Quality Standards

Schizophrenia

Care in the Community for Adults

October 2017

Health Quality Ontario

Let's make our health system healthier

Ontario
Health Quality Ontario

Summary

This quality standard addresses care for adults aged 18 years and older with a primary diagnosis of schizophrenia (including related disorders such as schizoaffective disorder). The quality standard focuses on care provided in the community, including primary care, hospital outpatient care, rehabilitation, and community supports and services. It also provides guidance on early psychosis intervention for people who experience first-episode psychosis, regardless of their age.

For a quality standard that addresses care for adults with schizophrenia who present at the emergency department or are admitted to hospital, see Quality Standard Schizophrenia: Care for Adults in Hospital.

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, patients, residents, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help patients, residents, families, and caregivers know what to ask for in their care
- Help health care professionals know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

The statements in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

They also include indicators to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps and areas for improvement and to guide measurement associated with their quality improvement efforts. These indicators measure process, structure, and outcomes.

In addition, tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact: qualitystandards@hqontario.ca.

About This Quality Standard

Scope of This Quality Standard

This quality standard addresses care for adults aged 18 years and older with a primary diagnosis of schizophrenia (including related disorders such as schizoaffective disorder). The quality standard focuses on care provided in the community, including primary care, hospital outpatient care, rehabilitation, and community supports and services. It also provides guidance on early psychosis intervention for people who experience first-episode psychosis, regardless of their age.

For a quality standard that addresses care for adults with schizophrenia who present at the emergency department or are admitted to hospital, see Quality Standard Schizophrenia: Care for Adults in Hospital.

Why This Quality Standard Is Needed

Schizophrenia is a severe, chronic mental health condition that usually begins in late adolescence or early adulthood. The symptoms of schizophrenia can be categorized as positive, negative or cognitive. Positive symptoms include hallucinations, delusions, and disorganized speech and behaviour.[1] Negative symptoms include apathy, social withdrawal, emotional flatness, and a restriction in the amount and content of speech.[1] Cognitive features include problems with memory, attention, planning, and organizing.[2]

In Canada, about 1 in 100 people have schizophrenia. A 2012 report identified schizophrenia as one of the five mental health and addictions-related conditions with the greatest impact on the life and health of people in Ontario.[3] The risk of developing schizophrenia is mainly accounted for by genetic factors. The risk is also higher in men, in people living in cities and in families of recent immigrants.[3,4]

People with schizophrenia die about 15 to 20 years earlier than the general population; the majority of these premature deaths result from cardiovascular or chronic respiratory disease.[5] People with schizophrenia are also much more likely to die by suicide compared with people without schizophrenia. Importantly, people with schizophrenia have an increased risk of having other psychiatric conditions, including substance use disorders, depression, and anxiety. They are more likely to experience trauma, homelessness, and unemployment.[6,7]

People with schizophrenia face important gaps in the quality of care they receive in Ontario. Only 25% of people who are hospitalized for schizophrenia or psychosis receive a follow-up visit with a physician within 7 days, and people hospitalized for schizophrenia have a high rate (12.5%) of readmission within 30 days of discharge.[8] Rates of emergency department visits for schizophrenia vary widely across the province.[9] Access to psychiatrists also varies across Ontario: in 2009, the number of psychiatrists per 100,000 people ranged from 7.2 to 62.7 per 100,000 individuals across Ontario's 14 local health integration networks.[10]

People with schizophrenia are often disproportionately affected by homelessness, or are precariously housed.[11] About 520,700 people living with mental illness are inadequately housed in Canada, and of those, as many as 119,800 are homeless.[11] People with schizophrenia are heavily overrepresented in these populations; it is estimated that 35% to 50% of Canada's chronically homeless population has schizophrenia.[12]

People with schizophrenia often also encounter beliefs and attitudes that stem from negative stereotypes about mental illness. Stigma, or the perception of stigma, can negatively affect a person's recovery, their ability to tell friends and family about their illness, and their willingness to seek help. Stigma may also impact people's ability to access health care services.

Based on evidence and expert consensus, this quality standard addresses key areas that have been identified as having considerable potential for quality improvement in the community-based care of adults with schizophrenia in Ontario. The 15 quality statements that make up this standard provide guidance on high-quality care and offer accompanying indicators to help health care professionals and organizations measure the quality of the care they provide. Each statement includes details about its effect on people with schizophrenia, their families and caregivers, health care professionals, community service providers, health care services, and community support services at large.

Principles Underpinning This Quality Standard

Care for people with schizophrenia should incorporate the principles of recovery. As described by the Mental Health Commission of Canada, "recovery refers to living a satisfying, hopeful, and contributing life, even with on-going limitations from mental health problems and illnesses. It refers to a process or journey of healing in which, to the greatest extent possible, people are empowered to make informed choices about the services, treatments and supports that best meet their needs."[13] The commission elaborates that "recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments."[14]

People with schizophrenia have a right to receive services in an environment that promotes hope, empowerment, and optimism, and that embeds the values and practices of recovery-oriented care. Many intersecting factors—including biological, psychological, social, economic, cultural, and spiritual considerations—may affect a person's mental health and well-being.[14]

People with schizophrenia and their families, caregivers, and personal supports should also receive services that are respectful of their rights and dignity, and that promote self-determination. People with schizophrenia should engage with their care providers in informed, shared decision-making about their treatment options. Each person is unique and has the right to determine their path toward mental health and well-being.[14]

Care for people with schizophrenia should also recognize and be responsive to the specific needs of people who are marginalized, underserved, or members of other at-risk subgroups (e.g., lesbian, gay, bisexual, transgender, and queer or questioning populations; Indigenous populations; immigrant, refugee, and racialized populations; specific cultural groups; or survivors of sexual abuse or violence).

How We Will Measure Our Success

A limited number of overarching objectives are set for this quality standard; these objectives have been mapped to indicators to measure the success of this quality standard as a whole:

- Percentage of adults with schizophrenia who have had an unplanned hospital readmission for a mental health or addictions condition in the past 30 days (data source: Discharge Abstract Database)

- Percentage of adults hospitalized for schizophrenia who had contact with a trained mental health professional within 7 and 28 days of hospital discharge (data sources: Discharge Abstract Database, Ontario Health Insurance Plan Claims Database)
- Percentage of adults with schizophrenia who report unmet care needs (suggested stratification: type of need) (data sources: Ontario Common Assessment of Need or local data collection)
- Percentage of adults with schizophrenia who report living in stable housing for the past year (data source: local data collection)

In addition, each quality statement within this quality standard is accompanied by one or more indicators. These indicators are intended to guide measurement of quality improvement efforts related to implementation of the statement.

Quality Statements in Brief

QUALITY STATEMENT 1:
Care Plan and Comprehensive Assessment
Adults with schizophrenia have a care plan that is regularly reviewed and updated, and that is informed by a comprehensive assessment.

QUALITY STATEMENT 2:
Physical Health Assessment
Adults with schizophrenia receive a physical health assessment on a regular basis.

QUALITY STATEMENT 3:
Self-Management
Adults with schizophrenia have access to information and education that supports the development of self-management skills.

QUALITY STATEMENT 4:
Family Education, Support, and Intervention
Families of adults with schizophrenia are given ongoing education, support, and intervention that is tailored to their needs and preferences.

QUALITY STATEMENT 5:
Access to Community-Based Intensive Treatment Services
Adults with schizophrenia have timely access to community-based intensive treatment services based on their needs and preferences.

QUALITY STATEMENT 6:
Housing
Adults with schizophrenia have a safe, affordable, stable living environment that reflects their needs and preferences.

QUALITY STATEMENT 7:
Antipsychotic Monotherapy
Adults with schizophrenia are prescribed a single antipsychotic medication.

QUALITY STATEMENT 8:
Treatment With Long-Acting Injectable Antipsychotic Medication
Adults with schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

QUALITY STATEMENT 9:
Treatment With Clozapine
Adults with schizophrenia who have not responded to previous adequate trials of treatment with two different antipsychotic medications are offered clozapine.

QUALITY STATEMENT 10:
Continuation of Antipsychotic Medication
Adults with schizophrenia whose symptoms have improved with antipsychotic medication are advised to continue their antipsychotic medication for life.

QUALITY STATEMENT 11:
Psychological Interventions
Adults with schizophrenia are offered cognitive behavioural therapy for psychosis, as well as other evidence-based psychological interventions, based on their needs.

QUALITY STATEMENT 12:
Promoting Physical Activity and Healthy Eating
Adults with schizophrenia are offered readily accessible interventions that promote physical activity and healthy eating.

QUALITY STATEMENT 13:
Promoting Smoking Cessation
Adults with schizophrenia are offered pharmacological and nonpharmacological interventions to help them reduce or stop smoking tobacco.

QUALITY STATEMENT 14:
Assessing and Treating Substance Use Disorder
Adults with schizophrenia are asked about their substance use and, if appropriate, they are assessed for substance use disorder and offered treatment for concurrent disorders.

QUALITY STATEMENT 15:
Employment and Occupational Support
Adults with schizophrenia who wish to find work or return to work are offered supported employment programs. Adults with schizophrenia who are not seeking paid work are supported in other occupational or education activities, in accordance with their needs and choices.

Quality Statement 1: Care Plan and Comprehensive Assessment

Adults with schizophrenia have a care plan that is regularly reviewed and updated, and that is informed by a comprehensive assessment.

Background

Every person with schizophrenia should have a care plan that they develop with their health care professional that is, ideally, also informed by input from their family, caregivers, and/or personal supports. The care plan needs to be tailored to the person's goals, personal strengths, and resources, and it should reflect their cultural beliefs and realities. It should aim to reduce symptoms, improve psychosocial functioning, and help the person fulfil their individual needs and aspirations.[15] Regular review of the care plan will enable the person and their health care professional to review progress, revisit goals, and make adjustments for changing needs and preferences.

A comprehensive assessment of the person with schizophrenia should inform the development of the care plan. The comprehensive assessment allows health care providers to thoroughly explore the biological, psychological, and social factors that may have contributed to the onset, course, and outcome of the person's illness, and that may influence their recovery. An assessment can determine a baseline level of functioning, activity, and participation, and be used to track changes in the person's status over time. Depending on how care is organized, the components of the assessment may be carried out by several members of an interprofessional team, or the person with schizophrenia may be referred to other health care professionals as needed to complete the assessment.

The care plan and findings from the assessment should be shared with the person with schizophrenia, and with relevant health service providers, as well as with the person's family or caregiver, unless the person indicates that they do not want such information shared.

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6]

Definitions Used Within This Quality Statement

Care plan
A care plan includes:

- Results of the comprehensive assessment (see definition below)
- Mutually agreed-upon goals based on the person's needs, strengths, and preferences, including activities of daily living, housing, daily structure and employment, symptom reduction, and family and social relationships
- Interventions, activities, and other steps the person and others might take to help them achieve their goals, optimize their capacity to function as independently as possible, and support their social inclusion
- A crisis plan that identifies potential early warning signs; describes self-management strategies; identifies where the person would prefer to be admitted in the event of hospitalization; describes practical needs if the person is admitted to hospital (e.g., care of children, other relatives or pets) and the involvement of family and friends in care (identifies named contacts)
- Roles and responsibilities of health and community service providers

Regularly reviewed and updated
The care plan should be reviewed every 6 to 12 months, or sooner if there is a clinical need or a significant change in a person's goals. Reviewing the care plan may require a partial or full reassessment, including revisiting recovery and treatment goals.

Comprehensive assessment
In collaboration with the individual, the comprehensive assessment should be undertaken by health care professionals who have expertise in the care of people with schizophrenia. It should be informed by communication with the person's primary care provider, mental health provider, and/or community treatment providers. The assessment should address the following:

- Self-identified goals, aspirations, personal strengths, and resources that are aligned with personal recovery
- Psychiatric symptoms and impairments; risk of harm to self or others; current and past treatment and response; alcohol and drug use (see Quality Statement 14)
- Medical considerations, including medical history and physical examination to assess medical conditions
- Physical health and well-being (see Quality Statement 2)
- Psychological and psychosocial status, including social networks, intimate relationships, and history of trauma or adversity
- Developmental needs (social, cognitive, sensory, and motor development and skills); consider neuropsychological assessment for people with an intellectual disability or functional impairment
- Social status (housing; culture and ethnicity; responsibilities for children or as a caregiver; role of family and involvement in the person's life; leisure activities and recreation; community participation)
- Occupational and educational situation, financial status
- Activities of daily living, instrumental activities of daily living, and home management
- Legal history and current legal involvement
- Service needs (assessed using a tool or instrument such as the Level of Care Utilization System, or Ontario Common Assessment of Need) to match resource intensity with care needs

What This Quality Statement Means

For Adults With Schizophrenia
Your health care team should work with you to develop a care plan that works for you. Your family or caregivers can be involved in making the plan, if you agree. A care plan is a written document that you agree to. It describes your goals, the care and services you will receive, and who will provide them. The care plan should be updated regularly.

Your care plan should be informed by a comprehensive assessment. This assessment should include questions about your physical and mental health, your medical history, what medications you are taking, your social situation, your goals for recovery, and how you are feeling.

For Clinicians
Work with adults with schizophrenia (and their family or caregivers, if they agree) to create an individualized care plan. The plan documents mutually agreed-upon goals, individual concerns

and preferences, care and services, and a crisis plan, and it incorporates the results of the comprehensive assessment. The plan should be reviewed and updated regularly.

For Health Services
Ensure that systems, processes, and resources are in place to help care providers develop, implement, and reassess care plans for adults with schizophrenia. This may include access to standardized care plan templates and comprehensive assessment tools, and access to the resources necessary to carry out the care plan.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who had a comprehensive assessment within 6 months of initial presentation

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who had a comprehensive assessment within 6 months of initial presentation
- Data source: local data collection

Percentage of adults with schizophrenia who have a care plan that has been reviewed in the past 12 months

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have a care plan that has been reviewed in the past 12 months
- Data source: local data collection

Percentage of adults with schizophrenia who have had their community service need assessed using a standardized, validated tool

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had their community service need assessed using a standardized, validated tool (such as the Level of Care Utilization System, or Ontario Common Assessment of Need)
- Data source: local data collection

Quality Statement 2: Physical Health Assessment

Adults with schizophrenia receive a physical health assessment on a regular basis.

Background

Adults with schizophrenia have poorer physical health and a shorter life expectancy than the general population: on average, men with schizophrenia die 20 years earlier and women 15 years earlier.[5] Common conditions that contribute to the high risk of morbidity and premature mortality in people with schizophrenia include cardiovascular disease, diabetes and metabolic syndrome, and lung disease.[7,17] Factors that contribute to poor physical health in people with schizophrenia include smoking, medication side effects, and lifestyle factors.[18] As well, disparities in health care provision—including difficulties accessing medical health services, lack of coordination of services, and under-recognition and under-treatment of physical health conditions—affect health outcomes for people with schizophrenia.[17-20]

Supporting the physical health of people with schizophrenia is an essential part of improving their overall health outcomes, promoting their capacity to set and achieve recovery goals, and enabling them to participate fully in their community. As part of this, it is important to comprehensively assess and monitor their physical health to enable treatment, if necessary. Access to timely and comprehensive primary health care is also key for managing people's general and preventative health care needs, including regular screening (e.g., cervical cancer, colon cancer), immunizations, and management of any chronic health conditions.

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Physical health assessment

The following should be assessed and recorded at baseline before starting antipsychotic medication (or as soon as feasible if the medication needs to be started quickly). They should also be monitored and recorded regularly and systematically during treatment, especially when titrating medications. Each assessment should inform the care plan (see Quality Statement 1).

- Weight and body mass index (at baseline, weekly for the first 6 weeks, then at 12 weeks, 1 year, and annually, plotted over time)
- Waist circumference (at baseline and annually, plotted over time)
- Pulse and blood pressure (at baseline, 12 weeks, 1 year, and annually)
- Fasting blood glucose and glycated hemoglobin (HbA1c; at baseline, 12 weeks, 1 year, and annually)
- Blood lipid panel—total cholesterol, low- and high-density lipoprotein cholesterol, triglycerides (at baseline, 12 weeks, 1 year, and annually)
- Prolactin (as clinically indicated)
- Electrocardiogram (as clinically indicated)
- Acute extrapyramidal symptoms and tardive dyskinesia

- Overall physical health (with particular attention to conditions common in people with schizophrenia, including cardiovascular disease, diabetes and metabolic syndrome, and lung disease)
- Age-appropriate physical health screening
- Nutritional intake and level of physical activity
- Smoking status
- Alcohol and drug use
- Sexual health
- Dental health

What This Quality Statement Means

For Adults With Schizophrenia
Following the assessment and as part of your regular checkups, your care team will look for health problems that are common in people with schizophrenia, such as diabetes, weight gain, or heart or lung disease. The results of these checkups should be part of your care plan.

For Clinicians
Complete a physical assessment that focuses on conditions that are common in people with schizophrenia. The assessment should inform the person's care plan.

For Health Services
Ensure that systems, processes, and resources are in place for health care professionals and teams to carry out ongoing comprehensive physical health assessments in people with schizophrenia. This includes access to standardized physical assessment protocols and tools.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who have a comprehensive physical health assessment within 12 weeks after starting antipsychotic medication

- Denominator: total number of adults with schizophrenia who are started on antipsychotic medication
- Numerator: number of people in the denominator who have a comprehensive physical health assessment within 12 weeks after starting antipsychotic medication
- Data source: local data collection

Percentage of adults with schizophrenia who have an annual comprehensive physical health assessment

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had a comprehensive physical health assessment within the previous 12 months
- Data source: local data collection
- Potential stratification: service type

Quality Statement 3: Self-Management

Adults with schizophrenia have access to information and education that supports the development of self-management skills.

Background

For people with schizophrenia, the ability to actively self-manage their health and well-being is an important factor in reducing the risk of relapse and a key step in the recovery journey. Self-management involves learning about schizophrenia and treatment options, improving illness-management skills, developing recovery and self-management strategies, and gaining skills to manage stress and life changes.[7] Peer support may help people manage their own health and recovery.

Sources: National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6]

Definitions Used Within This Quality Statement

Self-management
Self-management involves people actively managing their own recovery. For people with schizophrenia, self-management information and education should include:

- Information about causes, symptoms, and treatment of schizophrenia
- Effective use of medication
- Identifying and coping with symptoms
- Accessing mental health and other support services
- Managing stress
- Self-care
- Crisis planning
- Building a social support network
- Relapse prevention
- Setting personal recovery goals

What This Quality Statement Means

For Adults With Schizophrenia
When you understand schizophrenia better, you can be more actively involved in your own recovery. Your care team should give you information to help you manage your schizophrenia and understand this condition.

For Clinicians
Offer self-management education to adults with schizophrenia. Education should align with their needs and stage of illness, and focus on empowering people to engage in their own recovery. If you are not able to provide education onsite, ensure that people have access to it elsewhere (e.g., a partnership with local organization).

For Health Services
Ensure that health care professionals are able to offer self-management education or refer people to local programs.

Quality Indicators

Process Indicator

Percentage of adults with schizophrenia who have received education about self-management

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have received education about self-management
- Data source: local data collection

Quality Statement 4: Family Education, Support, and Intervention

Families of adults with schizophrenia are given ongoing education, support, and intervention that is tailored to their needs and preferences.

Background

Family—which can include relatives, caregivers, or people from a broader circle—can play a vital role in supporting a person's recovery, promoting their well-being, and providing care.[22] It is important that families be connected with education and supports that are tailored to their circumstances and needs, including programs for the parents, siblings, or children of people with schizophrenia; financial assistance; and respite care.[22]

Family members who have ongoing contact with a person with schizophrenia may benefit from family intervention. Family intervention aims to improve family members' support and resilience and enhance the quality of their communication and problem-solving. Delivered by a trained practitioner, family intervention also seeks to provide insight into the condition of the person with schizophrenia and teach family members to identify the signs and symptoms of relapse, improving their ability to anticipate and help reduce risk of relapse.[23]

People with schizophrenia should be encouraged to include family members in their treatment and recovery. If a person with schizophrenia chooses not to involve their family, family members should still be offered education and support.

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24] | Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Family
Family is whoever the person with schizophrenia defines it to be. It may include relatives, a significant other, children, siblings, personal supports, or a caregiver who is in close contact.

Education
Education consists of evidence-based information provided verbally and/or in print or multimedia format. It should include the following, at a minimum:

- Diagnosis and management of schizophrenia
- Positive outcomes and recovery
- Available support services and how to access them
- Self-care and coping strategies
- Role of teams and services
- Getting help in a crisis

During education, support should also be offered, if necessary.[7]

Support and intervention
Families should have access to a range of supports and interventions, which may include:

- Psychoeducation
- Support and information available by telephone and through the Internet
- Support groups
- Respite for caregivers
- Family intervention (involve the person with schizophrenia whenever possible; includes communication skills, problem-solving, and education)

What This Quality Statement Means

For Adults With Schizophrenia and Families
Your care team should also give your family or caregiver opportunities to learn about schizophrenia, and to get support if they need it. This is important so they can do a better job of helping you and supporting you in your recovery, while also looking after their own needs.

For Clinicians
Offer families education and supports that align with their circumstances and needs. If you are not able to provide education or support onsite, ensure that people have access to them elsewhere (e.g., through a partnership with a local organization).

For Health Services
Ensure that family-focused education, supports, and programs are available by providing adequately resourced systems and services.

Quality Indicators

Process Indicator

Percentage of adults with schizophrenia whose family members receive family intervention by a trained practitioner

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator whose family members receive family intervention by a trained practitioner
- Data source: local data collection

Outcome Indicator

Percentage of adults with schizophrenia whose family members or unpaid caregivers report continued feelings of distress, anger, or depression over a 12-month period

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator whose family members or unpaid caregivers report continued feelings of distress, anger, or depression over a 12-month period
- Data sources: adapted from RAI–Home Care (RAI-HC) assessments; local data collection

Quality Statement 5: Access to Community-Based Intensive Treatment Services

Adults with schizophrenia have timely access to community-based intensive treatment services based on their needs and preferences.

Background

People with schizophrenia need access to community-based intensive treatment services that meet their needs and preferences, at the right time, and in the right place to help them in their recovery. Services should be available regardless of factors such as gender, age, income, race, culture, ethnicity, immigration status, or whether they live in a rural or urban area. People's needs and preferences change over their lifespan and illness; a person may require different services (or changes in the intensity of services) at different times.[22] Assessment of level-of-service needs (using a tool such as the Level of Care Utilization System, or the Ontario Common Assessment of Need) can be useful in matching resource intensity with care needs.

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24] | Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Intensive treatment services
People experiencing first-episode psychosis should have access to early psychosis intervention.[6,7,16,21,24] This involves specialized treatment and support provided by a multidisciplinary team to reduce treatment delays, promote recovery, and reduce relapse.[7] These services provide a full range of pharmacological, psychological, social, occupational, and educational interventions for people with psychosis, as well as support services for families.[7]

People who have difficulty engaging with mental health services should have access to assertive community treatment and intensive case management.

- Assertive community treatment involves intensive treatment, rehabilitation, and support provided by a multidisciplinary team.[6,16,21,24,25] Team members work with the person to provide services that are tailored to meet the person's needs and goals. Services include assertive outreach; pharmacological, psychological, social, and occupational interventions; daily living support; and crisis assessment and intervention[15,26]
- Intensive case management involves a case manager who provides intensive, assertive outreach and facilitates coordinated access to services, supports, and resources from across the mental health system, as well as from other systems (e.g., housing, addictions, justice, education, social services)[6,16,26-28]

Timely access
Early psychosis intervention should be accessible to all people with a first presentation of psychosis within 2 weeks of referral, irrespective of the person's age or the duration of untreated psychosis.[7,29] Intake for assertive community treatment or intensive case management should be initiated within 2 weeks after initial contact.[15,28]

What This Quality Statement Means

For Adults With Schizophrenia and Families

- Depending on your needs, your care team may connect you with specialized treatment services:
  - Early psychosis intervention if you have a first episode of psychosis
  - Assertive community treatment, where a team works directly with you to provide services and supports that are tailored to meet your needs and goals
  - Intensive case management, where a case manager connects you with services and supports that are tailored to meet your needs and goals

These services will help you to live in the community, manage your symptoms, and reach your recovery goals.

For Clinicians

Refer people to the community-based services that will best meet their needs. Advise them on available services and how to access them.

For Health Services

Ensure that people with schizophrenia have timely and equitable access to the intensive treatment services they need, when they need them, by providing adequately resourced systems and services. Work collaboratively with stakeholders, communities, and people with lived experience, using local data and evidence to plan and develop population-based services that reach and meet the needs of all people with schizophrenia, particularly those who are socially disadvantaged or have barriers to accessing care. Ensure that health care professionals are aware of services and able to connect or refer people to them.

Quality Indicators

Process Indicators

Percentage of people with a first episode or first presentation of psychosis who receive access to early psychosis intervention within 2 weeks of referral

- Denominator: total number of people with a first episode or first presentation of psychosis
- Numerator: number of people in the denominator who receive access to early psychosis intervention within 2 weeks of referral
- Data source: local data collection

Percentage of adults with schizophrenia who have had their community service need assessed using a standardized, validated tool

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have had their community service need assessed by a standardized, validated tool (such as the Level of Care Utilization System, or Ontario Common Assessment of Need)
- Data source: local data collection

Quality Statement 6: Housing

Adults with schizophrenia have a safe, affordable, stable living environment that reflects their needs and preferences.

Background

Housing is a key social determinant of health. In Canada, about 520,700 people with mental illness are inadequately housed, and of those, as many as 119,800 are homeless.[13] Safe, affordable, stable, well-maintained housing supports good physical and mental health, facilitates social inclusion, and is an important foundation for recovery.[6,11,30] When a person's housing is not safe, affordable, stable, or of good quality, that person is at increased risk of negative outcomes related to their health and well-being.[11,31,32]

All people with schizophrenia—including those who are homeless or who have a concurrent disorder—should have access to housing and housing supports that meet their needs. People's housing needs vary and may change over time, so housing and housing supports need to be flexible and tailored to a person's strengths, needs, and preferences, while also being timely, accessible, affordable, and based on the person's choice. Standardized tools such as the Service Prioritization Decision Assistance Tool may be helpful for assessing a person's needs and support requirements.

Sources: Royal Australian and New Zealand College of Psychiatrists, 2016[6] | World Health Organization, 2012[33]

Definitions Used Within This Quality Statement

Safe, affordable, stable living environment
The person's living environment is facilitated using a continuum of community housing supports and services according to the person's needs, preferences, and supports needed, which may include:

- Home modifications
- Supported housing
- Independent housing with supports
- Affordable general housing
- Housing First interventions for people who are homeless or precariously housed, which may be delivered in conjunction with intensive care management or assertive community treatment (e.g., At Home/Chez Soi)

What This Quality Statement Means

For Adults With Schizophrenia
It's easier to focus on your recovery when you don't have to worry about having somewhere to live. Your care team should connect you with services that can help you find a safe, affordable, stable place to live, as well as housing supports, if you need them.

For Clinicians
Ensure that adults with schizophrenia have access to safe, affordable, stable housing and housing supports that reflect their needs and preferences.

For Health Services
Ensure that adults with schizophrenia can access the housing supports and services they need, when they need them, within the constraints of locally available resources. Ensure that health care providers are aware of these services and able to connect or refer people to them.

Quality Indicators

Outcome Indicators

Percentage of adults with schizophrenia who report living in a safe, affordable, and stable living environment

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report living in a safe, affordable, and stable living environment
- Data source: Ontario Common Assessment of Need; local data collection

Percentage of adults with schizophrenia who are homeless or precariously housed

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who are homeless or precariously housed
- Data source: local data collection

Structural Indicator

Local availability of funding for Housing First interventions for people with schizophrenia who are homeless or precariously housed

- Data source: local data collection

Quality Statement 7: Antipsychotic Monotherapy

Adults with schizophrenia are prescribed a single antipsychotic medication.

Background

Antipsychotic medication is usually effective in resolving psychotic symptoms and in preventing recurrence of symptoms.[7] A single antipsychotic medication should be prescribed, at the lowest dose effective for the person with schizophrenia.[7] People who show no improvement in their psychotic symptoms after 2 weeks of treatment with an appropriate antipsychotic agent (given at the recommended dose and with good adherence) may benefit from switching to another antipsychotic agent.[6,24,34] Taking two or more antipsychotic medications concurrently should generally be avoided; it has not been shown to be more effective than taking a single antipsychotic and is associated with an increased risk of adverse effects.[6,7,21,24,33] The use of antipsychotic medication—including benefits, risks, clinical response, and side effects—should be discussed with the person with schizophrenia. Whenever possible, include family members in these discussions. While a person is on antipsychotic monotherapy, they can take other types of medications (i.e., non-antipsychotic medications) to manage schizophrenia, or to treat other co-occurring psychiatric and medical conditions.

A long-acting injectable antipsychotic medication should be offered early in the course of antipsychotic treatment (see Quality Statement 8).

Review a person's medication and dosage regularly, including response, observed benefits, and side effects.[7] If psychotic symptoms do not improve with antipsychotic medication, consider the potential causes of nonresponse, including incorrect diagnosis, inadequate dose, poor adherence, concurrent substance use, and physical illness.[7] If the person with schizophrenia does not achieve an adequate response after trials of two different antipsychotic agents given separately at therapeutic doses for a sufficient duration, treatment with clozapine is indicated (see Quality Statement 9).

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Scottish Intercollegiate Guidelines Network, 2013[21] | World Health Organization, 2012[33]

What This Quality Statement Means

For Adults With Schizophrenia
You should be offered only one antipsychotic medication at a time. If your symptoms don't get better after taking a medication regularly for 2 weeks at the right dose, you should talk to your health care professional about switching to a different medication.

For Clinicians
Adults with schizophrenia should usually be prescribed one antipsychotic medication at a time. Consider switching them to another antipsychotic medication if their psychotic symptoms show no improvement after 2 weeks of treatment at an optimal dose. Regularly monitor and document people's symptoms.

For Health Services
Ensure that systems, processes, and resources are in place for health care professionals to appropriately trial one antipsychotic medication at a time and monitor people's response to treatment.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who are prescribed a single antipsychotic medication

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who are prescribed a single antipsychotic medication
- Data sources: Ontario Prescription Drug database for those age 65+; local data collection (for those less than age 65 and to identify the denominator)

Percentage of adults with schizophrenia who show no improvement in their psychotic symptoms after 2 weeks of treatment with an antipsychotic agent and who are provided a different antipsychotic agent

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator who show no improvement in their psychotic symptoms after 2 weeks of treatment with an appropriate antipsychotic agent (given at the recommended dose and with good adherence) and who are provided a different antipsychotic agent
- Data sources: Ontario Prescription Drug database for those age 65+; local data collection (for those less than age 65 and to identify the denominator)

Percentage of adults with schizophrenia who have had their antipsychotic medication reviewed in the past 12 months

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator who have had their antipsychotic medication reviewed in the past 12 months (including response, observed benefits, and side effects), or more frequently if clinically indicated
- Data source: local data collection

Outcome Indicator

Percentage of adults with schizophrenia who have been prescribed an antipsychotic medication (or their substitute decision-makers) and who felt involved in discussions about their medications, including benefits, risks, clinical response, and side effects

- Denominator: total number of adults with schizophrenia who have been prescribed an antipsychotic medication
- Numerator: number of people in the denominator (or their substitute decision-makers) who felt involved in discussions about their medications, including benefits, risks, clinical response, and side effects
- Data source: local data collection

Quality Statement 8: Treatment With Long-Acting Injectable Antipsychotic Medication

Adults with schizophrenia are offered the option of a long-acting injectable antipsychotic medication.

