BOOST

Best-Practices in Oral Opioid agoniSt Therapy Provincial Collaborative

Welcome

to the

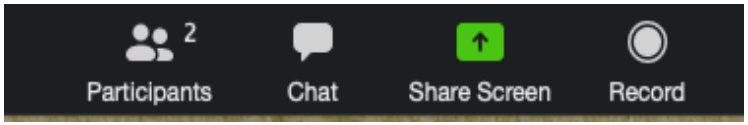
BOOST QI Network Educational Webinar 2

Please type your name, team name and location in the chat

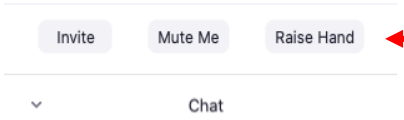
Tuesday, September 29th, 2020

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

ZOOM Control Panel

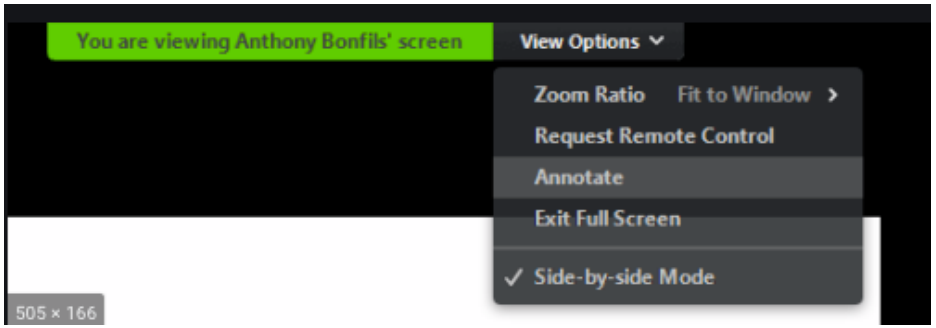


Chat or ask questions using the chat function



Use the “raise hand” feature to notify the host that you would like to be unmuted

Click “participants” and “raise hand” on the right-hand side of the screen



Click to use annotation tools

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

- Review OAT treatment options in the context of pandemic prescribing
- Discuss harm reductions strategies within a QI framework
- Explore the client and family perspectives on OUD
- Learn about the QI Network team reporting process and platform

Agenda

Time		Topic	Speaker
8:30	10 mins	Welcome	Valeria Gal
8:40	15 mins	Update on OAT treatment options and pandemic prescribing	Sharon Vipler
8:55	25 mins	A QI approach to harm reduction (interactive activity)	Cole Stanley
9:20	10 mins	The client/family perspective	Cole Stanley
9:30	15 mins	Team reporting overview	Cole Stanley, Angie Semple
9:45	15 mins	General Q&A	All

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How are you participating in the BOOST QI Network? (POLL)

As part of a team

On my own

Want to participate but haven't enrolled

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OAT treatment options and pandemic prescribing

