PROJECT CHARTER

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TOP COLLABORATIVE TEAM & SPONSORS

INITIATIVE	Treatment Optimization of Psychosis (TOP) Collaborative
START DATE	April 2020 (Planning Phase Began)

TOP COLLABORATIVE CORE TEAM

Name	Role	Affiliation
Dr. Harish Neelakant Harish.Neelakant@vch.ca	TOP Medical Lead	BC Centre for Excellence in HIV/AIDS
	Medical Manager, Urban Vancouver Community Mental Health	Vancouver Coastal Health
Valeria Gal VGal@bccfe.ca	Project Lead, Quality Improvement & Practice Support	BC Centre for Excellence in HIV/AIDS
Philip Charlebois Philip.Charlebois@vch.ca	TOP Operation Lead MHSU Operations Manager	Vancouver Coastal Health
Jessica Anonuevo Jessica.Anonuevo2@vch.ca	Clinical Nurse Educator	Vancouver Coastal Health
Joanna Ferguson JFerguson@bccfe.ca	Project Coordinator	BC Centre for Excellence in HIV/AIDS

KEY COLLABORATIVE SPONSORS

Name	Role	Affiliation
Dr. Rolando Barrios	Senior Medical Director	BC Centre for Excellence in HIV/AIDS
Mark Helberg	Senior Director, Internal and External Relations & Strategic Development	BC Centre for Excellence in HIV/AIDS
Dr. Mike Norbury	Interim Senior Medical Director	Vancouver Coastal Health
Dr. Randall White	MHSU Program Medical Director	Vancouver Coastal Health
Bob Chapman	Interim Vice-President, Vancouver Community	Vancouver Coastal Health
Lizzy Ambler	MHSU Operations Director	Vancouver Coastal Health

THE COLLABORATIVE IS SUPPORTED BY:

Core Team	Meet weekly (or as needed) to develop high-level vision, strategic direction and discuss ongoing operational tasks.
Working Group	A group of care providers, administrators, and community members who support people living with psychosis or who have a lived experience. The group is selected to provide their expertise and input to the overall direction of TOP.
Community of Practice	All members of the Collaborative teams who connect regularly through the listserv, monthly webinars and in-person sessions.

TOP OVERVIEW

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

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

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

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

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

COLLABORATIVE METHODOLOGY

BREAKTHROUGH SERIES MODEL

The Treatment Optimization of Psychosis (TOP) Collaborative will follow the Breakthrough Series (BTS) Collaborative methodology developed by the Institute of Healthcare Improvement (IHI) (Figure 1). The TOP Collaborative will be an organized effort of shared learning by a network of teams from across Vancouver Community, purposefully working together to achieve similar goals over the course of 12 months.

Throughout the Collaborative, it is expected that team participants maintain contact with each other and the TOP Core Team through monthly meetings, quarterly in-person learning sessions, teleconference calls, electronic mailing list, emails, webinars, and website access. This will create a community of learning in which teams collaborate with each other to discuss common issues, share ideas and common challenges, and spread best practices.

The basic structure of the Collaborative methodology has been adapted for the TOP Collaborative to include an in-person *Launch* where stakeholders and team representatives will assemble to commence Collaborative preparatory work (i.e., defining team membership, crafting improvement aims, collecting baseline measures, creating storyboards, etc.). Subsequently, experts will share approaches to system change and ideas for change at the first in-person *Learning Session* (LS). Each LS will be followed by *Action Periods* (AP) where teams are supported in actively testing and in implementing changes in care processes using the Model for Improvement (Figure 2).

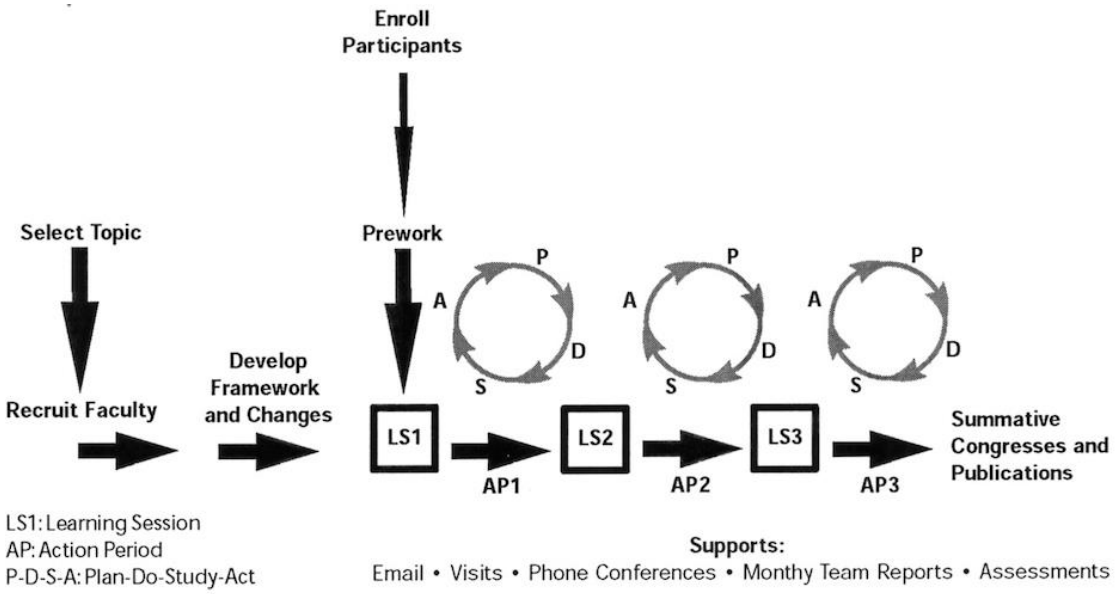


Figure 1. IHI Breakthrough Series Model

MODEL FOR IMPROVEMENT

Each Collaborative Team will create an improvement aim guided by the Model for Improvement (Figure 2). The teams will define answers to the three questions within the model.

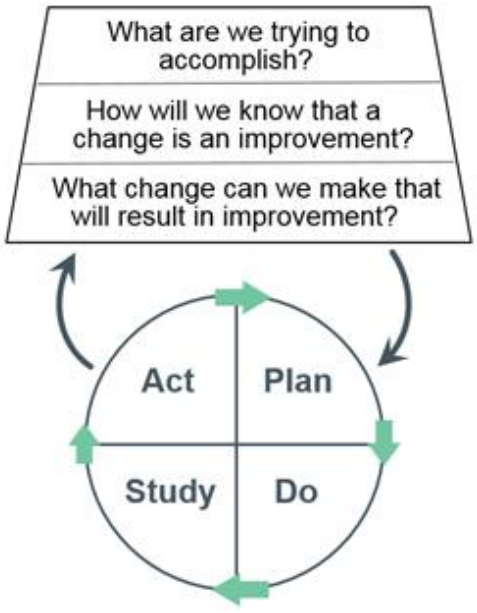


Figure 2. The Model for Improvement

These are:

1. **What are we trying to accomplish?** (Aim) *Here, participants determine which specific outcomes they are trying to change through their work.*
2. **How will we know a change is an improvement?** (Measures) *Here, team members employ appropriate measures to track their work.*
3. **What changes can we make that will result in improvement?** (Changes) *Here, teams identify key changes that they will actually test.*

When teams have selected changes, rapid cycle testing of these changes using a sequence of planning (P), doing (D), studying (S), and acting (A) is to be applied to guide improvement. Employing PDSA Worksheets, teams can design tests of change to achieve their defined aims.

COLLABORATIVE AIMS & OBJECTIVES

What are we trying to accomplish?

Problem	In Vancouver Coastal Health (VCH), psychosis is the number one cause of readmission to acute psychiatry within 30 days of discharge. Treatment of psychosis in community settings is suboptimal, lacking standardized approaches to monitoring adherence and retention in treatment with only limited use of compliance aids, long-acting antipsychotic medications and third line antipsychotic clozapine. It is estimated that 25-30% of patients with schizophrenia meet criteria for what is called Treatment Refractory Schizophrenia (TRS), and of those, 30-60% respond to clozapine, an antipsychotic medication that has shown clinical efficacy for the treatment of schizophrenia, in people for whom two other antipsychotic medications have not been effective. However, this medication is severely underutilized. For example, clozapine usage in Australia and New Zealand is estimated at about 30% in TRS, but only 17% in British Columbia.
Initiative Description	TOP will focus on optimizing schizophrenia treatment and on improving management of TRS by shifting clozapine initiation from hospital to community settings by building capacity at each community mental health team.
Rationale	The safety profile of clozapine is well known. Adverse drug reactions, such as postural hypotension, tachycardia, sedation, seizures, hyperthermia, metabolic syndrome, and more serious reactions such as agranulocytosis, and cardiomyopathy, led to previous recommendations of hospital admission when initiating clozapine. Such reactions can be minimized by close monitoring and support. In VCH, clozapine is still mostly initiated in acute care settings (e.g. hospital) or subacute care settings (e.g. facilities such as Venture) which is costly and creates barriers to appropriate care. Evidence from other jurisdictions (in the United Kingdom, Australia, New Zealand and the US) suggest that it is often safe and appropriate to initiate treatment with clozapine in community settings.
Expected Outcomes and Benefits	Treatment optimization of psychosis has the potential to improve the health of individuals, improve quality of life, decrease acute health care utilization, risk to self, and encounters with the legal system. Research has shown that clozapine, for instance, is associated with 18.6 fewer inpatients days per year per patient treated.
Key Considerations	• Stigma of severe mental illness • Clients and healthcare providers/clinicians are wary of the side effects of clozapine, often without balancing the benefits versus risks of using clozapine • Lack of awareness and support for the clients and family members • Insufficient support for physicians and case managers to monitor and manage clozapine adverse effects in the community • Healthcare providers/clinicians not feeling fully equipped to start clients on clozapine

TOP COLLABORATIVE AIM STATEMENT

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

- *100% of clients with treatment resistant schizophrenia (TRS)[1] will be offered clozapine*
- *90% of clients who are eligible for a clozapine start in the community, and who accept the treatment, will undergo titration in the community*
- *45% of clients undergoing clozapine treatment will see an improvement in their functioning as assessed by HONOS and PANSS-SV*

CORE MEASURES

Population of Focus: Clients with DSM IV diagnosis of Schizophrenia and Schizoaffective disorder who are sub optimally treated with clozapine and depot injection.

How will we know that a change is an improvement?

#	Core Measure	Numerator	Denominator	Target
1	**Non-adherent clients offered depot injection**	# of clients offered depot injections	# clients nonadherent to oral medication	100%
2	**Treatment Resistant Schizophrenia (TRS) clients offered clozapine**	# of clients diagnosed with TRS who have been offered clozapine	# of clients diagnosed with TRS	100%
3	**Clients who undergo titration in the community**	# of clients who start clozapine titration in the community	# of clients who are suitable for clozapine in the community	90%
4	**Clients retained on clozapine**	# of clients who remain on clozapine for more than the 8-week titration period	# of clients who are started on clozapine	70%
5	**Clients on clozapine that made progress on HONOS**	# of clients retained on clozapine and made any progress on HONOS score	# of clients diagnosed with TRS who are retained on clozapine	45%
6	**Clients on clozapine with a 20% improvement on PANSS -SV**	# of clients retained on clozapine and achieved 20% or more improvement on PANSS-SV	# clients diagnosed with TRS who are retained on clozapine	45%

[1] Treatment Resistant Schizophrenia (TRS) is defined as *inadequate medication response* to an *adequate medication trial* of 2 different antipsychotics. Inadequate medication response is based on clinician judgement if relevant measurement scale data does not exist or more than 20% improvement on PANSS-SV when this data exists. An adequate antipsychotic medication trial is defined as lasting at least 6 weeks, at a therapeutic dosage.

DRIVER DIAGRAM

What changes can we make that will result in improvement?

