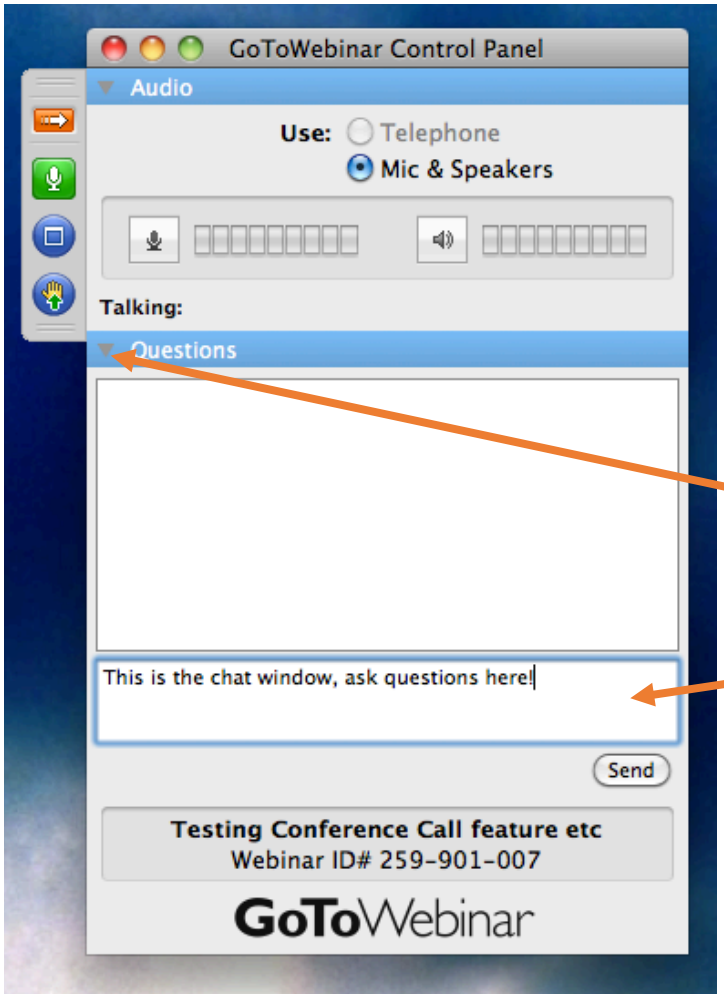
Welcome to the BOOST Collaborative!



Please familiarize yourself with the control panel. The webinar will begin at 12:30PM.

Click on the arrow to open the chat box

Type your questions to the moderator

Contact us: boostcollaborative@cfenet.ubc.ca

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

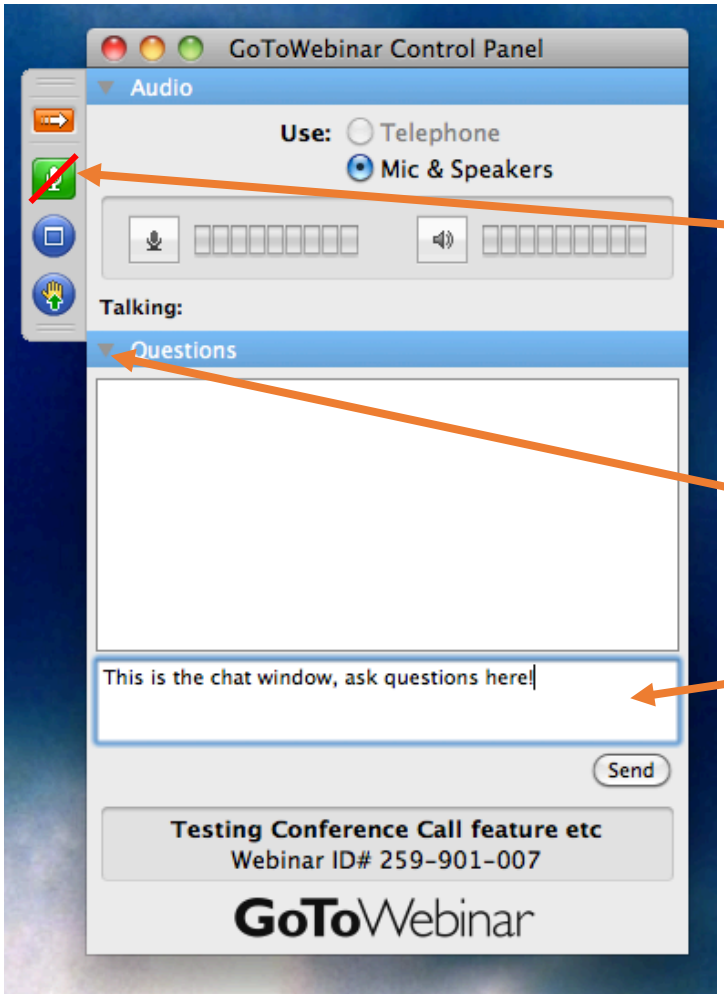
Best-Practices in
ORAL OPIOID AGONIST
THERAPY Collaborative

Collaborative Preparation Webinar

Friday, Aug 31st 2017

12:30 – 1:30 PM

Welcome to the BOOST Collaborative!



We will be recording the webinar

You will be muted during the Webinar

Click on the arrow to open the Questions box

Type your questions to the moderator

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Speakers

Cole Stanley, MD

Medical Lead, Continuous Quality Improvement, Vancouver Coastal Health (VCH) Community

Danielle Cousineau, RN

Quality Improvement Consultant, BC Centre for Excellence in HIV/AIDS

Laura Beamish, MSc

Quality Improvement Coordinator, BC Centre for Excellence in HIV/AIDS

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Overview

Laura Beamish	**Introductions and overview**	5 min
Dr. Cole Stanley	**Quality improvement fundamentals**	15 min
Danielle Cousineau Laura Beamish	**The BOOST Collaborative Methodology and preparation checklist**	15 min
	Questions and discussion	20 min

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Meeting Objectives

At the end of the webinar, participants will be able to:

- Define **quality improvement** and identify its key elements
- Describe **Structured Learning Collaborative** methodology and how it will be applied in the context of the BOOST Collaborative
- Define the **BOOST Collaborative aims and key drivers**
- Take the first steps needed to participate in the BOOST Collaborative including developing **team-specific aims** and defining your **population of focus**.

Poll

Quality Improvement Foundations

Dr. Cole Stanley, MD, CCFP

Medical Lead, Continuous Quality Improvement,
Vancouver Coastal Health (VCH) Community

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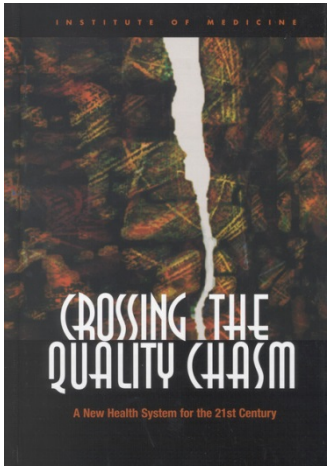
Dimensions of Care Quality

- 2001 Institute of Medicine Report *Crossing the Quality Chasm: Health Care in the 21st Century*
  - Safe
  - Timely
  - Effective
  - Efficient
  - Equitable
  - Patient-Centred



STEEEP

- In healthcare, we can use the Model For Improvement to improve the quality of care across one or more of these dimensions

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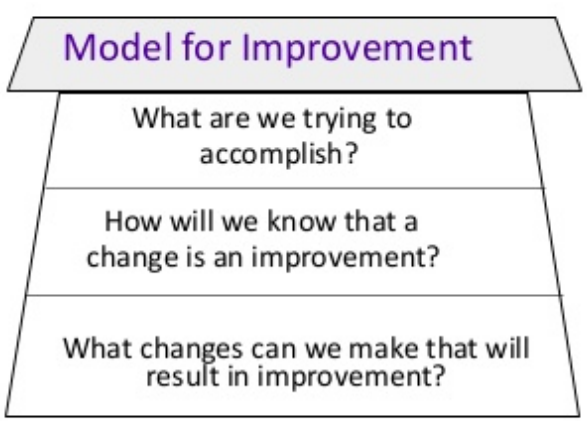
Model for Improvement

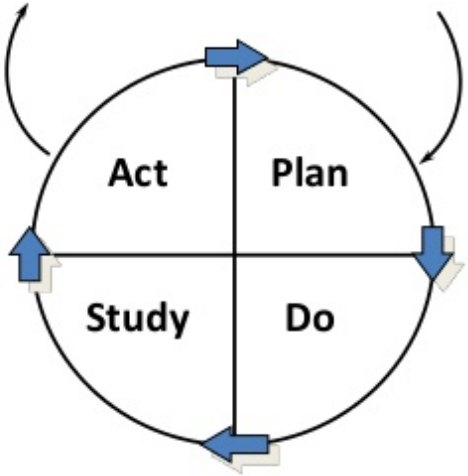


NHS Improving Quality

Aims

Measurements

Change ideas



Testing ideas before implementing changes

The Improvement Guide
Langley et al (1996)

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QI vs. Performance Evaluation vs. Research

Characteristic	Judgement	Research	Improvement
Aim	Achievement of target	New knowledge	Improvement of service
Testing strategy	No tests	One large, blind test	Sequential, observable tests
Sample size	Obtain 100% of available, relevant data	'Just in case' data	'Just enough' data small, sequential samples
Hypothesis	No hypothesis	Fixed hypothesis	Hypothesis flexible; changes as learning takes place
Variation	Adjust measures to reduce variation	Design to eliminate unwanted variation	Accept consistent variation
Determining if change is an improvement	No change focus	Statistical tests (t-test, F-test, chi-square, p-values)	Run chart or statistical process control (SPC) charts

Adapted from: "The Three Faces of Performance Management: Improvement, Accountability and Research." Solberg, Leif I., Mosser, Gordon and McDonald, Susan Journal on Quality Improvement. March 1997, Vol23, No. 3.

