



SCC Coaching Call

Cole Stanley, MD, CCFP

Medical Lead, Provincial BOOST Collaborative

May 30, 2019

IDC
John Ruedy Immunodeficiency Clinic



MSPQI



Disclosures

Dr. Stanley

- Travel grants received for conference attendance from the following
 - 2017 – Gilead Sciences
 - 2016 – Canadian Association for HIV Research (with support from Viiv), Gilead Sciences
- Advisory Board – Viiv Canada, March 2019
- Mitigating bias
 - No discussion of specific HIV or Hep C therapy in this talk

List of topics we can cover

- 1) Forming your QI team
- 2) Getting a QI coach
- 3) Meeting regularly
- 4) Developing aims
- 5) Measuring
- 6) Testing changes
- 7) Barriers you are encountering
- 8) Tips for other teams



SINEK
START WITH WHY

SIMON SINEK
Author of *Start With Why*



Daniel

Alex

Paul

- **Withdrawal suppression**
- **Decreased illicit opioid (and cocaine) use**
- **Reduced risk of HCV/HIV**
- **Better HIV control**

Opioid agonist therapy

- **Decreased criminal justice system involvement**
- **Significantly reduced mortality (both all-cause and substance-related)**

Retention on methadone and buprenorphine is associated with ***substantial reductions in the rate of all cause and overdose mortality***

OPEN ACCESS Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies



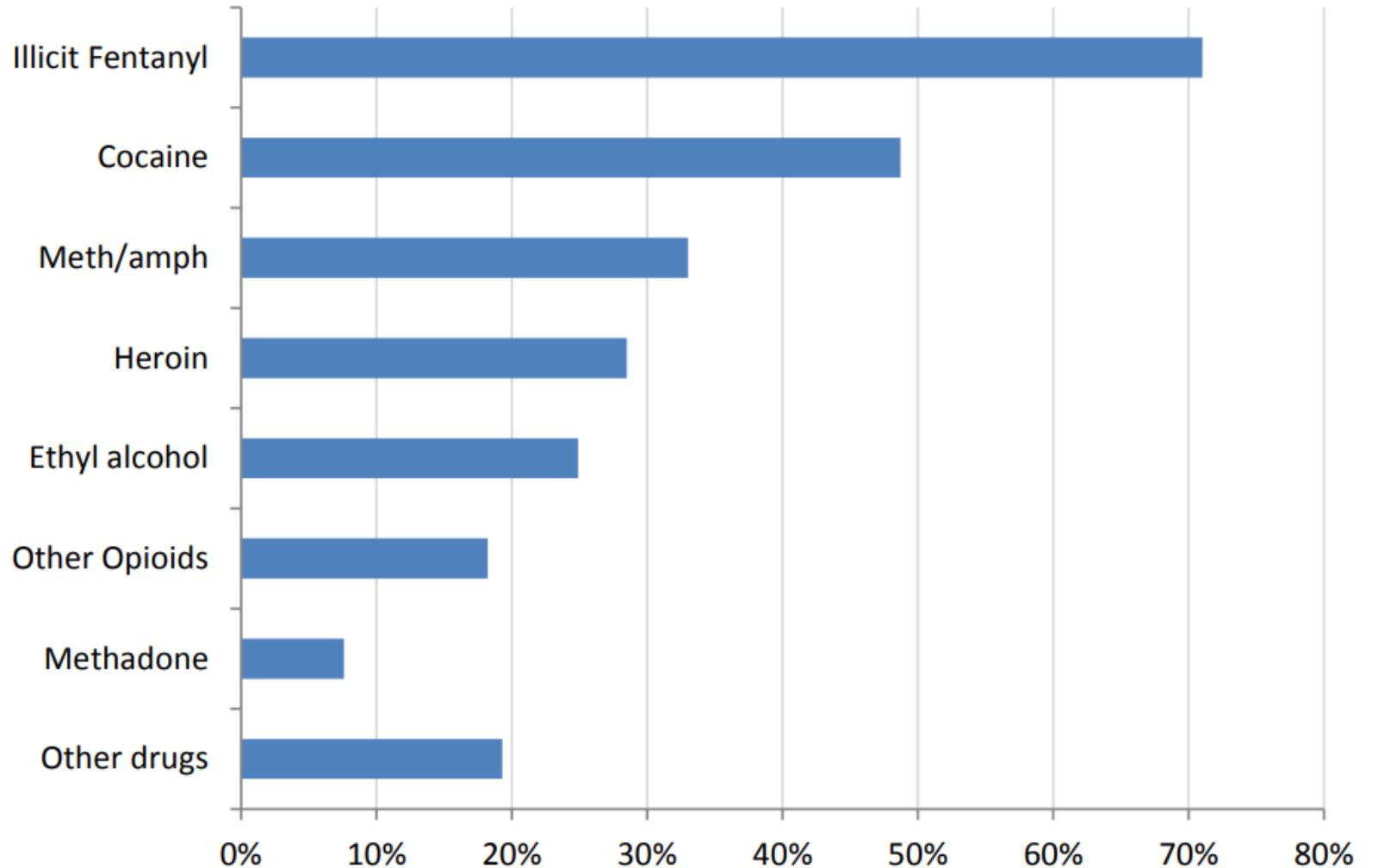
Accepted: 17 March 2017

Pooled all-cause mortality rates were 11.9 and 96.1 per 1000 person years in and out of methadone treatment (unadjusted out-to-in rate ratio 3.20, 95% confidence interval 2.65 to 3.86) and reduced to 4.3 and 9.5 in and out of buprenorphine treatment. The absolute number (age standardised prevalence) of people with opioid dependence worldwide increased from 10.4 million (0.20%) in 1990 to 15.5 million (0.22%) in 2015, a substantial contribution to the global disease burden.

B.C. Coroner's data...

