BRITISH COLUMBIA
CENTRE *for* **EXCELLENCE**
in **HIV/AIDS**

Preparation Resource Manual

The Preparation Resource Manual contains activities and tips to help your team prepare for successful participation in the Provincial BOOST Collaborative.

DECEMBER 2018

CONTENT

WELCOME TO THE BOOST COLLABORATIVE!

We embrace you as leaders in actively advancing healthcare quality improvement across British Columbia!

If this is your first experience in a Structured Learning Collaborative ('Collaborative'), you are likely to feel confused. If you don't even know what a Collaborative is, no problem; confusion is normal and this manual will help clarify things.

In the pages that follow, you will find a number of activities and tips that will help you and your team prepare for meaningful participation in the Provincial BOOST Collaborative. From tips on team formation, planning for quality improvement (QI) measurement and ideas for connecting with senior leaders, you should find a variety of resources that will serve you well along the way. In particular, a checklist of activities will help your team get up and running, and supplementary materials shed more light on the varied events, activities, methods, and models that are used in the Collaborative.

If at any time you are stuck with questions or in need of assistance, please connect with one of the Collaborative leaders. We can be your first point of contact and are committed to helping your team find value and success in the Collaborative.

All the best in your improvement journey and don't forget that we are here to help!

Best regards,

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OVERVIEW

The Best-practices in Oral Opioid agoniSt Therapy Collaborative (the 'BOOST Collaborative') is an initiative that will bring together quality leaders from across the province to work together to close gaps along the opioid use disorder (OUD) Continuum of Care[1].

The BOOST Collaborative uses the *Structured Learning Collaborative* (SLC)[2] methodology, developed by the Institute for Healthcare Improvement (IHI), so participating teams can easily learn from each other and from recognized experts in care of clients with OUD.

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1   The Continuum of OUD Care refers to the comprehensive and connected array of health services spanning all levels of intensity of care within the community and health system.

2   For more information on *Structured Learning Collaborative* methodology, refer to: Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org).

As a participant, you can expect to learn about current outcomes for people living with OUD, quality improvement tools and methods, ideas for closing gaps in care, and improving services and outcomes. You will be able to plan for improvement, test new ideas to improve care, measure your progress, develop a network of providers, and share what you learn.

The Collaborative core team will coordinate and facilitate a number of events and activities to keep you connected in learning, sharing, and improving. You will have access to expert advisors, regular coaching and feedback. Likewise, your team will be encouraged to take purposeful steps to sustain the changes that you test and implement over the course of the Provincial BOOST Collaborative.

At the end of the Collaborative, your team will be encouraged to maintain connections formed during the Provincial BOOST Collaborative and create an OUD community of practice to sustain and spread your performance gains.

LET'S BEGIN

This manual focuses on preparing you and your team for participation in the Provincial BOOST Collaborative. Below you will find a checklist of activities to prepare for successful participation in the Collaborative and a variety of reference materials that will serve you well in your journey. Let's begin!

PREPARATION CHECKLIST

☐ Understand Collaborative models, events, and activities
☐ Create your improvement team
☐ Create a plan for patient engagement
☐ Develop your team's aim statement
☐ Define your population of focus (POF)
☐ Review measurement strategy

Note: We have sequenced these tasks in a way we believe to be logical; however, we encourage you to read through the whole manual first and complete the tasks in an order that makes sense to you. You may find you have to jump back and forth on some tasks.

UNDERSTAND COLLABORATIVE MODELS, EVENTS, AND ACTIVITIES

A SLC is defined as a "short term (6 to 18 months) learning system that brings together a large number of teams to seek improvement in a focused topic area"[3]. The learning system includes a number of events, activities, and models that facilitate effective change. Here is a high level overview of the models that you will learn about and the events/activities in which your team will participate during the Provincial BOOST Collaborative:

INTRODUCTION TO THE COLLABORATIVE MODELS

THE MODEL FOR IMPROVEMENT [4]

The Model for Improvement is a simple, well-known model for accelerating change and improvement. As participants in the Provincial BOOST Collaborative, you will learn about this model and begin to use it to create improvement in your own settings.

Central to the model are three key questions: (1) *What are we trying to accomplish?* (aim); (2) *How will we know that a change is an improvement?* (measures); and (3) *What changes can we make that will lead to an improvement?* (changes). These questions elicit responses to create aims, measures, and a list of changes. The next step in the model is to take a change and test it on a small scale. The model describes a systematic, iterative approach to: plan the change (plan), carry out the plan (do), observe and reflect on the test (study), and then decide if you would like to implement the change, improve upon it, or abandon it altogether (act). This is the PDSA cycle.

[* See Reference 1: The Model For Improvement](#)

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3   The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2003. (Available on www.IHI.org)

4   Developed by the Associates in Process Improvement. Description available in: Langley J, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey-Bass, 2009.

THE EXPANDED CHRONIC CARE MODEL (EXPANDED CCM)

The province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model builds on the CCM, an evidence-based model for chronic disease management, to incorporate concepts and strategies from population health promotion[5].

The model lists the essential elements within and across health systems and the community that contribute to better health outcomes for populations. These elements include: self-management / develop personal skills, delivery system design / re-orient health services, decision support, information systems, build healthy public policy, create supportive environments, and strengthen community action.
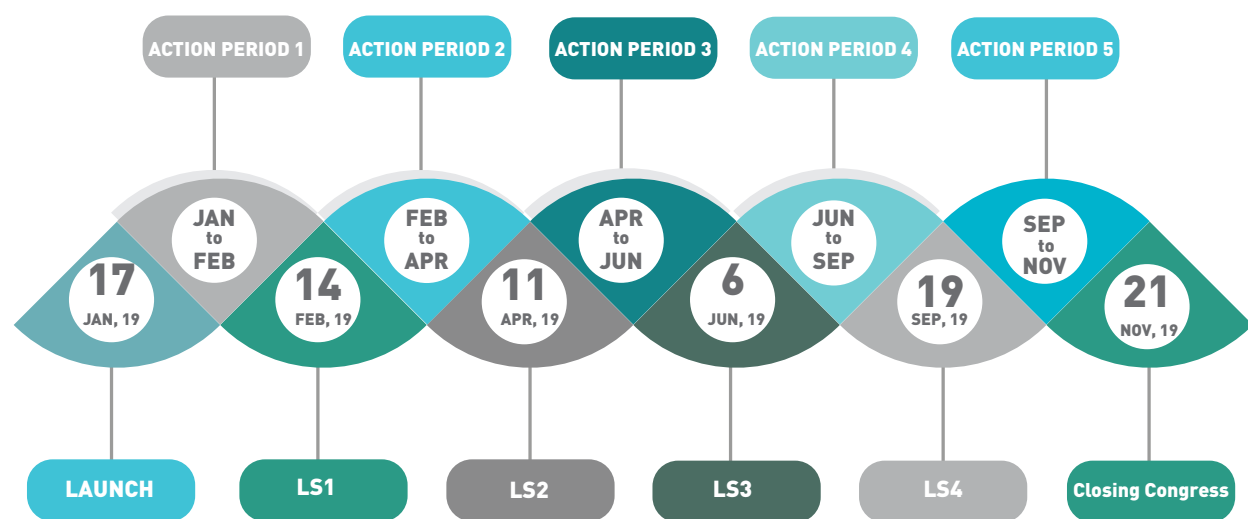
*See Reference 2: The Expanded Chronic Care Model

OPIOID USE DISORDER CASCADE OF CARE

Work is being done in British Columbia to develop a robust, evidence-based cascade of care for OUD which will complement the work of the Provincial BOOST Collaborative. Using a cascade of care framework has reduced morbidity and mortality in the care of people who live with HIV/AIDS. Repurposing this cascade for OUD programs has been suggested as a way to improve quality of care and measure outcomes, and therefore the Provincial BOOST Collaborative has developed a theoretical cascade of care for this initiative.
* See Reference 3: The Opioid Use Disorder Cascade Of Care

INTRODUCTION TO COLLABORATIVE EVENTS, ACTIVITIES, AND STRUCTURES

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5   Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Healthcare Quarterly, 7(1) November 2003: 73-82. Available at: http://www.longwoods.com/content/16763.

LAUNCH — JANUARY 17th 2019

The Launch is a full-day orientation to the improvement initiative ahead. Teams will be introduced to the Collaborative aims and expectations for participation. Teams will become familiar with the change ideas, measurement and reporting structure. There will be an opportunity for teams to refine their own team-specific aims and develop actionable plans for tests of change. The Launch is scheduled for January 17th 2019 and will mark the beginning of the Collaborative.

PREP WEBINAR — JANUARY 31st 2019

The Preparation Webinar will be a 60 minute focused webinar . The webinar will introduce teams to quality improvement and define its key elements, describe Structured Learning Collaborative Methodology, and present the overall aim of the Provincial BOOST Collaborative and some of the key metrics teams will be reporting.

PREPARATION PHASE — DECEMBER TO FEBRUARY 2019

The preparation phase is the time when sites formalize their improvement team, refine their aim statement, begin looking for data sources, and understand the events and activities ahead. This manual focuses on preparation.

LEARNING SESSIONS — FEB 14, 2019; APR 11, 2018; JUN 6, 2019; SEP 19,2019

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving OUD care, services, and outcomes. There are four Learning Sessions in the Provincial BOOST Collaborative.

ACTION PERIODS

Action Periods occur between Learning Sessions. During these times, team members have returned to their clinical settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

CLOSING CONGRESS — **NOVEMBER 21ˢᵗ 2019**

The Closing Congress is similar to Learning Sessions, though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the course of the Collaborative. The Closing Congress formally marks the end of the initiative.

COLLABORATIVE WEBSITE

The Collaborative website hosts a calendar of events and resource pages. Please use this space to find team resources, recordings of webinars, and information on events. The website is available at www.stophivaids.ca/oud-collaborative.

CREATE YOUR IMPROVEMENT TEAM

What should our team look like? Who should be on our team? These are common early questions and exactly the right questions because getting the right team is critical for change and improvement. Team selection is both an art and a science. While we provide some thoughts on both, your expertise of local factors will be critical to building an effective team.

BUILDING THE TEAM

Think about the purpose: The purpose of the Provincial BOOST Collaborative is to:

1) Improve the quality of care provided for our clients with OUD, and

2) Build QI capability

Consider the following questions when reflecting on prospective members to advance this purpose:

- What is our current population?
- Who does our service reach?
- What gaps can you identify when it comes to the quality of care for your clients with OUD (eg. low access, poor retention, etc)?
- Who in our organization is currently involved in these processes along the Continuum?
- Who should be involved in these processes to close gaps and ensure excellence (think about both inside and outside your organization)?
- Who might help us with the process of change and improvement?

Think about prospective members' characteristics: Select each prospective member for their process knowledge, enthusiasm for change, ability to engage peers, and ability to work effectively on a team. Good team members are often respected in their peer groups and adept at listening and communicating effectively.

Think about diversity of membership: Team effectiveness literature shows member diversity can increase creativity and ability to challenge assumptions; however too much can lead to conflict. Consider a balance of professional backgrounds, job functions, gender, perspectives, culture, age, etc.

Think about team size: In general, teams tend to be more effective when they have between three and eight members. Too many members can increase the complexity of relationships and communication while too few can lead to higher workloads and fewer ideas and perspectives.

Think about key roles: To increase team effectiveness, your team should fill the following key roles (note these roles are not mutually exclusive; one member may align with more than one characteristic):

KEY FUNCTION	CHARACTERISTICS AND ROLE	COMMITMENT
Senior leader/ Team Sponsor	The senior leader has authority to allocate team time and resources, and should have administrative authority over areas that may be affected by changes. This individual should be a champion and is responsible for spreading changes.	Encouraged to attend all Learning Sessions (Learning Session one and three at a minimum) and attend periodic team meetings.
Team leader	The team leader provides day-to-day leadership, coordination and communication between team members, Collaborative staff, and senior leaders. The team leader should be respected, knowledgeable, and enthusiastic about change.	Should attend all Learning Sessions, one team meeting every two weeks and attend monthly webinars.
Senior clinical champion	Look for senior clinical personnel sought out for their advice, who work well with others, and who are not afraid to test change.	The senior clinical champion should attend all Learning Sessions, one team meeting every two weeks and attend monthly webinars.
Clinical, technical and/or process expert	Look for those who know the care processes and subject matter intimately. These individuals may include front office, information systems, lab, medical records, nursing, outreach pharmacy, physicians, and/or quality personnel.	Should attend all Learning Sessions, one team meeting every two weeks and attend monthly webinars.
Person living with OUD or family member of a person living with OUD	It is recommended that every team support one to two clients to participate on their improvement team. People living with OUD have intimate knowledge of the user's experience and can help the team to surface assumptions, focus on purpose, and identify practical changes for delivering needs based care and services.	People living with OUD are encouraged to attend all Learning Sessions, one team meeting every two weeks and attend monthly webinars.
Quality improvement coach	The quality improvement (QI) coach provides change and QI expertise, guidance, and coaching to support team formation, aims definition, measurement for improvement, testing changes, implementing changes, and sustaining performance improvements. The coach should expect to attend regular team meetings in early months with the aim of building team capacity and autonomy in improvement and change.	Should attend all Learning Sessions and, at a minimum, the first four team meetings.

BUILDING THE HIGH PERFORMING TEAM

To get the best out of your team, use best practices for team development and team process. While it is the team leader who oversees and ensures proper team development and team process, all members should do their part to contribute to an effective team:

ENSURE ALL MEMBERS ARE VALUED FOR THEIR CONTRIBUTIONS

To get the best out of your team, use best practices for team development and team process. While it is the team leader who oversees and ensures proper team development and team process, all members should do their part to contribute to an effective team.

KEEP LANGUAGE CLEAR AND SIMPLE

This is an important, though surprisingly challenging principle to follow. All members should strive to avoid using acronyms and jargon. Everyone can help out with gentle reminders and by asking fellow teammates to explain further when needed.

DIVIDE AND CONQUER

Ultimately, the team leader is responsible for coordinating meetings, taking care of administrative details, orchestrating team activities, overseeing outputs, documenting the project, meeting timelines, and acting as a liaison between the team and the organization. However, effective leadership isn't about doing everything; rather it is about drawing on the strengths of all members and sharing the load. All members should make a priority effort to assist when needed and complete tasks in a timely fashion.

ADHERE TO BEST PRACTICES FOR RUNNING EFFECTIVE MEETINGS

To respect the time of all members and to get the most out of your meetings, we suggest that you start and end meetings on time, use and adhere to agenda, take minutes, and rotate the responsibilities for facilitating, agenda setting, and minute taking. Evaluate the effectiveness of each meeting e.g., did everyone feel heard? Did we accomplish our objectives? Etc.

