Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Friday, September 15th 2017

Creekside Community Centre

@BCCFE | @VCHhealthcare | #BOOSTqi

Welcome!

Launch Agenda

20 min	**Welcoming Remarks**
10 min	**Minister Darcy Address**
15 min	**Family Story**
15 min	**BOOST Collaborative Overview**
20 min	**OUD: Where are we at and where are we going?**
30 min	**Discussion**
15 min	**Break**
15 min	**Improving Opioid Agonist Therapies with System Change**
30 min	**Aspirations for Improving Care and Services**
20 min	**BOOST Collaborative Aims and Expectations**
30 min	**Core Collaborative Measures and Reporting Resources**
30 min	**Lunch**
40 min	**Team Aim Statements and Population of Focus**
40 min	**Change Package and Team Action Planning**
20 min	**Closing Remarks and Next Steps**
5 min	**Wrap-up and Evaluation**
2:30 PM	**Adjourn**

Launch Objectives

- Define and discuss the overall **aim of the BOOST Collaborative** and the **key drivers** influencing the aim
- Identify and explain the key **role teams play in closing the gaps** along the OUD continuum of care
- Explain the definitions and expectations for collecting and reporting on **Core BOOST Collaborative measures**
- Draft a preliminary **team-specific aim statement** and develop clear steps forward with **actionable plans** for tests of change (PDSA)
- Apply **QI fundamentals** in practice
- Identify and access **resources and supports** available to participating BOOST teams

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Welcoming Remarks

Mary Ackenhusen, President and CEO, Vancouver Coastal Health

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Welcoming Remarks

Dr. Julio Montaner, Director, BC Centre for Excellence in HIV/AIDS

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Message from the Minister of Mental Health and Addictions

Hon. Judy Darcy, Minister of Mental Health and Addictions

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Family Story

Frances Kenny, Chair of Vancouver Coastal Health Mental Health and Substance Use Parent Advisory Committee

Founder, PARENTS FOREVER

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HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

How ARE families affected?

Emotionally

- Parents and family members go through stages very similar to those of the stages of grief : shock, denial, anger, guilt, grief/loss and acceptance

Physically

- The continuous stress and anxiety parents and family members are under inevitably leads to health problems – both mental and physical

Spiritually

- Connections with family and friends are severely compromised. Feelings of blame, guilt and shame contribute to parents and family members becoming increasingly isolated and hopeless

Parents Forever - F. Kenny - Copy Right 2007

HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

SO... WHAT CAN PARENTS AND FAMILY MEMBERS DO IN ORDER TO COPE?

TO GET CONTROL BACK OF THEIR OWN LIVES?

TO STAY CONNECTED WITH THEIR LOVED ONES …..
OFFERING LOVE AND SUPPORT WITHOUT ALLOWING THE DISEASE TO CONTROL THEM?

TO STAY STRONG AND RESILIENT AND EVER HOPEFUL?

Parents Forever - F. Kenny - Copy Right 2007

HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

WE BELIEVE FAMILIES NEED A BRAND NEW TOOLBOX FILLED WITH TOOLS TO HELP THEM BEGIN THEIR OWN JOURNEY OF RECOVERY.....

"A FAMILY RECOVERY TOOLKIT"

EDUCATION

INFORMATION

SUPPORT

COPING SKILLS/STRATEGIES

HOPE

ACTION

HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

EDUCATION:

- Parents and family members need to educate themselves as quickly as possible about substance abuse as most not explored this topic until they are forced to as a result of their loved one becoming ill.

- We with “lived experience” believe it is the most empowering and practical step parents can take.

- There are many education series offered by Vancouver Coastal Health and a wide variety of websites offering information.

- In PARENTS FOREVER, we have a small lending library, speakers on various topics, ongoing education on new strategies such as “The List”, and sharing of wisdom and experience

HOPE FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

Support

- Regular, ongoing mutual support groups provide a safe and confidential place for parents and family members to come together to share their experiences, their wisdom and their courage

- Parents and family members learn new ways of coping including how to remain EVER HOPEFUL, WITH NO EXPECTATIONS

- Veteran parents continue to attend group meetings to offer support and encouragement as well as sharing their stories of success, whether it be a child making a decision to change or a parent regaining their strength and feelings of self-worth.

Parents Forever - F. Kenny - Copy Right 2007

ACTION FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

Action: Working for change...

When parents and family members regain their strength and their situation stabilizes to some degree, they are often ready to give back

Working towards improving services, creating awareness and eliminating stigma, changing policy to include the family voice

For 17 years one group has been working tirelessly in this direction is:

FROM GRIEF TO ACTION

They have been the voice for families who are struggling with loved ones with substance abuse and mental illness

ACTION FOR FAMILIES AFFECTED SUBSTANCE ABUSE

RESOURCES that FGTA provides to families:

- Coping kit - available on website
- Video – From Grief to Action by Force Four Entertainment
- Website www.fgta.ca
- Facebook page

FAMILY ADVOCACY SUBSTANCE ABUSE

- VCH Mental Health and Substance Use FAMILY ADVISORY COMMITTEE

- *Family Involvement Policy*

- FAMILY GROUP, BC Centre for Substance Use

- MOMS STOP THE HARM

- mumsDU

BOOST Collaborative Overview

Rolando Barrios, MD, FRCPC
Senior Medical Director, Vancouver Coastal Health
Assistant Director, BC Centre for Excellence in HIV/AIDS

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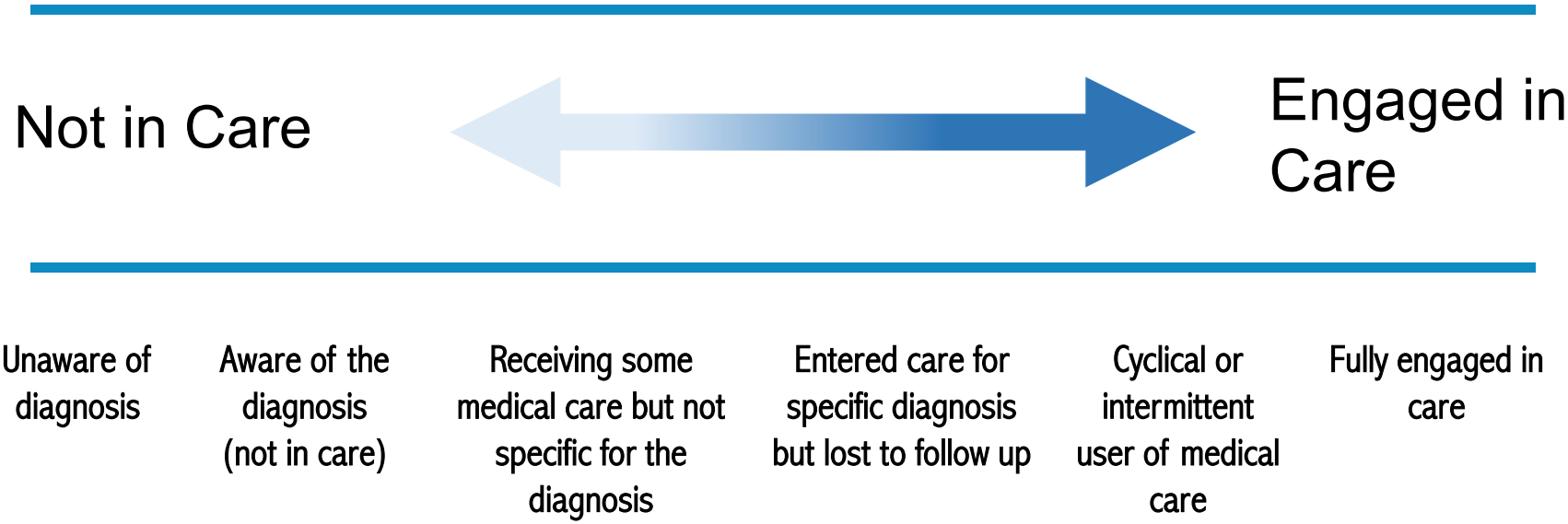
Outline

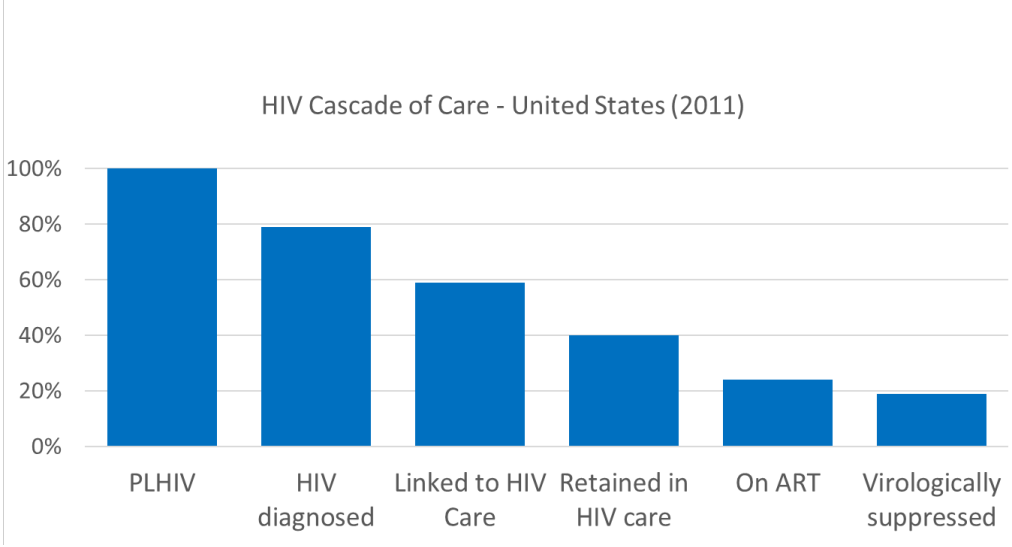
- Background
- Quality Improvement
  - Journey
  - Data
  - Science
  - Focus
  - Metrics
- What are we trying to accomplish?
  - Aim statement
- Summary

Background: Continuum of Care



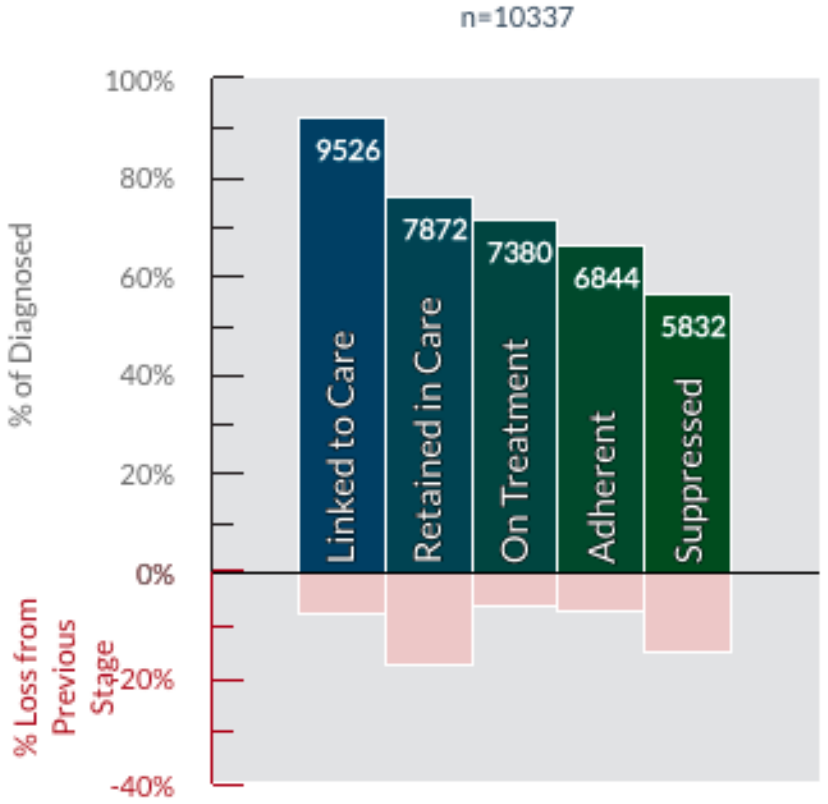
Adapted from: Giordano TP, Gifford AL, White AC Jr, et al. Retention in care: a challenge to survival with HIV infection. Clin Infect Dis 2007; 44:1493–9.
Modified from: Eldred L, Malitz F. Introduction [to the supplemental issue on the HRSA SPNS Outreach Initiative]. AIDS Patient Care STDS 2007; 21(Suppl 1):S1–S2.

Background: Cascade of Care and Existing Gaps



Adapted from: Giordano TP, Clin Infect Dis 2007; 44:1493–9.
Modified from: Eldred L, ET AL. AIDS Patient Care STDS 2007

Figure 5.1 Estimated Cascade of Care for BC, Year Ending 2017 Q2 [7]



QMR-Q2-2017. http://stophivaids.ca/qmr/2017-Q2/#/bc

QI is a journey of small steps

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Data don’t need to be perfect… only good enough!

BC OPIOID SUBSTITUTION TREATMENT SYSTEM

Performance Measures 2014/2015 - 2015/2016

Office of the Provincial Health Officer

With contributions by:

Medical Beneficiary & Pharmaceutical Services Division &
Population and Public Health Division
British Columbia Ministry of Health

March 2017

BRITISH COLUMBIA | Office of the Provincial Health Officer

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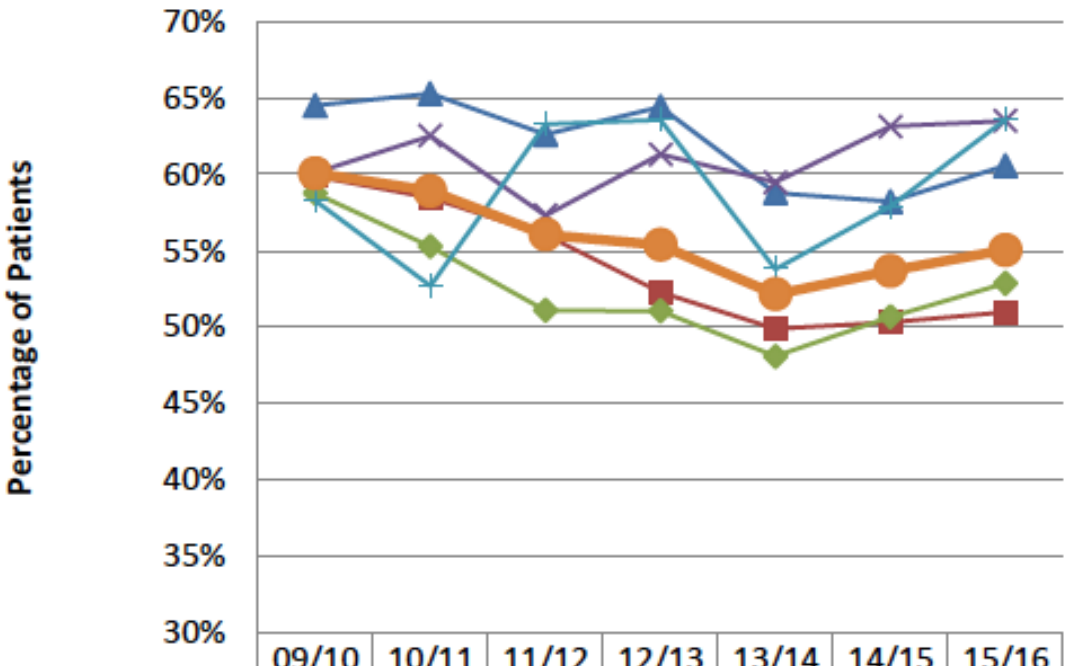
Figure 14. Percentage of Patients Receiving a Stabilization Dose of Methadone >60 mg, by Health Authority, BC, 2009/2010 to 2015/2016



	09/10	10/11	11/12	12/13	13/14	14/15	15/16
IHA	65%	65%	63%	64%	59%	58%	61%
FHA	60%	58%	56%	52%	50%	50%	51%
VCHA	59%	55%	51%	51%	48%	51%	53%
IslHA	60%	63%	57%	61%	59%	63%	64%
NHA	58%	53%	63%	64%	54%	58%	64%
BC Total	60%	59%	56%	55%	52%	54%	55%

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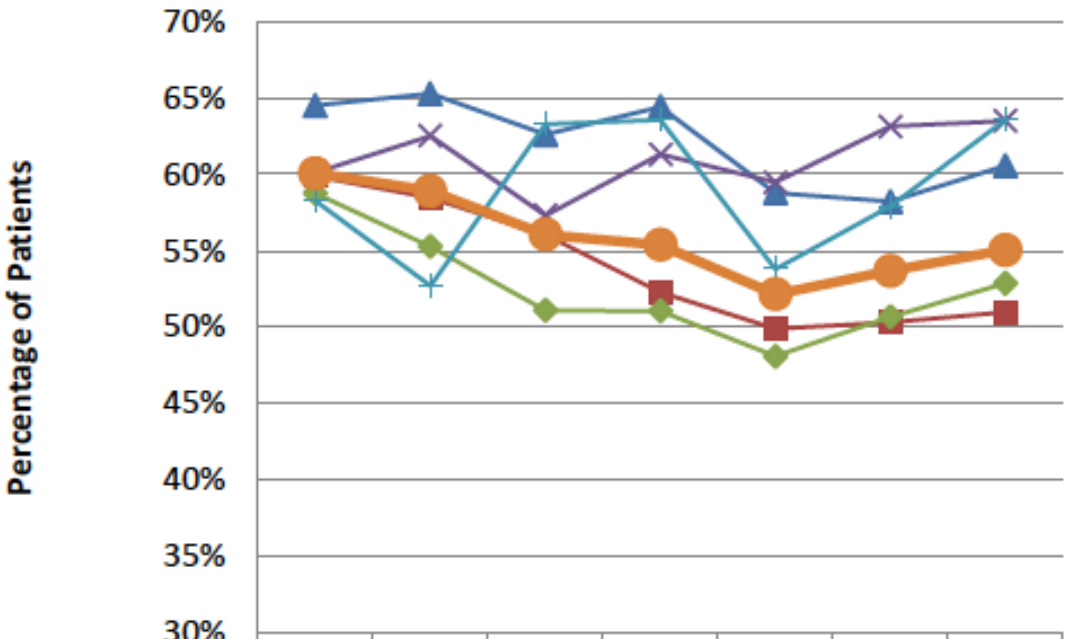
Figure 14. Percentage of Patients Receiving a Stabilization Dose of Methadone >60 mg, by Health Authority, BC, 2009/2010 to 2015/2016



	09/10	10/11	11/12	12/13	13/14	14/15	15/16
IHA	65%	65%	63%	64%	59%	58%	61%
FHA	60%	58%	56%	52%	50%	50%	51%
VCHA	59%	55%	51%	51%	48%	51%	53%
IslHA	60%	63%	57%	61%	59%	63%	64%
NHA	58%	53%	63%	64%	54%	58%	64%
BC Total	60%	59%	56%	55%	52%	54%	55%

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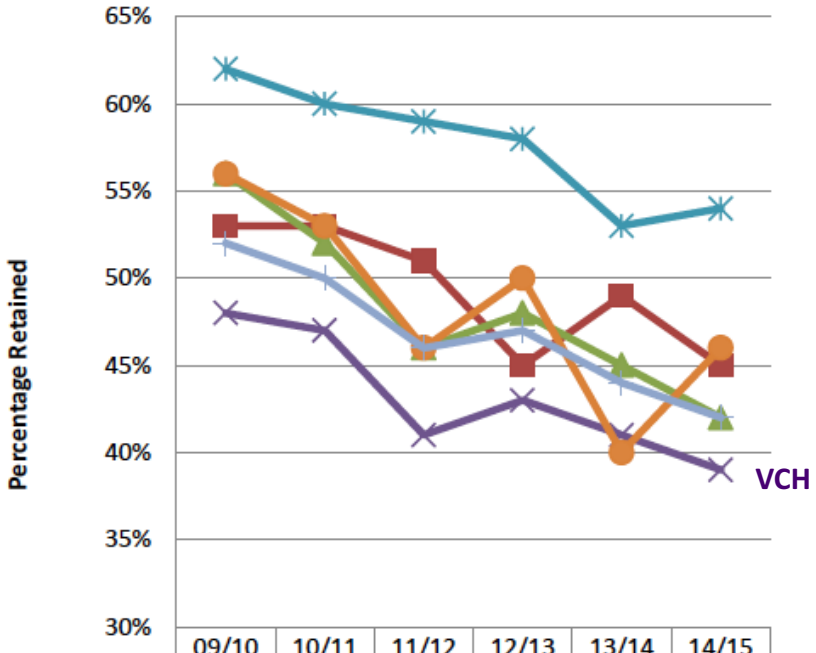
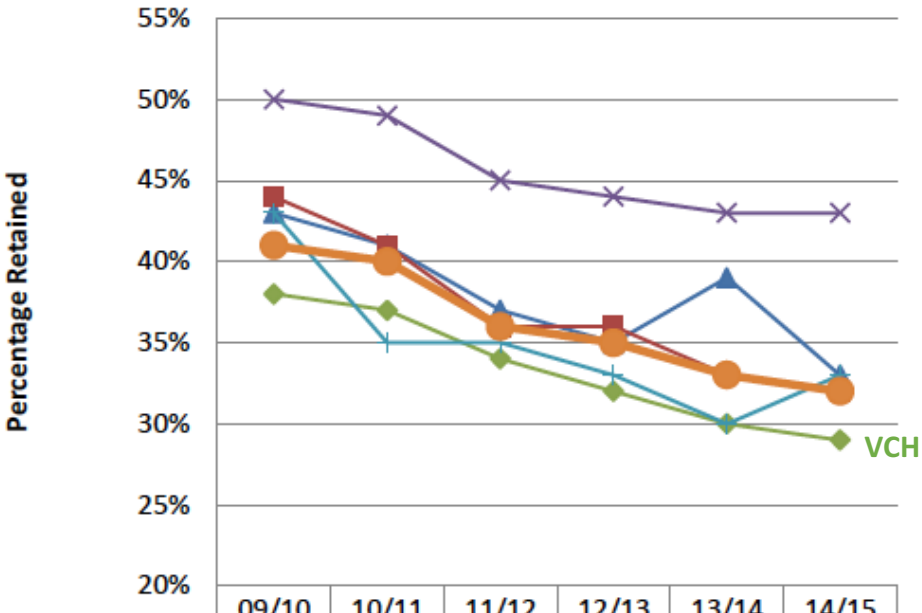
Figure 15a. Percentage of People Started on Methadone Maintenance Treatment Retained at 6 Months, by Health Authority, BC, 2009/2010 to 2014/2015



	09/10	10/11	11/12	12/13	13/14	14/15
IHA	53%	53%	51%	45%	49%	45%
FHA	56%	52%	46%	48%	45%	42%
VCHA	48%	47%	41%	43%	41%	39%
IslHA	62%	60%	59%	58%	53%	54%
NHA	56%	53%	46%	50%	40%	46%
BC Total	52%	50%	46%	47%	44%	42%

Figure 15b. Percentage of People Started on Methadone Maintenance Treatment Retained at 12 Months, by Health Authority, BC, 2009/2010 to 2014/2015[h]



	09/10	10/11	11/12	12/13	13/14	14/15
IHA	43%	41%	37%	35%	39%	33%
FHA	44%	41%	36%	36%	33%	32%
VCHA	38%	37%	34%	32%	30%	29%
IslHA	50%	49%	45%	44%	43%	43%
NHA	43%	35%	35%	33%	30%	33%
BC Total	41%	40%	36%	35%	33%	32%

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OPEN ACCESS

Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies

Luis Sordo,[1,2,3] Gregorio Barrio,[4] Maria J Bravo,[1,2] B Iciar Indave,[1,2] Louisa Degenhardt,[5,6] Lucas Wiessing,[7] Marica Ferri,[7] Roberto Pastor-Barriuso[1,2]

[1]National Centre for Epidemiology, Carlos III Institute of Health, Madrid, Spain
[2]Consortium for Biomedical Research in Epidemiology and Public Health (CIBERESP), Madrid, Spain
[3]Department of Preventive Medicine and Public Health, Faculty of Medicine, Complutense University, Madrid, Spain
[4]National School of Public Health, Carlos III Institute of Health, 28029 Madrid, Spain

ABSTRACT

OBJECTIVE

To compare the risk for all cause and overdose mortality in people with opioid dependence during and after substitution treatment with methadone or buprenorphine and to characterise trends in risk of mortality after initiation and cessation of treatment.

DESIGN

Systematic review and meta-analysis.

DATA SOURCES

Medline, Embase, PsycINFO, and LILACS to September 2016.

out of buprenorphine treatment (2.20, 1.34 to 3.61). In pooled trend analysis, all cause mortality dropped sharply over the first four weeks of methadone treatment and decreased gradually two weeks after leaving treatment. All cause mortality remained stable during induction and remaining time on buprenorphine treatment. Overdose mortality evolved similarly, with pooled overdose mortality rates of 2.6 and 12.7 per 1000 person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and 1.4 and 4.6 in and out of buprenorphine treatment.

CONCLUSIONS

Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk, which should be dealt with by both public health and clinical strategies to mitigate such risk. These findings are potentially important, but further research must be conducted to properly account for potential confounding and selection bias in comparisons of mortality risk between opioid substitution treatments, as well as throughout periods in and out of each treatment.

Introduction

Opioid dependence is a rising drug use disorder with substantial contribution to the global disease burden. The absolute number (age standardised prevalence) of people with opioid dependence worldwide increased from 10.4 million (0.20%) in 1990 to 15.5 million (0.22%)

Retention in methadone and buprenorphine is associated with substantial reductions in the rate of all cause and overdose mortality

The induction phase and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk.

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Bring science into practice

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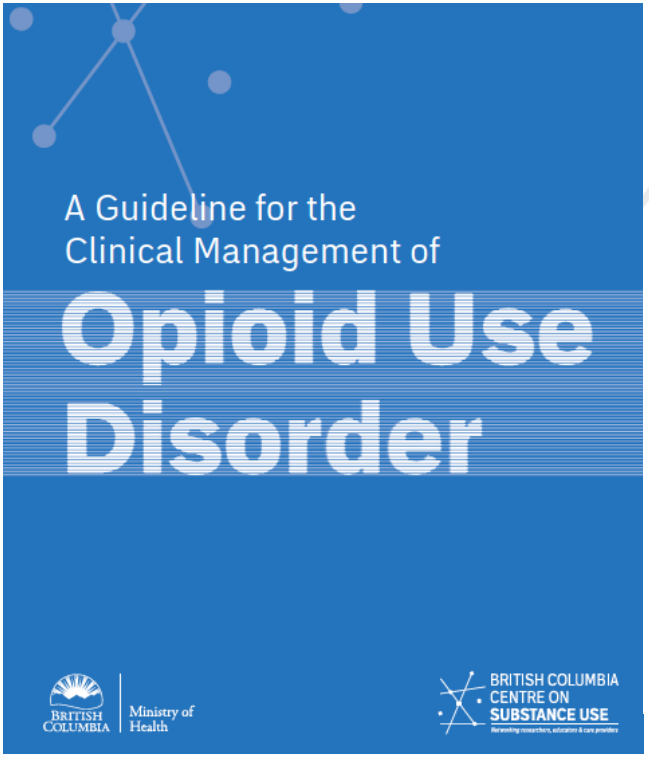
The science exists:



WITHDRAWAL MANAGEMENT [1–3]

Tapered methadone, buprenorphine, or alpha$_2$-adrenergic agonists

+/– psychosocial treatment [4]
+/– residential treatment
+/– oral naltrexone [5]

AGONIST THERAPIES

Buprenorphine/ naloxone [6] *(preferred)*

Methadone [7,8]

+/– psychosocial treatment
+/– residential treatment

SPECIALIST-LED ALTERNATIVE APPROACHES

Slow-release oral morphine [9,10]

+/– psychosocial treatment
+/– residential treatment

TREATMENT INTENSITY

LOW
If opioid use continues, consider treatment intensification. »

HIGH
Where possible, « simplify treatment.

HARM REDUCTION [11-13]

Across the treatment intensity spectrum, evidence-based harm reduction should be offered to all, including:

- Education re: safer user of sterile syringes/needles and other applicable substance use equipment
- Access to sterile syringes, needles, and other supplies
- Take-Home-Naloxone (THN) kits
- Access to Supervised Injection Sites (SIS)

http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

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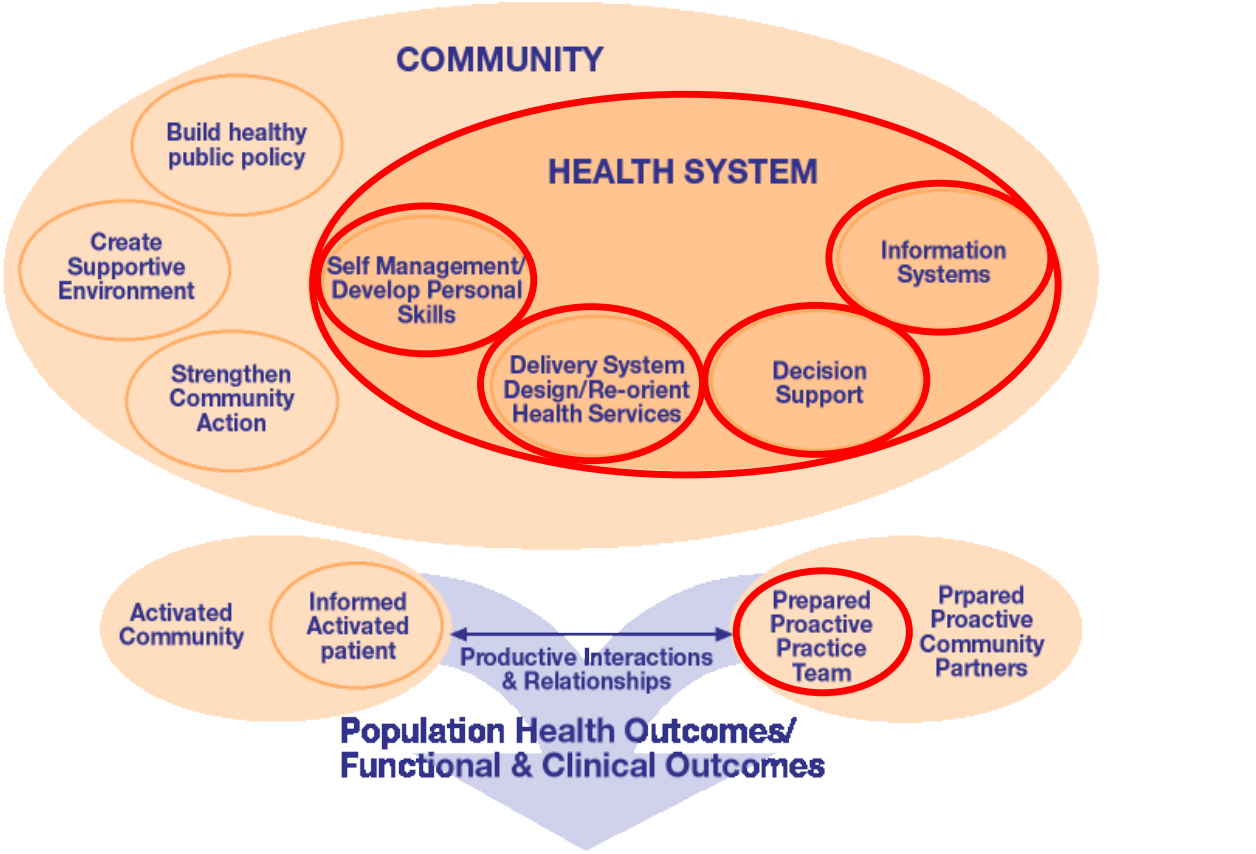
The Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robinson, brenda Marin-Link, Lisa Underhill, Anita Dotts & Darlene Ravensdale (2002)
Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? The Milbank Quarterly. 79(4), *and* World Health Organization, Helath and Welfare Canada and Canadian Public Health Association. (1986). Ottawa Charter of Health Promotion.

Hosp Q. 2003;7(1):73-82.**The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model.** Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. **Source:** Vancouver Island Health Authority.

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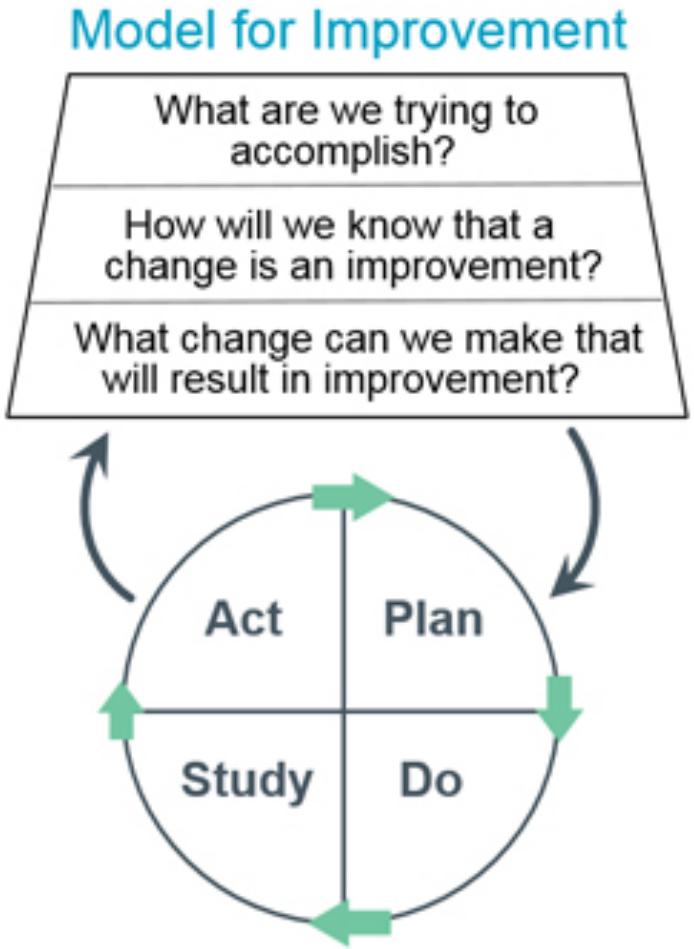
Model for Improvement



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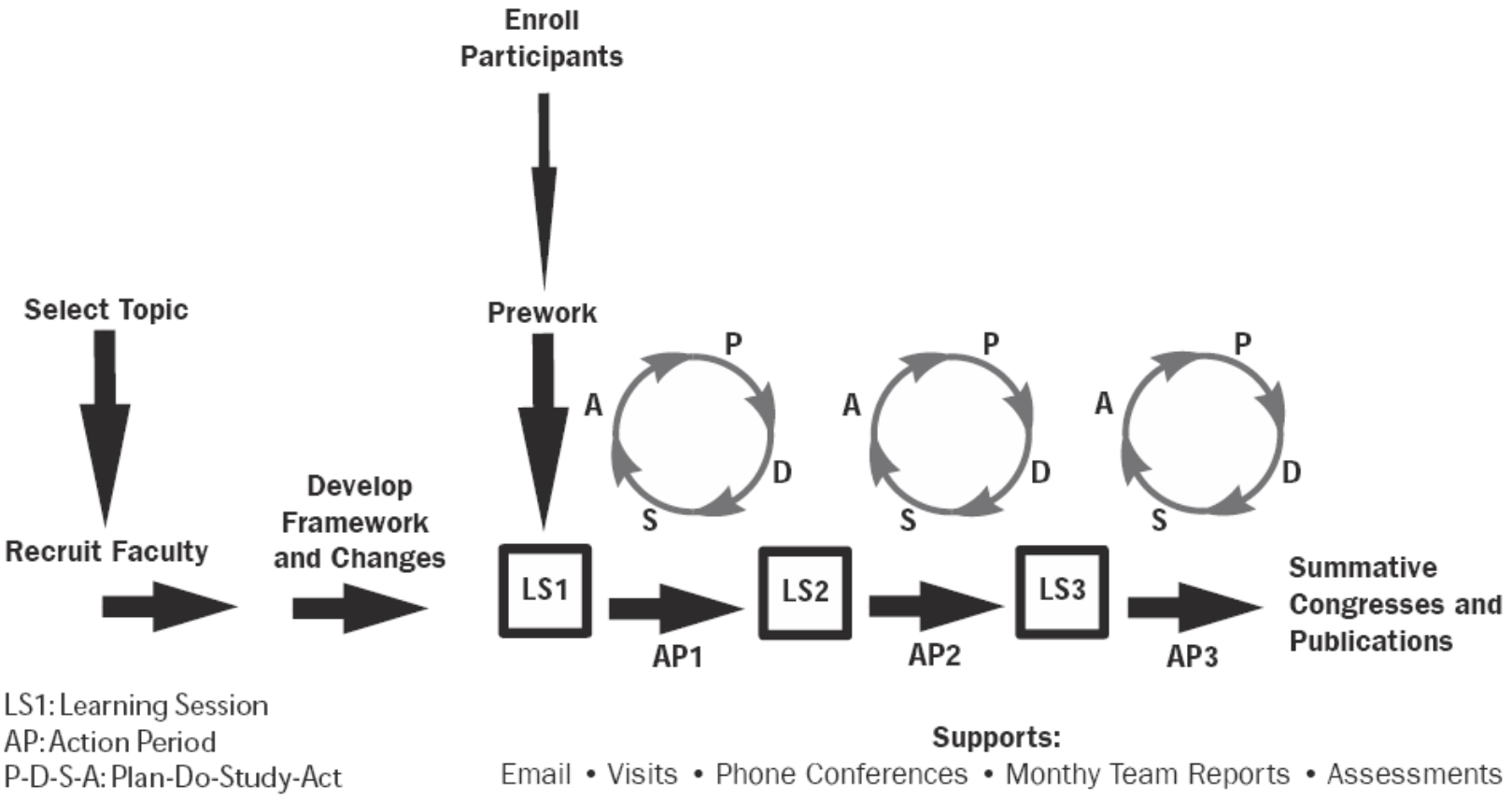
IHI Breakthrough Series Methodology



http://www.ihi.org/resources/pages/ihiwhitepapers/thebreakthroughseriesihiscollaborativemodelforachievingbreakthroughimprovement.aspx

QI requires focus

- The focus of this Collaborative will remain on oral therapies—local data tells us that this aspect of OUD care has not been optimized

What is QI?

QI is NOT …

X Evaluation / Performance Assessment

X Quality Control

X Research

QI is …

✓ A bottom-up approach that employs the frontline team as the drivers for change to the healthcare system they work in

✓ A systems approach

✓ Where small changes are tested first, then scope and scale are expanded

What are we trying to accomplish?

- Think BIG
- Start SMALL

Goals and aims:

By July 1st, 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 oOAT
- 95% retained in care for ≥3 months
- 50% average improvement in Quality of Life score

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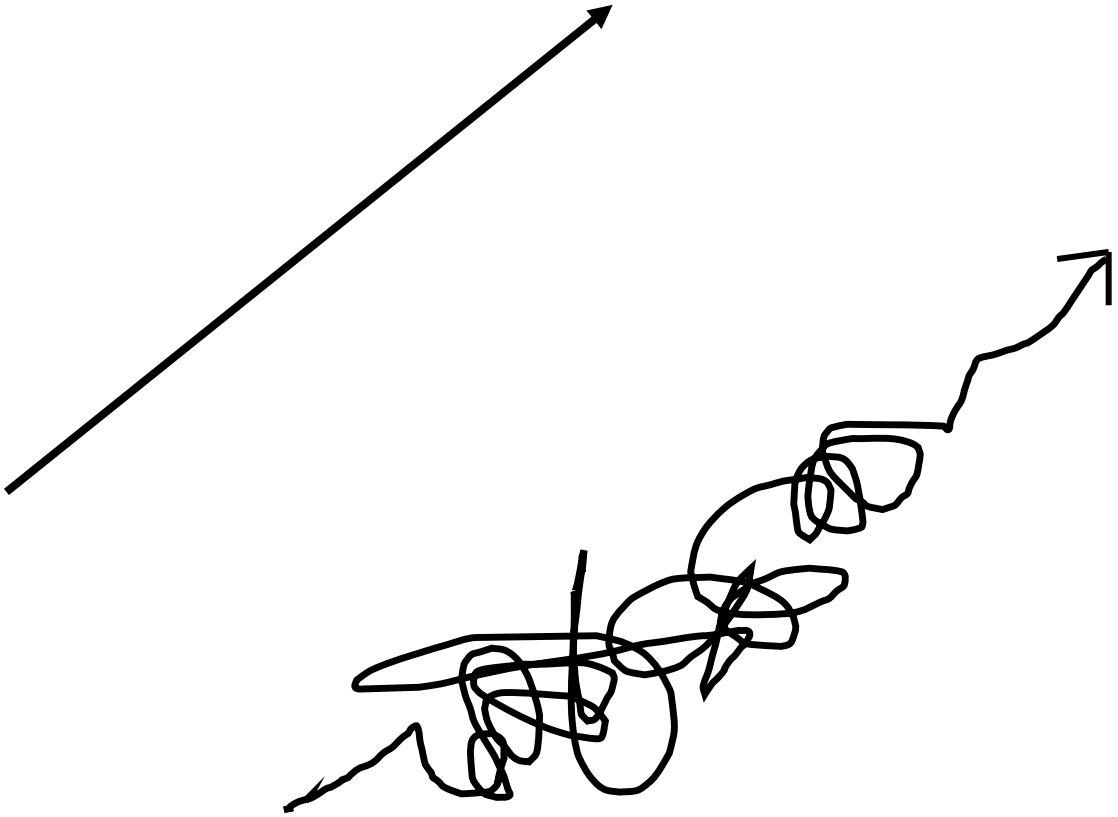
Summary

- Gaps in Care Exist:
  - Unknown timing of the diagnosis and initiation of treatment
  - Many patients are not benefiting from optimal OAT doses
  - Patients are being lost to care – retention rates are low
- This is not about the provider or client, this is about a system that is not designed to respond to the needs of the client.
- Do not wait for the perfect data to take action!

“Knowing is not enough; we must apply.
Willing is not enough; we must do.”

-Goethe

What success looks like…



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- Steal shamelessly…
- Share endlessly!

- “Picasso had a saying ‘good artists copy, great artists steal’ and we have always been shameless about stealing great ideas” – Steve Jobs
- “Share your knowledge. It is a way to achieve immortality – Dali Lama”

THANK-YOU!

Rolando Barrios: rbarrios@cfenet.ubc.ca

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Opioid Use in Vancouver 2017: Current State

Daniel Paré MD CCFP DABAM CCSAM
VCH Inner City Primary Care & Assertive Community Treatment (ACT) Team
Medical Coordinator, Downtown Community Health Centre (DCHC)
Medical Coordinator, DTES Connections Addiction Team
Clinical Instructor UBC Department of Family Practice

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Disclosures

- None

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Objectives

- Review current statistics and epidemiology of Opioid Use Disorder and Overdose crisis
- Review Current OUD treatment guidelines and recommendations
- Discuss DTES Connections care model

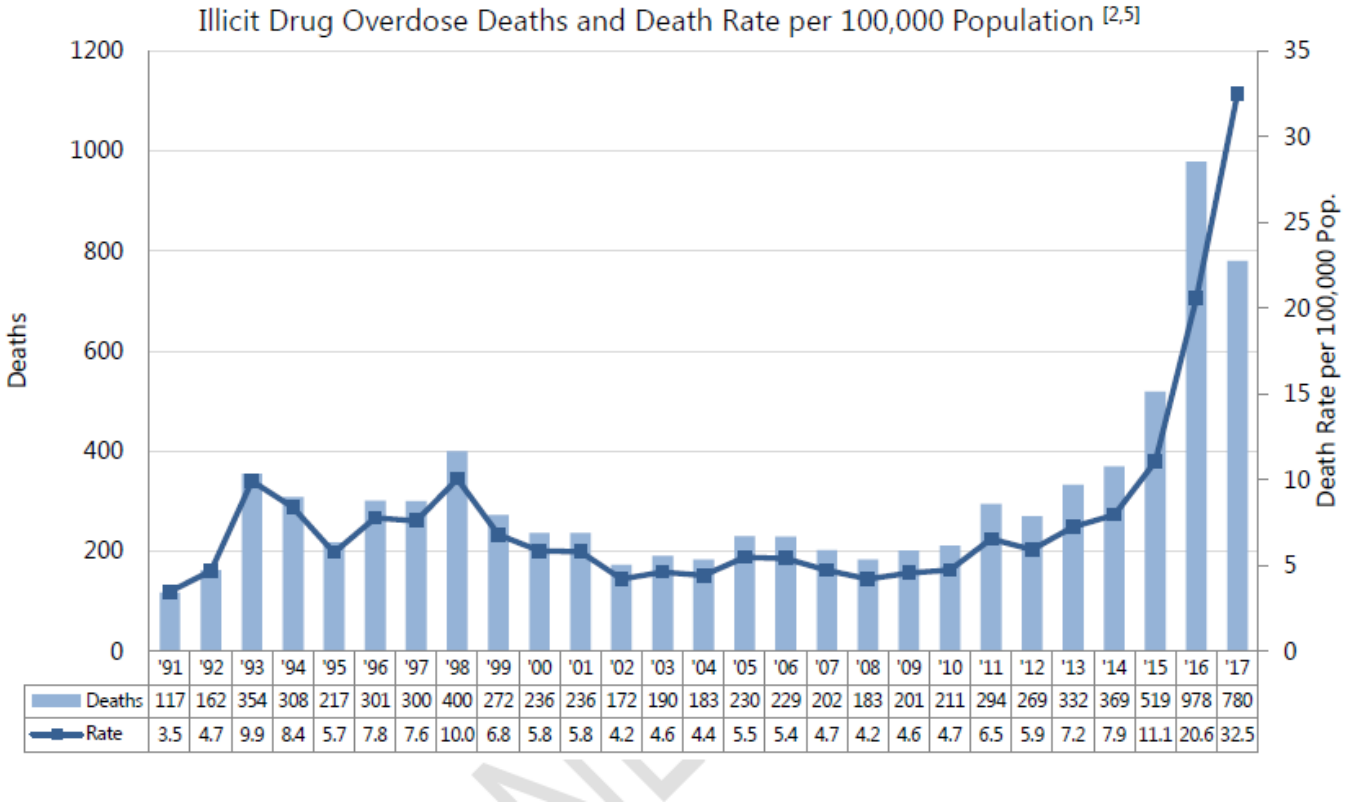
Opioid Use Disorder – DSM V

- The diagnosis of Opioid Use Disorder under DSM V can be applied to someone who uses opioid drugs and has at least two of the following symptoms within a 12 months period:
  - Taking more opioid drugs than intended.
  - Wanting or trying to control opioid drug use without success.
  - Spending a lot of time obtaining, taking, or recovering from the effects of opioid drugs
  - Craving opioids
  - Failing to carry out important roles at home, work or school because of opioid drugs.
  - Continuing to use opioids, despite use of the drug causing relationship or social problems.
  - Giving up or reducing other activities because of opioid use.
  - Using opioids even when it is physically unsafe.
  - Knowing that opioid use is causing a physical or psychological problem, but continuing to take the drug anyway.
  - Tolerance for opioids.
  - Withdrawal symptoms when opioids are not taken.

Mild: 2 or 3
Moderate: 4 or 5
Severe: >5

Prevalence estimated at 1 to 2% of Americans

Illicit Drug Overdose Deaths in BC



	'91	'92	'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
Deaths	117	162	354	308	217	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	294	269	332	369	519	978	780
Rate	3.5	4.7	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	7.9	11.1	20.6	32.5

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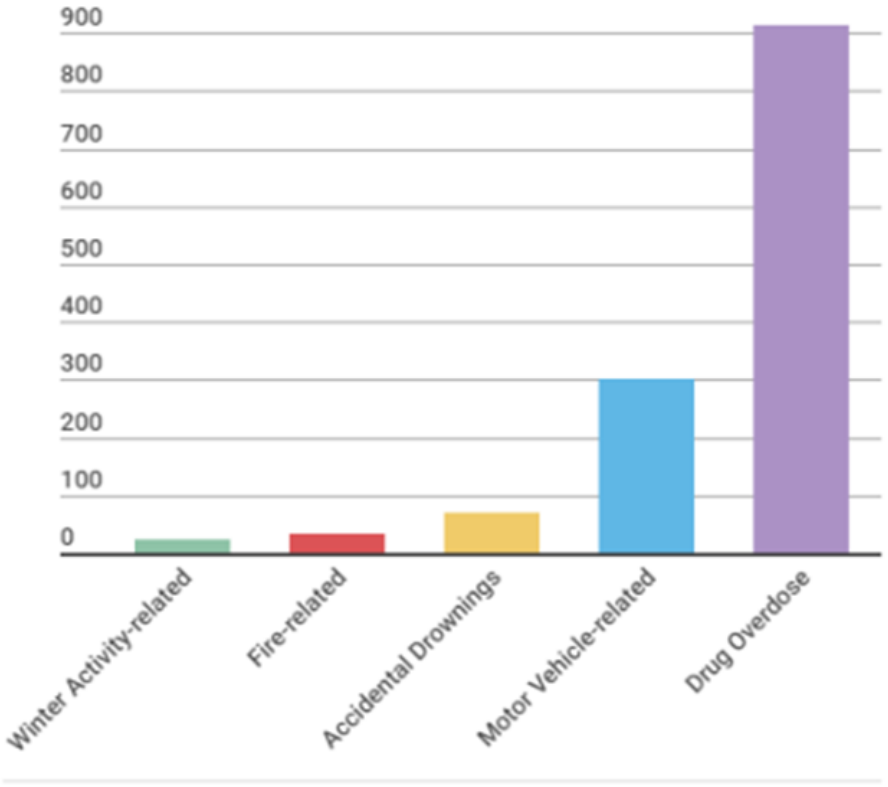
External Deaths in BC



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BC Data by Gender/Age

Illicit Drug Overdose Deaths by Gender, 2007-2017[2]											
Gender	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Female	47	49	55	49	82	75	79	86	101	192	142
Male	155	134	146	162	212	194	253	283	418	786	638
Total	202	183	201	211	294	269	332	369	519	978	780

Illicit Drug Overdose Deaths by Age Group, 2007-2017[2]											
Age Group	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
10-18	5	6	2	4	4	5	6	3	5	12	11
19-29	33	36	46	40	74	61	94	83	118	206	139
30-39	53	48	51	49	75	61	77	101	135	261	238
40-49	70	42	57	66	77	66	74	85	127	230	177
50-59	36	43	33	45	54	56	60	72	107	222	156
60-69	4	8	12	7	10	19	21	25	26	44	55
70-79	1	0	0	0	0	1	0	0	1	3	4
Total	202	183	201	211	294	269	332	369	519	978	780

Note: The age range of decedents of illicit drug overdose between 2007-2017 ranged from 14 to 76 years of age.

CORONERS SERVICE

BC Data by Place of Injury

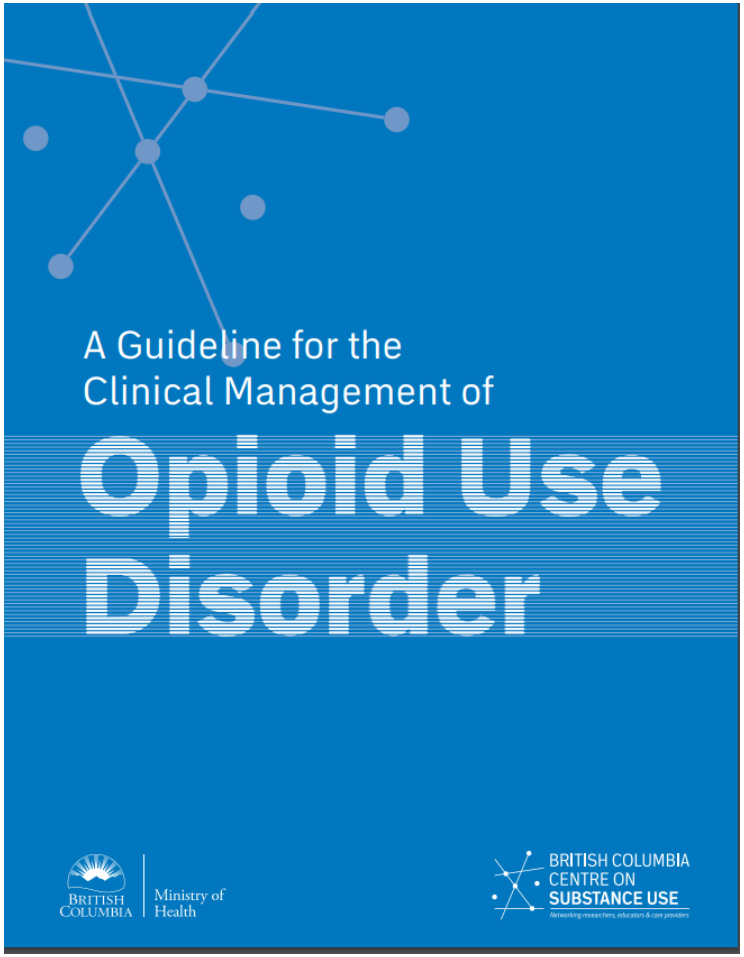
Illicit Drug Overdose Deaths by Place of Injury, BC, 2016-2017[2]		
	2016	2017
Inside:		
Private Residence	600 (61.3%)	448 (57.4%)
Other Residence	230 (23.5%)	211 (27.1%)
Other Inside	41 (4.2%)	38 (4.9%)
Outside	97 (9.9%)	77 (9.9%)
Unknown	10 (1.0%)	6 (0.8%)
Total	978	780

Preliminary circumstances suggest that the majority of fatal illicit drug overdoses in 2017 occurred in inside locations (89.4%) while 9.9% occurred outside.

