BRITISH COLUMBIA
CENTRE *for* EXCELLENCE
in HIV/AIDS

Treatment
Optimization of
Psychosis Collaborative

Vancouver
CoastalHealth

Preparation Resource Manual

The Preparation Resource Manual contains activities and tips to help your team prepare for successful participation in the Treatment Optimization of Psychosis Collaborative.

JUNE 2021

LAND ACKNOWLEDGEMENTS

We acknowledge we work on the traditional, ancestral and unceded territory of the Coast Salish peoples–Sḵwx̱wú7mesh (Squamish), Stó:lō and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) and xʷməθkʷəy̓əm (Musqueam) Nation

The TOP Collaborative is supported by:

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Welcome to the Treatment Optimization of Psychosis Collaborative!

We embrace you as leaders in actively advancing healthcare quality improvement across Vancouver! If this is your first experience in a Structured Learning Collaborative ('Collaborative'), you are likely to feel confused. If you don't even know what a Collaborative is, no problem; confusion is normal and this manual will help clarify things.

In the pages that follow, you will find a number of activities and tips that will help you and your team prepare for meaningful participation in the Treatment Optimization of Psychosis (TOP) Collaborative. From tips on team formation, planning for quality improvement (QI) measurement and ideas for connecting with senior leaders, you should find a variety of resources that will serve you well along the way. In particular, a checklist of activities will help your team get up and running, and supplementary materials shed more light on the varied events, activities, methods, and models that are used in the Collaborative.

If at any time you are stuck with questions or in need of assistance, please connect with one of the Collaborative leaders. We can be your first point of contact and are committed to helping your team find value and success in the Collaborative.

All the best in your improvement journey and don't forget that we are here to help!

Best regards,

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OVERVIEW

The TOP Collaborative is a quality improvement (QI) initiative led by the BC Centre for Excellence in HIV/AIDS (BC-CfE) in partnership with Vancouver Coastal Health (VCH) Mental Health Services.

Rooted in the experiences and accomplishments of the Treatment as Prevention Strategy (TasP), the BC-CfE has demonstrated capacity for quality improvement (QI) and created a legacy of health system improvement in BC through programs such as the Seek and Treat for Optimal Prevention (STOP) HIV/AIDS Program and the Best-Practices in Oral Opioid Agonist Therapy (BOOST) Collaborative.

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1 The Continuum of Psychosis Care refers to the comprehensive and connected array of health services spanning all levels of intensity of care within the community and health system.

2 For more information on *Structured Learning Collaborative* methodology, refer to: Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

Through strong partnerships with VCH in delivering these programs, clients in Vancouver and beyond have experienced positive change both in the care delivery they receive and in their health outcomes.

The TOP Collaborative will follow the same approach utilizing the Institute for Healthcare Improvement Breakthrough Series Collaborative methodology to support the implementation of TOP by shifting initiation from hospital to community settings and by building capacity at each community mental health team in the Vancouver Coastal region.

The approach is organized by a series of milestone events and deliverables outlined below with monthly reporting on metrics (both quantitative and qualitative). Measurement reporting will be reviewed and analyzed by the Project Team and Collaborative Faculty. Learnings from changes developed during the collaborative will be spread and expanded from participating team members to their colleagues at each site.

LET'S BEGIN

This manual focuses on preparing you and your team for participation in the TOP Collaborative. Below you will find a checklist of activities to prepare for successful participation in the Collaborative and a variety of reference materials that will serve you well in your journey. Let's begin!

PREPARATION CHECKLIST

- ☐ Understand Collaborative models, events, and activities
- ☐ Create your improvement team
- ☐ Create a plan for client engagement
- ☐ Develop your team's aim statement
- ☐ Define your population of focus (POF)
- ☐ Review measurement strategy

Note: We have sequenced these tasks in a way we believe to be logical; however, we encourage you to read through the whole manual first and complete the tasks in an order that makes sense to you. You may find you have to jump back and forth on some tasks.

UNDERSTAND COLLABORATIVE MODELS, EVENTS, AND ACTIVITIES

A Structured Learning Collaborative[1] is defined as a "short term (6 to 18 months) learning system that brings together a large number of teams to seek improvement in a focused topic area"[2]. The learning system includes a number of events, activities, and models that facilitate effective change. Here is a high-level overview of the models that you will learn about and the events/activities in which your team will participate during the TOP Collaborative

INTRODUCTION TO THE COLLABORATIVE MODELS

THE MODEL FOR IMPROVEMENT

The Model for Improvement[3], is a simple, well-known model for accelerating change and improvement. As participants in the TOP Collaborative, you will learn about this model and begin to use it to create improvement in your own settings.

Central to the model are three key questions: (1) What are we trying to accomplish? (aim); (2) How will we know that a change is an improvement? (measures); and (3) What changes can we make that will lead to an improvement? (changes). These questions elicit responses to create aims, measures, and a list of changes. The next step in the model is to take a change and test it on a small scale. The model describes a systematic, iterative approach to: plan the change (plan), carry out the plan (do), observe and reflect on the test (study), and then decide if you would like to implement the change, improve upon it, or abandon it altogether (act). This is the PDSA cycle.

* See Reference 1: The Model For Improvement

[1] For more information on Structured Learning Collaborative methodology, refer to: Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

[2] The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

[3] Developed by the Associates in Process Improvement. Description available in: Langley J, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey-Bass, 2009.

THE EXPANDED CHRONIC CARE MODEL (EXPANDED CCM)[4]

The province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model builds on the CCM, an evidence-based model for chronic disease management, to incorporate concepts and strategies from population health promotion .

The model lists the essential elements within and across health systems and the community that contribute to better health outcomes for populations. These elements include: self-management / develop personal skills, delivery system design / re-orient health services, decision support, information systems, build healthy public policy, create supportive environments, and strengthen community action.

*See Reference 2: The Expanded Chronic Care Model

KEY ELEMENTS OF BREAKTHROUGH IMPROVEMENT

The Institute for Healthcare Improvement (IHI) uses a simple mantra to describe the essential elements for strategic improvement: Will, Ideas, and Execution. You have to have the will to improve; you have to have ideas about alternatives to the status quo; and then you have to make it real through execution.

* See Reference 3: Key Elements of Breakthrough Improvement

INTRODUCTION TO COLLABORATIVE EVENTS, ACTIVITIES, AND STRUCTURES

TOP COLLABORATIVE TIMELINE

[4] Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Revensdale (2002). Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). "Does the Chrosnic Care Model also serve as a template for Improving Prevention?" The Milbank Quarterly, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion. Available at: http://www.longwoods.com/content/16763

PREP WEBINAR — JUNE 15, 2021

The Preparation Webinar will be a 60-minute focused webinar. The webinar will introduce teams to quality improvement and define its key elements, describe Structured Learning Collaborative Methodology, and present the overall aim of the TOP Collaborative and some of the key metrics teams will be reporting.