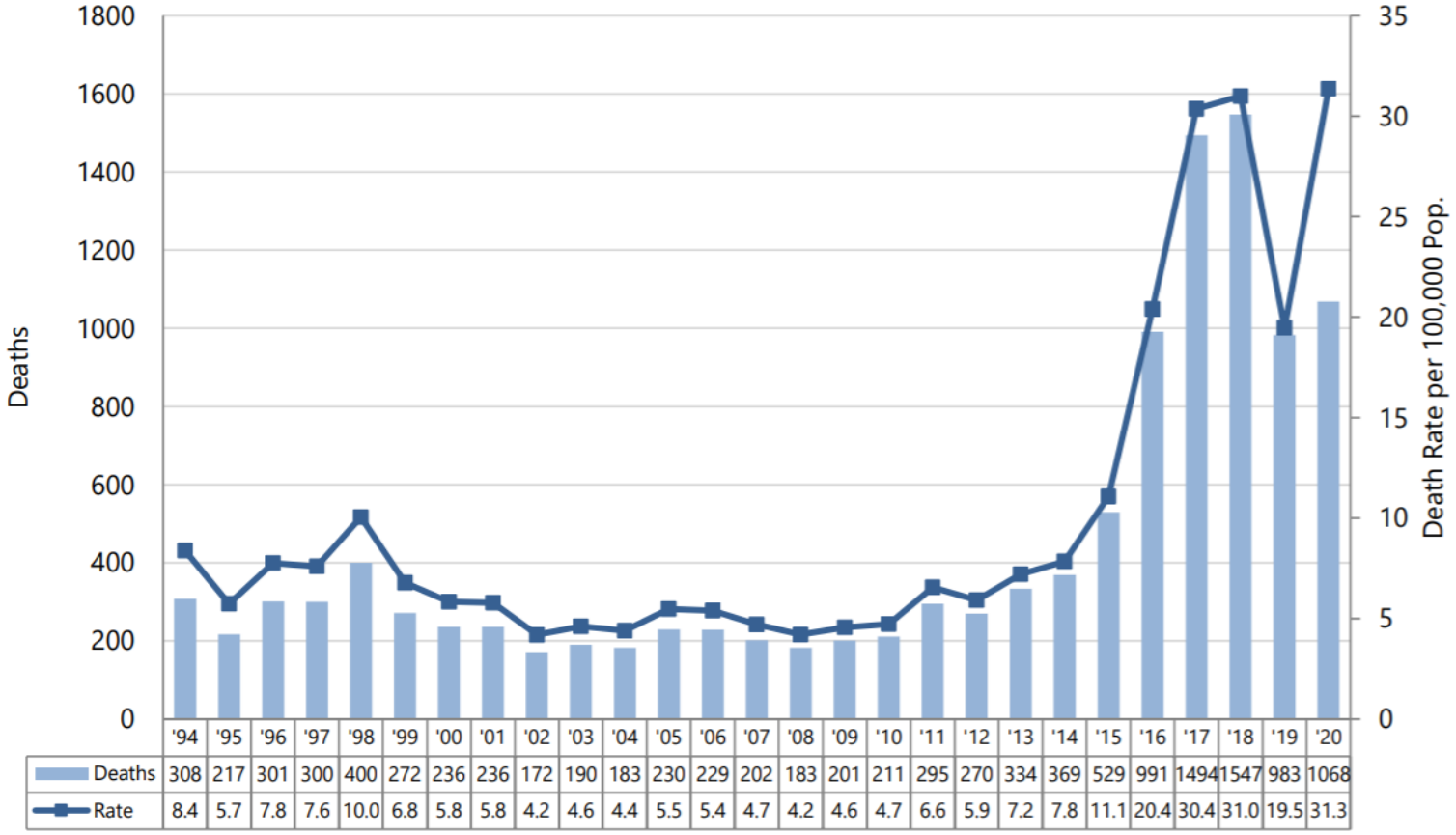
Sharon Vipler

BOOST QI Network Webinar

Tuesday 29 September 2020

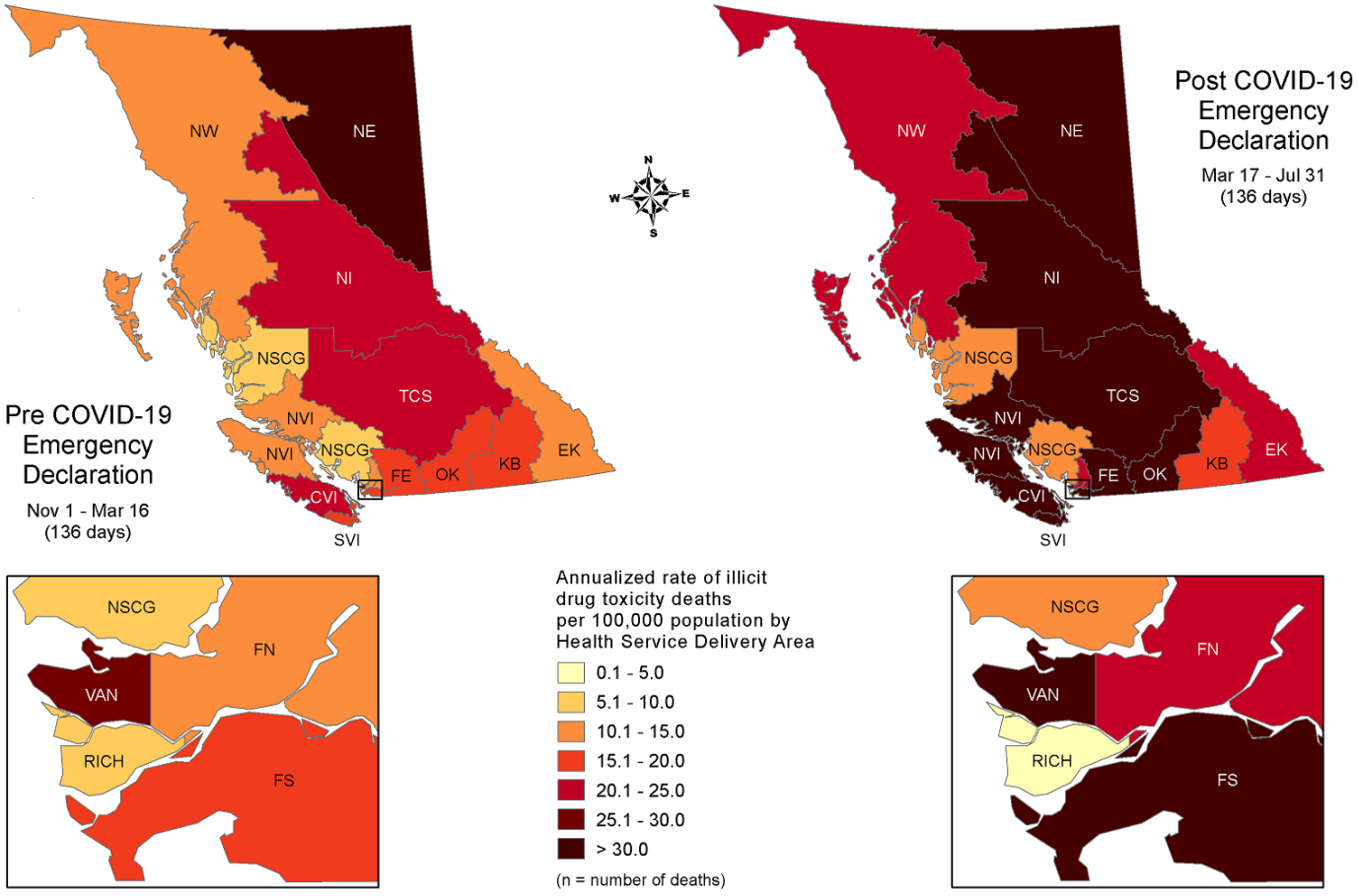
Sharon Vipler, MD, CCFP (AM), dipl.ABAM

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	1494	1547	983	1068
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	19.5	31.3

Illicit Drug Toxicity Deaths: Pre vs Post COVID-19 Emergency Declaration



Data from BC Coroners Service. Map created September 1, 2020 by BC Centre for Disease Control.

AUTHORIZED FOR PUBLIC RELEASE

FIRST NATIONS PEOPLE ARE DISPROPORTIONATELY REPRESENTED IN OVERDOSE DEATHS

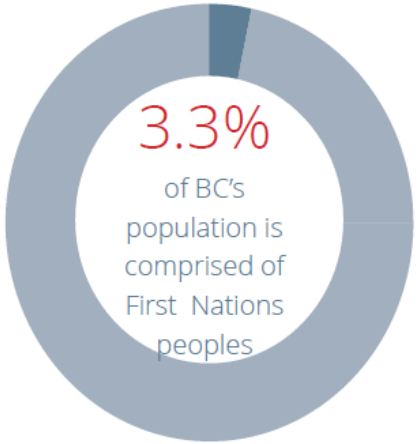
First Nations Health Authority
Health through wellness

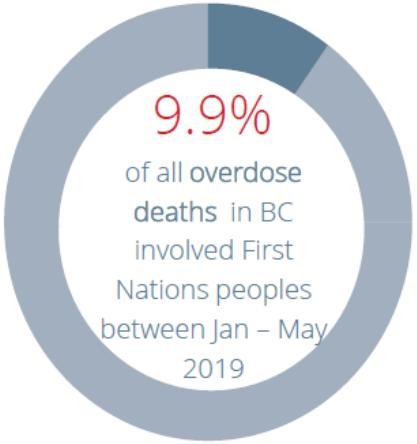
16%

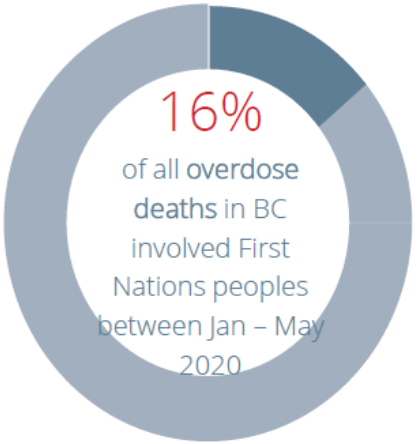
of all overdose deaths between January and May 2020 are First Nations people. This number was 9.9 per cent in 2019. First Nations represent only 3.3 per cent of the province's population.

First Nations people continue to be disproportionately impacted by overdose

First Nations Health Authority
Health through wellness







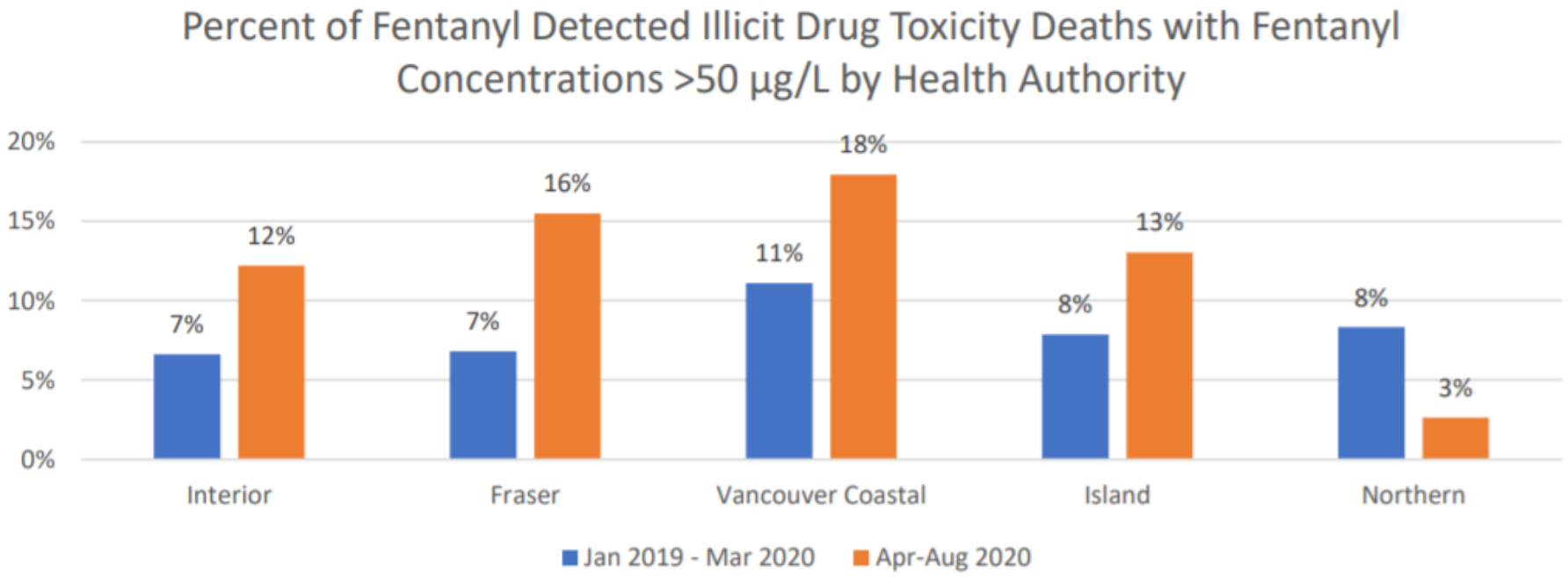
First Nations experienced overdose deaths **3.8X** more than other residents in 2019 (Jan – Dec)