Background

Long-acting injectable antipsychotic medications can improve treatment adherence and prevent relapse.[7,35] Relapses may contribute to worsening outcomes over the course of the illness.[36] Treatment with long-acting injectable medications provides people with medication on a consistent schedule and provides clinicians with a valid measure of treatment adherence, the major determinant of relapse.[7]

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Scottish Intercollegiate Guidelines Network, 2013[21] | World Health Organization, 2012[33]

Definitions Used Within This Quality Statement

Long-acting injectable antipsychotic medication
Antipsychotic medication given as an intramuscular injection every 2 weeks to every 3 months, depending on the medication. Health care professionals should discuss the option of long-acting injectable antipsychotic medications with the person early in their course of treatment. Whenever possible, family members should be included in these discussions.

What This Quality Statement Means

For Adults With Schizophrenia
You may want to take your antipsychotic medication as a long-acting injection so you don't have to remember to take a pill every day. Your health care professional should talk to you about whether this would be a good option for you. Depending on the medication, you would get an injection every 2 weeks to every 3 months. Not all antipsychotic medications can be given as a long-acting injection.

For Clinicians
Discuss the option of long-acting injectable antipsychotic medications with adults with schizophrenia. Offer this option early in the course of antipsychotic treatment.

For Health Services
Ensure that clinicians can offer long-acting injectable antipsychotic medications to adults with schizophrenia by providing adequately resourced systems and services.

Quality Indicators

Process Indicator

Percentage of adults with schizophrenia who have been offered a long-acting injectable antipsychotic medication

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have been offered a long-acting injectable antipsychotic medication
- Data source: local data collection

Outcome Indicator

Percentage of adults with schizophrenia who have been prescribed a long-acting injectable antipsychotic medication (or their substitute decision-makers) and who felt involved in discussions about their medication, including benefits, risks, clinical response, and side effects

- Denominator: total number of adults with schizophrenia who have been prescribed a long-acting injectable antipsychotic medication
- Numerator: number of people in the denominator (or their substitute decision-makers) who felt involved in discussions about their medication, including benefits, risks, clinical response, and side effects
- Data source: local data collection

Quality Statement 9: Treatment With Clozapine

Adults with schizophrenia who have not responded to previous adequate trials of treatment with two different antipsychotic medications are offered clozapine.

Background

Clozapine is uniquely effective and is the treatment of choice if a person with schizophrenia has not responded to other antipsychotic medications, or has had a partial response but experience persistent psychotic symptoms.[7] A trial of clozapine should also be considered for people with schizophrenia who experience significant side effects from other antipsychotic medications, [6] who exhibit persistent symptoms of aggression or violent behaviours, or who have persistent suicidal thoughts or behaviours.[6,16,24] If clozapine is not effective or not tolerated, consider a referral to a psychiatrist who specializes in treating schizophrenia.

Like other antipsychotic medications, clozapine is associated with a range of adverse effects that can influence physical health, and it requires ongoing physical health assessment and management (see Quality Statement 2).[24] Clozapine is also associated with an increased risk of several severe adverse effects, including agranulocytosis, myocarditis, and cardiomyopathy; protocols to monitor and manage these risks need to be followed rigorously.[6]

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] **|** Royal Australian and New Zealand College of Psychiatrists, 2016[6] **|** Schizophrenia Patient Outcomes Research Team, 2010[24] **|** Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Not responded
People with schizophrenia who continue to experience persistent and clinically significant positive symptoms (i.e., hallucinations, delusions, skewed perceptions, and disorganized thinking or behaviour[37]) after trials of two different antipsychotic medications at adequate dosage and duration, and with reasonable assurance of medication adherence during the trials.

What This Quality Statement Means

For Adults With Schizophrenia
If you have tried at least two different types of antipsychotic medications and you experience significant side effects, or your symptoms are not better, your health care professional should talk to you about taking a medication called clozapine.

For Clinicians
Offer clozapine to adults with schizophrenia if they have tried two different antipsychotic medications and their symptoms have not improved or remain distressing.

For Health Services
Ensure that systems, processes, and resources are in place so clinicians can offer clozapine as a treatment for schizophrenia, and so they can monitor and manage the risks associated with clozapine.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who receive clozapine after not responding to trials of two different antipsychotic medications

- Denominator: total number of adults with schizophrenia who did not respond to trials of two different antipsychotic medications
- Numerator: number of people in the denominator who receive clozapine
- Data sources: Ontario Prescription Drug database for those age 65+; local data collection for those less than age 65 and to calculate the denominator

Percentage of adults with schizophrenia who have had their clozapine medication reviewed in the past 12 months

- Denominator: total number of adults with schizophrenia who have been prescribed clozapine
- Numerator: number of people in the denominator who have had their clozapine medication reviewed in the past 12 months (including response, observed benefits, and side effects), or more frequently if clinically indicated
- Data source: local data collection

Quality Statement 10: Continuation of Antipsychotic Medication

Adults with schizophrenia whose symptoms have improved with antipsychotic medication are advised to continue their antipsychotic medication for life.

Background

People with an established schizophrenia diagnosis who experience remission from an acute episode with an antipsychotic medication can reduce their risk of relapse and development of treatment resistance by continuing to take the medication.[6,16,38,39] Antipsychotic medication should be reviewed at least once a year, taking into account response, observed benefits, and side effects.[6,7] The lowest dose that minimizes side effects and maximizes effectiveness should be used.[24] Treatment with a long-acting injectable antipsychotic medication should be offered early in the course of antipsychotic treatment (see Quality Statement 7).

To remain well, people need to continue to take antipsychotic medication for life. Any trial discontinuation of antipsychotic medication must be carried out under close supervision by the treating psychiatrist and team and include frequent follow-up to monitor for early signs of recurrence or relapse. Whenever possible, family members should be included in discussions about the risks associated with medication discontinuation, how to identify signs of recurrence, and the steps to take if symptoms recur.[33]

Sources: Canadian Psychiatric Association, 2005[16] | Schizophrenia Patient Outcomes Research Team, 2010[24]

What This Quality Statement Means

For Adults With Schizophrenia
If an antipsychotic medication works to make your symptoms better, you will need to keep taking it throughout your life to stay well. You should review your medications once a year with your health care professional to make sure the medication continues to work for you.

For Clinicians
Ensure that adults with schizophrenia continue to take their antipsychotic medication and that they and their family are educated about the role of maintenance medication in helping them stay well.

For Health Services
Ensure that systems, processes, and resources are in place so that adults with schizophrenia whose symptoms have improved can continue treatment with antipsychotic medication, and regular medication reviews can be conducted.

Quality Indicators

Process Indicator

Percentage of adults with schizophrenia using their antipsychotic medication

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator using their antipsychotic medication
- Data sources: Ontario Prescription Drug database for those age 65+ (measures if the medication was prescribed, not necessarily taken); local data collection for those less than age 65 and to calculate the denominator

Outcome Indicator

Percentage of adults with schizophrenia who experience a relapse

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who experience a relapse (a return or worsening of symptoms)
- Data sources: National Ambulatory Care Reporting system (for relapses resulting in an emergency department visit), Discharge Abstract Database (for relapses resulting in a hospitalization), Ontario Health Insurance Plan billing database (for relapses resulting in a physician visit), local data collection (for relapses not captured in other settings)
- Potential stratification: use of antipsychotics at the time of relapse

Quality Statement 11: Psychological Interventions

Adults with schizophrenia are offered cognitive behavioural therapy for psychosis, as well as other evidence-based psychological interventions, based on their needs.

Background

There is evidence supporting the effectiveness of several psychological interventions for people with schizophrenia, depending on their needs.

Cognitive behavioural therapy is a form of psychotherapy delivered by a trained therapist that helps a person become more conscious of their beliefs and patterns of thinking, and provides strategies to reshape their beliefs and thoughts to achieve a positive outcome. Cognitive behavioural therapy for psychosis, when combined with antipsychotic medication, can reduce symptom severity and rehospitalization rates in people with schizophrenia.[7] Evidence also supports offering cognitive behavioural therapy for treatment of concurrent depression and anxiety in people with schizophrenia.[6,7,21]

Cognitive remediation therapy is a behavioural-training-based intervention facilitated by trained clinicians. It helps people with schizophrenia who have cognitive impairment improve their cognitive processes—including memory, concentration, and problem-solving.[6] It also helps them develop skills to enhance their recovery in such areas of daily living and social or vocational functioning.[21,40] There is growing evidence that when it is applied as an adjunct to supported employment programs, cognitive remediation therapy can enhance employment outcomes.[41]

Other psychological interventions are available, but at this time we cannot provide guidance on their use because of insufficient or inconsistent evidence in the guidelines (see Emerging Practice Statement).

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24] | Scottish Intercollegiate Guidelines Network, 2013[21] | World Health Organization, 2012[33]

Definitions Used Within This Quality Statement

Cognitive behavioural therapy for psychosis
This therapy should be:

- Started during the initial phase, the acute phase, or the recovery phase
- Started in the community or inpatient setting
- Delivered over at least 16 planned sessions spanning 4 to 9 months
- Ideally delivered one-on-one, but can be delivered in a group, given resource availability
- Delivered by an appropriately trained therapist according to a treatment manual

Other evidence-based psychological interventions
These include:

- Cognitive behavioural therapy for concurrent depression and anxiety in people with schizophrenia[6,7,21]
- Cognitive remediation therapy for people with schizophrenia who have cognitive impairment that affects functioning[6,21]

What This Quality Statement Means

For Adults With Schizophrenia
You should be offered psychological therapy as part of your treatment, based on your needs. Two types are called “cognitive behavioural therapy” and “cognitive remediation therapy.” Cognitive behavioural therapy helps you focus on everyday problems and learn how your thoughts can affect your feelings. Cognitive remediation therapy helps you improve your memory, concentration, and problem-solving skills.

For Clinicians
Ensure that cognitive behavioural therapy and cognitive remediation therapy are offered to adults with schizophrenia who may benefit.

For Health Services
Ensure that adults with schizophrenia can access cognitive behavioural therapy and cognitive remediation therapy by providing adequately resourced systems and services. Ensure that clinicians are aware of and able to refer people to these services.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who have received cognitive behavioural therapy for psychosis

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have received cognitive behavioural therapy for psychosis
- Data source: local data collection

Percentage of adults with schizophrenia and concurrent depression and anxiety who have received cognitive behavioural therapy for depression and anxiety

- Denominator: total number of adults with schizophrenia and concurrent depression and anxiety
- Numerator: number of people in the denominator who have received cognitive behavioural therapy for depression and anxiety
- Data source: local data collection

Percentage of adults with schizophrenia and cognitive impairments that affect their functioning who have received cognitive remediation therapy

- Denominator: total number of adults with schizophrenia and cognitive impairments that affects their functioning
- Numerator: number of people in the denominator who have received cognitive remediation therapy
- Data source: local data collection

Structural Indicators

Local availability of cognitive behavioural therapy programs given by trained and certified professionals

- Data source: local data collection

Local availability of cognitive remediation therapy programs given by trained and certified professionals

- Data source: local data collection

Quality Statement 12: Promoting Physical Activity and Healthy Eating

Adults with schizophrenia are offered readily accessible interventions that promote physical activity and healthy eating.

Background

There are many reasons why people with schizophrenia experience a higher incidence of physical health conditions (see Quality Statement 2), but one important group of causes is lifestyle factors, including poor nutrition and lack of physical activity.[7] Several of the medications used to treat schizophrenia may also cause weight gain.[6,7] These factors also create barriers to recovery, restricting the goals people set for themselves and their uptake of opportunities. Offering people with schizophrenia interventions that promote physical activity and healthy eating can help to improve their physical and mental health.[7] Such programs need to be affordable and accessible. People with schizophrenia and their families should also be educated about the importance of physical activity and healthy eating, and encouraged to participate in related programs.

Sources: National Institute for Health and Care Excellence, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Interventions that promote physical activity and healthy eating
Behavioural interventions that provide information and support as a way of increasing physical activity levels and promoting healthy eating.

What This Quality Statement Means

For Adults With Schizophrenia
A healthy lifestyle can help improve your physical and mental health. Your care team should give you information about programs that help you exercise and eat healthy foods.

For Clinicians
Be aware of local healthy eating and physical activity programs and encourage adults with schizophrenia to access them.

For Health Services
Ensure that interventions are available in the community to promote physical activity and healthy eating for adults with schizophrenia.

Quality Indicators

Process Indicator
Percentage of adults with schizophrenia who receive interventions that promote physical activity and healthy eating

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who receive interventions that promote physical activity and healthy eating
- Data source: local data collection

Structural Indicator

Local availability of programs that promote healthy eating and physical activity for adults with schizophrenia

- Data source: local data collection

Outcome Indicators

Percentage of adults with schizophrenia who are obese

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who are obese (body mass index >30.0 kg/m^2)
- Data sources: Canadian Community Health Survey (to identify numerator) and local data collection (to identify denominator)
- Exclusion: survey non-response categories (refusal, don't know, and not stated)

Percentage of adults with schizophrenia who report being active during their leisure time

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report being active during their leisure time
- Data source: Canadian Community Health Survey (to identify numerator) and local data collection (to identify denominator)
- Exclusion: survey non-response categories (refusal, don't know, and not stated)

Quality Statement 13: Promoting Smoking Cessation

Adults with schizophrenia are offered pharmacological and nonpharmacological interventions to help them reduce or stop smoking tobacco**.**

Background

Cigarette smoking rates among people with schizophrenia are much higher than in the general population.[42] High tobacco use contributes to the main causes of morbidity and mortality in people with schizophrenia.[43] Tobacco use may also interfere with the effectiveness and mechanisms of action of certain antipsychotic medications.[44] People with schizophrenia who want to reduce or stop smoking should be offered pharmacotherapy and nonpharmacological interventions that are aligned with their readiness for change.[24,45] Health care providers should monitor a person's psychiatric symptoms, medication dosage, and response when they are reducing or stopping smoking.[45]

Sources: National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24]

Definitions Used Within This Quality Statement

Interventions to help people reduce or stop smoking tobacco
A range of pharmacological and nonpharmacological interventions are available to help people reduce or stop smoking tobacco. These may include:

- Adequately dosed pharmacotherapy (i.e., varenicline or bupropion)
- Nicotine replacement therapy products (e.g., transdermal patches, gum, inhalation cartridges, sublingual tablets, or spray)
- Motivational interviewing
- Behavioural support

What This Quality Statement Means

For Adults With Schizophrenia
Quitting or cutting down on smoking can help improve your physical and mental health. Your health care professional should talk with you about ways to stop smoking or smoke less.

For Clinicians
Offer behavioural interventions, counselling, or medications to help adults with schizophrenia who smoke tobacco to help them reduce or stop smoking.

For Health Services
Ensure that behavioural interventions and medications are available in the community to help adults with schizophrenia reduce or stop smoking.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who smoke tobacco and who have developed a plan in the past year to reduce or stop tobacco use

- Denominator: total number of adults with schizophrenia who smoke tobacco
- Numerator: number of people in the denominator who have developed a plan in the past year to reduce or stop tobacco use
- Data source: local data collection

Percentage of adults with schizophrenia who smoke tobacco and receive at least one pharmacological or nonpharmacological intervention to help them reduce or stop smoking tobacco

- Denominator: total number of adults with schizophrenia who smoke tobacco
- Numerator: number of people in the denominator who receive at least one pharmacological or nonpharmacological intervention to help them reduce or stop smoking tobacco
- Data source: local data collection
- Potential stratification: intervention method (i.e., pharmacological or nonpharmacological)

Outcome Indicator

Percentage of adults with schizophrenia who smoke tobacco daily

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report smoking tobacco daily
- Data sources: Canadian Community Health Survey (Statistics Canada); local data collection to calculate the denominator

Quality Statement 14: Assessing and Treating Substance Use Disorder

Adults with schizophrenia are asked about their substance use and, if appropriate, they are assessed for substance use disorder and offered treatment.

Background

Substance use and substance use disorder are more common in people with schizophrenia than in the general public.[27,46] Substance use is associated with poor functional recovery and higher risk of relapse and hospitalization.[27] Substance use may exacerbate the symptoms of schizophrenia and worsen its course; substance use may also interfere with the therapeutic effects of both pharmacological and nonpharmacological treatments.[27] Health care professionals should routinely screen people with schizophrenia for use of a range of substances, including alcohol, prescription or nonprescription medications, illicit drugs, tobacco, and caffeine. Blood and urine tests may be considered as part of the assessment, treatment, and management of substance use disorder, but the person with schizophrenia should agree to testing as part of their care plan.[27]

Substance use should not prevent people with schizophrenia from receiving treatment or services. Treatment for concurrent disorders should be integrated with mental health and addictions services and take into account people's needs, preferences, and readiness to change.[6,27]

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24] | Scottish Intercollegiate Guidelines Network, 2013[21]

Definitions Used Within This Quality Statement

Substance use disorder
The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* defines substance use disorder as a problematic pattern of substance use leading to clinically significant impairment in daily life or distress, as manifested by at least two of 11 criteria occurring within a 12-month period.[1] The presence of two to three criteria indicates mild substance use disorder; four to five indicates moderate substance use disorder; and six or more indicates severe substance use disorder.[1]

What This Quality Statement Means

For Adults With Schizophrenia
Alcohol and drugs may make your schizophrenia symptoms worse and make your treatment less effective. Your health care professional should ask you about whether you use alcohol and drugs and offer you treatment to help you stop using them, if you need it.

For Clinicians
Ask adults with schizophrenia about their substance use. If necessary, conduct a more thorough assessment to diagnose substance use disorder and offer treatment for concurrent disorders.

For Health Services
Ensure that systems and resources are in place to allow care providers to screen for substance use and assess for substance use disorder. Ensure that pathways to treatment for concurrent disorders are in place for when substance use disorder is identified.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who have been assessed in the past year for substance use

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who have been assessed in the past year for substance use
- Data source: local data collection

Percentage of adults with schizophrenia and a substance use disorder who receive treatment for their substance use disorder

- Denominator: total number of adults with schizophrenia and a substance use disorder
- Numerator: number of people in the denominator who receive treatment for their substance use disorder
- Data source: local data collection

Outcome Indicator

Percentage of adults with schizophrenia and a substance use disorder who report unmet care needs

- Denominator: total number of adults with schizophrenia and a substance use disorder
- Numerator: number of people in the denominator who report unmet care needs
- Data source: Ontario Common Assessment of Need or local data collection
- Potential stratification: type of unmet care need

Quality Statement 15: Employment and Occupational Support

Adults with schizophrenia who wish to find work or return to work are offered supported employment programs. Adults with schizophrenia who are not seeking paid work are supported in other occupational or education activities, in accordance with their needs and choices.

Background

People with schizophrenia experience high rates of unemployment.[47] Engaging in meaningful, productive work and other activities reduces social isolation, promotes inclusivity, and is an essential element of recovery.[47] Barriers to employment include stigma and discrimination; lack of opportunities for education and skills development; limited ongoing support to get and keep a job; and disincentives in income support/benefit programs, where returning to paid work can mean the loss of health care benefits or subsidies.[47] People should also be supported in other meaningful occupational or education activities and interests, regardless of their desire for or participation in paid employment. Promising new opportunities have emerged in the form of work integration social enterprises and paid peer-provider and peer-support positions in the mental health system.[47,48]

Sources: Canadian Psychiatric Association, 2005[16] | National Collaborating Centre for Mental Health, 2014[7] | Royal Australian and New Zealand College of Psychiatrists, 2016[6] | Schizophrenia Patient Outcomes Research Team, 2010[24] | World Health Organization, 2012[33]

Definitions Used Within This Quality Statement

Supported employment
This is an approach to vocational rehabilitation that involves trying to place people in competitive jobs right away and providing them with ongoing job support.[7] Key elements of supported employment include developing job opportunities, focusing on individual preferences, conducting a rapid job search, ensuring availability of ongoing job supports, and integrating vocational and mental health services.[24]

Other occupational or education activities
These activities may include pre-vocational training, supported education, and volunteering.[6,7]

What This Quality Statement Means

For Adults With Schizophrenia
Your health care team should ask you about your work and education goals, and help you find ways to meet those goals.

For Clinicians
Ask adults with schizophrenia about their employment and other occupational and education interests and goals. Include this information in their care plan (see Quality Statement 1). Connect people with supports that can assist with these pursuits.

For Health Services
Ensure that adults with schizophrenia can access supported employment programs and other occupational and education activities within the constraints of locally available resources. Ensure that health care providers are aware of and able to connect or refer people to these services.

Quality Indicators

Process Indicators

Percentage of adults with schizophrenia who wish to work and who participate in supported employment programs

- Denominator: number of adults with schizophrenia who wish to work
- Numerator: number of people in the denominator who participate in supported employment programs
- Data source: local data collection

Percentage of adults with schizophrenia who are not seeking paid work and who participate in other occupational or education activities, in accordance with their needs and choices

- Denominator: number of adults with schizophrenia who are not seeking paid work
- Numerator: number of people in the denominator who participate in other occupational or education activities, in accordance with their needs and choices
- Data source: local data collection

Structural Indicators

Local availability of supported employment programs for people with schizophrenia

- Data source: local data collection

Local availability of supported educational programs for people with schizophrenia

- Data source: local data collection

Outcome Indicator

Percentage of adults with schizophrenia who report contributing meaningfully to their community and to society

- Denominator: total number of adults with schizophrenia
- Numerator: number of people in the denominator who report contributing meaningfully to their community and to society
- Data sources: local data collection

Emerging Practice Statement: Peer Support, Illness Management and Recovery Training, Wellness Recovery Action Planning, and Social Skills Training

What Is an Emerging Practice Statement?

An emerging practice statement describes an area for quality improvement that has been prioritized by the advisory committee but for which there is insufficient or inconsistent evidence in the guidelines used in the development of the quality statements. An emerging practice statement acknowledges that there is a need for evidence-based guidance to be developed in an area, but the evidence base in this area is still emerging.

Rationale

We cannot provide guidance at this time on peer support, illness management and recovery (IMR) training, wellness recovery action planning (WRAP), and social skills training because of conflicting recommendations in the guidelines used to develop the quality statements. While there is a growing body of literature showing the effectiveness of these interventions, further evidence is needed before a quality statement can be made. The advisory committee suggested these are important areas to be considered in future work**.**

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References

(1) American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): The Association; 2013.

(2) Fioravanti M, Bianchi V, Cinti ME. Cognitive deficits in schizophrenia: an updated metanalysis of the scientific evidence. BMC Psychiatry. 2012;12:64.

(3) Ratnasingham S, Cairney J, Rehm J, Manson H, Kurdyak PA. Opening eyes, opening minds: the Ontario burden of mental illness and addictions report. An ICES/PHO report. Toronto (ON): Institute for Clinical Evaluative Sciences and Public Health Ontario; 2012.

(4) Anderson KK, Cheng J, Susser E, McKenzie KJ, Kurdyak P. Incidence of psychotic disorders among first-generation immigrants and refugees in Ontario. CMAJ. 2015;187(9):E279-86.

(5) Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. Br J Psychiatry. 2011;199(6):453-8.

(6) Galletly C, Castle D, Dark F, Humberstone V, Jablensky A, Killackey E, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Aust N Z J Psychiatry. 2016;50(5):410-72.

(7) National Collaborating Centre for Mental Health. Psychosis and schizophrenia in adults: treatment and management. National clinical guideline number 178 [Internet]. London: National Institute for Health and Care Excellence; 2014 [cited 2017 Mar 13]. Available from: https://www.nice.org.uk/guidance/cg178/evidence/full-guideline-490503565

(8) Health Quality Ontario. Taking stock: a report on the quality of mental health and addictions services in Ontario. Toronto (ON): Health Quality Ontario; 2015.

(9) Health Quality Ontario. Unpublished analysis. Located at: Health Quality Ontario; 2015.

(10) Kurdyak P, Stukel TA, Goldbloom D, Kopp A, Zagorski BM, Mulsant BH. Universal coverage without universal access: a study of psychiatrist supply and practice patterns in Ontario. Open Med. 2014;8(3):e87-99.

(11) Mental Health Commission of Canada. Turning the key. Assessing housing and related supports for persons living with mental health problems and illness. Ottawa (ON): The Commission; 2012.

(12) Trypuc B, Robinson J. Homeless in Canada [Internet]. Toronto (ON): Charity Intelligence Canada; 2009 [cited 2017 Aug 21]. Available from: https://www.charityintelligence.ca/images/Ci-Homeless-in-Canada.pdf

(13) Mental Health Commission of Canada. Changing directions, changing lives: the mental health strategy for Canada. Calgary (AB): The Commission; 2012.

(14) Mental Health Commission of Canada. Recovery [Internet]. Ottawa (ON): The Commission; 2017 [updated 2017; cited 2017 Mar 13]. Available from: http://www.mentalhealthcommission.ca/English/focus-areas/recovery

(15) Ministry of Health and Long-Term Care. Ontario program standards for ACT teams. 2nd ed. Toronto (ON): The Ministry; 2005.

(16) Canadian Psychiatric Association. Clinical practice guidelines. Treatment of schizophrenia. Can J Psychiatry. 2005;50(13 Suppl 1):7-57S.

(17) Leucht S, Burkard T, Henderson J, Maj M, Sartorius N. Physical illness and schizophrenia: a review of the literature. Acta Psychiatr Scand. 2007;116(5):317-33.

(18) Lawrence D, Kisely S. Inequalities in healthcare provision for people with severe mental illness. J Psychopharmacol. 2010;24(4 Suppl):61-8.

(19) Smith DJ, Langan J, McLean G, Guthrie B, Mercer SW. Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: cross-sectional study. BMJ Open. 2013;3(4).
(20) Mitchell AJ, Lord O, Malone D. Differences in the prescribing of medication for physical disorders in individuals with v. without mental illness: meta-analysis. Br J Psychiatry. 2012;201(6):435-43.
(21) Scottish Intercollegiate Guidelines Network. Management of schizophrenia. SIGN publication no. 131 [Internet]. Edinburgh: Scottish Intercollegiate Guidelines Network; 2013 [cited 2017 Mar 13]. Available from: http://www.sign.ac.uk/pdf/sign131.pdf
(22) Mental Health Commission of Canada. Toward recovery and well-being. A framework for a mental health strategy for Canada. Ottawa (ON): 2009.
(23) Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. Cochrane Database Syst Rev. 2010(12):Cd000088.
(24) Kreyenbuhl J, Buchanan RW, Dickerson FB, Dixon LB. The Schizophrenia Patient Outcomes Research Team (PORT): updated treatment recommendations 2009. Schizophr Bull. 2010;36(1):94-103.
(25) Bullock H, Waddell K, Lavis JN. Defining the mental health and addictions 'basket of core services' to be publicly funded in Ontario. Hamilton (ON): McMaster University; 2016.
(26) Dieterich M, Irving CB, Bergman H, Khokhar MA, Park B, Marshall M. Intensive case management for severe mental illness. Cochrane Database Syst Rev. 2017;1:Cd007906.
(27) National Collaborating Centre for Mental Health. Psychosis with coexisting substance misuse: assessment and management in adults and young people [Internet]. London: National Institute for Health and Care Excellence; 2011 [cited 2017 Mar 13]. Available from: http://www.dualdiagnosis.co.uk/uploads/documents/originals/NICE%20Substance%20Use%20and%20psychosis.pdf
(28) Ministry of Health and Long-Term Care. Intensive case management service standards for mental health services and supports. Toronto (ON): The Ministry; 2005.
(29) National Institute for Health and Care Excellence (NICE). Psychosis and schizophrenia in adults. Quality standard 80 [Internet]. London: The Institute; 2015 [cited 2017 Jun]. Available from: https://www.nice.org.uk/guidance/qs80
(30) Centre for Addiction and Mental Health. Joint submission to the Government of Canada on Canada's National Housing Strategy. Toronto (ON): The Centre; 2016.
(31) Krieger J, Higgins DL. Housing and health: time again for public health action. Am J Public Health. 2002;92(5):758-68.
(32) Wellesley Institute. National affordable housing strategy consultation. Toronto (ON): The Institute; 2016.
(33) World Health Organization. Evidence-based recommendations for management of psychosis and bipolar disorders in non-specialized settings [Internet]. Geneva: The Organization; 2012 [cited 2017 Mar 20]. Available from: http://www.who.int/mental_health/mhgap/evidence/psychosis/en/
(34) Samara MT, Leucht C, Leeflang MM, Anghelescu IG, Chung YC, Crespo-Facorro B, et al. Early improvement as a predictor of later response to antipsychotics in schizophrenia: a diagnostic test review. Am J Psychiatry. 2015;172(7):617-29.
(35) Agid O, Foussias G, Remington G. Long-acting injectable antipsychotics in the treatment of schizophrenia: their role in relapse prevention. Expert Opin Pharmacother. 2010;11(14):2301-17.
(36) Emsley R, Chiliza B, Asmal L, Harvey BH. The nature of relapse in schizophrenia. BMC Psychiatry. 2013;13:50.

(37) Ng R, Maxwell C, Yates E, Nylen K, Antflick J, Jette N, et al. Brain disorders in Ontario: Prevalence, incidence and costs from health administrative data. Toronto (ON): Institute for Clinical Evaluative Sciences; 2015.
(38) Stroup TS, Marder S. Pharmacotherapy for schizophrenia: acute and maintenance phase treatment [Internet]. Waltham (MA): UpToDate; 2017 [cited 2017 June 5]. Available from: https://www.uptodate.com/contents/pharmacotherapy-for-schizophrenia-acute-and-maintenance-phase-treatment
(39) Leucht S, Tardy M, Komossa K, Heres S, Kissling W, Davis JM. Maintenance treatment with antipsychotic drugs for schizophrenia. Cochrane Database Syst Rev. 2012(5):Cd008016.
(40) Barlati S, Deste G, De Peri L, Ariu C, Vita A. Cognitive remediation in schizophrenia: current status and future perspectives. Schizophr Res Treatment. 2013;2013:156084.
(41) McGurk SR, Wykes T. Cognitive remediation and vocational rehabilitation. Psychiatr Rehabil J. 2008;31(4):350-9.
(42) de Leon J, Diaz FJ. A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. Schizophr Res. 2005;76(2-3):135-57.
(43) Kelly DL, McMahon RP, Wehring HJ, Liu F, Mackowick KM, Boggs DL, et al. Cigarette smoking and mortality risk in people with schizophrenia. Schizophr Bull. 2011;37(4):832-8.
(44) Desai HD, Seabolt J, Jann MW. Smoking in patients receiving psychotropic medications: a pharmacokinetic perspective. CNS Drugs. 2001;15(6):469-94.
(45) Canadian Action Network for the Advancement Dissemination and Adoption of Practice-informed Tobacco Treatment (CAN-ADAPTT). Canadian smoking cessation clinical practice guideline [Internet]. Toronto (ON): CAN-ADAPTT and Centre for Addiction and Mental Health; 2011 [cited 2017 Mar 13]. Available from: https://www.nicotinedependenceclinic.com/English/CANADAPTT/Documents/CAN-ADAPTT%20Canadian%20Smoking%20Cessation%20Guideline_website.pdf
(46) Canadian Centre on Substance Abuse. Substance abuse in Canada: concurrent disorders. Ottawa (ON): 2009.
(47) Mental Health Commission of Canada. The aspiring workforce - employment and income for people with serious mental illness. Ottawa (ON): The Commission; 2013.
(48) Krupa T, Chen S. Psychiatric/psychosocial Rehabilitation (PSR) in relation to vocational and educational environments: work and learning. Curr Psychiatry Rev. 2013;9(3):195-206.

About Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by this single-minded purpose: **Better health for all Ontarians.**

Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voices of patients, caregivers and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large-scale quality improvements—by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters

We recognize that, as a system there is much to be proud of, but also that it often falls short of being the best it can be. Plus, certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

Quality Standards

Looking for more information?

Visit our website at **hqontario.ca** and contact us at **qualitystandards@hqontario.ca** if you have any questions or feedback about this guide.

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