Guide to Measurement

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, we would also like to recognize the improvement projects and efforts that came before LOUD in PC that heavily influenced the work in this measurement strategy. These groups include the BC Centre for Excellence in HIV/AIDS (BOOST Collaborative), Island Health (SOAR QI Project), and Health Quality BC (LOUD in the Emergency Department & CLEAR Wave 3.0). The input from these improvement efforts has been invaluable.

---

[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).

Table of Contents

Last updated: October 2023

Overview

The purpose of this document is to outline the measurement strategy for LOUD in PC and provide useful tools to monitor and assess whether the changes implemented are leading to improvement. Seeing as quality improvement is an iterative process, this *Guide to Measurement* is a working document and is subject to change. As teams engage in testing and documenting changes, the measurement strategy may be revised. If any changes are made to the document, teams will be notified and updated versions will be available in the Online Learning Portal.

Key outcome, process and balancing measures are a necessary part of evaluating progress towards our individual and shared aims. With the help of our expert panel and professionals in data analytics, we have identified a variety of metrics for this Collaborative that will be compiled over time and used in both individual teams' quality improvement work as well as in the overall evaluation of this initiative. These are related to the drivers and change ideas outlined in the LOUD in PC *Change Package*.

In this document, we have emphasized measures that will be tracked monthly by teams and reported to the quality improvement coaches at HQBC. There are additional measures mentioned in this document that may be relevant to individual teams depending on the ideas chosen for implementation. All measures are labelled and can be cross-referenced with the *Change Package* that has been provided. As needs arise throughout the Collaborative, additional tools and resources may be provided to support additional data collection.

Measurement for improvement should be useful.
Don't let perfection get in the way of 'good enough'.

PROBLEM STATEMENT

On April 14, 2016, BC's Provincial Health Officer declared a public health emergency that set in motion collective action to combat the number of opioid use-related deaths across the province (2). Despite incredible efforts, the number of deaths related to toxic drug poisonings continues to climb at an alarming rate. In 2022, there were 2,293 suspected drug toxicity deaths in BC, second only to 2021 (3). Data available at the end of July indicates that 2023 is on track to have the highest number of deaths yet (4). Despite the availability of effective treatment paths for OUD, access to the full range of options differs between primary care providers whose understanding and approach to OUD can vary greatly.

GOALS

1 Increase the number of people living with OUD who are benefiting from being on OAT in BC.

2 Improve retention on OAT in BC.

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."

---

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

Measurement for Improvement

Measuring is an important part of improvement work. How can we demonstrate that a change has led to the desired outcome? How do we know if the improved outcome is a result of our efforts and not other factors that coincide with our work?

Measurement for improvement helps us to:

- Understand current performance
- Observe if the changes we are implementing are leading to the desired outcome
- Understand if the changes implemented have unintended consequences (positive, negative, or neutral)
- Compare to similar sites to foster learning
- Communicate clearly about improvement efforts and outcomes
- Know if we have reached our aims

Characteristics of measurement for improvement that differ from measurement for accountability and research include:

- Testing via Plan-Do-Study-Act (PDSA) Cycles
- Accepting consistent bias
- Collecting small samples (sampling)
- Collecting and displaying data over time using run charts
- Having flexible hypotheses
- Sharing data to only those who are involved in the improvement work

THE PURPOSE OF MEASUREMENT IN LOUD IN PC

There are two distinct purposes of measurement in LOUD in PC:

