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# How Can We Evaluate and Improve Collaborative Mental Health Care Across Canada:

A Consultation Session to Develop Nationally Relevant and Useful Quality Indicators

Presented at the Collaborative Mental Health Care Conference

Dr. Nadiya Sunderji, Bonita Varga, Dr. Matt Menear, Dr. Gwen Jansz, Francine Knoops

June 2, 2018

# PRESENTER DISCLOSURE

- **None of the presenters have received any commercial support.**
- **Project received financial support from Health Canada via MHCC but there are no perceived conflicts arising**

# Learning Objectives

## Participants:

- Identify the dimensions of quality collaborative care.
- Apply their lived experience, clinical and program management expertise to prioritize measures of quality indicators for collaborative care.

## Presenters:

- Capture audience feedback on priority dimensions of collaborative care that should be measured, and how to measure them.
- Identify where front line is collecting data on collaborative care and how it is being used.
- Elicit advice on implementation strategies and communication channels.

# Presentation Overview

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**Introductions – 10min**

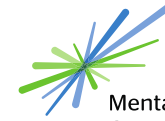
**Background – 25min**

- Why do we need quality indicators and how will they improve collaborative care?
- What does the evidence tell us?
- Project work to date

**Consultation – 40 in**

- Facilitated activity – 30 min
- Report back – 10 min

**Discussion and Q&A– 15min**



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# Introductions

How do you work in / experience collaborative care?

# The project partnership

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- Emerged from Ontario-based project: [Driving Improvements in the Implementation of Collaborative Mental Health Care: A Quality Framework to Guide Measurement, Improvement and Research.](#)

- The partners

- QI4CC\* team @ St. Michael's

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- Collaborative Working Group on Shared Mental Health Care



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- MHCC's Knowledge Exchange Centre – interest rooted in a number of recommendations in the Mental Health Strategy for Canada.

# Background

Why do we need quality indicators for collaborative mental health care?

How will they improve the practice of collaborative care?

What does the evidence tell us?

What have we done so far?

# What is collaborative care?

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Mental health specialists and primary care providers working together to improve access to, and quality of, mental health care for a specific target population. Once referred to as “shared care”.

Collaborative Mental Health Care is understood to occur along a spectrum of integration varying, from:

- co-located specialists delivering care at the primary care clinic,
- integrated or shared care involving increased communication and coordination of care,
- the collaborative chronic illness care model.



# Why develop a quality framework and measures?

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Primary care is the first and most continuous source of care, and many mental health problems are managed solely or primarily in primary care.

Collaborative mental health care models are effective and increasingly widespread but implementation is variable, leaving a gap between evidence and real-world performance.

Quality measurement can illuminate problems in practice, and identify potential causes and targets for quality improvement

There may be confusion about what are the essential components or functions of Collaborative Care that are applicable to any clinical context.

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# What is a quality indicator?

- A measure that summarizes information about a priority aspect of health care quality
  - Tells us how we're doing in healthcare delivery
  - May reflect population health or health system performance
- Indicators provide actionable information to guide efforts to improve healthcare
  - May be comparable across different settings
  - Should be able to track progress over time
- Often come as a “balanced set” of indicators that, taken together, reflect as much of the system as possible, without overlap or gaps in the information they provide

# Project Objectives

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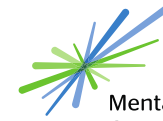
Develop and validate pan-Canadian framework for quality of collaborative mental health care

- Building upon the Ontario research report [Driving Improvements in the Implementation of Collaborative Mental Health Care](#)

