BOOST

Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

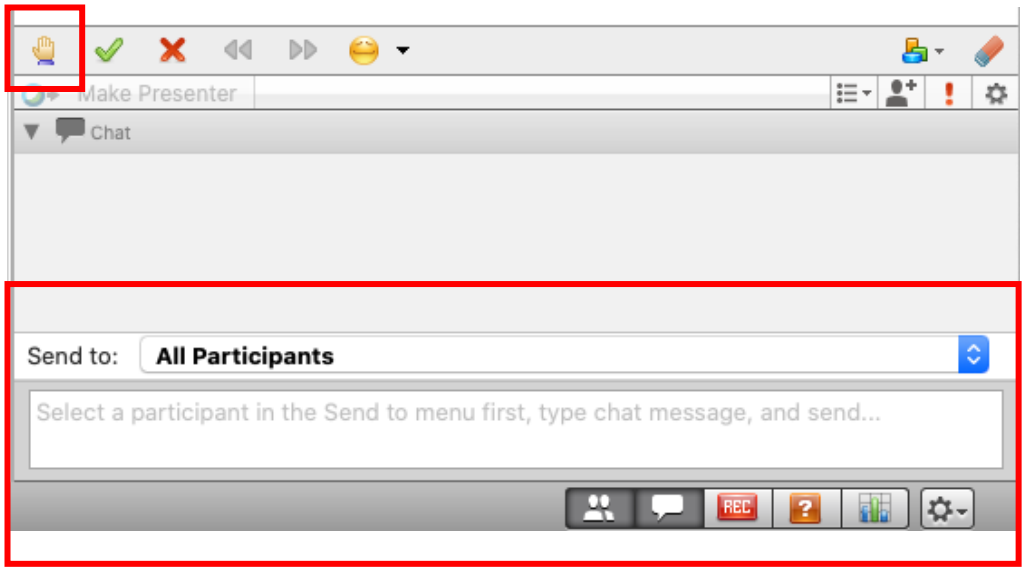
Welcome to the BOOST QI Network Launch

Please type your name & team name in the chat*

Thursday, June 25th, 2020

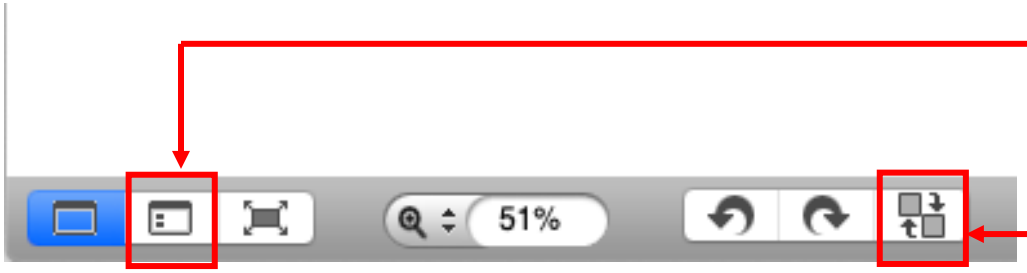
*The session will be recorded for educational purposes,
if there are any concerns with this please send a direct message to CfE WebEx (host)**

Session Control Panel



Chat Panel (bottom right)

- Type your question/comment to everyone
- OR “raise hand” to signal a question



Slide panel (bottom left)

- View presenter slide thumbnails
- Advance ahead or behind presenter slides
- Go back to presenter’s current slide

Annotation panel (top left)

- Use text or arrow functions during activities

Welcome and Introductions

We would like to begin by acknowledging that the land on which we gather is the unceded territory of the Coast Salish peoples.

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

Thank you
to all our funders and partners,
including
patient partners and family voices

Objectives

- Discuss the current state of the opioid crisis in BC and the impact of COVID-19
- Identify strategies/change ideas that other teams are using successfully to adjust care delivery to clients with OUD during COVID-19
- Understand the basics of quality improvement and how to run successful tests of change
- Learn about the BOOST QI Network plan, aims and timeline

Agenda

Time		Topic	Speaker
8:30	5 mins	Welcome, Intro and Objectives	Valeria Gal
8:35	15 mins	Update on the Opioid Crisis	Mark Lysyshyn
8:50	10 mins	Addiction Medicine in the Context of COVID-19	Sharon Vipler
9:00	15 mins	QI Refresher	Cole Stanley
9:15	10 mins	OUD Care in the Context of COVID-19	Keren Mitchell
9:25	5 mins	QI Network Overview	Valeria Gal
9:30	5 mins	General Q&A	All
9:35	30 mins	QI Network Q&A Period	All

I am here.....

……but I wish I was here

Update on British Columbia's Overdose Emergency

Mark Lysyshyn MD MPH FRCPC
Deputy Chief Medical Health Officer
Vancouver Coastal Health

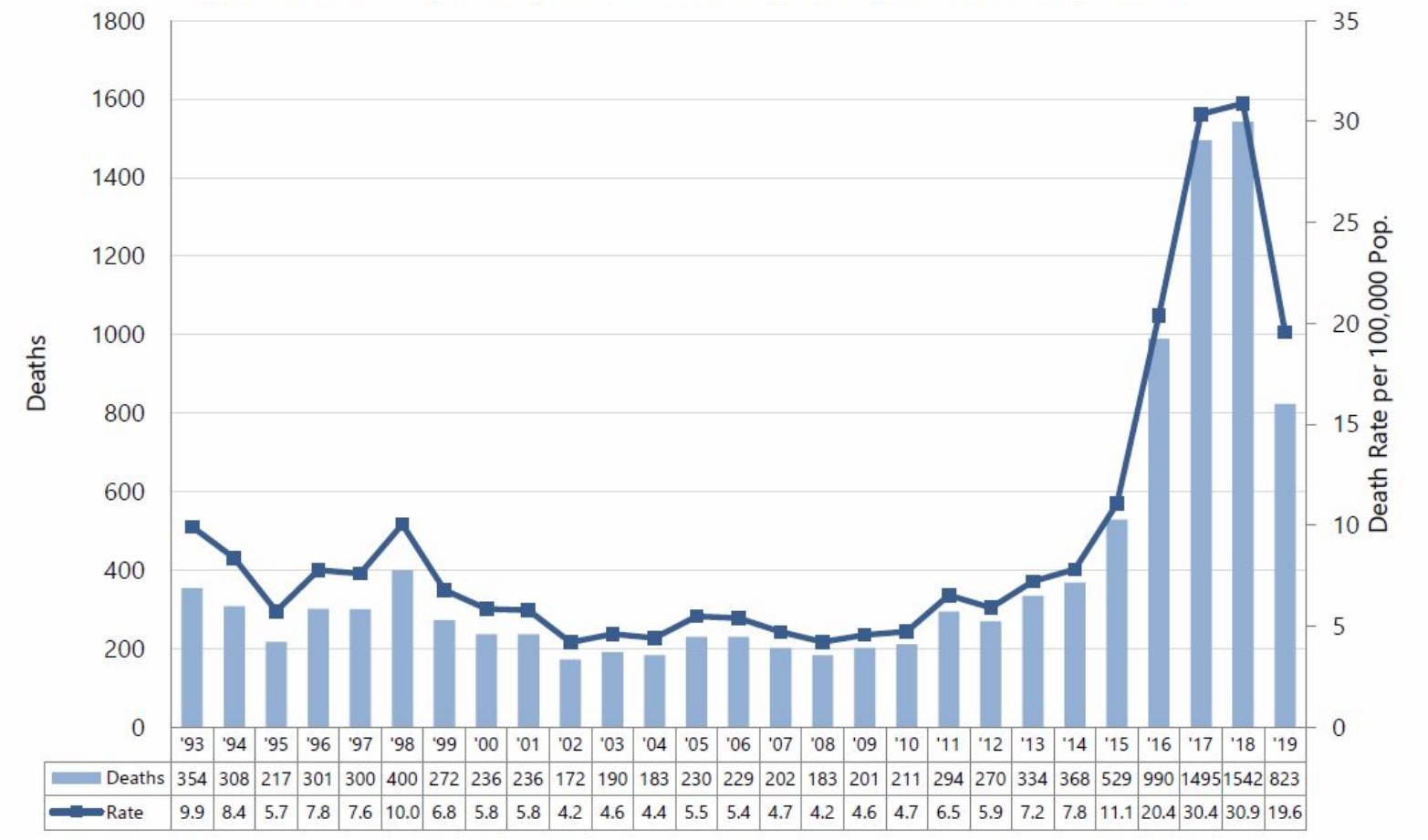
BOOST QI Network Launch
June 2020

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Disclosures

- None

BC's Overdose Emergency



	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19
Deaths	354	308	217	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	294	270	334	368	529	990	1495	1542	823
Rate	9.9	8.4	5.7	7.8	7.6	10.0	6.8	5.8	5.8	4.2	4.6	4.4	5.5	5.4	4.7	4.2	4.6	4.7	6.5	5.9	7.2	7.8	11.1	20.4	30.4	30.9	19.6

Source: BC Coroner's Service (2019)

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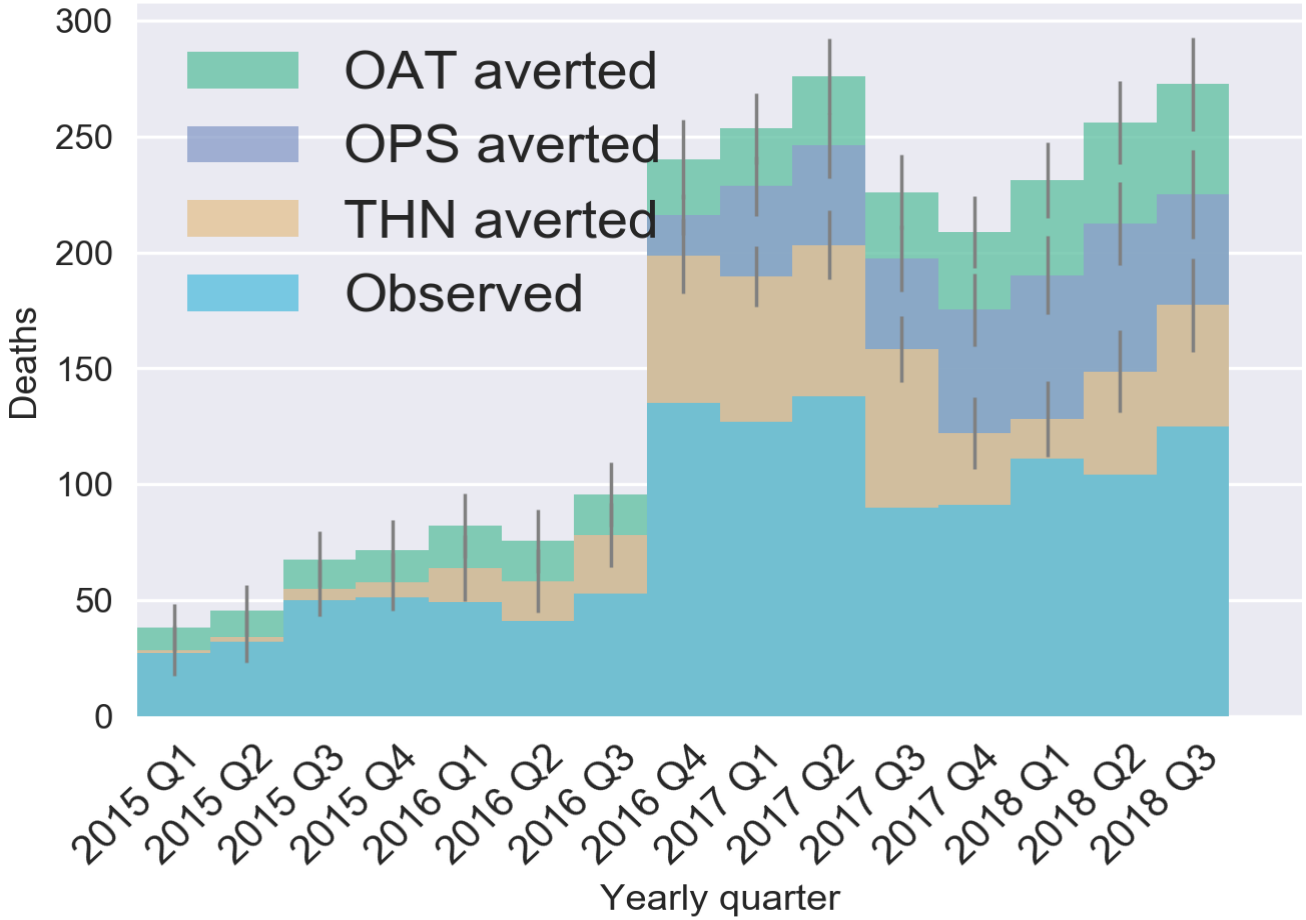
Impact of Overdose Response in VCH



Source: BC Centre for Disease Control (2019)

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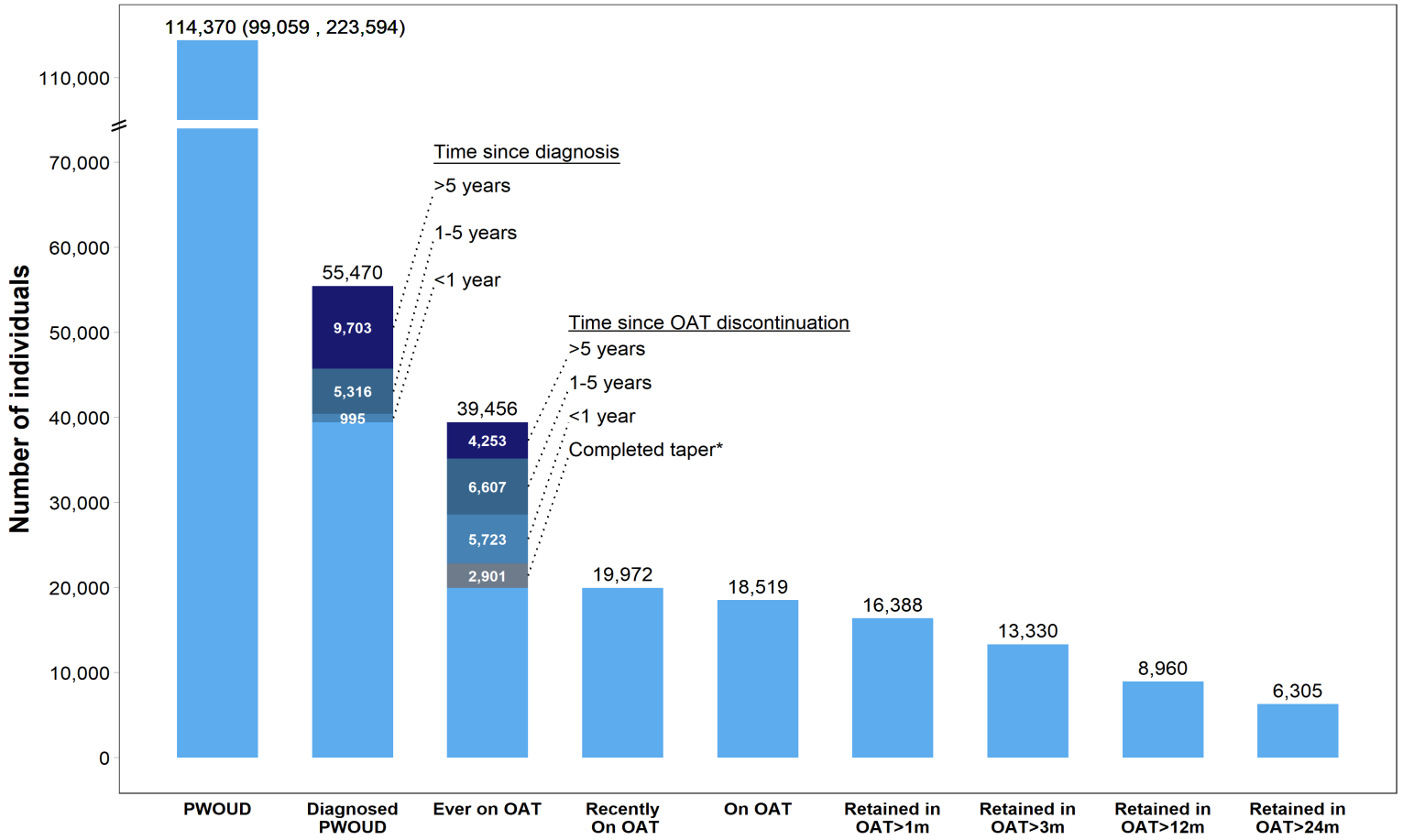
BC Cascade of Care for OUD



Source: BC Centre for Excellence for HIV/AIDS (2019)

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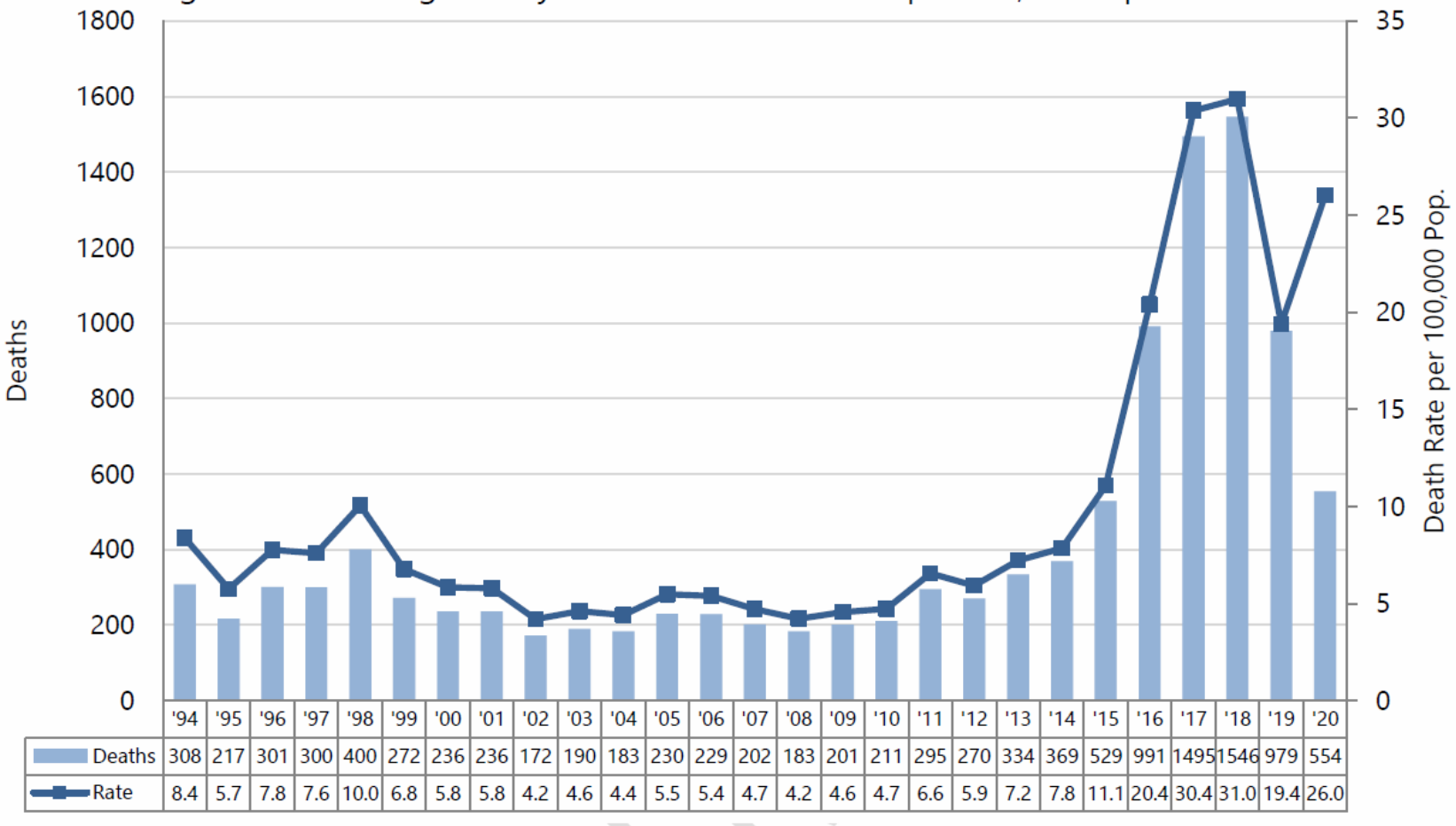
But…

BC's Overdose Emergency

Figure 1: Illicit Drug Toxicity Deaths and Death Rate per 100,000 Population [3,5]



	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20
Deaths	308	217	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	295	270	334	369	529	991	1495	1546	979	554
Rate	8.4	5.7	7.8	7.6	10.0	6.8	5.8	5.8	4.2	4.6	4.4	5.5	5.4	4.7	4.2	4.6	4.7	6.6	5.9	7.2	7.8	11.1	20.4	30.4	31.0	19.4	26.0

Source: BC Coroner's Service (2020)

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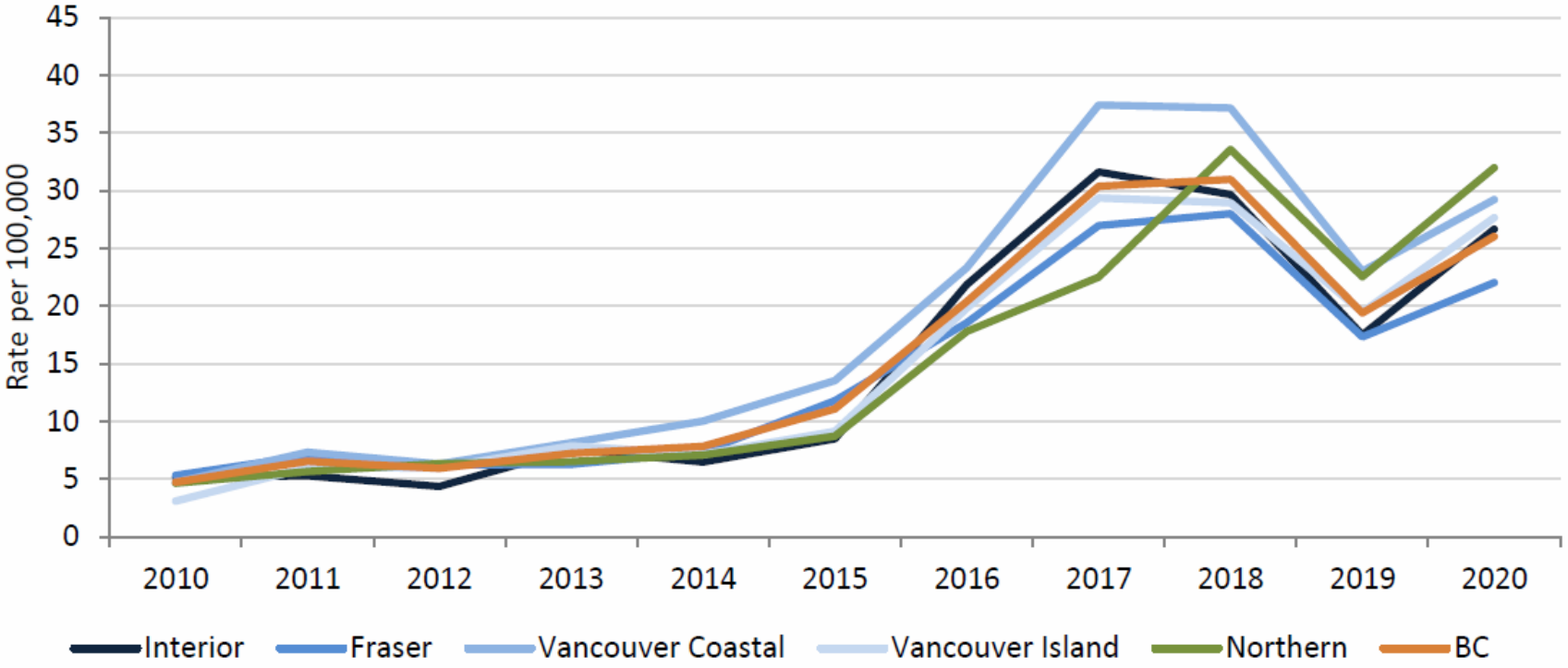
BC's Overdose Emergency

Figure 5: Illicit Drug Toxicity Death Rates by Health Authority, 2010-2020



Source: BC Coroner's Service (2020)

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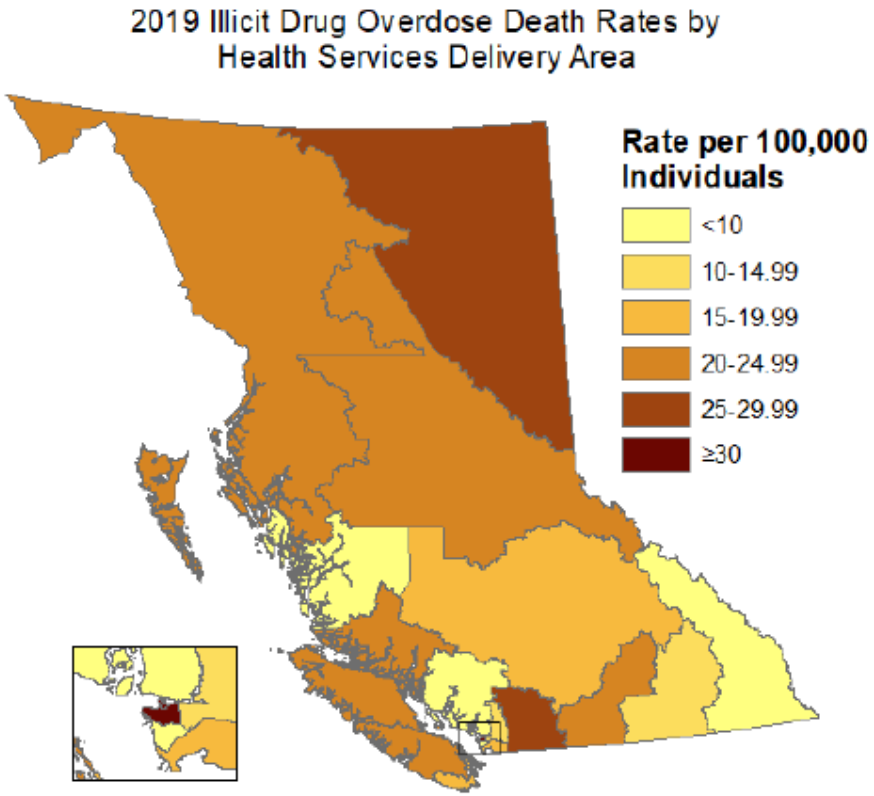
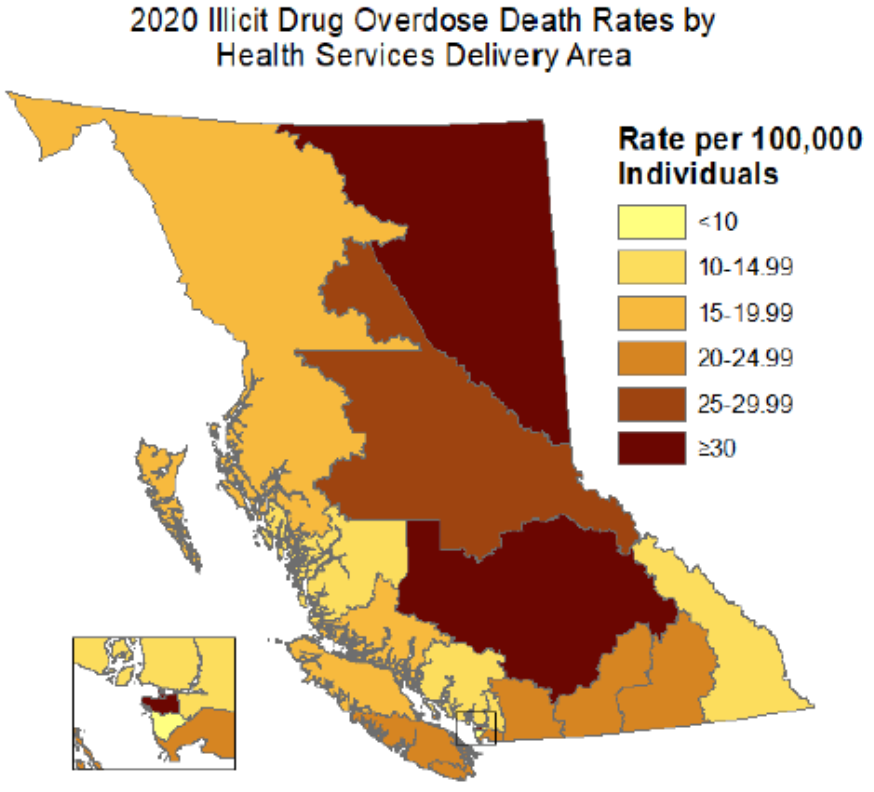
BC's Overdose Emergency





Source: BC Coroner's Service (2020)

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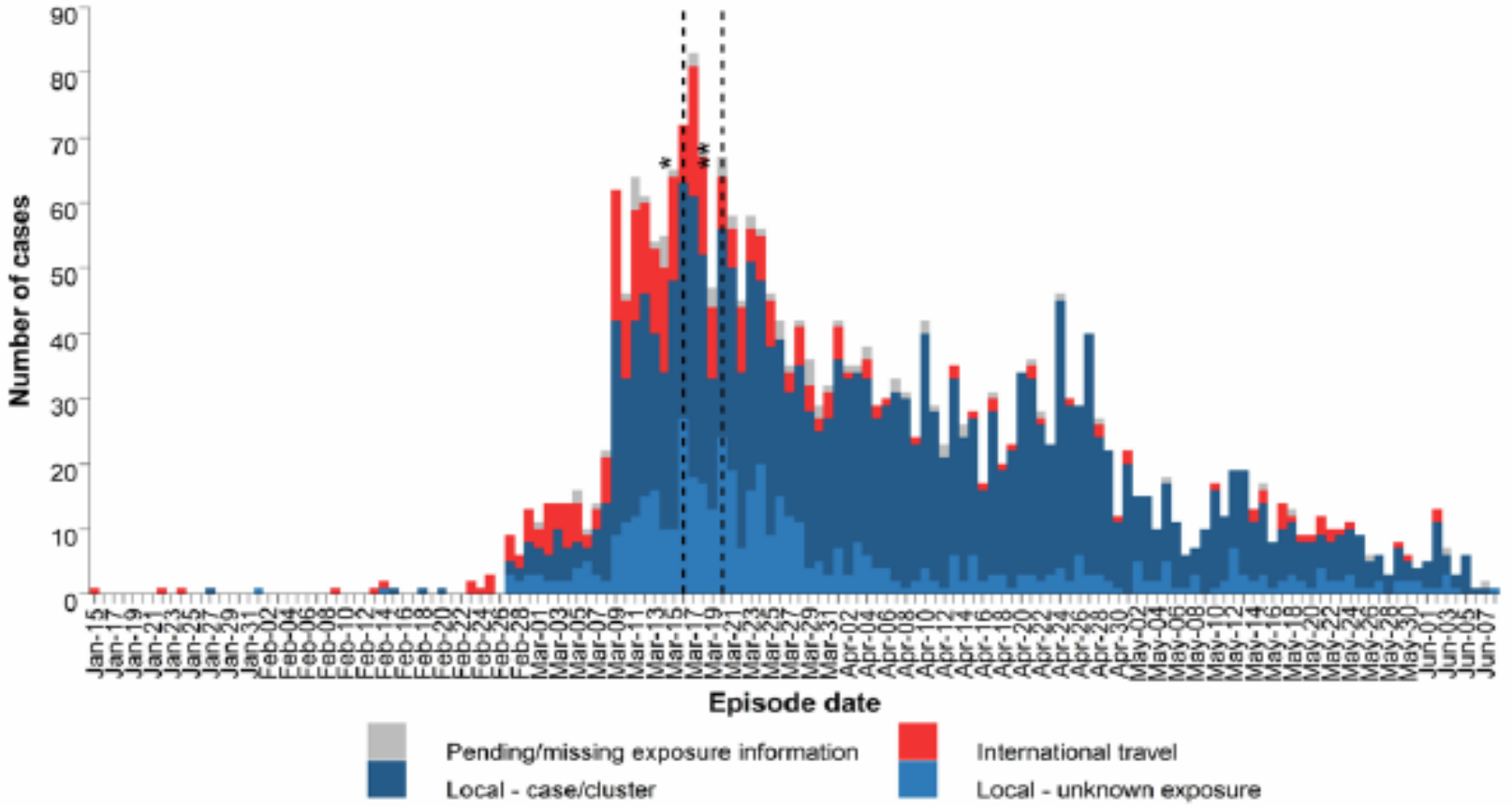
Impact of COVID-19

Figure 4: Likely source of infection for COVID-19 cases in BC by episode date[5], January 15 – June 8, 2020 **(N=2,669)**



Source: BC Centre for Disease Control (2020)

