e-QiP

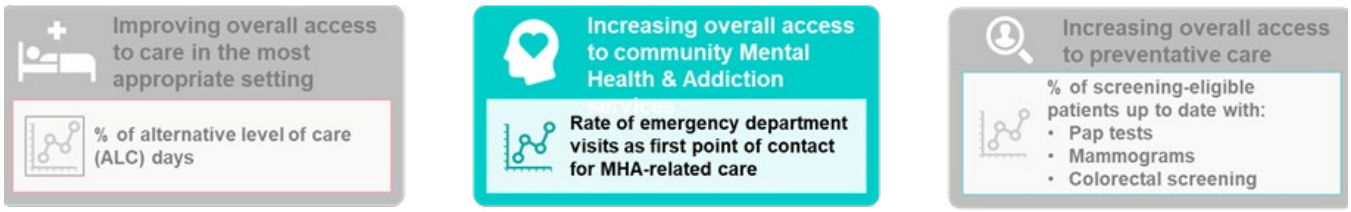
Excellence through Quality Improvement Project

Improving access to community MHA services

As a part of the overall vision of Ontario Health Teams (OHTs) delivering high-quality, integrated care to their attributed populations, the Ministry of Health is requiring OHTs (via their implementation funding transfer payment agreements) to submit collaborative Quality Improvement Plans (cQIPs) to support transformation. The cQIP focuses the improvement work of OHTs around a common set of provincial health system priorities, one of which is increasing overall access to community mental health and additions (MHA) services; the associated quality indicator is rate of emergency department visits as first point of contact for MHA-related care.

Table of Contents

Fig. 1) Mandatory areas of focus and associated quality indicators for cQIPs.



The objectives of this resource are to:

- Support providers in understanding the cQIP indicator and interpreting performance
- Support discussions across OHT providers
- Provide guidance on how to use local data and other data sources to understand performance
- Aid community agencies in making connections between their local QI activities and how these may influence the cQIP indicators

The audience for this resource is **mental health and addiction (MHA) agencies**, **OHT leads**, and **OHT members involved in the development of cQIPs for OHTs**.

This resource contains:

- A technical description of the indicator.
- Examples from community MHA agencies of the QI efforts that they have developed that may affect performance on this indicator and the data that community agencies are using to better understand performance on the indicator and opportunities for improvement. The examples focus on improving access to MHA services, which is the intention of the emergency department (ED) as the first point of contact for MHA care proxy measure.
- Ideas on how to reduce inequities for priority populations by providing support when and where it is needed. This can be found in the "How to embed equity" section on page 13.
- A description of available tools and associated data sources in the MHA sector including:
  - the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA),
  - the Virtual Client Experience Survey (VCES),
  - Staged Screening and Assessment (SS&A),
  - the Early Psychosis Intervention (EPI) programs that use the First Episode Psychosis Service Fidelity Scale (FEPS-FS), and
  - the Ontario Common Assessment of Need (OCAN).

For additional information, please contact the Excellence through Quality Improvement Project (E-QIP) at quality@e-qip.ca or the data source-specific contact included in the document.

Indicator Tech Specs

Field	
Unit of measurement	Percentage
Interpretation	The intent of this indicator is to measure the percent of people who seek MHA care for the first time in the ED as a means of identifying lack of access to community MHA services. The direction of improvement for this indicator is to reduce (lower). Although there are limitations to this indicator, it provides a starting point for discussion and an opportunity to understand gaps in service. When combined with other indicators, such as repeat ED visits, it may highlight opportunities to transition people to more appropriate and timely care.
Denominator	Number of people aged 0-105 with an incident (first in the period) unscheduled ED visit for MHA.
Numerator	Number of people in the denominator without any MHA related service contact in a 2-year look back period. **Note: MHA related service contacts include MHA-related outpatient visit that are OHIP billed or an MHA related hospital visit (admission or ED visit).**
Inclusions	Can be calculated for all people who present to the ED with a valid Ontario HCN; usually broken down by adults (16yrs+) vs child/youth.
Considerations / Limitations	This indicator relies on OHIP data, which may lead to coding errors and a lack of clinical detail. Physicians may also not always code an MHA diagnosis, when care has been provided for multiple conditions. People who are receiving care through non-OHIP billed services will not be captured. Community care provided by a non-physician such as a nurse practitioner, public health (e.g. harm reduction services) or community MHA providers, would not be captured if they do not bill through OHIP. Finally, in terms of identifying access to community services, the indicator does not capture emergency department visits that are prevented through other levels of care or emergency department visits that are appropriately escalated to the ED by a non-OHIP billed service provider. Although there are limitations to the indicator, it provides a starting point for discussion and an opportunity to provide a broader narrative on the area of focus and all the work that's happening in the community MHA sector already.
Data sources	OHIP database, NACRS (ED data), CIHI-DAD/OMHRS (hospitalizations), PCCF+, RPDB
Link to Tech Specs	Health Quality Ontario – Indicator Library MHA System Performance in Ontario Technical Appendix Scorecard – Page 11, Section 2.2.4 Ontario Health cQIP Technical Specifications – Pages 7-8

