The Ontario Deprescribing in Long-Term Care Forum
June 2019 Report

INSTITUT DE RECHERCHE Bruyère RESEARCH INSTITUTE

ONTARIO CLRI Centres for Learning, Research & Innovation in Long-Term Care

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Introduction

Reducing preventable medication-related harm is a global priority[1]. Polypharmacy, when an individual takes multiple medications, is a recognized contributor to medication-related harm[2]. In Canada, older adults living in long-term care (LTC) homes experience polypharmacy at higher rates than their community-living counterparts. Based on 2016 data from the Canadian Institute for Health Information, they receive an average of 10 medications daily compared to seven medications daily for those living in community settings[3]. Strategies to reduce polypharmacy are urgently needed. Integration of deprescribing, the planned and supervised process of dose reduction or stopping of medication that might be causing harm, or no longer be of benefit, into care processes in LTC homes aims to reduce the risks associated with polypharmacy to improve each person's quality of life.

In collaboration with the Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI), the overarching goal and vision of this initiative was to create an environment in LTC homes across Ontario where deprescribing is integrated into daily medication management practices.

To reach the goals of this deprescribing initiative, the Bruyère Deprescribing Research Team established the following objectives:

Phase 1 (October 2018 to April 2019):

- Engage and educate LTC health care providers, frontline personnel, people living in LTC homes, family/caregivers and other stakeholders
- Explore opportunities for further development and implementation of deprescribing initiatives in Ontario LTC homes

Phase 2 and 3 (April 2019 to March 2020):

- Develop a framework and research plan to promote sustainable uptake of deprescribing practices in Ontario LTC homes

Since 2013, work done by Dr. Barbara Farrell and the Bruyère Deprescribing Research Team has laid the foundation for understanding the key components needed to create a framework for deprescribing in LTC homes. This work began with the development of five evidence-based deprescribing guidelines and algorithms to help clinicians and people make informed decisions about deprescribing certain medication classes. The team then piloted the implementation of the evidence-based deprescribing algorithms in LTC homes and community settings, pursued further knowledge mobilization efforts focused on the public and health care providers, and undertook research to engage the community in deprescribing. The learnings from these projects helped shape the objectives and core activities for all phases of the current collaboration with the CLRI, including:

- Identifying a core group of advocates working in LTC homes, from members of the public and from provincial LTC organizations that influence deprescribing

- Identifying key components across LTC homes that describe strategies for implementation, evaluation and maintenance of deprescribing initiatives
- Providing education and support for uptake of existing evidence-based deprescribing tools and knowledge products

This report outlines results from an environmental scan conducted in phase 1 of this endeavour, as well as the proposal for a framework formulated during phase 2 to support behaviour changes that will facilitate deprescribing activities for people living in LTC homes in Ontario. The proposed framework represents the work of a group of stakeholders who met in Ottawa in June 2019 to discuss and prioritize feasible actions to support deprescribing.

Glossary

Language is important. During the Forum, various terms were used, sometimes for different purposes and with different understanding. We have standardized the language used in this report with each of these terms used in the following context:

Frontline personnel are individuals working in LTC homes who provide direct person care and/or psycho-social support on a regular, often daily basis, excluding medication administration. For example, these could be personal support workers (PSWs), physical therapy assistants (PTAs), occupational therapy assistants (OTAs), therapeutic recreation professionals or spiritual care providers.

A health care provider is an individual regulated professional providing health care but not necessarily directly to the person on a regular, daily basis. For example, these could be the prescribers, registered nurse, pharmacist, dietitian, occupational therapist, or physiotherapist.

A prescriber is a health care provider who is allowed to prescribe drugs. For example, this could be a physician or nurse practitioner.

The health care team is two or more people from any of the three groups listed above (and, when appropriate, other lay or professional people) who apply their complementary professional skills to accomplish an agreed-upon goal.

Support services personnel are individuals working in LTC homes who do not provide health care but regularly interact with the people living there. This could include people from administration, food services, housekeeping or environmental services.

Decision maker(s) refers to an individual or members of an organization that have a role in making important decisions that could influence change through policy or practice standards.

Behaviour is used in two contexts. It is used to describe the desired conduct of an individual or group of individuals (as in the desired behaviour changes we hope to see that could facilitate deprescribing activities). It is also used to describe the way in which people living in LTC homes may act or conduct themselves, especially toward others. A subset of these behaviours, often noted through observations like aggressiveness or calling out may be referred to as 'responsive behaviours'. Where applicable, we have attempted to make this distinction apparent throughout the document.

Long-term care (LTC) homes in Ontario are publicly funded facilities that provide access to 24-hour nursing and personal care, primarily to older adults who are unable to live independently in their own homes. In other Canadian provinces, these facilities may be known as personal care homes, nursing facilities, LTC facilities, special care homes, or residential care facilities for the aged. In the extant literature, this type of care setting is most commonly known as a nursing home.

Volunteers are members of the public or family/caregivers/friends of a person living in a long-term care home who support the persons' psycho-social needs usually under the supervision of a volunteer coordinator or the therapeutic recreation manager.

Phase 1: Environmental Scan

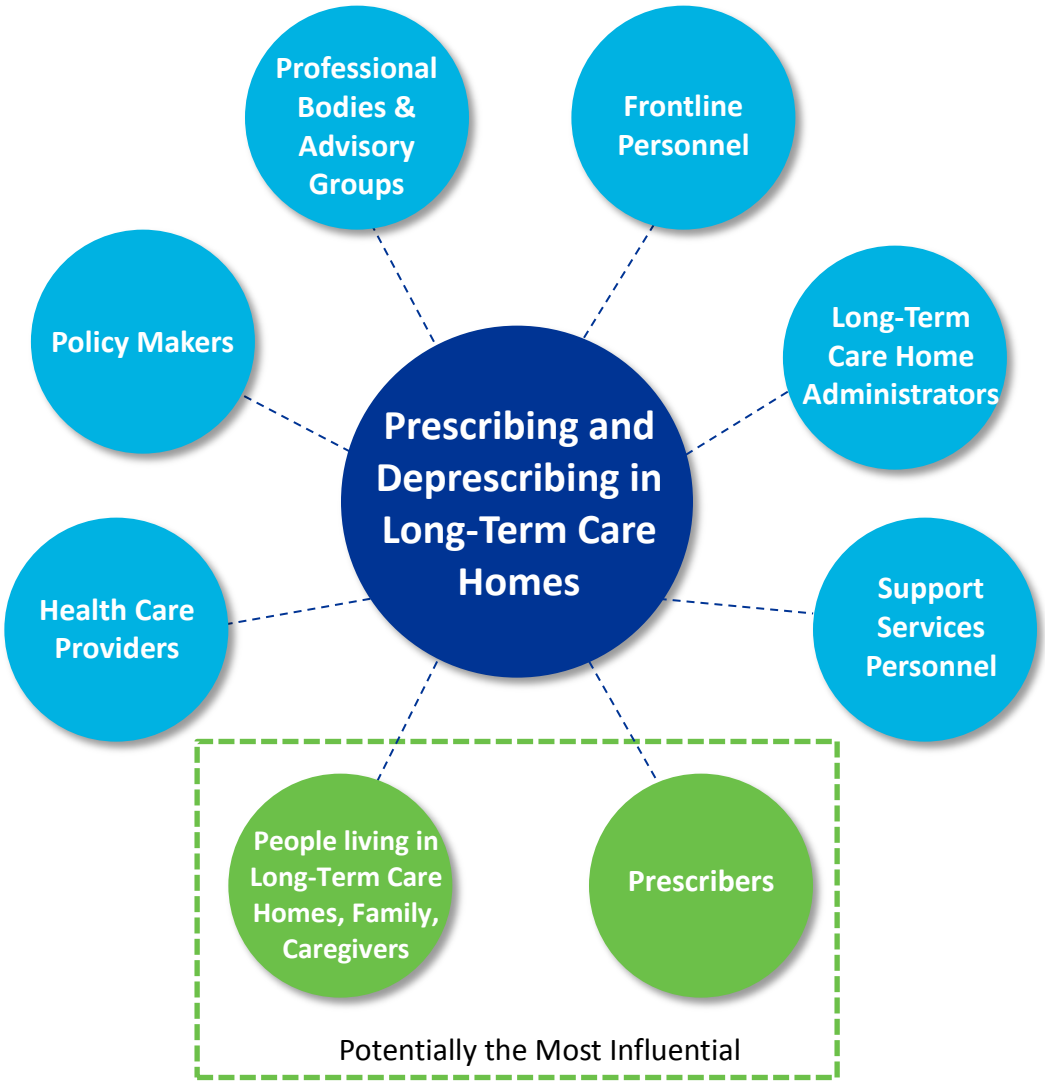
During phase 1, we conducted an environmental scan involving stakeholders from three LTC homes in the Ottawa area to explore current deprescribing knowledge and practices, as well as understand lessons learned from deprescribing projects already implemented. We also consulted stakeholders with a broader provincial connection to explore the feasibility of implementing deprescribing across the LTC sector in Ontario. In total, twenty-two meetings and nine outreach events were completed (see Appendix 1 for a summary of engagement activities).

Research work undertaken by this team has established that prescribing and deprescribing culture is influenced by multiple stakeholders within many levels of our health and social system. Problematic polypharmacy[4], taking more medications than may be necessary or for which harms exceed the benefits, and, deprescribing itself, are wicked problems from a sociological perspective. Wicked problems are those that are difficult to describe, challenging to gain consensus about by many involved stakeholders and potentially addressable through multiple solutions[5]. Individuals that participated in our phase 1 engagement activities identified that this is no different in LTC homes and Figure 1 illustrates those stakeholders discussed who may influence prescribing and deprescribing culture. Through many discussions, prescribers and people living in LTC homes/families/caregivers were highlighted as potentially the most influential in the process as they ultimately have the final decision if a drug is to be started, stopped or changed.

Though daunting to entertain a large number and wide variety of views, this is a necessary step in developing a framework given the benefits of partnering, including:

- Expertise on learning styles and education approaches that work for individual health care team members
- Insights from other frameworks or projects that have been initiated taking into account lessons learned
- More effective dissemination - building on other successful campaign strategies, accessing a large partner membership base across the province, lobbying with government decision makers
- Endorsement - promoting buy in from organization members, the public and other partners
- Expertise on effective evaluation strategies and technical support for generating reports

Figure 1: Stakeholder Groups Identified by Participants in Phase 1 that Influence Prescribing and Deprescribing Culture in Long-Term Care



All participants agreed that there was value and a need for deprescribing initiatives in LTC homes, in part, due to the observed polypharmacy and frailty common amongst people living in these homes.

In addition to the introduction of the Bruyère deprescribing guidelines and algorithms[6], stakeholders referenced tools from other organizations that have helped to enhance their focus on optimizing prescribing in this setting. More specifically, these included antipsychotic reduction approaches and reports produced by the Canadian Foundation for Healthcare Improvement[7], Health Quality Ontario[8] and Choosing Wisely Canada[9, 10].

Discussions identified many challenges and enablers to deprescribing. Stakeholders identified that LTC provides multiple opportunities for successful implementation and sustainability of deprescribing due to the existing supports and practices within their care models, including:

- Routine quarterly medication reviews and annual care conferences were viewed by many as ideal opportunities to initiate deprescribing conversations and allow for regular follow-up
- Any health care provider can lead and support the initiative if given the right resources; though many disciplines could champion or advocate for deprescribing, the pharmacist was consistently mentioned as a fit for this role given their medication expertise
- The evidence-based deprescribing algorithms and related work was well-known and well-received as useful tools for making deprescribing recommendations; more resources like these (with French translations) would help further deprescribing activities with more people in LTC homes
- Ongoing provincial government-driven deprescribing initiatives have been successful and built capacity among prescribers and other health care providers (e.g., antipsychotic reduction strategies)
- There is a current movement for LTC homes to provide more person-centred care (e.g., the Butterfly Model of Care[11] and the Eden Alternative[12]); deprescribing is well aligned with this movement because the focus is on optimizing a person's quality of life
- Measures of deprescribing can be included as quality indicators in LTC Quality Improvement Plans e.g., reduction in the use of antipsychotics

However, challenges still exist:

- Physicians, specialists and hospitalists were identified as the most challenging group to gain buy in from for deprescribing
- LTC home administrators may be resistant to or lack awareness of the potential benefits of deprescribing
- Engagement in medication management decisions by people living in LTC homes and their family/caregivers is considered low
- Limitations with health care provider and LTC personnel availability, scheduling issues and high turnover of personnel make it challenging to build a team rapport and to provide an interdisciplinary team approach; this then limits buy in for, implementation of and sustainability of deprescribing

See Appendices 2 through 5 for a more detailed list of identified facilitators and challenges.

Phase 2: The Ontario Deprescribing in Long-Term Care Forum

Planning

The second phase of our work toward developing a deprescribing framework for Ontario LTC homes was to convene a stakeholder Forum. Our global aim was to plan a sustainable intervention framework to facilitate deprescribing. Two objectives guided the interactive activities throughout the day:

- Identify options and actions that support capability, opportunity and motivation for stakeholders involved in deprescribing in LTC homes
- Prioritize and initiate planning for selected activities to support deprescribing in LTC homes

The Forum was planned over nine research team meetings (April to June 2019) to establish the objectives, vision and content. The research team sought to identify specific behaviours that would support deprescribing, and evidence-based actions that would facilitate those behaviours, thus, they chose to use an approach adapted from Michie et al's Behaviour Change Wheel (BCW) [13] as a guide for the Forum activities. This model provides a structured method for determining which evidence-based behaviour change strategies are applicable to a particular context and a systematic approach for analyzing available options for action. At the Forum, participants began by determining precisely what behaviours needed to change, then discussed what needs to happen in order for that behaviour to change (considering capability, opportunity and motivation in the target group).

The morning agenda included an introductory presentation with background information and goals for the day, a family member's perspective about the shared responsibility for medication management in the context of a LTC home, an overview of the phase 1 results, an introduction to the concepts of the Behaviour Change Wheel model as a guiding approach and roundtable discussions to identify and set priorities for desirable deprescribing behaviours in LTC homes.

A nominal group technique was used over the lunch hour to prioritize behaviours[14]. In the afternoon, groups considered each of the prioritized behaviours and developed a menu of actions, created a plan for each action, then using a World Café approach[15] to assess the appeal of each action using the APEASE criteria (affordability, practicability, effectiveness, acceptability, side effects and equitability)[13]. At the end of the day, options for building a champion driven initiative in LTC were discussed. A copy of the final agenda can be found in Appendix 6.

Attendees

The targeted invitations reached sixty-five Ontario long-term care stakeholders involved in a mix of private, not-for-profit, charitable, and municipal LTC homes and associations. Twenty-three participants representing twenty long-term care stakeholder organizations attended. Of the participants, we identified forty-eight percent as decision makers, thirty percent as health care providers, and twenty-two percent as public members.

Participant Feedback

Based on post-Forum questionnaires, participant feedback was very positive. Eighty-five percent of participants strongly agreed they left the event with a better idea of important actions that could support deprescribing behaviours. Ninety-five percent felt strongly that their opinions and experiences were respected and capitalized on during discussions. Participants stated that they found value in attending the Forum, and identified specific actions that they would take to support the implementation of deprescribing over the next six to twelve months.

The planning team felt the participants were the right level of decision makers for the Forum to be a success and that each participant offered in-depth insight, as well as actionable and practical ideas to help achieve the set objectives.

Behaviours and Actions

The remainder of this report outlines the four priority target behaviours and proposed actions that participants developed to support those behaviours. These have been articulated using notes taken by a non-participating person who observed each small group's discussions, as well as worksheets and flip charts, completed by participants themselves.

In an adaptation to the approach suggestion by the BCW, the research team will review the behaviours generated by workshop participants to determine their underlying drivers (i.e., capability, opportunity and motivation). We will then use this information to assess which actions, suggested by participants, are best aligned with the BCW, to ensure strong links between theory and evidence as the team pursues phase 3 of this work.

Summary of Desired Behaviours and Prioritized Actions

Participants determined many potential behaviour changes and prioritized four of the most important. Table 1 summarizes the behaviours identified and their related supporting actions.

Table 1: Target Behaviours and their Related Supporting Actions

1. People living in long-term care homes and their families/caregivers will participate in shared decision making to establish and monitor goals of care with respect to medication use considering effectiveness, safety and non-drug alternatives.
Supporting Action #1: Use approaches like modelling to illustrate positive outcomes through story sharing (felt to be promising/very promising).
Supporting Action #2: Offer/develop educational resources for people living in long-term care homes and their family/caregivers to inform them about their opportunities for contributions and to standardize approaches (felt to be promising/very promising).
Supporting Action #3: Schedule timely medication-focused discussions with the people living in long-term care homes/families/caregivers and the health care team (less promising due to affordability/practicability but worth considering).
Supporting Action #4: Develop regulations that mandate and monitor the person/family/caregiver involvement in care planning and medication review (new).
2. Prescribers in every health care setting will document reasons for use, goals and timelines for each medication.
Supporting Action #1: Incorporate relevant components (reason for use, goals of therapy, planned duration of use and date for review) into e-prescribing and electronic health records (felt to be promising with the caveats of affordability and possible inequity for those who are not technologically savvy).
Supporting Action #2: Develop regulations that mandate and monitor associated documentation standards and compliance (felt to be promising).
Supporting Action #3: Enable medication information sharing via centralized electronic records (felt to be very promising).

Table 1: Target Behaviours and their Related Supporting Actions (cont.)

3. All health care providers and personnel will observe for signs and symptoms in the people they care for, reporting changes as a result of medication adjustments, or changes that might prompt review for deprescribing.
Supporting Action #1: Provide education and training using tools that link signs and symptoms to medication-related effects (very promising).
Supporting Action #2: Use approaches like modelling to promote health care provider and personnel engagement through personal story sharing (very promising).
Supporting Action #3: Make tools to help monitor changes in signs and symptoms accessible at the point-of-care (promising).
4. All members of the health care team will participate in conversations about deprescribing.
Supporting Action #1: Develop role descriptions to facilitate collaboration amongst the health care team (felt to be promising).
Supporting Action #2: Create dedicated time and space for discussions during each shift, at care conferences and as needed (felt to be very promising).
Supporting Action #3: Establish a monitoring and evaluation framework for the impact of health care provider and personnel collaborations on deprescribing, care plans, quality of life, retention and workload (felt to be promising).
Supporting Action #4: Recognize health care provider and personnel who identify signs and symptoms that lead to a deprescribing conversation.

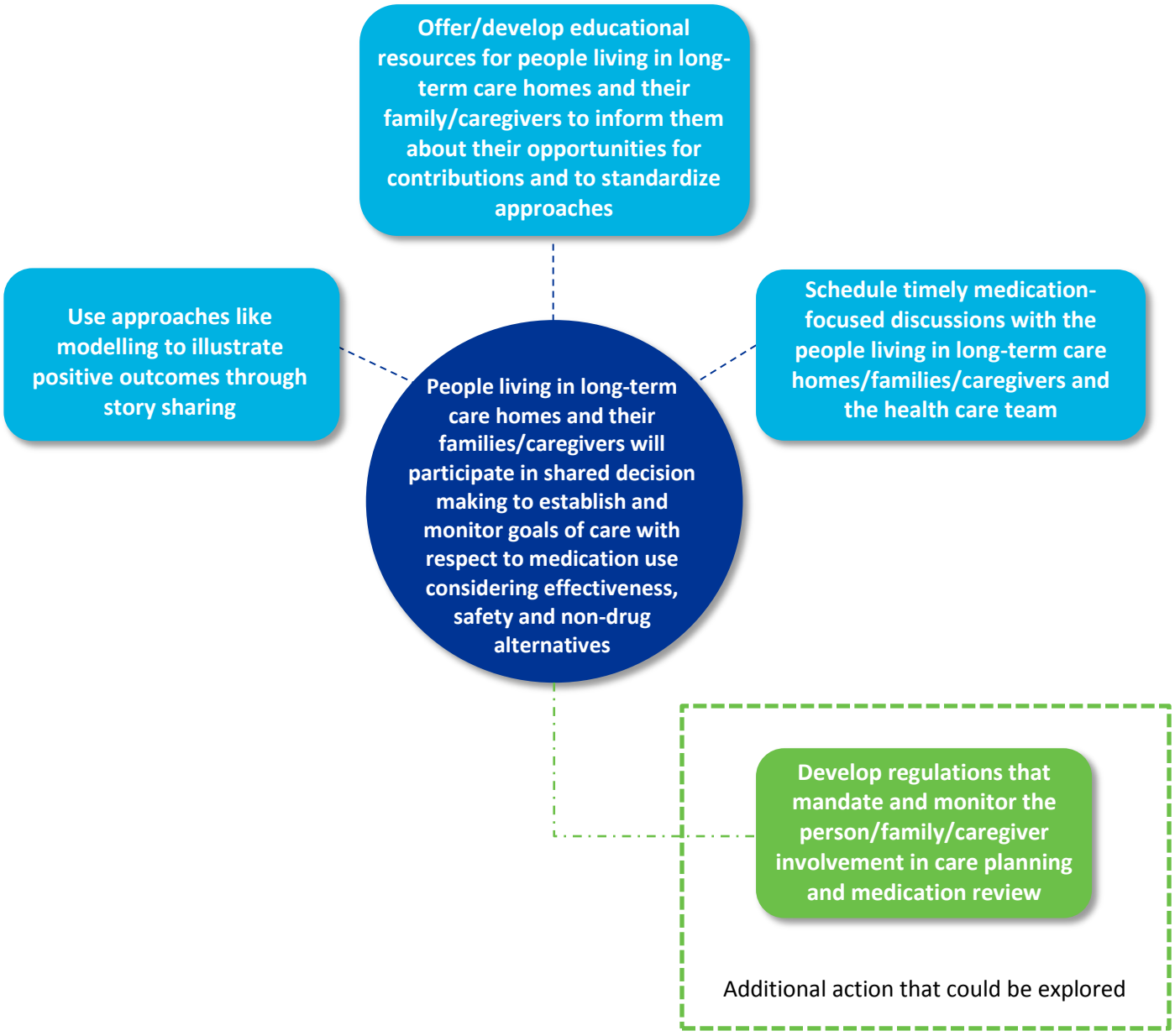
1. People living in long-term care homes and their families/caregivers will participate in shared decision making to establish and monitor goals of care with respect to medication use considering effectiveness, safety and non-drug alternatives.

Participants felt that the people living in LTC homes and their families/caregivers are not consistently involved in the current medication review process. Many may not be aware that quarterly medication reviews are conducted or that they can request a medication review. Annual care conferences can also provide opportunity for these discussions about medication-related goals. In addition, people living in LTC homes and their families/caregivers are uncertain of the role they might play, how they could ask to be involved, what options exist for discussing deprescribing, or even that deprescribing could be beneficial. Consideration of non-drug alternatives that complement deprescribing is another important element of these medications reviews as environmental, lifestyle and emotional supports are key components of personalized care plans. Focusing on this behaviour was viewed as a way to promote a more effective multidisciplinary and person-centred approach to medication management that would offset the increased time to engage in these discussions.

Table 2: Target Behaviour #1 Specifics (as compiled from participant worksheets and recorder notes)

Considerations Related to the Target Behaviour	Target Behaviour Specifics
***Who* needs to perform the behaviour**	▪ Person living in a LTC home and their family/caregiver ▪ Members of the health care team: nurses, care coordinators, physicians, pharmacists, social workers, PSWs
***What* do they need to do differently to achieve the desired change?**	▪ Schedule, co-ordinate, and invite people living in LTC homes and family/caregivers to sessions ▪ Educate: have resources available ▪ Contribute: be prepared and punctual, ask questions, active listening ▪ Evaluate the intervention
***When* do they need to do it?**	▪ Upon moving in ▪ At quarterly medication reviews ▪ At annual care conferences ▪ As needed ▪ When condition changes ▪ Plan follow up in a timely manner depending on medication changes
***Where* do they need to do it?**	▪ In an inviting space that promotes the ability to speak openly, feels safe
***How often* do they need to do it?**	▪ Always ▪ As per ministry guidelines ▪ At stakeholders' request ▪ When condition changes
***With whom* do they need to do it?**	▪ Person living in a LTC home and their family/caregiver ▪ Members of the health care team: nurses, care coordinators, physicians, pharmacists, social workers, PSWs

Figure 2: Actions to Support Target Behaviour #1



The centre circle represents the target behaviour. The outer blue boxes represent the behaviour change actions identified by Forum participants, while the green box represents actions identified by the research team upon review of the data after the event.

Supporting Action #1: Use approaches like modelling to illustrate positive outcomes through story sharing (felt to be promising/very promising).

Personal testimonials from people living in LTC homes/families/caregivers regarding their experiences in care planning and medication reviews could be useful to encourage and advise people about the value of contributing to medication-focused goals of care, as well as approaches and opportunities to participate. These testimonials could be used to both model or persuade people to participate. In Michie's Behaviour Change Wheel framework, modeling provides "an example for people to aspire to or imitate") and persuasion uses "communication to induce positive or negative feelings or stimulate action."[13]

A volunteer ambassador in some sites could play this role, or in sites where this approach is not yet available, the role could be taken on by other personnel (e.g., recreation therapist, social worker, nurse). Videos could be made accessible online for efficiency and reach to non-local family members. A health promotion package about the medication review process and deprescribing opportunities could be a supportive tool provided at the time of moving into the home. These ideas are closely aligned with those about education to inform and standardize approaches but are focused primarily on the challenges of awareness, engagement and empowerment. Enlisting the support of existing volunteer ambassadors was felt to be practical. However, the importance of establishing standards regarding the scope and expectations was raised; guidance about best practices and quality assessment would be needed to ensure objectivity and accuracy of the information provided. Participants raised concerns over equity as some LTC homes may not have family ambassadors; and that relying on volunteers can be problematic in times of high volume. Resident and Family Councils would ideally be involved in planning of the approach. Attention should be paid to ensuring people living in LTC homes/families/caregivers have access to these testimonials at different times of the day and week, as one moves into the home, and on an ongoing basis.

