Best-Practices in
ORAL OPIOID AGONIST
THERAPY Collaborative

Change Package

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Introduction

In 2016, a public health emergency was declared in British Columbia due to a dramatic increase in opioid-related overdose deaths. There were 967 confirmed overdose deaths in 2016, of which 211 occurred in Vancouver Coastal Health (VCH). Several targeted services were launched in response, but the number of opioid-related overdose deaths remains well above historical averages.

Evidence shows a significant proportion of individuals with opioid use disorder (OUD) will see improved outcomes with appropriate doses of oral opioid agonist therapy (oOAT) such as methadone, buprenorphine/naloxone or slow release oral morphine (SROM). However, current provincial data shows that only half of people receiving methadone achieve an optimal dose. Optimal doses of oOAT have been shown to improve treatment retention, prevent HIV and HCV infection, and lower mortality rates. Provincially, fewer than half of those who start methadone are still on this treatment at six months, and this number is even lower at one year.

Our current systems of care are not optimized to provide the highest quality healthcare to those living with OUD in British Columbia. Together, we can make improvements across the Continuum of OUD Care[1] and improve the lives of those we serve.

But what changes can we make that will result in improvement? This **Change Package** is a collection of ideas for change. It is designed to prompt your thinking and accelerate your team's ability to make improvements within your own context.

Using this document

This document includes ideas for improvement and change that are organized by the key domains of the cascade of care. They have been grouped into three sections:

1. Diagnosis and Treatment Initiation
2. Treatment Retention and Optimal Dosing
3. Quality of Life and Bundle of Care

Test ideas of interest in your own system using the PDSA method described in the **Preparation Resource Manual**. Each small test of change can collectively make a substantial difference to improve care for those living with OUD!

[1] The Continuum of OUD Care refers to the comprehensive and connected array of health services spanning all levels of intensity of care within the community and health system.

Guidelines for the Clinical Management of Opioid Use Disorder: Major Recommendations

→ Opioid withdrawal alone is not recommended for treatment of OUD in most patients because of increased risks of overdose death and infectious disease, particularly HIV through intravenous drug use, following detoxification (moderate-quality evidence; strong recommendation).

→ In the absence of contraindications, medically supervised opioid agonist treatment should be offered to all patients. Buprenorphine/naloxone is the preferred first-line treatment. Methadone is an alternative in certain patient populations (high-quality evidence; strong recommendation).

→ Psychosocial supports tailored to patient needs may be offered as an adjunct to medical treatment (moderate-quality evidence; conditional recommendation).

Key Points in Treating Opioid Use Disorder

1. Substance use is a complex but treatable disease that affects brain function and behaviour
2. No single treatment is appropriate for everyone
3. Treatment needs to be readily available
4. Effective treatment attends to multiple needs of the individual, not just their substance use
5. Remaining in treatment for an adequate period of time is crucial
6. In the absence of contraindications, medically supervised opioid agonist treatment should be offered to all patients
7. An individual's treatment plan must be assessed continually and modified as necessary to ensure it meets their changing needs
8. Many individuals with substance use disorder have other co-morbid mental health problems
9. Medically-assisted detoxification is only one stage of substance use treatment and is not recommended in isolation
10. Clients should be regularly assessed for ongoing substance use while on oOAT, as decreased use is a strong indicator that the treatment is working
11. Clients with OUD should be linked to a program that offers a full spectrum of primary care services.

Aim Focus 1: Diagnosis and Treatment Initiation

An estimated 3,200 individuals[2] in the Vancouver community have been diagnosed with OUD, [2]which likely grossly underestimates the true burden of OUD. Through increased screening of high risk populations (e.g. those on long-term opioid therapy for chronic non-cancer pain) and reaching out to our community's most marginalized and vulnerable, increases in estimated local prevalence are likely to be seen. If we offer low barrier easy-to-access services, coupled with harm reduction services, then we have a better chance at early linkage to care. With this, early diagnosis and treatment of OUD can lead to decreased morbidity and mortality, and lower the risk of relapse.