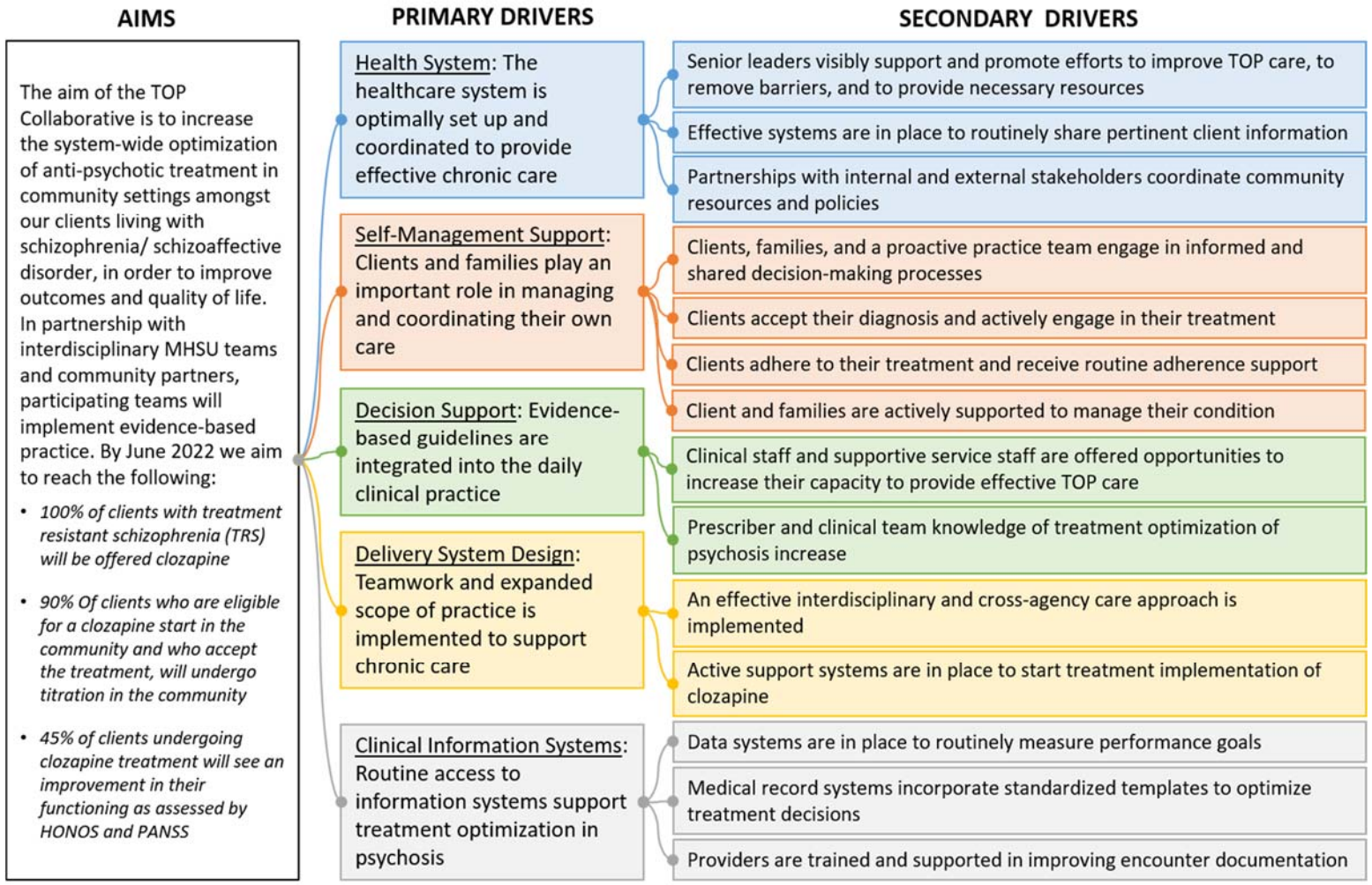


Figure 3. TOP Collaborative Driver Diagram

EXPECTATIONS AND COMMITMENTS

The BC Centre for Excellence in HIV/AIDS

- Establish a TOP Core Team consisting of a Project Lead, Medical Lead, Project Coordinator and expert faculty members
- Plan, deliver and facilitate all Collaborative activities (5 learning sessions, 5 educational webinars, 8 CME events), technical support for video, speaker fees and materials
- Provide a structured framework for completing QI in practice
- Provide QI training for all Collaborative participants
- Plan, design, and maintain a website of resources and a Collaborative listserv, including TOP-specific technical documents
- Provide monthly feedback and guidance in response to data and narrative reports
- Monitor progress in meeting shared goals and plan interventions as needed
- Manage financial budget to coordinate and deliver all Collaborative activities (learning sessions, educational webinars, CME Series) including technical support for video, speaker fees and materials

