Change Package

Learning about Opioid Use Disorder in Primary Care (LOUD in PC)

Territorial Acknowledgements

In doing work throughout the province, we at Health Quality BC (HQBC) would like to acknowledge that we are living and working with humility and respect on the traditional territories of the First Nations peoples of British Columbia. We specifically acknowledge and express our gratitude to the keepers of the lands of the ancestral and unceded territory of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and səl̓ilwətaʔɬ (Tsleil-Waututh) Nations, where our head office is located on what is now colonially known as Vancouver. HQBC also recognizes Métis people and Métis Chartered Communities, as well as the Inuit and urban Indigenous peoples living across the province on various traditional territories.

About LOUD in PC

The LOUD in Primary Care (LOUD in PC) Collaborative is a provincial collaborative all about supporting primary care providers and people living with opioid use disorder (OUD) to achieve their goals for care in communities across BC through increased accessibility[1] to Opioid Agonist Therapy (OAT) in primary care, particularly within semi-urban, rural and Indigenous communities.

LOUD in PC is led by HQBC in partnership with the BC Centre on Substance Use (BCCSU) and health system partners, with funding from the Ministry of Health, Ministry of Mental Health & Addictions, and Community Action Initiative. We would like to recognize all members of our Expert Group and participants of the OAT in BC journey mapping session in March 2023 whose contributions and perspectives are incorporated throughout the program materials. Their perspectives on receiving and delivering OAT in communities across BC have been invaluable in shaping this program.

In addition to these groups, change ideas were also sourced from:

- A Guideline for the Clinical Management of Opioid Use Disorder (BCCSU)
- LOUD in ED Collaborative (HQBC)
- BOOST Collaboratives (Centre for Excellence in HIV/AIDS)
- SOAR Quality Improvement sprint (Island Health)
- Journey Mapping: Opioid Agonist Therapy (HQBC)

[1] Accessibility is the extent to which people can readily obtain care when and where they need it. It is a dimension of quality that aims to overcome physical, financial, cultural and psychological barriers to receiving information and care. It includes a welcoming entry and seamless transitions between and within services (1).

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Last updated: October 2023

Overview

This change package has been designed for teams participating in the LOUD in PC Collaborative from September 2023 – September 2024. The purpose of this document is to provide teams with tangible ideas for implementation that can help to achieve their aims of improving the accessibility of opioid agonist therapy (OAT) in their communities. While the list is comprehensive, it is not exhaustive. Each change idea has been designed to make steps towards the goal of increasing the number of people started and retained on OAT.

Overall Aim Statement:

"Increase the number of people living with OUD who are prescribed OAT[2] by 30% from baseline in participating primary care settings by September 30, 2024."

Teams are encouraged to tailor the change ideas to their specific care setting and utilize the ideas that best align with their patients'[3] needs and clinic's goals. It is not expected that teams will implement all the change ideas listed, but they should challenge themselves to consider new ideas.

The primary drivers (i.e., major themes) that will help to achieve this aim include:

1. OAT & OUD education
2. Positive experience in care
3. Connections to community & peer services
4. Care flow

You can view the full list of change ideas presented in the driver diagram on pages 7 and 8. The driver diagram shows how each individual change can contribute to the overall aim, and in turn the outcomes of the collaborative.

[2] Prescribed OAT includes people receiving prescriptions for OAT initiation, restarts on OAT and continuous retention on OAT (≥3 months).

[3] We use the word *patient* in our resource and education tools to describe individuals who seek OAT services. In collaboration with our expert group, which includes people with lived and living experience (PWLLE), it was determined that *patient* and client are used interchangeably in practice, and that patient provides a helpful medicalized perspective on opioid use disorder.

NAVIGATING THE CHANGE PACKAGE

Driver Diagram

A driver diagram is a tool used during improvement projects to illustrate different theories of change and how they may lead to improvement. Driver diagrams assist in answering the question, "What changes can we make that will result in an improvement?" They do this by mapping the logic of potential change ideas to the intended outcome.

A driver diagram is typically broken down into several parts, including:

1. **Aim Statement:** This is the guiding statement for your project and is a measurable, time-bound goal.
2. **Primary Driver:** High-level factors that directly impact the aim. These factors often require multiple interventions to see improvement.
3. **Secondary Driver:** Specific factors that are believed to influence the primary driver. These are often easier to influence and change will be seen faster. They may also change as you discover what does and does not influence the primary drivers.
4. **Change Ideas:** Change ideas are tangible interventions that you can start testing today. As you test these change ideas, you will see if they have an impact on what you are trying to improve. Change ideas will likely evolve as they are tested under different circumstances and the knowledge of what works becomes stronger.

OAT Improvement Journeys

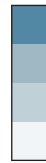
As your team begins mapping out your improvement journey, you may feel uncertain about what lies ahead. *Where do we begin with this wide range of change ideas? What are our team's and patients' goals? How can we get there together?*

This section of the LOUD in PC change package guides your team through the improvement journey by asking questions, providing video testimonials, and sharing examples of how to implement change ideas. Effectively navigating the planning and implementation of change ideas can increase OAT initiations and improve OAT retention in your care setting.

Change Ideas

Using expert knowledge and opinion, the change ideas in the driver diagram are sorted from *core ideas* to *enhanced ideas* within each secondary driver. This was done in acknowledgment of the wide variety of team compositions, patient demographics, and comfort with OAT prescribing within the collaborative. Teams can choose to focus primarily on core ideas (the concentrated colours in the driver diagram), jump to enhanced ideas (the lighter colours of the driver diagram), or adopt a combination of the two.

Core Ideas



Enhanced Ideas

Resources

There are resources available in the Learning Portal that correspond with the change ideas listed below. They include journal articles, video testimonials, webpages, templates, worksheets, point-of-care resources and more. Should you require additional support with your change ideas, do not hesitate to reach out to the LOUD in PC team to help identify additional resources.

Measurement

For each of the change ideas, there are corresponding measures in Appendix A of the *LOUD in PC: Guide to Measurement* to help you evaluate impact. This list of measures is not comprehensive but can act as a guide as you test changes using PDSA cycles.

LOUD in PC Driver Diagram

AIM STATEMENT	PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEA (Click on each change idea to read more details)
Increase the number of people living with OUD who are prescribed OAT by 30% from baseline in participating primary care settings by September 30, 2024	1 OAT & OUD Education	1.1 Equip prescribers with knowledge and training that can help them achieve their goals in prescribing OAT	1.1.1 Support prescribers to complete POATSP education and training
			1.1.2 Review current OAT treatment options and consider expansion
			1.1.3 Build individualized learning plans with team members
			1.1.4 Support prescribers to complete sublocade manufacturer training
		1.2 Integrate OAT into recruitment and onboarding processes	1.2.1 Incorporate OAT education into onboarding new team members
			1.2.2 Recruit more OAT prescribers
		1.3 Provide team learning and capacity-building opportunities	1.3.1 Use OAT practice supports
			1.3.2 Join or establish a community of practice
			1.3.3 Facilitate sharing among the team
			1.3.4 Educate using case studies and simulation
			1.3.5 Support non-prescribers to complete substance use education
		1.4 Provide prescribers with up-to-date and relevant information to provide high-quality OUD care	1.4.1 Review Guidelines for the Clinical Management of OUD annually
			1.4.2 Create OAT and OUD practice supports for prescribers
			1.4.3 Support/engage in continuous OAT education
	2 Positive Experience in Care	2.1 Standardize approach to frequent and effective communication with OUD patients	2.1.1 Standardize follow-up with patients
			2.1.2 Update patient contact information regularly
		2.2 Build patient awareness, knowledge, and autonomy regarding OAT through patient-oriented resources	2.2.1 Seek feedback on patient education materials
			2.2.2 Ensure OAT information is readily available and accessible for patients
			2.2.3 Inform patients when OAT options change or expand
			2.2.4 Inform patients about take-home buprenorphine/naloxone
		2.3 Address barriers to care in patient care planning	2.3.1 Build care plans collaboratively with patients
			2.3.2 Offer multiple treatment options
			2.3.3 Standardize OAT referral pathways
			2.3.4 Standardize screening for OUD
			2.3.5 Consider prescribed safer supply
		2.4 Create a welcoming and safe environment for patients	2.4.1 Support team members to complete anti-stigma and anti-racism training
			2.4.2 Address anti-Indigenous racism
			2.4.3 Support team members to complete trauma-informed practice training
			2.4.4 Design a low barrier waiting area
			2.4.5 Evaluate patient experience

