Pender CHC

- Pender CHC is a primary care clinic serving the Downtown Eastside with a patient population of approximately ~ 3000
- Our patients encounter numerous medical, psychiatric and social challenges, e.g. poverty and inadequate housing, addictions and chronic diseases, such as HIV, Hepatitis C and COPD
- Pender CHC provides primary care services by physicians, nurse practitioners and nurses
- Social Workers and Counsellors provide a variety of services, including outreaching patients to re-engage, providing individual and group counseling, e.g. Hepatitis C+ Treatment Support Group, Methadone and Suboxone Treatment Group, SMART Group etc.

Your Collaborative Team

Cathy Bennett, RN – Clinic Coordinator

Faiza Khalil – Community Liaison Worker

Yandi Kwa, Nurse Practitioner

Dr. Kristin Prabhakar

Karen St. Clair, Clerical Support Clerk

Lynda Thorson, RN – Clinic Coordinator

Alexandra Vause, RN

Aim Statement

By July 1, 2018, Pender Community Health Centre (CHC) will aim to provide Best-Practices in Oral Opioid Agonist Therapy (BOOST) to our population of patients with opioid use disorder (OUD) by assuring equitable access to integrated, evidence-based care. To achieve these goals, we will modify, as necessary, the current system of care for patients with OUD and measure the following to gauge our success:

- Seek new OUD patients (previously NOT diagnosed) by reviewing substance use history as part of every New Patient intake seen at Pender CHC
- Contact ALL known OUD patients to Pender CHC who have been lost to F/UP
- Contact ALL known OUD patients to Pender CHC who have identified gaps in care, e.g. non-adherent or NOT on oral opiate agonist therapy (oOAT) etc.

- Offer oOAT treatment to ALL OUD patients

- TARGET 95% OUD patients will be initiated on oral OAT
- TARGET 95% OUD patients will be retained in care for > 3/12
- TARGET 50% average improvement in the PROMIS Quality of Life score in ALL treated OUD patients

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Population of Focus

- Focus primarily on the known OUD patients at Pender CHC while seeking new OUD patients in the Downtown Eastside (DTES) inner-city community.

Changes Tested – PDSA #6 December 2017

- How does Pender CHC case manage OUD patients with Gaps in Care defined by ≥ 2 clinic visits in recent 9/12 previously Rx'd oOAT but did NOT F/UP?
- Based on Pender CHC's BOOST Baseline Registry Review, there were 67 patients on the Active Registry identified with Gaps in Care
- NOTE – 18 out of the 67 patients were targeted for referral to the OUD Outreach Team to attempt case management/ re-engagement for oOAT with recent Rx since 09/2017 but subsequently did NOT F/UP
- From the 18 patients who were referred to the Opiate Outreach Team in 11/2017 (identified with recent OAT Rx since 09/2017 but subsequently did NOT F/UP:
  - 6 patients restarted and remain on OAT currently
  - 1 patient restarted and remain on OAT currently that has MOGE
  - 10 patients are NOT on OAT
  - 4 patients DECLINED to restart OAT
  - 6 patients are NOT on OAT but briefly restarted in the last few months but subsequently did NOT F/UP
  - 2 patients have NOT been reachable by the Opiate Outreach Team
  - 3 patients were identified as having MOGE
- NOTE – of the 4 patients who DECLINED to restart OAT, the Opiate Outreach Team documented that patients DECLINED to restart OAT due to NOT wanting "to be monitored" or lack of readiness in keeping with initial predictions

Changes Tested – PDSA #6 December 2017

- How does Pender CHC implement case management for OUD patients Lost to F/UP defined by ≤ 1 clinic visit in recent 9/12?
- Based on Pender CHC's BOOST Baseline Registry Review, there were 20 patients on the Active Registry identified as Lost to F/UP who were referred to Faiza Khalil (Community Liason Worker) for case management/ re-engagement
- From the 20 patients who were referred to Faiza Khalil (CLW):
  - 1 patient restarted and remain on OAT currently (that has ALSO MOGE)
  - 19 patients are NOT on OAT
  - 3 patients DECLINED to restart OAT with 1 citing no OUD diagnosis (previously used MMT for chronic pain and 1 citing slow titration in Canada as reason for DECLINE)
  - 1 patient is NOT on OAT but briefly restarted in the last few months but subsequently did NOT F/UP
  - 4 patients have NOT been reachable by Faiza Khalil (CLW) as NFA
  - 6 patients have NOT been attempted for outreach by Faiza Khalil (CLW)
  - 4 patients are no longer active patients at Pender CHC with their file to be CLOSED
- NOTE – of the 4 patients who DECLINED to restart OAT, the Opiate Outreach Team documented that patients DECLINED to restart OAT due to NOT wanting "to be monitored" or lack of readiness in keeping with initial predictions

Lessons Learned

- Share your progress so far- what have you learned about your POF, partnerships, etc.
- Share any lessons learned or opportunities for improvement you encountered
- How did you address these?

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Looking forward…

- Develop a sustainable system to continue the CQI .

Long-term Goals :

- Maintain registry
- Maintain community outreach contacts and relationships
- Develop strategies/ opportunities for patient involvement

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

Looking forward…

- Future considerations
  - a PDSA to target NEW patients starting or restarting oOAT moving forwards in the interest of increased engagement/ retention
  - Consider role of oOAT, e.g. Suboxone for those patients with opiate abuse
  - Learn from other VCH BOOST Collaborative Teams who have implemented, for example:
    - appointment reminders T/C for patients with OUD via liaising with patient or their pharmacies
    - Assertive outreach for OUD patients with MISSED oOAT doses reported by pharmacies

Contact Information

- Pender Community Health Centre
- 59 West Pender Street, Vancouver, BC
- (604) 669-9181

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative