META:PHI RAAM clinic quality targets

Introduction

A rapid access addiction medicine (RAAM) clinic is a low-barrier, drop-in clinic that provides substance use–related care to people without requiring an appointment or referral. The underlying concept of the RAAM model of care is that low-barrier, rapid access to evidence-based addiction care improves treatment engagement and retention, and therefore treatment should be as accessible as possible. This translates into three core principles:

1. **Accessible care:** RAAM clinics offer low-barrier, drop-in, accessible care without the need for a referral or pre-booked appointment.
2. **Appropriate care:** RAAM clinics provide comprehensive access to psychosocial and medication-assisted treatment for any substance use concern at the first visit.
3. **Integrated care:** RAAM clinics are part of an integrated care pathway that facilitates connections and promotes smooth transitions among primary care, withdrawal management, hospitals, mental health services, social services, and cultural services.

As this care model has expanded across the province, clinics have worked to meet the needs of the communities that they serve, often with very limited resources. These quality targets are designed to identify and promote the key components of RAAM care delivery. The intention of this document is to create a shared understanding of what constitutes a RAAM clinic for sites already operating in this capacity and for those seeking to become one. The choice of quality *targets*, as opposed to quality *standards*, reflects the recognition that the RAAM model is relatively new and that clinics are in various stages of development. Furthermore, RAAM clinics often operate without the resources to meet all targets due to a lack of funding or appropriate health care personnel. These targets are therefore aspirational; clinics are encouraged to work towards these goals over time. Of note, we are committed to continuing to engage in self-reflection and consultation with our partners, including reviewing this document regularly to ensure that it reflects a vision of RAAM care that meets the needs of the communities we serve.

The targets connect to five overarching goals of care adapted from the Canadian Quality & Patient Safety Framework for Health Services (Healthcare Excellence Canada). These goals embody the RAAM clinic mission:

1. **People-Centred Care:** People using and delivering health services are partners in planning, developing, and monitoring care to make sure it meets service users' needs and to achieve the best outcomes.
2. **Safe Care:** Health services are safe and free from preventable harm.
3. **Accessible Care:** People have timely and equitable access to quality health services.
4. **Appropriate Care:** Care is evidence-based and based on service users' needs.
5. **Integrated Care:** Health services are continuous and well-coordinated. RAAM clinics should be part of an integrated care pathway involving withdrawal management, hospital units, primary care, specialists, and community services, promoting smooth transitions between them.

The quality targets are divided into three broad categories: administrative targets, clinical targets, and community targets. A description is provided for each target as well as indicators to measure their achievement.

Targets		People-centred	Safe	Accessible	Appropriate	Integrated
Administrative targets	1. The clinic keeps data regarding visits and discharge.			X	X	
	2. The clinic collects data on service user experience.	X			X	
	3. Access to service is timely.	X		X		
	4. The clinic is accessible from relevant local services.	X		X		X
	5. An appropriate range of services is available.	X			X	X
	6. The clinic provides connections to local community and health service agencies.	X	X		X	X
	7. Flexible care delivery options are available.	X		X		
	8. The clinic actively supports service user engagement.	X		X		
Clinical targets	9. Care addresses the spectrum of substance use.	X			X	
	10. Care is personalized to the service user.	X	X	X	X	
	11. Comprehensive assessments are offered.	X			X	
	12. Treatment or referral for concurrent health needs is provided.	X		X		X
	13. Care is culturally affirming.	X	X		X	
	14. Care is trauma informed.	X	X		X	
Community targets	15. The clinic is actively engaged in forging connections with local services.			X		X
	16. The clinic has processes for facilitating collaborative care with local services, including bi-directional referral pathways.	X		X		X
	17. Clinicians provide addiction medicine support to colleagues.			X		X
	18. Clinicians provide education to local service providers and agencies in order to build capacity.	X			X	X

Administrative targets

Target 1: The clinic keeps data regarding visits and discharge.

Both clinic-level and service user–level data should be kept in order to create an understanding of clinic flow. Clinics should keep track of visits, referrals, and service user dispensation.

Target indicators:

- Data kept on number of visits (Binary indicator: Y/N)
- Data kept on service user discharge, i.e., to primary care, WMS, OAT clinic, etc. (Binary indicator: Y/N)
- Data kept on referrals (Binary indicator: Y/N)

Target 2: The clinic collects data on service user experience.

