CCIM Community Care Information Management

camh

Using Standardized Tools to Improve Services

A webinar series for Ontario's mental health and addictions sector

June 11, 2020 10:30 am – 12:00 pm

This webinar is being recorded and will be posted along with the slides and resources on eenet.ca

Moderators

Moderators

Deanna Huggett, Manager of Implementation, Provincial System Support Program (PSSP), CAMH

Jennifer Zosky, Common Assessment Specialist, Community Care Information Management (CCIM)

Agenda

Looking to the future: Priorities for the sectors

Celine Mulhern, Manager, Strategic Policy & System Design, Mental Health and Addictions Division, Ontario Ministry of Health

Danyal Martin, Manager, Mental Health and Addictions Centre of Excellence, Ontario Health

Using the recovery model to support staff and client engagement using any standardized tool

Nicole Allin, Manager, Recovery West & Impact, Canadian Mental Health Association Peel Dufferin

Q&A

Using OCAN data to support system planning and improvement in Ontario

Janet Durbin, Independent Scientist, Provincial System Support Program, CAMH

Frank Sirotich, Director of Research and Evaluation, CMHA Toronto

Q&A

Objectives

Share innovative practices and new evidence from across the province.

Learn new ways to use standardized tools to improve client experiences and support quality improvement.

Provide an opportunity to network and communicate with experts in the field during and after the webinar.

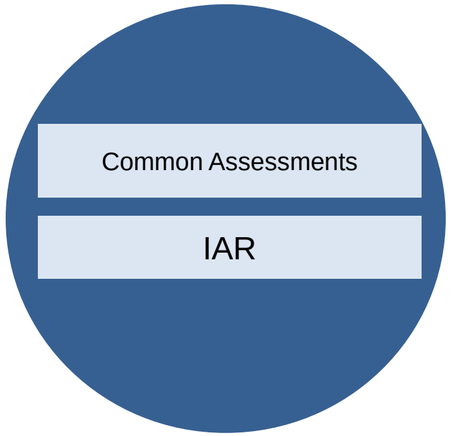
Looking to the future: Priorities for the sectors

Celine Mulhern, Manager, Strategic Policy & System Design, Mental Health and Addictions Division, Ontario Ministry of Health

Danyal Martin, Manager, Mental Health and Addictions Centre of Excellence, Ontario Health

Common Assessments & IAR

Ontario



The **Integrated Assessment Record (IAR)** is an application that enables client information collected in **common assessments** (standardized tools) to be shared between the client's circle of care across the continuum of health services in a secure and timely manner.

Data in IAR is being used for reporting at various levels to inform service planning and quality improvement strategies.

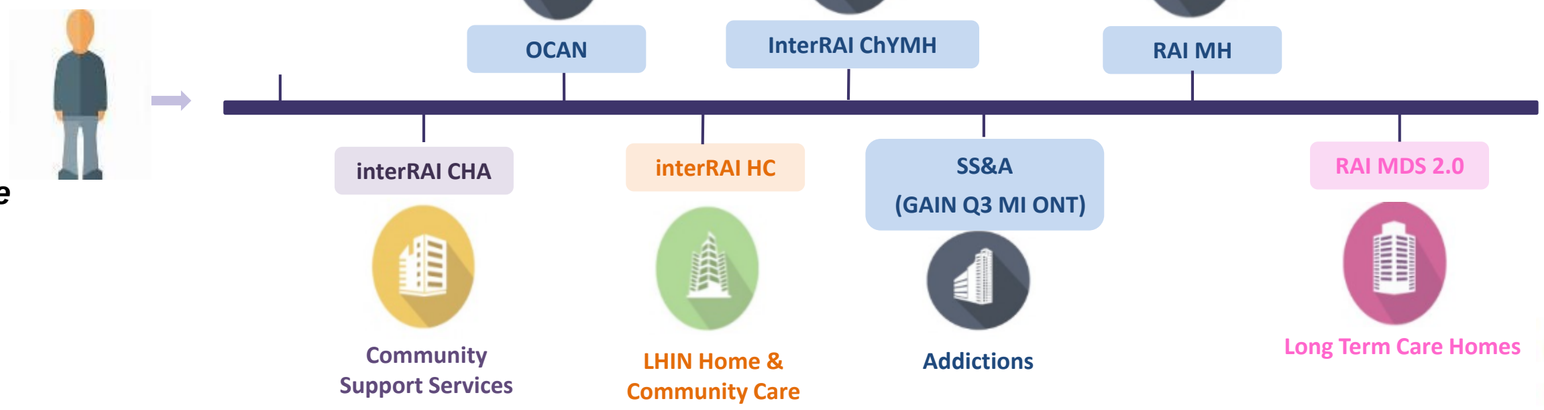
Client Journey

IAR

Over 9 million assessments

~ 2 million in the last 2 years

Data from ~ 1.9 million unique clients



CCIM Community Care Information Management

CCIM Community Care Information Management ACCESS TO INFORMATION

The **Provincial System Support Program (PSSP)** at CAMH works with communities, service providers and other partners across Ontario to move evidence to action to create sustainable, system-level change.

PSSP provides capacity and expertise in a number of areas, including implementation, knowledge exchange, evaluation and data management

PSSP supports the implementation of OPOC and SS&A, and is a partner in EQIP

Excellence through Quality Improvement Project (E-QIP)

E-QIP is led by Addictions and Mental Health Ontario (AMHO) and Canadian Mental Health Association, (CMHA) Ontario Division

Delivered in close partnership with the Provincial System Support Program (PSSP) at CAMH and Ontario Health

Goal is to promote and support QI within the community mental health and addiction sector

Current focus is using OPOC data to inform QI work

Canadian Mental Health Association
Peel Dufferin
Mental health for all

Recovery Focus

Using the Recovery Model to support staff and client engagement with assessments

- *12 years at CMHA*
- *Intake Lead 2016-2018*
- *Recovery-based assessment training*
- *LOCUS use and training*

Nicole Allin, RSSW

(Pronouns she/her, they/them)

Manager, Recovery West & Impact

CMHA Peel Dufferin

allinn@cmhapeel.ca

(289) 748-3226

Assessments at CMHA Peel Dufferin

C-SSRS

GAD-7

GAIN Q3

InterRAI Brief Mental Health Screener

LOCUS

MSE

Nursing assessments

OCAN

OPOC

PHQ-9

and more…

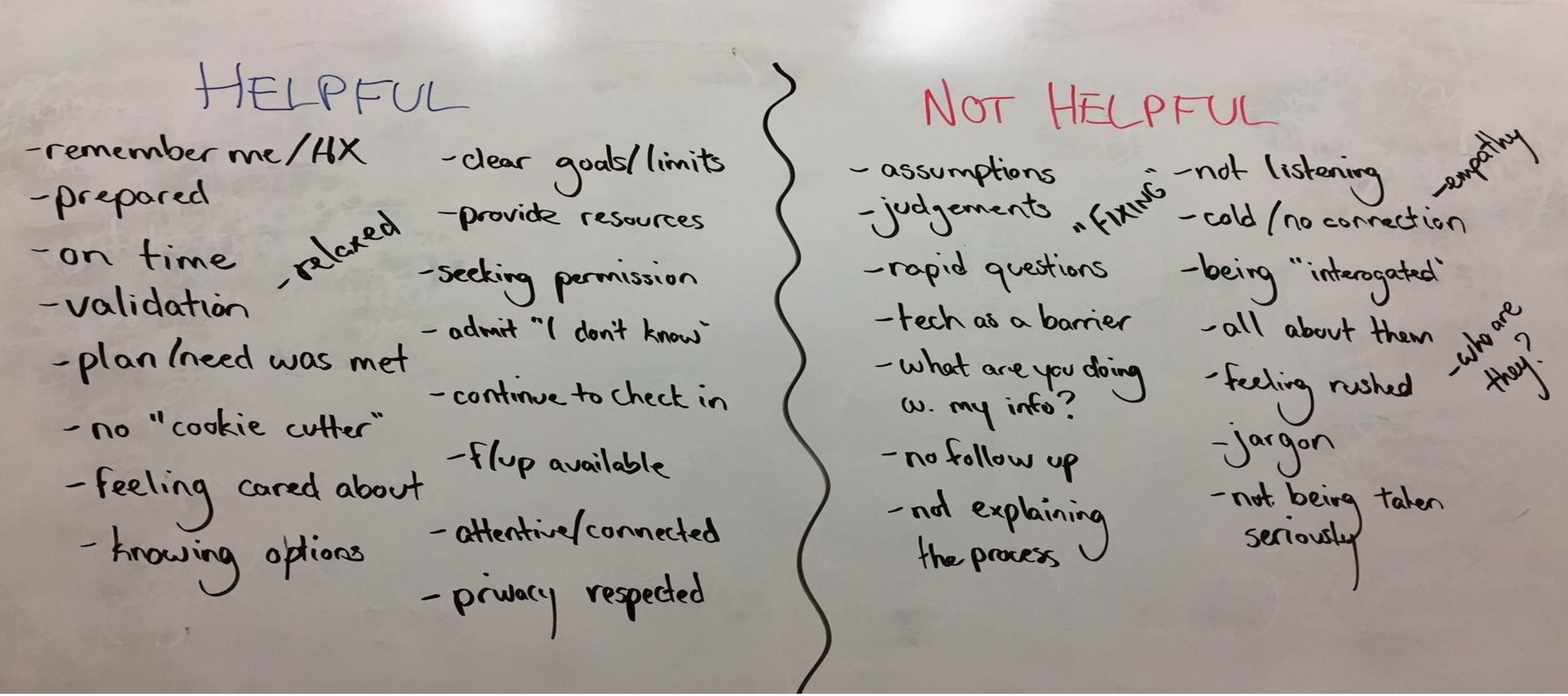
Where is all started…

- 2009, OCAN pilot
  - new staff trained at onboarding
- 2010, agency-wide Recovery training
- 2015, Merge Recovery and OCAN training
  - OCAN Lean
  - Quality Improvement Plan to reduce wait lists
- 2019, Recovery Assessment training