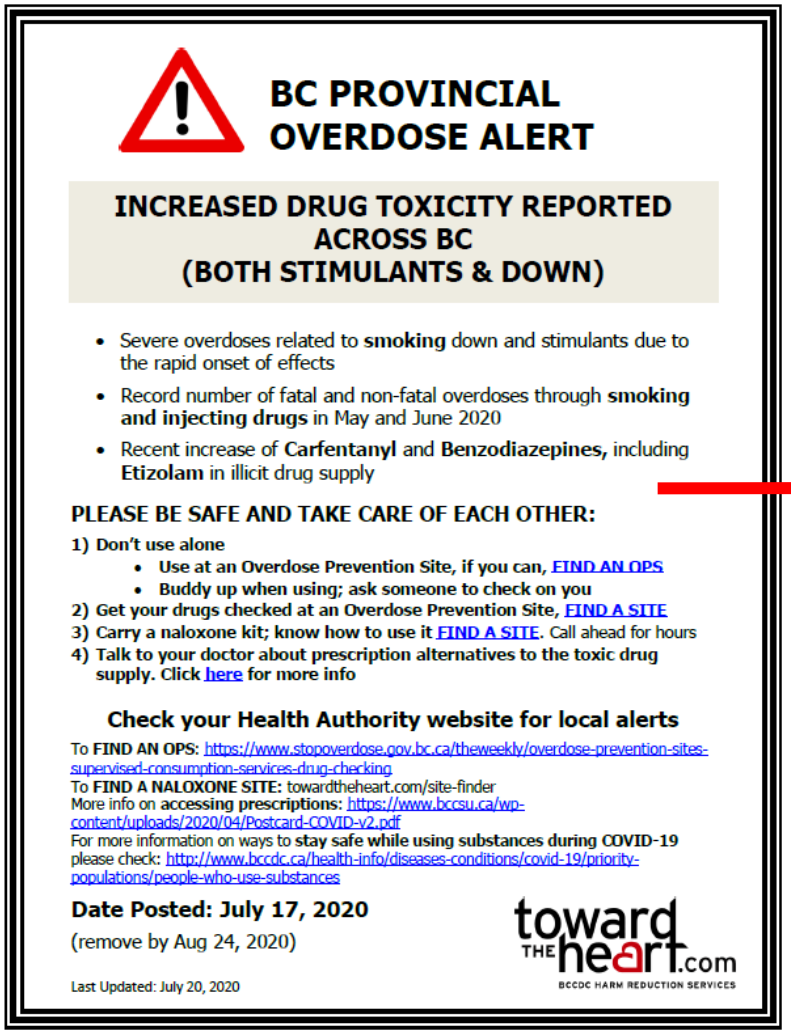
First Nations have experienced overdose deaths **5.6X** more than other BC residents between Jan – May 2020

The gap between First Nations and Other BC residents is widening in 2020.

WHY?

Increased Fentanyl Potency





BC PROVINCIAL OVERDOSE ALERT

INCREASED DRUG TOXICITY REPORTED ACROSS BC (BOTH STIMULANTS & DOWN)

- Severe overdoses related to **smoking** down and stimulants due to the rapid onset of effects
- Record number of fatal and non-fatal overdoses through **smoking and injecting drugs** in May and June 2020
- Recent increase of **Carfentanyl** and **Benzodiazepines,** including **Etizolam** in illicit drug supply

PLEASE BE SAFE AND TAKE CARE OF EACH OTHER:

1) **Don't use alone**
   - **Use at an Overdose Prevention Site, if you can, FIND AN OPS**
   - **Buddy up when using; ask someone to check on you**
2) **Get your drugs checked at an Overdose Prevention Site, FIND A SITE**
3) **Carry a naloxone kit; know how to use it FIND A SITE.** Call ahead for hours
4) **Talk to your doctor about prescription alternatives to the toxic drug supply. Click here for more info**

Check your Health Authority website for local alerts

To **FIND AN OPS:** https://www.stopoverdose.gov.bc.ca/theweekly/overdose-prevention-sites-supervised-consumption-services-drug-checking
To **FIND A NALOXONE SITE:** towardtheheart.com/site-finder
More info on **accessing prescriptions:** https://www.bccsu.ca/wp-content/uploads/2020/04/Postcard-COVID-v2.pdf
For more information on ways to **stay safe while using substances during COVID-19** please check: http://www.bccdc.ca/health-info/diseases-conditions/covid-19/priority-populations/people-who-use-substances

Date Posted: July 17, 2020
(remove by Aug 24, 2020)

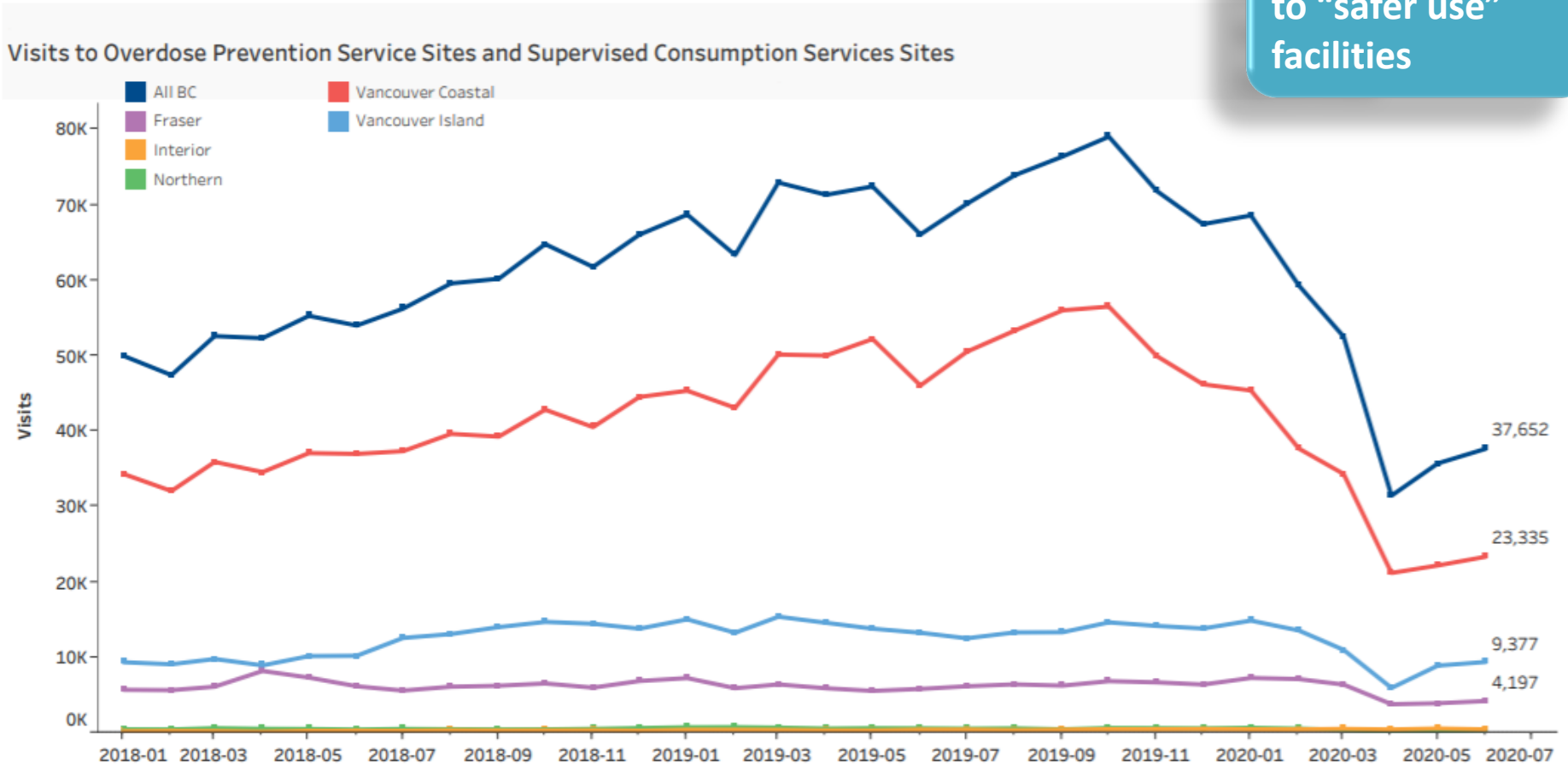
Last Updated: July 20, 2020

toward THE heart.com
BCCDC HARM REDUCTION SERVICES

Increased Contamination

Recent increase of **Carfentanyl** and **Benzodiazepines**, including **Etizolam** in illicit drug supply

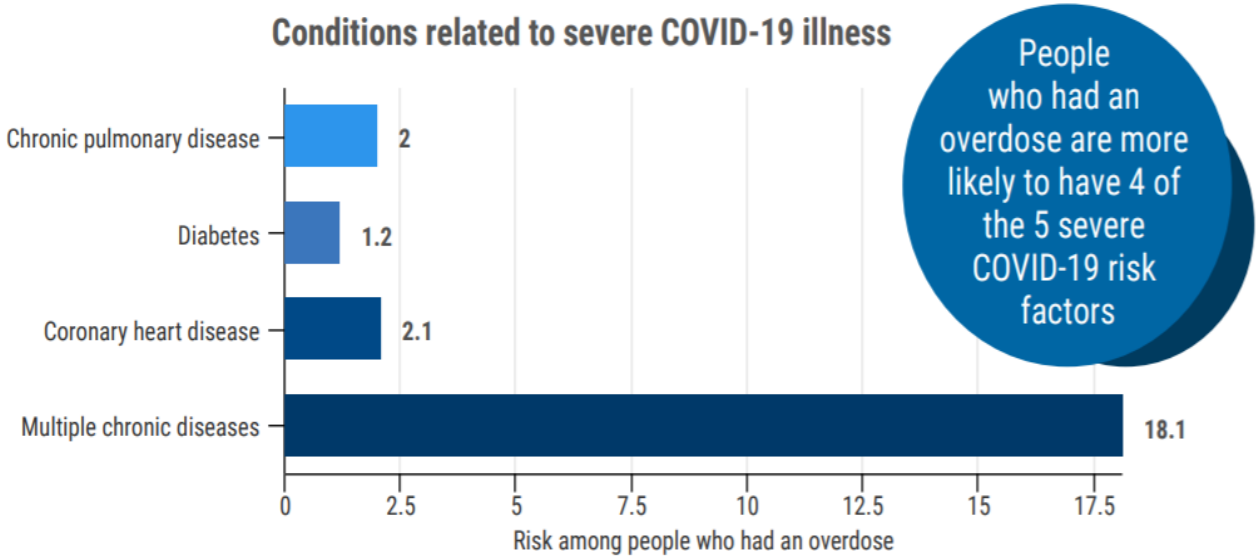
Decreased access to “safer use” facilities



