Building a system to support quality care

Current capacity for monitoring and quality improvement in Ontario Early Psychosis Intervention Programs

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EPION
EARLY PSYCHOSIS INTERVENTION ONTARIO NETWORK

camh
mental health is health

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MAIN MESSAGES

- Using data to monitor care and inform quality improvement (QI) is key to supporting delivery of high quality care across the community mental health and addiction system.
- We surveyed Ontario early psychosis intervention (EPI) programs to assess current capacity to use data for monitoring and improvement and to understand what supports are needed.
- We received feedback from 25 programs, about 50% of Ontario EPI programs.
- Programs reported modest capacity for collecting and using data, with just under half regularly using data for monitoring and QI. Accessing, analyzing and reporting data were common challenges and the majority of programs (60%) said they require more support to do this work.
- Few programs conduct formal QI projects. While many would like more support for QI, they preferred supports that can be accessed as needed (e.g., best practice resources, self-learning) rather than more formal intensive training programs. About half of programs were interested in QI and data coaching.
- In the last few years, the EPI sector has developed expertise and experience in conducting fidelity assessments. Programs find the fidelity assessments valuable to identify strengths and opportunities for improvement, but need more support to conduct follow up QI work.
- There is no common outcome monitoring in the EPI sector at present. We asked about capacity to report 12 measures recommended by an international EPI task group. For most measures, the majority of programs are collecting the required data but only a small proportion have the capacity to report these data. There are, however, five measures most programs can currently report. This may be an opportunity for beginning efforts towards common reporting.
- To move the dial on monitoring and improvement work, programs need to be equipped with the skills and resources to both collect and use data to inform patient care, quality improvement and program planning. This requires dedicated resources and processes, with a multiyear commitment. Specific recommendations include:
    - Expand program and central support to conduct and use fidelity assessments. The sector has developed considerable expertise in fidelity assessments but dedicated ongoing support is needed for sector-wide implementation and to support follow up QI.

- Develop and implement a common minimum dataset for outcome measurement. Development should build on learnings from other jurisdictions with robust EPI outcome monitoring systems (e.g., New York State and Oregon), be informed by the priorities of Ontario EPI programs, and align with the work of the Ontario Mental Health and Addictions Centre of Excellence.
- Secure funding for data collection infrastructure including: implementation support (e.g., engagement, training, site preparation, and coaching) so that programs are equipped to effectively collect and use the data; a common platform/strategy for data collection and reporting; and central capacity to aggregate and share results for sector learning and improvement.

BACKGROUND

Early Psychosis Intervention (EPI) is an evidence-based practice for supporting youth at early stages of psychosis. There are about 50 EPI programs in Ontario and most belong to the Early Psychosis Intervention Ontario Network (EPION). EPION is a province-wide network of EPI service providers, clients and persons with lived experience, and families, with a mandate to support delivery of high-quality care for young people with early psychosis.

In 2011, the Ontario Ministry of Health and Long-Term Care released program standards for EPI programs. [1] Routine collection of data is foundational to understanding program adherence to the standards and improving the quality of care. However, feedback from EPI programs collected by EPION, including a sector-wide key informant survey (2015)[2] and extensive program consultations (2016),[3] have indicated that Ontario EPI programs find collecting and using data for monitoring and improvement work difficult. These challenges are not unique to EPI programs, but have been identified across the community mental health and addiction sector.[4, 5] In 2016, as an initial step to address this gap, EPION started offering programs in-depth fidelity assessments.[6–8]

Fidelity assessments are an opportunity for external assessors to review how program practice aligns with the EPI model of care and to provide quality improvement (QI) recommendations. Seventeen programs have received fidelity assessments to date, with another cohort of assessments currently underway. While initial program feedback on the value of fidelity assessments has been positive, anecdotally programs report that using fidelity results for QI is challenging.

The Ontario health care system is in a period of transformation. Moving forward, it is likely there will be increasing expectations for routine monitoring and QI in the community mental health and addiction system. The Ontario Ministry of Health recently released the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*.[9] This plan includes the development and implementation of "provincial data standards across child, youth and adult community mental health services so system quality and performance can start to be measured in a reliable and consistent way."

In anticipation of changing provincial expectations, and in alignment with EPION's mandate to promote quality care, EPION and the Centre for Addiction and Mental Health (CAMH) partnered on a sector-wide key informant survey. This survey gathered program feedback on current capacity for collecting and using data for monitoring and QI, perceived value and use of the

fidelity assessments, and capacity to report a selected set of performance indicators recommended by the International Early Psychosis Association (IEPA).[10]

This report presents survey findings and recommendations for next steps for the sector. Building program capacity for data collection, monitoring and QI is important, not only to meet future accountability requirements but also to ensure high quality care for EPI clients.