AIM STATEMENT	PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEA (Click on each change idea to read more details)
Increase the number of people living with OUD who are prescribed OAT by 30% from baseline in participating primary care settings by September 30, 2024	**3 Connections to Community and Peer Services**	**3.1** Spread awareness and support of peer-led initiatives and peer worker roles in OUD care	**3.1.1** Share information about local peer-led initiatives and peer worker roles
			3.1.2 Invite people with lived and living experience to share their stories with team members
			3.1.3 Incorporate peer worker roles into your practice
		3.2 Support patients to utilize community support services, including harm reduction programs	**3.2.1** Provide take-home naloxone kits and facilitate training
			3.2.2 Spread awareness and build relationships with community services
			3.2.3 Provide support navigating community and other health services
			3.2.4 Support medication deliveries
	4 Care Flow	**4.1** Minimize door-to-dose time for OAT	**4.1.1** Identify areas for improvement using process mapping
			4.1.2 Optimize scope of practice
			4.1.3 Simplify patient intake
			4.1.4 Provide same-day assessment and treatment
		4.2 Design low barrier clinic processes	**4.2.1** Review and address policies that are barriers to care
			4.2.2 Automate patient reminders for appointments and medication
			4.2.3 Evaluate urine drug testing processes
			4.2.4 Offer on-call services
			4.2.5 Develop after-hours processes
			4.2.6 Offer drop-in hours
			4.2.7 Develop a process to bridge prescriptions
			4.2.8 Offer home starts
			4.2.9 Offer microdosing
		4.3 Improve pharmacy-clinic communication	**4.3.1** Include pharmacy introduction letters with prescriptions
			4.3.2 Build connections with pharmacies
			4.3.3 Ensure prescriptions do not end on a Friday
			4.3.4 Optimize workflows with pharmacy
			4.3.5 Collaborate with pharmacy to develop a process for missed doses
		4.4 Optimize functionality of electronic medical records	**4.4.1** Identify patients for OUD screening
			4.4.2 Use standard diagnostic codes
			4.4.3 Maintain appointment, medication and pharmacy data in EMR
			4.4.4 Create templates for OAT visits

OAT Improvement Journeys

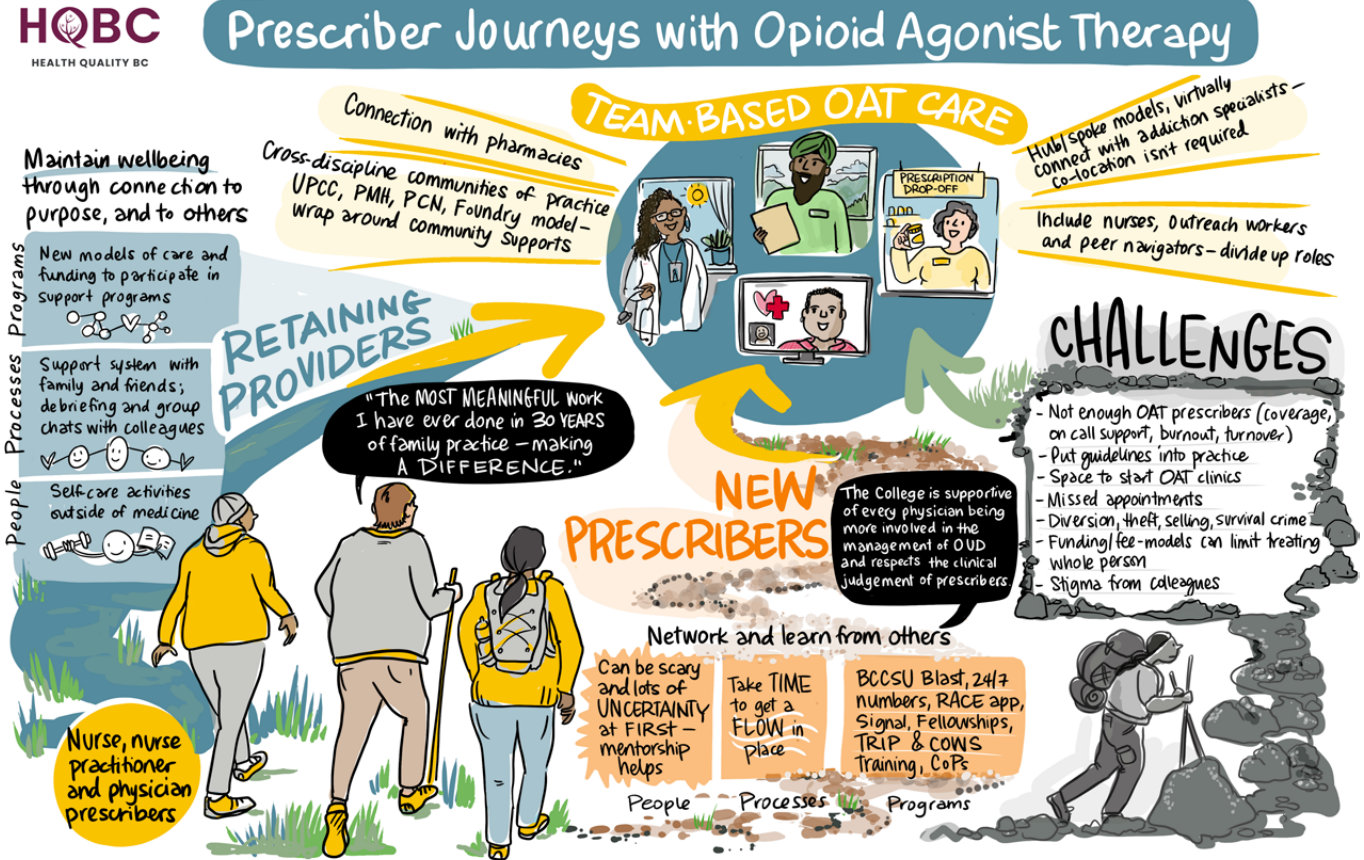


Figure 1: A graphic recording of 'the Prescriber Journey with OAT' created during a collaborative journey mapping session held by Health Quality BC on March 10, 2023.

As your team begins mapping out your improvement journey, you may feel uncertain about what lies ahead. *Where do we begin with this wide range of change ideas? What are our team's and patients' goals? How can we get there together?*

The following section guides your team through the improvement journey by providing framing questions, video testimonials and examples of how to implement **change ideas** within your primary care setting. Click the linked video testimonials to hear how clinical providers have implemented change ideas within their own practices. You can also learn more by clicking on the bolded change ideas which have been colour-coded according to their respective sections in the driver diagram. Effectively navigating the planning and implementation of change ideas can increase OAT initiations and improve OAT retention in your care setting.

Thank you to Sam Bradd with Drawing Change for his partnership in creating the graphic recording images found in this section.

INCREASING OAT INITIATIONS[4]

How could starting on OAT be made easier for patients?

Video testimonial: https://bit.ly/45FEKo2

The journey that patients on OAT face is not always fully understood by care providers. Like using a map when traversing through mountainous terrain, process mapping identifies barriers and lays out smoother paths for patients and providers. For patients, this may start with a welcoming clinic that has done anti-stigma and anti-racism training and has a simplified client intake process. Instead of significant detours, shortcuts can be used like drop-in hours and home starts. The medical office assistant (MOA) can be there as a guide with an optimized scope of practice.

How can we improve equitable access to OAT?

Video testimonial: https://bit.ly/3QmZyMT

OAT is like a means of transportation for patients to reach their goals and destinations. The problem is, not every patient is aware that it exists or that it can improve their journey. Equitable access to OAT means ensuring all patients have the opportunity of understanding if OAT is the right fit to reach their goals. Within primary care, equitable access is supported by thorough standardized screening for OUD and using standard diagnostic coding in the EMR. Clearly accessible OAT information can act as a beacon to recruit new patients, especially when materials are informed by PWLLE. Patient destinations and journeys are varied, so gradually expanding treatment options can provide broader access to your patients. When a patient's OAT requirements exceed what you are able to provide, then ensure that you have a clear referral process to connect them with other prescribers who can best support their OAT needs.

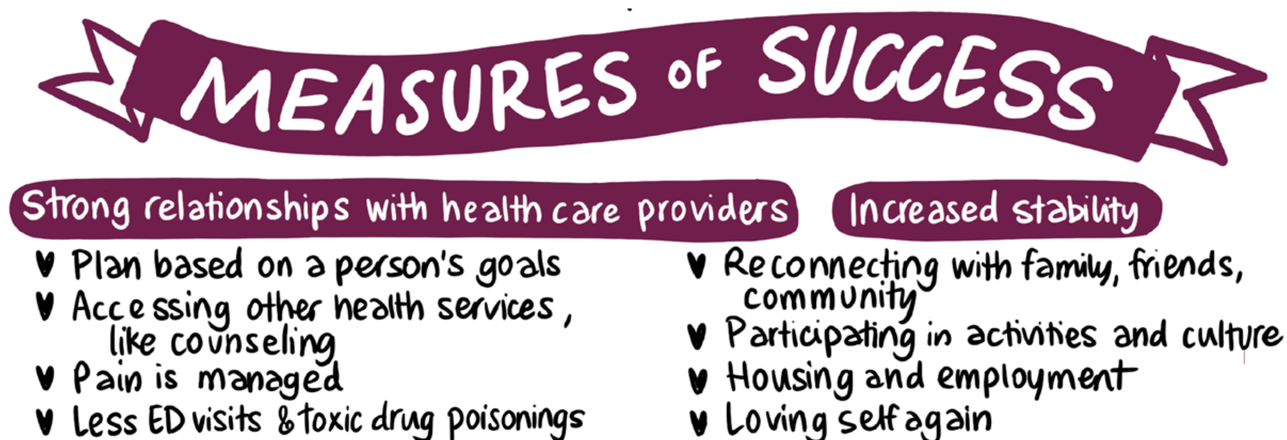


Figure 2: Part of a graphic recording of 'the Journey of People who Access OAT' created during a collaborative journey mapping session held by Health Quality BC on March 10, 2023.