Training Objectives

Build understanding of…

- Recovery Model and Strengths-Based practice
- Use of Recovery Oriented language, including in documentation
- Differences between Disease Centred (medical) and Client Centred (recovery/strengths-based) models of practice
- Initial meeting skills
- How assessment can support the beginning, middle and end of work with clients



How It's Done: Self-Reflection

The Truth About Assessment

Acknowledge common challenges/complaints about assessment

- Takes too long
- Distracts from client work
- Need time to “build rapport”
- Clients don’t want to tell their story again

Reframe thinking about assessment

- Raises issues important to client
- Supports a Recovery oriented approach
- Captures client progress over time (aka recovery!)
- Can inform quality improvement planning

What is the Recovery Model?

There is no single agreed upon definitior of recovery. However the main message is that hope, and restoration of a meaningful life are possible, even with serious mental illness (Deegan, 1988, Anthony, 1993.)

C – Connectedness

H – Hope and Optimism

I – Identity

M – Meaning

E – Empowerment

(Scottish Recovery Network)

Recovery Practice

- Unwavering belief in each person’s potential for recovery
- Sincere commitment to a client centred approach
- Openness to uncertainty, difference and chaos
- Investing self into the helping process

Strengths Based Practice

- Believing clients are most successful when they identify and utilize their strengths
- Assists clients to recognize strengths and resources within themselves
- Work with clients to regain power over their lives

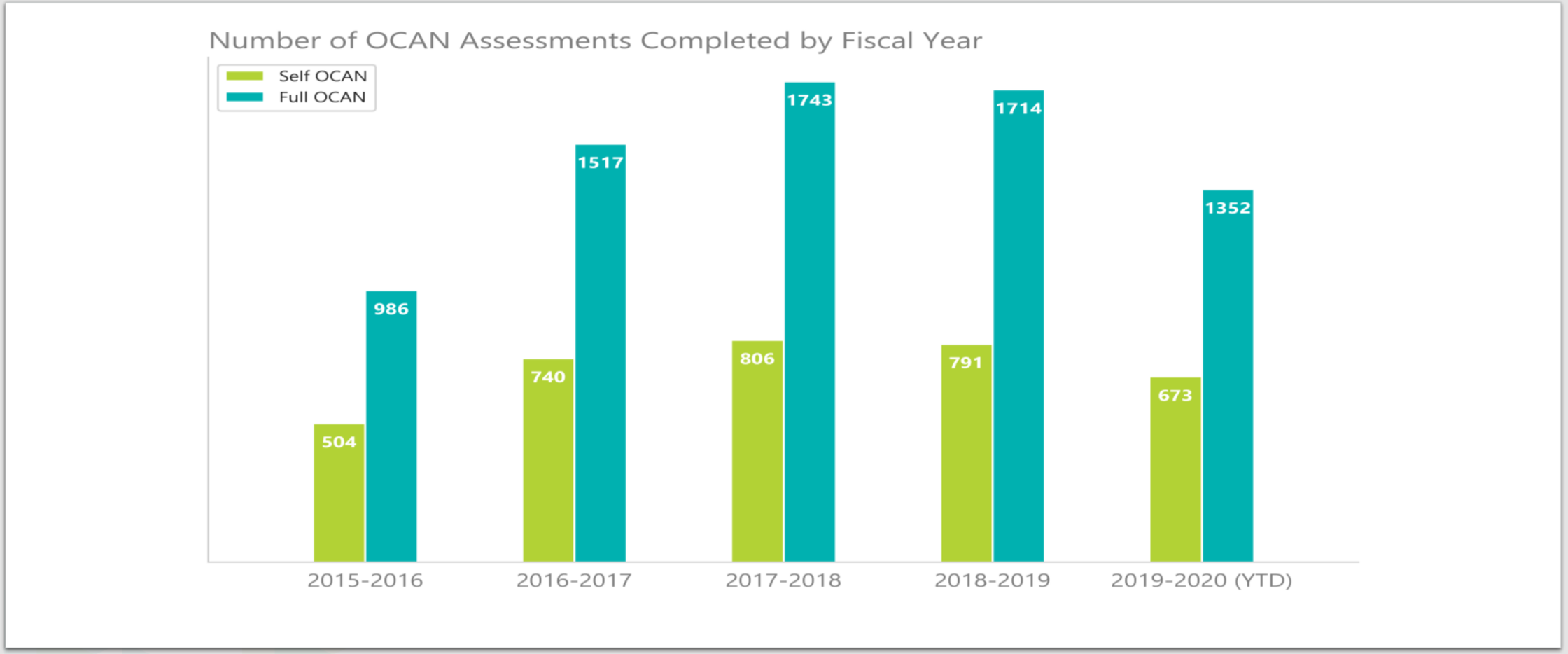
Recovery Oriented Language

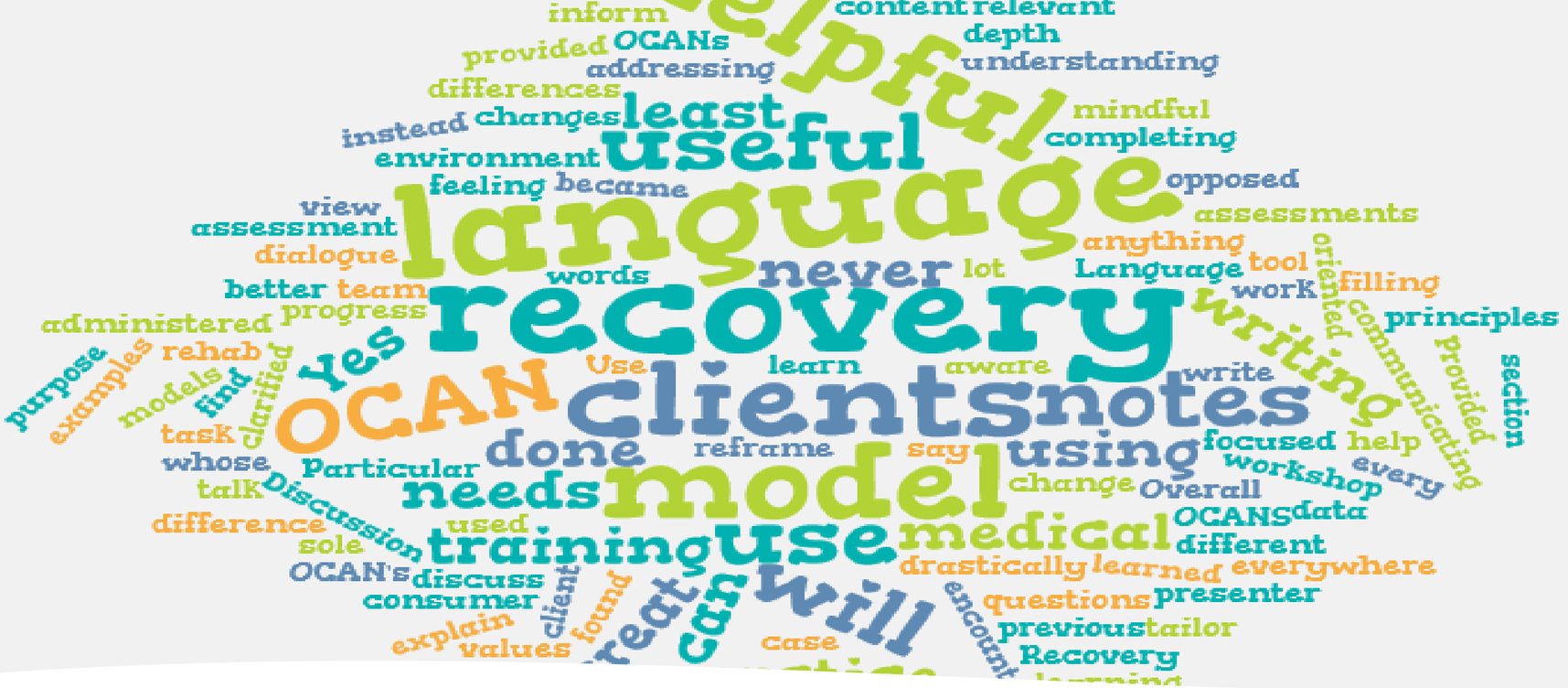
- What is it?
- Why is it important?
- Is this legal?
- Rewriting assessment/case note samples

Beginning, Middle and End

What needs to take place in an initial meeting?	Identify reason for service, agreement on terms of relationship/support, establish how service can assist client to move toward stated reason
Assessment helps establish goals	Whether working together short term or long term, identifying goals helps clarify what the work should focus on
Identifying outcomes informs discharge	Helps us ensure clients are receiving the right intensity of service, and progressing in recovery

More staff and client OCANs being completed





Participant Feedback

“Understanding the differences between Recovery Model and Medical Model and how to incorporate it with our clients”

“I found it very useful to learn how to reframe questions and dialogue with clients”

“Explaining how to tailor it to our own client’s needs…made a huge difference in my view of OCAN’s as a tool to help me work with clients as opposed to a task whose purpose is to collect data”

Thank you

Catch me at the World Café!