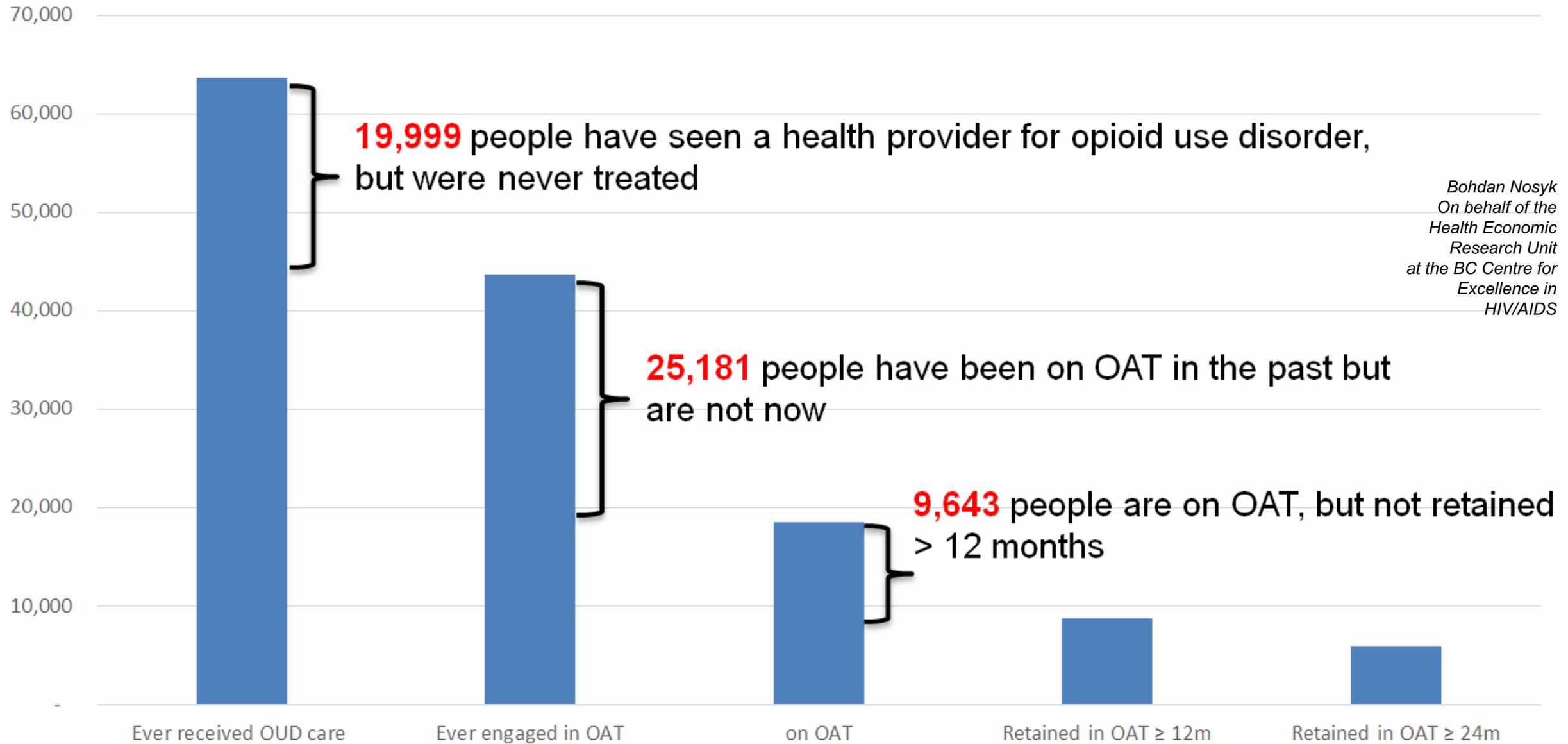
Top Relevant Drugs Detected Among Illicit Drug Overdose Deaths, 2016-2017

Suboxone saved Sabrina?



April 5, 2018

Majority started on OAT, minority retained on therapy for adequate period



Bohdan Nosyk
On behalf of the
Health Economic
Research Unit
at the BC Centre for
Excellence in
HIV/AIDS

SUBSTANCE USE TREATMENT JOURNEY MAP

what do peers experience?

NOT IN TREATMENT

"I don't believe help actually exists"

"I told counsellors what they wanted to hear to avoid being forced into treatment"

"There's a lot of trust [in the healthcare system] that's been broken"

"This is a human experience, not a criminal one"

"Using is ritualized, compulsive, comfort-seeking"

"The alternative for not being in treatment is death"

"You need to be honest, open, willing before seeking treatment"

WHY I LOOK FOR TREATMENT

Friends dying

FEAR - of overdose

MCFD, court system, employer mandating treatment

Loved ones ask you to quit

Overdose

Other health issues like HIV/HCV

It can be hard to leave this area because:

Need to be in withdrawal or already "clean" before treatment - and once you're in, you lose your autonomy

FEAR - of losing freedom, autonomy, privacy, friends and medication like benzos

Treatment means abandoning commitments to pets, work or family

Hard to work while in treatment; you can't claim addiction as a disability. Rent still needs to be paid

CONFUSION - There is a long wait for services - and it's confusing to know which ones to access

Don't want to feel the negative emotions that substances cover up

Peer pressure to keep using

HOPELESSNESS

TREATMENT & SUPPORT

It can be hard to stay in this area because:

Doctors offices are hard to get to

Need time off work and/or way to travel

Bills still need to be paid - but difficult to travel for work on OST

ID is needed

It's hard to know which treatment route will work - and different doctors needed for different medications

Pain
"Don't disqualify someone's pain because they have a history of drug abuse"

Mental Health
"This one size fits all treatment means we aren't allowed to use benzos any more"

Stigma/ Shame
"The climate doesn't allow us to talk openly about our addiction"

"As a society, we have a responsibility to care for one another. We've lost sight of this"

Financial Pressure
"If addiction is a disease like cancer, why does it cost so much for recovery?"

"I can't drive on OST - so how am I supposed to work?"

Access to Care
"I woke up wanting to start treatment, but my doctor told me to wait - there were no spots"

"I can wait a week for detox, or access my dealer with no wait at all"

What is a good life for me?

"Recovery means different things to each of us"

"Let me choose what success looks like"

Coercion
"Treatment centres are so controlling. I can't smoke in detox"

"Being in treatment is more punitive - worse than when you're using"

Lack of Trust
"Don't assume we're manipulating you!"

"The doctors say our visits are confidential, but I don't feel like they are"

Inflexible Treatment Options
"Methadone sets you up to lie"

"Methadone doesn't carry you for 24 hours"

"There needs to be transitions between therapies"

RECOVERY

These help me stay here:

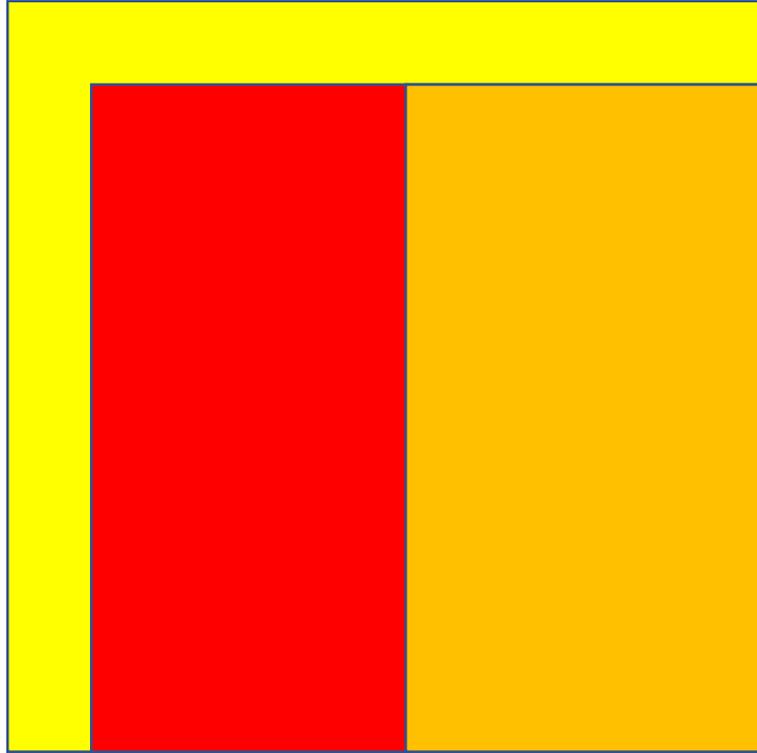
- Peer support networks
- Counselling
- Church
- Holistic approaches
- Gender/cultural needs met
- Social media
- 12 step groups
- Well educated, informed providers
- Getting my life back
- Being treated with respect/dignity

