Mental Illness and Addiction: Using an Integrated Approach to Improve Quality of Care

May 3, 2016

12:00 noon ET
Welcome to today’s webinar

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Ambulatory Care and Structured Treatments (ACST) Program
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Executive Director,
Complex Mental Illness (CMI) Program
Centre for Addiction and Mental Health (CAMH)
Today’s objectives

1. Learn about the positive impact that integrated care pathways are making in the lives of those living with schizophrenia and their families.

2. Discover how CAMH’s integrated mental health and addictions assessment tool reduces hospitalization and improves access to care.

3. Gain a new understanding of the full scope of CAMH’s commitment to ongoing improvement, and how evidence is being used to improve the quality of care for CAMH clients.
The Objectives of the EXTRA Program:

• Build the capacity of organizations to achieve and sustain improvement

• Enhance the capacity of teams of existing and emerging leaders to accelerate improvement

• Create a pan-Canadian community of leaders dedicated to improvement
Integrated Care Pathways

http://www.camh.ca/en/hospital/care_program_and_services/ICPs/Pages/default.aspx
About the Centre for Addiction and Mental Health

**Canada’s leading mental health teaching hospital**

- Leader in clinical care
  - Complex mental illness
  - Children & Youth
  - Seniors
  - Addictions

- World renowned research

- Education destination

- Provincial partner
  - Advocacy
  - Evidence-based public policy
  - System building
Numbers

CLIENTS
- Unique* clients: 38,837
- Unique clients by gender:
  - Male: 54.1%
  - Female: 44.9%
- Transgender, transsexual, unknown: 0.3%
- Outpatient visits: 4,766,867
- Inpatient admissions: 4,989
- Visits to Emergency Services: 6,968
- Average length of stay in days: 49.3

STAFF AND RESEARCH
- CAMH staff: 2,900
- CAMH physicians: 378 (includes 7 nurse practitioners)
- Research grants/contracts: 325
- Annual research funding awarded: $38,097,840

INFORMATION/EDUCATION
- Visits to www.camh.ca: 2,314,866
- Participants in professional training and public education events: 78,406

PRIMARY DIAGNOSIS OF UNIQUE* INPATIENT CLIENTS, 2012-2013
- Schizophrenia and other psychotic disorders (31.2%)
- Substance-related disorders (29.3%)
- Mood disorders (25.4%)
- Anxiety disorders (2.3%)
- Personality disorders (2.1%)
- Delirium, dementia and other cognitive disorders (2.0%)
- Other (3.1%)

NOTE:
- 42.6% of inpatients had more than 1 diagnosis
- 31.1% of inpatients had 2 diagnoses
- 11.2% of inpatients had 3 diagnoses

DISTRIBUTION OF PATIENTS BY LHINS, 2012-2013
- Toronto Central: 50.7%
- Central East: 9.1%
- Central West: 4.9%
- Mississauga Halton: 7.0%
- Other Ontario LHINS: 7.2%
- No fixed address: 2.3%
- Unknown: 9.6%

*Unique individual people who received care, regardless of number of visits
Creating an Integrated Mental Health and Addictions Assessment and Service Matching Process to Improve Ambulatory Care Access

May 3, 2016

Dr. Peter Voore, Medical Director
Ambulatory Care and Structured Treatments (ACST) Program
Centre for Addiction and Mental Health (CAMH)
Outline

• Our Context
• Our Problem and Aims
• Analysis of Our Evidence
• Integrated Assessment pilot “pop-up clinic”
• Our Results To Date
• Our Potential Impact
Our Context:
CAMH - the largest mental health and addiction teaching hospital in Canada
Our Context: CAMH Program Realignment

Access & Transitions

- Centralized Intake to reduce access delays
- Accountability aligned for Patient Flow
- Partnerships consolidated to benefit all CAMH programs

Complex Mental Illness
- Significant inpatient focus: Schizophrenia, Forensics
- Better care standards for: high acuity, rehabilitation, outpatient services
- Innovations (e.g., partial hospitalization)

Ambulatory Care and Structured Treatments
- Majority of Addiction and Mood treatments on scheduled basis
- Best practices for structured treatments (e.g., structured day treatment, psychotherapeutic modalities)

Underserved Populations
- Strategic populations: Child, Youth & Family, Geriatrics, Dual Diagnosis
- Strategic partnerships & initiatives
Our Context:
The Population of Interest to Our Program
(CAMH Longitudinal Ontario Population Study*)

Over the past 12 months in Ontario....