1. Measurement for improvement among participating teams

2. Measurement for evaluation and accountability of LOUD in PC

While the two purposes of measurement are related, they should be considered separately as they require different methods for data collection and analysis (5).
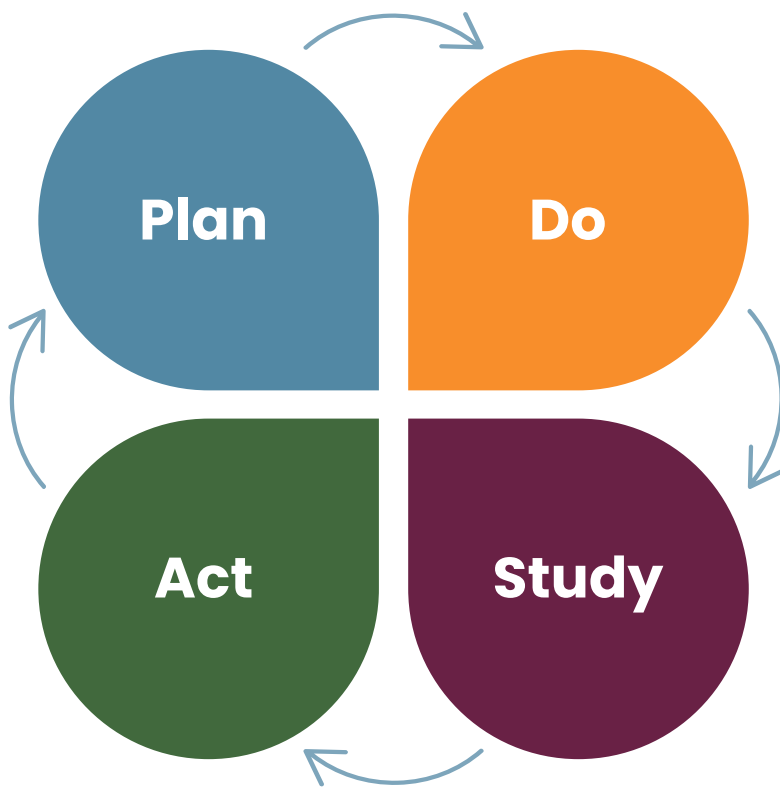
The Model for Improvement asks three basic questions:

1. What are we trying to accomplish?

2. How will we know that a change is an improvement?

3. What change can we make that will result in improvement?

SUPPORTING MEASUREMENT FOR IMPROVEMENT

The high-level plan for supporting measurement for improvement in the LOUD in PC Collaborative is to provide:

- Training to teams through Learning Sessions, as well as through asynchronous learning materials on the Online Learning Portal
- Resources and tools (i.e., LOUD in PC Quantitative & Qualitative Data Collection Tools) for doing the measurement work
- Coaching and support through team calls, 1:1 sessions and report feedback so that teams can analyze and interpret their own data

Figure 1: A graphic recording by Sam Bradd with Drawing Change during a journey mapping session exploring OAT care in BC held by HQBC on March 10, 2023.

Team Goal Setting

LOUD in PC coaches will help participating teams to establish and achieve their own improvement goal(s) for the increased access to OAT in BC that are specific, measurable, attainable, realistic and time bound (SMART).

The following *examples* display how teams can create their own aim statements to meet individual goals, while supporting the overall aim of the LOUD in PC Collaborative:

1. The average number of monthly OAT initiations at _____ clinic will increase from ____ to ____ by the end of the LOUD in PC Collaborative (September 30, 2024).

2. The percentage of people living with OUD maintained on continuous OAT for ≥3 months at _____ clinic will increase from ____ to ____ by the end of the LOUD in PC Collaborative (September 30, 2024).

Data Collection

There are several sources of data available to the LOUD in PC teams over the duration of the Collaborative. Additionally, teams will manually collect data in order to guide improvement work that is both timely and specific.

Despite monthly OAT data trends being provided by the HQBC team, it can still be valuable to embark on data sampling to provide more frequent review of the impact of improvement efforts. To support measurement efforts, a custom LOUD in PC Data Collection Tool will be provided to all teams. The custom tool is designed to help teams rapidly collect, display and interpret data and is supplementary to that collected and shared by the HQBC data analytics team. Each team will collect and submit seven Quality Improvement (QI) measures and a brief qualitative narrative summary on a monthly basis. For templates and monthly report due dates, please see the Online Learning Portal. The first report is due on **Friday, November 17, 2023**.