See the **Guide to measurement** for suggested measures.

With your team, identify where each change idea fits with the following rating scale (see Appendix I for details)**:**

A = Easy Wins **B = Highest Priority**

C = Strategic Ideas **D = Low Priority**

CHANGES TO TRY

Screening and Diagnosis

→ Consider expanding screening for high-risk populations (e.g. people with chronic pain).

→ Prepare a list of all clients in the clinic on long-term opioids and screen them for OUD at next regular visit.

→ Prepare a list of all urine drug screen results at the clinic in the past year and screen for OUD in those with positive opiates if there is no diagnosed OUD.

→ Ensure screening is offered in a culturally-sensitive, non-judgmental manner.

- San'yas Indigenous Cultural Safety Training.
- Trauma-informed practice training/education.

→ Social workers, nurses, counsellors, or peers perform initial evaluation, screening education.

→ Provide support and empathy throughout the screening process.

[2] Estimates from Profile EMR data pulled from the clinics participating in the Collaborative.

→ Standardize diagnostic code in client's Problem List. In Profile EMR, **always use 304.0 for opioid use disorder**.

- Should be straightforward for Profile EMR users if clients all have 304.0 in their problem list and primary POS is set appropriately.
- Clinicians validate client lists with related diagnostic codes and change to standard code (generate a list of clients with any keywords in the problem list, then add 304.00 where appropriate).
- Keywords may include: "Suboxone", "methadone", "MMT", "SROM", "Kadian", "OUD", "OAT", "ORT", "opioid", "opiate", "heroin", etc.).

→ Arrange for follow-up assessment and treatment for OUD on the same day.

→ Offer treatment options that align with client preferences.

A significant predictor of treatment success is shorter time to treatment from diagnosis. In addition, research shows that the first four weeks of treatment are the highest risk period for all-cause mortality and overdose-related mortality. It is essential for clients to feel supported and respected through the process from diagnosis to treatment initiation.

See the **Guide to Measurement** for suggested measures.

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CHANGES TO TRY

Linkage and Treatment Initiation

→ Make the first medical visit a good one.

- Look for and eliminate policies or guidelines that are acting as barriers to treatment initiation and deterring engagement.

- Examples include:
  - Remove requirement to attend groups prior to treatment.
  - Support OAT starts on first visit.
  - Wardstock OAT available for same day starts.
  - Establish walk-in hours.
  - Reduce time needed for inductions= door-to-dose in under two hours
- Elicit and dispel myths or popular misconceptions about treatment options
- Use client navigators and/or peer support during the initial visit.
- Allow sufficient time for initial visit.
- Help clients understand available services and focus on health literacy.
- Establish a client advisory board and/or gather feedback from each client's first visit.

→ Conduct a "walk-through" of your clinic as if you were a client trying to access care for your OUD. This may help identify barriers you may not realize exist.

→ Low barrier front desk and waiting room.

- Appropriate language use by front desk staff.
- Customer service training for front desk staff.
- Standard messaging/process for triaging clients for OAT.
- Comfortable and quiet waiting area.
- Separate private waiting area for patients with agitation/withdrawal.
- Availability of peer or front-line staff to engage clients as soon as they walk in the door.
- Educational or entertaining materials for client to review while waiting.
- Staggered appointment times to reduce total clients in waiting room.

→ Same day appointment booking availability to reduce waiting times.

→ Simplify the intake process as much as possible.

- Divide the assessment for OAT over multiple visits.
- Don't have the client repeat their story to multiple clinicians.
- Simplify and standardize the client consent form/process. E.g. Merge client consent for buprenorphine, methadone and SROM into one consent.
- Set standard for ECG to be completed at baseline or once a certain dose of methadone is reached (according to guidelines)

→ Where indicated, begin treatment in the next level of care as soon as possible, preferably offering same-day service.

→ Use recommended and evidence-based engagement skills that emphasize compassion, empathy, and respect.
→ Use techniques such as teach back or ask-tell-ask to deliver information respectfully.