Develop 2-4 key practice-level indicators

- Grounded in the national framework
- Complementary to the MHCC indicators

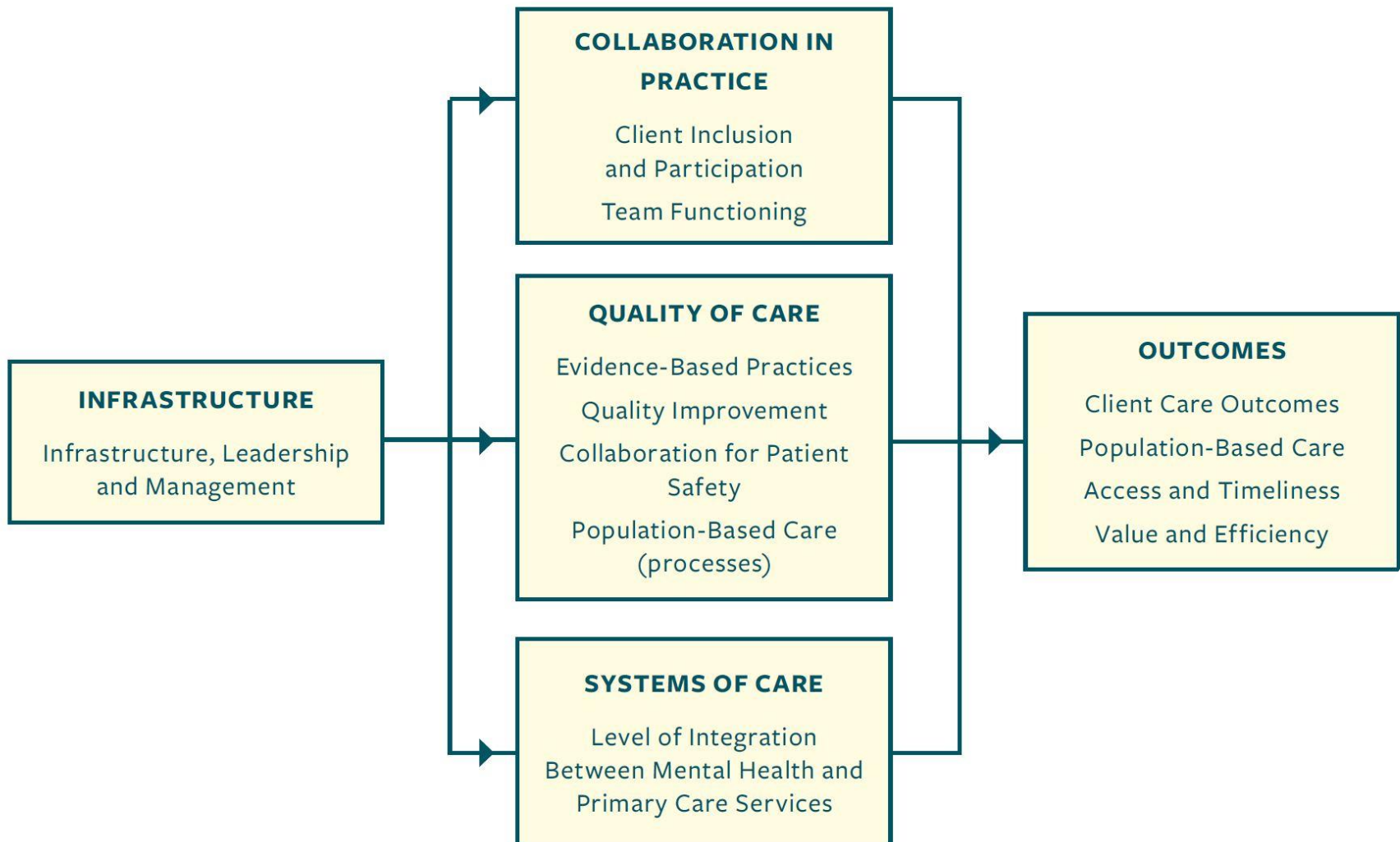
Design and implement a knowledge exchange plan

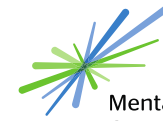


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# The framework we started from





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# What are we trying to achieve?

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## **CLIENT CARE OUTCOMES**

Care achieves good results for clients.

## **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 (i.e. services are equitable).

## **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.

## **CLIENT INCLUSION AND PARTICIPATION**

Care is geared toward providing the best possible experience for clients, and achieving outcomes that are important to clients.