The following are real QI examples from community MHA agencies that focus on **improving access to MHA services.** The examples are intended to help community agencies see the relationship between QI efforts to improve access to community MHA services and how this may affect or not affect the cQIP indicator. **These examples are in various stages of completion: some are ideas, some are completed, and some are in progress;** They are intended to share innovative ideas on how community MHA agencies and OHTS may improve access to services. They can also support OHTs when considering local data and other data sources to understand access to community MHA services.

Quality Improvement Plan Example #1: OPOC-MHA

PROBLEM STATEMENT

A community MHA service has identified long wait times as a problem for clients entering the service.

BRIEF DIAGNOSTICS

CHANGE IDEAS

Change ideas include an alternative service delivery option offering a single-session model, a redesign of the 'caseload' model to a 10-session service model, and transition from geographical service provision to a more centralized/virtual model.

MEASUREMENT

Using the OPOC-MHA question, "The wait time for services was reasonable for me", the percentage of clients that agree or strongly agree will be measured at baseline and post-intervention of the change ideas.

All change ideas will be tested using the Plan/Do/Study/Act (PDSA) strategy method.

The project will track number of clients attending new sessions and the number of clients on the wait list.

In addition, surveys will record client and staff satisfaction with changes in services.

RESULTS

CONNECTION TO MHA INDICATOR

Clients in crisis will likely need to seek service from the emergency department if wait times are excessive. By reducing client wait times, this service aims to increase access to their service.

This change could result in a reduction in the number of people using the ED which will reduce the denominator for the indicator.

OPOC-MHA Example #2:

PROBLEM STATEMENT

A QI initiative was designed with the goal of using OPOC-MHA data to support system-level service improvement and to align implementation and QI plans.

BRIEF DIAGNOSTICS

Partnership consisted of people with lived experience, community organizations, and hospital leadership. The project gathered and engaged participating agencies in a facilitated process to review aggregated OPOC-MHA data, identify QI opportunities, outline related actions, implement agency and system level changes, and evaluate the impacts of this process.

CHANGE IDEAS

Partners developed and reviewed a shortlist of potential interventions, and ultimately selected the Patient Oriented Discharge Summary (PODS) as the QI intervention.

MEASUREMENT

Intervention outcome data was collected among several community organizations and hospitals.

RESULTS

Overall, clients reported a favourable discharge experience and partners reported appreciating the opportunity to share data and ground their collaborative QI work in client feedback. This QI initiative enabled regional stakeholders to identify opportunities for system-level QI using OPOC data, and take collective action to enhance services for those accessing and engaged in care.

CONNECTION TO MHA INDICATOR

Accurate and client friendly discharge instructions may connect clients to community mental health services more readily and therefore could decrease repeat emergency department visits. This may change the volume of ED visits, however may not change the indicator.

OPOC-MHA Example #3:

PROBLEM STATEMENT

The priority identified was to reduce wait times and make access to community MHA services a priority.

BRIEF DIAGNOSTICS

A Regional systems table made up of hospital and community MHA agencies, as well as multi-sectoral partners, came together to help improve quality of and access to care, equity, best practice, and best system design for individuals living with MHA conditions and their families.

CHANGE IDEAS

The group identified OPOC-MHA as a critical standardized tool to support this work, as approximately 75% of MHA organizations in the region were actively using the tool.

MEASUREMENT

In support of this goal, the systems table developed a scorecard to track access and entry to services at a regional and sub-regional level, using data collected through the OPOC-MHA survey. All organizations using the OPOC-MHA agreed to share agency aggregate OPOC-MHA responses quarterly to OPOC-MHA questions:

#1. The wait time for services was reasonable for me.

#2. When I first started looking for help, services were available at times that were good for me.

RESULTS

The scorecard collated the average scores by sub-regions to track access and entry to services and identify areas of strength and opportunities for service improvement across sub-regions and the region as a whole.

CONNECTION TO MHA INDICATOR

This group was able to identify the areas of strength and opportunities in terms of reducing wait times. Reducing wait times is directly related to improving access to community MHA services. By sharing data across providers, this group may be able to more accurately measure first contacts by identifying the use of community services as well as OHIP billed services.

VCES Example

PROBLEM STATEMENT

A community MHA service conducted an in-house survey of staff and found that long wait times are an area that requires improvement.

BRIEF DIAGNOSTICS

The project aims to improve access to care through a mixed model of in-person and virtual services.

CHANGE IDEAS

Specifically, the community MHA agency will aim to increase clients' quality access to virtual care services by 10%.

MEASUREMENT

The data source for this project is the Virtual Client Experience Survey (VCES). The program hired and oriented a peer worker to administer the VCES by phone for this project.

RESULTS

"The tool and the process gave us perspectives that we would have not seen with just regular canvassing. They are not as difficult to use as we thought. The most significant lesson learned is the importance of using the client's voice in making improvements." – Program staff member.

CONNECTION TO MHA INDICATOR

Focused on improving long wait times, which is directly related to improving access to care.

This may change the volume of ED visits, however may not change the indicator if visits to community providers are not captured in the numerator.

EPI-SET Example

PROBLEM STATEMENT

Focused on improving access to MHA Services prior to the need for hospitalization.

CHANGE IDEAS

To provide more effective early intervention and promote better patient outcomes, programs are encouraged to undertake targeted education to increase awareness with programs likely to be a first point of contact for these clients.

MEASUREMENT

The fidelity assessment for EPI programs in Ontario uses the First Episode Psychosis Service Fidelity Scale (FEPS-FS) to rate how closely programs align with the Ontario EPI standards for consistent, high quality care across the province. The scale consists of 33 items rated on a 5-point scale, and a score of 4 or above is considered good fidelity to the standards. In the case of the EPI-SET project specifically, a series of fidelity assessments looks at whether/how implementation of the evidence-based NAVIGATE model of care affects program delivery in relation to EPI standards of care.

One item assesses what percentage of clients received inpatient care prior to their admission to the EPI program. A rating of 5 requires that less than 20% of clients are hospitalized prior to EPI program admission, as the program is intended for early intervention.

BRIEF DIAGNOSTICS

Item Specifics (for reference)

12. Early Intervention: The proportion of first episode psychosis patients who have been hospitalized prior to admission to the first episode psychosis (FEP) services reflects success in early intervention (last year, inpatient psychiatric admission).

Rating of 1: 80+% of FEP patients receive inpatient care prior to FEP service (FEPS) admission

Rating of 2: 60-79% of FEP patients receive inpatient care prior to FEPS admission

Rating of 3: 40-59% of FEP patients receive inpatient care prior to FEPS admission

Rating of 4: 20-39% of patients receive inpatient care prior to FEPS admission

Rating of 5: 0-19% of patients receive inpatient care prior to FEPS admission

RESULTS

CONNECTION TO MHA INDICATOR

EPI programs are able to engage community partners and provide public education to raise awareness of their services and promote the use of early intervention, which could affect the way people access care, ideally diverting people from using ED as the first point of care.

To be able to affect performance on the indicator, the team will have to integrate data from the EPI programs into the overall measurement.

OCAN Example #1

PROBLEM STATEMENT

A community MH organization sought to reduce the repeat MHA emergency department ED visits among individuals enrolled in case management services.

CHANGE IDEAS

To address unmet needs associated with repeat ED visits, the following change ideas were identified[1]:

- Pair case management with dialectical behavior therapy skills group to reduce unmet needs related to safety to self;
- Provide cognitive behavioural therapy for psychosis to reduce unmet needs related to psychotic symptomatology;
- Incorporate evidence-based concurrent disorder interventions in the case management model to address unmet needs related to drug and alcohol use.

MEASUREMENT

The OCAN could be used to track reduction in unmet needs associated with repeat ED visits.

BRIEF DIAGNOSTICS

Using OCAN data, the organization undertook a study to identify the prevalence of repeat MHA ED use among case management clients and to examine the characteristics and need profiles of clients with multiple ED visits for mental health reasons.

Approximately 6 % of intensive case management clients had two or more ED visits over a 6-month period. Repeat ED presenters enrolled in case management programs were more likely to

- be younger;
- have been in case management for a shorter duration;
- have unmet needs related to safety to self or others, psychotic symptomatology, and drug and alcohol use.

