Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Project Charter

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BOOST Collaborative Core Team

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Background

Opioid use disorder (OUD) can be characterized as a chronic relapsing illness which is associated with elevated rates of morbidity and mortality; however, it has the potential to be in sustained, long-term remission with appropriate treatment[1]. OUD may involve the use of illicitly manufactured opioids such as heroin or street fentanyl, or pharmaceutical opioid medications obtained illicitly or used non-medically. While current Canadian estimates are lacking, OUD is estimated to affect approximately 2.1% of Americans[2].

In 2016, the British Columbia (BC) Provincial Health Officer, Perry Kendall, declared a public health emergency in response to the dramatic increase in opioid-related overdose deaths[3]. In 2016, there were 922 confirmed overdose deaths in BC, of which 215 occurred in Vancouver[4]. BC is the epicentre of the crisis within Canada, with Vancouver's downtown eastside (DTES) reporting the highest overdose rates. To address the urgent need for intervention, a number of services were launched in late 2016 and early 2017, including 11 new supervised injection sites, distribution of 22,000 naloxone kits annually, and the upcoming introduction of injectable OAT. Despite the public health emergency declaration and addition of new services, the number of opioid-related overdose deaths continues to be far above historical averages, suggesting a need to address gaps in other areas of the continuum of care for people living with OUD.

A recent meta-analysis demonstrated retention in methadone and buprenorphine treatment is associated with substantial reductions in all cause and overdose mortality in people dependent on opioids[5]. The same study identified the first four weeks and treatment cessation as the highest risk period for overdose mortality, highlighting specific system-level intervention opportunities to reduce overdose deaths. Current data from the Office of the Provincial Health Officer shows a 67% increase in the number of BC patients receiving OAT (typically Methadone or Suboxone) from 2009/10 to 2015/16[6]. However, while treatment is expanding, data show only 55% of persons on Methadone are receiving optimal dose (>60mg). Other significant predictors of treatment success include shorter time to treatment from diagnosis and longer duration of treatment (≥3 years)[1]. In this respect, only 42% of persons on Methadone are retained at six months and only 32% at 12 months. Furthermore, the VCH data is below provincial averages, highlighting the urgent need to act quickly to address these gaps.

While we know that people living with OUD can benefit from oOAT, delivering the appropriate care is a complex process that requires collaboration among multiple care providers and services[7]. Additionally, there are often numerous barriers to delivering optimal oOAT, including capacity and access issues, licensing requirements, public and professional stigma, and regulatory and funding barriers[8]. To help overcome these issues, healthcare providers require effective systems to improve access and adherence to OUD treatment.

Increasingly, the healthcare community is employing quality improvement (QI) frameworks to promote system-level change and address gaps in care[9]. The Breakthrough Series (BTS) Structured Learning Collaborative (or SLC) methodology, developed by the Institute for Healthcare Improvement (IHI), is a quality improvement approach designed to help healthcare organizations close the gap between evidence and practice[10]. This approach has been successfully applied in other substance use treatment settings in the United States[11] and other chronic diseases in British Columbia[12,13].

Vancouver Coastal Health (VCH) and the BC Centre for Excellence in HIV/AIDS (BC-CfE) are sponsoring the development of the Best-practices in Oral Opioid agoniSt Therapy (BOOST) Collaborative to strengthen capacity for QI in primary care, mental health, substance use, withdrawal management and

outreach care settings in the Vancouver Community. The BOOST Collaborative will engage participating teams in joint QI activities to better coordinate seamless OUD services and enhance partnerships across OUD providers in Vancouver.

The BOOST Collaborative will be launched within the VCH Vancouver Community region and teams from primary care, mental health and substance use, and detox will be invited to participate. OUD programs need to establish an effective, high-quality cascade of services from diagnosis and referral to care, to engagement and adherence to treatment, in order to improve care for people living with OUD. Establishing an OUD cascade of care will allow for the identification of gaps in the continuum of care (see Figure 1) that are preventing people from fully benefitting from oOAT treatment.

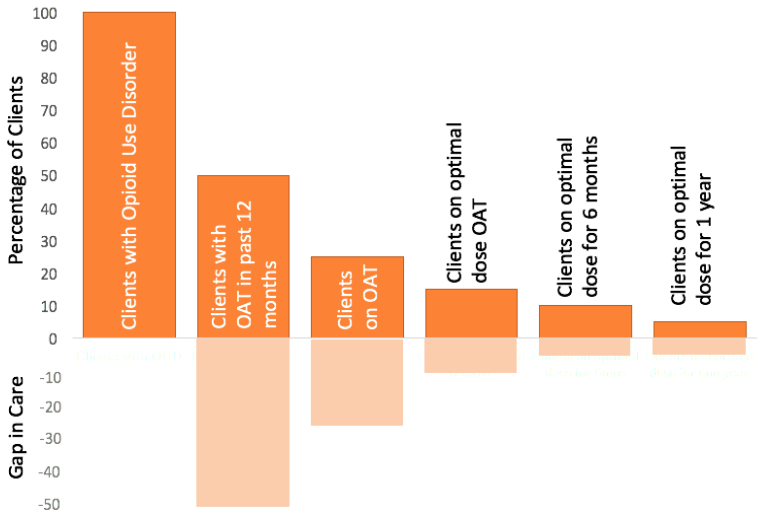


Figure 1. Theoretical Cascade of OUD Care

Key Collaborative Stakeholders

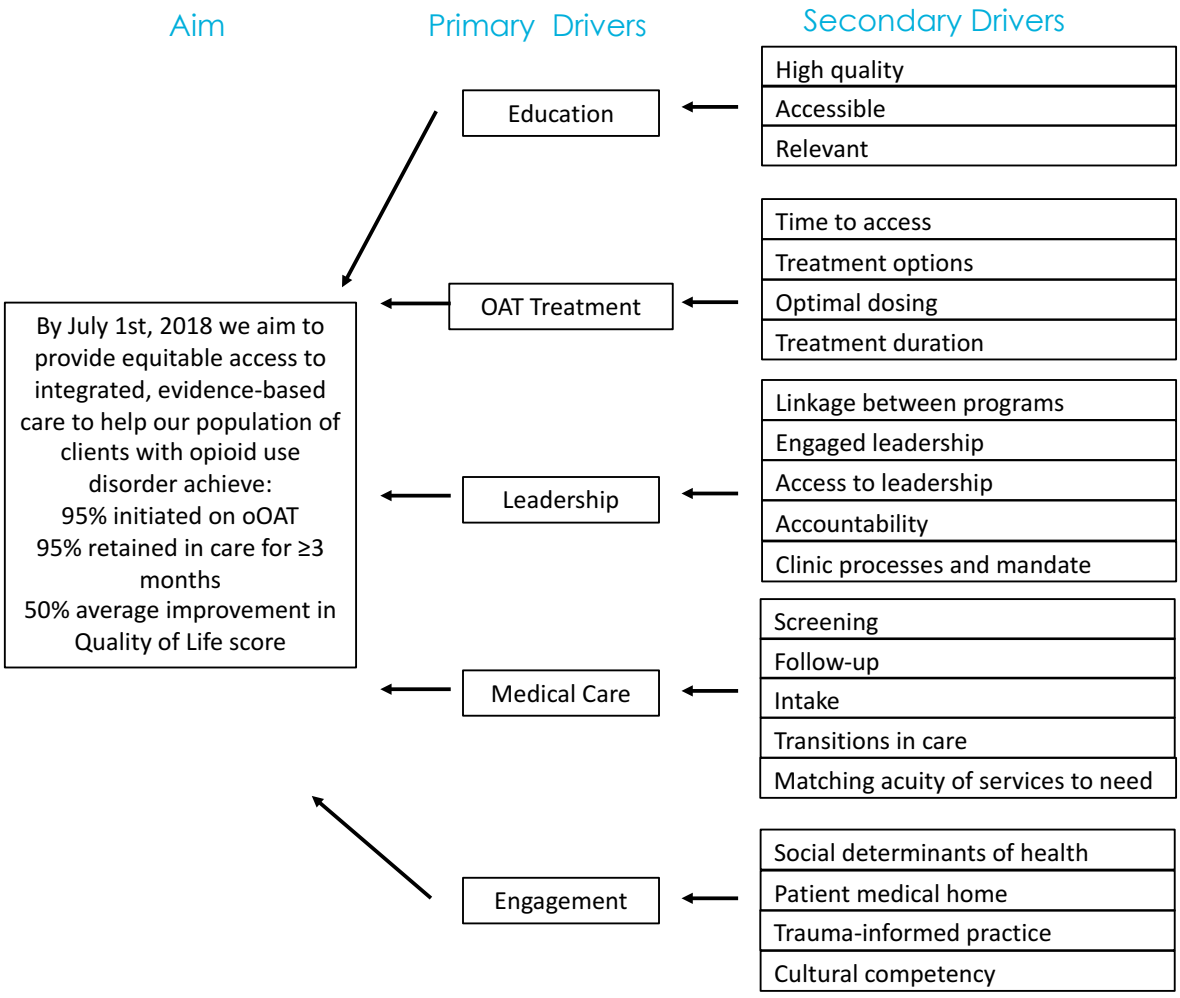
Name	Role and Affiliation	Role
Laura Case	Chief Operating Officer, VCH- Community	VCH Executive Sponsor
Dr. Rolando Barrios	Senior Medical Director, VCH-Community	VCH and BC-CfE Executive Sponsor
Andrew Day	Operations Director, VCH	VCH Project Sponsor
Dr. Ron Joe	Associate Medical Director, Addiction Services, VCH	VCH Project Sponsor
Yogeeta Dosanjh	Manager, PSP	Quality Improvement Advisor
Jano Klimas	Postdoctoral Fellow, BCCSU	Faculty

Collaborative Aims and Objectives

The BOOST Collaborative is a QI initiative launched by VCH in partnership with the BC-CfE. The initiative aims to improve the quality, effectiveness, and reach of substance use and support services in the Vancouver community to improve outcomes for people living with OUD. By July 1st, 2018, we aim to provide equitable access to integrated, evidence-based care to help our population of clients with OUD achieve:

- 95% initiated on oOAT
- 95% retained in care for ≥3 months
- 50% average improvement in Quality of Life score

We will achieve these aims by addressing barriers and closing gaps in harm reduction, treatment and care, and support services in Vancouver.



BOOST Collaborative Core Measures

Population of Focus (POF): Clients with ICD-9 codes: 304.7 and/or 304.00 and/or 304 and/or 304.0 and/or 304.9 and/or problem list include: Suboxone, methadone, MMT, SROM, Kadian, OUD, OAT, ORT, opioid, opiate, heroin, etc.).

#	Core Measure	Definition/Numerator	Denominator	Suggested Target
1	**Treatment Initiation** Linked- POF (L-POF)	Clients with OAT in past 12 months: Any client with a Rx for Methadone, Suboxone, Kadian recorded in the past 12 months for any length of time, regardless of dose. L-POF	POF	95%
2	**Treatment Engagement** Treatment- POF (T-POF)	Clients on OAT: Any client with a current (non-expired) Rx for Methadone, Suboxone, Kadian, regardless of dose T-POF	L-POF	95%
3	**Optimal Dosing**	Clients on optimal dose OAT: Any client with a current (non-expired) Rx for Methadone >60mg, >16mg Suboxone, >50mg(?) Kadian.	T-POF	95%
4	**Retention**	Clients on optimal dose OAT for 6 months: Any client with a current (non-expired) Rx for Methadone >60mg, >16mg Suboxone, >50mg(?) Kadian with previous Rx's at dose above listed doses for previous 3 months. Maximum Rx time gap in past 3 months is 2 weeks, unless known hospitalization, incarceration, etc.	T-POF	95%
5	**Quality of Life**	Average score on PROMIS Quality of Life survey	POF	50% increase
6	**Team Narratives**	Qualitative report.		

Collaborative Methodology

Over the next 18 months, a diverse set of Collaborative teams from across VCH Vancouver Community will work in partnership to improve access to high quality oOAT care; strengthen capacity for QI in primary care, mental health and addictions care settings; engage participating teams in joint QI activities to better coordinate seamless OUD services; and enhance partnerships across OUD providers in Vancouver. While participating in group Learning Sessions, collaborative teams will be challenged to implement evidence-based best practices and develop innovative change ideas.

The BOOST Collaborative will follow the Breakthrough Series (BTS) Collaborative methodology developed by the IHI[4] (Figure 2). This will be an organized effort of shared learning by a network of approximately 20 teams from across VCH Vancouver Community region, purposefully working together over the course of 18 months. Throughout the BOOST Collaborative, it is expected that team participants maintain continual contact with each other and with Faculty members through a Virtual Community of Practice, which includes monthly teleconference calls, electronic mailing list messages, an interactive discussion forum, emails, webinars, and website access. This will create a community of learning in which teams collaborate with each other to discuss common issues, share ideas, and spread best practices.

The basic structure of the Collaborative methodology has been adapted for the BOOST Collaborative to include an in-person Launch where stakeholders and team representatives will assemble to commence Collaborative preparatory work (i.e., defining team membership, crafting improvement aims, collecting baseline measures, creating storyboards, etc.). Subsequently, experts will share approaches to system change and ideas for change at the first in-person Learning Session (LS). Each LS will be followed by Action Periods (AP) where teams are supported in actively testing and in implementing changes in care processes using the Model for Improvement (described below).

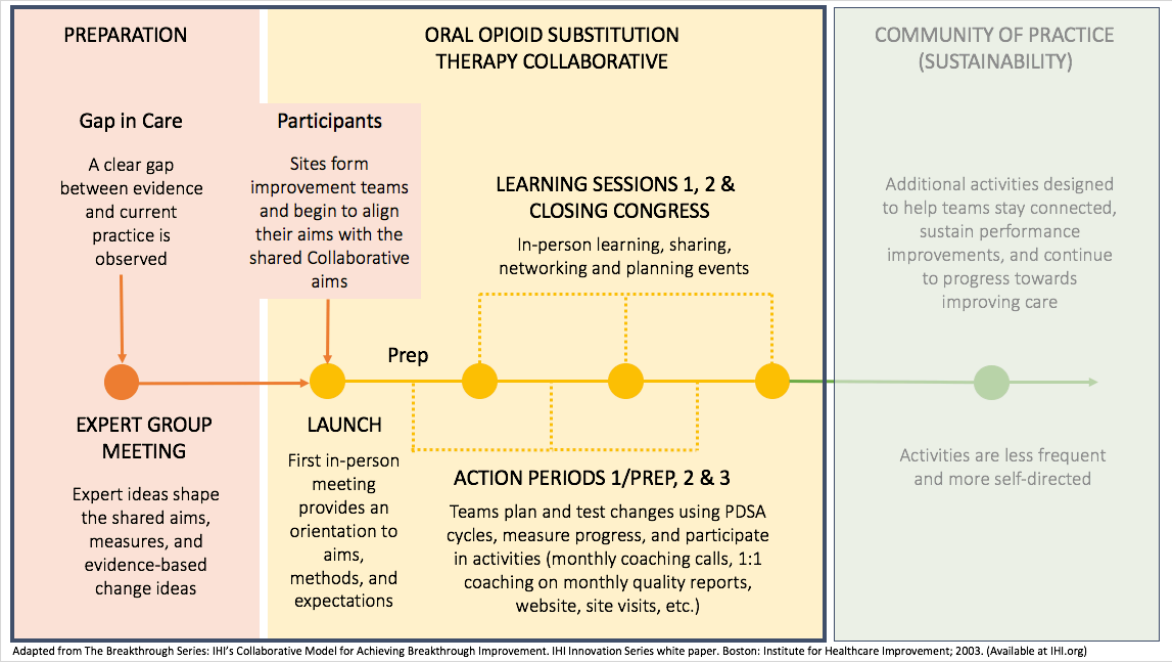


Figure 2. BOOST Collaborative Methodology

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

These are:

1. **What are we trying to accomplish?** *(Aim) Here, participants determine which specific outcomes they are trying to change through their work.*
2. **How will we know a change is an improvement?** *(Measures) Here, team members employ appropriate measures to track their work.*
3. **What changes can we make that will result in improvement?** *(Changes) Here, teams identify key changes that they will actually test.*

When teams have selected changes, rapid cycle testing of these changes using a sequence of planning (P), doing (D), studying (S), and acting (A) is to be applied to guide improvement. Employing PDSA Worksheets, teams can design tests of change to achieve their defined aims.

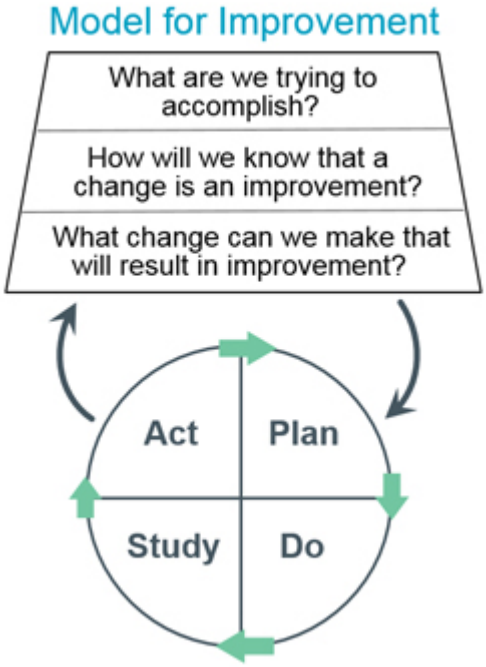


Figure 3. The Model for Improvement

The Collaborative is supported by:

Collaborative Core Team	Meet twice monthly (or as needed) to discuss ongoing operational tasks, provide support to the individual Collaborative teams.
Working Group	A group of individuals with experience in OUD care and quality improvement. This group meets at the start of the Collaborative to develop Collaborative content and design and may be consulted on an as needed basis thereafter.
Planning Group	A smaller group of subject matter experts who help guide the day-to-day delivery of the Collaborative.
Community of Practice	All members of the Collaborative teams.