[4] Initiations: The number of new OAT prescriptions that are written and filled.

How could PWLLE and peers support initiating new patients on OAT?

Video testimonial: https://bit.ly/45yDSBK

Those who benefit most from OAT may also be those most hardly reached. Improving equitable access to OAT requires addressing isolation from care. Stigma, racism, poverty, and unhealthy working conditions are systemic barriers. Dismantling this isolation from care requires the involvement of PWLLE, alternatively referred to as peers, to lend a trusting hand to those hardly reached. This can start with connecting to local peer-led initiatives and empowering clinical outreach with peer workers to accompany OAT initiations.

How do OAT providers find support?

Exploring the uncertain terrain of providing OAT will likely require trying several paths to determine the right direction. Providers are not alone on this journey and using Plan-Do-Study-Act Cycles will facilitate this testing. New prescribers can seek out mentorship, POATSP training and support services. Recruiting new prescribers can grow stronger OAT teams; navigating can be done collectively in communities of practice; and daily steps can be taken together with team sharing.

IMPROVING OAT RETENTION[5]

How could appointments for OAT care be more effectively managed?

Video testimonial: https://bit.ly/3rOFPfA

If OAT is a means of transport for patients to their goals, managing the care process is like a public transit network. In building a good system of transportation, convenience and reliability are key to retain service users and operators. Booking during each visit is like having a seamless transfer between buses, with **automated appointment reminders** acting as clear transit stops. Over time, reduce the number of transfers and appointments with **in-clinic testing** and providing **drop-in hours**. Reliability and convenience are expanded by providing inclusive hours of operation and **on-call services**. Like the night buses on public transit, working with other physicians for after-hour inquiries improves OAT retention.

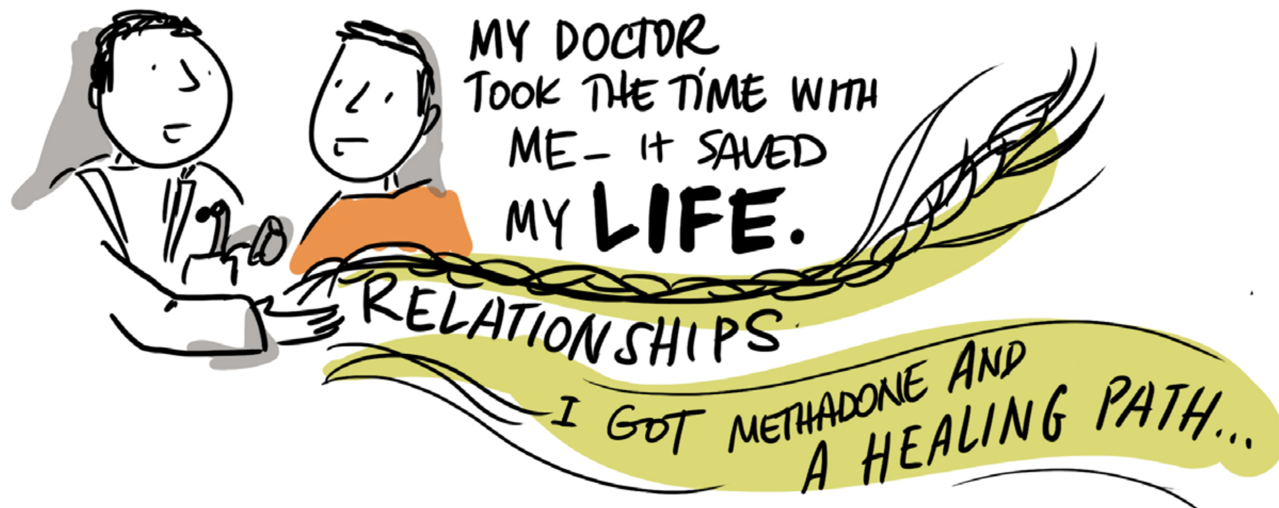


Figure 3: Part of a graphic recording of 'the Journeys of Indigenous People with Lived & Living Experience' created during a collaborative journey mapping session held by Health Quality BC on March 10, 2023.

How could pharmacists support OAT retention?

Video testimonial: https://bit.ly/3FmE78g

Pharmacies are an important partner with the primary care clinic, like a transportation hub that connects patients with health care and their medications. Strengthening connections between primary care clinics and pharmacies can begin with **introduction letters** and evolve by **optimized clinic-pharmacy workflows**. Pharmacists are like the local bus driver you see all the time, that can guide service users. With more pathways between hubs, patients won't get lost on their journey by using **missed dosing procedures**, or left behind by **checking prescriptions don't expire on Fridays**. **Medication delivery** can also be developed, like bullet trains connecting patients to their OAT.

[5] Retention: The percentage of people initiated who are still on OAT after at least three months.

How could peers and community services empower patients to achieve their goals?

Video testimonial: https://bit.ly/401gXhd

OAT is a vehicle that can bring patients towards their goals, defined in patient-oriented care planning, such as stable housing, employment, and relationships. These patient destinations vary from person to person and may change over time. Supporting ongoing **connection to community services** is that final transfer to reach their destinations, so equip your team with **contacts and community service information they can share** with patients. **Peer workers** can also be trusted guides for transfer beyond the clinic and in the community.

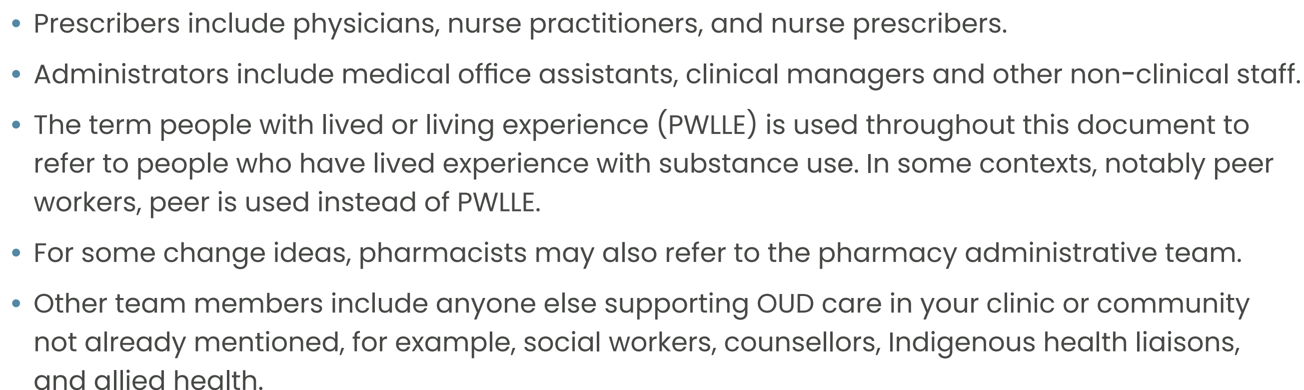
Figure 4: Part of a graphic recording of 'the Journeys of Indigenous People with Lived & Living Experience' created during a collaborative journey mapping session held by Health Quality BC on March 10, 2023.

Change Ideas

This section expands on the driver diagram with additional information about each change idea. We have provided descriptions for “who, what, when, and how” for each change idea, suggesting concrete steps and key people to involve when implementing a change idea to your practice. This information is meant to be a guide for teams and should be adapted to your context.

Please note the following about the “WHO” description:

These descriptions are provided to help guide you, but we recognize that there is great diversity across primary care teams in BC and depending on your setting it may make sense to include other people in these change ideas.



- Prescribers include physicians, nurse practitioners, and nurse prescribers.
- Administrators include medical office assistants, clinical managers and other non-clinical staff.
- The term people with lived or living experience (PWLLE) is used throughout this document to refer to people who have lived experience with substance use. In some contexts, notably peer workers, peer is used instead of PWLLE.
- For some change ideas, pharmacists may also refer to the pharmacy administrative team.
- Other team members include anyone else supporting OUD care in your clinic or community not already mentioned, for example, social workers, counsellors, Indigenous health liaisons, and allied health.

1 OAT & OUD EDUCATION

There are a variety of ways that all team members in a care space can engage in OUD and OAT education. By investing time in acquiring new knowledge and skills, teams can better deliver consistent OUD care using an evidence-based, trauma-informed, anti-stigma approach that ultimately increases initiations and retention on OAT.

1.1 Equip prescribers with knowledge and training that can help them achieve their goals in prescribing OAT

1.1.1 Support prescribers to complete POATSP education and training

WHAT: The Provincial Opioid Addiction Treatment Support Program (POATSP) is a comprehensive education and training program for those prescribing oral OAT and injectable OAT in BC. This education is tailored to various provider streams and their corresponding scope of practice.

WHY: For physicians and nurse practitioners to prescribe medications other than buprenorphine/naloxone, they will need to complete the POATSP training pathway. All OAT nurse prescribers must complete the basic training to begin prescribing buprenorphine/naloxone.

WHO: Prescribers.

HOW: Register online for POATSP training, which is delivered by the BCCSU. This training will be updated with changes to the guidelines that are anticipated this year.

1.1.2 Review current OAT treatment options and consider expansion

WHAT: A firm understanding of how your clinic's OAT options differ from those outlined by the BCCSU's guidelines can help you to expand services for the population that you serve. This includes reviewing any non-pharmacologic supports that are provided alongside OAT.

WHY: With continuously evolving evidence and medications available to individuals living with OUD, expanding services to include a variety of OAT medications allows clinicians and patients to co-create an individualized care plan. By reviewing and expanding all wrap-around services, including non-pharmacological supports, teams can improve patients' retention on OAT and/or other OUD care.

WHO: Prescribers, administrators and all other team members.

HOW: Generate a list of OAT and non-pharmacologic services. This can help with identifying gaps in services when compared to the BCCSU guidelines.

1.1.3 Build individualized learning plans with team members

WHAT: Identification of individual team members' goals as it relates to OAT therapy provision, anti-stigma training, cultural safety and humility, community connection, leadership, motivational interviewing, etc.

WHY: By attending to team members' individual goals, you not only improve the care provided to patients, but you improve the workplace for the staff. There are a variety of skills required to facilitate positive retention on OAT medication. The steps to achieve these skills are based on an individual's role and experience.

WHO: Prescribers, administrators and all other team members.

HOW: Teams can develop goals collectively or individually. Staff members should create SMART stretch goals that are routinely addressed and evaluated alongside supervisors.

1.1.4 Support prescribers to complete sublocade manufacturer training

WHAT: The manufacturers of sublocade (extended-release injectable buprenorphine) have created a training module for those who plan to administer this medication that takes approximately 15 minutes to complete.

WHY: Because of the serious risk of harm or death from self-injecting extended-release buprenorphine intravenously, it can only be administered by a certified health care provider. Extended-release buprenorphine is a valuable treatment option for individuals with OUD and is an option to expand care options at your clinic. Tailoring OAT care plans to the goals and needs of your patients will improve retention on OAT.

WHO: Prescribers.

HOW: Online training is available through the Sublocade manufacturer website.

1.2 Integrate OAT into recruitment and onboarding processes

1.2.1 Incorporate OAT education into onboarding new team members

WHAT: Development and delivery of standardized onboarding education about OAT that is tailored to their scope of practice, their role in care delivery, and the demographics that you serve.

WHY: By including training about OAT during onboarding, you ensure that all team members are receiving standardized information that is reflective of your organization's vision, mission, and values. This training lends itself well to reducing stigma around OUD and creating a safe space for patients.

WHO: Administrators and all new team members.

HOW: Develop synchronous or asynchronous education plans that are tailored to your care space and population. Including the patient voice is critical when creating educational material that is designed to reduce stigma.

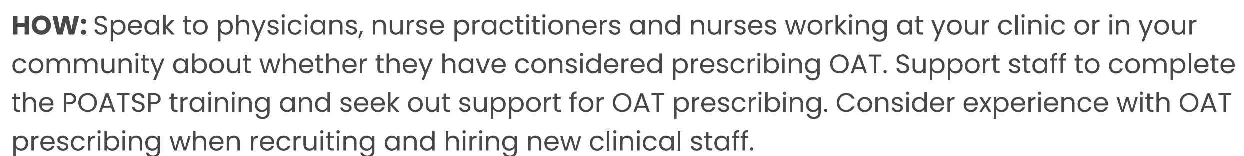
1.2.2 Recruit more OAT prescribers

WHAT: Recruit more prescribers or encourage existing team members to prescribe OAT.

WHY: To improve the accessibility of OAT, teams can increase their availability by adding new prescribers to their team. Whether this be in the form of training experienced nurses to become nurse prescribers, or recruiting new physicians or nurse practitioners. Having more clinicians available to prescribe OAT can build capacity within the team and improve access for patients.

WHO: Administrators and prescribers.

HOW: Speak to physicians, nurse practitioners and nurses working at your clinic or in your community about whether they have considered prescribing OAT. Support staff to complete the POATSP training and seek out support for OAT prescribing. Consider experience with OAT prescribing when recruiting and hiring new clinical staff.



1.3 Provide team learning and capacity-building opportunities

1.3.1 Use OAT Practice Supports

WHAT: There are several resources for clinicians seeking support in prescribing OAT. Two examples are Rapid Access Consultative Expertise Line (RACE Line) with addictions specialists available Mon-Fri 0800-1700 and BCCSU 24/7 Addiction Support Line.

WHY: Prescribers may feel uncomfortable or may encounter complex challenges when prescribing OAT. Having resources readily available increases confidence, especially when managing complex cases. By creating a tailored care plan for patients and receiving a second opinion, we can improve retention on OAT.

WHO: Prescribers.

HOW: Review available resources in your community for different prescribers and ensure that they are aware of how to access them. Creating easy to access resources on desktops or on posters can help to encourage their use by clinicians in care spaces.

1.3.2 Join or establish a community of practice

WHAT: Communities of practice provide invaluable support for clinicians who prescribe OAT and deliver care to patients living with OUD, and an opportunity for experienced OAT prescribers to provide guidance and build mentorship skills.

WHY: OAT prescribing is a new skill for many clinicians, and the challenges faced by those living with OUD are dynamic and complex. By joining a community of practice where new ideas and guidelines can be discussed with other clinicians, you enter a supportive setting for both new and experienced prescribers. Having communities that are specific to roles can also be helpful considering there are varying scopes and practice constraints. These communities help to ensure that everyone is aware of emerging trends and consistently providing high quality OAT care.

WHO: Prescribers.

HOW: Connecting with experienced and pre-established communities of practice. Developing new communities of practice within your region or health authority.

1.3.3 Facilitate sharing among the team

WHAT: Dedicated time for teams to meet and celebrate successes and discuss challenges in caring for those with OUD and prescribing OAT.

WHY: In some clinics in BC, creating space for team sharing has been a helpful avenue for teams to debrief and address systemic challenges of stigma, racism, and prejudice. By engaging in open dialogue with colleagues, without fear of judgment or repercussions, teams can build trust and psychological safety while supporting one another to provide high quality care to patients with OUD. Celebrating successes also helps to build motivation and momentum, especially when embarking on quality improvement work.

WHO: All team members.

HOW: Carve time out of existing team meetings or dedicate space for team members to come together and share. Create a facilitation guide and share it with the team in advance so that they can prepare appropriately.

1.3.4 Educate using case studies and simulation

WHAT: Routine case study reviews and/or simulation of patient encounters for both initiation of OAT and OAT follow-up.

WHY: Working through case studies individually or in teams allows for judgement-free exploration of OAT discussions with patients. This is an opportunity for team members to practice without risk, learn about potential gaps or barriers in care, and support one another through learning journeys.

WHO: Prescribers and administrators.

HOW: By designing standardized case studies that are relevant to your workplace and community, you can make the learning experience more valuable. There are standardized case studies available online and examples are available through the BCCSU's POATSP training.

1.3.5 Support non-prescribers to complete Substance Use education

WHAT: The Addiction Care and Treatment Online Course (ACTOC) is a comprehensive online course about diagnosing and treating substance use disorders along a continuum of care. This course is targeted towards health care providers, but anyone interested in learning about substance use disorders is encouraged to register.

WHY: Substance use disorders and the toxic drug poisoning crisis in BC are complex. Increasing understanding of these disorders and treatment options can help to reduce stigma and increase awareness in all team members.

WHO: Administrators and all other interested team members.

HOW: ACTOC is delivered by UBC CPD, and registration is available online. This training can be done gradually and is a useful resource for ongoing professional development.

1.4 Provide prescribers with up-to-date and relevant information to provide high-quality OUD care

1.4.1 Review Guidelines for the Clinical Management of OUD annually

WHAT: Annual review of OAT prescribing guidelines to check for updates/changes to apply to your current practices of providing OUD care.

WHY: OAT and OUD exist within a rapidly evolving landscape. New research and updated policies often have an impact on OAT guidelines for prescribers. Ensuring you stay current with these guidelines, ensures your team is providing treatment that is backed by the most current evidence.

WHO: Prescribers.

HOW: Review the BCCSU guidelines annually and share/discuss practice updates with your team. Sign up for the BCCSU email list to receive updates. **Note:** new BCCSU guidelines are anticipated in Fall 2023, and we will share an update when they are published.

1.4.2 Create OAT and OUD practice supports for prescribers

WHAT: Create practice supports (tools used at the point of care) for OAT and OUD. These supports should be designed with team members and be visually appealing and easy to interpret. Examples of practice supports include checklists, templates, and guidelines.

WHY: Practice supports are tools available at the point-of-care to support prescribers. These tools help in the standardization of care delivery, especially with novice or new team members.

WHO: Prescribers.