Questions?

Using the OCAN to Support System Planning and Improvement in Ontario

Standardized toolkits KE Event

March 12, 2020

Frank Sirotich & Janet Durbin

Canadian Mental Health Association Toronto

camh

Overview

We will discuss using the OCAN for:

- System planning in the context of OHTs
- Local quality improvement projects
- Monitoring adherence to program standards

Using the OCAN to Support Planning for OHTs and Quality Improvement within HSPs

Frank Sirotich & Kamalpreet Rakhra

Canadian Mental Health Association Toronto

Objectives

- Explore feasibility of using OCAN for population-based planning
  - Examining characteristics and need profile of clients with repeat MH emergency department visits
- Describe how OCAN data may be used to inform local QI projects
  - Promoting access to primary care

Characteristics and Need Profile of Service Users with Repeat MH Emergency Department Visits

Caution

- Analyses are preliminary
- Analyses are limited by:
  - Convenience sample that may not be representative of broader population enrolled in community MH&A services
  - Missing data (esp. race/ethnicity, LOS, physician attachment, ED visits)
  - Cross-sectional design (inferences of changes over time limited)

Methodology

Measures

- Staff version of OCAN utilized
- Focus on 20 needs domains

Sample

- Adults (16+) enrolled in ACT, EPI, ICM services in CY2016
- Last assessment for service user

Design

- Cross-sectional (snapshot in time)
- REB approval: UofT

Analyses

- Multilevel logistic regression modeling; backward elimination

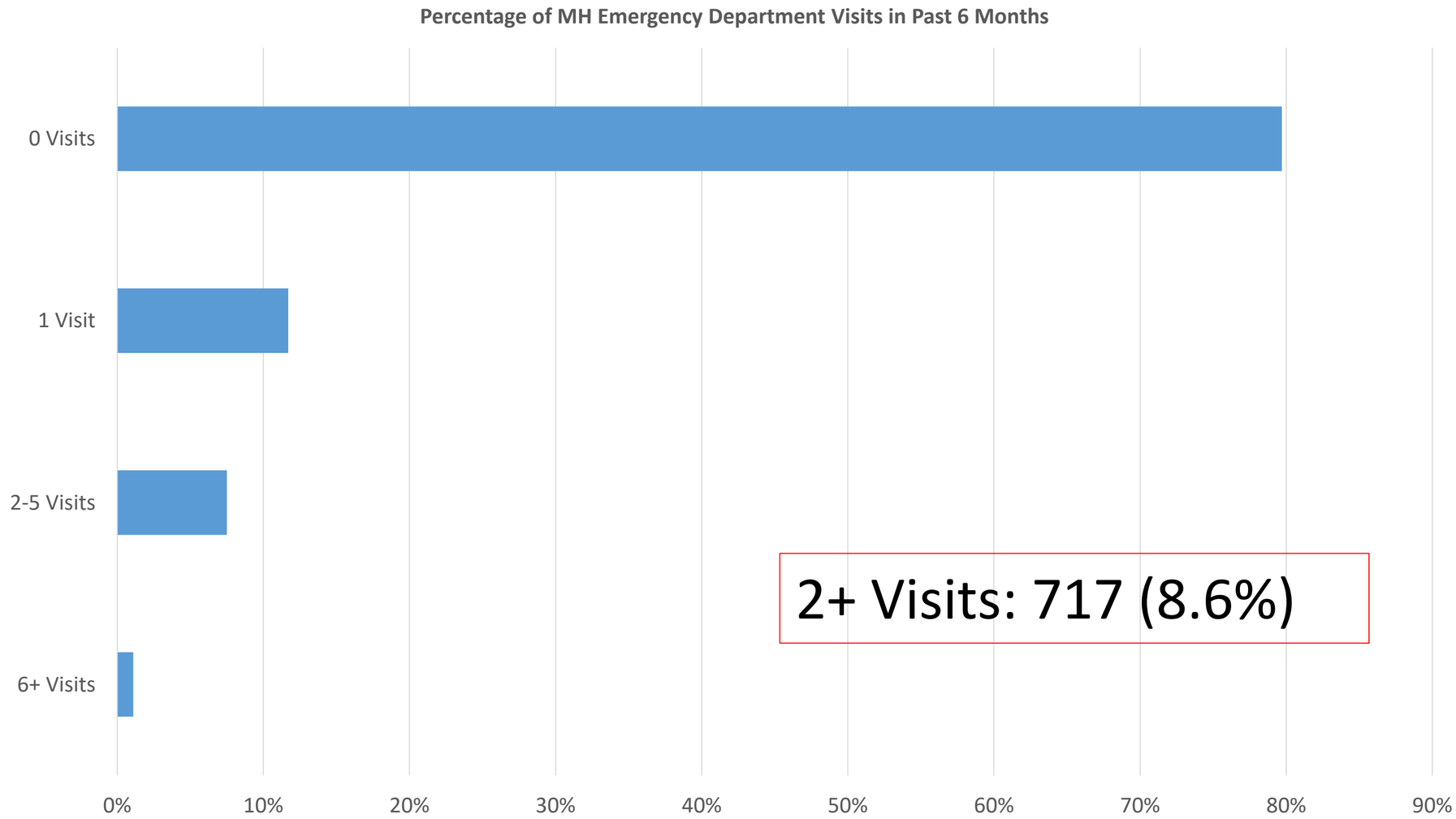
Service users with 2+ MH Emergency Department Visits

- 2+ MH emergency department visits in previous 6 month vs service users with 1 or no MH emergency department visits

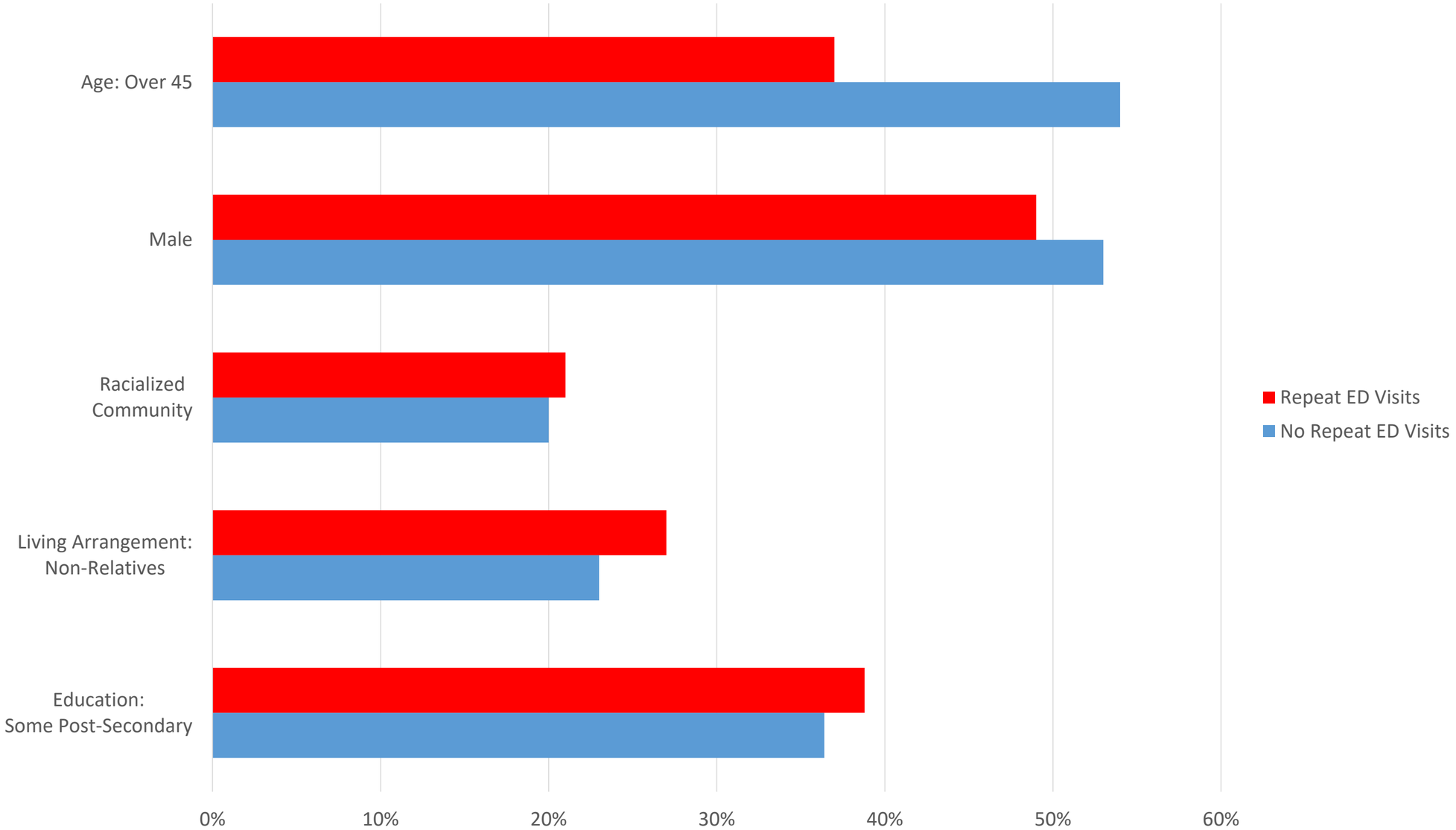
- Last OCAN completed in CY2016; cases excluded if LOS missing or ED visits missing/unknown; N= 8373 (54.6%)

Frequency of MH Emergency Department Visits

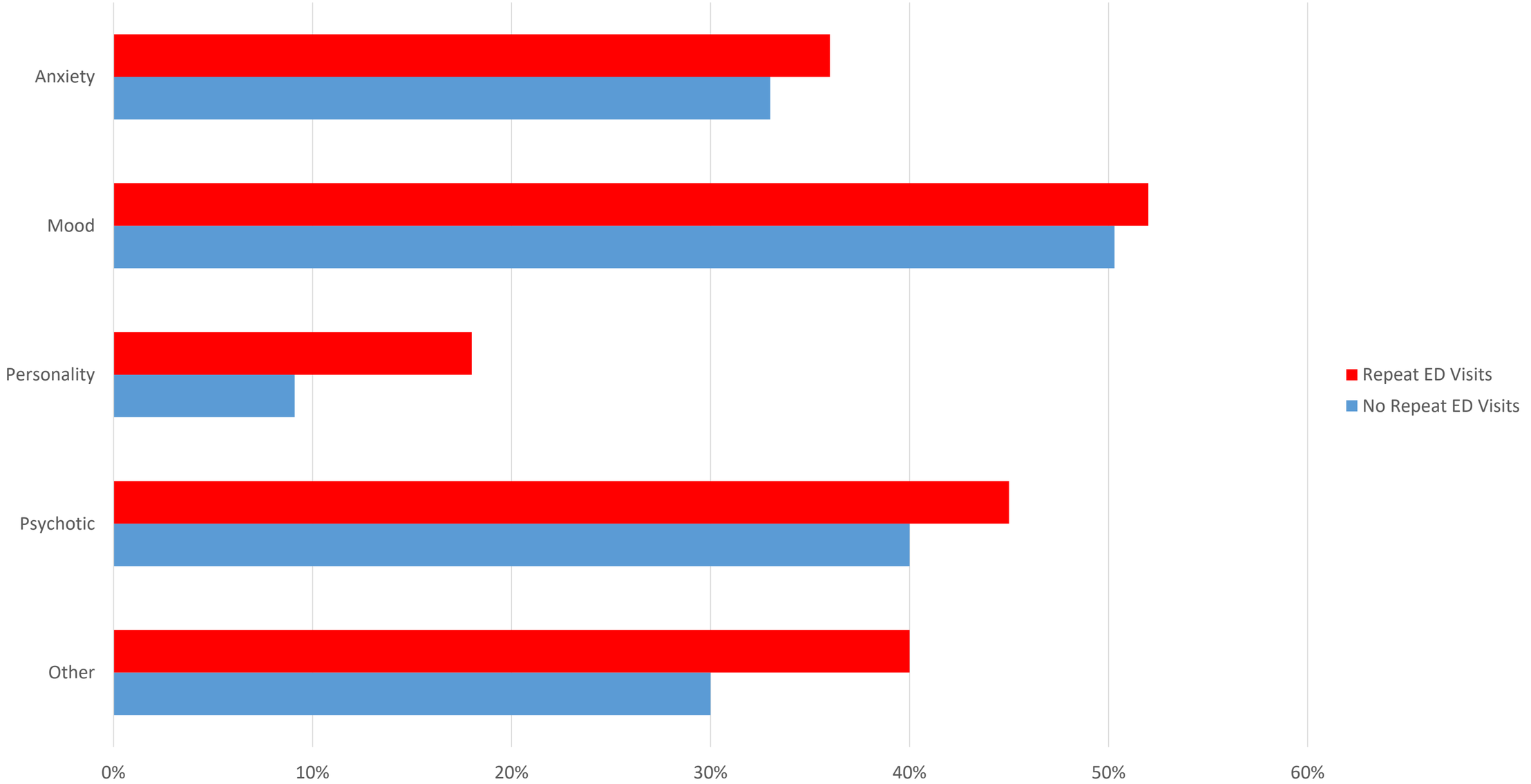
- 0 Visits: 6,677
- 1 Visit: 979
- 2-5 Visits: 717
- 6+ Visits: 93