- 1,380,500 (13.1%) experienced elevated psychological distress during the past few weeks
- 786,400 (7.5%) used prescribed antidepressant medication
- 938,300 (8.9%) used prescribed antianxiety medication
- 788,200 (7.5%) had moderate or high risk cannabis use
- 1,353,500 (13.7%) engaged in hazardous/harmful drinking
- 294,550 (2.8%) used prescription opioid pain relievers for nonmedical purposes
- 153,700 (1.5%) used cocaine
- 664,700 (6.6%) experienced symptoms of alcohol dependence

Our Context:
The Ambulatory Care and Structured Treatment (ACST) Program

Access & Transitions
Access CAMH + Emergency Department

Complex Mental Illness
Ambulatory Care and Structured Treatments
Underserved Populations

13,000 Clients Per Year
Our Context:
Highly specialized; fragmented; poor integration for

Addiction
- MAARS
  - MAARS
  - OCAT
  - Trauma Grp
  - CAITS
- Addic Assess
  - MWS
  - Cocaine
  - Aboriginal
- Addic Med
  - Rainbow
- Eating
  - Wo Addic
- Gambling
  - Nicotine

Mood & Anxiety
- Consult
  - CBT
  - AIM
  - Day

Women
- WIU
  - TCP
  - Day

BPD
- BPD
  - BPD

Gender
- Gender
Our context:

One story  ... and 13,000 Possible Variations of That Story
Our Context:
CAMH Vision 2020 Strategic Directions

DIRECTION ONE
Enhance recovery by improving access to integrated care and social support

Aims
- Clear pathways to care for clients, families and those who refer them
- Demonstrate the effectiveness of our work
- Partner to co-ordinate care for diverse and underserved populations
Our Problem and Aims

**PROBLEM:**
Difficulty assigning appropriate mental health & addictions ambulatory services in a timely way to match service needs of our clients.

**Aim 1:** To determine data required to improve service matching of high volumes of ambulatory mental health and addictions clients.

**Aim 2:** To prototype data-informed algorithms to guide assignment of clients to ambulatory services based on assessed service needs.

13,000 clients per year
Tentative Conclusions:
1. “Integrated” mental health and addictions programs may promote more efficient and effective service matching for concurrent needs; stepped care for differing levels of need & severity
2. Service matching criteria need to integrate mental health and addictions practices & cultures
3. No single assessment tool for integrated MH and A assessment
Our Evidence:
Access CAMH Referral Data and Focus Group Findings

Access CAMH Portal
9,000 new clients matched to ACST in past 12 months

Retrospective analysis of 500 clients

- 50% Addictions
- 38% Anxiety
- 37% Depression
- 50.4% identified at least 2 problems
- Trauma, Mania, Intellectual Disability, Disorder

FOCUS GROUP:
- Addictions - self referrals; matched for substance & service preference
- Anxiety & depression - GP referred; sent to physician consultation service for matching
Our Evidence:
Common Archetypes Served in Our Program

“Hard-to-Match”

1. MULTIPLE CONCURRENT NON-PSYCHOTIC DISORDERS
2. NON-PSYCHOTIC DISORDER(S) – FROM OUTSIDE GTA
3. NON-PSYCHOTIC DISORDER(S) WITH LIMITED SOCIAL SUPPORTS or SIGNIFICANT IMPAIRMENT
4. NON-PSYCHOTIC DISORDER(S) - SELF-REFERRED WITH NO GP
5. ADDICTIONS DISORDER – LOW MOTIVATION
6. NON-PSYCHOTIC DISORDER(S) - HIGH-RISK

“Easy-to-Match”

1. MOOD AND/OR ANXIETY DISORDER WITH LOW IMPAIRMENT
2. SUBSTANCE USE DISORDER WITH MOTIVATION
3. ADDICTION MEDICINE NEEDS (DEPENDENCY RISKS)
4. MEDICAL WITHDRAWAL NEEDS

Archetype Workshop
Our Evidence: Archetype Tracer Data

**Working Group Consensus:** Tracer Methodology, Selected Clients, Data Sources, Ethics, Client Relations
Data-informed Service Matching (NHS informed)