→ Schedule follow-up appointments before the end of each visit.

→ Support smooth transitions in care.
- Coordinate with emergency departments, detox, and treatment centres to support inpatients with OUD in their transition to outpatient care.
- Guide other programs (primary care, substance use, mental health, outreach, and withdrawal management) to make appropriate referrals and streamline referral process.

→ Introduce a roadmap to care to show the treatment choices the client will have to make in order to continue their care journey.

→ Support clients to access care.
- Include family, friends or peers throughout the process.
- Arrange for peer support/navigation throughout the process.
- Intensive outreach for individuals not engaged in care.

→ Establish a clear standard client consent and treatment agreement process.
→ What to expect at appointments and during treatment, and what is expected of them.

→ If necessary, combine multiple intake and assessment appointments to initiate clients on treatment more quickly.

→ Take a contingency management approach and offer incentives (e.g. gift cards) as motivation to follow up and succeed in treatment.

→ Reduce discrimination, stigma, and barriers to care linkage.

→ Monitor successful entry into care.
- Consider intensive outreach for individuals not engaged in care.
- Facilitate access and initial appointments by standardizing processes and providing clearly defined options for care.

Aim Focus 2: Treatment Retention and Optimal Dosing

Research shows retention on oOAT is associated with substantial reductions in all-cause mortality and overdose-related mortality in people with opioid use disorder. In addition, longer treatment duration is associated with a reduction in illicit opioid use and improved retention. Although a high proportion of clients in Vancouver community are initiated on treatment, only one third are retained in care after a year. This presents a great opportunity for improvement for teams with demonstrated benefits to clients.

See the **Guide to Measurement** for suggested measures.

With your team, identify where each change idea fits with the following rating scale (see Appendix I for details)**:**

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CHANGES TO TRY

Treatment Retention and Optimal Dosing

→ Look for and eliminate systems or policy barriers that make retention in care difficult.

→ Establish a proactive monitoring and notification system of prescription status for all clients with OUD in your care.

- Identify clients with expired or soon to expire prescriptions for OAT.
- Identify clients with missed doses of OAT.
- Implement standardized procedure for addressing missed doses and expired prescriptions.
- Ensure that there is up-to-date contact/address information for the client and their pharmacy.

→ Ensure your care team is trained on current evidence-based guidelines for OAT treatment.

- Decision support tools for the practice.
- Ongoing educational support for care teams.
- BCCSU and UBC CPD Provincial Opioid Addiction Treatment Support Program Online Course: https://ubccpd.ca/course/provincial-opioid-addiction-treatment-support-program
- Make addictions/substance use consult expertise available by referral or telehealth.
- Use motivational interviewing.

→ Ensure each client has a most responsible provider (MRP) to organize and coordinate care.

→ Optimize clinic workflows.
- Re-assign non-clinical tasks performed by clinicians.
- Create standardized policies/procedures to manage common care transitions and for key care guidelines.
- Adjust staff schedules to meet client demand.
- Eliminate excessive or duplicate paperwork or documentation.
- Use information systems to better understand retention and respond proactively.
- Provide warm hand-off between teams/clinicians.

→ Support clients with information about oOAT in a respectful way.
- Offer individual one-on-one oOAT education at treatment initiation and on an ongoing basis.
- Use group education and counseling intervention approaches
- Use shared decision-making when appropriate.
- Use client-centred methods of giving information (e.g. ask-tell-ask, teach back).
- Provide appropriate education about the importance of adherence.

→ Tailor treatment to each client's circumstances and needs.
- Ask client to participate in treatment planning.
- Offer outreach services.

→ Engage clients in options relating to oOAT.
- Respect clients' preferences and tolerance for oOAT.
- Shared decision-making for treatment options.
- Review contraindications to certain forms of treatment, and discuss pros and cons for acceptable treatment options

→ Use registry functionality to monitor retention.
- Standardize procedures for follow-up of missed appointments.
- Standardize outreach to clients who miss a dose or have expired prescription.
- Provide high acuity and at risk clients with case management services.

