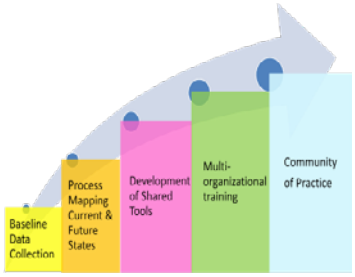
The Renfrew Country Mental Health and Addictions Coordinated Concurrent Care Pilot - EVALUATION REPORT

Executive Summary

The Renfrew Mental Health and Addiction services, with support from Champlain Pathways to Better Care, collaborated to develop a baseline understanding of the number of individual clients who are accessing both mental health and addictions services in Renfrew County and implemented a formalized coordinated process for concurrent clients in order to achieve better coordination of services that will ultimately lead to improved outcomes for these individuals.

Clients and families, front-line staff, administrators, and others collaboratively developed:

- Baseline data profile
- Agreement on concurrent disorder identification
- Current and desired future state processes
- Single Collaborative Care Initiation Sheet for all 5 organizations
- Clarity regarding care coordination flow between organizations and sectors
- Collaborative care plan template; client-centred appointments.
- Joint clinical training
- Weekly Community of Practice calls



Anticipated Outcomes	Observations
5 to 10 clients involved in pilots	Over 30 clients involved in concurrent care pilots
Improved Communication Between Services	• Enhanced communication ensured follow-up and follow-through on clients. (e.g. If a client did not fit the referral services, there was the ability to follow-up and get suggestions for other services). • Having an ongoing venue to communicate and have questions answered is appreciated. • Allows providers a venue to be able to meet and advocate for clients and bridge the gap between services.
Improved Client Outcomes	Too early in process to determine.
One care team with shared load	Positive feedback from frontline staff around improved relationships, communication and streamlined workflow.
Common philosophy and clinical best practices around concurrent disorders	• Common training was well attended • Community of Practice approach was well received. • Front line staff identified as learning from each other • Would like to continue a less rigorous (once a month) community of practice.

Recommendations

1. Support the usage of concurrent care plans through the development of clinical care pathways.
2. Enlist more physician and psychiatrist involvement.
3. Improve client “no shows” at collaborative appointments.
4. Evaluate client outcomes & assess change from baseline.
5. Development of an implementation plan for scaling up.
6. Continuous monitoring and quality improvement.
7. Evaluate this process’s alignment with Health Links.

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Project Overview

Addiction and Mental Health organizations in Renfrew County have been involved in the evolution of coordinated care approaches, like Health Links in their geographic service areas. While, Renfrew County Mental Health and Addictions (MHA) providers have an informal model in place to conduct joint treatment planning, this initiative worked to introduce a more formal process for clients who are accessing both mental health and addictions services (i.e., those with concurrent disorders).

The Coordinated Concurrent Care Planning (Concurrent Care) initiative for Renfrew County is currently coming to the end of its pilot phase. This document serves as an evaluation report of the pilot phase.

Project Leads: Lise Laframboise, Mireille Delorme, Kim McLeod, Liana Sullivan, Tom Carrol; With support from Champlain Pathways to Better Care

Partner Organizations: Pathways Alcohol and Drug Treatment Services Addictions Treatment Service, Sponsored by Renfrew Victoria Hospital; Mackay Manor; Renfrew County Community Withdrawal Management Services, Renfrew County Addiction Supportive Housing Program, Renfrew County Community Mental Health Services

Concurrent Disorders

The target population for this project is individuals with concurrent disorders. Individuals in this population typically:

- Have overall worse prognosis
- Seek treatment more often, but are more likely to drop out of treatment
- Use more health care services (ED visits, psychiatric admissions, addiction programs)
- Have more addiction relapses
- Have more suicide attempts and deaths than patients with psychiatric disorders alone
- Have more non-response to psych meds
- Are difficult to engage in a positive hopeful way

Goals

1. To achieve improved care coordination for clients with concurrent disorders.
2. To improve communication between Mental Health and Addictions service providers.
3. To utilize technology and tools to enhance and optimize the care coordination process across services.

Objectives

1. Develop a client profile for individuals with concurrent disorders.
2. Develop a baseline understanding of the number of individual clients accessing concurrent services in Renfrew County.

3. Pilot a refined Health Links process with a subset of clients with concurrent disorders in Renfrew County.
4. Pilot the use of collaborative care plans for care coordination and communication.
5. Enhance client and provider satisfaction with service coordination.

The Client's Voice

This project strove to include the client in all phases of work and feedback gained through input during planning and mapping sessions pre-pilot, showed that clients

- Believe the sooner the collaborative care starts the better
- Do not want to start from ground zero, ideally pick up and share information/assessments that have been done
- Want to sign one multi-agency consent form (not multiple)
- If you can only do one collaborative meeting, it should be the meeting developing the care plan
- Acknowledge successes & achievements i.e. reduction of usage, attendance at sessions.

Logic Model

			Outcomes	
Inputs	**Activities**	**Outputs**	**Short-Term**	**Long-Term**
• **Materials** • **Partnerships** • **Time** • **Staff** • **Budget** • **Office Space** • **Project Charter**	a) Track number of identified Concurrent Clients b) Develop a Baseline profile of concurrent service usage c) Develop common communication & collaboration tools d) Concurrent Training for Staff e) Pilot Coordinated care planning for 5 to 10 concurrent clients	• Data Definition/ Client Profile • Baseline data for concurrent services • Common facilitation tools (initiation form, CCP, process map) • Trained Participants • Refined Health Links Process	• Providers can consistently identify concurrent clients • Providers increase their knowledge and understanding of care coordination • Improved coordination/ integration of care between MH & A services • Improved communication between services • High level of client satisfaction with services • High level of stakeholder satisfaction with services	• Reduced relapse • Improved Symptoms • Clients are meeting their care goals

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Evaluation Framework

Activity	Metric	Description	Data Collection Source	Data Collection Method/	Data Collection/ Reporting Timelines
a) Track number of identified Concurrent Clients	# of clients identified as concurrent	Use operational definition to identify potential concurrent clients	Initiation forms	Compile data into **Client Data Table**	Annually
b) Develop a Baseline profile of concurrent service usage	# of referrals submitted offering clients concurrent services	Track referrals for concurrent service	Initiation Forms	Compile data into **Client Data Table**	Annually
c) Develop common communication & collaboration tools	Provider usage and satisfaction with tools	Collect provider perception/ satisfaction with tools	Service Providers	Feedback Interviews Community of Practice	Mid Pilot Weekly/Monthly
d) Concurrent Training for Staff	# of participants trained	Track attendance	Attendance sheets	Trainer or Host Organization	Post-Training
e) Pilot Coordinated care planning for 5 to 10 concurrent clients	# of clients included in the pilot phase	Identify number of pilot participants – track progress to completion of pilot	Service Providers	Pilot Data Collection Spreadsheet	Monthly
	# of Completed Coordinated Care Plans	Track updates and revisions to the CCPs of pilot participants	CCP	Pilot Data Collection Spreadsheet	Monthly
	# of coordinated appointments	Track the number of coordinated appointments between MH services and A services and the client	Service Providers	Pilot Data Collection Spreadsheet	Monthly
	Clients satisfaction with new services	Collect client perception/ satisfaction information	Clients	Focus Groups	Post Pilot
	Provider satisfaction with new services	Collect provider perception/ satisfaction information	Service Providers	Case Conferences	Mid Pilot

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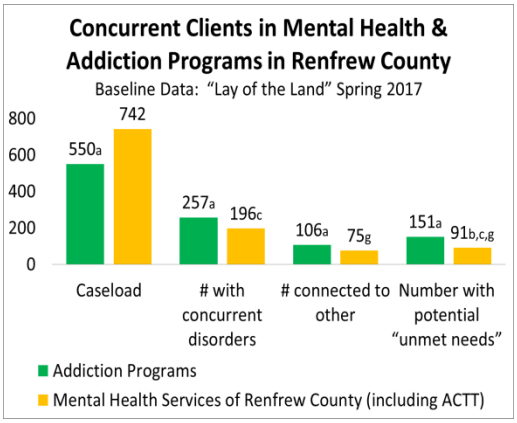
Methods

Tracking Concurrent Clients and Developing a Baseline Profile for Service Usage

In the pre-pilot phase of this project, the following baseline data was compiled. The data shows the approximate number of clients under the current case load of Renfrew County Mental Health Services and the aggregate caseloads of the various Addiction Agencies. The table also indicates, out of those caseloads, the number of clients identified as having a concurrent disorder. Of those clients identified, the data showed that approximately only 40% of individuals were connected to both mental health and addictions services and there were many individuals whose needs were not being met. Data is currently being compiled to present the post-pilot data on these variables.



Develop Common Communication & Collaboration Tools

To enhance a more formalized collaborative care model for concurrent disorders, the project team developed common tools to improve communication and streamline their processes. As previously stated, client feedback highlighted the need for these common tools in order to streamline care, allow stories to be shared less frequently and to enhance the continuity care. The project team developed:

1. ***Coordinated Concurrent Care Initiation Sheet:*** This form replaces multiple referral forms that were being used and includes a list of programs offered by each organization to help guide referrals to the appropriate organization as well as the contact information for each organization.

2. ***Concurrent Care Plan:*** This care plan in meant to be collaboratively completed by the mental health provider, addictions provider, and the client and/or substitute decision maker. The CCP becomes a working document that is continually updated and acts as a communication tool between the two providers as well as between the providers and the client. Lastly, the CCP includes a section which allows the client to assign consent for the sharing of information between different care team members.

Staff Training

A joint clinical training session was held on October 26, 2017. This training focused on:

- Tools to assist with effective collaboration between agencies to better serve clients who present with concurrent disorders.
    - Including, but not limited to areas such as screening, intake, and assessment.
- Asking clients the tough questions
- Effective Case Conferences

Beginning in February 2018, weekly community of practice teleconferences were set up. This voluntary teleconference was created to engage front line providers in a shared domain to allow for collective learning, knowledge seeking and support between participants.

Through 9 weeks, various participants joined these community of practice teleconferences and discussed the following themes:

1. Summaries of Experiences to Date
2. Questions
3. Thoughts on the Process
4. Updates
5. Support Requirements

Meeting summaries were shared with all providers involved in the pilot so that they could gain insight into the process even if they were unable to attend meetings in person. These topics allowed for the improvement and evolution of the pilot project.

Pilot Coordinated Care Planning for Concurrent Clients

In November 2017, the project leadership team outlined their support in identifying a minimum of 12 clients to test the coordinated concurrent care approach. All organizations committed to identifying 2-3 clients, with the exception of Mental Health Services of Renfrew County, which, as the only mental health service representative, committed to identifying 5 clients.

For clients identified as concurrent, the initial provider would complete the Coordinated Concurrent Care Initiation Sheet and send it on to the appropriate agency for referral. This agency was then responsible for following up on the initiation and both providers would work collaboratively to set up a coordinated appointment involving both providers and the client. At this coordinated appointment, the participants would work together to fill out the Coordinated Care Plan document.

Any other subsequent coordinated conferences were to occur over the telephone with the client present alongside one of the providers.

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In order to evaluate the intended process, the following were tracked:

1. # of Pilot clients
2. # Face-To-Face Coordinated Care Appointments
3. # Coordinated Care Plans Created

The expectation was that for every client identified and included in this pilot, they would have one initial coordinated appointment and one coordinated care plan.

The table below shows a breakdown of the number of clients that were included in this pilot project from each organization, the number of initial team care appointments that occurred and the number of coordinated care plans created.

Table 1. Pilot Data

Organization*	# of Initiated Pilot Clients	# of Face-To-Face Coordinated Care Appointments	# of Coordinated Care Plans
Pathways	8	5	5
ATS	24	9	2
Mental Health Services of Renfrew County	4	4	4
Total	**36**	**18**	**11**

* Missing data from MacKay Manor

Provider Feedback

On March 19, 2018, a provider feedback session was held during the regular community of practice teleconference. This was an opportunity for providers to share their feedback on the pilot work to date. A survey with the same questions was sent out for those who were unable to attend the session. The following key themes were extracted:

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Benefits to this New Approach	
Communication	▪ Enhanced communication has ensured follow-up and follow-through on clients. ▪ Allows providers an avenue to be able to meet and advocate for clients and bridge gaps between services.
Relationship Building	▪ Appreciating the opportunity to work with partner agencies and knowing who to contact when follow-up needs to occur. ▪ Having a better understanding of the work that is being done from both sides. ▪ This work has allowed providers to better understand which organization provides which service. ▪ Providers feel that they are more likely to refer to another service now that they have built relationships and know there will be more follow up and follow through
Streamlined Approach to Care	▪ From the intake perspective, having information in a care plan from both MH and addictions providers allows for coordination of care to start from the beginning. ▪ Using the same standardized tools and approaches has made the process more efficient. ▪ Creating deeply integrated care for the client and family. ▪ The pilot allows for constant adjustment and improvement to processes in an attempt to streamline care. ▪ Decreasing wait times for services through a more streamlines approach
Challenges to this New Approach	
Time	▪ Leaning something new takes time ▪ Providers have a heavy workload and thus feel that they might not have enough time, especially for face to face meetings
Standardization	▪ Ensuring all of the different players are on the same page. ▪ Different providers and organization have entered into the pilot at different times and thus are at different stages in their processes. ▪ When an organization or team learns something or wishes to make an adjustment to a process, there is a communication ripple that occurs and keeping track of up-to date changes as they occur can be difficult.
Learning Curve	▪ With any new initiative, there is a period of adjustment as providers and organizations acclimate. (New program, new forms, updates to forms always takes some time to get used to)

"Having ongoing communication is really helping me to know how to provide the best care possible for our mutual client. As someone without an addictions background, this is especially helpful, as it feels like my client is getting the full spectrum and appropriate care and services, and I think that that is fantastic!!

-- Mental Health Worker

Client Feedback

The initial approach to garnering client feedback was through focus group interviews. This proved unsuccessful and currently, the project leadership team is working to assess whether the OPOC tool can be leveraged to assess the client's perception of care they have been receiving through this project.

Preliminary Results

The Coordinated Concurrent Care Planning project came to fruition through the initiatives of local champions in the mental health and addictions agencies of Renfrew County who saw a need to improve care for those with concurrent disorders. Upon completion of the pilot phase of the Coordinated Concurrent Care Planning initiative, the following key success factors were identified:

- Professional relationship building and skill development; through joint clinical training and the community of practice
- Enhanced communication and streamlined workflow; through the development of common tools and well defined roles

Extensive work by all participating organizations throughout the pilot phase of the project led to the achievement of almost all intended outcomes, with the exception of obtaining client feedback and assessing client satisfaction with the pilot work at this time.

Staff training strengthened the provider's knowledge base of concurrent disorders and was used as a means of disseminating information to ensure that providers and organizations were consistent and aligned in their identification of individuals with concurrent needs. Joint clinical training sessions were conducted which allowed providers from different organizations to be trained together, exchanging knowledge and expertise in their own disciplines and skill building to help facilitate collaborative concurrent care.

Community of practice teleconferences allowed for collective learning, knowledge seeking and proving support for providers throughout the pilot. The community of practice calls were a space where providers could collectively problem solve issues with the collaborative process and disseminate lessons learned to help improve and streamline the work flow.

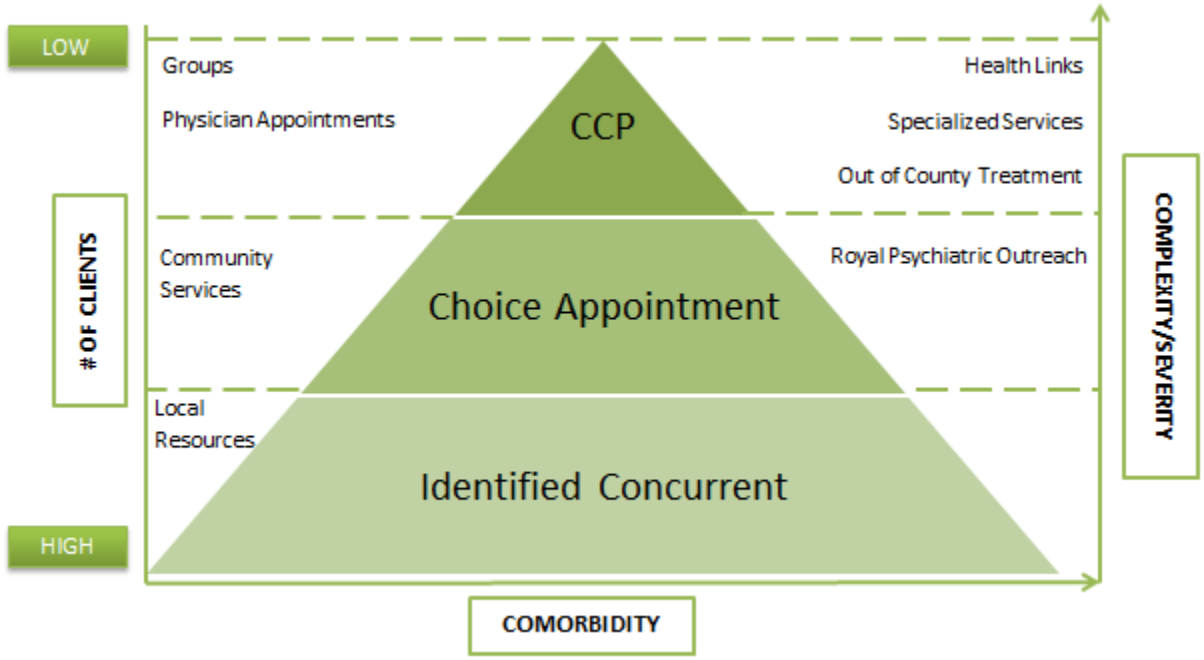
Both the trainings and the community of practice teleconferences were used to build and strengthen professional relationships as well as enhance communication between service providers within different organizations. Through these formal and informal sessions, providers began building their understanding of and comfort with the foundations of care coordination and concurrent disorders.

To enhance a more formalized collaborative care model for concurrent disorders, the project team developed common tools to improve communication and streamline their processes. As previously stated, client feedback highlighted the need for these common tools in order to streamline care, allow clients to share their story less frequently and enhance the continuity of their care. The project team developed a Coordinated Concurrent Care Initiation Sheet and a Concurrent Care Plan (CCP) which have allowed care to become more integrated which has ultimately enhanced the continuity of care received

by clients and reduced inefficiencies in the workflow for providers. The uptake of the initiation sheet was very high and its use has become standard practice.

As previously stated it was anticipated that organizations would be able to engage approximately 12 clients in the pilot. As indicated in the table above, organizations engaged considerably more clients than originally expected. Prior to the start of the pilot, groundwork was done to establish an intended workflow for concurrent disorder care planning. Initially, the workflow was considered to be fairly linear, as seen in the diagram below.

It was originally intended that any client identified as concurrent would go on to have an initial coordinated care appointment, which would lead to the development of a Coordinated Care Plan. As we can see from the pilot data in Table 1 above, that although many clients were identified as concurrent, many were not receiving a coordinated care appointment and even less were being involved in the creation of a CCP. Upon initial reflection, it was believed that there was a need for additional support in achieving the intended workflow and ensuring that all concurrent clients were getting a coordinated care appointment and a care plan. Upon further discussion and reflection, a new workflow was conceived that took into account the true nature of concurrent care, see below.



The diagram captures the non-linear flow of concurrent clients. The diagram shows the effect that complexity and severity has on the level of care required. The more complex a case is, the more concentrated the coordination efforts will be, including a choice appointment and a coordinated care plan. The number of clients who are identified as concurrent will therefore outnumber those who actually receive the top level of care coordination as only those who are most severe will require this intensive form of support and coordination. Clients who present with comorbid conditions which require managing and include multiple care members may be more suited for health links.

It was discussed that, client complexity and severity plays a major factor in the need for concurrent care planning. Some clients who are identified as concurrent are complex and have a severe enough mental health issues to follow the initial workflow and thus would have a coordinated care appointment and develop a concurrent care plan. However, some clients will not meet the criteria for Mental Health Services of Renfrew County but will be offered viable alternatives to support them with their mental health needs and thus a coordinated care plan will not be developed. There will also be some clients with increased complexity and possess several comorbid conditions that make them better candidates for health links care coordination.

By rethinking the process as non-linear we can redefine what success looks like for this project. Instead of identifying success as all clients who are identified as concurrent have a coordinated appointment and coordinated plan, it can now be defined as all clients and providers working through concurrent care identification and connections to services planning are receiving the right level of care and support respectively, to match their needs. Through this process, clients who require coordinated care planning by both addictions and mental health providers will be identified and supported, other clients who

require less coordination will be followed by either their addictions or mental health service provider, who with the support and guidance from other services, can support their client in their concurrent needs.

Client "no shows" at appointments was the single highest identified barrier impeding the workflow in this process. Support around improving client "no shows" at collaborative appointments must be addressed in order to improve the overall workflow of this process.

The baseline data above (Methods) showed a high proportion of concurrent clients whose needs were (potentially) not being met. Data is currently being compiled to present the post-pilot data on these variables. Through the improvements achieved during the pilot, it is expected that the number of identified clients with concurrent disorders will have increased due to expanded knowledge of concurrent disorders achieved through staff trainings. Through the formalized collaborative care model it is also expected that the number of clients connected with both mental health and addictions services will increase and that the number of individuals with unmet needs will decrease.

The provider feedback collected during the pilot phase was resoundingly positive. The key themes that providers discussed in terms of benefits of this new approach to coordinated care were around enhanced professional relationships, improved communication between providers and a streamlined workflow. Through joint clinical training and common tools, providers have described a better understanding of their role in coordinated care and are now more comfortable collaborating with providers from other agencies. One provider mentioned that they were now more likely to refer to other agencies as they believe there will be more consistent follow-through. Although there were some challenges identified with the new approach, many providers related them to the up-take of a new initiative and believed that in the long run, the benefits to improved communication, better relationships between organizations and providers, and a more streamlined process would outweigh the challenges being faced. Consistent messaging and ongoing forums for relationship building were crucial in mitigating these challenges.

Client feedback on the pilot process has yet to be obtained but through involvement of clients in all phases of work, the team is confident that this initiative has made improvements on many of the areas identified by clients. Collaborative care beings much earlier now thus decreasing the number of times a client must re-tell their story. The collaborative care plan tool allows clients to sign one consent form and also allows providers to readily exchange information and assessments for improved continuity.

Actions & Recommendations

While it is still too early to assess improved outcomes for clients, (e.g. relapse reduction, symptom improvement), the benefits of this new approach to concurrent disorders was strongly portrayed in the feedback given by providers. The following actions and recommendations are supported through the evaluation of this pilot project:

1. Support face-to-face join care conferences and the usage of concurrent care plans through the development of clinical care pathways. Ensuring that these become part of standard clinical care for concurrent disorder clients for those who require them will enhance communication, relationship building and the definition of roles.

2. Enlist more physician and psychiatrist involvement and support in Coordinated Care Plans. Similar to health links, where involvement in the Coordinated Care Plan extends to any care team member consented to by the client, this project could eventually expand to include other providers in collaborative concurrent care. Having the client's general practitioner or psychiatrist involved in care planning alongside the addictions and mental health providers could ensure more fulsome and coordinated care.

3. Improve client "no shows" at collaborative appointments. With this intended collaborative care appointments, a client missing an appointment affects the time of not just one, but two providers. To ensure a streamlined and efficient process, decreasing the number of "no show" appointments is imperative.

4. Evaluate client's perception of care and outcomes & assess change from baseline. This new approach is proving beneficial for providers but evaluating the client experience within this new approach is also valuable. Understanding the impact this new care model is having on client's satisfaction with their care and also their clinical outcomes is a key factor.

5. Develop an implementation plan for scaling up. The spread of this model to all concurrent pilots requires a planned approach to ensure success. Proper communication, training of new staff, and translation of the approach needs to spread throughout the organizations.

6. Continuous monitoring and quality improvement. Continue to monitor and assess the progress of implementation and continued improvements in access to concurrent services, using the baseline data as a comparator on a regular basis.

7. Evaluate this process's alignment with Health Links.