• Prioritization of all concurrent problems (diagnoses)
• Level of severity and risk
• Level of impairment
• Previous treatment trials
• Client preference and motivation
### NHS Clusters

<table>
<thead>
<tr>
<th>Care Cluster 0: Variance</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do not fit into other clusters; present variances</td>
<td>• Do not fit into other clusters; present variances</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 1: Common Mental Health Problems (Low Severity)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
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</thead>
<tbody>
<tr>
<td>• Minor problems of depressed mood, anxiety or other disorder</td>
<td>• Minor problems of depressed mood, anxiety &amp;/or addictions</td>
<td></td>
</tr>
<tr>
<td>• Risk low; Impairment low</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minor problems of depressed mood, anxiety or other disorder</td>
<td>• Minor problems of depressed mood, anxiety &amp;/or addictions</td>
<td></td>
</tr>
<tr>
<td>• Risk low; Impairment low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Previously treated but presenting due to reoccurrence of problems</td>
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</table>

<table>
<thead>
<tr>
<th>Care Cluster 3: Non-Psychotic (Moderate Severity)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Minor problems of depressed mood, anxiety or other disorder</td>
<td>• Minor problems of depressed mood, anxiety, addictions &amp;/or trauma</td>
<td></td>
</tr>
<tr>
<td>• Risk low; Impairment moderate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 4: Non-Psychotic (Severe)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe depression and/or anxiety or other disorders and increasing complexity of needs</td>
<td>• Severe depression &amp;/or anxiety, and addictions &amp;/or trauma with increasing complexity of needs</td>
<td></td>
</tr>
<tr>
<td>• Disruption in function in everyday life &amp; increasing likelihood of significant risks</td>
<td>• Disruption in function in everyday life &amp; increasing likelihood of significant risks; Impairment moderate to high</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 5: Non-Psychotic Disorders (Very Severe)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Severe depression and/or anxiety or other disorders and increasing complexity of needs</td>
<td>• Severe depression &amp;/or anxiety &amp;/or addictions, trauma with increasing complexity of needs</td>
<td></td>
</tr>
<tr>
<td>• Not psychotic but hold unreasonable beliefs</td>
<td>• Not psychotic but hold unreasonable beliefs</td>
<td></td>
</tr>
<tr>
<td>• May have high risk of suicide that present safeguarding issues &amp; have severe disruption to everyday living</td>
<td>• May have high risk of suicide that present safeguarding issues &amp; have severe disruption to everyday living; Impairment high</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 6: Non-Psychotic Disorder of Over-Valued Ideas</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moderate to severe disorders that are difficult to treat</td>
<td>• Moderate to severe disorders that are difficult to treat (depression or anxiety &amp; addictions or trauma)</td>
<td></td>
</tr>
<tr>
<td>• May include Eating Disorders, OCD (extreme beliefs held)</td>
<td>• May include Eating Disorders, OCD (extreme beliefs held)</td>
<td></td>
</tr>
<tr>
<td>• May include some personality disorders &amp; enduring depression</td>
<td>• May include some personality disorders &amp; enduring depression</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 7: Enduring non-Psychotic Disorders (High Disability)</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Moderate to severe disorders that are disabling</td>
<td>• Moderate to severe problems of depression, addictions &amp;/or trauma</td>
<td></td>
</tr>
<tr>
<td>• Treatment for a number of years</td>
<td>• Moderate risk of chronic nature</td>
<td></td>
</tr>
<tr>
<td>• Considerable disability remains that is likely to affect role functioning in many ways</td>
<td>• Treatment for a number of years; long term trajectory</td>
<td></td>
</tr>
<tr>
<td>• Considerable disability remains that is likely to affect role functioning; Moderate to severe impairment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders</th>
<th>Original NHS Characteristics</th>
<th>Project Adaptation (CAMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wide range of symptoms &amp; chaotic &amp; challenging lifestyles</td>
<td>• Wide range of symptoms &amp; chaotic &amp; challenging lifestyles</td>
<td></td>
</tr>
<tr>
<td>• Moderate to severe deliberate self-harm &amp;/or impulsive behavior &amp; chaotic, over-dependent engagement &amp;/or often hostile with services</td>
<td>• Moderate to severe deliberate self-harm &amp;/or impulsive behavior &amp; chaotic, over-dependent engagement &amp;/or often hostile with services</td>
<td></td>
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</table>
The Pilot ‘Pop-Up Clinic’