All members should make a priority effort to attend all meetings, be on time, and communicate effectively. The team leader should lead a conversation on member expectations. Members should be involved in the discussion, understand expectations, and agree on remedies for members not meeting expectations.
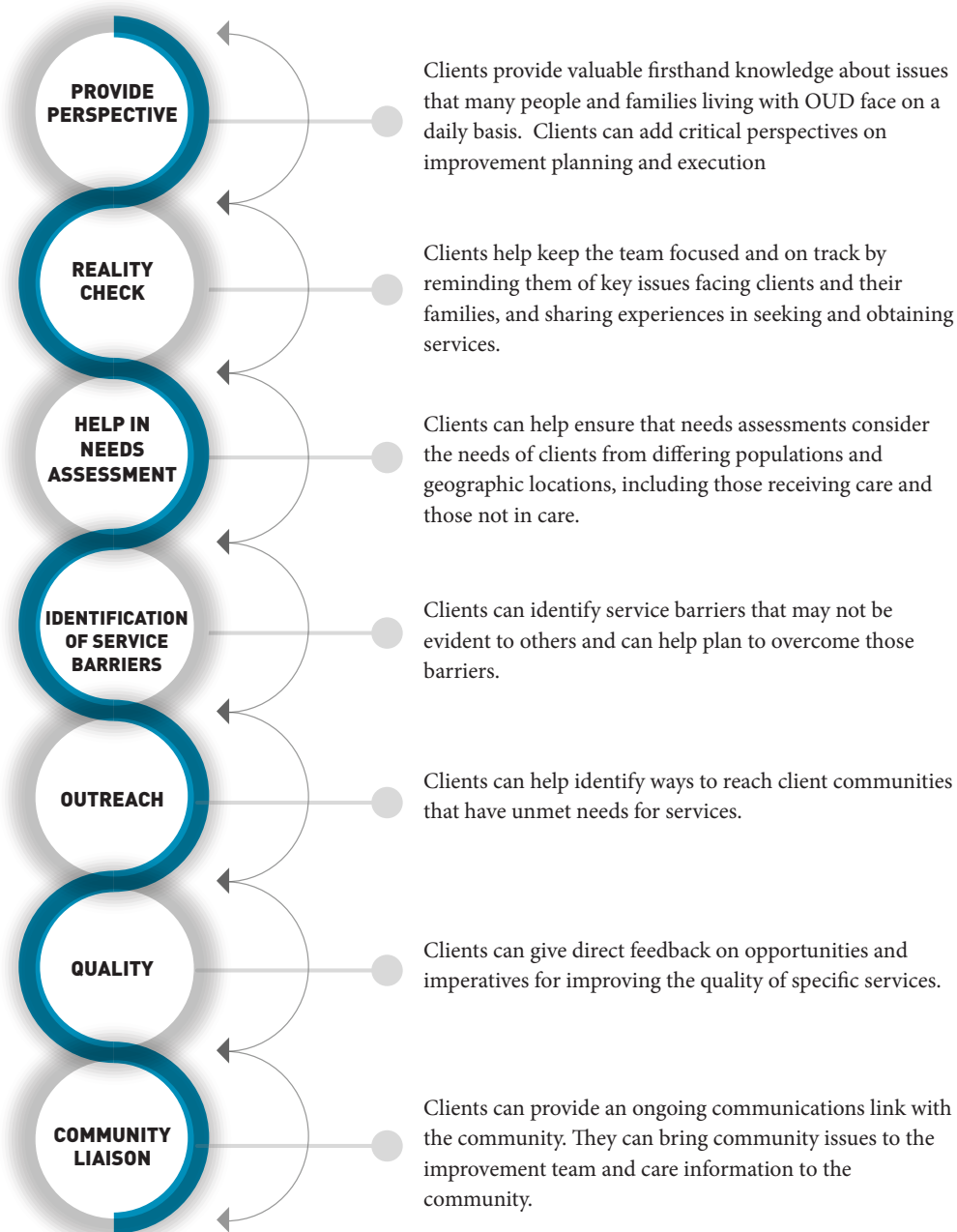
BE PATIENT

New teams experience some hallmark stages of team development on their way to becoming a high-performing team. Members will feel different thoughts and emotions, and it will be important for all members to recognize these stages so that they do not detract from the important work of the team.

CREATE A PLAN FOR PATIENT ENGAGEMENT

BENEFITS OF PATIENT PARTICIPATION

Involvement of persons living with OUD (clients) in the improvement process has many benefits:

PROVIDE PERSPECTIVE

Clients provide valuable firsthand knowledge about issues that many people and families living with OUD face on a daily basis. Clients can add critical perspectives on improvement planning and execution

REALITY CHECK

Clients help keep the team focused and on track by reminding them of key issues facing clients and their families, and sharing experiences in seeking and obtaining services.

HELP IN NEEDS ASSESSMENT

Clients can help ensure that needs assessments consider the needs of clients from differing populations and geographic locations, including those receiving care and those not in care.

IDENTIFICATION OF SERVICE BARRIERS

Clients can identify service barriers that may not be evident to others and can help plan to overcome those barriers.

OUTREACH

Clients can help identify ways to reach client communities that have unmet needs for services.

QUALITY

Clients can give direct feedback on opportunities and imperatives for improving the quality of specific services.

COMMUNITY LIAISON

Clients can provide an ongoing communications link with the community. They can bring community issues to the improvement team and care information to the community.

* Spportive document: Meaningful Involvement Of People Who Use Drugs

https://www.aidsunited.org/resources/

PLAN FOR ENGAGEMENT

All teams should develop a plan or strategy for client participation. Effective planning involves determining the appropriate level and duration of participation for your engagement (see resources below to support you). A helpful framework for your plan is to address the five Ws: **Who, What, Where, When Why, How?**

DIFFERENT LEVELS OF ENGAGEMENT, DIFFERENT GOALS IN MIND

There are many different ways to engage clients and to increase patient participation. Below is a framework that shows how different types of participation serve different functions:

INCREASING IMPACT ON THE DECISION →

	INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
CLIENT PARTICIPATION GOAL	Providing clients with balanced and objective information to assist them in understanding problems, changes, and/or solutions.	Seeking client feedback on analysis, changes, and/or proposed decision.	Working directly with clients throughout the process to ensure that patient-centred issues and concerns are consistently understood and considered.	Partnering with clients in each aspect of decisions including the development of alternatives and the identification of preferred solutions.	Placing final decision-making control in the hands of clients.
SAMPLE TOOLS AND METHODS	*Fact sheets *Websites *Open houses	*Public comment *Focus groups *Surveys *Public meetings	*Clients on team *Workshops *Deliberate polling	*Client advisory committees *Consensus-building *Participatory decision-making	*Citizen juries *Ballots *Delegated decisions

Adapted from the International Association for Public Participation's spectrum of engagement framework.
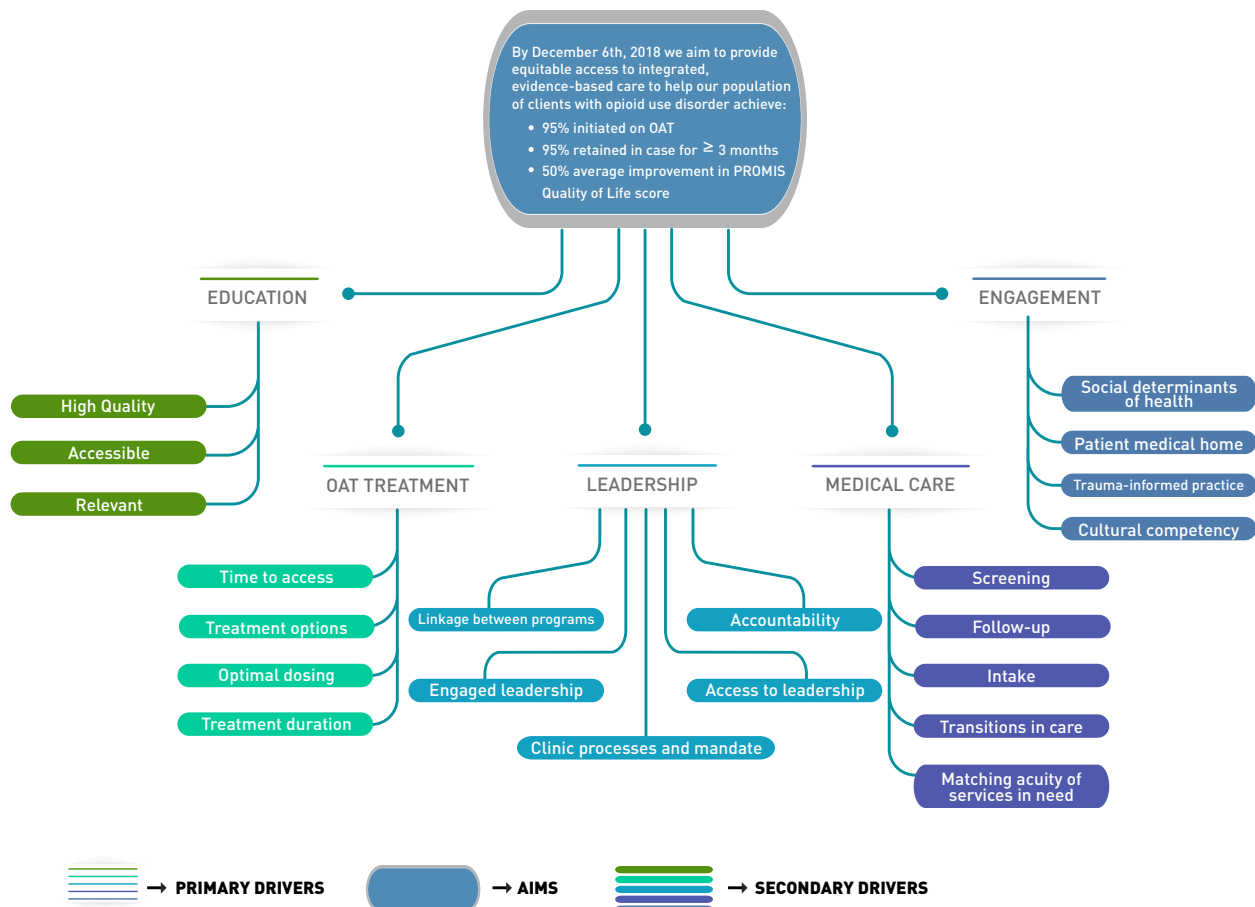
DEVELOP YOUR TEAM'S AIM STATEMENT

An aim statement is your team's most clear statement of purpose. Your team should devote early efforts to crafting an effective aim statement. When defining your aim, consider:

(1) **ALIGNMENT WITH THE PURPOSE OF THE PROVINCIAL BOOST COLLABORATIVE**

Review the purpose and drivers of the Provincial BOOST Collaborative. Align your aim with the purpose to get the most out of participation:
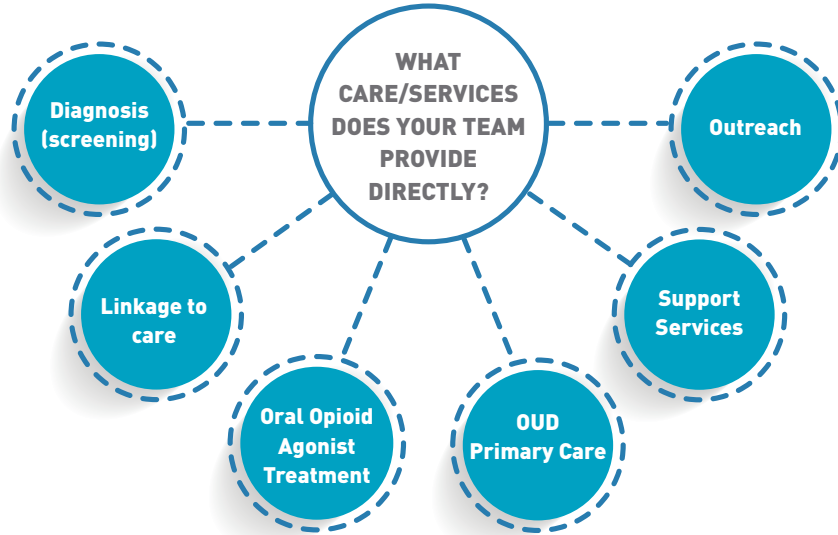
1. Improve the quality, effectiveness and reach of substance use and support services in British Columbia to improve outcomes for people living with OUD.

2. Strengthen capacity for QI in primary care, mental health, substance use, withdrawal management and outreach care settings.

3. Engage participating teams in joint QI activities to better coordinate seamless OUD services and enhance partnerships across OUD providers in British Columbia.

* An example from the Vancouver BOOST Collaborative

By December 6th, 2018 we aim to provide equitable access to integrated, evidence-based care to help our population of clients with opioid use disorder achieve:
- 95% initiated on OAT
- 95% retained in case for ≥ 3 months
- 50% average improvement in PROMIS Quality of Life score

EDUCATION
- High Quality
- Accessible
- Relevant

ENGAGEMENT
- Social determinants of health
- Patient medical home
- Trauma-informed practice
- Cultural competency

OAT TREATMENT
- Time to access
- Treatment options
- Optimal dosing
- Treatment duration

LEADERSHIP
- Linkage between programs
- Engaged leadership
- Clinic processes and mandate
- Accountability
- Access to leadership

MEDICAL CARE
- Screening
- Follow-up
- Intake
- Transitions in care
- Matching acuity of services in need

→ **PRIMARY DRIVERS**　　→ **AIMS**　　→ **SECONDARY DRIVERS**

WHAT CARE/SERVICES DOES YOUR TEAM PROVIDE DIRECTLY?

Diagnosis (screening)

Outreach

Linkage to care

Support Services

Oral Opioid Agonist Treatment

OUD Primary Care

GUIDANCE: BY HOW MUCH CAN YOU IMPROVE OUTCOMES IN YOUR CORE SERVICE AREA(S)?

WHAT CARE/SERVICES DOES YOUR TEAM INDIRECTLY INFLUENCE?

