Spotlight: How Patients Access OAT in Primary Care

Anyone taking opioids is at risk of developing Opioid Use Disorder (OUD).

The spectrum of care for patients with OUD includes opioid agonist therapy (OAT), which involves medications such as buprenorphine/naloxone or methadone. In Alberta, specialty programs or clinics offering OAT include the Alberta Virtual Opioid Dependency Program (VODP), Alberta Health Services Addiction and Mental Health Opioid Dependency Programs (ODPs) and independent providers. Patients may also be able to access OAT through the Buprenorphine/Naloxone Initiation in Emergency Departments Program developed through the Emergency Strategic Clinical Network. This program initiates OAT for patients in emergency departments/ urgent care centres with the intention to then refer the patient to specialty care or primary care clinics.

While OAT has typically been delivered outside of primary care, there is increasing evidence that patients may experience better outcomes and stay on OAT treatment if it's delivered within primary care.[1] Through the Primary Health Care Opioid Response Initiative (PHC ORI), there has been increased efforts across the province to train primary care providers to offer appropriate treatment, medication and care to patients and families affected by the opioid crisis. This includes improving access to OAT within primary care, especially buprenorphine/naloxone, and enhancing system integration and coordination of care to transition patients using opioids, including those with OUD, from specialty care back to primary care.

While the full impact of this work is yet to be realized, several individuals involved in transitions work shared their experiences and lessons learned.

Approaches to facilitate transition of patients between specialty care and primary care

The following approaches were identified as improving access to OAT within primary care and enhancing coordination of care between primary care and specialty care for individuals using opioids, including those with OUD;

Development of care pathways: Care pathways depict the recommended steps and processes to establish a care treatment plan for a specific group of patients. Specific pathways relating to transitions in care between health-care providers and/or location include: ODP to Primary Care transitions, and Primary Care to ODP transitions. These care pathways identify the roles and responsibilities of the specialty care provider, the patient and primary care provider. Other care pathways (also referred to as frameworks, flow charts, algorithms, etc.) were developed to provide the guiding steps needed to build the confidence of physicians to initiate buprenorphine/naloxone within primary care.

Change management and/or support roles: Designated liaison or facilitator-type roles were used to help transition patients moving between primary care and other parts of the system by acting as a connection point between the two parts of the system (e.g. VODP or local ODP clinics and primary care). From those that shared their experiences, the roles were funded by the PHC ORI grant or by other parts of the system (e.g. within VOPD). By developing local relationships, these roles acted as the primary contact between the two service delivery partners, communicating and advising on processes to refer and repatriate patients back to primary care and assisting with the implementation of pathways (where applicable). For example, the ODP clinic would provide a list of providers whose patients were currently in the ODP program. The liaison/facilitator would be responsible for working with their primary care providers to repatriate these patients back into primary care.

Building relationships/connections with local ODP programs/clinics: Primary care sites may have also developed connections and processes with local ODP programs/clinics or other areas of the health care system that offer OAT to refer/repatriate patients who are accessing OAT. For example, in one particular case, the primary care site sent letters to surrounding ODP clinics and other OAT prescribers to inform that the primary care was willing and able to support patients using OAT.

[1]Korownyk C, Perry D, Ton J, et al. Managing opioid use disorder in primary care: PEER simplified guideline [published correction appears in Can Fam Physician. 2019 Oct;65(10):687]. Can Fam Physician. 2019;65(5):321–330

What made for some successful transitions?

Individuals who shared their experiences in transitions in care activities provided the following pieces of advice that proved successful to their roles:

- When developing care pathways, ensure there is representation from across the health care spectrum, including individuals with lived experiences who can provide insight into the patient journey
- Make tools and resources easy to use and access for primary care providers (e.g., the Prescription Opioid Misuse Index or 'POMI' tool is useful for identifying patients)
- Communication is essential, particularly between primary care providers and patients. For example, care pathways should include confirmation of primary care provider and admit notification where applicable
- Patients should be seen as partners in transitions and made aware of their roles and responsibilities
- Take time to build trusting relationships between health care service delivery partners
- The work needs to be seen as a priority for all those involved
- A respectful and flexible approach may be required to facilitate the internal process required to transition patients between service delivery partners and to address the concerns of primary care physicians in receiving patients back
- Ensure primary care physicians feel adequately supported and either have the capacity to provide OAT or know how to access supports

> *"In one weekend, we had 3 young women die [in our community] leaving 5 children basically orphans… that was a wakeup call to all of us in our [primary care] practice and so we said we need to get on board and start looking at Suboxone™."* (Primary care provider)

What were some of the biggest challenges encountered in this work?

Individuals who shared their experiences regarding their involvement in transitions in care work reflected on the following challenges of their work:

- Timing needs to be coordinated to ensure all health service delivery partners mobilize at the same time
- Electronic systems are not set up to support information sharing among providers
- There are currently no standardized processes to connect unattached patients to a regular primary care provider
- Finding providers willing to accept unattached patients is a challenge
- Some patients are very mobile which can make it difficult to track where they are and when they enter different parts of the health care system, especially when they move between different cities or zones.
- Some patients lack a social support/network or someone who can act as an advocate and help them navigate their patient journey
- Patients require social supports in addition to pharmacologic treatments

What does this change mean for patients?

Evidence suggests that patients may experience better outcomes and have better retention to treatment if OAT is delivered within primary care.[2] Based on the experiences of those involved in transitions work, improving access to OAT within primary care and enhancing coordination of care between primary care and specialty care strengthens the long-term relationships primary care providers have with their patients. Having a trusted relationship with a primary care provider, as well as the extended supports of a Patient Medical Home, can be powerful for patients. Individuals who shared their experiences reported that patients who are able to remain in primary care and still have access to OAT may face less stigma from a primary care provider they know and trust. In many cases, remaining at their primary care clinic would mean patients do not have to travel to different clinics or sites to access OAT. Health outcomes and experiences may be improved by accessing OAT in primary care where providers have established trust through a prolonged patient/provider relationship and the patient's medical history is well known and understood.

More information about the PHC ORI and for additional tools and resources visit:
https://actt.albertadoctors.org/PMH/organized-evidence-based-care/Opioid/Pages/default.aspx

[2] *Korownyk C, Perry D, Ton J, et al. Managing opioid use disorder in primary care: PEER simplified guideline [published correction appears in Can Fam Physician. 2019 Oct;65(10):687]. Can Fam Physician. 2019;65(5):321–330*