EVALUATING THE IMPLEMENTATION OF HEALTH QUALITY ONTARIO STANDARDS FOR CARE OF PEOPLE LIVING WITH SCHIZOPHRENIA AT WAYPOINT CENTRE FOR MENTAL HEALTH CARE

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BACKGROUND

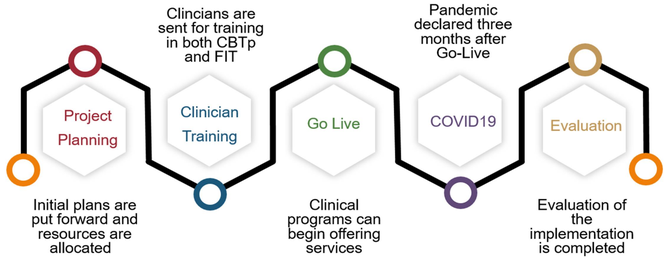
Waypoint Mental Health Care is a psychiatric hospital in rural Ontario, Canada. We implemented four of the Health Quality Ontario (HQO) quality standards for schizophrenia care to align clinical practice with existing evidence in the following areas:

1. Cognitive Behavior Therapy for Psychosis (CBTp)
2. Family Intervention Therapy (FIT)
3. Treatment with clozapine
4. Treatment with long-acting injectable antipsychotic medication

PROJECT DETAILS

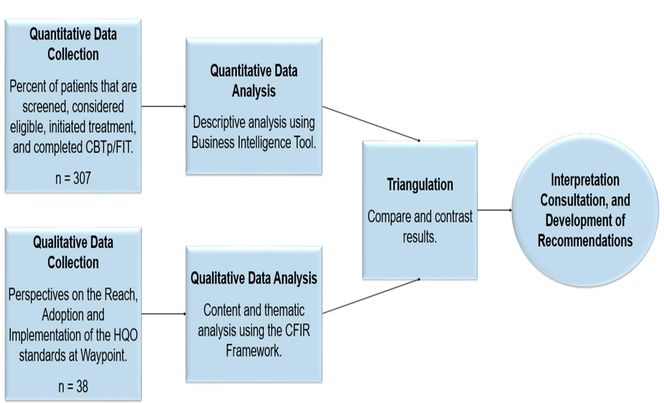
Project Overview

Waypoint planned for the HQO standards to be piloted on four clinical programs starting in December 2019. Two programs and two interventions (CBTp and FIT) went live as intended, and others were delayed , in part due to the COVID19 pandemic. In Summer 2020, between pandemic waves 1 and 2, we conducted a thorough mixed methods implementation evaluation focusing on CBTp and FIT.



Mixed Methods

A convergent mixed methods design allowed for a greater understanding of the implementation process and development of recommendations. Quantitative data was collected on 307 patients. Qualitative data was collected from 22 semi-structured interviews with diverse staff members and 16 structured interviews with patients. Quantitative and qualitative data was analyzed drawing from the RE-AIM and CFIR frameworks.



PROJECT OBJECTIVE

To evaluate the reach, adoption and implementation of the quality improvement initiative, and explore implementation facilitators and barriers. Drawing upon the RE-AIM framework and the Consolidated Framework for Implementation Research (CFIR), we investigated :

i. Reach – of the interventions to the patient population
ii. Adoption – by the organization, clinical programs and staff
iii. Implementation – fidelity to implementation plan, and adaptations made during delivery

RESULTS

Champions

"Most of the patients have a serious mental illness and or a very psychotic illness in nature, so certainly I was really glad that I ended up with two [trained] clinicians on the unit"