Service user experience should be measured as part of the clinic's quality improvement process. Clinics should solicit regular feedback from service users and use this feedback to identify gaps in care, process, and communication.

Target indicators:

- Clinic provides service users with the opportunity to share feedback (Binary indicator: Y/N)
- Clinic includes service users in program planning (Binary indicator: Y/N)

Target 3: Access to service is timely.

Timely access means that the clinic hours are appropriate to meet the community's needs. Service users can be seen at the clinic without needing an appointment or a referral, and the clinic does not have a waiting list. Individuals receive care, including treatment initiation if appropriate, at their first clinic visit. Ideally, clinics should offer some hours that do not fall within the typical "work week" (i.e., Monday to Friday, 9:00 to 5:00) in order to facilitate access for individuals who might have difficulty attending.

Target indicators:

- Clinic has drop-in hours each week (Binary indicator: Y/N)
    - Virtual (Number of hours/week)
    - In-person (Number of hours/week)
- Clinic provides drop in access at least three days per week
- Percentage of drop-in clinic sessions at which everyone who shows up receives care (Goal: 90%)
- Clinic has hours outside of M-F 9-5 (Binary indicator: Y/N)

Target 4: The clinic is accessible from relevant local services.

A clinic is *accessible* from a relevant local service (e.g., a withdrawal management service, an emergency department) if a client can receive clinic services without it being too difficult, expensive, or time-consuming. Geographical proximity is not necessary if the clinic facilitates access by providing transit/taxi fare and/or virtual care options.

Target indicators:

- Service user report of satisfaction with accessibility (Goal: At least 80% satisfaction rate)
- Virtual care options available (Binary indicator: Y/N)
- Local arrangements exist to support transportation to and from RAAM clinic (Binary indicator: Y/N)

Target 5: An appropriate range of services is available.

RAAM clinic teams are comprised of different types of service providers, including nurse practitioners, MDs, nurses, peers, social workers, and counselors, depending on local resources and funding. While there is no standard team composition, the clinic is able to provide pharmacotherapy, psychosocial support, connection to community services, and harm reduction supports during pre-booked and drop-in hours.

Target indicators:

- Team members provide pharmacotherapy (Binary indicator: Y/N)
- Team members provide psychosocial support (Binary indicator: Y/N)
- Team members provide harm reduction support (Binary indicator: Y/N)
- Team members provide pharmacotherapy during drop-in hours (Binary indicator: Y/N)
- Team members provide psychosocial support during drop-in hours (Binary indicator: Y/N)
- Team members provide harm reduction support during drop-in hours (Binary indicator: Y/N)

Target 6: The clinic provides connections to local community and health service agencies.

A well-connected RAAM clinic exists within an integrated care pathway that facilitates connections to complementary services, including primary care, withdrawal management, mental health services, social services, and cultural services. Service users should be supported to connect with social assistance, such as Ontario Works, Ontario Disability Support Program, and safe housing.

Target indicators:

- Database of relevant local community and health services kept so that appropriate referrals can be made (Binary indicator: Y/N)
- Referral forms or templates for local service providers are available (Binary indicator: Y/N)
- Transition of care forms or discharge note templates are available (Binary indicator: Y/N)
- Support available for service users for completion of standard provincial service forms, e.g., Ontario Works, Special Diet, Transportation (Binary indicator: Y/N)

Target 7: Flexible care delivery options are available.

RAAM services are delivered in a way that respects and meets the needs and preferences of diverse service users with diverse needs. Care should be accessible to service users who have mobility or transportation challenges, difficulty accessing technology, or face other barriers to service.

Target indicators:

- Availability of in-person, telephone, virtual, and mobile appointments (Goal: At least two types of delivery methods represented)
- Service user reports of satisfaction with care delivery (Goal: At least 80% satisfaction rate among surveyed service users)
- Service user reports of feeling safe, comfortable, and supported when expressing needs about care delivery (Goal: At least 80% agreement among surveyed service users)

Target 8: The clinic actively supports service user engagement.

RAAM clinics should have mechanisms in place that reduce barriers to initiating and continuing care, such as drop-in as well as booked appointments. Clinics should provide follow-up for missed appointments and communication with referring practitioners.

