BOOST Collaborative
Learning Lesson 3
June 2018

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

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

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

RAPID ACCESS ADDICTION CLINIC (RAAC)

June 1, 2018

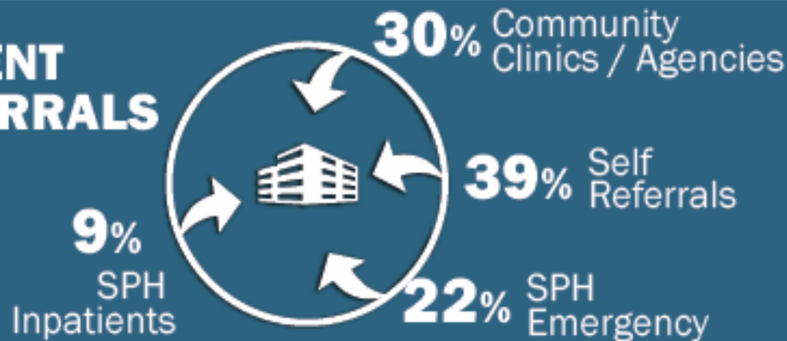
RAAC Opened

Patients seen

Number of patients referred for:

Opiate Use: **64%**
Alcohol Use: **22%**
Consult Only: **3%**
Benzo Use: **3%**
Stimulant Use: **3%**
Other: **5%**

PATIENT REFERRALS



1031

Patients transferred to community for continued care

The RAAC Team consists of:

17 Addiction Medicine Physicians
3 Full-Time Nurses
3 Social Workers
3 Peer Navigators
2 Administrative Assistant
1 Clinical Nurse Leader
1 Patient Care Manager

28 Average number of **new patients each week**

68.9 days

Average Length of Stay

Patients started on Opioid Agonist Therapy (OAT)
(e.g. Methadone, Suboxone)

930

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:

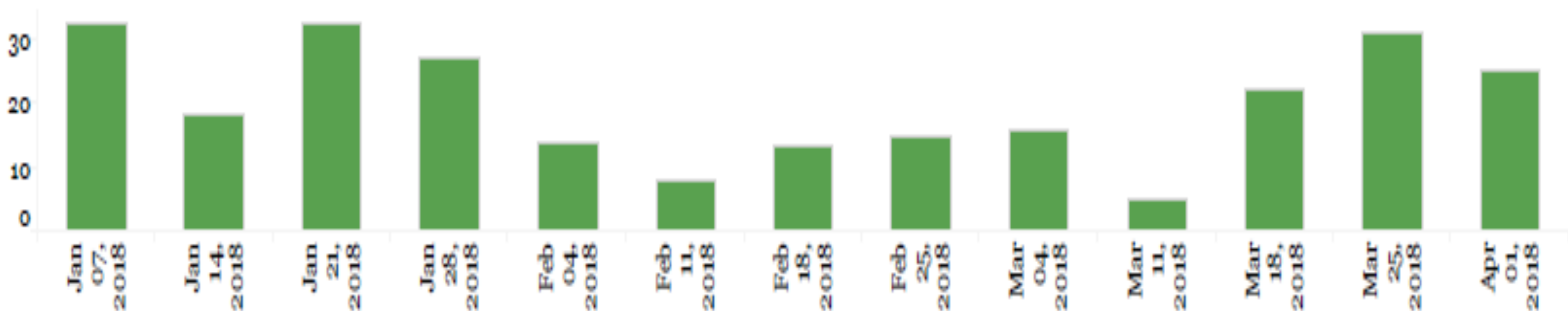
Patients with OUD presenting in ED with a primary diagnosis of opiate overdose, opiate intoxication, and opiate withdrawal

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

ED referrals to RAAC

- 27% ED referrals to RAAC presented RAAC in 2018
- 50% ED referral to RAAC are referred to OOT for engagement (the other 50% not referred as not OUD cases)



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 ALL patients who recently started OAT- started with 3x/wk, now 1x/wk
- LPNs task for follow up during clinic down-time
- Score patient on "Vulnerable to Lost Care" criteria after 8 weeks of follow up to determine discharge from list rather than at start of OAT
- 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

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

OAT Start Follow Up

Checking Process

- Updated list printed every Friday
- Look up Pharmanet for each client for up-to-date filling of script according to prescription
- **If client filled script:** all good
- **If client has not filled script:** review encounter notes of script details, ie. carries, vacations, other reasons

Follow-Up

- **If client filled script:** call for courtesy check-in
- **If client has not filled script:** call client to follow up for reason and support them to return to clinic for assessment
  - Chart phone call
  - After 3 attempts to contact and no-re-engagement, refer to OOT – REMOVE from list
- If no phone, but have address: send Follow-up Letter, refer to OOT – REMOVE from list
- If no contact info: refer to OOT – REMOVE from list

Discharge Evaluation

- Clients followed for 8 weeks
- After 8 weeks, use VLTC Scoring to determine if removing from list. If they score 3 or higher, client remains on list. If less than 3 – REMOVE from list
- If client has transferred to another provider and at lease one script from provider has been filled – REMOVE from list
- If client has been referred to OOT – REMOVE from list
- To REMOVE from list: in EMR, Task CNL ie. “OAT Start Follow Up- Remove from List”

Vulnerable to Lost to Care (VLTC)

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

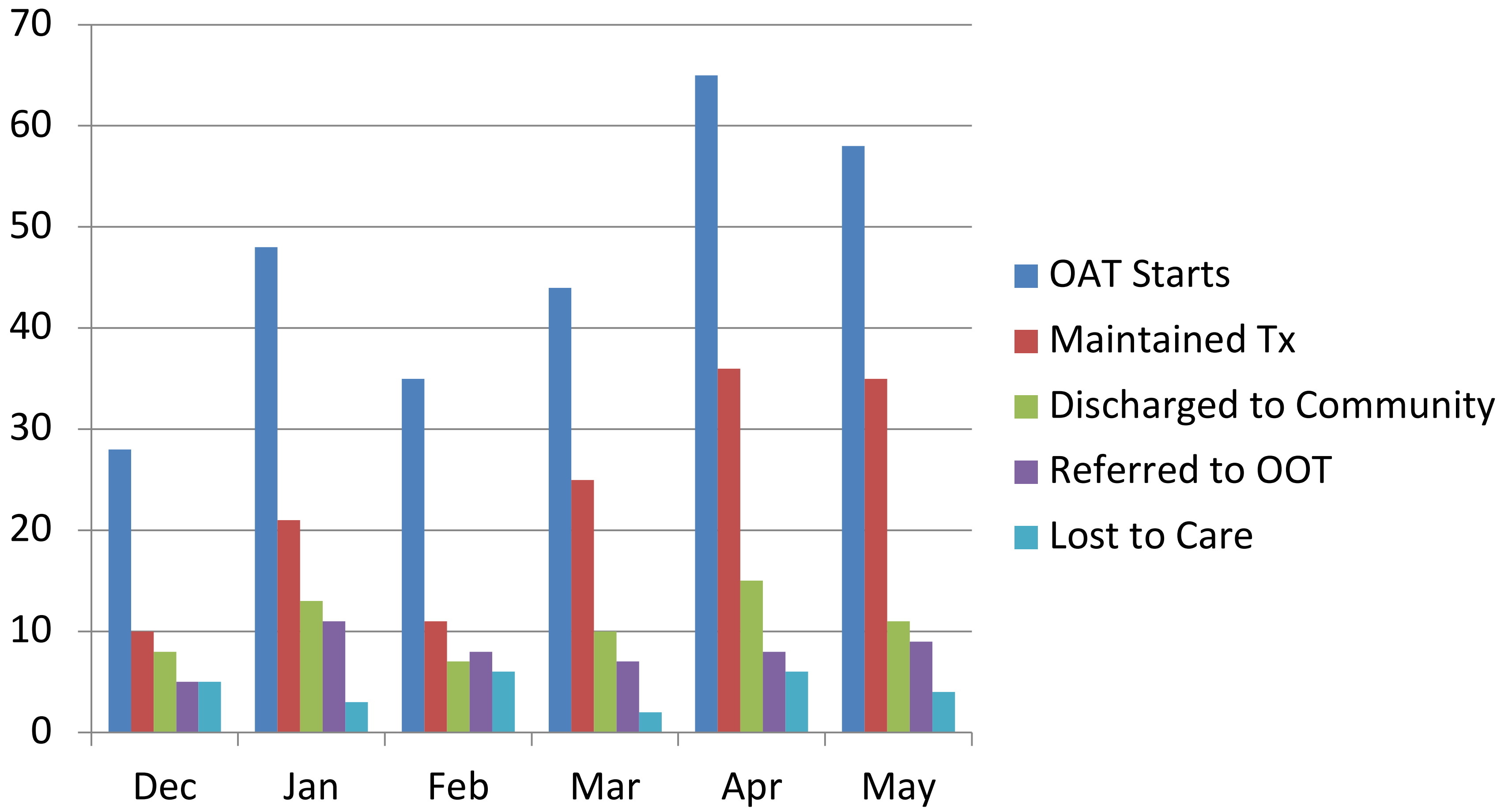
Done 8 weeks post OAT start (one point each):

- ❑ 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 3 or more, nursing staff to continue following for the next 4 weeks, then review scoring to determine discharge from list

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

OAT Start Data



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
- RAAC to provide support to community provider via consults

Lessons Learned

- Important to identify multiple OAT restarts

Created by Yu luck from Noun Project

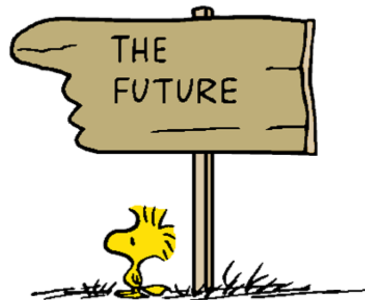
- Regular QI meeting established
- Data tracking is essential, data retrieval is still a challenge!
- Collaborative team work and communication
- Patient-centered model of care to be upheld (what is important to the client at the time)

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. Identify themes for disengagement.

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

- Place focus on the development and fostering of community partnerships and support capacity for community OAT clinics (Fraser Health)



Best-Practices in
ORAL OPIOID AGONIST
THERAPY Collaborative

How to contact us

RAAC: 604-806-8867

Mark.mclean@vch.ca

bgrierson@providencehealth.bc.ca

nchow@providencehealth.bc.ca

jfuno@providencehealth.bc.ca

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative