PROSPECTUS

Reducing Antipsychotic Medication Use in Long Term Care: Spreading an Approach from CFHI’s EXTRA Program for Healthcare Improvement

A 12-month Quality Improvement (QI) Collaborative

Canadian Foundation for Healthcare Improvement

cfhi-fcass.ca
Executive Summary

Overview
The Canadian Foundation for Healthcare Improvement (CFHI) is inviting applications now from teams to participate in a QI Collaborative for spreading innovation in healthcare. Despite the best intentions of everyone working in our healthcare systems, promising innovations remain isolated pockets of excellence. Any organization working to improve quality for patients and value-for-money for taxpayers today should ask, “What’s out there that works?”

The objectives for the QI Collaborative are to spread innovation and evaluate the results, reduce the use of antipsychotics in long term care residents, and analyse collective lessons learned about spreading innovation. The QI Collaborative responds to what partners across Canada are telling us they need in order to kick start sustainable innovation at the service delivery level: seed money and program structure.

The Innovation
One in three long term care residents in Canada takes antipsychotic drugs without a diagnosis of psychosis from a doctor. In 2011, Joe Puchniak and Cynthia Sinclair – at the time, Managers with the Winnipeg Regional Health Authority (WRHA) Personal Care Home Program – focused their EXTRA improvement project on determining if data they were already collecting could reveal insights on the use of antipsychotic medication to treat residents for dementia. More specifically, they sought to uncover whether the use of such drugs could be reduced without inducing adverse changes in residents’ behaviour. With the full support of Arlene Wilgosh, CEO of the WRHA, the project achieved success beyond the team’s expectations.

Timeline
The QI Collaborative will run from September 2014 to September 2015. However, prework begins in May 2014. At least two members from each team are expected to attend a launch opening webinar May 7 2014 and the June 4 2014 CFHI workshop Spreading healthcare innovations in a land of pilot projects following the National Health Leadership Conference (NHLC) in Banff Alberta. Spread plans and budgets will be completed and MOUs with CFHI signed by June 30 2014. By September 2014, teams will be ready to go.

Participation Criteria
To be eligible for participation, organizations must demonstrate readiness to implement innovation according to CFHI criteria.

Program Funding
CFHI is providing seed funding of up to $500,000 total distribution among a maximum of 10 sites for direct costs related to the implementation of the EXTRA innovation. At the same time, CFHI will provide faculty and staff (Appendix A) to help teams develop and execute their spread plans.

Contact
For information, please contact Linda Piazza, Senior Director Education and Training
linda.piazza@cfhi-fcass.ca
Why Participate?
On the new website, *How well is our health system actually working?*\(^1\) the Canadian Institute for Health Information (CIHI) provides Canadians with a snapshot of our overall health and a broad look at how our health system is performing. While in many areas we perform well, Canada has performance issues and this QI Collaborative is focused on spreading a promising solution to a serious issue:

- One in three long term care residents in Canada takes antipsychotic drugs without a diagnosis of psychosis from a doctor.

Potentially inappropriate medication in long term care is widespread. Research has shown that antipsychotic medications are, at best, only minimally effective in managing behavioral issues\(^2\), and have serious risks associated with them, especially in the elderly. In addition, we know that usage of these medications should not account for more than five to 15 percent of residents in custodial care.\(^3\)

In a recent Ottawa Citizen article, Dr. Andrew Wiens, a geriatric psychiatrist at the Royal Ottawa Mental Health Centre, estimated that the actual number of dementia patients who should remain on antipsychotics indefinitely “is probably less than one per cent.” In fact, across Canada, we see 30 per cent or more.

CFHI supported a team at the Winnipeg Regional Health Authority (WRHA) that analyzed the use of antipsychotics among the elderly in personal-care homes (PCHs). The team unleashed the potential for the Resident Assessment Instrument (RAI)/ Minimum Data Set (MDS) to inform decision making at clinical and managerial levels. Analysis showed that residents in PCHs using the care model known as P.I.E.C.E.S. (Physical, Intellectual, Emotional, Capabilities, Environment and Social)\(^4\) had a lower use of antipsychotic medications. The combination of using the data and implementing a solution formed the basis of the improvement project.

In six months, 27 percent of the cohort of residents being followed in one PCH were taken off their antipsychotic medication without causing any increase in behavioural symptoms or an increase in the use of physical restraint. Patients and families lives were improved. Front-line staff members were empowered. And the project yielded savings of $10,000. This translates to a potential saving of $400,000 in six months across the region. Given the success of the pilot, the improvement project is expanding to the remaining 38 Personal Care Homes in the WRHA.

\(^1\)CIHI website: [http://ourhealthsystem.ca](http://ourhealthsystem.ca)


Consider applying to join this collaborative if your organization is looking for solutions to similar issues addressed by the Winnipeg Regional Health Authority in the EXTRA project *Reducing Antipsychotic Medication Use in Long Term Care* (Appendix B).

**Who Should Participate?**

**Eligibility**

Canadian healthcare organizations and ministries are eligible to apply. Organizations include, but may not be limited to: healthcare service delivery organizations; regional health authorities and Local Health Integration Networks; government organizations and agencies; primary care office practices or physician groups; and community organizations (such as a Community Care Access Centre in Ontario). Applying organizations are encouraged to include patient, family and community representatives as active team members.

Participating organizations may wish to reach beyond their usual boundaries to develop multi-stakeholder partnerships. Partnering relationships could include health care organizations and groups such as social service agencies, local governments, disease-based agencies, public health departments, educational institutions, civic, and other non-profit or voluntary organizations focused on improving healthcare.

**Organizational Characteristics**

The QI Collaborative is designed to offer support to participating sites with the following characteristics:

- Quality improvement in the area related to the EXTRA innovation is a strategic priority supported at the most senior (e.g. CEO and Trustee) level of the organization. Participating teams must have the explicit support of their senior leadership and these leaders must stay actively connected to the team’s work. To maximize results, implementing the innovation should be a recognized priority supported by each organization’s governing board.
- The Resident Assessment Instrument (RAI)/Minimum Data Set (MDS)\(^5\) has been implemented.
- Meaningful populations or population segments can be (or have been) identified for intensive improvement related to the EXTRA innovation.
- Where necessary, key partners are identified and committed to participating.
- Strong improvement capabilities at the individual project level and at the organizational, system, or population level. Suitable organizations are skilled and agile in using improvement models, running small tests of change, and implementing change. (e.g., through the Accreditation Canada process, has the organization submitted and/or had approved leading practices in any areas?)

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\(^5\) The Resident Assessment Instrument – Minimum Data Set (RAI-MDS) is one of the interRAI instruments implemented to improve the care of frail elderly and disabled adults in chronic care and institutional long-term care homes by standardizing the assessment and care planning process.  
Team Characteristics

- Team members have demonstrated skills in executing improvement initiatives, know how to set aims and carry out well-designed implementation plans, and include clinicians in the relevant discipline.
- In addition to explicit support from the most senior level (e.g. CEO) of the organization, teams must have an Executive Sponsor (who could be the same person, e.g. CEO; or someone who reports directly to the CEO) on the team.
- There is a project lead with the time, resources, and accountability to succeed designated to oversee the day-to-day activities of development and execution of the implementation plan.
- There is an evaluation and measurement lead to support the tracking of results over time. Throughout the QI Collaborative, the CFHI team will convene the measurement leads from each team via ongoing coaching calls to discuss common measurement challenges and approaches.
- There is at least one clinician champion, who will work with the project lead and provide necessary clinical support to staff. Multiple clinician site champions can be included, but at least one should be a physician leader (e.g., medical director).
- A patient/family representative is desirable.

Expectations of the Participating Sites and Team Members

Dedicated project resources are in place and teams are committed to full participation in the QI Collaborative, including CFHI’s overall evaluation and performance measurement plan.

Successful sites will be asked to sign, by June 30 2014, a Memorandum of Understanding with CFHI that reflects CFHI’s support and the commitment of the site(s) and team members.

Collaboration Components and Timeline

Using an adult learning approach, CFHI’s QI Collaborative will promote networking and collaborative exchange among the entire cohort and will include:

- Participation of the teams on an opening webinar May 7 2014. The goal of the webinar is to prepare teams to start developing a spread plan in preparation for the June 4 in-person workshop in Banff.
- Participation of the teams at the CFHI workshop *Spreading healthcare innovations in a land of pilot projects* on June 4, 2014 following the National Health Leadership Conference (NHLC) in Banff Alberta. The workshop will provide a chance for teams to meet, hear from global experts on spreading innovation, and break out into interest groups focused on aspects of “how to” develop and execute a spread plan for implementing the specific EXTRA innovation.
- Access to online learning tools and activities
- Regularly scheduled progress reporting and content webinars
- Ongoing support from CFHI faculty and staff, including guidance from the improvement leads responsible for executing the original EXTRA innovation.

