Author’s response to reviews

Title: Implementation of a Regional Quality Improvement Collaborative to Improve Care of People Living with Opioid Use Disorder in a Canadian Setting

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Author’s response to reviews:

Reviewer 1: Anne Campbell
1. The Background should be a discrete section rather than within the Methodology section.
   In response the Context and Setting sections have been combined and moved, along with Health System Organization from the Methods section to the Background section. (Background: page 4, line113 in tracked manuscript; page 4, line 101 in clean manuscript)
2. The aims and objectives of the evaluation should be clearly outlined prior to the Methodology section. Is it a process evaluation? Is it simply a QI audit? What did you hope to measure and why?
   In response, the aims and objectives have been elaborated in the Background section as follows: “In 2017, the BC Centre for Excellence in HIV/AIDS (BC-CfE)—a provincial resource for HIV/AIDS care, treatment, education, research and evidence-based policy development—and Vancouver Coastal Health (VCH) launched a BTS Collaborative, titled the best-practice in oral opioid agonist therapy, or the BOOST Collaborative. The initiative aimed to systematically implement, measure and share best-practices in oral opioid agonist therapy (OAT) and improve outcomes for people living with OUD in Vancouver, Canada. The current paper sought to describe the planning and implementation of a BTS Collaborative aimed at closing gaps in care for people living with OUD through changes to workflow and care processes.” (Background:
The following edits have been made to the abstract: “…quality improvement (QI) initiative aimed at closing gaps in care for people living with OUD through changes to workflow and care processes in Vancouver, Canada.” (Abstract: page 2, line 38)

Seventeen health care teams from a range of health care practices caring for a total of 4301 patients with a documented diagnosis of OUD, or suspected OUD based on electronic medical record (EMR) chart data participated in the Collaborative. Teams followed the BTS methodology closely and reported monthly on a series of standardized process and outcome indicators. The majority of (59%) teams showed some improvement throughout the Collaborative as indicated by implementation scores. (Abstract: page 2, line 48)

3. The Conclusion is much too brief and does not represent the main points of learning from the 'evaluation/ audit'.

In response, the Conclusion has been revised to capture the essence of the BOOST Collaborative, its processes and accomplishments. (Please see Conclusion: page 16, line 426 in tracked manuscript; page 19, line 356 in clean manuscript)

4. The Abstract refers to qualitative data and it is not entirely clear what this means.

In response, we have replaced the word qualitative with “descriptive,” in the Abstract which reads as:

Descriptive data from the evaluation of this initiative illustrates its success. (Abstract: page 3, line 58 in tracked manuscript; page 3, line 55 in clean manuscript)

5. PG 7 Line 14 - Place the website address in the reference section

In response, we have added the website address (http://stophivaid.ca/oud-collaborative/) to the References section (References: page 20, line 635 in tracked manuscript; page 20, line 483 in clean manuscript)

6. It is not clear what the BOOST is until PG 5 line 128.

Please see Reviewer #1 comment 2. (Background: page 4, line 103 in tracked manuscript; page 4, line 91 in clean manuscript)

Reviewer 2: Steffani Bailey

1. Given the stated goal of describing implementation of the QI project, it seems that the Results should focus on implementation, not primarily on the demographics of patients.

Please see Reviewer #1 comment #2. (Background: page 4, line 103 in tracked manuscript; page 4, line 91 in clean manuscript)

2. The Conclusion discusses qualitative data that are not reported in the Results section. It is unclear what qualitative data are being referenced.

This comment is no longer relevant because we replaced qualitative with descriptive in response to Reviewer #1 comment #4 (Abstract: page 3, line 58 in tracked manuscript; page 3, line 55 in clean manuscript)

3. Can the authors provide a description of the most responsible provider (MRP)? Is this similar to a primary care physician in the US?

In response, we have included the following explanation to clarify what is meant by most responsible provider:

“The term most responsible physician/practitioner/provider (MRP), generally refers to regulated healthcare professional, who has overall responsibility for directing and coordinating the care and management of a patient at a specific point in time. While typically referring to a physician, this may include a nurse practitioner or other healthcare professional.” (Background: page 4, line 90 in tracked manuscript; page 4, line 78 in clean manuscript)

4. There is some repeated information in the Setting and Context sections. This reviewer suggests
combining these sections.
In response, we have combined the Setting and Context sections to a single Context section that comes before Health System Organization, follows (Please see Background: page 4, line 112 in tracked manuscript; page 4, line 100 in clean manuscript)

5. Can the authors define what is meant by treatment stage or provide an example?
In response, we have added a description of treatment stage as follows: “The term treatment stage refers to the nature of the prescription for OAT for the client. Treatment stage can be characterized as a new start (first ever OAT prescription); re-start (OAT prescription after treatment interruption); dose increase; dose decrease; and dose unchanged.” (Measurement and Evaluation: page 8, line 258 in tracked manuscript; page 8, line 191 in clean manuscript)

6. How was it identified if the encounter was for OUD? Was this based on EHR data from the problem list, ICD-10 codes?
A patient’s engagement in care for their OUD was documented using the OUD form, that was specifically created for the BOOST Collaborative and populates the EMR with relevant information specific to people living with OUD and/or on OAT. The form captures OUD diagnosis as per ICD-9 code 304 and/or OAT prescription. In response, we have clarified this in the manuscript: “1) engaged in care (a documented encounter with a primary care provider using the OUD form within the last 18 months)” (Measurement and Evaluation: page 8, line 271 in tracked manuscript; page 8, line 204 in clean manuscript)

7. Please reference the PROMIS Global 10.
In response, the PROMIS Scale reference has been added: http://www.healthmeasures.net/explore-measurement-systems/promis (Measurement and Evaluation: page 9, line 277 in tracked manuscript; page 9, line 208 in clean manuscript)

8. The results could be significantly strengthened by providing examples/more details. For example, could the authors provide examples of the evidence-based changes that the team could select?
In response, we have added the following examples: “Evidence-based changes to improve access to care included identifying clients lost to care (no encounter for >6 months), improving intake forms (standardizing data entry), proactive monitoring and follow-up after missed doses of OAT, and adding reminder or follow-up calls for appointments.” (Results: page 11, lines 308 in tracked manuscript; page 11, line 239 in clean manuscript)

9. Could more details be provided about the waiver of team selection based on the overall Collaborative aims, and how this was determined (who made this decision?).
In response, further details have been added “For example, team selection criteria required the participation of an OAT prescriber (physician or nurse practitioner); however, this criterion was waived for an outreach-focused team made up of nurses and social workers, whose main goal was to provide outreach support following an overdose and connect those participants to care. Decisions regarding selection criteria were made by the medical lead and Vancouver Coastal Health (VCH) project sponsors.” (Results: page 11, line 320 in tracked manuscript; page 11, line 251 in clean manuscript)

10. Provide examples of what were deemed to be facilitators and barriers of implementation to inform future QI projects. E.g.:
In response, the Discussion has been restructured and information added. (Please see the revised Discussion: page 13, line 347 in tracked manuscript; page 13, line 277 in clean manuscript)

11. The paper does not provide suggestions on how this systems-level approach could be improved upon through lessons learned.
Please see Reviewer #2 comment 10. (Discussion: page 13, line 347 in tracked manuscript; page 13, line 277 in clean manuscript)