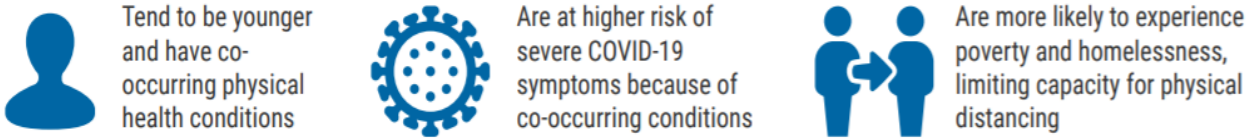
People who had an overdose are more likely to experience competing risk of both the overdose crisis and COVID-19 pandemic.

The increased likelihood of having COVID-19 risk factors is reflective of the social and health inequities experienced by people with a history of overdose.

The risk of overdose is higher when using substances alone (versus with others or in supervised settings) and access to safer environments to use substances has decreased during COVID-19.



Compared to the general population, people who had an overdose:



http://www.bccdc.ca/resource-gallery

RISK MITIGATION

IN THE CONTEXT OF DUAL PUBLIC HEALTH EMERGENCIES

Interim Clinical Guidance

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

OAT and Pandemic Prescribing

(aka Pharmaceutical Alternatives)

- Who?
  ? As a tool to uptitrate OAT
  ? In addition to OAT
  ? Tool to assist traditional SBX inductions
  ? No OAT, just pandemic prescribing
  ? no OAT, no OUD, sporadic use
- How will you (your clinic) decide?
- How will you adhere to your decisions?
- How will you measure?

the end

quick reminder from our last webinar

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.

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A QI approach to harm reduction

Cole Stanley

QI Rapid Refresher

Harm Reduction edition

Cole Stanley, MD, CCFP

Medical Lead, QI, VCH Community

Family Physician

Sep 29, 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**

#qualityimprovement ☆

1 | Add a topic

Friday, July 17th

Cole 10:47 AM

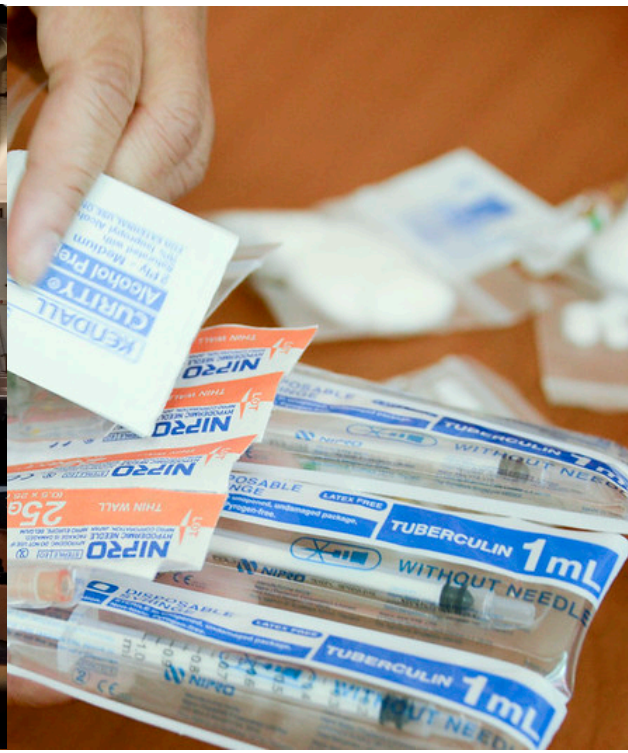
Debrief from yesterday - another patient death, likely overdose

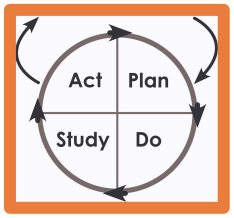
We discussed stories of contaminated drug supply in clients we have seen, MANY examples of this

Also discussed what we could do more of in context of ongoing opioid crisis

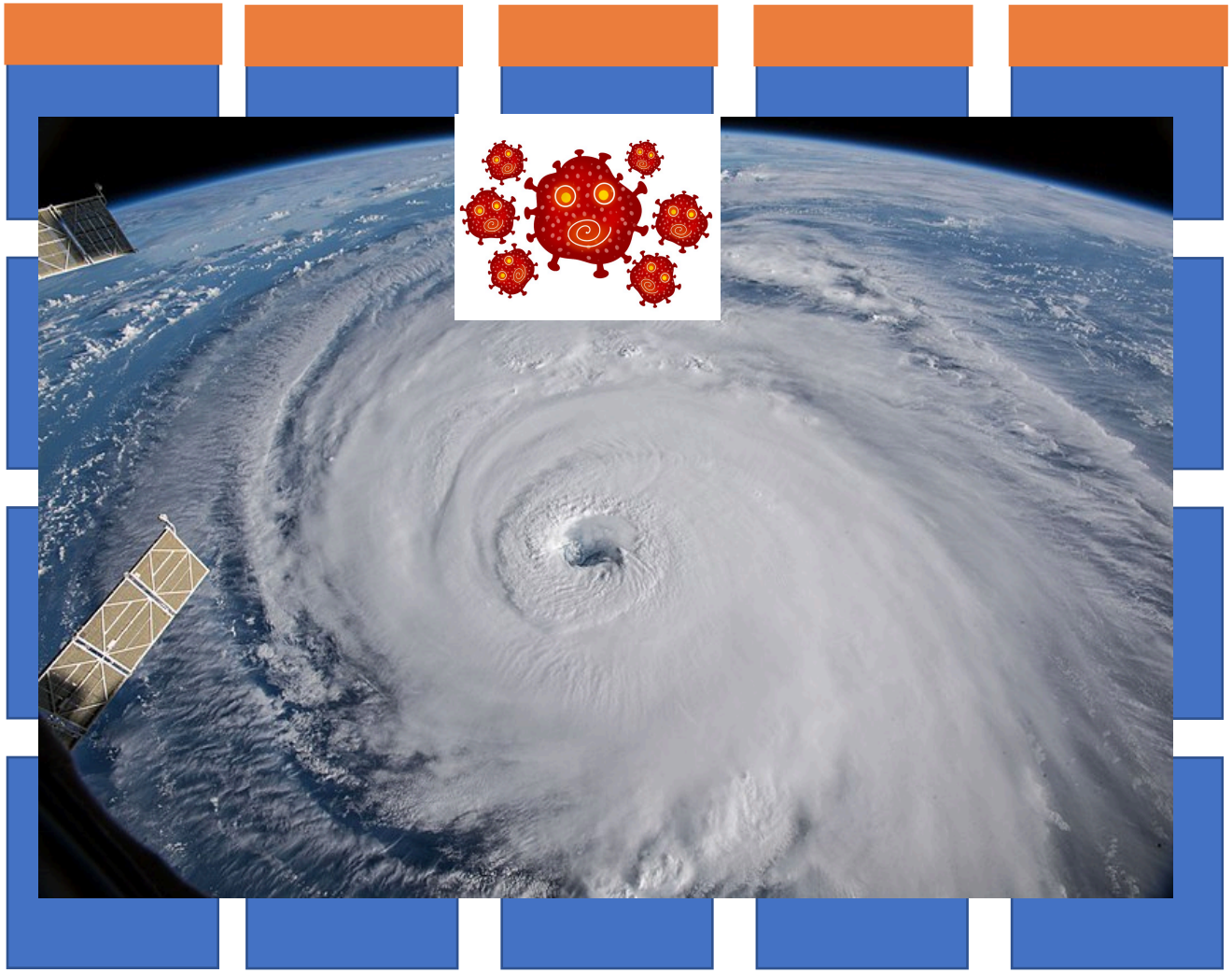
Hope2HealthClinic

- medicalqi-archived
- # medicaltriage
- # meetings
- # mentalhealth
- # moa
- physician
- psychosocialqi
- # psycosocialtriage
- # qualityimprovement





- Do the work



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.