APPROACH

Survey development

A team of researchers and EPI program stakeholders developed and piloted the survey with a small group of EPI staff for relevance, clarity and feasibility of completion. Items were based on a QI readiness assessment developed by the Ontario Excellence through Quality Improvement Project (E-QIP)[11] and a California survey of data collection practices in state EPI programs.[12] Additional items were added on perceived relevance and use of fidelity assessment data for EPI programs that received a review, and on program capacity to report performance measures recommended by IEPA.[10] The final survey included 38 items that addressed the following domains:

- program characteristics
- overall capacity to collect and use data for QI
- measurement and monitoring practices
- implementation of structured QI work
- ability to report performance measures (related to service delivery, use, impact)
- value/use of fidelity assessments.

The survey items were assessed with a “yes-no” response or on a Likert scale. There were also options for open-text responses.

Participants

All 50 EPI programs in Ontario were invited to participate in the online survey between February and June 2020. This extended completion period was due to the COVID-19 pandemic. Each program was asked to designate one person responsible for completing the survey on behalf of the program, with input from others as needed.

Twenty-five programs completed the survey (50%). These programs ranged in size and location across the province. Program clinical full time equivalent (FTE) staff size ranged from less than one to over 20 and currently registered clients ranged from five to over 500.

RESULTS

Capacity to collect and use data for practice improvement

Of the 25 programs that responded to the survey, more than half (52%) reported that they are not at all or somewhat using data to monitor practice and conduct improvement projects (***see figure 1***). A third reported using data a fair amount, and 16% reported they use data a great deal.

Additionally, 60% of programs said they require more support to do this work.

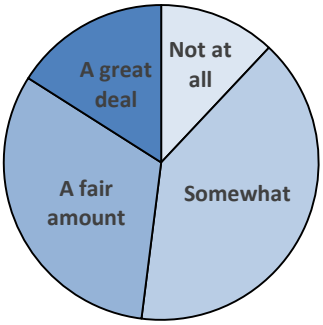


Figure 1: Extent currently using data for monitoring

We asked programs to indicate challenges collecting and using data. Programs reported the following tasks as barriers "a fair amount" or "a great deal":

- entering data into electronic records (32% of programs)
- extracting data from electronic records (36% of programs)
- analyzing the data and tracking indicators over time (44% of programs)
- interpreting/using data for improvement work (40% programs).

Sixty percent of programs maintain both paper and electronic client records, which may add additional complexity to using the data.

Text comments further explained these challenges.

> *We have capabilities to collect data using our documentation software, but the EPI programs do not have anyone trained on how to extract the data or run reports.*
>
> *Don't have the IT capacity to collect data, don't have fully electronic records*.
>
> *[Our organization] does not have adequate IT and decisions support system resources to build required measures … The mental health program has 1.0 FTE manager and 1.0 FTE Clinical Practice Leader to oversee 8 programs, thus limiting the degree of support available for enhanced quality measurement.*

Collection of standardized measures

We asked programs about the measures that they currently collect. A number reported collecting standardized provincial measures, most commonly the Ontario Perception of Care (OPOC; 56%) and the Ontario Common Assessment of Need (OCAN; 52%). Fewer are collecting the Global Appraisal of Individual Needs - Short Screener (GAIN-SS; 40%) and the interRAI (12%).

Programs also reported collecting a host of other standardized symptom and functioning scales,[i] but there was substantial variation across programs.

We delved further into program experiences with the OCAN. Of the 13 programs who use the OCAN, almost all (12 programs) collect it often or always at program entry, and most (10

[i] These included: the Personal and Social Performance Scale (PSP); Brief Cognitive Assessment Tool (B-CATS); Quality of Life Enjoyment Satisfaction Questionnaire (Q-LES-Q); Birchwood Social Functioning Scale; WHO Disability Assessment Schedule (WHODAS); Clinical Global Impression Improvement Scale (CGI-I); Clinical Global Impression Severity Scale (CGI-S); Brief Psychiatric Rating Scale (BPRS); Abnormal Involuntary Movement Scale (AIMS); Young Mania Rating Scale (YMRS); Quick Inventory of Depressive Symptoms (QIDS).

programs) also collect it every six months and at discharge. Slightly over half (7 programs) often or always upload completed OCANs to the Integrated Assessment Record (IAR).

When OCANs are uploaded to the IAR, they can support client care by providing a shared record across the client's circle of care, as well as supporting sector and system planning. However, we know from our prior work with EPI programs[2] that rates of OCAN collection are higher than uploads.