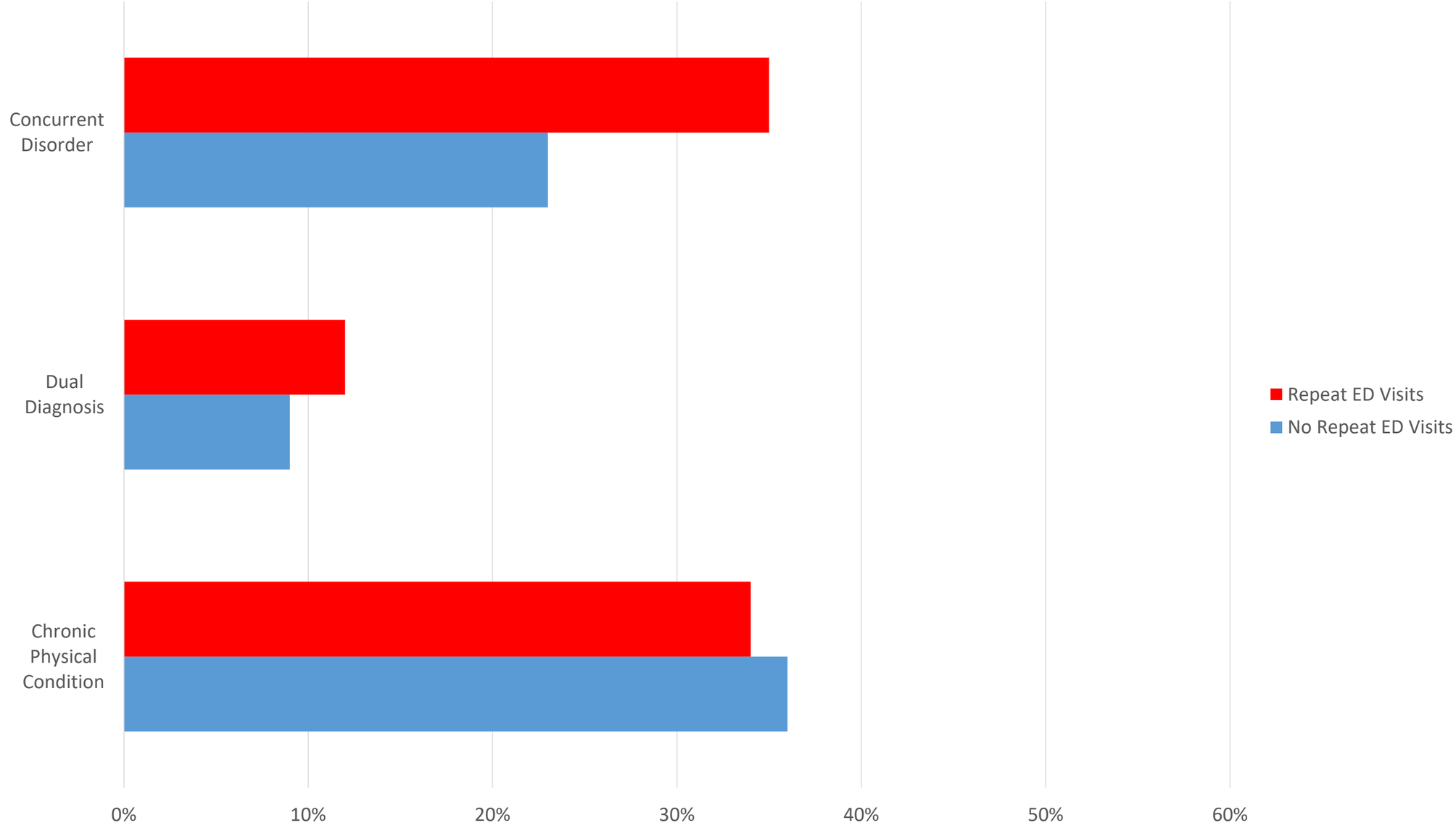
Socio-demographic Characteristics



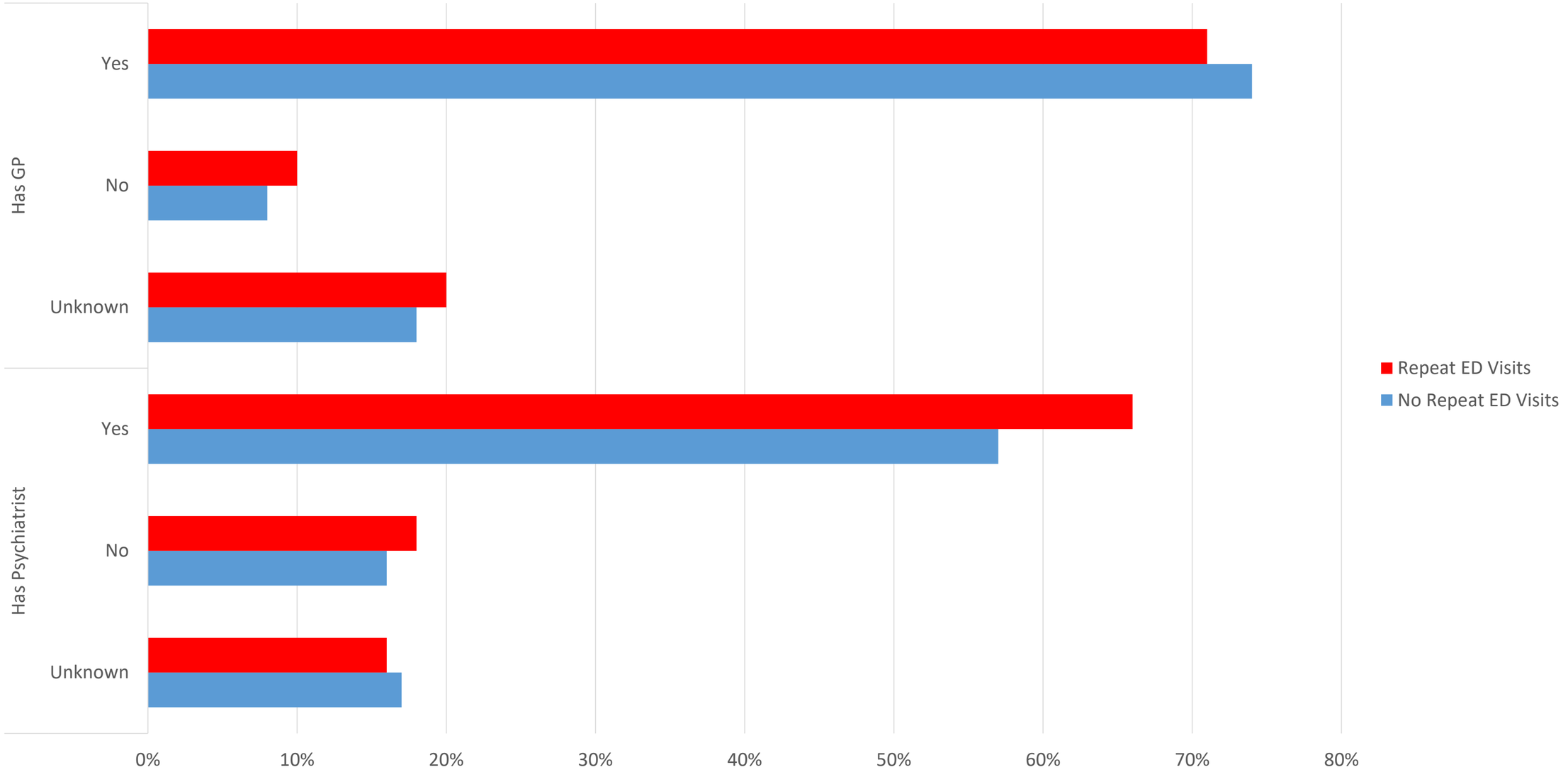
Mental Health Diagnoses



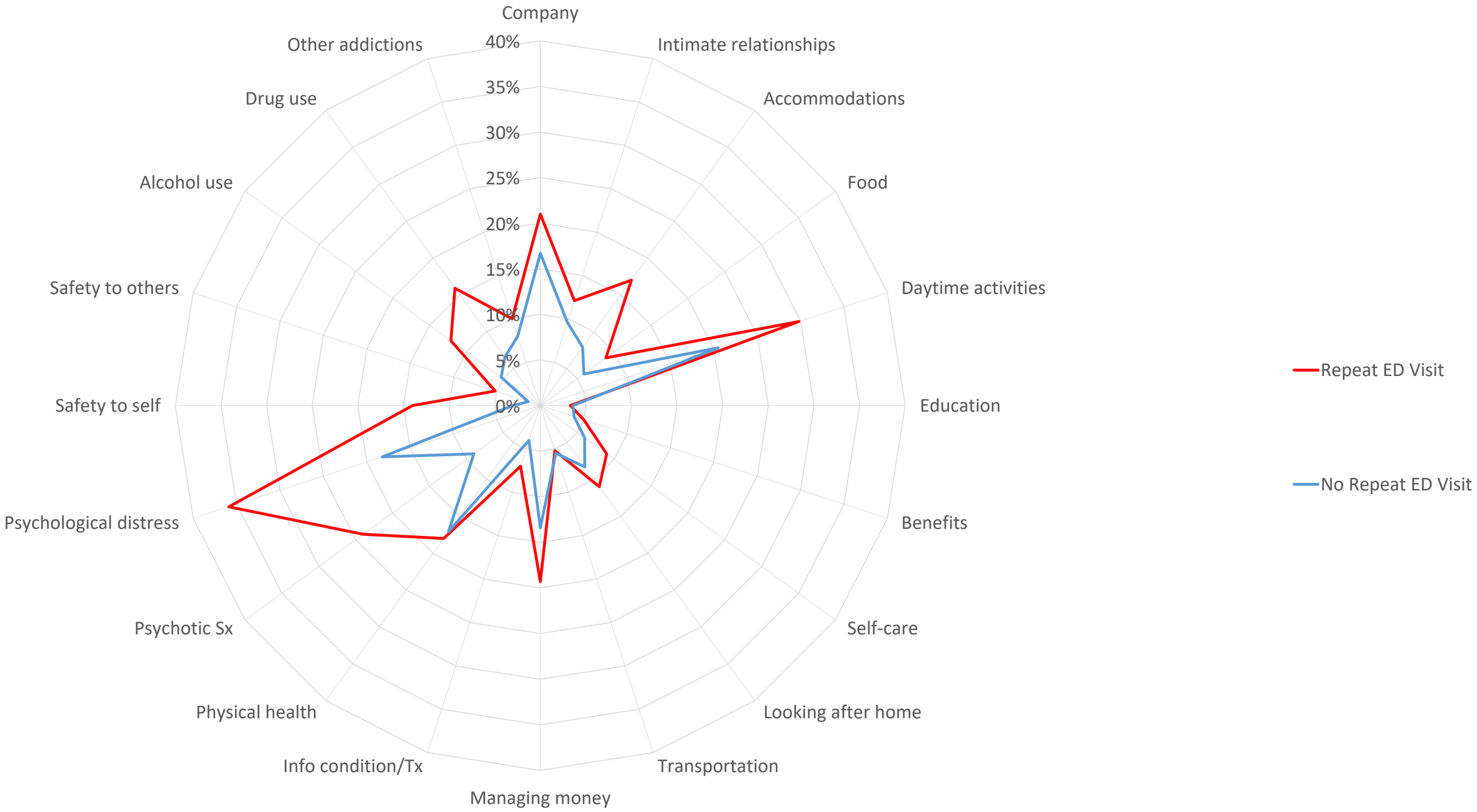
Co-occurring Conditions



Physician Attachment



Staff-Reported Unmet Need



Predictors of 2+ MH Emergency Department Visits

Medium Effect Size

- Safety to Self

Small Effect Size

- LOS: LT 1 year vs 2+ years
  1 year-LT 2 years
- Canadian Citizen vs Other
- Personality Disorder
- Psychotic Symptoms
- Age: 16-24 vs 55+
  25-34 vs 55+
- Psychological Distress
- Alcohol
- Accommodation

Implications: Service Users with Repeat ED Visits

Key Findings

- Represent a heterogeneous group
- Clinical needs: psychotic symptoms, psychological distress, substance use, safety to self
- Age: younger age may be related to onset of MH condition
- LOS: less time in service

Implications

- Leverage multi-disciplinary, evidence-based interventions targeting different clinical groups
  - Flexible ACT
  - DBT/CBT
  - IDDT

Using OCAN Data for Local QI Projects

Context of QI Project

- CMHA Toronto's strategic plan includes development of specialized services for primary care and concurrent disorders
- Invested in primary care (PC) and concurrent disorders (CD) capacity
- But…clients continue to have ongoing unmet needs related to physical health and alcohol use

Scope of Issue

Change in Unmet Needs: ICM Client (N=596)					
Need Domain	Unmet Needs Across Assessments				% Change
	Time 1	Time 2	Time 3	Time 4	Time 1-Time 4
Physical Health	80	76	79	79	-1.3%
Alcohol Use	22	22	29	20	-9.1%

What we did

- Developed primary care screener to support consistent scoring of physical health needs in OCAN

- Developed standard pathways based on need ranking and informed by Quality Standards for Schizophrenia

What we found

Preliminary results

- Much small number with unmet needs than anticipated
- 60% reduction unmet need in physical health
- 27% increase in comprehensive assessments

Implications

- OCAN can be used to promote improvements in attachment to primary care
- Opportunity to map OCAN need domains to Quality Standards

Early psychosis intervention delivery in Ontario

What can we learn from the OCAN?