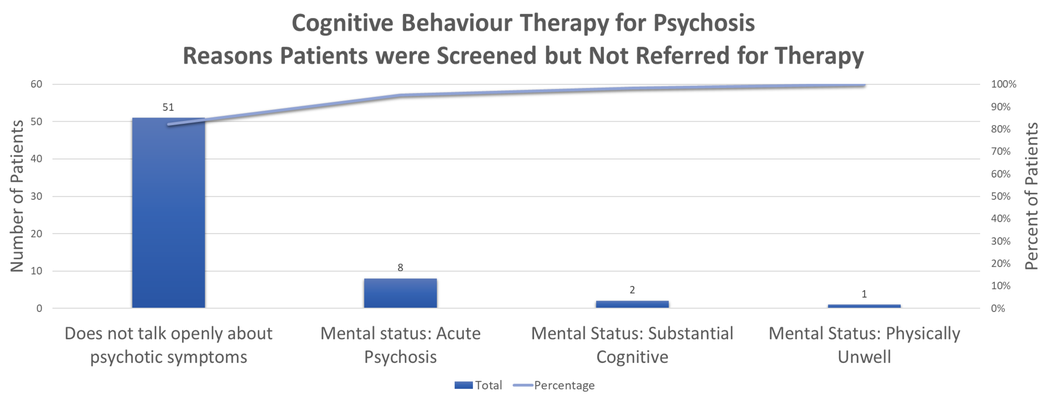
Key Stakeholders

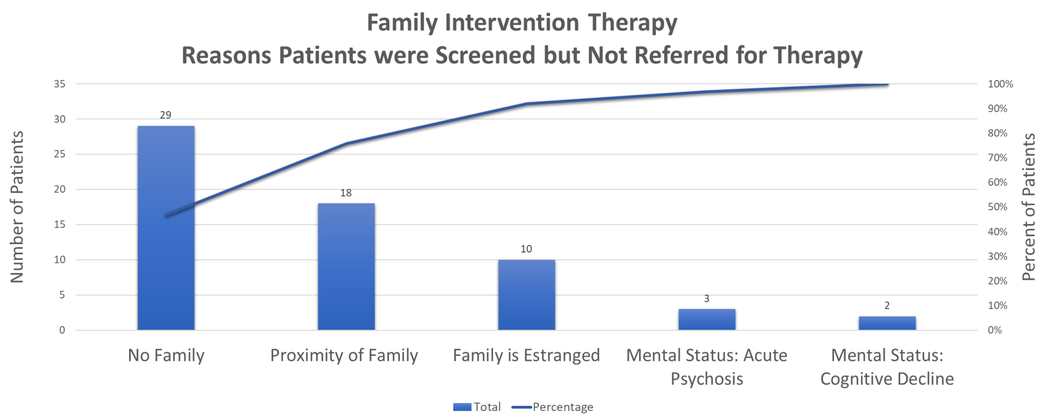
"[Not being included in trainings to deliver new therapies] it feels like they're taking away the social worker and we are just becoming administrative… The good and fun part [referring to working with patients] we aren't able to do."

Adaptability

"It is a huge catchment area. When it was first implemented, we didn't look at [virtual care] as a primary model of delivery, the Covid-19 virus was kind of interesting , because maybe there is something [more, with virtual care,] that we can do"

Pareto Charts





DISCUSSION

I. Reach

The reach of the initiative to patients and families had several barriers. The screening tool that was used requires modification to better reflect eligibility criteria. Patients were also not re-engaged and educated regularly, which is needed to overcome distrust whereby patients with schizophrenia were not forthcoming with their symptoms. Finally, the omission of virtual care proved a barrier for patients and families who reside geographically distant from the hospital.

II. Adoption

Adoption of the initiative has been stronger on the clinical programs that were assigned trained clinician champions. Communication and stakeholder engagement is also needed with other staff who were not specifically trained to deliver the therapies. Despite initial plans, data were not routinely shared with clinical programs, reducing 'ownership' over the initiative.

III. Implementation

Communications require augmentation through increasing both frequency and modes used. Earlier and more fulsome inclusion of patients and families in planning could have anticipated some of the barriers. Finally, while the pandemic introduced competing priorities and forced adaptations in care delivery, it has likely heightened the urgent need for these services and presented opportunities to rapidly advance the adoption of virtual care.

CONCLUSIONS AND FUTURE DIRECTIONS

Data focus: This evaluation benefited from easy access to quantitative data. This same data needs to be 'owned' by program leaders and staff to allow for frequent monitoring and local Plan-Do-Study-Act (PDSA) cycles to optimize reach.

Iterative communication and engagement: Patients have identified the need for multiple conversations, as well as written materials, about options for care.

Increasing accessibility with telemedicine: The COVID19 pandemic has catalyzed a rapid shift towards virtual care. Patients and families who access Waypoint's services span a large geographical catchment, and virtual care can help overcome transportation and financial barriers provided equity and infrastructure issues are addressed.

REFERENCES

1. Center for Clinical Management Research. Consolidated framework for implementation research. Ann Arbor: Center for Clinical Management Research; 2014. Available from: http://cfirguide.org/. Accessed 12 August 2020
2. Health Quality Ontario. Schizophrenia Care for Adults in Hospitals. Toronto: Queen's Printer for Ontario; 2016 p. 21-30.
3. Holtrop, J. S., Rabin, B. A., & Glasgow, R. E. (2018). Qualitative approaches to use of the RE-AIM framework: rationale and methods. BMC health services research, 18(1), 177.