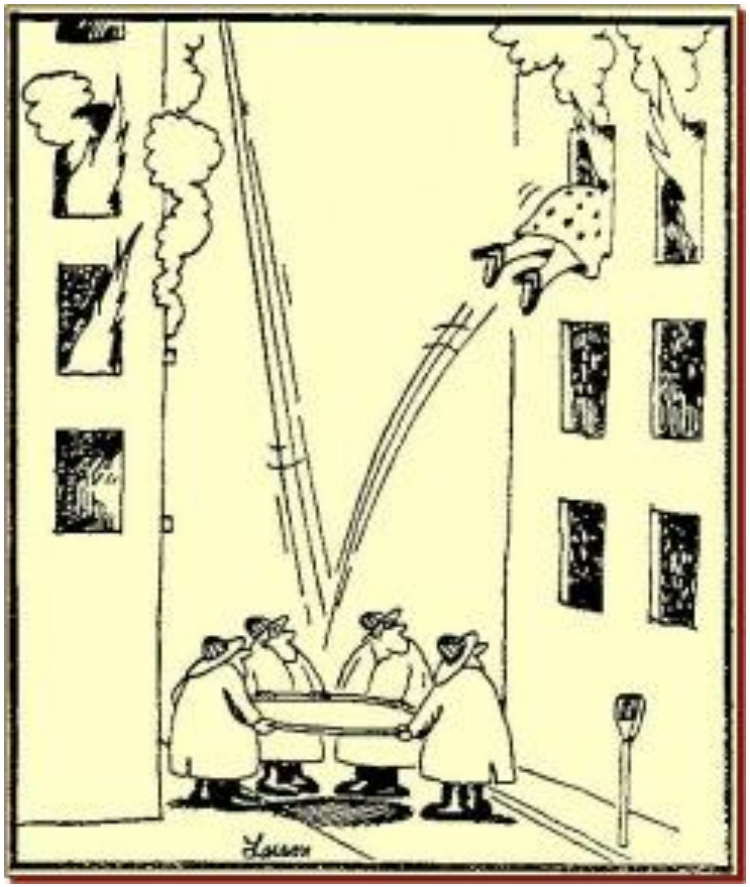
How do we know if we are effective?



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Generic quality domains do not address "Evidence to Practice" gaps in CC

Institute of Medicine/Health Quality Ontario

- Effective
- Efficient
- Patient Centered
- Timely
- Safe
- Equitable

Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions.* (National Academies Press (US), 2006).

Health Quality Ontario. *Quality Matters: Realizing Excellent Care for All.* (2015).

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Quality Framework: Specific Collaborative Care Domains

Sunderji, N., Ghavam-Rassoul, A., Ion, A., and Lin, E. "Driving improvements in the implementation of collaborative mental health care: A quality framework to guide measurement, improvement and research." 2016. Toronto, Canada.

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Mapping Quality Domains for Collaborative Care

COLLABORATIVE CARE QUALITY FRAMEWORK DOMAINS' ALIGNMENT WITH IoM DOMAINS

COLLABORATIVE CARE QUALITY DOMAIN	IoM DOMAIN
OUTCOMES	
Client Care Outcomes	Effective
Population-Based Care	Equitable
Access and Timeliness of Care	Timely
Value and Efficiency	Efficient
COLLABORATION IN PRACTICE	
Client Inclusion and Participation	Patient Centred
Team Functioning	N/A*
QUALITY OF CARE	
Evidence-Based Practices	Effective
Quality Improvement	All IoM domains
Collaboration for Patient Safety	Safe
Population-Based Care (processes)	Equitable
SYSTEMS OF CARE	
Level of Integration Between Mental Health and Primary Care Services	Effective Timely
INFRASTRUCTURE	
Infrastructure, Leadership and Management	Effective

* Dimensions and indicators of quality emerged during our study phases that did not align with any of the IoM domains of quality, many of which were included under our domain team functioning. As such, we have proposed a 7th domain termed "Culture of Health Care" to reflect this gap in the IoM Framework (see page 10 in report for more information).

Collaborative Care practice assessment worksheet

The **core principles** of effective collaborative care include a patient-centered care team providing evidence-based treatments for a defined population of patients using a measurement-based treat-to-target approach.

This tool provides an opportunity for **self-assessment** and reflection on your collaborative care practice.

		We apply this principle in the care of		
		None	Some	Most/All
		of our patients		
Patient Centered	Primary care and mental health providers collaborate effectively using shared care plans.	☐	☐	☐
	Each patient's treatment plan clearly articulates personal goals and clinical outcomes.	☐	☐	☐
Measurement-Based Treat to Target	Outcomes are routinely measured, e.g. symptom rating scales, e.g. measures of functioning and/or quality of life.	☐ ☐	☐ ☐	☐ ☐
	Treatments are adjusted if patients are not improving as expected.	☐	☐	☐
Evidence Based	Patients are offered treatments for which there is credible research evidence to support their effectiveness in treating the target condition.	☐	☐	☐
	Team has a shared understanding and uptake of a specific strategy of care for a specific condition (e.g. depression).	☐	☐	☐
	Medication reconciliation occurs at key points of vulnerability (e.g. transitions in care).	☐	☐	☐
	Mental health services are provided in a range of intensities and matched to patient needs and referring provider needs.	☐	☐	☐
Population-Based	Care team shares a defined group of patients tracked in a registry.	☐	☐	☐
	Practices track and proactively reach out to patients who are not improving or not following up.	☐	☐	☐
	Mental health specialists provide caseload-focused consultation, i.e. systematically review a panel or registry of patients, not just ad hoc advice.	☐	☐	☐
Quality & Patient Safety	Care team conducts quality improvement or patient safety interventions, i.e. *systematic* data-driven efforts to monitor and improve care (e.g. unsafe prescribing practices, appointment attendance rates).	☐	☐	☐

Dr. Nadiya Sunderji (sunderjin@smh.ca) and Dr. Abbas Ghavam-Rassoul (ghavamrassoula@smh.ca),
Psychopharmacology Update Day 2016
Adapted from the University of Washington AIMS Center (aims.uw.edu)

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Our Model

- Embedded psychiatric consultant 1 day/week
- 60% direct care vs. 40% indirect consultation
- Referrals streamlined via counselors/peer support workers (not GPs)
- Weekly rounds--intake meeting, case review
- Prioritize clients with no access to psychiatry
- Co-management and shared accountability
- Clients/patients registered at both MDAO and SBK--seamless
- Shared records
- Inter-organizational collaboration beyond direct care
- Academic partnership--adding trainees July 2018

What we did—Emerging Best Practices

- Conducted educational needs assessment
- Triage clients based on level of severity
- Caseload and waitlist management--weekly
- Range of modalities/intensities matched to clients' needs (informal stepped care)
- Measurement based (baseline BDI, GAD-7, YBOCS, Sheehan Disability, YMRS); repeated at Q3 and Q6mos
- Evidenced and guideline-based treatment
  - E.g. behavioral activation 1st line +/- RX mgmt.
- Developed registry of patients--database (demographics, diagnosis, hx of suicidality/safety, ER visits)

Safety and Risk Assessment: Columbia Suicide Rating Scale

- included as part of initial assessment
- score used as algorithm for clinical management

COLUMBIA-SUICIDE SEVERITY RATING SCALE

MDAO Screen with Triage Points

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are in bold and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."* ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."* ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past 3 months?***	**Lifetime** / **Past 3 Months**	

Response Protocol to C-SSRS Screening (Linked to last item marked "YES")

Item 1 Discuss and review risk at Intake
Item 2 Discuss and review risk at Intake
Item 3 Psychiatric Consult (+ allied health team) and develop Client Safety Plan
Item 4 Expedited Psychiatric Consult and (+ allied health team) and develop Client Safety Plan
Item 5 Expedited Psychiatric Consult and Safety Precautions (to ER, FORM 1)
Item 6 Discuss and review risk at Intake and consider Client Safety Plan
Item 6 Psychiatric Consult (+ allied health team) and consider Client Safety Plan

Disposition:
- Intake Team
- Psych Consult (+ team) and Client Safety plan
- Expedited Psych Consult and Safety Precautions

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Some Early Results to Date

- Access
  - Wait time to consultation--2-3 weeks
- Client care Outcomes
  - 23 point reduction in BDI-II*
  - 11 point reduction in GAD-7*
- Evidence-Based Practice
  - 70% accessed CBT/DBT/Mindfulness/other modality
  - 70% started on RX with 90% adherence
- Level of Integration
  - 25% discharged, 25% referred to specialized SBK/other program
- Collaboration for Patient Safety
  - Suicide Screening, ER Visits Monitored
- Team Functioning
  - 3 formal training sessions delivered (Group, DBT and CBT)

N=41 *not all clients have been reassessed

MDAO
PARTNERSHIP UPDATE

On December 19th, 2016 a Group Facilitation Training was conducted with the MDAO, Sunnybrook Psychiatry Department, and Mount Sinai Hospital Psychiatry Department. The four-hour training workshop was carried out by Dr. Molyn Leszcz, Psychiatrist-in-Chief at Mount Sinai Hospital and Dr. Rosalie Steinberg. The training session was for all of our counselors, support staff and group facilitators from across the province to help us improve our group services.

TESTIMONIAL

"I am extremely grateful that such a program exists, and knowing that these kinds of opportunities are available in the community is a great comfort, as it is easy to feel isolated when going through things like this, even when one (like myself) has numerous friends and family around. The MDAO is an extraordinary organization, and the peer support program specifically is a unique initiative. I am so grateful to have found out about it. I expect I have only so touched the surface of the value I will gain from my participation."

– Mark C.

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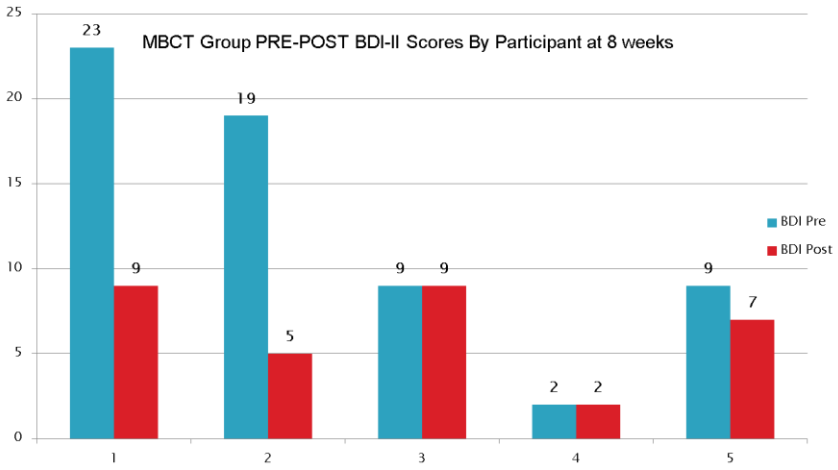
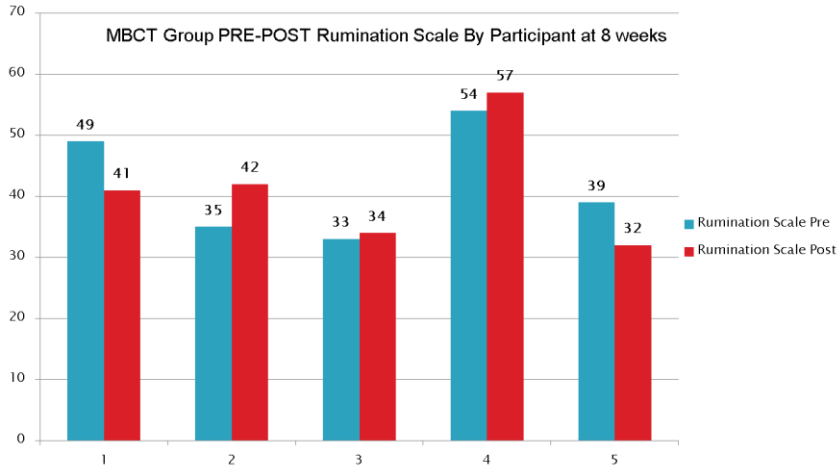
Mindfulness Group Data





Client Feedback

"I really liked this program as it has equipped me with tools to deal with troubling thoughts. Beauty of this program is that it is more experiential. I learned that "thoughts" of our own are responsible for how we feel. With mindfulness, we can reduce the intensity of negative thoughts".

"I liked the structure- facilitators were kind and challenging. I gained a new tool: mindfulness, exercise, CBT."