**WHEN:** Operated on 9 half-days, across 3 weeks, February 2016

**WHO:** Pilot Sample: 77 patients referred from Access CAMH:
- Addiction Assessment Service (Self-referrals: n=26)
- Mood Anxiety Service (GP Referrals: n =25)
- Internal referrals (Day Treatment Waitlist: n=21)

**Patient Panel**
- Each Clinic day had a cohort of 10-12 clients scheduled

**Panel Staffing**
- 2 Psychiatrists:
  - 1 MAAS + 1 Addiction
- 4 Allied Health clinicians:
  - SW & Nursing from Addictions, MAAS, IDT

**INTERPROFESSIONAL IMPLEMENTATION TEAM**
**Total Staff Involved**
- 6 physicians
- 9 Allied Health clinicians:
  - 7 SWs
  - 2 Nursing
- 1 Research
- 5 Project Team Members
Trial of a variety of Interprofessional Models

Our main model

Allied Health

Psychiatrist (initially or subsequently)

Other collaborations

Psychiatrist AND Allied Health “conjointly”

2 Allied Health “conjointly” (Mood and Addiction expertise)
Pilot Result: Increased Show Rate

<table>
<thead>
<tr>
<th>CLIENT UTILIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Clients Scheduled</td>
</tr>
<tr>
<td>88</td>
</tr>
</tbody>
</table>

Represents improvement over current state

 Comparator Show Rates for First Appt:
- MAAS: 70-80% (Period: Fall 2015)
- Addiction Asst: 65% (Period: Jan – March 2016)

Pilot strategies that contributed to higher show rate:
- Clients were called with the appt time fairly close to the date of the appt (days or 1-2 weeks)
- Clients also asked if they could be emailed a brief description of the pilot initiative: Receiving written details may have provided greater clarity about expectations, and enhanced motivation to attend
Patient Profile:
Addiction Concerns

### PRIMARY SUBSTANCE OF CONCERN

<table>
<thead>
<tr>
<th>Substance</th>
<th>% of ALL clients (N=74)</th>
<th>% of clients with SU Concern (n=46)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>30%</td>
<td>48%</td>
<td>22</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12%</td>
<td>20%</td>
<td>9</td>
</tr>
<tr>
<td>Street opioids</td>
<td>8%</td>
<td>13%</td>
<td>6</td>
</tr>
<tr>
<td>Cannabis</td>
<td>5%</td>
<td>9%</td>
<td>4</td>
</tr>
<tr>
<td>Sedatives</td>
<td>3%</td>
<td>4%</td>
<td>2</td>
</tr>
<tr>
<td>Prescription Opioids</td>
<td>1%</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Tobacco</td>
<td>1%</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>1%</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Other (cough syrup)</td>
<td>1%</td>
<td>2%</td>
<td>1</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0%</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>N/A</td>
<td></td>
<td></td>
<td>23</td>
</tr>
</tbody>
</table>

### Average AUDIT Score
(n=22 clients with alcohol concerns)

- **20.5**
  - Falls in ‘severe’ range.
  - Any score over 20 (out of possible 40) indicates the need for a referral to tx

- ▶️ 30% of all clients identify alcohol as a substance of concern, but of the clients presenting with substances of concern:
  - 48% have alcohol as the primary concern

### Secondary Substances of Concern:
- Cannabis (35%), Cocaine (25%), Sedatives (15%), Street Opioids (10%), Tobacco (10%)

### Non-goal Substance Use:
- 24% of all clients identify cannabis as a substance used, but not of concern; and of the clients presenting with substances of concern: 40% of the clients use cannabis and feel it is not a goal for them to address; Tobacco: 33%
# Patient Profile: Mental Health Concerns

## Average QIDS SCORE
(Severity of Depression)

<table>
<thead>
<tr>
<th>MMS ANXIETY Subscale</th>
<th>MMS MOOD Subscale</th>
<th>MMS PSYCHOSIS Subscale</th>
<th>MMS TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.3 (Anything above 10 is considered high and warrants a full assessment for the purposes of treatment planning)</td>
<td>13.7 (falls in 'moderate' range (Severe = 16+)</td>
<td>5.62 (out of 9)</td>
<td>3.55 (out of 6)</td>
</tr>
</tbody>
</table>