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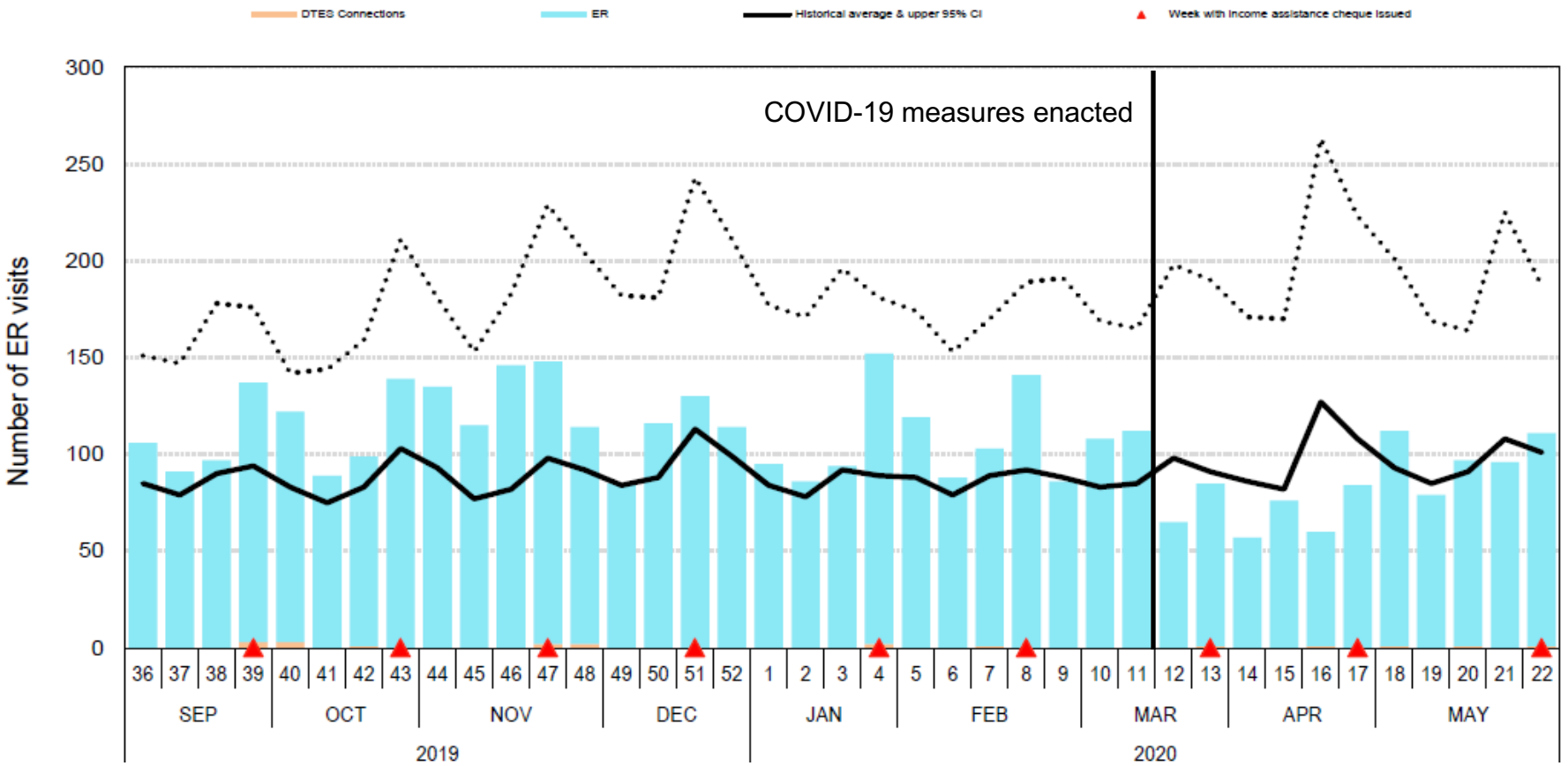
Decreased Visits to ED



Source: Vancouver Coastal Health (2020)

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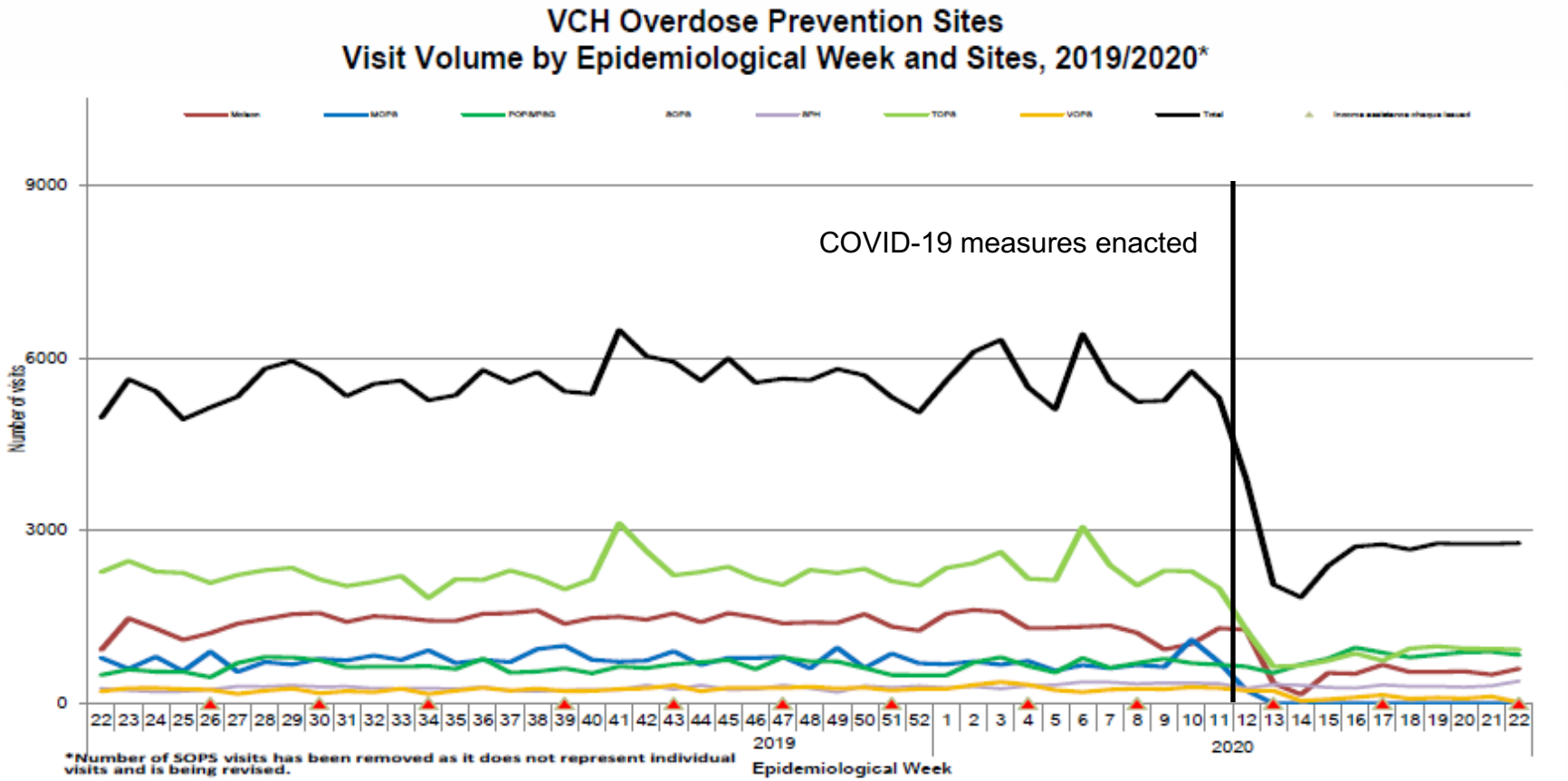
Decreased Visits to OPS



Source: Vancouver Coastal Health (2020)

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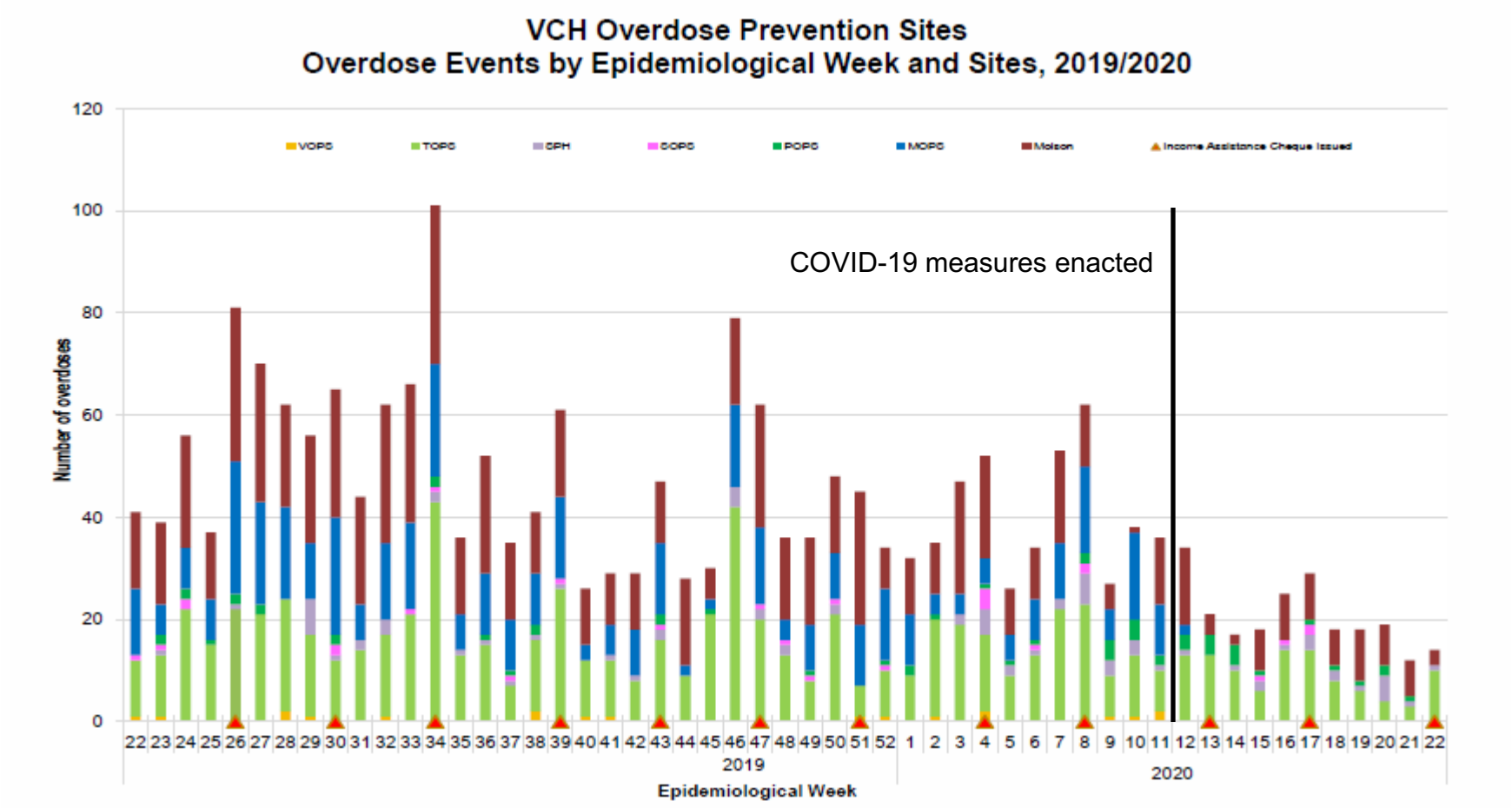
Decreased Overdoses at OPS



Source: Vancouver Coastal Health (2020)

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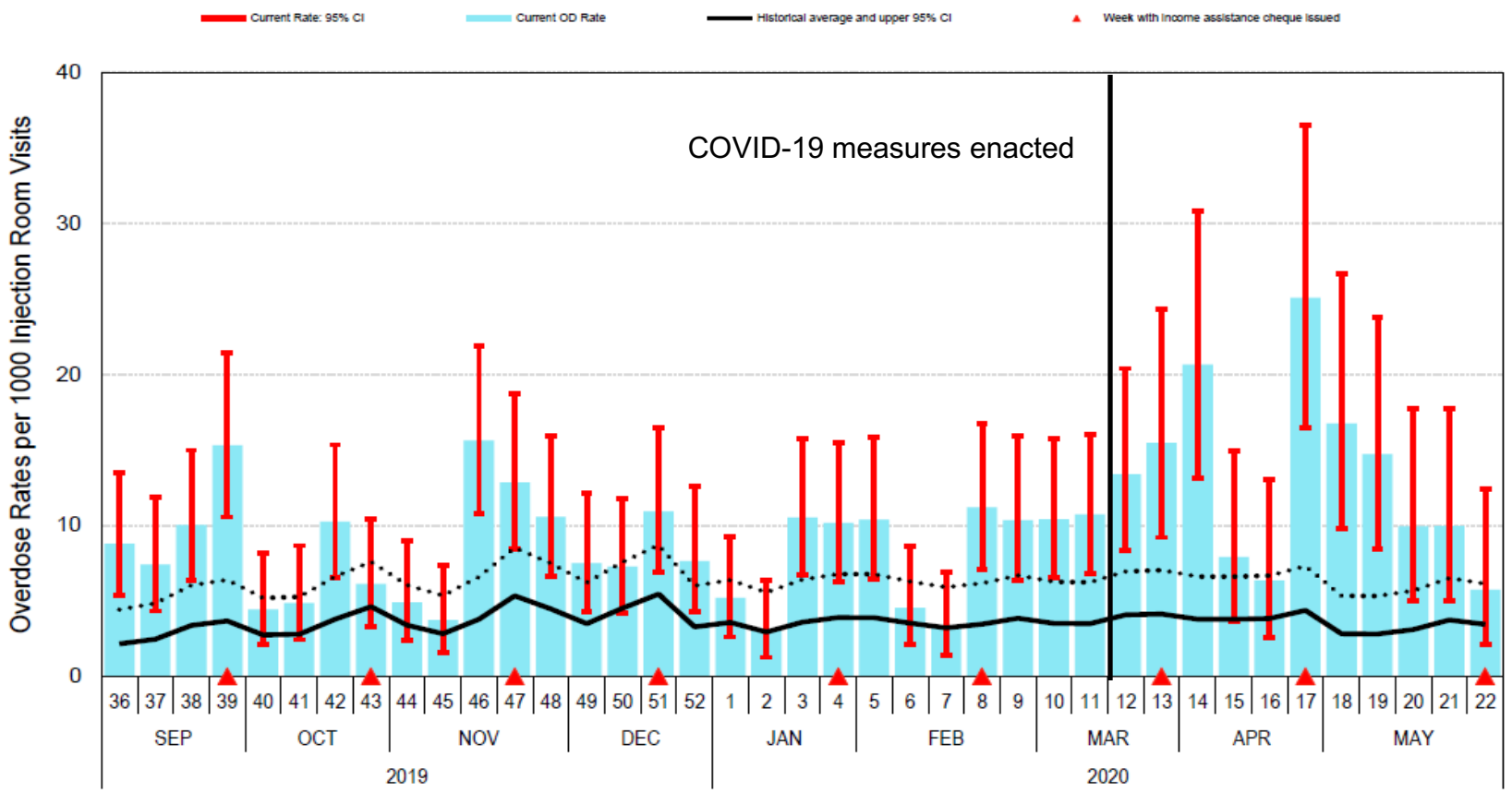
Increased Overdose Rate at SCS



Source: Vancouver Coastal Health (2020)

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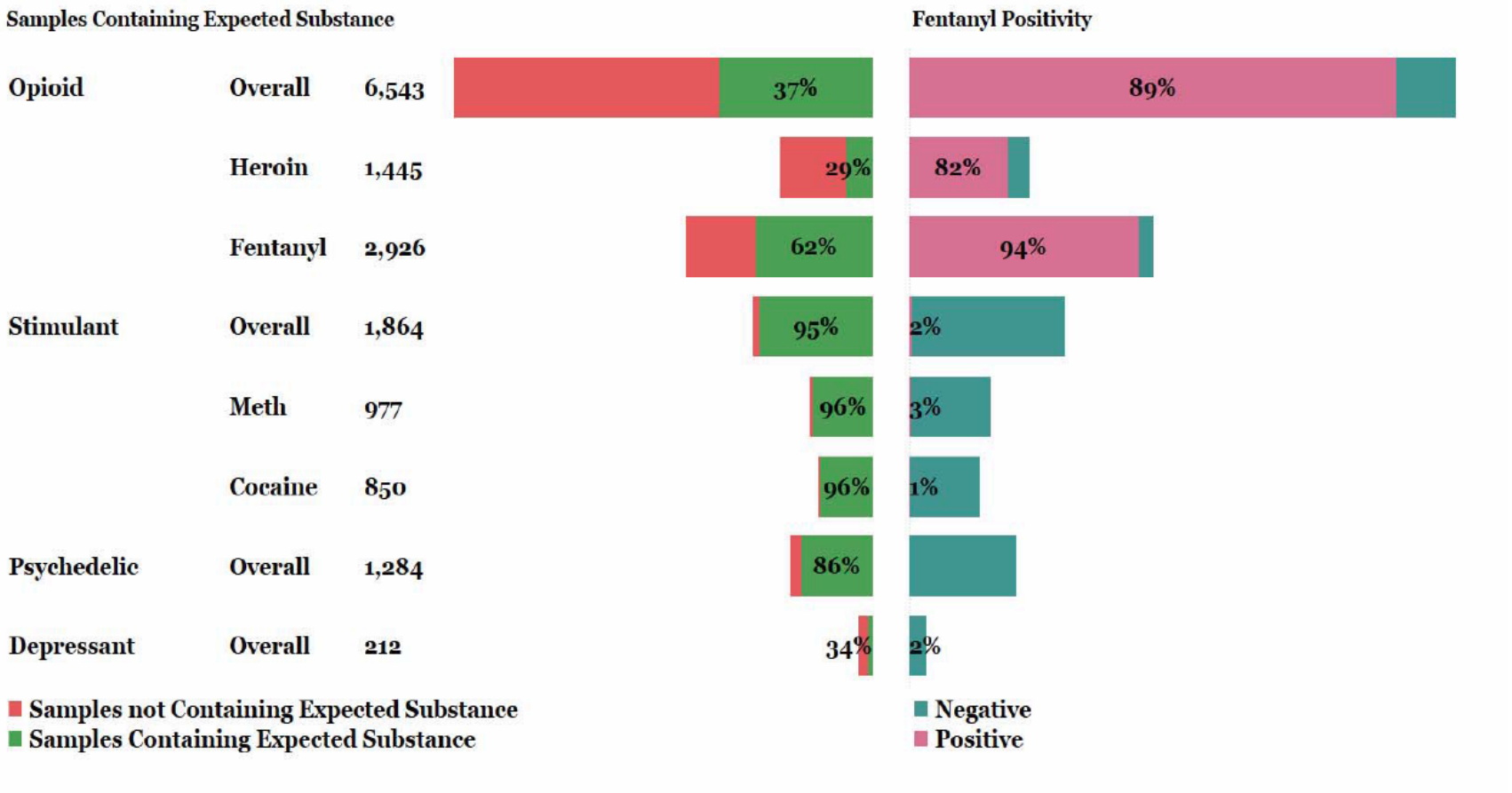
VCH Drug Checking Results



