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Early Intervention for Psychosis Programs: Guidelines and Best Practices

UC Davis/UCLA BHCOE Webinar

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Objectives

As a follow-up to the introduction on September 22, 2016, this webinar will focus the best practice discussion to:

1. Models of EPI implementation across different settings (e.g., urban, academic, community, rural, remote north)
2. Tips to identifying and implementing system-wide measures
3. Case study from two province-wide surveys about the use of networks to deliver EPI services

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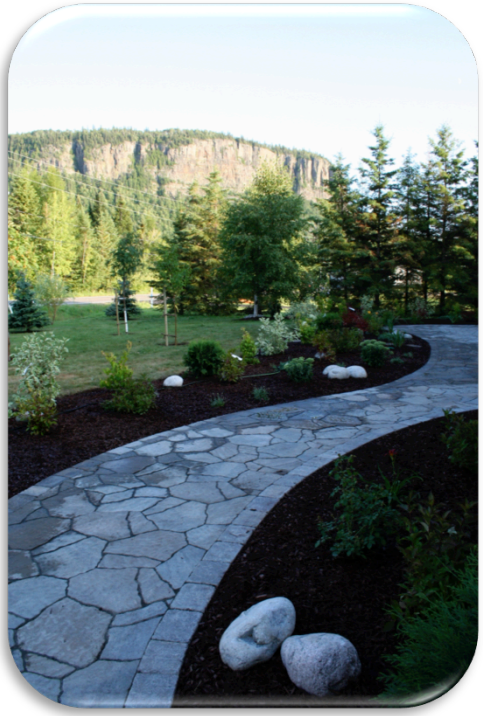

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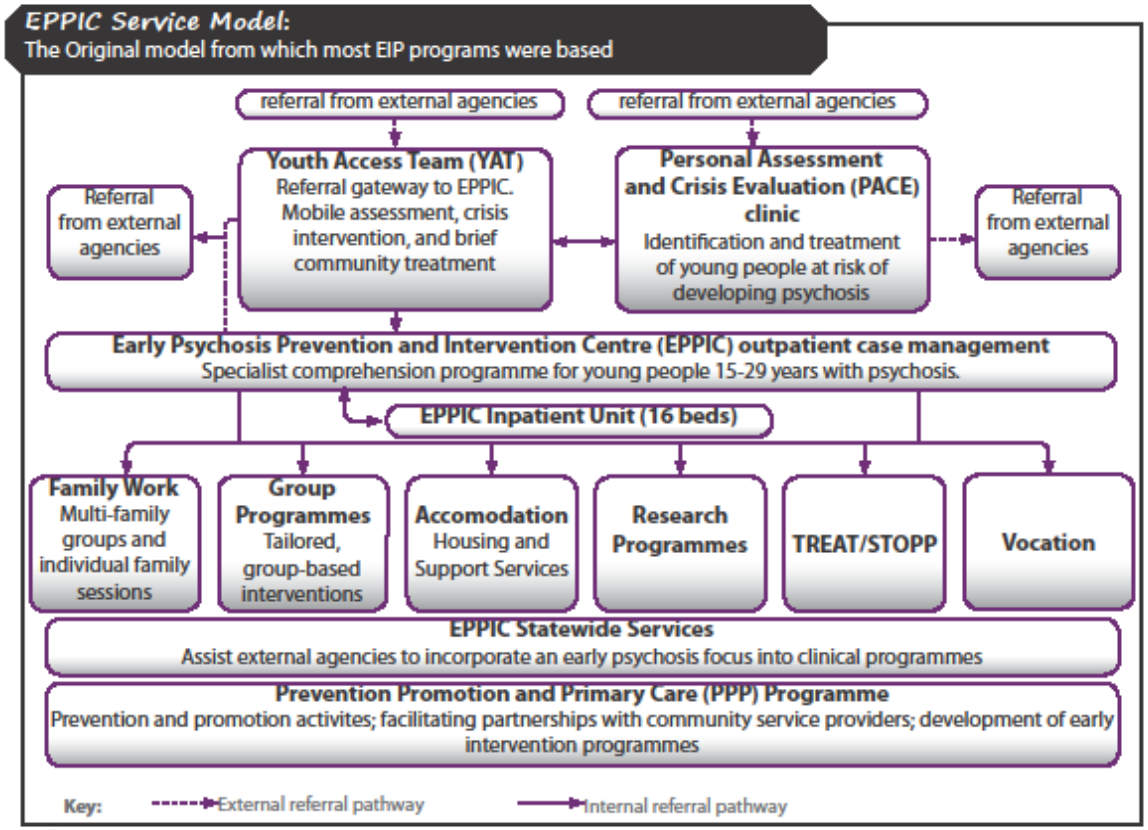
Models of EPI Service Delivery

Original Best Practice Model: EPPIC Service Model



source:
Edwards J, McGorry PD. (2002). "The EPPIC Service Model". Implementing Early Intervention in Psychosis: A guide to establishing early psychosis services. London, Martin Dunitz Ltd, 67.

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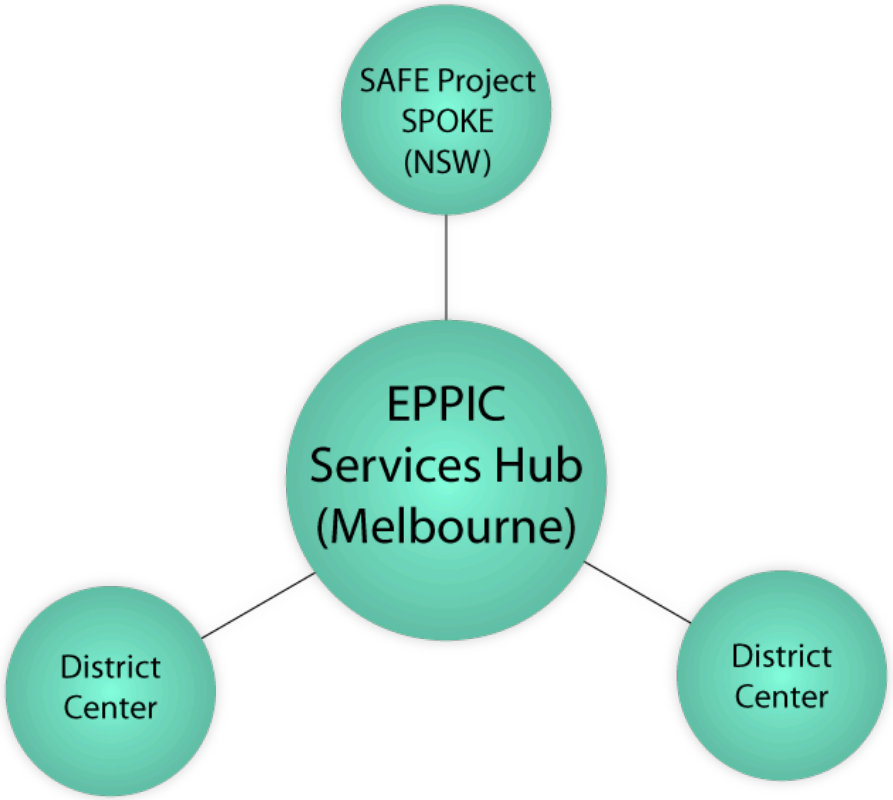
EPI Core Components

- Early identification and access (e.g., public education, outreach to primary care)
- Assertive case management
  - CBT, other non-medication based therapies
  - Appropriate trials of antipsychotics with intensive metabolic monitoring
- Crisis management
- Vocational, educational intervention/support
- Family support

EPPIC Hub-Spoke Service Model



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Question from Sept 22 webinar:

Can these programs be reproduced in the US?

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HOW TO TRANSLATE COMPLEX URBAN MODEL TO FIT LOW-DENSITY RURAL & REMOTE SETTING?

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Literature (Rural Service Provision) Key Messages

- Distinct differences from urban challenges
- Increased role of primary healthcare
- Specialist within generalist model
- Longer DUP and decreased access
- Increased monies needed for similar services
- Role of social network
- Vital role of adequate education, training, ongoing supervision

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Gordian knot:

How do we adapt an urban high density population model of care

- for rural areas?
- and be true to the model
- and provide good quality care

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Two rural service models

Tale of two rural areas

- Northern (west)
- size of Texas
- 45% of Ontario's landmass
- 2% of Ontario's population
- ~250,000 people
- 0.15 person/sq mi

- Southern (east)
- size of Connecticut
- 2% of Ontario's landmass
- ~4% of Ontario's population
- ~264,000 people
- 10 people/sq mi

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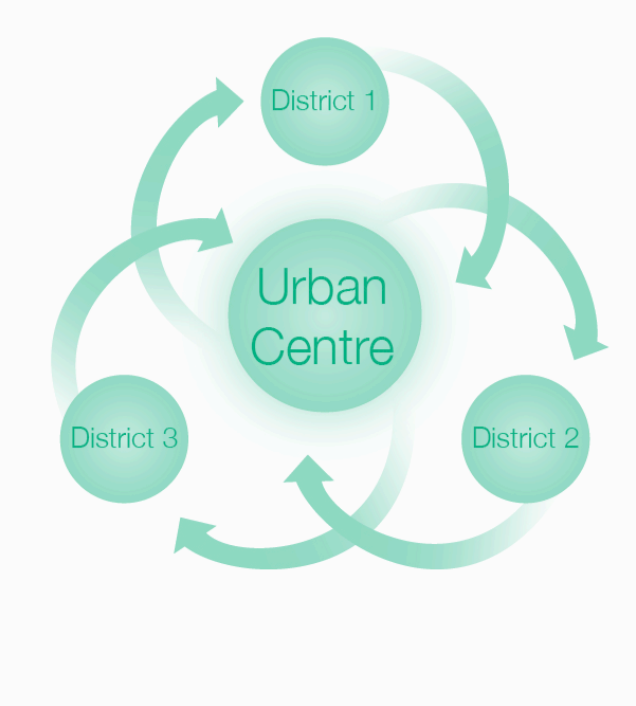
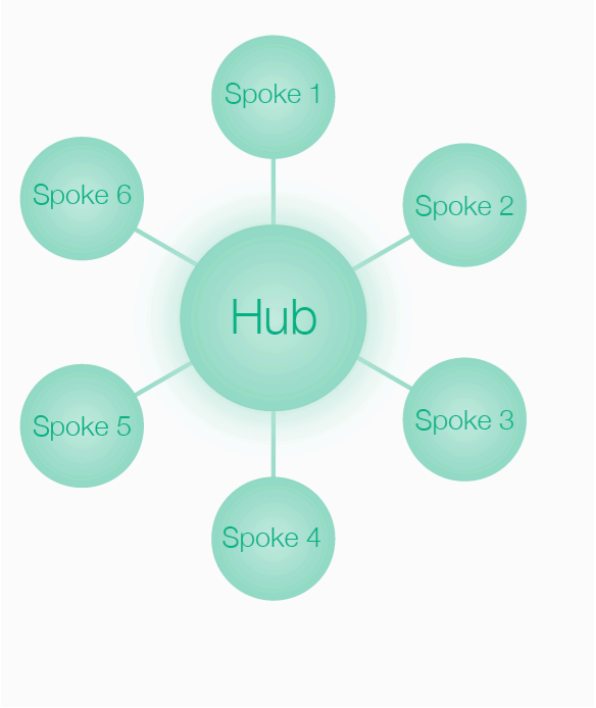
Rural Ontario EPI Service Models

Northwest: Specialized Outreach



Southeast: Hub and Spoke



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Why Adopt Specialized Outreach?

- NW started out as hub and spoke
- Difficult for 1 FTE to deliver full basket of core services
  - e.g., geography very large
- Difficult to ensure Standards are followed
  - e.g., supervision by non EPI program/agency, training from a distance takes longer
- Mandate drift
  - e.g., lower incidence of psychosis compared to other service needs
- Higher staff turn-over
  - e.g., high staff burnout

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Methods

- Data from the Matryoshka Project
  - 4 year, multi-site project
  - to examine the effects of new investments in community mental health programs on continuity of care
- Rural program data between 2005-2007
- Rural = population density <39 people/sq mi
- General functioning in the community
- Admissions to hospital, ER visits

Cheng et al. 2013

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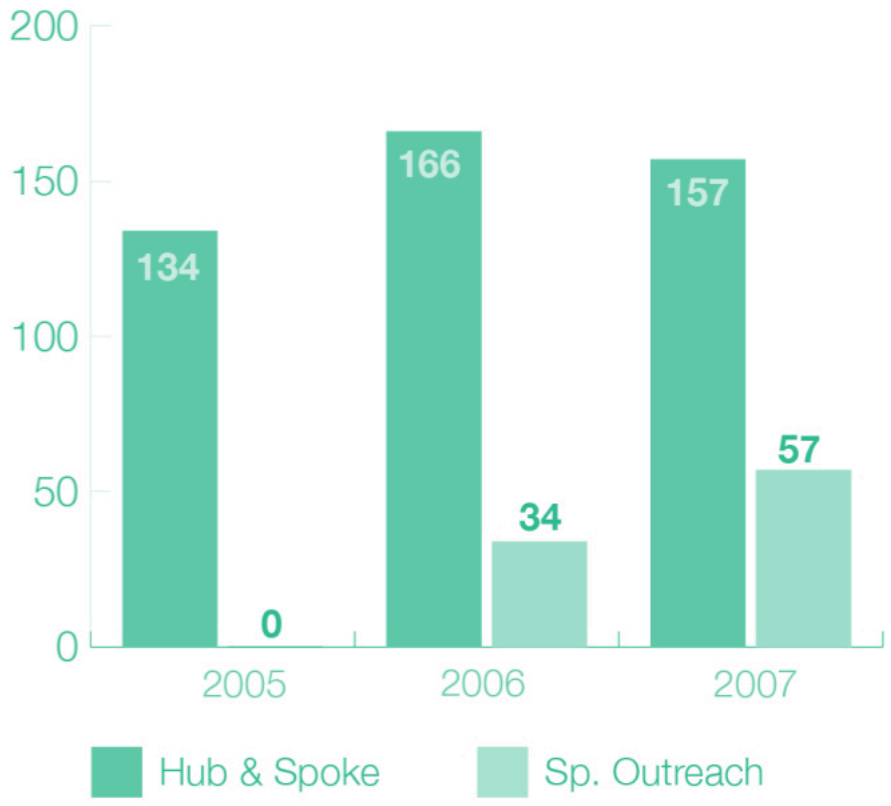
Specialized Outreach vs Hub & Spoke: clients serviced (enrolled) in each program



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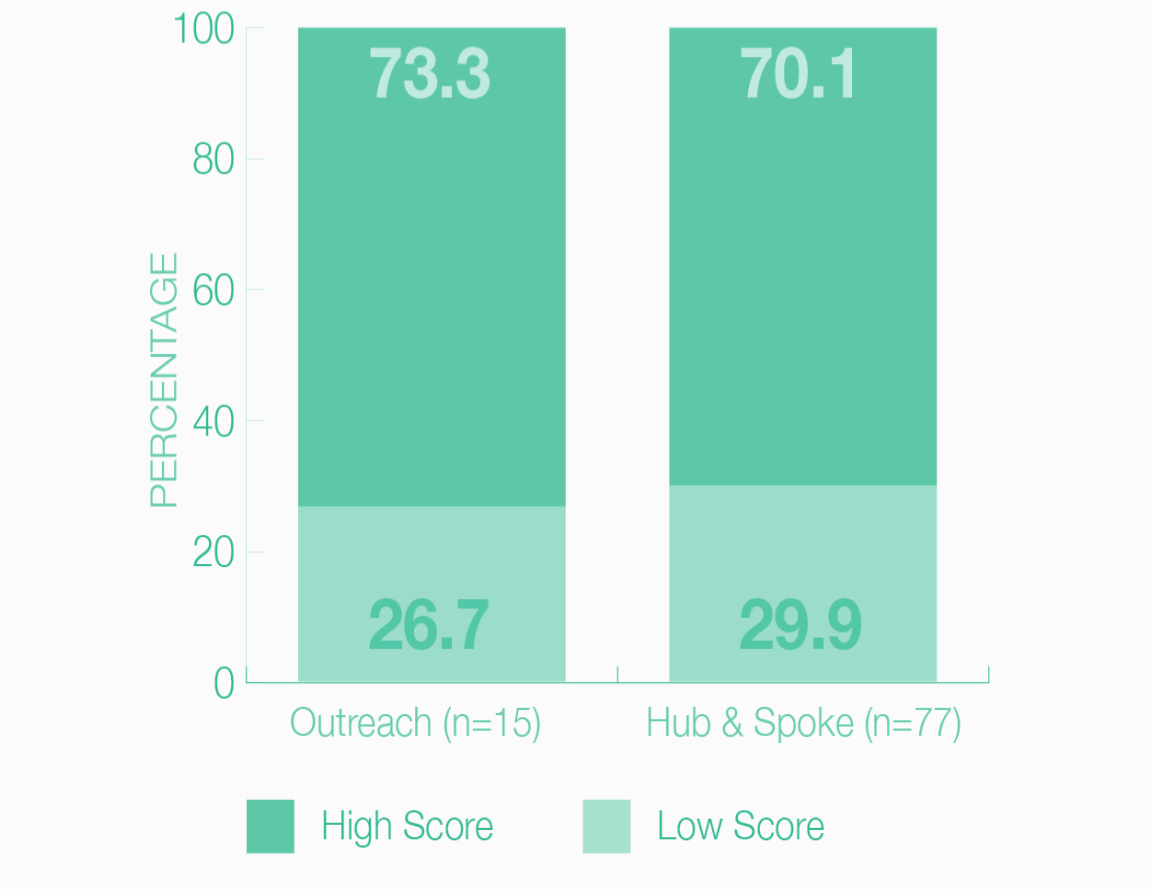
Specialized Outreach vs Hub & Spoke: community functioning



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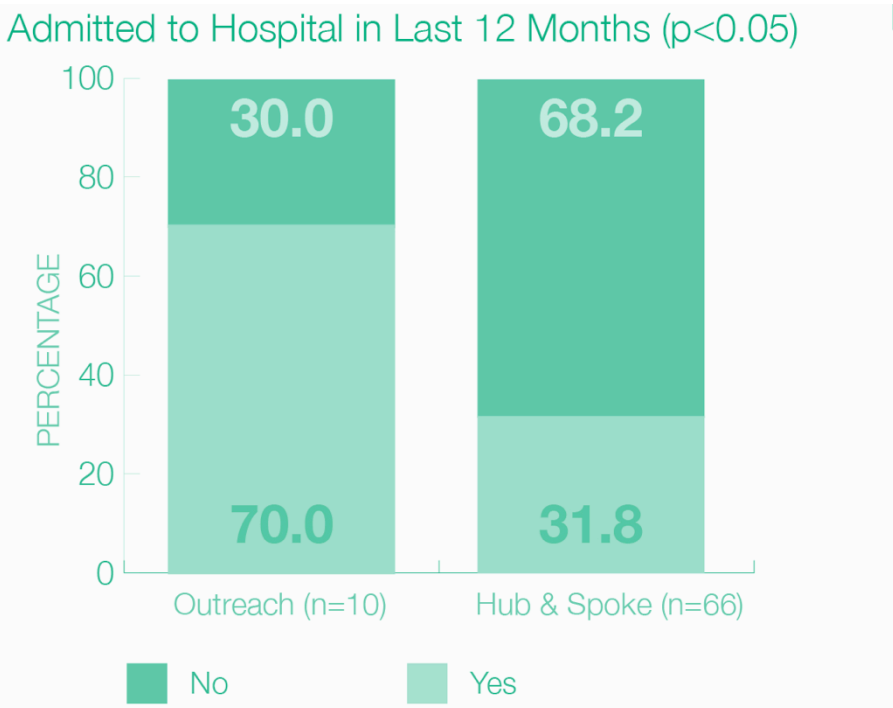
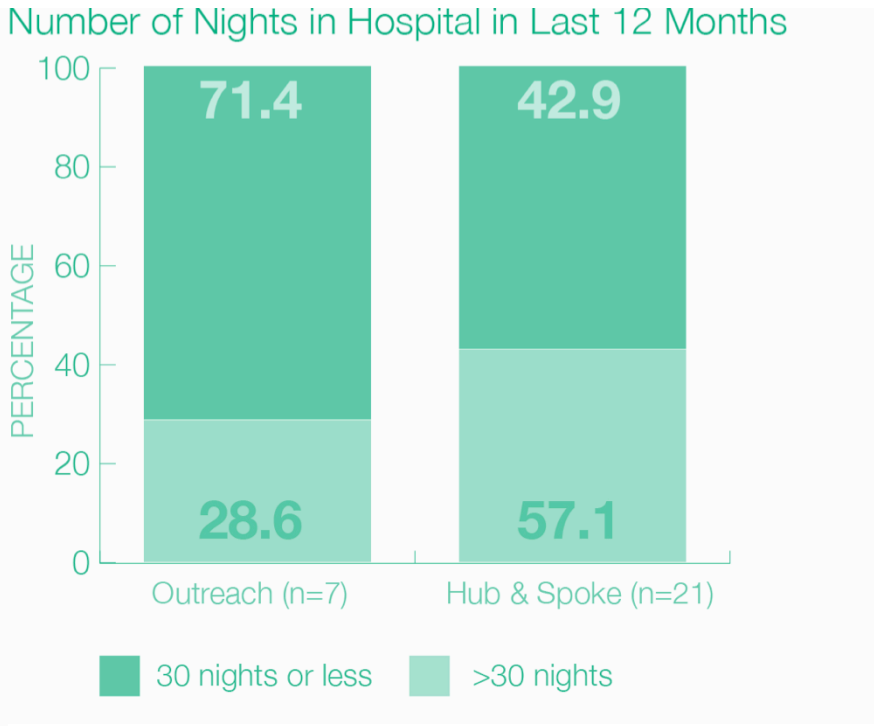
Specialized Outreach vs. Hub & Spoke: hospital admissions