SOME DEFINITIONS

1 **Collecting data or developing a change**

Don’t have an idea (theory) to test yet.

We’re learning about the system.

2 **Testing**

Trying/adapting existing knowledge on small scale.

Learning what works in your system.

3 **Implementing**

Making this change a part of day-to-day operation of system in your pilot population.

4 **Spreading**

Adapting change to areas or populations other than your pilot populations.

DEVELOPING CHANGES

Don’t do it all by yourself!

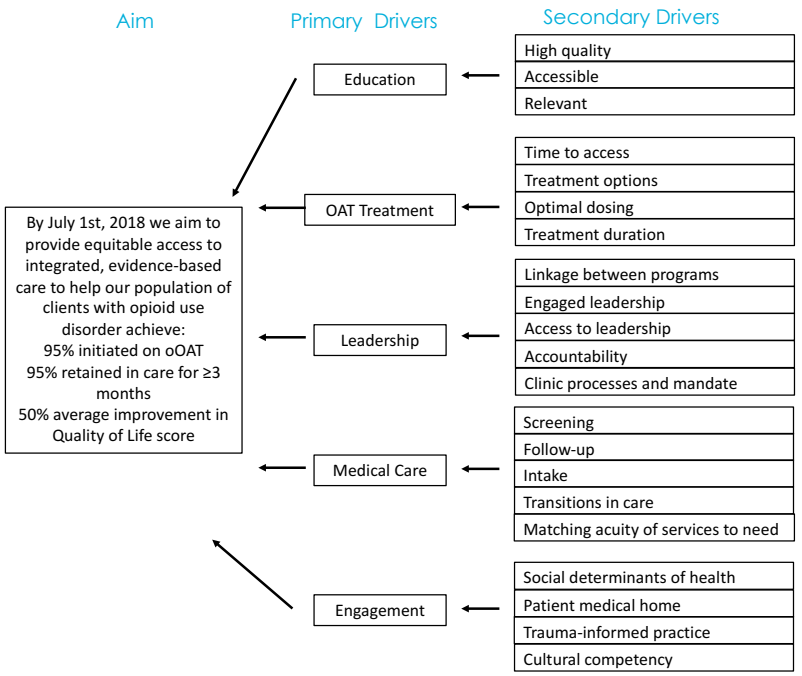
- Team approach (end user, patient voice, EMR developers, etc.)
- Creative thinking

DEVELOPING CHANGES

2

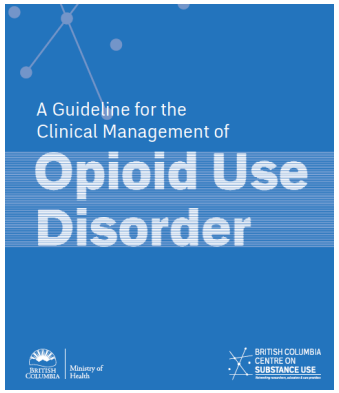
- Driver diagrams

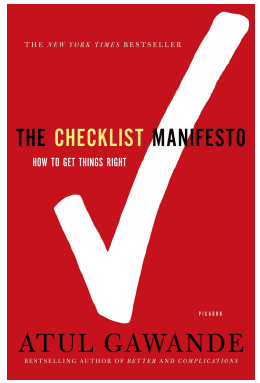
Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative



DEVELOPING CHANGES

- The 5 Whys
- Best practices / guidelines
- Benchmarking
- Lessons from other industries (e.g. aviation)





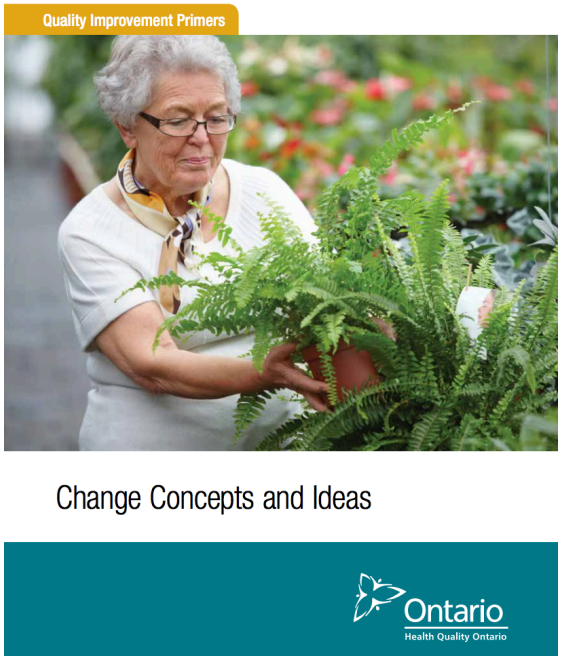
DEVELOPING CHANGES

- Quality Improvement Literature
- IHI programs (storyboards, abstracts, Collaboratives, etc.)
- Change Packages (from Collaboratives)
- 72 Change Ideas

BMJ Journals

DEVELOPING CHANGES

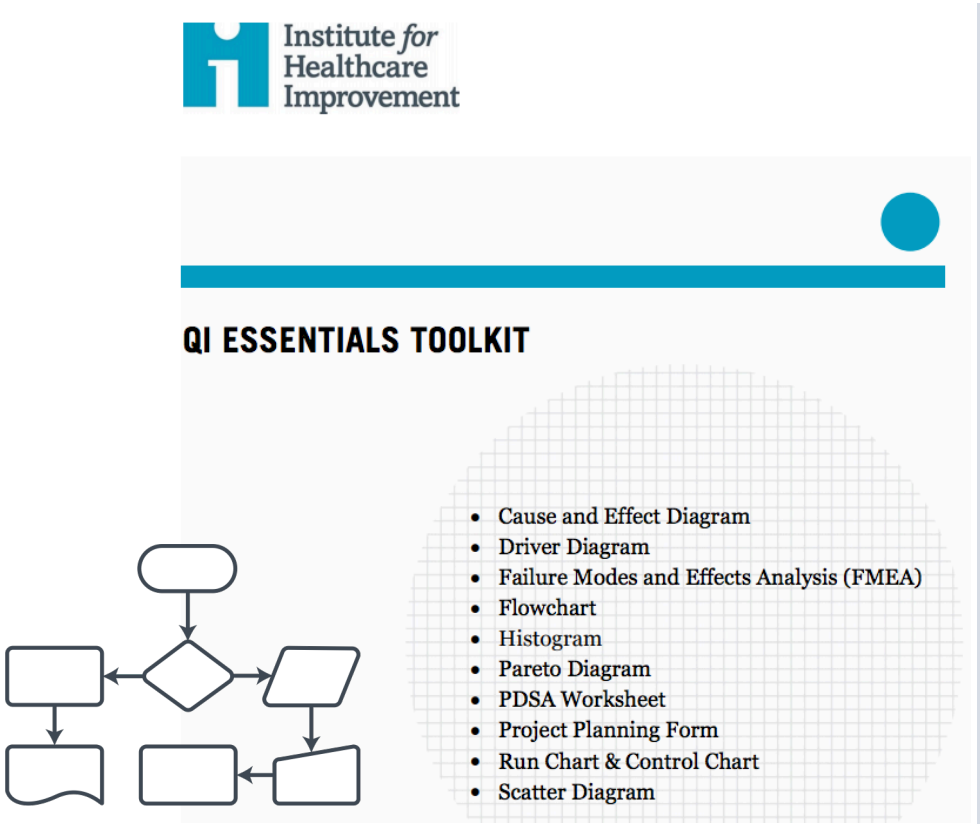
Change Concept	Change Idea
Manage Variation	Standardization (create a formal process)
Eliminate Waste	Remove number of steps to complete the process
Improve Workflow	Adjust to peak demand
Enhance the producer/customer relationship	Listen to customers
Manage Time	Reduce wait time



Source: "Change Concepts and Ideas" (2013) *Health Quality Ontario*, http://www.hqontario.ca/Portals/0/Documents/qi/qi-change-concepts-and-ideas-primer-en.pdf