Diagnosis (screening)

Outreach

Linkage to care

Support Services

Oral Opioid Agonist Treatment

OUD Primary Care
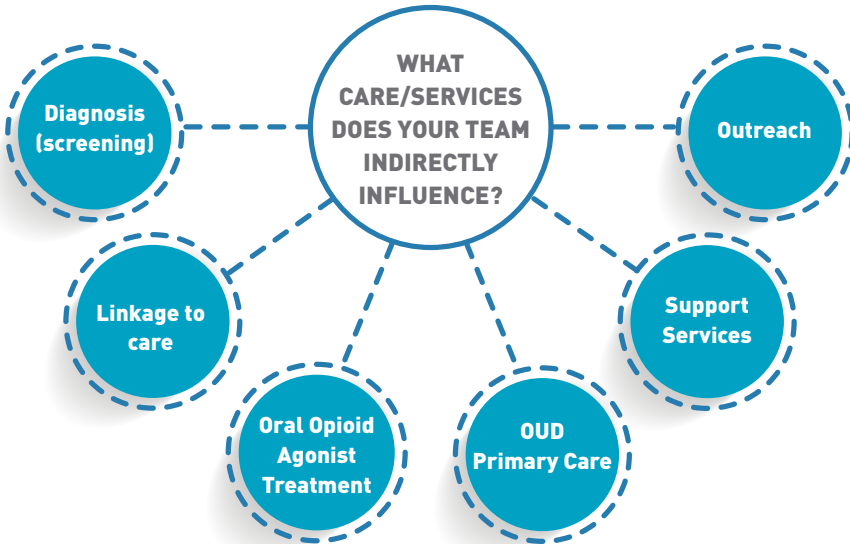
GUIDANCE: TO WHAT EXTENT CAN YOU INFLUENCE BETTER OUTCOMES IN OTHER SERVICE AREA(S)?

Examine population data within your organization. What are the priority gaps that your population faces along the OUD Continuum of Care? Refer to the section on defining population of focus.

PRO-TIPS FOR AN EFFECTIVE AIM STATEMENT

INVOLVE YOUR SENIOR LEADERS

Engage your senior leaders in the process of aim development to align your aim with organizational objectives.

BE AS CLEAR AND SPECIFIC AS POSSIBLE

The aim statement should be time-bound, realistic and measurable. it should also specify the population affected by the work..

INCLUDE ADDITIONAL GUIDANCE

What is in scope and out of scope? Describe any other partners that you plan to engage (e.g., community support organizations, Substance Use Services Organizations, clinics with whom you will liaise, etc.). Include specific strategies that your organization will follow. Include anything that you think is useful for guiding your team and making sure your path is clear.
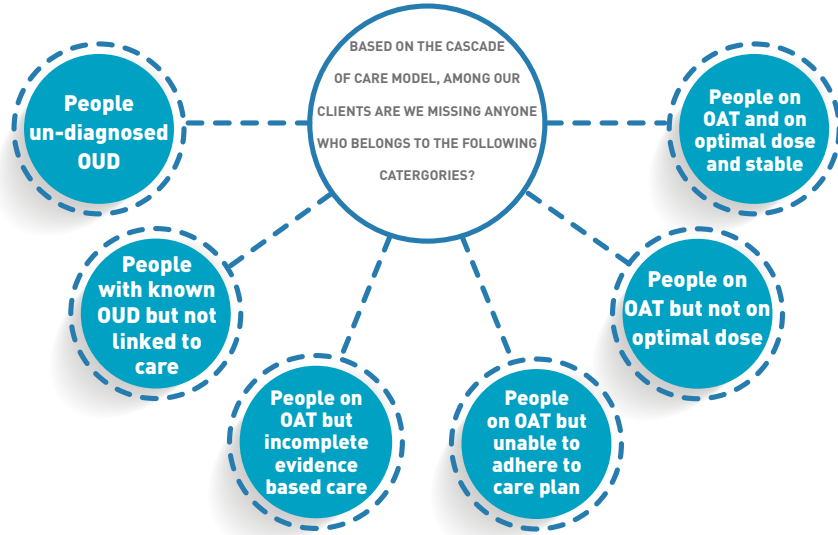
REVISIT YOUR AIM STATEMENT OFTEN

Expect your aim statement to change over time, especially as you gather new information and learn more about closing gaps.

DEFINE YOUR POPULATION OF FOCUS (POF)

Your POF is the population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality outcomes. To help you get started thinking about your POF, consider your reach:

BASED ON THE CASCADE OF CARE MODEL, AMONG OUR CLIENTS ARE WE MISSING ANYONE WHO BELONGS TO THE FOLLOWING CATERGORIES?

People un-diagnosed OUD

People on OAT and on optimal dose and stable

People with known OUD but not linked to care

People on OAT but not on optimal dose

People on OAT but incomplete evidence based care

People on OAT but unable to adhere to care plan

GUIDANCE:
FOR WHOM DO YOU CURRENTLY PROVIDE CARE AND SERVICES?

CLIENTS IN THE COMMUNITY THAT YOU MIGHT REACH OUT TO?

People un-diagnosed OUD

People on OAT and on optimal dose and stable

People with known OUD but not linked to care

People on OAT but not on optimal dose

People on OAT but incomplete evidence based care

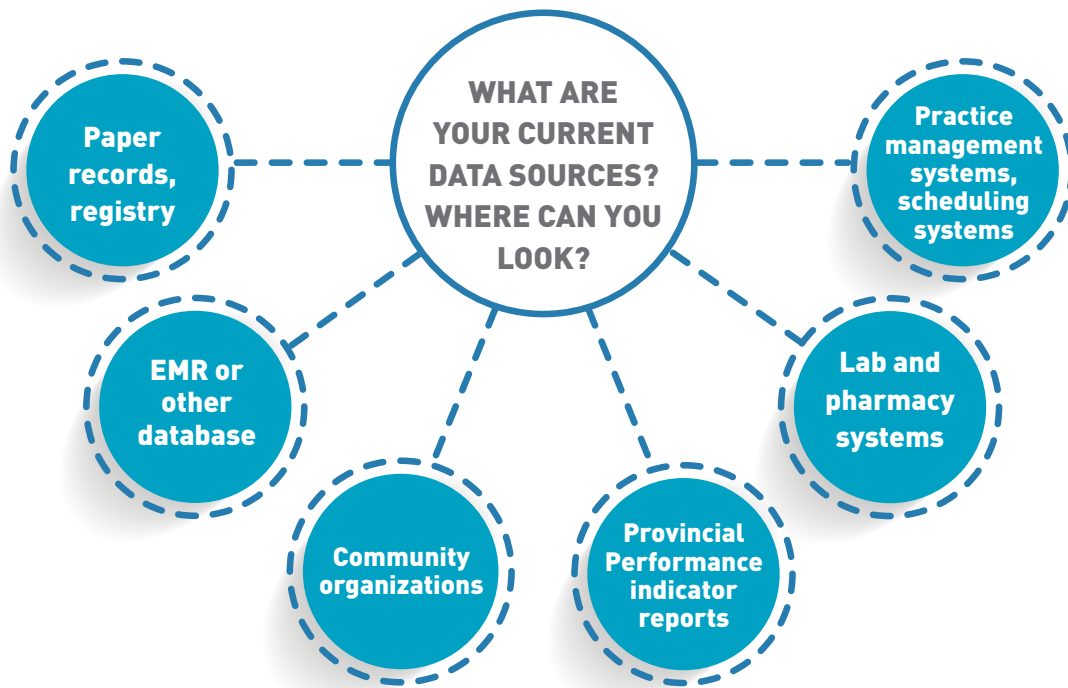People on OAT but unable to adhere to care plan

GUIDANCE: IS THERE ANYONE UNDERSERVED IN THE COMMUNITY THAT YOUR CARE AND SERVICES WOULD BENEFIT FROM?

2 WHAT DO YOU UNDERSTAND ABOUT THIS POPULATION?

Where to look? Think about what information or records you currently collect, receive, or have received. Consider:

Other sources? _____

3 CREATE A LIST

1. Look at records dating back one year.
2. Review all OUD patients that have been a recipient of your service.
3. Exclude any that have clear documentation of having Moved or Gone Elsewhere (MOGE), including:

   - Documentation of transfer of care (e.g., request for records from another primary care provider)
   - Documentation of death
   - Documentation of moved without local forwarding address.