HOW: When participating in learning opportunities keep copies of key resources and make them available at the point-of-care (e.g., print them out, keep them on your phone, and/or incorporate them into your EMR). Alternatively, identify areas of your clinical practice that a resource would be helpful and source them through learning opportunities, colleagues, LOUD in PC, or by creating your own.

1.4.3 Support/engage in continuous OAT education

WHAT: Participate in continuous learning opportunities about OUD/OAT.

WHY: Implementing OAT in your practice can be complex, seeking out continuous learning opportunities allows you to gain support and effectively implement guidelines and new research into practice. Bonus, it can help you receive required credits for your licence to practice.

WHO: Prescribers, administrators and all other interested team members.

HOW: Creating personal learning goals is a great place to start, this helps you identify which areas to focus on with learning opportunities. Some specific suggestions are provided within the resources for this change idea.

2 POSITIVE EXPERIENCE IN CARE

All individuals who engage with the care system have varying perspectives on how it functions, and in turn experience care differently. This includes patients and PWLLE, clinic staff, clinicians, pharmacists, peers, community resources and more. Striving to improve the experience in care for all involved helps to create an inviting environment that patients will return to, thus increasing successful initiation and retention on OAT.

2.1 Standardize approach to frequent and effective communication with OUD patients

2.1.1 Standardize follow-up with patients

WHAT: Development and adherence to standardized procedures for follow-up with patients who miss an appointment, miss dose(s), or have expired prescriptions.

WHY: Following up with patients and proactively identifying expired/soon to expire prescription supports OAT retention.

WHO: Administrators and pharmacists.

HOW: Utilize EMR to flag expired prescriptions, create standard phone, email and text scripts for each common issue encountered by your OAT patients. Use multiple methods of contact when possible.

2.1.2 Update patient contact information regularly

WHAT: Regular confirmation of patient information, including the best method to contact them and which pharmacy/clinic they are using.

WHY: Knowing the best way to contact people on OAT is important to facilitate reminders. This may differ from other patients at your clinic/pharmacy. Having the contact information of the pharmacy/clinic is important to facilitate a team-based approach to care. Accuracy of patient information is one of the primary reasons why appointment reminders don't work as anticipated. Regular contact with patients using a variety of communication modalities increases the likelihood that they will attend appointments and be retained in treatment.

WHO: Administrators and pharmacists.

HOW: Determine an appropriate interval to confirm patient contact information (e.g., every visit, once/week, once/month). Be creative in how you ascertain this information. For example, you could ask, 'If I wanted to get in touch with you to tell you that you won $1,000, how would I do it?'

2.2 Build patient awareness, knowledge, and autonomy regarding OAT through patient-oriented resources

2.2.1 Seek feedback on patient education materials

WHAT: Seeking input on patient education materials from PWLLE and any other end users.

WHY: Input from the people who use the materials helps identify areas for improvement and if the information is being interpreted as anticipated.

WHO: Prescribers, administrators and pharmacists.

HOW: Ask for feedback from end users (e.g., patients, families) on the education materials you provide them with at subsequent appointments. This can be achieved through conversations or anonymous surveying. Some people may be interested in being actively involved in developing future resources.

2.2.2 Ensure OAT information is readily available and accessible for patients

WHAT: Ensuring information about OAT is available in waiting rooms and treatment rooms for patients to take home.

WHY: People with OUD may want more information before they determine if OAT is a good fit for them. Using a format that can be taken home (e.g., brochure) allows patients to refer back to the information and have conversations with trusted people.

WHO: Prescribers and administrators.

HOW: Provide information in visible places that people have access to while waiting for care. When meeting with people with OUD, prescribers can ask if they saw the information and ask if they have questions. Information can be generic or customized to the particular community/ care setting. Consider providing educational materials in a variety of languages or ones that are specific to communities.

2.2.3 Inform patients when OAT options change or expand

WHAT: Spreading awareness with patients about emerging practices or new supports that make it easier to engage with OAT.

WHY: Some people who have tried OAT in the past, may be willing to try again if some of the barriers they experienced have been addressed (e.g., new medication options, policy changes, community supports, etc.). OAT delivery and medications are rapidly evolving and it can be challenging for patients to remain informed of options as they emerge.

WHO: Prescribers and pharmacists.

HOW: This change idea requires that you have a standard process for staying up to date on the emerging practice changes in OAT. Ask for permission to share updates on OAT with patients at visits. Explore other ways to communicate changes on a broader level (e.g., bulletins, connection with local organizations, communication with local pharmacies).

2.2.4 Inform patients about take-home buprenorphine/naloxone

WHAT: Informing eligible patients about the option to receive take-home buprenorphine/naloxone doses.

WHY: Patients may not be aware of the ability to take-home doses of buprenorphine/naloxone for 1-2 weeks at a time once stable. Daily witnessed ingestion can be a significant barrier for people on OAT and this provides more flexibility that may be better aligned with the patient's goals.

WHO: Prescribers and pharmacists.

HOW: When discussing OAT medication options, explain the benefits of each medication, including the option to "carry" or "take-home" doses. For patients that are candidates for take-home doses, discuss this as an option for them and any requirements (e.g., secure location for medications).

2.3 Address barriers to care in patient care planning

2.3.1 Build care plans collaboratively with patients

WHAT: Building care plans around patient goals and reviewing these plans at every visit.

WHY: When patients are actively involved in building care plans that incorporate a discussion of perceived barriers, it makes it more likely for patients to be successfully initiated and retained on OAT.

WHO: Prescribers.

HOW: Ask patients about their goals at every appointment and build/update a care plan around these goals. This should include a conversation around potential barriers (e.g., travel, pharmacy access, etc.) and how they can be addressed.

2.3.2 Offer multiple treatment options

WHAT: Offering treatment options that align with the patient's clinical needs **and** preferences.

WHY: If the selected treatment option does not align with a patient's preferences or address their concerns, they are less likely to be successfully initiated and retained on OAT.

WHO: Prescribers.

HOW: Ask patients about their preferences for OAT and any factors that might be relevant when selecting a therapeutic option. Receive training to be able to offer multiple treatment options and/or refer patients if you don't offer the most appropriate treatment option.

2.3.3 Standardize OAT referral pathways

WHAT: OUD is a complex medical diagnosis, and some cases will require referral to specialized addiction medicine services. Create a standardized process that will identify patients that require escalation of care and where they can receive this care. Similarly, create a standardized approach to resume care of these patients from the specialist after OAT has been initiated and they have stabilized.

WHY: Having a standardized approach ensures patients receive safe, timely and individualized care that meets their goals and preferences. Effective communication with the specialist helps facilitate a smooth step-up to specialist care and step-down to longitudinal OAT care in primary care.

WHO: Prescribers and administrators.

HOW: Use decision-making tools to help identify patients for referral and use standardized referral forms to ensure the prescriber and specialist have the information they need. Connect with the specialist(s) you will be referring patients to and ensure the process is smooth from both perspectives.

2.3.4 Standardize screening for OUD

WHAT: Using a standardized process to screen for OUD.

WHY: Screening for OUD is the first step to identify patients who would benefit from OAT or other interventions/supports. Using a standardized approach to screening will help you identify people who need support, address the needs of this population, and help mitigate bias in the care provided.

WHO: Prescribers.

HOW: Identify criteria that will be used to identify who you will screen for OUD. Use your EMR to identify who meets these criteria, screen them for OUD at their next appointment and/or contact them to schedule an appointment.

2.3.5 Consider prescribed safer supply

WHAT: Prescribed safer supply is a prescribed alternative to the toxic drug supply. It can be used independently or in conjunction with OAT. Its goals include harm reduction, treatment or a combination. For the purposes of LOUD in PC we will be focusing on prescribed safer supply in combination with OAT.

WHY: Prescribed safer supply can help prevent toxic drug poisonings, save lives and connect people who use drugs to other health and social services. It may also help patients be retained on OAT and engaged with supportive health care services.

WHO: Prescribers.

HOW: This would require education, training, resources, and sustainability efforts to see this through. It is recommended that you seek support from resources within your health authority or wider community when looking to include prescribed safer supply as a treatment option in your setting.

2.4 Create a welcoming and safe environment for patients

2.4.1 Support team members to complete anti-stigma and anti-racism training

WHAT: Completion of anti-stigma and anti-racism training by all team members.

WHY: Stigma impacts many people living with OUD who are accessing OAT and other care leading them to feel dismissed and dehumanized. Meeting people where they are at, without judgment, saves lives.

WHO: All team members.

HOW: Address myths and hesitancies with the entire clinic team about substance use and opioid use disorder. Seek out education opportunities and/or discussions about anti-stigma/anti-racism as appropriate for the team. If you are a health authority employee, reach out to your Diversity, Equity, and Inclusion teams for more support.

2.4.2 Address anti-indigenous racism

WHAT: Ongoing work by all team members in anti-Indigenous racism training to gain a wider understanding of the injustices faced by Indigenous People and the ongoing impacts that colonialism has had on their communities in Canada. Engage with Indigenous Health Liaisons and Indigenous leaders in your local community to build relationships that will help support patients and their communities as they navigate challenges of OUD. Collect race-based and Indigenous identity data in your clinic.