TOP COLLABORATIVE LAUNCH — JUNE 23, 2021

The Launch is a full-day orientation to the improvement initiative ahead. Teams will be introduced to the Collaborative aims and expectations for participation. Teams will become familiar with the change ideas, measurement and reporting structure. There will be an opportunity for teams to refine their own team-specific aims and develop actionable plans for tests of change. The Launch is scheduled for June 23, 2021 and will mark the beginning of the Collaborative.

PREPARATION PHASE — JUNE 23, 2021 TO SEPTEMBER 21, 2021

The preparation phase is the time when sites formalize their improvement team, refine their aim statement, begin looking for data sources, and understand the events and activities ahead. This manual focuses on preparation.

EDUCATIONAL WEBINARS — JULY 20, 2021; OCTOBER 19, 2021; JANUARY 18, 2022; APRIL 5, 2022

Educational Webinars are hour long virtual events focused on additional Collaborative content not covered during the learning sessions and/or a continuation of discussions from topics covered at learning sessions.

LEARNING SESSIONS

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving schizophrenia/schizoaffective disorder care, services, and outcomes. There are three Learning Sessions in the TOP Collaborative.

ACTION PERIODS

Action Periods occur between Learning Sessions. During these times, team members have returned to their clinical settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

CLOSING CONGRESS – MAY 24, 2022

The Closing Congress is similar to Learning Sessions, though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the course of the Collaborative. The Closing Congress formally marks the end of the initiative.

COLLABORATIVE WEBSITE

The Collaborative website hosts a calendar of events and resource pages. Please use this space to find team resources, recordings of webinars, and information on events. The website is available at https://topcollaborative.ca

CREATE YOUR IMPROVEMENT TEAM

Almost all healthcare organizations today have multiple improvement teams involved in the design and redesign of processes affecting health system performance and outcomes. An improvement team typically consists of three to seven individuals with expertise in the team's area of focus.

Improvement team membership should be multidisciplinary, including process experts, technical experts, clients, and others whose roles will likely be affected by the improvement work. Usually the team leader will be a manager or lead clinician in the area(s) of the organization affected by the team's work

BUILDING THE TEAM

What should our team look like? Who should be on our team?

These are common early questions and exactly the right questions because getting the right team is critical for change and improvement. Team selection is both an art and a science. While we provide some thoughts on both, your expertise of local factors will be critical to building an effective team.

Think about the purpose: The purpose of the TOP Collaborative is to:

1) Improve the quality of care provided for our clients with schizophrenia/schizoaffective disorder, and

2) Build QI capability

Consider the following questions when reflecting on prospective members to advance this purpose:

- What is our current population?
- Who does our service reach?
- What gaps can you identify when it comes to the quality of care for your clients with schizophrenia/schizoaffective disorder (e.g. adherence, clozapine education etc.)?
- Who in our organization is currently involved in these processes along the care delivery for clients living with psychosis?
- Who should be involved in these processes to close gaps and ensure excellence (think about both inside and outside your organization)?
- Who might help us with the process of change and improvement?

Think about prospective members' characteristics: Select each prospective member for their process knowledge, enthusiasm for change, ability to engage peers, and ability to work effectively on a team. Good team members are often respected in their peer groups and adept at listening and communicating effectively.

Think about diversity of membership: Team effectiveness literature shows member diversity can increase creativity and ability to challenge assumptions; however, too much can lead to conflict. Consider a balance of professional backgrounds, job functions, gender, perspectives, culture, age, etc.

Think about team size: In general, teams tend to be more effective when they have between three and eight members. Too many members can increase the complexity of relationships and communication while too few can lead to higher workloads and fewer ideas and perspectives.

Think about key roles: To increase team effectiveness, your team should fill the following key roles (note these roles are not mutually exclusive; one member may align with more than one characteristic):

KEY FUNCTION	CHARACTERISTICS AND ROLE	COMMITMENT
Senior Leader/ Team Sponsor	The senior leader has authority to allocate team time and resources, and should have administrative authority over areas that may be affected by changes. This individual should be a champion and is responsible for spreading changes.	Should attend the Launch, Closing Congress and other learning events at their discretion. Encouraged to also attend periodic team meetings.
Team Leader	The team leader provides day-to-day leadership, coordination and communication between team members, Collaborative staff, and senior leaders. The team leader should be respected, knowledgeable, and enthusiastic about change.	Should attend all Collaborative events and activities and all team meetings.
Senior Clinical Champion	Look for senior clinical personnel sought out for their advice, who work well with others, and who are not afraid to test change.	Should attend all Collaborative events and activities and all team meetings.
Process Expert	Look for those who know the care processes and subject matter intimately. These individuals may include front office, information systems, lab, medical records, nursing, outreach pharmacy, physicians, and/or quality personnel.	Should attend all Collaborative events and activities and all team meetings.
Person Living With Schizo-phrenia/ Schizoaffective Disorder or Family Member of a Person Living With Schizophrenia/ Schizoaffective Disorder	It is recommended that every team support one to two clients to participate on their improvement team. People living with schizophrenia/ schizoaffective disorder have intimate knowledge and can help the team to surface assumptions, focus on purpose, and identify practical changes for delivering needs-based care and services.	People living with schizophrenia/ schizoaffective disorder are encouraged to attend all Learning Sessions, one team meeting every two weeks and attend monthly webinars.
Quality Improvement Coach	The QI coach provides change and qi expertise, guidance, and coaching to support team formation, aims definition, measurement for improvement, testing changes, implementing changes, and sustaining performance improvements. The coach should expect to attend regular team meetings in early months with the aim of building team capacity and autonomy in improvement and change.	Should attend all Collaborative events and activities and all team meetings when possible, at minimum, once a month.

ENSURE ALL MEMBERS ARE VALUED FOR THEIR CONTRIBUTIONS

To get the best out of your team, use best practices for team development and team process. While it is the team leader who oversees and ensures proper team development and team process, all members should do their part to contribute to an effective team.

KEEP LANGUAGE CLEAR AND SIMPLE

This is an important, though surprisingly challenging principle to follow. All members should strive to avoid using acronyms and jargon. Everyone can help out with gentle reminders and by asking fellow teammates to explain further when needed.

DIVIDE AND CONQUER

Ultimately, the team leader is responsible for coordinating meetings, taking care of administrative details, orchestrating team activities, overseeing outputs, documenting the project, meeting timelines, and acting as a liaison between the team and the organization. However, effective leadership isn't about doing everything; rather it is about drawing on the strengths of all members and sharing the load. All members should make a priority effort to assist when needed and complete tasks in a timely fashion.

ADHERE TO BEST PRACTICES FOR RUNNING EFFECTIVE MEETINGS

To respect the time of all members and to get the most out of your meetings, we suggest that you start and end meetings on time, use and adhere to agenda, take minutes, and rotate the responsibilities for facilitating, agenda setting, and minute taking. Evaluate the effectiveness of each meeting e.g., did everyone feel heard? Did we accomplish our objectives? Etc.