DEVELOPING CHANGES

- Process Mapping
- QI essentials toolkit from IHI



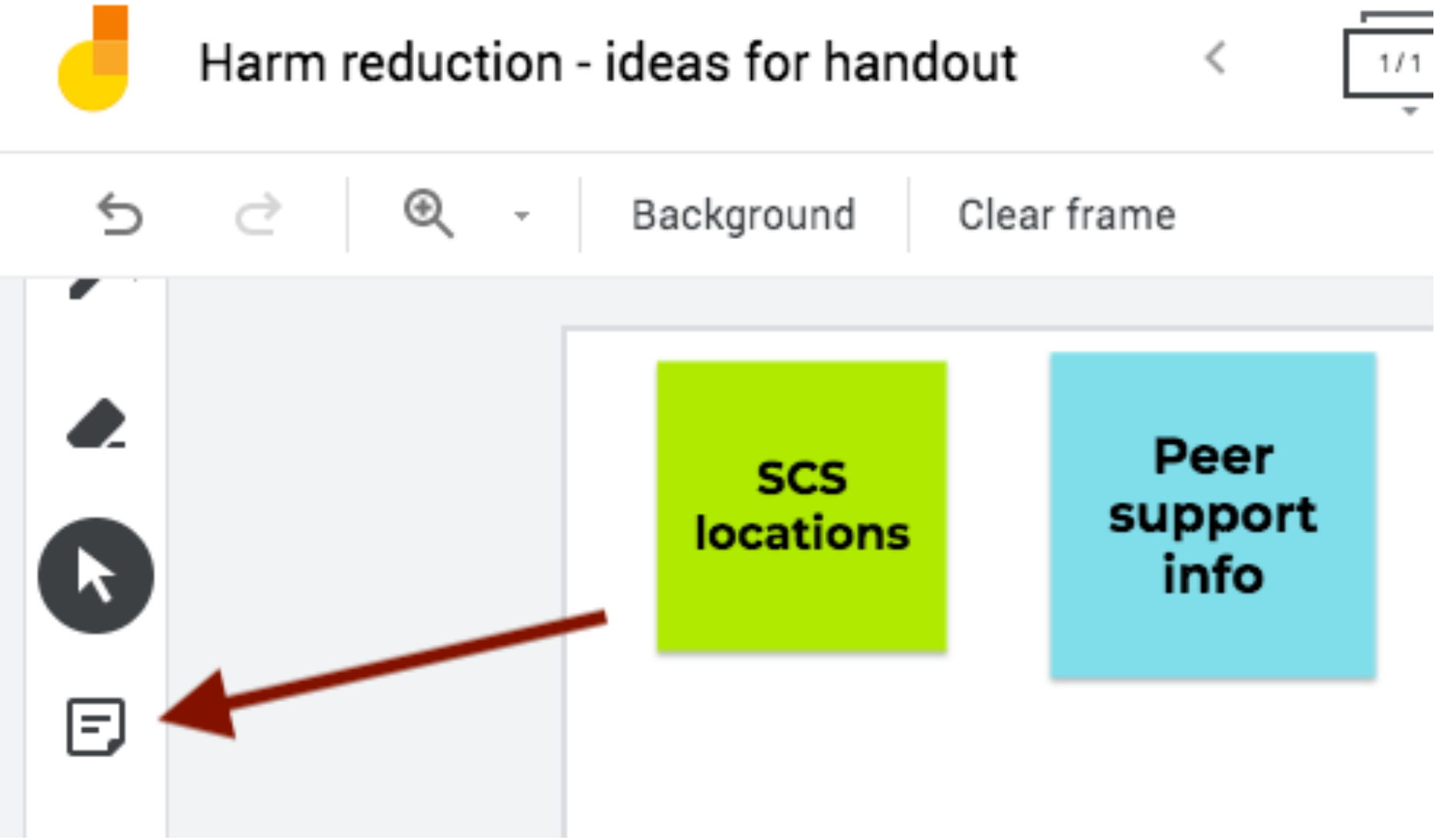
DEVELOPING CHANGES

1 "**Make a list** of all you can do to make sure that you achieve the worst result imaginable with respect to your top strategy or objective."

2 "Go down this list item by item and **ask yourselves**, 'Is there anything that we are currently doing that in any way, shape, or form resembles this item?' Be brutally honest to make a second list of all your counterproductive activities/programs/procedures."

3 "Go through the items on your second list and **decide** what first steps will help you stop what you know creates undesirable results?"

Source: "TRIZ," *Liberating Structures*, http://www.liberatingstructures.com/


Harm reduction - ideas for handout
1 / 1
Background
Clear frame
SCS locations
Peer support info

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

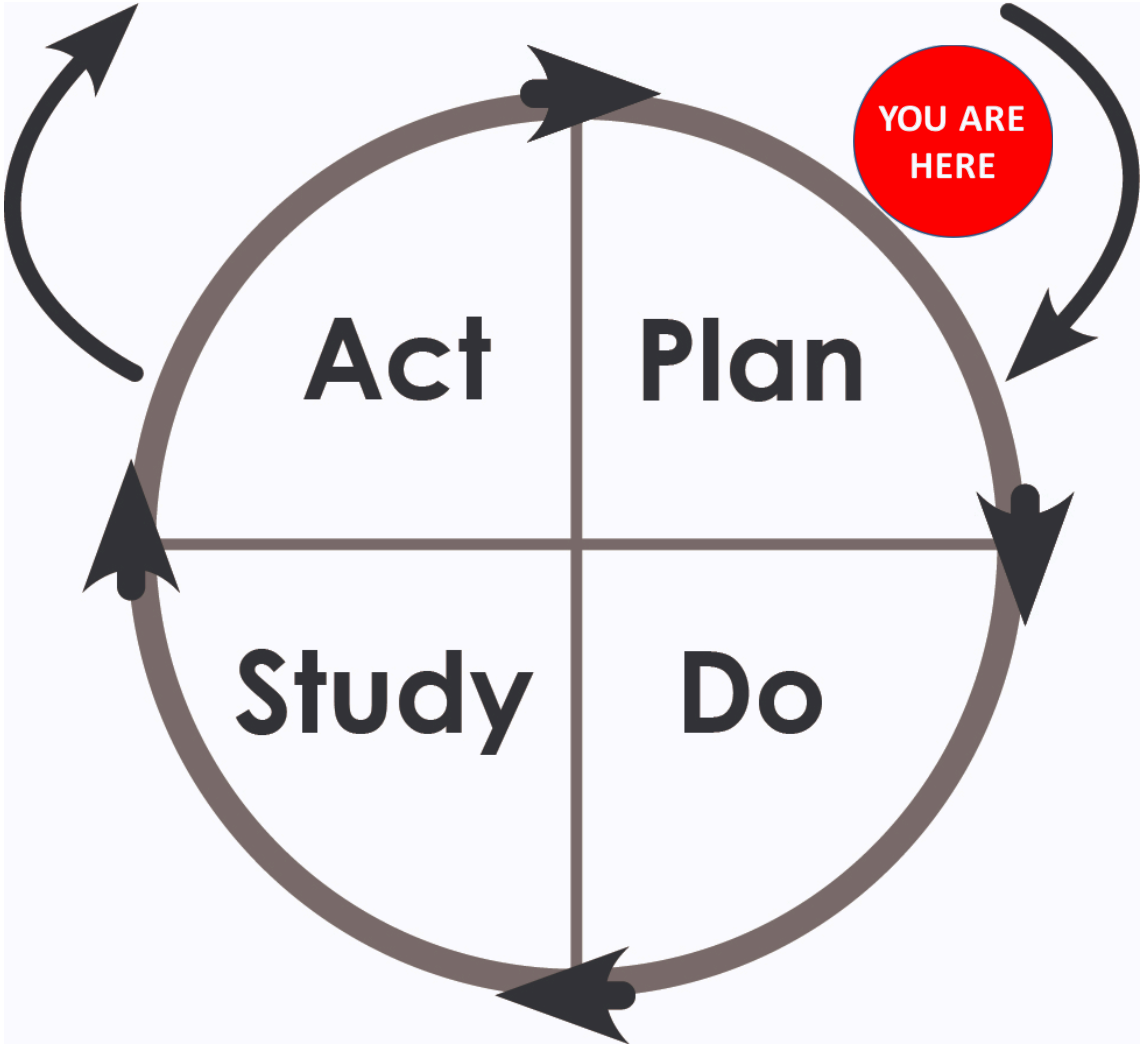
Number of tasks created based on commitments for follow-up

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

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 July 2021, we will deliver our medical bundle of care to 90% of our clients with opioid use disorder (medical bundle includes review of harm reduction handout)


YOU ARE HERE
Act
Plan
Study
Do

Plan

Describe your first (or next) test of change:

Who is responsible:	When is it to be done:	Where is it to be done:

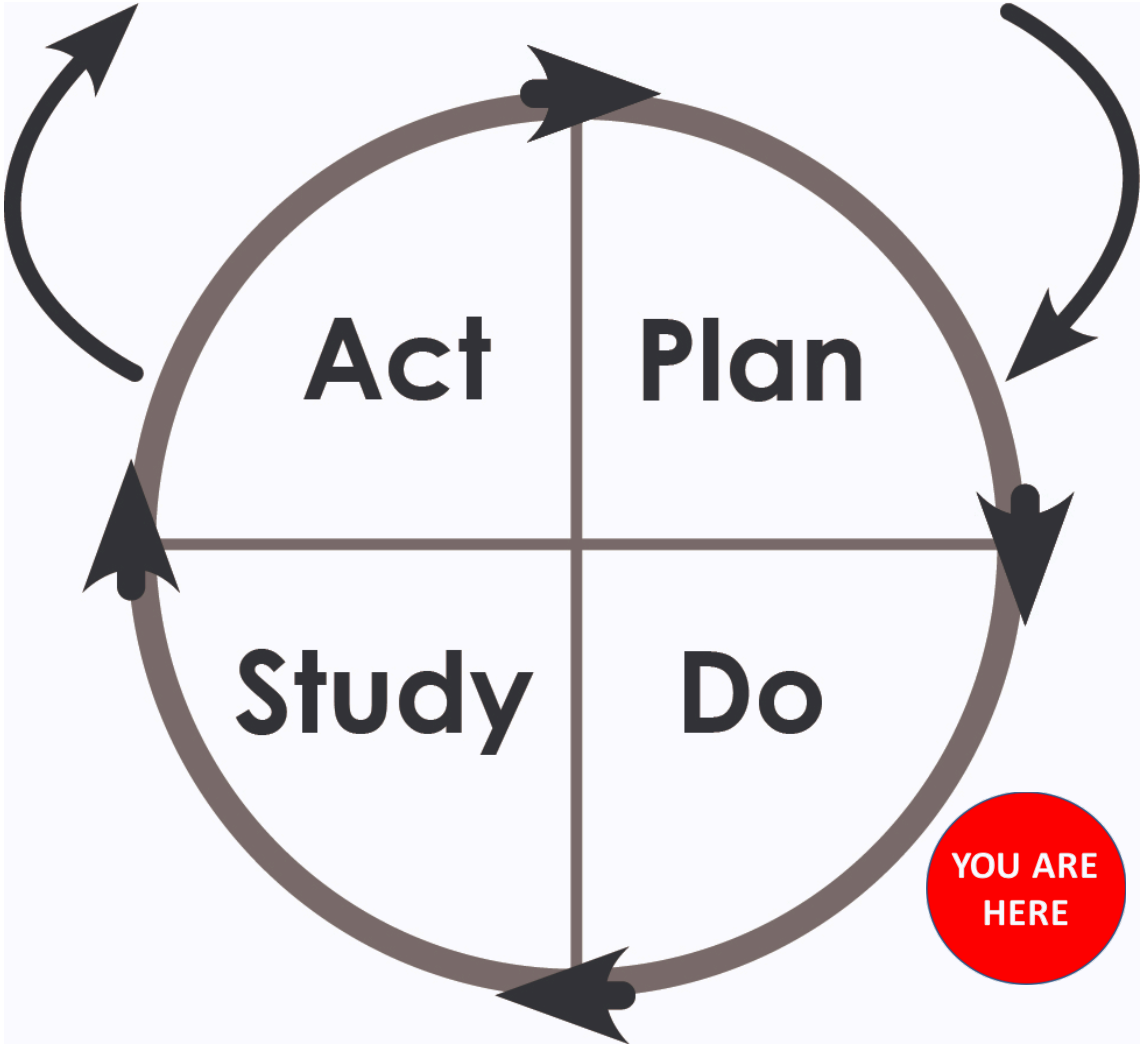
List the tasks needed to set up this test:	Who:	When:	Where:

Predict what will happen when the test is performed:

List measures for assessing the predictions:

- Outcome
- Process
- Balancing

Why measure at all?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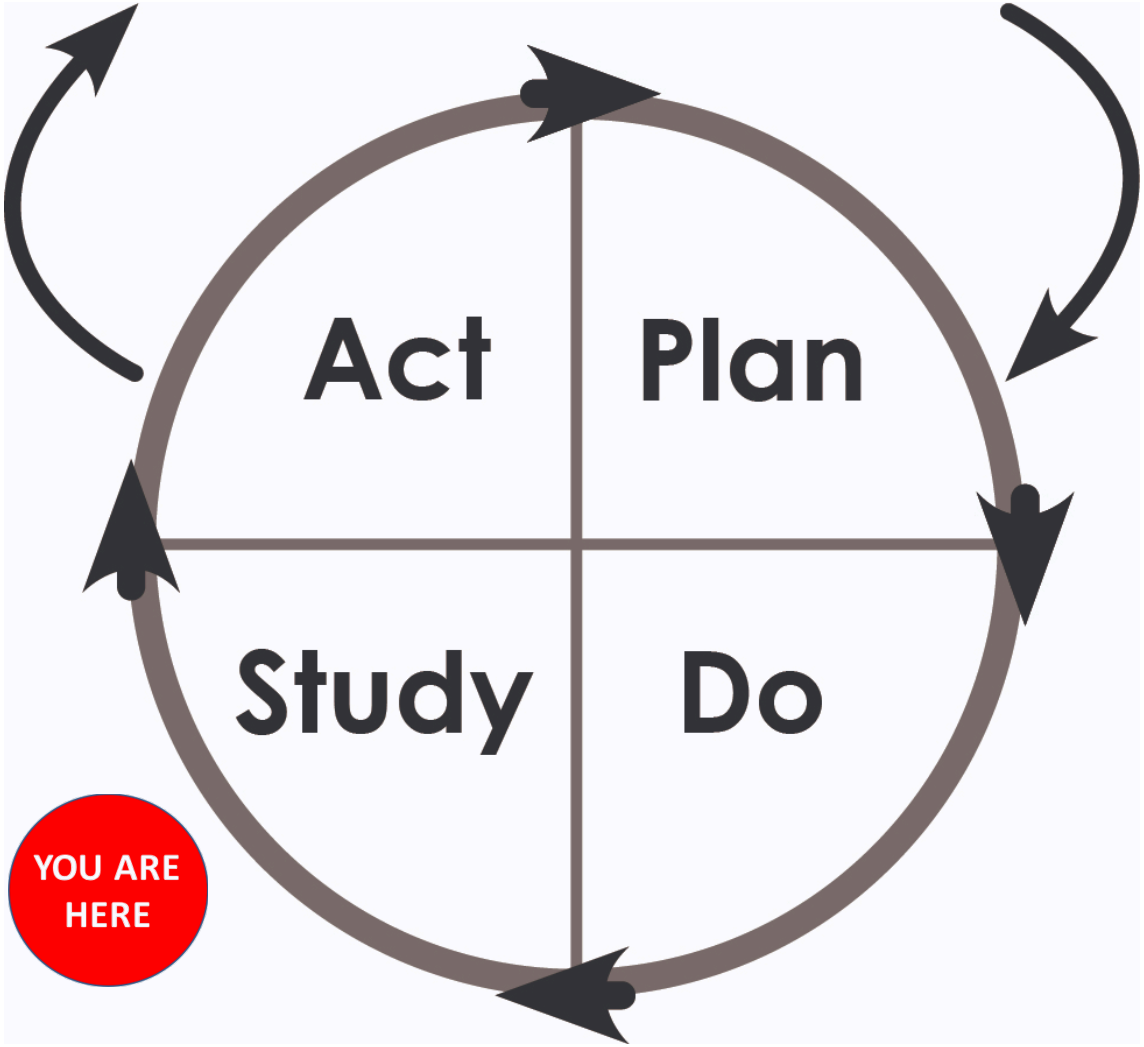
YOU ARE HERE