ENTRY POINTS

- Emergency Department
- Complementary therapies
- Hospital 'Psych ward'
- Peer networks
- Mental health services
- Walk-in clinics
- Residential care
- Family doctor
- Team-based care
- Jail
- Detox



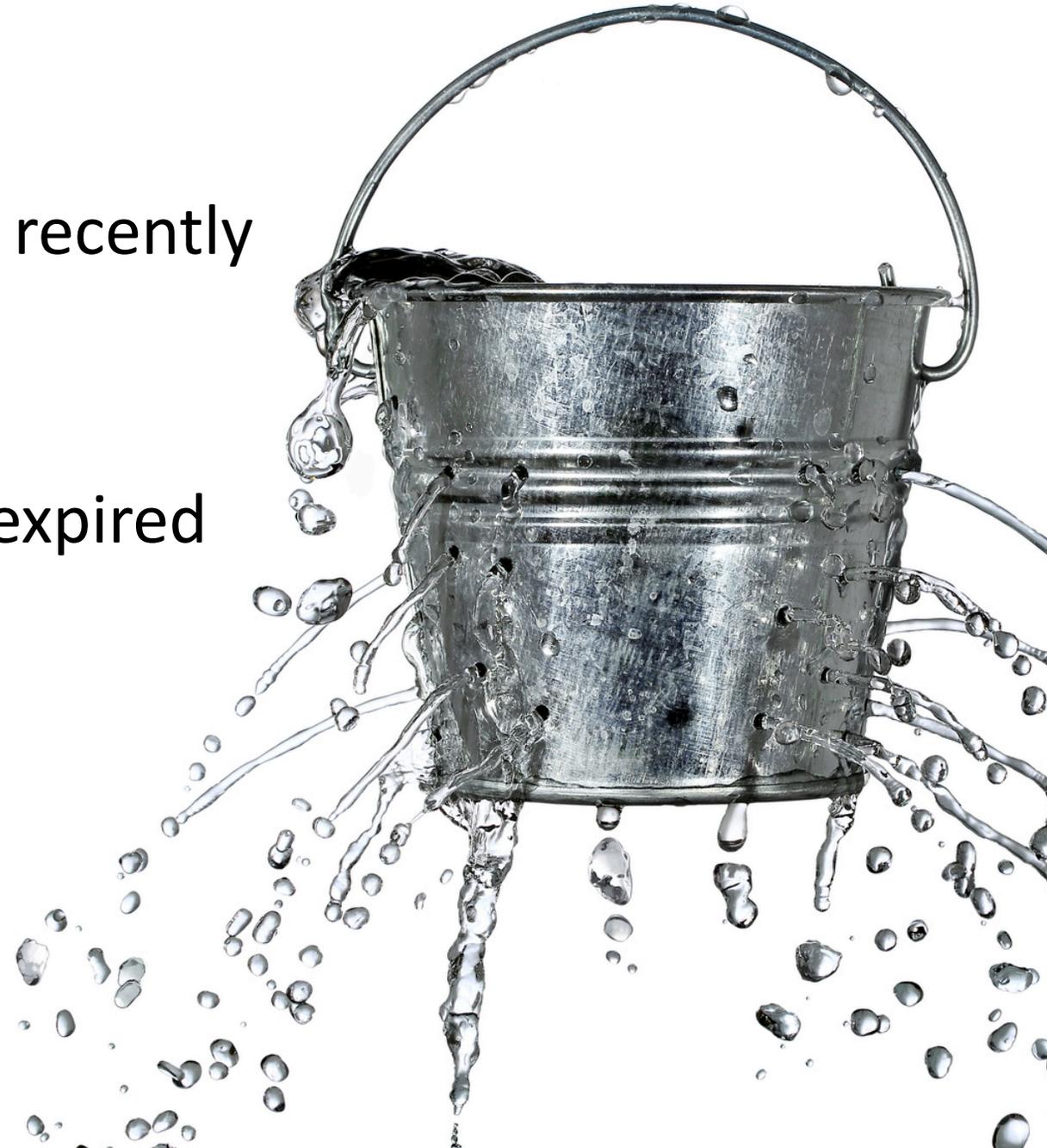
<https://bcpsqc.ca/documents/2017/12/Journey-Mapping-Substance-Use-Treatment-Report.pdf>



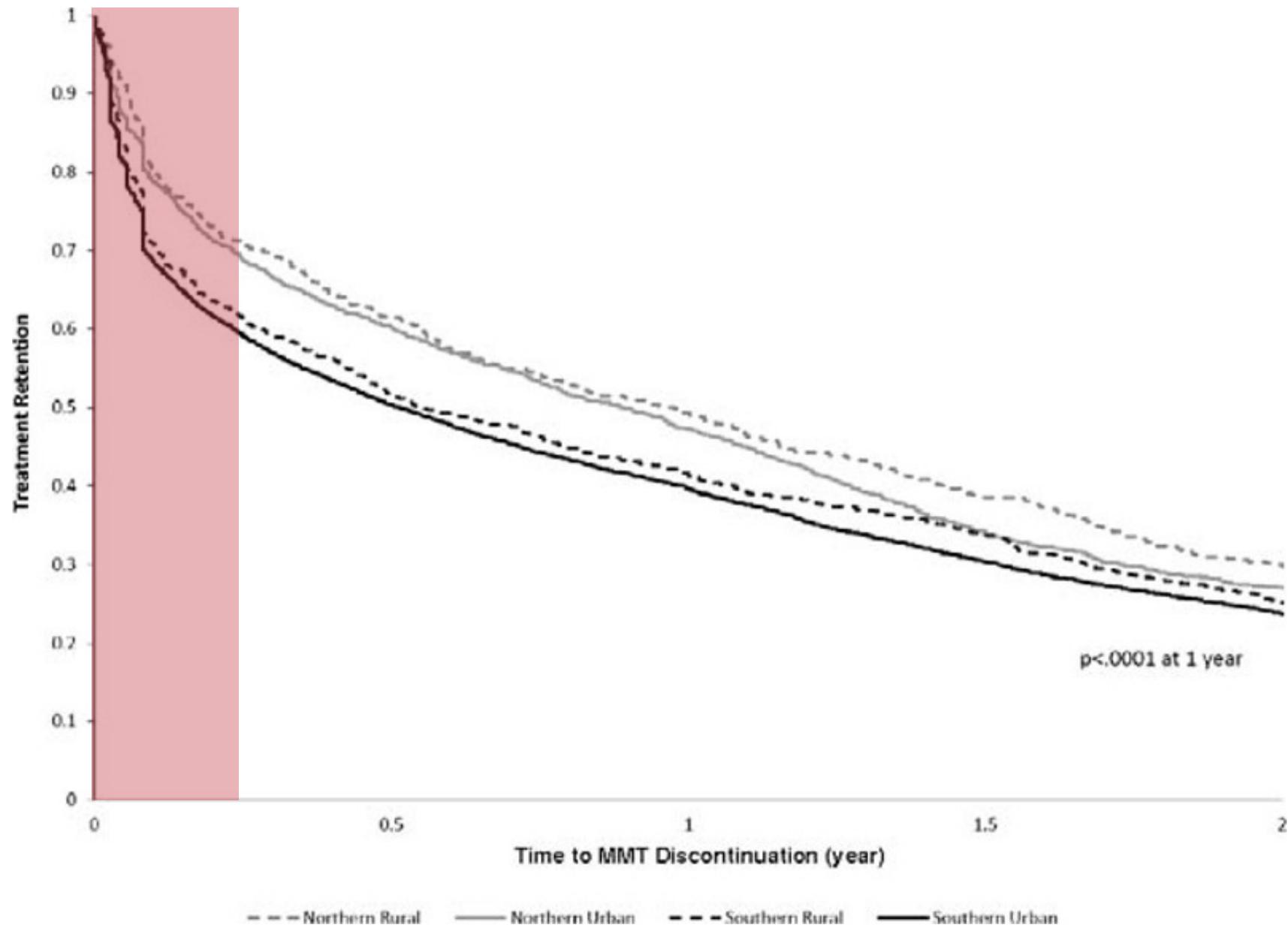
100 expired recently

80 actually expired

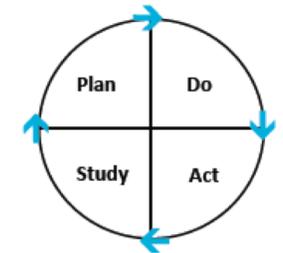
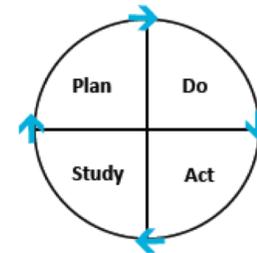
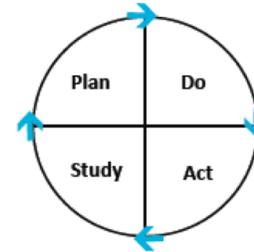
40 follow-up documented



Discontinuation rate is highest during first few months of therapy



- Standardize clinical data entry
- Regular client feedback surveys
- Reminder calls for appointments
- Reminder calls for expiring prescriptions
- Assertive outreach for clients lost to care
- Follow-up on missed oOAT dose faxes from pharmacies
- Work-flow changes to support Suboxone inductions



Testing Changes – PDSA Cycles

PLAN

What will happen if we try something different?
What question do we want to ask & what is our prediction?
Who will carry this out? (When? How? Where?)

DO

Let's try it!
Carry out your plan
Document any problems
Begin data analysis

STUDY

Did it work?
Complete data analysis
Compare results to your prediction
Summarize your results

ACT

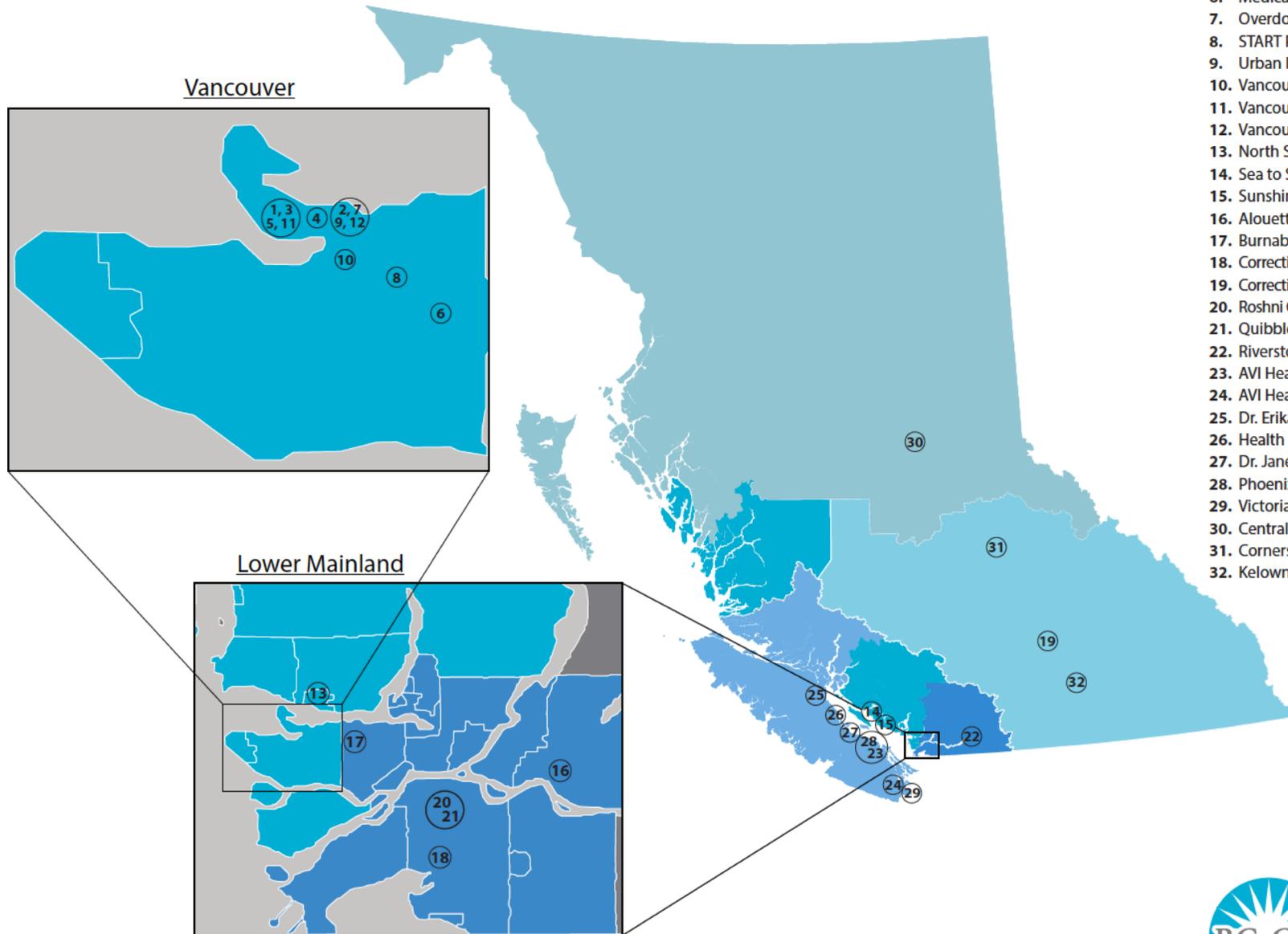
What's next?
Ready to implement/adapt?
Try something else/abandon?
Next cycle?

Collaborative Aims

- **95% of clients have an active OAT prescription**
- **95% of those clients with an active OAT prescription will be retained on therapy for greater than 3 months**
- **100% of teams have a process to monitor and incorporate the patient voice**

Provincial Teams

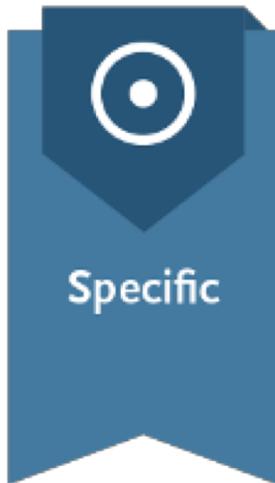
1. Dr. Peter Centre
2. DTES Connections - VCH
3. Foundry Vancouver Granville - PHC
4. Dr. Rodney Glynn-Morris - Vancouver
5. John Ruedy Clinic - PHC
6. Medicare Medical Clinic - Vancouver
7. Overdose Outreach Team - VCH
8. START Program - VCH
9. Urban Indigenous Healing and Health Centre
10. Vancouver Detox - VCH
11. Vancouver Native Health Society Clinic
12. Vancouver Rapid Access Addiction Clinic - PHC
13. North Shore OAT Services - VCH
14. Sea to Sky OAT Program - VCH
15. Sunshine Coast MHSU Services - VCH
16. Alouette Addiction Services - FH
17. Burnaby MHSU OAT Clinic - FH
18. Correctional Health Services - Surrey Pretrial CTT - PHSA
19. Correctional Health Services - Kamloops Regional Correctional Centre CTT - PHSA
20. Roshni Clinic - FH
21. Quibble Creek OAT Clinic - FH
22. Riverstone OAT Program - Chilliwack - FH
23. AVI Health Centre - Nanaimo
24. AVI Health Centre - Westshore
25. Dr. Erika Kellerhals - Campbell River
26. Health Connections Clinic - VIHA
27. Dr. Jane Clelland & Dr. Susan Booth - Oceanside
28. Phoenix Wellness - Duncan
29. Victoria Rapid Access Addiction Clinic - VIHA
30. Central Interior Native Health Clinic - NH
31. Cornerstone Chemical Dependency Clinic - Williams Lake
32. Kelowna MHSU Services - IH



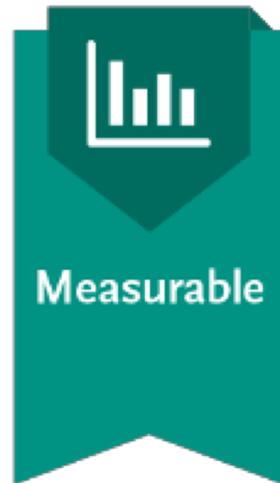
Team Aims

To align with Collaborative aims

S



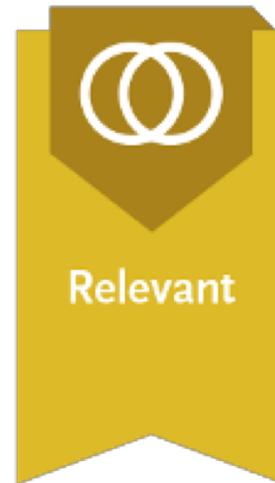
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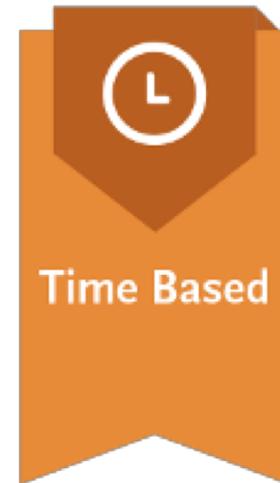
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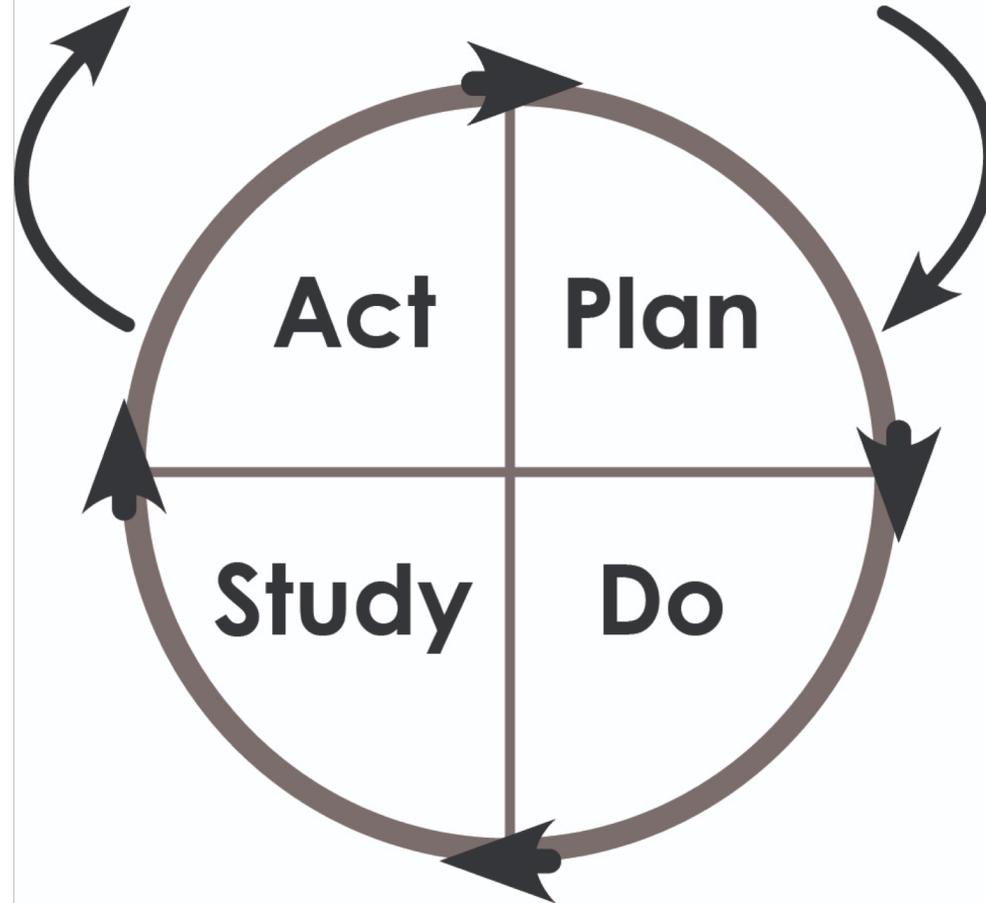


Model for Improvement

What are we trying
to accomplish?

How will we know that a change
is an improvement?

What change can we make that
will result in improvement?





Original research

Evolving quality improvement support strategies to improve Plan–Do–Study–Act cycle fidelity: a retrospective mixed-methods study



Chris McNicholas^{1, 2}, Laura Lennox¹, Thomas Woodcock¹, Derek Bell¹, Julie E Reed¹

Principle

Measure

Documentation

All PDSA cycle stages documented

'Study' section documented in past tense

Learning activity

Learning activity present in PDSA cycle

Prediction

Explicit prediction documented in PDSA cycle

Iterative cycles

PDSA cycle within iterative series of 2 or more cycles

Small-scale testing

PDSA iterative series increasing testing scale

Use of data over time

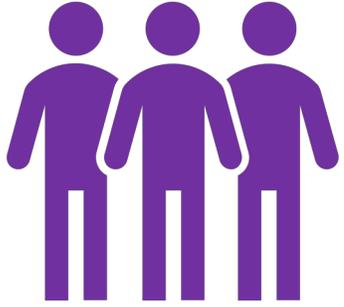
PDSA iterative series using regular data over time

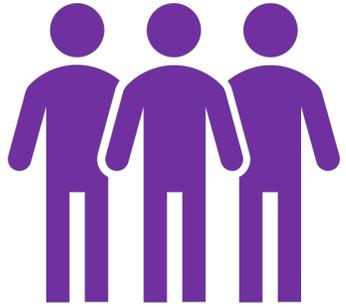
Project Progress Assessment Scale

- 0.5** - Intent to Participate
- 1.0** - Charter and team established
- 1.5** - Planning for the project has begun
- 2.0** - Activity, but no changes
- 2.5** - Changes tested, but no improvement
- 3.0** - Modest improvement
- 3.5** - Improvement
- 4.0** - Significant improvement
- 4.5** - Sustainable improvement
- 5.0** - Outstanding sustainable results



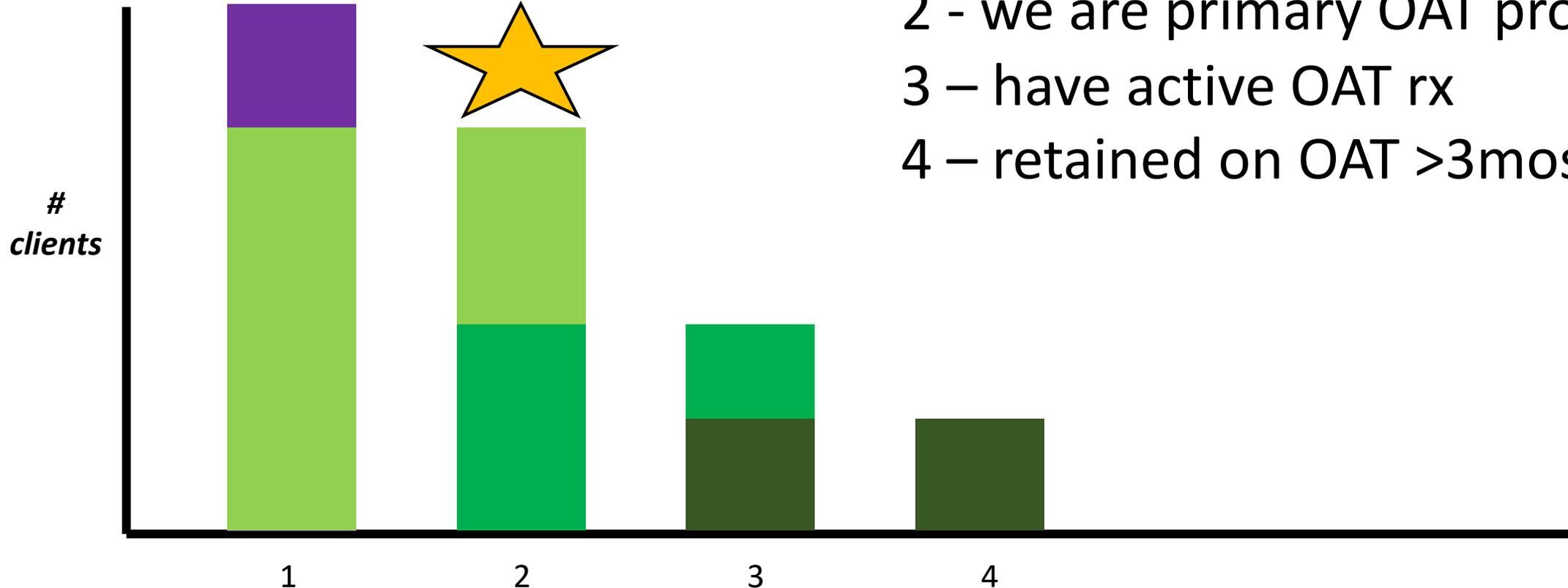
Who are we measuring?





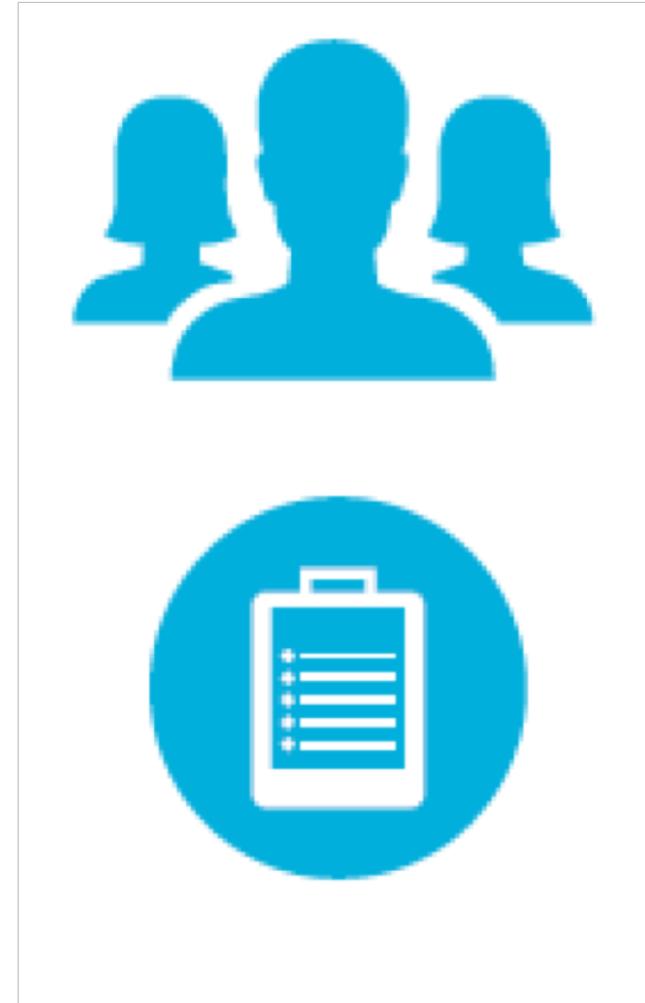
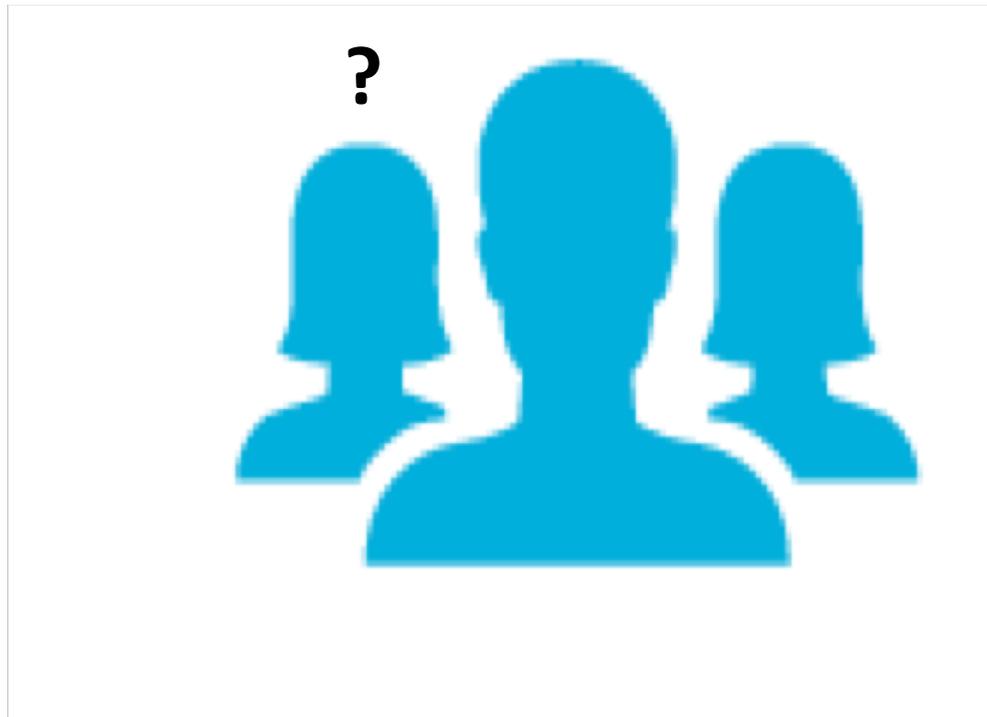
Population of Focus

