# Provincial BOOST Collaborative

# Project Charter

## *January 2019*

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## Key Collaborative Sponsors

| Name | Role and Affiliation | Role |
|---|---|---|
| Dr. Julio Montaner | Executive Director and Physician-in-Chief,<br>BC Centre for Excellence in HIV/AIDS | Project Sponsor |
| Irene Day | Senior Director, Internal/External Communications,<br>BC Centre for Excellence in HIV/AIDS | Project Sponsor |
| Richard Moyneur | Senior Director of Operations,<br>BC Centre for Excellence in HIV/AIDS | Project Sponsor |

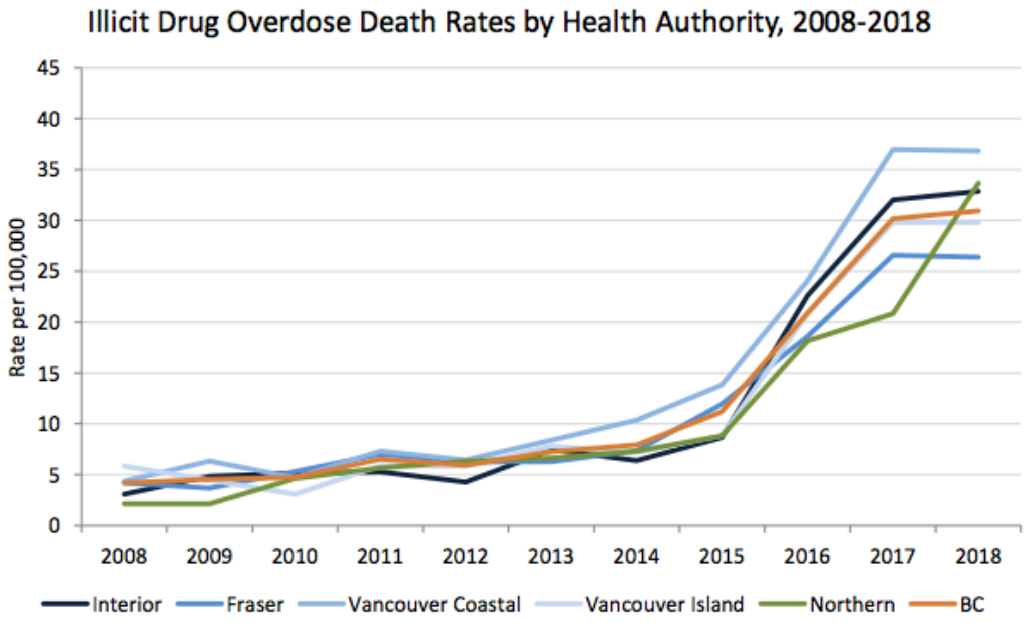
## The Collaborative is supported by:

| | |
|---|---|
| **Leadership Team** | Meet biweekly (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 work with people with OUD or have experience with OUD. The group was selected to provide their expertise and input to the overall direction of the Provincial BOOST Collaborative on an ongoing basis. |
| **Community of Practice** | All members of the Collaborative teams who connect regularly through the listserv, monthly webinars and in-person sessions. |

## Background

Opioid use disorder (OUD) can be characterized as a chronic relapsing illness and is associated with elevated rates of morbidity and mortality. However, it has the potential to be in sustained, long-term remission with appropriate treatment[1]. OUD may involve the use of illicitly manufactured opioids such as heroin or street fentanyl, or pharmaceutical opioid medications obtained illicitly or used non-medically.

In 2016, a public health emergency was declared in British Columbia due to a dramatic increase in opioid-related overdose deaths. Since the declaration, there have been approximately 3859 confirmed overdose deaths in the province. Several targeted services were launched in response; however, the number of opioid-related deaths remains well above historical averages.




**Illicit Drug Overdose Deaths by Health Authority, 2008-2018**[2,4,6]

| HA | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Interior | 22 | 35 | 37 | 38 | 31 | 54 | 47 | 64 | 168 | 244 | 216 |
| Fraser | 65 | 58 | 86 | 115 | 104 | 106 | 126 | 208 | 334 | 490 | 462 |
| Vancouver Coastal | 47 | 69 | 52 | 81 | 72 | 95 | 119 | 161 | 278 | 447 | 408 |
| Vancouver Island | 43 | 33 | 23 | 44 | 45 | 59 | 55 | 68 | 162 | 240 | 214 |
| Northern | 6 | 6 | 13 | 16 | 18 | 19 | 21 | 25 | 51 | 65 | 80 |
| BC | 183 | 201 | 211 | 294 | 270 | 333 | 368 | 526 | 993 | 1,486 | 1,380 |

