LOUD

Improving Access to Opioid Agonist Therapy in Primary Care

Guidance for Clinical Teams

HQBC
HEALTH QUALITY BC

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 Health Quality BC

Our purpose is improving health care quality across British Columbia.

Our work is to build a foundation of quality, and our impact means better health care for British Columbians.

We do this by delivering the latest knowledge from home and abroad to champion and support high-quality care for every person in BC. This system-wide impact requires creativity, innovative thinking, and evidence-informed strategies to shift culture, improve clinical practice and accelerate health care partners' improvement efforts.

We are uniquely positioned to build strong partnerships with patients and communities, care providers, health leaders, policymakers, senior executives, academics and others. These connections enable us to nurture networks, recognize the needs of BC's health care system and build capacity where it is needed the most. We provide advice and make recommendations to the health system, including the Minister of Health, on matters related to quality of care across the province.

To learn more about our work and how we help improve the quality of care, visit healthqualitybc.ca.

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Overview

BACKGROUND

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.[1] Despite incredible efforts across the province, the number of deaths related to toxic drug poisonings continues to remain elevated.

Sustained Opioid Agonist Therapy (OAT), in conjunction with behavioural and community supports, remains the most effective treatment option for people living with opioid use disorder (OUD).[2,3] Despite this widespread understanding, successful initiation and retention on OAT proves to be challenging. A recent study in British Columbia showed that less than 60% of all patients initiated on OAT complete the process and of those, only half reach the maintenance stage at the minimum effective dose.[4,5] Some of the barriers to OAT initiation and retention include inconsistent access to OAT prescribers, OAT medications, stable housing and community supports. It is undeniable that the treatment of OUD is complex, but by addressing these barriers teams can improve the lives of countless individuals with OUD.

ABOUT LOUD IN PC

The LOUD in Primary Care (LOUD in PC) Collaborative was designed to support primary care providers and people living with OUD to achieve their goals for care in communities across BC through increased accessibility to OAT, particularly within semi-urban, rural and Indigenous communities. LOUD in PC was led by HQBC in partnership with the BC Centre on Substance Use (BCCSU) and health system partners, with funding from the Ministry of Health and Ministry of Mental Health & Addiction, supported through the Community Action Initiative. We would like to recognize all members of our Expert Group (see Appendix B) and participants of the OAT in BC journey mapping session in March 2023 whose contributions and perspectives are incorporated in this resource.

In addition to these groups, change ideas were 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)

HQBC HEALTH QUALITY BC

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

cai community action initiative

[1] BC Ministry of Health. Provincial health officer declasres public health emergency. [Internet].; 2016 [cited 2025 Jan 3]. Available from: https://news.gov.bc.ca/releases/2016HLTH0026-000568.

[2] The Centre for Addiction and Mental Health. Canadian Opioid Use Disorder Guideline. [Internet]. [cited 2025 Jan 3]. Available from: https://www.camh.ca/en/professionals/treating-conditions-and-disorders/canadian-opioid-use-disorder-guideline.

[3] The Centre for Addiction and Mental Health. Opioid Agonist Therapy: A Synthesis of Canadian Guidelines for Treating Opioid Use Disorder. [Internet].; 2021 [cited 2025 Jan 3]. Available from: https://www.camh.ca/-/media/professionals-files/canadian-opioid-use-disorder-guideline2021-pdf.pdf

[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.

Navigating the Change Package

This change package was originally designed for teams participating in the LOUD in PC Collaborative. It has been adapted for use by the wider health system and includes the most utilized and successful change ideas implemented by participating teams and faculty members. The purpose of this document is to provide primary care teams with tangible ideas to improve access[5] to high-quality OUD care, including OAT. 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 initiated and retained on OAT.

Teams are encouraged to test and tailor the change ideas to their specific care setting and identify the ideas that best align with their patients' needs and clinic's goals.

The primary drivers (i.e., major themes) that helped to achieve the aim of increased initiation and retention on OAT include:

1. OAT & OUD education and training
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 page 7.

The images included throughout this document are taken from a Journey Mapping Session on OAT in Primary Care in BC held in 2023.

[5] Accessibility is the extent to which people can readily obtain care when and where they need it. As outlined in the BC Health Quality Matrix, 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.

Making Improvements

A key part of improving care may involve following a quality improvement process. A common Model for Improvement asks three basic questions: What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in improvement?

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 help 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.

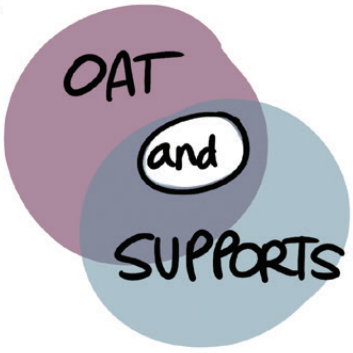
A driver diagram is typically broken down into several parts, including:

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.

Resources

There are resources available on the HQBC website that correspond with the change ideas listed below. They include journal articles, video testimonials, webpages, templates, worksheets, point-of-care resources and more.

https://healthqualitybc.ca/improve-care/substance-use/learning-about-opioid-use-disorder-loud/loud-in-primary-care-pc/



Driver Diagram

PRIMARY DRIVER	SECONDARY DRIVER	CHANGE IDEA (Click on each change idea to read more details)
1 OAT & OUD Education and Training	**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
		1.1.2 Support novice OAT prescribers with connection to mentorship
		1.1.3 Support prescribers to complete Sublocade manufacturer training and advanced injectable OAT (iOAT) training
	1.2 Provide team learning and capacity-building opportunities	1.2.1 Use just-in-time OAT practice supports
		1.2.2 Join or establish a community of practice
		1.2.3 Support non-prescribers to complete OUD education
		1.2.4 Incorporate OAT education into onboarding
	1.3 Provide prescribers with up-to-date resources on OUD care	1.3.1 Review Guidelines for the Clinical Management of OUD annually
		1.3.2 Adapt OAT and OUD practice supports for prescribers to your clinical context
2 Positive Experience in Care	**2.1** Build patient awareness, knowledge and autonomy regarding OAT	2.1.1 Build collaborative care plans with patients
		2.1.2 Inform patients when OAT options change or expand
		2.1.3 Ensure OAT patient information is available and accessible
	2.2 Address barriers in patient care planning	2.2.1 Standardize OAT referral pathways
		2.2.2 Standardize OUD screening
	2.3 Create a welcoming and safe environment for patients and team members	2.3.1 Support team members to complete anti-stigma and anti-racism training
		2.3.2 Address anti-Indigenous racism in your practice setting and processes
		2.3.3 Support team members to complete trauma-informed practice training
		2.3.4 Design a low-barrier waiting area
3 Connections to Community and Peer Services	**3.1** Spread awareness and support of peer worker roles in OUD care	3.1.1 Provide access to peer support workers in your clinic
	3.2 Encourage patients to use community support services	3.2.1 Provide Take Home Naloxone kits and facilitate training
		3.2.2 Provide low-barrier harm reduction supplies
		3.2.3 Build relationships with community services
4 Care Flow	**4.1** Minimize time to OAT administration	4.1.1 Provide same-day assessment and treatment
		4.1.2 Offer drop-in hours
		4.1.3 Optimize scope of practice and develop team-based care
	4.2 Design low-barrier clinic processes	4.2.1 Automate reminders for appointments and medication
		4.2.2 Standardize follow-up with patients
		4.2.3 Update patient contact information regularly
		4.2.4 Evaluate urine drug testing practices
		4.2.5 Develop a process to bridge OAT prescriptions
		4.2.6 Offer a variety of dosing schedules for OAT
	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 Optimize workflows with pharmacy
	4.4 Optimize functionality of charting systems	4.4.1 [EMR] Use standard diagnostic codes
		4.4.2 [EMR] Use templates and adjust chart views for OAT visits
		4.4.3 [Paper Charting] Develop standardized documentation/pre-printed assessment and treatment tools for care pathways