Vancouver Coastal Health

- Support teams with the required resources to participate in Collaborative activities
- Monitor team progress over time in achieving initiative aims through regular communication with the participating teams and TOP Core Team
- Provides input into the delivery and implementation of Collaborative activities
- Enable the collection and sharing of data and learning with other clinical teams and overall initiative leadership group

Mental Health & Substance Use Teams /Team Participants

- Create a quality improvement (QI) team that meets regularly to plan, discuss, and carry out Collaborative activities
- Work with a QI coach, to assist you in planning and executing your quality improvement activities
- QI team will ideally consist of: a psychiatrist GP specialist where available, clinical pharmacist where available, case manager, OT, admin staff, team manager or clinical supervisor, and client with lived experience or family member if available.
- Send and support between 2 and 4 members from your team to attend all Collaborative activities (learning sessions, educational webinars, CME Series)
- Protect time & provide backfill as needed to complete Collaborative activities (e.g. attending Learning Sessions, weekly or bi-weekly QI team meetings, quarterly webinars, collecting improvement data, testing changes, preparing monthly reports and sustainability activities)
- Provide/obtain support for data standardization, data entry and data extraction
- Complete pre-work activities (establish a QI team, regular meetings, etc.) laid out in the preparation manual before the first Learning Session
- Develop an aim statement aligned with your client population needs and the Collaborative goals
- Generate monthly reports on key QI metrics along with narrative change descriptions
- Develop and implement client involvement plans and/or include at least one client on your QI team
- Inform TOP Core Team of changes to team members and supports a transition of their role in this initiative to replacement staff
- A limited number of physicians will be compensated through sessional funding for their participation during the collaborative (inc. CME's, learning sessions, QI meeting time)

