FIR MODEL of CARE

FIR TRIAGE PROTOCOL

BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

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i. Acknowledgements

We would like to acknowledge that the FIR Triage Protocol was developed on the unceded, traditional and ancestral homelands of the Coast Salish People, specifically the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish) and səl̓ílwətaʔɬ (Tsleil-waututh) Nations

We would like to acknowledge the work of the Provincial Perinatal Substance Use Project Team in providing leadership for the development of the FIR Triage Protocol with the FIR multidisciplinary Triage Protocol Working Group. Specifically, the following members of the Triage Protocol Working Group are appreciated for their contributions:

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A note about gender and sexual orientation terminology: As in the FIR Model of Care document, the terms pregnant women and pregnant individual are used in the FIR Triage Protocol. This is to acknowledge and be inclusive of transgender individuals who are pregnant, and to respect those who wish to continue to be identified as pregnant women or mothers. We encourage all providers to not assume the gender identity or sexual orientation of the pregnant person (or their partner) and to respectfully and non-judgmentally ask all pregnant people about their preference for how they wish to be addressed.

Contents

1.0 INTRODUCTION AND OVERVIEW

Background and History

FIR is a provincial specialized perinatal service located in BC Women's Hospital and Health Centre in Vancouver BC. FIR provides care to antenatal and postpartum women who use substances, and to infants exposed to substances in a primary care/interdisciplinary team-based model. FIR opened in 2003 and was a first of its kind program in Canada.

The acute care program has 12 beds for women wishing to stabilize their substance use and address any pregnancy related concerns and/or withdraw from drug use during pregnancy. Care at FIR is provided by family physicians and a nurse practitioner, alongside a multidisciplinary team that includes pediatricians, nurses, social workers, counsellors, dietitians, recreation therapists and other allied care providers. FIR consults with obstetrics, internal medicine, pediatrics, maternal fetal medicine, reproductive mental health, anaesthesia, Oak Tree Clinic and Infectious Diseases at BC Women's Hospital.

Epidemiology of Perinatal Substance Use

The Canadian, Tobacco and Drugs Survey (CTADS) 2017 data estimates that 14.6% of women use alcohol in ways that exceed low risk drinking guidelines; 13% (2.1 million) of women smoke cigarettes; and 11% (1.7 million) women have used illicit substances (including opioids and cannabis) over the past year. Polysubstance use is common among many women who are using substances, including increasing rates of methamphetamine use.

First Nations Health Authority data reports that in 2018, among First Nations people, First Nations women experience overdose events and overdose deaths at a higher rate than non-First Nations women. Approximately 70% of women admitted to FIR identify as Indigenous.

Substance use during pregnancy is interconnected with issues such as trauma and interpersonal violence, lack of stable housing, social isolation, colonialism and racism (Poole & Isaac, 2001). Due to barriers in receiving care women may not have received any prenatal care. They may have complex medical issues related to lack of access to health care (e.g. HIV, Hepatitis C, other infections), concurrent mental health concerns (including post-traumatic stress disorder), and other chronic disease. Women may also be experiencing pregnancy-related complications (e.g., gestational diabetes, hypertension, IUGR, threatened pre-term labour). Women may have partners who use substances who are also be engaged in care.

In most cases, there is Ministry of Child and Family Development (MCFD) or Delegated Aboriginal Agency (DAA) involvement and potential for supervision orders. Many women have had unpleasant or traumatic encounters in acute care in the past and may be wary of trusting service providers.

Model of care and program description

FIR's mandate is to address the needs of antepartum and postpartum women who use substances and their infants exposed to substances in order to improve women's wellness and to ensure a safe labour, delivery and post-partum course. Through the provision of treatment and supports based on principle based practice and integrated programming, the interdisciplinary team at FIR focuses on stabilization, rooming-in and harm reduction within a recovery oriented approach to care.

The FIR recovery program includes access to social workers to assist with child custody concerns, counselling and support to enhance critical coping and life skills. All disciplines provide education focussed on parenting skills and techniques. The program provides recreation and expressive art therapy, Indigenous cultural support through a First Nations advocate and Indigenous Elder, nutrition assessment and support from a dietitian and advocacy for housing, income, and other social needs.

2.0 TRIAGE PROTOCOL

Purpose of Triage Protocol

The Triage Protocol document was created through 5 facilitated sessions with a small working group from the FIR interdisciplinary team, Sheway team and the Provincial Perinatal Substance Use Project team to guide the design of the working sessions. The purpose of the Triage Protocol is to provide the parameters in which equitable access to care at FIR is provided to individuals across the province who require, are eligible, and are anticipated to benefit from accessing services at FIR. This protocol is to be reviewed in detail after six (6) months of implementation (July 2021) and annually thereafter.