Quality Improvement is…

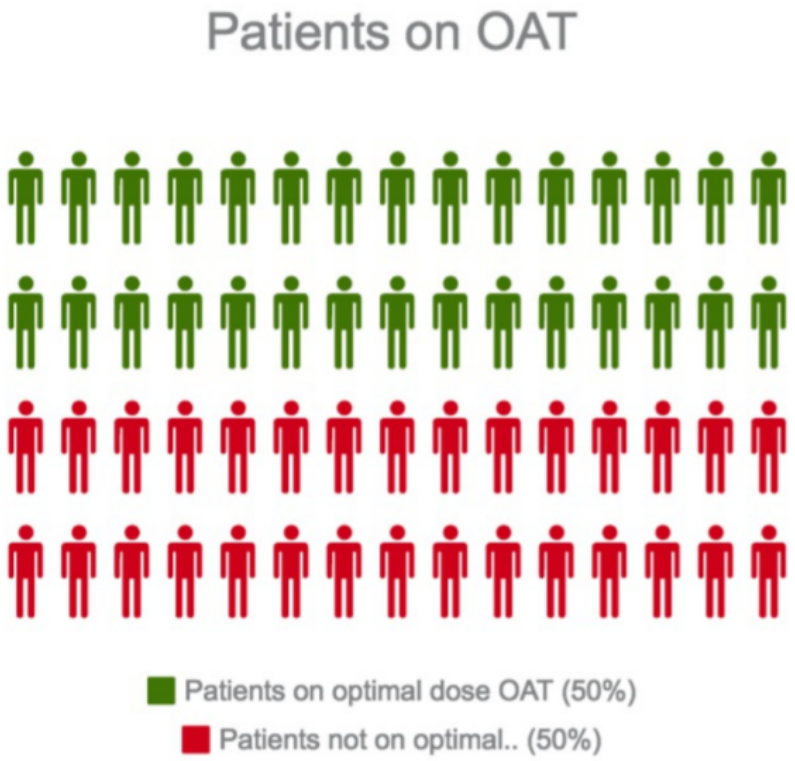
- A bottom-up approach that employs the frontline team as the drivers for change to the healthcare system they work in
- A systems approach
  - "Every system is perfectly designed to get the results that it gets"
  - Change the system to get better results
- Where small changes tested first, then scope and scale expanded

Quality Improvement Example

4 Optimal Dosing

Proportion of patients who are receiving optimal dose OAT

Aim: Increase proportion of patients on optimal dose



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Quality Improvement Example

- **Aims**: What are we trying to accomplish (identifying and closing care gaps)
- We know that only 50% of our patients on OAT are at optimal recommended doses
- Studies show better outcomes at optimal doses (quality dimension = Effectiveness)

Aim re: Optimal dosing

- **Aim**: We will increase the percentage of our OAT clients on optimal OAT dosing from 50% to 90% over the next six months

- **What?** *Percentage on optimal dosing*
- **For whom?** *OAT clients*
- **By how much?** *50% to 90%*
- **By when?** *Six months from now*

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Change Idea

- RN on team runs weekly list of OAT clients and flags those on non-optimal doses for clinician review

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?

Measures for our example

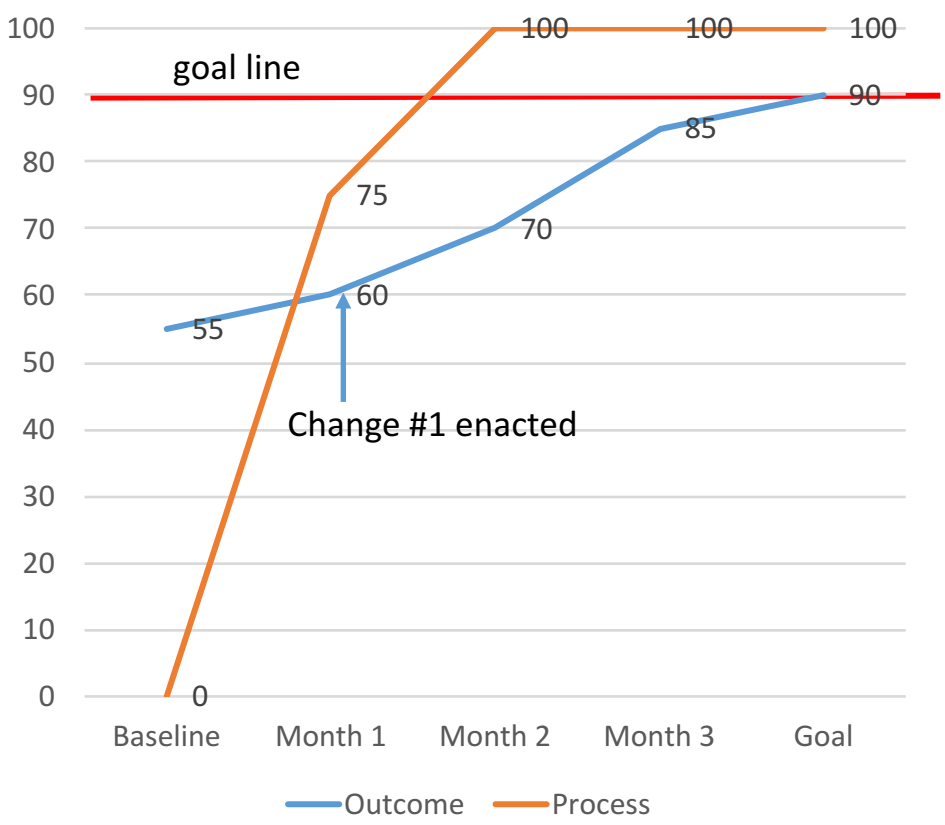
- **Outcome measure**: percentage of clients on OAT who are receiving optimal dosing
- **Process measures**:
  - percentage of weeks that RN runs list
  - percentage of flags followed up by clinician within two weeks
  - feedback on reasons for not being on optimal dosing (e.g. adherence, side effects, stable on low dose, etc.)
- **Balancing measures**: amount of time taken for RN to do this work