A meta-analysis demonstrated retention in methadone and buprenorphine treatment is associated with substantial reductions in all cause and overdose mortality in people with opioid use disorder[5]. The same study identified the first four weeks and treatment cessation as the highest risk period for overdose mortality, highlighting specific system-level intervention opportunities to reduce overdose deaths. Data from the BC Coroner's Office found that of the over 1800 deaths they reviewed over a 19-month period (January 2016 to July 2017)[6], none had buprenorphine present in their system. Data from the Office of the Provincial Health Officer shows a 67% increase in the number of BC patients receiving OAT (typically

methadone or buprenorphine) from 2009/10 to 2015/16[7]. However, while treatment is expanding, data show only 55% of persons on methadone are receiving optimal dose (>60mg). Other significant predictors of treatment success include shorter time to treatment from diagnosis and longer duration of treatment (≥3 years)[1]. In this respect, only 42% of persons on methadone are retained at six months and only 32% at 12 months.

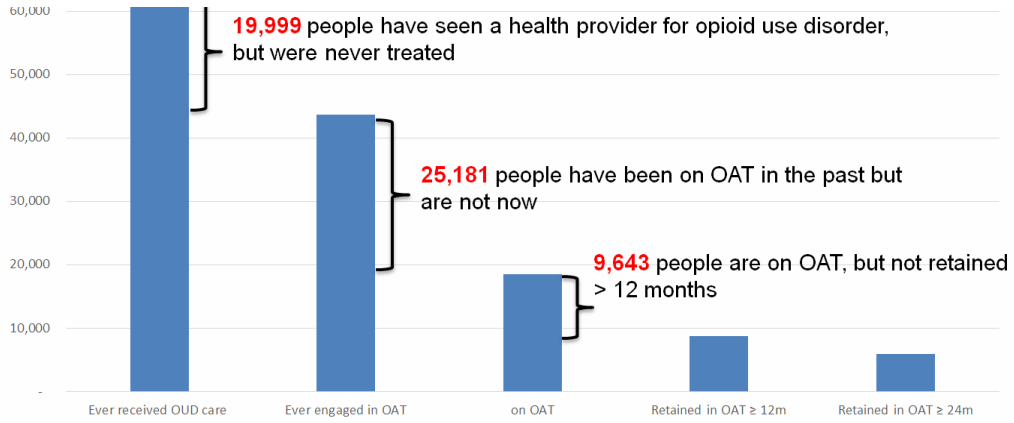
While we know that people living with OUD can benefit from OAT, delivering appropriate care is a complex process that requires collaboration among multiple care providers and services[8]. Additionally, there are often numerous barriers to delivering optimal OAT, including capacity and access issues, licensing requirements, public and professional stigma, and regulatory and funding barriers[8]. To help overcome these issues, healthcare providers require effective systems to improve access and adherence to OUD treatment.

Increasingly, the healthcare community is employing quality improvement (QI) methodology to promote system-level change and systematically address gaps in care[10]. Breakthrough Series (or BTS) methodology, developed by the Institute for Healthcare Improvement (IHI), is a QI approach designed to support healthcare organizations close the gap between evidence and practice[11]. This approach has been successfully applied in other substance use disorder treatment settings in the United States[12] and other chronic diseases in British Columbia[13,14].

The BC Centre for Excellence in HIV/AIDS (BC-CfE) with funding from Health Canada's Substance Use and Addiction Program are expanding to establish the Provincial Best-practices in Oral Opioid agoniSt Therapy (BOOST) Collaborative to improve care for people living with OUD in BC by systematically implementing, measuring and sharing best-practices in OAT.

The Provincial BOOST Collaborative will be launched in various communities throughout BC in Community health clinics and teams providing OUD care. OUD Programs need to establish an effective, high-quality cascade of services from diagnosis and referral, to engagement and retention on treatment, in order to improve care for people living with OUD. Establishing an OUD cascade of care will allow for the identification of gaps in the continuum of care (see Figure 1 below) that are preventing people from fully benefitting from OAT treatment.

*Figure 1: Bohdan Nosyk on behalf of the Health Economic Research Unit at the BC Centre for Excellence in HIV/AIDS*



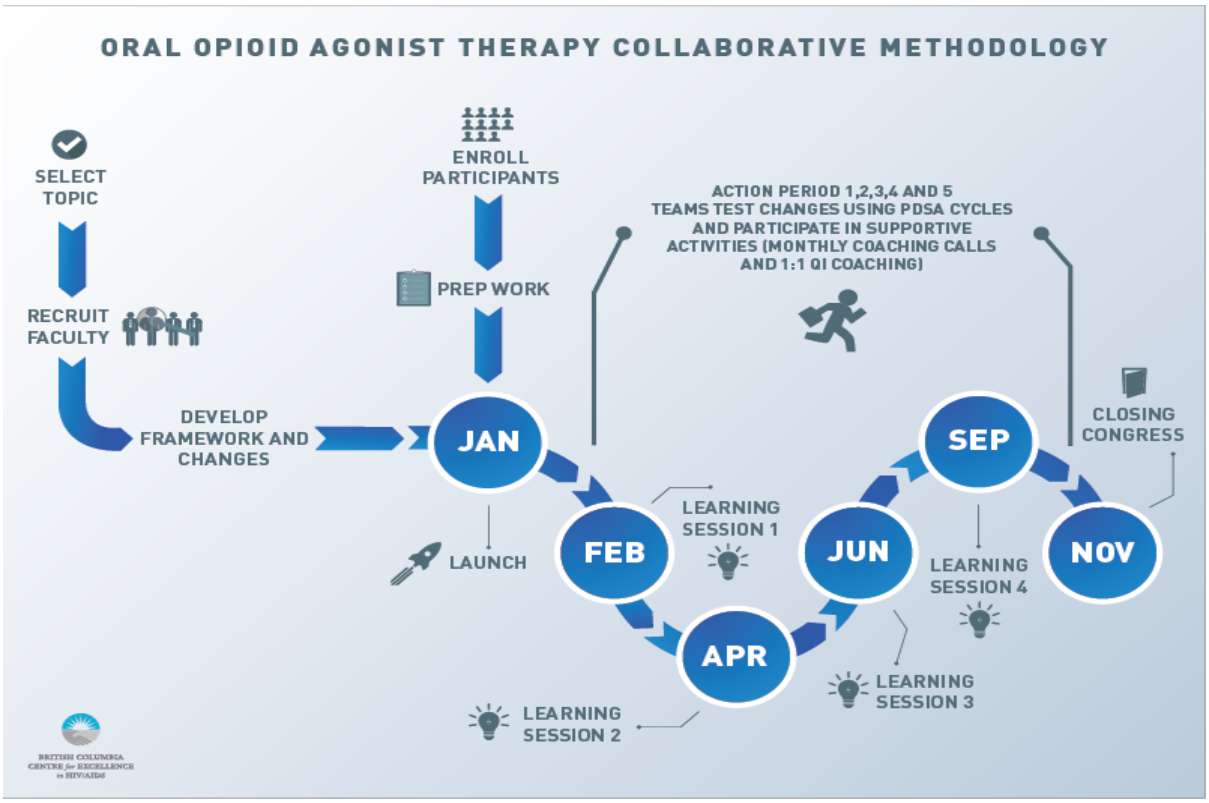
## Collaborative Methodology

The Provincial BOOST Collaborative will follow the Breakthrough Series (BTS) Collaborative methodology developed by the IHI[4] (Figure 2). BOOST will be an organized effort of shared learning by a network of teams from across British Columbia, 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 BOOST 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 spread best practices.

The basic structure of the Collaborative methodology has been adapted for the Provincial BOOST 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 (described below).

*Figure 1. Provincial BOOST Collaborative Methodology*



Each Collaborative Team will create an improvement aim guided by the Model for Improvement (Figure 3). The teams will define answers to the three questions within the model.

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.

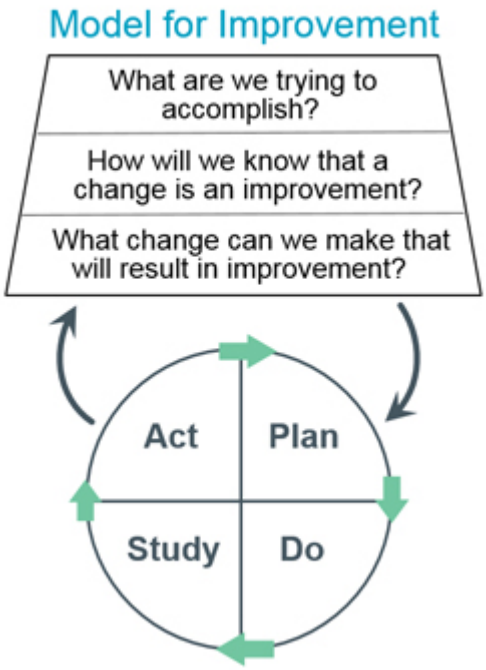
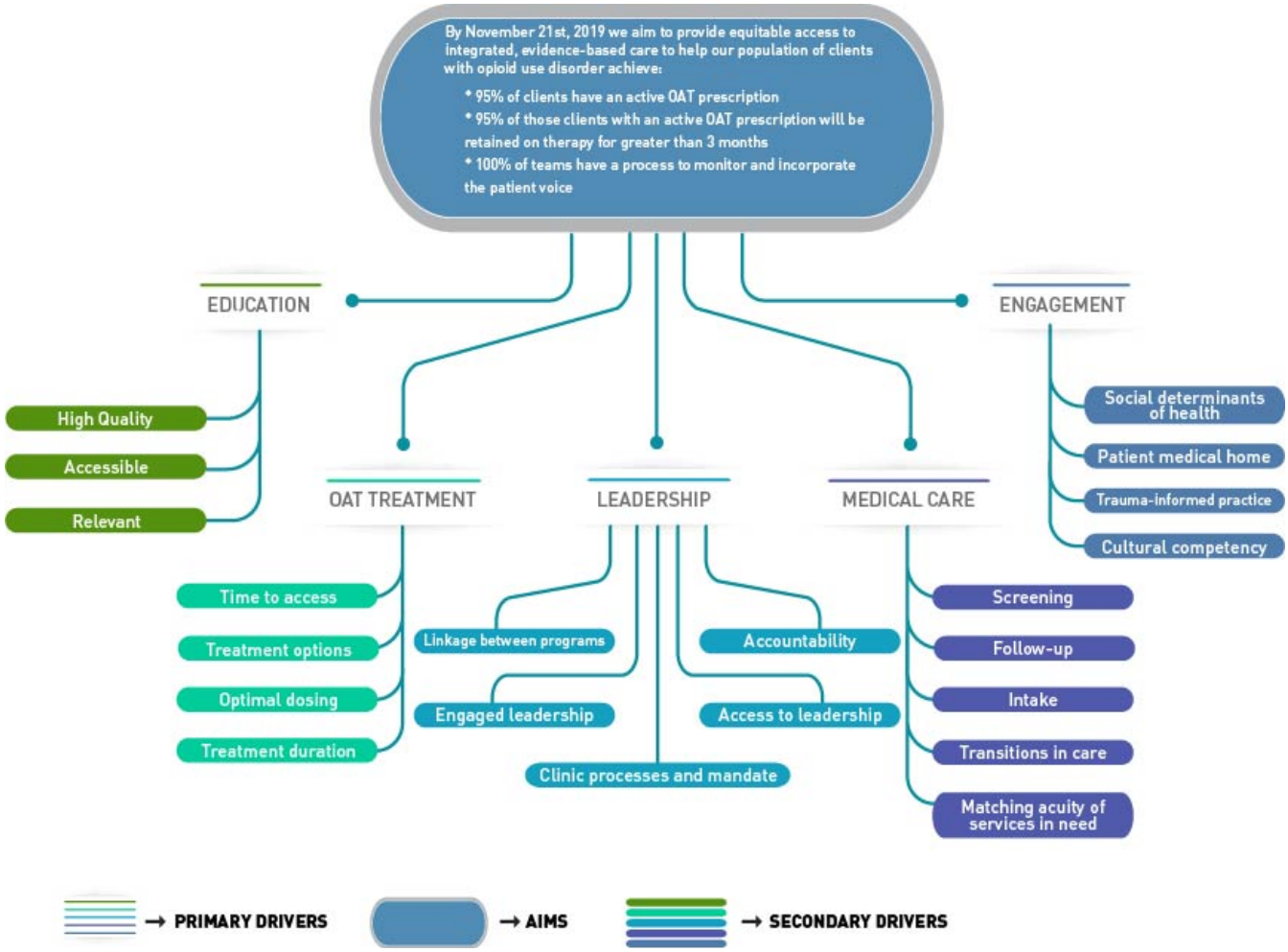



*Figure 2. The Model for Improvement*

## Collaborative Aims and Objectives

At the end of 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% of clients 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