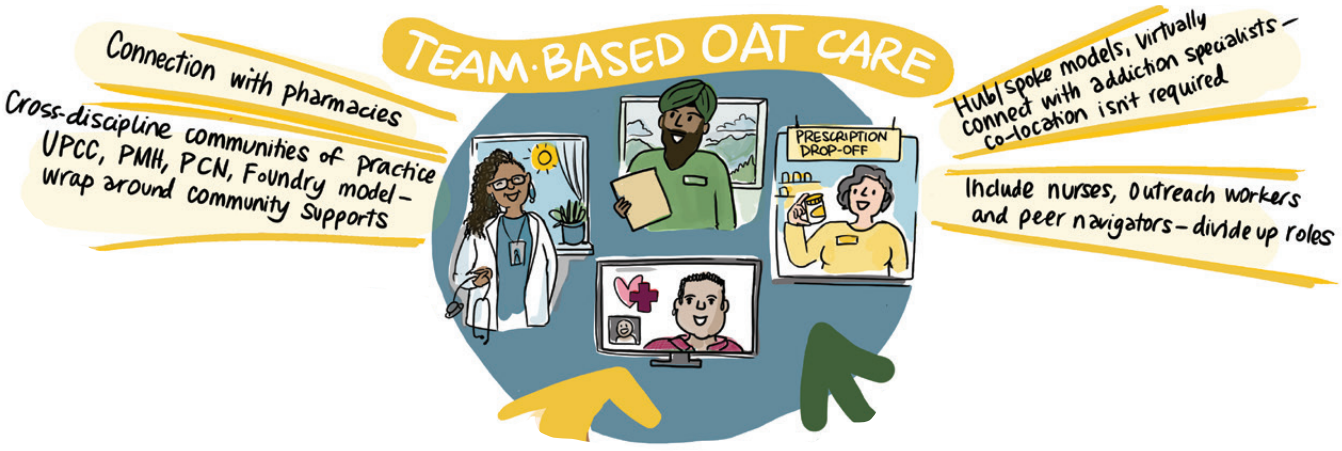
Change Ideas

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.

The 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.

Please note the following about the "WHO" description:

- Prescribers include physicians, nurse practitioners and nurse prescribers.
- Administrators include medical office assistants, clinical managers and other non-clinical staff.
- People with Lived or Living Experience (PWLLE) refers to people who have lived experience with substance use. This term is used throughout the document. Peer is used instead of PWLLE in some contexts, notably when referring to peer workers.
- Pharmacists may also refer to the pharmacy administrative team for some change ideas.
- 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 OPIOID AGONIST THERAPY & OPIOID USE DISORDER 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 Provincial Opioid Addiction Treatment Support Program (POATSP) education

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 nurses pursuing certified practice in OUD (CP-OUD) care must complete the basic training to begin prescribing buprenorphine/naloxone.

WHO: Prescribers.

HOW: Register online for POATSP training, which is delivered by the BCCSU.

1.1.2 Support novice OAT prescribers with connection to mentorship

WHAT: Mentorship for prescribers can be formal or informal, and can be within a clinic or outside of that space. Leaders can support prescribers by creating conditions for effective mentoring (e.g., education, programs) in OAT prescribing.

WHY: With the evolving toxic drug supply and emerging evidence in OUD care, having informal mentorship for prescribers is invaluable. This provides a trusted and consistent 'sounding board' for clinicians when making decisions in this complex patient population.

WHO: Prescribers and administrators.

HOW: Formal mentorship can include programs within clinics, health authorities or communities of practice. Informal mentorship can include encouraging prescribers to seek support from fellow clinicians that they have rapport with as they develop their OAT prescribing skills.

1.1.3 Support prescribers to complete Sublocade manufacturer training and advanced injectable OAT (iOAT) 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. Additionally, prescribers learn about iOAT prescribing and administration in the POATSP course offered through the BCCSU.