TIMELINE & SCHEDULE

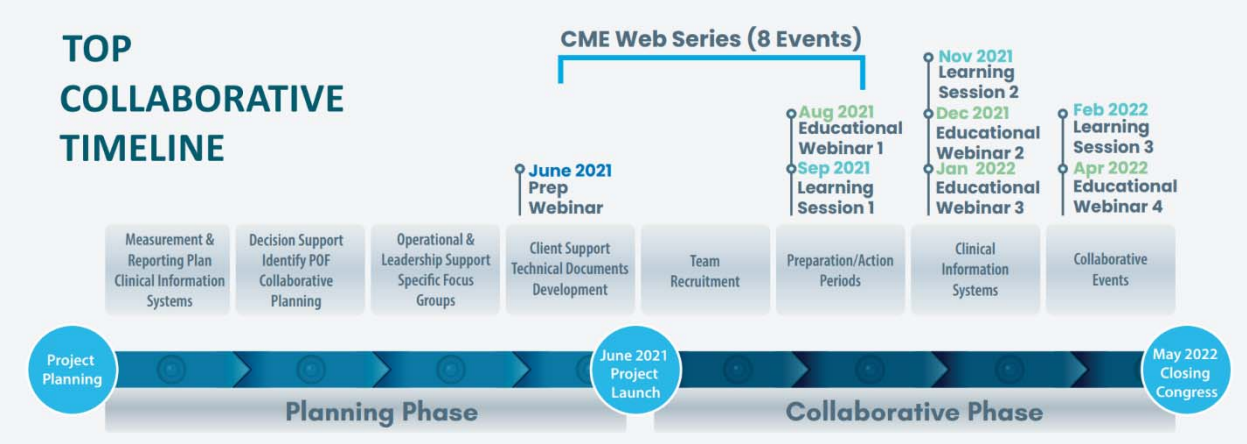


Figure 4. TOP Collaborative Timeline

Key Dates & Times

Date	Time	Hrs	Events and Activities
Tuesday, June 08, 2021	8:30-10am	1.5	CME 1: Canadian Schizophrenia Guidelines
Tuesday, June 15, 2021	8:30-9:30am	1	TOP Prep Webinar
Wednesday, June 23, 2021	9am-3pm	6	**TOP Collaborative Launch**
Tuesday, June 29, 2021	8:30-10am	1.5	CME 2: MI in the context of clozapine
Tuesday, July 13, 2021	8:30- 10am	1.5	CME 3: Clozapine Pharmacology
Tuesday, July 20, 2021	8:30-9:30am	1	TOP Educational Webinar 1
Wednesday, August 04, 2021	8:30-10am	1.5	CME 4: Following Schizophrenia and Schizoaffective Disorder Treatment Protocols in the Community
Tuesday, August 17, 2021	8:30-10am	1.5	CME 5: Rating Scales to assess Schizophrenia and Schizoaffective Disorders
Tuesday, August 31, 2021	8:30-10am	1.5	CME 6: Clozapine Side Effects Management
Tuesday, September 14, 2021	8:30-10am	1.5	CME 7: Use of Depot Antipsychotic Injections
Tuesday, September 21, 2021	9am-3pm	6	TOP Learning Session 1
Tuesday, October 05, 2021	8:30-10am	1.5	CME 8: MI in the context of Depot Injections
Tuesday, November 23, 2021	9am-3pm	6	TOP Learning Session 2
Tuesday, December 07, 2021	8:30-9:30am	1	TOP Educational Webinar 2
Tuesday, January 18, 2022	8:30-9:30am	1	TOP Educational Webinar 3
Tuesday, February 15, 2022	9am-3pm	6	TOP Learning Session 3
Tuesday, April 05, 2022	8:30-9:30am	1	TOP Educational Webinar 4
Tuesday, May 24, 2022	9am-3pm	6	**TOP Closing congress**

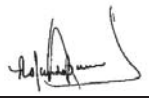
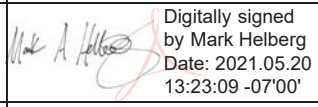
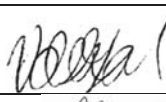
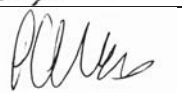
Key
Clinical Educational
Collaborative Launch
Webinars
Learning Session
Closing Congress

**These dates are subject to change*

***Additional educational events will be added as needed, particularly directed to nursing or case management*

****Due to COVID-19 restrictions, all in-person events have been moved to virtual until which time it is deemed safe to hold an in-person event*

SIGNATURES

Name	*Role*	*Collaborative Role*	*Signature*	*Date*
Dr. Rolando Barrios	Senior Medical Director	BC CfE Collaborative Sponsor		21/05/2021
Mark Helberg	Senior Director, Internal and External Relations & Strategic Development	BC CfE Collaborative Sponsor	 Digitally signed by Mark Helberg Date: 2021.05.20 13:23:09 -07'00'	
Dr. Mike Norbury	Interim Senior Medical Director	VCH Collaborative Sponsor		20/5/21
Dr. Randall White	MHSU Program Medical Director	VCH Collaborative Sponsor		19/5/2021
Bob Chapman	Interim Vice-President, Vancouver Community	VCH Collaborative Sponsor		20/5/2021
Lizzy Ambler	MHSU Operations Director	VCH Collaborative Sponsor		20/5/21
Dr. Harish Neelakant	TOP Collaborative Medical Lead	TOP Core Team		2021/05/21
Valeria Gal	Project Lead, Quality Improvement and Practice Support	TOP Core Team		2021/05/21
Philip Charlebois	TOP Operation Lead MHSU Operations Manager	TOP Core Team		2021/05/21
Jessica Anonuevo	Clinical Nurse Educator	TOP Core Team		2021/5/21
Joanna Ferguson	Project Coordinator	TOP Core Team		20/5/2021