## **VALUE AND EFFICIENCY**

From a system perspective, care delivers good value considering the costs.

# What conditions, activities are helping or hindering?

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## **INFRASTRUCTURE, LEADERSHIP AND MANAGEMENT**

Care is provided under appropriate conditions (e.g. appropriate physical space, having skilled health care providers from different disciplines).

## **LEVEL OF INTEGRATION BETWEEN MENTAL HEALTH AND PRIMARY CARE SERVICES**

Services are well coordinated within the collaborative mental health program in primary care, and also between the primary care team and outside mental health specialists.

## **EVIDENCE-BASED PRACTICES**

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

## **TEAM FUNCTIONING**

The clinical team of primary care and mental health providers work well together.

## **QUALITY IMPROVEMENT**

Collaborative Care team and program are continuously working to improve quality.

## **COLLABORATION FOR PATIENT SAFETY**

Collaborative Care program is organized to provide the safest possible care.

## Participant Demographics (n=21)

Variable	N (%)
<b><i>Region of Canada</i></b>	
Quebec	6 (29)
Prairies	4 (19)
Ontario	4 (19)
Atlantic	4 (19)
British Columbia	2 (10)
Northern Canada	1 (5)
<b><i>Perspective</i></b>	
Clinician & Researcher / Administrator	7 (33)
Clinician	6 (29)
Researcher	3 (14)
Administrator	2 (10)
Policy Expert	2 (10)
Patient Partner	1 (4)
<b><i>Discipline</i></b>	
Psychiatry	5 (24)
Family Medicine	4 (19)
Psychology	4 (19)
Administration	3 (14)
Collaborative Care Researcher	3 (14)
Lived Experience	1 (5)
Nursing	1 (5)

## Engagement so far

- Generated list of key informants in consultation with project partners
- Contacted 38 individuals across Canada
- Conducted 21 individual interviews and 2 focus groups with CC teams

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## Our analytic approach

- Transcripts were reviewed by five team members
- Measures suggested or utilized by key informants were coded under the four domains of interest
- Three team analysis meetings:
  - Refine coding
  - Refine wording of measures
  - Ensure suggested measures were grounded in data and reflected key informant perspectives



# Recommendations

Based on our findings to date, what practice-level indicators do we recommend?

- Access and timeliness

- Client care outcomes

- Client inclusion and participation

- Population based care and equity

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## Access and timeliness

- 1. Triage.** There is a mechanism or process by which to prioritize and sequence patient care other than a first come first serve basis.  
e.g. based on urgency  
indicator could be All of the time, Some of the time, Rarely, Never
- 2. Decision support.** Number of days from request to receipt of support for primary care provider(s) managing the patient  
e.g. could involve direct patient consultation or advice provided without seeing the patient depending on the circumstances
- 3. Wait time.** Time from recognizing a need for service to receiving an appropriate treatment.  
from the patient's perspective

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## Access and timeliness

“Patients [have] access to a system that provides **the right care by the right person at the right time**, depending on what they need in terms of crisis intervention or continuing counselling.”

“Once a month, **we all get together and we discuss cases...** that are posing any kind of questions or difficulties...Through email, through going down there... you can get advice from people or check in what’s going on with a referral...**the benefit is that the people involved are** all like getting different perspectives on mental health care and **getting different kind of input**. So **hopefully we’re getting better at it.**”

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# Client care outcomes

- 1. *Quality of life.*** Includes social and role functioning.  
e.g. SF-12 or Sheehan Disability Scale or EQ5D scale – to be determined.  
|
- 2. *Recovery.*** Includes wellness, hope, self-efficacy, social inclusion, meaning and purpose.
- 3. *Symptom reduction.*** Based on validated rating scales.  
e.g. PHQ-9, GAD-7.

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## Client care outcomes

“We would be looking at the whole person. So we would be looking at their physical health, their mental health, their social health, their financial health, their **quality of life** in terms of leisure and work. Like **we’d be looking at the whole person**, not just a segment of it.”

“I do think symptoms. Because if we don’t have great measures then... **I think symptom reduction is certainly something that**, my understanding, is that **clients or patients look for**. So I think that’s really important.”

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# Client inclusion and participation

1. Patients are included in their own care: *“In the last 12 months how often were you involved in decisions about your treatment to the extent that you wanted to be?”*  
response options: always, often, sometimes, rarely/never
2. Patients are meaningfully involved in program planning, evaluation, and improvement at all stages.  
From the PPEET questionnaire:
  - Organizational leaders ensure that public and patient input is used in [collaborative care] service planning and decision making
  - I am aware of PPE activities that have influenced relevant decisions at the [collaborative care] program level*Consider question about using client satisfaction data in decisions (lower level of engagement)*

# Engaging patients as partners in practice improvement



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Statement	Strongly Disagree 1	2	3	4	Strongly Agree 5
a. Engaging patients in practice improvement is worth the time and effort it takes.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
b. We have a formal strategy for how we recruit patients to serve in an advisory capacity.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
c. Our clinic leadership would like to find more ways to involve patients in practice improvement.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
d. We dedicate time at team meetings to discuss patient feedback and recommendations.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
e. Patient input helps shape strategic goals or priorities	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
f. Clinicians/staff regularly meet with patients to discuss clinic services and programs.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
g. Patients would make unrealistic requests if asked their opinion about how to improve clinic services and policies.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
h. Revealing the workings of the clinic to patients would expose the clinic to too much legal risk.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
i. Patient feedback has resulted in policy or program changes at our clinic.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
j. We are successful in engaging patient advisors who represent the diversity of the population we serve.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

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## Client inclusion and participation

“I have some clients who need direction. They don’t really want to have a huge input on what the treatment plan is. And then there’s some people we need to give options to. And they should be part of that – here are the options, here are the side effects, this is what we can and can’t do. **What would you like to do? What’s important for you to do?...Asking clients are they getting that option?...** Are they able to take part or **are they being asked to take part in their own care**, or are they just sort of being dictated what needs to happen?”

“**To have a consumer involved in the actual day-to-day leadership team...** Then you have somebody with that first voice kind of experience and is part of the decision-making on a day-to-day basis...**An advisory committee is every month or two. It’s not the same as the day-to-day stuff** that is really what matters.”



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## Population based care and equity

1. **Infrastructure.** The primary care organization has the infrastructure to collect, manage, and harness insights from data on the population of patients served.

Indicator could include sub-items for collect, manage, harness

Indicator could be All of the time, Some of the time, Rarely, Never

2. **Proactive care.** The organization uses available data to reflect upon the health needs of the population served (e.g. including social determinants of health), and to be more proactive in planning and delivering services

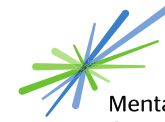
e.g. data may be from electronic health records, or  
community/region statistics

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## Population based care and equity

“To measure outcomes, that means you have to track people over time.  
And, **our systems are not... well-suited to doing that.**”

“We needed to connect how somebody was doing in terms of their PHQ-9 with when we could schedule their next appointment...If it was integrated into an EMR, it was much more doable. But the key there was the ongoing measurement of primarily PHQ-9s and trying to track interventions, and **whether or not to sort of move them up or down on a step care model according to how their PHQ-9s tracked over time.** So I think the concept was right but...it really required a smooth integration with the EMR.”



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# Consultation

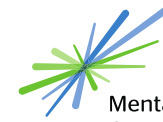
# Focus Group Activity

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- Based on what you've heard so far, do you see your experience of collaborative care reflected in the findings?
- Do you think the outlined measures:
  - Are relevant to defining the quality of collaborative mental health care?
  - Would provide useful feedback that informs improvement efforts?
  - Would be easy to collect?
  - Would be easy to understand?
  - Are something you would implement or recommend to implement? Why or why not?

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