Do

Describe what actually happened when you ran the test: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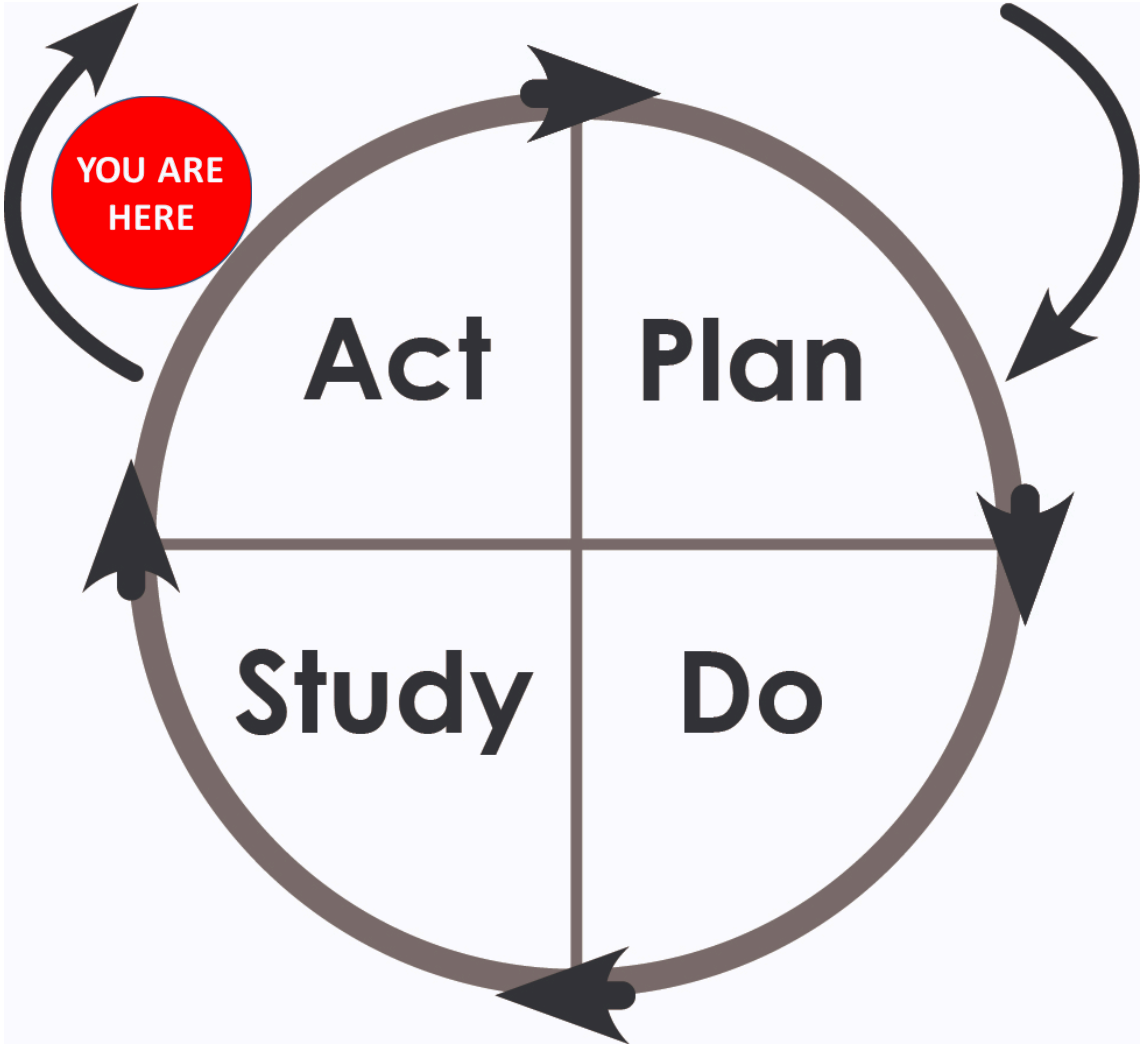
YOU ARE HERE

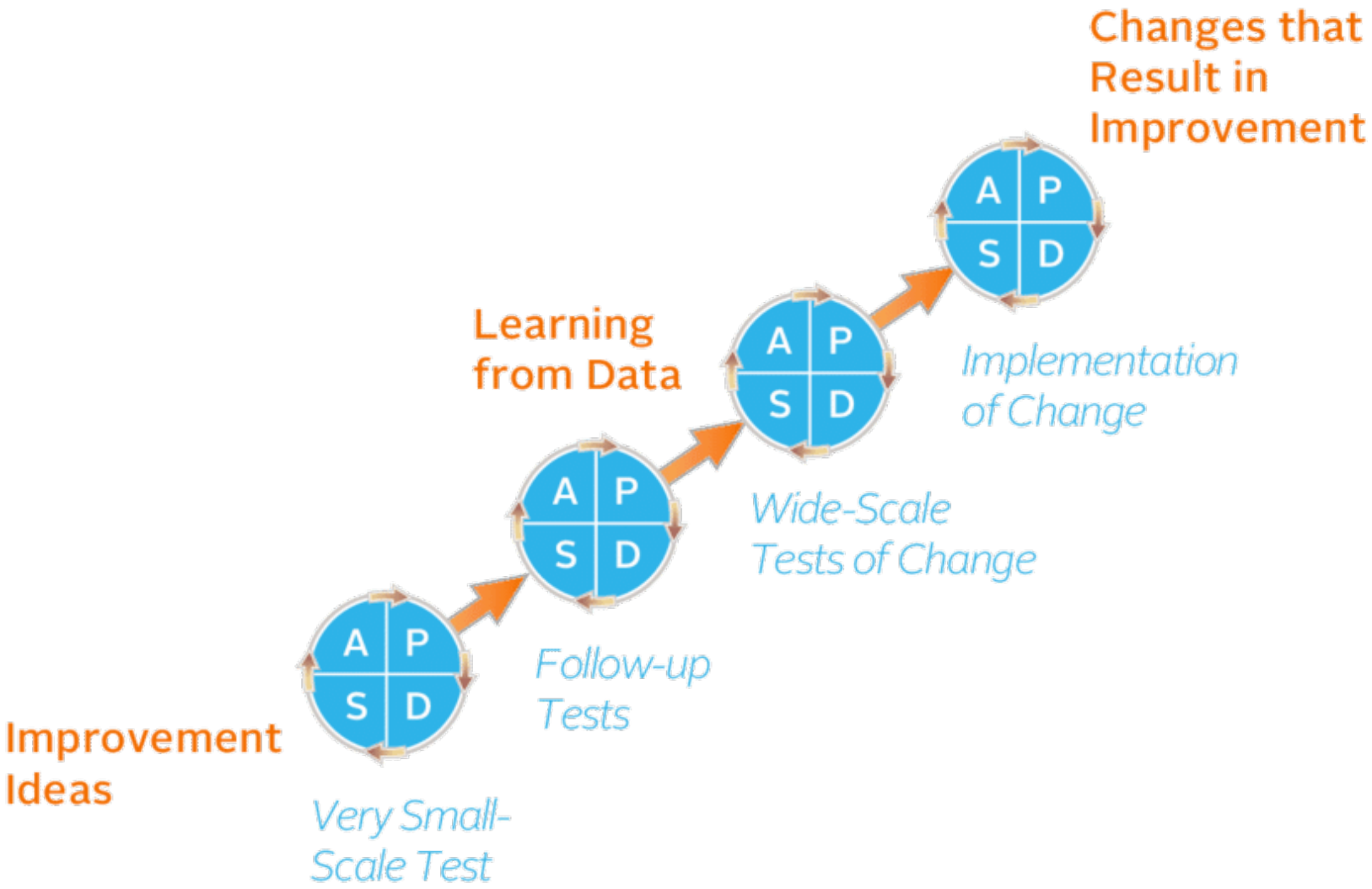
Study

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


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:


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

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BMJ Quality & Safety Latest content Current issue

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Article Text

Article info

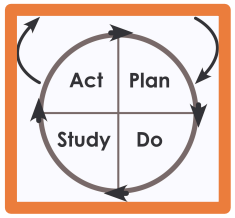
Original research

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

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The client and family perspective

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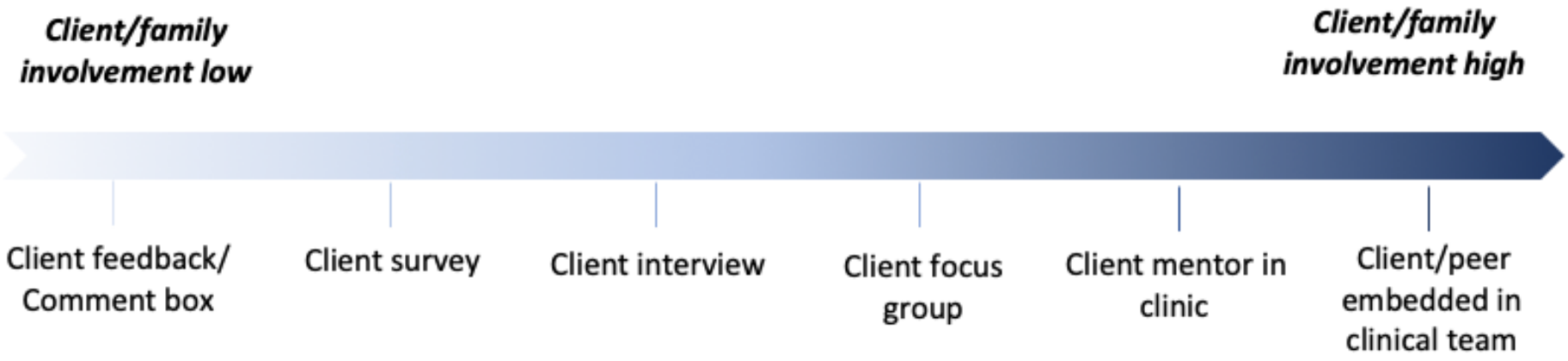
Which methods have you tried to incorporate the client or family voice?



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Team reporting process and platform

Cole Stanley
Angie Semple

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Questions & Discussion

Link in Chat

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THANK YOU!

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