WHY: Indigenous people are disproportionately represented in toxic drug poisoning fatalities. Health inequities experienced by Indigenous people reflect continuing structural and systemic disadvantages created through the history of colonization, as identified by the BC Coroner's Report on the review of illicit drug toxicity deaths (2022) and the *In Plain Sight* report (2020). Providing dedicated time for your team to learn about the history of colonialism in Canada and engaging in open dialogue about how you can work alongside Indigenous communities to address barriers in the health care system will have lasting impacts on not only patients being prescribed OAT, but everyone seen in your care space.

Collecting race-based and Indigenous identity data allows teams to identify the population that is served in the health care facility and helps teams to consider how they will create a physically, psychologically, and culturally safe space for everyone who interacts with their system.

WHO: All team members.

HOW: Seek out educational opportunities in your community and asynchronous online courses. Connect with Indigenous Health Liaisons if you belong to a health authority or with local Indigenous Leaders as appropriate. More information is available on the Online Learning Portal.

As outlined in Table 2 (page 9) of the CIHI Guidance on the Use of Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada, teams should collect race-based and Indigenous identity data from all patients.

2.4.3 Support team members to complete trauma-informed practice training

WHAT: Completion of trauma-informed practice training by all team members.

WHY: Trauma-informed practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma. Incorporating these approaches creates a safer environment for all patients, including those who use substances. Ensuring all team members use a trauma-informed approach to communication and practice will create a more inviting space and increase the likelihood that patients will be retained on OAT or in services.

WHO: All team members.

HOW: Seek out education and/or hold space for teams to discuss trauma-informed practice with consideration to your patient population and common shared experiences/triggers. Practice conversations using case-based learning or simulation with your teams.

2.4.4 Design a low barrier waiting area

WHAT: Creating a low barrier front desk and waiting room with a welcoming environment.

WHY: People receiving OAT spend a large amount of time accessing care. Removing barriers from accessing care and providing a welcoming space helps provide peace of mind, making it easier for them to engage in their care journey.

WHO: Administrators, prescribers, PWLLE and all other interested team members.

HOW: Seek feedback from patients and providers about the waiting room and front desk experience. Address any barriers and consider how to make the space more welcoming and comfortable. Some ideas for consideration include providing multi-language resources, creating comfortable spaces for privacy and rest, designing the general space (e.g., adding plants, colorful walls, culturally relevant art), having a space to store items, giving access to water, mints and snacks, and providing engaging activities like books or games.

2.4.5 Evaluate patient experience

WHAT: Regular evaluation of patient experience by asking for feedback.

WHY: Receiving feedback from your patients can be used to evaluate if your clinic is meeting patient needs and can help to identify areas for improvement. The only individuals who can accurately tell you if their needs for physical, psychological, and cultural safety are being met are PWLLE.

WHO: Administrators, prescribers, pharmacists and all other interested team members.

HOW: Identify what areas of your clinic you are hoping to evaluate, determine the best method to ask for feedback (survey, form, in-person feedback), collect the feedback, review the data, and make decisions based on data received. Ideas include: a suggestion box, select patients at random to interview while waiting for an appointment, or an anonymous survey.

As outlined in Table 2 of the CIHI Guidance on the Use of Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada, collect data about race and Indigenous Identity from all patients.

3 CONNECTIONS TO COMMUNITY AND PEER SERVICES

While OAT is a best practice recommendation for the treatment of OUD, it is common knowledge that initiation and retention on therapy is best achieved when delivered in conjunction with other resources. Having a firm understanding of peer and community services available to your patient population will help you to connect them with wrap-around services and improve the likelihood of successful retention on OAT.

3.1 Spread awareness and support of peer-led initiatives and peer worker roles

3.1.1 Share information about local peer-led initiatives and peer worker roles

WHAT: Prepare a list of peer-led initiatives in your community and share it in a visible and accessible format. Examples of peer-led initiatives include outreach teams, transportation, drug testing services, harm reduction supplies, community clean-up and support groups.

WHY: Connecting OAT patients to other peers (i.e., PWLLE) can improve retention and stability by giving opportunities to develop supportive relationships and to participate in community services. Patients may become connected to a broader range of OUD supportive services through peers, such as support groups or other treatment options.

WHO: Prescribers, administrators and peer workers.

HOW: Identify local peer-led initiatives by asking for input from patients and contacting the BC Community Action Initiative, a local peer group and/or the local Community Action Team. Provide a list of initiatives with current contact information to patients directly and have the information in your waiting room.

3.1.2 Invite people with lived and living experience to share their stories with team members

WHAT: Invitation of guest speakers with OAT experience (i.e., PWLLE) from the community to share their experiences with substance use, harm reduction and OAT with the clinical team. Consider recording and using these stories as training materials.

WHY: Storytelling from PWLLE is a significant driver to reduce stigma and to better understand the patient experience, which improves the delivery of care. A welcoming, empathetic environment improves equity and can potentially increase OAT initiations and overall retention to care with the clinic, even if the patient stops OAT.

WHO: Prescribers and peer workers.

HOW: Connect with a local peer group or network, such as those from peer-led initiatives and invite a PWLLE. It is important to meet with the peer first one-on-one, to ensure connection before content. Host a team meeting with staff and facilitate a dialogue with the peers. Alternatively, you could allow peers in the community to submit stories through email. Consolidate and save these stories to inform both staff training materials and patient education materials. If you plan to record stories for training materials, ensure you have disclosed this and received permission from the PWLLE first.

3.1.3 Incorporate peer worker roles into your practice

WHAT: Peer workers can hold a variety of roles for OAT and other related conditions (e.g., HCV, HIV, diabetes), including:

- Accompanying patients to OAT initiations and appointments
- OAT appointment reminders
- Distribution of harm reduction supplies (e.g., take-home-naloxone kits, sterile needles, etc.)
- Peer witnessing of substance use
- Navigation and referrals to services such as housing agencies
- OAT medication delivery
- Advocacy and outreach to hardly reached populations for OAT
- OAT program and policy development.

A peer worker can have regular contact with approximately 50 patients and navigates medication delivery and appointments for approximately 10 - 15 people each day (see rural case study).

WHY: There are well-known barriers to access and engagement in OAT, including known stigma facing people who use drugs, and stringent protocols (e.g., urine drug screens, daily dispensation, witnessed ingestion), which make access a challenge particularly in rural and remote communities. Peer workers serve as a point of contact to care, reducing fears regarding stigma and discrimination, and easing the burden of stringent OAT protocols. Peer workers can also help alleviate burdens on clinical staff.

WHO: Prescriber, pharmacists and peer workers.

HOW: Post a peer worker employment position to local community services and peer-led organizations and seek referrals.

3.2 Support patients to utilize community support services, including harm reduction programs

3.2.1 Provide take-home naloxone kits and facilitate training

WHAT: Provide free kits and training to patients who may be exposed to toxic drug poisonings.

WHY: Reduce harm from toxic drug poisonings for people in the community including OAT patients. Strengthen the relationship between the patient and the health care system by delivering training on a life-saving tool that is evidence-based.

WHO: Prescriber, administrators and peer workers.

HOW: Receive a facility response box with naloxone kits by contacting a harm reduction coordinator from Toward the Heart. Train new staff on using naloxone and set up a process to dispense kits to patients and their support network.

3.2.2 Spread awareness and build relationships with community services

WHAT: Updated list of community services with contact information and develop relationships with key contacts. Community services could be categorized as:

- **Harm Reduction Services:** local overdose prevention sites, drug checking services, supervised consumption and/or inhalation sites
- **Support Groups, In-Patient and Out-Patient Programs:** Narcotics Anonymous (NA), in-person or virtual Self-Management and Recovery Training (SMART groups), detox and accessible treatment program options.
- **Additional Support Services:** Resources for vulnerable patients, such as housing, transportation, outreach nursing and trauma counselling.

WHY: Community services can support patients to reach their goals, so patients realize greater benefits of staying on OAT. Ongoing communication with these services can ensure the prescriber is aware of changes and the service receives feedback from the prescriber's perspective. The community services can also help spread information about OAT.

WHO: Prescribers, administrators and peer workers.

HOW: Connect with the local Community Action Team and patients to get informed on relevant community services. Research additional local services online, through sites like Toward the Heart. Reach out to these organizations and continue to build relationships through ongoing communication. Set up clinical processes to inform patients about available services and ask for feedback on which services have been most valuable.

3.2.3 Provide support navigating community and other health services

WHAT: Connect patients to a social worker or peer worker to help them navigate and access community services and other health services (e.g., acute and tertiary care).

WHY: Patients who are at risk of dropping OAT due to instability, or are hardly reached by community services, can realize significant benefits from individual support. Service navigation strengthens the patient's relationship to health care and can improve retention by follow-up and providing additional support when required.

WHO: Prescribers and peer workers.

HOW: Implement a peer worker role to include service navigation and/or connect and partner with a community service that performs navigation. Alternatively, you can develop a team role that supports access services for vulnerable patients. Focus your attention on vulnerable populations or the most at-risk patients, such as Indigenous women, and people who receive income assistance or are unhoused.