- 1 – our clients with OUD
- 2 - we are primary OAT provider
- 3 – have active OAT rx
- 4 – retained on OAT >3mos





Population of Focus





<https://pollev.com/ranag760>





304.0 opioid use disorder



BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE

Networking researchers, educators & care providers

**DSM-5 CLINICAL DIAGNOSTIC CRITERIA
FOR OPIOID USE DISORDER¹**



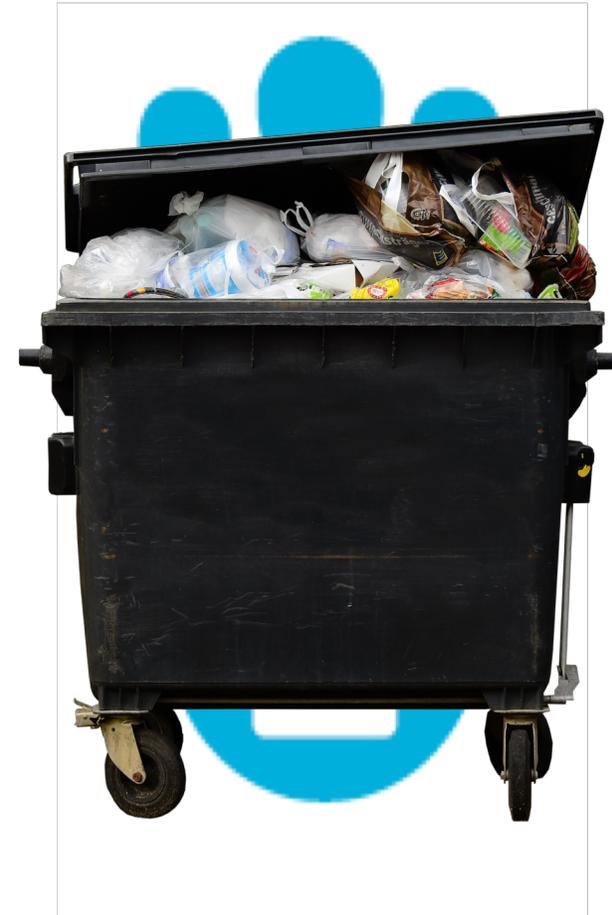
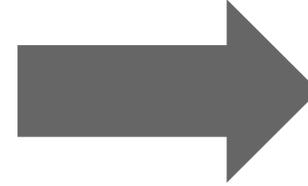
MRP – Dr. Cole Stanley