Respondents to this survey reported a number of challenges to uploading, including:

- lack of client consent (11/13 programs)
- staff buy-in (9/13 programs)
- not a program priority (5/13 programs)
- IT challenges linking to IAR (4/13 programs)
- time to upload (4/13 programs)
- collecting the OCAN on paper (3/13 programs)
- staff training (2/13 programs).

About a quarter of the 25 surveyed programs were interested in receiving support to collect and use the OCAN (28%), the OPOC (28%) and the GAIN-SS (24%).

Most of the surveyed programs (76%) collect client OHIP numbers. This creates a potential for linkage to other databases which could facilitate expanded learning about EPI program use and impact. At ICES, for example, through linkage we could learn about EPI client use of other system services prior to, during and after discharge (e.g., primary care and hospital services). At the system level, we could learn who is/is not accessing EPI services (socio-demographics) and service use patterns of those using/not using EPI services.

Quality improvement

Ten of the 25 programs that completed the survey reported they had conducted a structured QI project in the past two years.

Quality improvement (QI) is defined here as a systematic approach to improving quality and outcomes of care that includes identifying a quality issue, implementing a change and assessing if the change was successful. Measurement is a cornerstone of improvement work.

Examples of QI projects shared by programs included:

- use of the OPOC baseline assessments to monitor practice changes planned in follow-up to a fidelity assessment
- development of a care pathway and care plan document for clients
- implementation of a clinical dashboard to inform care discussions
- new method of charting using an "interactive view", which includes tick boxes and narrative to track intervention implementation.

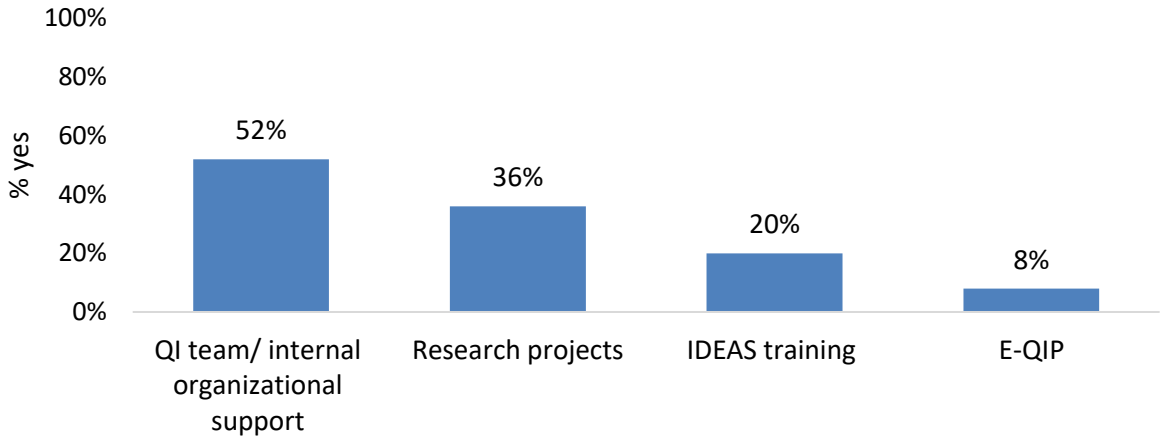
Value of QI projects

- Seven of 10 programs reported their QI projects **improved practice** a fair amount or great deal.
- Seven of 10 programs reported their QI projects were **feasible** to conduct a fair amount or great deal.
- 40% of all programs reported they were **required** to conduct QI in their program.