All members should make a priority effort to attend all meetings, be on time, and communicate effectively. The team leader should lead a conversation on member expectations. Members should be involved in the discussion, understand expectations, and agree on remedies for members not meeting expectations.

STEP 1: PRE-MEETING PREPARATION

Pre-meeting preparation is about knowing the context of the improvement team's project and communicating expectations of the update meeting to the team.

To prepare for the update meeting, sponsors should request the monthly data and narrative reports developed by teams and submitted to collaborative staff. Sponsors should be ready to remind the team why the project is important and how it fits into overall organizational goals. For example, an organizational goal might be to embed guidelines-based care into daily practice. One aim of the collaborative improvement team is to improve care and services using evidence-based decision supports (e.g., guidelines of care, flow sheets, etc.).

Sponsors and team leaders must establish a clear meeting structure that includes a high-level agenda and clear expectations (no big presentations, review aims, measures, results, prognosis, and ideas for next cycles of improvement).

STEP 2: THE MEETING ITSELF

Sponsors can contribute to effective team update meetings by starting with clarification of the aims (e.g., what, exactly, are you trying to accomplish with this project?). Look for clear aims that are set at or above the level of best practice. Subsequently, ask about the measures (e.g., please summarize for me the measures you're tracking to know whether you're moving towards your aim). Most teams will be tracking those measures required by the collaborative and will have adopted the collaborative suggested targets

STEP 3: MEETING FOLLOW-UP

Set a reminder to call or email the team leader in a week, and periodically thereafter, requesting results of tests of change. By doing so, your "attention" to the team will extend over a much longer time period, reinforce the importance of the team's work, and encourage many more cycles of improvement.

Communicate to the team what you have done in response to their requests for help. This communication could be at the next improvement project review, but it might be timelier if it were simply an email or other communication to team members.

BE PATIENT

New teams experience some hallmark stages of team development on their way to becoming a high performing team. Members will feel different thoughts and emotions, and it will be important for all members to recognize these stages so that they do not detract from the important work of the team.

IMPROVEMENT TEAM LEADERSHIP UPDATE MEETING CHECK-LIST

The purpose of a team leadership update meeting with sponsors and other senior leaders should be to:

- ☐ Learn whether the project is on track and to discuss any successes or challenges or is likely to fail;
- ☐ Understand whether the project is achieving the intended results. If not, to understand why (Is it lack of organizational will? Absence of strong ideas for improvement? Failure to execute changes?);
- ☐ Provide guidance, support, and stimulus to the improvement project team on will, ideas, and execution; and
- ☐ Review plans for spread and sustainability

CREATE A PLAN FOR CLIENT ENGAGEMENT

BENEFITS OF CLIENT PARTICIPATION

Involvement of persons living with schizophrenia/schizoaffective disorder (clients) in the improvement process has many benefits:

PROVIDE PERSPECTIVE

Clients provide valuable firsthand knowledge about issues that many people and families living with schizophrenia/schizoaffective disorder face on a daily basis. Clients can add critical perspectives on improvement planning and execution

REALITY CHECK

Clients help keep the team focused and on track by reminding them of key issues facing clients and their families, and sharing experiences in seeking and obtaining services.

HELP IN NEEDS ASSESSMENT

Clients can help ensure that needs assessments consider the needs of clients from differing populations and geographic locations, including those receiving care and those not in care.

IDENTIFICATION OF SERVICE BARRIERS

Clients can identify service barriers that may not be evident to others and can help plan to overcome those barriers.

OUTREACH

Clients can help identify ways to reach client communities that have unmet needs for services.

QUALITY

Clients can give direct feedback on opportunities and imperatives for improving the quality of specific services.

COMMUNITY LIAISON

Clients can provide an ongoing communications link with the community. They can bring community issues to the improvement team and care information to the community.

[5] Adapted from supportive document: Meaningful Involvement of People Who Use Drugs https://www.aidsunited.org/resources/

PLAN FOR ENGAGEMENT

All teams should develop a plan or strategy for client participation. Effective planning involves determining the appropriate level and duration of participation for your engagement (see resources below to support you). A helpful framework for your plan is to address the five Ws: **Who, What, Where, When, Why, How?**

DIFFERENT LEVELS OF ENGAGEMENT, DIFFERENT GOALS IN MIND

There are many different ways to engage clients and to increase patient participation. Below is a framework that shows how different types of participation serve different functions:

INCREASING IMPACT ON THE DECISION

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
CLIENT PARTICIPATION GOAL	Providing clients with balanced and objective information to assist them in understanding problems, changes, and/or solutions.	Seeking client feedback on analysis, changes, and/ or proposed decision.	Working directly with clients throughout the process to ensure that person-centred issues and concerns are consistently understood and considered.	Partnering with clients in each aspect of decisions, including the development of alternatives and the identification of preferred solutions.	Placing final decision-making control in the hands of clients.
SAMPLE TOOLS AND METHODS	*Fact sheets *Websites *Open houses	*Public comment *Focus groups *Surveys *Public meetings	*Clients on team *Workshops *Deliberate polling	*Client advisory committees *Conensus building *Participatory decision-making	*Citizen juries *Ballots *Delegated decisions

DEVELOP YOUR TEAM'S AIM STATEMENT

An aim statement is your team's most clear statement of purpose. Your team should devote early efforts to crafting an effective aim statement.

ALIGNMENT WITH THE PURPOSE OF THE COLLABORATIVE

Review the purpose and drivers of the TOP Collaborative. Align your aim with the purpose to get the most out of participation:

1. Improve the quality, effectiveness and reach of mental health support services in Vancouver to improve outcomes for people living with schizophrenia/schizoaffective disorder.

2. Strengthen capacity for QI within mental health and substance use sites across Vancouver Community.

3. Engage participating teams in joint QI activities to better coordinate seamless mental health services and enhance partnerships across mental health providers in Vancouver.