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, a monthly subcutaneous injection, is a valuable treatment option for individuals with OUD and is an option to expand care options at your clinic. This medication does not require daily witnessed ingestions and can be a good option for patients who are looking for more flexibility with their OAT. 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. POATSP for prescribers is available through the BCCSU.

1.2 Provide team learning and capacity-building opportunities

1.2.1 Use just-in-time OAT practice supports

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

WHY: Prescribers may feel uncomfortable, have questions 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 alongside basic education can help to encourage their use by clinicians.

1.2.2 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. The BC ECHO on Substance Use provincial community of practice hosted by the BCCSU is open to primary care providers, allied health providers and other frontline workers in BC.

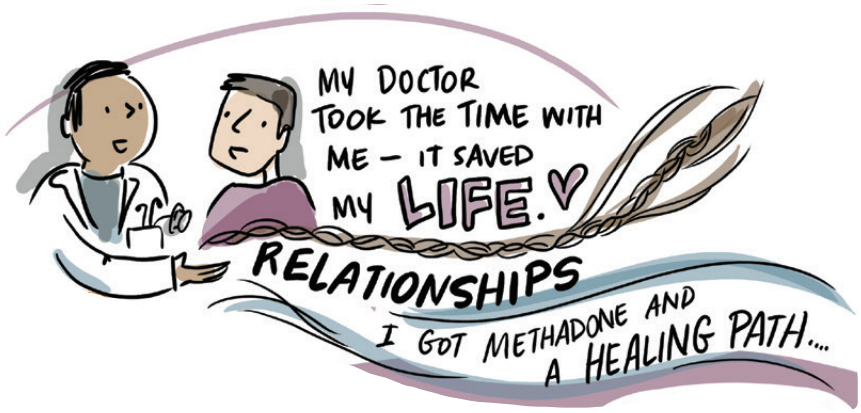
1.2.3 Support non-prescribers to complete OUD education

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. Several health authorities also host asynchrous education modules for both clinical and non-clinical staff members.

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.



1.2.4 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.

1.3 Provide prescribers with up-to-date resources on OUD care

1.3.1 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. This includes reviewing the BCCSU website for new and updated practice support tools and resources.

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 allows your team to provide 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 newsletter to receive updates.

1.3.2 Adapt OAT and OUD practice supports for prescribers to your clinical context

WHAT: Create or adapt practice supports (tools used at the point-of-care) for OAT and OUD. These supports should be co-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 for and source them through learning opportunities, colleagues or by creating your own.

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 people with lived or living experience (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 Build patient awareness, knowledge and autonomy regarding OAT

2.1.1 Build collaborative care plans 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. It allows for effective decision-making about the formulation of OAT that is most appropriate for the patient.

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.

2.1.2 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).

2.1.3 Ensure OAT patient information is available and accessible

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 Address barriers in patient care planning

2.2.1 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.

2.2.2 Standardize OUD screening

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. Ensure that you ask for consent to speak with the patient about substance use at the outset of the appointment.

2.3 Create a welcoming and safe environment for patients and team members

2.3.1 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 and 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. Connect with peer-led organizations in your community to learn more about what is available to your team.

2.3.2 Address anti-indigenous racism in your practice setting and processes

WHAT: Ongoing work by all team members in anti-Indigenous racism training to gain a wider understanding of the injustices faced by First Nations, Métis and Inuit People and the ongoing impacts that colonialism has on their communities. 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 the challenges of OUD. Collect race-based and Indigenous identity data in your clinic.