Supporting Action #2: Offer/develop educational resources for people living in long-term care homes and their family/caregivers to inform them about their opportunities for contributions and to standardize approaches (felt to be promising/very promising).

Participants felt that people living in LTC homes/family/caregivers, as well as other members of the health care team are not using a standardized approach to medication review and care planning. Consistent approaches and aligned expectations are required to ensure shared decision-making with respect to medication review and deprescribing. The importance of having people living in LTC homes, families/caregivers, physicians, pharmacists, nurses, personal support workers and other LTC personnel being 'on the same page' was emphasized. Many education tools and resources are available and could be adapted for use to ensure both accessibility (understandability) and relevance. Integration of these tools and resources should consider not only existing processes but how they can evolve as more homes move toward person-centred care. Resources to promote non-drug approaches for symptom management are also important and must be made available as participants felt offering these as safer alternatives would encourage deprescribing and shift the focus toward alternate supports. Standardized checklists could be designed for guiding discussion amongst all members of the health care team and the people living in LTC homes, families/caregivers. Participants felt that LTC personnel could liaise with Resident and Family Councils to organize education sessions; as above, options for online education and

flexibility around timing of live education sessions are important. A health promotion package about medication review and deprescribing could be a supportive tool when a person moves into the home. However, keeping in mind that people may feel overwhelmed in the first days, a tiered approach to providing information (e.g., what to expect in 2 weeks, in 6 weeks, in 3 months) could be useful.

Supporting Action #3: Schedule timely medication-focused discussions with the people living in long-term care homes/families/caregivers and the health care team (less promising due to affordability/practicability but worth considering).

The scheduling and organization of medication reviews with people living in LTC homes and families/caregivers could be challenging due to workload, lack of personnel available to organize meetings, and taking into account availability of both health care team members and family/caregivers. Enough notice must be provided to ensure attendance and time for preparation to make the interaction effective; minimally, participants felt that the first medication review would be scheduled after 3 months of living in the home. Ideally, a designated person would coordinate meeting times and attendance.

Another opportunity for these discussions is to align them with annual care conferences or quarterly medication reviews which are already mandated to occur. Given that people living in LTC homes and their families/caregivers participate in annual care conferences, attendees suggested this may be more feasible since these conferences, an expectation in care delivery, happen consistently. Devoting time to consider deprescribing at these meetings may be more acceptable to those involved, with little to no extra cost. Approaches that help prepare the person/family/caregiver for these meetings still need to be explored.

Supporting Action #4: Develop regulations that mandate and monitor the person/family/caregiver involvement in care planning and medication review (new).

Participants pointed out that there is currently no consistent requirement for who should be involved in medication reviews, only that they are legislated to be done on a quarterly and annual basis[16]. A standardized provincial approach would help, both in terms of who must participate, but also what must be discussed at each review (e.g., review of care goals, medication effectiveness/safety, options for non-drug approaches and options for deprescribing). In addition to the regular quarterly routine, medication reviews following a change in condition and at times of transition between healthcare settings, e.g., LTC homes and acute care, could be mandated.

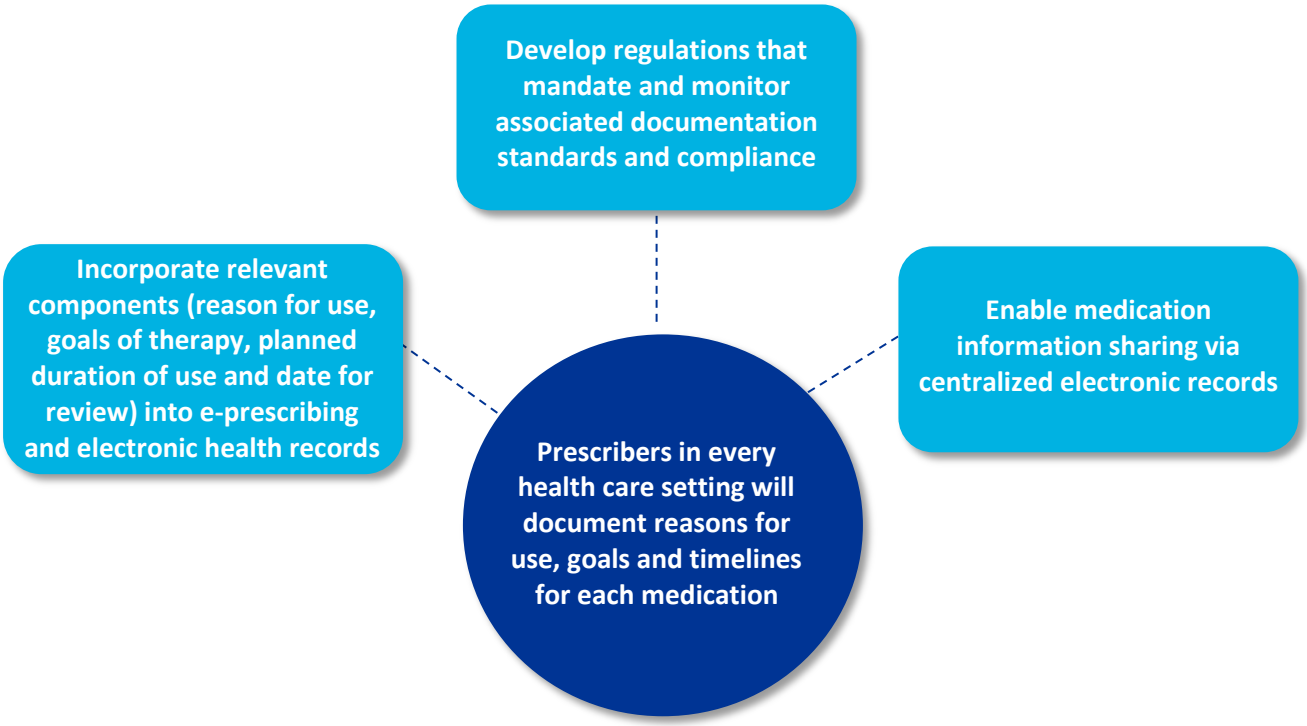
2. Prescribers in every health care setting will document reasons for use, goals and timelines for each medication.

Participants felt that the lack of information about why a medication was prescribed, when and for how long, as well as related goals of care and the factors that led to the prescribing decision are frequently unavailable. This information may not have been documented at all, or may have been lost over time as people transitioned between care settings and health care providers. Medication reviews are challenging to conduct and decisions about deprescribing are difficult to make when this information is lacking. Currently, prescribers, nurses and pharmacists invest a great deal of time attempting to find this information and to understand the initial thought process around prescribing to inform decision-making about continuing or deprescribing medications. Having this information readily available would facilitate confident decision-making about which medications to continue or deprescribe under various circumstances, as well as the monitoring needed to ensure safe and effective therapy, or safe deprescribing.

Table 3: Target Behavior #2 Specifics (as compiled from participant worksheets and recorder notes)

Considerations Related to the Target Behaviour	Target Behaviour Specifics
Who **needs to perform the behaviour**	▪ Prescribers in every health care setting
What **do they need to do differently to achieve the desired change?**	▪ For every medication, document reason(s) for use, goals of therapy, planned duration of use and date for review or deprescribing, and rationale for these decisions
When **do they need to do it?**	▪ With each new prescription written ▪ Upon moving in to the home
Where **do they need to do it?**	▪ A centrally accessible eHealth platform (should be linked to existing medication recording) ▪ Should be accessible to health care team members (including pharmacists, nurses and those who distribute medication), people living in LTC homes and their family/caregivers, LTC homes
How often **do they need to do it?**	▪ With each new prescription written ▪ Upon moving in to the LTC home
With whom **do they need to do it?**	▪ Office personnel of the prescriber involved with charting and documentation

Figure 3: Actions to Support Target Behaviour #2



The centre circle represents the target behaviour. The outer blue boxes represent the behaviour change actions identified by Forum participants.

Supporting Action #1: Incorporate relevant components (reason for use, goals of therapy, planned duration of use and date for review) into e-prescribing and electronic health records (felt to be promising with the caveats of affordability and possible inequity for those who are not technologically savvy).

Participants' experience is that these elements are not currently routinely documented. Components, such as reason for use, goals of therapy, anticipated duration and date for review were felt to be important. Including justifications for the decisions related to these components was also felt to be useful information to support subsequent decision-making. To facilitate this documentation, standard components must be incorporated into both e-prescribing and electronic health record systems across all care settings. Participants discussed the respective advantages and disadvantages of making the documentation mandatory e.g., building in forcing functions into documentation. Participants acknowledged that this could be a costly venture but felt it would ultimately save money by facilitating better documentation, decision-making about medication use and deprescribing (e.g., if medication benefits no longer outweigh risks; if goals of therapy change with worsening dementia or frailty). This documentation will also reduce the time investment required of health care team members trying to find this information. It would improve communication and care amongst health care team members (e.g., for pharmacists who are often unaware of reasons for use) and across transitions in care settings (e.g., to and from hospital). Links to guidelines and decision-aids could be incorporated to further inform decision-making. Challenges for prescribers who have difficulty with technology may slow adoption. Participants discussed that the use of drop-down menus to facilitate field completion may help improve speed of documentation but acknowledged the risk of inaccurate information being selected, particularly if previous reasons for prescribing are unknown.

Supporting Action #2: Develop regulations that mandate and monitor associated documentation standards and compliance (felt to be promising).

Regulations for both electronic health records/e-prescribing developers/vendors, as well as standards for health care providers are needed. Consistent, mandated 'best practice' approaches to incorporating the relevant fields within e-prescribing and electronic health records will help prescribers and other health care team members from across different settings know what is expected and to learn to complete this documentation more easily. Eventually, mandatory completion of these fields will force compliance. Accreditation standards and licensing requirements will facilitate this effort. For health care providers, the current use of verbal orders (i.e., in which the prescriber provides the name of a medication and directions for use to a nurse or pharmacist) will need to be reviewed in this context and regulations for what information must be provided at the time of prescribing, or during the move to a LTC home, and who should document that information, must be developed and implemented. Required documentation can be monitored initially through compliance reports to promote quality improvement (using techniques such as competitive incentivization). Additional quality indicators could include links to Resident Assessment Instrument-Minimum Data Set (RAI-MDS) [17] data (correlation to diagnoses) and options to document the needs/preferences of the person living in the LTC home.

From a compliance perspective, participants felt that there would be a small, incremental cost by using existing quality improvement approaches. Regulatory changes require working with the Ministry of Health, the Ministry of Long-Term Care and the relevant professional groups (especially with regard to enhancing professional standards); monitoring must occur at the individual LTC home level, perhaps involving Health Quality Ontario. Additional time for health care team members to meet these documentation requirements will ultimately be offset by a reduction in the time needed to search for this information.

Supporting Action #3: Enable medication information sharing via centralized electronic records (felt to be very promising).

Many electronic health record (EHR) and prescription dispensing databases are used across Ontario LTC homes. This makes standardization requirements, accountability and information transfer difficult. While a skeleton system (ConnectingOntario Clinical Viewer) includes medication dispensing information for medications for adults aged 65 and over, the system does not contain the documentation components described above, nor is it universally accessible to those health care team members who need it (e.g., a nurse, PSW, pharmacist). In addition, the information is not easily viewed and it can be time-consuming and inefficient to search. A centralized and accessible electronic database (health record) that incorporates the documentation standards described above would be a promising approach toward equipping the right person with the right information at the right time. Considerations include ensuring privacy and confidentiality of information while optimizing ease of access for health care team members who may not be onsite in LTC homes (e.g., pharmacists), avoiding duplication and careful planning amongst the Ministry of Health, Ministry of Long-Term Care, LTC senior leaders, health care providers, frontline personnel and EHR vendors to ensure viability and usability.

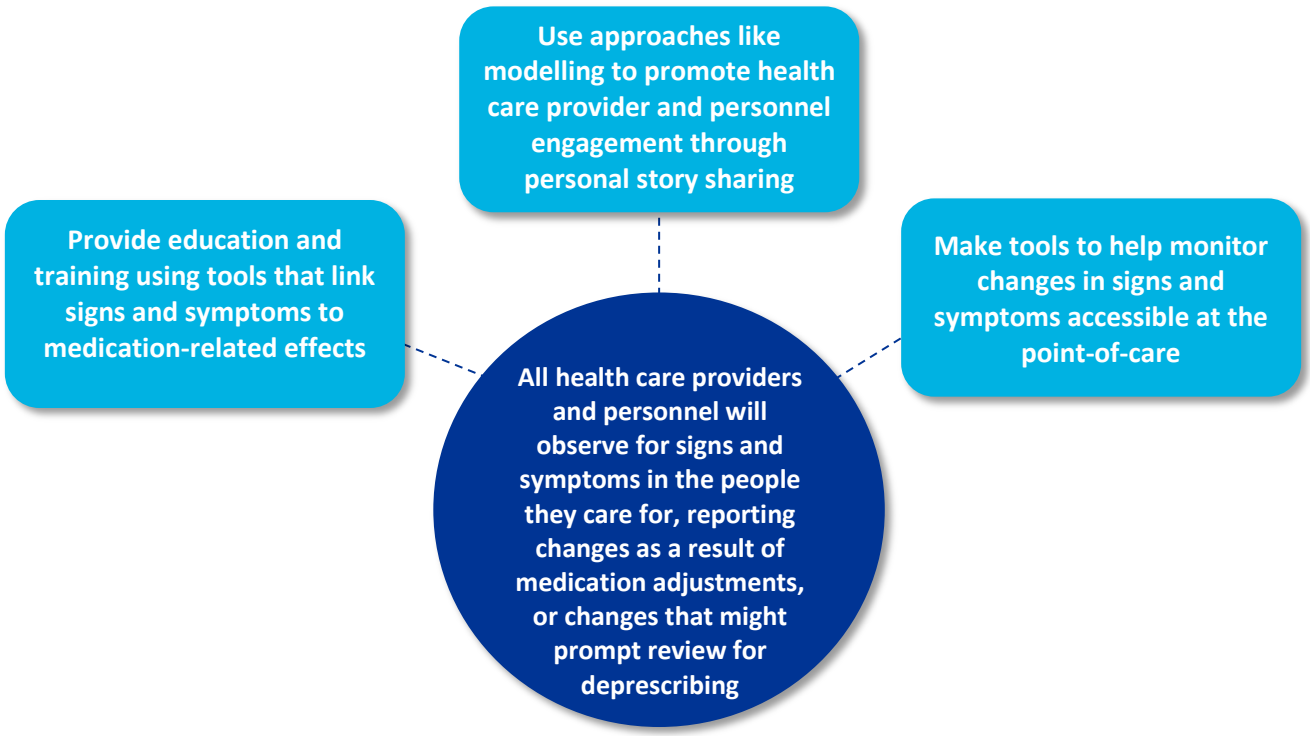
3. All health care providers and personnel will observe for signs and symptoms in the people they care for, reporting changes as a result of medication adjustments, or changes that might prompt review for deprescribing.

Participants felt that there was potential for other personnel, beyond health care providers, to be involved in the monitoring and reporting of changes in the person they care for that might suggest deprescribing could be considered or those arising from medication change(s). Given the daily contact and close relationships with people living in LTC homes, participants felt that these personnel were in an ideal position to observe and monitor the people they care for, but currently do not have the skills to provide such insights to the rest of the health care team and may not be empowered to do so. This behaviour has two important components: 1) identifying signs and symptoms that may prompt a review for drug-related causes and deprescribing, and 2) monitoring (according to checklists or criteria) for the impact of medication changes. Relevant signs or symptoms could include behaviours, mobility, function, cognition and demeanour. Overall, participants felt the inclusion of these individuals in the observation and monitoring of the person in their care was important for accountability and team cohesion. This behaviour builds on the move towards person-centred care models which aim to empower all personnel to observe and act on signs and symptoms of physical and emotional distress, as well as celebrate improvements in overall well-being of the person in their care. This behaviour is closely aligned with the next behaviour which is focused on the importance of ensuring deprescribing conversations occur. Similarities between behavior 3 and 4 included the need for clarity about roles, having dedicated time and space for discussion, recognition and accountability. However, behaviour 3 hones in on the 'what' that is required versus the 'how', and expands the 'who' to include everyone who interacts with the person living in a LTC home.

Table 4: Target Behaviour #3 Specifics (as compiled from participant worksheets and recorder notes)

Considerations Related to the Target Behaviour	Target Behaviour Specifics
***Who* needs to perform the behaviour**	▪ All members of the health care team including support services personnel (examples: PSWs, recreational therapists, dieticians, housekeeping)
***What* do they need to do differently to achieve the desired change?**	▪ Make it part of the LTC home culture to report observations ▪ Coordinate a set time for reporting (i.e., huddles) ▪ Education on what changes in signs or symptoms to observe (use a checklist or guide) ▪ Have access to a reporting/follow up system ▪ Consistency in personnel to person assignments ▪ All points above need support from leadership
***When* do they need to do it?**	▪ As soon as a change is observed ▪ All the time (needs to become an always practice) ▪ Huddles, shift change
***Where* do they need to do it?**	• Includes verbal and written/electronic forms of communication -Private area/confidential -Uninterrupted -Consistent format and place in chart -Easily accessible
***How often* do they need to do it?**	▪ Anytime a change is observed ▪ Continuously ▪ When drugs tapered or stopped ▪ Transitions of care (e.g., hospital back to the LTC home)
***With whom* do they need to do it?**	▪ Registered nurse overseeing care of the person ▪ Prescriber

Figure 4: Actions to Support Target Behaviour #3



The centre circle represents the target behaviour. The outer blue boxes represent the behaviour change actions identified by Forum participants.