Source: VCH Public Health Surveillance Unit (2020)

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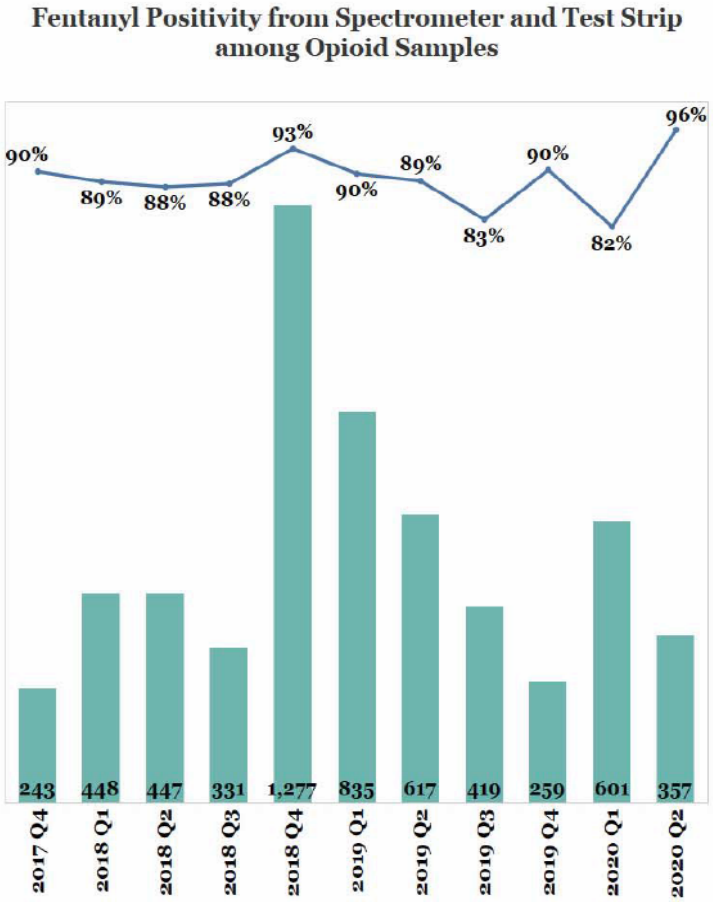
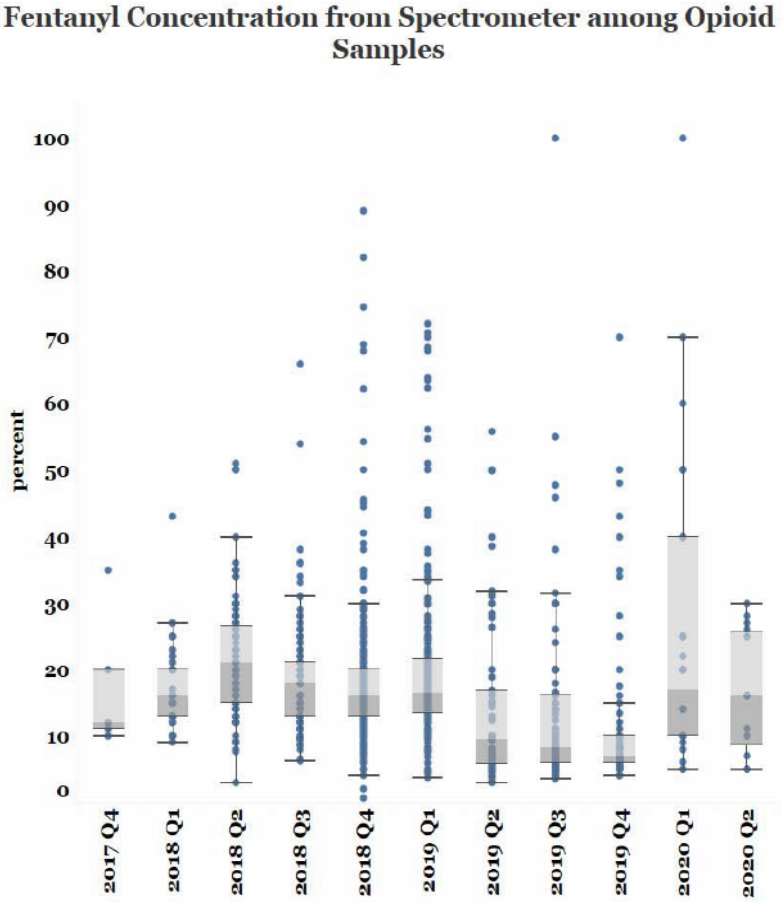
Increasing Fentanyl Contamination





Source: Vancouver Coastal Health (2020)

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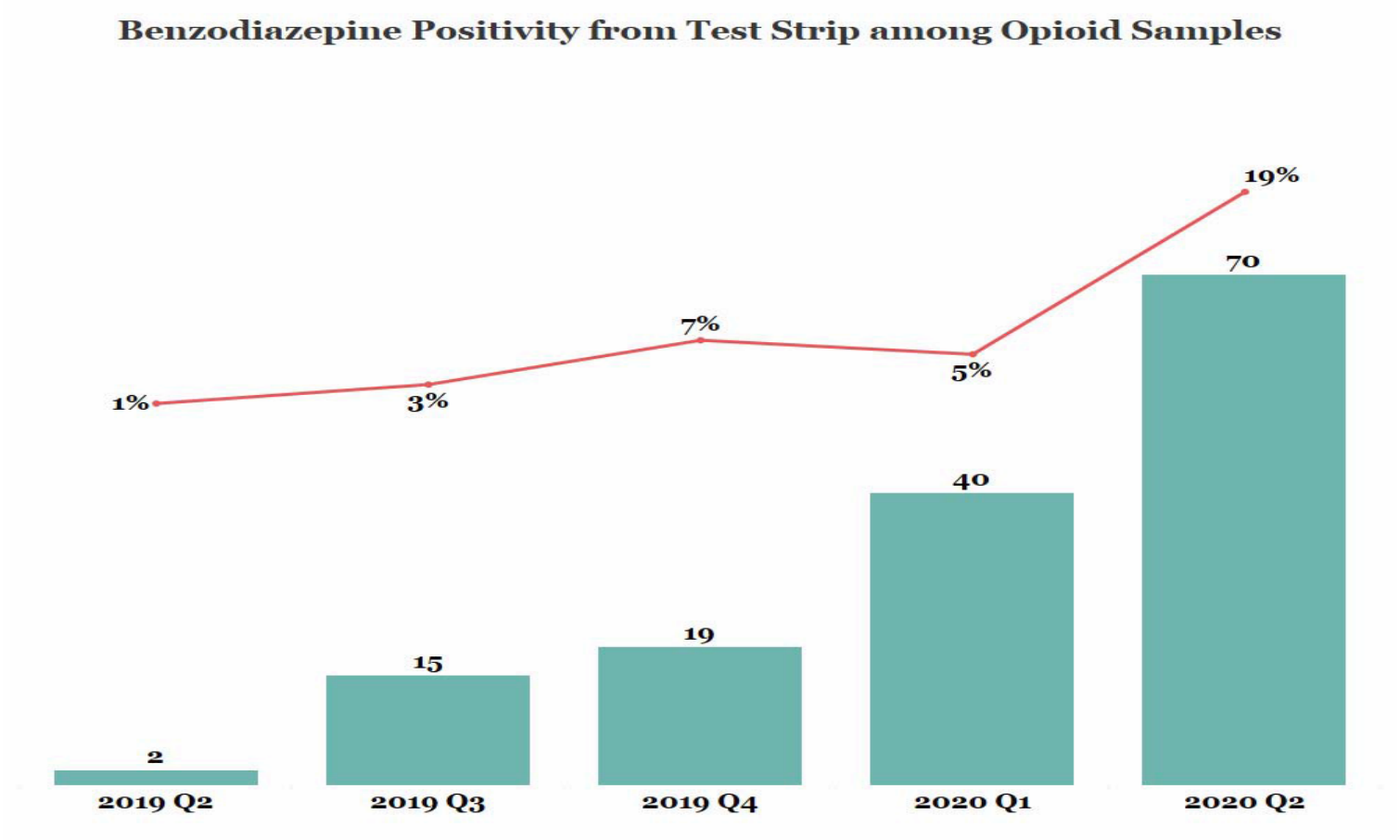
Benzodiazepine Contamination



Source: Vancouver Coastal Health (2020)

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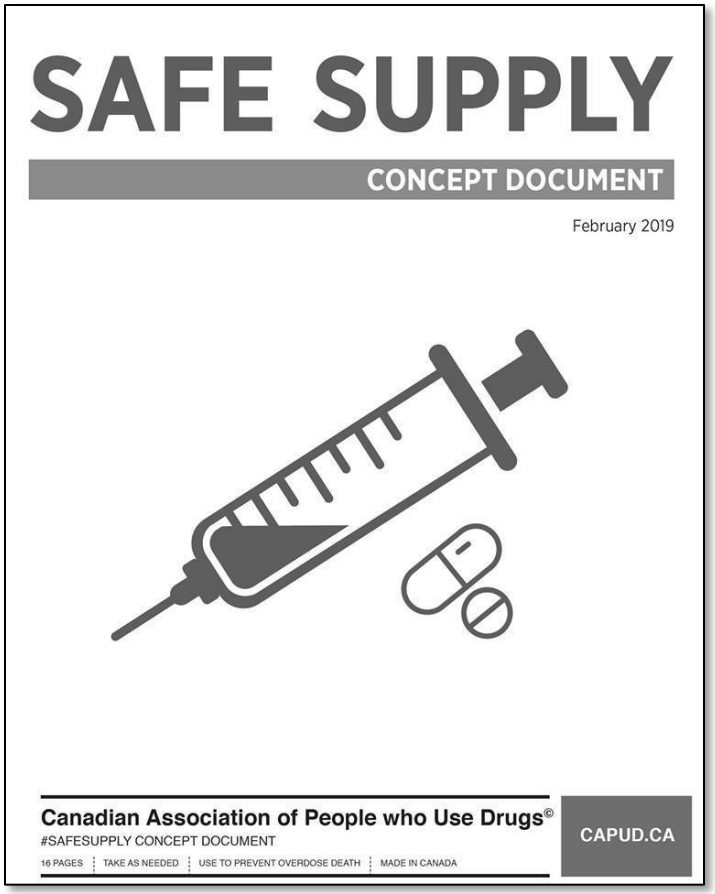
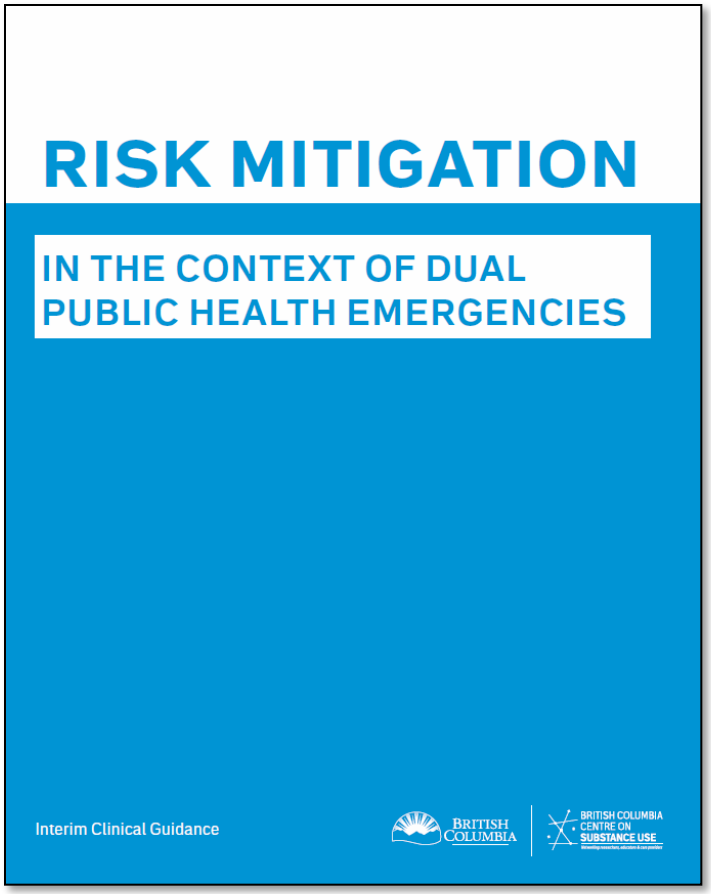
Safer Supply Initiatives





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Questions

Addiction Medicine in the Context of COVID-19

Sharon Vipler

March 11, 2020 - World Health Organization declared COVID-19 a pandemic

March 17, 2020 - BC declared a public health emergency

Social distancing measures may mean there are reduced hours of operation of pharmacy and clinic services to meet the needs of patients.

Some hypothesize it may also mean disruptions in drug supply for people who use drugs

RISK MITIGATION

IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

Interim Clinical Guidance

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Subsection 56(1) class exemption for patients, practitioners and pharmacists prescribing and providing controlled substances in Canada during the coronavirus pandemic

Pursuant to subsection 56(1) of the *Controlled Drugs and Substances Act* (CDSA), and subject to the terms and conditions herein, practitioners and pharmacists, authorized within their scope of practice, are hereby exempted from the following provisions of the CDSA and its regulations when prescribing, selling, or providing a controlled substance to a patient or transferring a prescription for a controlled substance to a pharmacist in Canada:

- Section 5 of the CDSA;
- Subsection 31(1), and section 37 of the Narcotic Control Regulations (NCR);
- Sections G.03.002 and G.03.006 of Part G of the Food and Drug Regulations (FDR);
- Paragraphs 52 (c) and (d), subsection 54(1) of the Benzodiazepines and Other Targeted Substances Regulations (BOTSR).

- Permit pharmacists to extend and renew prescriptions
- Permit pharmacists to transfer prescriptions to other pharmacists;
- Permit prescribers to verbally prescribe prescriptions with controlled substances; and
- Allow pharmacy employees to deliver prescriptions of controlled substances to patients at their homes or an alternate location.

What did CPSBC say about prescribing during the COVID19 Pandemic?

None of the College standards create barriers to facilitating adequate and safe supply of medications to patients. Physicians should assess the prescription needs of their patients and assess risks and benefits to both the patient and the public.

Physicians must use good professional judgment and exercise prudent clinical practice (including using distance medicine and virtual care) during this crisis. The College expects that physicians will make decisions in good faith and with patient and public safety as a principal consideration.

What did CPSBC say about telehealth?

During this time, it is reasonable and expected that physicians increase phone or video consultations with patients. This will have an impact on prescribing. Enhanced collaboration with community pharmacists is required.

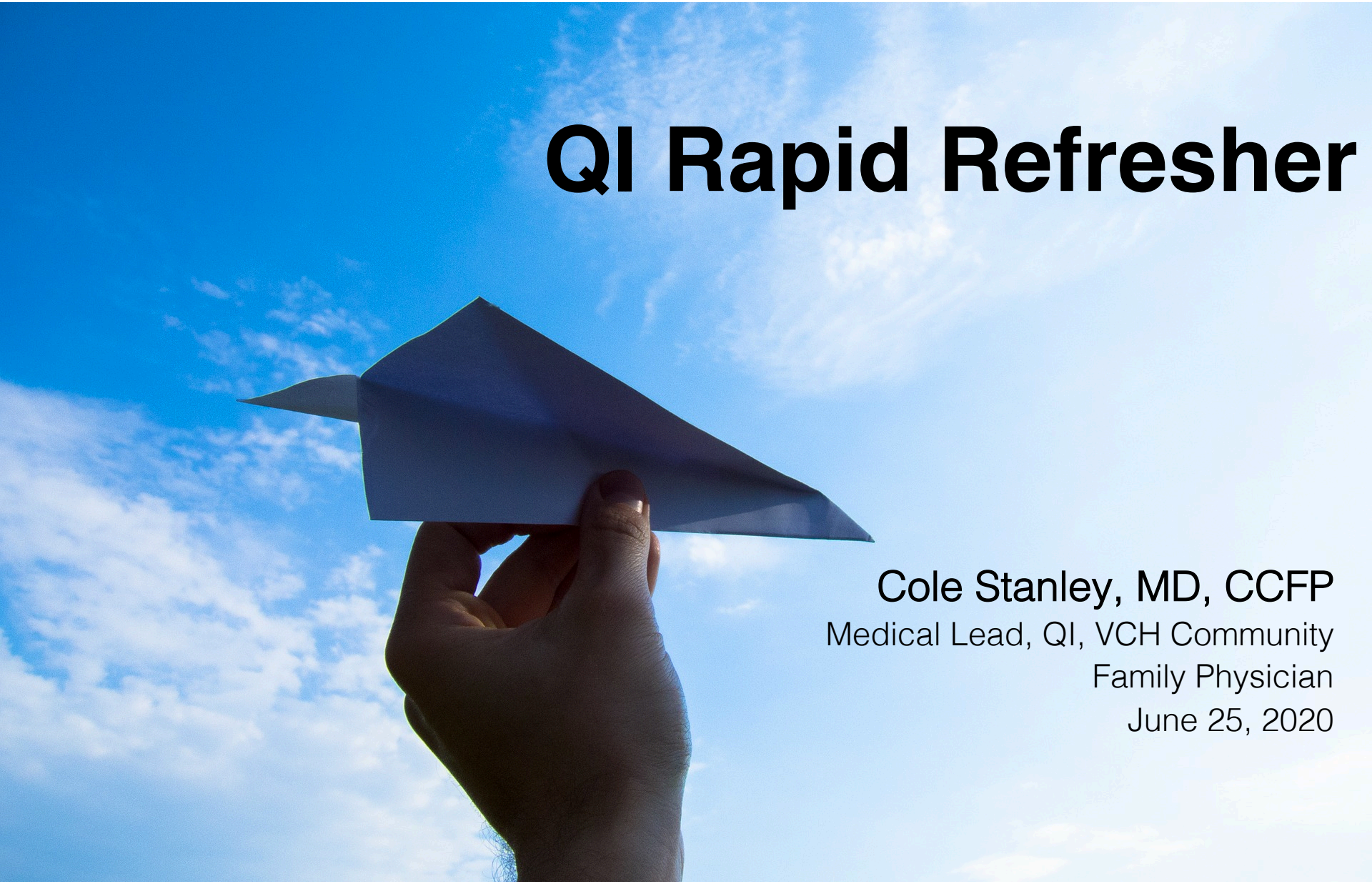
Physicians should consider the following:

For non-controlled medications: Renew prescriptions by phone or fax to a pharmacy after a phone conversation or telemedicine visit with a patient and eliminate the need for a patient to obtain an original paper prescription with a wet signature, which they then have to take to a pharmacy. It is not acceptable to text or email photographs of prescriptions from a phone as photographs contain patient information and these are retained (often on cloud-based servers in other countries), which inevitably increases the risk of an information/privacy breach.

For controlled medications (such as narcotic pain medication): Phone or fax a prescription to a pharmacist (and deliver the original duplicate form). This should only be done if the physician has a longitudinal relationship with a patient and understands their care needs. This may entail prescribing for longer durations; physicians must weigh the benefits of larger dispenses with the risk of overdose or diversion. Patients on long-term opioids should have naloxone kits.

For opioid agonist treatment (OAT): Ensure patients have a steady supply of these essential medications. This might include alternatives to daily witnessed ingestion such as more frequent delivery of medications. In certain circumstances this could include more take-home doses ("carries") if the patient is stable on their OAT. Consider rotations to medications with lower risk of overdose and diversion (such as buprenorphine/naloxone preparations) if carries of methadone or sustained-release morphine present too much risk.

PharmaNet: Physicians are expected to take full medication histories and to check PharmaNet whenever possible to ensure safe prescribing.

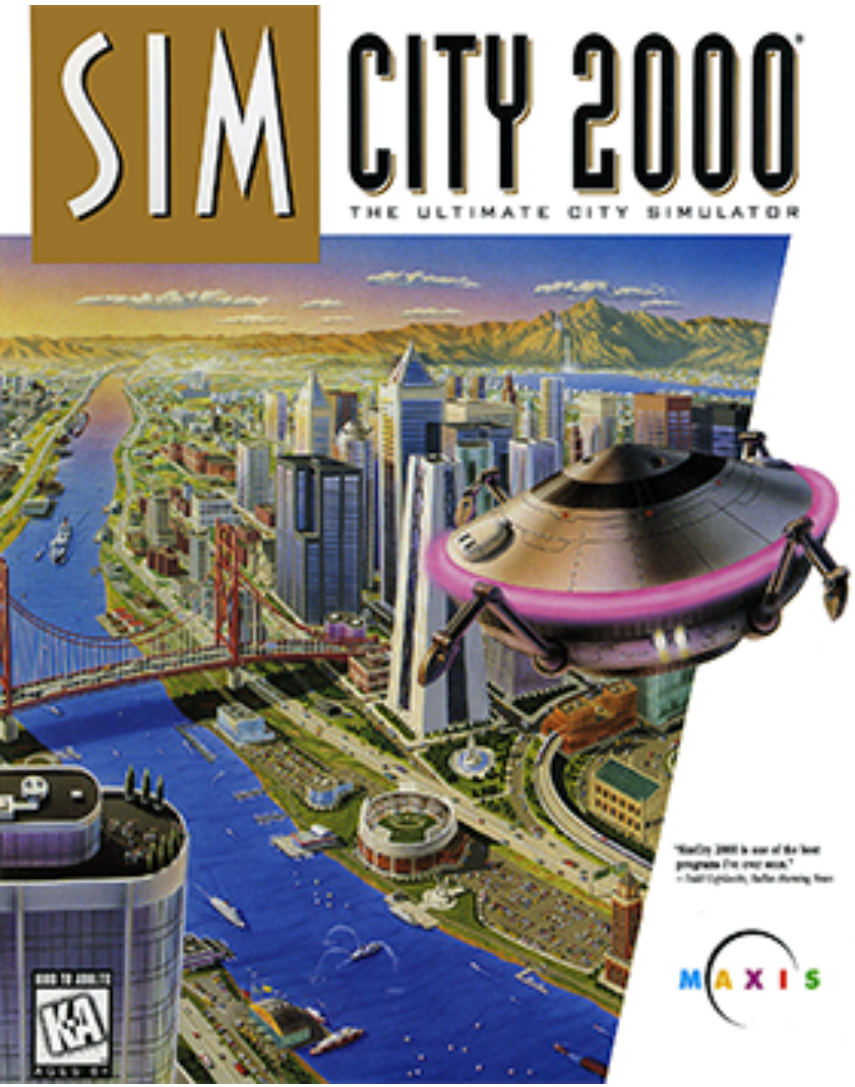


QI Rapid Refresher

Cole Stanley, MD, CCFP
Medical Lead, QI, VCH Community
Family Physician
June 25, 2020

Disclosures

- Travel grants received for conference attendance from the following
  - 2019 – Canadian Association for HIV Research (with support from Viiv)
  - 2017 – Gilead Sciences
  - 2016 – Canadian Association for HIV Research (with support from Viiv), Gilead Sciences
- Advisory Board – Viiv Feb 2019
- Mitigating bias
  - **No discussion of specific HIV or Hep C therapy in this talk**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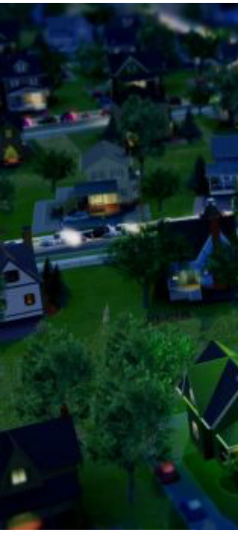
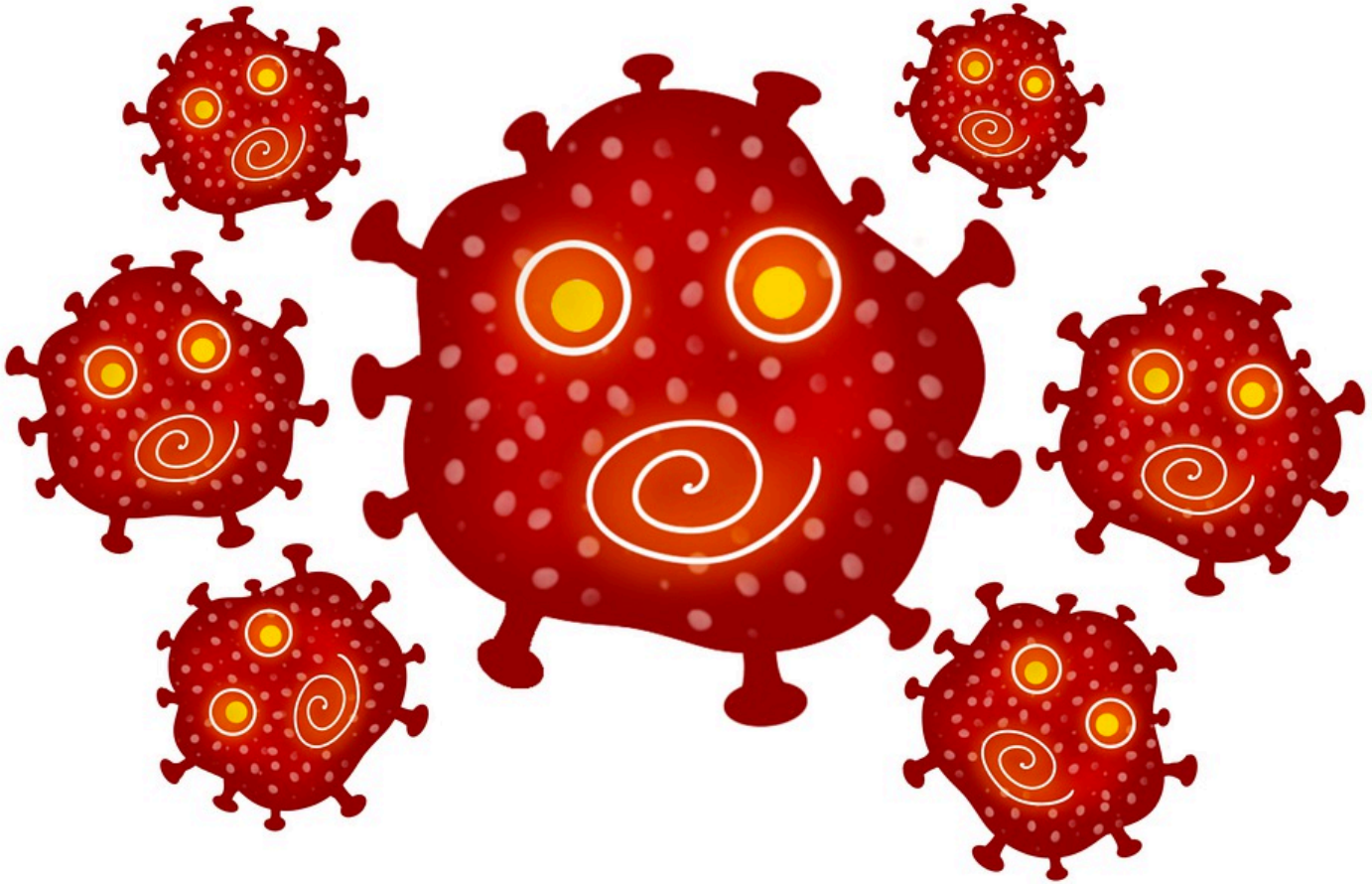
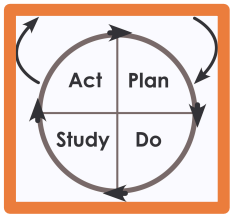
THE ULTIMATE CITY SIMULATOR
MAXIS

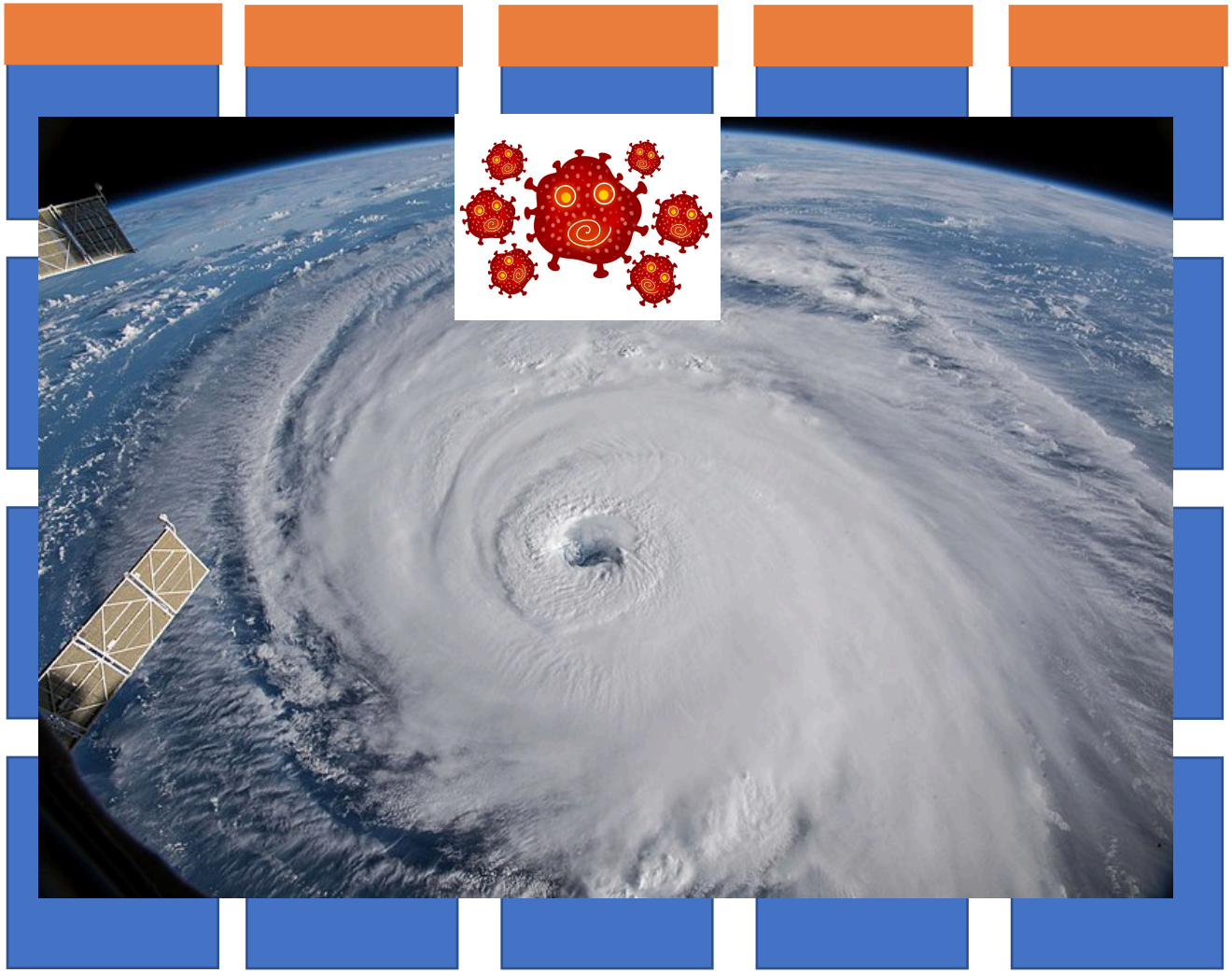

CASE







- Do the work



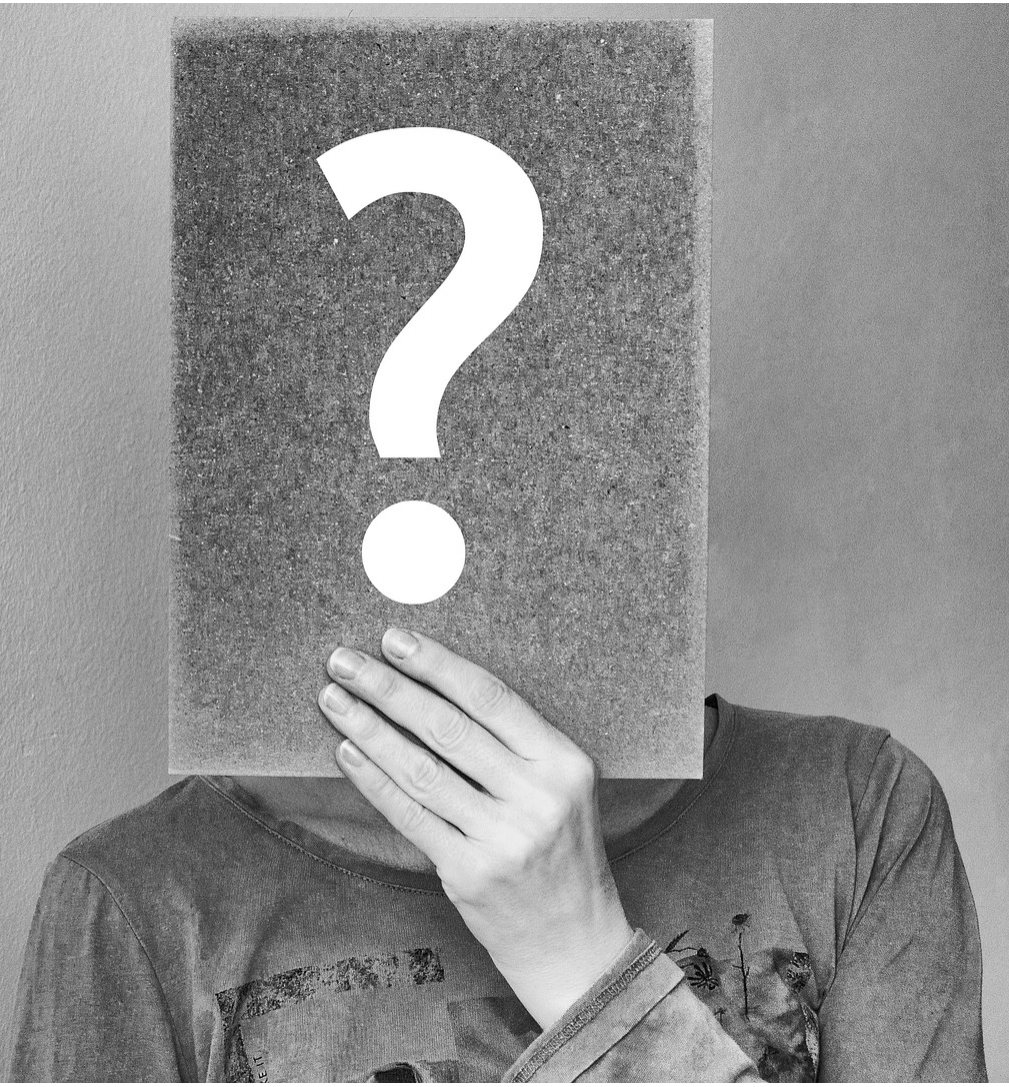
"…Not with a bang, but with a whimper."