Standardized tools webinar

June 10, 2020

CCIM Community Care Information Management

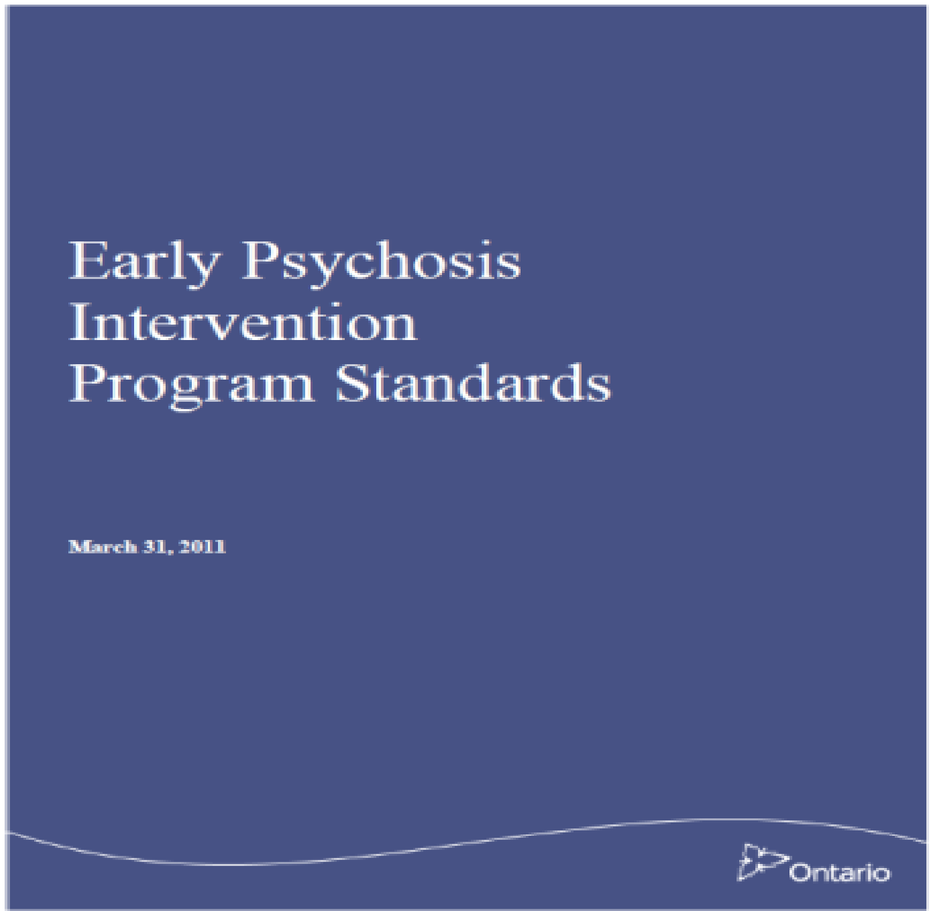
Canadian Mental Health Association Toronto

EPION EARLY PSYCHOSIS INTERVENTION ONTARIO NETWORK

camh

Background

- Early Psychosis Intervention (EPI) Program Standards released by Ministry in 2011
- 13 standards each including multiple statements on practice expectations
- OCAN data provide opportunity to monitor quality of care in relation to the EPI Program Standards



camh
mental health is health

Project team

- Janet Durbin, CAMH, EPION Standards Committee
- Avra Selick, CAMH, EPION Standards Committee
- Gordon Langill, CMHA, Haliburton, Kawartha, Pine Ridge Branch; Chair EPION Standards Committee
- Frank Sirotich, CMHA, Toronto Branch
- Anna Durbin, MAP Center for Urban Health Solutions, St. Michael's Hospital, Unity Health
- Elizabeth Lin, CAMH

Funder: PSSP, CAMH.

Partner: Early Psychosis Intervention Network Ontario (EPION)

Project Aims

1. Assess how OCAN data can inform understanding of EPI service delivery in relation to the EPI Program Standards and guide improvement work

2. Assess quality of OCAN data submitted by EPI programs to the provincial data repository

Method

- Sample: admission assessments uploaded by EPI programs to the IAR during 2014-16
- Only assessments with both client and staff ratings were included (57%)
- N=683 (with both staff and client report)
- Reported results for 5 quality statements in the Standards ➔ program access & initial care planning
- Based on data availability

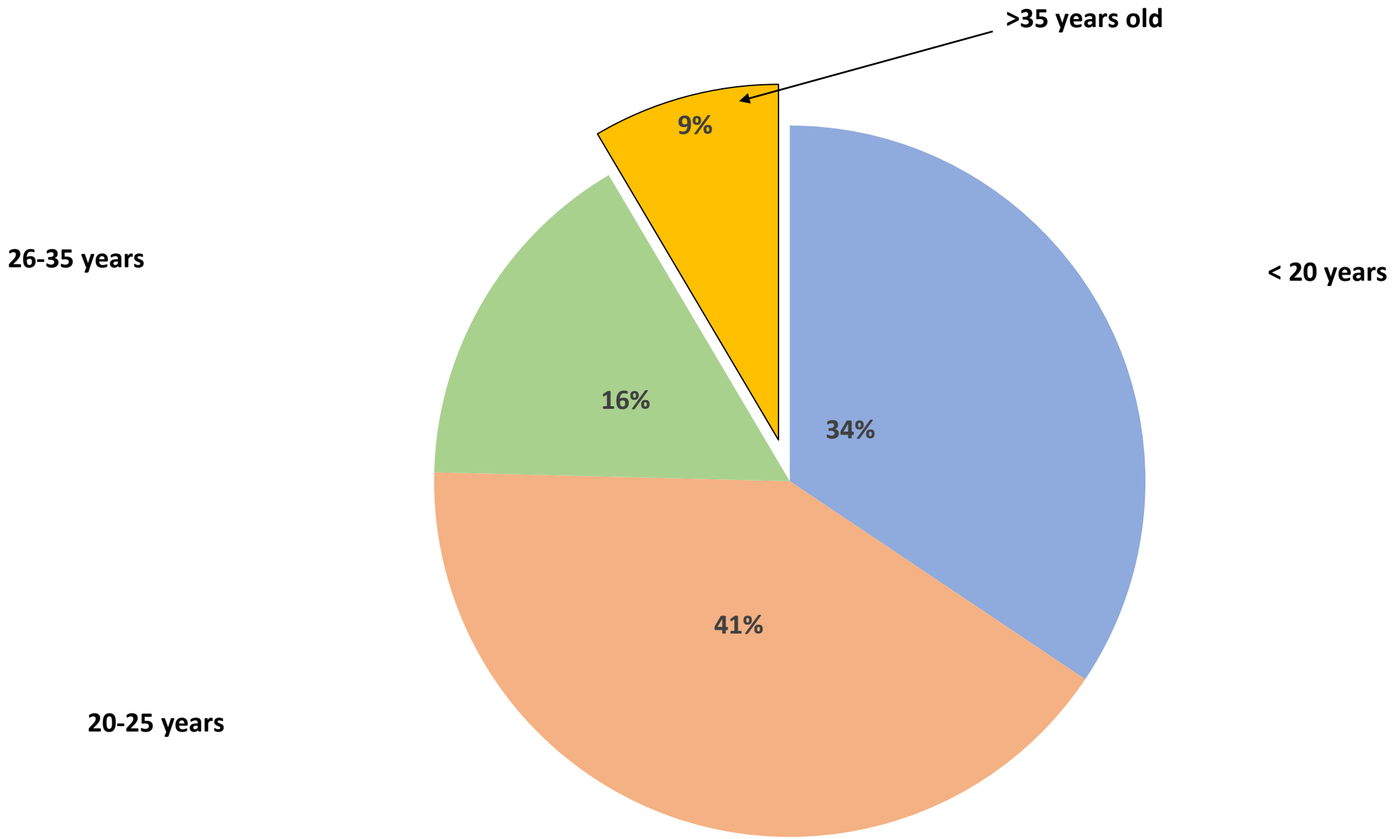
Standards & relevant OCAN items: Admission