## % clients who reported TRAUMA HISTORY

- % clients stated they had experienced or witnessed a traumatic event: 52%
- % clients stated they had re-experienced the awful event in a distressing way in the past month: 34%
- % clients stated they had problems within the past month being disturbed by memories of distressing past experiences: 60%
- % clients reported engaging in SELF HARM: 19%
### Pilot Outcomes: Patient Profile - Domain #2: All CD Problems

#### % of clients with CD

| Internalizing disorders: (GAIN): Depression, Anxiety, trauma, suicide risk | 76% |
| Externalizing disorders: Attention deficit, hyperactivity, impulsivity, conduct problems | 60% |
| Trauma symptom (GAIN): Problems within the past month of being disturbed by memories of distressing past experiences | 60% |
| Trauma symptom (MMS): Re-experienced the awful event in a distressing way in the past month | 34% |
| Likelihood of Substance Use Disorder (GAIN) | 59% |
| Anxiety (MMS) |  |
| Mood (MMS) |  |
| Psychosis (MMS) |  |
# Pilot Outcomes: Patient Profile-Domain #3: Level of Impairment

<table>
<thead>
<tr>
<th>LEVEL OF IMPAIRMENT</th>
<th>Recent ED VISIT (n=74)</th>
<th>Recent HOSPITALIZATION (n=74)</th>
<th>History of HEAD INJURY (n=74)</th>
<th>PERCEIVED SOCIAL SUPPORT (from family &amp; friends) (n=74)</th>
<th>Average QIDS SCORE (Severity of Depression)</th>
<th>Average AUDIT SCORE Among Clients with Alcohol Concerns (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent ED VISIT</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
<td>13.7 (falls in ‘moderate’ range)</td>
<td>20.5 [Falls in ‘severe’ range. Any score over 20 (out of possible 40) indicates the need for a referral to treatment]</td>
</tr>
<tr>
<td>Recent HOSPITALIZATION</td>
<td>9%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: AMS/ MWS/MDAD not included in pilot which would have elevated AUDIT scores</td>
</tr>
<tr>
<td>History of HEAD INJURY</td>
<td>28%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERCEIVED SOCIAL SUPPORT (from family &amp; friends)</td>
<td>52.9%</td>
<td></td>
<td></td>
<td>Average score: 3.7/7 = moderate support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average QIDS SCORE (Severity of Depression)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average AUDIT SCORE Among Clients with Alcohol Concerns</td>
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</tbody>
</table>
Pilot Outcomes: Patient Profile - Domain #4: Treatment History

<table>
<thead>
<tr>
<th>Treatment History</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Addictions Tx (n=53)</td>
<td>45%</td>
</tr>
<tr>
<td>Any Mental Health Tx (n=60)</td>
<td>65%</td>
</tr>
<tr>
<td>Any CD Tx (n=52)</td>
<td>8%</td>
</tr>
<tr>
<td>Recent HOSPITALIZATION (n=74)</td>
<td>9%</td>
</tr>
<tr>
<td>Recent ED VISIT (n=74)</td>
<td>12%</td>
</tr>
<tr>
<td>% with a GP (n=74)</td>
<td>72%</td>
</tr>
<tr>
<td>% with THERAPIST (n=74)</td>
<td>16%</td>
</tr>
</tbody>
</table>

▼ ▼ ▼ 28% do NOT have a GP
Pilot Service Matching Outcomes

A total of 71 ‘same-day’ service-matching dispositions were made
- 31 to Addiction services (44%) and
- 31 Mood services (44%)
- 9 to external-to-CAMH services (13%)
- 1 client was sent to the CAMH ED (Form 1) for acute suicide risk and intoxication

Of clients with CD:
- 71% (the majority of all clients) were referred to Addiction services
- 17% were referred to Mood services, and
- 11% were referred externally

% clients who were service-matched to more than 1 service: **38%**
% of Psychiatrists who sent copy of the Consult note back to GP: **85%**
% clients who consented to Research Contact: **69% by PDSA Week 3!**
Our Potential Impact: Organizational Level

- ACST serves 40% of CAMH clients; continuous quality improvement of access to integrated treatment (CAMH Vision 2020)
- Creation of a novel, evidence-based program structure for the treatment of adults with concurrent disorders
- Opportunity for evidence-based innovation and learning that can be transferred across organization
- Enhanced access to ambulatory service (right level of integrated, stepped care) should reduce reliance on Emergency Department and inpatient care
- Improved efficiency: 3 to 5% decrease in program operating budget per annum; anticipated increase of volumes from 13,000 to 16,000 clients per year in next 3 years
Our Potential Impact: Health Systems Level