--- T.S. Eliot

Why not just implement?

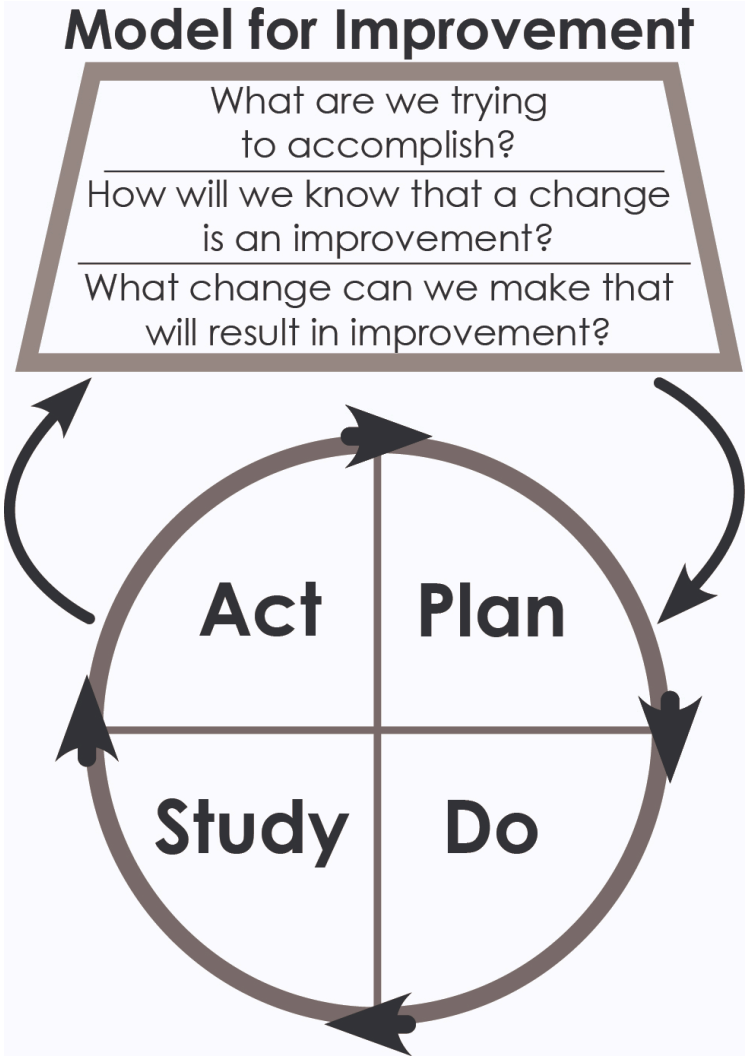
Teams don’t have enough **good ideas** to test.	Teams **jump to implementation** WITHOUT testing or measuring.
Teams lose focus from week to week and so fail at **execution** of their plans.	Teams don’t have enough regularly **scheduled time** to do the improvement work.

What's the Problem



Problem at Hope to Health Clinic

Only **45%** of our clients with OUD have an active OAT or opioid (risk mitigation) prescription



- Aims
- Measures
- Change Ideas

PDSA Worksheet (short version)

1: Define your aim, the overall goal you wish to achieve. 2. Plan the first (or next) test of change toward achieving the aim. 3. Do the test. 4. record and study the results. 5. Act to modify the plan for your next test.

Aim: By September 2020, we aim to increase our proportion of clients with OUD who have an active OAT or risk mitigation prescription from 45% to 80%.

Plan

Describe your first (or next) test of change:

We will test having a morning OUD rounds with the team, where we rapidly review the list of clients with OUD but no active prescription. Team members will commit to follow-up actions with particular clients to complete over the week.

Who is responsible:	When is it to be done:	Where is it to be done:
The whole team	During our morning team meeting time for QI or case management work	Charting room

List the tasks needed to set up this test:

	Who:	When:	Where:
Create a report in EMR that shows clients without an active prescription	Cole	Before meeting	
Run report to see list of clients for review at meeting.	MOA	At start of meeting	
Run report to see proportion of clients with active prescription.	Cole	Before meeting and one week after meeting	
As team members commit to follow-up, tasks will be recorded in EMR as reminders.	MOA	During meeting	

Predict what will happen when the test is performed:

Follow-ups will result in MORE clients with active prescription when we check one week later.

We will be able to review the list within 45min.

Given the current opioid crisis conditions, team members will feel that this test is worthwhile.

List measures for assessing the predictions:

OUTCOME: Number of clients with active prescription

Time spent reviewing the list as a team

Number of tasks created based on commitments for follow-up

Qualitative feedback on how the meeting went and how we can improve it

Aims

Aim: By September 2020, we aim to increase our proportion of clients with OUD who have an active OAT or risk mitigation prescription from 45% to 80%.

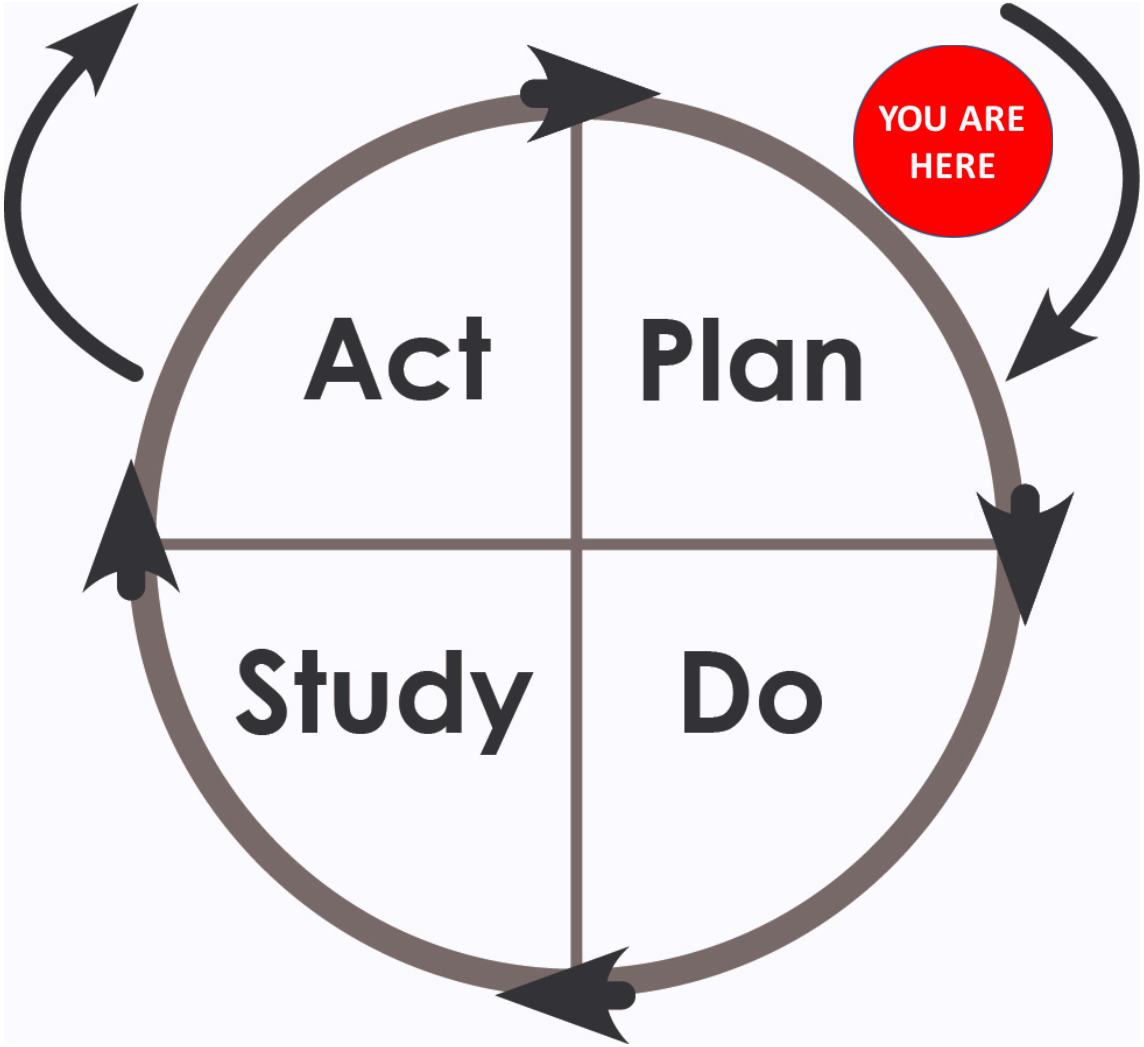
Measures

Outcome measure for this aim: Proportion with active prescription

Change Ideas

Describe your first (or next) test of change:

We will test having a morning OUD rounds with the team, where we rapidly review the list of clients with OUD but no active prescription. Team members will commit to follow-up actions with particular clients to complete over the week.


YOU ARE HERE
Act
Plan
Study
Do

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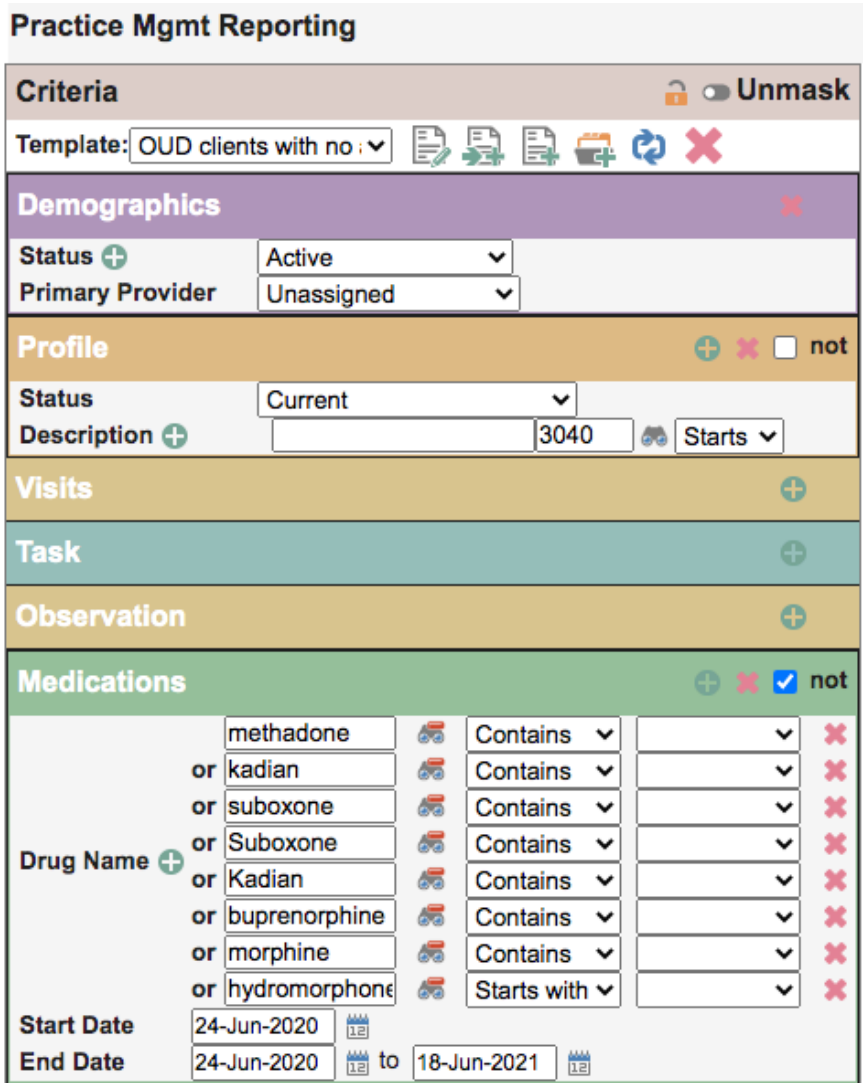
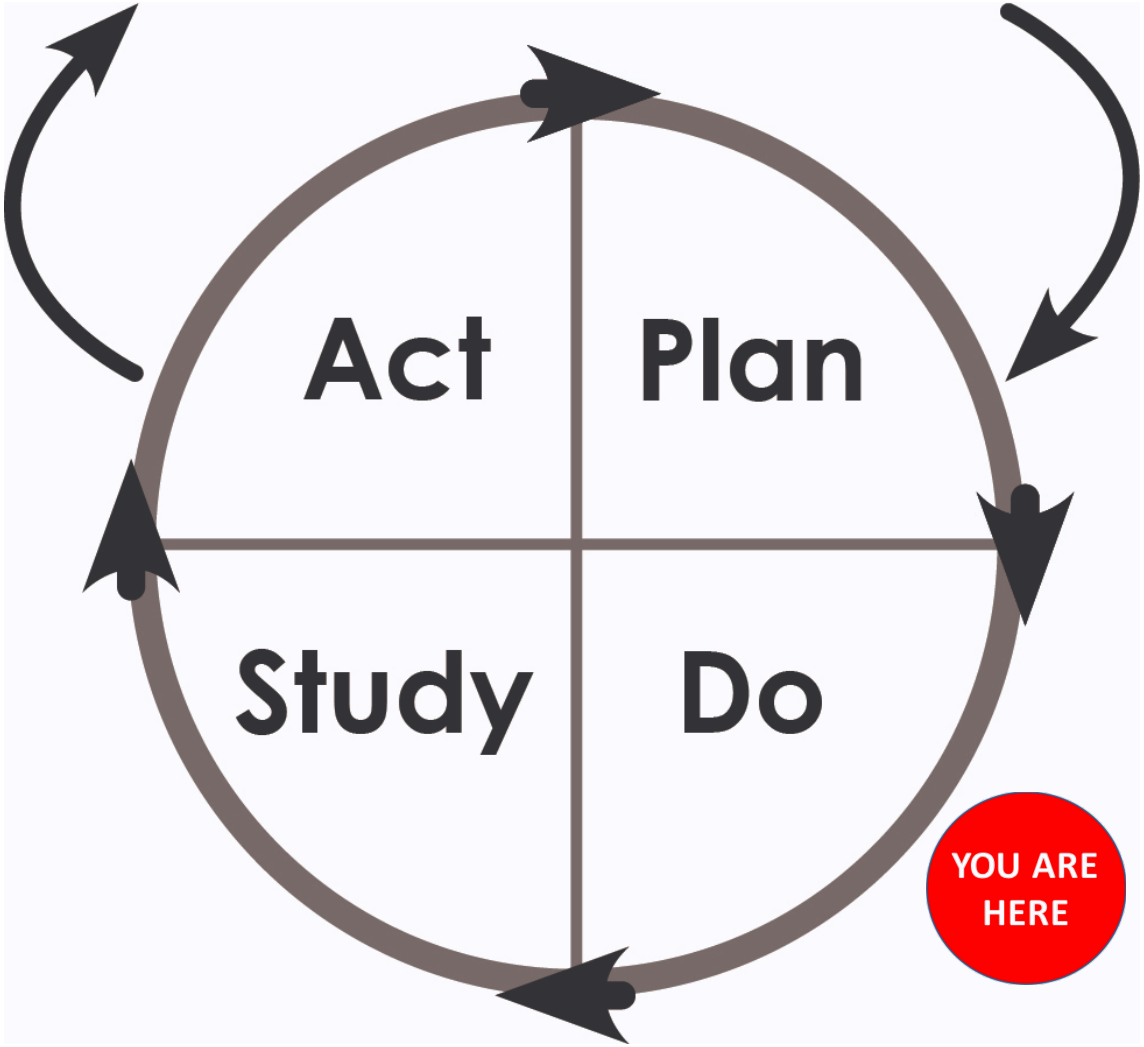

Practice Mgmt Reporting
Criteria
Unmask
Template: OUD clients with no
Demographics
Status
Active
Primary Provider
Unassigned
Profile
not
Status
Current
Description
3040
Starts
Visits
Task
Observation
Medications
not
Drug Name
methadone
Contains
or kadian
Contains
or suboxone
Contains
or Suboxone
Contains
or Kadian
Contains
or buprenorphine
Contains
or morphine
Contains
or hydromorphone
Starts with
Start Date
24-Jun-2020
End Date
24-Jun-2020
to
18-Jun-2021

Predict what will happen when the test is performed:	List measures for assessing the predictions:
Follow-ups will result in MORE clients with active prescription when we check one week later. We will be able to review the list within 45min. Given the current opioid crisis conditions, team members will feel that this test is worthwhile.	OUTCOME: Number of clients with active prescription Time spent reviewing the list as a team Number of tasks created based on commitments for follow-up Qualitative feedback on how the meeting went and how we can improve it

- Outcome
- Process
- Balancing

Why measure at all?