Target indicators:

- Clinic has a process for arranging and communicating follow-up appointments to service users (Binary indicator: Y/N)
- Clinic has a process for follow-up with service users who missed appointments that does not only depend on the use of technology such as phone and e-mail (Binary indicator: Y/N)
- Clinic has a process for connecting with referring practitioners and culturally appropriate support persons where applicable (Binary indicator: Y/N)

Clinical targets

Target 9: Care addresses the spectrum of substance use.

RAAM clinicians should have the knowledge and capacity to provide care that addresses a wide range of substance-related concerns, including harm reduction, psychosocial support, and pharmacotherapy for different substances. All RAAM clinics should be able to provide evidence-informed support for concerns related to alcohol and opioids, including pharmacotherapy with first-line medications; RAAMs should develop capacity to support people using other substances including stimulants, benzodiazepines, and cannabis.

Target indicators:

- RAAM provides support (including system navigation, counselling, and appropriate pharmacotherapy) to individuals with any substance use concern (Binary indicator: Y/N)
- All first-line medications for alcohol and opioid use disorders are prescribed (Goal: At minimum, buprenorphine (sublingual and depot), methadone, and naltrexone)
  - Buprenorphine SL
  - Buprenorphine depot
  - Methadone
  - Naltrexone
  - Acamprosate
- RAAM can support or facilitate management of alcohol withdrawal (Binary indicator: Y/N)

Target 10: Care is personalized to the service user.

The care provided by the RAAM clinic should be person-centred, committed to building trust, informed by current best practices, and tailored to each individual's goals and preferences in order to maximize engagement. Clinicians should engage in collaborative goal-setting with service users, who determine their own measures of success based on their own lived experiences, with regard to substance use and other issues of concern, such as housing, mental health, and other social needs. Clinics should support a continuum of goals related to their use of particular substances, which should be reviewed and revised as appropriate through the course of care.

Target indicators:

- Service user goals consistently identified and affirmed at intake (Binary indicator: Y/N)
- Service user reports of consent to and satisfaction with care plan (Goal: At least 80% satisfaction rate among surveyed service users)

Target 11: Comprehensive assessments are offered.

The service user should be seen and valued holistically, as their emotional, mental, physical, and spiritual health is impacted greatly by their lived experience. Medical, mental health, and social issues should be assessed in collaboration with the service user and their circle of care where possible at intake so that concurrent health

needs can be incorporated into the care plan. Clients should have access to testing for medical complications of substance use, such as liver disease, HIV, and hepatitis C, as early as possible and simultaneously be offered culturally relevant supports through this.

Target indicators:

- RAAM intake includes collecting medical, mental health, and social history (Binary indicator: Y/N)
- Testing pathway, either on site or through referral, for medical complications of substance use is part of RAAM processes (Goal: At minimum, testing pathway for HIV and hepatitis C)
- Team members provide culturally relevant supports where necessary with and through community services (Binary indicator: Y/N)

Target 12: Treatment or referral for concurrent health needs is provided.

RAAM clinicians should be able to provide service users with support for concurrent health needs, including both mental health conditions, such as depression and PTSD, and physical conditions, such as hepatitis C, liver disease, and skin and soft tissue infections. Cultural support should also be provided, which may include access to traditional medicines and medicine bundles for Indigenous service users. A treatment plan for co-occurring mental and physical conditions should be developed in collaboration as early as possible.

Target indicators:

- Treatment pathway for managing concurrent health needs either on site or through referral is part of RAAM processes (Goal: At minimum, treatment pathway for HIV, hepatitis C, liver disease, and mental health disorders)
- First-line medications for mood and anxiety disorders (e.g., SSRIs, SNRIs, etc.) are initiated at the RAAM when appropriate (Binary indicator: Y/N)
- Treatment of soft tissue infections related to substance use is initiated (Binary indicator: Y/N)
- Traditional Indigenous medicine bundles on hand for service users to take and use as needed (Binary indicator: Y/N)

Target 13: Care is culturally affirming.

Care that is culturally affirming involves respecting an individual's cultural identity while acknowledging and understanding systemic oppression that they and their communities have faced and continue to face. In practice, this includes ongoing self-reflexivity and learning to recognize and address a multitude of power imbalances between service users and service providers. A commitment to person-centred care involves engaging in meaningful discussions with service users about how they define themselves, their story, ways of being, culture, community, and means of connection. Culturally affirming care requires service providers to value the importance of cultural practices as elements of care, and is particularly important for service users who are Indigenous, racialized, and/or members of the 2SLGBTQ+ community.

Target indicators:

- Opportunities for learning about Indigenous cultural safety are provided to all clinic team members (Goal: 100% of team members take an accredited course on Indigenous cultural safety, in line with Call #23 in the Truth and Reconciliation Commission Calls to Action)
- Clinic supports a visiting (rotating or permanent) Indigenous Elder or Community Knowledge Keeper to share guidance and support for service users and care providers (Binary indicator: Y/N)

- Opportunities for learning about culturally affirming care for 2SLGBTQ+ and racialized individuals are provided to all clinic team members (Goal: At least 80% of team members take courses on affirming health care for 2SLGBTQ+ individuals and for racialized individuals)
- Service user partners are engaged in discussions about culturally affirming care (Binary indicator: Y/N)
- Partnerships exist with local cultural leaders to inform care provision (Binary indicator: Y/N)
- A process is in place for referrals to culturally specific care (Binary indicator: Y/N)

Target 14: Care is trauma informed.

Clinic teams should be aware of the pervasiveness of trauma among people who experience challenges with substance use and provide trauma-informed care through attention to its principles: self-reflexivity, safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, consent, cultural and historical context, and gender diversity. Clinic team members should also be supported to address potential burn-out and vicarious trauma.

Target indicators:

- Opportunities for learning about the principles and practice of trauma-informed care are provided to all clinic team members (Goal: At least 80% of team members take an accredited course on trauma-informed care)
- Service user reports of satisfaction in dimensions of trauma-informed care (Goal: At least 70% satisfaction rate among surveyed service users)
- Considerations are made to address potential care provider burn-out and vicarious trauma (Binary indicator: Y/N)

Community targets

Target 15: The clinic is actively engaged in forging connections with local services.

RAAM clinics should exist as part of an integrated care pathway with clear connections to local services, such as the emergency department, withdrawal management centres, primary care, psychiatry, and community services. Clinicians should be engaged in active outreach with other health and community service agencies in order to ensure that all community stakeholders are aware of the RAAM clinic and that the clinic is meeting the needs of communities.

Target indicators:

- Clinic is a partner in local drug strategy networks/teams (Binary indicator: Y/N)
- Regular collaboration with local services (Goal: Collaboration with withdrawal management services, housing, primary care, community services)

Target 16: The clinic has processes for facilitating collaborative care with local services, including bi-directional referral pathways.

Clinics should create processes that facilitate smooth and timely transitions and collaborative care between different services, including WMS, housing, primary care, correctional settings, and community services. This may involve referral templates, shared EMRs, or other mechanisms that allow for streamlined shared care while being transparent in its processes to the service user.

Target indicators:

- Referral forms to specialists/community organizations exist and are embedded within the RAAM clinic's collection of clinical resources (Binary indicator: Y/N)
- Consultation/intake notes are shared with the referral source, including the ED (Goal: Consultation notes are sent to the referring provider for at least 90% of service users referred)
- Progress updates and discharge letters are consistently sent to providers in service users' circles of care, including primary care and psychiatry (Goal: Progress notes are sent to providers in the circle of care when there is a change in the care plan for 80% of service users; discharge summaries are sent to providers for 80% of service users)
- Clinic has a process for connecting service users without a primary care provider to primary care resources (Binary indicator: Y/N)
- Clinic has a process for coordinating admissions to live-in treatment centres (Binary indicator: Y/N)
- Clinic has a process for coordinating care with local WMS (Binary indicator: Y/N)
- Clinic has a process for following up on referrals to ensure that care is continued (Binary indicator: Y/N)

Target 17: Clinicians provide addiction medicine support to colleagues.

RAAM clinicians should provide support to colleagues regarding substance-related issues when requested, including consultation by telephone/e-Consult as appropriate or shared care to assist with care in settings outside the RAAM.

Target indicators:

- Consultations are provided (Binary indicator: Y/N)

Target 18: Clinicians provide education to local service providers and agencies in order to build capacity.

RAAM clinicians should contribute to activities that decrease stigma and increase capacity in other health services by supporting educational activities (e.g., lunch-and-learns, hospital rounds) and mentorship on topics related to management of substance use.

Target indicators:

- Number of educational sessions delivered to community partners (Goal: At least 2 per year)
- Shadow opportunities for local care providers seeking education and increased knowledge (Binary indicator: Y/N)
- Partnership with Indigenous community leaders and organizations to include perspectives that were (and often continue to be) systematically excluded (Binary indicator: Y/N)