Supporting Action #1: Provide education and training using tools that link signs and symptoms to medication-related effects (very promising).

Educating HCP and personnel to help flag people for medication assessment or to report on the effects of deprescribing could be done through the provision of tools (e.g., a table with lists and explanations linking types of signs and symptoms to medication side effects). Relevant signs or symptoms could include behaviours, mobility, function, cognition and demeanor. Such tools could standardize the process and build confidence. Preliminary discussion centered on how and when to most effectively deliver education but no consensus was reached; questions were raised about how to cost-effectively plan and schedule such education (including how to find the time for all HCPs and LTC personnel to participate). While thought to be practical and affordable, there was concern about overwhelming LTC personnel if other initiatives are being rolled out at the same time. A well-developed implementation and dissemination plan would facilitate successful uptake from health care providers and frontline personnel. Senior leadership support would be essential. Relevant tools would need to be identified or developed for use.

Supporting Action #2: Use approaches like modelling to promote health care provider and personnel engagement through personal story sharing (very promising).

Again, this action reflects Michie's Behaviour Change Wheel framework, where approaches like modeling provide "an example for people to aspire to or imitate" and persuasion uses "communication to induce positive or negative feelings or stimulate action."[13] Examples of success stories from the people working in LTC homes and using these to showcase the benefits with other personnel to promote participation was felt to be important and promising. These could be shared via video (considering affordability), in newsletters, on bulletin boards, in photo journals, and at various advisory committee meetings held at the home. Privacy and confidentiality would need to be considered. Attention should be paid to ensuring that people or families/caregivers who have had challenging experiences do not perceive that only positive outcomes are being shared. Lessons learned from all experiences can be powerful and allow for more robust conversations during the shared decision making process.

Supporting Action #3: Make tools to help monitor changes in signs and symptoms accessible at the point-of-care (promising).

Electronic health records (EHRs) like PointClickCare® (a widely used EHR system in Ontario LTC) were seen as an ideal location to host relevant tools to help health care providers and frontline personnel. However, there could be a cost for such development and there is a risk of overwhelming personnel with another 'flag' or multiple materials, or creating a 'check-list phenomenon' shifting focus away from a holistic approach to a 'list'. Resource binders or paper charts or bulletin boards could also house tools, and this may be more helpful for personnel who do not have access to PointClickCare®. The value of such tools in potentially improving care, and reducing costs, as well as engaging all personnel in feeling accountable for the care they provide cannot be underestimated.

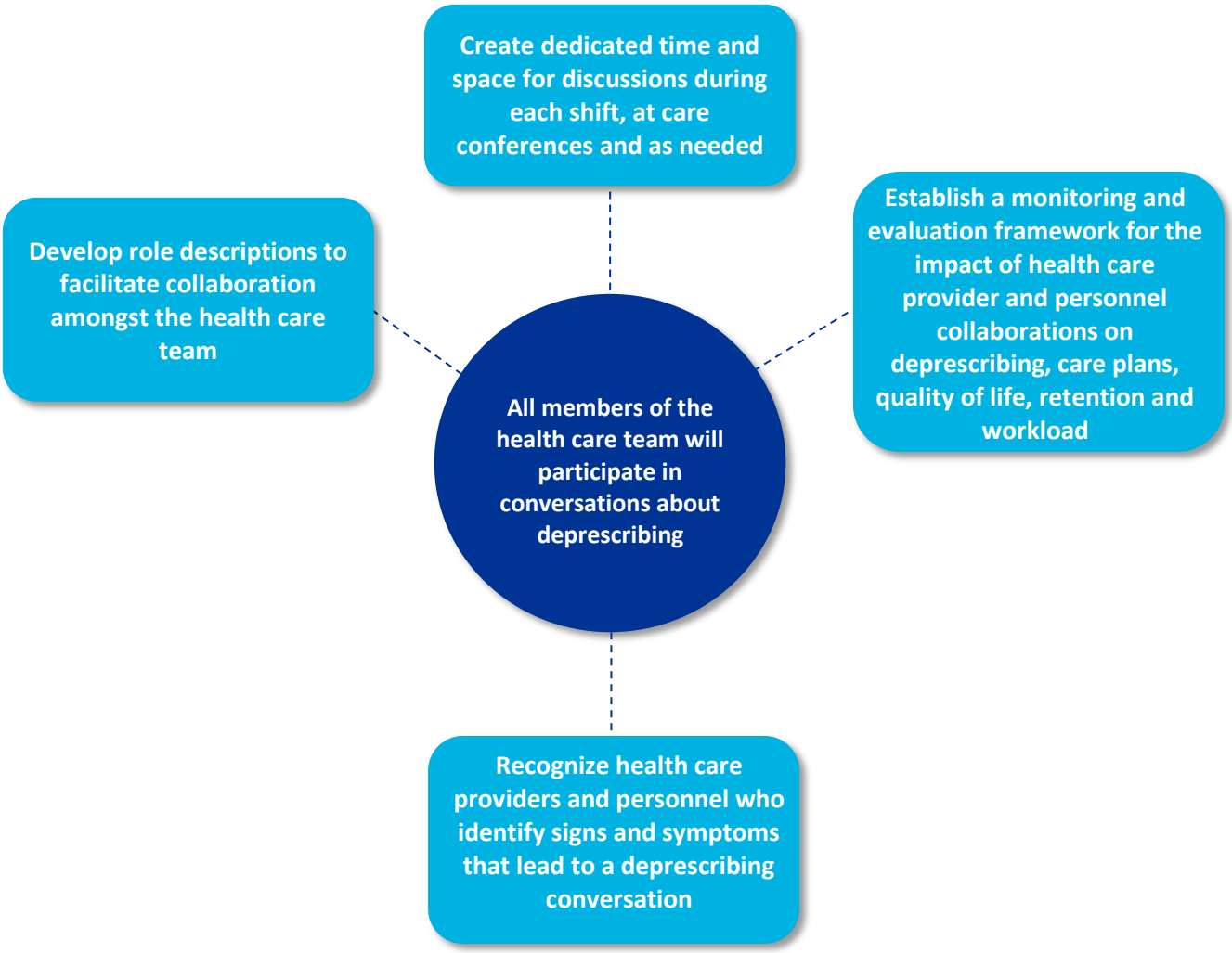
4. All members of the health care team will participate in conversations about deprescribing.

Participants identified several areas where communication about deprescribing could be improved to create opportunities and capability for reporting observations and discussing impact about medication changes and options for deprescribing. Within a LTC home, the person living there and all of those involved in their care (e.g., PSW, nurse, recreation therapist, physician, pharmacist, and family/caregiver) should be engaged regularly in these conversations. Attendees voiced the need to foster trusting and strong relationships amongst all personnel and people/families/caregivers to help identify signs and symptoms and keep the person at the centre of care. This would allow those working closest with that person to share observations and assume responsibility for improving care. Here, too, suggesting and introducing non-drug approaches would have a role. Across care transitions, the importance of a conversation about deprescribing initiatives between the discharging physician and the LTC primary care provider was highlighted, however, the remainder of workshop participants' discussion focused on communication within the LTC home. The primary challenges identified by the participants were those related to corporate and individual accountability and how to best evaluate this anticipated change in behaviour.

Table 5: Target Behaviour #4 Specifics (as compiled from participant worksheets and recorder notes)

Considerations Related to the Target Behaviour	Target Behaviour Specifics
Who **needs to perform the behaviour**	▪ Person living in a LTC home/family/caregiver ▪ Members of the health care team: nurse, administrators, prescriber, PSW, aide, recreation therapist, pharmacist
What **do they need to do differently to achieve the desired change?**	▪ Have standardized discussions about deprescribing
When **do they need to do it?**	▪ At shift change (part of regular routine) ▪ When acute changes of condition occur ▪ At care conferences ▪ When changes in behaviour occur
Where **do they need to do it?**	▪ Appropriate space in LTC home ▪ Undisturbed
How often **do they need to do it?**	▪ Minimum once per year ▪ At quarterly medication reviews ▪ As needed ▪ Frequency may be drug dependent
With whom **do they need to do it?**	▪ With each other

Figure 5: Actions to Support Target Behaviour #4



The centre circle represents the target behaviour. The outer blue boxes represent the behaviour change actions identified by Forum participants.

Supporting Action #1: Develop role descriptions to facilitate collaboration amongst the health care team (felt to be promising).

Participants described opportunities for role clarification in terms of identifying those who could champion deprescribing practices, take responsibility for following through on, and evaluating the outcomes of changes, and who could participate in direct observational monitoring. In particular, expanding the role of the PSW in observing and reporting changes in signs or symptoms that might be linked to medications was highlighted. Prioritizing consistent matching of personnel to individual people for care was recommended as it promotes the relationship building needed to ensure familiarity with that person's usual behaviour or symptoms. It also improves the ability and confidence to report changes or suggest personalized non-drug approaches. Participants also pointed out that perspectives from support services personnel (e.g., food services, housekeeping) should be considered. Education and training, as well as job description revision must occur to ensure people are aware of, and comfortable with monitoring and reporting on changes in behaviour or symptoms.