Act
Plan
Study
Do
YOU ARE HERE

Do

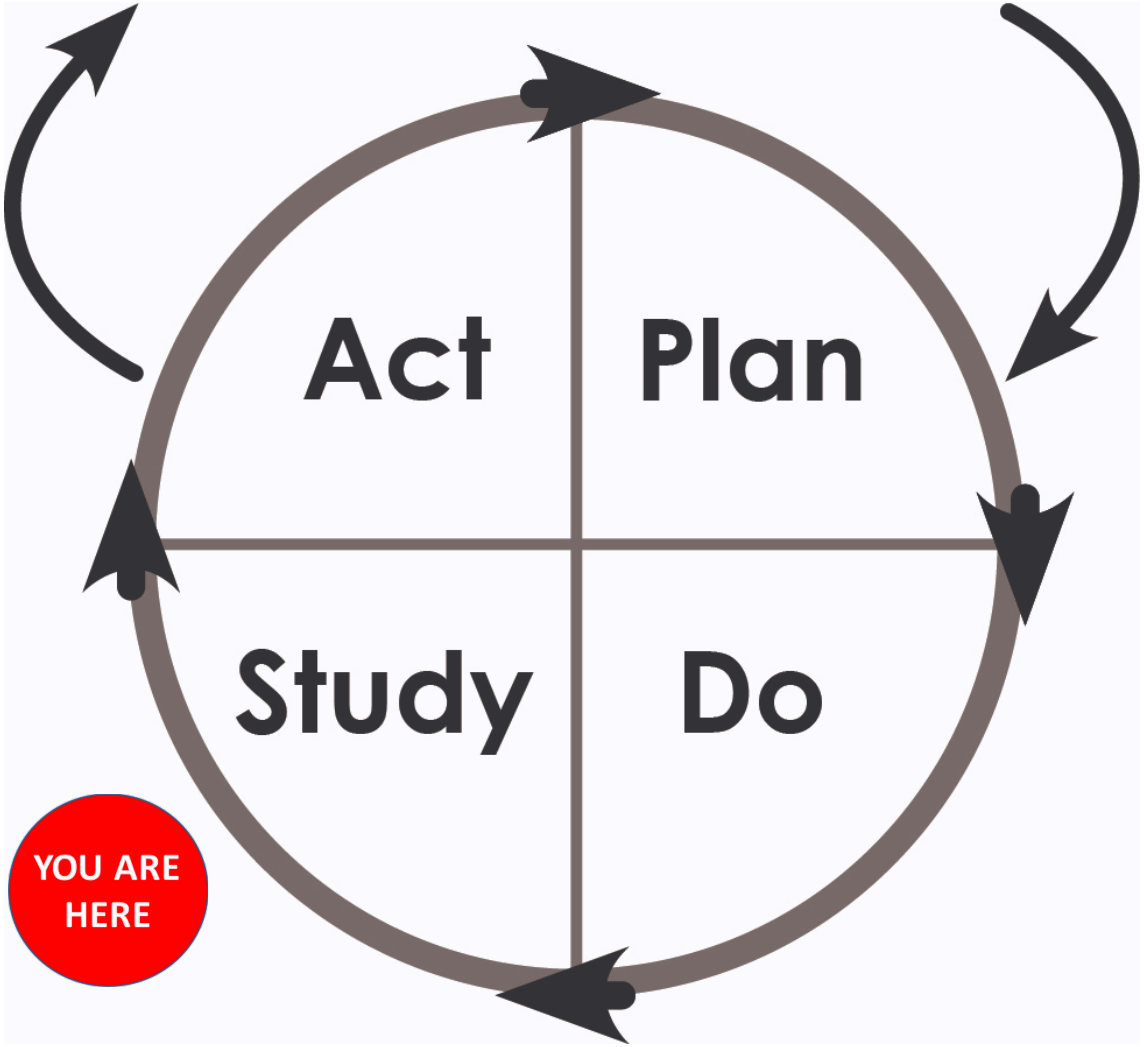
Describe what actually happened when you ran the test:

Got through almost the entire list - about 4 people left to review at end of our 45min time slot

Some difficulty avoiding detailed review of complex clients, which slowed down the process

Some clients were disengaging from care and we didn't have adequate contact info to get in touch.

Many clients were connected to Overdose Outreach Team.


Act
Plan
Study
Do
YOU ARE HERE

Study

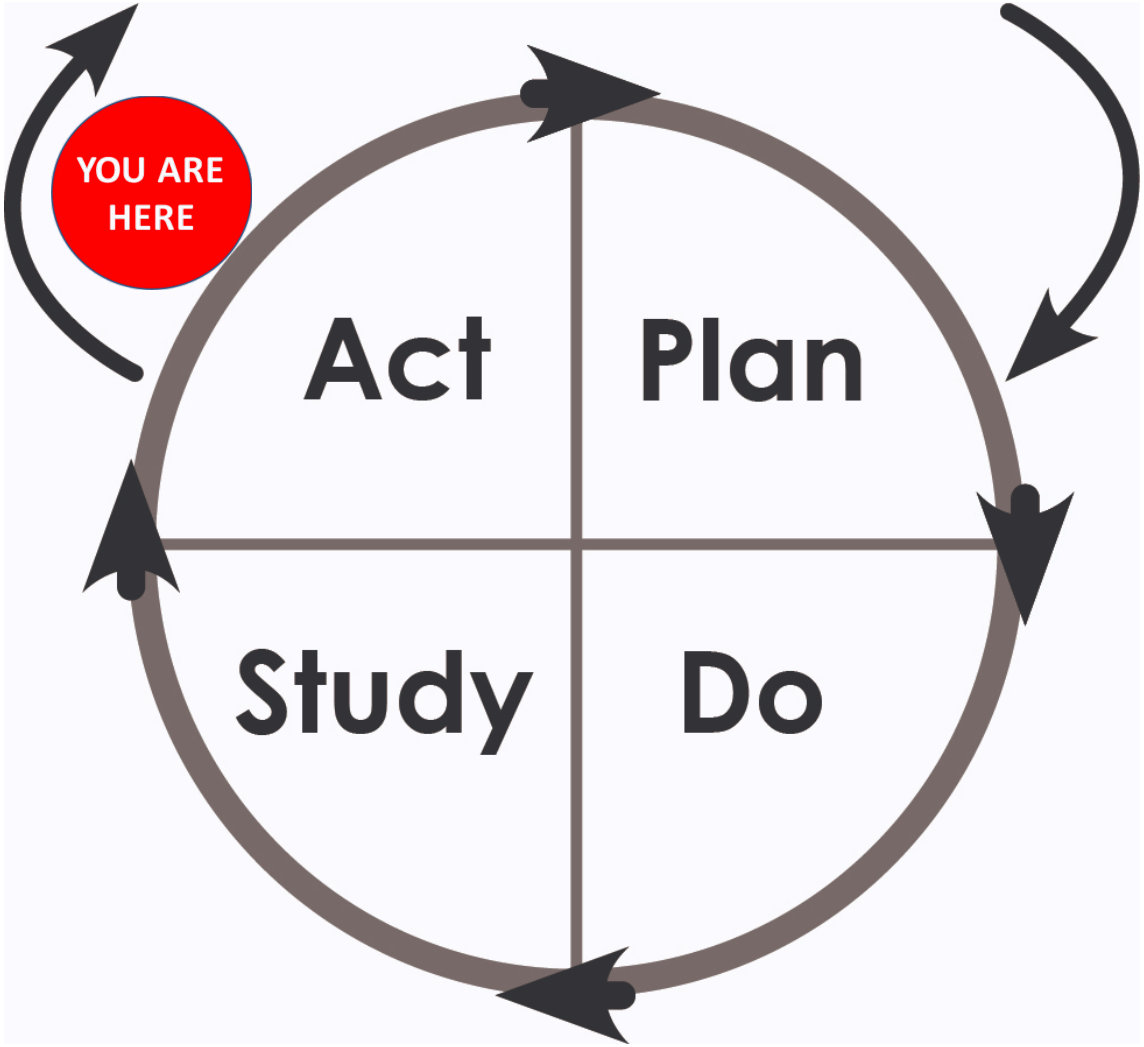
Describe the measured results and how they compared to the predictions:

We increased our proportion with an active prescription as predicted (went from 45% to 50%).

We didn't get through the entire list in the time alloted, but were close.

We estimate that about 15 EMR tasks were created, but didn't formally count.

The team thought it was a good use of our morning meeting time.


YOU ARE HERE
Act
Plan
Study
Do

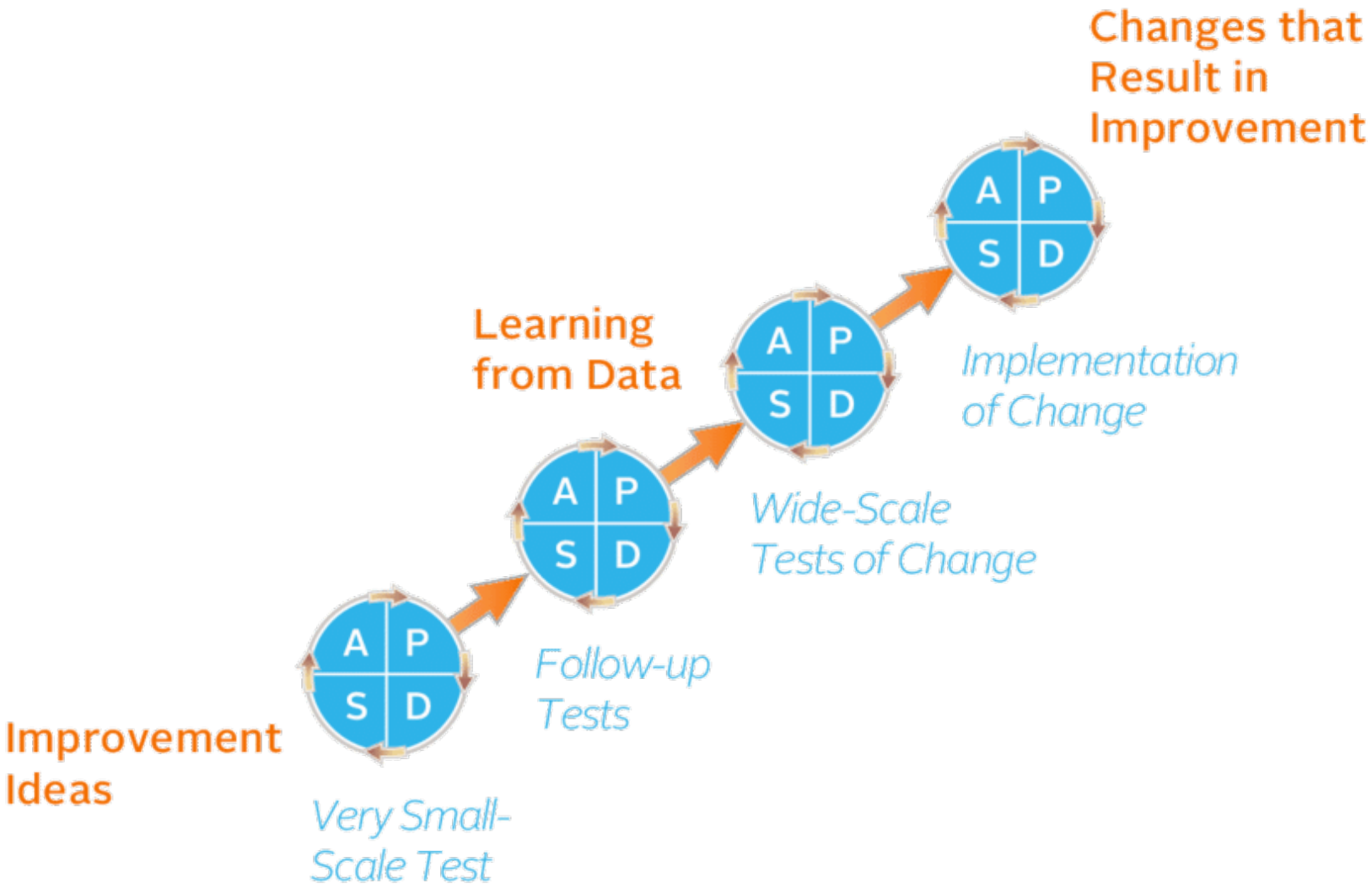
Act

Describe what modifications to the plan you'll make for the next cycle, based on what you learned:

Some success, so ADAPT

Repeat the rounds the following week.
Test out a commitment sentence that is also recorded in EMR task: "I will follow-up with this client by doing this by this date."
Identify a timekeeper and facilitator to keep meeting on track.
Formally track the number of tasks.
Keep a list of clients who are connected to Overdose Outreach Team so they can be reviewed as a batch.

Think about separate QI work to improve our contact information, so we can re-engage clients more easily.


Changes that Result in Improvement
A P S D
Learning from Data
A P S D
Implementation of Change
A P S D
Wide-Scale Tests of Change
A P S D
Follow-up Tests
Improvement Ideas
Very Small-Scale Test

Imperial College London

HOME HONOURS AND MEMBERSHIPS **RESEARCH** PUBLICATIONS

DR JULIE E. REED

/// Faculty of Medicine, School of Public Health

Health Foundation Fellow

BMJ Quality & Safety Latest content Current issue

Home / Archive / Volume 28, Issue 5

Article Text

Article info

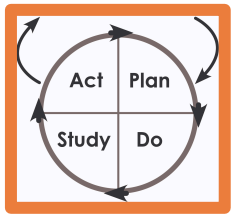
Original research

Evolving quality improvement support strategies to improve Plan–Do–Study–Act cycle fidelity: a retrospective mixed-methods study

Chris McNicholas[1, 2], Laura Lennox[1], Thomas Woodcock[1], Derek Bell[1], Julie E Reed[1]

Principle	Measure
Documentation	All PDSA cycle stages documented

"2% adhered to all six measures"



- Do the work

FOUNDRY

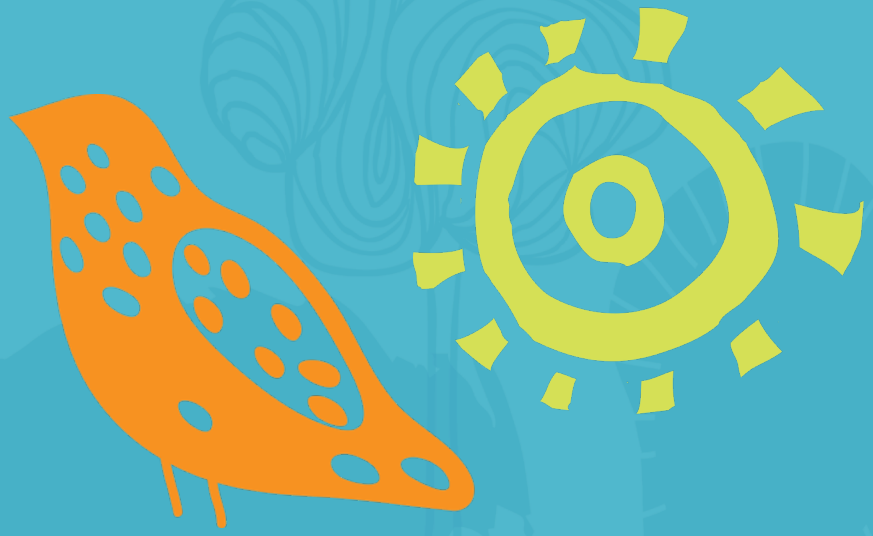
WHERE WELLNESS TAKES SHAPE

CARING FOR YOUTH WHO USE OPIOIDS DURING COVID-19

- KEREN MITCHELL, MN-NP(F)
- ADJUNCT PROFESSOR, UBC SCHOOL OF NURSING

- FOUNDRY VANCOUVER GRANVILLE
- PROVIDENCE HEALTH CARE

- JUNE 25, 2020



·FOUNDRY·
WHERE WELLNESS TAKES SHAPE

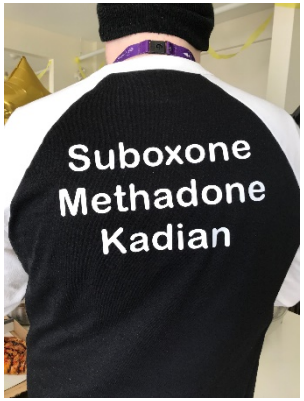
- *NO FINANCIAL DISCLOSURES OR CONFLICTS OF INTEREST*

- Foundry is a network of youth health and social service centres providing mental health, substance use, primary care and social services to young people ages 12-24.
- There are currently 8 Foundry centres open, and 11 more are under development across the province. (**foundrybc.ca**).
- Foundry Vancouver Granville (FVG) – Home to the Inner City Youth Program (ICY)
- ICY = Intensive Case Management Team (ICM) for high-risk youth ages 16-24 with moderate to severe mental health and/or SUD, and significant psychosocial barriers
- Common concerns include SUD, mood and anxiety disorders, psychosis, intellectual disabilities, trauma, and homelessness
- OAT available to youth ages 12-24 via the primary care team and/or via the "OATreach" program for high-risk youth who require outreach.