"Program was great, helped me to reinforce using meditation as part of my self-care routine. Thanks!"

"Worthwhile program. You both were (are) caring and empathetic. Thank you."

"For me, the program could have been a couple of weeks longer".

"I really like the idea of a tune-up- sort of like a safety net"

"It was a challenge to get here, but very worthwhile. I've learned to be more accepting of myself in a way I'd never thought possible"

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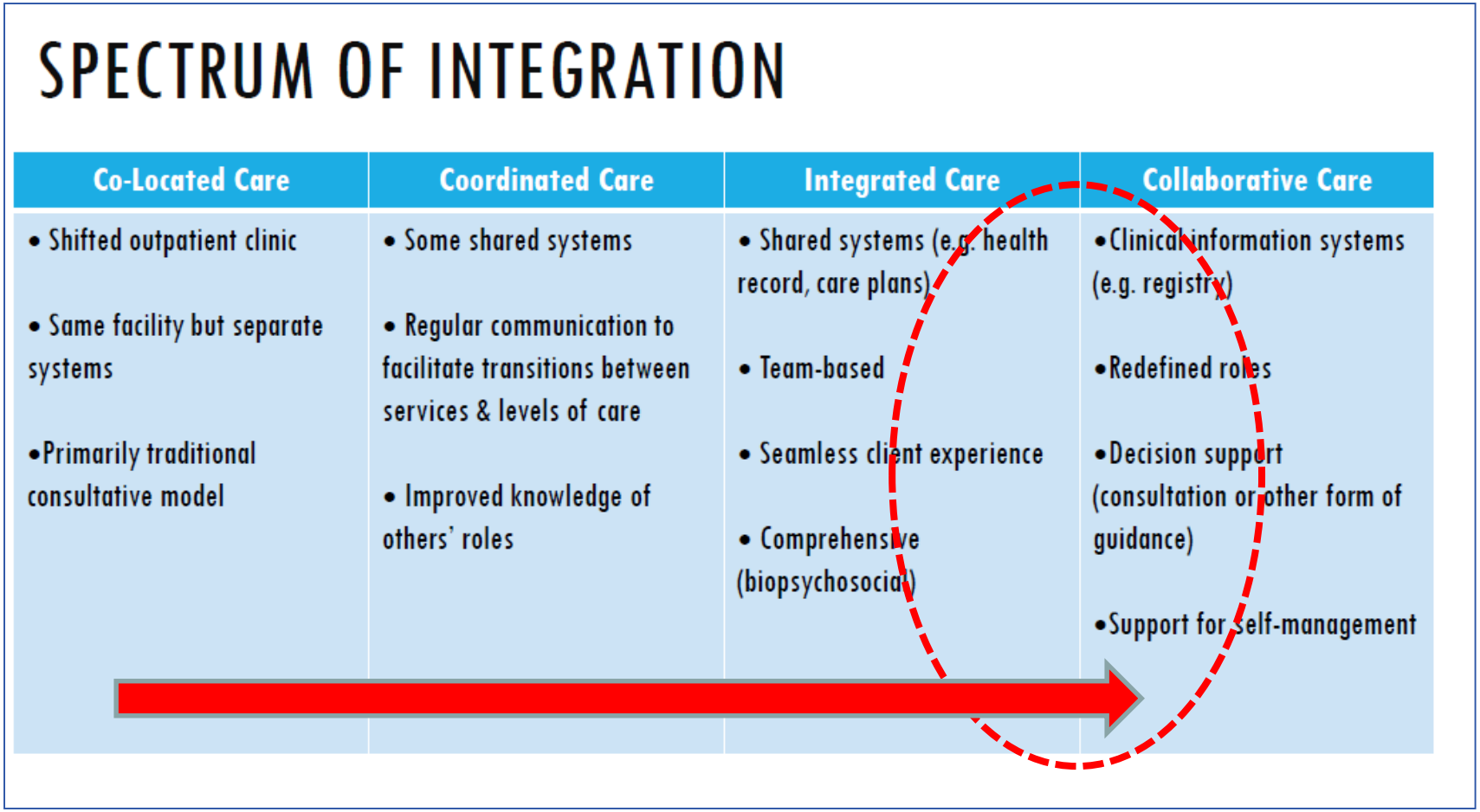
Where are we on the spectrum?