Support for QI

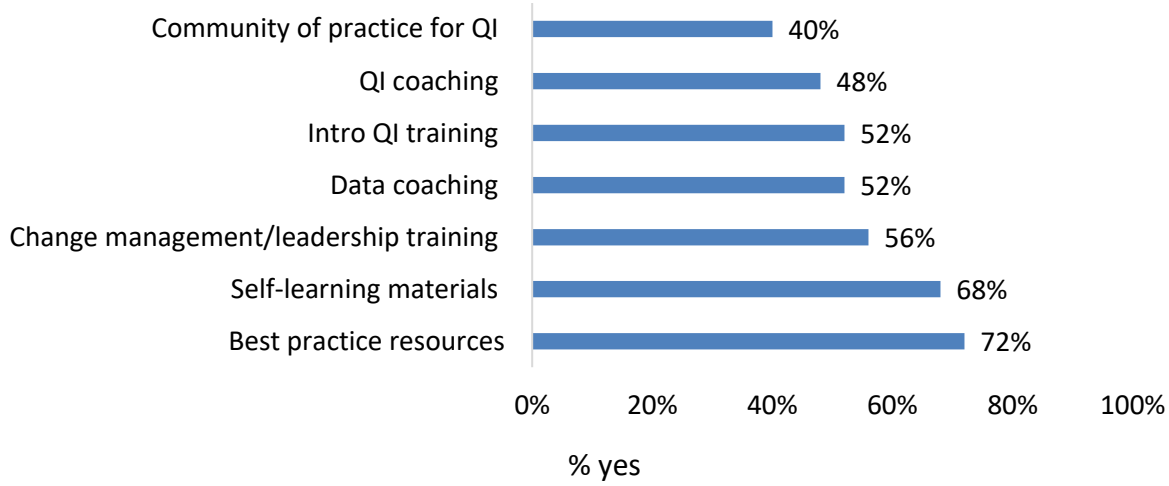
We asked programs about supports that they have received to conduct QI. Of the 25 programs in the survey, about half have received support from their own organization and one third have received support through participation in a research project (***see figure 2***). Fewer have received support through formal training such as the IDEAS program or E-QIP.

Figure 2: Current sources of QI support (n=25)



Many of the 25 programs, however, showed interest in receiving future support to conduct QI if available (***see figure 3***). Programs were most interested in were resources and training. Fewer programs were interested in intensive resources such as coaching and a community of practice.

Figure 3: Interest in future support for QI (n=25)



> *Our program has knowledge to develop and implement, though lacks the resources to develop and sustain new initiatives.*

Performance measurement

The International Early Psychosis Association (IEPA) recently proposed a set of performance measures to monitor quality of EPI care.[10] Common reporting of performance measures could be used by the sector to show current performance and to identify service gaps and needed supports to improve the quality of client care. We asked programs whether they would be able to report these measures. With the exception of "duration of untreated psychosis", most programs were collecting these data. However, fewer could report them (***see table 1***). We did not ask programs to rate the value of these specific measures for program management or evaluation and we did ask programs what else they would be interested in measuring.

Table 1: Current collection of performance measures

Performance measure	% of programs (n=25)			
	Able to report	**Collect, not able to report**	**Not collecting**	**Don't know**
Domain: Early intervention				
Wait time from referral to first appointment	88	8	4	0
Duration of untreated psychosis	24	16	52	8
Client hospitalizations before referral to EPI	64	20	12	4
Domain: Patient outcome				
Client length of stay in program	84	12	0	4
Antipsychotic medication doses	64	20	12	4
Admissions to hospital while in program	76	20	0	4
Client participation in education	44	24	20	12
Client participation in employment	44	28	20	8
Domain: Health and safety				
Client assessed for tardive dyskinesia	44	32	16	8
Client BMI	48	20	24	8
Suicide attempts	24	52	12	12
Annual metabolic parameters	56	28	8	8

* Items that more than 60% programs are currently able to report are in green.

Fidelity review

Since 2016, EPION has conducted fidelity assessments in 17 Ontario EPI programs. Fidelity assessments offer a systematic process for identifying program delivery practices, strengths and challenges in relation to the EPI program standards. We asked programs about the value of the assessments and whether the feedback motivated or contributed to follow-up practice changes. Eight of the programs who responded to the survey had received fidelity assessments and answered this part of the survey.

Overall, the programs were positive about the relevance and value of the assessments (***see table 2***). They reported using the feedback to demonstrate program accomplishments (6 programs), inform QI (5 programs), and for advocacy (4 programs). All of the programs shared the fidelity results with their teams and most also shared the results with their funders. All were interested in a follow-up assessment in the future.

Table 2: Value of fidelity assessments

The fidelity assessment….	**# reporting fair amount/great deal***
Was an accurate reflection of your practice	8
Identified your program strengths	7
Identified areas for improvement	7
Focused on important areas of practice/ measured the right things	7
Provided useful ideas for practice change	6

* out of 8 programs who received assessments.

> *Fidelity monitoring is such a valuable initiative—keep it going ... and support the clinics in developing QI projects and then even see if there are provincial themes that can be worked on.*

However, programs expressed a need for more support for conducting follow-up QI work based on fidelity feedback. The main challenges identified by programs included insufficient time and dedicated resources to support QI work. The programs indicated interest in using the following supports if they were available:

- having a QI coach to help programs implement recommendations (7 of 8 programs)
- regular follow up with programs to ensure report is being used (6 of 8 programs)

- community of practice with other programs that received a fidelity assessment (6 of 8 programs)

> *I think the idea of having a coach who would help the manager/lead and even staff identify a QI project and then help to break it down into steps and help with implementation and evaluation—this would ensure that the info from the fidelity assessment would actually be used and there would be follow through. I think (or at least for our clinic) these kinds of things get pushed to the side as there are many other demands and balls to keep up in the air—so having someone else's brain to help with this practical piece would be great.*
>
> *[It would help to provide] follow up with the team that was assessed at specific intervals to get an understanding of the progress that is being made, or if the report is on the shelf collecting dust.*

One program also identified the importance of reporting aggregated fidelity results to support shared learning and allow programs to see how their practice compares to other program experiences.