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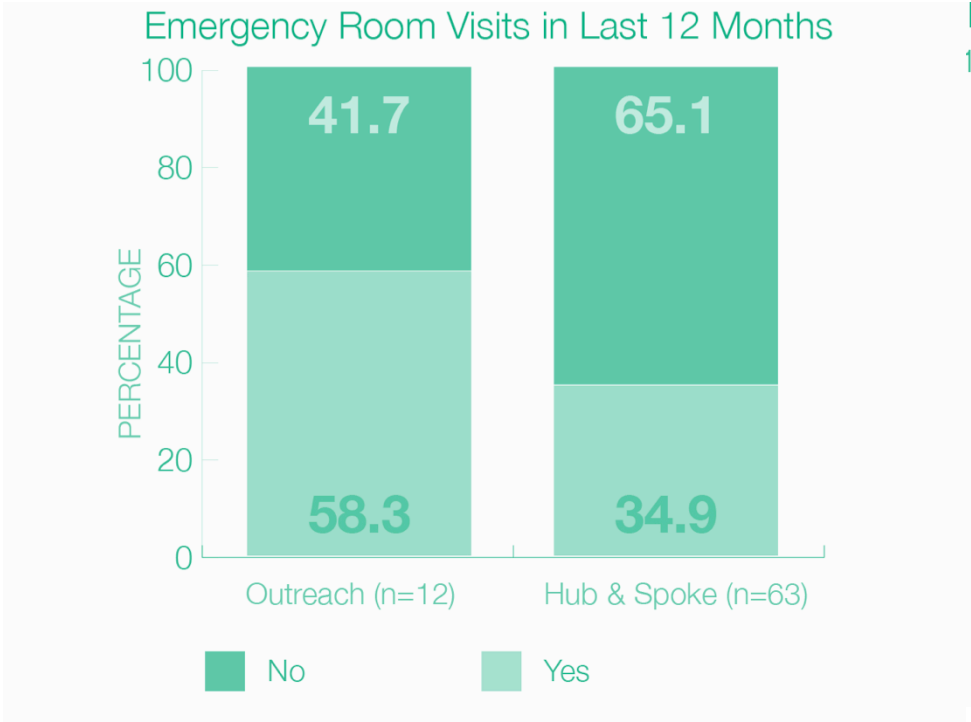
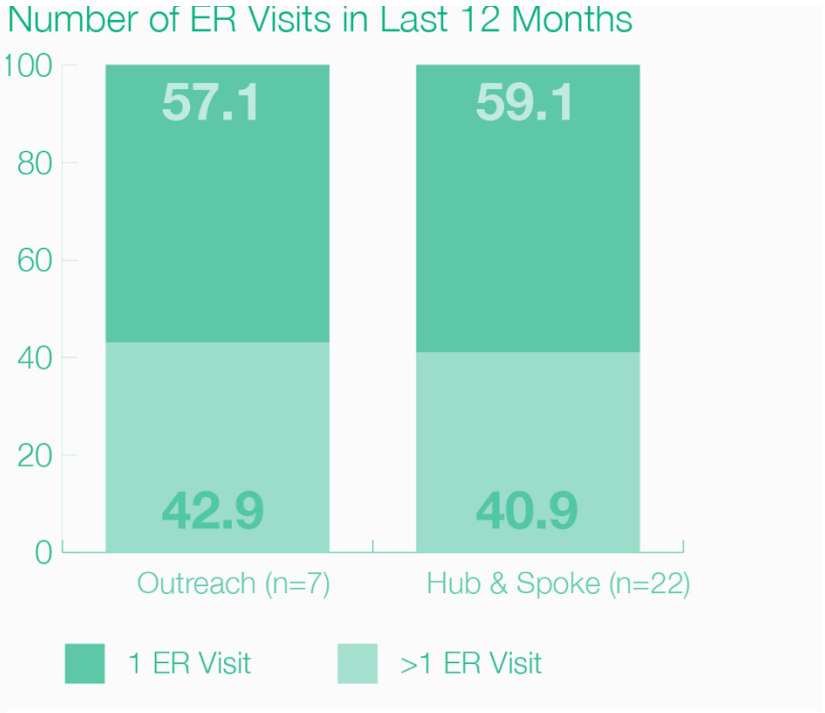
Specialized outreach vs Hub & Spoke: emergency room visits





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Successes

Specialized Outreach

- Adherence to EPI best practices
- Quality, flexibility
- Consistent, regular psychiatry services

Hub & Spoke

- Local clinicians
- New EPI services in remote areas
- Formalized (new) partnerships

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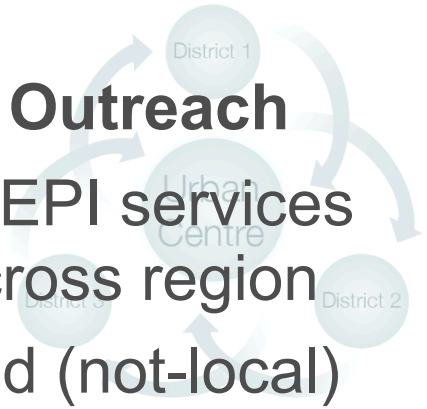
Challenges

Specialized Outreach

- Providing EPI services equally across region
- Centralized (not-local) clinicians
- Wide scope of practice



Hub & Spoke

- Variable access to physician services
- Part-time equivalent staffing
- Wide scope of practice

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Policy implications

- Two different models
  - hub-spoke, modeled after Australia
  - specialized outreach adapted after hub-spoke didn't work
- How to explain different outcomes
- Need follow up research to determine why differences
  - is it due to inequitable access to services?
  - Is it because of the models of care?