Collaborative Expectations

General Commitments

- Agree to the dates of the collaborative: June 2017 to June 2018
- Alignment with the BC Centre on Substance Use mandate and greater provincial aims
- Learning sessions are in-person and will require travel to a venue in downtown Vancouver
- Role of the health authority to support teams with financial resources to participate in activities and processes and monitor team progress over time
- Role of the BC-CfE/VCH is to develop, coordinate and implement the activities of the Collaborative and monitor progress over time to achieve project aims

VCH Program Manager Commitments

- Establish QI teams or support a pre-established QI team to participate
- Have a QI coach available to assist each team in planning of and executing their QI activities (PSP)
- Reimburse between 3-6 members per team for travel expenses (i.e. parking/transit) and backfill to attend three to four in-person Learning Sessions
- Support each team to dedicate time to QI activities (e.g. attending in-person Learning Sessions, monthly team meetings, collecting improvement data, testing changes)

BC-CFE Commitments

- Provide financial support from VCH Vancouver Community to coordinate and deliver three to four in person Learning Sessions (including a full-day Launch), including technical support for video, speaker fees and materials
- Establish a Structured Learning Collaborative (SLC) Core Team consisting of a Project Sponsor, Clinical Lead, Project Manager, OUD expert and QI expert
- Plan, design, and maintain a Virtual Community of practice that coordinates aspects of the SLC, including website of resources, listerv, quarterly webinars, and monthly teleconferences
- Provide monthly coaching (Practice Support Program) to all participating teams based on reported numerical and qualitative QI data
- Monitor progress in meeting shared goals and plan interventions as needed
- Provide dedicated website to post information pertinent to the Collaborative and to disseminate Collaborative findings and news

Participating Teams

- Create a QI team that meets regularly to plan, discuss, and carry out Collaborative activities
- Complete pre-work activities laid out in the preparation manual before the first Learning Session
- Develop an aim statement aligned with the BCCSU mandate and provincial aims
- Initiate QI change cycles focusing on relevant aspects of the Continuum of oOST care
- Report monthly on Collaborative progress with numeric QI measures and qualitative narrative related to Collaborative goals
- Develop a plan for patient involvement and/or include at least one peer on your QI team
- Send between two and three team members to attend the launch and in-person sessions
- At least one team representative attends improvement activities between learning sessions, including monthly teleconferences and quarterly webinars

The Collaborative Faculty

- Provide QI frameworks, such as the improvement and Breakthrough Series Collaborative Model, to structure this Collaborative
- Facilitate and deliver monthly teleconferences, quarterly webinars, and other learning activities to facilitate team success
- Respond to monthly data and narrative reports with guidance and feedback
- Facilitate and coordinate 3-4 in-person learning sessions
- Provide QI training in Collaborative activities for all participants including OUD providers and clients

Preliminary Milestone Timeline

	Event and Activities
April 2017	• Pre-Planning Meeting 1 • Invite Working Group members • Continue work on metrics, change package and TOR • Finalize Planning Meeting date, time, and location
May	• Pre-Planning Meeting 2
June	• Pre-Planning Meeting 3
July	• Working Group Meeting • Planning Group Meeting (1-hr meeting) • Technical Document Development
August	• Planning Group Meeting (1-hr meeting) • Technical Document Development
September	• Launch • Planning Group Meeting (1-hr teleconference)
October	• Team Preparation • Planning Group Meeting (1-hr teleconference) • Technical Document Refinement
November	• Team Preparation • Planning Group Meeting (1-hr teleconference) • Technical Document Refinement
December	• Learning Session 1 • Planning Group Meeting (1-hr teleconference)
January 2018	• Action Period 1 • Planning Group Meeting (1-hr teleconference)
February	• Action Period 1 • Planning Group Meeting (1-hr teleconference)

March	• Learning Session 2 • Planning Group Meeting (1-hr teleconference)
April	• Action Period 2 • Planning Group Meeting (1-hr teleconference)
May	• Action Period 2 • Planning Group Meeting (1-hr teleconference)
June	• Closing Congress • Planning Group Meeting (1-hr teleconference)

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