Opioid Potentially Better Practices:

Rationale, Evidence, and Implementation Advice

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IMPROVE THE PATIENT EXPERIENCE

Establish a multidisciplinary quality improvement team and consider including a patient with lived experience

Rationale

"Those who do the work change the work."

Involving care team members on a quality improvement team allows the care team to own the work. Care team members are an important source of solutions as they are experts in their own workflow. Bringing in members from all areas of the care team allows for the most effective decision making because everyone brings their perspective to the table.[1] Care teams who work effectively together are better able to implement improvements to patient care. Research shows that care teams with greater cohesiveness are associated with better clinical outcome measures, lower burnout, and higher patient satisfaction.[2–5]

For optimal care to occur, both patients and clinicians need to be involved.[6] Patients and their families bring personal knowledge on their life circumstances and preferences, while clinicians offer guidance and advice on treatment and intervention options. Patient-centered care occurs when clinicians engage patients in a way that builds trust, motivation, and confidence.

> This potentially better practice entails true engagement of patients as advisors or participants on quality improvement teams. Persons with lived experience can be a patient or a family member of a patient.[7] Alberta care teams who have implemented practice changes and engaged patients on their care teams have reported stronger patient-centered processes that are more beneficial for patients because they are based on actual, lived experience. [8]

"Those who do the work change the work."

Implementation advice

1. **Form an improvement team**[9]

- Ensure cross-sectional representation of clinic roles.
- Ensure that you have someone with decision making authority on the care team (e.g., physician champion and office manager).
- Ensure that you include someone with quality improvement facilitation skills.
- Consider including an external stakeholder (e.g., a patient or family member of a patient).

2. **Engage individuals with lived experience**[7]

- Assume patients are the experts on their own experience and that they have information you need to hear and act on.
- Know that families are primary partners in a patient's experience and health.

Things to consider include:

- How can we ensure a safe and welcoming environment for all patients?
- What matters most to patients when seeking help for opioid use?
- How can we use patient experience to build community and improve our processes?

Test and implement a patient-centred care planning approach

Rationale

Care planning[1] is defined as "the *process* by which healthcare professionals and patients discuss, agree upon, and review an action plan to achieve the goals or behavior change of most relevance and concern to the patient."[6] Care planning is usually done to improve patient self-management, communication, and coordination between multiple healthcare providers[2] involved in the longitudinal care of patients with complex health needs. A patient centered approach to primary care may positively affect patient satisfaction and activation, and perceived quality of care.[10–12] Emerging evidence indicates a patient centered approach where treatment preferences are taken into account results in a reduction in substance use.[13]

An Alberta based initiative called Patients Collaborating with Teams (PaCT) found implementing care planning and use of a patient-centred care plan template helped care teams transform their processes and strengthen their relationships with patients to enable improved relational, informational, and management continuity of care.[14–16]

Patients presenting with chronic pain, currently using opioids, or with opioid use disorder (OUD) should be approached from a lens of complexity – through a biopsychosocial-spiritual approach — as comorbidity and social determinants of health are frequently implicated;[17] Social factors such as the ability to afford medications, access transportation, and manage competing priorities are known to significantly impact health outcomes.

[1] Not limited to the annual Complex Care Plan (CCP; 03.04J billing code)

[2] Not limited to coordination between health care providers within a clinic, PCN, community health services, specialty services, and tertiary care

Addressing and documenting social history in the care plan is critical if we hope to improve outcomes, reduce overall costs, and improve patient satisfaction. Although providers may not be able to alleviate all issues, demonstrating empathy and concern shown can strengthen the therapeutic alliance.[18] Evidence shows that a shared decision making approach results in the strongest outcomes for patients with mental health conditions and patients requiring long-term care of chronic health conditions.[13,19]

Implementation advice

Use a standard care plan template to document biopsychosocial-spiritual factors to enable whole-person care

To get to know a patient and what is going on in their world, it can be helpful to inquire about some of the social aspects of their life. It is common that the social factors in a patient's life may be the root cause of why the patient may or may not be following health recommendations, such as a lack of financial means to purchase their medication, or uncertainty of how they may get to their next follow-up appointment.

Patient-centred interactions

Knowing at times it can be uncomfortable for providers to know how to uncover patient struggles and for patients to open up and share aspects of their life, it can be helpful to apply these four practice principles:

First ask, then offer | Wait for 8 | Invite the client to write | Trial and error

Create a culture that allows for open conversation about opioids

Rationale

Culture is an important aspect of clinical care as it affects how clinics operate and contributes to the overall safety and health outcomes of patients.[20] Culture can be defined as "norms, values, and basic assumptions of a given organization".[21] Culture affects both the behaviour of people who work in the clinic and the patients who access services.[22]

Opioids may be a sensitive topic for both patients and providers because it is often associated with stigma.[23–28] Creating an open culture that encourages discussion of opioids can help to improve patients' experiences. An important first step in creating a culture open to the realities of substance use and harm reduction is to ensure that all care team members are on the same page in their knowledge, beliefs, and attitudes. Evidence shows

that two major barriers to primary care treatment of chronic pain and opioid use disorder are knowledge and confidence gaps in the field of addiction, and a lack of belief in opioid agonist therapy.[29–40]

Language used to discuss opioids matters, may have an effect on how willing patients are to discuss opioids. Teams should be cognizant of their verbal conversations (e.g., scheduling an appointment, having a discussion with the patient) and written text (e.g., EMR documentation, posters on the clinic walls, or a patient handout). Changing the language used to describe people with opioid use disorder[41,42] and using harm reduction strategies can reduce stigma.

Research has shown that the vast majority of individuals who experience problems with opioid misuse have current or past experiences of trauma and violence. North American evidence has shown that at least 60% of primary care patients reported at least one adverse childhood experience.[43] This demonstrates how common trauma experiences are and the importance of adopting a trauma-informed practice.[44,45]

Implementation advice

Conversations within clinic team:

1. Using the Guiding Principles, have a conversation with your care team to increase awareness of the magnitude of the opioid crisis. Discuss the role of primary care in addressing the opioid crisis, review patient panel data, and/or MD snapshot report.
2. As a team, facilitate the Team Behaviours Assessment tool to identify areas of strength and opportunities for improvement.
3. Facilitate a discussion about trauma informed practice (TIP) and decide as a care team how to incorporate TIP principles.
4. Test and implement harm reduction language changes used to describe patient use of opioids, illicit substance use, and/or opioid use disorder (OUD).

Conversations between clinic team members and patients:

1. Test and implement patient-centred scripting to support conversations that focus on harm reduction and safety.
2. Use posters and print materials to engage patients and invite a conversation about opioids.

IDENTIFY PANELED PATIENTS FOR CARE IMPROVEMENTS

Generate lists of patients using prescribed opioids
Generate lists of patients using illicit opioids

Rationale

A panel lists the unique patients that have an established relationship with a primary care provider and where there is an explicit agreement that the identified primary care provider will provide primary care services to the patient. This two-way relationship is a key enabler for relational continuity.

Once a primary care provider's panel is identified, processes must be put in place to maintain the list as patients may come and go. Active panel maintenance allows for panel management, which is a fundamental element of high-performing primary care; panel management has been associated with improved quality and care process outcomes.[46–50] Panel management has been shown to be an important first step in the adoption of clinical practice guidelines to improve quality of care (as demonstrated by the Alberta Screening and Prevention Initiative).[51] Once panel processes are in place, it enables teams to establish lists in the EMR, which is one of the foundations of organized evidence-based care.[52]

Being able to actively identify and manage patients who are prescribed an opioid is important given the prevalence and complex care needs of this population. Using the EMR as a clinical decision support can be a powerful tool to help automate care processes, like flagging patients for increased monitoring or automating follow-up reminders.

Implementation advice

1. In order to identify and maintain accurate panel lists, teams should work through the STEP Checklist and establish a process for checking panel confirmation rates. The confirmation rate should be used in the clinic for improvement.
2. Use the maintained panel to generate lists so that patients who are prescribed an opioid may be quickly identified in the EMR.
3. Consider testing some changes from the continuity change package to improve relational continuity. For example, review the HQCA Primary Healthcare Panel Report and track your clinic teams' continuity[3]
4. Consider uploading panel data to CII/CPAR to better understand your patient population. Consider how the confirmation rate will reflect in the CPAR panel conflict reports. Work with your care team to reduce the total number of patients on this conflict report.

[3] Individual physicians can request their panel report from Health Quality Council of Alberta (HQCA) and are encouraged to share with their team for improvement purposes. Measures to support continuity are found in these reports as well as more data that provide insights into panel behaviours and characteristics to aid in all areas of improvement.

OPTIMIZE CARE MANAGEMENT AND PRESCRIBING

Assess the risk of opioid misuse for patients before initiating opioid therapy

Rationale

Some of the risks associated with prescribing opioids include developing opioid use disorder (OUD), poisoning, overdose, impaired function, injuries or diverting medication to others.[53] Risk factors associated with these adverse effects include personal or family history of substance abuse, younger age, history of sexual abuse, mental health diagnosis, or co-prescription of certain psychiatric medications.[17] A personal history of abuse of illicit drugs or alcohol remains the strongest predictor of opioid misuse.[54] There is evidence that the risk of developing these adverse effects may outweigh the benefit of prescribing opioids.[54] Therefore, assessment of risk is recommended prior to prescribing opioids.

Many tools exist to aid in risk assessment, however, none have been shown to reliably stratify patients into predictable risk categories (i.e., low vs high risk) for prediction of aberrant behaviours.[54] Despite the lack of evidence for risk stratification, assessing risk of opioid misuse is an important component of a comprehensive assessment for any patient being considered for pain management therapy.[55,56] Patients at risk may require alternate treatment options (e.g., non-pharmacological), or approaches (e.g., collaborative care planning with multidisciplinary care team).[54]

Implementation advice

The Opioid Risk Tool [57] is one assessment tool that has been used in primary care. The tool assesses for most of the known risk factors associated with opioid misuse. Existing studies do not provide definitive evidence for the scoring scheme of the tool. Some practical considerations on how to use the Opioid Risk Tool are offered:

- Opt for clinician-administered rather than patient self-administered.
- Adopt a standardized method of documenting risk assessments.
- Rather than using the scoring scheme for risk stratification, use it to help structure the conversation around risk and/or case finding to rule in further assessment.

Additional screening tools (as recommended by CPSA[53]) that may be used prior to initiating opioids include the CAGE Substance Abuse Screening Tool, the Drug Abuse Screening Test, and the Alcohol Use Disorders Identification Test (AUDIT).

Engage patients in a conversation about the benefits, adverse effects and risks prior to prescribing opioids

Rationale

Some risks associated with prescribing opioids include developing opioid use disorder (OUD), poisoning, overdose, impaired function, injuries or diverting medication to others.[53] In light of the limited evidence of the benefits of opioids for chronic pain treatment, it is very important for patients to be informed of all risks and benefits prior to initiating opioid therapy.[54–56,58]

Many licensing boards (e.g., College of Physicians and Surgeons of Alberta) and clinical practice guidelines recommend opioid contracts or agreements as part of opioid prescribing to mitigate risk, however, the evidence is lacking for effectiveness of opioid contracts.

Adopting a standardized practice to discuss and document the risks and benefits of using an opioid with all patients is a good safety precaution. It may help prevent future confusion, conflict, and unintentional stigmatization of individual patients. Engaging patients in shared decision making – taking into account their values and preferences – is a critical pillar of evidence-based medicine.[59] To support patients to make informed decisions and be actively involved in their own care, documentation should be accessible, and written using plain language (6-7th grade reading level). When implemented collaboratively, shared decision making reinforces relational continuity and trust between care team members and patients.[54,60]

Implementation advice

Rather than a contract or agreement, which may be perceived as coercive[61], a conversation checklist[62] (such as that recommended in the Opioid Change Package) can be used to help frame discussions around practical arrangements and your practice's prescribing policies, including:

- Who oversees the prescribing of the patient's opioid
- How follow up visits will be organized
- Who the patient should contact with concerns that arise outside of clinic hours

Establish a process where Netcare is reviewed prior to prescribing opioids

Rationale

Netcare is an integrated, province-wide electronic health record in Alberta that is accessible by healthcare providers across the healthcare system. One of the benefits of Netcare is that it shows all medications dispensed at a community pharmacy to a patient, which helps prevent prescription duplications, adverse drug interactions, and the identification of possible opioid misuse or diversion. The College of Physicians and Surgeons of Alberta has outlined a Standard of Practice for prescribing drugs associated with substance use disorders or substance-related harm, stating that prior to prescribing an opioid a physician

should gather a medication history and review dispended medications in Netcare. This standard applies to initiating a new prescription, renewing a prescription initiated by another prescriber and at minimum every three months if the opioid prescription is for long-term treatment.[53] The process of reviewing Netcare prior to prescribing opioids is a way to enhance safety and reduce the likelihood of opioid diversion, overdose, and addiction.[63]

To maximize efficiency, this potentially better practice requires coordination and preparation of the care team prior to patients presenting for their appointments. Research shows that team-based care results in improved quality and outcomes of care and enables successful implementation of primary care innovations.[3,50,64–66]

Implementation advice

Preparing for visits ahead of time with the care team can help to ensure that all documents and tools are ready and available at the point-of-care in the EMR. Ensure that the entire care team has access to the EMR and assign a team member to populate the care plan template by routinely and systematically pulling relevant data from the EMR and Netcare: medications, screening, lab results, diagnostics, other MD visits, and any relevant assessments (review with primary care provider).

Create a current state process map for appointments where opioids are prescribed or renewed. Consider starting from when the appointment is scheduled. Review the current state map as a team and discuss the following:

- Where are the current bottlenecks?
- Where is work being duplicated?
- What work can be standardized?
- Does each step add value? If not, can it be eliminated?
- Are all team members working to their full scope?
- At which stage in the process is Netcare currently being reviewed?

Consider a future state process map and discuss:

- When should the Netcare profile be reviewed?
- Who (other than the primary care provider) could help facilitate this process?

Reassess patients taking opioids for changes in function, pain, side effects, and mental health

Rationale

In Canada, the prevalence of patients using prescription opioids is estimated to be 13%,[67] which makes it highly likely that a practice will have patients on their panel who require reassessment. In 2017/18, 88.6%[68] of patients with at least one opioid prescription were paneled to a primary care practice that was a member of a Primary Care Network. The CPSA Standard of Practice provides the following reassessment schedule:

- At minimum, reassess the patient within four weeks of initiating long-term opioid therapy and every three months thereafter; document function and pain at each reassessment and continue to prescribe only if there is measureable improvement that outweighs the risk.
- At minimum, review Netcare every three months when the prescription is for the long-term treatment of a patient. (See PBP: Establish a process.)[53]

Additionally, the CPSA Advice to the Profession recommends that when initiating any opioid prescription for longer than seven days, complete a reassessment within 7-10 days.[53]

While powerful medication for pain, there are many side effects that opioids have such as sleep disturbance, mental fog, constipation, and addiction. The seriousness of the side effects warrants greater monitoring of treatment response, including changes in pain, function, side effects, and mental health status.

Patients receiving opioid therapy for chronic pain often cite pain relief as the most important treatment goal, however, those who develop adverse outcomes cite greater importance to avoidance of adverse outcomes, while providers may prefer to reframe treatment goals around improved function and quality of life; all of these are important factors to consider and discuss with patients.

Establishing regular reassessment schedules for patients taking opioids may mitigate the risk of developing opioid use disorder. One large study using administrative data found that each refill and additional week of opioid prescription was associated with a 44% increase in opioid misuse among opioid naive patients post-surgery.[69] These findings suggest that proactive or early reassessment of opioid use and pain management may mitigate future risks of harm.

Specific population segments to consider for reassessment are:

- Patients on long-term opioid therapy to ensure opioid therapy is not causing increased pain
- “Inherited” patients to ensure there is alignment between the patient and the new provider with clearly defined and documented goals of therapy
- Post-surgical patients including both planned and unplanned surgeries

Implementation advice:

1. Incorporate proactive reassessment into the care plan when initiating opioid therapy; collaborate with patient to create functional goals for treatment and revisit them regularly (some reassessment tools include the Brief Pain Inventory and mental health assessments (e.g. PHQ9, GAD7, ACEs).
2. Optimize the EMR to set up reminders for reassessment.
3. In the context of shared decision making, use assessment of function, pain, side effects, and mental health to inform the decision between continuing or discontinuing opioid therapy.

Improved functional outcomes can include the following:[70]

- Return to work and/or work retention
- Social functioning
- Physical functioning
- Mood and mental health

Preparing for reassessment visits ahead of time with the care team can help to ensure that all documents and tools are ready and available at the point-of-care in the EMR. Ensure that the entire care team has access to the EMR and assign a team member to:

- Populate the care plan template by routinely and systematically pulling relevant data from the EMR and Netcare: medications, screening, lab results, diagnostics, other MD visits, and any relevant assessments.
- Generate any required lab and diagnostic imaging requisitions in advance of the encounter and review with the primary care provider.
- Prepare relevant resources (e.g., community resources and program information) in advance of patient encounter.
- Identify and have appropriate assessment tools ready to use.
- Send assessment tools and requisitions to patient in advance of encounter if appropriate.

Assess patients for opioid use disorder (OUD)

Rationale

Opioid Use Disorder (OUD) has been characterized as a "chronic, relapsing condition that requires long-term chronic disease management."[71] It is estimated that 5.5%[54] of patients using opioids will develop OUD. Recent evidence suggests that OUD is best managed in primary care using evidence-based harm reduction approaches.[72] People experiencing OUD are at increased risk of overdose and death, however, there are many barriers to care such as not being attached to a primary care provider, geography, stigma, and misinformation on harm reduction. Given the adverse outcomes that can result from OUD, this potentially better practice advocates for routinely assessing patients using opioids for possible OUD rather than waiting until the patient develops negative impacts from OUD.[72] With the proper diagnosis, care teams can better coordinate their efforts to offer support to patients that meets their health needs.

Implementation advice

Assess all patients taking an opioid for OUD using a validated tool

The PEER Simplified Guideline for Managing OUD recommends using the Prescription Opioid Misuse Index (POMI) in primary care if assistance is required in identifying patients with chronic pain who might have OUD.[72] Once identified, patients with OUD can be offered Opioid Agonist Therapy (OAT), an evidence-based treatment shown to mitigate the risk of overdose and death.

Assess patient readiness to change

According to the transtheoretical model of change, people must pass through specific stages before they become ready to make a personal change.[73] Optimizing the offer of care involves offering treatment to a patient who is ready to change. Patients who are not ready to change would benefit from other harm reduction approaches to enhance self-efficacy and motivation, and re-offered care at a later time.[74–76] This approach is also aligned with the harm reduction model, as recovery should not be expected to be linear; a patient's readiness may revert to previous stages if a relapse occurs. A useful framework for assessing readiness for change is ask RICk (readiness, importance, confidence, knowledge.

STANDARDIZE DOCUMENTATION

Record all opioid prescriptions in the EMR

Record illicit opioid use in the EMR

Rationale

With established panel processes in place, care teams can leverage their EMR data to proactively manage populations (or panel segments). This benefits practices by enabling:

- Lists of patients that can be generated to identify people who could benefit from specific care[4]
- Planned care and automatic reminders, i.e., follow up visits for care planning
- More productive opportunistic encounters by having pertinent patient information at the point-of-care
- Clean and accurate lists to provide insightful data for quality improvement

Implementing process improvements for opioid care may be more manageable if practices start with a small group of patients to test the impact of change. Segmenting the panel starts with defining key criteria that is searchable in the EMR. Two key populations to start with are patients currently prescribed any opioid medication and patients using illicit opioids (i.e., non-prescription).

Primary care practices may not currently know of any patients using illicit opioids. However, there is a missed opportunity to identify at-risk patients and offer them the appropriate care (e.g., offer of opioid agonist therapy or Naloxone kits) if it is not documented.

[4] Implementing any of the potentially better practices in the 'Optimizing care management and prescribing' section of the Opioid Change Package will be facilitated by optimizing the EMR

Implementation advice

When implementing this potentially better practice, it is recommended that teams document opioid prescriptions in the EMR prescription module. Opioid prescriptions can also be scanned into the patient chart and searched when a standardized keyword is used. It is also important to document illicit opioid use in a standardized way such as in the social history section of the EMR. This could be done when the provider asks about other substance use such as tobacco, alcohol and cannabis. By weaving the question in with other substances it can be less stigmatizing for patients.

To start identifying patients who are currently prescribed an opioid, the team can:

1. Use the CPSA MD Snapshot (with primary care provider permission). Patients included in this report may not be panelled patients so it is important to confirm attachment prior to adding.
2. Review the triplicate pad.
3. Review existing documentation practices and see if searches can be generated from those locations (i.e., EMR fields such as: History, Profile, Risks).

Record offers of Opioid Agonist Therapy (OAT) in the EMR

Rationale

Once identified, patients with Opioid Use Disorder (OUD) can be offered Opioid Agonist Therapy (OAT), an evidence-based harm reduction treatment shown to mitigate the risk of overdose and death (see PBP: Assess for OUD). Patients with OUD face many challenges to initiating and adhering to OAT treatment, such as mental health diagnoses and comorbid substance use disorders and psychosocial challenges. There is strong evidence that patients with complexity benefit from having a continuous relationship and care plan with a primary care provider. Establishing this relationship of trust with high needs patients may require significant shifts in how care is offered. To test these new approaches, documenting offers of care will help care teams understand if the changes they are making are leading to improvement.

Process measures, like number of offers of care, are more than simply counting number of patients on OAT. Offers of care is a process measure that can highlight whether there is a gap between the offer and the initiation of a clinical intervention; it helps care teams identify what improvements the team needs to make to increase the likelihood of the offer of care being successful. Given the complex nature of OUD, it is likely that there may be multiple encounters and offers of care before a patient decides to make a change, like initiating OAT. Measuring offers of care will help teams understand where process improvements can be made, as both provider behaviours (e.g., patient centeredness) and patient behaviours (e.g., readiness to change) affect the outcome of an offer of OAT.

Implementation advice

Despite the benefits to improving quality of patient care, most EMRs do not include specific functionality for documenting "offers." To support quality improvement and optimize patient care, there are ways that the EMR can be used to automate the tracking of offers of care to enable relational and informational continuity and organized evidence-based care.[77] The Opioid EMR Guides provides specific instructions on how to create manual lab entries to track offers of care.

COORDINATE CARE IN THE MEDICAL HOME

Establish clear roles and responsibilities and a shared mental model for opioid processes amongst your medical home team

Rationale

Patients who experience challenges with their opioid use often benefit from the care of a multidisciplinary team.[78] In the patient's medical home (PMH) model, care is provided by a variety of team members (e.g., nurses, pharmacists, mental health consultants, kinesiologists, dietitians, etc.) both within and outside of the PMH. While having access to multidisciplinary team members is important, true team-based care is achieved when multidisciplinary team members collaborate in their efforts. This requires a shift in mental model[5] from a 'primary care provider-centric' referral approach to a collaborative 'team based' approach to provide optimal patient-centered care.[79] When mental models are misaligned, team effectiveness can be significantly reduced.

A high functioning PMH team is one where all members have a shared mental model, and are able to appropriately distribute the workload amongst the various roles. These teams exhibit higher levels of satisfaction, experience less burnout, and achieve a higher quality of care.[2,4,5,80] Research shows that team based care results in improved quality and outcomes of care and enables successful implementation of primary care innovations.[3,64–66] The stronger the teamwork among the patient's providers, the better the outcomes. After investing in team development, studies reported improved patient outcomes, and improved team processes and morale.[2,4,5,80] To implement team-based care, team members must distribute the workload. This then enables patients to experience better access to care, team members to work to the full scope of their practice, which is more challenging and rewarding, and primary care providers have time to see the more complex patients.

[5] A mental model is more than a set of beliefs and values. Mental models determine what we pay attention to, what options and possibilities we consider, and how we make sense of events and experiences, solve problems, formulate judgments, and ultimately make decisions and act (Wagner, Austin, Toon, Barber & Green, 2019).[79]

Implementation advice

1. Assess the functioning of your team using the team assessment.
    - A Practice Facilitator can help your team by providing constructive feedback, facilitating a discussion with your team, and suggesting improvement ideas.
2. Review your process map and team roles and responsibilities.
    - Can you identify opportunities for optimizing team members' roles?
    - Are there times when team members other than primary care providers could complete the task?
    - Try to balance the workload so no one is overloaded.
    - Identify areas in the clinic that rely on a single person and consider cross-training so there is always a backup person that can help.
    - Talk to patients about the value of having a team provide their care.
3. Try a clinic 'touch point' or 'huddle.'
    - Clinics are typically busy places and days rarely go as planned.
    - It's a chance to talk and coordinate things among team members on a regular basis.
    - Once or twice per day can help to ensure an efficient clinic day with fewer surprises.
    - Huddles can help teams provide proactive patient care because the team can quickly plan a strategy

COORDINATE CARE IN THE HEALTH NEIGHBOURHOOD

Establish processes for coordinating care of paneled patients using opioids (e.g., specialty and community services, pain, mental health) within your community and zone

Rationale

Patients who take opioids often require a complex management approach and support provided from both the Patient's Medical Home and resources within the Health Neighbourhood (e.g., mental health services, pain specialists, social supports etc.). Coordinating care from the Patient's Medical Home to the health neighbourhood has been shown to positively impact quality of care, increased patient satisfaction, and improve access to care. A recent systematic review found that multidisciplinary and coordinated care delivery models are an effective strategy to implement treatment and improve access for opioid use disorder.[78,81–83]

- Establishing processes for care coordination increases informational and management continuity, and results in less fragmented care.

- Untapped resources outside of the Patient's Medical Home likely exist, and may be facilitated by reaching out to partners within the community.
- Helping patients engage with community resources supports a biopsychosocial-spiritual approach.

Implementation advice

Consider who else is involved in the patient's care outside of the Patient's Medical Home team. The Patient's Medical Home team includes all inter-professionals who work together within the medical home for the benefit of the patient. Invite Alberta Health Service specialty programs, specialists, and community resources to share relevant information.

Coordinate care

- Assign a dedicated team member to follow-up on actionable items. Teams may consider identifying someone dedicated to complete referrals (e.g., a "referral royalty").
- Follow-up on referrals (referral sent, referral received, visit scheduled, visit happened, report generated, report received).
- Have processes in place to share the care plan and updates on information in the care plan with others involved in the care that are outside of the Patient's Medical Home walls. (
- When possible, introduce care team members that will be involved in the patient's care using a warm-hand off.
- Give updates to the primary care provider during scheduled review of patients or as needed.
- Have an updated inventory of community resources available at the practice (use the 'Who Can Help' framework as a template).
- Evaluate patient and care team satisfaction with community resources and referrals.
- Have care team meetings to discuss the evidence on effectiveness of OAT, access to addiction expertise through telehealth, mentored prescribing, and coordination with local experts in addiction.

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