Background: OUD Care at Foundry

- 2015 – FVG opens. All oral OAT available via primary care.
- 2018 – OAT-reach begins with a Bupernorphine/Naloxone Microdose clinic, provided via street outreach and home visits. Clinic evolves to offer all oral OAT.
- 2019 – OATreach adds an in-reach OAT clinic at the St Helen's Hotel (BOOST project with COAST Mental Health)
- 2019 – Sublocade program begins
- 2019 – Partnership formed with BCCH

- **March 2020 - COVID-19 makes us rethink our strategy…**


Suboxone
Methadone
Kadian

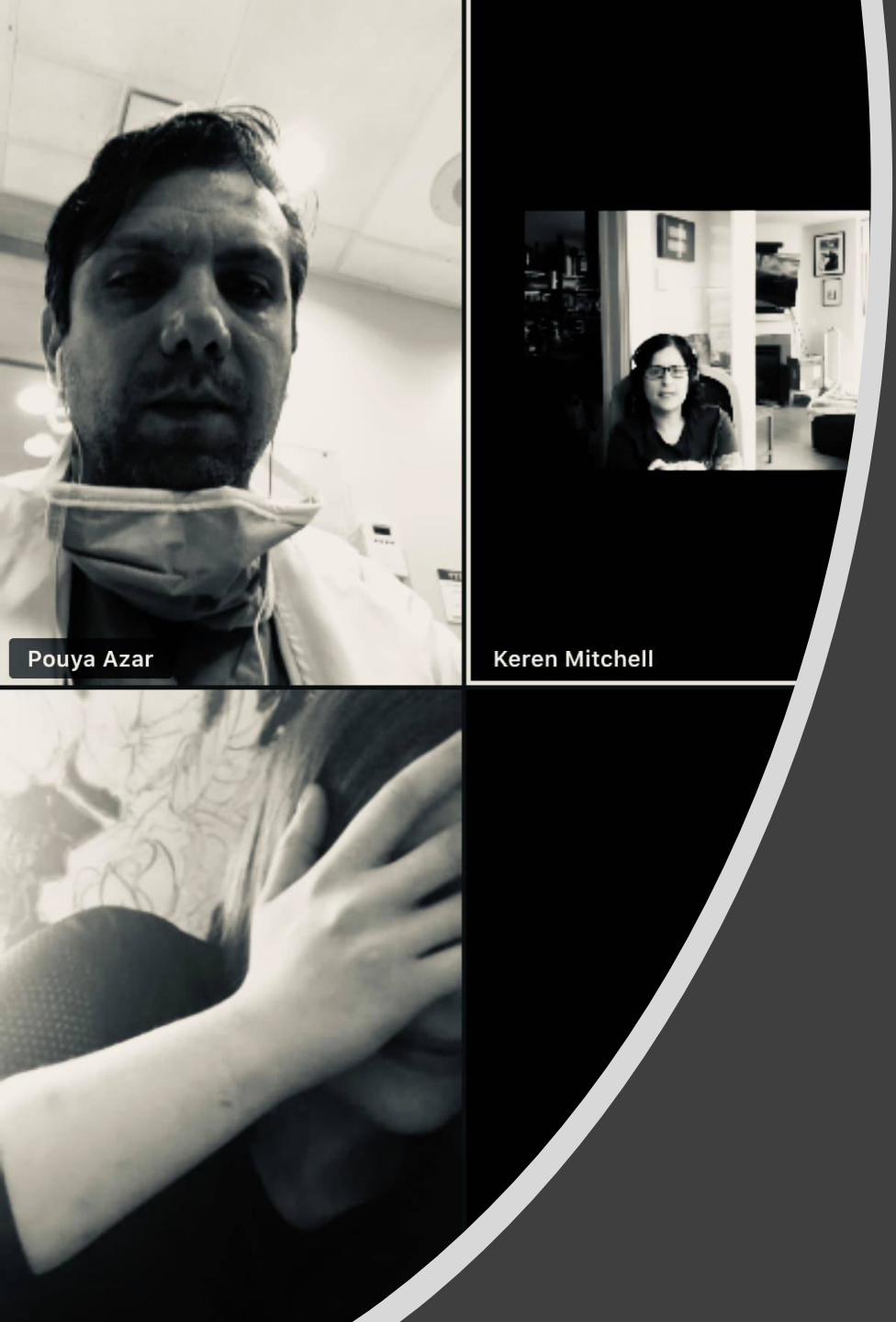
BOOST 2019 – "OAT-reach" clinic at the St Helen's Hotel

- Partnership with Foundry and Coast Mental Health
- Approx. 12 youth with OUD live at the St Helen's Hotel
- Problem:
  - Multiple overdoses, including some fatalities, and low numbers on OAT
- QI Project
  - Twice weekly OAT in-reach clinic run by social worker and NP, and supported by the BOOST Team partnership
  - Used door knocks and "reverse trick or treating"
  - Contingency management for 5/7 days on OAT and/or negative UDS

- **Post-COVID: Clinic goes virtual**

- **On-site social worker assists youth with Zoom, collects UDS, and continues to provide contingency management**

- **21% on OAT at the start of BOOST (January 2019)**
- **80% on OAT two weeks into pandemic (April 2020)**
- **73% on OAT and/or safer supply currently (June 2020)**



Post-COVID OUD Care at FVG

- “Pandemic Withdrawal Management” initiated in >20 youth (opioids and stimulants)
- Offer OAT and/or Safer Supply
- Zoom, FaceTime, phone, and text replaced prescriber outreach
- In-clinic visits reduced
- RNs and outreach workers assist with telehealth
- Youth attend clinic for Sublocade
- No fatalities

Harm Reduction During COVID-19

- Frequent hand washing, especially before eating, or before using or preparing drugs
- Prepare substances yourself
- Disinfect surfaces where drugs are prepared
- Do not share pipes, smokes
- Carry naloxone
- Check your drugs
- Do not use alone – use SCS or the buddy system. Can sit 2 metres apart
- Have a contingency plan for getting drugs and supplies if quarantined

3 Months Post-Covid (June 2020)

Challenges

- Some youth find it difficult to engage with telehealth
- Some youth lack technology for telehealth
  - Plans to install tablets in SROs
- Limited guidelines and experience with PWM
- Ethical concerns with PWM
- Unknown future for Safer Supply

Benefits

- Some youth prefer telehealth
- Addiction psychiatry consults in real time using Zoom
- Increased ability to see younger adolescents
- Ability to see youth outside of downtown catchment
- ***Safer supply***

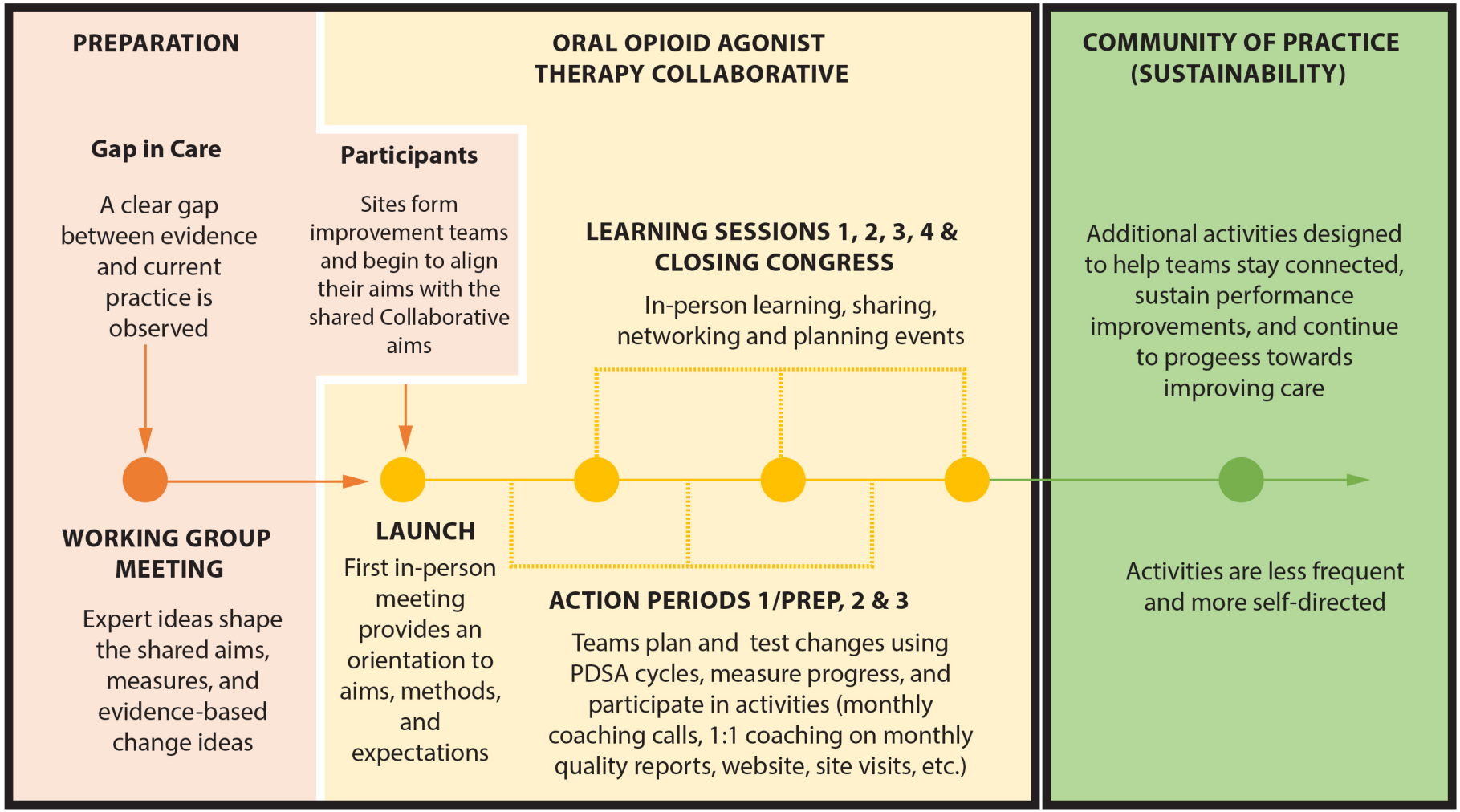

FOUNDRY
WHERE WELLNESS TAKES SHAPE

BOOST
Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

BOOST QI Network Overview

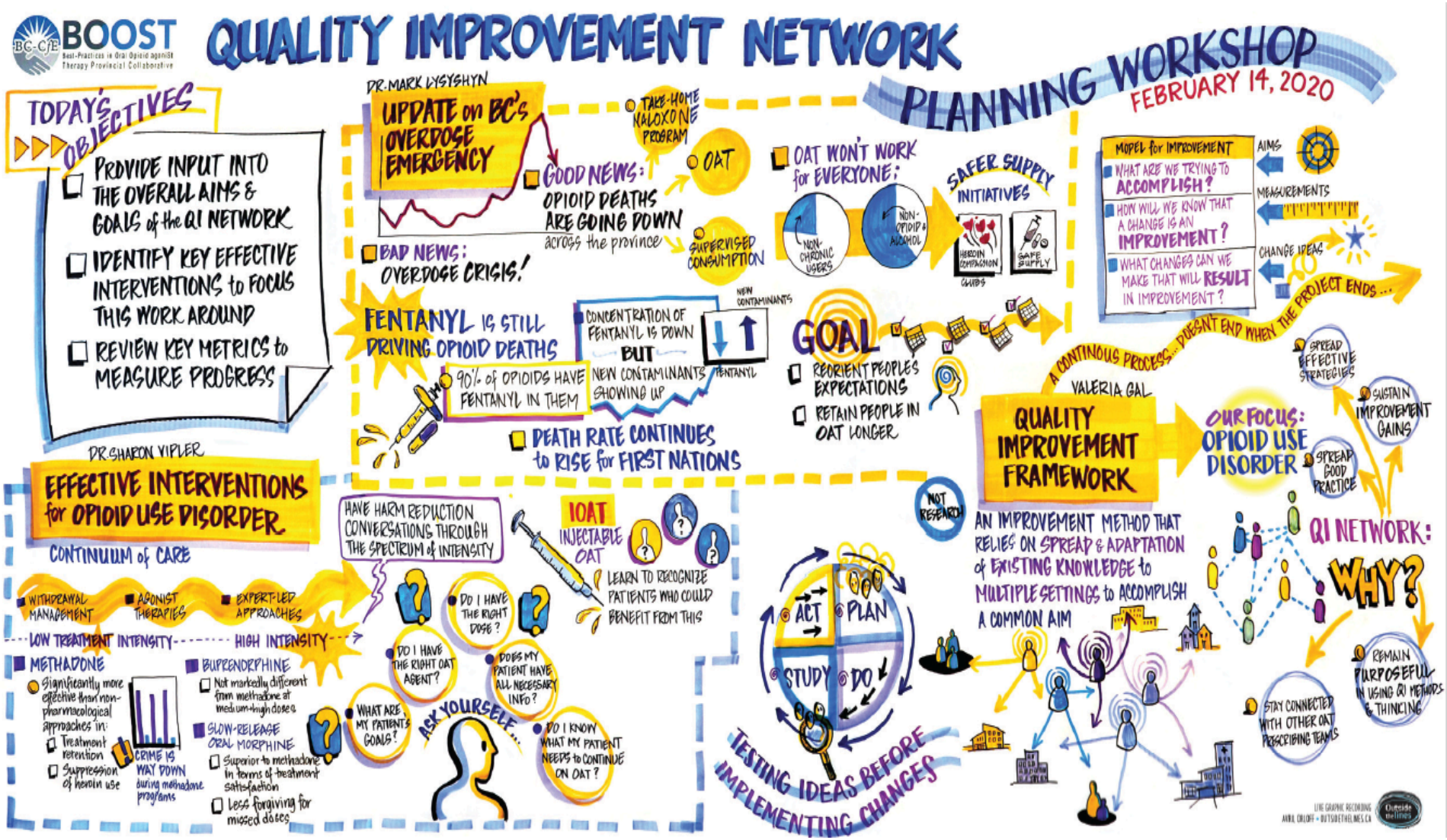
Valeria Gal
Project Lead - QI & Practice Support, BC Centre for Excellence in HIV/AIDS

BOOST QI Network Overview



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

BOOST QI Network Planning



BOOST QI Network Focus

- Similar to the BOOST Collaboratives, but less intense
- Mainly virtual
- Aims to:
  - Sustain the progress made by teams during the BOOST Collaboratives
  - Maintain the community of practice formed over the past few years

BOOST QI Network Activities

Consists of:

- 6 Educational Webinars
- 2 Learning Sessions (virtual or in-person)
- Quarterly team reporting and individualized feedback reports
- Action periods – actively testing and implementing changes
- Continued QI coaching
- Continued management of the BOOST listserv

QI Network Timeline

Proposed Timeline of Events

Reporting Schedule

Next Steps

"EVERY SYSTEM IS PERFECTLY DESIGNED TO GET THE RESULTS IT GETS"

-Paul B. Batalden, MD
Co-Founder of The Institute for Healthcare Improvement (IHI)

Link in Chat

BOOST
Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

Questions & Discussion

BOOST

Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

THANK YOU!

Please stay on for a QI Network Q&A period

CONTACT US: boostcollaborative@cfenet.ubc.ca

VISIT THE WEBSITE: http://www.stophivaids.ca/oud-collaborative