Private Residence – includes driveways garages, trailer homes and either decedent's own or another's residence.
Other Residence - includes hotels, motels, rooming houses, shelters, etc.
Other Inside – includes facilities, occupational sites, public buildings, and businesses.
Outside – includes vehicles, streets, sidewalks, parking lots, public parks, wooded areas, and campgrounds

ONERS SERVICE

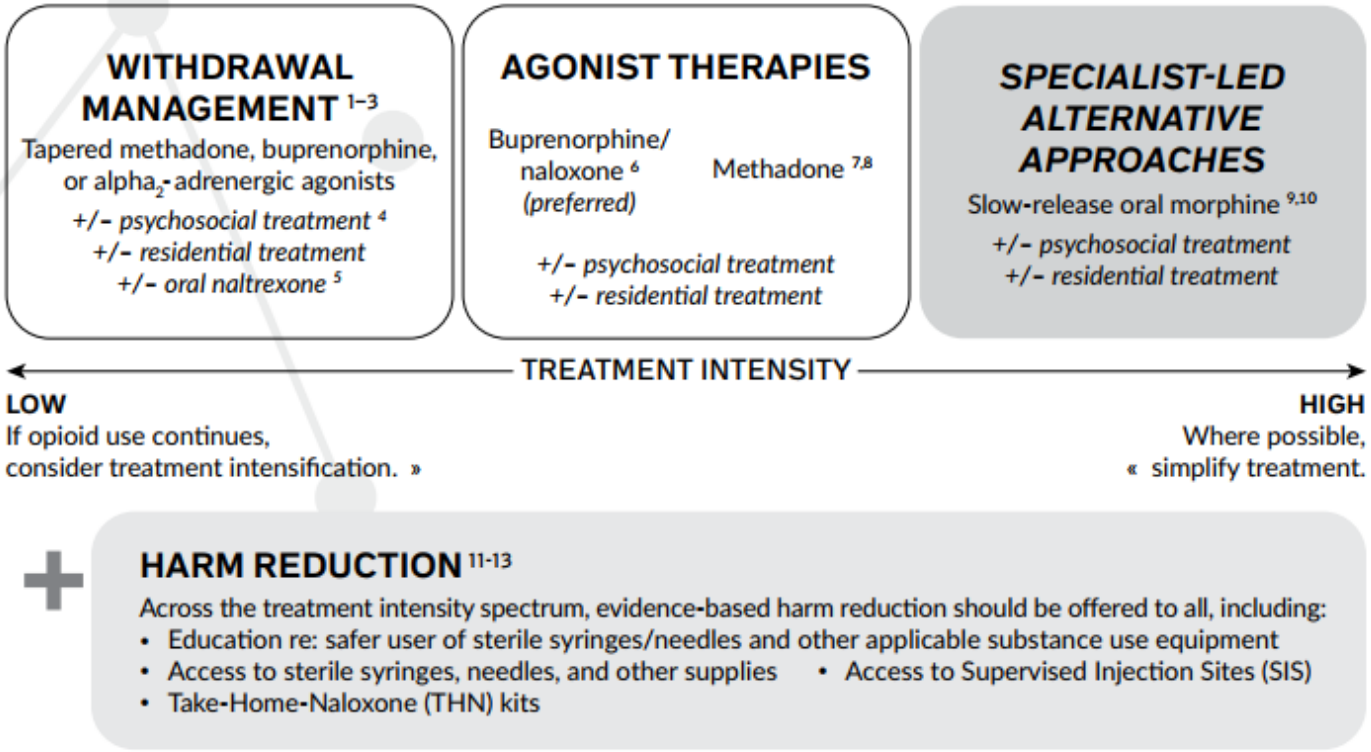
Treatment



Best-Practices in
ORAL OPIOID AGONIST
THERAPY Collaborative

Treatment

Table 1. Clinical management of opioid use disorder



Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Outcomes associated with Methadone and Buprenorphine

- Treatment retention
- Withdrawal suppression
- Decreased illicit opioid (and cocaine) use
- Reduced risk of HCV/HIV
- Increased ARV adherence, lower vL
- Decreased criminal activity
- Significantly reduced mortality; both all-cause and drug/substance related

Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study

Gráinne Cousins[1], Fiona Boland[2], Brenda Courtney[2], Joseph Barry[3], Suzi Lyons[4] & Tom Fahey[2]

School of Pharmacy, Royal College of Surgeons in Ireland, Dublin, Ireland,[1] Health Research Board Centre for Primary Care Research, Royal College of Surgeons in Ireland, Dublin, Ireland,[2] Trinity College Centre for Health Sciences, Tallaght Hospital, Dublin, Ireland[3] and Health Research Board, Dublin, Ireland[4]

ABSTRACT

Aim To assess whether risk of death increases during periods of treatment transition, and investigate the impact of supervised methadone consumption on drug-related and all-cause mortality. **Design** National Irish cohort study. **Setting** Primary care. **Participants** A total of 6983 patients on a national methadone treatment register aged 16–65 years between 2004 and 2010. **Measurement** Drug-related (primary outcome) and all-cause (secondary outcome) mortality rates and rate ratios for periods on and off treatment; and the impact of regular supervised methadone consumption. **Results** Crude drug-related mortality rates were 0.24 per 100 person-years on treatment and 0.39 off treatment, adjusted mortality rate ratio 1.63 [95% confidence interval (CI) = 0.66–4.00]. Crude all-cause mortality rate per 100 person-years was 0.51 on treatment versus 1.57 off treatment, adjusted mortality rate ratio 3.64 (95% CI = 2.11–6.30). All-cause mortality off treatment was 6.36 (95% CI = 2.84–14.22) times higher in the first 2 weeks, 9.12 (95% CI = 3.17–26.28) times higher in weeks 3–4, compared with being 5 weeks or more in treatment. All-cause mortality was lower in those with regular supervision (crude mortality rate 0.60 versus 0.81 per 100 person-years) although, after adjustment, insufficient evidence exists to suggest that regular supervision is protective (mortality rate ratio = 1.23, 95% CI = 0.67–2.27). **Conclusions** Among primary care patients undergoing methadone treatment, continuing in methadone treatment is associated with a reduced risk of death. Patients' risk of all-cause mortality increases following treatment cessation, and is highest in the initial 4-week period.

Table 2. Advantages and disadvantages of methadone vs. buprenorphine/naloxone

METHADONE	BUPRENORPHINE
ADVANTAGES	
• Potentially better treatment retention • May be easier to initiate treatment • No maximum dose • Potentially better alternative if buprenorphine was unsuccessful in relieving withdrawal symptoms, or was associated with severe side effects • Approved in Canada for the primary purpose of pain control (as split dose BID or TID dosing; Health Canada exemption to prescribe methadone for analgesia also required)	• Less risk of overdose due to partial agonist effect and ceiling effect for respiratory depression (in the absence of benzodiazepines or alcohol) • Reduced risk of injection, diversion, and overdose due to naloxone component, allowing for safer take-home dosing schedules • Milder side effect profile • Easier to rotate from buprenorphine/naloxone to methadone • More flexible take-home dosing schedules may contribute to increased cost savings and patient autonomy • Shorter time to achieve therapeutic dose (1–3 days) • Potentially more effective analgesic for treatment of concurrent pain (however, see disadvantages) • Fewer drug interactions • Milder withdrawal symptoms and easier to discontinue, thus may be a better option for individuals with lower intensity opioid dependence (e.g., oral opioid dependence, infrequent or non-injectors, short history of opioid dependence, currently abstinent but risk of relapse), and individuals anticipated to be successfully tapered off maintenance treatment in a relatively short period of time • Alternate day dosing schedules (as daily witnessed or take-home doses) are possible • Optimal for rural and remote locations where daily witnessed ingestion at a pharmacy is not possible
DISADVANTAGES	
• Higher risk of overdose, particularly during treatment initiation • Generally requires daily witnessed ingestion • More severe side effect profile (e.g., sedation, weight gain, erectile dysfunction, cognitive blunting) • More expensive if daily witnessed ingestion required • Longer time to achieve therapeutic dose (see Appendix 1) • More difficult to transition to buprenorphine once on methadone • Higher potential for adverse drug-drug interactions (e.g., antibiotics, antidepressants, antiretrovirals) • Higher risk of non-medical or other problematic use • Increased risk of cardiac arrhythmias as a result of QTc prolongation • At high doses, may block some of the analgesic effect of concurrent opioid medications administered for pain	• Potentially higher risk of drop-out • If appropriate dose induction schedules are not used (see Appendix 2), may cause precipitated withdrawal • Doses may be suboptimal for individuals with high opioid tolerance • At high doses, may block the analgesic effect of concurrent opioid medications administered for pain • Not approved in Canada for the primary purpose of pain control, though moderate evidence of efficacy • Reversing effects of overdose can be challenging due to pharmacology of buprenorphine

Best-Practices in
ORAL OPIOID AGONIST
THERAPY Collaborative

Impact of treatment for opioid dependence on fatal drug-related poisoning: a National cohort study in England

- Aims: To compare the change in illicit opioid users' risk of fatal drug-related poisoning (DRP) associated with opioid agonist pharmacotherapy (OAP) and psychological support, and investigate the modifying effect of patient characteristics, criminal justice system (CJS) referral and treatment completion.

Intervention	In treatment, modality received								< 0.001
	Residential	3.8	15	3.9	(2.4, 6.5)	1.50	(0.90, 2.49)	1.28	(0.76, 2.13)
	OAP	272	712	2.6	(2.4, 2.8)	1		1	
	Psychological support	31	163	5.3	(4.5, 6.1)	2.00	(1.69, 2.38)	2.07	(1.75–2.46)
	Out of treatment	136	609	4.5	(4.1, 4.9)	1.74	(1.56, 1.94)	1.92	(1.72, 2.15)

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

OAT and Psychosocial Treatment

- Methadone Maintenance Therapy Summary
- In general, the studies reviewed **provide support for the use of psychosocial interventions in the context of MMT**.
- Nine of the 14 studies reviewed reported **significant effects of the psychosocial treatment on treatment attendance and drug use**.

- Specifically, 5 studies (Hesse and Pedersen, 2008; Hser et al., 2011; Chen et al., 2013; Gu et al., 2013; Kidorf et al., 2013) demonstrated greater treatment attendance and 2 studies (Gerra et al., 2011; Gu et al., 2013) demonstrated lower treatment dropout rates when psychosocial treatment was provided relative to a comparison group.
- Five studies (Gruber et al., 2008; Chawarski et al., 2011; Hser et al., 2011; Chen et al., 2013; Marsch et al., 2014) demonstrated decreased opioid use among MMT clients receiving psychosocial treatment relative to a comparison group. In addition, 7 studies revealed significant effects of psychosocial interventions on secondary outcomes including HIV risk (Chawarski et al., 2011), psychosocial functioning (Hesse and Pedersen, 2008; Gerra et al., 2011), adherence to psychiatric medications (Kidorf et al., 2013), alcohol use (Gruber et al., 2008), and fear of detoxification (Stotts et al., 2012) relative to a comparison group. It should be noted that the comparison groups varied across studies and the majority were not MMT-only conditions.

Dugosh, Karen et al. "A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction." *Journal of Addiction Medicine* 10.2 (2016): 91–101. *PMC*. Web. 8 Sept. 2017.

OAT and Psychosocial Treatment

- **Buprenorphine** Treatment Summary
- In general, the support for the efficacy of delivering concurrent psychosocial interventions was less robust for buprenorphine.
- **Three of the 8 studies reviewed found significant effects of the psychosocial treatment on treatment attendance and drug use**.

- One study (Katz et al., 2011) demonstrated higher rates of treatment retention, completion, and attendance among groups receiving concurrent psychosocial treatment.
- Two studies (Brigham et al., 2014) found reductions in opioid use in groups assigned to receive psychosocial interventions, and 1 study (Ruetsch et al., 2012) found that it improved buprenorphine compliance.
- In addition, 3 studies found significant differences for secondary outcomes including treatment satisfaction (Ling et al., 2013), counselor rating (Katz et al., 2011; Ruetsch et al., 2012), and 12-step/self-help meeting attendance (Ruetsch et al., 2012).

Dugosh, Karen et al. "A Systematic Review on the Use of Psychosocial Interventions in Conjunction With Medications for the Treatment of Opioid Addiction." *Journal of Addiction Medicine* 10.2 (2016): 91–101. *PMC*. Web. 8 Sept. 2017.

Sustained-Release Oral Morphine (SROM)

- Less QTc prolongation
- ? Reduced cravings
- ? Fewer side effects
- ? Improved depression/anxiety/mood symptoms

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Supervised-injectable opioid assisted treatment (siOAT)

Summary

- 46-65% of patients discontinue methadone treatment in the first year
- 40-70% of patients discontinue buprenorphine/naloxone treatment in the first six months
- Diacetylmorphine treatment is beneficial in terms of reducing illegal or non-medical opioid use, treatment drop-out, criminal activity, incarceration, and mortality
- 67-88% of patients retained on diacetylmorphine in the first six months
- 77% of patient retained on hydromorphone in the first six months
- Average length of diacetylmorphine treatment is approximately three years

Supervised-injectable opioid assisted treatment (siOAT)

Summary HAT vs Methadone Treatment- v*ia Centre for Interdisciplinary Addiction Research at Hamburg University*

- Higher Retention
- Higher reduction in criminality
- Better Quality of Life
- Better Working Ability
- Less Alcohol Use
- Positive long-term effects: health, drug use, social stabilization
- Comparable results also in patients without previous maintenance treatment

Centre for Interdisciplinary Addiction Research of Hamburg University. Haasen et al, 2007, 2010; Eiro-Orosa et al., 2010; Karow et al., 2010; Löberman & Verthein, 2009; Reimer at al., 2011; Schäfer et al., 2010; Verthein, Degkwitz et al., 2008; Verthein, Bonorden-Kjej et al, 2008, Haasen & Reimer, 2011

Barriers

- Methadone/buprenorphine prescribers
- Intake processes
- Titration to therapeutic dose
- Clinical environment
- MSP/pharmacare coverage
- Clinic fees
- Pharmacy fees
- Supervised dosing
- Missed doses
- Refills/maintenance requirements

Model of Care Case Study

4.2 Low-threshold methadone clinic/Low-threshold addiction care

- An area identified as a critical gap in recent years is low-threshold methadone. To this end, VCH will establish a care team in the DTES for people with untreated opioid
- Addiction who have proven to be difficult to engage and retain in health services.

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

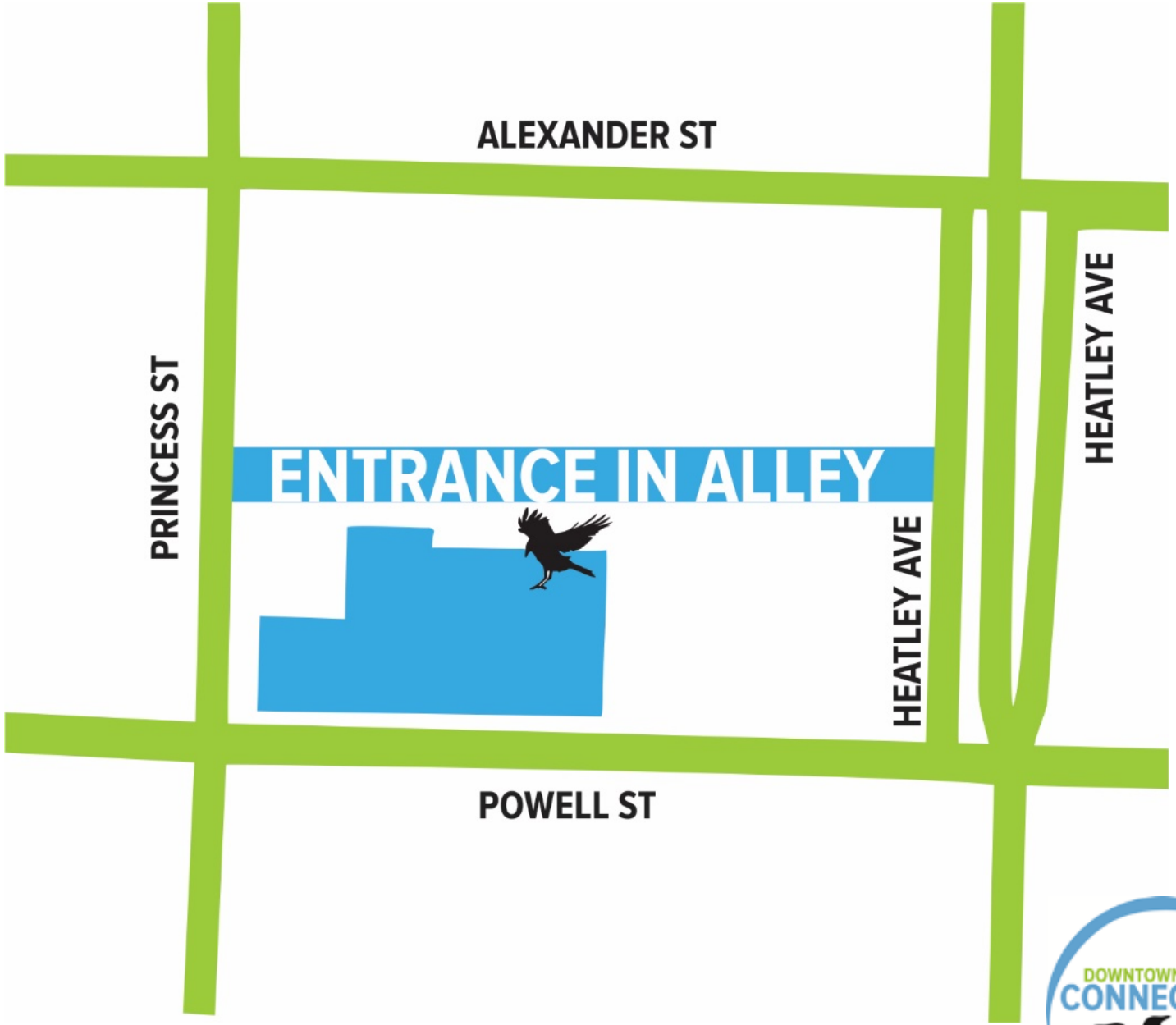
Plan

To provide a care team and facility in the Downtown Eastside for people with untreated opioid use disorder who have proven to be difficult to engage and retain in health services. A multi-disciplinary team would provide opiate agonist therapy and linkage to primary care, HIV, substance use and mental health services.

The objectives of this service are:

- ***Engage*** this population with a low threshold approach,
- ***Address*** *obstacles* to treatment initiation, adherence, and retention,
- ***Generate and enhance pathways*** and links for the client to other health services, particularly mental health, addiction, primary care and HIV care.
  - *As well as addresses directly, and seeks to minimize, the inherent individual & public health risks associated with the use and availability of prescribed opioids

DOWNTOWN EASTSIDE CONNECTIONS


ALEXANDER ST
PRINCESS ST
ENTRANCE IN ALLEY
HEATLEY AVE
HEATLEY AVE
POWELL ST
DOWNTOWN EASTSIDE
CONNECTIONS

Plan

Accessibility

- **Open 7 days/week**; including 7 days/week, *365 days/year physician coverage*
- Located in the DTES, close to other services (DCHC, Living Room, ASC, VNH, Sheway, etc.)
- Low-barrier philosophical approach and staffing model (peer support, etc.)
- **NO FEES**
- Able to serve clients/residents recently arrived from out-of-province/country and do not yet have MSP coverage

Engagement

- **Nutrition/meal program**
- **"Drop-in" atmosphere**; TVs, Computer access, board games, etc.
- Social work, counselling, financial liaison, peers, health navigators
- On-site supportive groups to enhance motivation, build self-management skills and reduce isolation

DOWNTOWN EASTSIDE CONNECTIONS

Plan

Harm Reduction Approach

- Reduction in use as primary goal, but not requiring abstinence
- Robust Take-Home Naloxone distribution
- Distribution of general harm reduction supplies (drug use equipment, condoms etc.)
- Access to Nicotine Replacement Therapy

Efficient & Expedited Intake Assessment & Initiation

- Nurse led, physician and interdisciplinary team supported
- **Goal of same day starts: ideally w/in 120mins of program entry**
- On site phlebotomy, full access to CareConnect, PARIS, Pharmanet, VCH Primary Care EMR system
- Staffing and systems designed to support buprenorphine induction (which can be challenging and resource intensive in other settings); including integrated pharmacy team

DOWNTOWN EASTSIDE CONNECTIONS

Plan

Maximize Retention

- In-house, health authority managed, dedicated clinic pharmacy for program patients
- Access to RN/MD team for primary care issues
- Focus on efficient and timely dose adjustments and titration; pharmacy/nursing/MD coordinated post-dose assessments (with aim to minimize time required to reach full therapeutic dose)
- Outreach capacity; nursing, HCW ability to outreach clients/patients who have missed doses
- Collaboration with other ORT providers to enable short term continuation of methadone/buprenorphine for patients on weekends/holidays who may have missed refill appointments, etc. (with aim of preventing relapse and/or the need for large dose decreases)
- Staffing and protocols in-place to support rapid dose re-titration for those who have missed multiple days (i.e. ability to provide post-dose monitoring)

DOWNTOWN EASTSIDE CONNECTIONS

Plan

Linkage and Transition to Care

- Referrals and collaboration with mental health system, HIV care and Hepatitis C treatment programs
- MD/RN team will also provide essential primary care
- Shared EMR/health record with PC network will greatly facilitate transfer when stability has increased

Education and Research

- Built with intent to provide rich teaching environment for all disciplines
- Direct relationship with the BC CfE Hope to Health research clinic
- E.g. early planning already in progress for a RCT of the treatment of stimulant users

DOWNTOWN EASTSIDE CONNECTIONS

Safety

- On site pharmacy, with pharmacists as key members of care team, and trained to assist with opiate intoxication/withdrawal assessments
- Increased use of buprenorphine therapy, with it's better safety profile
- Strict "no carries" policy for methadone (goal will be for patients who have stabilized to transfer to other programs)
- Take-Home Naloxone program
- Strict benzodiazepine policy (similar to PHS policy; e.g. only for EtOh withdrawal or controlled tapers)
- Full cooperation and collaboration with other DTES partners in Primary Care, PHS, VNH, private methadone clinics, etc.

DOWNTOWN EASTSIDE CONNECTIONS

Challenges

- Transitions
- Capacity & volume
- Staffing; especially MD
- Bridging issues

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Discussion

Break

Return at 10:40 AM

Improving Opioid Agonist Therapies with System Change

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BOOST LAUNCH
VANCOUVER, BC SEPTEMBER 15, 2017

Disclosures

- Dennis McCarty is a Principal Investigator and co-investigator on awards from the National Institutes on Health (R01 MH1000001; P50 DA018165; R01 DA030431; R01 DA029716; R21 DA031361; R21 DA035640; UG1 DA015815)

Walter Ling, MD
On Addiction and Sin

- *““From the very beginning our policy has been: Addicts are sick, they need help; but they also sin and must suffer a little.*
- *So we built treatment programs and put up barriers making it difficult for patients to get into treatment.”*

Overview

- System change to promote adoption of oral opioid agonist therapy for opioid use disorders
  - NIATx
    - Primer on process improvement
  - Advancing Recovery and the Medication Research Partnership
  - Opioid agonist therapy reduces emergency and inpatient care

NIATx: Process Improvement for Addiction Treatment

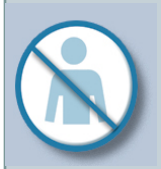
- Network for the Improvement of Addiction Treatment
- Support from the …
  - Robert Wood Johnson Foundation
  - Center for Substance Abuse Treatment
  - National Institute on Drug Abuse
- Initially 39 community-based treatment organizations
- NIATx 200 = 5 states & 40 programs/state
- See www.niatx.net for tools and details

NIATx overview

- Simplified IHI approach for quality improvement
- Plan-Do-Study-Act (PDSA) cycles to improve organizational processes and services
- Strategies implemented in many industries, including health care and substance abuse treatment
- Treatment programs use research to improve practice

NIATx Aims (and Measures)

Reduce Wait Times (days to trt)



Reduce No-Shows (% kept appts)

Increase Admissions (# admits)

Increase Continuation Rates
(% returning for next visit)

Process Improvement Principles

1. Understand and involve the customer
2. Focus on customer concerns
3. Select an influential change leader
4. Seek ideas from outside the field
5. Use rapid cycle testing:
   Plan-Do-Study-Act

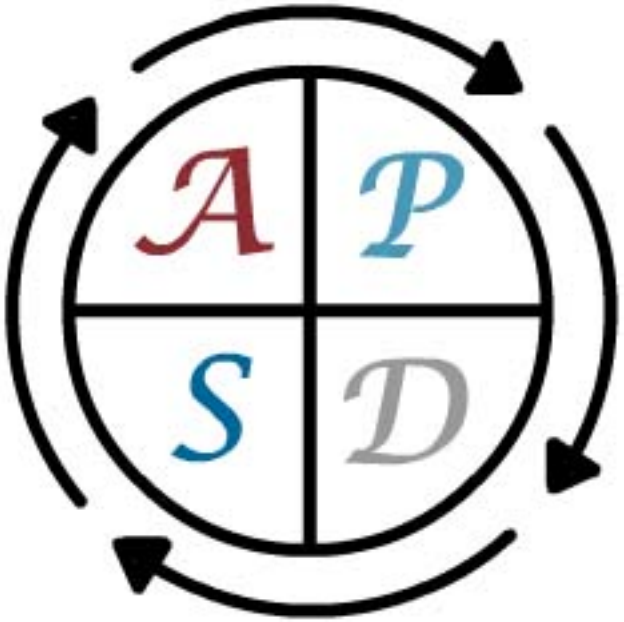
Rapid-Cycle Testing

Rapid-Cycle changes

- Are quick – a few patients & a short time

PDSA cycles

- **P**lan the change
- **D**o the plan
- **S**tudy the results
- **A**ct on the new knowledge



Rapid Cycles …

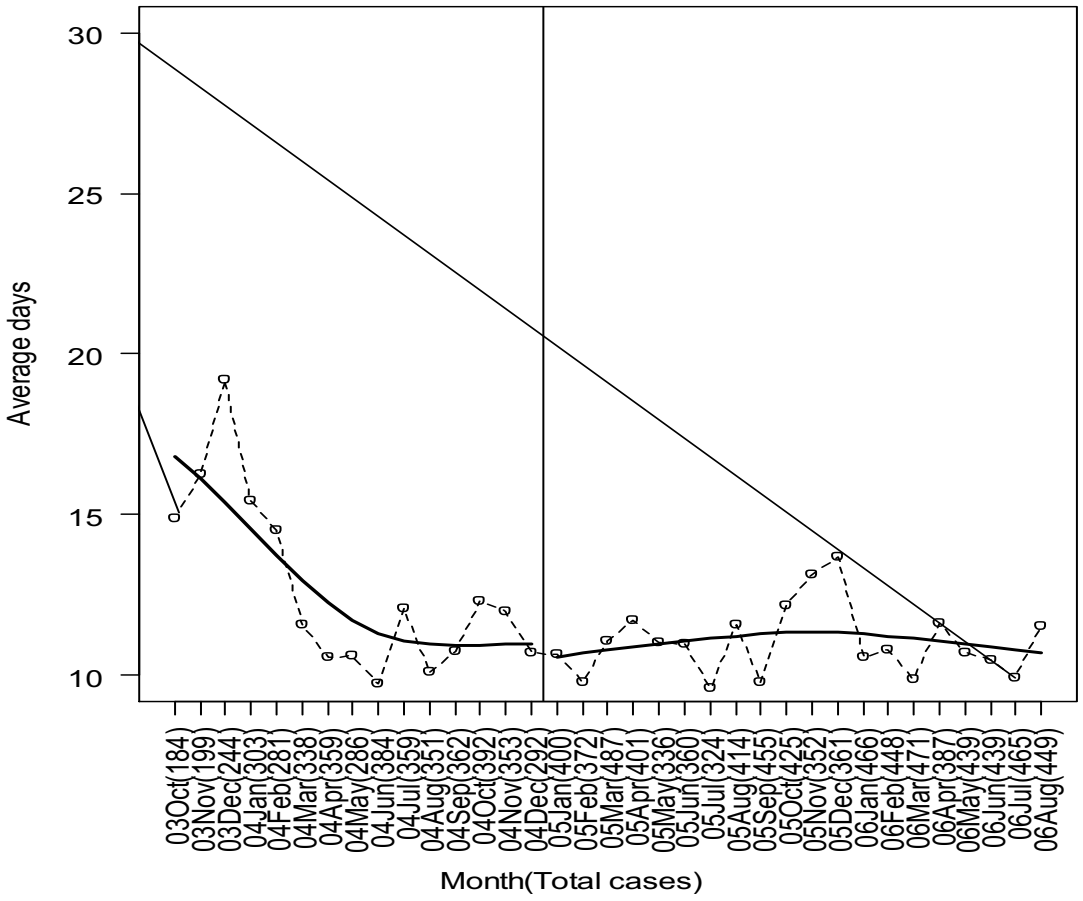
- "…reduce staff resistance to change because they engage staff at a low level – the change is temporary and begins small."