RESULTS

CONNECTION TO MHA INDICATOR

The study - using OCAN data - identified the need profile and characteristics of people with repeat ED use. An OHT could use this information to identify individuals with the above-noted unmet needs and prioritize access to intensive community supports services focused on addressing these needs. It could then measure if this results in a reduction in ED contacts.

This could reduce the volume of visits to the ED however may not alter the indicator since the QI activity is focused on reducing hospital revisits.

1 Sirotich, F., Durbin, A., & Durbin, J. (2016) Examining the need profiles of patients with multiple emergency department visits for mental health reasons: A cross-sectional study. Soc Psychiatry Epidemiology (51), 777–786. Retrieved from: https://www.researchgate.net/publication/295249083_Examining_the_need_profiles_of_patients_with_multiple_emergency_department_visits_for_mental_health_reasons_a_cross-sectional_study

OCAN Example #2

PROBLEM STATEMENT

A group of community MHA providers working on a collaborative QIP within an OHT attempted to identify factors that led to the rise in the waitlist for intensive case management.

CHANGE IDEAS

The providers are using this information to identify possible service options to address these gaps and map these service options to OCAN need ratings. An unmet need rating in the above-noted need domains would trigger referral to the identified service options, thereby creating standardized pathways to services. It is hoped that this would better meet the needs of current case management clients and increase more timely throughput, thereby increasing access to case management services for individuals currently waitlisted.

MEASUREMENT

The OCAN will be used to see if these pathways to services result in reduced unmet need. Length of time in service and the number of new clients admitted will also be tracked to see if reduction in need results in shorter time in service and more throughput.

CONNECTION TO MHA INDICATOR

A reduction in persistent unmet needs may result in a shorter duration in service, which may open capacity in community MHA agencies. Additionally, better integration of services and addressing unmet needs could reduce the need for acute services such as ED visits.

Performance on this indicator could be affected by better connecting people to other services, including physicians and by addressing unmet needs before they become acute and require ED visits.

BRIEF DIAGNOSTICS

These providers used a staff survey, administrative data and OCAN data to help diagnosis potential root causes for the rise in the waitlist. Based on a survey of staff and administrative data, the providers found that existing case management clients were staying longer in service because case managers were unable to link clients to needed services that would facilitate discharge and enable uptake of new clients currently waiting for case management.

To better understand these service gaps, the providers reviewed OCAN data to identify need areas that remained unmet over three consecutive assessment cycles (approximately 18 months). The providers found the following areas had the largest prevalence of persistent unmet need among clients with at least three OCAN assessments: psychological distress (19%), physical health (15%) and daytime activities (15%).

RESULTS

The providers found the following areas had the largest prevalence of persistent unmet need among clients with at least three OCAN assessments: psychological distress (19%), physical health (15%) and daytime activities (15%). The providers are using this information to identify possible service options to address these gaps, better integrate services and create standardized pathways to these needed services. It is hoped that this would better meet the needs of current case management clients and increase more timely throughput, thereby increasing access to case management services for individuals currently waitlisted.

SS&A Example

PROBLEM STATEMENT

Determine how to use the GAIN Q3 MI ONT Catalyst Reports to improve access to MHA services and other needs.

BRIEF DIAGNOSTICS

The recently launched GAIN Q3 MI ONT Catalyst reports allow agencies to examine aggregate data from all assessments completed at the agency, and filter the data according to sociodemographic data and staff member. The information provided includes hospitalizations for both mental and physical health. Agencies can also filter all the assessment information by hospitalization frequency to examine potential trends in high-frequency users, including across programs when filtered by staff member.

CHANGE IDEAS

Identifying trends in these high-frequency users may indicate gaps in care, or opportunities to modify or add programming to reflect client need, depending on the agency's capacity.

MEASUREMENT

CONNECTION TO MHA INDICATOR

The aggregate data provided in the SS&A Catalyst reports allows agencies to examine current trends by client and staff member(s), and therefore informs program planning and resource allocations to appropriately address the needs of their client population.

This project may improve access to services in the community and increase the number of people receiving care. To be able to change performance on the indicator, use of community services will need to be captured in the numerator.

RESULTS

These GAIN Q3 MI ONT and screener reports have only recently become available; however, organizations are now starting to use the data. For example, agencies have altered intake processes to better accommodate clients, including creating assessment groups to support a larger number of clients in a timely manner and waitlist groups to offer clients support while they wait for access to the full program. Particularly with OHTs, opportunities exist to create pathways to support clients in a wraparound way. Smaller agencies have relied on partnerships to make improvements without exceeding their capacity.

How to embed health equity

The examples from community MHA providers in this resource focus on improving access to MHA services. Improving access to services by providing support when and where it is needed can reduce inequities for priority populations. Examining the data on access to community MHA services collected by the various standardized tools described in this resource can lead to the identification of change opportunities to enhance access to community supports, and create better transitions to more appropriate and timely care.

Many of the standardized tools described in this resource also collect sociodemographic data, such as language, age, gender, sexual orientation, racial or ethnic group, income and year arrived in Canada. This sociodemographic data can be used in conjunction with agency and census data to create a general profile of service recipients and regional populations to determine whether there is need to adjust services to better serve specific or marginalized groups. Measuring indicators across groups to show variations can help to identify inequities in access to services and focus improvement activities where gaps exist, including for specific sub-populations. Focusing QI efforts on the most marginalized populations enhances care for all populations.

Ideas on how to reduce inequities for priority populations by providing support when and where it is needed:

- Utilize sociodemographic data from multiple data sources (ex. OCAN, OPOC, additions data, census data, etc.) to determine inequities in access to services
- Stratify measures by sociodemographic characteristics to determine if there are disparities in outcomes/ client experience

Data Sources

The data sources discussed in this resource are standardized tools that are at various stages of implementation and uptake in Ontario:

- Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA)
- Virtual Client Experience Survey (VCES)
- Staged Screening and Assessment (SS&A)
- Early Psychosis Intervention (EPI) programs that use the First Episode Psychosis Service Fidelity Scale (FEPS-FS)
- Ontario Common Assessment of Need (OCAN)

The considerations for the data sources include the data not being available at the level of the attributed population, not all data sources having a provincial data repository, the fact that the tools are not mandatory (resulting in variable uptake), and that the tools are at different stages of development and implementation. More information on these data sources are included below.

Data Source: Ontario Perception of Care Tool for Mental Health and Addictions

The Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA) is a standardized tool used to gather client feedback on the quality of care received in hospital and community settings. A client's perception of care is a recognized key indicator of quality of care. This tool brings the client's voice forward as a source of evidence to support program, agency and system QI efforts.

There are currently five versions of the OPOC-MHA: for Registered Clients, for Non-Registered Clients, for Caregivers, for Supportive Housing, and for Crisis. Perceptions of care are gathered across several quality domains, with an opportunity for written comments following each domain. Demographic information is also collected to help identify potential inequities in service. Each version is available in English and French.

OPOC-MHA data is stored in a provincial database hosted by the Drug and Alcohol Treatment Information System (DATIS). DATIS is a program within the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH) that supports Ontario's community-based health services.

OPOC-MHA data can be used at the program, agency, regional, and system level for QI. Having a central provincial database and reporting portal allows organizations to access OPOC-MHA results, which can be filtered and analyzed in a customized manner. Organizations also have access to aggregated, comparable provincial data. Overall, roughly 240 MHA organizations have implemented OPOC-MHA and there are about 100,000 surveys completed in the provincial database.

More information on the OPOC-MHA survey can be found at: http://improvingsystems.ca/projects/ontario-perception-of-care. If you have further questions about the OPOC-MHA, please contact: opoc.mha@camh.ca

Data source: Virtual Client Experience Survey (VCES)

During the pandemic, CAMH developed the Virtual Client Experience Survey for Mental Health and Addictions (VCES) to help organizations evaluate the quality of virtual client care from a client perspective. The VCES takes a person-centered approach to measuring multiple dimensions of health care quality. The VCES is available in English and French. A Groups version (VCES-Groups) is also available to evaluate the quality of group-based virtual care.

The VCES complements and has overlap with the OPOC-MHA survey by providing an approach that measures client experience with a specific focus on virtual care. It is a point-in-time survey whereas the OPOC-MHA assesses client feedback about their overall experience with a particular program or service. The VCES includes five items from the OPOC-MHA and similar sociodemographic questions to support data comparison. There is no provincial data repository for the VCES at this time.

For information about the VCES and to receive a copy, visit https://edc.camhx.ca/redcap/surveys/?s=7CRKNYT7FY. If you have questions about the VCES, please contact vces@camh.ca.