→ Offer additional retention support.
- Offer reminder devices and interactive communication technologies as tools.
- Use multidisciplinary education and counseling intervention approaches.
- Offer peer support.
- Offer interventions providing case management services and resources to address food insecurity, housing and transportation need.

- Provide screening, management, and treatment for depression and other mental illnesses in combination with counseling.
- Offer contingency management (incentives) to improve retention.

→ Support clinicians to make clinical decisions in challenging situations.
- Telehealth linkages for advice to make recommendations in highly complex situations.
- Pharmacy support services available.
- Consultation with OUD experts.

→ Continued monitoring of engagement in care and oOAT dosing.

→ Anticipate challenges and proactively provide support.

→ Bolster client support networks to provide ongoing whole-person needs of individuals.

→ Regularly assess client experience and act on the data.

→ Use reminders to promote appointment attendance.
- Text message reminder for upcoming appointments.
- Personal phone call reminders.
- Use consistent and positive messaging to reinforce kept appointments.
- Incorporate client preferences into reminder strategy.

→ Clear process for bridging OAT prescriptions
- Agreement between programs
- Shared care model in clinics
- Clear guidelines from BCCSU

→ Optimize use of outreach resources
- Use as bridge between hospital and community
- Exhaust clinic based resources before accessing outreach
    - Phone calls to client, client's housing, and/or frequented places
- Use to engage client and build trust

Aim Focus 3: Quality of Life and Bundle of Care

Even when linked to care, a significant number of clients do not engage in ongoing care for a variety of reasons. Clients are especially vulnerable during the period just following the initiation of oOAT and after treatment cessation, and benefit from the support of a trusting relationship.

For clients who engage in care initially, retention in care is not guaranteed. Systems issues such as inconvenient access, a bad client experience, lack of cultural sensitivity, and lack of systematic follow-up can contribute. Client-centric issues such as substance use, mental health problems and social determinants of health may also interfere with ongoing engagement.

Engagement can be monitored by tracking visit frequency, participation in clinical monitoring (UDS), uptake of oOAT, and immunization and screening status.

See the **Guide to Measurement** for suggested measures.

With your team, identify where each change idea fits with the following rating scale (see Appendix I for details)**:**

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CHANGES TO TRY

Engagement in Care and Support

→ Look for and eliminate systems or policy barriers that make engagement in care difficult.

→ Establish harm reduction programs.

- Needle/syringe distribution programs.
- Overdose prevention with take-home naloxone.
- Supervised consumption services.

→ Regularly assess client experience and act on the data (e.g. use PROMIS quality of life measurement tool).

→ Provide client-centred care.
- Reduce fragmentation by coordinating multiple services and appointments (e.g. pair physician and pharmacy appointments for client convenience).
- Promote easy access to care (e.g. walk-in welcome, evenings available, Saturday hours, holidays).
- Engage the client in determining goals and most important first steps.
- Provide culturally safe and competent care.
- Ensure confidentiality.
- Utilize client engagement strategies including shared decision-making.
- Ask 'how are you doing?' before reviewing clinical data.

→ With client consent, link to support services (counsellor, social work, etc.) within 48 hours of first treatment.

→ Use information systems to better understand retention and respond proactively.
- Use registry functionality to monitor retention.
- Standardize procedures for follow-up of missed appointments.
- Standardize outreach to clients who miss a dose or have expired prescription.
- Provide high acuity and at risk clients with case management services.

→ Support clients between visits.
- Ensure all clients know who to contact with questions and after hours.
- Link clients with reliable sources of information (handouts, key resources, etc.).
- Link clients with appropriate community organizations.
- Encourage self-management goal setting and follow-up.

→ Offer telephone support by clinicians and/or peers.

→ Emphasize trusting relationships and respect for client priorities in care provision.
- Pacing - respect where people are and what they can do.

→ Assign a peer buddy or navigator.

→ Build community among clients.

→ Support client parents and families.
- Parents FOREVER- http://www.parentsforever.ca/
- From Grief to Action- https://www.fromgrieftoaction.com/
- Parent/family education sessions
- Offer Naloxone training for parents and families

- VCH Family Involvement Policy- http://centreforpatients.vch.ca/content.php?pid=76630&sid=5790772

→ Establish an attendance policy.

→ Establish a standardized procedure to follow up with no-shows.

→ Give counsellors and support services regular feedback on no-shows and retention.

→ Offer groups for clients not ready to start treatment.

→ Offer and book a follow-up appointment for clients not ready to start treatment

→ Remind clients about appointments.

→ Transition clients to the next level of care/appropriate level of care as soon as they are ready.

→ Provide multidisciplinary education and counseling intervention approaches.

→ Offer routine HIV testing.

→ Offer routine HCV screening test.

→ Offer STI screening.

→ Ensure immunization records are up to date.

- Hep A, Hep B, etc.

References & Resources

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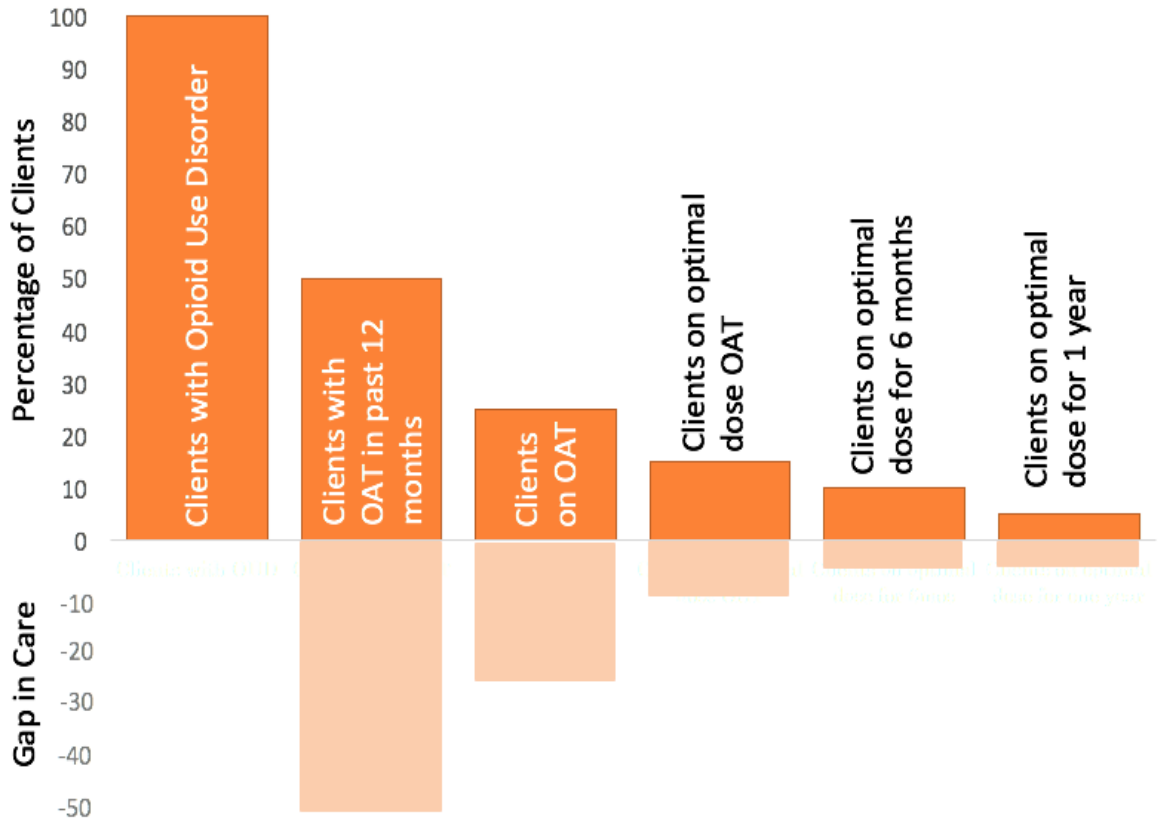
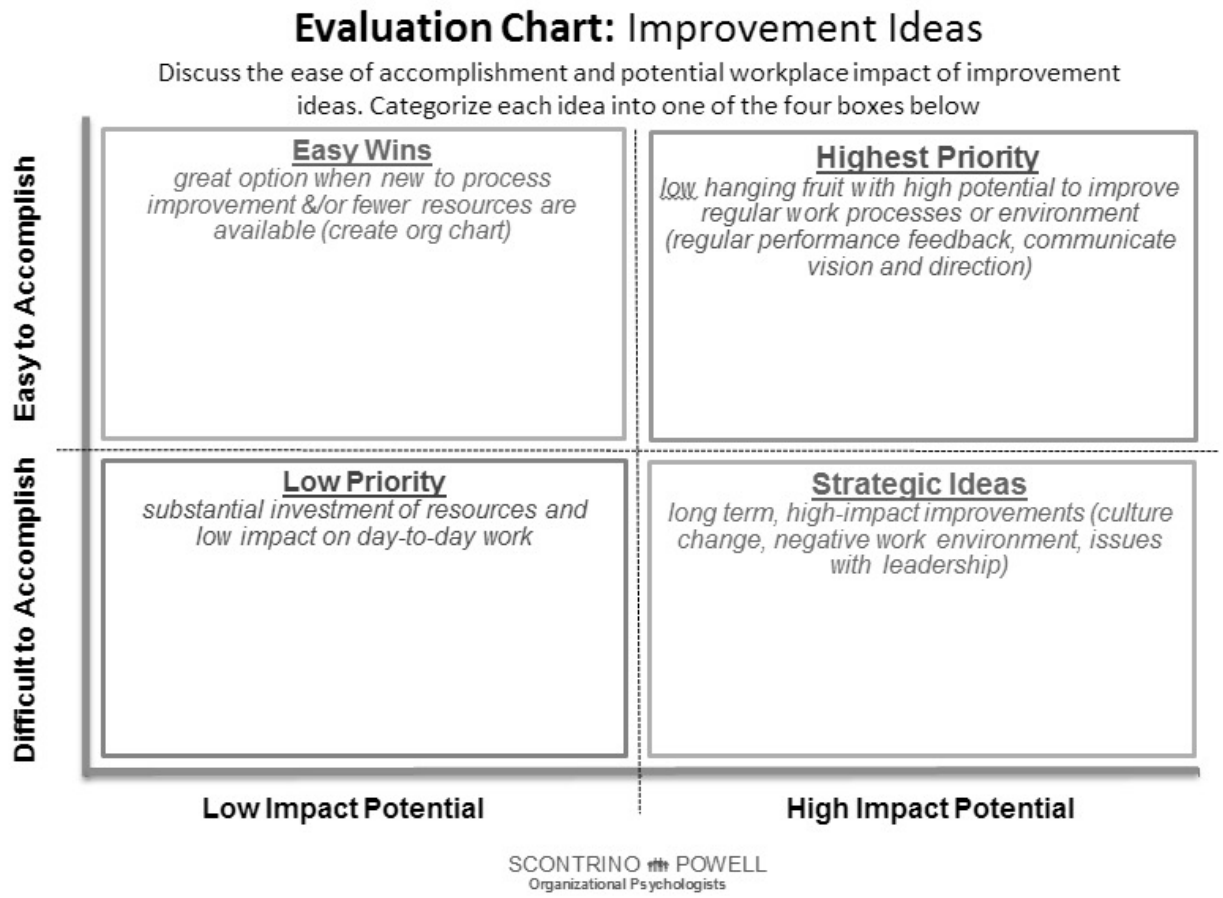
Proposed Opioid Use Disorder Cascade of Care (Theoretical)



Change Idea Evaluation Chart