BOOST Collaborative Learning Lesson 2

Team: Mark McLean, RAAC Physician Lead
Brynn Grierson, Patient Care Manager
Nancy Chow, Clinical Nurse Lead
Jennifer Funo, Addiction Assessment Nurse

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Your Collaborative Team

Mandate: The RAAC is a low-barrier outpatient clinic providing short-term outpatient clinical treatment for people living with substance use.
The RAAC also provides consultation for community providers on challenging cases.

Goals: To stabilize patients of their addiction and connect patients to treatment programs and primary care in the community.

Services: Addiction medicine (including OAT starts and switches, alcohol management, benzo tapers), assessment and screening for iOAT, bridging scripts, HCV/HIV screening, groups, treatment applications, financial aid applications, access to shelters, access to Van Detox, linkage to community providers

Team: Addiction specialists, Nurses, Social Workers, Peer Navigators

RAAC Team

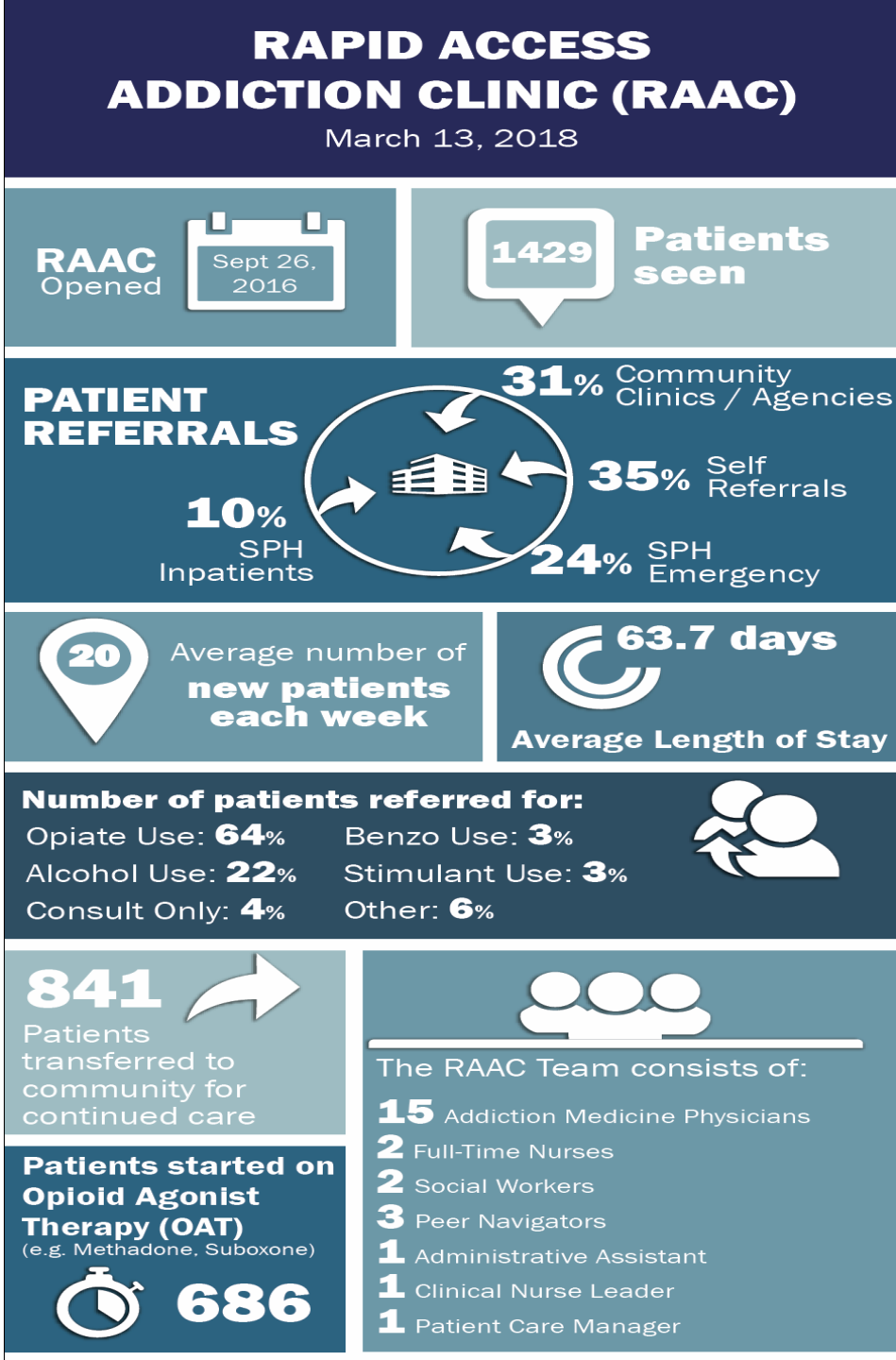
Who do we serve?

Clinic is located on the 2nd floor of Burrard Building- above the SPH ED

Referrals source:

- SPH ED
- AMCT (SPH inpatient units)
- Community (Family MDs, CHCs, Detox, VCH Mental Health Team, ICY, POS, etc)
- Self

Latest numbers at RAAC



Working on BOOST QI: AIM#1

Improve engagement of referred patients who presented in ED with opiate overdose, intoxication, or withdrawal

AIM:

By October 1st 2018, we aim to decrease the number of clients lost to care when referred from SPH ED to RAAC or community provider by 50%

POF:

Patients with OUD presenting in ED with a primary diagnosis of opiate overdose, opiate intoxication, and opiate withdrawal

Changes Tested:

- Tracking ED referrals
- ED Addiction Assessment Nurse to triage patients and coordinating patient for community care (RAAC or community providers)
- Referral to OOT
- Obtain monthly report of activities
- Creating Dashboard in collaboration with ED for quality improvement

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AIM#2- revised

Assess the effectiveness of OAT of clients deemed vulnerable to disengagement and provide close follow up x 8 weeks after OAT start

AIM:

By October 1st, 2018, we aim to have 100% of clients initiated on OAT to receive follow up post OAT start

POF:

Clients with OUD initiated on OAT especially those who are identified as vulnerable to "loss to care"

Changes Tested:

- Tracking patients who recently started OAT- RN to do, started with 3x/wk, now 1x/wk
- Score patient on "Vulnerable to Lost Care" criteria to identify clients to monitor
- Monitor lost to care- Pharmanet check for missed doses, missed appointments
- Follow up with client via phone, letter, or referral to OOT to engage
- Identify most common reasons for disengagement to guide follow up
- Clients on new OAT not identified as VLTC, to receive a follow up check up from nurses

Vulnerable to Lost to Care (VLTC)

To score clients on Vulnerability criteria for **VLTC** based on the following:

First stage of scoring (one point each):

- ❑ Unstable Housing (including no phone)
- ❑ History of disengagement (multiple failed OAT starts)
- ❑ Daily Stimulant users

If score 3, nursing staff to follow for 4 weeks

Second stage of scoring (one point each):

- ❑ Unstable Housing (including no phone)
- ❑ History of disengagement (multiple failed OAT starts)
- ❑ Daily Stimulant users
- ❑ No primary care provider
- ❑ History of incarceration
- ❑ History of multiple overdoses

If score 4 or more, nursing staff to follow for the next 4 weeks before removing from follow up list

AIM#3- update

Improve continuity of care in community for clients stable on SROM

AIM:

By October 1st, 2018, we aim to have 75% of clients stable on SROM at RAAC transferred to appropriate community providers.

POF:

Clients stable on SROM, ready for discharge from RAAC

Changes Tested:

- Assess discharge rate of clients stable on SROM
- Build list of community providers to target support and referral source
- Develop education team to build community capacity for SROM provider
- Provide education sessions for community providers (Reach Clinic in Feb)
- RAAC to provide support to community provider via consults

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Lessons Learned

- Important to identify multiple OAT restarts
- Regular QI meeting established (biweekly)

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from Noun Project

- Data tracking is essential, data retrieval is still a challenge!
- Collaborative team work and communication
- Patient-centered model of care to be upheld (what is important to the client at the time)

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Looking forward…

- Continue to focus on Lost to Care patients, how to track, how to support, who do we get involved- plan to conduct a predictive analytic project to study client disengagement

- Working on improving discharge planning process and focus on supporting returning clients

- Place focus on the development and fostering of community partnerships

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How to contact us

RAAC: 604-806-8867

Mark.mclean@vch.ca

bgrierson@providencehealth.bc.ca

nchow@providencehealth.bc.ca

jfuno@providencehealth.bc.ca

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