The Triage Protocol development follows the FIR model of care. The aspirational model of care is a strengths-based approach to building on existing practices as well as establishing new, wise and evidence based practices and approaches to perinatal substance use as needed.

Triage Protocol Overview

The resulting triage protocol will complement the FIR Model of Care by supporting equitable access to FIR and identifying a process to connect women to care that are not admitted on the unit. The FIR triage team, an interdisciplinary team including Medical Director, Physician, Nurse Practitioner, Patient Care Coordinator, Nurse, Social Worker, will support connection to care for patients regardless of planned admission date. A woman may be admitted to FIR at antepartum or postpartum if she has substance use disorder and either 1) requires in-patient stabilization or 2) is at risk of relapse or 3) requires support to promote mother baby togetherness. Woman currently certified under the Mental Health Act requiring in-patient care may not be eligible for admission to FIR.

Assessment considerations for admission may include: homelessness, recent overdose events, intimate partner violence, lack of prenatal care or at a later gestational age. Individuals who have access to appropriate services in their community, can be stabilized and managed at other hospitals are not appropriate referrals to FIR. In the case that women are not eligible for admission or doesn't require same day admission, FIR will connect to a woman's local community provider to ensure services are in place in the interim. Additionally, the Patient Care Coordinator will actively work with community and acute health care providers to identify opportunities for safe and suitable services and supports in other care settings.

REFERRALS:

- The referring agent will forward the completed referral form (*Appendix A*), including all relevant documents to the FIR unit by phone or fax. Referrals to be completed to the best of one's ability. Patient Care Coordinator can contact referring agent to support completing the remaining sections of the form following referral review.
- FIR's Patient Care Coordinator will ensure all required information has been received and will review referral form and documents with the FIR Triage Team regularly.
- The outcome for the referral will be communicated to the referring agent by the Patient Care Coordinator.
- An email of alternate recommendations will be provided to the referring agent by the Patient Care Coordinator and/or Medical Director for patients who are not a match for FIR treatment and programming. In the instance where an alternative program or hospital is a better match, the Patient Care Coordinator/Medical Director/Nurse Practitioner will advise the referring agent by telephone call/email.

AFTER HOURS REFERRALS:

If referring provider contacts FIR after hours or on weekends, the Charge Nurse (CN) will consult with the on-call Perinatal Addictions Service to determine **obstetrical or medical eligibility/urgency** for admission and plan best site of admission. FIR unit bed availability will be updated on Cerner regularly and will allow Perinatal Addictions Service physician to determine FIR bed availability. On call physician for Perinatal Addiction Service will connect with the referring provider or patient directly to decide on appropriate plan if there are no Fir beds available and admission is deemed urgent (e.g., assessment in UCC, admission to other BC Women's unit, admission to another hospital).

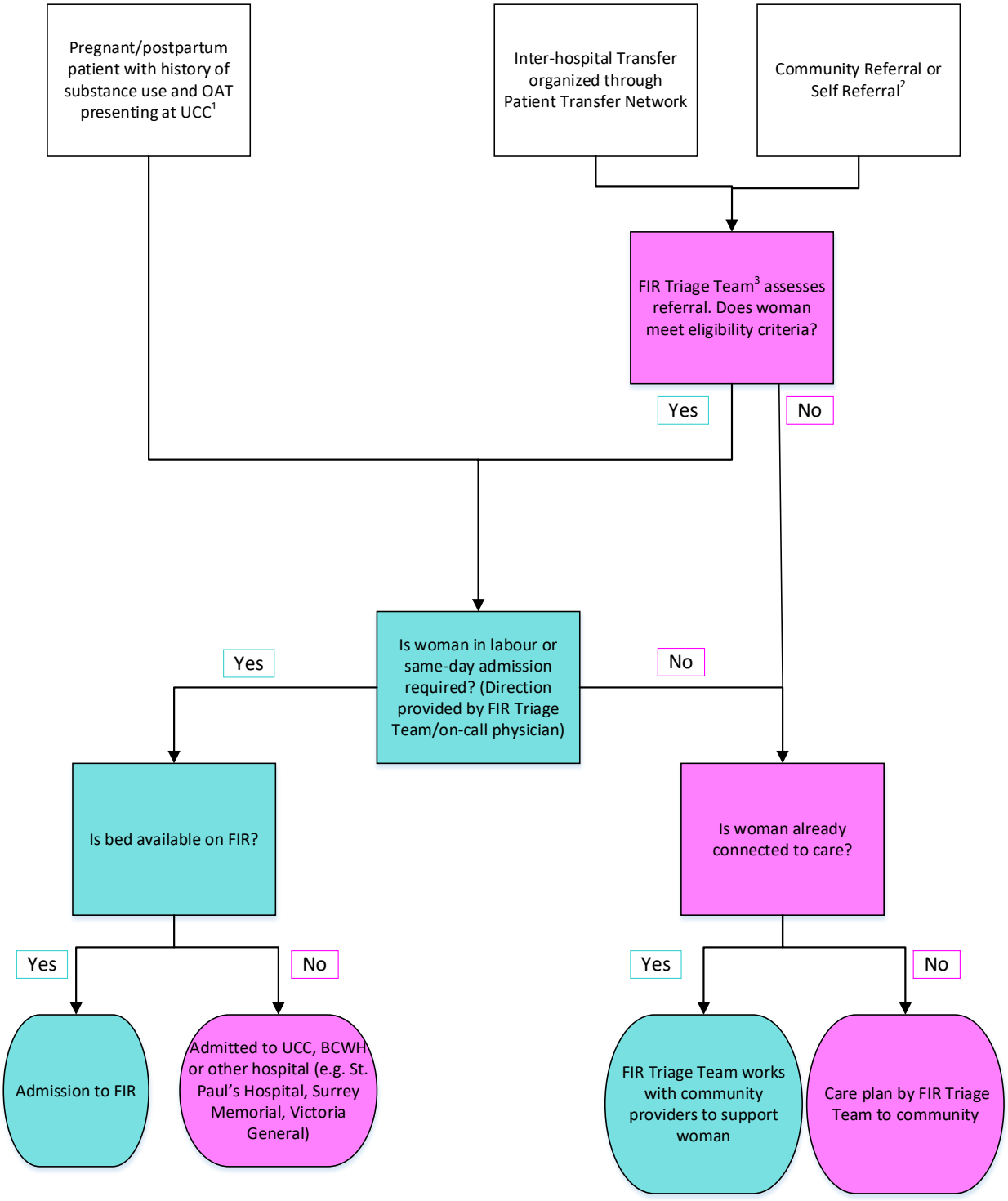
BED AVAILABILITY

- If the FIR Triage team screening process approves the client's referral form, the Patient Care Coordinator will notify the referring agent.
- Patient Care Coordinator will make regular updates to referral forms during FIR Triage Team daily referral reviews.
- When a bed is available, the referring agent and/or patient will be notified by the Patient Care Coordinator and will advise FIR Team to plan for intake. Patient Care Coordinator will ensure arrangements are made with community providers and patient to support patient's admission to the unit.
- The length of time a bed will be held for an incoming patient will be determined by the FIR Triage Team on a case by case basis.

In the instance of a transfer from within BC Women's Hospital, an Internal Transfer form will be completed (In development and to be added as an appendix).

Additional questions from referring agents can be directed to the Patient Care Coordinator (Nurse in Charge during afterhours) who will be able to assist in completing the form and provide further information

FIGURE 1. FIR Triage Protocol Algorithm



[1] If Patient presents at UCC unattached to care, UCC to contact Perinatal Addiction Service (PAS) Physician

[2] If woman self-refers from another acute care facility, information required will include treatment plan and patient history

[3] FIR Access Team includes a physician, patient care coordinator, nurse practitioner, social worker

Triage Protocol & Referral Criteria

1. Referrals include:

- Self -referral
- Community health care and services, with consent
- Acute (includes BC Women's, UCC, SPH)
- All referrals can take place ante, intra or post-partum

2. Eligibility for admission

Inclusion criteria	Exclusion criteria
Antepartum & Postpartum • Has substance use disorder that either requires: 1. In-patient stabilization; or 2. Is at risk of relapse 3. requires support to promote mother baby togetherness	• Currently certified under the Mental Health Act requiring in-patient care

3. Admission

Patient is assessed at UCC and admitted to FIR.

4. FIR Triage Team Membership

Medical Director, Physician, Nurse Practitioner, Patient Care Coordinator, Nurse, Social Worker

3.0 TRANSITIONS & CONTINUITY OF CARE

Transition Plan Components

Planning for transition from FIR is a critical step for women and their families. The transition plan is a fluid document that is completed over the course of a woman's admission. Transition planning needs to be led by each woman with the support of FIR Social Work and the inter-professional team, family, friends, community supports and when appropriate MCFD/DAA.