3.2.4 Support medication deliveries

WHAT: A direct delivery of OAT medications from a pharmacy to the patient, typically achieved through a peer delivery service or housing service.

WHY: There are several barriers in accessing OAT, including proximity to a pharmacy, clinic and pharmacy hours, and frequency of care access to name a few. A peer delivery service reduces the burden on the patient with OUD and can lead to increased retention on OAT.

WHO: Pharmacists and community resources.

HOW: Connect with existing community resources in your area to explore if peer delivery is an option for pharmacies that you are working with. Ensure to engage early with pharmacy partners if you are looking to pursue this option.

4 CARE FLOW

Providing OUD & OAT services can be complex. When clinical teams have a strong understanding of their processes and flow, they can better address challenges that arise. Understanding where inequities influence access to health care in their communities will help teams to target change ideas that will increase access to OAT services and thus, increase initiations and retention.

4.1 Minimize door-to-dose time for OAT

4.1.1 Identify areas for improvement using process mapping

WHAT: Development of a process map that outlines a patient's experience of initiating OAT and attending follow-up appointments.

WHY: A process map helps identify areas in a specific process that could be improved by highlighting barriers, bottlenecks and inefficiencies. These areas can then be targeted with improvement efforts.

WHO: Prescribers, administrators, pharmacists, PWLLE and all other team members.

HOW: Work with your team and patients to list the step-by-step process of prescribing OAT. There are a wide range of tools that you can use to visualize the process including pen and paper, Miro board, Microsoft whiteboard, etc. Once the process has been documented, review the process holistically to identify areas for improvement, challenges, and inefficiencies. More resources on process maps will be provided in the first learning session.

4.1.2 Optimize scope of practice

WHAT: Review team roles and ensure all members are working to their full scope of practice while providing OUD care.

WHY: When team members are allowed and supported to work to their full scope of practice and utilize a team based care model it improves staff satisfaction, productivity, culture and care.

WHO: Prescribers, pharmacists, administrators and all other team members.

HOW: Develop an understanding of each profession's scope of practice by having conversations and reviewing guidance from professional organizations (e.g., BC College of Nurses and Midwives, College of Pharmacists of British Columbia, College of Physicians and Surgeons of BC). Consider if hiring additional non-clinical staff could increase OAT capacity at your clinic and in your community. You may also find the "Team Effectiveness Tool" helpful to guide these conversations.

4.1.3 Simplify patient intake

WHAT: Simplification of the intake process at your clinic, ensuring that it is patient-centred.

WHY: Simplifying the intake process can reduce induction times and removes some barriers for OAT initiation. Some patients may not be ready to share sensitive information with the MOA or pharmacy on their first visit in front of other patients.

WHO: Administrators, prescribers and all other interested team members.

HOW: Identify what information is critical for prescribers and/or pharmacists to begin an OAT initiation and consider removing any unnecessary or non-critical questions from the standard tool used, or gathering this information in subsequent appointments. Focus on building rapport in the initial appointments in order to build trust and improve communication. Connect with patients and ask for feedback on how the intake process could be improved.

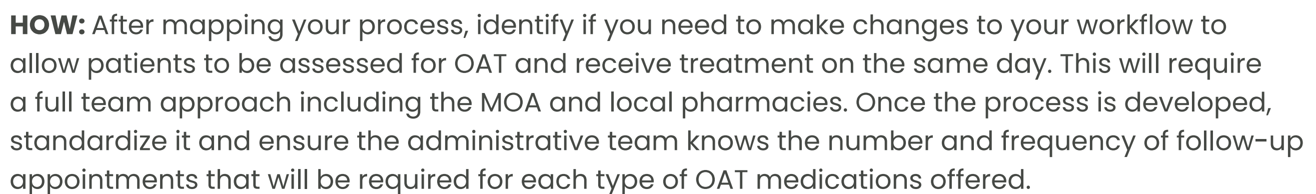
4.1.4 Provide same-day assessment and treatment

WHAT: Arrangement for the patient to be assessed for OAT and treated on the same day.

WHY: Patients may experience barriers accessing the clinic. If OAT can be started on the same day as the assessment or reassessment of the patient, it removes a barrier to treatment and increases the likelihood of initiation or retention on OAT.

WHO: Prescribers and administrators.

HOW: After mapping your process, identify if you need to make changes to your workflow to allow patients to be assessed for OAT and receive treatment on the same day. This will require a full team approach including the MOA and local pharmacies. Once the process is developed, standardize it and ensure the administrative team knows the number and frequency of follow-up appointments that will be required for each type of OAT medications offered.



4.2 Design low barrier clinic processes

4.2.1 Review and address policies that are barriers to care

WHAT: Identification and elimination of policies that act as barriers to OAT initiation and retention.

WHY: Improve access to OAT, increase retention, and decrease the number of missed doses by ensuring policies are patient centric and do not unnecessarily introduce barriers.

WHO: Administrators, prescribers, pharmacists and all other team members.

HOW: Conduct a conversation with your team and review relevant policies (e.g., urine drug tests, intake process, missed doses process, follow-up appointments, reminders, requirement for daily witness dosing, requiring government issued ID, peer delivery, bridging prescriptions, carries, etc.). Ask for feedback from patients and PWLLE to help identify areas to focus on. Note: this change idea is closely related to several others.

4.2.2 Automate patient reminders for appointments and medication

WHAT: Automate reminders prior to appointments, medication expiry, and medication refills.

WHY: Improve attendance of patients at initial and subsequent appointments and improve retention of OAT.

WHO: Administrators.

HOW: Review the ability of your booking system to send automated reminders and/or explore alternatives to your current booking system. Using multiple methods (i.e., text, phone and/or email) is recommended by the literature.

4.2.3 Evaluate urine drug testing processes

WHAT: Review your current urine drug testing (UDT) processes and evaluate them. Consider implementing in-clinic UDT and explore when OAT can be prescribed without drug screening.

WHY: There is stigma surrounding UDTs. Therefore, they can be a barrier to OAT initiation and retention.

WHO: Prescribers and administrators.

HOW: Evaluate current policies around in-clinic drug screening, ensuring that UDT is applied only when appropriate (e.g., evaluating treatment response and outcomes, supporting decision-making regarding take-home doses). Consider implementing in-clinic UDT if feasible. Ensure to discuss UDT frequency and rationale with patients, including how it informs their treatment plan. It is important to emphasize that it is not punitive.

4.2.4 Offer on-call services

WHAT: Development of a call structure for out-of-hour prescriptions and calls about OAT.

WHY: Reduce barriers to emergency/after-hours access of OAT care.

WHO: Prescribers, administrators and other clinical teams.

HOW: Work with your prescriber team, and/or other known clinics/prescribers to develop on-call services. This can look like creating an on-call rotation schedule every week with other prescribers.

4.2.5 Develop after-hours processes

WHAT: If there is no on-call structure available for OAT care, ensure there is guidance for patients on how to manage care after clinic hours, including on weekends or holidays. Also consider coverage when prescribers and/or pharmacists are on vacation.

WHY: Reduce barriers for emergency and after-hours access to OAT care.

WHO: Prescribers, pharmacists and administrators.

HOW: Curate a list about after-hour contacts that can provide support and address concerns or questions of OAT care. Ensure to have prior communication with the listed clinics/providers that patients may be re-directed to them after hours. The list can include contact/address information of other clinics or practices that provide OAT care in your community or virtually and have extended hours, nurse emergency line, counselling supports, and pharmacy supports. If listing pharmacy supports, create a process with pharmacists for after hour emergencies regarding prescription expiration and refills.

4.2.6 Offer drop-in hours

WHAT: Availability of drop-in appointment times for OAT patients.

WHY: Reduce barriers to urgent/emergency access of OAT care.

WHO: Administrators and prescribers.

HOW: Prescribers need to work with MOAs and clinic managers to determine the best approach to drop-in hours. Discussions could involve topics of prescriber capacity and scheduling. Consider allotting specific blocks of drop-in times every day or throughout the week, or “reserving” appointment times throughout the day for drop-in patients.

4.2.7 Develop a process to bridge prescriptions

WHAT: Collaboration with pharmacies and other clinics to bridge prescriptions.

WHY: Ensure patients on OAT can access medications in emergency or rare situations (e.g., travel), increasing retention and reducing risk of withdrawal/relapse in these situations.

WHO: Administrators, pharmacists and prescribers.

HOW: Work with pharmacies and other OAT prescribers/clinics in developing guidelines and processes for bridging prescriptions. Determine eligibility (i.e., patient and situation), whether pharmacists or other OAT prescribers will take on extending/refilling prescriptions until the patient's next appointment, how to confirm a patient's next appointment, clear contact information for all pharmacies/providers involved in the collaboration, and clear follow-up processes. Resources regarding other support should also be available (e.g., counselling, community supports, etc.).

4.2.8 Offer home starts

WHAT: Offering buprenorphine/naloxone home starts for patients who meet eligibility.