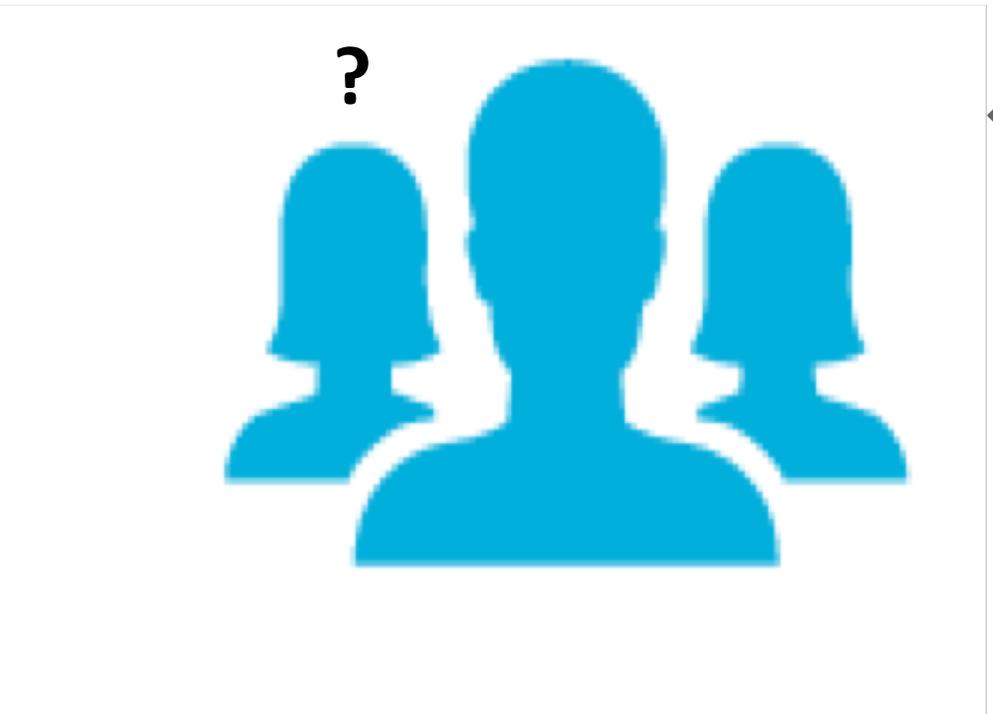




POS – John Ruedy Clinic







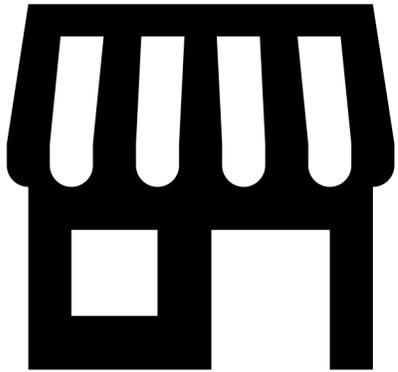
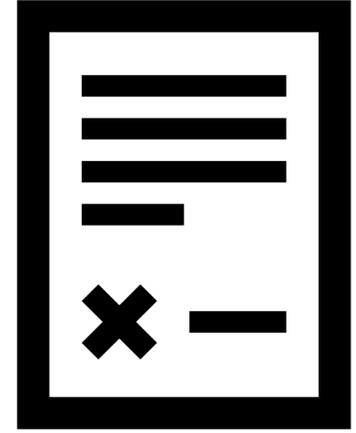
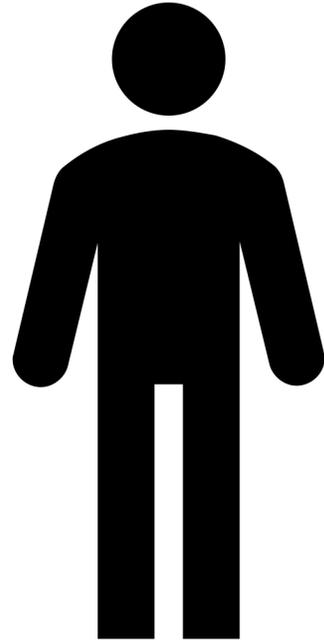
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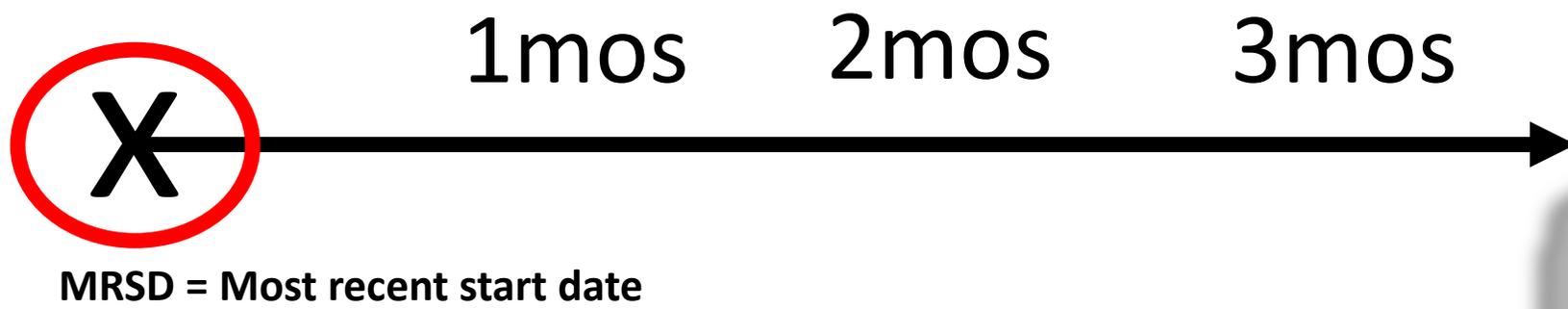
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Start small





	A	B	C	D	E	F	G
1	Patient ID	OAT	dose	Start	End	MRSD	MRP
2	1	methadone	50	15-Jan	02-Feb	01-Jan-17	Dr X
3	2	Suboxone	24	28-Jan	07-Feb	15-Jan-19	Dr Y
4	3	Kadian	400	15-Jan	27-Jan	28-Dec-18	Dr Y
5	4	none					Dr Z
6	5	methadone	100	05-Jan	31-Jan	12-Oct-18	Dr X



	A	B	C	D	E	F	G	H	I
1	Date	Patient ID	OAT	dose	Start	End	MRSD	MRP	Retention (days)
2	15-Jan	1	methadone	50	15-Jan	02-Feb	01-Jan-17	Dr X	744
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5	16-Jan	4	none					Dr Z	
6	05-Jan	5	methadone	100	05-Jan	31-Jan	12-Oct-18	Dr X	85

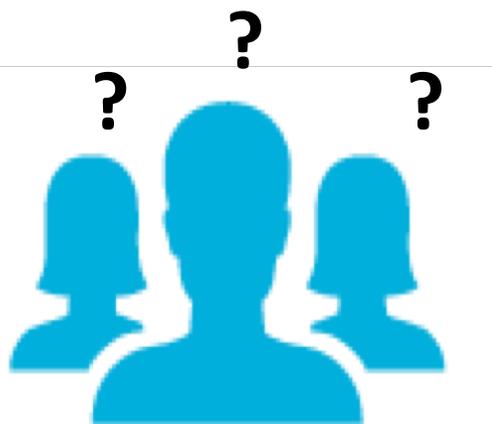
12 x ✓ fx =-DAYS(G2, A2)

Today is Jan 31, 2019

	A	B	C	D	E	F	G	H	I
1	Date	Patient ID	OAT	dose	Start	End	MRSD	MRP	Retention (days)
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Partial POF = 5



X

Active Rx = 3

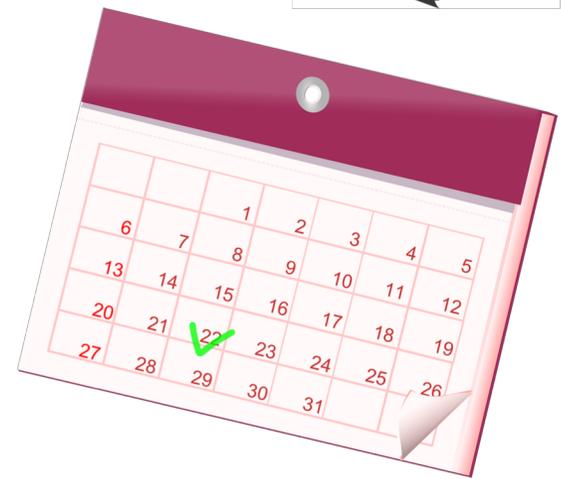
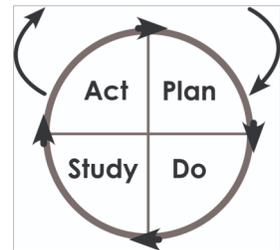
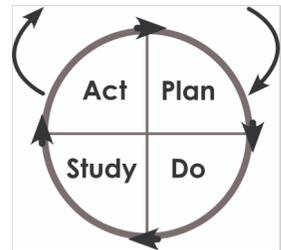
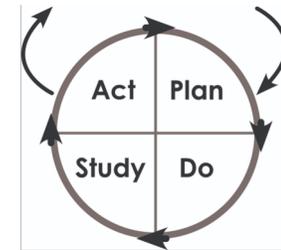
1mos

2mos

3mos

RTN > 3mos = 1





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