For this QI Collaborative, CFHI faculty and staff, with input from the QI Collaborative members, will design content and facilitate exchange on key topics for implementing innovation, including:

- Spread plan development, implementation and measurement
- Stakeholder engagement (patients, families, front-line providers)
- Leadership and change management
The QI Collaborative will run from September 2014 to September 2015 (see draft timeline of activities Appendix C). However, prework begins in May 2014. At least two members from each team are expected to attend a 1-hour opening webinar May 7 2014 and the 1-day June 4 2014 CFHI workshop Spreading healthcare innovations in a land of pilot projects following the National Health Leadership Conference (NHLC) in Banff Alberta.

**How to Apply**

To apply, please download and complete the Expression of Commitment.

By completing the application form, the organization and team members confirm that they understand CFHI’s Conflict of Interest Policy, including rules regarding eligibility of foundation employees, trustees and agents.

Expressions of commitment (applications) will be reviewed and screened on a rolling basis and readiness interviews conducted. The deadline for submission of the expression of commitment is April 15, 2014, or when CFHI determines that the program has reached capacity.

CFHI plans to limit enrollment in the QI Collaborative to up to 10 organizations; therefore, you are encouraged to apply well before the deadline. Teams will be selected based on the strength of their applications as aligned with characteristics described within this document and on CFHI considerations of overall composition of the cohort of teams in terms of setting and context. Note that this QI Collaborative going forward depends on identification of a strong, willing and able cohort.

The Canadian Foundation for Healthcare Improvement is a not-for-profit organization funded through an agreement with the Government of Canada. The views expressed herein do not necessarily represent the views of the Government of Canada.
APPENDIX A: QI Collaborative Faculty and Staff

LINDA PIAZZA MHA, CFHI Senior Director Education and Training
JENNIFER MAJOR PhD, CFHI Senior Advisor Education and Training

TERRENCE SULLIVAN PhD Professor, Department of Health Policy University of Toronto is the independent board chair of the Canadian Agency for Drugs and Technologies in Health (CADTH). He also chairs the board of Public Health Ontario (the Ontario Agency for Health Protection and Promotion). From 2001 to March 2011 he occupied successively responsible positions at Cancer Care Ontario (CCO), the final seven years as President and CEO during which period the entire organization transformed its business model to performance measurement and improvement of cancer services.

CYNTHIA SINCLAIR RN is Special Projects Manager for the Winnipeg Regional Health Authority Personal Care Homes Program and is currently completing her B.N. She has an Adult Education Certificate from the University of Manitoba and is also a Certified Diabetes Educator. She is a recent graduate of CFHI’s EXTRA Program where her intervention project focused on using data collected with the MDS tool to improve quality care in the PCH sector and to inform decision-making and strategic planning at both the program and facility level.

LORI MITCHELL Ph.D, is a researcher with the Winnipeg Regional Health Authority (WRHA) Home Care Program. Her primary role is to develop, support, and contribute to research, evaluation and quality improvement activities that assist in evidence based decision-making in the Home Care program. In addition, her work assists quality of care, program performance, and policy development. Prior to joining the WRHA, Dr. Mitchell worked for 11 years in academia conducting gerontological and health services research. Her doctoral training is in Community Health Sciences from the University of Manitoba and graduate training in Gerontology from the University of Waterloo and Simon Fraser University.

LISA SCHILLING RN, MPH, is National Vice President of Health Care Performance Improvement and Director of the Kaiser Permanente Improvement Institute. She is currently leading the enterprise-wide deployment of a performance improvement and execution system, and managing relationships with external organizations that are performance excellence leaders in quality and safety.

MARIE W. SCHALL MA, Director, Institute for Healthcare Improvement (IHI), directs improvement and innovation projects focused on outpatient-based care and is responsible for IHI programming in this area. In addition, she directs and is senior faculty for IHI’s Breakthrough Series College and is also responsible for the ongoing development of IHI’s spread methodology and programming.