LOUD in PC Specific Data Collection (Teams)

The easiest way for teams to consistently track the same measure is to use the operational definitions[3] outlined in the Required Measures section of this document. For the optional measures, we suggest that teams clearly outline operational definitions to ensure consistency. This includes standardizing how the data is collected and recorded to maximize its utility. In the table below, there are several measures that will be evaluated by the HQBC team, but improvement teams can complete sampling to evaluate timely data that will reflect ongoing changes.

LOUD in PC Specific Data Collection (HQBC)

The LOUD in PC Collaborative will utilize administrative health data provided through the Health Data Platform BC (HDBPC) by the BC Ministry of Health, and will support teams in using any other existing datasets (i.e., Medinet) for the purposes of improvement work.

LOUD in PC Evaluation

Evaluation is linked to measurement. An evaluation plan is documented separately.

Data Collection Plan

Population of Focus Stratification

Teams can measure its population of focus as often as needed and will report back to the LOUD in PC team monthly.

MEASURE	OPERATIONAL DEFINITION	COLLECTION STRATEGY	FREQUENCY
Population of Focus	Patients[4] diagnosed with OUD and receiving OUD care from the participating team. To identify the population of focus, follow these steps: 1. Identify patients with OUD by generating/ creating a list. 2. Remove patients who have an external provider for OUD/OAT. 3. Remove patients not found after adequate follow-up/outreach efforts, or they have moved, are seeking care elsewhere or have died.	Manual (LOUD Data Collection Tool)	Monthly

---

[3] An operational definition provides a clear and precise description of a measure to establish common understanding. Developing an operational definition requires agreement on the method of measurement and criteria for judgment.

[4] 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.

Required Measures

ID	MEASURE	OPERATIONAL DEFINITION	STRATEGY	FREQUENCY
OUTCOME MEASURES				
O.1	Percentage of patients diagnosed with OUD with an active OAT prescription	This is defined as the number of patients diagnosed with OUD with an active OAT prescription divided by the POF: $$\frac{\text{\# of Patients with an active OAT prescription}}{\text{Population of Focus}} \times 100\%$$ An 'active OAT prescription' is an OAT prescription that has an end date on the same day or later than the date of data collection, regardless of dose.	Sampling (LOUD data collection tool)	Monthly
O.2	Number of patients receiving an OAT prescription for the first time	This measure is determined by the number of patients who received OAT for the first time this month at your primary care clinic and who have never previously been prescribed OAT. If people are started and restarted in the month only count them once. This data is calculated by counting the number of patients receiving an OAT prescription for the first time each month. **Exclusions:** Anyone who has been on OAT in the past regardless of how long the gap in OAT was.	HQBC (Health Data Platform BC) Sampling (LOUD data collection tool)	Monthly
O.3	Percentage of patients retained on OAT treatment at 3 months	For ease of calculation and in alignment with other measures, this measure is defined as the number of patients with an active OAT prescription for an uninterrupted period of 3 months or greater divided by the POF: $$\frac{\text{\# of Patients on OAT for an uninterrupted period of} \geq 3 \text{ months}}{\text{Population of Focus}} \times 100\%$$ An 'interrupted period' is defined as any time a patient needs to return to their initial dose due to missed medication.	HQBC (Health Data Platform BC) Sampling (LOUD data collection tool)	Monthly
O.4	Patient experience in care	There are a variety of ways that patient experience can be measured. There is no formula for this measure, but some examples and tools will be provided for teams if required. Teams should decide on a standardized method to assess the patient's experience in care to be reported monthly.	LOUD monthly narrative tool	Monthly

ID	MEASURE	OPERATIONAL DEFINITION	STRATEGY	FREQUENCY
O.5	Indigenous Cultural Safety	Cultural safety is an outcome defined by respectful engagement that recognizes and addresses power imbalances inherent in the health care system. It is achieved when an environment is free of racism and discrimination, and when people feel safe accessing health care (6). Indigenous cultural safety is specific to Indigenous Peoples (including First Nations, Inuit and Métis), and therefore, can only be assessed by PWLLE who identify as Indigenous. Recognizing that Indigenous people are over-represented among those living with OUD and experience significant stigma and racism in the Canadian health care system, it is especially important to ensure care is physically, psychologically, and culturally safe for them. Teams will be asked to describe how they are assessing and addressing Indigenous cultural safety in their care setting.	LOUD monthly narrative tool	Monthly