- Special note: you may find that some clients receive service/care from other external clinics/practices. Do not exclude these clients from your POF if there is not clear MOGE documentation. Instead, you may find that these shared care arrangements are prime targets for improvement.

4. You have described your initial POF (this may change).

5. If you do not have a standard process for defining and maintaining your POF, it is highly recommended to develop this now. Contact the Core Team if you require support with this.

EXAMPLE TO DEMONSTRATE THIS PROCESS:

You work in a clinic that provides OUD primary care. You look into your paper records, dating back one year, and find that 105 individuals have sought care at your clinic over this time. You also find that 30 have transferred care to another provider, 5 have passed away, and there are 8 you're not really sure what happened to.

You determine that your POF is:

List = 105; MOGE = 30 + 5 = 35

POF is 105 − 35 = 70

The 8 clients you're not sure what happened to remain in your POF.

When you look into care for your POF, you find that:

Twenty clients have an expired Rx within the last year, ten are not on treatment, and five are not on an optimal dose of OAT

You think that these will be prime gaps to improve and they should be reflected in your aim.

REVIEW MEASUREMENT STRATEGY

Measurement is an investment of time but it is an important and worthy investment. Simply put, we must measure things to know if they are getting better or worse.

MEASUREMENT STRATEGY

After the Launch in January 2019, all teams will be required to regularly collect and report monthly *numerical and qualitative data* for the duration of the Collaborative. The specific measures that you will collect and report will depend on your team's improvement focus along the OUD Continuum of Care. The Collaborative core team will work with each team to ensure measurement is meaningful for the services provided and the population served.

From these monthly reports, each team will receive custom coaching, feedback, and encouragement from experts in OUD quality improvement. Teams will also be asked to share their reports with the Collaborative community, and experts will use the volume of reports to design relevant learning activities and to connect different teams working on similar issues.

See example metrics from the **Vancouver BOOST Structured Learning Collaborative** below.

BOOST COLLABORATIVE METRICS	DEFINITION	TARGET
Treatment Initiation	Clients with OAT in the past 12 months: Any client with a Rx for suboxone, methadone, kadian recorded in the past 12 months for any length of time, regardless of dose.	95%
Treatment engagement	Clients on OAT: Any client with a current (non-expired) Rx for suboxone, methadone, kadian, regardless of dose	95%
Optimal Dosing	Clients on optimal dose OAT: Any client with a current (non-expired) Rx for Suboxone >16mg, >60mg, >50mg Kadian (SROM)	95%
Retention	Clients on optimal dose OAT for 6 months: Any client with a current (non-expired) Rx for suboxone >16mg, methadone >60mg, kadian >50mg with previous Rx's at dose above listed doses for previous 3 months. Maximum Rx time gap in past 3 months is 2 weeks.	95%
Quality of Life	Average score on PROMIS Quality of Life survey	50% increase

SOME PRINCIPLES OF MEASUREMENT FOR IMPROVEMENT

- The objective of measurement for improvement is to learn and improve. It is different from other types of measurement (i.e., for the purposes of research or accountability[8]) because measurement for improvement is designed to speed up improvement. **The aim is to generate data which is useful even if not perfect.**

- When it comes to measurement, we don't want to re-invent the wheel. Whenever possible, we will suggest relevant measures that are already well-established.

- Improvement measures are designed to tell you if you are progressing in achieving your aim. For that reason, measures are designed to align with your aims. For example, if you are seeking improvements in retention in care, you will measure key processes and outcomes related to retention.

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8 For a more robust discussion on the distinction between measurement for improvement, research, and accountability see Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability, and research. Jt Comm J Qual Improv. 1997 Mar;23(3):135-47.
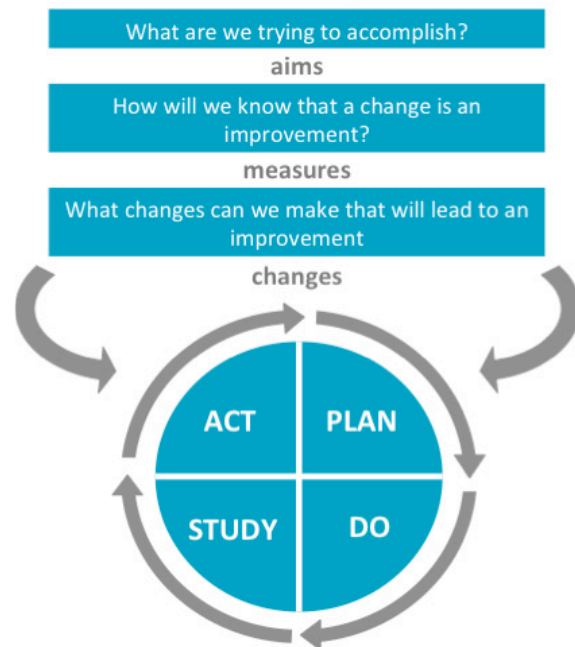
REFERENCE 1: THE MODEL FOR IMPROVEMENT

The improvement model is based on three fundamental questions:

1 **WHAT ARE WE TRYING TO ACCOMPLISH?**

The first question is meant to establish an aim to make explicit what the team is trying to accomplish. The aim should be aligned with the Collaborative.

An effective aim is clear and unambiguous. Try using the mnemonic SMART to create an effective aim: Specific, Measurable, Actionable, Realistic, and Time-bound).

The Model for Improvement

What are we trying to accomplish?

aims

How will we know that a change is an improvement?

measures

What changes can we make that will lead to an improvement

changes

ACT   PLAN

STUDY   DO

Langley J, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. The Improvement Guide: A Practical Approach to Enhancing Organizational Performance. Jossey-Bass, 2009.

2 **HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?**

All improvement requires change, but not every change will result in improvement; therefore, we must measure things to know if they are getting better or worse. When we measure for improvement, we seek useful data not perfect data. In the Collaborative, we encourage the use of a standard family of measures, which allows us to learn together about improvement and avoid having to each re-invent quality indicators.

3 **WHAT CHANGES CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?**

What can you do to achieve your aim? What changes will be needed to your current processes for coordinating and delivering care and services? Change ideas come from evidence, people living with OUD, other industries, and peers in improvement. The Collaborative will provide a compendium of evidence-based and experience-based ideas for changing care and services along the Continuum of Care.

Changes can look pretty shiny on paper; however, sometimes these changes can fail to translate into improvement. Therefore, it is a good strategy to test an idea before committing to it (implementing). The PDSA cycle is a systematic, iterative testing approach. The approach helps teams to plan for the change (what are we going to do, and where?), do the change (try it out as you planned it), study the effects of the change (what was observed, anything unexpected?), and then act on what you observed:

- adapt (improvement observed, time to implement), or
- adopt (shows promise but back to drawing board for another PDSA), or
- abandon (just not going to work).