JEAN-LOUIS DENIS PhD is a Professor at the École Nationale d’Administration Publique (ÉNAP) and holds the Canada Research Chair on governance and transformation of healthcare organizations and systems at ÉNAP. He is a visiting professor at Euromed Management (Marseille, FR) and researcher at the Institut de recherche en santé publique de l'Université de Montréal. He pursues research on governance and processes of change in healthcare organizations and systems. He was the founding Academic Coordinator (2003-2007) of the EXTRA Program for Healthcare Improvement.
KAYE PHILLIPS PhD is Director of Evaluation and Performance Improvement at the Canadian Foundation for Healthcare Improvement, bringing ten years of experience in applied research and evaluation to the position. Kaye is responsible for leading the design, implementation and integration of performance measurement and evaluation across CFHI’s programs and for providing support to our collaborative improvement teams as they generate on-going learning’s and measurable results. Kaye holds a Ph.D. from the University of Toronto’s School of Social and Administrative Pharmacy and is an alumna of the Ontario Training Center in Health Services and Policy Research (OTC).
APPENDIX B: The EXTRA Project
Reducing Antipsychotic Medication Use in Long Term Care

The Problem
For years, healthcare providers at the Winnipeg Regional Health Authority (WRHA) have collected data to assess the needs of elderly men and women who reside at the organization’s 38 personal care homes. The data—known as Minimum Data Set (MDS) and Resident Assessment Instrument (RAI)—are compiled four times a year. The improvement team investigated whether this data could be used to help front-line providers improve care for residents and reduce costs for the WRHA.

The Solution
Joe Puchniak and Cynthia Sinclair – at the time, Managers with the WRHA Personal Care Home Program – focused their EXTRA improvement project on determining if this data could reveal insights on the use of antipsychotic medication to treat residents for dementia. More specifically, they sought to uncover whether the use of such drugs could be reduced without inducing adverse changes in residents’ behaviour. With the support of Arlene Wilgosh, CEO of the WRHA, the project achieved success beyond the team’s expectations.

“It was a pleasure to help lead a project that resulted in improved quality of life for residents, and reduced financial cost to the healthcare system.”
– Joe Puchniak Manager, Client Affairs, Alberta Canadian Institute for Health Information

Results and Impacts
Puchniak and Sinclair discovered that facilities where residents with dementia reported markedly lower use of antipsychotic drugs, relied on the ‘Physical, Intellectual, Emotional, Capabilities, Environment, and Social care model’ or P.I.E.C.E.S™. The P.I.E.C.E.S approach encourages staff to treat patients by looking at not only their health files, but also their personal histories, such as their former careers.

During the six-month improvement project, of the 70 residents already on antipsychotic medications, 27 percent (19 patients) were taken off of their medication. This translates to a 25 percent reduction of antipsychotic medications for the total resident population. This was also achieved without causing any increase in behavioural symptoms or rise in the use of physical restraints.

Decreasing the overall use of these drugs at the pilot site has enabled it to save $10,000. Given these impressive results, Puchniak and Sinclair put a business plan forward to expand the improvement to the remaining 38 personal care homes in the Winnipeg Regional Health Authority.

For more details, please click on the following links:

1. Wave article: Formula for success (Wave is Winnipeg’s health and wellness magazine. It is published six times a year by the Winnipeg Health Region in cooperation with the Winnipeg Free Press).
2. **Video: CIHI data helps change practice**
   [http://www.cihi.ca/land/Article/Data+In+Action/cihi011336](http://www.cihi.ca/land/Article/Data+In+Action/cihi011336)
APPENDIX C: DRAFT Timeline  
Reducing Anti-psychotic Medication Use in Long Term Care (LTC):  
Spreading an approach from CFHI’s EXTRA Program for Healthcare Improvement  
A 12-month Quality Improvement (QI) Collaborative

Timeline
For this QI Collaborative, CFHI faculty and coaches will design, in collaboration with selected teams, content and facilitate exchange on key topics for implementing innovation, including:
- Spread plan development, implementation and measurement
- Stakeholder engagement (patients, families, front-line providers)
- Leadership and change management
- Sustaining and further spreading the change
- Data collection and analysis
- Communication strategies.

From September 2014-September 2015, the following timeline and content is draft, for discussion and refinement as teams are selected and needs assessed.

Timeline at a Glance

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* Or when the program reaches full capacity  
** Optional in-person attendance at EXTRA program Module 5 in Vancouver February 2015  
*** A summative workshop will likely be organized, date and venue to be decided.

March 4-April 15 2014  
**Expression of commitment submissions and organization selection:** Expressions of commitment (applications) will be reviewed and screened on a rolling basis and *readiness* interviews conducted. The deadline for submission of the expression of commitment is April 15, 2014, or when the program has reached capacity.
May-September 2014
Prior to the September 15 2014 start date, teams will:

- Understand the EXTRA innovation, including barriers and facilitators related to spread
- Understand the concept of readiness to spread and its application
- Understand different spread models and how they might work for implementing your innovation
- Learn the basics of what makes an improvement effort sustainable
- Develop a plan and budget for spread of the EXTRA innovation.

Launch webinar May 7 (11:30-13:30 ET) 2014: The webinar will provide an overview of the QI collaborative and introduce teams to resources related to spreading innovation generally and the EXTRA project in particular. The goal of the webinar is to prepare teams to start developing a spread plan in preparation for the June 4 in-person meeting in Banff. It is expected that, at a minimum, the project and measurement leads from each team will attend this webinar.

Pre-work for the June 4 workshop: It is expected that teams will have developed an initial draft of an Aim Statement and Spread Plan before the June 4 workshop. A spread plan addresses the how of spread and includes communication methods and channels to reach and engage the target population; a measurement system to assess progress in meeting the spread aims; and anticipation of the actions needed to embed the changes into the organization’s operational systems.

In-person workshop: On June 4 2014, the CFHI workshop Spreading healthcare innovations in a land of pilot projects will be held in Banff Alberta. At a minimum, the project leader and measurement lead from each participating organization are expected to attend. The workshop will allow teams to refine and receive feedback on their spread plans.

The workshop will provide a venue for teams to connect with the EXTRA innovation coaches and understand unique elements and tools involved in spreading the innovation.

The workshop will also provide coaches and teams with the opportunity to identify topics and resources that may be required to execute their spread plans. The schedule of topics below may change or be augmented as a result of what we hear at the June 4 workshop.

Memorandum of Understanding (MOU) with CFHI: By June 30 2014, participating organizations will sign a MOU with CFHI. Spread plans refined as a result of the June 4, 2014 workshop and an overall budget will be attached as addendums to each MOU and will form the basis of the commitment of CFHI and the innovating organizations.

Over July and August 2014 CFHI will facilitate virtual engagement of teams with EXTRA innovation coaches.

Regularly scheduled coaching calls (data/measurement and general) will proceed throughout the 12-month period.

September 2014 - November 2014
Webinars and/or self-directed resources will be provided on the following topics:
Understanding the EXTRA innovation interactive webinar September 15 2014: The objectives will include giving teams a chance to report on summer work and address issues, clarifications etc. related to implementing the EXTRA innovation in your unique setting.

Stakeholder engagement webinar September 2014: In order to increase your chances of success and sustainability, you will need to engage other leaders, front-line staff and patient/family advisors. This will be a crucial period for communicating the goals and expectations for and from key stakeholders. As you begin to implement the initial steps of your spread plan, adjustments will need to be made to the plan.

Patient and family engagement September 2014: Resources will be available on the online platform.

Leadership and change management resources and simulation exercise, October: Resources, including a facilitated change management simulation exercise, will be available on the online platform.

Progress reporting November: Teams will report to their peers, faculty and coaches on their progress via interactive webinars. The expectation is that your progress report will focus on stakeholder engagement, change methodology and how you are taking advantage of the strengths in your organization and circumventing the barriers of the project.

December 2014 – March 2015
Webinars and/or self-directed resources will be provided on the following topics:

Process and outcome measurement: Each team in the learning collaborative will develop a system of measures to address outcomes related to care, efficiencies and health (if applicable), as well as process measures to guide learning and gauge their progress in a shorter time frame than outcome measures. While measures will have been identified earlier in the spread plan, teams will gather data over time, integrating them into a system to support quality improvement work.

Refining, accelerating and sustaining change February 2015 in Vancouver BC: An optional in-person workshop, at participating organizations’ own expense, is offered in collaboration with CFHI’s EXTRA program. For those who cannot attend, remote access to presentations will be available.

Progress reporting interactive webinar March x 2015: Teams will be expected to report to peers, faculty and coaches on their successes and challenges related to progress, particularly related to measurement.

April 2015 – June 2015
Webinars and/or self-directed resources will be provided on the following topics:

Data synthesis and analysis: In April, teams will revise their spread plan to include: details and results of implementation including facilitators and barriers and how these were addressed; measurement plan results to date.

Communication strategies, May: Resources will be available on the online platform.
**Progress Reporting:** In mid-June, teams will report to peers, faculty and coaches on their successes and challenges and receive feedback that will be helpful in completing the final report over the summer.

**July 2015 - September 2015**

**Final reports:** By August 8, teams will be expected to submit to CFHI final reports in impact story format and up to 5 PowerPoint slides that will be presented at the summative workshop in September 2015.

**Summative workshop September x 2015:** Teams will convene to share experiences, lessons, results and future action plans. The expectation is that new insights will emerge from the collective experience of teams regarding best and promising practices related to spreading innovation.