Plan Do Study Act

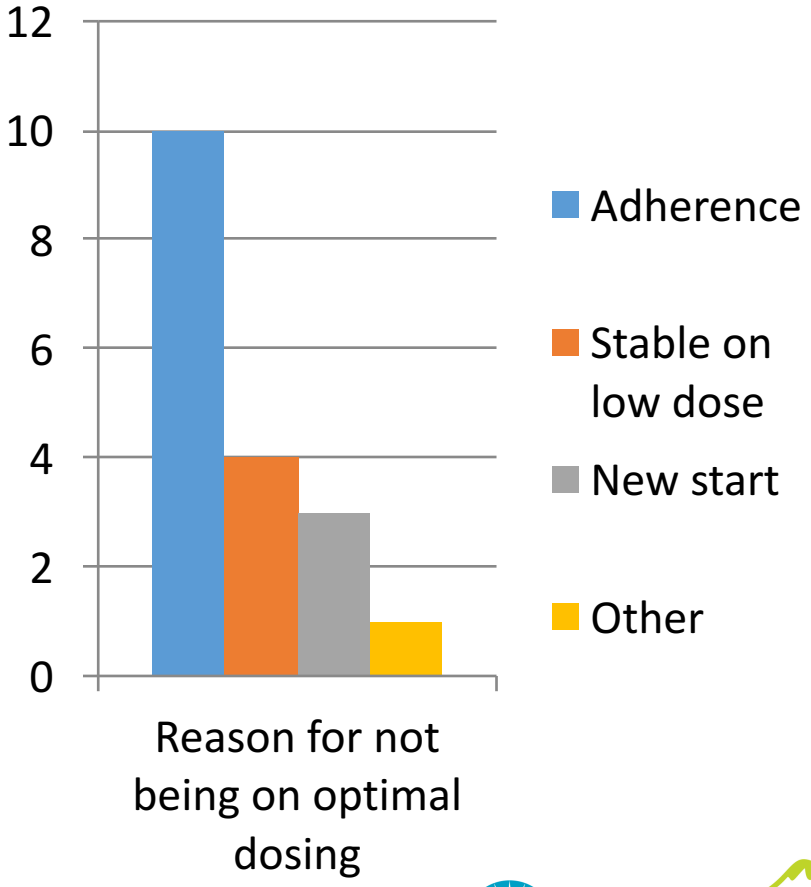
- After one month, outcome measure increases from 55% to 60%
- **Process measures**:
  - List run and flags created on ¾ weeks in the month
  - flags followed up by clinician 70% of time
  - *Pareto chart* of reasons for not being on optimal dosing (next slide)
- **Balancing measures**: took 30min of RN time weekly

Tracking progress

Run chart



Pareto chart



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Plan Do Study Act

- Team keeps weekly list review and flagging, but this time will try having LPN complete the work
- Team learns that some of their clients are stable on low “non-optimal” doses, so agrees that a “100% on optimal dosing” goal is unrealistic
- Team focus turns to related aim of increasing adherence, as it appears to be driving this outcome
- Cycle is repeated