A FIR transition plan will include (not limited to) the following elements:

- Primary health care for mother and babies
- Substance use treatment program (incl. OAT prescriber)
- Relapse prevention plan (initiated first week of admission)
- Connections to mental health and substance use supports in community
- Obstetrical and contraception follow-up
- Public health nursing (Nurse Family Partnership; Lactation Consultants)
- Indigenous serving agencies including Aboriginal Friendship Centres, on reserve supports etc.
- Safe/Supported housing
- Financial needs
- Community resources including access to food banks, community kitchens, community based supports for mothers and infants, local community centres etc
- Transportation needs
- MCFD/DAA involvement re: supervision orders etc.
- Peer involvement and support until a woman has safely returned and connected to community
- Transition plan may include connections to a doula, recreation therapy, spiritual care, treatment/day program, Alcoholics Anonymous/Narcotics Anonymous

Discharge Plan Components

A FIR Discharge Plan includes all tasks that must be completed on or just before day of discharge, whether it is a planned discharge or early exit such as patient-initiated discharge. There are two discharge checklists: one for FIR staff's reference and one for the patient (shorter and with specific information such as follow up appointments). The discharge checklists include the following:

- Medications and arrangements for ongoing OAT
- Communication and arrangements with housing destination
- Safety Plan
- Naloxone training/ re-training prior to discharge and THN dispensed
- Relapse Prevention Plan reviewed/updated
- Providing confirmation of discharge to MCFD/DAA
- Arrange transportation including support with car seats
- Follow up appointment lists (date, time, who, what, where, why)
- Notification of primary care provider
- Notification of Public Health Nurse
- Notification of community supports (A & D counsellor, outreach worker, etc.)
- Infant Development Plan
- Pediatric follow-up

Communication

Communication includes significant and ongoing collaboration between FIR inter-professional team and community services and supports. This includes:

- Communication and arrangements between community support/outreach and FIR multidisciplinary team and MCFD/DAA if they are involved
- Communication is to continue from the time of referral until the patient has been successfully settled into safe and supported housing in the community
- The FIR Patient Care Coordinator will contact the referring community provider on a continuous basis throughout the admission and the community provider will actively participate in transition planning

Monitoring & Follow up Requirements

To monitor process and outcomes for women admitted to FIR, the Patient Care Coordinator and inter-professional team will collect and assess performance indicators. Data collected may include:

- Referring providers and communities
- Length of stay for each patient
- Substance Use Disorder diagnoses
- Discharge destination (parent and baby)
- MCFD involvement and parenting supports

Reporting requirements

FIR Triage Team reports to the Director, Operations and the Medical Director.

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5.0 Appendix A

Referral Form

FIR Unit

4500 Oak Street Vancouver, BC V6H 3N1
Tel: 604 875 2229 Fax: 604 875 2221
www.bcwomens.ca

Due Date:	
Expected date/time of arrival:	

Instructions: Please complete the referral form and return by fax to 604 875 2221.
Incomplete forms will be accepted and reviewed.

Date:	**Time:**

Patient Information

Patient Name:	**PHN:**	**DOB:**
Address:		
Telephone:	**Email:**	
Identify as Indigenous: ☐ **Yes** ☐ **No** **Status No.:**_____	**Referral submitted with patient's consent:** ☐ **Yes** ☐ **No**	**FIR Team can contact patient directly:** ☐ **Yes** ☐ **No**

Referral Source

Name:	**Service/Position:**
Self-Referral: ☐ **Yes** ☐ **No**	**Telephone:**

Key Support:

Can FIR Team contact key supports? ☐ **Yes** ☐ **No**

Name:	**Email:**	**Telephone:**
Address:		

Is woman connected to Community Health Care team: ☐ **Yes** ☐ **No**

Care Team: _____

Contact Name: _____

Phone Number: _____

Goal of Admission (Check all that apply):		
Stabilization of Substance Use ☐	Intra partum care ☐	Postpartum care ☐
Undetermined – ie. No/limited prenatal care ☐		
Current safety concerns: IPV ☐ Overdose Risk ☐ Self Harm ☐ Homeless ☐		

Patient Personal History:

Substance(s) used

Opioids☐ Stimulants ☐ Alcohol ☐ Non-beverage alcohol ☐ Benzodiazepines ☐

Other:_____

Experienced an overdose in the last 3 months? ☐ Yes ☐ No

Additional comments if yes? _____

List all medications:

_____ _____

_____ _____

_____ _____

Medical/mental health concerns

_____

_____

_____

Obstetrical History:		
G___P___A___L___	**Gestational age:**	**Most recent ultrasound date:**
Obstetric risks:		
What prenatal care was provided and from whom:		

Housing Status
Current housing status:
Plan post discharge:

Action Box

FOR INTERNAL USE ONLY: REFERRAL INFORMATION		
DATE REFERRAL RECEIVED:	**PROJECTED ADIMISSION DATE:**	
DATE REFERRAL REVIEWED BY FIR TRIAGETEAM:	**FIR PHYSICIAN INVOLVED:**	
DATE ADMISSION WAS OFFERED:	**DATE ADMISSION ACCEPTED:**	**DATE ADMISSION REFUSED:**
DATE ADMISSION POSTPONED AND REASON	**DATE OF CONTACT ATTEMPTS & BY WHO**	