## BOOST Collaborative Core 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% |

# Collaborative Expectations

**Health Care Clinic/Team Commitments**

- Create a quality improvement (QI) team that meets regularly to plan, discuss, and carry out Collaborative activities
- Work with a QI coach (supported by your local heath authority or other organization) to assist you in planning and executing your quality improvement activities
- Support between 1 and 4 members from your team to attend in-person Learning Sessions
- Reimburse these team members for public transportation/parking and backfill their time to attend the Learning Sessions
- Provide additional back-fill/coverage for frontline staff when needed to complete Collaborative activities (e.g. attending in-person Learning Sessions, coaching meetings, weekly or bi-weekly QI team meetings, monthly webinars, collecting improvement data, testing changes, preparing monthly reports and sustainability activities)
- Protect time to complete Collaborative activities (e.g. attending quarterly in-person Learning Sessions, coaching meetings, weekly or bi-weekly QI team meetings, monthly 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 the needs of your client population and the Collaborative goals
- Initiate rapid tests of change that focus on relevant aspects of the continuum of substance use disorder care
- Generate monthly reports on key QI metrics along with narrative change descriptions
- Develop and implement a plan for patient involvement and/or include at least one patient on your QI team

**The BC Centre for Excellence in HIV/AIDS Commitments**

- Establish a Provincial BOOST Core Team consisting of a Project Lead, Medical Lead, Quality Improvement Coordinator, Project Assistant, and expert faculty members
- Plan, deliver and facilitate 6 in-person Learning Sessions (including a full-day launch) including 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
- Plan, deliver and facilitate monthly educational webinars and other activities to build QI and other clinically relevant skills
- Provide monthly feedback and guidance in response to data and narrative reports

## Milestone Timeline

| | Event and Activities |
|---|---|
| **April 2018** | • **Health Canada Contribution Agreement review**<br>• **Participating team recruitment/engagement** |
| **May to August** | • **Health Canada SUAP Grant Funding approved**<br>• **Participating team recruitment/engagement**<br>• **Pre-Planning Meeting** |
| **September to November** | • **Technical Document Refinement**<br>• **Planning Meeting**<br>• **Planning Workshop** |
| **December** | • **Team Enrollment Phase**<br>• **Planning Meeting** |
| **January 2019** | • **Collaborative Launch**<br>• **Preparation Webinar**<br>• **Action Period 1 (January 18 to February 13)** |
| **February** | • **Learning Session 1**<br>• **Action Period 2 (February 15 to April 10)**<br>• **Working Group Meeting** |
| **March** | • **Educational Webinar 2**<br>• **Working Group Meeting** |
| **April** | • **Learning Session 2**<br>• **Action Period 3 (April 12 to June 5)**<br>• **Working Group Meeting** |
| **May** | • **Educational Webinar 3**<br>• **Working Group Meeting** |
| **June** | • **Learning Session 3**<br>• **Action Period 4 (June 7 to September 18)**<br>• **Working Group Meeting** |
| **July** | • **Educational Webinar 4** |

| | |
|---|---|
| | • **Working Group Meeting** |
| **August** | • **Educational Webinar 5**<br>• **Working Group Meeting** |
| **September** | • **Learning Session 4**<br>• **Action Period 5 (September 20 to November 20)**<br>• **Working Group Meeting** |
| **October** | • **Educational Webinar 6**<br>• **Working Group Meeting** |
| **November** | • **Closing Congress** |

## Key Dates & Events

| Date | Event and Activities |
|---|---|
| **January 17, 2019** | **Launch** - *full day in-person session* |
| **January 18 - February 13, 2019** | **Action Period 1** - *Team meetings, measurement, changes* |
| January 31, 2019 | **Educational Webinar 1** |
| **February 14, 2019** | **Learning Session 1** - *full day in-person session* |
| **February 15 – April 10, 2019** | **Action Period 2** - *Team meetings, measurement, changes* |
| March 7, 2019 | **Educational Webinar 2** |
| **April 11, 2019** | **Learning Session 2** - *full day in-person session* |
| **April 12 – June 5, 2019** | **Action Period 3** - *Team meetings, measurement, changes* |
| May 16, 2019 | **Educational Webinar 3** |
| **June 6, 2019** | **Learning Session 3** - *full day in-person session* |
| **June 7 – September 18, 2019** | **Action Period 4** - *Team meetings, measurement, changes* |
| July 11, 2019 | **Educational Webinar 4** |
| August 8, 2019 | **Educational Webinar 5** |
| **September 19, 2019** | **Learning Session 4** - *full day in-person session* |
| **September 20 – November 20, 2019** | **Action Period 5** - *Team meetings, measurement, changes* |
| October 17, 2019 | **Educational Webinar 6** |
| **November 21, 2019** | **Closing Congress** - *full day in-person session* |

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