> *We have used our fidelity report and standards extensively to advocate within our organization recently. It would be useful to have more explicit comparative info with other EPI programs in Ontario e.g., what are psychiatry FTE per patient ratio in other EPI programs? How did our program compare on specific domains in the fidelity assessment to other EPI programs? What is the staff to patient ratio in other EPI programs?*

Future fidelity reviews

- Of the eight programs who <u>have</u> received an assessment, all would like to receive another fidelity assessment in the future.
- Of the 17 programs who <u>have not</u> received an assessment, four were interested and three were not interested in receiving an assessment in the future. Ten were unsure.

SUMMARY OF FINDINGS

Using data to monitor care and inform QI is key to supporting delivery of high quality care across the system and is a priority for the Ontario government. We know, however, that monitoring care is often a challenge in the community mental health and addiction sector. The aim of this survey was to better understand EPI program data management strengths and challenges and to identify what kind of support is needed. Feedback was obtained from 25 programs, about 50% of Ontario EPI programs. The results in this report may not be fully representative of the sector, but they align with prior sector feedback[2, 3] and with other reports of capacity across the community mental health and addiction system.[4]

Programs reported modest capacity for collecting and using data, with just under half regularly using data for monitoring and QI. Accessing, analyzing and reporting data were common challenges and the majority of programs (60%) said they require more support to do this work.

Few programs conduct formal QI projects. While many would like more support for QI, they preferred supports that can be accessed as needed (e.g., best practice resources, self-learning) rather than more formal intensive training programs. That said, about half of programs were interested in QI and data coaching.

Building common data sources is one way to advance sector monitoring and improvement work. Fidelity assessments using a standardized fidelity scale provide one common source and in the last few years EPION has developed expertise and experience in conducting fidelity assessments. These provide feedback for program improvement and support shared learning across programs.

There is no common outcome monitoring in the EPI sector at present, though there has been some discussion about what would be meaningful to collect and what a minimum dataset of outcomes might include. We looked at standardized provincial measures in use across programs. The most commonly used tools were the OPOC and the OCAN, in use at just over half of programs in this survey. However, completion of the OCAN does not consistently follow the expected protocol (every six months) and programs reported numerous barriers to uploading OCAN data to a central repository for treatment planning and for system use. We also asked programs about their capacity to report 12 measures recommended by a task group from the IEPA.[10] For most measures, the majority of programs are collecting the required data but a smaller proportion have the capacity to report these data. Despite this trend, there are five measures that can currently be reported by most programs (over 64%): wait time from referral

to first appointment, hospitalizations before referral, length of stay, antipsychotic medication dosage, and hospital admission. These five measures, along with the fidelity assessments, could be a starting point for sector performance measurement.

NEXT STEPS AND RECOMMENDATIONS

If we want to move the dial on monitoring and improvement work, we need to build sector capacity to collect and use data. While many programs are collecting data, fewer currently have the capacity to use these data for monitoring or QI and use of common measurement tools is variable. Ontario EPI programs increasingly recognize the value of data to support quality care and many programs want to engage in this work if supported.

In order to ensure young people in their first episode of psychosis receive high quality care, Ontario EPI programs need to be equipped with the skills and resources to both collect and use data to inform patient care, quality improvement and program planning. To advance this aim we recommend the following:

- Expand program and central support to conduct and use fidelity assessments. The sector has developed considerable expertise in fidelity assessments but dedicated ongoing support is needed for sector-wide implementation and to support follow up QI.
- Develop and implement a common minimum dataset for outcome measurement. Development should build on learnings from other jurisdictions with robust EPI outcome monitoring systems (e.g., New York State and Oregon), be informed by the priorities of Ontario EPI programs, and align with the work of the Ontario Mental Health and Addictions Centre of Excellence.
- Secure funding for data collection infrastructure including: implementation support (e.g., engagement, training, site preparation and coaching) so that programs are equipped to effectively collect and use the data; a common platform/strategy for data collection and reporting; and central capacity to aggregate and share results for sector learning and improvement.

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