REFERENCE 2: THE EXPANDED CHRONIC CARE MODEL (EXPANDED CCM)

The Chronic Care model (CCM) is an evidence-based model that describes important elements of a healthcare system that contributes to high quality systems that produce better patient outcomes[9]. The Expanded CCM builds on this model, incorporating concepts and strategies from population health promotion.[10]

The Province of British Columbia has formally adopted the Expanded CCM to guide improvements in primary healthcare. The model specifically identifies essential elements of a health system and community that contribute to better health outcomes for its population.
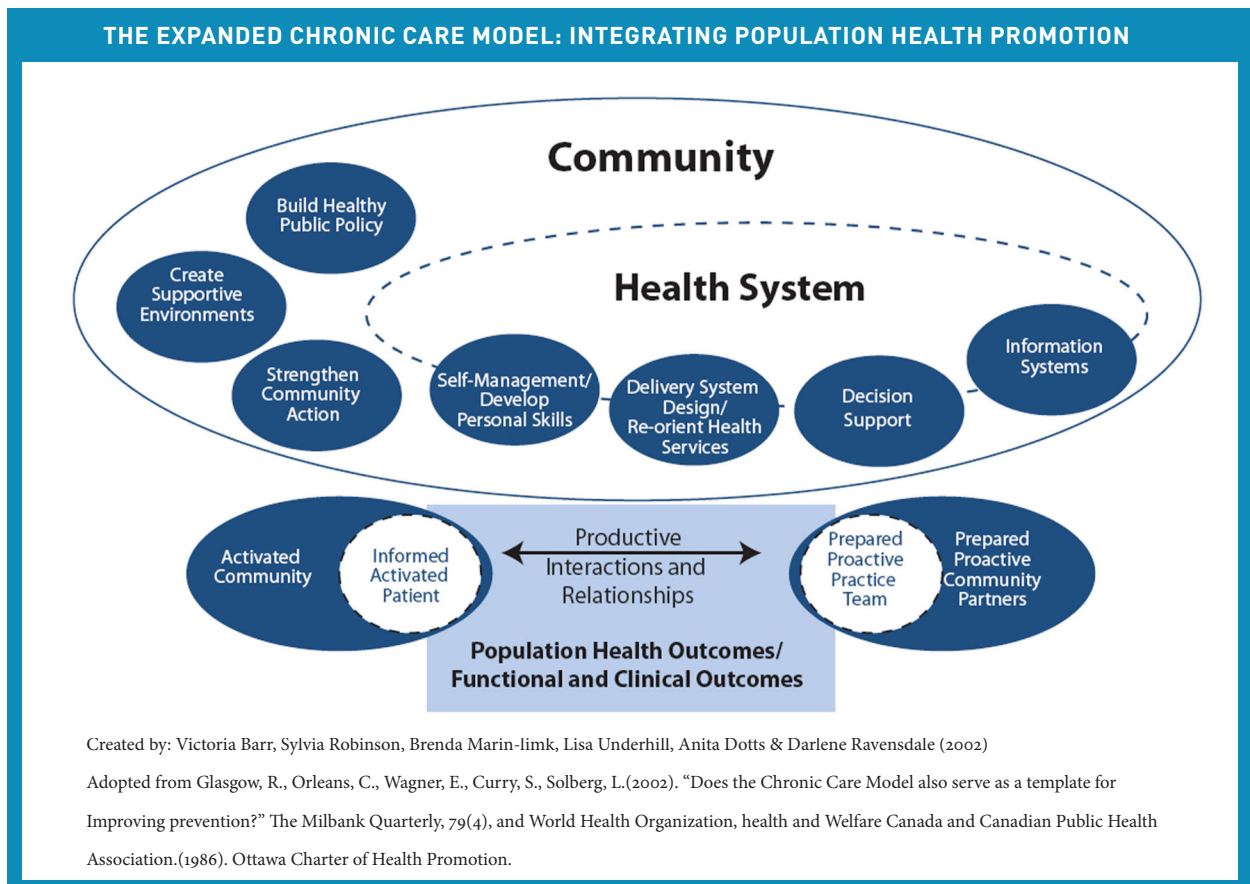
The model is represented in the image below. It shows health systems (individual healthcare organizations) as entities within the community. Both play a role in promoting the flow of ideas, resources, and people. The following are elements of the Expanded CCM:

- Self-management / Develop personal skills: The health system and community supports and coordinates self-management in coping with chronic conditions and supports the development of personal skills for health and wellness.
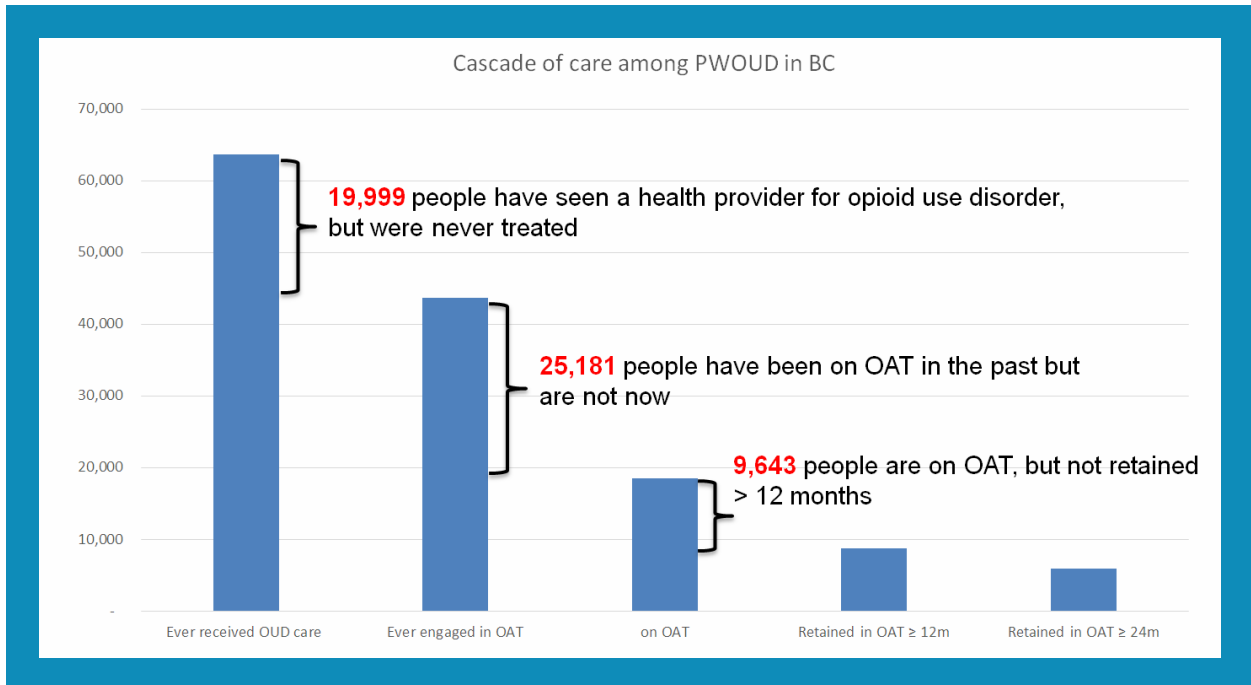
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9 The model is based on the "Chronic Care Model" used by a national program in the United States called Improving Chronic Illness Care (ICIC). This program is based at the McColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound. http://www.improvingchroniccare.org/index.php?p=the_chronic_caremodel&s=2

10 Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. The Expanded Chronic Care Model: An Integration of Concepts and Strategies from Population Health Promotion and the Chronic Care Model. Healthcare Quarterly, 7(1) November 2003: 73-82.

- Delivery System Design / Re-orient Health Services: The health system and community work to support individuals and communities in holistic ways (e.g., advocacy on behalf of vulnerable populations, emphasis on health, quality of life, and clinical outcomes).