  Arthur Schut, CEO, MECCA, Iowa City, IA, June 27, 2006

Conduct a Walkthrough
Become a customer

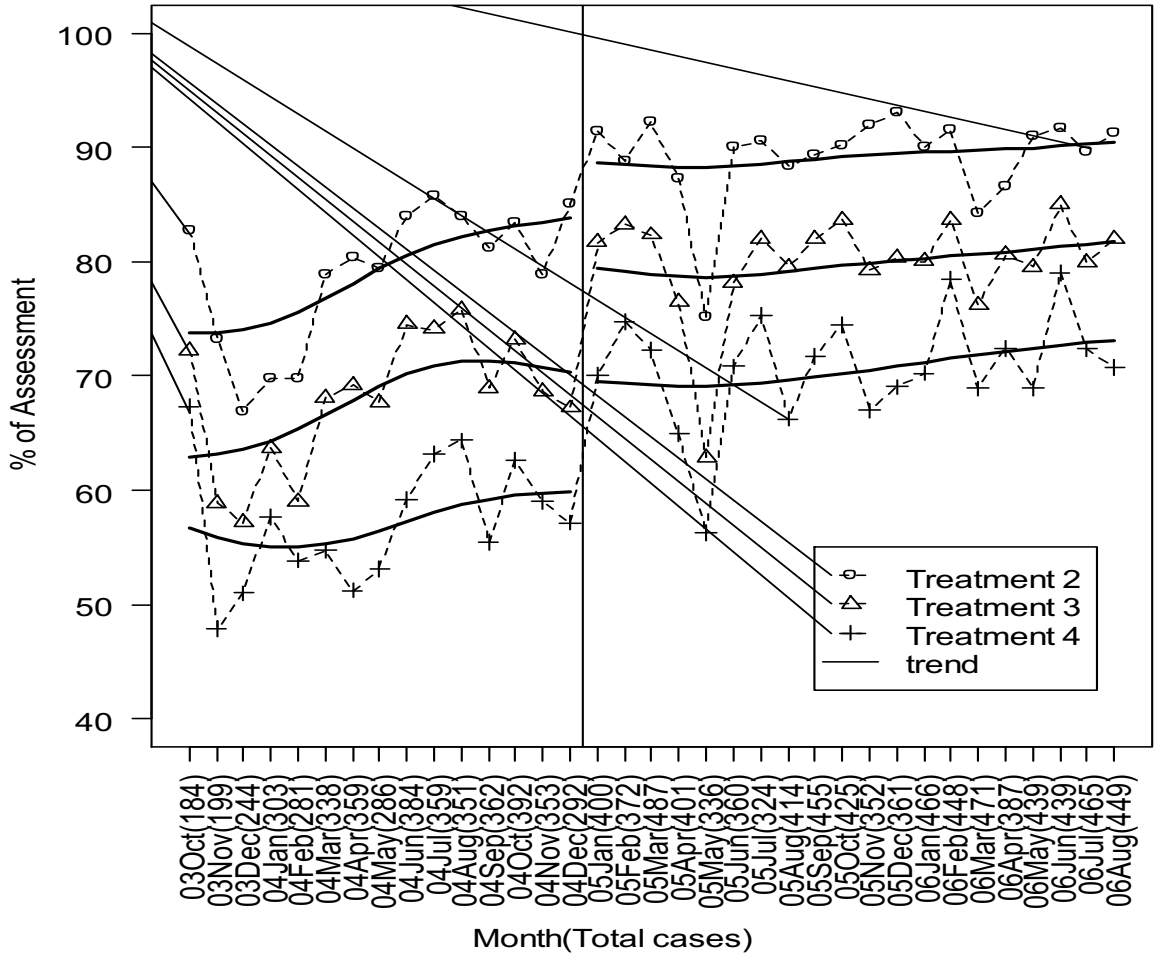
- Role play a “patient”
  - Call for an appointment: What happens?
  - Arrive for the appointment:
    - How are you greeted?
    - Were directions clear and accurate?
  - Complete an intake process:
    - How long does it take?
    - How redundant are the questions?
  - What did you learn? What will you change?

Access Improvements Sustained
(Hoffman et al., 2008, Drug & Alcohol Dependence)



Retention Improvements Sustained

(Hoffman et al, 2008, Drug & Alcohol Dependence)



NIATx Measures: Summary

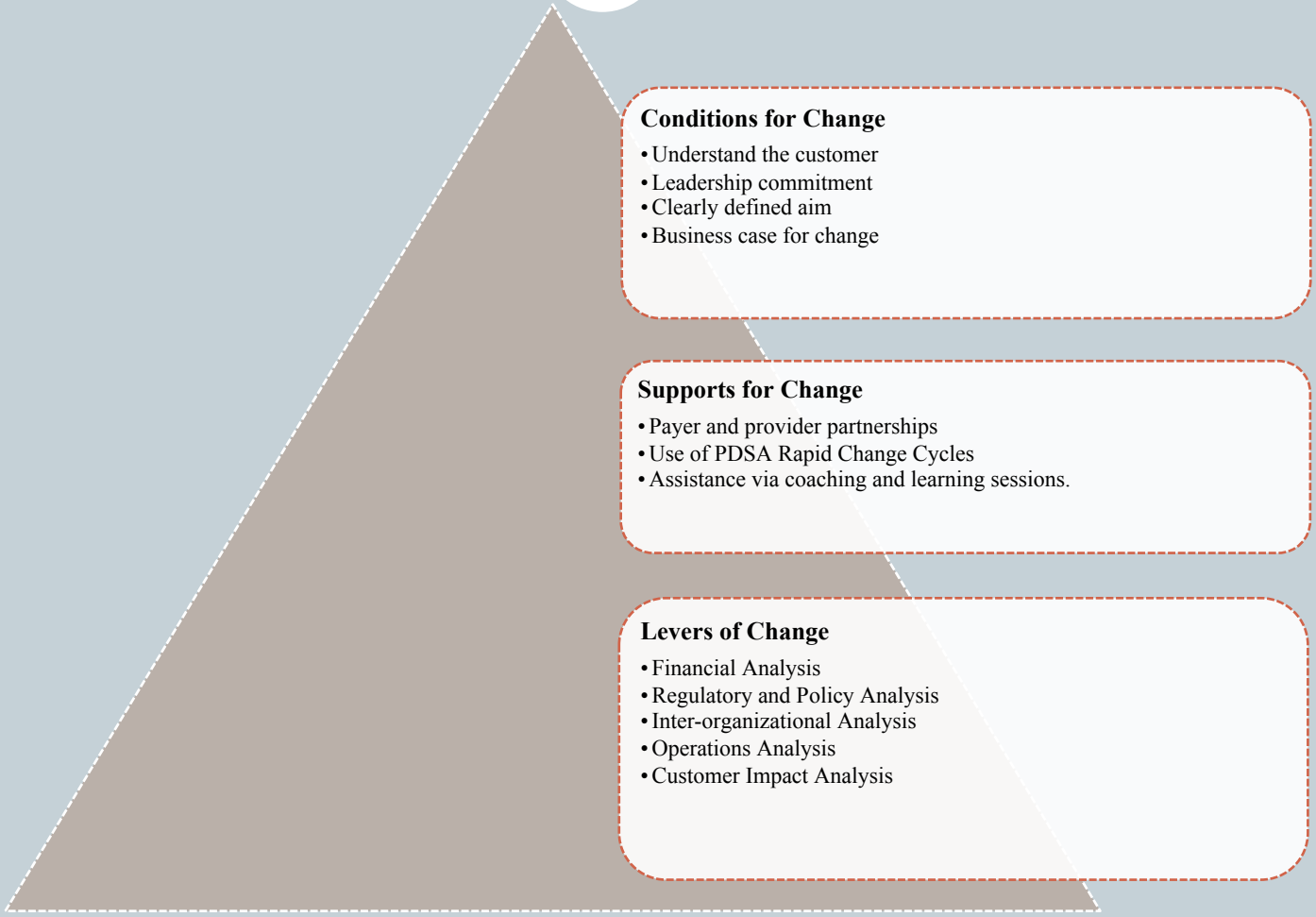
- Simple measures
- Direct indicators of the process being addressed
- Collect automatically or with minimal burden
- Monitor easy processes to begin
- Expand measures with experience
- Limit the number of key measures

NIATx 200: Spreading and Testing

- 201 treatment centers in MA, MI, NY, OR, & WA
- Randomized to a) interest circle calls, b) coaching, c) learning sessions, d) all 3 supports
- Days waiting declined
- Coaching increased admissions 20%
- Retention did not improve
- Coaching (change leader advising) was most cost-effective method

- (Gustafson et al, *Addiction, 2013)*

Advancing Recovery Systems Change Model



Conditions for Change

- Understand the customer
- Leadership commitment
- Clearly defined aim
- Business case for change

Supports for Change

- Payer and provider partnerships
- Use of PDSA Rapid Change Cycles
- Assistance via coaching and learning sessions.

Levers of Change

- Financial Analysis
- Regulatory and Policy Analysis
- Inter-organizational Analysis
- Operations Analysis
- Customer Impact Analysis

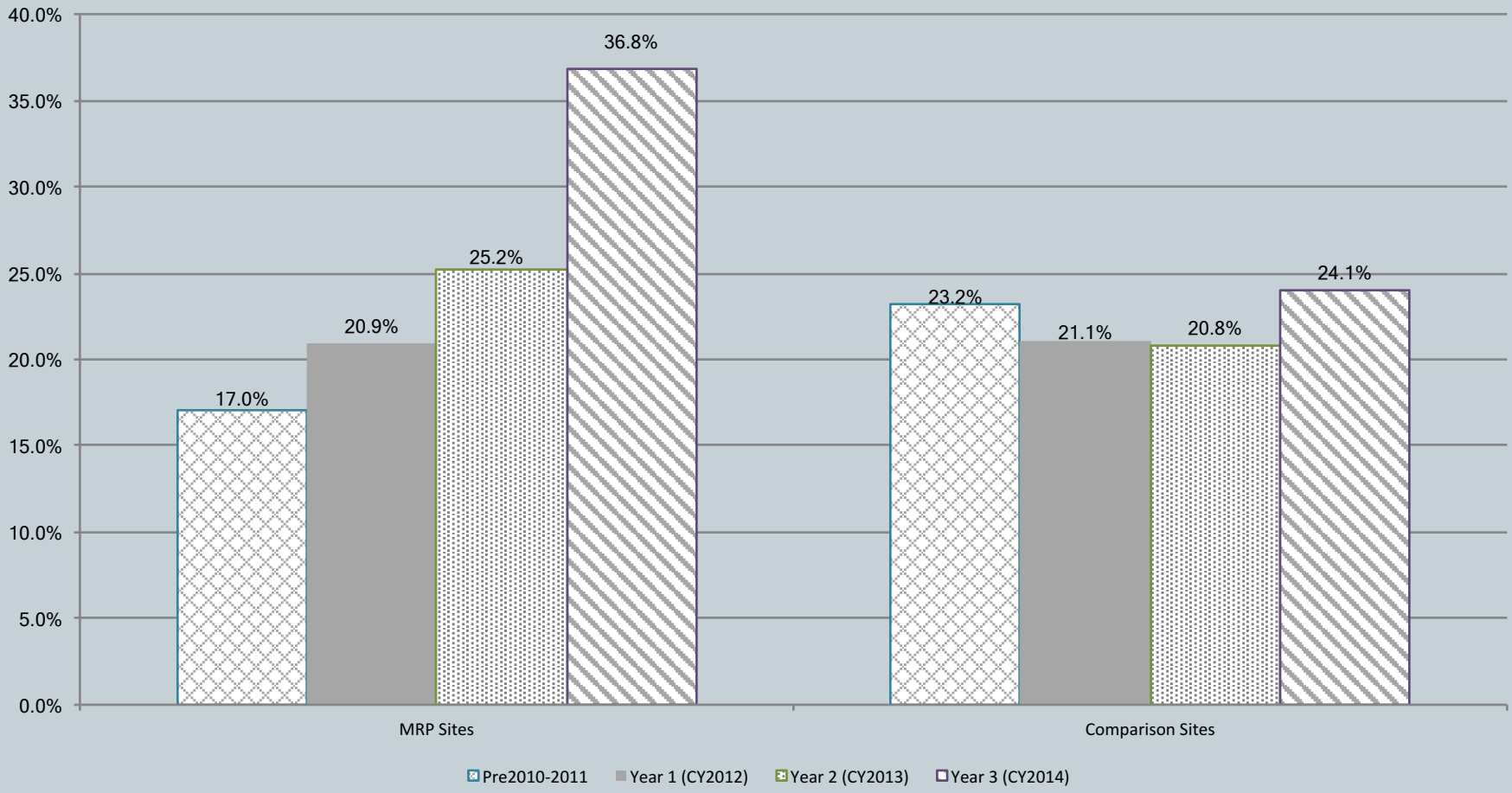
Patients on medication
(admissions per quarter)

Quarter	Colorado	Dallas	Maine	Missouri	West VA
	XR-Ntx	Bup	Bup	Etoh meds	Bup
Q1			39	13	57
Q2			41	48	63
Q3			77	48	59
Q4			87	61	63
Q5	20	27	97		68
Q6	45	19	95		64
Q7	16	20	82	111	76
Q8	13	33	78		
Total	94 patients	99 patients	596 patients	281 patients	450 patients

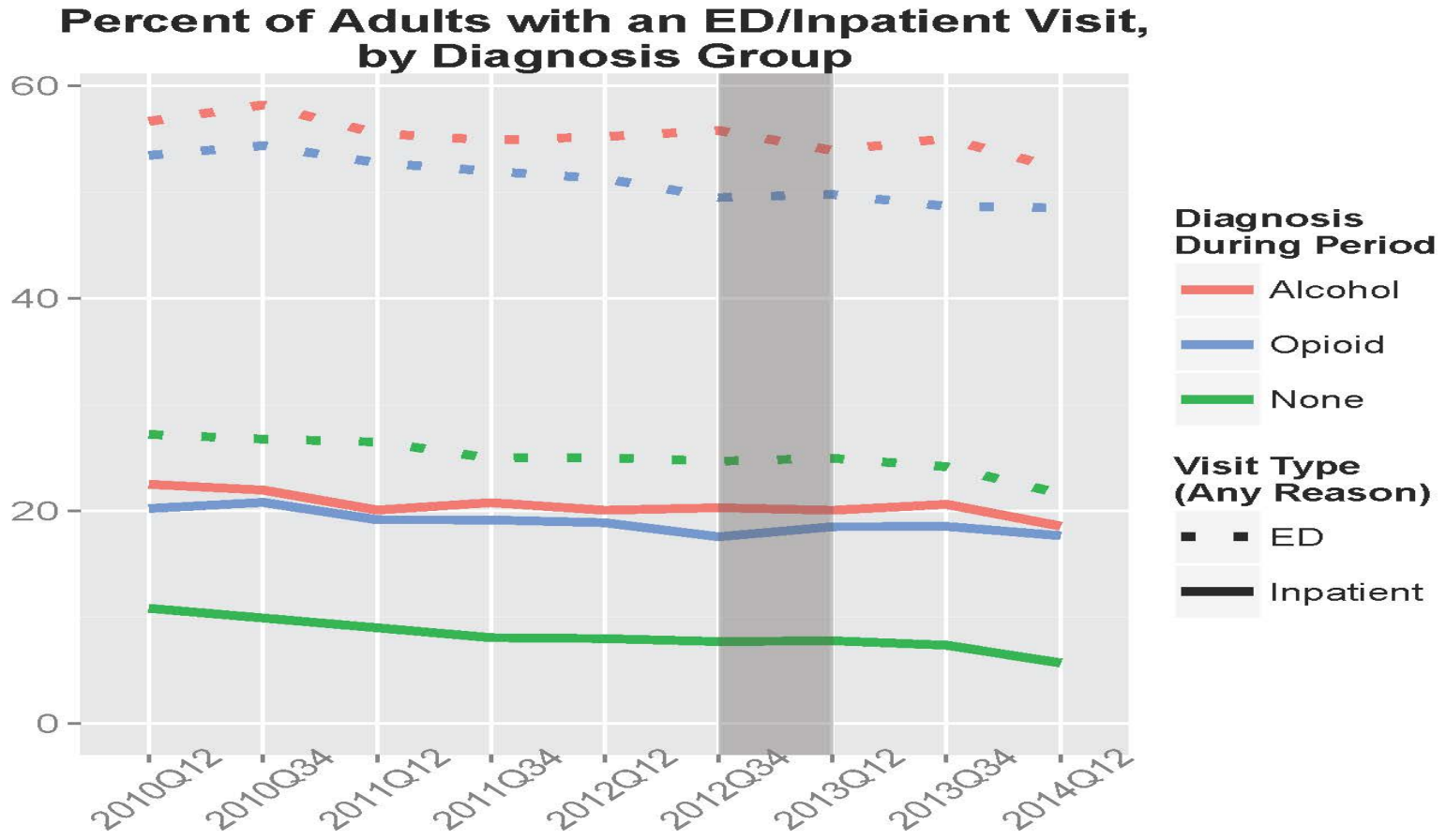
Medication Research Partnership

- Advancing Recovery extended to commercial health plan
- Clinics increased use of alcohol and opioid meds
- Health plan incentivized use of XR-NTX
  - Allowed 25 days of inpatient care
- Programs increased slowly but steadily
  - New physicians that support use of meds
  - Corporate support
  - Staff training and linkages with community physicians

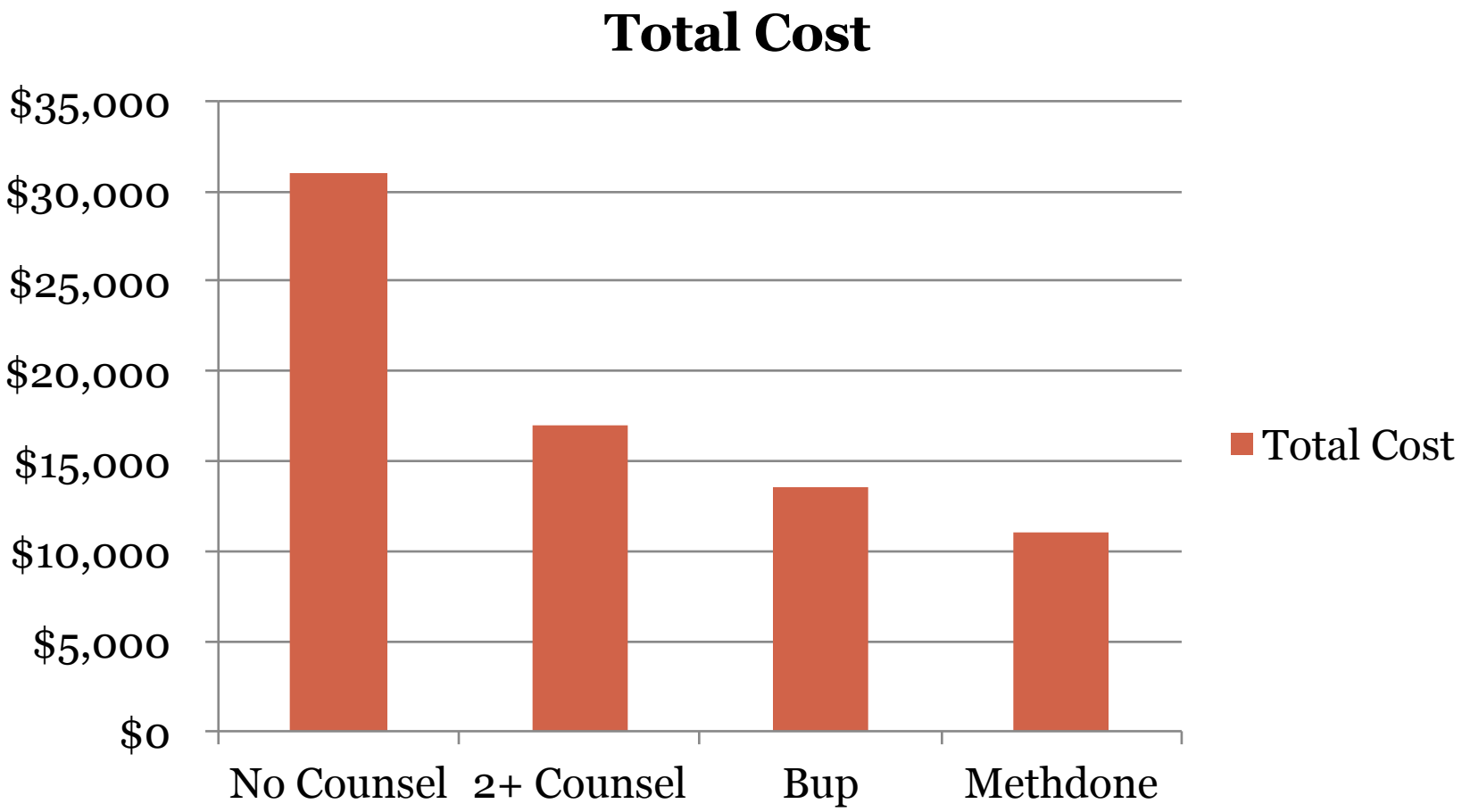
OUD patients on medication by year



ED Visits and Inpatient Days by Diagnosis



OUD Costs of Care: Bup Costs Similar to Counseling Only (Lynch et al 2014; 2008 $)



Primary Care Models for treating OUDs

- Hub and Spoke – specialty clinic stabilizes patient on buprenorphine and transitions to regular care
- Project Echo – telemedicine coaching and support
- Nurse Care Manager – nurse leads screening and intake, assists in induction, and manages future care
- ED initiation – patients in emergency care, inducted on buprenorphine & transferred to continuing care
- Inpatient initiation – inpatients stabilized on bup and transitioned to primary care when discharged
- Korthuis et al (2017) *Annals of Internal Medicine*

Walter Ling, MD On Detoxification

- "Detoxification is good for many things.
- Staying off drugs is not one of them."

Aspirations for Improving Care and Service

Activity

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

BOOST Collaborative Areas of Focus

- Diagnosis and Treatment Initiation
- Treatment Retention and Optimal Dosing
- Quality of Life and Bundle of Care

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Questions to consider…

- Within one of these focus areas or any point along the continuum of care, where do you see the highest leverage opportunities to close gaps in care?
  - Be specific
- What would be the first step in addressing that gap in care? What is something you can do tomorrow?

BOOST Collaborative Aims and Expectations

Laura Beamish, MSc | BOOST Collaborative Lead
Quality Improvement Coordinator, BC Centre for Excellence in HIV/AIDS
Danielle Cousineau, RN | BOOST Collaborative Lead
Quality Improvement Consultant, BC Centre for Excellence in HIV/AIDS

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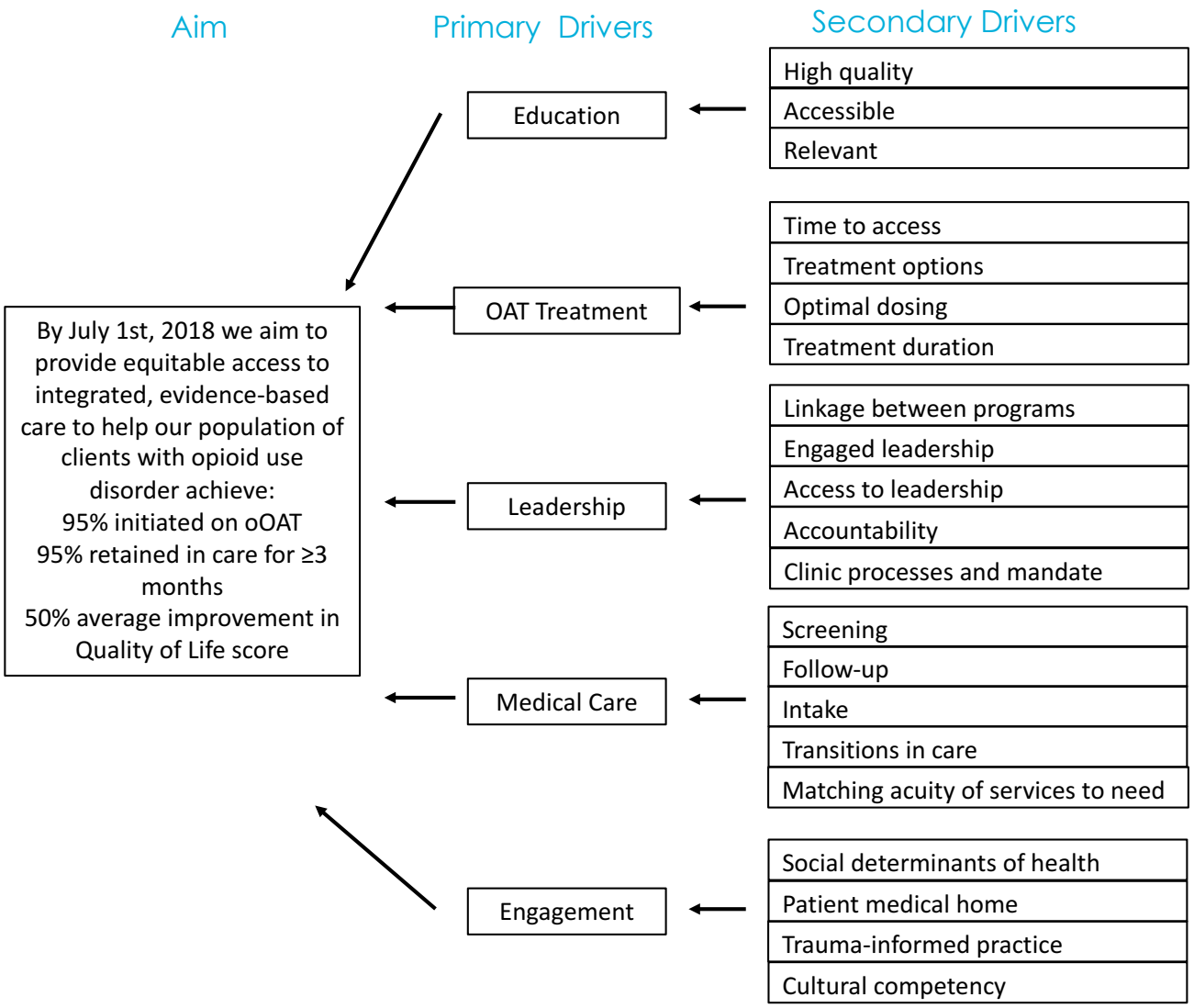
What are we trying to accomplish?



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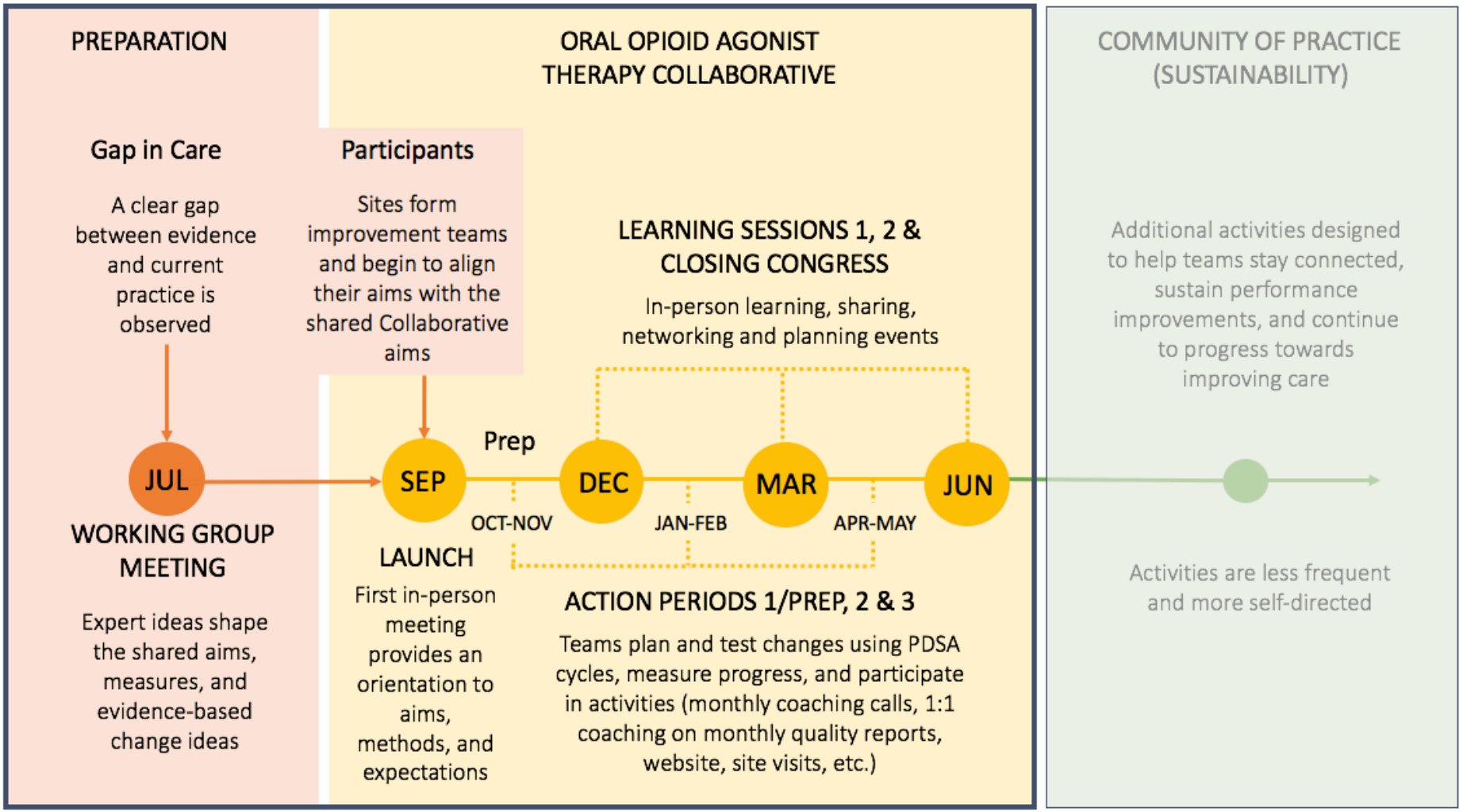
How will we accomplish this?

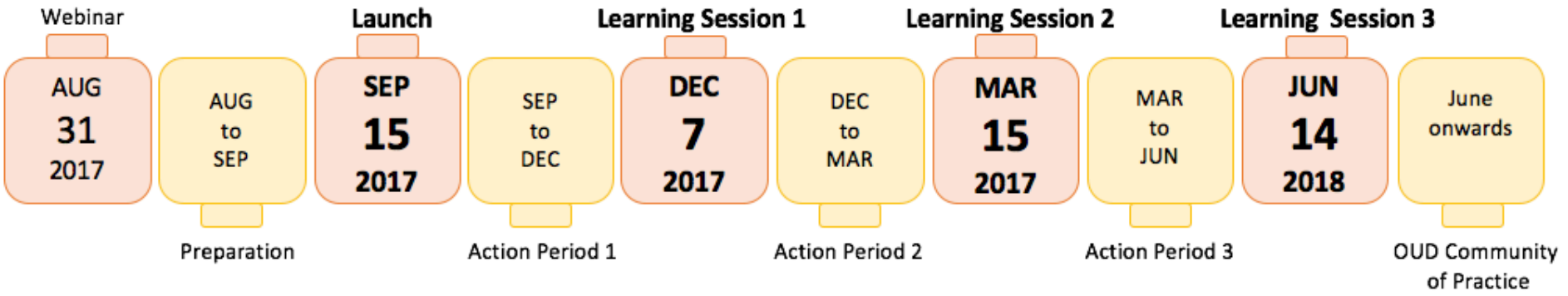
BOOST Collaborative Methodology



Adapted from 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)

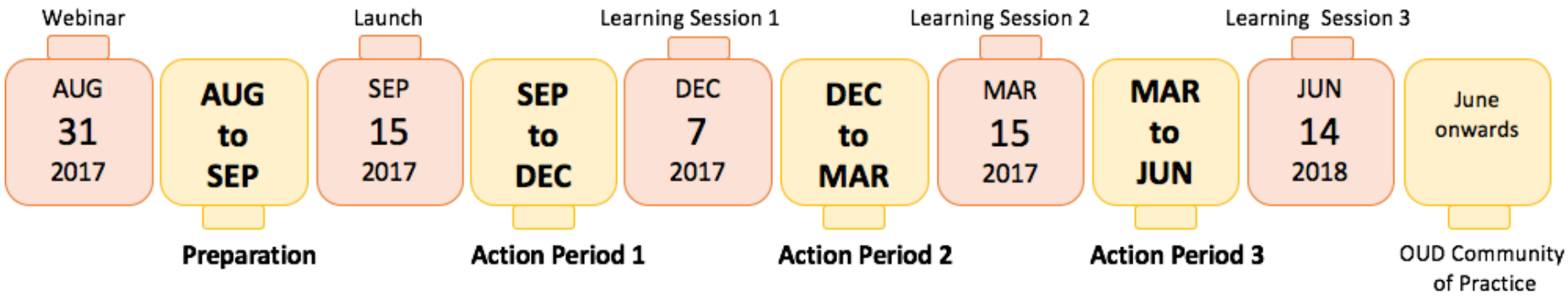
Timeline- Learning Sessions

- Launch + 3 in-person Learning Sessions
  - Opportunity for learning, sharing, and networking
- **Learning Session 1:** December 2017
  - Key focus on linking clients to care and outreach and oOAT dosing
- **Learning Session 2:** March 2018
  - Key focus on spreading change, client engagement, personal action planning and chronic pain and OUD
- **Learning Session 3:** June 2018
  - Key focus on sustaining improvements, collaborative successes, and injectable OAT



Timeline- Action Periods

- Preparation Webinar + Three Action Periods
- **Action Period 1**: September to December 2017
  - Key focus on testing change on a small scale, measurement optimization, and team engagement
- **Action Period 2**: December 2017 to March 2018
  - Key focus on testing and adapting changes for spread, ongoing measurement reporting, relationship building, trauma informed care, and cultural competency
- **Action Period 3**: March to June 2018
  - Key focus on results in process and outcome measures, maintaining momentum, housing and developing an OAT community of practice



Collaborative Measures and Reporting

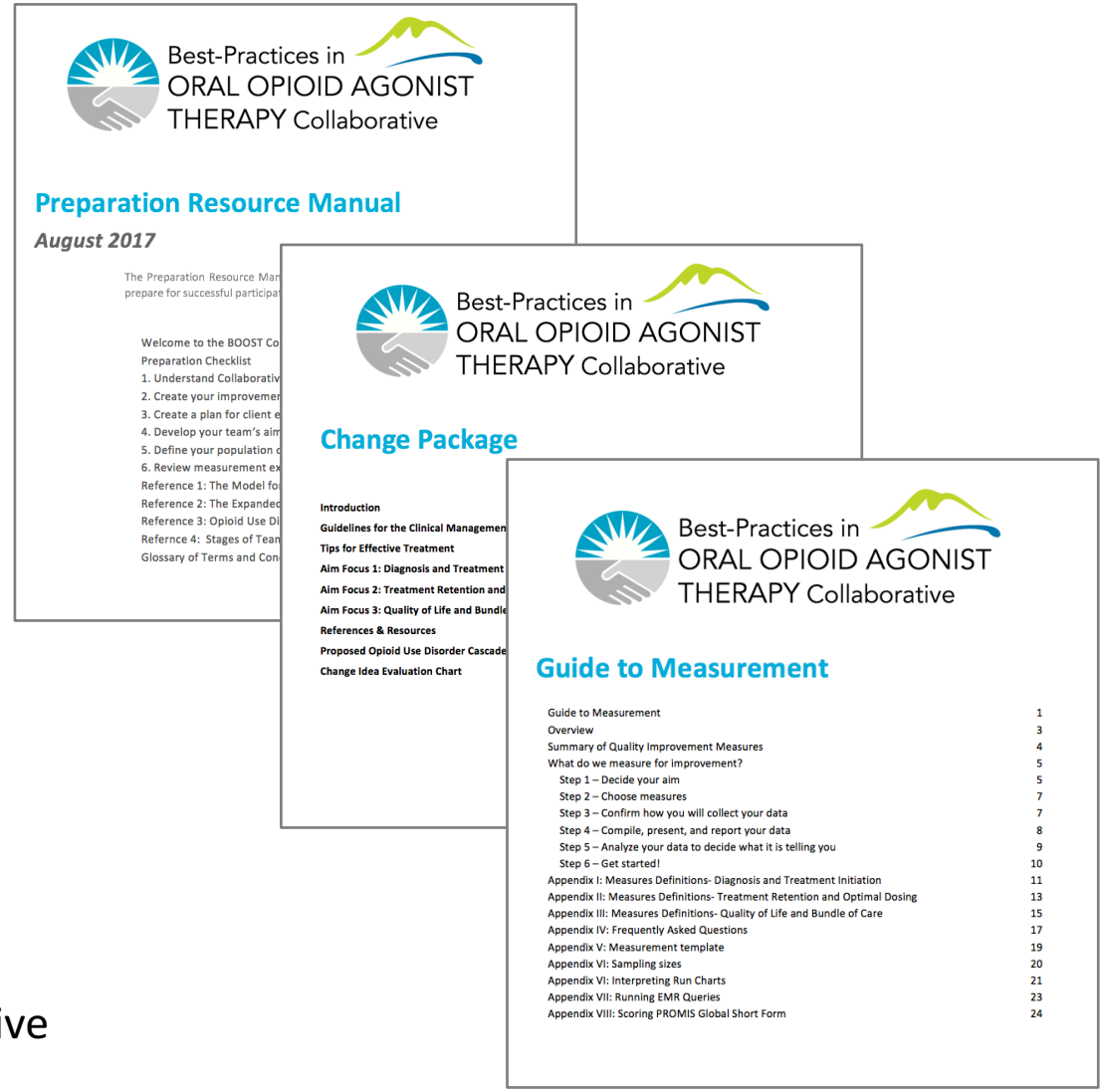
- Key metric focus areas
  - Diagnosis and Treatment Initiation
  - Treatment Retention and Optimal Dosing
  - Quality of Life and Bundle of Care
- Monthly reporting
  - Quality metrics
  - Team Narrative
  - Last Thursday of every month starting October 26th, 2017
  - Monthly measurement summary report for all teams

Support Activities

- Webinars
  - Monthly webinars and/or coaching calls on topics you request!
- In-practice coaching
  - In-practice QI support from PSP
- LISTERV
  - Interactive two-way communication between all members of the Collaborative
- Expert Faculty
  - Expert consultation
- Report summaries
  - Monthly summaries sent to teams on how we are doing collectively at achieving our aims

Technical Documents

- Preparation Manual
- Navigation Booklet
- Change Package
- Guide to Measurement



www.stophivaids.ca/oud-collaborative

Core Collaborative Measures and Reporting Resources

Cole Stanley, MD, CCFP

Family Physician, Raven Song & IDC

Medical Lead, Continuous Quality Improvement, Vancouver Coastal Health

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Outline

- Outcome, process, and balancing measures
- EMR OUD visit template
- EMR Queries
- Excel reporting tool
- Population of focus
- Key Metrics
  - Engagement (1.2)
  - OAT access (1.3)
  - Active oOAT (2.2)
  - Optimal oOAT dosing (2.3)
  - Retention on oOAT (2.4)
  - Quality of Life score (3.2)
- Optional measures

Three types of measures

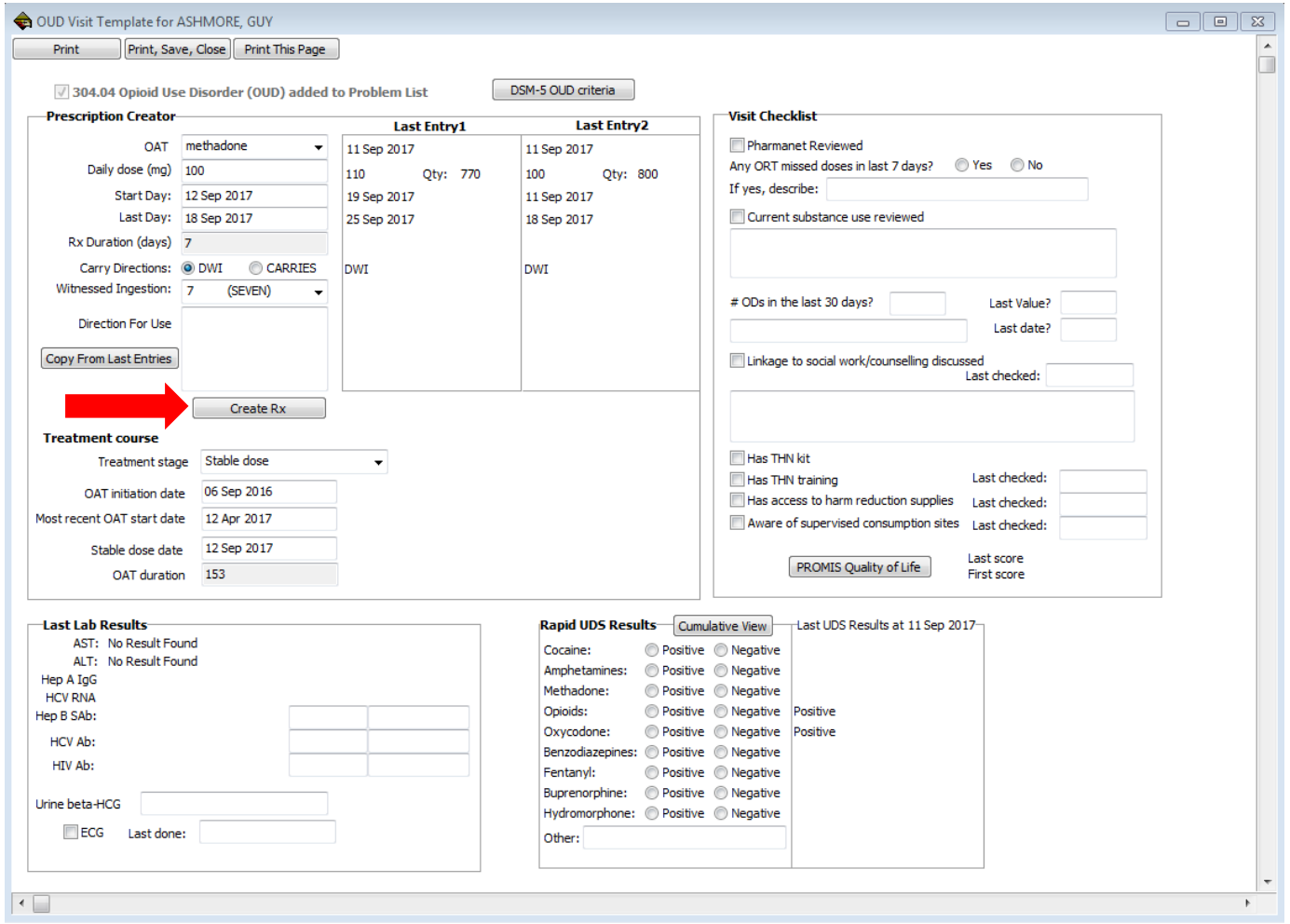
- How will we know that our changes resulted in an improvement?
- **Outcome measures**: what are we trying to achieve?
- **Process measures**: Are we doing the right things to get there?
- **Balancing measures**: Are our changes causing problems to other parts of the system?

Three types of measures - Example

- The team decides to test a change where the LPN will call patients on day before rx is due as a check-in/reminder, with hopes of decreasing missed doses and increasing retention

- **Outcome measures**: Number of missed doses, Retention on oOAT
- **Process measures**: percentage of missed dose faxes from pharmacy that prompted a phone call to patient
- **Balancing measures**: Time taken by LPN to do this work

EMR OUD Visit Template



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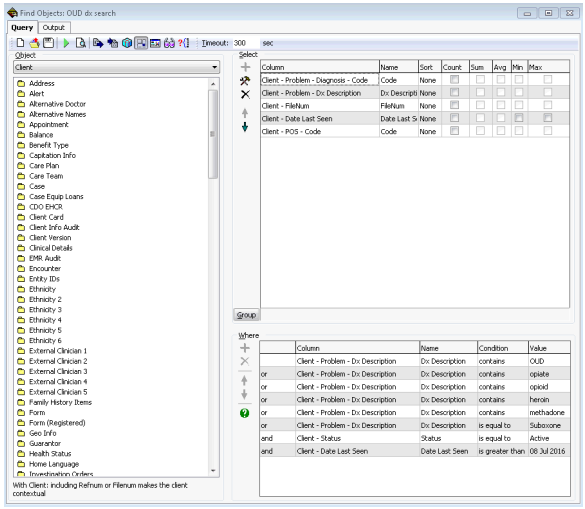
EMR Queries

- Each team on Profile EMR should have at least one person with access to QI/queries environment so that queries can be run and reports created monthly
- Contact cole.stanley@vch.ca if you need to gain access for a team member

Profile EMR queries - Examples

BOOST 1 POF baseline
BOOST 1 POF 304.0 opioid use disorder

BOOST 1.2N Engaged in care/lost to care
BOOST 1.2D Engaged in care/lost to care
BOOST 1.3N oOAT access



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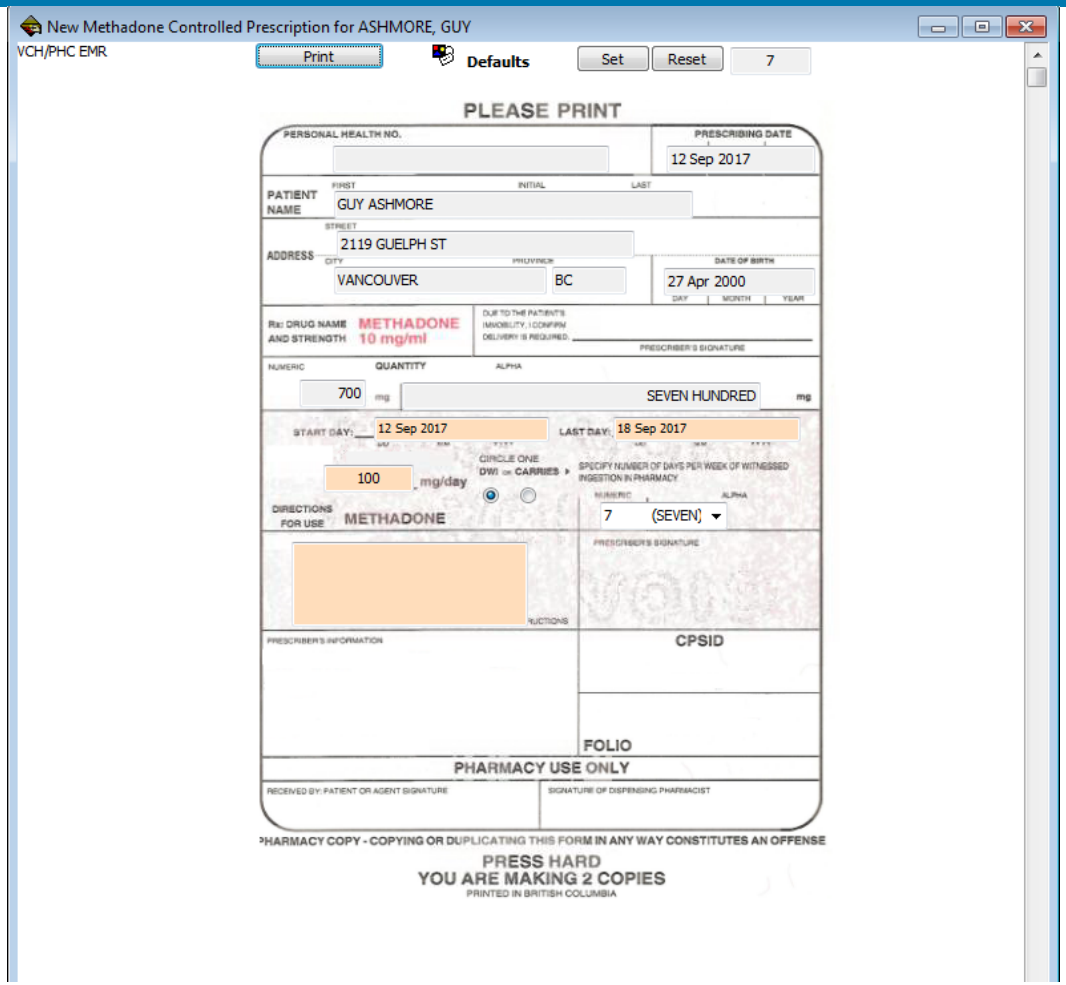
EMR OUD Visit Template



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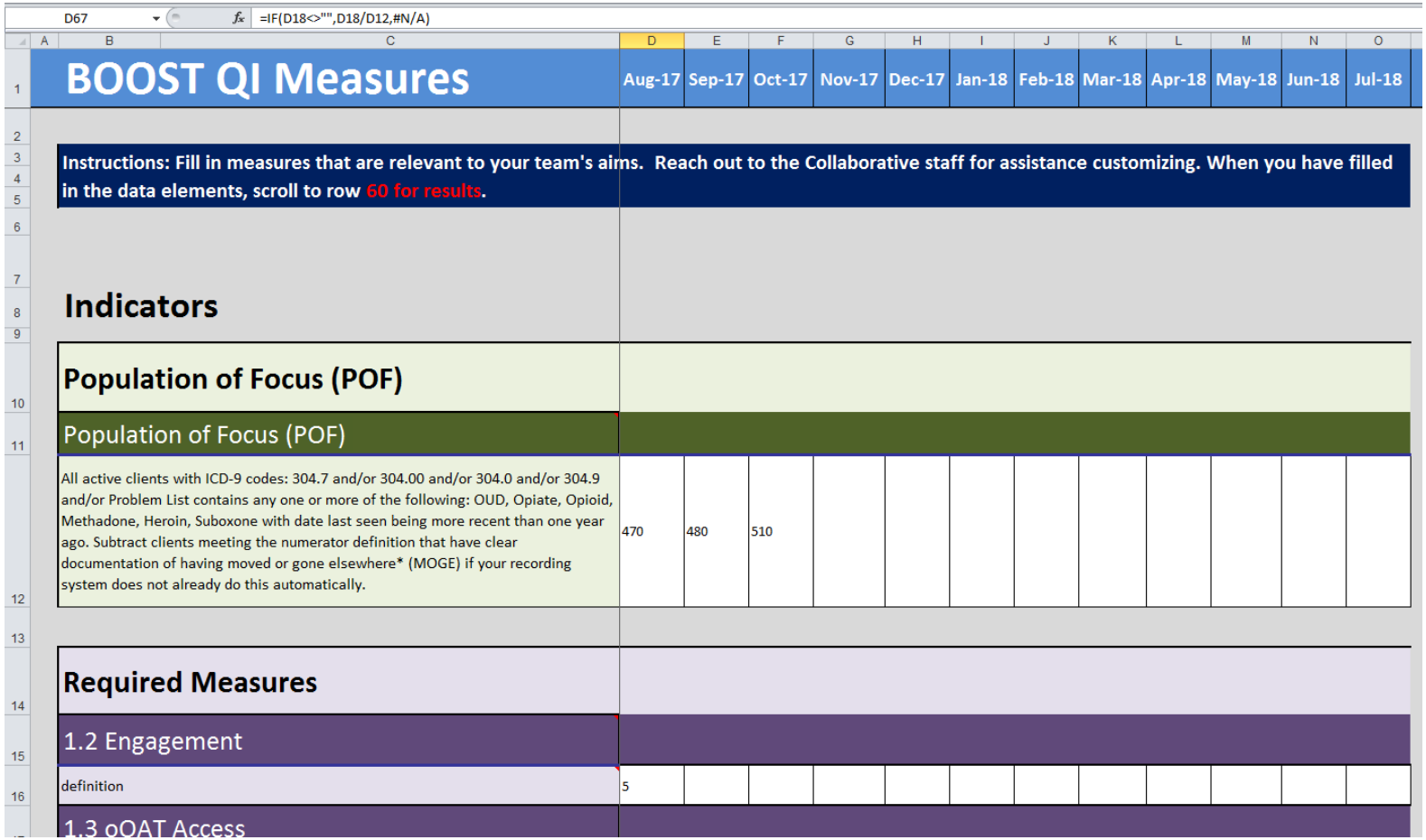
Excel Reporting Tool