Quality Statement	OCAN data elements	EPI Program Standard
1. Programs serve adolescent/young adults (14-35 years of age)	Age	Introduction: Eligibility
2. Programs reflect the diversity of the communities they serve	Gender, Preferred language, Aboriginal origin	Standard 11: Barrier-free service
3. Programs develop network of providers and organizations to assist with early identification and make timely referrals	Referral source Prior hospital admission	Standard 1: Facilitating access and early identification
4. Programs conduct a comprehensive assessment that covers psychiatric and physical exam, risk assessment, psycho-social assessment.	Need ratings for 24 clinical, functional and social domains (staff & client)	Standard 2: Comprehensive Client Assessment
5. The client, family and team negotiate and document a comprehensive, individualized, client-centered wellness/ recovery plan.	Staff-client agreement on need	Standard 3: Treatment

Quality Statement

Programs serve adolescent/young adults (14-35 years of age)

Client age at admission



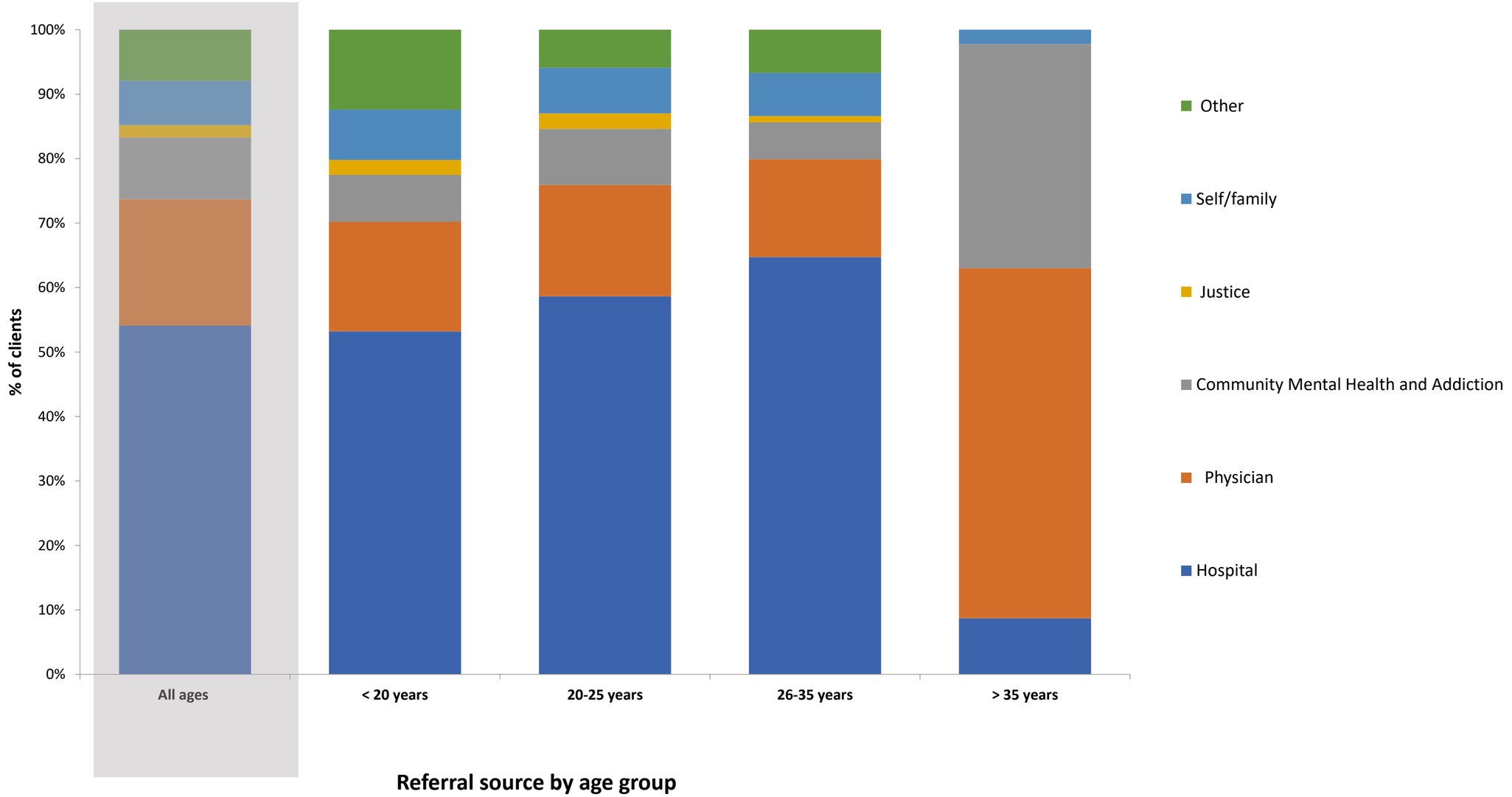
Client socio-demographics by age

	Within target age			Outside targeted age
Client characteristic	**< 20 years**	**20-25 years**	**26-35 years**	**>35 years**
Sex				
% male	**68**	**71**	**74**	**31**
Living with				
% Self	3	7	7	19
% Spouse/partner/children	2	3	16	69
% Parents/relatives	87	75	68	13
% Non-relatives	9	15	9	0
Primary income source				
% Employment	8	22	25	24
% ODSP	8	16	28	19
% Social assistance	9	14	14	5
% Family	65	35	16	20
% Other/unknown	9	13	16	32**
Employment/ Education				
% working	21	35	37	30
% in school	63	31	14	4
% not working or in school	31	45	54	59

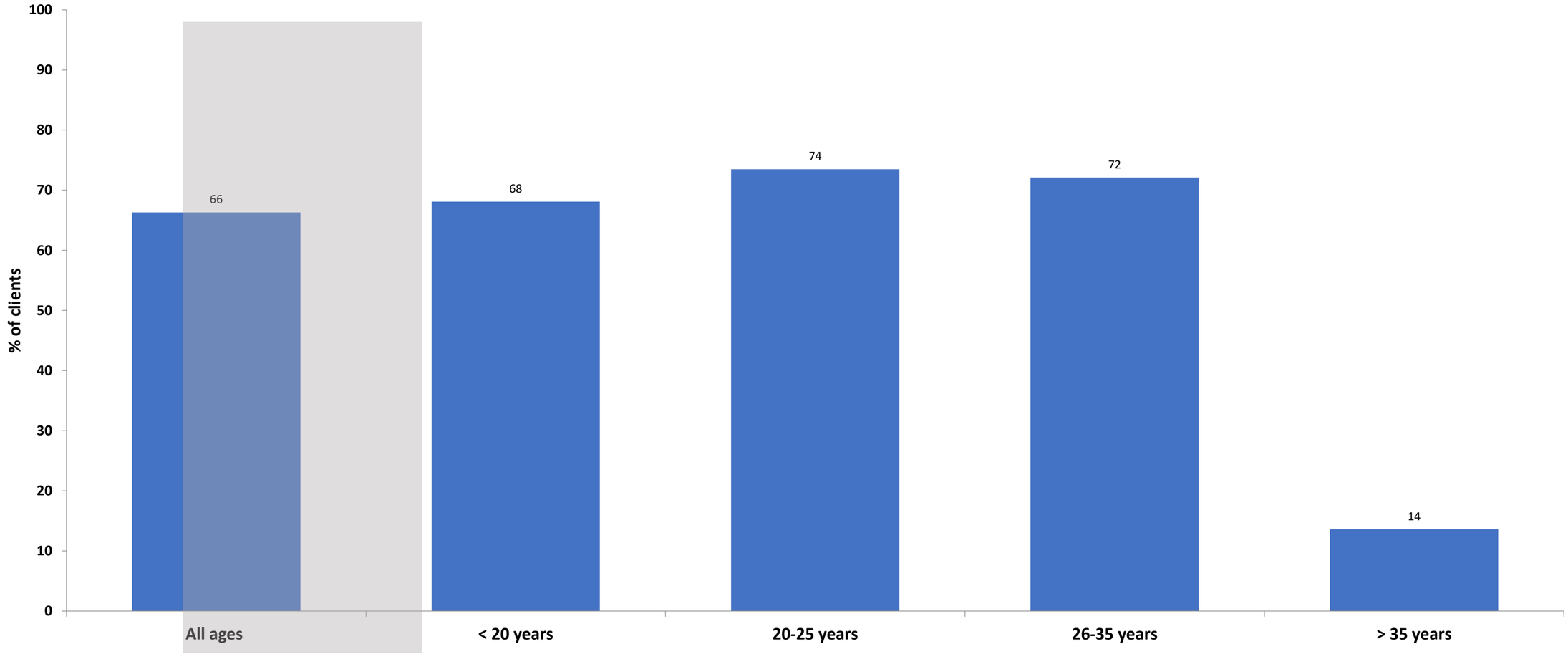
Quality Statement

Programs develop network of providers and organizations to assist with early identification and make timely referrals.