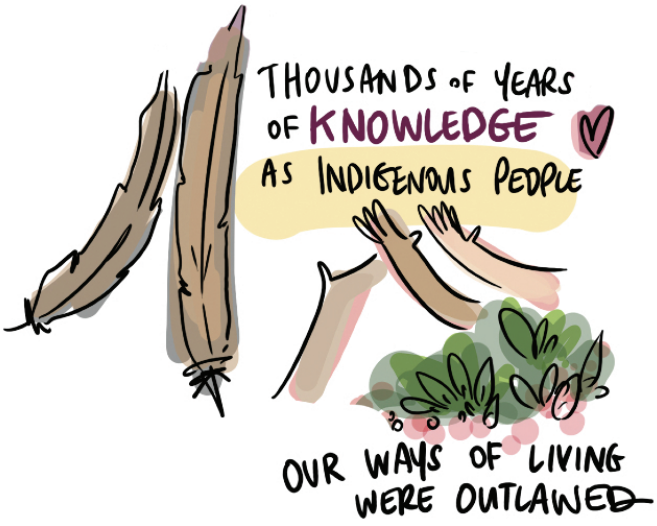
WHY: Indigenous People are disproportionately represented in toxic drug poisoning fatalities. Health inequities experienced by Indigenous People reflect continuing structural and systemic disadvantages created through the impacts of ongoing colonization and wide-spread Indigenous-specific racism, as 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, recognizing the centrality of cultural connection and sovereignty as a source of healing, 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.

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 in an appropriate and respectful manner.



2.3.3 Support team members to complete trauma-informed practice training

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

WHY: Trauma and violence-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. Review educational offerings hosted by your health authority or professional bodies.

2.3.4 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, colourful 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.

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 worker roles in OUD care

3.1.1 Provide access to peer support workers in your clinic

WHAT: Peer workers can hold a variety of roles for OAT 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.

WHY: There are well-known barriers to access and engagement in OAT, including known stigma facing people who use substances, 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: Prescribers, pharmacists and peer workers.

HOW: Post a peer worker employment position to local community services and peer-led organizations and seek referrals. Connect with your health authority and Community Action Team (CAT) to discuss supports available for peer support workers in the primary care setting.

3.2 Encourage patients to use community support services

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: Prescribers, 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 Provide low-barrier harm reduction supplies

WHAT: Harm reduction supplies include but are not limited to supplies for safer injection and inhalation, drug checking supports including fentanyl test strips and Take Home Naloxone kits. Low-barrier access implies that these supplies are available to anyone in the clinic, regardless of patient-status or appointment time/location.

WHY: Harm reduction saves lives. This helps to reduce transmission of disease and infection and can reduce the risk of a toxic drug poisoning event. Additionally, having supplies readily available in clinic signals to patients that you have their best interests in mind and that you are a safe person for them to discuss their substance use with.

WHO: Prescribers and pharmacists.

HOW: Low-barrier access could look like supplies available in an unlocked cupboard or designated space in the waiting area. Some clinics have them available in small vending machines in their entrance.

3.2.3 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.

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 time to OAT administration

4.1.1 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 medical office assistant (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 medication offered.

4.1.2 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 medical office assistants (MOA) 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.

4.1.3 Optimize scope of practice and develop team-based care

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 use 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.

4.2 Design low-barrier clinic processes

4.2.1 Automate reminders for appointments and medication

WHAT: Automate patient 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.

4.2.2 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 prescriptions supports OAT retention.

WHO: Administrators and pharmacists.

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

4.2.3 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 methods 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?'

4.2.4 Evaluate urine drug testing practices

WHAT: Review your current urine drug testing (UDT) processes and evaluate them. Consider 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.

4.2.5 Develop a process to bridge OAT prescriptions

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

WHY: It ensures that 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.).

4.2.6 Offer a variety of dosing schedules for OAT

WHAT: This includes offering buprenorphine/naloxone home starts or low-dose initiations for patients who are eligible.

WHY: Both strategies reduce barriers to access to OAT, especially for those who live in rural/remote communities and face significant barriers to regular in-person appointments. Low-dose initiations reduce the risk of a patient experiencing precipitated withdrawal from OAT initiation and allows for a gradual titration to reduce withdrawal symptoms.

WHO: Prescribers and pharmacists.

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 initiations 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.

4.3 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 expanded scope is key to delivering more effective, timely and 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.

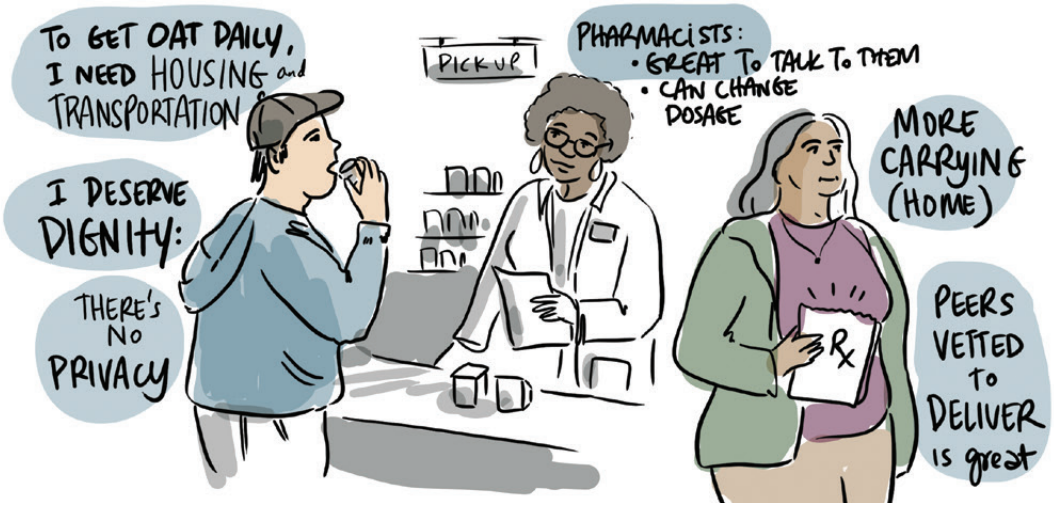
4.3.3 Optimize workflows with pharmacy

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 identification, communication methods, missed doses, harm reduction and more. For teams with existing processes, you can use process mapping to help identify areas of improvement.



4.4 Optimize functionality of charting systems

4.4.1 [EMR] Use standard diagnostic codes

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

WHY: Optimize processes for tracking, monitoring and 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.

WHO: Administrators and prescribers.

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

4.4.2 [EMR] Use templates and adjust chart views for OAT visits

WHAT: Development of EMR templates for patients receiving OAT.

WHY: Increase efficiency and accuracy of OAT care documentation.

WHO: Administrators.

HOW: 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.

4.4.3 [Paper Charting] Develop standardized documentation/pre-printed assessment and treatment tools for care pathways

WHAT: Develop standard templates for patient visits, including patient intake and screening, new OAT initiation, missed dose protocol, OAT restart protocol and escalation of care.

WHY: Increase efficiency and accuracy of OAT care documentation. This also facilitates accurate data collection related to OAT improvement work.

WHO: Administrators.

HOW: Team to develop a standard fillable charting template for various roles. This team-based care exercise can include a variety of options that guide clinical care and decision-making, while also leaving room to customize based on collaborative care planning.

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/
- **NA:** Narcotics Anonymous
- **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.
- **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

APPENDIX B: EXPERT GROUP

We would like to recognize all members of the LOUD in PC Expert Group whose experience and perspectives were incorporated throughout the program materials:

Aman Haji, Fraser Health, First Nations Health Authority & Provincial Health Services Authority
Amber Froste, First Nations Health Authority
Chase Simms, Guidelines & Protocols Advisory Committee
Chelsea Hochfilzer, Health Quality BC
Cole Stanley, Shared Care Committee & BOOST Collaborative
Colin O'Neill, Health Quality BC
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Donna Molina, Health Quality BC
Douglas McTaggart, Guidelines & Protocols Advisory Committee
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Greg Hemminger, Tailgate Toolkit
Jenny McDougall, Coalition of Substance Users of the North
Jill Murray, Ministry of Mental Health & Addictions
Joanna Paterson, Carrier Sekani Family Services
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