D67 | =IF(D18<>"",D18/D12,#N/A)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1		**BOOST QI Measures**		Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
2															
3		**Instructions: Fill in measures that are relevant to your team's aims. Reach out to the Collaborative staff for assistance customizing. When you have filled in the data elements, scroll to row 60 for results.**													
4															
5															
6															
7															
8		**Indicators**													
9															
10		**Population of Focus (POF)**													
11		Population of Focus (POF)													
12		All active clients with ICD-9 codes: 304.7 and/or 304.00 and/or 304.0 and/or 304.9 and/or Problem List contains any one or more of the following: OUD, Opiate, Opioid, Methadone, Heroin, Suboxone with date last seen being more recent than one year ago. Subtract clients meeting the numerator definition that have clear documentation of having moved or gone elsewhere* (MOGE) if your recording system does not already do this automatically.		470	480	510									
13															
14		**Required Measures**													
15		1.2 Engagement													
16		definition		5											
		1.3 oOAT Access													

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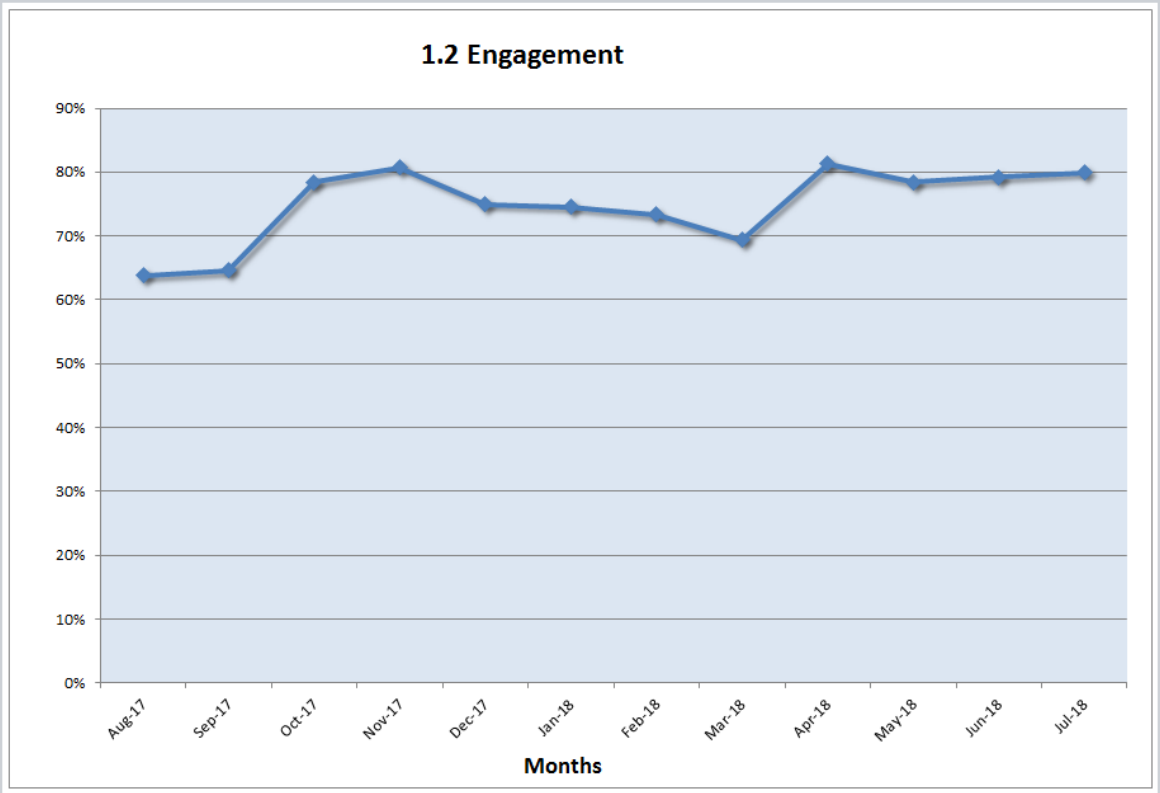
Excel Reporting Tool



1.2 Engagement | 1.3b | 1.4 | 2.2ab | 2.3 | 3.2 | 3.3 | 1.5 | 1.6 | 1.7 | 1.8 | 1.9 | 2.4 | 2.5 | 2.6 | 2.7 | 2.8 | 3.4 | 3.5 | BLANK

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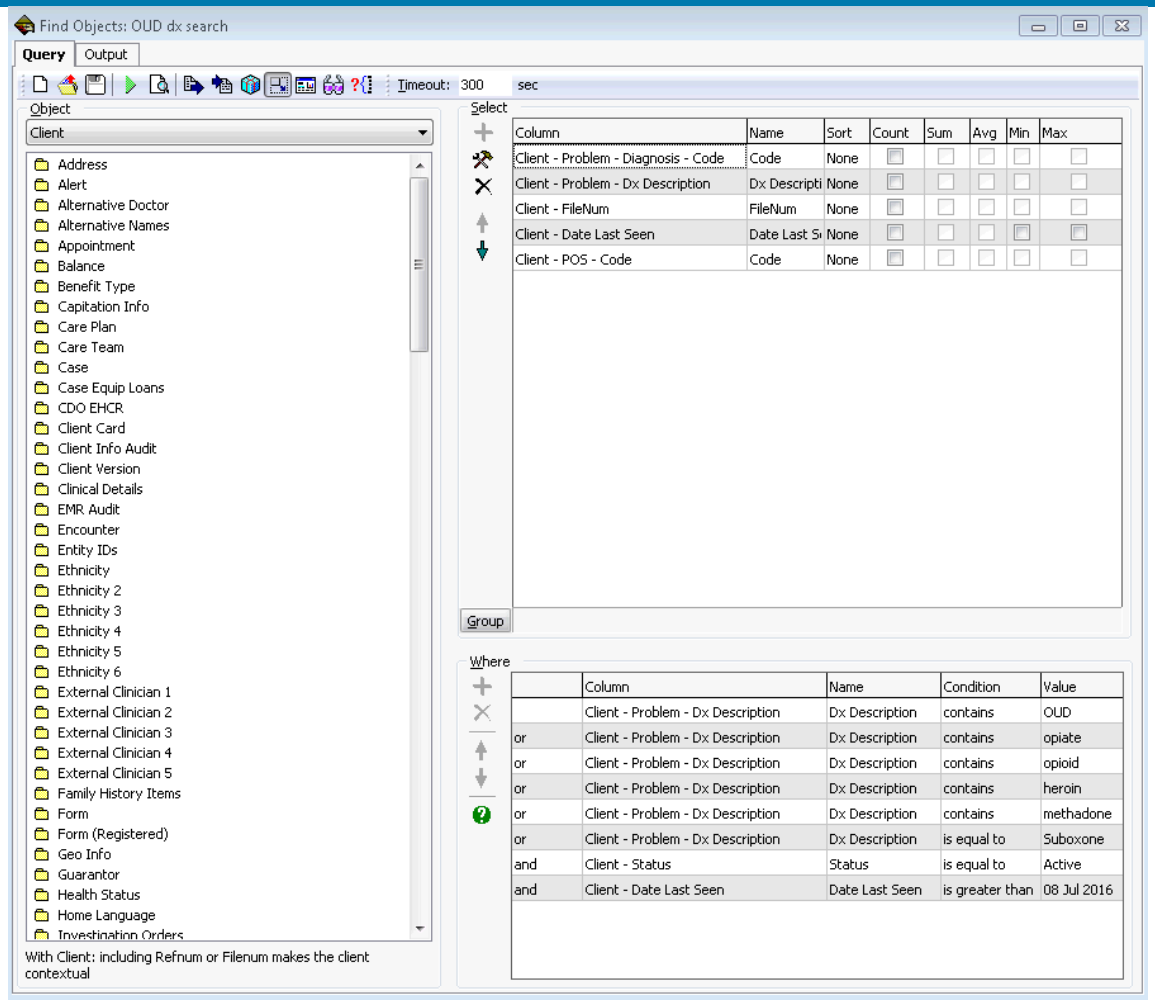
Population of focus (POF)

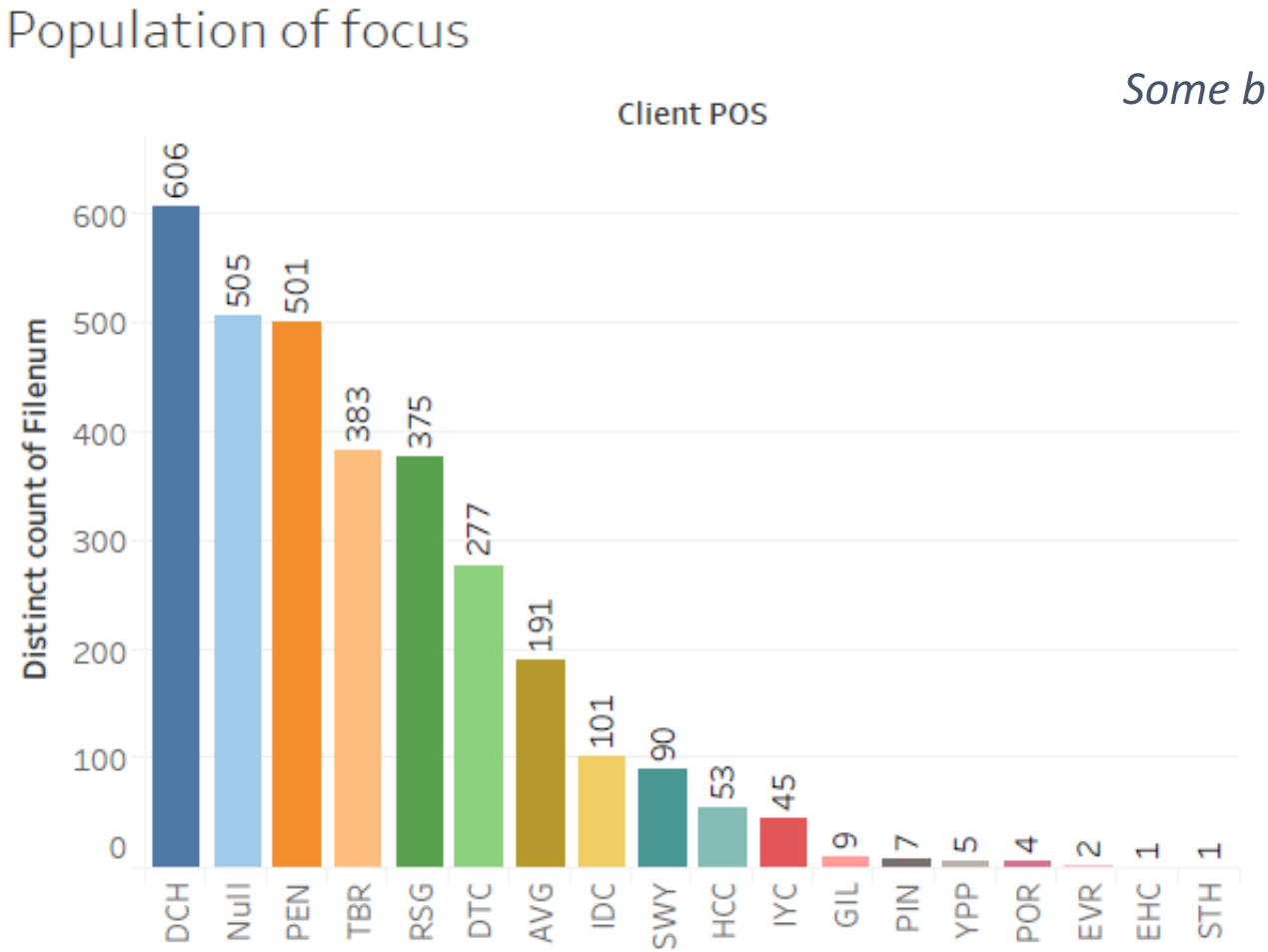
- List of active clients within our team who have opioid use disorder
  - Difficult to get list currently due to incomplete or inaccurate problem lists
- Operational definition for *baseline* data from Profile EMR (query "BOOST POF baseline" available in QI/query environment)
  - POS="our clinic code" (eg. Raven Song = RSG)
  - Status = "active"
  - Date Last Seen > today-1y (date last seen is within past year)
  - Problem list descriptions contain any ONE or more of the following:
    - OUD
    - opiate
    - opioid
    - methadone
    - heroin
    - Suboxone
- Teams not on Profile EMR will need different operational definition

Population of focus (POF)



Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Population of focus (POF)



Some baseline data

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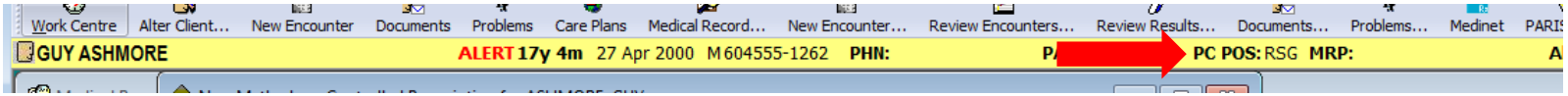
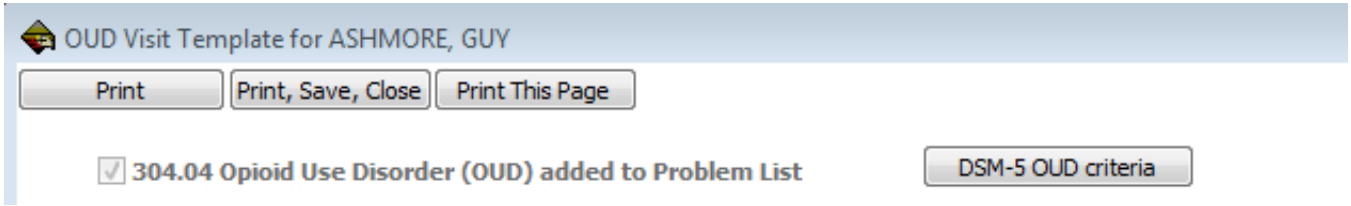
Population of focus (POF)

- Data clean-up
  - Ensure POS and MRP are correct
  - For patients who are no longer to be followed
    - Inactivate charts
    - Close PARIS referrals
    - Remove MRP designation



  - Ensure 304.0 Opioid Use Disorder added to Problem List
    - Once added for all, will simplify query and give more accurate POF list (BOOST 1 POF 304.0)



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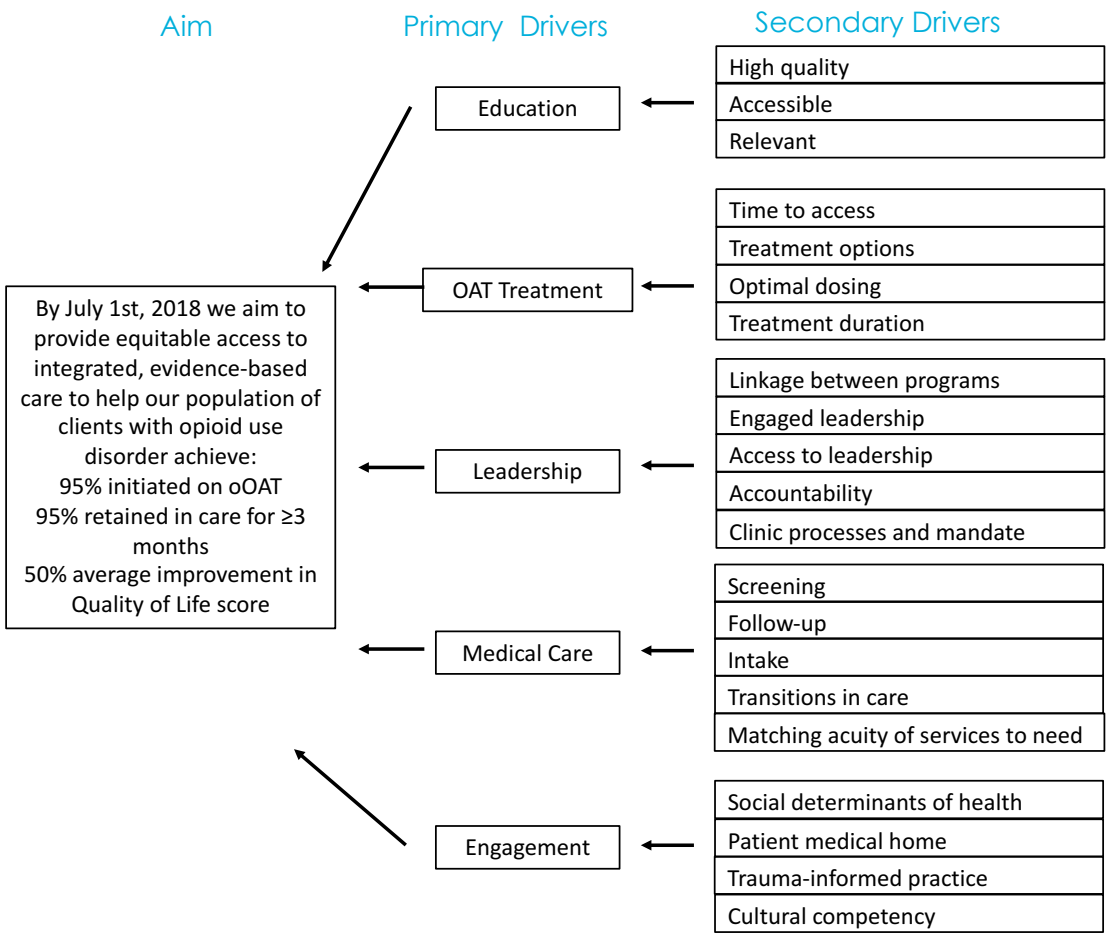
Population of focus (POF)

- Data clean-up
  - Patients who see us for one type of care but get their OAT elsewhere
  - Should we include these patients in POF?
  - Example: John Doe receives OAT from a private methadone clinic but follows up at our clinic for primary care
  - What do you think?

Driver diagram



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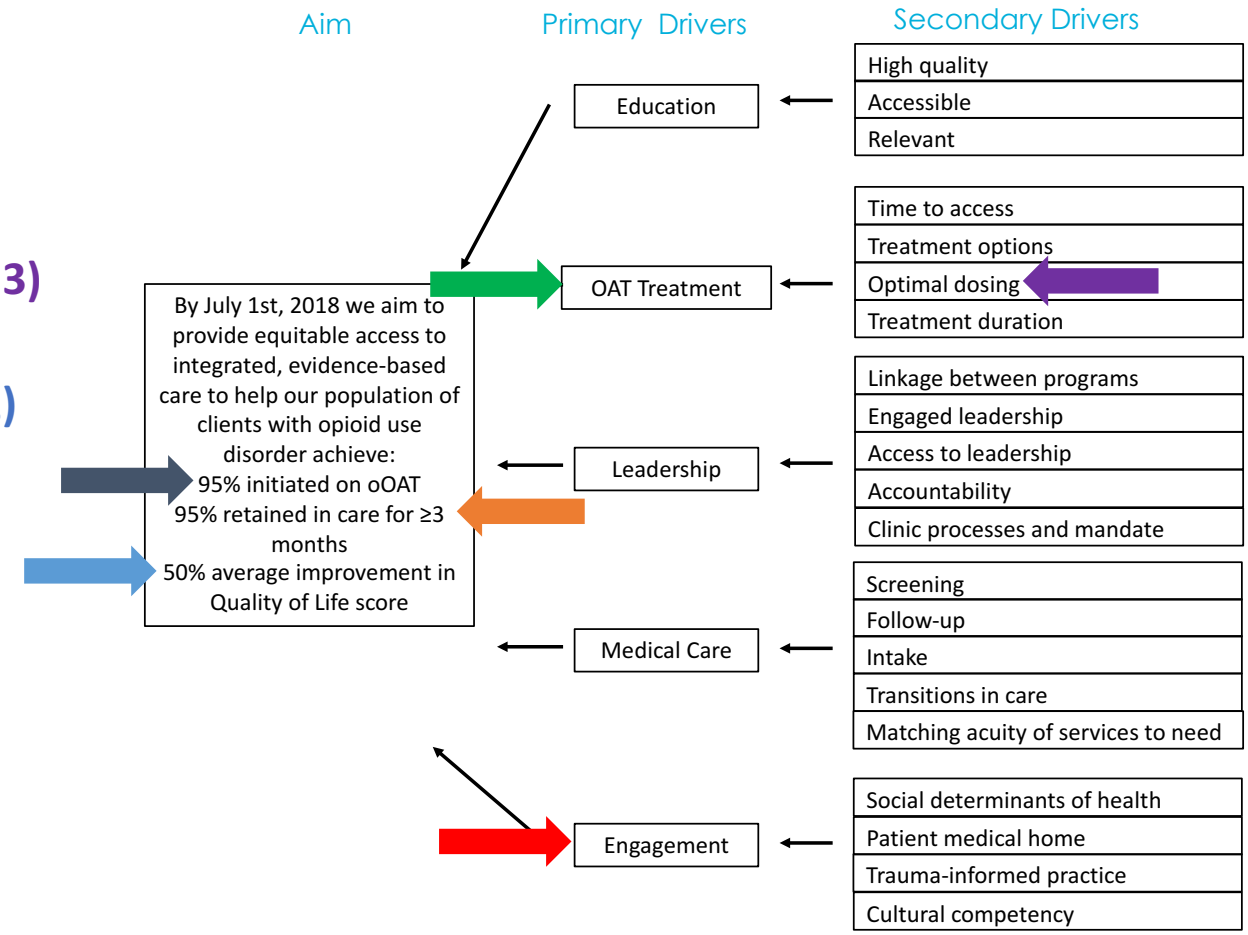
Key Metrics (Outcome Measures)

- **Engagement (1.2)**
- **oOAT access (1.3)**
- **Active oOAT (2.2)**
- **Optimal oOAT dosing (2.3)**
- **Retention on oOAT (2.4)**
- **Quality of Life score (3.2)**



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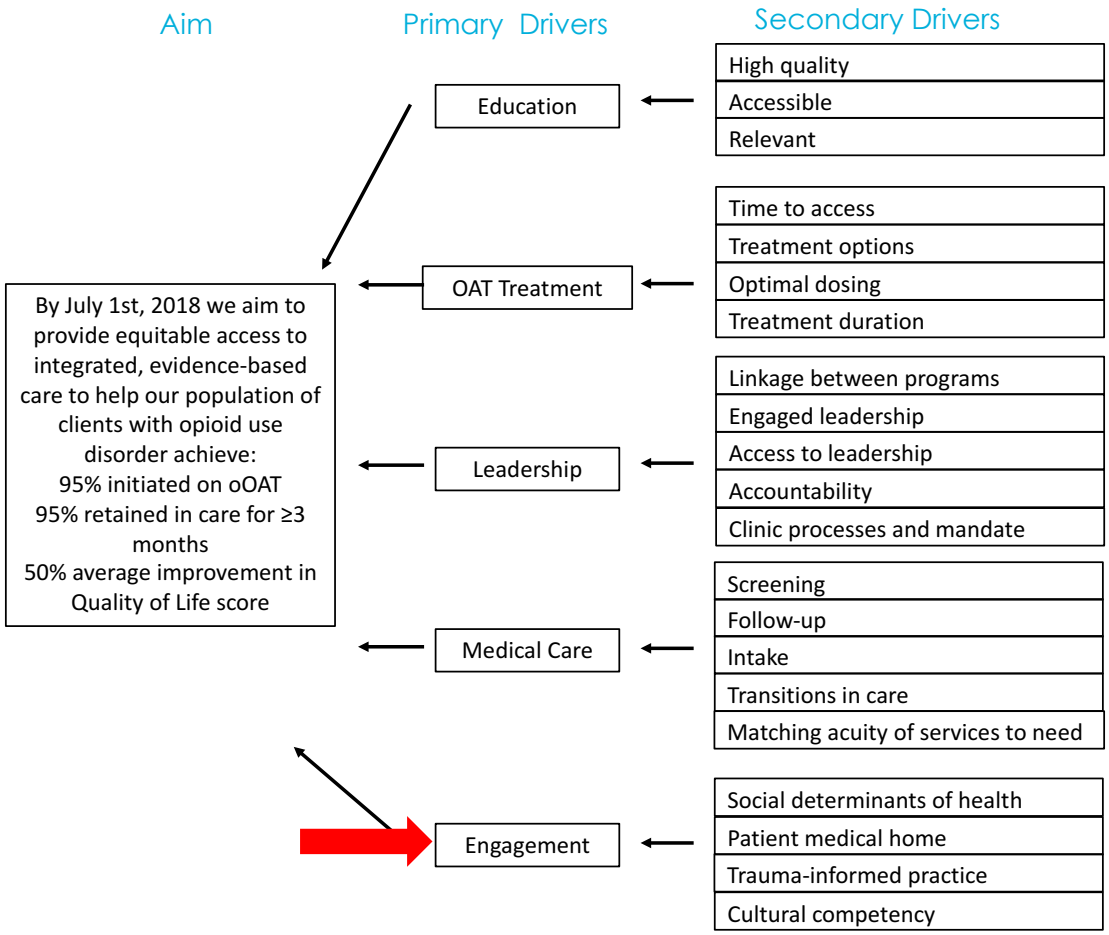
Engagement

- **Engagement (1.2)**



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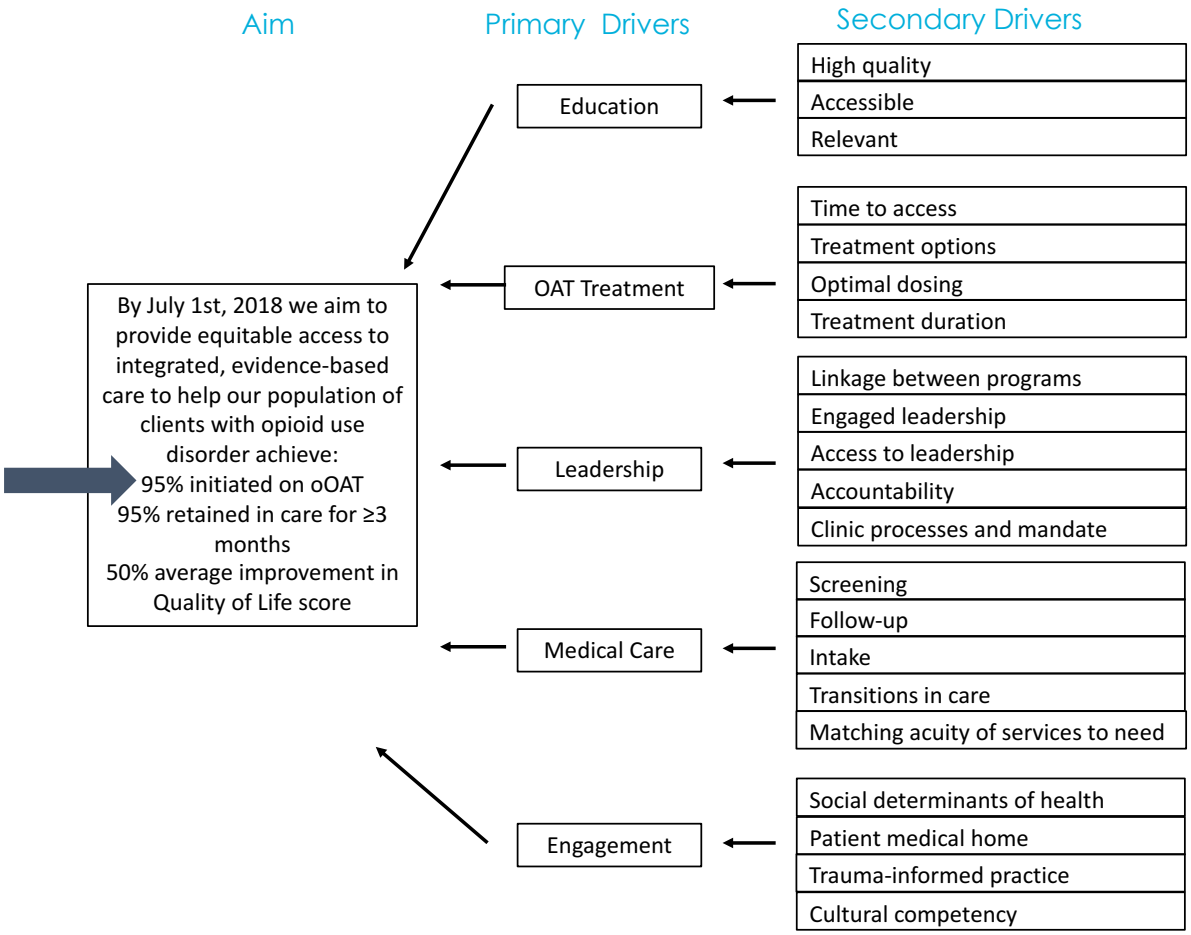
Engagement

- **Engagement (1.2)**

Numerator	Teams will determine their definition of “engagement” and/or “lost to care” based on their client population and program. For example, a team can define engaged in care as all clients with at least two care visits (with MD, NP, RN, etc.) in the last 12 months.
Denominator	POF
Calculation 1	(Numerator / Denominator) x 100% = [Proportion Engaged in Care]
Calculation 2	100-[Proportion Engaged in Care] = Lost to Care
Suggested goal	95% Engaged in Care
Notes	Teams will work together to come up with a definition that is feasible and hopefully comparable between teams.
Profile EMR queries	BOOST 1.2N Engaged in care/lost to care BOOST 1.2D Engaged in care/lost to care = POF

oOAT Access

- **oOAT access (1.3)**



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oOAT Access

- **oOAT access (1.3)**

Numerator	Number of clients with a treatment initiation date entered in OUD form (notNull)
Denominator	POF
Calculation	(Numerator/Denominator) x 100%
Suggested goal	95%
Notes	Using the new OUD visit template, providers will fill in approximate first OAT initiation date if person has ever been on OAT. This can then be used to accurately identify all those who have accessed treatment. This differs from baseline data presented that was based on having an OAT prescription in the EMR in the past 12 months.
Profile EMR queries	BOOST 1.3N oOAT access BOOST 1.3D oOAT access = POF

oOAT Access

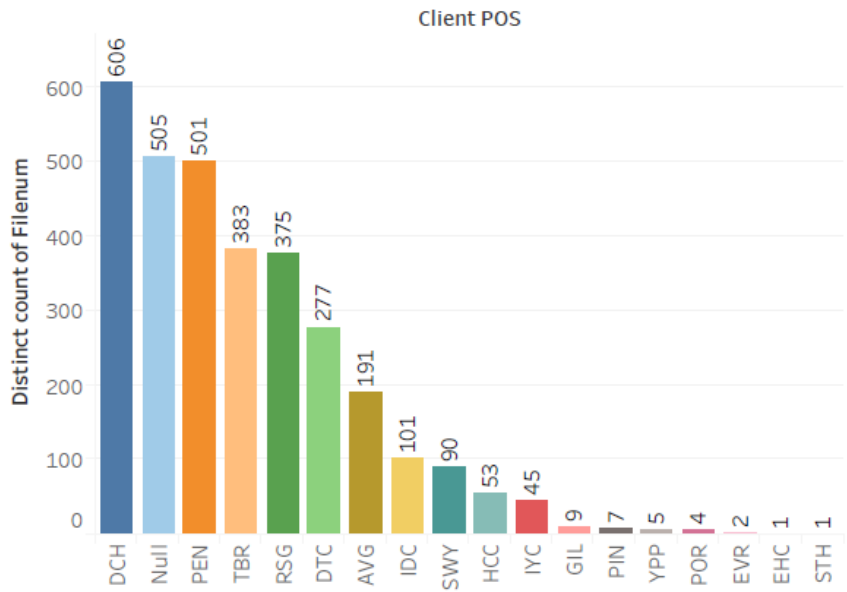
- **oOAT access (1.3)**
  - Baseline - Proportion of clients in POF who have at least one prescription for methadone, Kadian (SROM), or Suboxone on EMR (any POS)
  - When new EMR form used – Proportion of clients with an OAT initiation date entered (notNull)
  - For baseline data - need to run query of ALL MMT and duplicate rx in the EMR, then link this data to OUD clients identified in POF query
  - Simpler query when new EMR form used

oOAT Access

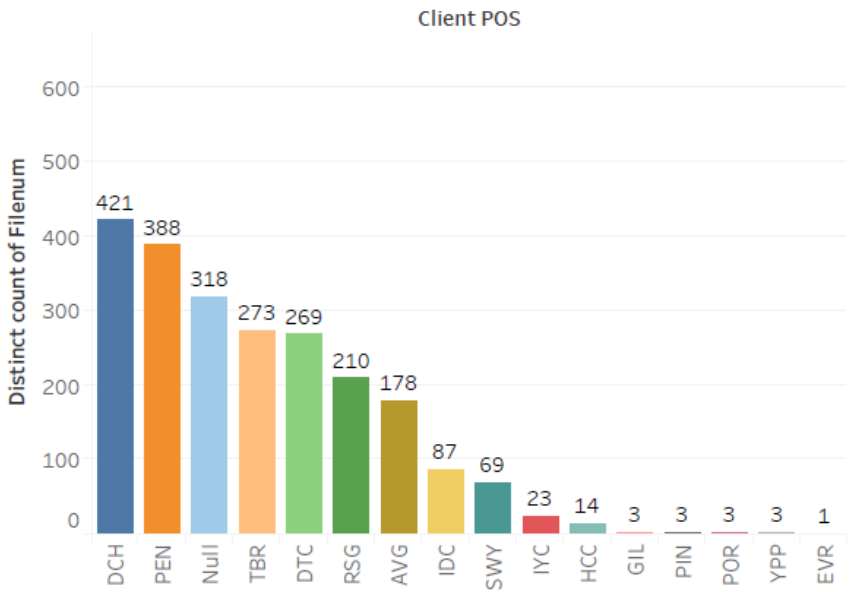
- **oOAT access (1.3)**

Some baseline data

Population of focus



OAT accessed in past 12 months



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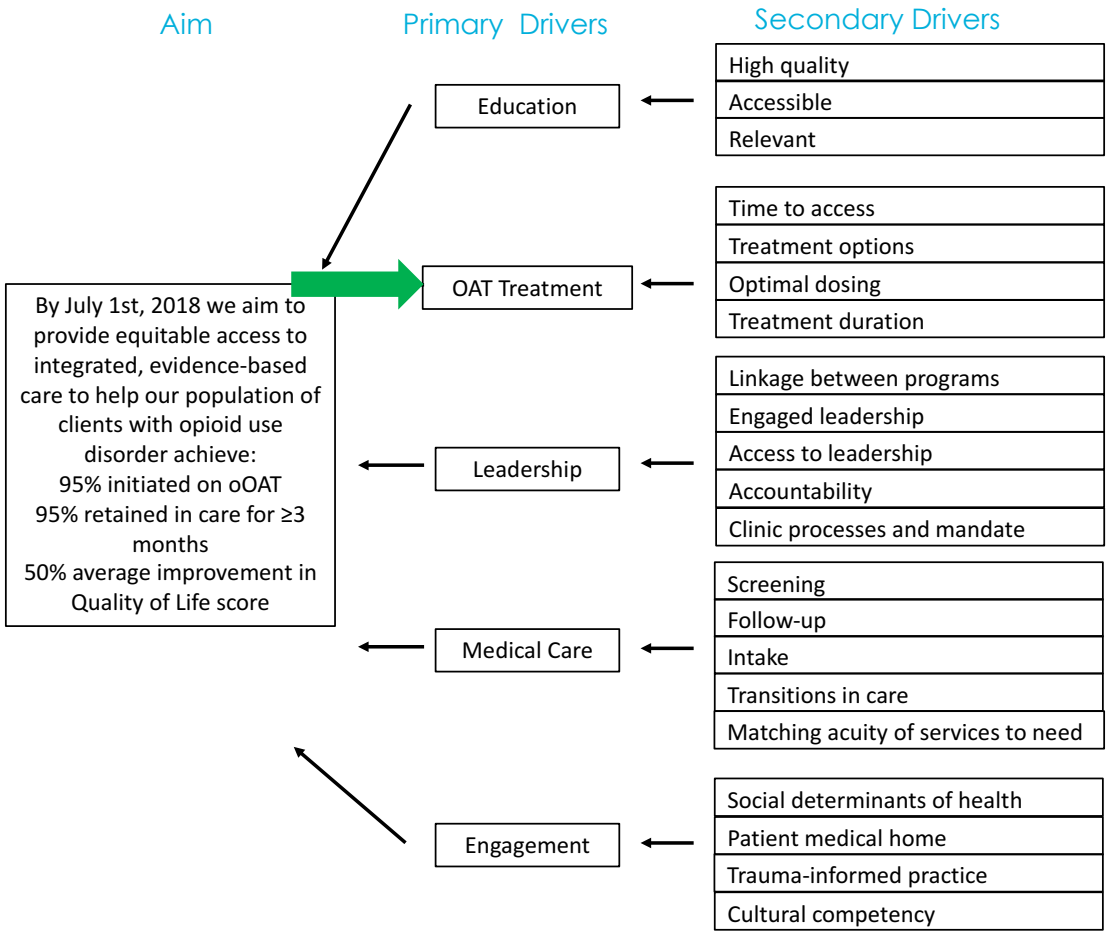
Active oOAT

- **Active oOAT (2.2)**



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Active oOAT

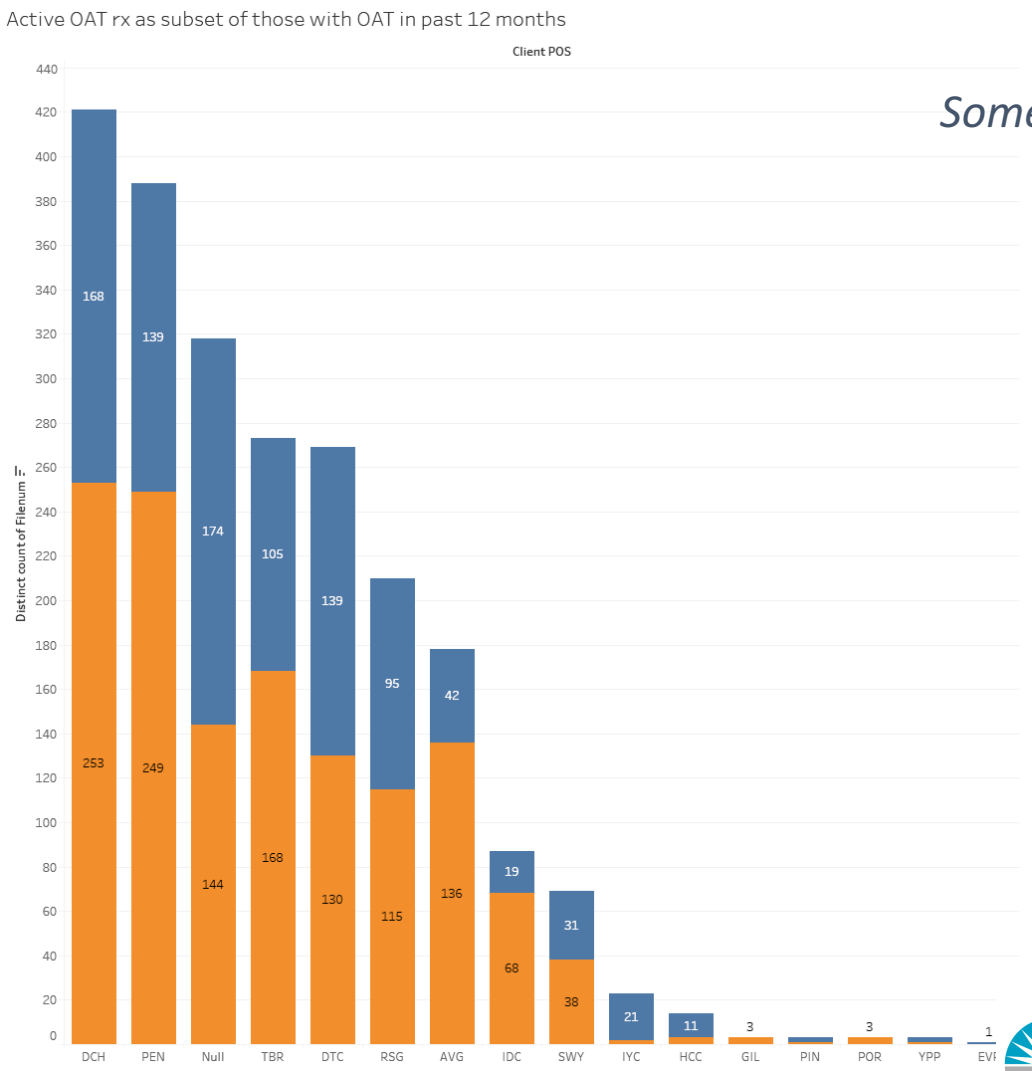
- **Active oOAT (2.2)**

Numerator	Number of clients who have an active (non-expired) prescription for Methadone, Kadian (SROM), or Suboxone – operationally in EMR Profile this is number of clients with a Last Day in the Prescription Creator on the OUD visit template form that is greater than the refresh date of the QI/query environment
Denominator	POF
Calculation	(Numerator/Denominator) x 100%
Suggested goal	95%
Profile EMR queries	BOOST 2.2N Active oOAT BOOST 2.2D Active oOAT

Active oOAT

- **Active oOAT (2.2)**

Some baseline data



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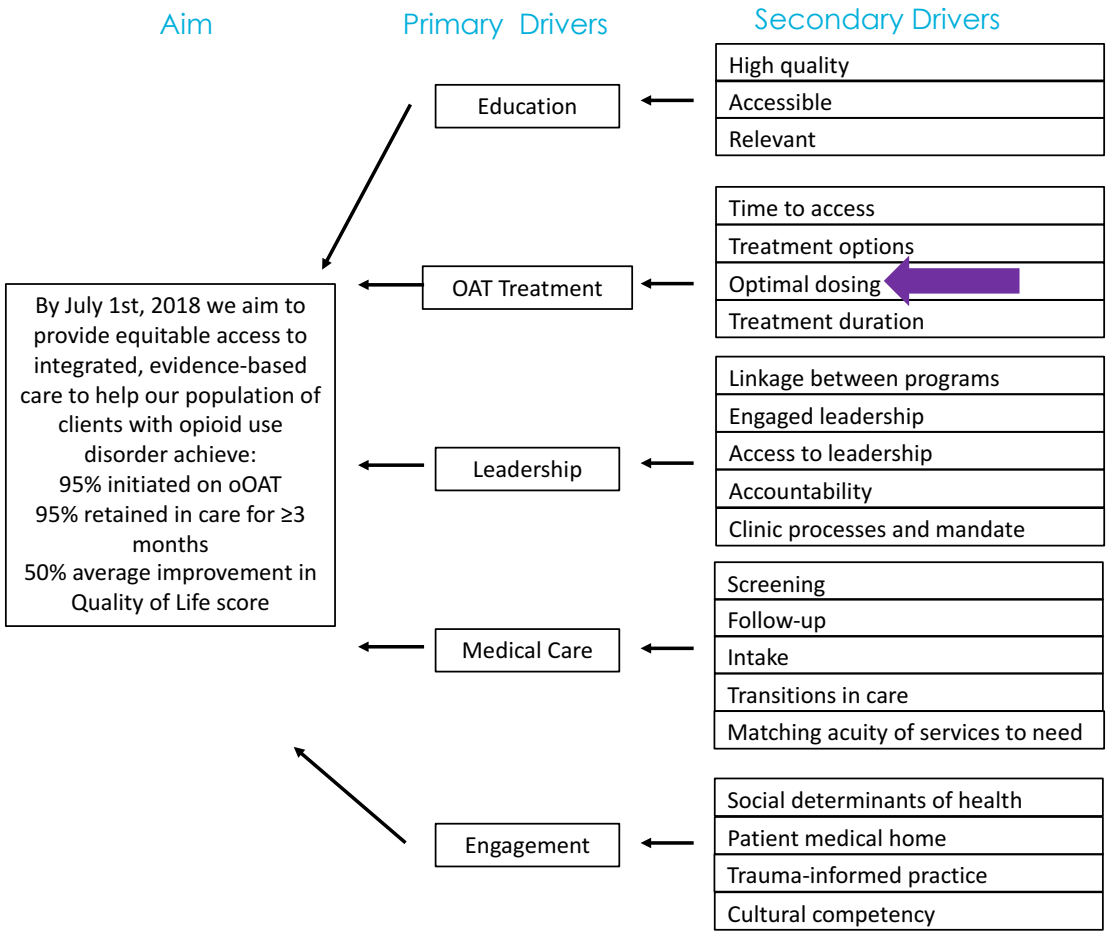
Optimal oOAT dosing

- **Optimal oOAT dosing (2.3)**



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Optimal oOAT dosing

- **Optimal oOAT dosing (2.3)**

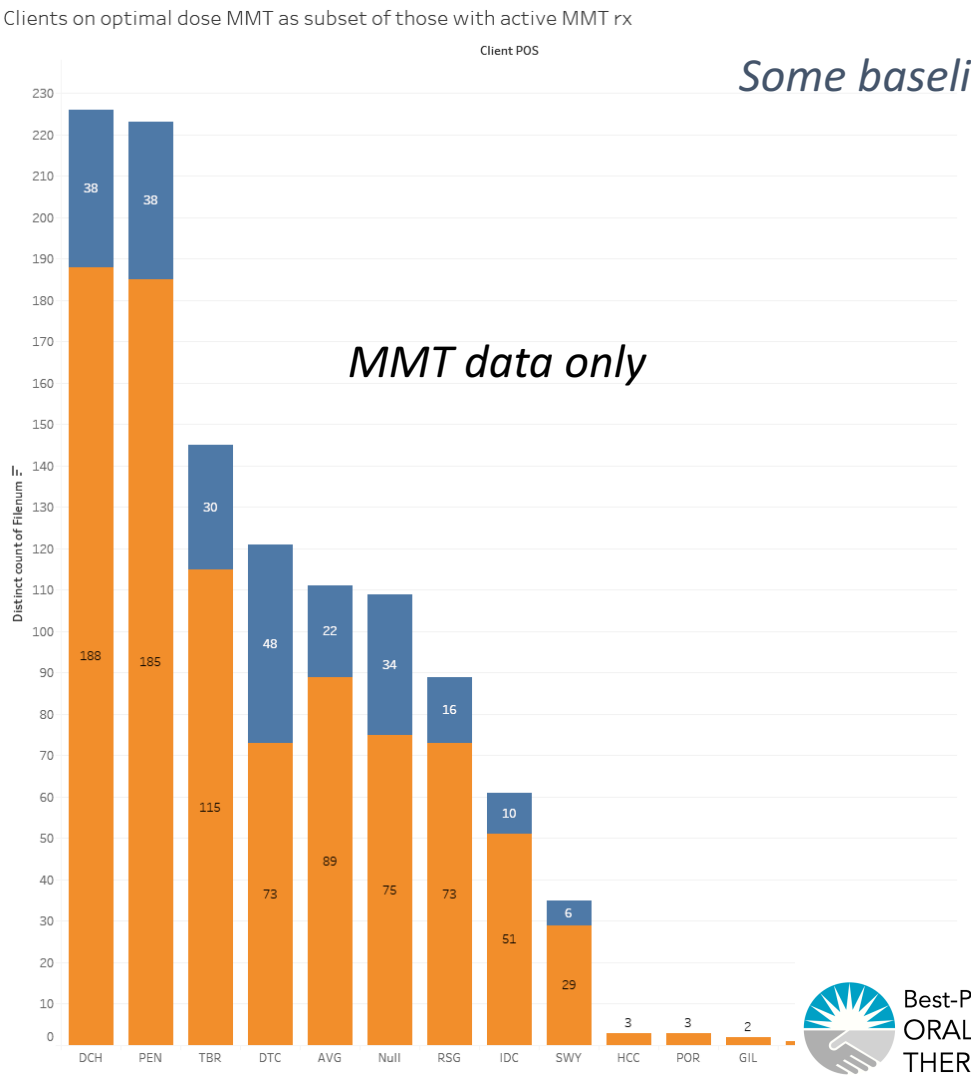
Numerator	Number of clients receiving at or above 60mg for Methadone and 16mg for buprenorphine
Denominator	Numerator from 2.2 Active oOAT excluding those clients on Kadian (SROM)
Calculation	(Numerator/Denominator) x 100%
Suggested goal	95%
Notes	*The denominator for this calculation is the numerator of the Active oOAT excluding those on Kadian (SROM) as there is no commonly accepted value for optimal dose
Profile EMR queries	BOOST 2.3N Optimal oOAT dosing BOOST 2.3D Optimal oOAT dosing

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Optimal oOAT dosing

- **Optimal oOAT dosing (2.3)**

Some baseline data

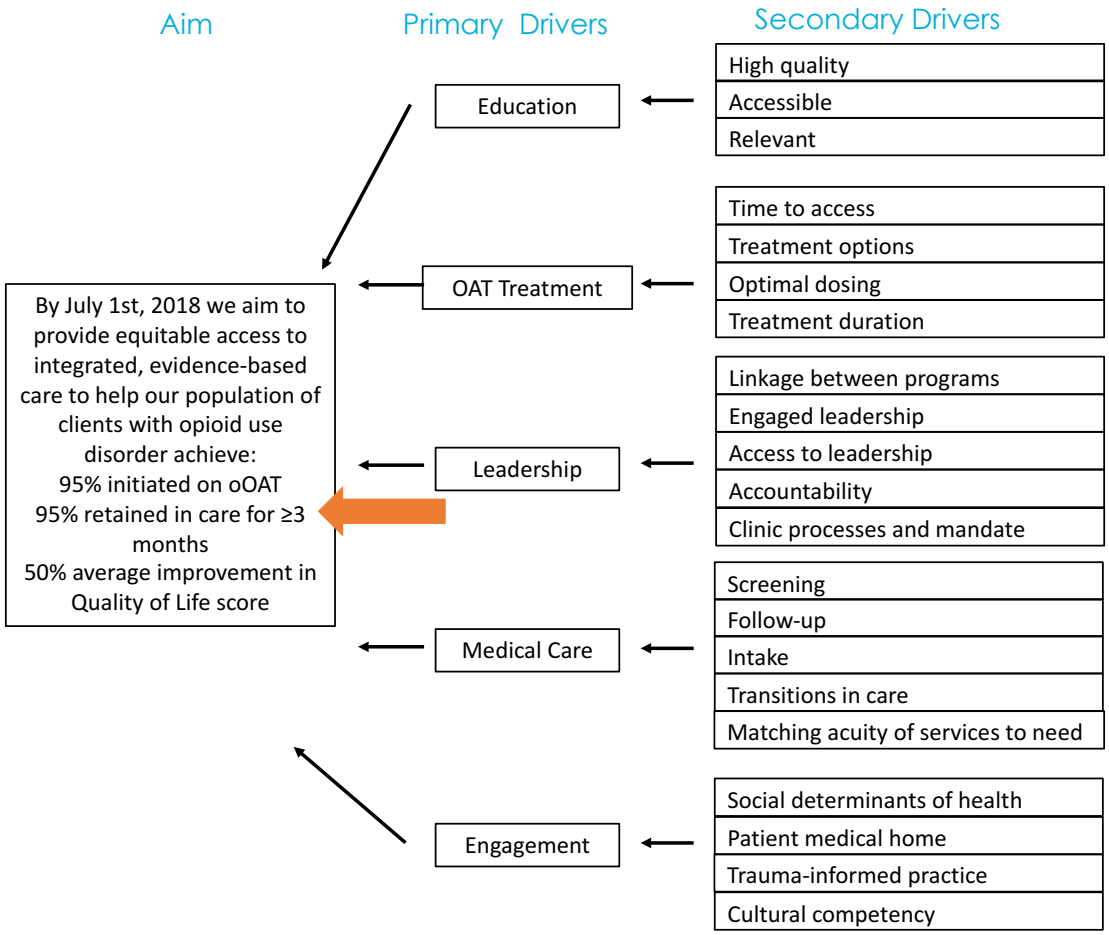


MMT data only

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Retention on oOAT

- **Retention on oOAT (2.4)**



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Retention on oOAT

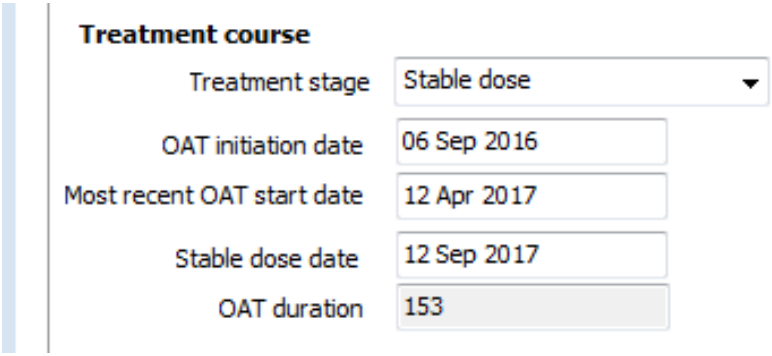
- **Retention on oOAT (2.4)**

Numerator	Number of clients with OAT duration > 90 days on OUD visit template form
Denominator	Numerator from 2.2 Active oOAT
Calculation	(Numerator/Denominator) x 100%
Suggested goal	95%
Profile EMR queries	BOOST 2.4N Retention on oOAT BOOST 2.4D Retention on oOAT