The aim of the TOP Collaborative is to increase the system-wide optimization of anti-psychotic treatment in community settings amongst our clients living with schizophrenia/ schizoaffective disorder, in order to improve outcomes and quality of life. In partnership with interdisciplinary MHSU teams and community partners, participating teams will implement evidence-based practice. By June 2022 we aim to reach the following:

- 100% of clients with treatment resistant schizophrenia (TRS) will be offered clozapine
- 90% of clients who are eligible for a clozapine start in the community and who accept the treatment, will undergo titration in the community
- 45% of clients undergoing clozapine treatment will see an improvement in their functioning as assessed by HONOS and PANSS-SV

HEALTH SYSTEM: The healthcare system is optimally set up and coordinated to provide effective chronic care

- Senior leaders visibly support and promote efforts to improve TOP care, to remove barriers, and to provide necessary resources
- Effective systems are in place to routinely share pertinent client information
- Partnerships with internal and external stakeholders coordinate community resources and policies

DECISION SUPPORT: Evidence-based guidelines are integrated into the daily clinical practice

- Clinical staff and supportive service staff are offered opportunities to increase their capacity to provide effective TOP care
- Prescriber and clinical team knowledge of treatment optimization of psychosis increase

SELF-MANAGEMENT SUPPORT: Clients and families play an important role in managing and coordinating their own care

- Clients, families, and a proactive practice team engage in informed and shared decision-making processes
- Clients accept their diagnosis and actively engage in their treatment
- Clients adhere to their treatment and receive routine adherence support
- Client and families are actively supported to manage their condition

DELIVERY SYSTEM DESIGN: Teamwork and expanded scope of practice is implemented to support chronic care

- An effective interdisciplinary and cross-agency care approach is implemented
- Active support systems are in place to start treatment implementation of clozapine

CLINICAL INFORMATION SYSTEMS: Routine access to information systems support treatment optimization in psychosis

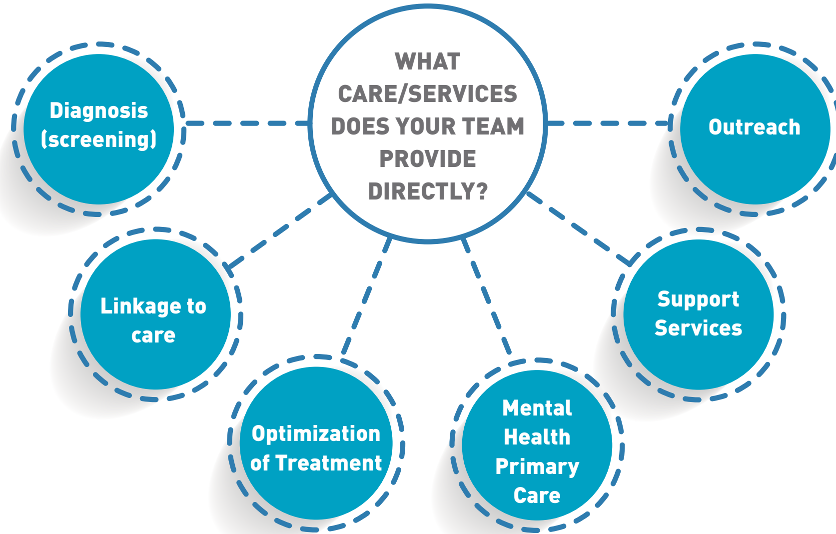
- Data systems are in place to routinely measure performance goals
- Medical record systems incorporate standardized templates to optimize treatment decisions
- Providers are trained and supported in improving encounter documentation

→ AIM

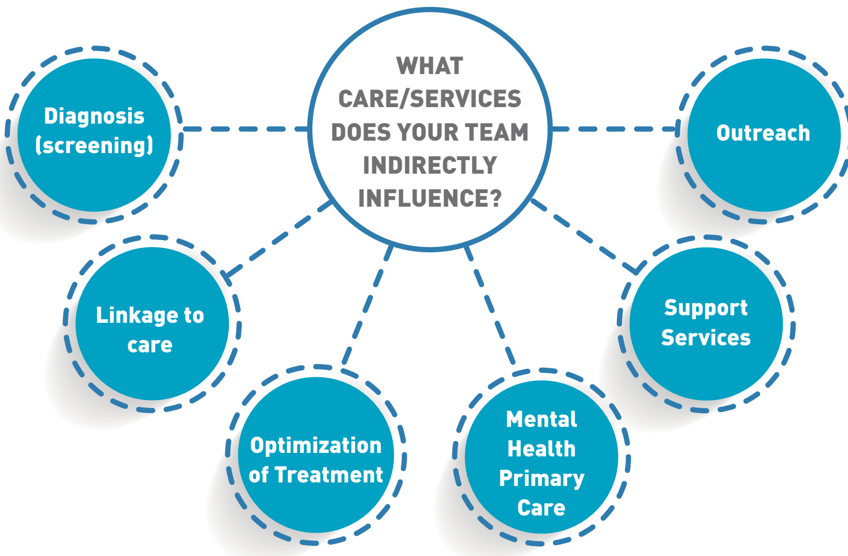
→ PRIMARY DRIVERS

→ SECONDARY DRIVERS

2 THE CARE AND SERVICES YOU CAN INFLUENCE AND IMPROVE



GUIDANCE: BY HOW MUCH CAN YOU IMPROVE OUTCOMES IN YOUR CORE SERVICE AREA(S)?



GUIDANCE: TO WHAT EXTENT CAN YOU INFLUENCE BETTER OUTCOMES IN OTHER SERVICE AREA(S)?

3 NEEDS WITHIN YOUR POPULATION OF FOCUS

Examine population data within your site. What are the priority gaps that your population faces along the schizophrenia/schizoaffective disorder Continuum of Care? Refer to the section below.

PRO-TIPS FOR AN EFFECTIVE AIM STATEMENT

INVOLVE YOUR SENIOR LEADERS

Engage your senior leaders in the process of aim development to align your aim with organizational objectives.

BE AS CLEAR AND SPECIFIC AS POSSIBLE

The aim statement should be time-bound, realistic and measurable. it should also specify the population affected by the work.

INCLUDE ADDITIONAL GUIDANCE

What is in scope and out of scope? Describe any other partners that you plan to engage (e.g., community support organizations, BC Schizophrenia Society, clinics with whom you will liaise, etc.). Include specific strategies that your organization will follow. Include anything that you think is useful for guiding your team and making sure your path is clear.

REVISIT YOUR AIM STATEMENT OFTEN

Expect your aim statement to change over time, especially as you gather new information and learn more about closing gaps.

DEFINE YOUR POPULATION OF FOCUS (POF)

Your POF is the population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality outcomes. To help you get started thinking about your POF, consider your reach:

TOP POPULATION OF FOCUS (POF) DEFINITION AND PROCESS OF IDENTIFICATION

DEFINITION OF THE POF

Clients who may have treatment resistant schizophrenia or schizoaffective disorder. This includes clients with Schizophrenia/ Schizoaffective disorder who:

- have latest HONOS scores on Question 6 of 3 or higher,
- are not currently on clozapine, and
- do not currently have active destabilizing medical and psychosocial factors (e.g. substance use, comorbidities, no fixed address, etc.)

RELEVANT DEFINITIONS:

TREATMENT RESISTANT SCHIZOPHRENIA:

Treatment Resistant Schizophrenia (TRS) is defined as inadequate medication response to an adequate medication trial of 2 different antipsychotics.

INADEQUATE MEDICATION RESPONSE:

Inadequate medication response is based on clinician judgement if relevant measurement scale data does not exist or <20% improvement on PANSS-SV when this data exists.