- Toronto Central LHIN: access to care is a priority
  - “open door”
  - integrated access points
  - seamless transitions in care

- Receptive to our specific program reconfiguration vision; opportunity to contribute to more efficient system of care

- Need more collaboration with community partners: transitions & service matching must extend beyond our One House walls

- Must transform expectations of our stakeholder community: historical reputation of being hard to access; reassurance that changes will equate with improved access and outcomes

- Innovation: opportunity to adapt British model for integrated mental health & addictions & test in our context (gap in the literature)
EXTRA:
Impact on Our Program

- Engagement, collaboration, reduced fragmentation
- Education: ourselves & stakeholders
- Discipline: evidence review; project management
- Consolidation of vision to improve structures, procedures
- Program-level & system-level thinking (populations); yet focused on client-centered care
- “Evidence-based innovation”
Reducing Unnecessary Variation in Care: The Development of an Integrated Care Pathway for Schizophrenia

April Collins
Centre for Addiction and Mental Health
Context

- Quality agenda seeks to ensure that *the right patients, receive the right service, at the right time, to the right standard*

- There is a gap between evidence and what is being delivered at the point of care ... the gap needs to be closed OR,
  - Patients may not receive the best possible care
  - Limited resources wasted on inefficient, ineffective – even harmful treatments

- Health care sector funding increasingly tied to evidence based or evidence informed practice

- Demand for quality initiatives that emphasize standardization of care that is safe, cost effective and of the highest quality
Context & Problem to be Solved

Schizophrenia -- serious mental illness with significant morbidity and mortality

Affects approximately 0.6% of population

Increased risk for suicide, substance use, homelessness

Life expectancy 15-20 years less than general population
  • 31,000 hospitalizations, 2.3 million hospital days, costs > $7 billion annually (direct and indirect costs)

Robust evidence base for medical and psychosocial treatments

BUT..........

Care remains variable with inconsistent use of evidence, including the service provided at CAMH
Opportunity

Development and implementation of an evidence based pathway will enhance the quality of client care by:

• Improving patient outcomes

• Improving patient/family experience

• Optimizing the use of resources

• Improved health equity through standardization of and decrease in variation of care
Scope of EXTRA Project

Project Objective:
To create sustainable change in care delivery and improve quality of care and services through the development, implementation and evaluation of an Integrated Care Pathway (ICP) for patients with schizophrenia in an inpatient setting.

Success Criteria:
Develop key project milestones for pilot unit
Design the overall inpatient Integrated Care Pathway protocol
Usability testing to operationalize and validate core components
Implementation of the ICP protocol and processes
Design and implementation of ICP evaluation methodology
Develop staged rollout to other inpatient units serving patients with schizophrenia.
What is an INTEGRATED CARE PATHWAY (ICP)

“A Clinical Pathway is a **multidisciplinary** outline of anticipated care, placed in an **appropriate timeframe**, to help a patient with a specific condition or set of symptoms move progressively through a **clinical experience to positive outcomes**”. Middleton S Barnett J & Reeves D (2001)

Benefits of ICP include:

- Evidence based care
- Improved collaboration, communication, teamwork and care between professionals
- Reduce unnecessary variations in patient care
- Outcome based, measuring improvements in care and outcomes
- Improve the patient and family experience of care
Core principles of ICP  Adapted from Alberta Health Services

What to do?
Evidence based practice – pharmacological and non-pharmacological interventions

When to do it?
Sequence of activity and timing of intervention

Who will do it?
Clear roles – interdisciplinary team

How to do it?
Clear responsibilities – i.e. documentation procedures

Where will it be done?
Most appropriate setting for treatment (i.e. inpatient, outpatient, community etc.)
CAMH Integrated care pathways include:

- Pharmacological Interventions (Medication Algorithms/Titration Schedules)
- Non-Pharmacological Interventions (Psychosocial/Behavioural interventions)
- Clinical Team Intervention (High Performing Teams/Inter-professional Collaboration)
- ICP Implementation, Evaluation and Sustainability support (Dedicated ICP Program at CAMH)
The task is not to see if a practice works. Rather, it is to implement in a fashion so that it will work (Hudgens, 2005)
Adapted from “How to produce and evaluate an integrated care pathway (ICP): information for staff”, by Great Ormond Street Hospital for Children (NHS UK)
Our Strategies to Support Change