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Question from Sept 22 webinar:

How do non-physician clinicians help clients while the medications are being sorted out?

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System-wide Measures

Why System-wide Measures?

- Engagement of service users (clients/families)
- Support feedback about care received
- Aggregate data to inform planning and decision making
  - e.g., organization, local, regional, provincial
- Inter-agency communication
- Outcomes measurement
  - e.g., is the promise of EPI realized?

Measure Used

- Community Care Information Management
  - www.ccim.on.ca
  - Resident Assessment Instrument (RAI)
  - Ontario Common Assessment of Need (OCAN)
- OCAN (Zosky 2015)
  - Standardized assessment tool for community mental health sector
  - Based on Camberwell Assessment of Need
  - 2007-2015
    - 4 phases
      - initiation, pilot, implementation, operations/sustainability

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Other Measures

- Ontario Healthcare Reporting Standards (OHRS/MIS)
  - Program level financial, statistical data (e.g., expenses, FTEs, individuals served, number of interactions)
- Common Data Set (CDS)
  - Program level client data (e.g., demographics, basic clinical info, legal status, basic client outcomes)
- Ontario Perception of Care (OPOC)
  - Survey of client/family perception of care (e.g., access, services provided, participation, staff, discharge)
- ConnexOntario (Service Inventory)
  - Inventory of mental health programs

Durbin & Selick, 2016 (draft)

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Challenges

- Varying capacity in programs for data collection
  - e.g., high clinical volume, insufficient time/resources
- Not consistent collection across province
  - e.g., unreliable data quality
- Insufficient ongoing training
- Electronic medical records (EMR) compatibility
- Compliance/resistance from frontline
  - e.g., data collected “disappears” into database

Durbin & Selick, 2016 (draft)

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Tips for System-wide measures

- Decide on simple, user friendly measures (just a few)
- Centralized administration
  - Centralized collection
  - Or, sufficient resources for local collection
- Regular feedback loop (of data) to programs
- Ongoing training and oversight
- Adequate resourcing for data collection, analysis, knowledge exchange

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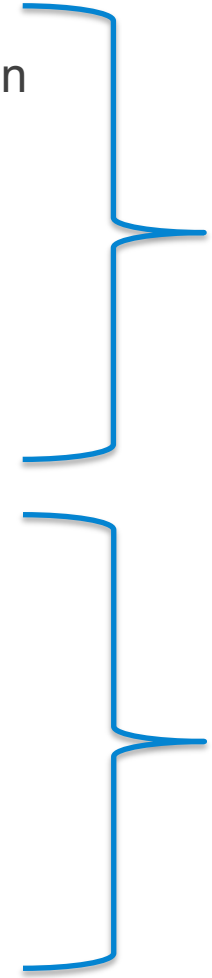
Case Example from Provincial Surveys

(Durbin and Selick, 2012, 2015)

Ontario EPI Program Standards (2011)

- **Service delivery domains**
  - Facilitating access and early identification
  - Comprehensive assessment
  - Treatment
  - Psychosocial support
  - Family support
  - Transition
- **Quality Support domains**
  - Training
  - Evaluation and research
  - Barrier free service
  - Network participation
- **Accountability domains**
  - Records, privacy, reporting



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Both surveys ….

- 2 key informant surveys reached out to every funded EPI program (full service) in the province
  - Survey 1 (2012): feedback from 52 program sites (~92%)
  - Survey 2 (2014): feedback from 56 program sites (100%)
- Showed awareness of Standards
  - efforts to implement
  - shared learning & improvement
  - role of provincial network (EPION)
- Local health authority engagement

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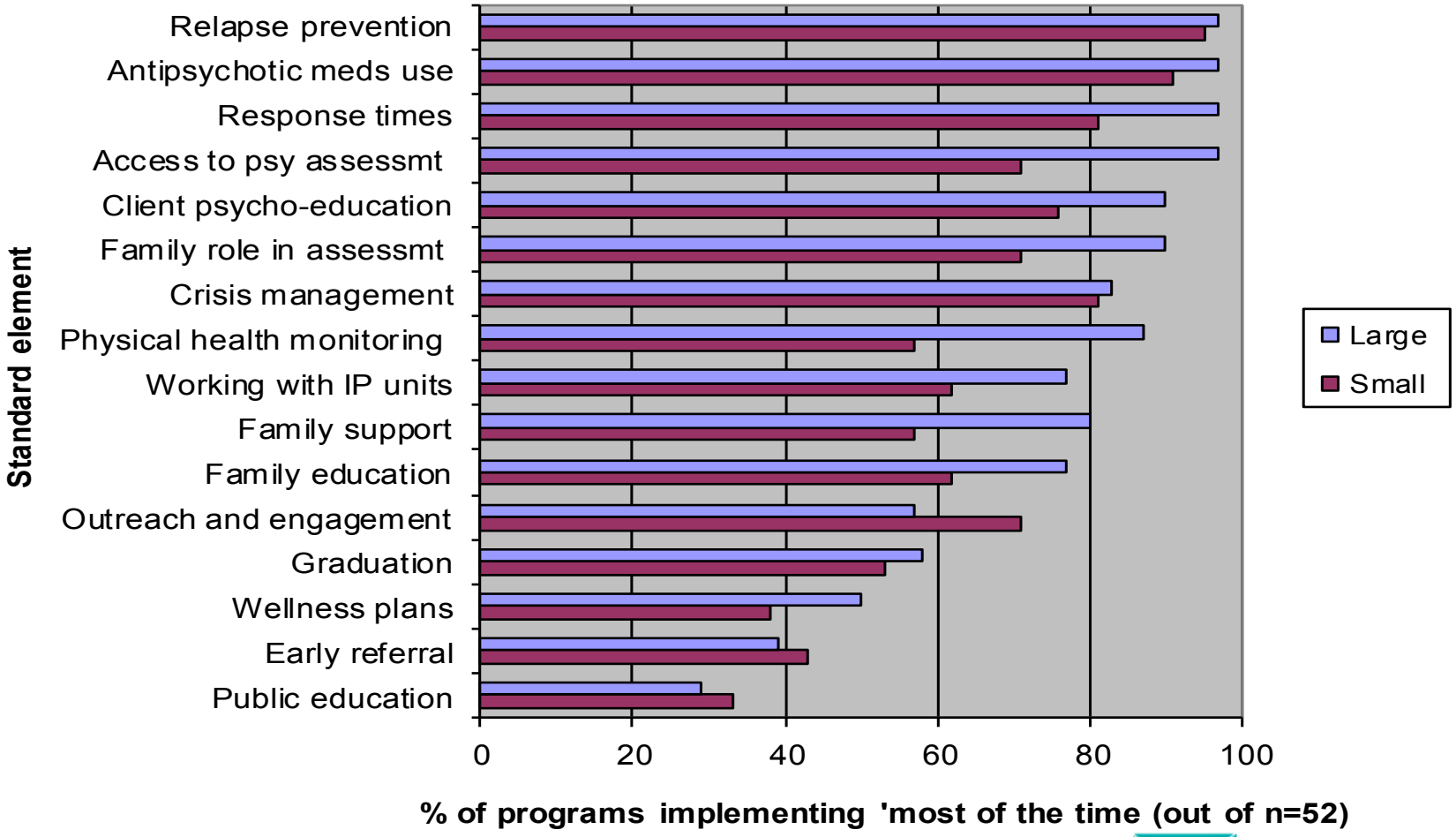
Survey 1: Standards 1-6 (2012)



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Survey 2: Standards 7-13 (2014)

- **Provincial capacity**
- **Standards**
  - Training & education
  - Research, evaluation and data collection
  - Barrier free services
  - Program networks
  - Accountability & regulatory (records, complaints, reporting)
- **Feedback**
  - Global (contribution to quality of care)
  - Strategies, challenges
  - Good practice examples

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Provincial capacity

- 56 EPI program sites, 220 clinical staff, ~4000 clients
- EPI service in every region
- High heterogeneity
  - e.g., staffing and clients served
- 45% of program sites - 2 or fewer clinical FTE staff
- Average caseload: 21 clients/clinical staff
  - higher than recommended
- Signs of resource drift and erosion

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* NHS Benchmarking Network, 2014
** Bird et al., 2010

Program networks

Aim:

- Networks are unique feature of the Ontario Standards
- EPI multi-component, complex model
- Network arrangement can expand capacity, quality, geographic reach

Most programs are part of a network, arrangements variable …

- one central program with satellite sites
- multiple small programs embedded in local agencies
- multiple dedicated programs
- traveling teams with local supports
- combination of the above models.

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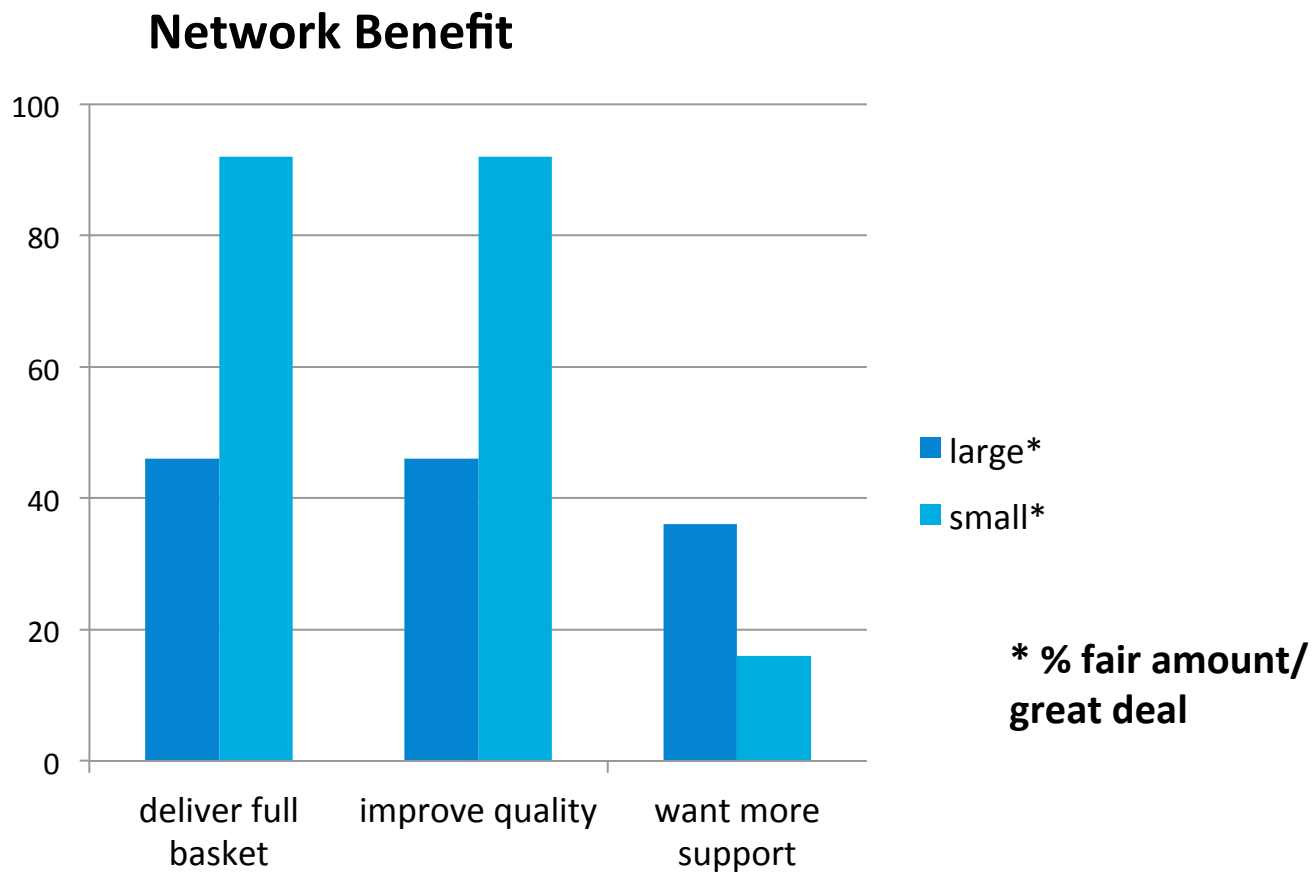
Program Networks



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Question from Sept 22 webinar:

How important is the team approach?

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Research, evaluation & data collection

Aims:

- Help programs deliver high quality, relatively consistent care across the province

Survey feedback:

- Standard where programs reported lowest use and most challenge
  - 50% = use data to monitor/improve practice ‘fair amount/great deal’
  - 54% = more evaluation support would improve ability to deliver EPI

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Professional Training & Education

Aims:

- Effective EPI delivery requires skilled professionals (team, community)
- Young field ➔ new knowledge, integrate into practice

Feedback:

- Many programs report training prepares staff to provide high quality service (77%)
- More support could improve delivery of EPI (41%)
- Small programs similar to large, many reported support from their networks

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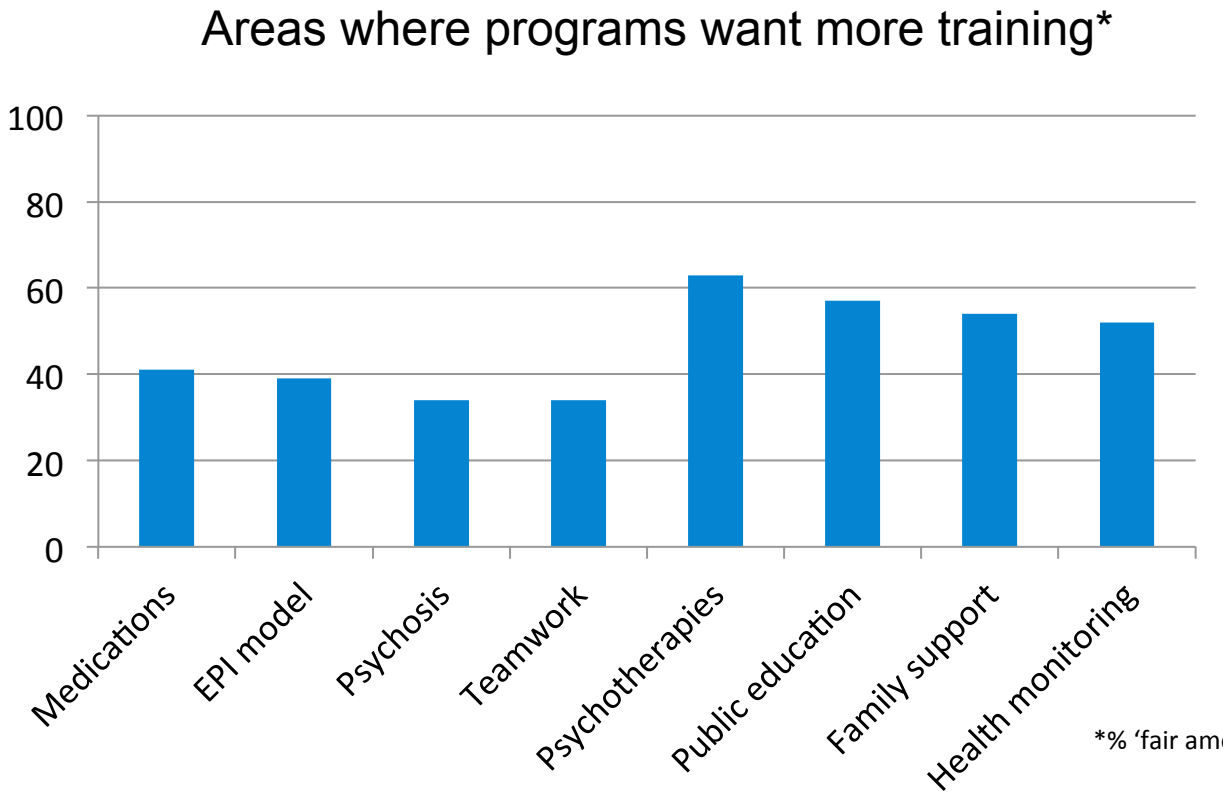
Professional Training & Education



*% 'fair amount, great deal

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Acknowledgements

- SISC (Standards Implementation Steering Committee)
  - Dr Janet Durbin, Avra Selick
- Funders:
  - CIHR Strategic Training Program (Research in Addictions and Mental Health Policy and Services, RAMHPS)
  - Ontario Mental Health Foundation
  - Ontario Ministry of Health & Long-Term Care
  - Sick Kids Foundation (jointly with CIHR-Institute of Human Development, Child and Youth Health)

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