PROCESS MEASURES

ID	MEASURE	OPERATIONAL DEFINITION	STRATEGY	FREQUENCY
P.1	Number of new prescribers delivering OAT services	This data is a count of *all* new prescribers of OAT at your practice each quarterly reporting period. Please note that this count is not limited to just the team you work with for LOUD, but all new OAT prescribers at your practice. See the monthly report template for timelines. **Exclusions:** Any new prescribers included in previous reports, and existing prescribers who are expanding their practice.	Sampling (LOUD data collection tool)	Quarterly

BALANCING MEASURES

ID	MEASURE	OPERATIONAL DEFINITION	STRATEGY	FREQUENCY
B.1	Percentage of toxic drug poisoning events	Number of toxic drug poisoning events will be assessed using the health data platform, but recognizing that not all toxic drug poisoning occurrences are captured by medical records (e.g. if a patient is treated for toxic drug poisoning in the community and does not go to the hospital afterwards), manual data collection from each team may provide more timely and reliable data. These events may be patient-reported, witnessed by staff, or noted in the EMR. This measure is defined as the total number of known toxic drug poisoning events each month. 'Toxic drug poisoning events' are defined as events where a person takes too great of a dose of a substance, leading to toxicity or death. **Inclusions:** Only opioid-related toxic drug poisoning events. This will be calculated by the following formula: $$\frac{\text{\# of known toxic drug poisoning events}}{\text{Population of Focus}} \times 100\%$$	Sampling (LOUD data collection tool)	Monthly

Optional Measures

ID	MEASURE	DESCRIPTION
OUTCOME MEASURES		
O.6	Percent of patients retained in active treatment or clinic care	Not all patients will choose to remain on OAT but may remain in the care of the team's clinic and seek other treatment options. This measure allows teams to identify those who may not meet the criteria of 3-month retention on OAT (outcome measure).
O.7	Number of new OAT prescriptions that are dispensed by the pharmacy	While measure O.2 tracks the number of patients who receive a new OAT prescription, this measure is intended to assess how many of these initial prescriptions are filled and dispensed by the pharmacy.
O.8	Number of prescribers delivering expanded OAT services	This process measure allows teams to identify how many providers have completed additional training for prescribing OAT. This can be a useful measure for teams who are not bringing on new prescribers but are looking to expand access to OAT.
O.9	Number of clients who report a reduction in opioid use since being connected to OAT services	This measure can be used to assess the improvement efforts focused on increasing supports and retention on OAT.
O.10	Number of clients who indicate an increase in harm reduction practices since being connected to OAT services	This measure can be used by any teams who are looking to improve harm reduction and safer supply work. Additionally, it can be used to assess goals of care conversations and overall trauma-informed practices.
PROCESS MEASURES		
P.2	Percentage of encounters with the population of focus where goals of care are discussed	This measure helps to assess if goals of care defined by patients living with OUD are assessed with each encounter. 'Goals of care' include any aims that are informed by a patients' values and priorities to guide decisions on medical treatment, including social aims beyond treatment such as housing, job stability, etc. (7)
P.3	Number of patients successfully connected with community supports	This helps to assess if patients are accessing community resources that they are referred to.
P.4	Number of team members who complete OAT educational modules	This measure assesses how often POATSP and ACTOC training are being accessed. These educational modules can be used as a tool to engage and educate staff, whether in a clinical or administrative role.
P.5	Number of team members who complete POATSP training/ preceptorship	This measure assesses the efforts of new prescribers in their journey to prescribing OAT, including their training hours. POATSP training and preceptorship is required for those who wish to expand prescribing practices.

ID	MEASURE	DESCRIPTION
P.6	Number of patients who are provided with (or information about where to obtain) harm reduction supplies	This measure can be reflective of harm reduction improvement efforts. An important aspect of providing trauma-informed care to those with OUD is to include wrap-around services.
P.7	Number of prescriptions acquired using peer delivery services	This measure is only applicable if engaging in efforts that include a medication peer delivery service from pharmacies.
P.8	Number of patients lost to contact	This measure would be useful for teams endeavouring to improve retention on OAT and those connecting patients with community resources.
P.9	Patient evaluation of stigma in the primary care setting	This measure is useful for teams endeavouring to reduce stigma, improve trauma-informed practice, and create a sense of community in their care setting. Patients can be surveyed for their assessment of stigma experienced in the clinic.
P.10	Number of and rationale for missed OAT appointments	When endeavoring to improve retention on OAT, it can be helpful to assess the number of missed appointments the clinic experiences. Taking it a step further and capturing the patient voice in why they missed an appointment can help to assess improvement efforts and identify new ones moving forward.
BALANCING MEASURES		
B.2	Time required to collect data/ feasibility	An important balancing measure of improvement work is to assess the time it takes to evaluate efforts. This can be assessed by tracking time to measure efforts, or through qualitative staff surveys.
B.3	Impact on care delivery (i.e., clinic wait times, clinic booking space)	By engaging in OAT improvement work, it is important to assess if there are unintended impacts on other areas of care delivery. This is a balancing measure that can be used to assess not only impact but the sustainability of improvement efforts.
B.4	Staff experience in care	It is important to note that experience in care encompasses everyone in the primary care environment, including staff/team members. This can be helpful in assessing change ideas that impact workflows or culture.
B.5	Community partners' experience in care	It is particularly important to assess community partners' experiences when engaging in improvement efforts together. Community partners could include pharmacists, peer navigators, etc.

Appendices

APPENDIX A: OPTIONAL MEASURES & ASSOCIATED CHANGE IDEAS

This appendix is designed to guide measurement of the change ideas outlined in the LOUD in PC Change Package. These measures are suggestions of how implemented changes can be evaluated, and the list is not exhaustive. Depending on the change idea, some *process* or *balancing* measures can be an *outcome* measure, and vice versa. If you have any questions about measurement or require further support, please reach out to the LOUD in PC team.

CHANGE IDEA ID	OPTIONAL MEASURE ID
1.1.1	O.8, P.4, P.5
1.1.2	O.7, O.8, O.9, P.10, B.2, B.4
1.1.3	O.8, P.4, P.5, B.4
1.1.4	O.8, O.9, O.10, B.3, B.4
1.2.1	O.6, O.10, P.3, P.6, P.8, P.9, P.10, B.3, B.4, B.5
1.2.2	O.8, P.4, P.5, B.4
1.3.1	O.8, B.4
1.3.2	O.8, B.4
1.3.3	O.8, P.9, P.10, B.4
1.3.4	O.8, P.9, P.10, B.4
1.3.5	P.4, P.5, P.8, P.9, P.10, B.4
1.4.1	O.7, O.8, O.9, O.10
1.4.2	O.7, O.8, O.9, O.10, P.3, P.6, P.8, P.9, P.10, B.2, B.3, B.4, B.5
1.4.3	O.8, P.4, P.5, P.9, B.4
2.1.1	O.6, O.9, O.10, P.2, P.3, P.8, P.10, B.2, B.3, B.4, B.5
2.1.2	O.6, P.8, P.9, P.10, B.3, B.4
2.2.1	P.9, P.10
2.2.2	O.7, O.9, O.10, P.3, P.6, P.9, B.5
2.2.3	O.6, O.7, O.8, O.9, O.10, P.2, P.8, B.3, B.5
2.2.4	O.9, O.10, P.2, B.2, B.3, B.4
2.2.5	O.7, O.8, O.9, O.10, P.10, B.3, B.4
2.3.1	O.6, O.7, P.2, P.3, P.6, P.7, P.9, P.10, B.2, B.3, B.4, B.5
2.3.2	O.6, O.9, O.10, P.2, P.10, B.3
2.3.3	O.6, O.9, O.10, P.2, P.9, B.2, B.3, B.4
2.3.4	O.6, O.8, O.9, O.10, P.2, P.3, P.6, P.8, P.9, P.10, B.3, B.4
2.4.1	O.6, P.2, P.3, P.6, P.9, P.10

CHANGE IDEA ID	OPTIONAL MEASURE ID
2.4.2	O.6, P.2, P.3, P.6, P.9, P.10
2.4.3	O.6, P.2, P.3, P.6, P.9, P.10
2.4.4	O.6, P.8, P.9, P.10, B.3, B.4
2.4.5	O.6, P.3, P.8, P.9, P.10, B.2, B.4
3.1.1	O.6, O.9, O.10, P.3, P.6, P.7, P.8, P.10, B.2
3.1.2	O.6, O.8, P.4, P.5, P.9, B.4
3.1.3	O.6, O.10, P.3, P.6, P.7, P.8, P.9, P.10, B.2, B.3, B.5
3.2.1	P.2, P.6, P.8, P.9, B.3
3.2.2	O.6, O.10, P.3, P.6, P.7, P.8, P.9, P.10, B.2, B.3, B.5
3.2.3	O.6, O.9, O.10, P.3, P.6, P.7, P.8, P.9, P.10, B.2, B.3, B.5
3.2.4	O.6, O.9, O.10, P.3, P.6, P.7, P.8, P.9, P.10, B.2, B.3, B.5
4.1.1	O.6, O.7, P.2, P.3, P.6, P.7, P.8, P.10, B.2, B.3, B.4, B.5
4.1.2	O.8, P.3, P.10, B.3, B.4
4.1.3	O.6, O.7, P.2, P.8, P.9, P.10, B.2, B.3, B.4
4.1.4	O.7, O.9, O.10, B.3, B.4
4.1.5	O.7, O.9, O.10, P.2, B.3, B.4
4.2.1	O.6, O.7, O.9, O.10, P.2, P.7, P.8, P.9, P.10, B.2, B.3, B.4, B.5
4.2.2	O.6, O.7, O.9, O.10, P.8, P.10, B.2, B.3 B.4
4.2.3	O.6, O.7, O.9, O.10, P.7, P.8, P.9, P.10, B.2, B.3, B.4, B.5
4.2.4	O.7, O.9, O.10, B.2, B.3, B.4
4.2.5	O.7, O.9, O.10, B.2, B.3, B.4
4.2.6	O.7, O.9, O.10, P.9, B.2, B.3, B.4
4.2.7	O.7, O.9, O.10, P.9, B.2, B.3, B.4
4.2.8	O.9, O.10, P.2, P.9, B.2, B.3, B.4
4.2.9	O.9, O.10, P.2, P.9, B.2, B.3, B.4
4.3.1	O.7, O.9, O.10, P.3, P.7, P.9, P.10, B.2, B.3, B.4, B.5
4.3.2	O.7, O.9, O.10, P.3, P.7, P.9, P.10, B.2, B.3, B.4, B.5
4.3.3	O.7, O.9, O.10, P.3, P.7, P.9, P.10, B.2, B.3, B.4, B.5
4.3.4	O.7, O.9, O.10, P.3, P.7, P.9, P.10, B.2, B.3, B.4, B.5
4.3.5	O.7, O.9, O.10, P.3, P.7, P.9, P.10, B.2, B.3, B.4, B.5
4.4.1	O.6, O.9, O.10, P.2, P.3, P.6, P.9, B.3, B.4, B.5
4.4.2	O.6, O.7, O.9, O.10, P.3, P.6, B.3, B.4
4.4.3	O.6, O.7, O.9, O.10, P.2, P.3, P.6, P.8, P.9, P.10, B.2, B.3, B.4, B.5
4.4.4	O.6, O.7, O.9, O.10, P.2, P.3, P.6, P.8, P.9, P.10, B.2, B.3, B.4, B.5

APPENDIX B: ABBREVIATIONS & DEFINITIONS

This appendix provides definitions and further information for abbreviations and words commonly used throughout the Measurement Guide.