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Application of Quality Framework in a Community-Hospital Partnership

We were able to:

- ✓ Monitor functional and clinical outcomes of shared clients
- ✓ Provide seamless patient-centered care
- ✓ Manage complexity and decrease risk
- ✓ Facilitate care coordination to match resource intensity to client need
- ✓ Build organizational capacity through knowledge exchange

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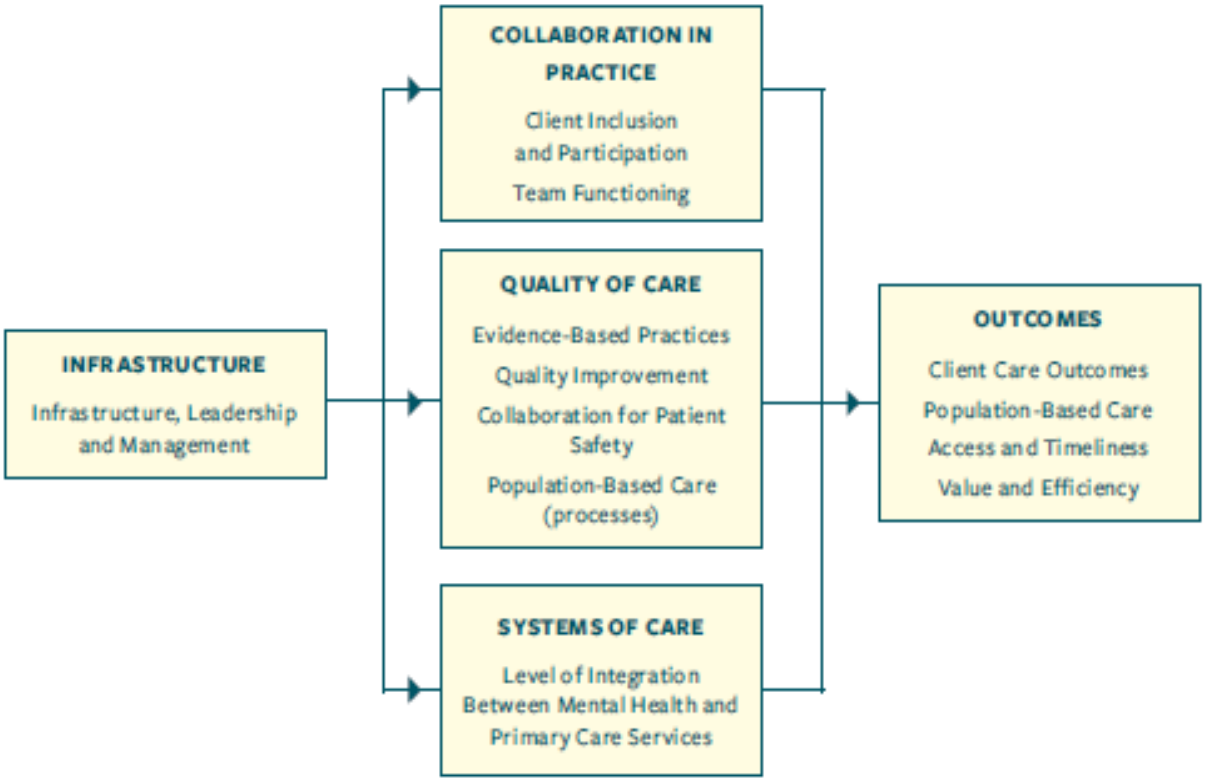
Collaborative Care Quality Domains

FIGURE 2. INTER-RELATIONSHIP OF COLLABORATIVE CARE DOMAINS OF QUALITY



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Lesson Learned

- Unique culture of community mental health—non medical model
- What to do with a psychiatrist? Antipsychiatry?
- Easier to identify a shared population in CMH> primary care
- Challenge of supporting data collection in the community
- Sustaining capacity-building with staff turnover
- Building a quality-driven culture takes time

Where to from here?

- Potential for service expansion, quality drives what, when, and how
- Identify and plan specific measures to consistently track
- Evaluation of stepped care model in a community MH agency
- Evaluation of efficacy, cost-effectiveness and team functioning
- Enhance client inclusion and participation in evaluation
- Include learners and trainees in quality measurement

Thank You

Questions?

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