Retention on oOAT

- **Retention on oOAT (2.4)**

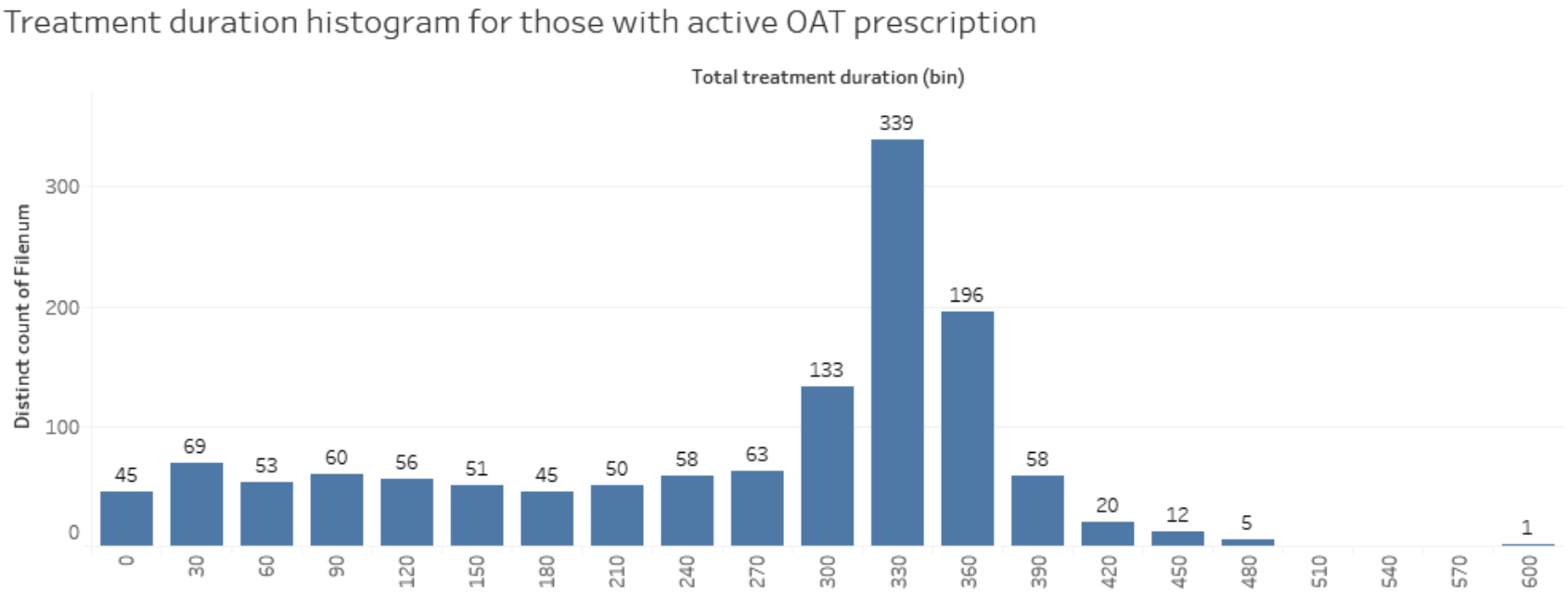
  - For baseline data, can look over past year and calculate sum of all prescription durations for the client
  - Difficult to do accurately because some people get multiple prescriptions on same day, or prescription durations overlap
  - Prospectively, we built this into our EMR form so it is easier to track
    - Form will be able to show clinician how long client has been retained on treatment



Retention on oOAT

- **Retention on oOAT (2.4)**

Some baseline data



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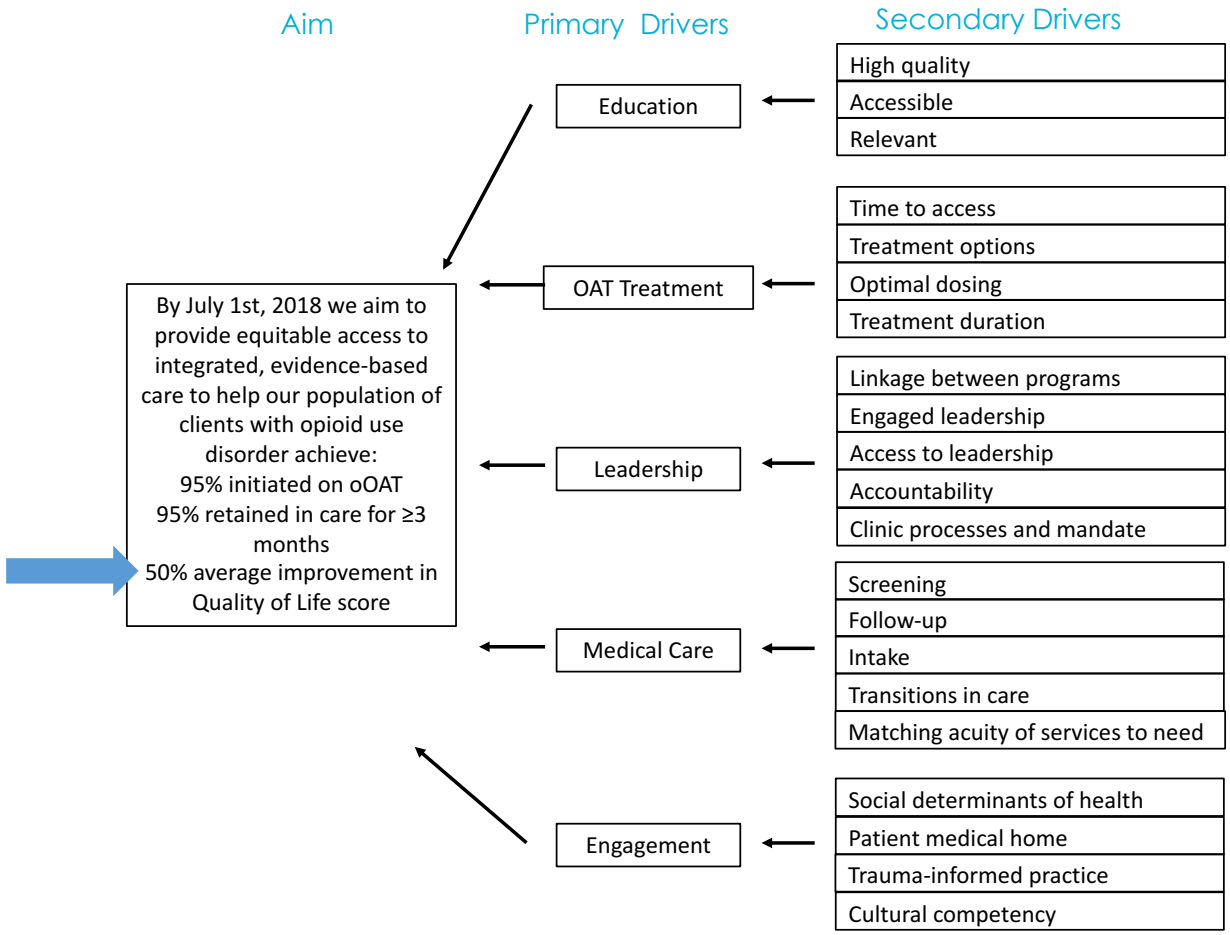
Quality of Life score

- **Quality of Life score (3.2)**



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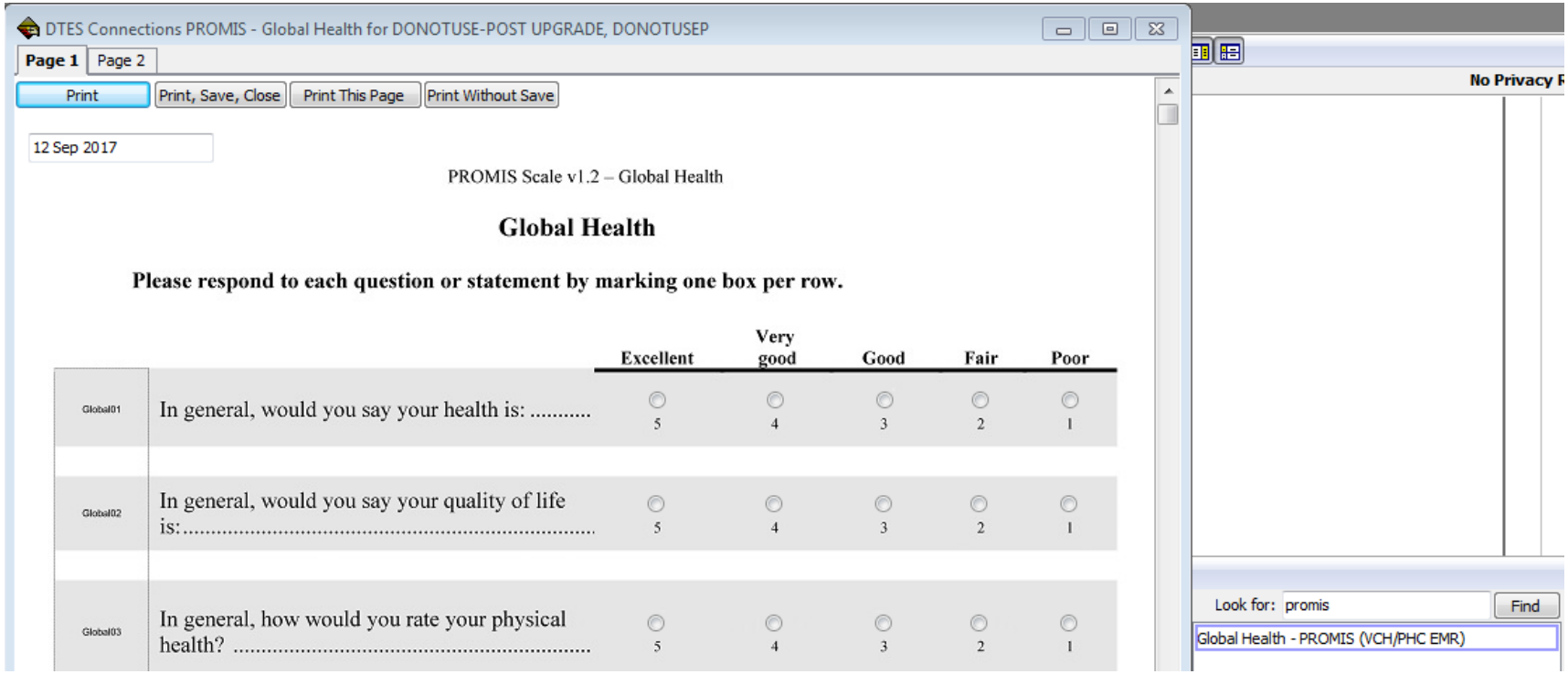
Quality of Life score

- **Quality of Life score (3.2)**

Calculation	Using the PROMIS v1.1 scoring method for this 10 question Quality of Life scale, find the raw score out of 50 and then average all the results for most recent completed PROMIS forms
Suggested goal	Increase average score by 50%
Profile EMR queries	BOOST 3.2 Quality of life

Quality of Life score

- **Quality of Life score (3.2)**



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Optional Measures

Optional Measures
1.4 Outreach
1.5 Rate of THN training
1.6 Self-reported number of Ods
2.5 Time from Induction to Optimal Dose
2.6 Other Substance Use
3.3 HIV Screening Rate
3.4 HCV Screening Rate
3.5 Syphilis Screening Rate
3.6 Hep A and B Vaccinations
3.7 Depression Screening with PHQ-9

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Lunch

Return at 12:45 PM

Team Aim Statement and Population of Focus

Activity

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

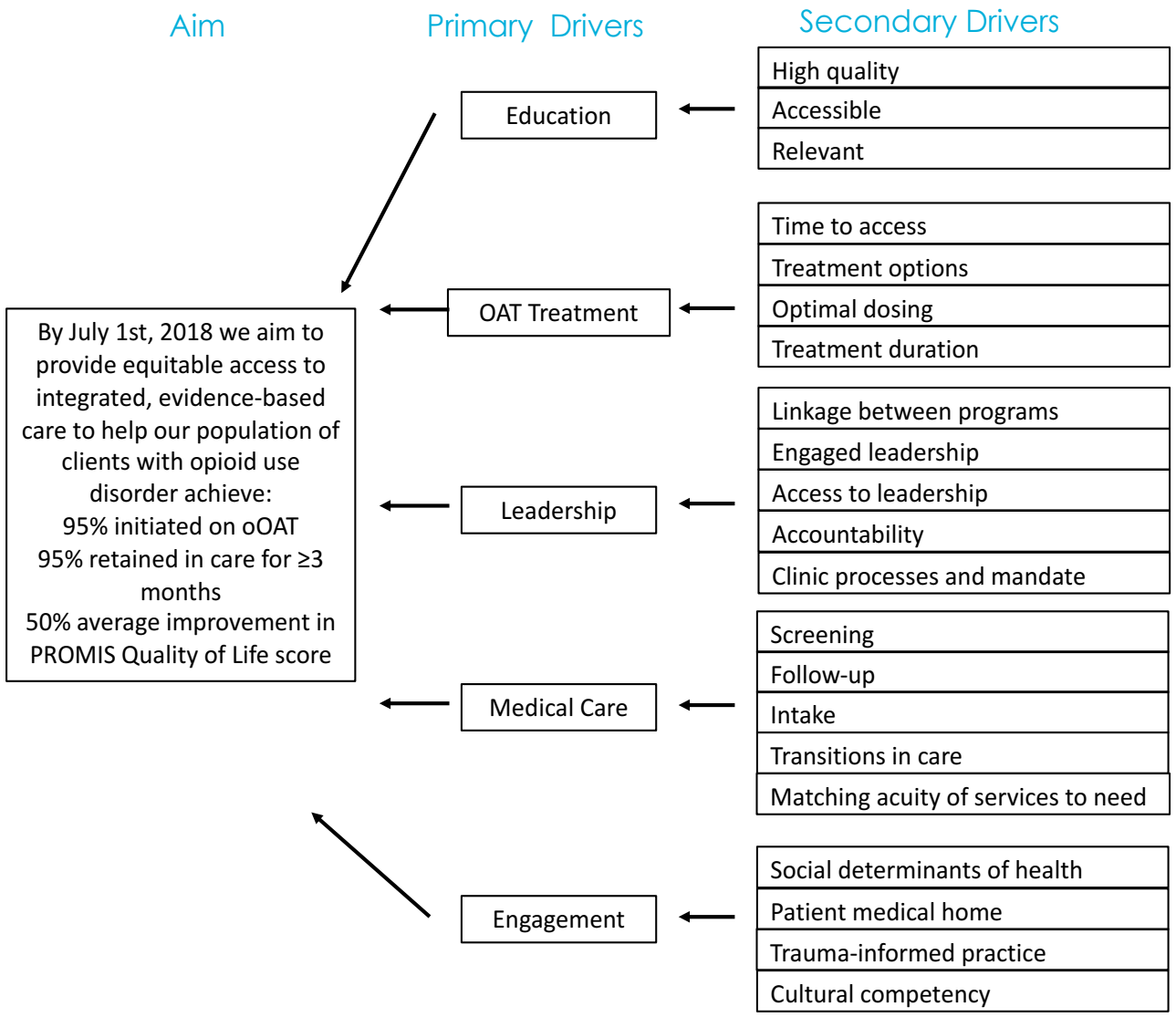
Developing your team's aim statement

- 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 the following:

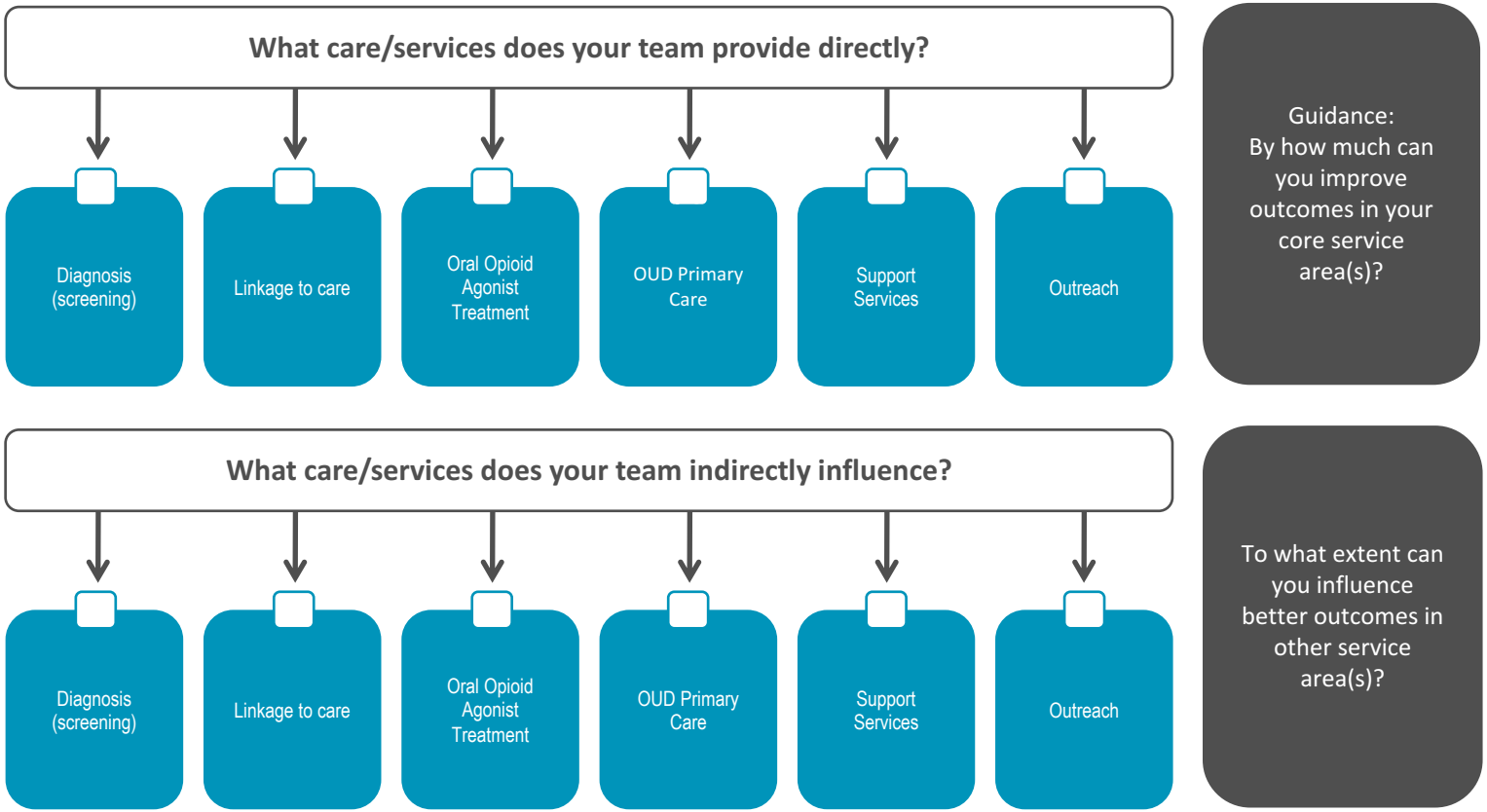
1. Alignment with the purpose of the BOOST Collaborative

- Review the purpose and drivers of the BOOST Collaborative. Align your aim with the purpose to get the most out of participation:
  - Improve the quality, effectiveness and reach of substance use and support services in the Vancouver community region to improve outcomes for people living with OUD.
  - Strengthen capacity for QI in primary care, mental health, substance use, withdrawal management and outreach care settings.
  - Engage participating teams in joint QI activities to better coordinate seamless OUD services and enhance partnerships across OUD providers in Vancouver

1. Alignment with the purpose of the BOOST Collaborative



2. The care and services you can influence and improve



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3. Needs within your population of focus (POF)

- Examine population data within your organization
- What are the priority gaps your population faces along the OUD continuum of care?

Tips for Setting Aims

- State the aim clearly
- Include numerical goals that require fundamental change to the system
- Set stretch goals
- Avoid aim drift
- Be prepared to refocus the aim
- Evaluate what others achieved provides appropriate context for choosing the numerical portion of an organization's aim

Example Aim Statements

Example 1: By July 1st, 2018, we aim to use our information system for monitoring important clinical outcomes, partner with community and others to outreach and connect our clients with important resources, and deliver the best possible experience in care. We will be satisfied we have achieved our aim when:

- 95% of our population of focus is on oOAT
- 95% of our population of focus on oOAT have missed less than 10% of their doses in the last 3 months
- We see a 50% average increase in the PROMIS Quality of Life score in our population of focus

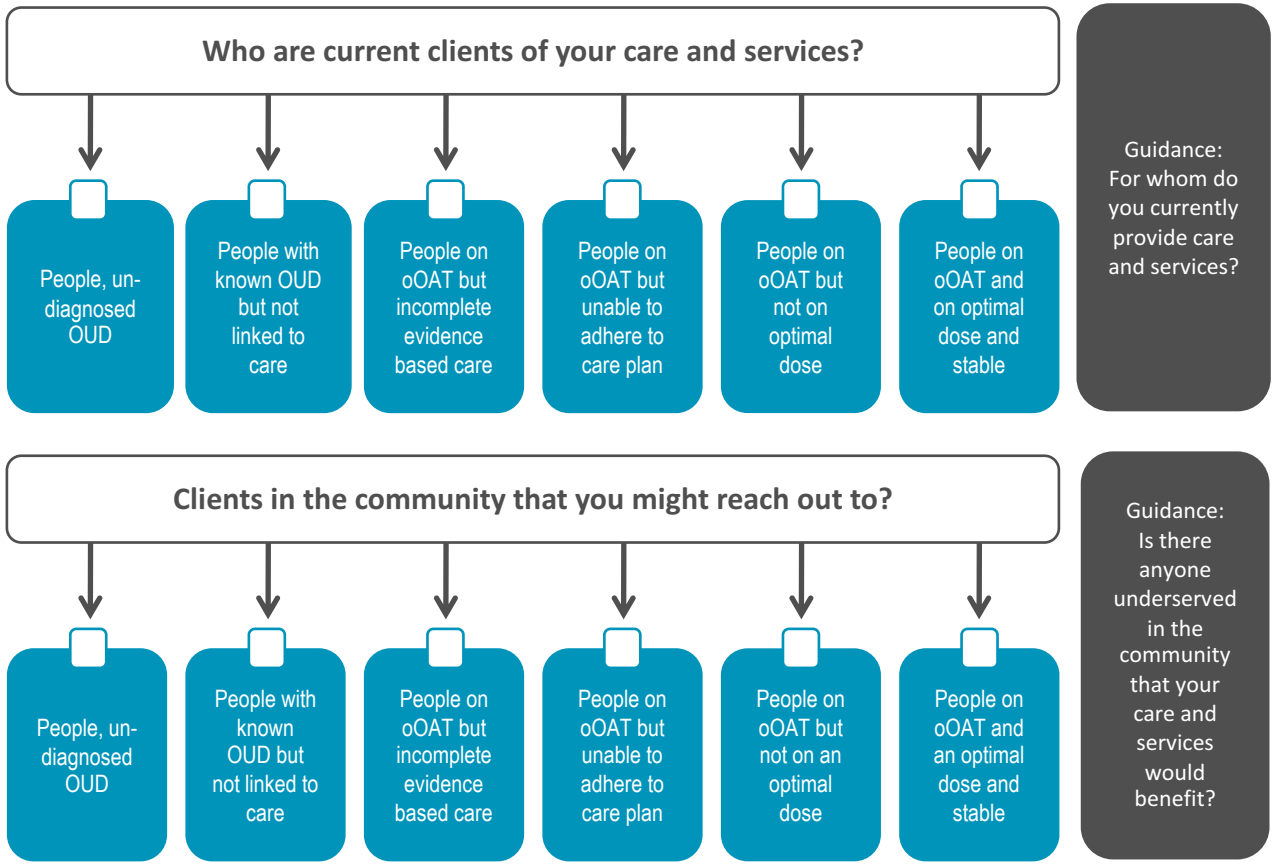
Example 2: By July 1st, 2018, we aim to create better linkages with mental health and substance use teams to ensure our clients are receiving wrap-around care for their opioid use disorder. We will have achieved our aims when:

- 95% of our population of focus is retained in care at 3 months
- 100% of our population of focus is screened for depression using the PHQ-9 questionnaire
- 90% of our population of is screened using the PROMIS Quality of Life survey

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 indicators. To help you get started thinking about your POF, consider your reach:

1. What is the current and possible reach of your care and services?



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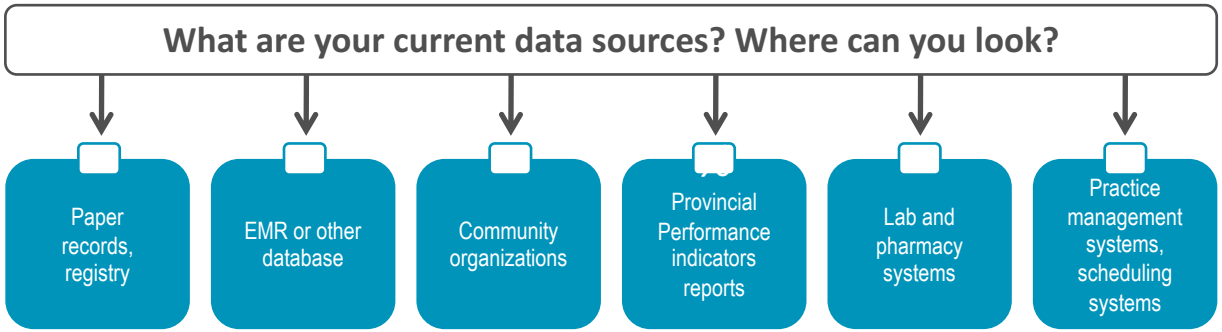
2. What do you understand about this population?

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



Change Package and Team Action Planning

Activity

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Closing Remarks

Laura Case, COO, Vancouver Community,
Vancouver Coastal Health

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THERAPY Collaborative

Next steps…

Learning Sessions and Action Periods

- **Watch:** BOOST Preparation Webinar
  - http://stophivaids.ca/boost-webinar-recordings/
- **Action Period 1**: September to December 2017
  - Key focus on testing change on a small scale, measurement optimization, and team engagement
- **Learning Session 1:** December 7th 2017
  - Key focus on linking clients to care and outreach and oOAT dosing
  - *TBC

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Support Activities and Coaching

- **PSP Coaching support:** Connect with the PSP coordinator to schedule a time for 1:1 coaching- sing-up sheet available.
  - Meet in the next 2 weeks
- **Webinar 1**: Measurement Run Through and Troubleshooting
  - October 12th 12:00 to 1:00PM
- **Coaching Call 1**: Client Engagement
  - November date TBC

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Next Steps

1. Familiarize yourself with the Collaborative models
    a. Model for Improvement
    b. Structure Learning Collaborative/Breakthrough Series Method
2. Develop an Aim Statement for your team
3. Define your population of focus
4. Understand the key metrics
5. Use the BOOST Technical Documents

Final Requests

- Stay in touch! Use the Listerv!
- www.stophivaids.ca/oud-collaborative
- boostcollaborative@cfenet.ubc.ca

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THANK-YOU!

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