Supporting Action #2: Create dedicated time and space for discussions during each shift, at care conferences and as needed (felt to be very promising).

Options for the timing of deprescribing discussions were suggested: at shift change, during care conferences, with any new change in behaviour or condition. Approaches to ensuring healthcare providers and frontline personnel have an opportunity to participate should be considered (e.g., PSWs and nurses at shift change, all health care team members during care conferences and medication reviews). Dedicated time and a designated confidential space at shift change must be built into the process to avoid overtime and to emphasize the importance of this activity. This could occur in a variety of ways, for example within existing short 'care huddles' or 'morning reports'. A standard agenda for the huddle should include 'deprescribing input'. Huddles can be a good way for health care providers and personnel to touch base, especially during a time of change. Participants recommended directors of care work with the people they employ to identify appropriate times and names for such discussions, as the purpose of a huddle versus a morning report may differ. A Canadian Foundation for Healthcare Improvement huddle template was recommended as a useful resource. While huddles are a cost-effective and widely used approach in many LTC homes, approaches to timely communication with those unable to attend (e.g., pharmacists, prescribers, the person/families/caregivers) must be considered. The Dementia Observation System was highlighted as an example of a communication tool. Participants discussed that while the addition of deprescribing to huddle conversations would potentially have positive impacts, this must be balanced with potential risks that the added time may take away from documentation, or direct person care time. New routines take time to establish.

Supporting Action #3: Establish a monitoring and evaluation framework for the impact of health care provider and personnel collaborations on deprescribing, care plans, quality of life, retention and workload (felt to be promising).

This action focuses on accountability and improving uptake. Although incorporating all of the health care team into conversations about deprescribing could be rewarding and promote person-centred care, it is viewed as time-consuming, with associated costs. These costs may be offset by potential cost savings for the broader health system that may be realized through deprescribing (e.g., savings if fewer medications are used which may translate into reduced medication-related harm and associated use of health system resources). Participants recommended developing a framework for monitoring the impact (i.e., both intended and unintended consequences) of this new activity, possibly as an Accreditation standard.

Supporting Action #4: Recognize health care providers and personnel who identify signs and symptoms that lead to a deprescribing conversation.

Particularly for those taking on new responsibilities within these discussions, the importance of recognition as a motivating factor cannot be underestimated. Participants spoke about different options for positive recognition, including highlighting contributions during huddles, in newsletters, on bulletin boards, by senior leadership and with small tokens of appreciation. The rating of how promising this action could be was not recorded by participants.

Phase 3: Building a Champion Driven Initiative

During this part of the Forum, attendees discussed options to develop and host a champion-driven initiative to support deprescribing implementation across the province. A wide range of potential audiences were identified; attendees felt the session should have a broad reach to include people living in LTC homes, families/caregivers, all health care providers, frontline personnel, support services personnel, senior leadership and stakeholders with attention paid to multiple LTC homes settings (not-for-profit, for-profit, rural, urban) rather than focusing on building champions with one target discipline or group.

The discussion centred on how "champion teams" from several LTC homes could be established then used to build and motivate communities of practice for spreading successful deprescribing initiatives province-wide.

Forum participants felt that if an in-person event were hosted, it should:

- start with a common session (e.g., foundational information about deprescribing and its importance, motivation and modeling through featured person/family/caregiver/HCP/frontline personnel success testimonials and attendee story sharing that champions can subsequently share to motivate others at their sites, covering common messaging such as the potential for deprescribing to improve health care and reduce time spent on unproductive tasks)
- include breakout sessions for targeted training/education for target discipline or stakeholder groups (e.g., tools for skill building) using case-based training to help people problem solve and collaborate with others (perhaps demonstrating the concept of a 'deprescribing huddle'), as well as to take back to their sites for further implementation
- help champions tailor activities appropriately to their sites, with tools and processes to facilitate an environmental scan; the Forum event report can also be used to guide activities
- use video or written records of the testimonials and stories to help celebrate successes
- end with an opportunity to lay out a plan of action for themselves as champions and site-specific implementation and to develop an evaluation process that includes a measure of accountability

Subsequent activities (e.g., additional webinars or 'on the ground' visits) would enable participants to take and evaluate concrete efforts at targeting behaviour change, and to report on their experiences for others.

There was also dialogue about the potential need for a long-distance option [e.g., a virtual classroom with a dedicated facilitator, a 'travelling' workshop, a series of webinars following the initial event using existing LTC learning management systems (e.g., Surge Learning)] and provincial education approaches that would extend reach beyond individuals or teams in the Ottawa area.

A key objective of a champion driven initiative (and long-distance options) should also include approaches to informing provincial policy makers and other organizations to ensure ongoing support and facilitation for implementation of the deprescribing framework in LTC homes and sustainable behaviour change. All stakeholders should be engaged in their understanding that deprescribing aligns with current health policies (particularly the emphasis on person-centred living); and that infrastructure and financial supports will make certain actions more affordable and attainable. Additional input to support government-level strategies could come from the Ontario Seniors Consultation Survey[18].

Target Audience and Invitation Strategy:

All agreed that the initiative could aim to target 3 to 4 LTC homes that represent different settings (not-for profit, for-profit, rural, urban) and could act as 'champion teams'. Organizations like the Ontario Long-Term Care Association (OLTCA), Ontario Long-Term Care Clinicians (OLTCC), Registered Nurses' Association of Ontario (RNAO) or AdvantAge Ontario could help identify highly motivated sites that want to implement a comprehensive deprescribing initiative as an 'early adopter' and would be willing to subsequently share their experiences with other communities. Advertising and recruitment can also be done through the Ontario Association of Residents' Councils (OARC) and Family Councils Ontario (FCO). Physician groups (e.g., OLTCC, Ontario Medical Association) should be engaged to help recruit physicians and identify strategies for continuing medical education credit.

It was recognized that with no funding for travel/time release, it may be challenging to identify LTC homes outside Ottawa who could commit to sending multiple team members for a face-to face event.

Evaluation of the Champion Initiative:

Evaluation of the champion initiative will need to consider at least two components:

- impact of the initiative itself (e.g., using RE-AIM framework[19] to capture reach, adoption, implementation, effectiveness and maintenance of subsequent interventions)
- implementation at individual LTC homes every 3 to 6 months (e.g., quality improvement indicators, developmental evaluation at timed intervals with subsequent feedback)

Appropriate tools like existing reports, feedback surveys or interviews should be explored and content may need to be flexible in order to accommodate differences in quality indicators that a LTC home may identify as important. Improvements in both qualitative (e.g., HCP or LTC personnel experience re: tools used, behaviour changes etc.) and quantitative measures (e.g., reduction in medications, important clinical outcomes from both health care team and person/family/caregiver perspective like falls reduction) should be considered.

Processes for evaluation could include surveys (e.g., mailed, emailed or links provided from webinars) and interviews.

Evaluation feedback presented at subsequent webinars/events was felt to be important to garner accountability.

Next Steps:

Ontario's long term care system is fast becoming a dynamic area of transformational change, particularly with respect to the transition to person-centred models of care. Deprescribing is well aligned with this transformation and the Bruyère Deprescribing Research team is committed to facilitating phase 3 of this initiative within this context.

Starting in August, our team has partnered with attendees from the June Forum who have volunteered to participate in a planning committee. These members will help develop the objectives of the next phase of the initiative, determine the format, identify the target audience, identify speakers, recruit LTC homes, and develop an implementation, evaluation and follow up plan.

In addition, our team will help build the content, provide communication and planning support, provide follow up support for champion sites and finally, collect and collate the evaluation data.