Referral source by age



Hospital admission for mental health past 2 years by age group

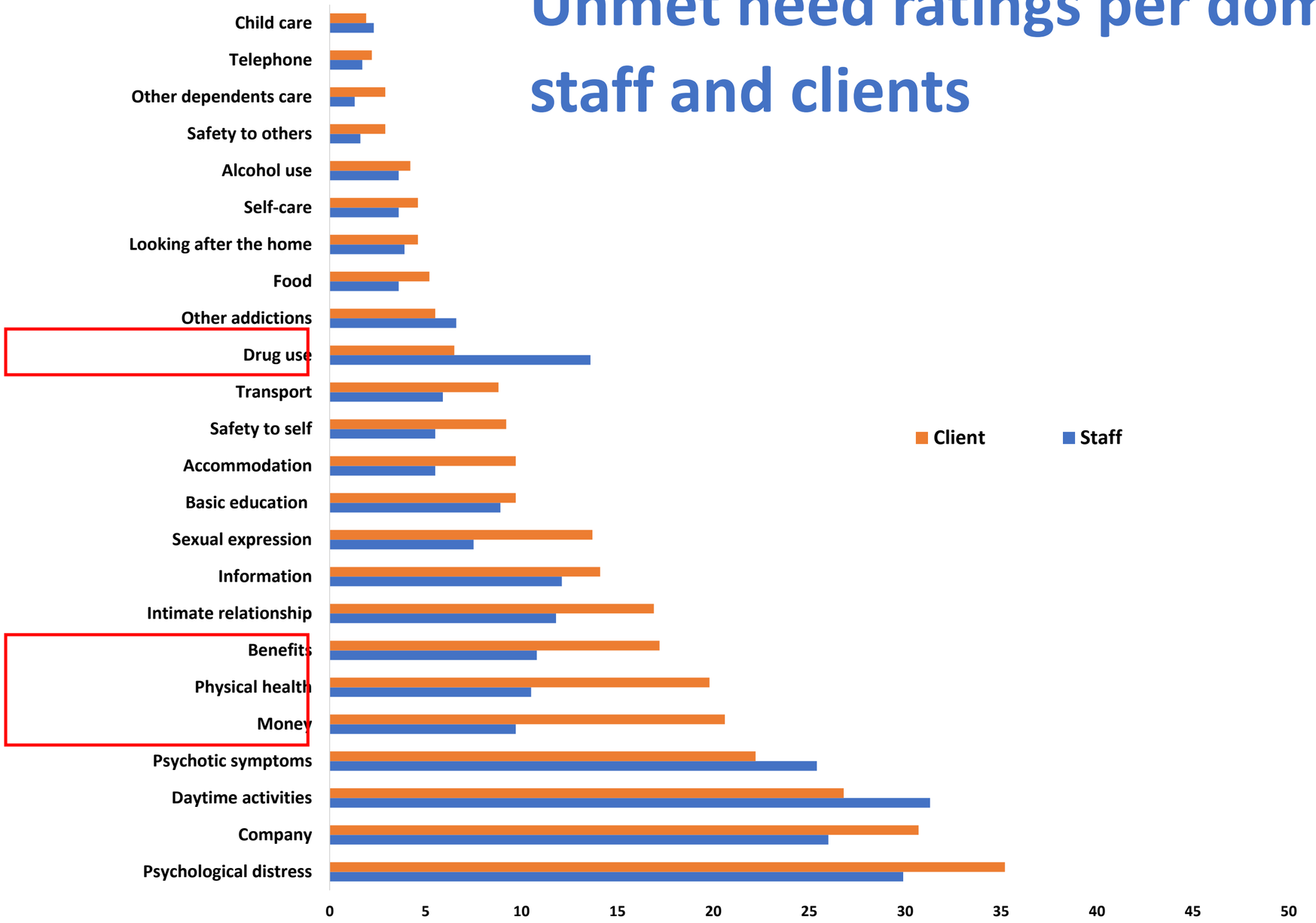


Quality Statement

Programs conduct a comprehensive assessment that covers psychiatric and physical exam, risk assessment, psycho-social assessment.

The client, family and team negotiate and document a comprehensive, individualized, client-centered wellness/ recovery plan.

Unmet need ratings per domain by staff and clients



Conclusion

- OCAN data can inform EPI program efforts to deliver care in alignment with Standards and stimulate important discussions about practice and policy

- Relevance for understanding client access could be strengthened with further refinement of variables related to pathway to care and client profiles
- Limitations
  - Convenience sample
  - Limited to mandatory items – high completion rates

Limitations

- Convenience sample - not necessarily representative of system services or service users
- Limited to mandatory items – high completion rates
  - Results for some relevant variables could not be reported (social determinants, clinical, service entry dates)
- Validity of results requires further investigation

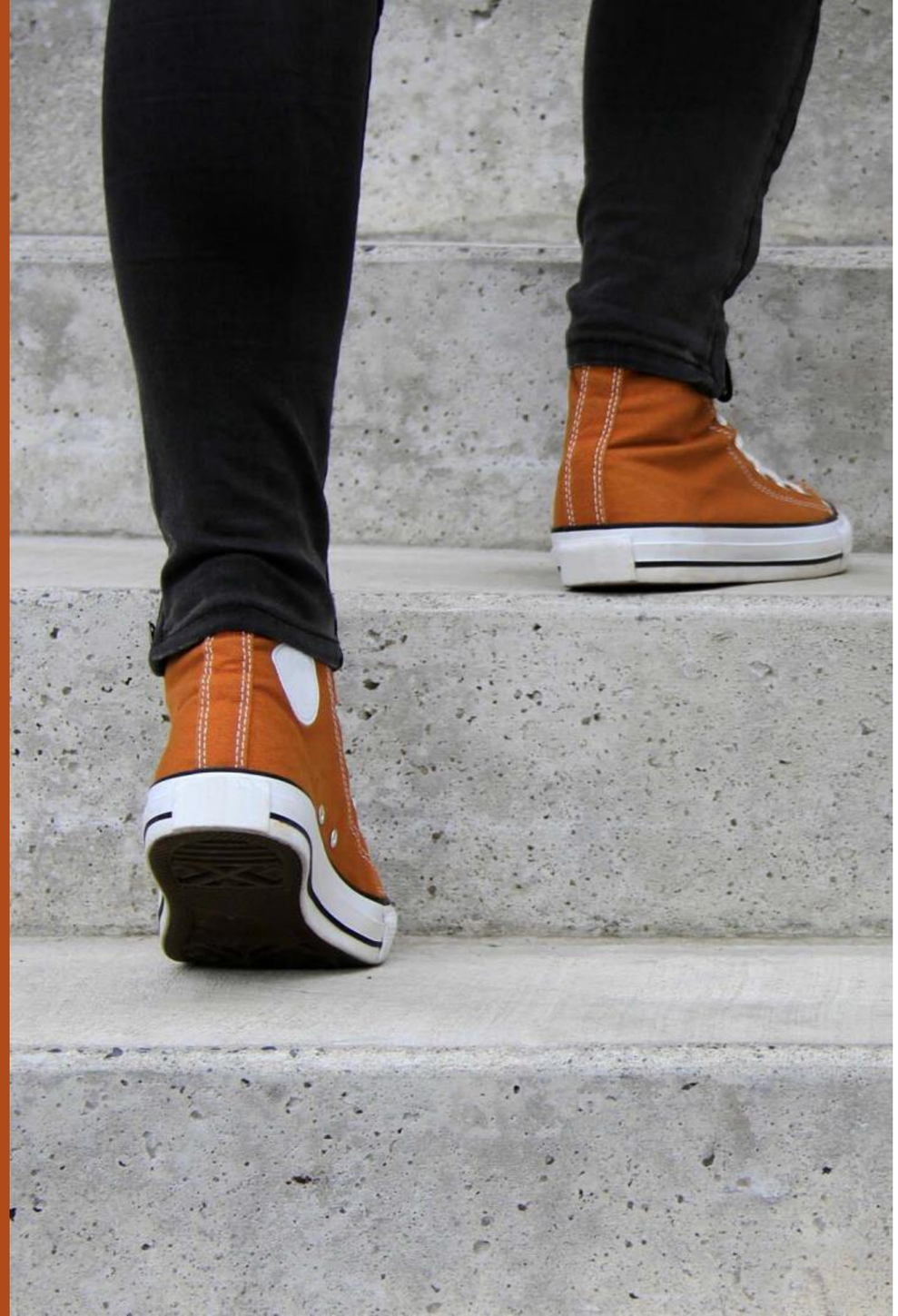
For additional information

- Jennifer Zosky: Jennifer.zosky@Ontario.ca
- Frank Sirotich: fsirotich@cmhato.org
- Janet Durbin: janet.durbin@camh.ca


Questions?

Closing remarks

What stood out for you today?



Next steps

Evaluation

Please complete today

Sending out slides and handouts

Within the next week

Summary document

Within the next month


thanks!
Tombow ABT
Acid Free
N15