- **Balancing Measure:** A measure that helps to assess unintentional impacts of an implemented change idea. This is done to ensure that changes to improve one part of the system are not causing new problems in other areas. Balancing measures can be assessing positive or negative impacts on the system.

- **Cultural Safety:** An outcome of cultural competence and responsiveness, defined and experienced by those who receive the service. It is based on understanding the power differential discriminations inherent in the health service delivery system.

- **OAT (Opioid Agonist Therapy):** 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 (8).

- **Person living with OUD (Opioid Use Disorder):** Person who meets criteria for opioid use disorder (OUD) as defined by the DSM-5.

- **Outcome Measure:** These measures show if changes are leading to improvement and achieving the overall aim of the project. Outcome measures are closely aligned with the aims of your improvement efforts.

- **People with lived and living experience (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 (9). This population has experienced the system firsthand and can lend invaluable insight to improvement efforts. PWLLE is sometimes used interchangeably with the term "peers".

- **Process Measure:** These measures show whether a specific change is having its intended effect.

- **Toxic Drug Poisoning:** Defined as events where a person takes too great of a dose of a substance, leading to toxicity or death.

References

1. Health Quality BC. [Internet].; 2020 [cited 2023 Aug 31]. Available from: https://healthqualitybc.ca/bc-health-quality-matrix.

2. BC Ministry of Health. Provincial health officer declases public health emergency. [Internet].; 2016 [cited 2023 Aug 30]. Available from: https://news.gov.bc.ca/releases/2016HLTH0026-000568.

3. British Columbia Coroners Service. Illicit Drug Toxicity Deaths in BC, January 1, 2016 - December 31, 2022. [Internet].; 2023 [cited 2023 Aug 30]. Available from: https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/bccs_illicit_drug_summary_infographic_2016-2022_infographic.pdf.

4. British Columbia Coroners Service. Unregulated Drug Deaths in B.C. (to Jul. 31, 2023. [Internet].; 2023 [cited 2023 Aug 30]. Available from: https://app.powerbi.com/view?r=eyJrIjoiYTdiOGJlMmYtZTBmMC00N2FlLWI2YmYtMDIzOTY5NzkwODViIiwidCI6IjZmZGI1MjAwLTNkMGQtNGE4YS1iMDM2LWQzNjg1ZTM1OWFkYyJ9

5. Solberg, L. I., Mosser, G., & McDonald, S. The three faces of performance measurement. Jt Comm J Qual Improv. 1997; 23(3); 135-47.

6. British Columbia Patient-Centred Measurement. Our Journey: The Development of a Module of Self-Reported Questions to Explore Cultural Safety from the Perspective of British Columbia's Patients [Internet.].; 2022 [cited 2023 October 3]. Available from: https://fs.hubspotusercontent00.net/hubfs/21093253/BCPCM_January2022/Pdf/IAC%20Cultural%20safety%20SHORT%20DECK%202021.11.10.pdf.

7. Secunda, K., Wirpsa, M., Neely, K., Szmuilowicz, E., Wood, G., Panozzo, E., McGrath, J., Levenson, A., Peterson, J., Gordon, E., & Kruser, J. Use and meaning of "Goals of Care" in the healthcare literature: a systematic review and qualitative discourse analysis. J Gen Intern Med. 2020; 35(5); 1559-66.

8. Vancouver Coastal Health. Protocol: Harm Reduction and Substance Use Safety Planning – Community and Long Term Care. [Internet].; 2023 [cited 2023 October 3]. Available from: http://shop.healthcarebc.ca/vch/VCHDSTs/D-00-13-30292.pdf.

9. Canadian Centre on Substance Use and Addiction. [Internet].; 2023 [cited 2023 October 3]. Available from: https://www.ccsa.ca/lived-and-living.