ADEQUATE MEDICATION TRIAL:

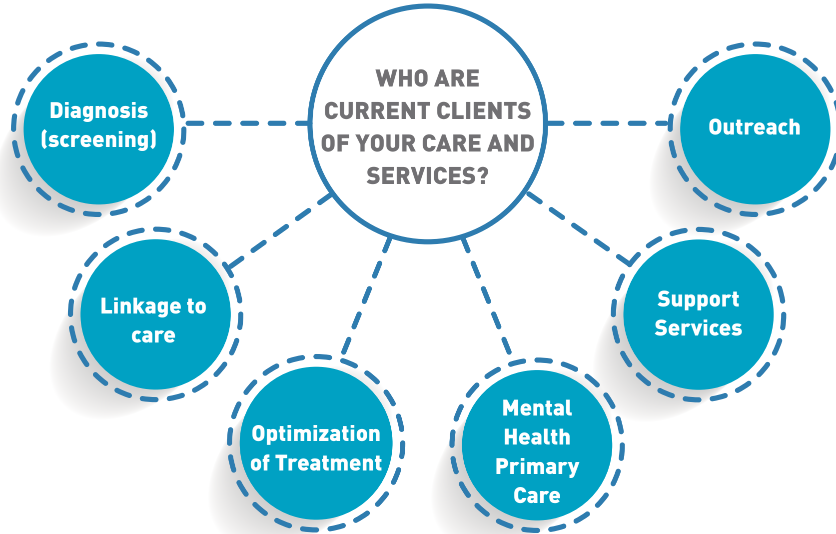
An adequate antipsychotic medication trial is defined as lasting at least 6 weeks, at a therapeutic dosage.

THERAPEUTIC DOSAGE:

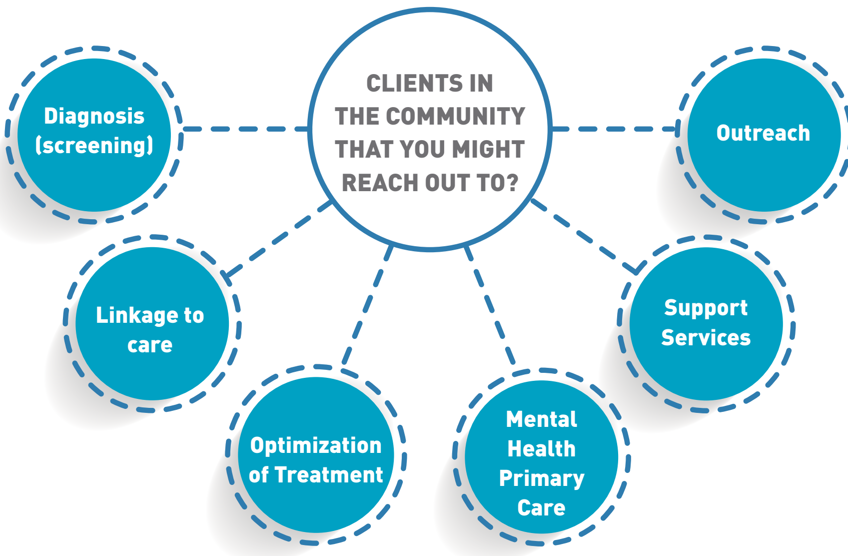
Therapeutic dosage is defined as:

- For oral antipsychotic drugs, at least 6 weeks of treatment at the midpoint or greater of the licensed therapeutic dose range.
- For LAI antipsychotic drugs, given for at least 6 weeks after it has achieved steady state (generally at least 4 months from commencing treatment)

1 WHAT IS THE CURRENT AND POSSIBLE REACH OF YOUR CARE AND SERVICES?



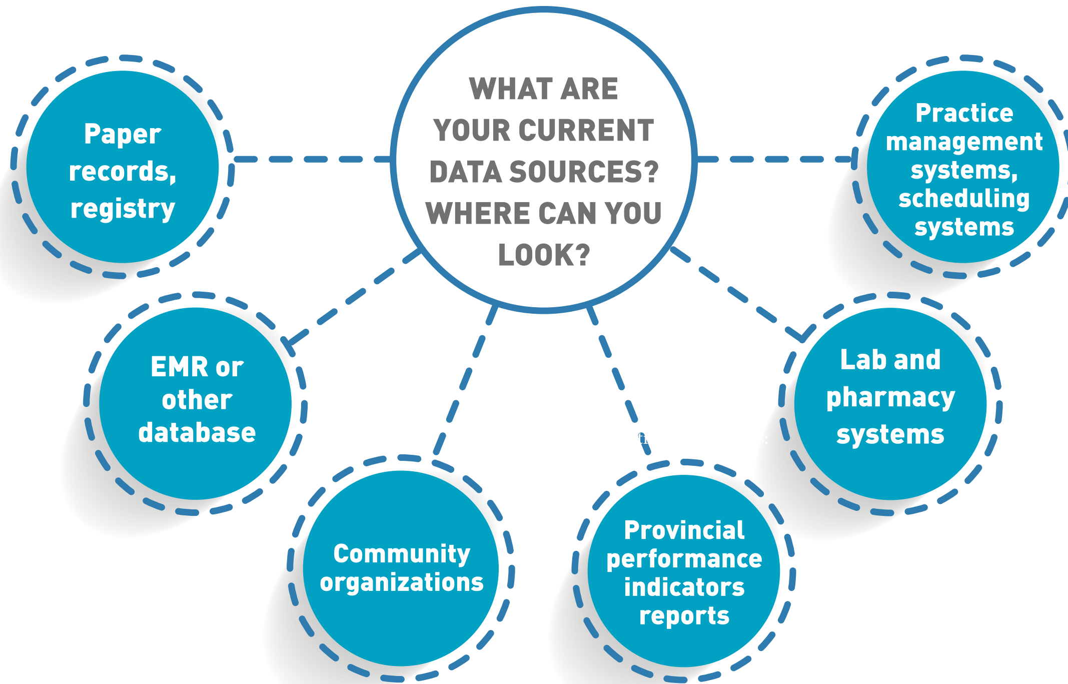
GUIDANCE:
FOR WHOM DO YOU CURRENTLY PROVIDE CARE AND SERVICES?



GUIDANCE: IS THERE ANYONE UNDERSERVED IN THE COMMUNITY THAT YOUR CARE AND SERVICES WOULD BENEFIT?

2 WHAT DO YOU UNDERSTAND ABOUT THIS POPULATION?

Where to look? Think about what information or records you currently collect, receive, or have received. Consider:



Other sources? ____

3 POF IDENTIFICATION PROCESS:

See flowsheet for guidance

Step 1. Make a list of all your clients diagnosed with Schizophrenia/ Schizoaffective disorder who have latest HONOS scores on Question #6 of 3 or higher

Step 2. For any clients without a HONOS score or with HONOS scores more than 6 months old: have the team to complete HONOS with these clients and review results as per step #1

Step 3. Remove those who are currently on clozapine

Step 4. Of the remaining, remove those who have active destabilizing medical and psychosocial factors (e.g. substance use, comorbidities, no fixed address, etc.). Offer them appropriate treatment options, they will not be part of your POF

Remaining Clients are your population of focus

Step 5. Of the remaining, note those who have been on clozapine in the past, they may have TRS; explore retrial

Step 6. Of the remaining, note those with suspected adherence issues and those who are currently on depot injection; they may have TRS; evaluate prior med trials, poly- pharmacy, PANSS-SV, etc.

Step 7. Note the remaining (not on clozapine, never been on clozapine, no active destabilizing substance use, no have adherence issues, and not currently on depot injection); consider LAI .

TOP COLLABORATIVE POPULATION OF FOCUS IDENTIFICATION PROCESS FLOWSHEET

Step 1
Make a list of all your clients diagnosed with schizophrenia/ schizoaffective disorder who have latest HONOS scores on Question 6 of 3 or higher

Step 2
Are any without a HONOS score or with HONOS scores more than 6 months old?
- YES → Complete HONOS with these clients and review results as per step #1
- NO → Step 3

Step 3
Are they currently on clozapine?
- YES → Outside POF → Optimize Therapy
- NO → Step 4

Step 4
Is there active destabilizing factors (medical substance use, comorbidities, NFA, etc.)?
- YES → Outside POF → Offer appropriate intervention
- NO → Step 5

Population of Focus

Step 5
Have they been on clozapine in the past?
- YES → Include in POF → May have TRS/ explore retrial
- NO → Step 6

Step 6
Are there suspected issues with adherence?
- NO → Include in POF → May have TRS/evaluate prior med trials, poly pharmacy PANSS-SV, etc.
- YES → Step 7

Step 7
Are they currently on depot injection?
- YES → Include in POF
- NO → Include in POF → Consider LAI

REVIEW MEASUREMENT STRATEGY

Measurement is an investment of time but it is an important and worthy investment. Simply put, we must measure things to know if they are getting better or worse.

MEASUREMENT STRATEGY

After the Launch on June 23, 2021, all teams will be required to regularly collect and report monthly numerical and qualitative data for the duration of the Collaborative. The specific measures that you will collect and report will depend on your team's improvement focus. The TOP core team will work with each team to ensure measurement is meaningful for the services provided and the population served.

From these monthly reports, each team will receive custom coaching, feedback, and encouragement from experts in schizophrenia/schizoaffective disorder, psychosis guidelines, clozapine initiation, and quality improvement. Teams will be encouraged to share their reports with the TOP Collaborative community, and experts will use the volume of reports to design relevant learning activities and to connect different teams working on similar issues.

CORE MEASURES

#	CORE MEASURE	NUMERATOR	DENOMINATOR	TARGET
1	**Non-adherent[6] clients offered depot injection**	# of clients offered depot injections	# clients non-adherent to oral medication	100%
2	Treatment Resistant Schizophrenia (TRS)[7] clients offered clozapine	# of clients diagnosed with TRS who have been offered clozapine	# of clients diagnosed with TRS	100%
3	**Clients retained on clozapine**	# of clients who remain on clozapine for more than the 8-week titration period	# of clients who are started on clozapine	70%
4	Clients on clozapine that made progress on HONOS	# of clients retained on clozapine and made any progress on HONOS score	# of clients diagnosed with TRS who are retained on clozapine	45%
5	**Clients on clozapine with a 20% improvement on PANSS -SV**	# of clients retained on clozapine and achieved 20% or more improvement on PANSS-SV	# clients diagnosed with TRS who are retained on clozapine	45%
6	Client Voice	# of participating teams with a regular and ongoing process in place to capture the client voice	# of participating teams	100%

[6] Nonadherence is defined as taking less than 80% of prescribed dose as determined by pill counts, dispensing chart review, Pharmacare or pharmacy report, or patient/caregiver report (patient report alone is unlikely to be sufficient). In addition, given that there may still be covert nonadherence, antipsychotic blood levels may provide additional evidence. (TRRIP Guidelines, Am J Psychiatry, 2017)

[7] Treatment Resistant Schizophrenia is defined as inadequate medication response to an adequate medication trial of 2 different antipsychotics.

SOME PRINCIPLES OF MEASUREMENT FOR IMPROVEMENT

- The objective of measurement for improvement is to learn and improve. It is different from other types of measurement (i.e., for the purposes of research or accountability[8]) because measurement for improvement is designed to speed up improvement. The aim is to generate data which is useful even if not perfect.
- When it comes to measurement, we don't want to re-invent the wheel. Whenever possible, we will suggest relevant measures that are already well-established.
- Improvement measures are designed to tell you if you are progressing in achieving your aim. For that reason, measures are designed to align with your aims. For example, if you are seeking improvements in retention in care, you will measure key processes and outcomes related to retention.

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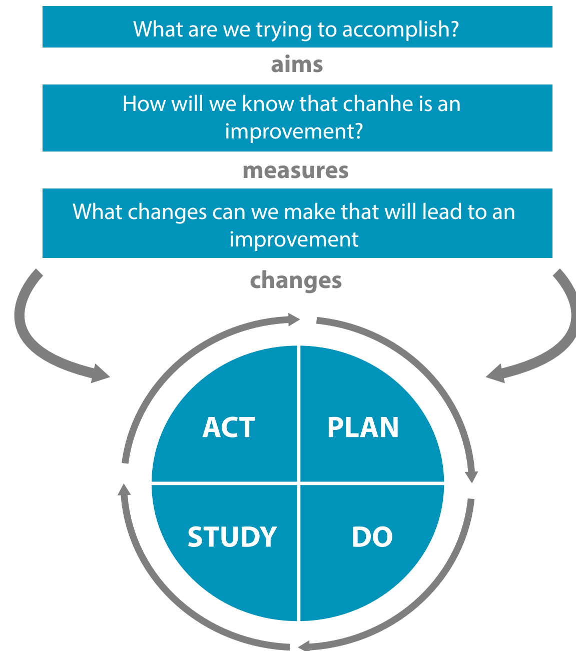
8 For a more robust discussion on the distinction between measurement for improvement, research, and accountability see Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability, and research. Jt Comm J Qual Improv. 1997 Mar;23(3):135-47.

REFERENCE 1: THE MODEL FOR IMPROVEMENT

The improvement model is based on three fundamental questions:



Langley J, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey-Bass, 2009.

1 WHAT ARE WE TRYING TO ACCOMPLISH?

The first question is meant to establish an aim to make explicit what the team is trying to accomplish. The aim should be aligned with the Collaborative. An effective aim is clear and unambiguous. Try using the mnemonic SMART to create an effective aim: Specific, Measurable, Actionable, Realistic, and Time-bound.

2 HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?

All improvement requires change, but not every change will result in improvement; therefore, we must measure things to know if they are getting better or worse. When we measure for improvement, we seek useful data not perfect data. In the Collaborative, we encourage the use of a standard family of measures, which allows us to learn together about improvement and avoid having to each re-invent quality indicators

3 WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?

What can you do to achieve your aim? What changes will be needed to your current processes for coordinating and delivering care and services? Change ideas come from evidence, people living with schizophrenia/schizoaffective disorder, other industries, and peers in improvement. The Collaborative will provide a compendium of evidence-based and experience-based ideas for changing care and services along the Continuum of Care.

PLAN, DO, STUDY, ACT CYCLE (PDSA CYCLE)

Changes can look pretty shiny on paper; however, sometimes these changes can fail to translate into improvement. Therefore, it is a good strategy to test an idea before committing to it (implementing). The PDSA cycle is a systematic, iterative testing approach. The approach helps teams to plan for the change (what are we going to do, and where?), do the change (try it out as you planned it), study the effects of the change (what was observed, anything unexpected?), and then act on what you observed:

- adapt (improvement observed, time to implement), or
- adopt (shows promise but back to drawing board for another PDSA), or
- abandon (just not going to work).

REFERENCE 2: THE EXPANDED CHRONIC CARE MODEL (EXPANDED CCM)

The Chronic Care model (CCM) is an evidence-based model that describes important elements of a healthcare system that contributes to high quality systems that produce better patient outcomes[9]. The Expanded CCM builds on this model, incorporating concepts and strategies from population health promotion.[10]

The Province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model specifically identifies essential elements of a health system and community that contribute to better health outcomes for its population.

The model is represented in the image below. It shows health systems (individual healthcare organizations) as entities within the community. Both play a role in promoting the flow of ideas, resources, and people. The following are elements of the Expanded CCM:

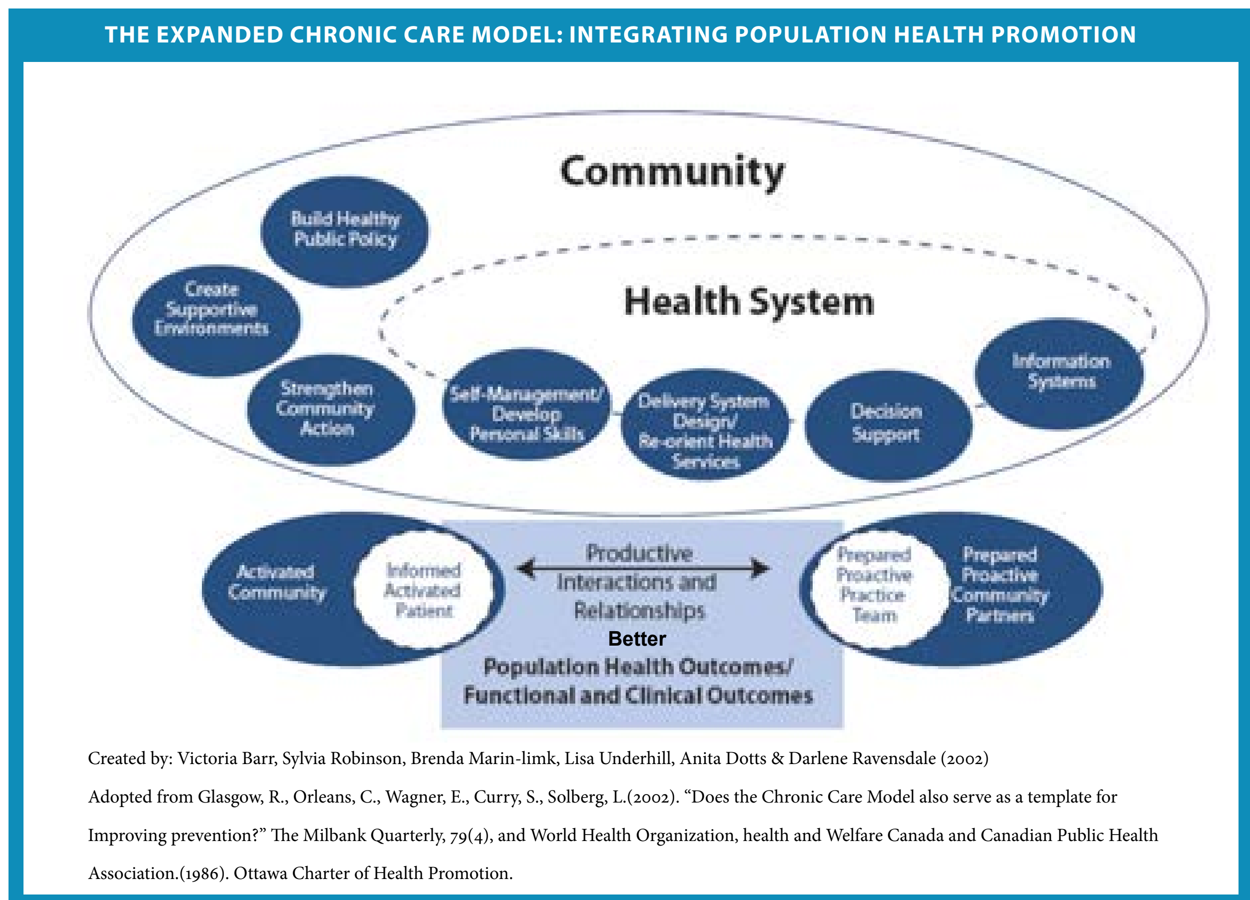
- Self-management / Develop personal skills: The health system and community supports and coordinates self-management in coping with chronic conditions and supports the development of personal skills for health and wellness.

9 The model is based on the “Chronic Care Model” used by a national program in the United States called Improving Chronic Illness Care (ICIC). This program is based at the McColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound. http://www.improvingchroniccare.org/index.php?p=the_chronic_caremodel&s=2

10 Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Healthcare Quarterly, 7(1) November 2003: 73-82.

- Delivery System Design / Re-orient Health Services: The health system and community work to support individuals and communities in holistic ways (e.g., advocacy on behalf of vulnerable populations, emphasis on health, quality of life, and clinical outcomes).
- Decision Support: Integrate evidence-based guidelines for care, treatment, being well, and staying healthy into daily practice (e.g., use flow sheets that synthesize evidence-based treatment guidelines, develop health promotion and prevention best-practice guideline).
- Information Systems: Develop information systems based on patient populations to provide relevant client, community, and contextual data for decision-making.
- Build Healthy Public Policy: Development and implementation policies designed to improve population health to foster greater equity in society, and to increase the availability of safe and healthy goods, services, and environments.
- Create Supportive Environments: Contribute to strategies that foster conditions for optimal levels of health in social and community environments based on evidence that describes the significant impact of social supports on overall health and quality of life.
- Strengthen Community Action: the health system works with and mobilizes the community to set priorities and achieve goals that improve the health of the community. Public participation is key to removing barriers to healthy living.

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION



Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-limk, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)

Adopted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L.(2002). “Does the Chronic Care Model also serve as a template for Improving prevention?” The Milbank Quarterly, 79(4), and World Health Organization, health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

REFERENCE 3: KEY ELEMENTS OF BREAKTHROUGH IMPROVEMENT

	INDICATOR	REMEDY
Will	• **Resources necessary to the project's success are not made available** • **A few loud naysayers are blocking implementation and spread of good ideas** • **Absence of any obvious connection between this project and key strategic goals** • **Lack of executive and board attention to this project** • **Line managers appear to be on the sidelines, not responsible for project success**	If will is the problem, sponsors or other senior leaders can have a major impact. Sponsors can make resources available, deal with the few loud voices, channel attention to the importance of the project, make the connection to key organizational strategies, and assign responsibility to managers.
Ideas	• The team has not reviewed the Change Package • The team is not using client voice and feedback • The team has not gone outside the organization, or outside health care, to find the best ideas • Few cycles of improvement have been attempted • "Big Ideas" appear to be absent—changes being tested are safe, incremental, not radical redesigns • The team does not regularly attend monthly teleconferences or invest time in seeking out ideas from colleagues using the virtual community of practice • The team can't tell you who has the best results in the world on this topic	If ideas are the problem, ask questions that will stimulate the search for ideas: • "What ideas do you have for further improvement?" • "Is there something in the Change Package we can try?" • "Where else are you looking for ideas?" (e.g., clients, external colleagues or organizations, outside healthcare, etc.) • "Who's the best in the world at this? How could we find out?" Encourage small-scale tests of big ideas. "It sounds as if you have a number of good ideas already. How could you test one of those ideas, and have an answer by the end of the week?" Sponsors doing a good review have to be comfortable pushing and supporting innovation and small tests.

	INDICATOR	REMEDY
Execution	• Project setup, and project management appear weak • Preparation for spread is not part of the project from inception • The team does not understand quality improvement frameworks • The project gets good results on tests, but never seems to scale up • The team does not understand the distinction between testing and implementation	If execution is the problem, it is a good opportunity for you to teach good project management and change leadership skills to the project team, and to learn about the larger organization's barriers to execution in its culture, information systems, human resource policies, and other areas.

Will

Ideas

Execution

REFERENCE 4: STAGES OF TEAM DEVELOPMENT

STAGE 1 — **ORIENTATION**

Eager, high expectations
Anxiety about fit and expectations
Testing situation and figures
Assessing authority and hierarchy
Needing to find a place and establish oneself

STAGE 2 — **DISSATISFACTION**

Discrepancy between hopes and reality
Dissatisfied with dependency on authority
Angry about goals, tasks, and action plans
Feeling confused or incompetent
Negative about leaders and/or teams
Competing for power and/or attention

STAGE 3 — **RESOLUTION**

Decreasing dissatisfaction
Resolving discrepancies between expectations and reality
Resolving animosities and polarities
Developing harmony, trust, support, and respect
Developing self-esteem and confidence
Being more open and giving more feedback
Sharing responsibility and control
Using team language

STAGE 4 — **PRODUCTION**

Excited about participation
Working collaboratively and inter-dependently
Feeling team strength
Showing high confidence in accomplishing tasks
Sharing leadership
Feeling positive about task successes
Performing at high levels

GLOSSARY OF TERMS AND CONCEPTS

ACTION PERIOD

Action Periods occur between Learning Sessions. During these times, team members have returned to their home settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

AIM OR AIM STATEMENT

A written statement of purpose that is Specific, Measurable, Actionable, Realistic, and Time-bound. The aim statement may also include guidance such as a general description of the work, the population of focus, and the numerical goals. At the end of your improvement effort, your aim statement should help you to determine if you have been successful.

ANNOTATED RUN CHART

A line chart that shows data plotted over time (i.e., time is the x-axis) with annotations (small notes) that links qualitative descriptions of changes to the times at which they occurred on the plot. This allows the viewer to connect changes made with specific results.

CHAMPION

An individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement, and spread changes. Teams need at least one clinical champion. Champions in other disciplines who work on the process are important as well. This champion should have a good working relationship with colleagues and with the day-to-day leader(s), and be interested in driving change in the system.

CHANGE CONCEPT

A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

CHANGE IDEA

An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment (e.g., simplify the process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart).

CLOSING CONGRESS

The Closing Congress is similar to Learning Sessions, though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the course of the Collaborative.The Closing Congress formally marks the end of the initiative.

COLLABORATIVE (AS KNOWN AS STRUCTURED LEARNING COLLABORATIVE)

A systematic approach to healthcare quality improvement in which organizations and providers test and measure practice changes, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."

COLLABORATIVE CORE TEAM

Staff and experts that coordinate the events and activities of the Collaborative and provide teaching and coaching to participating teams.

COLLABORATIVE TEAM (A.K.A. IMPROVEMENT TEAM)

All individuals from the participating organizations that drive and participate in the improvement process. This team coordinates and actively participates in the improvement process and supports representatives to attend the Collaborative Learning Sessions and other learning activities.

DATA COLLECTION PLAN

A specific description of the data that the team will collect, the frequency of data collection, data sources from which data artifacts will be obtained, and key roles and responsibilities to oversee data collection, reporting, and analysis.

IMPLEMENTATION

Implementation is a process in which a change is made a permanent part of the system. During this process, organizations will formally adopt the change, communicate it widely, change job descriptions, codify the change in policy, etc. Changes should only be implemented after they have been successfully tested and there is a high degree of belief that the change will bring about improvement.

INFORMATION SYSTEMS (IS)

Refers to the information system of an organization, usually the computerized information system.

KEY CONTACT

The person on the team who takes responsibility for maintaining communication between the team and the Collaborative core team, including reporting monthly and disseminating information to team members.

LEARNING SESSION

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving schizophrenia/schizoaffective disorder care, services, and outcomes. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes. There are four Learning Sessions in the TOP Collaborative.

LISTSERV

An automatic mailing list. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcasted to everyone on the list. The result is similar to a newsgroup or forum except that the messages are transmitted as an e-mail and are therefore available only to individuals on the list.

MEASURE (A.K.A. QUALITY INDICATOR, IMPROVEMENT MEASURE)

A focused, reportable unit that will help a team monitor progress towards achieving their aim. The Collaborative will describe the measures and strategy for measurement.

PDSA CYCLE

A systematic and iterative approach to testing out a change, which includes four phases: Plan, Do, Study, and Act. At the end of each cycle, teams will choose to adopt, adapt, or abandon the change.

POPULATION OF FOCUS (POF)

The population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality indicators.

RUN CHART

See "annotated run chart."

SPREAD

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation. http://blog.leanmonitor.com/early-adopters-allies-launching-product/

TEST

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.