BOOST
Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

BOOST Preparation Webinar – Handouts

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Objectives

1) Review BOOST Collaborative aims
2) Review BOOST Collaborative key measures
3) Define Population of focus, help determine it, and explain why it is important
4) Review BOOST Collaborative key elements and time commitments

Interactive Poll Everywhere link: https://pollev.com/ranag760

BOOST Collaborative website: http://stophivaids.ca/oud-collaborative/

Twitter hashtag: #BOOSTqi

Notes

1) BOOST Collaborative Aim Statement
    - By the end of the 12 months, the aim of the *Provincial BOOST Collaborative* is to provide equitable access to integrated, evidence-based care to help our population of clients with OUD achieve:
        - 95% have an active OAT prescription
        - 95% of those clients with an active OAT prescription will be retained on therapy for greater than 3 months
        - 100% of teams have a process to monitor and incorporate the patient voice

2) At the Launch, we used the analogy of the Egg-and-spoon race, where the egg is the OAT. Our goal is to not just give people eggs, but help them keep the eggs on the spoon as they run the race. https://en.wikipedia.org/wiki/Egg-and-spoon_race

3) Substance use journey map from BC Patient Safety and Quality Council: https://bcpsqc.ca/documents/2017/12/Journey-Mapping-Substance-Use-Treatment-Report.pdf

4) Presentations from Launch available on BOOST website: http://stophivaids.ca/oud-collaborative/

5) Success requires that we tailor intensity of services to individual needs, so that we are able to help even our most complex clients be retained on therapy. Consider the following questions with your team:

   - Who has a higher risk of not being retained on therapy?
   - Where should most of our efforts be devoted?
   - Who is more likely to show up for appointments?
   - Does your current system devote enough effort to those who don't show up?
   - Does our current system value extra efforts devoted to our complex clients?
   - If we devote an equal amount of time to each client, is this equitable?

Simple	Complex
Employed	Unemployed
Social determinants optimized	Social determinants disparities
No comorbid illness	Marginalized communities
	Past traumas
	Comorbid illness

6) **Disclaimer:** There are individuals and teams out there who are *already* doing great work and going the extra mile for their clients. With BOOST, we want to develop a common framework so that these efforts can be recognized, tested, and spread.

7) During action periods, teams with use **The Model for Improvement**, with Aims, Measures, and Change Ideas, to work towards their aims. A QI coach that is an *integrated* part of your team will help you achieve this.

8) Always remember to measure for improvement. The measures don't have to be perfect, but they are a vital part of the process.

   Sports game analogy: If you aren't keeping score, *you are just practicing*.

9) We need to measure the following items:
   - Population of focus (POF)
   - Active OAT prescription
   - Retention on OAT > 3mos
   - Patient Voice Process

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10) Operational definitions for our measures

#	Core Measure	Definition/Numerator	Denominator	Target
1	**Population of Focus (POF)**	Clients diagnosed with an opioid use disorder and receiving OUD care from the participating team.	N/A	N/A
2	**Active OAT prescription**	Clients with a current OAT prescription that has an end date of the same day or a later date regardless of dose.	POF	95%
3	**Retention on OAT for >3months**	Clients with an OAT prescription for an un-interrupted period of 3 months or greater.	POF with an RX start date of 3 months or greater	95%
4	**Patient Voice Process**	Participating teams with a regular and ongoing process in place to capture the patient voice.	Total number of participating teams	100%

- Uninterrupted retention means: without the need to go back to the OAT starting dose. This is different based on the OAT
- Regular/ongoing patient voice process: Teams need to have a documented process in place. How often, who and how the patient voice is captured is necessary.

11) The proportion of clients with an active OAT prescription can be considered our *process measure*. This is something that is necessary but not sufficient for what we are trying to accomplish. It is a measure that we can quickly act on. It is kind of like the score on the scoreboard.

12) The proportion of clients with an active OAT prescription who are retained on therapy > 3mos without need to restart is our *outcome measure*. This measures what we want to achieve.

13) Process for monitoring and incorporating the client voice

- Ideally there is a peer and/or patient on your QI team
- Monthly report to include brief description of this process

14) Population of focus – our clients diagnosed with OUD who we are seeing for OUD care. We need to develop a list of these clients for ongoing management and measurement. If we measure people we aren't actually seeing, we dilute our change efforts. If we are seeing people not on our list, we miss measuring potential improvements.

15) Finding your Population of Focus – teams will take different approaches based on your current state. Your QI coach and our core team can help in deciding the best way for you to develop this list.

16) Key elements for developing a Population of Focus

- Use a standard diagnosis code – we used 304.0 opioid use disorder in our EMR for the Vancouver BOOST Collaborative
- Consider assigning an MRP to each client
- If there are multiple clinics on the same EMR, ensure the client is tagged with the correct Point of Service (POS)

17) A major limitation of using EMR-produced lists at the beginning is that there may have been no empanelment process. The list your EMR gives you may be far off from your actual Population of Focus. In Vancouver, considerable list clean-up was required, and this delayed our improvement efforts.

18) Consider building your Population of Focus list as your clients come into the clinic. If we assume that most of our clients with OUD will come into the clinic within a few months, we can quickly get to a reasonable list for our POF, and start testing changes and measuring for this list of clients.

19) Assess your clinic process. Could someone on your staff start maintaining a simple Excel spreadsheet to track your POF? Who is most suitable to do this?

20) Most of the information that is needed about the client is contained on the OAT prescription. If you are able to start building a list of your clients with OUD, and keep track of a few details (OAT, dose, and Rx start and end dates), you are off to a good start. For measurement of retention, you just need to know when they last restarted OAT.

I2 =-DAYS(G2, A2)

	A	B	C	D	E	F	G	H	I
1	**Date**	**Patient ID**	**OAT**	**dose**	**Start**	**End**	**MRSD**	**MRP**	**Retention (days)**
2	15-Jan	1	methadone	50	15-Jan	02-Feb	01-Jan-17	Dr X	744
3	27-Jan	2	Suboxone	24	28-Jan	07-Feb	15-Jan-19	Dr Y	12
4	15-Jan	3	Kadian	400	15-Jan	27-Jan	28-Dec-18	Dr Y	18
5	16-Jan	4	none					Dr Z	
6	05-Jan	5	methadone	100	05-Jan	31-Jan	12-Oct-18	Dr X	85

21) Tracking of the POF can be automated with EMR solutions. In Vancouver, we developed and implemented a solution for Profile EMR, and a solution for Oscar was in development.