Data Source: Staged Screening and Assessment (SS&A)

Staged Screening and Assessment (SS&A) is an evidence-based staged process for screening and assessing individuals accessing care in the addiction sector that assists with the accurate identification of their needs, development of a collaborative treatment plan, and matching the service user to the most appropriate level and type of care.

The process has four parts (three screening tools and a First Stage Assessment):

1. Global Appraisal of Individual Needs – Short Screener (GAIN-SS)

2. Modified Mini Screener (MMS) for adults, and the Problem Oriented Screening Instrument for Teens (POSIT) for those 17 and under

3. Global Appraisal of Individual Need Quick3 Motivational Interviewing Ontario (GAIN Q3 MI ONT)

Organizations are able to access agency-level aggregated data, as well as reports that can be filtered according to their QI aims. The reports are available through Catalyst, operated by DATIS. DATIS is a program within PSSP at CAMH that supports Ontario's Community-based health services.

SS&A is currently being implemented across the province. As of January 2022, more than 170 agencies are engaged at various stages in training, certification and implementation. Training and certification on the GAIN Q3 MI ONT has been provided to more than 1,500 service providers who have completed over 10,000 GAIN Q3 MI ONT assessments.

More information on SS&A can be found at: http://improvingsystems.ca/projects/provincial-screening-and-assessment. If you have further questions about SS&A, please contact: ssa@camh.ca.

Data Source: Early Psychosis Intervention – Spreading Evidence-based Treatment (EPI-SET)

The Early Psychosis Intervention – Spreading Evidence-based Treatment (EPI-SET) is an implementation research project that aims to improve the delivery of early psychosis intervention (EPI) service and its quality across Ontario. This project uses the NAVIGATE model – a comprehensive, recovery-focused, and evidence-based treatment program that provides a structured framework to coordinate services provided by a multidisciplinary team. NAVIGATE facilitates consistent and early engagement of patients and their families in all aspects of EPI services.

There are currently six sites involved in the EPI-SET research project. Sites use their own electronic medical record system for the project; there is no consistent database across all sites.

More information on EPI-SET can be found at:
https://www.epi-set.com/.

Data Source: Ontario Common Assessment of Need (OCAN)

The Ontario Common Assessment of Need (OCAN) is used to assess individuals/clients accessing community mental health services. The primary objective of OCAN is to provide a standard tool for assessing client needs to inform and coordinate care planning and measure outcomes over time. The standard is to complete the assessment every six months.

OCAN includes the following components:

1. **Needs Assessment:** Embedded within the OCAN is the Camberwell Assessment of Need, which is an internationally used measure of health and social needs for people with mental illness. The OCAN includes 24 need domains covering a range of areas (i.e.., physical health, safety to self, accommodation, relationships). The tool includes a client self-assessment and a staff assessment. This component identifies areas of unmet need and can be used to evaluate performance by measuring change in unmet need over time.

2. **Client profile and characteristics:** socio-demographic information is collected and can provide a health equity measure to facilitate identification of disparities that can identify potential inequities in service. OCAN collects additional data to describe the client including medical conditions, mental health diagnosis, ED visits, hospital use and criminal justice involvement.

3. **Service use information:** OCAN captures the referral source and types of services the client is accessing within and outside of the community mental health sector including access to physicians.

OCAN data is collected in organizations' client management systems and uploaded to a central provincial repository called the Integrated Assessment Record (IAR), managed by Ontario Health.

More information can be found at:

Tools for Common Assessments in Community Care | Ontario Health

IAR (Integrated Assessment Record) Systems | Ontario Health

Acknowledgements

We would like to thank the partner organizations, Ontario Health and the MHA organizations and community tables they support for the examples provided within this document.

The Excellence through Quality Improvement Project (E-QIP) is a QI program focused on leadership and capacity building led by Addictions and Mental Health Ontario (AMHO) and the Canadian Mental Health Association (CMHA), Ontario with direct support from and in close partnership with the Provincial System Support Program (PSSP) at CAMH. E-QIP is funded by and delivered in collaboration with Ontario Health. E-QIP works collaboratively with the Mental Health and Addictions Centre of Excellence at Ontario Health to foster a data driven approach to improving care in the community mental health and addiction sector and to support the implementation of The Roadmap to Wellness.

We would like to acknowledge the leadership of PSSP in developing the content in collaboration with E-QIP.

Addictions & Mental Health ontario

camh

Canadian Mental Health Association Ontario

Ontario Health

e-QiP
Excellence through Quality Improvement Program

Return to Table of Contents