- Decision Support: Integrate evidence-based guidelines for care, treatment, being well, and staying healthy into daily practice (e.g., use flow sheets that synthesize evidence-based treatment guidelines, develop health promotion and prevention best-practice guideline).

- Information Systems: Develop information systems based on patient populations to provide relevant client, community, and contextual data for decision-making.

- Build Healthy Public Policy: Development and implementation policies designed to improve population health to foster greater equity in society, and to increase the availability of safe and healthy goods, services, and environments.

- Create Supportive Environments: Contribute to strategies that foster conditions for optimal levels of health in social and community environments based on evidence that describes the significant impact of social supports on overall health and quality of life.

- Strengthen Community Action: the health system works with and mobilizes the community to set priorities and achieve goals that improve the health of the community. Public participation is key to removing barriers to healthy living.

THE EXPANDED CHRONIC CARE MODEL: INTEGRATING POPULATION HEALTH PROMOTION

Created by: Victoria Barr, Sylvia Robinson, Brenda Marin-limk, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)

Adopted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L.(2002). "Does the Chronic Care Model also serve as a template for Improving prevention?" The Milbank Quarterly, 79(4), and World Health Organization, health and Welfare Canada and Canadian Public Health Association.(1986). Ottawa Charter of Health Promotion.

REFERENCE 3: OPIOID USE DISORDER CASCADE OF CARE (THEORETICAL)

Cascade of care among PWOUD in BC

19,999 people have seen a health provider for opioid use disorder, but were never treated

25,181 people have been on OAT in the past but are not now

9,643 people are on OAT, but not retained > 12 months

Bohdan Nosyk, On behalf of the Health Economic Research Unit at the BC Centre for Excellence in HIV/AIDS

REFERENCE 4: STAGES OF TEAM DEVELOPMENT

STAGE 1 **STAGE 2** **STAGE 3** **STAGE 4**

ORIENTATION

*Eager, high expectations
* Anxiety about fit and expectations
*Testing situation and figures
*Assessing authority and hierarchy
*Needing to find a place and establish oneself

DISSATISFACTION

*Discrepancy between hopes and reality
*Dissatisfied with dependency on authority
*Angry about goals, tasks, and action plans
*Feeling confused or incompetent
* Negative about leaders and/or teams
* Competing for power and/or attention

RESOLUTION

*Decreasing dissatisfaction
*Resolving discrepancies between expectations and reality
*Resolving animosities and polarities
*Developing harmony, trust, support, and respect
*Developing self-esteem and confidence
*Being more open and giving more feedback
* Sharing responsibility and control
*Using team language

PRODUCTION

*Excited about participation
*Working collaboratively and inter-dependently
*Feeling team strength
* Showing high confidence in accomplishing tasks
*Sharing leadership
* Feeling positive about task successes
*Performing at high levels

GLOSSARY OF TERMS AND CONCEPTS

ACTION PERIOD

Action Periods occur between Learning Sessions. During these times, team members have returned to their home settings and work on testing and implementing ideas acquired from Learning Sessions and other learning and sharing activities. Throughout these periods, teams will actively test changes, will report regularly on their progress, participate in webinars and teleconferences, and receive coaching support and feedback.

AIM OR AIM STATEMENT

A written statement of purpose that is Specific, Measurable, Actionable, Realistic, and Time-bound. The aim statement may also include guidance such as a general description of the work, the population of focus, and the numerical goals. At the end of your improvement effort, your aim statement should help you to determine if you have been successful.

ANNOTATED RUN CHART

A line chart that shows data plotted over time (i.e., time is the x-axis) with annotations (small notes) that links qualitative descriptions of changes to the times at which they occurred on the plot. This allows the viewer to connect changes made with specific results.

CHAMPION

An individual in the organization who believes strongly in quality improvement and is willing to work with others to test, implement, and spread changes. Teams need at least one clinical champion. Champions in other disciplines who work on the process are important as well. This champion should have a good working relationship with colleagues and with the day-to-day leader(s), and be interested in driving change in the system.

CHANGE CONCEPT

A general idea for changing a process, usually developed by an expert panel based on literature and practical application of evidence. Change concepts are usually at a high level of abstraction, but evoke multiple specific ideas for how to change processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

CHANGE IDEA

An actionable, specific idea for changing a process. Change ideas can be tested to determine whether they result in improvements in the local environment (e.g., simplify the process for data entry by having front desk staff enter visit information daily from a duplicate copy while the original is filed in the chart).

CLOSING CONGRESS

The Closing Congress is similar to Learning Sessions, though focuses principally on reflection, celebration, and sharing of the work that has been accomplished over the course of the Collaborative. The Closing Congress formally marks the end of the initiative.

COLLABORATIVE (AS KNOWN AS STRUCTURED LEARNING COLLABORATIVE)

A systematic approach to healthcare quality improvement in which organizations and providers test and measure practice changes, then share their experiences in an effort to accelerate learning and widespread implementation of best practices. "Everyone teaches, everyone learns."

COLLABORATIVE CORE TEAM

Staff and experts that coordinate the events and activities of the Collaborative and provide teaching and coaching to participating teams.

COLLABORATIVE TEAM (A.K.A. IMPROVEMENT TEAM)

All individuals from the participating organizations that drive and participate in the improvement process. This team coordinates and actively participates in the improvement process and supports representatives to attend the Collaborative Learning Sessions and other learning activities.

DATA COLLECTION PLAN

A specific description of the data that the team will collect, the frequency of data collection, data sources from which data artifacts will be obtained, and key roles and responsibilities to oversee data collection, reporting, and analysis.

IMPLEMENTATION

Implementation is a process in which a change is made a permanent part of the system. During this process, organizations will formally adopt the change, communicate it widely, change job descriptions, codify the change in policy, etc. Changes should only be implemented after they have been successfully tested and there is a high degree of belief that the change will bring about improvement.

INFORMATION SYSTEMS (IS)

Refers to the information system of an organization, usually the computerized information system.

KEY CONTACT

The person on the team who takes responsibility for maintaining communication between the team and the Collaborative core team, including reporting monthly and disseminating information to team members.

LEARNING SESSION

Learning Sessions are highly interactive meetings that bring together team representatives in plenary sessions, small group discussions, and team meetings to build networks and learn about best practices for improving OUD care, services, and outcomes. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes. There are four Learning Sessions in the provincial BOOST Collaborative.

LISTSERV

An automatic mailing list. When e-mail is addressed to a LISTSERV mailing list, it is automatically broadcasted to everyone on the list. The result is similar to a newsgroup or forum except that the messages are transmitted as an e-mail and are therefore available only to individuals on the list.

MEASURE (A.K.A. QUALITY INDICATOR, IMPROVEMENT MEASURE)

A focused, reportable unit that will help a team monitor progress towards achieving their aim. The Collaborative will describe the measures and strategy for measurement.

PDSA CYCLE

A systematic and iterative approach to testing out a change, which includes four phases: Plan, Do, Study, and Act. At the end of each cycle, teams will choose to adopt, adapt, or abandon the change.

POPULATION OF FOCUS (POF)

The population of clients for whom your team will base what it is that you want to accomplish (aim) and for whom you will measure key quality indicators.

RUN CHART

See "annotated run chart."

SPREAD

The intentional and methodical expansion of the number and type of people, units, or organizations using the improvements. The theory and application comes from the literature on the concept of Diffusion of Innovation. http://blog.leanmonitor.com/early-adopters-allies-launching-product/

TEST

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement, and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.