Structured Learning Collaborative

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

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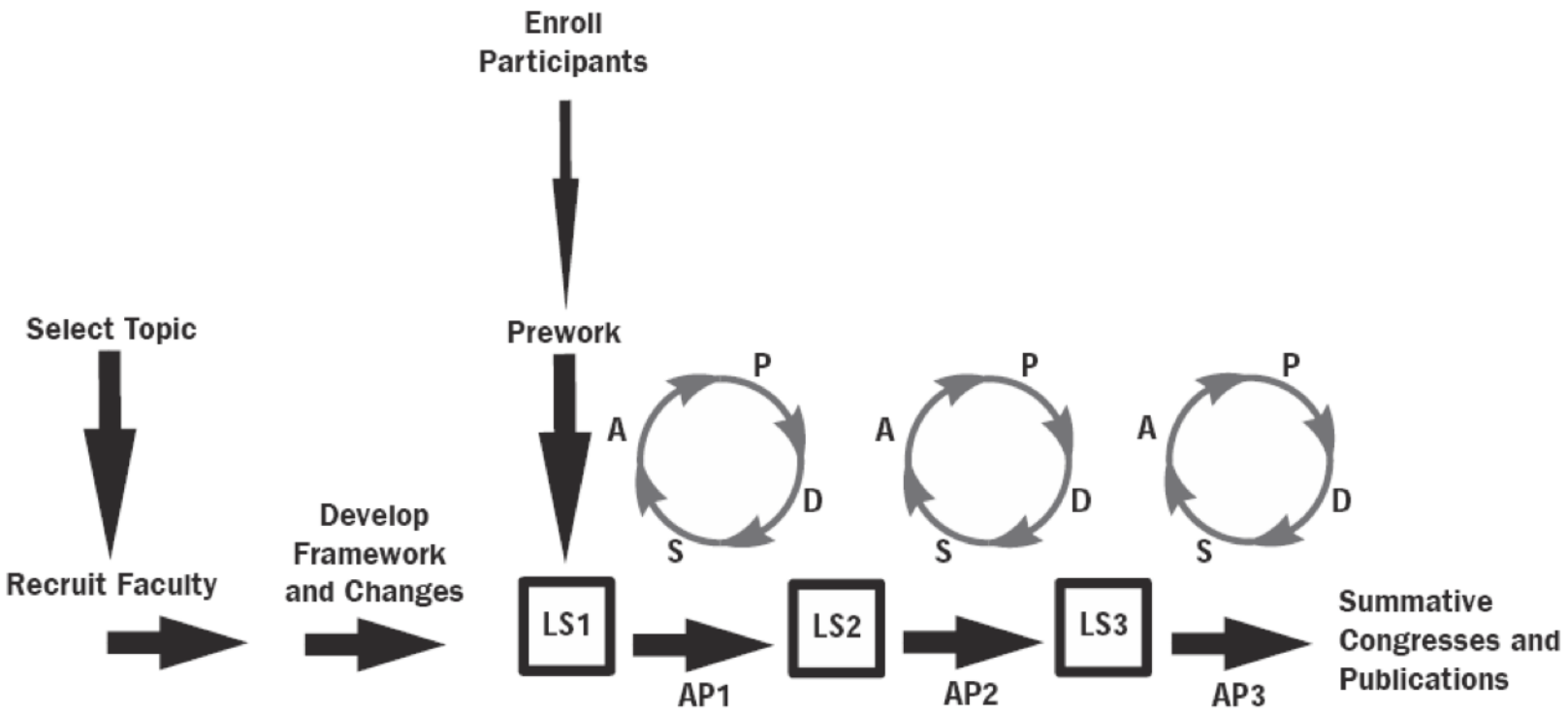
Rationale for the BOOST Collaborative

- BC is currently experiencing an opioid overdose emergency
- VCH has some of the highest mortality rates
- OUD has the potential to be in sustained long-term remission with appropriate doses of oral opioid agonist therapy (oOAT)
- Retention rates for clients receiving oOAT are unacceptably low
- The science exists- BC Centre on Substance Use Clinical Guidelines
- The healthcare **system** is not supporting our clients

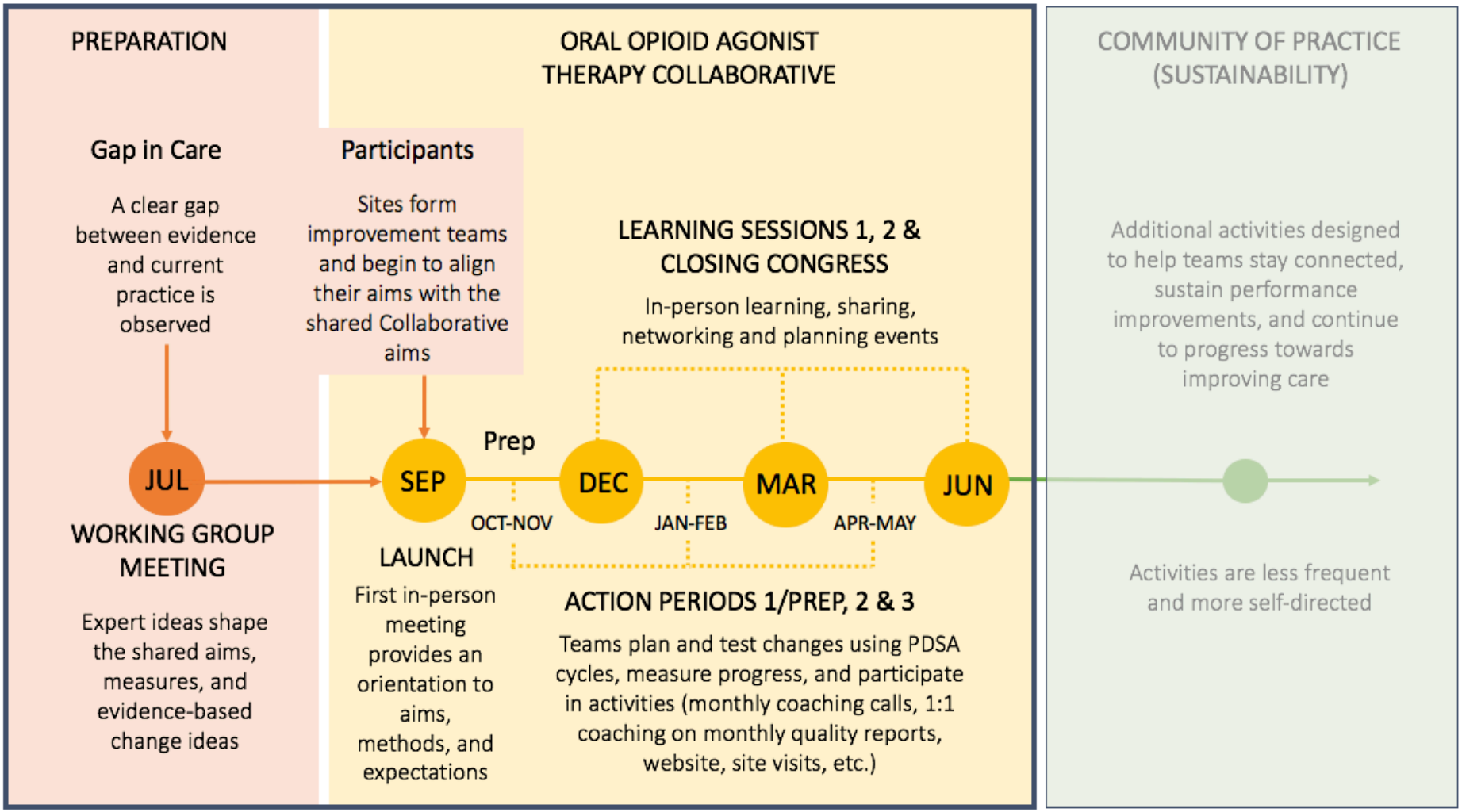
Next Steps

1. Familiarize yourself with the Collaborative models
    a. Model for Improvement
    b. Structure Learning Collaborative
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

1. IHI's Structured Learning Collaborative Methodology

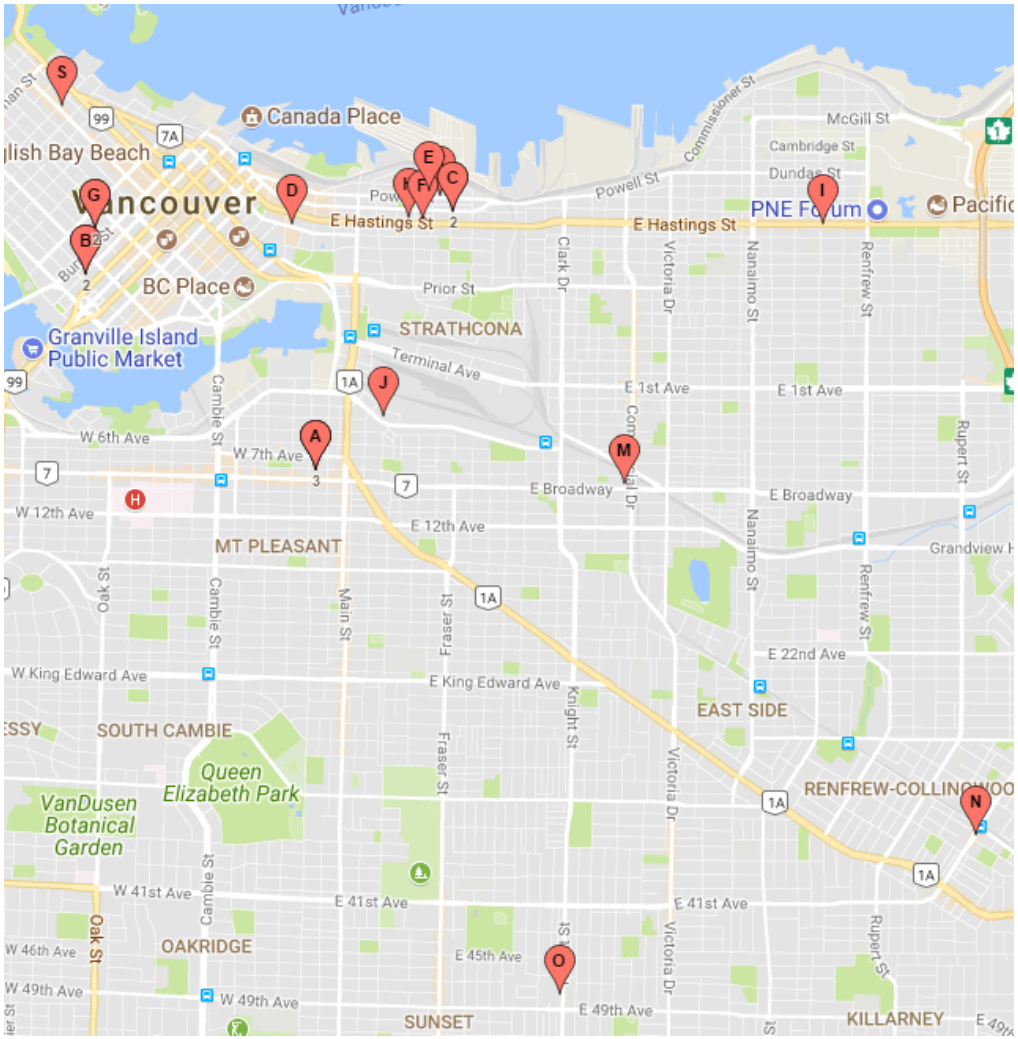


1. BOOST Collaborative Methodology



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)

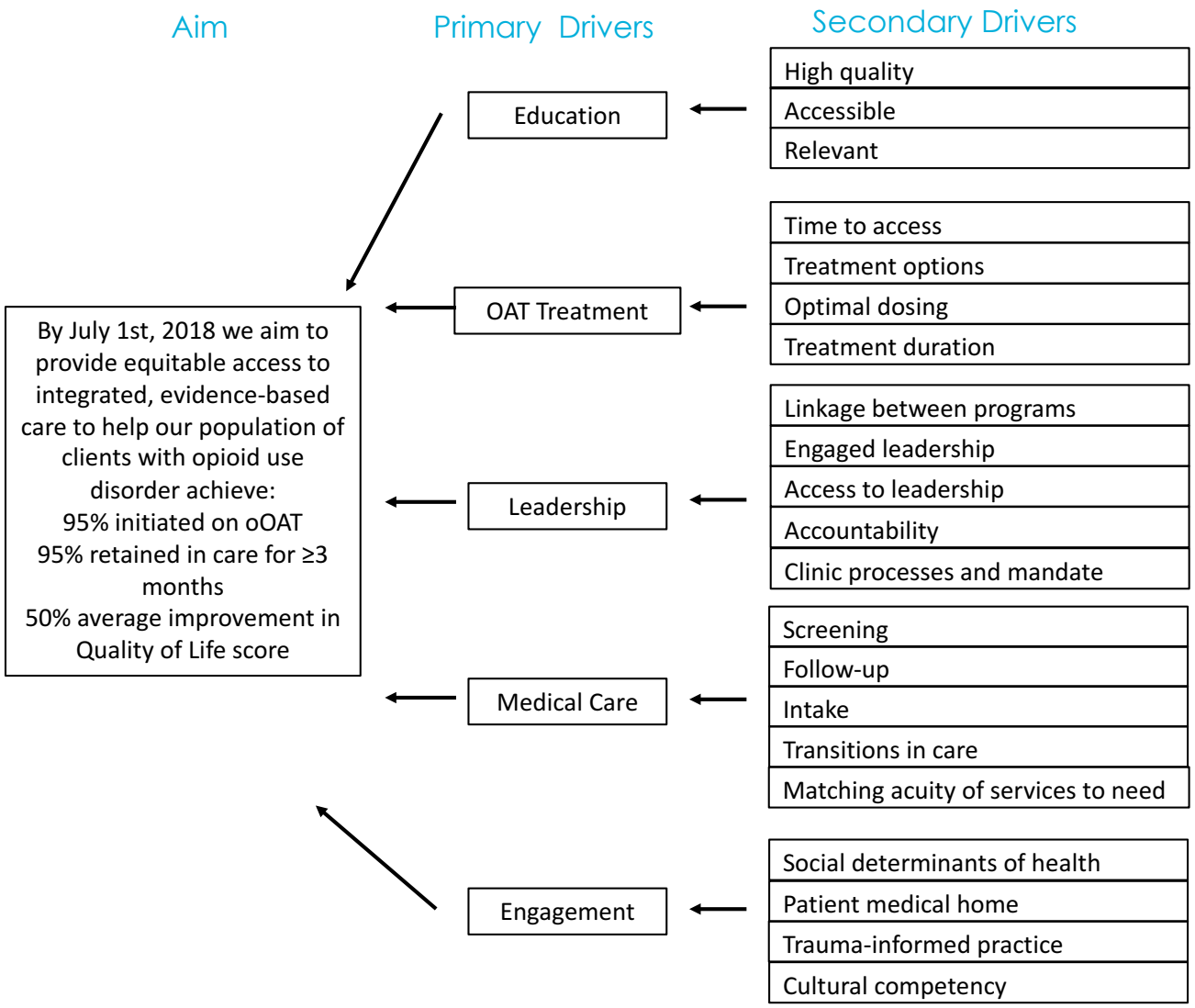
1. BOOST Collaborative Teams



2. Developing an aim statement

- Clear statement of purpose for your team
- Alignment with the purpose of the BOOST Collaborative
  - By July 1st, 2018 we aim to work collaboratively between programs to provide equitable access to integrated, evidence-base opioid use disorder care to help our collective population achieve:
    - 95% initiated on oOAT;
    - 95% retained in care for ≥ 3 months; and
    - 50% average improvement in Quality of Life score
- The care and services that you can influence and improve
  - What care/services does your team provide directly?
  - What care/services does your team indirectly influence?
- Needs within your Population of Focus

2. Driver Diagram



3. Population of Focus

- Your Population of Focus 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.
- What is the current and possible reach of your care and services?
  - Who are current clients of your care and services?
  - Clients in the community that you might reach out to?
- What do you understand about this population?
  - What are your current data sources?
  - Where can you look?
  - Create a list of your clients.

4. Key Metrics - Focus Areas

1. Diagnosis and Treatment Initiation
2. Treatment Retention and Optimal Dosing
3. Quality of Life and Bundle of Care

4. Key Metrics - Required Metrics

1. Diagnosis and Treatment Initiation
   - Access to oOAT
2. Treatment Retention and Optimal Dosing
   - Active oOAT
   - Optimal oOAT
   - Retention in oOAT
3. Quality of Life and Bundle of Care
   - Quality of Life

5. BOOST Collaborative Technical Documents

- **Preparation Manual**
- **Navigation Booklet**
- **Change Package**
- **Guide to Measurement**
- Find these documents here: www.stophivaids.ca/oud-collaborative

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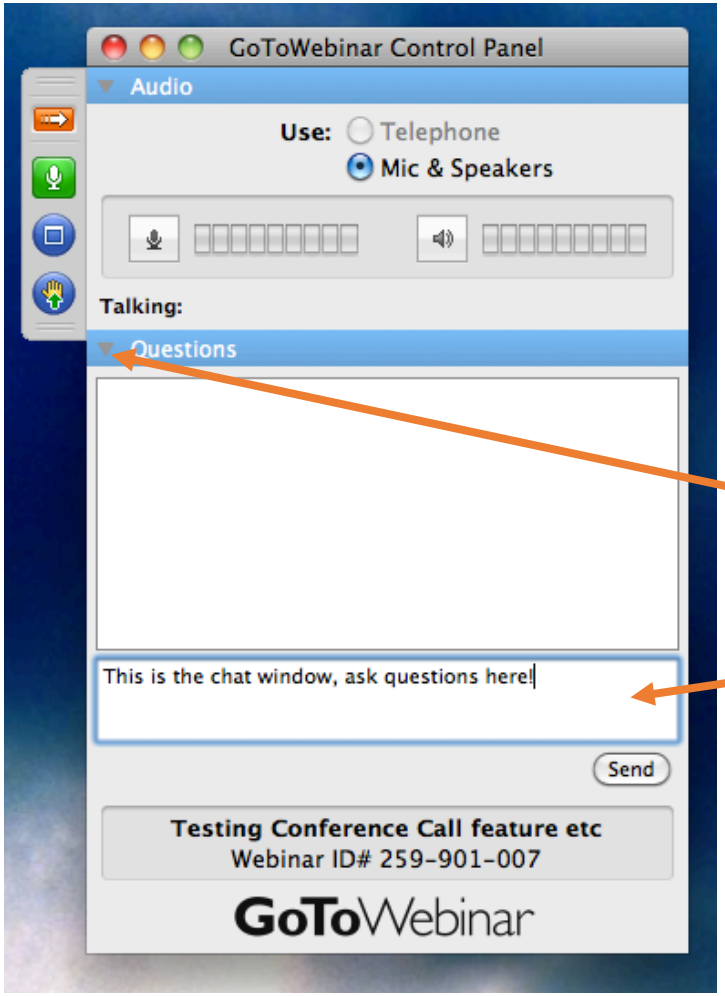
Questions and Discussion



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THANK-YOU!

Laura Beamish: lbeamish@cfenet.ubc.ca

Danielle Cousineau: danielle.cousineau@shaw.ca

Cole Stanley: cole.stanley@vch.ca

Angie Semple: asemple@cfenet.ubc.ca

CONTACT US: boostcollaborative@cfenet.ubc.ca

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

References and Resources

- Collaborative Website: http://stophivaids.ca/oud-collaborative
- 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.
- NIATx: https://niatx.net/
- BC Centre on Substance Use- Opioid Use Disorder Clinical Management Guidelines: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf
- IHI Open School courses: http://www.ihi.org