Appendix 1: Summary of Engagement Activities Conducted by the Bruyère Deprescribing Research Team from October 2018 to April 2019

Environmental Scan of Three Local LTC homes (Ottawa)	Broad Outreach to Provincial Stakeholders	Presentations/Conferences/Workshops
1. Hillel Lodge (The Bess and Moe Greenberg Family) ▪ 3 meetings with various personnel 2. Élisabeth Bruyère Residence (EBR) and Saint-Louis Residence (SLR) ▪ 5 meetings with various personnel ▪ 1 presentation to the Resident Council (Feb 2019) 3. MediSystem Pharmacy ▪ 1 meeting with the Pharmacy Manager	1. 11 meetings with representatives from: ▪ Champlain BASE™ eConsult Team ▪ Ontario Centres for Learning, Research and Innovation in Long-Term Care at Bruyère ▪ Nurse Educator Specialist, University of Ontario Institute of Technology ▪ Revera, Long-Term Care ▪ Canadian Association of Retired Persons National ▪ Canadian Foundation for Healthcare Improvement ▪ Medical Pharmacies National Corporation ▪ MediSystem Pharmacy National Corporation ▪ Ontario Long Term Care Association ▪ Ontario Personal Support Workers Association ▪ Ontario Long-Term Care Clinicians 2. One demonstration session on PointClickCare® electronic health record documentation	1. Canadian Association of Retired Persons, Chapter 26 Fall Event Presentation (Oct 2018) 2. Ontario Long-Term Care Clinicians Conference Workshop (Nov 2018) 3. Ottawa Quality & Patient Safety Conference Presentation, Exhibitor Booth (Nov 2018) 4. AdvantAge Ontario, Region 7 Meeting Presentation (Nov 2018) 5. LOOP Fall Prevention Community of Practice Webinar (Feb 2019) 6. Champlain Region Family Council Network Executive Member monthly meeting Presentation (Feb 2019) 7. Family Council, Grace Manor LTC Presentation (March 2019) 8. MediSystem Pharmacy, National Conference Workshop (April 2019)

Appendix 2: Lessons Shared by Long-Term Care Stakeholders During Phase 1 of the Environmental Scan Regarding Existing Deprescribing Tools and Strategies

Facilitators	▪ Supports from policy makers mandating reporting of drug use (focused on accountability and tracking of prescribing habits), providing educational opportunities for health care providers and frontline personnel (e.g., toolkits, train-the-trainer sessions) ▪ Education and supports for non-pharmacological interventions (e.g., behavourial support teams in the case of antipsychotic reduction) ▪ Administrator buy in and support [CEOs, DOCs, medical directors, pharmacy managers] to address the added time needed for implementing deprescribing and address any personnel educational needs ▪ Current evidence-based deprescribing algorithm tools are highly utilized and valued for their rigour and ease of use
Challenges	▪ Health care team members reported concerns about deprescribing having a negative impact on their workload (requires more time than usual care)and person outcomes (especially when targeting medications that are thought to be helping with responsive behaviours) ▪ Unclear reason why a drug was prescribed increases the unwillingness to deprescribe it ▪ Often specialists or hospitalists restart deprescribed medications or are unwilling to deprescribe ▪ The misconception that deprescribing is a one-time, drug-class-focused process instead of a review of the whole medication profile with the pseron's goals of care as the focus ▪ A perception that deprescribing is inappropriately initiated in order to meet provincial requirements; this is based on their experiences with the antipsychotic reduction initiative where homes may strive to meet benchmark numbers but may not comment on the overall impact on life quality or the rationale for deprescribing

Appendix 3: Lessons Shared by Long-Term Care Stakeholders During Phase 1 of the Environmental Scan Regarding Implementation of Deprescribing Strategies

Facilitators	▪ Confidence in the competencies of the health care team members and a strong rapport improve acceptance of deprescribing recommendations by prescribers ▪ The successes with deprescribing any medication build capacity and confidence to address future similar cases or expand the process to more medication classes and all people living in the LTC home ▪ Leveraging health care team member roles makes the process more efficient; for example, nursing personnel are capable and willing to provide support for a deprescribing plan if given the right tools and guidance - they are well-positioned to help with monitoring changes in signs and symptoms, and are the first point of contact with the person living in the LTC home/family/caregiver ▪ Include PSWs as part of the health care team and implementation strategy. PSWs spend the most time with the person, can identify people of high priority for a deprescribing approach, and help throughout the monitoring phase ▪ The first care conference organized within six weeks of moving in to the LTC home is often the first opportunity for deprescribing conversations to occur ▪ Providing bilingual resources
Challenges	▪ Prescribers identified as the most challenging group to gain buy in. Those who have experience working in a multidisciplinary team, younger graduates or those who have had success with deprescribing in the past, are more likely to be open to deprescribing ▪ Personnel scheduling may inhibit team building and establishing rapport amongst the health care team. For example, at many sites, the consultant pharmacist and physician working in the home may never meet in person due to different visit days ▪ Reimbursement model for both prescribers and pharmacists does not support deprescribing interventions and the time it takes to implement them ▪ Negative connotations attached to the word deprescribing implying that the prescriber has been doing something wrong, that all medications are bad or that one is giving up on the person once they move into a LTC home ▪ Person and family/caregiver engagement is not a consistent step in the process due to unease on the part of the health care provider in discussing deprescribing or due to lack of awareness by the person/family/caregivers that they can be a part of the solution ▪ Families report the fears of not being listened to or being intimidated if they present concerns or suggestions

	▪ Frustrations of health care provider and personnel when not involved in the decision process. For example, nurses often left explaining deprescribing rationale to families without being provided background information or the proper drug knowledge ▪ Variation amongst homes in documentation processes: level of technology integration can make it more difficult for evaluation of strategies across sites; access by all LTC personnel who can help in the monitoring process may not be consistent (e.g., PSWs may not be allowed to document their observations in progress notes); potential resistance from personnel to document more parameters if they are already overwhelmed with the current expectations

Appendix 4: Lessons Shared by Long-Term Care Stakeholders During Phase 1 of the Environmental Scan Regarding Evaluation of Deprescribing Strategies

Facilitators	▪ All sites report the effectiveness of using various internal analytical reports to gain buy in from HCPs, personnel and senior leadership; these reports focus on prescribing drug trends and comparisons to peer institutions across Ontario (drug utilization reviews, audits); these are generated via the Pharmacy provider and/or government statistics, and are quite robust due to the large number of homes they draw from across Ontario. ▪ PointClickCare® electronic records have the capability for producing reports ▪ Regular review with stakeholders at Advisory Committee meetings, promotes sustainability of current practices and discussion for expanding initiatives
Challenges	▪ Long or complicated reports provide less meaningful data and not utilized ▪ Quantitative data can be misleading: -Comparing data to track improvements can be difficult; for example, if there is a time frame where antipsychotic use in the people moving into the LTC home is high, this could give the false impression that antipsychotic prescribing is increasing -Medication numbers per person can appear high as they may include orders for drugs taken as needed, but are rarely or never used -Limited capabilities to easily track appropriate dose reductions or changes to more appropriate alternatives (part of good deprescribing) -Limited capabilities to easily track medication changes to drugs that are still inappropriate; for example, suspicions that there has been an increase in trazodone prescribing as an alternative for antipsychotics despite its limited effectiveness and high side effect risks ▪ Qualitative data regarding person/family/caregiver and health care team experiences often not captured: -Reduction in drug numbers is not as meaningful to family/caregiver members of the Family Council or other public member Advisory groups in comparison to positive personal testimonials and improvements in personal outcomes

Appendix 5: Lessons Shared by Long-Term Care Stakeholders during Phase 1 of the Environmental Scan regarding Maintenance of Deprescribing Strategies

Facilitators	▪ Broadening the focus from targeting drug classes to an approach that fosters overall appropriate prescribing and reduction in pill burden; this would then apply to all people living in LTC homes and take into account goals of care ▪ Mandatory corporate or government policies that support deprescribing. For example, a requirement to report drug class prescribing numbers, mandatory education for new personnel that is corporately supported, staffing and education support for non-drug interventions, requirement to document medication reason for use ▪ Administrators who identify and maintain appropriate prescribing as a key performance indicator at a site to avoid losing momentum to other competing priorities ▪ A consistent process for person/family/caregiver engagement in deprescribing opportunities
Challenges	▪ Conflicting recommendations from specialists and hospitalists ▪ Turnover of LTC personnel means a loss of deprescribing champions, constant education of new personnel, and constant advocating with new administrators that deprescribing is important ▪ Competing priorities with other quality improvement initiatives and government regulations that may arise

Appendix 6: Agenda

Thursday, June 13, 2019	
8:30 – 9:00	*Registration and breakfast*
9:00 – 9:30	**Welcome** Barbara Farrell, Bruyère Research Institute
9:30 – 9:45	**A caregiver's perspective** Susan Conklin, MA
9:45 – 10:15	**Facilitators and challenges for deprescribing in LTC: Lessons learned from stakeholder consultations** Pam Howell, Bruyère Research Institute
10:15 – 10:30	*Morning Break*
10:30 – 10:45	**Using the behaviour change wheel model to plan for deprescribing actions in LTC** Lisa McCarthy, Women's College Research Institute
10:45 – 12:00	**Roundtable discussion: identifying and setting priorities for deprescribing behaviours in LTC** Barbara Farrell
12:00 – 12:45	*Lunch Break*
12:45 – 1:45	**Identifying actions that support deprescribing behavior** Lisa McCarthy
1:45 – 2:30	**World Cafe: Arriving at prioritized actions** Barbara Farrell
2:30 – 2:45	*Afternoon Break*
2:45 – 3:00	**LTC deprescribing framework overview** Lisa McCarthy
3:00 – 3:45	**Implementation Options – building a champion driven initiative for Fall 2019** Barbara Farrell
3:45 – 4:00	**Reflection and next steps** Lisa McCarthy

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