WHY: Reduce barriers of retention/access to OAT, especially for those who may live in a remote area or face significant barriers to regular in-person appointments.

WHO: Prescribers, pharmacists and administrators.

HOW: If patients are eligible as outlined in BCCSU's Guidelines for the Clinical Management of OUD (i.e., previous experience with buprenorphine/naloxone, demonstrated reliability, faces significant barriers to attend appointments regularly/challenges in retention, etc.), then buprenorphine/naloxone home inductions can be considered. Develop a process for regular follow-ups/support via telehealth appointments, with clear recommendations or expectation of an in-person appointment within two days of initiating OAT. Ensure that the patient is clear about the risk of withdrawal and has been provided written office contact information, education, instructions to dosing and timing, and instructions for situations of concern/emergency. Ensure contact information about supports are available to patients in the case of increasing anxiety around withdrawal.

4.2.9 Offer microdosing

WHAT: Offering OAT rapid micro-induction (microdosing) using buprenorphine/naloxone.

WHY: Increases OAT accessibility and patient-oriented care by reducing induction time and severe withdrawal symptoms as it does not require prior withdrawal like traditional induction. Check-ins can be done via telehealth once the patient is stabilized and well-educated on treatment. It also has broader availability compared to other OAT, especially in rural/remote communities.

WHO: Prescribers and pharmacists.

HOW: Introduce microdosing via the Bernese method, which is done through the gradual induction overlapping with full use of agonist or consider prescribed safer supply in place of the agonist. Work with pharmacies regarding/developing patient education, especially for outpatient regimens, as it is key to avoiding withdrawal. Monitor regularly for precipitated withdrawal as microdosing is a longer process to reach optimal dosing.

4.3 Improve pharmacy-clinic communication

4.3.1 Include pharmacy introduction letters with prescriptions

WHAT: Include a letter of introduction to the pharmacist with all the OAT medications your team prescribes.

WHY: When working with a new pharmacy, an introduction letter can answer initial questions a pharmacist may have about the prescription and who is prescribing it, and is a good first step to building a relationship and establishing expectations with the pharmacy team moving forward.

WHO: Administrators and prescribers.

HOW: Attach a letter of introduction as a cover page for all OAT prescriptions. This letter can include who you are, your clinic contact information and location, what OAT services you provide, and next steps so the pharmacy team knows what to expect.

4.3.2 Build connections with pharmacies

WHAT: Build relationships with the pharmacies your patients use (e.g., phone, in-person connections).

WHY: Pharmacists and their teams play a significant role in OAT delivery and are a critical component of your team. They have an extensive skill set and knowledge in medication and patient education, and help inform complex treatment plans in the community. They also assess/interact with OAT patients frequently as part of dispensing their medications on a regular basis. Building relationships with pharmacists and understanding their scope is key to integrating them into your team and delivering more effective/timely/patient-oriented OAT services.

WHO: Administrators, pharmacists and prescribers.

HOW: Locate pharmacies in your area or those that may be willing to work with you and have an initial meeting with their team. Discuss the OAT services you provide, clarify scope of both your teams, what workflows can look like and develop an understanding of expectations for working together.

4.3.3 Ensure prescriptions do not end on a Friday

WHAT: Work with pharmacists to ensure that OAT prescriptions do not end on a Friday.

WHY: Reduce barriers of accessing after-hours OAT care as clinics are often closed on weekends.

WHO: Prescribers, administrators and pharmacists.

HOW: Establish a process for MOAs to double-check that OAT prescriptions do not end on a Friday before faxing off to pharmacists. Pharmacy teams should be made aware of this process so they can also double check that expirations do not fall on a Friday.

4.3.4 Optimize workflows with pharmacy

WHAT: Discuss workflows and develop standardized procedures between pharmacy and clinic.

WHY: Improve teamwork and communication between pharmacy and clinic teams to deliver patient-centred and timely OAT care.

WHO: Administrators, pharmacists, prescribers and all other interested team members.

HOW: Develop/adjust standard operating procedures with the pharmacy team(s) you work with, covering topics of previous experience with OAT care, challenges providing OAT care, business hours, expectations of working together, OAT delivery, bridging prescriptions, patients without government issued ID, communication methods, missed doses, harm reduction, and more. For teams with existing processes, you can use process mapping to help identify areas of improvement.

4.3.5 Collaborate with pharmacy to develop a process for missed doses

WHAT: Weekly (or regular) review of missed doses.

WHY: Inform OUD care planning by looking at retention and flagging challenges for discussion with patient and care team.

WHO: Pharmacists and prescribers.

HOW: Pharmacist and prescribers to establish a regular process for reviewing missed doses, including methods of communication, frequency, and use of "RU" (missed) and "RE" (reversed) coding on PharmaNet.

4.4 Optimize functionality of electronic medical records

4.4.1 Identify patients for OUD screening

WHAT: Generating a list of all patients on long-term opioids and screen them for OUD at their next visit (high-risk population).

WHY: Increase equitable access to OAT care for entire patient panel and create opportunity for promoting secondary preventative measures those at risk of developing OUD.

WHO: Prescribers and administrators.

HOW: Prescribers to work with MOAs to identify existing patients on long-term opioids in electronic medical record (EMR), flagging for OUD screening at next visit. Develop your screening tool based on the BC Guidelines on Clinical Management of OUD and other existing screening tools such as the Prescription Opioid Misuse Index "POMI" or Opioid Risk Tool "ORT".

4.4.2 Use standard diagnostic codes

WHAT: Utilization of standard diagnostic codes in EMR charting for empanelment.

WHY: Optimize processes for tracking/monitoring/documenting treatment of patients using opioids, receiving OAT, and/or diagnosed with OUD. This can also help with sending out reminders regarding appointments or medications and evaluating OAT continuity of care (see change idea 4.4.3).

WHO: Administrators and prescribers.

HOW: Prescribers to develop standard coding and work with MOAs to update charting in EMR using a custom code to identify patients receiving OAT, patients using opioids (illicit or prescribed), and patients diagnosed with OUD.

4.4.3 Maintain appointment, medication and pharmacy data in EMR

WHAT: Maintenance of appointment, medication and pharmacy information regarding follow-up frequency, expired prescriptions, soon-to-expire prescriptions, and missed doses, etc.

WHY: Improve OAT retention by sending reminders and addressing challenges re: prescription expiration and missed doses.

WHO: Administrators, pharmacists and prescribers.

HOW: MOAs to work with pharmacists and clinical team to track medication expiry dates, refill dates, and missed doses in the EMR. Develop follow-up process (i.e., who, what, when, how) with patients about missed doses or expired prescriptions. Reminders to be sent out regarding upcoming expiry, follow-up, and refill dates.

4.4.4 Create templates for OAT visits

WHAT: Development of EMR templates for patients receiving OAT.

WHY: Increase efficiency and accuracy of OAT care documentation.

WHO: Administrators.

HOW: MOAs to develop fillable EMR templates regarding initiations for all OAT medications, follow-up visits, etc. Initiation templates can also include notes regarding dosing stages and recommended visit frequency.

Appendices

APPENDIX A: ABBREVIATIONS & DEFINITIONS

This appendix provides definitions and further information for abbreviations and words commonly used throughout the Change Package.

- **ACTOC:** Addiction Care and Treatment Online Course. Register online: https://ubccpd.ca/learn/learning-activities/course?eventtemplate=6
- **BCCSU:** BC Centre on Substance Use. Website: https://www.bccsu.ca/
- **BOOST Collaborative:** Best practices in Oral Opioid agoniST Therapy Provincial Collaborative. Website: https://stophivaids.ca/provincial-boost-tools-resources/
- **EMR:** Electronic medical record
- **HQBC:** Health Quality BC. Website: https://www.healthqualitybc.ca
- **LOUD in PC:** Learning About Opioid Use Disorder in Primary Care. Website: https://healthqualitybc.ca/improve-care/substance-use/learning-about-opioid-use-disorder-loud/loud-in-primary-care-pc/
- **MOA:** Medical office assistant
- **NA:** Narcotics Anonymous
- **OAT:** A set of prescribed treatment options for Opioid Use Disorder (OUD). OAT includes oral and injectable options, depending on the goals, needs, and preferences of the patient.
- **Person living with OUD:** Person who meets criteria for opioid use disorder (OUD) as defined by the DSM-5.
- **POATSP:** Provincial Opioid Addiction Treatment Support Program. Register online: https://ubccpd.ca/learn/learning-activities/course?eventtemplate=43-provincial-opioid-addiction-treatment-support-program
- **PWLLE:** People with lived and living experience of OUD and/or OAT in this context. This refers to anyone who has experience with substance use, either in the past or currently. This population has experienced the system firsthand and can lend invaluable insight to improvement efforts. PWLLE is sometimes used interchangeably with the term “peers”.
- **RACE Line:** Rapid Access Consultative Expertise Line. Website: http://www.raceconnect.ca/
- **SMART Groups:** Self-Management and Recovery Training Groups
- **Toxic Drug Poisoning:** Defined as events where a person takes too great of a dose of a substance, leading to toxicity or death.
- **UDT:** Urine drug testing