Grounded in CAMH’s new strategic plan

Don’t be defensive – new approach is about better care and improved access

Go out early and consult stakeholders face-to-face

An organic process, build from the bottom up

- Usability testing to operationalize and validate core components + LEAN
- Incorporate high performing team effectiveness training

Use consistent messaging for all audiences, with a tailored approach, tone and emphasis
Characterize the changes as a manageable series of steps which will be monitored and can be adjusted
Identify thought leaders in order to convert them to champions (spread the message)

REVISE COMMUNICATION PLAN AND MESSAGING AS PROCESS UNFOLDS
Barriers/Facilitators

Barriers:
Operational demands
Availability & nature of required resources
Need to share authority with and/or retain support of others

Facilitators:
Commitment of leadership
Involvement of stakeholders in development
Usability testing as an engagement strategy
Well resourced
Sample of dashboard shared with the staff on a Bi-weekly basis

<table>
<thead>
<tr>
<th>Measure</th>
<th>With</th>
<th>Without</th>
<th>Change</th>
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<tr>
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Note: Tables only include ICP Clients - defined as those with a LOS < 2 days

* Does not include transfers; includes 5 AMA & 1 ULOA
** For clients discharged between Jan 5th and February 4th
a Includes 2 AMA

Comparison With and Without Checklist

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<td>Discharge Suicide Risk Assessment**</td>
<td>82%</td>
<td>71%</td>
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</table>

* Does not include transfers; includes 2 AMA
** For clients discharged between Jan 5th and February 4th

Note: Tables only include ICP Clients - defined as those with a LOS < 2 days
Integrated Care Pathway - Early Psychosis Unit (EPU)

ICP PROGRESS UPDATE AND RESULTS

ICP Updates
- Since its launch in January 2015, 187 patients have entered the Early Psychosis Unit Integrated Care Pathway (EPU ICP).
- Patient and family satisfaction surveys are now available on the unit. Feedback from the surveys will help identify any areas for improvement.
- New improvement initiatives in the coming months include:
  - Koizan Event to improve and organize the nursing station. Improvements will include disposing of
    unneeded items, creating a clutter free work environment, reducing over processing/ production.

Results
Completion rates of various ICP components for the month of September 2015

Pharmacological Interventions Results
- 93.3% of patients received medication breakdown.
- 70.5% of patients received first stage of medication.
- 57.5% of patients received second stage of medication.
- 10.2% of patients received stage 3.

Non-Pharmacological Interventions Results
- 66% of patients were on at least one pathway medication with Olanzpine.
- 74% of patients received first stage, and 53% received the third stage of nicotine withdrawal.

Available in English only
Results: Tree with Branches

- IP SCZ ICP scaled and spread to rehab units
  n=198 patients enrolled
- Late Life SCZ ICP developed
- IP Early intervention for psychosis developed
GAF improvement

% client with GAF improved 10 or more points

81.60% ICP
55.90% Pre-ICP
Average LOS

<table>
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<th>LOS (days)</th>
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<tbody>
<tr>
<td>ICP</td>
<td>62.3</td>
</tr>
<tr>
<td>Pre-ICP</td>
<td>64.6</td>
</tr>
</tbody>
</table>
LOS Data – EPU ICP

Average length of stay

Jan - Mar 2014: 24.1
Jan - Mar 2015: 20.8
Jan - Mar 2016: 17.25

Average length of stay

Linear (Average length of stay)
Where has the Pathways initiative taken us?

- Confidence that CAMH patients are getting care based on evidence
- Local, regional and national interest
- Work with HQO on developing quality statements for the care and treatment of people with SCZ
Thank you
Questions?

Please submit your questions/comments electronically using the “Chat Box” on the bottom of your webinar screen.

Veuillez nous transmettre vos questions ou vos commentaires à l'aide de la « boîte de dialogue » située au bas de l’écran de ce webinaire.
June 2, 2016: Transforming Regions Into High Performing Health Systems

Le 2 juin, 2016: Transformer les regions en systems de santé plus performants

Thank you!
Merci!